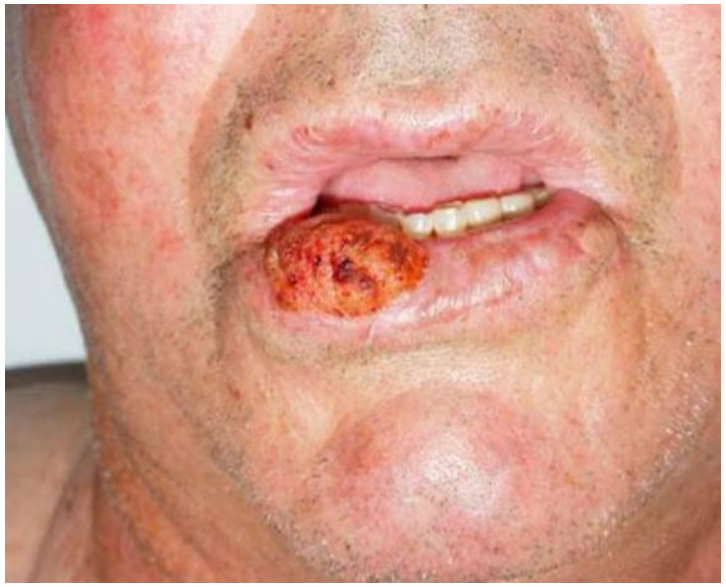
CASE PRESENTATION

Mr. Krishnan
65 years old male
from Teynampet
Working as watchman
Belonging to lower middle class



Came to the hospital with **CHIEF COMPLAINTS** of

- an ulcer on the right side of lower lip for past 2 years
- Pain over ulcer for past 5 months

HISTORY OF PRESENTING ILLNESS

Patient was apparently normal 2 years back

After which he developed an **ULCER**

- For 2 years
- Insidious in onset
- Initially small in size
- Gradually progressive
- To attain present size
- Associated with **DISCHARGE** – scanty serous, not foul smelling, not blood stained

HISTORY OF PRESENTING ILLNESS

PAIN:

- For the past 5 months
- Over the ulcer
- Insidious onset
- Intermittent, pricking type of pain
- Not referred, not radiating
- No aggravating and relieving factors

- H/O difficulty in chewing
- H/O difficulty in swallowing

HISTORY OF PRESENTING ILLNESS

- No H/O excessive salivation
- No H/O difficulty in opening the mouth
- No H/O difficulty in protruding the tongue
- No H/O deviation of tongue
- No H/O difficulty in speech
- No H/O numbness or paresthesia
- No H/O trauma, evening rise of temperature
- No H/O swelling elsewhere in the body
- No H/O loss of weight or appetite

PAST HISTORY

- Patient had no similar complaints in the past
- No H/O previous surgery or hospitalization
- No H/O DM, HT, TB, Asthma, Epilepsy, Jaundice
- No H/O ill fitting dentures
- No H/O tooth extraction, sharp tooth
- No H/O STDs
- No H/O chronic drug intake or irradiation

PERSONAL HISTORY

- Consumes mixed diet
- Normal bowel and bladder habits
- Smoker for past 40 years, 3 cigarettes/day
- Alcoholic, consumes 180ml occasionally
- H/O spicy food intake
- No H/O drug or food allergy

FAMILY HISTORY

- No significant family history

GENERAL EXAMINATION

- Patient is conscious, oriented, moderately built and nourished
- Pallor present
- No icterus
- No cyanosis
- No clubbing
- No pedal edema
- No generalized lymphadenopathy

VITALS

- **PULSE RATE**: 82/min, regular in rhythm, normal in volume, no specific character, no radio radial/ radio femoral delay, felt in all peripheral pulses

- **BLOOD PRESSURE**:128/80 mmHg measured in the right upper arm in sitting posture

- **RESPIRATORY RATE**: 16/min, abdomino thoracic

- **TEMPERATURE**: afebrile

LOCAL EXAMINATION OF ORAL CAVITY

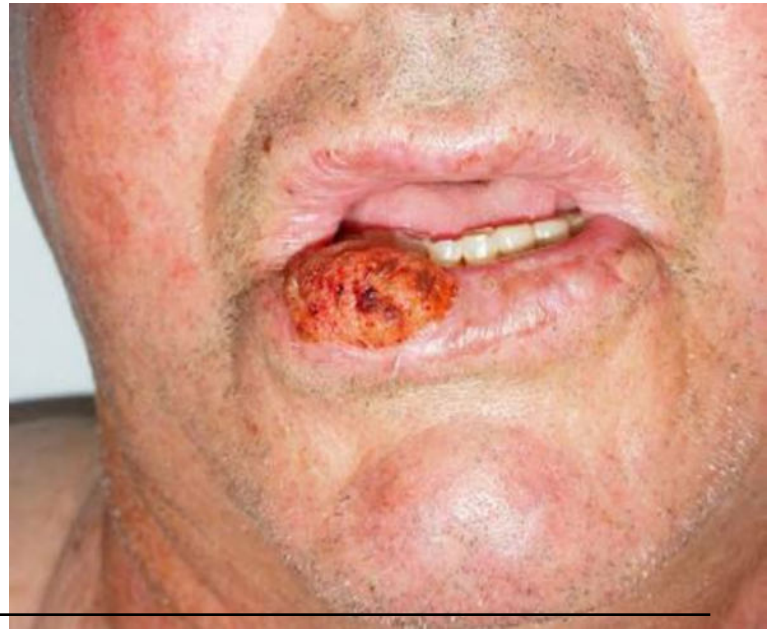
INSPECTION

After getting consent, the patient is examined in bright light

LIPS: a single oval ulcer of 3x3cm, in the lower lip on the right side

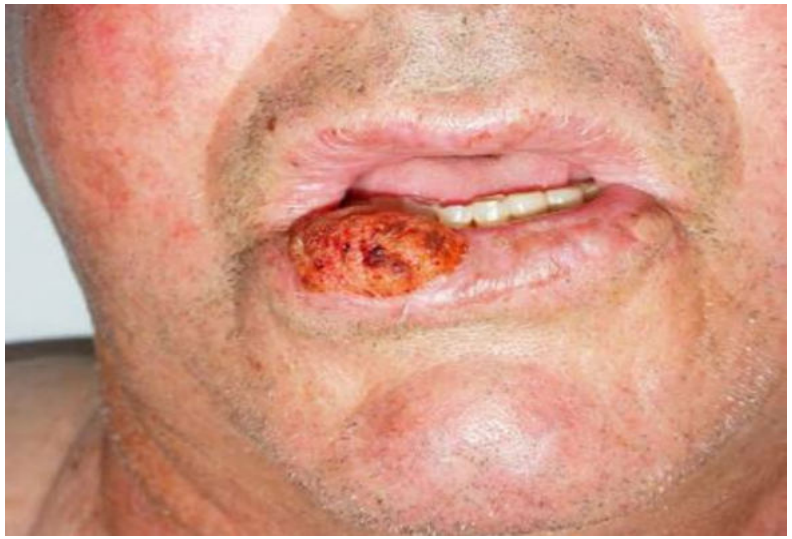
Extent:

- Anterior - upto vermillion border
- Posterior - 2cm from lower gingivo buccal sulcus
- Lateral - 0.5 cm from angle of mouth
- Medial - midline (not crossing the midline)



INSPECTION

- With well defined margins
- Everted and rolled out edges
- Floor has necrotic material
- with serous discharge
- Surrounding skin – normal
- No scars, sinuses, dilated veins
- No pigmentation



- **GUMS** : normal
- **ALVEOLA** : normal
- **BUCCAL MUCOSA** : normal
- **TEETH** :

2123	2123
2123	2123

- No dental caries
- No sharp tooth
- No staining of teeth
- Good oral hygiene, no halitosis

TONGUE :

- Pink in colour
- Dorsal and ventral surfaces – normal
- No ulcers or lesions
- Able to protrude the tongue
- No deviation
- Mobility of tongue normal

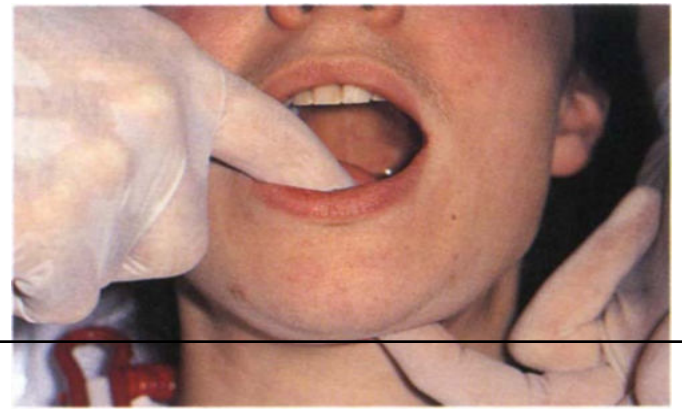
RETROMOLAR TRIGONE : normal

FLOOR OF MOUTH : normal

- **HARD AND SOFT PALATE :** normal
- **UVULA:** in midline
- **ANTERIOR AND POSTERIOR PILLAR :** normal
- **TONSILS**: normal
- **POSTERIOR PHARYNGEAL WALL**: normal
- **TEMPERO MANDIBULAR JOINT**: normal, no restriction of movements

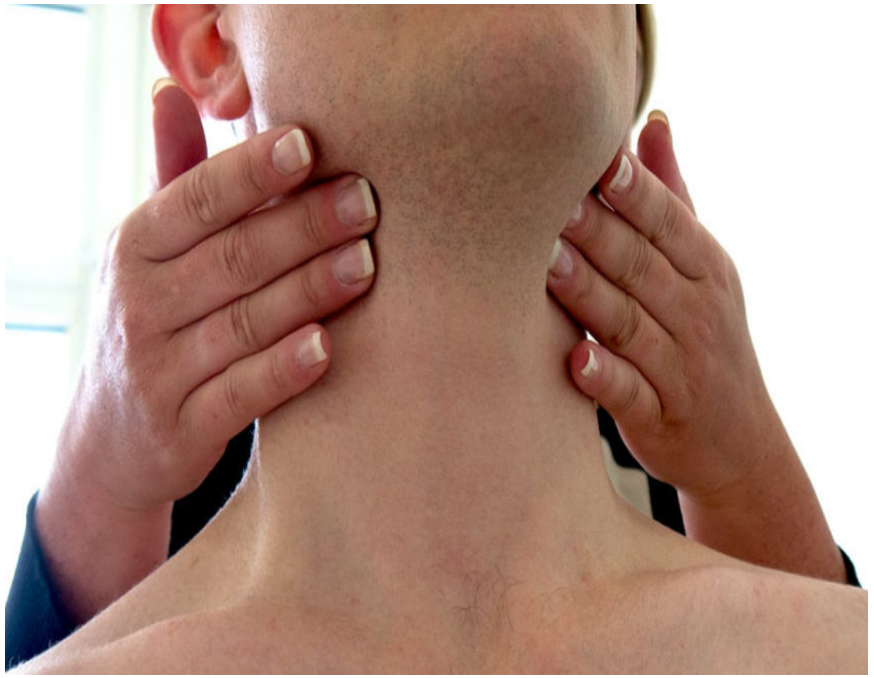
PALPATION

- Warmth +
- Not tender
- Inspectory findings of site, size, shape, extent are confirmed
- Hard in consistency
- Base indurated
- Surrounding skin indurated upto 1 cm around lesion
- Mobile
- Do not bleed on touch
- Not fixed to mandible
- No mandibular thickening



EXAMINATION OF LYMPH NODES

A single, round, mobile, hard lymph node of size 2x1cm palpable in the right jugulo - digastric region (level 2)



SYSTEMIC EXAMINATION

RESPIRATORY SYSTEM:

- Normal vesicular breath sounds heard
- No added sounds

CARDIOVASCULAR SYSTEM:

- S1,S2 heard
- No murmurs

CENTRAL NERVOUS SYSTEM:

No focal neurological deficit

ABDOMEN:

- Soft, non tender, no organomegaly, no free fluid, no palpable mass
- Hernial orifices free
- External genitalia - normal

DIAGNOSIS

- CARCINOMA OF LOWER LIP ON RIGHT SIDE
- INVOLVING LEVEL II LYMPH NODES OF NECK
- WITH TMN STAGING OF T2 N1 M0
- STAGE III

Stage			
0	Tis	N0	M0
I	T1	N0	M0
II	T2	N0	M0
III	T3	N0	M0
	T1, T2, T3	N1	M0
IV	T4	N0	M0
	Any T	N2	M0
	Any T	N3	M0
	Any T	Any N	M1

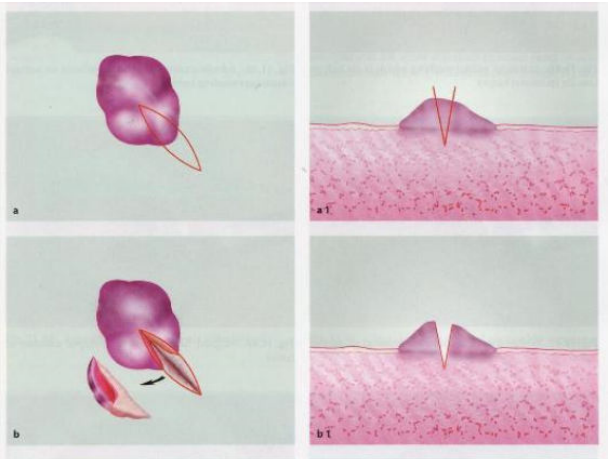
T1	<2 cm
T2	>2 cm to 4 cm
T3	>4 cm
T4	Adjacent structure
N1	Ipsilateral single <3 cm
N2	Ipsilateral single >3 cm Ipsilateral multiple <6 cm Bilateral, contra lateral <6 cm
N3	>6 cm
MX	Distant metastasis cannot be assessed
M0	No distant metastasis
M1	Distant metastasis

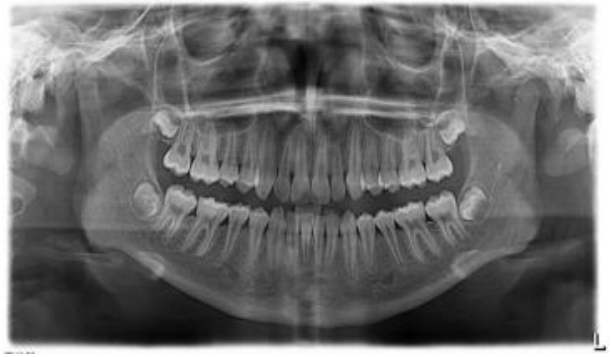
BASELINE INVESTIGATIONS

- Complete hemogram – TC, DC, ESR, Hb%
- Urine - sugar, proteins, deposits
- Blood - sugar, urea, creatinine
- Xray chest
- ECG

SPECIFIC INVESTIGATIONS

- Edge wedge biopsy
- USG neck
- FNAC of the node
- Orthopantomogram
- CT for bone invasion
- MRI for soft tissue invasion
- Laryngoscopy





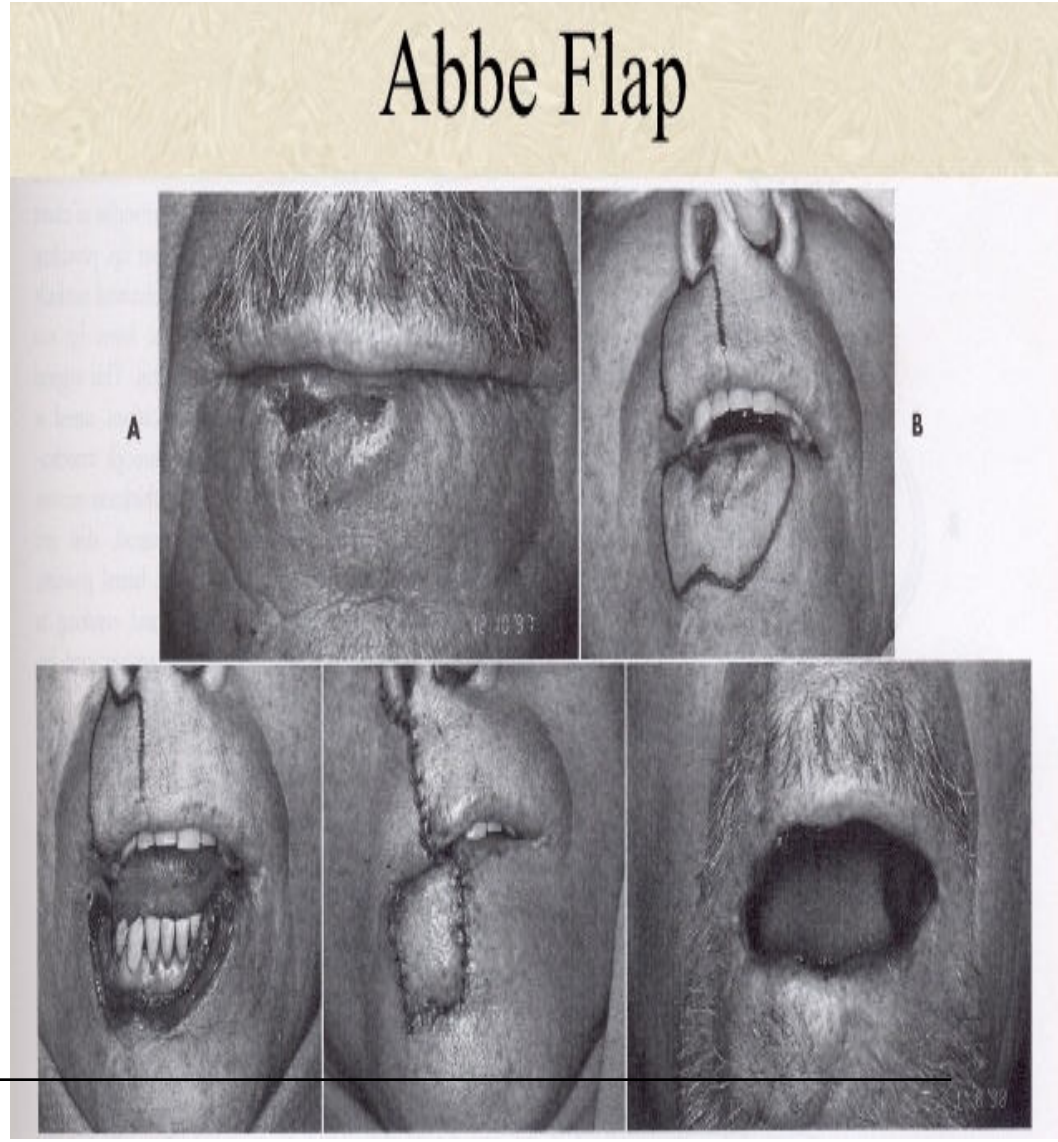
- **FOR METASTASIS**: Xray chest, USG abdomen

TREATMENT

TUMOR OF SIZE >2 CM

Resection and Reconstruction

- Abbe's flap (flap based on labial artery)
- Bernard rotation flap



METASTATIC LYMPH NODE

- Selective supra omohyoid neck dissection