**RADIOLOGY REPORT**

**Created Date:** 09/05/2020

**Study Done:**

**MRI HEAD & NECK ( PLAIN)**

***Clinical Information:* Complaints of ulcer in right lateral border of tongue.**

A heterogenously enhancing mass seen in the mid third of the right lateral border of theoral tongue measuring 2

x 1.2 x2.1 cm just reaching the right sublingual space.Floor of mouth is free.

No involvement of contralateral side of tongue.

Larynx and pharynx appear normal.

Multiple suspicious level Ia, right level Ib ,II noted largest measruing 11x7mm in the right level Ib.

Bilateral carotid and jugular vessels appear normal.

Both submandibular and parotid salivary glands appear normal.

Thyroid gland show heterogenous signals - needs ultrasound correlation

Bones show normal signal.

**Impression:**

• **Heterogenously enhancing soft tissue along the lateral border and dorsum mid third of the**

**right lateral border of the tongue just reaching the right sublingual space-suggestive of**

**malignancy.**

• **Multiple suspicious level Ia, right level Ib ,II as described.**

**RADIOLOGY REPORT**

**Created Date:** 18/05/2020

**Study Done:**

**ULTRASOUND NECK**

Right lobe; 14 x 18 x 37 mm.

Left lobe: 15 x 19 x 40 mm.

Isthmus: 4 mm.

Few solid predominantly cystic nodules noted in both lobes of thyroid.

Thyroid gland shows increased vascularity.

Multiple oval hypoechoic lymph nodes noted in left level II, III and IV largest in left level IV measuring 9 x 7

mm.

Prior MRI dated 09/05/2020 lymph nodes in right level Ib, II and Ia remains status quo.

**Impression:**

***Known case of carcinoma tongue - for assessment of neck nodes.***

• **Multiple oval hypoechoic suspicious lymph nodes noted in left level II, III and IV.**

• **Thyroid gland shows features suggestive of thyroiditis.**

• **Prior MRI documented suspicious nodes in right level Ib, II and Ia remains status quo.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 15/05/2020

**Received on :** 15/05/2020

**Reported Date :** 19/05/2020

**Clinical Impression :**

Carcinoma right tongue

**Gross Description :**

Received fresh is a specimen labelled as "Posterior tongue lesion", consists of 2 mucosa attached tissue bit

measuring 0.7x0.6x0.3cm.

Frozen read as: Mild to moderate dysplasia

Subsequently received in formalin are 13 specimens.

Specimen I labelled as "WLE double anterior single superior", consists of right half of tongue with attached floor

of mouth mucosa laterly whole measuring 6 (AP) x 4(SI) x 2.6(MI) cm. There is an ulceroproliferative lesion on

the right lateral board of tongue measuring 2.5(SI) x 2.5(AP) x 0.9 (MI) cm. Depth of excision 0.8cm. The

lesion is

2cm from the anterior soft tissue margin and lip of tongue

1.5cm from posterior tongue mucosal and soft tissue margin

1.3cm from right lateral floor of mouth mucosal soft tissue margin

0.7cm from medial soft tissue margin

0.7cm from superomedial tongue mucosal margin

Representative sections are submitted as follows:

A1 - Anterior soft tissue margin and lip of tongue (Radial)

A2 - Posterior soft tissue and mucosal margin (Radial)

A3 - Inferiolateral floor of mouth mucosal and soft tissue margin (Radial)

A4 - Supero-medial mucosal margin and medial soft tissue margin (Radial)

A5 - Lesion with maximum depth of invasion

A6 - Lesion proper and lateral mucosa and soft tissue

A7-A8 - Lesion proper

Specimen II labelled as "level IA", consists of nodular fibrofatty tissue measuring 3x3x1cm. 2 lymph node

identified measuring 0.5cm in greatest dimension. Entire specimen submitted in B1 to B3 cassettes.

B1 - 2 lymph node

B2-B3 - 1 lymph node

Specimen III labelled as "Right level IB", consists of nodular fibrofatty tissue measuring 5.3x3.3cm. Salivary

gland identified measuring 4x3x3.2cm. 5 lymph node identified largest measuring 1cm in greatest dimension,

smallest measuring 0.5cm in greatest dimension. Cut surface of salivary gland unremarkable. Representative

sections are submitted in C1 to C4 cassettes.

C1 - 3 lymph node

C2 - 2 lymph node

C3 - Salivary gland

C4 - Fibrofatty tissue

Specimen IV labelled as "Left level IB", consists of nodular fibrofatty tissue measuring 5x3.5x2.2cm. 3 lymph

node identified largest measuring 1.1cm in greatest dimension, Smallest measuring 0.3cm. Salivary gland

identified measuring 4x3x2cm. Cut surface of salivary gland unremarkable. Representative sections are

submitted in D1 to D3 cassettes.

D1 - 3 lymph node

D2 - Salivary gland

D3 - Fibrofatty tissue

Specimen V labelled as "Right level IIA", consists of nodular fibrofatty tissue measuring 2.5x2x1cm. 5 lymph

node identified largest measuring 1.5cm in greatest dimension, smallest measuring 0.3cm in greatest

dimension..Entire specimen submitted in E1 to E4 cassettes.

E1-E2 - 1 lymph node bisected

E3 - 4 lymph node

E4 - Fibrofatty tissue

Specimen VI labelled as "Left level IIA", consists of fibrofatty tissue in aggregate measuring 3x3x2cm. 5 lymph

node identified largest measuring 1cm in greatest dimension smallest measuring 0.5cm in greatest dimension.

Entire specimen submitted in F1 to F4 cassettes.

F1 - 3 lymph node

F2 - 2 lymph node

F3-F4 - Fibrofatty tissue

Specimen VII labelled as "Right level IIB", consists of nodular fibrofatty tissue measuring 2x1.5x1cm. 3 lymph

node identified measuring 0.5cm in greatest dimension. Entire specimen submitted in G1 and G2 cassettes.

G1 - 3 lymph node

G2 - Fibrofatty tissue

Specimen VIII labelled as "Left level IIB", consists of 3 nodular fibrofatty tissue measuring 2x1.5x1cm. 5 lymph

node identified largest measuring 0.8cm in greatest dimension, smallest measuring 0.3cm .Entire specimen

submitted in H1 and H2 cassettes.

H1 - 5 lymph node

H2 - Fibrofatty tissue

Specimen IX labelled as "Right level III and IV", consists of nodular fibrofatty tissue measuring 3.3x2.5x2cm. 4

lymph node identified largest measuring 2cm in greatest dimension, smallest measuring 0.5cm in greatest

dimension.Entire specimen submitted in J1 and J6 cassettes.

J1-J2 - 1 lymph node bisected

J3 - 3 lymph node

J4-J5 - Fibrofatty tissue

J6 - 1 lymph node bisected

Specimen X labelled as "Left level III", consists of single brofatty tissue measuring 2.8x1.5x0.5cm. 4 lymph

node identified largest measuring 0.7cm in greatest dimension,smallest measuring 0.3cm in greatest dimension.

Entire specimen submitted in K1 and K2 cassettes.

K1 - 4 lymph node

K2 - Fibrofatty tissue

Specimen XI labelled as "Left level IV", consists of nodular fibrofatty tissue measuring 2.5x1.3x1cm. 4 lymph

node identified largest measuring 1.3cm in greatest dimension,smallest measuring 0.3cm in greatest dimension.

Entire specimen submitted in L1 to L3 cassettes.

L1-1 Lymph node bisected

L2-3 Lymph nodes

L3-Fibrofatty tissue

Specimen XII labelled as "Additional posterior mucosal margin", consists of mucosa attached tissue bit

measuring 1x0.7x0.5cm. Entire specimen submitted in cassette M.

Specimen XIII labelled as "Additional lateral mucosal margin", consist of mucosa attached tissue bit measuring

0.5x0.5x0.3cm. Entire specimen submitted in cassette N.

**Microscopic Description :**

Frozen-Posterior Tongue Lesion: Frozen section confirms frozen report

Section from right posterior tongue shows an ulceroproliferative lesion composed of neoplasm arising from

overlying dysplastic epithelium arranged in solid sheets, nests, trabeculae and islands (<15 cells). Individual cells

have moderate eosinophilic cytoplasm, round vesicular nucleus with prominent nucleoli. Occasional brisk

mitosis. Keratin pearls noted. Tumour front is discohesive. Dense discontinuous lymphocytic infiltrate present at

interface. Stroma shows desmoplasia. Overlying epithelium shows ulceration.

No lymphovascular emboli.

No perineural invasion.

Tumour infiltrates into the underlying muscle.

Margins: All soft tissue and mucosal margins are free of tumour, Closest being medial soft tissue margins 0.7 cm

away

Salivary gland appears unremarkable

B] Level IA - 2 lymph nodes free of tumour

C] Right level I B -5 lymph nodes, free of tumour

D] Left level I B - 4 lymph nodes, free of tumour

E] Right level II A - 10 lymph nodes, free of tumour

F] Left level II A - 10 lymph nodes, free of tumour

G] Right level II B - 6 lymph nodes, free of tumour

H] Left level II B - 4 lymph nodes, free of tumour

J] Right level II & IV - 7 lymph nodes, free of tumour

K] Left level III - 9 lymph nodes, free of tumour

L] Left level IV - 9 lymph nodes, free of tumour

M] Additional posterior mucosal margin - Free of tumour

N] Additional lateral mucosal margin - Free of tumour

**Impression :**

WLE Tongue + Bilateral selective nodal dissection + Additional Margins:

- Moderately differentiated SCC, right lateral tongue

- Tumour size: 2.5 x 2.5 x 0.7 cm

- Depth of invasion: 0.7 cm

- WPOI: 4

- LHR: Dense discontinuous

- No lymphovascular emboli

- No perineural invasion

- Risk group: Intermediate risk

- Tumour involves underlying muscles

- Margins: All mucosal and soft tissue margins are free of tumour. Closest margin is medial soft tissue being 0.7

cm away.

- Lymph nodes: 66 reactive nodes, free of tumour

- Salivary gland: Unremarkable

PT2N0

**Radiology Report**

**Created Date:** 27/05/2022

**Study Done:**

**CT NECK CONTRAST**

**Clinical indication** - Case of carcinoma tongue on the right lateral border(T2 N0), S/P WLE + B/L SND (I - IV)

under GA on 15/05/2020.

Ill defined enhancement measuring 2 x 1cm is seen along the left lateral border of the mid third of tongue.

No significant cervical lymph nodes.

Larynx and pharynx appear normal

Bilateral neck vessels are normal.

Thyroid gland shows small nodules in both lobes - needs further evaluation with ultrasound

**Impression:**

• **Suspicious enhancing lesion as described in the left lateral border of mid third of oral tongue**

**needs clinical correlation.**

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| **Date of Admission :**14/05/2020 | **Date of Procedure :**15/05/2020 |

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| **Date of Discharge :**20/05/2020 |

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

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| **DIAGNOSIS :** |
| Carcinoma Right Tongue cT2N2cM0 |

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| **PROCEDURE DONE :** |
| WLE + B/L SND (I-IV) under GA on 15-05-2020. |

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| **DRUG ALLERGIES :** No known drug allergies. |

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| **HISTORY :** |
| 60 year old male not a smoker/alcoholic with no co morbs came with complaints of ulcer in right lateral border of tongue - noticed 3 months back. No history of pain/dysphagia/odynophagia showed to a dentist and took biopsy from outside, HPR- B-347/2020- MDSCC. He now admitted for further management. |

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| **PAST HISTORY :** |
| No h/o DM/HTN/DLP/Asthma/TB/Seizures/Thyroid dysfunction/CAD/CVA |

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| **PERSONAL HISTORY :** |
| Good effort tolerance No recent fever/cough Normal bowel and bladder habits |

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| **CLINICAL EXAMINATION :** |
| On Examination: General condition fair. Vitals stable. Mouth opening adequate 3x3 cm lesion in the right lateral border floor of mouth free No neck nodes palpable |

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| MRI HEAD & NECK: Heterogenously enhancing soft tissue along the lateral border and dorsum mid third of the right lateral border of the tongue just reaching the right sublingual space-suggestive of malignancy. Multiple suspicious level Ia, right level Ib ,II as described. |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| The patient was admitted with above mentioned complaints. Relevant investigations were done. He underwent WLE + B/L SND (I-IV) under GA on 15-05-2020. Post operative period was uneventful with no major issues. Left neck drain was removed on POD 3. He tolerated oral feeds and hence RT was removed on 4. Other neck drain was removed on POD 5. At the time of discharge, patient is stable and afebrile and taking well orally. |

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| **OPERATIVE FINDINGS :** |
| Diagnosis: Carcinoma Right Tongue cT2N2cM0 Surgery: WLE + B/L SND (I-IV) under GA on 15-05-2020. Findings: 2x2 cm upg involving the middle Lateral border of the right tongue. Very small suspicious lesion at the circumvillate papillae on right side - Frozen s/o Mild to Moderate dysplasia. Multiple significant nodes seen B/L Level-IB,II,III and IV. Procedure: Nasotracheal intubation done and patient was taken under ga with sterile and aseptic precautions. Patient positioned, cleaned and draped. Wide Local Excision: Bite block inserted on Left side. betadine wash given. 2x2 cm upg involving the middle Lateral border of the right tongue. Very small suspicious lesion at the circumvillate papillae on right side - Frozen s/o Mild to Moderate dysplasia. FOM/BOT/tip of the tongue free from growth . Taking adequate margins wide local excision done. Hemostasis acheived. Wound was left as such for secondary healing. B/L Selective neck dissection(I-IV): 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. Significant 1x1cm peri-facial lymph nodes and level-Ib fibrofatty tissue along with submandibular gland removed in toto and sent for hpe. External jugular vein preserved. Left Sternomastoid retracted laterally ? ijv, carotids and spinal accessory nerves preserved. Left Level-IIa, IIB, III and IV lymphnodes and fibrofatty tissue removed and sent for hpe seperately. Hemostasis acheived. Right side same steps repeated by preserving the Sterno-Mastoid, IJV and SAN. Valsalva given to check bleeding ? no active bleeding seen. 14# romovac drain secured. Wound closed in layers. Patient shifted to 41 ICU for immediate post op care. |

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| **ADVICE ON DISCHARGE :** |
| Wound care. Oral care. |

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| **WHEN TO OBTAIN URGENT CARE:** |
| In case of bleeding/ infection or high grade fever. |

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| **DIET RECOMMENDATIONS :** |
| Soft Oral diet |

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| **PHYSICAL ACTIVITY :** |
| As tolerated |

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| **DISCHARGE MEDICATION :** |
| \*All current medication have been reviewed and reconciled into the medication list. Tab. Ciplox 500mg 1-0-1 x 3 days Tab.Pan 40mg 1-0-0 x 3days. Tab.Dolo 650mg 1-1-1 x 3days, sos hence Cholrhexidine mouth gargles 1-1-1 x 7 days Tab. Chymoral Forte 1-1-1 x 3 days Syp. Zincovit 10ml 1-0-1 x 7 days |

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| **HEAD AND NECK - TUMOUR BOARD** |

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|  | **TB Date:**  13/05/2020 |
|  | **Tumour Type:** Primary |
| **Presenting Complaints: Ulcer** | | |
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| **Descriptive History and Examination:**  60 year old male not a smoker/alcoholic no co morbs c/o ulcer in right lateral border of tongue - noticed 3 months back no h/o pain/dysphagia/odynophagia showed to a dentist and took biopsy from outside outside HPR- B-347/2020- MDSCC o/e- mouth opening adequate 3x3 cm lesion in the right lateral border floor of mouth free no neck nodes palpable | | |
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| |  |  | | --- | --- | |  | **MRI:**  A heterogenously enhancing mass seen in the mid third of the right lateral border of theoral tongue measuring 2 x 1.2 x2.1 cm just reaching the right sublingual space.Floor of mouth is free. No involvement of contralateral side of tongue. Larynx and pharynx appear normal. Multiple suspicious level Ia, right level Ib ,II noted largest measruing 11x7mm in the right level Ib. Bilateral carotid and jugular vessels appear normal. Both submandibular and parotid salivary glands appear normal. Thyroid gland show heterogenous signals - needs ultrasound correlation Bones show normal signal. Impression: Heterogenously enhancing soft tissue along the lateral border and dorsum mid third of the right lateral border of the tongue just reaching the right sublingual space-suggestive of malignancy. Multiple suspicious level Ia, right level Ib ,II as described. | |  | |  |  |  |  |  | | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | **Descriptive Plan:**  Carcinoma tongue cT2N2bM0 WLE + I/L SND under ga Plan:To be discussed with Dr Sandhya madam for nodes mailnly contralateral WLE + I/LSND +/- Contralateral snd based on usg neck + STF 20.05.2020: WLE + B/L SND (I-IV) under ga on 15-05-2020. |  | |  |  | | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | |  |  | |  |  | |  |  | | |  |  |  |  | | --- | --- | | |  | | --- | |  | |   **HP Tumour Board Discussion**  **Relevant clinical details :**  DIAGNOSIS :  Carcinoma Right Tongue cT2N2cM0  PROCEDURE DONE :  WLE + B/L SND (I-IV) under GA on 15-05-2020.  **Histology (include histology done / reviewed elsewhere) :**  WLE Tongue + Bilateral selective nodal dissection + Additional Margins:  - Moderately differentiated SCC, right lateral tongue  - Tumour size: 2.5 x 2.5 x 0.7 cm -  Depth of invasion: 0.7 cm  - WPOI: 4  - LHR: Dense discontinuous  - No lymphovascular emboli  - No perineural invasion  - Risk group: Intermediate risk  - Tumour involves underlying muscles  - Margins:  All mucosal and soft tissue margins are free of tumour. Closest margin is medial soft tissue being 0.7 cm away.  - Lymph nodes: 66 reactive nodes, free of tumour - Salivary gland: Unremarkable  pT2N0  OBSERVATION.  Regular followup at 3 monthlys intervals for the First 2 years  Each followup - evaluated for locoregional recurrence, EORTC- QOL & CTCAE - Acute & Longterm RT  Toxicity rate AT 3Monthly.  **Progress Notes**  **Date : 08/05/2020**  **ProgressNotes :**  60 year old male  c/o ulcer in right lateral border of tongue - noticed 3 months back  showed to a dentist and took biopsy from outside  outside HPR- B-347/2020- MDSCC  o/emouth  opening adequate  3x3 cm lesion in the right lateral border  floor of mouth free  no neck nodes palpable  plan  preops /PAC  mri head and neck with contrast  **Operative Notes**  **Date : 15/05/2020**  **ProgressNotes :**  Diagnosis:  Carcinoma Right Tongue cT2N2cM0  Surgery:  WLE + B/L SND (I-IV) under ga on 15-05-2020.  Findings:  2x2 cm upg involving the middle Lateral border of the right tongue.  Very small suspicious lesion at the circumvillate papillae on right side - Frozen s/o Mild to Moderate  dysplasia.  Multiple significant nodes seen B/L Level-IB,II,III and IV.  Procedure:  Nasotracheal intubation done and patient was taken under ga with sterile and aseptic precautions.  Patient positioned, cleaned and draped.  Wide Local Excision:  Bite block inserted on Left side.  betadine wash given.  2x2 cm upg involving the middle Lateral border of the right tongue.  Very small suspicious lesion at the circumvillate papillae on right side - Frozen s/o Mild to Moderate  dysplasia. FOM/BOT/tip of the tongue free from growth .  Taking adequate margins wide local excision done.  Hemostasis acheived.  Wound was left as such for secondary healing.  B/L Selective neck dissection(I-IV):  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.  Significant 1x1cm peri-facial lymph nodes and level-Ib fibrofatty tissue along with submandibular gland  removed in toto and sent for hpe.  External jugular vein preserved.  Left Sternomastoid retracted laterally ? ijv, carotids and spinal accessory nerves preserved.  Left Level-IIa, IIB, III and IV lymphnodes and fibrofatty tissue removed and sent for hpe seperately.  Hemostasis acheived.  Right side same steps repeated by preserving the Sterno-Mastoid, IJV and SAN.  Valsalva given to check bleeding ? no active bleeding seen.  14# romovac drain secured.  Wound closed in layers.  Patient shifted to 41 ICU for immediate post op care. | |  |  | | | | |
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**Progress Notes**

**Date : 03/01/2024**

**ProgressNotes :**

Carcinoma Right Tongue pT2N0M0

s/p WLE + B/L SND (I-IV) under GA on 15-05-2020.

CT Neck (12-11-2021) -No evidence of any nodes / local recurrence in post op site.

ct neck (27-05-2022)-- Ill defined enhancement measuring 2 x 1cm is seen along the left lateral border of the

mid third of tongue. No significant cervical lymph nodes.

c/o multiple oral ulcers +dyrness

c/o-l/r nad

glossitis

no frank ulcers

b/l palm hyperpigmentation ++

adv

review after as per SPT protocol (on curcumin and metformin)

derma consult for hand discolouration

syp Lactihep 10 ml HS