



HEAD AND NECK CANCER SURVIVORS AND SWALLOWING DISORDERS

BONNIE M. HARRIS, PH.D.

INTRODUCTION

The evaluation and treatment of swallowing, speech, and voice problems in patients following treatments for head and neck cancer have been a primary focus of my clinical activity as a speech-language pathologist over the past 19 years. That experience has been, and continues to be highly rewarding. I have had the opportunity to get to know and treat hundreds of patients with head and neck cancer, and have observed and taken part in advances in behavioral treatments related to communication and swallowing problems. Though these experiences have been most positive, clinical practice in this area can also be frustrating because treatment advances haven't occurred fast enough, and many patients have persistent difficulties despite the application of treatments. Furthermore, head and neck cancer has not received the attention it deserves in terms of media, education or financial support. I am sure that many members of SPOHNC and their families share these sentiments. While survival from the cancer is the ultimate goal for many, quality of life is equally important and should not be understated. Despite this frustration, I remain highly optimistic, especially in terms of the consumer advocacy that so many patients have generated at local, state, and federal levels.

Swallowing ability and disability associated with head and neck cancer will be the focus of this article. However, speech, vocalization, and swallowing are often equally or partially involved in functional impairments. Swallowing should be a simple process. After all, we begin swallowing before we are born and we swallow about once every minute as adults. Swallowing frequency increases sig-

nificantly during eating and drinking. Like any basic bodily function, we tend to take swallowing for granted until the predictable function becomes unreliable and unsafe and no longer meets our nutritional needs. Contrary to the simple process of swallowing, the sequential and simultaneous muscle contractions that occur when we swallow are highly complex. The nervous system control over swallowing consists of highly complicated networks of tiny nervous structures in the brain and is not clearly understood. Swallowing function is also somewhat variable between individuals and changes with age, disease and various materials that are swallowed. The complexity and variability of normal swallowing function results in challenges when attempting to treat swallowing disorders, commonly referred to as *dysphagia*.

NORMAL SWALLOWING

The normal swallow requires contraction of certain muscles and critical actions that result in the transport of food and liquid through the mouth to the stomach. Airway protection is an additional component. These sequential and simultaneous actions include:

1. Containing the material in the mouth by the lips and with contact of the tongue to the palate (i.e. roof of the mouth);
2. Mixing the material with saliva and chewing, if necessary, performed by muscles of the jaw, tongue and the teeth;
3. Movement of the liquid or chewed food backward through the mouth by the posterior movement of the tongue and pressing of the tongue to the palate;
4. Triggering of the pharyngeal events, i.e. "throat-part" of the swallow that are critical for preventing *aspiration*, (choking or food going down the windpipe).

These events include:

- Upward and backward movement of the soft part of the palate to close off the nasal cavity during swallowing.
- Lifting and closing of the *larynx* or voice box.
- Pushing the food or liquid through the throat chamber by forceful backward movement of the very base of the tongue and by squeezing or contraction of the muscles of the throat.
- Contraction of muscles of the pharynx.
- Opening of the valve at the top of the lower swallowing tube, i.e. *esophagus*.
- Wave-like contraction of the muscles of the esophagus.
- Relaxation and opening of the valve at the bottom of the esophagus that permits flow of swallowing material into the stomach.

SWALLOWING continued on next page



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COMING IN SUMMER, 2001

Soft Tissue Sarcomas of the Head and Neck

Norman D. Bloom, MD

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If any of the muscles and structures involved in these actions are totally or partially removed, there may be a significant impact on one's ability to eat and drink safely, efficiently and adequately to maintain good nutrition and hydration. The degree of disability will, in part, be related to the size of the surgical defect, the nature of the wound closure and additional medical treatments such as radiation therapy and chemotherapy. While these treatments are often necessary to enhance survival, they can cause injury to preserved healthy tissues and add to, or be the primary cause of the swallowing problem.

COMMON SWALLOWING PROBLEMS ASSOCIATED
WITH HEAD AND NECK CANCER TREATMENTS

Oral Cavity Surgeries

Surgery to remove cancers of the oral cavity may involve resection of portions of the lips, tongue, floor of mouth, and palate. This type of surgery not only disrupts the functional movement of muscles and structures, but may also reduce the sensation or feeling in the mouth. Impairment of sensation or movement of the muscles of the lip lead to problems holding the food, particularly liquid, within the oral cavity. Because of the sensory loss, the patient may not be aware of occasional or frequent drooling until the embarrassing occurrence is observed by them or others. Patients can be trained to effect a tighter lip closure, and muscles of the lip may be retrained to improve the range and strength of their movement. The tongue is a major mobile structure that is extremely important for *bolus* (i.e. food or liquid material) control, airway protection, and propulsion of the bolus through the pharynx (i.e. throat). If the front or sides of the tongue are involved, the patient typically has difficulty holding the material on the tongue, causing portions of the bolus to fall to the floor of the mouth. It may also be difficult for the patient to reach this residue and to raise the tongue to the palate to efficiently clear the mouth. This results in foods sticking to the palate and on the remaining tongue. With swallowing therapy by a specially trained speech-language pathologist (SLP), the patient can usually regain functional swallowing ability with some necessary modifications in food or liquid texture. Patients will typically have an easier time with softer foods rather than dry solid foods, but this will vary from patient to patient and is partly dependent on the condition and presence of remaining teeth. When the surgery involves the back part of the oral tongue (i.e. the part of the tongue back that is visible when looking into the mouth), the patient may experience difficulty with premature entry of the bolus into the pharynx. This is typically related to impaired ability of the tongue base to oppose a downward and forward soft palate. When this seal is disrupted, the leading edge of the bolus can enter the pharynx before the airway closes. This problem may be intensified if the surgery involved partial or total resection of the soft palate, and regurgitation of some of the bolus into the nasal cavity is not uncommon under these circumstances. Appliances may be made by a dental prosthodontist and SLP that prevent nasal regurgitation and that also enhance overall speech and swallowing function.

SWALLOWING continued on page 3

SWALLOWING continued from page 2

Pharyngeal Surgeries

The tongue base is the very back and bottom of the tongue that is not visible when looking into the mouth, and attaches to structures at the top of the larynx. In cases where the base of the tongue is partially or totally removed, the patient may experience significant problems protecting his/her airway when pushing the food through the pharynx. The functional result is rapid and premature entry of the material into the open airway and sticking or lodging of the food in the natural pockets of the pharynx. These swallowing problems place the patient at risk for aspiration. Over the past 10-15 years, new strategies have been developed to compensate for this loss of tongue base tissue and function, and include exercises to recruit and strengthen muscles of the throat to assist in pushing the material through the pharynx. Patients whose surgeries involve the muscles connecting the tongue to the larynx may experience problems with forward movement, lifting and closure of the larynx and increasing the likelihood of aspiration. However, advances in exercise techniques that incorporate principles of exercise physiology are resulting in the patient's ability to increase the range and strength of this important movement of the larynx during swallowing.

Head and neck tumors may also grow in the walls of the throat. If the lesion is surgically removed, the patient will experience difficulty pushing the bolus through the pharynx with pocketing or sticking of foods. This pocketed food residue may result in overflow to the open airway after the initial swallowing attempt is completed. Patients with this type of swallowing disorder may benefit from strengthening exercises and/or eating and drinking postures or maneuvers that assist in pharyngeal clearance and aspiration prevention

Laryngeal Surgeries

Like other surgical resections of the head and neck, the presence or type of swallowing problem will partly depend on the extent or number of structures that necessitate removal. Tumors involving structures of the larynx above the level of the vocal cords or folds are often referred to as *supraglottic* tumors. The physician's decision to perform a partial

resection of the larynx will depend on the size and location of the lesion. Because of the increased threat of aspiration with removal of the supraglottic structures, the surgeon also considers the expected functional outcome and physical tolerance of the patient. The valves that are usually involved in this type of surgery include the leaf-like structure (i.e. epiglottis) that covers the larynx as it lifts upward and forward during the swallow, and the ventricular (i.e. false vocal folds) that sit above the true vocal folds. If these valves are removed, the patient will experience some temporary problems with rapid falling of the bolus toward the vocal folds and airway during the swallow attempt, and increase the likelihood of aspiration. However, select patients following supraglottic laryngectomy often return to functional swallowing ability through use of learned compensatory maneuvers to assist them in airway protection. If the surgeon must remove portions of the tongue base or additional structures of the larynx in addition to the supraglottic region, increased problems with bolus clearance through the pharynx and airway protection will result. Some patients undergo surgeries that remove approximately one-half of the larynx, and through reconstructive techniques and rehabilitation many of these patients return to oral intake and have a good vocal result.

When the size of the tumor warrants entire removal of the larynx, there is complete separation of the airway from the swallowing pathway. Therefore, following total laryngectomy, patients seldom have significant swallowing problems. However, if the lesion is large and the surgical closure is tight, there may be some narrowing of the throat and upper esophagus. This is sometimes prevented by inserting grafts or sections of tissue from other parts of the body, such as the small bowel, that act like the new swallowing passageway. If the patient has a *tracheoesophageal puncture* (i.e. TEP) for voice restoration, there is some linkage between the breathing and swallowing tubes. Though leakage around or through the prosthesis may occur, it is not commonly a significant functional complication and can be efficiently managed by the SLP and surgeon. The prosthesis can be adapted to prevent the likeli-

hood of aspiration during a swallow in a patient following laryngectomy and TEP. Other partial laryngeal surgeries are performed that attempt to conserve vocal function and swallowing with the primary goal being cure of the cancer. These operations are increasingly being refined and hold promise regarding the functional outcomes of the patients.

Chemotherapy and Radiation Therapy

There is increasing evidence for using chemotherapy and radiation therapy as first-line or primary treatments for some cancers of the head and neck. Also, both of these therapies have been used and continue to be used as adjuvant to surgical treatments. It is important for the patient and care giver to understand that even though structures are not surgically removed, changes may result that impair swallowing, speech and vocal function during these treatments. The SLP should carefully follow and work with patients during their treatment regime in order to monitor airway protection and swallowing ability, and to work with them on appropriate compensatory strategies and exercises to optimize function during and after the treatment.

EVALUATION OF SWALLOWING PROBLEMS AND APPROPRIATE TREATMENT SELECTION

Swallowing function varies between individuals, even with similar surgical resections. Based on this fact, a patient must be seen for an instrumental evaluation of swallowing function in order to determine the exact nature of the swallowing problem. Further, therapy strategies should be applied in a systematic fashion during the evaluation to identify their impact on the patient's swallowing ability. The most common instrumental swallowing evaluation is called the Modified Barium Swallow (MBS) study which is a videotaped or digitally recorded fluoroscopic examination. The study takes place in a radiology department or suite and is conducted jointly between the SLP and the radiologist. The MBS allows the clinician to examine structural movements of swallowing as they relate to flow of the bolus. Spe-

SWALLOWING continued on page 6

A TIME FOR SHARING Radiation Therapy – A Patients View

My name is Jerry Reynolds. I was diagnosed with squamous cell carcinoma of the base of tongue with metastases to the right neck lymph nodes in August of 1998. I had surgery September, 1998 that involved the removal of 1/2 of the base of my tongue and a neck dissection on the right side. Reconstruction of the tongue was done with a radial free flap. The free flap donor site was the left forearm. I also had a tracheotomy that was performed during surgery and remained for the week following surgery.

Radiation treatment began on December 12, 1998 and continued for a total of thirty-five treatments (seven weeks). I did not have a PEG tube. I lost a total of 62 pounds going from 205 lbs. to 143 lbs. two months post radiation.

Being treated for head and neck cancer, such as I have described, can be the biggest single event that one will ever face in a lifetime. Considering the magnitude of what is involved in the treatment of this type of disease, it is not surprising that physicians and nurses have difficulties fully preparing us for what lies ahead. It would virtually take hours of explaining all the possible situations that a patient *might* encounter.

During my first meeting with the radiation oncologist she explained all the things that I might experience during radiation therapy. The main problem here is that one is not really of the proper mindset to accept all that is being said. Doctors also may have a tendency to list, in one lump sum, all that's going to happen. Save for the surgery itself, the radiation treatment and the side effects of treatment probably had more impact on me than anything else. All this was explained, mostly in "techno medico babble" in about thirty minutes. As I think back now, two years later, I realize that I was no more prepared for what was about to happen than if they had explained how I was going to a space station!

At 30 months post treatment, I am cancer free. Rehabilitation for my cancer was indeed difficult; however, I now feel good

and can eat almost anything I want; some things just take longer than others.

Here are the side effects of my treatment and how I was able to deal with them:

- ◆ Fear! – I prayed and relied on strength given me by my wife Gail, friends and loved ones. Fear is very difficult to overcome.
- ◆ Dysphagia - difficulty in swallowing – This was caused by surgery and augmented by radiation. I worked through it using a numbing solution.
- ◆ Sore throat - I didn't swallow unless it was absolutely necessary. To be able to swallow and tolerate anything in my mouth, I

At 30 months post treatment, I am cancer free. Rehabilitation for my cancer was indeed difficult; however, I now feel good and can eat almost anything I want; some things just take longer than others.

gargled with a solution of 1/3 Lidocaine Hydrochloride Oral Topical Solution, 1/3 Maalox and 1/3 Benadryl before each meal. (This solution has many names such as Mary's Magic Elixir)

- ◆ Loss of taste - There was nothing I could do...nothing tasted or felt good. However, taste started to return about two months post radiation. At 30 months I can finally eat spicy foods again. So far the only thing that still tastes bad is chocolate.
- ◆ Hair loss - I lost some hair at the back of my neck, but it has grown back. My facial

hair has not grown back. I do not have to shave. My goatee and mustache were not in the field of radiation; consequently I still have them.

◆ Irritated and burned skin - I used Aquaphor ointment at first. The last three weeks I used LiquidShield, a cyanoacrylate-based product. In my opinion LiquidShield saved my skin. At about two weeks post op my skin felt like baby's skin.

◆ Stiff neck – radiation induced fibrosis - I stretch my neck daily. I have recovered about 90 percent.

◆ Shoulder stiffness and pain – Neurogenic fibrosis, limited movement - caused by surgery and radiation. Exercise reduces the pain somewhat; however, there seems to be no cure. The pain in my shoulder is centered at the shoulder blade and is aggravated by standing, walking and sitting upright. This difficulty along with xerostomia led to my permanent disability and the use of a wheelchair for extended periods of time.

◆ Stiffness in jaw movement (Trismus) – Prior to radiation, I was able to open my mouth 53cm. At two months post radiation, the opening had decreased to 23cm. It was highly recommended to do stretching exercises daily while in therapy and thereafter. I did not, and paid the price. I can now open my mouth to about 30cm.

◆ Jaw pain, earaches. Not much to do here. At 30 months this pain has subsided.

◆ Thrush – oral candidiasis - I took Diflucan and Mycelex troches. The best prevention is good oral hygiene. Brush with Biotene toothpaste and scrape the tongue after each brushing. The thrush was much easier to control, when I started scraping my tongue. This particular malady is very difficult to control. It runs rampant when your white blood cell count is low due to the radiation therapy.

◆ Lack of Stamina – exhaustion - Fatigue may become greater as treatments continue. At about 18 months I had regained enough strength and stamina to last the day without naps

◆ **Dry mouth – Xerostomia** - Dry mouth can be a lifetime issue. I use Salagen to help stimulate salivary flow. It may take up to twelve weeks for the drug to start working. A side effect of this drug is sweating which can be very uncomfortable. However, I found by taking Salagen with meals, the side effects are almost completely eliminated. Patience and determination are a must. Other suggestions to help control dry mouth. 1. Don't talk more than necessary, 2. Sip water, 3. Use Biotene's OralBalance Gel to help keep the mouth moist, especially at night.

◆ **Hoarseness and laryngitis** - I experienced these symptoms as a result of the swelling in my throat and larynx. My voice returned about two weeks after completion of treatments. Because of Xerostomia I experience hoarseness and laryngitis if I talk for extended periods, like an hour or more.

◆ **Mucositis**. I gargled with a solution of 1-teaspoon baking soda and 1-teaspoon salt in a pint of water. This helped to keep the mucous loose. Good news, at 18 months most of the issues of thick mucous, coughing and spitting had abated except while eating.

◆ **Low thyroid** - This was discovered at 24 months post radiation treatment. I am now on lifetime maintenance of L-Thyroxine/Levoxyl Tabs. □

◆ **Weight and appetite loss** - I am 6'1" and weighed about 205 pounds before my treatment. At two months post radiation I was at 143 pounds. I am now stabilized at 149 pounds. During therapy I ate scrambled eggs, custards, cream of wheat, canned ravioli and Spaghetti O's until I went on a full liquid diet. My appetite improved once my taste started to return at about two months post treatment.

◆ **Canceritis** – Not a real word but coined to describe a condition where you think every little thing is cancer – again! This is a tough one. Don't know how not to feel this way. The feelings associated with having had cancer never completely go away.

Of all of these maladies, the sore throat, in combination with dysphagia and xerostomia and at times thrush, was the worst. Because it was so severe, I had extreme diffi-

culty eating. I had decided I would not have a feeding tube, if at all possible. I had a terrible fear of having another surgical procedure.

By the fifth week of treatments I had resorted to a liquid diet of Ensure. I was instructed to drink eight cans a day. On many days I could only manage 6 cans and that took several hours. To be able to swallow and tolerate anything in my mouth, I gargled with the solution containing Lidocaine Hydrochloride Oral Topical Solution, as mentioned above. Without this solution I could not have taken nourishment orally. I did persevere and continued to eat by mouth. Eating during this time was the most difficult thing I've ever done.

I've often been asked would I have a PEG Tube if I had it to do over. I don't think so. Of everything involved with having cancer there is very little I can say I personally accomplished. Making it through radiation by eating on my own was a personal achievement that has given me strength, not only in fighting this dreaded disease but in my personal life as well. However, this may not be the best way for others. It is a very individual thing.

REMEDIES AND SOLUTIONS I COULD NOT HAVE DONE WITHOUT

◆ **Salagen**- I take Salagen, 5mg, 3 times a day. Initially it took about 8 weeks for me to notice a difference. The difference for me is NOT saliva flow but rather a moist mouth vs. completely dry mouth. I take this medication immediately after eating breakfast, lunch and dinner. By doing this, I have absolutely no side effects. I've taken Salagen for 2 1/2 years and it will be a lifetime maintenance drug for me.

◆ **Milk** – I now drink milk with meals instead of water. Water is just about the most difficult substance to swallow. I believe that the fat in milk helps in swallowing. It's an old wives' tale that milk creates mucous. It just thickens it while drinking.

◆ **Tongue Cleaning** – To help control thrush I used a tongue scraper after every meal. This seemed to work as well as drugs!

◆ **Numbing Mouth Wash** -- During radiation therapy in order to eat (drink Ensure) I gargled with a solution of 1/3 Lidocaine Hydrochloride Oral Topical Solution, 1/3 Maalox, 1/3 Benadryl

◆ **LiquidShield** - LiquidShield is painted on the skin in a very thin layer to provide protection against friction, shear (clothing rubbing against the skin) and moisture. These three irritants can lead to skin breakdown in radiation patients.

◆ **Biotene Dry Mouth Toothpaste** - In my opinion, Biotene is the only toothpaste in the world that works like the body's natural defenses to fight cavities, periodontal disease and oral infections due to dry mouth. It was also the only toothpaste I could tolerate in my mouth.

◆ **Biotene Mouthwash** - Biotene Mouthwash can be especially beneficial to individuals experiencing dry mouth or having oral irritations.

◆ **Biotene Oral Balance** - This mouth moisturizing gel is extremely helpful in relieving severe dry mouth symptoms: burning, sore tissues, cotton palate, and swallowing difficulties. I use it at night. It helps prevent dry mouth while sleeping.

◆ **Websites** - The following websites were of enormous help to me:

<http://www.isoc.net/bds/index.htm>

The web site of Barry Sebastian, a fellow head and neck cancer patient.

<http://www.spohnc.org/>
a great resource.

<http://www.acor.org/head-neck-onc.html>
Association of Cancer Online Resources,
specifically the Head and Neck List.

Jerry Reynolds
Long Beach, California

Editor's Note. For Jerry's complete journal, please email him at glrinlb@gte.net. He'll be glad to forward a copy by email.

cific swallowing disorders with or without aspiration can be easily identified, and effective strategies that optimize swallowing function are made clear. flexible fiberoptic endoscopic evaluation of swallowing may also be conducted in place of or as an adjunct examination to the MBS. This test does not require x-ray exposure; rather swallowing structures are viewed through a flexible tube inserted into the nose and advanced to the pharynx above the larynx. While this technique provides excellent visualization of structures before and after the swallow, visualization during swallows may be difficult as the moving structures touch the tip of the scope and obliterate the view. Sensory testing of the throat may also be applied during the fiberoptic swallowing evaluation using a specialized flexible scope. It is important that patients and their significant others strongly advocate for one or both of these swallowing evaluations. In the absence of an examination that permits visualization of swallowing function, the clinician is only able to treat the patient based on the best clinical guess approach. Like any diagnostic procedure in our current health care arena, third party payers often contest the necessity of the MBS or other swallowing assessments. Nonetheless there is ample and increasing and scientific evidence that clearly point to the efficacy and necessity of these procedures. The ultimate goal is to optimize the safety and efficiency of the patient's swallowing ability and to ensure adequate nutrition and hydration. Even though a patient may be able to eat and drink modified food and liquid textures based on the outcome of the evaluation, supplemental feeding through a nasogastric or gastrostomy tube may be warranted temporarily or permanently to ensure adequate nutrition and hydration.

□ADVANCES AND CLASSIFICATIONS OF BEHAVIORAL SWALLOWING TREATMENTS

In recent years, significant advances have been made in the surgical approaches used to treat patients with head and neck can-

cer. While the surgeon's priority is to remove the tumor and optimize the chance for cure, surgeons are also placing increased emphasis on functional considerations. However, while we are encouraged by the new surgical techniques, there is no one surgical approach that will cure a swallowing problem. Further, clinical studies of the effects of medications on improving swallowing have been scant. These problematic issues further speak to the complexity and multi-factorial nature of most swallowing problems. Despite these limitations, we are increasingly optimistic regarding the proven effectiveness of some behavioral strategies on specific swallowing impairments. There are four major categories of behavioral swallowing treatments that may be suggested as part of the overall swallowing treatment plan. These include the following: modification of bolus variables; compensatory postures and maneuvers; isometric exercises; and techniques for maximizing sensation. Treatment approaches should be selected based on positive outcomes documented in clinical studies related to the specific swallowing problem. Patients should be cautious regarding information on a technique or procedure that promises all things to all patients.

I have purposely avoided writing a "laundry list" of currently used swallowing therapy techniques because patients and clinicians often use these methods inappropriately with detrimental outcomes. Consult the speech-language pathologist(s) in your geographic area with demonstrated training and experience in the evaluation and treatment of swallowing disorders associated with head and neck cancer. The staff of the American Speech Language and Hearing Association (ASHA) and the Special Interest Division 13 of ASHA: Swallowing and Swallowing Disorders can direct you to speech-language pathologists with swallowing interest and expertise, and to reference materials regarding specific swallowing disorders and therapy techniques (ASHA web site: www.asha.org; 1-800-498-2071).

The approach to swallowing treatment should be a collaborative team effort. The members of that team include first and fore-

most the patient and support system, the surgeon, the speech-language pathologist, clinical dietitian, nurse and may involve the oncologist, radiation oncologist, primary care physician, occupational and physical therapist. The patient must be intimately involved in setting the functional goals of swallowing treatment, be highly motivated and diligently in their practice. Of course you know that...you've been there and you teach us so much!

Editor's Note: Bonnie M. Harris, Ph.D. is the Director of the MUSC Evelyn Trammell Institute for Voice and Swallowing Disorders and Assistant professor in the departments of Otolaryngology Head and Neck Surgery and College of Health Related Professions. Dr. M. Harris is the Coordinator of SID 13: ASHA Specialty Interest Division on Swallowing and Swallowing Disorders, and founder, past director and consultant to the Evelyn Trammell Voice and Swallowing Center at Saint Joseph's Hospital of Atlanta (A SPOHNC chapter site).

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" Thought is the blossom; language the bud;
action the fruit behind it."

---- Ralph Waldo Emerson

These words were used to describe Mort Silverblatt at the celebration of his 75th birthday brunch in Miami Beach on March 12, 2001.

Mort Silverblatt is a 28 year survivor of oral cancer. He has been actively offering support and encouragement to oral and head and neck cancer patients for the last 18 years. In 1992, Mort met Nancy Leupold at a meeting of the National Coalition of Cancer Survivorship in Charlotte, North Carolina.

The word " action" became Mort's creed to give back and offer ideas, help and support. A committed involved man, he began actively motivating those who were on similar journeys.

In February 1994 Mort's " A Time for Sharing" was published in the SPOHNC Newsletter. He has continued to support SPOHNC and it's mission and work. Eight years ago he started as a volunteer at the Sylvester Comprehensive Cancer Center at the University of Miami, Florida. His volunteerism was shared with any cancer patient, yet , his calling was to start a support group for the head and neck cancer patients.

Among friends, survivors, members of the medical community and his very special family on a landmark birthday, Mort was honored with the naming of the newest SPOHNC chapter: SPOHNC-MIAMI, FL, Mort Silverblatt Head and Neck Group. The charter was presented April 26, 2001 during a reception in his honor.



from PAT'S PANTRY
PROVENÇAL

Tuna or Shrimp Casserole

- 1 large can tuna, drained (or 2 cans shrimp)
- 1 1/2 cups fresh or frozen peas
- 3 carrots (not the green ends)
- 1 large onion or 1 leek
- 1 cup uncooked angel hair pasta, rice or couscous grains
- 1/2 cup grated cheese or cheese whiz

Cook the vegetables in water for 1/2 hour or until tender. Drain . Cook the pasta or rice separately in water and drain. Blend everything together with the tuna or shrimp adding milk as needed. Pour into casserole dish and bake in a preheated 350° oven until bubbly.

May Tip: We need fish at least twice a week. It is lighter and contains less fat than meat. Try to use tuna in water or in olive oil, but tuna in olive oil may be difficult to find.

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Presenters

Jed Pollack, M.D., North Shore-LIJ Health System, New Hyde Park, NY; Bhadrasain Vikram, MD, Montefiore Medical Center, NY; George Laramore, M.D., Ph.D., University of Washington School of Medicine, Seattle, WA, and James J. Sciubba, D.M.D., Ph.D., Johns Hopkins Medicine, Baltimore, MD.

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