

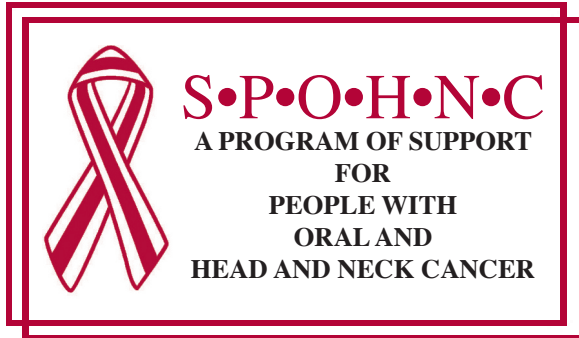
NEWS FROM S·P·O·H·N·C



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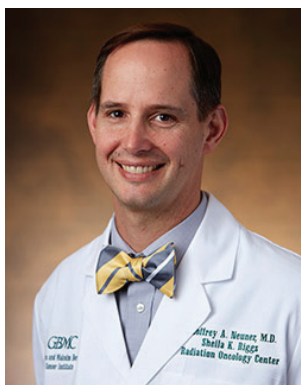


Recurrent and Metastatic Head and Neck Cancer

Geoffrey Neuner, MD

Introduction

It is an understatement to say head and neck cancer is a challenging disease for patients, caregivers and clinicians. Curative treatment consists of either surgery, radiation or both, often combined with cytotoxic chemotherapy. The individual treatments for head and neck cancer have improved somewhat over the past 30 years with the development of minimally



invasive surgical techniques, organ sparing radiation techniques, better side effect control for chemotherapy, and newer systemic agents such as immunotherapy. However, the overall backbone of curative treatment has changed little in that time period and is associated with significant toxicity. As survivors of head and neck cancer understand, once diagnosed there can be a permanency of the disease or its sequelae in the lives of patients and their caregivers. Although improvements in outcomes are occurring in the oropharyngeal subgroup of patients, this improvement is mainly related to the distinct biological differences in the origin of this disease as well as the generally better health of these patients. Even still, there is a significant risk of recurrence in both oropharyngeal patients with advanced disease and in patients with oral, laryngeal,

sinus, hypopharyngeal, or nasopharyngeal cancer. This can consist of recurrence of disease in the site of origin (local), the neck (regional recurrence), as well as in organs distant from the original cancer (distant metastases), or any and all of these areas. A lack of studies guiding treatment in these situations, called “salvage treatment,” requires patients and clinicians to be astute in the nature of the recurrence, probable outcomes, and risks of further treatment toxicity. This article will discuss some of the most common recurrence scenarios encountered in head and neck cancer patients.

Local and Regional Recurrence of Disease

Unfortunately, there is no subsite in the head and neck that is associated with a 100% cure rate after local therapy. After surgery, radiation, or chemotherapy combined with radiation (chemoradiation) are well established treatment regimens used to reduce the risk of recurrence, but up to 30% of patients recur nonetheless. The need for salvage treatment is not just limited to patients treated primarily by surgery. In trials and retrospective reports, 10-15% of patients undergoing curative radiation for very small larynx cancers will require removal of the larynx afterward, either for return of the cancer or for a second tumor that arises years later. Salvage treatment after initial curative treatment can be challenging, as anatomy may have already been altered by initial surgery, radiation, or both, and further treatment may severely limit functional outcomes.

Salvage treatment of head neck cancer is a very specialized field and requires input from experienced clinicians, including head and neck surgeons, radiation oncologists and medical oncologists who specialize in head and neck cancer. As head and neck cancer is actually a rare disease, specialization in the treatment of recurrence is something that is best undertaken at large referral centers that possess the expertise to advise patients accurately and manage both the salvage treatment and potential sequelae thereof.

Treatment is often tailored to very individualized situations, and the salvage treatment recommended depends on the initial therapy that was delivered, site of disease, patient health, and even the location within the organ. For example, a well lateralized recurrent oral tongue cancer may be excised, but another recurrent oral tongue cancer of the same size in the middle of the tongue may require complete removal of the tongue. In retrospective reports, patients who are able to undergo surgery as a salvage local treatment tend to fare better. Although this may point to the biology of the recurrent cancer itself, if patients are able to undergo surgery, it is generally preferred because of this data. Recurrent cancer, in general, is a reason to receive radiation. In patients with a previous history of radiation treated with salvage surgery, there is very little data to guide treatment

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recommendations, though one phase 3 clinical trial has compared immediate post-operative chemo reirradiation to observation. Although local control of the cancer was improved with post-operative therapy, life span was no different and severe adverse events were higher in the group that received immediate therapy. This is thought to be due to many reasons, including the multiple medical problems these patients have at this point in their lives as well as the high risk of the cancer to have spread to other organs after the application of salvage surgery.

Regional recurrence of disease describes regrowth of cancer in the lymph nodes of the neck, one of the primary routes of spread of head and neck cancer. In the event that a patient hasn't had radiation, regional recurrence can be managed with chemoradiation or surgery. However, if radiation was given before, regional recurrences are best managed with surgery, when possible. Reirradiation or chemo reirradiation can be given after surgery, but again there are risks given the neck muscles, skin, blood vessels, nerves, and spinal cord have all been radiated, and could sustain potential injury from the second dose of radiation. One radiation option performed in very specialized centers with experience in this area is brachytherapy. Meaning "near-therapy," it consists of the placement of radioactive sources right next to the area at risk for recurrence. This potentially limits the amount of radiation given to the already treated neck, while delivering a substantial dose of radiation right to the tissues at risk.

For patients who are unable to undergo salvage surgery, re-irradiation or chemo re-irradiation are potential options. Unfortunately, long term control of the recurrent cancer as well as survival of these patients are poor, for the same reasons listed above; poor patient health, further local/regional recurrence, and a high risk of spread to other organs. In addition, re-irradiation as a treatment modality is often limited because it is considered unsafe to deliver another full dose of radiation, and the therapeutic benefit doesn't justify further treatment of sites that may have be at risk for spread. In addition, if the patient has received radiation before, the blood supply to the tissue will often be poorer than it was before receiving radiation, and this can cause radiation to be less effective, as radiation at low doses requires oxygen in the tissue to help facilitate the destruction of tumor DNA.

Radiation is typically given in small daily doses for 6 weeks in the recurrent setting. Radiation oncologists can lower the dose per treatment and give two treatments per day, which should biologically make the radiation easier on the normal tissues surrounding the tumor. This is important, because patients who receive radiation for a second time have a small risk of severe life threatening tissue damage. A newer form of treatment called stereotactic body radiotherapy is delivered with high doses per treatment over 1 to 2 weeks, which biologically may overcome some of the issues with tissue oxygenation. These radiation regimens have not been compared and any one of them may be more appropriate based on the tumor location, patient prognosis, patient health, and patient desires. Finally, there are situations where proton therapy may have a therapeutic advantage, given its ability to deposit less dose in the surrounding normal tissues.

The poor outcomes with reirradiation are reflected in the National Comprehensive Cancer Network Guidelines (www.nccn.org)

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org) for recurrent/persistent/advanced head and neck cancer, as clinical trial enrollment is preferred for these patients. If not amenable to clinical trial and/or not eligible for reirradiation, systemic therapy such as chemotherapy or immunotherapy are possible treatments. For many years, this consisted of platinum based chemotherapy, the same sorts of agents used in combination with radiation for definitive treatment, combined with other cytotoxic chemotherapy. More recently, cetuximab, an antibody to a growth factor receptor often found on head and neck cancer cells, was found to improve outcomes in patients with recurrent or metastatic head and neck cancer when combined with cytotoxic chemotherapies Cisplatin and 5-FU.

More recently, excitement has been generated by results seen in clinical trials comparing immunotherapy to chemotherapy in patients who have suffered a recurrence of their cancer. Considered second line treatment, to be given after the failure of platinum based regimens, these therapies work differently by “waking up” the immune system when it had been turned off by the cancer. Although long term control rates are modest with immunotherapy as a whole, there have been patients, albeit a small minority, who have experienced complete disappearance of their recurrent cancer for several years. The two agents currently approved for use in recurrent head and neck cancer are nivolumab and pembrolizumab. These agents have been described in great detail in the April 2018 issue of SPOHNC. In a large clinical trial, nivolumab was found to have less side effects and better improvement in patient quality of life than chemotherapy in this setting.

Metastatic spread

Patients who demonstrate growth of cancer outside of the original head and neck site or lymph nodes of the head and neck have developed distant metastases, and are considered to have incurable disease. As mentioned above, some of these patients have demonstrated complete resolution of their disease with immunotherapy, but that is a minority. In addition, there is a group of patients with limited metastatic spread that have better outcomes, and treatment of their disease will be described below in

further detail. Most patients with metastatic spread have tumors that appear most often in the lungs, liver, and bones, but also sometimes occur in the lymph nodes of the chest or abdomen, or even in the skin, amongst other uncommon sites. Patients may have symptoms based on the location of the tumors (bone tumors causing pain, for example), but are often asymptomatic or only demonstrate mild systemic symptoms such as weight loss, fatigue, or loss of appetite.

In terms of treatment, it should be noted that the NCCN guidelines for metastatic disease mentioned give preference to clinical trial enrollment for patients who have developed metastatic spread. Although patients are often, understandably, very worried about receiving experimental therapy because they may miss out on the more effective standard therapy, it should be noted that the standard therapies have been largely ineffective for decades in terms of delivering long term disease control for patients with metastatic spread. Even though there has been demonstrable improvement in outcomes in patients with metastatic disease using immunotherapy, the majority of patients eventually progress and succumb to their disease. Therefore, it is imperative that new agents are developed and that novel combinations of treatments are found which will improve the outcomes of patients with both advanced local/regional recurrences or metastatic spread of disease. This can only happen through the altruism of patient participation in clinical trials.

The first step in treating the patient with metastatic disease is to assess their performance status. Those with significant irreversible health issues or cancer related symptoms may actually fare worse with treatment, and may be best served with palliative care/hospice. Although patients often think of this as “giving up,” it is rather a very appropriate service to address the multitude of physical, psychological and social issues that arise at the end of life. Good clinical trials have actually shown palliative care services EXTEND the lives of patients when they are incorporated early in the care of the patient with incurable cancer.

For those able to receive treatment for metastatic spread, treatment again consists

mainly of systemic therapies: cytotoxic chemotherapy, cytotoxic chemotherapy combined with cetuximab, or immunotherapy. For those who have a significant burden of symptoms but are still able to receive systemic therapy, single agent rather than combination therapy is recommended. For those with a minimal burden of symptoms and a good ability to participate in the daily activities of life, multi-agent systemic therapy is the treatment of choice after clinical trial enrollment, and can consist of the agents discussed in the local/regional recurrence setting above. Usually, if the cancer becomes resistant to the current regimen, the patient is switched to new regimens until the patient is unable to tolerate further therapy or the cancer grows beyond the control of any therapy. At that time, palliative care services are essential for symptom control, end of life planning, and psychological counseling.

Oligometastatic disease

Over the past 40 years, it has become more and more apparent that, regardless of cancer, there are patients who develop limited metastatic spread of cancer who may be cured by local therapy to the site of spread. Limited metastatic spread is called “oligometastatic” disease, and classically has been defined as having 1-5 metastases. The curative potential of patients with oligometastatic disease was first shown in patients with colorectal cancer with limited spread to the liver; up to 25% of these patients were cured with resection of the primary tumor and metastases in the liver. This was an important finding, because we now know that the metastatic tumors themselves can spread to other areas, not just the primary tumor. Over the years, reports of patients with other cancers with limited metastatic spread, who do well with local therapy to the site of spread, have emerged, including patients with breast cancer, prostate cancer, sarcoma, and even lung cancer. More recently, studies have shown that patients with limited metastatic head and neck cancers, particularly from the oropharynx, may have prolonged survivals after treatment of their sites of limited metastatic disease.

Treatment for oligometastatic disease can be surgery or radiation, usually SBRT. The latter is used because the sites of

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spread have usually not been radiated before, and are often in organs which can tolerate a large, destructive dose of radiation to a small part of the organ. These treatments can be delivered in as little as one treatment of radiation, and are associated with control rates of upwards of 90%. In cases where disease responds to systemic therapy and comes back in limited spots (oligorecurrent), or if most of the disease disappears except for a few spots (oligopersistent), SBRT can be used to ablate the recurrent or persistent areas in these patients as well. It has been difficult to accrue patients to clinical trials testing the hypothesis behind this treatment, as more and more clinicians believe it to be unfair to withhold such treatment in these situations.

Conclusions

The treatment of recurrent disease is an extremely difficult and nuanced situation for the head and neck patient. Local/regional recurrence is likely best treated with surgery. The application of repeat courses of chemoradiation afterward have to be considered carefully. Repeat courses of chemoradiation as a definitive treatment can be effective in a minority of patients, but are usually mostly palliative. In the patient not eligible for surgery, clinical trial enrollment is encouraged. Although systemic therapy for local/regional recurrence or distant spread were associated with poor survival for decades, recent improvements including immunotherapy are changing the landscape and allowing for more multimodality management, including the aggressive treatment of oligometastatic, oligorecurrent and oligopersistent disease.

Editor's Note: Geoffrey Neuner is a radiation oncologist in Baltimore. He completed his residency in 2011 at the University of Maryland Medical Center after graduating from Eastern Virginia Medical School in 2006. He currently is a radiation oncologist with Radiation Oncology Healthcare, PA. Dr. Neuner is the main consulting radiation oncologist for the Milton J. Dance, Jr. Head and Neck Center, a private head and neck cancer treatment and rehabilitation center. He has a diverse private practice, but concentrates on the treatment of patients with head and neck, breast and prostate cancers.

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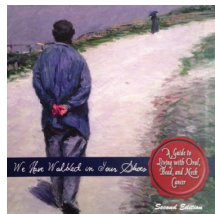


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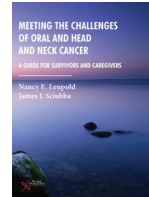
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*Compiled and Edited by Nancy E. Leupold, Survivor, Founder & President Emeritus
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- 1.5 lb. ground beef
- ¾ c. dried breadcrumbs
- 1 egg
- ¼ c. onions, chopped finely
- 2 Tbsp. dried parsley
- 1/14/ tsp. salt
- ¼ tsp. paprika
- 1/8 tsp. pepper
- 1 tsp Worcestershire sauce ½ c milk
- 1 can beef bouillon
- Cooking sherry



Saute chopped onions in butter or margarine. Combine with all other ingredients except bouillon and cooking sherry and form into small cocktail sized meatballs. Simmer meatballs, covered, in a pan with whole can bouillon, seasoned with a touch of cooking sherry. Serves 6. 336 calories/serving.

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April is Oral, Head and Neck Cancer Awareness Month

SPOHNC Founder, Survivor and President Emeritus Nancy Leupold

SPOHNC is honoring a very special birthday— one that holds deep meaning for all of us here at SPOHNC.

March 21st of this year marked a significant birthday for our Founder, Survivor and President Emeritus, Nancy Leupold. We're not giving away her secret, but we want to wish this visionary, and remarkable woman a very, very Happy Birthday!

Nearly 30 years ago, Nancy, began her journey with oral, head and neck cancer, and her quest to help and provide hope, healing and support for those who would travel a journey similar to her own.

An amazing woman with a vision created Support for People with Oral and Head and Neck Cancer (SPOHNC) beginning with one support group, formed on Long Island, and an organization that started in her home, to the now more than 120 support groups across the United States, and a matching program that is more than 200 strong. Nancy was determined to keep moving forward and creating new programs

and materials that would help future newly diagnosed patients and their families as they looked ahead.

Fast forward to 2019, SPOHNC now has a large social media presence, along with 2 cookbooks, 2 print publications for newly diagnosed patients, a newsletter published 8 times per year and a Product Directory, as well as a newly redesigned website. SPOHNC continues to grow and thrive as we uphold the mission that Nancy created.

Nancy has been the driving force behind SPOHNC and our programs and services since the beginning. Her passion and dedication will always mean so much to those who have benefited from the support and camaraderie offered through SPOHNC.

Pictured here during recent special

family time where everyone celebrated the most important occasion, it seems our Founder is enjoying a new addition to the family. Congratulations to all!!!

Happy Birthday to someone who has taught us the value of support, friendship, living life to the fullest and appreciating every single day. With gratitude, appreciation and respect for being such an inspiration to all newly diagnosed patients, survivors and their families...

We hope you have beautiful celebrations, and a wonderful year, Nancy!!! Sending much love - from your ENTIRE SPOHNC family!



Gifts Have Been Received In Honor Of

- | | | |
|--|--|---|
| <i>All Living with Head and Neck Cancer</i>
by Leone Locke | <i>Maria Folchetti</i> by Angelo Aquilino | <i>Carl Reimerdes</i> by Alfred & Susan Carfora |
| <i>Barbara Arienti</i> by Christina Young | <i>Barbara Geller</i> by Alfred & Susan Carfora | <i>Sharon Renkes</i> by Richard Hamel |
| <i>Larry Baldwin</i> by Bob Baldwin | <i>Gale Gildow</i> by John Gildow | <i>Hannelore Ring</i> by Eric Ring |
| <i>Lewis Beilman II</i>
by Lewis J. Beilman III, Adele Bitowft | <i>Robert Harben</i> by Herbert Hummel | <i>Mr. & Mrs. George Saire</i>
by Mr. & Mrs. Brindle |
| <i>Mr. & Mrs. David Bernstein</i>
by Alfred & Susan Carfora | <i>Craig Hoppe</i> by Mark Wentz | <i>Garrett Smetana</i>
by Mr. & Mrs. James Gavigan |
| <i>Richard J. Bowman</i> by Richard Bowman | <i>Sandra Knipe</i> by John & Rita Lamont | <i>Scott Stone</i> by Adriana Gomez |
| <i>Michael Brown</i> by Melissa Tolson | <i>Nancy Leupold</i>
by Dr. & Mrs. Eugene Myers | <i>Dr. Elliot W. Strong</i>
by Eileen Sini-Gormley |
| <i>Jerry Bryant</i> by Jerry Bryant | <i>Cecelia Luna</i> by Francesca Luna | <i>Brett Thornsberry</i> by Alison Tomecko |
| <i>Mr. & Mrs. John Couri</i>
by Alfred & Susan Carfora | <i>Sherri Neeley</i> by Cynthia Hanks | <i>Debbie Weber</i> by Norco Civic Association |
| <i>Steven Donahue</i> by Mary Donahue | <i>Joseph E. Parisi</i> by Joseph Parisi | <i>Scott Weiskamp & the 2018 Animal Run</i>
by Kent Thompson |
| <i>Butch Eaton</i> by Sarah Williams | <i>The Pepler Family</i> by John Quealy | <i>Paul Welch</i> by Nancy Duke |
| <i>Dr. Joanne Fishman</i> by Arlene Orenstein | <i>Joseph Prete</i> by Marie Prete | <i>Laurie Wennerholm</i> by Steven Stern |
| | <i>Sean M. Provencher</i> by Leone Locke | |

Rick Agee's Loving Page of Remembrance
Gifts Have Been Given In Memory Of

- Wendy Abbott** by Gail Fass
- Rick Agee** by Lynn Erickson, Steve Tauber,
Martha Trubey
- Vince Angelo** by Nancy Nye
- Trisha Adamski Appelhans** by Daniel Mouch
- Harold Aptaker** by Ruth Aptaker
- Paul Bauer** by Judy Thompson
- Chuck Bernard** by Mary Kay Bernard
- George F. Bohley, Jr.** by Jane Bohley
- Maria Boland** by Edward Boland, Mary Ford
- Doug Brino** by Lewis & Amy Beilman
- Richard Broome** by Hershey Penn
SPOHNC Chapter, Lee and Patrice Saurman
- James Richard Butterfield** by Sandra Knipe
- Sal Caputo** by Lisa Drance
- Elena Cuomo** by Linda Swalling
- David Davis** by Emilia Read
- Marc Devane** by Gregory Doll, Cynthia Paraday
- James Donelan** by Andrea Donelan
- Rebecca Vivian Fishman** by Joanne Fishman
- Ellen Foss** by Amber Wood
- Gloria Gelineau** by Frederick Insogna,
Anne Kinney
- Harvey Gendreau**
by Charles Colarullo, Cara Florio,
Bruce Gregory, Marsha Martin
- Scott Genova** by Edward Lawrence
- Frank Gormley** by Eileen Sini-Gormley
- Cynthia Green** by Iris Trotman
- Janet Greenspan** by Lisa Lachs
- Alice Grossman** by Gary Friedman
- Linda Hanlin** by George Hanlin
- Robert Harben** by Herbert Hummel
- Mary Havings** by Ben Kimbler
- Steven Holloway** by Sharon Evans
- James Huser** by Linda Slack
- Mario Iacona** by Linda Swalling
- John E. Jackson IV**
by Richard Amedee, Robin Barry,
Heather Berley, Eric Broadbridge,
Renee Conley, Robyn Crossman,
Tiffany McEntee, Brenda Morgan,
Roy Nelson, Patrick North,
James Person, Robert Scanlon,
John Solaski, Elizabeth Taylor,
Victoria Williams, Jerry Winston
- David Kabat**
by Laura Boyle, Ann Eiden,
Douglas Engledow, Ted Gibbs
- Dr. William Keane** by Carol Keane
- Robert Klauber** by Alfred Tuckman
- Felix Kleinman** by Mark Kleinman
- Barry Landers** by Bruce & Lynn Blatt
- David Lehman** by Donald Roufs,
Michael Sevig
- Monica Levine** by Michael Levine
- James J. Lewis, DDS** by Tanya Lewis
- Sandy Litch** by Philip Litch
- Mary Elizabeth Loeser**
by Chuck Loeser
- Rose and Sidney Mann** by Howard Mann
- Brian J. Mayer** by Delrose Koch,
Susan Mayer
- Cody McDonald** by Vicki McDonald
- Robert McGeachie** by Catherine McGeachie
- Greg McLelland** by Janet McLelland
- Martha A. Miller** by Edward Miller
- Paul Mintautas**
by Christina Barabolak,
Giedre Balciuniene, Zita Baltramonas,
Luc Bernard, Robert Caro,
The Cuomo Family, Ruta Galinaitis,
Elizabeth Hannaway, Jane Hsiao,
Steven Ito, Monte Koerner,
Christine Krahulik, Virginia Maciulis,
Lydia Milne, Catherine Mintautas,
Karen Schmitz, Kaori Tabion,
Liliana Velez, Carolyn Worniak
- Ron Muller** by Judy Martin
- Micki Naimoli** by Ben Naimoli
- Dorothy Necker** by Gary Friedman
- Roger Nelson** by Paul Hough
- Michael P. Nicklos** by Teri Nicklos
- Evan Niizawa** by Carey Tokirio
- Colleen Olden** by Lewis & Amy Beilman
- Steven Oliva** by Mary Oliva
- Lois Reed** by Lewis & Amy Beilman
- Sherry Seitz** by Margaret Seitz
- Mark Shemansky**
by Jenifer Barrer, Lynette Barrett,
Robert Beall, Jane Bondar, Matilde Garza,
Marlene Gerarge, Joseph Hammond,
Annemarie Holland, Bernadette Klimes,
James Russian, Mr. & Mrs. Severn,
Sheila Shaffer, Mr. & Mrs. Verdick
- Neil Shuster** by Dale Morganstern
- David Silver** by Shelly DeVries, Jeff Weiner
- Ronald L. Smith** by Nancy Monroe Clifford
- Robert L. Stanford** by Mollie Stanford
- Oneida Stowe** by Lee Dravidzius
- Sheryl Strear** by Mitchell Strear
- Those who have passed from this cancer
in 2018** by Annette Dippolito
- John Torres** by Elena Torres
- Barton Vest** by Paul Jung
- Jeannie Walsh** by Andrew Erman
- Madelyn Harper Walsh** by Bill Walsh
- William Wesp**
by Romney Bathurst, Bob Campbell,
Keith Clark & June Darmofal,
Steven Hartman, Tone and Nancy Kwas,
Dr. & Mrs. William Leahy,
Bradford Lovette, Fernando Moreno,
Celeste Morin, Judith Pesin,
Mr. & Mrs. Saraceni,
Mr. & Mrs. John Stahl, Alice Steiner,
Hans Ulrich, George Vollmuth,
Dennis Witmer
- Tamra Sue Hamm Williams**
by Sue Hamm
- Dorothy Winberry** by Jean Menchen
- Ronald Wright** by Catherine Wright
- your mother, Joanne** by Denise Anello
- your dad, Michele Ascioti**
by Maria Bonavita

CHAPTER NEWS

“WHAT GROUP MEANS TO US”

BY MARY ELLEN MCBRIDE, LMSW, OSW-C

AND MEMBERS OF THE ANN ARBOR, MICHIGAN CHAPTER OF SPOHNC

On a cold evening in March 2015, I fussed over preparations for the first meeting of the Ann Arbor chapter of SPOHNC. I had a sign-in sheet, blank name tags, educational materials from SPOHNC to share, and even some bottles of Ensure on ice (!) As a Radiation Oncology social worker, I had seen a great need for a group specific to Head & Neck Cancer patients. I reached out to patient Ron and his spouse/ caregiver Joanne for their advice, and to SPOHNC for their support. I sent letters of invitation to all our Head & Neck Cancer patients from the previous two years, but was still concerned about whether this was something our patients wanted. As it turned out four couples participated in that first meeting, and four years later they still attend. It has been gratifying to see the group grow in size over the years.

Our group meets for 1 ½ hours one evening a month. The first half hour is usually devoted to a guest speaker or a special topic, after which we have open discussion. Our speakers have included Radiation Oncologists, a Medical Oncologist, a Surgeon, our Director of Research, a Dentist, an insurance verifier, and a Physical Therapist. Popular repeat guests include a Speech Therapist, a Nutritionist, and a Chaplain. Special topics have included Advance Directives, depression, and fear of recurrence.

“I don’t know why more people don’t join, because they’d gain so much,” member Don M. regularly observes. “I can’t absorb all the information from the doctors; I learn at group.” Most patients and families have experienced the information overload at the time of diagnosis and beginning of treatment. At group we slow down the news feed, allowing everyone to better understand important information. Members may even advise someone new to take notes.

Speakers have taught us exercises to help stretch neck and jaw muscles, to enhance recovery and prevent future problems such as Trismus. Such preventive measures are necessary since radiation therapy is “the gift that keeps on giving,”

as caregiver Heather R. and other members note. We learn about recipes to help maintain nutritional status, and products to combat dry mouth. Each stage of the cancer journey is challenging, but for those with Oral, Head, & Neck Cancers survivorship continues to be so because of these long-term side effects. “There’s something about being with a whole group of people who have gone through the same thing,” caregiver Pat M. states.

Group member Matt R. somehow found the strength to ride his bike to most treatments, which amazed his wife Heather and other members. Caregiver Heather R. has been compiling an account of their cancer journey. Heather writes, “Our first group meeting turned out to be one of the best things we’ve ever done. Not only did we learn new information, but Matt found true camaraderie with his fellow members as did I with the caregivers.... I saw Matt come out of his shell as never before. This emboldened me to share things that I couldn’t even share with our families.” Heather concludes, “All in all the best way to articulate how we feel is simple: group has expanded our family.”

“Group opened the door for me to get through treatment,” Jim M. tells us. Each patient and caregiver have had their own adjustments to make, but Jim’s words resonate with everyone. “We’ve been very open in group – I didn’t feel alone.” Robin B. comments. Don and Pat M. mention how they “look forward to it every month.” “Group gives you power – connectivity that gets you through – bridging that gap, getting people to understand,” Rob M. relates. He also mentions how attending group gives him “insight and perspective.”

Our group welcomes caregivers and we believe they are essential to our success. I feel strongly that caregivers’ needs are also important. It is gratifying when a caregiver attends even if the patient is unable, which has happened several times. Another oncology professional who attends our meetings is Head & Neck Nurse Navigator Deb Young, RN. Deb points out that group members have had a pivotal role over the years in improving our hospital’s Head &

Neck Cancer program, by bringing issues to our attention and giving us the opportunity to make improvements. In this way, they have a direct influence on the care of future patients.

Original members Hope B. and caregiver Sean B. thought they “weren’t really the support group type.” They left the first meeting, however, anticipating the next. Hope writes, “It helped me to realize I was not alone in what I was feeling physically and mentally. It helped Sean to understand he was not ‘helpless’ and that he was making a difference. Group has taught us everyone reacts differently to the treatments and that there is no right or wrong way to do things.” Hope explains why they continue to come to group: “we go so we can celebrate the progress others make...to share information... finally, we continue to go as it reminds us of how far we’ve come. We have a unique group, one that I will always be grateful for.”

Our group has lost two members to cancer. We will not forget them and the time we spent together. Members have shared setbacks and been supported through them, perhaps encouraged to go back to their physician regarding a problem. But we are also able to laugh about a member choosing to drink cheap beer because he can’t taste it anyway. “The humor is very remarkable and healing,” caregiver Nancy M. rightly observes. Each month as group members arrive early and linger afterward, they share hugs and handshakes, phone numbers and photos of grandchildren. As original member/caregiver Joanne H. concludes, “It’s absolutely like a family.”

*“In everyone’s life, at some time,
our inner fire goes out.
It is then burst into flame by an
encounter with another human
being. We should all be thankful
for those people
who rekindle the inner spirit.”*

~ Albert Schweitzer

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

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