The Swedish Head & Neck Surgery Clinic at the Swedish Cancer Institute completed another rewarding clinical year in 2014. Since establishing a state-of-the-art head and neck treatment center nearly six years ago, our service line has grown. We now offer the highest quality comprehensive care, and nearly every available treatment modality for complex head and neck cancers, from robotic surgery to free tissue transfer. As we’ve grown, we’ve received the support of physicians in the community and the faith of our patients.

In the past year, our clinical volume expanded significantly, yet we have remained dedicated to personalized medicine delivery. Each cancer patient entrusted to our care is reviewed by a multidisciplinary tumor board. Then we work closely with our patients to develop a plan for ongoing care. What sets us apart, however, is our availability. A dedicated team is ready to help our patients around the clock; before, during and after their care at Swedish Medical Center.

In the past year, the team has also grown to match the increase in patients. The care team now includes: physicians, physician assistants, an oncology nurse, speech and swallow therapists, oncology social workers, nutritionists and others. We understand the difficult journeys our patients are navigating, thus we thrive on ensuring every issue they face can be resolved in a timely fashion.

In July, Dr. Joseph Sniezek joined our staff. He brought with him immense experience in thyroid and parathyroid surgery. He has elevated the care of thyroid tumors by initiating a comprehensive thyroid clinic, and more importantly, by starting the first dedicated multidisciplinary thyroid tumor board in the Pacific Northwest.

In November, Dr. Sam Bobek joined Swedish Medical Group in the maxillofacial surgery division. He brings a wealth of skills and expertise that complement and enhance head and neck surgery.

In the new year, we will continue to seek excellence in patient care, to learn from our patients, to remain humbled by our patients’ strengths, and to stay grateful for the commitment and confidence of our peers and colleagues.

Wishing you a happy 2015!

Namou Kim, M.D.
Medical Director, Head & Neck and Reconstructive Surgery
Swedish Medical Center
**Updates**

**Multidisciplinary Head & Neck Tumor Board**
The Head and Neck Tumor Board at Swedish Cancer Institute continued to expand its volume, with a total of 216 cases presented in 2014. However, the major innovation was the establishment of a new, multidisciplinary thyroid tumor board. Each month, complex thyroid tumors are discussed, along with appropriate, novel and diagnostic molecular testing and therapeutic planning. Both the head and neck and thyroid tumor boards are open CME events, and all providers are encouraged to submit cases and participate. Please contact larynx@swedish.org for submissions.

**Pacific Northwest Head & Neck Cancer Symposium**
In April 2014, the focal topic of the 4th Annual Symposium was HPV-induced oropharyngeal tumors and it was well received by attendees. Our keynote speakers included, Dr. Gregory Weinstein (University of Pennsylvania) and Dr. Mitch Machtay (Case Western Reserve University). The 5th Annual Symposium will be held on April 10, 2015, at the Cherry Hill campus of Swedish Medical Center. The focus will be on the management of thyroid and parathyroid diseases. The keynote speakers will be Dr. Bob Sofferman (University of Vermont) and Dr. Michael Tuttle (Sloan Kettering).

**Surgical education**
SCI is the principal head and neck surgery rotation for otolaryngology residents at Madigan Army Medical Center. In addition, Swedish general surgery residents each spend three dedicated months on the head and neck surgery service. We thrive on making an impact on all residents in the most productive manner. In the past two years, two of our residents have decided to pursue head and neck and microvascular fellowships. Dr. Scott Bevans (Madigan) will be receiving his microvascular training at the University of Washington, and Dr. Virginie Achim (Swedish) has matched at Oregon Health & Science University in head and neck surgery.

**Microvascular reconstructive surgery**
We continue to build our very busy, free tissue transfer program. In 2014, we completed a total of 53 free flaps, with a 95 percent success rate.

Since the FDA approval of the DaVinci system for select oropharyngeal cancers, we’ve been pioneers in the West. In 2010, we introduced TORS (trans oral robotic surgery) at Swedish and since then we’ve compiled a very robust series of TORS.

In particular, we’ve become facile in treating unknown primary tumors. With an ever-increasing incidence of HPV-induced oropharyngeal cancers, many of the patients present with only neck metastases but have primary tumors that are undetectable by conventional diagnostic tools (CT, PET/CT, laryngoscopy with biopsy). Unfortunately, the patients will need wide-field radiation to the entire oropharynx, which diminishes the potential for good swallow function, and increases other side-effects of radiation. In the vast majority of cases we’re able to turn cases from Tx to a T1 or T2 using TORS, as well as excellent pathologic analysis. We’ve been able to find and completely excise tumors as small as 3mm. This allows our radiation colleagues to more specifically target radiation to a smaller anatomical subset.

In turn, this smaller field radiation translates to a better functional swallow outcome and less side-effects.

Also, after completing a total of 12 robotic transaxillary thyroidectomies, we voluntarily closed off this service line in 2013. However, as of autumn 2014, we’ve reopened an approved protocol for robotic thyroidectomy program.
Case Highlight: From biopsy to diagnosis in one stop and one day

JK is a 67-year-old female with primary hyperparathyroidism. She underwent successful excision of a parathyroid adenoma via a minimally invasive approach in June 2013. At that time, a right thyroid nodule was noticed. Ultrasound (US) examination of the thyroid nodule was performed, which indicated that the nodule was 1.3 cm at its greatest extent. The nodule showed mixed solid and cystic components and no evidence of microcalcifications. An ultrasound-guided fine needle aspiration biopsy (US-guided FNA) was performed. Results indicated the nodule was benign.

Presentation (August 2014)
The patient returned to the clinic for re-evaluation of her thyroid nodule. Her parathyroid function and calcium levels were normal. Physical examination did not reveal any palpable neck masses or thyroid nodules. A repeat US examination of the thyroid nodule indicated that it measured 1.9 x 1.6 x 1.4 cm. Solid and cystic components of the nodule were again identified, although the exam showed some small calcifications within the nodule. (See Figures 1 and 2.)

Due to the increase in nodule size and new concerning features on the US examination, a US-guided FNA was performed. (See Figures 3 and 4.) Pathology evaluation of the sample obtained during FNA was suspicious for papillary thyroid carcinoma (PTC).

Management
The patient underwent total thyroidectomy as treatment for PTC. She recovered uneventfully with normal voice and post-operative calcium levels. (See Figure 5.)

Discussion
Thyroid nodules can convert from a benign to a malignant state. If a patient elects observation of their thyroid nodule, a repeat follow-up and US examination should be performed. Six to 12 months is generally accepted as a reasonable period of time before repeating physical and US examinations. A US-guided FNA should be repeated if the nodule grows in size or any new and concerning ultrasonographic features appear, such as microcalcifications.

Patient and provider convenience was greatly enhanced by consolidating head and neck US, US-guided FNA procedures and surgical counseling into a single encounter at one location. Multiple patient visits were deemed inconvenient and unnecessary.

Figure 1. Transverse image of the right thyroid nodule showing solid and cystic components.

Figure 2. Longitudinal image of the right thyroid nodule showing solid and cystic components.

Figure 3. Transverse image of right thyroid nodule undergoing FNA biopsy. Notice that the needle is positioned to biopsy the most suspicious portion of the nodule, near the small calcifications.

Figure 4. Crowded cluster suspicious for papillary thyroid carcinoma and adjacent sheet of benign follicular cells on FNA, air-dried, DQ-stained, 200x.

Figure 5. Papillary thyroid carcinoma on histology, H&E-stained, 400x.
Providers

Swedish Head and Neck Surgery Team

Front row left to right
Susan Vetto, RN
Christine Tiu, PA-C, M.P.A.S.
Jeffery Robin, PA-C
David Moore, M.D., M.B.A., F.A.C.S.

Back row left to right
Sam Bobek, M.D., D.D.S.
Joseph Sniezek, M.D., F.A.C.S.
Namou Kim, M.D., F.A.C.S.
Not pictured: Joanne Fenn, M.S., CCP-SLP
Mark Filler, LICSW

Services

- Head and neck surgery
- Microvascular (free flap) reconstructive surgery
- Thyroid surgery and diagnostic ultrasonography
- Minimally invasive parathyroid surgery and radio-guided surgery
- Transoral robotic surgery (TORS)
- Transoral laser microsurgery (TLM)
- Transaxillary robotic thyroid surgery
- Anterior skull base surgery
- Cutaneous cancers of the head and neck
- Salivary gland tumors
- Congenital head and neck reconstructive surgery
- Complex trauma reconstruction to head and neck
- Maxillofacial surgery