A 65-year old female was admitted with progressive dysphagia for 2 months and 5 kg weight loss.
Her past medical history was significant for osteoporosis treated with calcium lactate tablets, daily, for 5 years.
Upper gastrointestinal endoscopy described a 4 cm whitish firm mass in the middle esophagus (Fig.1) and a semi-circumferential deep ulcer with irregular borders on the opposite mucosa (Fig.2).
During endoscopy a pedicle was not identify by handling a polipectomy snare around the esophageal mass.
Upper gastrointestinal series with gastrografin (Fig.3) revealed an ovoid lacunar image at the distal part of the esophagus esophageal, inhomogeneous, with calcifications and smooth contours.
During peristalsis the image was mobile and no pedicle was identified.
The esophageal lumen was enlarged with a diverticula development at the posterior wall.
Also computer tomography of the thorax excluded a pedunculated tumor, describing an intra-luminal calcified esophageal mass (Fig.4).
The biopsies obtained from the esophageal ulcerated mucosa revealed inflammatory cells, without malignancy.
Based on these endoscopic and imagistic results a bezoar was supposed to have been developed in an esophageal diverticula, subsequently with ulcerated mucosa.
The esophageal mass was removed with an endoscopic snare in one piece, as the fragmentation was not physically possible.
The macroscopic appearance revealed a 4 cm, globular mass, heterogeneous, dense, whitish, in places with harsh yellow foci, most likely dystrophic calcification.
The macroscopic examination on cross section revealed a light gray aspect (fibrous appearance) that includes multiple harsh yellow-orange structures, difficult to section (Fig.5).
This mass was immersed into trichloracetic acid for decalcification.
Microscopic examination revealed hyaline fibrous tissue (Fig.6a), stained in green in Tricrom Mason (Fig.6b), with numerous crystalline basophils deposits of minerals, rare fibrocytes and very few vessels.
The presence of capillary structures, rare fibroblasts and collagen fibers brought in discussion a mesenchymal originating mass, most likely a fibrovascular polyp.
A definitive histological diagnosis was not possible, as the pedicle was not identified, but the presence of the connective tissue suggested the previous presence of a pedicle into the lesion.
The long term calcium tablets intake might explain the calcification process developed into the vascular-connective tissue, revealed on histology by the numerous crystalline basophils deposits of minerals.
One month later the patient was asymptomatic.
The endoscopy did not revealed an enlarged esophagus, the appearance of the esophageal mucosa was normal (without ulcerations) and no diverticula was identified.
No motility disturbances were found on esophageal manometry.
Based on the clinical course, the history of calcium lactate intake and histological appearance a diagnosis of an esophageal benign mesenchymal originating mass (most probably a fibrovascular polyp) auto-amputated and calcified was formulated.