The mass was not tender and had no ulceration however the skin was attached to the underlying tumour. The respiratory, cardiovascular, gastrointestinal, genitourinary, and central nervous systems were essentially unremarkable. A diagnosis of an anterior chest wall mass was made, and the patient was worked up for surgery.

The following investigations were done; haematological profile, serum electrolyte, urea and creatinine as well as liver function tests which were all within normal limits. The frontal and lateral chest radiographs (Fig. 2 and 3) done show a well circumscribed mass of soft tissue density arising from the middle portion of the sternum without any calcification within. There was no obvious lung parenchyma disease. The heart size was normal with a cardiothoracic ratio of 11.5/25.5.

Contrast enhanced computed tomography showed a lobulated, osteolytic expansile, non-enhancing, mixed density mass, measuring 12 x10cm in size localized in the sternum. There was breach of the sternal cortex and extension into the anterior and posterior soft tissue, and compressing posteriorly the anterior margin of the heart. The overlying skin was thinned out merging imperceptibly with anterior margin of the sternal mass. There were multiple amorphous calcifications within the mass (Fig. 4).

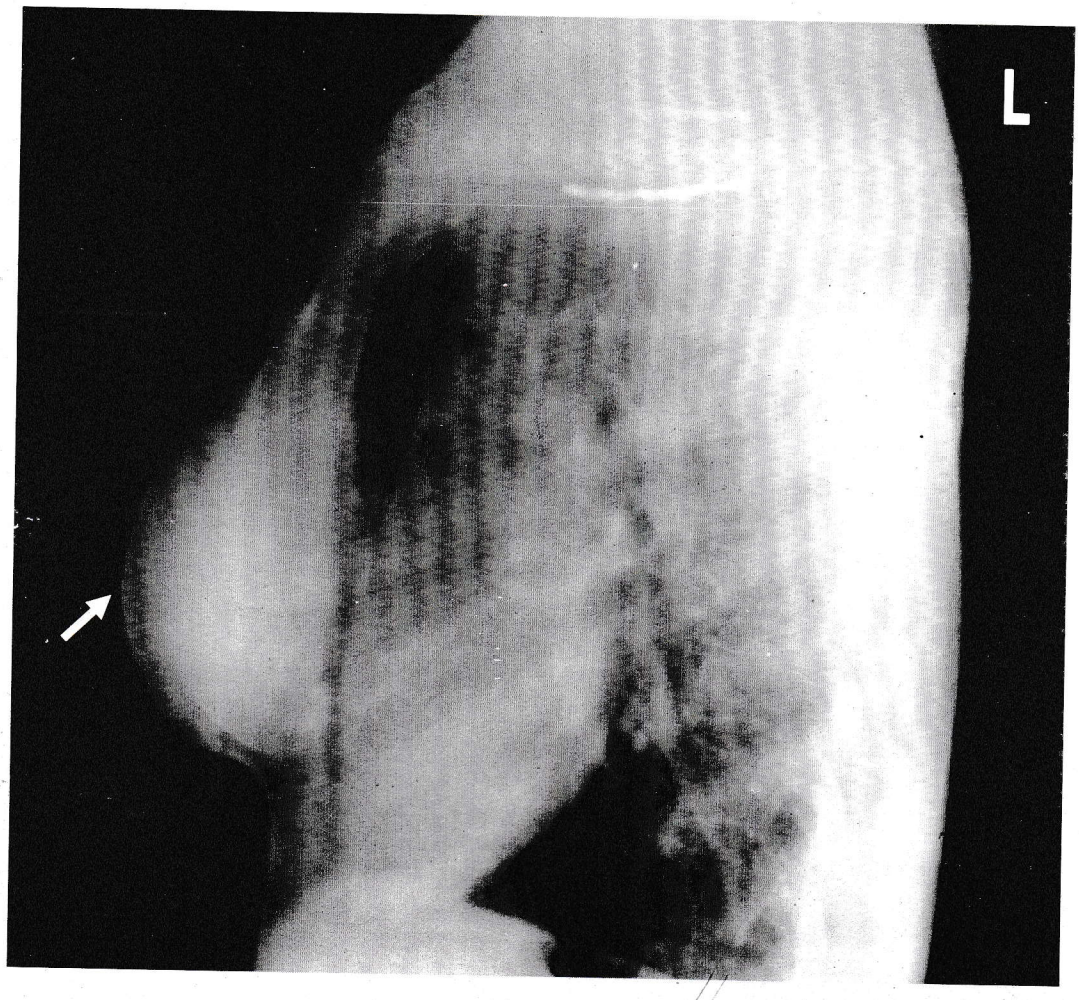

Fig. 3: Lateral chest radiograph of the same patient showed clearly a well-defined soft tissue mass overlying the middle portion of the anterior wall of the sternum (white arrow). There is no obvious extension to the mediastinal structures.