**Radiology Report**

**Created Date:** 14/05/2015

**Study Done:**

**CT CHEST WITH NECK [CONTRAST]**

***Known case of carcinoma lip.***

A 2.8 x 4.5 cm enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of

any bony erosion.

Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm.

Thyroid/cricoid and arytenoid cartilages are normal.

The larynx and the tracheal air way are normal.

Hypopharynx and laryngopharynx are normal.

No evidence of any retropharyngeal lesion.

Parapharyngeal spaces are normal.

Bilateral neck vessels are normal.

Thyroid gland shows homogenous dense enhancement and is normal in size and outline. No focal lesion seen.

No evidence of any enhancing lung lesion / nodule.

**Impression:**

• **Lesion in the lower lip as described suggestive of carcinoma lip. No evidence of any bony**

**erosion.**

• **Submental nodes noted as described.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 14/05/2015

**Received on :** 14/05/2015

**Reported Date :** 15/05/2015

**Gross Description :**

Received in formalin is a specimen consists of 2 mucosa covered grey white soft tissue bits one measuring

0.6x0.5x0.3cm, Other measuring 0.4x0.3x0.2cm. Entire specimen submitted in one cassette.

**Microscopic Description :**

Section shows 2 fragments of tissue lined by stratified squamous epithelium showing an infiltrating neoplasm

arising from the epithelium,composed of cells arranged in nests and lobules. With the nests the cells have distinct

cell borders, round to oval mild to moderately pleomorphic vesicular nuclei with prominent nucleoli and

moderate amount of eosinophilic cytoplasm. Single cell keratinisation and keratin pearls are noted. Scattered

mitotic figures are seen. No necrosis. No LVE / perineural invasion noted.

**Impression :**

Incisional biopsy mucosa lip :-

Suggestive of Well differentiated squamous cell carcinoma

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 05/06/2015

**Received on :** 05/06/2015

**Reported Date :** 11/06/2015

**Clinical Impression :**

Carcinoma lower lip

**Gross Description :**

Received in formalin are 12 specimens. The I specimen labelled as "WLE of upper lip + marginal

mandibulectomy, tagged with sutures" consists of the same, measures 6x5.5x4cm. There is an ulceroproliferative

lesion in the gingiovo buccal sulcus, extending into the buccal mucosa measuring 2.2x2x3.6cm. The lesion is

extends to the skin as a protruding mass and also involving the deep muscle. The lesion is 0.5cm from the lateral

soft tissue and mucosal margin. 0.6cm from the medial mucosal margin, 1.5cm from the lateral skin and soft

tissue margin, 1.5cm from the medial skin and soft tissue margin, 1.2cm from superior mucosal margin. The

lesion is 1cm from the bone. Bone (mandible) with attached 4 teeth noted. The lesion is abutting the anterior

skin. Lesion is 0.8cm from the inferior skin and soft tissue margin. Representative sections are submitted as

follows :-

A1 - Lateral skin and soft tissue margin

A2 - Medial skin and soft tissue margin

A3, AFB2 - Lesion with lateral mucosal margin

A4, AFB1 - Lesion with medial mucosal margin

A5 - Lesion with superior mucosal margin

A6 - Lesion with anterior skin margin

A7 - Lesion with inferior skin and soft tissue

A8 - A10 - Lesion

Specimen II labelled as "Right lateral mucosal margin", consists of a tissue fragment measures 1x0.1x0.2cm.

Entire specimen submitted in cassette B.

Specimen III labelled as "Level Ia - Neck dissection", consists of a fibrofatty measures 4.5x3x1cm. 2 lymph

nodes identified. Largest measures 1cm in greater dimension. Entire specimen submitted in C1 - C5 cassettes.

Specimen IV labelled as "Right level Ib", consists of a nodular fibrofatty tissue measures 5x4x1.5cm consists

salivary gland measures 4x3.5x2cm and one lymph node. Largest lymph node measures 2.5cm in greater

dimension. Representative sections are submitted in D1 - D3 cassettes.

Specimen V labelled as "Right level IIa", consists of nodular fibrofatty tissue measures 4x1.5x1cm. One lymph

node measures 1cm in greater dimension. Representative sections are submitted in E1 - E4 cassettes.

Specimen VI labelled as "Right level IIb", consists of nodular fibrofatty tissue measures 2.5x1x0.7cm.

Representative sections are submitted in F1 - F2 cassettes.

Specimen VII labelled as "Right level III", consists of 2 fibrofatty tissue, one measures 4x3x1cm. Other

measures 3.5x3.5x1cm. Representative sections are submitted in G1 - G2 cassettes.

Specimen VIII labelled as "Right level IV", consists of a nodular tissue measures 2.5x2x1cm. Representative

sections are submitted in H1 - H2 cassettes.

Specimen IX labelled as "Left level IB", consists of a fibrofatty tissue measures 5.5x5x1.5cm. Representative

sections are submitted in J1 - J2 cassettes.

Specimen X labelled as "Left level II", consists of a fibrofatty tissue measures 4x1.5x1cm. 3 lymph nodes

identified. Largest measures 1.5cm in greater dimension. Representative sections are submitted as follows :-

K1 - Largest lymphnode

K2 - 2 lymph nodes

K3 - Salivary gland

Specimen XI labelled as "Left level III", consists of fibrofatty tissue measures 5x2.5x1cm. Representative

sections are submitted in L1 - L3 cassettes.

Specimen XII labelled as "Left level IV", consists of fibrofatty tissue measures 2x1x0.8cm. Entire specimen

submitted in cassette M.

**Microscopic Description :**

Type of specimen: WLE lower lip+marginal mandibulectomy

Histological type: Squamous cell carcinoma

Differentiation: Moderate

Invasive front: Cohesive

Tumor size: 2.2x2x3.6cm

Maximum depth of invasion : 2.2cm

Vascular invasion- Present

Skeletal muscle invasion - Present

Nerve invasion - Present

Skin invasion - Present

Bone invasion- Absent

Margins: The tumor is 0.6cm from medial mucosa and soft tissue, 1.5cm from medial skin, 1.2cm from superior

mucosal margins, 0.4cm from lateral mucosal margin, 1cm from inferior skin and soft tissue margin.

Bone margins: Free of tumor.

"Additional Right lateral mucosal margin": Free of tumor.

Lymph nodes:

C: "Level IA": Three lymph nodes, free of tumor.

D: "Right level IB": Two lymph nodes and salivary gland, free of tumor.

E: "Right level IIA": 12 lymph nodes, free of tumor.

F: "Right level IIB": One lymph node, free of tumor.

G: "Right level III": Six lymph nodes, free of tumor.

H: "Right level IV": One lymph node, free of tumor.

J: "Left level IB": Salivary gland, free of tumor.

K: "Left level II": Six lymph nodes, free of tumor.

L: "Left level III": Seven lymph nodes, free of tumor.

M: "Left level IV": Two lymph nodes, free of tumor.

**Diagnosis :**

Type of specimen: WLE lower lip+marginal mandibulectomy

Histological type: Squamous cell carcinoma

Differentiation: Moderate

Invasive front: Cohesive

Tumor size: 2.2x2x3.6cm

Maximum depth of invasion: 2.2cm

Vascular invasion- Present

Skeletal muscle invasion - Present

Nerve invasion - Present

Skin invasion - present.

Bone invasion - Absent

Margins: The tumor is 0.6cm from medial mucosa and soft tissue, 1.5cm from medial skin, 1.2cm from superior

mucosal margins, 0.4cm from lateral mucosal margin, 1cm from inferior skin and soft tissue margin.

Bone margins: Free of tumor.

"Additional Right lateral mucosal margin": Free of tumor.

Lymph nodes:

"Level IA": Three lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level IIA": 12 lymph nodes, free of tumor.

"Right level IIB": One lymph node, free of tumor.

"Right level III": Six lymph nodes, free of tumor.

"Right level IV": One lymph node, free of tumor.

"Left level IB": Salivary gland, free of tumor.

"Left level II": Six lymph nodes, free of tumor.

"Left level III": Seven lymph nodes, free of tumor.

"Left level IV": Two lymph nodes, free of tumor.

pTNM stage: pT4aN0

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| **Date of Admission :**03/06/2015 | **Date of Procedure :**04/06/2015 |

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| **Date of Discharge :**15/06/2015 |

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

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| **DIAGNOSIS :** |
| Squamous cell Carcinoma lower Lip. |

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| **PROCEDURE DONE :** |
| WLE of Lower lip lesion + BL SND (I-IV) + Radial forearm soft tissue free flap reconstruction + Tracheostomy + SSG under GA on 4/06/15. |

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| **HISTORY :** |
| 71 yr old Antony had ceramic crowns applied for the Rt lower teeth following which he had whitish mucosal thickening in the Rt side of lower lip for past 1 year. Now c/o ulceroproliferative growth in the same site 1 month .No pain / bleeding. Came here for further management. |

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| **PAST HISTORY :** |
| HT on treatment no other comorbidity |

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| **CLINICAL EXAMINATION :** |
| 3x4 cm ulcerative growth in the mucosal aspect of lower lip extending upto the GB sulcus. involving the skin of lower lip with surrounding induration (4.5x 3 cm) (1cm from Rt angle & 2 cm from the left angle); Restricted mobility over the mandible Left level II single 1.5 cm LN palpable. no other nodes palpable VLS- oropharynx & larynx :NAD |

**INVESTIGATIONS :**

**Haemogram:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Hb: g/dl** | **PCV: %** | **PLT: ku/ml** | **TC: ku/ml** | **DC: N %** | **L: %** | **E: %** | **ESR: mm/1st hr** |
| 05/06/2015 | 12.6 | 35.9 | 203 | 13.3 | 88.0 | 6.0 | 0.2 | - |
| 06/06/2015 | 11.4 | 34.4 | 235 | 17.3 | 81.6 | 10.5 | .030 | - |
| 08/06/2015 | 11.5 | 31.8 | 233 | 14.2 | 73.0 | 17.0 | 0.9 | - |

**Renal Function Test and Serum Electrolytes:**

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| --- | --- | --- | --- | --- |
| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 05/06/2015 | - | - | 134.4 | 4.0 |
| 07/06/2015 | - | - | 133.7 | 3.2 |
| 08/06/2015 | - | - | 127.1 | 3.3 |
| 09/06/2015 | - | - | 128.4 | 3.3 |

Date: 13/06/2015

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| Glucose [Urine] : Negative mg/dl | Bilirubin [Urine] : Negative umol/L |

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| --- | --- |
| Ketone [Urine] : Negative mmol/L | Specific Gravity-urine : <=1.005 NONE |

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| --- | --- |
| Blood [Urine] : \* 1+ EU | Urobillinogen-urine : Normal umol/L |

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| Urine pH : 7.0 NONE | Nitrite-urine : Negative |

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| Clarity-urine : Cloudy | Color-urine : Straw |

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| Leucocytes-urine : 2+ | Pus Cells : 15-20 HPF NONE |

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| Urine Protein : Negative | Hyaline Cast : NIL |

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| Red Blood Cell : 10-15 HPF NONE | Epithelial cells : NIL |

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| Trichomonad : Absent | Granular Cast : NIL |

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| Calcium Oxalate : NIL | Bacteria Urine : ABSENT |

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| Amorphous phosphate : NIL | Uric acid crystals : NIL |

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| Mucus : ABSENT | Yeast cells : NIL |

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| Triple Phosphate : NIL | Other sediment findings : Nil |

Date: 08/06/2015

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| RBC-COUNT-Blood : 3.49 M/uL | MCV-Blood : 91.2 fL |

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| --- | --- |
| MCH-Blood : 33.1 pg | MCHC-Blood : 36.2 g/dl |

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| --- | --- |
| RDW-Blood : 13.4 % | MPV-Blood : 7.3 fL |

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| --- | --- |
| MONO -Blood : 9.0 % | BASO-Blood : 0.1 % |

Date: 06/06/2015

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| --- | --- |
| RBC-COUNT-Blood : 4.02 M/uL | MCV-Blood : 85.6 fL |

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| MCH-Blood : 28.4 pg | MCHC-Blood : 33.2 g/dl |

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| RDW-Blood : 10.7 % | MPV-Blood : 7.12 fL |

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| MONO -Blood : 7.65 % | BASO-Blood : .251 % |

Date: 05/06/2015

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| Compatibility test; cross match complete (3 tests) : Compatible | RBC-COUNT-Blood : 3.90 M/uL |

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| MCV-Blood : 92.1 fL | MCH-Blood : 32.2 pg |

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| MCHC-Blood : 35.0 g/dl | RDW-Blood : 13.6 % |

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| MPV-Blood : 7.8 fL | MONO -Blood : 5.7 % |

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| BASO-Blood : 0.1 % |  |

Date: 03/06/2015

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| Compatibility test; cross match complete (3 tests) : Compatible |  |

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| Radiology Report Patient Name :Mr. P. V. ANTONY MRD# :1561939 Date of birth :03/08/1943 Sex :Male Visit Type :OP0001 Created Date:14/05/2015 Study Done: CT CHEST WITH NECK [CONTRAST] known case of carcinoma lip. A 2.8 x 4.5 cm enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of any bony erosion. Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm. Thyroid/cricoid and arytenoid cartilages are normal. The larynx and the tracheal air way are normal. Hypopharynx and laryngopharynx are normal. No evidence of any retropharyngeal lesion Parapharyngeal spaces are normal. Bilateral neck vessels are normal. Thyroid gland shows homogenous dense enhancement and is normal in size and outline. No focal lesion seen. No evidence of any enhancing lung lesion / nodule. Impression: ?Lesion in the lower lip as described suggestive of carcinoma lip. No evidence of any bony erosion. ?Submental nodes noted as described. 　 Surgical Pathology Report Patient Name :Mr. P. V. ANTONY MRD# :1561939 Date of birth :03/08/1943 Sex :Male Visit Type :OP0001 Service :Histopath-Excision biopsy (small) Department :Head And Neck Surgery And Oncology Ref By :Dr Subramania Iyer Date of sample collection :14/05/2015 Received on :14/05/2015 Reported Date :15/05/2015 Histology Lab No :S15-5935 Gross Description : Received in formalin is a specimen consists of 2 mucosa covered grey white soft tissue bits one measuring 0.6x0.5x0.3cm, Other measuring 0.4x0.3x0.2cm. Entire specimen submitted in one cassette. (Dr Radhika/AS/gb) Microscopic Description : Section shows 2 fragments of tissue lined by stratified squamous epithelium showing an infiltrating neoplasm arising from the epithelium,composed of cells arranged in nests and lobules. With the nests the cells have distinct cell borders, round to oval mild to moderately pleomorphic vesicular nuclei with prominent nucleoli and moderate amount of eosinophilic cytoplasm. Single cell keratinisation and keratin pearls are noted. Scattered mitotic figures are seen. No necrosis. No LVE / perineural invasion noted. Impression : Incisional biopsy mucosa lip :- Suggestive of Well differentiated squamous cell carcinoma |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Patient was admitted . Biopsy was done - Well differentiated squamous cell carcinoma , CECT was done -A 2.8 x 4.5 cm enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of any bony erosion. Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm. His case was discussed in Tumor board and planned for surgery . He underwent WLE of Lower lip lesion + BL SND (I-IV) + Radial forearm soft tissue free flap reconstruction + Tracheostomy + SSG under GA on 4/06/15. He had urinary retention so urology consult was done , catheterised and started on urimax. Rest of post op period was uneventful. Condition at discharge: vitals stable, Afebrile, foley's catheter in situ. |

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| **OPERATIVE FINDINGS :** |
| WLE of Lower lip lesion + BL SND (I-IV) + Radial forearm soft tissue free flap reconstruction + Tracheostomy + SSG under GA on 4/06/15. Findings: 3x4 cm ulcerative growth in the mucosal aspect of lower lip extending upto the GB sulcus. involving the skin of lower lip with surrounding induration (4.5x 3 cm) (1cm from Rt angle & 2 cm from the left angle); Procedure: Under GA with aseptic and antiseptic precautions , patient is taken. Wide local excision of lower lip lesion (more than 90% ) along with marginal mandibulectomy done. Midline chin split incision with transverse cervical skin crease incision kept. BL Selective Neck dissection(I-IV) was done. Left level II - 1.5 cm node seen . Other Bilateral small lymph nodes seen in level II and III. Right radial forearm free flap harvested of around 7x5 cm . Flap detached and inset was done with palmaris sling for lip competence. Micro anastomosis done with facial artery to radial artery and cephalic vein with facial vein and vena commitant with lingual vein. Heamostasia achieved. wound closed in layers . Donor site closed and defect closed with Left thigh SSG. Tracheostomy done with portex single lumen 7.5 tube. No peri op complications. |

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| **PROGNOSIS ON DISCHARGE :** |
| Good. |

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| **ADVICE ON DISCHARGE :** |
| Discharging with Foley's catheter. |

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| **DIET RECOMMENDATIONS :** |
| Soft + liquids orally. |

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| **PHYSICAL ACTIVITY :** |
| Moderate. |

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| **DISCHARGE MEDICATION :** |
| Tab.Pan 40 mg 1-0-0x 1 week Tab.Levoflox 500mg 1-0-0 x 5 days Tab.Urimax 0.4 mg 0-0-1 x 1 week syp.looz 30 ml HS x 1 week Tab.covance D 1-0-0 to be cont. Tab.covance 0-0-1 to be cont. Tab.Dolo 650 mg 1-0-1 x 5 days Clohex gargles 4th hourly and oral care as advised. |

**Tumour Board Discussion**

**Date of tumor board discussion :** 20/05/2015

**Attendees :**

Dr Iyer/Dr KK/Dr Sunil/Dr Deepak/Dr Anoop/Dr Pushpaja/Dr Prameela/Dr Sandhya/Dr Chaya

Dr Maya/Dr Shreya/Dr Adharsh A/Dr Shashi

**Relevant clinical details :**

71 yr old

had ceramic crowns applied for the Rt lower teeth following which he had whitish mucosal thickening in the Rt

side of lower lip for past 1 year

Now c/o ulceroproliferative growth in the same site 1 month

No pain / bleeding

HT on treatment

no other comorbidity

3x4 cm UP growth in the mucosal aspect of lower lip extending upto the GB sulcus

involving the skin of lower lip with surrounding induration (4.5x 3 cm) (1cm from Rt angle & 2 cm from the left

angle);

Restricted mobility over the mandible

Left JD single 1.5 cm LN

no other nodes palpable

VLS oropharynx & larynx NAD

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

Bx - Well differentiated squamous cell carcinoma

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

CECT HN

A 2.8 x 4.5 cm enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of

any bony erosion.

Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm.

**Agreed Plan of management :**

CECT chest

WLE + B/L SND + STF/local construction + adjuvant

**Tumour Board - HPE Discussion**

**Date of tumor board discussion :** 01/07/2015

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

Type of specimen: WLE lower lip+marginal mandibulectomy

Histological type: Squamous cell carcinoma

Differentiation: Moderate

Invasive front: Cohesive

Tumor size: 2.2x2x3.6cm

Maximum depth of invasion: 2.2cm

Vascular invasion- Present

Skeletal muscle invasion - Present

Nerve invasion - Present

Skin invasion - present.

Bone invasion - Absent

Margins: The tumor is 0.6cm from medial mucosa and soft tissue, 1.5cm from medial skin, 1.2cm from superior

mucosal margins, 0.4cm from lateral mucosal margin, 1cm from inferior skin and soft tissue margin.

Bone margins: Free of tumor.

"Additional Right lateral mucosal margin": Free of tumor.

Lymph nodes:

"Level IA": Three lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level IIA": 12 lymph nodes, free of tumor.

"Right level IIB": One lymph node, free of tumor.

"Right level III": Six lymph nodes, free of tumor.

"Right level IV": One lymph node, free of tumor.

"Left level IB": Salivary gland, free of tumor.

"Left level II": Six lymph nodes, free of tumor.

"Left level III": Seven lymph nodes, free of tumor.

"Left level IV": Two lymph nodes, free of tumor.

pTNM stage: pT4aN0

**Agreed Plan of management :**

Adjuvant RT

**Progress Notes**

**Date : 13/05/2015**

**ProgressNotes :**

71 yr old

had ceramic crowns applied for the Rt lower teeth following which he had whitish mucosal thickening in the

Rt side of lower lip

Now c/o ulceroproliferative growth in the same site 1 month

No pain / bleeding

HT on treatment

no other comorbidity

brother had CA oral cavity & died of disease

Sis had some liver cancer no details

Ex smoker stopped 20 yrs back (10 to 15 cigarettes for 30 yrs)

Occassional alcoholic

no other habits

O/E

ECOG 0

3x4 cm UP growth in the mucosal aspect of lower lip extending upto the GB sulcus

involving the skin of lower lip with surrounding induration (4.5x 3 cm) (1cm from Rt angle & 2 cm from the

left angle);

Restricted mobility over the mandible

Left JD single 1.5 cm LN

no other nodes palpable

VLS oropharynx & larynx NAD

Adv

CECT H&N & Chest

BX; PAC

**PROGRESS NOTE**

**Progress Notes**

**Date : 25/04/2018**

**ProgressNotes :**

doing well

flap- healed well, mucosalised

neck nad

r.a 6 months

**Speciality :** RadiationOncology

**D/O Commencement of RT** 15/09/2015 **D/O Completion of RT** 15/09/2015

**FINAL DIAGNOSIS, STAGE AND HISTOLOGY**

Carcinoma Lower Lip

WLE of Lower lip lesion + Bilateral SND (I-IV) + Radial forearm soft tissue free flap reconstruction +

Tracheostomy + SSG under GA on 04/06/15.

pT4aN0M0

Moderately Differentiated Squamous cell carcinoma

Completed Post Operative Adjuvant Radiation therapy.

**CLINICAL HISTORY AND PHYSICAL FINDINGS**

71 year old gentleman, had ceramic crowns applied for the Right lower teeth following which

he had whitish mucosal thickening in the Right side of lower lip for past 1 year. Now complaints of an

ulceroproliferative growth in the same site since 1 month. No complaints of pain or bleeding. He came here for

further management. Clinical examination revealed a 3 x 4 cm ulcerative growth in the mucosal aspect of lower

lip extending upto the GB sulcus involving the skin of lower lip with surrounding induration (4.5x 3 cm) (1cm

from Right angle & 2 cm from the left angle). Restricted mobility over the mandible Left level II single 1.5 cm

LN palpable. no other nodes palpable. CT Chest with Neck Contrast [Dated: 14/5/2015] showed a 2.8 x 4.5 cm

enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of any bony

erosion. Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm. Incisional biopsy

[Dated: 15/5/2015] reported as Well differentiated squamous cell carcinoma. He was advised for surgery and

underwent WLE of Lower lip lesion + Bilateral SND (I-IV) + Radial forearm soft tissue free flap reconstruction

+ Tracheostomy + SSG under GA on 4/06/15. Intraoperatively found a 3x4 cm ulcerative growth in the mucosal

aspect of lower lip extending upto the GB sulcus. involving the skin of lower lip with surrounding induration

(4.5x 3 cm) (1cm from Right angle & 2 cm from the left angle). Post OP HPR [Dated:11/6/2015] reported as

Histological type: Squamous cell carcinoma.Differentiation: Moderate. Invasive front: Cohesive. Tumor size:

2.2x2x3.6cm. Maximum depth of invasion: 2.2cm.Vascular invasion- Present. Skeletal muscle invasion–

Present.Nerve invasion – Present. Skin invasion – present.Boneinvasion – Absent. Margins: The tumor is 0.6cm

from medial mucosa and soft tissue, 1.5cm from medial skin, 1.2cm from superior mucosal margins, 0.4cm from

lateral mucosal margin, 1cm from inferior skin and soft tissue margin. Bone margins: Free of tumor. "Additional

Right lateral mucosal margin": Free of tumor. Lymph nodes: "Level IA": Three lymph nodes, free of

tumor."Right level IB": Two lymph nodes and salivary gland, free of tumor. "Right level IIA": 12 lymph nodes,

free of tumor. "Right level IIB": One lymph node, free of tumor. "Right level III": Six lymph nodes, free of

tumor. "Right level IV": One lymph node, free of tumor. "Left level IB": Salivary gland, free of tumor. "Left

level II": Six lymph nodes, free of tumor. "Left level III": Seven lymph nodes, free of tumor. "Left level IV":

Two lymph nodes, free of tumor. He was pathologically staged as pT4aN0M0. His case was discussed in

multidisciplinary tumor board and was planned for Post Operative Adjuvant Radiation therapy with a dose of

6000 cGy in 30 fractions.

**INVESTIGATIONS :**

**Haemogram:**

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

**ku/ml**

**TC:**

**ku/ml**

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

**mm/1st hr**

21/07/2015 13.2 38.5 232 7.6 45.6 31.7 10.7 -

27/07/2015 13.0 38.4 231 11.0 56.3 21.4 9.5 -

03/08/2015 13.1 38.3 281 8.3 57.0 20.9 8.7 -

10/08/2015 13.5 39.8 308 9.3 63.5 16.8 7.5 -

17/08/2015 13.6 40.4 288 9.7 62.7 15.7 7.6 -

24/08/2015 13.1 41.2 317 6.85 57.3 15.7 6.12 -

**Renal Function Test and Serum Electrolytes:**

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

21/07/2015 - 0.84 - -

03/08/2015 25.2 0.84 131.2 3.8

17/08/2015 26.6 0.86 132.1 3.8

24/08/2015 32.8 0.92 128.3 4.3

Date: 24/08/2015

RBC-COUNT-Blood : 4.88 M/uL MCV-Blood : 84.4 fL

MCH-Blood : 26.9 pg MCHC-Blood : 31.9 g/dl

RDW-Blood : 12.1 % MPV-Blood : 5.85 fL

MONO -Blood : 20.2 % BASO-Blood : .641 %

Date: 17/08/2015

Glucose [R]-Plasma : 102.8 mg/dl RBC-COUNT-Blood : 4.45 M/uL

MCV-Blood : 90.8 fL MCH-Blood : 30.7 pg

MCHC-Blood : 33.8 g/dl RDW-Blood : 14.8 %

MPV-Blood : 7.3 fL MONO -Blood : 13.6 %

BASO-Blood : 0.4 %

Date: 10/08/2015

RBC-COUNT-Blood : 4.35 M/uL MCV-Blood : 91.4 fL

MCH-Blood : 31.0 pg MCHC-Blood : 33.9 g/dl

RDW-Blood : 14.4 % MPV-Blood : 6.8 fL

MONO -Blood : 11.8 % BASO-Blood : 0.4 %

Date: 03/08/2015

RBC-COUNT-Blood : 4.23 M/uL MCV-Blood : 90.6 fL

MCH-Blood : 31.0 pg MCHC-Blood : 34.2 g/dl

RDW-Blood : 14.9 % MPV-Blood : 7.0 fL

MONO -Blood : 13.0 % BASO-Blood : 0.4 %

Date: 27/07/2015

RBC-COUNT-Blood : 4.19 M/uL MCV-Blood : 91.5 fL

MCH-Blood : 31.0 pg MCHC-Blood : 33.9 g/dl

RDW-Blood : 15.1 % MPV-Blood : 7.6 fL

MONO -Blood : 12.7 % BASO-Blood : 0.1 %

Date: 21/07/2015

RBC-COUNT-Blood : 4.19 M/uL MCV-Blood : 91.8 fL

MCH-Blood : 31.4 pg MCHC-Blood : 34.2 g/dl

RDW-Blood : 15.1 % MPV-Blood : 7.3 fL

MONO -Blood : 11.6 % BASO-Blood : 0.4 %

**HISTOPATHOLOGY REPORTS**

1. Incision Biopsy [Dated: 15/5/2015, Histology Lab No :S15-5935]

Suggestive of Well differentiated squamous cell carcinoma

2. Post OP HPR [Dated:11/6/2015]

Histological type: Squamous cell carcinoma

Differentiation: Moderate

Invasive front: Cohesive

Tumor size: 2.2x2x3.6cm

Maximum depth of invasion: 2.2cm

Vascular invasion- Present

Skeletal muscle invasion - Present

Nerve invasion - Present

Skin invasion - present.

Bone invasion - Absent

Margins: The tumor is 0.6cm from medial mucosa and soft tissue, 1.5cm from medial skin, 1.2cm from

superior mucosal margins, 0.4cm from lateral mucosal margin, 1cm from inferior skin and soft tissue margin.

Bone margins: Free of tumor.

"Additional Right lateral mucosal margin": Free of tumor.

Lymph nodes:

"Level IA": Three lymph nodes, free of tumor.

"Right level IB": Two lymph nodes and salivary gland, free of tumor.

"Right level IIA": 12 lymph nodes, free of tumor.

"Right level IIB": One lymph node, free of tumor.

"Right level III": Six lymph nodes, free of tumor.

"Right level IV": One lymph node, free of tumor.

"Left level IB": Salivary gland, free of tumor.

"Left level II": Six lymph nodes, free of tumor.

"Left level III": Seven lymph nodes, free of tumor.

"Left level IV": Two lymph nodes, free of tumor.

pTNM stage: pT4aN0

**RADIOLOGY AND NUCLEAR MEDICINE REPORTS**

CT Chest and Neck with Contrast [Dated: 14/5/2015]

A 2.8 x 4.5 cm enhancing lesion noted in the lower lip. The lesion seen involving the entire lip. No evidence of

any bony erosion. Few (3-4) lymphnodes noted in the submental region largest measuring 11 x 9 mm.

Thyroid/cricoid and arytenoid cartilages are normal. The larynx and the tracheal air way are normal.

Hypopharynx and laryngopharynx are normal.No evidence of any retropharyngeal lesion. Parapharyngeal spaces

are normal. Bilateral neck vessels are normal. Thyroid gland shows homogenous dense enhancement and is

normal in size and outline. No focal lesion seen. No evidence of any enhancing lung lesion /nodule.

Treatment Given:

**SURGERY DETAILS :**

He underwent WLE of Lower lip lesion + BL SND (I-IV) + Radial forearm soft tissue free flap reconstruction +

Tracheostomy + SSG under GA on 4/06/15.

**RADIATION DETAILS :**

Intent: Curative [Post Operative Adjuvant Radiation Therapy]

Technique: IMRT.

Site of Disease: Lower Lip

Cat Scan Simulation on 10/8/2015

Complex Computerised Treatment Planning on

RT Started on

RT Completed on

Treatment breaks- Nil

Total Dose: 6000 cGy in 30 fractions

**Primary Tumour And Drainage Area :**

Site:

Portals:

Energy: 6 MV Photons

Dose: 000 cGy in fractions

Schedule: 200 cGy per fraction and 5 fractions a week

Dose prescribed to 100% isodose line

**TREATMENT COURSE :**

72 year gentleman, diagnosed as a case of Carcinoma Lower Lip, Post operative, pT4N0M0,

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 Combined 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 months].

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. Orally as tolerated