

What Is your Diagnosis?

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A 28 year old female presented with dyspepsia for three weeks duration. The patient underwent upper endoscopy which indicated a broad base white cap polypoid lesion that measured 8 x 8 mm, incidentally seen in the proximal third of the esophagus (Figure 1).

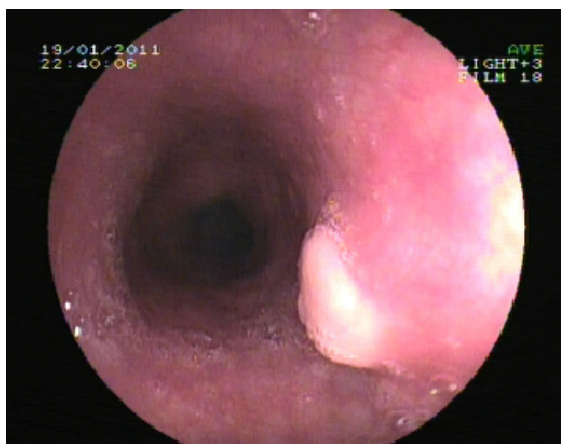


Fig. 1: Upper endoscopy showing broad base white cap polyp in the proximal esophagus.

Biopsy was performed. The pathology specimen showed proliferation of slightly ovoid cells with abundant eosinophilic granular cytoplasm separated by collagenous septae into distinct nests (Figure 2).

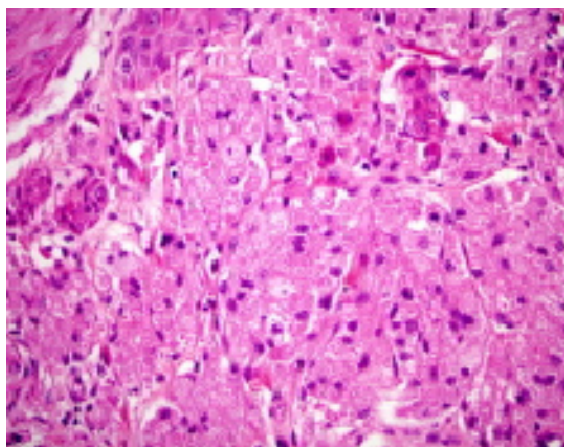


Fig. 2: Hematoxylin and eosin staining showing proliferation of slightly ovoid cells with abundant eosinophilic granular cytoplasm separated by collagenous septae into distinct nests.

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Immunohistochemical staining was positive for S-100 protein (Figure 3) and vimentin, and negative for smooth muscle actin and cytokeratin.



Fig. 3: S-100 immunohistochemical staining.

Diagnosis: Granular Cell tumor of the esophagus

These findings were consistent with granular cell tumor (GCT).

Differential diagnosis of benign esophageal raised lesions in endoscopy may include: GCT, squamous papilloma, inflammatory fibroid polyp, leiomyoma, lipoma and fibrovascular polyp.

GCTs are seen in many organs such as the tongue, breast, skin and GI tract. Only 10% of GCTs are located in the GI tract, most commonly in the esophagus.^{1,2}

Nevertheless, GCTs of the esophagus are rare and endoscopic incidence is about 0.03%, constituting 1% of all benign esophageal tumors. Only 15% of esophageal GCTs are located in the proximal esophagus and more than 50% are asymptomatic.¹ The vast majority of esophageal GCTs are benign, with only three reported cases of malignant esophageal GCTs.³

Treatment is mainly endoscopic³, however as long as the patient is asymptomatic treatment may not be needed.²

CONFLICT OF INTEREST

The authors declare no conflict of interest related to this work.

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