Case Report

Intern B組 嚴崇文 廖翊伶 郭明樹 陳依涵 吳詠霞
指導老師 陳玉昆 醫師暨口腔病理科全體醫師
101/10/29
General data

- Name: 葉○○
- Sex: Female
- Age: 58 y/o
- Native: 高雄市
- Marital status: Married
- Attending V.S.: 陳中和 醫師
- First visit: 101/10/03
Chief complaint

- Swelling over upper left canine area about 2+ months

101/10/27
Present Illness

- 101/10/03
  - Referred from LDC for swelling mass over L’t canine space then received incisional biopsy
Past History

- Past Medical History
  - Underlying disease : denied
  - Hospitalization(+)  
    - 盲腸,結紮
  - Surgery under GA (+) : as above
  - Drug allergies : denied
- Past Dental History
  - Routine dental treatment
  - Attitude to dental treatment : cooperative
Personal History

- Risk factor related to malignancy
  - Alcohol: (-)
  - Betel nut : (-)
  - Cigarette : (-)
- Special oral habits : Denied
- Irritation factor: Denied
OMF Examination

- Size: 3cm x 1.5cm
- Color: whitish
- Mobility: fixed
- Surface: smooth
- Pain (+)
- Tenderness (+)
- Induration (+)
- LAP (-)
There is a ill defined unilocular irregular radiolucency without a cortical margin extending from the distal side of tooth 28 to the apical of tooth 23 and invading the floor of the maxillary sinus, measuring approximately 3.5X0.7cm.
Image Finding (Panorex)

- 101/10/03

- Missing: teeth 27
- Mesial tilting: 35
- Restoration: 11, 21, 38, 37, 47, 48
Impression: An expansile soft tissue mass in left maxillary sinus with erosion over adjacent sinus walls and alveolar process with invasion of right nasal cavity and soft palate.

Sinus carcinoma could not be excluded.

2) No evidence of enlarged cervical adenopathy.

3) AJCC preliminary cancer staging: III (T3N0Mx).

4) Small bilateral submandibular and internal jugular lymph nodes (n1, n2).
Bone Scan

- **Impression** :
  - (1) High probability of local bone invasion from maxillary sinus cancer to the maxilla with low probability of distant bone metastasis.
  - (2) X-ray exam & follow-up bone scan may be recommended.
Chest PA(101/10/17)

- Impression:
  - Status post insertion of endotracheal tube and right subclavian line.
  - Suspect nipple shadows in the bilateral lower chest.
  - Mild spondylosis deformans of the L-spine.
Differential Diagnosis
Peripheral / intrabony

- Size: 3cm x 1.5cm
- Color: whitish
- Mobility: fixed
- Surface: smooth
- Pain (+)
- Tenderness (+)
- fluctuation(+)
- Induration (+)
- LAP (-)
Peripheral / intrabony

CT: An expansile soft tissue mass in left maxillary sinus with erosion over adjacent sinus walls and alveolar process size: 47.2x 39.2x 39.8 mm

Intrabony Lesion
## Peripheral / intrabony

<table>
<thead>
<tr>
<th></th>
<th>our case</th>
<th>peripheral</th>
<th>intrabony</th>
</tr>
</thead>
<tbody>
<tr>
<td>mucosal lesion</td>
<td>-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>induration</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>bony expansion</td>
<td>+</td>
<td>-</td>
<td>+ -</td>
</tr>
<tr>
<td>cortical bone destruction</td>
<td>+</td>
<td>-</td>
<td>+ -</td>
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<tr>
<td></td>
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<td>inflammation</td>
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<td></td>
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<tr>
<td>redness</td>
<td>-</td>
<td>+</td>
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<tr>
<td>swelling</td>
<td>+</td>
<td>+</td>
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<tr>
<td>local heat</td>
<td>?</td>
<td>+</td>
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<tr>
<td>pain</td>
<td>+</td>
<td>+</td>
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<tr>
<td></td>
<td>our case</td>
<td>Non-inflammation Cyst</td>
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<td>------------------------</td>
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<tr>
<td>Fluctuation</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Well defined border</td>
<td>-</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Bone expansion</td>
<td>+</td>
<td>+</td>
<td></td>
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<tr>
<td>progression</td>
<td>fast</td>
<td>slow</td>
<td></td>
</tr>
<tr>
<td>sclerotic margin</td>
<td>-</td>
<td>+</td>
<td></td>
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<tr>
<td></td>
<td>our case</td>
<td>Benign</td>
<td>Malignancy</td>
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<td>------------------------</td>
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<td>--------</td>
<td>------------</td>
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<tr>
<td>Border</td>
<td>ill-defined</td>
<td>well-defined</td>
<td>ill-defined</td>
</tr>
<tr>
<td>Margin</td>
<td>irregular</td>
<td>smooth</td>
<td>Irregular</td>
</tr>
<tr>
<td>Sclerotic margin</td>
<td>-</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>Destruction of cortical margin</td>
<td>+</td>
<td>+ -</td>
<td>+</td>
</tr>
<tr>
<td>Progressive</td>
<td>fast</td>
<td>slow</td>
<td>fast</td>
</tr>
<tr>
<td>Swelling with intact epithelium</td>
<td>+</td>
<td>+</td>
<td>-</td>
</tr>
<tr>
<td>pain</td>
<td>+</td>
<td>-</td>
<td>+</td>
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<tr>
<td>Induration</td>
<td>+</td>
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</table>
Working Diagnosis

- Osteosarcoma
- Mixed tumor carcinosarcoma
- Ewing’s sarcoma
<table>
<thead>
<tr>
<th></th>
<th>our case</th>
<th>Osteosarcoma</th>
<th>Chondrosarcoma</th>
<th>Ewing’s sarcoma</th>
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</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>58</td>
<td>10-20</td>
<td>Older than 50</td>
<td>20+</td>
</tr>
<tr>
<td><strong>Sex predilection</strong></td>
<td>F</td>
<td>M</td>
<td>M/F</td>
<td>M</td>
</tr>
<tr>
<td><strong>Site and prevalence</strong></td>
<td>Buccal mucosa (Maxilla)</td>
<td>Maxilla or Mandible</td>
<td>Maxilla</td>
<td>Mandible&gt; Maxilla</td>
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<tr>
<td><strong>Radiographic findings</strong></td>
<td>RL</td>
<td>RO or mixed or RL</td>
<td>Mixed RL and RO</td>
<td></td>
</tr>
<tr>
<td><strong>Margins</strong></td>
<td>Ill-defined</td>
<td>Ill-defined</td>
<td>Ill-defined</td>
<td>Ill-defined</td>
</tr>
<tr>
<td><strong>Border</strong></td>
<td>irregular</td>
<td>irregular</td>
<td>irregular</td>
<td>irregular</td>
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<tr>
<td><strong>Swelling</strong></td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>+</td>
</tr>
<tr>
<td><strong>pain</strong></td>
<td>+</td>
<td>+</td>
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</table>
Diagnosis

- Left maxillary carcinoma, suggestive of neuroendocrine, ycT4a N0 M0 stage IV
Discussion

What is neuroendocrine carcinoma?
Neuroendocrine carcinoma

- Neoplasms arise from cells of the endocrine & nervous systems
- Many NE tumors are benign, while some are malignant
- Most commonly occur in intestine, lung, rest of the body
- Many kinds of NETs, treated as a group of tissue
  - cells of these neoplasms share common features
  - special secretory granules/producing biogenic amines & polypeptide hormones
Neuroendocrine system

- Arise from various neuroendocrine cells
- NE cells are present in endocrine glands throughout the body produce hormones, diffused in all body tissue.
History

- 1907
  - small intestinal neuroendocrine tumors were first distinguished from other tumors
  - named carcinoid tumors
  - slow growth was considered to be “cancer-like” rather than truly cancerous

- 1938
  - some of these tumors could be malignant
Incidence

- 2.5~5 per 100000
- 2/3 carcinoid tumors; 1/3 other NETs
WHO classification

- well-differentiated NETs
  - benign tumor
  - with uncertain behavior
- well-differentiated (low grade) NE carcinomas
- Poorly differentiated (high grade) NE carcinomas
WHO classification

- Depends on
  - size
  - lymphovascular invasion
  - mitotic counts
  - invasion of adjacent organs
  - presence of metastases
  - whether produce hormones
Diagnosis-Imaging

- CT-scans
  - 95% of tumor > 3cm
  - generally not tumor < 1cm
- MRIs
- sonography (ultrasound)
- endoscopy (including endoscopic ultrasound)
- Molecular imaging
Treatment

- Symptomatic relief
- Surgery
- CCRT
- Hepatic artery
Cancer of the Oral Cavity*

**Workup**
- History & Physical examination
- Biopsy/pathology review
- Head & neck CT/MRI
- Panorex
- Chest X-ray
- ABD sono
- CBC, SMA
- Dental evaluation
- Multidisciplinary consultation/committee discussion
- PET/CT optional

**Clinical Staging**

- T1-2, N0
  - Preferred for surgery ± neck dissection
  - External-beam RT ± Brachytherapy
  - Adverse features in histopathology
    - Residual disease
    - Salvage surgery

- Resectable, T3, N0
  - Surgery and neck dissection
  - Postop adjuvant RT ± Chemo

- Resectable, T1-3, N1-3
  - External-beam RT ± Brachytherapy
  - Adverse features in histopathology
    - Residual disease
    - Salvage surgery

- Residual disease in primary
  - Concurrent chemoradiotherapy
    - Complete response in primary but residual on neck
      - Neck dissection
      - Observation
    - Complete response in primary and neck, initial N1 stage
      - Observation or neck dissection
    - Complete response in primary and neck, initial N2-3 stage
      - Salvage surgery

**Treatment of Primary and Neck**

- Postop adjuvant RT ± Chemo

**Follow-up**
- Physical examination:
  - Year 1, every 1-3 mo
  - Year 2, every 2-4 mo
  - Year 3-5, every 4-6 mo
  - >5 yr, every 6-12 mo
- Chest imaging annually, or earlier if clinically indicated
- TSH every 6-12 mo, if neck irradiated

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*Including of buccal mucosa, floor of mouth, anterior tongue, alveolar ridge, retromolar trigone, and hard palate.

*Adverse features in histopathology: 1. more than one positive node; 2. postop uptake to T3-4; 3. close/positive surgical margins; 4. perineural/lymphatic/vascular invasion; 5. nodal extracapsular spread.

*One positive node only without adverse features in postop pathology; RT optional.

*RT optional in: 1. deep invasion in tongue cancer; 2. buccal in origin.
Cancer of the Oral Cavity

**Workup**
- History & physical examination
- Biopsy/pathology review
- Head & neck CT/MRI
- Panorex
- Chest X-ray
- ABD sono
- CBC, SMA
- Dental evaluation
- Multidisciplinary consultation / committee discussion
- PET/CT optional

**Clinical Staging**
- Resectable, T4, any N
  - Surgery and neck dissection
    - Concurrent chemoradiotherapy
    - Residual disease in primary
      - Complete response in primary but residual on neck
      - Complete response in primary and neck, initial N1 stage
      - Complete response in primary and neck, initial N2-3 stage
    - Residual surgery
    - Observation
    - Observation or Neck dissection
  - Resectable, poor medical / surgical risk
    - External-beam RT ± Brachytherapy
      - *ECOG PS 0-1
      - *ECOG PS 2-4
    - Concurrent chemoradiotherapy
      - Sequential chemo/RT
      - Definitive RT alone
      - Best supportive care

**Treatment of Primary and Neck**
- Postop adjuvant RT ± Chemo

**Follow-up**
- Year 1, every 1-3 months
- Year 2, every 2-4 months
- Year 3-5, every 4-6 months
- 5 yr, every 6-12 months
- Chest imaging annually or earlier if clinically indicated
- TSH every 6-12 months, if neck irradiated

*ECOG (Eastern Cooperative Oncology Group) Performance Status:
0- Fully active, able to carry on all pre-disease performance without restriction.
1- Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.
2- Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.
3- Capable of only limited self-care, confined to bed or chair more than 50% of waking hours.
4- Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair.
Treatment Plan

- Frozen section
- hemimaxillectomy

101/10/03
101/10/27
醫學倫理與全人照護
醫學倫理與全人照護

- 醫學倫理：一種道德思考、判斷和決策，以倫理學的觀點出發，以期能做出對病人最有利益、最能符合道德倫理規範的醫療決策

- 醫病關係的轉變：醫師中心模式轉變為病人中心模式 (physician-centered model → patient-centered model)
醫學倫理原則

- 由Tom Beauchamp & James Childress在1979提出
- 自主原則(Autonomy)
- 不傷害原則(Non-maleficence)
- 行善原則(Beneficence)
- 公義原則(Justice)
自主原則(Autonomy)

- 原則：一位具理性思考能力的病人，在完全瞭解醫療處置方針的利弊得失下，有權決定自己的行爲，包括決定及選擇醫療專業人員和治療方式。

- 臨床意義
  1. 病人之自主行爲不應遭受他人之操控或干涉。
  2. 指醫療人員應提供充分且適當之資訊，以促成病人針對診療方式主動作一抉擇。
不傷害原則 (Non-maleficence)

- 源自希波克拉底之醫師誓約，即醫師之職責：「最首要的是不傷害」
- 原則：不殺害病人、不能侵害病人權益和福祉以及平衡利害得失，使痛苦減到最低
- 臨床意義
  - (1)醫療上是必須的，或是屬於醫療適應症範圍，
  - 因所施行的各種檢查或治療而帶來的傷害應符
  - 合不傷害原則
  - (2)權衡利害原則 → 兩害相權取其輕
  - (3)保護病人的生命安全
行善原則(Beneficence)

- 原則：行善原則包括不傷害原則的反面義務(不應該做的事)和確有助益的正面義務(應該做的事)，包括維護和促進病人的健康、利益和福祉，為基本倫理原則，也是醫護人員的基本義務。

- 臨床意義
  - (1) 勿施傷害：不得故意對他人施予傷害或惡行
  - (2) 預防傷害：應該預防傷害或惡行
  - (3) 移除傷害：應該移除傷害或惡行
  - (4) 維持善行：應該致力於行事或維持善行
公義原則(Justice)

- 原則：強調資源合理分配、賞罰分明以及合乎正義之事。醫療上公平原則指基於正義與公道，以公平合理的態度來對待病人、病人家屬和受影響的社會大眾

- 臨床意義
  - (1) 公平地分配不足的資源
  - (2) 尊重病人的基本權利
  - (3) 尊重道德允許的法律，法律之前人人平等
  - (4) 先來先服務與急重症優先
臨床案例討論

- 病人已了解自己的病狀，治療方法(f/u，手術) 復發的可能性，併發症

  自主原則(Autonomy)
臨床案例討論

- 預10/22行左胸動脈導管‘有胸靜脈導管植入，麻醉照會已完成，因上排牙齒搖晃建議照會牙科，經牙科醫師評估無需固定

- 行善原則(Beneficence): 預防傷害：應該預防傷害或惡行，移除傷害：應該移除傷害或惡行

不傷害原則(Non-maleficence)
最後，整個治療過程不只是關心到病人的身體上的病狀，也包含病人生活上的品質與心理上的照顧，完美無缺的達到了全人照顧的要素。
總述

・ 經過執行的Treatment course可檢討到:

・ 讓病人了解症狀的嚴重性，並持續的f/u，可能會減少到手術範圍
Thanks for your attention