No other pathology in the chest can be so deceiving and present just as the tip of the iceberg as chest wall tumours. 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. There have been numerous incidences of trigger happy cowboys trying to biopsy, what appears to be a small bump, and then 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, almost half are benign. The most common benign chest wall tumors are osteochondroma, chondroma and fibrous dysplasia. More than 50% of the malignant chest wall tumors are metastasis or invasion from adjacent structures. Primary chest wall malignancies are usually sarcomas with 55% from bone or cartilage and 45% from soft tissue.

Major defects require reconstruction with or without prosthetic material and quite often require a multidisciplinary approach involving both thoracic and plastic surgical teams. 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.

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.

REFERENCES: