2026

DEBATES AND DIDACTICS in Hematology and Oncology

EMORY WINSHIP CANCER INSTITUTE
National Cancer Institute-Designated Comprehensive Cancer Center

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Patient-based Panel Discussion: H&N Cancer

All Speakers: Drs. Saba, Kaka, Baliga

Case presented by Tyler Kristoff, MD

Case Presentation

Clinical Presentation

A 58-year-old man with a 40-pack-year smoking history and moderate alcohol use presents with a 3-month history of a painful, non-healing ulcerative lesion on the right lateral tongue extending to the floor of mouth. He reports progressive difficulty with speech and oral intake, and a 10-pound unintentional weight loss. He has no significant past medical history and an ECOG of 0.

Examination and Initial Workup

- Oral exam: 4.5 cm ulcerated, indurated mass of the right lateral tongue crossing midline, extending to the floor of mouth. Depth of invasion estimated at 15 mm on palpation.
- MRI face/neck: 4.6 × 3.2 cm mass of the right oral tongue with invasion into the floor of mouth musculature. Depth of invasion 16 mm. Two pathologically enlarged right level II nodes (2.6 cm and 1.8 cm) and one right level III node (1.5 cm), all with central necrosis.
- CT chest: No evidence of distant metastatic disease.
- PET/CT: FDG-avid primary (SUVmax 18.2) and right cervical nodes (SUVmax 12.4, 9.1, 7.3). No distant disease.
- Biopsy: Moderately differentiated squamous cell carcinoma, p16-negative.
- PD-L1 CPS: 45

Clinical Staging: cT4aN2b

Treatment

Treatment Decision

- He receives 2 cycles of neoadjuvant pembrolizumab 200 mg IV every 3 weeks.

Response Assessment After Neoadjuvant Therapy

- Restaging MRI (6 weeks after cycle 1): The primary mass has decreased to 1.8 × 1.2 cm. The level II and III nodes have decreased to 1.0 cm, 0.8 cm, and 0.6 cm, respectively.
- PET/CT: Marked reduction in FDG avidity at the primary site (SUVmax 3.1) and cervical nodes (SUVmax 2.4).
- No immune-related adverse events during neoadjuvant therapy.

Surgical Procedure

- The patient undergoes composite resection including right partial glossectomy, floor of mouth resection, right marginal mandibulectomy, and right modified radical neck dissection (levels I–V) with radial forearm free flap reconstruction

Surgical Pathology

- Primary site: No residual viable tumor identified. Treatment bed shows extensive fibrosis, chronic inflammation, foamy histiocytes, and cholesterol clefts consistent with complete treatment effect.
- Neck dissection: 0/42 lymph nodes with residual carcinoma. Three nodes show treatment effect (fibrosis, giant cell reaction) without viable tumor.
- Pathologic staging: ypT0N0 — Pathologic complete response (pCR).
- No lymphovascular invasion, no perineural invasion, no extranodal extension.

Discussion

Given the complete pathologic response, is there a role for omitting adjuvant radiation entirely and continuing adjuvant pembrolizumab monotherapy?

Is there a role for omitting or reducing the duration of adjuvant pembrolizumab?

Does the patients CPS value (45) play a role in your decision?

Are there additional biomarkers (e.g., tumor mutational burden, interferon-gamma gene expression profile, ctDNA) that could further refine adjuvant treatment decisions in a patient with pCR?

Could the surgical approach have been de-escalated based on the neoadjuvant response?

Q&A