**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 08/08/2018

**Received on :** 08/08/2018

**Reported Date :** 16/08/2018

**Clinical Impression :**

C/o carcinoma right lower alveolus and FOM

**Gross Description :**

Received in formalin are 13 specimens.

The Ist specimen labelled "Segment of mandibulectomy" consists of a segment of mandible which is measuring

8.2(AP)x4.5(SI)x2.3(ML)cm. There is an ulceroproliferative lesion on the (alveolar) mucosal aspect measuring

1.5(AP)x1.7(SI)x1.4(ML) extending to the 2nd premolar and seen extending into to medial FOM and buccal

mucosa. The lesion is 3.5cm from anterior margin, 5.6cm from posterior margin, 1.1cm from FOM margin,

1.1cm from medial mucosal margin .Depth of the lesion is 1.1cm. Representative sections are submitted as

follows:

A- Salivary gland

AFB1- antero-medial bony margin

AFB2 - Posterior bony margin

AFB3 - Buccal mucosal margin

AFB4 - FOM margin

AFB5 - Cordlike structure possibly nerve

AFB6 - Medial mucosal margin

AFB7 - Posterior soft tissue margin

AFB8 - Salivary gland

AFB9 - Antero-medial soft tissue margin

AFB10 to AFB14 - Lesion proper

AFB15 - Tumour with bone.

Specimen II labelled "Additional anterior gingival margin" consists of same measuring 0.5x0.5cm. Entire

specimen submitted in cassette B.

Specimen III labelled "Left EJV node" consists of same measuring 0.2x0.2cm. Entire specimen submitted in

cassette C.

Specimen IV labelled"left prefacial node" consists of same measuring 0.6x0.6cm. Entire specimen submitted in

cassette D.

Specimen V labelled " Level Ia" consists of fibrofatty tissue measuring 1x1cm. Entire specimen submitted in

cassette E.

Specimen VI labelled"Level Ib" consists of fibrofatty tissue measuring 3.5x2.5x0.5cm. Salivary gland

identified.1 lymph node identified measuring 1x1.1x0.1cm. Entire specimen submitted in cassettes F1 & F2.

Specimen VII labelled "Level Level IIA" consists of fibrofatty tissue measuring 3x2x1.5cm. Representative

sections are submitted in cassettes G1 & G2.

Specimen VIII labelled" Left level II b" consists of same measuring 2x1x0.8cm. Entire specimen submitted in

cassettes H1 & H2.

Specimen IX labelled "left level III" onsists of linear fibrofatty tissue measuring 5cm length.4 lymph nodes

identified, largest measuring 1.6x1x0.5cm. Entire specimen submitted in cassettes J1 to J4.

Specimen X labelled "left level IV"consists of fibrofatty tissue measuring 2.5x1.5x0.8cm. No lymph nodes

identified. Entire specimen submitted in cassettes K1 to K3.

Specimen XI labelled "Right level II" consists of fibrofatty tissue measuring 1.8x1.8x0.5cm. Entire specimen

submitted in cassettes L1 & L2.

Specimen XII labelled" right level III" consists of 2 fibrofatty tissue measuring 2.5x1.5x0.5cm. Node

measuring 2x1x0.3cm. Entire specimen submitted in cassettes M1 to M3.

Specimen XIII labelled "Right level IV" consists of same measuring 2.8x1.5x0.5cm. Entire specimen submitted

in cassettes N1 to N3.

**Microscopic Description :**

A. Sections from rigth segmental mandibulectomy shows an infiltrating neoplasm composed of dysplastic

squamous cells arranged in lobules and nests. Cells are midly pleomorphic with prominent nucleoli,moderate

amount of eosinophilic cytoplasm. Numerous keratin pearls seen with areas of keratinisation. Necrosis seen.

LVI, PNI not seen. Interface show mild lymphocytic infiltrate. Areas of salivary gland noted appears normal.

B. Right additional anterior gingival margin - Free of tumour

C. Left EJV node -Shows fibrofatty tissue, free of tumour

D. Left prefacial node -Single node, free of tumour

E. Level IA -Single node, free of tumour

F. Level IB- Single node shows metastasis. No ENE seen. Salivary gland is free of tumour

G. Left level IIA - Single node and salivary gland is free of tumour

H. Left level IIB -Single node free of tumour

J. Left level III - 1/5 nodes show metastasis with minimal ENE. Deposit measuring 1.2cm

K. Left level IV - Single node, free of tumour

L. Right level II - 3 nodes- free of tumour

M. Right level III - 2 nodes, free of tumour

N. Right level IV - 4 nodes , free of tumour

**Impression :**

Segmental mandibulectomy right with additional margins and bilateral node dissection :

- Moderately differentiated squamous cell carcinoma right mandible

- Tumour measures -1.5x1.7x1.4cm.

- Depth -1.1cm

- Bony invasion - Not seen

- LVE -Not seen

- PNI -Not seen, score 0

- LHR - Score 2

- WPOI-Type 4, score 1

- Histological risk assessment score - 3 (high risk)

- Margin - All margins are free

- Lymph nodes - 2 Metastatic nodes, left level III with minimal ENE and left level IB without ENE.

Largest deposit measuring 1.2cm

pTN - pT3N2b

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 07/01/2020

**Received on :** 07/01/2020

**Reported Date :** 08/01/2020

**Clinical Impression :**

Esopheal growth in mid-esophagus

**Gross Description :**

Received in formalin is a specimen labelled as "Esophagal biopsy", consists of 4 grey white tissue bits in

aggregate measuring 0.3x0.2x0.1cm. Entire specimen submitted in one cassette.

**Microscopic Description :**

Sections show multiple fragments of esophageal mucosa infiltrated by atypical squamous cells in nests, alveolar

pattern with invasion into muscularis mucosae. Tumor cells are polygonal with hyperchromatic nucleus and

prominent nucleoli and dyskeratosis. Mitotic activity is noted. There is associated chronic active inflammation.

**Impression :**

Esophageal biopsy -Moderately differentiated squamous cell carcinoma with chronic active inflammation.

**Radiology Report**

**Created Date:** 16/01/2020

**Study Done:**

**CT CHEST-CONTRAST**

***Clinical Information: Case of Ca floor of mouth status post surgery and Chemo and carcinoma esophagus.***

Post operative changes noted in the right side of floor of mouth and right mandible. NG tube noted insitu.

Extensive circumferential wall thickening of esophagus with enhancement noted extending from D1-D2 level to

below the subcarinal level at D6-D7 vertebrae ...

The lumen of esophagus is completely obliterated in this segment along with narrowing of trachea with AP

diameter of trachea at D3 level of 6.8mm.

The lesion is abutting the descending aorta with more than 180o contact. The lesion is also seen to extend into

AP window and along the left mainstem bronchus with mild narrowing of the same. Extension also noted

along the right mainstem bronchus.

Left hilar lymph nodes seen measures 2.3 x 2cm. Few subcentimetric pre vascular lymph nods also noted.

The tracheobronchial tree is normal.

A tiny pleural based nodule noted in anterior segment of right upper lobe.

No pleural effusion.

Visualized upper abdominal organs appears unremarkable.

Degenerative changes seen in dorsolumbar spine.

**Impression:**

• **Extensive circumferential wall thickening of esophagus narrowing the trachea with**

**mediastinal infiltration as described.**

• **Left hilar and prevascular lymph nodes as described.**

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| **Date of Admission :**06/08/2018 |

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

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| **DIAGNOSIS :** |
| k/c/o Ca Right lower alveolus |

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| **PROCEDURE DONE :** |
| Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA |

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| **HISTORY :** |
| 53/m Advocate by profession C/C alcoholic and smoker diagnosed case of ca FOM cT4aN2cMx Biopsy-Squamous cell carcinoma He went to RCC for further management He completed 3 cycles of Induction Chemotherpay with Paclitaxel +Carboplatin from Cochin Cancer Hospital C1 on 5.4.2018 C2 on 26.4.2018 C3 on 17.5.2018 with Inj.Paclitaxel 175mg/m2 nd Inj.Carboplatin ,last on 18.5.2018 After 3 cycles of Induction chemo,he showed good response (Response assessment clinically ) Options regarding Surgery and RT was explained to the patient and he came here for further management comorbidities- CBD Stenting, History of Carcinoma bladder-15 yrs back |

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| **PAST HISTORY :** |
| CBD Stenting History of Carcinoma bladder-15 yrs back |

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| **CLINICAL EXAMINATION :** |
| On Examination: KPS 90 mouth opening adequate ulceroproliferative growth right side of floor of mouth opposite lateral incisor reaching till 2nd lower premolar, minimal induration limited to lesion cystic swelling over right lower lateral incisor and canine gingiva, slough in sockets of extracted right lower molar teeth Neck-right 1x1cm hard node with restricted mobility rest nad |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| 53 Year old C.Ajithkumar came to Head and Neck OPD with above mentioned complaints.After all preliminary examinations and investigations he underwent wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA.Peri and post op period uneventful. Conditions at discharge: GC Fair Vitals stable Drains removed |

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| **OPERATIVE FINDINGS :** |
| procedure- wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA surgeons- DR SI/DB/Mohit sir/ DR Janardhan sir, Dr Ankita, Dr Ridhi Sood findings - ulceroproliferative lesion right floor of mouth abutting mandible, level Ib node infiltrating digastric anterior belly and mylohyoid. multiple level II-III-IV b/l nodes under GA with all aseptic precautions transverse skin crease incision taken from angle of mandible on one side to opposite side, vertical incision with midline lip split given subplatysmal flaps elevated cheek flap raised on right side to expose mandible preplating done bone cuts made btw c/l lateral incisor and canine and sub condylar level soft tissue with 1 cm margin around the tumor left on specimen side which included cuff of ventral surface of tongue and floor of mouth, sublingual gland, level Ib also delivered with specimen bl SND levels I-IV done marginal mandibular and spinal accessory nerve identified and preserved on both sides specimen sent for HPE hemostasis achieved free fibula flap harvested from left leg, with skin paddle of approx size 8x6cm with pedicle length if approx 10cm, 2 osteotomies done to obtain three segments of bone donor site closed with SSG from right thigh flap inset done- bone secured in place with screws microanastomosis done- arterial to facial artery and venous to facial vein skin paddle used to cover floor of mouth and ventral done defect neck closure done tracheostmy done procedure uneeventful |

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| **DISCHARGE MEDICATION :** |
| \*All current medication have been reviewed and reconciled into the medication list. Tab Dolo 650mg 1-0-1 Tab Pan 40mg 1-0-0 Continue all previous medications |

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| **Date of Admission :**29/08/2018 |

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| **Date of Discharge :**31/08/2018 |

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| **DIAGNOSIS :** |
| k/c/o Ca Right lower alveolus s/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA on 06/08/2018. |

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| **HISTORY :** |
| k/c/o Ca Right lower alveolus s/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA on 06/08/2018. presently admitted for possible decannulation. |

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| **CLINICAL EXAMINATION :** |
| cuffed tracheostomy in situ RT in situ flap well taken up leg- fibula donor site healthy ssg donor thigh min raw area |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| patient was admitted for feasibility of decannulation and swallowing evaluation. he underwent VFS which was suggestive of aspiration. CXR was done which was normal. BAL culture sensitivity was sent. At present patient is not fit for decannulation. Has been taught swallowing maneuvers and advised to practice at home. stable for discharge with RT and tracheostomy tube in situ. |

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| **ADVICE ON DISCHARGE :** |
| daily bathing use crepe bandage for walking tracheostomy tube care |

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| **DIET RECOMMENDATIONS :** |
| RTF 100cc/hr |

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| **DISCHARGE MEDICATION :** |
| \*All current medication have been reviewed and reconciled into the medication list. ensure protien powder 2 scoop bd with milk syp dexorange 10cc RT BD tab dolo 650mg sos for pain hexidine mouth washes |

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| **Date of Admission :**10/09/2018 |

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| **Date of Discharge :**19/09/2018 |

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

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| **DIAGNOSIS :** |
| Carcinoma right lower alveolus and FOM, S/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction. |

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| **PROCEDURE DONE :** |
| De-cannulation -> strapping + swallowing theraphy. |

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| **HISTORY :** |
| 53 year old male patient ,known case of Carcinoma Right lower alveolus. S/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA on 06/08/2018. Now came for follow up on cuffed TT and RT feeds. HPR (S18-11232) Segmental mandibulectomy right with additional margins and bilateral node dissection : - Moderately differentiated squamous cell carcinoma right mandible - Tumour measures -1.5x1.7x1.4cm. - Depth -1.1cm - Bony invasion - Not seen - LVE -Not seen - PNI -Not seen, score 0 - LHR - Score 2 - WPOI-Type 4, score 1 - Histological risk assessment score - 3 (high risk) - Margin - All margins are free - Lymph nodes - 2 Metastatic nodes, left level III with minimal ENE and left level IB without ENE. Largest deposit measuring 1.2cm. pTN - pT3N2b |

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| **PAST HISTORY :** |
| Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA. |

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| **PERSONAL HISTORY :** |
| Good effort tolerance. Normal bowel and bladder habits. Normal appetite. |

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| **CLINICAL EXAMINATION :** |
| On Examination: General condition fair. Vitals stable. L/e : post surgical status, metal tracheostomy tube and RT insitu. Well healed scar. |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| 53 Year old C. Ajith Kumar admitted with above mentioned complaints.Swallowing assessment was sought and advised to start on oral feeds with thick blend diet ,Multiple swallows advised, Maintained NGT for liquids and adequate nutrition. The patient was managed conservatively. Decannulation and strapping done. Ryle's tube also removed. patient taking adequately. At the time of discharge, patient is stable and a febrile. |

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| **WHEN TO OBTAIN URGENT CARE:** |
| Fever respiratory distress noisy breathing |

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| **DIET RECOMMENDATIONS :** |
| Soft blend diet. |

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

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| **DISCHARGE MEDICATION :** |
| \*All current medication have been reviewed and reconciled into the medication list. Tab.Pan 40mg 1-0-0 x 5days. Tab.Dolo 650mg 1-1-1 x 5days. Syp.Dexorange 10cc BD x 3wks Chlorhexidine mouth wash BD x 10days Ensure protein powder with milk 2 scoops BD x 3wks |

**Tumour Board Discussion**

**Relevant clinical details :**

53/m

Advocate by profession

C/C alcoholic and smoker

diagnosed case of ca FOM cT4aN2cMx

Biopsy-Squamous cell carcinoma

He went to RCC for further management

He completed 3 cycles of Induction Chemotherpay with Paclitaxel +Carboplatin from Cochin Cancer Hospital

C1 on 5.4.2018 C2 on 26.4.2018 C3 on 17.5.2018 with Inj.Paclitaxel 175mg/m2 nd Inj.Carboplatin ,last on

18.5.2018

After 3 cycles of Induction chemo,he showed good response (Response assessment clinically ) Options

regarding Surgery and RT was explained to the patient and he came here for further management

comorbidities- CBD Stenting, History of Carcinoma bladder-15 yrs back

O/E KPS 90

mouth opening adequate ulceroproliferative growth right side of floor of mouth opposite lateral incisor reaching

till 2nd lower premolar, minimal induration limited to lesion cystic swelling over right lower lateral incisor and

canine gingiva, slough in sockets of extracted right lower molar teeth

Neck-right 1x1cm hard node with restricted mobility

rest nad

PET MRI was reviewed

plan segmental mandibulectomy with bl ND with +/- bone flap/ STF

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

Mri reviewed by Dr Sandhya Ma'am : Lesion extending from central incisior to RMT

**Agreed Plan of management :**

segmental mandibulectomy with bl ND with +/- bone flap/ STF

if no bone segment then STF only

**Histopathology Tumour Board Discussion**

**Date of tumor board discussion :** 19/09/2018

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

Segmental mandibulectomy right with additional margins and bilateral node dissection : - Moderately

differentiated squamous cell carcinoma right mandible All margins are free, 2 Metastatic nodes, left level III

with minimal ENE Largest deposit measuring 1.2cm

pTN - pT3N2b

**Agreed Plan of management :**

CTRT

**Tumour Board Discussion**

**Relevant clinical details :**

CA FOM s/p surgery and adjuvant CTRT in Nov 2018

Now with dysphagia

Scopy- At 24 cm a proliferative lesion with luminal narrowing.The growth was noted to extend till 34 cm

upper and mid thoracic esophagus - SCC

CECT chest - Extensive circumferential wall thickening of esophagus with enhancement noted extending from

D1-D2 level to below the subcarinal level at D6-D7 vertebrae ... The lumen of esophagus is completely

obliterated in this segment along with narrowing of trachea with AP diameter of trachea at D3 level of 6.8mm.

The lesion is abutting the descending aorta with more than 180o contact. The lesion is also seen to extend into

AP window and along the left mainstem bronchus with mild narrowing of the same. Extension also noted along

the right mainstem bronchus. Left hilar lymph nodes seen measures 2.3 x 2cm. Few subcentimetric pre vascular

lymph nods also noted.

Locally advanced CA esophagus

On Ryles tube feeds

**Progress Notes**

**Date : 06/07/2018**

**ProgressNotes :**

53/m

Advocate by profession

C/C alcoholic and smoker

diagnosed case of ca FOM cT4aN2cMx

Biopsy-Squamous cell carcinoma

He went to RCC for further management

He completed 3 cycles of Induction Chemotherpay with Paclitaxel +Carboplatin from Cochin Cancer Hospital

C1 on 5.4.2018 C2 on 26.4.2018 C3 on 17.5.2018 with Inj.Paclitaxel 175mg/m2 nd Inj.Carboplatin ,last on

18.5.2018

After 3 cycles of Induction chemo,he showed good response (Response assessment clinically )

Options regarding Surgery and RT was explained to the patient and he came here for further management

comorbidities-

CBD Stenting, History of Carcinoma bladder-15 yrs back

O/E

KPS 90

mouth opening adequate

ulceroproliferative growth right side of floor of mouth opposite lateral incisor reaching till 2nd lower premolar,

minimal induration limited to lesion

cystic swelling over right lower lateral incisor and canine gingiva, slough in sockets of extracted right lower

molar teeth

Neck-right 1x1cm hard node with restricted mobility

rest nad

Medical oncology

**Progress Notes**

**Date : 30/01/2020**

**ProgressNotes :**

Carcinoma Floor of Mouth Squamous cell carcinoma

Post Induction chemotherapy 3 cycles with Paclitaxel and Carboplatin

S/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral tongue),

with b/l SND levels I to IV with free fibula flap reconstruction on 06/08/2018. ypT4N2bM0

Completed Radiation therapy using Tomotherapy technique.

RT Completed on 17/11/2018.

Has dysphagia x 2 weeks.

Weight loss +

Endoscopy done showed:UES noted at 19 cm. At 24 cm a proliferative lesion with luminal narrowing was

noted. The scope could not be advanced further. Under fluroscopic guidance, a guide wire was passed into

stomach and the scope was passed over it. The growth was noted to extend till 34 cm. Hiatus hernia was noted.

Rest of the esophagus and stomach was normal. D1 was normal. A diverticulum was noted in D2 Ryles tube

was inserted on 06/01/20

Esophageal biopsy -Moderately differentiated squamous cell carcinoma with chronic active inflammation.

Referred here for further management.

Planned for CTRT with Pacli Carbo cross protocol

had Ist cycle of chemo, due for 2nd week of same

Completed 7 # of RT till today

HB- 8.3, TC 5000 Neu- 87

creat- N

PRBC transfusion

WEEK: 2/5 DATE: 31/1/2020

1. Inj PALONOSETRON 0.25mg + Inj DEXONA 8mg in 100 ml NS

2. Inj AVIL 1 amp IV STAT + Inj RANTAC 2 ampoule slow IV push

3. Inj. PACLITAXEL 70 mg in 250ml NS I.V over 1 hrs

4. Inj CARBOPLATIN 150mg in 1 bottle 5% dextrose > 1 hr

5. Tab Domstal 10MG 1-0-1 x 3 days

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

**Progress Notes**

**Date : 04/01/2020**

**ProgressNotes :**

Carcinoma Floor of Mouth Squamous cell carcinoma Post Induction chemotherapy 3 cycles with Paclitaxel

and Carboplatin S/p Wide local excision, (right segmental mandibulectomy, excision of floor of mouth and

ventral tongue), with b/l SND levels I to IV with free fibula flap reconstruction on 06/08/2018. ypT4N2bM0

Completed Radiation therapy using Tomotherapy technique. RT Started on 8/10/2018 RT Completed on

17/11/2018

c/o cough with liquid diet since 2 weeks

no h/o fever

c/o weakness

o/e- L/R ned

adv- VFS today to r/o aspiration

enroll in mandible study

**Speciality :** RadiationOncology

**D/O Commencement of RT** 23/01/2020 **D/O Completion of RT** 03/02/2020

**FINAL DIAGNOSIS, STAGE AND HISTOLOGY**

Squamous cell carcinoma esophagus

Squamous cell carcinoma

Received 9 fractions External beam Radiationtherapy

**CLINICAL HISTORY AND PHYSICAL FINDINGS**

55 year oldman a case of Carcinoma FOM s/p surgery and adjuvant CTRT in November 2018

Now with dysphagia upper and mid thoracic esophagus - Squamous Cell Carcinoma. CECT chest - Extensive

circumferential wall thickening of esophagus with enhancement noted extending from D1-D2 level to below the

subcarinal level at D6-D7 vertebrae.The lumen of esophagus is completely obliterated in this segment along with

narrowing of trachea with AP diameter of trachea at D3 level of 6.8mm. The lesion is abutting the descending

aorta with more than 180o contact. The lesion is also seen to extend into AP window and along the left mainstem

bronchus with mild narrowing of the same. Extension also noted along the right mainstem bronchus. Left hilar

lymph nodes seen measures 2.3 x 2cm. Few subcentimetric pre vascular lymph nods also noted. Locally

advanced carcinoma esophagus. He was planned for External beam Radiationtherapy

**INVESTIGATIONS :**

**HISTOPATHOLOGY REPORTS**

Histopathology:08.01.2020:Esophageal biopsy -Moderately differentiated squamous cell carcinoma with chronic

active inflammation.

**RADIOLOGY AND NUCLEAR MEDICINE REPORTS**

CT Chest Contrast:16.01.2020: Extensive circumferential wall thickening of esophagus narrowing the trachea

with mediastinal infiltration as described.

Left hilar and prevascular lymph nodes as described.

Treatment Given:

**RADIATION DETAILS :**

Intent: Curative

Technique: IGRT

Cat Scan Simulation on: 21.01.2020

Computerised Treatment Planning on: 23.01.2020

RT Started on: 23.01.2020

RT Received on: 03.02.2020

Received dose on : 1800cGy in 9 fractions

**Primary Tumour And Drainage Area :**

Site: PTV 50(GTV+Margin)

Energy: 6 MV Photons

Dose: 1800cGy in 9 fractions

Schedule: 200cGy per fraction and 5 fraction per week

Site: PTV 45(PTV 50+Margin)

Energy: 6 MV Photons

Dose: 1800cGy in 9 fractions

Schedule: 180cGy per fraction and 5 fraction per week

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

To Review in Radiation oncology after 1 month

**operative notes**

**Date : 12/08/2018**

**ProgressNotes :**

procedure- wide local excision, (right segmental mandibulectomy, excision of floor of mouth and ventral

tongue), with b/l SND levels I to IV with free fibula flap reconstruction with tracheostomy under GA

findings - ulceroproliferative lesion right floor of mouth abutting mandible, level Ib node infiltrating digastric

anterior belly and mylohyoid. multiple level II-III-IV b/l nodes

under GA with all aseptic precautions

transverse skin crease incision taken from angle of mandible on one side to opposite side, vertical incision with

midline lip split given

subplatysmal flaps elevated

cheek flap raised on right side to expose mandible

preplating done

bone cuts made btw c/l lateral incisor and canine and sub condylar level

soft tissue with 1 cm margin around the tumor left on specimen side which included cuff of ventral surface of

tongue and floor of mouth, sublingual gland, level Ib also delivered with specimen

bl SND levels I-IV done

marginal mandibular and spinal accessory nerve identified and preserved on both sides

specimen sent for HPE

hemostasis achieved

free fibula flap harvested from left leg, with skin paddle of approx size 8x6cm with pedicle length if approx

10cm, 2 osteotomies done to obtain three segments of bone

donor site closed with SSG from right thigh

flap inset done- bone secured in place with screws

microanastomosis done- arterial to facial artery and venous to facial vein

skin paddle used to cover floor of mouth and ventral done defect

neck closure done

tracheostmy done

procedure uneeventful