**Radiology Report**

**Created Date:** 09/10/2014

**Study Done:**

**CT CHEST CONTRAST**

*Clinical info: Known case of Ca tongue*

Normal mediastinal vascular structures.

The hila are normal.

The tracheobronchial tree is normal.

Normal lung parenchyma.

No pleural pathology.

Chest wall is normal.

Visualized upper abdomen unremarkable except for 2.3x1.7 cm simple cyst in segment IV A of liver.

Degenerative changes noted in bony vertebrae.

**Impression:**

***Known case of Ca tongue***

• **No focal lung parenchymal lesion.**

• **Simple hepatic cyst.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 28/10/2014

**Received on :** 28/10/2014

**Time of Sample receipt by Lab:** 12:10pm **Reported Date :** 28/10/2014

**Clinical Impression :**

Case of Ca. tongue

**Gross Description :**

Specimen (fresh) IV labelled " Ulcer right lateral border of tongue", consists of a single grey white tissue bit

measuring 0.7x0.5x0.3cm.

**Impression :**

Ulceration with dense inflammation and reactive atypia.

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 28/10/2014

**Received on :** 28/10/2014

**Reported Date :** 01/11/2014

**Clinical Impression :**

Left lateral border tongue SCC

**Gross Description :**

Received in fresh are 4 specimens. The I specimen labelled as "Additional deep medial margin", consists of a

single grey brown tissue bit measures 1.1x0.4x0.3cm.

Specimen II labelled as "Deep soft tissue margin", consists of a single grey brown tissue bit measures

1.8x1.1x0.5cm.

Specimen III labelled as "Additional left FOM margin", consists of a single grey brown tissue bit measures

1x0.5x0.2cm.

Frozen I,II and III read as : Negative

Specimen IV labelled as "Ulcer right lateral border of tongue", consists of a single grey white tissue bit measures

0.7x0.5x0.3cm.

Frozen IV read as :- Ulceration with reactive change

Subsequently received in formalin are 12 specimens. The I specimen labelled as "Sub total glossectomy

specimen", consists of tongue measures A-P 8cm, M-L 5cm, S-I 4cm. Left lateral surface shows a ulcerated

growth measures 3.8x2x1.5cm. The tumor is 1.5cm from anterior, 2cm from posterior, 1cm form left lateral

mucosa and soft tissue, 0.5cm from inferomedial mucosal and 1cm from inferomedial soft tissue margin. Tumor

depth-1.5cm. Representative sections are submitted as follows:-

A1 - Floor of mouth mucosal margin

A2 - Anterior

A3 - Posterior

A4 - Tumor with left lateral margin

A5 - A6: consecutive sections(tumor with inferomedial margin)

FB- tumor near deep margin.

Specimen II labelled as "Additional superior medial margin", consists of mucosa covered tissue bit measures

1x0.9x0.3cm. Entire specimen submitted in cassette B.

Specimen III labelled as "Left prefacial node", consists of a nodular fibrofatty tissue measures 2.5x2.4x1.5cm. 2

lymph nodes identified largest measures 1cm in greater dimension. Entire specimen submitted in C1 - C2

cassettes.

Specimen IV labelled as "Level Ia", consists of an fibrofatty tissue measures 4x1.5x0.5cm. 2 lymph nodes

identified largest measures 0.7cm in greater dimension. Representative sections are submitted in D1 - D2

cassettes.

Specimen V labelled as "Left level IB", consists of an nodular mass measures 5x4x1.8cm. Cut section shows

salivary gland appearance. 4 lymph nodes identified, largest measures 1.5cm. Representative sections are

submitted in E1 - E3 cassettes.

Specimen VI labelled as "Left level IIA", consists of an fibrofatty tissue measures 3.5x2.2x1cm. 5 lymph nodes

identified, largest measures 1.5cm in greater dimension. Representative sections are submitted in F1 - F3

cassettes.

Specimen VII labelled as "Left level IIB", consists of an fibrofatty tissue measures 1.5x1.2x0.3cm. 4 lymph

nodes identified, largest measures 0.5cm in greater dimension. Representative sections are submitted in G1 - G2

cassettes.

Specimen VIII labelled as "Left level III", consists of 2 nodular piece of fibrofatty tissue measures 4.5x4x1.3cm.

4 lymph nodes identified, largest measures 1.2cm in greater dimension. Representative sections are submitted in

H1 - H4 cassettes.

Specimen IX labelled as "Left level IV", consists of an fibrofatty tissue measures 1.5x1.1x0.8cm. Entire

specimen submitted in cassette J.

Specimen X labelled as "Right level Ib", consists of an nodular fibrofatty tissue measures 4x3.5x2cm. Cut

section shows salivary gland. ? 1 lymph node identified measures 1cm in greater dimension. Representative

sections are submitted in K1 - K3 cassettes.

Specimen XI labelled as "Right level IIa and III", consists of an fibrofatty tissue measures 5x4.5x1.4cm. 8 lymph

nodes identified, largest measures 1.6cm in greater dimension. Representative sections are submitted in L1-L3

cassettes.

Specimen XII labelled as "Right level IIb", consists of an fibrofatty tissue measures 2.5x1.5x0.9cm.

Representative sections are submitted in M1 - M2 cassettes.

**Microscopic Description :**

A and FB: "Subtotal glossectomy":

Shows mucosa with an infiltrating Moderately differentiated Squamous cell carcinoma. The tumor is 1.5cm from

anterior, 2cm from posterior, 1cm form left lateral mucosa and soft tissue, 0.5cm from inferomedial mucosal

and 1cm from inferomedial soft tissue margin. Vascular emboli and perineural invasion - absent. Tumor

depth-1.5cm.

B: " Additional superior medial margin": Shows mucosa, free of tumor.

C: "Left prefacial node": Three lymph nodes, free of tumor.

D: "Level Ia": One lymph node, free of tumor.

E: "Left level Ib": Six lymph nodes and salivary gland, free of tumor.

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

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

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

J: "Left level IV":Shows only fat and no lymph nodes, free of tumor.

K: "Right level Ib":Shows salivary gland, free of tumor.

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

M: "Right level IIb": Shows fibroadipose tissue and no lymph nodes, free of tumor.

**Diagnosis :**

Type of specimen: "Subtotal glossectomy":

Histological type: Squamous cell carcinoma

Differentiation : Moderate

Invasive front: Cohesive

Maximum depth of invasion: 1.5cm

Tumor size: 3.8x2x1.5cm

Vascular invasion- Absent

Nerve invasion-Absent

Margins:

The tumor is 1.5cm from anterior, 2cm from posterior, 1cm form left lateral mucosa and soft tissue, 0.5cm from

inferomedial mucosal and 1cm from inferomedial soft tissue margin.

"Additional superior medial margin": Free of tumor.

Lymph nodes:

"Left prefacial node": Three lymph nodes, free of tumor.

"Level Ia": One lymph node, free of tumor.

"Left level Ib": Six lymph nodes and salivary gland, free of tumor.

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

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

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

"Left level IV":Shows only fat and no lymph nodes, free of tumor.

"Right level Ib":Shows salivary gland, free of tumor.

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

"Right level IIb": Shows fibroadipose tissue and no lymph nodes, free of tumor.

pTNM stage: pT2N0

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| **Date of Admission :**27/10/2014 | **Date of Procedure :**28/10/2014 |

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| **Date of Discharge :**19/11/2014 |

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

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| **DIAGNOSIS :** |
| Moderately differentiated Squamous cell carcinoma of tongue |

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| **PROCEDURE DONE :** |
| 1. subtotal glossectomy + right 1-3 SND + left 1-4 SND+ ALT flap under GA on 28-10-2014 2. Re exploration and Debridement of ALT + Left Radial Forearm free flap under GA on 30-10-2014 3. Resuturing on 11-11-2014 4. PEG placement on 17-11-2014 |

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| **HISTORY :** |
| 67 year old Mr. Scaria Scaria presented here with lesion in left side tongue since 3 months gradually progressive. MRI done outside showed 2.4X3.6X2.8 cms lesion in left tongue, Few small oval to round lymph nodes are seen in level Ia, Ib, II and III. Largest node measures 1.4X0.7 cms. Biopsy reported as Infiltrating SCC- MDSCC. Came here for further management. |

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| **CLINICAL EXAMINATION :** |
| O/E- 5X4 cms endophytic lesion in left lateral border tongue extending from the tip to about 2 cms from circumvallate papillate . Laterally extending to floor of mouth, Mandible free. Lesion crossing midline BOT- Normal on palpation Scopy-- NAD Neck- 2x2 swelling in left level II region |

**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** |
| 29/10/2014 | 12.6 | 38.6 | 297 | 12.0 | 91.1 | 3.7 | 0.0 | - |
| 30/10/2014 | 9.8 | 29.6 | 225 | 9.8 | 88.6 | 6.4 | 0.0 | - |
| 31/10/2014 | 8.1 | 24.7 | 190 | 6.1 | 83.4 | 7.9 | 0.5 | - |
| 01/11/2014 | 10.3 | 31.1 | 174 | 10.8 | 90.4 | 4.9 | 0.0 | - |
| 02/11/2014 | 10.4 | 31.4 | 273 | 11.6 | 86.7 | 4.6 | 0.9 | - |
| 06/11/2014 | 11.0 | 33.4 | 510 | 16.4 | 84.9 | 5.6 | 2.3 | - |
| 16/11/2014 | 10.3 | 31.4 | 389 | 4.1 | 68.9 | 17.7 | 3.6 | - |

**Liver Function Test:**

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| **Date:** | **T. Bilirubin: mg/dl** | **D. Bilirubin: mg/dl** | **SGOT: IU/L** | **SGPT: IU/L** | **ALP: IU/L** | **T. Protein: gms/dl** | **S. Alb: g/dl** | **S. Glob: g/dl** |
| 30/10/2014 | 0.71 | 0.16 | 30.3 | 67.8 | 71.1 | 4.65 | 2.48 | 2.2 |

**Renal Function Test and Serum Electrolytes:**

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| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 28/10/2014 | - | - | 129.2 | 4.5 |
| 29/10/2014 | - | - | 127.7 | 4.2 |
| 30/10/2014 | 33.0 | 0.96 | 129.9 | 4.2 |
| 31/10/2014 | - | - | 129.4 | 4.0 |
| 01/11/2014 | - | - | 129.7 | 4.0 |
| 03/11/2014 | 28.2 | 0.72 | - | - |
| 05/11/2014 | 31.0 | 0.68 | 120.4 | 3.8 |
| 06/11/2014 | 40.4 | 0.68 | 125.7 | 4.2 |
| 07/11/2014 | 35.1 | 0.74 | 120.4 | 4.5 |
| 09/11/2014 | 26.5 | 0.76 | 122.1 | 3.7 |
| 11/11/2014 | 21.3 | 0.69 | 124.6 | 4.0 |
| 12/11/2014 | - | - | 120.3 | 3.6 |
| 13/11/2014 | 23.9 | - | 127.0 | 3.8 |

Date: 16/11/2014

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| PT[Prothrombin Time with INR]-Plasma : 17.4/14.60/1.25 sec | RBC-COUNT-Blood : 3.63 M/uL |

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| MCV-Blood : 86.4 fL | MCH-Blood : 28.5 pg |

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| MCHC-Blood : 33.0 g/dl | RDW-Blood : 14.5 % |

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| MPV-Blood : 5.8 fL | MONO -Blood : 9.5 % |

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| BASO-Blood : 0.3 % |  |

Date: 14/11/2014

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| Osmolality; urine : 386.0 mOsm/kg | Sodium; urine : 72.5 mmol/L |

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| Osmolality; blood : 270.0 mOsm/kg | T4 [Thyroxine] free-Serum : 1.30 ng/dl |

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| TSH [Thyroid Stimulating Hormo-Serum : 0.1341 uIU/ml |  |

Date: 06/11/2014

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| RBC-COUNT-Blood : 3.82 M/uL | MCV-Blood : 87.6 fL |

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| MCH-Blood : 28.7 pg | MCHC-Blood : 32.8 g/dl |

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| RDW-Blood : 13.8 % | MPV-Blood : 6.2 fL |

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| MONO -Blood : 7.0 % | BASO-Blood : 0.2 % |

Date: 02/11/2014

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| RBC-COUNT-Blood : 3.63 M/uL | MCV-Blood : 86.4 fL |

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| MCH-Blood : 28.8 pg | MCHC-Blood : 33.3 g/dl |

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| RDW-Blood : 13.6 % | MPV-Blood : 6.3 fL |

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| MONO -Blood : 7.4 % | BASO-Blood : 0.4 % |

Date: 01/11/2014

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| RBC-COUNT-Blood : 3.61 M/uL | MCV-Blood : 86.3 fL |

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| MCH-Blood : 28.6 pg | MCHC-Blood : 33.2 g/dl |

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| RDW-Blood : 13.5 % | MPV-Blood : 7.1 fL |

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| MONO -Blood : 4.4 % | BASO-Blood : 0.3 % |

Date: 31/10/2014

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| RBC-COUNT-Blood : 2.85 M/uL | MCV-Blood : 86.8 fL |

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| MCH-Blood : 28.3 pg | MCHC-Blood : 32.6 g/dl |

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| RDW-Blood : 13.5 % | MPV-Blood : 6.7 fL |

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| MONO -Blood : 8.0 % | BASO-Blood : 0.2 % |

Date: 30/10/2014

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| HB A1C[Glycated Hemoglobin]Whole Blood : 5.9 % | RBC-COUNT-Blood : 3.48 M/uL |

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| MCV-Blood : 84.9 fL | MCH-Blood : 28.1 pg |

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| MCHC-Blood : 33.1 g/dl | RDW-Blood : 13.0 % |

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| MPV-Blood : 7.0 fL | MONO -Blood : 4.9 % |

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| BASO-Blood : 0.1 % |  |

Date: 29/10/2014

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| Compatibility test; cross match complete (3 tests) : Compatible | RBC-COUNT-Blood : 4.54 M/uL |

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| MCV-Blood : 85.2 fL | MCH-Blood : 27.9 pg |

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| MCHC-Blood : 32.7 g/dl | RDW-Blood : 12.9 % |

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| MPV-Blood : 6.9 fL | MONO -Blood : 5.1 % |

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| BASO-Blood : 0.1 % |  |

Date: 28/10/2014

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| Glucose [F]-Plasma : 145.3 mg/dl | Compatibility test; cross match complete (3 tests) : Compatible |

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| Created Date:09/10/2014 Study Done: ULTRASOUND OF ABDOMEN LIVER Measures 13.5 cm. A 2.1 x 2 cm simple cyst in segment IV. No other focal lesions in liver. G.B Distended, multiple calculi noted largest measuring 8 mm. CBD/PV CBD appears normal. Portal vein shows normal calibre. SPLEEN Measures 8.1 cm. No focal lesion seen. PANCREAS Pancreatic head appears normal. Pancreatic body and tail is not visualised due to overlying bowel loops. KIDNEYS Normal in size, shape, position and echotexture. Corticomedullary differentiation is preserved. Cortical thickness is normal. Sinus echoes are normal. No hydronephrosis. BLADDER Distended. Echo free lumen. Walls are of normal thickness PROSTATE Measures 21 cc, Appears normal. No free fluid in abdomen. Retroperitoneum is not visualized due to overlying bowel gas. Impression: Known case of Ca tongue. Simple hepatic cyst. Cholelithiasis. Created Date:09/10/2014 Study Done: CT CHEST CONTRAST Clinical info: Known case of Ca tongue Normal mediastinal vascular structures. The hila are normal. The tracheobronchial tree is normal. Normal lung parenchyma. No pleural pathology. Chest wall is normal. Visualized upper abdomen unremarkable except for 2.3x1.7 cm simple cyst in segment IV A of liver. Degenerative changes noted in bony vertebrae. Impression: Known case of Ca tongue No focal lung parenchymal lesion. Simple hepatic cyst. Surgical Pathology Report Date of sample collection :28/10/2014 Received on :28/10/2014 Reported Date :01/11/2014 Histology Lab No :S14-12834 Clinical Impression : Left lateral border tongue SCC Gross Description : Received in fresh are 4 specimens. The I specimen labelled as "Additional deep medial margin", consists of a single grey brown tissue bit measures 1.1x0.4x0.3cm. Specimen II labelled as "Deep soft tissue margin", consists of a single grey brown tissue bit measures 1.8x1.1x0.5cm. Specimen III labelled as "Additional left FOM margin", consists of a single grey brown tissue bit measures 1x0.5x0.2cm. Frozen I,II and III read as : Negative Specimen IV labelled as "Ulcer right lateral border of tongue", consists of a single grey white tissue bit measures 0.7x0.5x0.3cm. Frozen IV read as :- Ulceration with reactive change Subsequently received in formalin are 12 specimens. The I specimen labelled as "Sub total glossectomy specimen", consists of tongue measures A-P 8cm, M-L 5cm, S-I 4cm. Left lateral surface shows a ulcerated growth measures 3.8x2x1.5cm. The tumor is 1.5cm from anterior, 2cm from posterior, 1cm form left lateral mucosa and soft tissue, 0.5cm from inferomedial mucosal and 1cm from inferomedial soft tissue margin. Tumor depth-1.5cm. Representative sections are submitted as follows:- A1 - Floor of mouth mucosal margin A2 - Anterior A3 - Posterior A4 - Tumor with left lateral margin A5 - A6: consecutive sections(tumor with inferomedial margin) FB- tumor near deep margin. Specimen II labelled as "Additional superior medial margin", consists of mucosa covered tissue bit measures 1x0.9x0.3cm. Entire specimen submitted in cassette B. Specimen III labelled as "Left prefacial node", consists of a nodular fibrofatty tissue measures 2.5x2.4x1.5cm. 2 lymph nodes identified largest measures 1cm in greater dimension. Entire specimen submitted in C1 - C2 cassettes. Specimen IV labelled as "Level Ia", consists of an fibrofatty tissue measures 4x1.5x0.5cm. 2 lymph nodes identified largest measures 0.7cm in greater dimension. Representative sections are submitted in D1 - D2 cassettes. Specimen V labelled as "Left level IB", consists of an nodular mass measures 5x4x1.8cm. Cut section shows salivary gland appearance. 4 lymph nodes identified, largest measures 1.5cm. Representative sections are submitted in E1 - E3 cassettes. Specimen VI labelled as "Left level IIA", consists of an fibrofatty tissue measures 3.5x2.2x1cm. 5 lymph nodes identified, largest measures 1.5cm in greater dimension. Representative sections are submitted in F1 - F3 cassettes. Specimen VII labelled as "Left level IIB", consists of an fibrofatty tissue measures 1.5x1.2x0.3cm. 4 lymph nodes identified, largest measures 0.5cm in greater dimension. Representative sections are submitted in G1 - G2 cassettes. Specimen VIII labelled as "Left level III", consists of 2 nodular piece of fibrofatty tissue measures 4.5x4x1.3cm. 4 lymph nodes identified, largest measures 1.2cm in greater dimension. Representative sections are submitted in H1 - H4 cassettes. Specimen IX labelled as "Left level IV", consists of an fibrofatty tissue measures 1.5x1.1x0.8cm. Entire specimen submitted in cassette J. Specimen X labelled as "Right level Ib", consists of an nodular fibrofatty tissue measures 4x3.5x2cm. Cut section shows salivary gland. ? 1 lymph node identified measures 1cm in greater dimension. Representative sections are submitted in K1 - K3 cassettes. Specimen XI labelled as "Right level IIa and III", consists of an fibrofatty tissue measures 5x4.5x1.4cm. 8 lymph nodes identified, largest measures 1.6cm in greater dimension. Representative sections are submitted in L1-L3 cassettes. Specimen XII labelled as "Right level IIb", consists of an fibrofatty tissue measures 2.5x1.5x0.9cm. Representative sections are submitted in M1 - M2 cassettes. (Dr.Neenu/sh) Microscopic Description : A and FB: "Subtotal glossectomy": Shows mucosa with an infiltrating Moderately differentiated Squamous cell carcinoma. The tumor is 1.5cm from anterior, 2cm from posterior, 1cm form left lateral mucosa and soft tissue, 0.5cm from inferomedial mucosal and 1cm from inferomedial soft tissue margin. Vascular emboli and perineural invasion - absent. Tumor depth-1.5cm. B: " Additional superior medial margin": Shows mucosa, free of tumor. C: "Left prefacial node": Three lymph nodes, free of tumor. D: "Level Ia": One lymph node, free of tumor. E: "Left level Ib": Six lymph nodes and salivary gland, free of tumor. F: "Left level IIa": Six lymph nodes, free of tumor. G: "Left level IIb": Six lymph nodes, free of tumor. H: "Left level III": Four lymph nodes, free of tumor. J: "Left level IV":Shows only fat and no lymph nodes, free of tumor. K: "Right level Ib":Shows salivary gland, free of tumor. L: "Right level IIa and III": Six lymph nodes, free of tumor. M: "Right level IIb": Shows fibroadipose tissue and no lymph nodes, free of tumor. Diagnosis : Type of specimen: "Subtotal glossectomy": Histological type: Squamous cell carcinoma Differentiation : Moderate Invasive front: Cohesive Maximum depth of invasion: 1.5cm Tumor size: 3.8x2x1.5cm Vascular invasion- Absent Nerve invasion-Absent Margins: The tumor is 1.5cm from anterior, 2cm from posterior, 1cm form left lateral mucosa and soft tissue, 0.5cm from inferomedial mucosal and 1cm from inferomedial soft tissue margin. "Additional superior medial margin": Free of tumor. Lymph nodes: "Left prefacial node": Three lymph nodes, free of tumor. "Level Ia": One lymph node, free of tumor. "Left level Ib": Six lymph nodes and salivary gland, free of tumor. "Left level IIa": Six lymph nodes, free of tumor. "Left level IIb": Six lymph nodes, free of tumor. "Left level III": Four lymph nodes, free of tumor. "Left level IV":Shows only fat and no lymph nodes, free of tumor. "Right level Ib":Shows salivary gland, free of tumor. "Right level IIa and III": Six lymph nodes, free of tumor. "Right level IIb": Shows fibroadipose tissue and no lymph nodes, free of tumor. pTNM stage: pT2N0 |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Patient was evaluated. After all preliminary investigations and evaluation he was taken up for surgery. He underwent 1. subtotal glossectomy + right 1-3 SND + left 1-4 SND+ ALT flap under GA on 28-10-2014. Re exploration and Debridement + Left Radial Forearm free flap under GA on 30-10-21014. Post operatively he had haematoma collection in neck so evacuation of heamatoma and Resuturing done on 11-11-2014. Patient was tried to feed orally with clear liquids, but patient had some aspiration hence swallowing consultation done. Gastromedicine consultation done for the PEG insertion. PEG placement done on 17-11-2014. Radiation oncology and Dental consultation done as per tumor board discussion. As per the PT2N0 he is planned for observation. During the hospital stay he had hyponatreamia and hiccups hence Nephrology consultation done and managed as per their advice. Cardiology consultation sought for the hypertension. Endocrinology consultation done for the diabetic management. Condition at discharge: Vitals stable,Afebrile. |

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| **OPERATIVE FINDINGS :** |
| 1) Subtotal glossectomy + right 1-3 SND + left 1-4 SND + ALT flap + Tracheostomy under GA 28/10/14 Findings: 5x4 cm , ulcero-infiltrative growth left tongue and dorsum, crossing midline, abutting the CV papillae, extending to the floor. left level IIA, IIB ,III LN +, largest 2x1 cm, firm right pre facial nodes + 0.5x0.5 cm ulcer right lateral tongue. procedure: per-oral WLE of tongue lesion done. class III defect, L+T+S. FS from margins negative. hemostasis achieved. close excision of right tongue lesion done. FS- reactive. B/L SND done preserving the facial vessels. drains put. Plastic Reconstructive Surgery Notes Reconstruction notes- ALT flap harvested from Rt thigh measuring about 7X7 cms with one perforater supplying the flap. Donor site closed with skin graft. Anastomosis done with facial artery and tributory just joing the IJV. Drains palced and closed in layers POD 2- Pt was reexplored on 30 10 14, Both artery and vein thrombosis was present hence flap was debrided and RAFF flap measuring 7X5 cms harvested from left forearm and inset done in subtotal glossectomy defect. Anastomosis done with lt superior thyroid artery and lt common facial vein. Flap was bleeding well wound closed in layers after placing drains. 2.Re exploration and Debridement + Left Radial Forearm free flap under GA on 30-10-21014 Procedure: Under GA, Free Radial Artery Forearm Flap Dimensions(7X5 cm) marked on Lt hand after draping and marking, tornique applied. Medial longitudinal skin incision is given. Suprafacial Dissection done medial to lateral using tenotomy scissors without damaging the medial antebrachial cutaneous nerve traveling in the muscular fascia. As dissection proceeds laterally, subfascial dissection done over the palmaris longus tendon (if present) and the flexor carpi radialis tendon without damaging the paratenon on these tendons. The radial longitudinal skin incision given and performed lateral-to-medial subfascial /suprafacial dissection over the large brachioradialis. The dorsal radial nerve is preserved. Brachioradialis tendon is widely undermined the and retracted it laterally. The radial artery pedicle is dissected distally. The cephalic vein is included / not included in the harvest. Fasciocutaneous paddle is pedicled by only the lateral intermuscular septum 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 or bipolar cautery on small vascular branches between the pedicle and underlying musculature. Donor area closed .SSG done. Flap harvested and insetted into the oral cavity. 3.Heamatoma evacuation+ Resuturing done on 11-11-2014 |

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| **ADVICE ON DISCHARGE :** |
| Review after 2 weeks in Head and Neck OPD |

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| **DIET RECOMMENDATIONS :** |
| PEG FEEDS 2.5 L per day |

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| **DISCHARGE MEDICATION :** |
| Tab. Glycomet GPI 1-0-1 X to be continued. Tab. Metoprolol 50 mg 1-1-1 to be continued. Tab. Nicardia 20 mg 1-1-1 to be continued. Tab. Losartan 25 mg to be continued. Tab. Pan 20 mg X 3 days Tab. Dolo 650 mg SOS for pain |

**Tumour Board Discussion**

**Date of tumor board discussion :** 15/10/2014

**Attendees :**

15.10.14

WLE tongue (Subtotal glossectomy)+ B/L Neck dissection+ ALT/ Gastro omental flap + Adjuvant

Pt not keen on stomach flap

**Tumour Board Discussion**

**Date of tumor board discussion :** 19/11/2014

**Attendees :**

PLAN:

close observation

Rationale :

discussed in TB and the issue was clinically although the tumour was big, the lesion was 3.8 cm and 1.5 cm deep

, so it is a pT 2No , no risk factors , margins well clear and so the protocol is close observation

**Progress Notes**

**Date : 01/12/2014**

**ProgressNotes :**

DIAGNOSIS :

Moderately differentiated Squamous cell carcinoma of tongue

PROCEDURE DONE :

1. subtotal glossectomy + right 1-3 SND + left 1-4 SND+ ALT flap under GA on 28-10-2014

2. Re exploration and Debridement of ALT + Left Radial Forearm free flap under GA on 30-10-2014

3. Resuturing on 11-11-2014

4. PEG placement on 17-11-2014

HPE report :

and TB discussion:

PLAN:

close observation

Rationale :

discussed in TB and the issue was clinically although the tumour was big, the lesion was 3.8 cm and 1.5 cm

deep , so it is a pT 2No , no risk factors , margins well clear and so the protocol is close observation

came for follow iup :

l/e:

locoregionally NAD

scopy done - rt vocal cord palsy , lt cords moving but not compensating

aspiration present

CSB iyer sir

ADV:

swallowing execises havw to be taught

follow up monthly

diabetic and hypertensive medications to be taken from a local physician

23/02/2015

came for review

nil special

no h/o aspiration as of now

o/e

flap - NED

scopy

Advised ; swallowing assesment

PEG to be retained for the time being

dental consult

**Progress Notes**

**Date : 06/03/2024**

**ProgressNotes :**

Moderately differentiated Squamous cell carcinoma of tongue

PROCEDURE DONE :

1. subtotal glossectomy + right 1-3 SND + left 1-4 SND+ ALT flap under GA on 28-10-2014

2. Re exploration and Debridement of ALT + Left Radial Forearm free flap under GA on 30-10-2014

3. Resuturing on 11-11-2014

4. PEG placement on 17-11-2014

PEG removal done in May 2021

follow up

No fresh complaints

O/E

LR NAD

pt taking orally

adv

review sos