

presentation seems consistent in all case reports as patients often present with recurrent chest infections, the other significant proportion are discovered on routine chest x-ray. Radiological variations existed and in most cases biopsies from bronchoscopy were negative. This shows the need for a high index of suspicion for the malignant condition and one should proceed to thoracotomy even without prior tissue diagnosis. Complete surgical excision was the consistent factor among all the cases with favourable outcomes including our local cases.

CR71

Tracheal rupture after adult endotracheal intubation: a case report with analysis of aetiological and management issues

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Introduction: Tracheal rupture is a rare but potentially life threatening complication of endotracheal intubation. The usual site in adults is the membranous portion of the trachea. The mechanism of injury is still unclear. Patient risk factors include age, short stature, obesity, chronic steroid use and chronic illness. Anaesthetic risk factors include tube size, stylet use and balloon inflation volume. There is also no clear consensus on the management of such a complication. The past literature favoured direct surgical repair which carries a relatively high morbidity and mortality. Recently, conservative management is gaining support.

Aim: A case report of a 68 year old woman with a tracheal rupture after ophthalmic surgery under general anaesthesia is being presented. Conservative management was used together with a tracheostomy. Our experience with this patient was compared to a literature review.

Methodology: A preformed endotracheal tube, size 7.5mm, was used to secure the airway for cataract surgery. On extubation, subcutaneous emphysema of the face and neck was noted. No pneumothorax was identified on chest radiographs. High resolution computed tomography of the neck and thorax confirmed extensive pneumomediastinum and a 5cm tracheal rupture starting 1cm above the carina in the right membranous trachea. Patient risk factors identified included short stature, obesity, asthma and chronic steroid inhaler use. Conservative management included intravenous piperacillin and tazobactam but the emphysema was noted to be deteriorating due to chronic cough. The patient was deemed not ideal for open thoracic surgery repair and an open tracheostomy was done to decompress the airway pressures produced by coughing and vocalisation. Flexible tracheoscopy confirmed the location and size of the perforation.

Results: Subcutaneous emphysema resolved rapidly after the tracheostomy was performed. The patient was discharged home without need for major surgery.

Conclusion: Prevention of such injuries should be advocated by identifying high risk patients and using smaller size endotracheal tubes and lower cuff pressures, or even avoiding unnecessary intubation. High resolution computed tomography of the neck and thorax is as effective as flexible tracheoscopy to detect gross tracheobronchial perforations. Conservative management should be taken into consideration as first line treatment of such iatrogenic tracheal perforations irrespective of the size of the perforation provided that the patient is haemodynamically stable and the complication is recognized early. A tracheostomy is a useful, much less invasive adjunct to conservative measures that can be used irrespective of the site of the perforation in relation to the carina.

CR72

An unusual cause of headaches and hearing loss – rhabdomyosarcoma

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Rhabdomyosarcoma affects about five in every one million children per year. It can arise from any site of the body, and presentation will depend on site involved. A 14 year old girl presented with a few month history of headaches, unilateral conductive hearing loss and recent onset diplopia. She was found to have a parameningeal rhabdomyosarcoma. The child also had a family history of breast cancer and Ewing's sarcoma, suggestive of Li-Fraumeni syndrome. A discussion of the pathophysiology, presentation, diagnosis, staging and treatment of this tumour will be presented.

CR73

A chronic red eye: conjunctival mucosa associated lymphoid tissue lymphoma and systemic lymphoma

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Introduction: We describe a case of a 68 year old lady who presented with salmon coloured follicular conjunctival folds involving bilateral nasal bulbar conjunctiva, caruncles and superior and inferior fornices. A conjunctival biopsy was carried out and the histology confirmed low grade extranodal marginal zone B cell lymphoma of mucosa associated lymphoid tissue (MALT). A bone marrow aspirate also showed nodular and interstitial infiltrates of CD5, CD20 and bel-2 positive small to medium sized lymphocytes. The diagnosis was consistent with low grade lymphoma involving the bone marrow.

Management: A computed tomography (CT) scan showed enlarged lymph nodes in pre-tracheal and para-tracheal region, along upper para-aortic region and lesser gastric curvature. It also showed moderate splenomegaly. The patient received six cycles of chemotherapy consisting of rituximab, cyclophosphamide, vincristine and prednisolone. Post-treatment CT scan showed that there had been a good response to treatment since the lymph nodes had decreased in size.

Discussion: MALT lymphomas are solid tumors that originate from cancerous growth of immune cells that are recruited to secretory tissue such as the gastrointestinal tract, salivary glands, lungs, and the thyroid gland. Conjunctival lymphoma may be localised (stage 1) or may be accompanied by systemic disease (stage II-IV) in 31% of patients. The initial CT scan in this case was consistent with stage IV disease (Cotswold's modification of the Ann Arbor lymphoma staging system). These lymphomas are characterised by CD20+, CD10-, CD23-, bel-6- and this helps to differentiate them from benign lymphoproliferative disorders. The underlying aetiology often remains unknown, however associations with hepatitis and Chlamydia psittaci have been suggested.

Conclusion: The diagnosis of these lymphomas may be delayed as they may masquerade as chronic conjunctivitis and may initially respond to steroids. The prognosis is very good even with systemic involvement since complete response to treatment is observed in 67 to 100% of patients.