TIP OF THE ICEBERG

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No other pathology in the chest can be so deceiving and present just as the tip of the iceberg as chest wall tumours.[1] What may appear to be a lump or bump on the chest wall, painless more often than not, is ominously just the tip of a chest wall tumor which may range in size from 1 to over 10 cm.[2] There have been numerous incidences of trigger happy cowboys trying to biopsy, what appears to be a small bump, and then when uncontrollable hemorrhage starts, they end up the creek without a paddle sending frantic SOS calls to Thoracic surgery.

Primary chest wall tumors account for 5% of all thoracic tumors and 1 to 2% of all primary tumors,[3] almost half are benign. The most common benign chest wall tumors are osteochondroma, chondroma and fibrous dysplasia.[2,4] More than 50% of the malignant chest wall tumors are metastasis or invasion from adjacent structures.[5], Primary chest wall malignancies are usually sarcomas with 55% from bone or cartilage and 45% from soft tissue.[3]

Major defects require reconstruction with or without prosthetic material and quite often require a multidisciplinary approach involving both thoracic and plastic surgical teams.[6-8] The main aim is not to have a debilitating flail segment which would compromise respiratory function and reservoir. Postoperatively quite a few patients require ventilator support and therefore these cases should only be done where ICU facilities are available and an ICU bed is booked before taking the patient to theatre.[9,10]

Peshawar experience of a large number of cases over 14 years is presented in this issue which reiterates the above that these lesions can be very safely treated in a well equipped and staffed thoracic unit, and are best handled by thoracic surgeons, rather than trigger happy cowboys with knives trying to take biopsies here and there.

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