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A Clinical, Radiological, Histopathological Examination of Lung Cancer in Patients Attending Ghccd

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Abstract: *50 Patients Attending Ghccd With Complaints Of Cough,Haemoptysis ,Chest Pain And Shortness Of Breath With Chest Xray Suggestive Of Mass Lesion Were Taken. Cect Chest Was Done.Depending Upon The Chest Lesion, Ct Guided/Transthoracic Or Bronchoscopic Guided Fnac/Biocpsy Done And Specimen Sent For Cytohistopathological Examination.The Results Were Analysed.Male Patients Aged 41-60yrs Were More When Compared To Female Patients. Common Histopathological Patterns Are Adeno Carcinoma And Squamous Cell Carcinoma. Smoking Was A Major Risk Factor.*

I. Introduction

In the 21st century lung cancer emerged as the most common cause of malignant disease in world. Lung cancer contributes about 13% of all cancers.

Aim: To study clinical, radiological and histopathological profile of the lung cancer patients attending GHCCD

II. Materials And Methods

In current study patients between age group from 40 to 70+ years were included over a period of 2 years and 3 months i.e. September 2012 to November 2014. 50 participants, already diagnosed with lung carcinoma on basis of their clinical history, diagnostic procedure e.g. transthoracic lung biopsy/fnac, bronchoscopy thoracoscopy, were included.

III. Results

Out of the 50 patients studied, it was observed that male patients 42[84%] outnumbered the female patients 8[16%]. Majority of patients were in age group of 41-60 years 29 in number 58%. Smoking was found to be the commonest risk factor among 44[88%] followed by occupational risk factor among 10 [20%].Weight loss ,cough and hemoptysis were the predominant symptoms present in 80%,74%, and 48% of cases, respectively. Parenchyma lesions were present in 44 [88%] cases,2 [4%] had pleural effusion and 4 [8%] had hilar prominence on chest X-ray .Commonest. Histopathological pattern was adenocarcinoma in 21 [42%]followed by squamous cell carcinoma in 20 [40%] and small cell carcinoma in 6 [12%], undifferentiated carcinoma in 2[4%],and atypical cells in 1[2%].

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Lung Cancer –List Of Patients

1.B.ESWARAMMA	F39	EPITHELIAL CELL CARCINOMA
2.B.VARALAMMA	F61	UNDIFF CARCINOMA
3.J.NARASAMMA	F60	SQUAM CELL CARCINOMA
4.K.RAMU	M50	LTPANCOAST[SQAMCELL RCINOMA]
5.JAGANMOHAN	M65	SQUAM CELL CARCINOMA
6.M.RAMU	M60	SQUAM CELL CARCINOMA
7.B.PADMANABHASWAMI	M73	SQUAM CELL CARCINOMA
8.SATISH	M60	ADENOCARCINOMA
9.SATTAMMA	F65	ADENOCARCINOMA
10.K.RAMARAO	M71	SMALL CELL CARCINOMA
11.L.GANGAMMA	F65	SQUAM CELL CARCINOMA
12.S.GANGAMMA	F76	ATYPICAL CELLS
13.MOHAMMED	M64	SQUAM CELL CARCINOMA
14.ADINARAYANA	M53	SQUAM CELL CARCINOMA
15.BUDHIA	M45	ADENOCARCINOMA
16.CH.RAMUNAIDU	M60	ADENOCARCINOMA

17.R.SIMHACHALAM	**M87**	**SQUAM CELL CARCINOMA**
18.T.RAMAKRISHNA	**M56**	**SQUAM CELL CARCINOMA**
19.B.VENKINAIDU	**M60**	**SMALL CELL CARCINOMA**
20.K.NOOKA RAJU	**M65**	**SMALL CELL CARCINOMA**
21.P.SATYA NARAYANA	**M58**	**ADENOCARCINOMA**
22.E.BABULU	**M48**	**ADENOCARCINOMA**
23.M.SANYASI RAO	**M60**	**ADENOCARCINOMA**
24.V.SANYASI	**M70**	**SQUAM CELL CARCINOMA**

25.CHUCUAN	**M57**	**ADENOCARCINOMA**
26.K.MOHANA RAO	**M74**	**SMALL CELL CARCINOMA**
27.NARASIMHULU	**M50**	**SQUAM CELL CARCINOMA**
28.D.CHINNA RAO	**M71**	**SMALL CELL CARCINOMA**
29.G.POTHU RAJU	**M58**	**SQUAM CELL CARCINOMA**
30.B.MUTYALU	**M60**	**ADENOCARCINOMA**
31.S.SATYA VATHI	**F60**	**ADENOCARCINOMA**
32.B.SRI RAMULU	**M50**	**SQUAM CELL CARCINOMA**

33.G,.RAMAMURTHY NAIDU	**M85**	**ADENOCARCINOMA**
34.PALTNA RAMAYYA	**M50**	**UN DIFFERENTIATED CARCINOMA**
35.P.VENKATA PATHI	**M67**	**SQUAM CELL CARCINOMA**
36.L.JAGANNADHAM	**M70**	**ADENOCARCINOMA**
37.M.SATISH	**M50**	**ADENOCARCINOMA**
38.KORANGI RAMU	**M58**	**SQUAM CELL CARCINOMA**
39.B.RAMU	**M67**	**ADENOCARCINOMA**
40.NAINI THRINADH	**M50**	**ADENOCARCINOMA**
41.ESAMPALLI BODDANNA	**M60**	**ADENOCARCINOMA**

42.A.POLAMMA	F65	**SQUAM CELL CARCINOMA**
43.CHILLI RAMU NAIDU	M50	**ADENOCARCINOMA**
44.GAYATRI PITHAMBARAM	M55	**ADENOCARCINOMA**
45.B.APPALA RAJU	M55	**ADENOCARCINOMA**
46.MUDILA JAGANNADHAM	M64	**SQUAM CELL CARCINOMA**
47.P.SATYAM	M50	**SQUAM CELL CARCINOMA**
48.N.VENKATA SATYANARAYANA	M53	**SMALL CELL CARCINOMA**
49.S.BAHADUR	M70	**SQUAM CELL CARCINOMA**
50.M.APPA RAO	**M50**	**ADENOCARCINOMA**

IV. Conclusion

Study showed that incidence of lung carcinoma was commonest among 41-60 years age group with smoking as the most common risk factor and adenocarcinoma was the main type. Most of cases were diagnosed in advanced stage. To conclude, an old patient with history of chronic cough, unexplained weight loss, hemoptysis should be evaluated for lung cancer. The outcome of lung cancer is poor .Increased survival is possible, if the disease is detected early and treated adequately with multimodality approach.

Initiation of population based screening for early detection of cancer and primary and secondary prevention strategies for reducing the prevalence of tobacco consumption are high priorities to reduce lung cancer burden . At least 30% of the future cancer burden is potentially preventable by tobacco control. Spread of tobacco addiction, promoted by commercial interests in the world, is responsible for the lung cancer epidemic that is already taking hundreds of thousands of lives annually, unless checked , cigarettes will in next decade cause more than 1 crore deaths from cancer.

Action is also possible on dietary modification. Evidence has accumulated in recent years shows that excessive fat in the diet may induce some cancers and that whole grains, vegetables and fruits are protective . The same diet that lowers the risk of cardiovascular disease may inhibit the development of diet associated cancers.