

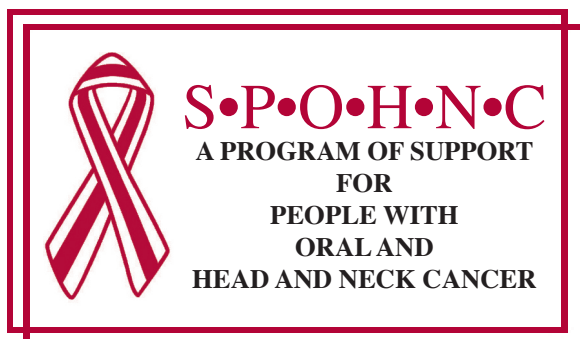
NEWS FROM S•P•O•H•N•C



VOL. 25 NO. 5

SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.

FEBRUARY 2016



Prevention/Reduction of Oral Side Effects and Quality of Life

Susan E. Calderbank, DMD

Current estimates show that one in every two males and one in every three females will develop cancer in their lifetime. Of those patients receiving chemotherapy, 30-40 % will develop treatment-related side effects. If the treatment of choice is a bone marrow or stem cell transplant, this figure expands to 75%. When a person is diagnosed with head and neck cancer and the treatment of choice is radiation, the incidence of oral side effects can become as high as 90%. These side effects may be so severe that the treatment has to



be altered or stopped completely for a short time to allow recovery prior to restarting therapy. The prevention and management of oral side effects during cancer treatment enhances a patient's chance of survival and ensures a better quality of life during and after treatment.

Two key issues are at the forefront of this subject: prevention or reduction of oral side effects and quality of life. They are simultaneously the important and yet the most neglected aspects of treatment planning for these patients. Following the National Institutes Consensus Development Conference on the Oral Complications of Cancer Therapies in 1989, the involvement of the dental team in the management and prevention these of oral complications has been the standard of care.

Dentists have been schooled in the concept of prevention from the very first days in dental school. Prevention of caries and periodontal problems are the benchmarks of a successful dental practice so the dental team should be actively involved in the care of the cancer patient. When the Dentist is an integral part of the cancer management team, treatment - induced side effects can be

greatly diminished or prevented.

The concept of "quality of life" is an important and timely topic in health care but it is one that often seems to bypass the patient receiving cancer therapy. The frightening diagnosis of cancer may lead a patient down an aggressive path of treatment that is often solely focused on the eradication of the malignancy with little regard to the "rest of the patient." The medical treatment team may be so focused on the cancer that the side effects of treatment are treated, as an inevitable sequela of what they hope will be a cure.

The current prevalence of HPV- induced cancer of the oropharynx has changed the landscape of dental treatment. Patients are developing these cancers decades earlier than cases where smoking and excess alcohol use were at issue. Radiation therapy is an important component of the standard of care for treatment and as always, "is the gift that keeps on giving." Radiation to the oral cavity, neck, salivary glands and surrounding tissues can produce permanent xerostomia (dry mouth), resulting in teeth that become sensitive, brittle and have an increased level of decay and periodontal disease.

These side effects must be minimized or managed by a team including the radiation oncologist, medical oncologist, the primary care provider, the head and neck surgeon and the dentist. First and foremost, prior to the beginning of head and neck radiation treatment, patients must to be referred to a dentist for proper evaluation. The cancer patient may arrive at the dental office confused and apprehensive. A comprehensive orientation and educational session will usually convert the anxious patient into a knowledgeable, motivated and compliant patient. The educational session must be given to both the patient and their significant other or caregiver. Caregivers then will become an advocate for good oral health during cancer treatment. Supplying these patients with printed handout material is also a good way to help assure compliance and to enable patients to have a resource that they may refer to as they go through treatment. It is also helpful for the patient to understand that they are headed down an arduous road but that their dentist will travel this road with them and offer help along the way.

A patient's understanding of treatment-related side effects is an essential aspect of cancer care. Patients must understand that during the ensuing treatment, control over the oral environment is truly one of the few areas where the patient has a measure of control. They have limited control over the treatment protocol, no control over the activity of the cancer cells, and no control over their body's reaction to treatment. Patients are made aware that they can control the bacterial growth on their teeth, restrict their use of sugar and add fluoride to their daily routine. Stretching exercises are essential as radiated muscles, tendons and ligaments will become scarred or fibrotic and lose the inherent flexibility which allows a patient to open their mouth. Adherence to prescribed rinsing protocols,

Find SPOHNC on Facebook



BOARD OF DIRECTORS

Nancy E. Leupold, MA, President & Founder
James J. Sciubba, DMD, PhD, Vice President
Walter E. Boehmler, Treasurer
Gail Fass, Secretary
Dorothy Gold, MSW, LCSW-C, OSW-C
Eugene N. Myers, MD, FACS, FRCS Edin (Hon)

EXECUTIVE DIRECTOR

Mary Ann Caputo

MEDICAL ADVISORY BOARD

| | |
|--|--|
| David M. Brizel, MD <i>Duke University Medical Center</i> | Jed Pollack, MD <i>North Shore/LIJ Health System</i> |
| Allen M. Chen, MD <i>Univ of CA at UCLA</i> | Karrie Zampini Robinson, LCSW <i>Fighting Chance, Sag Harbor, NY</i> |
| David W. Eisele, MD, FACS <i>Johns Hopkins Univ. School of Medicine</i> | David L. Schwartz, MD <i>UT Southwestern Medical Center</i> |
| Bonnie Martin-Harris, PhD, CCC-SLP <i>Medical University of South Carolina</i> | James J. Sciubba, DMD, PhD <i>Greater Baltimore Medical Center</i> |
| David Myssiorek, MD, FACS <i>New York University</i> | Elliot W. Strong, MD, FACS, Emeritus <i>Memorial Sloan-Kettering Cancer Center</i> |
| David G. Pfister, MD <i>Memorial Sloan-Kettering Cancer Center</i> | Everett E. Vokes, MD <i>University of Chicago Medical Center</i> |
| Randal S. Weber, MD, FACS <i>MD Anderson Cancer Center</i> | |

NEWSLETTER EDITOR

Chris Traxler

News From SPOHNC is a publication of
 Support for People with Oral and Head and Neck Cancer, Inc.
 Copyright ©2015-2016

DISCLAIMER: Support for People with Oral and Head and Neck Cancer, Inc. does not endorse any treatments or products mentioned in this newsletter. Please consult your physician before using any treatments or products.

IN THIS ISSUE

| | |
|------------------------------|------|
| Head & Neck Cancer News..... | 4,10 |
| Memorials & Honorariums..... | 5,6 |
| Time For Sharing..... | 7 |
| Chapter Happenings..... | 9 |
| Chapters of SPOHNC..... | 11 |

continued from page 1

stretching exercises, use of fluoride trays, and the avoidance of foods that may traumatize the oral tissue (pretzels, chips, crusty bread) will enable the patient to continue through treatment with good nutrition in a pain-free manner.

A complete dental examination including radiographs must be done. If teeth are to be retained they must be cleaned and fluoride trays constructed. Sharp edges of both teeth and prosthetic devices need to be smoothed to avoid trauma to the mucous membranes which, when damaged, may possibly result in a portal of entry for bacteria. When extractions are necessary a minimum of 2-3 weeks of healing time prior to the initiation of radiation is necessary. This is one primary reason for early referral to the dental team so that there is not a delay in cancer treatment. The goal of dental treatment at this time is to reduce oral inflammation, bacterial burden and to eliminate all potential sources of infection. Healthy, non-inflamed tissue does not break down as easily during cytotoxic cancer treatments.

Many patients receive both radiation and chemotherapy. Frequent dental visits during treatment serve to detect and manage oral side effects and to help allay patient fears. Side effects from chemotherapy usually completely resolve shortly after chemotherapy is finished. This is not the case with the side effects of radiation of the head and neck. The oral side effects of head and neck radiation can be divided into those during treatment and those that persist well after treatment is finished. There are 3 major side effects during treatment:

- Mucositis (soreness and ulcerations)
- Fungal infections
- An overall immuno-compromised state

Oral side effects are at their worst when the patient's white cell count is at its lowest level secondary to, in large measure, chemotherapy. This is generally when mucositis develops. In general, mucositis or ulceration, can be effectively managed by utilizing a combination of anti-microbial and anti-inflammatory rinses. Sometimes the mucositis is so severe that topical or systemic pain medication is necessary to enable patients to eat. Mucositis in the field of radiation may result in chronic thin and atrophic mucosa which can ulcerate more easily.

Viral infections can become problematic especially if the immune status of the patient is compromised. Fungal infections, however, are the most common infection. They often develop during treatment and can be alleviated by the use of systemic anti-fungal agents, often given for periods of 10-14 days. Topical anti-fungal agents often contain large amounts of sugar. Fungal infections at the corners of the lips are best treated using topical anti-fungal ointments. Often the brief weekly dental visits during treatment help to identify potential side effects before they become problematic. These visits also reinforce patient compliance with fluoride trays, rinses, stretching and good oral home care. In addition, advice on how a patient may meet their nutritional needs is given. The patient whose mouth is uncomfortable and who cannot taste their food simply does not feel like eating. For these patients, eating can become a painful, pleasure less chore. When patients are unable to swallow they lose weight and have a less positive response to the treatments.

Post treatment side-effects are more difficult in their ongoing management. It is statistically proven that head and neck
 continued on page 3

continued from page 2

radiation patients are usually compliant, post treatment, for 18 months. At the initial educational sessions, it should be emphasized to these patients that certain procedures must be done FOREVER. These include:

- Daily stretching – opening as widely as possible 10 times, 3 times daily - muscles, ligaments and tendons can become fibrotic and not be as flexible, resulting in an inability to open widely enough to even do routine examinations and receive dental care
- Dental checkups every 3 months as opposed to the normal 6 month exams – decay can develop quickly and progress faster in the patient who has received head and neck radiation
- Daily use of fluoride
- Daily use of baking soda rinses to neutralize acidic conditions in the mouth

Absence of adequate amounts of saliva may continually plague the post-treatment head and neck radiation patient. The magnitude of this problem is dependent on the radiation dose and the area exposed to the radiation field. Salivary gland tissue is very radiosensitive, thus are damaged early and more severely than most other tissues in the head and neck with an often profound reduction in saliva production. Resultant saliva becomes thicker and the more harmful strains of bacteria will become more virulent. The mouth, as a result, becomes more acidic. In the dry mouth, fungal infections are the most common infection seen post radiation. Dry mouth is an ever-present problem for the patient who receives head and neck radiation. Sucking on lemon drops or hard candy is one of the worst things a patient can do, as this can lead to severe dental decay.

Strategies that help head and neck radiation patients with dry mouth symptoms can be very beneficial. Bear in mind that a dry mouth is also an acidic mouth. Checking a patient's saliva with litmus paper is a great way to determine an oral acidity level. Normal oral pH ranges from 6.8 to 7.2. It is not unusual to see oral salivary pH as low as 4.6 in the patient with xerostomia. Daily use (3X/day) of a dilute solution of baking soda water rinse will instantly neutralize the acidity.

A printed strategy produced by SPOHNC listing products that relieve dry mouth is a godsend for these patients, and can be found in *“Meeting the Challenges of Oral and Head and Neck Cancer”*, by Nancy Leupold and Dr. James Sciubba. Additionally, The Natural Dentist line of products offer a great deal of additional product information concerning dry mouth.

In a patient with remaining teeth, fluoride use in a tray delivery system is essential. Neutral pH sodium fluoride gel is the product of choice. This is obtained directly from a dental office. When patients stop using these trays, the breakdown of the teeth can be very rapid. The extraction of such teeth can be problematic due to the risk of developing osteoradionecrosis. This condition is reflective of scarring of the tiniest capillaries in the bone due to the radiation. When this occurs, bone that is traumatized, for instance by an extraction, may not heal resulting in formation of necrotic or dead bone. Hyperbaric oxygen is often employed to minimize the risk of this condition but in some cases it is unavoidable.

This is why, upon the initial consultation, if a tooth has a questionable prognosis it needs to be extracted. If clinical conditions permit, at least 2 weeks, ideally 3 weeks, should be allowed for adequate healing between the extraction and the initiation of radiation. Also, the question of “Have you ever had head and neck radiation?” should also be on every medical/health questionnaire. Cancer patients, once they have finished with cancer treatment, may not even think to relate this on a future health history. Prior to performing any extraction the patient should be asked this question or offer the information to their dentist.

Oncologists often cite delay of treatment as a reason for not referring the cancer patient to the dental office. All dental offices should have an oncological dental program. Oncologists should be aware of dental practitioners who are able to treat their patients. The need for speed should be primary in their scheduling. Dialogues between dental professionals and those professionals in the field of oncology should be an ongoing event and a component of the planning phase in the management of head and neck cancer. Public education programs alerting the cancer patient to the necessity

of initial and continuing dental care should be developed.

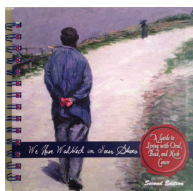
To provide optimum care for the cancer patient, a communicative and interactive team approach is essential. Treatment decisions may be complex. It is difficult to limit the effects of cancer treatment only to the cancer cells. Due to oral side effects, nutrition may be at risk. Providing education and information to both the patient and their caregivers is necessary to maximize patient understanding and compliance. In addition, this aspect of care is critical to the success of any preventative pretreatment strategy. Management of post - treatment symptoms requires a partnership between health care providers and their patients. It is crucial for patients to actively play a role in their symptom management along with their health care providers. Remember the acronym for the word team: Together Everyone Achieves More.

Editors Note: Dr. Calderbank is a 1977 graduate of the University of Pittsburgh. She is currently in private practice in Greenville, Pennsylvania. In addition to being a staff dentist at the University of Pittsburgh Medical Center/Horizon Campus, Dr. Calderbank is an associate instructor at the University of Pittsburgh School of Dental Medicine. She currently is a staff dentist at the University of Pittsburgh's Graduate Practice Residency. She served on the Pennsylvania State Dental Board for 13 years and was the first female chairman in its history. She is currently a chief examiner for Commission on Dental Competency Assessments. Dr. Calderbank holds fellowships in the Pierre Fauchard Society, the International College of Dentists and the American College of Dentists. In April of 2003, Dr. Calderbank received the Pennsylvania Dental Association's Special/Public Service Award in recognition of her commitment to raising awareness of the Oral Complications of Cancer Therapies. Dr. Calderbank is also a speaker for the prestigious American Dental Association Seminar Series. She is designated as a consultant to the American Dental Association.

“You have touched so many people over the years and made a great improvement in their lives in learning how to cope with the effects of their cancer as well as radiation and chemotherapy. Keep up the good work.”

~ P. LoPresti, MD

“Like” SPOHNC on Facebook

GET YOUR COPY NOW!***We Have Walked In Your Shoes: A Guide to Living With Oral, Head and Neck Cancer Second Edition***

and

- Contains the basics about the symptoms and diagnosis of head and neck cancer, types of treatment and common side effects.
- Offers a section to list your healthcare team, a personal calendar and journal, diet and nutrition information, and a list of resources.
- Beautifully illustrated with impressionistic paintings of the 1800's.

Go to www.spohnc.org to purchase a single copy for \$14.95 includes shipping and handling.

Bulk order pricing - 25+ books \$13.50/book and 50+ books \$12.50/book includes shipping & handling. For bulk orders please call 1-800-377-0928 or email us at info@spohnc.org.

*"We Have Walked In Your Shoes" is a tremendous resource for OHNC patients."
~ Valerie T.*

**HEAD AND NECK CANCER NEWS****Novel surgical approach improves local recurrence rates in oral cancers**

"Genetically altered cells are often widespread across the oral mucosa of patients with squamous cell carcinoma, which presents as low-grade disease or normal tissue clinically and histologically," Catherine F. Poh, DDS, PhD, associate professor of dentistry at University of British Columbia and clinical scientist in the Integrative Oncology and Cancer Control Research Program at BC Cancer Research Centre in Vancouver, British Columbia, and colleagues wrote. "Development of new approaches that can be adopted easily in clinical settings to facilitate the detection of clinically occult fields with a high risk for oral cancer remain a pressing need."

Fluorescence visualization (FV) can aid in the identification of high-risk oral lesions, thus allowing clinicians to visualize and map occult disease, according to study background.

Thus, Poh and colleagues sought to validate FV-guided surgery as an effective strategy for the reduction of locoregional recurrence and improvement of OS in patients with oral cancers.

The researchers reviewed data from 246 patients (mean age, 60 ± 12 years; 56.1% men) who received treatment at an oral oncology clinic between September 2004 and August 2009. All patients underwent curative surgery for a high-grade oral lesion

or squamous cell carcinoma smaller than 4 cm, with at least one follow-up visit. Ninety patients had high-grade lesions and 156 patients had squamous cell carcinoma.

Key study objectives included local recurrence of oral lesions with a histologic grade of severe dysplasia or higher, the presence of regional failure, and DFS after surgery. Surgical options included FV-guided surgery (n = 154) and conventional surgical treatment (n = 92). The researchers did not observe significant differences in age, smoking history, anatomical lesion site, tumor size or previous oral cancer between groups.

Among patients with squamous cell carcinoma, the rate of 3-year local recurrence appeared significantly lower among those treated with FV-guided surgery (n = 92) compared with those treated with conventional surgery (n = 64; 6.5% vs. 40.6%; P < .001).

Similarly, a smaller proportion of patients with high-grade lesions who underwent FV-guided surgery (n = 62) experienced local recurrence than patients who underwent conventional surgery (n = 28; 8.1% vs. 39.3%; P < .001).

Compared with those who underwent conventional surgical approaches, a smaller proportion of patients with squamous cell carcinoma treated with FV-guided surgery

experienced regional failure (15.2% vs. 25%) and died (13% vs. 20.3%). However, these differences did not reach statistical significance.

Results of a multivariate analysis of patients with squamous cell carcinoma showed the association with FV-guided surgery and reduction in local recurrence persisted (HR = 0.16; 95% CI, 0.06-0.39), whereas older age increased risk for local recurrence (HR 1.05; 95% CI, 1.02-1.08). Further, having a previous cancer increased risk for regional failure (HR = 5.51; 95% CI, 1.79-17).

Among patients with high-grade lesions, FV-guided surgery reduced risk for recurrence (HR = 0.16; 95% CI, 0.05-0.51), whereas having a previous cancer increased recurrence risk (HR = 2.99; 95% CI, 1.05-8.52). The researchers acknowledged the potential for selection bias as a study limitation. However, they reported that the FV-guided surgical approach is being investigated in the ongoing multicenter, phase 3 Canadian Optically Guided Research for Oral Lesions Surgical (COOLS) Trial.

"If validated in the COOLS trial, level one evidence will support this novel approach to be implemented in the clinical setting to change practice and, subsequently, improve patients' outcomes," Poh and colleagues wrote.

*Rick Agee's
2015 Page of Remembrance
in Loving Memory of*

Rick Agee

by ADS Sports Eyewear, Jane Agee,
John & Cynthia Agee, Lynn Agee,
Kristen Anderson/Oak Street
Wholesale Nursery LLC, Steven & Sarah Bartfield,
Joe Bennett, Biggerstaff Construction,
Martin Brantley, Bill & Betty Brooks/
Brooks Family Charitable Trust,
Bob & Elena Brown, Anne Burkett,
Michelle Cardwell/The K Group,
Sabrina Childs/Ball Seed Co.,
Thomas Conley, Bill & Sue Cotton,
John Crawford, Laura Dial,
Ronald & Danna Dunn/
Metro Landscape Maintenance,
Pamela Erickson, Joan Erkinson,
Eureka Gas Company, Tiffany Evans,
Excelerate Energy Limited Partnership,
Fantastic Movers, Pat Farquharson,
Roland Fillion-Robin, Floratech & Staff,
Susan S. Fixler, Jeff & Susan Frasier/
Floraltech, Inc., Orlando J. Gant Jr.,
Gabriel Garcia-Angeli/
Garcia Angeli Family Foundation,
Johanna Harpole, Melvin & Juanelle Harris,
Anne Heap, Robert Helbing,
Jack & Pam Hess, Mark Horan,
Joe & Patti Horton, Judee Houston,
Frank & Franne Jackson, Vickie R. Jones,
Mojca Klabjan/Nestle Nutrition,
Mary Klein, Nancy Koger, Robert J. Lambe,
Jerry Larsen, Leslie Love, William Mason,
Sharon McCants, Grady McCright,
Connie McGuire, James McKee,
Hank & Sandy McNeese,
Tammy F. McSwain, Bruce Miller Nursery,
Jack & Maryellen Mitchell, Jill Mullaney,
Elizabeth Munse, Kim Murphy,
Stacy Nabasny, Katherin Narvarte,
Chris & Cathryn Nolan,
Michael & Janet Passons, Kimberly Phemister,
Don Pittman, Greg Pray, Bob Quimby/
Green Lake Nursery, Judy Racs,
Jack Robertson, Lance Rogers,
Jeffrey Rutkowski/Jr. Nursery LLC,
Frank Sanker, Pat Scanlan, David Schwartz, MD,
Linda Scott,
Mike & Irene Speed, Molly J. Spinks,
Dan Stack, David & Amanda Stober,
Mike Sweeny, Steve Taber/
Southwest Wholesale Nursery,
Laszlo Takacs, Susan J. Tomson,
Dorothy Totzke, Martha Trubey,
Virginia Stark-Vance, Becky Waterfield,
William Weeks/M Anders Maintenance,
Charley & Lori West, Bill Wilson,
Joe H. Wood/Exceptional Landscapes, Inc.,
David Woodward, Alan Wright,
Y.C. Nursery

Trisha Appelhans

by Daniel & Sharon Mouch

Ed Blucher

by Lewis & Amy Beilman

Maria Boland

by Edward Boland, Mary Ford

Matthew Boroughf

by James & Marilyn Uhart

John Brownlee

by J. Steven & Linda Gambrill,
Michael Kehart & Colleagues

Mark Carroll

by Angela K. Ballinger, Mary L. Bennett,
Brian T. Cahill, Fred & Pat Cloppert,
L. Kathleen Froehle, Beatrice Goodman,
Peter & Margaret Janotka, Judith B. Jasper,
Steven & Gale Klayman, Jodi Remer,
Laura Richter, Fallon Ruff, Jason Slayton

Rick Charney

by Ben & Micki Naimoli

Jim Cullen

by Lewis & Amy Beilman

Robert Dale

by Kimberly Marshall DPT, CLT/
Progressive Physical Therapy

Steven Donahue

by Mary Lynne Donahue

LeAnn Dragano

by Andrew Cruse, Taressa Frenndling/
Team Industrial Services Inc.,
Carolyn K. Hart, Jeffrey & Brenda Klein,
Harrell & Angela Newsome,
Courtney Pollard, Don & Robin Rabun,
Stewart Shevitz

Valerie Faulkner

by John & Jean Callahan

Bob Ferguson

by Fay Phelps

Susan Fichtelberg

by Lewis & Amy Beilman

Vivian Rebecca Fishman

by Joanne Fishman, PhD

Richard P. Gangler

by Nancy Rock

Gregory Goodman

by Mark Fogle, Scott George,
Michael Porterfield

Frank Gormley

by Eileen J. Gormley

Janet Greenspan

by Lisa Lachs

Margaret Haralambos

by Charles & Diane McGaughey,
Diane DeCario

Madelyn Harper Walsh

by Hal Bankier/
Huntersville Planning Board,
Jerry & E. Maria Bobins, Daniel E. Boone
& Members of Olde Huntersville
Historical Society, Henry R. Brandt,
Jody Conner, Amanda Flanagan,
Bob & Dina Gerardi,
Mitchell Kornet DVM & Friends/
Mid Island Animal Hospital,
Stephanie Kunen, Nancy Leupold,
Rebecca Miyares, Geraldine Shikora,
Alice Steiner, Charles & JoAnn Tripi,
Barry & Rita Wilson

Jeanette Healy

by Reynold & Helene Mangones

David Kieschnick

by Joe & Lynn Murphy

Bob Klauber

by Alfred Tuckman

Michael Krawczyk

by Alton and Jill Jones

Robert J. Kreps

by Robert Kreps

Owen Laird

by Edward Boland

Barry Landers

by Bruce & Lynne Blatt

Ilene F. Levin

by Steven Goldfine

Thomas Magoulas

by Douglas K. Frank MD, FACS/Northwell

James Maier

by James Spannagel

Michael McCausland

by Robert Schoenfeld

Scott McClenahan

by Joseph & Ann Aragosa, Betsy Austin,
Phyllis Hess, Diane Hoyt,
Thomas & Kimberly LaBelle, Leanna Len-
hart, Jane Mackintosh,
Alison McClenahan, Peter & Karen Racette,
Kathryn Newton Rowley

Eldon Milburn

by Josef Meditz

Caroline Mills

by Chuck & Jody Bartlett

Chris Nicolau

by Robert & Dyan Cutro

James Nolfo

by Dennis & Kathy Staropoli

Patricia O'Rourke

by Steven C. Church

Brad Pate

by Kirstin Ramsay, DDS/
Preston Ridge Dental

Thomas Rabbitt

by Vicki Guth, Robert & Traci Luitjohan, Mary
Beth McInnis, Lydia O'Dell/
Mercy Radiant, Lynn Rabbitt, Joan Sackett,
Ladislaus & Marie Skrbín, Larry & Judy White

Katherine M. Rosbrook

by Catherine A. Berghahn

Karsten Schwan

by Marcia Angel, Chao Chen/Georgia Tech,
T. Ronda Flagg, Weiming Gu,
Vishakha Gupta, Kevin Hendricks,
Abhishek Iyer/Oracle Corp.,
Srinivasa M. Karlapalem,
Hyesoon Kim, Denise Knight, Ajay Kohli,
David J. Lillethun, Christian Poellabauer,
Rajiv Ramnath, Rita V. Rodriguez,
Peter Schwans, Vinod R. Singhal,
Richard Snodgrass, Vanish Talwar,
Tim & Mary Terrell, Prashant Thakare,
Wenli Xiao, Jun Xu

Todd Schwartz

by Jamie Bilsky

Bernard "Sonny" Sharkey

by Michele Gaguski

John Simmons

by Lawrence Boyd, Dominique Hollomon,
William Barry Jones, Robert Simmons,
Michael & Marie Tomek

Carolyn Taylor

by Lewis & Amy Beilman

Karen Testa

by Wendy D. Testa

Bob Thompson

by Lewis & Amy Beilman

Rosemarie Towler

by Bruce Hecktman, Sheldon Lavin,
Christine Pavel

Betty VanLonden

by Lewis & Amy Beilman

Luis Villarejos

by Lewis & Amy Beilman

Harris Weinstein

by David Weinstein

David Wolk, MD

by Karen Wolk

Gifts Have Been Received In Honor Of

Edward Martin & Bill O'Rourke

by Paul W. Hayden,
Francis & Carolyn McKenna,
Eric J. Morrison, Neil Morrison

Lewis & Amy Beilman

by Alton and Jill Jones

Mr. & Mrs. David Bernstein

by Alfred & Susan Carfora

Mr. & Mrs. John Couri

by Alfred & Susan Carfora

Frank Delnero

by Pam Delnero

Mrs. Barbara Geller

by Alfred & Susan Carfora

Gary Heape

by Stacy Bratton

Cindy Henry

by Danielle S. Lamaestra

Terry Herron

by Mark A. Courtney

David W. Keim by The DeWolfe,
Fenstermacher and Keim Families
& Jean Keim

Douglas A. Nielsen

by The Grand Court Order of Amaranth

Mr. Carl Reimerdes

by Alfred & Susan Carfora

Mrs. Patty Reimerdes

by Alfred & Susan Carfora

Robert & Jeanna Richelson

by Louise Spector

Rene Rodriguez

by Taino Lopez/Mas Group LLC

Mikhail & Sarah Rubinshteyn

by Steven & Rachel Stern

Dale Schnoke

by Ashley Devine

Elliot W. Strong, MD, FACS

by Eileen J. Gormley

Dave Terry

by Trudi Svenson

Rhett (Dad) Vereen

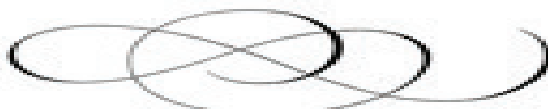
by Christine Vereen

Becky Weber

by William Plasse
& Members of the 501st Legion/
Bast Alpha Garrison

Christopher B. Williams

by Paul & Janet Bunnell



Time for Sharing...My Own Saga

I only recently learned of the existence of SPOHNC and have now read many of the publications and the stories contained therein. I immediately connected to those tales of the various head and neck cancers, and agreed to write my own saga; I also recognized how fortunate I had been to have had a strong support group along the way, that I now realize I may have taken for granted.

My story begins in the spring of 2009; I was getting hoarse more than usual and constantly trying to clear my throat. Though I was almost sure it was just allergies, it had lasted too long and I was getting somewhat frustrated, at which time I decided it was



time to have it checked out. I am an attorney and was in the midst of a two week Federal Court trial (as a side note, won a large verdict) but had a day off in the middle of the trial. Prior to this, I never had any serious health issues. I went to a local ENT and was told, after being scoped, that I had a lesion on my larynx or vocal cord that had to be removed and biopsied. I should mention that being scoped, i.e. a camera through the nose, is uncomfortable. Your eyes water, you gag and it is just an unpleasant experience.

Since that first experience, I have had it done probably close to a hundred times and whereas I am now used to it, have never found it to be anything but dreadful. I was referred to a ENT that specialized in vocal cord lesions - Dr. Lucian Sulica at NYU and had the biopsy done July 10, 2009; thereafter I went on vacation to Spain with my wife and another couple while awaiting the results. Though I was concerned, I was somewhat resigned and prepared for the bad news since Dr. Sulica appeared to believe it was cancer; the pathology showed I had stage "1a" laryngeal cancer which, though

I was not thrilled about, was advised that it was about as "good" a cancer diagnosis as you can get. It's a non aggressive, non life threatening cancer and "1a" is minimal.

After researching the options, with eventual cure and voice quality in mind, I elected radiation vs. surgery - 28 sessions, 5 days a week; at the time, it was the standard of care and had a 90% plus success rate. I chose, for a lot of reasons both personal and professional, to only tell a very limited number of people. Most of my friends, even my parents, and certainly my four children, ages 10-15, were kept in the dark about my illness. This decision was not easy and hardest on my wife, Esther. My hope was to advise people, after the anticipated successful radiation treatment, that I had contracted cancer but it was behind me.

It is worth mentioning that, as part of my research into my treatment options, I had a phone conversation with Dr. Steven Zeitel at Massachusetts General Hospital. He felt I was too young - 52 - to have radiation, and should come up to see him to review surgical options. I chose not to at that time and, moreover, went with the radiation. I suffered through radiation, where I was constantly spitting white fluids, and got two infections (thrush) that made it extremely difficult and painful to eat or just swallow for two prolonged periods. My neck was deep red, and I received numerous comments and questions about it. I was able to blame the redness as a sloppy application of sun tan lotion while golfing, and that seemed to satisfy the questioners. Upon completion of the radiation treatment, my voice was barely audible and the swelling was somewhat severe so another biopsy was ordered; I found out that I had "failed" radiation and was given this news on December 22, 2009, my daughter's birthday and two days prior to a planned family Jamaica vacation. Over the years since my ordeal, I have referred to various stages as body blows, with the first, i.e. the original diagnosis, not so bad since I was prepared. Failing radiation was unexpected and was, conversely, a major setback and I knew I would need surgery pretty soon thereafter. At this point, I became an open book regarding the disease and no longer kept it a secret; I first delivered the news to my kids during the vacation. Though

they were concerned, they handled the news pretty well.

Upon my return, I started the process of choosing a surgeon, and chose Richard Smith, at Montefiore in the Bronx. I then had to decide on open neck surgery, vs endoscopic laser surgery, one being 7-10 days hospitalization, and the other 24 - 48 hrs. After discussing the relative success percentages and finding them to be within a few percentage points, I chose to have the surgery done endoscopically.

The surgery was on January 21, 2010 - and it seemed to have been successful, though a lot of trauma was caused to the region. In the recovery room, I felt like I had licked a big pile of sand and they would not allow me to drink anything and I was miserable. My wife finally persuaded the nurses to let me have some ice chips, but I vividly recall being extremely uncomfortable. I was out of the hospital in 24 hours and, for the first time in close to a year, heard my old voice and was overjoyed, fully believing that this chapter of my life would soon be behind me.

continued on page 8

*Be one of the first to own
SPOHNC's newly designed*



***Oral, Head and Neck Cancer
Awareness Wristband!***

***Purchase at a special discounted
price of 5 for \$10.***

These wristbands were created to raise awareness and show support to the thousands of patients, survivors, caregivers and healthcare professionals who have endured the journey of oral, head and neck cancer.

Call 1-800-377-0928 or go to
www.spo-hnc.org to place your order.

continued from page 7

However, once the scar tissue built up again, the raspiness returned. After the surgery, I had monthly office visits and though my voice was still not what it was, it was significantly better. During one of the office visits, Dr. Smith said he saw something on my vocal cord, that was most likely scar tissue, but that I would need another biopsy to determine what it was that he was seeing. The thought that it was not over, after all I had already gone through, was depressing. As it turned out, he confirmed that it was, in fact, scar tissue and I was incredibly relieved. However, in October, Dr. Smith again said he saw something and I had to have another biopsy – it turned out that he didn't get it all, and I needed another operation. In retrospect and in later conversations I had with both he and others, it seems that he was likely wrong about the earlier scar tissue diagnosis. This was devastating news as I knew, based on an earlier conversation with Dr. Smith, that if another surgery was required, there was a good chance I would have to have my entire voice box extracted to insure that they removed all the cancer. This was a MAJOR body blow!

So, getting a smoker's disease while not being a smoker, not having any of the risk factors for this disease, failing radiation against all odds, and then having an unsuccessful operation, I became an odds maker's nightmare. But there was nothing to be done but move on, and I was resolved to do what was required to put this cancer behind me, and do what it would take to accomplish that. However, despite my positive attitude, I dreaded a voice box due to how I would be looked at and treated by others. Having a raspy voice means that you lose your privacy because it is your first contact with people; on a daily basis, I would get comments, as soon as I would open my mouth, like "you should have some tea with honey" or "have you been screaming at your kids" or other comments or tips, designed to be helpful to cure what was perceived to be a simple case of laryngitis. You learn to handle these intrusions since everyone means well, but it would not be the case if the voice wasn't so quickly noticed, unlike other diseases that can be more hidden. A voice box, though, would make me a sympathetic figure and treated differently..... but if that is what it would take, I would accept this treatment option. After all, my choices were limited.

At this point, I asked if I could wait until after my son's Bar Mitzvah, which was scheduled for December 4, 2010. Dr. Smith said yes, BUT had to be done asap thereafter.

Accordingly, I scheduled my surgery for 12/7/10 and whereas he advised he would certainly try to save my voicebox, the most important thing was to get rid of the cancer. I tried my best to prepare myself mentally for this, but could not shake the dread of having a mechanical voicebox.

As I prepared myself, I sent an email around to provide an updated status to my friends and family. One of the recipients was Max April, MD, who is both a friend of mine AND close to Dr. Zeitels, who was his mentor at medical school. He suggested I speak to Dr. Zeitels again. We spoke on a Saturday, and he suggested I come up the next day, a Sunday. I did, and he advised he believed he could save my voice box. I therefore canceled my surgery with Dr. Smith and scheduled my surgery in Boston for 12/14, which became 12/16. I should note that I did make the congregation at my son's Bar Mitzvah a little weepy, despite my best efforts to keep it light and about my son Teddy, not me. However, during the prayer to our son, one of my lines was "I pray that he continues to heed my advice, even if given in a more muted voice". As I was delivering this sentence, my voice cracked and my normal stoicism was lost in the moment.

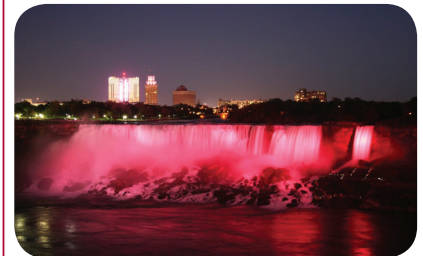
I had a 10 hour surgery, during which I was catheterized – an experience that is not recommended - and spent 15 days in the hospital, 14 of which I had a trach, a tube placed in a hole made in my neck. Dr. Zeitels was able to save my voice box by using an aortic graft from a cadaver to preserve the structure. This was an innovative procedure and I was the 15th patient to have this type of surgery. The hospital stay brought me into a whole new world. For instance, though I knew I would have a trach during my stay, and that there was no guarantee that I would leave the hospital without one, I never fully understood what that meant. I knew, for example, that I wouldn't be able to speak but never imagined I couldn't even whistle. This realization, once I tried whistling, made me feel very silly because it should have been obvious... I had a hole in my neck and the air couldn't reach my mouth, but it just is used to illustrate how this experience was

something entirely new. I was given a pad and communicated with my wife, and those few visitors I allowed to see me, through writing and my own sign language. My wife started calling me a loud mute and we strived to keep it light. I also started a blog, through Care Pages, and had quite a following.

Entering updates, and philosophizing on this blog was tremendous therapy as it connected me to the outside world, and gave me a chance to show my normalcy, but for the cancer, to my captive audience. After I left the hospital, a book was created from the blog, and I must say it makes a good read. One of the keys to being released from the hospital and one of the important aspects of my having the trach removed was being able to swallow. This was not easy and, in fact, I was minutes away from having a feeding tube inserted when I finally was able to properly swallow. Prior attempts were not as successful and I developed pneumonia due to some Ensure, my hospital diet, invading my lungs. Between the pneumonia, and the steroids I was being given, there were a few days that I would soak through my pajamas and sheets 3-4 times a night, and

continued on page 9

April Awareness Month is almost here!



April Awareness Month is almost here. Are you doing something to raise awareness of oral, head and neck cancer? Please remember to let SPOHNC know, so we can feature you in the newsletter, on Facebook and on our website.

***Need ideas or assistance?
Contact SPOHNC
at 1-800-377-0928
for help.***

Connect with SPOHNC's "group" on Facebook

continued from page 8

I was miserable. I was also coughing on a regular basis, and this caused me to have a constant headache that was not helped by the morphine drip. However, on the bright side, the staff was incredible and I eventually got discharged WITHOUT a trach. That day, despite leaving the hospital with a hole in my neck, was a celebration; my son, my wife and I and another couple went out to a local dinner and it felt like my life was going to get back on track.

Since the surgery, I have had regular checkups as well as both cat scans, and MRIs. On these occasions, I would usually hop on an 8 AM shuttle to Boston and return on the noon shuttle. Early on, I asked Dr. Zeitels if I could have a local MRI and have the films sent. I did this once, and it was a huge mistake. The radiologist at St. Francis never saw a graft before and was ready to admit me since he thought I had widespread

cancer. He told me this only after it was all cleared up when he reviewed the films with the Boston radiologist and the graft was explained. After that, I had all my exams and tests in Boston.

My voice is far from perfect but I can be heard, and am living a relatively normal life. I avoid loud places, to the extent I am able, but I have adapted pretty well to this new reality. The graft replaced a vocal cord so, unlike a cord, that side does not vibrate and I continue to be raspy, some say sexy; it also does not open and close like a normal vocal cord so that means I have a restricted airway. This mostly has an impact on my recovery time when I get out of breath, but something I have learned to deal with and I have altered my gym activities accordingly. What seems crazy to me is that, other than during radiation and following the two surgeries, I never felt sick. Prior to this

disease, I had been under anesthesia once, for a colonoscopy. Since the diagnosis, between operations and biopsies, eight more times. I did end up retiring prematurely – for my type of practice, voice quality is important, but I could have kept it going; significantly, I didn't have to. I chose to and thankfully I was able to without it having impact my life financially.

December 2015 will be five years and in October of 2015, my last visit to Dr. Zeitels in Boston, he confirmed that the disease is now behind me, though he still wants to monitor my progress every 6-8 months indefinitely. I received that part of the news as an indication that he likes seeing me, not that I need to be seen. He is my savior, gave me back my quality of life, albeit different that what it was. I feel incredibly grateful to Dr. Zeitels, Dr. April and my support group of family and friends.

~ Daniel Tannenbaum
dmtlaw4@gmail.com

Chapter Happenings

Greetings from Greenville!

SPOHNC is pleased to announce the rejuvenation of the Greenville, SC SPOHNC Chapter. The group is facilitated by Bill and Linda Clyne, who have been involved with SPOHNC since



Bill's diagnosis in 2006, when they became members of SPOHNC, and as volunteers for the National Survivor Volunteer Network match program

since 2011 as both a patient match volunteer and a caregiver match volunteer. SPOHNC staff, volunteers and conference attendees were pleased to meet the happy couple at our 20th Anniversary Conference and Celebration of Life in 2012, when they made the long trip from their former home in The Sea Ranch, CA to meet other survivors and share their experience.

Their sense of humor, kindness and supportive and caring ways make them an asset to our community of SPOHNC Chapter Facilitators. The Greenville, SC Chapter group meets on the 3rd Thursday of the month at 6:30pm at the St. Francis Cancer Center in Greenville. If you're in the Greenville area, and are seeking support either as a newly diagnosed patient, caregiver, or a survivor or family member, stop in for the meeting, or contact SPOHNC at 1-800-377-0928 for more information.

Medford...and Magnets

SPOHNC is always glad to hear from our Chapter Facilitators with Chapter News, Survivor News, and anything newsworthy to share with our readers. We recently received a special delivery from our Medford, Oregon Chapter Facilitator, Richard Boucher. Richard shared with us his New Years gift to those who attend his Chapter Support group.



Richard has been involved with SPOHNC since his diagnosis in 2000, becoming a volunteer for the National Survivor Volunteer Network in 2004, and as the Facilitator of the Medford, Oregon SPOHNC Chapter since 2008. His wisdom, curiosity and willingness to help are what make him such a wonderful volunteer, and his group is lucky to have someone so dedicated as their leader.

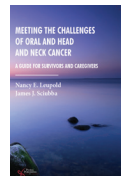
As 2015 came to a close and the promise of 2016 was right around the corner, Richard decided to create a useful gift for those he meets with each and every month, offering guidance, support and a caring hand. Richard created a calendar/refrigerator magnet for the year, with the SPOHNC logo replacing the date of each monthly Medford, OR SPOHNC Chapter meeting. What a thoughtful gift!

We tend to forget that happiness doesn't come as a result of getting something we don't have, but rather of recognizing and appreciating what we do have. Spread love to those around you; remember that not only today but each day you can make a difference in someone's life, you don't need an excuse or a special day to show someone you care.

Meeting the Challenges of Oral and Head and Neck Cancer A Guide for Survivors and Caregivers - Second Edition

featuring

5 New Chapters,
Updated Information,
Product Resources



\$27.00 includes shipping and handling

Place your order today at
www.spohnc.org or
call 1-800-377-0928

Head and Neck Cancer News

Experience Can Count in Radiation for Head and Neck Cancer

January 12, 2016 - NEW YORK (Reuters Health) - Head-and-neck cancer (HNC) patients treated with intensity modulated radiotherapy (IMRT) do better when radiation oncologists are more experienced, according to U.S. and Chinese researchers. "Essentially the more patients a provider treats the better the outcomes," Dr. James D. Murphy told Reuters Health by email.

"One interpretation of our study," he added, "is that we should direct patients with head-and-neck cancer toward experienced providers or larger centers with higher patient volumes. However, redirecting patients is not feasible in many circumstances due to patient-related factors compounded by the constraints of our current health care system."

In a January 4 online paper in the *Journal of Clinical Oncology*, Dr. Murphy, of the University of California San Diego, La Jolla, and colleagues note that they came to this conclusion after examining the impact of provider volume on outcome in 6,212 Medicare beneficiaries with a single primary tumor.

Between 2000 and 2009, almost

4,000 patients underwent conventional radiotherapy with the numbers split equally between high- and low-volume providers. There was a similar distribution in the remaining 2,242 patients who received IMRT. The patients were treated by a total of 788 radiation oncologists, with provider volume ranging from 1 to 70 patients throughout the study period.

In the conventional radiation group, there was no significant relationship between provider volume and patient survival or any toxicity end point. However, in the IMRT group, the risk of all-cause mortality decreased by 21% for every additional five patients treated per provider per year. Within subgroups, there was also a reduction in HNC-specific mortality (hazard ratio 0.68) and a decreased risk of aspiration pneumonia (HR 0.72).

Summing up, Dr. Murphy added, "Another way to look at these findings is that it emphasizes the importance of delivering high-quality radiation. Improving the quality of radiation delivery can come from many angles such as continuing provider education or telemedicine. As a specialty we should

strive to minimize this experience gap with the goal of improving outcomes for our patients."

Commenting on the findings by email, radiation oncologist Dr. Beth M. Beadle told Reuters Health this is "an important issue in the modern treatment of patients with head and neck cancer as technological advances in radiation oncology continue to evolve. Although IMRT has significantly impacted the outcomes of our patients in a positive way, with fewer side effects and excellent cancer control, this study highlights that it is best done by physicians who are experienced in treating head and neck cancer."

Dr. Beadle, of the University of Texas MD Anderson Cancer Center, Houston, concluded, "Even during the stress of a new cancer diagnosis, patients will benefit from doing their research and finding physicians who treat a high volume of head and neck cancer. This skill and experience is especially important in the era of IMRT."

The National Institutes of Health supported this research. Three co-authors reported disclosures.

###

Something sweet for your sweetheart on Valentines Day, from...

Eat Well Stay Nourished A Recipe and Resource Guide for Coping With Eating Challenges Volume 1

Strawberry Pudding

2 env. Knox unflavored gelatin
½ c. cold water
1 c. skim milk
¼ c. sugar
1 tsp. almond extract
1 qt. fresh strawberries



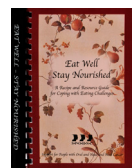
In a blender, add ½ c. cold water. Sprinkle gelatin over water. Let stand 3 - 4 minutes. In small saucepan, heat milk until boiling. Add milk to blender and process on low until gelatin is completely dissolved, about 2 minutes. Add remaining ingredients and process on high speed until strawberries are pureed. Pour into desert dishes or a bowl and chill until set. Serves 8.

~ Hildegard Voelker, NY

Eat Well Stay Nourished A Recipe and Resource Guide for Coping With Eating Challenges

\$20.00 includes shipping and handling.

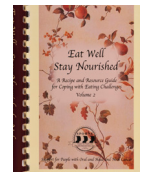
- Recipes & Information About Eating Challenges and Nutrition
- Cancer Journeys of Survivors
- Suggestions and "Tips from the Pros"



Eat Well Stay Nourished A Recipe and Resource Guide for Coping With Eating Challenges Volume 2

\$23.00 includes shipping and handling.

- New Recipes
- Chapter Devoted to Fortifying Foods
- Nutritional Information Included with Every Recipe

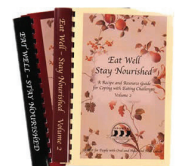


LIMITED TIME OFFER EXTENDED!

(while supplies last)

Two Volume Set

\$40.00 includes shipping and handling.



Share SPOHNC on Facebook

CHAPTERS OF SPOHNC (125+ and growing!)

Contact SPOHNC at 1-800-377-0928 for Chapter information & Facilitator contact information

ALABAMA
BIRMINGHAM

ARIZONA
CHANDLER, MESA/GILBERT,
PHOENIX, SCOTTSDALE

ARKANSAS
HOT SPRINGS, NORTHWEST

CALIFORNIA
ENCINITAS, NEWPORT BEACH,
ORANGE-UCI, SACRAMENTO,
SAN DIEGO, SOUTH SAN FRANCISCO,
SANTA MARIA, STANFORD, VENTURA

COLORADO
COLORADO SPRINGS,
DENVER, PUEBLO

CONNECTICUT
NEW LONDON, NORWICH

DC
GEORGETOWN

FLORIDA
FT MYERS, GAINESVILLE,
JACKSONVILLE/ACC,
JACKSONVILLE/UFS, JUPITER,
LECANTO, MIAMI/UMS, NAPLES,
OCALA, PALM COAST/NORTHEAST,
SARASOTA, TAMPA, THE VILLAGES,
WINTER PARK

GEORGIA
ATLANTA-EMORY, AUGUSTA,
COLUMBUS, SAVANNAH

ILLINOIS
EVANSTON/HIGHLAND PARK,
MAYWOOD, MORRIS, SPRINGFIELD

INDIANA
FORT WAYNE, INDY-WEST,
SOUTH BEND, TERRE HAUTE

IOWA
DES MOINES

KANSAS
KANSAS CITY, TOPEKA

LOUISIANA
BATON ROUGE, NEW ORLEANS

MARYLAND
BALTIMORE-GBMC,
BALTIMORE-JHMI, LIBERTYTOWN

MASSACHUSETTS
BOSTON, CAPE COD,
MID-CAPE ON CAPE COD, DANVERS

MICHIGAN
ANN ARBOR, DETROIT,
ST. JOSEPH, WARREN

MINNESOTA
MINNEAPOLIS, ST. PAUL

MISSOURI
ST. LOUIS/SLUCC, ST. LOUIS/DPCC,
ST. PAUL

MONTANA
BOZEMAN, KALISPELL

NEBRASKA
OMAHA/MCC, OMAHA/NMC

NEW JERSEY
ENGLEWOOD, LONG BRANCH,
MORRISTOWN,
PRINCETON/UMC, SOMERVILLE,
TOMS RIVER

NEW MEXICO
ALBUQUERQUE

NEW YORK
BUFFALO, MANHATTAN/BI,
MANHATTAN/MS, MANHATTAN/NYU,
MIDDLETOWN, NEW HYDE PARK,
ROCHESTER, STONY BROOK, SYOSSET

NORTH CAROLINA
ASHVILLE, DURHAM/CHAPEL HILL,

OHIO
CINCINNATI, CLEVELAND,
DAYTON, LIMA, MENTOR

OREGON
MEDFORD

PENNSYLVANIA
DUNMORE, HARRISBURG,
HERSHEY, LANCASTER,
PHILADELPHIA/UNIV. PENN HOSPITAL,
YORK

RHODE ISLAND
WAKEFIELD

SOUTH CAROLINA
GREENVILLE (UPSTATE)

TENNESSEE
CHATTANOOGA, NASHVILLE

TEXAS
AUSTIN, DALLAS/BICMC,
DALLAS/NCC, DALLAS/UTS,
HOUSTON, McALLEN, PLANO,
SAN ANTONIO

VIRGINIA
CHARLOTTESVILLE, FAIRFAX,
NORFOLK

WASHINGTON
SEATTLE

WISCONSIN
APPLETON, EAU CLAIRE,
MADISON, MILWAUKEE

"My diagnosis was 5 years ago, and my SPOHNC Chapter meetings and newsletters have been a great help and resource."

~ Claire N.



SUPPORT FOR PEOPLE WITH
 ORAL AND HEAD AND NECK CANCER
 P. O. BOX 53
 LOCUST VALLEY, NY 11560-0053

NON-PROFIT
 ORGANIZATION
 U.S. POSTAGE
 PAID
 LOCUST VALLEY, NY
 PERMIT NO. 28

ADDRESS SERVICE REQUESTED



SPOHNC
can meet all of your needs

- ~ 128+ Chapter Support Groups
- ~ NSVN Patient Match Program
- ~ Membership Benefits
- ~ We Have Walked In Your Shoes
- ~ Eat Well Stay Nourished
A Recipe and Resource Guide
- ~ Meeting The Challenges
of Oral and Head and Neck Cancer
- ~ Facebook (Closed) Group
- ~ Facebook Page
- ~ Telephone Support

Call 1-800-377-0928 to become a member and make a contribution by credit card or order online at www.spoync.org

- CONTRIBUTIONS**
- Booster, \$25+ Donor, \$50+ Sponsor, \$100+
 - Patron, \$500+ Benefactor, \$1,000+ Founder, \$5,000+
 - Leaders Circle, \$10,000+ Visionary Circle \$15,000+

- ANNUAL MEMBERSHIP**
- \$25.00 individual \$30.00 family
 - \$35.00 Foreign (US Currency)

First time member _____ Returning member _____

Please Check: Survivor _____ Friend _____ Health Professional (Specialty) _____

City _____ State _____ Zip _____

Address _____

Address _____ Email Address _____

Name _____ Phone (_____) _____

Membership includes subscription to eight issues of *News From SPOHNC*

MEMBERSHIP APPLICATION
SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.
P.O. Box 53, Locust Valley, NY 11560

SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER (SPOHNC)