**Progress Notes 114**

**Date :28/09/2019**

ProgressNotes :

50 year male,hailing friom andaman, without any co-morbs came with

c/o Lower alveolus lesion - 2-3months

asso.with pain

No h/o neck swelling

no h/o voice change/Dysphagia

No h/o Bleeding/Hemoptysis/Bone pain

O/E:

KPS-90

O/C,OPx:

Proliferative growth extending from Right incisior to the Left RMT, Involving the left buccal muocsa

Tongue and lingual cortex free.

Neck:

No nodes palpable

Biopsy(Twice in Andaman):

Pseudo-epitheliomatous hyperplasia

Impression:

Carcinoma Lower alveolus (Right incisor to Left RMT)

csb Dr DB sir

Advice:

PAC

PAC Ix

MR Head and Neck with contrast

CT Chest - plain

scopy:b/l vocal cords are mobile and normal(28/09/19)

Plan:

WLE+Segmental mandibulectomy + B/L ND + Bone flap under ga

**Date :03/10/2019**

ProgressNotes :

follow up case ?Carcinoma Lower alveolus (Right incisor to Left RMT)

s/b Dr DB

biopsy taken and sent for HPR

case postponed today ivo fanacial issues and pending biopsy report

to plan surgery tentatively in next week

**Date :08/10/2019**

ProgressNotes :

Diagnosis- ? Ca left Lower alveolus

Procedure- WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019

Transoral, lip split incision

findings- Ulcerolproliverative lesion involving the left lower alveolus from cental incisiors to the RMT with involvement of the left buccal mucosa

Since Biopsy wasn't definitive, patient and bystanders had been discussed with and plan for surgery was proceeded with

Under GA

Left cervical skin crease incision taken with a midline lip splitincision

bite block was placed and WLE with adequate magins including the lower labial mucosa and soft tissue anteriorly, left GBS and buccal mucosa laterally and RMT with anterior tonsillar pillar posteriorly, marginal mandibulectomy in the deeper part and upper alveolectomy superiorly.

left cervical skin crease incision extended

Subplatysmal flaps were elevated

Facial vessels were preserved and clipped for anastomosis

Level IA, left Level IB, submandibular gland were dissected and sent for HPE.

Left IJV, SAN, Carotids were identified and level II, III, IV cleared.

hemostasis checked and Romovac no 14 drain was placed

left RAFF harvested

Free Radial Artery Forearm Flap

Dimensions: 10 X 5 cm marked on Lt handafter draping and marking, tornique applied. Medial longitudinal skin incision is given. Subfascial / Suprafacial : Dissection done medial to lateral using tenotomy scissors without damaging the medial antebrachial cutaneous nerve traveling in the muscular fascia. As dissection proceeds laterally, subfascial dissection done over the palmaris longus tendon (if present) and the flexor carpi radialis tendon without damaging the paratenon on these tendons. The radial longitudinal skin incision given and performed lateral-to-medial subfascial /suprafacial dissection over the large brachioradialis. The dorsal radial nerve is preserved. Brachioradialis tendon is widely undermined the and retracted it laterally. The radial artery pedicle is dissected distally. The cephalic vein is included / not included in the harvest. Fasciocutaneous paddle is pedicled by only the lateral intermuscular septum and the radial artery pedicle. Proximally, incision from the skin paddle to the antecubital fossa is given. Then, performed subcutaneous dissection to elevate skin flaps medially and laterally. Followed the radial artery pedicle to the antecubital fossa using microclips or bipolar cautery on small vascular branches between the pedicle and underlying musculature. Flap harvested and anastomosis done to Left facial artery and vein. Haemostasis secured. Donor area closed primarily / SSG done.

Flap inset was done

incision closed in layers

**Date :18/10/2019**

ProgressNotes :

K/C/O Ca lower alveolus.

S/p WLE+Marginal Mandibullectomy+RAFF Hepatisis B+.

Tried with sips of water orally and posterior placement, head back and assisted lip seal.

-Patient tolerating well.

-Posterior placement of bolus with head back and assisted lip seal.

-No post swallow cough.

-No post swallow voice change.

-No post swallow distress.

-No signs of aspiration/penetration.

Impression: For for oral feeds (sips of water).

Plan:

Start on sips of water.

Posterior placement with head back and assisted lip seal advised.

Blend trial to be done.

Maintain adequate feeding position.

Avoid lying down soon after feeds.

Maintain adequate oral hygiene.

Shall review.

Seen by: Ms Arya CJ, Kaustav.

Entered by: Bhanupiriya

**Date :23/10/2019**

ProgressNotes :

healed well

taking orally

some superficial necrosis of lip split - deeper holding

hpr discussed in tb - planned for adg RT

plan

SR today

to meet Dr.Anoop in RT

r.a 1 week

**Date :23/10/2019**

ProgressNotes :

Case of Ca alveolus

Planned for RT

Limited mouth opening

Requires oral prophylaxis

Will report with OPG on Nov 8th.

To check for status of teeth from OPG to rule out foci of infection

Signed By:Dr. Nitin Anand Krishnan

**Date :12/11/2019**

ProgressNotes :

Limited mouth opening

Scaling done.

Can be taken up for RT

**Date :13/11/2019**

ProgressNotes :

Ca left Lower alveous

PROCEDURE DONE : WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019 (Transoral, lip split incision)

HP TB:

Agreed Plan of management : Adj RT

USG: Suspicious right level IB lymphnode as described (contralateral)

Patient is planned for USG and guided FNAC tomorrow.

adv:

To proceed with the guided FNAC

if node is positive then affected contralateral region to be covered by RT.

if node is negative then only ipsilateral neck to be covered by RT.

**Date :03/01/2020**

ProgressNotes :

post RT

reactions +

mouth opening 1.5 cms

asked to resume mouth opening exercise once mucosisits reduces

some lip incompetence left side

flap and donor site healthy

to use spoon and upgrade to semi solid diet

to r.a 3 months

Signed By:Dr. Deepak Balasubramaian

**Date :07/11/2020**

ProgressNotes :

ZOOM Consultation

DIAGNOSIS : ? Ca left Lower alveous

PROCEDURE DONE : WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019 Transoral, lip split incision

HPER: WLE with marginal mandibulectomy +upper alveolectomy + left SND (1-IV) - Well differentiated squamous cell carcinoma,lower alveolus. -Tumour measures 5.4x2.7x2.3cm. - Depth of invasion - 0.9 cm - WPOI -Pattern 4 - LHR- Score 0 - PNI -Score 0 - No LVEmboli seen - Risk group - intermediate - Bony invasion seen into the mandible Margin status: All mucosal , bony and soft tissue margins and the additional ones taken are free tumour. Lymph nodes All sampled lymph nodes (0/17) are free of tumour. AJCC stage- pT4N0

RT Commencement: Date:20/11/19

Planned RT Dose:60Gy in 30# PTV 60GY: Left ITF + Sx bed + Left RP+Left Lev I,II,III PTV 54Gy: Left Lev IVA,V and Right Lev Ib, II

CO-MORBIDITIES : Hepatitis B on Tab.Tenofovir 25mg OD.

c/o swelling over the lower lip

c/s/b Dr DB:

adv: quarantine as per institutional COVID protocol

review in OPD afterwards

Imaging to be done

Signed By:Dr. Tejal Patel

**Date :25/11/2020**

ProgressNotes :

csb Dr DB

Plan;

WLE + PMMC vs ALT Flap under ga

Advise:

PAC

PAC Ix

**Date :27/11/2020**

ProgressNotes :

Diagnosis:

Recurrent Carcinoma Lower Alveolus/Lower Lip rT4aN0M0

Surgery:

WLE+Segmental mandibulectomy + PMMC under ga on 26-11-2020

Surgeons:

Dr DB/Dr Nagesh

Findings;

Severe trismus noted with nil mouth opening.

UPG involving the Skin, Left Lower lip, Commissure, upper lip, lower alveolus, buccal mucosa and upper alveolus.

Procedure:

Under GA, PPD.

Incision marked around the skin lesion with adequate margins.

Incision made. mandible exposed anteriorly at the level of right canine, posteriorly at the condylar notch.

Bony cuts made anteriorly and posteriorly on the mandible and Left upper alveolus.

Mucosal and soft tissue cuts made with adequate margins, specimen delivered in toto and sent for hpe.

Hemostasis achieved.

Defect repaired with PMMC flap.

Left PMMC Flap harvest:

Dimensions: 15x8cm with skin

The clavicle, xiphoid, ipsilateral sternal border are identified, and then the size and location of the skin paddle being located at the inferior-medial border of the pectoralis major muscle are marked.

The vascular axis is drawn on the skin of the chest.

The initial incision is made at the lateral part toward the anterior axillary line down to the pectoralis major muscle.

The inferior, medial and lateral incisions are made through the skin, subcutaneous fat and pectoralis fascia down to the chest wall.

The superior incision is made down to the muscle fibres and the skin island is tightened to the muscle with sutures to protect the skin island during operative handling and shearing.

As the muscle is elevated inferiorly to superiorly, the pedicle is identified by palpation and visualization on the deep surface of the muscle. While cutting the muscle along the sternal attachment, care was taken not to injury the internal mammary perforators adjacent to the sternum that supply the deltopectoral flap.

After dissection of the flap off the chest wall, a subcutaneous tunnel is formed under the skin between neck and the chest and the flap is passed underneath the skin bridge and brought into neck.

Flap inset done to the defect.

Exposed part of the flap covered with skin graft.

Donor site closed with skin graft.

**Date :01/12/2020**

ProgressNotes :

Debridement under ga on 01-12-2020

Procedure:

Under GA, PPD

Distal ~5x5cm part of the flap necrosis noted, which was debrided till bleeding appears.

Residual flap sutured to the upper and lower lip.

Dressing applied.

**Date :31/12/2020**

ProgressNotes :

Dr.Janarthanan, Dr.Shravan, Dr.Vasundhra

Debridement of PMMC flap+Forehead flap cover+SSG under GA

-Parts painted and drapped

-Necrotic tissue over the previous PMMC flap debrided

-Edges freshened

-Forehead flap based on the left superficial temporal artery raised

-Flap tunneled superficial to the left maxilla into the oral cavity to recreate the left lower lip

-Flap inset done

-Donor site SSG placed and tie over dressing done

-Lower aspect of PMMC SSG placed

**Date :13/01/2021**

ProgressNotes :

Surgeon- dr janarthanan, dr vasundhra

procedure- secondary suturing under LA

3x4cm defect at left commissure; s/p forehead flap done

wound debrided

edges freshened

wound closed with 3-0 vicryl and 4-0 nylon

**Date :06/07/2022**

ProgressNotes :

K/C/O Carcinoma left Lower alveolus S/P WLE+Segmental mandibulectomy + PMMC under GA on 26-11-2020,

Developed partial flap necrosis Debridement of PMMC flap+Forehead flap cover+SSG under GA on 31/12/2020

Second suturing under GA on 13/01/2021

PAtient has chronic Hepatitis B. On Tenofovir

came for follow up

o/e- NAD

SB DR DB

R/A 1YEAR

**Date :10/07/2023**

ProgressNotes :

K/C/O Carcinoma left Lower alveolus

S/P WLE+Segmental mandibulectomy + PMMC under GA on 26-11-2020, Developed partial flap necrosis Debridement of PMMC flap+Forehead flap cover+SSG under GA on 31/12/2020

Second suturing under GA on 13/01/2021

HPR WLE + Segmental Mandibulectomy + Palatal Mucosal Margin Clearance:. - Well differentiated squamous cell carcinoma - Tumour size - 3.8x2.4x2.1cm. - Depth of invasion -1.6cm.

- AJCC staging rT4Nx

k/c/o Carcinoma left Lower alveous WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019 Transoral, lip split incision

HPER: WLE with marginal mandibulectomy +upper alveolectomy + left SND (1-IV) - Well differentiated squamous cell carcinoma,lower alveolus. -Tumour measures 5.4x2.7x2.3cm.

AJCC stage- pT4N0

RT Commencement: Date:20/11/19

RT Completed: 30.12.2019

Planned RT Dose:60Gy in 30#

PAtient has chronic Hepatitis B. On Tenofovir

came for follow up

on liquid diet

o/e- L/R -NAD

mo 1.5fb

multiple scar +

left commisure incompetence noted

with pmmc flap hanging

SB DR DB

suggested --lip competence surgery - +flap debulking under LA-- minor ot

day case

patient to revert back aftr discussing with family

to plan FFF for left jaw defect after 1 year

Signed By:Dr. Mahajan Avani Rajendra

**Date :09/12/2024**

ProgressNotes :

k/c/o Carcinoma left Lower alveous

WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019 Transoral, lip split incision

HPER: WLE with marginal mandibulectomy +upper alveolectomy + left SND (1-IV) - Well differentiated squamous cell carcinoma,lower alveolus. -Tumour measures 5.4x2.7x2.3cm.

AJCC stage- pT4N0

RT Commencement: Date:20/11/19

RT Completed: 30.12.2019

Planned RT Dose:60Gy in 30#

K/C/O Carcinoma left Lower alveolus

S/P WLE + Segmental Mandibulectomy + Palatal Mucosal Margin Clearance:. + PMMC under GA on 26-11-2020,

Developed partial flap necrosis Debridement of PMMC flap+Forehead flap cover+SSG under GA on 31/12/2020

Second suturing under GA on 13/01/2021

HPR

- Well differentiated squamous cell carcinoma - Tumour size - 3.8x2.4x2.1cm. - Depth of invasion -1.6cm.

- AJCC staging rT4Nx

Patient has chronic Hepatitis B. On Tenofovir

now growth in left FOM SINCE 1MNTH

O/E KPS 80

MO 1.5FB

on liquid diet

partially denatte

multiple scars , forhead flap

Prolifertaive growth in left fom from the adjecent commisure to Lfet rmt along the lenght of inner aspect of forehead flap

abutting the tongue

multiple neck scar +, post RT skin changes

Left FOM - Squamous proliferative lesion with dysplasia .(PROV )

sb dr DB

MRI HEAD NECK CONTRAST

CT CHEST

Signed By:Dr. Mahajan Avani Rajendra

**Date :11/12/2024**

ProgressNotes :

k/c/o Carcinoma left Lower alveous

WLE of Ca left Lower Alveolus with marginal mandibulectomy and left upper alveolectomy + Left SND (I-IV) + lt. RAFF reconstruction with tracheostomy under GA on 8.10.2019 Transoral, lip split incision

HPER: WLE with marginal mandibulectomy +upper alveolectomy + left SND (1-IV) - Well differentiated squamous cell carcinoma,lower alveolus. -Tumour measures 5.4x2.7x2.3cm.

AJCC stage- pT4N0

RT Commencement: Date:20/11/19

RT Completed: 30.12.2019

Planned RT Dose:60Gy in 30#

K/C/O Carcinoma left Lower alveolus

S/P WLE + Segmental Mandibulectomy + Palatal Mucosal Margin Clearance:. + PMMC under GA on 26-11-2020,

Developed partial flap necrosis Debridement of PMMC flap+Forehead flap cover+SSG under GA on 31/12/2020

Second suturing under GA on 13/01/2021

HPR

- Well differentiated squamous cell carcinoma - Tumour size - 3.8x2.4x2.1cm. - Depth of invasion -1.6cm.

- AJCC staging rT4Nx

Patient has chronic Hepatitis B. On Tenofovir

now growth in left FOM SINCE 1MNTH

O/E KPS 80

MO 1.5FB

on liquid diet

partially denatte

multiple scars , forhead flap

Prolifertaive growth in left fom from the adjecent commisure to Lfet rmt along the lenght of inner aspect of forehead flap

abutting the tongue

multiple neck scar +, post RT skin changes

Left FOM biopsy - Squamous proliferative lesion

Note : Interpretation limited as there is no deeper tissue to comment on invasion. Suspicious for recurrence of squamous cell carcinoma recurrence in a known case,

ct chest

Subsegmental collapse with adjacent traction bronchiectasis in right right middle lobe and lingula.

Fibrotic changes in apical segment of right upper lobe and apico-posterior segment in left upper lobe.

sb dr DB

plan wle + rt SND +regional flap - latismuss dorsi (to raise the flap and look for skin vascularilty - sos delay )

fic /pac

fic only for hn major biopsy+grade 1 recon given

**Date :24/12/2024**

ProgressNotes :

diagnosis- Recurrent wdscc left neoBM (flap) & left lower alveolus (cT4aN0) s/p ca lower alveolus s/p surgery s/p RT

surgery- midline lip split-- wle + marginal mandibulectomy + left snd (i-iv) + RAFF + tracheostomy under GA on 19-12-24

surgeons- Dr DB/Dr Kiran/Dr Avani

findings- upg involving left side pmmc flap , left upper alveolus

2 cm behind left oral commissure

post- involving RMT

medially- abutting left lateral boreder tongue

overlying skin- nad

previous lip aplit scar, left forehead flap and pmmc flap +

multiple nodes in left level ia, iia and iii, largest in right iia (1x1 cm)

steps-

pt laid supine

nasotracheal intubation done

PPD

midline lip split incision on previous scar mark given and left lower cheek flap elevated with previous forehead flap

tumor excised and esent for frozen- frozen----> WDSCC

taking adequate margin all around the tumor area, left side pmmc in buccal mucosa , remaining left mandible ramus, inferior partial maxillectomy and left side tongue part excised intoto

defect reconstructed with RAFF (10X6 CM)

right snd

Skin crease incision made.

Subplatysmal flaps elevated superiorly till angle of mandible, inferiorly till clavicle.

Ipsilateral and contralateral anterior belly of digastric muscle defined.

Fibrofatty tissue from the level-Ia taken and sent for hpe.

Facial artery and common facial vein identified and ligated, stump preserved for end-to-end anastomosis.

peri-facial lymph nodes and level-Ib fibrofatty tissue along with submandibular gland removed in toto and sent for hpe.

External jugular vein identified and preserved for anastomosis.

Sternomastoid retracted laterally ijv, carotids and spinal accessory nerves preserved.

Level-IIa, IIB, III lymphnodes and fibrofatty tissue removed and sent for hpe seperately.

Hemostasis acheived.

Valsalva given to check bleeding no active bleeding seen.

14# romovac drain secured.

Wound closed in layers.

flap- right RAFF (10X6 CM) cm harvested

Operative procedure : Under GA, parts painted and draped.

Allens test performed and ulnar artery patency confirmed.

Flap marking done. Under torniquet, incision made first on the lateral aspect, dissection proceeded in suprafascial manner till lateral border of Brachioradialis preserving the radial cutaneous nerve. Incision made in the deep fascia and dissection proceeded sub fascially.

Distal incision made and deepened. Radial pedicle identified in between Brachioradialis and FCR,

ligated and divided. Medial incision made, dissection proceeded suprafascially till medial border of FCR,

fascia incised and dissection continued till pedicle.

Dissection proceeded distal to proximal ligating and dividing all encountered branches. Incision made till cubital fossa exposing the pedicle in the entire length in between the brachioradialis and FCR muscles till origin.

Flap perfusion confirmed and divided at origin. Flap taken for inset.

Hemostasis achieved.

14 F Romovac drain placed and closed in layers with 2 0 vicryl, 3 0 vicryl and skin staples.

Defect in distal forearm resurfaced with SSG harvested from right thigh

Flap inset - Microvascular anastamosis performed in the neck in between flap artery to right facial artery and vena commitant to right facial vein with 9- 0 nylon sutures under microscope.

Flap perfusion confirmed.

Inset completed with intermittent vicryl sutures.

Flap inset over the facial side completed with intermittent 4 0 nylon sutures, glove drain placed at the flap and the anastamotic site in the neck

**Date :09/01/2025**

ProgressNotes :

diagnosis- Recurrent wdscc left neoBM (flap) & left lower alveolus (cT4aN0) s/p ca lower alveolus s/p surgery s/p RT

surgery- midline lip split-- wle + marginal mandibulectomy + left snd (i-iv) + RAFF + tracheostomy under GA on 19-12-24

pt came with swelling left side of neck left side

o/e-

small fistulous tract present left upper cheek region

20 ml pus drained out

DW DR DB sir

pt advised admission but refused due to financial issues

pus culture sent already

Inj Magnex Forte 1.5 mg IV BD

tab dolo 650 mg

tab pan 40 mg

Signed By:Dr. Arjun Roy

**Date :13/01/2025**

ProgressNotes :

diagnosis- Recurrent wdscc left neoBM (flap) & left lower alveolus (cT4aN0) s/p ca lower alveolus s/p surgery s/p RT

surgery- midline lip split-- wle + marginal mandibulectomy + left snd (i-iv) + RAFF + tracheostomy under GA on 19-12-24

hpe-

Impression : Specimen type : WLE Left lower alveolus

Histological diagnosis : Squamous cell carcinoma

Grade : Well differentiated

Type: Conventional

Tumor site and laterality: Floor of mouth - left

Tumor dimensions: 3 x 2 cm

Tumor thickness: 0.5 cm

Depth of invasion :0.5cm

Tumor extent - PMMC flap, lateral border

Margin clearance :

Closest margin is RMT mucosal margin which is 1.2cm away.

Bony margins- free of tumor

Bony invasion - seen

LVE - Not seen

WPOI - Pattern 3

PPOI - Pattern 3

LHR - score 1

PNI - score 0

Risk group (Brandwein et al) - Intermediate

Lymph Nodes

Levels of nodes sampled - Right I B - Right IV

No. of nodes sampled - 11

No. of nodes showing metastasis - 0

AJCC stage pT4N0

developed small fistulous tract present left upper cheek region, 20 ml pus drained out in last visit

started on inj magnex, 5 doses given

OE-15 cc pus drained

SB DR DB

Vedio consultation with Dr Krishnapriya at 2 pm

Signed By:Dr. Deepak Balasubramanian

**Date :15/01/2025**

ProgressNotes :

ProgressNotes :

diagnosis- Recurrent wdscc left neoBM (flap) & left lower alveolus (cT4aN0) s/p ca lower alveolus s/p surgery s/p RT

surgery- midline lip split-- wle + marginal mandibulectomy + left snd (i-iv) + RAFF + tracheostomy under GA on 19-12-24

hpe-

Impression : Specimen type : WLE Left lower alveolus

Histological diagnosis : Squamous cell carcinoma

Grade : Well differentiated

Type: Conventional

Tumor site and laterality: Floor of mouth - left

Tumor dimensions: 3 x 2 cm

Tumor thickness: 0.5 cm

Depth of invasion :0.5cm

Tumor extent - PMMC flap, lateral border

Margin clearance :

Closest margin is RMT mucosal margin which is 1.2cm away.

Bony margins- free of tumor

Bony invasion - seen

LVE - Not seen

WPOI - Pattern 3

PPOI - Pattern 3

LHR - score 1

PNI - score 0

Risk group (Brandwein et al) - Intermediate

Lymph Nodes

Levels of nodes sampled - Right I B - Right IV

No. of nodes sampled - 11

No. of nodes showing metastasis - 0

AJCC stage pT4N0

o/e- wound - small fistula present upper check region (Lt) side

SB DR DB sir

adv- Ideally patient needs radiation , depends on wound healing.

Tab Ciplox 500 mg 1-0-1 x 7 days

tab metrogyl 400 mg 1-1-1 x 3 days

Pt wants to go Andaman tomorrow

r/v after 1 weeks on Zoom consultation

Signed By:Dr. Arjun Roy