THYROID CANCER
Sumeet M. Anand M.D.,
Mark L. Urken M.D.

Thyroid cancer is the most rapidly increasing malignancy in the United States. The intent of this article is to provide information about thyroid cancer, its risks, symptoms, diagnosis, management and follow-up care.

The thyroid gland is located in the midline of the front of the neck below the Adam’s apple and above the collar bone. The gland is in the shape of a butterfly with 2 equal sides, the right and the left lobes, that are joined by the isthmus. In most individuals, the thyroid cannot be seen or felt. Behind the thyroid gland and resting directly on its surface are 4 parathyroid glands, which make parathyroid hormone, that also plays a significant role in regulating the level of calcium circulating in the body.

The thyroid gland is comprised of 2 main types of cells: thyroid follicular cells and C cells (parafollicular cells). The follicular cells absorb iodine from the bloodstream to produce thyroid hormone, which helps to regulate the body’s metabolism. Hypothyroidism occurs when there is a low level of thyroid hormone causing decreased body metabolism, producing symptoms of: fatigue, weight gain, feeling cold and lack of energy. Hyperthyroidism occurs when there is a high level of thyroid hormone and can harmfully elevate the body’s metabolism and cause an irregular or elevated heartbeat, anxiety, diarrhea, hunger, weight loss, feeling too warm and difficulty sleeping. The pituitary gland is located at the base of the brain and produces thyroid-stimulating hormone (TSH), which regulates the amount of thyroid hormone released by the thyroid gland. The C cells produce calcitonin, a hormone that regulates how the body uses calcium.

Types of Thyroid Cancer
Various types of tumors can develop in the thyroid gland. At times, the orderly process of normal cell death and growth is altered and an overdevelopment of cells creates a nodule. Thyroid nodules can develop at any age, however, they are more common in adults. When the thyroid gland is evaluated with an ultrasound machine, nearly half of all adults are found to have a thyroid nodule that is too small to feel. Most thyroid nodules, approximately 90-95%, are benign, however, 1 in 20 are cancer.

The majority of thyroid nodules are cysts containing a stored form of thyroid hormone called colloid. Solid nodules are more likely to be cancer, albeit, the majority of these are also benign. The presence of several large nodules in the thyroid is generally a benign condition known as a multinodular goiter. Benign nodules often do not require treatment unless they become very enlarged or cause symptoms.

Papillary carcinoma and follicular carcinoma are the 2 most common types of thyroid cancer. These tumors develop from thyroid follicular cells and are known as well differentiated cancers.

Papillary carcinoma makes up about 80 percent of thyroid cancers and typically grows very slowly. In many instances, papillary carcinoma can spread to the lymph nodes in the neck. If diagnosed early, this cancer can be successfully cured.

Follicular carcinoma makes up about 10 percent of all thyroid cancers and tend not to spread to the lymph nodes in the neck. The prognosis for follicular carcinoma is also quite favorable, though not as good as that of papillary carcinoma. If diagnosed early, this cancer can be successfully treated.

The other types of thyroid cancer occur less frequently and include medullary thyroid carcinoma and anaplastic carcinoma.

Medullary thyroid carcinoma (MTC) makes up about 4 percent of thyroid cancers and develops from the C cells of the thyroid gland. These cancers produce an abnormally high level of calcitonin in the blood. This cancer can spread to lymph nodes in the neck, the lungs, or the liver. Since medullary cancers do not absorb radioactive iodine, which is often used for the treatment of papillary and follicular cancer, the prognosis is not as favorable. Familial MTC is genetic, and can occur in multiple generations of a family, often developing in children and can be found linked to other types of tumors.

Anaplastic carcinoma makes up about 2 percent of thyroid cancers. It is also known as undifferentiated carcinoma. Although this tumor begins in follicular cells of the thyroid, under the microscope the cancer often appears very different from thyroid.
THYROID CANCER continued from page 1

cells. This cancer usually occurs in older persons, grows very rapidly, invades surrounding structures in the neck and spreads very quickly. Anaplastic carcinoma has a poor prognosis and is difficult to treat.

Statistics about Thyroid Cancer

In the United States, it is estimated there will be 48,020 individuals newly diagnosed with thyroid cancer in 2011, with approximately 36,550 women and 11,470 men affected. Thyroid cancer is the seventh most commonly diagnosed malignancy in females. The SEER (Surveillance Epidemiology and End Results) Cancer Statistics Review compiled by the National Cancer Institute showed that the number of people in the United States with thyroid cancer, known as prevalence, on January 1, 2008 was approximately 458,000.

Over the past two decades, the incidence of thyroid cancer has increased at a higher rate than other cancers in the body. It is thought this is partly due to an improved ability to detect early thyroid disease, including smaller cancers, with an increased use of the ultrasound machines. However there is also an increased number of larger thyroid cancers being detected.

The overall 5-year relative survival for thyroid cancer from 2001-2007 is reported as 97.2%. The death rate from thyroid cancer is very low compared to most other cancers and has been relatively stable for several years. It is estimated that approximately 1,740 men and women will die of cancer of the thyroid in 2011.

Risk factors for thyroid cancer

Research has identified certain risk factors that increase the chance of developing thyroid cancer. The risk factors that are known include:

- Exposure to high levels of radiation is a known risk factor for papillary and follicular thyroid cancer. Sources of high radiation include radiation fallout from a nuclear power plant accident and also some medical treatments.

- Individuals exposed to radiation incidents, such as the Chernobyl accident in 1986, have been shown to have a significantly higher risk for thyroid cancer, particularly if they were children at the time of exposure. Adults living close to Chernobyl in 1986, or who played a role in the cleanup after the accident, also have had a higher rate of thyroid cancer.

- An exposure to head and neck radiation treatments is a risk factor for thyroid cancer, particularly in children. From the 1920s to 1950s, children were at times treated with radiation for conditions that are not currently treated with radiation such as acne, enlarged tonsils or adenoids, or an enlarged thymus gland. Formal radiation therapy has and is currently used for some cancers in children including neuroblastoma, sarcoma, lymphoma and Wilms tumors. Research has shown that some individuals who have received such treatments have developed thyroid cancer. An exposure to head and neck radiation is an adult has a lower risk of leading to a thyroid malignancy.

- Although the reasons are not understood, women are about 5 times more likely than men to develop thyroid cancer. Thyroid cancer can develop at any age, however, there is an increased risk among women older than 40-50 years old and men older than 50 years old.

- Iodine is a substance commonly found in iodized (table) salt or shellfish. In areas of the world where there is low

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iodine in the diet there is an increased risk for follicular thyroid cancer. In the United States, most individuals have enough iodine in a regular diet.

- Having a first-degree relative such as a parent, sibling or child with a differentiated thyroid cancer has been shown to increase the risk of developing papillary and follicular thyroid cancers.

An estimated 20 percent of medullary thyroid carcinomas (MTCs) are associated with the inheritance of an abnormal RET gene. This can occur alone in familial medullary thyroid carcinoma or with other cancers as a multiple endocrine neoplasia (MEN) syndrome. In addition to MTC, in MEN the other tumors can include pheochromocytomas, parathyroid gland tumors, or neuromas. If there is an abnormality of the RET gene, which can be detected with a blood test, there is a very high risk of other family members developing MTC.

Symptoms of Thyroid Cancer

Often there are no symptoms associated with early thyroid cancer. As thyroid cancer grows, however, the following signs and symptoms may develop:

- A swelling or nodule in the front or the side of the neck
- Hoarseness
- Difficulty swallowing (dysphagia)
- Difficulty breathing (dyspnea)
- Blood in the sputum (hemoptysis)

However, commonly, these signs and symptoms are not due to thyroid cancer. An individual with such findings should seek the care of a physician so a diagnosis can be made and treatment, if needed, can be started.

Attention to thyroid cancer signs and symptoms at an early point is the best way to diagnose and treat this disease at the point when the chance for cure is optimal. Many early thyroid cancers are identified during a routine physical examination or if a patient asks their physician about a neck nodule or lump that has recently developed. Uncommonly, thyroid cancers can go unnoticed until they reach an advanced stage. An ultrasound or other imaging of the neck completed for a different health problem often diagnoses a nodule in the thyroid.

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**Follicular thyroid cancer**

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**Medullary thyroid cancer** (based on patients diagnosed between 1985 and 1991)

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**Treatment of thyroid cancer**

The choice of treatment will generally depend upon the type of thyroid cancer (papillary, follicular, medullary or anaplastic), and factors that are specific to the cancer as well as factors that are specific to the patient, such as their age and other medical conditions.

The treatment options for thyroid cancer may include: surgery, radioactive iodine treatment, thyroid hormone therapy, external beam radiation therapy and chemotherapy. The vast majority of patients with differentiated thyroid cancer are treated with surgical removal of the thyroid gland, and often the regional lymph nodes. In select cases, the decision to administer radioactive iodine is based on the postoperative determination of the stage of the disease. Only in rare instances are patients treated with external beam radiotherapy and chemotherapy.

**Surgery**

The main treatment in nearly every case of thyroid cancer is surgery, except for some anaplastic thyroid cancers. Once a thyroid cancer is suspected or diagnosed based on biopsy, a surgeon will remove all or part of the thyroid gland. A total thyroidectomy is most commonly performed in conjunction with the removal of lymph nodes located in the central area of the neck. If thyroid cancer has spread to nearby lymph nodes in the neck then the lymph nodes are removed along with the thyroid gland at the time of surgery. This is uniformly done in the treatment of medullary thyroid cancer. In differentiated (papillary or follicular) thyroid cancer, enlarged lymph nodes are often removed when they are believed to contain cancer. In select circumstances the surgeon may not know that a thyroid nodule is cancer and that diagnosis may not be able to be established on frozen section. The performance of a lobectomy for diagnostic purposes may leave open the question of whether a completion thyroidectomy should be performed at a second operation. That decision is made based upon a number of factors related to the stage and the patient’s overall health.

In almost all instances there is a small remnant of thyroid tissue that remains following surgery that can be eliminated with radioactive iodine. After total thyroidectomy, the patient will be dependent upon a daily dose of thyroid hormone (levothyroxine).

**Perioperative Risks and Side Effects:**

Potential risks of thyroid surgery include:

- Temporary or permanent voice changes: this can occur if the nerves to the vocal cords are stretched or damaged during surgery.
- Temporary or permanent hypocalcemia: the parathyroid glands, attached to the thyroid, regulate the level of calcium in the blood. Removal or damage to these glands will require the patient to take calcium and vitamin D, either temporarily or permanently.
- Radioactive iodine (radioiodine) therapy: Radioactive iodine (I-131) therapy is used as an additional form of treatment for differentiated papillary and follicular thyroid cancers. When a large enough dose of radioactive iodine (RAI), also known as I-131, is administered, it can destroy the thyroid gland and any other thyroid cells (including cancer cells) that take up iodine, with little effect on the rest of the body.

**Conclusions:**

The most common forms of thyroid cancer are successfully treated with a combination of surgery and radioactive iodine. In addition, patients are most often placed on a slightly higher dose of thyroid hormone in order to achieve the goal of suppression of TSH. One of the unique features of thyroid cancer management is the ability to monitor a patient’s clinical course by measuring the biomarker, thyroglobulin, which is only produced by thyroid cells that are malignant. Rises in thyroglobulin often indicate a recurrence of disease that may require further diagnostic efforts and therapy. Despite the very high cure rates for differentiated thyroid cancer, there is a requirement to monitor patients throughout their lives due to the risk of delayed emergence of either recurrent or metastatic disease.

**REFERENCES and Guides:**


SHARING STORY...Maggie & Daniel - Part Two

I started going to the Cancer Support Group in Homewood during the last week of March. Every Tuesday night I would meet with from five to eight cancer patients most of whom were still battling their cancer. I still go most Tuesdays. I found that I wasn’t alone with my fears and dealing with problems caused by my cancer treatments. I met two wonderful women there, both battling breast cancer. They kind of adopted me and made sure that I was invited to and attended all the social functions put on by the group so that I could overcome the social stigma that I thought existed.

I then started going to a SPOHNC support group at the University of Chicago, which meets the last Tuesday of every month. The people in this group were all oral, head and neck cancer survivors. Through the people I met there in the group, and the resources offered by SPOHNC, I came to realize that although I now had some limitations, I was no different than thousands of other survivors with the same cancer.

By March 2010, I was not totally recovered in all aspects of my life, but I was no longer sinking in my boat of despair and bailing like a crazed man. I found myself at sixty-one-years of age desperately wanting a relationship with a woman. I have never been married nor do I have any children, but having gone through this “valle of tears” by myself, I wanted very badly to connect with someone with whom I could share the rest of my life. I went on an Internet Dating Service called Christian Mingle in March of 2010, putting only some basic information. I would not post a picture. I had no photographs of me after my cancer journey and since I was changed so much I would not put a photo of me before cancer. If I found someone to connect with, I wanted her from the start to know the real but changed me. I went to counseling sessions at Illinois Masonic Hospital where I found the help I needed, to overcome the last fear I had – that a total stranger would not or could not be interested in me because of my appearance. I finally posted a passport photo, completed my survey and waited for the results.

I had gotten very far away from my core Christian beliefs before my journey with cancer began, but there is nothing like looking into the void of eternity to bring one back to one’s childhood belief in God. I sincerely believe that God showed me His grace and mercy by giving me three miracles. The first miracle was surviving oral cancer. (All my doctors had believed that I was terminal, yet now after four and a half years I am still cancer free from my head to my toes.) The second miracle was my emotional and spiritual healing. I’ve been able to move from being in a state of despair to now actually looking forward to meeting new people and doing new things even with my limitations. And the third miracle is a woman named Margaret Ann Jensen Olson.

After I posted the rest of my story and photo on Christian Mingle, six women replied to my initial contact. Only one of them kept up an ongoing email relationship. That was Maggie Olson. Maggie, as she is known to her friends (who are countless), is a most amazing woman. She is a devoted Christian woman, a wonderful mother to four adult children and grandmother to four grandchildren. She is a professor at the University of Wisconsin. She is an amateur violinist and artist. She can beat my pants off at pool and Hearts. She has an extremely dry sense of humor that she loves to tease me with.

At this point of the story, I turn the floor over to Maggie.

Daniel and I first connected in March of last year – the day before my birthday. We emailed at first, and quickly started emailing every day. After about two weeks of daily emails he finally got up the nerve to tell me about his “limitations”. He was so afraid that after he told me about the permanent effects of his treatment I would run the other way. He said that when he had told other women, all he had heard back was silence. My response to him was, “You will not hear silence from me, Daniel!”

By mid-May he had captured my heart and asked him if he could call and talk to me on the telephone. He was a nervous wreck! He warned me that due to his dry mouth he sounded a bit like he had a sock stuffed in his mouth and that he might have to ask me to repeat myself due to his hearing loss. Yet even before he called, he made arrangements to come to visit me in Wisconsin in June. When I mentioned that he seemed a bit sure of himself, he replied, “Confidence is my middle name!”

We finally met in person at the end of June, spending the day together in Madison. I was excited, but also very nervous! Here was a man that I had fallen in love with without ever seeing him in person! How were we going to relate to each other face to face? The day was wonderful, but not without its challenges for me.

As we sat across the table from each other in the park after having a picnic I experienced a mixture of emotions. I was looking at a man who had no teeth, and whose hearing was impaired. I felt like I knew the inner man, but I was now faced with the outer man. I had been telling him for several months that his limitations did not matter to me at all; now I knew that they DID matter. The question was could I find a way to get past them? Could we really make this relationship work?

The day after our first meeting in Madison, I shared with Daniel that I had been telling my girlfriends all about our first date. “It was a date, wasn’t it?” I said. “NO!!! It wasn’t a date! I didn’t even buy you dinner!!!” On his drive back to Chicago it had dawned on him that he had never even THOUGHT about feeding me dinner. After his experience with oral cancer, he just never gets hungry and only eats now because he knows he must eat to live! After asking me if I’d ever seen “The Little Shop of Horrors” (I had to Google it) we have come up with a plan: when we are out and about together and I get hungry, I am to say to him, “Feed me, Daniel, FEED ME!” Then he will realize that it’s time to eat, whether he is hungry or not.

In July, Daniel asked me to marry him; we were engaged in September. For a variety of reasons we have not yet set a date. I have had my moments of doubt and uncertainty. It really hit me hard the first time he came to Wisconsin for the weekend and we attended worship in Wausau; he had warned me about how his hearing loss affects him when in a crowd, but I got first-hand knowledge when introducing him to my friends before and after the service and I realized that he missed much of the conversations. After he went back to Chicago I realized that I was struggling with all that his limitations would mean for our social life.

I find it very interesting that God brought us together. I believe we will be wonderful life partners. There will be challenges, for sure.
Take the
Breaking Through Survey Today

If you haven’t already done so, please read below and take the survey, which will provide important information for a study of patients with breakthrough pain.

Dear Friends of SPOHNC,

Many individuals with oral, head and neck cancers experience constant, background pain related to their cancer. On top of this background pain, many also experience brief, intense and sudden flares of pain called breakthrough pain in cancer (BTPc). Even though BTPc can have an extremely debilitating effect on an individual’s quality of life, it continues to be a poorly understood and highly under-diagnosed condition.

In light of this, Support for People with Oral, Head and Neck Cancer (SPOHNC) is joining forces with other cancer advocacy groups to support a new educational campaign called Breaking Through: Voices of Breakthrough Pain in Cancer Patients. An integral part of this campaign is a nationwide survey to better understand patient experiences with BTPc.

Since many of you may have experienced BTPc, we urge you to participate in this survey and support SPOHNC in this important initiative. Please also encourage and direct members of your support groups to take this survey. Your collective insights will be valuable in identifying barriers that deter people from discussing pain with their oncologists and developing educational programs.

To participate in the survey, visit our website at www.spohnc.org, or go to: https://www.visioncriticalsurveys.com/skin/breakingthrough/SPOHNC.html

Daniel Milkovich
danielmilkovich@charter.net
Margaret Olsen
olekids@charter.net

Hope is an adventure, a going forward, a confident search for a rewarding life.

~ Dr. Karl Menninger
SUPPORT FOR PEOPLE WITH
ORAL AND HEAD AND NECK CANCER (SPOHNC)
20TH ANNIVERSARY CONFERENCE AND CELEBRATION OF LIFE
NEW YORK LAGUARDIA AIRPORT MARRIOTT
August 10th - 12th, 2012

SATURDAY ~ AUGUST 11, 2012
SPOHNC Registration/Information
7:30 AM – 10:00 AM

CONTINENTAL BREAKFAST
7:30 AM – 8:40 AM

Opening Remarks
8:45 AM
Nancy E. Leupold, Survivor, President and Founder of (SPOHNC) Support for People with Oral and Head and Neck Cancer
James J. Sciubba, DMD, PhD, Moderator 
Vice President of SPOHNC

Guest Honoree, Gene Monahan
Survivor, Retired NY Yankees Head Athletic Trainer

New Treatments for Head and Neck Cancer
Dennis Kraus, MD, Head and Neck Surgeon
Memorial Sloan - Kettering Cancer Center
Christine Chung, MD, Medical Oncologist
Sidney Kimmel Comprehensive Cancer Center-Johns Hopkins

Refreshment Break with Exhibitors

David Brizel, MD, Radiation Oncologist
Duke University Cancer Institute

The Role of a Patient Navigator
Joanne Stein, RN, Nurse Navigator
Fox Chase Cancer Center

BUFFET LUNCH

Key Note Presentation:
Self Love…The All Time Greatest Healer
Denise DeSimone,
Survivor, Author and Inspirational Speaker

Clinical Trials for Head and Neck Cancer
Bettie Steinberg, PhD, Researcher, Investigator
North Shore /LIJ Health Systems

Refreshment Break with Exhibitors

Speech & Swallowing Function in Patients with Head & Neck Cancer
Jan Lewin, PhD
UT MD Anderson Cancer Center

Quality of Life for Head and Neck Cancer Survivors
Dorothy Gold, MSW, LCSW-C, OSW-C
Greater Baltimore Medical Center

SPOHNC’S ANNIVERSARY RECEPTION AND ENTERTAINMENT

Comedian
Stewie Stone, Survivor, Brooklyn, NY
Headlined in Las Vegas, Atlantic City, New York

Music
The Electric Dudes Band
Voted the #1 Band on Long Island

SUNDAY ~ AUGUST 12, 2012
SPOHNC Registration/Information
7:30 AM – 9:00 AM

Opening Remarks
8:30 AM
Nancy Leupold, Survivor, President & Founder of SPOHNC

BUFFET BREAKFAST

How Far Have We Come in 20 Years
James J. Sciubba, DMD, PhD
Vice President of SPOHNC

Salute to Volunteers, Making a Difference
Mary Ann Caputo,
Executive Director of SPOHNC

Salute to Survivors
All Survivors of Oral and Head and Neck Cancer
Mary Ann Caputo,
Executive Director of SPOHNC

Closing Remarks
Nancy E. Leupold, Survivor
President & Founder, SPOHNC

Support for People with Oral and Head and Neck Cancer
http://www.spohnc.org
E-mail-- info@spohnc.org
Newer radiation technology improves head and neck cancer patients’ long-term quality of life

Phoenix, AZ - January 26, 2012 - Intensity modulated radiation therapy, or IMRT, is a highly specialized form of external beam radiation therapy that allows the radiation beam to better target and conform to a tumor. It is a newer treatment that has become widely adopted for treating head and neck cancer. Prior studies have shown that IMRT decreases the probability of radiation therapy related side effects, including dry mouth and chewing and swallowing problems, but no study has been conducted to measure long-term quality of life in head and neck cancer patients treated with various forms of radiation therapy.

Investigators from the University of California, Davis, School of Medicine, prospectively administered the University of Washington Quality of Life instrument, a standardized, previously validated questionnaire that patients complete after radiation therapy, to 155 patients undergoing treatment for cancers of the head and neck and analyzed the scores over time. Fifty-four percent of patients were initially treated with IMRT and 46 percent were treated with non-IMRT techniques.

The researchers showed that the early quality of life gains associated with IMRT not only are maintained but become more magnified over time. At one-year post-treatment, 51 percent of IMRT patients rated their quality of life as very good or outstanding compared to 41 percent of non-IMRT patients. However, at two-years after treatment, the percentages changed to 73 percent and 49 percent, respectively. Also, 80 percent of patients treated with IMRT reported that their health-related quality of life was much better or somewhat better compared to the month before developing cancer. In contrast, only 61 percent of patients treated by non-IMRT techniques felt similarly.

Although the researchers acknowledged that quality of life is somewhat of a subjective concept, they nonetheless believe their findings support the widespread use of IMRT for head and neck cancer.

“Hopefully, these results provide some reassurance to patients that radiation therapy using contemporary techniques in the hands of expert specialists can maintain their function and long-term quality of life, while still curing them of cancer,” Allen Chen, MD, lead author of the study and director of the radiation oncology residency training program at the University of California, Davis School of Medicine in Sacramento, Calif., said. “Radiation therapy for head and neck cancer is without a doubt an intensive process and very intimidating to most patients. Folks think about the prospects of six to seven weeks of radiation and naturally expect the worst. It is nice to know that technological advances have made the treatment much more tolerable than in the past.”

Allen Chen, M.D.

Oral temperature changes in head and neck cancer patients predicts side effect severity

Phoenix, AZ - January 26, 2012 - Mucositis, or mouth sores, is a common side effect of chemoradiotherapy for head and neck cancer that is painful and can be very severe. Physicians cannot predict which patients will have mild mucositis or severe mucositis that would require narcotic pain medication, nutritional support and/or feeding tubes.

Researchers in this study hypothesized that using sensitive thermal imaging technology to measure temperature changes of less than one-tenth of a degree early in treatment could predict the severity of mucositis later in treatment. This knowledge could allow for early intervention and potential changes in therapy using a technology that is simple, harmless and non-invasive.

Patients receiving chemoradiotherapy underwent baseline and weekly thermal imaging of their oral mucus membranes. All patients displayed an increase in temperature and severe mucositis was found in 53 percent of patients.

“If we could predict which patients were going to suffer the greatest toxicity, we could proactively make changes to their care that could ameliorate or prevent side effects,” Ezra Cohen, MD, lead author of the study and co-director of the head and neck cancer program at The University of Chicago in Chicago, said. “Ultimately, we could identify the patients at higher risk of severe complications from treatment.”

Ezra Cohen, M.D.
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**CHAPTERS OF SPOHNC**

**ILLINOIS-MAYWOOD**
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Iowa Methodist Medical Center
1st & 4th Wednesday: 4:00 - 5:00 PM
Tel: 812-535-2587
mryarryan2@juno.com

**KANSAS-KANSAS CITY**
Univ. of Kansas Hospital
2nd & 4th Wednesdays: 4:00 - 5:00 PM
Tel: 913-588-3630
jwitt@ihs.org

**LOUISIANA-BATON ROUGE**
Cancer Services of Greater Baton Rouge
3rd Wednesday: 4:00 PM
Tel: 225-927-2273
esachse@cancerservices.org

**MONTANA-BOZEMAN**
Bozeman Deaconess Hospital
3rd Thursday: 12:00 Noon-1:00 PM
Tel: 406-586-0828
nancydoug@theglobal.net

**NEW JERSEY-BUFFALO**
Roswell Park Cancer Institute
3rd Tuesday: 6:00-8:00 PM
Tel: 716-845-4947
jim.smaldino@roswellpark.org

**NEW JERSEY-MANHATTAN**
Mount Sinai Medical Center
3rd Tuesday: 6:00-8:00 PM
Tel: 212-484-8775
jim.smaldino@roswellpark.org

**NEW JERSEY-PRINCETON, UMC**
NYU Clinical Cancer Center, 11th flr
1st and 3rd Thursday: 2:00 PM
Christine Nolin, LCSW 212-731-5141
christine.nolin@nyumc.org

**NEW YORK-NEW HYDE PARK**
North Shore-LIJ Health System
3rd Thursday: 6:30 PM - 8:00 PM
Sharon Lerman, LCSW 718-470-8964
Lynn Gormley 516-628-1219 / 516-314-8897
lgormley1@optonline.net

**NEW YORK-ROCHESTER**
Strong Memorial Hospital
1st Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW 585-276-4529
Sandra_Sabatka@URMC.Rochester.edu
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