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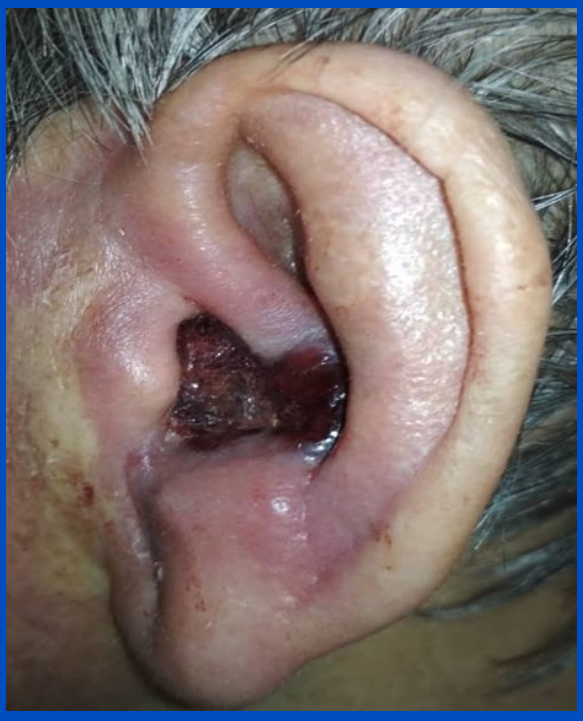

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The BIMJ publishes articles ranging from original research papers, review articles, medical practice papers, special reports, audits, case reports, images of interest, education and technical/innovation papers, editorials, commentaries and letters to the Editor. Topics of interest include all subjects that relate to clinical practice and research in all branches of medicine, basic and clinical including topics related to allied health care fields. The BIMJ welcomes manuscripts from contributors, but usually solicits reviews articles and special reports. Proposals for review papers can be sent to the Managing Editor directly. Please refer to the contact information of the Editorial Office.

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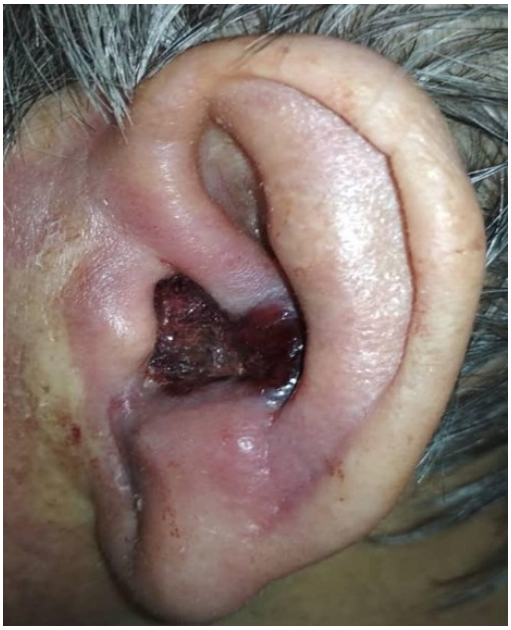

Figure 1

An elderly 88-year-old female with underlying diabetes mellitus and hypertension presented with a three-month history of intermittent left-sided otalgia with otorrhagia. Additionally, no associated facial asymmetry, headache or constitutional symptoms were revealed. There was no associated nasal symptoms or neck swelling. On examination, reddish mass was noted to occupy entire external auditory canal (EAC) extending into the conchal part of left pinna (Figure 1) whilst otoscopic examination of right ear was unremarkable. Computed tomography of temporal bone revealed heterogenous ill-defined mass occupying cartilaginous part of left EAC, extending to the conchal and anti-helix of pinna with minimal erosion of the cartilaginous part of EAC.

What is the diagnosis?

Answer*: refer to page 92*

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DISCLOSURE: There is no conflict of interest and consent has been obtained from patient for use of these images.

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(Refer to page 91)

ANSWER: ANGIOSARCOMA OF EXTERNAL EAR CANAL.

Biopsy of the EAC mass performed under local anaesthesia revealed squamous epithelium, ulcerative malignant cells with anastomosing vessels (Figure 2) suggestive of angiosarcoma with positive CD31 and Ki67 of 80%. CT Brain till abdomen showed no signs of metastasis. Patient was referred to the Oncology unit for chemoradiotherapy as she refused surgery.

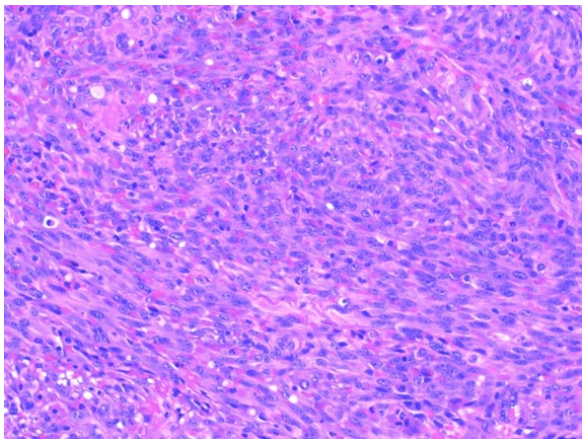

Figure 2: Infiltration of malignant cells with high mitotic activity (40x magnification; H&E).

Angiosarcoma is an aggressive, rare vascular malignancy of endothelial cells and represents 2% of all sarcomas[1] which exhibits high local recurrence rate with early metastatic potential Albeit 50% of angiosarcoma involves skin of head and neck,[2] this is the first case reporting on angiosarcoma involving EAC. Previous aural cases reported involved angiosarcoma of the external ear or pinna[3] and middle ear.[4] Accruing vague presentation, EAC angiosarcoma can be overlooked and diagnosed late. Chronic otorrhea has been deemed as the main risk factor of sarcoma and is the main presentation in our patient. Additionally, presentation of chronic otorrhea with otorrhagia resistant to treatment should alarm attending physicians of a more sinister condition notably malignancy warranting immediate biopsy and imaging.

Gold standard in diagnosis of EAC angiosarcoma is histopathological examination along with immunohistochemistry study. Computed tomography aids in evaluating the site of involvement along with extension of tumour in addition to presence of metastasis. Staging classification for EAC angiosarcoma follows University of Pittsburgh Staging System for Squamous Cell Carcinoma of the Temporal Bone (Appendix 1) as it can guide both treatment as well as prognosis.[3]

Treatment of choice for EAC Angiosarcoma is wide surgical resections with canalplasty. Margin involvement is common in angiosarcoma following its multifocal nature.[1] Additionally, ensuing the high risk of local recurrence, adjuvant radiotherapy is (> Gy 50) is recommended. To date, no solid evidence is present on role of neoadjuvant or adjuvant chemotherapy after surgery or radiotherapy. Cytotoxic chemotherapy has been reported with promising results for various angiosarcomas albeit no standard regime has been reported.

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Table I: University of Pittsburgh Staging System for Squamous Cell Carcinoma of the Temporal Bone.

T Status	
T1	Tumor limited to the EAC without bony erosion or evidence of soft tissue involvement
T2	Tumor with limited EAC bone erosion (not full thickness) with limited (< 0.5 cm) soft tissue involvement
T3	Tumor eroding the osseous EAC (full thickness) with limited (< 0.5 cm) soft tissue involvement or tumor involving the middle ear, mastoid, or both
T4	Tumor eroding the cochlea, petrous apex, medial wall of the middle ear, carotid canal, or jugular foramen of dura; or with extensive soft tissue involvement (>0.5 cm), such as involvement of the temporomandibular joint or stylomastoid foramen; or with evidence of facial paresis
N Status	
N0	No regional lymph node metastasis
N1	Regional lymph node metastasis
M Status	
M1	No distant metastasis
M2	Distant metastasis