method when the obstructive prostatic enlargement includes a large intravesical median lobe, 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 and morbidity by a good pre-operative and intra-operative planning.

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Isolated recurrence at tracheostomy site in a non-laryngeal head and neck cancer

Sir,
A 36-year-old-man presented with T3N1M0 squamous carcinoma of anterior two-thirds of the tongue. He had received two cycles of platinum-based chemotherapy at the referral hospital. He underwent anterior two-third glossectomy with bilateral modified neck dissection and reconstruction with a pectoralis major myocutaneous flap. A tracheostomy was performed through a separate neck incision using separate instruments after cleaning the tracheostomy site and placement of new drapes. Postoperatively, histopathology showed all cut margins to be free of tumor and three positive nodes with perinodal extension in two. Patient was decannulated three weeks after surgery once wounds had well healed.

He received 6000-cGray post-operative radiotherapy. The tracheostomy site and the superior mediastinum were included in the radiation field. Five months after completion of radiotherapy, the patient presented with a 4 x 4 cm proliferative mass at the tracheostomy site [Figure 1], biopsy of which proved to be metastasis of squamous carcinoma similar to the tongue lesion morphologically. There was no evidence of recurrent disease at the primary site or the neck. Computed tomography scan of the neck revealed a large proliferative mass at the tracheostomy site infiltrating the anterior wall of trachea and extending into the soft tissues of the neck [Figure 2]. Chest X-ray did not reveal pulmonary metastases. In view of the extensive soft tissue disease extending into the superior mediastinum, only palliative chemotherapy was offered. The patient died 3 months later.

Recurrence at tracheostomy site in the present case is probably due to implantation of neoplastic cells at the time of the original surgery or seeding of the tracheostomy site by haematogenously disseminated cells. Lymphatic metastasis does not appear to be the reason for the metastases in view of the midline location of the recurrence, but it cannot be excluded conclusively, considering the atypical lymphatic dissemination in patients with metastatic disease in the neck nodes. Contiguous spread is also unlikely in view of the absence of local or regional recurrence.

Neoplastic implantation is a well-known but uncommon cause of tumour recurrence. Manipulation of tumor at the...
time of surgery may also cause dissemination of tumor cells in to the circulation leading to distant metastases.\textsuperscript{[2,3]} The seeding of cancer cells at distant sites can be stimulated by trauma and/or inflammation as damaged tissues provide a fertile soil for the development of metastases from haematogenously disseminated tumor cells.\textsuperscript{[2,3]} The treatment of tracheostomy site recurrence may require an extended total laryngectomy or high dose radiotherapy if the site was not included in the radiation ports. A method of delivering high-dose radiation to the stomal area by implanting iridium applicators in the tracheostomy tube have been described in patients who have received full-course radiotherapy.\textsuperscript{[4]} Since only a few cases have been reported, specific recommendations cannot be provided, but a meticulous surgical technique, isolation of the surgical field with proper placement of drapes, change of instruments and gloves after removal of the specimen may theoretically reduce the risk of neoplastic implantations.

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