Case Report

Intern B組 嚴崇文 廖翊伶 郭明樹 陳依涵 吳詠霞
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101/10/29

General data

- Name:葉ＯＯ
- 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

Present Illness

- 101/10/03
  - Refered 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 :CT(101/10/03)
- 1) 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

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

	our case	peripheral	intrabony
mucosal lesion	-	+	-
induration	+	+	-
bony expansion	+	-	±-
cotical bone destruction	+	-	+ -

intrabony

~~Inflammation~~/Cyst/Neoplasm

	our case	inflammation
redness	-	+
swelling	+	+
local heat	?	+
pain	+	+

~~Cyst~~/Neoplasm

	our case	Non-inflammation Cyst
Fluctuation	+	+
Well defined border	-	+
Bone expansion	+	+
progression	fast	slow
sclerotic margin	-	+

Malignancy Neoplasm

	our case	Benign	Malignancy
Border	ill-defined	well-defined	ill-defined
Margin	irregular	smooth	Irregular
Sclerotic margin	-	+	-
Destruction of cortical margin	+	+ -	+
Progressive	fast	slow	fast
Swelling with intact epithelium	+	+	-
pain	+	-	+
Induration	+	-	+

Working Diagnosis

- Osteosarcoma
- Mixed tumor carcinosarcoma
- Ewing’s sarcoma

	our case	Osteosarc-oma	Chondrosarc-oma	Ewing's sarcoma
Age	58	10-20 Or older than 50	Older than 50	20+
Sex predilection	F	M	M/F	M
Site and prevalance	Buccal mucosa (Maxilla)	Maxilla or Mandible	Maxilla	Mandible> Maxilla
Radiographic findings	RL	RO or mixed or RL	Mixed RL and RO	
Margins	Ill-defined	Ill-defined	Ill-defined	Ill-defined
Border	irregular	irregular	irregular	irregular
Swelling	+	+	-	+
pain	+	+	+	+

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

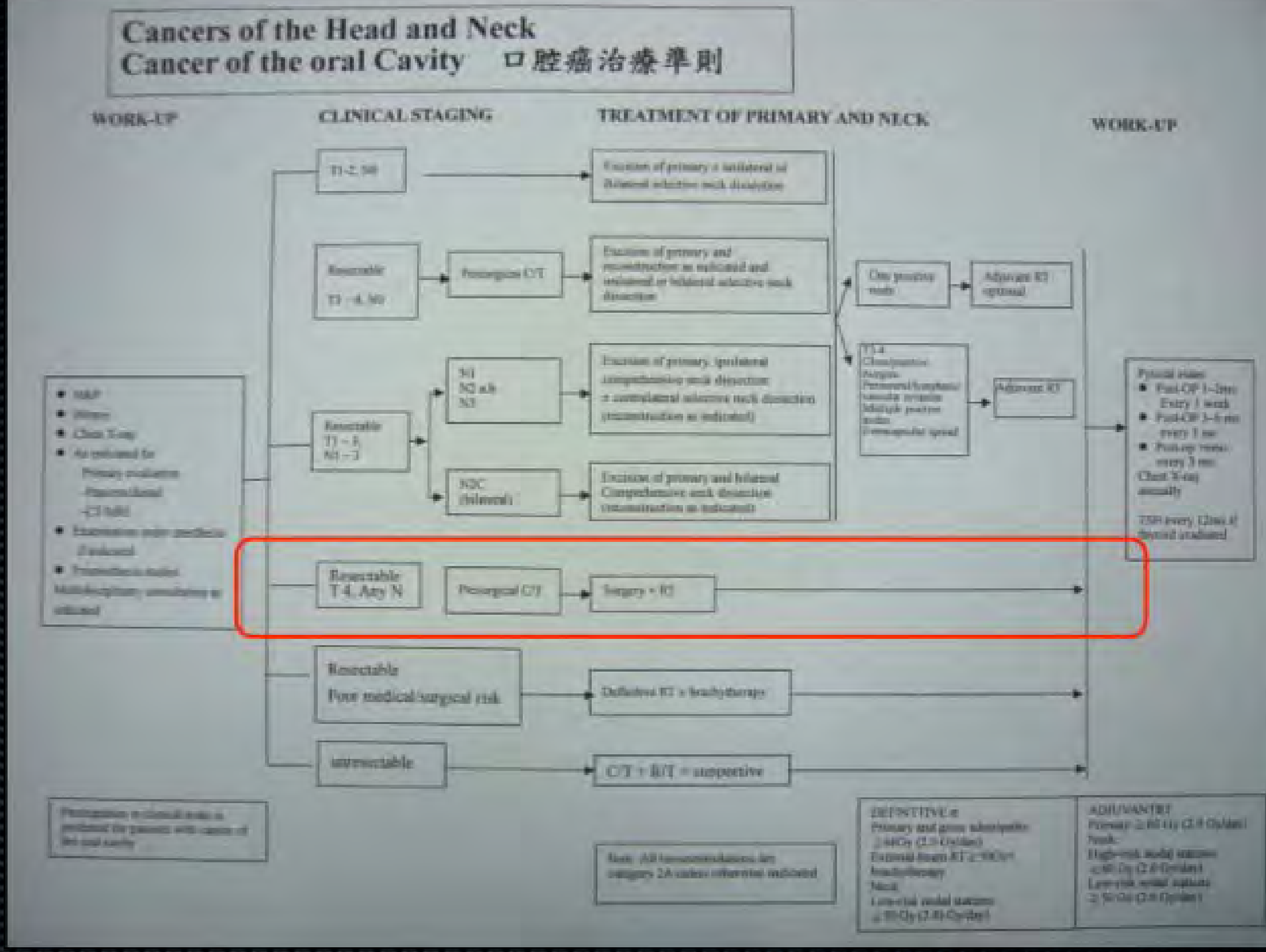
Diagnosis-Imaging

- 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

Cancers of the Head and Neck
Cancer of the oral Cavity　口腔癌治療準則



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
- Resectable, T2, N0
- Resectable, T1-3, N1-3

Treatment of Primary and Neck

T1-2, N0
- Preferred for: Surgery ± neck dissection
  - Adverse features in histopathology[A,B,C]: Postop adjuvant RT ± Chemo
- External-beam RT ± Brachytherapy
  - Residual disease: Salvage surgery

Resectable, T2, N0
- Surgery and neck dissection: Postop adjuvant RT ± Chemo

Resectable, T1-3, N1-3
- Preferred for: Surgery and neck dissection
  - Adverse features in histopathology[A,B]: Postop adjuvant RT ± Chemo
- External-beam RT ± Brachytherapy
  - Residual disease: Salvage surgery
- Concurrent chemoradiotherapy
  - Residual disease in primary: Salvage surgery
  - Complete response in primary but residual on neck: Neck dissection
  - Complete response in primary and neck, initial N1 stage: Observation
  - Complete response in primary and neck, initial N2-3 stage: Observation or neck dissection

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

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

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

[B]**One positive node only** without adverse features in postop pathology: RT optional.

[C]**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

Treatment of Primary and Neck

Resectable, T4, any N → Surgery and neck dissection → Postop adjuvant RT ± Chemo

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

Resectable, Poor medical / Surgical risk → External-beam RT ± Brachytherapy

Unresectable:
- *ECOG PS 0-1 → Concurrent chemoradiotherapy; Sequential chemo/RT
- ECOG PS 2-4 → Sequential chemo/RT; Definitive RT alone; Best supportive care

Follow-up

- Physical exam: 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

*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 selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours.

3- Capable of only limited selfcare, 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：醫師中心模式轉變爲病人中心模式 (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預
  (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，爲基本倫理原則，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