Dr Kenny Ngo, MD, FRCSC
Otolaryngology–Head & Neck Surgery
Skin cancers - Face, Head and Neck

62 Colborne Street East
Orillia, Ontario. L3V 1T6
Tel: 705.326.7779
Fax: 705.326.9969

2025-Oct-23

Dr. Yu

Barrie, ON

Patient:	Veronica Laycock
PHN:	7768 134 954hr
Birthdate:	1958-Dec-31
Address:	452 Forest Ave S Orillia L3V 6M6
Phone:	(705) 242-0103 (705) 000-0000

Dear Dr. Yu,

Please see Veronica, a 66 year old female for long term follow up of her metastatic Papillary thryoid cancer.

had total thyroidectomy and right neck dissection last week... pathology is still pending and will be fowarded once available

Relevant findings and investigations are attached.
Please do not hesitate to contact me if you have any questions regarding the care of Veronica.

Sincerely,

Kenny Ngo, MD
Electronically Reviewed to Expedite Delivery

Enclosures
2025-Oct-23: Queued 2025-Oct-23 1-F/U-Thyroid, Total/Completion To: Dr. JUSTIN PORTER (705) 326-1534
2025-Oct-15: MEDICAL RECORDS
2025-Sep-04: Printed 2025-Sep-12 0-NP-Thyroid To: Dr. JUSTIN PORTER (705) 326-1534

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2025-Oct-23

Dr. PORTER
OSMH EMERG
Orillia, ON

Patient:	Veronica Laycock
PHN:	7768 134 954hr
Birthdate:	1958-Dec-31
Address:	452 Forest Ave S Orillia L3V 6M6
Phone:	(705) 242-0103 (705) 000-0000

Dear Dr. PORTER,

Veronica was seen regarding follow up of:

Total Thyroidectomy, RIght neck dissection, right paratrache lymph Node sampling

started on levothyroxine 125 mcg OD

US Thyroid/Neck June 13 2025 reported as
3.1cm mass inferior to right thyroid lobe with hypereochoic foci
Rt 4.2cm TR3 nodule
Rt 1cm mid pole TR4 nodule
bilat normal neck lymph nodes

US guided Core Biopsy Aug 6 2025
Rt neck mass
metastatic PTC

USGFNA Rt throid
PTC

CT head, neck, chdst Aug 25 2025
no intra-cranial mets.
5cm right heterogenous thyroid lobe.
Rt medial 2.1cm supraclavicular LN.
bilat LNs WNL.
no mediastinal mets. no pulm mets. upper lobe emphysema
*reviwed online
agree
no other obv right neck adenopathy

S:
seen with husband

Veronica is doing well

taking levothyroxine qhs

good voice
swallowing well w/o dysphagia

O:
dressing sutures removed
healing well

scope
-normal larynx
vocal folds moving well

pathology
-pending

A/P:

Normal Post-op

TSH. PTH, iCa to be done today for baseline

will titrate thyroid supplemtn for TSH suppression over time

wait 3 more weeks before using bio oil, sunscreen or Vit E
cover area when outside in sun for now to avoid hyperpigmentation

follow up 5 weeks
TSH, Tg and anti-Tg blood work to be done then

referral to endocrinology to be made today

Sincerely,

Kenny Ngo, MD
Electronically Reviewed to Expedite Delivery

Patient	LAYCOCK, VERONICA	**Home Phone**	7053455157	**Work Phone**	
Health #	7768134954HR	**Sex**	F	**Patient ID**	36949
Age	66 years				
DOB	1958-Dec-31				

Facility Report #:	3533576267		
Sent to:	Ngo, Kenny	Reported By:	Facility #4108
Collection Date:	2025-Oct-15	Reviewed:	2025-Oct-16 by KNgo
Message Unique ID:	20251016070246419^Q851617924^4108^MR^3533576267^202510160702^P^^F^2020211275025^64		
Source Author:	^Ngo^Kenny^Q^		
Updated On:	2025-Oct-16 10:15 AM		

	Flags	Results	Ref Range
MEDICAL RECORDS (S)			
Operative Note		See Below	

OSMH
170 Colborne Street West
Orillia, Ontario L3V 2Z3

(705)325-2201

PATIENT DEMOGRAPHICS PROVIDERS
NAME: LAYCOCK, VERONICA
ADDR: 452 FOREST AVE S FAMILY: Porter, Justin
ORILLIA, CANON L3V6M6 ATTENDING: Ngo, Kenny
PHONE: 705-345-5157

DOB: 1958-12-31
MRN: 81958 HCN: 7768134954 HR

VISIT LOC: 4 Comm Tower 5-O

OPERATIVE REPORT

LAYCOCK, VERONICA MRN: 81958
Date of Birth: 1958/Dec/31 MOH: 7768134954
Operation Date: 2025/Oct/15 FIN#: 00005488569

DIAGNOSIS: Metastatic papillary thyroid cancer.

PROCEDURE: Total thyroidectomy and levels 3, 4, and 5 neck dissection along with right paratracheal lymph node sampling.

SURGEON: Dr. Kenny Ngo.

ANESTHESIA: General anesthetic.

ANESTHETIST: Dr. Mark.

ASSISTANT: Dr. Abdel-Razek.

COMPLICATIONS: Ms. Laycock was identified. Consent was obtained for the aforementioned procedure. She had biopsy-proven metastatic papillary thyroid cancer to a bulky lower right level 5 lymph node verging on levels 3 and 4. The right side of her neck was marked for the side of her neck dissection. The patient was brought to the operating room, induced under general anesthetic and intubated orally in the usual sterile fashion. A mild neck extension was achieved using the patient's pillow. A horizontal incision was designed two finger breadths below the cricoid, extending from over the left sternomastoid muscle across to the right side, extending to the supraclavicular fossa. Local anesthetic was infiltrated in the form of 1% Xylocaine with 100,000 Epinephrine. A total of 20 mL was used. The patient was then prepped and draped in the usual fashion. A horizontal incision was made using a 15 blade down to the platysma muscle. Bipolar cautery was used for hemostasis. A small bleeding vein was controlled. Superior and inferior subplatysmal skin flaps were elevated using monopolar cautery. Strap muscles were then divided along the midline using monopolar cautery and freed off of the right and left thyroid lobes.

We started on the right side. Lateral veins were ligated using bipolar cautery. Retraction was then done. I was able to

identify the carotid sheath, which was then retracted laterally. Inferiorly, I was able to identify the recurrent laryngeal nerve, which was followed from the inferior to the superior aspect, ligating overlying vessels. I then approached the superior pole. The avascular plane between the superior pole and the cricothyroid muscle was dissected using bipolar cautery and Stevens scissors. The superior pole vessels were isolated and ligated using silk ties. This allowed for better medial and superficial retraction on this large thyroid lobe with what was felt to be the primary cancer. The recurrent laryngeal nerve was followed from the inferior to the superior aspect, ligating overlying vessels and reflecting small tissues off of the nerve onto the gland. This allowed the right thyroid lobe to be dissected off of the trachea, leaving the recurrent laryngeal nerve intact and leaving what looked to be a superior parathyroid reflected laterally and by the superior pole. I did notice some small lymph nodes along the nerve on this right side, which were dissected off the nerve using mosquito forceps, bipolar cautery, and Stevens scissors. These lymph nodes were sent separately as right paratracheal lymph nodes.

I then approached the left side. The recurrent laryngeal nerve was identified in the usual fashion laterally along the inferior pole region. Superior pole vessels were identified and ligated using silk ties in a similar fashion as to the other side. This allowed for better medial and superficial retraction on the small left thyroid lobe. The recurrent laryngeal nerve was followed from the inferior to superior aspect, ligating overlying small vessels using bipolar electrocautery and Stevens scissors. The nerve was followed towards its insertion into the cricotracheal joint region. The overlying small left thyroid lobe was dissected off the trachea using bipolar electrocautery and a 15 blade. This allowed for the thyroid isthmus to be dissected off of the trachea. Also, I did not appreciate a primary lobe.

This total thyroidectomy specimen was examined. I did not appreciate any implanted parathyroid tissue. Sutures were placed along the right superior pole region for orientation, and this total thyroidectomy specimen was sent separately in formalin.

We then approached the neck dissection. The large external jugular vein was identified along level 5 of the neck and the supraclavicular fossa. The vein was skeletonized and retracted laterally gingerly using right angle retraction. Allis forceps were then placed along the sternocleidomastoid muscle and along the posterior aspect. This allowed for the fatty tissues in the posterior triangle of the neck to be dissected off of the sternocleidomastoid muscle and underneath the muscle. The dissection was carried towards the internal jugular vein into level 4. The omohyoid muscle was identified, and dissection superior to that into level 3 was performed. Again, the internal jugular vein was skeletonized of this fatty tissue along the posterior aspect. Dissection was then done from an anterior to posterior aspect, ligating numerous small vessels. I then proceeded to go to the inferior aspect of the dissection below the omohyoid muscle. Dissection along here allowed for identification of the transverse cervical artery, which was then followed laterally, and the overlying soft tissues were reflected using Stevens scissors, bipolar cautery, and mosquito forceps.

During the dissection, I identified a couple of small cutaneous nerves. Stimulation of those nerves using the nerve stimulator did not set off the shoulder. Dissection then was performed from the inferior to the superior aspect, taking soft tissues off of the scalene muscle along the floor of the neck. This allowed for dissection around this large metastatic lymph node from a posterior, inferior, deep, and anterior aspect. Dissection superiorly into level 3 of the neck off of the internal jugular vein was done using mosquito forceps, monopolar cautery, bipolar cautery, and Stevens scissors. This allowed for this large right metastatic lymph node to be dissected out of levels 3, 4, and 5 en bloc with a cuff of normal fatty tissue. During the dissection, I did appreciate a couple of small lymph nodes from levels 3 and 4 left en bloc with this large metastatic mass. This right neck dissection specimen was then sent in formalin for final pathology.

The neck was irrigated with copious normal saline. Valsalva maneuver showed no active bleeding. A drain was placed coming out the lateral aspect of the incision line and sutured through the skin using silk. I then reassessed the thyroidectomy site. No active bleeding could be seen after normal saline irrigation and Valsalva maneuver. Gelfoam was placed over both recurrent laryngeal nerves. Paratracheal drains were placed bilaterally, one coming out the lateral aspect of the left incision line, the other one coming out the mid-incision line, sutured to the skin with silk on both sides. The skin was then closed in two layers using buried interrupted 4-0 Polysorb for the platysma muscle and running 5-0 suture Prolene for the skin along with numerous Steri-Strips. The patient tolerated the surgery well. She was subsequently brought out of the anesthetic and returned to Recovery in stable condition.

Kenny Ngo, MD, FRCS(C)
AUTHENTICATED ACCORDING TO POLICY #X11-50
DICTATED BUT NOT READ
Dict: 2025/October/15 15:02 Trans: 2025/Oct/16 / CJ
Conf#: 28868545 TID: 26010894

cc: Kenny Ngo MD FRCSC
cc: Justin Porter MD CCFP

***** THE PROVIDERS LISTED IN THIS REPORT MAY NOT HAVE RECEIVED THE REPORT EITHER ELECTRONICALLY OR BY AUTOFAX *****

Principal Author: Ngo, Kenny

Dr Kenny Ngo, MD, FRCSC
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Skin cancers - Face, Head and Neck

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Sep 04, 2025

Dr. PORTER
OSMH EMERG
Orillia, ON

Patient:	Veronica Laycock
PHN:	7768 134 954hr
Birthdate:	Dec 31, 1958
Address:	452 Forest Ave S Orillia L3V 6M6
Phone:	(705) 242-0103 (705) 000-0000

Dear Dr. PORTER,

Problem History:	None Recorded
Risk Factors:	None Recorded
Active Medications:	None Recorded
External Medications:	None Recorded
Surgical/Medical History:	blood work - PTH 5 (WNL) TSH < 0.01 iCa 1.24 Tg 108 (high) anti-Tg Ab 16 (WNL) Mg 0.82 WNL Vit D 25-hydroxy 81 (WNL), CT Head, Neck, Chest - no intra-cranial mets. 5cm right heterogenous thyroid lobe. Rt medial 2.1cm supraclavicular LN. bilat LNs WNL. no mediastinal mets. no pulm mets. upper lobe emphysema, GERD
Known Allergies:	None Recorded
Lifestyle Notes:	None Recorded
Family History:	None Recorded
Alerts Imported HS:	None Recorded
Immunizations Imported HS:	None Recorded
Procedures/Investigations:	None Recorded
Uncategorized Problems:	None Recorded

Veronica was seen regarding:

papillary thyroid cancer

PMH
OA, severe Lt Knee
osteomyelitis Lt Great TOe 1993

Allergies
Known Allergies: None Recorded
aeroallergens No

Smoker
No,quit 2018

1ppd for about 30 yrs
no
no cannabis

S:
seen with her husband

presented to AHC as right neck mass above clavicle April 2025

no family history of thyroid disease or cancer

no exposure to head and neck radiation

normal swallowing and voice

some GERD/Heartburn
not on management, just takes ginger as needed

O:

neck exam
-right supra-clavicular neck mass at posterior aspect of SCM
-no other palapble neck
right thyroid fullness

scope
-nasopharynx pale and edematous, suggestive of reflux
-posterior larynx edematous and red, suggestive of reflux
-normal larynx
vocal folds moving well

US Thyroid/Neck June 13 2025 reported as
3.1cm mass inferior to right thyroid lobe with hypereochoic foci
Rt 4.2cm TR3 nodule
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5cm right heterogenous thyroid lobe.
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bilat LNs WNL.
no mediastinal mets. no pulm mets. upper lobe emphysema
*reviwed online
agree
no other obv right neck adenopathy

A/P:

Ms Laycock has a metastatic right papillary thyroid cancer to slightly bulky Level 5B lymph node

She will need a **total thyroidectomy and right neck dissection**

I reviewed the risks of **total thyroidectomy and right neck dissection** include, but are not limited to

1. Anesthetic
2. Bleeding
3. Infection
4. Voice changes
   a. Recurrent laryngeal nerve injury (weaker raspy voice in some)
- Majority are temporary
- 5-10% permanent resulting in a hoarse voice and possibly swallowing difficulties
  b. Unable to "sing high notes" due to strap muscles needing healing and external branch of superior laryngeal nerve being injured

5. Hypocalcemia due to HYPOPARATHRYOIDISM
approx 30% temporary
around 4% permanent requiring Calcium and Vitamin D supplementation

blood work will be checked twice a day to monitor the calcium levels
THIS IS THE MAIN REASON FOR POSTOP admission as severe hypocalcemia postop can be life threatening

6. Numbness of the skin above the incision line which sometimes persists

Neck drain(s) will be place as a part of the surgery. Patient are admitted to the hospital for 1 - 2 days to observe the calcium levels... but this can sometimes be longer. The neck drain will be removed 2-3 days after surgery... and sometimes before discharge from hospital.

The dressing and suture can be removed one week later by your family physician or by myself.

Cancellation of OR must be done within 2 weeks of OR time otherwise a $50 cancellation fee will be charged unless there is a medical reason (GP note) or family emergency.

There is a chance

Sincerely,

Kenny Ngo, MD
Electronically Reviewed to Expedite Delivery