



S•P•O•H•N•C

A PROGRAM OF SUPPORT
FOR
PEOPLE WITH ORAL
AND
HEAD AND NECK CANCER

RADIATION IMPLANTS (BRACHYTHERAPY) FOR HEAD AND NECK CANCER

BHADRSSAIN VIKRAM, MD

Radiation Implant Therapy (also known as Brachytherapy) consists of putting radioactive sources directly into the cancer, so that the radiation does not have to travel through healthy tissues in order to reach the cancer. This minimizes the dose of radiation to the healthy tissues thereby minimizing the side effects of radiation, and facilitates much higher doses of radiation to the cancer thereby increasing the rate of cure. In the management of head and neck cancer, Radiation Implant Therapy may be used as a treatment for early cancers as well as advanced or recurrent cancers.

Temporary and Permanent Implants

Radiation implants may be temporary or permanent. A temporary implant requires the patient to stay in the hospital for a few days, while in the case of a permanent implant the patient can usually go home the same day. Permanent implants are in the form of little metallic radioactive "seeds" (each about the size of a grain of rice) that are inserted into the cancerous area with a needle and then left there permanently. Iodine-125 or Palladium-103 are the most commonly used radionuclides for these implants. They give off radiation to the cancer slowly over a few weeks, killing the cancer cells, and then becoming inert. Generally, these implants pose no danger to the patient or to other people.

In the case of temporary implants, thin plastic hollow tubes (catheters) are threaded through the cancerous area, and radioactive sources, that are much more intense than the permanent seeds,

traverse the cancerous area through these tubes. Iridium-192 is the most commonly used radionuclide for these implants. After a few days the catheters are removed and the patient can go home.

Many small cancers in the head and neck region can be cured by radiation implants with minimal or no radiation dose to the salivary glands. In this way it is possible to prevent xerostomia (dry mouth) in properly selected patients. Larger cancers or cancers involving the lymph glands in the neck will require external radiation therapy which will generally result in a much higher dose of radiation to the salivary glands. However, even in such cases, it is sometimes possible to reduce the dose of external radiation by careful supplementation with radiation implants. Radiation implants can also be used to supplement surgery in the treatment of head and neck cancer. Sometimes the implant is done while surgery is in progress; in other cases it is performed after the surgery.

Another very important role for radiation implants is in the treatment of cancer that has recurred. In many instances, radiation implants might be the only method to cure recurrent cancer, or at least to provide meaningful relief from distressing symptoms such as pain, bleeding or disfigurement. In some cases of this nature, radiation implants are combined with one or two courses of chemotherapy in order to enhance their safety and effectiveness. Generally, chemotherapy does not cure head and neck cancer, but the tumor shrinkage caused by chemotherapy might permit the radiation implants to be more easily or safely performed.

Evaluation for a Radiation Implant

The desirability and feasibility of using Radiation Implant Therapy will depend upon a careful evaluation of the kind and extent of the cancer, as seen by a physical examination, an examination under anesthesia (if required) and results of radiological examinations such as CT, MRI and PET scans. This is known as determination of the target volume. Consideration must also be given to the physical condition of the patient and his/her ability to undergo the necessary local or general anesthesia in order to place the radiation seeds or catheters.

Following temporary or permanent implantation, specialized X-rays or scans are taken to verify the positioning of the radiation sources. In the case of temporary implants, these X-rays and scans are utilized to help perform some elaborate calculations in order to tailor the amount and intensity of the radiation to the precise volume of the cancer. Permanent implants are generally suitable for small cancers, but temporary implants are necessary for larger cancers. There are, however, many exceptions to this, and many other factors enter into the decision of which kind of implant is likely to be the most beneficial for any individual patient.

BRACHYTHERAPY continued on next page



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COMING IN WINTER, 2001

The When and Why of a Tracheotomy
David P. Wolk, MD

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High Dose Rate Brachytherapy

Generally, a patient with a temporary implant must remain in the hospital for several days. In the past, the use of traditional implant techniques resulted in the patient emitting radioactivity for several days until the removal of the implant. Consequently, the patient would have to be quarantined. However, recently there has been a major technological innovation, known as remote controlled high dose rate brachytherapy.

This innovation has made life much easier for the patient, the medical staff taking care of the patient, and visitors as well. In addition to the convenience, this technology greatly improves the precision of radiation implants in head and neck cancers. With this new modality the patient stays in a standard room, with unrestricted visiting and nursing care. He/she is brought down to the Department of Radiation Oncology a couple of times a day for about 20-30 minutes. There the plastic tubes are connected to the high dose rate brachytherapy machine, which delivers the treatment in just a few minutes, rather than the several hours it took with the traditional techniques which date back to the discovery of radium by Madame Curie 100 years ago. The convenience and precision associated with high dose rate brachytherapy have greatly increased the utility of radiation implants after external beam irradiation, chemotherapy and/or surgery.

Radiation Implant Therapy has long been used in the treatment of cancers of the skin, nose, ears and lips. Inside the mouth, we have used implants for cancers of the tongue, cheek, palate, tonsil, floor of the mouth and pharynx. The power of this technique is illustrated by our experience in the treatment of cancer of the nasopharynx. This is a cancer that is relatively common among people of Chinese origin. The cancer starts in an area in the back of the nose, just below the base of the brain and, if inadequately treated, can grow into the base of the brain with catastrophic consequences. Treatment is difficult as this area is virtually impossible to safely attack surgically, and external radiation is also severely constrained by the proximity of critical structures such as the brain, the spinal cord, and the nerves to the eyes. However, over the past few years we have been successful in safely treating this cancer in its site of origin by employing a relatively modest dose of external irradiation, supplemented by radiation implants. Similarly, among patients who underwent surgery to remove cancers from their mouths or throats but whose surgical margins proved unsatisfactory, adding radiation implants has yielded a gratifying improvement in the results.

In recent years organ-preserving treatment employing new surgical and/or chemo-radiotherapy techniques has become increasingly common. The judicious use of radiation implants in conjunction with organ-preserving techniques is likely to result in improved tumor control and fewer complications.

Editor's Note: Bhadrasingh Vikram, MD is Radiation Oncologist-in-Chief at Montefiore Medical Center, and Professor and Chairman of the Department of Radiation Oncology, Albert Einstein College of Medicine. ■

Comment: It is important to remember that head and neck brachytherapy requires a skilled and experienced physician who does such work routinely. This will minimize the chance of complications.



Cancer Registry Shows Increased Incidence And Survival Improvement In Tongue Cancer Among Young Adults

Stimson P. Schantz, M.D., Guo-Pei Yu, M.D.

Since the mid-1980s, several reports have noted that oral tongue cancer seems to be increasing among young adults within the United States. In 1986, Depue reported an increase in tongue cancer mortality among young adults under the age of 30. The increase was cited as beginning in the mid-1970s. Subsequently, Chen et al also found that between the 1960s and the early 1990s, young males 30 to 39 years of age had a nearly fourfold increase in oral cancer incidence in Connecticut. A recent clinical report indicated that the percentage of young adults with oral tongue cancer as a percentage of the total tongue cancer population seen at the M.D. Anderson Cancer Center increased from 4% in 1971 to 18% in 1993. Because incidence rates for overall head and neck cancer in all ages have remained stable since the 1970s, the increase of young adult patients is cause for concern.

Younger patients consistently make up less than 5% of all squamous cell carcinoma of the tongue in reported series. It is therefore difficult to accumulate sufficiently large numbers of young patients to make any statistically significant conclusions. On the other hand, mortality data and hospital-based statistics can not confirm a real increase of this disease due to therapeutic influences or a lack of population denominator.

Our Analysis

Based on the SEER Data in the U.S

To update information and gain stronger evidence for the increase of tongue cancer among young Americans, we recently used a large cancer surveillance database (Surveillance, Epidemiology, and End Results Program, SEER) in the United States to conduct statistical analysis. This database contains incidence data from nine populations, i.e., five states (Connecticut, Hawaii, Iowa, New Mexico, and Utah) and four standard metropolitan statistical areas (Atlanta, Detroit, San Francisco-Oakland, and Seattle-

Puget Sound). These registries cover approximately 10% of U.S. population.

From 1973 to 1997, there were 63,409 head and neck cancer patients in the nine SEER registries. Of these, 3,339 patients were less than 40 years old. Comparing 1973-1984 to 1985-1997 period, the overall incidence for head and neck cancer was stable. Tongue cancer among young Americans, however, increased 62% over the same periods.

Tongue cancer incidence trends for young and old Americans changed at very different rates. In young Americans below 40, there was a significantly upward trend from 1973 through 1997 and a sharp acceleration of tongue cancer incidence was found from 1973 until 1985. After 1985, the incidence stopped rising but remained steadily high.

Increases in Tongue Cancer: Possible Risks

We found that the most significant increase in tongue cancer among young Americans was related to persons born between the years 1938 and 1948. In addition, we found an increase in incidences within the age groups of 40-44 and 45-49 years when corresponding birth information was available. This suggests that those persons born since 1938 may have experienced a changing carcinogenic influence on the oral tongue; carcinogen(s) distinct from those contained within tobacco.

According to the National Health Interview Survey (NHIS), the prevalence of cigarette smoking has markedly decreased among Americans since the mid-1960s. Similarly, cigarette smoking prevalence among youths declined sharply in the 1970s, though the decline slowed significantly in the 1980s. Like cigarette smoking, alcohol use also shows a decline since the 1970s. Other reports indicated that smoking-related cancers such as cancers of the lung, larynx

and oral cavity are actually declining in North America. Age-specific analyses of lung cancer revealed that rates in males first declined at younger ages and then for each older age group successively over time. Thus, changing behavior and/or environmental exposures contributing to the rising trend in tongue cancer incidence must be reviewed in relationship to the decreasing influence of tobacco use and alcohol consumption.

One such factor may be smokeless tobacco use (moist snuff and chewing tobacco) which has increased dramatically in the United States over the last 30 years. There has been strong evidence that smokeless tobacco can cause oral cancer and precancerous oral lesions (leukoplakia), though it was not proved as a causal factor for increases of young adult tongue cancer. Several contradictory elements limit this explanation. The prevalence of smokeless tobacco use is extremely low, only 0.3 percent, among American young women less than 45 years and has not been significantly changed since the 1970s. Yet, a significantly increased incidence of tongue cancer was also seen among young women from 1973 to 1997. Likewise, smokeless tobacco should induce cancer in regions where it is held in contact, such as the cheek or gum, but the incidence of these non-tongue oral cancers has remained relatively stable.

Another significant factor may be marijuana use. Approximately 31% of the United States population, 12 years or older in 1992, had used marijuana. The prevalence of marijuana use sharply increased in the United States among both male and female teenagers and young adults in the mid-to-late 1960s, i.e., among persons born between 1941 and 1955. Assuming marijuana use is associated with cancer risk with an induction/latency period of 20-30 years, the persons born between 1941 and 1955 will be the earliest possible group to experience and

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A TIME FOR SHARING

It all began in January 1999. I noticed an irritation along with drainage (otorrhea) in my left ear canal. My doctor prescribed an antibiotic. It seemed better and over the next six months I used over-the-counter medications. However, the irritation and drainage never completely disappeared.

By late May I had a major ear infection that made the left half of my head ache and pound. I needed to see a specialist. For the next six months I was seen by all three partners of a local ENT group, all of whom agreed on the same diagnosis... an outer ear infection. Then it became an underlying fungal infection, similar to Athletes Foot, as one of them put it. Over the course of my visits, they treated me with Boric Acid powder, antifungal cream, Domboro drops (an acetic acid solution - the same acid as in vinegar) and they suctioned and irrigated my ear canal. I complained to them about pain and how ineffectual treatments had been. By the time of my January 4, 2000 appointment my pain had become so unbearable that I pleaded with the doctor to do a x-ray. He finally heard me and ordered a CAT scan.

On January 11, 2000, a year after my first symptoms and six months after my first visit, the doctor reviewed the CAT scan. He described my condition as necrotic, but not cancerous. He then referred me to an otologist (ear specialist).

I visited the otologist on January 19, 2000. He took a look, went over my CAT scan, suctioned my ear canal and discussed with me all the treatments that hadn't worked. This doctor took a computerized picture of the lesion by putting a camera probe in my ear canal that projected onto a computer screen. He suggested a biopsy. It was done the same day under local anesthesia. On February 2, 2000 the results of biopsy report indicated Squamous Cell Carcinoma.

I didn't react, I guess I was expecting something and now my suspicions were validated. The Otologist told me I needed a Lateral Temporal Bone Resection and he ordered another CAT scan with contrast to see if lymph nodes were affected. A week later the results of the second CAT scan showed one node was possibly affected. By now my case had been reviewed by the Tumor Board and the consensus of the board was a Lateral Temporal

Bone Resection (removal of the ear canal and about one inch of the surrounding bone), a Perotidectomy (surgical removal of the perotid gland and lymph nodes), possible removal of the facial nerve, a Neck Dissection and finally RADIATION.

I went for a second opinion at Memorial Sloan Kettering Cancer Center and then a third opinion at New York Presbyterian Hospital. Basically all physicians concurred and it was now up to me to select the surgeon and medical facility. During this whole ordeal, I had been doing a great deal of research, mostly over the Internet. I had read scientific journal articles relating to my type of cancer. The articles were case studies over the past 20 years. Surgery and radiation were explained and survival rates were discussed. Basically, I had a pretty good idea of what needed to be done.

I decided on the otologic neurobiologist at N.Y. Presbyterian Hospital and met with him and his associate, a head and neck surgeon on February 29, 2000. I asked all my questions and when all was said and done these doctors agreed to try and preserve my facial nerve.

While researching my cancer I was so concerned with the nerves that were involved that I completely ignored the muscles. I didn't ask any questions about muscle involvement and no one offered any information. I knew that when I woke up after surgery, I would be deaf in one ear, temporarily paralyzed on the left side of my face, with asymmetrical ears and with a scar down the side of my neck, but I knew nothing about how a neck dissection would affect my shoulder muscles.

My nine-hour surgery on March 1, 2000 included a lateral temporal bone resection, a perotidectomy and a modified radical neck dissection. In the recovery room my doctor asked me to smile, blink and pucker my lips in order to assess the function of my facial nerve. He was pleased with the results. However, the next morning I found that the left side of my face was partially paralyzed, I had limited eyelid movement and I drooled. It took about 7 months for the paralysis to completely subside and a few months longer for my smile to be symmetrical.

The morning after my surgery, a resident came into my room to check on me and clear

my drains. He pulled vigorously on the ear drain, causing pain and making the room appear to flip up side down. This was the onset of my balance problems. For 48 hours I could feel my right eyeball rotating in its socket and I could focus on nothing. I was nauseous and I could not walk. Five days later I was able to look at stationary objects but could not look out at the road while in a moving car. This severe imbalance lasted for about 5-6 weeks, gradually subsided, only to return again at the conclusion of my radiation treatments.

By the end of 29 radiation treatments, I had lost my taste and salivary function and I was severely fatigued, which could probably be attributed to the combination of work and radiation. I kept a water bottle with me at all times. I had radiation burns to the left side of my head and neck and I lost the hair encircling my ear, which has not grown back.

Two months post radiation, I had a delayed reaction to the radiation therapy. The first symptom was a deterioration in my balance. Then one morning I just couldn't get my head up from the kitchen table. Severe fatigue set in but even worse than before. The skin of my outer ear peeled for a second time and again taste and saliva were limited. After about two-three weeks, I gradually regained enough strength to go back to work.

For me, the most debilitating part of my recovery was the pain I endured in my shoulder. It was constant and burning and almost nothing I did helped relieve it. Exercise and stretching helped temporarily. Medications like codeine, celebrex, ultram, did little. I went to Long Island Pain Management. TENS (Transcutaneous Electrical Nerve Stimulator) was suggested which gave me temporary relief but was inconvenient to wear. I was given neurontin (dizziness was a major side effect for me). By the time I reached the desired dose I couldn't walk straight. The only time I was not in pain was lying down and sleeping. My working hours was generally torturous. When the doctor at L.I. Pain Management told me there was nothing else he could do I was emotionally devastated. The love and support of my husband and family kept me going plus the very wise guidance of a wonderful friend and therapist, Rhea.

With the help of my very talented massage therapist, Paula, and the drug, Aleve, the

pain finally subsided almost 14 months after surgery. This, along with the return of my energy, made a remarkable difference in my spirit.

During one of my follow-up consultations with my otologist, we discussed hearing aid alternatives; Cross-Aids (a transmitter on the deaf side and a receiver on the good side) and a Bone Anchored Hearing Aid (BAHA) (a sound processor attached to a titanium screw set into the skull). To be a candidate for the BAHA I needed a functioning nerve... my auditory nerve had been destroyed.

One-sided hearing has its very difficult moments. Loud noise is unbearable, sound location is gone, you pick up 50% of conversations and much less when you add background noise to a situation. In a restaurant or my noisy working environment or when a television is on, understanding speech becomes almost impossible. I used Cross-Aid hearing aids for 7 months. Although they helped a little, they picked up every decibel of noise imaginable.

Some time later, the Swedish company that makes BAHAs, Entific Medical Systems, began recruiting people with one-sided hearing loss, like mine, to participate in a study. My otologist asked if I would like to be part of the study. Since this was a Clinical Trial,

there would be no cost to me. I would have to undergo minor surgery (the implant of the titanium screw into the left side of my skull just above my deaf ear) and a series of hearing tests and questionnaires.

The surgery was done in February 2001, almost one year after my cancer surgery. There was a three-month healing period for the skull bone to heal around the titanium implant (osseointegration). This is the same concept as in dental implants. At the end of May 2001, I received the sound processor to the BAHA. After using it for one month my hearing was tested. Although I don't know the official results of the hearing test, life with a BAHA is significantly better. Background noise is almost eliminated and sound location is sometimes there. Hearing in noisy situations is still difficult, but as my audiologist says "most situations are not conducive to hearing."

Today, I can taste almost everything. As a result of the peritidectomy, I have about a 25% loss in saliva (do-able) and sweating on the left cheek while eating which started about 14 months post-op (annoying but also do-able). My left shoulder is weak, stiff and achy, especially after a stressful day at work (I am partially left handed - so bowling is out for now). I exercise it almost every day along

with neck exercises. I walk as much as I can to help my balance, which, I think, might be a life long issue for me. I just have to remember to do things more slowly.

I did have a "canceritis" scare recently. My right ear lobe was infected and none of the over-the-counter medications worked. I showed my doctor and he gave me antibiotic pills and cream and told me to see a dermatologist if it didn't clear up. It took a while but it finally cleared up.

I have been working full time since November 2000. The first six months were very difficult, having to deal with pain every day. I have been feeling "almost" myself since May 2001, which is when the shoulder pain subsided. I now treat myself to medical massages every 2-3 weeks and I have hired a cleaning service for my house. My follow-up care includes visits to the head and neck surgeon every two months; visits to the radiation oncologist, and blood work and chest x-rays every three months. A CAT scan with contrast is done every 6 months and last but not least, I attend monthly meetings with my newly founded SPOHNC friends who have helped me so much.■

Mary McInerney
Mt. Sinai, NY

FIVE NEW CHAPTERS ADDED TO SPOHNC NETWORK

Plans are well underway for the development of five new chapters of SPOHNC, the first of which held its organizational meeting in July, 2001. This chapter, known as **SPOHNC-MANHATTAN, NY** is an offshoot of the "Moving Forward" head and neck support group at Memorial Sloan Kettering Cancer Center. The coordinator and facilitator of this group is Barney Phair. He can be contacted at 212-288-5718. His email address is: <barney@newyork.com> **SPOHNC-MANHATTAN, NY** meets at 2:00 PM on the fourth Tuesday of the month, 215 East 68th Street, Ground Floor, New York, NY.

SPOHNC-LONG ISLAND, NY EAST is also an offshoot from another support group. Alice Peters, Coordinator/Facilitator of this chapter, has been a member of the **SPOHNC-LONG ISLAND, NY** chapter for several

years. With the encouragement of her "home" chapter, Alice is developing another Long Island **SPOHNC** chapter. This chapter, meeting in Suffolk County, will give our friends from the eastern part of Long Island the opportunity to be part of the **SPOHNC** network. **SPOHNC-LONG ISLAND, NY EAST** will meet at the Otolaryngology-Head and Neck Treatment Center, 37 Research Way, Stonybrook NY, on the first Thursday of each month at 7:00 PM. Alice can be contacted at 631-585-1121 <tinakidluv@aol.com>

Dan Stack was a member of **SPOHNC-ATLANTA, GA** for quite some time, before moving to Dallas, Texas. Realizing the benefit that he received from his group back in Atlanta, he has volunteered his time to coordinate and facilitate a support group in Dallas. The **SPOHNC-DALLAS, TX** chapter

will meet at the Baylor Irving-Coppell Medical Center for its initial meeting on Saturday, November 10th at 10:00 AM. For more information, please contact Dan at 972-373-9599 or <danstack@aol.com>.

For several years, a head and neck cancer support group has met at the Carol Simon Cancer Center in Morristown, NJ. This group recently voted to become a chapter of SPOHNC. **SPOHNC-MORRISTOWN, NJ**, coordinated and facilitated by Howard Sakolsky, a survivor, and Catherine Owens, LCSW, meets on the third Wednesday of each month. To contact Harold, call 973-586-3522 or email <hesakolsky@aol.com>.

The newest group to join our network is **SPOHNC-WASHINGTON, DC LCC**. This chapter is coordinated and facilitated by Joanne Assarsson, LSW. Joanne can be
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clinically manifest elevated risks of tongue cancer. The assumption is consistent with our findings, that there is a higher incidence of tongue cancer among birth groups beginning in 1938. The carcinogenic effect of marijuana has been concluded from a series of case reports, laboratory, and experimental evidence. Zhang et al showed that marijuana smoking was associated with a dose-dependent increased risk of head and neck cancer. The risk was more pronounced in young patients. However, current studies could not prove causation between marijuana use and tongue cancer.

The third suspected factor is human papillomavirus (HPV) infection. There is evidence for the correlation of HPV infection with oral cavity carcinoma. Positivity for HPV in oral neoplastic tissues varies from 14% to 91%. About five-fold higher expression of HPV can be seen in oral squamous carcinoma than in normal oral mucosa.

It is clear from laboratory studies that HPV integration into the oral epithelial cell will enhance carcinogenic potential of relevant chemical compounds. However, we are not certain that HPV infection increased among young Americans in the last decades, or if such an increase could be one of the responsible factors for the rising trend of oral tongue cancer.

Five-year Survival Among Young Patients

In this study, we also used the SEER data to analyze five-year survival for young patients. The data in the 1984-1997 period showed that survival declined with increasing age: 70.6% for the age group of 40 years or younger; 49.8% for 40-64 years of age; and 45.8% for those older than 65 years, respectively.

The absolute increase of survival between 1975-1984 and 1985-1997 periods was the largest among young adults less than 40 years of age. Survival improvement was more pronounced in young patients who were males, white, and advanced tumor stage. In contrast, young non-white patients showed declining survival rates when comparing 1973-1984 to 1985-1997 period. The absolute increases in survival were similar in different sexes, races, and stages among older adults except for blacks who were 40-64 years old. The five-year relative survival rates in 1985-1997 period for young patients

with local stage, regional stage, and distant stage tumor were 83.6%, 52.7%, and 44.3%, respectively. More than 20% survival improvement was seen in young patients with regional and distant stage. The increase in survival was only 3% in young patients with localized disease.

The stage and survival characteristics of tongue cancer in individuals born since the early 1940's suggest a distinct disease process. In these younger Americans, the disease typically presents itself in earlier stages and is associated with a higher five-year determinant survival than in older adults. This observation supports the conclusions of Lacy et al who, likewise, concluded in their analysis of a hospital registry that young adults have a more favorable disease process.

The five-year survival has not appreciably changed in young patients with localized disease between 1973-1984 and 1985-1997 periods. In contrast, five-year survival has improved more than 20% in young patients with regional and metastatic disease. Significantly, the improved survival and earlier staged disease was not observed in the young black population. This suggests the possibility that various socioeconomic strata are contributing to the emergence of a distinctly different disease process. The survival disadvantage for young blacks with tongue cancer needs further investigation.

Summary

In summary, there is a sharply increasing trend in incidence of tongue cancer in young Americans since the mid-1970s. The increase may be attributed to persons who were born between 1938 and 1947 and is associated with a less virulent disease course.

One contributing factor for the rising trend of young American tongue cancer may be the use of marijuana. Its possible association should continue to be monitored. In addition, other etiologic clues may be gleaned from the changing incidence patterns associated with race and, most likely, socioeconomic status. One must look to lifestyle factors which changed during the 1940s and which appear to be more prevalent in the higher socioeconomic strata. Potential factors are diverse and could reflect changes in dental care, diet, food process-

ing, nutritional supplementation, sexual habits, and others. The potential for interaction of each of these factors on biologic processes involving oral tongue mucosa must also be considered. Clearly, the concern is that observed trends are a "tip of the iceberg" phenomenon. As the current North American population ages, will the incidence of this changing tongue cancer disease process increase? Continued vigilance involving this phenomenon is required.

Editor's Note: Stimson P. Schantz, MD, is Head of the Division of Head and Neck Surgery at New York Eye and Ear Infirmary and Professor of Head and Neck Oncology at New York Medical College. Guo-Pei Yu, M.D. is Head of the Biostatistics and Epidemiology Service at New York Eye and Ear Infirmary and Assistant Professor in the Department of Otolaryngology at New York Medical College. ■



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SPOHNC-WASHINGTON, DC LCC
 meets on the third Monday of each month from 3:00 PM to 4:30 PM at the Lombardi Cancer Center (LCC).

We are indeed pleased to welcome these new chapters to our SPOHNC network and look forward to sharing information, support and encouragement to each chapter and each of its members.

If you are interested in helping to organize a chapter of SPOHNC in your area, please contact Nancy Leupold at 1-800-377-0928 or email NLeupold@sphnc.org. ■

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So Far Away and Yet So Near

During the ten years of SPOHNC's existence and the many times I have answered phone calls, letters and e-mails from patients, family members and others seeking information, support and encouragement, I have been amazed and humbled when observing the way in which information travels around the world through our connections on the Internet. Our office has been contacted by thousands of people from all over the globe and in all walks of life. Although messages may vary from one individual to another and from one topic to another, genuine concern is always felt.

Recently, an email arrived from a gentleman who was looking for information concerning oral cancer. Although, he did not give his address, from the content of his message I surmised that he was not living in the United States. Ordinarily we would respond to an inquiry by mailing information; however, I sensed that this individual needed information as soon as I could get it to him and so, I emailed him an article about oral cancer that had been published in one of our past newsletters.

It was only a few days after I sent the article, that we experienced the horrendous tragedies of September 11th. Though consumed with his own adversity, this gentleman from India, upon hearing of the horror of September 11th, took the time to contact me and to express his heartfelt grief for the American people. I was deeply touched by the subject line of his email "WE SUPPORT YOU." In his message he told of the plight of his own country and the terrorism that his people had faced for many many years. In his message also, he shared his deep need for us to know we were not alone and that he prayed for "peace and harmony and courage to everybody."

These words of support from a stranger...from someone I will never meet...from so far away...they made a difference.

The spirit that moved this stranger to offer his support is drawn from the same source that underlies the fundamental purpose of SPOHNC's existence: to support and encourage others, and in so doing, draw strength from our unity.

God Bless America and all our friends.

Nancy E. Leupold
 President & Founder
 SPOHNC

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