



# *2007 Annual Meeting Program American Head & Neck Society*

**APRIL 28 - 29, 2007**

**SAN DIEGO, CA**

**President: Randal S. Weber, MD, FACS**

**Program Chair: Ehab Y. Hanna, MD**

**The American Head & Neck Society (AHNS)**

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[www.ahns.info](http://www.ahns.info)

## **FUTURE AHNS MEETING DATES AND LOCATIONS**

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### **2008 DATES**

**Seventh International Conference  
on Head & Neck Cancer**

San Francisco Marriott

July 19-23, 2008 in San Francisco, CA

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## **THANKS TO THE 2007 AHNS MEETING SUPPORTERS!**

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The AHNS gratefully acknowledges the following companies for their generous support of the 2007 meeting.

### **PLATINUM LEVEL**

**Bristol-Myers Squibb  
Imclone Systems Inc.**

### **SILVER LEVEL**

**Gyrus ACMI  
Karl Storz Endoscopy  
IRX Therapeutics**

### **BRONZE LEVEL**

**Fanconi Anemia Research Fund  
Richard Wolf Medical Instruments  
Synthes CMF  
Viventia Biotech, Inc.**

# General Information

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## 2007 ANNUAL MEETING OF THE AMERICAN HEAD & NECK SOCIETY

April 28 - 29, 2007

Manchester Grand Hyatt  
One Market Place  
San Diego, CA 92101

### ON-SITE REGISTRATION HOURS

Wednesday, April 25	5:00 pm – 8:00 pm
Thursday, April 26	7:00am – 5:00 pm
Friday, April 27	7:00am – 5:00 pm
Saturday, April 28	7:00am – 5:00 pm
Sunday, April 29	7:00am – 2:00 pm

### EXHIBIT HALL HOURS

#### Located in the Douglas Pavilion

Thursday, April 26	9:30 am – 3:30 pm (lunch)
Friday, April 27	9:30 am – 3:30 pm (lunch)
Saturday, April 28	9:30 am – 3:30 pm (lunch) 5:30 pm – 7:00pm (reception)
Sunday, April 29	9:30 am – 1:00 pm

Exhibit hours may be subject to change.

## ACCREDITATION STATEMENT

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The American Head & Neck Society is accredited by the Accreditation Council for Continuing Medical Education (A.C.C.M.E.) to sponsor Continuing Medical Education for physicians. The American Head & Neck Society (AHNS) designates the 2007 Annual Meeting for a maximum of **15.75 AMA PRA Category 1 Credit(s)**<sup>™</sup>. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Please return your completed evaluation form to the AHNS registration desk to receive your CME credits. Certificates will be mailed after the meeting.

## AHNS MEETING OBJECTIVES

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The conference is designed to facilitate discussion regarding the approaches used in the diagnosis, treatment, and rehabilitation of head and neck neoplasms throughout the world. Participants should accomplish the following at the conclusion of this event:

- Identify important basic science advances in head and neck oncology research;
- Develop an understanding of current issues in the diagnosis, evaluation, and treatment of head and neck neoplasms;
- Improve treatment strategies for head and neck patients;
- Facilitate discussion regarding the approaches used in the diagnosis, treatment, and rehabilitation of head and neck neoplasms;
- Recognize current research ideas in understanding the head and neck neoplastic process.

# About the American Head & Neck Society

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## HISTORY OF THE SOCIETY

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On May 13, 1998, The American Head and Neck Society (AHNS) became the single largest organization in North America for the advancement of research and education in head and neck oncology. The merger of two societies, the American Society for Head and Neck Surgery and the Society of Head and Neck Surgeons, formed the American Head and Neck Society.

The contributions made by the two societies forming the AHNS are significant in the history of surgery in the United States. Dr. Hayes Martin conceived the Society of Head and Neck Surgeons in 1954, a surgeon considered by many to be the “father of modern head and neck tumor surgery.” The purpose of the society was to exchange and advance the scientific knowledge relevant to the surgery of head and neck tumors (exclusive of brain surgery) with an emphasis on cancer of the head and neck. Two years later, The American Society for Head and Neck Surgery was organized with the goal to “facilitate and advance knowledge relevant to surgical treatment of diseases of the head and neck, including reconstruction and rehabilitation; promote advancement of the highest professional and ethical standards as they pertain to the practice of major head and neck surgery; and to honor those who have made major contributions in the field of head and neck surgery, or have aided in its advancement”.

The new Society remains dedicated to the common goals of its parental organizations.

## MISSION STATEMENT

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The purpose of this society is to promote and advance the knowledge of prevention, diagnosis, treatment and rehabilitation of neoplasms and other diseases of the head and neck, to promote and advance research in diseases of the head and neck, and to promote and advance the highest professional and ethical standards.

## WHY JOIN THE AHNS?

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The American Head and Neck Society is an organization of physicians, scientists and allied health professionals dedicated to improving the understanding of Head and Neck Cancer and the care of patients afflicted with that disease. Membership is open to a wide variety of interested individuals in several categories that differ both in terms of responsibility and level of involvement in the society.

## MEMBERS

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**Please attend the AHNS Business Meeting on Sunday, April 29, 2007 at 12 PM to welcome the following new members:**

## 2007 CANDIDATES FOR MEMBERSHIP IN THE AHNS

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### Active

Alnajjar, Samer  
Beasley, Nigel  
Bell, R. Bryan  
Damrose, Edward  
Dulguerov, Pavel  
Fernandes, Rui  
Goldstein, David  
Gurushanthaiah, Deepak  
Klem, Christopher  
Lansford, Christopher  
Larian, Babak  
Lian, Timothy  
Magnuson, Jeffery  
Mendez, Eduardo  
Newkirk, Kenneth

Oh, Young  
Raynor, Eileen  
Roh, Johg-Lyel  
Rosenthal, Eben  
Thurnher, Dietmar  
Tufano, Ralph  
Tulunay, Ozlem

### Associate:

Carlson, Diane  
Chen, Chu  
Cohen, Ezra  
Farrag, Tarik  
Ghossein, Ronald  
Martin-Harris, Bonnie  
Sarlis, Nicholas  
Tseng, Jennifer

Younes, Maher  
Yuen, Hon

### Candidate:

Chaiyasate, Kongkrit  
El-Sayed, Ivan  
Gil, Ziv  
Ha, Patrick  
Jacobson, Adam  
Jameson, Mark  
Moretz III, William  
Moukarbel, Roger  
Resto, Vicente  
Rezaee, Rod  
Shrime, Mark  
Topham, Neal  
Yehuda Moshe

### Corresponding:

Barreira da Costa, Carlos  
Bolzoni Villaret, Andrea  
Cheung, Wing Yung  
Chiesa, Fausto  
De Bree, Remco  
Ho, Wai-Kuen  
Homma, Akihiro  
Klop, Willem  
Lombardi, Davide  
Ng, Wai Man  
Nordgren, Mats  
Reddy Martha, Vishnu  
Yuen, Anthony



## **RANDAL S. WEBER, MD, FACS**

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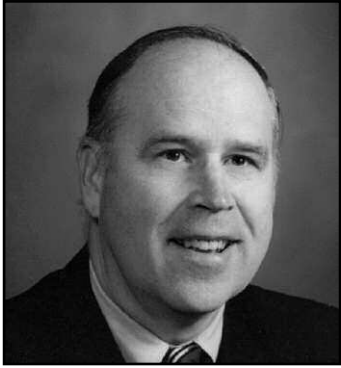
**Professor and Chair of the Department of Head and Neck Surgery at The University of Texas M. D. Anderson Cancer Center**

Dr. Weber earned his medical degree from the University of Tennessee Health Science Center, College of Medicine. After completing a surgery internship at the National Naval Medical Center in Bethesda, Maryland, Dr. Weber completed residencies in surgery and otolaryngology at Baylor College of Medicine in Houston, Texas. He received specialized training in head and neck surgical oncology, completing a two-year fellowship at The University of Texas M. D. Anderson Cancer Center in Houston. Dr. Weber joined the faculty of M. D. Anderson Cancer Center in 1986, with a joint appointment at Baylor College of Medicine. He then served as Gabriel Tucker Professor and Vice Chair, Department of Otorhinolaryngology, Head and Neck Surgery at the Hospital of the University of Pennsylvania, from 1996 to 2003. In 2003, Dr. Weber returned to M. D. Anderson, where he is Chairman of the Department of Head and Neck Surgery and recipient of the Hubert L. and Olive Stringer Distinguished Professorship in Cancer Research. He has published more than 180 articles and invited articles and 40 book chapters focused on the basic science, surgery, and clinical

treatment for head and neck cancer. He is Editor of *Head & Neck: Journal for the Sciences and Specialties of the Head and Neck*; he is Associate Editor for Cancer and currently serves on the editorial board for *Journal of Clinical Oncology*. Committed to oncologic research, cancer prevention, and the education of future leaders in the field, Dr. Weber has been active in the organization of multiple national and international conferences and symposia on head and neck cancer and has presented and moderated more than 70 lectures, invited lectures, and panel discussions. In addition, he has been honored as guest lecturer and visiting professor at numerous institutions both nationally and internationally. Dr. Weber has consistently been named one of America's Top Doctors by the Castle Connolly Guide. He was President of the Society of University Otolaryngologists-Head and Neck Surgeons and President of the American Radium Society, 2005–2006. Dr. Weber's clinical interests are nonmelanoma skin cancer, thyroid cancer, and therapeutic strategies for organ preservation.

# Guests of Honor

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## **ROBERT MAXWELL BYERS, MD**

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Born in 1937 in Baltimore, Maryland, raised in a small town on the Eastern Shore of Maryland (pop. 2500). Educated Duke University (1955-1959), AB in English; University of Maryland Medical School (1959-1963); AOA General Surgical Residency University of Maryland (1963-1968). US Navy with Marines in Da Nang, Viet Nam (1968-1969). Chief of Surgery US Naval Hospital, Rhode Island (1969-1970). Fellowship in cancer (Head and Neck and General) at UT System Cancer Center, M.D. Anderson Hospital and Tumor Institute (1970-1971). Faculty at UT M.D. Anderson Cancer Center (1972-2001), Professor and Surgeon (1981), Professor Emeritus (2001-Present). President of Society of Head and Neck Surgeons. President of American Radium Society. Hayes Martin Lecturer.

I married Marcia Davis in 1961 and have 4 sons: John, Robby, Matt and MacGregor. I also have 9 grandchildren.

I feel very blessed to have had a very fulfilling career supported by a loving family, dear friends and colleagues in the Society and at M.D. Anderson Cancer Center. As a mentor and teacher, I hold a special place in my heart for all of the men and women to which I have played a role in their training.

I will always remember and appreciate my selection as a Guest of Honor in the American Head and Neck Society.



## **HELMUTH GOEPFERT, MD**

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### **Professor Emeritus in Head and Neck Surgery, UTMD Anderson Cancer Center**

Born in Santiago de Chile where he attended the Deutsche Schule and graduated as M.D. from the Universidad de Chile in 1962.

After a 2-year residency in Valdivia the earthquake-damaged city in the South of Chile, he came to the USA to pursue 4 years of training in solid tumor chemotherapy and surgery at UCLA (64-66) and MD Anderson Hospital (66-68).

Returned to Chile and, after 2 years, immigrated to this country and completed a residency in Otolaryngology/Head and Neck Surgery in 1974.

Chairman of Head and Neck Surgery from 1981 until retirement in September 2003.

Life in retirement is great and it is a joy to see how my three sons are either practicing physicians or in training, how my daughter leads as a corporate news director and how the three grandchildren challenge their parents and still be lovable kids! My wife Joann admits that it is wonderful to spoil grandchildren, but something else to be married to a cranky grandfather!

And I wish more time could be available to ride the motorcycle.



## OSCAR M. GUILLAMONDEGUI, MD

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Dr. Oscar M. Guillamondegui was born in May 1937 in Buenos Aires, from a family of Basque and Spanish origin. His great grandparents moved to Argentina in the 1850's. There were no close relatives in the medical field, although many men in the family found a home in the Armed Forces since the Wars of Independence.

He graduated from Medical School in Buenos Aires in 1960, finished a General Surgery Residency in Michigan, at Wayne State University Hospitals, and completed a Fellowship in Surgical Oncology at the University of Texas M.D. Anderson Cancer Center. Dr. Guillamondegui joined the Staff of the Department of Head and Neck Surgery in 1968 as Dr. William S. Mac Comb retired and Dr. Richard Jesse became Chairman. Dr. Jesse, a brilliant, pragmatic man, who became an extraordinary mentor and friend, was the major influence in Oscar Guillamondegui's medical education process as a Surgical Oncologist. He did not shine as a Basic Scientist or a Medical Administrator, but he is very proud to have been a positive motivating factor in the lives of many young physicians. He strongly believed that an educator can not be considered a great teacher unless many of his disciples eventually surpass him in ability, surgical skills, and, of course, fame.

In 1990-1991, as a member of the United States Army Reserve, LtC. Guillamondegui was deployed to the Persian Gulf with the 41st Combat Support Hospital, operating in Saudi Arabia, Kuwait and Iraq.

In 1991, he became President of the then "Society of Head and Neck Surgeons", a true highlight of his surgical career.

He retired from M.D. Anderson Cancer Center in 1994, with an academic rank of Professor of Surgery and a member of numerous Surgical Societies in the U.S. and South America. Moving back to Argentina, Dr. Guillamondegui became President of the Argentine Society of Head and Neck Surgeons from 1997 to 1999. He was elected Chairman of the Department of Surgery at the German (Deutsches) Hospital of Buenos Aires in 1999.

Oscar M. Guillamondegui retired from the Medical profession in May 2006.

Through the years, he played tennis with more enthusiasm than skill, was an avid hunter, and for a while raised Arabian Horses in Texas. Now he hikes, climbs mountains and fly fishes, seeking trout and salmon everywhere. Photography has been his hobby for a long time, which gives he and his wife Nilda a good reason to travel to unusual places.

Oscar M. Guillamondegui has five children and nine grandchildren. His son Oscar is an Assistant Professor of Surgery in the Division of Trauma and Surgical Critical Care at Vanderbilt University School of Medicine.

Dr. Guillamondegui and his wife now divide their time between their home in downtown Buenos Aires, a house in the Andes Mountains, and Dallas and Nashville in the United States.

# Hayes Martin Lectureship

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## JESUS E. MEDINA, MD, FACS

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Jesus E. Medina, M.D., F.A.C.S. was born in Peru where he attended medical school. Following training in otorhinolaryngology at Wayne State University School of Medicine, he did a fellowship in Head & Neck Surgery at the M.D. Anderson Hospital and Tumor Institute in Houston, Texas. In 1981, he became an Assistant Professor in the Department of Head and Neck Surgery at M.D. Anderson. In 1984 he accepted a position as an Associate Professor and Director of the Head and Neck Cancer Program in the Department of Otorhinolaryngology at the University of Oklahoma. He became Chairman of the Department in 1991 and he currently holds the Paul & Ruth Jonas Chair in Cancer Treatment and Research.

Dr. Medina has devoted his career to the care of patients with head and neck cancer and has authored numerous scientific publications, textbooks and book chapters on a variety of topics in head and neck oncology. He has lectured extensively in the United States and abroad.

In addition to his clinical and academic responsibilities, Dr. Medina serves on the Board of Directors of the American Board of Otolaryngology and is the current President of the Board. He was selected to be a candidate for President-Elect of the American Academy of Otolaryngology Head and Neck Surgery in 2002. Dr. Medina served as Vice-President for the Middle Section Triological Society in 2002. He was Vice-President of the Society of Head and Neck Surgeons and became the second President of the American Head and Neck Society in 2000.

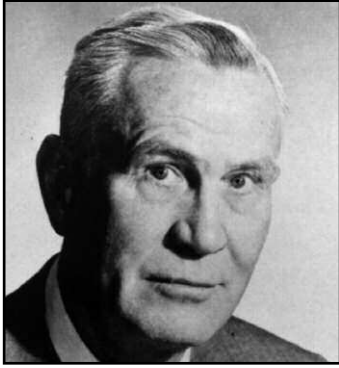
Dr. Medina has received numerous awards including the Honor Award and the Distinguished Service Award from the American Academy of Otolaryngology; an American Cancer Society Professor of Clinical Oncology Award and two Presidential Citations from the American Society for Head and Neck Surgery.

Dr. Medina and his wife Libby have been married for 30 years, they have three children: Katherine, Joey and Kristine, and they are enjoying immensely their three grandchildren.



# Hayes Martin Biography

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## HAYES MARTIN, MD

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Hayes Martin was born in Dayton, a small town in north central Iowa. He attended the University of Iowa at Iowa Falls before being accepted to the medical school in 1913 on the same campus, finishing 4 years later in a class of 20.

World War I began in April 1917 while Hayes was in his final year of medical school. Many of his classmates at the medical school were in the Army ROTC units; however, Hayes opted for the Navy, which he joined on the day America entered the war. He traveled to Europe on the USS Arkansas and was assigned to his permanent duty station at the U.S. Navy Air Station, La Trinite, Sur Mer, France – a small seaside village on the southern coast of Brittany. The purpose of this base was antisubmarine warfare using blimps and kite balloons. Hayes was made commanding officer of the air station for a brief period of time when the line officer in charge had become ill; it was a unique position for a medical officer in the Navy to take command during wartime.

After the war Hayes returned to the U.S and sought out an internship at the old Poly Clinic Hospital in New York City, which was temporarily made into a Veteran's Administration hospital. Part of his internship was spent at Bellevue in the fourth surgical division, where he felt he would have the best possible training in general surgery. The chief of the second division was John A. Hartwell, MD, the distinguished surgeon memorialized by the Fellow's Room in the library of the New York Academy of Medicine. Hartwell suggested that Hayes go to Memorial Hospital to learn about cancer.

Hayes received an internship at Memorial in the summer of 1922 and stayed on as a resident until 1923. He then had two years at the second surgical service at Bellevue, where he operated to his heart's content and got the surgical education he so strongly desired. Once

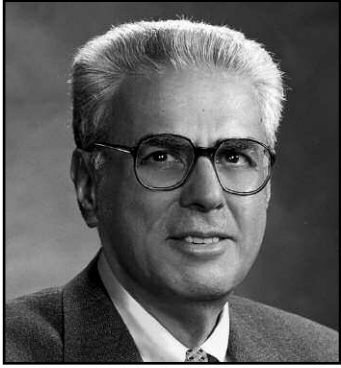
he finished his residency, Hayes returned to Memorial where he joined as clinical assistant surgeon on the staff.

Dr. Martin made the use of aspiration biopsy on all solid tumors popular throughout Memorial. Now, this procedure is done throughout the world. Hayes co-authored the first report on the subject published in the *Annals of Surgery*. Numerous other articles followed, including Hayes' two most famous publications, "Cancer of the Head and Neck," published in two issues of the *Journal of the American Medical Association* in 1948, and "Neck Dissection," appearing in *Cancer* in 1951. These two papers were so extensively requested that the American Cancer Society made reprints by the thousands available to those who requested them as many as 20 years after publication. Hayes' bibliography encompasses more than 160 articles.

In 1934, Hayes was appointed chief of the head and neck service at Memorial Hospital. It wasn't until 1940 that surgery began to take over as the treatment of choice for the majority of cancers of the head and neck. In that year, the beginnings of improved anesthesia permitted advances in surgery. Later, during World War II, antibiotics became available and surgery began to dominate much of head and neck cancer management.

Dr. Martin wrote extensively on many subjects, most within the realm of head and neck surgery. His ideal was to be the complete head and neck surgeon and he treated a wide variety of head and neck abnormalities. His book, *Surgery of the Head and Neck Tumors*, was published in 1957.

Hayes retired from active practice in 1957 at the age of 65. He performed his last operation at Memorial Hospital, assisted by Dr. Elliot Strong, in October 1959, but continued to see patients in his office. Hayes died in Memorial Hospital on Christmas Day, 1977.



## KENNETH I. SHINE, MD

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On November 24, 2003, Kenneth I. Shine, MD, joined The University of Texas System as Executive Vice Chancellor for Health Affairs. In that capacity he is responsible for the six U. T. System health components and their aggregate operating budget of almost \$6 billion.

Kenneth I. Shine, MD, was President of the Institute of Medicine (IOM), from 1992-2002. Under Dr. Shine's leadership, the IOM played an important and visible role in addressing key issues in medicine and health-care. IOM reports on quality of care and patient safety, heightened national awareness of these issues. IOM researchers led studies on nutrition, food safety, child development; and examined availability and side effects of vaccines.

Dr. Shine also focused attention on meeting the health-care needs of all Americans: he organized symposia to underscore the importance of cultural sensitivity in healthcare and supported programs to increase immunization rates, decrease use of tobacco among adolescents, and improve care of the dying. He emphasized communication of scientific findings and recommendations. Under his guidance, IOM staff developed CDs, videotapes, guidelines for community-based research, and publications for researchers, practitioners, policy-makers, and the public.

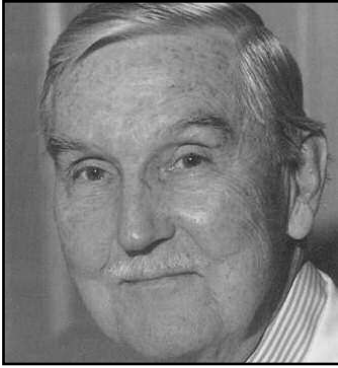
Dr. Shine was the founding Director of the RAND Center for Domestic and International Health Security. He led the Center's efforts to make health a central component of U.S. foreign policy and guide the Center's evolving research agenda. Dr. Shine brought to this new role decades-long experience working with international health experts on global issues such as emerging infectious illnesses, bioethics, and access to care.

Dr. Shine is Professor of Medicine Emeritus at the University of California, Los Angeles (UCLA) School of Medicine. A cardiologist and physiologist, he received his M.D. from Harvard Medical School in 1961. Before becoming president of the IOM, he was Dean and Provost for Medical Sciences at UCLA.

Dr. Shine is a member of many honorary and academic societies, including Phi Beta Kappa and Alpha Omega Alpha, Fellow of the American College of Cardiology, Master of the American College of Physicians, and was elected to the Institute of Medicine in 1988. He served as Chairman of the Council of Deans of the Association of American Medical Colleges from 1991-1992, and was President of the American Heart Association from 1985-1986.

# John J. Conley Biography

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## JOHN J. CONLEY, MD

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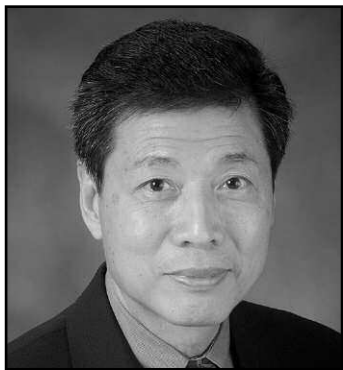
Although he looked and sounded like an English nobleman, Dr John Conley was born in Carnegie, Pennsylvania, a small steel mill town just outside of Pittsburgh. He graduated from the University of Pittsburgh and later its school of medicine. He interned at Mercy Hospital in Pittsburgh. During that year, the nuns who ran the hospital suggested that Dr. Conley take a residency in cardiology and come back to Mercy as their cardiologist. He went to Kings County Hospital in Brooklyn, a very busy city hospital with a huge patient population. Shortly after he began his training, he had an arrhythmia diagnosed as paroxysmal atrial tachycardia. Little was known about this benign condition at that time. Dr. Conley was told that cardiology was too stressful and that he should go into an easier, less-stressful field with better working hours, like ENT. He did an otolaryngology residency at Kings County Hospital. This was followed by four years of military service during World War II, which included experience in otolaryngology and plastic and reconstructive and maxillofacial surgery in the U.S. Army Medical Corps, both in this country and in the South Pacific theater. Exposure to the reconstruction of war wounds would prove invaluable to him later on in applying these principles to reconstruction following ablative head and neck surgery.

Dr. Conley returned to New York City after the war. He became an assistant and then an associate of Dr George T. Pack, a technically superb general oncologic surgeon at Memorial Hospital who taught Dr. Conley major ablative surgery of the head and neck. They worked day and night catching up with the backlog of surgery that was neglected during the war years. The combination of his training in otolaryngology, the exposure to ablative surgery, and the World War II experience in reconstructive surgery set the stage for Dr Conley to evolve his unique approach to head and neck surgery.

Ironically, despite the admonition of the cardiologists about hard work, Dr. Conley did a prodigious amount of major head and neck reconstructive surgery. This proved to be more than ample to provide training to many fellows. His commitment to education is further attested to by the position he held for many years as Clinical Professor of Otolaryngology at the College of Physicians and Surgeons at Columbia University. He loved his appointment at Columbia and particularly his involvement in teaching the residents.

Dr. Conley's vast surgical experience, together with active research interests, led to the authorship of almost 300 contributions to the scientific literature, and eight books. As a result of his productivity and rhetorical eloquence, he was very much in demand as a speaker in this country and abroad. He gave many prestigious eponymous lectures in our field and received many awards for his work, including the Philip H. Hench Award as the Distinguished Alumnus of the University of Pittsburgh School of Medicine, and the DeRoaldes and Newcomb Awards of the American Laryngological Association.

Dr. Conley's contributions to the scientific literature, many technical innovations and surgical experience placed him in the position to receive many honors and important leadership positions, such as President of the American Academy of Otolaryngology and Ophthalmology, member of the Board of Governors of the American College of Surgeons, founding member of the Society of Head and Neck Surgeons, and founding member and first President of the American Society for Head and Neck Surgery. During those years, Dr Conley used, to the great benefit of us all, his wisdom and diplomacy in carrying out such high-level responsibilities.



## KIE-KIAN ANG, MD

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Prof. Ang began his career in the field of radiation oncology at the University of Leuven in 1980. In 1984, he was recruited to the University of Texas M. D. Anderson Cancer Center where he progressed to the rank of Professor and Deputy Chairman of Radiation Oncology in 1990 and was awarded the Robert R. Herring Professorship in Clinical Research in 1992 and the Gilbert H. Fletcher Distinguished Chair in 1996.

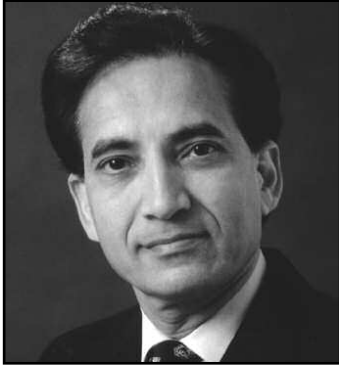
His clinical research emphasis focuses on refinement of therapy for head and neck cancer patients through development of biologically sound therapy regimens to be tested in multi-institutional randomized trials. He has chaired the Head and Neck Cancer Committee of the RTOG since 1999. This committee has completed four major randomized trials during the last six years that have contributed to changing the standard-of-care for head and neck carcinomas. He has been the Principal Investigator of a Program Project entitled “Modulation and Prediction of Radiation Response”, which fosters interactions between laboratory and clinical scientists in developing novel therapy strategies for

selective sensitization of tumors and protection of normal tissue injury. For example, the combination of radiotherapy with cetuximab was recently established as an approved therapy for a frontline treatment of patients with locally advanced head and neck carcinoma.

Prof. Ang has served many societies in various capacities, such as the President of the American Society of Therapeutic Radiology and Oncology (ASTRO) and a Trustee of the American Board of Radiology. He has received many awards and has given keynote lectures such as the Clinical Research Award of the European Society for Therapeutic Radiology and Oncology (1984), the Verstandig Award of the University of Tennessee (1994), Emmanuel van der Schueren Lecture of Belgian Society of Radiation Oncology (2000), the Dallas Fort Worth Living Legend Faculty Achievement Award in Clinical Research (2000), the Wharton Lecturer of the University of Toronto (2005), etc. He has contributed over 250 peer-reviewed journal papers, over 50 chapters, and has edited six textbooks.

# Jatin P. Shah Biography

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## JATIN P. SHAH, MD, MS, FACS, FRCS

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Professor Jatin P. Shah graduated from the Medical College of MS University in Baroda, India, and received his training in Surgical Oncology and Head and Neck Surgery at Memorial Sloan Kettering Cancer Center. He is Professor of Surgery, at the Weil Medical College of Cornell University, and Chief of the Head and Neck Service, Leader of the Head and Neck Disease Management Team, and holds The Elliott W. Strong Chair in Head and Neck Oncology at Memorial Sloan-Kettering Cancer Center in New York City.

Dr Shah is a national and international leader in the field of head and neck surgery, having served as President of The New York Cancer Society, The New York Head and Neck Society, The Society of Head and Neck Surgeons, The North American Skull Base Society and the International Academy of Oral Oncology. He found The International Federation of Head and Neck Oncologic Societies, in 1986. He currently serves as Chairman of the AJCC task force on Head and Neck. He was Chairman of the Joint Council for advanced training in head and neck oncologic surgery in the USA. He was also Chairman of The 4th International Conference on Head and Neck Cancer in Toronto in 1996. He has served in varying capacities for The American Board of Surgery, and The American College of Surgeons.

Professor Shah has been the recipient of numerous awards from various parts of the world, and is the recipient of honorary fellowships from The Royal College of Surgeons of Edinburgh, London and Australia. He has been elected as an honorary member of several head and neck societies in Europe, Asia,

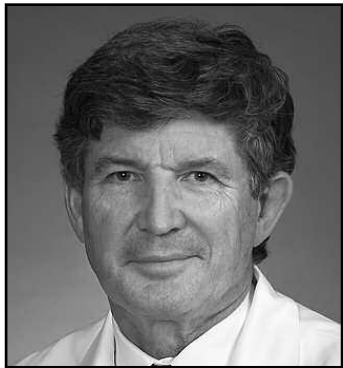
Australia, Africa and Latin America. He has been continuously listed in the “Best Doctors in America” directories for several years. He serves on the Editorial and Review Boards of 18 scientific journals and has published over 300 peer-reviewed articles, 50 book chapters and 7 books. His textbook of Head and Neck Surgery and Oncology won First Prize from The British Medical Association and The Royal Society of Medicine and was awarded the George Davey Howells Prize from the University of London, for the best published book in otolaryngology in the preceding five years.

He is a much sought after speaker who has delivered over 890 scientific presentations including, 27 eponymous lectures, numerous keynote addresses, and visiting professorships in the United States, Canada, United Kingdom, Scotland, Sweden, Belgium, Germany, Italy, Spain, Poland, Russia, Croatia, Turkey, Egypt, South Africa, India, China, Korea, Japan, Hong Kong, Singapore, Australia and all the countries in South America. He was the recipient of The Royal Society of Medicine Visiting Professorship for 1997.

In recognition of his outstanding contributions, and World Leadership in Head and Neck Surgery, Memorial Sloan Kettering Cancer Center, has established The “Jatin Shah Chair in Head and Neck Surgery and Oncology”, The International Federation of Head and Neck Oncologic Societies has established “The Jatin Shah Lecture”, at its world congresses, and the American Head and Neck Society has established the “Jatin Shah Symposium” at its annual meeting each year.

# Distinguished Service Award

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## ERNEST A. WEYMULLER, JR., MD

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Ernest A. Weymuller, Jr. was born in New York City. He graduated from Dartmouth College, BA (1962) and Harvard Medical School, MD (1966). After completing his Surgical Internship and Junior Assistant Residency at Vanderbilt University Hospital (1966-68), he served as a Captain, USAF Medical Corps (1968-70), thereafter completing Otolaryngology training at Massachusetts Eye and Ear Infirmary (1970-73).

He began his postgraduate career in 1973 with Boston Ear Nose and Throat Associates and also served as Associate Director of the Head and Neck Tumor Clinic at Massachusetts Eye and Ear Infirmary. He returned to academic medicine in 1978 with an appointment as an Assistant Professor at the University of Washington, became Professor and Vice-Chairman in 1985, and Chairman of the Department of Otolaryngology-Head and Neck Surgery in 1992. Current local responsibilities include Co-directorship of the UW Head and Neck Oncology Fellowship; Principal Investigator, Oto-HNS NIH Training Grant; and Surgeon-in-Chief, UW Medical Center.

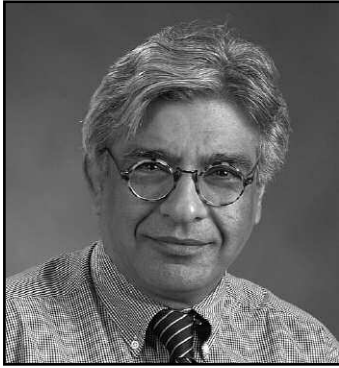
He has over 100 publications in peer reviewed journals, has co-authored two surgical atlases, contributed 30 chapters to various textbooks, and serves on numerous editorial review boards. His major areas of academic focus are the development and testing of the UW Head

and Neck Quality of Life Instrument and the establishment of an International Head and Neck Cancer Database.

National activities include President of the American Head and Neck Society (2000-01), Senior Examiner of the American Board of Otolaryngology, and membership on the Advisory Council of NIDCD. He has chaired AAO-HNS committees on Ethics (1991-94), Research (1992-1997), Research Liaison and Development (1997-1999), and is now a member of the Board of Directors. Dr. Weymuller has presented invited lectures at the University of Toronto (Abbott Lecturer), the British National Head and Neck Society, National Cancer Center of Singapore (Ministry of Health), National Head and Neck Meeting in India (Hiranandani Oration), and the International Congress of Head and Neck Cancer in Rio de Janeiro, Brazil. He was recently awarded Honorary Fellowship in the Royal Australasian College of Surgeons (2005).

Dr. Weymuller's day-to-day clinical activities focus on sinus surgery and head and neck cancer management.

Ernie and Alice Crownover Weymuller have enjoyed 39 years of marriage and are extraordinarily proud of their children, EA III and Sims, and their respective families.



## ADEL K. EL-NAGGAR, MD, PHD

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Dr. El-Naggar is a nationally and internationally renowned head and neck pathologist with 20 years experience in this field. He contributed extensively to the histopathology, clinicopathologic, flow cytometric and molecular diagnostics of head and neck tumors with over 400 peer-reviewed publications. He has made a significant contribution integrating molecular and biological markers in the diagnosis and management of head and neck cancer. One of his major contributions was in 1990 with the establishment of the first comprehensive tissue acquisition programs in the nation. This program has been the model for different institutional programs and has served numerous programmatic and individual proposals since its inception. He also has made seminal contributions in the molecular genetic analysis of mucosal and salivary gland tumors. Through genomic analysis he and his group has, for the first time, identified a set of genes that distinguish conventional squamous carcinoma from other phenotypic squamous carcinoma variants.

Dr. El-Naggar and his group have extensively studied the hyper-methylation of cancer genes in both squamous and salivary gland carcinomas. In these studies they have characterized target genes for potential diagnostic and therapeutic applications. He is also one of the first to identify the t(11:19) translocation gene as a sole cytogenetic alteration in mucoepidermoid carcinoma of salivary gland. This has led to the subsequent cloning of the METC1/MAML2 fusion gene resulting from this translocation. He is also in the forefront of the hormonal and signal transduction pathways research in the biology of high-grade adenocarcinoma of salivary

glands. His studies are the first to recognize the ER- $\beta$  as the dominant estrogen isotype in a subset of these tumors. He and his group were the first to report the exclusive expressions of ER- $\beta$  subtype and hormonal receptor co-activators in a subset of salivary duct carcinoma.

Dr. El-Naggar is also a leader in head and neck surgical pathology and was selected to outline the molecular alterations in salivary gland tumors for WHO classifications of head and neck tumors. He also established a specialized head and neck cancer pathology training program at M. D. Anderson Cancer Center. The program is the first in the nation and worldwide to train physician/scientist in both surgical and molecular pathology of head and neck cancer with emphasis on the multidisciplinary role of pathologist in the management of these tumors. In 1997, Dr. El-Naggar was awarded The B. Rothschild Senior Research Scholarship at the Curie-Institute in France and holds the Kenneth D Miller Endowed Professorship in Cancer Research at M. D. Anderson Cancer Center.

Nationally, Dr. El-Naggar is the only pathologist on the NCI-Head and Neck Steering Committee and is a member of the RTOG Steering, Pathology and Surgery Committees. He also led the Correlative Science Subcommittee of the SWOG Head and Neck Committee from 2002-2006. In these settings he is actively involved in efforts to standardize and coordinate pathology and biomarker evaluations within and between cooperative groups.



## **HENRY T. HOFFMAN, MD**

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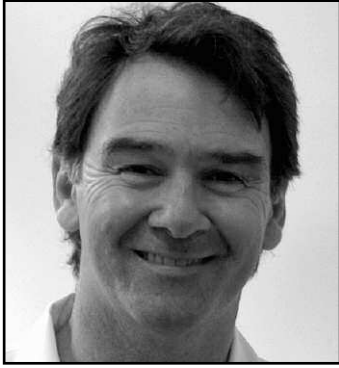
Henry T. Hoffman, MD MS FACS, is Director of Head and Neck Oncology and a Professor of Otolaryngology at the University of Iowa. He graduated from the University of California, San Diego School of Medicine and completed his Otolaryngology Residency at the University of Iowa. After two years in private practice in Charlotte, North Carolina, he

completed a two year Head and Neck Surgery Fellowship at the University of Michigan. Dr. Hoffman is a member of the Commission on Cancer and has directed much of his research to the analysis of cancer in large datasets. He is Director of the Voice Clinic and is extensively involved in research addressing laryngeal pathophysiology.



# Presidential Citation

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## CHRISTOPHER J. O'BRIEN, MD

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Chris O'Brien graduated in Medicine from the University of Sydney in 1976 and then undertook his residency and surgical training at Royal Prince Alfred Hospital, Australia's oldest and most famous university teaching hospital. In 1983 he spent a year of full time research in microvascular surgical techniques and then decided to specialise in head and neck oncology. This led to clinical fellowships at the Royal Marsden Hospital, London and the University of Alabama, Birmingham. In 1987 Professor O'Brien returned to Australia and was appointed to the staff of Prince Alfred Hospital as a consultant head and neck surgeon. There he expanded the clinical service making it the largest in the country and set up the most comprehensive head and neck database in Australia, establishing it as one of the largest in the world. He also established basic research and international fellowship programs. These initiatives were consolidated into the Sydney Head and Neck Cancer Institute which he founded in 2002. Chris O'Brien has two post graduate degrees, a Masters and a Doctorate, and is a full Professor of the University of Sydney.

He has developed an international reputation for his clinical research and publications on head and neck melanoma, salivary gland tumours, metastatic cutaneous cancer involving the parotid gland, oral cavity cancer and metastatic cancer in the neck. Professor O'Brien has over one hundred scientific publications and 17 book chapters and is widely sought after as an international speaker and visiting professor. He has been honoured with invitations to give numerous prestigious named lectures, including the Hayes Martin Lecture, the Eugene Myers International Lecture, the inaugural Jatin P Shah Lecture in Prague last year and the Semon Lecture. He is an honorary member of the Australian Society for Otolaryngology Head and Neck Surgery and was also recently honoured with an Honorary Fellowship of the Royal College of Surgeons of England in recognition of his contribution to the training of British maxillofacial surgeons.

In 1998, he founded the Australian and New Zealand Head and Neck Society, a multidisciplinary society comprising surgeons of all disciplines, radiation and medical oncologists and allied health professionals. He was President in 2004. The Society is flourishing and will hold its 9th Annual Scientific Meeting this year.

He joined the Society of Head and Neck Surgeons in 1986 and has been a member of the American Head and Neck Society since its inception. He was invited to join the Council in 2005.

In 2003 Professor O'Brien became Director of the Sydney Cancer Centre, based at RPA Hospital and the University of Sydney, while maintaining all of his clinical, teaching and research responsibilities. He also took on the responsibility of directing the provision of cancer services for 1.3 million people in one of Sydney's largest health service areas. During this time he has developed a proposal to transform the Sydney Cancer Centre into a \$200 million world class comprehensive cancer centre and that project is moving forward with great momentum.

In addition to his numerous professional roles, Chris O'Brien is also widely known to the people of Australia for his many appearances over the last 12 years on the multiaward winning reality TV program, RPA, filmed at Royal Prince Alfred Hospital. He was honoured by his country in 2005 when, on Australia Day that year, he was made a Member of the Order of Australia (AM) for his services to medicine.

Chris O'Brien is a devoted husband and father with many interests including running, skiing, reading and playing guitar. Unfortunately, in November last year he was diagnosed with a malignant brain tumour. His initial treatment has been successful and he continues on with his therapy with a totally positive and confident outlook. He has stepped down from all of his clinical and administrative positions in order to concentrate on his recovery.

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Terry Day, MD	2006-2008
Floyd ("Chris") Holsinger, MD	2006-2008
Frank R. Miller, MD	2006-2008

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Wayne M. Koch, MD	2004-2007
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Douglas B. Villaret, MD	2006-2008

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Richard V. Smith, MD	2004-2007
Richard O. Wein, MD	2004-2008
James P. Malone, MD	2005-2008
David Myssiorek, MD	2005-2008
Ralph W. Gilbert, MD	2006-2009
Gady Har-El, MD	2006-2009
Andrew McWhorter	2006-2009
Douglas Trask, MD	2006-2009
Marilene B. Wang, MD	2006-2009

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Andre L. Carvalho, MD, PhD	2006-2008
Claudio R. Cernea, MD	2006-2008
D. Gregory Farwell, MD, FACS	2006-2008
Robert L. Ferris, MD, PhD	2006-2008
Gerry F. Funk, MD	2006-2008
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Patrick Ha	2006-2008
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Bhuvanesh Singh, MD	2006-2008
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M. Boyd Gillespie, MD, MS	2004-2007
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---

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Eben L. Rosenthal, MD	2006-2009

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Dennis H. Kraus, MD	2006-2009
Richard J. Wong, MD	2006-2009

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Amy Chen, MD, MPH
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Gerry F. Funk, MD
Ralph W. Gilbert, MD
Jeffrey N. Myers, MD, PhD
Karen T. Pitman, MD
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Eben L. Rosenthal, MD
Maisie Shindo, MD
Bhuvanesh Singh, MD, PhD
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David J. Terris, MD
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Randal S. Weber, MD
Bevan Yueh, MD

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## AMERICAN ACADEMY OF OTOLARYNGOLOGY-HEAD AND NECK SURGERY BOARD OF GOVERNORS

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Jonas T. Johnson, MD

## AMERICAN BOARD OF OTOLARYNGOLOGY LIAISON

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Paul A. Levine, MD

## AMERICAN COLLEGE OF SURGEONS COMMISSION ON CANCER

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Amy Chen, MD

## ARCHIVES OF OTOLARYNGOLOGY ASSOCIATE EDITOR

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Bevan Yueh, MD

## ARCHIVES OF OTOLARYNGOLOGY NEWS EDITOR

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David W. Eisele, MD

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Joseph A. Califano, MD

Gary L. Clayman, MD, DDS

Jesus E. Medina, MD

Ashok R. Shaha, MD

Peter M. Som, MD

Gregory T. Wolf, MD

## AMERICAN JOINT COMMITTEE ON CANCER

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Carol R. Bradford, MD

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Amy Chen, MD (*Co-Chair*) 2006-2009

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Bruce J. Davidson, MD 2006-2009

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Amy C. Hessel, MD 2006-2009

Wayne M. Koch, MD 2006-2009

Thom R. Loree, MD 2006-2009

William M. Lydiatt, MD 2006-2009

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Ralph P. Tufano, MD 2006-2009

Robert L. Witt, MD 2006-2009

Bevan Yueh, MD 2006-2009

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---

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Ashok R. Shaha, MD - 1999  
Jesus E. Medina, MD - 2000  
Ernest A. Weymuller, Jr., MD - 2001  
Keith S. Heller, MD - 2002

Paul A. Levine, MD - 2003  
Jonas T. Johnson, MD - 2004  
Patrick J. Gullane, MD - 2005  
John J. Coleman, III, MD - 2006

## AMERICAN SOCIETY FOR HEAD AND NECK SURGERY

---

John J. Conley, MD\* - 1959-61  
Paul H. Holinger, MD\* - 1961-63  
Joseph H. Ogura, MD\* - 1963-65  
John F. Daly, MD\* - 1965-67  
W. Franklin Keim, MD\* - 1967-69  
George A. Sisson, MD - 1969-70  
John S. Lewis, MD - 1970-71  
Burton J. Soboroff, MD\* - 1971-72  
Edwin W. Cocke, Jr., MD - 1972-73  
Charles M. Norris, MD - 1973-74  
Daniel Miller, MD\* - 1974-75  
Emanuel M. Skolnick, MD\* - 1975-76  
George F. Reed, MD\* - 1976-77  
John A. Kirchner, MD - 1977-78  
William M. Tribble, MD\* - 1978-79  
Loring W. Pratt, M.D - 1979-80  
J. Ryan Chandler, M.D - 1980-81

Douglas B. Bryce, MD - 1981-82  
Jerome C. Goldstein, MD - 1982-83  
Paul H. Ward, MD - 1983-84  
Hugh F. Biller, MD - 1984-85  
Robert W. Cantrell, MD- 1985-86  
John M. Lore, Jr., MD\* - 1986-87  
Charles J. Krause, MD - 1987-88  
Eugene N. Myers, MD- 1988-89  
Willard N. Fee, Jr., M.D - 1989-90  
Helmuth Goepfert, MD - 1990-91  
Michael E. Johns, MD - 1991-92  
Bryon J. Bailey, MD - 1992-93  
James Y. Suen, MD - 1993-94  
Gary L. Schechter, MD - 1994-95  
Charles W. Cummings, MD - 1995-96  
Nicholas J. Cassisi, MD - 1996-97  
Dale H. Rice, MD - 1997-98

## THE SOCIETY OF HEAD AND NECK SURGEONS

---

Hayes Martin, MD\* - 1954  
Hayes Martin, MD\* - 1955  
Hayes Martin, MD\* - 1956  
Hayes Martin, MD\* - 1957  
Grant Ward, MD\* - 1958  
Danely P. Slaughter, MD\* - 1959  
Arnold J. Kremen, MD - 1960  
Arnold J. Kremen, MD - 1961  
H. Mason Morfit, MD - 1962  
H. Mason Morfit, MD - 1963  
Calvin T. Kloop, MD\* - 1964  
Harry W. Southwick, MD\* - 1965  
Edgar L. Frazell, MD\* - 1966  
Oilver H. Beahrs, MD - 1967  
Arthur G. James, MD - 1968  
William S. MacComb, MD\* - 1969

Ralph R. Braund, MD\* - 1970  
Harvey W. Baker, MD\* - 1971  
Charles C. Harrold, MD - 1972  
Robin Anderson, MD - 1973  
Alfred Ketcham, MD - 1974  
Richard H. Jesse, MD\* - 1975  
Condict Moore, MD - 1976  
Donald P. Shedd, MD - 1977  
William A. Maddox, MD- 1978  
John C. Gaisford, MD - 1979  
Robert G. Chambers, MD\*- 1980  
Elliot W. Strong, MD - 1981  
John M. Moore, MD - 1982  
Alvin L. Watne, MD - 1983  
Darrell A. Jaques, MD - 1984  
Alando J. Ballantyne, MD\*- 1985

Frank C. Marchetta, MD\*- 1986  
William R. Nelson, MD - 1987  
Robert D. Harwick, MD - 1988  
James T. Helsper, MD - 1989  
M.J. Jurkiewicz, MD - 1990  
Jatin P. Shah, MD - 1991  
Oscar Guillaumondegui, MD - 1992  
Stephen Ariyan, MD - 1993  
J. Edward M. Young, MD - 1994  
Michael B. Flynn, MD - 1995  
Robert M. Byers, MD - 1996  
John R. Saunders, Jr., MD - 1997  
Ronald H. Spiro, MD - 1998

\* Deceased

# Awards

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## PAST HAYES MARTIN LECTURERS

---

William S. MacComb, M.D.	1972
Oliver H. Beahrs, M.D.	1973
Arthur G. James, M.D.	1974
Charles C. Harrold, M.D.	1975
Edgar L. Frazell, M.D.	1976
Harry W. Southwick, M.D.	1977
Harvey W. Baker, M.D.	1978
Edward F. Scanlon, M.D.	1979
Condict Moore, M.D.	1980
Richard H. Jesse, M.D.	1981
Milton Edgerton, M.D.	1982
John J. Conley, M.D.	1983
William A. Maddox, M.D.	1984
Alfred S. Ketcham, M.D.	1985
Donald P. Shedd, M.D.	1986
Elliot W. Strong, M.D.	1987
M.J. Jurkiewicz, M.D.	1988
George A. Sisson, M.D.	1989
Alando J. Ballantyne, M.D.	1990
Ian Thomas Jackson, M.D.	1991
John M. Lore, M.D.	1992
Ronald H. Spiro, M.D.	1993
John G. Batsakis, M.D.	1994
Helmuth Goepfert, M.D.	1995
Joseph N. Attie, M.D.	1996
Blake Cady, M.D.	1997
Jatin P. Shah, M.D.	1998
Jean-Louis H. LeFebvre, M.D.	1999
Robert M. Byers, M.D.	2000
William Wei, M.S.	2001
Eugene Myers, M.D.	2002
Michael Johns, M.D.	2003
Christopher J. O'Brien, M.D.	2004
Richard K. Reznick, M.D., M.Ed.	2005
Keith S. Heller, MD.	2006

## PAST JOHN D. CONLEY LECTURERS

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Edward Hughes, MD	2001
Rabbi David Saperstein	2002
Jonathan D. Moreno, MD	2003
David C. Leach, MD	2004
James F. Battey, Jr., MD	2005
John Stone, MD, MACP	2006

## DISTINGUISHED SERVICE AWARDS

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Jatin P. Shah, M.D.	1989
Stephan Ariyan, M.D.	1990
Ashok R. Shaha, M.D.	1991
Elliot W. Strong, M.D.	1995
John J. Coleman, III M.D.	1999
David L. Larson, M.D.	1999
Harold J. Wanebo, M.D.	1999
Jonas T. Johnson, M.D.	2001
Helmuth Goepfert, M.D.	2003
Mark D. Coltrera, M.D.	2004
Wayne Koch, M.D.	2005
John A. (Drew) Ridge, M.D. Ph.D.	2006

## SPECIAL RECOGNITION AWARDS

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Paul B. Chyetien, M.D.	1984
John M. Lore, Jr., M.D.	1985
William S. MacComb, M.D.	1986
Calvin T. Klopp, M.D.	1987
Edgar L. Fazell, M.D.	1988
Harvey W. Baker, M.D.	1989
Vahram Y. Bakamjian, M.D.	1991
Jean-Louis Lefebvre, M.D.	1995

# Robert Maxwell Byers Award

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## ROBERT MAXWELL BYERS, MD

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The Robert Maxwell Byers Award, in the amount of \$1000, is for the best clinical or basic science research paper submitted for presentation at the annual meeting of the American Head and Neck Society.

Robert Maxwell Byers, M.D. was born in Union Hospital, Baltimore, Maryland on September 24, 1937. He grew up on the Eastern Shore of Maryland in the small town of Elkton. Very active in the varsity sports of baseball, basketball and track during his high school years, he continued his athletic participation at Duke University along with his pre-med studies. He entered the University of Maryland Medical School in Baltimore in 1959, where he excelled in his medical studies and received membership in AOA and the Rush Honor Medical Society. The highlight of his sophomore year was his 1961 marriage to Marcia Davis, a high school sweetheart. During his junior year, he was commissioned an Ensign in the United States Naval Reserve and later rose to the rank of Captain in 1986.

In 1963, Dr. Byers began his general surgical residency with Dr. Robert Buxton at the University Hospital in Baltimore. Five years later, as a fully trained general surgeon, he went to the Republic of Vietnam with the 1st Marine Division where he received a unit commendation medal and a combat action ribbon. On return to the United States, he spent a year at Quonset Point, Rhode Island Naval Hospital as Chief of Surgery. In 1969, he was certified by the American Board of Surgery. After discharge from the Navy in 1970, Dr. Byers and his family moved to Houston, Texas where he began a fellowship in Surgical Oncology at the University of Texas M.D. Anderson Cancer Center under the guidance of Drs. R. Lee Clark, Richard Martin, Ed White, William MacComb, Richard Jesse and Alando J. Ballantyne. This move proved to be a decisive event, as he never left. His career in Head and

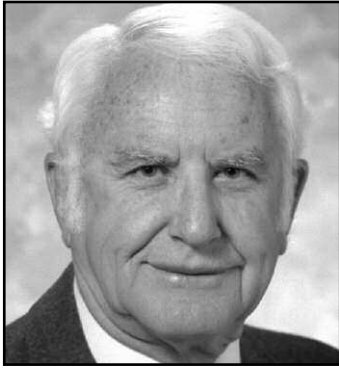
Neck Surgical Oncology was born, nurtured, and matured during the 31 years of his academic/clinical practice at the University of Texas M.D. Anderson Cancer Center.

During his tenure at M.D. Anderson Cancer Center he rose through the ranks from Assistant Professor in 1972 to Associate Professor in 1976 and, finally, Professor and Surgeon in 1981. In 1998, he was honored with the Distinguished Alando J. Ballantyne Chair of Head and Neck Surgery. He is the author or co-author of over 200 published papers, book chapter and monographs. He has given invited lectures all over the world. Most recently (1999), he was selected to give the Hayes Martin Memorial Lecture at the 5th International Conference on Head and Neck Cancer. He has been President of the American Radium Society and President of the Society of Head and Neck Surgeons both in 1995 – 1996. His research interests and his expertise have been focused on cancer of the oral cavity, head and neck cancer in young people and treatment of the neck involved with metastatic cancer with a particular interest in various neck dissections. Dr. Byers is a member of many prestigious societies, of which the Southern Surgical Association, the Texas Surgical Society, the American College of Surgeons and the Society of Surgical Oncologists are but a few. He is a peer reviewer for many medical journals and on the Editorial Board of three. During his 31 years at the University of Texas M.D. Anderson Cancer Center, he has participated in the surgical education of over 300 residents and fellows, many of who have gone on to become prominent members of the specialty. The youth community of Houston has benefited from his coaching expertise in baseball and basketball while he has indulged in the hobbies of hunting, travel, and collecting toy soldiers.



# *Alando J. Ballantyne Resident Research Pilot Grant*

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## **ALANDO J. BALLANTYNE, MD**

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Alando J. Ballantyne, M.D., a giving teacher, dedicated surgeon, and a devoted husband and father, is memorialized by the Alando J. Ballantyne Resident Research Pilot Grant. This award, in the amount of \$10,000, is for the best grant application by a resident.

Alando, known simply as Jay, grew up in a loving Mormon home that taught him the values of family, excellence, integrity and hard work. Jay graduated Phi Beta Kappa from the University of Arizona and was then awarded a scholarship to Columbia Medical School. During World War II, Jay served as an army captain and medical doctor and had the good fortune to meet his wife, Maria, in San Antonio. In 1947, Dr. Ballantyne became the first resident at the new M.D. Anderson Hospital in Houston. After his year-long residency, he went for further training at the Mayo Clinic in Rochester, Minnesota. He returned to the Anderson staff in 1952, where he quickly advanced from Assistant Surgeon in the Head and Neck Service to Associate Surgeon, and then from 1974 until his retirement in 1994, held the title of Surgeon and Professor of Surgery in the Department of Head and Neck Surgery as well as the title of Ashbel Smith Professor.

Dr. Ballantyne is credited as the first surgeon in the United States to pioneer modified radical neck dissection. His contributions to his subspecialty, the result of an undying curiosity and uncanny powers of observations, have been published in numerous scientific papers and book chapters. Jay lectured at local, national, and international forums and loved his travels. He held

memberships in many distinguished medical and surgical societies and served as President and Hayes Martin Lecturer of the Society of Head and Neck Surgeons and President of the Texas Surgical Society.

To honor the contributions of this world-renowned surgeon, the Cynthia and George Mitchell Foundation established the Alando J. Ballantyne Distinguished Chair in Head and Neck Surgery at the University of Texas M.D. Anderson Cancer Center.

Dr. Ballantyne's contributions to the subspecialty of Head and Neck cancer surgery have been the result of an undying curiosity and uncanny powers of observation. He was the father of conservative surgery, removing the cancer while preserving the function. He had a relentless desire to eradicate his patients' disease, yet was able to balance this fervor with a desire to maintain quality of life for all his patients.

Always an advocate of reconstruction and preservation of cosmesis as well as function, those fortunate enough to have worked with him and been taught by him are forever indebted to his wisdom, surgical expertise, and devotion to his patients. He was beloved by his patients, admired by his peers and idolized by his family.

The Alando J. Ballantyne Resident Research Pilot Grant is funded by the generous contributions of members of the Ballantyne family, including Dr. Gilchrist L. Jackson, a respected member of the American Head and Neck Society.

# AHNS Committee Meeting Schedule

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## FRIDAY, APRIL 27<sup>TH</sup>

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6:00 – 7:00 AM	Prevention Committee	GREGORY B
7:00 – 8:00 AM	CME Compliance Committee	GREGORY A
	Fellowship and Scholarship Committee	EDWARD D
	Publications Committee	EDWARD C
	Research Committee	GREGORY B
1:00 – 5:00 PM	AHNS Council Meeting	BETSY A

## SATURDAY, APRIL 28<sup>TH</sup>

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6:00 – 7:00 AM	Advanced Training Council (ATC)	GREGORY B
6:30 – 8:00 AM	2008 Planning Meeting	BETSY A
7:00 – 8:00 AM	Quality Committee	EDWARD C

### **RULES FOR ASKING QUESTIONS DURING SCIENTIFIC SESSION:**

- You may question the presenter by proceeding to the microphone to ask a question from the floor.
- When recognized by the moderator, give your name, hospital or university affiliation, city, country and a commercial disclosure (including “nothing to disclose”) before asking your question.
- Please ask your question in a clear, concise manner and indicate the name of the presenter to whom your question is directed.
- Please do not give comments or information about results of a similar study, except as part of your question.
- Each questioner is limited to one question, not a discussion.

**PLEASE COMPLETE THE MEETING EVALUATION FORM AND  
RETURN TO THE AHNS REGISTRATION DESK  
TO RECEIVE YOUR CME CERTIFICATE.**

**CERTIFICATES WILL BE MAILED AFTER THE MEETING.**

# Schedule at a Glance

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## **SATURDAY APRIL 28<sup>TH</sup> 2007**

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8:00 - 8:15 AM	Welcome and Introduction of Guests of Honor
8:15 - 9:15 AM	Scientific Session (1)
9:15 - 10:00 AM	John Conley Lecture: "Quality and Safety in American Medicine Today"
10:00 - 10:20 AM	Break with Exhibitors
10:20 - 11:30 AM	Scientific Session (2)
11:30 - 12:00 PM	Keynote Lecture: "Translating Lab Discoveries to the Bedside"
12:00 - 1:00 PM	Lunch with Exhibitors
1:00 - 2:00 PM	Scientific Session (3) (Endocrine)
2:00 - 3:00 PM	Jatin Shah Symposium: "Clinical Controversies in Head and Neck Cancer"
3:00 - 3:20 PM	Break with Exhibitors
3:20 - 4:20 PM	Endocrine Video Session
4:20 - 5:30 PM	Scientific Session (4) (Endocrine)
5:30 - 7:00 PM	Poster Viewing and Reception in Exhibit Hall
5:45 - 6:30 PM	Fellowship Information Session
6:30 - 7:00 PM	Poster Tours
7:15 - 8:30 PM	President's Reception - All AHNS attendees welcome

## **SUNDAY APRIL 29<sup>TH</sup> 2007**

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8:00 - 9:00 AM	Scientific Session (5)
9:00 - 9:45 AM	Hayes Martin Lecture: "Head and Neck Surgery: Meeting the Needs of the 21st Century"
9:45 - 10:00 AM	Awards Ceremony
10:00 - 10:20 AM	Break with Exhibitors
10:20 - 11:20 AM	Panel: "Management of Cancer of the Oropharynx"
11:20 - 11:25 AM	Introduction of the President of AHNS
11:25 - 12:00 PM	Presidential Address and Presidential Citations: "Improving Quality in Head and Neck Cancer Care"
12:00 - 1:00 PM	Lunch on Own OR AHNS Business Meeting for Members
1:00 - 2:00 PM	Scientific Session (6)
2:00 - 3:00 PM	Panel: "Current Controversies in Head and Neck Reconstruction: Reconstruction of the Maxilla and Salvage of Chemoradiation Failures"
3:00 - 3:20 PM	Break
3:20 - 4:10 PM	Cooperative Groups Update
4:10 - 5:30 PM	Scientific Session (7)

LOCATION: Elizabeth DE (unless otherwise stated)

SATURDAY APRIL 28<sup>TH</sup> 2007

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8:00-8:15 **WELCOME AND INTRODUCTION OF GUESTS OF HONOR** Randal S. Weber, MD  
**Guests of honor:** Helmuth Goepfert, MD;  
Robert Byers, MD;  
Oscar M. Guillimondegui, MD

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8:15-9:15 **SCIENTIFIC SESSION (1)**  
**Moderators:** Claudio R. Cernea, MD; Ann M. Gillenwater, MD

8:15 **Cryoablation for Treatment of Early Glottic Carcinoma** Claudio F. Milstein, MD

8:23 **Endoscopic CO<sub>2</sub> Laser Surgery of Glottic Cancer Recurred After Radiotherapy: Oncological and Functional Results** Fausto Chiesa, MD

8:31 **Transoral Laser Microsurgery for Advanced Laryngeal Cancer** Michael L. Hinni, MD

8:39 **Discussion**

8:45 **Factors Predictive of Survival in Advanced Laryngeal Cancer** Amy Y. Chen, MD

8:53 **Predictor Factors for Patients with Recurrent Head and Neck Cancer Treated By Laser Thermal Therapy** Michael Bublik, MD

9:01 **Malpractice Litigation After Surgical Injury of the Spinal Accessory Nerve** Luc G. Morris, MD

9:09 **Discussion**

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9:15-10:00 **JOHN CONLEY LECTURE**  
***Quality and Safety in American Medicine Today***  
**KENNETH I. SHINE, MD, UNIVERSITY OF TEXAS SYSTEM**  
*The AHNS acknowledges a generous educational grant in support of this lecture from Imclone.*

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10:00-10:20 **Break with Exhibitors (Location: Douglas Pavilion)**  
*Supported in part by our Silver Level Donors:*  
*Gyrus ACMI*  
*Karl Storz Endoscopy*  
*IRX Therapeutics*

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10:20-11:30 **SCIENTIFIC SESSION (2)**  
**Moderators:** Jay O. Boyle, MD; Amy Chen, MD  
*The AHNS acknowledges a generous educational grant in support of this session from Imclone.*

10:20 **Racial Differences in Diagnosis, Treatment, and Outcome of Oral and Pharyngeal Cancer** K. Lawrence Yen, MD

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10:28	<b>Prognostic Factors in Squamous Cell Carcinoma of the Oropharynx</b>	Luiz Paulo Kowalski, MD
10:36	<b>Aspiration in Chemoradiated Head and Neck Cancer Patients</b>	Alexander Langerman, MD
10:44	<b>Discussion</b>	
10:50	<b>Pathologic Response in Post-Treatment Neck Dissection Predicts Outcome in Head and Neck Cancer Patients Treated With Primary Radiation</b>	M. Lango, MD
10:58	<b>Is a Selective Neck Dissection Appropriate for Advanced Disease Following Adjuvant Therapy?</b>	Adam S. Jacobson, MD
11:06	<b>Role of the Immune System in the Monoclonal Antibody Therapy Directed to the Epidermal Growth Factor Receptor</b>	Robert L. Ferris, MD
11:14	<b>Prognostic Effect of EGFR, MMP-2, MMP-9 and VEGF Expression in Locally Recurrent Oral and Oropharyngeal Squamous Carcinomas Submitted to Salvage Surgery</b>	Luiz P Kowalski, MD
11:22	<b>Discussion</b>	

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11:30-12:00	<b>KEYNOTE LECTURE</b> <i>Translating Lab Discoveries to the Bedside</i> <b>KIE-KIAN ANG, MD, PhD, M.D. ANDERSON CANCER CENTER</b>	
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12:00-1:00	<b>LUNCH WITH EXHIBITORS (Location: Douglas Pavilion)</b>	
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1:00-2:00	<b>SCIENTIFIC SESSION (3) (ENDOCRINE)</b> Moderators: Ralph P. Tufano, MD; Ashok Shaha, MD	
1:00	<b>Cost-Effective Management of Low-Risk Papillary Thyroid Carcinoma</b>	Mark G. Shrime, MD
1:08	<b>Thyroid Function After Unilateral Total Lobectomy: Risk Factors for Postoperative Hypothyroidism</b>	Claudio R. Cernea, MD
1:16	<b>Papillary Thyroid Carcinoma: Impact of Pre-Operative Ultrasound Staging of the Neck</b>	Hernán E. Gonzalez, MD
1:24	<b>Discussion</b>	
1:30	<b>Identifying Patients Undergoing Thyroidectomy for Papillary Thyroid Cancer at Risk for Harboring Multiple Central Neck Lymph Node Metastases</b>	Tarik Y. Farrag, MD
1:38	<b>Revision Central Compartment Surgery: Indications, Management and Outcomes in 60 Consecutive Patients</b>	Moshe N. Yehuda, MD
1:46	<b>Invasive Well-Differentiated Thyroid Carcinoma of the Upper Aerodigestive Tract: A Retrospective Analysis</b>	Etai Funk, MD
1:54	<b>Discussion</b>	

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2:00-3:00

**JATIN P. SHAH SYMPOSIUM:  
CLINICAL CONTROVERSIES IN HEAD AND NECK CANCER**

***How Much is Too Much?***

***Recurrent Thyroid Cancer with Minimal Tumor Burden***

Moderator: John A. Ridge, MD, PhD

**James I. Cohen, MD:** “More May be Better”

**Keith S. Heller, MD:** “Too Much of a Good Thing?”

**Maisie L. Shindo, MD:** “Central Compartment Dissection: What is the Threshold?”

**Quan-yang Duh, MD:** “Imaging in the Setting of Minimal Disease”

**Peter A. Singer, MD:** “Thyroglobulin: Putting it in Perspective”

3:00-3:20

**BREAK WITH EXHIBITORS (Location: Douglas Pavilion)**

*Supported in part by our Silver Level Donors:*

*Gyrus ACMI*

*Karl Storz Endoscopy*

*IRX Therapeutics*

3:20-4:20

**ENDOCRINE VIDEO SESSION**

Moderator: David J. Terris, MD

**Gregory L. Randolph, MD:** “Recurrent Laryngeal Nerve Monitoring”

**Jatin P. Shah, MD:** “Conventional Thyroidectomy”

**Gary L. Clayman, MD:** “Video-Assisted Thyroidectomy”

**Brendan C. Stack, MD:** “Minimally Invasive Radioguided Parathyroidectomy”

4:20-5:30

**SCIENTIFIC SESSION (4) (ENDOCRINE)**

Moderators: Michael E. Kupferman, MD; Lisa A. Orloff, MD

- 4:20 **Minimally Invasive Video-Assisted Thyroidectomy:  
A Multi-Institutional North American Experience** David J. Terris, MD
- 4:28 **Objective and Subjective Scar Aesthetics in Minimal Access  
vs. Conventional Parathyroidectomy and Thyroidectomy  
Surgeries, a Paired Cohort Study** Daniel A. O’Connell, MD
- 4:36 **Minimally Invasive Parathyroidectomy Using the Lateral Approach  
Under Conscious Sedation: Technique and Results** Joshua Rosenthal, MD
- 4:44 **Discussion**
- 4:50 **Ex-vivo Radioactivity Measurements of Normal,  
Hyperplastic and Adenomatous Parathyroids** Paul Schalch, MD
- 4:58 **The Link Between Plasma 25-hydroxyvitamin D Levels,  
Severity of Primary Hyperparathyroidism and Disease  
Localization on Sestamibi Scans: A Study of 344 Consecutive  
Patients Undergoing Targeted Parathyroidectomy** Emad Kandil, MD

5:06 **The Utility of Ultrasonography in Parathyroid Surgery** Bridget A Boudreaux, MD

5:14 **Laryngeal Nerve Monitoring and Minimally Invasive Thyroid Surgery** Tammara Watts, MD

5:22 **Discussion**

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5:30 – 7:00 **POSTER VIEWING AND RECEPTION IN EXHIBIT HALL**  
(Location: Douglas Pavilion)

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5:45 – 6:30 **FELLOWSHIP INFORMATION SESSION** Jay O. Boyle, MD

Residents interested in pursuing a Head and Neck fellowship are invited to this informational session.

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6:30 – 7:00 **POSTER TOURS**

*Please meet the tour guides by poster number 74 at 6:30pm.*

Chair: David W. Eisele, MD

Basic Science Tour Guide: Robert L. Ferris, MD

Translational Research Tour Guides: Buvanesh Singh, MD; Jeffrey N. Myers, MD

Plastic and Reconstructive Tour Guides: Gerry F. Funk, MD; Ralph W. Gilbert, MD

Head & Neck Tour Guides: Karen T. Pitman, MD; Eban L. Rosenthal, MD;  
Claudio R. Cernea, MD

Endocrine Tour Guides: Ralph P. Tufano, MD; Maisie L. Shindo, MD,  
Brendan C. Stack, MD

Outcomes and Quality of Life Tour Guides: Bevan Yueh, MD; Amy Chen, MD

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7:15 – 8:30 **PRESIDENT'S RECEPTION (Location: Randle DE)**

Please join President Weber for cocktails and hors d'oeuvres.

**ONLY AHNS MEETING ATTENDEES ARE INVITED TO ATTEND.**

*Supported in part by our Platinum Donors:*

*Bristol-Myers Squibb*

*Imclone*

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## SUNDAY APRIL 29<sup>TH</sup> 2007

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8:00-9:00	<b>SCIENTIFIC SESSION (5)</b> Moderators: David W. Eisele, MD; Eban L. Rosenthal, MD
8:00	<b>Metastatic Cervical Squamous Cell Carcinoma from Occult Head and Neck Primary – A ‘Conservative’ Approach</b> Rajan S Patel, MD
8:08	<b>Trends in Self-reported General Health Measures Predict Survival in Head and Neck Cancer Patients</b> Mark J. Jameson, MD
8:16	<b>The Management of Head and Neck Melanoma: Recurrence, Radiotherapy and Prognosis.</b> Richard Martin, MS
8:24	<b>Discussion</b>
8:30	<b>Trans Antral Robotic Surgery of the Skull Base</b> Ehab Y. Hanna, MD
8:38	<b>Trans Oral and Trans Cervical Robotic Skull Base Surgery in a Preclinical Model</b> Bert W. O’Malley, MD
8:46	<b>Transoral Robotic Surgery (tors) Radical Tonsillectomy for Squamous Cell Carcinoma of the Tonsillar Region: Technique and Outcomes</b> Gregory S. Weinstein, MD
8:54	<b>Discussion</b>

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9:00-9:45 **HAYES MARTIN LECTURE**  
*Head and Neck Surgery:  
Meeting the Needs of the 21st Century*  
**JESUS E. MEDINA, MD;**  
**THE UNIVERSITY OF OKLAHOMA HEALTH SCIENCES CENTER**

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9:45-10:00 **AWARDS CEREMONY**  
Randal S. Weber, MD; Maisie L. Shindo, MD; Jay O. Boyle, MD  
– ALANDO J. BALLANTYNE RESIDENT RESEARCH PILOT GRANT  
– AHNS PILOT GRANT  
– AHNS/AAO-HNSF SURGEON SCIENTIST AWARD  
– AHNS/AAO-HNSF YOUNG INVESTIGATOR AWARD  
– ROBERT MAXWELL BYERS AWARD  
– FANCONI ANEMIA RESEARCH FUND AWARD  
– BEST RESIDENT BASIC SCIENCE RESEARCH PAPER  
– BEST RESIDENT CLINICAL RESEARCH PAPER

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10:00-10:20 **BREAK WITH EXHIBITORS (Location: Douglas Pavilion)**  
*Supported in part by our Silver Level Donors:*  
*Gyrus ACMI*  
*Karl Storz Endoscopy*  
*IRX Therapeutics*



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- 10:20-11:20      **PANEL: “MANAGEMENT OF CANCER OF THE OROPHARYNX”**  
Moderator: David J. Adelstein  
**Guy J. Petruzelli, MD:** “Surgical Management”  
**David I. Rosenthal, MD:** “Radiation Therapy”  
**David J. Adelstein, MD:** “Chemotherapy and Targeted Therapy”  
**Jan S. Lewin, MD:** “Functional Outcomes”
- 
- 11:20-11:25      **INTRODUCTION OF THE PRESIDENT OF AHNS**  
**Gregory T. Wolf, MD**
- 
- 11:25-12:00      **PRESIDENTIAL ADDRESS AND PRESIDENTIAL CITATIONS**  
**Randal S. Weber, MD;** AHNS President 2006-2007  
*Improving Quality in Head and Neck Cancer Care*
- 
- 12:00-1:00      **LUNCH ON OWN**  
**OR**  
**AHNS BUSINESS MEETING FOR MEMBERS (BOXED LUNCH)**
- 
- 1:00-2:00      **SCIENTIFIC SESSION (6)**  
Moderators: Robert L. Ferris, MD; Karen T. Pitman, MD
- 1:00      **Sinonasal Adenoid Cystic Carcinoma:**  
**M.D. Anderson Cancer Center Experience**      Allison D. Lupinetti, MD
- 1:08      **The Importance of Comorbidity in Treatment of Salivary**  
**Gland Cancer; Results of the Dutch Head and Neck**  
**Oncology Cooperative Group (NWHHT)**      Robert J. Baatenburg de Jong, PhD
- 1:16      **Evaluation of Hardware-related Complications in**  
**Vascularized Bone Grafts with Locking Mandibular**  
**Reconstruction Plate Fixation**      Philip D. Knott, MD
- 1:24      **Discussion**
- 1:30      **The Use of a Stereolithographic Model as an Aid to Plate**  
**Application in Oro-mandibular Reconstruction with Fibular Free**  
**Flaps: A Comparison of Fixation Techniques**      R. Bryan Bell, MD
- 1:38      **Carotid Body Tumors: Evolving Management Based on a**  
**20 Year Experience in the Treatment of 186 Tumors**  
**Occurring in 130 Patients.**      Chad A. Zender, MD
- 1:46      **Do Clear Surgical Margins Significantly Influence**  
**Survival in Patients Undergoing Salvage Surgery for**  
**Nasopharyngeal Carcinoma?**      Alexander C. Vlantis, MD
- 1:54      **Discussion**
-

2:00-3:00

**PANEL: “CURRENT CONTROVERSIES IN HEAD AND NECK RECONSTRUCTION: RECONSTRUCTION OF THE MAXILLA AND SALVAGE OF CHEMORADIATION FAILURES”**

**Moderator:** Ralph W. Gilbert, MD

**Panelists:** Gerry F. Funk, MD; Neal D. Futran, MD; Peirong Yu, MD;  
Mark L. Urken, MD

3:00-3:20

**BREAK**

*Supported in part by our Silver Level Donors:*

*Gyrus ACMI*

*Karl Storz Endoscopy*

*IRX Therapeutics*

3:20-4:10

**COOPERATIVE GROUPS UPDATE**

**Moderator:** Jeffrey N. Myers, MD

**EORTC:** Remco de Bree, MD

**ECOG:** Robert L. Ferris, MD

**RTOG:** Kie-Kian Ang, MD, PhD

**SWOG:** Gregory T. Wolf, MD

4:10-5:30

**SCIENTIFIC SESSION (7)**

**Moderators:** Buvanesh Singh, MD; Bevan Yueh, MD

- 4:10 **WNT1, An Activator of the Wnt Pathway, is Overexpressed In Salivary Gland Tumor Cells** Lurdes Queimado, PhD
- 4:18 **A Highly Selective Inhibitor of Inducible Nitric Oxide Synthase (iNOS) Impairs the Growth of iNOS- expressing Human Melanoma in Vivo and Prolongs the Survival of Tumor-bearing SCID/NOD Mice** Andrew G Sikora, MD
- 4:26 **The Effect of Altered TLR4 Signaling on the Development of Cancer Cachexia** Trinitia Cannon, MD
- 4:34 **The Side Population of a Head and Neck Cancer Cell Line Contains Stem Cell-like Cancer Cells** Mark H. Tabor, MD
- 4:42 **Discussion**
- 4:50 **Invasive Mechanism for HPV+ Cancers: E6 Induces Loss Of PTP-BAS Allowing Invasive Growth.** John H. Lee, MD
- 4:58 **RET/PTC Rearrangement Papillary Thyroid Carcinoma is More Sensitive to be Targeted by Bay 43-9006 (Sorafenib) than BRAF Mutated Cell Lines** Gary Clayman, MD
- 5:06 **Immunohistochemical Validation of Microarray Gene Expression Differences Between Follicular Adenomas and Follicular Carcinomas** Paul C. Bryson, MD
- 5:14 **Integrative Genomic Approach to Finding Novel Head and Neck Squamous Cell Carcinoma-causing Genes** Ian M. Smith, MD
- 5:22 **Discussion**

5:30

**MEETING ADJOURNS**

# Poster Session

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## Posters will be displayed in the Exhibit Hall (Douglas Pavilion)

Saturday, April 28, 2007      9:30 am – 7:00 pm  
Sunday, April 29, 2007      9:30 am – 1:00 pm.

## Poster Tours will be held 6:30 pm – 7:00 pm on Saturday Evening during the Reception.

### Poster # 74

Effectiveness of Surgeon Interpretation of Tc99m Sestamibi Scans in Localizing Parathyroid Adenomas, *Scott R. Anderson, MD*

### Poster # 75

p16, p53, p63 Protein and DNA content as Prognostic Markers for Malignant Transformation in Oral Lichen Planus; A Pilot Study, *Gregory P. Danielson, MD*

### Poster # 76

Decreasing Secondary Skin Graft Donor Site Morbidity in the Fibula Free Flap Harvest, *Terry Fleck, MSIV*

### Poster # 77

Prognostic Factors in Patients with Multiple Recurrences of Well-Differentiated Thyroid Carcinoma, *Theresa Holler, MD*

### Poster # 78

XRCC1 Polymorphisms, Dietary Folate Intake, and Risk of Squamous Cell Carcinoma of the Head and Neck, *Jonathan R. George, BA*

### Poster # 79

Latissimus-Serratus-Rib Free Flap for Oromandibular and Maxillary Reconstruction, *Paul D. Kim, MD*

### Poster # 80

Nasopharyngeal Carcinoma in Patients with Ectodermal Dysplasia, *Shamir P. Chandarana, MD*

### Poster # 81

Computer Image-guided Surgery for Total Maxillectomy, *Akibiro Homma, MD*

### Poster # 82

Neoadjuvant Chemo-Selection of Patients for Organ Preservation in Advanced Laryngeal Cancer: Failure of Chemotherapy as Definitive Treatment for Complete Responders to Neoadjuvant Therapy, *Amy A. Lassig, MD*

### Poster # 83

In vivo Imaging of Primary Recurrence and Cervical Lymph Node Metastases in an Orthotopic Nude Mouse Model of Squamous cell Carcinoma of the Head and Neck, *Maher N. Younes, MD*

### Poster # 84

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## 1. CRYOABLATION FOR TREATMENT OF EARLY GLOTTIC CARCINOMA

**Claudio F Milstein PhD;** Douglas Hicks PhD; Thomas Abelson MD; Marshall Strome MD, Cleveland Clinic

**Introduction:** A clinical trial together with an animal-model study were undertaken to evaluate the effects of adjunctive cryoablative therapy instituted in concert with laser resection for the treatment of carcinoma of the glottis.

**Materials and Methods:** 46 patients with early stage glottic carcinoma (Tis-T2) were treated with endoscopic CO2 laser resection in conjunction with cryoablation between 1997 and 2006. Pre-operative and serial post-operative videostroboscopic exams, vocal outcomes, and quality of life measures were analyzed. A canine acute injury model was conducted in twelve adult male dogs that underwent bilateral endoscopic CO2 laser transmuscular cordectomy followed by randomized unilateral endoscopic glottic cryotherapy. Videostroboscopies and histopathological outcomes analysis were performed in all animals.

**Results:** Results of the clinical study showed an overall disease-free mean follow-up of 27.6 months (five recurrences were re-treated with the same combined therapy, to-date, all patients are disease free). CO2 laser resection and cryoablative therapy were associated with a significant improvement in subjective voice quality ( $P < 0.0005$ ), and mucosal waves ( $P < 0.0001$ ). Long-term dysphonia was uniformly improved when compared with the pre-treatment condition, even among patients with the most advanced disease undergoing the widest resections. Two webs were noted among 9 patients with anterior commissure involvement. Results of the animal model demonstrated an earlier restoration of glottic volume and a return of mucosal waves among vocal folds treated with combined therapy by 6 weeks post-treatment. The mean depth of inflammatory reaction in the vocal cords treated with combined therapy was 1.07 mm vs. 1.15 mm in vocal cords treated with CO2 laser therapy alone. At 2 and 6 weeks post-operatively, combined treatment was associated with a decreased volume of collagen. At 12 weeks post-operatively, combined treatment was associated with greater collagen organization, normalized collagen histoarchitecture and decreased keratinization.

**Conclusions:** Adjuvant cryotherapy appears to alter glottis-specific wound healing, leading to decreased and more organized collagen formation and decreased keratinization with a resultant improvement in glottic function, when compared with CO2 laser surgery alone, in an acute canine injury model. In patients, the combined treatment yielded excellent primary site control while improving subjective and objective measures of voice quality. Combined laser surgery and cryotherapy is our current standard of care, and a viable alternative to radiation therapy for selected patients with early stage glottic carcinoma who desire curative therapy while optimizing vocal outcomes.

## 2. ENDOSCOPIC CO2 LASER SURGERY OF GLOTTIC CANCER RECURRENT AFTER RADIOTHERAPY: ONCOLOGICAL AND FUNCTIONAL RESULTS

**Mohssen Ansarin MD;** Marek Planicka MD; Silvana Rutondo BS; Luigi Santoro; Daniela Alterio MD; Fausto Chiesa MD, European Institute of Oncology, Milan Italy

**Background:** Surgery is the option of choice for salvage treatment of laryngeal recurrences after radiotherapy. Total laryngectomy is mandatory in the treatment of locally extended recurrences. Endoscopic laser surgery (ELS) can be an effective treatment of small recurrences.

This retrospective study evaluates local control rates, organ preservation and complications of 47 consecutive cases who underwent ELS as a salvage procedure for recurrent glottic cancer after Radiotherapy.

**Methods:** Inclusion criteria: rcTis, rcT1 and selected rcT2 glottic cancer; adequate exposure of the larynx; no previous open surgery; signed consent.

**Results:** From February 2000 to October 2004, 97 consecutive patients have been referred at the IEO Head and Neck Surgery Divisions for treatment of a recurrent glottic cancer after radiotherapy. Forty-seven patients (40 males, 7 females) were eligible for treatment by endoscopic laser surgery. Tumour recurrences had been classified as rcTis in 7 patients,

rcT1a in 28, rcT1b in 7 and ycT2 in 5 patient.

Pathological classification was rpT0: 2, rpT1a: 21, rpT1b: 12 and rpT2: 12. Mean follow up was 104 months (24-80 m). 13 of 47 patients (27,6%) developed a local recurrence: 4 underwent a second endoscopic surgery and 9 a total laryngectomy. Two patients who underwent total laryngectomy died because of their cancer. Local control rate was 78.7% (37/47), the ultimate local control rate (including both endoscopic and open salvage surgery) was 95.7%(45/47). Larynx preservation rate was 78.7% (37/47 patients). Laryngeal stenosis was the more frequent major complication and occurred in 3 out of 7 female patient, and they maintain tracheostomy after 12 months from laser surgery.

**Conclusions:** In selected cases ELS is a safe and effective procedure as salvage organ preservation surgery after radiotherapy failure; oncological results are satisfactory but there is a risk of laryngeal stenosis, mainly in female patients (3/7).

## 3. TRANSORAL LASER MICROSURGERY FOR ADVANCED LARYNGEAL CANCER

**Michael L Hinni MD;** John R Salassa MD; David G Grant MD; Bruce Pearson MD; Richard E Hayden MD; Alexios Martin MD; Hans Christiansen MD; Bruce H Haughey MD; Brian Nussenbaum MD; Wolfgang Steiner, Mayo Clinic Arizona, Mayo Clinic Jacksonville, University of Göttingen, Washington University in St. Louis

**Background:** Current opinion on the appropriate management of advanced laryngeal cancer is varied and controversial.

Randomized data suggest that in select stage III and stage IV disease the use of concurrent chemotherapy and radiotherapy offers superior locoregional control rates compared to either sequential surgery and radiotherapy or radiotherapy alone. The precise role of organ preserving laryngeal surgery and in particular endoscopic laser surgery in relation to these strategies has yet to be defined.

**Objectives and Setting:** The purpose of the present study is to report the experience of four academic, tertiary referral centers with Transoral Laser Microsurgery (TLM) in the treatment of advanced laryngeal cancer.

**Patients:** One hundred and seventeen patients with pathologically confirmed T2-T4, stage III or IV, glottic or supraglottic carcinoma of the larynx were treated with TLM between 1997 and 2006. All patients had a minimum follow-up period of 2 years.

**Interventions:** TLM in 117 patients with neck dissection in 91 and adjuvant radiotherapy in 45 patients.

**Main Outcome Measures:** End points analyzed included overall survival, disease-free survival, local control, locoregional control and laryngectomy-free survival. Postoperative complications, tracheotomy rate and feeding tube dependence were also examined.

**Results:** The mean follow-up period was 3.8 years. At two years the proportion of patients with an intact larynx after TLM with or without radiotherapy was 91%. Two-year local control and locoregional control was 83% and 77% respectively. Two-year disease-free and overall survival was 68% and 75% respectively. The 5-year Kaplan-Meier estimates were: local control, 75%; locoregional control, 68%; disease-free survival 58% and overall survival 55%. Four patients (3%) suffered treatment related deaths. Seven patients (6%) suffered a postoperative hemorrhage. Of those patients with a preserved, disease-free larynx at last follow-up, 4 (3%) were tracheotomy dependent and 9 (8%) feeding tube dependent. **Conclusions:** In patients with advanced laryngeal cancer, TLM with or without radiotherapy is a valid treatment strategy for organ preservation. In addition, low morbidity and mortality make TLM an attractive management option.

## 4. FACTORS PREDICTIVE OF SURVIVAL IN ADVANCED LARYNGEAL CANCER

**Amy Y Chen MD;** Michael Halpern PhD, Emory University and American Cancer Society

**Introduction:** Incidence and survival rates for advanced laryngeal cancer have remained unchanged for the past decade. A previous report has suggested that the increasing use of non-surgical treatment may lead to decreased survival among patients with advanced laryngeal cancer.

**Objective:** The purpose of this study was to determine the factors

predictive of improved survival among patients with advanced laryngeal cancer.

**Methods:** We used the National Cancer Database, a cancer registry jointly sponsored by the American College of Surgeons and the American Cancer Society, and extracted cases of advanced laryngeal cancer diagnosed from 1995-1998. Only patients treated with total laryngectomy (TL), radiation alone (RT), or combined chemotherapy and radiation therapy (chemo-RT) were included. Multivariate proportional hazards survival analysis with age stratification was performed to evaluate the impact of treatment type on survival while control for potential confounders, including clinical/treatment factors (T stage, overall stage, year of diagnosis, and treatment facility type) and demographic variables (sex, age, health insurance, race, and area-based income and education).

**Results:** Of 10,590 patients meeting initial inclusion criteria, 7019 had appropriate non-missing values in all study variables and were included in the analysis. Overall, TL was significantly associated with increased likelihood of survival compared to RT or chemo-RT. Among stage III patients, TL and chemo-RT had similar impacts on survival (each of which showed increased survival compared to RT), while TL was associated with significantly greater survival than chemo-RT or RT among stage IV patients. Overall survival was also decreased among men, blacks (compared to whites), and patients with Medicare, Medicaid, or uninsured compared to those with private insurance.

**Conclusions:** Among patients with the most advanced disease (stage IV), TL is associated with increased survival compared to chemo-RT or RT, while both TL and chemo-RT improve survival over RT among stage III patients. Insurance type and black race also showed significant associations with survival, which suggest barriers in access to care.

## 5. PREDICTOR FACTORS FOR PATIENTS WITH RECURRENT HEAD AND NECK CANCER TREATED BY LASER THERMAL THERAPY

**Michael Publik MD;** Joel A Sercarz MD; Michael Mastermann BS; Mark Polyakov BS; Marcos B Paiva MD, UCLA School of Medicine

**Background:** Laser induced thermal therapy (LITT) has been developed in a step-wise fashion at UCLA as a minimally invasive treatment for head and neck cancer.

**Study Design:** This is a Phase II study using the Nd:YAG laser as a palliative treatment for recurrent tumors. Study Design/Methods- This was a single group study in patients with recurrent carcinoma of the head and neck, who failed at least one treatment modality. The primary end points of the study were objective tumor response, and survival. Prognostic values were assessed by uni- and multivariate analysis using the Kaplan-Meier method and Cox model, respectively.

**Results:** One hundred and four patients were treated by LITT. Best results were seen in oral cavity tumors where Kaplan Meyer curves showed average survival of 20.3 months (10.7-30mo; 95%CI) compared to neck (avg.=14.4 months, 7.5-20.7mo; 95%CI) and other tumor sites, (avg.=18 months, 13.8-22.3mo; 95%CI). Further analysis of neck treatments showed that tumors away from the common carotid in cervical lymph nodes located in levels I, IV, and V had median survival of 25.9 months (mean=37.7mo), compared to 11.4 months (mean=10.9mo) in patients with tumors near, or encroaching the carotid in upper and lower jugular levels II and III. In conclusion, patients tolerated LITT well on an outpatient basis, and were successfully palliated for periods ranging from 39 days to 90 months post-treatment.

**Conclusions:** Based on the findings of this study it was possible to show that proximity to the carotid artery was the most relevant factor in projecting patient survival

## 6. MALPRACTICE LITIGATION AFTER SURGICAL INJURY OF THE SPINAL ACCESSORY NERVE

**Luc G Morris MD;** David J Ziff; Mark D DeLacure MD, New York University School of Medicine, New York, NY

**Objectives:** To review the background, case characteristics, and outcomes of malpractice litigation resulting from surgical injury of the spinal accessory nerve.

**Study design:** Retrospective review of state and federal civil litigation alleging surgical spinal accessory nerve injury.

**Methods:** A computerized legal database was used to review

court decisions and jury verdict reports. All relevant cases between January 1, 1985 and July 1, 2006 were identified. Data concerning the patient, plaintiff, defendant physicians, details of surgery, allegations of wrongdoing and injury, expert witnesses, and jury verdict or settlement were analyzed. Awards were adjusted for inflation.

**Results:** 81 cases of alleged surgical injury to the spinal accessory nerve were identified. Morbidity included weakness (100%), pain (37%), inability to work (25%), need for nerve repair procedure (20%), deformity (11%), and numbness (5%). Most operations were cervical lymph node biopsies (71%), followed by sebaceous cyst excisions (8%), neck dissections (5%), and other procedures. Defendant physicians included 36 general surgeons, 17 otolaryngologists, 4 plastic surgeons, 2 orthopedists, 2 pediatric surgeons, 2 vascular surgeons, 1 thoracic surgeon, and 4 non-surgeons. Types of malpractice alleged included negligent surgical technique (98%), lack of informed consent (21%), and failure to diagnose the injury (20%). 37 cases (46%) were decided for the defendant, 32 (39%) for the plaintiff, and 12 (15%) settled. Mean jury award was \$515,968. Mean settlement was \$356,132. Patterns of malpractice allegation, case outcome, awards and settlements are discussed.

**Conclusions:** Injury to the spinal accessory nerve is a feared complication of head and neck surgery, and a significant source of malpractice litigation. Surgeons of all specialties operating in the posterior triangle of the neck should be cognizant of the medicolegal implications of accessory nerve injury. Almost all plaintiffs alleged negligent surgical technique, and most did not deny receiving full informed consent. Despite the relative homogeneity of these cases, jury decisions and awards were highly variable.

## 7. RACIAL DIFFERENCES IN DIAGNOSIS, TREATMENT, AND OUTCOME OF ORAL AND PHARYNGEAL CANCER

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**Objective:** To evaluate racial differences in the standard of care in terms of diagnostic evaluation, treatment rendered and the impact of such disparities on survival to patients inflicted with oral and pharyngeal squamous cell carcinoma (OPCa).

**Design:** Retrospective cohort analysis using linked secondary data from South Carolina Central Cancer Registry and Office of Research Statistics medical claims record.

**Subjects:** Subjects included 986 White and 463 Black patients newly diagnosed with OPCa from 1997 to 2002 in South Carolina, and registered by the SCCC. Patients were followed for a minimum of 2 years or until death, whichever occurred first. Logistic regression analyses were used to estimate odds ratios (ORs) for early (local) stage in diagnosis, and the receipt of cancer directed surgery. Cox proportional hazard analyses were performed to estimate the hazard ratios (HRs) for survival, adjusting for individual, disease, financial, socioeconomic and ecological characteristics.

**Results:** Racial differences in the stage of diagnosis and receipt of treatment were found. Blacks were only two-third as likely as Whites to have their cancer diagnosed at the early stage (OR 0.67, 95% CI 0.51-0.89), while they were less likely to receive a cancer directed surgery (OR 0.70, 95% CI 0.57-0.91), after controlling for medical and non-medical factors. For survival, after adjusting for all the covariates, race was no longer a significant factor, reducing the hazard ratio to 1.15 (95% CI 0.96-1.37) as compared to Whites. A modifiable feature that was significant throughout all three outcome measures was having private health insurance. Having private insurance were significantly more likely to be associated with an early diagnosis (OR 2.41, 95% CI 1.60-3.64), the receipt of cancer directed surgery (OR 1.48 95% CI 1.04-2.12) and better survival (HR 0.65, 95% CI 0.50-0.83) than public or uninsured patients.

**Conclusion:** Less favorable distribution of disease stage was found for Blacks when compared to Whites. Blacks were also less likely to receive cancer directed surgery than Whites. Having private health insurance significantly resulted in earlier diagnosis, receipt more optimal surgical treatment and collectively improved on overall survival.

## 8. PROGNOSTIC FACTORS IN SQUAMOUS CELL CARCINOMA OF THE OROPHARYNX

**Luiz Paulo Kowalski PhD;** Paola A G Pedruzzi; Benedito V Oliveira MD; Fábio Tironi; Inês N Nishimoto MD, Hospital Erasto Gaertner - Hospital A C Camargo

**Introduction:** The anatomic extent of the disease is one of the most important factors considered in the treatment planning of patients with oropharynx carcinoma and it is also the most important predictor of outcome. However, the prognosis can be influenced by a multitude of factors other than TNM stage. The main objective of this study was to assess the prognostic significance of several factors in oropharyngeal squamous cell carcinoma submitted to radiotherapy or radiochemotherapy in two tertiary cancer centers.

**Methods:** The medical charts of 361 patients treated from 1990 to 2001 were reviewed. Patient-related factors included age, race, gender, tobacco smoking, alcohol consumption, performance status, weight loss, number of symptoms, symptom stage, comorbidities, second primary tumors, hemoglobin levels; TNM stage and other TN-based stage modifications systems (Hart, Berg, Tanis 3, Tanis 4, Tanis 7, Kiricuta e Hall), histologic grade, anatomic site, morphology (exophytic versus endophytic); smoking during radiotherapy, chemotherapy, dose and duration of radiotherapy. These factors were compared using disease free survival (DFS), overall survival (OS) and treatment response.

**Results:** the 5 five-year overall survival rate was 17.6% and disease-free survival was 16.2%. Patient-related factors such as performance status ( $p < 0.001$ ), weight loss ( $p = 0.0022$ ), clinical symptoms ( $p < 0.001$ ), comorbidities ( $p < 0.001$ ), all stage grouping system ( $p < 0.001$ ) and dose of radiotherapy ( $p < 0.001$ ) had a significant impact on OS, DFS and treatment response. The other variables associated with survival were second primary tumors ( $p = 0.0077$ ), number of symptom ( $p < 0.001$ ), symptom stage (0.0083). The variables associated with treatment response were anatomic site of tumor ( $p = 0.022$ ), morphology ( $p = 0.022$ ), number of symptom ( $p = 0.005$ ), and symptom stage (0.0083).

**Conclusion:** TNM-based stage modifications are all very useful predictors of survival in oropharyngeal carcinoma. In addition, clinical tumor-related factors were also important prognostic factors.

## 9. ASPIRATION IN CHEMORADIATED HEAD AND NECK CANCER PATIENTS

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**Objective:** To review the incidence of aspiration among chemoradiated head and neck cancer (HNC) patients.

**Design:** Retrospective review of 118 (91%) of the 130 patients enrolled at one institution between 1998 and 2002 as part of a larger, multi-institution, prospective study of induction chemotherapy followed by chemoradiation for advanced HNC for whom oropharyngeal motility study (OPM) data was available.

**Main Outcome Measures:** Incidence of trace (5% or less of swallowed bolus) and frank (>5%) aspiration determined by pre- and post-treatment OPM and correlation of findings with patients' reported symptoms.

**Results:** Eighty-one patients (69%) had at least one OPM demonstrating aspiration within the first year following chemoradiation, with 30 (25%) demonstrating frank aspiration. Of the patients who aspirated, 61 (75%) reported no symptoms of coughing or choking (80% of trace and 67% of frank aspirators). The 27 (23%) patients with larynx cancer were more likely to be trace and frank aspirators ( $p = 0.025$ ). The presence of a tracheostomy did not significantly correlate with aspiration ( $p = 0.29$ ). For the 62 patients with pre-treatment OPM data, 33 (53%) demonstrated aspiration at baseline. Fifty-nine percent of the 29 baseline non-aspirators went on to have aspiration and 88% of the baseline aspirators continued to have aspiration in the first year after treatment.

**Conclusions:** Aspiration was highly prevalent among advanced HNC patients at baseline and worsens after chemoradiation. The vast majority of these patients will report no symptoms. Larynx primary, but not tracheostomy, was significantly correlated with increased incidence of aspiration. Advanced HNC patients should undergo instrumental swallow assessment, even in the absence

of symptoms, to detect subclinical aspiration and to institute therapeutic maneuvers and swallow precautions, as well as to determine the safety of oral feeding.

## 10. PATHOLOGIC RESPONSE IN POST-TREATMENT NECK DISSECTION PREDICTS OUTCOME IN HEAD AND NECK CANCER PATIENTS TREATED WITH PRIMARY RADIATION

**M Lango MD;** S Ahmad BS; G Andrews MD; S Feigenberg MD; J Ridge MD, PhD, Fox Chase Cancer Center

**Objective:** To characterize outcomes in patients with advanced stage head and neck squamous cell carcinoma (HNSCC) treated with definitive radiation or chemoradiation followed by post-treatment neck dissection (ND).

**Patients:** 67 patients with resectable HNSCC underwent a ND following primary radiation from 1993 to 2004. 38 patients (56.7%) also received induction, concurrent or sequential chemotherapy. ND's were performed regardless of clinical response for patients staged N2a or greater. 7 patients initially staged N-1 with clinically incomplete responses were also included. ND was unilateral in 62 patients and bilateral in 5 patients. Of 72 comprehensive ND's, 18 were radical while the rest were modified radical, performed a mean 7.2 weeks (range 4-15 weeks) after completion of radiation.

**Results:** The first site of failure was local in 8 patients (12%), neck in 5 (7.5%) and distant in 7 (10.4%). Pathologically confirmed residual disease was found in 27 patients (40.3%). Level-specific staging of 25 specimens demonstrated disease in the following levels: Level I 5/25 (20%), Level II 13/25 (52%), Level III 14/25 (56%), Level IV 8/25 (32%) and Level V 9/25 (36%). No residual cancer was detected in Level V in patients initially staged N1-N2a. No variable tested including clinical response or time to ND reliably predicted pathologic response. All patients with subsequent neck recurrences had pathologically positive neck specimens. For patients with pathologically positive neck specimens, the most common initial site of failure was the primary site (6 patients), neck (4 patients) and distant sites (4 patients). Using Cox proportional hazards analysis, residual cancer in the neck specimen (HR 3.6, 95%CI 1.6-8.1,  $p = 0.001$ ), initial nodal size (HR 1.6, 95%CI 1.2-2.0,  $p = 0.001$ , radical ND (HR 5.6, 95CI 1.8-17.1,  $p = 0.003$  and female sex (HR .17, 95%CI .04-.71,  $p = 0.02$ ) were found to independently predict disease recurrence. Residual disease (HR 3.4, 95%CI 1.6-7.2,  $p = 0.001$ ), radical ND (HR 3.9, 95%CI 1.7-8.8,  $p = 0.001$ ) and age (HR 1.09, 95%CI 1.03-1.15,  $p = 0.001$ ) also impacted overall survival. The addition of chemotherapy had no effect on pathologic response, recurrence-free or overall survival in patients treated with a post-treatment ND.

**Conclusion:** In patients treated with primary radiation or chemoradiation, post-treatment neck dissection is an effective method of achieving regional control. The presence of residual cancer in the neck specimen represents biologically aggressive disease.

## 11. IS A SELECTIVE NECK DISSECTION APPROPRIATE FOR ADVANCED DISEASE FOLLOWING ADJUVANT THERAPY?

**Adam S Jacobson MD;** Jean Anderson Eloy MD; Sachin Gupta; Eric M Genden MD, Mount Sinai Hospital

**Educational Objective:** At the conclusion of this presentation, the participant should be able to determine the efficacy of the selective neck dissection for advanced head and neck cancer following adjuvant radiation or chemoradiation.

**Introduction:** Cervical lymphadenectomy has been established as a critical component of the treatment of head and neck squamous cell carcinoma. The radical and modified radical neck dissections have long been accepted as the gold standard for management of advanced neck disease following radiation therapy. The selective neck dissection (SND) has become more commonly used for management of squamous cell carcinoma without the associated morbidity. The objective of this study is to determine the efficacy of the SND for advanced squamous cell carcinoma following radiation or chemoradiation.

**Methods:** A retrospective chart review was performed on 58 patients with N2 or N3 squamous cell carcinoma of the head and neck who were treated primarily with radiation or chemoradiation followed by a selective neck dissection. Age, stage, site of the pri-

mary tumor, pathological lymph node status, survival, and cause of death, were determined.

**Results:** Fifty-eight patients underwent a SND following radiation or chemoradiation for advanced regional metastatic squamous cell carcinoma. The median time of follow up was 37 months, range 17 to 71 months, following neck dissection. The primary sites included base of tongue (15), hypopharynx (12), pharynx (16), larynx (11), and unknown primary (4). A total of 74 SNDs were performed on 58 patients. Pathologically, 31% of patients had viable tumor cells identified in the neck dissection specimen. Seventy-two percent of the patients are currently alive while 28% expired as a result of distant disease (50%), local or regional recurrence (31%), or other causes (CVA, MI, another malignancy) (19%). Of those patients who died from distant disease, 13% had viable tumor cells identified in the neck dissection specimen. Of those patients who died from local or regional disease, 40% (2/5) had viable tumor cells identified in the neck dissection specimen.

**Conclusion:** In this study, the rate of regional recurrence following SND is similar to reported rates following modified/radical neck dissection. This suggests that SND provides an appropriate surgical option for advanced neck disease following adjuvant therapy.

## 12. ROLE OF THE IMMUNE SYSTEM IN THE MONOCLONAL ANTIBODY THERAPY DIRECTED TO THE EPIDERMAL GROWTH FACTOR RECEPTOR

**Andres Lopez Albaitero MD;** Robert L Ferris MD, University of Pittsburgh Cancer Institute

Despite the contribution of an immune mediated response to the clinical success of monoclonal antibody (mAb) based therapies; little is known about immune activation induced by epidermal growth factor receptor (EGFR) specific mAbs against squamous cell carcinoma of the head and neck (SCCHN). In particular, two EGFR-specific mAb's, cetuximab (IgG1 isotype) and panitumumab (IgG2 isotype) are now in clinical use. Immune activation, through ADCC appears to differ significantly between these two mAbs, depending of FcGamma receptor IIa codon 131 or FcGamma IIIa codon 158 polymorphisms. We also demonstrate that these mAbs activate NK cells and monocytes and this response is associated with host factors such as FcGamma receptor expression. Election of the antibody should be weighted keeping in mind these factors to achieve maximum benefit from these therapies.

## 13. PROGNOSTIC EFFECT OF EGFR, MMP-2, MMP-9 AND VEGF EXPRESSION IN LOCALLY RECURRENT ORAL AND OROPHARYNGEAL SQUAMOUS CARCINOMAS SUBMITTED TO SALVAGE SURGERY

Ivan M Agra MD; Everton M Pontes MD; João Gonçalves-Filho MD; Clovis A Pinto MD; André L Carvalho MD; **Luiz P Kowalski MD,** Hospital do Cancer A C Camargo

**Introduction:** Local and regional relapses are the main sites of treatment failure in patients with oral and oropharyngeal squamous cell carcinoma, and salvage surgery is the most used treatment approach.

**Objective:** The aim of this study is to analyze the prognostic effect of the expression of EGFR, MMP-2, MMP-9 and VEGF in patients with recurrent cancer submitted to salvage surgery.

**Methods:** The charts of 111 patients with local recurrence of oral or oropharyngeal squamous cell carcinomas were retrospectively analyzed. The tumor site was: lip in 11 cases (9%), oral cavity in 68 (61%) and oropharynx in 33 (30%). The previous treatment was: surgery in 33 patients (30%), radiotherapy with or without cisplatin based chemotherapy in 46 (41%) and surgery with adjuvant radiotherapy in 32 (29%). The expression of EGFR, MMP-2, MMP-9 and VEGF were analyzed with tissue microarray immunohistochemical technique.

**Results:** The disease free interval ranged from 0.89 to 140.9 months with a median of 6.87 months. The recurrences were diagnosed in less than 1 year in 69 patients (62.2%) and more than 1 year in 42 (37.8%). The group with shorter disease free interval presented the worse prognosis ( $p=0.01$ ). The clinical stage of recurrence (rCS) was I/II in 31 cases (27.9%) and III/IV in 80 (72.1%). Patients with more advanced diseases (rCS III/IV) had the worse rates of cancer specific survival (CSS) ( $p=0.04$ ). Overexpression of EGFR was associated with worse treatment results. Positive EGFR

cases had a 3 year CSS of 27.2%, while EGFR negative patients had 64.3% ( $p=0.001$ ). The MMP-2 and MMP-9 overexpression were also associated with worse prognosis but without statistical significance. ( $p=0.83$  and  $p=0.15$ ). VEGF expression did not show prognostic significance in this group of patients. In a multivariate analysis only the disease free interval and overexpression of EGFR were associated with a higher risk of death.

**Conclusion:** Local recurrence in oral and oropharyngeal squamous cell carcinomas carry a bad prognosis. A disease free interval over 1 year and the negative EGFR expression are the main prognostic factors related to a better cancer specific survival in patients treated with salvage surgery.

## 14. COST-EFFECTIVE MANAGEMENT OF LOW-RISK PAPILLARY THYROID CARCINOMA

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**Background:** Optimal treatment for low-risk papillary thyroid cancer is a matter of controversy. Randomized, controlled trials to address this controversy are unfortunately prohibitively large and difficult to execute, and retrospective studies are limited in their ability to predict outcomes. Decision analysis can, however, circumvent these limitations.

**Objectives:** To compare the twenty-year cost-effectiveness of hemithyroidectomy with total thyroidectomy in the management of small papillary thyroid cancers in the low-risk patient.

**Design:** A systematic literature review was conducted to determine key statistics for decision analysis, including rates of recurrence, rates of complications for all interventions undertaken, and rates of death. Costs were obtained from the 2004 National Inpatient Sample maintained by the US Department of Health and Human Services, standardized for patients between the ages of 18 and 45, as well as from pharmacy and medical device costs. Future costs were discounted. A state transition (Markov) decision model was constructed based on the most recent American Thyroid Association recommendations. Cost-effectiveness analysis was performed using both global state-transition probabilities and a Monte Carlo microsimulation with 1,000,000 simulated patients; effectiveness was defined as cause-specific mortality, recurrence-free survival, or recurrence-and-complication-free survival. Separate decision analyses were undertaken for each effectiveness measure. After base case results were determined, sensitivity and threshold analyses were performed to assess the strength of the recommendations.

**Results:** We reviewed 1605 abstracts, identified 28 pertinent studies that included a total of 13,980 patients undergoing thyroidectomy and attendant procedures, and extracted key statistics from those papers. Over twenty years, total thyroidectomy and its follow-up cost between \$30,987.90 and \$31,392.60, whereas hemithyroidectomy and its follow-up cost between \$34,667.20 and \$36,317.50. Cause-specific mortality was similar for both treatment strategies, while recurrence-free survival and recurrence-and-complication-free survival were both improved by total thyroidectomy. Sensitivity and threshold analyses demonstrated these results to be very robust.

**Conclusions:** Although cause-specific mortality is similar for both surgical procedures, initial hemithyroidectomy presents a more costly overall treatment protocol in patients with low-risk papillary thyroid carcinoma.

## 15. THYROID FUNCTION AFTER UNILATERAL TOTAL LOBECTOMY: RISK FACTORS FOR POSTOPERATIVE HYPOTHYROIDISM

Dirival DeCarlucci, Jr. MD; Marcos R Tavares MD; Marcos R Takeo MD; Leandro L Martins MD; Flávio C Hojaj MD; **Claudio R Cernea MD,** Department of Head and Neck Surgery - Hospital das Clínicas - University of Sao Paulo Medical School - Sao Paulo, Brazil

**Background:** Unilateral thyroid lobectomy is considered an appropriate surgical procedure for benign thyroid nodules. The reported frequency of postoperative hypothyroidism after this operation varies from 5% to 35%.

**Objective:** To evaluate the incidence of postoperative hypothyroidism among patients submitted to unilateral total lobectomy, trying to identify clinical, pathological and technical related factors.

**Design of the study:** Retrospective chart analysis.

**Patients and Method:** From March 1996 to July 2005, 228 euthyroid patients underwent unilateral total lobectomy for benign diseases. One-hundred and eighty-six had all required information. Patients had assessment of blood levels of TSH and anti-thyroidal antibodies, as well as ultrasonographical evaluation of the remaining thyroid lobe and review of all histological specimens, with special emphasis for lymphocytic infiltration.

Hypothyroidism was defined as TSH levels higher than 5.5 mU/l.

**Results:** Most patients were female (88%), with a median age of 45 year-old (16yo to 72yo). Hypothyroidism occurred in 61 cases (32.8%), in a median follow-up period of 29 months (6 to 108 months). It was statistically related to: higher preoperative TSH levels (2.1 mU/l among hypothyroid patients X 1.2 mU/l in euthyroid patients;  $p < 0.001$ ), smaller thyroid remnant volume (3.9 ml X 6.0 ml, respectively;  $p = 0.003$ ); right X left lobectomy ( $p = 0.006$ ) and higher Anti-TPO antibody blood levels ( $p = 0.009$ ).

**Conclusions:** Postoperative hypothyroidism appeared in 32.8% of the cases in this series, especially among patients with elevated preoperative TSH and postoperative anti-TPO antibody levels, after right lobectomy and when a smaller thyroid remnant was left. These results may support the indication for early postoperative hormone supplement in these instances, after confirmation with larger prospective series.

## 16. PAPILLARY THYROID CARCINOMA: IMPACT OF PRE-OPERATIVE ULTRASOUND STAGING OF THE NECK

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Papillary thyroid carcinoma (PTC) is a malignancy with a high rate of lymph node metastasis. Routine thyroid ultrasound and physical examination of the neck may underestimate metastatic disease. Thus, we propose that all patients with confirmed diagnosis of PTC should undergo a comprehensive pre-operative ultrasound staging of the neck.

**Aim:** To determine the frequency of cervical metastasis detected by pre-operative ultrasound staging of the neck in patients with PTC with none-palpable adenopathy.

**Methods:** This is a prospective study that included 60 patients diagnosed with PTC without evidence of adenopathy on clinical examination treated between January and June 2006. Lymph nodes were characterized by ultrasound as highly suspicious of metastasis with any of the following criteria: minor axis greater than 10 mm, minor axis greater than 50% of major axis or hyperechogenicity with or without microcalcifications. The presence of metastasis in patients with highly suspicious adenopathy was confirmed by pre-operative FNA or intraoperative frozen section. A neck dissection was performed in patients with confirmed metastasis. The localization of metastasis was pathologically correlated with the anatomic node level of the neck reported by the ultrasound.

**Results:** Of 60 patients with clinically negative neck, pre-operative ultrasound staging detected 12 cases (20%) with highly suspicious adenopathy. Biopsy confirmed metastatic disease in 11/12 (91.6 %) patients with suspicious adenopathy, and therefore underwent a neck dissection. In the 11 patients a positive biopsy, the final pathology revealed a 100% correlation between the lymph node levels reported to be suspicious by ultrasound and the actual nodal basin involved with metastatic disease. However, 9 patients had 2 to 3 additional involved neck levels undetected by ultrasound. In one patient (2.1%) with a negative ultrasound, careful exploration of the central compartment revealed metastasis undetected by ultrasound (false negative).

**Conclusion:** Our results suggest that pre-operative ultrasound staging of the neck identifies a significant number of patients with non-palpable macroscopic neck metastasis, allowing for a better surgical approach in the primary surgery of patients with CPT.

## 17. IDENTIFYING PATIENTS UNDERGOING THYROIDECTOMY FOR PAPILLARY THYROID CANCER AT RISK FOR HARBORING MULTIPLE CENTRAL NECK LYMPH NODE METASTASES

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**Objective:** To characterize the patient population with primary papillary thyroid cancer (PTC) at risk for harboring multiple central neck lymph node (LN) metastases.

**Study Design:** Retrospective chart review.

**Methods:** We reviewed the charts of 51 consecutive patients with PTC who underwent primary thyroidectomy and concurrent removal of central neck LNs from March 2000 to November 2006 in our institution.

**Results:** Patients were divided into 2 categories: (I) 15 patients, with their operative notes denoting directed removal of suspicious LN(s) only (1-6 LNs removed; median=2); and (II) 36 patients, with their operative notes denoting an attempt at a clearing of more than just suspicious LNs (4-27; median=13). Category (II) was further divided into 2 groups: (A) 5 patients: negative for metastasis; and (B) 31 patients: who had multiple positive LNs (2-20; median=6) on final pathology. Comparisons between (A) and (B) were performed utilizing 4 factors; 1-primary tumor size  $\geq 3$ cm; or multi-focal thyroid lesion: 3/5 patients of (A) vs. 16/31 of (B) (Positive predictive value "PPV"= 82%; sensitivity "S"= 45%); 2- Lateral LN suspected metastasis through pre-operative imaging (ultrasound and/or CT) followed by fine needle aspiration (FNA), and/or intra-operative frozen section confirmation: 1/5 of (A) vs. 18/27 of (B) (PPV= 89%; S= 63%) (excluding 4 patients); 3- Pre-operative suspicion of central LN metastasis via physical examination and imaging (CT or ultrasound "US"): 0/5 of (A) vs. 7/27 of (B) (PPV= 100%; S= 26%) (excluding 4 patients); and 4-histo-pathologic confirmation of central neck LN metastasis upon intra-operative evaluation: 2/5 of (A) vs. 28/31 of (B) (PPV= 93%; S= 91%). Factor (4) met statistical significance for multiple central LN metastases ( $P=0.008$ ). 2 patients of category I had central compartment recurrence.

**Conclusion:** Intra-operative central LN evaluation, with frozen section confirmation of metastasis, is an important step during thyroidectomy for PTC to predict those who are likely to harbor multiple LN metastases. The other 3 factors are highly predictive of patients harboring multiple nodal metastases; however, they had variable sensitivity. A central neck dissection maximizing the number of LN's removed should be performed when factor 4 is present and should be highly considered when the other factors are present to reduce the chance of central compartment recurrence.

## 18. REVISION CENTRAL COMPARTMENT SURGERY: INDICATIONS, MANAGEMENT AND OUTCOMES IN 60 CONSECUTIVE PATIENTS

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**Objectives:** To review outcomes for thyroid bed re-operation in patients with recurrent well differentiated (WDTC) and medullary (MTC) thyroid cancer. Design: Retrospective analysis of 60 patients who underwent 64 procedures for suspected loco-regional recurrence of WDTC or MTC in the thyroid bed +/- upper mediastinum +/- the lateral neck, treated at a tertiary referral center from 1992 to 2006. Method: The charts of 60 patients who underwent revision surgery for recurrent or persistent WDTC/MTC were reviewed for demographic data, previous surgeries and outcomes, diagnostic modalities used to diagnose the recurrence(s), the procedures done, the final pathology, complications, outcomes and normalization of Thyroglobulin/Calcitonin.

**Results:** Demographic information was registered. Prior to the first re-operation done in our institution, most patients had undergone one operation. Previous pathologies were papillary thyroid carcinoma (53), benign disease(4), medullary carcinoma (2) and unknown(1). 60 patients underwent 64 procedures. The diagnosis was established by clinical exam, serum thyroglobulin

or calcitonin and / or imaging (US, I131, CT, MRI, PET) +/- FNA. 106 procedures involved re-dissecting one recurrent laryngeal nerve. Of the 64 procedures, malignant disease was detected in 55. Surgical complications included: 2 (3.1%) permanent and 2 (3.1%) temporary laryngeal nerve palsies, 11 (17.2%) permanent and 6 (9.4%) with temporary hypoparathyroidism, 2 (3.1%) temporary chyle leaks, 1 (1.5%) transient accessory nerve weakness, 2 (3.1%) hematomas, 1 (1.5%) seroma and 1 (1.5%) wound infection. In follow-up, 5 patients underwent resection of loco-regional recurrence, and had an additional 7 procedures (4 lateral neck dissections and 3 sternotomies). At last follow up 31 of 60 (51.7%) patients had no evidence of disease, another 2 (3.3%) NED but with thyroglobulin antibodies. 10 (16.7%) had elevated thyroglobulin levels without disease localization. 12 (20%) are alive with known recurrent or persistent disease, 1 (1.6%) was dead of disease and 1 of other primary cancer. 3 patients had no evidence of malignancy in both prior or redo procedure. Normalization of thyroglobulin in the patients with papillary carcinoma, (excluding patients (3) with no malignancy, (6) lung metastasis, (2) anti-thyroglobulin antibodies or (2) medullary carcinoma ) was achieved in 31 of 47 of patients (66%) and 28 of 56 procedures (50%).

**Conclusion:** The management of loco-regional recurrence in patients with WDTC can present a diagnostic and therapeutic challenge. Our approach and outcomes is presented. The results indicate that re-operation in this group can be successfully performed with an acceptable complication rate. An algorithm is presented to outline our approach to this challenging problem.

## 19. INVASIVE WELL-DIFFERENTIATED THYROID CARCINOMA OF THE UPPER AERODIGESTIVE TRACT: A RETROSPECTIVE ANALYSIS

**Etai Funk MD;** Julio A Allo MPH; Karla A Gutierrez MPH; Floyd C Holsinger MD, MD Anderson Cancer Center, Baylor College of Medicine

**Objective:** To determine the rates of long-term survival and local-regional control after surgical resection for invasive well-differentiated thyroid carcinoma involving the upper aerodigestive tract. **Methods:** A retrospective chart review of patients presenting to M.D. Anderson Cancer Center from 1954 to 2002 with invasive well-differentiated thyroid carcinoma involving the upper aerodigestive tract was performed. A database was constructed evaluating tumor stage, anatomic structures involved, surgical treatment, and oncologic outcomes. Survival and local-regional control rates were determined by Kaplan-Meier analysis and statistical comparisons were calculated using log-rank analysis.

**Results:** 27 patients were identified with invasive disease involving the upper aerodigestive tract. Histologic findings identified papillary thyroid carcinoma (77.8%), Hurthle cell variant (14.8%), follicular carcinoma (3.7%), and papillary-follicular with spindle cells (3.7%). 44.44% presented as previously untreated disease, 11.11% with residual primary disease, and 44.44% with recurrent disease. All patients underwent various surgical treatments including partial laryngectomy, total laryngectomy, tracheal resection, or total laryngopharyngectomy. Upper aerodigestive tract invasion occurred in the larynx (70.4%), trachea (66.7%), esophagus (37%), and pharynx (3.7%). 5 (18.5%) patients had partial resections while 22 (81.5%) patients had total resections. 16 (72.7%) patients had total laryngectomies and 6 (27.3%) patients had total laryngopharyngectomies. No patients with partial resection received a subsequent total resection as the two that recurred subsequently died before salvage surgery could be performed. Total recurrence rate was 18.5%. 4 (80%) partial resection patients required post-operative radiation treatment while 12 (54.5%) patients with total resections required post-operative radiation. Total survival rates at 2, 4, 6, and 8 years out were 85.2%, 64.34%, 64.4%, and 21.5% respectively. The addition of radiation did statistically improve survival rates.

**Conclusion:** Partial resection of well-differentiated invasive thyroid carcinoma of the aerodigestive tract can allow preservation of function while having comparable rates of survival to total resection. However, total resection does play a significant role in improving survival in patients with extensive disease. Post-operative radiation does demonstrate statistical significance for survival in both groups of patients.

## 20. MINIMALLY INVASIVE VIDEO-ASSISTED THYROIDECTOMY: A MULTI-INSTITUTIONAL NORTH AMERICAN EXPERIENCE

**David J Terris MD;** David Steward MD; Peter Angelos MD; Alfred Simental MD, Medical College of Georgia, University of Cincinnati, University of Chicago, Loma Linda University

**Background:** Minimal access thyroid surgery was conceived in Europe and Asia, and has only recently been embraced in the United States. We report a multi-institutional experience with the minimally invasive video-assisted thyroidectomy (MIVAT).

**Design:** Prospective, non-randomized analysis of a consecutive series of patients from 4 academic thyroid surgical practices.

**Methods and Materials:** Patients requiring thyroid surgery were carefully selected at surgeon discretion to undergo minimally invasive video-assisted thyroidectomy. Data were recorded prospectively, and included age, gender, indication for surgery, size of nodules and complications of surgery.

**Results:** 226 patients were identified, and data pooled. The mean age ( $\pm$  S.D.) was  $44.9 \pm 10.9$  years. There were 27 males and 199 females. There were no hematomas, and no cases of permanent hypoparathyroidism or permanent VCP. Seven patients had a transient TVC paresis, and 2 suffered temporary hypocalcemia.

**Conclusions:** The MIVAT technique has been adopted cautiously in the United States. The safety of the procedure represented by the data from this multi-institutional experience would support increased acceptance by high-volume surgeons.

## 21. OBJECTIVE AND SUBJECTIVE SCAR AESTHETICS IN MINIMAL ACCESS VS. CONVENTIONAL PARATHYROIDECTOMY AND THYROIDECTOMY SURGERIES, A PAIRED COHORT STUDY

**Daniel A O'Connell MD;** Hadi R Seikaly MD; Jeffrey R Harris MD, University of Alberta, Edmonton, AB, Canada

**Objective:** To determine the visibility, aesthetic and patient quality of life impact of scars created in minimal access vs. conventional parathyroidectomy and thyroidectomy surgeries following complete healing and scar remodeling.

**Design:** Paired cohort. Prospective minimal access incision and scar cohort. Sex and age-matched retrospective conventional incision and scar cohort.

**Patients:** All patients diagnosed with primary hyperparathyroidism undergoing surgical treatment via a minimal access incision were prospectively enrolled. A sex and age matched retrospective cohort of patients was selected from a patient population undergoing surgical treatment of thyroid neoplastic diseases using a conventional approach. 37 patients enrolled in prospective limb over a 2 year time frame, 15 patients included in final analysis. 15 patients sex and age matched conventional thyroidectomy patients were included for comparison.

**Interventions:** Minimal access parathyroidectomy surgery vs. conventional thyroidectomy surgeries. Post-operative follow-up assessment of scar aesthetics by patient and objective viewer. Digital photography and analysis of surgical incision site. All study follow-up a minimum of 9 months post-operatively.

**Main outcome measures:** 1. Patient and Observer Scar Assessment Scale (POSAS) 2. Vancouver Scar Scale 3. Photographic scar analysis by naïve viewers.

**Results:** 1. No significant difference in scar assessment scale scores between the minimal access and conventional cohorts. 2. No significant difference in overall patient satisfaction with scars between the two cohorts. 3. Increased visibility of conventional scars to naïve viewers.

**Conclusions:** Although being more readily visible to naïve viewers, conventional (larger) cervical scars created in parathyroidectomy or thyroidectomy surgery does not translate into an increase in patient dissatisfaction with their scar result. This may indicate a limited quality of life benefit in using minimal access approaches in trans-cervical surgeries.

## 22. MINIMALLY INVASIVE PARATHYROIDECTOMY USING THE LATERAL APPROACH UNDER CONSCIOUS SEDATION: TECHNIQUE AND RESULTS

Maisie L Shindo MD; **Joshua Rosenthal MD**, State Univ. of New York @ Stony Brook

Minimally invasive parathyroidectomy (MIP) has become the standard surgical approach for treatment of primary hyperparathyroidism. Local anesthesia with conscious sedation is suitable for excision of the inferiorly located superficial adenomas. However, it is difficult to explore the superior glands under local anesthesia, since these glands are located much more posteriorly or sometimes retroesophageally. Thus, many surgeons still use general anesthesia to perform MIP. This report describes our experience with MIP under local anesthesia with conscious sedation using the focused "lateral approach" technique for excision of posteriorly located parathyroid glands.

**Methods:** The records of 159 consecutive patients who underwent MIP at our institution between 2003 and 2006, were reviewed. The lateral approach was used in 87 patients, which forms the basis of this study. The lateral approach was used when preoperative sestamibi SPECT scan or ultrasound showed an adenoma located superiorly, posteriorly or retroesophageally. Intraoperative rapid PTH assay was used to confirm single gland pathology in all cases. A short video of the surgical technique will be shown.

**Results:** Eighty two (94%) cases were successfully carried out under sedation. The mean operative time was 45 minutes. In 7 patients the procedure was converted from lateral to anterior approach. Seventy patients (80%) were discharged the same day. There were no major complications. One patient experienced transient vocal cord paresis. One patient developed a small pneumomediastinum which resolved without intervention. Another patient developed a small hematoma which required not treatment and resolved on its own. All patients were normocalcemic at their first postoperative visit.

**Conclusions:** The focused lateral approach is a safe and effective procedure for excision of parathyroid glands which are located superiorly, posteriorly or retroesophageally. Its major advantage is the ability to remove glands located deep and posteriorly through a small incision under conscious sedation.

## 23. EX-VIVO RADIOACTIVITY MEASUREMENTS OF NORMAL, HYPERPLASTIC AND ADENOMATOUS PARATHYROID GLANDS

Michael Friedman MD; Berk Gurpinar MD; **Paul Schalhch MD**; Jay Shah BS; Ninos J Joseph BS, Department of Otolaryngology and Bronchoesophagology, Rush University Medical Center, Chicago, IL USA

**Background:** Although controversial, many centers utilize in-vivo or ex-vivo radioactivity level to identify parathyroid tissue and to predict its histology. Ex-vivo tissue characteristics have been previously defined and accepted. Published data identifies tissue by ex-vivo radioactivity level without consideration to tissue weight.

**Hypothesis:** The previously published data on ex-vivo characteristics are not accurate in three respects. 1) Radioactivity levels above 20% of background activity is not pathognomic of parathyroid adenoma. 2) Radioactivity level above 2.29% is not diagnostic of parathyroid tissue. 3) Ex-vivo radioactivity levels are related to the weight of the tissue.

**Design:** A retrospective analysis of a prospective dataset of patients.

Setting: Tertiary care referral center.

**Methods:** Patients undergoing thyroid and parathyroid surgery between December 2004 and December 2006 were injected with 20 mCi 99Tc sestamibi between 1.5 and 3.5 hours prior to surgery. At surgery, normal parathyroids were biopsied and ex-vivo radioactivity recorded. Normal thyroid tissue and lymph nodes were also biopsied and ex-vivo radioactivity recorded. Hyperplastic parathyroids, and adenomatous glands were excised and radioactivity was recorded. Finally, some enlarged glands were cut into segments and radioactivity counts were recorded and compared to the weight of the tissue. All counts were compared to background counts.

**Results:** Data was collected from 47 patients. Ex-vivo radioactivity level is clearly related to specimen weight. Segments of adeno-

mas had lower counts than the entire adenoma. Normal glands had radioactive counts between 2.2 and 9.89% of background activity. Hyperplastic glands had radioactive counts between 49-109% of background activity. Adenomas had radioactivity counts between 40%-389% for single and 176%-280% of background activity for multiple adenomas. Thyroid tissue had radioactivity counts between 0.27%-31.19%.

**Conclusion:** Ex-vivo radioactivity monitoring is helpful in identifying parathyroid tissue. It can differentiate normal from abnormal parathyroids. It cannot differentiate between hyperplasia and adenoma. If centers use ex-vivo radioactivity levels to identify tissue, they need to know the true radioactive behavior of different normal and pathologic tissues.

## 24. THE LINK BETWEEN PLASMA 25-HYDROXY VITAMIN D LEVELS, SEVERITY OF PRIMARY HYPERPARATHYROIDISM AND DISEASE LOCALIZATION ON SESTAMIBI SCANS: A STUDY OF 344 CONSECUTIVE PATIENTS UNDERGOING TARGETED PARATHYROIDECTOMY

**Emad Kandil MD**; Frank Lin MD; Anthony P Tufaro MD; Ralph P Tufano MD, Johns Hopkins Medical Institutions, Department of Surgery (EK, APT) and Department of Otolaryngology-Head and Neck surgery (FL, RPT), Baltimore, Maryland

**Background:** Vitamin D metabolism was studied in 344 consecutive patients that underwent targeted surgery for primary hyperparathyroidism (PHPT). The purpose of this study was (i) to determine if there is a relationship between preoperative measurements of 25-hydroxyvitamin D (25(OH) D) and the severity of PHPT and to (ii) to explore whether the presurgical 25(OH) D level could be used to predict whether a sestamibi scan would be positive or negative. We hypothesized that the severity of hypovitaminosis D would correlate with severity of PHPT and would therefore predict the likelihood of a positive sestamibi scan.

**Methods:** We performed a retrospective analysis of 344 consecutive patients who underwent preoperative sestamibi scintigraphy and a targeted parathyroid exploration for PHPT. Analysis included patients with surgical confirmation of a parathyroid adenoma. A linear model was used to examine the association of 25(OH)D levels with respect to mean differences in serum calcium, intact parathyroid hormone (iPTH), and alkaline phosphatase (ALKP) levels, gland weight, and sestamibi scan results.

**Results:** Adjusted for age and gender, iPTH, ALKP concentrations and parathyroid adenoma weight were significantly higher in patients with lower 25(OH) D levels. Significant correlations were observed between serum 25(OH) D concentrations and parathyroid adenoma weight ( $p < 0.001$ ); iPTH levels ( $p = 0.001$ ) and ALKP levels ( $p = 0.007$ ). No statistically significant differences were observed with respect to serum calcium. Mean 25(OH) D levels were lower in patients with positive sestamibi scans ( $p = 0.02$ ).

**Conclusions:** Patients with hypovitaminosis D present with more advanced signs of primary hyperparathyroidism. There is strong evidence to suggest that lower vitamin D levels are associated with higher gland weight, iPTH, and ALKP levels. Lower basal plasma 25(OH) D levels were predictive of positive sestamibi scans. Parathyroid sestamibi scanning may be more useful for this subset of patients when planning for targeted therapy.

## 25. THE UTILITY OF ULTRASONOGRAPHY IN PARATHYROID SURGERY

**Bridget A Boudreaux MD**; Scott A Asher BS; Glenn E Peters MD, University of Alabama at Birmingham

**Objective:** The aim of this study was to assess the role of high resolution ultrasonography (US) in the preoperative evaluation of patients presenting with hyperparathyroidism.

**Methods:** A retrospective review was performed of all patients who underwent parathyroidectomy by the senior author between October 2003 and October 2006 (331 patients). After excluding patients without preoperative US performed by radiology, there were 317 remaining patients who qualified for the study. Information collected included patients' age, sex, type of hyperparathyroidism (HPT), preoperative imaging results (both Tc-99m sestamibi (MIBI) and US), operative findings, and histopathologic findings. Analysis of the data focused on determining the number



of patients presenting with HPT who had clinically significant concomitant thyroid disease and on comparing the accuracy of MIBI (cost \$910) versus that of US (cost \$289) in the localization of parathyroid adenomas.

**Results:** There were 317 patients, 78 (24.6%) males with a mean age of 54.3 and 239 (75.4%) females with a mean age of 58.1. Of the 317 patients undergoing parathyroidectomy, 96 (30.3%) had clinically significant concomitant thyroid disease requiring partial or total thyroidectomy. Of these patients, 80 had benign thyroid disease and 16 (5%) had thyroid carcinoma on histopathology. There were 249 patients with primary HPT with both MIBI and US included in their preoperative workup. This included 49 (19.7%) males with a mean age of 60.3 and 200 (80.3%) females with a mean age of 58.8. MIBI was read as localizing in 63.1% and was able to correctly localize the parathyroid lesion in 86.0%. The US exam was read as localizing in 67.5% and correctly localized the lesion in 88.1%. US was able to correctly localize the parathyroid lesion in 46 patients with nonlocalizing or incorrectly localizing MIBI.

**Conclusion:** US should be included in the preoperative workup of all patients being evaluated for parathyroidectomy as an effective tool for diagnosis of concomitant thyroid disease and for localization of parathyroid adenomas.

## 26. LARYNGEAL NERVE MONITORING AND MINIMALLY INVASIVE THYROID SURGERY

David J Terris MD; Susan Anderson MD; **Tammara Watts MD**; Edward Chin MD, Medical College of Georgia

**Objectives:** Recent technological advances have led to the advent of endoscopic and minimally invasive thyroid surgery and routine utilization of laryngeal nerve monitoring (LNM). These technologies would appear to be complementary, however their combined use in thyroid surgery has not yet been described.

**Study Design:** Prospective, non-randomized analysis of surgical experience at a single-institution.

**Methods and Materials:** Demographic data from a consecutive series of patients undergoing both minimally invasive thyroid surgery and LNM were prospectively entered into a database and analyzed. Variables considered included age, gender, pathology, incision length, and incidence of temporary or permanent recurrent laryngeal nerve (RLN) injury.

**Results:** Two hundred and eighty-eight patients underwent thyroid surgery at the MCG Thyroid Center between February of 2003 and November of 2006; 143 (49%) had some type of minimal access approach (endoscopic or non-endoscopic). LNM was utilized in 57% of these cases, although the proportion of cases on which it was used increased from 0% in 2003 to 96% in 2006. There were no cases of permanent nerve injury. The incidence of temporary RLN paresis for those patients where the LN monitor was utilized was 4.6% (5 of 108 nerves at risk, NAR) compared with 6.3% in those cases where the nerve was visually identified, and without use of a monitor (5 of 80 NAR). While this difference failed to reach statistical significance ( $p=0.24$ ), the trend supports the likelihood of a clinical advantage.

**Conclusions:** Monitoring of the laryngeal nerves is feasible in minimal access thyroid surgery and may serve as a meaningful adjunct to visual identification of nerves.

## 27. METASTATIC CERVICAL SQUAMOUS CELL CARCINOMA FROM OCCULT HEAD AND NECK PRIMARY - A "CONSERVATIVE" APPROACH

**Rajan S Patel MD**; Kan Gao MSc; Christopher J O'Brien MD; Jonathan R Clark MD, Sydney Head & Neck Cancer Institute, Royal Prince Alfred Hospital & University of Sydney, Australia

**Background and Objective:** Increasingly aggressive treatment protocols have been recommended for treatment of metastatic cervical squamous cell carcinoma (SCC) from occult primary. The purpose of this study was to assess the efficacy of our treatment protocol of limiting treatment to the involved neck and reserving other therapies for salvage.

**Patients and Methods:** This was a retrospective cohort study of 69 patients, who were treated at an academic medical centre, and whose clinicopathological details had been entered prospectively onto a computerised database. Inclusion criteria included pathologically confirmed metastatic cervical squamous cell carcinoma with

no evidence of head and neck primary tumor following extensive clinical examination, radiological investigation and targeted biopsies in previously untreated patients. Our treatment protocol was neck dissection alone in patients with pN1 disease confined to the lymph node. All remaining patients (i.e. tumor extension beyond the lymph node capsule, pN2, or pN3) received neck dissection and post-operative radiotherapy to the involved neck. Outcomes included recurrence (local, ipsilateral neck, contralateral neck, and distant metastases) and disease-specific survival.

**Results:** The study cohort parameters included: 56 men and 13 women; median follow-up of 45 months in survivors; nodal distribution of pN1, 15%; pN2a 26%; N2b 26%; N2c, 4%; and N3, 29%. Neck dissection alone was performed in 11 patients (16%), whilst 58 patients (84%) underwent neck dissection and post-operative radiotherapy to the involved (ipsilateral) neck. The primary tumor site emerged in 5 patients (7%). The 5-year control rates were: 87% at the primary site; 81% in the ipsilateral (involved) neck; and 95% in the contralateral (uninvolved) neck. The 5-year disease-specific survival rate was 60%. Advanced nodal stage or extracapsular spread were statistically significant (both  $p < 0.05$ ) adverse prognostic factors.

**Conclusion:** The efficacy of our treatment protocol for SSC from occult primary compares favorably with other studies reporting more aggressive treatment protocols, including those recommending neck dissection with post-operative chemoradiation. The advantage of our protocol is that patients are spared potentially morbid therapies, which are reserved for salvage.

## 28. TRENDS IN SELF-REPORTED GENERAL HEALTH MEASURES PREDICT SURVIVAL IN HEAD AND NECK CANCER PATIENTS

**Mark J Jameson MD**; Lucy H Karnell PhD; Alan J Christensen PhD; Gerry F Funk MD, University of Iowa Hospitals and Clinics

**Objective:** To demonstrate that first-year trends in a self-reported, subjective general health assessment tool can provide prognostic information and help predict long-term survival in head and neck cancer patients.

**Design:** Prospective observational cohort study. Self-reported general physical health assessments were collected using the Medical Outcomes Study Short Form 36 (SF-36) survey at diagnosis (pre-treatment) and at 3, 6, 9, and 12 months after diagnosis. **Setting:** Tertiary care center.

**Patients:** 403 patients with carcinoma of the upper aerodigestive tract who were enrolled in a longitudinal outcomes project between January 1995 and December 2005.

**Main Outcome Measure(s):** Actuarial five-year observed (all deaths) and disease-specific (death with cancer present) survival. **Results:** Mean physical component summary (PCS) scores across the first year exhibited different trends according to duration of survival. All scores dropped at 3 months, but patients who died within the 2nd or 3rd year showed virtually no recovery, whereas those who died within the 4th or 5th year showed some recovery, and those who survived five or more years approached baseline status by 12 months. In the same 3 patient groups, the degree of decline in the mean 12-month PCS score increased as the duration of survival decreased. Overall, patients whose 12-month PCS score was lower than their pretreatment score had worse observed and disease-specific survival than patients whose 12-month score was equivalent to or higher than their pretreatment score.

**Conclusions:** First-year trends in the SF-36 PCS score, a self-reported, subjective measure of general physical health, were predictive of both observed and disease-specific survival.

## 29. THE MANAGEMENT OF HEAD AND NECK MELANOMA: RECURRENCE, RADIOTHERAPY AND PROGNOSIS

Richard Martin MS; **Chris O'Brien MD**; J Thompson MD; K Shannon, Sydney Head and Neck Cancer Institute and Sydney Melanoma Unit

**Aim:** To analyse the management of cervical nodes in melanoma. **Methods:** A retrospective cohort study of the Sydney Melanoma Unit (SMU) and Sydney Head and Neck Cancer Institute (SHNCI) databases was performed. The inclusion criteria were all cervical node surgery for melanoma between 1990 and 2004 conducted at



the SMU or SHNCI with a minimum follow up of 12 months. The exclusion criteria were multiple primaries or other site lymphadenectomy for melanoma.

**Results:** A total of 856 cases of cervical node surgery were identified with 716 meeting the study criteria with a median follow up of 34.7 months. The majority of patients were males (73%) with a median age of 61 years.

The surgical groups included; 131 elective node dissection, 339 sentinel node biopsies, 223 therapeutic neck dissections, and 23 node biopsies. A total of 396 neck dissections were performed (158 parotidectomies) with 114 receiving radiotherapy.

The lymph node failure was 8.5 % for therapeutic neck dissections and 9.5% for sentinel node biopsy patients who underwent a therapeutic neck dissection. The false negative rate of sentinel node biopsy was 7%.

Radiotherapy did not improve regional (lymph node) control ( $p=0.51$ ), and on multivariate analysis lymph node group ( $p<0.001$ ) and ulceration ( $p<0.027$ ) were the only significant factors for regional failure.

Survival was significantly better for node negative patients ( $p<0.001$ ), with the sentinel node negative group having the best survival (91% 5YSR). The addition of radiotherapy did not confer a survival benefit ( $p=0.538$ ).

**Conclusions:** The status of cervical nodes is the single most significant factor for recurrence rates and survival. Radiotherapy did not confer a benefit for regional control in this retrospective non-randomised cohort of head and neck melanoma patients.

### 30. TRANS ANTRAL ROBOTIC SURGERY OF THE SKULL BASE

**Ehab Y Hanna MD;** Chris F Holsinger MD; Franco Demonte MD; Michael E Kupferman MD, MD Anderson Cancer Center

**Background:** Transnasal endoscopic approaches are being increasingly utilized for surgical access and resection of tumors of the anterior and central skull base. One major limitation of this approach is the inability to provide water tight dural closure and reconstruction.

**Objective:** To describe a novel robotic surgical approach that allows adequate endoscopic access for resection of tumors involving the anterior and central skull base, and allows two-handed tremor-free endoscopic suturing and reconstruction of dural defects.

**Materials and Methods:** Three human cadaver specimens were used for this study. The surgical approach starts with bilateral sublabial incisions and wide anterior maxillary antrotomies (Caldwell-Luc). Transantral access to the nasal cavity is gained through bilateral wide middle meatal antrotomies. A posterior nasal septectomy facilitates bilateral access by joining both nasal cavities into one surgical field. The DaVinci surgical robot is then "docked" by introducing the camera arm port through the nostril and the right and left surgical arms ports through the respective anterior and middle antrotomy, into the nasal cavity. A 5-mm dual-channel endoscope coupled with dual CCD camera is inserted in the camera port, and allows for 3-D visualization of the surgical field at the surgeon's console. Using the robotic surgical arms, the surgeon may perform endoscopic anterior or posterior ethmoidectomy, sphenoidotomy, or resection of the middle or superior turbinates depending on the extent of needed surgical exposure. In addition, resection of the cribriform plate is performed robotically with sharp dissection of the skull base. The dural defects is then repaired with 7-0 nylon suture (Ethicon).

**Results:** Adequate access to the anterior and central skull base including the cribriform plate, fovea ethmoidalis, medial orbits, planum sphenoidale, nasopharynx, pterygo-palatine fossa and clivus was obtained in all cadaveric dissections. The 3-D visualization obtained by the dual-channel endoscope at the surgeon's console was superior to the 2-D view obtained by the traditional single channel nasal endoscopes. The most significant advantage was the ability of the surgeon to perform two-handed tremor-free endoscopic closure of dural defects.

**Conclusions:** Trans-antral robotic surgery provides adequate endoscopic access to the anterior and central skull base. This novel approach also allows for three-dimensional, two-handed, tremor-free endoscopic closure of dural defects. These advantages may expand the indications of minimally invasive endoscopic approaches to the skull base.

### 31. TRANS ORAL AND TRANS CERVICAL ROBOTIC SKULL BASE SURGERY IN A PRECLINICAL MODEL

**Bert W O'Malley MD;** Gregory S Weinstein MD, The University of Pennsylvania School of Medicine

Robotic surgical technology has gained significant momentum in the fields of urologic, abdominal, and cardiothoracic surgery, and now head and neck surgery. Advantages of robotic surgery include excellent three dimensional visualization of anatomy, the ability to use a variety of wristed instrumentation with finely scaled movements, and tremor filtration. These attributes should prove advantageous when applied to skull base microsurgery. However, the size of the present endoscopic camera system and the configuration of the instruments has posed even a great challenge for clinical relevant skull base surgery that what we overcame for Trans Oral Robotic Surgery (TORS).

**Methods:** We performed one live canine and three cadaver experiments to assess the feasibility and identify the technical challenges and obstacles in performing robotic skull base surgery. Both transoral and transcervical approaches were performed and issues of instrument size, angulation, visualization, and maneuverability were assessed.

**Results:** For transoral robotic surgery, we determined that parapharyngeal and infratemporal fossa surgery was technically feasible and visualization was adequate to the bony skull base and vascular and neural foramina. However, access to the superior clivus, sella, and anterior fossa was limited due to the required instrument angulation and palate interference. In order to overcome these limitations, we proposed and tested a new concept of minimally invasive transcervical robotic surgery which involved placement of the robotic instrumentation through small trochars in the submandibular region in concordance with transoral placement of the endoscopic camera. This configuration and approach allowed us to overcome many of the transoral obstacles and successfully operate on the sella and anterior skull base.

**Conclusion:** Robotic skull base surgery is technically feasible in preclinical models and issues of visualization and instrument access can be overcome using classic TORS and novel transcervical approach strategies.

### 32. TRANSORAL ROBOTIC SURGERY (TORS) RADICAL TONSILLECTOMY FOR SQUAMOUS CELL CARCINOMA OF THE TONSILLAR REGION: TECHNIQUE AND OUTCOMES

**Gregory S Weinstein MD;** Bert W O'Malley, Jr. MD; Wendy Snyder BS, The University of Pennsylvania

**Objectives:** To describe a new surgical technique for Transoral Robotic Surgery (TORS) Radical Tonsillectomy utilizing the da Vinci Surgical Robot and report on safety, postoperative management, complications, and functional outcomes.

**Design:** An IRB-approved prospective human trial. Mean follow-up was 6 months.

**Setting:** Academic, tertiary referral center. **PATIENTS:** A total of 18 patients who underwent TORS Radical Tonsillectomy for previously untreated invasive squamous cell carcinoma of the tonsillar region without free flap reconstruction.

**Interventions:** One patient had received prior radiation therapy for another cancer. An associated neck dissection was performed in 17 patients (94%). Postoperative radiation therapy without chemotherapy was administered to 5 patients (28%), and postoperative radiation with chemotherapy in 12 patients (67%). Postoperative chemotherapy alone was administered in 1 patient (5%)

**MAIN Outcome Measures:** Intraoperative mortality, and perioperative mortality were determined. Final pathological margin status was reported. Local recurrence was reported. The need for short and long term tracheotomy were assessed. Operatives times were recorded. The need for gastrostomy tube feedings among patients followed with a minimum of 6 months was assessed. The incidence of significant postoperative surgical and medical complications was recorded.

**Results:** No intraoperative or perioperative mortality occurred. No local recurrences were noted in this series. Final negative margins were achieved in 18 patients (100%). There were no significant surgical complications. Other complications included moder-

ate trismus in 2 patients, and nasal voice in one patient. One patient (5%) underwent tracheostomy, which was removed on postoperative day 14. Among patients with a minimum of 6 months follow-up 1 patient continued to need tube feedings via gastrostomy. No patients needed long-term tracheostomy. The average robotic setup time was 11 minutes and 12 seconds. The average time to perform TORS was 1 hour and 34 minutes. The mean duration of hospitalization was 4.8 days.

**Conclusions:** TORS Radical Tonsillectomy, is a new technique that offers excellent access for resection of carcinomas of the tonsillar region with minimal morbidity. Future studies should focus on long-term oncologic outcomes.

### 33. SINONASAL ADENOID CYSTIC CARCINOMA: MD ANDERSON CANCER CENTER EXPERIENCE

**Allison D Lupinetti MD:** Dianna B Roberts PhD; Micheal E Kupferman MD; Michelle D Williams MD; David I Rosenthal MD; Franco Demonte MD; Adel El-Naggar MD; Randal S Weber MD; Ehab Y Hanna MD, MD Anderson Cancer Center

**Objective:** Adenoid cystic carcinoma of the sinonasal tract is a rare disease but accounts for 10% of all malignancies at this site. It is the second most common malignancy of the sinonasal tract. The purpose of this study was to evaluate prognostic factors, treatment outcomes, recurrence patterns and survival rates for sinonasal adenoid cystic carcinoma.

**Study Design:** Retrospective chart review

**Methods:** Between 1990 and 2003, 97 patients were evaluated for adenoid cystic carcinoma of the sinonasal tract at one institution. Demographics, presentation, anatomic site, TNM staging, pathology, treatment, recurrences and survival were evaluated.

**Results:** Ninety seven patients with adenoid cystic carcinoma were evaluated, 53 female and 44 male, with a median age of 50 years and a mean follow up of 47 months. The maxillary sinus (53%) and the nasal cavity (32%) were the most common primary tumor sites. The majority of patients presented with T3/T4 (70%), N0 (90%), M0 (88%) disease. Fifty two percent of patients underwent surgery with post-operative radiation as treatment for their primary disease. Local recurrence and distant metastases rates were 30% and 33%, respectively. Five year overall survival rate was 65%.

**Conclusions:** Adenoid cystic carcinoma of the paranasal sinuses is a rare disease and the ideal treatment paradigm has yet to be defined. Our data suggests that surgical resection with post-operative radiation therapy offers durable local control and compares favorably with historical data. Although local recurrences develop in a significant percentage of patients, survival from this disease exceeds that of other sinonasal malignancies. Further studies will help define the therapeutic modalities that would maximize outcome and minimize treatment-related morbidity.

### 34. THE IMPORTANCE OF COMORBIDITY IN TREATMENT OF SALIVARY GLAND CANCER; RESULTS OF THE DUTCH HEAD AND NECK ONCOLOGY COOPERATIVE GROUP (NWHHT)

**Robert J. Baatenburg de Jong PhD;** Marc Van der Schroeffer; Kim Van Schie; H. Lubsen PhD; Chris H.J. Terhaard PhD, Erasmus MC Rotterdam

**Introduction:** The prognosis of patients with salivary gland cancer is usually based on the TNM and histological type. However, this classification neglects significant patient factors, such as comorbidity. For patient counselling and treatment decisions a comprehensive prognostic model would be helpful.

**Purpose:** (1) To determine the effect of comorbidity on prognosis in patients with salivary gland cancer. (2) To design a comprehensive prognostic model for these patients.

**Methods and Materials:** In 666 patients with salivary gland cancer (parotid gland 56%, minor salivary glands 32% and submandibular glands 13%). Treatment period 1985-1994.

**Results:** In 610 of 666 patients an ACE27 score could be retrieved retrospectively: grade 0: 392; grade 1: 120; grade 2: 69; grade 3: 29; unknown: 56. Distribution of ACE-27 grade, correlated with age and sex (male higher grade). Five and ten years overall survival were 70% and 65%, 50% and 30%, 40% and 0%, for grade 0, grade 1-2, grade 3 respectively. Multivariate analysis (Cox) for

overall survival included: sex, age, site of tumor, size of the tumor, ACE27, invasion of skin, pN and WHO-72 classification. Significant predictors of overall survival were: age, ACE27, size and site, pN and invasion of skin. The RR's of ACE27 grade 1, 2 and 3 were 1.37, 1.71 and 3.10, respectively. Histological type was not an independent predictor of survival.

A dynamic and comprehensive prognostic model will be presented during the lecture.

**Conclusions:** Comorbidity is a significant predictor of overall survival

-A dynamic and comprehensive prognostic model is useful and feasible

### 35. EVALUATION OF HARDWARE-RELATED COMPLICATIONS IN VASCULARIZED BONE GRAFTS WITH LOCKING MANDIBULAR RECONSTRUCTION PLATE FIXATION

**Philip D Knott MD;** Jeffery D Suh MD; Vishad Nabili MD; Joel A Sercarz MD; Christian Head MD; Elliot Abemayor MD; Keith E Blackwell MD, UCLA Medical Center

**Purpose:** To identify the incidence of hardware and bone healing complications in patients who underwent locking mandibular reconstruction plate (LMRP) fixation of vascularized bone grafts for reconstruction of segmental mandibular defects.

**Patients and Methods:** One hundred and one patients with a minimum follow up of 6 months were analyzed to determine the incidence of screw loosening, osteosynthesis nonunion, and complications that required hardware removal. Patient-related characteristics (age, sex, comorbidity level, diagnosis, tumor stage, history of radiation therapy, chemotherapy, or prior surgery) and defect-related characteristics (type of bone graft used, defect length, number of osteosyntheses, screw diameter, and number of screws implanted) were analyzed to determine their association with the incidence of loose screws, osteosynthesis nonunion, and complications that required hardware removal.

**Setting:** An academic tertiary care medical center.

**Results:** The incidence of loose screws among 984 locking screws implanted was 0.8 %. The incidence of nonunion among 290 osteosyntheses was 0.7 %. Overall, 15 of 101 (14.8%) LMRPs were removed for hardware-related complications, with plate extrusion (n=10) being the most common complication that required hardware removal. Pathologic diagnosis (P < .002), radiation therapy (P < .0001), and cancer recurrence (P = .034) were statistically significant predictors of LMRP related complications on univariate analysis. On multivariate analysis, radiation therapy (P < .002) remained a statistically significant predictor of LMRP related complications.

**Conclusions:** LMRPs are highly effective for fixation of vascularized bone grafts in patients undergoing mandibular reconstruction, with a high incidence of bone graft healing and a low incidence of complications related to loose screws. Nevertheless, there remains a 15% incidence of hardware-related complications, mostly related to hardware extrusion. Radiation therapy is a statistically significant predictor of LMRP related complications.

### 36. THE USE OF A STEREOLITHOGRAPHIC MODEL AS AN AID TO PLATE APPLICATION IN OROMANDIBULAR RECONSTRUCTION WITH FIBULAR FREE FLAPS: A COMPARISON OF FIXATION TECHNIQUES

**R. Bryan Bell MD;** Jason K Potter MD; Mark Buehler MD; Eric J Dierks MD; Bryce E Potter MD, Legacy Emanuel Hospital and Health Center; Oregon Health & Science University

**Purpose:** The purpose of this retrospective cohort study was to assess the outcomes of a series of patients that underwent oromandibular reconstruction with fibular osteocutaneous free flaps and to determine whether the method of fixation influenced the complication rate, operative time or the esthetic result.

**Methods:** The records of 100 consecutive patients with post-ablative oro-mandibular defects who underwent reconstruction with fibular osteocutaneous free flaps from 2000-2006 were retrospectively reviewed. The study cohort was divided according to the fixation technique: group 1, pre-bent 2.4 or 2.0mm locking reconstruction plate (with stereolithographic model); group 2, in-situ bent 2.4 or 2.0mm locking reconstruction plates (no stereolitho-

graphic model); group 3, mini-plate fixation. Descriptive statistics were recorded and the group variables were compared using the chi-squared and t-test methods. Post-operative esthetics were assessed using a 3-point scale based upon mandibular projection, facial symmetry, and the potential for prosthetic rehabilitation. The primary outcome measures were complications related to fixation failure or the need for plate removal, operative time and esthetic result.

**Results:** The overall success and complication rate of flap reconstruction was 93% and 34% respectively. There was no statistically significant difference in overall complications among the 3 sub-groups ( $p>0.5$ ), however, patients with mini-plates required plate removal more frequently ( $p<0.5$ ). Although the use of stereolithographic models to pre-bend the reconstruction plates offered several technical advantages compared to the other methods, there was no significant difference in operative time ( $p>0.5$ ). The use of reconstruction plates was thought to have yielded superior esthetic outcomes when compared to mini-plates ( $p<0.5$ ).

**Conclusion:** The use of reconstruction plates to stabilize fibular flaps may result in a less frequent need for hardware removal and more predictable esthetics when compared to mini-plate fixation. The use of stereolithographic models to pre-bend plates offers the advantage of precise adaptation regardless of the oncologic requirements during ablative surgery.

### 37. CAROTID BODY TUMORS: EVOLVING MANAGEMENT BASED ON A 20 YEAR EXPERIENCE IN THE TREATMENT OF 186 TUMORS OCCURRING IN 130 PATIENTS

James L Netterville MD; **Chad A Zender MD**; Cecilia E Schmalbach MD; Brian B Burkey MD; Robert Sinard MD; Milton Ochieng' MD, Vanderbilt University Medical Center

**Introduction:** Through our experience with a large cohort of Carotid Body Tumors (CBT), we would like to review their evolving management over the last several decades. Significant changes include a decrease in the use of diagnostic angiography, an increase in non-operative observation in asymptomatic mature patients, greater emphasis on cranial nerve preservation during resection, and the targeted use of pre-operative embolization for larger tumors.

**Methods:** After IRB approval we reviewed our established paraganglioma database. We identified 130 patients with 186 carotid body tumors who were treated by the head and neck service during the 20-year period from 1986 to 2006.

**Results:** The mean age was 42 years with a range from 15 to 88 years. There were 75 females and 55 males. The most common mode of presentation was a neck mass, which was seen in 91% of patients. Diagnosis was made preoperatively on radiographic imaging revealing a vascular tumor splaying the internal and external carotid arteries. Catecholamine secretion was seen in 15% of the patients, often secondary to other paragangliomas. Bilateral CBTs were seen in 43% of patients, associated vagal paragangliomas seen in 33%, and jugular tumors seen in 31% of patients. A familial inheritance pattern was identified in 35% of the patients. Preoperative embolization was utilized in 44% tumors. One hundred and seven patients underwent surgical excision of either unilateral or bilateral tumors via a trans-cervical approach. Internal Carotid artery resection and reconstruction was performed in 21% of patients. Locoregional metastasis was identified in 9% of patients. Postoperative cranial nerve dysfunction was seen in 8% of patients, mainly associated with malignant and locally aggressive tumors. No postoperative strokes or deaths occurred. Baroreflex failure was seen in 18.5% of patients.

**Conclusion:** Most of our knowledge to date on CBTs has been extrapolated from small studies of twenty or thirty patients. Through our experience with this large cohort we have seen that the familial inheritance pattern is more common than previously reported. Our Internal carotid resection rate of 21%, and the increased rate of malignancy of 9% compared to commonly quoted 5% incidence, is probably due to the tertiary nature of our practice. The primary treatment of the majority of CBTs is still surgical resection, which can be performed with curative intent with a very low rate of morbidity.

### 38. DO CLEAR SURGICAL MARGINS SIGNIFICANTLY INFLUENCE SURVIVAL IN PATIENTS UNDERGOING SALVAGE SURGERY FOR NASOPHARYNGEAL CARCINOMA?

**Alexander C Vlantis MD**; Raymond KY Tsang MD; Brian KH Yu MD; Michael KM Kam; Michael CF Tong MD; Andrew C van Hasselt MD, Department of Surgery, Department of Clinical Oncology, The Chinese University of Hong Kong, Prince of Wales Hospital, Shatin, Hong Kong

**Objective:** To determine whether clear surgical margins affect the survival of patients with local residual or recurrent nasopharyngeal carcinoma undergoing salvage surgery.

**Study Design:** Retrospective case review

**Setting:** Tertiary referral centre

**Patients:** Seventy nine consecutive patients (M:F 61:18) underwent a nasopharyngectomy at the Prince of Wales Hospital with curative intent. The minimum follow-up was 24 months.

**Intervention(s):** The surgical approaches to the nasopharynx were transoral-transpalatal, transmandibular-transpalatal, maxillary swing and midfacial-degloving.

**Main Outcome Measure(s):** Overall survival was measured from the date of treatment to the date of the last follow-up, at or within 2 years of treatment, or to the date of death from any cause. The Kaplan-Meier method was used to estimate the probability of overall survival. Differences in survival rates between surgical margin statuses were assessed using the log-rank test.

**Results:** The 4-year overall survival rate for patients with clear margins was 80%, for patients with close margins 50% ( $p<0.05$ ) and patients with positive margins 23% ( $p<0.05$ )

**Conclusions:** In our series, clear surgical margins at the time of nasopharyngectomy for residual or recurrent local nasopharyngeal carcinoma significantly influences the survival of the patient.

### 39. WNT1, AN ACTIVATOR OF THE WNT PATHWAY, IS OVEREXPRESSED IN SALIVARY GLAND TUMOR CELLS

**Lurdes Queimado PhD**; David Obeso MS; Melissa D Hatfield MS; Antonio M Reis MD, Departments of Otorhinolaryngology and Dermatology University of Oklahoma Health Sciences Center, Oklahoma City, OK

The Wnt signaling pathway controls many events during embryogenesis and oncogenesis. Activation of this pathway is a well established oncogenic signal in several human and mouse tissues. In transgenic mouse models activation of the Wnt pathway leads to a high frequency of salivary gland benign and malignant tumors. Interestingly, transgenic mice over-expressing the Pleomorphic Adenoma Gene 1 (PLAG1), a known human and mouse salivary gland oncogene, show great activation of the Wnt pathway. In contrast with mouse salivary gland tumors, little is known about the role of the Wnt pathway in human salivary gland tumors. Recently, we have shown that the Wnt inhibitory factor-1 (WIF1) gene, which encodes a secreted protein antagonistic to Wnt-dependent signaling, is targeted for rearrangement and loss in human salivary gland cancer. WIF1 protein binds and inhibits WNT1, a secreted activator of the Wnt pathway. Here we determined the expression level of WNT1 in normal salivary gland tissue and in cell lines established from primary salivary gland tumors and correlated WNT1 expression levels with Pleomorphic Adenoma Gene 1 (PLAG1) expression. The expression of WNT1 and PLAG1 was analyzed by northern and/or western blot. A relationship between the expression of PLAG1 and WNT1 protein was determined by Pearson's linear correlation. We show for the first time that WNT1 is up-regulated in cells derived from benign and malignant salivary gland tumors. Furthermore, our data suggest that WNT1 over-expression is driven by PLAG1 expression. This is the first report showing over-expression of WNT1 in human salivary gland tumors. Our work pinpoints the Wnt pathway as a putative therapeutic target in human salivary gland tumors.

## 40. A HIGHLY SELECTIVE INHIBITOR OF INDUCIBLE NITRIC OXIDE SYNTHASE (iNOS) IMPAIRS THE GROWTH OF iNOS-EXPRESSING HUMAN MELANOMA IN VIVO AND PROLONGS THE SURVIVAL OF TUMOR-BEARING SCID/NOD MICE

**Andrew G Sikora MD;** Yared Hailemichael PhD; Suhenden Ekmekcioglu PhD; Elizabeth A Grimm PhD; Willem W Overwijk PhD, University of Texas MD Anderson Cancer Center

**Background:** Melanoma, one of the fastest-growing cancers in the US, commonly presents in the head and neck region. While early-stage melanoma can often be cured by surgery, the dismal prognosis of patients with stage III and stage IV melanoma requires the development of new therapeutic strategies. One such novel strategy is inhibition of inducible nitric oxide synthase (iNOS) activity in melanoma cells. iNOS expression has been shown to be an independent predictor of poor survival in stage III melanoma. In vitro, nitric oxide (NO) enhances melanoma proliferation and reduces sensitivity to cisplatin-mediated apoptosis. Tumor-derived NO has been shown to promote tumor angiogenesis and suppress the induction of anti-tumor immunity in vivo. Highly specific chemical inhibitors of iNOS have been developed, and used in human clinical studies for nonmalignant diseases such as asthma. We tested the hypothesis that iNOS inhibition by a clinically validated small-molecule antagonist inhibits the growth of human melanoma in an orthotopic mouse model.

**Methods and Results:** The expression of iNOS in a panel of human melanoma cell lines was evaluated by immunocytochemistry, and the iNOS-expressing line mel624 used in subsequent in vivo experiments. Mel624 was injected subcutaneously into the ventral area of immunodeficient NOD/SCID mice and allowed to grow for 3 days at which time mice were treated for 21 days with the highly selective iNOS inhibitor L-nil (L-N6-[1-Iminoethyl]lysine) 0.15% in drinking water, or plain drinking water control. The ability of L-nil to inhibit iNOS-derived NO production in vivo was verified by inhibition of NO production in mice challenged intraperitoneally with LPS. All mice in the control group experienced uncontrolled tumor growth (tumor size 177 +/- 56 mm<sup>2</sup> at day 32) and had a median survival time of 36 days. Tumor growth was inhibited in L-nil-treated mice (tumor size 54 +/- 15 mm<sup>2</sup> at day 32), and median survival extended to 56 days ( $p < 0.029$  with respect to control). L-nil-treated mice did not experience weight loss or other signs of toxicity from treatment. **Conclusions:** iNOS inhibition by monotherapy with an orally-delivered highly selective iNOS antagonist impairs growth of human melanoma in vivo, and extends the survival time of tumor-bearing SCID/NOD mice without apparent toxicity. These data suggest a potential role for selective iNOS inhibitors in the treatment of melanoma and other iNOS-expressing tumors.

## 41. THE EFFECT OF ALTERED TLR4 SIGNALING ON THE DEVELOPMENT OF CANCER CACHEXIA

**Trinitia Cannon MD;** Denis Guttridge PhD; Carol Shores MD; Victor Lai MD; Jonathan George BS; Marion Couch MD  
The University of North Carolina, The Ohio State University

**Objective:** Given equal tumor burdens, some hosts develop cancer cachexia while others do not. Our overall hypothesis is that the genetic predisposition of the host to mount an inflammatory response may determine the severity of cancer cachexia and that mice with an inability to mount an intact pro-inflammatory cytokine response due to defects in a Toll-like receptor (TLR) pathway will be less likely to develop cancer cachexia.

**Methods:** Six week old female C3H/HeJ and C3H/HeN mice were housed in individual cages to obtain daily food weights and body weights (BW). These congenic strains of mice differ only in that C3H/HeJ mice have a double mutation for TLR4 signaling (TLR<sup>-/-</sup>). All mice were injected in the flanks with equal numbers of SCCF/VII cells. Pre- and post-tumor body composition was performed using a Lunar PIXImus densitometer. Western blot analysis for Lipid Mobilizing Factor (LMF), a tumor-derived factor implicated in lipolysis, was done on SCCF/VII cells in vitro. Cytokine analysis was determined using Multiplex Cytokine analysis. Northern Blot analysis was performed on RNA isolated from quadriceps muscle of all mice using probes specific for a marker of muscle atrophy, the ubiquitin ligase muscle ring-finger1 (MuRF1). **Results:** The C3H/HeN mice gained an average of 2.6 g while the

TLR<sup>-/-</sup> mice gained an average of 4.9 g ( $p = 0.006$ ). Interestingly, the C3H/HeN mice consumed more food at every time point and had an average cumulative food intake of 102.58 g (SE = 5.81) while the less cachectic TLR<sup>-/-</sup> mice consumed an average of 76.4 g (SE = 0.94). Body composition revealed that the C3H/HeN mice had a percent change in lean body mass (LBM) of 27.5% while the TLR<sup>-/-</sup> mice had a 56.5% LBM change. Fat mass (FM) percent change was also less in the C3H/HeN mice when compared to the less cachectic TLR<sup>-/-</sup> mice, 17.9% versus 34.6%. Although LMF expression was seen in the SCCF/VII cell line, only the C3H/HeN mice demonstrated evidence of lipolysis by body composition. Of the eighteen serum cytokine and chemokines analyzed, only IL-1 $\beta$  was found to be significantly elevated in tumor-bearing C3H/HeN mice when compared to tumor-bearing TLR<sup>-/-</sup> mice ( $p = 0.45$ ). Both strains of mice had evidence of muscle wasting.

**Conclusions:** In spite of increased food intake and smaller tumors, the mice with intact TLR4 signal pathway had more cachexia than the mice with deficient signaling. IL-1 $\beta$  production appears to be an important mediator of cachexia in C3H/HeN mice. Since the mice are congenic except for this double mutation in TLR4 pathway signaling, the impaired ability to secrete pro-inflammatory cytokines such as IL-1 $\beta$  may protect these animals from developing cancer cachexia in this novel murine system.

## 42. THE SIDE POPULATION OF A HEAD AND NECK CANCER CELL LINE CONTAINS STEM CELL-LIKE CANCER CELLS

**Mark H Tabor MD;** Matthew R Clay BS; Carol R Bradford MD; Thomas E Carey PhD; Gregory T Wolf MD; Mark E Prince MD, University of Michigan

**Objective:** To identify and characterize stem cell-like cancer cells within a head and neck squamous cell carcinoma (HNSCC) cell line.

**Design:** In vitro cancer cell line study.

**Main Outcome Measures:** The cancer stem cell hypothesis concludes that a small subpopulation of cells within a cancer, the cancer stem cells (CSC), have the unique ability to self-renew and repopulate the tumor. The CSC represent the critical population of cancer cells that are responsible for tumor growth, treatment failure and recurrence. Subsets of cells called side populations (SP) have been identified in many tissues based on differential ability to actively efflux the DNA binding dye Hoechst 33342. SP cells and stem cells share many characteristics suggesting that the SP isolated from malignant tumors may contain the tumorigenic CSC subpopulation. In this study the SP was isolated from a HNSCC cell line and evaluated for stem cell-like characteristics.

**Results:** A distinct SP was consistently identified in the HNSCC cell line UM-SCC-10B. The SP was clonogenic in vitro and demonstrated the ability to reproduce both SP and non-side population (NSP) cells from even a single cell. The SP had lower expression of nuclear active beta-catenin and was more resistant to 5-fluorouracil. Real time PCR analysis of reverse transcribed cDNA from the SP demonstrated greater expression of BMI-1 (4.3-fold) and ABCG2 (1.4-fold), genes traditionally associated with stem cells. These characteristics observed in the SP are consistent with those expected from a population of CSC.

**Conclusions:** The HNSCC cell line UM-SCC-10B contains a small identifiable SP representing a population of stem cell-like cancer cells. The SP in HNSCC cell lines has the potential to serve as a valuable in vitro model for understanding self-renewal mechanisms in cancer stem cells and the development of novel treatment strategies.

## 43. INVASIVE MECHANISM FOR HPV+ CANCERS: E6 INDUCES LOSS OF PTP-BAS ALLOWING INVASIVE GROWTH.

John H Lee MD, University of Iowa and Dept. of Veteran Affairs  
Human papilloma virus (HPV) is the second most common single attributable cause of cancer worldwide because it plays a critical role in the malignant transformation oropharyngeal and anogenital keratinocytes. Many of the cellular mechanisms that are altered by HPV16 to result in transformation have also been shown to be altered in non-HPV related malignancies thereby making HPV transformation a paradigm to understand critical mechanisms of cellular transformation. HPV16 accomplishes some of these aspects of transformation through the actions of

the polyfunctional viral oncogene, E6. Although some transformation mechanisms of E6 have been identified significant past work supports that the key mechanism that allows invasion is associated with the E6 PDZ motif of high risk viral subtypes. Here we show the loss of PTP-BL/PTP-Bas in primary mouse and human epithelial cells either by expression of E6 or by an shRNA strategy allows for anchorage independent growth and synergizes with a known oncogene to result in invasive growth in vivo. Studying E6 mutations we have shown that the E6 loss requires the PDZ motif and physical interaction. These findings not only describe an oncogenic mechanism for HPV related cancer but also describe a role for PTP-BL in the signaling processes involved in allowing cells to grow outside its normal environment.

#### **44. SORAFENIB POTENTLY INHIBITS PAPILLARY THYROID CARCINOMA CELL LINES HARBORING RET/PTC1 REARRANGEMENT**

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1Departments of Head & Neck Surgery and Endocrine Center and  
2Cancer Biology, The University of Texas M. D. Anderson Cancer  
Center, Houston, Texas

**Background:** Papillary thyroid carcinomas (PTC) are the most common type of malignancy of the thyroid. PTC carry one of two mutations, RET/PTC rearrangement which results in constitutive activation of RET tyrosine kinase or BRAF mutation that results in constitutive activation of BRAF. Both mutations are able to activate the MEK/ERK signaling transduction pathway and result in activation of a variety of transcription factors that regulates cellular proliferation, differentiation, and apoptosis. Sorafenib (BAY 43-9006) is a multi-kinase inhibitor and has been shown to inhibit Raf, RET kinase, PDGF receptor, and c-kit.

**Methods:** The effects of sorafenib on cell proliferation and cell signaling was evaluated in vitro on PTC cells carrying either BRAF mutation or RET/PTC rearrangement.

**Results:** The IC50 of sorafenib for the PTC cells carrying the RET/PTC1 rearrangement was 42 nM and for the PTC cells carrying the BRAF mutation was 1.5  $\mu$ M, both readily achievable serum concentrations.

**Conclusions:** PTC cells carrying the RET/PTC1 rearrangement were more sensitive to sorafenib than the PTC cells carrying the BRAF mutation. Since RET/PTC rearrangement is a unique characteristic of thyroid carcinomas, our findings support the clinical evaluation of sorafenib for patients with recurrent and aggressive PTC and may provide a biomarker for the identification of patients most likely to respond to sorafenib treatment.

#### **45. IMMUNOHISTOCHEMICAL VALIDATION OF MICROARRAY GENE EXPRESSION DIFFERENCES BETWEEN FOLLICULAR ADENOMAS AND FOLLICULAR CARCINOMAS**

**Paul C Bryson MD**; Carol F Shores MD PhD; Luke M Richey BA,  
Alexander Farag BA; Craig F Hart MD; Adam M Zanation MD,  
University of North Carolina - Chapel Hill

**Background:** Multiple gene microarray studies suggest that benign and malignant follicular neoplasms have different gene expression profiles. The gene expression data was compiled and this was cross-matched for commercially available immunohistochemical antibodies. We used the five most differentially expressed, commercially available antibodies identified and evaluated the immunohistochemical staining of follicular thyroid carcinoma (FTC), follicular adenoma (FA), papillary thyroid carcinoma (PTC), and follicular variant of papillary thyroid carcinoma (FVTC).

**Methods:** Using titrated and optimized immunohistochemical staining protocols (IHC), tissue microarrays containing previously collected samples of follicular thyroid carcinoma, follicular adenoma, papillary thyroid carcinoma, and follicular variant of papillary thyroid carcinoma were stained with Galectin-3, Autotaxin, Intestinal trefoil factor 3 (TFF-3), EMMPRIN, and GADD153 antibodies. The staining was then classified based on intensity, per-

centage of cells staining, and staining pattern. Chi-squared tests and multivariate analysis were used to compare benign from malignant lesions.

**Results:** Tissue microarrays were constructed with previously collected cases of FA (n=62), FVTC (n=58), FTC (n=62), and PTC (n=22). A significantly higher percentage of malignant cells stained with Galectin-3 (p=0.002), EMMPRIN (p=0.007), and GADD153 (p=0.011). Galectin-3 (p=0.104) and EMMPRIN (p=0.076) showed a trend toward having a higher intensity of staining malignant cells. TFF-3 stained follicular adenomas with greater intensity compared to malignant lesions (p=0.015). Quantitative comparison between microarray gene expression levels and protein expression levels show variable correlations. Preliminary multi-protein IHC analysis algorithms are shown with their corresponding predictive values.

**Conclusions:** Protein expression data validate the pooled gene expression data that differentiate FTC from FA. Our results show promise for multi-protein IHC analysis algorithms and their predictive ability. Future studies will focus on clinical translation of these IHC schemes for preoperative analysis of FNA samples of follicular thyroid neoplasms.

#### **46. INTEGRATIVE GENOMIC APPROACH TO FINDING NOVEL HEAD AND NECK SQUAMOUS CELL CARCINOMA-CAUSING GENES**

**Ian M Smith MD**; Suhail K Mithani MD; David Sidransky MD;  
Joseph A Califano, Johns Hopkins Medical Institutes

With the advent of high-throughput techniques to study cancer genetics, new useful methods to compare large datasets using integrative methods are emerging. We utilized previously existing knowledge of chromosomal loss and gain in Head and Neck Squamous Cell Carcinoma (HNSCC) found from literature meta-analysis and previously published CGH high-definition array data in combination with the recent publication of the human cancer genome in Sjöblom et.al.s October 2006 Science paper. This approach will define candidate functional oncogenes activated by amplification or tumor suppressor genes inactivated by deletion. Gene targets were profiled using mRNA expression array on tissue. To validate areas of chromosomal loss/gain, we used qPCR of extracted tumor tissue DNA. Expression differences were demonstrated by quantitative RT-PCR of tumor tissue in a matched cohort with the DNA.

We found 20 genes that were in areas of amplification or deletion that overlapped with the cancer genome somatic mutants. Three were chosen for further study based on in silico genetic profiling: RUNX1T1 (acute myelogenous leukemia translocation 1), RFC4 (replication factor C 4), and DLEC1 (deleted in esophageal cancer isoform 1). 12 matched tumors DNA's and RNA's were studied for each gene in HNSCC. 6/12 (50%) of the tumors demonstrated amplification of the RUNX1T1 locus of greater than 4 copies, and 4 of those 6 (66.7%) demonstrated upregulated transcription of this gene. 5/12 (41.6%) of the tumors demonstrated amplification of the RFC4 locus of greater than 6 copies, and 2 of those 5 (40%) demonstrated upregulated mRNA transcription of the gene. 4/12 (33%) of the tumors demonstrated deletion in the DLEC1 locus (consistent with previously published 3p22 loss rates of 40%), and 3 of those 4 (75%) demonstrated marked reductions in mRNA expression of the gene. RUNX1T1 is a zinc finger transcription factor protein and a demonstrated oncoprotein in acute myeloid leukemia. RFC4 forms a complex with PCNA and is involved in DNA replication, DNA repair, DNA modification, and chromatin modeling. DLEC1 is a putative tumor suppressor involved in carcinogenesis of the lung, esophagus, and kidney. Using an integrative genomic approach, we were able to identify 20 candidate genes that may be involved in the tumorigenesis of HNSCC. We chose three of these genes based on mRNA expression profiling: DLEC1, RFC4, RUNX1T1 to demonstrate chromosomal deletion or amplification with concomitant change in mRNA expression.

## 74. EFFECTIVENESS OF SURGEON INTERPRETATION OF TC99M SESTAMIBI SCANS IN LOCALIZING PARATHYROID ADENOMAS

**Scott R Anderson MD;** Andrew Vaughn MD; Daniel Karakla MD; J. Trad Wadsworth MD, Dept of Otolaryngology-HNS, Eastern Virginia Medical School, Norfolk, VA

**Objectives:** This study evaluated the ability of surgeons to predict the laterality of parathyroid adenomas from technetium-99m sestamibi scans, and compared their results to radiology interpretations.

**Design:** Retrospective chart review with single blinded review of sestamibi scans.

**Setting:** Tertiary care academic medical center

**Patients:** 110 consecutive parathyroidectomy cases of two head and neck surgeons from January 2001 to June 2004. Inclusion criteria were biochemically proven primary hyperparathyroidism, with documented serum hypercalcemia and elevated parathyroid hormone levels. Only cases due to a single adenoma cured with a single surgery were included.

**Intervention:** All patients underwent resection of a parathyroid adenoma following a preoperative Tc-99m sestamibi localization study and serum calcium and parathyroid hormone level analysis. Adenoma removal was confirmed with frozen section pathologic examination and intraoperative PTH measurements at baseline and 15 minutes after removal.

**Main Outcome Measure:** Adenoma location was determined from review of operative and pathology reports. Two head and neck surgeons performed a blinded review of all scans, and their findings were compared to the radiology reports.

**Results:** 51 (61.2%) of 82 adenomas were correctly lateralized in the radiology report, while the other 31 were interpreted as normal scans. The sensitivity and specificity of the radiology interpretations for parathyroid adenomas in all primary hyperparathyroidism patients were 62.2% and 83.3%, respectively. The scan interpretation of the two surgeons produced accurate lateralization of 91.0% and 90.9% of these single adenomas. Of the 31 adenoma scans read as nonlocalizing by the radiologist, the surgeons correctly lateralized 22/29 (75.9%) and 21/28 (75.0%) of the adenomas.

**Conclusions:** Surgeon interpretation of sestamibi scans resulted in a higher localization accuracy of single adenomas when compared to the radiology reports, including scans read as nonlocalizing. The review of sestamibi scans by surgeons allows accurate localization of parathyroid adenomas that may not be identified by standard radiologic interpretations.

## 75. P16, P53, P63 PROTEIN AND DNA CONTENT AS PROGNOSTIC MARKERS FOR MALIGNANT TRANSFORMATION IN ORAL LICHEN PLANUS; A PILOT STUDY

**Gregory P Danielson MD;** Marcus Bosenberg MD; Robert A Sofferman MD, University of Vermont and Fletcher Allen Health Care

**Background:** Oral lichen planus (OLP) is a chronic inflammatory oral mucosal disease of unknown etiology. About 1% of patients with OLP will develop squamous cell carcinoma (SCC). Currently there is no way of identifying which patients with OLP are at risk of malignant degeneration.

**Research Questions:** 1. Are the tumor markers p16, p53 and p63 useful in identifying which patients with OLP are likely to develop malignancy? 2. Is the presence of alteration in DNA content (ploidy) useful in identifying which patients with OLP are likely to develop malignancy?

**Study Design:** Case control. Archived tissue specimens of 5 patients with biopsy proven OLP who developed cancer in the region of their OLP were compared to specimens of 40 patients with OLP that never developed a cancer.

**Methods:** Cases in which the pathologic diagnosis of OLP had been issued between January 1, 1996 and Dec 31, 2004 were identified. From this, archived tissue specimens of 5 patients with cancer that developed in the setting of OLP and 40 patients with OLP without evidence malignant transformation, were obtained. Immunohistochemical stains were applied to test for the presence of p16, p53 and p63 and evaluated in a blinded fashion. Laser scanning cytometry was used to analyze the specimens for alter-

ations in DNA content (ploidy). The results from the cases and controls were compared using fisher's exact test and Wilcoxon on p value.

**Results:** Patients who developed cancer had a greater degree of p53 cytoplasm staining than those that did not develop cancer ( $p=0.06$ ). Positive p53 nuclear staining and the absence of p16 cytoplasm staining showed promise as indicators for later development of cancer ( $p=0.14$  and  $p=0.13$ ). p63, p16 nuclear staining and DNA content analysis with laser scanning cytometry did not help to predict which patients would develop malignancy.

**Conclusion:** As a pilot study, this research suggests that the use of p53 and p16 staining in the histologic analysis of oral tissue specimens with lichen planus may provide useful clinical information in determining the risk of malignant transformation. Laser scanning cytometry to determine changes in DNA content and staining for p63 are not useful in predicting malignancy.

## 76. DECREASING SECONDARY SKIN GRAFT DONOR SITE MORBIDITY IN THE FIBULA FREE FLAP HARVEST

**Paul D Kim MD;** **Terry Fleck MSIV;** Ryan Heffelfinger MD; Keith Blackwell MD, Loma Linda, University Medical Center, University of California at Los Angeles Medical Center

Cancer involving the oral cavity is frequently treated with mandibular resection. The fibula osteocutaneous free flap for oromandibular reconstruction has many advantages, however the secondary wound from the donor site often requires skin grafting resulting in another wound site. The skin graft donor site is often a source of pain and discomfort during the healing time. In order to decrease the morbidity of a skin graft site, a series of 20 patients underwent harvest of the skin graft overlying the expected cutaneous paddle before commencement of the fibula flap harvest. After flap harvest, this skin was replaced over the donor site and sutured in the usual fashion. The flap is sutured into the oral/oropharyngeal defect with the skin paddle deepithelialized.

No patients had flap failure, skin graft take in these patients was 100%. Patients noticeably had earlier mucosalization of the intraoral and oropharyngeal flap. One patient with a large oropharyngeal and oral cavity defect needed a revision and intraoral skin graft due to adhesions that developed. One patient with a thin lower extremity had incomplete skin graft harvest of the expected skin paddle due to the curvature of the skin overlying the fibula and an addition skin graft was needed.

This technique does not change the outcome of free flap survival. Harvesting the skin graft site over the expected donor site skin paddle results in decreased lower extremity morbidity and good intraoral/oropharyngeal results. This technique should be considered when harvesting all fibula free flaps.

## 77. PROGNOSTIC FACTORS IN PATIENTS WITH MULTIPLE RECURRENCES OF WELL-DIFFERENTIATED THYROID CARCINOMA

**Theresa Holler MD;** Richard J Payne MD; Johnathan Clarke MD; Spiro Eski MD; Jeremy L Freeman MD, University of Toronto

**Introduction:** There is a large body of research directed towards the determination of prognostic factors following a diagnosis of well-differentiated thyroid carcinoma (WDTC). In a previous study, we found patients with multiple recurrent thyroid cancer to have markedly reduced disease specific and overall survival when compared to patients with either no recurrences or only one recurrence of their disease. It appears that patients with multiple treatment failures follow a poorer clinical course overall. However, the factors that affect outcome in this patient population have not been delineated. Thus, the purpose of the present investigation is to determine prognostic factors which would allow for better initial risk stratification in patients with multiple recurrences of WDTC.

**Methods:** All patients treated for more than one recurrence of WDTC were retrospectively identified from the thyroid cancer database at Mount Sinai Hospital, University of Toronto, Ontario (1963-2000). Data on patient and tumor characteristics, as well as the location and treatment of recurrences were collected. Each patient was scored with the use of the Metastasis, Age, Completeness of resection, Invasion, and Size (MACIS) index.

**Results:** A total of 31 patients with multiple recurrences were identified (11 male, 20 female; mean age 46 [range 16-83 yrs]). Histological diagnosis was papillary carcinoma in 19 (61.3%), tall cell variant in 5 (16.1%), follicular carcinoma in 4 (12.9%) and mixed in 3 cases (9.7%). According to TNM staging, 4 patients were stage I (12.9%), 8 were stage II (25.8%), 11 were stage III (35.5%) and 8 had stage IV disease (25.8%) at the time of diagnosis. Mean follow up time was 12.6 years (range 9 mo. to 35.48 yrs). Of the 31 patients with multiple recurrences, 10 were found to be dead of disease, 9 remained alive with no disease and 12 were alive with disease. Using univariate analysis, age >45, stage III or IV disease, distant metastasis, vascular invasion, MACIS score >6 and a time to recurrence of <12 months were found to be predictive factors for mortality.

**Conclusions:** Age >45 years, advanced stage of disease (TNM stage III or IV), presence of distant metastasis, angioinvasion and time to recurrence of <12 months were the most significant predictors of mortality among patients with multiple recurrences of WDTC. These patients follow a poor clinical course marked with multiple treatment failures and a substantial risk of mortality.

## 78. XRCC1 POLYMORPHISMS, DIETARY FOLATE INTAKE, AND RISK OF SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK

**Jonathan R George BA;** Andrew F Olshan PhD; Mia M Gaudet PhD; Mark C Weissler MD, University of North Carolina - Chapel Hill

**Background:** Genetic variation in DNA repair enzymes may play a role in determining genetic susceptibility to head and neck cancer. Specifically, X-ray repair cross-complementing group 1 (XRCC1) encodes a protein involved in the base-excision DNA repair pathway. Folic acid may be involved in modifying DNA repair processes. Prior studies have not investigated the relationship between single-nucleotide polymorphisms (SNPs) in XRCC1, dietary folate intake, and the risk of squamous cell carcinoma of the head and neck (SCCHN).

**Methods:** We examined the role of dietary folate intake and its interaction with SNPs in XRCC1 (194 Arg/Trp, 399 Arg/Gln) and the risk of SCCHN in a hospital-based case-control study in North Carolina. Food frequency questionnaires were administered to cases (n=182) and age- and gender-matched controls (n=202). XRCC1 genotypes were obtained from polymerase chain reaction-restriction fragment length polymorphism (PCR-RFLP) assays performed on extracted blood samples. Epidemiologic analysis using SAS (version 9.0) was used to estimate odds ratios (O.R.) and 95% confidence intervals (C.I.) for the independent and joint effects of folate intake and XRCC1 genotype on SCCHN carcinogenesis.

**Results:** Those persons with low dietary folate intake (<303.5 mcg/day) had a slightly increased risk of SCCHN (adjusted O.R. = 1.37, C.I. = 0.78 - 2.39), while those individuals in the top quartile of folate intake had a reduced risk of SCCHN (adjusted O.R. = 0.68, 95% C.I. = 0.3 - 1.55). 399 Arg/Gln and 399 Gln/Gln genotypes were found to reduce SCCHN risk in the context of increased dietary folate intake (O.R. = 0.76, C.I. = 0.40 - 1.45; and O.R. = 0.04, C.I. = 0.01 - 0.024, respectively). The 399 Gln/Gln genotype in particular significantly reduced SCCHN risk among subjects with lower dietary folate intake (O.R. = 0.02, C.I. = 0.001 - 0.27).

**Conclusions:** These findings provide evidence for an increased risk of SCCHN carcinogenesis in the context of dietary folate deficiency and suggest that XRCC1 399 Gln/Gln and 399 Arg/Gln genotypes may surprisingly decrease SCCHN risk in the context of increased dietary folate intake. There appears to be little interaction between XRCC1 genotype and folate deficiency in the development of SCCHN. Future studies which comprehensively evaluate DNA repair genotypes in the context of dietary folate deficiency will permit biologic interpretation of these epidemiologic findings.

## 79. LATISSIMUS-SERRATUS-RIB FREE FLAP FOR OROMANDIBULAR AND MAXILLARY RECONSTRUCTION

**Paul D Kim MD;** Keith Blackwell MD

Loma Linda University Medical Center, University of California at Los Angeles Medical Center

**Objective:** To review complications and outcome associated with latissimus-serratus-rib free flap oromandibular and midface reconstruction.

**Design:** Retrospective medical record review.

**Setting:** Two academic tertiary care medical centers

**Patients:** Twenty-eight patients with segmental resection of the mandible and one patient with combined resection of the mandible and maxilla after excision of neoplasms of the oral cavity whom were felt to be poor candidates for fibula free flap reconstruction were identified.

**Interventions:** Twenty-seven latissimus-serratus-rib osteomusculocutaneous free flaps and two serratus-rib osteomuscular free flap were performed.

**Main outcome Measures:** The outcome of microvascular free tissue transfer as well as short and long term complications were recorded.

**Results:** There were no perioperative free flap failures. Delayed partial rib graft resorption occurred in one patient 33 months after free flap transfer for maxillary reconstruction. Among 28 cases of mandibular reconstruction, there was one case of bone graft nonunion was noted after a postoperative period of 57 months. All other cases achieved successful restoration of mandibular continuity. Donor site morbidity was well tolerated in all patients.

**Conclusions:** Latissimus-serratus-rib osteomusculocutaneous free flaps are effective for reconstruction of composite defects of the mandible in patients whom are not candidates for more commonly used vascularized bone-containing free flaps.

## 80. NASOPHARYNGEAL CARCINOMA IN PATIENTS WITH ECTODERMAL DYSPLASIA

**Shamir P Chandarana MD;** John Yoo MD, University of Western Ontario, London Health Sciences Centre - London, Ontario, Canada

**Background:** Ectodermal Dysplasia (ED) results from the abnormal morphogenesis of embryonal ectoderm. Head and neck manifestations of ED are well documented and include lack of mucous/sweat glands and abnormalities in dentition and hair growth. Nasopharyngeal Carcinoma (NPC) can be linked to both genetic and environmental factors. Prognosis in the general population is 50-70% five year survival with adequate treatment.

**Objectives:** To draw associations and provide considerations for patients diagnosed with NPC in pre-existing ED.

**Methods:** Retrospective chart review.

**Results:** Two patients with ED diagnosed with NPC (AJCC Stage I and IIa respectively) were reviewed. Both received concurrent curative chemotherapy and radiotherapy. Both had very quick deterioration of their NPC and died from metastatic disease. In addition, one of the patients suffered significant side-effects of therapy, likely related to pre-existing ED. Possible theories accounting for rapid deterioration in this unique patient population are discussed.

**Conclusion:** We document the first two cases where both ED and NPC co-exist. This report suggests less successful treatment outcome in this group of patients. Significant side-effects from therapy should be anticipated.

## 81. COMPUTER IMAGE-GUIDED SURGERY FOR TOTAL MAXILLECTOMY

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**Background:** In total maxillectomy, the entire upper jaw including tumor is freed and removed en bloc from the facial skeleton with accuracy, depending on the situation of the tumor. Computer image-guided sinus surgery has become popular these days. Computer interactive imaging is clearly helpful with regard to ori-



entation during surgical procedures. However, the usefulness of this system for head and neck surgery is still controversial. This study evaluated the significance of this system in total maxillectomy.

**Patients and Methods:** Five patients with maxillary sinus neoplasm (3 squamous cell carcinoma, 1 adenoidcystic carcinoma, 1 leiomyosarcoma) were operated with the use of navigation system (StealthStation, Medtronic). The head set was used for anatomic registration during the preoperative CT scan and surgical procedure as in the case of endoscopic sinus surgery.

**Results:** Registration took 10.2 minutes (range: 10-12 minutes) on an average. The average of accuracy in this series was 0.95 mm (range: 0.6-1.19). Computer imaging system provided the desired level of accuracy until the end of the resection in all cases. Navigation system helped us to confirm anatomical location and decide extent of removal in real-time. Especially it was useful when the zygoma, the frontal process, the orbital floor and the pterygoid process were divided. All patients are alive without disease despite the follow up period is short (3-41 months, median 12 months).

**Conclusions:** Computer interactive imaging was significantly useful to recognize the target points accurately in real-time. As a result, it helps surgeons determine the minimum and accurate bone resection line and enter more straightly to the lesion. We must understand 3-D anatomical understanding and decide adequate extent of removal, depending on the situation of the tumor. Navigation system plays a supplementary role in total maxillectomy. Moreover, it has the potential to help reducing the skin incision and the extent of removal, ensuring the oncological safety.

## 82. NEOADJUVANT CHEMO-SELECTION OF PATIENTS FOR ORGAN PRESERVATION IN ADVANCED LARYNGEAL CANCER: FAILURE OF CHEMOTHERAPY AS DEFINITIVE TREATMENT FOR COMPLETE RESPONDERS TO NEOADJUVANT THERAPY

Francis P Worden MD; Gregory T Wolf MD; Avraham Eisbruch MD; Julia Lee MS; Carol R Bradford MD; Douglas Chepeha MD; Theodoros Teknos MD; Mark Prince MD; Norman Hogikyan MD; Christina Tsien MD; Susan G Urba MD; Thomas Carey PhD; **Amy A Lassic, MD**, University of Michigan Comprehensive Cancer Center

**Background:** We conducted a phase II organ preservation trial for stage III/IV laryngeal cancer (LC) patients (pts) in an attempt to identify pts, who were complete histologic responders (CHR) following 1 cycle of induction chemotherapy (CT), that might be curable with chemotherapy alone.

**Methods:** Pts received 1 cycle of cisplatin 100 mg/m<sup>2</sup> & 5-FU 1000 mg/m<sup>2</sup>/day x 5 days (P+5FU). Pts with 100% response (HCR) received 1 cycle of P+5FU, followed by weekly docetaxel (D) 35 mg/m<sup>2</sup> x 3 wks, followed by 1 cycle of P+5FU. Pts with >50% (but < 100%) response (PR) received chemoradiation (CRT) with 70 Gy & P 100 mg/m<sup>2</sup>, days 1, 22, & 43. Pts with < 50% response underwent laryngectomy. Final planned tumor assessment with direct laryngoscopy with biopsy was performed 8 wks after CRT or 3 wks after the last cycle of P+5FU (CT alone arm). Pts with HCR after CT alone received 2 cycles of P+5FU alternating with 2 cycles of D. Pts with HCR after CRT received 2 cycles of P+5FU, & pts with residual disease had planned salvage surgery.

**Results:** 32 eligible pts were enrolled, 24 M; 8 F; median age 56, stage III/IV- 7/25. After 1 cycle CT, 4 pts (13%) had HCR & received CT alone; 24 (75%) had PR & received CRT; 3 had surgery; & 1 refused surgery. Of pts who had CT alone, 4/4 had regional failures; 3/4 underwent neck dissection & 1/4 had laryngectomy & neck dissection; all had adjuvant RT because of multiple nodes or extracapsular spread; 3/4 are alive without disease & 1/4 is dead of complications. 5/24 who received CRT failed; 2/24 had surgery & 3/24 were unresectable.

**Toxicity:** Gr 3/4 granulocytopenia 19%, Gr 3/4 mucositis with CT alone 12.5%. Median follow-up is 16.5 months. 1 yr overall survival (OS) is 93.4% (95% CI = 84.6%, 100%). 2 yr OS is 88.2% (95% CI = 75.3%, 100%). 1 yr disease-free survival (DFS) is 81.8% (CI=67.2%, 96.5%). 2 yr DFS is 76% (CI=58.4%, 93.5%). The proportion of pts alive & free of cancer with intact larynx at 1 yr is 69.1% (CI = 51.9%, 86.3%) & at 2 yrs is 63.8% (CI=45%, 82.5%). 1 pt developed distant metastases. Larynx preservation was

achieved in 24 pts (75%).

**Conclusions:** CT alone is not an effective strategy for advanced LC in complete responders to induction CT. CT alone is associated with a high failure rate in regional nodes. Planned integration of early regional control by surgery or RT may be necessary to allow CT only treatment approaches that spare patients radical RT.

## 83. IN VIVO IMAGING OF PRIMARY RECURRENCE AND CERVICAL LYMPH NODE METASTASES IN AN ORTHOTOPIC NUDE MOUSE MODEL OF SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK

**Maher N Younes MD**; Ge Zhou PhD; Samar A Jasser BS; Jeffrey N Myers MD, University of Texas M.D. Anderson Cancer Center

There has been no significant improvement in the survival of patients with squamous cell carcinoma of the head and neck for the past three decades. Recurrences in the primary site as well as regional (cervical lymph nodes) and distant (lung) metastases comprise the majority of cases that fail original treatment. The lack of a mouse model that can faithfully recapitulate the natural behavior of SCCN has hindered our understanding and ability to address this problem. We have generated an orthotopic mouse model of SCCN whereby we stably transfected a highly metastatic cell line OSC19 with the luciferase gene. When injected in the tongue of athymic nude mice, it forms a tumor that readily metastasizes to the cervical lymph nodes. In addition, when mice are injected with luciferin, both the tumor and the metastatic foci can be readily imaged and quantitated. Furthermore, we have adapted a surgical technique where we partially or completely remove the primary tumor by performing partial glossectomy. This model will help us address the different mechanisms involved in SCCN recurrences as well as the molecular aspects involving lymph nodal metastases. Furthermore, this model is useful for studying the impact of novel therapeutic strategies in the setting of minimal residual disease.

## 84. MUCOSAL MELANOMA; THE EMORY EXPERIENCE

**JN Mclean MD**; Chen Amy MD; Muller Susan MD, Emory University

**Objective:** to review all cases of head and neck mucosal melanomas (HNMM) treated at Emory University during a 20 year period and evaluate their outcomes.

**Materials and Methods:** A retrospective review of medical records of 30 cases of HNMM treated at Emory University between 1986 and 2006 was performed. Medical records, operating reports, radiation therapy records and pathologic material were reviewed. Comparison was performed between each group.

**Results:** A total of 30 cases of HNMM (oral (8) and sinonasal (22)) were identified and analyzed. Thirteen patients were stage I (46%), 9 patients were stage II (32%) and 6 patients were stage III (21%). Mean age was 67.8 years. The median follow up was 18.3 months.

Patients with sinonasal melanomas had a lower incidence of nodal metastasis at initial presentation when compared with those with oral cavity lesions (23.8 vs. 50%) (p<.05). Surgery was performed in 28/30 patients (93%). Two patients because of advanced stage at diagnosis had no treatment. Radiation was used in 50% (15) of the patients and radiation as postoperative therapy was administered to 43% (13) of the patients. The combination of surgery, radiation and adjuvant therapy was administered to 33% (11/30) of the patients. The recurrence rate was 43% (13 patients) with a mean time of 13.7 months. Twenty-one patients (70%) died.

The overall survival mean time was 21 months. The 1 year survival rate was 60%, 2 year survival rate was 29% and the 5 year survival was 8%. The 2 patients still alive after 5 years had oral cavity tumors. Survival time did not correlate with stage, surgery or adjuvant therapy.

**Conclusions:** Mucosal melanoma of the head and neck is a rare entity. Unfortunately, most patients present with advanced local disease. Local, regional recurrences and distant metastasis still occur despite of an aggressive treatment, including surgery, radiation and adjuvant therapy.



## 85. FREE TISSUE TRANSFER RECONSTRUCTION OF THE HEAD AND NECK IN A VA POPULATION

Larry L Myers MD; **Robert J Defatta MD**; Abu Minhajuddin PhD, The University of Texas Southwestern Medical Center

**Objective:** The aim of this study is to retrospectively review consecutive patients undergoing free tissue transfers for head and neck reconstruction performed by a single academic department at the Dallas VA Hospital.

**Methods:** The study period was between 1July2000 and 30September2006. We reviewed the medical records of 55 patients that underwent 57 free tissue transfers in the head and neck region. Data were collected for age, comorbid conditions, prior history of chemotherapy and/or irradiation therapy, vessel anastomosis details, harvest and ischemia times, type and dimensions of flap, major and minor intraoperative and perioperative complications, estimated blood loss, intensive care unit (ICU) length of stay and total hospital stay.

**Results:** The overall success rate was 93% (53 of 57 flaps). Clinical factors significantly affecting flap survival were: flap type ( $p = 0.01$ ); amount of intraoperative crystalloids administered ( $p = 0.03$ ); and presence of major postoperative complications ( $p = 0.002$ ). Nine different types of flaps were used. The average cutaneous flap area was 119.8 cm<sup>2</sup>. For the 10 (18%) procedures with an osseous component, the average bone length was 7.5 cm. Major and minor complications occurred in 9 (16%) and 18 (32%) of the flaps, respectively. Average ICU and hospital stay were 7.4 days and 16.0 days, respectively.

**Conclusions:** Free tissue transfer in the VA population can safely be performed with excellent flap success rates, complication rates and hospital days that are similar to non-VA populations. When performing free tissue transfers on this patient population, care must be taken to minimize intraoperative fluid administration and postoperative major complications.

## 86. MANAGEMENT OPTIONS FOR MUCINOUS ECCRINE ADENOCARCINOMA OF THE HEAD AND NECK

**Peter O'Connor MD**; Etai Funk MD; Jason Nash MD; Gary Clayman MD, M.D. Anderson Cancer Center, Walter Reed Army Medical Center, and Baylor College of Medicine

Mucinous eccrine adenocarcinoma is a rare neoplasm of the skin that originates deep within a sweat gland. The tumor typically presents as a solitary, flesh colored lesion of the adnexa with an indolent growth pattern but may also be locally aggressive. The majority of cases reported in the literature arise in the head and neck region with a propensity toward the periorbital region. Widespread metastasis can occur but local recurrence of up to 50% is more typical. We present a case of primary mucinous eccrine adenocarcinoma originating in the submental region of a 59-year-old female with a prior history of other benign skin lesions.

Management of this rare tumor begins with proper workup and pathologic analysis. Establishing the diagnosis includes ruling out metastatic disease from elsewhere in the body. Immunohistochemical staining may play a role in determining the origin and character of the tumor helping to differentiate it from other more common breast or colon primaries. Treatment primarily involves surgical resection but because of the propensity for recurrence, adjuvant therapies may play a role. Pathologic and immunohistochemical images will be presented. In addition, a review of the literature to examine reported rates of recurrence, the recommended work-up and treatment options will be discussed including the role for positron emission tomography and post-surgical radiation therapy as was used in this patient.

## 87. TUMORS OF THE CERVICAL SYMPATHETIC CHAIN

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**Introduction:** We are presenting the largest series of tumors of the cervical sympathetic chain in the literature to date. The purpose of this paper is to discuss the demographics, presentation, diagnosis, surgical management and the post-operative sequela of treating these tumors.

**Methods:** After obtaining IRB approval a retrospective review of the medical records of all patients in our parapharyngeal space tumor database from 1986 to 2006 were reviewed. Twenty-one patients were found to have tumors of the cervical sympathetic chain. Eighteen of the twenty-one patients had complete records for further analysis.

**Results:** The median age was 46 with a range of 25 to 79 years. There were 8 males and 10 females. The most common presenting complaint was that of a neck mass (9/18), and nine patients (9/18) were found to have Horner's syndrome on physical exam at the time of presentation. Radiographic imaging revealed anterior-lateral displacement of the carotid artery in all patients, supporting the diagnosis of a sympathetic tumor preoperatively.

Seventeen patients elected for surgical resection, and one patient because of age and co-morbidities was observed. A trans-cervical approach was used releasing the stylomandibular ligament when necessary for exposure. In all cases the vagus and superior laryngeal nerves were found lateral to the tumor, which was originating from the cervical sympathetic chain. The two most common pathologies identified were schwannomas ( $n=10$ ) and paragangliomas ( $n=7$ ). The average length of stay was 2.9 days (range 1 to 5 days). Complications included two patients having an immediate vocal cord paresis. Another patient had a temporary weakness of cranial nerves seven and twelve with complete recovery.

**Conclusion:** Tumors of the cervical sympathetic chain are a rare occurrence. They most commonly present as a neck mass, and are frequently misdiagnosed preoperatively. These tumors typically result in anterior-lateral displacement of the carotid artery unlike the more common vagal tumors that result in anterior-medial displacement. The trans-cervical approach is preferred because it allows excellent access to the parapharyngeal space and skull base with minimal morbidity to the patient. None of our patients required a transmandibular approach even for large tumors (>6cm), and transecting the stylomandibular ligament allowed for greater exposure when necessary.

## 88. EFFECTIVENESS OF SELECTIVE NECK DISSECTION IN THE TREATMENT OF THE CLINICALLY POSITIVE NECK

**Rajan S Patel MD**; Christopher J O'Brien MD; Marc Dom MD; Kan Gao MSc; Jonathan R Clark MD, Sydney Head & Neck Cancer Institute, Royal Prince Alfred Hospital & University of Sydney, Australia

**Introduction:** The management of head and neck cancer continues to evolve with therapies becoming increasingly targeted, allowing preservation of function without compromising effectiveness. The aim of this study was to analyse whether those treated with therapeutic selective neck dissections (SND) were disadvantaged compared to those undergoing comprehensive procedures.

**Methods:** This retrospective cohort study analyzed patients whose clinicopathological details had been entered prospectively onto our database. Inclusion criteria included: previously untreated patients, clinical evidence of metastatic cervical SCC, minimum two years follow-up.

**Results:** A total of 208 patients were analysed (170 males, 38 females; median age 60 years). Primary sites included: oral cavity ( $N=70$ ), oropharynx ( $N=72$ ), hypopharynx ( $N=46$ ), larynx ( $N=20$ ). N2 or N3 disease was recorded in 130 patients. A total of 229 neck dissections were carried out - 82 radical (RND), 79 modified radical (MRND) and 68 SND. Post-operative radiotherapy was given to 85% of patients. Median number of histologically positive nodes was 3 (range 0-20) for RND, 2 (range 0-55) for MRND and 2 (0-30) for SND.

Ipsilateral neck recurrence, with primary site controlled, occurred in 12% of RND, 10% of MRND and 3% of SND patients. Patients treated by SND had a significantly better survival than those treated with RND, reflecting the fact that those having the more aggressive neck surgery had more extensive disease.

**Discussion:** These results indicate that, in selected patients, SNDs can be used to effectively treat clinical metastatic squamous carcinoma in the neck. All operations, RND, MRND and SND are limited by the presence of multiple positive nodes and extra capsular spread and adjuvant radiotherapy is recommended in that setting.

## 89. ENDOSCOPIC CO2 LASER FIBER SURGERY FOR SINUS AND SKULL BASE LESIONS

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**Objectives:** To describe the use of an emerging technology in laser surgery for management of sinus and skull base lesions. A new CO2 laser fiber has been used in combination with endoscopic instrumentation. The ability of this new system to overcome the limitations of the traditional "line of sight" laser beam surgery was assessed.

**Patients and Methods:** Ten consecutive patients with sinus and skull base lesions were managed with endoscopic flexible CO2 laser surgery. Demographics, pathology, intraoperative technique, and final histology were evaluated.

**Results:** 3 patients had malignant tumors; 3 patients had benign tumors; 2 patients with recurrent tumors (1 juvenile angiofibroma and 1 inverted papilloma); 2 patients had mucocele with intracranial extension. Surgical goals were achieved in all cases and no complications were noted. The surgeons report ease of use and enhanced maneuverability compared to the traditional laser beam. The surgeons were especially satisfied with the ability of the system to cut "around the corner" and, with the use of an angled guide, to perform tissue removal and cutting in a posterior-to-anterior direction.

**Discussion / Conclusions:** While the CO2 laser energy described herein does not have additional "magical" therapeutic or oncologic properties, its novel delivery system allows the surgeon ease of use and increased maneuverability. Coupling this technology with endoscopic instrumentation has allowed us to work comfortably within the tight structures of the sinuses and skull base. In addition, since no electrical energy is used, it is possible to work close to the dura and the optic nerve.

## 90. RECONSTRUCTION OF PAROTIDECTOMY DEFECTS WITH DERMAL FAT GRAFTS

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**Objectives:** To examine the use of free dermal fat grafts in (FDFGs) in the reconstruction of soft tissue contour defects associated with parotidectomy.

**Methods:** Retrospective chart review of patients undergoing parotidectomy for benign and malignant parotid lesions with FDFG reconstruction. All patients underwent superficial or total parotidectomy with reconstruction with FDFG. Extirpated parotid tissue was measured, and an equivalent FDFG was harvested from the abdomen with an oblique incision, accounting for tumor volume. The epidermis was removed in-situ using a fine-tip electrocautery. The graft was secured using absorbable sutures. Charts were reviewed for patient satisfaction, length of hospitalization, post-operative complications, facial nerve function, and presence of Frey's syndrome.

**Results:** Twenty five patients underwent ablative parotid surgery with FDFG during the study period. Twenty two patients were followed for a minimum of three months after surgery. Fifteen patients were females. Nine patients underwent total parotidectomy, and 13 underwent superficial parotidectomy. Neck dissection was performed in nine patients. Mean follow up was 7.2 months with a range of 3 to 12 months. One patient experienced post-operative fat necrosis with drainage, which was treated with observation and prophylactic antibiotics. After radiation therapy, the same patient developed a delayed infection of the graft 8 months post-operatively, which was treated with oral antibiotics. No other complications related to the grafts were encountered. All patients and physician ratings of cosmesis were good to excellent. Volume retention of the dermal fat grafts was excellent. No patients experienced donor site complications, epithelial cysts, prolonged hospitalization or Frey's syndrome.

**Conclusions:** FDFG is a safe and effective method of soft tissue contour reconstruction in selected patients undergoing superficial and total parotidectomy.

## 91. THE ROLE OF ULTRASOUND-GUIDED FINE NEEDLE ASPIRATION OF THYROID NODULES PERFORMED IN THE OFFICE SETTING

Kristin A Seiberling MD; Jose C Dutra MD, Northwestern Memorial Hospital

**Introduction:** It has been shown that ultrasound (US) scan may be used to guide the FNA of a thyroid nodule to improve specimen adequacy. Generally this is done by a radiologist. This is however, inconvenient to the patient, delays time of diagnosis and incurs additional cost. The same procedure may be done in the referring physician's office if an ultrasound machine is available and the physician is trained in the procedure.

**Objective:** To evaluate the accuracy and specimen adequacy of thyroid FNAs performed in the office under US guidance by one senior Otolaryngologist.

**Methods-** Retrospective chart review of 119 patients who underwent ultrasound guided (USG) FNA of the thyroid gland between 9/2005-10/2006 in the office setting. An US-guided FNA of the thyroid gland was performed in the office by one senior Otolaryngologist (J.D.). Specimens were reviewed onsite at the time of biopsy for cellular adequacy by a cytotechnologist.

**Results:** One hundred and nineteen patients, 106 females and 13 males, underwent USG-FNA of the thyroid gland. A total of 181 FNA biopsies were performed. One hundred and thirty-nine were satisfactory specimens (77%), 27 were unsatisfactory (15%) and 15 (8%) were limited due to blood clotting. Of the FNA specimens that had enough cells to evaluate, 105 were negative for malignancy (colloid cyst, hyperplastic adenoma, adenomatous nodule, chronic lymphocytic thyroiditis), 27 were indeterminate for malignancy (follicular nodule, Hurthle cell nodule, papillary cells) and 12 were positive for malignancy (papillary carcinoma). Eighty-three nodules were considered non-palpable (less than 1.5cm) and 98 nodules were greater than 1.5 cm (average size 2.46cm). Seventy-nine patients had only a single nodule biopsied. In 42 patients, multiple biopsies were taken, either from both sides of the gland or multiple nodules on a single side.

**Discussion:** The availability of an office US machine allows the referring physician to perform a service that is normally done in a different department. This saves both time and money to the patient and physician. In addition, it allows the referring physician to more thoroughly evaluate the thyroid gland, take biopsies of multiple nodules and sample non-palpable nodules.

**Conclusion:** This study shows that a trained physician may perform and USG-FNA of the thyroid gland in the office with results comparable to interventional radiology.

## 92. IMMUNOHISTOCHEMICAL EXPRESSION PATTERN OF SODIUM IODIDE SYMPORTER, GLUCOSE TRANSPORTER-1, HEXOKINASE TYPE I, II IN THYROID GLAND MALIGNANCIES AND METASTATIC CERVICAL LYMPH NODES

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**Introduction:** Sodium iodide symporter (NIS) is a protein which is related with active uptake of iodide at thyroid gland. NIS overexpression of thyroid tumors is associated with high differentiation, good prognosis, positivity on radioiodine scan. Meanwhile, glucose transporter-1 (Glut-1) and hexokinase I, II, which related with intracellular migration and phosphorylation, respectively, are associated with poor differentiation, bad prognosis, fluorine-18-fluorodeoxyglucose (FDG) uptake on positron emission tomography (PET) in thyroid tumors. The aim of this study was to see immunohistochemical expression pattern of NIS, Glut-1, hexokinase I and II in thyroid carcinomas with synchronous lymph node metastasis.

**Materials and Methods:** Thyroid malignant tumors and metastatic lymph nodes were immunostained. Forty eight specimens from 29 patients were included and there were 19 primary tumors matched with metastatic lymph nodes.

**Results:** Except for Glut-1, the other markers had homogenous staining. NIS showed a tendency of stronger staining in metastatic lymph nodes than in primary tumors, while the other markers did in primary tumors. Except for Glut-1, the other markers

showed no significant difference of staining intensity between primary tumors and metastatic lymph nodes. NIS showed more frequent positive staining in follicular carcinomas than anaplastic carcinomas, while hexokinase I did in anaplastic carcinomas than in follicular carcinomas. NIS had inverse relation with hexokinase I rather than Glut-1 in staining intensity.

**Conclusion:** NIS showed more frequent expression in good prognostic type of thyroid carcinomas like follicular carcinomas, while showing less frequent expression in poor prognostic type like anaplastic carcinomas, and hexokinase I had the reverse expression pattern. NIS and hexokinase I showed no significant difference in staining intensity between primary thyroid tumors and metastatic cervical lymph nodes and NIS and hexokinase I showed reciprocal staining intensity pattern at primary tumors. Therefore, if one knows expression pattern of NIS and hexokinase I at primary thyroid tumors, it is possible to predict more exactly the chances of the uptake and the response of the tumor to radioiodine therapy and that would be useful to determine the radicality of surgical treatment over cervical lymph nodes.

### 93. EFFECT OF COMBINATION OF ORAL TARCEVA AND FUSARIC ACID ON THE GROWTH OF HEAD AND NECK SQUAMOUS CELL CANCER IN VIVO

**Yeumeng Dai MD;** Brett M Clarke MD; Jennings R Boyette BS; Brendan C Stack, Jr. MD, University of Arkansas for Medical Sciences

Head and neck squamous cell carcinoma can be poorly or transiently responsive to single agent chemotherapy. In order to determine whether the combination of oral agents Tarceva (EGFR tyrosine kinase inhibitor) and fusaric acid inhibit HNSCC cell growth in vivo, twenty-three 5-week old male athymic nude mice were subcutaneously injected with  $2 \times 10^6$  UMSSC-1 cells in the left flank and then randomly assigned to two groups. Mice ( $n=11$ ) in the treatment group were transorally gavaged once daily with 0.1 mL of Tarceva (8mg/mL) and 0.1 mL of fusaric acid (2.5mg/mL), while those ( $n=12$ ) in the control group with the same amount of sterile saline. Tumor size was measured daily and day zero was designated once the tumor volume reached 5 mm<sup>3</sup> in at least 50% of the control-group mice. After Day zero, the tumor size was measured twice weekly. Mice were sacrificed at Day 40 and the tumor weight was recorded. Tumor volume analysis showed that the mice receiving combination Tarceva and fusaric acid demonstrated significantly slower tumor growth rates after Day 18, compared to the control-group mice ( $p = 0.03$ ). At the conclusion of the experiment on Day 40, the average tumor volume in the control group is 4.4-fold larger than those in the treatment group ( $p = 0.017$ ) and the average tumor weight in the control group is 0.8g, whereas it is 0.27g in the treatment group ( $p = 0.024$ ). CD34 staining showed that there are significantly fewer blood vessels (anti-CD34 positive) in tissue sections of treatment-group tumors compared with control-group tumors (average micro-vessel density:  $9.7 \pm 3.0$  /field vs  $17 \pm 4.4$  /field,  $p = 0.006$ ). Terminal transferase dUTP nick end labeling assay (TUNEL) on all tumor sections showed few tumor cells underwent apoptosis in either group and there is no significant difference between these two groups. These findings suggest that the combination of oral Tarceva and fusaric acid can strongly inhibit HNSCC cell growth in vivo, which may be partly attributed to the inhibition of angiogenesis, but is likely independent of apoptosis.

### 94. AN UNUSUAL PRESENTATION OF A LARYNGEAL GRANULAR CELL TUMOR

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**Educational Objective:** At the conclusion of this presentation, the participant should understand the differential diagnosis, histological findings, natural history, management and prognosis of a laryngeal granular cell tumor.

**Introduction:** Mass lesions of the larynx are commonly encountered during routine clinical practice. Most often they are lesions such as nodules, cysts, polyps, granulomas, and carcinomas. These abnormalities most commonly present as hoarseness, although, they can present with more worrisome complaints such as dyspnea, hemoptysis, and stridor. We report a case of a patient who presented with progressively worsening "asthma"

which slowly developed into inspiratory stridor. After years of asthma treatment the patient presented to the otolaryngology service and was found to have massively redundant arytenoid mucosa bilaterally which was causing a ball-valve effect in her larynx resulting in dyspnea and inspiratory stridor. Operative direct laryngoscopy with CO<sub>2</sub> laser excision of this mucosa resulted in a diagnosis of a laryngeal granular cell tumor. We will discuss the case as well as the differential diagnosis, histological findings, natural history, management options, and prognosis of granular cell tumors.

**Conclusion:** Massive mucosal hyperplasia of the larynx can be an unusual presentation of a laryngeal granular cell tumor

### 95. CLINICAL OUTCOME STUDY OF WELL-DIFFERENTIATED THYROID CANCER INVADING THE AIRWAY

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**Objective:** The overall prognosis for thyroid neoplasia is excellent with morbidity and mortality being quite low; however, there is a group of patients with locally invasive airway disease in whom management is more complex and for whom the disease is more morbid. This study is done to report characteristics of thyroid cancer invading the airway and present morbidity and mortality data as well as describe our treatment.

**Design:** Retrospective chart review

**Setting:** Tertiary care referral center

**Materials and Methods:** We conducted a retrospective chart review of patients with thyroid cancer treated at the University of North Carolina Memorial Hospital between October 31, 1987 and November 20, 2006. Patients included in the study were those patients with well-differentiated primary thyroid carcinoma with invasion of the larynx or trachea. For each case that met these criteria, the following information was collected: demographic characteristics; thyroid cancer type including invasion site; surgeries and/or treatments provided, and morbidity and mortality information. Mean and median survival is reported and Kaplan-Meier curves are constructed.

**Results:** Of the 752 cases of thyroid cancer seen at UNC Memorial Hospital between 1987 and 2006, 18 (2.4%) were found to invade the airway. Three of these patients had medullary or anaplastic variants of thyroid cancer and so were excluded from this study. Overall survival was 46.7% in patients with well-differentiated thyroid cancer invading the airway, with a mean follow up time of 57 months. The thyroid tumor recurred in 60% of all cases at an average of 38 months after primary diagnosis. Of the cases identified, the thyroid cancer involved invasion of the trachea (6), the larynx (2), the larynx and trachea (4), and the trachea and esophagus (3).

**Conclusion:** Invasion of the airway by well-differentiated thyroid cancer is a rare occurrence but survival and local disease control is clearly achievable with appropriate surgical treatment. Overall survival in our study was 47% with a 60% recurrence rate. Knowledge of outcomes and treatment planning of locally invasive thyroid cancer is necessary for future improvements in patient care.

### 96. MOLECULAR AND BIOMARKER CLASSIFICATION OF UNDIFFERENTIATED SKULL BASE AND PARANASAL SINUS NEOPLASMS

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**Introduction:** The paranasal sinus and skull base region give rise to a diverse range of neoplasms which share overlapping morphologic features and, consequently, present challenging diagnostic dilemmas. Specifically, the undifferentiated "small round blue cell tumors" require expertise and ancillary immunohistochemical evaluation for optimum classification. As more molecular signatures are discovered, incorporation of auxiliary tests may aid in the diagnosis of this complex anatomic region. The advent

of multimodality treatment and targeted therapy demands accurate classification and diagnosis of these tumors.

**Methods:** Fifty-one fresh and 61 paraffin tissue samples available at the University of Texas M.D. Anderson Cancer Center from 1991-2006 formed the basis of this study. Tumors comprised Ewing's sarcoma, rhabdomyosarcoma, melanoma, and poorly-differentiated neuroendocrine tumors and carcinomas from the sinonasal region. mRNA transcripts for EWS/FLI-1 fusion gene and the hASH1 gene were performed on fresh tissue. Immunohistochemical analysis for cytokeratin 7, desmin, myogenin, CD99, CD56, synaptophysin, chromogranin, S100, pan-melanoma markers, neurofilament, OCT3/4 and p63 was performed on paraffin sections.

**Results:** The EWS/FLI-1 fusion gene transcript was detected in 4 of 11 (36.3%) Ewing's sarcoma samples and was not detected in any other tumor types. The hASH1 gene transcript was detected in all esthesioneuroblastomas and neuroendocrine carcinomas, one sinonasal undifferentiated carcinoma, and in no other tumor types. Immunohistochemical analysis supported the phenotypic diagnosis and molecular results.

**Conclusion:** Paranasal sinus and skull base undifferentiated tumors can be categorized through a combined set of immunohistochemical markers and supplanted, in rare occasions, with molecular analysis. In addition, the hASH1 gene transcript is shown to be a sensitive and specific marker for tumors of neuroendocrine differentiation.

## 97. TRANSNASAL, TRANSFACIAL ANTERIOR SKULL BASE RESECTION OF OLFACTORY NEUROBLASTOMA

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**Objective:** Using a trans-nasal, trans-facial, microscope assisted anterior skull base approach, we have removed olfactory neuroblastomas obviating the need for a frontal craniotomy. The objectives were: to investigate whether this approach can achieve clear margins, to assess patient survival, and to recommend eligibility criteria.

**Design:** Retrospective chart review at a university based medical center between 2002 to 2006, identifying patients diagnosed with olfactory neuroblastoma who underwent a trans-nasal, trans-facial, sub-frontal anterior skull base resection.

**Subjects:** Thirteen patients with biopsy proven olfactory neuroblastoma staged via the Dujgeurov-Calcaterra system (T1 = 0 patients; T2 = 7; T3 = 3; T4 = 3).

**Interventions:** Patients underwent a lateral rhinotomy, medial maxillectomy approach to remove the sino-nasal components of the tumor. Neurosurgical microscope-assisted removal of the anterior skull base components of the tumor via the trans-nasal, trans-facial exposure followed.

**Results:** Twelve of the thirteen patients had clear post-surgical margins. One patient had residual intracranial disease due to coagulopathy preventing further resection. All thirteen patients are currently alive with nine patients remaining disease free with follow-up ranging from 6 to 54 months. Three patients presented with recurrent disease initially, and had recurrences. Two patients had CSF leaks postoperatively that were repaired via our initial surgical approach.

**Conclusions:** While craniofacial resection remains an accepted approach for surgical treatment of olfactory neuroblastomas, we have adopted a trans-nasal, trans-facial approach eliminating the need for a frontal craniotomy. This approach allows for adequate exposure of the cribriform plate, dura, and anterior skull base. Our technique prevents frontal lobe retraction, and minimizes dural defects. Long-term follow-up is needed to compare survival using this approach, however our results to date are quite promising.

## 98. METASTATIC MALIGNANT MELANOMA TO THE LARYNX: TREATMENT AND FUNCTIONAL OUTCOME

**Biana G Lanson MD,** Mark D Delacure MD; Nicholas J Sanfilippo MD; Beverly Y Wang MD, NYU Medical Center

**Objective:** Review of the subject of laryngeal metastatic malignant melanoma, its proper treatment and evaluation of functional outcome.

**Study Design:** Case report

**Methods:** Chart review, video review, review of the literature

**Results:** Metastatic mucosal malignant melanoma is extremely rare. Review of the literature shows that 0.6% to 9.3% of patients with cutaneous malignant melanoma will have metastases to the mucosa of the upper aerodigestive tract. Of these mucosal metastatic sites 12% are laryngeal. However, melanoma is one of the more common metastatic tumors to the larynx and evokes important therapeutic dilemmas and challenges. This article will discuss a 61-year old patient with laryngeal metastatic malignant melanoma, who provided a history of left supraclavicular malignant melanoma of the skin treated with excision and immunotherapy seven years previously in Russia. A partial laryngopharyngectomy and a radial forearm microvascular free flap were performed for tumor removal, pyriform sinus wall and aeroepiglottic fold reconstruction, and achievement of functional restoration. Postoperatively, the patient also received a full adjuvant course of radiation therapy. The patient was subsequently decannulated, returned to normal voice, and tolerated a regular diet without difficulty. Postoperative endoscopic exam revealed bilateral true vocal cord mobility and an adequate airway.

Unfortunately, the patient developed multiple other metastatic sites and expired seven months after his surgery. This case presentation is accompanied by review of the literature on the treatment of laryngeal metastatic malignant melanoma, histology, and radiation treatment, as well as, the presentation of audiovisual materials including patient interviews, surgical photographs, pre- and postoperative fiberoptic laryngoscopy and stroboscopy.

**Conclusion:** Although laryngeal metastatic malignancy presents a therapeutic challenge to head and neck surgery and oncology teams, surgery and postoperative adjuvant radiation therapy can be performed with the achievement of good laryngeal function preservation.

## 99. UNILATERAL AUGMENTATION AND REDUCTION IN BILATERAL VOCAL CORD PARALYSIS

**Andrew J Lerrick MD;** Myriam D Riboh MS; Jhuli R Patel MS, Rush University Medical Center

**Introduction:** Vocal cord augmentation enhances the voice in the setting of a paralyzed vocal cord. Arytenoidectomy enlarges the airway in cases of bilaterally adducted vocal cords caused by paralysis of the recurrent laryngeal nerves. We present a patient with bilateral vocal cord paralysis who achieved a better voice and improved airway after undergoing a combined augmentation and reduction procedure on one cord.

**Case History:** A 72 year-old female with metastatic breast cancer presented with mediastinal invasion of the left recurrent laryngeal nerve, causing left vocal cord paralysis (0/4), moderate dysphonia, and aspiration. A Gelfoam injection trial to improve her voice and facilitate swallowing was proposed. Medical clearance delayed timely surgical intervention, during which time she developed dyspnea, which progressed to moderate stridor, necessitating an emergency room visit. Flexible fiberoptic laryngoscopy (FFL) revealed a new right vocal cord paresis (1/4). Her voice was soft and breathy. She adamantly refused a tracheotomy. Monitored in the ICU, her airway stabilized with steroids.

**Hospital Course:** With both cords dysfunctional, the proposed procedure was modified in order to accomplish the original goals; she underwent augmentation of the anterior third of the left true vocal cord with Gelfoam to improve her speech, ablation of the posterior third, and a left arytenoidectomy.

**Result:** Post-operatively she achieved a stable airway and a stronger voice. Despite the arytenoidectomy, her ability to tolerate liquids also improved. FFL revealed a plump anterior one-third, transitional middle one-third, and absent posterior one-third.

**Conclusion:** Unilateral vocal cord augmentation and reduction with arytenoidectomy may improve speech, airway, and swallowing performance in cases of bilateral vocal cord paralysis.

## 100. THYROID FINE NEEDLE ASPIRATION BIOPSY: A TEN-YEAR EXPERIENCE

**Carol M Lewis MD;** Kuo-Ping Chang MD; Martha Pitman MD; William C Faquin MD; David Zurakowski PhD; Kristna Gorti MD; Gregory W Randolph MD, Massachusetts Eye and Ear Infirmary, Massachusetts General Hospital, Boston Children's Hospital

**Objective:** To describe our institutions' experience with and evaluate the efficacy of thyroid fine needle aspiration (FNA). **Study Design:** Data from patients who underwent thyroid FNA biopsies between January, 1993 and March, 2003 at two academic medical centers was retrospectively reviewed. **Methods:** Thyroid FNA cytopathology was classified into four categories: malignant, indeterminate, benign, and non-diagnostic. In those patients who subsequently underwent surgery, histologic findings were correlated with pre-operative FNA cytopathology. When performing analyses, malignant and indeterminate FNA results were considered positive tests, as these both lead to the recommendation of surgical resection.

**Results:** 1590 patients underwent 2120 thyroid FNA biopsies, of which 134 (6.1%) were positive for malignancy, 492 (20.3%) were indeterminate, 1283 (60.5%) were benign, and 215 (10.1%) were non-diagnostic. 746 surgical resections were performed. There were 10 (4.8%) false negatives, 4 (0.8%) were false positive (malignant FNA with a benign histology). Sensitivity was 94.2%, specificity was 48.7%, positive predictive value was 43%, negative predictive value was 91.7%, with an overall accuracy of 62%.

**Conclusion:** Thyroid FNA is a valuable screening tool with high sensitivity and poor specificity. Its efficacy could be further improved by standardization of cytologic result reporting with an emphasis on interpretative categories rather than cytologic description, and by standardization of statistical reporting in with regard to the indeterminate category.

## 101. POSITRON EMISSION TOMOGRAPHY-COMPUTED TOMOGRAPHY IN PATIENTS WITH ADVANCED HEAD AND NECK CANCER AFTER PRIMARY CHEMORADIOTHERAPY; EVALUATION OF ITS EFFICACY IN IDENTIFYING RESIDUAL DISEASE

**Sofia Lyford-Pike;** Patrick K Ha MD; Heather A Jacene MD; John R Saunders MD; Ralph P Tufano MD, Johns Hopkins University School of Medicine, Greater Baltimore Medical Center

**Objective:** To evaluate the efficacy of Positron Emission Tomography-Computed Tomography (PET-CT) to predict residual nodal disease in patients who received primary chemoradiation (CRT) for advanced stage squamous cell carcinoma of the upper aerodigestive tract with nodal disease staged N2 or greater through correlation with final surgical pathology.

**Methods:** A retrospective cohort analysis of patients from two institutions (January 2003 to December 2006) who received primary CRT for advanced head and neck cancer with N2 or greater disease, PET-CT for residual disease evaluation and planned neck dissection within 3 months of treatment completion, was performed. PET-CT imaging results for neck sides (right and/or left) were correlated with final pathologic nodal status from neck dissection specimens for that region. The sensitivity, specificity and predictive values were calculated.

**Results:** A total of 46 neck sides (including bilateral neck dissections) for 38 patients were analyzed. Nine neck regions were determined to have either PET-CT result reports (5) or pathology reports (4) that were indeterminate and were excluded. The sensitivity and specificity are 57.1% and 73.9% respectively (PPV= 57.1%, NPV 73.9%).

**Conclusion:** PET-CT is neither highly sensitive nor highly specific for identifying residual nodal metastases after primary chemoradiation for advanced stage SCC of the head and neck. Physicians should not rely solely on this modality to determine treatment interventions on the neck after CRT. An additional weakness of this technique is that interpretation of the PET-CT results, and thus the presence of residual disease, is subject to inter-observer variability.

## 102. TRACHEOTOMY MANAGEMENT AFTER OPEN PARTIAL LARYNGECTOMY WITH OR WITHOUT RADIATION THERAPY

**Aysenur Meric Teker MD;** Walter T Lee MD; Robert R Lorenz MD; Benjamin G Wood MD; Ramon M Esclamado MD; Marshall Strome MD; Jerrold Saxton MD; Joseph Scharpf MD; David J Adelstein MD, Cleveland Clinic

**Objective:** To evaluate the management and complications of tracheotomy after partial laryngectomy with or without radiation therapy.

**Study Design:** Retrospective chart review of partial laryngectomy patients between 1996 and 2006.

**Main outcome measures:** Tracheotomy duration and subsequent complications.

**Results:** A total of 56 patients underwent open partial laryngectomy during the study period. 12 patients were excluded due to lack of follow-up. Of the remaining 44 patients, 18 were treated by surgery alone and 26 had surgery and radiation therapy. The median follow up time for surgery alone and surgery with radiation was 28.5 and 22.0 months respectively. No patients required permanent tracheotomy in either group. Median decannulation time for the surgery alone versus surgery and radiation group was 21 versus 28 days respectively. For those patients who had preoperative radiation, the median time to decannulation was 19.5 days, compared with 35 days in the post-operative radiation group. 3 patients needed a second tracheotomy due to airway compromise and all had received radiation. Secondary tracheotomies were present for a mean of 44 days. Persistent tracheocutaneous fistulas which had to be closed surgically in the surgery alone and surgery with radiation were 11.1% and 22.2% respectively. Laryngeal or tracheal granulomas were present in 30.7% of the surgery alone group compared with 3.8% in the surgery with radiation group.

**Conclusion:** Patients with partial laryngectomy and radiation have an increased incidence of persistent tracheocutaneous fistula and airway compromise after decannulation requiring secondary tracheotomy. Furthermore, the outcome data presented in this series assists in postoperative tracheotomy management and preoperative patient counseling.

## 103. ERGONOMICS OF THE SURGEON IN THYROID SURGERY CAN BE IMPROVED

**B J Davidson MD;** E Guardiani BA, Georgetown University Hospital

**Background:** Surgeon postures utilized during open surgical procedures often require prolonged static flexion, a position which has been shown in the occupational health literature to be associated with tension neck syndrome (pain, muscle tenderness and stiffness) and a potential risk factor in cervical disk disease. As a result of both widespread use of magnification loops and reduced thyroidectomy incision length, thyroid surgeons are increasingly at risk of prolonged static flexion. We have attempted to reduce static neck flexion in thyroid surgery through the use of an operating microscope. This allows the surgeon and assistant to maintain an upright posture while performing thyroid surgery.

**Setting:** Academic tertiary referral hospital

**Methods:** The operating microscope has been used during thyroidectomy by the senior author since early 2006. Surgical procedure times for total thyroidectomy were compared between cases done between 2/06 and 8/06 using the operating microscope and those procedures done in the previous 18 months. Patients undergoing lobectomy, or concomitant modified or radical neck dissection were excluded.

**Statistical methods:** Procedure times (incision to completion of closure) were stratified by procedure code (60240, 60252, 60271) and compared using Student's t test.

**Results:** The operating microscope was used in 32 total thyroidectomy procedures between 2/06 and 8/06. (10 total thyroidectomies, 15 total thyroidectomy for malignancy, 7 substernal thyroidectomies). The surgical times for patients operated using the operating microscope were longer (187.6 min vs. 160.8 min,  $p=0.002$ ). The increase was seen only in those patients who underwent thyroidectomy for malignancy (203.4 min vs. 156.7 min,  $p=0.002$ ) while those undergoing total thyroidectomy for benign disease (158.8 vs. 154.1,  $p=ns$ ) or substernal thyroidectomy

(194.9 min vs. 193.3min,  $p=ns$ ) were equivalent. Incision length was initially extended to the classic standard length of 8cm, but has now been reduced to 5-6cm in the majority of cases.

**Conclusion:** Using the operating microscope during thyroidectomy allows surgeons to avoid static neck flexion associated with open surgical procedures. Surgical times are extended for patients undergoing thyroidectomy for malignancy with medial compartment node dissection in this early series.

## 104. LOCAL RECURRENCE AND MORTALITY AT TWO YEAR FOLLOW UP CORRELATED TO MARGIN DISCREPANCIES OF ORAL SCC TUMORS

**Allen C Cheng DDS;** Brian Schmidt DDS MD PhD, University of California San Francisco

**Background:** The goal of this study is to analyze the amount of margin discrepancies between margins measured intraoperatively and those measured microscopically based on tumor location and staging, and to examine their relationships to treatment outcome.

**Methods:** Fifty-two patients who had surgery with curative intent for primary oral SCC were in this study. All patients had tumors resected with a 1 cm margin by one surgeon. Specimens were submitted to UCSF Pathology. The closest histologic margin was compared to the intraoperative margin (1 cm) to determine percentage discrepancy. Percent discrepancies were grouped by locations (buccal mucosa, mandibular alveolus and retromolar trigone in Group 1, maxillary alveolus and hard palate in Group 2, and oral tongue in Group 3) and analyzed. Percent discrepancies grouped by stages T1/T2 or T3/T4 were compared. Patients who had at least two years of follow up or who had treatment failure (recurrence, neck metastasis, or death) were included in an outcomes analysis ( $n=29$ ). Margin discrepancies were compared between disease free patients and patients with treatment failure. Odds ratios based on locations and stage were calculated.

**Results:** The mean discrepancy was 73.56% for Group 1, 54.29% for Group 2, and 38.50% for Group 3 ( $p=0.0035$ ). The mean discrepancy in T1/T2 tumors was 50.53% and T3/T4 tumors was 74.29% ( $p=0.0029$ ). The mean discrepancy was 51.76% in the disease free group and 75% in the treatment failure group ( $p=0.033$ ). OR=1.24 for Group 1, OR=1.5 for Group 2, OR=0.6 for Group 3 tumors. OR=0.61 for T1/T2 tumors, OR=1.625 for T3/T4 tumors.

**Conclusions:** Oral SCC margin discrepancies are highly significant. Tumors located in Group 1 demonstrate greater discrepancies than tumors of the maxilla or tongue. Late stage tumors also show greater margin discrepancies. These discrepancies, based on tumor location and stage, correlate with poorer outcomes. These findings suggest that it might be prudent to consider tumor site and stage when outlining margins.

## 105. CUTANEOUS LEIOMYOSARCOMA OF THE CHEEK

**William A Kennedy MD;** Marilene B Wang MS, From the Division of Head and Neck Surgery, David Geffen School of Medicine at the University of California, Los Angeles, CA (WAK and MBW) and the Department of Surgery, VA Greater Los Angeles Healthcare System, Los Angeles, CA (MBW)

**Objective:** To recognize and describe optimal treatment for cutaneous leiomyosarcoma of the cheek, a rare tumor of the head and neck.

**Design and Methods:** Case report and literature review

**Results:** A patient presented with a rapidly enlarging, exophytic mass over the zygoma. CT scan demonstrated a pedunculated epidermal mass with no invasion of the parotid. The patient underwent wide local excision of the lesion, with reconstruction using a cervicofacial rotation flap. Pathological examination revealed a low-grade, cutaneous, leiomyosarcoma, strongly immunoreactive for smooth muscle actin, and negative for pankeratin, S-100, and HMB-45. The patient has remained free of disease for one year.

**Conclusions:** Superficial cutaneous leiomyosarcomas generally follow a benign course, usually presenting as a slowly growing, well circumscribed mass. However, leiomyosarcomas originating in the subcutaneous tissues exhibit more aggressive behavior, with a higher incidence of recurrence. Treatment of leiomyosarcoma

includes wide local excision, with postoperative radiation reserved for subcutaneous tumors only. In this patient, although the clinical behavior indicated rapid growth, histopathology revealed a superficial cutaneous tumor, and wide local excision alone was curative. The head and neck surgeon should recognize this rare tumor and plan appropriate treatment.

## 106. INITIAL CT FINDINGS AS A PREDICTOR OF LATE NECK METASTASIS IN EARLY TONGUE AND ORAL FLOOR CANCER

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**Purpose:** Detecting the risk factors for late neck metastasis in early tongue and oral floor cancer is important for providing an accurate prognosis and for achieving a high survival rate. The histopathologic factors reported to be reliable parameters for determining neck metastasis are commonly unavailable before definitive surgical exploration and/or treatment, which implies that a decision on regional treatment is not possible based on histologic findings. This study thus aimed to find a more useful predictor based on the initial contrast-enhanced CT findings.

**Methods:** Patients in this study had either stage I or II tongue and oral floor cancer. Between April 1997, and March 2006, each patient underwent resection of the primary tumor or interstitial radiotherapy without neck dissection after the initial CT. We measured the short- and long-axis diameters of the nodes in the whole neck identified on CT images. When a patient was suspected of having late neck metastasis after the initial treatment, neck dissection was indicated. The metastatic lymph nodes were pathologically identified in the dissected materials.

**Results:** The initial CT images of 38 patients were reviewed, and of the 38 patients, 20 had late neck metastasis and 18 did not. All patients without late neck metastasis were followed for over 12 months. CT images showed a total of 161 lymph nodes. Twenty-five of the 161 lymph nodes developed into late neck metastasis and were labeled the goccult lymph nodes on the initial CT images. The remaining 136 lymph nodes that did not develop into neck metastasis were considered reactive nodes. Forty-two metastatic lymph nodes were pathologically identified in the neck dissection. Sixty percent of these metastatic lymph nodes were identified and labeled goccult lymph nodes based on retrospective analyses of the initial CT images. Comparison between the 25 goccult and 136 reactive lymph nodes revealed significant differences in the short-axis diameters on the initial CT images ( $p=0.01$ ). A criterion of 6 mm in short-axis diameter as goccult lymph nodes had a sensitivity of 64%, a specificity of 81%, a positive predictive value of 38% and a negative predictive value of 92% for the development of late neck metastasis.

**Conclusion:** The short-axis diameter of the neck lymph nodes on initial CT images is a useful predictor for late neck metastasis in patients with early tongue and oral floor cancer.

## 107. UTILITY OF CT SCAN TO DETECT CERVICAL METASTATIC DISEASE IN WELL-DIFFERENTIATED THYROID CARCINOMA

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**Objective:** While the necessity of cervical lymph node dissection for subclinical well-differentiated thyroid carcinoma (WDTC) remains controversial, a trend has emerged favoring its performance when disease is suspected preoperatively on radiographic grounds. The utility of computed tomography (CT) scan in the setting of WDTC has yet to be determined. The aim of this study was to characterize the ability of CT scan to identify subclinical cervical metastatic disease in the setting of well-differentiated thyroid carcinoma.

**Methods:** A retrospective review was performed of all patients undergoing neck dissection as part of the management of WDTC by the senior author over a two year period. Per practice pattern, all patients had CT scan preoperatively. CT scans were then re-evaluated in a blinded fashion by a neuroradiologist and reported by formal neck level. Positive criteria included size greater than

10mm, cystic or low attenuation, round morphology, calcification, or enhancement. The surgical pathologic findings were correlated with the CT findings. Sensitivity, specificity, positive predictive value (PPV), and negative predictive value (NPV) were calculated separately for central compartment (level 6) and lateral compartment (level 3 and 4) dissections.

**Results:** 104 patients underwent selective neck dissection for WDTC during the study period and had preoperative CT scans available for review. 43 cases represented primary surgery and 61 were secondary in nature. Overall there were 115 lateral compartment dissections and 146 central compartment dissections. The overall sensitivity of CT scan to identify cervical metastatic disease was 59% for the central compartment and 61% for the lateral compartment. Specificity was 76% and 81% respectively. PPV and NPV were 84% and 47% for the central compartment and 74% and 52% for the lateral compartment. Prior surgery or radioactive iodine treatments did not significantly affect these values.

**Conclusion:** CT scan has a limited capability to identify subclinical metastatic cervical disease in WDTC, with sensitivity near 60% and NPV near 50%. Relying solely on CT scan will miss a significant portion of disease, likely due to the high incidence of microscopic foci. However using strict criteria, a positive finding on CT scan does provide useful information, as it predicts with a fairly high specificity that disease will in fact be found in a specific compartment during surgical dissection.

## 108. NODULAR FASCIITIS: A CASE SERIES

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**Background:** Nodular fasciitis is a rare, benign pseudo-neoplastic process occurring on mucosal, fascial, and tendinous surfaces. Its overall incidence has been cited as 0.025%, of which 15% localize to the head and neck region. Given its rarity, varied histological presentation, and often pseudosarcomatous appearance, nodular fasciitis is frequently misdiagnosed on preoperative, intraoperative, and final analysis. Specialized staining, including smooth-muscle and muscle-specific actins, vimentin, and KP1 (a histiocyte marker) can aid in the diagnosis.

**Study Design:** Case-series; tertiary care center.

**Methods:** From 1999 through 2006, four female patients between the ages of 39 and 71 with a final diagnosis of nodular fasciitis were reviewed. Patients underwent preoperative workup for a head or neck mass that included a contrast-enhanced computed tomographic scan of the neck, and fine-needle-aspiration (FNA). A frozen section was reviewed intraoperatively. The final diagnosis was based on pathological results of the mass in its entirety.

**Results:** Physical and radiologic examinations were consistent with a parapharyngeal tumor, probably neurogenic, in one patient; a level 4 neck mass suspicious for lymphoma in one patient; a sternoclavicular mass in a patient with a known breast cancer suspicious for metastasis; and a cheek mass consistent with an accessory parotid tumor. FNA results reported findings consistent with a neurogenic tumor in two patients and an undifferentiated malignancy in two patients. Frozen section examination most commonly included masses with spindle cell-types. The final diagnosis of nodular fasciitis was made only after permanent sections and immunohistologic studies.

**Conclusions:** Nodular fasciitis, although rare, can be mistaken for other benign or malignant head or neck lesions. Radiographic and pathological studies can lead to equivocal diagnoses. Such preoperative findings can have a negative effect on surgical planning, with unnecessary risk of injury to adjacent structures. In a patient with nonspecific results on workup of a head or neck mass, nodular fasciitis may be considered. Use of appropriate immunohistochemical markers will aid in the final diagnosis.

## 109. THE EFFECT OF DEPRESSION ON SURVIVAL OR DISEASE RECURRENCE IN PATIENTS WITH HEAD AND NECK CANCER (HNC) ENROLLED IN A DEPRESSION PREVENTION TRIAL

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**Objective:** To determine whether depression portends a worse prognosis in patients with HNC.

**Design:** Retrospective chart analysis of subjects enrolled in a randomized placebo-controlled trial of citalopram for the prevention of major depression during treatment for HNC.

**Setting:** Academic Medical Center

**Patients:** Thirty-six patients randomized to trial, 35 with one or more evaluations for depression form the basis of this report.

**Outcome measurements:** Hamilton Depression Rating Scale (HDRS), minimum follow-up of 24 months if no evidence of disease (NED) or until recurrence (RD) or death from disease (DD).

**Results:** 14 of 35 subjects were depressed at any time during the study (HAM-D > 15). Seven of the 14 subjects in the depressed group were DD or had RD, compared to 4/21 who never developed depression. (chi-squared = 3.734 p = 0.053). Stage of disease was equivalent in the two groups: 71% of the depressed subjects were stage IV compared with 65% of non-depressed subjects. 15% of depressed subjects were stage I/II compared with 10% of non-depressed subjects.

**Conclusions:** This study reports data that suggest that depression in subjects with HNC portends a worse prognosis when considering both baseline and emergent depression.

## 110. PROGNOSTIC INDICATORS OF LOCOREGIONAL FAILURES IN LATE STAGE TUMORS - A RETROSPECTIVE REVIEW OF 2275 PATIENTS WITH SQUAMOUS CELL CARCINOMAS OF THE GINGIVOBUCCAL COMPLEX

**Rohan R Walvekar MD;** **Devendra A Chaukar MD;** Anil K D'Cruz MD, Tata Memorial Hospital

**Background:** Squamous cell carcinoma of the gingivobuccal complex (GBC) is the most common oral cancer in India. Loco-regional control is the main therapeutic goal in the treatment of these cancers. Most of the series that have studied GBC lack the strength of numbers required to draw meaningful conclusions with respect to the biological behavior of these distinct tumors. The purpose of our study was to analyze the prognostic indicators of loco-regional failures in a large number of patients with advanced stage squamous cell carcinomas of the gingivobuccal complex treated at a single institution.

**Methods:** A retrospective chart review of 2275 patients diagnosed with squamous cell carcinomas of the gingivobuccal complex, was performed at the Tata Memorial Hospital, Mumbai, India, a tertiary cancer institute. The final analysis included 642 patients of advanced cancers of the gingivobuccal, who fulfilled our inclusion criteria. Statistical analysis of relevant clinico-pathological factors was performed and outcomes in terms of recurrence rates and disease-free survival were reported.

**Results:** During a median follow up of 2.51 years, 237 (36.9%) locoregional failures. 80% of all failures occurred within the first 24 months and the median survival for patients with recurrences was 2.7months. Two-year and 5-year disease free survival was 63.8% and 53.3%. On multi-variate analysis, disease free survival showed a significant statistical correlation with tumor depth and metastatic lymphadenopathy.

**Conclusions:** Gingivobuccal cancers tend to fail locoregionally. Nodal metastasis and tumor depth seem to be the most important prognostic factors influencing disease free survival.

## 111. ACKERMAN'S TUMOR (VERRUCOUS CARCINOMA) OF THE ORAL CAVITY

**Rohan R Walvekar MD;** **Devendra A Chaukar MD;** Anil K D'Cruz MD, Tata Memorial Hospital

**Background:** Oral verrucous carcinoma (OVC) is a rare variant of oral squamous cell carcinoma. OVC are locally aggressive and rarely presents with regional or distant metastasis. Diagnosis mandates a close collaboration between the clinician and the pathologist. The etiopathogenesis of OVC is unclear. Surgery is the treatment of choice, although recurrences are common. Our aim was to study the clinicopathological predictors of local recurrence and overall outcomes were studied.

**Design:** A retrospective chart review of 302 patients with OVC was performed. 101 patients met our inclusion criteria. There were 79 male and 22 females and the mean age at presentation was 53.9 years. A univariate analysis (UVA) of relevant prognostic

variables was performed and outcomes in terms of recurrence rates and disease-free survival (DFS) were reported.

**Results:** The incidence of tobacco chewing, smoking, and alcohol intake was 77%, 42%, and 10% respectively. 34 patients (33.7%) had premalignant lesions on oral cavity examination; leukoplakia (20.8%) and oral submucous fibrosis (SMF), (13.9%) were the most frequently encountered lesions. The buccal mucosa was involved most commonly. Early stage tumors accounted for 39.7%; while late stage tumors accounted for 60.4% of all tumors. All the patients were treated surgically with a curative intent. 31 patients (30.7%) presented with lymphadenopathy. However, there was no evidence of pathological nodal involvement. Pathological bone invasion was seen in 6 patients (5.9%). On UVA, tumor location, presence of a premalignant lesion, smoking, and positive margins were significant. 28 patients had recurrences; 19 (18.8%) recurred locally and 7(6.9%) had second primary cancers. 66.7% of the recurrences could be salvaged with a median post-recurrence survival was 16 months (range, 10-83 months). The overall 5 year disease free survival with surgical therapy was found to be 77.6%.

**Conclusion:** OVC have an excellent prognosis with surgical management. The statistical significance of positive margins emphasizes the need for wide surgical resection. The high incidence of local recurrences and second primary cancers mandates a close follow-up. Premalignant lesions in the presence of an OVC could indicate a potential for multicentricity. Neck dissection if considered may be limited to supraomohyoid neck dissection.

## 112. INTERESTING CLINICAL PRESENTATIONS OF PRIMARY HYPERPARATHYROIDISM MIMICKING AS MALIGNANCY

**Pankaj Chaturvedi MD;** P S Pai MD; A Puri MD; M G Agarawal MD; A K D'cruz MD, Tata Memorial Hospital

**Case 1.** A pregnant women presented with a lytic lesion in the upper end of humerus with a large soft tissue mass. The core biopsy of the lesion reported giant cell tumor following which she underwent a excision of the upper end of humerus and placement of prosthesis. The final histopathology revealed brown tumor (BT).

**Case 2.** A 50 year old female presented with mandibular swelling with 3rd trimester of pregnancy. Since the lesion appeared like an epulis, patient was advised to undergo further investigation and possible surgery after her delivery. After her delivery, investigation revealed it to be a BT.

**Case 3.** A 22 year female presented with right sided palate swelling and cytology reported a giant cell lesion. The patient was planned for palatal excision and she decided to have 2nd opinion at our hospital and we diagnosed it as a BT.

**Case 4.** A GP referred a 56 year old lady to our hospital for palliative chemotherapy for multiple bony metastases. Later, she was referred to us for a neck swelling and we found that she had primary hyperparathyroidism (PHP).

**Case 5.** A young male was diagnosed to have a bone tumor in his index finger for which a surgical extirpation was planned. However, patient visited our hospital for a second opinion and we diagnosed BT.

**Case 6.** A young female presented with fracture of the right ulna following a fall. The X- ray showed a lytic lesion with pathological fracture. While waiting for the surgery, her blood investigations revealed PHP.

All these patients were mistaken for malignancy. Neck exploration and removal of the adenoma cured all these patients. Warning signs of PHP such as early fatigability, constipation, thirst or depression can be easily overlooked and this causes delayed diagnosis. In any lytic lesion of the bone, the possibility of BT should always be kept in mind to prevent any surgical misadventure. A simple blood calcium and parathormone assay is confirmatory. Finding of the giant cells in cyto-pathology, as seen in our patient, does not exclude a BT. It is mandatory to correct PHP before the childbirth to prevent postpartum hypercalcemic crisis in mother and hypocalcemic crisis in the fetus.

## 113. PRIMARY INTRAOSSEOUS CARCINOMA OF THE MAXILLA: AN UNUSUAL CASE AND REVIEW OF THE LITERATURE

**Nadia G Mohyuddin MD;** Mike Yao MD; Kristen Pytynia MD, University of Illinois-Chicago Department of Otolaryngology/Head & Neck Surgery

**Objective:** This report is to make the reader aware of the unusual entity of primary intraosseous carcinoma arising in the anterior maxilla.

**Study Design:** This is a case report with review of the literature.

**Methods:** A literature search for publications pertaining to primary intraosseous carcinoma of the maxilla was performed and the results are reviewed. A case of primary intraosseous carcinoma of the anterior maxilla is described with a discussion on the presentation, pertinent work-up including imaging, and treatment options.

**Results:** The results of the literature search are presented as well as pertinent photographs, histological data and imaging studies relating to the case report.

**Conclusion:** Primary intraosseous carcinoma arising in the jaws is a rare entity. It includes several histologic types with various etiologies. In this case report, the location of the lesion in the anterior maxilla is even rarer with only a handful of published cases. There are strict guidelines for the diagnosis and classification of these lesions, however the presentation, treatment and prognosis for these patients is variable. A case of primary intraosseous carcinoma of the anterior maxilla is reported and a brief review of the literature is presented.



## 114. SINGLE STAGED RECONSTRUCTION OF LARGE TRACHEA DEFECTS - A CASE REPORT

**Jonathan Kulbersh MD;** Oleg Miliitsakh MD; Judy Skoner MD; Daniel Rosner MD; Terry Day MD, Medical University of South Carolina

**Introduction:** Reconstruction of various tracheal defects often presents a challenge for a head and neck and thoracic surgeons. There are few descriptions in the literature of different methods to reconstruct large tracheal defects. This reconstruction becomes especially difficult in the setting of prior irradiation and frequently requires a free tissue transfer. In our patient, we describe a novel approach in repair of a large tracheal defect in a single stage procedure with free tissue transfer, self-expanding polyflex stent, and absorbable mesh without need for tracheostomy.

**Case report:** Patient is a 70-year-old male who was diagnosed with squamous cell carcinoma of the larynx 5 years prior to the most recent presentation. He was treated with radiation therapy with complete response. He presented with a chief complaint of 6 month history of hoarseness. The patient was found to have a 1.5 cm ulcerative lesion 2 cm below the true vocal cords.

**Surgical Technique:** We utilized an ulnar forearm microvascular free tissue transfer, supporting absorbable mesh, and a temporary self-expanding intratracheal polyflex stent to maintain the tracheal lumen.

**Postoperative course:** Patient was extubated on the day 5. His endotracheal polyflex stent was removed after 3 months without evidence of granulation tissue or tracheomalacia

**Discussion:** The Polyflex stent is an ideal stent for large tracheal reconstructions with utilization of free tissue transfer. The stent is able to conform to the unique post-surgical anatomy and maintain the airway. The outside structured covering of the stent prevents migration and has a minimal inflammatory response. More importantly, it eliminates the need for tracheostomy or T-tube placement. This is especially important in patients like ours, who require tracheal reconstruction of the long segment from cricoid to below sternal notch. The placement of tracheostomy in our patient would have to be accomplished through the flap and



reconstruction mesh, thus, potentially compromising flap survival or reconstructed segment stability.

## 115. VIDEO-ASSISTED THYROIDECTOMY: EXPERIENCE IN 135 CASES

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**Background:** Since the landmark description by Kocher in 1905, thyroidectomy has been performed in the same fashion. The video-assisted technique was described by Miccoli in 1997.

**Objective:** To describe a 135 cases experience in the video-assisted technique, performed by the same surgical team.

**Design:** Retrospective study; case series.

**Main Outcome Measure:** Feasibility of the new technique in a developing country

**Methods:** Between September 2004 and July 2006, 135 video-assisted thyroidectomies has been performed - 133 females and 2 male. Age: 18 - 61, median 34 years. **Indications:** Suspicion of malignancy, without any cervical surgery, radiotherapy, thyroid volume under 20 cc and nodules under 3 cm.

**Results:** Surgery time: 25 - 180, median time 82 minutes for total and 57 minutes for partial thyroidectomy. The incision: 1,6 - 3,5cm, median 2,5cm. Four conversions to conventional technique are related. Nerve palsy was observed in 5,3%. There was no hypoparathyroidism or hematoma in this series. All patients were released in the first postoperative day.

**Conclusions:** The video assisted approach is a safe procedure, and its complication index is similar to the conventional technique, with advantages in incision size and postoperative evolution. However, more studies are needed to confirm these findings.

## 116. RISK PREDICTION OF Lymph NODE METASTASIS IN WELL-DIFFERENTIATED THYROID CARCINOMA BASED ON DIGITAL QUANTIFICATION OF GALECTIN-3 IMMUNOEXPRESSION IN SUBCELLULAR COMPARTMENTS OF THE MALIGNANT THYROCYTE

**Elaine Stabenow PhD**; Alexandre M Ab'Saber PhD; Marcos R Tavares PhD; Vera L Capelozzi PhD; Alberto R Ferraz PhD, Head and Neck Surgery and Pathology Department of Hospital das Clínicas, São Paulo University Medical School, São Paulo, Brazil Papillary and follicular carcinomas are low grade malignancies classified as well-differentiated thyroid carcinoma (WTC). Despite this classification, lymph node metastases are observed in approximately 30% of patients. Prediction of individual risk to develop metastasis would allow surgeons to offer a more adequate treatment in each case. Therapy is chosen according to prognostic factors and nowadays biomarkers can be associated with them. Galectin-3 is a biomarker that carries out a wide range of functions in the subcellular compartments of the malignant cells. Cytoplasmic immunexpression of galectin-3 has been investigated in cytological specimens obtained from thyroid nodes and was associated to a malignant phenotype. However, its role in WTC remains controversial.

**Objective:** In order to investigate if galectin-3 can be used to predict the individual risk of WTC lymph node metastasis, the following hypotheses were verified: if galectin-3 immunostaining in subcellular compartments of the malignant thyrocyte is different when comparing patients with and without lymph node metastasis and if it is possible to obtain a individual risk prediction model for metastasis based on digital quantification of the galectin-3 immunostaining, in each subcellular compartment.

**Methods:** It was performed a retrospective case-control study involving 109 patients treated and followed up for more than 5 years. They were divided into two equivalent groups: with and without WTC lymph node metastasis. Clinical data were analyzed; pathological evaluation and digital immunohistochemical analysis with galectin-3 antibody were performed in the primary resected tumor specimens.

**Results:** immunostaining was observed in the following subcellular compartments of the malignant thyrocytes: cytoplasmic, nucleoplasmic and nucleolar region. The average of the nucleolar galectin-3 positive index was higher in lymph node metastasis group ( $1.78 \pm 0.41$  nucleoli/HPF versus  $0.35 \pm 0.13$ ,  $P=.004$ , statisti-

cal power=.966). The logistic model allowed predicting the individual risk of cervical lymph node metastasis: this risk was almost 100% for patients with carcinomas displaying more than four galectin-3 immunostained nucleoli by microscopic high power field.

**Conclusion:** It was possible to predict the individual risk of WTC cervical lymph node metastasis based on quantification of the nucleolar galectin-3 immunostaining.

## 117. MAJOR ANASTOMOTIC DEHISCENCE (MAD) AFTER CRICO-TRACHEAL RESECTION AND ANASTOMOSIS (CTRA): PREDISPOSING FACTORS, MANAGEMENT, AND OUTCOMES

**Cesare Piazza MD**; Giorgio Peretti MD; Piero Nicolai MD, Department of Otolaryngology - Head and Neck Surgery, University of Brescia, Italy

**Objective:** CTRA is applied both to benign and selected neoplastic stenoses of the crico-tracheal junction and cervical trachea with a success rate around 95%. Nonetheless, a number of complications are frequently encountered. Aim of this paper is to describe predisposing factors, management, and outcomes of MAD, one of the most feared CTRA's complication.

**Methods:** Between '96 and '06, 91 patients received CTRA for inflammatory (61) or neoplastic (30) airway stenoses. A retrospective charts review identified 8 (9%) patients who developed a MAD: 4 had been treated for a post-intubation stenosis, 2 for thyroid cancer infiltrating the airway, 1 for a recurrential SCC lymph node metastasis involving the trachea and oesophagus, and 1 for cricoid chondrosarcoma.

**Results:** MAD occurred from 2 to 20 days after surgery (mean, 8). Extent of resection was considered the main predisposing factor in 2 patients with a 5 and 5.5 cm airway resection. In 1 patient, an epileptic crisis during the 1st postoperative day caused the anastomotic rupture, while intense emesis was encountered in 2.

Concomitant total thyroidectomy with central compartment neck dissection in 3, tracheo-oesophageal fistula closure in 2, and preoperative RT in 2 were thought to be responsible for MAD in the others. Three patients had an association of 2 or more predisposing factors. Univariate analysis by Fisher Exact or Pearson Chi Squared test taking into account different variables (length of resection, cricoid involvement, concomitant thyroidectomy with central compartment dissection, oesophageal surgery, preoperative RT, postoperative emesis, and diabetes) showed statistically significant association between MAD and length of resection equal or superior to 5 cm ( $p=0.007$ ), preoperative RT ( $p=0.02$ ), and intense postoperative emesis ( $p=0.007$ ). MAD was managed by total laryngectomy with forearm free flap for oesophageal closure in 1 case and permanent tracheostomy in another one (both with neoplastic stenoses after RT failure). The other patients (75%) achieved a patent airway after redo-CTRA in 5 and endoluminal Dumon prosthesis insertion in 1. The overall decannulation rate was 97%.

**Conclusions:** Besides length of airway resection exceeding 5 cm, other factors predispose to MAD. Preoperative RT should be considered a contraindication to this procedure for neoplastic stenoses. Moreover, management of patients after CTRA must include an aggressive anti-emetic therapy in the immediate postoperative course.

## 118. BIOACTIVITY OF PARATHYROID HORMONE FOLLOWING TOTAL THYROIDECTOMY

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**Background:** Parathyroid hormone (PTH) is an 84 amino acid peptide secreted by the parathyroid glands. It plays a vital role in calcium homeostasis and its activity is crucial for the maintenance of calcium levels following total thyroidectomy. PTH is modified by proteolysis and is present in the serum as both an active intact protein (PTH 1-84) and in the form of different fragments, most abundantly, an inactive C-terminal truncated peptide (PTH 7-84). At our institution, we measure PTH and calcium at regular intervals (1,6,12 and 20 hrs post-op) following thyroid surgery. The majority of patients with post-op hypocalcemia are found to have low PTH

levels. However, a rare subgroup of patients (~5%) are found to have low serum calcium with a paradoxical normal PTH level.

**Study:** The purpose of our study is to announce this previously unpublished phenomenon, and to validate our hypothesis that in this subgroup of patients, a variety of insults during surgery, such as mechanical trauma to the parathyroid glands, transient ischemia, or the induction of general anaesthesia, may lead to the formation of an increased amount of the truncated PTH resulting in a drop in serum calcium.

**Design:** We conducted a prospective study (N=22) comparing the ratio of active (1-84) to inactive (7-84) PTH (measured by the Scantibodies PTH Accuratio™ Panel), in patients with low calcium and normal PTH levels, and randomly chosen control patients with normal calcium and normal PTH, post total thyroidectomy.

**Results:** The two groups of patients were found to have statistically similar ratios of active and inactive peptides. Therefore, the hypocalcemia in patients with normal PTH level post thyroidectomy is not caused by increased amount of truncated, inactive PTH. Further studies are needed to determine the cause of this phenomenon, published for the first time in this article. We suggest monitoring urine cAMP levels post-operatively to determine if the body is actively utilising PTH, or measuring serum levels of PTH antagonists, such as calcitonin.

## 119. UTILITY OF PET-CT IN IDENTIFICATION OF PULMONARY METASTASES IN PATIENTS WITH SUSPECTED RECURRENT HEAD AND NECK CANCER

Christine G Gourin MD; **Tammara L Watts MD**; Hadyn T Williams MD; Vijay S Patel MD; Teresa A Coleman MD; Paul A Bilodeau MD, Medical College of Georgia

**Objectives:** Patients with recurrent head and neck squamous cell cancer (HNSCC) following definitive treatment have an increased risk of distant metastases, most commonly to the lungs, which translates into poorer survival. We sought to investigate the utility of PET-CT in identifying pulmonary malignancy in patients with suspected recurrent HNSCC following definitive treatment.

**Study Design:** Non-randomized retrospective cohort analysis.

**Materials and Methods:** The medical records of all patients treated for advanced HNSCC from April 2003- April 2006 were reviewed. Patients with suspected recurrent HNSCC following definitive treatment who underwent PET-CT imaging were eligible for inclusion. Patients with previous known distant metastatic disease were excluded.

**Results:** Sixty-four patients met study criteria; 81% had TNM stage III or IV disease. PET-CT was suspicious for pulmonary malignancy in 14 patients (22%) and indeterminate in 6 patients (9%). Pulmonary metastases or a new lung primary were present in 10 patients (16%): 7 of 14 patients with positive PET-CT scans (50%) and 3 of 50 patients with negative or indeterminate PET-CT scans (6%). The sensitivity and specificity of PET-CT in predicting pulmonary malignancy was 70% and 87%, respectively, with a positive predictive value of 50% and a negative predictive value of 94%. There was a significant correlation between standardized uptake value (SUV) on PET-CT and positive histology, with a mean SUV of 8.45 (range, 4.7-16.2) in patients with pulmonary malignancy compared to a mean SUV of 2.91 (range, 1.9-4.2) in patients with benign pathology ( $r=0.87$ ,  $P=0.0004$ ). Including non-pulmonary sites, the overall incidence of distant disease was 28% (18/64) with 23% (15/64) unsuspected prior to PET-CT.

**Conclusions:** These data suggest that PET-CT improves detection of metastatic disease in the high risk patient and should be performed as part of the routine evaluation of patients with suspected recurrence prior to surgical intervention.

## 120. THE RELATIONSHIP AND SIGNIFICANCE OF EXPRESSION OF SERUM VEGF, HGF IL-6, IL-8 AND TELOMERASE ACTIVITY IN PERIPHERAL BLOOD OF PATIENT OF HEAD AND NECK CANCER

**Byung-Joo Lee PhD**; Soo-Geun Wang PhD; Jin-Choon Lee MD; Kyong-Myong Chon PhD; Eui-Kyung Goh PhD, Department of Otolaryngology, Pusan National University Hospital

**Objective:** This study investigates the expression rate of serum VEGF, HGF, IL-6, IL-8 and telomerase by taking blood samples of

peripheral blood of patients of head and neck cancer and examines the relation between the expression rate of these biomarker and clinicopathologic parameters with prognosis.

**Methods:** Peripheral blood samples were collected from 50 head & neck squamous cell cancer patients and 15 normal control group. The measurements of VEGF, HGF, IL-6 and IL-8 were performed with using enzyme linked immunosorbent assay kits (R&D Systems, Minneapolis, MN, U.S.A.). The telomerase activity in peripheral blood mononuclear cells was measured by TRAP assay using TRAPeze telomerase detection kit (intergen Co. USA). Pearson chi-square test was used to analyze the correlation of telomerase expression with clinicopathologic parameters. Kaplan-Meier method were used for prognostic analysis.

**Results:** Only the expression rates of telomerase ( $p<0.001$ ) and VEGF ( $p<0.001$ ) of head and neck cancer group showed the statistically significantly higher expression rates than those of normal control group. Only VEGF of head and neck cancer group shows the statistically significant increase of expression according to the progression of T stage ( $p=0.001$ ). Only the case of lymph node metastasis showed higher expression of telomerase and VEGF ( $p=0.001/p<0.001$ ). Only the expression of telomerase and VEGF showed significant increase as AJCC stage progresses ( $p=0.009/p<0.001$ ). Serum VEGF was significantly related with the expression of telomerase in PBMCs of patients of head and neck cancer, ( $p=0.002$ ) The difference of the expression rate of telomerase and VEGF is significantly related to the survival rate ( $p=0.045/p<0.028$ ).

**Conclusion:** The serum VEGF and telomerase expression in PBMCs of patients of head and neck cancer is a simple and very useful molecular marker for the progression and prognosis of head and neck cancer.

## 121. HYPERPARATHYROIDISM FOLLOWING PARATHYROID SURGERY

Carolyn Redman BA; Donald Bodenner MD; Paul M Spring MD; **Brendan C Stack, Jr. MD**, University of Arkansas for Medical Sciences

Primary hyperparathyroidism is most often treated by surgery. The operation itself can be straightforward and, with preoperative localization, can be performed as an outpatient through a small incision. PTH levels decreasing by 50% or more intraoperatively are generally accepted as a sign of a successful surgery; these criteria have been established to correlate with a curative surgery the vast majority of the time. This has also been our institution's approach to treating primary hyperparathyroidism. We routinely follow our patients at one week postoperatively with conventional intact PTH assays matched with total and ionized calcium. Upon reviewing this post parathyroid excision data, we have noted that several patients had elevated parathormone levels postoperatively, in the setting of normal total and/or ionized calcium. To evaluate this phenomenon, we retrospectively reviewed the records of a cohort of patients who had undergone parathyroidectomy in our institution by several surgeons and had a complete data set from January 2003 to November 2006. 55 cases were identified. Of those, 14 patients (25%) had elevated PTH within one week post operatively. 4 of the 14 (28% of hyperparathormonemia patients, 7% of total) had biochemical evidence of primary HPT (elevated PTH and hypercalcemia) and 3 of the 4 had a subsequent positive sestamibi parathyroid localization. 7 of the remaining 9 patients had low-normal calcium (8.7-9.15 mg/dl). 4 of the 7 patients with high PTH and low calcium had vitamin D levels less than 30 ng/ml. Conversely, 2 of the 4 patients with primary HPT had vitamin D levels less than 30 ng/ml. These results suggest that the etiology of elevated PTH levels after parathyroidectomy is from vitamin D deficiency 57 % of the time and a second adenoma 28 % of the time. 15% of patients are without an obvious reason for post operative hyperparathormonemia. We recommend that practitioners monitor parathyroid hormone in addition to calcium following parathyroidectomy. The first response to an elevated post operative PTH level should be to order a 25 OH vitamin D level. Additionally, the practitioner should have a high index of suspicion for vitamin D deficiency in patients with post operative biochemical abnormalities.

## 122. SEQUENTIAL CHEMOTHERAPY AND CONCURRENT CHEMOTHERAPY AND IRRADIATION IN ADVANCED, RESECTABLE HEAD AND NECK CANCERS: A PHASE II TRIAL

**S Kyle Kaneaster MD;** Greg A Krempf MD; Carl R Bogardus MD; Vikki Canfield MD; Jesus E Medina MD, The University of Oklahoma Health Sciences Center

**Design:** Prospective phase II trial.

**Setting:** Two tertiary referral centers in Oklahoma City, Oklahoma.

**Patients:** Thirty consecutive patients with advanced, resectable squamous cell carcinoma of the pharynx and larynx.

**Interventions:** Induction combination chemotherapy with paclitaxel, ifosfamide, and cisplatin followed by concurrent chemoradiation for patients with adequate responses to induction chemotherapy.

**Main Outcome Measures:** Response rate, duration of remission and survival.

**Results:** There were 14 (46.7%) laryngeal, 13 (43.3%) oropharyngeal, and 3 (10%) hypopharyngeal tumors. One patient failed to initiate treatment. Twenty-nine patients underwent chemotherapy. Twenty-five of twenty-nine (86.2%) proceeded to radiation with adequate chemotherapeutic response. There were four patients who underwent surgical salvage for inadequate response to chemotherapy. There were no local recurrences. Two patients died from the disease, one of these after surgical salvage. After a mean follow up of 36 months, actuarial and disease-specific survivals were 76% and 91%, respectively.

**Conclusions:** The regimen used can induce a partial response in 86.2% of cases with advanced, resectable squamous cell carcinoma and result in a high rate of loco-regional control and survival.

## 123. PLASMOCITOMA OF THE THYROID: REPORT OF A CASE AND REVIEW OF THE LITERATURE

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**Background:** Extramedullary plasmocitomas are rare in the thyroid and may precede the multiple myeloma in 17 - 32% of the patients.

**Objective:** To report a case of intrathyroidal plasmocitoma.

**Report:** Female, 79 years, thyroid nodule with progressive growth. Subclinical hypothyroidism using Levothyroxine. Blood cell count, calcitonin and chest X-ray with no alterations. Bone densitometry: discrete osteopenia in lumbar and femoral region. Gama GT: 1.10, Alkaline fosfatase: 309, CPK 51, Ca: 5.0, PTH:129.

**Pathologic findings:** Malignant neoplasia. Medular carcinoma? Plasmocitoma?

**Macroscopy:** Thyroid 2.5x2.5x1.6cm, atrofied, with a 2.4cm white nodule

**Microscopy:** Atypical plasmocites, giant and anaplastic cells. Intense lymphocites infiltrate and lymphoid follicles.

**Immunohistochemical:** Restriction of the kappa immunoglobulin light chain, citokeratin - A negative, calcitonin negative and therefore the diagnosis of plasmocitoma was made.

**Diagnosis:** Primary plasmocitoma of the thyroid, patient underwent radiotherapy for treatment.

**Conclusion:** Clinic-pathological correlation is important in the differential diagnosis with multiple myeloma compromising the thyroid.

## 124. CORRELATION STUDY BETWEEN PRELIMINARY IMPRESSION BASED ON DIFF QUIK STAINED SLIDES AND FINAL DIAGNOSIS IN 287 HEAD AND NECK FNAs

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**Background:** Fine needle aspiration (FNA) is a useful tool for immediate assessment of palpable lesions, especially in the head and neck region. In current practice, a cytopathologist performing an FNA provides a preliminary impression (PI) after immediate microscopic examination of air-dried Diff Quik (DQ)-stained slides, and subsequently issues a final diagnosis (FD) within 24

hours after reviewing additional slides, usually Papanicolaou (Pap)-stained slides and H&E stained cell block (CB) slide or Pap-stained cytospin (Cy) slide. Addendum reports would be added for special studies such as immunocytochemical and/or special staining or flow cytometric analysis. The objective of this study is to evaluate the degree of correlation between PI and FD and further improve the efficiency of FNA practice.

**Material and Methods:** 287 cytopathologist-performed FNAs from the head and neck region were evaluated. Number of passes, number and type of slides and correlation (virtual agreement, modified/refined final diagnosis and disagreement) between PI and FD were evaluated.

**Results:** Among 287 FNAs, the average number of passes per FNA case was 2 (range 1-5.) The mean number of slides reviewed per case was 5 including 2 DQ, 2 Pap and 1 CB/1Cy. 247 of 287 (86%) cases showed virtual agreement between PI and FD. Final diagnosis on 36 out of 287 cases (12.5%) was slightly modified or refined after reviewing additional slides. A major diagnostic discrepancy was noted in 4 cases (1.5%), 3 of which were classified as squamous cell carcinoma on final diagnosis, and confirmed on surgical follow-up. The fourth case, initially diagnosed as chronic sialadenitis was later favored to be salivary gland neoplasm; surgical follow-up is not yet available.

**Conclusion:** Accurate diagnosis can be achieved in the majority (86%) of head and neck FNAs based on immediate examination of DQ stained slides alone. In a small number of cases (12.5%), reviewing additional slides may refine the final diagnosis. In rare cases, especially cystic squamous lesions, Pap stained slides appeared to be helpful. It is plausible to use DQ stained slides only with most head and neck FNAs in order to provide more cost effective and efficient triaging and patient management.

## 125. METASTATIC MALIGNANT MELANOMA MIMICKING BENIGN LESIONS IN THE HEAD AND NECK REGION

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**Background:** Metastatic malignant melanoma (MM) can have an unusual clinical presentation, occasionally appearing clinically benign or mimicking other tumors. We report 2 cases of head and neck which appeared non-neoplastic benign lesions clinically, and were ultimately found to be MM after histology and immunohistochemical studies. In both cases, the preoperative differential diagnosis did not expect MM, underscoring the peculiar behavior of MM.

**Materials and Methods:** Patients were examined and treated at Tisch Hospital, NYU Medical Center. Patient's medical history and chart were reviewed. Follow-up information was obtained. Specimens were routinely processed. Case 1: a 63 year female with a cyst on the helix of right ear and a palpable mass in right superior neck. She had breast lobular carcinoma, treated with mastectomy 17 years ago. Dermatological impression was a benign ear cyst. The ear cyst was excised and the neck mass was biopsies. Case 2: a 61 year old male with a laryngeal polyp. His past medical history included MM of left supraclavicular skin and Hodgkin's lymphoma. Laryngeal polyp was removed.

**Results:** Case 1: Frozen section on ear cyst reported "Favor metastatic breast carcinoma". The epidermis of overlying ear cyst was unremarkable. Final pathology of the ear cyst and neck mass showed an unexpected metastatic MM of unknown primary. The neck mass consisted of a lymph node replaced by metastatic MM. Case 2: Histology revealed a classic vocal cord polyp covered by ulcerated squamous mucosa. The polyp was composed of plasmacytoid cells with pigmentation, making initial diagnosis challenging. Both cases demonstrated positivity for S100 protein, HMB-45, and Melan-A, and were excluded as breast by negative staining for ER/PR, BREST-2, and Her-2-Neu (Case 1), and excluded as lymphoma by negative for LCA (Case 2).

**Conclusion:** Metastatic MM can have unusual clinic presentations, mimicking benign appearing lesions. This diagnostic pitfall emphasizes the need for confirmation of clinical impression with intraoperative pathologic consultation.

## 126. INACTIVATION OF THE TUMOR-SUPPRESSOR GENES CAUSING THE HEREDITARY SYNDROMES PREDISPOSING TO HEAD AND NECK CANCER VIA PROMOTER HYPERMETHYLATION IN SPORADIC HEAD AND NECK CANCERS

**Ian M Smith MD;** Joseph A Califano MD, Johns Hopkins Medical Institutions

Fanconi Anemia (FA) and Dyskeratosis Congenita (DC) are rare inherited dispositions to head and neck cancer. Their primary phenotype is bone marrow failure, but these patients develop striking oral premalignant lesions that often progress to malignant head and neck squamous cell carcinoma (HNSCC), absent traditional risk factors. Prior studies of inherited forms of cancer have been extremely important in elucidating tumor-suppressor genes inactivated in sporadic tumors. One means of gene inactivation, whose role in tumorigenesis has been increasingly apparent is transcriptional inactivation of tumor suppressor genes by methylation of CpG islands in gene promoters. Because this means of gene inactivation has demonstrated significance in HNSCC development, this study seeks to find if methylation silences the genes causing the inherited forms of head and neck cancer. Clinical significance is elevated by recent evidence demonstrates that epigenetic silencing of the Fanconi complex is responsible for cisplatin sensitivity in ovarian cancers.

We investigated the incidence of promoter hypermethylation of all the Fanconi-associated genes and the genes responsible for dyskeratosis congenita. Initially all 17 loci that cause the inherited HNSCC syndromes were studied by bisulfite sequencing of 10 tumor and 10 normal patients across any present CpG islands in the respective promoters. Genes that showed only methylation in the tumor patients were chosen for quantitative methylation-specific PCR (qMSP). 45 patients with HNSCC and 16 normal patients were studied with QMSP.

Three gene promoters showed differences in methylation between tumor patients and normal control patients. These genes were FancB (FAAP95, FA core complex), FancJ (BRIP1, DNA Helicase/ATPase), and DKC1 (dyskeratin). Only FancB and DKC1 showed no methylation in normal patients, but the presence of promoter hypermethylation in tumor patients via bisulfite sequencing. On qMSP, 1/16 (6.25%) of the normal patients and 14/45 (31.1%) of the tumor patients demonstrated hypermethylation of the FancB locus ( $p$  value  $< 0.05$ ) and 8/45 (17.8%) of the tumor patients and 2/16 (12.5%) of the normal patients and showed promoter hypermethylation and inactivation of the DKC1 locus,  $p$  value not significant. These results suggest that inactivation of the Fanconi anemia complex of genes, specifically FancB may play a role in the pathogenesis of sporadic head and neck cancer.

## 127. SELECTION OF SUITABLE REFERENCE GENES FOR ACCURATE NORMALIZATION OF GENE EXPRESSION PROFILE STUDIES IN ORAL SQUAMOUS CELL CARCINOMAS

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Nowadays, gene expression analysis is an important approach in biological research and real-time reverse transcription polymerase chain reaction (RT-PCR) is becoming the method of choice for high-throughput and accurate expression profiling of selected genes. Given the high sensitivity, reproducibility and large dynamic range of this methodology, the requirements for the selection of a proper housekeeping gene to be used in the normalization of DNA input in each reaction have become increasingly stringent. The suitability of housekeeping genes for normalization of real-time PCR analyses in oral cancer tissues has not been sufficiently investigated. The objective of this study was to select from a panel of 10 housekeeping genes the most stable genes in oral tissues. The expression level of ACTB, GAPDH, B2M, HMBS, HPRT1, PPIA, TBP, RPLO, BGUS and PGK genes was evaluated in cancer tissues specimens obtained from 10 oral carcinomas and 10 normal oral tissue form individuals without cancer by real-time RT-PCR. The genes studied displayed an exten-

sive expression range with cycle threshold values between 14 and 25. Two independent analyses, using the softwares GeNorm and NormFinder, were conducted to define the most appropriate reference genes for oral tissues. TBP (TATA box binding protein) and PPIA (cyclophilin A) were identified in both analyses. For purpose of gene profiling studies in oral cancer using real-time RT-PCR analyses, these genes should be considered as the best choice for normalization.

## 128. PROMOTER HYPERMETHYLATION OF PREMALIGNANT LESIONS IN HEREDITARY SYNDROMES PREDISPOSING TO HEAD AND NECK CANCER

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Fanconi Anemia (FA) and Dyskeratosis Congenita (DC) are rare inherited bone marrow failure syndromes which are associated with development of oral premalignant lesions and head and neck squamous cell carcinoma (HNSCC) in the absence of traditional risk factors. Transcriptional inactivation of tumor suppressor genes by methylation of CpG islands is well described in HNSCC. DNA from salivary rinses of patients with HNSCC and oral premalignant lesions has been shown to carry disease-specific increased incidences of promoter hypermethylation of tumor suppressor genes.

We investigated the incidence of promoter hypermethylation of the p16, DCC, MGMT, MINT31, and TIMP3 genes from DNA extracted from salivary rinses of 12 patients with Fanconi anemia, 8 Fanconi anemia heterozygotes, 10 patients with dyskeratosis congenita, and 3 first degree relatives of dyskeratosis congenita patients utilizing quantitative methylation specific PCR. We compared these findings to previous studies of promoter hypermethylation in salivary rinses from HNSCC patients and at risk screening population.

DC patients demonstrated incidences of promoter hypermethylation of the DCC, MGMT, and p16 genes which are significantly different than the incidence in the at-risk screening population ( $p$  value  $< .05$ ). 50% of DC patients demonstrated promoter hypermethylation of at least one gene. Leukoplakia was present in DC patients with promoter hypermethylation at these loci. FA patients demonstrated an incidence of promoter hypermethylation of the DCC allele which was significantly greater ( $p < .05$ ) than in the screening population. No FA patients with leukoplakia demonstrated promoter hypermethylation of any tested genes. MINT31 promoter hypermethylation was associated with subsequent development of HNSCC in a single FA patient.

Our results point to a potentially disparate role for promoter hypermethylation in HNSCC carcinogenesis in FA and DC.

## 129. A COMBINED APPROACH TO LARGE TUMORS OF THE NASOPHARYNX, OROPHARYNX, AND PARAPHARYNGEAL SPACE

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**Background:** Large, recurrent tumors of the oropharynx (OP), nasopharynx (NP), and parapharyngeal space (PPS) pose a technical challenge due to limited access with close proximity to the internal carotid artery (ICA). Safe, wide resections of these tumors can be difficult and are often considered unresectable. We have combined two standard approaches to provide control of the ICA while obtaining a wide resection margin.

**Study Design:** Case series at a tertiary care hospital

**Methods:** Six patients who had large, recurrent tumors involving the NP, OP, and PPS underwent a combined cervical-parotid and transhyoid pharyngotomy (CP/TH) for resection of the gross tumor followed by postoperative chemotherapy and reirradiation. The CP approach allows access to the PPS to the level of the skull base. Once the ICA is safely exposed, a TH pharyngotomy is used for the tumor resection followed by free flap reconstruction. Patients were followed for peri-operative morbidity, locoregional recurrence.

**Results:** All 6 patients underwent successful resection with no intraoperative complications. In the immediate postoperative

period, 2 patients developed neck hematomas, and 2 patients developed a wound infection along the free tissue flap, each requiring simple operative drainage. None of the patients had any permanent cranial nerve deficits.

Pathologic analysis revealed 2 of the 6 patients with positive microscopic tumor margins at the deep skull base.

Follow-up period ranged from 4 to 20 months. Each patient underwent postoperative chemotherapy and reirradiation. None of the 6 patients had local recurrence in the followup period.

**Conclusion:** The cervical parotid approach with the transhyoid pharyngotomy provides access to tumors of the NP, OP, and PPS. This procedure allows control of the internal carotid artery, allowing for a safe resection. The gross reduction of tumor bulk in combination with chemotherapy and reirradiation may increase survival.

### 130. TP63: ANALYSIS OF A NOVEL TUMOR-SUPPRESSOR GENE PROTEIN EXPRESSION AMONG PATIENTS WITH LARYNGEAL CANCER IN A SINGLE INSTITUTION

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**Background:** TP63 is a recently codified gene with great structural similarity with TP53. Its protein product (p63) plays a role in epidermal differentiation and has been associated with different types of epithelial tumor.

**Objective:** To evaluate the expression of p63 in laryngeal squamous cell carcinoma (LSCC), as well as its prognostic significance.

**Study design:** retrospective.

**Patients and methods:** Paraffin-embedded blocks from 133 patients submitted to total laryngectomy for SCC between 1998 to 2000 were selected, and immunorexpression of p63 was performed. Clinical and pathological staging, as well as p63 expression were correlated with outcome. Most patients were male(88%), with median age of 59 year-old, and had supraglottic tumors (57.9%).

**Results:** 54.9% of the cases were pN+, 73.7% had pT4 lesions and 80.5% were stage IV. 99.2% showed positive immunoreactivity to p63, which was strongly expressed (>30% of neoplastic cells) in 95.4%. Nearly 60% of patients with positive p63 expression in < 30% of cancer cells, 38.1% of the cases with expression between 30 and 70% and 47.6% with expression > 70% died. One patient with no p63 expression is still alive.

**Conclusions:** In this series, p63 expression was highly prevalent in patients with LSCC, but the prognostic relevance was unclear, suggesting a role in the early steps of carcinogenesis.

### 131. OPTICAL IMAGING OF ORAL CAVITY LESIONS

**Jing Shen MD**; Shawn Newlands MD; Massoud Motamedi PhD, University of Texas Medical Branch

**Objective:** Fluorescence imaging and optical coherence tomography have both been evaluated for detection of oral cavity neoplasms. Fluorescence image guided optical coherence tomography (Fig-OCT) is a new imaging modality combining the autofluorescence property of head and neck neoplasms and optical coherence tomography technology into one system. In lesions where autofluorescence is detected by the Fig-OCT probe, OCT image can be obtained to show the tissue microstructure. In this study, we examine the feasibility and diagnostic potential of Fig-OCT for screening and imaging cancerous and pre-cancerous lesions in oral cavity.

**Method:** The Fig-OCT probe system was developed by the biomedical engineering department in our institute. In animal model, neoplasm was induced in the hamster cheek pouch by applying carcinogen. Fig-OCT was used to examine the induced cancerous and pre-cancerous lesions in the cheek pouch mucosa. In vivo Fig-OCT Images of suspicious oral cavity lesions were also obtained from 6 patients prior to biopsy. Fig-OCT images were compared to the representative histological cross-sections of the area scanned for correlation.

**Result:** In hamster cheek-pouch model, Fig-OCT distinguished carcinoma in situ and invasive carcinoma from normal tissue. In

vivo Fig-OCT images were collected from floor of mouth, lateral tongue and lip lesions. The pathology imaged included necrotizing granuloma, leukoplakia and squamous cell carcinoma. Fig-OCT distinguished cancerous lesion from benign lesion based on autofluorescence of the lesion and change in the microstructure of the tissue where fluorescence was detected.

**Conclusion:** Fig-OCT can potentially be a powerful imaging modality in early detection of cancerous and pre-cancerous lesions in oral cavity.

### 132. PERIOPERATIVE COMPLICATION RISK FACTORS IN A VETERAN POPULATION UNDERGOING EXTENDED HEAD AND NECK SURGERY

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**Objective:** To assess the relationship of intraoperative fluid administration and comorbidity on perioperative complications in patients undergoing extended head and neck surgery.

**Design:** Retrospective cohort study of patients undergoing extended head and neck surgery at a tertiary care VA medical center.

**Methods:** A total of 167 patients who underwent surgery lasting longer than 2 hours and who required postoperative admission to the intensive care unit between September 1999 and September 2005 were included. Multiple data were gathered from the chart. Comorbidity was measured by the Adult Comorbidity Evaluation-27 (ACE-27) grade and American Society of Anesthesiologists (ASA) scale. Student's t-test was used to identify relationships between the variables. In addition, the effect of fluid administration on postoperative complications was adjusted for comorbidity status using a multiple logistic regression model.

**Results:** Among the total group of 167 patients, 64 (38%) had postoperative complications. In comparing the group of patients who had complications with the group that did not, there was a statistically significant difference in ACE-27 grade (p-value < 0.001), ASA class (p-value < 0.001), length of surgery (p-value = 0.07), and intravenous fluid received intraoperatively (p-value = 0.09). The association between fluid administration and complications was strengthened after adjusting for other risk factors in a multiple logistic regression model. Significant risk factors with odds ratios (95% confidence intervals) included ASA class 2.8 (1.3, 6.2) p=0.01, ACE-27 grade 1.7 (1.1, 2.6) p=0.03 and the volume of intraoperative fluid administration 1.2 (1.0, 1.3) p=0.02.

**Conclusion:** In contrast to other reports, complications in this series were not only associated with advanced comorbidity, but analysis also revealed an increased risk of perioperative complications among patients with increased intraoperative fluid administration, independent of preoperative comorbidity. This increased risk of complications was not simply associated with large amounts of intraoperative fluid administration but increased in a continuous manner as administered fluid volume increased. This may represent an area for intervention to decrease the risk of postoperative complications.

### 133. PACLITAXEL INDUCED APOPTOSIS IN MEDULLARY THYROID CARCINOMA FOLLOWING INHIBITION OF SURVIVIN

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**Objective:** Medullary thyroid carcinoma (MTC) is a neuroendocrine tumor which is primarily treated surgically as it is highly resistance to chemotherapy and radiation therapy. Resistance to treatment is afforded by aberrations in cellular protein expression. Survivin, an inhibitor of apoptosis, has been identified in MTC cell lines and shown to be overexpressed, resulting in decreased cell death. The purpose of this study was to investigate the effects of Paclitaxel in MTC following modulation of Survivin expression.

**Methods:** Survivin expression was analyzed in human MTC cell lines DRO8-1 and TT using RT-PCR and Western blot. Modulation of Survivin was accomplished using siRNA transfection and adenoviral vector infection for downregulation and upregulation,

respectively. These cells were exposed to Paclitaxel at concentrations of 10 nM, 30nM and 100nM, and apoptosis was analyzed using DNA ladder and flow cytometry. Western blot was used to analyze the levels of caspase-7, a pro-apoptotic protein that is inhibited by survivin, as a marker of apoptosis.

**Results:** siRNA transfection resulted in approximately 90% reduction in the levels of Survivin, while adenoviral vector infection increased the levels by 60%. Control cells and upregulated cells treated with Paclitaxel demonstrated an increase in Survivin and resistance to apoptosis. Downregulated cells treated with Paclitaxel were induced to undergo apoptosis. Caspase-7 was also increased in cells with Survivin downregulation.

**Conclusion:** This study has demonstrated the following: 1. Survivin expression in MTC provides resistance against Paclitaxel. 2. Downregulation of Survivin increases cell death in MTC treated with Paclitaxel. These findings have significant implications for the role of Survivin in MTC chemotherapy resistance and provide an argument for the development of directed therapy targeting Survivin.

## 134. MUCOSAL MELANOMA OF THE NOSE AND PARANASAL SINUSES

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**Introduction:** Sinonasal mucosal melanoma is a rare disease associated with a poor outcome. Prognostic indicators are not uniform among the different series published.

**Objectives:** To assess the clinical characteristics, outcomes and to identify prognostic factors for patients treated for this disease at a large cancer center.

**Methods:** The medical records of 56 patients with sinonasal melanoma treated at MD Anderson Cancer Center between 1993 and 2004 were reviewed. Primary and salvage treatment approaches were evaluated, and the survival rate was calculated by the Kaplan-Meier method. Patients were staged according to the AJCC staging system and prognostic indicators were determined by univariate and multivariate analysis.

**Results:** There were 32 males and 24 females and the mean age at presentation was 64 years old. Twenty-seven patients (48%) were previously untreated, whereas 29 had persistent or recurrent disease. The tumor originated in the nasal cavity in 35 patients (63%) and in the paranasal sinuses in 21 (37%) patients, with the maxillary sinus most frequently involved. Orbital involvement was present in eleven patients (19%). 14 patients (25%) presented with stage I disease, 17 with stage II (30%), 9 with stage III (16%) and 16 with stage IV (28%). 52 patients (89%) were treated with surgery being medial maxillectomy the most frequent procedure performed. Postoperative radiation therapy was used in 29 patients (52%) while 7 patients (13%) had other forms of radiation. Distant metastasis was the initial form of failure in 9 patients (16%). The median follow-up was 20 months and the 5 year survival was 41%. The stage of disease at presentation was a strong predictor of overall patient outcome, (5 year survival: I & II - 59.2%, III & IV - 18%,  $p = 0.011$ ). Tumor size was also found to be predictive of outcome (5 year survival: T1 & T2 - 52.8%, T3 & T4, 21.2%;  $p = 0.038$ ). Surgical treatment, radiation therapy, gender, age, status of disease at presentation, location of the primary and stage of the neck did not reach statistically significant values.

**Conclusions:** For patients with sinonasal melanoma treated at our institution, initial staging and tumor size were found to be important prognostic indicators. The overall survival of our patient cohort compares favourably with recent international series. Further investigation is required to define the ideal treatment paradigm for these patients.

## 135. VOCAL SPECTROGRAPHIC EVALUATION IN PATIENTS SUBMITTED TO THYROIDECTOMY

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**Background:** Recent studies have showed voice alterations after thyroidectomy even with a preserved function of the recurrent

laryngeal nerve. However, there is no study on such patients to evaluate the voice alterations using the narrow band spectrographic analysis.

**Purpose:** To evaluate the vocal spectrography of subjects before and after thyroidectomy.

**Methods:** Prospective study of a consecutive series of patients submitted to thyroidectomy at a tertiary cancer center. A video-laryngoscopic exam, a narrow band spectrographic acoustic evaluation (Multi-Speech - Kay Elemetrics) and a perceptual auditory analysis (GRBAS) were performed before and 2 weeks after surgery. A total of 44 patients were enrolled and 30 (68%) were eligible to the study. Ten percent of patients were tobacco users and 43.3% alcohol users. In 80% of patients a total thyroidectomy was performed, and in 6.6% the intubation was considered difficult. Even with observed alterations in the voice subjective parameters 2 weeks after surgery, there was no significant difference in the vocal narrow band spectrographic evaluation between the pre and postoperative assessments.

**Conclusion:** Subjects who underwent thyroidectomy can present vocal alterations even with a preserved function of the recurrent laryngeal nerve, however, the narrow band spectrographic evaluation can not be considered a good and sensitive method to analyze such voices. The vocal signs and symptoms presented in this sample could suggest a vocal tract alteration instead of an exclusive glottic level impairment.

## 136. INTRAOPERATIVE LARYNGEAL NERVE MONITORING DURING THYROIDECTOMY - ANALYSIS OF ITS EFFECT ON LARYNX AND VOICE

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**Background:** The results of studies related to intraoperative laryngeal nerve monitoring during thyroidectomy are controversial, and its effectiveness need to be investigated further. However, voice alterations can occur even with preserved laryngeal nerve integrity.

**Purpose:** To evaluate the larynx and voice in patients submitted to thyroidectomy with intraoperative nerve monitoring, before and 2 weeks after surgery, and compare the results to a similar group of patients without intraoperative nerve monitoring.

**Methods:** A prospective study of a consecutive series of patients undergoing thyroid surgery using the intraoperative nerve monitoring was performed. All patients were submitted to a subjective voice perceptual auditory analysis, acoustic analysis (Multi Speech - Kay Elemetrics), videolaryngoscopic exam, and a Voice Handicap Index (VHI) questionnaire before and 2 weeks after surgery. A previous consecutive series of 100 similar patients without nerve monitoring was used to compare the results.

**Results:** A total of 104 subjects with intraoperative nerve monitoring were evaluated. A total thyroidectomy was performed in 65 patients (62.5%). The mean anesthetic time was 167.6 minutes, and in 12 patients the intubation was considered difficult. A well-differentiated carcinoma was diagnosed in 47 patients (45.2%). Postoperative complications occurred in 11 patients (0.6%). Twelve patients (11.5%) presented vocal fold immobility after surgery. Among the 92 patients without vocal fold immobility, 17 (18.5%) showed alterations in the general dysphonia degree in the perceptual auditory analysis after surgery, being the instability the most frequent impaired parameter (19.6%). The VHI final score was impaired in just 3 subjects (3.3%). In the previous series of 100 similar patients who underwent thyroidectomy without nerve monitoring, 12 patients (11.2%) presented vocal fold immobility, 22 (29.7%) of the patients without vocal fold immobility presented alterations on the perceptual analysis, being roughness the most frequent impaired parameter, and the final VHI score was altered in just 2.2% of the subjects. The acoustic analysis showed impaired parameters in both groups after surgery without a significant difference between both groups.

**Conclusion:** Despite of a similar occurrence of vocal fold immobility in both groups, it was observed a lower number of vocal alterations in the group of patients using the intraoperative nerve monitoring. These findings could be secondary to a lesser extent of laryngeal nerve dissection with a limited handling of the nerve

and the muscles around the operative field, and also, to a better identification and preservation of the external branch of the superior laryngeal nerve.

### 137. MOLECULAR PROFILE OF EXOSOMES IN SERA OF PATIENTS WITH HEAD AND NECK CANCER (HNC): MAY SERVE AS BIOMARKERS OF DISEASE PROGRESSION

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**Objective:** Exosomes are membranous vesicles (MV) originating from normal or malignant cells. Tumor-derived MV induce apoptosis of activated immune cells. This study was performed to determine whether the molecular profile of MV isolated from sera of patients with HNC could serve as a biomarker of disease activity and outcome.

**Methods:** Sera were collected from consecutively-seen patients with HNC at the outpatient clinic of the University of Lubeck and maintained frozen until processed at the University of Pittsburgh. MV were isolated from sera of patients (n=34) and normal controls (NC; n=25) by chromatography on Sepharose 2B and ultracentrifugation (100,000 x g, 2h). Immunoblots of MV were performed with antibodies to MAGE 3/6, FasL and soluble MHC class I molecules (sMHCI) and semi-quantitatively analyzed using densitometry. Caspase activation in Jurkat cells expressing the CD8 receptor was evaluated with Z-VAD-FITC binding (% Z-VAD+ Jurkat cells) by flow cytometry after 6 h of co-incubation with isolated MV. MV isolated from supernatants (SN) of PCI-13, a HNSCC line transfected with the human FasL gene, and FasL-specific mAb (CH-11) were used as positive controls in apoptosis assays. Clinical data of patients were correlated to experimental results and statistically analyzed using SPSS software. p values <0.05 were considered significant.

**Results:** MV derived from 74% of HNC serum samples induced apoptosis in Jurkat cells (up to 84% Jurkat cells were Z-VAD+; mean= 30% +/- 25), while MV isolated from NC sera showed little Z-VAD binding (0.02% +/- 0.01). In patients with lymph node (LN) metastasis (n=15), MV induced caspase activity in 45% +/- 30 Jurkat cells compared to 18% +/- 13 with MV of patients without LN metastases (n=14) (p=0.008). Quantification of FasL expression on MV from active disease patients (n=20) was high (497 units), in NED patients (n=14) it was 311 units and in NC, 60 units (p<0.01). MV in 32% of patients expressed this tumor marker.

**Conclusion:** Tumor-derived MV in HNC sera had a molecular profile distinct from that of MV in NC. The ability of MAGE 3/6+ MV to induce apoptosis in Jurkat cells correlated with the presence of LN metastasis. These MV were characterized by expression of FasL and sMHCI (apoptosis markers). Preliminary data suggest that MV/exosomes present in sera of HNC patients are biomarkers relevant to disease progression.

### 138. DERMATOFIBRO-SARCOMA PROTUBERANS OF THE SCALP

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A 35-year old man noticed a small, soft nodule on the hairline of his left forehead three years prior to being seen at our institution. With time, the mass had gradually increased in size to involve most of the left side of the forehead and scalp. On physical examination, a large soft tissue mass, firm and solid in consistency, was seen extensively involving the scalp and left forehead, with extension to the left orbital rim. An area of ulceration was present that involved the entire superior surface. The rest of the examination was unremarkable.



Computed tomography of the head revealed a soft tissue mass on the scalp measuring 11.8 x 17.0 x 15.0 cm and heterogeneous in density with cystic and/or necrotic areas. A region of bone erosion measuring 1.0 x 0.6 cm was found involving the outer table of the frontal bone. The orbits were uninvolved. The patient had an incisional biopsy which revealed spindle cells forming a swirling or storiform pattern, as well as infiltration of subcutaneous fatty tissue. Immunohistochemical stains were positive for CD34 and vimentin, and negative for S100 protein, pancytokeratin, MART-1 and Melan-A. The above findings were consistent with dermatofibro-sarcoma Protuberans. Our case is unique for the remarkably large size of this rare tumor and the treatment challenges it poses.

### 139. VALIDATION OF COMORBIDITY INDEXES IN OLDER PATIENTS WITH HEAD AND NECK CANCER

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**Background:** Validation of indexes developed to measure comorbidities is an important step in its generalization. The most common indexes are NCI comorbidity index, ACE-27 index and Washington University Head and Neck Comorbidity Index (WUHNC). Our objective was to assess predictive and discriminative power of these three indexes in a cohort of older patients with head and neck cancer.

**Methods:** A cohort of 330 patients older than 70 years with histological diagnosis of head and neck cancer was used. We calculate each index value. NCI index and WUHNC index were classified by levels as suggested by developers. Overall survival curves using Kaplan-Meier method were built to assess predictive ability of each index. C-statistic was calculated to compare discriminative ability.

**Results:** 5-y overall survival for each index value were: NCI 0 (46.7%), NCI 1 (50.6%), NCI 2 (42.1%) and NCI >2 (26.6%); ACE27 0 (53.7%), ACE27 1 (46.6%), ACE27 2 (29.8%) and ACE27 3 (14.2%); WUHNC 0 (51.5%), WUHNC 1 (24.1%), WUHNC 2 (39.5%) and WUHNC >2 (19.5%). Log rank test p values were 0.047 for NCI and <0.001 for ACE27 and WUHNC. C-statistic values were 0.651 for NCI, 0.656 for ACE27 and 0.685 for WUHNC.

**Conclusion:** Discriminative ability of the indexes was similar when measured with C-statistic. However, predictive ability of ACE-27 was better. ACE-27 is a good discriminative and predictive index of comorbidity in head and neck cancer patients. WUHNC was not able to adequately predict overall survival in the cohort analyzed.

### 140. ULTRASOUND GUIDED ASPIRATION CYTOLOGY FOR THE ASSESSMENT OF THE CLINICALLY NO NECK; ITS ACCURACY REAPPRAISED

Maarten Borgemeester BA; Michiel van den Brekel MD; **Fons Balm MD;** Frank Pameijer MD, Netherlands Cancer Institute

**Background and Purpose:** To deal with the problem of occult neck metastases, one can either opt to treat necks electively or carefully wait and watch. To improve detection and minimize the prognostic impact of delayed metastasis detection, ultrasound guided-fine needle aspiration cytology (US-FNAC) can be used for initial staging and during follow-up.

**Methods:** A retrospective study was performed in 163 surgically treated patients without palpable neck nodes (NO). Patients were divided in 2 groups: 125 patients underwent a planned elective



neck dissection (END), and 38, mainly with T1 primary oral cancers, were planned for a watch and wait (WW) strategy but had preoperative USFNAC that could change this policy if metastases were detected.

**Results:** In the END group, US-FNAC had a sensitivity of 23% and a specificity of 100%. In the WW group, US-FNAC had a sensitivity of 9% and a specificity of 100%. There was a great variation in accuracy of different ultrasonographers. During follow-up, in the WW group neck node metastases were detected in 29 % of the patients, 5 to 145 weeks post-surgery (mean 31 weeks). Overall survival in the WW group was 87%, not different from the oral cancers in the END group.

**Conclusion:** The sensitivity of US-FNAC in this study of clinically N0 patients is low, and lower than reported in other studies. This study clearly shows that in the sensitivity of imaging is significantly lower in small primary tumors. As metastases are detected early during follow-up, prognosis seems not affected.

## 141. TUMOR RESPONSE CRITERIA ASSOCIATED WITH INCREASED SURVIVAL FOLLOWING ADENOVIRAL P53 GENE THERAPY IN PATIENTS WITH RECURRENT SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK

**Robert E Sobol MD;** John Nemunaitis MD; Gary Clayman MD; John Hamm MD; Sunil Chada PhD; Kerstin Menander MD; W. Jarrard Goodwin MD, Introgen Therapeutics, University of Texas M.D. Anderson Cancer Center, Houston, TX; Mary Crowley Medical Research Center, Dallas, TX; University of Louisville, Louisville, KY, University of Miami Sylvester Cancer Center, Miami, FL

There is a growing body of data indicating that conventional WHO and RECIST criteria do not optimally identify tumor responses associated with increased survival. We compared several response criteria to assess the efficacy of intratumoral adenoviral p53 gene therapy (Advexin) in a series of 106 patients with recurrent squamous cell carcinoma of the head and neck (SCCHN). The percentage of patients with tumor responses defined by reductions in bi-dimensional tumor area by CT scans of 50%, 25%, 10% or stable disease of > 3 months were 8%, 11%, 16% and 20% respectively. The median survival for the entire population was 5.9 months while the responder populations defined by tumor decreases of 50%, 25%, 10% or stable disease > 3 months had median survivals of 40.8, 13.7, 12.3 and 11.4 months respectively. There was a statistically significant increase in median survival for each of the responder populations compared to non-responders ( $p < 0.01$  for all comparisons by logrank test). Statistical significance was maintained for each of the response definitions in landmark analyses excluding patients with survivals less than 3 and 6 months respectively. Our findings suggest that convention WHO response criteria (> 50% reduction in tumor area) underestimates the percentage of patients who may benefit from Advexin therapy. Recurrent SCCHN tumor response definitions based upon smaller reductions in tumor size or the absence of progression (stable disease > 3 months) more accurately identified Advexin treated patients with increased survival than conventional response criteria.

## 142. END-TO-SIDE ANASTOMOSIS TO THE INTERNAL JUGULAR VEIN - A 10-YEAR EXPERIENCE

**Eric G Halvorson MD;** Cordeiro G Peter MD, Memorial Sloan-Kettering Cancer Center

**Introduction:** Venous patency is critical for successful free tissue transfer in head and neck reconstruction. Although multiple suitable arteries are often found, venous recipients are usually limited to the internal jugular vein, stumps of its branches, and/or the external jugular vein. We have found that preferential use of end-to-side anastomosis to the internal jugular vein offers distinct advantages, and has consistently yielded excellent outcomes. A 10-year experience with 320 cases is presented.

**Methods:** A prospectively maintained database was queried for patients who underwent free flap reconstruction of head and neck

oncologic defects from 1996 to 2006. Intravenous heparin was given prior to flap harvest, and aspirin was administered for 5 days post-operatively. End-to-side venous anastomosis was performed with 9-0 nylon continuous suture. Patient demographics, donor and recipient sites, and complications were noted for all patients.

**Results:** Over a 10-year period, 320 patients underwent free tissue transfer for head and neck reconstruction with end-to-side anastomosis to the internal jugular vein. Mean patient age was 56 years (range 7-88). The most common flaps employed were the rectus (33%), forearm (28%), and fibula (21%) flaps. The most common recipient sites were the mandible with or without floor of mouth (27%), pharyngoesophagus (25%), and tongue or cheek (17% each). Partial flap loss was seen in 2%. Total flap loss, arterial thrombosis, and venous thrombosis all occurred in less than 1% of patients.

**Conclusion:** Presented is a large series of consecutive cases by a single surgeon at one institution over a 10-year period, with preferential use of end-to-side anastomosis to the internal jugular vein for free flap reconstruction of head and neck oncologic defects. Excellent outcomes were noted, which compare very favorably with other described techniques. The size, constant anatomy, patency, and possibility for multiple anastomoses make use of the internal jugular vein very advantageous. In addition, kinking is not observed when the neck is rotated. Contrary to other studies, no cases of internal jugular vein thrombosis were noted.

## 143. USE OF SUPERFICIAL TEMPORAL VESSELS AS FIRST CHOICE RECIPIENTS IN MICROVASCULAR ORBIT AND SCALP RECONSTRUCTION

**Eric G Halvorson MD;** Cordeiro G Peter MD; Joseph J Disa MD; Elizabeth Wallin MD; Babak J Mehrara MD, Memorial Sloan-Kettering Cancer Center

**Introduction:** The superficial temporal artery and vein (STA/V) are often considered second choice recipient vessels due to anecdotal reports that they are unreliable and prone to spasm. This is unfortunate, as the position of these vessels in relation to the scalp and orbit greatly facilitates reconstruction. The purpose of this study was to evaluate our experience with these vessels in upper craniofacial reconstruction and to compare success rates with traditional neck recipient vessels.

**Methods:** All patients who underwent microvascular head and neck reconstruction over a 4-year period by a single surgeon were identified. Outcomes in flaps anastomosed to the STA/V were compared with those anastomosed to neck vessels using a 2-tailed Fisher's Exact Test.

**Results:** During the study period, 145 patients underwent free flap craniofacial reconstruction. The STA/V were the first choice recipient vessels for orbit/scalp reconstruction and were explored in 18 patients and used in 15 patients (83%). In 2 of these 15 patients the STV was inadequate requiring the use of the posterior auricular vein in 1 case and the internal jugular vein in the other. Two patients (13%) with a history of radiation therapy experienced vessel thrombosis and were salvaged by vein grafting to neck vessels. There were no complete (0%) and 2 partial flap losses (13%) in the STA/V group. Neck vessels were used in 130 patients. Microvascular thrombosis occurred in 5 (3.8%), of which 2 were salvaged (total flap loss rate of 2.3%); 4.6% had partial flap loss. The differences in outcomes between the two patient groups were not statistically significant.

**Conclusion:** The STA/V are reliable and available in most patients for microsurgical transfer, and should be considered as first choice recipient vessels for reconstruction of the orbit and scalp. Although great care is necessary in their dissection, the STA/V offer proximity, allowing more flexibility in flap pedicle length requirement and avoiding the use of vein grafts. Caution should be exercised if there is a history of radiation or ipsilateral neck dissection.



## 144. IS ELECTIVE DISSECTION OF LEVEL II-B NECESSARY IN PATIENTS UNDERGOING LATERAL NECK DISSECTION FOR FNA-CONFIRMED NODAL METASTASES IN PAPILLARY THYROID CANCER?

**Tarik Y. Farrag, MD;** Frank R. Lin, MD; Noel Brownlee, MD, PhD; Matthew Kim, MD; Sheila Sheth, MD; Ralph P. Tufano, MD, Johns Hopkins School of Medicine

**Objective:** To determine the utility of elective dissection of level II-B in patients with papillary thyroid cancer (PTC) undergoing lateral neck dissection for ultrasound guided FNA confirmed nodal metastases.

**Study Design:** Retrospective chart review.

**Methods:** Charts of 41 consecutive patients (February 2002-April 2006) with PTC who underwent lateral neck dissection that included at least levels II-A and II-B that were designated as such prior to surgical pathology specimen processing. Reports of the pre-operative FNA cyto-pathologic findings, the extent of lateral neck dissection by levels, and the post-operative final histo-pathological examination were reviewed.

**Results:** 41 patients underwent lateral neck dissection for FNA-confirmed nodal metastasis of PTC. 36 patients had PTC, 4 had PTC (tall cell variant), and 1 had follicular variant of PTC on final surgical pathology. 8 patients underwent neck dissection at the time of thyroidectomy, while 33 underwent neck dissection for neck recurrence/persistence of PTC after thyroidectomy. 35 patients underwent unilateral neck dissection; while 6 had bilateral neck dissection resulting in a total of 47 neck dissection specimens evaluated. Levels II-A and II-B were excised in 47/47 neck dissections, with 26 out of 47 specimens (26/47=55%) positive for metastasis. Level II-B was positive 4 times (4/47=8.5%) 95% CI: (2.4, 20.4). One patient had undergone a previous neck dissection that did not include level II-B. Level III was excised 46 times and was positive in 28 specimens (61%). Level IV was excised 45 times and was positive in 21 specimens (47%). Level V was excised 35 times and was positive in 11 specimens (31%).

**Conclusion:** Cervical lateral neck metastases in PTC occur in a predictable pattern. Patients with PTC undergoing lateral neck dissection for FNA confirmed nodal metastases might harbor disease in level II-B. Consideration should be given to level II-B excision in this patient population.

## 145. MUTANT RAD50-MEDIATED DISRUPTION OF THE MRN DNA REPAIR COMPLEX SENSITIZES HUMAN HEAD AND NECK CANCER TO CISPLATIN

**Waleed M Abuzeid MD;** Guoli Shi PhD; Joung Rhee PhD; James Carney PhD; Bert W O'Malley, Jr. MD; Daqing Li MD, Department of Otorhinolaryngology - Head & Neck Surgery, University of Pennsylvania Health System, Philadelphia, PA, USA; Departments of Biochemistry and Radiation Oncology, University of Maryland School of Medicine, Baltimore, MA, USA

Survival from head and neck squamous cell carcinoma (HNSCC) has not improved over several decades. Cisplatin is the mainstay of adjuvant treatment for HNSCC. However, HNSCC cells often display cisplatin resistance, necessitating dose escalations, which produce severe toxicity. A key mediator of cisplatin resistance is the Mre11, Rad50, Nbs1 (MRN) complex, which repairs DNA double-strand breaks (DSBs). We hypothesize that molecular disruption of MRN will enhance cisplatin cytotoxicity. We have designed a novel, recombinant adenoviral vector containing a mutant Rad50 gene (Ad-Rad50) that disrupts the function of the MRN complex. Cell proliferation assay showed that Ad-Rad50, with cisplatin, produced significantly slower cancer cell growth than any other treatment group. This was associated with increased DNA DSBs, quantified by neutral comet assay, relative to all other groups ( $P < 0.01$ ). Impairment of MRN-mediated DNA repair by Ad-Rad50 allows lethal cell damage to accumulate in cisplatin-treated cells. HNSCC cells can achieve immortality through telom-

erase activation. MRN mediates telomerase function. Telomere length analysis revealed shorter telomeres in the Ad-Rad50 with cisplatin group, relative to all other groups ( $P < 0.01$ ), contributing to enhanced cisplatin cytotoxicity. Cisplatin induces a dose-dependent G2/M cell cycle arrest. At tested doses, flow cytometry showed no increase in the proportion of arrested cells treated with cisplatin alone. The addition of Ad-Rad50 produced G2/M arrest in the majority of HNSCC cells ( $P < 0.005$ ) by allowing cisplatin-induced damage to accumulate, producing arrest. Mice, treated with Ad-Rad50 and cisplatin in combination, had significantly smaller tumors than untreated controls and other treatment groups. Preliminary data suggests that Ad-Rad50, with low-dose cisplatin, can produce tumor volume reduction which matches or exceeds that produced by higher, clinically-utilized doses of cisplatin. Our study demonstrates that Ad-Rad50 enhances cisplatin cytotoxicity in HNSCC by increasing DNA DSBs, telomere shortening, and through enhancement of G2/M cell cycle arrest. This translates to tumor volume reduction in vivo. Sensitizing HNSCC to cisplatin with Ad-Rad50 may allow for the use of lower and safer cisplatin doses, clinically.

## 146. ALLOGENEIC VACCINE WITH IMMUNOMODULATION FOR ORAL CANCER

**M Couch MD;** T Cannon MD; S Epperly MD; S Cowherd MD; T Moran MD; E Jaffee MD; J Serody MD, 1University of North Carolina, Chapel Hill, NC; 2Johns Hopkins Hospital, Baltimore, MD

**Objective:** Previous work in our laboratory demonstrated that genetically engineered autologous tumor cells that secreted granulocyte monocyte - colony stimulating factor (GM-CSF) generated an anti-tumor response. Our current hypothesis was that the secretion of GM-CSF by an allogeneic whole tumor cell vaccine would prevent or suppress progression of head and neck squamous cell carcinoma (HNSCC) in an immunocompetent murine model using SCCF/VII cells in C3H/HeN mice. Our second hypothesis was that specific chemotherapy agents, given in a single low dose, would act as an immunomodulator and augment the anti-tumor effect of the vaccine if given in proper sequence with the vaccine.

**Methods:** Flow cytometry using a monoclonal antibody to the HER-2/neu transmembrane receptor protein (Ab-4) was used to determine whether the SCCF/VII cell line had endogenous expression of this proto-oncogene. ELISA assays determined the GM-CSF levels in the transfected cell lines. Protection assays were used to determine the anti-tumor effect of the vaccinations. The NIH 3T3 cell line had both GM-CSF and HER-2/neu transfected into it. Mice were vaccinated in the floor of mouth (FOM), and draining lymph node basins then challenged in 7 days with SCCF/VII cells that had HER-2/neu transfected into them. Tumor development and tumor size were monitored. Intracellular cytokine staining was performed to monitor T cell response. Cyclophosphamide or paclitaxel was given 1 day prior to vaccination in a second set of related experiments. Blood was collected to determine if the chemotherapeutic agents were causing the white blood cell count to decrease.

**Results:** The genetically engineered allogeneic whole tumor cells with GM-CSF secretion were effective as a vaccine since this delayed tumor growth and size. Survival was enhanced in the vaccine groups. A tumor-specific response was seen that was greater than the allogeneic response seen. The addition of either cyclophosphamide or paclitaxel one day prior to the vaccination enhanced the anti-tumor effect seen.

**Conclusions:** This represents a novel approach to adjuvant therapy for HNSCC. This approach takes advantage of cross-presentation to stimulate the immune system. The allogeneic whole tumor cell vaccine avoids the technical difficulties of using syngeneic tumor cells such as harvesting the tumor cells and standardizing each vaccine. A dose-response anti-tumor response was seen using the single low dose of a chemotherapeutic agent as an immune modulator.

# Certificate of Incorporation

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## CERTIFICATE OF INCORPORATION OF

### THE AMERICAN HEAD AND NECK SOCIETY, INC.

*Under Section 803 of the Not-for-Profit Corporation Law*

1. The name of the Corporation is THE AMERICAN HEAD AND NECK SOCIETY, INC.
2. This Corporation has not been formed for pecuniary profit or financial gain, and shall not be conducted or operated for profit, and no part of the assets, income or net earnings of the Corporation is distributable or shall inure to the benefit of the directors, officers, or other private persons, except to the extent permitted under the Not-for-Profit Corporation Law. Upon the dissolution of this Corporation, no director, officer, or other private person shall be entitled to any distribution or division of its remaining property or its proceeds, and the balance of all money and property of the Corporation shall pass to, or shall inure to the benefit of, those organizations described in Section 201 of the Not-for-Profit Corporation Law and Section 501(c)(3) of the Internal Revenue Code of 1986, which are not private foundations described in Section 509(a) of such Code. Any such assets not so disposed of shall be disposed of by the Supreme Court of the State of New York for the County in which the principal office of the Corporation is then located, as provided by law, exclusively for such purposes or to such organization or organizations as said Court shall determine, which are organized and operated for the purposes set forth in Paragraph "3" below.
3. The purposes for which the Corporation is formed and the powers which may be exercised by the Corporation, in addition to the general powers set forth in Section 202 of the Not-for-Profit Corporation Law of the State of New York, are:
  - (a) to advance knowledge relevant to medical and surgical control of neoplasms of the head and neck;
  - (b) to solicit, obtain, apply for, and spend funds in furtherance of any activities or purposes of the Corporation;
  - (c) in general, to do any and all acts or things and to exercise any and all powers which may now or hereafter be lawful for the Corporation to do or exercise under and pursuant to the laws of the State of New York for the purpose of accomplishing any other purpose of the Corporation as set forth herein;
  - (d) to engage in any and all lawful activities incidental to any of the foregoing purposes of the Corporation.
4. The Corporation is organized exclusively to achieve public objectives, including for such purposes, the making of distributions to organizations that qualify as exempt organizations described in Section 115 or Section 501(c)(3) of the Internal Revenue Code of 1986, provided that such organizations are not private foundations described in Section 509(a) of such Code. The Corporation shall not carry on any other activities not permitted to be carried out by a corporation exempt from federal income tax under Section 501(c)(3) of such Code or by a corporation contributions to which are deductible under Section 170(c)(2) of such Code (or the corresponding provisions of any future United States Internal Revenue Law.)
5. Nothing contained herein shall authorize this corporation to undertake or to carry out any of the activities specified in paragraphs (b) through (u) of Section 404 of the Not-for-Profit Corporation Law, or to establish, maintain or operate a hospital or to provide hospital service or health-related service, a certified home health agency, a hospice, a health maintenance organization, or a comprehensive health services plan, as provided for by Article 28, 36, 40 and 44, respectively, of the Public Health Law or to solicit, collect or otherwise raise or obtain any funds, contributions or grants from any source, for the establishment, maintenance or operation of any hospital or to engage in the practice of medicine or any other profession required to be licensed by Title VIII of the Education Law.
6. No substantial part of the activities of this Corporation shall consist of carrying on propaganda or otherwise attempting to influence legislation, and the Corporation shall not participate in, or intervene in (including the publication or distribution of statements), any political campaign on behalf of any candidate for public office.
7. The Corporation is a corporation as defined in subparagraph (a)(5) of Section 102 of the Not-for-Profit Corporation Law, and it is a Type B Corporation.
8. The principal office of the Corporation is to be located in the City of Syracuse, County of Onondaga and State of New York.
9. The territory in which the Corporation's activities are principally to be located is the territorial limits of the United States of America, the Domain of Canada and the Pan-American countries.
10. The number and manner of election or appointment of the directors constituting the Board of Directors shall be as provided in the Bylaws, except that the number of said Board members shall not be less than three (3). Members of the Board of Directors need not be residents of the State of New York. The names and addresses of the Directors of the Corporation who shall act until the first meeting of the Board of Directors, all of whom are over the age of eighteen (18) and are citizens of the United States, are:

NamesAddresses  
[Names and Addresses omitted.]
11. Management of the business and affairs of the Corporation is vested in the Board of Directors which shall use its best efforts to carry out in good faith the purposes of the Corporation.
12. To further the Corporation's objectives and purposes, the Corporation shall have and may exercise all of the powers conferred by the New York Not-for-Profit Corporation Law in pursuit of the purposes expressed in Paragraph THREE hereof. Without limiting the generality of the foregoing, the Corporation shall have power to sue and be sued, to own, take

# Certificate of Incorporation

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title to, receive and hold, lease, sell and resell, in fee simple or otherwise, property real, personal or mixed wherever situated and however acquired, without limitation as to amount or value. The Corporation shall have authority to encumber property by deed of trust, pledge or otherwise; to borrow money and secure payment of same by lien or liens of the realty or personal property of the Corporation; to lease, build, erect, remodel, repair, construct and/or reconstruct any and all buildings, houses or other structures necessary, proper or incident to its needs and proposes; and to do any and all things incident to the carrying out of the objectives and purposes as stated and as limited herein. The Corporation shall have full powers or management, investment and reinvestment and the collection of all rents, revenues, issues and profits arising therefrom.

13. The Corporation is to have members.
14. The Corporation is to be divided into such classes of members as the By-Laws provide. The designation of each class of members, the manner of election or appointment, and the qualification and rights of the members of each class (including conferring, limiting, or denying the right to vote) shall be set forth in the By-Laws.
15. The Secretary of State of the State of New York is hereby designated as the agent of the Corporation upon whom process may be served, and the post office address to which the Secretary of State shall mail a copy of any such process served upon him is as follows: c/o Richard R. Gacek, M.D., Professor and Chairman, Department of Otolaryngology, State University of New York Health Science Center, 750 East Adams Street, Syracuse, New York 13210.

## Constitution

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### ARTICLE I

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**Section 1.** The name of the Corporation shall be The American Head and Neck Society, Inc.

### ARTICLE II

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**Section 1.** The purpose of this Society is to promote and advance the knowledge of diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and the prevention of neoplasms and other diseases of the head and neck.

**Section 2.** It is the objective of this Society to promote and advance research in neoplasms and other diseases of the head and neck.

**Section 3.** It is the objective of this Society to promote the highest professional and ethical standards.

### ARTICLE III

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**Section 1.** Members of this Society shall be designated as Fellows, and shall consist of six classes

- (a) Active
- (b) Honorary
- (c) Corresponding
- (d) Senior
- (e) Associate
- (f) Candidate

**Section 2.** Active Fellows of this Society shall be those who maintain a license to practice medicine and who are actively engaged in diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and the prevention of neoplasms and other diseases of the head and neck.

**Section 3. Qualifications for Active Fellowship.** An applicant for Active Fellowship shall be a Diplomate of a particular specialty board, or have credentials that are equivalent to those issued by member boards of the American Board of Medical Specialties.

Surgeons must be a member of the American College of Surgeons, a Fellow of the Royal College of Surgeons (Canada), or have similar credentials. A significant portion of practice shall be concerned with managing patients with neoplasms and other diseases of the head and neck. Further qualifications and requirements for Active Fellowship are contained in the By-Laws, Article VI, Sections 1 and 2.

**Section 4. Qualifications for Honorary Fellowship.** Honorary Fellowship shall be a distinction bestowed by the Society on an individual who has made outstanding contributions to the field of head and neck oncology.

**Section 5. Qualifications for Corresponding Fellowship.** Corresponding Fellowship shall be granted to those who, in the judgment of the Council, are actively engaged in the prevention, diagnosis, treatment and rehabilitation of patients with neoplasms and other diseases of the head and neck and who reside in a country other than the United States or Canada.

**Section 6. Qualifications for Senior Fellowship.** Any Active Fellow, upon cessation of active practice, may request by writing to the Secretary a change in status to Senior Fellowship.

**Section 7. Qualifications for Associate Fellowship.** A candidate for election to Associate Fellowship shall be a physician, dentist or allied scientist who has demonstrated a special interest in the field of head and neck oncology.

**Section 8. Qualifications for Candidate Member.** The trainee currently enrolled in, or a graduate of, an approved residency program in Otolaryngology, Plastic Surgery, or General Surgery or in a Fellowship Program approved by the Joint Training Council may become a Candidate Member. This nonvoting membership is subject to fees established by the Council. The membership shall expire if the candidate member has not made application for Active Fellowship in The American Head and Neck Society, Inc. five years after the completion of training.

**Section 9. Privileges of Members.** All members shall have the same rights and privileges except that only Active Fellows in good standing shall have the privileges of voting in the conduct of the affairs and business of the Society or of holding office or of chairing Standing Committees.

# Constitution

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## ARTICLE IV

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### Meetings

**Section 1.** The annual meeting of this Society shall be held at such time and place as may be fixed by the Council at its annual meeting.

**Section 2.** The annual meeting shall consist of at least one scientific session and one business session.

**Section 3.** The scientific session shall be open to all Fellows of the Society and members of the medical profession. Attendance at any business session is limited to Fellows of the Society.

**Section 4.** Only Active Fellows in good standing shall have the privilege of a vote in conduct of the affairs and business of the Society.

## ARTICLE V

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### Officers

**Section 1.** The officers of this Society shall be President, President-Elect, Vice-President, Secretary, and Treasurer.

## ARTICLE VI

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### Board of Directors

**Section 1.** The governing body of this Society shall be the Council, consisting of the President, President-Elect, Vice-

President, Secretary, Treasurer, and Past Presidents (for a period of three years following the termination of term of office). In addition, there shall be nine Fellows-at-Large, three of whom shall be elected each year to serve terms of three years each. At no time shall the Council exceed eighteen in number. The manner of election of officers and members of the Council is stated in the By-Laws, Article VII, Sections 1 and 2.

## ARTICLE VII

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### Amendments to the Constitution or Bylaws

**Section 1.** A proposed amendment to the Constitution or By-Laws must be submitted to the Secretary in writing not less than two months before a meeting of the Council, and must be signed by at least two Active Fellows. The Secretary shall forward the proposed amendment to the Constitution and Bylaws Committee for review and comment. The Constitution and Bylaws Committee will make a periodic review of the Constitution and Bylaws and recommend modification which may be submitted as amendments. Any proposed amendment must first be acted upon by the council. The Secretary shall mail a copy of any proposed amendment to each Active Fellow not less than one month prior to the annual meeting of the Society. Two-thirds vote of the Active membership present at the meeting shall be required for acceptance.

# Bylaws

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## ARTICLE I

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### Rights and Duties of Members

**Section 1.** Any Active Fellow shall have all the rights of Fellowship, shall be subject to all the duties, roles and responsibilities incumbent upon the members of any scientific parliamentary body.

## ARTICLE II

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### Delinquents

**Section 1.** Unless excused by the Council, a Fellow delinquent in dues for two consecutive years, or attendance for four consecutive years, shall be dropped from Fellowship. Delinquency in dues is defined as failure to pay by the end of the calendar year.

## ARTICLE III

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### Dues

**Section 1.** The amount of the Society's dues shall be determined by the Council. The Council shall have the authority to establish an initiation fee or special assessment.

## ARTICLE IV

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### Order of Business

**Section 1.** The regular order of business at annual meetings shall be carried out in a manner prescribed by the Council.

## ARTICLE V

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### Special Provisions

**Section 1.** All conditions, circumstances, emergencies or contingencies not covered by this Constitution and its Bylaws shall be dealt with and administered by the directive of the Society's Council, subject to approval by the membership at the next annual meeting.

## ARTICLE VI

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### Qualifications for Fellowship

**Section 1.** Candidates desiring election to Fellowship in any class other than Associate Fellow must hold a valid, unrestricted license to practice medicine in the state or country in which they reside and shall be proposed by two Active Fellows with at least one from the applicant's local geographical area. A special form will be provided by the Secretary for this purpose. Both of the sponsors must submit letters of recommendation pertaining to the qualifications of the candidate.

**Section 2.** *Special Qualifications for Active Membership.*

- A. In addition to fulfilling the requirements under the Constitution, Article III, Section 3, surgeon candidates must submit evidence that they have the skill and capacity to diagnose and treat neoplasms and other diseases of the head and neck.
- B. An applicant for Active Fellowship shall provide documenta-

tion that he or she has received adequate training in the management of patients with head and neck tumors and that a significant portion of current professional activity is devoted to the care of such patients. Such documentation will include a description of experience during residency and/or fellowship training, a summary of subsequent post training experience, and a listing of at least 35 patients with head and neck tumors managed during preceding year. Additional evidence of academic activity such as one paper published on cancer of the head and neck is required.

C. Active Fellows must be members of the American College of Surgeons or its equivalent.

### **Section 3.** *Special Qualifications for Corresponding Fellowship.*

A. Corresponding Fellows shall be physicians who, by their professional associations and publications, would appear in the judgment of the Council to be qualified to treat neoplasia and diseases of the head and neck. All proposals for candidates for Corresponding Fellowship shall be accompanied by a curriculum vitae of the candidate, a letter of recommendation from at least two Active Fellows. The delinquent clause relative to failure to attend meetings will not pertain to this class of membership.

### **Section 4.** *Election to Fellowship*

A. All proposals for candidates for any class of Fellowship shall be sent to the Council through the Secretary. Subsequent to approval by the Council, nominees' names must be circulated to the membership at least 120 days before the annual meeting. Fellows shall be given an opportunity to make written objections at least 90 days in advance of the annual meeting. Objections will be investigated by the Credentials Committee and presented to the Council for a vote. The Council will use the AMA Code of Ethics as a guide in this matter.

B. Election to any class of membership shall require three-fourths favorable vote of the Council.

C. A candidate for Active Fellowship must be present at the annual meeting to be inducted.

## **ARTICLE VII**

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### **Officers of the Society**

**Section 1.** *Election of Officers.* The officers of the Society shall be a President, President-Elect, Vice-President, Secretary, and Treasurer, who shall be elected at regular annual business meetings of the Society.

**Section 2.** *Accession to Office.* The newly elected officers shall assume their duties before the adjournment of the meeting at which they have been elected.

### **Section 3.** *Tenure of Office.*

A. The President and President-Elect, and Vice-President shall serve for a term of one year. The Secretary and the Treasurer shall serve for a term of three years and may be elected to one additional term.

B. An outgoing President (Past President) automatically becomes a member of the Council to serve for a period of three years. A past-president's membership on the Council which shall be terminated by death or other incapacity to serve shall remain vacant until filled by regular succession.

**Section 4.** *Vacancies in Office.* Vacancies in office occurring between elections shall be filled by appointment by the President. These appointments shall be subject to written approval of a majority of the Council. Should the office of the President become vacant between elections, it shall automatically be filled by the President-Elect. Should the offices of both President and President-Elect become vacant, these offices will be served by the Secretary.

## **ARTICLE VIII**

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### **Duties of the Officers**

#### **Section 1.** *Duties of the President.*

A. The President shall preside at meetings of the Society and shall have the power to preserve order and to regulate the proceedings according to recognized rules.

B. The President shall serve as Chairman of the Council.

C. The President shall appoint standing and special committees, except the Nominating Committee. See Article X, Section 2.

D. The President shall fill vacancies in offices that occur in the interim between regular meetings subject to approval by a Council majority.

E. The President shall be an ex-officio member of all standing committees.

#### **Section 2.** *Duties of the Vice President.*

A. The Vice-President shall serve and assist the President and President-Elect.

B. *Oversees the work of the committees. Shall direct, plan and implement the long range and strategic planning retreat of the Council listed in Article IX section 2E.*

#### **Section 3.** *Duties of the President-Elect.*

A. The President-Elect shall perform all duties that may be delegated to him or her by the President.

B. In the absence of the President, the President-Elect shall perform all duties of the President and shall preside at all meetings.

#### **Section 4.** *Duties of the Secretary.*

A. The Secretary shall keep or cause to be kept in permanent form an accurate record of all transactions of the Society.

B. The Secretary shall send due notice of all meetings to members; notice of at least 15 days shall be provided prior to Council meetings.

C. The Secretary shall notify all committee members of their appointments and the duties assigned to them.

D. The Secretary shall notify all applicants for membership of the action taken by the Society.

E. The Secretary shall keep a correct alphabetical list of members, together with their current addresses and shall supply application forms to members who apply for same.

F. The Secretary shall act as custodian of all papers of the Society and its committees.

#### **Section 5.** *Duties of the Treasurer.*

A. The Treasurer shall collect, receive and be accountable for funds accrued by the Society from dues or other sources.

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- B. The Treasurer shall deposit all moneys in a special bank account under the official name of the Society, in a city of his choice.
- C. The Treasurer shall disburse from the treasury such funds as may be necessary to meet appropriations and expenses of the Society.
- D. The Treasurer's financial records shall be audited at each regular annual meeting by a specially appointed auditing committee, who will report at the business session.
- E. Shall prepare and submit an annual budget for the following year to the Finance committee for subsequent approval of the Council at the fall meeting.

## ARTICLE IX

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### The Council

**Section 1. *Composition of the Council.*** The Council shall consist of the officers, the three immediate Past Presidents, and nine Fellows at Large, three of whom shall be elected annually to serve staggered three-year terms. A Fellow at Large elected to the Council may not succeed himself or herself.

**Section 2. *Duties of the Council.***

- A. The Council shall conduct the affairs of the Society during the interim between sessions.
- B. The Council shall pass on all applicants for Fellowship and present its recommendations to the Society at one of its business sessions so that necessary action may be taken.
- C. The Council shall report to the members at regular business sessions all decisions and recommendations made so as to obtain approval of the whole membership of its actions.
- D. Should the membership disapprove of any action of the Council the questions shall be referred back for further consideration and reported at the next business meeting.
- E. The Council shall have a long range and strategic planning retreat at least every three years.

**Section 3. *Quorum and Manner of Acting.***

- A. A majority of officers and Council members shall constitute a quorum. A majority of the quorum at any meeting of the Council shall constitute action by the Council unless otherwise provided by law or by these By-Laws.
- B. Any action required or permitted to be taken at a meeting of the Council may be taken without a meeting if a consent in writing setting forth the action to be taken shall be signed by all Council members entitled to vote.
- C. Meetings may be conducted by telephone provided that all officers and Council members participating in such a meeting may communicate with each other. A majority of officers and Council members shall constitute a quorum for telephone meetings and the act of a majority of the quorum shall constitute action by the Council.
- D. Officers and Council members shall not receive compensation for their services, but, by action of the Council, expenses may be allowed for attendance at meetings of the Council or for official representation of the Society and the Council may underwrite any activities that it deems essential to the functioning of the Society.

## ARTICLE X

### Committees

**Section 1.** Other than as specifically stated below, The President shall appoint committee members to serve for three years. Initial appointments shall be staggered such that approximately one-third of committee members shall change each year (other than the Scientific Program Committee and Nominating Committee).

**Section 2. *Scientific Program Committee.*** This committee shall be appointed by the President to serve for one year and shall consist of at least three Active Fellows. It shall be the duty of this committee to establish a scientific program at the Annual Meeting.

**Section 3. *Nominating Committee.*** The Nominating Committee shall consist of the three immediate past presidents and two Active Fellows elected at the business meeting. The Nominating Committee shall be chaired by the immediate past President. This committee shall prepare a slate of officers and members-at-large of the Council for vote at the next annual meeting. (See Article VII, section 2).

**Section 4. *Credentials Committee.*** This committee shall be chaired by the President and shall additionally consist of the two immediate Past Presidents plus two Active Fellows appointed by the President. In addition, the Secretary shall be a member, ex officio. The Credentials Committee shall advise the Council on the credentials of candidates for membership.

**Section 5. *Education Committee.*** This committee shall consist of at least three Active Fellows. It shall be the duty of this committee to develop appropriate educational activities for the Society.

**Section 6. *Research Committee.*** This committee shall consist of at least six Active Fellows. It shall be the duty of this committee to: increase the quality and quantity of research conducted in head and neck oncology; encourage the design and implementation of new research protocols; review applications for research funds; and suggest possible new methods of research funding.

**Section 7. *Council for Advanced Training in Oncologic Head and Neck Surgery.*** This committee shall consist of ten Active Fellows, each to serve a five-year term, with appointments staggered so that two Active Fellows are appointed to membership on this committee each year. The President's appointments to this committee shall be submitted for approval by the Council. It shall be the duty of this committee to evaluate training programs as to whether they qualify for Phase III training and to make recommendations to this Society concerning what constitutes adequate training in head and neck oncologic surgery.

**Section 8. *Constitution and By-Laws Committee.*** This committee shall consist of at least five Active Fellows, with the Secretary serving ex-officio. It shall be the duty of this committee to completely evaluate the Constitution and By-Laws every three years to maintain their relevance.

**Section 9. *Finance Committee.*** This committee shall consist of three Active Fellows elected at the business meeting to serve three year terms so that one member is elected each year. The Treasurer shall be an ex officio member. It shall be the duty of this committee to audit the financial records of the Society and review investments and to report at the annual business meeting. *It shall review the financial reports of the Treasurer prior to the presentation to the Council.*

**Section 10. *Standing Committees.*** Other standing Committees shall be constituted as described in the Policies and Procedures.

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**Section 11.** *Ad hoc Committee(s).* As necessary, the President may appoint one or more Ad Hoc committees to serve for one year.

## ARTICLE XI

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### Quorum

**Section 1.** A quorum for any meeting of the Council shall be a majority of those persons then serving as members of the Council.

**Section 2.** A quorum for the regular business session of the society shall be 18 Active Fellows.

## ARTICLE XII

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### Society Assets

**Section 1.** The interest in the funds property and other assets of the Society of any member whose membership shall terminate for any reason except the dissolution of the Society shall, ipso facto, immediately cease and such members and the representatives of such member shall have no claim against the Society or against the other members of their representatives or any of them.

**Section 2.** In the case of dissolution of the Society, the funds, property, and other assets shall be used for the purpose of furthering the expressed purposes for which this Society was formed and no member shall be entitled to receive any of the assets upon liquidation.

**Section 3.** If the Society's annual receipts exceed the annual expenses in any given year, the Council may, by a majority vote, elect to distribute the surplus for such scientific or educational uses as the Council shall deem to be most consistent with the Society's purposes; or it may, should it reasonably anticipate a need for operating surplus to meet future expenses, accumulate such surplus in an interest bearing account or otherwise.

## ARTICLE XIII

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### Indemnification

**Section 1.** The Society shall indemnify any and all of the directors or officers former directors or officers, employees, agents, or any person who may have served at its request or by its election as a director or officer of another society or association, or his heirs, executors and administrators, against expenses (including attorney fees, judgments, fines and amounts paid in settlement) actually and necessarily incurred by them in connection with the defense or settlement of any action, suit or proceeding in which they, or any of them, are made parties or a party, by reason of being or having been directors or a director, officer, employee or agent of the Society or of such other Society or association, except in relation to matters as to which any such action, suit or proceeding to be liable for willful misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability. The termination of any action, suit, or proceeding by judgment, order, settlement, conviction, or upon a plea of nolo contendere or its equivalent shall not, of itself, create a presumption that the person is engaged in willful misconduct or in conduct in any way opposed to the best interests of the Society. The provisions of this section

are severable, and therefore, if any of its provisions shall contravene or be invalidated under the laws of a particular state, country or jurisdiction, such contravention or invalidity shall not invalidate the entire section, but it shall be construed as if not containing the particular provision or provisions held to be invalid in the particular state, country, or jurisdiction and the remaining provisions shall be construed and enforced accordingly. The foregoing right of indemnification shall be in addition to and not exclusive of other rights to which such director, officer, employee or agent may be entitled.

## ARTICLE XIV

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### Merger Provisions

To facilitate the merger of the Society with The Society of Head and Neck Surgeons, an Illinois nonprofit corporation ("SHNS"), pursuant to an agreement calling for the SHNS to be dissolved and its assets transferred to the Society and the Society recast as The American Head and Neck Society, Inc. ("AHNS") to serve as a successor of both entities, notwithstanding any other provision of the Constitution or these By-Laws to the contrary:

1. The Council shall be expanded as necessary to include the officers and directors of the SHNS, who shall serve on the Council with their voting status as provided by the SHNS bylaws until their term of office within the SHNS shall expire. The Council shall return to its size and with its composition provided in Article IX hereof through the passage of time.
2. The President-Elect of the SHNS shall become as President-Elect of the AHNS following the completion of his term as President-Elect of the SHNS. The President-Elect of the Society shall become President of the AHNS to serve a term of six months (i.e., from May 15, 1998 through November 14, 1998), whereupon the said President-Elect of the SHNS shall serve as President of the AHNS to serve a term of six months (i.e., from November 15, 1998 through the membership meeting in May of 1999 or until his successor shall assume office). During the combined one-year term of office, the two said individuals shall regularly consult and cooperate with each other on all meaningful and significant decisions to be made during the year so that it may appear that they are serving as co-presidents for the full year, provided, however, that the AHNS shall have only one President in office at one time. At the conclusion of this one-year term, the President-Elect next in line shall succeed to the Presidency.
3. The members of the SHNS shall be admitted to the Society recast as the AHNS in the membership category that correspond to that which they hold in the SHNS. More specifically, Active Members of the SHNS shall become Active Fellows of the AHNS; Senior Member of the SHNS shall become Senior Fellows of the AHNS. Consulting Members of the SHNS shall become Associate Fellows of the AHNS. International Corresponding Members of the SHNS shall become Corresponding Members of the AHNS. Honorary Members of the SHNS shall become Honorary Fellows of the AHNS. Candidate Members of the SHNS shall become Candidate Members of the AHNS.
4. The Council shall act to preserve the unique heritage and history of the SHNS and the ASHNS.

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## **FUTURE AHNS MEETING DATES AND LOCATIONS**

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### **2008 DATES**

**Seventh International Conference on Head & Neck Cancer**

San Francisco Marriott

July 19-23, 2008 in San Francisco, CA

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