Head and Neck Case 1
PATIENT HISTORY

Patient History
May 7, 2007

Otolaryngology Head & Neck Subjective: Patient was recently seen by a dentist, who noted a roughness in his lower alveolus, and wanted to have this evaluated prior to denture fitting. Patient denies any pain or bleeding, or other symptoms from this midline roughness, and he feels that it has been present since the time of the surgery.

Physical Exam: Face – He has an approximately dime shaped lesion on his right cheek. On his left eyelid there is some laxity and edema that has improved since last visit. On his left lower face, lower cheek area there is some significant lymphedema. Mouth: The patient is edentulous. He has symmetric palate elevation. In the inferior, anterior portion of the left side of the patient's tongue there is a small area that is mildly indurated with no ulcerations, is non-tender to palpation. On the anterior mandibular alveolus there is a small, bumpy lesion that is not ulcerated and nontender to palpation. The remainder of his oral cavity is free of lesions. Neck: No cervical lymphadenopathy is appreciated.

Assessment and Plan:
Pt is a 64-year-old gentleman who has two areas of concern, one on his tongue on the left side and the other on the mandibular alveolus each warranting biopsy.

Head and Neck Case 1
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
May 10, 2007

Final Diagnosis:
Oral mucosa, mandibular alveolus, biopsy: Squamous cell carcinoma in-situ. No evidence of invasive carcinoma.
Tongue, inferior anterior, biopsy: Squamous cell carcinoma in-situ, no evidence of invasive carcinoma. See comment.

Comment: There is very minimal stromal tissue so evaluation for the presence of invasive carcinoma is very limited.

END Head and Neck Case 1

Head and Neck Case 2
OPERATIVE REPORT

Operative Report
September 1, 2007

Procedures:
1. Right total parotidectomy with facial nerve dissection.
2. Right modified radical neck dissection.

Indications: Patient is a 48-year-old male with a two-month history of right cheek swelling. Examination revealed a right parotid mass. FNA was consistent with possible mucoepidermoid carcinoma. Grade was not specified.

Findings: There was an approximately 6-cm mass in the deep lobe of the right parotid gland. There was no obvious malignant lymphadenopathy, although there were some scattered benign appearing lymph nodes throughout the neck.

Head and Neck Case 2
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
September 13, 2007

Specimen: Right total parotidectomy and neck dissection, levels I, II, III, IV

Final Diagnosis:
Parotid, right, total parotidectomy with radical neck dissection:
1. Adenoidcystic carcinoma arising in pleomorphic adenoma (carcinoma ex-pleomorphic adenoma) with peripheral areas of dedifferentiation
   Tumor size: 6.0 x 4.2 x 4.0 cm
   Resection margins negative for tumor
2. One of sixteen lymph nodes positive for malignancy (1/16)
   Intraparotid: one lymph node negative for malignancy (0/1)
   Level I: one lymph node negative for malignancy (0/1)
   Level II: no lymph node identified
   Level III: eight lymph nodes negative for malignancy (0/8)
   Level IV: one of six lymph nodes positive for malignancy (1/6)

END Head and Neck Case 2

Head and Neck Case 3
CLINIC HISTORY AND PHYSICAL

History and Physical
January 16, 2007

History: The patient is a chronic smoker (75 pack year smoking history), chronic drinker, who just quit smoking and drinking a few months ago. He presented with a palpable lymphadenopathy over the left hemineck and was referred from his primary care physician to oral surgeon. He was found to have multiple lesions in the soft palate, in the tonsil, and also in the left hemitongue. Multiple biopsies were done, which confirmed invasive carcinoma in the left tonsil involving the retromolar trigone to soft palate and most likely the gingival area. He has separate lesion over the left hemitongue, mainly the lateral surface and biopsy shows squamous cell carcinoma. CT scan confirmed lymphadenopathy over the left hemineck but no evidence of disease was found in the chest.

Physical examination shows a thin patient, not emaciated. Head and neck palpation shows obvious lymphadenopathy over the left hemineck in the subdigastric region, measuring just under 3 cm. No other lymphadenopathy found. No bone pain found. Blood pressure 140/93, pulse 90 per minute and regular. Oral examination shows the patient is edentulous. He has an obvious lesion arising from the left tonsil, extending up to the soft and hard palate junction and also to the upper gingiva. Laterally, I think it has crossed the retromolar trigone to involve the buccal mucosa and the lower jaw gingiva. He has a separate lesion in the left lateral tongue measuring about 1.5 cm. It is ulcerated with an indurated base. Biopsy, as I have said, showed carcinoma in those areas.

Summary: The patient has extensive disease and I think he has a synchronous cancer in the tongue and in the tonsil since they are quite separated. They are not contiguous. I have discussed with him the treatment options including surgery versus chemo/radiation. In my opinion, I think surgery might give him a slightly better chance if he is operable and if the morbidity is not significant. If for whatever reason surgery is not an option or the patient refuses surgery, we can consider concurrent chemo/radiation using surgery as salvage. The patient is aware of the potential side effects of chemo/radiation but he needs to explore the option of surgery first. In view of that, I have asked the patient to get in touch with me after consultation with ENT surgery and after he makes a final decision.

END Head and Neck Case 3

Head and Neck Case 4
OPERATIVE SUMMARY

Operative Summary
February 28, 2007

Operation: Direct laryngoscopy with biopsy, esophagoscopy, bronchoscopy

Findings: The patient is a female who has a long history of alcohol and tobacco abuse who presented with a large left neck mass, level II left neck mass, and a left tonsillar lesion which is very suspicious for squamous cell carcinoma. CT scan of the neck demonstrated a 4 x 3.6 cm necrotic mass in the posterior triangle of the neck. In addition, there was a smaller necrotic anterior lymph node at a higher level. Additional workup including a chest x-ray demonstrated no obvious metastases.

There was a granular exophytic mass very suspicious for squamous cell carcinoma starting on the soft palate, left of uvula and extending along the free margin of the soft palate fully involving the left tonsil and extending down through the tonsillar fossa with extension into the base of the tongue adjacent to the tonsil. Palpation of the neck revealed a 5cm mass at the junction of level 2 and 3 in the left neck. The mass appeared to be mobile.

Head and Neck Case 4
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
February 28, 2007

Final Diagnosis:
A. Tonsil, biopsy left: Poorly differentiated squamous cell carcinoma.
B. Tongue, biopsy left base: Poorly differentiated squamous carcinoma.
C. Hypopharynx bx: Squamous mucosa showing mild chronic inflammation. No evidence of malignancy.
D. Uvula bx: Fragment of squamous mucosa showing superficial squamous cell carcinoma, well-to moderately differentiated.

END Head and Neck CASE 4

Head and Neck Case 5
HISTORY AND PHYSICAL

History and Physical
April 27, 2007

History of Present Illness: This patient noticed a progressive soreness of his throat since Thanksgiving. He denies any dysphagia or trismus. He has no fevers, chills, night sweats or weight loss. He has no complaints of hoarseness or dysphonia. He has refused any attempts at biopsy and suggestions regarding further work-up and possibly treatment.

Physical Examination: Oral cavity examination reveals a large bulky mass involving the left tonsillar region, carcinoma. Tumor appears to extend onto the soft palate from the region of the anterior tonsillar pillar and onto the retromolar trigone to the buccal mucosa on the left side. The tongue is not tethered. He has no trismus. Flexible nasopharyngoscopy reveals a second lesion involving the right aryepiglottic fold, extending into the arytenoids area, carcinoma. The right cord is immobile. Palpation of the neck reveals a 3 cm. fixed nodule involving the accessory chain superiorly and a jugulodigastric node approximately 2 cm and fixed on the left side. Both nodules are on the left neck. There is no other adenopathy.

Head and Neck Case 5
CT SCAN OF HEAD AND NECK

CT Scan of Head and Neck (Infused)
April 28, 2007

There appears to be an enhancing tumor involving the posterior oral tongue and the lateral left base of tongue, extending through the glosso-tonsillar sulcus into the tonsil inferiorly. It is not clear whether the tumor extends to the midline of the tongue.

A bulky tumor is present involving the right pyriform sinus, throughout its entire vertical extent. The tumor is most marked along this ventromedial aspect of the pyriform sinus, and infiltrates the aryepiglottic fold. The true cords and subglottic larynx are normal.

There is a 2 cm metastatic high left jugular node, and a 2.5 metastatic high left spinal accessory node. Smaller metastatic nodes are present in the mid left spinal accessory chain. A 2 cm mid left jugular metastatic node is present. Multiple additional metastatic nodes are present in the mid and low left spinal accessory chain.

Impression:
Multiple abnormalities are present. Bilateral metastatic lymphadenopathy is present in the neck, far worse on the left. There is a large right pyriform sinus carcinoma. A left base of tongue/glosso-tonsillar sulcus carcinoma is also suspected.

END Head and Neck Case 5

Head and Neck Case 6
HISTORY AND PHYSICAL

History and Physical
August 21, 2012

Patient has history of verrucous carcinoma of left vocal cord diagnosed June 3, 2007. On July 17, 2012, patient had microlaryngoscopy without biopsy showing an exophytic right bulky vocal fold lesion. No lymphadenopathy on physical exam.

Operative Procedures: July 20, 2012. Excision: Papillomatosis exophytic white growth involving right vocal cord to anterior commissure, possible tumor. August 21, 2012 Hemilaryngectomy: Carcinoma with focal superficial invasion.

Head and Neck Case 6
SURGICAL PATHOLOGY REPORT #1

Surgical Pathology Report
July 20, 2012

Final Diagnosis: Right vocal cord tissue: Verrucous carcinoma with no evidence of invasion.

Head and Neck Case 6
SURGICAL PATHOLOGY REPORT #2

Surgical Pathology Report
August 21, 2012

Final Diagnosis: Vocal cord lesion, right (hemilaryngectomy): Verrucous carcinoma with focal superficial invasion.

END Head and Neck Case 6

Head and Neck Case 7
HISTORY AND PHYSICAL

History and Physical
October 3, 2007

The patient is a 75-year-old Caucasian male who was referred after his primary dentist noticed an exophytic lesion of the left maxillary alveolar ridge. The patient is wearing full dentures on the maxilla, and the tumor was covered by the denture. On clinical examination, there was area of granular papillary mass on the left maxillary alveolar ridge extending anterior to the region of the premolar/molars and on the buccal aspect toward the vestibule. There was some area of ulceration, as well, some evidence of epulis fissuratum where the flange of the denture rests anteriorly. The biopsy slides were retrieved and were reviewed and revealed papillary squamous cell carcinoma in situ.

The patient was informed about the biopsy reports and was informed that the definitive treatment for this condition would be a wide local excision of the tumor with 1 cm margins. CT scans with bony windows were obtained to evaluate any bone involvement and revealed no evidence of bone involvement. The patient was informed that our initial intent was to reflect the tumor from the bone, and at that time carefully evaluate the periosteum as well as the underlying bone, and if there was no evidence of involvement, then we would proceed with the wide local excision with only soft tissues, but if there was any evidence of periosteal involvement and/or bone involvement, then he would require dissection.

Head and Neck Case 7
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
October 3, 2007

Final Diagnosis:
A. Palatal mucosa, biopsy: Squamous mucosa with no evidence of malignancy
B. Lateral palatal mucosa, biopsy: Squamous mucosa with severe dysplasia
C. Anterior buccal mucosa, biopsy: Moderate squamous dysplasia
D. Posterior buccal mucosa, biopsy: Squamous carcinoma in situ
E. Lateral palatal mucosa #2, biopsy: Squamous carcinoma in situ
F. Lateral palatal mucosa #3, biopsy: Squamous mucosa with no evidence of malignancy
G. Left maxillary alveolar ridge, resection: Papillary squamous cell carcinoma, no invasion seen. Carcinoma in situ is seen within 1 mm from the lateral margin

END Head and Neck Case 7

Head and Neck Case 8
SURGICAL PATHOLOGY REPORT #1

Surgical Pathology Report
March 2, 2007

Clinical History: Patient with posterior tongue leukoplakia.

Final Diagnosis:
A. Left lateral tongue, biopsy: Fragments of necrotic squamous cell carcinoma

Head and Neck Case 8
OPERATIVE REPORT

Operative Report
April 5, 2007

Preoperative Diagnosis:
1. Left lateral tongue lesion
2. Left floor of mouth lesion

Procedure: The patient was brought into the operating room and sedated with out complications. Next using 1% lidocaine with epinephrine a lingual nerve block on the left was conducted. In addition, 2 cc of 1% lidocaine with epinephrine were injected into the site of the left lateral tongue and floor of mouth lesions. The left lateral tongue lesion was 2 x 1 cm in diameter, it was a raised white patch. The left floor of mouth lesion appeared to be approximately 1 x 0.5 cm in length.

Head and Neck Case 8
SURGICAL PATHOLOGY REPORT #2

Surgical Pathology Report
April 5, 2007

Final Diagnosis:
A. Tongue, left lateral, biopsy: Invasive moderately differentiated keratinizing squamous cell carcinoma
B. Left floor of mouth, biopsy: Severe dysplasia/carcinoma in situ with superficial invasion

END Head and Neck Case 8

Head and Neck Case 9
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
February 4, 2007

Operative Diagnosis:
Carcinoma in situ and extensive leukoplakia of the oral cavity and oral pharynx. Excision of superficial carcinoma right retromolar trigone and tonsillar fossa (3x2 cm). Excision of superficial carcinoma left tonsillar fossa. Excision of leukoplakia left ventral tongue (2 cm diameter). Laser treatment was given to sites of oral leukoplakia.

Final Diagnosis:
A. Soft tissue right retromolar trigone, excision: Grade 2/4 superficially invasive squamous cell carcinoma involving the mucosa posteriorly. The adjacent mucosa shows moderate dysplasia.
B. Soft tissue, right tonsillar fossa, excision: Superficially invasive grade 2/4 squamous cell carcinoma with extensive carcinoma in situ at the prior biopsy site. Tumor involves the right inferior tonsillar fossa, retromolar trigone, and base of tongue. The adjacent mucosa shows moderate dysplasia. Surgical resection margins, including the deep, are negative for tumor.
C. Soft tissue left tonsillar fossa, excision: Superficially invasive grade 2/4 squamous cell carcinoma. The adjacent mucosa shows moderate dysplasia.
D. Soft tissue left retromolar trigone, excision: Mucosa shows moderate dysplasia with no malignancy identified.
E. Soft tissue left ventral tongue, excision: Squamous cell carcinoma in situ with no invasive carcinoma identified.

END Head and Neck Case 9

Head and Neck Case 10
HISTORY AND PHYSICAL

History and Physical
October 31, 2011

History: The patient has a history of left tonsillar carcinoma diagnosed in December 2007. He is status post preoperative radiation and chemotherapy with Cisplatin and 5-FU at that time. He failed initial therapy and underwent a left composite resection in June 2008. The patient did quite well after that. He presents now with a six-month history of problems swallowing and hoarseness for the past two months. He also notes a 40 pound weight loss over the past year.

Physical Examination: Head: unremarkable. Neck: without clear adenopathy on the right neck. On the left there are post treatment changes only. Oral cavity has an infiltrating lesion involving the soft palate and extending down to the right pharyngeal wall with what appears to be extension into the right tongue base. The airway is satisfactory.

Head and Neck Case 10
OPERATIVE REPORT

Operative Report
October 31, 2011

The patient underwent a triple endoscopy, which showed a massive lesion involving the right tonsil, extending up through the soft palate to the junction of the hard and soft palate as well as extending down through the tonsillar fossa into the right tongue base and apex of the right floor of the mouth and most inferiorly to the level of the epiglottis. No palpable neck mass was felt at the time of presentation.

Head and Neck Case 10
SURGICAL PATHOLOGY REPORT

Surgical Pathology Report
November 8, 2011

Final Diagnosis
Total tonsilectomy, mandibulectomy, pharyngectomy, palatectomy, and base of tongue resection: invasive poorly differentiated squamous cell carcinoma involving right dorsal base of tongue, palatine tonsil, soft palate and pyriform sinus. No invasion of mandibular bone is seen. Size of tumor: 8.5 x 4.5 cm. Right neck dissection shows 13 lymph nodes all negative for metastatic carcinoma.

END Head and Neck Case 10