ORAL CAVITY CASE
FOR LEARNING UNIT VI
ORL 251

Instructions: Accomplish the following tasks indicated in this case.

OPD SUBSPECIALTY CLINIC CONSULT: *ORAL CAVITY*

S> MD 44 Female from Iba, Zambales

Chief Complaint:
tongue mass, left lateral aspect

History of Present Illness:

1 year PTA: Patient noted a 1x1 cm ulceration on the L lateral side of the tongue initially associated with tenderness on tongue movement, pain NRS 5/10, usually when eating food, with no noted bleeding, Patient did not seek consult at this point in time.
In the interim, patient noted gradual enlargement of ulcer.

6 months PTA, Persistence of ulceration growing into a palpable mass prompted consult with a private GP where she was diagnosed to have a slow-healing tongue ulceration secondary to uncontrolled Diabetes Mellitus. Patient was given Metformin for sugar control.

2 months PTA: Non-resolution of ulcerated mass, in spite of anti-diabetic medication prompted second opinion from another physician. Patient was prescribed Metformin, Glimeperide, Betadine gargle. Still noted gradual enlargement of mass.

2 weeks PTA: Patient sought PGH ORL OPD consult where tongue tissue biopsy and Neck CT were done.

Review of Systems:

ROS:	(+) fever - occasional, low-grade (-) cough (-) colds (+) weight loss (-) palpitation (-) tremors	(+) tongue pain, NRS 6/10 (-) dyspnea (-) dysphagia (-) odynophagia (-) hoarseness	(-) headache (-) vertigo (-) ear pain (-) dizziness (-) BOV (-) diplopia (-) otorrhea (-) otorrhagia	(-) rhinorrhea (-) anosmia (-)nasal congestion / obstruction

Past Medical History:

(+) Diabetes Type II, on Glimeperide, Metformin
(-) Diabetes mellitus
(-) Pulmonary tuberculosis
(-) Bronchial asthma
(-) Allergies

Family Medical History:

(-) Hypertension
(+) Diabetes mellitus - mother
(-) Pulmonary tuberculosis
(-) Bronchial asthma
(-) Allergies

Social History:
Smoker, 1 pack per day, from 21 years old to present
Occasional alcoholic beverage drinker
Occasional betel nut chewer
Currently a housewife; high school graduate
Lives in a 2-story apartment house with her husband and daughter

O> On PE, the patient has the following findings: (description)

Ear: The pinna and external auditory canal were unremarkable, with no noted lesions or swelling. The right tympanic membrane and the left tympanic membrane were intact with positive cone of light. No noted discharge.

Nose: The nasal septum was midline with no deviations or septal spurs. No congestion or erythema was appreciated. On posterior rhinoscopy, there was no noted post-nasal drip, the turbinates and eustachian tube openings were visualized with no noted obstruction. No noted tenderness of the maxillary sinuses noted on palpation.

Oral: On inspection, noted left lateral tongue mass, more erythematous than the rest of the tongue, around 3.5 x 2.5 x 1 cm firm. On palpation, mass is tender but does not seem to cross the midline, not involving the base of tongue and floor of mouth. Tongue is still midline, uvula midline. Noted no limitations of range in motion. No noted exudates or active bleeding. Not involved are the lip, buccal mucosa, retromolar trigone, hard palate, gingiva, floor of mouth, base of tongue.

Indirect Laryngoscopy and Neck Exam: Fully mobile vocal folds without any mass.
On palpation of neck, noted 2x2x1 cm firm, nontender cervical lymphadenopathy on the left, Level II area of neck. Trachea palpated to be at midline.

TASK 1: Translate the above findings into the ENT Physical Examination drawings then take a picture or scan. (10%)

TASK 2: Based on the history and PE give at least 3 differential diagnoses and briefly explain. (10%)

DIAGNOSTICS:

The following are the diagnostic findings for our patient

CT Neck with Contrast	Contiguous axial images of the neck from the skull base to the thoracic inlet were obtained during the intravenous injection of

	non-ionic iodinated contrast. The visualized base of the skull and brain parenchyma appear normal. Focal defect possibly ulceration is noted along the left lateral surface of the anterior tongue, around 3.2 x 1.0 x 0.9 cm. Associated peripheral enhancement is appreciated. There is no evidence of a mass in the rest of the oral cavity and nasopharynx. The visualized sinuses are clear. An enlarged lymph node with necrosis is noted at the left side of the neck, Level II, around 1.9 x 1.4 x 1.5 cm. Several unenlarged lymph nodes are noted in either side of the neck. No mass is appreciated within the rest of the different neck spaces in both sides. The visualized vascular structures show normal enhancement with no evidence of thrombus formation within. The aerodigestive tract is patent. The submandibular, parotid, and thyroid glands are normal. The laryngeal structures as well as the hypopharyngeal region are normal. The thoracic inlet is normal. Impression: Focal defect possibly ulceration along the left lateral surface of the anterior tongue with associated peripheral enhancement. Consider an infectious/inflammatory etiology vs. new growth. Tissue correlation is recommended. Enlarged necrotic jugulodigastric lymph node, left.
Punch biopsy of the Tongue	Squamous Cell Carcinoma, keratinizing
Fasting blood sugar	100 mg/dL (normal)
HbA1c	6% (normal)
Chest X-ray	Essentially normal chest findings
Liver Ultrasound	Essentially normal liver ultrasound findings
Serum chemistry	AST 27 (normal) ALT 81 (normal) Alk Phos 81 (normal) Alb 49 (normal) Calcium 2.47 (normal)

A> TASK 3: Based on the history, PE and diagnostics give your complete assessment or diagnosis. (5%)

P> TASK 4: What are the plans for the patient? (15%)

A. Pharmacologic if any
B. Diet if any
C. Maneuvers if any
D. Lifestyle modification if any

E. Other diagnostics
F. Surgical option/s
G. Follow-up or admission

SURGICAL PLAN:

Assuming the patient underwent or was diagnosed with Tongue mass, probably malignant; Diabetes Mellitus, Type 2 and confirmed to have Tongue Squamous Cell Carcinoma Stage III (T2cN1M0). She was advised admission to undergo Wide Excision of Tongue mass, Level I-V neck dissection.

WARD 10 ADMISSION:

The patient was admitted at Ward 10. He/ she underwent Wide Excision of Tongue mass, Level I-V neck dissection under Elective OR. The following were the OR findings: Noted left tongue specimen positive for squamous cell carcinoma, well-differentiated, 2.5 centimeters in greatest tumor dimension. Tumor depth of invasion of 1.0 centimeter. Lymphovascular space and perineural invasion are present. Positive for tumor, 4/11 Level IIA Lymph nodes. Extranodal extension (1 mm) present with a 2 mm distance from the lymph node capsule.

FINAL HISTOPATHOLOGIC DIAGNOSIS

WIDE EXCISION, FROZEN SECTION AND LYMPH NODE DISSECTION:

SQUAMOUS CELL CARCINOMA, WELL - DIFFERENTIATED, 2.5 CENTIMETERS IN GREATEST TUMOR DIMENSION, SPECIMEN LABELED "LEFT TONGUE".
TUMOR DEPTH OF INVASION OF 1.0 CENTIMETER.
LYMPHOVASCULAR SPACE AND PERINEURAL INVASION ARE PRESENT.

POSITIVE FOR TUMOR:
-4 OUT OF 11 "LEVEL IIA LYMPH NODES".

EXTRANODAL EXTENSION (1 MM)IS PRESENT WITH A 2 MM DISTANCE FROM THE LYMPH NODE CAPSULE.

NEGATIVE FOR TUMOR;
- ANTERIOR MARGIN (0.5 CENTIMETER);
- POSTERIOR MARGIN (0.5 CENTIMETER);
- BASAL MARGIN (0.1 CENTIMETER);
- ANTEROMEDIAL MARGIN (0.5 CENTIMETER);
- ANTEROLATERAL MARGIN (0.1 CENTIMETER);
- POSTEROMEDIAL MARGIN (0.5 CENTIMETER);
- POSTEROLATERAL MARGIN (0.9 CENTIMETER);
- MEDIAL MARGIN (0.5 CENTIMETER);
- LATERAL MARGIN (1.0 CENTIMETER);
- FIBROMUSCULAR AND ADIPOSE TISSUES IN SPECIMEN LABELED "BASE OF TONGUE";
- FIBROMUSCULAR AND ADIPOSE TISSUES IN SPECIMEN LABELED "ANTEROLATERAL TONGUE";
- BENIGN SALIVARY GLANDS IN SPECIMEN LABELED "LEVEL IB";
- ALL 10 "LEVEL IA LYMPH NODES";
- ALL 5 "LEVEL IIB LYMPH NODES;
- ALL 8 "LEVEL III LYMPH NODES";
- ALL 2 "LEVEL IV LYMPH NODES"; and
- ALL 11 "LEVEL V LYMPH NODES";

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6 hrs post-op on dressing change, Jackson-Pratt drain noted to be 100 cc serosangunious in amount. Noted expanding hematoma on neck area.

TASK 5: What are all the possible complications of doing a neck dissection? Explain the signs and symptoms of the complications (things to watch out for). (15%)

TASK 6: What is most likely complication that the patient experienced? What is the treatment or management? (10%)

The patient was managed, operated for exploration and ligation of bleeders as an Emergency OR. After 2 days, noted decreasing trend in JP output, and JP drain removal was done. She eventually got well.

TASK 7: What is the discharge diagnosis of the patient? (5%)

he post-op medications given to the patient were the following:

Paracetamol tablet 500 mg/tab q6 as needed for pain
Co- amoxiclav 625 mg/tablet 3x a day for 7 days
Chlorhexidine gargle 3x a day for 7 days
Mupirocin ointment, apply once a day on post-operative site

TASK 8: Write the prescription for the patient. Scan or take a picture and attach. (15%)

The patient was advised to have the post-op labs done.

Follow-up one week with ORL after discharge for suture removal; follow-up with Oncology.

TASK 9: In your own words, preferably in Filipino, write your script on how you would explain the discharge diagnosis, prescription, other plans and follow-up to the patient. (15%)