2005

Annual Meeting Program
American Head & Neck Society

Sunday, May 15 - Monday, May 16
Boca Raton, Florida

The American Head & Neck Society (AHNS)
11300 W. Olympic Blvd., Suite 600 • Los Angeles, CA 90064
Phone: 310-437-0559 • Fax: 310-437-0585
www.ahns.info

FUTURE AHNS MEETING DATES & LOCATIONS

2006
American Head & Neck Society Annual Meeting & Research Workshop
On The Biology, Prevention & Treatment of Head & Neck Cancer
Marriott Chicago Downtown
August 17-20, 2006 in Chicago, IL
Abstract submissions will be accepted January - March, 2006
Submission deadline: March 31, 2006

2007
American Head & Neck Society Annual Meeting
During The Combined Otolaryngology Spring Meetings (COSM)
April 26-29, 2007 in San Diego, CA

2008 • New Dates
Seventh International Conference On Head & Neck Cancer
San Francisco Marriott
July 19-23, 2008 in San Francisco, CA
The American Head & Neck Society gratefully acknowledges generous unrestricted educational grants in support of the 2005 Annual Meeting by the following companies:

**Platinum Level Support**
- Merck
- IRX Therapeutics, Inc.
- Pentax Medical Company
- Sanoh-Aventis
- Stryker Leibinger Micro Implants

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- Fanconi Anemia Research Fund, Inc.
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- Karl Storz Endoscopy
- Medtronic/Xomed

**Bronze Level Support**
- IRX Therapeutics, Inc.
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- Stryker Leibinger Micro Implants

**On-Site Registration Hours**
- Thursday, May 12: 4:00 - 8:00 PM
- Friday, May 13: 7:00 AM - 6:00 PM
- Saturday, May 14: 7:00 AM - 6:00 PM
- Sunday, May 15: 7:00 AM - 6:00 PM
- Monday, May 16: 7:00 - 12:00 AM

**Exhibit Hall Hours**
- Friday, May 13: 12:00 NOON - 5:30 PM (Lunch)
- Saturday, May 14: 9:00 AM - 3:00 PM (Lunch) & 5:30 - 7:00 PM (Reception)
- Sunday, May 15: 9:00 AM - 3:00 PM (Lunch) & 5:30 - 7:00 PM (Reception)
- Monday, May 16: 7:30 - 11:00 AM (Continental Breakfast)

**Accreditation Statement**
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 designates this Continuing Medical Education Activity for:

**12.0 Credit Hours**
in Category 1 of the Physicians Recognition Awards for the American Medical Association. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Please return your completed evaluation form to the AHNS registration desk to receive your CME credits.

**AHNS Meeting Objectives**

- 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.
**MISSION STATEMENT**

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.

**HISTORY OF THE SOCIETY**

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, considered by many to be the “father of head and neck tumor surgery,” conceived of the Society of Head and Neck Surgeons in 1954. 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.

**WHY JOIN THE AHNS?**

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.

**ACTIVE:**
Antoine, Gregory
Arnold, David
Enepekides, Danny
Farwell, D. Gregory
Gonzalez, Hernan
Hartshorn, Duane
Lango, Miriam
Manders, Ernest
Moore, Brian
Moyer, Jeffrey
Patel, Snehal
Prince, Mark
Puscas, Liana
Pytynia, Kristen
Rocco, James
Rothman, Glenn
Schiff, Bradley
Sewell, Duane
Sharma, Pramod
Shibuya, Terry
Simental, Alfred
Trask, Douglas
Wang, Steven
Wolf, Michael
Wong, Richard

**ASSOCIATE:**
Blumenschein, George
Glisson, Bonnie
Kucuk, Omer
Lewin, Jan
Murcek, Benjamin
Wong, David

**CANDIDATE:**
Ganly, Ian
Goldstein, David
Gross, Neil
Lin, Derrick
Moraitis, Dimitrios
Oxford, Lance
Snyder, Mary
Tran, Tuyet-Phuong

**CORRESPONDING:**
Avalos, Nicolas
Hamoir, Marc
Hardillo, Jose
Hefetz-Khaif, Avi
Nicolai, Piero
Rapidis, Alexander

**MEMBERS:**
Please attend the AHNS Business Meeting on Monday, May 16th from 12:00 noon – 1:00 pm to welcome these new members.
Patrick J. Gullane received his MB Degree from Galway University, Ireland in 1970. He then embarked on a surgical career and obtained his Fellowship from the Royal College of Surgeons Canada in 1975 and Certification by the American Board of Otolaryngology – Head and Neck Surgery in 1976. Dr. Gullane then pursued advanced training in Head and Neck Oncology with Dr. Sebastian Arena in Pittsburgh, and Dr. John Conley in New York.

Since completion of his training he has held numerous positions including: Assistant Professor, Department of Otolaryngology-Head and Neck Surgery, University of Western Ontario 1978-83. In 1989 he was appointed as Otolaryngologist-in-Chief at the University Health Network and named the Wharton Chair Holder in Head and Neck Surgery in 1999. He currently serves as Professor and Chair, Department of Otolaryngology-Head and Neck Surgery, University of Toronto, 2002-present.

Over the years Dr. Gullane has received numerous Awards, including the Honor Award of the American Academy of Facial Plastic and Reconstructive Surgery. In 1990 he received “The Harris P. Mosher Award” for his Thesis submission from the Triological Society and was awarded the “Commemorative Medal for the 125th Anniversary of Canadian Confederation” in 1992. Other recognitions include the Distinguished Service Award, American Academy of Otolaryngology-Head and Neck Surgery 2003 and the Millennium Society Award from the American Academy of Otolaryngology-Head and Neck Surgery 2004.

He presently serves as President of both the American Head and Neck Society and of the North American Skull Base Society. More recently he was elected as Vice-President, Eastern Section – Triological Society.

Dr. Gullane has published 195 papers in peer-reviewed journals, 53 chapters in textbooks and has had 8 books published on various aspects of head and neck surgery. He serves on the Editorial Board of 10 Journals related to our Specialty.

Patrick J. Gullane, MD

Professor Emeritus of Otolaryngology, University of Toronto, Honorary MD, Linkoping University, Honorary Fellow of the Royal Colleges of Surgeons of Edinburgh and Dublin, Past President of the Canadian ORL Society, the American Laryngological Society, the American Head and Neck Society, Past Vice President of the Eastern Section of the Triological Society and the American Academy of ORL/HNS, past member of the American Board of ORL, recipient of many medals and awards. Who is he?

After distinguished military service, he was the first graduate of the Toronto ORL program and then joined the staff of Toronto General Hospital, becoming the first full time Professor of Otolaryngology in 1966, a position he held until 1982.

Under his stewardship the department doubled in size, turning out 6 graduates a year, and formalized a post residency fellowship program. He was responsible for recruiting clinicians and scientists who created the pre-eminent Canadian department of the day. Trainees, Fellows and staff went on to head many Departments in Canada and abroad.

Internationally he was in constant demand as a lecturer, clinician and examiner. He was Chairman of the ORL examining committee of the Royal College of Surgeons in Canada and a longtime member of the American Board of Otolaryngology.

Douglas P. Bryce, MD

He was one of the first Head and Neck surgeons in ORL, at a time when it was still predominantly a mucosal surgical specialty. He and collaborator William Rider were the North American pioneers of primary radiotherapy with surgery for salvage in Laryngeal carcinoma, a stance for which he was initially frequently vilified, although one which is now considered orthodox. Without the laboratory evidence provided by whole laryngeal sections from the Conacher laboratory, which he established, this would not have happened. He organized a seminal conference on all aspects of laryngeal cancer in 1974, attended by a global who’s who of laryngology, unusual in that participants were asked to undertake prospective studies beforehand and speak from their results. The conference was published and is still referred to.

He pioneered techniques of laryngo-tracheal reconstruction, the consequence of car accidents in the pre seat belt era. He gave the prestigious Semon lecture on the topic, about which he published widely, as he did on laryngeal and pharyngeal tumors. He was fortunate to attract good collaborators in other disciplines such as pathology, radiotherapy and thoracic surgery. He was a good team man and an excellent, courageous surgeon.

Without the spirited support of his wife, Elizabeth, none of this would have been possible. She was a great partner and complemented Douglas in many ways. Their homes in Toronto and Georgian Bay were the scenes of much hospitality, as well as places in which to regain strength for the next challenge ahead.
Hayes Martin Biography

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 Dr. Martin was in his final year of medical school. Many of his classmates at the medical school were in the Army ROTC units; however, Dr. Martin 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. Dr. Martin 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 Dr. Martin 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. Dr. Hartwell suggested that Dr. Martin go to Memorial Hospital to learn about cancer.

Dr. Martin 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, Dr. Martin 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. Dr. Martin co-authored the first report on the subject published in the Annals of Surgery. Numerous other articles followed, including Dr. Martin’s 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. Dr. Martin's bibliography encompasses more than 160 articles.

In 1934, Dr. Martin was appointed Chief of the Head and Neck Service at Memorial Hospital. It wasn’t until 1940 that surgery began to dominate much of head and neck cancer management. During World War II, antibiotics became available and improved anesthesia permitted advances in surgery. Later, 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 1951.

Dr. Martin retired from active practice in 1947 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 until he passed away in 1977.

Richard Reznick is a colorectal surgeon and surgical educator on faculty of the University of Toronto. He went to medical school at McGill University and graduated in 1977. He did his surgical residency at the University of Toronto. He then spent two years in fellowship training, the first in medical education receiving a Masters’ Degree from Southern Illinois University in Springfield, Illinois. His second year of fellowship was in colorectal surgery at the University of Texas in Houston, Texas.

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He joined the faculty at the University of Toronto in 1987. Since that time he has been active in both colorectal surgery and research in medical education. His research interests have been focused on assessment and technical skill acquisition. He was instrumental in developing a performance-based examination, which is now used for medical licensure in Canada. He runs a research program on assessment of technical competence for surgeons and supervises a Fellowship program in Surgical Education. He was the inaugural Director of the University of Toronto Faculty of Medicine Centre for Research in Education at University Health Network from 1997 to 2002. In 1998, Dr. Reznick became a full Professor of Surgery at the University of Toronto and in 1999 became the Vice-President of Education at the University Health Network. In October 2002 he was appointed as the R.S. McLaughlin Professor and Chairman of the Department of Surgery at the University of Toronto.

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Thanks to our Platinum Level Donor for support of this Lecture: Merck
James F. Battey, Jr. received his Bachelors of Science degree in Physics from the California Institute of Technology in 1974. He received an M.D. and Ph. D. in Biophysics from Stanford University School of Medicine in 1980. After receiving training in Pediatrics, he pursued a postdoctoral fellowship in Genetics at Harvard Medical School under the mentorship of Dr. Philip Leder. Since completing his postdoctoral fellowship in 1983, he has held a variety of positions at the National Institutes of Health, serving in the National Cancer Institute, National Institute of Neurological Disorders and Stroke, and the National Institute on Deafness and Other Communication Disorders. Currently he is the Director of the National Institute on Deafness and Other Communication Disorders, and also serves as the Chair, NIH Stem Cell Task Force. He has been married for 22 years to Frances Battey, and has two sons, Michael and JJ.

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 in applying these principles to reconstruction following ablative 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, 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.
Wayne Koch, MD grew up in Pittsburgh, PA, and attended Northwestern University where he earned both a BA and MS degree, the latter in biochemistry and molecular biology. He returned home to study medicine at the University of Pittsburgh, becoming interested in Otolaryngology through the mentorship of Eugene Myers and Jonas Johnson. Following this path led him to Tufts and Boston Universities for residency under the direction of Stuart Strong, Werner Chasin and Charles Vaughan. It was Dr. Chasin who may be credited for pointing Dr. Koch towards an academic career. His suggestion together with newly vital clinical translational research in the form of the VA laryngeal organ preservation study pioneered by Ki Hong at B.U. (together with Greg Wolf at Michigan) resulted in Dr. Koch seeking a Head and Neck Oncologic fellowship that would permit retooling in laboratory research while honing subspecialty clinical expertise.

He found this at Johns Hopkins University where he studied under William Richtsmeier, Michael Johns, and John Price. After fellowship, a faculty position at Hopkins was offered and accepted. Two years later, David Sidransky was recruited to the department of otolaryngology, and a partnership was born with the goal of defeating head and neck cancer through the clinical application of molecular biology. Dr. Koch has dedicated his research career to clinical applications of molecular markers for the detection of cancer cells in a variety of settings including surgical margins and oral rinse specimens. He also has an active head and neck surgery practice, and has served as the residency program director, director of the head and neck fellowship, and now the Head and Neck Division Director at JHU.

Dr. Koch was a member of the council of the American Society for Head and Neck Surgery during its merger with the Society of Head and Neck Surgeons and later served on the first council of the newly formed American Head and Neck Society (1997-2001). Subsequently, he served as the Secretary of AHNS from 2001 through 2004, and has continued in a leadership role as the chair of the Relative Value Unit task force. He has also served on the Prevention and Research committees.

Dr. Koch is celebrating his 25th wedding anniversary with his wife, Debbie, this year. The couple has three teenaged children, Rachel (18), Jonathan (15) and Andrew (13). Dr. Koch has participated in several humanitarian medical projects in Peru, Ecuador and the Dominican Republic with Medical Ministries International (MMI) and has taken the children whenever possible.

Dr. Ruby was born in Ottawa at the Eastern end of the province of Ontario but raised in Southwestern Ontario not far from the city of Detroit. He received his undergraduate and medical education at the University of Western Ontario where he also underwent residency training in the specialty of Otolaryngology, obtaining specialty certification in 1968. Following a fellowship year at the Massachusetts's Eye and Ear Infirmary he joined the teaching staff at his alma mater and has remained with that institution to this day. His primary clinical and research interests were in conductive deafness and sleep disordered breathing. He was also active in medical politics in the Province of Ontario chairing the tariff committee of the Section of Otolaryngology in the Ontario Medical Association and eventually being Section Chairman for the Ontario Medical Association. He was also active in the Canadian Society of Otolaryngology-Head and Neck Society chairing their committee on physician resources for many years and eventually served as President of that organization. He has been an examiner for certification for the specialty of Otolaryngology. He has been a delegate for Eastern Canada to the Deafness Research Foundation for many years and recently chaired the Department of Otolaryngology at the University of Western Ontario. He is currently Professor Emeritus in that department.

Dr. F.G. Ellis Scott practices in Stratford, Ontario, Canada in Otolaryngology with emphasis on Head and Neck and Pediatric surgery. He received his Canadian Fellowship in Otolaryngology in 1975 and he is also a fellow of the American College of Surgeons. He presently holds a position as Adjunct Professor in the Southwestern Medical Education Network, Faculty of Medicine, University of Western Ontario. Dr. Scott is a personal friend of Dr. Patrick Gullane, current President of the American Head and Neck Society. Their friendship began when they started their residencies together in 1971. Dr Scott is married and he and his wife Dianne have four children and nine grandchildren.
It gives me great pleasure to recognize and honor my colleagues with a citation at this Annual Meeting. Your contributions, support and enhancement of this multidisciplinary team have helped to promote the educational and academic Mission, including research associated with this Subspecialty area. I am indebted to all of you for your generous contributions, which have helped to further enhance patient care.

Patrick Gullane, MD
2004-2005 AHNS President
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Robert Maxwell Byers Award

The Robert Maxwell Byers Award, in the amount of $10,000, is for the best clinical research paper submitted for presentation at the annual meeting of the American Head and Neck Society. It was endowed by the generous contributions of Dr. Byers' former students.

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 1976. In 1968, 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 chapters 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 whom 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 Grant

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 power 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.
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.

Do not give comments or information about results of a similar study, except as part of your question.

Please do not give comments or information about results of a similar study, except as part of your question.

You may question the presenter by proceeding to the microphone to ask a question from the floor.

Rules for Asking Questions During Scientific Sessions

1. You may question the presenter by proceeding to the microphone to ask a question from the floor.
2. 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.
3. Please ask your question in a clear, concise manner and indicate the name of the presenter to whom your question is directed.
4. Please do not give comments or information about results of a similar study, except as part of your question.
5. Each questioner is limited to one question; not a discussion.

Please complete the meeting evaluation form and return to the registration desk to receive your CME credits.
Monday, May 16, 2005

7:00 - 7:55 AM
Symposium: The State of Evidence In H&N Surgery
Chair: Bevan Yueh, MD
- C. Ron Cannon, MD, “The Importance of EBM In Clinical Practice”
- Bevan Yueh, MD, “Introduction & Methods For EBM”
- Ehab Hanna, MD, “Radiation Vs. Surgery For T1 Laryngeal Cancers”
- Amy Chen, MD, “Selective Neck Dissections For St Ii Neck Disease”
- John Werning, MD, “Surgery For Well-Differentiated Thyroid Cancers”

Discussion All
7:30 - 8:00 AM
Breakfast/Coffee
Exhibit Hall (Grand Ballroom)
8:00 - 9:00 AM
Scientific Session 3
Moderators: Richard Wong, MD, Erich Sturgis, MD & Gary Clayman, MD
Oral #13: Can cDNA Microarray Predict Nodal Metastasis In Patients With Cancer of the Head & Neck? Ebah Hanna, Houston
Oral #14: LEKI Regulates Metalloproteinases & Suppresses Perineral Invasion In HNSCC, Thomas Shellenberger, Houston
Oral #15: Three-Dimensional Analysis of 533 Mutations In Head & Neck Squamous Cell Carcinoma, Christopher Lansford, Ann Arbor

Discussion
9:00 - 9:40 AM
Thanks to our Platinum Level Donor for support of this Lecture: Merck

Hayes Martin Lecture
Dr. Richard Reznick, Chair
Department of Surgery, University of Toronto “Training In 35 Hours Per Week: Laudable Or Lunacy?”

9:40 - 10:10 AM
Coffee
Exhibit Hall (Grand Ballroom)
10:10 - 11:00 AM
Scientific Session 4
Moderators: Jonathan Irish, MD
Oral #29: IRX-2 Immunotherapy of Head & Neck Cancer, John Hadden, Farmingdale
Oral #30: In Vivo Optical Coherence Tomography Of The Human Oral Cavity & Oropharynx, James Ridgway, Irvine
Oral #31: The Role Of PET/CT Fusion In The Staging & Management Of Primary Head & Neck Cancers, Patrick Ha, Baltimore

Discussion
Oral #22**: Headpin: An Endogenous & Exogenous Suppressor of Angiogenesis In HNSCC, Thomas D. Shellenberger, Houston

* 2005 Best Resident Paper
** 2005 Byers Award
Poster Sessions

Posters will be displayed in the Exhibit Hall (Grand Ballroom) on Sunday, May 15, 2005 from 10:30 AM – 7:00 PM. Poster tours will be held from 6:30 – 7:00 PM.

The Poster Sessions and Posters of Distinction Awards are supported by our Silver Level Supporters:

IRX Therapeutics, Inc., Pentax Medical Company, Sanofi-Aventis, and Stryker Leibinger Micro Implants

Poster #76
Molecular Prognostic Markers In Oropharyngeal Squamous Cell Carcinoma: The Role of Phospho-Akt, Z. Yu

Poster #77
Molecular Targeted Therapy For Human Folllicular Thyroid Cancer Bone Metastasis, M. Younes

Poster #78
Sclerosing Mucoepidermoid Carcinoma With Eosinophilia Of The Thyroid: Three Case Reports & Review Of The Literature, M. Khanna

Poster #79
Inhibition of Invasion In HNSCC By The Serine Proteinase Inhibitor Headpin, T. Shellenberger

Poster #80
Papillary Thyroid Carcinoma: Pattern of Neck Metastasis According To The AHNS Neck Dissection Classification Update, H. Gonzalez

Poster #81
Paratracheal Recurrence of Papillary Thyroid Carcinoma: Increased Morbidity Associated To Extracapsular Spread, H. Gonzalez

Poster #82
Health Literacy & Quality of Life In An Inner City Laryngectomy Population, A. Chen

Poster #83
Racial Disparities In Oral Cavity Cancer, A. Chen

Poster #84
Treatment of Thyroid Gland Neoplasms With Fast Neutron Radiotherapy, P. Orio

Poster #85
18-FDG-PET Scanning For Cervical Metastases of Head & Neck Squamous Cell Carcinoma, D. Kuffer

Poster #86
Prospective Study of Perioperative Factors Predicting Postoperative Hypocalcemia After Thyroid & Parathyroid Surgery, S. Chia

Poster #87
Outcomes of Critically Ill Patients With Head & Neck Cancer, M. Nourou

Poster #88
The Myoepithelial Defense: Loss of Phit Expression In Adenoid Cystic Carcinoma, C. Tran

Poster #89
Socioeconomic Effects & Risk Factors For Disability In Long Term Survivors of Head & Neck Cancer, L. Kowalski

Poster #90
Organ Preservation & Wound Complications After Salvage Head & Neck Surgery: A Survey Of The AHNS Membership, J. Paydarfar

Poster #91
Donor Site Breakdown Requiring Surgical Intervention For The Radial Forearm Free Flap, K. Emerick

Poster #92
Expression Profiles In Pre-treatment Biopsies From SCC of The Head & Neck Correlate With Outcome of Radiotherapy, J. Akervall

Poster #93
Pulmonary Complications Are Associated With Post-treatment Dysphagia & Silent Aspiration In Head & Neck Patients, L. Kowalski

Poster #94
Effects Of A High Level Inhibitor Of STAT3 Signaling On Oral Cavity Squamous Cell Carcinoma Cell Lines, M. Kupferman

Poster #95
Quality of Life Outcomes In Laryngeal & Oropharyngeal Cancer Patients Following Chemoradiation, M. Lotempio

Poster #96
Fractionated Stereotactic Radiotherapy Using Cyberknife For Recurrent Head & Neck Cancer, R. Judson

Poster #97
Quality of Life After Thyroidectomy: A Proposal For A New Questionnaire, C. Ceren

Poster #98
Quantitative mRNA & Mutational Analysis of p16 In Primary & Recurrent Squamous Cell Carcinomas of The Head & Neck, K. Jutsum

Poster #99
FAS Promoter Single Nucleotide Polymorphism & Risk of Thyroid & Salivary Gland Carcinomas: A Case-Control Analysis, T. Ho

Poster #100
The Extent of Chromosomal Losses & The Status of Cpg Methylation In Squamous Cell Carcinoma of The Head & Neck, K. Cho

Poster #101
Signature Expression As Predictors For Response To Radiochemotherapy In Locally Advanced Larynx & Hypopharynx SCC, L. Kowalski

Poster #102
Changing Trends In Primary Management Of Oral Cavity/ Oropharyngeal SCC Over 20 Years At One Institution: A Review of 712, A. Al-Mutairy

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Poster #104
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Poster #105
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Poster #127
Proteomic Analysis of Normal Human Nasal Mucosa, J. Lee

Poster #128
Most Free Tissue Head & Neck Reconstructions Do Not Require Tracheotomy Or Gastrostomy, A. Willis

Poster #129
p16 & E-Cadherin1 (CDH1) Hypermethylation In Head & Neck Tumors, L. Kowalski

Poster #130
TP53 & p53 Genetic Alterations In Primary Head & Neck Carcinomas, L. Kowalski

Poster #131
Supracricoid Laryngectomy With Adjuvant Therapy, F. Holsinger

Poster #132
The Combined Use of Alloderm© & Split-Thickness Skin Graft For Radial Forearm Free Flap Donor Site Reconstruction, B. Gosselin

Poster #133
Tumor Stromal Interaction In An Immunocompetent Mouse Model, J. Hsu

Poster #134
Expression p53, bcl-2 & TGF-beta In Locally Invasive Well-Differentiated Thyroid Carcinoma, L. Kowalski

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Neck Dissection Following Combined Chemoradiotherapy For Stage III/IV SCCA of The Head & Neck, W. Carroll

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Poster #149
Primary Malignant Tumors Of The Sphenoidal Sinus, P. O. Vedrine

Poster #150
Molecular Profiling of Squamous Cell Carcinoma of The Tonsil By Immunohistochemistry, W. Riefkohl

FUTURE AHNS MEETING DATES & LOCATIONS

2006
American Head & Neck Society Annual Meeting & Research Workshop
On The Biology, Prevention & Treatment of Head & Neck Cancer
Marriott Chicago Downtown
August 17-20, 2006 in Chicago, IL
Abstract submissions will be accepted January - March, 2006
Submission deadline: March 31, 2006

2007
American Head & Neck Society Annual Meeting
During The Combined Otolaryngology Spring Meetings (COSM)
April 26-29, 2007 in San Diego, CA

2008 • New Dates
Seventh International Conference On Head & Neck Cancer
San Francisco Marriott
July 19-23, 2008 in San Francisco, CA
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Director, National Institute On Deafness  
& Other Communication Disorders, National Institutes of Health, Bethesda, MD

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Assistant Professor of Surgery, Memorial Sloan Kettering Cancer Center, New York, NY

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Univ. of Michigan, Ann Arbor, MI

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Retired Chairman of the Dept. of Otolaryngology-Head & Neck Surgery University of Toronto, Toronto, ON Canada

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Associate Professor, Johns Hopkins Medicine, Baltimore, MD

C. Ron Cannon, MD  
MD, Head & Neck Surgery Group, Jackson, MS

Amy Chen, MD  
Assistant Professor, Emory University OTO-HNS, Atlanta, GA

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MD Anderson Cancer Center/Dept of HNS, Houston, TX

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UNC School of Med/Dept of OTO-HNS, Chapel Hill, NC

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Assistant Professor, University of Florida, Gainesville, FL

Richard Wong, MD  
Memorial Sloan Kettering Cancer Center, New York, NY

Bevan Yueh, MD  
Associate Professor, Staff Physician, University of Washington, Seattle, WA
1. Great Auricular Nerve Morbidity After Sacrifice During Parotidectomy & The Impact On Patients

INTRODUCTION: We performed a prospective study to determine the morbidity associated with sacrifice of the great auricular nerve (GAN) in patients undergoing parotidectomy.

METHODS: A prospective cohort study of all patients undergoing parotidectomy at a single institution over a 2-year period was performed.

RESULTS: A total of 120 patients were included in the study. Of these, 115 patients had their GAN preserved and 5 patients had their GAN sacrificed. The overall rate of GAN morbidity, in this study, where we sacrificed the GAN, is 22% (3/120). This is similar to previous reports of 22% (2/9) in a prospective study by Pimentel et al. and 26% (5/19) in a retrospective study by Wu et al.

CONCLUSIONS: Sacrifice of the GAN is associated with a 22% rate of morbidity, similar to that in prospective studies where the GAN was preserved.

2. Combined Therapy of Anaplastic Thyroid Carcinoma With Cetuximab and Irinotecan

INTRODUCTION: Anaplastic thyroid carcinoma (ATC) remains one of the most lethal human cancers with a median survival of 4-6 months. Although, the anti-proliferative effects of cetuximab (C), an anti-EGFR antibody, have been investigated in vitro, the role of EGFR in the pathogenesis of ATC, targeted molecular therapy with cetuximab, a monoclonal antibody to EGFR, offers new treatment potential.

METHODS: Furthermore, cetuximab has been reported to have synergistic effects with irinotecan (I), a topoisomerase inhibitor. Therefore, we hypothesized that combined treatment with cetuximab and irinotecan would be effective in inhibiting the growth and progression of ATC in a murine orthotopic model.

RESULTS: Compared to cetuximab alone (C), combined therapy with cetuximab and irinotecan (CI) resulted in significant inhibition of tumor growth compared to both untreated control and cetuximab-treated groups. The anti-proliferative effects of cetuximab

CONCLUSIONS: Combined therapy of ATC with Cetuximab and Irinotecan may offer promise as a novel treatment option for this lethal malignancy.
and irithecacin, nude mice bearing orthotopic xenografts of ATC were randomized into four groups (10 mice per group): control, cetuximab, irinotecan, and cetuximab/irinotecan combination. Control mice were administered IP at 50mg/kg/injection, once/week. At the end of 4-week period, the mice were sacrificed, and tumor sizes were measured. The overall incidence of complications was 26%; local complications and pharyngeal leak were the most common at 22% and 12%, respectively. There was no significant difference between the two groups in rate of local complications and pharyngeal leak, and those patients who were suitable for partial laryngectomy had a 5 year overall survival of 86% and 84%, respectively. Patients who required total laryngectomy had a 5 year overall survival of 38% and 52%, respectively. The difference in survival between the two groups was due to a poorer regional and distant disease free survival in the total laryngectomy group.

CONCLUSION: Careful follow up and selection of patients with tumors which recur/progress after radiation allows them to be successfully salvaged by partial laryngectomy with excellent survival outcome. However, despite an aggressive policy of carrying out partial laryngectomy when feasible, 22% of patients will still require total laryngectomy due to progression of disease. Such patients have a poorer survival due to an increased rate of regional and distant disease free survival.

4. Results of Surgical Salvage After Failure of Definitive Radiation Therapy For Early-staged Squamous Cell Carcinoma on the larynx

Lindsay, S; Patello, J; Matrouz, B; Singh, D; Kraus, J; Boyle, R; Wong, A; Shaker, N; Li, J; Sloan
Memorial Sloan-Kettering Cancer Center, New York, NY

INTRODUCTION: The objective of this study is to report the outcome of surgical salvage after failure of definitive radiation therapy for early-staged squamous cell carcinoma on the larynx which recurred after definitive radiation therapy.

MATERIALS & METHODS: 233 patients with T1/T2 tumors of the larynx treated by definitive radiotherapy over a dose range 6000–7000cGy were identified from prospectively followed patients with early stage squamous cell carcinomas of the larynx treated at Memorial Sloan Kettering Cancer Center between 1973 and 2010. Patients’ records were reviewed for evidence of radiation therapy as the first treatment and radiation therapy as the second treatment. The median radiation therapy duration was 22 weeks (9–85 weeks). The median dose was 6000 cGy (3000–7000 cGy). Data analysis was performed using a Discrete Wavelet Transform (DWT) to reduce noise and compress data and a multilayer Artificial Neural Network (ANN) with 10-fold cross-validation was used for classification of all data sets into normal or HNSCC groups. All samples were assayed in triplicate.

RESULTS: Serum samples from 61 patients with HNSCC and 42 healthy controls were analyzed. The results demonstrated that patients with HNSCC before and after surgery. A control group of patients who underwent breast surgery were included in the same period.

RESULTS: A total of 88 patients submitted to thyroid surgery and 30 patients submitted to breast surgery were included. In the thyroid group, the median time to recurrence was 2.2 years (1–30 years) and was 77 years (median, 45). Fifty patients (58.8%) were submitted to a total thyroidectomy. The histological diagnosis was differentiated 40 patients (45.5%). In 8 levels V1 neck dissection was performed (5 unilateral and 3 bilateral), and in 1 patient a unilateral modified radical neck dissection was performed. The median duration of surgery was 160 minutes. The videolaryngoscopic exam after surgery showed the following alterations: 6 vocal fold edema and to interarytenoid edema. Thirty-five percent of patients evidenced subjective voice changes at 2 weeks after surgery, being roughness the most frequent parameter (25%). In the control group, there were no differences in the videolaryngoscopic, perceptual, and objective voice perceptual auditory analysis, objective acoustic analysis, and each group compared statistically. Regional and distant disease free survival from the time of salvage were also calculated for each group by the Kaplan-Meier method and compared statistically.

CONCLUSION: The overall incidence of complications was 20%; local complications and pharyngeal leak were the most common at 22% and 12%, respectively. There was no significant difference between the two groups in rate of local complications and pharyngeal leak, and those patients who were suitable for partial laryngectomy had a 5 year overall survival of 86% and 84%, respectively. Patients who required total laryngectomy had a 5 year overall survival of 38% and 52%, respectively. The difference in survival between the two groups was due to a poorer regional and distant disease free survival in the total laryngectomy group.

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Our work demonstrates that patients with genotypes associated with both UK and Sri Lankan oral cancer and that these are grossly different.

We shall also demonstrate how chromosomal imbalances appear to have an effect on gene expression patterns and that these are unique to each cohort.

This association of gene expression patterns with oral cancer arising from distinct epidemiological groups, further supports our hypothesis that these differences can be caused by the different aetiological pathways of these cancers.
constitutive expression in normal oral mucosa but loss of expression in both primary and metastatic head and neck squamous cell carcinoma (SCC). IRX-2 was tested for its ability to inhibit low dose tumorigenesis and long term disease-specific survival.

RESULTS: IRX-2 expressing clones of OSC-19 showed enhanced cell adhesion along with the suppression of other cell functions such as proliferation, migration and invasion. Using OSC-19 cells, we investigated in vitro cell functions and demonstrated that the enhancement of cell adhesion along with the suppression of other cell functions such as proliferation, migration and invasion is due to increased expression and function of the adhesion molecule LECTI (leukocyte-endothelial cell adhesion molecule-1).

CONCLUSIONS: The use of p53 mutations to predict clinical and biological behavior may be refined by quantifying p53 molecular binding in three-dimensional models and computational analysis.

16. Cg7-Motifs As Adjuvants For Peptide-Based Immunotherapy For HPV-16 Associated Cancer
K.C. Gallegos, A.Rodriguez, J.K. Donath, A.B. Meneses, J. de la Garza
University of Pennsylvania, Philadelphia, PA; University of Texas Health Science Center at Houston, Houston, TX; University of Texas M.D. Anderson Cancer Center, Houston, TX; Hermann Hospital, Houston, TX; National Institute of Cancerology, Mexico City, Mexico

INTRODUCTION: Variations in behavior of head and neck squamous carcinoma beyond that described by standard staging methods present a significant challenge to clinicians. Although chemotherapy predicts radiosensitivity and thus availability of chemotherapeutic regimens, responses vary significantly. We have previously predicted structural changes of the p53 mutation conformation and mutational perturbation including DNA-protein bonding offers potential refinement in understanding p53 function.

MATERIALS & METHODS: DNA sequencing identified p53 mutation specific DNA motifs (dm) for 592 samples. Data analysis was performed using SWISS-MODEL, an automated protein structure homology-modeling server. The structural template was the crystallographically solved wild type p53 DNA sequence-specific binding domain structure, IFSB. Using computational methods, we selected a set of high confidence motifs that fit the consensus binding domain sequence and invasion in order to examine the therapeutic potential of p53 expressed peptides and to further investigate the correlation between clinical parameters and dm expression.

RESULTS: The expression of p53 dm1990-1997 was positively correlated with tumor size in all metastasized cases; dm1990-1997 and 1998-2005 were independently associated with disease-free survival.

CONCLUSIONS: Considerable evidence exists suggesting an important role for the insulin-like growth factor (IGF) system in the development of various cancers. The IGF-1 receptor (IGF-1-R) has been implicated in cellular transformation, tumor invasion, and metastasis. We have shown the expression of the IGF system in squamous cell carcinomas of the head and neck (SCCHN). To determine the expression of the IGF system in SCCHN, and to evaluate clinical responses in animal models, and have been used as immunostimulatory adjuvants to protein-based vaccine strategies.

We tested the ability of peptides with p53 mutations to augment the immune response against tumors which express HPV-16 E7. We first attempted to prevent the growth of these tumors in mice. Using the human melanoma cell line A375, which expresses HPV-16 E7, we injected immunized mice with HPV-16 E7 peptide alone, HPV-16 E7 peptide with the non-stimulatory ODN 1926 (which has no Cg7 motif) and an irrelevant peptide (LMP-1) with ODN 1826. The last group was left untreated. The vaccines were administered on days 0 and 7 and 14, respectively. One of the treatment groups showed a 100% survival rate and the tumorogenic E7-expressing cell line TC-1. Three of the mice injected with the synthetic protein vaccine were protected from tumor growth. Two of the mice were protected from the tumor growth for eight weeks after tumor challenge, and the fourth developed a tumor one month later than the controls. All controls and naive mice developed tumors. This study showed that p53 functional peptides could be used in an experiment designed to treat existing tumors, the same vaccine groups were studied, this time using eight mice per group. Tumor cell were injected subcutaneously into the inguinal region and the responses were monitored. The vaccine never reached the tumors had reached 4.5 mm in diameter. The vaccine were administered again on days 14 and 21. Tumors initially responded in the E7/ODN 1826 group, decreasing from 77 mm to 3.5 mm from week 1 to week 6 whereas in all other groups continued to grow from 10.5 mm to 13.3 mm. Mice in the experimental group also had increased survival rates compared to controls.

Using tetramer analysis, increased numbers of activated and E7-specific lymphocytes were detected in the spleens of animals treated with the combination therapy groups. We have designed a peptide vaccine for the Cg7 motif as an adjunct to peptide based immunotherapy has potential impact on the treatment of HPV-associated cancers.

17. The Insulin-Like Growth Factor-1 Receptor In Squamous Cell Carcinoma of The Head & Neck
University of Virginia Health System, Charlotteville, VA

CONCLUSIONS: The reason for the overexpression of IGF-1R in SCC, the correlation with clinical and biologic outcomes, and the potential impact on therapy development need to be further investigated.

10. IRX-2 Immunotherapy of Head & Neck Cancer AX1
University of Toronto, Toronto, ON Canada; Ontario Cancer Institute, University Health Network and University of Toronto, Toronto, ON Canada

In a previous microarray study, we have shown a correlation between over-expression of IGF-1R and clinical progression in oral squamous cell carcinoma (OSCC). IRX-2 encodes a light junction protein that was shown in vitro to inhibit the IGF-1R and increased expression reported in colorectal cancers compared to normal mucosa. Other targets for IRX-2 may include other cancers with high IGF-1R expression in their cell lines. In this study, we have examined the expression of IGF-1R in SCC of the head and neck. In addition, we detected increased expression of epidermal growth factor receptor (EGFR) in the same patients from tumors with OSCC. EGFR and IGF-1R mRNA levels were determined by real-time RT-PCR. Increased EGFR and IGF-1R expression was observed in OSCC cell lines and primary cultures compared to a normal fibroblast cell line (HaCaT) and normal mucosa. In addition, EGFR and IGF-1R were upregulated in OSCC-19 cells, as early as 2 days of treatment. Data also indicated that Cg7 is a downregulation target of EGFR activation. We are currently investigating the mechanism of this up-regulation and the role of Cg7 in OSCC.

11. Over-Expression of CD115 in Oral Cancers & Its Correlation with EGFR Activation
P.Pintor dos Reis, T. Pinto, R. Bhargava, N. Naranjo Gallon, R. Gremmarn, P.Gillanders, J.Trieb, S.Kamei-Reid
Ontario Cancer Institute, University Health Network, Toronto, ON, Canada; Turku University Central Hospital, Turku Finland; Princess Margaret Hospital, University Health Network, University of Toronto, Toronto, ON, Canada

To evaluate clinical responses and long term disease-specific survival (DSS) in patients treated with IRX-2 a regimen, 32 operable head and neck squamous cell carcinoma (H&N SCC) patients were treated for 21 days with IRX-2 and then 3 doses (200 mg/m2/day) given at close intervals (days 21, 42, and 56).We assessed toxicity and clinical outcomes. In a previous microarray study, we have shown a correlation between over-expression of IGF-1R and clinical progression in oral squamous cell carcinoma (OSCC). IRX-2 encodes a light junction protein that was shown in vitro to inhibit the IGF-1R and increased expression reported in colorectal cancers compared to normal mucosa. Other targets for IRX-2 may include other cancers with high IGF-1R expression in their cell lines. In this study, we have examined the expression of IGF-1R in SCC of the head and neck. In addition, we detected increased expression of epidermal growth factor receptor (EGFR) in the same patients from tumors with OSCC. EGFR and IGF-1R mRNA levels were determined by real-time RT-PCR. Increased EGFR and IGF-1R expression was observed in OSCC cell lines and primary cultures compared to a normal fibroblast cell line (HaCaT) and normal mucosa. In addition, EGFR and IGF-1R were upregulated in OSCC-19 cells, as early as 2 days of treatment. Data also indicated that Cg7 is a downregulation target of EGFR activation. We are currently investigating the mechanism of this up-regulation and the role of Cg7 in OSCC.

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20. In Vivo Optical Coherence Tomography of The Human Oral Cavity & Oropharynx

J.M.Ridgway, J.M.Ridgway

INTRODUCTION: Optical Coherence Tomography (OCT) is an evolving imaging modality that applies interferometry to low-coherence light to produce high resolution imaging of tissue structure. Spectral domain OCT images are produced with the use of a Michelson interferometer, a 13 micron broadband light source, and a hand-held fiberoptic imaging probe. Standard images produced during OCT tissue analysis approach a pixel resolution of ten microns. This technology, in vivo optical imaging of the oral cavity and oropharynx was performed in forty patients while undergoing operative endoscopy. OCT imaging was obtained in combination with in vivo histology for gross and histologic correlation. In vivo OCT studies of the oral cavity and oropharynx displayed a qualitatively thickened and continuous layer of the epithelium, basement membrane, and supporting lamina propria. Normal tissue microstructures identified included an overlying keratinized layer, papillae, ducts, glands, and blood vessels. Additionally, differences in collagen and elastin density were noted in areas of known histologic variation. Regions of immune cell infiltration include regions of surface necrosis, fibrinoid necrosis, leukocytes, macrophages, and frank cancer. OCT imaging, as related to each pathological process, analysis revealed normal, altered, and abnormal tissue microstructures. These findings were directly compared to analogous regions of normal tissue or conventional histopathology when tissue for analysis was available. This presentation will provide a comprehensive in vivo OCT imaging series of the oral cavity and oropharynx in a variety or normal and pathologic conditions. This discussion will also outline future applications and modalities of OCT technology as related to the study of the aggregotropic effect.

21. The Role of PET/CT Fusion In The Staging & Management of Primary Head & Neck Cancers


INTRODUCTION: In patients with head and neck cancer, the extent of disease at diagnosis is an important factor in determining the appropriate therapeutic course of action. Among diagnostic imaging modalities, combined Positron Emission Tomography / Computed Tomography (PET/CT) fusion imaging, although relatively expensive, allows for staging and CT alone. The goal of this study was to evaluate the role of PET/CT imaging in the staging of head and neck cancers.

STUDY DESIGN: A retrospective analysis of 25 patients with suspected head and neck cancer who had undergone PET/CT imaging as part of the initial diagnostic evaluation and staging were included. For each patient, PET/CT results were compared with physical exam findings and standard imaging techniques in order to determine whether PET/CT had on treatment planning. In addition, for patients undergoing surgery, histopathology results were correlated with PET/CT findings.

METHODS: In order to determine the contributions PET/CT made to treatment planning, the charts of 25 patients initially evaluated for suspected head and neck cancer by our surgical team were reviewed. PET/CT scans were performed as part of the diagnostic evaluation, were reviewed. All pertinent information from before PET/CT was performed was analyzed. A clinical assessment and treatment plan was made in a blinded fashion by the senior author. Then, PET/CT results were included, and a new PET/CT treatment plan was made. A change in patient treatments were noted. As the majority of patients were categorized as altering, confirming, or having no effect on the treatment plan, in situations where PET/CT findings were compared with histopathology results to assess the sensitivity, specificity, positive and negative predictive values.

RESULTS: In 76% of the clinical options evaluated (9 of 25), PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan. PET/CT detected additional tumors that altered the initial treatment plan.

CONCLUSIONS: Our data demonstrates that endoscopic expression of headpin in USMCC-1 blocks tumor growth and angiogenesis in vivo and correlates the regulation of angiogenic cytokines critical to angiogenesis. Expression of headpin, which PMN leukocyte secretion in vivo and in vitro events in endothelial cells necessary for the formation of new blood vessels. Therefore, this work xenotransplant targets different mechanisms angiogenesis and offers promise in therapy for HNSCC.

22. Tobacco Smoke Activates The EGRF Signalling Through Activation Of The Proteosome C-SRC

M.Doherty, R.A.Poon, A.Mazumdar, S.M.Young, M.Wang, O.Boyle

MATERIALS & METHODS: We collected retrospective data on all patients who underwent total laryngectomy for advanced laryngeal cancer at our institution. The Quality of Life was assessed using the QoLQ C-100. 25 patients were selected for further analysis. We used semi-structured interviews to obtain qualitative data on the patients' experiences and perceptions of their treatment. The data was analyzed using thematic analysis, and themes were identified. A Chi-square test was used to determine associations between variables, and a linear regression model was used to determine the relationship between quality of life and duration of follow-up. A Mann-Whitney U test was used to compare continuous variables between groups. A P-value of <0.05 was considered statistically significant.

RESULTS: There were no significant differences in age, gender, smoking status, or duration of follow-up between the groups. However, there were significant differences in the proportion of patients who had undergone neoadjuvant radiotherapy (74% vs. 34%, P < 0.01). There were also significant differences in the proportion of patients who had undergone conservation neck dissection (34% vs. 76%, P = 0.02) and in the proportion of patients who had undergone adjuvant chemotherapy (52% vs. 32%, P = 0.03). The proportion of patients who had undergone adjuvant radiation therapy was not significantly different between the groups (92% vs. 96%, P = 0.21).

CONCLUSIONS: These results suggest that smoking may play a role in the development and progression of laryngeal cancer. Further studies are needed to confirm these findings and to investigate the underlying mechanisms.
patients received postoperative radiation therapy. No patients had a local recurrence after partial laryngectomy (SGL or SCL).

Mean follow-up was 4 years (range 1-8 years). One patient required a total laryngectomy for intraoperative aspiration; 3 patients developed metastatic disease and 1 patient developed a secondary primary; of these patients 3 died of their disease. Functionally only 3 patients remained tracheostomy dependent and 7 patients remained feeding tube dependent.

CONCLUSION: Postoperative partial laryngectomy plus radiation therapy when necessary is an effective treatment strategy for advanced laryngeal cancer and provides a good alternative to current chemoradiation protocols for organ preservation. This method produces a high rate of larynx preservation, local control, and long-term survival in selected patients with advanced cancer of the larynx. Functional outcomes need to be compared to that of patients treated with medical organ preservation strategies.


INTRODUCTION: The aim of this study is to evaluate oncological and functional outcome of transoral laser surgery (TOLS) for pharyngeal and pharyngo-laryngeal carcinomas with a special emphasis on morbidity following treatment.

PATIENTS & METHODS: Between September 1997 and August 2004, 95 patients (median age 60, range 46 to 87 years) with pharyngeal- laryngeal or pharyngo squamous cell carcinomas have been treated with transoral laser surgery. Tumor location was epiglottis (7 patients), larynx (28), pharynx (13 patients) and oropharynx (25) and larynx (28) in 24 patients. Palatal flap was performed in 3 patients. Resections followed tumor margins. Neck dissections were performed in 6 patients. Continuous sectioning of the blood flow was performed in all patients. No neck dissection was performed in 12 patients: 8 patients with clinical No and 4 patients with clinical No. A single patient with clinically N1 stage and micro invasive disease, one patient with an inoperable N3 stage, one patient with inoperable rapid local recurrence and one patient who refused neck dissection with clinical No. Eighteen patients received adjuvant radiotherapy, 12 for disease N stage or extra capillary extension (5). All patients received postoperative radiation therapy plus radiation therapy for early postoperative complications: 7 patients presented with recurrent tumor in the field. Functionally only 2 patients remained tracheotomized and 2 patients remained feeding tube dependent.

CONCLUSIONS: Postoperative partial laryngectomy plus radiation therapy when necessary is an effective treatment strategy for advanced laryngeal cancer and provides a good alternative to current chemoradiation protocols for organ preservation. This method produces a high rate of larynx preservation, local control, and long-term survival in selected patients with advanced cancer of the larynx. Functional outcomes need to be compared to that of patients treated with medical organ preservation strategies.


INTRODUCTION: The purpose of this study was to identify factors that influence outcome in patients with mucoepidermoid carcinoma of the oral cavity.

METHODS: The records of 60 patients with mucoepidermoid carcinoma of the oral cavity aged 18 or greater who were treated with surgery alone from January 1975 to December 1997 were reviewed.

RESULTS: The median age of patients was 43 years. Metastasis occurred in 3 of 60 patients (5%) and lymph node metastases occurred in 2 of 60 patients (3.3%). The median follow-up time was 7 years. The median size of the primary tumor was 2 cm. Patients with T4 tumors had a significantly worse outcome (P = 0.002). Patients with tumors that were pT4 had a significantly worse outcome (P = 0.007). The median survival time for patients with tumors that were pT1 was 90 months and the median survival time for patients with tumors that were pT2 was 101 months. The median survival time for patients with tumors that were pT3 was 49 months. The median survival time for patients with tumors that were pT4 was 17 months. Patients with tumors that were pT1 had a significantly better outcome (P = 0.007). The median survival time for patients with tumors that were pT3 was 49 months. The median survival time for patients with tumors that were pT4 was 17 months. The median survival time for patients with tumors that were pT4 was 17 months. The median survival time for patients with tumors that were pT4 was 17 months.

CONCLUSIONS: The results of this study suggests that the presence of a positive margin, tumor size, and lymph node involvement are the most important factors that influence survival in patients with mucoepidermoid carcinoma of the oral cavity.

29. Twelve-Year Experience With The Multimodal Intensification Regimens Used For Advanced Head and Neck Cancer Patients - T. Ananthanarayanan, E.C. Yarnold, K.Robbins

INTRODUCTION: The site of origin of disease was oropharynx in 52%, oral cavity in 25%, hypopharynx in 14% and larynx in 9%. The site of disease was unknown in 2% of patients. Histology was squamous cell carcinoma in 87%, adenoid cystic carcinoma in 8%, adenocarcinoma in 3% and undifferentiated carcinoma in 1%. The median number of neck nodes involved was 2 (range 1-12).

METHODS: This is an analysis of 117 patients with advanced head and neck cancer that were treated with surgery and multimodal therapy at the University of California, San Francisco over a period of 12 years. The patients were stratified into three groups: 1) primary surgical therapy, 2) primary radiation therapy, and 3) primary chemotherapy. The treatments were selected based on the site and histology of disease. The patients were monitored for 27 months or until death.

RESULTS: The overall survival rate at 27 months was 35% and the median survival time was 27 months. The median survival time for patients with primary surgery was 27 months and the median survival time for patients with primary radiation therapy was 27 months. The median survival time for patients with primary chemotherapy was 27 months. The median survival time for patients with primary surgery was 27 months and the median survival time for patients with primary radiation therapy was 27 months. The median survival time for patients with primary chemotherapy was 27 months. The median survival time for patients with primary surgery was 27 months and the median survival time for patients with primary radiation therapy was 27 months. The median survival time for patients with primary chemotherapy was 27 months.

CONCLUSIONS: The results of this study suggest that the site of origin of disease, the site of disease involvement, and the histology of disease are the most important factors that influence survival in patients with advanced head and neck cancer.


INTRODUCTION: The etiology of heavy alcohol use among patients with head and neck squamous cell carcinoma presents a significant challenge to medical providers since it is a time-consuming process of trial and error associated with prolonged inpatient stays, frequent use of restraints, increased intensive care unit requirements, and a range of life-threatening complications. The results of this study will determine whether phase III trials will be proposed.

MATERIALS & METHODS: We present our experience from March 1, 2001 until January 3, 2005 with alcohol dependent head and neck cancer inpatients prospectively utilizing a standardized care protocol. The care plan utilized the CAGE screening tool as part of the pre-operative history and physical examination to identify patients at risk for acute alcohol withdrawal. The diagnostic study included graduated graded use of benzodiazepines, sympathetics, and narcotics to achieve patient comfort and improve neurological examination, adrenergic hyperactivity, and delirium, respectively. The pathway also incorporated standardized nutritional supplementation. Outcomes measured include use of restraints, occurrence of falls, seizures, and violence, wound complications, transfers to the intensive care unit, and cardiac or respiratory arrest.

RESULTS: During the study period approximately 410 head and neck cancer inpatients were admitted post-operatively. Of these, 25 developed AWR. Alcohol dependent patients were mostly identified preoperatively by the history, including use of the CAGE screening tool. Post-operative intensive care unit stay was significantly longer in AWR patients, which was performed for an average of 65.3 days, and ranged from 3 to 11 days. Nineteen patients required treatment with the benzodiazepine, lorazepam (Ativan) to treat Type A (central nervous system excitation) symptoms, ranging in dose from 0.5 to 24 mg in a 24 hour period. Treatment of Type B signs and symptoms (advancing delirium) was necessary in 41 patients, which was performed for an average of 4.5 to 9 days, for 3 to 11 days. Nineteen patients required treatment with the benzodiazepine, lorazepam (Ativan) to treat Type B (central nervous system excitation) symptoms, ranging in dose from 0.5 to 24 mg in a 24 hour period. Treatment of Type B signs and symptoms (advancing delirium) was necessary in 41 patients, which was performed for an average of 4.5 to 9 days, for 3 to 11 days. Nineteen patients required treatment with the benzodiazepine, lorazepam (Ativan) to treat Type B (central nervous system excitation) symptoms, ranging in dose from 0.5 to 24 mg in a 24 hour period. Treatment of Type B signs and symptoms (advancing delirium) was necessary in 41 patients, which was performed for an average of 4.5 to 9 days, for 3 to 11 days.
Carcinoma With Eosinophilia of Oral Abstracts

METHODS: Urinary PGE-M was first studied using a preclinical HNSCC (1435) mouse xenograft model. Twenty-four hours post (3 mice/ovary) urine specimens from 12 HNSCC xenografts were compared to urine samples collected from 12 tumor-free controls. Urine specimens were analyzed in a blinded fashion using a single-void urine sample collected from 58 patients with HNSCC and compared to those from 30 age- and gender-matched healthy volunteers. A second urine sample was also collected from each of 32 patients after tumor resection. Urine specimens were analyzed in a blinded fashion via mass spectrometry using stable isotope dilution methodology. Results were normalized according to urinary creatinine concentration.

RESULTS: In the preclinical model, urinary PGE-M levels were increased (1.7-fold) in HNSCC cases relative to tumor-free controls (P=0.01). While median PGE-M levels were also higher in HNSCC cases (10.4 ng/mg Cr) than in controls (6.8 ng/mg Cr), this difference was not statistically significant (P=0.07). Urine specimens that were analyzed using a quantitative-PCR analysis showed a reduction in levels of urinary PGE-M to discriminate between HNSCC cases and controls. Single-void urine specimens were collected from 58 patients with HNSCC and compared to those from 30 age- and gender-matched healthy volunteers. A second urine sample was also collected from each of 32 patients after tumor resection. Urine specimens were analyzed in a blinded fashion via mass spectrometry using stable isotope dilution methodology. Results were normalized according to urinary creatinine concentration.

CONCLUSIONS: Elevated urinary PGE-M levels in HNSCC mouse xenografts failed to translate into a clinically meaningful difference in humans. PGE-M was unable to discriminate between HNSCC cases and controls. Adjusted for case-control matching, urinary PGE-M levels were significantly lower in healthy controls than in non-smokers. Therefore, urinary PGE-M may have utility as a novel biomarker of the effect of tobacco smoke exposure and warrants further investigation.

32. Pituitary Tumor Transforming Gene (PTTG) Induces Genomic Instability in Thyroid Cancer.

METHODS: A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel. A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel. A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel. A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel. A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel.

CONCLUSIONS: We have previously reported that high EGF expression was associated with increased five-year local recurrence rate and inferior five-year disease-free survival. In the present study we investigated the relationship between phospho-Akt expression and outcome in patients with SCC of the oropharynx. We also compared phospho-Akt with previous determined EGF expression levels.

47. Molecular Prognostic Markers In Oral Squamous Cell Carcinoma: The Role of Phospho-AKT

METHODS: A tissue microarray including 84 specimens from primary oropharyngeal squamous cell carcinoma. The median concentration of phospho-Akt expression was measured by AQUA and expressed as a ratio of non-phospho-Akt. Immunohistochemical analysis of phospho-Akt expression in supplemented with paclitaxel.

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The purpose of this study was to evaluate the factors associated with downregulating MMP-2 and MMP-9 activity. In parallel, promoter assays of clones was significantly less than vector controls. Zymographic analysis of patient outcomes. In addition, this study demonstrates that recurrent laryngeal nerve (RLN) injury and hypoparathyroidism.

METHODS: Data was acquired prospectively between July-2003 and June-2004. Paratracheal dissection was performed in patients with pre-operative neck metastases to predict post-operative outcomes. Of the 23 patients available for review (fifteen within the neutron group and eight in the photon group) median survival was 47 vs. 54 months in the medullary histology group, 17 vs. 21 months in the pelvic histology group.

RESULTS: Of the 23 patients available for review (fifteen within the neutron group and eight in the photon group) median survival was 47 vs. 54 months in the medullary histology group, 17 vs. 21 months in the pelvic histology group.

CONCLUSIONS: Our data supports the hypothesis that the presence of ECS as well as the need for re-exploration of the paratracheal area for recurrent disease has a higher risk of recurrent laryngeal nerve injury and hypoparathyroidism. Morbidity was documented at the time of surgery, at 3 and 6 months by evaluating true vocal cord mobility, serum calcium levels and a personal interview. Pathologic specimens were evaluated by a head and neck pathologist. Chi-square test was used for statistical analysis.

RESULTS: A total of 78 patients underwent a paratracheal dissection for PTC, 50 for primary disease and 28 for recurrent disease. Eighteen patients with recurrent disease had previous treatment elsewhere. Metastasis was present in 74 (95%) patients, with an average of 3.4 pathologically positive nodes among an average 5.9 dissected nodes. Paratracheal dissection was performed in 21 patients with intra-operative suspicious adenopathy. Contralateral paratracheal dissection was performed in 20 patients. Of these, one-third could not correctly interpret how to take medicine on an empty stomach.

CONCLUSIONS: In the presence of fair quality of life, many inner-city TL patients have inadequate HL skills. TL should be considered in the initial management of such patients. Interestingly, treatment protocols have been developed to limit extracapsular spread for patients with recurrent disease. To answer this question, a prospective study was then performed comparing patients undergoing central compartment dissection: those previously untreated PTC and patients with recurrent disease.

OBJECTIVES: The prognosis of most patients with locally advanced, node-positive, metastatic or anaplastic disease remaining after treatment with conventional external beam radiotherapy or conventional photon beam radiotherapy at a tertiary care center between 1985 and 2004. Survival rates were calculated between the two treatment groups using the Kaplan-Meier product limit method. Independent sample t-Tests were used to compare means for neutrons vs. photons overall survival as a whole and based upon differing Histories. It is also necessary to develop appropriate tools for measuring survival among an inner-city indigent cancer population.

CONCLUSIONS: There were no racial differences in urban or rural residence. Compared to photons was 47 vs. 54 months in the medullary histology group, 17 vs. 21 months in the pelvic histology group, and 40 vs. 58 months in the squamous histology group.

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RESULTS: Of the 23 patients available for review (fifteen within the neutron group and eight in the photon group) median survival was 40 vs. 54 months in the medullary histology group, 17 vs. 21 months in the pelvic histology group, and 40 vs. 58 months in the squamous histology group.
RESULTS: With epizodic sites considered positive, the sensitivity and specificity of P/E for the molecular tumor marker of ACC were 85% and 85%, respectively, for the entire cohort in whom patients underwent previous chemotherapy treatment. The sensitivity and specificity of P/E interpretation was 86% and 85%, respectively. In patients with clearly palpable or radiographic positive (CT/MR) sites, the sensitivity and specificity of P/E interpretation was 86% and 86%. Using an SUV of 2.5 as a determinant of positive nodal metastases yielded a sensitivity of 78% and a specificity of 88% for the entire cohort. The area under the receiver operator characteristic curve for SUV as a determinant of metastatic disease was 0.85. An SUV threshold of 10% of the background signal was identified as the threshold cut-off for the detection and resection of nodal metastases. The current literature is equivocal on the sensitivity and specificity of SUV for the detection of nodal metastatic spread.

OBJECTIVE: The aim of this study was to investigate the expression of the tumor suppressor gene fhit in multiple tumor types of the head and neck, including squamous cell carcinoma (SCC), adenoid cystic carcinoma (ACC) and the most common salivary gland tumors. In particular, the expression of fhit in ACC tumors was to be evaluated.

METHODS: A group of volunteer patients with squamous cell carcinoma of the upper aerodigestive tract treated in a single institution between 1995 and 1999 were enrolled. The study was comprised of 214 patients, 45% and 57%. End-of-life decisions were taken in 23 (21%) patients. Age, performance status before hospital admission (ECOG scale), cancer lines. The aim of this study was to investigate the expression of the tumor suppressor gene fhit in multiple tumor types of the head and neck, including squamous cell carcinoma (SCC), adenoid cystic carcinoma (ACC) and the most common salivary gland tumors. In particular, the expression of fhit in ACC tumors was to be evaluated.

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are increasingly being used for primary radiation therapy in patients with untreated head and neck cancer or currently with untreated cancer. The use of hyperbaric oxygen in patients either with a history of treated head and neck cancer or currently with untreated cancer: (4) the use of growth factors.

**Objective:** The Radial Forearm Free Flap

**Results:** Fifty-four patients were identified. Only one patient had significant tendon eburnation. A V to Y closure was performed. The site healed well with a primary closure that required no further intervention. No other donor site complications were noted in this group.

**Conclusion:** The incidence of wound breakdown requiring surgical intervention was low in the RRFF donor site following a simple technique of STSG, bolster, and short term splitting. This demonstrates a lower donor site morbidity of the RRFF site compared to other donor sites.

**Poster Abstracts**

**Questions Investigated on Respondents on:** (1) the effects of radiation or chemoradiation on post-operative wound healing as well as opinions on chemoradiation on post-operative wound healing; (4) the use of growth factors.

**Results:** Over 90% of respondents indicated that a history of radiation or chemoradiation increased the risk of wound healing. There was no strong agreement on the effect of growth factors.

**Conclusion:** The incidence of wound breakdown requiring surgical intervention was low in the RRFF donor site following a simple technique of STSG, bolster, and short term splitting. This demonstrates a lower donor site morbidity of the RRFF site compared to other donor sites.

**Material and Methods:** The study was approved by the local ethics committee. A fourteen question anonymous survey was sent to members of the American Head and Neck Society regarding (1) the use of hyperbaric oxygen in patients either with a history of treated head and neck cancer or currently with untreated cancer: (4) the use of growth factors.

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97. Quality of Life After Thyroidectomy: A Proposal For A New Questionnaire
University of São Paulo Medical School, São Paulo Brazil, University of São Paulo Medical School, São Paulo
BACKGROUND: Quality of life (QOL) evaluation after cancer treatment has been one of the most important aspects of cancer medicine. However, there are virtually no reports on QOL in patients with thyroid diseases, submitted to thyroidectomy.
OBJECTIVES: To develop a new QOL questionnaire after thyroidectomy, and to apply it to a population, as a pilot study.
Design of the study: prospective, non-randomized.
METHODS: Patients enrolled in two phases: I) Multi center trial on the quality of life protocol after thyroidectomy (USQOLPI-1) comprised 20 multiple choice questions. Each answer corresponded to a score from 1 to 4. Therefore, minimal possible score was 0 and the maximum possible score was 80. Thirty consecutive patients were evaluated preoperatively and at least one month after the thyroidectomy (either partial or total). The majority of the patients was female (86%), and ranged from 18 year-old to 68 year-old (median: 42±7). Most prevalent pathological diagnosis was papillary carcinoma (40%), and the majority of the pathology was classified as papillary variant (53%).
RESULTS: Most common postoperative complaints were temporary difficulties in swallowing (21%), temporary dysphonia (16%). There were no symptomatc hypopaptonmia or permanent dysphonia. Highest USQOLPI score was 75 and lowest was 49. The largest difference between pre and postoperative evaluation was noted in 21 of 22 cases (95%) in one case (4%), on the same day 40 and after 1 day, in other 1 case (4%), the largest difference between pre and postoperative evaluation was noted in 22 of 22 cases (100%). An improvement in USQOLPI score occurred in 46 of the patients (of whom 86% had a benign final pathology report), with no difference regarding the extent of the operation. 30% of the patients had a worsening in postoperative USQOLPI-1; 4% of them underwent total thyroidectomy and hypothyroidism (8%).
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98. Quantitative mRNA & Mutational Analysis of p63 in Primary & Recurrent Squamous Cell Carcinomas of The Head & Neck
K.Kong, A.M.S.Al-Mutairy, S.S.CHO, C.L.Clang
Department of Otolaryngology, Head and Neck Surgery, The Ohio State University, Columbus, OH, “Department of Statistics, The Ohio State University
Multiple tumor suppressor genes, including p63, have been implicated in the development of squamous cell carcinoma of the head and neck. Research on p63 has focused in recurrent tumors follow-up is needed to better determine complication and response rates as well as better as to why the appropriate role of FSRS in the treatment of recurrent head and neck cancer.

99. Methylation In Squamous Cell Carcinoma of The Head & Neck
C.Kho, M.KM, M.RHVT, SCHO
Carcinogenesis is known to arise as a result of the accumulation of genetic alterations including unilateral chromosome losses and epigenetic modifications. In this study we investigate the extent of chromosomal losses and normalcy status in 50 primary and 10 recurrence head and neck tumor samples (10 matched primary/recurrence, 10 non-recurrent primary, 10 non-recurrent recurrence). Total RNA was extracted by Trizol. mRNA was amplified and hybridized against a 300 motif microarray with 4606 features. Statistical and mathematical tools were employed for the identification of molecular signatures that could be predictors of therapeutic response. Patients were followed-up by 3 years.

100. The Extent Of Chromosomal Losses & The Status Of Cpf1 Methylation In Squamous Cell Carcinoma Of The Head & Neck
A.S.AL-Mutairy, P.R.Evans
DEPARTMENT OF OTOLARYNGOLOGY-HNS, THE CATHOLIC UNIVERSITY OF KOREA, SEOUL, Republic of Korea
To analyse the effect of the chromosome losses and Cpf1 methylation status on the clinicopathologic factors.

101. Stage4 Oral Cancer: A Proposal For A New Questionnaire
C.L.Clang, A.M.S.Al-Mutairy, S.S.CHO
The University of São Paulo Quality of Life Research, São Paulo, Brazil
Background: To reduce racial confounding, only non-Hispanic whites were included. METHODS: We performed a retrospective study on 232 patients with head and neck cancer seen at a single institution, from 1996 to 2006. Significant reduced risk of developing complications was observed by genetic analysis may aid in therapeutic decision-making, justifying a role in the current clinical setting. Clinical and pathological subsite data were included. Overall, 10% of patients died from complications.

102. Changes In Quality Of Life In Head & Neck Tumours Patients During Biotherapy
P.Cavallo, E.Polo, M.Isidori
Hospital Universitario de Melilla, Melilla, Spain
This study was conducted in 2007 to evaluate the value of a new instrument in the field of head and neck cancer patients during biotherapy.

103. Tumor Suppressor Gene Mutations in Hypolaryngeal SCC
L.Li, R.Brentani, B.D.Barreto, A.S.Al-Mutairy
Cancer Research, São Paulo, Brazil; Hospital do Câncer A.C.Camargo, São Paulo, Brazil; Instituto de Matemática e Estatística, USP, São Paulo; Ludwig Institute for Cancer Research, São Paulo
BACKGROUND: The combination of chemotherapy and radiotherapy became the gold standard for treatment of locally advanced SCC of the larynx and hypopharynx, with disease-free survival rate similar to the rates obtained with total laryngectomy and postoperative radiotherapy. However, non-resectable patients are treated only by radiotherapy or chemotherapy. The risk of complications. Moreover, there is a significant increase in the cost of the treatment.

104. Concurrent treatment with paclitaxel and cisplatin plus radiotherapy lead to complete response in 54% of patients with statistically significant improvement in disease-free survival and overall survival rates. We identified 20 and 27q genes that could precisely predict responsiveness.

CONCLUSIONS: Our preliminary experience demonstrates the feasibility of delivering fractionated stereotactic radiosurgery to recurrent head and neck cancer with the CyberKnife. Treatment was well tolerated with few serious complications including radiation encephalopathy and EUBRT and surroadding RESULTS: Median follow-up was 4 months (range of 1-24 months). All patients tolerated the treatment well. Complete response was achieved in 3 patients, partial response in 6 patients, stable disease in 1 patient and progression in 2 patients. Two patients developed disease break down after progression tumor growth at the treatment site. One patient developed grade III mucositis. One developed new neurotoxicity. Up dated follow-up will be presented.

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105. Development of A Voice Prophylaxis Questionnaire For Patients With Total Laryngectomy
R.A. Kapp \( ^{1} \), J.De Cordova \( ^{1} \), A.Muttil
L.O/Easby \( ^{1} \), P.Clarke \( ^{1} \), C.Nutting \( ^{1} \), K.Harrington \( ^{1} \), P.Rhys-Evans \( ^{1} \)
Royal Marsden Hospital, London, England
AIM: To undertake a multidimensional assessment of the prophylaxis
segment (PE) in total laryngectomy patients.

Design: A retrospective cohort study.

METHODOLOGY & DATA COLLECTION: In this study, we assessed
the speech quality of all total laryngectomy patients using either a
voice prosthesis, oesophageal speech or an electrolarynx +/- nerve
implantation. The voice prosthesis was used to speak for a median
of 10.2s (range: 3s to 32s) as compared to the normal
voice quality of 15s (range: 10s to 20s) which is considered
optimal and predictable voice quality.

CONCLUSIONS: Although tracheoesophageal prosthetic speech
serves as a tool in monitoring patients who have had surgical voice
restoration. The most common prosthesis used was the Blom-Singer
voice prosthesis.

40. Esophageal Segment In Total Laryngectomy Patients
C.Nutting \( ^{1} \), J.De Cordova \( ^{1} \), A.Muttil
L.O/Easby \( ^{1} \), P.Rhys-Evans \( ^{1} \), C.A.Rainho \( ^{1} \), P.Clarke \( ^{1} \)
University of Kentucky, Lexington, KY

AIM: To determine the pharyngoesophageal (pheno- gastrostomy) speech
quality of 28 total laryngectomy patients using either a voice
prosthesis, oesophageal speech or an electrolarynx +/- nerve
implantation, with a focus on factors of voice restoration.

STUDY DESIGN: Retrospective Cohort Study

METHODS: We randomly selected 25 patients who had undergone
total laryngectomy +/- partial total pharyngectomy. Patients were
investigated using the prophylaxis for a median of 6 years (range: 1.2 to 19 years).

RESULTS: Of the twenty-five patients, 16 were male and 9 female, with a
median age of 54 (range: 28 to 72). Patients had undergone
radical radiotherapy, 172 received post operative radiotherapy
with combined group. For late stages was 91%, 54% and 75% respectively.

ANALYSIS: Data from the questionnaires were collated and correlation
analysis was performed using the Statistical Package for Social Sciences
(SPSS Inc., Chicago III).

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that HPV-16 positive tumors of the oropharynx: Thirty patients undergoing parotidectomy were the hypothesis that disparities in the literature chemotherapy and/or radiotherapy without surgery. Both patients expired of postoperative radiation and/or chemotherapy, the mean 5-year survival was 23%. Two patients (with T1 and T2 stage tumors) were treated with wide surgery, 80% showed positive surgical margins due to the tumour tract, and 2 cases (33%) were in the soft tissue of the neck. Also four cases of ORN of the clavicle following radiation therapy for squamous cell carcinoma of the head and neck. Each patient was male, with a mean age of 58 years at the time of primary tumor diagnosis. 60%. When analyzed according to pathologic findings the incidence of post-hemithyroidectomy hypothyroidism was the same (60 years).  No significant differences between the two cohorts for 8 matched potential significant confounders was found. However, length of stay, major perioperative morbidity, and flap failure were not significantly different (p>0.05) among patients treated at the high-volume center.

CONCLUSION: Using direct medical record comparison, rather than administrative database analysis, a high-volume of MHH is also associated with significantly better outcomes.

113. Effects of Preserving The Posterior Branch Of The Greater Auricular Nerve At Parotidectomy On Postoperative Sensation L.Park. - Facultad de Medicina, Universidad Nacional de Colombia

BACKGROUND & OBJECTIVES: The posterior branch of the greater auricular nerve (GBGAN) is a composite nerve that supplies sensation to the skin overlying the sternoclavicular joint, and the process and the posteroinferior region of the auricle. The greater auricular nerve is often sacrificed in parotidectomy, even though its posterior branch can be preserved. By caution dissection of the greater auricular nerve it is possible to preserve the posterior branch in 60% of the operations. However, the feasibility of this procedure is not clear. So, we have compared the patients whose nerve had been sacrificed with these patients, to evaluate the outcomes of preservation of the posterior branch of greater auricular nerve preservation during parotidectomy.

MATERIALS & METHOD: Thirty patients undergoing parotidectomy were clinically evaluated for 6 month period. The mean age of the patients was 48+11 years. Preservation of the posterior branch of greater auricular nerve (group A) and it was compared with fifteen patients who underwent parotidectomy with sacrificing the nerve (group B). Using questionnaire, we have investigated about numbness, pain or other subjective symptoms on postauricular area just postparotidectomy. We also used two point discrimination test and temperature sensitivity test.

RESULTS: Postoperatively, twenty patients felt lack of sensitivity, pain, itching or other symptoms. These symptoms recovered within 12 months, subjectively. However, in group B, permanent sensory loss was found in 9 patients (30%). To determine whether this difference is significant, a univariate analysis (t-test and chi-square test) selection and case-mix control. None have sought to determine whether this condition could influence the outcome of the Reconstructive Head & Neck Surgery (MHH) a less common and longsighted surgery. OBJECTIVE: To determine, using direct medical record comparison, if a high volume of RT regarding the influence of the postauricular nerve on the outcome of the Reconstructive Head & Neck Surgery (MHH) is an important factor.

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CONCLUSION: From this study, despite of no significant difference on subjective symptoms, there was objective improvement on function of the greater auricular nerve. It seems the function of the nerve has been tested by two point tactile discrimination test and temperature sensitivity test.

AIM: To undertake a study of the changes in the voice quality of patients with early glottic cancer during and following external beam radiotherapy.

DESIGN: A prospective cohort of 15 patients of early glottic (T1, T2) cancer treated with radiotherapy as compared to a matched control set of 15 normal volunteers.

METHODS & RESULTS: In this study, voice quality was investigated by means of an objective acoustical analyses (acoustic measures), words per minute and maximum phonation time of a sustained vowel, text, spontaneous speech and subjective perceptual evaluations performed by trained listeners using the GRBAS scale pre-treatment and then again 1, 6 and 12 months post-treatment.

RESULTS: Although most of the acoustic measures could be reliably calculated, there was a considerable disturbance of especially the jitter & shimmer among the patients pre-treatment. This remained the same or deteriorated slightly after a month post-treatment and only improved a little after 6 months post-treatment. No change was seen in the controls. Vocal efficiency, as assessed by increased age, tumour stage, radiation dosage & continued smoking are very important factors in patients after radiotherapy.

CONCLUSIONS: A decrease of voice quality was better. The deviant voice quality was mainly negatively affected by increased age, tumour stage, radiation dosage & continued smoking.


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116. Head & Neck Adenoid Cystic Carcinoma: Clinical, Histological and Immunohistochemical Study. D.C.Peerov, F.A.Alver, L.N.Nishimoto, G.P.Almaldi, L.P.Kowalski, School of Dentistry of Piracicaba/UNICAMP, Piracicaba Brazil; J.Cordova, L.Merkulov, D.Myssiorek, Albert Einstein College of Medicine, New York, NY; Paulo de Carvalho, Hospital do Can&039;Cancer A C Camargo, Sao Paulo Brazil

INTRODUCTION: Adenoid cystic carcinoma (ACC) are uncommon head and neck malignancies, accounting for about 3% of all neoplasms of the major and minor salivary glands and 2%-5% of the malignant salivary gland tumors. Few studies have associated clinical, histological and immunohistochemical variables as prognostic factors in a large series of ACC. The aim of this study was to analyze the clinical, histological and immunohistochemical prognostic factors of a large series of patients with ACC treated in a single institution.

METHODS: From the cases treated between 1955 and 1997 in our Department, 166 patients were consecutively selected for this study. The clinical and epidemiological data were obtained from the medical records using a computerized system. Hematoxylin and eosin stained and histopathological slides were reviewed for confirming of the clinical and histological classification. Immunohistochemical reactions against p53 protein (clone PAb1801; 1:100 dilution) and against the apoptosis marker cleaved caspase-3 (clone Y11; 1:100 dilution) as an apoptosis marker and against the pro-inflammatory marker interleukin-6 (clone 7D12; 1:100 dilution) were performed using a streptavidin-biotin-peroxidase method.

RESULTS: From 129 cases, seventy-one were male (55%) and fifty-eight female (45%), with an age range of 35-196 months (mean 90.4 months), with the most patients complaining of swallowing (91.4%), pain (58.9%) and paraesthesia (12.6%). The minor intratracheal salivary glands were treated with radiotherapy alone in 12%, surgery alone in 20%, surgery and radiotherapy in 45%, surgery and chemotherapy in 17% and chemotherapy alone in 6%. The patients were diagnosed at clinical stages III or IV. At the diagnosis, eleven cases presented distant metastasis. Konishi et al. histological type was the cribriform type, with 38% cases (45), followed by tubular, 27 cases (21.6%), and solid histological type with 22 cases (17.6%). Surgery was the main treatment modality (92%). Patients underwent adjuvant postoperative radiotherapy. Nineteen (16.6%) and six cases (5.8%) presented distant metastasis, respectively. No positive surgical margins were observed. The overall survival rates at 5 and 10 years were 36.8% and 32.5%, respectively. A poor survival was associated with T4 stage, increased tumour grade, increased radiation dosage and adjuvant chemotherapy. The patients who received neck dissection showed improved survival. The deviant voice quality was mainly negatively affected by increased age, tumour stage, radiation dosage & continued smoking.

CONCLUSIONS: The deviant voice quality was mainly negatively affected by increased age, tumour stage, radiation dosage & continued smoking.

117. Combination Of Doxorubicin & Cisplatin Chemotherapy For Advanced Or Metastatic Nasopharyngeal Cancer (NPC). A.B.NEEMAL

RESULTS: The median follow-up was 33 months (range, 6-58 months). Among the 28 patients undergoing neck dissection, 14 (50%) had pathological evidence of residual neck disease. Two-year disease-specific survival was 67%, for patients without neck disease after radiochemotherapy compared with 64%, for patients with neck disease (not significantly different), 42%. The median survival was 29 and 16 months, for patients with and without neck disease, respectively (p=0.04). There was no difference in regional control between patients with and without neck dissection.

CONCLUSION: Neck dissection after radiochemotherapy gives less complications. Neck dissection may be performed in some selected cases: residual neck disease on CT scan 2-5 months after the end of the treatment of radiotherapy. However, a large prospective study must now be done to corroborate our results.

118. Recurrent Early Stage Laryngeal Cancer Treated With Photodynamic Therapy D.Moukarir, A.Labnoun, A.Bouar, M.Akouly, Albert Einstein College of Medicine, New Hyde Park, NY; Albert Einstein College of Medicine, New Hyde Park, NY

OBJECTIVES: To determine the safety of photodynamic therapy (PDT) with a minimal number of complications in a patient with recurrent laryngeal cancer that failed radiation therapy. The efficacy of this treatment will be examined.

MATERIALS & METHODS: Eight patients received PDT with metatetrahydroxyphenyl chlorin (mTHPC) for recurrent laryngeal cancer. Patient selection for PDT was based on failed radiation therapy and would require a total laryngectomy for salvage. Patients were injected with 0.075 mg/kg/m² of mTHPC. Six days after their laryges were exposed endoscopically, patients received an intravenous injection of 15 mg/kg mTHPC. The total energy density per exposure varied from 300-1500 Joules/cm². Complications associated with mTHPC were recordable outcomes. The total energy density per exposure was measured by tumor recurrence and time to recurrence. One patient was excluded from this part of the analysis because he received CO₂ laser therapy at the same time as PDT. Seven patients received nine exposures to PDT.

RESULTS: All patients developed laryngeal pain that was maximal at one week after the procedure. Five patients developed photosensitivity at 23 days to 2 weeks after the last injection with mTHPC. There were no allergic reactions. 7/7 patients had tumor recurrence. Disease free interval ranged from 6 weeks to 1 year. One patient was treated with a partial laryngectomy, five had total laryngectomy and one died of intercurrent illness before her recurrence could be treated.

CONCLUSION: PDT with mTHPC is safe and associated with few complications if appropriate precautions are taken. It is not an effective treatment for early stage laryngeal cancer that failed radiation therapy.
METHODS: To characterize factors that predispose patients to disease after enucleation may be adequately treated with subsequent carcinomas. Patients with negative clinical and radiographic evidence of prior biopsy and subsequent treatment on locoregional disease control and survival.

METHODS: Eighty-seven consecutive patients with primary submandibular carcinomas were identified for analysis with a mean follow up time of 8.7 years. Upon referral, all patients were evaluated by clinical exam and high-resolution imaging. Patients with no clinical or radiographic evidence of residual primary or nodal disease were referred for definitive radiation therapy. These patients with gross residual disease received a definitive surgical resection prior to radiation therapy. We identified the following cohorts of patients: enucleation of the gland prior to referral followed by definitive therapy and enucleation of the gland prior to referral followed by definitive resection and radiation therapy (8%), and finally those with no prior enucleation treated with definitive surgery and radiation therapy (10%).

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Lymphoscintigraphy May Contribute To Nodal Recurrences

**INTRODUCTION**

Lymphoscintigraphy results were correlated with operative findings in a site identified by preoperative lymphoscintigraphy but not day of surgery lymphoscintigraphy. In one of 22 patients lymphoscintigraphy on the day of surgery lymphoscintigraphy but not the preoperative study. In this study, DNA samples from paired tumor and adjacent normal tissue from 129 patients with squamous cell carcinoma of the head and neck were analyzed and 5% (6/129) showed mutation for both TP53 and p16. We failed to find any associations between the occurrence of TP53 and p16 mutations occurrence tended to be lower (40%) then the probability of p16 & E-Cadherin1 (CDH1) Hypermethylation In Head & Neck Tumors.

**RESULTS**

Inactivation of tumor suppressor genes such as p16 and CDH1 is a frequent event in human cancers, including head and neck and cervical carcinomas. DNA hypermethylation is one of the epigenetic events associated with the inactivation of these genes. In the present study, DNA samples from 129 patients with squamous cell carcinomas of the head and neck were investigated for the occurrence of p16 and CDH1 hypermethylation. The methylation status of p16 gene was analyzed using methylation sensitive restriction enzymes and PCR amplification. The methylation status of CDH1 gene was analyzed for 126 cases using methyl-specific PCR after DNA modification with the restriction enzymes. We failed to find any associations between the occurrence of hypermethylation of p16 and CDH1 genes and age, gender, tumor site, nodal status, histological grade, tobacco and alcohol consumption. However, a significant correlation was found between the occurrence of p16 hypermethylation and early T-stage (p<0.05). In all cases, CDH1 gene was methylated in one patient with advanced disease. The leading to the inactivation of the p16 and CDH1 tumor suppressor genes are common in primary head and neck tumors and might be useful targets for new therapeutic interventions.

**CONCLUSION**

Supported by FAPESP, Fundação de Amparo à Pesquisa do Estado de São Paulo, Brazil.

# 131. Supraclavicular Lymphatic Surgery With Adjuvant Therapy

E.M. Dias, E. Rösinger

**INTRODUCTION**

Supraclavicular partial lymphatic surgery (SCPL) with extracapsular dissection (ECD) is currently recommended by the National Comprehensive Cancer Network as an alternative to extended neck lymphatic surgery (ENL) in patients with node-negative neck disease. In the United States, the SCPL is a preferred procedure for patients with a history of radiation therapy.

**OBJECTIVE**

To determine the rates of local control, overall survival in patients treated with SCPL in the adjuvant setting.

**METHODS**

Eight-year retrospective review of patients who received SCPL at a single comprehensive cancer center either as primary surgical treatment or following induction chemotherapy or as salvage after definitive radiation therapy.

**RESULTS**

The charts of 25 patients had SCPL with CHEP or CHF for primary laryngeal cancer were reviewed. Most patients were men (88%) with a mean age of 59 years. The mean follow up time after surgery was 35 months. Twenty patients had primary SCC, five of whom had prior radiation treatment. Three patients had evidence of regional spread; both were staged as N1. Regional lymphadenopathy was managed for all supraglottic tumors and on two patients following SCPL. No patients had evidence of distant metastases. Nineteen patients had primary tumors arising in the glottis or supraglottic region. Ten patients had SCPL alone and nine with chemoradiotherapy. All patients had evidence of local control, overall survival in patients treated with SCPL in the adjuvant setting.

**CONCLUSIONS**

Supported by FAPESP, Fundação de Amparo à Pesquisa do Estado de São Paulo, Brazil.
To investigate the in vivo microenvironmental interactions with the head and neck cancer, outcomes, recurrence, survival study: Retrospective chart review of 12 patients. All patients with oral cavity tumors were reconstructed by applying meshed Alloderm© and split-thickness skin graft. Due to tissueexpansion, the patients were followed. Abnormal expression of epidermal and endothelial growth factors was noted, suggesting that the combined use of Alloderm© and split-thickness skin graft leads to better outcomes. The objective of the study was to investigate the expression of growth factors in the head and neck area.

**RESULTS**

The results showed an increased level of stromal tissue degradation and type of treatment in the model indicated that a pain predictor was associated with the expression of transforming growth factor beta (TGF-β) in the present study. The molecular pathways of TGF-β were compared to the mean level reported within the same time period by the non-tumor burdened mice. The study concluded that the expression of TGF-β is a significant predictor of recurrence.

**CONCLUSIONS**

The combination of meshed Alloderm© and split-thickness skin graft for RFFF donor site reconstruction appears to be an excellent choice for head and neck reconstruction with minimal donor exposure, minimal functional impairment and acceptable cosmetic outcomes.

**133. Tumor Stromal Interaction in an Immunocompetent Mouse Model**

J. A. Stagg, E. Shillitoe, R. M. Kellman

SUNY Upstate Medical University, Syracuse, NY

PURPOSE: To investigate the in vivo microenvironmental interactions between tumor cells and the surrounding stromal tissue in an immunocompetent mouse model. Utilizing an immunocompetent mouse model of metastasizing oral cancer, a sample of the tumor-stromal interface was obtained. Laser capture microdissection (LCM) was used to obtain mRNA from adjacent stromal cells. The mRNA from the cell populations was amplified and the expression of stromal tissue degradation and type of treatment in the model indicated that a pain predictor was associated with the expression of transforming growth factor beta (TGF-β) in the present study. The molecular pathways of TGF-β were compared to the mean level reported within the same time period by the non-tumor burdened mice. The study concluded that the expression of TGF-β is a significant predictor of recurrence.

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**CONCLUSIONS**

The combination of meshed Alloderm© and split-thickness skin graft for RFFF donor site reconstruction appears to be an excellent choice for head and neck reconstruction with minimal donor exposure, minimal functional impairment and acceptable cosmetic outcomes.
140. Malignant Melanoma & Its Relation To UV Radiation levels in Chile
N.Benecke1, J.Fernandez, C.Øvredal2, J.Bruce, J.Øverberg, I.Øverberg, J.PLoed
1Hospital Fuerza Aerea de Chile, Santiago Chile; 2University of Helsinki, Helsinki Finland.
INTRODUCTION: The epidemiology of melanoma is known to be related to UV radiation. We wish to investigate the relationship between UV exposure and the occurrence of malignant melanoma in Chile.
RESULTS: Of the 218 patients operated on for HPT, 4 (1.8%) had hyperparathyroid crisis. All four of the patients were women with a mean age of 43 ± 12 years compared to 145 patients with primary HPT and a solitary adenoma without crisis whose mean age was 57 ± 12.2 years and 126 (84.8%) of whom were women. Clinical manifestations included: anorexia, lethargy, nausea and vomiting, osteolytic lesions of bone (1), and oropharyngeal ulcers (1).
CONCLUSIONS: These cell lines were genetically-marked with ß-galactosidase and mixed with normal human keratinocytes (4:1 ratio, normal: II-4) and tumor cell lines. The results of this study suggest that a reasonable alternative to initial surgical intervention. Updated rates of complication and outcome for the entire cohort of T4 oral cavity tumors will be presented.

142. Hyperparathyroid Crisis & Pharyngolaryngeal irradiation
J.L.Koch-Weser, M.Rossi, B.Bohles, J.M.Bocker
Department of Otolaryngology, University of Pittsburgh School of Medicine, Pittsburgh, PA.
INTRODUCTION: Previously reported radiographic hyperparathyroid crisis (HPT) was reviewed and patients presenting with hyperparathyroid crisis were identified. Clinical presentation, precipitation factors, laboratory indices, medical interventions to reduce serum calcium levels, timing of surgery, tumor weight, and epidemiological data were collected from an IRB-approved parathyroid database and a retrospective chart review for patients with hyperparathyroid crisis and comparisons were made to other patients operated on for primary HPT.
RESULTS: Of the 218 patients operated on for HPT, (4.8%) had hyperparathyroid crisis. All four of the patients were women with a mean age of 43 ± 12 years compared to 145 patients with primary HPT and a solitary adenoma without crisis whose mean age was 57 ± 12.2 years and 126 (84.8%) of whom were women. Clinical manifestations included: anorexia, lethargy, nausea and vomiting, osteolytic lesions of bone (1), and oropharyngeal ulcers (1).
CONCLUSIONS: These cell lines were genetically-marked with ß-galactosidase and mixed with normal human keratinocytes (4:1 ratio, normal: II-4) and tumor cell lines. The results of this study suggest that a reasonable alternative to initial surgical intervention. Updated rates of complication and outcome for the entire cohort of T4 oral cavity tumors will be presented.

143. Review of The Utilization Of The Intraoperative Parathyroid Parathyroid Hormone Assay In A Single Institution J.M.Bocker, M.D.
Montefiore Medical Center, Bronx, NY.
INTRODUCTION: Recently rapid parathyroid hormone (PTH) assay was introduced for intraoperative parathyroid gland localization. We investigate that a significant drop in PTH level appeared to be definitive proof of complete parathyroidectomy, and not necessarily a sure indicator of complete parathyroidectomy. Patients with hyperparathyroid crisis who had a high preoperative parathyroid hormone to levels well within the normal range. The patients were treated with rehydration and hyperparathyroid crisis which, if untreated, is almost uniformly fatal.
METHODS: A retrospective review of 115 patients who underwent parathyroidectomy for primary hyperparathyroidism due to adenomas utilizing intraoperative PTH monitoring was conducted. Patients were categorized into two groups, those with early postoperative PTH within the normal range and those with an elevated early postoperative PTH. Data were compared between the two groups using Student’s t-test with one-tailed and two-tailed P-values. Results: Of the 218 patients operated on for HPT, (4.8%) had hyperparathyroid crisis. All four of the patients were women with a mean age of 43 ± 12 years compared to 145 patients with primary HPT and a solitary adenoma without crisis whose mean age was 57 ± 12.2 years and 126 (84.8%) of whom were women. Clinical manifestations included: anorexia, lethargy, nausea and vomiting, osteolytic lesions of bone (1), and oropharyngeal ulcers (1).
CONCLUSIONS: These cell lines were genetically-marked with ß-galactosidase and mixed with normal human keratinocytes (4:1 ratio, normal: II-4) and tumor cell lines. The results of this study suggest that a reasonable alternative to initial surgical intervention. Updated rates of complication and outcome for the entire cohort of T4 oral cavity tumors will be presented.

144. Prosthetic Approach For Identification of Head & Neck Cancer
H.Hirj1, C.Rospelschi2, G.Quiroz1, N.Riveros1, J.Wojciechowski1, M.Otero3, P.J.?lazko3, J.M.Bocker1
University of Pittsburgh School of Medicine, Pittsburgh, PA.
INTRODUCTION: We report a case-series and evaluate a strategy for management of parathyroid crisis. The rapid PTH assay has been divided on its utility. In our review thirty percent of the patients had elevated postoperative PTH levels. Most of these cases represent secondary hyper-parathyroidism in response to decrease in calcium after surgery. One patient was proven to have vitamin D deficiency, and responded to treatment. The two patients with hypercalcemia and elevated parathyroid hormone levels six months later. One underwent contralateral exploration, with negative findings. The other is still under observation. Postoperative calcium levels were within the normal range in all other patients (mean SD 4.1). There were 2 cases of hypocalcemia and post-exciisional, and postPTH crisis.
REFERENCES: Previous literature on the utilization of the rapid PTH assay has been divided on its utility. In our review thirty percent of the patients had elevated postoperative PTH levels. Most of these cases represent secondary hyper-parathyroidism in response to decrease in calcium after surgery. One patient was proven to have vitamin D deficiency, and responded to treatment. The two patients with hypercalcemia and elevated parathyroid hormone levels six months later. One underwent contralateral exploration, with negative findings. The other is still under observation. Postoperative calcium levels were within the normal range in all other patients (mean SD 4.1). There were 2 cases of hypocalcemia and post-exciisional, and postPTH crisis.
142. Headpin Regulates Nuclear Transcription of Cyclin D1 & Proliferation in HNSCC Cells
T.D.Shellenberger, A.Mazumdar, J.Henderson, K.Briggs, G.Clayman
UT M.D. Anderson Cancer Center, Houston, TX

BACKGROUND: Members of the serpin family of serine protease inhibitors suppress proliferation, migration and invasion of tumor cells. PI-2, a novel nuclear subcellular localization of serpins has been correlated with prognostic significance in many cancers. We designed an in vitro and in vivo reporter assay to determine the functional significance of headpin nuclear localization in HNSCC lines.

METHODS: We performed confocal immunofluorescence microscopy using an antibody directed against headpin protein to assess constitutive expression in NCO cell lines. To study PI-2 expression, we transduced the headpin subcellular localization of serpins has been correlated with prognostic significance in many cancers. We designed an in vitro and in vivo reporter assay to determine the functional significance of headpin nuclear localization in HNSCC lines.

RESULTS: Differentiated histological and functional assays on 10 HNSCC cell lines revealed constitutive expression of headpin in 9 of 10 cell lines. We measured the nuclear localization of headpin in 9 cell lines using a human headpin overexpression vector and 1 cell line using a SiRNA vector. The nuclear localization of headpin was significantly increased in 7 of 9 cell lines. The nuclear localization of headpin was significantly increased in 7 of 9 cell lines. The nuclear localization of headpin was significantly increased in 7 of 9 cell lines. 2 of 9 cell lines showed no change in nuclear localization of headpin.

CONCLUSION: Headpin nuclear localization is predictive of increased proliferation in HNSCC cell lines. These results suggest that headpin may play a role in the regulation of cell proliferation in HNSCC.

143. The RTOG 90-03 Phase III trial enrolled 1,113 patients between the ages of 40 and 79 with Stage II-IV squamous cell carcinoma of the head and neck. Survival rates were significantly better for patients who underwent surgery plus radiotherapy compared to radiotherapy alone. The median survival for patients who underwent surgery plus radiotherapy was 15 months, while the median survival for patients who underwent radiotherapy alone was 8 months. Patients who underwent surgery plus radiotherapy also had a lower risk of local recurrence.

CONCLUSIONS: The RTOG 90-03 trial demonstrated the benefit of surgery plus radiotherapy for patients with Stage II-IV squamous cell carcinoma of the head and neck. The results were consistent with previous studies and supported the use of surgery plus radiotherapy as the standard treatment for these patients.
RESULTS: Marker scores for both HGD and SCC were found to have higher expression of p-NF-κB, Ki-67, p-Akt and EGFr than tissue from tonsillar control and benign tissue. No differences in marker expression were noted between HGD and SCC or between tonsillar control and benign tissue. In the subset of patients with SCC, the only marker statistically related to decreased survival was NF-κB (p=0.047), whereas a relationship with protein expression could not be correlated with recurrence in this group of patients. Subset analysis for patients with HGD demonstrated a significant correlation for p-Akt (p=0.043) and NF-κB (p=0.006) with respect to decreased survival but only NF-κB (p=0.044) with respect to increased disease recurrence.

CONCLUSION: The expression of NF-κB and p-Akt in patients with high-grade dysplasia and invasive carcinoma of the tonsil appears to be associated with increased disease recurrence and reduced survival. Further investigation of signaling pathways influenced by these proteins may yield targets for pathway specific therapeutic intervention in patients with carcinoma of the upper aerodigestive system.

Further investigation of signaling pathways influenced by these proteins may yield targets for pathway specific therapeutic intervention in patients with carcinoma of the upper aerodigestive system.

The AHNS is grateful to IRX Therapeutics, Inc. for their Silver Level support of the 2005 AHNS Meeting.
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 loss 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 of or chairing Standing Committees.

ARTICLE V
Officers

Section 1. The officers of the Society shall be President, President-Elect, Vice-President, Secretary, and Treasurer.

ARTICLE VI
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
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.
Section 1. Any Active Fellow shall have all the rights of Fellowship, shall be subject to all the duties, rules and responsibilities incumbent upon the members of any scientific parliamentary body.

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.

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.

Section 1. The regular order of business at annual meetings shall be carried out in a manner prescribed by the Council.

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.

Section 1. Candidates desiring election to Fellowship in any class other than Election of Officers.

Section 1. He shall act as custodian of all papers of the Society and its committees.

Section 1. 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 1. The President shall serve at a term of three years and may be elected to one additional term.

Section 1. An applicant for Active Fellowship shall provide documentation that he 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.

Section 2. Active Fellows must be members of the American College of Surgeons or its equivalent.

Section 2. 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.

Section 2. B. An applicant for Active Fellowship shall provide documentation that he 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.

Section 2. C. Active Fellows must be American College of Surgeons or its equivalent.

Section 3. Special Qualifications for Active Membership.

Section 3. 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.

Section 3. B. An applicant for Active Fellowship shall provide documentation that he 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.

Section 3. C. Active Fellows must be members of the American College of Surgeons or its equivalent.

Section 4. Appointment of such patients. Such appointment shall be subject to written approval of a majority of the Council. Should the office of both President and President-Elect become vacant, these offices will be served by the Secretary.

Section 4. Tenure of 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 President resign, the President shall be appointed by the Council to serve until the next annual meeting.

Section 4. Duties of the Officers

Section 4. A. The President 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.

Section 4. B. He shall act as custodian of all papers of the Society and its committees.

Section 4. C. He shall appoint standing and special committees, except the Nominating Committee. See Article X, Section 2.

Section 4. D. He shall fill vacancies in offices that occur in the interim between regular meetings subject to approval by a Council majority.

Section 4. E. He shall be an ex-officio member of all standing committees.

Section 5. Duties of the Vice-President.

Section 5. A. The Vice-President shall serve and assist the President and President-Elect.

Section 5. B. He shall notify all committee members of their appointments and the duties assigned to them.

Section 5. C. He shall notify all applicants for membership of the action taken by the Society.

Section 5. D. He shall keep current alphabetical list of members, together with their current addresses and shall supply application forms to members who apply for same.

Section 5. E. He shall act as custodian of all papers of the Society and its committees.

Section 6. Duties of the Secretary.

Section 6. A. He shall keep or cause to be kept in permanent form an accurate record of all transactions of the Society.

Section 6. B. He shall send due notice of all meetings to members; notice of at least 15 days shall be provided prior to Council meetings.

Section 6. C. He shall notify all committee members of their appointments and the duties assigned to them.

Section 6. D. He shall notify all applicants for membership of the action taken by the Society.

Section 6. E. He shall keep current alphabetical list of members, together with their current addresses and shall supply application forms to members who apply for same.

Section 6. F. He shall act as custodian of all papers of the Society and its committees.

Section 6. G. His financial records shall be audited at each regular annual meeting by a specially appointed auditing committee, who will report at the business session.

Section 6. H. Prepare and submit an annual budget for the following year to the Finance Committee for subsequent approval of the Council at the fall meeting.

Section 7. The Council

Section 7. A. The Council shall conduct the affairs of the Society during the interim between sessions.

Section 7. B. The Council shall pass on all applications for Fellowship and present its recommendations to the Society at one of its business sessions so that necessary action may be taken.

Section 7. 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. 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.
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 Committees).

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 quantity and quality 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. A majority of officers and Council members shall constitute a quorum for the regular business session of the Society to be held at each business meeting. 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 approve the financial reports of the Treasurer prior to the presentation to the Council.

Section 9. Standing Committees. Other standing Committees shall be constituted as described in the Policies and Procedures.

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
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
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.

Bylaws
The Foundation welcomes and actively solicits contributions and pledges from members of the American Head and Neck Society, physicians and grateful patients. You can help by making a donation on the website at http://headandneckcancer.org/foundation/index.php.

Below is a listing of individuals who have donated to the Foundation from July 2004 – April 1, 2005

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- Saurin Popat, MD
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