time of surgery may also cause dissemination of tumor cells in to the circulation leading to distant metastases.[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.[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.[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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References

Use of artificial eye and conjunctival squamous cell carcinoma

Sir,
A 65-year-old man presented in 2003 with a mass growing from his left orbit [Figure 1], the eye from the orbit having been enucleated 50 years ago. The mass was reported to be growing fast in the previous few months before presentation at our eye clinic and bled briskly, but off and on. The cause of enucleation was an ocular injury sustained by the patient when he was 15 years old. Since then he had used a prosthetic eye in the anophthalmic socket. He reported he had chronic irritation in the socket.

He was hypertensive, gave history of myocardial infarction in 1992 and was treated for pulmonary tuberculosis in 1954. On examination, the right eye had a 20/40 visual acuity and a nuclear sclerotic cataract. The patient had a large, cauliflower-like mass arising from his left socket and with several bleeding sites on it. Regional lymph nodes were not palpable. On CT scan, there were no signs of invasion of the surrounding bony orbit. Two days after his presentation at the eye clinic a total excision of the mass was performed under local anesthesia. The mass measured 5 x 4 x 2 cm in dimensions. Histologic examination revealed a moderately-differentiated squamous cell carcinoma. No distant metastasis was detected. Histopathology revealed tumour-free tissue margins.

He was then referred for radiotherapy and from April 28th 2003 to June 14th 2003 his left orbit and its adjacent areas underwent radiotherapy. The dose ranged from 5000 cGy at 200cGy/F in 25 fractions followed by boost treatment to the tumor bed and 6800 cGy at 200cGy/F in 34 fractions. The patient tolerated the treatment well. For the first 3 months, the patient was followed up monthly and then every 6 months. So far there has not been any complication or recurrences. The left socket was clean and without any residual mass [Figure 2]. In November 2003, phacoemulsification was performed to remove cataract from the right eye, followed by implantation of an intraocular lens. The vision in the eye has improved to 20/25.

To the best of our knowledge, there have been only two reports in the world that described three cases - two in the United States and one in the UK - in whom conjunctival squamous cell carcinoma had developed after several years of ocular prostheses use.[1,2] Chronic irritation caused by the artificial eye may have resulted in the development of cancer in this case. However, the viral cause of the cancer cannot be ruled out because we did not do molecular testing to try and identify a viral cause.

Our case was unique in that the patient presented very late for treatment with a large rapidly growing mass with several bleeding points. The cases reported by Campanella and colleagues had new sanguineous conjunctival discharge, foreign body sensation and focal eyelid swelling. The case reported by Whittaker and colleagues was a 62-year-old man with a long-standing conjunctival squamous cell carcinoma-in-situ associated with an ocular prosthesis.

Squamous cell carcinoma of the conjunctiva is not a frequent tumor. It is most commonly reported in males (male: female ratio 3:1), caucasians, people aged around 60 years and those with a history of high sun exposure such as black Africans. In people with HIV infection, the tumour can also be found at a young age. Although human papillomavirus has been found in specimens taken from conjunctival tumor, there is not sufficient evidence to show its causal role in the development of squamous cell carcinoma of the conjunctiva. Individuals living closer to the equator present at an earlier age than those at a distance. Other factors associated with squamous cell carcinoma of the conjunctiva include cigarette smoking, exposure to petroleum products, chronic inflammation, actinic exposure, chronic wear of contact lenses and xeroderma pigmentosum.[1,3]
Letters

Figure 1: A large, cauliflower-like mass arising from patient’s left socket has several bleeding sites on it.

Figure 2: The left eye after complete surgical excision of the mass followed by radiotherapy.

The treatment in our case was complete surgical excision under operating microscope followed by radiotherapy as adjuvant treatment. The recurrence is as high as 50 and 10% in cases of incompletely excised tumors and completely excised tumors, respectively. The prognosis is generally considered to be good.

The patient in our case presented very late for treatment with a large rapidly growing mass. We conclude that symptoms such as unusual irritation, sanguineous conjunctival discharge and focal eyelid swelling among individuals wearing ocular prostheses need prompt investigation. We also recommend regular examination and regular follow ups of the sockets of patients wearing ocular prostheses for early diagnosis of these tumors.

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References


Hemorrhagic bullae with nebulised ipratropium bromide

Sir,
A 68-year-old man with chronic obstructive pulmonary disease (COPD) maintained on salbutamol inhaler, was commenced on nebulised salbutamol and ipratropium bromide (IB) for acute exacerbation of COPD. He developed haemorrhagic bullae affecting his hard palate [Figure 1] within 24 hours of starting IB. The patient told us that he had developed similar lesions when he had nebulised IB (Atrovent) one year ago for exacerbation of COPD. He was a fit man and had no history of hypertension or diabetes. He had no blood dyscrasia and was not on any anti-coagulation. IB was withdrawn and he was treated with salbutamol alone. The bullous lesions improved within 48 hours of stopping IB and healed completely within a week.

Skin and mucous membrane are very common sites involved in any adverse drug reaction ranging from mild skin rash to Stevens-Johnson syndrome. Angina bullosa haemorrhagica (ABH), however, is a benign condition characterized by acute blood blisters affecting the palate and the lesions heal spontaneously within a week. The pathogenesis is unknown.