MARVIX AI

SAMPLE ORAL CANCER SCREENING SOAP NOTE

HIGH-RISK SCREENING — 6-WEEK NON-HEALING INDURATED LATERAL TONGUE ULCER WITH FLOOR-OF-MOUTH ERYTHROLEUKOPLAKIA AND LEVEL IIA LYMPHADENOPATHY; URGENT BIOPSY AND HEAD AND NECK ONCOLOGY REFERRAL

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1 PATIENT INFORMATION

1 PATIENT & VISIT DETAILS

NAME	Wendell R. Ostrowski
DATE OF SERVICE	07/17/2026
DOB	11/26/1964
PROVIDER	Dr. Marcus A. Delacroix, DDS, MS — Oral Medicine
AGE / SEX	61 / Male
CREDENTIALS	DDS, MS, Diplomate ABOM
MRN / PATIENT ID	OM-448193
VISIT TYPE	Oral Cancer Screening — urgent, lesion-based

REFERRAL SOURCE
General dentist (Dr. L. Hargreaves, DMD) — 6-week non-healing tongue ulcer noted at recall

PRIMARY CARE PROVIDER
Dr. S. Whitcombe, MD — Internal Medicine (last visit 03/2026)

CC CHIEF COMPLAINT

2 REASON FOR SCREENING

> *'My dentist found a sore on the side of my tongue that hasn't gone away since spring. It catches when I eat and my right ear has started aching.'*

Purpose: Lesion-based, high-risk oral cancer screening in a **40 pack-year smoker with heavy daily alcohol use.** Two findings drive the visit: (1) a **6-week non-healing, indurated right lateral tongue ulcer** with referred otalgia, and (2) a separate **mixed red-white lesion of the anterior floor of mouth** found on today's systematic screening exam.

S SUBJECTIVE

3 SCREENING HISTORY & RISK PROFILE

3a REASON FOR SCREENING, SYMPTOMS & COURSE

- **Reason for screening:** Referral-based and lesion-based — not routine. Dentist identified the ulcer at a 06/2026 recall and referred urgently after it failed to resolve with removal of a sharp cusp on #30.
- **Current symptoms:** Persistent right lateral tongue soreness aggravated by acidic and spicy food; intermittent contact bleeding when brushing; a 'rough patch' sensation on the tongue edge. Denies burning mouth or generalized oral pain.

- **Onset and course:** First noticed early June 2026 (~6 weeks). **Enlarging, not improving** — patient estimates it has roughly doubled in size; the ulcer has never fully epithelialized despite the dental trauma source being eliminated 4 weeks ago.

3b HIGH-RISK SYMPTOMS & ANATOMIC LOCATION

- **High-risk symptoms — POSITIVE: Right-sided referred otalgia** (3 weeks, normal ear exam by PCP), mild odynophagia to firm foods, and **unintentional 11 lb weight loss** over 3 months. **NEGATIVE** for hoarseness, trismus, airway symptoms, or spontaneous bleeding.
- **Anatomic location:** Primary lesion — **right lateral/ventrolateral tongue, mid-third**, the highest-risk intraoral subsite. Second lesion — **anterior floor of mouth, right of midline.**

3c TOBACCO, ALCOHOL & OTHER EXPOSURE RISKS

- **Tobacco:** Cigarettes, 1 pack/day since age 21 — **40 pack-years, current smoker.** Two prior quit attempts (longest 3 months, 2019). Denies smokeless tobacco; occasional cigars at social events. No vaping or nicotine pouches.
- **Alcohol: 4–6 standard drinks daily** (beer plus spirits) for approximately 30 years; heavier on weekends. Reports never having been advised to cut down. **Synergistic tobacco–alcohol exposure is the dominant risk driver in this case.**
- **Other exposures:** No betel/areca nut. No cannabis. 22 years as a commercial roofer (sun exposure — relevant to lip); no known occupational carcinogen exposure. **No prior head and neck radiation.** HPV risk factors not disclosed and not pressed.

3d PRIOR ORAL LESIONS, CANCER HISTORY & DENTAL HISTORY

- **Prior oral lesions:** A right buccal white patch was noted by a previous dentist in 2018 and documented as ‘smoker’s keratosis’; **never biopsied, never followed.** No prior oral dysplasia diagnosis, no prior oral or head and neck cancer, no prior biopsy of any kind.
- **Dental history:** Irregular care — recall gaps of 2–4 years. Fractured cusp on #30 (smoothed 06/2026), generalized moderate periodontitis, heavy calculus, **poor oral hygiene.** No dentures or removable prosthesis.

3e MEDICAL & FAMILY HISTORY

- **Medical:** Hypertension (lisinopril 20 mg), GERD (omeprazole 20 mg), mild COPD, alcohol-related hepatic steatosis on 2024 ultrasound. **No immunosuppression, no transplant, no prior malignancy, no chemotherapy or radiation therapy.** No autoimmune or chronic mucosal disease.
- **Family history:** Father — laryngeal carcinoma at age 66 (lifelong smoker). Maternal uncle — esophageal carcinoma. **Positive family history of aerodigestive malignancy.**

3f PRIOR EVALUATION & PERTINENT NEGATIVES

- **Prior evaluation:** Dental examination 06/2026 with occlusal adjustment of #30 as a presumed trauma source; **no photographs, no biopsy, no imaging performed to date.** No prior ENT, oral surgery, or oncology evaluation. Bitewing and periapical radiographs from 06/2026 reviewed today.

- **Pertinent negatives:** Denies dysphagia to liquids, hoarseness, trismus, facial numbness, airway compromise, spontaneous oral bleeding, night sweats, or fever. No loose teeth, no non-healing extraction site.

ROS ORAL CANCER SCREENING REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

- **Oral lesion / ulcer / lump:** POSITIVE — non-healing ulcer, right lateral tongue; separate FOM lesion
- **Oral pain / burning / numbness / taste:** POSITIVE for contact pain; NEGATIVE for numbness, burning, taste change
- **Otalgia / neck mass / facial swelling:** POSITIVE — right referred otalgia; palpable right neck node
- **Fever / fatigue / night sweats / weight loss:** POSITIVE — 11 lb unintentional loss; NEGATIVE fever, sweats
- **White / red / mixed lesion:** POSITIVE — mixed red-white floor of mouth; buccal keratosis
- **Dysphagia / odynophagia / hoarseness / trismus:** POSITIVE mild odynophagia; NEGATIVE hoarseness, trismus
- **Loose teeth / denture intolerance / non-healing socket:** NEGATIVE
- **Exposure history:** POSITIVE — 40 pack-years tobacco, heavy daily alcohol; NEGATIVE betel nut, radiation, immunosuppression

O OBJECTIVE

5 MEASURABLE & OBSERVED FINDINGS

V VITALS

TEMPERATURE	98.4 °F
BLOOD PRESSURE	148 / 88 mmHg
HEART RATE	82 bpm
RESPIRATORY RATE	16 / min
OXYGEN SATURATION	96% on room air
WEIGHT / BMI	171 lb / BMI 24.1 (down from 182 lb, 04/2026)
PAIN SCORE	3 / 10 at rest; 6 / 10 with acidic foods

5a GENERAL APPEARANCE

Alert, cooperative, in no acute distress. **Mildly cachectic appearance** with temporal wasting consistent with recent weight loss. Voice clear and unstrained; speech intelligible with a slight tendency to guard the right tongue. Hydration adequate. Mouth opening unrestricted. Nicotine staining of fingers and dentition noted.

5b EXTRAORAL EXAMINATION

- **Face / skin:** Symmetric, no swelling. Diffuse actinic damage of the face and lower lip with focal **lower-lip vermilion keratosis and blurred vermilion border** — consistent with actinic cheilitis.
- **Cervical nodes: Right level IIa node, 1.8 cm, firm, non-tender, minimally mobile.** Right level Ib 0.9 cm, soft, mobile. Left neck, submental, and supraclavicular fields negative.

- **Salivary glands:** Parotid and submandibular glands non-enlarged, non-tender; no ductal expressate abnormality.
- **Function / nerves:** Maximal incisal opening 46 mm — **no trismus.** CN V and VII grossly intact; no facial or lingual sensory deficit. No observable swallowing difficulty; no stridor.

5c INTRAORAL EXAMINATION — SYSTEMATIC SCREENING

- **Lips / labial mucosa:** Lower lip vermilion with rough, scaly keratotic change and loss of demarcation; no ulceration or induration.
- **Buccal mucosa:** Right buccal, along the occlusal line, a **12 × 6 mm homogeneous non-removable white plaque** — stable in appearance vs. 2018 description, soft, non-indurated. Left buccal unremarkable.
- **Gingiva / alveolar ridge:** Generalized marginal erythema, heavy calculus, moderate periodontitis. No exophytic lesion, no non-healing socket, no mobile teeth beyond periodontal grade I.
- **Tongue:** Dorsum coated, no lesion. **Right ventrolateral mid-third: 14 × 9 mm ulcer with rolled, everted borders, a granular fibrinous base, and firm surrounding induration extending ~5 mm beyond the visible margin.** Tongue protrusion midline and full; **no fixation or tethering.** Left lateral tongue clear.
- **Floor of mouth: Anterior FOM right of midline — 18 × 10 mm mixed red-white (erythroleukoplakic) lesion**, non-removable, granular surface, soft to palpation, not indurated, not fixed to periosteum. Salivary pooling normal; Wharton duct orifices patent bilaterally.
- **Palate:** Hard palate with mild nicotinic stomatitis pattern; soft palate clear. No mass, ulceration, or petechiae.
- **Retromolar trigone:** Clear bilaterally; no ulceration, tissue change, or tenderness.
- **Oropharynx:** Tonsils symmetric, no mass, exudate, or ulceration. Posterior pharyngeal wall normal to the limits of the oral examination.
- **Dentition / prostheses:** #30 previously smoothed and currently atraumatic to the tongue; **no remaining trauma source that accounts for the ulcer.** No prosthesis. Poor hygiene, heavy staining.

LD LESION DESCRIPTION

6 LESION-BY-LESION DOCUMENTATION

LESION 1 — RIGHT VENTROLATERAL TONGUE

LOCATION / LATERALITY
Right ventrolateral tongue, mid-third

SIZE
14 × 9 mm (up from ~7 mm per patient estimate)

SHAPE / BORDER
Irregular oval; rolled, everted margins

COLOR / CHARACTER
Ulcerated with granular fibrinous base; peripheral erythema

SURFACE TEXTURE
Granular, friable

REMOVABLE PLAQUE
Not applicable — ulcerative

INDURATION / FIXATION
INDURATED, ~5 mm beyond visible margin; not fixed to deep tissue

FRIABILITY / BLEEDING / DRAINAGE
Contact bleeding on gentle probing; no drainage, no necrosis

RELATIONSHIP TO TRAUMA
Adjacent #30 cusp smoothed 4 weeks ago; lesion progressed despite removal of the irritant

PHOTOGRAPHS
Yes — 3 clinical images with scale reference, filed to chart

LESION 2 — ANTERIOR FLOOR OF MOUTH

LOCATION / LATERALITY
Anterior floor of mouth, right of midline

SIZE
18 × 10 mm

SHAPE / BORDER
Irregular, ill-defined

COLOR / CHARACTER
Mixed red-white (erythroleukoplakia)

SURFACE TEXTURE
Granular, slightly velvety

REMOVABLE PLAQUE
Non-removable on gauze wipe

INDURATION / FIXATION
Non-indurated, mobile over periosteum; no ulceration

PHOTOGRAPHS
Yes — 2 clinical images with scale reference

RA ORAL CANCER RISK ASSESSMENT

7 RISK PROFILE

- **Tobacco:** 40 pack-years, **current** daily smoker — major risk factor
- **Alcohol:** 4–6 drinks/day × 30 years — **synergistic** with tobacco
- **Betel / areca nut:** None reported
- **Prior dysplasia / oral cancer:** None diagnosed; 2018 keratosis never biopsied
- **Prior head and neck cancer:** None
- **Immunosuppression / transplant:** None
- **HPV-related factors:** Not disclosed; not assessed
- **Chronic traumatic irritation:** Prior sharp cusp — eliminated, lesion progressed
- **Radiation exposure:** None; heavy occupational UV (lip relevance)
- **Family history:** Father laryngeal Ca; uncle esophageal Ca
- **Field cancerization: Multiple synchronous mucosal lesions** across two high-risk subsites
- **Overall stratification: HIGH RISK — lesion features and profile concerning for malignancy**

RF HIGH-RISK FINDINGS / RED FLAGS

8 CONCERNING FEATURES — PRESENT / ABSENT

- **Non-healing ulcer >3 weeks:** PRESENT — 6 weeks, persisted after trauma removal
- **Persistent red lesion:** PRESENT — FOM erythroleukoplakia
- **Persistent white lesion:** PRESENT — buccal keratosis, ~8 years
- **Mixed red-white lesion:** PRESENT — anterior floor of mouth
- **Induration:** PRESENT — tongue lesion, ~5 mm beyond margin
- **Fixation:** ABSENT — tongue mobile, FOM lesion not tethered
- **Spontaneous bleeding:** ABSENT (contact bleeding only)
- **Rapid enlargement:** PRESENT — approximately doubled in 6 weeks

- **Exophytic / verrucous growth:** ABSENT
- **Trismus:** ABSENT — MIO 46 mm
- **Unexplained otalgia:** PRESENT — right referred otalgia, normal ear exam
- **Oral numbness / cranial nerve deficit:** ABSENT
- **Persistent neck mass:** PRESENT — right level IIa, 1.8 cm, firm
- **Dysphagia / odynophagia:** PRESENT — mild odynophagia to firm foods
- **Unexplained weight loss:** PRESENT — 11 lb over 3 months
- **Non-healing extraction site:** ABSENT

PP PROCEDURES PERFORMED

9 SCREENING-RELATED PROCEDURES — THIS VISIT

- **Comprehensive palpation-based oral cancer screening** — full oral cavity, oropharynx to the limits of oral exam, and bimanual neck examination. Tolerated well.
- **Incisional biopsy, right ventrolateral tongue** — indication: non-healing indurated ulcer with high-risk profile. Written informed consent obtained (risks: bleeding, infection, pain, scarring, altered sensation, need for further surgery). 2% lidocaine with 1:100,000 epinephrine, 1.8 mL, lingual infiltration. **8 × 4 mm elliptical wedge** taken from the ulcer margin to include the transition zone with adjacent normal epithelium; specimen in 10% neutral buffered formalin, labeled 'R ventrolateral tongue, margin of ulcer.' Hemostasis with pressure; **two 4-0 chromic gut sutures.** Estimated blood loss <2 mL. No complications.
- **Incisional biopsy, anterior floor of mouth** — indication: erythroleukoplakia. Same consent and anesthetic protocol; **6 × 4 mm** representative wedge from the most erythematous zone; separate container, labeled 'Anterior FOM, R of midline.' One 4-0 chromic gut suture. No complications.
- **Clinical photography** — 5 standardized images with scale reference, both lesion sites, filed to the chart for surveillance comparison.

DR DIAGNOSTIC RESULTS

10 REVIEWED & ORDERED

- **Pathology:** Two specimens submitted today — **results PENDING** (expected 3–5 business days). Requisition flagged **URGENT — clinical suspicion of squamous cell carcinoma**, with request for dysplasia grading on the FOM specimen.
- **Imaging ordered: CT neck with contrast** — evaluation of primary lesion depth of invasion, mandibular involvement, and cervical nodal disease (right level IIa node). Panoramic radiograph obtained today: no cortical erosion or mandibular lytic change.
- **Imaging reviewed:** Bitewings and periapicals (06/2026) — no bony pathology; #30 restoration intact.
- **Laboratory ordered:** CBC with differential, CMP (including hepatic panel given alcohol history), albumin and prealbumin for nutritional assessment.
- **Prior records reviewed:** Dental chart notes 2018 and 06/2026, PCP notes 03/2026, 2024 abdominal ultrasound report. **No prior pathology exists for this patient.**

A ASSESSMENT

11 SCREENING-SPECIFIC CLINICAL INTERPRETATION

Screening result: SUSPICIOUS — lesion requiring urgent biopsy and specialist referral. A 61-year-old male with a 40 pack-year smoking history and heavy daily alcohol use presents with a 6-week, **enlarging, indurated 14 × 9 mm ulcer of the right ventrolateral tongue** that persisted after elimination of the presumed traumatic source, accompanied by **referred otalgia, mild odynophagia, an 11 lb unintentional weight loss, and a firm 1.8 cm right level IIa cervical node.** This constellation is **highly concerning for invasive squamous cell carcinoma with possible regional nodal metastasis.**

Working diagnosis: Invasive squamous cell carcinoma, right ventrolateral tongue (clinically cT1–T2 by size, cN1 pending imaging), pending histopathology. **Second lesion:** anterior floor-of-mouth erythroleukoplakia — clinically favors **moderate-to-severe epithelial dysplasia** within a field-cancerization pattern; carcinoma in situ cannot be excluded. **Third finding:** right buccal homogeneous leukoplakia, low-risk morphology, and **actinic cheilitis** of the lower lip.

Differential considered and argued against: traumatic ulcer (trauma removed 4 weeks ago, lesion progressed); major aphthous ulcer (wrong site, wrong duration, induration atypical); tuberculous or deep fungal ulcer (no systemic infectious features, no exposure history); necrotizing sialometaplasia (palatal, not lingual); syphilitic chancre (no risk history disclosed, morphology atypical); **none of these explain induration plus a firm ipsilateral node.**

High-risk features: PRESENT and multiple — non-healing duration, induration, rapid enlargement, referred otalgia, weight loss, persistent neck mass, mixed red-white second lesion, and a synergistic tobacco–alcohol exposure profile. **This is a two-week-wait equivalent presentation; management proceeds as malignant until pathology proves otherwise.**

P PLAN

12 SCREENING MANAGEMENT

- **Diagnostic:** Both incisional biopsies completed today with **urgent pathology flag.** CT neck with contrast ordered as **expedited — to be completed within 5 business days.** Labs drawn. Clinical photographs archived for comparison.
- **Referral — urgent: Head and neck oncology / ENT surgical oncology referral placed today** with direct provider-to-provider phone handoff; target evaluation **within 7–10 days** and not contingent on pathology return. Multidisciplinary tumor board listing requested pending histology and imaging.
- **Contingency:** If pathology confirms carcinoma, the patient transitions to the head and neck oncology pathway (staging, dental oncology clearance prior to any radiotherapy). If pathology returns dysplasia only, **rebiopsy or excisional biopsy of the tongue lesion is mandatory** given the degree of clinical suspicion — a benign report will not be accepted as final.
- **Surveillance of non-biopsied lesions:** Right buccal leukoplakia and lower-lip actinic cheilitis photographed and measured; reassess at 8 weeks. Biopsy if any change in size, color, texture, or symptom.
- **Risk reduction: Tobacco cessation** — brief intervention delivered, patient contemplative; varenicline discussion deferred to PCP, quitline referral made with patient consent. **Alcohol reduction** — AUDIT-C administered (score 8, positive); PCP notified for formal assessment and support pathway. Continued exposure materially worsens both surgical and second-primary risk; this was stated plainly.

- **Local irritants and dental care:** #30 confirmed atraumatic. Periodontal therapy and full dental stabilization arranged with the referring dentist — **to be completed before any potential radiotherapy** to reduce osteoradionecrosis risk. Hygiene instruction given; alcohol-free chlorhexidine 0.12% rinse twice daily.
- **Post-biopsy care:** Soft diet 48 hours, no smoking (wound healing rationale reinforced), avoid acidic and spicy foods, warm saline rinses from day 2. Acetaminophen 650 mg q6h PRN; NSAIDs avoided per GERD history.
- **Patient education:** Oral self-examination technique demonstrated with mirror. Written warning-sign sheet given. Biopsy rationale, timeline, and the realistic possibility of a cancer diagnosis discussed openly; patient's wife present with consent. **Return precautions:** uncontrolled bleeding, spreading swelling, fever >101 °F, difficulty breathing or swallowing, or new numbness — seek same-day care.

F FOLLOW-UP

13 REASSESSMENT PLAN

- **3–5 days:** Telephone contact for pathology result; in-person same-week appointment offered if malignant.
- **10–14 days:** In-office review — pathology discussion, suture check (chromic gut expected to resorb), wound assessment, CT results review, and confirmation that the head and neck oncology appointment has occurred.
- **8 weeks:** Reassessment and remeasurement of the non-biopsied buccal leukoplakia and lip actinic cheilitis, with repeat photography — **only if the patient is not already in active oncologic care**, in which case surveillance transfers to that team.
- **Care coordination:** Referring dentist and PCP both sent a copy of this note today. Clinic to **actively track** the oncology referral; failure to attend triggers outreach within 48 hours.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT
62 minutes

COUNSELING / COORDINATION OF CARE
24 minutes

E/M LEVEL
99204 — new patient, high complexity MDM

PROCEDURE CODE(S)
41108 × 2 (biopsy of floor of mouth / tongue, separate sites — modifier 59 on second); 99000 specimen handling

BASIS FOR BILLING
Medical Decision Making (high) — procedures billed separately with modifier 25 on E/M

PRIMARY ICD-10
K13.79 — Other lesions of oral mucosa (right lateral tongue ulcer, pending histology)

SECONDARY ICD-10
K13.21 Leukoplakia of oral mucosa · K13.24 Leukokeratosis nicotina palati · R59.0 Localized enlarged lymph nodes · R63.4 Abnormal weight loss · F17.210 Nicotine dependence, cigarettes · Z72.89 Other problems related to lifestyle (alcohol use)

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Marcus A. Delacroix	DDS, MS	Oral Medicine	07/17/2026	11:42