

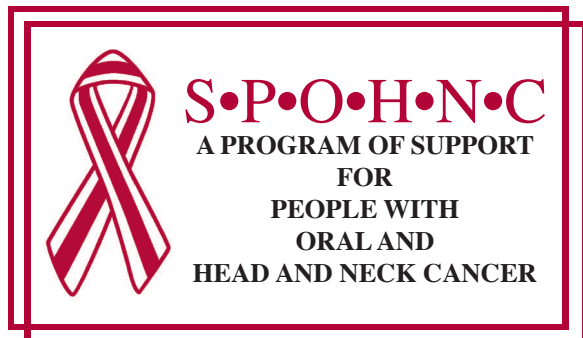
NEWS FROM S·P·O·H·N·C



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

FEBRUARY 2018



Head and Neck Cancers—Major Changes in the American Joint Committee on Cancer Eighth Edition Cancer Staging Manual

Introduction

Assigning the proper clinical and pathological stage is one of the key activities for clinicians caring for those afflicted with cancer. Staging entails stratification into similar groups based on anatomic and nonanatomic criteria to assist in estimating prognosis and planning treatment.

Head and neck oncology encompasses a group of malignancies that arise in the mucosal surfaces of the upper aerodigestive tract (UADT), including the oral cavity, pharynx, larynx, and paranasal sinuses, as well as cancers of the major and minor salivary glands. As such, the staging of malignancies arising in the UADT was defined in the American Joint Committee on Cancer (AJCC) Staging Manual, seventh edition, in the chapters pertaining to head and neck cancer.

Recognizing the prognostic power of newly validated pathologic features of some primary tumors and of cervical lymph node metastases, and differentiating high-risk human papilloma virus (HR-HPV)-associated oropharyngeal cancer (OPC) from OPC with other causes, the AJCC Cancer Staging Manual, eighth edition head and neck chapters introduce significant changes from the seventh edition.

Background on the AJCC Head and Neck Task Force

The AJCC Head and Neck Task Force consisted of 28 specialists selected for their breadth of expertise and depth of knowledge in staging and head and neck cancer biology. These principles served as guides for determining which aspects of the staging system warranted modification and which should remain unchanged. A comprehensive analysis of each of the chapters, undertaken by subgroups of experts, led to recommendations that were

submitted for approval and comment to the full task force. When changes were advised by the task force, additional analyses were performed to determine whether the available data would support the revision. This iterative process led to the changes introduced in the eighth edition.

Cancer Staging Considerations for the Eighth Edition

Cancer staging is an important component of patient care across the world. Preserving universal ability to stage cancers, regardless of a country's level of resources, and scrupulously assuring harmony between the AJCC and Union for International Cancer Control (UICC) staging systems were crucial goals. Balancing the demand to maintain consistency across past versions of the staging system with the need for innovation and contemporary applicability were important requirements. The nature and type of treatment determines the variety and quality of data available for use in prognostication and staging. For head and neck cancers that are largely treated using nonsurgical modalities (eg, nasopharyngeal cancer), pathological staging data, such as the number of involved lymph nodes or microscopic ENE, are seldom available; therefore, such diseases are staged using only the clinical TNM (cTNM) system. Cancers that are usually treated surgically (eg, oral cavity cancer [OCC]) provide robust pathological and clinical staging information; therefore, separate cTNM and pathological TNM (pTNM) systems are described for these situations.

Changes to Staging in HR-HPV-Associated OPCs

Since 1990, the incidence of cancers of the tonsil and tongue base associated with HR-HPV has risen at an alarming 5% per year in the United States and elsewhere. HPV types 16 and 18 are the most commonly detected, transcriptionally active HR-HPV types in head and neck cancer. Demographically, HR-HPV-associated OPC represents a novel disease that occurs more often in younger, healthier individuals with little or no tobacco exposure. The entity is highly responsive to treatment and carries an excellent prognosis.

Because site or histology alone cannot differentiate the 2 entities, it was imperative to identify an accurate or characteristic test to distinguish the 2 types of OPC. The test should be simple, inexpensive, and reproducible. Direct HR-HPV detection can be performed on tissue samples by in situ hybridization (ISH), but it is expensive and is not universally available, rendering ISH suboptimal for worldwide adoption. In many institutions, HPV-ISH is "sent-out," which increases turnaround time. Immunohistochemistry for overexpression of the tumor suppressor protein p16 is an established, robust surrogate biomarker for HPV-mediated carcinogenesis; it is also an independent positive prognosticator in the context of OPC. Immunohistochemical staining for p16 is inexpensive, has near universal availability, and is relatively straightforward to interpret. Hence, OPCs are

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now staged according to 2 distinct systems, depending on whether or not they overexpress p16. Staging by the HR-HPV-associated OPC system should only be assigned when p16 overexpression is determined using established criteria.

A variety of treatment approaches for p16-positive, HR-HPV-associated OPC are currently used. The National Comprehensive Cancer Network Guidelines consider radiation-based or surgically based treatment equally acceptable as first-line therapy. The data that led to the need for a new staging system and the data to create and validate the staging systems were broad based and came from centers treating primarily with radiation or primarily with surgical resection as the initial, definitive form of therapy. In view of the rising frequency of p16-positive oropharynx cancer, the urgency to define staging criteria necessitated use of data from both published and unpublished sources.

The p16-positive, HR-HPV-associated OPC cTNM classification is applicable to all patients before treatment (regardless of the intended form of treatment). cTNM employs information from physical examination and whatever imaging is performed. Clinically involved lymph nodes, whether one or multiple, as long as they were ipsilateral and less than 6 cm in size, had similar impact on survival and thus are included in the same N category: N1. Survival with clinically palpable and/or radiographically evident, bilateral or contralateral lymph nodes was distinguishable with a worse outcome than N1. Therefore, contralateral or bilateral lymph nodes are classified as N2. Lymph nodes greater than 6 cm foretold the worst survival from regional disease and thus warranted the highest N category: N3. This represents a significant change from the non-HR-HPV-associated (p16-negative) OPC N category.

pTNM is obviously applicable only to patients who are managed with surgery. Neither lymph node size nor presence in the contralateral neck was predictive of survival, unlike the situation for lymph nodes treated with radiation. However, a fundamental difference in outcome was observed based on the number of pathologically positive lymph nodes. The breakpoint in behavior appeared at 1 to 4 (N1) versus 5 or more (N2) lymph nodes. Because accurately counting the number of involved lymph nodes preoperatively is not possible for a pretreatment clinical stage classification, and because these data were exclusively derived by analyzing pathological lymph node numbers, this classification approach will be confined to pTNM. Therefore, the eighth edition for p16-positive tumors will have 2 separate staging systems, one for cTNM and one for pTNM.

Combining T and N into stage groupings was then accomplished using both the clinical and pathological data sets described above. The significantly better overall survival seen in HR-HPV-associated OPC allowed for much clearer discrimination into 3 curves representing stages I, II, and III. The paradigm reserves stage IV for patients with distant metastatic disease, a group known to have a much poorer survival. This represents a sharp contrast with non-HR-HPV-associated (p16-negative) cancers of the oropharynx, hypopharynx, oral cavity, paranasal sinuses, larynx, and salivary gland, in which stage IV is subdivided into IVA, IVB and IVC, and IVC is reserved for distant metastatic disease.

STAGING continued on page 3

STAGING continued from page 2**Unknown Primary**

Squamous cell carcinoma in lymph nodes arising from an undetected primary cancer is a well recognized clinical entity in the head and neck. The typical presenting finding is of an enlarged cervical lymph node with carcinoma identified by biopsy. A search through history, physical examination, appropriate imaging, and biopsy of candidate sites must yield no evidence of a primary tumor. These patients are categorized as T0 but cannot be assigned to a specific anatomic site. Currently, greater than 90% of these T0 (unknown primary) designations (lymph nodes in patients with no detectable primary) reflect HR-HPV-associated cancers. A large majority of nasopharyngeal cancers are positive for Epstein-Barr virus (EBV). Consequently, in the proper clinical context, demonstrating the presence of either EBV or HPV can establish an anatomic site of origin. HPV-ISH, p16 immunohistochemistry, and EBER-ISH are recommended for all cervical lymph nodes with carcinoma of unknown primary site. Thus, one key change from prior editions of the TNM system is the elimination of the T0 category in sites other than the nasopharynx, HR-HPV-associated OPC, and salivary gland cancers. If no primary lesion can be identified, then the lymph node may have emanated from any mucosal site, so there is no rationale to support retaining the T0 designation outside of the virally associated cancers of the oropharynx and nasopharynx. The specificity of p16 overexpression alone as a surrogate HR-HPV biomarker is limited to OPC. Cervical lymph node metastases that are HR-HPV ISH-positive/p16-positive with no primary tumor identified through history, physical examination, or available imaging studies will be staged as p16-positive, HR-HPV-associated OPC, which includes a T0 category. EBV-positive cancers identified in a cervical lymph node with no detected primary tumor will be staged according to the nasopharynx classification in which the T0 category remains. Squamous carcinoma in a cervical lymph node that is negative for EBER and p16 cannot be assigned to any specific head and neck primary site and will be staged according to the system detailed in the cervical node and unknown primary chapter.

Changes to the T Category

Primary tumor (T) categories have been revised in OCC, NMSC, and nasopharyngeal

cancer. The T category for OCC acknowledges the different biological behavior of deeply invasive but small tumors and incorporates depth of invasion (DOI). It has been recognized for decades that the prognosis of OCC worsens when the tumor is thicker. More recent data suggest that DOI is a better predictive parameter than tumor thickness.

Since the inception of the TNM system, clinicians have been using physical examination to reflect subtle differences in size and extension of tumors, so distinguishing less invasive lesions (≤ 5 mm), from those of moderate depth (from >5 to ≤ 10 mm) or deeply invasive cancers (>10 mm) should not be problematic. DOI will affect T category, accentuating the distinction between superficial or exophytic tumors and those that are more invasive. Staging will no longer depend solely upon greatest surface dimension.

Neck Classification Change in the Nasopharynx

In the N classification of nasopharynx, the iconic, traditional description of the supraclavicular fossa that was unique to this site will be replaced by contemporary definitions used for other head and neck sites and more suited to axial cross-sectional imaging. In addition, low neck involvement and >6 cm size will be merged into a single N3 designation (formerly N3a and N3b), and T4 and N3 will both designate stage IVA (formerly IVA and IVB) in stage grouping.

ENE in N Categorization

The status of the regional lymph nodes in head and neck cancer has tremendous prognostic significance, so the cervical lymph nodes must be assessed for each patient. ENE has been added as a prognostic variable for regional lymph node metastases in addition to the number and size of metastatic lymph nodes. Evidence has existed for decades that ENE profoundly affects prognosis for head and neck cancers, with the recently recognized exception of p16-positive, HR-HPV-associated OPC. The risk that newer staging versions would move those patients who had cancers with a worse outcome into more advanced stages, thus artificially creating better outcomes in early stage disease (a concept known as stage migration), was balanced against the

need for better hazard discrimination and consistency. To minimize stage migration, incorporating ENE into the clinical staging system requires a high bar for inclusion. Current imaging modalities have significant limitations and lack sensitivity and specificity in their ability to identify early or minor ENE. Radiological evidence alone may be supportive but is not sufficient.

Validation of Staging Algorithms Using an Oral Cavity Data Set

OCC is largely a surgically treated disease. Therefore, ample histopathologic data from relatively large data sets are available. Most OCC, like cancers of the larynx, hypopharynx, and paranasal sinuses, are HR-HPV-negative or, when positive, tend to behave similarly to their negative counterparts. Consistent with seventh edition staging for oral cavity, larynx, paranasal sinus, and hypopharynx and adopting the premise that nonvirus-associated tumors tend to behave in a similar fashion, the N categorization for all sites has been changed based upon the data from oral cavity sites.

Conclusion

The eighth edition Head and Neck AJCC Cancer Staging Manual incorporates significant changes based on advances in our understanding of the etiology and certain histologic attributes of tumors. These include a separate staging algorithm for HPV-associated cancer of the oropharynx; changes to the tumor T categories in the nasopharynx and oral cavity; and the addition of tumor ENE to the lymph node category for most sites. The revisions included in the eighth edition were based on evidence available from large institutional and collaborative data sets.

The process that led to these changes highlights the need to collect high-fidelity cancer registry-level data that can be used to confirm prognostic observations identified in institutional data sets. Future versions of the staging system may well incorporate nomograms and personalized approaches; but, for now, the eighth edition strikes a balance between a personalized, complex system and a more general, simpler one that maintains the user-friendliness and worldwide acceptability of the traditional TNM staging paradigm.

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A Time For Sharing... The Cycle of the Scan; Traveling from the Beginning of Cancer to the End?

When I was originally diagnosed with cancer of the tongue, I had no idea that the plethora of scans I would get since 2009 would ultimately be my roadmap along this journey. There are a lot of bad metaphors people who without cancer use, but for me as a stubborn, naïve and now sometimes cranky person with cancer, the trip metaphor works. My journey has been chronological in the technical aspects that have been part of the disease. I was first diagnosed with squamous cell carcinoma in the back of my tongue in 2009.

I had a recurrence in 2012, followed by recurrence in my lung in 2014, battle number four in both lungs in 2015, and that battle continues to this day. Several destinations on this journey, with a whole bunch of detours, some wonderful surprises and some that just downright pissed me off.

My emotional journey has been more like a series of vignettes, the more powerful episodes I revisit, void of real time anchors, often triggered by reading about those who have died of cancer, or frankly, the death of anyone or anything that mattered to me in my life, including our dogs. Our dogs. Susan and I started our pack in 2001, when she and I started dating. We had a lab mix, Ella, our first dog, then added Ruby, our rescue fox hound in 2002, and they became our companions for my third cancer fight. In 2007, we added our upstart, Lula, a black mini Shar-Pei that could best be described as sassy and aloof, but with a heavy dose of love. Our pack became an integral part of how we embraced the simple things in life along our cancer journey.

With that first diagnosis and treatment, I realized almost immediately that my life had changed, *OUR lives had changed*, perhaps more significantly than any of the other changes that I had lived through. At age 46 and otherwise a very healthy middle aged man, mortality stared me down. From the beginning of the journey back in 2009, when I discovered the lump in my neck, until a couple of fights with the insurance

company around what they would pay or not pay, the required protocol for diagnosis, two failed biopsies, and then finally a decision on a radical neck dissection, there was little humanity along the way, with the exception of my surgeons. When explaining what the plastic surgery part would look like, one doctor drew what we always remember as the kite, the graphic of what the surgery would entail, taking a graft from my wrist, along with the vein, putting that graft in the back of my throat to replace the



tissue that would be removed surrounding the tumor, and that I would then have this scar on my arm. My sister-in-law would later quip “women dig scars!” A few days prior to the surgery, I received notification from my insurance company that the plastic surgery would not be covered because it was cosmetic. They would pay for the front part of the surgery, sawing my jaw in two, a lengthy incision going from my lower lip, down my chin and across the left side of my neck, removal of part of the base of my tongue and 44 lymph nodes (of which one would be cancerous), but that putting me back together was cosmetic. We prevailed in our fight with the insurance carrier, less than 24 hours before reporting to the hospital.

The surgery lasted over ten hours, I spent a week in ICU, and did not respond well to Ativan. The nurses put a wristband on me, “FALL RISK.” Apparently, I tried to get out of bed and didn’t land with grace. To this day, to hear Susan tell the story brings tears of laughter regarding this entire week. I have no memory, as I was drugged up to the max. Dr. Rothman was my medical guide for the next five years and we built a strong patient/doctor relationship. There is no other medical professional in my life that I have trusted or respected more. He would apologize for having to do damage on me through the surgery. I remember many times simply thinking, “You saved my life. There are no apologies for that.” I recovered from the surgery more rapidly

than most predicted. This part of the journey is pure stubbornness. I will be damned if I was going to have to use a feeding tube more than was absolutely necessary. I had a goal to accomplish; in less than two months I needed to be back in the swing of things because we were going to Argentina as part of my doctoral studies. By the way, during this time I had started my doctorate in education in 2008, and finished on time in 2011. Cancer could not beat getting my degree! Other than coughing out ice chips through the tracheotomy hole in my neck, we transitioned off the feeding tube with due speed. I relished that first regular meal after a couple of weeks, no syringes with my formula, no gradual relearning to swallow, and minimal choking. From May 11th to June 21st, 2009, we made the transition from surgery, ICU, feeding tube and then back to eating real food just in time to travel to Maine for Susan’s parent’s 50th anniversary celebration, then from Maine to Buenos Aires. We made the trip and returned successfully.

The tale of the scans really began here. Every three months. Scan. What did we see? Nothing. Next scan, three months. Nothing. Next scan, three months, and again nothing. PET scans, CT with contract, CT without contract, MRI, chest x-ray, scan. First year, cancer free. Life went on. We traveled to Oaxaca, Mexico for the second travel abroad portion of my doctorate. We lived life understanding that cancer was part of our journey, just that it would not stop life. By 2011, I was now in the scan every six months routine. We had no signs of cancer through 2011. Two years to the day after my surgery, May 11, 2011, I graduated with my doctorate.

2012 changed the journey destination again. Once we were hoping for that magic cancer free mark of five years, but we didn’t get past year three. The second episode was more profound than the first. Four new tumors on the left side of my neck, where we had the surgery before. Surgery was out. There was no tissue left we could safely remove. Radiation and chemo ruled this round. 3 two-day cycles of cisplatin, 36 radiation sessions, a permanently altered hairline in back, the most painful sore throat one could possibly imagine. But no damned feeding tube! I missed two months of work, spent way too much time in bed, having the

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dogs by my side the whole time. Just their presence was therapeutic. They always brought joy, and they really didn't care about cancer, they just loved being with their people. Radiation was hard. Having your head strapped to the table while wearing a mask that prevents any movement is not for those who are claustrophobic.

Three months after treatment, scan. Three months, scan. Three months, scan. Three months, scan. Nothing. We continued life, went to Costa Rica in 2013, and were thankful for all that life had brought us. No whining about cancer. In 2014 I changed jobs, deciding to apply for a position in Washington State, getting the job running Human Resources in the Bellevue School District. It was the first time in my professional career (and my life), living outside of Arizona. Scan. We discovered a small spot in my lung, but too small to determine anything. We made it through 2014, Susan living in Arizona and me in Washington. 2015 saw us having to put Ruby down. She made it to the age of 16 and had a great life. Susan moved up to Washington with me in the summer of 2015. Scan, biopsy, cancer. Back in my lung, squamous cell, again. Three months fighting with the insurance company. This fight we lost. The recommended course of treatment, cyber knife, was considered investigational and not covered. We lost the appeal. So, surgery in the fall of 2015 removed the tumor and a wedge of lung. Hurry up and wait. Scan in three months, nothing. Toward the end of 2015, I began in earnest to contemplate the possibility of the end of my life, not surviving this round with cancer. It was a somber holiday. In January 2016, we lost Lula to of all things, complications of cancer. She was a tough dog and her loss broke our spirit for a few weeks. Scan. Scan in six months, five tumors in both lungs. Next detour.

Spring and summer of 2016 were challenging. This time we went away from traditional chemo, opting for Erbitux. We did genetic sequencing, and could not find any indicators that would provide a specific direction regarding immunotherapy. I continued to work, not missing very much time. I reacted very badly to the Erbitux. My face and body broke out in a severe rash. My scalp was covered with lesions. I shaved my head to make it easier to treat

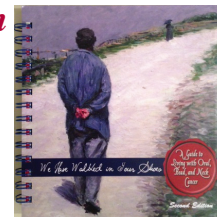
my bloody scalp. After four treatments, we stopped. My oncologist, Dr. Wahl was extremely apologetic. Apparently, I had the most severe reaction she had ever seen. So, we went to immunotherapy. Insurance would cover this, but not any of the other potential treatment options or clinical trials we began exploring. We adopted a new dog, Roxy, a rescue pit bull mix. She was a godsend. In September, at the age of 15, Ella left us, and our pack that we started in 2001 was gone. We added Maddie our sweet labradoodle, thus creating our new pack in November 2016. She is an absolute delight and she and Roxy have bonded beautifully. We now have new laughs and joys.

Immunotherapy continued through January 2017. Scan, no response, tumors actually progressed. I thought about all the commercials that had been airing regarding the various immunotherapy treatments, touting results of extending life that were false for me. Now what? With cancer, you prepare to live and prepare to die at the same time. That is the nature of the disease. Clinical trials. We explored dozens, narrowed down to a handful, and found one in Bethesda, Maryland at the National Cancer Institute. I became a clear match, having HPV-16 related cancer. But, we also decided to go back a few steps, carboplatin and Taxol at the suggestion of Dr. Wahl. What would happen if we did this more traditional chemo approach first? So, we did. February 2017, we began an intense four-week cycle, cisplatin and Taxol, Taxol, Taxol, repeat. I actually had my hair fall out this time. Luckily, my head is mostly symmetrical with a pretty round dome. I do bald well. Scan, response. Scan, better response. Scan, maintaining. Modify the cycle, continue, and repeat. My hair grew back. So, here we are today, fall, 2017, nine months and counting with this treatment regimen. My scans show maintaining, positive response, significant shrinking of tumors, no new occurrence. The clinical trial in Maryland won't take me for treatment as long as I am responding to my current chemo. That's a good thing. Today I will go back to work, suffer through my neuropathy, maybe some fatigue, but continue the journey, waiting for my next scan. And as we continue the journey, are we there yet?

~ Jeff Thomas

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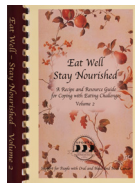


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Fudge Truffle Cheesecake (from Volume Two)

2 c. Hershey's semi sweet chocolate chips
3 8 oz. pkg. cream cheese, softened
1 (14 oz) can sweetened condensed milk (not evaporated)
4 eggs
2 tsp. vanilla extract

Chocolate Crumb Crust:

1 ½ c. vanilla wafer crumbs
½ c. powdered sugar
1/3 c. Hershey's cocoa
1/3 c. melted butter or margarine

For Crust: In medium bowl, combine all ingredients and press firmly on bottom of 9" springform pan.

For Cake: Heat oven to 300 degrees. Prepare chocolate crumb crust as above. Set aside. In a heavy saucepan, over very low heat, melt chips, stirring constantly. In a large mixing bowl, beat cheese until fluffy. Gradually beat in sweetened condensed milk until smooth. Add melted chips and remaining ingredients. Mix well. Pour into prepared pan. Bake 1 hour and 5 minutes until center is set. Cool. Chill. Refrigerate leftovers. *Serves 14 to 16. 515 calories/serving.*



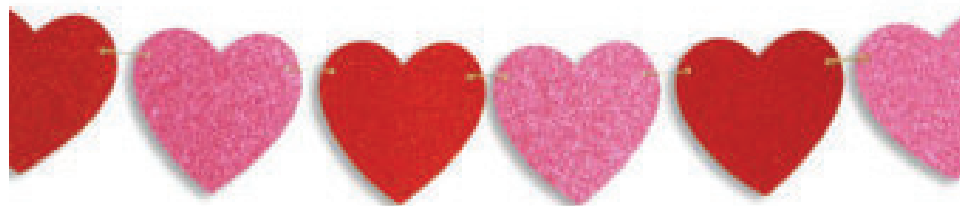
~ Joanne T., New York

Hot Chocolate Super Soy Milk (from Volume Two)

2 c. water
2 tbsp. Ghirardelli sweet ground chocolate powder
1 scoop WN Organic Soy Protein Smoothie Mix
1 sprinkle nutmeg and/or cinnamon

Place all ingredients in a blender in order listed. Secure lid. Blend at low speed until smooth. Heat gently in saucepan. *Serves 2. 372 calories/serving.*

~ Sean G., Colorado



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in Loving Memory of*

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Sheryl Strear
by Mitchell Strear

Steve Sturgeon
by Ronald Sturgeon

Your beautiful daughter, Tamra
by John Hamm

John Tignor
by Robert Hoffman

John Torres
by Elena Torres

Madelyn Harper Walsh
by Bill Walsh

David Wolk, MD
by Karen Wolk

Ronald Wright
by Catharine Wright



Gifts Have Been Received In Honor Of

Harold Aptaker
by Ruth Aptaker

**Mr. & Mrs. Bernstein, Mr. & Mrs. Couri,
Mrs. Barbara Geller, Mr. Carl Reimerdes**
by Alfred and Susan Carfora

Michael Brown
by Melissa Tolson

Rocco Cardone
by Maria Mandy

Jill Daly
by Patricia Schiela

Jim Donelan
by Andrea Donelan

Dr. Joanne Fishman
by Arlene Orenstein

Dr. John Glover
by J. Wray Pearce

**Valerie Goldstein and the Boston,
Massachusetts SPOHNC Chapter**
by Rob Ann Tomlinson

Lynn Gormley
by Patricia Unger

Cindy Henry
by Danielle Lamaestra

Sandra Knipe
by John & Rita Lamont

Robert Lehr
by Robert Lehr

Nancy Leupold
by Eugene Myers, MD, FACS, FRCS,
Edin (Hon)

Barry Kroner
by Marilyn Kroner

My wife, Micki
by Ben Naimoli

Douglas Neilsen
by Laura Landtiser

Janet Papper
by Dennis & Janet Papper

Joseph Parisi
by Joseph Parisi

Theresa Peduto
by Nanci Brody

Martin Piepoli
by Sharon Dills

Sean M. Provencher
by Leone Locke

Marge Putnam
by Michael Putman

Mr. & Mrs. George Saire
by Jane Brindle

Garrett Smetana
by Regina Abbott, Claire Smetana,
Susan Smetana

Charlene Smith
by Charlene Smith

**Those that have survived
and those that have cured them**
by Billye Jones

**Those that have or will have
oral, head and neck cancer**
by Maria Weiss

Bill and Anne Wesp
by Katie Leary

Shane Willis
by Richard Boucher

Kevin Wolfe
by Scott Erwin

Your Journey with Cancer
by Cheryl Minnich



**Photo
courtesy of
PJ Jordan, Caregiver and
SPOHNC NVSN Volunteer**

We Challenge You!

Join SPOHNC and the Your Cancer Game Plan Challenge!

We're excited to announce that we've joined Merck on the Your Cancer Game Plan Challenge, a social sharing program that will help us raise funds and continue our support of oral, head and neck cancer patients, caregivers, healthcare providers and others. We'd like to challenge you to join our team.

During the month of February, Merck will donate \$5 to SPOHNC for every social share of Your Cancer Game Plan, a resource to help patients take an active role in developing a "game plan" focused on the emotional, health and communication challenges that go along with cancer.

To participate in the Challenge, please visit YourCancerGamePlan.com, click on the



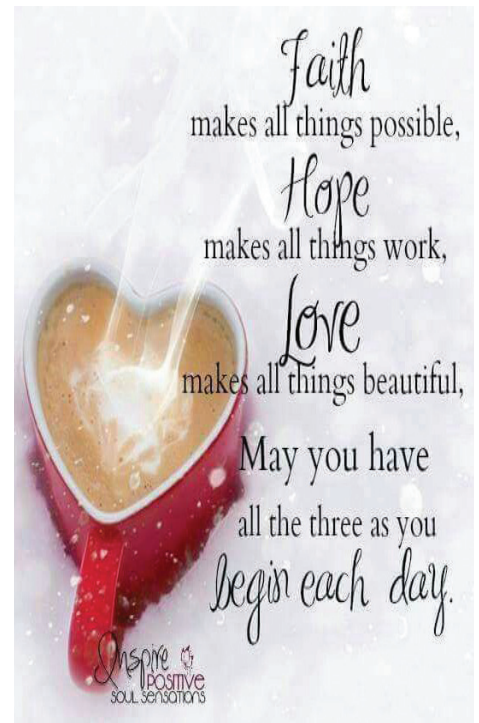
SPOHNC logo and share the website with your friends and family through your social networks.

While cancer is not something anyone plans for, it's important to have a game plan if diagnosed. SPOHNC and Your Cancer Game Plan can offer that much needed support along the way.

Visit today, learn something new and start sharing! You'll



be helping SPOHNC and supporting those living with oral, head and neck cancer.



SPOHNC is Celebrating YOU!

SPOHNC is grateful to all of our Chapter Facilitators. You give of yourselves every day, utilizing your professional experience and some of you, your unique perspective as a head and neck cancer survivor, to help those who look to you for inspiration and support.

SPOHNC is blessed to have one such very special man in our family, who has been affiliated with SPOHNC since 2004 when he joined us as a volunteer for our National Survivor Volunteer Network match program. Richard Boucher just couldn't get enough of SPOHNC, so he became the Chapter Facilitator for the Medford, Oregon SPOHNC Chapter, in 2008.



Since his retirement from the world of business a few years ago, Richard has been very busy - building decks, vacationing, spending time with family and friends - and also - celebrating birthdays! Yes - we heard that January 11th was a special day for a special man. Happy Birthday Richard!

Although Richard is so busy, he still finds time to work with SPOHNC helping us to stay connected to our Chapter Facilitators as our Chapter Facilitator Liaison through several avenues, including our newly developed closed Facebook SPOHNC Chapter Facilitator page, active since last year. Richard is terrific in getting conversations started among this very dedicated group of special SPOHNC family members.

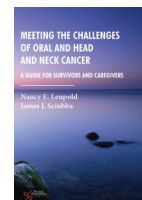
Richard, SPOHNC wishes you the best of everything in the coming year - more rafting, fishing, building and connecting SPOHNC family members! We hope you have a terrific year - nothing but the best!



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

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Head and Neck Cancer News

Oral Microbiome Population May Affect Risk for Head & Neck Cancer

Researchers evaluated oral microbiota samples from 129 patients with HNSCC and 254 controls to determine whether any link exists between particular bacteria and HNSCC risk. The abundance of particular bacteria in the oral microbiome may affect one's risk for head and neck cancer, according to a study published in *JAMA Oncology*.¹

Smoking, alcohol use, and human papillomavirus (HPV) status are each risk factors for head and neck cancer, the most common variety of which is head and neck squamous cell carcinoma (HNSCC). There is, however, also evidence that the diverse bacterial community in the human mouth plays a role in HNSCC development.

For this prospective study of 2 large cohorts (the American Cancer Society Cancer Prevention Study II Nutrition Cohort and the Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial), researchers evaluated oral microbiota samples from 129 patients with HNSCC and 254 controls to determine whether any link exists between particular bacteria and

HNSCC risk.

Patients and controls were similar in age, gender, and ethnicity; patients with HNSCC were, however, more likely to be smokers, drinkers, and positive for HPV-16 in oral samples. Greater abundance of *Actinobacteria* was linked to a greater HNSCC risk (fold change [FC], 1.21), though this finding was not robust. Greater abundance of *Corynebacterium* (FC, 0.58) and of *Kingella* (FC, 0.63) were, however, associated with a reduced HNSCC risk. This risk persisted regardless of smoking, drinking, and HPV status. The authors noted that these bacteria are "functionally related to xenobiotic biodegradation and metabolism pathways, including capacity to metabolize several toxicants found in cigarette smoke."

The authors concluded that the presence of *Corynebacterium* and *Kingella* in the oral microbiome may affect HNSCC risk, and noted that these "findings may have implications for HNSCC prevention in conjunction with other control measures."

###

Head and Neck Cancer News

Hearing Loss, Tinnitus May Predict Worse Outcomes for Cancer Survivors

December 18, 2017 - Hearing loss can adversely impact a cancer survivor's quality of life.

Development of chemotherapy-induced neuropathy (CIN), hearing loss (HL), and/or tinnitus (TIN), in cancer survivors may be predictive of increased risk of severe symptom burdens and reduced quality of life (QoL), according to a study published in the *European Journal of Oncology Nursing*.

CIN significantly detracts from patient QoL in numerous ways, including a decrease in physical function, sleep disorders, and significant psychological distress. Recent studies have assessed the impact of hearing loss and tinnitus, and investigators hypothesized that survivors who develop more neurotoxicities would have worse outcomes.

For this study, researchers recruited 754 cancer survivors with CIN and requested that they complete a self-reported questionnaire

that collected information on factors such as QoL, demographic, clinical, and pain characteristics, and also symptoms of CIN such as sensation, balance, perceived stress, and symptom burden. Of the 371 evaluable patients, 217 patients only had CIN, 69 patients had CIN/HL, and 85 patients had CIN/HL/TIN.

Reports of CIN/HL/TIN were not only associated with worsened physical symptoms (eg, pain, loss of protective sensation, and balance), but those survivors also had increased anxiety, depression, and poorer QoL.

Significantly worse outcomes were associated with having CIN/HL/TIN and CIN/HL compared with only CIN on some outcome measures such as longer duration of CIN, and worse self-reported balance problems.

Patients who had all three neurotoxicities were also less likely to report child care

DON'T MISS OUT!

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To love is nothing.
To be loved
is something.
But to love
and be loved,
that's everything.

"Thank you so much for the timely and most informative newsletters. SPOHNC has been there every step of the way, assisting and educating throughout."

~ Gene M.

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good care of a lot of awesome
folks!”*

~ Betty C.



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