**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 16/05/2018

**Received on :** 16/05/2018

**Reported Date :** 17/05/2018

**Clinical Impression :**

Carcinoma tongue.

**Gross Description :**

Received for review are 4 slides and 4 blocks

210/18 B- 6974 A

210/18 D- 6974 B

210/18 E- 6974 C

210/18 H- 6974 D

**Microscopic Description :**

Excised Specimens- Well differentiated squamous cell carcinoma of tongue.

-The tumor appears exophytic with infiltration which appears largely broad front.

-Focally at the base large nest of tumor is seen to infiltrate the muscle.

-The depth is >0.5cm.

-The tumor interface shows moderate lymphocytic infiltrates.

-No lymphovascular emboli seen.

-No perineural invasion seen.

**Impression :**

Tongue Excision:-

-Well differentiated squamous cell carcinoma

- pT2 Nx Mx

**Radiology Report**

**Created Date:** 18/06/2018

**Study Done:**

**CT CHEST PLAIN**

Clinical information: k/c/o carcinoma tongue. To rule out metastasis.

Bilateral lung parenchyma are normal. No nodules.

Normal mediastinal vascular structures.

The hila are normal.

The tracheobronchial tree is normal.

No pleural effusion.

Upper abdomen and bones are normal.

**Impression:**

• Normal CT plain study of chest.

• No lung nodules.

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 18/06/2018

**Received on :** 18/06/2018

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

**Clinical Impression :**

Carcinoma tongue

**Gross Description :**

Received fresh is a specimen labelled "Medial mucosal margin dorsum of tongue" consists of single fibrofatty

tissue measuring 1.6x0.3x0.3cm.

1 section.

Frozen read as - negative for tumor

Also received fresh tissue labelled "WLE tongue oriented with suture double short suture posterior , double long

stitch material, single long anterior" consists of fibrofatty tissue with mucosa covered tissue bit measuring

6x4x2.8cm.Raw surface inked and specimen serially sliced from anterior to posterior in to 6 slices . Surface

shows an indurated area which is 0.5cm from lateral mucosal margin. The tip of tongue appearss distorted.

Overlying epithelium shows no gross lesion. On slicing , a palpable irregular induration is seen 1.5cm from the

anterior mucosal and soft tissue margin. The overlying epithelium is unremarkable. Grey white indurated

thickening ( lesion) noted at the anterior part of tongue which measures 2(SI)x1(SP)x1(ML)cm. Depth of lesion

1cm. The lesion is around 0.5cm from the lateral mucosal and soft tissue margin. Lesion 1cm from the anterior

mucosal and soft tissue margin , 0.5cm from medial soft tissue margin (deep), 1.5cm from superior mucosal

margin and 3cm from posterior mucosal and soft tissue margin

Representative sections are submitted as follows:

A1 - Lateral mucosal and soft tissue margin (radial)

A2 - Deep margin

A3 - Anterior mucosal and soft tissue shaved

A4 - Posterior mucosal and soft tissue shaved

A5 - Superior mucosal and soft shaved

A6 & A8- Lesion

Subsequently received in formalin are 15 specimens.

Specimen II labelled"Prefacial node left " consists of single grey brown tissue bit measuring 0.9x0.8x0.9cm.

Entire specimen submitted in cassette B

Specimen III labeled"Additional anterior mucosalmargin gingival" consists of single grey white tissue measuring

1x0.8x0.4cm. Entire specimen submitted in cassette C.

Specimen IV labelled "Additional anterior deep soft tissue margin" consists of single grey brown tissue

measuring 1.2x1x0.1cm. Entire specimen submitted in cassetteD.

Specimen V labelled"level I lymph node" consists of nodular fibrofatty tissue measuring 2x3x1.5cm. ? 1lymph

node identified. Entire specimen submitted in cassette E1 to E4.

Specimen VI labelled"Left level IB" consists of salivary gland tissue measuring 4x3x1.3cm. 2 lymph nodes

identified,largest measuring 1.2cm in greatest dimension. Representative sections are submitted in cassettes F1

to F3.

Specimen VII labelled "Left level IIA" consists of multiple nodular tissue bit measuring aggregate measuring

3x1.8x1cm. A lymph node identified, largest measuring 0.7cm in greatest dimension. Smallest measuring

0.4cm in greatest dimension. Entire specimen submitted in cassettes G1 to G3.

Specimen VIII labelled "left level IIB" consists of nodular fibrofatty tissue measuring aggregate measuring

3x2x0.8cm. 4 lymph nodes identified. largest measuring 0.6cm in greatest dimension. Smallest measuring

0.4cm in greatest dimension. Entire specimen submitted in cassettes H1 to H3.

Specimen IX labelled "Left level III" consists of 3 nodular tissue bit in aggregate measuring 2x2.5x1.3cm.

Entire specimen submitted in J1 to J3.

Specimen X labelled "Left level IV" consists of fibrofatty tissue measuring 3x1.5x0.4cm. 5 lymph nodes

identified, largest measuring 0.6cm in greatest dimension. Smallest measuring 0.3cm in greatest dimension.

Entire specimen submitted in cassettes K1 & K2.

Specimen XI labelled "EJV node" consists of single node measuring 0.4cm in greatest dimension. Entire

specimen submitted in cassette L.

Specimen XII labelled"Right level IB" consists of salivary gland lesion measuring 3.5x2.5x2.5cm. 3 lymph

nodes identified, largest measuring 1.2cm greatest dimension. Smallest 0.5cm in greatest dimension.

Representative sections are submitted in cassettes M1 to M4.

Specimen XIII labelled"Right level IIA" consists of multiple nodular tissue measuring 3x3x1.3cm. 12 lymph

nodes identified., largest measuring 2.5x0.9x1cm.Smallest measuring 0.5cm in greatest dimension. Entire

specimen submitted in cassettesN1 to N5.

Specimen XIV labelled " Right level IIB" consists of nodular tissue in aggregate measuring 2x1x0.6cm. 6

lymph nodes identified.largest measuring 0.6cm. Smallest measuring 0.3cm in greatest dimension. Entire

specimen submitted in cassettes P1 to P3.

Specimen XV labelled "Right level III" consists of nodular tissue measuring 2.8x2x0.8cm. 5 lymph nodes

identified.Largest measuring 1cm in greatest dimension. Smallest measuring 0.5cm in greatest dimension.

Sections submitted in cassettes Q1 to Q4.

Specimen XVI labelled "Right level IV" consists of nodular fibrofatty tissue measuring 1.8x1.4x0.8cm. 1

lymph node identified measuring 0.6cm in greatest dimension. Sections submitted in cassettes R1 to R3.

**Microscopic Description :**

A. Sections show no residual tumour with epithelium showing mild low grade dysplasia.Subepithelium show

band like lymphoid ,neutrophilic and plasma cell infiltrate with post biopsy changes.

All the margins are free of tumour.

B. Left prefacial lymph node - Single lymph node - free of tumour

C. Additional mucosal margin - No evidence of tumour / dysplasia

D. Additional anterior deeper soft tissue margins - No evidence of tumour / dysplasia.

E. Level IA - 3 lymph nodes -free of tumour

F. Left level IB - 2 reactive lymph nodes with unremarkable salivary gland

G. Left level IIA - 5 lymph node - free of tumour

H. Left level II B - 5 lymph nodes - free of tumour

J. Left level III - 4 lymph nodes - free of tumour

K. Left level IV - 7 lymph nodes - Free of tumour

L. EJV node -Single lymph node - free of tumour

M. Right level IB - 3 reactive lymph nodes with unremarkable salivary gland

N. Right level IIA - 14 lymph nodes - free of tumour

P. Right level II B - 7 lymph nodes - Free of tumour

Q. Right level III -2 lymph nodes - Free of tumour

R. Right level IV - 2 lymph nodes - Free of tumour.

**Impression :**

WLE tongue with bilateral LND and additional margins (S/P excision biopsy):

- No residual tumour seen.

- All margins and additional margins taken are free of tumour.

- All lymph nodes (0/49) sampled are free of tumour.

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| **ate of Admission :**17/06/2018 | **Date of Procedure :**18/06/2018 |

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| **Date of Discharge :**28/06/2018 |

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

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| **DIAGNOSIS :** |
| Carcinoma Tongue |

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| **PROCEDURE DONE :** |
| Wide Local excision of tongue + B/L Level I- Iv ND + Left RFFF under GA |

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| **HISTORY :** |
| A 57 years old female patient, a housewife from Lakshadweep with no co-morbidity. Referred here with complaints left sided tongue ulceration x 2 months associated with pain and can take liquid and soft diet. She had underwent Excision biopsy of lesion done in Krishna Hospital on 1.5.18 which showed Mod Diff SCC. She came here with same complaints and underwent Tongue Excision which showed Well differentiated squamous cell carcinoma - pT2 Nx Mx. Hence planned for further management. |

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| **PAST HISTORY :** |
| No h/o DM/ HTN/ TB/DLP/Asthma/ Seizures/Thyroid disorder/ CAD/CVA No h/o Previous blood transfusions Good Effort Tolerance No Recent fever/cough Normal Bowel and bladder habits Not habituated to alcohol or smoking |

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| **CLINICAL EXAMINATION :** |
| O/E: KPS 90 OSMF changes noted edentulous 3x2 cm indurated ulceration on left ant tongue reaching ant to tip going left FOM not crossing midline BOT and tonsillar fossa-supple on palpation mouth opening reduced Sutures noted of previous biopsy (Outside) neck- small left level Ib node palpable |

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| CT CHEST PLAIN Impression: -Normal CT plain study of chest. -No lung nodules. Surgical Pathology report Impression : WLE tongue with bilateral LND and additional margins (S/P excision biopsy): - No residual tumour seen. - All margins and additional margins taken are free of tumour. - All lymph nodes (0/49) sampled are free of tumour. |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Bebejan came with above mentioned complaints. After all preliminary examinations and investigations her case was discussed and planned for surgery. She Underwent Wide Local excision of tongue + B/L Level I- Iv ND + Left RFFF under GA . She was shifted to ICU and later to ward for post operative recovery. Her drain was removed. On POD 8 all her clips were removed and alternate sutures were removed and On POD 9 all here sutures were removed. Her swallowing assessment was done and removed Ryles tube on POD 10. Her post operative period was uneventful. Conditions at discharge:GC Fair,Vitals stable |

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| **OPERATIVE FINDINGS :** |
| Wide Local excision of tongue + B/L Level I- Iv ND + Left RFFF under GA Findings : 3x2 cm indurated ulceration on left ant tongue reaching ant to tip going left FOM not crossing midline BOT and tonsillar fossa-supple on palpation mouth opening reduced Procedure : Patient under GA.PPD. Peroral Wide local excision marked with 1cm margin around the above desribed lesion .WLE completed as marked .Defect assesed and decision to do RFFF reconstruction made . Right SCM delineated Right Level I- IV lymphnode dissection completed ,.Left SCM delineated and Left Level I- Iv lymphnode dissection completed, RFFF raised , Flap inset done , microanastamosis completed .Hemostasis achieved . RVD secured and Closure done in layers .Patient tolerated the procedure well. |

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| **DISCHARGE MEDICATION :** |
| Tab.Pan 40 mg 1-0-0 X 5 days Tab.Dolo 650 mg 1-1-1 X 5 Days Chlorohexidine mouth gargles. (TID after food) |

**Tumour Board Discussion**

**Relevant clinical details :**

A 57 years old female patient, a housewife

no co-morbidity

C+

Referred here for

c/o left sided tongue ulceration x 2 months

Asso with pain

can take liquid and soft diet

Excision biopsy of lesion done on 1.5.18

O/E: KPS 90

OSMF changes noted

edentulous

3x2 cm indurated ulceration on left ant tongue

reaching ant to tip

going left FOM

not crossing midline

BOT and tonsillar fossa-supple on palpation

mouth opening reduced

Sutures noted of previous biopsy (Outside)

neck- small left level Ib node palpable

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

Evaluated

Excision biopsy Mod Diff SCC

AIMS

Tongue Excision:- -Well differentiated squamous cell carcinoma - pT2 Nx Mx

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

MRI neck 11.05.18

ill defined altered signal areas 3x2 cm involving left ant tongue

no erosion of adjacent mandible

few small LN noted in submental area.

: FOM involved , Lesion crossing midline , hyoid not involved.B/L nodes +

**Agreed Plan of management :**

Near total glossectomy + B/L ND+ ALT flap + PEG

**Histopathology Tumour Board Discussion**

**Date of tumor board discussion :** 04/07/2018

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

WLE tongue with bilateral LND and additional margins (S/P excision biopsy): - No residual tumour seen. - All

margins and additional margins taken are free of tumour. - All lymph nodes (0/49) sampled are free of tumour.

**Agreed Plan of management :**

Observation

**Progress Notes**

**Date : 16/05/2018**

**ProgressNotes :**

A 57 years old female patient, a housewife

no co-morbidity

C+

Referred here for

c/o left sided tongue ulceration x 2 months

Asso with pain

can take liquid and soft diet

Excision biopsy of lesion done in on 1.5.18

O/E: KPS 90

OSMF changes noted

edentulous

3x2 cm indurated ulceration on left ant tongue

reaching ant to tip

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not crossing midline

BOT and tonsillar fossa-supple on palpation

mouth opening reduced

Sutures noted of previous biopsy (Outside)

neck- small left level Ib node palpable

Evaluated

Excision biopsy Mod Diff SCC

MRI neck 11.05.18

ill defined altered signal areas 3x2 cm involving left ant tongue

no erosion of adjacent mandible

few small LN noted in submental area.

adv

Slide and block review

PAC

PAC Ix

**PROGRESS NOTE**

**Progress Notes**

**Date : 25/06/2024**

**ProgressNotes :**

case of Carcinoma Tongue Wide Local excision of tongue + B/L Level I- Iv ND + Left RFFF under GA

18/6/18

Adv

locoregionally NAD

advised review after 1 yr