The Journal of Laryngology and Otology
May 1996, Vol. **110**, pp. 480–482

Giant hamartoma of the oropharynx

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Abstract
Giant polypoidal hamartomas of the pharynx and oesophagus are rare benign tumours of unknown origin, exceptionally arising from the oropharynx. We report the case of a 74-year-old man who developed sudden nausea and a foreign body sensation. Shortly afterwards he regurgitated a 25 × 3 × 1.5 cm pedunculated fleshy mass, still attached to the inside of his throat. The patient was anaesthetised, the mass traced to the right tonsillar fossa and adjacent oropharyngeal wall. The pedicle was clamped and the lesion excised. Histology was consistent with a giant oropharyngeal hamartoma. We discuss the pathogenesis and potential complications of this condition. The literature is reviewed.

Key words: Oropharynx; Hamartoma

Introduction

In 1904, Albrecht introduced the term hamartoma to describe a tumour-like malformation composed of tissue elements indigenous to the organ in which they arise. Walter and Israel (1987) describe hamartoma as a local development error in which tissues are unstructured with an excess of one or more of the components. It differs from the teratoma in that it is not foreign to surrounding tissues and it has no tendency towards excessive growth. In our patient this was not the case. Pedunculated polyps of the pharynx and oesophagus have long been known. Arrowsmith in 1847 is cited by Fuller (1963) as having reported a man with a two inch long pedunculated polyp attached to the posterior wall of the upper end of the oesophagus. Many polypoidal lesions have since been described, most of them (90 per cent) in the upper oesophagus (Siddins and Cade, 1991).

Stout and Lattes (1957), based on the histopathological findings of benign non-keratinizing squamous epithelium lining the surface and predominant fibrous and vascular elements in the submucosa, recommended the term fibrovascular polyp, but many others have been used. Based on Stout's classification, Jang *et al.* (1969) reported 53 cases with the characteristic radiological findings of an intraluminal mass, free passage of barium around the tumour and absence of a shelf or asymmetrical narrowing of the lumen. The presence of a stalk confirms the diagnosis and computerized tomography (CT) scan will usually reveal the site of attachment (Walters and Coral, 1988).

Hamartomas are benign tumours found in any organ, though they are rare in the pharynx (Patterson *et al.*, 1981). The uncomplicated regurgitation of a giant hamartoma arising from the palatine tonsil in a previously healthy patient is an extremely unusual finding.

Case report

A previously healthy 74-year-old male was watching television when he suddenly felt nauseated, experienced a sensation of foreign body in his throat and regurgitated a 25 × 3 × 1.5 cm pedunculated fleshy mass (Figure 1). This remained attached to the inside of his throat, so he presented to the Accident and Emergency Department.

On fibreoptic endoscopy the oesophagus was found normal down to 40 cm from the incisors (an incidental diverticulum in the first part of the duodenum was noted). The polypoidal lesion seemed to arise from the oropharynx. The patient was then examined under general anaesthesia, positioned as for tonsillectomy. The right tonsil was absent, the left normal. The mass was traced to the right tonsillar fossa and adjacent oropharyngeal wall, it was excised from the pedicle and the wound closed with

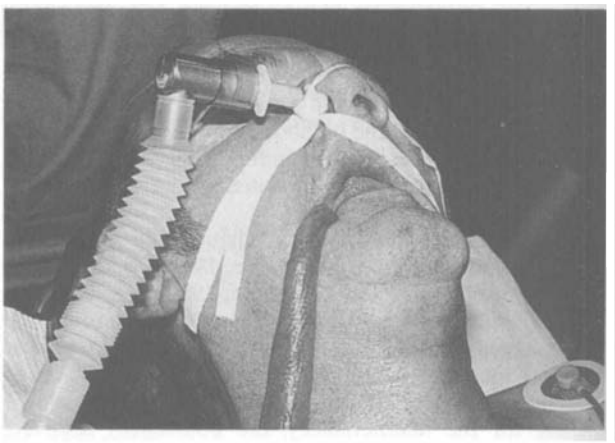

FIG. 1
The giant polypoidal hamartoma protruding from the side of the mouth. The patient is anaesthetized.

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Accepted for publication: 13 January 1996.

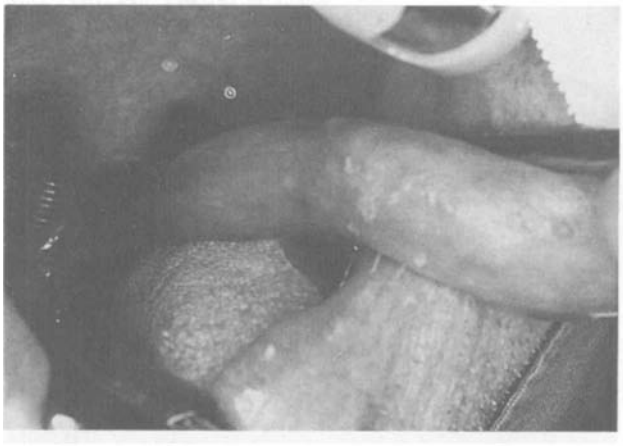

FIG. 2(a)
Intraoral approach. See sketch for details.

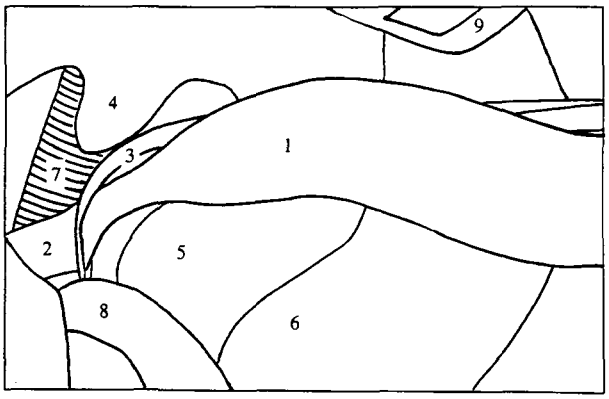

FIG. 2(b)
A schematic figure of 2(b) 1: polyp; 2: clamped pedicle; 3: Negus forceps; 4: uvula; 5: tongue; 6: lip; 7: anaesthetic tube; 8: and 9: mouth gag.

4/0 vicryl (Figure 2a). A nasogastric tube was passed. An uneventful recovery followed.

Histopathology

The polyp had a mottled mucosal covering, and sectioning showed a soft gelatinous stromal core (Figure 3). Histology revealed the stromal core to be composed of myxoid fibrous tissue which contained islands of fat, many thick-walled blood vessels and a few strands of smooth muscle (Figure 4). The covering squamous epithelium was hyperplastic and showed focal superficial ulceration. The features were of giant oropharyngeal hamartomatous polyp.

Discussion

The most common presenting symptom of a pharyngeal or oesophageal polyp is dysphagia which can be intermittent, or a sensation of food 'sticking'. Painful swallowing has not been reported (Jang *et al.*, 1969; Lewis *et al.*, 1988) and food regurgitation as an initial sign is only common in hypopharyngeal or oesophageal hamartoma (Fuller, 1963; Jang *et al.*, 1969). Other symptoms include sensation of a lump in the throat, hiccups, anorexia, weight loss and with large polyps, dyspnoea and stridor.

These symptoms may be absent due to the softness of the tumour. In fact, in most cases the mass has grown larger than 10 cm before it becomes symptomatic. With oesophaeal polyps, 75 per cent are diagnosed coincidentally on routine examination (Lewis *et al.*, 1988). Oropharyngeal hamartomas also present late in spite of their location in an accessible site, as this case and the one reported by Lupovitch *et al.* (1993) demonstrate. In our case, the oropharyngeal polyp grew down the oeosphagus and was gradually stretched by peristalsis over the years.

Undetected or asymptomatic giant polyps of the upper gastrointestinal tract can have a life-threatening presentation, requiring aggressive airway intervention if they become impacted in the larynx (Watson-Williams, 1935; Alberti-Flor *et al.*, 1986; Owens *et al.*, 1994). Deaths due to asphyxia have been reported (Le Jeune, 1955; Cochet *et al.*, 1980).

The late presentation and non-specific symptoms underline the need for a thorough examination in any case which suggests the presence of a mass in the pharynx. Once diagnosed, management involves firstly securing the airway, then identifying the site of origin, followed by excision. The mass can be approached by transoral, transcervical (lateral pharyngotomy or oesophagotomy) or endoscopic routes. In our case, the transoral approach was considered the safest option. General anaesthesia and endotracheal intubation are usually necessary.

Recurrence has been reported in oesophageal lesions (Pyun and Friedman, 1985) but in general, fibrovascular polyps have a good prognosis, providing that laryngeal impaction does not occur.

Acknowledgements

We would like to thank Mr D. R. Hanson who kindly allowed us to present this case for publication and all those who contributed in any way to the elaboration of this article.

TABLE I
REPORTED POLYPOIDAL LESIONS ARISING FROM THE OROPHARYNX

Site	Diagnosis	Author
Posterior third of tongue	Hamartoma	Fuller, 1963
Vallecula	Juvenile fibrous hamartoma	Baarsman, 1979
Palatine tonsil	Hamartoma	Lupovitch *et al.*, 1993
	Haemangioma	Abu Shara *et al.*, 1991
	Fibrous polyp (×2)	Giusan, 1992
	Fibrous lymphangiectatic polyp	Italia and Chasseur, 1982
	Papillary lymphoid polyp	Pyun and Friedman, 1985

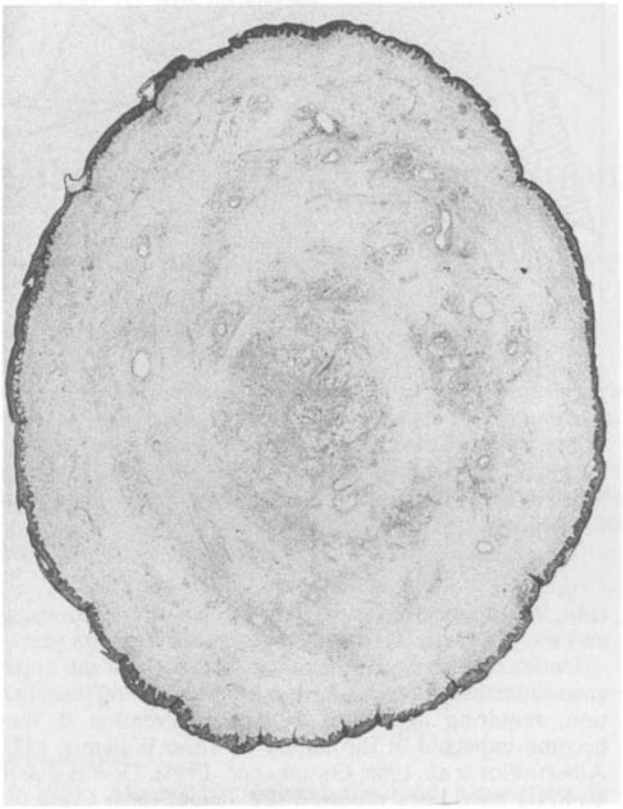

FIG. 3

Low power microscopic view showing a transverse section through the polyp (magnification ×4).

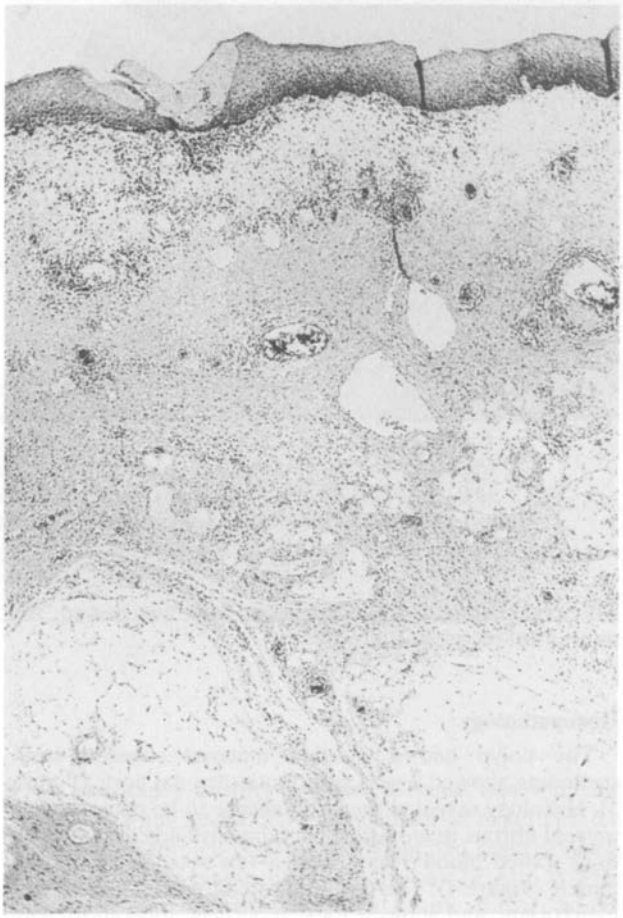

FIG. 4

The polyp has a covering of squamous epithelium, which overlies a loose connective tissue stroma containing many blood vessels, islands of mature fat cells and a few strands of muscle (H & E; ×30).

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