Case Study	**Complete Reversal of Stage IV Squamous Cell Carcinoma**	
Background	See screenshot of journal article Abstract.	
Case presentation	71yo male.	
Investigations	CT, 12/08/2009. Punch biopsy, Histopathology, 12/08/2009. Serum biochemistry, 12/08/2009. Fused MR/PET, 19/08/2009. Physical exam, 08/09/2009. Repeat staging CT, 04/02/2010. Physical exam, 31/03/2010. Serum biochemistry, 19/05/10. CT, 08/09/2010. Serum biochemistry, 14/07/10.	
Differential diagnosis	Moderately differentiated squamous cell carcinoma (SCC), CT, 12/08/2009; punch biopsy, Histopathology, 12/08/2009. T4N0M1 SCC, 5cm sagittal, PET FDG uptake, 08/09/2009, reported in slide 8. Chemo-resistant SCC, 10/02/2010. Stage IV SCC, T4N0M1, lung metastases progressive disease post chemotherapy, 31/03/10.	
Treatment	5 cycles Carboplatin/5FU Palliative radiotherapy, prior to 26/05/2010, date? Begin ECRL investigations and treatment, 26/05/2010.	
Outcome and follow-up	Patient declined palliative radiotherapy, February 2010. Patient declined palliative radiotherapy, 31/03/2010. 21/04/2010, rapid tumour progression reported. 50% reduction in size of SCC, photographs, 08/06/2010. 75% reduction in size of SCC, photographs, 22/06/2010. 85% reduction in size of SCC, photographs, 06/07/2010. Primary site SCC: no definite mass seen, destructive mandibular lesion, CT, 08/09/2010. 100% reduction in size of SCC, photograph, 21/09/2010. Deceased ~18 months after 21/09/2010.	

Current Issue
Editorial
- What is science, anyway?
Article
- Matter is not made out of matter
Research
- Extended Ultra-Low DC via Acupuncture Point Normalizes Hepatic Neoplasms
Musings

Richard Malter
James Woessner
Alan Loader
Helen Tyrrell

Complete Reversal of Stage IV Squamous Cell Carcinoma

Background

A 71 year old male was diagnosed by a multidisciplinary oncological and radiological team as having a stage IV squamous cell carcinoma (SCC) of the floor of the mouth measuring 5cm maximal sagittal diameter filling the whole area long the teeth. Diagnosis was confirmed by PET and CT scans and histological analysis from a punch biopsy. Symptoms were bleeding from the tumour, dysarthria, difficulty eating, severe weight loss, and lethargy. The patient was informed that his cancer was incurable, but treatment might prolong his life. Treatment of five cycles of Carboplatin and 5FU was given, but after initial positive response the tumour was chemo-resistant and increased in size. Second line chemotherapy and radiotherapy were then recommended for palliative symptomatic benefit only not survival, but were declined by the patient who decided to discontinue all standard oncological examination and treatment and seek alternative treatment. The patient was assessed and treated using the Bi-Digital O-Ring Test (OMURA Y, 1977-2010; BDORT) electromagnetic field (EMF) resonance technique between two identical substances. Biochemical parameters, non-organic toxins and presence of viral infection that always exist in a malignant tumour have previously repeatedly been identified and confirmed by BDORT research [1,2]. A large amount of HBV surface antigen was detected by BDORT in the mouth SCC. Because of this finding, the liver was examined and a large HBV infection was found by BDORT measurement on the visceral surface of the organ.

Journal of the Science Healing Outcomes

Radiology

#1. 1/2

Patient :

12 Aug 2009

CT NECK, CHEST, ABDOMEN AND PELVIS

Clinical notes:
Large mass floor of mouth, ? SCC.

Technique:
Oral and intravenous contrast enhanced examination.

Findings:
There is a large ill–defined heterogenous lobulated soft tissue mass seen in the floor of the mouth which appears to be arising from the left side. It measures up to 5cm in maximal sagittal diameter. It is not possible to obtain an accurate axial diameter as it is ill–defined. It involves the deep tissues of the floor of the mouth extending up to and possibly invading the platysma. Given it's location and appearance it may be a mass arising from the left sublingual gland and may represent a SCC though histological diagnosis is beyond the scope of CT.

There are no definite enlarged lymph nodes seen in the neck. No other soft tissue mass.

In the chest, there is no mediastinal or hilar lymph node enlargement. No pleural or pericardial effusion.
An 11mm sub pleural soft tissue nodule is seen in the right middle lobe anteriorly. A similar sized sub pleural soft tissue nodule is seen posterolaterally in the sub pleural space of the left lower lobe. A 6mm nodule is seen in the right lower lobe.

In the abdomen and pelvis, a 12mm hypodense area is seen in segment 2 of the liver. This is likely to be a cyst but this should be confirmed with ultrasound. The liver has an otherwise normal appearance. The kidneys, adrenal glands, pancreas and spleen have a normal appearance. No para–aortic or pelvic lymph node enlargement. No ascites. The bowel has a grossly normal CT appearances.

There is a 1.8cm sclerotic area in the left ilium adjacent to the left sacroiliac joint. No other focal bony lesion demonstrated.

Conclusion:

Large mass in the floor of the mouth which appears to be left sided and may be centered upon the left sublingual salivary gland. It's appearance are in keeping with an SCC. No

continued ...

Collected: 12/08/2009 - 12:00 AM **Notified by:** on 00/00/00
Reported: 12/08/2009 **Message:**

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HISTOPATHOLOGY REPORT

#2. 1/1

CLINICAL NOTES:
Fungating tumour floor of mouth - punch biopsy.

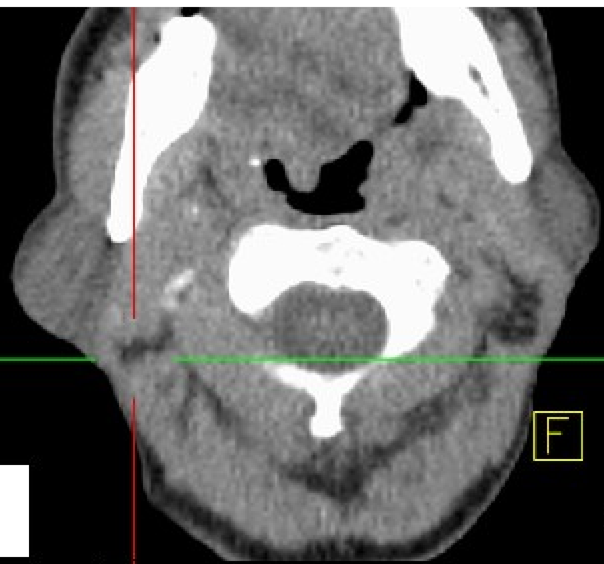
SPECIMEN:
Floor of mouth: A punch biopsy 2mm in diameter and 3mm in length. All processed. One block. (SNM/rs/

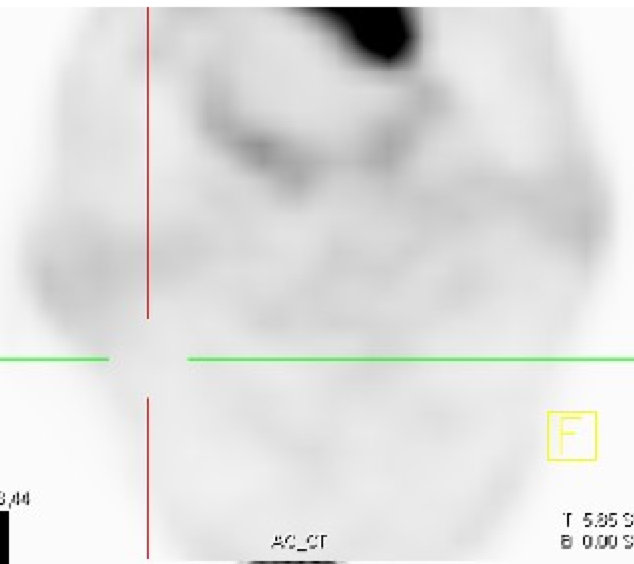
MICROSCOPY: Section shows squamous mucosa with invasive islands of moderately atypical squamous epithelium which infiltrate into the underlying connective tissue. The lesion extends to the base of the specimen.

CONCLUSION: Floor of mouth: Moderately differentiated squamous cell carcinoma.

PET^PMCC_SWB (Adult)
TrueD Save Screens
Se: 19/08/2009 13:55:11

968x968
Zoom: 294 %
Compression: 1:1 (lossless)
W: 259 L: 128

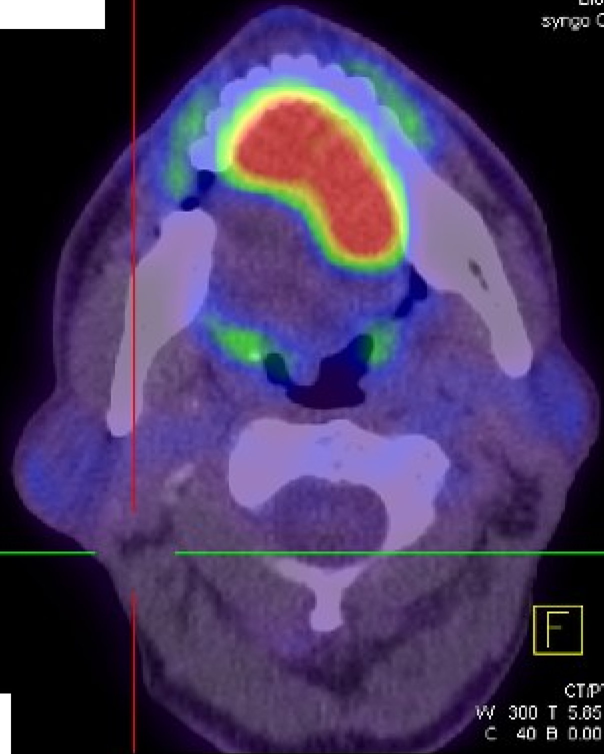




19/08/2009
12:53:01 PM

FUSED MPR

Baseline



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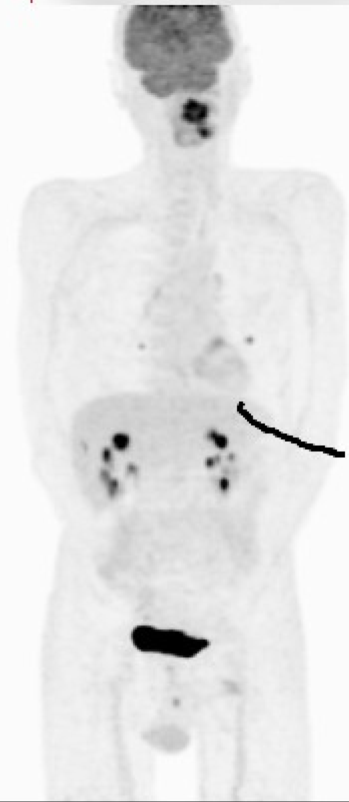
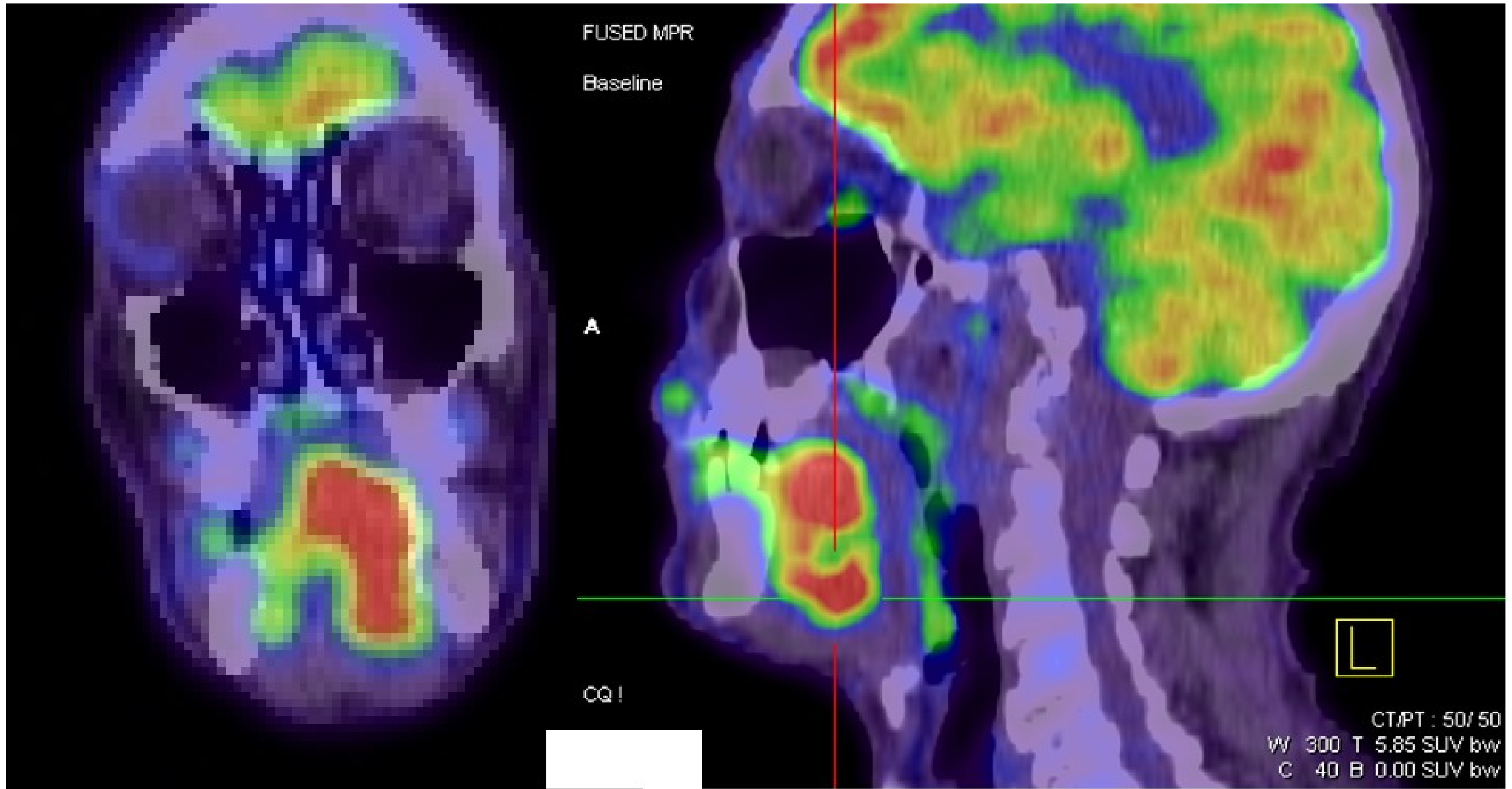


AUGUST 19 2009



AUGUST 19 2009

#3. 1/1

Collected: 12/08/2009 - 10:00 AM   Notified by: on 00/00/00
Reported: 12/08/2009   Message:

SERUM BIOCHEMISTRY

Test		Result	Unit	Ref.Range	
Sodium	:	138	mmol/L	(136-146)	
Potassium	:	4.6	mmol/L	(3.5-5.0)	
Chloride	:	100	mmol/L	(95-110)	
Bicarbonate	:	28	mmol/L	(22-31)	
Urea	:	2.3	mmol/L	(3.0-10.0)	**
Estimated GFR	:	> 90	mL/min	(> 60)	
Creatinine	:	58	umol/L	(60-110)	*
Total Bilirubin	:	7	umol/L	(< 20)	
Ala. Aminotransferase (ALT)	:	18	U/L	(< 35)	
Asp. Aminotransferase (AST)	:	20	U/L	(< 35)	
Alkaline Phosphatase (ALP)	:	54	U/L	(35-110)	
Gamma Glutamyl Trans. (GGT)	:	13	U/L	(< 50)	
Total Protein	:	83	g/L	(60-85)	
Albumin	:	44	g/L	(36-48)	
Globulin	:	39	g/L	(22-38)	*
Calcium	:	2.51	mmol/L	(2.15-2.65)	
Cor. Calcium	:	2.43	mmol/L	(2.15-2.65)	
Phosphate	:	1.0	mmol/L	(0.8-1.4)	

Liver Function Test normal

Collected: 12/08/2009 - 12:08 PM   Notified by: on 00/00/00
Reported: 12/08/2009   Message:

#4. 1/2

08/09/2009 (typed: 09/09/2009)

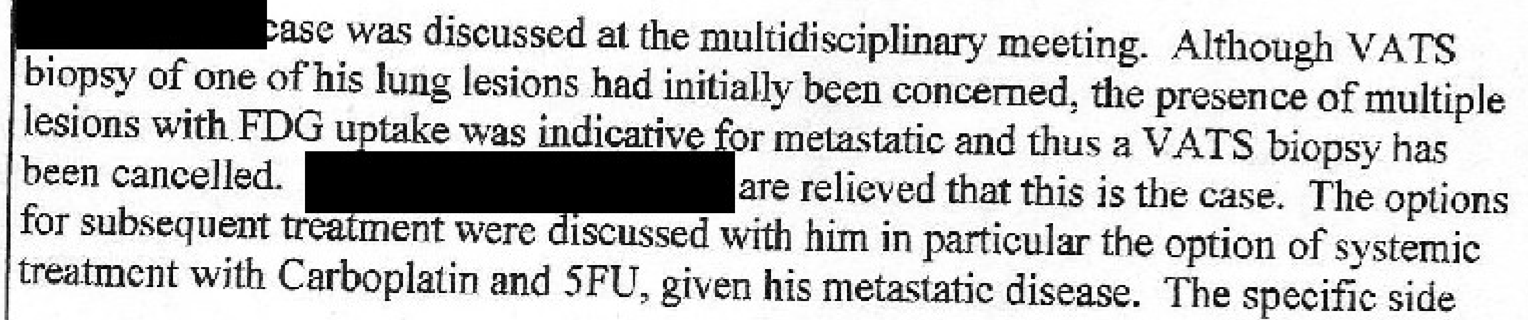
Re:

was reviewed in the Head & Neck clinic today. He is year old gentleman with a T4N0M1 moderately differentiated squamous cell carcinoma of the floor of mouth with lung metastases. He initially presented with a self detected lump and some associated discomfort under his tongue. He was investigated for this with a biopsy which revealed squamous cell carcinoma. Further investigations revealed a 5cm tumour in the floor of mouth. Staging investigations revealed bilateral pulmonary lesions. A subsequent PET scan demonstrated FDG uptake within the left side of the floor of mouth consistent with his known primary as well as two subpleural nodules; one in the left lobe and a second in the right middle lobe with increased FDG uptake as well as a further smaller 5mm nodule in the right lower lobe posteriorly consistent with multifocal pulmonary metastases.

He has lost approximately 5-6 kilograms in weight and has some dysarthria and a little bit of bleeding from the lesion in the floor of mouth. He does not have any pulmonary symptoms. His ECOG performance status is 1.

He has no significant past medical history of note. He is not on any medications. He

Physical examination revealed a large tumour in the floor of mouth. There is no palpable cervical lymphadenopathy. Cardiovascular and respiratory examinations were within normal limits.



case was discussed at the multidisciplinary meeting. Although VATS biopsy of one of his lung lesions had initially been concerned, the presence of multiple lesions with FDG uptake was indicative for metastatic and thus a VATS biopsy has been cancelled. are relieved that this is the case. The options for subsequent treatment were discussed with him in particular the option of systemic treatment with Carboplatin and 5FU, given his metastatic disease. The specific side

#5. 1/2

10/02/2010 (typed: 11/02/2010)

RE:

DIAGNOSIS: Stage IV squamous cell carcinoma of the floor of mouth with known lung metastases which has proved chemo-resistant to the Carboplatin and 5FU.

Thank you very much for your referral of to our radiation oncology clinic. I had the pleasure of reviewing him today. As you know, has an extensive SCC of the floor of his mouth which I understand initially had good response to chemotherapy but has now proved to be chemo-resistant.

His repeat staging CT scan performed on 4/2/10 showed progression of one of his lung nodules but no other metastatic disease.

I reviewed him with Dr [redacted] and we believe that palliative radiotherapy would be a reasonable next step for [redacted] in consideration of his progressive symptomatology. We intend to treat him with a regime of 36/12/5 to the floor of his mouth. We discussed this treatment in detail with [redacted] today explaining the purpose of the treatment as for symptomatic relief rather than cure and he understood this. We also discussed the possible side effects of the treatment in detail and we were able to allay some of his concerns regarding this. He agreed to have his simulation today and I understand he is seeing you later this afternoon for further discussion regarding his ongoing treatment.

Naturally, we will keep you informed of his progress throughout treatment.

Many thanks.

Yours sincerely,

#5. 2/2

31/03/2010

Dear

Diagnosis: *Stage IV SCC of the floor of mouth (T4 N0 M1) with lung metastases, progressive disease after 5 cycles of Carboplatin/5FU*
Patient declined palliative radiotherapy

Management: *Review in 2 months*

#6. 1/2

Management: *Review in 2 months*

was reviewed in our Medical Oncology Clinic on the 31st of March. As you know, he declined radiotherapy in the end and decided to go onto a cleansing diet and then high dose Vitamin C tablets. tells me he would like to increase the dose of Vitamin C but is unable to take this orally and he has therefore been in touch with you about some Vitamin D injections. At this point in time he is not interested in trying any chemotherapy nor radiotherapy, and I have to say treatment options are limited and mainly for symptom benefit.

Physical examination revealed no peripheral lymphadenopathy, the tumour underneath the tongue is now filling the whole area along the teeth, it is quite irregular and dark, the remaining examination was unremarkable apart from having lost further weight.

We will see again in 2 months.

#6. 2/2

Yours sincerely

21/04/2010

#7. 1/2

Diagnosis: *Stage 4 SCC of floor of mouth with lung metastases, progressive disease of the primary after 5 cycles of Carboplatin/5FU*
Patient declined palliative radiotherapy in February 2010

#7. 2/2

Thank you for seeing [redacted] as discussed earlier on the phone today with regards to radiotherapy. As you know, he cancelled very last minute when everything was lined up for him in February of this year but since then the tumour has progressed quite rapidly and [redacted] can see the need for local treatment. As explained to him, I would like to keep chemotherapy for later on if we have to treat either a local recurrence once more or if his metastatic disease becomes bothersome. [redacted] now has increasing problems with eating and speaking. He is very well aware of his limited options and will need just a bit of gentle encouragement to overcome his fear of radiotherapy and the side effects, which have been painted in dramatic ways in the past to him.

Thank you again for seeing him, a tentative review appointment with me has been booked for the end of May.

Yours sincerely

#8. 1/1

dorevitch Pathology

Pathology Report

UR No: NA

Dr Ref:

Patient:

Address:

Postcode:

DoB:

Gender: M Age: Years

Tests Requested: FBE,CRP

* = Tests Outstanding

Receipt date: 19/05/10

Collected: 19/05/10 @ 09:00

Printed: 20/05/10 @ 10:00

Doctor:

HAEM

					Units	Ref.Range
Coll.Date:	12/08/09	19/05/10				
Coll.Time:	10:00	09:00				
Haemoglobin:	14.7	9.3	--	--	g/dL	(13.0-18.0)
WCC:	7.7	8.8	--	--	$x10^9/L$	(4.0-11.0)
Platelets:	307	611	--	--	$x10^9/L$	(150-450)
PCV:	43.5	29.9	--	--	%	(40.0-54.0)
RCC:	4.58	3.00	--	--	$x10^{12}/L$	(4.50-6.50)
MCV:	95	100	--	--	fL	(80-96)
MCH:	32.1	31.0	--	--	pg	(27.0-32.0)
MCHC:	33.7	31.1	--	--	g/dL	(32.0-36.0)
Neutrophils:	5.5	5.8	--	--	$x10^9/L$	(2.0-8.0)
Lymphocytes:	1.3	1.5	--	--	$x10^9/L$	(1.0-4.0)
Monocytes:	0.7	1.1	--	--	$x10^9/L$	(0.0-1.0)
Eosinophils:	0.2	0.4	--	--	$x10^9/L$	(0.0-0.5)
Basophils:	0.1	0.1	--	--	$x10^9/L$	(0.0-0.2)
ESR:	17	76	--	--	mm/hr	(0-15)

12/08/09 7556661 The ESR is mildly elevated.

19/05/10 1674179 Red cells: macrocytes+, rouleaux2+, White cells: show normal morphology Platelets: appear mildly increased. Progress report - patient with known Ca mouth. The ESR is moderately elevated.

Ca markers found by BDORT research

Quick and Non-Invasive Screening and Diagnosis of Cancer by Measuring Telomere, 8-OH-dG, Integrin a5b1, Acetylcholine, Hg etc and Safe & Effective Treatment of Cancer: Marked Decrease of the Telomere of Cancer Cell & Increase of the Normal Cell Telomere by Stimulating the Press Needle Inserted at ‘True ST 36’ and Effective Treatment & Longevity Effect of Selective Drug uptake enhancement method.
Omura Y.
6th Biennial International Symposium on the Bi-Digital O-Ring Test, Japan, 2004.

Research of Reference Control Substances Related to Increase or Decrease of Tumor Markers.
Ohki M, Nishimura M, Kawabata R, Shimotsuura Y.
13th Annual Meeting of Japan Bi-Digital O-Ring Test Medical Society, Japan 2003.

Neoplastic biomarkers: BDORT research

1) increase in Oncogene C-fos Ab2
2) increase in Integrin alpha5beta1
3) increase in mercury
4) decrease in Acetylcholine
5) increase in viral infection
6) decrease in Nitric Oxide
7) increase in Glucose (except some lung Ca)
8) increase in Telomere
9) increase in Cycline E
10) increase in KI 67
11) increase in 8-OH-dG
12) decrease in Folic Acid
13) increase in asbestos

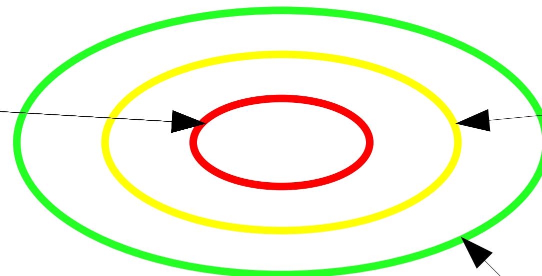
Normal cell telomeres: <<10ng TTAGGG. 1yg <CCCTAA<1pg

Border 'A'
Oncogene c-fosAb2: 600ng
Hg: 50mgU

Border 'B'
Integrin a5b1: 655ng
Hg: 210mgU
ACh: 1pg

Border 'C'
CCCTAA: 1700ng
TTTAGG: 1700ng
* HBVe: 1100ng
Asbestos: 15mg

Border 'C' contains parameters of borders 'B' and 'A'



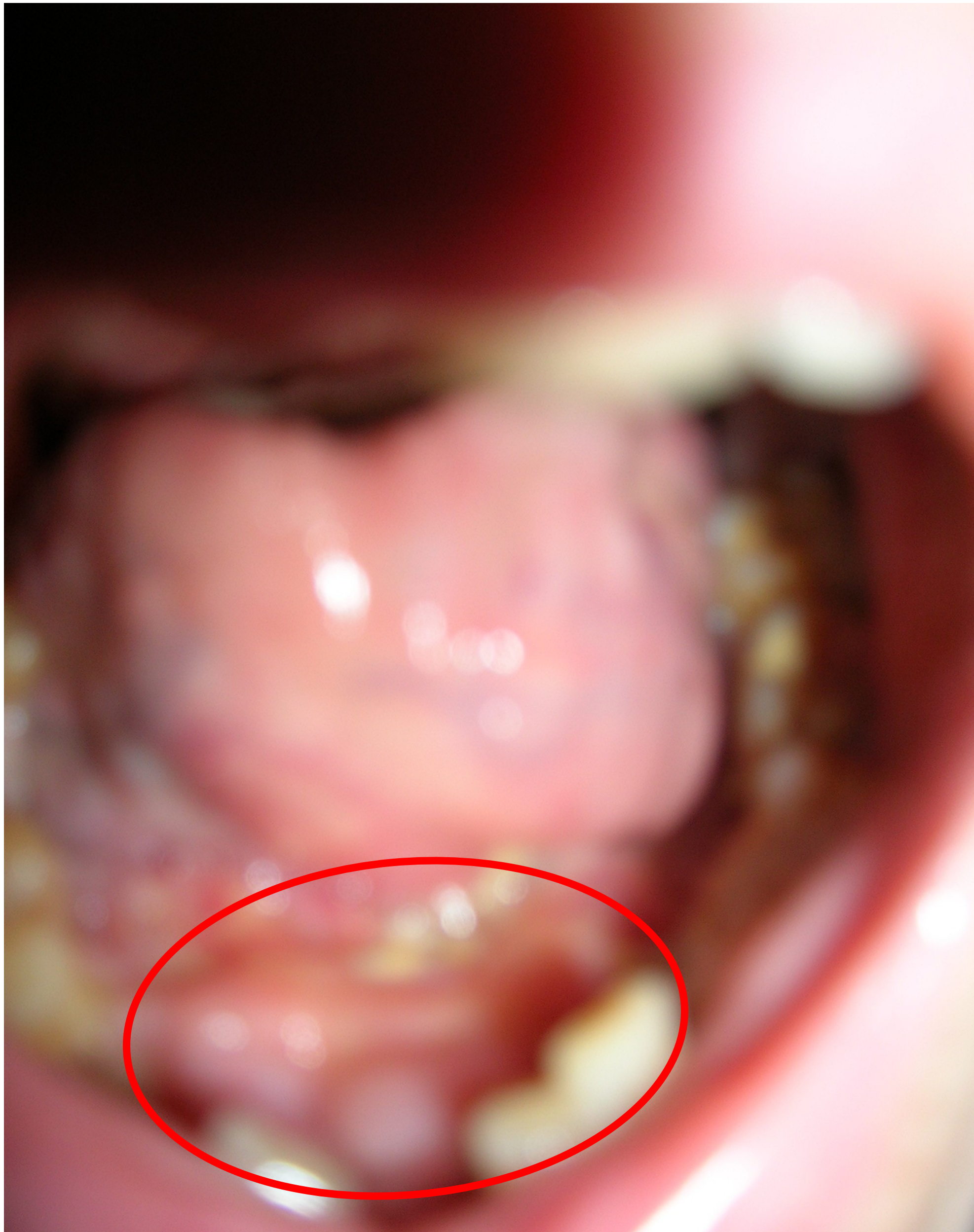
Border 'B' contains parameters of border 'A'

'A'

Date	MAY 25 2010	JUNE 08 2010	JUNE 22 2010	JULY 06 2010	AUG 10 2010
Liver	**Liver**	**Liver**	**Liver**	**Liver**	**Liver**
CCCTAA / TTTAGG	1600Ng / 1600ng	440ng / 440ng	680ng /690ng	840ng 850ng	950ng / 950ng
TXB2	>>1010ng	<1ng	<1ng	<1ng	<1ng
L-Homocysteine	??	7mg	0.1mg	0.1mg	0.1mg
Amyloid 'AA'	1000ng	1ng	1ng	1ng	1ng
TNF	1ng	1ng	1ng	700ng	1ng
HBVe/s	1000ng	400ng	200ng	<1ng	<<1ng
Anti-Prion	<<1ng	<<1ng	<<1ng	110ng. Blood at radial: 80ng	<1ng
Liver	**Liver**	**Liver**	**Liver**	**Liver**	**Liver**
TTAGGG	=normal cell TTAGGG	440ng	680ng	850ng	950ng
CCCTAA	=normal cell CCCTAA	440ng	690ng	840ng	950ng
SCC (central border)	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**
Asbestos	15mg	<0.05mg	<0.05mg	<0.05mg	<0.05mg
Hg	Hg 210mg	0.5mg	0.5mg	0.5mg	0.5mg
ACh	<1pg	1mg	1mg	1mg	1mg
Oncogene c-fos Ab2	600ng	1ng	1ng	3ng	<1ng
TXB2 / PLGF	↑↑↑ / ↑↑↑	1ng / 1ng	1ng / 1ng	1ng / 1ng	1ng / 1ng
Integrin a5b1	655ng	9ng	2ng	1ng	<1ng
HBVs/e	**1100ng**	<<1ng	<<1ng	<<1ng	<<1ng
CCCTAA	1700ng	440ng	680ng	840ng	950ng
TTAGGG	1700ng	440ng	690ng	850ng	950ng
p53	900ng	??	2ng	1ng	1ng
Glucose	GI ??	??	40mg	30mg	30mg
Size of original mass	100% (5cm)	50%	20-25%	10-15%	0%
Normal Cell TTTAGG	<<10ng	420ng	680ng	850ng	950ng
Normal Cell CCCTAA	1yg <CCCTAA<1pg	420ng	690ng	840ng	950ng

Treatment

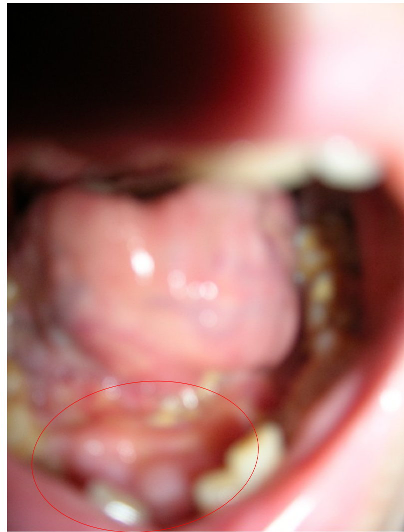
- Flaxseed oil (virus, inflammation)
- Cilantro tincture (detoxification)
- Chlorella 500mg tablets (detoxification)
- AC kHz c fiber arteriole nerve block for increased uptake



After 2 weeks treatment

Patient report:
Able to talk freely again.
Able to eat freely again.
Appetite very good and gaining weight.

JUNE 08 2010: 50% reduction in size

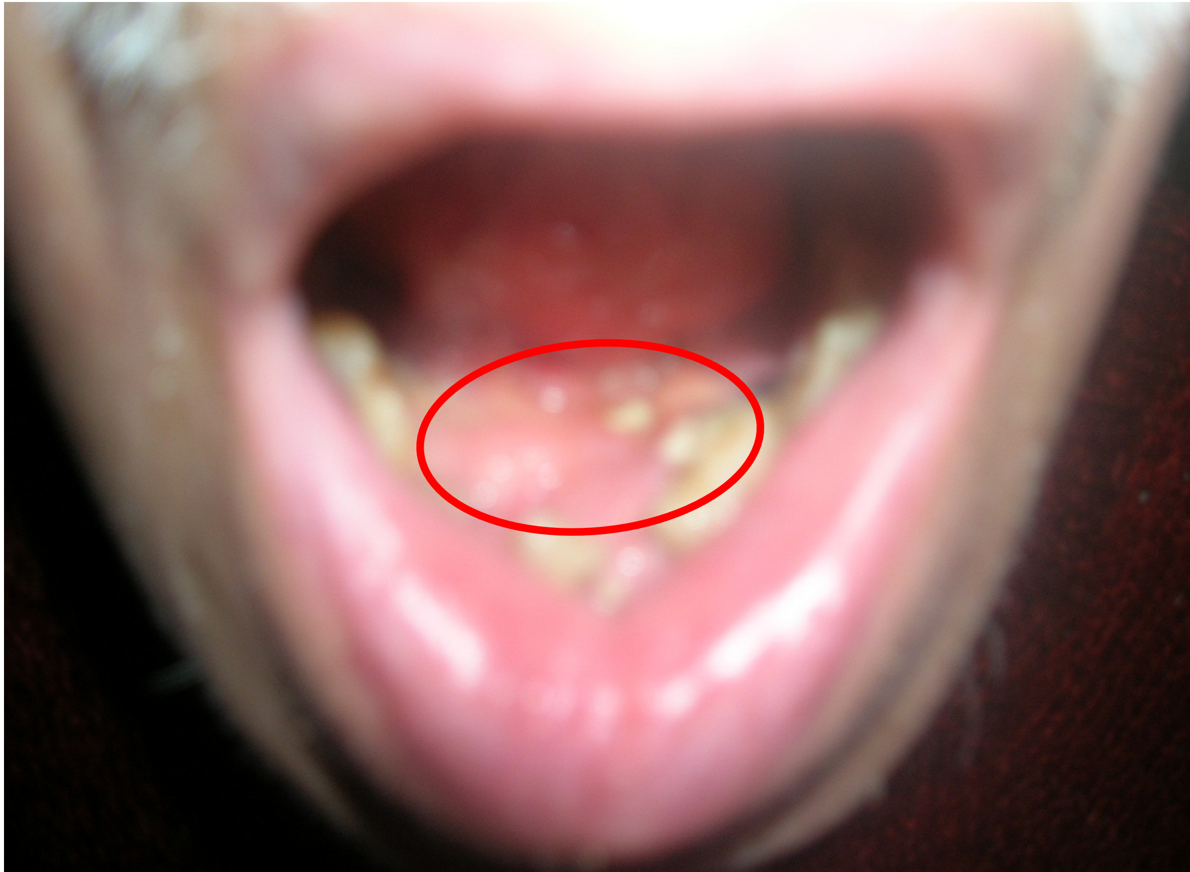


JUNE 08 2010

Tumour:
X-Y laser scan border:
Integrin a5b1: 9ng
Oncogene c-fos AB2: 1ng
ACh: 1mg
Hg: 0.5mg
Asbestos: <0.05mg
BDORT -5
TXB2: 1ng
PLGF: 1ng
TTAGGG: 440ng
CCCTAA: 440ng
HBV(e): <<1ng
Pelvic area:
p53: 1ng
Integrin a5b1: 1ng
Oncogene c-fos AB2: 1ng

Normal cell telomeres:
TTAGGG: 440ng
CCCTAA: 440ng

Liver
Amyloid-'AA': 1ng
TXB2: 1ng
Hg: 0.5mg
Asbestos: <0.05mg
L-homocysteine: 7mg
HBV: 400ng
HBVe: 400ng

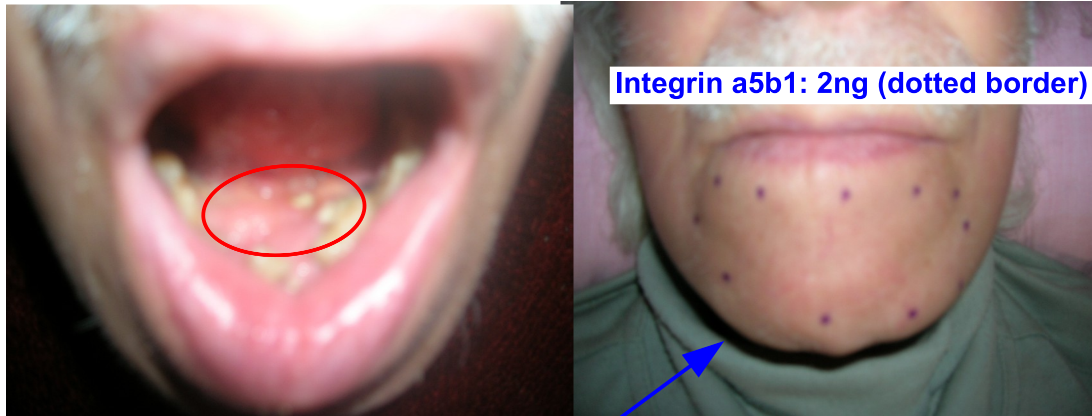


After 4 weeks liver treatment

Patient report:

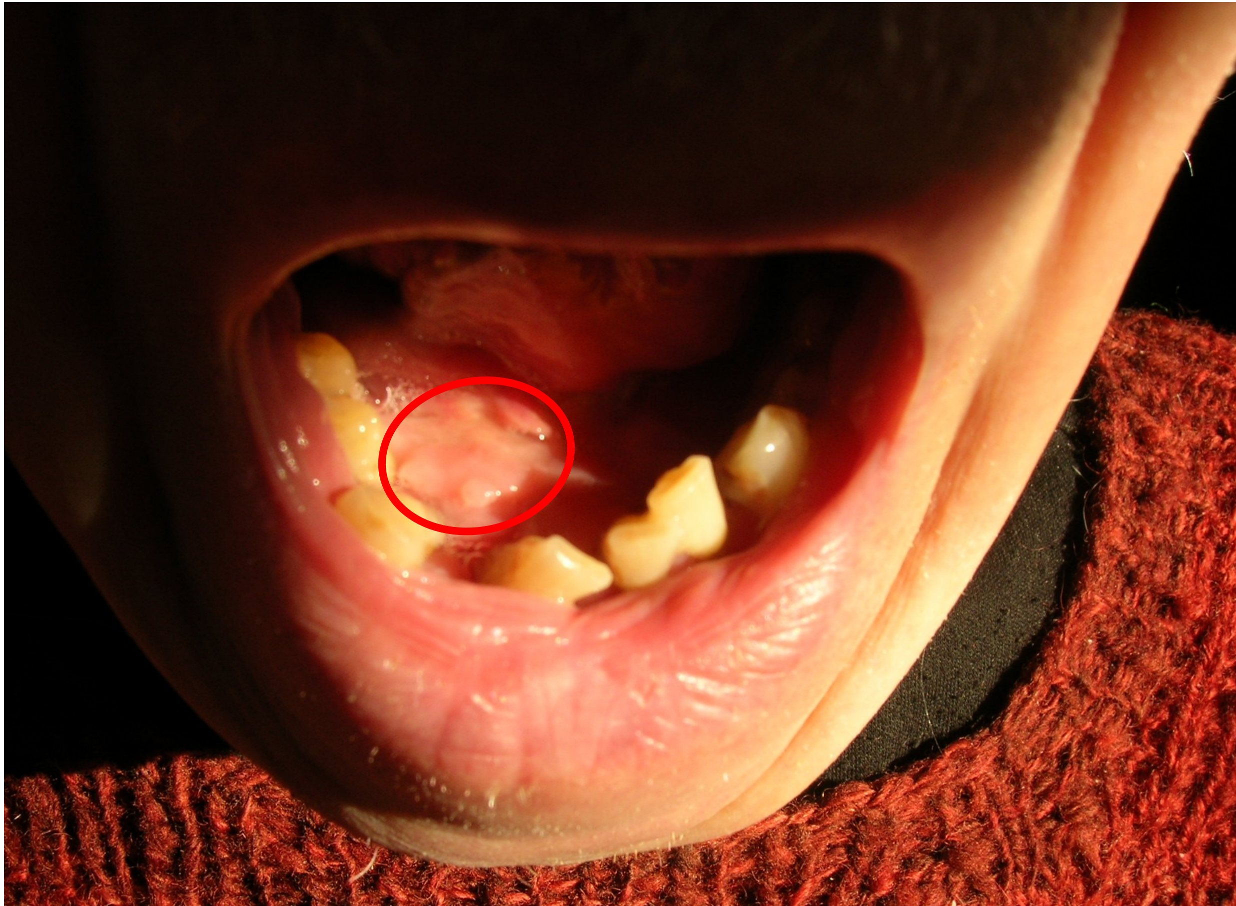
Talking freely. Eating solid foods normally.
Appetite very good.
Weight increasing.
Normal bowel movements.
Normal feeling inside mouth returning.
Energy good and increasing.
Very cheerful.

JUNE 22 2010: 75-80% reduction in size



JUNE 22 2010

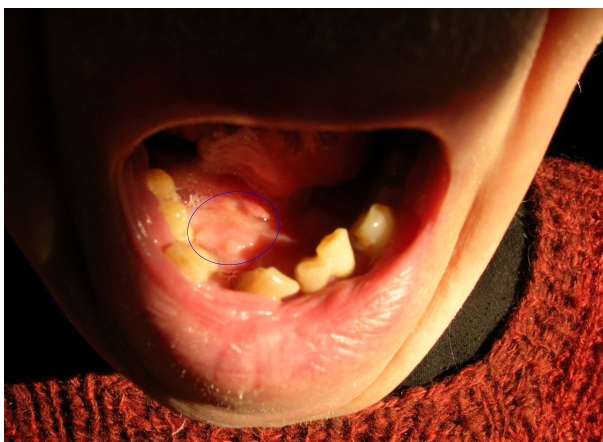
Tumour:	**Normal cell telomeres:**
Integrin a5b1: 2ng	**TTAGGG: 690ng**
Oncogene c-fos AB2: 1ng	**CCCTAA: 680ng**
p53: 2ng	
ACh: 1mg	
Hg: 0.5mg	**Liver**
Asbestos: <0.05mg	**DHEA: 1pg**
BDORT -5	**HBV: 200ng**
TXB2: 1ng	**HBVe: 200ng**
PLGF: 1ng	
ACh: 1mg	
DHEA: 130ng	
Glucose: 40mg	
8OHdG: 1pg	
TTAGGG: 690ng	
CCCTAA: 680ng	
HBV(e): <<1ng	



After 6 weeks treatment

Patient report:
Feeling very well.
Functioning normally.
Weight increasing.
Very cheerful.

JULY 06 2010: 85-90% reduction in size

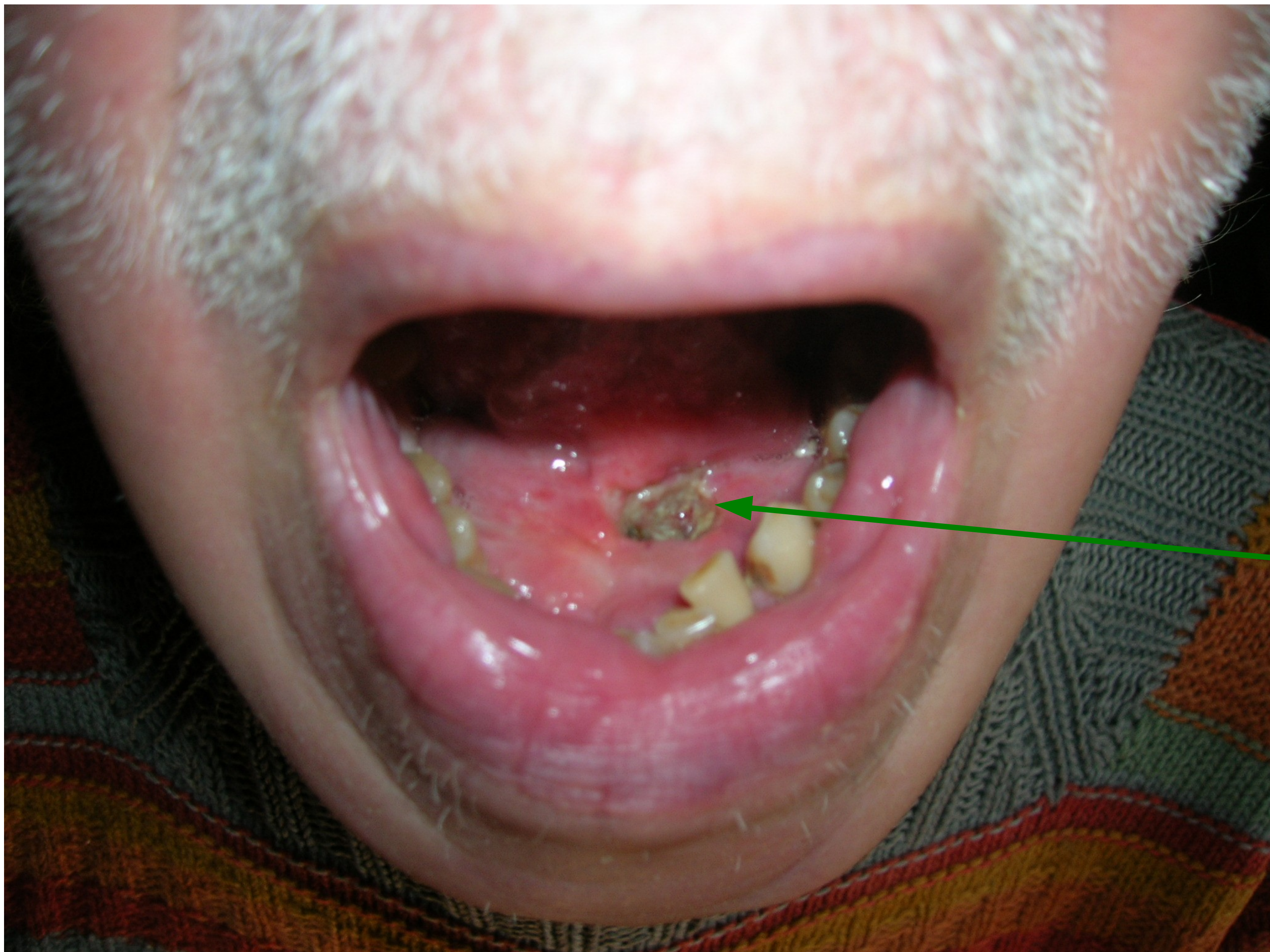


JULY 06 2010

Tumour:
Asbestos: <0.05mg
Hg: 0.5mg
ACh: 1mg
Oncogene c-fos AB2: 3ng
TXB2 / PLGF: 1ng / 1ng
Integrin a5b: 1ng
HBVe: <<1ng
HBVs: <<1ng
CCCTAA: 840ng
TTAGGG: 850ng
P53: 1ng
Glucose: 30mg

Normal cell telomeres:
CCCTAA: 840ng
TTAGGG: 850ng

Liver
CCCTAA: 840ng
TTAGGG: 850ng
TXB2: <1ng
L-Homocysteine: 0.1mg
Amyloid 'AA': 1ng
TNF: 700ng
HBVe/s: <1ng
PrP: 110ng (bloodstream: PrP: 80ng)



Sub-lingual cavity. Tumour previously covered this area.

SEPT 21 2010: NO TUMOUR

Date	**MAY 25 2010**	**JUNE 08 2010**	**JUNE 22 2010**	**JULY 06 2010**	**AUG 10 2010**
Liver (visceral)	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**	**Liver (visceral)**
CCCTAA / TTTAGG	1600Ng / 1600ng	440ng / 440ng	680ng /690ng	840ng 850ng	950ng / 950ng
TXB2	>>1010ng	<1ng	<1ng	<1ng	<1ng
L-Homocysteine	??	7mg	0.1mg	0.1mg	0.1mg
Amyloid 'AA'	1000ng	1ng	1ng	1ng	1ng
TNF	1ng	1ng	1ng	700ng	1ng
HBVe/s	1000ng	400ng	200ng	<1ng	<<1ng
Anti-Prion	<<1ng	<<1ng	<<1ng	110ng. Bloodstream: 80ng	<1ng
Liver (anterior)	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**	**Liver (anterior)**
TTAGGG	=normal cell TTAGGG	440ng	680ng	850ng	950ng
CCCTAA	=normal cell CCCTAA	440ng	690ng	840ng	950ng
SCC (central border)	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**	**SCC (central border)**
Asbestos	15mg	<0.05mg	<0.05mg	<0.05mg	<0.05mg
Hg	Hg 210mg	0.5mg	0.5mg	0.5mg	0.5mg
ACh	<1pg	1mg	1mg	1mg	1mg
Oncogene c-fos Ab2	600ng	1ng	1ng	3ng	<1ng
TXB2 / PLGF	↑↑↑ / ↑↑↑	1ng / 1ng	1ng / 1ng	1ng / 1ng	1ng / 1ng
Integrin a5b1	655ng	9ng	2ng	1ng	<1ng
HBVs/e	**1100ng**	<<1ng	<<1ng	<<1ng	<<1ng
CCCTAA	1700ng	440ng	680ng	840ng	950ng
TTAGGG	1700ng	440ng	690ng	850ng	950ng
p53	900ng	??	2ng	1ng	1ng
Glucose	GI ??	??	40mg	30mg	30mg
Size of original mass	100% (5cm)	50%	20-25%	10-15%	0%
Normal Cell TTTAGG	<<10ng	420ng	680ng	850ng	950ng
Normal Cell CCCTAA	1yg <CCCTAA<1pg	420ng	690ng	840ng	950ng

Patient: [redacted] DOB: [redacted]
Subject: Ct Neck To Pelvis With Contras Date: 08 Sep 2010

FINAL CT SCAN REPORT

SURGERY PATIENT ID NUMBER -

CT NECK, CHEST, ABDOMEN PELVIS

#8. 1/2

Clinical notes: metastatic carcinoma floor of mouth post chemoradiotherapy surveillance

Technique: Arterial phase chest, portal venous phase abdomen and pelvis with multiplanar reformats. Oral contrast was given.

Findings:
NECK:
Primary site: no definite mass seen. There is asymmetry of the oropharynx with the right lingual tonsil larger with focal calcification probably benign
Nodes: No lymphadenopathy seen.
Metastases: Destructive expansile mass of the anterior symphyseal mandible measures 19 x 27 mm (AP x TR).

Incidental findings: both carotid bulbs show calcified plaque causing 50% plus stenoses; both internal carotid arteries are patent

CHEST:
Nodes: No lymphadenopathy.
Metastases: innumerable pulmonary nodules have increased in size and number: for example, target lesion in the superior segment left lower lobe now 30 x 35 mm compared to 8 x 9 mm previously.

Pleural and pericardial spaces clear.

FINAL CT SCAN REPORT

ABDOMEN PELVIS:
Nodes: no lymphadenopathy seen
Metastases: no liver metastases seen. No significant ascites.
There is a sclerotic lesion in the left ilium which could either be a chondroid lesion or possibly metastasis. This is unchanged.

Incidental findings:
Bulky seminal vesicles. Extensive atherosclerotic calcification of the aorta without focal aneurysm patient. Renal calcifications are probably vascular

CONCLUSION:
Progressive pulmonary metastatic disease
Destructive mandibular lesion? Metastasis or direct extension from primary site

Copy to:
Ordered by:

#8. 2/2

#9. 1/1

Dorevitch PATHOLOGY — **Pathology Report** — RCPA

This document is issued in accordance with the NATA/RCPA accreditation requirements

UR NO: LAB NUMBER
PATIENT:
ADDRESS:
DOB: M Years PH:
DOCTOR:

SERUM BIOCHEMISTRY

Test		Result	Units	Ref. Range
Sodium	:	136	mmol/L	(136-146)
Potassium	:	4.7	mmol/L	(3.5-5.0)
Chloride	:	98	mmol/L	(95-110)
Bicarbonate	:	30	mmol/L	(22-31)
Urea	:	3.5	mmol/L	(3.0-10.0)
Estimated GFR	:	> 90	mL/min	(> 60)
Creatinine	:	58	umol/L	(60-110)
Total Bilirubin	:	6	umol/L	(< 20)
Ala. Aminotransferase (ALT)	:	15	U/L	(< 35)
Asp. Aminotransferase (AST)	:	19	U/L	(< 35)
Alkaline Phosphatase (ALP)	:	79	U/L	(35-110)
Gamma Glutamyl Trans. (GGT)	:	9	U/L	(< 50)
Total Protein	:	73	g/L	(60-85)
Albumin	:	40	g/L	(36-48)
Globulin	:	33	g/L	(22-38)
Calcium	:	2.45	mmol/L	(2.15-2.65)
Cor. Calcium	:	2.45	mmol/L	(2.15-2.65)

BIOCHEMISTRY — NORMAL FILE — NOTES REQUIRED — RECALL PATIENT — URGENT — NON URGENT

Tests Requested: MBI,FBE — Collected: 13/10/10 00:00 — Reported: 14/10/10 09:00 — Authorised:

MBI

Dorevitch PATHOLOGY — **Pathology Report** — RCPA

This document is issued in accordance with the NATA/RCPA accreditation requirements

UR NO: LAB NUMBER
PATIENT:
ADDRESS:
DOB: M Years PH:
DOCTOR:

FULL BLOOD EXAMINATION

Test	Result	Ref. Range
HB :	13.7 g/dL	(13.0-18.0)
PCV:	41.5 %	(40.0-54.0)
RCC:	4.50 $x10^{12}$/L	(4.50-6.50)
MCV:	92 fL	(80-96)
MCH:	30.4 pg	(27.0-32.0)
MCHC	33.0 g/dL	(32.0-36.0)

($x10^9$/L)	%	Result	Ref. Range
WHITE CELL COUNT:		6.3	(4.0-11.0)
Neutrophils:	61%	3.8	(2.0-8.0)
Lymphocytes:	20%	1.3	(1.0-4.0)
Monocytes :	12%	0.8	(0.0-1.0)
Eosinophils:	6%	0.4	(0.0-0.5)
Basophils :	1%	0.1	(0.0-0.2)
PLATELETS :		349	(150-450)

COMMENT: Red cells, white cells and platelets are within normal limits.

HAEMATOLOGY — NORMAL FILE — NOTES REQUIRED — RECALL PATIENT — URGENT — NON URGENT

Tests Requested: MBI,FBE — Collected: 13/10/10 00:00 — Reported: 14/10/10 09:00

FBE