ANNUAL CLINICAL MEETING

DEPARTMENT OF OTORHINOLARYNGOLOGY AND HEAD AND NECK SURGERY

BUCCAL MALIGNANCY AND ULCERS CASE SERIES

DR. SHUBHANGI PRASAD

EPIDEMIOLOGY

- Buccal mucosa- commonest site for oral cancers in South East Asia- upto 40% cases
- Carcinogenic agents- tobacco, areca nut, alcohol (synergistic effect)
- In India- male to female ratio: 4:1
- Typically occurs over 40 years of age
- Oral submucous fibrosis and lichen planus- premalignant conditions

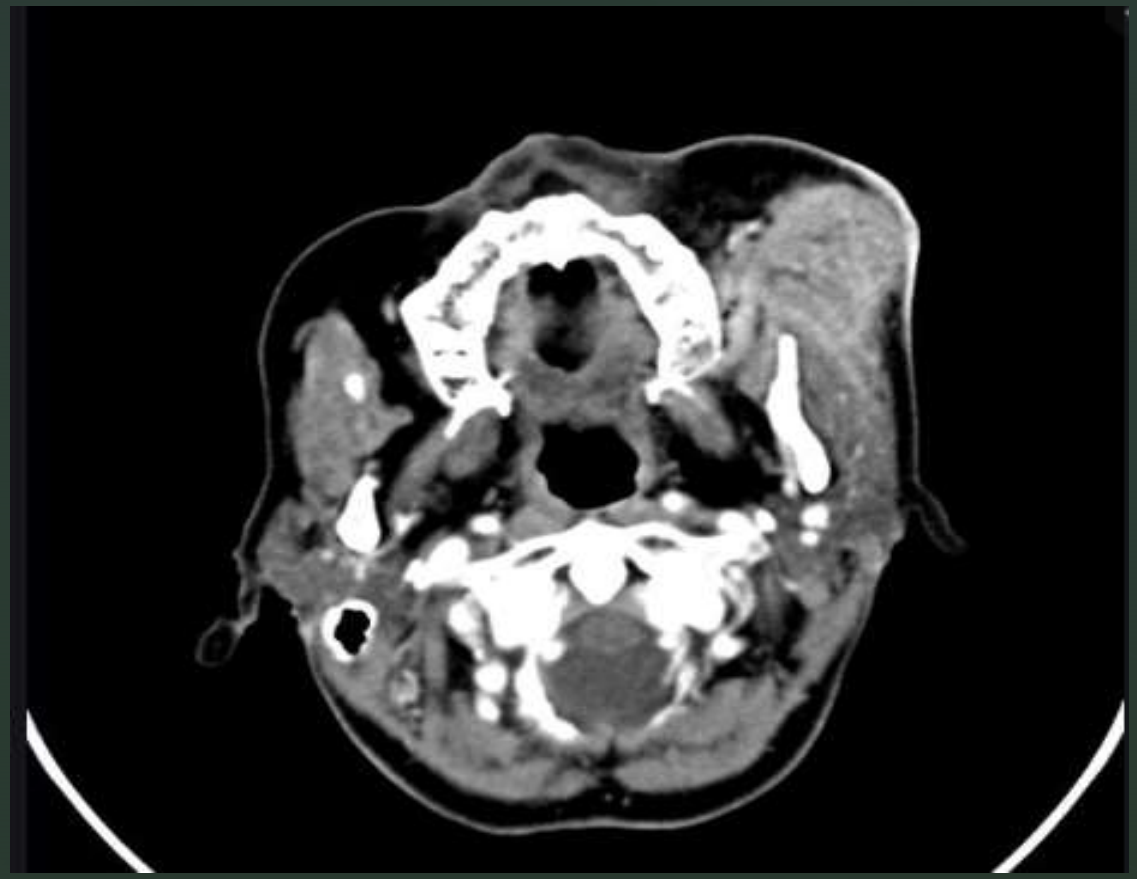
- From January 2019 to December 2020, over 1 year period, 15 carcinoma buccal mucosa patients were admitted under ENT dept at Dr D Y PATIL HOSPITAL, and evaluated
- Detailed history was taken and thorough clinical examination was done
- The combined assessment of biopsy reports and imaging was used
- TNM staging was done based on clinical examination
- 7 of the cases which involved base of tongue or with distant metastasis (stage IV b or IV c) were sent for palliative chemoradiotherapy.
- Rest of the above mentioned cases were either stage I, II, III or IVa and were managed by surgical intervention and adjuvant therapy wherever necessary.

- Presentation- verrucous, or exophytic, or ulceroproliferative character
- Pain with intra oral mass, ulceration or trismus
- Patients who chew betel often have erythroplakia of buccal mucosa, or submucous fibrosis and trismus
- Buccal carcinoma associated with paan chewing is less likely to metastasize to regional lymph nodes, because of local fibrosis associated with submucous fibrosis
- Trismus- difficult for examining physicians and surgeons

INVESTIGATIONS

- Biopsy: it should include the deep margins of tumour in addition to the mucosa at the periphery of the lesion.
- The imaging modality depends on the clinical extent of disease (puffed cheeks)
- CT- for bone involvement.
- MRI- for soft tissue extent
- USG for cervical lymphadenopathy

- CT scan gives assessment for tumour location, spread and is the imaging of choice if suspecting bone involvement e.g. mandibular involvement



- MRI gives accurate soft tissue involvement and extent.

RISK FACTOR STUDY IN ABOVE CASES

CASES	ALCOHOL	TOBACCO CHEWING/MISHRI	SMOKING
8	YES	YES	YES
4	YES	YES	NO
2	YES	NO	YES
1	YES	YES	YES

- According to detailed clinical examination, biopsy reports, and imaging studies, out of the 15 cases, 7 cases were inoperable, either due to extensive local infiltration, or due to distant metastasis. Palliative chemoradiotherapy was given to these patients.

- The rest 8 cases were operated according to their subsequent staging

CASE NUMBER	STAGE	LN INVOLVEMENT	SURGICAL MANAGEMENT	HISTOPATHOLOGICAL FINDING
3	T1N0M0	No	Wide Local Excision	Leukoplakia
1	T1N0M0	No	Wide Local Excision	Erythroplakia
2	T2N0M0	No	Wide Local Excision	Squamous Cell Carcinoma
1	T1N1M0	Yes (Ipsilateral IB)	Wide Local Excision with Supraomohyoid Neck Dissection	Squamous Cell Carcinoma
1	T4aN2aM0 (Mandible involvement)	Yes (Ipsilateral IB)	Wide Local Excision + Hemimandibulectomy + MRND Type III	Poorly Differentiated

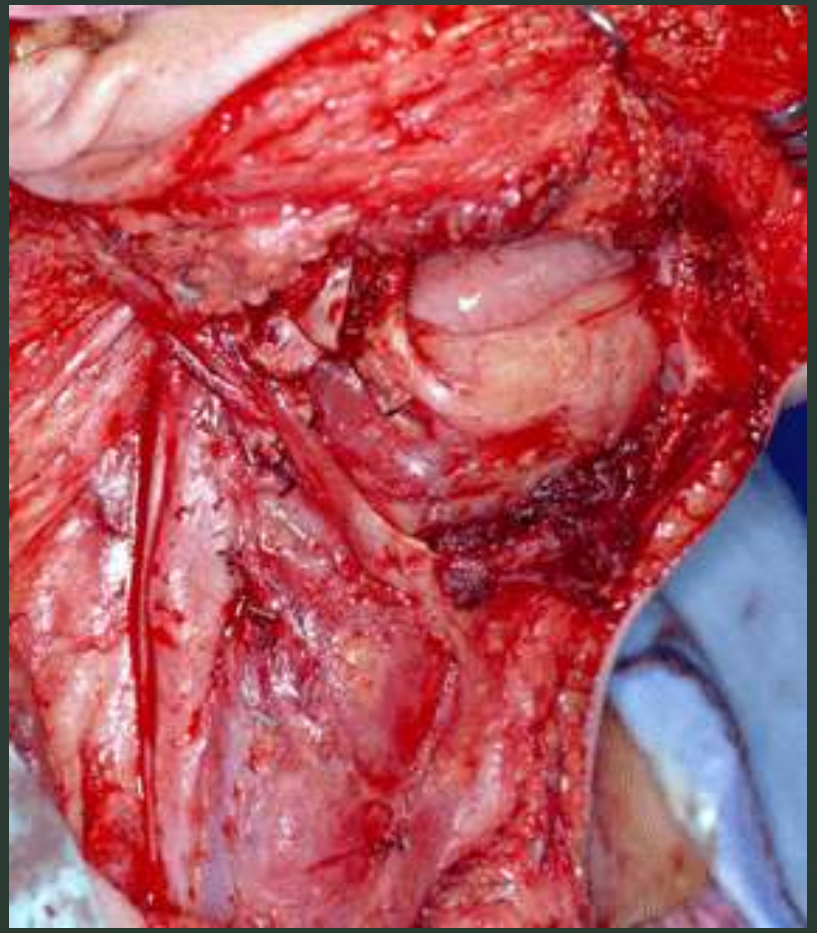
- Of the above 8 operated cases, 1 case was diagnosed as poorly differentiated on HPE examination, and 2 cases were having positive tumour margins, and these cases were sent for post operative radiotherapy.

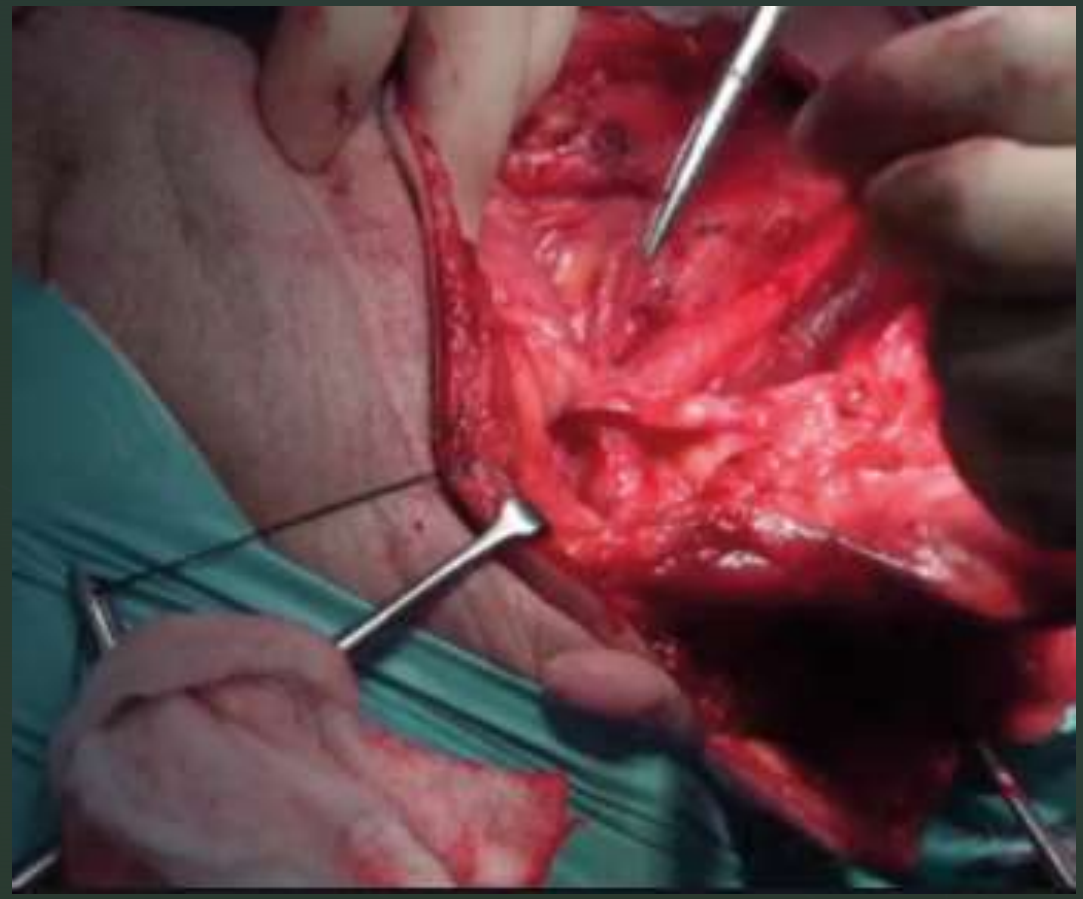
An ulceroproliferative growth on the right buccal mucosa of size 1x2 cm, 0.5cm behind the angle of mouth, with no palpable lymph node

An ulceroproliferative growth of size 3x4cm present on the left buccal mucosa, adjacent to left lower 1st and 2nd molar, with induration around the margins and palpable ipsilateral level IB lymph node

An ulceroproliferative growth of size 5x6cm present on the right buccal mucosa, involving the right lower gingivobuccal sulcus and right retromolar trigone, and bilateral palbable level IB lymph nodes

An ulceroproliferative growth of size 3x2cm present on the right buccal mucosa, adjacent to right 3rd molars, invading the right retromolar trigone and the right lower gingivobuccal sulcus, with submucous fibrosis of hard palate and left retromolar trigone, as well as the rest of the buccal mucosa with bilateral palpable level IB lymph nodes





CONCLUSION

- Even in node negative cases, elective neck dissection should be done as it significantly reduces the nodal recurrence as well as the local recurrence (especially in T2 or tumour thickness >5mm)
- Surgical procedure has to be selected based on the stage of the disease and the extent of the disease.
- Post operative adjuvant therapy (radiation/chemotherapy) is preferred for-

1. LN metastasis (2 or more)
2. Extracapsular spread
3. Positive margins or margins <3mm
4. Stage III/IV

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SCHWANNOMAS IN ENT

DR. AASTHA BHATNAGAR

INTRODUCTION

- Schwannomas, also known as neurilemmomas, are benign peripheral nerve sheath tumours.
- They originate from any nerve covered with Schwann cell sheath.
- Schwannomas constitute 25–45% of benign tumours of the head and neck.

About 4% of head and neck schwannomas present as a Sinonasal schwannoma.

We saw 2 cases in our OPD – A Sinonasal schwannoma and a Facial Nerve schwannoma.

Complete extracapsular excision of the tumours was achieved by micro-neurosurgical technique .

Benign Nasal Spindle Cell Schwannoma of the Left Nasal Cavity

History

- Chief Complaints:

a) Left sided nasal obstruction since 2 years

b) Left sided nasal discharge since 1 year

H/O Anosmia since 6 months +

H/O Pain below the left eye +

H/O Epistaxis since 2 months +

H/O Excessive sneezing +

H/O Epiphora +

H/O Nasal Twang +

H/O Nasopharyngeal Insufficiency +

EXAMINATION

General Examination:

Conscious, Cooperative and well oriented to time, place and person

BP: 150/90 mmHg

P: 72 bpm

RR:12 cycles/min

No pallor, icterus, clubbing, cyanosis, lymphadenopathy, edema.

Systemic Examination:

CVS: WNL

RS: WNL

PA: WNL

CNS: WNL

Local Examination:

Nose:

Saddle nose deformity +. Widening of nasal bridge +

Pearly white Nasal mass present in the left nasal cavity filling the entire cavity, pushing the septum towards right . Mucopurulent discharge present.

Probe Test – Attached Posteriorly.

DNS to Right.

Left sided ethmoid, maxillary sinus tenderness present.

- Eye:

Epiphora +

Infra-orbital numbness + -- S/O Maxillary invasion.

Inter-canthal distance : Normal

- Throat :Hard palate – Normal

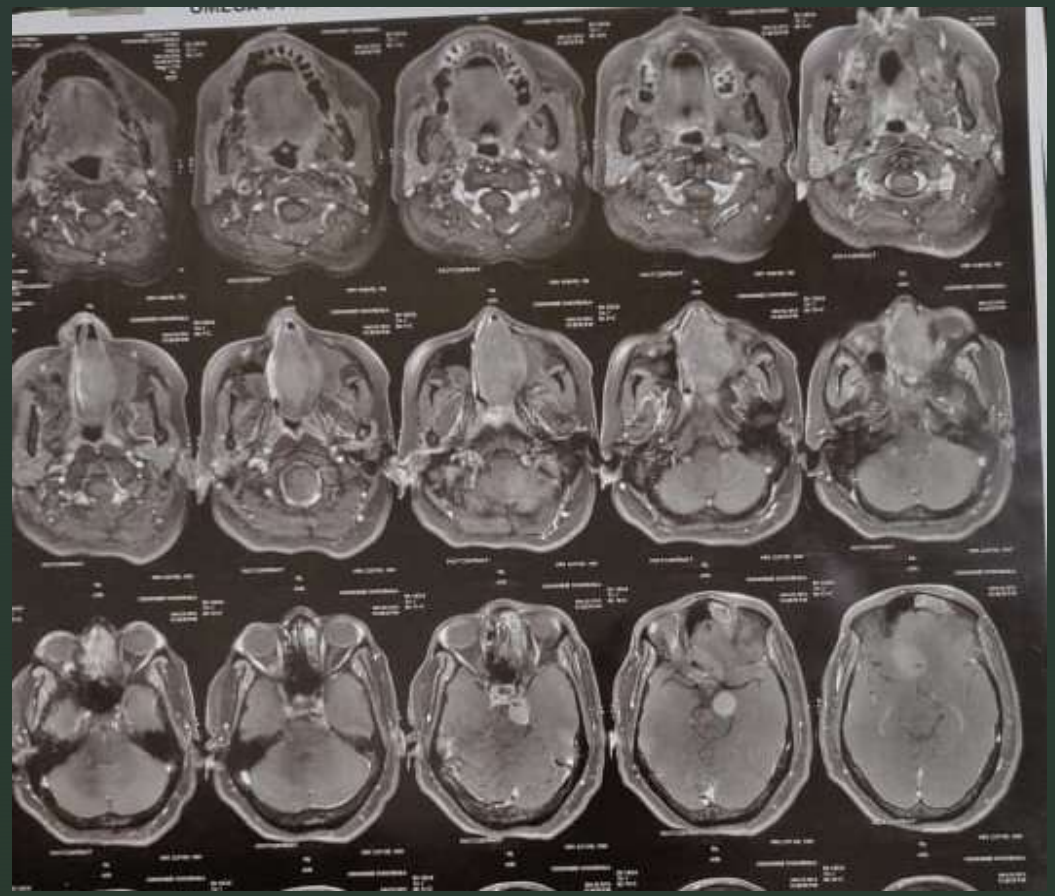
  Soft Palate – Normal

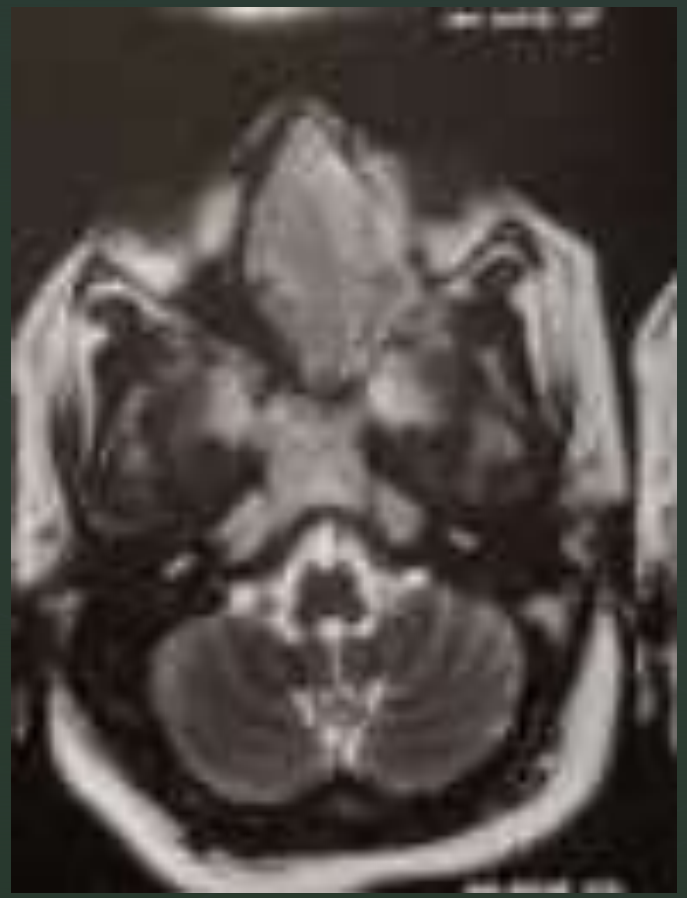
  B/L grade 2 tonsillar enlargement

- Neck: No Neck nodes palpable.
- Ear : WNL

LAB INVESTIGATIONS:

- CBC , Sr. Electrolytes, LFT, RFT, Sr. Ca, Sr. Mg - WNL
- Perimetry – Study WNL
- CT Brain + Paranasal Sinuses –





Management – Endoscopic Debulking of Nasal Mass using Coblater.

Intra-Operative Findings:

Mass occupied the left sphenoid sinus and eroded nasal floor.

Seen originating from the sphenopalatine fossa. Vidian Nerve visualized.

HPE of left nasal mass arising from the left sphenopalatine foramen – S/O Ancient schwannoma

Facial Nerve Schwannoma

History

Chief Complaints:

a) Left sided facial weakness since 4mth

-Insidious onset, gradually progressive

H/O left eye watery discharge

H/O left sided aural fullness

H/O reduced hearing from left ear

EXAMINATION

General Examination:

Conscious, Cooperative and well oriented to time, place and person

BP: 110/80 mmHg

P: 72 bpm

RR: 18 cycles/min

No pallor, icterus, clubbing, cyanosis, lymphadenopathy, edema.

Systemic Examination:

CVS: WNL

RS: WNL

PA: WNL

CNS: WNL

- EAR

- Right ear: TM retracted
- Left ear: reddish mass present behind intact TM
- Tuning fork tests:

	Right	Left
Rinne's (256)	Positive	Negative
(512)	Positive	Positive
(1024)	Positive	Positive
Weber's	Lateralised to left	
ABC	Same as examiner	Same as examiner

Nystagmus: absent

Fistula test: Negative for both ears

Rhomberg’s test: Negative

Facial nerve examination:

Left sided facial nerve palsy, LMN type, grade 5 of House Brackmann

classification

NOSE: NAD

THROAT: NAD

Investigations

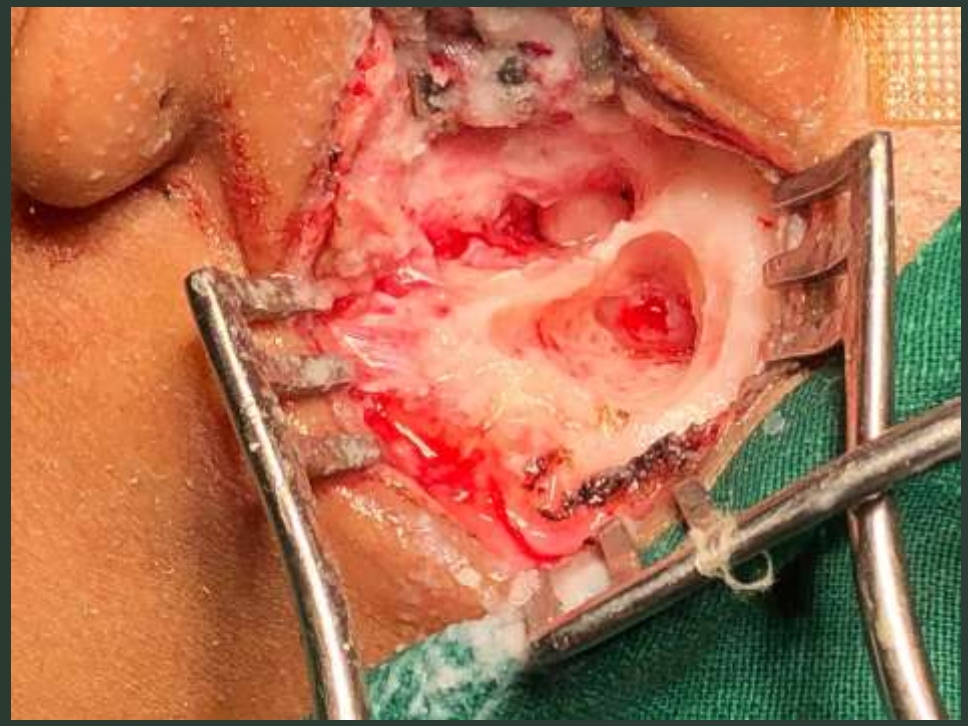
- CBC , Sr. Electrolytes, LFT, RFT, Sr. Ca, Sr. Mg - WNL
- Mastoid X-ray B/L Schuller’s view
- PTA:

- Right ear: 15 dB AB gap
- Left ear: 20 dB AB gap

HRCT Temporal bone - Soft tissue mass of left middle ear involving mastoid and tympanic segment of left facial nerve, aditus, antrum.

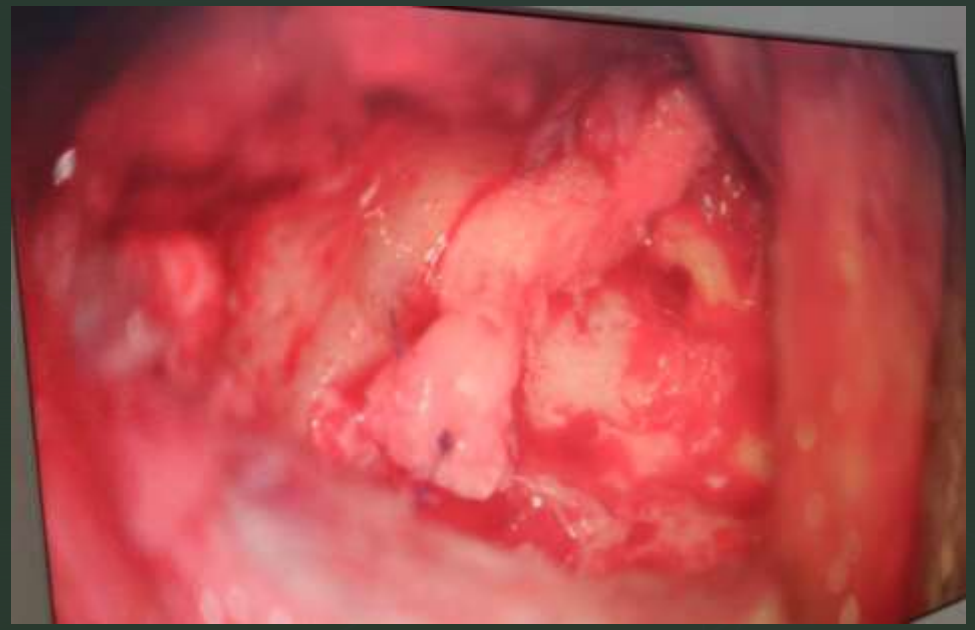
MRI Temporal bone - soft tissue mass involving mastoid and tympanic segment of left facial nerve, no intralabyrinthine/intracranial involvement

INTRAOPERATIVELY



Management

- Patient was planned for left facial nerve schwannoma excision
- Along with nerve grafting
- Sural nerve was to be used as a nerve graft



Conclusion

- Head and neck schwannoma though rare should be considered as a differential diagnosis of a unilateral slow growing mass in the head and neck region, particularly in an adult.
- Schwannomas are always a diagnostic dilemma as they are asymptomatic for long time, and histopathology is the gold standard for diagnosis.
- As a rule, treatment is surgical and dictated by the location of the tumour and nerve of origin. Due to its rarity, complex anatomical location and morbidity risk post-excision, they can pose a formidable challenge to surgeons.

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EMBRYONAL RHABDOMYOSARCOMA OF RIGHT MIDDLE EAR

DR. ANUJA SATAV

Introduction

- Rhabdomyosarcomas are soft tissue cancers derived mainly of undifferentiated mesoderm .
- Embryonal rhabdomyosarcomas are the most common subtype.
- Most common in children (0-4 years old) with incidence of 4 in 1 million.
- Most commonly involved sites in head and neck region are nasal and oral cavities, second most common being the orbit and middle ear.
- Anaplasia is a very important prognostic feature with significant nuclear variation and presence of atypical multipolar mitotic figures.

Case History:

9 year old male came with the chief complaints of :

- discharge from right ear since childhood
- symptoms of facial nerve palsy since 9 days
- he was suspected to have right squamosal COM with facial paralysis.
- He was operated for Right canal wall down Modified Radical Mastoidectomy with facial nerve decompression on 14-02-2020

❖Patient presented with following symptoms a month later :

- Right postauricular swelling since 6 days associated with right ear discharge.
- Otoscopic findings revealed polypoidal mucosa in the right EAC highly suggestive of recurrence of CSOM.
- Associated with pain over the mastoid region.
- No h/o nausea or vomiting
- No h/o giddiness
- No h/o tinnitus
- No h/o fever
- No h/o any other nose and throat complaints

On examination:

- General Examination:

Patient is conscious, cooperative oriented to time, place and person

Pulse- 77 bpm

BP – 100/60 mmHg

RR- 22 Cycles/min

- Systemic Examination:

CVS: S1 S2 present

RS : Breath sounds equal on both sides

CNS : within normal limits

Per Abdominal: no obvious organomegaly seen

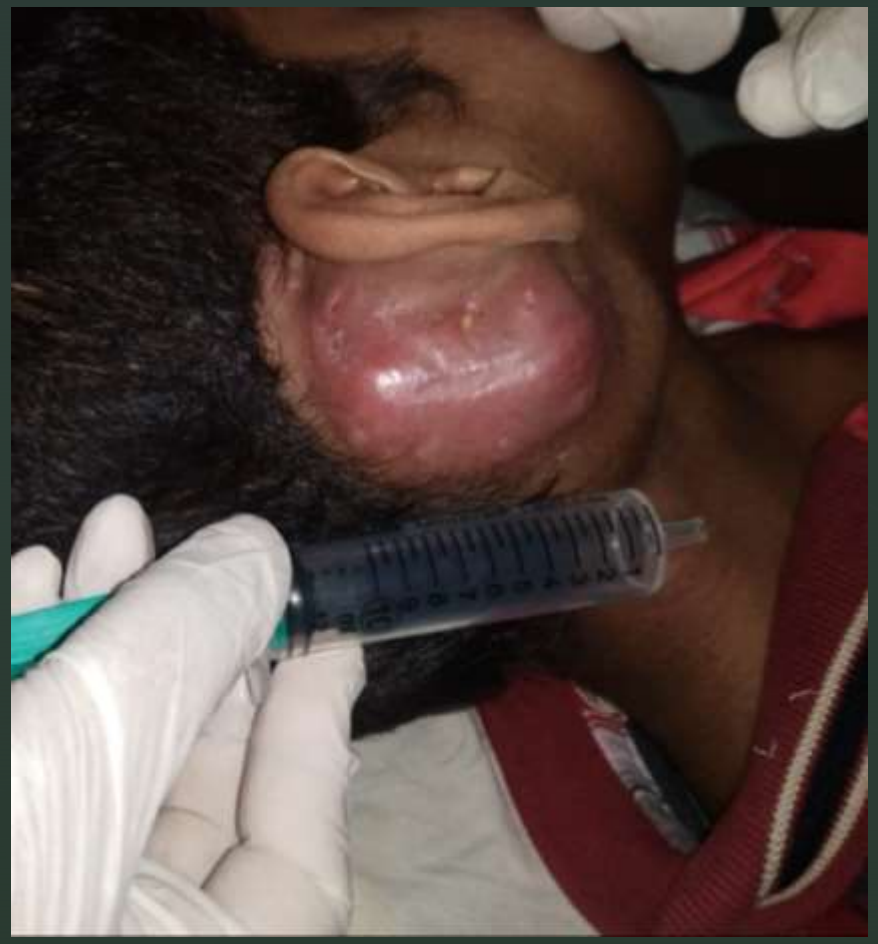
Local Examination

- Patient presented with postauricular swelling of size 3×2 cm with mastoid tenderness, local rise of temperature and eversion of pinna
- Tuning fork tests:

	Right	Left
Rinne's : 256Hz	Negative	Positive
512Hz	Negative	Positive
1024Hz	Negative	Positive
Weber's	Lateralized to right ear	
Absolute bone conduction	Reduced	Same as examiner

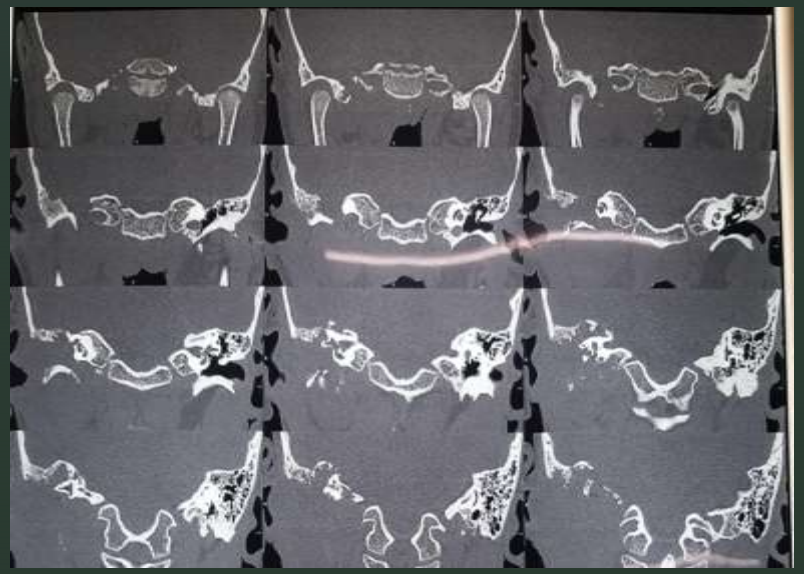
- Persistent deviation of angle of mouth to the left and incomplete eye closure suggestive of no improvement in signs of facial nerve palsy Grade V
- Nystagmus : Absent
- Fistula test : Negative
- Rhomberg’s test : Negative
- Nose:
- Throat:

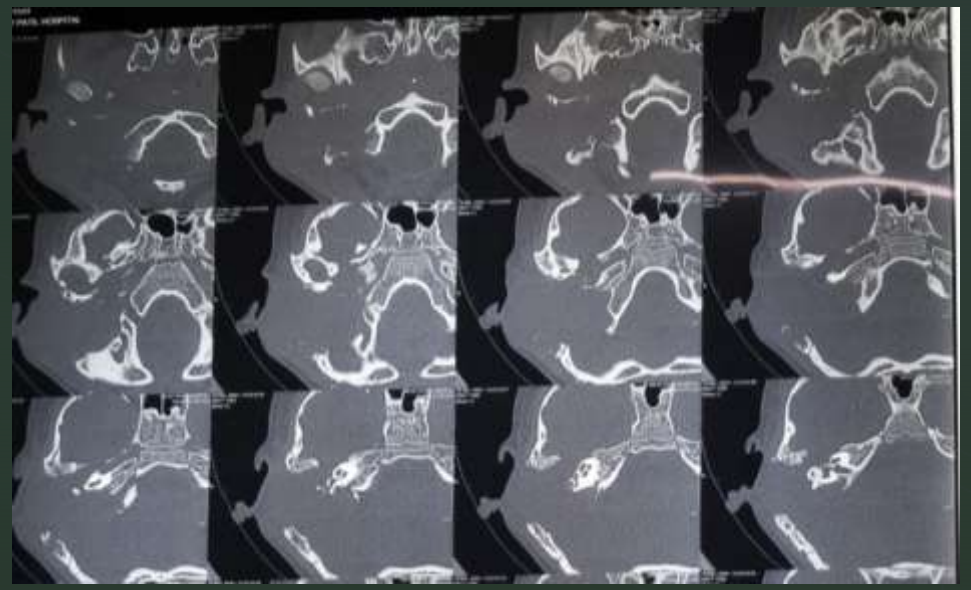
Within normal limits



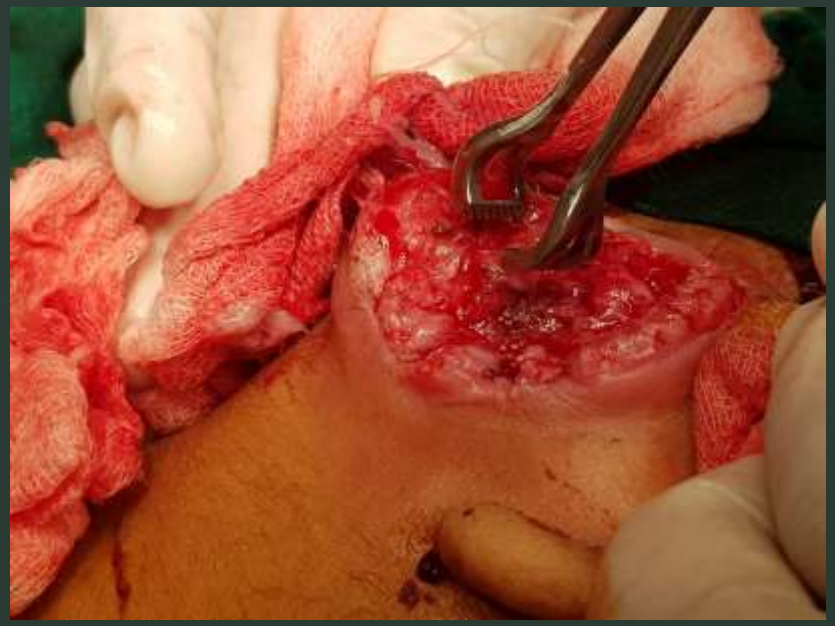
Investigations:

• HRCT Temporal bone S/O: Soft tissue mass 46 x 25 x 35mm seen in region of right petromastoid region, middle ear and EAC. Destruction of Right Petrous Canal , walls of vertical portion of right carotid canal and Jugular Foramen, tegmen tympani and sinodural plate. Intracranial extension of soft tissue in posterior cranial fossa and involvement of right sternocleidomastoid.





Intraoperatively



•On exploration of the swelling it opened up to be firm mass which was adherent to the skin, for which debulking was done and specimen sent for HPE and IHC.

•Following which the wound was sutured.

•**Histopathological examination S/O :**

Round cell tumor

•**Immunohistochemistry S/O:**

Embryonal Rhabdomyosarcoma highly positive for Desmin , Myogenin, CD99, FLI-1

- Patient later developed symptoms of bleeding from the postauricular swelling and episodes of seizures.
- Following the workup it suggested spread of the malignant condition to lungs.
- Thus indicative of stage 4 disease according to TNM staging
- HRCT Thorax S/O: Multiple soft tissue density roughly rounded nodules in both lungs.
- Patient was further referred to higher center for chemo-radiotherapy and palliative management.

Conclusion:

- Rhabdomyosarcomas are a rare class of carcinomas and highly aggressive tumors
- Immediate management with respect to stage of the disease is necessary
- For every Pediatric case of Cholesteatoma and middle ear granulation tissue on exploration, sample should be sent for histopathological examination

THANK YOU