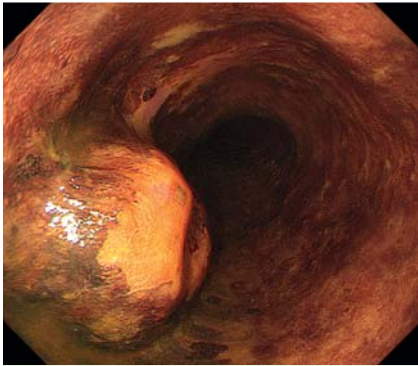
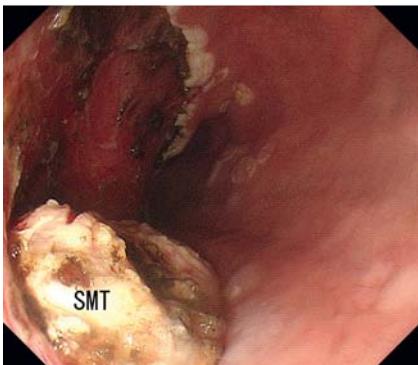


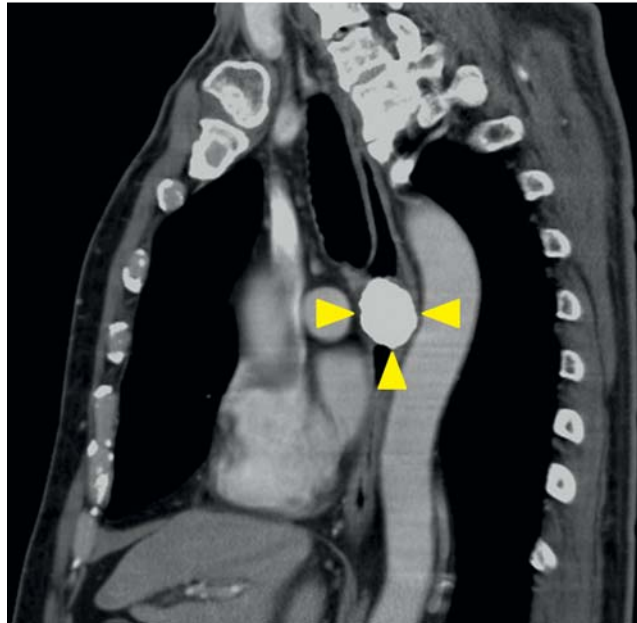
## An unusual cause of dysphagia after endoscopic resection of an early esophageal cancer



**Fig. 1** Endoscopy showing the esophageal cancer on the surface of the submucosal tumor and spreading distally.



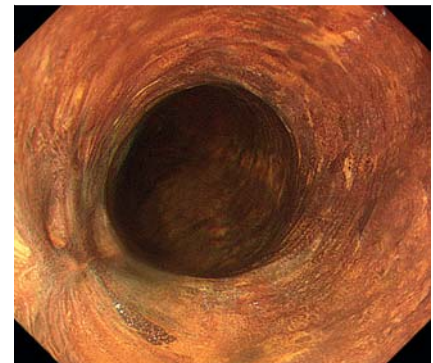
**Fig. 3** Endoscopic view after endoscopic submucosal dissection (ESD) showing only the cancerous lesion had been resected, leaving the submucosal tumor (SMT) untouched.



**Fig. 2** Computed tomography (CT) scan showing the highly calcified tumor, measuring 30 × 40 mm, located in the mid-esophagus adjacent to the aorta (arrowheads).



**Fig. 4** Endoscopy 3 months after endoscopic submucosal dissection (ESD) showing a giant mass in the esophageal lumen.



**Fig. 5** Follow-up endoscopy 3 months after the removal of the esophageal submucosal tumor showed only an esophageal ulcer scar, with no recurrence or stricture.

A 72-year-old man was referred to our hospital for endoscopic treatment of an early esophageal cancer. He had been aware of a submucosal tumor (SMT) in the mid-esophagus for 30 years. Endoscopy revealed that the cancer was located on the surface and had spread distally (● **Fig. 1**) [1]. The SMT was visualized as a high-intensity mass on computed tomography (CT), suggesting that it was almost entirely highly calcified. Because the CT scan showed that the SMT was located adjacent to the aorta (● **Fig. 2**), only the cancerous part was resected by endoscopic submucosal dissection (ESD), leaving the rest of the SMT untouched (● **Fig. 3**) [2]. Although the procedure was completed without complications, 3 months later the patient complained of dysphagia. Endoscopy revealed a giant mass in the

esophageal lumen (● **Fig. 4**), attached via a narrow pedicle to the ESD scar. We recognized the mass as the original SMT, which had become exposed to the esophageal lumen after the mucosal defect had been repaired. We severed the pedicle with a snare; however, because of its large size, we were unable to remove the tumor through the patient's mouth. We then failed to disrupt the tumor using several endoscopic devices, including mechanical lithotripsy and electrohydraulic lithotripsy, because of its marked hardness. Fortunately, the tumor was eventually expelled through the anus without causing intestinal obstruction. However, we missed re-

trieving the tumor from the feces so a histopathologic examination could not be done. Follow-up endoscopy showed only an esophageal ulcer scar without any recurrence or stricture formation (● **Fig. 5**). Indications for endoscopic treatment for SMT are limited [3]. However, as we have shown in the present case, once an SMT is exposed to the lumen, it may be removed on its own. This suggests the possibility of using endoscopic treatment for removing a large SMT.

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**Competing interests:** None

**Y. Nakanishi, S. Miyamoto, S. Ishizu,  
H. Seno, M. Muto, T. Chiba**  
Department of Endoscopy, Kyoto  
University Hospital, Kyoto, Japan

### References

- 1 *Takubo K.* Pathology of the esophagus. An atlas and textbook. 2nd edn. Tokyo: Springer; 2007: 131 – 132
- 2 *Inoue H, Minami H, Kaga M et al.* Endoscopic mucosal resection and endoscopic submucosal dissection for esophageal dysplasia and carcinoma. *Gastrointest Endosc Clin N Am* 2010; 20: 25 – 34
- 3 *Zhou XD, Lv NH, Chen HX et al.* Endoscopic management of gastrointestinal smooth muscle tumor. *World J Gastroenterol* 2007; 13: 4897 – 4902

### Bibliography

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### Corresponding author

**S. Miyamoto**  
Department of Endoscopy,  
Kyoto University Hospital  
54 Shogoin-Kawaharacho  
Sakyo-ku  
Kyoto  
Japan 606-8507  
Fax: +81-75-751-4596  
shmiyamo@kuhp.kyoto-u.ac.jp