

## CASE #1

### Physical Exam

58YOF presented with a right neck mass. On 4/4/19, presented to hematology oncologist due to easy bruising. Physician noticed an enlarged **mobile 3cm lymph node** in the submandibular region, somewhat posterior, **firm but not rock hard. There are no oral lesions.** Malignant process needs to be excluded. She will need to have this resected.

### Xray

- 5/15/19 CT Neck, over 3cm mass right carotid space. Possibilities include glomus vagale, schwannoma, and solitary enlarged ln.
- 5/17/19 Neck MRI lobulated 3.7cm mass at right carotid space, favor possible LN metastasis. Possible 7mm lesion associated with right epiglottis.
- 6/10/19 PET intense uptake large 2.8cm rt level 2 LN, and smaller adjacent 9mm LN within the right neck. C/w bx proven metastatic SCC. No FDG avid mucosal lesions. Nodular opacity right upper lobe of lung could be inflammatory.

### Scope

7/1/19 direct laryngoscopy with bxs tongue base, and right tonsillectomy: right and left piriform sinus, postcricoid esophagus, glottis, all appeared free of tumor. No subglottic lesions seen. Oropharynx including tongue base, no mucosal abnormalities. Blind cup forceps bx of right tongue base taken. Cystic lesion on epiglottis, biopsied with cup forceps. Palpation of right tonsillar fossa, nodularity identified. Rt tonsillar fossa excised. Decision not to do rt selective neck dissection given close proximity to pharynx.

### Pathology

- 5/23/19 right cervical LN core bx, SCC poorly diff, c/w a metastasis. p16 negative.
- 7/1/19 BXS lingual surface epiglottis, rt tongue, rt tonsillectomy, all benign
- Staged by Med Onc cT0 cN2b cM0

### Chemotherapy

- 8/27/19 Cisplatin, 60mg

### Radiation

- Radiation 6X photons to oropharynx/head and neck
- Start 8/26/19- End 10/15/19 Total: H&N 6X to 70gy
- Photons, VMAT to Oropharynx; elsewhere says to "Head and Neck"
- Phase 1: 70gy at 2gy/fraction X 35 fractions
- Phase 2: 63gy at 1.8gy/fraction X 35 fractions
- Phase 3: 56gy at 1.6gy/fraction X 35 fractions

## CASE #2

03/12/2022 HOSPITAL A ER – PATIENT PRESENTED TO THE ED WITH NECK GROWTH THAT STARTED 2 MONTHS AGO OF GRADUAL ONSET. THE MASS IS LOCATED TO THE LEFT ANTERIOR NECK. ON PE TODAY THERE IS ANTERIOR CERVICAL ADENOPATHY, LEFT INDURATED, NONTENDER, FIXED MASS ON THE LEFT ANTERIOR AREA. PATIENT RECOMMENDED TO FOLLOWUP WITH HIS PCP FOR FURTHER WORKUP AND BIOPSY.

03/12/2022 HOSPITAL A – NECK CT – EXTENSIVE LEFT CERVICAL ADENOPATHY NOTED IN A LEVEL 2 THROUGH 4 DISTRIBUTION WITH ENHANCING POSSIBLY NECROTIC NODES PRESENT, LARGEST 4 CM. ASYMMETRIC FULLNESS IN THE LEFT TONSILLAR FOSSA RAISING THE POSSIBILITY THAT THE ADENOPATHY IS ON THE BASIS OF UNDERLYING NEOPLASTIC ETIOLOGY, DIRECT VISUALIZATION IS ADVISED.

03/27/2022 HOSPITAL B- WHITE HISPANIC MAN PRESENTED TO AN OUTSIDE ED WITH NECK GROWTH THAT STARTED 2 MONTHS AGO OF GRADUAL ONSET. THE MASS IS LOCATED TO THE LEFT ANTERIOR NECK. ON PE TODAY THERE IS ANTERIOR CERVICAL ADENOPATHY, LEFT INDURATED, NONTENDER, FIXED MASS ON THE LEFT ANTERIOR AREA. PT HAS PATHOLOGIC APPEARING LEFT SIDED ADENOPATHY WITH A LEFT TONGUE BASE/GLOSSOTONSILLAR SULCUS FULLNESS, CONCERNING FOR OROPHARYNGEAL CARCINOMA VERSUS LYMPHOMA.

FLEXIBLE LARYNGOSCOPY – BASE OF TONGUE SYMMETRICAL, FULLNESS IN THE LEFT GLOSSOTONSILLAR SULCUS. NO OTHER ABNORMALITIES NOTED.

04/06/2022 HOSPITAL B – ULTRASOUND GUIDED LEFT NECK LYMPH NODE FNA

- POSITIVE FOR MALIGNANT CELLS, SQUAMOUS CELL CARCINOMA
- P16 POSITIVE
- HPV RNA ISH HIGH RISK DETECTED

04/18/2022 HOSPITAL B PET SCAN – INTENSE ACTIVITY IN THE LEFT TONSIL WITH MULTIPLE FDG AVID LEFT CERVICAL NODES. THE FINDINGS ARE SUSPICIOUS FOR A PRIMARY LEFT TONSILLAR CARCINOMA WITH ASSOCIATED IPSILATERAL REGIONAL NODAL METS. NO EVIDENCE OF CONTRALATERAL NODAL OR DISTANT METASTATIC DISEASE

04/25/2022 HOSPITAL B –PATIENT WAS PRESENTED IN MULTIDISCIPLINARY TUMOR BOARD, GIVEN THAT HE HAS BULKY ADENOPATHY WITH LIKELY EXTRANODAL EXTENSION ON IMAGING AS WELL AS BULKY PRIMARY TUMOR OF THE GLOSSOTONSILLAR SULCUS; UPFRONT CHEMOTHERAPY WITH XRT IS BEING RECOMMENDED FOR CURATIVE INTENT. RECOMMEND AGAINST SURGERY GIVEN THE HIGH RISK OF NEEDING ADJUVANT XRT AND POSSIBLY ADJUVANT CHEMO.

MED ONC NOTE - PATIENT WITH T1N1M0 HPV RELATED LEFT TONSIL SQUAMOUS CELL CARCINOMA P16+.

RAD ONC SCCA OF THE LEFT TONSIL/GT SULCUS CT2N1 P16+

*NEED PRIMARY TUMOR SIZE – COULD NOT FIND ANYWHERE – WROTE TO MD AND HE STATED IT WAS 2-2.5 CM*

## Head and Neck 2023

05/10/2022 HOSPITAL B NECK MRI – LEFT JUGULAR CHAIN LYMPHADENOPATHY SHOWS NO CHANGE, POSSIBLE PRIMARY TUMOR AT THE JUNCTION OF THE LEFT BOT AND LEFT TONSIL, MAY BE THE CAUSE OF LYMPHADENOPATHY

MEDICAL ONCOLOGY-05/21/2022 – 07/11/2022 HOSPITAL B CISPLATIN

HOSPITAL B - XRT WAS DELIVERED TO THE LEFT TONSIL AND BILATERAL NECK WITH PROTONS IMRT TECHNIQUE, TOTAL OF 70 GY AT 2 GY PER FRACTION, TOTAL OF 35 FRACTIONS FROM 05/22/2022 TO 07/17/2022

### TREATMENT SUMMARY

- 05/22/2022-06/13/2022 LEFT TONSIL 70P 2 GY PER FRACTION, 15 FRACTIONS, TOTAL DOSE 30 GY
- 06/14/2022-06/20/2022 LEFT TONSIL 70 P 2 GY PER FRACTION, 5 FRACTIONS, TOTAL DOSE 10 GY
- 06/21/2022 –06/29/2022 LEFT TONSIL BOOST 70 P 2 GY PER FRACTION, 5 FXS, TOTAL DOSE 10 GY
- 07/01/2022 - 07/17/2022 LEFT TONSIL BOOST 70P 2 GY PER FRACTION, 10 FXS, TOTAL DOSE 20 GY

## CASE #3

### Physical Exam

9/10/21 ENT office, patient noted fullness rt neck 1 month ago. Seen in ER, noted 3.5cm mass, possible LN rt level 2 on CT. "never smoker." No oral cavity lesions.

### XRAY

9/4/21 CT neck, right 3.5cm soft tissue mass suspicious for level 2 enlarged LN, neoplastic origin is suspected, tissue bx may be warranted. Differential includes lymphoma.

10/18/21 PET focal asymmetric uptake right palatine tonsil concerning for primary site of malignancy. Recommend tissue sampling. Rt level II cervical chain metastatic to a lymph node. No distant metastasis.

### Laryngoscopy

9/10/21 ENT office laryngoscopy, exam of larynx normal, pharyngeal walls normal, pyriform sinuses normal, BOT normal, Nasopharynx normal, hypopharynx normal.

### Operative report

11/2/21 Right tonsil tumor approximately 2cm, excised, and grossly pathological level 2 LN.

### Surgery

11/2/21 transoral robotic radical right tonsillectomy, rt neck dissection levels 2-4 (26 LNS)

### Path

- 9/27/21 right neck mass biopsy, metastatic pd SCC, patchy non-diffuse staining for p16, argues against HPV related neoplasm.
  - HPV RNA ISH High risk, detected
  - low risk not detected
- 11/2/21 right radical tonsillectomy
  - rt tonsil, SCC "very focally keratinizing" poorly diff, up to 1cm in linear extent. p16 positive.
  - grade 3/3 poorly diff
  - margins negative > 2mm
  - Suspicious for LVI
  - HPV RNA ISH High risk detected; hpv rna ish 16/18 high risk, detected. Low risk not detected.
  - No perineural invasion
  - right neck dissection, 07+ of 24 LNS with metastatic carcinoma, up to 19mm, with focal extranodal extension (10mm).
  - 00 of 02 right level 2B lns.
  - Pathologist: positive LNS are ipsilateral including midline

### Stage

- Clinically staged by oncologist T1 N1 M0 rt tonsil SCC.
- Staged by pathologist pT1 N2

## Head and Neck 2023

### Chemo

- 12/28/21 Cisplatin 75mg

### Radiation

- 12/28/21-2/9/22 Photons VMAT Total 60gy postop tonsil
- Site "oropharynx"
- 30 fractions, 2gy per fraction, 60gy
- 30 fractions, 1.8gy per fraction, 54gy
- 11/19/21 Rad onc note, presented to TB, recomm bilateral neck radiation and chemotherapy
- Decision for adjuv chemo radiation due to presence of extranodal extension on pathology.