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

**UPDATE:
THE ROLE OF CHEMOTHERAPY IN
THE TREATMENT OF SQUAMOUS
CELL HEAD AND NECK CANCER**

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Introduction

Although many different types of cancer can arise from the structures and tissues that comprise the head and neck, the term “head and neck cancer” is generally reserved for those malignancies that develop in the tissues lining the upper respiratory and digestive tracts. These include cancers of such structures as the larynx (voice box), tongue, and tonsils. Squamous cell cancer is the most common type of cancer found. Current estimates suggest that approximately 40,000 individuals (representing 5% of all cancers) are diagnosed in the United States each year with head and neck cancer. Tobacco and alcohol use are by far the most important risk factors for most of these diseases, leading to a high incidence of second cancers and other medical problems among these patients.

Historically, surgery and radiation have been the cornerstones of treatment for squamous cell head and neck cancers (SCHNC), especially when the disease is limited to above the collarbones and cure is possible. Chemotherapy by itself is rarely, if ever, curative for these tumors. Its use in the past was mainly for situations in which relief of symptoms or palliation was the goal. The results of clinical research over the last 15 years, however, have expanded the indications for chemotherapy to more patients. This article will focus on the role of chemotherapy in the management of SCHNC.

General Concepts

Several drugs have activity against SCHNC and most are administered by vein. Methotrexate, cisplatin, 5-fluorouracil, carboplatin, paclitaxel (Taxol), docetaxel (Taxotere), and ifosfamide (IFEX), are among the most widely used. Cisplatin combined with 5-fluorouracil or paclitaxel represent commonly used “combination chemotherapy” regimens. Other drugs, including biologic therapies like alpha-interferon, also have reported activity in SCHNC but are not commonly employed in standard clinical practice. Not all chemotherapy is the same, and the above drugs vary in the way they work, their side effects, dose, and dosing schedules. For example, methotrexate works by interfering with a key metabolic function of the cancer cell. It is very well tolerated at doses commonly used for treatment of SCHNC causing little or no nausea, and is routinely given as an outpatient. Cisplatin, on the other hand, damages the genetic material within the cancer. At standard doses, it is associated with more side effects than methotrexate, and is more cumbersome to administer. Nausea and vomiting can be significant, so preventive anti-nausea medicines are routinely given and are successful in preventing vomiting in the majority of patients. Paclitaxel, which interferes with cancer cell division, may lead to serious allergic reactions because of the liquid in which it is dissolved, and premedications to prevent this side effect are required. When given by itself, paclitaxel is generally better tolerated than cisplatin, but significant hair loss is more common. It is customary for the doctor to review the dosing schedule and side effects of chemotherapy with the patient prior to proceeding with treatment. If more than one drug is given together, the odds of tumor shrinkage may improve, but side effects generally increase.

Chemotherapy is frequently combined with surgery and/or radiation. This is done in a variety of ways. The chemotherapy can be given before (“neoadjuvant” or “induction” chemotherapy), after (“adjuvant” chemotherapy), or during (“concomitant” or “concurrent” chemotherapy) these local treatments. Of note, concomitant chemotherapy strategies have focused on the integration of chemotherapy with radiation, not surgery.

How well chemotherapy works depends on the setting in which it is given. For example, the chances of a response are highest in patients who have received no prior treatment, and much lower in patients with local recurrence of their disease after surgery and radiation. Similarly, the odds of shrinkage are higher and the likelihood of side effects lower in fitter patients as compared to more debilitated patients.

After reviewing available treatment options, many patients opt for participation in a clinical trial (or study). Different types of trials are available to patients. An Institutional Review Board or equivalent committee should have reviewed all studies for their ethical and scientific soundness. Certain eligibility criteria must be fulfilled in order to participate in a clinical trial, and an informed consent document will need to be signed after review with the patient’s doctor.

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COMING IN OCTOBER, 2002

Eat Right, Think Right, Maintain a Healthy Body

John O'Brien, MD

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Many different types of clinical trials are important in the development of new drug therapies for cancer, and they vary significantly in their design and intent. Phase I studies are intended to determine the best doses and schedules for new agents. The early identification of potential side effects is also an important goal of these studies. Usually, patients with different types of cancer are eligible for phase I studies. Phase II studies of chemotherapy drugs are often conducted after phase I studies to determine how well the treatment works. These studies are usually restricted to patients with a specific type of cancer. Promising drugs and chemotherapy combinations identified by phase I and II studies are then evaluated in phase III studies or "randomized clinical trials." These studies are essential to the determination of whether one chemotherapy drug (or combination) works better than another, or whether the addition of chemotherapy to surgery and/or radiation improves outcome compared to these treatments alone. When they enroll in such a study, patients are randomly assigned (or "randomized") to one of the compared treatments. Randomization means that neither the patient nor the physician chooses which treatment will be given, and this key design element allows the study to produce more scientifically sound results. In some randomized trials, the study drug is compared to a placebo (the so called "placebo-controlled" study). Because of these qualities, randomized studies are among the most important in determining which treatments work better, the same, or worse than others. Occasionally, the results of several randomized studies that address similar clinical questions are combined and analyzed in a "meta-analysis." Our recommendations regarding the use of chemotherapy in the management of SCHNC are largely based on the results of randomized trials or meta-analyses of several randomized studies.

Indications for Chemotherapy

To better understand how chemotherapy is used in the management of SCHNC, a brief review of standard treatment is helpful. Considering three main treatment settings will help orient the reader and organize the discussion.

Early Stage (small tumors with no or minimal spread to the lymph nodes in the neck, and no spread below the collarbones)

These patients generally receive surgery or radiation, and the majority are cured. Chemotherapy has not been well studied in this group, and there is no standard role for it in most patients. However, there is growing interest in preventive drugs (also known as "chemopreventive agents") for these early stage patients after treatment with the intent of reducing the risk of future cancers.

A class of oral vitamin A analogues called "retinoids" (e.g., isotretinoin [Accutane]) is currently receiving the greatest attention in this regard, although many other chemopreventive drugs are being evaluated with interest (e.g., the COX-2 inhibitor, celecoxib [Celebrex]). Retinoids can improve precancerous lesions in certain patients, although the lesions often regrow when the drug is discontinued. Placebo-controlled, randomized studies to determine if different retinoids (e.g. isotretinoin or etretinate) can reduce the risk of second cancers when given to patients after treatment for their first tumor have had conflicting results. Ongoing clinical trials are under-

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CHEMOTHERAPY continued from page 2 way to define the appropriate use of retinoids and other chemopreventive drugs. Until more information is available, chemopreventive agents are not currently recommended as a standard treatment. Because tobacco and alcohol are the principal risk factors for SCHNC, addressing these habits remains one of the most important preventive measures in patients with a history of SCHNC.

Advanced Stage With No Distant Metastases (larger tumors and tumors with significant spread to the lymph nodes in the neck, without spread below the collarbones)

Historically, the treatment approach for advanced cancers has depended on whether surgery was possible. When operable, patients generally underwent surgery followed by postoperative radiation therapy. Unfortunately, surgery in this setting can lead to altered facial appearance and difficulties with key functions such as speaking, chewing, and swallowing. Furthermore, because of the advanced nature of these tumors, some patients were inoperable, and they usually received radiation alone. Cure rates for patients receiving radiation alone were more disappointing. In an effort to increase cure rates and to avoid the potentially adverse cosmetic and/or functional sequelae of extensive surgery, researchers have extensively studied the addition of chemotherapy to surgery and/or radiation. Current data support the use of chemotherapy in several settings.

Initial attempts to improve cure rates involved giving chemotherapy sequentially before (neoadjuvant) and/or after (adjuvant) the planned treatment to the primary tumor and neck lymph nodes. Patients with operable disease received the greatest attention, so the chemotherapy was integrated most frequently with surgery and radiation therapy. These randomized studies unfortunately yielded disappointing results. Although the sequential addition of chemotherapy appeared to decrease the spread of cancer outside the head and neck area, it did not appear to improve survival over surgery and radiation therapy alone. As such, the use of chemotherapy in this fashion is not recommended outside of an investigational protocol.

The data for the administration of chemotherapy and radiation at the same time ("concomitant" chemoradiotherapy) are much more encouraging with respect to improvements in cure. Past concomitant chemo-radio-

therapy studies focused more commonly on patients with inoperable disease for which radiation alone was the historic standard treatment. When combined with a single chemotherapy drug, continuous, uninterrupted radiation is more feasible. The concurrent addition of two or more chemotherapy drugs often necessitates the use of split-course radiation with planned breaks in the radiation schedule, to allow recovery from side effects. In general, the side effects of radiation are increased when it is given together with chemotherapy. This literature is difficult to interpret given the variety of drugs and schedules that have been evaluated. Not all studies have shown an improvement with the concomitant addition of chemotherapy to radiation. However, a recent high-quality meta-analysis showed a survival benefit with concomitant chemoradiotherapy compared to radiation alone. In patients with inoperable SCHNC in whom chemotherapy can be safely given, current data support the use of concomitant chemotherapy as standard practice.

Because of the success of concomitant chemoradiotherapy in patients with inoperable SCHNC, several modern studies have investigated the benefits of this approach in patients with surgical options. Patients with advanced SCHNC who undergo surgical removal of the primary tumor and affected lymph nodes often require postoperative (or adjuvant) radiation to further reduce the risk of tumor recurrence. Two recent clinical trials have been reported in which patients with advanced tumors undergoing surgery were randomized to receive either postoperative chemo-radiotherapy or radiation alone. Although these studies had some conflicting results, one has shown significant improvement in cure rates for individuals receiving concomitant therapy, and this treatment approach may be appropriate for certain patients with high-risk disease. More research and follow-up are awaited to better evaluate the role of this approach.

In addition to improving cure rates, chemoradiotherapy has an established role in reducing the need for debilitating surgery in patients with advanced SCHNC. This indication evolved in part from the neoadjuvant chemotherapy studies in patients with operable tumors. Researchers noted that some patients whose tumors had a major shrinkage to initial chemotherapy, ultimately refused their planned surgery, yet achieved long-term re-

mission with radiation alone. In these studies, chemotherapy-responsive disease appeared also to respond to radiation; conversely, chemotherapy-resistant tumors often failed to respond to radiation. From these observations evolved a treatment approach (pioneered at MSKCC and other centers) in which initial chemotherapy was given; patients having major or complete shrinkage of their tumors went on to radiation alone whereas chemotherapy non-responders, or patients with disease that was persistent or recurrent after chemotherapy and radiation, would proceed to salvage surgery.

Allowing patients to keep their voice box has been the function preservation issue of greatest interest to date. This is not surprising, in that total laryngectomy (removal of the voice box) is among those operations most feared by patients. Laryngectomy is often necessary when initial surgical management is pursued for advanced tumors of the voice box or the areas next to it, and this subject has been addressed by several studies including randomized trials that compared a chemotherapy/radiation approach to immediate surgery and postoperative radiation therapy. Overall, these trials demonstrated that the chemotherapy/radiation approach avoided total laryngectomy in a substantial proportion of patients, with survival that was equivalent to that observed in patients undergoing immediate surgery. These data support the chemotherapy/radiation approach as a legitimate standard treatment option. It should be emphasized that such a treatment plan requires cooperation and communication between the involved surgical, radiation, and medical oncologists, as well as a compliant patient.

The optimal way to integrate chemotherapy with surgery and/or radiation is still being defined and represents an extremely active area of clinical investigation. For example, readers might inquire, "What works better: sequential or concomitant chemotherapy with radiation?" The randomized trials that have addressed this question suggest that a concomitant approach will produce better disease control for patients with SCHNC. These trials include the recently reported Intergroup study for patients with advanced laryngeal tumors. Based on such data, concomitant chemotherapy/radiation programs are increasingly being evaluated as an alternative to initial extensive surgery. Occasionally, concomitant and sequential strategies are combined. For example, one important trial compared radia-
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A TIME FOR SHARING ...Life Is Good

It was April 1998 and life was good. I lived in a nice house, had a good job, and was surrounded by good friends. Springtime in Atlanta, cool sunny days, concerts in the park, the azaleas and dogwoods were blooming, my favorite time of the year. My son and daughter were both happily married. They had actually matured from adolescence and developed into likable human beings in spite of their objective to make me an "old man before my time." Yes, life was good.

Then, on one of those clear sunny days, I felt a lump on the left side of my neck.

As cancer survivors, we've all experienced some variation of what happened next. For me, it was Squamous Cell Carcinoma, primary site unknown, followed by radiation twice a day for 32 days, 5 days a week. In retrospect, I probably fared better than some, but I had never felt worse in my entire life. I lost 30 pounds, along with all my energy and I could barely speak or eat due to the sores on the inside of my mouth and throat. At night, I thought I could escape into peaceful slumber, only to be awakened every 15 minutes due to the pain experienced by simply swallowing.

Prior to treatments, I had been in reasonably good shape and had always bounced back from injuries quickly. Therefore, when I was told that it would be 4 to 6 weeks before I would feel some resemblance of normality, I assumed it would be more like 2 to 3 weeks. Unfortunately, this was not the case.

During my treatments, what kept me motivated was the vision of gaining my weight back by eating my favorite foods; a big thick steak, a plate of Mexican food with extra jalapeno peppers, or a Pizza with all my favorite toppings. The eating binge was about to begin.....NOT! Three months had passed since my last radiation treatment and I could barely swallow solid foods without taking some kind of pain medication. It didn't take long before my depression started.

Then a friend told me about a local support group for people with head & neck cancer. I had never belonged to a support group, nor did I think I ever needed one, but decided to attend a meeting anyway due to my des-

peration. At that meeting, I met with several other survivors who listened to me explain the difficulties I was experiencing eating, sleeping, talking and swallowing. They just smiled, nodded their heads and told me they too struggled with those same challenges. What I was experiencing was just the "status quo" after radiation treatments. NORMAL, WHAT A RELIEF! During that first meeting as we shared our stories, I began to feel a calmness about my recovery for the first time.

I looked forward to each monthly meeting and the group became a family of good friends. We had become our own "Band of Brothers" (and sisters) battling the symptoms of our treatments. So many in the group had such a great sense of humor. We would discuss embarrassing situations that continued to take place in our lives, and talk about the struggle we were having trying to be normal again. Inevitably, we would end up laughing at our common blunders. Every meeting continued to provide me the comfort and support, which I desperately needed to turn the corner on my recovery.

About a year later I was transferred to Dallas, Texas. I had to leave my good friends at SPOHNC-Atlanta but looked forward to involvement with a new group. I soon found out there was no SPOHNC-Dallas.

A new job kept me busy for a few months but I truly missed the time I spent with my fellow survivors. Until then my experience with the other group had been as a participant, but now I felt the need to help others as I was once helped. That is when I made the decision to start a support group in Dallas.

Without knowing exactly where to start, I discussed the possibility with my Oncologist during my next check up. He thought the best way to present it to his patients was for me to write a letter of introduction as a fellow survivor, then he would attach his own cover letter and make them available to his patients during office visits. Having benefited so much from the SPOHNC newsletters, I also contacted Nancy Leupold, the founder of SPOHNC, for advice. Once we determined the appropriate zip codes for the Dallas/Ft.

Worth area, she sent a copy of the same letter I had written for my Oncologist to present members of SPOHNC along with those who had previously contacted the organization requesting information.

After a few visits to local cancer centers in the area in order to spread the word, responses started coming in. Apparently, there was a demand for such a group and all that was needed was a facilitator. I started receiving emails from survivors expressing their interest. Hope Andresen, a local ENT nurse, called to offer assistance. We needed a place to meet. Hope arranged for us to use a room at one of the Baylor Hospital facilities, and had vendors provide samples of Scandi-Shake and Biotene for our newly formed group.

We had our first meeting just five weeks later with six survivors. As we talked among ourselves at that first meeting, I realized that many who had been challenged with the effects of recent treatments, were hearing the "same things" that comforted me three years earlier. The satisfaction of being able to provide similar information and support to other survivors was one of the best blessings I have experienced.

Our group has continued to grow. After five months, our chapter has 26 survivors, many who regularly attend meetings. In addition, several of their spouses also attend. It is rare that a week goes by that I don't hear from someone new who is interested in SPOHNC-DALLAS.

I have received overwhelming support from the professional community. The visits of introduction to local cancer centers not only generated referrals, but also created an interest from several local oncologists who have attended our meetings on several occasions to offer their support. Their input during these visits not only provided valuable information for our group, but has also given us a perspective on treatments from an oncologist's viewpoint.

I encourage anyone who is interested in starting a group to do so. The rewards are so satisfying. Yes, life is STILL very, very good.....

Dan Stack
Dallas, Texas

THE FEAR OF RECURRENCE AND THE RESILIENCE OF THE HUMAN SPIRIT

by Roger Granet, MD, FAPA

The cancer journey is a potent emotional challenge that both tests and validates the resilience of the human spirit.

Surprisingly, moving from treatment into survivorship can be as disturbing and stressful as facing up to diagnosis or choosing treatment. Often the transition comes suddenly. One day, you see your doctor, who lays a kind hand on your shoulder and says, "You're in remission. No reason to see you again for six months." And in that moment the world changes into something new. Suddenly you are again a "normal" person, someone who can enjoy doing everyday things. But, at the same time, a note of anxiety may creep into this new, deliciously normal way of life. For months, perhaps even years, your life has been defined by doctors' visits, laboratory tests, diagnostic and curative surgeries, chemotherapy infusions, and sessions under a radiation machine. You have lived in a strange network of physicians, nurses, social workers, medical assistants, and technicians. Now that world is gone, and you are on your own. Some people find themselves profoundly anxious at this separation from people they have come to know and depend on.

Although it can be difficult, one can make the change. A number of scientific studies of cancer survivors show that a large majority does very well, particularly after an adjustment period that lasts from months to two years after treatment. Typically people are able to pick up their lives where they left off, returning to their families, jobs, and social activities. But survivors face a number of physical and psychological issues.

The most difficult issue is the fear of recurrence. Commonly referred to as "The Damocles Syndrome," the threat of recurrence always hangs over the survivor, like the precarious sword of Greek mythology.

The fear that cancer can return underlies the psychological landscape for all survivors. They are reminded repeatedly of the reality that cancer recurrence may be detected every time they go in for a follow-up exam. Typically anxiety builds before the visit to the doctor and remains in the air until the test results come back. Then survivors can breathe a sigh of relief until the next follow-up exam. But a news story on cancer or a mention of the disease during a friendly conversation can trigger a powerful response of dread and anxiety.

After all, anyone who has had the disease understands the anguish associated with it and has every reason to fear another episode.

In some people this dread takes the form that I call the "one-cell fear." The apprehension is that cancer treatment, no matter how thorough, has missed one malignant cell somewhere in the body. This single evil cell is looking for a place to attach and grow, and once it does, the disease will bloom again. The individual with one-cell fear lives in a state of anxious hyper vigilance, frightened that the least snuffle, cough, or vague ache is the returning cancer's first sign. This fear can be carried to extreme lengths, usually for reasons that are more psychological than physical. Yet there is an antidote to such fear. Ultimately, each person must "find a place" for their history of cancer: accepting the uncertainty and lack of control that exists in all of our lives, whether one lives with or without a history of malignancy, and in turn embracing our existence with a renewed emotional respect and vigor.

Surviving Survivorship with Resilience

•*Acknowledge that you will be experiencing a range of emotional reactions.* Particularly early on in survivorship, you will be pulled in opposite directions. On the one hand, there is the fantastic sense of relief and the new freedom of "normalcy." On the other hand, there is concern over recurrence and ironically, separation anxiety from the day-to-day medical system, mixed in with the paradox of the inevitable letdown that follows a battle fought well and won.

•*Know that a state of limbo lasts for a while.* The first few weeks or months of survivorship add up to an odd, disconcerting period when you are no longer an active cancer patient, yet not fully returned to life. Don't judge what is happening or push it. Limbo will end in its own time.

•*Expect to be tired.* Then expect your strength to return. At first, don't demand too much of yourself or feel guilty that you can't immediately resume all responsibilities and activities. In time, though, you'll probably find that your stamina will return to normal as the full emotional import of survivorship makes its way into your psyche.

•*A million people will ask, "How are you*

feeling?" The concern is touching, but unfortunately it comes right when you are trying to put distance between yourself and cancer. Don't take it personally.

•*And then they will forget to ask how you are doing.* After a while, people stop asking about your health. Again, don't take it personally, and don't let it hamper your growth.

•*Look back with family and friends.* Talk about both your experiences and theirs during diagnosis and treatment. All of you will have more emotional stamina for this discussion and a better perspective on it than you did during the actual crisis.

•*Take time to reflect.* If you objectively assess your efforts during diagnosis and treatment, you'll probably discover that you underestimated your coping skills beforehand and learned new ones in the course of dealing with the disease. This will give you new emotional strength and confidence.

•*Consult as needed.* If emotional symptoms trouble you, seek professional help. If your concerns focus on death; talk with members of the clergy. If you don't like organized religion, read or study philosophy instead. Just don't be afraid to seek help or guidance from other sources.

•*Relax.* Learn or continue to practice relaxation techniques such as yoga, the relaxation response, or judicious use of medication.

•*Play.* Have as good a time as you can at your level of energy. Start with the movies, then make it a short walk to notice nature, then try an afternoon stroll around the lake. Mount Everest can wait until next year.

•*Most importantly, "find a place" for a life with a history of cancer.* The fear of recurrence is an inevitable by-product of the cancer experience. But, anxiety and sadness can be minimized by mobilizing the resilience of the human spirit. In reality, we all live our lives, with uncertainty and a lack of control. Accepting this and recognizing our emotional strength speaks to a life fully and richly experienced. Cancer is a powerful validator of human resiliency. It often taps into resources an individual never realized existed.

Cancer delivers a potent wake-up call to review and rewrite our lives. No other journey offers a more powerful catalyst for psychological. RESILIENCE continued on page 6

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tion alone to concomitant chemotherapy/radiation followed by chemotherapy alone (adjuvant chemotherapy) for patients with advanced nasopharynx cancer. There was marked improvement in all outcomes of interest (including overall survival) with the addition of chemotherapy. Although it is difficult to determine from this study if the improvements are due to the concomitant therapy, the adjuvant chemotherapy, or both, chemotherapy is now an important component in the management of nasopharynx tumors.

Recurrent Tumors or Distant Metastases (recurrence after surgery and/or radiation or spread to structures below the collarbones)

If a tumor recurs above the collarbones and surgery or radiation is feasible, one or both of these approaches is generally utilized and some patients experience long-term tumor control. For patients with distant metastases or whose tumors are not amenable to surgery or radiation, the prognosis is worrisome. In these situations, chemotherapy has been widely used with symptom improvement, not cure, as the goal. A common question addressed by randomized trials in this setting is whether combination chemotherapy works better than using only one drug at a time. Studies to date reveal that treatment with combinations of drugs (like cisplatin with 5-fluorouracil or paclitaxel) can significantly increase the odds of a response compared to therapy with a single drug alone. Unfortunately, when compared to single-agent therapy, combination chemotherapy is often more toxic and does not clearly result in a significant improvement in overall survival. As such, multi-drug treatment is not routinely indicated as standard palliative therapy in this setting.

Because of the disappointing effectiveness of the standard drugs, innovative experimental therapies are receiving careful consideration. Gene therapy to exploit the p53 tumor suppressor gene status of cancer cells is one modern approach that has received considerable attention in both the lay and scientific press. We and others are pursuing so called "targeted" treatments that attack tumors by inhibiting specific targets in the cancer cell necessary for growth. For example, C225 (Erbbitux) is an antibody against the epidermal growth factor receptor (EGFR, a protein receptor which is frequently found on SCHNC cells). C225 has been employed in several studies including a recently reported randomized, placebo-controlled trial to determine its

safety and activity in patients with SCHNC. Alternative drugs that target this pathway such as ZD1839 (Iressa) and OSI-774 (Tarceva) are under development elsewhere. At present, we are focusing our research on determining the importance of blocking a different receptor (the vascular endothelial growth factor, VEGF) on the growth of SCHNC. In this regard, a clinical trial with SU5416 (an anti-angiogenic inhibitor of VEGF) is currently underway at MSKCC.

Summary

Although not yet part of standard clinical practice, chemopreventive agents administered with the intent of reducing the occurrence of second primary cancers represent an exciting and active area of investigation. Current data support the integration of chemotherapy with radiation in treating patients with inoperable SCHNC or advanced nasopharynx cancer (for improvement in cure rates), and with advanced larynx or hypopharynx cancer (for improvement in functional outcome by avoiding total laryngectomy). Recent studies suggest there may also be a role for concomitant chemo-radiotherapy given as an adjuvant treatment following complete surgical resection of operable tumors with a poorer prognosis as well as an increased role for this approach as part of an organ preservation strategy. These combined treatments require interdisciplinary cooperation and communication, as well as a compliant patient in order to succeed. In patients with incurable disease, chemotherapy may provide palliation of symptoms. The disappointing efficacy of standard drugs in this setting prompts many patients to pursue investigational therapies.

Clearly, much important advancement in our understanding of the role of chemotherapy in the management of SCHNC has occurred in recent years. Innovative clinical research studies remain a fundamental part of this process.■

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spiritual, and interpersonal evolution. Cancer encourages us to discover emotional survival in both sickness and health. And, by paying closer attention to this short-term lease called life, our time becomes deep and full.

Ultimately, this is cancer's good fortune, especially during survivorship.■

This article was adapted from Surviving Cancer Emotionally: Learning How to Heal. (Wiley, 2001), by the author.

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from PAT'S PANTRY
PROVENÇAL

Poule au Blanc (Poached Chicken in Cream Sauce)

- | | |
|----------------------------|---|
| 3 boneless chicken breasts | 1 bouquet garni (1/2 tsp. thyme,
1 bay leaf, 1 Tbs. parsley. |
| 1 sprig tarragon | 2 Tbs. olive oil |
| 2 carrots | 1 egg yolk |
| 2 onions | 1/2 cup heavy cream or sour cream |
| 2 leeks, white part only | Salt and pepper to taste |
| 1 stalk celery | |

A dash of nutmeg

Put the chicken, vegetables, olive oil and herbs in a deep pot with just enough water to cover. Bring to a boil and simmer gently for 2 hours. When done, take out 1 cup of the liquid, stir the egg yolk rapidly into it; then return the liquid to the casserole. Add the cream, stir for 30 seconds and then remove from the stove. Blend in blender adding milk as needed to thin the mixture.

September's Tip: Leek is a mild, sweet sister of the onion. If onions are too strong for you or to spruce up a soup recipe, substitute leeks. They add a delicious flavor to any dish.

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