**MDCT NECK AND CHEST (CONTRAST)**

*Case of Ca tongue*

3.2 x 2.0 cm size mildly enhancing mass lesion is seen along anterior lateral border.

Rest of the oropharynx, nasopharynx and laryngopharynx appear normal.

Thyroid appear normal.

< 9 mm size bilateral level IB nodes.

Hyoid bone, thyroid, cricoid and arytenoid cartilage appear normal.

Carotid arteries and internal jugular vein are normal.

Mild bilateral centrilobular emphysema in upper lobes.

No focal lung lesions.

Mediastinum is in center. No mass.

Concentric hypertrophy of left ventricle.

No pleural effusion.

Chest wall and bones appear normal.

Multiple small bilateral simple renal cortical cyst.

Visualized neuroparenchyma appear normal.

**IMPRESSION**

*Case of Ca tongue*

        **Small enhancing growth along left lateral border of tongue.**

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| **OPERATION NOTE** |

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| **Age :**92Y 31D |

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| **Date :**17/02/2011 |

**SURGERY DETAILS**

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| **Preop Diagnosis:**Ca Lt tongue |

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| **Surgery planned:**WLE + Lt ND ( I-IV) +RFFF + Tracheostomy |

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| **Other Details :** |
| Under general anaesthasia.C/o 2 X2cm ulcer involving the Lt lateral border of tongue with surrounding induration.Margin marked.Wide excision done maintaining haemostasis. Frozen sent from all margin negative defect was 7 X6cms. Neck dissection done from LV I-IV. Sparing facial vessels. EJV IJV spinal accessory nerve.Radial forearm flap of 7X6cm harvested. Insetting done. Facial artery anastomosed to radial artery.EJV anastomosed to cephalic vein and vena commotants. Anastomosis achieved. Drain kept closed in layers. Tracheostomy done. |

**SURGICAL PATHOLOGY REPORT**

**Date of sample collection :** 17/02/2011

**Received on :** 17/02/2011

**Reported Date :** 21/02/2011

**Clinical Impression :**

Ca. tongue, post chemotherapy.

**Gross Description :**

Received fresh are 9 specimens. The Ist specimen labelled "Anterior Soft tissue" consists of single grey white

tissue bit measuring 0.5x0.5x0.2cm.

Specimen II labelled "Anterior Tip Mucosa", consists of grey white tissue bit measuring 0.6x0.5x0.2cm.

Specimen III labelled "Middle Dorsal Mucosa",consists of grey white tissue bit measuring 0.4x0.4x0.3cm.

Specimen IV labelled "Anterior Dorsal Mucosa" consists of grey white tissue bit measuring 0.4x0.4x0.2cm.

Specimen V labelled "Posterior Ventral Mucosa" consists of single grey white tissue bit measuring

0.5x0.4x0.2cm.

Specimen VI labelled "Anterior Ventral Mucosa" consists of grey white tissue bit measuriing 0.7x0.4x0.2cm

Specimen VII labelled "Posterior Dorsal Mucosa" consists of single grey white tissue bit measuring

0.5x0.5x0.2cmm.

Specimen VIII labelled "Middle Soft Tissue", consists of single grey white tissue bit measuring 0.4x0.4x0.2cm.

Specimen IX labelled "Posterior Soft Tissue", consists of single grey white tissue bit measuring 0.4x0.4x0.1cm.

Frozen read as

I. Anterior soft tissue margin - Negative

II. Anterior tip margin - Negative

III. Middle dorsal mucosa - Negative

IV. Anterior dorsal mucosa - Negative

V. Posterior ventral mucosa - Negative

VI. Anterior ventral mucosa - Negative

VII. Post dorsal mucosa - Negative . No mucosa seen.

VIII - Middle soft tissue - Negative (No mucosa)

IX. Posterior soft tissue - Negative (No mucosa)

Subsequently received in formalin are 6 specimens. The Ist specimen labelled "WLE tongue", consists of

tongue measuring 5.5x4x3cm, lateral border shows an ulcerative lesion measuring 0.5x0.5x0.2cm which is

situated 3cm from mucosal margin, 2.3cm from posterior mucosal margin, 2cm from superior mucosal margin

and 1cm from intramucosal margin . The lesion is situated 1cm from inferior mucosal margin, 2cm from superior

mucosal margin, 2cm from posterior mucosal margin. Entire specimen submitted as follows:

A1 - Anterior mucosal soft tissue margin

A2 - Posterior mucosal soft tissue margin

A3 - Superior mucosal soft tissue margin

A4 - Inferior mucosal soft tissue margin

A5 - Inked deep margin

A6 to A8 - From tumour

A9 - Soft tissue

A10 to A17 - Inferior half of tongue, anterior to posterior

A18 to A28 - Superior half of tongue, anterior to posterior

Specimen II labelled " Level Ia", consists of single fibrofatty tissue measuring 3.5x2x1cm. 2 lymph nodes

identified, larger one measuring 0.6x0.4x0.2cm, smaller one measuring 0.3x0.2x0.1cm. Representative sections

are submitted in cassette B.

Specimen III labelled "Left Level Ib", consists of 2 fibrofatty tissue in aggregate measuring 4.5x3.5x3cm. Cut

surface showed salivary gland tissue with 1 lymph node measuring 1.5x0.7cm. Representative sections are

submitted in cassettes C1 to C3.

Specimen IV labelled "Left Level II", consists of single fibrofatty tissue measuring 4.5x3x2cm. 4 lymph nodes

identified ranges from 0.2-0.3cm. Representative sections are submitted in cassettes D1 & D2.

Specimen V labelled "Left Level III", consists of 2 fibrofatty tissue measuring 4x3x3cm.. 2 lymph nodes

identified, each measuring 0.3cm. Cut surface pale brown. Representative sections are submitted in cassette E.

Specimen VI labelled "Left Level IV", consists of 2 fibrofatty tissue in aggregate measuring 5x4x4cm. 3 lymph

nodes identified size ranges from 0.8-0.2cm. Representative sections are submitted in cassettes F1 & F2.

**Microscopic Description :**

Frozen permanent confirms the frozen report.

WLE with left neck dissection (left Level Ia, Ib, left level II, III and IV) :

- Residual tumour seen in a K/C/O squamous cell carcinoma tongue, post chemotherapy.

- Residual tumour measures 0.5x0.5x0.2cm in maximum dimension. Adjoining areas show lymphoplasmacytic

and foreign body giant cell reaction.

- Superior, inferior , anterior , posterior mucosal soft tissue margins are all free of tumour.

- Superior half of tongue (anterior to posterior) is free of tumour infiltration.

- Inferior half of tongue ( 2 sections labelled A14 and A15) shows tumour.

- Lymphovascular emboli seen.

- 2 left level Ia lymph nodes show reactive change (0/2).

- 1 left level Ib lymph node show metastasis with perinodal spread (1/1).

Lymph node measures 1.5x0.7cm in maximum dimension.

- Salivary gland is free of tumour infiltration.

- 4 left level II lymph nodes show reactive change (0/4).

- 2 left level III lymph nodes show reactive change (0/2).

- 3 left level IV lymph nodes show reactive change (0/3).

rpTNM - rpT1N1Mx.

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| **Date of Admission :**14/02/2011 |

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| **Date of Discharge :**16/02/2011 |

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

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| **DIAGNOSIS :** |
| Carcinoma tongue. |

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| **HISTORY :** |
| 78 year old K. Madhusoodhanan presented to Head and Neck OPD with history of laryngopharyngeal malignancy, diagnosed in 1979 and received RT at RCC Trivandrum. He noticed a slow growing ulcer in the left lateral border of tongue. Biopsy done outside showed Well differentiated squmous cell carcinoma. Initial growth 5 x 4 cms or 4 x 3 cms - (2 different notes). He was given two cycles of Docetaxal and cisplatin - since nov 2010.MRI brain done outside showed suggestive of infarcts with oedema - however no neurological complaints.Now admitted for pre op investigations and ealuation. |

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| **PAST HISTORY :** |
| HTNx 30 yrs DM x 2 months, on insulin Had history of laryngopharyngeal malignancy in 1979 -RT at RCC |

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| **CLINICAL EXAMINATION :** |
| Examination revealed about 2 x 2 cms ulcer in the left lateral tongue min induration around it no ankyloglossia BOT - free Floor free Tongue movements - normal Neck - NAD |

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| MDCT NECK AND CHEST (CONTRAST) Date : 1/02/2011 Small enhancing growth along left lateral border of tongue |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| The patient was evaluated admitted for pre op investigations and ealuation. MDCT of neck was done on 01-02-2011, which showed small enhancing growth along left lateral border of tongue. Neurology consultation was done as MRI brain report showed infarcts with oedema. Endicrinology and Cardiology consultation was done for fitness for the surgery. |

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| **ADVICE ON DISCHARGE :** |
| Review in Head and Neck OPD. |

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| **PLAN ON DISCHARGE :** |
| Surgery. |

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| **Date of Admission :**16/02/2011 | **Date of Procedure :**17/02/2011 |

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| **Date of Discharge :**09/03/2011 |

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

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| **DIAGNOSIS :** |
| Carcinoma left tongue Post chemotherapy |

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| **PROCEDURE DONE :** |
| Wide local excision + Left neck dissection( level I-IV) + Radial forearm free flap reconstruction + Tracheostomy ( Head and Neck Major Resection , Reconstruction for cancer defect Grade II ) on 17-02-2011 under GA |

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| **HISTORY :** |
| 78 year old K. Madhusoodhanan presented to Head and Neck OPD with history of laryngopharyngeal malignancy, diagnosed in 1979 and received RT at RCC Trivandrum. He noticed a slow growing ulcer in the left lateral border of tongue. Biopsy done outside showed Well differentiated squmous cell carcinoma.and received two cycles of Docetaxal and cisplatin - since nov 2010. MRI brain done outside showed suggestive of infarcts with oedema - however no neurological complaints. Came here for further management |

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| **PAST HISTORY :** |
| Hypertensive x 30 yrs Diabetes Mellitus x 2 months, on insulin Had history of laryngopharyngeal malignancy in 1979 -RT at RCC |

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| **CLINICAL EXAMINATION :** |
| Examination revealed about 2 x 2 cms ulcer in the left lateral tongue min induration around it no ankyloglossia BOT - free Floor free Tongue movements - normal Neck - NAD |

**INVESTIGATIONS :**

**Haemogram:**

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| **Date:** | **Hb: g/dl** | **PCV: %** | **PLT: ku/ml** | **TC: ku/ml** | **DC: N %** | **L: %** | **E: %** | **ESR: mm/1st hr** |
| 17/02/2011 | 12.4 | 36.4 | 182.0 | - | - | - | - | - |
| 18/02/2011 | 10.3 | 30.2 | - | 8.92 | 88.6 | - | 0.0 | - |
| 19/02/2011 | 11.0 | - | - | - | 79.6 | - | 0.052 | - |
| 21/02/2011 | - | - | - | 11.2 | - | - | - | - |

**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** |
| 05/03/2011 | - | - | - | - | - | - | 2.36 | - |

**Renal Function Test and Serum Electrolytes:**

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| **Date:** | **Urea: mg/dl** | **Creatinine: mg/dl** | **Na+: mEq/L** | **K+: mEq/L** |
| 17/02/2011 | - | - | 139.2 | - |
| 20/02/2011 | - | - | 132.6 | - |
| 21/02/2011 | - | - | 132.8 | 3.74 |
| 27/02/2011 | - | - | 126.0 | - |
| 28/02/2011 | - | - | 132.0 | 3.6 |
| 02/03/2011 | - | - | 128.9 | - |
| 05/03/2011 | 32.5 | - | 129.5 | - |

Date: 08/03/2011

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| T4 [Thyroxine] free-Serum : 1.29 ng/dl | TSH [Thyroid Stimulating Hormo-Serum : 0.90 uIU/ml |

Date: 05/03/2011

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| CRP (C-reactive protein) : 151.87 mg/L |  |

Date: 21/02/2011

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| RBC-COUNT-Blood : 3.4 M/uL | MCH-Blood : 29.6 pg |

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| RDW-Blood : 16.3 % | MPV-Blood : 6.16 fL |

Date: 19/02/2011

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| RBC-COUNT-Blood : 3.76 M/uL | MONO -Blood : 6.13 % |

Date: 18/02/2011

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| MPV-Blood : 8.55 fL | BASO-Blood : 0.246 % |

Date: 17/02/2011

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| MCH-Blood : 29.9 pg | BASO-Blood : 0.437 % |

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| MDCT NECK AND CHEST (CONTRAST) Date : 1/02/2011 IMPRESSION Small enhancing growth along left lateral border of tongue. Surgical Pathology Report Service :Histopath - Wide local excision # buccal mucosa/Lip/Tongue Received on :17/02/2011 Reported Date :21/02/2011 Histology Lab No :S11-1802 Microscopic Description : Frozen permanent confirms the frozen report. WLE with left neck dissection (left Level Ia, Ib, left level II, III and IV) : - Residual tumour seen in a K/C/O squamous cell carcinoma tongue, post chemotherapy. - Residual tumour measures 0.5x0.5x0.2cm in maximum dimension. Adjoining areas show lymphoplasmacytic and foreign body giant cell reaction. - Superior, inferior , anterior , posterior mucosal soft tissue margins are all free of tumour. - Superior half of tongue (anterior to posterior) is free of tumour infiltration. - Inferior half of tongue ( 2 sections labelled A14 and A15) shows tumour. - Lymphovascular emboli seen. - 2 left level Ia lymph nodes show reactive change (0/2). - 1 left level Ib lymph node show metastasis with perinodal spread (1/1). Lymph node measures 1.5x0.7cm in maximum dimension. - Salivary gland is free of tumour infiltration. - 4 left level II lymph nodes show reactive change (0/4). - 2 left level III lymph nodes show reactive change (0/2). - 3 left level IV lymph nodes show reactive change (0/3). rpTNM - rpT1N1Mx. |

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| **COURSE IN THE HOSPITAL AND DISCUSSION :** |
| The patient was evaluated. MDCT neck and chest was done on 1-02-2011, which showed small enhancing growth along left lateral border of tongue. His case was discussed in Head and neck tumour board and it was decided to treat him with surgery. The patient was admitted and after all preliminary investigations and evaluation he was taken up for surgery. He underwent Wide local excision + Left neck dissection( level I-IV) + Radial forearm free flap reconstruction + Tracheostomy ( Head and Neck Major Resection , Reconstruction for cancer defect Grade II ) on 17-02-2011 under GA. Postoperatively he developed persistant hyponatermia, Nephrology consultation was sought and managed accordingly. On the sixth postoperative day tracheostomy tube was decannulated, but re insert the tube as he was not tolerated. He also developed both lower limb weakness, Neurology consulation sought and NCV done suggestive of diffuse sensory motor neuropathy secondary to diabetes and with possible contribution from chemotheraphy and critical illness neuropathy. Physiotherapy consultation was kept for the management of the same. Endocrinology consultation was sought for the management of high blood sugar. Based on the final histopathology report it was decided to treat him with adjuvant chemoradiation(Chemotheraphy deferred in view of comorbities and age). RT consultation deferred now due to poor genral condition. Condition at discharge: Afebrile, Ryles tube insitu, all sutures removed, Serum sodium: 129.5 mmol/litre. |

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| **OPERATIVE FINDINGS :** |
| Under general anaesthasia.C/o 2 X2cm ulcer involving the Lt lateral border of tongue with surrounding induration.Margin marked.Wide excision done maintaining haemostasis. Frozen sent from all margin negative defect was 7 X6cms. Neck dissection done from LV I-IV. Sparing facial vessels. EJV IJV spinal accessory nerve.Radial forearm flap of 7X6cm harvested. Insetting done. Facial artery anastomosed to radial artery.EJV anastomosed to cephalic vein and vena commotants. Anastomosis achieved. Drain kept closed in layers. Tracheostomy done. |

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| **DIET RECOMMENDATIONS :** |
| High protein diet / diabetic diet (2.5 litres/day) Added salt 8 gm /day Start oral blend diet |

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| **DISCHARGE MEDICATION :** |
| Tab. Pan 20 mg 1-0-1 x 5 days Tab. Dolo 650 mg SOS (10) Tab. Tenormin plus 100 mg 1-0-0 to be continued Cap. Renerve Plus 1-0-0 to be continued Inj. H. Actrapid 18-18-0 units S/C to be continued Inj. H. Mixtard 30/70 0-0-18 units S/C to be continued Hexidine mouth wash every fourth hourhly |

**PROGRESS NOTE**

**Progress Notes**

**Date : 28/03/2011**

**ProgressNotes :**

k/c/o ca left side of tongue post chemo and WLE+left ND+RFFF+tracheostomy

come for decannulation