THE ISRAEL MEDICAL ASSOCIATION
THE ISRAELI SOCIETY OF HEAD AND NECK SURGERY AND ONCOLOGY

PROGRAM BOOK
and Abstracts

2013 Annual Meeting
of the Israeli Society of Head and Neck Surgery and Oncology

November 7-9, 2013
Dead Sea, Israel
www.ishnos.com
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### Scientific Program

**Thursday – 7 November**

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<td>09:30-10:25</td>
<td>Registration, Refreshments &amp; Visit to the Exhibition</td>
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<tr>
<td>10:25-10:30</td>
<td>Opening Remarks - <strong>A. Khafif Hefetz, Chairman</strong></td>
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<td>10:30-11:00</td>
<td>Biologic Treatment of Head and Neck Cancer - <strong>A. Popovtzer</strong></td>
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<td>11:00-11:30</td>
<td>Mucosal Melanomas of the Head and Neck - <strong>J.E. Medina</strong></td>
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<td>11:30-12:00</td>
<td>Surgical Treatment of Cancer of the Salivary Glands – The Difficult Parotid - <strong>J.P. Shah</strong></td>
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<td>12:00-12:10</td>
<td>Discussion</td>
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**Session 01: (sponsored by AstraZeneca)**

**Moderators: A. Khafif Hefetz, O. Ronen**

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<td><strong>Maxillectomy Bony Reconstruction-Current Approach - A. Aharon</strong></td>
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<td>12:10-12:17</td>
<td>Adjusting Head &amp; Neck Cancer Treatment plan according to patient staging - Getting the reconstruction and prognosis into the equation - <strong>D. Ad-EI</strong></td>
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<td>12:18-12:25</td>
<td>Gross examination by the Surgeon is an alternative to frozen section for assessment of adequacy of surgical margin in Head and Neck Squamous Cell Carcinoma - <strong>P. Chaturvedi</strong></td>
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<td>12:26-12:33</td>
<td><strong>17beta-Estradiol Promotes Aggressive Laryngeal Cancer through Membrane-Associated Estrogen Receptor Alpha-36 - N. Schwartz</strong></td>
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<td>12:34-12:41</td>
<td><strong>The role of Radionuclide Imaging in Evaluation of Thyroid Nodules with Indeterminate Cytology - G. Avior</strong></td>
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<td>12:42-12:49</td>
<td><strong>Aggressive behavior of Cutaneous Squamous Cell Carcinoma in patients with Chronic Lymphocytic Leukemia - H. Gavriel</strong></td>
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<td>13:00-14:00</td>
<td>Lunch</td>
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Thursday – 7 November

Session 03: Moderators: M. Yehuda, R. Pfeffer

14:00-14:30 Neck Dissection- Evolution of the Operation - J.P. Shah
14:30-15:00 The Treatment of the Neck in Thyroid Cancer - A. Shaha
15:00-15:30 Salvage Treatment Protocols for the Management of Loco regional Recurrence of Head and Neck cancer- L. Harrison
15:30-16:00 Coffee Break & Visit to the Exhibition

Session 04: Moderators: G. Bechar, S. Desai

16:00-16:30 Recurrent Parathyroidectomies- Pearls and pitfalls - A. Shaha
16:30-17:00 Treatment of the N Positive Neck in the Era of "Organ" Preservation - J.E. Medina
17:00-17:10 Discussion

Session 05: Moderators: P. Chaturvedi, E. Sela

17:10-17:30 Challenges running randomized controlled studies in Head and Neck Surgery - K.-C. Soo
17:30-17:50 Prognostic factors and treatment of Young patients with HNSCC - L. Kowalski
17:50-18:00 Discussion

Session 06: Moderators: L. Harrison

18:00-19:00 Panel: Oral Cavity and Oropharyngeal Cancer
Participants: I. Dowek, T. Shpitzer, R. Ben-Yosef, K.-C. Soo, L. Kowalski, J. P. Shah
19:00 Adjourn
19:10 Elections : New Chairman & Committee Members

20:00 Dinner
21:00 Evening Event – Stand-up show - Dror Keren
### Scientific Program

**Friday – 8 November**

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<td>07:00-08:00</td>
<td>Breakfast</td>
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<td>08:00-08:20</td>
<td>Salvage Laryngectomy Myths and Pitfalls - J. E. Medina</td>
<td>Treatment of Oral Cavity Cancer: The Tata Memorial Experience - A. D'Cruz</td>
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<td>08:20-08:40</td>
<td>Recurrent Thyroid Carcinoma - A. Shaha</td>
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<td>08:40-09:00</td>
<td>Cancer of the Oral cavity- What's New? - J.P. Shah</td>
<td>Current status of Robotic Thyroid and Parathyroid surgery in Europe - P. Aidan</td>
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<td>09:00-09:10</td>
<td>Discussion</td>
<td>New Approaches to Management of Metastatic Cancer to the Neck with Unknown Primary - L. Harrison</td>
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<td>Prognostic factors and treatment of old patients with HNSCC - L. Kowalski</td>
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<td>Treatment of Oral Cavity Cancer: The Tata Memorial Experience - A. D'Cruz</td>
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<td>Natural history of Small Bone Metastases seen on Postradioiodine Ablation and have no structural correlate on imaging studies - E. Robenshtok</td>
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<td>11:08-11:15</td>
<td>Laryngeal Suspension – Treatment of Post operative dysphagia – D. Sharad</td>
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<td>11:16-11:23</td>
<td>Natural history of Small Bone Metastases seen on Postradioiodine Ablation and have no structural correlate on imaging studies - E. Robenshtok</td>
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<td>11:24-11:31</td>
<td>Endoscopic 3-Surgeon Parathyroidectomy - J. Cohen</td>
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11:48-11:55  Patterns of Failure in Head and Neck Squamous Cell Carcinoma following Curative Treatment - P. Chaturvedi
11:56-12:03  Paradigm shift in the management of sinonasal tumours - P. Prathamesh

Session 10:  Moderators: A. Khaffif Hefetz

12:04-13:00  Panel: Treatment of the Neck – Challenging cases

Participants: O. Gotfeld, G. Bachar, J. E. Medina, A. Shaha, J.-Y. Sichel, Y. Talmi

13:00-13:10  Closing Remarks- A. Khaffif Hefetz
13:10-14:00  Lunch

Session 11:  Moderators: D. Schindel, D. Chaukar

Instructional Course: Neck Dissection. How I do it ?:

14:00-14:30  The Neuroanatomical basis for Modified Neck Dissections - K.-C. Soo
14:30-15:30  Neck Dissection- Surgical Technique - J. E. Medina

19:30-21:30  Dinner
21:30  Evening Event
Prof. Jatin P. Shah

Prof. Jatin Shah is Leader of the Head and Neck Program, and holds The Elliott W. Strong Chair in Head and Neck Oncology at Memorial Sloan-Kettering Cancer Center in New York City. Prof. Shah has served as President of The New York Cancer Society, The New York Head and Neck Society, The Society of Head and Neck Surgeons, The North American Skull Base Society, and the International Academy of Oral Oncology. He is Founder and CEO of The International Federation of Head and Neck Oncologic Societies. Prof. Shah has been the recipient of numerous awards from all continents and is an honorary member of several head and neck societies in Europe, Asia, Australia and South America. He serves on the Editorial and Review Boards of 18 scientific journals and has more than 350 peer-reviewed publications, 65 book chapters and 8 books. His textbook of Head and Neck Surgery and Oncology won First Prize from The British Medical Association and The Royal Society of Medicine, and was awarded the George Davey Howells Prize from the University of London for the best published book in otolaryngology in the preceding five years. He is a much sought-after speaker who has delivered 60 named lectures and keynote addresses and over 1,000 scientific presentations in 49 countries. In recognition of his outstanding contributions and world leadership in head and neck surgery, Memorial Sloan-Kettering Cancer Center has established an endowed Chair in his name, the American Head and Neck Society has named an annual symposium in his honor, and the IFHNOS has established an eponymous lecture at its World Congresses. Prof. Shah attended the annual meeting of the Israeli Society of Otolaryngology in the past and we are thrilled to have him as our distinguished guest of honor this year.
Prof. Louis B. Harrison

Physician-in-Chief, Continuum Cancer Centers of New York; Chairman and Gerald J. Friedman Chair of Radiation Oncology, Beth Israel Medical Center, St. Luke's and Roosevelt Hospitals; Professor of Radiation Oncology and Otorhinolaryngology-Head and Neck Surgery, Albert Einstein College of Medicine.

Prof. Harrison is an internationally recognized and extensively published expert in the areas of head and neck cancer, sarcomas and intraoperative brachytherapy. He has been a leader in the development of multidisciplinary management strategies which prioritize cancer cure with organ and function preservation. He is Co-Editor of the textbook "Head and Neck Cancer: A Multidisciplinary Approach", published by Lippincott-Raven in October 1998; and "Intraoperative Irradiation: Techniques and Results", published by Humana Press in 1999. Before joining Beth Israel Medical Center in 1997, Dr. Harrison was Chief of the Brachytherapy Service and Leader of the Head and Neck Cancer Disease Management Team at Memorial Sloan-Kettering Cancer Center. He is active in a variety of medical committees and professional organizations including the American Board of Radiology, the American Brachytherapy Society and the Society of Head and Neck Surgeons. He is a past-president of the American Brachytherapy Society and is currently the Vice Chairman of the Refresher Course Program for the American Society of Therapeutic Radiology and Oncology. He is the recent recipient of the Boyer Young Investigator Award for Biomedical Research. Prof. Harrison is frequently named to the list of top doctors, and most recently appeared in the Castle Connolly 2011 edition of "Top Doctors: New York Metro Area," "America’s Top Doctors" and "America’s Top Doctors for Cancer." Dr. Harrison is among New York Magazine's "Best Doctors" as listed in the June 2011 edition of the magazine. The New York Magazine is excerpted from Castle Connolly's annual guidebook, "Top Doctors: New York Metro Area."
Prof. Jesus E. Medina

Prof. Jesus E. Medina, M.D., F.A.C.S. was born in Peru where he attended medical school. Following training in otorhinolaryngology at Wayne State University School of Medicine, he did a fellowship in Head & Neck Surgery at the M.D. Anderson Hospital and Tumor Institute in Houston, Texas. In 1981, he became an Assistant Professor in the Department of Head and Neck Surgery at M.D. Anderson. In 1984 he accepted a position as an Associate Professor and Director of the Head and Neck Cancer Program in the Department of Otorhinolaryngology at the University of Oklahoma. He became Chairman of the Department in 1991 and he currently holds the Paul & Ruth Jonas Chair in Cancer Treatment and Research.

Prof. Medina has devoted his career to the care of patients with head and neck cancer and has authored numerous scientific publications, textbooks and book chapters on a variety of topics in head and neck oncology. He has lectured extensively in the United States and abroad. In addition to his clinical and academic responsibilities, Prof. Medina serves on the Board of Directors of the American Board of Otolaryngology and is the current President of the Board. He was selected to be a candidate for President-Elect of the American Academy of Otolaryngology Head and Neck Surgery in 2002. Prof. Medina served as Vice-President for the Middle Section Triological Society in 2002. He was Vice-President of the Society of Head and Neck Surgeons and became the second President of the American Head and Neck Society in 2000. Prof. Medina has received numerous awards including the Honor Award and the Distinguished Service Award from the American Academy of Otolaryngology; an American Cancer Society Professor of Clinical Oncology Award and two Presidential Citations from the American Society for Head and Neck Surgery.

Prof. Medina attended the annual meeting of our society on 2007 and we are honored to have him again as our distinguished guest of honor.
Invited Speakers

Prof. Soo Khee Chee
Director of National Cancer Centre of Singapore

Prof. Soo graduated from medical school at the University of Singapore with a distinction in biochemistry in 1975. He moved to Australia where he was trained as a Surgical Resident at Royal Adelaide Hospital, Bankstown Hospital and Prince of Wales Hospital, NSW. Surgical Registrar positions in a number of Surgery departments in Australian hospitals between 1979 and 1983 led to the position of Senior Surgical Registrar/Lecturer in Surgery at the Royal Marsden Hospital and the Institute of Cancer Research in London from 1983 to ‘85. Specializing in Head and Neck surgery Prof. Soo spent a further year at the Royal Marsden before continuing his training at the Department of Surgery, Memorial Sloan Kettering Cancer Center, New York, USA.

As the Director of the National Cancer Centre, Prof. Soo provides strategic leadership to over 500 staff engaged in clinical care and research. His distinguished career also includes his professorship at the National University of Singapore. He is on the board of examiners for the final MBBS exams. In addition, Prof. Soo holds the position of Director, Research Council, Singapore Health Services Pte Ltd and Member of the National Medical Research Council.

He has trained international surgeons and has been well consulted as Visiting Professor in the University of Toronto, Jaslok Hospital and Research Centre, Mumbai, India, Gleneagles Medical Centre, Penang as well as Stanford University Medical Center, USA. To honour his commitment to training, he has been conferred the Outstanding Teachers’ Award in 1996 and Best Teacher (Undergraduate) Award in 2001.

Prof. Soo has wide ranging research interests but has gained a particular reputation in the conduct of clinical trials for new cancer treatments and in the field of biophotonics and its role as a new imaging modality for the early detection of cancer. In 2003, Prof. Soo was awarded the National Day Award, Public Admin Medal (Gold) for his contribution to the country.
Invited Speakers

Prof. Ashok R. Shaha

Prof. Shaha is an Attending Surgeon on the Head and Neck Service at Memorial Sloan-Kettering Cancer Center, Jatin P. Shah Chair in Head and Neck Surgery, and Professor of Surgery at Cornell University Medical College, New York.

Prof. Shaha completed his surgical training at M.S. University of Baroda, India and worked as a House Surgeon at Tata Memorial Hospital, where he developed an interest in head and neck surgical oncology. After his arrival at Memorial Sloan-Kettering Cancer Center in 1975, Prof. Shaha did a surgical oncology fellowship and subsequently completed his surgical training at Downstate Medical Center in Brooklyn, New York.

Prof. Shaha returned to Memorial Hospital in 1981 as a Fellow in Head and Neck Surgery. He joined the Department of Surgery at Downstate Medical Center in 1982 as a Head and Neck Surgeon, rising to the rank of Professor of Surgery in 1992. During this period, he was also Chief of Head and Neck Surgery at King’s County, Brooklyn VA Hospital and University Hospital. From 1987 to 1989, Prof. Shaha spent two years as Acting Chief of Surgery at Brooklyn VA Medical Center.

In August of 1993, Prof. Shaha moved to Memorial Sloan-Kettering Cancer Center as an Attending Surgeon on the Head and Neck Service. During his post-graduate training, Prof. Shaha secured several gold medals and was given the Golden Apple Teaching Award at Downstate Medical Center. Other awards Prof. Shaha received include: Faculty Member of the AOA Honor Medical Society, the Outstanding Teacher Award at Memorial Sloan-Kettering Cancer Center in 1996, the Honor Award from the American Academy of Otolaryngology/Head and Neck Surgery, and he was named Visiting Professor of the Society of Head and Neck Surgeons in 1997 and 1998.
He has been honored by visiting professorships at University of Santa Tomas, Manila, and Sun Yat-Sen University Guang Zhou, China. Prof. Shaha has been actively involved in local and national head and neck societies, as well as having been President of the New York Head and Neck Society, the American Society for Surgeons of Indian Origin, and the Brooklyn Surgical Society.

He was Co-President of the American Head and Neck Society, 1998-1999, and was President of the New York Cancer Society, 1999-2000 and President of the New York Surgical Society, 2004-2005. He is a member of many scientific organizations and serves on the editorial board of the Journal of Surgical Oncology, Head and Neck, Annals of Surgical Oncology, Brazilian Journal of Surgery, and Journal of Clinical Oncology. He is an honorary member of the Brazilian College of Surgeons, the Cuban Surgical Society, Association of Surgeons of India, the Korean Head and Neck Society, Latin Head and Neck Society, Panamanian Society of Oncology, Chilean College of Surgeons, and Costa Rican Endocrine Society.

He has been a visiting professor at many universities throughout the United States, as well as a guest speaker in many South American, Asian and European countries. He was the Program Chairman for the Fifth International Head and Neck Oncology Meeting in San Francisco (2000) and served as the Conference Chairman for the Sixth International Head and Neck Meeting in 2004.

Recently Prof. Shaha was the recipient of the Distinguished Service Award by the American Academy of Otolaryngology – Head and Neck Surgery; he was recently nominated as President of the American Association of Endocrine Surgeons. Recently he was elected to the American Surgical Association.

Prof. Shaha has been academically active at national and international meetings, with approximately 585 papers, 435 of which are peer-reviewed (Pubmed and Scopus). His Curriculum Vitae includes 140 published abstracts, 63 posters and 45 scientific exhibits presented. His research interests include tracheal reconstruction and an experimental model of tracheomalacia and thyroid cancer. Prof. Shaha has dedicated his professional career to the training of medical students and residents and has developed a preceptorship program at Cornell University Medical College in head and neck training for medical students. He is Chairman of the Advanced Training Council for Head and Neck Oncology Fellowships in the USA.
Prof. Kowalski Luiz
Director, Head and Neck Surgery and Otorhinolaryngology Department
Hospital A C Camargo, Brazil

Luiz Paulo Kowalski, M.D., PhD earned his medical degree from the Medical School of the UFPR (1979). After a 3-year medical residency in Surgical Oncology at Hospital A C Camargo, he undertook a one-year Fellowship in Head and Neck Surgery at Hospital Heliópolis. He obtained a MS degree (1986) and PhD degree (1989) in Otorhinolaryngology from UNIFESP. He also completed a 6-months observership in Head and Neck Surgery at MSKCC (1988). On 1996 he obtained the academic title of Free-Professor of Oncology at FMUSP. On 1990, joined the faculty of Hospital A C Camargo and since then he has been serving as Director of the Department of Head and Neck Surgery and Otorhinolaryngology. He is also Professor of the Postgraduation Courses of Oncology. He is a member of several professional organizations, including the International Academy of Oral Oncology, American Head and Neck Society, Brazilian Head and Neck Surgery Society, Brazilian Society of Otolaryngology and Brazilian College of Surgeons. He served as President of the IV Brazilian Oral Cancer Congress, President of the 8th International Congress on Oral Cancer, and President of the Brazilian Head and Neck Surgery Society (2005-2007). Prof. Kowalski has authored or co-authored more than 450 peer reviewed articles (305 in international peer reviewed journals), written 3 Thesis and 100 book chapters, and edited 9 books. Prof. Kowalski’s basic science and clinical interests are epidemiology, prognostic factors, oral and oropharyngeal cancer, thyroid cancer salvage surgery, management of the neck and biomarkers.
Prof. Patrick Aïdan
American Hospital of Paris, France

Head of Otolaryngology and Head and Neck Department. American Hospital of Paris, France.

Course Director of Robotic Thyroid Surgery program at European School of Surgery in Paris, France.

Scientific Director of Masterclass of Robotic Thyroid Surgery. American Hospital of Paris, France.

Instructor of Robotic Thyroid Surgery program at the Rabin Medical Center, Prof. R. Feinmesser, Israel.
Invited Speakers

Prof. Anil D'Cruz
Director and also Chief, Department of Head & Neck Surgery at the Tata Memorial Hospital, India.

Prof. Anil D'Cruz is the director at the Tata Memorial Hospital, Mumbai, India. In addition, he is professor and chief, department of head and neck surgery at the hospital.
The head and neck services at the Tata Memorial Hospital are one of the busiest in the world registering over 7000 new cases and performing over 2000 major surgeries every year.
He teaches for the Mch Specialty Training Programme in surgical oncology and is actively involved in teaching post graduates in Otorhinolaryngology, head neck surgery, general surgery and surgical oncology.
He is also an examiner at various Universities across the country.
Prof. D'Cruz is a member of numerous professional bodies in India and abroad and has just completed his tenure as president of foundation of head and neck oncology (2008-2010), India as well as secretary for the Action Council for Tobacco Control (2007-2009).
He has also served as a member of the task force for chronic diseases at the department of biotechnology, Ministry of Science and Technology Government of India.
He is currently the president of the Asian Society of Head Neck Oncology.
He is actively involved in research in head and neck cancers and plays a pivotal role in numerous trials.

He has been Global Principal Investigator as well as part of the steering committee of a number of multicentric, multinational trials. Some of these include a Phase1 trial to evaluate the role of interstitial PDT in the treatment of Head & Neck cancers, as well as targeted therapy in the concurrent, adjuvant and palliative settings.
Invited Speakers

His major areas of interest in clinical research are management of neck metastasis, conservative laryngeal and laser surgery, cancers of the oral cavity and thyroid as well as quality of life issues.

He is currently running a large prospective, randomized, controlled trial to evaluate the role of elective neck dissection in the management of early oral cancers.

He is pioneering research in the use of curcumin in head and neck cancer patients for which he receives funding from the government of India’s Ministry of Science and Technology department of biotechnology.

He is a part of a project to develop and validate Molecular Cytogenetic Studies/Proteomics in oral cancers. Results of this work have been filed for a patent.

Prof. D’Cruz has more than 125 peer-reviewed publications and chapters to his name and is also an editor for a two volume text book on head and neck Surgery.
He has delivered more than 250 invited lectures and orations both nationally and internationally including the prestigious Eugene Myers International Lecture in Head and Neck cancers at the American Academy of Otolaryngology - Head and Neck surgery.

He is a member of the editorial board of Head and Neck, Oral Oncology associate editor of Head and Neck Oncology and a reviewer for several scientific journals both national and international.
Prof. Pankaj Chaturvedi

MBBS, MS, FAIS, FICS, FACS, MNAMS - he is Professor and Head and Neck cancer Surgeon at Tata Memorial Hospital, Mumbai.

Prof. Chaturvedi did his medical schooling and post graduation in General Surgery at Banaras Hindu University. He was adjudged the best Intern and the best post graduate during his tenure in Banaras Hindu University. Later, he decided to work in field of surgical oncology and received his formal training at Tata Memorial Hospital, Mumbai. He has been invited as visiting faculty in 22 institutions in 18 countries. He is member of several prestigious national and international organizations and he is reviewer of several leading journals and he is the editor of the Textbook of Head and Neck Surgery. He is the Assistant Editor of the International Journal of Head and Neck surgery. He has authored 6 book chapters and 70 papers in international peer reviewed journals. He is Principal investigator of several clinical trials and his main area of interest is early detection of oral cancer. He is the recipient of the Robert Maxwell Byers award of the American Head and Neck society in year 2010. He was nominated as Council Member of the prestigious International Academy of Oral Oncology. He is one of the founding members of South Asian Federation of Oncology and in the steering committee of the Eurasian Head and Neck Oncology Society. He is the founder and treasurer of the Head Neck Cooperative Oncology Group. Prof. Chaturvedi has tremendous interest in Public Health issue especially related to Tobacco control. He was the coordinator of the Smoke free Mumbai campaign. He started the famous Voice of Tobacco Victims Campaign which has allowed the cancer victims to voice their opinion on the issue of tobacco control. This campaign was instrumental in ban on Gutka all over India and also increase in Tobacco Taxes. He received WHO Director General’s award in 2010 for this campaign. He represented India as Global Cancer Ambassador to New York to lobby with UN representatives for the special UN summit on Non Communicable diseases. He was awarded Outstanding Young Indian award for his public health initiatives. He was selected as a speaker on behalf of the Civil Society in UN Summit on Non Communicable diseases in New York on 19th September, 2011. He is also the recipient of the Judy Wilkenfield Award for excellence in Tobacco Control by Campaign for Tobacco Free Kids, Washington, USA.
Prof. Prathamesh S. Pai

MS(ENT), DNB, DORL, MNAMS

He is currently Professor and MCh (Head Neck Surgical Oncology) Teacher in the Department of Head & Neck Surgical Oncology at the Tata Memorial Hospital.

After having graduated from Grant Medical College, Mumbai and completing his post graduation in Otolaryngology Head Neck Surgery from Seth G S Medical College and KEM Hospital, Mumbai, he trained in Head & Neck Surgical Oncology at Tata Memorial for 3 years under tutelage of Prof. Sultan Pradhan. Thereafter in 2002 he received the prestigious UICC International Fellowship for training in Endoscopic Approaches to Sinonasal and Skull Base tumours, under Professor Dr. Wolfgang Draf, Fulda, Germany.

He also received the Hargobind Medical Fellowship in 2007 for training in Minimally Invasive Endoscopic Surgery of the Skull Base and Pituitary at the University of Pittsburgh, USA with Professors Amin Kassam, Ricardo Carrou and Carl Synderman.

His areas of special interests are Transoral Laser Microsurgery, Voice Conservative Laryngeal surgery, Skull Base surgery and Endoscopic Sinonasal & Anterior Skull Base tumour surgery.

He is convener of the Multidisciplinary Skull Base Clinic at the Tata Memorial Hospital.

He also is on the Tata Memorial Centre, Institutional Review Board and is a reviewer for several national and international journals.

He has published articles on Near-Total Laryngectomy, Transoral Laser Surgery for Early Glottic Cancers, Endoscopic Sinonasal surgery amongst 48 indexed publications.
Dr. Sharad Desai

Graduation - MBBS, Karnataka Medical College, Hubli 1990;
Post Grad - MS (Gen Surgery), Gujarat University, Ahmedabad, 1994;
Specialisation - MCh (Surgical Oncology), Gujarat university, Ahmedabad, 1997;
Cheif Deptt of Surgical Oncology, SSG Cancer Hospital, Miraj, 1998-2000;
Cheif Dept Surgical Oncology, Sushrut Hospital, Miraj, 2000-2004;
Cheif Surgeon and Director, Mahatma Gandhi Cancer Hospital, Miraj, 2004 -- present ;
Field of interest - Head and Neck Oncology, Esophageal Cancers;
Presentations in numerous National and Regional conferences and meetings;
Organising secretary- National Conference of the Indian Association of Surgical Oncology, 2012 ;
Secretary - Gokarma Oncology Association ;
Chairman -Mahatma Gandhi Cancer Charitable Trust;
Member - Association of Surgeons of India;
Member - Indian Association of Surgical Oncology;
Member - Federation of Head and Neck Organisations, India;

Mahatma Gandhi Cancer Hospital is a semi rural speciality hospital in the town of Miraj.
The hospital is a high volume center for Cancer treatment and teaching. The aim of the hospital is to achieve high survivorship at low cost
Mucosal Melanoma of the Head and Neck

Jesus E. Medina M.D.

Mucosal melanomas of the head and neck are rare cancers with a potentially grave prognosis. These tumors can be separated into two broad categories based on their initial anatomic location: sinonasal and oral cavity melanomas. Sinonasal melanomas are more common, representing approximately 60% of mucosal melanomas of the head and neck. In this presentation, the clinical characteristics and diagnostic evaluation of patients with mucosal melanomas of the head and neck will be discussed in detail. Surgery with curative intent is the mainstay of treatment of these tumors. Unfortunately, the prognosis has been generally poor with an overall 5-year survival of less than 20%. Thus, this presentation will describe the attempts aimed at improving patient survival, which have led to the performance of increasingly aggressive surgical procedures, such as craniofacial resections, and to the use of radiation therapy postoperatively and possibly targeted systemic therapy. Since the role of post-operative radiotherapy in these patients has not been fully elucidated, a meta-analysis of contemporary studies comparing outcomes of these two treatment strategies will be presented, as it may provide better evidence to guide treatment decisions and appropriate patient counseling. Also, since the use of targeted therapy is predicated on the basis of expression of specific markers, the author’s recent work to elucidate the expression of key markers will be presented.
Maxillectomy Bony Reconstruction—Current Approach

Amir Aharon, Matanes Issa, Vadim Reiser
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Backgrounds: Maxilla bone defects are classified by Cordeiro into 4 types. Defects graded 2-4 all comprise the lower 5 walls of the bone. The void is commonly filled with prosthesis that supports the soft tissue. Local flaps or free flaps are mainly used for complex cases involving large soft tissue defect or those requiring critical structures support, i.e., orbital floor and rim or cranial base.

Objectives: On the grounds of common practice using prosthesis reconstruction we have encountered patients asking for delayed reconstruction of the bony defect or resorting for a correction of secondary deformities.

Methods: We describe 15 patients treated for various maxillectomy defects. Four patients underwent delayed reconstruction. Only one local nasolabial flap was used to release lip contracture and other patients were treated with free flaps. Soft tissue flaps included Radial Forearm, Rectus Abdominis, Anterolateral Thigh. Bony reconstruction was approached with 2 Scapula flaps and 5 Fibula flaps. For one patient with bilateral maxillectomy a computerized model design was used for the resection and reconstruction.

Results: One scapula flap failed and was replaced with prosthesis. All patients were rehabilitated and completed adjuvant treatment as necessary.

Conclusions: Defects of the maxilla should be addressed primarily with autologous tissue and no defect left for secondary healing. Using soft tissue flap provides adequate support and promotes recovery but should be preserved for complex cases. Composite osseous flap is the preferred approach and should be considered the gold standard similar to mandibular reconstruction. Preoperative computerized modeling of the defect and flap shorten operation time and enable precise bony reconstruction.
Abstracts

Adjusting head & neck cancer treatment plan according to patient staging – Getting the reconstruction and prognosis into the equation

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Abstract:

When facing with advanced cancer patient especially in the head & neck region, the caring team must address patient status, regional metastasis, general health etc..

Extensive resection and time consuming microsurgical reconstruction can solve the surgical problem, but have a tremendous burden on the patient and not always improve quality of in his already short life span.

We suggest a simple algorithm taking into account, patient general status, disease staging and the nature of the necessary resection and reconstruction when planning the treatment. We present few demonstrative cases.

We believe that the recovery time from the operation and its relationship to the life expectancy is a crucial part of the algorithm.
Gross examination by the surgeon is an alternative to frozen section for assessment of adequacy of surgical margin in Head and Neck Squamous Cell Carcinoma

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Background:
Surgical margin (SM) status is an established prognostic factor. Intra-operative Frozen Section (FS) is utilized in nearly all head and neck squamous cell carcinoma (HNSCC) patients to assess the adequacy of the SM. The accuracy and cost effectiveness of the FS has been questioned by several authors. Moreover, FS facility is sparsely available in that part of the world that harbors largest burden of HNSCC.

Aim: We aimed to compare the efficacy of the gross assessment of margins utilizing a scale to the FS assessment for achievement of the adequate surgical margin.

Methodology:
We performed a prospective observational study in 141 consecutive patients undergoing surgery for HNSCC between August' 2011 to February' 2012. Following surgery, the margins were first assessed and documented by the surgeons with the help of a calibrated metallic scale. All these specimens were then examined using FS and subsequently studied in Permanent Section (PS).

Results:
This is a study of 565 mucosal margins and 104 soft tissue margins in consecutive 141 patients. While all margins were assessed by gross examination and PS, FS was done in 152 mucosal margins and 90 soft tissue margins. FS had 75% sensitivity / 100% specificity for mucosal margin and 95% sensitivity / 100% specificity for soft tissue margin. Surgeon’s gross examination of the mucosal
margin (with 7 mm as safe margin) had 89% sensitivity and 81% specificity. For assessment of the soft tissue margin, gross examination had 95% sensitivity and 100% specificity. Overall, 83% (55/66) inadequate margins were detected by FS and gross examination alone detected 91% (60/66) of these inadequate margins.

**Conclusion:**
Achievement of 7 mm surgical margin measured by a surgeon utilizing a scale obviates the need for FS. In a litigious society, this study offers good evidence to help surgeons avoid unnecessary FS and save exchequer’s money.
Abstracts

17beta-Estradiol Promotes Aggressive Laryngeal Cancer through Membrane-Associated Estrogen Receptor Alpha-36

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Background: Despite rising from a secondary sex organ and having a clear gender disposition, laryngeal cancer is not uniformly accepted as hormone-dependent. ERα36, a novel membrane receptor has been implicated as a substantial mediator of 17β-estradiol (E₂) proliferative and anti-apoptotic effects. Thus cancers previously regarded as hormone independent due to the absence of traditional receptors, may in fact be susceptible to E₂.

Objectives: Elucidate the role of E₂ in the tumorigenesis of laryngeal cancer, both in vitro and in vivo.

Methods: ERα36 presence was evaluated in membranes of the laryngeal carcinoma cell line (Hep2), using PCR, Western Blot and immunohistochemistry. Furthermore the effects of E₂ on proliferation and activation of anti-apoptotic and angiogenic pathways were assessed in vitro. Histological sections of laryngeal cancer samples were evaluated for the present of the ERα36 and VEGF and correlated to the tumor stage and metastasis.
**Results:** ERα36 was found to mediate rapid activation of protein kinase C and phospholipase D by E₂, leading to increased proliferation and protection against chemotherapy-induced apoptosis. Furthermore, in response to E₂ activation of ERα36, an upregulation of angiogenic and metastatic factors was observed. Clinical analysis of laryngeal tumors revealed a similar association between the amount of ERα36 and VEGF, and indicated a role in lymph node metastasis.

**Conclusions:** These findings present compelling evidence of ERα36-dependent E₂ signaling in laryngeal cancer. Targeting ERα36 may reduce the deleterious effects of E₂ in laryngeal cancer, suggesting a role for anti-estrogen therapy or the production of novel drugs that specifically target ERα36.
The role of Radionuclide Imaging in Evaluation of Thyroid Nodules with Indeterminate Cytology

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**Background:**
Thyroid lesions with indeterminate cytology represent about 15% of all thyroid biopsies with the risk of malignancy 15-30%. So the identification of low risk patients in this group is very important. Few studies evaluated thyroid Tc-99m MIBI scan as a tool for work-up of indeterminate cytology thyroid lesions. The negative predictive value of this test in excluding malignancy appears to be high (95%). But it is not used routinely.

**Objectives:**
This study evaluated the role of MIBI scan in the assessment of these lesions.

**Methods:**
Patients with indeterminate cytology and Tc-99m Pertechnetate thyroid scan-cold nodules were included in the study during the period of 01/2009 -08/2012 retrospectively. MIBI scan was offered to the patients who initially did not accept surgery as a treatment option.

**Results:**
20 patients were included in the analysis (3 men and 13 women, age:52±15 years, lesion size 21±8 mm). All patients had suspicion for follicular lesion cytology (Bethesda 3). Three patients (18.7%) had ‘cold’ lesions on MIBI scan and surveillance was offered. The follow up of 12-36 months showed no sonographic and clinical changes in these patients. Thirteen patients had ‘hot’ lesions. Nine patients (69%) were operated and 4(44%) of them had
malignancy (two papillary carcinoma, one follicular variant of papillary carcinoma and one follicular carcinoma). Four patients with ‘hot’ MIBI nodule refused operation and continued the follow up during 6-12 months with stable sonographic characteristics.

**Conclusions:**
In our small sample size experience, we were able to define a low risk of malignancy in 18.7% of the patients with MIBI scan assessment. This protocol helped to decrease unnecessary surgical intervention from 67 to 56%. Larger studies with longer follow-up are needed to validate the amount of ‘cold’ lesions in this unique subgroup and mainly the long term consequences of the patients with “active surveillance” policy.
Abstracts

Aggressive behavior of cutaneous squamous cell carcinoma in patients with chronic lymphocytic leukemia

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ABSTRACT

Background:
Immunosuppression in organ-transplant recipients increases the incidence and aggressiveness of cutaneous squamous cell carcinoma (cSCC). However there is little clinical data on cSCC in patients with immunosuppression due to chronic lymphocytic leukemia (CLL).

Objectives:
To describe the clinical features, patterns of failure and outcomes of cSCC in patients with CLL.
**Abstracts**

**Methods:**
A review was performed of 42 consecutive patients with cSCC and CLL presenting to our institution between July 2000 and July 2010. Baseline characteristics, treatment details and outcomes were analyzed.

**Results:**
Thirty-four patients presented with primary cSCC (33 node-negative, 1 node-positive) and 8 patients presented with nodal disease without a simultaneous index primary. The 2-year cumulative incidence of local failure for primary cSCC was 15%. Nodal failure occurred in 36% of node-negative patients. The 3-year overall and cause-specific survival rate for all patients was 37% and 65%, respectively. In patients managed curatively for nodal disease at presentation or relapse (n=17), the 3-year overall and cause-specific survival rate was 21% and 53%, respectively.

**Conclusion:**
Patients with cSCC and CLL experience higher rates of recurrence and death from cSCC than expected in an immunocompetent population. Novel strategies are needed to improve outcomes.
MANAGEMENT OF NECK IN THYROID CANCER

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The incidence of thyroid cancer has almost quadrupled in the last quarter of a century. The incidence of nodal metastasis is approximately 50-70% with patients with well differentiated thyroid cancer. However, interestingly, the biology of this tumor is such that nodal metastasis does not have major impact on the long-term outcome however it does have a concern in the form of recurrent neck disease and additional surgical intervention. Nodal metastasis does have some impact on the prognosis and recurrence in patients with larger tumors, multiple nodal metastasis, gross extranodal extension, older patients or with aggressive histology. These prognostic parameters are well understood and appropriate intervention should be considered based on this prognostic factors. The metastatic disease generally progresses in a sequential fashion with paratracheal, and tracheoesophageal groove nodes involvement initially and subsequently jugular lymph nodes. The patients presenting with lateral neck nodes are generally treated with modified neck dissection.

There continues to be considerable debate about extent of nodal dissection in patients presenting with lateral nodal dissection. A variety of procedures such as selective nodal dissection, modified neck dissection, compartment oriented neck dissection have been described. Radical neck dissection is rarely indicated in well differentiated thyroid cancer. The incidence of nodal metastasis at level I is quite rare and generally this region is not dissected unless there is gross disease present in submandibular area. The level IIB nodal metastasis is also quite rare and generally the accessory nerve is not dissected extensively. The most common procedure involves removal of lymph nodes from level II to level V with preservation of the sternomastoid muscle, jugular vein and accessory nerve. The major complications related to modified neck dissection include hematoma, extended chyle leak especially more common on the left side, shoulder weakness due to accessory nerve dissection and rarely Horner’s syndrome.
Locoregional recurrence of head and neck cancer is a devastating event, and presents a complex life threatening problem. These patients are heterogeneous and their care must be individualized. However, there are certain evidence based principles which can be applied to the management of these patients and this will be the central focus of this presentation.

While care must be individualized, the data would support that the optimal outcomes are achieved with multidisciplinary care. Specifically, surgical resection, full course radiation therapy, and chemotherapy, used together, seem to achieve the beset results. The challenge for the physician is to create this personalized treatment program in a cohort of patients who have had prior treatment, and to deliver this treatment with acceptable toxicity.

The approach for salvage therapy at Beth Israel Medical Center/Continuum Cancer Centers of New York will be presented in this lecture. We have combined major resection, high dose rate intraoperative radiation therapy, full flap reconstruction, and postoperative IMRT with chemo/biological therapy. Cases will be included to highlight the details of management, and the technique of intraoperative radiation therapy.
Abstracts

Recurrent Parathyroidectomies- Pearls and Pitfalls

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Parathyroid Re-exploration

Even with major nuances in surgery for parathyroid disease, we are still faced with a failure rate of 2-3% after initial surgery for hyperparathyroidism either from inability to identify an enlarged parathyroid gland in the neck or due to its abnormal location.
Such individuals will require intense localization studies followed by re-exploration and, in rare circumstances, mediastinal exploration. The main reasons for surgical re-exploration in parathyroid surgery are related to failed initial surgical procedure, development of recurrent hyperparathyroidism mainly related to multiglandular disease, or recurrence and spread of parathyroid carcinoma.
Treatment of the Neck in the Era of "Organ Preservation"

Jesus E. Medina M.D.

The treatment of advanced carcinomas of the larynx and pharynx has evolved from surgery and postoperative radiation to “organ preservation” strategies with various combinations of radiation and chemotherapy and more recently to tissue-sparing transoral endoscopic and robotic surgery. This has brought up several dilemmas in the management of the cervical lymph nodes, both electively and therapeutically.

The first dilemmas to be addressed in this presentation concern the timing and extent of elective node dissection, as well as the need to address the retropharyngeal lymph nodes, in patients with oropharyngeal tumors treated transorally with endoscopic or robotic assisted resection.

The second set of dilemmas concern the management of patients with clinically obvious lymph node metastases, particularly those with advanced neck disease (N2 – N3), who are initially treated with radiation with or without chemotherapy. Issues to be discussed are whether or not a planned neck dissection should be performed, irrespective of the response of the tumor in the neck, the timing of the decision to dissect the neck nodes and the role of CT and PET scanning in identifying the subset of patients who need a neck dissection and in the decisions about the extent of the node dissection.
Salvage Laryngectomy: Myths and Pitfalls

Jesus E. Medina M.D.

Most laryngectomies today are done for persistent or recurrent carcinoma of the larynx after organ preservation attempts using radiation therapy with and without chemotherapy. A number of myths and pitfalls exist regarding issues such as outcomes, management of the neck nodes, complications and rehabilitation in these patients.

The outcomes reported by RTOG (RTOG-911) for local regional control, survival and complications are encouraging. However, other recent publications have reported abysmal results. Therefore, in this presentation we will discuss outcomes from our institution and others in order to substantiate the expectations of patients and clinicians following salvage surgery.

Lymph node metastases appear to be an important consideration in patients undergoing salvage laryngectomy. However, the role of elective dissection of the neck in these patients is not well defined. Based on our experience and a review of the literature, elective neck dissection seems warranted in patients undergoing salvage laryngectomy.

In comparison to primary laryngectomy, the rate of pharyngo-cutaneous fistula after salvage laryngectomy is 5 times higher. These high rates have prompted surgeons to reinforce the pharyngeal closure with non-irradiated tissue, such as a pectoralis muscle, myocutaneous and free flaps. The outcomes of such efforts will be discussed.

Voice restoration is an important quality of life element in patients who undergo total laryngectomy and tracheoesophageal puncture currently is the preferred method for voice restoration in these patients.

It has been shown that a primary TEP is successful and safe and may, in fact, be preferable in patients in whom a total laryngectomy is performed as the initial treatment modality for larynx cancer. This presentation will address in detail the myths and pitfalls regarding the safety and efficacy of a primary TEP when a laryngectomy is performed as a salvage procedure.
Recurrent Thyroid Cancer

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The subject of recurrent thyroid cancer is an extremely important issue in view of reasons in the development of recurrence, appropriate evaluation of the extent of the disease, and definitive treatment and concerns about future recurrences which may be life threatening.

The recurrent thyroid cancer can be divided into local recurrence in the thyroid bed as a result of initial presentation of advanced and aggressive thyroid cancer. Nodal recurrence which is fairly common in well differentiated thyroid cancer and distant metastasis occur between 5-10% of the individuals. Most of the distant recurrences occur either in the lungs or in the bones, rarely brain. The mainstay of treatment in distant metastasis continues to be radioactive iodine ablation and recently with targeted therapies. Several drugs have been employed with variable results however satisfactory rate of stabilization of distant metastasis.

The major reason behind local recurrence in the thyroid bed is initial presentation of advanced thyroid cancer involving the surrounding soft tissues such as strap muscles, recurrent laryngeal nerve, and central compartment of the neck with involvement of the tracheal wall or tracheal lumen and esophageal musculature. The esophageal lumen is rarely involved in locally aggressive thyroid cancer.

However, tracheal involvement can be divided in four different stages as described by Grillo where the tumor may be adherent to the tracheal wall, involving minimally the tracheal cartilage, or submucosal extension of the disease or frank intraluminal disease. In advance stage of tracheal involvement sleeve resection is appropriate.

The decisions about the management of the recurrent laryngeal nerve in patients with well differentiated thyroid carcinoma are quite complex and appropriate surgical intervention should be undertaken to remove all gross tumor.
Occasionally, in young individuals the nerve could be spared with a microscopic disease left on the nerve to be treated with radioactive iodine which appears to be quite satisfactory however in elderly individuals with aggressive thyroid cancer or aggressive histology appropriate surgical resection of the nerve if the tumor is encircling the nerve should be considered. Any residual tumor with aggressive histology may develop future recurrences which can be life threatening. The decisions about nodal recurrence are also quite complex since the majority of the nodal recurrences now are detected by thyroglobulin levels and ultrasound of the neck. Ultrasound is able to document even sub centimeter nodal metastases which probably has very little impact in the long-term outcome. However, patients presenting with a suspicious lymph node below 1cm may be considered observation and follow-up and consider intervention only if there is a progression of the disease. Patient’s initially presenting with multiple nodal metastasis may remain persistent with mild hyper thyroglobulinemia where the recurrent disease may be difficult to identify unless the nodal recurrence is larger than 1cm.

Such patients should be observed carefully and closely for any progression of the disease and intervention undertaken only if the disease is imminently likely to involve vital structures or there is a clear cut progression of the nodal metastasis.

Thyroid cancer continues to be a continuum of diseases starting from well differentiated thyroid carcinoma to anaplastic thyroid carcinoma with progression of the disease from tall cell, insular to poorly differentiated thyroid carcinoma. Understanding the histology is extremely critical and dividing our patients into low, intermediate and high risk is also very important. The patients in the high risk group are more likely to develop future recurrences local, nodal or distant metastasis. These individuals require close follow-up and thoughtful evaluation based on the biology of the disease. Recurrent thyroid cancer continues to be a challenge to the endocrinologist, radiation therapist, medical oncologist and the operating surgeon. Occasionally, certain individuals with recurrent thyroid cancer and aggressive histology may be benefited with external radiation therapy. The role of external radiation therapy is important to reduce the incidence of local recurrence however unlikely to cure most of these individuals.
Robotic thyroid surgery by transaxillary approach. Technical tips.

Dr P. Aïdan, Dr G. Boccara, Dr N. Beressi, Dr H. Monpeyssen.

Transaxillary gasless robotic thyroid surgery has been proposed as an alternative to open or endoscopic methods and its efficacy and safety have been reported. We describe in detail the fundamental surgical techniques relevant to this procedure and provide tips as to patient selection and technique modifications to ensure successful outcomes. The technique’s efficacy, benefits and limitations are discussed, along with modifications to the approach for different populations, referenced to surgical experience at the authors clinical centre.
New Approaches to Management of Metastatic Cancer to the Neck with Unknown Primary

Louis B. Harrison, MD, FASTRO

The management of patients with cancer metastatic to the neck with unknown primary site has evolved significantly over the past few decades. The historical approach has involved neck surgery followed by radiation therapy. The historical radiation therapy approach has prioritized radiation to the bilateral necks as well as the entire pharyngeal axis including the nasopharynx, oropharynx, larynx and hypopharynx. While oncologically effective, this is a very morbid treatment. Developments in diagnostic evaluation have allowed oncologists to tailor treatment into a more rational and less toxic approach. This presentation will provide an overview for the historical evolution, and present the experience at Beth Israel Medical Center – Continuum Cancer Centers of New York.

We have prospectively adopted an approach that restricts the radiation therapy to the necks and the oropharynx alone. This is combined with chemotherapy and surgery in prospectively selected cases. The algorithm of care, the outcomes, plus the current literature in other major centers will be presented. This data was most recently presented at ASTRO 2012.*

Abstracts

Outcome of Multiple Direct Laryngoscopies in patient with Precancerous Lesions

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Introduction:

The course and the most appropriate management of precancerous lesions of the larynx continue to be controversial. Some patients have recurrent laryngeal leukoplakia and require multiple direct laryngoscopic evaluation and biopsies over the follow up years. This group of patients has the potential to develop malignant lesions. The purpose of this study was to describe a series of patients with recurrent precancerous lesions of the vocal cords and to estimate the rate of malignant transformation.

Material and Methods:

We conducted a retrospective cohort study, including 50 patients who underwent 216 recurrent direct microlaryngoscopic procedures and biopsies from 1999 to 2012 at Assaf Harofeh Medical Center. We examined patient’s clinical data, histological diagnosis and risk factors for malignant transformation. The follow up period ranged from 6 months to 16 years (mean 4.4 years), an average of 3.6 procedures per patient were done in this period with a range of 2 to 11 procedures per patient.

Results:

Eleven patients (22%), all males except one, developed invasive cancer. six were initially diagnosed with mild dysplasia, one with moderate dysplasia, three with high grade dysplasia and one with no dysplasia.

Conclusion:

No correlation was found between the dysplastic grade and malignant transformation. Therefore we recommend extensive excision in all dysplastic lesions as well close follow up as a safe strategy for management of these lesions.
Abstracts

Laryngeal Suspension - Treatment of Post operative dysphagia

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Abstract

Resection of the some regions of the oral cavity and the oropharynx disconnect the Laryngopharyngeal apparatus from the oropharynx leading to dysphagia. We studied a innovative procedure to stabilise the larynx from the zygomatic arch. Totally 8 cases were studied. Technique was extremely simple and with low costs. Results found excellent improvement in voice quality, dysphagia and overall general health. 4 cases were treated prophylactically. These patients showed still better results. We advocate this procedure in major resections of the base tongue, oropharynx, and the central arch mandible especially if a bone reconstruction is unavailable.

Key words - laryngeal suspension, postoperative dysphagia.
Natural history of Small Bone Metastases seen on Postradioiodine Ablation and have no structural correlate on imaging studies

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Background: Bone metastases from differentiated thyroid cancer are generally resistant to commonly used activities of radioiodine (RAI) and are associated with poor prognosis. However, in a recent study from our group we noted a small subgroup of patients with RAI-avid bone metastases who had no structural correlate on imaging studies, and had no skeletal complications during follow-up. The goal of the current study was to describe the characteristics and the natural course of this subgroup of patients.

Patients and Methods: In a retrospective review of medical records at Memorial Sloan-Kettering Cancer Center 288 patients were identified with bone metastases from thyroid cancer between 1960 and 2011. Out of this group, 14 patients who had a RAI-avid bone metastasis with no structural correlate on CT or MRI were included in the study. Eighty six percent of patients had papillary thyroid carcinoma (11 patients), one had Follicular carcinoma, and 2 patients had Hurtle cell carcinoma.

Results: After a median follow-up period of 5 years (range 2-14 years) all patients were alive, none had evidence of structural bone metastases, and none had experienced skeletal related events. The final disease status was defined as NED in 5 patients (36%), stable biochemical persistence in 2 patients (14%), stable structural persistence (in the neck and/or lungs) in 6 patients (43%), and one patient with Hurtle cell carcinoma had slowly progressive pulmonary nodules over a follow-up period of 10 years.

Conclusion: RAI-avid bone metastases with no structural correlate on high resolution imaging studies often resolve following RAI treatment, do not cause skeletal related complications, and do not significantly affect prognosis. Recognition of this unusual type of bone metastases is important as it may prevent overtreatment, and allow a less aggressive approach to long term surveillance.
Abstracts

Endoscopic 3-Surgeon Parathyroidectomy

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Background:
A comprehensive 4-gland parathyroid exploration has traditionally been the standard procedure for primary hyperparathyroidism. In the past couple of decades minimally invasive parathyroidectomy has become the vogue. This is a broad title encompassing many different techniques, all via small incisions, all of which have several advantages, such as smaller incision, shorter operating room time, option of operating under local anesthesia, and perhaps also reduced risk of recurrent laryngeal nerve damage. This technique is not appropriate for all patients, and the patients referred to this operation have to be carefully selected after localization of the pathological gland.

Objectives:
We present our method and results using a 45 degree endoscope and a 3-surgeon approach. Tactics, including application of lateral and central incisions, are depicted. Relevance of supportive pre and intra-operative laboratory data is discussed. We feel our modus operandi provides full field exposure to the entire team affording a "safe and sound" procedure.

Methods:
Retrospective analysis of 50 consecutive endoscopic parathyroidectomies between the years 2009-2013.

Results:
Out of 50 endoscopic parathyroidectomies, 1 patient had a double adenoma (on lithium treatment), 2 patients had an intra-thyroidal parathyroid gland, and none had 4-gland hyperplasia. No patient suffered from permanent recurrent laryngeal nerve paralysis although 2 patients had a transient paresis. In addition, although revision surgery is a relative contraindication for minimally invasive procedures, we have had occasional success.

Conclusions:
The endoscopic 3-surgeon approach is a safe and efficient technique for a minimally invasive parathyroidectomy.
Pharyngocutaneous Fistula Following Total Laryngectomy; Identifying Risk Factors and Reducing Morbidity

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Abstract

Background: Pharyngocutaneous fistula (PCF) following Total Laryngectomy (TL) is a complication associated with considerable morbidity and adversely affecting patient's quality of life.

Objective: To review our experience and further clarify the clinical course and risk factors leading to the formation of a PCF following TL in patients with laryngeal cancer.

Methods: A retrospective analysis of all patients who underwent TL at a university-affiliated tertiary care medical center between 2006 and 2010 was performed. Data on demographics, risk factors, site and extent of disease, treatment, complications and outcome were collected and analyzed. Patients with insufficient data and/or follow-up of less than 2 years were excluded from the study.

Results: A total of 66 patients were eligible for the study. Mean age was 63 years (range, 40-87 years). There were 58 men (87.8%) and 8 women. The majority of patients (46 patients) underwent salvage laryngectomy due to failure of radiotherapy/chemoradiotherapy (RT/CRT) and the remaining 20 patients underwent TL as the primary treatment. Following TL 18 patients (27.7%) developed PCF. The only factor found to increase the risk of PCF was prior RT/CRT (p=0.008).

Pectoralis Major Myocutaneous Flap (PMMF) was used in 20 patients (30.3%) during TL. The use of PMMF did not reduce the risk for the development of a PCF, neither in general and nor in the RT/CRT group (p>0.23).

Conclusions: Salvage laryngectomy following RT/CRT carries an increased risk for the development of a PCF and its associated morbidity. The use of a PMMF did not prevent the formation of PCF.
Abstracts

Smoking habits among Israeli hospital doctors: a survey and historical review

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Abstract

**Background:** Smoking is a serious health issue worldwide and a major risk factor for head and neck squamous cell carcinoma. Smoking trends among physicians predict similar trends in the general population. Little is known about current smoking rates among physicians.

**Objectives:** To investigate current smoking trends among Israeli physicians.

**Methods:** All practicing physicians at a tertiary university-affiliated medical center in central Israel were invited to complete a Web-based questionnaire on smoking habits and smoking-related issues via the institutional email. Findings were compared to those in the general population and between subgroups.

**Results:** Of the 90 responders (53 male, 88 Jewish), 54 (60%) had never smoked, 21 (23.3%) were past smokers, and 15 (16.7%) were current smokers. The rate of current smokers was lower than in the general population. The proportion of current smokers was higher among residents than attending physicians and among physicians in surgical than medical specialties. Among otolaryngologists, the rate of smoking was 27.3% (3/11). Past smokers accounted for 17.9% of the residents (average age at quitting 26.2 years) and 28.1% of the attending physicians (average age at quitting 33.0 years). Non-smokers more frequently supported harsh anti-smoking legislation.

**Conclusions:** The rate of smoking is lower in physicians than in the general population but has not changed over the last 15 years. Anti-smoking programs should particularly target physicians in surgical specialties.
Head and neck squamous cell carcinomas represent a diverse group of cancer, which are frequently aggressive in nature. It is one of the most common cancer in India and most patients present with advance disease. Patients with advanced HNSCCs have a very poor long term survival, not only because of metastatic disease but also because of loco-regional failure. The pattern of failure depends upon host factors, tumor factors as well as treatment factors. Among the tumor factors most important prognostic factor is cervical lymph node metastasis followed by T status. According to several studies, lymph node metastasis with extra nodal spread (ENS) is associated with a decrease in survival ranging between 29% and 60%, and increase in neck recurrence. The traditional treatment for advanced HNSCC is surgery and adjuvant radiotherapy. A number of studies suggest, use of postoperative chemoradiotherapy, instead of post operative radiotherapy, significantly increases loco regional control (LRC) rate and as well as disease free survival (DFS). But no statistically significant difference was observed in case of distant metastases and overall survival. The widespread use of high precision radiotherapy like IMRT, 3DCRT may also change the failure pattern. Though there is sharp dose falloff and steep dose gradients inherent in high-precision radio therapeutic techniques, almost all studies suggests that ‘in-field failure’ is more common with high precision radiotherapy than ‘marginal failure’. A meta analysis to compare the effect of altered fractionation radiotherapy with conventional radiotherapy suggests that there was significant increase in local and regional control with altered fractionations, and overall survival was highest with hyper-fractionation arm. With the increased use of neo-adjuvant therapy for advanced squamous cell carcinoma of the head and neck, it has been observed that pattern of failure has changed from predominantly loco-regional sites to distant metastasis.
Abstracts

Paradigm Shift in the Management of Sinonasal Tumours

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Surgery forms the mainstay of treatment of sinonasal tumours. However, surgical morbidity and low cure rates are perturbing while treating these tumours. Being rare tumours with innumerable histologies, it has taken a while to understand their individual biology. Nasoethmoid tumours have now been shown to have predominantly non-squamous histology with better prognosis.

Transnasal surgery which is a natural orifice surgery has been part of the otolaryngologists’ repertoire in dealing with trauma, infection and cosmesis for more than a century. It was thus a natural evolution for the use of this trajectory in removal of sinonasal and anterior skull base tumours. Endoscopic technology and instrumentation with better ergonomics and visualisation permit endonasal surgery to be minimal in access but as extensive as conventional surgery. Reduced morbidity and improved quality of life make this approach an important and elegant addition to our armamentarium. Large series from across the globe as well as our own series from Tata Memorial Hospital have shown similar if not better control rates when compared to conventional surgery demonstrating the oncologic safety of the endoscopic procedure.

While endoscopic endonasal surgery is fascinating in its simplicity, we have to be judicious in applying this approach for malignant tumours focusing on maintenance of oncologic safety. Extensive surgical training, respect for tumour biology, modular resection and standardised reporting will go a long way in incorporating endoscopic endonasal surgery as standard of care for sinonasal tumours.
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