**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 27/08/2011

**Received on :** 27/08/2011

**Reported Date :** 29/08/2011

**Clinical Impression :**

Right lateral border of tongue ulcer.

? Ca tongue.

**Gross Description :**

Received in formalin is a specimen labelled as "biopsy", consists of multiple grey brown tissue bits in aggregate

measuring 1.3x1x0.5cm. Entire specimen submitted in one cassette.

**Microscopy and Impression :**

Bx Right lateral border of tongue ulcer : Moderately differentiated squamous cell carcinoma.

**DEPARTMENT OF NUCLEAR MEDICINE AND PETCT**

**Date : 31/08/2011**

**WHOLE BODY PET CT IMAGING REPORT**

**PROCEDURE :**

8 mCi of 18F Flouro Deoxy Glucose (FDG) was injected IV in euglycemic status. One hour later Whole body

PET CT Imaging (Head to mid thigh) was performed on a GE Discovery PET 8 slice CT scanner.

Oral & IV contrast given for CT study.

Standardized Uptake Value (SUV) calculated for body weight and expressed as g/ml.

Fasting Blood Sugar: 89 mg / dl.

**FINDINGS :**

PET FINDINGS:

\* Abnormal increased FDG uptake noted in illdefined enhancing soft tissue lesion in

left lateral border of tongue (SUV Max 18.3).

\* Focal abnormal increased FDG uptake noted in another illdefined, enhancing soft tissue

lesion in floor of mouth right side (SUV Max 9.3).

\* Focal abnormal increased FDG uptake noted in multiple bilateral cervical level II & III

lymph nodes (SUV Max 11.1).

\* No abnormal focal / diffuse FDG uptake seen in other lymph nodes, bilateral lungs, liver, spleen &

adrenal glands.

\* No abnormal FDG tracer uptake seen in skeleton imaged up to mid thigh.

\* Normal physiological FDG uptake seen in brain, pharyngeal tonsils, vocal cords, myocardium, liver,

intestinal loops, kidneys and urinary bladder.

CT FINDINGS:

Brain:

\* Normal neuroparenchyma. No focal lesion.

Neck:

\* Illdefined enhancing soft tissue lesion noted in left side of tongue.

\* Another illdefined soft tissue lesion of size 14.6 X 13.7 mm noted in right side of floor of mouth

superior to myelohyoid muscle.

\* Bilateral enlarged level II and III lymph nodes noted.

\* Oropharynx, nasopharynx, laryngopharynx and thyroid gland appear normal.

\* Common carotid artery and internal jugular vein appear normal.

Chest:

\* Lung fields appear clear. No focal lesion.

\* Mediastinum is central.

\* Cardia and major vessels are normal.

\* No pleural effusion.

Abdomen:

\* Liver, gall bladder, spleen and pancreas appear normal.

\* Adrenals, kidneys and urinary bladder appear normal.

\* No retroperitoneal mass lesion.

\* No significant lymphadenopathy.

\* Contrast filled bowel loops are normal.

**CONCLUSION :**

\* FDG AVID ENHANCING SOFT TISSUE LESION ALONG LEFT LATERAL BORDER OF TONGUE

- PRIMARY TONGUE MALIGNANCY.

\* METABOLICALLY ACTIVE ENHANCING SMALL SOFT TISSUE DENSITY LESION IN

FLOOR OF MOUTH - ? LYMPH NODAL METASTASIS.

\* FDG AVID BILATERAL LEVEL II & III CERVICAL LYMPH NODAL METASTASES.

\* NO EVIDENCE OF ANY OTHER FDG AVID DISTANT METASTASIS.

**Impression :**

**MDCT NECK - CONTRAST**

There is seen a ill defined heterogenously enhancing with non enhancing necrotic areas in the left lateral aspect of tongue crossing the midline involving ipsilateral genioglossus muscle, hyoglossus muscle. Lesion in extending into sublingual space and into ipsilateral mylohyoid -muscle and probably involving anterior aspect of the deep lobe of submandibular gland.

Ipsilateral submandibular gland its enlarged in size and shows increased enhancement and prominent duct.

There are seen multiple enlarged level II and level III group of lymphnodes bilaterally and right sided submandibular group most of lymphnodes shows non enhancing necrotic areas.

Thyroid/cricoid and arytenoid cartilages are normal.

The larynx and the tracheal air way are normal.

Hypopharynx and laryngopharynx are normal.

No evidence of any retropharyngeal lesion.

Parapharyngeal spaces are normal.

Bilateral neck vessels are normal.

Thyroid gland shows homogenous dense enhancement and is normal in size and outline. No focal lesion seen.

**IMPRESSION**

      **Neoplastic lesion in left side of tongue crossing midline extending to floor of mouth and probably involving the submandibular gland.**

      **Bilateral cervical lymphadenopathy probably metastatic nodes.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 13/09/2011

**Received on :** 13/09/2011

**Reported Date :** 17/09/2011

**Clinical Impression :**

Known case of Carcinoma Tongue

**Gross Description :**

Received in fresh are two specimens. The I specimen labelled as "Left base tongue lesion", consists of single

fibrofatty tissue measures 1x1x0.5cm.

Specimen II labelled as "Hyoid bone margin", consists of single grey brown tissue bit measures 0.5x0.3cm.

Frozen I read as : Base tongue - Minor salivary gland tissue, overlying epithelium free.

Frozen II read as : Hyoid bone margin - Free.

Subsequently received in formalin are 12 specimens. The I specimen labelled as "Total Glossectomy", consists

of tongue, salivary gland and attached soft tissue with muscle, whole measures 10x8.5x4.5cm. Tongue measures

9x6.5x3cm. An ulcero infiltrative growth is seen on the left side of the tongue extending upto the middle

measures 6x3.5x3cm. Anteriorly tumor is seen extending upto the deep margin infront of the salivary gland.

Growth is situated 1cm from lateral buccal mucosal margin, 0.7cm from posterior mucosal margin. Deep free

margin posteriorly is 1cm and 1mm in front of the salivary gland. Attached soft tissue on cut section shows grey

white areas (tumor deposit in the muscle). Tiny grey white nodules were also noted apart from the main lesion.

Representative sections are submitted as follows:

A1 - Posterior shaved mucosal margin free

A2 - Left lateral buccal mucosal margin

A3 - Tumor with inked deep margin anteriorly

A4 - Shaved deep margin, postero lateral

A5 - Shaved deep margin postero medial

A6 - Tumor with deep soft tissue margin

A7 - A9 - Tumor anterior to posterior

A10 - A12 - Tumor with salivary gland

A13 - A14 - Tiny grey white nodules in soft tissue

A15 - A17 - Larger grey white nodules with inked deep margin

A18 - ? Lymphnode

A19 - ? Salivary gland tissue

Specimen II labelled as "Additional left lateral mucosal margin", consists of single mucosa covered tissue bit

measures 4.5x1cm. External surface inked. Entire specimen submitted in cassette B.

Specimen III labelled as "Hyoid bone with margin", consists of multipe grey brown tissue bit in aggregate

measures 2x1x0.5cm. No bony tissue identified. Entire specimen submitted in cassette C.

Specimen IV labelled as "Tissue adjacent to hyoid bone", consists of multiple grey brown tissue bit in aggregate

measures 5x4x1.5cm. No bony tissue identified. Representative sections are submitted in cassette D1-D4

cassettes.

Specimen V labelled as "Level Ia", consists of single fibrofatty tissue measures 4x4x0.5cm. 3 lymphnodes

identified, largest measures 1x0.8cm. Cut section grey brown to grey white. Representative sections are

submitted in cassette E.

Specimen VI labelled as "Right level Ib", consists of fibrofatty tissue measures 5x5x2cm. Cut section lobulated.

No solid areas identified. 2 lymphnodes identified, larger measures 1x1cm. Representative sections are submitted

in F1-F3 cassettes.

Specimen VII labelled as "Right level IIa", consists of a single fibrofatty tissue measures 5x3x2.5cm. Cut section

grey white to grey brown in colour. 2 lymphnodes identified, larger measures 1cm. Representative sections are

submitted in cassette G.

Specimen VIII labelled as "Right level IIb", consists of single fibrofatty tissue measures 4.5x3x1cm. Cut section

grey white, fatty. 5 lymphnodes identified, largest measures 0.3cm. Cut section grey brown. Representative

sections are submitted in cassette H.

Specimen IX labelled as "Right level III", consists of single fibrofatty tissue measures 3.5x3x1cm. 5 lymphnodes

identified, largest measures 1cm. Cut section grey brown to grey white. Representative sections are submitted in

J1 - J3 cassettes.

Specimen X labelled as "Right level IV lymphnode", consists of single fibrofatty tissue measures 5.5x3.5x1cm. 2

lymphnodes identified, largest measures 1cm. Cut section grey brown. Representative sections are submitted in

K1 - K3 cassettes.

Specimen XI labelled as "Left level Ib", consists of single fibrofatty tissue measures 7x4x2cm. Cut section

lobulated. 4 lymphnodes identified, largest measures 1.3cm. Cut section grey brown. Representative sections are

submitted in L1 - L5 cassettes.

Specimen XII labelled as "Left level II,III & IV", consists of 2 fibrofatty tissue in aggregate measures

8.5x3.5x2cm. 12 lymphnodes identified, largest measures 2cm. Cut section grey brown to grey white.

Representative sections are submitted in M1 - M6 cassettes.

**Microscopic Description :**

Permanent sections from frozen confirms the frozen report.

A) Sections from total glossectomy shows moderately differentiated squamous cell carcinoma. Tumor has

infiltrating margins. Tumor size - 6x3.5x3cm. Depth of invasion 3cm. Lymphovascular emboli and perineural

invasion seen. Tumor margins show moderate chronic inflammatory reaction. Tumor infiltrates intrinsic muscles

of tongue and adjacent salivary gland tissue. Anteriorly (infront of salivary gland) free deep margin is 1mm and

posteriorly,free deep margin is 1cm. All other margins are free and well away. Attached soft tissue shows 2

metastatic tumor deposits, largest of which measuring 1cm in greatest dimension. Inked deep margin from the

metastatic deposits is 3-4mm.

B) Additional left lateral mucosal margin - free of tumor. Features consistent with Leukoplakia. No dysplasia

seen.

C) Hyoid bone margin - Free of tumor

D) Tissue adjacent to hyoid bone - Shows 3 metastatic tumor deposits, largest measures 7mm.

E) Level I a - 1/3 lymph nodes show metastasis, no perinodal spread seen.

F) Right level Ib - 2 reactive nodes

G) Right level IIa - 3/3 nodes positive for metastasis, 1 shows perinodal spread

H) Right level IIb - 5 reactive nodes

J) Right level III - 5/5 lymphnodes shows metastasis, 3 nodes show perinodal spread

K) Right level IV - 2/5 lymphnodes shows metastasis

L) Left level Ib - 1/3 lymphnodes shows metastasis

M) Left level II,III,IV - 5/13 lymphnodes shows metastasis, 2 nodes shows perinodal spread.

**Impression :**

Total Glossectomy and bilateral neck dissection:

- Moderately differentiatred squamous cell carcinoma

- Tumor size - 6x3.5x3cm, depth of invasion - 3cm

- Lymphovascular emboli and perineural invasion seen

- Deep soft tissue margin is close 1mm, anteriorly

-17/39 lymphnodes show metastatis, 6 nodes show perinodal spread

Stage : pT3N2cMx

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| **Date of Admission :**12/09/2011 | **Date of Procedure :**13/09/2011 |

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| **Date of Discharge :**12/10/2011 |

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

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

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| **PROCEDURE DONE :** |
| 1. Total glossectomy + Bilateral neck dissection (I-IV) + Gastroomental flap + Gracilis flap + Tracheostomy on 13-09-2011 under GA 2. Re-exploration + vascular anastamosis of gastroomental flap on 16-09-2011 under GA 3. Debridement + Radial forearm free flap on 20-09-2011 under GA |

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| **HISTORY :** |
| 27 year old Mr. Binu presented to Head and Neck OPD with complaints of ulcer on the right lateral border of tongue noticed initially as a small lesion six months back, treated conservatively by a local practitioner. The lesion progressively increased to the present size over the last six months. Came here for further management |

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| **CLINICAL EXAMINATION :** |
| Examination revealed about 6X4 cm ulceroproliferative growth on the right lateral border of oral tongue, induration crossing midline and involving the oropharyngeal tongue. Lesion reaches floor of mouth and is abutting the gingiva. Clinically alveolus does not appear eroded. Approximately 1.5 x 1.5 cm right level II, III and left level II firm lymph nodes palpable, with restricted mobility. |

**INVESTIGATIONS :**

**Haemogram:**

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| **Date:** | **Hb: g/dl** | **PCV: %** | **PLT: ku/ml** | **TC: ku/ml** | **DC: N %** | **L: %** | **E: %** | **ESR: mm/1st hr** |
| 15/09/2011 | - | - | - | - | 91.4 | 4.35 | - | - |
| 16/09/2011 | - | - | 186.0 | - | - | - | - | - |
| 17/09/2011 | 10.9 | - | - | - | - | - | - | - |
| 18/09/2011 | - | - | - | - | - | 8.88 | - | - |
| 19/09/2011 | - | 25.0 | - | - | - | - | - | - |
| 20/09/2011 | - | 25.9 | - | 10.5 | - | - | - | - |
| 21/09/2011 | - | - | - | 7.43 | - | - | - | - |
| 22/09/2011 | 9.37 | 27.4 | - | - | - | - | - | - |
| 23/09/2011 | - | - | 286.0 | 11.0 | 86.9 | 6.69 | - | - |
| 27/09/2011 | - | - | - | 9.89 | - | - | - | - |
| 28/09/2011 | - | - | 673.0 | 8.93 | 73.2 | - | - | - |

**Renal Function Test and Serum Electrolytes:**

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| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 15/09/2011 | - | - | 136.1 | - |
| 16/09/2011 | - | - | 134.6 | 3.52 |
| 21/09/2011 | - | - | 138.9 | 3.61 |
| 22/09/2011 | 18.6 | 0.56 | - | - |
| 23/09/2011 | 16.0 | 0.6 | 133.4 | 3.45 |
| 24/09/2011 | 13.8 | 0.58 | - | - |
| 25/09/2011 | - | - | 131.6 | 4.12 |
| 26/09/2011 | 17.7 | 0.62 | - | - |

Date: 28/09/2011

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| MPV-Blood : 7.02 fL | MONO -Blood : 10.4 % |

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| BASO-Blood : 0.558 % |  |

Date: 27/09/2011

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| RBC-COUNT-Blood : 3.22 M/uL | MCHC-Blood : 34.3 g/dl |

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| RDW-Blood : 14.9 % | MPV-Blood : 8.39 fL |

Date: 24/09/2011

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| MCH-Blood : 27.9 pg | MCHC-Blood : 33.2 g/dl |

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| RDW-Blood : 15.0 % | MPV-Blood : 8.38 fL |

Date: 23/09/2011

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| PT[Prothrombin Time with INR]-Plasma : 16.8/14.60/1.18 sec | MCH-Blood : 28.4 pg |

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| MCHC-Blood : 34.8 g/dl | RDW-Blood : 14.8 % |

Date: 21/09/2011

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| RBC-COUNT-Blood : 3.33 M/uL | MCV-Blood : 81.7 fL |

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| MCH-Blood : 28.7 pg | MCHC-Blood : 35.1 g/dl |

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| RBC-COUNT-Blood : 2.85 M/uL |  |

Date: 20/09/2011

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| PT[Prothrombin Time with INR]-Plasma : 13.7/14.60/0.93 sec | RBC-COUNT-Blood : 3.17 M/uL |

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| MCV-Blood : 81.5 fL |  |

Date: 19/09/2011

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| MCV-Blood : 81.5 fL | MCH-Blood : 24.5 pg |

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| MCHC-Blood : 30.1 g/dl | RDW-Blood : 14.1 % |

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| MPV-Blood : 7.27 fL |  |

Date: 18/09/2011

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| MCV-Blood : 81.3 fL | MCH-Blood : 27.9 pg |

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| MCHC-Blood : 34.3 g/dl | MONO -Blood : 6.77 % |

Date: 17/09/2011

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| RBC-COUNT-Blood : 3.95 M/uL | MCV-Blood : 81.3 fL |

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| MCH-Blood : 27.5 pg | MCHC-Blood : 33.9 g/dl |

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| RDW-Blood : 14.1 % |  |

Date: 16/09/2011

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| BASO-Blood : 0.194 % |  |

Date: 15/09/2011

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| MCH-Blood : 27.6 pg | MCHC-Blood : 33.9 g/dl |

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| RDW-Blood : 14.6 % |  |

Date: 12/09/2011

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| Anti HCV - Emergency Screen : 0.05Non Reactive | HIV - Emergency Screen(P24 Ag and HIV 1 and 2 Ab) : 0.05Non Reactive |

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| Surgical Pathology Report Service :Histopath-Excision biopsy (small) Received on :27/08/2011 Reported Date :29/08/2011 Histology Lab No :S11 - 9615 Microscopy and Impression : Bx Right lateral border of tongue ulcer : Moderately differentiated squamous cell carcinoma MDCT NECK - CONTRAST Date : 27/08/2011 IMPRESSION Neoplastic lesion in left side of tongue crossing midline extending to floor of mouth and probably involving the submandibular gland. Bilateral cervical lymphadenopathy probably metastatic nodes. DEPARTMENT OF NUCLEAR MEDICINE AND PETCT Date :31/08/2011 CONCLUSION : \* FDG AVID ENHANCING SOFT TISSUE LESION ALONG LEFT LATERAL BORDER OF TONGUE - PRIMARY TONGUE MALIGNANCY. METABOLICALLY ACTIVE ENHANCING SMALL SOFT TISSUE DENSITY LESION IN FLOOR OF MOUTH - ? LYMPH NODAL METASTASIS. FDG AVID BILATERAL LEVEL II & III CERVICAL LYMPH NODAL METASTASES. NO EVIDENCE OF ANY OTHER FDG AVID DISTANT METASTASIS FINAL PATHOLOGY REPORT Received on :13/09/2011 Reported Date :17/09/2011 Histology Lab No :A11-10159 Impression : Total Glossectomy and bilateral neck dissection: - Moderately differentiatred squamous cell carcinoma - Tumor size - 6x3.5x3cm, depth of invasion - 3cm - Lymphovascular emboli and perineural invasion seen - Deep soft tissue margin is close 1mm, anteriorly -17/39 lymphnodes show metastatis, 6 nodes show perinodal spread Stage : pT3N2cMx |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| The patient was evaluted. Biopsy was done on 27-08-2011, revealed as moderately differentiated squamous cell carcinoma. MDCT neck(Contrast) was done on 27-08-2011 showed neoplastic lesion in left side of tongue crossing midline extending to floor of mouth and probably involving the submandibular gland and bilateral cervical lymphadenopathy probably metastatic nodes. PET done on 31-08-2011 is negative for distant mets. His case was discussed in Head and Neck tumour board and decided to treat him with surgery(TB plan : total glossectomy +Bil ND+ double flap + intra op PEG insertion). He was admitted on 12-09-2011 and after all preliminary investigations and evalution he was taken up for surgery. He underwent Total glossectomy + Bilateral neck dissection (I-IV) + Gastro-omental flap + Gracilis flap + Tracheostomy on 13-09-2011 under GA. On the third postoperative day, gastro-omental flap found to compramised and he was taken up for re-exploration + vascular anastamosis of gastro-omental flap on 16-09-2011 under GA and later he underwent debridement + Radial forearm free flap on 20-09-2011 under GA. Postoperatively he developed neck wound gaping and managed conservatively with twice daily dressing. Tracheostomy tube decannulated at the time of discharge. Based on the final pathology report he is planned for postoperative adjuvant chemoradiation. Medical and Radiation oncology consultation was sought for the same. Dental consultation was sought for pre RT dental prophylaxis. Condition at discharge: Stable,afebrile, ambulating, tracheostomy tube decannulated, on FJ feeds, discharge from the neck wound reduced. |

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| **OPERATIVE FINDINGS :** |
| 1. Under general anesthesia. Visor flap elevated. Lower skin flap elevated. Bilateral neck dissection done from level I-IV. Bilateral enlarged lymph nodes with extracapsular spread adherent to surrounding structure in level II-III. Tongue ulceroinfilterative lesion involving the entire tongue except posterioly on the left side. Gingiva is stripped off from the mandible. Tongue pulled down through neck. Wide excision done with posterior base of tongue left out. Gastro-omental flap insetting done for mucosal side. Gracilis to provide bulk,placed underneath the gastro-omental flap. hemostasis acheived. Drain kept on both sides. Closed in layers. Tracheostomy done. Gastro-omental and Gracilis flap elevated and inset into the defect 2. Gastroomental flap absent perfusion. Gracilis flap function present. Approach through the previous incision. Vessels identified. Thrombosis of artery and vein present. Thrombus removed. Edges of both vessels prepared. Vein graft taken from right forearm and anastomosed between the facial artery and perforator artery of the flap. Also another vein graft used for anastamosis between the common facial vein-end to side and flap vein- end to end. After anastamosis flap vascularity regained. Incision closed in single layers with 4-0 ethilon 3. Previous transverse incision was opened on the left half. Complaints of fistula. Gastroomntal flap debrided. Tongue reconstruction done with 12 x 8 cm radial forearm flap taken from left hand. Flap artery anastamosed with external carotid artery-end to end after ligating ECA. Flap vein anastamosed with IJV end to side. Incision closed with 3-0 ethilon. Single layer over glove drain |

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| **ADVICE ON DISCHARGE :** |
| Maintain oral hygeine Twice daily dressing with saline solution as taught Review after one week in Head and Neck OPD Review in Medical Oncology on the day of follow up Review in Radiation Oncology on the day of follow up Apply coconut oil over the donor area(Thigh) and massage nicely |

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| **DIET RECOMMENDATIONS :** |
| Feeding jejunostomy (2.5 litre/ day) High protein diet |

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| **DISCHARGE MEDICATION :** |
| Tab. Ciplox 500 mg 1-0-1 x 5 days Tab. Dolo 650 mg SOS (6) Tab. Pan 20 mg 1-0-1 x 5 days Hexidine mouth gargles fourth hourly Saline 100 ml x 2 bottle Dressing kit 5 Micropore 1  **Progress Notes**  **Date : 31/08/2011**  **ProgressNotes :**  case of CA tongue  ADV  discussed in TB today  advised near total glossectomy with flap reconstruction +b/l neck dissection  PET scan report awaiting  to review on FRIDAY for surgery date and to review the PET scan report  pac and pain and palliative consultation today  **Progress Notes**  **Date : 09/02/2012**  **ProgressNotes :**  seen in swallowing clinic  oral prep and oral stage: affected,anterior to posterior movement tongue affected  [haryngeal stage: nl  adv:oral trial started with blend diet  technique: head back with gravity and jet feeding  **Progress Notes**  **Date : 15/12/2011**  **ProgressNotes :**  MDSCC Tongue pT3 N2c with neck recurrence in short time, very aggressive disease with poor prognosis.  On Rt with weekly cisplatin  Had 5 doses, RT was disconinued in between  Completed 23# of RT till today  Tolerated well, except for vomiting  CBC-N  Week 6 15/12/2011  Inj.Ondansetron 8mg + Inj.Dexona 20mg in 100ml NS>15min  Isolyte M 2 bottles  Inj.Cisplatin 47mg in 1 bottle NS >2hrs  Inj.Lasix 20mg IV  DNS 1 bottle with Inj.MgSO4 25% 1amp  DNS 2 bottle  Tab.Domperidone 1 bid x 3 days  Cap. Omeprazole 20mg OD x 5 days  Review on 22/12/2011 with CBC, RFT   |  | | --- | | **OPERATIVE FINDINGS :** | | 1. Under general anesthesia. Visor flap elevated. Lower skin flap elevated. Bilateral neck dissection done from level I-IV. Bilateral enlarged lymph nodes with extracapsular spread adherent to surrounding structure in level II-III. Tongue ulceroinfilterative lesion involving the entire tongue except posterioly on the left side. Gingiva is stripped off from the mandible. Tongue pulled down through neck. Wide excision done with posterior base of tongue left out. Gastro-omental flap insetting done for mucosal side. Gracilis to provide bulk,placed underneath the gastro-omental flap. hemostasis acheived. Drain kept on both sides. Closed in layers. Tracheostomy done. Gastro-omental and Gracilis flap elevated and inset into the defect  2. Gastroomental flap absent perfusion. Gracilis flap function present. Approach through the previous incision. Vessels identified. Thrombosis of artery and vein present. Thrombus removed. Edges of both vessels prepared. Vein graft taken from right forearm and anastomosed between the facial artery and perforator artery of the flap. Also another vein graft used for anastamosis between the common facial vein-end to side and flap vein- end to end. After anastamosis flap vascularity regained. Incision closed in single layers with 4-0 ethilon  3. Previous transverse incision was opened on the left half. Complaints of fistula. Gastroomntal flap debrided. Tongue reconstruction done with 12 x 8 cm radial forearm flap taken from left hand. Flap artery anastamosed with external carotid artery-end to end after ligating ECA. Flap vein anastamosed with IJV end to side. Incision closed with 3-0 ethilon. Single layer over glove drain  **Progress Notes**  **Date : 09/02/2012**  **ProgressNotes :**  Ca tongue post OP  Completed 33 fractions of adjuvant 3DCRT on 28/12/2011.  Patient had neck node progression on RT  RT started as IMRT and Had 3 fractions earlier to 3D which was discontinued due to patient factors.  Taking into account both of this Total dose to the tumor area is >= 72 Gy .  At present, post RT follow up: 6 weeks  FJ tube insitu- taking diet through tube as well.  Pain improved. On morphine may be made SOS.  Not able to swallow solid diet, able to swallow liquid diet.  No fever.  Cough +  Clinically  KPS 90  Oral cavity : Grade I mucositis most areas.  Skin no reactions.  Has nausea and vomiting tendency.  Nodes : < 1 cms partially fixed along the left sternomastoid in level III and IV. Also right SCLN <1 cms hard  mobile. Regressed in size.  CXR done show features of LRI.  PLAN: Antibiotics for 1 week.  Review in HNS  PLAN for USG neck and reassessment after 1 month.  Tab Augmentin 625 1-1-1  Tab Mucolite 1-1-1  Tab Dolo650 1-1-1  Coming for follow up in HNS on 23.2.12. | |