the tumour has attained a considerable size. Other symptoms include: weight loss, respiratory distress, fever, gastrointestinal bleeding, odynophagia and even oral regurgitation and protrusion of the tumour. The differential diagnosis include lymphoma, but it is difficult to establish this without surgical removal and histological examination.

With such limited worldwide experience in managing this condition, a single method by which this condition can be treated is unestablished. The unorthodox surgical management in this case was needed due to the sheer size and site of fixation of the tumour. It reveals that perhaps these rare oesophageal tumours can be resected without the need for formal oesophagectomy if a narrow pedicle can be identified.

**Giant prostatic hyperplasia:**

Surgical management of a case

Sir,

We report the uncomplicated removal of the largest ever prostate from India and the 13th case exceeding 500 grams in the world literature.

A 73-year-old man presented with mild to moderate lower urinary tract symptoms (LUTS) of 5 months’ duration. American Urological Association (AUA) score was 12. Physical examination revealed a firm suprapubic mass and massive prostatomegaly on digital rectal examination. Transrectal ultrasound (TRUS) confirmed prostatic enlargement, measuring 11.4 x 8.5 x 9.8 (= 522 grams). Pelvic MRI showed large intravesical median lobe [Figure 1]. Uroflowmetry showed a maximum flow rate of 9 ml/sec with obstructive flow pattern. Serum PSA was 20.2 ng/ml, however multiple trucut prostate biopsies showed benign hyperplasia.

The patient underwent transvesical (suprapubic) prostatectomy under general anaesthesia. We strove to acquire the specimen in a single piece with minimal bleeding, which none of the previous authors could achieve, however this was quite challenging in the presence of such a big gland. To accomplish this, following modifications were made to the contemporary technique. We obtained an early precautionary control of bilateral internal iliac arteries with vascular tapes, to facilitate their ligation, should the need arise. A narrow deaver retractor was used, as finger-dissection failed to reach the apex of gland and the gland was enucleated in a single piece just like the head of the baby in a vaginal delivery. Approximate blood loss was 300 ml, requiring only one unit of blood transfusion.

Post-operative stay was uneventful. Pathologic examination of the specimen showed a gross weight of 522 g and measured 11 cm in the greatest diameter. Histology revealed giant prostatic adenoma with glandular and stromal hyperplasia; there was no evidence of malignancy. On follow-up, one year after the surgery, patient is asymptomatic. TRUS shows a residual gland of 24 g and a maximum flow rate of 24 ml/sec on uroflowmetry.

Giant prostatic hyperplasia (GPH) denotes an exceedingly rare entity of prostatic gland larger than 500 g. With the advent of the medical therapy and the minimally invasive endoscopic management for benign prostatic hyperplasia, open surgical procedures for this disease have become things of the past. Open prostatectomy today is kept reserved for patients with specific indications or when the patient has a gland that is too large to be comfortably resected transurethrally. When the adenoma completely obscures the trigone and the ureteral orifices, as in the present case, an open procedure is preferred. Most urologists are comfortable removing up to 50 to 75 g of tissue transurethrally. Open prostatectomy, therefore, should be considered when the obstructive tissue is estimated to weigh more than 75 g. An open procedure in these cases takes less time, probably has no greater morbidity and is likely to have better result. Patients with very large glands are infrequently seen today and so as these open surgical procedures, as these patients tend to be treated at an earlier stage of the disease process. Transvesical or suprapubic prostatectomy is probably the most frequently performed open prostatectomy and is preferred.
method when the obstructive prostatic enlargement includes a large intravesical median lobe,\cite{3} as in our case.

In the present era where TURP has become synonymous with the surgical management of BPH, open prostatectomy still makes a management option for large glands and this may be satisfactorily accomplished with minimum blood loss\cite{4} and morbidity by a good pre-operative and intra-operative planning.

**Rajeev Sood, Vikas Jain, D Chauhan**
Division of Urology, Department of Surgery, Dr. Ram Manohar Lohia Hospital, New Delhi - 110 001, India

Correspondence:
Rajeev Sood, E-mail: dr_vikasin@yahoo.co.in

**References**