In 1995, Kim et al first described the laparoscopic management of a CSF pseudocyst, which involved excision of a portion of the cyst and repositioning the catheter within the peritoneal cavity.\(^7\) Laparoscopic management reduces the risk of a laparotomy and the formation of intraperitoneal adhesions. Furthermore, laparoscopy allows visual confirmation of the adequate flow of the CSF from the end of the catheter after it is repositioned. The entire abdominal cavity can be assessed for the presence of adhesions and adhesiolysis undertaken whenever necessary. This allows placement of the catheter in the quadrant of the abdomen with the maximum absorptive surface.\(^8\)

This minimally invasive technique in the setting of a non-infected pseudocyst has proven to be safe, with results comparable to the conventional open technique. However, the long-term success rate is still unknown.

In spite of the numerous complications, VP shunt remains the method of choice for long-term relief of raised intracranial pressure. Improved shunt devices and careful surgical techniques may lead to a decrease but not elimination of the incidence of these complications. A high degree of suspicion and careful clinical and radiological examination could help diagnose and treat CSF pseudocysts, minimizing major complications.

REFERENCES

Chondrosarcoma in the forefoot

Omer Selim Yildirim, Hakan Celik, Onur Saruhan, Nesrin Gurhan*, Ali Okur
Department of Orthopaedic Surgery and *Pathology, Ataturk University Medical Faculty, Aziziyeh Hospital, Erzurum, Turkey.

ABSTRACT
Chondrosarcoma is a tumour rarely seen in the foot. An 18-year-old male patient visited our clinic with the complaints of swelling and pain in his right foot. On plain radiographs, there were lytic areas in the fifth metatarsal and the fourth and fifth fingers of the right foot. Computerized tomography revealed that there were mass lesions in the fourth and fifth fingers’ phalanges, causing a wearing off irregularly limited to adjacent fat plans and hypodense calcifications the fifth metatarsus, occurring destruction in bone. An open biopsy was taken from the region of the lesion under local anaesthesia. Histopathological diagnosis was reported as low-grade chondrosarcoma. We applied ray amputation to the patient under general anaesthesia for the fourth finger disarticulation and the fifth metatarsus. In a 3-year follow-up, no local recurrence and metastasis were observed. The difference of our case from the ones reported in the literature is that the patient was young (18-year-old) and had a lesion involving two different compartments synchronously as localization.

KEY WORDS
Chondrosarcoma, foot, phalanges, surgical treatment.

How to cite this article: Yildirim OS, Celik H, Saruhan O, Gurhan N, Okur A. Chondrosarcoma in the forefoot. Indian J Surg 2004;66:363-5.

Address for correspondence: Dr. Omer Selim Yildirim, Atalar Mah. Pasalar Cad, Atalar Apt. No: 26/5 25250, Erzurum / Turkey. E-Mail: omers@atauni.edu.tr
CASE REPORT

An 18-year-old male patient visited our clinic with the complaints of swelling and pain and shoe-pinched on the tips of his fourth and fifth fingers of the right foot, which had occurred nearly six months ago as a result of his trauma.

Radiographs also detailed lytic areas in the diaphysis of the fifth metatarsal and the fourth and fifth fingers of the right foot, and there were mass lesions, having soft tissue overlap, causing expansion and destruction in the periosteum; there was pathologic fracture within the proximal phalangeal joint of the fourth finger (Figure 1).

An open biopsy was taken from the fourth phalanges under local anaesthesia. In pathological examination, tumoral structure, consisting of pleomorphic cartilages cells eroding the bone as well as soft tissue elements in the sections, was observed. We applied ray amputation from the fifth metatarsus and the fourth finger disarticulation, under general anaesthesia, to the patient diagnosed as low-grade chondrosarcoma. In histopathological examination, hardening in lacunas with basophilic stroma in the sections, tumoral structure more than one atypical pleomorphic chondrocyte in lacunas, and slight myxoid changes in the matrix in the form of frayed foci were observed (Figure 2). It was diagnosed as low-grade chondrosarcoma.

After the operation, the follow-up was done once in three months, with respect to local recurrence. In a 3-year follow-up, no local recurrence and metastasis were observed.

DISCUSSION

Chondrosarcomas of small bones like the hand and foot are rarely seen, and they may have potential of fatality.\(^1\)\(^2\) Damron et al (1995) reported only three cases (involving the feet and hands) among 2588 tumours.\(^3\) Chondrosarcoma in the foot frequently involves the tarsal bones. The calcaneus and the fifth finger are the regions that are involved the most.

The age distribution of the cases has been found to be mostly in the sixth and seventh decade.\(^5\) Our case in the second decade shows a distinction in terms of sex distribution.

Very few cases developing enchondroma secondarily have been reported in the literature.\(^6\) It is very difficult to distinguish between enchondroma and chondrosarcoma because the pathologic appearance of both tumours in the hand and foot bones is similar. Pain is not used as a criterion in distinguishing chondrosarcoma from enchondroma. Radiological imagination is certainly valuable in diagnosis. Cortical destruction and soft tissue mass can be in permeative pattern.\(^6\) The treatments of these two situations are certainly different from each other. Enchondroma is treated with either intralesional curettage or is left without treatment.\(^7\)

Metastasis and staging in chondrosarcoma are associated with histological grade and their prognosis depends on the histological grade of the tumour with sufficient treatment.\(^1\)
Effective treatment is crucial for avoiding recurrent incidence and depends on excising all tissues with carcinoma. As the tumour is radio-resistant, complete removal is the only treatment of choice. A wide excision for low-grade chondrosarcoma is generally advised. Following open biopsy, local excision or, if required, reconstruction is advised.\(^5\)

In our case, we think that the removal of the tumoral tissue from the normal tissue margin is the treatment of choice. Our case is a young case that had Grade 1 chondrosarcoma in his fourth and fifth finger and fifth metatarsal diaphysis. The difference of our case from the ones reported in literature is that he was young (18-year-old) and had a lesion involving two different compartments synchronously as localization.

**CONCLUSION**

Chondrosarcoma is a tumour rarely seen in the foot. Low-grade chondrosarcoma in an extremity can be treated with limited surgery.

**REFERENCES**


---

**Osteoma of occipital bone**

**R. Meher, B. Gupta, I. Singh, A. Raj**

Dept. of ENT and Head and Neck Surgery, Maulana Azad Medical College and associated, L. N. Hospital, New Delhi - 110002, India.

**ABSTRACT**

Osteomas are benign, bone-forming tumours located within bones or developing on them. In the head and neck region they are commonly seen in the frontoethmoidal region. Occipital osteomas are very rare tumours. They are often asymptomatic and are incidentally found on radiological investigations. The main clinical symptom is headache of varying intensity and quality, though some patients may complain of dizziness in cases of large tumours. We describe here a case of occipital osteoma in a female, arising from the inner table. It was asymptomatic and osteoma was removed for cosmetic purpose. CT scan is a must to confirm the diagnosis, the involvement of the inner table as well as to look for any intracranial extent of the osteoma.

**KEY WORDS**

Osteoma, occipital bone.

**How to cite this article:** Meher R, Gupta B, Singh I, Raj A. Osteoma of occipital bone. Indian J Surg 2004;66:365-7.

**CASE REPORT**

A 35-year-old female reported to the ENT OPD of Lok Nayak Hospital with a swelling on the right side of her head for more than 7 years. It was gradually increasing in size. There was no history of trauma, headache, hearing impairment, otorrhea, dizziness, vomiting, visual trouble, or neurological deficit. On examination it was found to be around 4 cm x 3 cm in size, smooth, bony hard, and non-tender. X-ray skull showed a well-circumscribed dense bony mass. Her CT scan (Figure 1) head revealed a bony mass in the right squamous part of the occipital bone measuring 4 cm x 3 cm. It originated from the outer table of the skull with no evidence of destruction of the inner table or extension of the mass intracranially. Hence, a diagnosis of

---

**Address for correspondence:** Dr. Ravi Meher, B-2/62, Sector-16, Rohini, Delhi - 110085, India. E-mail: meherravi@hotmail.com

**Paper Received:** August 2003. **Paper Accepted:** October 2003. **Source of Support:** Nil.