INTRODUCTION

Tracheal tumours are either primary or secondary. The primary tracheal tumours are histologically similar but 100 times less common than main stem tumours and are responsible for 0.1% of tracheal cancer related deaths. Secondary tumours are much rare and may be a result of direct invasion and/or metastasis. The tracheal neurofibromas/neurilemomas are also rare tumours with non-specific symptoms. The patient presents mainly with stridor, dypsnoea, or massive haemoptysis. Although cough may invariably be present, but it does not have any distinctive characteristics. However, a chronic cough not responding to any treatment one must consider a fiberoptic bronchoscopy to evaluate the airways for any tumour.

This case report describes a case of tracheal schwannoma in a middle aged man.

CASE REPORT

In January a middle-aged man was presented with episodes of cough for last 02 years. It was non-productive initially and had treated by broadspectrum antibiotics off and on. The cough used to improve only to recur in a 3-4 months time. One month before presentation the cough became productive of haemoptysis and a week before presentation he started experiencing stridor. There was no history of fever, dyspnoea or chest/neck pain.

On physical examination, the only positive finding was a biphasic stridor. No lymph nodes were palpable in the neck. No abnormality was detected on chest radiograph. His diagnostic bronchoscopy revealed a pedunculated growth in the left lateral wall of mid third of the trachea, 5 cm from the vocal cords. Punch biopsy of the growth revealed it to be a schwannoma. On CT scan it was found to be a pedunculated growth of 4 x 2 cm size, besides the 7th tracheal ring.

Endoscopic cautery was considered but the facility was not available and the peduncle was very broad, so resection of the lesion was planned and performed in February 2008 through a transverse neck incision. Platysma was incised in the line of incision, strap muscles were retracted and thyroid was divided over isthmus. Trachea was thus exposed and dissected. Tracheal excision was done from 8-10th ring including tumour (Figure 1). Reconstruction was performed with 4/0 vicryl. Haemostasis was secured, a closed suction drain was placed and the wound was closed in layers. Neck holding stitches were placed. The patient was extubated after completion of the procedure. He showed an excellent postoperative recovery from anaesthesia and there was no airleak. Antibiotic cover was provided with Ticarcillin 3.2 gm intravenously (IV) 12 hourly and Amikacin 500 mg (IV) 12 hourly for the next 5 days. The suction drain was removed on the 2nd postoperative day and no wound infection was encountered till 7th postoperative day. He was discharged from the hospital and the neck stitches were removed on the 14th post-
operative day. The histopathology report has assessed the lesion to be a schwannoma and resection margins were clear of the tumour.

Postoperatively, the patient remained well and had near normal PEFR after one and a half year of follow-up. The follow-up bronchoscopic examination excluded any recurrence so far.

**DISCUSSION**

The neurogenic tumours are usually an independent identity. There is one reported case of a tracheal neurofibroma associated with neurofibromatosis I, but no such relationship of schwannomas was found in literature. Amongst the long list of reported tracheal tumours, chondromas and papillomas are the most frequent and neurofibromas are the rarest of benign tumours. There have been 36 reported cases of tracheal schwannomas and one patient of a peritracheal schwannoma, since 1950. The male: female ratio is 7:21. The site of the lesion is variable and has been found as low down as the lingular bronchus.

Keeping in view the delayed presentation, this patient had a non-specific cough that was relieved by broadspectrum antibiotics which indicate that, the stimulus for cough was more because of the infectious process rather than any irritation caused by the tumour itself. Thereby, episodic cough of a long duration should be investigated thoroughly for the cause especially in the settings of a developing country. Endoscopic removal of the pedunculated lesions can be planned whenever the facility is available.

Tracheal resectional surgery has special risks of the intraoperative hazards which may be in the form of loss of airway and haemorrhage. Postoperatively the complication of anastomotic leakage is the greatest hazard. Its risk is augmented especially if postoperative surgical site infection is contracted. Delayed complications include stricture formation and recurrence. These complications were avoided by pre-operative administration of prophylactic antibiotics and peroperative meticulous aseptic precautions. Postoperatively he was administered injectable Ticarcillin and Amikacin. A close follow-up was performed for any postoperative stricture or recurrence, none of which has been detected so far.

**REFERENCES**