

dysphagia and penetration, but there were no findings specific to treatment type.

**CONCLUSIONS:** The use of chemoradiation to treat low-volume stage IV oropharyngeal cancer resulted in a trend toward more swallowing toxicity and PEG placement during therapy. However, there may be no difference in long-term feeding tube dependence and severe swallowing dysfunction.

11:14 AM

### **Response of Neck Metastases to Chemoradiation.**

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**OBJECTIVE:** 1. To analyze the response of neck disease to treatment with primary chemoradiation. 2. To determine when neck dissection should be done following chemoradiation.

**METHODS:** Retrospective review of patients with head and neck cancer (HNSCC) treated with chemoradiation with curative intent at a Veterans' Administration hospital, with specific attention given to the response of the neck disease to the treatment.

**RESULTS:** Thirty-two patients were identified who received concomitant chemotherapy and radiation: 8 patients with N1, 19 with N2, and 5 with N3 disease; 63% of patients had complete clinical and radiographic response of their neck disease following treatment. One additional patient had radiographic evidence of neck disease post-treatment that continued to diminish in size on subsequent CT scans over the following year. Eleven patients underwent neck dissection post-treatment (two patients with N1, six patients with N2, and three patients with N3 disease); 36% of the neck specimens had pathologically positive nodes. One of the N1, 2 of the N2, and one of the N3 neck dissections had positive nodes. Two patients who had complete clinical and radiographic response in the neck went on to recur at their primary site and die of their disease. Seventy-eight percent of patients were alive without evidence of recurrent disease in the primary site or neck at last follow-up.

**CONCLUSIONS:** The majority of HNSCC patients treated with chemoradiation have complete response in the neck. Patients with clinical and radiographic evidence of complete response in the neck may not require neck dissection, even with N2 or greater disease.

11:24 AM

### **Stenosis of Stensen's Duct: Is Parotidectomy Necessary?**

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**OBJECTIVE:** Isolated scarred stenosis or strictures of Stensen's duct are not frequent diagnoses. Parotidectomy is often recommended. In this clinical study the presenters (1) evaluate the use of interventional sialoscopy in this disease,

and (2) point out the indication for duct reconstruction and/or stent implantation.

**METHODS:** From 2002 to 2005, 39 patients (23 female and 16 male; age: 16-74 years) suffering from scarred stenoses of Stensen's duct were treated. Diagnosis was proven by clinical examination, ultrasound, and sialoscopy.

**RESULTS:** In six patients stenoses were due to iatrogenic manipulations. The youngest patient continuously chewed the mucosa in the region of the ostium causing a stenosis. Three patients suffered from duct stenosis years after a parotidectomy has been carried out. In 29 patients (74%) no reasons for the stenoses could be found. Treatment options included interventional sialoscopy (56%), and duct reconstruction and reinsertion (+/- stent implantation) (31%). Parotidectomy was carried out in 2 patients.

Altogether in 95% of all patients the parotid gland could be preserved. Best results were obtained by interventional sialoscopy. Duct reconstruction led to fair results in nine of the 12 patients; three patients of this group had an acceptable result with a narrowed ostium causing symptoms occasionally.

**CONCLUSIONS:** In the case of scarred stenoses of Stensen's duct, first choice of treatment is interventional endoscopy. Duct reconstruction and reinsertion within the buccal mucosa (+/- stent implantation) is a possible treatment, if the stenosis can be approached transorally.

Parotidectomy is reserved for all other cases or recurrences.

11:32 AM

### **Sentinel Node Biopsy: An Endoscopic Approach in the Pig Neck**

Kelly Michele Malloy, MD (presenter);  
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David Rosen, MD  
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**OBJECTIVE:** 1. Assess the feasibility of endoscopic sentinel node biopsy in an animal model. 2. Determine a reliable tracer dye for endoscopic sentinel node identification.

**METHODS:** This was a prospective, nonrandomized experimental study in Yorkshire pigs. The posterior-lateral tongues of three animals were injected with a one-to-one solution of carbon dye to methylene blue dye. Three trocar sites per side were used to establish an endoscopic pocket that was maintained by carbon dioxide insufflation. A Harmonic scalpel was used to assist with lymph node dissection. Lymph nodes were identified and retrieved endoscopically, followed by an open dissection to recover any remaining nodes. All specimens were analyzed by a pathologist for staining, size, and structural integrity.

**RESULTS:** Six unilateral endoscopic sentinel node dissections were performed. No significant complications (i.e. bleeding or conversion to open surgery) occurred. During endo-