**Radiology Report**

**Created Date:** 31/01/2018

**Study Done:**

**CT CHEST-PLAIN**

***Clinical info:c/o Ca Tongue***

A linear atelectatic band noted in the left lower lobe (superior segment). No focal lung lesions.

Normal mediastinal vascular structures.

Few subcentimetric bilateral upper paratracheal and lower paratracheal lymphnodes seen ,largest measuring 9

mm .

The hila are normal.

The tracheobronchial tree is normal.

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No pleural effusion/thickening.

Chest wall is normal.

Bilateral simple renal cysts seen.

Rest of the visualised upper abdomen is unremarkable.

**Impression:**

• **A linear atelectatic band in the left lower lobe (superior segment). No nodules in both lungs.**

• **Bilateral simple renal cysts.**

**RADIOLOGY REPORT**

**Created Date:** 01/02/2018

**Study Done:**

**MRI HEAD AND NECK CONTRAST**

**Clinical info:** *c/o carcinoma tongue on left lateral aspect - well differentiated squamous cell carcinoma.*

**Findings**:

Soft tissue enhancing mass measuring 4.5 x 2.7 x 4.7 cm(AP x TR x CC) seen involving the left lateral border of

the oral tongue extending into the sublingual space and partially crossing the midline. Suspicious involvement

of left tonsil noted.Myelohyoid muscles are spared.Orifice of left submandibular salivary gland appear occluded

by the mass causing dilatation. Tip of tongue is spared.

A 13 x10mm left level Ib & level II lymph node noted.

Soft tissue planes of the neck appear normal.

Naso & oropharynx appear normal.

Larynx appear normal.

Both parotid and submandibular salivary glands appear normal.

Bones show normal signal.

**Impression:**

• **Enhancing mass seen involving the left lateral border of the tongue extending into the**

**sublingual space and crossing the midline. Myelohyoid muscles are spared.Suspicious left**

**level IB ,II nodes**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 07/02/2018

**Received on :** 07/02/2018

**Reported Date :** 14/02/2018

**Clinical Impression :**

Ca. left lateral border tongue

**Gross Description :**

Received in formalin are 12 specimens.

The Ist specimen labelled "Total glossectomy" consists of tongue with attached tissue and salivary gland;

attached short superior, long anterior measuring 8.5x6x7.5cm. Raw surface inked and sliced. Cut surface shows

ulcerative grey white lesion over the inferolateral aspect; lesion seen to cross the mid line and abutt the salivary

gland. The inferior most soft tissue is free.Lesion measuring 5.3x3.4x2.3cm. (APxSIxML). Depth of lesion is

2.1cm. No lymph node identified.

Distance from margins: Anterior margin 2.3cm,Posterior margin 1.8cm,Right lateral 3.3cm, Left lateral

0.8cm,Deep margin 0.7cm, Inferior soft tissue 3.3cm. Representative sections are submitted as follows:

A1- Anterior margin shaved

A2 - Posterior margin shaved

A3- Left lateral mucosal margin

A4 - Right lateral mucosal margin

A5 - Deep margin

A6 - Lesion with salivary gland

A7 - Lesion maximum depth

A8 - Inferior soft tissue margin shaved

A9 & A10 - Lesion with adjacent mucosa

Specimen II labelled "Level IA lymph node" consists of fibrofatty tissue measuring 4.5cm in greatest dimension.

3 lymph nodes identified, largest measuring 1.1cm in greatest dimension, smallest 0.5cm in greatest dimension.

Representative sections are submitted in cassette B.

Specimen III labelled "Left level IB lymph node"consists of salivary gland measuring 4 lymph nodes along with

salivary gland 1.2cm in greatest dimension. Smallest 0.4cm in greatest dimenion.Representative sections are

submitted in cassettes C1 & C2.

Specimen IV labelled " Left level IIA lymph node" consists of fibrofatty tissue measuring 4cm in greatest

dimension. 4 lymph node identified, largest measuring 1.6cm in greatest dimension, smallest 0.4cm in greatest

dimension, largest lymph node 1.6 cm in greatest dimension,smallest measuring 0.4 cm. Representative

sections are submitted in cassettes D1 to D4.

Specimen V labelled "Left level II B"consists of 2 lymph nodes 0.4cm in greatest dimension. Entire specimen

submitted in cassettes E1 to E3.

Specimen VI labelled "Left level III" consists of 6 lymph node, largest 1.3cm in greatest dimension, smallest

0.5cm in greatest. Representative sections are submitted in cassettes F1 to F4.

Specimen VII labelled" Left level IV"consists of fibrofatty tissue measuring 3cm in greatest dimension. 6

lymph nodes identified, largest measuring 1.2cm in greatest dimension. Smallest measuring 0.2cm in greatest

dimension. Representative sections are submitted in cassettes G1 & G2.

Specimen VIII labelled "Right level IB" consists of salivary gland along with fibrofatty tissue.5 lymph nodes

identified along with salivary gland . Representative sections are submitted in cassettes H1 to H3.

Specimen IX labelled "Right level IIa" consists of 6 lymph node identified, largest measuring 1cm in greatest

dimension. Smallest 0.6cm in greatest dimension. Representative sections are submitted in cassettes J1 to J6.

Specimen X labelled "Right level II b" consists of ?1 lymph node measuring 0.4cm in greatest dimension along

with fibrofatty tissue. Entire specimen submitted in cassettes K1 & K2.

Specimen XI labelled "Right level III lymph node": consists of 2 lymph nodes along with fibrofatty tissue largest

1.2cm in an smallest 0.7cm.Representative sections are submitted in cassettes L1 to L3.

Specimen XII labelled "Right level IV lymph node" consists of fibrofatty tissue measuring 3cm in greatest

dimension. 2 lymph nodes identified, largest measuring 0.7cm in greatest dimension. Representative sections

are submitted in cassettes M1 to M3.

**Microscopic Description :**

Sections studied show an infiltrative neoplasm composed of dysplastic squamous epithelial cells with extensive

keratin pearl formation. Foci of perineural invasion seen. No lymphovascular invasion noted.

**Impression :**

Near total glossectomy + bilateral nodes:

-Tumour type - Moderate to well differentiated

- Tumour measures 5.3x2.4x2.3cm.

- Depth of lesion - 2.1 cm

- Invasive front - Dyscohesive

- Tumour extent - Lateral tongue crossing the midline and extending into inferior soft tissue.

- Perineural invasion seen (small nerves)

- No LV emboli seen

Margin assessment:

- Deep margin is close (0.4cm)

- All other mucosal and soft tissue margins are free of tumour

Lymph nodes:

Single left level IIA (1/3) and single (left) level III (1/6) nodes show metastasis with extranodal extension,

largest metastatic focus measures 1.2cm (left level IIA)

3 nodes from right level IIA region show metastasis from papillary thyroid carcinoma (follicular variant). No

extranodal extension noted. Rest of 4 lymph nodes from right level IIA are free from tumour.

All other lymph nodes (level IA, left level IB (0/3), left level IIB (0/4), left level IV (0/6), right level IB (0/5),

right level II B (0/3), right level III (0/3), right level II (0/2)) are free of tumour.

Note: In view of metastatic deposits from PTC in right level IIA lymph nodes, evaluation of the thyroid status is

advised.

Stage pT3N3b

**RADIOLOGY REPORT**

**Created Date:** 18/02/2018

**Study Done:**

**ULTRASOUND NECK**

Right lobe of thyroid gland measures - 18x19x26 mm. Shows a isoechoic solid cystic nodule with peripheral

hypoechoic hallow and peripheral vascularity measuring 1.9x1.6 cm. Nodule shows foci of macro calcification

within (TIRADS-3).

Left lobe of thyroid gland measures - 13x17x25 mm

Isthmus measures - 3 mm

Neck nodes could not be assessed due to post neck dissection wound.

**Impression:**

• **TIRADS - 3 nodule in right lobe of thyroid as described however in view of neck nodes from**

**histopathology shows metastatic deposits from papillary thyroid carcinoma. Suggest FNAC.**

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| **Date of Admission :**02/02/2018 | **Date of Procedure :**07/02/2018 |

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| **Date of Discharge :**22/02/2018 |

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

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| **DIAGNOSIS :** |
| carcinoma tongue(Stage pT3N3b) |

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| **PROCEDURE DONE :** |
| Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction +tracheostomy under GA on 07/02/2018 |

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| **HISTORY :** |
| 56 year old male patient , residing in saudi arabia. came to our OPD with a history of ulcer over left lateral part of tongue since 8 months. Initially sit started with 1x1cm which has been gradually progressive in size.He also complaints of pain in left ear , left face and head ache since 1 month -pain is severe. he also mentions that he is not able to chew or talk, not able protrude tongue because of pain.He was on liquid diet since 15 days.later he went to travancore medical college hospital, kollam where a biopsy was done which reported as WDSCC (14/2/18 ) .He has co morbidities - CAD, HTN , CKD , DM (diet control) and no other habits.He came here for further management and his case was discussed in the tumor board and all investigations were done and planned for surgery. |

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| **CLINICAL EXAMINATION :** |
| On Examination: GC fair Vitals stable. Local examination KPS-80 Oral cavity - mouth opening is good. no tongue protrusion. ulceroinfiltrative lesion measuring 3.5x3cm, inferior border not visualised. induration of lesion extends 5mm beyond midline and left BOT. tongue is tender, not able insinuite finger into FOM. right and midline FOM free scopy- normal BOT, Tonsil, TL sulcus no mucosal lesion seen neck: left level IB firm 1x1cm node palpable |

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| CT CHEST-PLAIN 31/01/2018 Impression: A linear atelectatic band in the left lower lobe (superior segment). No nodules in both lungs. Bilateral simple renal cysts. MRI HEAD AND NECK CONTRAST 01/02/2018 Impression: Enhancing mass seen involving the left lateral border of the tongue extending into the sublingual space and crossing the midline. Myelohyoid muscles are spared.Suspicious left level IB ,II nodes Surgical Pathology Report 07/02/2018 Impression : Near total glossectomy + bilateral nodes: -Tumour type - Moderate to well differentiated - Tumour measures 5.3x2.4x2.3cm. - Depth of lesion - 2.1 cm - Invasive front - Dyscohesive - Tumour extent - Lateral tongue crossing the midline and extending into inferior soft tissue. - Perineural invasion seen (small nerves) - No LV emboli seen Margin assessment: - Deep margin is close (0.4cm) - All other mucosal and soft tissue margins are free of tumour Lymph nodes: Single left level IIA (1/3) and single (left) level III (1/6) nodes show metastasis with extranodal extension, largest metastatic focus measures 1.2cm (left level IIA) 3 nodes from right level IIA region show metastasis from papillary thyroid carcinoma (follicular variant). No extranodal extension noted. Rest of 4 lymph nodes from right level IIA are free from tumour. All other lymph nodes (level IA, left level IB (0/3), left level IIB (0/4), left level IV (0/6), right level IB (0/5), right level II B (0/3), right level III (0/3), right level II (0/2)) are free of tumour. Note: In view of metastatic deposits from PTC in right level IIA lymph nodes, evaluation of the thyroid status is advised. Stage pT3N3b |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| patient was admitted with complaints of odynopahgia ,After primary evaluation,Ryles tube was inserted and referred to cardiology for his known case of CAD and morning giddiness.He was reviewed and asked for 24 hour holter monitoring Since he has complains of difficulty in swallowing he was referred to pain and palliative department,They reviewed him and accordingly medications were given.cardiology doctors has reviewed him and he was fit for surgery with mild to moderate risk from their side. he underwent Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction +tracheostomy under GA. His postoperative period he was under consultation with nephrologist and cardiologists. on post op day 14 patient underwent VFS study which was found to be normal and patient was started orally. his case was discussed in tumour board for rt level IIa node showing PTC mets, decision taken to give adjuvant RT and 6weeks post RT to plan thyroidectomy. |

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| **OPERATIVE FINDINGS :** |
| Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction +tracheostomy under GA Surgeons : Dr SI sir / DR KK si/ Dr VIdhyadharan sir/ Dr YOgesh Findings : ulceroinfiltrative lesion measuring 3.5x3cm, inferior border not visualised. induration of lesion extends 5mm beyond midline and left BOT. Left FOM involved right and midline FOM free Left Level I b and Level II LN + Procedure: Patient taken under Ga PPD.A horizontal neck crease incision taken , subplatysmal flaps raised superiorly till inferior border of body of mandible inferiorly till clavicle . A visor approach done Anterior belly of digastric muscle delineated and digastric and myelohyoid separated from mandible and FOM incised and pull through done to deliver tongue in neck right side cuts taken under direct vision and enblock specimen of near total glossectomy with FOM and b/l digastric and myelohyoid resected and sent for HPR. Sliver of normal tongue tissue preserved on rt side B/L SND Level I \_ IV completed. Three hole drilled in the inferior border of mandible and Mandibulo-hyoido-thyropexy done with 2-0 Prolene suture for hyoid elevation. PMMC flap raised .Flap inset done . Hemostasis achieved . RVD secured. Closure done in layers. Reconstruction notes : Left PMMC flap. A skin paddle of size 6 cm X 7cm with pre -design of tongue , the skin is incised by bevelling radially and dissection extended till pectoralis major muscle.Skin paddle tacked with pectoralis muscle with sutures the incision is extended along anterior axillary fold to preserve the skin territory for DP flap. Skin then elevated till clavicle . Inferiorly skin elevated to expose lateral border of pectoralis major muscle . The Pectoralis muscle then freed along side sternum, Dissection done along the lateral border of muscle and continued in the intermuscular plane. Inferiorly rectus muscle sheath included in the flap. Dissection continued in the intermuscular plane and vascular pedicle identified . With pedicle under view humeral attachment divided. Supraclavicular tunnel made and flap delivered in the neck . Flap inset done skin paddle suturing to remanent tongue on rt side . Skin paddle for tongue suture to mandible with interdental stitches to form oral diaphragm Hemostasis achieved . RVD secured Closure done in layers. |

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| **DIET RECOMMENDATIONS :** |
| blend diabetic oral diet |

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| **DISCHARGE MEDICATION :** |
| tab aldactone 25mg od x to continue lulifin cream LA BD x 1week tab euthyrox 25mcg od x to continue tab carvidilol 12.5mg bd x to continue tab rosuvastatin 10mg od x to continue tab dolo 650mg sos medications to continue till review |

**Tumour Board Discussion**

**Relevant clinical details :**

56 year old male patient , residing in Dubai h/o ulcer over left lateral part of tongue since 8 months. initially

started with 1x1cm which has been gradually progressive in size.

c/o pain in left ear , left face and headache since 1 month. pain is severe. patient is unable to chew or talk

because of pain. not able protrude tongue due to pain patient on liquid diet since 15 days biopsy done at

travancore medical college hospital, kollam - WDSCC (142/18 )

Co morbidities - CAD, HTN , CKD , DM (diet control)

no habits

o/e: KPS-80 Oral cavity - mouth opening is good. no tongue protrusion. ulceroinfiltrative lesion measuring

3.5x3cm, inferior border not visualised. induration of lesion extends 5mm beyond midline and left BOT. tongue

is tender, not able insinuite finger into FOM. right and midline FOM free

scopy- normal BOT, Tonsil, TL sulcus no mucosal lesion seen neck: left level IB firm 1x1cm node palpable.

impression : ca tongue cT4aN1

**Agreed Plan of management :**

subtotal glossectomy b/l Neck dissection + PMMC

**Histopathology Tumour Board Discussion**

**Date of tumor board discussion :** 21/02/2018

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

Near total glossectomy + bilateral nodes:

-Tumour type - Moderate to well differentiated

- Tumour measures 5.3x2.4x2.3cm.

- Depth of lesion - 2.1 cm

- Invasive front - Dyscohesive

- Tumour extent - Lateral tongue crossing the midline and extending into inferior soft tissue.

- Perineural invasion seen (small nerves)

- No LV emboli seen

Margin assessment:Deep margin is close (0.4cm)

- All other mucosal and soft tissue margins are free of tumour

Lymph nodes:

Single left level IIA (1/3) and single (left) level III (1/6) nodes show metastasis with extranodal extension,

largest metastatic focus measures 1.2cm (left level IIA)

3 nodes from right level IIA region show metastasis from papillary thyroid carcinoma (follicular variant). No

extranodal extension noted. Rest of 4 lymph nodes from right level IIA are free from tumour.

All other lymph nodes (level IA, left level IB (0/3), left level IIB (0/4), left level IV (0/6), right level IB (0/5),

right level II B (0/3), right level III (0/3), right level II (0/2)) are free of tumour.

**Agreed Plan of management :**

ideally CT but ivo Chronic renal disease Adjuvant RT only ,

**Progress Notes**

**Date : 02/02/2018**

**ProgressNotes :**

Non healing ulcer in left lateral side of tongue

Case of carcinoma tongue (stage IV)

In Medcity taken biopsy on 23/01/2018 reported as Well differentiated squamous cell carcinoma

known case of CAD + CKD + htn + dm.

Adv: MRI Head and Neck with contrast

To see in Cardiology,GI and Nephrology

Posted for subtotal glossectomy \_ bNeck dissection + reconstruction

**Operative Notes**

**Date : 16/02/2018**

**ProgressNotes :**

Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction

+tracheostomy under GA

Findings : ulceroinfiltrative lesion measuring 3.5x3cm, inferior border not visualised. induration of lesion

extends 5mm beyond midline and left BOT. Left FOM invoved right and midline FOM free Left Level I b

and Level II LN +

Procedure: Patient taken under Ga PPD.A horizontal neck crease incision taken , subplatysmal flaps raised

superiorly till inferrior border of body of mandible inferriorly till clavicle .A visor approach done Anterior

belly of diagastric muscle delineated and diagastric and myelohyoid separated from mandible and FOM

incised and pull through done to deliver tongue in neck right side cuts taken under direct vision and enblock

specimen of near total glossectomy with FOM and b/l digastric and myelohyoid resected and sent for

HPR.Sliver of normal tongue tissue preserved on rt side B/L SND Level I \_ IV completed.

Three hole drilled inthe inferior border of mandible and Mandibulo-hyoido-thyropexy done with 2-0 Prolene

suture for hyoid elevation. PMMC flap raised .Flap inset done . Hemostasis achieved . RVD secured.

Closure done in layers.

Reconstruction notes : Left PMMC flap. A skin paddle of size 6 cm X 7cm with pre -design of

tongue , the skin is incise around the skin paddle by bevelling radially and dissection extended till pectoralis

major

muscle.Skin paddle tacke with pectoralis muscle with sutures the incision is extended along anterior axillary

fold to preserve the skin terriotory for DP flap. Skin then elveated till clavicle . Inferiorly skin elevate dto

expose lateral border of pectoralis major muscle .The Pectoralis muscle then freed along side sternum,

Dissection done along the lateral border of muscle and continued in the intermucular palne. Inferiorlly rectus

muscle sheath included in the flap. Dissection continued in the intermuscular plane and vascular pedicle

identified .With pedicle under view humeral attachment divided. Supraclavicular tunnel made and flap

delivered in the neck ..Flap inset done skin paddle sutring to remenant tongue on rt side .Skin paddle for

tongue suture to mandible with interdental stitches to form oral diaphragm Hemostasis achievd .RVD secured

Closure done in ;layers

**Progress Notes**

**Date : 06/08/2018**

**ProgressNotes :**

Carcinoma Tongue (Stage pT3N3b) S/P Near Total glossectomy + B/L SND Level I-IV +

Mandibulo-hyoido-thyropexy + PMMC flap reconstruction + tracheostomy under GA on 07/02/2018

pT3N3M0 Autoimmune kidney disorder S/p CTRT with weekly Carboplatin Completed RT on 3/5/2018

Pleural Biopsy:- - In keeping with metastatic squamous cell carcinoma

**Speciality :** RadiationOncology

**D/O Commencement of RT** 20/03/2018 **D/O Completion of RT** 03/05/2018

**FINAL DIAGNOSIS, STAGE AND HISTOLOGY**

Carcinoma Left lateral border Tongue

S/P Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction

+tracheostomy under GA on 07/02/2018

pT3N3bM0, Stage IV B

Moderate to well differentiated squamous cell carcinoma

Completed Post Operative concurrent chemoradiation therapy using Tomotherapy technique

synchronous papillary carcinoma Thyroid

Rt cervical node level IIA shows metasases from papillary ca thyroid [follicular varient]

**CLINICAL HISTORY AND PHYSICAL FINDINGS**

Mr. Antony Lawrence, 56 year old male patient, residing in saudi arabia , presented with history of ulcer over

left lateral part of tongue since 8 months. Initially it started with 1x1cm which has been gradually progressive in

size. He also complaints of pain in left ear, left face and head ache since 1 month -pain is severe. He also

mentions that he is not able to chew or talk, not able protrude tongue because of pain. He was on liquid diet since

15 days. Later he went to travancore medical college hospital, kollam where a biopsy was done which reported

as Well Differentiated Squamous cell Carcinoma. He came here for further management and his case was

discussed in the tumor board and all investigations were done and planned for surgery.

On Examination: GC fair Vitals stable. Local examination KPS-80 Oral cavity - mouth opening is good. no

tongue protrusion. ulceroinfiltrative lesion measuring 3.5x3cm, inferior border not visualised. induration of

lesion extends 5mm beyond midline and left BOT. tongue is tender, not able insinuite finger into FOM. right and

midline FOM free scopy- normal BOT, Tonsil, TL sulcus no mucosal lesion seen neck: left level IB firm 1x1cm

node palpable .

He was evaluated with CT Chest Plain [Dated: 31/01/2018]

A linear atelectatic band in the left lower lobe (superior segment). No nodules in both lungs. Bilateral simple

renal cysts.

MRI Head and Neck with Contrast [Dated: 01/02/2018]

Enhancing mass seen involving the left lateral border of the tongue extending into the sublingual space and

crossing the midline. Myelohyoid muscles are spared. Suspicious left level IB ,II nodes

After all pre op evaluation he underwent Near Total glossectomy + B/L SND Lvel I-IV +

Mandibulo-hyoido-thyropexy +PMMC flap reconstruction +tracheostomy under GA on 07/02/2018.

Post OP HPR [Dated: 7/2/2018]

Near total glossectomy + bilateral nodes:

Tumour type - Moderate to well differentiated

Tumour measures 5.3x2.4x2.3cm.

Depth of lesion - 2.1 cm

Invasive front- Dyscohesive

Tumour extent - Lateral tongue crossing the midline and extending into inferior soft tissue.

Perineural invasion seen (small nerves)

No LV emboli seen

Margin assessment: Deep margin is close (0.4cm)

All other mucosal and soft tissue margins are free of tumour Lymph nodes: Single left level IIA (1/3) and single

(left) level III (1/6) nodes show metastasis with extranodal extension, largest metastatic focus measures 1.2cm

(left level IIA)

3 nodes from right level IIA region show metastasis from papillary thyroid carcinoma (follicular variant).

No extranodal extension noted.

Rest of 4 lymph nodes from right level IIA are free from tumour. All other lymph nodes (level IA, left level IB

(0/3), left level IIB (0/4), left level IV (0/6), right level IB (0/5), right level II B (0/3), right level III (0/3), right

level II (0/2)) are free of tumour.

Note: In view of metastatic deposits from PTC in right level IIA lymph nodes, evaluation of the thyroid status is

advised.

Stage pT3N3bM0

His case was re discussed in Head and Neck tumor board and was planned for Post Operative Concurrent

chemoradiation therapy .

In view of pathology report of Rt cervical node level IIA showing metastases from papillary ca thyroid

[follicular varient]. The case was rediscussed with HPR in Tumour Board and decided to offer surgery after 6-12

weeks of completion of radiation. on 18/2/18 USG neck was done and it showed of 3 nodule in right lobe of

thyroid.

Details were explained to patient and relative [wife, son]

comorbidities: Chronic Kidney Disease Stage G3 A3; Creatinine Clearance Value:50.43 mL/min . Autoimmune

kidney disorder Coronary Artery Disease - ACS - STEMI - complicated with VF [3/3/15] - S/p CPR and

mechanical ventilation with inotropic support - ECG post arrest - extensive anterior wall STEMI - CAG [4/3/15]:

SVD [Prox, mid and distal LAD had severe critical lesion] - S/p PTCA with stenting with Resolute integrity 2.5

x 14 mm to distal LAD Resolute integrity 3 x 22 mm to mid LAD Resolute integrity 3.5 x 9 mm to proximal

LAD [Almana hospital, Saudi Arabia]- 4/3/15 - Severe LV dysfunction / NSR - Post PTCA IABP placed via

right femoral artery - Last Echo [22/1/18]: Dilated LV, LAD territory RWMA; Moderate to severe LV

dysfunction [EF: 30-35%]; Trivial MR; Large organised LV apical CLOT present 2. Diabetes mellitus type II -

since 5 years; on OHA 3. Systemic Hypertension 4. Hypothyroidism - since 5 years ; on Thyronorm 25 mcg

**INVESTIGATIONS :**

**Haemogram:**

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

**ku/ml**

**TC:**

**ku/ml**

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

**mm/1st hr**

19/03/2018 12.1 35.5 236 5.17 61.2 27.3 7.0 -

26/03/2018 12.6 37.9 221 4.62 59.5 26.6 6.7 -

02/04/2018 12.2 36.0 170 4.25 78.6 14.1 3.5 -

09/04/2018 11.9 35.9 135 3.08 70.1 14.8 3.1 -

16/04/2018 11.8 34.6 102 3.79 70.4 18.7 2.4 -

19/04/2018 11.1 31.6 99 2.8 64.2 24.3 3.4 -

23/04/2018 10.4 32.3 109 2.33 68.9 16.9 4.4 -

24/04/2018 10.4 29.9 96 3.98 88.6 5.6 2.6 -

26/04/2018 10.0 28.5 114 2.61 78.9 10.7 5.0 -

03/05/2018 10.1 29.1 357 2.96 77.0 9.8 4.1 -

**Liver Function Test:**

**Date: T.**

**Bilirubin:**

**mg/dl**

**D.**

**Bilirubin:**

**mg/dl**

**SGOT:**

**IU/L**

**SGPT:**

**IU/L**

**ALP:**

**IU/L**

**T.**

**Protein:**

**gms/dl**

**S. Alb:**

**g/dl**

**S. Glob:**

**g/dl**

19/03/2018 0.83 0.30 41.3 38.6 44.0 6.0 3.5 2.56

**Renal Function Test and Serum Electrolytes:**

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

19/03/2018 - 1.29 134.8 4.1

26/03/2018 - 1.29 - -

02/04/2018 - 1.14 - -

16/04/2018 - 1.18 132.2 3.7

26/04/2018 - 1.09 - -

Date: 03/05/2018

RBC-COUNT-Blood : 3.38 M/uL MCV-Blood : 86.1 fL

MCH-Blood : 29.9 pg MCHC-Blood : 34.7 g/dl

RDW-Blood : 16.0 % MPV-Blood : 9.1 fL

MONO -Blood : 8.8 % BASO-Blood : 0.3 %

Date: 26/04/2018

RBC-COUNT-Blood : 3.33 M/uL MCV-Blood : 85.6 fL

MCH-Blood : 30.0 pg MCHC-Blood : 35.1 g/dl

RDW-Blood : 15.8 % MPV-Blood : 10.5 fL

MONO -Blood : 5.0 % BASO-Blood : 0.4 %

Date: 24/04/2018

RBC-COUNT-Blood : 3.45 M/uL MCV-Blood : 86.7 fL

MCH-Blood : 30.1 pg MCHC-Blood : 34.8 g/dl

RDW-Blood : 15.4 % MPV-Blood : 10.3 fL

MONO -Blood : 3.0 % BASO-Blood : 0.2 %

Date: 23/04/2018

RBC-COUNT-Blood : 3.64 M/uL MCV-Blood : 88.8 fL

MCH-Blood : 28.6 pg MCHC-Blood : 32.2 g/dl

RDW-Blood : 15.1 % MPV-Blood : 8.8 fL

MONO -Blood : 9.4 % BASO-Blood : 0.4 %

Date: 19/04/2018

RBC-COUNT-Blood : 3.72 M/uL MCV-Blood : 84.9 fL

MCH-Blood : 29.8 pg MCHC-Blood : 35.1 g/dl

RDW-Blood : 14.8 % MPV-Blood : 9.4 fL

MONO -Blood : 7.7 % BASO-Blood : 0.4 %

Date: 16/04/2018

Calcium; total - Serum : 9.27 mg/dl RBC-COUNT-Blood : 4.02 M/uL

MCV-Blood : 86.1 fL MCH-Blood : 29.4 pg

MCHC-Blood : 34.1 g/dl RDW-Blood : 14.5 %

MPV-Blood : 10.0 fL MONO -Blood : 7.7 %

BASO-Blood : 0.8 %

Date: 09/04/2018

RBC-COUNT-Blood : 4.02 M/uL MCV-Blood : 89.3 fL

MCH-Blood : 29.5 pg MCHC-Blood : 33.0 g/dl

RDW-Blood : 14.1 % MPV-Blood : 9.0 fL

MONO -Blood : 11.7 % BASO-Blood : 0.3 %

Date: 02/04/2018

RBC-COUNT-Blood : 4.07 M/uL MCV-Blood : 88.5 fL

MCH-Blood : 30.0 pg MCHC-Blood : 33.9 g/dl

RDW-Blood : 14.0 % MPV-Blood : 10.3 fL

MONO -Blood : 3.3 % BASO-Blood : 0.5 %

Date: 26/03/2018

RBC-COUNT-Blood : 4.19 M/uL MCV-Blood : 90.5 fL

MCH-Blood : 30.1 pg MCHC-Blood : 33.2 g/dl

RDW-Blood : 14.0 % MPV-Blood : 9.0 fL

MONO -Blood : 6.9 % BASO-Blood : 0.3 %

Date: 19/03/2018

RBC-COUNT-Blood : 3.99 M/uL MCV-Blood : 89.0 fL

MCH-Blood : 30.3 pg MCHC-Blood : 34.1 g/dl

RDW-Blood : 14.4 % MPV-Blood : 9.8 fL

MONO -Blood : 3.9 % BASO-Blood : 0.6 %

**HISTOPATHOLOGY REPORTS**

Post OP HPR [Dated: 7/2/2018]

Near total glossectomy + bilateral nodes:

Tumour type - Moderate to well differentiated

Tumour measures 5.3x2.4x2.3cm.

Depth of lesion - 2.1 cm

Invasive front- Dyscohesive

Tumour extent - Lateral tongue crossing the midline and extending into inferior soft tissue.

Perineural invasion seen (small nerves)

No LV emboli seen

Margin assessment: Deep margin is close (0.4cm)

All other mucosal and soft tissue margins are free of tumour Lymph nodes: Single left level IIA (1/3) and single

(left) level III (1/6) nodes show metastasis with extranodal extension, largest metastatic focus measures 1.2cm

(left level IIA)

3 nodes from right level IIA region show metastasis from papillary thyroid carcinoma (follicular variant).

No extranodal extension noted.

Rest of 4 lymph nodes from right level IIA are free from tumour. All other lymph nodes (level IA, left level IB

(0/3), left level IIB (0/4), left level IV (0/6), right level IB (0/5), right level II B (0/3), right level III (0/3), right

level II (0/2)) are free of tumour.

Note: In view of metastatic deposits from PTC in right level IIA lymph nodes, evaluation of the thyroid status is

advised.

Stage pT3N3b

**RADIOLOGY AND NUCLEAR MEDICINE REPORTS**

CT Chest Plain [Dated: 31/01/2018]

A linear atelectatic band in the left lower lobe (superior segment). No nodules in both lungs. Bilateral simple

renal cysts.

MRI Head and Neck with Contrast [Dated: 01/02/2018]

Enhancing mass seen involving the left lateral border of the tongue extending into the sublingual space and

crossing the midline. Myelohyoid muscles are spared. Suspicious left level IB ,II nodes

18/2/18: USG neck : TIRADS - 3 nodule in right lobe of thyroid as described however in view of neck nodes

from histopathology shows metastatic deposits from papillary thyroid carcinoma. Suggest FNAC.

Treatment Given:

**SURGERY DETAILS :**

Near Total glossectomy + B/L SND Lvel I-IV + Mandibulo-hyoido-thyropexy +PMMC flap reconstruction

+tracheostomy under GA on 07/02/2018

**RADIATION DETAILS :**

Intent: Curative, adjuvant concurrent chemoradiation

Technique: Tomotherapy

Site of Disease: Tongue

Cat Scan Simulation on 10/3/2018

Complex Computerised Treatment Planning on 16/3/2018

RT Started on 20/3/2018

RT Completed on 3/5/2018

Treatment breaks on 16/4 & 17/4/18 as patient was not able to lie down comfortably and refused treatment

26/4/18: due to severe fatigue after chemotherapy

Total Dose: 6600 cGy in 30 fractions

**Primary Tumour And Drainage Area :**

Site: Left level II, III HRR

Energy: 6 MV Photons

Dose: 6600 cGy in 30 fractions

Schedule: 220 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line.

Site: Surgical bed+ entire tongue bed , Bilateral level I, II, III, IV, V a and Left RPN

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: Bilateral level IV B, V B

Energy: 6 MV Photons

Dose: 5400 cGy in 30 fractions

Schedule: 180 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line.

**CHEMOTHERAPY DETAILS :**

Autoimmune kidney disorder

CYCLE 1 DATE: 19/03/2018 Inj Carboplatin 150mg

CYCLE 2 DATE: 26/03/2018 Inj Carboplatin 150mg

23/04/2018 TC low, chemo postponed

CYCLE 3 DATE: 2/04/2018 Inj Carboplatin 150mg

CYCLE 4 DATE: 9/04/2018 Inj Carboplatin 150mg

16/04/2018 chemo postponed due to low plt count

24/04/2018 chemo postponed due to fatigue

CYCLE 5 DATE: 26/04/2018 Inj Carboplatin 150mg

**TREATMENT COURSE :**

56 year old gentleman, diagnosed as a case of carcinoma Left lateral border Tongue, Post

Operative, pT3N3bM0, completed planned course of Post Operative Concurrent chemo radiation therapy.

PLAN: In the present nodal desscetion Rt cervical node level IIA shows metastases from papillary ca thyroid

[follicular varient]. USG neck showed nodules in the thyroid.The case was rediscussed with HPR in Tumour

Board and decided to offer surgery- Thyroidectomy after 6-12 weeks of completion of radiation.

**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.

4. To ressess for Total Thyroidectomy after 6-12 weeks of completion of radiation.

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 3 months routinely

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

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: Ryles tube feeds

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

liquid diet. Orall feeds after asessment in swallowing clinic advise.

Medical onco

**PROGRESS NOTE**

**Week 5**

**Date : 26/04/2018**

**ProgressNotes :**

Carcinoma Tongue (Stage pT3N3b)

S/P Near Total glossectomy + B/L SND Level I-IV + Mandibulo-hyoido-thyropexy + PMMC flap

reconstruction + tracheostomy under GA on 07/02/2018 pT3N3M0

Autoimmune kidney disorder

On CTRT with weekly Carboplatin

Had 4 weeks of chemo and on RT

Due for 5th week of the same

Completed 25# RT on 25/4/2018

Patient feels better

CBC

ANC- >2000

To give chemo today after Gcsf

CYCLE 5 DATE: 26/04/2018

1. Inj Ondansetron 8mg IV stat

2. Inj Carboplatin 150mg in 500mL 5 % Dextrose > 2 hrs IV

3. Inj IVF Fluids NS 500mL > 2hrs

1. Tab DOMSTAL 10mg 1-0-1x 3 days

2. Cap Omez 20mg 1-0-0 (Before food) x 5 days