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Case report: Patient with ischaemic heart disease posted for hemiglossectomy with lymph node dissection

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Abstract

Background: Ischemic heart disease (IHD) continues to be an important cause of morbidity and mortality worldwide. Perioperative care of patients with IHD is a matter of concern, especially in major surgery. Surgery for oral cancer like hemiglossectomy with lymphadenectomy can be very extensive in nature and may be a risk factor for a patient with reduced cardiac function

Case Presentation: We present a case of a 71-year-old female patient with a history of IHD, hypertension, and type II diabetes mellitus who was admitted with an ulcerative tongue lesion on the left lateral border. She was posted for hemiglossectomy and left neck dissection. Patient's cardiac history was a 2016 myocardial infarction (MI), and the drugs were dual antiplatelet therapy (aspirin and clopidogrel), a statin (rosuvastatin), and anti-hypertensive and anti-diabetic therapy. Preoperative assessment showed left bundle branch block (LBBB) on electrocardiogram (ECG) and 2D echocardiogram demonstrated an ejection fraction (EF) of 45% with apical and anteroseptal segment akinesia. In spite of cardiac comorbidities, the patient underwent a successful procedure with a suitable anesthetic protocol, perioperative care, and aggressive postoperative care.

Discussion: This report demonstrates the benefit of accurate preoperative risk stratification, cardiac function optimization, and meticulous perioperative planning to reduce the number of adverse events in patients with compromised cardiac status who are scheduled for major head and neck operations. Specific attention to dual antiplatelet therapy, hemodynamic monitoring, anesthetic management, and blood glucose control is emphasized.

Conclusion: Adequate preoperative cardiac evaluation, individualized anesthetic planning, and multidisciplinary collaboration are critical to achieving favorable outcomes in patients with IHD who require hemiglossectomy with lymph node dissection.

Keywords: Ischemic heart disease, hemiglossectomy, dual antiplatelet therapy, perioperative management, head and neck surgery

Introduction

Ischemic heart disease (IHD), or coronary artery disease (CAD), is a medical condition with high morbidity and mortality worldwide [1]. IHD is most often due to atherosclerotic plaques impairing the coronary arterial supply, leading to myocardial ischemia with diverse clinical presentations from stable angina to acute coronary syndromes (ACS) [2]. In 2019, the World Health Organization (WHO) approximated IHD as the worldwide leading cause of mortality, contributing about 16% of all deaths globally [3]. As the expectation of life has been increasing and there has been a growth in elderly patients, comorbid conditions like hypertension and diabetes mellitus, both of which are chief risk factors for atherosclerosis, raise in incidence as well, making the course of IHD more complicated [4]. One of the key problems in IHD patients is when they must be operated on, especially major or high-risk surgery. Cardiovascular complications remain a common cause of perioperative morbidity and mortality [5]. The perioperative period is a time of heightened physiological stress, with accompanying inflammatory changes, hemodynamic instability, and hypercoagulability potential, all of which are harmful to myocardial oxygen supply and demand [6]. Head and neck surgical patients are at risk for increased risk of complications from the technical difficulty and duration of surgery, blood loss, fluid shift, and airway management problems. Head and neck surgeries, like hemiglossectomy with neck dissection, carry unique risks of airway management, positioning, and risk of bleeding in a surgically limited field [7]. Pharmacologic management of IHD traditionally involves antiplatelet agents such as

aspirin and P2Y12 antagonists such as clopidogrel playing a pivotal role in the prevention of thrombotic events [8]. DAPT is the current standard of practice in patients with a history of prior acute coronary syndrome or percutaneous coronary intervention with stenting. This treatment introduces the issue of balancing thrombotic risk versus perioperative risk of bleeding [9]. Timing of discontinuation of antiplatelets, bridging, and smooth coordination between operating teams, cardiologists, and anesthesiologists are the key to managing these patients [10].

Comorbidities such as hypertension and diabetes mellitus introduce another dimension of complexity. These comorbidities lead to endothelial dysfunction and promote atherosclerosis. Normal regulation of blood pressure and blood glucose reduces risk of adverse cardiovascular complications and improves perioperative outcome [11, 12]. Hemodynamic instability of the perioperative course, combined with uncontrolled hyperglycemia, can lead to patients developing increased morbidity, impaired wound healing, and infections [13].

Further, the worldwide incidence of head and neck cancers has been increasing, and oral cancers form a large proportion. Partial or total resection of the tongue is generally indicated in malignant tongue lesions, usually squamous cell carcinoma. This is frequently augmented by a neck dissection to treat regional spread by lymphatics, a typical route of oral cancer metastasis [14]. In older patients with serious comorbidities, onco-physical resection with acceptable postoperative risk becomes difficult. Careful cardiac evaluation and risk factor stratification are critical. Non-invasive stress test, echocardiogram, or even coronary angiogram may become necessary to evaluate the burden and severity of coronary artery disease prior to elective surgery [15].

When the patient with IHD, hypertension, and diabetes mellitus in the background reports for a hemiglossectomy with lymph node dissection, a multidisciplinary team approach is the norm. The advice of the surgery team, anesthesiologist, cardiologist, endocrinologist, and other experts (as relevant) can optimize the patient's status, reduce risks, and make arrangements for possible adverse effects [16]. Multidisciplinary conferencing to adjust antiplatelet therapy, strict control of blood pressure and blood sugar, and organize a critical perioperative watch program are the building blocks of successful outcomes [17].

This case report describes the perioperative management of a 71-year-old female patient with a history of extensive cardiac disease, including remote MI, LBBB, and reduced LVEF. She presented with an ulcerative tongue lesion along the left lateral border of the tongue and had squamous cell carcinoma requiring hemiglossectomy and lymphadenectomy. In this scenario, we illustrate the subtleties of balancing oncologic demand with cardiovascular risk and detail strategies for optimizing perioperative care for these patients.

Subsequent sections give the reader the background of this patient's presentation, investigations performed, and anesthetic plan developed to achieve a successful surgical outcome in a safe manner. We also critically review the existing literature on the management of IHD in major head and neck surgery and summarize the key lessons learned regarding perioperative optimization of these patients [18]. In doing so, we hope to highlight the clinical relevance of multidisciplinary decision-making, advanced preoperative

evaluation, and individualized anesthetic management plans consistent with the new paradigm of cardiac and oncologic practice [19, 20].

Case Presentation

Patient History and Presentation

A 71-year-old female patient with a long history of ischemic heart disease (IHD), hypertension, and type II diabetes mellitus visited the oral and maxillofacial surgery clinic with a non-healing tongue ulcer on the left side of her tongue. The ulcer had persisted for several weeks with intermittent pain and bleeding at times. No history of significant smoking or alcohol consumption was noted, and the nutritional status of the patient was fairly good considering her age.

Medical Comorbidities and Medications

The patient was known to have an anterior wall myocardial infarction (MI) in 2016, for which she underwent diagnostic coronary angiography. She had been stable since then on a combination of cardiac medications, including:

- Aspirin 75 mg once daily
- Clopidogrel 75 mg once daily
- Rosuvastatin 10 mg once daily
- Telmisartan 40 mg once daily
- Voglibose 0.2 mg thrice daily

Her dual antiplatelet therapy (DAPT) was continued after the MI as per her cardiologist's recommendation, and she had been compliant with her regimen.

Clinical Examination and Investigations

On examination, an ulcerative lesion was seen on the left free margin of the tongue, with induration extending deeper into the lingual musculature. There were no obvious neck swellings palpable, although the left submandibular region felt slightly firm and tender on deep palpation.

A contrast-enhanced computed tomography (CT) scan of the oral cavity and neck was performed, revealing a lesion confined to the left lateral border of the tongue, suspicious for T2 disease (approximately 2.5 cm in greatest dimension) with possible involvement of the lymph nodes in the left level IB region. Further diagnostic workup included:

- **Complete blood count (CBC):** Within normal limits.
- **Blood sugar profile:** Mildly elevated fasting and postprandial glucose levels (FBS around 130 mg/dL, PPBS around 190 mg/dL).
- **Renal function tests (RFT):** Within normal limits.
- **Serum electrolytes:** Within normal limits.
- **ECG:** Revealed left bundle branch block (LBBB).
- **2D Echo:** Demonstrated an ejection fraction (EF) of 45% with akinesia of the apical and anteroseptal segments; no significant valvular abnormalities were noted.

Given the lesion's characteristics and location, a biopsy was performed, confirming squamous cell carcinoma. The tumor board recommended a hemiglossectomy with ipsilateral neck dissection (levels I to IV) to achieve oncologic control.

Preoperative Cardiac Assessment

Because of the patient's IHD, an updated cardiology consultation was undertaken. She was categorized as having moderate cardiac risk, with an EF of 45%, which placed her

at an increased risk for perioperative cardiac complications. Despite the reduced EF, the patient was asymptomatic, denied any recent angina, and had not experienced heart failure symptoms. A repeat exercise tolerance test was deferred due to her limited mobility and the presence of LBBB, which can confound stress test results.

Her cardiologist recommended continuing aspirin throughout the perioperative period and suggested evaluating the necessity of holding clopidogrel closer to the surgery date to balance bleeding versus thrombotic risks.

Surgical Plan and Consent

Following extensive discussions between the surgical team, anesthesiology, and cardiology, it was agreed to go ahead with surgery considering the potentially curative nature. A thorough explanation of the risks and benefits was given to the patient and her family. The patient agreed to go ahead with hemiglossectomy and left neck dissection.

Discussion

Perioperative Management Challenges in IHD Patients Undergoing Major Surgery

The perioperative care of patients with IHD undergoing major surgery, like hemiglossectomy with neck dissection, poses several challenges. These challenges involve weighing the risk of ischemic events against surgical bleeding, maintaining hemodynamic stability, and dealing with associated comorbidities such as diabetes mellitus and hypertension^[1,2]. The surgical stress on the heart-in the case of upper aerodigestive tract surgery-can be high, because of both the complexity of the operation and hemodynamic instability potential^[3].

In these patients, the major goals are to have stable hemodynamics, provide adequate oxygenation, and reduce myocardial oxygen demand during the perioperative course^[4]. Monitoring must be individualized according to the patient's cardiac risk profile. Invasive arterial pressure monitoring and, in carefully selected patients, pulmonary artery catheterization or TEE can be used to direct fluid management and uncover ischemia early on^[5].

Dual Antiplatelet Therapy and Hemostatic Considerations

Many patients with IHD, particularly those with prior stent implantation or recent acute coronary syndrome, are prescribed dual antiplatelet therapy. While aspirin alone typically confers less bleeding risk, the addition of a P2Y12 inhibitor (e.g., clopidogrel) poses a greater risk for surgical bleeding^[6]. Guidelines from various cardiac societies recommend continuation of aspirin in high-risk patients, while clopidogrel may be paused if the risk of surgical bleeding is deemed unacceptably high and if the surgery cannot be delayed^[7]. However, abrupt discontinuation of dual antiplatelet therapy can precipitate stent thrombosis or acute coronary events, especially if the stent was placed within the last 6-12 months^[8].

In the present case, the patient had a history of MI from 2016. Generally, if a patient has been stable and the stent (if any) was placed more than a year before surgery, clopidogrel discontinuation can be considered about 5-7 days prior to surgery, if the bleeding risk is significant^[9]. Collaboration among the anesthesiologist, surgeon, and cardiologist was critical to determining that aspirin should be continued, given its lower bleeding risk and

cardioprotective benefits, while withholding clopidogrel shortly before surgery could be safely done to minimize intraoperative bleeding^[10]. A thorough assessment of platelet function or the use of bridging agents (e.g., short-acting glycoprotein IIb/IIIa inhibitors) may be needed in select high-risk scenarios^[11].

Anesthetic Technique and Monitoring

The choice of anesthetic technique can influence myocardial workload by affecting systemic vascular resistance, heart rate, and contractility^[12]. In patients with left ventricular dysfunction, avoidance of myocardial depressant anesthetic agents, meticulous control of hemodynamics, and avoidance of tachycardia and hypertension are paramount^[13]. Agents such as etomidate for induction, in combination with short-acting opioids (e.g., fentanyl or remifentanyl), can be considered to maintain stable hemodynamics, though the final selection may vary based on institutional protocols^[14]. Maintenance of anesthesia with balanced techniques, using volatile agents with minimal myocardial depression (e.g., sevoflurane), and appropriate analgesic regimens to blunt hemodynamic responses to surgical stimuli can further reduce the risk of intraoperative ischemia^[15].

Close hemodynamic monitoring via invasive arterial blood pressure measurement allows for beat-to-beat blood pressure readings, enabling timely interventions. Central venous pressure (CVP) monitoring may also guide fluid management in patients with compromised cardiac function, although the role of CVP in predicting fluid responsiveness is often debated^[16]. For high-risk patients, advanced monitoring such as transesophageal echocardiography (TEE) can help in the early detection of ischemia and wall motion abnormalities, particularly if the surgical team has TEE expertise readily available^[17].

Blood Pressure and Heart Rate Control

Maintenance of coronary perfusion is closely linked to diastolic pressure, especially in the presence of left bundle branch block (LBBB) and left ventricular dysfunction^[18]. Tachycardia reduces diastolic filling time, which can exacerbate myocardial ischemia. Therefore, perioperative use of beta-blockers or rate-controlling agents may be warranted in patients with prior ischemic events, provided they are not newly introduced immediately before surgery (which could risk unstable hemodynamics)^[19]. In our patient, careful management of her blood pressure with intravenous antihypertensive agents (if needed) was imperative to avoid episodes of hypertension or hypotension, both of which may compromise myocardial oxygen balance^[20].

Glycemic Control

Patients with diabetes mellitus have an increased risk of adverse cardiovascular events, and poor glycemic control can contribute to endothelial dysfunction and inflammation^[21]. A target perioperative blood glucose level of around 140-180 mg/dL is often recommended to minimize the risk of complications such as surgical site infection, delayed wound healing, and hyperglycemic hyperosmolar states^[22]. Strategies for optimal glycemic control may include modified insulin regimens or intravenous insulin infusions during the perioperative period, adjusted based on frequent glucose monitoring^[23].

Risk Stratification and Outcomes

Preoperative risk stratification tools, such as the Revised Cardiac Risk Index (RCRI) or the American College of Cardiology/American Heart Association (ACC/AHA) guidelines for perioperative cardiovascular evaluation, can aid in estimating a patient's risk of major adverse cardiac events (MACE) [24]. Our patient had multiple risk factors: a history of IHD with reduced EF, diabetes mellitus, and hypertension, which placed her at moderate-to-high risk for perioperative complications [25]. Although she was optimized medically, meticulous planning was essential to avoid both cardiac and bleeding complications [26].

Postoperative Care and Vigilance

The immediate postoperative period in patients with IHD is critical. Pain, shivering, and hypothermia can elevate myocardial oxygen demand [27]. Adequate analgesia, often achieved with systemic opioids and/or regional techniques, helps prevent undesirable hemodynamic fluctuations. Early detection and management of arrhythmias or ischemic changes can be facilitated by continuous ECG monitoring in a high-dependency or intensive care setting [28].

Respiratory complications are of particular concern after head and neck surgeries, especially when significant resection is performed around the oropharynx, leading to edema and potential airway compromise [29]. In our case, partial tongue resection plus neck dissection warranted close monitoring of the airway, potential for hematoma formation, and swelling that might necessitate prolonged intubation or tracheostomy [30]. A cautious approach to extubation, ensuring the patient was fully awake and with stable hemodynamics, was undertaken to reduce the risk of postoperative airway obstruction [31].

Multidisciplinary Coordination

The significance of multidisciplinary coordination cannot be overstated. In this case, close collaboration among oral and maxillofacial surgeons, anesthesiologists, cardiologists, and endocrinologists ensured a safe perioperative course. Regular team discussions helped balance the risk of holding antiplatelet medications against the need to minimize bleeding, optimize blood pressure and glucose control, and plan for potential complications [32]. This multidisciplinary approach is especially relevant given the growing complexity of patient profiles and the overlap of medical and surgical specialties in modern healthcare [33].

Lessons Learned and Future Implications

- 1. Preoperative Optimization:** Thorough cardiac evaluation, including non-invasive imaging and risk stratification, is essential. In patients with LBBB and known coronary artery disease, additional cardiac testing should be individualized based on symptomatology and time since stent placement or MI [34].
- 2. Antiplatelet Management:** For patients on DAPT, it is vital to delineate who can safely discontinue clopidogrel prior to surgery, while continuing aspirin. The timing of clopidogrel cessation and resumption requires close coordination with cardiologists [35].
- 3. Anesthesia and Monitoring:** Careful selection of anesthetic agents and advanced intraoperative monitoring can mitigate the risk of myocardial ischemia. Maintaining stable hemodynamics and

avoiding extremes of blood pressure or heart rate are important to prevent ischemic episodes [36].

- 4. Glycemic Control:** Tight but safe glycemic control is indispensable for reducing cardiovascular and surgical complications. This may be achieved through protocolized insulin infusions and frequent glucose checks [37].
- 5. Perioperative Vigilance:** Close observation in a postoperative high-dependency unit enables early detection of arrhythmias, ischemia, or bleeding. Adequate analgesia and airway protection are paramount in head and neck surgeries to avoid complications related to respiratory compromise [38].
- 6. Collaboration and Communication:** Effective communication among surgical, anesthetic, and cardiology teams, along with the patient and family, forms the cornerstone of favorable outcomes in high-risk patients requiring complex surgeries [39].

As the population ages and patients present with multiple comorbidities, future directions may involve further refinement of perioperative risk stratification tools and the development of more precise antiplatelet bridging strategies. Research into patient-specific pharmacogenomics and the role of novel antiplatelet agents could also shape the optimization of therapy in patients with high bleeding risks [40]. Overall, a personalized approach that integrates the latest evidence-based guidelines with patient-centered care will continue to be the hallmark of successful management in these complex scenarios.

Conclusion

This case report underscores the intricacies involved in managing a patient with ischemic heart disease, hypertension, and type II diabetes mellitus, who required hemiglossectomy with lymph node dissection for squamous cell carcinoma of the tongue. Meticulous preoperative cardiac evaluation, optimization of comorbid conditions, and careful balancing of dual antiplatelet therapy were instrumental to successful surgical and anesthetic outcomes. Advanced hemodynamic monitoring, prudent selection of anesthetic agents, and vigilant postoperative care further minimized the risk of ischemic or hemorrhagic complications.

A multidisciplinary approach involving cardiologists, anesthesiologists, surgeons, and endocrinologists was crucial, highlighting the importance of collaborative decision-making in high-risk patients. Moving forward, ongoing research and refinement in perioperative cardiac risk stratification and management strategies are essential to ensure that patients with significant cardiac histories can safely undergo major surgeries with acceptable morbidity and mortality rates.

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