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 retrieving 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).

Competing interests: None

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