From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 05/05/2025 07:44 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **May 5, 2025** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link:
https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=mfc78dae0822cebe0e3bb9dae1af0a8c3Monday, May 5, 2025, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2517 860 3513
Meeting password: 050525

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

ame: XXXX	**Age-** 37 years	**Gende**r-male	**CR No-** 20240035264
OA: 22/10/2024	**DOS:** 28/10/24		**DOD:** 20/11/24
linician in-charge- ENT **nit II –** Dr. Madhu Priya		**Clinical Discussant:** Dr Deepak Kumar	
ddress:		Bhaguwala, Bijnor, Uttar Pradesh	

istory-

atient presented with complaint

- Voice change : 5 months (since Nov 2023)
  - Insidious onset
  - Gradually worsening
  - Non remitting
  - No diurnal variation
  - No aggravating and relieving factors
  - Hoarse in quality with low pitch.

- No pain during speech

- Difficulty in breathing : 4 months (since Dec 2023)
  - Insidious, progressive , noisy breathing
  - Persistent
  - Aggravated on exertion.
  - No positional variation
  - No relieving factor

ersonal history :-

- Mixed diet
- **H/o tobacco chewing for 7 yrs.**

ast history:

- No significant past history
- Tracheostomized (in view of critical airway)- outside in **Jan 2024**
- Evaluated with DL scopy & biopsy done **twice - outside (inconclusive)**

Examination:

Built: Well-built

Height– 155 cm

Weight – 64 kg

BMI- 26.6 kg/m2

Respiratory- B/L chest clear.

CVS - S1 S2 heard normally, no murmur present.

P/A- Soft, No palpable organomegaly, BS present.

CNS – intact higher mental function, GCS = E4V5M6 =15/15

General examination:

No pallor, icterus, clubbing, cyanosis, pedal edema or peripheral lymphadenopathy

Local Examination:

- 7.5mm cuffed tracheostomy tube in-situ
- Normal flexion and extension.
- Trachea in midline
- **No laryngeal tenderness, widening or loss of crepitus.**
- Thyroid examination - normal
- No clinically palpable cervical lymphadenopathy
- No engorged veins

70-degree endoscopy:

- **Smooth-surfaced, well-mucosalized mass noted in subglottic**
- **Completely obstructing the airway at subglottis**
- Bilateral mobile vocal cords.
- Normal supraglottis.
- Glottic chink normal.

Clinical diagnosis: **Malignancy larynx**

	18/9/24	**13/11/24**		**18/9/24**	**13/11/24**
HB	16.5		**UREA**	29	16
TLC	12.08		**CREATININE**	1.01	1.38
PLATELET	350K		**NA^+**	135	135
PT/INR	12.6/1.04		**K^+**	4	3.7
TOTAL BILIRUBIN	1.47	0.57	**CL^-**	100	101
DIRECT BILIRUBIN	0.16	0.12	**TOTAL CALCIUM**	9.5	6.5
SGPT/SGOT	30/28	21/28			
ALP/GGT	167/37	136/NA	**T3/T4/TSH**	3.1/1.57/26	
TP/SA	8.8/4.5	4.4/2.2	**Viral Markers**	Non-Reactive	

Chest X ray	WNL
Histopathology **s-4902/24**	CT-guided transcervical core needle biopsy:

(03/08/24)	cartilage framework, no definite evidence of malignancy- *Impression:* **Inconclusive**
Histopathology **s-5913/24** **(21/09/24)**	DL Scopic biopsy moderate squamous dysplasia *Impression: -* **Inconclusive**
CECT neck and thorax **(15/04/2024)**	• An ill- defined heterogeneously enhancing mass lesion measuring 20 x 27 x 33 mm is seen in the glottis involving the right true & false vocal cord with associated right vocal cord palsy. • Inferiorly it is extending into the subglottis and causing near complete airway narrowing. • It is causing erosion of cricoid cartilage, arytenoid cartilage, anterior commissure and posterior commissure. • Laterally it is infiltrating into the paraglottic space and abutting the right lamina of thyroid cartilage without its erosion • Posteriorly it is abutting the vertebrae without its erosion • Supraglottis is not involved • Few subcentimetric and enlarged lymph nodes are seen in level la, bilateral level ib, II, III • TT tube is seen in situ ***Impression*:** • ***An ill- defined heterogeneously enhancing mass lesion in the glottis involving subglottis extension, right vocal cord palsy and relations as described.***
Intra-op finding	A smooth lined ? Cartilaginous lesion of size 3 x 3 cm is noted in subglottic region extending superiorly till bilateral false vocal cord and paraglottic space, completely obliterating subglottic lumen
Course during hospital stay	The patient with above mentioned diagnosis was admitted in ENT ward. Routine investigation was done. PAC fitness was done. He underwent **check hypopharyngoscopy followed by wide field total**

	laryngectomy + total thyroidectomy + bilateral selective neck dissection (II-IV) + primary tracheoesophageal puncture + reconstruction of neopharynx by primary closure and end tracheostomy under GA on 28 /10/2024. Bilateral neck drain removed on POD-7. Complete suture removed from stoma site on pod 14. Weaned off tube feeding after POD 15. Patient is vitally stable and being discharged.
Condition at discharge	Patient vitally stable on oral feed, with permanent tracheostomy.
Follow up	Able to vocalize using TEP after 3 weeks, Joined back to work and improved quality of life.