**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 27/10/2015

**Received on :** 27/10/2015

**Reported Date :** 30/10/2015**Gross Description :**

Specimen labelled as "Subtotal Glossectomy" consists of tongue oriented with sutures, whole msg 8x4.5x4cm.

An ulcerated leison is seen in the dorsum of the tongue msg 2.5x2x4.2cm. the tumor is 2cm from superomedial

mucosal and soft tissue margin, 0.5cm from inferolateral mucosal and soft tissue margin, 1cm from posterior

mucosal and soft tissue margin, 2cm from anterior mucosal and soft tissue margin and 1cm from deep inked

margin

A1- Superomedial mucosa and soft tissue margin

A2- Inferolateral mucosa and soft tissue margin

A3- deep margin

A4- anterior mucosa and soft tisuee margin

A5- posterior mucosa and soft tissue margin

A6-9: Tumor proper

B: Specimen labelled as "Additional anteroinferior mucosal and soft tissue" consists of mucosa with soft tissue

msg 2.5x2x1cm( ESP in 2C)

C: Specimen labelled as "Additional lateral mucosal margin" consists of mucosa with soft tissue msg

2.7x0.4x0.3cm( ESP in 1C)

D: Specimen labelled as "final additional anteroinferior margin" consists of mucosa with soft tissue msg

1.3x0.5x0.3cm( ESP in 1C)

E: Specimen labelled as "Left level IIA" consists of nodular tissue msg 4.5x4x2cm. Three lymph nodes

identified, largest msg 1.2cm. ESP in E1-3.

F: Specimen labelled as "Left level IIB" consists of nodular tissue msg 4x2.5x1cm. Three lymph nodes

identified, largest msg 1cm. ESP in E1-2.

G: Specimen labelled as "Left level IB" consists of salivary gland with attached lymph nodes msg 5.9x5.5x1.5cm

ESP in G1,2.

H: Specimen labelled as "Right level IV" consists of nodular tissue msg 3.5x2.5x1cm. One lymph node

identified msg 0.4cm ESP in H1-3

J: Specimen labelled as "Right level IIB" consists of nodular tissue msg 3.7x1.8x1cm. 4 lymph nodes identified

largest msg 1cm in greatest dimension. ESP in 2C.

K : Specimen labelled as "Right level IIA" consists of nodular tissue msg 3x2x1cm. Largest lymph node msg

2.2cm ESP in K1,2.

L: Specimen labelled as "Right level Ib" consists of salivary gland with attached lymph nodes msg 4.3x5.5x2cm.

Largest lymph node msg 0.5cm; ESP in L1-3.

M: Specimen labelled as "Right level III" consists of nodular tissue msg 5x2.8x1.5cm. Largest lymph node msg

1cm ESP in M1-3.

N: Specimen labelled as "Left level III" consists of nodular tissue msg 3.5x2x1cm. Two lymph nodes seen.

Largest lymph node msg 1cm ESP in N1,2.

P: Specimen labelled as "level IA" consists of nodular tissue msg 3x2x1cm. 3 lymph nodes seen, Largest lymph

node msg 2.2cm ESP in P1,2.

**Microscopic Description :**

Type of specimen: Subtotal Glossectomy

Histological type: Sections show mucosa with an infiltrating Well to Moderately differentiated Squamous cell

carcinoma. Few mitoses, keratin pearls, stromal desmoplasia and secondary chronic inflammation are present.

Invasive front: Cohesive. Large lymphoid aggregates are present at the tumor front. Tumor size: 2.5x2x4.2cm.

Maximum depth of invasion: 3.9cm. Vascular invasion- Absent. Nerve invasion - present (occasional, small

nerves).

Margins: the tumor is 2cm from superomedial mucosal and soft tissue margin, 0.5cm from inferolateral mucosal

and soft tissue margin, 1cm from posterior mucosal and soft tissue margin, 2cm from anterior mucosal and soft

tissue margin and 1cm from deep inked margin.

"Additional anteroinferior mucosal and soft tissue, additional lateral mucosal margin, final additional

anteroinferior margin:Free of tumor.

Lymph nodes:

"Left level IIA": Four lymph nodes, free of tumor

"Left level IIB":Three lymph nodes, free of tumor.

"Left level IB": Three lymph nodes and salivary gland, free of tumor

"Right level IV": Two lymph nodes, free of tumor.

"Right level IIB":Six lymph nodes, free of tumor.

"Right level IIA": Two lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level III": Five lymph nodes, free of tumor.

"Left level III": Three lymph nodes, free of tumor

"Level IA": Three lymph nodes, free of tumor

**Impression :**

Type of specimen: Subtotal Glossectomy

Histological type: Squamous cell carcinoma

Differentiation : Well to Moderate

Invasive front: Cohesive

Tumor size: 2.5x2x4.2cm

Maximum depth of invasion: 3.9cm

Vascular invasion- Absent

Nerve invasion - present (occasional, small nerves)

Margins: the tumor is 2cm from superomedial mucosal and soft tissue margin, 0.5cm from inferolateral mucosal

and soft tissue margin, 1cm from posterior mucosal and soft tissue margin, 2cm from anterior mucosal and soft

tissue margin and 1cm from deep inked margin.

"Additional anteroinferior mucosal and soft tissue, additional lateral mucosal margin, final additional

anteroinferior margin:Free of tumor.

Lymph nodes:

"Left level IIA": Four lymph nodes, free of tumor

"Left level IIB":Three lymph nodes, free of tumor.

"Left level IB": Three lymph nodes and salivary gland, free of tumor

"Right level IV": Two lymph nodes, free of tumor.

"Right level IIB":Six lymph nodes, free of tumor.

"Right level IIA": Two lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level III": Five lymph nodes, free of tumor.

"Left level III": Three lymph nodes, free of tumor

"Level IA": Three lymph nodes, free of tumor

pTNM stage pT3N

**RADIOLOGY REPORT**

**Created Date:** 17/10/2016

**Study Done:**

**ULTRASOUND OF NECK**

Both thyroid gland appear normal .

No significant lymph nodes.

No evidence of any collection.

Skin and subcutaneous edema noted.

**Impression:**

***Known case of Ca tongue status post WLE***

• No significant lymphnodes.

• Skin and subcutaneous edema noted.

|  |  |
| --- | --- |
| **Date of Admission :**17/10/2015 | **Date of Procedure :**27/11/2015 |

|  |
| --- |
| **Date of Discharge :**06/11/2015 |

|  |
| --- |
|  |

|  |
| --- |
| **Discharging Status :**FOLLOW UP DISCHARGE SUMMARY |

|  |
| --- |
| **DIAGNOSIS :** |
| Carcinoma tongue |

|  |
| --- |
| **PROCEDURE DONE :** |
| WLE + B/L SND + RAFF+ tracheastomy under GA on 27.10.15 |

|  |
| --- |
| **HISTORY :** |
| 46 yr old male patient presented with c/o right sided tongue - non healing ulcer - since 3 months progressive , painful he was evaluated in gulf and diagnosed to have SCC of tongue. Comorbidities: DM on insulin , HTN on Omnesartan , Depression on anti depressants |

|  |
| --- |
| **CLINICAL EXAMINATION :** |
| O/E: 4x2 cm ulceroproliferative lesion on right lateral border of tongue, 1 cm from the base and the floor of mouth. No palpable lymph nodes. Laryngoscopy was normal. |

**INVESTIGATIONS :**

**Haemogram:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Hb: g/dl** | **PCV: %** | **PLT: ku/ml** | **TC: ku/ml** | **DC: N %** | **L: %** | **E: %** | **ESR: mm/1st hr** |
| 21/10/2015 | 13.9 | 43.4 | 331 | 13.3 | 60.5 | 28.1 | 2.8 | - |
| 27/10/2015 | 10.0 | 31.4 | 214 | 25.6 | 86.6 | 6.9 | 0.1 | - |
| 28/10/2015 | 11.1 | 35.5 | 220 | 20.7 | 87.3 | 8.2 | 0.0 | - |
| 29/10/2015 | 9.2 | 27.9 | 178 | 18.1 | 84.8 | 7.4 | 0.0 | - |
| 30/10/2015 | 9.08 | 29.0 | 205 | 14.8 | 75.3 | 15.2 | .444 | - |
| 31/10/2015 | 9.4 | 28.7 | 229 | 11.7 | 72.8 | 16.7 | 1.7 | - |
| 02/11/2015 | 10.6 | 32.4 | 383 | 18.5 | 81.1 | 10.1 | 1.0 | - |

**Renal Function Test and Serum Electrolytes:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 27/10/2015 | - | - | 141.6 | 3.8 |
| 28/10/2015 | 17.3 | 0.77 | 138.6 | 4.2 |

Date: 05/11/2015

|  |  |
| --- | --- |
| Glucose [F]-Plasma : 124.9 mg/dl |  |

Date: 02/11/2015

|  |  |
| --- | --- |
| RBC-COUNT-Blood : 3.75 M/uL | MCV-Blood : 86.4 fL |

|  |  |
| --- | --- |
| MCH-Blood : 28.2 pg | MCHC-Blood : 32.6 g/dl |

|  |  |
| --- | --- |
| RDW-Blood : 15.3 % | MPV-Blood : 9.2 fL |

|  |  |
| --- | --- |
| MONO -Blood : 7.4 % | BASO-Blood : 0.4 % |

Date: 31/10/2015

|  |  |
| --- | --- |
| RBC-COUNT-Blood : 3.29 M/uL | MCV-Blood : 87.0 fL |

|  |  |
| --- | --- |
| MCH-Blood : 28.6 pg | MCHC-Blood : 32.9 g/dl |

|  |  |
| --- | --- |
| RDW-Blood : 14.9 % | MPV-Blood : 9.5 fL |

|  |  |
| --- | --- |
| MONO -Blood : 8.4 % | BASO-Blood : 0.4 % |

Date: 30/10/2015

|  |  |
| --- | --- |
| TSH [Thyroid Stimulating Hormo-Serum : 2.3298 uIU/ml | T4 [Thyroxine] free-Serum : 0.88 ng/dl |

|  |  |
| --- | --- |
| Free T3-Serum : 2.29 pg/ml | RBC-COUNT-Blood : 3.41 M/uL |

|  |  |
| --- | --- |
| MCV-Blood : 85.2 fL | MCH-Blood : 26.6 pg |

|  |  |
| --- | --- |
| MCHC-Blood : 31.3 g/dl | RDW-Blood : 12.7 % |

|  |  |
| --- | --- |
| MPV-Blood : 6.08 fL | MONO -Blood : 8.18 % |

|  |  |
| --- | --- |
| BASO-Blood : .879 % |  |

Date: 29/10/2015

|  |  |
| --- | --- |
| RBC-COUNT-Blood : 3.23 M/uL | MCV-Blood : 86.5 fL |

|  |  |
| --- | --- |
| MCH-Blood : 28.5 pg | MCHC-Blood : 32.9 g/dl |

|  |  |
| --- | --- |
| RDW-Blood : 14.8 % | MPV-Blood : 10.1 fL |

|  |  |
| --- | --- |
| MONO -Blood : 7.7 % | BASO-Blood : 0.1 % |

|  |  |
| --- | --- |
| Troponin I : <0.0012 ng/ml |  |

Date: 28/10/2015

|  |  |
| --- | --- |
| Troponin I : <0.0012 ng/ml | PT[Prothrombin Time with INR]-Plasma : 16.7/14.60/1.19 sec |

|  |  |
| --- | --- |
| RBC-COUNT-Blood : 4.13 M/uL | MCV-Blood : 86.0 fL |

|  |  |
| --- | --- |
| MCH-Blood : 28.1 pg | MCHC-Blood : 32.6 g/dl |

|  |  |
| --- | --- |
| RDW-Blood : 14.8 % | MPV-Blood : 8.6 fL |

|  |  |
| --- | --- |
| MONO -Blood : 4.5 % | BASO-Blood : 0.0 % |

Date: 27/10/2015

|  |  |
| --- | --- |
| RBC-COUNT-Blood : 3.62 M/uL | MCV-Blood : 86.7 fL |

|  |  |
| --- | --- |
| MCH-Blood : 27.7 pg | MCHC-Blood : 32.0 g/dl |

|  |  |
| --- | --- |
| RDW-Blood : 14.7 % | MPV-Blood : 9.6 fL |

|  |  |
| --- | --- |
| MONO -Blood : 6.4 % | BASO-Blood : 0.0 % |

|  |  |
| --- | --- |
| Glucose [F]-Plasma : 136.0 mg/dl |  |

Date: 26/10/2015

|  |  |
| --- | --- |
| Compatibility test; cross match complete (3 tests) : Compatible | Blood typing; ABO and RhD : O Rh D Positive |

|  |  |
| --- | --- |
| HBs Ag Test - Emergency Screen : 0.25 : Non reactive | Anti HCV - Emergency Screen : 0.07 : Non reactive |

|  |  |
| --- | --- |
| HIV - Emergency Screen(P24 Ag and HIV 1 and 2 Ab) : 0.17 : Non reactive |  |

Date: 21/10/2015

|  |  |
| --- | --- |
| PT[Prothrombin Time with INR]-Plasma : 13.9/14.60/0.94 sec | RBC-COUNT-Blood : 5.22 M/uL |

|  |  |
| --- | --- |
| MCV-Blood : 83.1 fL | MCH-Blood : 26.6 pg |

|  |  |
| --- | --- |
| MCHC-Blood : 32.1 g/dl | RDW-Blood : 14.4 % |

|  |  |
| --- | --- |
| MPV-Blood : 9.0 fL | MONO -Blood : 8.3 % |

|  |  |
| --- | --- |
| BASO-Blood : 0.3 % |  |

Date: 18/10/2015

|  |  |
| --- | --- |
| Urine Protein / Creatinine Rat : 0.1 | Glucose [Urine] : 2+ mg/dl |

|  |  |
| --- | --- |
| Bilirubin [Urine] : Negative umol/L | Ketone [Urine] : Trace mmol/L |

|  |  |
| --- | --- |
| Specific Gravity-urine : 1.025 NONE | Blood [Urine] : Negative EU |

|  |  |
| --- | --- |
| Urobillinogen-urine : Normal umol/L | Urine pH : 5.5 NONE |

|  |  |
| --- | --- |
| Nitrite-urine : Negative | Clarity-urine : Clear |

|  |  |
| --- | --- |
| Color-urine : Light Yellow | Leucocytes-urine : Negative |

|  |  |
| --- | --- |
| Pus Cells : 0-2 HPF NONE | Urine Protein : Negative |

|  |  |
| --- | --- |
| Hyaline Cast : NIL | Red Blood Cell : 1-2 HPF NONE |

|  |  |
| --- | --- |
| Epithelial cells : NIL | Trichomonad : Absent |

|  |  |
| --- | --- |
| Granular Cast : NIL | Calcium Oxalate : NIL |

|  |  |
| --- | --- |
| Bacteria Urine : ABSENT | Amorphous phosphate : NIL |

|  |  |
| --- | --- |
| Uric acid crystals : NIL | Mucus : PRESENT |

|  |  |
| --- | --- |
| Yeast cells : NIL | Triple Phosphate : NIL |

|  |  |
| --- | --- |
| Other sediment findings : NIL | Magnesium : 1.9 mg/dl |

|  |  |
| --- | --- |
| Cholesterol, total -Plasma : 191.4 mg/dl | Cholesterol HDL-Plasma : 31.7 mg/dl |

|  |  |
| --- | --- |
| Cholesterol LDL-Plasma : 130.3 mg/dl | Cholesterol VLDL : 39.0 mg/dl |

|  |  |
| --- | --- |
| Triglycerides -Plasma : 193.0 mg/dl |  |

|  |
| --- |
| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Patient was admitted for in-patient preoperative evaluation and surgery. He was investigated and optimized. He tolerated the surgical procedure well. Post procedure drains were removed and he was ambulated. Flap was monitored and he was shifted out of ICU on POD5. He was decannulated on POD6. He was gradually sarted on oral diet and Ryle's tube was removed. He is now taking orally, flap is healthy, euglycemic and fit for discharge. |

|  |
| --- |
| **OPERATIVE FINDINGS :** |
| FINDINGS: right lateral border of tongue show ulceroinfltrative lesion 4/2.5 cm extending 1 cm anterior to BOT, involving Tip and extending below onto ventral surface of tongue. laterally lesion extends on to ventral surface reaching upto floor of mouth. b/l prefacial nodes are 0.5/0.5cm . multiple enlarged lyphnodes involving right level II A. Procedure : wide local excision done with a rim of 1 cm margin. defect involved > 50% of tongue volume. after tumour grossing additional antero lateral soft tissue and lateral mucosal margin taken . right level II A show multiple enlarged lymph nodes. right level IA-IV cleared. rent in inferior end of IJV on right was repaired with 6-0 prolene. haemostasis achieved. under CTVS guidance additional SCM muscle was used to plug the rent and sutured with 6-0 prolene. haemostasis reconfirmed. no chyle leak. left no significant lymphadenopathy. left level IB-III cleared. tongue reconstructed with left RAFF 8/6 cm skin paddle harvested with interdental suture fixation. artery and vein anastomosed to superior thyriod and common facial respectively. haemostasis achieved. wound closed in layers |

|  |
| --- |
| **DIET RECOMMENDATIONS :** |
| Soft blended diet orally |

|  |
| --- |
| **PHYSICAL ACTIVITY :** |
| Normal |

|  |
| --- |
| **DISCHARGE MEDICATION :** |
| Tab OLMESARTAN 20 mg 1-0-0 x daily Tab METFORMIN 500 mg 1-0-1 x daily (30 minutes before food) Tab OLEAZ 5 mg 1-0-0 x daily Tab CetiCR 25 mg 1-0-0 x daily HEXIDINE mouthwash thrice a day and after meals |

**Tumour Board Discussion**

**Date of tumor board discussion :** 21/10/2015

**Relevant clinical details :**

46 yr old male patient presented with c/o

right sided tongue - non healing ulcer - since 3 months

progressive , painful

he was evaluated in gulf and diagnosed to have SCC of tongue

comorbidities:

DM on insulin , HTN on Omnesartan , Depression on anti depressants

habits:occasional alcoholic

right side tongue - 5 x 4 cm ulceroinfiltrative lesion involving the lateral border , ventral surface, of tongue and

extending to FOM

mandible is not involved

lesion reaches upto the midline

neck - level 1 b - palpable nodes on the right side

**Histology (include histology done / reviewed elsewhere) :**

Biopsy - MDSCC

**Other relevant investigations (including metastatic workup) :**

CT chest - NAD

**Agreed Plan of management :**

WLE +B/L SND + STF(Lateral arm flap) under GA

**Tumour Board HPR Discussion**

**Date of tumor board discussion :** 11/11/2015

**Relevant clinical details :**

Type of specimen: Subtotal Glossectomy Histological type: Squamous cell carcinoma Differentiation : Well to

Moderate Invasive front: Cohesive Tumor size: 2.5x2x4.2cm Maximum depth of invasion: 3.9cm Vascular

invasion- Absent Nerve invasion - present (occasional, small nerves) Margins: the tumor is 2cm from

superomedial mucosal and soft tissue margin, 0.5cm from inferolateral mucosal and soft tissue margin, 1cm from

posterior mucosal and soft tissue margin, 2cm from anterior mucosal and soft tissue margin and 1cm from deep

inked margin. "Additional anteroinferior mucosal and soft tissue, additional lateral mucosal margin, final

additional anteroinferior margin:Free of tumor. Lymph nodes: "Left level IIA": Four lymph nodes, free of tumor

"Left level IIB":Three lymph nodes, free of tumor. "Left level IB": Three lymph nodes and salivary gland, free

of tumor "Right level IV": Two lymph nodes, free of tumor. "Right level IIB":Six lymph nodes, free of tumor.

"Right level IIA": Two lymph nodes, free of tumor. "Right level IB": Two lymph nodes and salivary gland, free

of tumor. "Right level III": Five lymph nodes, free of tumor. "Left level III": Three lymph nodes, free of tumor

"Level IA": Three lymph nodes, free of tumor pTNM stage pT3N0

**Agreed Plan of management :**

ADJUVANT RT

**Progress Notes**

**Date : 31/10/2015**

**ProgressNotes :**

WLE + B/L SND + RAFF+ tracheastomy under GA on 27.10.15

surgeons : DR SI/ DR KK/ Dr deepak/Dr Vidya/Dr shreya/ dr samkruthi / Dr radhika

FINDINGS: right laeral border of tongue show ulceroinfltrative lesion 4/2.5 cm extending 1 cm anterior to

BOT, involving Tip and extending below onto ventral surface of tongue. laterally lesion extends on to ventral

surface reaching upto floor of mouth. b/l prefacial nodes are 0.5/0.5cm . multiple enlarged lyphnodes involving

right level II A.

Procedure : wide local excision done with a rim of 1 cm margin. defect involved > 50% of tongue volume.

after tumour grossing additional antero lateral soft tissue and lateral mucosal margin taken . right level II A

show multiple enlarged lymph nodes. right level IA-IV cleared. rent in inferior end of IJV on right was

repaired with 6-0 prolene. haemostasis achieved. under CTVS guidance additional SCM muscle was used to

plug the rent and sutured with 6-0 prolene. haemostasis reconfirmed. no chyle leak. left no significant

lymphadenopathy. left level IB-III cleared. tongue reconstructed with left RAFF 8/6 cm skin paddle harvested

with interdental suture fixation. artery and vein anastomosed to superior thyriod and common facial

respectively. haemostasis achieved. wound closed in layers

**Progress Notes**

**Date : 18/06/2016**

**ProgressNotes :**

17.6.2016:

Carcinoma Right lateral border Tongue Post WLE + B/L SND + RAFF+ tracheastomy under GA on 27.10.15

pT4aN0M0, Stage IV A Well to Moderately Differentiated Squamous cell carcinoma. Completed Post

Operative Adjuvant Radiation therapy using IMRT technique on 9/1/2016

has a white patch on the dorsum flap - feels soft maybe desquamation

neck nad

no san and mm normal

r/a 1 month

**D/O Commencement of RT** 30/11/2015 **D/O Completion of RT** 09/01/2016

**FINAL DIAGNOSIS, STAGE AND HISTOLOGY**

Carcinoma Right lateral border Tongue

Post WLE + B/L SND + RAFF+ tracheostomy under GA on 27.10.15

pT4aN0M0, Stage IV A

Well to Moderately Differentiated Squamous cell carcinoma.

Completed Post Operative Adjuvant Radiation therapy using IMRT technique.

**CLINICAL HISTORY AND PHYSICAL FINDINGS**

Mr. Stevenson P S, 46 year old gentleman, working in Sharjah, noticed a non healing ulcer on the right side of

the tongue of 3 months duration which was progressive and painful in nature.. He was evaluated in Gulf and was

diagnosed to have Squamous Cell Carcinoma of tongue. He then came to AIMS for further management.

Clinical Examination of right side tongue showed a 5 x 4 cm ulceroinfiltrative lesion involving the lateral

border , ventral surface of tongue and extending to FOM. Mandible is not involved. Lesion reaches upto the

midline neck - level 1 b palpable nodes on the right side. Laryngoscopy was normal. The case was discussed in

tumor board and the agreed plan of management was surgery followed by adjuvant therapy. After all pre

operative evaluation and investigations he underwent WLE + B/L SND + RAFF+ tracheastomy under GA on

27.10.15 . Post OP HPR reported as Squamous cell carcinoma. Differentiation : Well to Moderate. Invasive

front: Cohesive. Tumor size: 2.5x2x4.2cm. Maximum depth of invasion: 3.9cm. Vascular invasion- Absent.

Nerve invasion - present (occasional, small nerves). Margins: the tumor is 2cm from superomedial mucosal and

soft tissue margin, 0.5cm from inferolateral mucosal and soft tissue margin, 1cm from posterior mucosal and soft

tissue margin, 2cm from anterior mucosal and soft tissue margin and 1cm from deep inked margin. "Additional

anteroinferior mucosal and soft tissue, additional lateral mucosal margin, final additional anteroinferior

margin:Free of tumor. Lymph nodes: "Left level IIA": Four lymph nodes, free of tumor "Left level IIB":Three

lymph nodes, free of tumor. "Left level IB": Three lymph nodes and salivary gland, free of tumor "Right level

IV": Two lymph nodes, free of tumor. "Right level IIB":Six lymph nodes, free of tumor. "Right level IIA": Two

lymph nodes, free of tumor. "Right level IB": Two lymph nodes and salivary gland, free of tumor. "Right level

III": Five lymph nodes, free of tumor. "Left level III": Three lymph nodes, free of tumor "Level IA": Three

lymph nodes, free of tumor. He was pathologically staged as pT4aN0M0

He was referred to Radiation Oncology for further management and was planned for Post Operative Adjuvant

Radiation therapy with a dose of 6000 cGy in 30 fractions.

Clinical Examination: prior to surgery

A 4x2 cm ulceroproliferative lesion on right lateral border of tongue, 1 cm from the base and the floor of mouth.

No palpable lymph nodes.

Laryngoscopy was normal.

Post operative:

Wound healed well

Neck- no nodes palpable B/L neck

Oral cavity- Flap healthy

chest clear

**INVESTIGATIONS :**

**Haemogram:**

**Date: Hb: g/dl PCV: % PLT:**

**ku/ml**

**TC:**

**ku/ml**

**DC: N % L:% E: % ESR:**

**mm/1st hr**

21/12/2015 10.8 33.4 242 7.2 71.4 13.6 4.5 -

**Renal Function Test and Serum Electrolytes:**

**Date: Urea: mg/dl Creatinine: mg/dl Na+: mEq/L K+: mEq/L**

21/12/2015 - 0.80 136.5 3.9

Date: 21/12/2015

RBC-COUNT-Blood : 4.07 M/uL MCV-Blood : 82.0 fL

MCH-Blood : 26.5 pg MCHC-Blood : 32.2 g/dl

RDW-Blood : 14.0 % MPV-Blood : 9.1 fL

MONO -Blood : 10.0 % BASO-Blood : 0.5 %

Date: 05/11/2015

Glucose [F]-Plasma : 124.9 mg/dl

**HISTOPATHOLOGY REPORTS**

Post OP HPR [Dated:Date :30/10/2015, Histology Lab No :S15- 13599]

Histological type: Squamous cell carcinoma

Differentiation : Well to Moderate

Invasive front: Cohesive

Tumor size: 2.5x2x4.2cm

Maximum depth of invasion: 3.9cm

Vascular invasion- Absent

Nerve invasion - present (occasional, small nerves)

Margins: the tumor is 2cm from superomedial mucosal and soft tissue margin, 0.5cm from inferolateral mucosal

and soft tissue margin, 1cm from posterior mucosal and soft tissue margin, 2cm from anterior mucosal and soft

tissue margin and 1cm from deep inked margin.

"Additional anteroinferior mucosal and soft tissue, additional lateral mucosal margin, final additional

anteroinferior margin:Free of tumor.

Lymph nodes: "Left level IIA": Four lymph nodes, free of tumor

"Left level IIB":Three lymph nodes, free of tumor.

"Left level IB": Three lymph nodes and salivary gland, free of tumor "Right level IV": Two lymph nodes, free of

tumor. "Right level IIB":Six lymph nodes, free of tumor.

"Right level IIA": Two lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level III": Five lymph nodes, free of tumor.

"Left level III": Three lymph nodes, free of tumor

"Level IA": Three lymph nodes, free of tumor

pTNM stage: pT4aN0M0

Treatment Given:

**SURGERY DETAILS :**

Post WLE + B/L SND + RAFF+ tracheastomy under GA on 27.10.15

**RADIATION DETAILS :**

Intent: Curative [Post opeartive Adjuvant radiation therapy]

Technique: VMAT

Site of Disease: Tongue

Cat Scan Simulation on 19/11/2015

Complex Computerised Treatment Planning on 30/11/2015

RT Started on 30/11/2015

RT Completed on 9/1/2016

Treatment breaks- Nil

Elapsed days:41

Total Dose: 6000 cGy in 30 fractions

**Primary Tumour And Drainage Area :**

Site: Tumor bed Entire Tongue, Surgical bed+ Bilateral level I, II, III and Right level IV[ in the surgical bed]

Nodal region

Energy: 6 MV Photons

Dose: 6000 cGy in 30 fractions

Schedule: 200 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line.

Site: Right RPN + Left level V and IV Nodal region and Right level V below surgical bed

Energy: 6 MV Photons

MRD No:1622126 Name:Mr. STEVENSON P.S

Page 3 of 4 Printed On:11/08/2024 10:16:10

Dose: 5400 cGy in 30 fractions

Schedule: 180 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line

**TREATMENT COURSE :**

Mr. Stevenson P S, 46 year old gentleman, diagnosed as a case of Carcinoma Tongue, Post Operative, completed

planned course of Post Operative Adjuvant Radiation Therapy well without interruptions.

**ADVICES AT DISCHARGE, MEDICATIONS AND FURTHER PLAN**

1. Review after 1 and 2 weeks in RT OPD.

2. Review after 4-6 weeks in HNS-RT Combined Follow Up Clinic for evaluation of Primary Disease, Neck

Nodes

3. Review every month in RT OPD for one year and then as advised.

Investigations:

1. CXR PA View, CBC, RFT and Liver Enzymes [SGOT, SGPT and Alkaline Phosphatase] 4- 6 weeks post RT

and then as advised by the Physician [CXR every 6 months].

2. TFT [T3, T4, TSH] every 6 months routinely to rule out post RT hypothyroidism.

Oral and Skin Care:

1. Mix a pinch of Soda Bicarbonate powder and one table spoon of common salt in a liter of water and use as

mouth wash every 4 to 6 hours. Neem Leaf mouth wash as advised.

2. Skin care: Avoid applying oil and washing with soap. Gentle splashing of water followed by mopping with

towel. Normal daily bath can be resumed after 3 weeks of completion of RT. Apply ointments or creams only

as per Doctors' advice.

3. Silver Sulfadiazine Cream for Local Application TID for wounds [for healing].

Specific:

High calorie feeds: 3500 calorie and 120 gm protein with mineral and vitamin supplementation in 2.5 liters of

liquid diet.