Effective treatment is crucial for avoiding recurrent incidence and depends on excising all tissues with carcinoma. As the tumour is radio-resistant, complete removal is the only treatment of choice. A wide excision for low-grade chondrosarcoma is generally advised. Following open biopsy, local excision or, if required, reconstruction is advised.5

In our case, we think that the removal of the tumoral tissue from the normal tissue margin is the treatment of choice. Our case is a young case that had Grade 1 chondrosarcoma in his fourth and fifth finger and fifth metatarsal diaphysis. The difference of our case from the ones reported in literature is that he was young (18-year-old) and had a lesion involving two different compartments synchronously as localization.

CONCLUSION

Chondrosarcoma is a tumour rarely seen in the foot.

Osteoma of occipital bone

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ABSTRACT

Osteomas are benign, bone-forming tumours located within bones or developing on them. In the head and neck region they are commonly seen in the frontoethmoidal region. Occipital osteomas are very rare tumours. They are often asymptomatic and are incidentally found on radiological investigations. The main clinical symptom is headache of varying intensity and quality, though some patients may complain of dizziness in cases of large tumours. We describe here a case of occipital osteoma in a female, arising from the inner table. It was asymptomatic and osteoma was removed for cosmetic purpose. CT scan is a must to confirm the diagnosis, the involvement of the inner table as well as to look for any intracranial extent of the osteoma.

KEY WORDS
Osteoma, occipital bone.


CASE REPORT

A 35-year-old female reported to the ENT OPD of Lok Nayak Hospital with a swelling on the right side of her head for more than 7 years. It was gradually increasing in size. There was no history of trauma, headache, hearing impairment, otorrhoea, dizziness, vomiting, visual trouble, or neurological deficit. On examination it was found to be around 4 cm x 3 cm in size, smooth, bony hard, and non-tender. X-ray skull showed a well-circumscribed dense bony mass. Her CT scan (Figure 1) head revealed a bony mass in the right squamous part of the occipital bone measuring 4 cm x 3 cm. It originated from the outer table of the skull with no evidence of destruction of the inner table or extension of the mass intracranially. Hence, a diagnosis of
osteoma was made. Surgical excision was carried out for cosmetic purposes using a chisel and mallet. It was arising from the outer table with a small stalk. The osteoma was attached with (to the?) underlying bone with a small stalk. The gross specimen (Figure 2) was smooth, ivory white in appearance, ovoid in shape and about 4 cm x 3 cm in size. The histopathology report was osteoma composed of compact bone. The patient had an uneventful recovery with no recurrence in the 9-month follow-up.

DISCUSSION

Osteoma is a slow-growing tumour formed by mature bone tissue. Stuart first defined osteoma as a benign, circumscribed, slow-growing bony tumour of mastoid. The common site for osteomas is the frontoethmoidal region. The incidence of osteomas is highest in frontal followed by, ethmoid and maxillary sinuses. They are rare in the sphenoid sinus and extremely rare on occipital squama. A careful search of the English literature failed to reveal any previously reported case of occipital osteoma. Most often they are localized on sutures. Except for cortical lesions that are seen initially as cosmetic deformities, these tumours are usually unsuspected roentgenographic findings. The main clinical symptom is headache of varying intensity and quality, and in most cases not proportional to the size of the osteoma, which ranges from the size of a pepper bean to the size of a child’s head. In addition to headache, there can be sensitivity to pressure in the region of the frontal sinus or dizziness. Treatment is indicated for symptomatic osteomas. Tumours involving the middle and inner ear are most frequently small and tend to remain stable in size; consequently they are usually managed expectantly. Surgery is indicated in cases of deafness, discharge, dizziness and headache. Temporal osteoma has been found to produce intracranial complications, justifying surgical removal. In our case the patient did not have any complaints, the swelling was removed for cosmetic reasons.

The cause of osteoma has still not been defined. Since the tumour has been found to develop after puberty Haymann believed it to depend on conditions regulating growth in the cranial bones. Friedberg suggested trauma with consequent periostitis as a predisposing factor. Most authors feel that it originates from the pre-osseous connective tissue. The clinical presentation and radiological features of osteoma are characteristic but differential diagnosis should include eosinophilic granuloma, giant cell tumour, monostotic fibrous dysplasia, a solitary multiple osteoma, and osteoblastic metastasis. One should also rule out Gardner’s syndrome in patients presenting with large skull osteomas. It includes a clinical triad of familial polyposis coli, osteomas, and soft tissue tumours.

CONCLUSION

Osteomas are rarely rarely originate from the flat bones of the skull and their management depends upon the symptomology. Small osteomas are harmless and can be left as such; surgery is indicated only in cases of cosmetic problem. Large osteomas causing dizziness, headache and intracranial extension or compression, need excision. Differential diagnosis of other bony tumours should also be kept in mind while dealing with them.
Stump appendicitis with lipohyperplasia of the ileocecal valve: Report of a case

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ABSTRACT
A case report of recurrent appendicitis, 40 years after appendectomy is presented. In the present case, we failed to diagnose stump appendicitis preoperatively due to the existence of the lipohyperplasia of the ileocecal valve which showed features of ileocolic intussusception causing right lower abdominal pain and nausea. Inflammation of the appendiceal stump after appendectomy is a rare complication, but in the assessment of patients with lower quadrant abdominal pain who have previously undergone appendectomies, stump appendicitis should be considered.

KEY WORDS
Stump appendicitis, Lipohyperplasia, Ileocecal valve.

INTRODUCTION

The diagnosis of stump appendicitis in patients who have previously undergone appendectomies is very difficult because of the low incidence and other diseases with a similar clinical presentation. We herein report a case of stump appendicitis we failed to diagnose preoperatively owing to the existence of lipohyperplasia of the ileocecal valve which showed features of ileocolic intussusception.

CASE REPORT

A 49-year-old man presented to the hospital on February 27, 2003 for investigation of a right lower abdominal pain and nausea that had persisted for two days. He had a past history of appendectomy 40 years prior to admission. On physical examination, a soft mass with tenderness located in the lower quadrant of the abdomen was found. Blood examination showed leukocytosis (white blood cell count 11,600/mm³). The C reactive protein (CRP) level was elevated (4.7 mg/dl). Computed tomography (CT) and ultrasonography of the abdomen showed an intraluminal mass with a characteristic layered appearance called a target sign of the ascending colon (Figure 1). An ileocolic intussusception was highly suspected, and laparotomy was performed on May 27, 2003. At surgery, the terminal ileum and cecum were edematous and covered with fibrous adhesive granulation tissue and the appendiceal stump could not be identified. An intraluminal mass was found in the ascending colon, but an intussusception did not exist. Ileocecal resection with the excision of the granulation tissue was carried out.