**Progress notes-102**

**Date :02/05/2012**

ProgressNotes :

Ward consultation

Carcinoma floor of mouth clinically T4.

D/W Dr.Krishnakumar.

Needs adjuvant RT preferably with IMRT.

Need an estimate.

Discussion with son only.

Deatiled counselling to be done after obtaining the HPR.

Dr.Vijayagopal

Radiation Oncology

**Date :21/01/2013**

ProgressNotes :

Carcinoma floor of mouth cT4 N0 Mx.

Composite resection ( Wide local excision of carcinoma floor of mouth+ anterior segmental mandibulectomy) + bilateral level I-IV neck dissection and reconstruction with left free fibula osteomyocutaneous flap on 19-04-2012 under

HPR: Squamous cell carcinoma - moderately differentiated.

- Tumor size 1.5x1.5x2.3cm.

- Depth of invasion 2cms.

- Tumor is seen infiltrating adjascent muscle and mandiular bone.

- No lymphovascular / perineural invasion seen.

- All resection margins free and well away.

- 25 reactive nodes.

pT4a N0.

Patient completed adjuvant chemoradiation with 64Gy/32# RT in Mangalore. In view of pain USG was done from there which showed subcutaneous nodules bilaterally, FNA of which is reported as metastatic WDSCC. Has been put on Geftinib and morphine by the local oncologist.

O/e: Tongue edemtous. No evidence of any obvious local lesion.

Right side of neck shows a firm area ~2x1 cm, with surface ulceration near the lower third of sternocledomastoid muscle, from where the FNAC has been taken.

S/b Dr SI:

It appears that area from where FNA has been done may be a fungating cervical lymph node. So advised to do a PET CT scan first. If negative for disease elsewhere, plan for salvage.

Signed By:Shawn T Joseph

**Date :23/01/2013**

ProgressNotes :

Carcinoma floor of mouth cT4 N0 Mx.

Composite resection ( Wide local excision of carcinoma floor of mouth+ anterior segmental mandibulectomy) + bilateral level I-IV neck dissection and reconstruction with left free fibula osteomyocutaneous flap on 19-04-2012 under

HPR: Squamous cell carcinoma - moderately differentiated.

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O/e: Right side of neck shows a firm area ~2x1 cm, with surface ulceration near the lower third of sternocledomastoid muscle, from where the FNAC has been taken.

PET CT Done: FDG AVID ENHANCING SOFT TISSUE LESION AROUND THE RAMUS OF MANDIBLE RIGHT SIDE & EXTENDING INTO THE BASE OF TONGUE. ? METABOLICALLY ACTIVE RECURRENT PRIMARY MALIGNANCY.

FDG AVID SUBCUTANEOUS NODULE IN RIGHT NECK, ANTERIOR TO THYROID GLAND METASTATIC DEPOSIT.

NO METABOLICALLY ACTIVE LYMPH NODAL / OTHER DISTANT METASTASIS.

Case discussed in TB and was planned for excision biopsy of the nodule to see if it is a LN met or a subcut nodule met.

If it is a LN met - Considering the locoregional spread of the disease patient can be offered option of curative intent surgery.

If it is a subcut deposit then considering it as systemic spread patient to be offered palliative therapy.

Csb Dr. SI:

Both the options discussed with b ystanders and patient posted for excision biopsy of the right neck swelling under LA tomorrow in OT.

It appears that area from where FNA has been done may be a fungating cervical lymph node. So advised to do a PET CT scan first. If negative for disease elsewhere, plan for salvage.

**Date :25/01/2013**

ProgressNotes :

24.1.2013:

Excision biopsy of the right lower neck subcutanoeus nodule done in 11OT under LA

Findings: 3 x 1 cms nodule with a fibrous track extendign superiorly. Nodule with skin and part of the tract excised. The end of the tract identified with a prolene stitch

Wound closed in layers. No undue complications

**Date :29/01/2013**

ProgressNotes :

Carcinoma floor of mouth cT4 N0 Mx.

Composite resection ( Wide local excision of carcinoma floor of mouth+ anterior segmental mandibulectomy) + bilateral level I-IV neck dissection and reconstruction with left free fibula osteomyocutaneous flap on 19-04-2012 under

HPR: Squamous cell carcinoma - moderately differentiated.

- Tumor size 1.5x1.5x2.3cm.

- Depth of invasion 2cms.

- Tumor is seen infiltrating adjascent muscle and mandiular bone.

- No lymphovascular / perineural invasion seen.

- All resection margins free and well away.

- 25 reactive nodes.

pT4a N0.

Patient completed adjuvant chemoradiation with 64Gy/32# RT in Mangalore. In view of pain USG was done from there which showed subcutaneous nodules bilaterally, FNA of which is reported as metastatic WDSCC. Has been put on Geftinib and morphine by the local oncologist.

O/e: Right side of neck shows a firm area ~2x1 cm, with surface ulceration near the lower third of sternocledomastoid muscle, from where the FNAC has been taken.

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FDG AVID SUBCUTANEOUS NODULE IN RIGHT NECK, ANTERIOR TO THYROID GLAND METASTATIC DEPOSIT.

NO METABOLICALLY ACTIVE LYMPH NODAL / OTHER DISTANT METASTASIS.

Case discussed in TB and was planned for excision biopsy of the nodule to see if it is a LN met or a subcut nodule met.

If it is a LN met - Considering the locoregional spread of the disease patient can be offered option of curative intent surgery.

If it is a subcut deposit then considering it as systemic spread patient to be offered palliative therapy.

Csb Dr. SI:

Both the options discussed with b ystanders and patient posted for excision biopsy of the right neck swelling under LA tomorrow in OT.

Excision biopsy of the right lower neck subcutanoeus nodule done under LA.

HPR: Moderately differentiated squamous cell carcinoma. Tumor is 3mm from the overlying skin. No lymhoidal background seen.

Csb Dr. SI

plan: To rediscuss in TB for surgery