

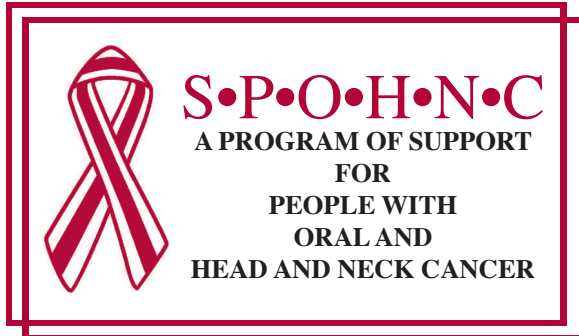
# NEWS FROM S·P·O·H·N·C



VOL. 28 NO. 6

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

MARCH 2019



## How Integrative Oncology Services Can Help Those Affected by Head and Neck Cancers

Santosh Rao, MD

Head and neck cancers, occurring in such a sensitive area of the body, can pose a number of issues for those undergoing treatment. The mainstays of curative treatment are surgery and/or radiation, both of which can cause many symptoms during and after treatment. Surgical treatment can result in loss of function or disfigurement. Radiation can result in pain, swallowing



dysfunction, and xerostomia (dry mouth). Chemotherapy with cisplatin, a mainstay of head and neck cancer treatment, often causes nausea and vomiting and can sometimes result in long-standing neuropathy and fatigue. Adequate nutrition and weight maintenance can plague individuals during and after treatment as well. While some of these are more difficult to fix than others, we must try whatever we can using a multi-disciplinary approach and all available options. It is with this spirit that we look to

integrative oncology for help.

“Integrative oncology is a patient-centered, evidence-informed field of cancer care that utilizes mind and body practices, natural products and/or lifestyle modifications from different traditions alongside conventional cancer treatments. Integrative oncology aims to optimize health, quality of life and clinical outcomes across the cancer care continuum, and to empower people to become active participants, before, during and

beyond cancer treatment.” *From: A Comprehensive Definition for Integrative Oncology*

Integrative oncology is growing in popularity and support within the oncology community. Recent guidelines have been established for the use of integrative oncology in breast cancer and survivorship, and research is giving us a better understanding of the impact of different strategies and approaches on those affected by cancer. The importance of including lifestyle and complementary approaches, which we would call integrative approaches, identifies patients at the center of their care and active partners in their treatment and follow up. Too often, the focus on helping cancer patients, in this case head and neck cancer patients, revolves around the important decisions regarding systemic therapy and local therapy options (surgery or radiation). These decisions are central in the care of head and neck cancer patients. However, the experience and short and long term tolerability and outcomes from these treatments can be modified using integrative approaches and keeping patients engaged and active in the plan of their care.

During an integrative oncology consult, recommendations are individualized depending on where in the course of treatment the patient stands and what he or she needs at the time. These recommendations can change with different stages of treatment. Symptoms are first considered and how to address them. Many people come to integrative oncology just to see what’s safe and what they should avoid in terms of supplements, exercise, or diet choices. Diet, exercise routines, stressors and how one relieves stress, sleep, supplements, spiritual concerns and other miscellaneous items are discussed.

One of the great aspects about integrative oncology is the team approach that is employed. It is an opportunity to involve a range of health practitioners to work together and answer questions to really help people where they are in their journey. These include dietitians, health psychologists, acupuncturists, yoga therapists, chaplains, exercise physiologists and physical therapists, massage therapists and Reiki practitioners among others. The key is to coordinate our recommendations and use all the skills and knowledge of the team to help; that is one of the special things about integrative oncology, bringing people together that previously were not part of a conventional cancer center.

### *Integrative Care Before or After Surgery*

For those who undergo surgery for head and neck cancer, often losing part of the palate, tongue, or other disfiguring surgeries, there are many steps towards healing that integrative oncology can assist. One important consideration up front is tobacco cessation. Head and neck cancer is often related to smoking, and current smoking is a contraindication to surgery. We use acupuncture, hypnosis, essential oils, medications and counseling to assist those who want to quit.

INTEGRATIVE ONCOLOGY continued on page 2

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Otherwise, pain with cancer and with surgery is common. Relaxation techniques such as guided imagery, Reiki and other energy healing modalities, music therapy, massage and acupuncture can all help with pain and anticipation of surgery. Anxiety over surgery and functional impairment can be aided through meditation, yoga, guided imagery, massage and aromatherapy. What better way to transcend physical changes through treatment than with prayer and meditation?

As mentioned earlier, part of the involvement of integrative practitioners is to help answer questions. Frequently, those newly diagnosed with cancer will read on the internet or go to groups and then start supplements or changes in behavior that may not be helpful, especially before surgery. It is important to guide in the use of supplements, especially those that might increase the risk of bleeding prior to surgery. So many questions come up, ideas about alkaline and ketogenic diets, hyperbaric oxygen, vitamin c, things people often entertain on the side of conventional care but don't involve their doctors. Integrative practitioners try to keep it simple, especially in sensitive times such as pre-op periods and post-op periods, where it's not wise to experiment.

*Integrative Care During Chemotherapy*

Systemic therapy options used to treat head and neck cancer depend on the stage of disease and other concurrent therapies such as radiation. Cisplatin, taxanes, 5FU, cetuximab, and now immunotherapy all have their place depending on other clinical factors. Cisplatin in particular is one of the most commonly used chemotherapy agents in head and neck cancer treatment. Nausea and vomiting can be reduced with acupuncture, which can be offered during chemotherapy. Ginger tablets or fresh ginger with tea is also commonly used. There is also some evidence for certain acupressure points to reduce nausea from chemotherapy. Acupuncture for neuropathy prevention and treatment can also be considered. Our patients notice if they get acupuncture or not during chemotherapy.

For fatigue, physical activity is recommended. That can mean 10 minutes a day for those with severe fatigue from chemotherapy, but otherwise 30 minutes a day is recommended. Getting sunlight in the morning helps not only with energy but to train the circadian rhythm. American ginseng can be used during chemotherapy to increase energy. Not a lot of other supplements during chemotherapy are recommended. There is interesting research suggesting the importance of the microbiome and even probiotics with those receiving immunotherapy (in advanced head and neck cancer for example).

From a dietary perspective, integrative providers work with dietitians to try to maintain nutritional needs, which is often difficult. It is advisable to limit sugar if at all possible (meaning that someone is getting plenty of nutrition). What really should be a focus is maintaining a positive attitude, expressing concern and emotion in a healthy way, and helping patients stay in the moment. Meditation, including mindfulness meditation, can be very helpful to help ground people during this turbulent time. Health psychologists can help with sleep through cognitive behavioral therapy. Trying to maintain a routine and sleep enough is also important. Diet, stress, and sleep all can modify tumor behavior, so why not try to focus on these things rather than the anxieties that come with treatment.

INTEGRATIVE ONCOLOGY continued on page 3

INTEGRATIVE ONCOLOGY continued from page 2

*Integrative Therapies During Radiation*  
The use of supplements during radiation should be limited. There is controversy regarding strong antioxidants such as melatonin, and whether it's helpful or harmful during radiation. Sometimes radiation oncologists feel strongly one way or another. Many discussions such as these are theoretical, with less than definitive studies supporting one claim or another. That makes offering strong recommendations difficult in integrative oncology. Many of the same issues with pain and anxiety occur during and after radiation, and integrative approaches are often similar.

There is really limited evidence on what to do post radiation. Some treatments commonly used for radiation burns are aloe and other lotions, topical vitamin E, etc. Hyperbaric oxygen does have a place post radiation for healing as well. The use of frankincense oil topically has been suggested to improve healing but studies are still preliminary.

For oral ulcerations and loss of appetite, medical honey (Manuka), which has the secondary benefit of giving some calories, is sometimes recommended. Taste issues are common and difficult to manage, though sometimes oral zinc will help.

Another troubling symptom is dry mouth (xerostomia). Studies have shown that acupuncture can reduce dry mouth and increase salivary flow when done post radiation. It is probably the most important reason to involve integrative oncology in head and neck cancer patients treated with radiation. Treatment can be given once to twice per week on an ongoing basis.

*Integrative Approaches  
in Advanced Disease*

Most people with metastatic head and neck cancer will be treated with chemotherapy, immunotherapy, or be on some kind of clinical trial. The primary focus will be on symptoms such as pain, anxiety and fatigue, working alongside other specialists such as palliative care many times. Many of the recommendations above hold true for pain and anxiety in the advanced setting, utilizing specialists in mind/body medicine (yoga therapists, health psychologists, Reiki and other energy healers) along with integrative approaches to pain such as acupuncture, massage and aromatherapy. In the metastatic

setting, it is important to also help patients with their personal and treatment goals. It is easy to lose motivation and purpose; having a purpose, expressing yourself in these situations often helps people continue the battle through bad news and suffering. Spiritual counseling, focusing on purpose and goals and hope, lifting resentments and fears, can really aid. All of us are involved in some way or another in this counseling, not just the chaplains, but the integrative practitioner, the psychologist, the yoga therapist and the massage therapist.

In those who have advanced stages of cancer, it may be ok to be more liberal with some supplements and other integrative therapies. This needs to be coordinated with other doctors of course, and one should be certain to identify supplements that are more helpful than harmful. These are controversial topics and many do not agree with this approach, especially since we do not have precise information regarding benefit, harm, dosing etc. But research doesn't move fast enough to answer some of these questions in real time, and many people need help with symptoms and rightfully want to try something they are optimistic will help. Some favored supplements in this setting are turmeric, an anti-inflammatory spice from India which has many anti-cancer properties, and melatonin, a very safe immune-modulating hormone that helps with sleep and has been shown to have some clinical activity in the advanced cancer setting. The evidence is weak but these supplements are relatively safe. If there are other supplements someone wants to use, caregivers should go through them individually, and also consider some supplements or other modalities of treatment for specific symptoms. Whatever helps and doesn't interfere with therapy at all.

It is clear that no two people practice Integrative Oncology the same way. While that may sound intriguing, in reality it is because we do not have enough evidence to be precise in our recommendations, we do not have the same algorithmic approach we do in other areas of cancer care. It's messy right now in terms of where the research is and understanding the mechanisms behind some of the therapies that have been discussed. Hopefully, in time that will change, and we can really integrate acupuncture, the use of natural supplements,

and dietary recommendations, in a way that right now is very subjective.

*Editors Note: Dr. Rao is the Medical Director of Integrative Medicine for Banner MD Anderson. His interest in Integrative Medicine began in college and was a significant influence on his decision to pursue a career in the medical field. After studying biophysics at the University of Michigan, he went on to obtain his medical degree at the University of Michigan as well. Dr. Rao then completed his internship and residency in Internal Medicine at the University of California, San Diego. Dr. Rao has studied Hematology and Oncology at University Hospitals Case Medical Center. He previously was employed at Scripps Green Hospital in San Diego, where he observed the practice of Integrative Medicine and developed strong relationships with leaders in the field.*

*Dr. Rao is passionate about incorporating Integrative Oncology and Cancer Prevention in cancer care. He completed an Associate Fellowship in Integrative Medicine at the University of Arizona in 2006 as a Bravewell Fellow. Dr. Rao is on the board of trustees for the Society of Integrative Oncology, where he has chaired the 2018 annual conference in Scottsdale and is co-chair of this year's conference in New York. He also teaches Integrative Medicine fellows at the University of Arizona, and has been a leading contributor to education modules for the cancer curriculum. Dr. Rao has a strong interest in Ayurveda; he has travelled to India multiple times studying Ayurveda, and he is currently enrolled in an Ayurveda courses with a goal of offering Ayurvedic services.*

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for what you do.”***

*~ Natasha W.*

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## HEAD AND NECK CANCER NEWS

### Adjuvant radiation improves survival in advanced squamous cell carcinoma with certain features

February 11, 2019 - Adjuvant radiation therapy improved survival outcomes among patients with advanced cutaneous squamous cell carcinoma that included perineural invasion and regional disease, according to findings published in *JAMA Otolaryngology-Head & Neck Surgery*.

“Optimal treatment of advanced cutaneous squamous cell carcinoma remains controversial because there are only a few large retrospective series that describe clinical outcomes, and no randomized clinical trials are available to guide decision-making,” Brianna N. Harris, MD, resident physician in the department of otolaryngology at University of California, Davis, and colleagues wrote. “Dermatologic series for all cutaneous squamous cell carcinomas have demonstrated that tumor differentiation, diameter, depth of invasion and perineural invasion are indicative of recurrence and poor survival.”

Researchers conducted a retrospective analysis of 349 patients (mean age, 70 years; range, 32-94; 86.5% men) with head and neck cutaneous squamous cell carcinoma who had undergone primary resection with or without adjuvant radiation therapy at University of California, Davis, or Washington University School of Medicine between Jan. 1, 2008 and June 30, 2016.

More than half of the patients (58.5%, n = 204) had recurrent tumors, 39% (n = 136) had perineural invasion, 37% (n = 129) had regional disease, 24.4% (n = 85) had poorly differentiated histologic features and 19.2% (n = 67) had extracapsular tumor extension. A total of 176 patients underwent adjuvant radiation therapy and an additional 15 (5.4%) were treated with adjuvant chemoradiation therapy. Adjuvant therapy was more commonly used for patients with larger, regionally metastatic, poorly differentiated tumors with perineural invasion, and for those who were younger and immunosuppressed. Median follow-up was 37 months (standard deviation, 55).

Kaplan-Meier estimates showed 5-year DFS of 59.4% and OS of 47.4%.

Cox proportional hazards multivariate regression, controlling for patient and tumor data, showed poorer DFS among patients with periorbital tumors (HR = 2.48; 95% CI, 1-6.16), perineural invasion (HR = 1.9; 95% CI, 1.12-3.19), or nodal disease that was N2 or greater (HR = 2.16; 95% CI, 1.13-4.16).

Results also showed poorer OS among patients with immunosuppression (HR = 2.17; 95% CI, 1.12-4.17) and N2 or greater nodal disease (HR = 2.43; 95% CI, 1.42-4.17).

Univariate analysis found no association between adjuvant radiation therapy and OS or DFS. However, on multivariate analysis, researchers observed improved OS with adjuvant radiation therapy among the entire cohort (HR = 0.59; 95% CI, 0.38-0.9). A subset analysis of tumors with perineural invasion showed an association between adjuvant radiation therapy and improved DFS (HR = 0.47; 95% CI, 0.23-0.93) and OS (HR = 0.44; 95% CI, 0.24-0.86). Patients with regional disease who received adjuvant radiation therapy also demonstrated improved DFS (HR = 0.36; 95% CI, 0.15-0.84) and OS (HR = 0.3; 95% CI, 0.15-0.61).

“In our series of surgically treated advanced cutaneous squamous cell carcinoma of the head and neck, adjuvant radiation therapy was more commonly given to patients with perineural invasion, increased tumor diameter, poor differentiation or regionally metastatic disease,” the researchers wrote. “In patients with perineural invasion and regional disease, adjuvant radiation therapy was associated with improved survival compared with surgery alone.” – *by Jennifer Byrne*

**Disclosures:** Harris reports no relevant financial disclosures. Please see the study for all other authors’ relevant financial disclosures.

### In Memoriam

SPOHNC was deeply saddened to learn of the passing of our Minneapolis, Minnesota SPOHNC Chapter Co-Facilitator, Justin Amand. Justin sought support and was passionate about helping others going through head and neck cancer.



As Co-Facilitator of the SPOHNC Chapter, he was such an integral part of the SPOHNC family there, helping to support those who came to the group seeking hope. He was an amazing man who brought something so special to the group. He was kind and

caring, and always willing to lend a listening ear. That takes a special kind of man, and Justin was just that man.

Chapter Co-Facilitator Chuck Bartlett, and the entire SPOHNC family in Minneapolis will miss him dearly. SPOHNC will keep Justin and his wife, Melissa and children, Ryan and Matthew, in our thoughts and prayers.



## CHAPTER NEWS

from the desk of Amy Beilman -  
SPOHNC Palm Coast, FL Chapter Facilitator

### Grief

We started the New Year off with a super good meeting, having guest speaker Karen Grant, the oncology social worker for Advent Health (FHF). Karen has had over 20 years experience dealing with grief at Hospice and is a certified bereavement counselor. Her insight and suggestions were so useful to all of us when we try to help others who have experienced a loss. She helped us think through what we could say to someone who is grieving.

We talked about some of the “normal” reactions to loss...anger, sorrow, sadness, frustration, hopelessness, etc. The process is so individual, so dependent on a person’s background and upbringing, that there is literally NO FORMULA to say or do the right thing. Just because you are talking to someone who lost a father and you lost your father, you can’t really say, “I know how you feel.” Each person’s individual story is just that...different and unique. The best thing for a person to do is simply “be there.” Each person goes through this process differently,

so that the duration and intensity varies greatly from individual to individual.

It is important to offer people “the space” to grieve. That was so interesting to me especially, just hearing that if you are merely “listening” you are doing something so worthwhile. When you see a person in pain and suffering it’s human nature to try and “fix it.” You can’t fix it. You can say, “I’m here if you feel like talking.” You can offer to help with the simple day to day things that might feel overwhelming.

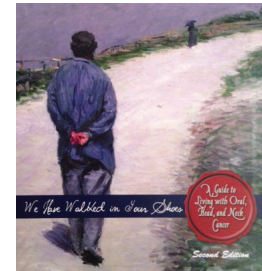
Karen also mentioned that death is accumulative...that over the years, things mount up, and sometimes there are grief triggers, like sights/songs/smells that can trigger a period of grief...years later.

Grieving is the price you pay for loving. If you have lost someone who you loved intensely, you are going to be more apt to grieve with intensity. Again, you can’t fix this, or solve it. You can just be there. Being present for them is a gift on its own.

Thank you Karen, for doing an awesome job.

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## SPOHNC IS CELEBRATING YOU!

It’s that time of year when Spring begins to appear, birds are chirping and people open up their hearts to the sunshine that’s about to put a smile on each of our faces. It’s also a special time when we celebrate a very special lady’s birthday here at SPOHNC... Chris Leonardis.



For those of you who don’t know Chris, she is SPOHNC’s Outreach Administrator as well as the Editor of our successful “News From SPOHNC” newsletter. Since her arrival several years ago she has graced us with her presence and her talents by supporting patients and their families in many different ways. She always goes the extra mile so that when one is suffering in one way or another

she seeks out the best care and advice to calm their concerns and worries.

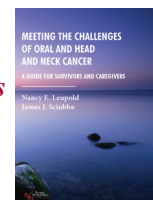
Chris has developed many friends here at SPOHNC through her sensitivity to the needs of others. She is one of the many gifts that we have been blessed with. All of us here at SPOHNC wish Chris a bounty of happiness and joy, today and always. If you get a chance drop her a line...she loves special handwritten notes, which proudly grace her office wall!

~ Mary Ann Caputo, Executive Director



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## HEAD AND NECK CANCER NEWS

### Greater Financial Burden Seen for Head and Neck Cancer Patients

#### *Poor and publicly insured patients hit with highest out-of-pocket costs*

February 21, 2019 - Patients with head and neck cancer (HNC) are at a distinct financial disadvantage compared with patients with other types of cancer, according to a recent study.

Specifically, patients with HNC incurred \$2,400 more in annual medical expenses and spent a greater percentage of their income on out-of-pocket expenses, reported Sean Massa, MD, of Washington University in St. Louis, and colleagues.

The highest relative out-of-pocket costs occurred among poor patients and those who were publicly insured.

“For patients with HNC, limited resources and higher expenses manifest as higher mean out-of-pocket expenses as a percentage of their income,” the authors wrote in *JAMA Otolaryngology-Head & Neck Surgery*. “In some cases, out-of-pocket medical expenses consume all of a household’s income for a given year.”

Massa and colleagues reviewed data on 16,771 patients with cancer from the Medical Expenditure Panel Survey from 1998 to 2015. Of these, 489 patients were diagnosed with HNC.

Patients diagnosed with HNC were more commonly of a minority race/ethnicity, male, poor, publicly insured, and had less education, with a lower general and mental health status.

Each year, patients with HNC spent a median of \$8,384 on medical expenses compared with a median of \$5,978 for patients with other types of cancer (difference of \$2,406). This total expense amount included expenses reported by the household of each patient and practitioner survey components.

Interestingly, Asian patients had almost half the annual expenses compared with whites (\$5,359 vs \$10,078). Patients from the Northwest had greater annual expenses (\$10,549) compared with Westerners (\$8,094) and Midwesterners (\$5,656). Finally, there was a \$10,000 difference in annual median medical expenses for patients with better health status compared with those with poor health status (\$6,714 vs \$16,990). The relative out-of-pocket expenses were similar, but still higher, for patients with HNC compared with other cancer types (3.93% vs 3.07%). These differences “appear to be explained primarily by the differences in income,” according to the researchers. Patients with higher total income and higher income rating on the poverty index had lower relative expenses. Those patients with public insurance had higher relative out-of-pocket expenses compared with privately insured patients (5.35% vs 2.87%); as did poor patients (13.07% vs 2.06% for high-income patients), and those with lower health status (10.2% vs 1.58% for those with excellent health).

In an accompanying editorial, Daniel Deschler, MD, of Massachusetts Eye and Ear Infirmary in Boston, pointed out that although the study was strong, it only included information on about 500 patients with head and neck cancer; more information is needed.

“We cannot immediately alter the patient demographics associated with disproportionate financial burdens for patients with HNC,” Deschler wrote. “Poverty, bias, lack of education, and impaired physical and mental health are society’s great challenges, but we can be alert for those individuals at risk in our world.”

To begin to collect data and combat the problem, Deschler suggested harnessing the power of big data.

“Now that we have unleashed the leviathan of the electronic medical record, which so dominates all aspects of our clinical and expanding clerical care, we need to harness the vast information potentially accessible with this technological beast for the benefits of the survivor of HNC,” Deschler wrote. “If an electronic medical record can assess our adherence with a *meaningful use* initiative, perhaps we can *meaningfully use* that same electronic medical record to identify resources to lessen the economic burden for our patients.”

###



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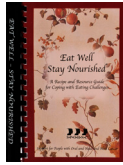
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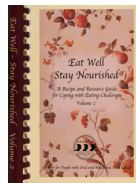


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Compiled and Edited by Nancy E. Leupold, Survivor, Founder & President Emeritus

**An Old Leek and Potato Soup (from Volume Two)**

- 5 – 6 leeks
- 3 Tbsp. butter
- 3 c. diced potatoes
- 1 qt. chicken broth
- 2 tsp. salt or to taste
- ¼ tsp. cayenne pepper (OPTIONAL)
- ½ tsp. nutmeg
- 2 Tbsp. butter
- 2 Tbsp. flour



Wash leeks and split lengthwise, removing tough outer leaves and most of the dark green. Cut into thick slices after removing all sand. Saute in 3 Tbsp of butter in large skillet for 4 minutes. Add the potatoes and broth and bring to boil. Boil for 2 minutes. Reduce heat and simmer until potatoes are tender. Season to taste with a few spices. Strain out the vegetables and put through food mill or ricer (I use blender with some of the broth). Melt butter in a saucepan over low heat and stir in flour. Add 1 ½ cups of broth and blend well, stirring until mixture thickens. Return all ingredients to kettle and stir until soup comes to boil. Serve!  
*Serves 4. 315 calories/serving.*

~ Leta P., CA

**Banana Pudding (from Volume One)**

- 1 - 14 oz can Eagle Brand condensed milk
- 1 ½ c. condensed milk
- 1 (4 serving size) pkg. instant vanilla pudding mix
- 2 c. whipping cream, whipped
- 40 to 48 vanilla wafers
- 3 medium bananas



In large bowl, combine the milk and water. Add the pudding mix and beat well. Chill for 5 minutes. While pudding mix is chilling, whip the whipping cream. Fold whipped cream into pudding mix. Spoon 1 cup of mixture into serving bowl. Top with 1/3 each of wafers, bananas and pudding mix. Repeat layering, ending with pudding and top with wafers. Chill for several hours. Refrigerate leftovers. *Yields 8 - 1 cup servings. 576 calories/serving.*

~ Steve and Terry J., TX



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## It is in the Shelter of Each Other that the People Live

*March 17, 2017*

If you are like me, you sometimes take for granted that you are fortunate to have a shelter—a home, apartment, or some kind of physical dwelling—a place where you get to live and sleep on a daily basis. I'm not always as appreciative as I should be about the fact that I have always been blessed to have such a shelter in my life. I am aware that I often take for granted another kind of shelter that I live in, and that is the shelter that the love of friends and family provides for me each day. It is this kind of shelter to which the beautiful Irish proverb that appears above is referring: "It is in the shelter of each other that the people live." There are many ways we can provide the kind of shelter for one another that this proverb describes. As I wrote last week, one way we can provide shelter is to truly listen to one another. We can also offer any or all of the following: compassion, love, patience, forgiveness, acceptance, and gratitude—all of which are forms of shelter.

In honor of St. Patrick's Day I want to highlight a wonderful Irish tradition, that of offering blessings and well wishes to one another. In this way the Irish, and the rest of us who can learn from them, can provide emotional and spiritual shelter to our friends, neighbors, and families. Even if you are not Irish yourself, you likely are already familiar

with these wonderful sentiments offered to others. Google "Irish Blessings" and you will find a long list.

One way I know about the shelter a blessing can be for any of us is the many times I have heard stories, from clients and parishioners alike, about the pain they have endured when the blessing from a loved one was withheld. I have heard stories of great sadness when a person shared how a significant person in their life—a parent, grandparent, boss, close friend—did not bless the person they were or an important decision they had made. "It has always been painful for me that I never received my \_\_\_\_\_'s blessing" is almost always said through tear-filled eyes.

I have also heard stories of how much it has meant to people to receive the blessing of a significant person in their lives. Their eyes sparkle with joy and their faces light up as they share their story of feeling blessed. To be blessed by someone is to experience the shelter of their unconditional love and positive regard.

There are indeed many ways to celebrate St. Patrick's Day. This year, I invite you to join me in celebrating this holiday by remembering to be a blessing to others and to continuously offer blessings to your friends, families and neighbors.

I close with a beautiful Irish blessing, one that reminds us of the many kinds of shelter we can, in fact, offer to one another.

May you always have...

Walls for the winds

A roof for the rain

Tea beside the fire

Laughter to cheer you

Those you love near you

And all your heart might desire.

Happy St. Patrick's Day!

~ *The Rev. Dr. D. Scott Stoner*

*NOTE: This column first appeared in the Weekly Words of Wellness, a weekly column written by the Rev. Dr. Scott Stoner, the Founder and Director of the Living Compass Wellness Initiative, and is reprinted with his permission. You can find out more at [www.LivingCompass.org](http://www.LivingCompass.org).*

## HEAD AND NECK CANCER NEWS

### Study Finds Gender Disparities in Head and Neck Cancer Treatment and Outcomes

**CHICAGO** – An analysis of cancer registry data from a California hospital system shows that women with head and neck cancer were less likely to receive intensive chemotherapy (35% vs. 46%) and radiation (60% vs. 70%) compared to men. Controlling for factors such as age and serious medical conditions, a mathematical model also shows that the ratio of cancer to non-cancer mortality was two times higher for women than the ratio for men. When taken collectively, the findings raise the possibility women with head and neck cancer may be undertreated. The authors explain that there are some confounding factors, so further prospective investigation is necessary to fully address this possibility.

The study was featured in a press briefing and presented at the 2018 American

Society of Clinical Oncology (ASCO) Annual Meeting.

"We weren't looking for gender differences, so the results were really surprising. Besides undertreatment, there are a number of factors that could contribute to the differences in outcomes between women and men with head and neck cancer, and it's clear we need further investigation," said senior study author Jed A. Katzel, MD, a medical oncologist at Kaiser Permanente in Santa Clara, CA. "With this mathematical model, we have a tool that can help us identify patients likely to benefit from more intensive treatment, as well as those more likely to die from other non-cancer related causes. The hope is that by integrating this model into our care, we can improve the care of all patients with head and neck cancer."

Head and neck cancers account for approximately 4% of all cancers in the United States and are more than twice as common among men as they are among women.

When considering treatment, oncologists take into account a patient's activity level and other medical problems. Patients with head and neck cancer who have good performance status (a measure of overall well-being) may be offered more intense treatments, including platinum-based chemotherapy with radiation therapy. Patients who cannot tolerate intensive chemotherapy may be offered less intensive treatments, such as targeted therapy cetuximab (Erbix) with radiation, radiation alone, or even no cancer treatment [at all](#).

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Another factor influencing head and neck cancer treatment and outcomes is whether the cancer is caused by the human papillomavirus (HPV). HPV-related head and neck tumors are more responsive to treatment, and people with such cancers generally have a better prognosis. HPV-related head and neck cancer is more common in men than in women. In the authors' prior analysis of patients in Northern California, for example, they found that only about 22.6% of HPV-related cancers occurred in women, compared with 77.4% in men.

#### About the Study

Researchers evaluated health outcomes for 223 female and 661 male patients with stage II-IVB head and neck cancer treated at Kaiser Permanente Northern California. The odds of receiving intensive cancer treatment were estimated using logistic regression models and adjusting for factors such as age, gender, tumor stage, Charlson Comorbidity Index, and history of smoking and alcohol use. A mathematical tool called the generalized competing event (GCE) model was used to compare the risk of dying

from cancer to the risk of dying from other causes. The GCE model controls for differences in age, gender, tumor site, and Charlson score. In this analysis, the researchers did not control for differences in tumor type with respect to HPV status.

#### Key Findings

Overall, the study identified several differences by gender:

- **Treatment:** The odds of receiving intensive chemotherapy were 35% for women versus 46% for men, and the odds of receiving radiation were 60% for women and 70% for men.
- **Mortality:** At a median follow up of 2.9 years, 271 patients died of cancer and 93 from other causes. While both men and women were more likely to die of cancer than of other causes, the ratio of cancer deaths versus non-cancer deaths was 1.92 times higher for women than for men.

- **HPV-related cancers:** Fewer women than men had oropharyngeal cancers (38% vs. 55%). While further analysis is ongoing, this may also be a factor driving higher cancer-related mortality rates in women, as HPV-related cancers occur most frequently in the oropharynx.

#### Next Steps

Researchers plan to conduct a more detailed review of treatments that women in the study received. They're also interested in determining causes for the gender differences in survival, such as if the findings reflect the difference in the rate of HPV-related head and neck cancers between women and men. Additionally, "the GCE model will be further evaluated in the NRG-HN004 trial that is currently enrolling patients," said Dr. Katznel. "It is a trial that we will be participating in."

This study received funding from Kaiser Permanente Northern California Graduate Medical Education Department.

## HEAD AND NECK CANCER NEWS

### Head and Neck Surgery Risk Index Can Guide Counseling for Patients Awaiting Surgery

Researchers have developed a preoperative head and neck surgery risk index (HNSRI) that clinicians can use to counsel patients awaiting head and neck cancer surgery (*JAMA Otolaryngology Head Neck Surg.* 2019 Feb 21. Epub ahead of print).

"Patients 65 years or older are the most frequent users of operative resources and are also the most vulnerable to postoperative adverse events," explained lead investigator Marco Antonio Mascarella, MD, Department of Otolaryngology–Head and Neck Surgery, McGill University, Montreal, Quebec, Canada, and colleagues.

"Frailty indices are increasingly being used for preoperative risk stratification within head and neck cancer surgery, but most models lack a multifactorial basis and cannot be directly applied to clinical practice," they said, adding that clinicians need a practical risk index to gauge preoperative risk factors.

Thus, Dr. Mascarella and colleagues sought to create a preoperative risk index of short-term major postoperative adverse events for patients with head and neck cancer preparing to undergo surgery.

Using American College of Surgeons (ACS)

National Surgical Quality Improvement Program (NSQIP) data spanning from 2006 to 2016, the investigators analyzed a cohort of 31,999 patients undergoing inpatient ablative or reconstructive head and neck cancer surgery.

Simple and multiple logistic regression were used to evaluate sociodemographic, frailty-related, and surgical factors in the derivation cohort, and risk factors were integrated into a preoperative HNSRI and compared with existing models via a validation cohort (n=15,699).

Among the 31,999 cases reviewed, patients had a mean age of 56.9 years, and 16,994 (54.1%) involved women. Major postoperative adverse events were reported in 4556 (14.5%) patients, and 209 (0.7%) died.

Factors independently associated with major adverse events or death as per multiple regression analysis (C statistic, 0.83) were older age, being a man, smoking, anticoagulation, recent weight loss, functional dependence, free-tissue transfer, tracheotomy, surgery duration,

wound classification, anemia, leukocytosis, and hypoalbuminemia.

In the validation cohort, the area under the curve of the HNSRI to predict major adverse events (including death) was 0.84 (95% confidence interval [CI], 0.83-0.85), with a sensitivity of 80.1% (95% CI, 79.4%-80.8%) and specificity of 72.3% (95% CI, 70.3%-74.2%).

Notably, the HNSRI outperformed existing risk models for adverse event prediction; the delta C index of the HNSRI to the modified frailty index 11 was 0.23 (95% CI, 0.22-0.25); to the American Society of Anesthesiologists classification was 0.14 (95% CI, 0.13-0.16); and to the ACS risk calculator was 0.02 (95% CI, 0.01-0.03).

"The proposed HNSRI demonstrated a high sensitivity and specificity for major postoperative AEs and death in the studied population," Dr. Mascarella and colleagues said.

"This risk index can be used to counsel patients awaiting head and neck cancer surgery," they concluded.—*Hina Khaliq*

###

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## HEAD AND NECK CANCER NEWS

### *Regular Physical Activity — Even Initiated Postdiagnosis — Improves Survival for Cancer Patients*

January 14, 2019 - Researchers examined the association between cancer outcomes and RPA, with particular attention to frequency, intensity, duration, and type of exercise performed.

Oncology nurses have some good news to share with their patients. A new study has found that patients who exercise regularly may experience a significant improvement in survival. In addition, the risk of death appears to be lower even for those who begin exercising after their cancer diagnosis. The study, which was published in the journal *Cancer Causes & Control*, found that people who exercised regularly as a lifestyle — both before and after diagnosis — experienced a 39% reduced risk of mortality compared with patients who were inactive as a lifestyle.

“This reduction in mortality was observed independent of BMI, smoking status, and tumor stage,” said study investigator Rikki Cannioto, PhD, EdD, assistant professor of oncology in the Department of Cancer Prevention and Control at Roswell Park Comprehensive Cancer Center, in Buffalo, New York. This association was noted in obese patients, persistent smokers, and in those with advanced-stage tumors at diagnosis.

In addition, patients with cancer who reported being completely inactive in the decade prior to diagnosis but reported adopting regular exercise as a lifestyle within the year after diagnosis experienced a 25% to 28% survival advantage compared with patients who remained inactive.

#### THE STUDY

Dr Cannioto and colleagues examined the impact of exercise both before and after a cancer diagnosis in 5807 patients (55% female) enrolled in the Data Bank and BioRepository (DBBR). The DBBR, established in 2003, has accumulated extensive clinical and epidemiologic data from cases of newly diagnosed cancer, including patients' age, weight, lifestyle, and exercise habits. In this cohort, 24.4% (1390 patients) reported no regular recreational physical activity (RPA) prior to their diagnosis and 41.9% (2400 patients) who reported no regular RPA postdiagnosis.

Participants' diagnoses covered a wide range of early-stage to late-stage cancer types, including breast, prostate, hematologic, lung, colorectal, kidney, esophageal, bladder, ovarian, endometrial, pancreatic, liver, stomach, sarcoma, head and neck, cervical, thyroid, testicular, brain and skin cancers. The researchers examined the association between cancer outcomes and RPA, with particular attention to frequency, intensity, duration, and type of exercise performed.

#### WHAT WAS LEARNED

Study results showed hazard ratios (HRs) for all-cause mortality (0.61) and cancer-specific mortality (0.64) were decreased by 39% and 36%, respectively, in habitually inactive patients, compared with those who were habitually active. Interestingly, results also showed that it is never too late to benefit from adopting an exercise program. Previously inactive patients who began regular exercise after their cancer diagnosis experienced a 28% decrease in all-cause mortality (HR = 0.72) and cancer-specific mortality (HR = 0.72) compared with patients who remained inactive.

“Some of the more detailed observations made in the study were somewhat surprising, and offer good news for all cancer patients. Specifically, that patients who start exercising after diagnosis experienced a significant survival advantage suggests that it is never too late to make healthy lifestyle changes that may affect the survival trajectory,” Dr. Cannioto told *Oncology Nurse Advisor*.

Patients who engaged in 3 to 4 sessions of exercise per week experienced the greatest survival advantages. However, the fact that even only 1 to 2 days of exercise per week resulted in a significant survival advantage is good news for patients who may be overwhelmed by recommendations of at least 30 minutes of moderate-to-intense physical activity daily.

#### IMPLICATIONS FOR NURSES

The strongest link between exercise and reduced risk of death was seen across 8 cancer types: breast, colon, prostate, ovarian, bladder, endometrial, esophageal,

and skin. Rather surprisingly, the strong association between physical activity and a decreased risk of death held across all the patients regardless of age, sex, body mass index (BMI), smoking status, or stage of cancer. Overall, the findings suggest that physical activity may be an independent, modifiable predictor of survival for patients with cancer.

Few studies have investigated the link between regular physical activity and cancer outcomes across multiple disease sites. This large study is one of the first to examine the beneficial effect of regular physical activity before and after a cancer diagnosis across many different cancer types.

These observations solidify the clinical and public health importance of the message that some regular activity is better than inactivity. Furthermore, the study findings suggest the potential value of implementing exercise programs into the supportive care continuum for cancer. These findings also may help better inform targeted intervention trials designed to improve clinical outcomes among patients with a wide range of malignancies, note the authors.

#### Reference

Cannioto RK, Dighe S, Mahoney MC, et al. Habitual recreational physical activity is associated with significantly improved survival in cancer patients: evidence from the Roswell Park Data Bank and BioRepository [published online November 28, 2018]. *Cancer Causes Control*. doi: 10.1007/s10552-018-1101-5

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**~ Mitch S.**

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