**Radiology Report**

**Created Date:** 28/02/2017

**Study Done:**

**MRI TOUNGUE**

Enhancing lesion measuring 33.5 AP x 12.4 LAT x 21.7 CC mm (volume 8.9 cc)seen along the left lateral

border of middle third of oral tongue with infiltration of sublingual space.Myelohyoid is free.Lesion involves

styloglossus and hyoglossus muscle.Lesion do not cross the midline.Lesion show diffusion restriction

Total volume of tongue is 108 cc.

Rounded suspicious nodes are seen in left Ib and Ia.

Larynx and pharynx appear normal.

Bones appear normal..

**Impression:**

• **Enhancing lesion along the left lateral border of middle third of oral tongue with infiltration**

**of sublingual space suspicious nodes in left level Ib.**

**Radiology Report**

**Created Date:** 27/02/2017

**Study Done:**

**CT CHEST - CONTRAST**

***Clinical information- Known case of Ca tongue, to rule out metastasis***

***Status post ? right partial lobectomy for TB.***

Reduced volume of right lung seen likely due to post lobectomy changes.

Fibrosis with traction bronchiectasis seen in right middle lobe.

Nodular pleural thickening seen in right basal segments.

No lung nodules seen.

Subcentimetric right lower paratracheal nodes seen.

Tracheobronchial tree is normal.

Mediastinal vasculature is normal.

Liver appears normal in size and enhancement.

No focal lesion. No IHBRD.

Gall bladder and CBD are normal.

Pancreas is normal.

Adrenals are normal.

Visualized bones are normal.

**Impression:**

• **Fibrosis with traction bronchiectasis seen in right middle lobe.**

• **Nodular pleural thickening seen in right lower lobe.**

• **No lung nodules seen.**

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 01/03/2017

**Received on :** 01/03/2017

**Reported Date :** 04/03/2017

**Clinical Impression :**

Ca Tongue

**Gross Description :**

Received in formalin are 8 specimens.

The Ist specimen labelled as "WLE left lateral tongue (double stitch anterior, single stitch medial)" consists of

the same measuring 7 (A-P) x 5.5 (M-L) x 3.5 (S-I) cm. An ulceroinfiltrative lesion is noted on the lateral side of

tongue measuring 4.5 (A-P) x 3.5 (M-L) x 1 (S-I) cm. Another vague reddish lesion is noted at the anterior

margin (abutting) measuring 1.2 x 1 x 1 cm. The distance between the two lesions is 1.8 cm. Raw surface inked

and specimen is serially sliced into 14 slices. Main lesion is seen from slices 5 to 11. Cut surface shows grey

brown lesion, firm in consistency and is 3.2 cm from anterior soft tissue and mucosal margin, 2.5 cm from

posterior soft tissue and mucosal margin, 1 cm from medial soft tissue and mucosal margin, 0.7 cm from lateral

soft tissue and mucosal margin, 0.7 cm from deep inked soft tissuemargin. Depth of lesion - 1 cm. Thickness -

1.2 cm. Representative sections are submitted as follows

A1 - Anterior soft tissue /mucosal margin

A2 - Posterior soft tissue /mucosal margin

A3 - Medial soft tissue / mucosal margin

A4 - Lateral soft tissue / mucosal margin

A5 - Deep inked margin

A6 - A7 - Lesion

Specimen II labelled as "Final alveolar mucosal margin" consists of grey brown tissue bits measuring 0.4 cm in

greatest dimension. Entire specimen submitted in cassette B.

Specimen III labelled as "Level I A" consists of fibrofatty tissue measuring 5 x 3.5 x 1 cm. 1 Lymph node

identified measuring 0.5 cm in greatest dimension. Representative sections are submitted as follows

C1 - 1 Lymph node, bisected

C2 - 1 Lymph node

C3 - Fibrofatty tissue

Specimen IV labelled as "Left level I B" consists of multiple nodular fibrofatty tissue in aggregate measuring 6 x

4 x 2.5 cm. 7 Lymph nodes identified. Largest measuring 1 cm in greatest dimension. Specimen submitted as

follows

D1 - Largest Lymph node, bisected

D2 - 5 Lymph nodes

D3 - Salivary gland

Specimen V labelled as "Left level II A" consists of fibrofatty tissue measuring 4.5 x 4.5 x 1.5 cm. 4 Lymph

nodes identified. Largest measuring 1 cm in greatest dimension. Representative sections are submitted as follows

E1 - Largest Lymph node, bisected

E2 - 3 Lymph nodes

E3 - Fibrofatty tissue

Specimen VI labelled as "Left level II B" consists of nodular fibrofatty tissue measuring 3.5 x 2.5 x 1.5 cm. 4

Lymph nodes identified, largest measuring 1 cm in greatest dimension. Entire specimen submitted as follows

F1 - 1 Lymph node, bisected

F2 - 2 Lymph nodes

F3 - 1 Lymph node

F4 - F5 - Fibrofatty tissue

Specimen VII labelled as "Left level III" consists of nodular fibrofatty tissue measuring 5 x 2.5 x 2 cm. Largest

Lymph node measuring 1 cm in greatest dimension. Representative sections are submitted as follows

G1 - 3 Lymph nodes

G2 - 1 Lymph node, bisected

G3 - Largest Lymph node, bisected

Specimen VIII labelled as "Left level IV" consists of multiple nodular fibrofatty tissue measuring 5 x 2.5 x 2 cm.

2 Lymph nodes identified. Entire specimen submitted as follows

H1 - 2 Lymph nodes

H2 - H4 - Fibrofatty tissue

**Microscopic Description :**

Sections show tongue with an infiltrative neoplasm arising from the mucosal epithelium with superficial

ulceration composed of squamoid cells arranged in nests, anastomosing cords, trabeculae and singly scattered.

The cells have large nuclei with coarse clump chromatin and 1 - 2 conspicuous nucleoli. Cytoplasm is

eosinophilic with many showing individual cell keratinization. Keratin pearls noted. Spotty necrosis present.

Bizarre large tumour cells, multinucleated giant cells noted. Patchy dense lymphoplasmacytic cuffing noted at

the tumour infiltrating front. Adjacent epithelium show acanthosis.

**Impression :**

WLE left lateral tongue with additional margins and LND:

- Moderately differentiated squamous cell carcinoma.

- Tumour dimensions: 4.5 x 3.5 x 1 cm

- Depth of invasion - 1 cm

- LV emboli : Absent

- PNI present (>1 mm) (score 3+)

- WPO1 - Pattern 5 (3+)

- LHR Score - 1+

- Risk - High

Margin clearance:

Lateral soft tissue margin: 0.3 cm

Lateral mucosal margin :0.7 cm

Deep margin :0.5 cm

Anterior mucosal and soft tissue:3.2 cm

Posterior mucosal and soft tissue: 2.5 cm

Medial margin :1 cm

Final Alveolar mucosal margin :Free of tumour

Lymph nodes

Level I A: 1 Lymph node - free of tumour

Left level I B : 6 Lymph nodes - free of tumour

Left level II A : 3 Lymph nodes - free of tumour

Left level II B : 12 Lymph nodes - free of tumour

Left level III : 5 Lymph nodes - free of tumour

Left level IV : 5 Lymph nodes - free of tumour

pT3N0

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| **Radiology Report** |

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| |  | | --- | | **Created Date:**  03/01/2018 | |  | |
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| |  | | --- | | **Study Done:**  **MDCT NECK -CONTRAST**  ***Clinical details :- Follow up case of Ca tongue ( SCC ) involving left lateral border involving FOM. Status post WLE, ND ,  forearm flap, on 28/2/2017, chemotherapy and radiotherapy.***  Tongue shows surgical defect and post operative changes. No evidence of any abnormally enhancing foci to suggest recurrence.  No significant cervical lymphnodes, however tiny normally looking nodes present.  Rest of the neck spaces are normal.  No evidence of bony erosion. | |  | |
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| |  | | --- | | **Impression:**   1. **Clinical details:- Follow up case of Ca tongue (SCC) involving left lateral border involving FOM. Status post WLE, ND,  forearm flap, on 28/2/2017, chemotherapy and radiotherapy.** 2. **Tongue shows surgical defect and post operative changes. No evidence of any abnormally enhancing foci to suggest recurrence.** | |

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| **Radiology Report** |

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| |  | | --- | | **Created Date:**  03/01/2018 | |  | |
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| |  | | --- | | **Study Done:**  **CT CHEST-CONTRAST**  ***Clinical details :- Follow up case of Ca tongue ( SCC ) involving left lateral border involving FOM. Status post WLE, ND ,  forearm flap, on 28/2/2017, chemotherapy and radiotherapy.***  Reduced volume of right lung.  Fibrosis with traction bronchiectasis involving right middle lobe probably as a sequelae of pulmonary TB.  Irregular left sided pleural thickening.  rest of the lung parenchyma is normal. No metastatic lesions.  No significant mediastinal or hilar lymphnodes.  Mediastinal vascular structures are normal.  Bones are normal.  Liver appears normal. | |  | |
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| |  | | --- | | **Impression:**   1. **Clinical details:- Follow up case of Ca tongue (SCC) involving left lateral border involving FOM. Status post WLE, ND forearm flap, on 28/2/2017, chemotherapy and radiotherapy.** 2. **Fibrosis with traction bronchiectasis involving right middle lobe probably as a sequelae of pulmonary TB.** 3. **Irregular left sided pleural thickening.** | |

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| **Date of Admission :**26/02/2017 | **Date of Procedure :**28/02/2017 |

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| **Date of Discharge :**13/03/2017 |

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

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| **DIAGNOSIS :** |
| Squamous cell carcinoma of left lateral border of tongue involving FOM. |

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| **PROCEDURE DONE :** |
| WLE + ND + Forearm flap under general anesthesia on 28/02/2017. |

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| **DRUG ALLERGIES :** Not known. |

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| **HISTORY :** |
| 42 year old male patient, wholesale vegetable vendor, came with presenting complaints of left lateral border ulcer since 4 months. History of pain presents. No comorbidities. He was evaluated at a local hospital last week. Squamous cell biopsy had taken. Now came here for further management. |

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| **PERSONAL HISTORY :** |
| No comorbidities |

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| **CLINICAL EXAMINATION :** |
| On examination: General Condition fair. Vitals stable. Left lateral border 3 x 3 cm ulceroinfiltrative lesion. Tender, involving FOM but away from lower alveolus, 2cm away from tip , 2cm away from pharyngeal tongue, well away from midline. Mobility of tongue - not restricted neck . No lymph nodes palpable . |

**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** |
| 26/02/2017 | 16.1 | 48.3 | 224 | 10.5 | 65.4 | 22.7 | 2.0 | - |
| 01/03/2017 | 15.3 | 44.8 | 226 | 18.2 | 92.1 | 5.4 | 0.0 | - |
| 02/03/2017 | 12.8 | 37.7 | 203 | 15.27 | 86.4 | 10.1 | 0.1 | - |
| 04/03/2017 | 11.6 | 33.3 | 233 | 12.40 | 77.1 | 17.7 | 1.5 | - |
| 06/03/2017 | 11.3 | 32.4 | 293 | 13.10 | 78.1 | 15.3 | 1.6 | - |

**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** |
| 26/02/2017 | 0.56 | 0.07 | 34.0 | 48.8 | 99.0 | 6.82 | 4.07 | 2.8 |

**Renal Function Test and Serum Electrolytes:**

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| --- | --- | --- | --- | --- |
| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 26/02/2017 | 16.5 | 1.18 | 136.1 | 3.9 |
| 28/02/2017 | - | - | 138.3 | 3.9 |
| 01/03/2017 | - | - | 135.1 | 4.5 |

Date: 06/03/2017

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| RBC-COUNT-Blood : 3.86 M/uL | MCV-Blood : 83.9 fL |

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| MCH-Blood : 29.3 pg | MCHC-Blood : 34.9 g/dl |

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| RDW-Blood : 12.3 % | MPV-Blood : 9.5 fL |

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| MONO -Blood : 4.7 % | BASO-Blood : 0.3 % |

Date: 04/03/2017

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| RBC-COUNT-Blood : 3.96 M/uL | MCV-Blood : 84.1 fL |

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| MCH-Blood : 29.3 pg | MCHC-Blood : 34.8 g/dl |

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| --- | --- |
| RDW-Blood : 12.1 % | MPV-Blood : 10.8 fL |

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| MONO -Blood : 3.5 % | BASO-Blood : 0.2 % |

Date: 03/03/2017

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

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| Ketone [Urine] : \* 3+ mmol/L | Specific Gravity-urine : 1.010 NONE |

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| Blood [Urine] : Negative EU | Urobillinogen-urine : Normal umol/L |

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| Urine pH : 6.0 NONE | Nitrite-urine : Negative |

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| Clarity-urine : Clear | Color-urine : Light Yellow |

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| Leucocytes-urine : Negative | Pus Cells : 0-2 HPF NONE |

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| Urine Protein : Negative | Hyaline Cast : NIL |

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| Red Blood Cell : NIL HPF NONE | Epithelial cells : OCCA |

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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: 02/03/2017

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| RBC-COUNT-Blood : 4.40 M/uL | MCV-Blood : 85.7 fL |

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| MCH-Blood : 29.1 pg | MCHC-Blood : 34.0 g/dl |

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| --- | --- |
| RDW-Blood : 12.2 % | MPV-Blood : 10.9 fL |

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| --- | --- |
| MONO -Blood : 3.2 % | BASO-Blood : 0.2 % |

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| --- | --- |
| RBC-COUNT-Blood : 4.38 M/uL | MCV-Blood : 84.9 fL |

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| --- | --- |
| MCH-Blood : 28.5 pg | MCHC-Blood : 33.6 g/dl |

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| RDW-Blood : 12.3 % | MPV-Blood : 11.0 fL |

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| MONO -Blood : 3.3 % | BASO-Blood : 0.1 % |

Date: 01/03/2017

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| HB A1C[Glycated Hemoglobin]Whole Blood : 7.0 % | Compatibility test; cross match complete (3 tests) : Compatible |

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| Compatibility test; cross match complete (3 tests) : Compatible | RBC-COUNT-Blood : 5.29 M/uL |

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| MCV-Blood : 84.7 fL | MCH-Blood : 28.9 pg |

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| MCHC-Blood : 34.2 g/dl | RDW-Blood : 12.1 % |

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| MPV-Blood : 10.3 fL | MONO -Blood : 2.4 % |

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| BASO-Blood : 0.1 % |  |

Date: 28/02/2017

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| Glucose [F]-Plasma : 112.2 mg/dl |  |

Date: 27/02/2017

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

Date: 26/02/2017

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| Blood typing; ABO and RhD : O Rh D Positive | HBs Ag Test - Emergency Screen : 0.23 : Non reactive |

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| Anti HCV - Emergency Screen : 0.05 : Non reactive | HIV - Emergency Screen(P24 Ag and HIV 1 and 2 Ab) : 0.19 : Non reactive |

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| APTT[Activated Partial Thrombo-Plasma : 30.2/32.2 s | PT[Prothrombin Time with INR]-Plasma : 13.2/14.60/0.88 sec |

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| Glucose [R]-Plasma : 184.6 mg/dl | RBC-COUNT-Blood : 5.49 M/uL |

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| MCV-Blood : 87.9 fL | MCH-Blood : 29.3 pg |

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| --- | --- |
| MCHC-Blood : 33.3 g/dl | RDW-Blood : 13.3 % |

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| --- | --- |
| MPV-Blood : 8.4 fL | MONO -Blood : 9.4 % |

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| BASO-Blood : 0.5 % |  |

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| Surgical Pathology Report Clinical Impression :Ca Tongue Gross Description :Received in formalin are 8 specimens. The Ist specimen labelled as "WLE left lateral tongue (double stitch anterior, single stitch medial)" consists of the same measuring 7 (A-P) x 5.5 (M-L) x 3.5 (S-I) cm. An ulceroinfiltrative lesion is noted on the lateral side of tongue measuring 4.5 (A-P) x 3.5 (M-L) x 1 (S-I) cm. Another vague reddish lesion is noted at the anterior margin (abutting) measuring 1.2 x 1 x 1 cm. The distance between the two lesions is 1.8 cm. Raw surface inked and specimen is serially sliced into 14 slices. Main lesion is seen from slices 5 to 11. Cut surface shows grey brown lesion, firm in consistency and is 3.2 cm from anterior soft tissue and mucosal margin, 2.5 cm from posterior soft tissue and mucosal margin, 1 cm from medial soft tissue and mucosal margin, 0.7 cm from lateral soft tissue and mucosal margin, 0.7 cm from deep inked soft tissuemargin. Depth of lesion - 1 cm. Thickness - 1.2 cm. Representative sections are submitted as follows A1 - Anterior soft tissue /mucosal margin A2 - Posterior soft tissue /mucosal margin A3 - Medial soft tissue / mucosal margin A4 - Lateral soft tissue / mucosal margin A5 - Deep inked margin A6 - A7 - Lesion Specimen II labelled as "Final alveolar mucosal margin" consists of grey brown tissue bits measuring 0.4 cm in greatest dimension. Entire specimen submitted in cassette B. Specimen III labelled as "Level I A" consists of fibrofatty tissue measuring 5 x 3.5 x 1 cm. 1 Lymph node identified measuring 0.5 cm in greatest dimension. Representative sections are submitted as follows C1 - 1 Lymph node, bisected C2 - 1 Lymph node C3 - Fibrofatty tissue Specimen IV labelled as "Left level I B" consists of multiple nodular fibrofatty tissue in aggregate measuring 6 x 4 x 2.5 cm. 7 Lymph nodes identified. Largest measuring 1 cm in greatest dimension. Specimen submitted as follows D1 - Largest Lymph node, bisected D2 - 5 Lymph nodes D3 - Salivary gland Specimen V labelled as "Left level II A" consists of fibrofatty tissue measuring 4.5 x 4.5 x 1.5 cm. 4 Lymph nodes identified. Largest measuring 1 cm in greatest dimension. Representative sections are submitted as follows E1 - Largest Lymph node, bisected E2 - 3 Lymph nodes E3 - Fibrofatty tissue Specimen VI labelled as "Left level II B" consists of nodular fibrofatty tissue measuring 3.5 x 2.5 x 1.5 cm. 4 Lymph nodes identified, largest measuring 1 cm in greatest dimension. Entire specimen submitted as follows F1 - 1 Lymph node, bisected F2 - 2 Lymph nodes F3 - 1 Lymph node F4 - F5 - Fibrofatty tissue Specimen VII labelled as "Left level III" consists of nodular fibrofatty tissue measuring 5 x 2.5 x 2 cm. Largest Lymph node measuring 1 cm in greatest dimension. Representative sections are submitted as follows G1 - 3 Lymph nodes G2 - 1 Lymph node, bisected G3 - Largest Lymph node, bisected Specimen VIII labelled as "Left level IV" consists of multiple nodular fibrofatty tissue measuring 5 x 2.5 x 2 cm. 2 Lymph nodes identified. Entire specimen submitted as follows H1 - 2 Lymph nodes H2 - H4 - Fibrofatty tissue (Dr. Sikha/Son) Microscopic Description :Sections show tongue with an infiltrative neoplasm arising from the mucosal epithelium with superficial ulceration composed of squamoid cells arranged in nests, anastomosing cords, trabeculae and singly scattered. The cells have large nuclei with coarse clump chromatin and 1 - 2 conspicuous nucleoli. Cytoplasm is eosinophilic with many showing individual cell keratinization. Keratin pearls noted. Spotty necrosis present. Bizarre large tumour cells, multinucleated giant cells noted. Patchy dense lymphoplasmacytic cuffing noted at the tumour infiltrating front. Adjacent epithelium show acanthosis. Impression : WLE left lateral tongue with additional margins and LND: - Moderately differentiated squamous cell carcinoma. - Tumour dimensions: 4.5 x 3.5 x 1 cm - Depth of invasion - 1 cm - LV emboli : Absent - PNI present (>1 mm) (score 3+) - WPO1 - Pattern 5 (3+) - LHR Score - 1+ - Risk - High Margin clearance: Lateral soft tissue margin: 0.3 cm Lateral mucosal margin :0.7 cm Deep margin :0.5 cm Anterior mucosal and soft tissue:3.2 cm Posterior mucosal and soft tissue: 2.5 cm Medial margin :1 cm Final Alveolar mucosal margin :Free of tumour Lymph nodes Level I A: 1 Lymph node - free of tumour Left level I B : 6 Lymph nodes - free of tumour Left level II A : 3 Lymph nodes - free of tumour Left level II B : 12 Lymph nodes - free of tumour Left level III : 5 Lymph nodes - free of tumour Left level IV : 5 Lymph nodes - free of tumour pT3N0 |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| Patient came to our hospital with above mentioned complaints. After all investigation and evaluation he underwent the procedure. Post operative period was uneventful. At the time of discharge he is stable and afebrile. |

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| **OPERATIVE FINDINGS :** |
| Reconstruction with radial artery free flap under GA on 28/02/2017. WLE of tongue- defect involving more than half of tongue with floor of mouth and GB sulcus. Flap markings done on the left forearm after Allen's test. flap of 8x6cms marked,Under tourniquet control distal incision placed radial artery identified & ligated & divided. Medial incision placed & flap raised suprafacially from medial to lateral, the superficial radial nerve preserved. radial artery & cephalic vein dissected & harvested along with flap keeping the paratenon on all tendons intact. flap raised upto the cubital fossa & flap harvested. donor site closed in layers proximally & distally by ssg taken from the thigh. Flap inset done vessels tunneled under the mandible by a red rubber cathether to reach the left side of neck. Microvascular anastomosis - Flap pedicle to the left facial artery & EJV. Flap bleeding assessed. Treacheosotmy done. Left hand dressing & POP given.   |  |  | | --- | --- | | **ate of Admission :**27/03/2017 | **Date of Procedure :**28/03/2017 |  |  | | --- | | **Date of Discharge :**29/03/2017 |  |  | | --- | |  |  |  | | --- | | **Discharging Status :**FOLLOW UP DISCHARGE SUMMARY |  |  | | --- | | **DIAGNOSIS :** | | Squamous cell carcinoma of left lateral border of tongue involving FOM. S/p-WLE + ND + Forearm flap under general anesthesia on 28/02/2017. Bulky flap intra orally |  |  | | --- | | **PROCEDURE DONE :** | | Flap Reduction under GA on 28/03/2017 |  |  | | --- | | **HISTORY :** | | 42 year old male patient is a case of Squamous cell carcinoma of left lateral border of tongue involving FOM. S/p-WLE + ND + Forearm flap under general anesthesia on 28/02/2017. O/E: Flap bulky and pushing the tongue to the opposite side causing tongue bite(significant). Now admitted here for further management. |  |  | | --- | | **CLINICAL EXAMINATION :** | | On examination: General condition fair Vital stable Flap bulky and pushing the tongue to the opposite side causing tongue bite |   **INVESTIGATIONS :**  **Renal Function Test and Serum Electrolytes:**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** | | 28/03/2017 | - | - | 138.8 | 4.0 |   Date: 28/03/2017   |  |  | | --- | --- | | Glucose [F]-Plasma : 101.4 mg/dl |  |   Date: 27/03/2017   |  |  | | --- | --- | | Compatibility test; cross match complete (3 tests) : Compatible |  |  |  | | --- | | **COURSE IN THE HOSPITAL AND DISCUSSION :** | | 42 year old male patient came to our hospital with above mentioned complaints , S/p-WLE + ND + Forearm flap. After all investigation and evaluation he underwent Flap Reduction under GA. Post operative period was uneventful. On discharge he is stable, Afebrile. |  |  | | --- | | **OPERATIVE FINDINGS :** | | Flap Reduction under GA on 28/03/2017 Patient in supine position parts painted & draped. Flap at the tip of tongue raised, & flap thinned out. pedicle identified & ligated again after reducing the bulk of flap . hemostasis achieved. flap sutured with 3.0 vicryl. patient withstood procedure well. |  |  | | --- | | **PROGNOSIS ON DISCHARGE :** | | Stable Afebrile |  |  | | --- | |  | |  |  |  | | --- | | **PREVENTIVE ADVICE (LIFE STYLE MODIFICATION / HEALTH EDUCATION)IF ANY:** | | Wound care Oral care |  |  | | --- | | **DIET RECOMMENDATIONS :** | | Orally diet allowed diabetic diet |  |  | | --- | | **PHYSICAL ACTIVITY :** | | Normal |  |  | | --- | | **DISCHARGE MEDICATION :** | | Tab Pan 40mg 1-0-0 x 5 days Tab Dolo 650mg 1-1-1 x 5 days Tab Ciplox 500mg 1-0-1 x 5 days Chlorhexidine gargles 4-5 times per day T-Bact ointment for Local application at hand Tab. Telekast A 0-0-1 x continue Inj. Human Mixtard S/C 15-0-15 half hour before feeds x continue |  |  | | --- | | **PLAN ON DISCHARGE :** | | As Alveolar mucosal margin is free lateral to lateral margin Only Adj RT  **Tumour Board Discussion**  **Date of tumor board discussion :** 22/02/2017  **Relevant clinical details :**  42 yr old male patient, wholesale vegetable vendor, came with presenting complaints of:  left lateral border ulcer - since 4 months  h/o pain ++  S+(-, 4yrs),A+, C+(- 4yrs)  no comorbidities  was evaluated at a local hospital last week  was biopsied- SCC  have come here for further management  l/e:  KPS:90  left lateral border 3 x 3 cm ulceroinfiltrative lesion, tender, involving FOM but away from lower alveolus, 2cm  away from tip , 2cm away from pharyngeal tongue , and well away from midline  mobility of tongue - not restricted  neck - no lymph nodes palpable  **Histology (include histology done / reviewed elsewhere) :**  SCC  **Other relevant investigations (including metastatic workup) :**  MRI Head and Neck with contrast  CT Chest  Imp:Ca Tongue cT2N0M0  **Agreed Plan of management :**  Imaging  WLE + Left SND + /- STF +/-Adj  **Histopathology Tumour board**  **Date of tumor board discussion :** 15/03/2017  **Histology (include histology done / reviewed elsewhere) :**  WLE left lateral tongue with additional margins and LND:  - Moderately differentiated squamous cell carcinoma.  - Tumour dimensions: 4.5 x 3.5 x 1 cm  - Depth of invasion - 1 cm  - LV emboli : Absent  - PNI present (>1 mm) (score 3+)  - WPO1 - Pattern 5 (3+)  - LHR Score - 1+  - Risk - High  Margin clearance:  Lateral soft tissue margin: 0.3 cm  Lateral mucosal margin :0.7 cm  Deep margin :0.5 cm  Anterior mucosal and soft tissue:3.2 cm  Posterior mucosal and soft tissue: 2.5 cm  Medial margin :1 cm  Final Alveolar mucosal margin :Free of tumour  Lymph nodes  Level I A: 1 Lymph node - free of tumour  Left level I B : 6 Lymph nodes - free of tumour  Left level II A : 3 Lymph nodes - free of tumour  Left level II B : 12 Lymph nodes - free of tumour  Left level III : 5 Lymph nodes - free of tumour  Left level IV : 5 Lymph nodes - free of tumour  pT3N0  **Agreed Plan of management :**  As lateral margin is 0.3 cm  CT+RT  Re-discussion  As Alveolar mucosal margin is free lateral to lateral margin  Only Adj RT  **Progress Notes**  **Date : 20/03/2017**  **ProgressNotes :**  Squamous cell carcinoma of left lateral border of tongue involving FOM.  S/p-WLE + ND + Forearm flap under general anesthesia on 28/02/2017.  LE-edema in the neck, aspirated  OC-flap bulky, pushing the tongue to opposite side, causing biting  Plandoxycyline  x 5 days  review on next monday  RT to be decided on next visit  **Progress Notes**  **Date : 28/12/2020**  **ProgressNotes :**  Carcinoma Left Lateral border Tongue  Post WLE + ND + RAFF under general anesthesia on 28/02/2017.  Moderately Differentiated Squamous Cell Carcinoma  pT3N0M0  Completed Post Operative Adjuvant Radiation therapy using VMAT technique.  D/O Commencement of RT 24/04/2017  D/O Completion of RT 03/06/2017  o/e: L/R: NED  adv: review after 6 months  **Speciality :** RadiationOncology  **D/O Commencement of RT** 24/04/2017 **D/O Completion of RT** 03/06/2017  **FINAL DIAGNOSIS, STAGE AND HISTOLOGY**  Carcinoma Left Lateral border Tongue  Post WLE + ND + Forearm flap under general anesthesia on 28/02/2017.  Moderately Differentiated Squamous Cell Carcinoma  pT3N0M0  Completed Post Operative Adjuvant Radiation therapy using VMAT technique.  **CLINICAL HISTORY AND PHYSICAL FINDINGS**  42 year old gentleman, presented with complaints of left lateral border ulcer since 4 months  associated with pain for which was evaluated at a local hospital last week and was advised biopsy which reported  as Squamous Cell Carcinoma. He came to AIMS and was evaluated here at Head and Neck Surgery OPD  Clinical Examination showed left lateral border 3 x 3 cm ulceroinfiltrative lesion. Tender, involving FOM but  away from lower alveolus, 2cm away from tip , 2cm away from pharyngeal tongue, well away from  midline.Mobility of tongue - not restricted neck. No lymph nodes palpable .  He was evaluated with MRI Tongue [Dated: 28/2/2017] which showed enhancing lesion measuring 33.5 AP x  12.4 lateral x 21.7 CC mm (volume 8.9 cc) seen along the left lateral border of middle third of oral tongue with  infiltration of sublingual space.Myelohyoid is free. Lesion involves styloglossus and hyoglossus muscle. Lesion  do not cross the midline. Lesion show diffusion restriction. Total volume of tongue is 108 cc. Rounded  suspicious nodes are seen in left Ib and Ia.  CT Chest with Contrast fibrosis with traction bronchiectasis seen in right middle lobe. Nodular pleural  thickening seen in right lower lobe. No lung nodules seen.  After staging work up was he was diagnosed as a case of Locally advanced Carcinoma Left lateral border  Tongue and clinically staged as cT3N?MO  Hence he was planned for WLE + ND + Forearm flap under general anesthesia on 28/02/2017.  Post OP HPR reported as Moderately Differentiated Squamous Cell Carcinoma. Tumor size 4.5 x 3.5 x 1 cm.  DOI - 1 cm -LVI - Absent -PNI present (>1 mm) (score 3+) -WPO1 - Pattern 5 (3+) Margin clearance: Lateral  soft tissue margin: 0.3 cm Lateral mucosal margin :0.7 cm Deep margin :0.5 cm Anterior mucosal and soft  tissue:3.2 cm Posterior mucosal and soft tissue: 2.5 cm Medial margin :1 cm Final Alveolar mucosal margin  :Free of tumour Lymph nodes Level I A: 1 Lymph node - free of tumour Left level I B : 6 Lymph nodes - free of  tumour Left level II A : 3 Lymph nodes - free of tumour Left level II B : 12 Lymph nodes - free of tumour Left  level III : 5 Lymph nodes - free of tumour Left level IV : 5 Lymph nodes - free of tumour  He was pathologically staged as pT3N0  His case was re discussed in Head and Neck 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**  02/05/2017 14.6 44.8 282 11.37 92.5 4.8 0.0 -  08/05/2017 14.6 46.0 239 8.90 81.2 12.9 1.2 -  15/05/2017 14.9 46.2 233 6.59 80.4 12.4 1.5 -  22/05/2017 16.2 49.8 205 4.80 78.4 13.3 2.7 -  29/05/2017 15.1 47.4 245 6.62 87.0 6.2 1.2 -  **Renal Function Test and Serum Electrolytes:**  **Date: Urea: mg/dl Creatinine: mg/dl Na+: mEq/L K+: mEq/L**  02/05/2017 8.0 0.96 133.2 -  08/05/2017 9.1 0.87 138.2 3.9  15/05/2017 7.9 0.93 136.7 4.1  22/05/2017 8.6 0.70 138.0 4.29  29/05/2017 9.4 0.69 136.0 4.22  Date: 29/05/2017  RBC-COUNT-Blood : 5.59 M/uL MCV-Blood : 84.8 fL  MCH-Blood : 27.0 pg MCHC-Blood : 31.9 g/dl  RDW-Blood : 14.0 % MPV-Blood : 9.3 fL  MONO -Blood : 5.3 % BASO-Blood : 0.3 %  Date: 22/05/2017  Glucose [R]-Plasma : 120.3 mg/dl RBC-COUNT-Blood : 5.95 M/uL  MCV-Blood : 83.7 fL MCH-Blood : 27.2 pg  MCHC-Blood : 32.5 g/dl RDW-Blood : 13.6 %  MPV-Blood : 9.3 fL MONO -Blood : 5.2 %  BASO-Blood : 0.4 %  Date: 15/05/2017  Glucose [R]-Plasma : 127.6 mg/dl RBC-COUNT-Blood : 5.43 M/uL  MCV-Blood : 85.1 fL MCH-Blood : 27.4 pg  MCHC-Blood : 32.3 g/dl RDW-Blood : 13.6 %  MPV-Blood : 9.7 fL MONO -Blood : 5.5 %  BASO-Blood : 0.2 %  Date: 08/05/2017  RBC-COUNT-Blood : 5.37 M/uL MCV-Blood : 85.7 fL  MCH-Blood : 27.2 pg MCHC-Blood : 31.7 g/dl  RDW-Blood : 13.9 % MPV-Blood : 10.6 fL  MONO -Blood : 4.4 % BASO-Blood : 0.3 %  Date: 02/05/2017  RBC-COUNT-Blood : 5.26 M/uL MCV-Blood : 85.2 fL  MCH-Blood : 27.8 pg MCHC-Blood : 32.6 g/dl  RDW-Blood : 13.6 % MPV-Blood : 10.2 fL  MONO -Blood : 2.4 % BASO-Blood : 0.3 %  **HISTOPATHOLOGY REPORTS**  Post OP HPR [Dated; 4/3/2017, Histology Lab No :  S17-2563]  Moderately differentiated squamous cell carcinoma.  Tumour dimensions: 4.5 x 3.5 x 1 cm  Depth of invasion - 1 cm  LV emboli : Absent  PNI present (>1 mm) (score 3+)  WPO1 - Pattern 5 (3+)  LHR Score - 1+  Risk - High  Margin clearance:  Lateral soft tissue margin: 0.3 cm  Lateral mucosal margin :0.7 cm  Deep margin :0.5 cm  Anterior mucosal and soft tissue:3.2 cm  Posterior mucosal and soft tissue: 2.5 cm  Medial margin :1 cm  Final Alveolar mucosal margin :Free of tumour  Lymph nodes  Level I A: 1 Lymph node - free of tumour  Left level I B : 6 Lymph nodes - free of tumour  Left level II A : 3 Lymph nodes - free of tumour  Left level II B : 12 Lymph nodes - free of tumour  Left level III : 5 Lymph nodes - free of tumour  Left level IV : 5 Lymph nodes - free of tumour  pT3N0  **RADIOLOGY AND NUCLEAR MEDICINE REPORTS**  CT Chest with Contrast [Dated: 27/2/2017]  Reduced volume of right lung seen likely due to post lobectomy changes.Fibrosis with traction bronchiectasis  seen in right middle lobe. Nodular pleural thickening seen in right basal segments. No lung nodules  seen.Subcentimetric right lower paratracheal nodes seen. Tracheobronchial tree is normal.Mediastinal  vasculature is normal.Liver appears normal in size and enhancement.No focal lesion. No IHBRD.Gall bladder  and CBD are normal.Pancreas is normal.Adrenals are normal.Visualized bones are normal.  Impression:  Fibrosis with traction bronchiectasis seen in right middle lobe.  Nodular pleural thickening seen in right lower lobe.  No lung nodules seen.  MRI Tongue [Dated: 28/2/2017]  Enhancing lesion measuring 33.5 AP x 12.4 LAT x 21.7 CC mm (volume 8.9 cc)seen along the left lateral  border of middle third of oral tongue with infiltration of sublingual space.Myelohyoid is free.Lesion involves  styloglossus and hyoglossus muscle.Lesion do not cross the midline.Lesion show diffusion restrictionTotal  volume of tongue is 108 cc.Rounded suspicious nodes are seen in left Ib and Ia.Larynx and pharynx appear  normal.Bones appear normal..  Impression:  Enhancing lesion along the left lateral border of middle third of oral tongue with infiltration of sublingual  space suspicious nodes in left level Ib.  Treatment Given:  **RADIATION DETAILS :**  Intent: Curative  Technique: VMAT  Site of Disease: Tongue  Cat Scan Simulation on 13/4/2017  Complex Computerised Treatment Planning on 24/4/2017  RT Started on 24/4/2017  RT Completed on 3/6/2017  Treatment breaks- Nil  Total Dose: 6000 cGy in 30 fractions  **Primary Tumour And Drainage Area :**  Site:PTV 60 Gy [Tongue + Bilateral level I, II, III Nodal station]  Energy: 6 MV Photons  Dose: 6000 cGy in 30 fractions  Schedule: 200 cGy per fraction and 5 fractions a week  Dose prescribed to 100% isodose line.  Site:PTV 54 Gy= Left RP, Left IV, VI , Right IV- VI Nodal station  Energy: 6 MV Photons  Dose: 5400 cGy in 30 fractions  Schedule: 180 cGy per fraction and 5 fractions a week  Dose prescribed to 100% isodose line.  **TREATMENT COURSE :**  42 year old gentleman, diagnosed as a case of Carcinoma Tongue, Post Operative, completed  planned course of Post operative adjuvant Radiation therapy well without interruptions.  **ADVICES AT DISCHARGE, MEDICATIONS AND FURTHER PLAN**  1. Review after 1 and 2 weeks in RT OPD.  2. Review after 4-6 weeks in HNS-RT 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. | |