08/2017

**Received on :** 31/08/2017

**Reported Date :** 05/09/2017

**Clinical Impression :**

k/c/o Carcinoma tongue

**Gross Description :**

Received for review are one block and one slide

**Impression :**

Punch Biopsy tongue 1 slide and 1 block for review : Well differentiated squamous cell carcinoma

Tumour involves entire thickness of biopsy with a minimum depth of 3 to 4mm.

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 31/08/2017

**Received on :** 31/08/2017

**Reported Date :** 08/09/2017

**Clinical Impression :**

Ca. left lateral tongue

**Gross Description :**

Received in formalin are 12 specimens. T

he Ist specimen labelled "WLE left lateral border of tongue", consists of the same with long stitch anterior and

short stitch superior. Lesion measuring 5(AP)x4.5(ML)x0.8(SI)cm. The lesion is 2.1cm from anterior mucosal

margin, 1.4cm from posterior mucosal margin, 2cm from medial mucosal margin, 1.5cm from lateral mucosal

margin and 1cm from inferior inked margin. Depth of the lesion 0.5 cm. Representative sections are submitted as

follows:

A1 - Shaved anterior mucosal margin

A2 - Shaved posterior mucosal margin

A3 - Medial mucosal and soft tissue margin

A4 - Medial mucosal margin maximum depth

A5 - Lesion proper A6 - Lesion with deep inked margin

A7 - Lateral mucosal and soft tissue margin shaved

Specimen II labelled "Level IA+ level IB" consists of nodular tissue measuring 5x4x2cm. Consists of salivary

gland and 5 lymph nodes largest measuring 1.5cm in greatest dimension. Smallest measuring 0.3cm in greatest

dimension. Representative sections are submitted in cassettes B1 to B5.

Specimen III labelled " Left level IIA", consists of nodular tissue measuring3.5x2.5x1.5cm. 4 lymph nodes

identified. Largest measuring 2.5x1x1cm. Entire specimen submitted in cassette C.

Specimen IV labelled "left level IIB", consists of nodular tissue bit in aggregate measuring 2.5x2x0.8cm. Entire

specimen submitted in cassette D. Specimen V labelled "Left level III", consists of fibrofatty tissue measuring

4x2.5x1cm. Entire specimen submitted in cassette E.

Specimen VI labelled "Left level IV", consists of nodular tissue bit measuring 2.5x1.51cm. 1 lymph node

identified measuring 1.5cm in greatest dimension. Entire specimen submitted in cassette F1 & F2.

Specimen VII labelled "Right level I B", consists of nodular tissue bit measuring 5.5x4x1.5cm. On slicing

salivary gland single lymph node identified measuring 1.6cm in greatest dimension. Representative sections are

submitted in cassettes G1 to G3.

Specimen VIII labelled "Right level II A", consists of irregular nodular tissue bit measuring 4x2x1cm. Entire

specimen submitted in cassette H1 & H2.

Specimen IX labelled "Right level IIB", consists of fibrofatty tissue measuring 2x2x0.5cm. Entire specimen

submitted in cassette J.

Specimen X labelled " Right level III", consists of nodular tissue bit measuring 3.5x1.5x1cm ? matted lymph

node. Entire specimen submitted in cassette K1 to K3.

Specimen XI labelled "Right level IV", consists of single nodular tissue measuring 2x1.5x1cm. Entire specimen

submitted in cassette L.

Specimen XII labelled " Right prefacial node", consists of 2 nodular tissue bit measuring 1.3x1x0.8cm. Other

0.8cm in greatest dimension. Entire specimen submitted in cassettes M1 & M2.

**Microscopic Description :**

A. Sections studied show lingual tissue lined with stratified squamous epithelium with focal hyperkeratosis and

parakeratosis and an ulceroproliferative neoplasm composed of moderately to poorly differentiated squamous

cells infiltrating in diffuse sheets. Desmoplastic changes are seen in stroma. Lymphocytic infiltration is present

in tumour interface. Keratin pearls are present.

No lymphovascular emboli/ perineural invasion seen.

All mucosal margins are free of tumour

Lymph node status:

B. Left level IA/IB - 5 lymph nodes noted involved, free of tumour. Salivary gland - free of tumour

C. Left level IIA - 5 lymph nodes, free of tumour

D. Left level IIB - Single node - free of tumour

E. Left level III- No lymph nodes, fibrofatty tissue - free of tumour

F. Left level IV - 3 lymph nodes studied, free of tumour

G. Right level IB - 3 lymph nodes, one show micrometastasis - No ENE seen

H. Right level IIA - 4 lymph nodes - free of tumour.

J. Right level IIb - Single node - free of tumour

K. Right level III - 3 lymphnodes - free of tumour

L. Right level IV- 1 lymph node -free of tumour

M. Right prefacial node - 2 lymph nodes studied - free of tumour

**Impression :**

WLE left lateral border of tongue with bilateral ND:

- Poorly differentiated squamous cell carcinoma

- Dimensions :5x4.5x0.8cm

- Depth of invasion :0.5cm

- Invasive front:Infiltrative and dyscohesive

- No vascular invasion seen

- No nerve invasion seen

- All mucosal margins free of tumour

Lymph nodes :Single lymph node (right level IB) shows micrometastasis.

No perinodal spread seen.

All other sampled lymph nodes are free of tumour

Stage - pT3N2a(mic)

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| **Date of Admission :**30/08/2017 | **Date of Procedure :**31/08/2017 |

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| **Date of Discharge :**09/09/2017 |

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

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| **DIAGNOSIS :** |
| Carcinoma tongue (Final HPR awaited) |

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| **PROCEDURE DONE :** |
| WLE + BL SND + RAFFF + Trach under GA on 31.08.17 |

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| **HISTORY :** |
| A 59 yr old patient from Thrishur, Businessman Co-morb- DM on OHA Habits: C+ Referred here for C/O Non healing ulceration over tongue region x 6 months progressively increased to present size Non painful Can eat normal diet No difficulty in swallowing or breathing Outside evaluated Biopsy 22.08.17 - Well Diff SCC MRI HN 19.08.17 A T2 hyperintense lesion involving left lat border of tongue crossing midline and extending to left sublingual space abutting left sublingual gland and lingual vessels. Subcentimetric nodes in neck Right Ib- 7.6mm, IIa- 9mm Left Ib- 6mm, IIa- 9mm, IIb-7mm. Came here for further management. |

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| **PAST HISTORY :** |
| KCO DM |

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| **PERSONAL HISTORY :** |
| No recent history of fever or cough No h/o HTN, CAD, CVA, Dyslipedemia, seizures, Thyroid disease, TB bowel and bladder habits normal Good effort tolerance |

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| **CLINICAL EXAMINATION :** |
| On examination: KPS 90 Approx 4 x 4 cm Ulceroproliferative lesion involving left ant border of tongue involving tip of tongue going down to involve FOM left sided Not involving vestibular surface of mandible Crossing midline and involving right ant tongue and FOM BOT and TL sulcus free No trismus or ankyloglossia Dentate fully Neck- Small LN palpable at BL neck level Ib. |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Patient came to OPD with above mentioned complaints. He was evaluated clinically and hia case was discussed in tumour board. He was surgically treated, WLE + BL SND + RAFFF + Trach under GA on 31.08.17 done. His peri and post operative periods were uneventful. On discharge- stable, afebrile and taking oral diet |

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| **OPERATIVE FINDINGS :** |
| WLE + BL SND + RAFFF + Trach under GA on 31.08.17 by Dr. SI/KK/DB, Dr. Shashi, Dr. Aadharsh, Dr. Shikha Findings: 4 x 4 cm Ulceroproliferative lesion at left lateral border of tongue going to FOM crossing the midline and approaching tip of tongue and right FOM and ventral tongue also BL large level Ib and II LN. Procedure: Under GA nasally intubated patient taken for procedure Aseptic precautions taken. Per oral WLE done with adequate margins- sent for HPE Neck dissection BL done via midline transverse cervical incision Skin with subplatysmal flap elevated BL level Ia, Ib, IIa, IIb, III and IV removed and sent for HPE. Hemostasis achieved and wash given. BL neck drains kept RVD 14. RAFF 7x8 cm harvested and reconstructed to defect Microanastomosis done with facial artery and vein. Hemostasis achieved Neck closure done in layers Elective tracheostomy done and double lumen cuffed portex tube inserted no 7.5 Patient shifted to 11 ICU for post op care. |

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| **PROGNOSIS ON DISCHARGE :** |
| Afebrile Stable |

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| **ADVICE ON DISCHARGE :** |
| To review in Head and Neck OPD with prior appointment |

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| **PREVENTIVE ADVICE (LIFE STYLE MODIFICATION / HEALTH EDUCATION)IF ANY:** |
| Wound care oral care |

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| **DIET RECOMMENDATIONS :** |
| Orally soft and blend diet allowed |

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

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| **DISCHARGE MEDICATION :** |
| Tab Pan 40 mg 1-0-0 x 1week Tab Dolo 650 mg 1-1-1 x 1week Tab Ultracet 1 TAB SOS on pain hexidine gargles 3-4 times a day x 1 week Megaheal ointment for LA BD x 1 week Continue all On medications as per schedule. |

**Tumour Board Discussion**

**Relevant clinical details :**

A 59 yr old patient

Co-morb- DM on OHA

Referred here for

C/O Non healing ulceration over tongue region x 6 months

progressively increased to present size

Non painful

Can eat normal diet

No difficulty in swallowing or breathing

Outside evaluated

Biopsy 22.08.17 - Well Diff SCC

MRI HN 19.08.17

A T2 hyperintense lesion involving left lat border of tongue

crossing midline and extending to left sublingual space abutting left sublingual gland and lingual vessels.

Subcentimetric nodes in neck

Right Ib- 7.6mm, IIa- 9mm

Left Ib- 6mm, IIa- 9mm, IIb-7mm.

O/E KPS 90

Approx 4 x 4 cm Ulceroproliferative lesion involving left ant border of tongue

involving tip of tongue

going down to involve FOM left sided

Not involving vestibular surface of mandible

Crossing midline and involving right ant tongue and FOM

BOT and TL sulcus free

No trismus or ankyloglossia

Dentate- tobacco stained teeth

Neck- Small LN palpable at BL neck level Ib.

**Agreed Plan of management :**

WLE + BL SND + RAFFF + Trach under GA on 31.08.17

Waiting for final HPR

**Histopathology Tumour board**

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

WLE right lateral border of tongue with bilateral ND: - Poorly differentiated squamous cell carcinoma of right

lateral border of tongue - Dimension :5x4.5x0.8cm - Depth of invasion :0.5cm - Invasive front:Infiltrative and

dyscohesive - No vascular invasion seen - No nerve invasion seen - All mucosal margins free of tumour Lymph

nodes :Single lymph node (right level IB) shows micrometastasis. No perinodal spread seen. All other sampled

lymph nodes are free of tumour Stage - pT3N1(mic)

**Agreed Plan of management :**

adjuvant RT

**Progress Notes**

**Date : 25/08/2017**

**ProgressNotes :**

A 59 yr old patient

Co-morb- DM on OHA

Referred here for

C/O Non healing ulceration over tongue region x 6 months

progressively increased to present size

Non painful

Can eat normal diet

No difficulty in swallowing or breathing

Outside evaluated

Biopsy 22.08.17 - Well Diff SCC

MRI HN 19.08.17

A T2 hyperintense lesion involving left lat border of tongue

crossing midline and extending to left sublingual space abutting left sublingual gland and lingual vessels.

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involving tip of tongue

going down to involve FOM left sided

Not involving vestibular surface of mandible

Crossing midline and involving right ant tongue and FOM

BOT and TL sulcus free

No trismus or ankyloglossia

Dentate- tobacco stained teeth

Neck- Small LN palpable at BL neck level Ib.

Adv

PAC

PAC investigation

Pre Op serology

ECG

Chest X ray

Plan- WLE + SND BL + STF (lateral arm flap/RAFF) + Trach under GA

**Operative Notes**

**Date : 31/08/2017**

**ProgressNotes :**

WLE + BL SND + RAFFF + Trach under GA on 31.08.

Findings: 4 x 4 cm Ulceroproliferative lesion at left lateral border of tongue going to FOM

crossing the midline and approaching tip of tongue and right FOM and ventral tongue also

BL large level Ib and II LN.

Procedure: Under GA nasally intubated patient

taken for procedure

Aseptic precautions taken.

Per oral WLE done with adequate margins- sent for HPE

Neck dissection BL done via midline transverse cervical incision

Skin with subplatysmal flap elevated

BL level Ia, Ib, IIa, IIb, III and IV removed and sent for HPE.

Hemostasis achieved and wash given.

BL neck drains kept RVD 14.

RAFF 7x8 cm harvested and reconstructed to defect

Microanastomosis done with facial artery and vein.

Hemostasis achieved

Neck closure done in layers

Elective tracheostomy done and double lumen cuffed portex tube inserted no 7.5

Patient shifted to 11 ICU for post op care.

**Progress Notes**

**Date : 26/05/2023**

**ProgressNotes :**

Carcinoma Left lateral border Tongue,

Stage - pT3N1(mic) S/p WLE + BL SND + RAFFF + Tracheostomy under GA on 31.08.17

Flap repositioning done under GA on 28/09/17.

Well differentiated squamous cell carcinoma pT3N2cM0 [ Contralateral node single node ENE negative ]

Completed Post Operative Adjuvant radiation therapy using Tomotherapy technique. RT Started on

16/10/2017 RT Completed on 25/11/2017. c/o excessive flap tissue -while chewing and speaking wait for 6

months for flap debulking

O/E: locoregionally NED

angular cheilitis+

had recently viral infection with oral ulcers

resolving now

Adv:

Multivitamin for cheilitis x 2 months

wants tongue release for speech if possible- next visit

**Speciality :** RadiationOncology

**D/O Commencement of RT** 16/10/2017 **D/O Completion of RT** 25/11/2017

**FINAL DIAGNOSIS, STAGE AND HISTOLOGY**

Carcinoma Left lateral border Tongue

S/ P WLE + BL SND + RAFFF + Trach under GA on 31.08.17

Well differentiated squamous cell carcinoma

pT3N2cM0 [ Contralateral node single node ENE negative ]

Completed Post Operative Adjuvant radiation therapy using Tomotherapy technique.

**CLINICAL HISTORY AND PHYSICAL FINDINGS**

Mr. P N Rajagopalan, 59 year old gentleman, from thrissur, presented with complaints of non healing ulceration

over tongue region since 6 months progressively increased to present size

Non painful. No difficulty in swallowing or breathing. he was initially evaluated at outside hospital with biopsy

which reported as Well Differentiated squamous cell carcinoma

MRI Head and Neck [Dated: 19.08.17] showed a T2 hyperintense lesion involving left lat border of tongue

crossing midline and extending to left sublingual space abutting left sublingual gland and lingual vessels.

Subcentimetric nodes in neck. Right Ib- 7.6mm, IIa- 9mm. Left Ib- 6mm, IIa- 9mm, IIb-7mm. He came here for

further management and was evaluated here at Head and Neck surgery OPD.Clinical Examination revealed 4 x 4

cm ulceroproliferative lesion involving left anterior border of tongue involving tip of tongue going down to

involve FOM left sided. Not involving vestibular surface of mandible. Crossing midline and involving right ant

tongue and FOM . BOT and TL sulcus free. No trismus or ankyloglossia

Neck- Small lymph node palpable at bilateral neck level Ib.

After all pre operative evaluation and investigations he underwent WLE + BL SND + RAFFF + Tracheostomy

under GA on 31.08.17 done. Intraoperatively found a 4 x 4 cm ulceroproliferative lesion at left lateral border of

tongue going to FOM crossing the midline and approaching tip of tongue and right FOM and ventral tongue also

BL large level Ib and II LN.

Post OP HPR [Dated; 8/9/2017]

Poorly differentiated squamous cell carcinoma. Dimensions:5x4.5x0.8cm. Depth of invasion :0.5cm. Invasive

front:Infiltrative and dyscohesive. No vascular invasion seen - No nerve invasion seen. All mucosal margins free

of tumour Lymph nodes :Single lymph node (right level IB) shows micrometastasis. No perinodal spread seen.

All other sampled lymph nodes are free of tumour

He then underwent Flap repositioning done under GA on 28/09/17.

His case was discussed in multidisciplinary tumor bard and was planned for Post Operative Adjuvant Radiation

therapy using Tomotherapy technique

**INVESTIGATIONS :**

**Haemogram:**

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

**ku/ml**

**TC:**

**ku/ml**

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

**mm/1st hr**

07/11/2017 10.7 33.8 200 6.56 79.0 9.7 4.3 -

**Renal Function Test and Serum Electrolytes:**

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

07/11/2017 - 0.81 - -

Date: 07/11/2017

Glucose [R]-Plasma : 80.6 mg/dl RBC-COUNT-Blood : 4.18 M/uL

MCV-Blood : 80.8 fL MCH-Blood : 25.7 pg

MCHC-Blood : 31.8 g/dl RDW-Blood : 15.3 %

MPV-Blood : 8.8 fL MONO -Blood : 6.6 %

BASO-Blood : 0.4 %

**HISTOPATHOLOGY REPORTS**

Punch Biopsy, Slide and block review for second opinion [Dated: 5/9/2017]

Well differentiated squamous cell carcinoma. Tumour involves entire thickness of biopsy with a minimum depth

of 3 to 4mm.

Post OP HPR [Dated; 8/9/2017]

Poorly differentiated squamous cell carcinoma. Dimensions :5x4.5x0.8cm. Depth of invasion :0.5cm. Invasive

front:Infiltrative and dyscohesive. No vascular invasion seen - No nerve invasion seen. All mucosal margins free

of tumour Lymph nodes :Single lymph node (right level IB) shows micrometastasis. No perinodal spread seen.

All other sampled lymph nodes are free of tumour

Stage - pT3N2c [ Contralateral node single node ENE negative ]

Treatment Given:

**SURGERY DETAILS :**

S/ P WLE + BL SND + RAFFF + Tracheostomy under GA on 31.08.17

**RADIATION DETAILS :**

Intent: Curative

Technique:Tomotherapy

Site of Disease: Left lateral border tongue

Cat Scan Simulation with IV contrast on 10/10/2017

Complex Computerised Treatment Planning on 14/10/2017

RT Started on 16/10/2017

RT Completed on 25/11/2017

Treatment breaks- Nil

Total Dose: 6300 cGy in 30 fractions

**Primary Tumour And Drainage Area :**

Site:Bilateral level Ib, Left level II A Node

Energy: 6 MV Photons

Dose: 6300 cGy in 30 fractions

Schedule: 210 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line.

Site: Tumor bed+ Surgical bed+ Bilateral level I, II, III, IV a and V Nodal stations

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 + RPN

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.

**TREATMENT COURSE :**

59 year old gentleman, diagnosed as a case of Carcinoma Left lateral border Tongue, Post

Operative, completed planned course of Post Operative Adjuvant radiation therapy well without interruptions.

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

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

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

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

Investigations:

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

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

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

Oral and Skin Care:

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

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

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

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

per Doctors' advice.

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

Specific:

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

liquid diet.