**Radiology Report**

**Created Date:** 14/06/2018

**Study Done:**

**CT CHEST-PLAIN**

**Clinical Information :** Known case of Carcinoma Tongue to rule out lung metastasis

Atelectatic band in medial segment of right middle lobe.

Rest of lung parenchyma normal

Normal mediastinal vascular structures.

The hila are normal.

The tracheobronchial tree is normal.

No pleural pathology.

No suspicious nodules seen.

Chest wall is normal.

**Impression:**

• **No significant abnormality detected.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 16/06/2018

**Received on :** 16/06/2018

**Reported Date :** 25/06/2018

**Clinical Impression :**

C/o Ca. tongue left lateral border

**Gross Description :**

Received in formalin are 13 specimens.

The Ist specimen labelled "Main specimen- lateral tongue - double stitch anterior , single stitch supero-medial"

consists of the same measuring 9.4x3.6x4cm. An ill circumscribed grey white / ulcerated lesion is noted in the

posterolateral aspect of tongue measuring 2x1.5x1.5cm. The lateral surface of tongue shows an ill

-circumscribed grey white lesion, extending from antero-lateral aspect to postero-lateral aspect. Mediolateral and

inferior raw surface inked. Specimen is serially sliced from anterior to posterior into 14slices. The lesion

measures 3.5x1.2x4.3cm. The lesion is 1.7cm away from the posterior base of tongue, 2cm away from anterior

soft tissue /mucosal margin, abutting the lateral mucosal margin, 2cm away from the superomedial margin,

abutting the sublingual salivery gland (otherwise clearance 0.8cm). Depth of the lesion is 1.5cm. Representative

sections are submitted as follows:

A1- Anterior margin

A2 - Posterior base of tongue

A3 - Lesion abutting lateral mucosal margin

A4 - Lesion with adjacent salivary gland

A5 - Lesion with inferior inked margin

A6 - Superomedial margin

A7 & A8 - Lesion proper.

Specimen II labelled "left level Ia" consists of a fibrofatty tissue measuring 3.5x3x0.6cm. No lymph node

identified grossly. Representative sections are submitted in cassette B1 & B2.

Specimen III labelled"Left level Ib" consists of an irregular fibrofatty tissue measuring 5.5x5.5x2.5cm. ? 2

lymph nodes identified. Largest measuring 1.2cm in greatest dimension. Representative sections submitted

cassettes C1 to C4.

Specimen IV labelled "Left level IIa" consists of fibrofatty tissue measuring 4x2.5x1cm. 1 lymph nodes

identified measuring 1.6cm in greatest dimension. Representative sections are submitted in cassettes D1 & D2.

Specimen V labelled "left external EJV node" consists of fibrofatty tissue measuring 1.3x0.6x0.3cm.?1 lymph

node identified. Entire specimen submitted in cassette E.

Specimen VI labelled "Left level IIb" consists of a nodular fibrofatty tissue measuring 3x2.5x2cm. ? 2 lymph

nodes identified, largest measuring 1.5cm in greatest dimension. Representative sections are submitted in

cassettes F1 to F3.

Specimen VII labelled "left level III" consists of a nodular tissue bit measuring 4x2x1.5cm. ?2 lymph nodes

identified,largest measuring 1cm in greatest dimension. Representative sections are submitted in cassettes G1 to

G4.

Specimen VIII labelled "left level IV" consists of 1 lymph node and 2 nodular tissue bits , largest measuring

1.5cm in greatest dimension. 2 nodular tissue bits in aggregate measuring 2.5x2.5x1cm. Representative

sections are submitted in cassettes H1 & H2.

Specimen IX labelled " Right Ib level" consists of irregular fibrofatty tissue measuring 5x4.5x2.5cm. No lymph

node identified. Representative sections are submitted in cassettes J1 to J3.

Specimen X labelled "right IIa level " consists of an irregular grey brown tissue bit measuring 4x2.5x2cm. 2

lypmh nodes identified largest measuring 1cm in greatest dimension. Representative sections are submitted in

cassette K1 to K3.

Spcimen XI labelled "Right level IIb" consists of a nodular fibrofatty tissue measuring 2.5x2x15cm. ? 1 lymph

node identified. Entire specimen submitted L1 to L3.

Specimen XII labelled "Right level III and IV" consists of grey brown tissue bits measuring 2x1.5x1.2cm. ?1

lymph node identified measuring 1.5cm in greatest dimension. Entire specimen submitted in cassettes M1 & M2.

Specimen XIII labelled "Right prefacial node" consists of a tiny grey brown tissue bits measuring 1x0.5x0.5cm.

Entire specimen submitted in cassette N.

**Microscopic Description :**

A. Left lateral tongue - Sections show an infiltrative neoplasm arising from epithelium arranged in trabeculae,

nests and cords. The cells are polygonal with vesicular or coarse chromatin with individual cell keratinisation

and intercellular bridging . Keratin pearl noted. Stroma is desmoplastic with continuous moderate to mild

lymphocytic peritumoral infiltrate. Perineural invasion of large nerves noted. Adjacent mucosa shows mild

dysplasia.

B. Left level Ia - Only fibrofatty tissue . No lymph node / tumour identified.

C. Left level Ib - 3 lymph nodes - free of tumour

D. Left level IIa - Single lymph node - Free of tumour

E. Left external jugular vein node - Single lymph node - free of tumour

F. Left level IIb - 4 lymphnodes - free of tumour

G. Left level III - 3 out of 5 lymph nodes show metastasis with two showing extranodal spread. The surrounding

soft tissue also shows evidence of metastasis.

H. Left level IV - single reactive lymph node with unremarkable salivary gland.

J. Right level IB - No lymph node identified, fibrofatty tissue - free of tumour

K. Right IIA - 3 lymph nodes - Free of tumour

L. Right level IIB - 7 lymph nodes - free of tumour

M. Right level III and level IV - 3 lymph nodes - free of tumour

N. Right prefacial node - Shows an artery; No lymph nodes identified.

**Impression :**

WLE left lateral tongue and bilateral neck dissection:

- Moderately differentiated squamous cell carcinoma

- Tumour size - 4.5x3.5x1.5cm.

- Depth of the lesion - 1.5cm

- Margins -Tumour is abutting left lateral soft tissue margin

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

- WPOI - Type 2 (0)

- Lymphocytic infiltrate - continuous band (0)

- Perineural invasion - Large nerve invasion seen(3)

- Histological risk - High

Lymph nodes - 3/28 lymph nodes show metastasis with extranodal spread in all of them (left level III)

- Largest metastatic deposit measures 0.8 cm

- All other nodes show reactive hyperplasia.

Stage pT3N3b

**DEPARTMENT OF NUCLEAR MEDICINE AND PETCT**

**Date : 27/02/2019**

**WHOLE BODY PET CT IMAGING REPORT**

**PROCEDURE :**

5.21 mCi of 18F FlouroDeoxy 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: 87 mg / dl.

**FINDINGS :**

PET FINDINGS:

\* No abnormal increased FDG uptake in post operative changes in floor of mouth.

\* Abnormal increased FDG uptake in the following lesions:

a) Destructive lytic lesion with soft tissue component involving left arch of C1 vertebra

(SUV Max 10.2), left 2nd & 3rd rib anterior aspect (SUV Max 17.6), sternum

(SUV Max 23.3) and L2 vertebral body (SUV Max 19.2)(soft tissue component indenting

the anterior thecal sac),

b) Soft tissue lesion involving apical and posterior segment of right lung upper lobe

(SUV Max 10.0),

c) Two peripherally enhancing ill-defined soft tissue lesion in left trapezius muscle

(SUV Max 11.4),

d) Hypodense lesion in the intraventricular septum (SUV Max 9.1).

e) Heterogeneously enhancing soft tissue nodules in bilateral adrenal gland

(SUV Max 13.8),

f) Ill-defined hypodense lesion in lower pole of right kidney and interpolar region

of left kidney (SUV Max 6.5).

\* Abnormal increased FDG uptake in right lateral border of tongue (SUV Max 6.8).

\* No abnormal focal / diffuse FDG uptake seen in any lymph nodes, left lung, liver, spleen,

and in rest of skeleton imaged upto mid thigh.

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

intestinal loops and urinary bladder.

CT FINDINGS:

Brain:

\* Normal neuroparenchyma. No focal lesion.

Neck:

\* Post operative changes with surgical clips seen in floor of mouth.

No recurrent / residual lesion.

\* No significant cervical lymph nodes.

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

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

Chest:

\* Fibrotic bands with ill-defined soft tissue lesion, measuring 7 (T) x 3.6 (AP) x 3.0(CC) cm

seen involving apical and posterior segment of right lung upper lobe.

No air bronchogram / cavitation / calcifications within.

\* Atelectatic bands in posterobasal segments of left lung lower lobe.

Rest of lung fields are clear.

\* No pleural effusion.

\* Right hemidiaphragm is elevated.

\* Subcentimetric right lower paratracheal and paraaortic lymph nodes noted.

\* Two peripherally enhancing ill-defined soft tissue lesion measuring 2.2 x 2.1 cm and

3.2 x 5.6 cm noted in left trapezius muscle.

\* A 2.4 x 2.0 cm hypodense lesion sen in the interventricular setpum.

\* Mediastinum is central.

\* Major vessels is normal.

Abdomen:

\* Heterogeneously enhancing soft tissue nodules seen in bilateral adrenal gland, largest on

right adrenal gland, measures 3.4 x 2.8 cm.

\* Right renal cyst noted in upper pole.

\* Ill-defined hypodense lesions seen in the lower pole of right kidney (13 x 15 mm) and

interpolar region of left kidney (19 x 14 mm).

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

\* No significant intra-abdominal lymph nodes.

\* Contrast filled bowel loops are normal.

Bones:

\* Destructive lytic lesions with soft tissue component seen in the following bones:

a) Left arch of C1 vertebra, b) Left 2nd and 3rd anterior rib.

c) Sternum, d) L2 vertebral body.

\* Soft tissue component adjacent to the left 2nd and 3rd anterior rib measures 24 x 44 mm.

\* Soft tissue component adjacent to L2 vertebral body is indenting the anterior thecal sac.

**CONCLUSION :**

\* NO EVIDENCE OF METABOLICALLY ACTIVE RECURRENT PRIMARY MALIGNANCY

OF TONGUE.

\* FDG AVID SOFT TISSUE LESION IN APICAL AND POSTERIOR SEGMENT OF

RIGHT LUNG UPPER LOBE

- ? PRIMARY RIGHT LUNG MALIGNANCY / ? METASTASES,

SUGGESTED: BIOPSY CORRELATION.

\* FDG AVID DESTRUCTIVE LYTIC LESION WITH SOFT TISSUE COMPONENT INVOLVING

LEFT ARCH OF C1 VERTEBRA, LEFT 2ND AND 3RD ANTERIOR RIBS, STERNUM AND

L2 VERTEBRAL BODY (SOFT TISSUE COMPONENT INDENTING THE THECAL SAC)

- SKELETAL METASTASES.

\* FDG AVID TWO PERIPHERALLY ENHANCING ILL-DEFINED SOFT TISSUE LESION IN

LEFT TRAPEZIUS MUSCLE, HYPODENSE LESION IN INTERVENTRICULAR SEPTUM,

HETEROGENEOUSLY ENHANCING SOFT TISSUE NODULES IN BILATERAL ADRENAL

GLANDS AND ILL DEFINED HYPODENSE LESION IN LOWER POLE OF RIGHT KIDNEY

AND INTERPOLAR REGION OF LEFT KIDNEY

- METABOLICALLY ACTIVE METASTATIC DEPOSITS.

\* ABNORMAL FDG UPTAKE IN RIGHT LATERAL BORDER OF TONGUE - ? INFLAMMATORY

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| **Date of Admission :**13/06/2018 | **Date of Procedure :**14/06/2018 |

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| **Date of Discharge :**23/06/2018 |

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

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| **DIAGNOSIS :** |
| ca tongue left lateral border c T4aN2cMx HPR awaited |

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| **PROCEDURE DONE :** |
| wide local excision tongue with bl SND levels I-IV with radial free forearm flap with trachesotomy under GA 14/06/2018 |

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| **HISTORY :** |
| 48 year old male patient c/o ulcer over left side of tongue noticed 4 months back gradually progressive in size, no comorbidities/habits |

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| **CLINICAL EXAMINATION :** |
| o/e mouth opening adequate 4x 3 cm ulcerative lesion left lateral border pf tongue, 3 cm away from tip, posteriorly reaching uptill tonsilolingual sulcus, induration approx 1-1.5cm, not crossing midline over dorsum, floor of mouth min induration . BOT supple tongue movements are normal post extent confirmed on scopy neck no palpable nodes ct neck dtd 9.6.18 ill defined enhancing lesion 4.4x1.0x2.7cm lateral border of tongue on left side with thickening of myelohyoid, loss of planes with left SMG no significant involvement of mandible multiple cervical LN bl level 1b,II,III, IV and V, 13x10mm in level II L side largest biopsy- 5.5.18 MD SCC |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| patient was admitted with above complaints and evaluated. he underwent wide local excision tongue with bl SND levels I-IV with radial free forearm flap with trachesotomy under GA 14/06/2018. post operative period was uneventful. patient is stable for discharge. |

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| **OPERATIVE FINDINGS :** |
| procedure- wide local excision tongue with bl SND levels I-IV with radial free forearm flap with trachesotomy under GA findings-4x 3 cm ulcerative lesion left lateral border pf tongue, 3 cm away from tip, posteriorly reaching uptill tonsilolingual sulcus, induration approx 1-1.5cm, not crossing midline over dorsum, floor of mouth min induration b/l multiple level Ib, II,III and IV small nodes steps under GA with all aseptic precautions wide local excision of left lateral tongue lesion done with 1cm margins in 3 dimensions, resection included floor of mouth, posteriorly reaching till left ant pillar specimen oriented and sent for HPE bl SND levels I-IV (preserving bl spinal accessory nerve) b/l multiple level Ib, II,III and IV small nodes were found specimen sent for HPE hemostasis achieved radial free fore arm flap harvested from left forearm inset done to cover tongue and floor of mouth defect microanastomosis done to facial artery and EJV on left side hemostasis achieved closure done in layer donor site closed with SSG harvested from left thigh tracheostomy done procedure uneventful. Procedure: Radial Artery Forearm Free Flap for glossectomy defect Procedure: A flap marked keeping the radial artery in the centre. Part painted and draped and torniquet applied. Medial longitudinal skin incision is given. Suprafacial dissection done medial to lateral using tenotomy scissors till the lateral edge of FCR tendon without damaging its paratenon. The radial longitudinal skin incision given and performed lateral-to-medial suprafacial dissection over the brachioradialis. The dorsal radial nerve is preserved. Brachioradialis tendon is retracted laterally. The radial artery pedicle is dissected distally. The cephalic vein joining to the VC was appreciated. Fasciocutaneous paddle is pedicled by only the lateral intermuscular sep-tum and the radial artery pedicle. Proximally, incision from the skin paddle to the antecubital fossa is given. Then, performed subcutaneous dissection to elevate skin flaps medially and laterally. Followed the radial artery pedicle to the antecubital fossa using microclips and bipolar cautery on small vascular branches between the pedicle and underlying musculature. The bifurcation of the brachial artery identified. Flap harvested and delivered. |

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| **ADVICE ON DISCHARGE :** |
| daily bathing left fore arm can be left open during bathing, to dry after bath and apply jelonet sheet to keep right thigh dressing dry |

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| **DIET RECOMMENDATIONS :** |
| soft oral diet |

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| **DISCHARGE MEDICATION :** |
| tab dolo 650mg tds x 7days tab pan 40mg od x 7days hexidine gargles qid |

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| **Date of Admission :**25/02/2019 |

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| **Date of Discharge :**01/03/2019 |

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| **Discharging Status :**NA |

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| **DIAGNOSIS :** |
| Carcinoma Left lateral border Tongue S/P Wide local excision tongue with B/L SND levels I-IV with radial free forearm flap with trachesotomy under GA 14/06/2018 HPR: Moderatly Differentiated SCC pT3N3bM0 S/P Post Operative Concurrent chemoradiation therapy using Tomotherapy technique last on 04/09/2018 Total Dose: 6600 cGy in 30 fractions PTV 66 Gy= Left level III Nodal region PTV 60 Gy= Tongue+ Left level I- IV a Nodal region PTV 54 Gy= Right level Ib- VI and Left level IVb- VI Nodal region Received Concurrent chemotherapy with Inj Cisplatin 100mg/m2 q 3 weekly Now with Extensive metastases. |

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| **HISTORY :** |
| 48 yr old gentleman, diagnosed with carcinoma Left lateral border Tongue, postop and post RT status completed in September 2018. DFS 4 months. In feb 2019 he noticed a swelling in left posterior aspect of neck. Initially was evaluated in a local center where he underwent USG guided FNAC. Reported as metastatic SCC. Followed by he developed Right pelvic pain x 3 days which is non radiating and no h/o weakness. Pain was so severe that it affected his daily activities. Also c/o cough + sputum (bloody streak). He came here to Amrita hospital for further management. |

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| **MEDICINE ON ADMISSION :** |
| Inj Morphine infusion Cap Pregabalin 75 1-0-1 Tab Morphine sos Syr Cremaffin plus 10ml HS Tab Myospas BD Tab Pan 40 OD |

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| **PAST HISTORY :** |
| No comorbidities |

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| **PERSONAL HISTORY :** |
| Normal bowel and bladder habits decreased sleep due to pain |

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| **CLINICAL EXAMINATION :** |
| O/E: ECOG:60 Vitals stable L/E: 2x1.5cm swelling noted in Left trapezius postyerior margin. non tender , fixed to muscle , not fixed to skin. Systemic examination: NAD |

**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** |
| 27/02/2019 | 8.6 | 27.3 | 256 | 9.04 | 75.8 | 11.2 | 3.9 | - |

**Renal Function Test and Serum Electrolytes:**

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| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 27/02/2019 | 13.4 | 0.85 | - | - |

Date: 27/02/2019

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| Glucose [R]-Plasma : 87.7 mg/dl | RBC-COUNT-Blood : 3.23 M/uL |

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| MCV-Blood : 84.5 fL | MCH-Blood : 26.7 pg |

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| MCHC-Blood : 31.6 g/dl | RDW-Blood : 13.7 % |

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| MPV-Blood : 6.3 fL | MONO -Blood : 8.8 % |

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| BASO-Blood : 0.3 % |  |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Mr Anilkumar, 48 year old gentleman, known case of Carcinoma Left lateral border Tongue, pT3N3bM0, presented in Radiation oncology OPD with above mentioned complaints. He was admitted and evaluated. Started on analgesics and supportive care. Pain clinic opinion sorted for pain control. PETCT was taken that revealed Abnormal increased FDG uptake in the following lesions: a) Destructive lytic lesion with soft tissue component involving left arch of C1 vertebra (SUV Max 10.2), left 2nd & 3rd rib anterior aspect (SUV Max 17.6), sternum (SUV Max 23.3) and L2 vertebral body (SUV Max 19.2)(soft tissue component indenting the anterior thecal sac), b) Soft tissue lesion involving apical and posterior segment of right lung upper lobe (SUV Max 10.0), c) Two peripherally enhancing ill-defined soft tissue lesion in left trapezius muscle (SUV Max 11.4), d) Hypodense lesion in the intraventricular septum (SUV Max 9.1). e) Heterogeneously enhancing soft tissue nodules in bilateral adrenal gland (SUV Max 13.8), f) Ill-defined hypodense lesion in lower pole of right kidney and interpolar region of left kidney (SUV Max 6.5). \* Abnormal increased FDG uptake in right lateral border of tongue (SUV Max 6.8). Impression: Disease recurrence & progression. Medical oncology opinion was sought for Palliative chemotherapy. Palliative radiotherapy to the painful sites was also discussed.The prognosis and disease status have been explained in detail to bystander and they have understood that further treatment is palliative by nature. They wish to continue palliative chemotherapy and other further supportive care from their local center in Trivandrum. Hence requested to discharge today. He is being discharged in hemodynamically stable condition. |

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| **ADVICE ON DISCHARGE :** |
| To start on palliative chemotherapy at local center as early as possible. Palliative radiotherapy to the painful sites. To review in palliative care at local center in Trivandrum for further management. |

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| **DISCHARGE MEDICATION :** |
| \*All current medication have been reviewed and reconciled into the medication list. Cap Pregabalin75mg 1-0-1 to continue Tab Morphine 20mg 1/2-1/2-1/2-1/2-1 to continue as advised[6AM, 10AM, 2PM, 6PM, 10PM] Tab Paracetamol 650 mg 1-1-1-1 to continue [8AM, 12Noon, 4 PM, 8PM] Syp Cremaffin plus 10-15ml HS to continue Tab Decdac 4mg 1-0-0 x 5 days After food Tab Pan 40 1-0-0 on empty stomach, to continue. |

**Tumour Board Discussion**

**Relevant clinical details :**

48 year old male patient

c/o ulcer over left side of tongue noticed 4 months back

gradually progressive in size,

no comorbidities/habits

o/e

mouth opening adequate

4x 3 cm ulcerative lesion left lateral border pf tongue, 3 cm away from tip, posteriorly reaching uptill

tonsilolingual sulcus, induration approx 1-1.5cm, not crossing midline over dorsum, floor of mouth min

induration . BOT supple

tongue movements are normal

post extent confirmed on scopy

neck no palpable nodes

ct neck dtd 9.6.18 ill defined enhancing lesion 4.4x1.0x2.7cm lateral border of tongue on left side with

thickening of myelohyoid, loss of planes with left SMG

no significant involvement of mandible

multiple cervical LN bl level 1b,II,III, IV and V, 13x10mm in level II L side largest

biopsy- 5.5.18 MD SCC

imp ca tongue left lateral border c T4aN2cMx

PAC - PLan WLE(transmandibular)+ND(Bl)+STF

chest CT Plain

**Histopathogy Tumour Board Discussion**

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

WLE left lateral tongue and bilateral neck dissection: - Moderately differentiated squamous cell carcinoma -

Tumour size - 4.5x3.5x1.5cm. - Depth of the lesion - 1.5cm - Margins -Tumour is abutting left lateral soft tissue

margin - All other mucosal and soft tissue margins are free of tumour - WPOI - Type 2 (0) - Lymphocytic

infiltrate - continuous band (0) - Perineural invasion - Large nerve invasion seen(3) - Histological risk - High

Lymph nodes - 3/28 lymph nodes show metastasis with extranodal spread in all of them (left level III) - Largest

metastatic deposit measures 0.8 cm - All other nodes show reactive hyperplasia. Stage pT3N3b

**Agreed Plan of management :**

CRT

**Progress Notes**

**Date : 13/06/2018**

**ProgressNotes :**

48 year old male patient

c/o ulcer over left side of tongue noticed 4 months back

gradually progressive in size,

no comorbidities/habits

o/e

mouth opening adequate

4x 3 cm ulcerative lesion left lateral border pf tongue, 3 cm away from tip, posteriorly reaching uptill

tonsilolingual sulcus, induration approx 1-1.5cm, not crossing midline over dorsum, floor of mouth induration

min induration . BOT supple

tongue movements are normal

post extent confirmed on scopy

neck no palpable nodes

ct neck dtd 9.6.18 ill defined enhancing lesion 4.4x1.0x2.7cm lateral border of tongue on left side with

thickening of myelohyoid, loss of planes with left SMG

no significant involvement of mandible

multiple cervical LN bl level 1b,II,III, IV and V, 13x10mm in level II L side largest

biopsy- 5.5.18 MD SCC

imp ca tongue left lateral border c T4aN2cMx

adv

PAC - PLan WLE(transmandibular)+ND(bl)+STF

chest CT Plain

review

**Progress Notes**

**Date : 30/01/2019**

**ProgressNotes :**

Carcinoma Left lateral border Tongue

S/P Wide local excision tongue with bl SND levels I-IV with radial free forearm flap with trachesotomy under

GA 14/06/2018 pT3bN3bM0

Completed Post Operative Concurrent chemoradiation therapy using Tomotherapy technique on 4/09/18

o/e locoregionally NAD

neck - no lap

scopy: Normal.

ADVICE:

Review after 1month

**PROGRESS NOTE**

**Progress Notes**

**Date : 25/02/2019**

**ProgressNotes :**

Carcinoma Left lateral border Tongue

S/P Wide local excision tongue with bl SND levels I-IV with radial free forearm flap with trachesotomy under

GA 14/06/2018

pT3bN3bM0

Completed Post Operative Concurrent chemoradiation therapy using Tomotherapy technique on 4/09/18

RT Started on 25/7/2018

RT Completed on 4/9/2018

Treatment breaks- Nil

Total Dose: 6600 cGy in 30 fractions

PTV 66 Gy= Left level III Nodal region

PTV 60 Gy= Tongue+ Left level I- IV a Nodal region

PTV 54 Gy= Right level Ib- VI and Left level IVb- VI Nodal region

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noticed swelling in left posterior aspect of neck in feb 2019

FNAC (done elsewhr) : metastatic SCC

c/o: R pelvic pain x 3 days

non radiating , no weakness

not able to walk due to pain

- cough +sputum (blopody streak)

o/e:

L/E: 2x1.5cm swelling noted in Left trapezius postyerior margin. non tender , fixed to muscle , not fixed to

skin.

PLAN:

admission

PETCT as metastatic workup

pain clinic