

Outpatient History & Physical  
07/30/2007

Chief Complaint: Right true vocal cord lesion

HPI: 6-week history of dysphonia with right true vocal cord lesion noted on exam

Medications: Amaryl

Allergies: NKDA

PH: Femur fractures (multiple procedures). Leg fracture. Toe surgery 2004

Review of Systems: Negative

Physical Examination:

General: WDWN, alert & oriented

HEENT: PERRLA, normocephalic, no JVD, neck is supple

Heart: No murmurs, gallops; NSR

Lungs: Clear to auscultation, no consolidation percussed

Abdomen: Soft, no organomegaly, no rebound or guarding. Bowel sounds normal.

Extremities: No clubbing or edema. Pulses normal.

Neuromuscular: No pathologic reflexes

Diagnosis: Right true vocal cord lesion

Plan: Micro with biopsy

Operative Report  
07/30/2007

Preoperative Diagnosis: Right true vocal cord lesion

Postoperative Diagnosis: Right true vocal cord lesion

Anesthesia: General

Procedure: Microlaryngoscopy with excision of right true vocal cord lesion

Estimated Blood Loss: Minimal

Indications: The patient is a 56-year-old male with a two-month history of advancing dysphonia. The patient had undergone a general anesthetic approximately two weeks prior to the onset of his dysphonia. The patient does have a significant history of tobaccoism. Evaluation in the office revealed a pedunculated erythematous lesion originating from the free edge of the right true vocal cord. The patient was thus a candidate for the above procedure.

Findings: The patient had a prominent erythematous nodular mass involving the anterior aspect of the right true vocal cord. The anterior commissure was not involved and the lesion extended to approximately the midportion of the right vocal cord. This did not extend onto the laryngeal ventricle and was very easily removed with cup biopsy forceps. The lesion did extend down to the vocal ligament. Of note is preoperative laryngeal evaluation revealed normal vocal cord mobility with no impairment.

Procedure: Following informed consent, the patient was brought to the Operating Room placed on the Operating Room table in the supine position. Following administration of a general endotracheal anesthesia, the head and body were draped in a sterile fashion. The tooth guard was placed. A Dildo laryngoscope was introduced into the oral cavity for full evaluation of the oropharynx, hypopharynx, pyriform sinus, postcricoid region and the larynx. The laryngoscope was then placed in suspension. An operating microscope was brought into position in front of the laryngoscope. The right true vocal cord lesion was then excised using cupped biopsy forceps. It was felt the majority of the lesion was completely removed via excision. Some bleeding from the biopsy site was controlled with a 1:1,000 adrenalin cottonoid which was left in position for 2-3 minutes. Once this was removed, there was no further bleeding seen. The laryngoscope was removed as was the tooth guard. The patient was subsequently awakened and transferred to the Recovery Room in a good condition. No complications. He tolerated the procedure well.

Pathology Report  
07/30/2007

Clinical Information: Right true cord lesion

Specimen:  
Right true cord lesion

Gross Description:

The specimen consists of three fragments of tissue measuring from 0.2 up to 0.6 cm in greatest dimension. The largest fragment is bisected, and the entire specimen is submitted in Cassette 1A.

Final Diagnosis:

Right true cord lesion: Squamous cell carcinoma in situ, see comment.

Comment: Because of the superficial nature of the biopsy, definitive stromal invasion cannot be identified.

Radiation Oncology Consultation  
08/13/2007

Chief Complaint: Hoarseness, larynx cancer

History: Patient is a 56-year-old gentleman with a long history of tobacco abuse who had an operation on the toe in May. He states that after that operation it sounds as if he was intubated at that time. He had hoarseness, this did not resolve. He sought attention for this. He did originally see an ENT physician. Fiberoptic laryngoscope showed a nodular mass in the right proximal true vocal cord. He then had a CT of the neck, which did show this nodular prominence in the right focal cord and no other obvious disease. Lymph nodes showed no increased size. He did undergo microlaryngoscopy and excision of the right true vocal cord lesion under general anesthesia on 07/30/2007. Findings were an erythematous nodular mass involving the anterior aspect of the right true vocal cord. It did not involve the anterior commissure or the posterior portion of the right cord. It did extend down to the vocal ligament. Preoperatively he was noted to have normal true vocal cord mobility. No other lesions were noted on examination. It was felt that the majority of the lesion was completely removed via excision. Pathology revealed three fragments of tissue measuring from 0.2 up to 0.6 cm in greatest dimension. Squamous cell carcinoma in situ was noted but because of the superficial nature of the biopsy definitive stromal invasion could not be identified. He is now referred to discuss definitive radiation.

Allergies: Codeine, which is not a true reaction. It sounds like intolerance. He was "so drugged up".

Medications:

1. Amaryl 1 mg q.d.
2. B complex 400 mg q.d.
3. Zinc and selenium supplements

Past Medical History: Adult-onset diabetes mellitus for one year. He had a broken left lower extremity at age 18 and then again in 1995. He had some type of surgery on the right toe in April. Status post tonsillectomy as a child.

Family History: Mother has just recently completed radiation and chemotherapy for what he states is a parasite-induced malignancy of her lower extremity that she had a parasite involving the soft tissues of her lower extremity when she was in Turkey. Sister diagnosed with Hodgkin's disease, treated with radiation at age 19, alive and well at age 57. It sounds as if she may have had one recurrence at some time and underwent a splenectomy. A maternal aunt with larynx cancer.

Psychosocial History: He is divorced, accompanied by his fiancée. He has three adult children. He lives with his significant other. Self-care and transportation are independent. He is an electrician. He smoked a pack and a half of cigarettes per day for 40 years. He quit July 30, 2007. He does drink a couple of beers per week, occasionally some Crown Royal. He has done so for about 35 years. He tried marijuana as a young adult, no other drug use.

Review of Systems:

Constitutional: Good appetite, no weight loss

HEENT: His hoarseness has resolved after his biopsy. Voice quality is normal. Negative for palpable neck mass or dysphagia.

Neurologic: Negative for headaches or dizziness

Cardiovascular: Negative for chest pain and palpitations

Respiratory: Negative for shortness of breath or cough

Gastrointestinal: Negative for nausea, vomiting, blood per rectum. Occasionally some constipation.

Genitourinary: Negative for frequency or urgency

Musculoskeletal: Negative for bone pain. He has some restriction of motion at his left ankle.

Skin: Negative for rash or itching

Psychiatric: Negative for depression, positive for sleep disturbance

Physical Examination:

General: He is a middle-aged gentleman appearing his stated age. He is alert and oriented and answers questions appropriately. His voice quality currently is good. HT: 5 feet 7 inches. WT: 167 pounds. BP: 135/80. P: 67. R: 20. T: 96.9.

HEENT: Extraocular muscles are intact. Sclerae nonicteric. Oral cavity shows his own dentition in good repair. He has no lesions noted in the oral cavity or the oropharynx. After topical anesthetic direct laryngoscopy is performed. The larynx is inspected. He has no lesion currently on the right true vocal cord. The vocal cords do move freely and meet in the midline. He has what appears to be a slight defect in the right anterior to mid vocal cord from his biopsy. No specific lesions noted elsewhere on laryngoscopy.

Neck: Supple. Trachea midline. No palpitations cervical or supraclavicular adenopathy.

Heart: Regular rate and rhythm

Lungs: Clear to auscultation bilaterally

Abdomen: Thin, bowel sounds present. Soft, nontender, nondistended. No hepatomegaly or masses noted.

Extremities: He has no peripheral edema noted

Skin: No petechiae or rashes

Neurologic: Grossly intact

Laboratory Data: CT and pathology as stated

Assessment and Plan: Patient is a 56-year-old gentleman with at least squamous cell carcinoma in situ of the right true vocal cord. Potentially he could have invasive disease, which is a concern though is difficult to prove on the biopsies due to the superficial nature of this disease. I did discuss with the patient and his fiancée the rationale of definitive radiation for either in situ disease or early invasive disease. I discussed the simulation process, the daily radiation treatments Monday through Friday for six to six and a half weeks. I discussed typical risks, benefits and side effects associated with this. His questions were answered and today he verbalizes understanding and wishes to proceed with treatment. He will undergo a CT simulation and planning session early next week and will begin the treatment the following Monday. With his either early invasive or at least in situ disease he should have approximately a 90%+ chance of cure and slightly lower percentage chance of larynx preservation.

Radiotherapy Summary  
09/16/2007

Patient is a 56-year-old gentleman with hoarseness who was noted on direct laryngoscopy under anesthesia to have right true vocal cord lesion involving the anterior aspect of the right true vocal cord. It did extend to the vocal ligaments. A biopsy revealed there was squamous cell carcinoma in situ, but it was a superficial area examined. I spoke with ENT surgeon. He is concerned that this was actually invasive disease. The majority of the lesion was completely removed via excision. Outside CT of the neck had shown no lymphadenopathy. He had no lymphadenopathy on examination. Chest x-ray had shown no acute abnormalities. We reviewed the treatment with definitive radiation, the potential risks, benefits and side effects as well as probability of control with treatment. He verbalized understanding and wished to proceed with therapy. A simulation which was CT based with immobilization with a face mask and a three dimensional isodose plan per dose volume histograms was incorporated. Treatment was as follows.

Site: Larynx  
Machine: Varian 2100  
Energy: 6 MV  
Field Arrangement: Opposing laterals  
Prescription Reference: 99%  
Dose per Fraction: 2.0 Gy  
Total Fractions: 32  
Total Dose: 64 Gy  
Treatment Start: 08/23/2007  
Treatment End: 10/06/2007  
Total Elapsed Days: 43

He tolerated treatment well. He was not treated on the Labor Day holiday. He otherwise required no treatment breaks.

He did develop some hoarseness. I did place him on Nexium, and he had Hydrocodone to use p.r.n. He was also treated with Xenaderm for his skin changes. His appetite remained good. His weight was completely maintained throughout. He never lost any weight during his treatment. He continued with a normal diet. He denied any obvious changes in his energy level. He continued to work 12 hours per day 7 days per week. On his physical examination at end of treatment the skin showed moderate erythema and some dry desquamation. No palpable adenopathy. The plan is to follow up in one month, continue his skin care. Call in the interim if there are problems. Continue his pain medications p.r.n. Will also have him follow up with ENT.