Operative Report
07/19/2007

Preoperative Diagnosis: (none given)

Postoperative Diagnosis: (none given)

Operative Procedure: (none given)

Indications: The patient is a 56-year-old gentleman who noted a mass in his right neck for over a month. It was initially felt to be related to a dental infection, however, the mass has not resolved. He has had some diminution in size and diminution in the discomfort of the mass with oral antibiotics, but with persistence of the mass. A CT scan has revealed a 2 x 2 cm mass in the right neck. He presents for fine needle aspiration of the mass.

Procedure: With the patient in the supine position, the skin overlying the mass, which was just inferior to the angle of the mandible, was infiltrated with 1% Xylocaine with 1:100,000 epinephrine. With a 3 mL syringe, a 23-gauge needle, multiple passes were made into the mass. Good aspirates were obtained. The cytotechnician was present to take the aspirates as they were obtained. He tolerated the procedure satisfactorily, and was discharged, to be followed in the office.

Pathology Report
07/19/2007

Clinical History: Right neck mass

Specimen:
Thyroid nodule FNA

Gross Description:
The specimen consists of approximately 0.5 ml of red fluid which is concentrated and submitted for 2 Wright stained slides, 6 direct Papanicolaou stained slides, and 1 cell block.

Microscopic Description:
Received for evaluation are 2 Wright stained air dried smears, 6 Papanicolaou stained smears, and 1 H&E cell block from fine needle aspiration biopsy of thyroid nodule. Smears are essentially acellular.

Final Diagnosis:
Thyroid, fine needle aspiration biopsy of nodule: Insufficient material for evaluation

Radiology Report
07/29/2007

Sonogram Rt Neck

Real time grey scale sonographic imaging was acquired through the region of the right neck mass. There is an ill defined area anterior to the jugular and carotid vessels. This does not clearly represent thyroid tissue. The area was marked and sterilely prepped and draped. Under sonographic guidance, three passes were made using a 21 G needle and specimens were transferred to pathology. The patient tolerated the procedure well and left the department in stable condition. There is no evidence of post biopsy hematoma.

The patient tolerated the procedure well and left the department in stable condition. FNA of right neck mass.

Pathology Report
07/29/2007

Clinical History: Thyroid nodule.

Preoperative diagnosis: Right neck mass.

Specimen:
Right neck mass FNA

Gross Description:
The specimen consists of approximately 0.1 ml of red fluid which is concentrated and submitted for six Papanicolaou stained slides and two Wright stained slides. The quantity is not sufficient for a cell block.

Microscopic Description:
Received for evaluation are six Papanicolaou stained smears and two air dried Wright stained smears from fine needle aspiration biopsy of right neck mass. Several smears are abundantly cellular revealing background of necrotic debris and discohesive aggregates of highly atypical squamous cells with nuclear pleomorphism, nuclear molding and dense basophilic to orangiophilic cytoplasm.

Final Diagnosis:
Neck, right, fine needle aspiration biopsy: Positive for squamous cell carcinoma. See comment.

Comment: Dr. X has reviewed selected slides and concurs in the above interpretation.

Consultation: Radiation Oncology
08/19/2007

Reason for Consultation: Patient is a 56-year-old Caucasian gentleman seen in consultation regarding his recently diagnosed squamous cell carcinoma involving the right neck from as yet, an undetermined primary site.

History of Present Illness: The patient's history dates back at least until April of this year, when he noted a mass in the right neck, which was gradually enlarging. The patient reports antecedent symptoms of sore throat and a dry mouth. Previous ENT evaluations in this regard were unremarkable. The patient had, after presenting with an enlarging right neck mass, a CT scan of the neck on June 9, 2005, at Hospital B. and this demonstrated an enlarged right-sided cervical lymph node contiguous with the anterior margin of the right internal carotid artery, just distal to the bifurcation, measuring 2.4 centimeters in greatest dimension and the remainder of the study was unremarkable. The patient was evaluated by ENT surgeon. Subsequent ultrasound guided biopsy on July 29, 2007, with an FNA confirmed squamous cell carcinoma. Endoscopy at that time was unremarkable, according to the patient's notes.

The patient was further evaluated by a medical oncologist. Subsequent further staging studies including a PET scan on August 15, 2007, was obtained and this revealed a large, submandibular area of intense accumulation consistent with a known squamous cell cancer and corresponding to the neck mass on CT scan. Several smaller foci of increased activity were noted in the anterior midline of the submandibular region, consistent with involved nodes. No other areas of suspicious activity were noted, in particular, there was no evidence of a primary site. On my review of the images, there is some symmetrical increased activity in the base of the tongue region of uncertain significance. A repeat CT scan of the neck on August 16, 2007, revealed a mass in the right neck measuring 3.1 x 3.5 centimeters, just deep to the anterior aspect of the sternocleidomastoid muscle on the right and anterior to the internal carotid and jugular veins. There was a lymph node in the lower neck, which was nonspecific, measuring 12 millimeters. A mass in the right tonsillar region could not be excluded. The patient is seen today in consultation.

Currently, the patient states that he has had increased pain in the right neck area since his most recent clinical examination approximately one week ago. He also reports slurred speech for the past one-week and some pain and difficultly with swallowing. He further reports a tendency to bite the right side of his tongue for the past one week.

Past Medical History:
1. Significant for chronic low back pain. This relates to a back injury in December of 2002. He is status post spinal injection, secondary to chronic pain and has been on narcotic analgesics for many months.
2. He is status post cholecystectomy
3. He has a history of pneumonia
4. Borderline glaucoma
5. History of urinary tract infections and kidney stones

6. He has a history of arthritis
7. He does not have any history of prior radiation therapy

Allergies: The patient reports an allergy to penicillin and fentanyl. On questioning, he reports a possible intravenous dye exposure, however, he has not had any difficulties with his recent ct scans, which all included intravenous contrast.

Family History: Significant for the patient's father who died of colon cancer

Social History: The patient lives in a nearby city. He is accompanied today by his wife. He is disabled and used to work in maintenance at the local high school. He is a three pack per day for 50 years smoking history and continues to smoke. The patient was advised to quit smoking immediately. He has a positive alcohol history, but quit three years ago.

Review of systems:
Constitutional: The patient denies any fevers, poor appetite or weight loss
HEENT: Per history of present illness
Neurologic: The patient notes right neck pain, which causes headaches. He is also negative for any dizziness or sensory loss.
Cardiovascular: Negative
Respiratory: The patient notes an occasional cough
Gastrointestinal: Negative
Genitourinary: Negative
Musculoskeletal: Negative except for chronic low back pain

The remaining review-of-systems is unremarkable.

Physical Examination:
General: Patient is resting comfortably, in no acute distress
Vital Signs: WT: 220 pounds. BP: 146/86. P: 80. R: 18.
HEENT: Pupils equal, round, reactive to light and accommodation. Extraocular movements intact. Examination of the oral cavity reveals normal oral mucosa. Dentition is in poor repair. No unusual masses or lesions are noted in the oral cavity and visualized oropharynx.
Neck: Neck examination reveals a large mass in the right upper cervical area at approximately level 2. An area of induration measuring approximately 4 centimeters is noted with some surrounding soft tissue edema. The mass is semi-fixed and tender. Examination of the remainder of the neck is unremarkable bilaterally.
Lungs: Clear to auscultation and percussion
Back: Spine is nontender
Cardiovascular: Regular rate and rhythm without murmurs or rubs noted
Abdomen: A soft, nontender abdomen with normal abdominal bowel sounds and evidence of hepatosplenomegaly or masses.
Extremities: Without clubbing, cyanosis, or edema
Neurologic: Does not reveal any focal motor or sensory deficits noted in any of the upper or lower extremities. Evaluation of the cranial nerves reveals right-sided tongue deviation,

indicating a likely cranial nerve XII palsy on the right. The remaining cranial nerves appear to be intact. The patient walks with a cane.
Psychiatric: The patient is alert, oriented and cooperative

Radiographic Data: On June 9, 2007, a CT scan of the neck per History of Present Illness.
August 15, 2007, PET scan, per History of Present Illness.
August 16, 2007, CT scan of the neck per History of Present Illness.
August 16, 2007, CT scan of the brain was unremarkable for any suspicious findings.

Impression: Patient is a 56-year-old gentleman who presents with clinical stage TxN2aM0 squamous cell carcinoma of the right neck from an unknown primary, pending further evaluation.

Recommendations:
1. I discussed with patient and his wife the aforementioned clinical impression. I have had an opportunity to discuss the patient's case as well with the ENT surgeon. The patient has an appointment to see ENT early next week.
2. The next step in further evaluation is to have the patient to undergo triple endoscopy with blind biopsies in consideration of bilateral tonsillectomies in order to evaluate for potential occult sites.
3. As I discussed with the ENT surgeon, I am concerned that the patient's lymph node disease in the right upper cervical area (level 2) may be involving the peripharyngeal space and affecting the hypoglossal nerve, which would account for the patient's symptoms and clinical findings.
4. The ENT surgeon noted that he will be scheduling the patient to likely undergo further evaluation with triple endoscopy, as described above, once he has had an opportunity to re-evaluate the patient early next week. In addition, I have asked the patient to be evaluated at a nearby university hospital. From my standpoint, the patient would be a good candidate for aggressive combined chemoradiation therapy treatment, although I would note that the size of the lymph node in the right upper neck is at the upper limits of the ability of this treatment to provide local control. Potentially, the patient could require a solid surgical procedure.
5. Final recommendations will be pending the outcome of the tentatively planned triple endoscopy. I have asked the patient to contact this clinic once he has undergone this procedure so I can follow up with him regarding further treatment recommendations.

Thank you again for allowing me to participate in the care and evaluation of this very pleasant gentleman.

Sincerely,

DR RADIATION ONCOLOGIST

History & Physical

Admission Date: 08/30/2007

The patient is a 56-year-old gentleman who presents to the hospital with a chief complaint of painful swelling in the right side of his neck, which has been proven to be a metastatic squamous cell carcinoma.

History of Present Illness: This gentleman has a history of a progressively enlarging lymph node in his right neck, since about April of 2007. Associated with that, he has complained of a sore throat. Repeated head and neck examinations including indirect laryngoscopy and flexible nasopharyngoscopy have failed to detect any obvious abnormality of the upper aerodigestive tract. However, he has a large lymph node in the right neck, for which he has undergone fine needle on two occasions. The initial aspiration was non-diagnostic, but a subsequent fine needle aspiration was positive for squamous cell carcinoma. Since he had that positive fine needle aspiration, he has undergone oncology and radiation therapy evaluations. A PET scan has revealed intense uptake in the right neck and possible uptake in the right tonsillar area. As of this time, his primary site is undetermined. He presents to the hospital at this time for endoscopic evaluation of the upper aerodigestive tract.

Past Medical History: Previous surgical procedures include a cholecystectomy.

Current Medications:
1. Toprol 50 mg once a day
2. Nexium 40 mg twice daily
3. Aspirin 81 mg once daily
4. Advil on an as-needed basis
5. Percocet 10/325 one every three to four hours as needed for back pain and neck pain
6. Bactrim one twice daily
7. Nortriptyline 25 mg two to three times daily

Allergies: Penicillin and questionably to Fentanyl

Family History: Positive for cancer in his father, who died of colon cancer. There is a family history of heart disease. No family history of tuberculosis, bleeding disorders, or diabetes.

Social History: The patient is medically disabled because of back pain. He is married. He has a history of smoking 1-1/2 to 2 packs of cigarettes daily for many years. Past history of alcohol use, but currently denies any use of alcohol.

Review of Systems:
HEENT: As mentioned in the history of present illness. The mass in his neck has been causing considerable pain. He has also complains of pain with swallowing and he has recently been noted to have a right hypoglossal nerve paresis. There is no history of hoarseness, no history of shortness of breath.
Respiratory: The patient denies any current shortness of breath. He has a past history of pneumonia. No history of persistent cough. No history of hemoptysis.

Cardiovascular: History of hypertension, controlled with medication. No complaints of chest pain or palpitations.
Gastrointestinal: History of significant reflux which is controlled with proton pump inhibitors. He complains of increased thirst.
Genitourinary: History of previous history of renal stones and urinary tract infections. No current complaints of dysuria or frequency.
Musculoskeletal: The patient has significant back pain, for which he has been on narcotics for over a year. He has limited ambulation because of his back pain.
Neurologic: No history of seizure disorder. No history of sleep apnea.

Physical Examination:
General: Shows an alert, cooperative gentleman in no acute distress
HEENT: Inspection of the ears shows the ear canals to be patent and tympanic membranes are translucent. Middle ear is well ventilated. Inspection of the eyes shows the pupils to be equal and round. Sclerae and conjunctivae are normal. Examination of the nose shows the mucosa to be moist and normal in color. Septum is relatively midline. No abnormal secretions are present. Internal oral examination shows the oral mucosa to be moist and intact. Floor of mouth, buccal mucosa, retromolar trigone, and tonsillar fossae are also clean. The right side of the tongue is atrophic and the tongue deviates to the right side, when the tongue is protruded. Posterior pharyngeal wall looks normal. The gag reflex is appropriate. An indirect laryngoscopy shows no obvious lesions of the base of the tongue. The epiglottis is mildly erythematous, with retained secretions on the tip of the epiglottis. No exophytic or ulcerative lesions are noted. The supraglottic laryngeal mucosa is intact. Both vocal cords have normal mobility. Palpation of the neck reveals a large 3-4 centimeter mass at level 2 in the right neck. The mass is tender to palpation. It remains mobile. There is no other appreciable adenopathy of the posterior or anterior chain on either side of the neck, supraclavicular fossae has no palpable masses.
Chest: Auscultation of the chest reveals equally clear breath sounds on either side.
Heart: Heart has a regular rhythm. No murmurs or extra sounds were heard.
Abdomen: Palpation of the abdomen is deferred
Extremities: The extremities are grossly symmetric and normal. There is no muscle wasting noted.
Back: Full back examination is deferred. The patient does have some pain with flexion of the back and bending from side to side.
Neurologic: The neurologic examination shows the focal deficit of the right hypoglossal nerve. No other peripheral nerve deficits are noted.

Diagnostic Impression:
1. Squamous cell carcinoma of the right neck, rule out primary tumor of the base of the tongue or epiglottis
2. History of hypertension
3. History of gastroesophageal reflux disease
4. History of chronic back pain

SIGNED: ENT SURGEON

Operative Report
08/30/2007

Preoperative Diagnosis: Metastatic squamous cell carcinoma of the right neck, primary undetermined

Postoperative Diagnosis: Metastatic squamous cell carcinoma of the right neck, tongue based primary carcinoma

Operative Procedure: Direct laryngoscopy and biopsy

Anesthesia: General anesthesia

Indications: The patient is a 56-year-old gentleman with a fine needle aspirate proven squamous cell carcinoma metastatic to a lymph node in the right neck. He has complained of a sore throat and he has recently developed a right hypoglossal nerve paresis. He presents to the operating room for direct laryngoscopy and a biopsy in an attempt to determine the primary site of his carcinoma.

Findings: The lingual surface of the epiglottis was thickened and friable and there was a lobulated, somewhat exophytic mass in the vallecula which was friable. The mass was confined to the vallecula and base of tongue and lingual surface of the epiglottis. The laryngeal surface of the epiglottis was normal in appearance. The supraglottic mucosa was mildly erythematous without mucosal ulceration or submucosal lesions. The tonsil fossa was clean on either side. The midline of the tongue posteriorly had a black hairy dorsum.

Procedure: The patient was brought to the operating room and placed on the table in the supine position. Satisfactory general anesthesia was administered per orotracheal tube. The eyes were taped. A dental guard was applied to the upper teeth. The anterior commissure laryngoscope was introduced. The posterior pharyngeal wall and tonsillar fossa were inspected and appeared normal. The laryngoscope was introduced and some blood was suctioned from the base of the tongue. The scope was passed into the vallecula and the abnormal appearing mucosa was apparent. The scope was then passed under the epiglottis and the larynx inspected with no mucosal abnormalities noted. There was some mildly erythematous mucosa around the cervical esophageal limit which was consistent with his history of significant reflux.

The laryngoscope was then repositioned so that the vallecula and base of the tongue were exposed and biopsies were taken from the abnormal mucosa. There was a small amount of bleeding which was controlled with topical adrenaline.

The scope was then removed and the oral cavity, including the tonsillar fossa and base of tongue was palpated. The vallecula could not be reached with the finger and that portion of the tongue and oral cavity which could be palpated revealed no mucosal or submucosal masses.

He tolerated the procedure satisfactorily. At the conclusion of the procedure he was extubated and transported to the recovery room in satisfactory condition.

SIGNED: ENT SURGEON

Pathology Report
08/30/2007

Clinical History: Metastatic squamous cell carcinoma right neck lymph nodes

Specimen:
Vallecula

Gross Description:
The specimen consists of fragments of tissue in aggregate measuring 0.9 cm. The specimen is submitted in Cassette 1A.

Final Diagnosis:
Vallecular biopsy: Poorly differentiated squamous cell carcinoma

Outpatient Radiation Oncology Clinic Note
09/18/2007

Requesting physician, Medical Oncologist

Dear Colleagues,

I had the pleasure of seeing the patient today in follow up regarding further treatment recommendations for his recently diagnosed squamous cell carcinoma of the head and neck region. To briefly summarize, the patient was seen in consultation by myself on 08/19/2007. He presented with an enlarging right upper cervical lymph node. Subsequent FNA confirmed squamous cell carcinoma. Subsequent PET scan revealed a large area of increased uptake in that region corresponding to the neck mass. Several small areas of increased activity concerning for involved lymph nodes were noted. Repeat CT scan of the neck revealed the right neck mass to measure 3.5 centimeters in greatest dimension with a smaller lymph node, nonspecific, measuring 12 mm in the lower neck. The patient did not have an identifiable primary at that point. He was re-evaluated by ENT surgeon.

The patient was brought to the operating room on 08/30/2007 and underwent direct laryngoscopy and biopsy. Operative findings revealed the lingual surface of the epiglottis to be thickened with an exophytic mass in the vallecula which was friable as well as a thickened, friable lingual surface of the epiglottis. The mass was confined to the vallecula, base of tongue and lingual surface of the epiglottis. The laryngeal surface of the epiglottis was normal in appearance. Tonsillar fossa were clean bilaterally. Biopsy from the vallecula confirmed poorly differentiated squamous cell carcinoma. The patient subsequently recovered from this procedure well. He was evaluated at Dental Oncology Clinic and on 09/06/2007 he underwent teeth extractions in both the mandibular and maxillary aspects by oral surgeon. The patient is recovering from this procedure and is seen today in re-evaluation.

Currently patient states he continues to have chronic low back pain. He continues on narcotic analgesics for this which are currently Percocet 10/325 one every 4 hours with good control of his discomfort. He also notes right jaw pain which is controlled as well with Percocet. He continues to eat soft foods. He, otherwise denies any new symptoms.

Physical Examination:
General: Patient is resting comfortably in no acute distress. Weight is 215 lb. BP: 132/70, P: 72, R: 19.
HEENT: Reveals again, a large, right upper cervical lymph node which is approximately 4 centimeters in greatest dimension at level 2 on the right. It is tender. No other adenopathy is noted in the right or left neck. Examination of the oral cavity reveals normal oral mucosa. Sutures are in place in the posterior mandibular and maxillary areas. No unusual masses or lesions are identified.
Lungs: Clear to A P.

Impression:
Patient is a 56-year-old gentleman who is diagnosed with a T2N2M0, stage 4A squamous cell carcinoma of the vallecula/oropharynx.

Recommendations: I reviewed with the patient treatment options from my standpoint. I did have an opportunity to discuss the patient's case in considerable detail with ENT surgeon. The main treatment options after a multidisciplinary evaluation include radiation therapy only or radiation therapy with concurrent systemic chemotherapy. I discussed that the overall treatment course would be seven weeks. I noted that an IMRT treatment planning approach would be undertaken in order to minimize the risk of long-term xerostomia and spare the salivary glands, in particular the contralateral parotid. I discussed in considerable detail the risks, benefits and side effects of the proposed radiation therapy. I discussed potential acute side effects such as fatigue, skin irritation and irritation of the throat which could be severe and limit swallowing abilities, particularly towards the end of the treatment. The patient would also likely experience decreased/altered taste, as well as dry mouth type symptoms. I also discussed potential long-term risks including, but not limited to the likelihood of long-term dry mouth type symptoms which I hope to limit using the aforementioned IMRT treatment approach, decreased taste as well as a small chance of serious damage to the jaw bone, nerves, remaining teeth, spinal cord or other tissues which could be serious. The patient was provided educational information and expresses a strong interest in proceeding with treatment. The patient has already undergone the necessary dental extractions and will be re-evaluated next week at the Dental Oncology Clinic for adequate healing.

Multiple randomized trials have shown a significant benefit with concurrent systemic chemotherapy during radiation treatments in order to improve the overall survival. In particular, the Gortec randomized patients to 70 Gy of radiation therapy only or concurrent with Platinum based systemic chemotherapy. This trial mainly included Stage 3-4 oropharynx sites similar to the patient. They noted a significant improvement in disease free and overall survival with the addition of concurrent systemic chemotherapy.
Patient has expressed a strong interest in being treated aggressively and wants to pursue this treatment option.

I will arrange coordination of the start of radiation therapy with medical oncologist. The patient is scheduled to undergo initial simulation today. He will be scheduled to start his radiation therapy in approximately 10 days by which time he likely will have adequately recovered from his recent dental extractions and the treatment planning process will be complete. I will be providing further updates once he has completed his radiation therapy which is expected to last 7 weeks. Also, prior to starting radiation therapy I have recommended to the patient that he have a PEG tube placed for nutritional support. I will be making these arrangements to have this done in the next 1-2 weeks.

Thank you again for allowing me to participate in the care and treatment of this very pleasant gentleman.
SIGNED: RADIATION ONCOLOGIST

Radiotherapy Summary
11/15/2007

REFERRING PHYSICIAN: MEDICAL ONCOLOGIST

Dear colleagues,

I would like to provide you with the patient's formal treatment details regarding his aggressive radiation therapy and the combined modality treatment of his T2, N2b, M0, stage IVA squamous cell carcinoma of the vallecula/base of tongue area. The patient was initially seen in consultation by myself on August 19, 2007. The patient had undergone FNA of a large right upper cervical neck node mass which confirmed squamous cell carcinoma. The patient subsequently was evaluated by ENT surgeon and endoscopy revealed, on August 30, 2007, the lingual surface of the epiglottis to be thickened and friable with a somewhat exophytic mass on the vallecula. Biopsies confirmed poorly differentiated squamous cell carcinoma. The patient's right neck mass measured approximately 3.5 cm in greatest dimension and had involved the hypoglossal nerve on clinical examination. After multidisciplinary discussion with ENT surgeon and medical oncologist, we concurred that the patient was a good candidate for aggressive and combined chemoradiation therapy. The patient underwent pre-radiation dental evaluation at the Medical Center dental oncology clinic. The patient also underwent placement of a feeding tube. Subsequently, the patient was started on radiation therapy.

SITE:	Planning treatment volume.
TECHNIQUE:	7 field/IMRT
MACHINE:	Varian
DOSE PER FRX:	200 cGy to the 93.3% isodose line.
NUMBER OF FRX:	35
TOTAL DOSE:	70 Gy
TREATMENT:	September 26, 2007 to November 15, 2007

The patient was initially simulated on our dedicated CT scanner. An Aquaplast mask was used for mobilization. IV contrast was also used during the initial simulation. The images were brought to the treatment-planning computer where the primary target volume was carefully contoured on multiple axial slices as were the gross lymph node volume. In addition, a variety of normal structures were contoured. An inverse intensity modulated radiation therapy treatment plan was developed. After careful review this was approved from my standpoint. This provided 70 Gy to the planning treatment volume, which included the primary site at the vallecula, base of tongue and epiglottis as well as to the right level 2 lymph node with an expansion to account for daily set up variation. In addition, 63 Gy was prescribed to the adjacent CTV-70 regions. 56 Gy was then prescribed to the remaining ipsilateral and contralateral neck nodes including the retropharyngeal lymph node areas. The patient's care underwent careful physicist quality assurance testing. After approval, the patient was started on treatment.

Clinical Treatment Course: The patient received systemic cisplatinum chemotherapy during the course of his treatment under the direction of the medical oncologist. Clinically, the patient had

difficulty with nausea initially during the course of his treatment, however, this was subsequently controlled. The patient developed moderate mucositis and dermatitis. Radix skin care was prescribed. The patient continued on Percocet with good control of his pain. The patient noted significant improvement in the mobility of his tongue and on clinical examination, less deviation of his tongue was noted and the right neck mass also significant decreased during the course of his treatment. The patient remained on morphine in addition to Percocet. He continued to use his tube feedings for nutritional support. At the time of his end of treatment evaluation, the patient was feeling quite weak and had been evaluated in a nearby emergency department and he had required IV fluids. The patient did require Phenergan for anxiety. The patient's weight at the time of his end of treatment evaluation was 188.5 pounds as compared to his pretreatment weight of 215 pounds.

I have encouraged the patient to increase his tube feedings. I understand that he is scheduled for follow-up with his local physician next week. I have asked him to undergo repeat CT scan of the neck in approximately three weeks and to follow-up with myself one week later.

Thank you again for allowing me to participate in the care and treatment of this very pleasant gentleman. I did remind the patient that it would likely be several months by the time that he has adequately recovered from his very aggressive combined chemoradiation therapy treatments. I have asked him to contact me sooner than one month should he have any questions, concerns or new or unusual symptoms.

Please contact me if there are any questions.

Sincerely,
RADIATION ONCOLOGIST