SCC

Case

Type of cell situated
malignancy arising
from
melanocytes

BIODATA :-

Name - Mr. ~~XXX~~ ~~Pradeep~~ Biju
Age - 48 years
Sex - Male
Occupation - Daily wage labourer
~~Address~~ - ~~Ganj circle, Raichur~~ ~~NAD~~ Kakkanad.
Education - no formal educat^n
Income - 5000 / month
Socioeconomic status - lower middle class (POOR MAN'S DS) → BUERGER'S DS.

Chief Complaints:

Pain in left foot since 4 months.
Blackish discolouration of left foot since 3 months.

HOPC -

Pt. was apparently well 4 months back, when he started feeling pain in <u>left foot</u> on walking, which is continous, servere, localised to left foot and aching in nature. Pain aggrevates on lying down and is relieved by hanging his leg. There is no diurnal variation. H/o intermittent claudication present with claudication distance of 500m. Increased to become restpain within a month.

restpain ↓ pre-gangrenous condition
restpain → pain at night, when pt. is in bed → due to ischamea of corresponding nerves. → cry of dying nerves.

Arterial claudication is much severe.

Mention whether there is pain in thigh or calf.

If pain in thigh the common iliac block

If pain calf then femoropopliteal junct^n → block in superficial femoral A → at hiatus of adductor magnus

Common manifestation of TAO – instep claudication.
Function of greater toe (hallucis longus)
Pain on left foot → where ?
Intermittent Claudicam – Boyd's

* Grade 1 : Pain on walking, but when he continues to walk, pain disappears.
Grade 2 : Pain still persists while walking
Grade 3 : Pt. has to take rest.
} is chemia of the muscles

Why Rest pain ?
Anerobic metabolic → Substance P accumulam
Last – Ischemia of the nerves → vasa nervosum
pain of the dying nv.

* FONTAN Classificam :-
Stage 1 : no clinical symptoms
Stage 2 : pt. has intermittent claudicam → 2A > 200 m well compensated
2B < 200 m, poorly compensated
Stage 3 : Rest pain
Stage 4 : Gangrene & ulcer

* Rutherford Classification :- (6)
0 – Asymptomatic
1 – mild
2 – moderate
3 – severe
} claudicam
4 – Rest pain
5 – minor tissue loss
6 – major tissue loss.

Ischemic pain more at night.

Causes of pain in foot – Diabetic neuropathy (peripheral neuropathy)
tendonitis
Metatarsalgia
March fracture

H/o blackish discolouration of left 1st toe noticed 3 months back, which was insidious in onset, associated with increased sensation, with no h/o trauma to foot. He underwent amputation of toe at local hospital.

H/o blackish discolouration of remaining toes of left foot for 1 month. The blackish discolouration progressed to involve the whole of left foot & lower part of left leg in last 1 month. It is associated with loss of sensation of left foot with no h/o trauma to foot.

Cause of blackish discolouration – Gangrene – Dry → Clear cut line of demarcation
no foul odour
no injectn
collaterals develop (slow occlusion)

Wet Gangrene in relation to vascularity → Embolism
no time for collaterals to develops ⇒ results in massive gangrene.

Imp. causes of embolism: AF, Mitral valveds. (young pt.)
Aneurysm
Atherosclerotic (elderly pt.)
MI

Pain, pallor, pulselessness, poikilothermia, paraesthesia

The dried black area over dorsum and lateral part of ankle sloughed off and he developed ulceration 1 week back. It developed spontaneously, painful, hypersensitive with no discharge.

He is K/c/o DM type II since 7 years and was OHA for 7 years and on Insulin for last 1 month.

He is K/c/o HTN on medication since 4 years.

He is K/c/o smoker, smokes 4 to 5 cigarettes per day for the last 20 years.

Slough ? Dead subcutaneous tissue

Vascular complication of DM - Macroangiopathy such as femoral, common iliac A.
Microangiopathy
↓
capillaries

Smoking & arterial occlusive ds → Nicotine - vasoconstriction
Carboxy Hb → hypoxia
Vasospasm

Thromboangitis obliterans - other name for Buerger's ds.
↳ microthrombus in media

Smoking Index > 300 ⇒ concerning & risk factor

No h/o claudication pain in left thigh, R LL & both upper limb.
No h/o fainting, transient blackouts (to rule out CCA occlusion)
No h/o chest pain (→ CAD), abdominal pain (→ mesenteric ischemia (postprandial pain or ↑ ang-)), GI symptoms, blurring of vision (→ involvement of retinal A ⇒), oliguria, weakness / paraesthesia in UL, fever, superficial thrombophlebitis.

Rule out other causes :- TIA, syncope, blurring of vision
Impotence (bilateral common iliac A - involvement
↳ LERISCH syndrome

Rule out other common causes of ulceration -
DKA - severe vomiting abdominal pain oliguria, anuria
Rule out lipid abnormalities.

Effect of medicine on symptoms?

Pt. would have to hang his leg.

Buergers → all 3 layers of artery is inflammed.

Lipid abnormalities are familial.

Past History :-

Not a K/C/O TB, asthma, CAD, epilepsy
H/O amputation of 1st toe of left foot 3 months back.
N/O major surgery or long term hospitalis

Drug History :-

Tab. METFORMIN 500mg 1-0-1 (DM) for 7 years and on regular insulin for last 1 month.
Tab. TELMISARTAN 40mg 1-0-0 ✓
Tab. HYDROCHLOROTHIAZIDE 12.5mg 1-0-0
No H/O any known drug allergy

Personal History :-

Consumes mixed diet.
Appetite - N
Sleep - disturbed (due to rest pain) (usually seen at night, pt. cannot sleep at night)
Bowel & Bladder - normal & regular
Known smoker - Smokes 4-5 cig/day - 20 yr.
Consumes alcohol occasionally

Family History :-

Married & has 3 children
No relevant history in family

Why amputation is done?

for gangrene as the ulcer has to heal.

If pt. has pedal edema → DM pt. probably has injection of foot. ↓ cellulitis ↓ spreading s/c inflammation

Abscess - localized collection of pus.

Thickening of brachial artery - Decreased brachialis or dancing brachialis ↓ Atherosclerosis

low volume pulse + thickened vessel wall → PVD

General Physical Examination

Patient is conscious, coherent, cooperative, well oriented in time, place & person.

Sitting comfortably with legs hanging below the level of bed.

Consent was taken.

He is moderately built & nourished.

Height = 155 cm

Weight = 55 kg

BMI = 22.89 kg/m²

Pallor was present

No icterus, cyanosis, clubbing, generalised lymphadenopathy, pedal edema

VITALS :-

1) Pulse - 100 bpm, right radial, regular rhythm, normal volume, character, no radial-radial delay, no radio-femoral delay, no vessel wall thickening.
2) BP = 134/90 mm Hg in both arms in supine position.

RR = 16 cycles/min

Temp = 98.5°F

Local Examination :-

Pt is explained about the procedures and is examined in supine position under adequate light exposure.

Both the limbs are completely exposed from the level of ASIS to the tip of toes -

Inspection of left lower limbs:

Attitude of limbs - legs hangs down from bed
1st toe - amputed.

There is black mummified appearance and
dry gangrene of remaining toes with blackish
discolouration of entire foot and lower part
of leg till 2cm above malleolus with clear
line of demarcation.

The left leg below the knee shows signs of
Ischemia - like thining of skin, loss of hair,
subcutaneous fat & lustre. The nails show
transverse ridges and are brittle.

There are 2 ulcers:-
5 x 4cm over dorsum of foot.
8 x 3cm over lateral malleolus.

Both ulcers are irregular in shape, punched out
with irregular margin, grey fibrotic tissue on
floor, extensor tendons exposed on dorsum
of foot, lateral malleolus exposed on
lateral side. No discharge found over ulcer.
Surrounding skin is dry and pale.
Wasting of calf muscles noticed in
left lower limb.

don't say signs of chronic ischemia
start inspection from distal to proximal.

- talk about the biggest ulcer

Burger's angle of circulatory insufficiency

Burger's Vascular Angle :- Toes already gangrenous indicating severe ischemia. less than 30° is significant.

Capillary filling time - prolonged (>,20 secs)

Ischemia - Reversible stage of tissue hypoperfusion.

Venous refilling - Veins are guttered & delayed refilling is noticed.
→ ↑ in AV fistula formation.

Infarction - Irreversible

Thigh of the affected limb is normal.

Right LL - N

No engorged veins.

Pre Gangrene -
1) Rest pain
2) Edema
3) Color Δ
4) Hyperesthesia

PALPATION :-

The left leg is cold when compared to right leg. Skin temp. feels normal just below knee joint.

Gangrenous toes are shrivelled & mummified.

Black mummified appearance, dry gangrene of remaining toes, loss of sensation, with black discolouration of entire foot and lower part of leg till them above malleolus with ochre line of demarcation.

Tenderness is noticed at junction of gangrenous area and normal tissue.

no need to mention ← Crossed leg test / Fuschig test - Oscillatory movement of left leg noted.

PALPATION OF LEFT LIMB :-

Pulse chart should come first and then motor & nv. examination

Movement of joints :- At intertarsal, mid tarsal, ankle joints movements lost. At knee and hip joint movements possible.

Motor System Examination :-

Tone - normal
Power - Normal
Bulk - decreased

	R	L
Calf	35cm	29cm
Thigh	50 cm	50 cm

Sensory System of left leg :-
Crude & fine touch, pain sensation, temp. sensation above ankle above 2cm from medial malleolus - N.
Hyperesthesia of left foot - present.
→ Patellar reflex ⊕ on both sides.
→ Ankle reflex not able to elicit in left foot.
→ Plantar reflex - Ⓐ
→ Region LN examination - N.

Skin lesions
Dry g *

Palpation of peripheral pulses :-

++ = Norm
+ = Weak
- = Abs

Artery	Right	Left
Dorsalis pedis	+	-
Ant. tibial	+ +	-
Post. tibial	+ +	-
Popliteal	+ +	-
Femoral	+ +	+ +
Radial	+ +	+ +
Brachial	+ +	+ +
Axillary	+ +	+ +
Subclavian	+ +	+ +
Sup. temp.	+ +	+ +
Common carotid	+ +	+ +

Person TAO
+
Thrombophlebitis
↓
migratory superficial thrombophlebitis
↓
Sign?

Examine abdomen - To r/o pelvic mass.
Examine cardiac heart sounds → Reason of embolism

Diagnosis :-
PVD due to atherosclerosis at the femoral