Case Study	Reversal and normalization of biopsy diagnosed squamous cell carcinoma of the throat.
Background	Patient complained of chronic mild cough, reported minor vocal cord impairment with speech, and gastric discomfort. Gastric biopsies found chronic active helicobacter gastritis, without evidence of malignancy. Ongoing symptoms led to a neck CT that did not discover the vocal cord lesion, “a cause for the hoarse voice was not demonstrated”; single finding was a pathologic thyroid gland with largest cystic nodule in the isthmus. With ongoing symptoms, endoscopy and biopsy of the right vocal cord followed.
Case presentation	Slides 1-8, 62yo female.
Investigations	CT neck, 01/10/2013, slide 3, reported same date, slide 4. Gastric/duodenal biopsies, 18/10/2010, slide 2. Endoscopy, 10/12/2013, slide 6. Biopsy of upper surface of right vocal cord, histopathology, 10/12/2013, slide 5. Endoscopy, ??/08/2014, slides 1 & 7.
Differential diagnosis	Right side squamous cell carcinoma in situ suggestive of invasive, histopathology, 10/12/2013, slide 5.
Treatment	Lesion scheduled for radiotherapy after biopsy, 10/12/2013. Patient declined conventional oncological treatments for alternative treatments. ECRL investigations and treatment, January 2014 – August 2014.
Outcome and follow-up	Major reversal and normalization of neoplastic tissue, slides 1 & 8. No conventional oncological treatments received. Patient survived without evidence of recurrence, 2020.

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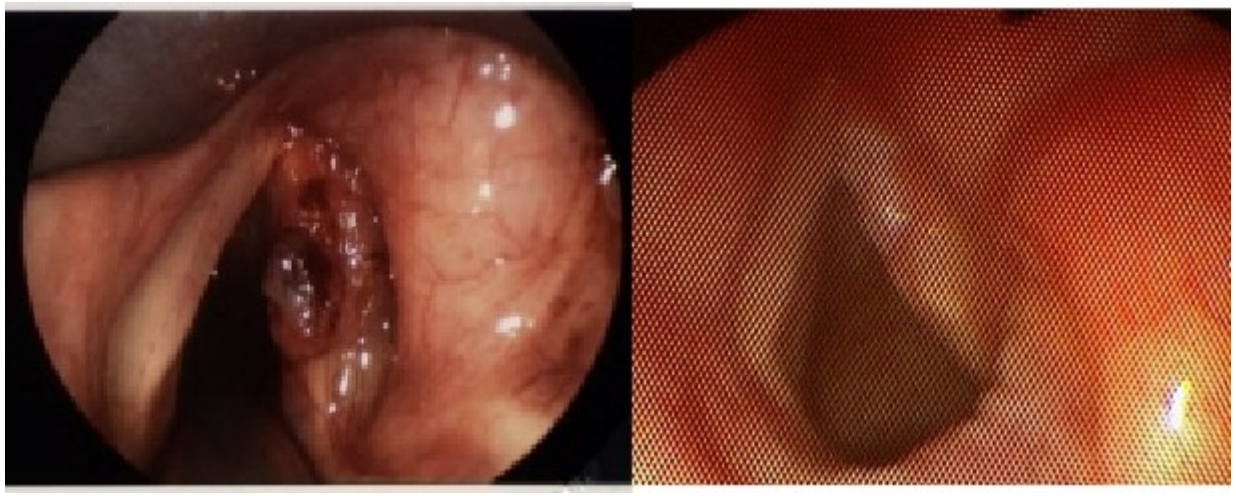
4/20 Clarendon Street, Frankston, VIC 3199, Australia.
Telephone: +61 3 9028 5689 Fax: +61 3 8582 9706
Email: contact@electromedicine.org.au
www.electromedicine.org.au

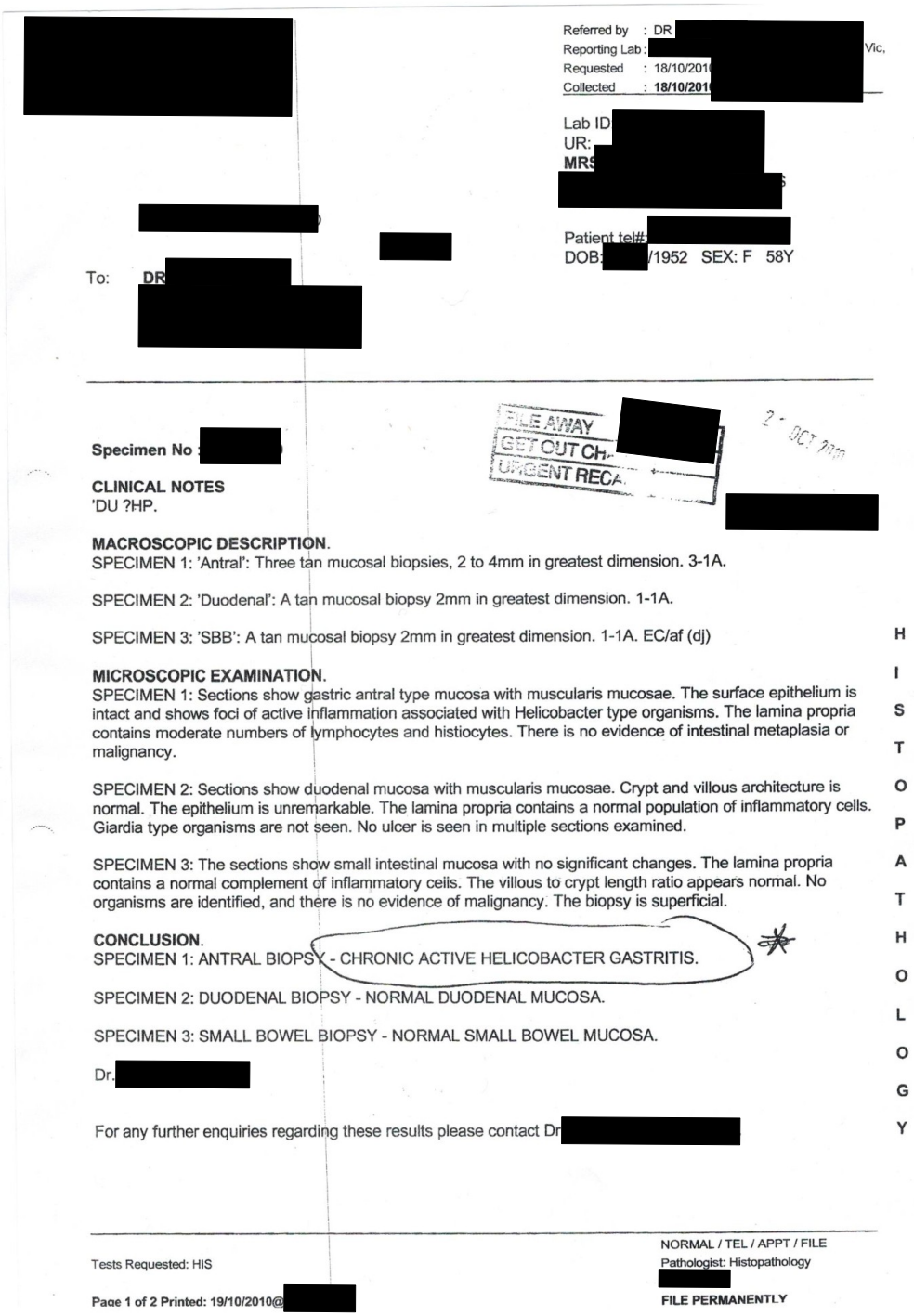
Reversal and normalization of biopsy diagnosed squamous cell carcinoma (cancerous tumor) of the throat.

No conventional oncological treatment (no chemotherapy or radiotherapy) given.



DEC 2013 **AUG 2014**

Gastric biopsies negative for malignancy.



[redacted]

Referred by : DR [redacted]
Reporting Lab : [redacted] Vic,
Requested : 18/10/201[redacted]
Collected : 18/10/201[redacted]

Lab ID [redacted]
UR: [redacted]
MRS [redacted]

Patient tel# [redacted]
DOB: [redacted]/1952 SEX: F 58Y

To: DR [redacted]

[redacted]

FILE AWAY [redacted]
GET OUT CH[redacted]
URGENT RECA[redacted]
21 OCT 2010

[redacted]

Specimen No [redacted]

CLINICAL NOTES
'DU ?HP.

MACROSCOPIC DESCRIPTION.
SPECIMEN 1: 'Antral': Three tan mucosal biopsies, 2 to 4mm in greatest dimension. 3-1A.

SPECIMEN 2: 'Duodenal': A tan mucosal biopsy 2mm in greatest dimension. 1-1A.

SPECIMEN 3: 'SBB': A tan mucosal biopsy 2mm in greatest dimension. 1-1A. EC/af (dj)

MICROSCOPIC EXAMINATION.
SPECIMEN 1: Sections show gastric antral type mucosa with muscularis mucosae. The surface epithelium is intact and shows foci of active inflammation associated with Helicobacter type organisms. The lamina propria contains moderate numbers of lymphocytes and histiocytes. There is no evidence of intestinal metaplasia or malignancy.

SPECIMEN 2: Sections show duodenal mucosa with muscularis mucosae. Crypt and villous architecture is normal. The epithelium is unremarkable. The lamina propria contains a normal population of inflammatory cells. Giardia type organisms are not seen. No ulcer is seen in multiple sections examined.

SPECIMEN 3: The sections show small intestinal mucosa with no significant changes. The lamina propria contains a normal complement of inflammatory cells. The villous to crypt length ratio appears normal. No organisms are identified, and there is no evidence of malignancy. The biopsy is superficial.

CONCLUSION.
SPECIMEN 1: ANTRAL BIOPSY - CHRONIC ACTIVE HELICOBACTER GASTRITIS.

SPECIMEN 2: DUODENAL BIOPSY - NORMAL DUODENAL MUCOSA.

SPECIMEN 3: SMALL BOWEL BIOPSY - NORMAL SMALL BOWEL MUCOSA.

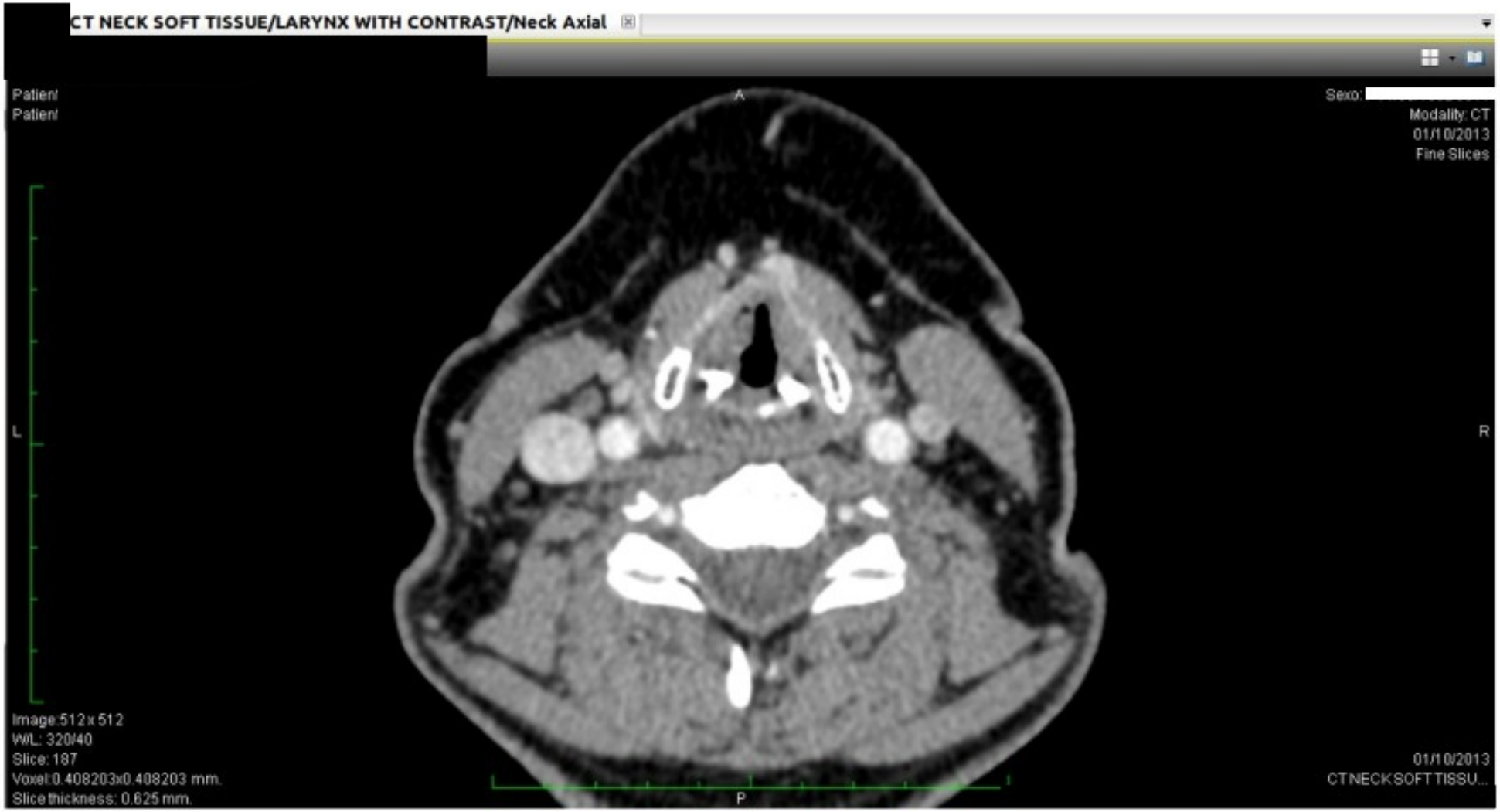
Dr. [redacted]

For any further enquiries regarding these results please contact Dr [redacted]

HISTOPATHOLOGY

Tests Requested: HIS

NORMAL / TEL / APPT / FILE
Pathologist: Histopathology
[redacted]
FILE PERMANENTLY



CT scan of neck did not report the vocal cord lesion.

01 10 2013

[redacted]

[redacted]

[redacted]

1st October 2013

Patient ID: [redacted]
EP ID:
Order: [redacted]
Folio: [redacted]
UR Number:
Typist: [redacted]
Exam Date:1st October 2013
[redacted]

Dr [redacted]

Re: Ms [redacted] /1952

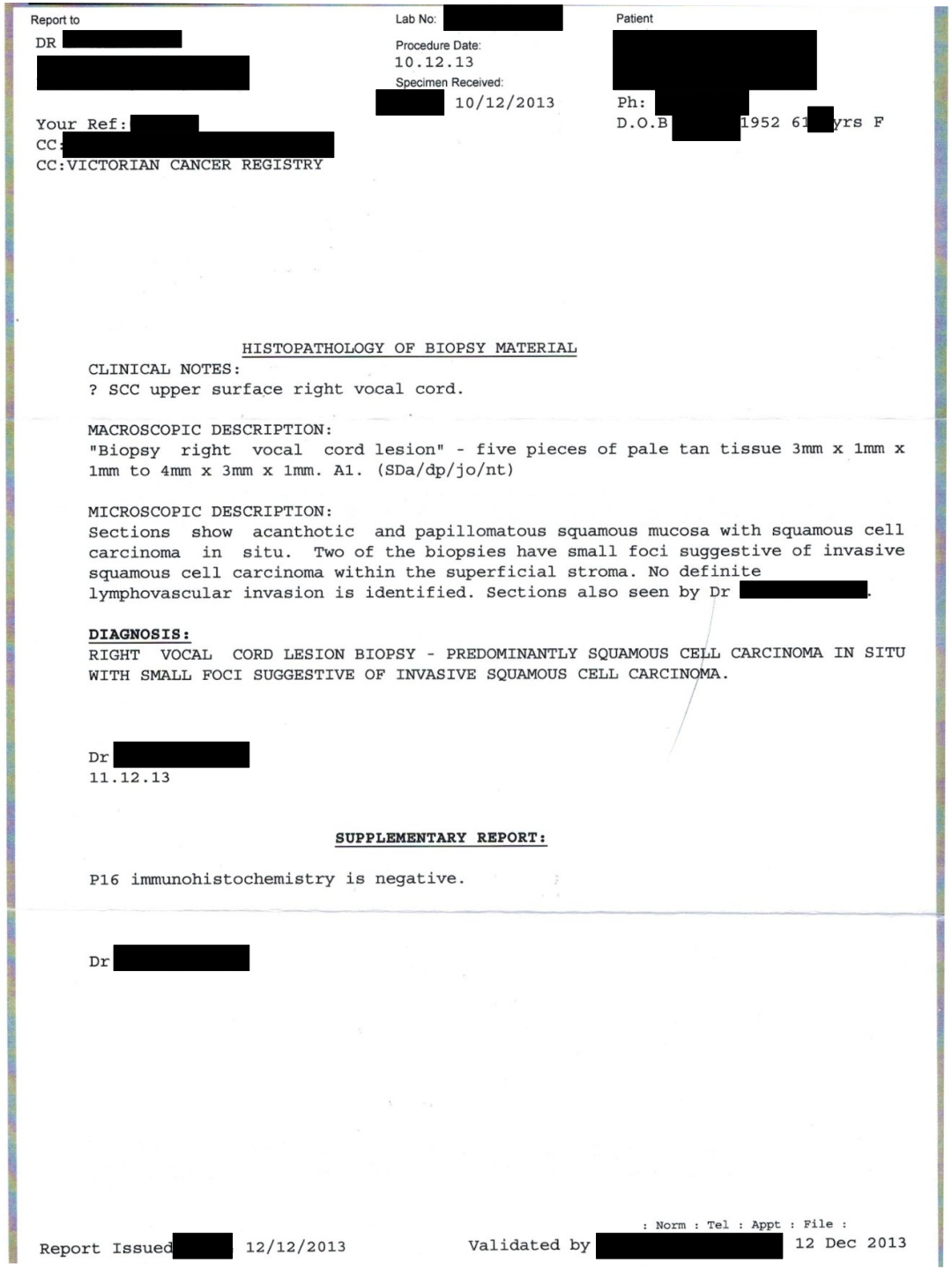
CT SCAN NECK

Post-contrast assessment was obtained from the posterior fossa through the neck to the upper mediastinum.
The parotid and submandibular glands are normal.
The thyroid gland is enlarged with each lobe having a length of 67mm and a width of 17mm on the right and 23mm on the left.
The isthmus is enlarged and has a nodule measuring 34mm in height, 23mm AP diameter and 21mm in transverse diameter. This nodule contains irregular calcifications. There is a smaller cystic area also present within this nodule of 6mm. Each lobe also contains low density colloid cysts.
The lower pole of each lobe of the thyroid and the isthmic nodule reach the level of the sternal notch.
The trachea itself is not narrowed or deviated.
The mucosal spaces of the nasopharynx, oropharynx and hypopharynx appear normal.

Conclusion: A pathologic thyroid gland is demonstrated. Clinical and ultrasound correlation is warranted. The largest nodule involves the isthmus which contains calcifications and a cystic component. A cause for the hoarse voice however has not been demonstrated.

Dr [redacted]
Verified Tue 01/10/2013 [redacted]

Biopsy of vocal cord lesion following endoscopy.



Report to
DR [redacted]
[redacted]

Your Ref: [redacted]
CC: [redacted]
CC:VICTORIAN CANCER REGISTRY

Lab No: [redacted]
Procedure Date:
10.12.13
Specimen Received:
[redacted] 10/12/2013

Patient
[redacted]
Ph: [redacted]
D.O.B [redacted] 1952 61 yrs F

HISTOPATHOLOGY OF BIOPSY MATERIAL

CLINICAL NOTES:
? SCC upper surface right vocal cord.

MACROSCOPIC DESCRIPTION:
"Biopsy right vocal cord lesion" - five pieces of pale tan tissue 3mm x 1mm x 1mm to 4mm x 3mm x 1mm. A1. (SDa/dp/jo/nt)

MICROSCOPIC DESCRIPTION:
Sections show acanthotic and papillomatous squamous mucosa with squamous cell carcinoma in situ. Two of the biopsies have small foci suggestive of invasive squamous cell carcinoma within the superficial stroma. No definite lymphovascular invasion is identified. Sections also seen by Dr [redacted].

DIAGNOSIS:
RIGHT VOCAL CORD LESION BIOPSY - PREDOMINANTLY SQUAMOUS CELL CARCINOMA IN SITU WITH SMALL FOCI SUGGESTIVE OF INVASIVE SQUAMOUS CELL CARCINOMA.

Dr [redacted]
11.12.13

SUPPLEMENTARY REPORT:

P16 immunohistochemistry is negative.

Dr [redacted]

: Norm : Tel : Appt : File :

Report Issued [redacted] 12/12/2013

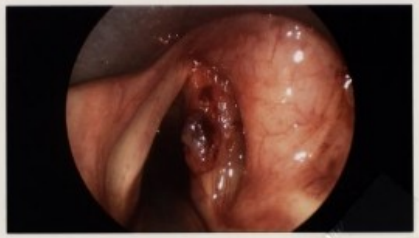
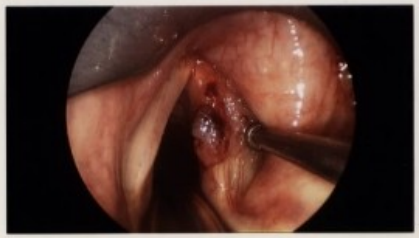
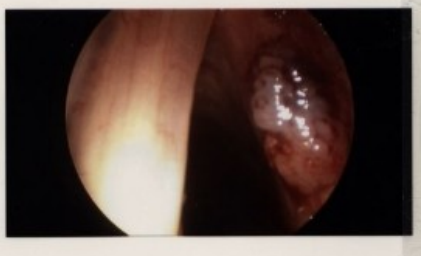
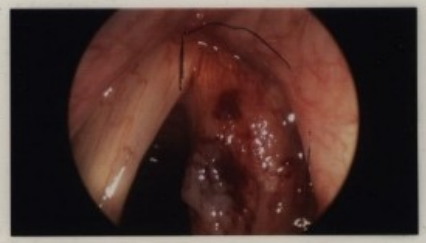
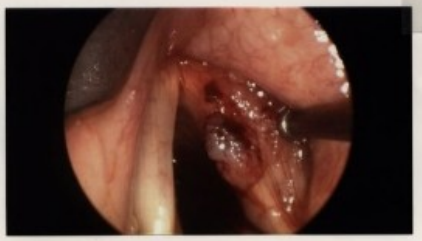
Validated by [redacted] 12 Dec 2013

[redacted]

Patient Reference	Name	Date Of Birth	Procedure Date
[redacted]	[redacted]		10/12/2013

[redacted]

Surgeon	[redacted]	Procedure	
Patient Notes			

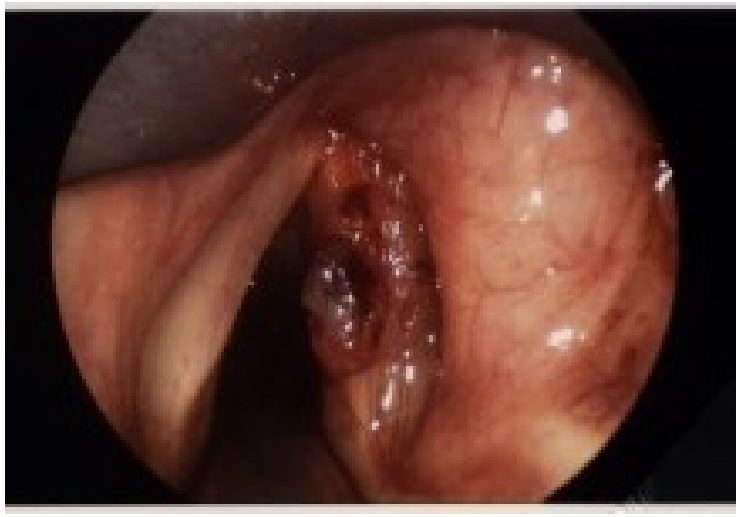






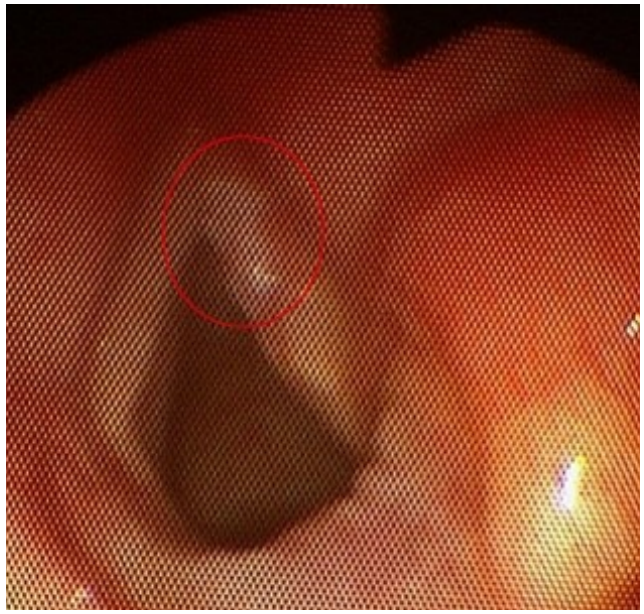
This is about to scale with the August photo 2014

[redacted]

Printed on: Tuesday, 10 December 2013

Endoscopy 10/12/2013.





December 2013 **August 2014**

Comparison endoscopy images very near to scale before and after ECRL treatments.

GP letter to patient urging biopsy and treatment for “cure”.

[redacted]

Dr [redacted]
Dr

09/10/2014

Mrs [redacted]
c/-

Dear [redacted]

I have tried to ring you several times to follow up on the letter I received from Mr [redacted], Ear, Nose & Throat surgeon dated 22.8.14, which was a copy of the letter he sent to you.

I am writing in the hope that you can let me know that you have decided to go ahead with the biopsy of the abnormality he found on your vocal cord.

I feel his letter was very clear and I totally concur with what he said.

I think to delay having effective treatment of your condition any longer is to risk the chance of cure.

I hope that by the time you get this letter you will have already had the biopsy or at least decided to go ahead with it.

I would appreciate very much if you could let me know by return letter what you have decided to do either way and acknowledge that you have received my letter.

yours sincerely [redacted]

Dr [redacted]