MARVIX AI

SAMPLE ORAL LESION EVALUATION SOAP NOTE

NON-HEALING LATERAL TONGUE ULCER — HIGH MALIGNANCY RISK

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1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME	Brendan T. Calloway
DATE OF SERVICE	05/06/2026
DOB	11/03/1981
PROVIDER	Dr. Nathaniel Park, DDS, MD — Oral Medicine
AGE / SEX	44 / Male
MRN / PATIENT ID	ENT-2026-0411
CREDENTIALS	DDS, MD, Diplomate ABOM
VISIT TYPE	Oral Lesion Evaluation — Urgent Referral

REFERRAL SOURCE

Dr. Michael Torres, DDS — General Dentist (Calloway's dentist of 12 years)

DENTAL PROVIDER / PCP

Dr. Michael Torres, DDS; Dr. Rachel Connelly, MD — Family Medicine (PCP)

CC CHIEF COMPLAINT

2 PRIMARY ORAL LESION CONCERN

> *'I have a sore on the side of my tongue that won't go away. My dentist saw it at my last cleaning and told me to come here right away.'*

Duration: Brendan first noticed a 'rough spot' on the left lateral tongue approximately 6 weeks ago (late March 2026). He initially attributed it to biting his tongue, but it has not healed, and over the past 2–3 weeks it has become progressively more painful and slightly larger. His dentist Dr. Torres identified the lesion at a scheduled cleaning on 04/30/2026 and triaged this as an urgent oral medicine referral the same day, noting: 'indurated non-healing lateral tongue ulcer in a heavy smoker — urgent biopsy evaluation needed.' Brendan presents today, 6 days after his dental appointment.

S SUBJECTIVE

3 PATIENT-REPORTED LESION HISTORY & RISK FACTORS

3a ONSET, DURATION, LOCATION & CHANGE OVER TIME

- **Onset:** Approximately 6 weeks ago (late March 2026). Patient recalls he thought he had 'bitten my tongue on a sharp chip or something.'
- **Location:** Left lateral tongue — he points to the junction of the anterior and middle thirds of the left lateral tongue, slightly toward the ventral surface. The area has 'always been on the same spot.'

- **Change over time:** ‘At first it was just rough and a little sore. Over the past 2–3 weeks it’s gotten more painful. I think it’s gotten a little bigger — it’s hard to see it myself.’ He has NOT noticed any decrease in size at any point; the lesion has never partially healed.
- It is a **persistently non-healing ulcer** — the most important red flag in oral lesion evaluation. He denies any similar prior lesions that resolved. This is the first lesion of this type in this location.

3b ASSOCIATED SYMPTOMS & FUNCTIONAL IMPACT

- **Pain:** 4/10 at rest; 7/10 when eating — especially spicy, acidic, or rough-textured foods. Worsening progressively over the past 2–3 weeks. He avoids eating on the left side.
- **Referred otalgia:** Noticed yesterday a dull ache extending to the left ear. Clinically significant — referred otalgia from a tongue lesion is a recognized presentation of lingual squamous cell carcinoma with involvement of the lingual nerve (CN V3) or glossopharyngeal nerve.
- **Swallowing / speech / opening:** No dysphagia, no odynophagia, no speech difficulty, no trismus. No xerostomia complaint.
- **Weight:** Eating less (‘it hurts to eat’) — approximately 5–7 lb weight loss over the past 3–4 weeks, attributed to reduced eating from tongue pain.
- **Functional:** Affecting eating significantly; affecting concentration at work (‘I keep being aware of it all day’).

3c TRAUMA / IRRITATION, DENTAL/ORAL & MEDICAL HISTORY

- **Trauma / irritation:** Initially attributed to biting. However: (1) the lesion has not healed in 6 weeks, far exceeding healing time for a traumatic bite injury (typically 7–14 days); (2) Dr. Torres noted no adjacent sharp tooth, fractured restoration, or appliance to account for the lesion; (3) the patient denies recurrent self-biting in this area. **Trauma etiology: EXCLUDED** — non-healing, progressive, and lacking a persistent trauma source. This is the critical clinical reasoning step.
- **Dental / oral history:** No dentures or appliances. No prior oral lesions, surgery, or biopsy. No history of oral cancer or pre-malignant lesions. No recurrent aphthous ulcers. Good dentition — attends Dr. Torres every 6 months. No periodontal disease per referral.
- **Medical history:** No significant past medical history. No chronic conditions, immunosuppression, cancer, radiation, chemotherapy, HIV, autoimmune, IBD, nutritional deficiency, or skin disorders. Medications: ibuprofen PRN (daily x2 weeks for tongue pain) and a multivitamin.
- **Allergy:** Penicillin (rash as a child).

3d EXPOSURE HISTORY, PRIOR EVALUATION & PERTINENT NEGATIVES

- **Tobacco:** CURRENT SMOKER. 25 pack-year history, started at age 19, currently 1 pack/day, never attempted cessation. The highest-risk modifiable factor for oral squamous cell carcinoma.
- **Alcohol:** Initially ‘social drinker’ (~4–5 drinks/week); on direct questioning, 3–4 drinks Fri/Sat plus 1–2 on weekday evenings — more consistent with 14–18 drinks/week (heavy use). Tobacco plus heavy alcohol has a synergistic (multiplicative) carcinogenic effect on oral mucosa.
- **Other exposures:** No vaping, no betel nut. Cannabis occasional (a few times a month). Construction project manager — no known significant carcinogen exposure. HPV unvaccinated (born before routine adolescent HPV vaccination).
- **Prior evaluation:** None for this lesion prior to Dr. Torres’ referral. No prior specialist evaluation, head/neck imaging, or labs.
- **Pertinent negatives:** No neck mass noticed by patient. No facial swelling, trismus, dysphagia, or odynophagia. No unexplained weight loss beyond pain-limited eating. No fever, night sweats, skin lesions, genital lesions, or ocular symptoms.

ROS ORAL LESION REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Oral pain / bleeding / ulceration:** POSITIVE — left lateral tongue ulcer x6 weeks, non-healing; pain 4/10 rest, 7/10 eating; progressive worsening; mild bleeding on contact; NO spontaneous bleeding
- **Dysphagia / odynophagia / chewing difficulty:** NEGATIVE for dysphagia/odynophagia; chewing difficulty present (pain-limited eating on left side)
- **Fever / fatigue / night sweats / weight loss:** POSITIVE — ~5–7 lb weight loss over 3–4 weeks (pain-limited eating; no systemic illness); NO fever, NO night sweats
- **Skin / ocular / genital / systemic mucosal lesions:** NEGATIVE — no skin lesions; no genital ulcers; no ocular symptoms
- **White / red / mixed mucosal changes:** POSITIVE — mixed red and white lesion at ulcer margins; indurated base
- **Numbness / tingling / altered taste / dry mouth:** POSITIVE — referred otalgia (left ear ache), clinically significant for lingual/glossopharyngeal nerve involvement; NO tongue numbness or paresthesia directly
- **Neck mass / facial swelling / jaw pain / trismus:** NEGATIVE — no neck mass noticed by patient; no facial swelling, jaw pain, or trismus (full mouth opening)
- **Tobacco / alcohol / vaping / carcinogen exposure:** POSITIVE — 25 pack-year current smoker (1 ppd); heavy alcohol use (est. 14–18 drinks/week); HPV unvaccinated

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
37.0°C — afebrile

BLOOD PRESSURE
128/82 mmHg

PAIN SCORE
4/10 left lateral tongue at rest; 7/10 with eating

WEIGHT / BMI
186 lbs / BMI 27.4 — 6 lb loss vs 3-month-prior PCP weight

5a EXTRAORAL EXAMINATION

- **Facial symmetry:** Intact. No facial swelling or asymmetry.
- **Cervical lymph nodes (critical):** RIGHT neck — Levels I–V not palpable. LEFT neck — a single firm, mobile, non-tender node ~12 mm in the left submandibular region (Level IB). **Clinically significant** — a palpable left submandibular node with a non-healing left lateral tongue lesion in a heavy smoker is a red flag for potential metastatic cervical lymphadenopathy. It does not confirm malignancy but significantly elevates concern and changes management. Left Levels II–V not palpable.
- **Salivary glands:** Bilateral parotid and submandibular glands non-enlarged, non-tender.
- **Skin:** No facial or neck lesions. Nicotine staining of fingertips noted (confirms active smoking).
- **TMJ:** Full mandibular range of motion (42 mm maximum interincisal opening). No tenderness, no joint sounds.

- **Cranial nerves:** CN V — light touch grossly intact bilaterally; tongue sensation slightly reduced on direct palpation at the lesion margin ('it feels a little different there') — may reflect early perineural involvement or reactive change; to be followed. CN VII intact and symmetric. CN XII — tongue protrudes midline, no fasciculations or hemiatrophy.

5b INTRAORAL EXAMINATION

LIPS & LABIAL MUCOSA
Normal, moist, no lesions. Nicotine staining at labial commissures.

BUCCAL MUCOSA
Bilateral mild diffuse leukoplakia (white, non-removable) along the occlusal line — consistent with frictional/tobacco irritation. A SEPARATE finding from the primary tongue lesion; requires monitoring.

GINGIVA & ALVEOLAR RIDGE
Moderate generalized gingivitis. Mild recession lower anterior. No significant periodontal pocketing on gross assessment. Mild tobacco-related gingival changes (fibrotic, pale margin).

TONGUE — DOMINANT LESION SITE (LEFT LATERAL)
PRIMARY LESION: irregular ulcer on the left lateral tongue at the junction of the anterior and middle thirds, extending slightly to the ventral surface. Base yellowish-gray with erythematous halo. Margins INDURATED (firm, raised, rolled) — induration is the most important clinical finding. Fixed to underlying tissue on deep palpation.

TONGUE — DORSAL, VENTRAL, RIGHT LATERAL
Dorsal: moderate white coating (smoking). No focal lesions. Ventral: no lesions. Right lateral: clear bilaterally (important for documentation).

FLOOR OF MOUTH
Normal. No masses, swelling, or lesions. Wharton's ducts patent bilaterally. Floor of mouth and lateral tongue are the two highest-risk sites for oral SCC.

PALATE (HARD & SOFT)
Hard palate: moderate nicotinic stomatitis pattern (red dots on white background) — chronic heavy smoking. Soft palate: mild erythema. No discrete lesions.

OROPHARYNX & TONSILS
Bilateral tonsils grade 1, no exudate. No posterior pharyngeal lesions or asymmetry. Normal on indirect mirror exam — no tonsillar or base-of-tongue lesions.

DENTITION & APPLIANCES
Full dentition (no extractions). No sharp teeth or restorations adjacent to the lesion — specifically documented by Dr. Torres. No appliances. No trauma sources identified.

SALIVARY POOLING & MOISTURE
Adequate salivary pooling bilaterally. No xerostomia on examination. Saliva slightly viscous (smoking).

LD LESION DESCRIPTION

6 PRECISE LESION CHARACTERIZATION

LESION NUMBER
1 primary ulcerative lesion. Separate finding: bilateral buccal mild leukoplakia (monitored separately).

EXACT LOCATION / LATERALITY
Left lateral tongue, junction of anterior and middle thirds, extending 2–3 mm onto the ventral surface. ~15 mm from the lateral tongue tip.

SIZE
14 mm (AP) × 9 mm (SI) — measured with graduated probe. A significant-sized ulcer for a lateral tongue location.

SHAPE
Irregular oval with ragged, rolled margins.

COLOR
Central base: yellowish-gray necrotic slough. Surrounding: erythematous halo (bright red, ~3–4 mm

SURFACE TEXTURE
ULCERATED — surface absent at center. Peripheral border indurated, raised, rolled, firm on palpation.

wide). Peripheral white elevated border.

Surrounding mucosa slightly thickened.

BORDERS / MARGINS

ROLLED, RAISED, AND INDURATED — this triad is the classical presentation of invasive squamous cell carcinoma. Irregular, not cleanly defined. No sharply punched-out borders.

BASE OF LESION

Hard, indurated base on deep palpation. Induration extends ~3–4 mm beyond the visible ulcer edge — suggesting an invasive process rather than superficial ulceration.

INDURATION / FIXATION / BLEEDING

INDURATED: YES — critical red flag. FIXED to underlying tissue on deep palpation. Tender on contact and deep palpation. Bleeds on gentle contact. No spontaneous bleeding.

SURROUNDING ERYTHEMA / KERATOSIS

Erythematous halo as above. No surrounding leukoplakia adjacent to this specific lesion (bilateral buccal leukoplakia is a separate field-change finding).

RELATIONSHIP TO TEETH / TRAUMA

NO adjacent sharp tooth or restoration — confirmed by Dr. Torres at dental exam 04/30/2026. No appliance, denture, or trauma source in contact.

REMOVABLE / NON-REMOVABLE

NON-REMOVABLE — cannot be scraped off. Consistent with an invasive lesion, not a superficial plaque or candidal pseudomembrane.

CLINICAL PHOTOGRAPHS

YES — 10 photographs at standardized distances with graduated probe. Saved to EHR (OLE-2026-0411-PHOTO-01 through -10): size, induration, rolled margins, erythematous halo, and buccal leukoplakia separately.

OC ORAL CANCER / HIGH-RISK LESION SCREENING

7 MALIGNANCY RISK ASSESSMENT

Malignancy risk: VERY HIGH. This lesion meets multiple high-risk criteria simultaneously:

1. **Non-healing ulcer x6 weeks** — the most important single red flag; a lateral tongue ulcer failing to heal in 6 weeks with no trauma source in a heavy smoker requires biopsy and urgent workup.
2. **Induration** — firm, rolled, raised borders and an indurated base extending beyond the visual margins; highly suspicious for invasive carcinoma (traumatic, aphthous, and inflammatory lesions do not typically induce palpable induration).
3. **Fixation** — fixed to underlying tissue on palpation, suggesting invasion into submucosal or deeper tissues.
4. **Rolled margins** — the classical morphology of invasive SCC.
5. **Site** — lateral tongue, the highest-risk intraoral site for SCC (~25–30% of intraoral SCC).
6. **Tobacco** — 25 pack-year current smoker; active smoking strongly associated with SCC at this site.
7. **Alcohol** — heavy use (est. 14–18 drinks/week); tobacco + heavy alcohol = synergistic risk.
8. **Referred otalgia** — left ear ache with a left lateral tongue lesion; a recognized symptom of lingual/glossopharyngeal nerve involvement, which can indicate perineural invasion.
9. **Palpable left Level IB node** — firm, 12 mm mobile node ipsilateral to the lesion; must be considered potentially metastatic until proven otherwise.

Overall: URGENT biopsy required. This presentation demands same-day biopsy (performed today — see procedures) and urgent CT neck with contrast to evaluate cervical lymphadenopathy and tumor extent. Time-sensitive.

PP PROCEDURES PERFORMED

8 PROCEDURES THIS VISIT

Incisional biopsy — left lateral tongue. Indication: indurated, non-healing, fixed oral ulcer in a high-risk patient — urgent biopsy required for diagnosis.

- **Consent:** Informed consent obtained and signed. Risks discussed: pain, bleeding, hematoma, tongue swelling, paresthesia, potential need for further procedures. Patient told directly: 'This lesion has features that concern me enough to biopsy today and to recommend imaging.' He was calm and receptive.
- **Anesthesia:** Infiltration with 2% lidocaine 1:100,000 epinephrine, 1.2 mL at the periphery of the lesion (avoiding injection into the lesion center to prevent tumor cell tracking); anesthesia achieved within 3 minutes.
- **Technique:** Incisional biopsy at the lesion margin (interface between the indurated border and surrounding mucosa — the preferred site for suspected SCC). 6 mm punch at the anterior-inferior margin (point of maximum induration), including margin, indurated border, and a rim of normal mucosa. Depth ~4–5 mm to include submucosal tissue.
- **Hemostasis:** Significant bleeding controlled with direct gauze pressure x5 minutes; primary closure with two interrupted 3-0 chromic gut sutures. The tongue is highly vascular; bleeding was anticipated and managed. No complications.
- **Specimen handling:** Single specimen labeled 'Left lateral tongue, incisional biopsy, indurated ulcer — URGENT' in 10% buffered formalin to Oral Pathology with URGENT/PRIORITY designation. Note to pathologist: 'Clinical concern for SCC — please prioritize and call for preliminary read.'
- **Tolerance:** Good despite significant clinical anxiety.
- **Post-procedure:** Salt-water rinse BID (no chlorhexidine on this sensitive site); soft diet; no alcohol; written post-op instructions provided.

L LAB & DIAGNOSTIC RESULTS

9 REVIEWED & ORDERED DATA

PATHOLOGY — URGENT BIOPSY SUBMITTED TODAY

Left lateral tongue incisional biopsy (6 mm punch) submitted URGENT with priority processing. Preliminary result expected 3–5 business days; final 5–7 days. H&E; requested stains: p16 IHC (HPV surrogate) and Ki-67 (proliferative index). Call-back requested for preliminary read.

LABORATORY STUDIES ORDERED

CBC with differential (baseline); CMP (liver function given heavy alcohol; renal function for contrast); HIV test (consent obtained); hepatic function panel (alcohol-related liver disease; surgical risk if SCC confirmed). To be drawn at Memorial Regional today.

CT IMAGING — ORDERED STAT

CT neck with contrast ordered STAT through Dr. Connelly (PCP), coordinated with Memorial Regional Radiology. Purpose: (1) characterize the left submandibular node; (2) identify additional cervical lymphadenopathy; (3) assess deep tissue invasion (tongue base, floor of mouth, mandible); (4) establish baseline staging. Same-day/next-day priority; patient directed to Radiology immediately after this visit.

PRIOR RECORDS REVIEWED

Dr. Torres referral (04/30/2026): direct description and 2 clinical photographs — comparison confirms growth from ~11×7 mm (04/30) to 14×9 mm today; the lesion has visibly GROWN in 6 days. Dr. Connelly PCP records: no prior oral cancer history; last physical 01/2026 (no oral cancer screening — patient counseled that it should be routine for high-risk patients).

A ASSESSMENT

10 ORAL LESION CLINICAL INTERPRETATION

Primary working diagnosis: Oral squamous cell carcinoma (SCC) of the left lateral tongue — presumed, pending biopsy. **Confidence: HIGH.** The combination of findings is essentially pathognomonic for invasive SCC until proven otherwise:

1. Non-healing ulcer x6 weeks (no healing trajectory).
2. Indurated, fixed, rolled-margin ulcer morphology.
3. Documented growth (11×7 mm on 04/30 → 14×9 mm on 05/06 — ~3 mm in 6 days).
4. Palpable ipsilateral left Level IB node (12 mm, firm, mobile).
5. Referred otalgia (possible perineural involvement).
6. Extreme high-risk exposures: 25 pack-year current smoker + heavy alcohol use.
7. Lateral tongue site (highest-risk intraoral location).

- **Differential:** (1) SCC — primary working diagnosis, very high probability; (2) traumatic ulcer — EXCLUDED (no trauma source, non-healing 6 weeks, indurated); (3) aphthous ulcer — EXCLUDED (not indurated/fixed, heals 10–14 days); (4) infectious ulcer (TB, fungal, syphilitic gumma) — low probability, H&E will address; (5) salivary gland malignancy — possible but site/morphology favor SCC; pathology will differentiate.
- **Separate finding — bilateral buccal leukoplakia:** A field-cancerization concern in this heavy smoker; requires independent monitoring and possible biopsy at a later visit.
- **Staging consideration:** If SCC confirmed, clinical staging will be required: CT neck (ordered today) + CT chest + PET/CT (per oncology). The palpable Level IB node suggests possible N1 disease.
- **Urgency:** Managed as an oncologic emergency — biopsy submitted URGENT today, CT ordered STAT, preliminary pathology call within 3–5 days, ENT/Head & Neck Oncology referral placed today.

P PLAN

11 ORAL LESION MANAGEMENT

1. **Biopsy follow-up:** URGENT biopsy submitted with call-back request. Patient given Dr. Park's direct cell and after-hours number; expect a call within 3–5 business days. If preliminary read is positive for SCC, same-day referral to Head & Neck Oncology.
2. **CT neck with contrast:** Ordered STAT — patient directed to Memorial Regional Radiology immediately after this visit. Results to Dr. Connelly and Dr. Park; ENT referral escalated if a suspicious node or primary mass is confirmed.
3. **Labs:** CBC, CMP, hepatic function panel, HIV — drawn at Memorial Regional today.
4. **ENT / Head & Neck Oncology referral:** Placed today (Dr. Victor Ambrose, MD, FACS). Referral includes clinical photographs, lesion description, biopsy reference number, and CT order. Triaged URGENT — ideally within 1–2 weeks; expedited to 3–5 days if biopsy confirms SCC.

5. **Tobacco cessation:** Addressed directly — smoking is the primary risk factor; stopping now is urgent regardless of the result. Varenicline (Chantix) 2-week starter pack given (coordinated with Dr. Connelly). Referral to Memorial Regional Tobacco Cessation Program placed.
6. **Alcohol reduction:** Heavy alcohol use named as a significant contributing risk factor. Referral to behavioral health for alcohol counseling placed (coordinated with Dr. Connelly).
7. **Post-biopsy care:** Soft diet, salt-water rinses BID, NO alcohol (reinforced), acetaminophen for the first 48 hours (hold NSAIDs 48 hours due to mild bleeding risk), then ibuprofen PRN.
8. **Return precautions:** Call or go to ED immediately for uncontrolled tongue bleeding, rapidly increasing tongue swelling or difficulty breathing, rapidly enlarging neck mass, fever >38.5°C, or increasing difficulty swallowing.
9. **Patient education:** A biopsy result does not change the urgency of imaging and specialist evaluation — both are needed simultaneously. He was calm, engaged, and asked appropriate questions; his partner was briefly included in the post-visit summary with his permission.

F FOLLOW-UP

12 REASSESSMENT PLAN

- **Biopsy result call:** Within 3–5 business days (target 05/09–05/13/2026). If positive for SCC: same-day ENT escalation and urgent oncology pathway activation with Dr. Connelly.
- **CT result:** Expected within 24–48 hours; reviewed by Dr. Park and communicated to Dr. Connelly.
- **Oral medicine follow-up:** 05/20/2026 (2 weeks) — review biopsy and CT results, ENT appointment status, post-biopsy healing, tobacco cessation progress, and buccal leukoplakia monitoring plan.
- **Bilateral buccal leukoplakia:** Reassessed and biopsied at a subsequent visit (not today — one procedure at a time). Scheduled 06/10/2026 if tongue lesion workup is underway.

TIME DOCUMENTATION & BILLING

TOTAL TIME
65 minutes

COUNSELING / COORDINATION TIME
20 minutes (CT coordination, ENT referral, tobacco/alcohol counseling, PCP coordination, patient/partner education)

CPT / E/M CODE(S)
99204 — New patient E/M, moderate-high complexity; D7285 — Incisional biopsy of oral tissue (URGENT)

BASIS FOR BILLING
Medical Decision Making — High Complexity; urgent biopsy; CT ordered; ENT referral; tobacco cessation

PRIMARY ICD-10 CODE
K14.0 — Glossitis (oral ulcer, left lateral tongue — pending SCC confirmation)

SECONDARY ICD-10 CODE(S)
F17.210 — Nicotine dependence, cigarettes; F10.10 — Alcohol use disorder, mild-moderate; D36.0 — Benign neoplasm of lymph nodes (Level IB node — pending)

PROVIDER SIGN-OFF

ORAL MEDICINE SPECIALIST	CREDENTIALS	SPECIALTY	DATE	TIME
Nathaniel Park, DDS, MD	DDS, MD, Diplomate ABOM	Oral Medicine	05/06/2026	5:00 PM