



which require different treatments than the more common squamous cell carcinoma. A confirmatory biopsy must be obtained prior to beginning treatment for a cancer of the base of the tongue unless a patient has an obvious tumor and a metastatic lymph node.

Functionally, the tongue base is most important in the transition from the oral to the pharyngeal phases of swallowing. The tongue base functions like a piston driving the bolus of food from the oropharynx into the dilated opening of the esophagus (pharyngoesophageal segment). Loss of volume or sensation of the tongue base from surgery or extensive scarring and paralysis from aggressive chemotherapy and radiation therapy cause the post-treatment swallowing problems observed in treated patients.

MANAGEMENT ALTERNATIVES FOR BASE OF TONGUE CANCER

GUY J. PETRUZZELLI MD, PHD, FACS

Carcinomas of the base of the tongue are extremely menacing. Frequently, the head and neck surgeon will diagnose a patient as having carcinoma of the tongue when the patient presents with a metastatic cervical lymph node and an unknown or "occult" primary tumor and after careful examination and biopsy. Traditionally these tumors have been treated by a combined modality approach of surgery with postoperative radiation therapy. We will begin with a review of the anatomy and tumor staging of tongue base cancer and conclude with a survey of current treatment options.

Tongue Anatomy

The tongue is divided into two sections; the oral tongue contained within the oral cavity and the tongue base contained within the oropharynx. The tongue base begins at the circumvallate papillae (taste buds), which are arranged in a V configuration, approximately 2/3 of the way toward the back (posteriorly) along the surface (dorsum) of the tongue. The tongue base extends down (inferiorly) to meet the supraglottic larynx (epiglottis). The junction of the tongue base and epiglottis is called the vallecula.

Two sets of muscles are responsible for tongue motion. The extrinsic tongue muscles i.e. genioglossus, hyoglossus, styloglossus, and palatoglossus insert into the tongue base. The extrinsic tongue muscles function as a group to pull the entire tongue upward, downward, forward and backward. The second group, or intrinsic muscles of the tongue, is an interlacing bundle of muscle fibers that functions to change the shape of the oral tongue during speech and swallowing.

The mucosa or lining tissue of the tongue base contains minor salivary glands and lymphoid follicles. These tissues may give rise to minor salivary gland malignancies and lymphomas,

Diagnostic Evaluation and Staging

Patients presenting with tumors of the base of the tongue should be evaluated in a combined modality treatment setting with input from surgical, medical and radiation oncologists. Other participating health care professionals including oncologic dentists, speech and language therapists, nutritionists, plastic and reconstructive surgeons may also participate in treatment planning. A detailed medical history and physical examination and a detailed head and neck examination should be performed. In general, computed cross-sectional imagery with computed tomography (CT) or magnetic resonance imagery (MRI) complements the evaluation of tongue cancers. However, radiographic evaluation of tongue base tumors may be best performed with magnetic resonance imaging.

Prior to the initiation of therapy a tissue diagnosis must be obtained. Minor salivary gland malignancies and tongue base lymphomas should be excluded by the examination of permanent histologic evaluation, not by frozen section analysis. Traditionally, examination and biopsy under anesthesia have been performed prior to therapy. However, with appropriate instruments and techniques tongue base tumors can easily be staged in the office setting under topical anesthesia. We routinely biopsy oropharyngeal lesions at the time of office evaluation and perform direct laryngoscopy and esophagoscopy at the time of definitive resection.

Tumors of the base of the tongue follow the staging criteria of the American Joint Committee on Cancer (AJCC) for oropharyngeal tumors:

- T1: Tumor 2 cm or less in greatest dimension
- T2: Tumor > 2 cm but < 4 cm in greatest dimension
- T3: Tumor > 4 cm in greatest dimension

T4: Tumor invades adjacent structures (cortical bone, soft tissues of the neck, deep muscles of the tongue)

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COMING NEXT MONTH

The Role of Patient Education in the
Rehabilitation of the Head and Neck Cancer Survivor

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Surgical Approaches to the Base of Tongue

A variety of approaches exist for exposure and resection of tongue base cancer. The correct approach is best determined by the location and extension of the tumor, expertise of the surgeon, exposure required for complete tumor extirpation, available instrumentation and planned method of reconstruction.

Transoral resection of tongue base cancer has historically been limited by the ability to completely visualize beyond the tumor into the vallecula and/or epiglottis. The combination of appropriate exposure, the CO laser and the operating microscope has allowed us to completely remove large base of tongue tumors transorally.

When tumors of the base of the tongue cannot be satisfactorily resected through the mouth they can be approached through the neck. In these approaches the oropharynx can either be entered from the side (lateral pharyngotomy) or from the front (transhyoid pharyngotomy). There are advantages and disadvantages to each exposure. When tumors cannot be reached transorally we prefer the transhyoid pharyngotomy. Visualization of the anterior tongue to the circumvallate papillae can also be accomplished. Accurate reconstruction provides for restoration of the vallecula and good postoperative deglutition.

Very large tumors of the base of the tongue, or tumors that invade the mandible, may require an extensive resection in which the mandible is either removed or temporarily split and reconstructed. These transmandibular resections of cancer of the tongue base can be divided into posterior segmental mandibulectomy ("composite resection"), marginal or cortical mandibulectomy, and osteotomy with mandible transposition ("mandibular swing").

Tumors of the tongue base can extend under the tongue's surface and become extremely large. Extension may require either total glossectomy with or without laryngectomy to completely remove the tumor. Patient factors such as advanced chronic obstructive pulmonary disease may require total laryngectomy or other maneuvers to prevent chronic aspiration and debilitating pneumonia.

Reconstruction following surgical resection of the tongue base can be technically challenging. Replacing the tongue base with too much bulk can cause unintelligible speech, poor swallowing mechanisms and potential airway obstruction. Too little bulk, or tethering the remaining tongue, can cause poor speech and chronic aspiration, limiting the patient's ability to eat. Transoral resections of tongue base tumors require no reconstruction. A surprising amount of tongue base can be resected without soft tissue reconstruction. Articulation in these patients is very good but many require swallowing rehabilitation post operatively. Rehabilitative efforts in these patients are focused mainly on laryngeal evaluation techniques and variations on the "supraglottic swallow".

Microvascular free tissue transfers, specifically the lateral arm and radial forearm fasciocutaneous flaps, are well suited for reconstruction in this area. These flaps are thin and pliable and can be sculpted to reconstruct the three dimensional defects of the posterior oropharynx and tongue base. The lack of bulk prevents tethering and allows for excellent motion of the tongue-flap reconstruction while the epithelial covering facilitates deglutition.

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Patients with oropharyngeal defects reconstructed with the lateral arm flap have been shown to have more rapid decannulation (removal of a tracheotomy tube) and re-summation of oral diet than those reconstructed with a pedicle pectoralis major flap.

Nonsurgical Treatments

Historically, nonsurgical therapy for cancer of the base of the tongue has consisted of external beam radiation therapy with a boost dose to the primary site. The boost can either be administered with a cone down external technique or by brachytherapy. A bite block is usually required to provide some immobilization of the tongue to keep it within the radiation therapy field during treatment.

Brachytherapy involves lacing looping plastic tubes through the tumor and the tongue base and confirming their placement with X-rays. This requires a general anesthetic and usually a temporary tracheotomy to safely protect the airway, a palatal shield to protect the palate from damage by the radiation, and nasogastric tube for feeding. Once the catheters are in satisfactory position, the radiation oncologist will load them with a radioactive source, Iridium 192 wire, leaving them in place until the appropriate dose has been delivered. Current technological advances in radiation oncology, including three-dimensional conformal radiotherapy (3D-CRT) may provide an opportunity to delivery similar high dose local radiotherapy without the need for these invasive procedures.

However it is administered, radiation therapy of tongue base tumors is technically demanding. Under-dosing this area places the patients at a high risk for tumor recurrence. Overdosing can cause radionecrosis of the mandible and or the larynx. Oropharyngeal structures such as the tongue base and posterior pharyngeal wall are also close to the cervical spine necessitating precise targeting of the treatment beams to prevent spinal cord damage.

Like surgery, radiation therapy is a local treatment designed to treat the primary tumor and whatever disease may have spread to the neck. Currently, many head and neck oncologists feel that if we are to make significant progress in preventing locally recurrent and distant (metastatic)

tumors, systemic therapy (chemotherapy) should be added to the treatment programs.

In general, chemotherapy and radiotherapy has been delivered in one of several schedules:

- sequential radiotherapy following induction (neoadjuvant) chemotherapy
- standard dose radiation with single agent chemotherapy used as a radio-sensitizer
- rapidly alternating cycles of chemotherapy and radiation and suspending one while delivering the other
- concurrent full dose chemoradiotherapy with planned treatment breaks in the radiation (i.e. split-course radiation therapy)
- concurrent chemoradiation using high dose selective intra-arterial chemotherapy delivered directly into the tumor
- concurrent chemoradiation with hyperfractionated radiotherapy schedules

The ability of certain drugs to enhance the toxicity of ionizing radiation has been known for many years. By concurrently administering a radiosensitizing drug with ionizing radiation, both enhancement of the locoregional radiotherapeutic effect and the elimination of micrometastatic distant disease can be expected. Concurrent chemoradiation using drugs such as mitomycin, 5-fluorouracil, hydroxyurea, cisplatin, carboplatin, and, recently, paclitaxel in conjunction with varying radiation therapy schedules is now being investigated as primary nonsurgical therapy for advanced cancer of the tongue base.

Traditionally, the oncology literature has been focused on the technical aspects of surgery, reconstruction, and patient outcome measurements such as tumor control. Recently, there has been a shift to more closely examine functional outcomes such as recovery of intelligible speech, swallowing and quality of life. Treatment alternatives for cancer of the base of the tongue must to be evaluated in the context of how well they contribute to the overall restoration of normal functioning in these individuals.

Conclusions

In summary, treatment of malignant tumors of the tongue base remains a difficult problem in head and neck oncology. The overall 5-year survival of patients with

SPOHNC Welcomes New Member to Medical Advisory Board

Support for People with Oral and Head and Neck Cancer is pleased to welcome Linda K. Clarke, MS, RN, CORLN to its Medical Advisory Board. Ms. Clarke has been involved in otorhinolaryngology-head and neck nursing (ORL) practice for over 30 years. For the past 20 years, she has been the Head and Neck Clinical specialist for the Milton J. Dance, Jr. Head and Neck Rehabilitation Center at the Greater Baltimore Medical Center in Baltimore, Maryland where her responsibilities include pre and postoperative patient education, co-leading patient and family support groups and quality improvement.

Ms. Clarke has been an active member of the Society of Otorhinolaryngology and Head-neck Nurses (SOHN) since 1980 and has served in a number of capacities including National President, 1994-1995. She is currently the editor of the *ORL-Head and Neck Nursing*, the official journal of SOHN.

early stage disease remains good (approximately 78 to 80 %). Unfortunately the majority of patients present with advanced primary disease or neck node metastasis (stage also defined by nodal metastasis) and five year survival is poor (approximately 30-60%). These patients should be treated in centers with sufficient experience in combined modality treatment to offer patients good functional as well as oncologic outcomes. Multimodality chemoradiotherapy treatment protocols should be available to patients as well. Our experience with base of tongue lesions has shown that these tumors can be resected via mandible sparing or transmandibular approaches. The use of free tissue reconstruction is critical to the recovery of intelligible speech and functional deglutition in patients treated surgically.

Editor's Note: Guy J. Petruzzelli, MD, PhD, FACS is a Professor of Otolaryngology-Head & Neck Surgery and General Surgery at the Stritch School of Medicine and the Loyola University Medical Center in Chicago, Illinois. Dr. Petruzzelli is the Chief of Loyola's Head and Neck Surgery Service and the Director of the Head and Neck Oncology Program at the Cardinal Bernardin Cancer Center in Maywood, Illinois.

A TIME FOR SHARING

I am not a head-neck-throat cancer survivor, but Doc, my neighbor and good friend, is. He is a doctor, but he would never think about writing an article about himself. He's too busy taking care of his family and his dog, keeping up his log cabin on the lake and the additional buildings—a bunkhouse for his five kids and grandkids, a gazebo overlooking the lake, and a large garage that houses his many large and small tools, fishing poles and hunting gear. Then there is his boat, his lawn, the trees that need to be cut for firewood—and you can bet that when the season is announced, Doc's busy hunting. Doc grew up in the north woods, and that is where he is living today. He's a guy who says he likes peace and quiet.

Doc has given me permission to share with you, the story of his struggle with throat cancer, a dance with death which followed an already long list of ordeals and tragedies in his life. He has also given me permission to share with you what saved him: a diet of homemade, blended food that he and I devised when he was close to succumbing to starvation. He was starving because a year after his radiation therapy, Doc could still not handle solid food, and, as he can admit today, he probably never will.

Doc is 71 years old. In the 1970's, his troubles began: he lost an adopted son in a hunting accident, his first grandchild to leukemia, and his sister at age 40 to breast cancer. Both his dad and brother had died young of heart attacks.

Shortly after the death of his sister, Doc's own ordeals began. In 1976 he contracted cancer in the soft tissue of his jaw. A tumor was removed surgically, but the medical team accidentally cut the nerve on the right side of his tongue. He still has trouble speaking. Then in 1979, he suffered a cardiac arrest. His life was saved by his dog, who began barking wildly when Doc's heart stopped. The dog made such a racket that the family came running and gave him CPR. He was rushed to the hospital, where his heart began beating again. He doesn't remember any of this. He only remembers going hunting the week before.

After the cardiac arrest, Doc was obliged to retire from the medical profession. His health no longer allowed him to work under the strain of his job. This was a man who had worked his way through medical school while supporting a wife and a growing family and who had established himself as a respected practitioner in his field. He loved medicine. He worked ungodly hours, volunteered his time freely to do more. Retirement at the age of 50 must have been difficult for him.

In 1998, Jack's wife died of lung cancer, after a year-long battle. Four months later doc began feeling an irritation in his throat, but the local doctors said it was nothing. Then one morning, using a mirror, he, himself, saw a tumor. It was biopsied in April of 1998 and found to be malignant.

Doc was told that the "treatment of choice" was radiation therapy without surgery. This technique boasted a 70% cure for those patients who "made it to the end" of the treatment sessions. He underwent about 30 treatments between April and June, that year, five days a week until the end, at which time the treatments were spread out to two times a week. It was so painful that he almost quit. "I was going to stop treatments, but I decided I'd better go to the end, because it was my only hope to live."

In all of the years I have known Doc, up until the throat cancer, he handled all of the tragedies. He carried the family through all the ups and downs. He says he was always there to push them. He means that he was there to take care of them and be their leader. Everyone depended on him. He always valued life. Maybe he took all the pain inside and kept it hidden there, to lessen it for the others. But the throat cancer and the loss of his wife, really became the mountains. The fact that he couldn't eat and continued to endure a lot of pain for a year after treatment seemed to take a heavy toll on this man. As I look back on those days, I think he must have felt really afraid and alone.

For the first year after treatment, Jack kept himself alive by drinking Ensure Plus. He was living alone in his cabin. Most of

his kids lived three hours away. The winters in the north are cold and long. He drank about five cans of Ensure a day, about 1800 calories. His hope was that his throat and all the rest would go back to normal within a few months. He had trouble talking, as his mouth quickly became very dry. He drank water constantly to keep his throat and mouth moist. At night he was up every hour, because of this dryness. He was plagued by mucus in his nose, which was always plugged, and his throat was always sore. He had headaches much of the time. He ran a steamer at night in his bedroom to moisten his throat. He didn't talk about any of that until a year later.

Last summer, when I returned home to our family cabin for my annual visit, I visited with Doc. I found that he had lost 20 pounds in a year's time. He weighed 142 pounds, he said, when he "jumped up and down on the scale." His throat condition had not changed. His morale was very low. His heart specialist said he needed work on his heart, but surgery was too risky because of his weakened condition—he might very well die on an operating table.

Doc and I sat down that very day and discussed something I had suggested the year before—a structured diet of balanced meals, which could be pureed and which could help him gain weight and find his way back to health. He agreed to let me set something up for him.

When Doc and I sat down that day to figure out a way to help him, I already had a few ideas of how to go about the food preparation. I had consulted with several dieticians and the health teacher at the school in which I work in Provence, France, about the diet idea before returning home to the US for the summer. Things began to fall into place.

The first night I was back in the US, I made a chicken soup stew for dinner at my parents' cabin. It was made with fresh carrots, celery, onion, a bouquet garni, and chicken. After dinner, I took what looked like a normal portion, put it in the blender, added some milk, and mixed it up. Then I

walked next door to Doc's house and presented it to him in a large glass. He said it looked too thick. We poured it into his blender and added milk to thin it. "Like your Ensure," I said, because he was still hesitating.

He drank it; said it tasted bad, but we both knew he had started his new diet. I made up large portions of a few different dishes, more of the chicken stew with some peas added, and a beef dish with mixed vegetables. Then Doc's daughter said something to me that helped me chart my course. She said, "He needs someone to structure his eating for him." And I understood that it was up to me to set up a schedule that he could eventually follow by himself.

I live in France, near the Mediterranean. My idea was to try to follow the principles of the traditional Mediterranean diet, which is high in fiber, vegetables, and fruits, and low in animal fat, and boasts a very low incidence of heart disease. This is a good diet for everybody, but especially for cardiac patients like Doc. A study done some years ago and published at a national health symposium in Madrid revealed that the people of Crete (on the Mediterranean) have the lowest rate of heart disease in the world. They live on a diet of fruits, vegetables, fiber, and very little meat and fish. And they consume large quantities of olive oil daily. Olive oil has been found to reduce cholesterol. All of the people who live around the Mediterranean Sea eat this way.

Before putting Doc on this Mediterranean diet, it was first necessary to get his weight up by 20 to 30 pounds, so that for a time, this Mediterranean diet would be "beefed up" with fat and some sugar, to give him extra, much needed calories. His insulin level was so low at the beginning of our program that his doctor said I wouldn't have to worry about the fat or sugar for a while.

The Diet Program

I devised a set of recipes. I told Doc that I would teach him to prepare the meals himself, because it was important for him to be able to learn to take care of himself. He informed me that he knew how to cook fish, campfire meals, and breakfasts, so I knew I had some work ahead of me.

Each recipe devised for this diet contains ingredients for a complete nutritional meal. The recipes are prepared with fresh ingredients whenever possible. And I also insisted on using a wide variety of ingredients, to insure that there would be a good range of nutrients in the diet.

I used the basic formula for the Mediterranean diet in my menu planning. It is a 2/2—4/4 chart: 2 parts dairy products and 2 parts meat/fish products per day, 4 parts fiber/carbohydrates and 4 parts vegetable/fruit products per day and always a couple tablespoons of olive oil in each meal.

I searched out and bought many different kinds of fiber or "whole cereal grains," like brown rice, cornmeal, bulghur wheat, barley, wheat germ, oatmeal, spelt, plus lots of different cereal breads. I also stocked up on dried legumes: red and white beans, black eyed peas, lentils, split green peas, whole peas, and carbohydrates like couscous, white rice, and pastas. All of these things can be kept a long time in the cupboard. Legumes combined at the same meal with cereals produce a complete protein, and this provides a good meat substitute and no animal fat, which raises cholesterol levels.

I then went to my French Mediterranean cookbooks and got to work. The people of the Mediterranean are said to be able to recite 75 vegetable recipes at will. A real vegetable-oriented culture! The cookbooks gave me the ideas I needed to create the recipes for Doc. I had to eliminate citrus fruits and tomatoes as they burned his mouth and throat when he swallowed them.

Doc drank about two pints of this pureed food at each of the three mealtimes. He continued drinking 5 cans of Ensure per day, at one or two hour intervals after the meals.

Breakfast. Breakfast for Doc became a blended mixture of a cereal grain, usually oatmeal, with fruit and milk. Doc likes oatmeal. He usually makes it with bananas.

Lunch and Dinner. In the first week, I created "Set 1", a meal schedule with a list of 8 different meals, using varied ingredients. Since Doc didn't know how to cook, I used a simple cooking technique: food was usually simmered in water and then blended. This is how soups and stews

are made. I simply combined the meat and vegetables in water and cooked them until tender, or cooked vegetables and added fish for the last ten minutes. I added pasta, couscous grains (easy to blend), or other cereal grains to the meat and vegetables, or sometimes just potatoes. When everything was cooked, I blended the mixtures with cooking juices and milk, and sometimes added sour cream or grated cheese, etc. Then I placed the blended meals in refrigerator dishes, labeled them, and froze them.

Since the food was already cooked and frozen, it could be defrosted and kept a couple of days in the refrigerator. It was important for Doc not to eat the same meal repeatedly, but to vary his meals and his ingredients, so he began to have several containers defrosted at once in the "fridge."

I wrote out four "Meal Sets" (Set I, Set II, Set III, and Set IV), each set being a list of 8 nutritionally balanced recipe "meals" of 6 to 8 servings. One set was enough food for one month of lunches and dinners. The sets were devised to be alternated, Set 1, then one month later, Set II, etc. The four sets contain 48 "meals" in all.

The recipes in the four "Meal Sets" were put into a "recipe box" (I actually bought a recipe box and recipe cards), so that Doc could follow them after checking his "Meal Set" list. The idea was to cook all of the eight meals of each set in advance, so that they could be eaten alternately for a month, thus providing a wide range of elements and correct levels of nutrients.

During the first six weeks of the diet plan, Doc gained nearly 20 pounds. I saw him last Christmas. He's cooking now. I made him his favorite Chicken Supreme, and he corrected me on the technique. He looks healthy. He is maintaining his weight. He checks his insulin level every morning and seems to be managing well with his new diet.

Patricia Choffrut
Provence, France

Editor's Note: Beginning with this issue of News from SPOHNC, one recipe from the meal sets will be featured each month. Please see Pat's Pantry Provençal on page 7.

Obtaining Disability Benefits. . .David versus Goliath?

Scott E. Davis, Esq.

Remember the epic battle between David and Goliath? On paper, David clearly had no chance to win, fortunately his heart and soul did not know it, and with determination, persistence *and divine intervention* he prevailed! Ever wonder what might have happened if he was aware of his predicament? Would he have fought or run the other way?

Every day at the Social Security Administration (SSA), seemingly epic battles between disability claimants and SSA are fought. *The Bounty? Disability benefits.*

The battle unfolds like this: You become unable to work due to a physical and/or mental illness and apply for disability benefits. After all, you've paid into the system all these years for this exact situation. Even your doctor says you can't work. You figure it is simply a matter of completing paperwork and time until you begin receiving benefits; however, you are starting to experience financial problems.

As the *months* go by without an answer, you reassure yourself that this must be a simple case and the delay is "due to government bureaucracy." After *several more months* your frustration grows; you call SSA and get no answers, or worse, the ones you get are all different! The bureaucrats you speak with seem put off by your phone call. You remind yourself that the SSA is on your side. It's job is to help people like yourself by paying disability benefits, right? But. . . You begin to feel like David.

The Big Day. . .

You finally receive an envelope from SSA. You tear it open expecting to find a benefit check. Instead you read: *We have denied your claim for disability benefits as our trained staff and medical doctors have determined you are not disabled under our laws.*"

You're angered, frustrated, scared, intimidated and now overwhelmed by the thought of fighting Goliath. . .the Federal Government.

Pages into the decision it mentions appeal rights, but the decision seems so final and leaves you with no hope. You don't know the law, the system or even if it is worth a fight. *You feel alone and defeated.*

As a disability attorney I meet with clients everyday who tell me this same story. Fortunately, those clients took the bold step of appealing the denial and fighting for benefits.

What should you do? Persevere!

70 to 75% of all disability applicants initially will be denied benefits! Half of those denied will give up and not appeal the denial! However, 53% of the applicants who persevere to a hearing before an Administrative Law Judge obtain benefits!

Now you understand how the system works, it is designed to *deny* benefits to as many people as possible. SSA denies initial applications because it knows 50% of the people will give up and not appeal! But for those who persevere and appeal the denials, the majority are eventually granted benefits.

Understanding the System

1. **Initial application** - Every claim for disability benefits begins with the initial application. *70% to 75% of all applicants are denied at this step.* SSA looks for a reason to deny benefits. The decision is based on forms you completed and medical records, you won't meet with anyone involved in making the decision. It is surprising when anyone wins at this step. Don't quit—You must appeal a denial within 60 days.

2. **Reconsideration** - The second step in the system but the results are worse. *80% of all applicants are denied at this level.* SSA reviews your file again and issues a denial, unfortunately it may take months to receive. At this step, only 50% of the original applicants are still in the system, the rest gave up. Appeal the denial immediately.

Up to this point in the system you have been a social security number and a file.

3. **Request for Hearing before Administrative Law Judge** - Congratulations! You have persevered in the system and now have a good chance to win benefits. *53% of all claimants win at this stage!*

Why? Primarily because your claim is entitled to a *de novo or new review* by a Judge who knows the law and does not work for SSA. Also, you get to testify before the Judge about your inability to work and she/he assesses your credibility. Finally, hopefully you have obtained opinions from your doctors about your inability to work.

You must win your case at the hearing stage; if you do not, you can appeal but your claim will be tied up perhaps for years with the likelihood of success dramatically reduced.

Increase your odds of Winning

Now that you have an understanding of how the system works, here are some tips on how you can maximize your chance for success.

1. **Appeal every Denial** - It bears repeating, *DO NOT QUIT* after receiving a denial. Now you understand you must get to a hearing. Up to that point SSA and the odds are overwhelmingly against you - receiving a denial may be cause to celebrate because your a step closer to a hearing.

2. **Retain a Disability Attorney** - Retaining an attorney who specializes in disability law should substantially increase your odds of winning. Most claimants have no idea what they need to prove to win their case. Practically all disability attorneys work on a contingency fee - *you only pay a fee if you win your case.* Also, *Federal law sets the maximum amount the fee can be in your case.* An attorney will develop your case by obtaining the necessary medical and vocational records and opinions from your doctors that are critical in

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proving disability.

3. **Complete Social Security Forms** - You will complete a dizzying array of forms requesting all sorts of information. Be honest and *very brief* when completing forms. You won't win your case with the information you give on the forms but you could lose it.

4. **Involve your Treating Physician** - Your treating physician is critical to success. Judges give a treating physician's opinion regarding a patients' disability tremendous weight. If your physician is not sympathetic to your claim you may want to make a change to one who is.

The purpose of this article is to convey hope that you can win your case and obtain benefits with perseverance and knowledge of the system. Please do not give up. . . appeal and keep fighting!

In the next issue of *News From SPOHNC*, I will discuss how to prepare your disability case based on a diagnosis of head and neck cancer.

Editor's Note: Scott E. Davis is a social security and long-term disability insurance attorney in Phoenix, AZ. Scott represents clients nationwide. He is intimately familiar with head and neck cancer as his father passed away after a three-year battle with oral cancer in November, 1998. He invites your questions and inquiries regarding representation at (602) 482-4300, or via email: harris.davis@azbar.org.



from PAT'S PANTRY
PROVENÇAL



Chicken Supreme

- 2 boneless chicken breasts
- 4 medium potatoes
- 1 slice of bread, preferably whole grain
- 1 bunch of fresh asparagus or 1 1/2 cups frozen asparagus
- 1 medium onion
- 2 tablespoons olive oil
- 1/2 c. sour cream or 1 pot of plain yoghurt
- 1 tsp salt
- A pinch of pepper

Milk as needed for blending

Cut up the meat, potatoes, onion, and asparagus into large chunks. Put them in a stewpot with the olive oil and salt. Just barely cover with water, Bring to a boil, then simmer about 45 minutes until the vegetables are cooked and the meat tender. Place the stew in your blender, add the bread cut in chunks and the sour cream or yoghurt and at least 1 cup of milk. Blend at high speed, adding more milk as needed to liquify it to the consistency you desire. Freeze extra portions in small tupperware containers.

For a more Gourmet flavor, add 2 tsp. fresh crushed tarragon.

September's tip: Olive oil has healing properties. It is used in skin creams and other beauty products in Provence and prescribed for many ailments (stomach problems, high cholesterol, etc.) It may also soothe the throat and palate.

MEMBERSHIP APPLICATION
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Membership includes subscription to nine issues of *News From SPOHNC*

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- \$20.00 individual
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- Booster, \$10+
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- Founder, \$5000+
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PLEASE NOTE THE CHANGE OF DATE FOR
SPOHNC MEETINGS.
SPOHNC WILL MEET ON THE
FOURTH THURSDAY EACH MONTH
September - June, 2000-2001

MOVING FORWARD
A RESOURCE PROGRAM FOR PEOPLE TREATED
FOR HEAD AND NECK AND ORAL CANCERS
Will meet on Thursday, September 14, 2000 at 2:30 P.M.
Post-Treatment Resource Program
Memorial Sloan-Kettering Cancer Center
Rockefeller Research Laboratories, 430 East 67th Street, New York, NY
For information, counseling or reservations, please call 212 717-3527

For more information and directions, please call S.P.O.H.N.C at (516) 759-5333
RESERVATIONS NECESSARY

Will meet on the fourth Thursday of the month - 7:00 P.M.
September 28, 2000
Syosset Public Library
225 South Oyster Bay Road
Syosset, NY 11791

S.P.O.H.N.C



SUPPORT FOR PEOPLE WITH
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Medical Update on Head and Neck Cancer:

The State-of-the-Art

October 12, 2000

12:00 Noon-1:00 PM

William Michael Lydiatt, MD, University of Nebraska Medical Center, Oscar Streeter, Jr., MD, Kenneth Norris Hospital, Los Angeles, David G. Pfister, MD, Memorial Sloan Kettering Cancer Center, New York, and James J. Sciubba, DMD, PhD, Johns Hopkins Medical Center, Baltimore, MD will address treatment options, symptom management, doctor/patient communication and quality of life issues.

CALL 1-800-813-4673 for more information.

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ALZA Pharmaceuticals)