SAMPLE HEAD & NECK CANCER FOLLOW-UP SOAP NOTE

OROPHARYNGEAL SCC — 18-MONTH SURVEILLANCE

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1 Patient Information

1 PATIENT DETAILS

Name
Raymond K. Abernathy

Date of Service
05/06/2026

DOB
02/14/1964

Provider
Dr. Vanessa L. Kim, MD — Otolaryngology / Head & Neck Surgery

Age / Sex
62 / Male

MRN
ENT-2026-0441-F

Visit Type
Head & Neck Cancer Follow-Up / Surveillance

Cancer Diagnosis
HPV+ Squamous cell carcinoma, right oropharynx (base of tongue primary), p16-positive

Stage
Stage III, T3N2aM0 (AJCC 8th Ed)

Treatment History
Definitive concurrent chemoradiation — IMRT 70 Gy + cisplatin (completed November 2024)

Time Since Treatment
18 months post-treatment completion

CC Chief Complaint

2 PRIMARY REASON FOR FOLLOW-UP

Mr. Abernathy presents for his 18-month post-treatment surveillance visit. He is generally doing well and has been compliant with all surveillance visits. However, today he reports a new concern: he has noticed 'a fullness on the right side of my neck just below the jaw' beginning approximately 4 weeks ago. It has not resolved and he believes it may have slightly enlarged. He states: 'I know I'm supposed to check myself and I found something. I don't know if I'm just being paranoid but my wife thinks it feels different from the other side. I haven't had this since treatment finished.' This visit also includes review of his most recent surveillance CT neck/chest (obtained 04/28/2026 — results discussed below) and ongoing post-treatment toxicity management.

S Subjective

3 INTERVAL HISTORY, CANCER STATUS & SURVEILLANCE CONCERNS

3a CANCER HISTORY / INTERVAL STATUS

HPV+ (p16-positive) squamous cell carcinoma of the right base of tongue, T3N2aM0 Stage III, diagnosed October 2024 following a 2-month history of right neck mass (right level II, 2.8 cm) and right-sided throat discomfort. Staging PET/CT (10/2024): right BOT primary SUVmax 14.8, right level II LN SUVmax 9.2, no distant metastases. Definitive concurrent chemoradiation initiated 10/08/2024: IMRT 70 Gy to right oropharynx + bilateral elective cervical fields; concurrent cisplatin 100 mg/m² Q3 weeks x3 cycles. Treatment completed 11/19/2024. Post-treatment PET/CT (02/2025, 12 weeks post-treatment): COMPLETE METABOLIC RESPONSE — no FDG-avid disease; prior right level II node reduced to 0.8 cm, non-avid. Surveillance CT neck (04/28/2026, 18 months post-treatment): REVIEWED TODAY — see imaging section. NEW CONCERN: Right neck fullness x4 weeks — must be evaluated urgently in the context of prior disease at this exact anatomic location.

3b CURRENT HEAD & NECK SYMPTOMS

NEW SYMPTOM — RIGHT NECK FULLNESS x4 WEEKS: Right submandibular/upper jugular region (right level II — prior primary nodal site). Non-tender. Appears slightly firm per patient's self-palpation. No overlying skin changes. No lymphangitis or skin redness. THROAT/OROPHARYNX: Mild right-sided throat discomfort 2–3/10 — patient attributes to xerostomia and dry mucosa; present chronically since treatment but NEW mild increase in discomfort x3 weeks. Right otalgia: intermittent (2/10) — this is new within the past 3 weeks. VOICE: Hoarse quality persists since treatment completion — rated as 60% of baseline voice quality. DYSPHAGIA: Persists — primarily solid foods. Currently eats soft diet supplemented with high-calorie shakes (3x/day). No aspiration events since treatment. No feeding tube since it was removed in January 2025.

3c TREATMENT-RELATED EFFECTS

XEROSTOMIA: Significant — saliva production approximately 20% of pre-treatment level by patient's estimate. Constant dry mouth affecting eating, speaking, and sleeping. Using pilocarpine 5 mg TID (moderate benefit). Oral moisturizing spray and xylitol gum continuously. HYPOTHYROIDISM: Diagnosed 6 months post-treatment (TSH 22.4 in May 2025) — on levothyroxine 100 mcg daily; TSH 3.2 at last check (02/2026 — well-controlled). DYSPHAGIA: Persistent — modified-consistency diet (soft, moist foods), high-calorie shakes. SLP outpatient sessions x8 (completed March 2026) — some improvement in swallow function. DENTAL: Root canal x2 teeth (2025) from radiation-related dental caries — now on fluoride tray treatments nightly. No ONJ (osteoradionecrosis of the jaw) to date. NECK FIBROSIS: Mild right neck tightness and some scar tissue — physical therapy stretching exercises ongoing. FATIGUE: Moderate — 5/10 energy level. Better than at 6 months but not at baseline. SKIN: Prior radiation field skin is healed — mild hyperpigmentation of the right neck persisting.

3d NUTRITION & WEIGHT

Oral Intake / Diet
Soft, moist foods only — no dry, hard, or dense foods. 3 high-calorie shakes/day (Boost VHC x3 = +900 kcal). Total estimated intake 1,800–2,000 kcal/day.

Feeding Tube Status / Weight
No feeding tube since January 2025. Weight today: 171 lbs — up 12 lbs from nadir of 159 lbs at treatment end (pre-treatment 188 lbs — net down 17 lbs from pre-treatment baseline; still recovering)

Appetite / Hydration
Appetite: 6/10. Eats 4–5 small meals/day. Hydration: adequate — drinks 64+ oz daily (important for xerostomia management).

Nutritional Supplementation
Boost VHC x3/day + oral fluoride trays nightly

3e FUNCTIONAL STATUS

ECOG performance status: 1 — some limitations in strenuous activity, fully active otherwise. Returned to part-time work (office manager) in March 2025. Full-time work since July 2025. SPEECH: Hoarse, somewhat reduced volume — adapts with effort. SWALLOWING: Functional but modified — avoids public dining due to slow eating pace and need to take small bites. FATIGUE: Moderate but improving. ACTIVITY: Regular walking 30 min/day. No strenuous exercise yet. MOOD: Anxiety about cancer recurrence — PHQ-9: 7 (mild depression, attributable to cancer worry). Follows up with psychologist Dr. Sandra Reeves monthly.

3f TOBACCO / ALCOHOL & PRIOR TESTING

Tobacco / Alcohol
Tobacco: never smoker. Alcohol: Social use — 1-2 drinks/week (maintains this level per patient; counseled to minimize further). No change from prior visit.

Prior Interval Testing
Most recent surveillance CT neck/chest: 04/28/2026 — reviewed today. Prior PET/CT (02/2025, 12 weeks post-treatment): Complete metabolic response. Thyroid labs (02/2026): TSH 3.2 (well-controlled on levothyroxine 100 mcg).

3g PERTINENT NEGATIVES

Denies unintentional weight loss since last visit (weight is up 2 lbs from 6-month visit). Denies hemoptysis. Denies progressive dysphagia worsening from recent baseline. Denies new hoarseness change (voice has been at this level since treatment end). Denies fever, night sweats, or rigors. Denies vision changes or diplopia. Denies new arm or leg weakness. Denies severe pain. Key exclusion: No progressive dysphagia, no new hoarseness change, no hemoptysis, no weight loss — these are partially reassuring; however, the new right neck fullness and new right otalgia in the exact anatomic prior disease site demand urgent evaluation.

ROS ENT / Oncology Review of Systems

4 PERTINENT POSITIVES & NEGATIVES

- **Oral pain / lesions / bleeding:** Mild right throat discomfort 2-3/10 (chronic, with new mild increase x3 weeks); no bleeding
- **Dysphagia / aspiration:** POSITIVE — persistent soft-food dysphagia; no new worsening; no aspiration
- **Hoarseness / voice change:** POSITIVE — chronic post-treatment hoarseness at stable baseline (no new change)
- **Otalgia / hearing change:** POSITIVE — right otalgia 2/10, NEW x3 weeks; referred otalgia pattern of concern for oropharyngeal involvement
- **Neck mass / swelling / lymphedema:** POSITIVE — NEW right level II neck fullness x4 weeks — primary concern today
- **Nasal obstruction / epistaxis:** Denied
- **Weight loss / appetite / dehydration:** No unintentional weight loss since last visit; appetite 6/10
- **Xerostomia / dysgeusia / dental:** POSITIVE — xerostomia significant; 2 prior root canals; fluoride trays ongoing
- **Dyspnea / stridor / hemoptysis:** Denied
- **Fever / night sweats / fatigue:** No fever; moderate fatigue 5/10 (stable)

O Objective

5 HEAD & NECK CANCER SURVEILLANCE FINDINGS

V VITAL SIGNS

Temperature
98.1°F

Blood Pressure
122/76 mmHg

Heart Rate
68 bpm

Respiratory Rate
14 breaths/min

Oxygen Saturation
98% on room air

Height / Weight
5'11" / 171 lbs (BMI 23.8) — up 2 lbs from 6-mo visit

BMI
23.8 — appropriate

Pain Score
2/10 right throat discomfort; 2/10 right ear

Performance Status (ECOG)
1 — some activity limitations; fully active otherwise

5a GENERAL APPEARANCE

Well-appearing, well-nourished male in no acute distress. Mild voice hoarseness — unchanged from prior visit per comparison. Right neck hyperpigmentation consistent with prior radiation field. No facial droop. Alert and clearly anxious today about the new right neck finding. Cooperative throughout.

5b HEAD & FACE / EYES

Head & Face
No facial asymmetry. No new facial masses. No periorbital edema. Right neck: see dedicated neck exam section. Temporal and masseter wasting: mild, improved from early post-treatment period.

Eyes
EOMs intact. No proptosis. No diplopia. Sclerae clear.

5c EAR EXAM

RIGHT EAR: External ear: normal, no masses. Canal: mild cerumen buildup — cleaned today. TM: Intact. MILD RIGHT MIDDLE EAR EFFUSION PRESENT — right TM slightly retracted, reduced mobility on pneumatic otoscopy; air-fluid level faintly visible. This is NEW compared to the most recent prior visit note (6 months ago — right TM was normal). Right middle ear effusion in the context of new right-sided referred otalgia and right neck fullness in a head and neck cancer surveillance patient is a RED FLAG for nasopharyngeal or right oropharyngeal pathology impairing right Eustachian tube function. LEFT EAR: Normal TM, full mobility. No mastoid tenderness bilaterally.

5d NASAL EXAM

External nose: normal. Nasal mucosa: mildly dry bilaterally (radiation-related and xerostomia). Septum: midline. Turbinates: reduced (radiation effect). No mucosal lesions. No polyps. No discharge. Anterior rhinoscopy limited but no masses identified anteriorly.

5e ORAL CAVITY / OROPHARYNX — PRIMARY SURVEILLANCE SITE

LIPS: Dry, fissured — xerostomia-related. ORAL MUCOSA: Mildly dry, slight pallor — radiation effect. No new lesions, no ulceration, no leukoplakia, no erythroplakia. TONGUE: Intact mobility, protrudes midline. Lateral border and dorsum: no new lesions, no focal erythema beyond chronic radiation mucosal change. FLOOR OF MOUTH: No masses or induration. DENTITION: Prior root canal teeth intact with fluoride trays visible. No new cavities apparent. RIGHT BASE OF TONGUE / PRIMARY TREATMENT SITE: RIGHT BOT — on endoscopy (see procedures section): mild mucosal irregularity in the right base of tongue consistent with chronic radiation change — no discrete new mucosal mass or frank ulceration on today's endoscopic view; however, subtle asymmetric fullness in the right base of tongue requires comparison with prior imaging and biopsy consideration. TONSILS: Absent bilaterally from radiation (tonsillar tissue involuted post-IMRT). Uvula: midline. Posterior pharynx: dry mucosa.

5f NECK — LYMPH NODE & SURGICAL SITE SURVEILLANCE

RIGHT LEVEL II: NEW FINDING — a palpable firm, rounded mass approximately 1.8 cm in the right upper jugular chain (right level II) — located precisely at the site of the prior involved node (prior right level II node 2.8 cm at diagnosis, reduced to 0.8 cm post-treatment PET/CT). The mass today is 1.8 cm, firm, slightly tender on deep palpation, mobile but with some resistance to displacement — NOT freely mobile. COMPARISON: At 6-month visit, this region was soft, non-palpable — no residual nodal tissue noted. At 12-month visit (11/2025): no palpable nodes. TODAY: 1.8 cm palpable mass at right level II. This represents interval growth at a surveillance site and is highly concerning for locoregional recurrence. Right level IB: No palpable nodes. Right level III: No palpable nodes. Left neck: No palpable nodes. Trachea: midline. Thyroid: No enlargement. No cervical lymphedema.

5g LARYNX / VOICE / RESPIRATORY / NEUROLOGICAL

Voice / Laryngeal
Voice: hoarse at chronic post-treatment baseline — no acute new change. Phonation sustainable. No stridor.

Respiratory / Airway
Breathing comfortably. No stridor. SpO2 98%. Clear to auscultation.

Cranial Nerves
CN V: intact. CN VII: Symmetric, intact. CN IX/X: Palate elevation symmetric. CN XI: Full shoulder shrug bilateral. CN XII: Tongue midline. No new neurologic deficits.

PP Procedures Performed

6 ENT / HEAD & NECK SURVEILLANCE PROCEDURES

FLEXIBLE NASOPHARYNGOSCOPY AND LARYNGOSCOPY (surveillance endoscopy): Indication: 18-month post-treatment head and neck cancer surveillance + evaluation of new right neck mass and right middle ear effusion. Technique: 4% lidocaine topical nasal spray bilateral nares. 3.8mm Olympus ENF scope through right nasal cavity. NASOPHARYNX: CRITICAL FINDING — RIGHT EUSTACHIAN TUBE ORIFICE: RIGHT EUSTACHIAN TUBE ORIFICE REGION has subtle fullness/irregularity of the right Rosenmüller fossa compared to left — this area must be correlated with MRI. If right nasopharyngeal involvement (from base of tongue lateral spread or separate nasopharyngeal disease) is confirmed, it would explain the right middle ear effusion (ETD from nasopharyngeal mass effect). No discrete nasopharyngeal mass visible. OROPHARYNX / RIGHT BASE OF TONGUE: Chronic mucosal changes from radiation (telangiectasias, irregular mucosa). Subtle right BOT asymmetric fullness visible endoscopically — could represent radiation fibrosis vs recurrent submucosal tumor. No frank mucosal ulceration or mass. Left BOT: normal-appearing treated mucosa. HYPOPHARYNX / PYRIFORM SINUSES: No masses. Pooling: minimal. LARYNX: Right vocal cord: mild hypomobility — unchanged from prior. Left: full mobility. No supraglottic or glottic masses. No new lesions. CERUMEN REMOVAL (right ear): Cerumen removed with suction-assisted technique — TM then fully visualized (effusion confirmed, see exam section). Patient tolerated all procedures well. No adverse events.

L Lab & Surveillance Diagnostic Results

7 HEAD & NECK CANCER FOLLOW-UP DATA

7a IMAGING STUDIES

CT NECK AND CHEST WITH CONTRAST (04/28/2026 — REVIEWED TODAY with Dr. Kim and radiologist Dr. Chen by telephone): RIGHT LEVEL II LYMPH NODE: 1.7 cm right level II lymph node — NEW compared to 12-month CT (was 0.7 cm at 12-month surveillance CT). Interval growth 1.0 cm in 6 months at prior disease site. Node: round morphology, homogeneous, no central necrosis on CT. RIGHT BASE OF TONGUE: Asymmetric thickening of right base of tongue compared to left — 0.9 cm maximum asymmetric submucosal thickening. No definite discrete mass with CT contrast enhancement. This asymmetry may represent radiation fibrosis vs recurrent tumor — MRI with gadolinium is superior for soft tissue characterization at this site. CHEST: No pulmonary nodules. No mediastinal adenopathy. No pleural effusion. BONE: No lytic or blastic lesions on chest CT lung windows. IMPRESSION: Interval growth of right level II lymph node and right BOT asymmetric thickening — HIGHLY SUSPICIOUS for locoregional recurrence. PET/CT ORDERED TODAY (urgent): to characterize metabolic activity of the right level II node and right BOT thickening (FDG-avidity vs scar). MRI OROPHARYNX with gadolinium: also ordered urgently for soft tissue characterization.

7b PATHOLOGY / CYTOLOGY

MOST RECENT PRIOR PATHOLOGY (original diagnosis, 10/2024): Right neck level II FNA — SCC HPV+ (p16 positive). Right BOT biopsy (panendoscopy): moderately differentiated SCC, p16 positive. HPV status confirmed: HPV-associated (p16 positive IHC). PLANNED TODAY: Ultrasound-guided FNA of right level II node (new 1.8 cm mass) — ORDERED URGENTLY. Interventional radiology (Dr. Chen) — FNA scheduled 05/07/2026 (tomorrow). FNA to include cytology, cell block, p16 IHC (to confirm HPV relationship), and HPV ISH (in situ hybridization). If FNA non-diagnostic: core needle biopsy to follow.

7c LABORATORY STUDIES

TSH (02/2026): 3.2 mIU/L — well-controlled on levothyroxine 100 mcg. Recheck TSH today (ordered). CBC (from PCP, 03/2026): WBC 7.2, Hgb 13.8, Plt 244 — WNL. LDH: 198 U/L (normal). No tumor markers routinely used in oropharyngeal SCC surveillance (no standard serum marker for HPV+ SCC). EBV titers: not indicated (HPV+ not EBV-related). New labs ordered today: TSH, CBC, CMP, LDH.

7d SWALLOW / SPEECH / DENTAL / NUTRITION

SLP assessment (outpatient, completed March 2026, Dr. Andrea Wells): Functional oropharyngeal dysphagia with soft-food diet and compensatory strategies. No aspiration events. Ongoing swallowing home exercise program. Dental oncology (Dr. Brian Park, DDS): Follow-up March 2026 — fluoride tray therapy, 2 root canals completed, no ONJ, no extraction required. Nutrition (dietitian Keisha Brown, RD): 4-month follow-up (02/2026) — weight trending up, adequate caloric intake on current regimen. BMI 23.8 today — appropriate.

A Assessment

8 HEAD & NECK CANCER SURVEILLANCE INTERPRETATION

Mr. Raymond Abernathy is a 62-year-old male with HPV+ Stage III oropharyngeal SCC (right BOT), status post-definitive chemoradiation (November 2024), at 18-month surveillance. Today's evaluation reveals a HIGHLY CONCERNING CLUSTER OF FINDINGS SUSPICIOUS FOR LOCOREGIONAL RECURRENCE: (1) NEW RIGHT LEVEL II LYMPH NODE — 1.8 cm palpable today; 1.7 cm on CT (04/28/2026); was 0.7 cm at 12-month CT (6 months prior) — interval growth of 1.0 cm at the prior involved nodal site. (2) RIGHT BOT ASYMMETRIC THICKENING on CT (0.9 cm) — at the primary treatment site. (3) NEW RIGHT MIDDLE EAR EFFUSION — right TM retraction + effusion today; was normal at 12-month visit. Right middle ear

effusion in a treated oropharyngeal SCC patient with new neck mass suggests right Eustachian tube dysfunction from regional recurrence (nasopharyngeal extension or right oropharyngeal recurrence impairing ET drainage). (4) RIGHT SUBTLE ROSENMÜLLER FOSSA FULLNESS on nasopharyngoscopy — needs MRI correlation. (5) NEW RIGHT REFERRED OTALGIA — 3 weeks' duration; referred otalgia via Jacobson's nerve is a classic symptom of oropharyngeal malignancy (same as at initial diagnosis). While radiation fibrosis, post-treatment change, and reactive adenopathy can mimic recurrence, the combination of interval nodal growth, CT findings, new middle ear effusion, referred otalgia, and subtle nasopharyngoscopy findings creates a HIGH CLINICAL SUSPICION for locoregional recurrence. The overall clinical picture warrants urgent biopsy and PET/CT before any management decisions. HPV+ oropharyngeal SCC recurrences can be amenable to salvage surgery (salvage neck dissection ± TORS) or salvage chemoradiotherapy depending on extent, timing, and location. ALTERNATIVE: Late radiation-related change is possible but less likely given interval nodal growth.

P Plan

9 SURVEILLANCE & MANAGEMENT

9a SURVEILLANCE TESTING — URGENT

1. FNA right level II node: 05/07/2026 (tomorrow) — ultrasound-guided, IR Dr. Chen. Cytology, cell block, p16 IHC, HPV ISH. Results expected 05/09/2026. 2. PET/CT with FDG: Ordered STAT — scheduling 05/08/2026. Will characterize FDG avidity of right level II node (recurrence vs scar/ benign). 3. MRI oropharynx and neck with gadolinium: 05/07/2026 (same day as FNA). Superior soft tissue characterization of BOT asymmetric thickening vs recurrent tumor. 4. TSH, CBC, CMP, LDH: drawn today. 5. Direct laryngoscopy + biopsy of right BOT asymmetric thickening: to be planned after PET/CT and MRI review — panendoscopy under GA will be required if imaging suggests recurrence.

9b SYMPTOM MANAGEMENT

XEROSTOMIA: Continue pilocarpine 5 mg TID. Oral moisturizing spray, xylitol gum, hydration coaching. Add cevimeline 30 mg TID (superior sialogue) if pilocarpine tolerance allows — will discuss at next visit. HYPOTHYROIDISM: Continue levothyroxine 100 mcg. Recheck TSH today. DYSPHAGIA: Continue soft diet + high-calorie shakes. Continue SLP home exercise program. Re-refer to SLP if recurrence confirmed and surgical treatment planned (may significantly affect swallowing further). RIGHT MIDDLE EAR EFFUSION: No intervention today (likely to resolve if underlying cause addressed). Monitor at next visit. DENTAL: Continue fluoride trays nightly, dental oncology follow-up every 6 months.

9c REFERRALS & COORDINATION

URGENT MULTIDISCIPLINARY TUMOR BOARD: Case presented to head and neck MDT today by phone — tumor board meeting scheduled 05/13/2026. Attendees to include: Dr. Kim (H&N Surgery), Dr. Okafor (Radiation Oncology), Dr. Park (Medical Oncology), Dr. Chen (Radiology), Dr. Wells (Pathology), Dr. Wells (SLP), Dr. Brown (Nutrition). MEDICAL ONCOLOGY: Message to Dr. Park today re: imaging findings — monitoring for expedited review. RADIATION ONCOLOGY: Message to Dr. Okafor today — prior field mapping to be retrieved for salvage planning consideration. PSYCHOLOGY: Dr. Reeves (patient's psychologist) notified of clinical concern — patient may need additional emotional support through this evaluation period.

9d TOBACCO / ALCOHOL COUNSELING & PATIENT EDUCATION

Tobacco: Never smoker — not applicable. Alcohol: Counseled to restrict to minimal use (1 drink max/week) during this evaluation period — alcohol is a co-carcinogen and immunosuppressant. PATIENT EDUCATION — TODAY'S CONVERSATION: Dr. Kim spoke with Mr. Abernathy and his wife for 25 minutes at the end of the visit. Explained clearly: (1) The new right neck node combined with the CT findings and new symptoms are concerning for possible cancer return and require urgent evaluation over the next 2 weeks; (2) A biopsy of the neck node tomorrow and advanced imaging will tell us definitively what this is; (3) Even if this is a recurrence, HPV+ oropharyngeal SCC has relatively favorable salvage rates with surgical or re-irradiation options; (4) Nothing is confirmed — it may also be scar tissue or a reactive node, but we need to know definitively before making any treatment decisions; (5) All results will be reviewed at MDT on 05/13 and they will be called with results as they become available. Mr. Abernathy was tearful but composed. He expressed gratitude for the thorough evaluation and the clear communication. Warning signs: new airway difficulty, sudden further voice change, rapidly enlarging neck mass, fever → ER immediately with ENT notification.

F Follow-Up

10 SURVEILLANCE SCHEDULE & REASSESSMENT PLAN

Follow-Up Schedule

FNA right level II node: 05/07/2026. MRI oropharynx: 05/07/2026. PET/CT: 05/08/2026. FNA results (telephone): 05/09/2026. MDT tumor board: 05/13/2026. ENT clinic (results + plan): 05/13/2026. If recurrence confirmed: panendoscopy + BOT biopsy in OR to be scheduled urgently (within 2 weeks of confirmation).

TIME DOCUMENTATION & BILLING

Total Time
65 minutes

E/M Level
99215 — Established patient, high complexity

Counseling / Coordination Time

Procedure Code(s)

30 minutes	31575 — Flexible laryngoscopy (surveillance nasopharyngoscopy); 69210 — Cerumen removal, right

Basis for Billing
Medical Decision Making — High Complexity (new suspicious finding in cancer surveillance)

Primary ICD-10 Code
Z85.818 — Personal history of malignant neoplasm of other and unspecified sites of lip, oral cavity, and pharynx (HPV+ oropharyngeal SCC, 18-month surveillance)

Secondary ICD-10 Code(s)
R22.1 — Localized swelling, mass and lump, neck (new right level II node); H65.01 — Acute serous otitis media, right ear (new middle ear effusion); E03.9 — Hypothyroidism post-radiation; K11.7 — Disturbances of salivary secretion (xerostomia)

PHYSICIAN NAME, MD	SPECIALTY	DATE	TIME
Vanessa L. Kim, MD	MD — Otolaryngology / Head & Neck Surgery | Board Certified (ABOto)	05/06/2026, 4:00 PM	

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