Pathology Report
11/17/2007

Clinical History: Bx done @ ENT office for ulceration from floor of mouth/tongue; R/O CA

Specimen:
Bx tongue

Gross Description:
The specimen is recent in formalin, labeled with the patient's name, and further designated as "tongue lesion". The specimen consists of a red-tan fragment of tissue, measuring 0.4 cm in greatest dimension. The specimen is submitted in one cassette.

Final Diagnosis:
Tongue biopsy: Moderately differentiated squamous cell carcinoma

Hospital A
Radiology Report
11/24/2007

CT Neck with contrast

Reason for exam: Cancer in the floor of the mouth

Technique: Axial images were obtained through the soft tissues of the neck following IV administration of 95 ml. Omnipaque 300.

Findings: The visualized brain demonstrates atrophy. A definite abnormal enhancing mass in the visualized portions of the brain is not appreciated. Visualized paranasal sinuses appear clear. The orbital and globes appear unremarkable. The thyroid appears normal. The parotid glands appear unremarkable. The submandibular glands appear normal.

The nasopharynx appears normal. Unfortunately the oropharynx is poorly evaluated due to the extensive metal artifact in the patient's mouth causing streak artifact. A mass in the floor of mouth cannot completely be excluded. The hypopharynx, larynx and vocal cords appear unremarkable. Significant adenopathy in the jugular chain is not appreciated. The visualized portions of the lung apices appear clear apart from what likely is a nodular area of scarring in the right apex.

Impression:

1. Poor visualization of the tongue and floor of the mouth due to streak artifact created by the patient's metal orthodontic hardware. A mass cannot be excluded.
2. No definite cervical adenopathy is appreciated.

Freestanding Rad/Onc Center
Radiation Consultation
11/30/2007

Diagnosis: Squamous cell carcinoma of the floor of mouth, clinical stage, T4a, N1, M0.

History of Present Illness: This is an 82-year-old white male with a 2-3 month history of modest pain in the mouth and speech difficulty. He has had some weight loss although this is not able to be quantified by either the patient or his family. He was seen by his primary care physician and referred for an ENT evaluation. At that time he was noted to have a mass on the ventral surface of the tongue and filling the floor of mouth. Biopsy was obtained dated 11/17/2007 with pathology returned showing a moderately differentiated squamous cell carcinoma. The patient subsequently had a CT scan of the neck performed dated 11/24/2007. This had significant streak artifact through the oral cavity and pharynx area due to restoration and therefore the primary anterior floor of mouth cannot be visualized. The area of the lymph nodes is reasonably well visualized and by report is free of any discreet adenopathy.

The patient was subsequently seen in referral to ENT. He was felt to have locally advanced disease, which would require an extensive resection and reconstruction from the surgical standpoint. It is felt likely that he would need postoperative radiation and possibly in light of recent randomized trials, both from RTOG and EORTC, combination therapy postoperatively. It was felt that this would require extensive tongue resection with subsequent speech difficulties. The patient wishes to avoid this and presents today for discussion and recommendation regarding further evaluation and management.

Previous Medical History/Medications: His previous medical history is otherwise fairly sketchy from the patient. He denies any cardiac or pulmonary disease. He is not diabetic. He does have prior trauma to the right hip and walks with a significant limp subsequent to this. He is on a number of medications including digitak, diclofenac, Zocor, terazosin, an aspirin per day, and some vitamin and supplements.

Previous surgeries include hip surgery on the right side at the age of nine. He has had a hernia repair approximately ten years ago.

Allergies: No known drug allergies

Family History: Negative for malignancy

Social History: Pertinent for tobacco use which he contained until 1994. The patient also chewed tobacco for a few years after that. I believe he has a very extensive alcohol intake history remotely but is not currently drinking or smoking. He is a bachelor; he lives by himself. He does have family support with a number of cousins close by.

Review of Systems: Negative for any constitutional problems such as fevers. Positive for an unknown amount of weight loss. HEENT review of systems is as per the history of present illness. Chest is negative for exertional chest pain or palpitations. No cough, sputum production or hemoptysis noted. Gastrointestinal review of systems is negative for change in bowel habits,

melena or hematochezia. No genitourinary symptomatology of dysuria or frequency. Musculoskeletal review of systems is negative for bone pain. No skin problems such as pleuritis or rash. No stigmata diabetes such as polyphagia or polydipsia. No hematologic symptoms such as easy bruising, bleeding or anemia at this time. No lymphatic trouble such as peripheral edema or nodules. No neurologic symptoms of seizures, or focal motor or sensory deficits. No psychiatric disturbance such as change of cognition or affect.

Physical Examination: Currently on exam this is an elderly male seen in the company of two cousins. Weight is 150 pounds. Blood pressure 170/60. Pulse 44. Respirations 16. Extraocular movements are intact, and sclerae are non-icteric. Pupils are equal and reactive. Examination of the oral cavity shows the patient to have almost a full set of natural dentition. There is an ulcerative infiltrating lesion in the anterior floor of mouth. This is slightly asymmetric with extension further posteriorly on the right side compared to the left. It extends to approximately the second premolar on the right and to alveolar ridge. This appears to be deeply infiltrative. The patient cannot protrude his tongue fully although can protrude it somewhat. With speech he has some tethering.

On palpation he has firmness of the oral tongue to approximately halfway to the circumvallate papilla. The lymph node areas reveal what I believe is a 1.5 cm lymph node in the left submandibular area. No other adenopathy was appreciated in the head and neck area. Chest is clear with breath sounds throughout. There are no rales, rhonchi or wheezes present. Cardiac exam is unremarkable with the patient having a regular rate and rhythm without rubs or murmurs. There are no carotid bruits. Abdomen is soft and nontender. There is no sign of ascites or mass. There is no hepatomegaly appreciated. There is no CV angle tenderness. No pain to palpation of the chest wall or spine appreciated. Skin is warm and dry. The lymph node areas of the cervical and supraclavicular areas are negative. He ambulates with a marked stoop; he has what appears to be a leg length discrepancy with a shorter leg on the right side. Neurologically the patient is intact with no focal motor or sensory deficits or cranial nerve deficits.

Assessment/Plan: This is a patient with what I believe is a deeply infiltrative carcinoma originating in the floor of mouth. I feel that this involves the extrinsic musculature of the tongue and therefore is clinical stage T4a, N1. To better delineate the extent of this disease I have scheduled him for an MRI scan of the soft tissues of the neck.

At this time he is scheduled for dental extractions. I feel that he should best be served following his extractions with a combined concurrent approach utilizing radiation and chemotherapy. To this end I will set him up to be evaluated by medical oncology. I have recommended that he has a PEG tube inserted and will arrange this through his primary care physician’s office. I will schedule him to return after his extractions for treatment planning and simulation and will coordinate with medical oncology. I have discussed with the patient and his cousins possible placement. He would prefer to try to live in his home and therefore we will arrange for some home healthcare for PEG tube support and anticipated analgesics. I have been clear to tell him that he may require placement for closer support and surveillance.

Hospital B
Radiology Report
12/02/2007

MRI Neck with and without contrast

History: Cancer floor of the mouth

Axial T2 FSE, T1, T1 post contrast and coronal STIR images of the neck were performed.

T2 axial images suggest some heterogeneous isointense to low signal within the right side of the floor of the mouth. On the T1 axial images some isointense signal is also seen on the right side and anteriorly, more inferiorly. Midline raphe appears intact within the mid and portion of the mouth though anteriorly difficult to visualize. On the coronal STIR images there is a moderate amount of increased signal with the right side. The floor is mildly extended to the midline and perhaps beyond the midline anteriorly. This nearly abuts the inner portion of the mandible. There is some signal void in this region and could be due to dental amalgam or post surgical change on the right. I do not see significant adenopathy within the neck. There is multiple degenerative disc disease of the cervical spine. Post contrast images suggests some amorphous slightly enhancing the material within the anterior and right side of the mouth. This appears to be above the belly of the digastric. Small focal area of signal void is seen in the right just inside the mandible. This could represent post surgical change or clip versus a calcification, other artifact or other etiology. Enhancement appears to extend to the midline raphe on the axial image. There is a focal rounded area of increased T2 signal within the anterior right neck which appears to be just anterior to the carotid and jugular vein. On the coronal sequences this is just along the lateral and inferior aspect of the thyroid cartilage. This may represent a thyroid nodule. Lymph node would be an additional consideration but less likely.

Impression:

1. Abnormal signal within the anterior right floor of the mouth extending to the midline raphe possibly slightly beyond the midline to the left anteriorly. This could represent neoplastic lesion however post surgical change could have similar appearance. Please correlate with clinical and surgical history. In addition, correlation with post contrast CT of the neck as well as CAT scan would probably be beneficial. Comparison with previous studies would be helpful if any prior studies are available.
2. Rounded lesion within the anterior right paramidline neck, just lateral to the trachea and anterior to the carotid jugular vessels most likely represents a thyroid nodule. Correlation with thyroid sonogram would be recommended for additional evaluation.

Freestanding Rad/Onc Center
End of Treatment Summary
03/02/2008

Diagnosis: Squamous cell carcinoma of the floor of mouth, clinical stage T4A, N1, M0.

Case Summary: This 82-year-old white male presenting with a mass in the anterior floor of mouth. He was found to have squamous cell carcinoma. After extensive discussion it was elected to treat him with combined therapy. A PEG tube was placed for nutritional support. Chemotherapy consisted of weekly Taxol. His radiation is now completed.

Treatment Parameters:

Field Numbers:	1 & 2
Field Arrangement:	Opposed laterals
Field Size:	18.5 x 20.0 cm
Site:	Upper neck and oral cavity
Machine:	Varian Clinac 6100
Mode/Energy:	6 MV photons
Daily Dose per Fraction:	2.0 Gy
Total Dose:	50.0 Gy
Treatment Dates:	01/03/2008 through 02/09/2008

Note: The posterior neck was blocked at 40.0 Gy and supplemented with electrons to a total dose of 50.0 Gy.

Field Numbers:	3 & 4
Field Arrangement:	Opposed laterals
Field Size:	18.5 x 17.0 cm
Site:	Anterior floor of mouth and submandibular submental area
Machine:	Varian Clinac 6100
Mode/Energy:	6 MV photons
Daily Dose per Fraction:	2.0 Gy
Total Dose:	20.0 Gy
Treatment Dates:	02/10/2008 through 03/10/2008

Note: This brings the total cumulative dose to the gross tumor volume to 70.0 Gy.

Field Numbers:	5
Field Arrangement:	AP
Field Size:	16.0 x 15.0 cm
Site:	Supraclavicular fossa
Machine:	Varian Clinac 6100
Mode/Energy:	6 MV photons
Daily Dose per Fraction:	2.0 Gy

Total Dose: 50.0 Gy
Treatment Dates: 01/03/2008 through 02/09/2008

Note: Three dimensional treatment planning procedures were utilized to delineate the gross tumor volume, nodal volumes, clinical nodal volumes, spinal cord, and salivary glands.

Patient Tolerance: The patient had extensive dermatologic and mucosal reactions. He had wet desquamation in the posterior neck area as well as over the area of his chin. He did receive a one week treatment break, which occurred between the sixth and seventh week of his treatment, primarily for dermatologic reactions. He had appeared to clear his tumor at approximately the fifth week of treatment although this was difficult to ascertain given the extensive mucosal reactions.

Assessment and Plan: This is a patient with T4, N1 squamous cell carcinoma of the anterior floor of mouth now having completed radiation therapy with weekly Taxol based chemotherapy. It is planned to see him back in two weeks. He does have home health helping with his skin reactions, which were improving in the posterior neck area. They are also helping with his PEG tub feedings.

Radiation Oncologist #1

Hospital C
End of Treatment Outpatient Clinic Note

Dear Colleagues,

I would like to provide you with patient's formal treatment details regarding his radiation therapy to the right and left posterior neck in the aggressive treatment of his T4a, N1, M0 squamous cell carcinoma of the floor of the mouth. The patient was initially seen in consultation by my colleague, Dr. Radiation Oncologist #1, at the Freestanding Radiation Clinic. The patient subsequently started external photon radiation therapy at the RT clinic. He was seen at this facility in order to provide high-energy electrons to the right and left posterior neck in order to complete treatment to these regions. This dictation will concern this treatment only.

Treatment:

Site:	Right and left posterior neck
Technique:	En face electrons
Energy:	9 MeV electrons
Dose per Fraction:	2 Gy to 90%
Number of Fractions:	Total fractions 5
Total Dose:	10 Gy
Treatment Dates:	02/03/2008 to 02/09/2008

Clinical Treatment Course: Patient continued to have moderate mucositis symptoms with moderate erythema over the neck and lower jaw during the course of his radiation therapy in this clinic. He continued to use his PEG tube for nutritional support. He was prescribed Silvadene cream with "Gelciar" p.r.n. The patient completed his radiation therapy in this clinic without difficulty and was subsequently referred back to the Freestanding RT Clinic to complete his radiation at that facility.

Thank you again for allowing us to participate in the care and treatment of this very pleasant gentleman. Please contact me if there are any questions or concerns.

Sincerely,

Radiation Oncologist #2
Hospital C