Case 1:

- 45 yo white male without co-morbidities presents with a right neck mass x 6 weeks, sore throat and mild dysphagia.
- Review of Systems:
  - Odynophagia, coughing after swallowing, 6 pound weight loss
- Endoscopy: 3 cm right base of tongue mass biopsy positive for squamous carcinoma, p16+ (HPV associated)
- CT scan shows a 3.8 cm mass in the base of tongue concerning for malignancy and three lymph nodes in the right neck concerning for metastatic disease the largest measuring 3.0 cm.
- The patient is planned for concurrent chemoradiation.

Questions:

- From the standpoint of supportive care, what should be done immediately for symptom control?
- From the standpoint of the SLP, what would be the appropriate evaluation at this point in time?
- From the standpoint of the Radiation Oncologist and Medical Oncologist, what are the things that need to be taken into account with regards to treatment planning and/or monitoring during treatment?

Case 2:

- The same patient has now completed therapy. He developed severe mucositis during chemoradiation and required feeding tube placement.
- Exam:
  - No oral mucositis, thick stranding secretions, moderate to severe lymphedema involving submental, neck and cheek regions, awake and alert
- He was seen by SLP and given swallow exercises but was not compliant due to pain, fatigue and neurocognitive abnormalities.
- He is now two months post treatment and has started to recover. His mucositis has resolved but he still has mild mucosal sensitivity.
- He is states he is now interested in progressing his diet so that he can get off the feeding tube.

Questions:

- From the standpoint of the SLP, is an instrumental assessment of swallow function needed at this time?
- From the standpoint of Radiation Oncology and Medical Oncology, when do you consider referral to SLP? What information do you want from the SLP to help guide your treatment?
- From the standpoint of supportive care, what additional therapy should be considered?

Case 3:

- The same patient recovered swallow function after aggressive therapy and tincture of time. He is now two years post chemoradiation and is complaining that he is now having issues with swallowing solids. He feels that food “gets stuck”.
- Exam and imaging fails to demonstrate evidence of recurrence.
- A diagnostic procedure was done.

Questions:

- From the standpoint of the SLP: what test would you recommend at this time and what are the likely findings?
- If a stricture is identified, what are the treatment options and what is the likelihood of success?
- From the standpoint of the Radiation Oncologist and the Medical Oncologist, how does this change your follow-up?
- From the standpoint of supportive care, what are the other concerns with regards to this patients over all care?

Case 4:

- The same patient was found to have a stricture and underwent serial dilations. He did well for a while but required repeat procedures.
- He is now 8 years post chemoradiation. His swallowing is becoming progressively worse. He has a history of sporadic aspiration, but returns to you stating that he has had 3 aspiration pneumonias in the last 6 months. During the last admission, he was intubated and transferred to the ICU. A CT done at that time demonstrated acute on chronic interstitial disease consistent with acute pneumonia superimposed on chronic changes.
- On exam the patient has a “woody neck” with markedly decreased range of motion in his neck and shoulders.

Questions:

- From the standpoint of SLP: What is the likely cause of the patient's swallow dysfunction? Are there any therapeutic strategies to improve his function?
- From the supportive care standpoint: What are the major support considerations in this patient?
- From the standpoint of the Radiation Oncologist and the Medical Oncologist, when do you place a permanent feeding tube and/or consider a laryngectomy?