



S•P•O•H•N•C

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

LASER SURGERY FOR CANCER OF THE LARYNX (VOICE BOX)

EUGENE N. MYERS, MD
JONATHAN C. SMITH, MD

Introduction

Over the past 30 years, surgical lasers have become a very useful tool in the treatment of cancer of the head and neck. As with all new inventions, the design of lasers, and the indication for the use of lasers, has expanded over time.

Theodore Maiman, while working in a physics laboratory, described the first laser in 1960. Only a year and a half later, a laser was used to treat a patient with a tumor of the retina. By the mid 1960s experiments with lasers were being used to treat cancer of the skin and specific disorders of the middle ear causing hearing loss. The first two types of lasers discovered were the ruby laser and the neodymium-glass laser¹. Dr. Geza Jako of Boston is recognized as the first person to study the effects of the laser in cancer of the head and neck, particularly in treating cancer of the larynx (voice box)². In 1967, Jako discovered that he could focus a carbon dioxide laser through an operating microscope in order to cut tissue on the vocal cord of a cadaver. He was able to control the depth, and consequently the amount of tissue removed, using the laser. By 1971, Jako started using the carbon dioxide laser on patients in clinical trials of laryngeal surgery.

Laser Treatment of Early Laryngeal Cancer

For many years, and even now, most patients with early cancer of the larynx (voice box) have been treated for cure with radiation therapy. Many authors have reported excellent results using the

carbon dioxide laser in the treatment of early cancer of the voice box. When the carbon dioxide laser is used in conjunction with an operating microscope, the surgeon can remove cancer with great precision. The carbon dioxide laser is not visible to the human eye and therefore it is always used in conjunction with a helium-neon laser. The helium-neon laser, which is visible, is aligned in exactly the same plane and direction as the carbon dioxide laser. In this way, the surgeon has excellent control over where the carbon dioxide laser contacts the tissue.

Since the introduction of the carbon dioxide laser, many otolaryngologists (physicians who specialize in disorders of the ear, nose, throat, and related structures of the head and neck) have gained a considerable amount of experience using this laser to treat early cancer of the larynx³.

Prior to the discovery of the carbon dioxide laser most physicians treated patients with early laryngeal cancer either with radiation therapy or open laryngeal surgery. In open laryngeal surgery, the part of the voice box containing the cancer is removed through an incision in the neck. With the advent of the carbon dioxide laser, small cancers of the vocal fold were able to be removed through an endoscope, a metal tube extending from the lips to the larynx. Endoscopic excision of small cancers of the vocal cord with the carbon dioxide laser performed as an ambulatory surgery procedure avoided the scar, postoperative discomfort, and hospitalization associated with open laryngeal surgery. In addition, patients treated with endoscopic excision were found to have a voice as good as those patients treated with radiation for similar size cancers.

Over the past few decades many surgeons have come to favor endoscopic excision over radiation therapy for early cancers on the vocal folds in order to avoid the disadvantages of radiation. Radiation therapy has the disadvantage of making follow-up examinations and possible future biopsies more difficult to interpret. No one has satisfactorily proved that the patient's voice is better after radiation therapy than with partial surgery. Radiation therapy may also make future conservation (voice sparing) surgery more difficult to perform in the event of a recurrence and can possibly prevent the future use of radiation depending on the field of exposure. In addition, radiation is more costly in terms of both actual costs⁴ of treatment and non-tangible costs⁵ to the patient and family. Non-tangible (hidden) costs, such as travel time, treatment time, and the amount of work missed by the patients and the family members were all found to be greater in patients treated with radiation when compared to patients treated with endoscopic excision. The carbon dioxide laser was used in a large portion of the patients who were treated with endoscopic excision, which is an ambulatory surgery procedure.

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S•P•O•H•N•C, INC.

P. O. BOX 53
LOCUST VALLEY, NY 11560-0053
Email: info@spohnc.org Web site: http://www.spohnc.org

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NEWSLETTER EDITOR

Nancy E. Leupold, MS

WEBMASTER

Barry Sebastian

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COMING IN FEBRUARY, 2003
Head and Neck Cancer Imaging

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We, as well as many other authors, have achieved very high cure rates treating early glottic (vocal cord) cancer with endoscopic excision, usually using the carbon dioxide laser. When we examined 54 patients treated with endoscopic excision of early glottic cancer, we found that the majority (83%) were cured with endoscopic excision(s) alone. When we included the selective application of radiation therapy and more invasive open laryngeal surgery for patients with recurrence, all patients were without evidence of disease, and 96% still had their voice box³. These results compare favorably with radiation therapy in which results with radiation therapy alone are in the range of approximately 60-70% cure and brings the cure rate to approximately 80% with salvage surgery – usually total laryngectomy.

The carbon dioxide laser has also been found to be very useful in the treatment of supraglottic cancer, which is cancer of that part of the voice box just above the vocal folds. In 1978, Vaughn was the first to report the excision of a supraglottic cancer with a carbon dioxide laser used through an operating microscope. Since this time, other surgeons have reported a relatively high success rate treating cancer of the supraglottic larynx with the carbon dioxide laser.^{6,7,8} The main advantage of carbon dioxide laser excision of supraglottic cancer is the ability to avoid the tracheotomy for the placement of a temporary breathing tube between the skin of the neck and the trachea or “windpipe.” However, because cancers located above the vocal folds frequently spread to the lymph nodes in the neck, all patients, except those with the smallest and most superficial supraglottic cancers, should undergo bilateral neck dissections to remove the lymph nodes from the neck.

Conclusion

In 2002 lasers clearly have a role in the treatment of cancer of the larynx (voice box). The decision as to when it is best to use, or not to use, a laser in the treatment of cancer of the larynx is complex. The potential advantages need to be weighed against the disadvantages and possible side effects. For example, the carbon dioxide laser can potentially cause an airway fire which may cause severe burns. In addition, in some situations lasers can increase costs, set-up time, and treatment time, without providing any benefit to the patient. The surgeon’s decision to use a particular laser in the treatment of cancer of the larynx is influenced by his/her experience, location and type of cancer, extent or stage of cancer, and availability of various lasers. Continued research with lasers and with combining lasers with surgery, chemotherapy, and radiation for advanced disease, gives hope to all people suffering from the traumatic effects of cancer of the head and neck. ■

Editor’s Note: Dr. Myers is Professor and Eye & Ear Foundation Chair of the Department of Otolaryngology at the University of Pittsburgh School of Medicine and Director of the Oral Cancer Center at the University of Pittsburgh. He is the author of over 250 articles and several textbooks; including Cancer of the Head & Neck and Operative Otolaryngology-Head & Neck Surgery. Dr. Smith is currently a chief resident in the Department of Otolaryngology at the University of Pittsburgh. He has co-authored, with Dr. Myers, a book chapter and several articles on cancer of the larynx.

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CANCER AND SPIRITUALITY by Maxwell Travis

I have been working primarily with cancer patients and their families for twenty-two years providing pastoral care and facilitating support and education programs at Baylor/Sammons Cancer Center in Dallas, Texas. I listen to people as they express their concerns, express their gratitude, and tell their stories. I see the impact that spirituality has on how one interprets his/her experiences. Spirituality may be revealed in a variety of ways—how one evaluates the quantity or quality of his/her faith or how one sees God at work in their experience. Spirituality is demonstrated when one finds new meaning and new priorities in life, and when one attempts to live in the present rather than worry about the future.

Religion and spirituality are commonly confused. Spirituality deals with the more internal issues of meaning, purpose, value and relationship with the Higher Power. Religion relates to the more external institutions, doctrines, creeds, and formal structure. I feel that the best religion is very spiritual. Spirituality has to do with one's inner life and how that inner life is expressed in actions.

A diagnosis of cancer raises questions about the ultimate meaning of life, our personal identity in the world, our origin, and our ultimate destiny. Spirituality's primary concern has to do with people's relationship to themselves, others, and God.

One cancer survivor said to me, "Getting cancer was a spiritual experience for me because I came to realize there is a Higher Power, and it is not me." A cancer diagnosis often creates a feeling of loss of control, causes one to face his/her mortality, and opens the door for refocusing energy on living. It can be a time of change when one looks deeply within him/herself and begins to ask the significant questions about life and to focus on a dynamic hope that helps one live with his/her circumstances.

Questions of meaning are common. This encompasses looking inside one's self to understand what life is about. Why me? Why now? What is going to happen? What did I do to make this happen? What do all these questions mean about me? One person's quest to find meaning led her to a group who tried to explain why people get certain cancers. She heard the interpretation that people get oral, throat, and neck cancers

because they have difficulty articulating their feelings. Most of us have difficulty articulating our feelings, but this easy answer does not seem to fit. There may be many dead end roads to the quest for meaning before one finds direction in their experience.

Questions of trust also surface. Can I trust others and can I trust my Higher Power? What is reliable? What is going to happen to me tomorrow and in the future? Can I learn to live one day at a time and focus on the gift of this day, a day that may not be perfect? What does it mean to be human, vulnerable, mortal, but very valuable to God and to others?

Sometimes feelings of guilt may move toward blame of self or others. The feeling of injustice may become an issue when one who feels he/she is a good person is diagnosed with cancer. One has taken a significant step when he/she begins to realize that there are no simple answers to difficult questions regarding why someone may have a cancer diagnosis. Sometimes we must honestly say, "I do not know." Another significant step in our spirituality comes when we are able to forgive ourselves for not being perfect and allow ourselves to be forgiven and empowered by our Higher Power.

Often at the same time while one is dealing with issues of meaning, he/she may begin to explore issues of purpose. Questions related to our relationships are examined. Who am I in relation to God? Who am I in relation to other people? For what am I here? What is my purpose in life? This is a time when some patients isolate themselves because others will not understand, or because they are embarrassed that they have cancer or about the cosmetic effect of the cancer or limitations of the ability to communicate or to eat certain foods. Some patients feel far from their Higher Power and estranged from their community of faith.

People can begin to confront these issues in a group of oral and head and neck cancer survivors who understand these concerns. It may be the beginning of trust to allow another person to enter into their world—a world that is not usually understood by those who have not confronted the issues that a cancer patient has been forced to face. Beginning to trust others who care and to reach out and to know that you will not be rejected is an important

step. We all have to decide who and what we will trust, what is reliable, and try to move on with life. When one can move past a focus on "Why me?" and begin to focus on, "Since this has happened, what can I do to make life meaningful?" he/she will have taken a vital step toward living with the diagnosis rather than feeling alone and isolated in the predicament.

Another issue that seems to be inevitable is the issue of value. What is important? Who is important? What has enduring value? When patients look at these issues, they often tell me that they tend to focus away from things and begin to focus on the value of people and relationships. In addition, the inner convictions related to honesty, faithfulness, and integrity often become more important. It is essential to give self-affirmation to be "who we really are" rather than what others may want us to become.

Often, patients find it easier to say "no" in order to say "yes" to those things that are important to them. Many patient and family members begin to refocus on life as a gift to be shared and lived and celebrated. For some life slows down, family get-togethers occur more often, and there is a quality of trust and care that was not present when family members were living in the "fast lane." When values are examined, our desire is to invest in that which has enduring value. This often takes the shape of investing in other people, of giving something back to others through care and/or support of others who are going through the same experience. Life may be shared both in the joy and in the suffering because joy shared is increased and suffering shared is decreased through mutual trust and mutual support groups. The ultimate goal is a sense of connectedness with others and with our Higher Power.

A cancer diagnosis gives people permission to look inward. It helps them focus on surrendering that aspect of human nature that strives for control. Our spiritual life demands that we simply accept and move forward with life. Exploring issues of meaning, purpose, and value can lead to recognition of human limitations and of the transcendence of God.

The happiest, most fulfilled, most joyful people I know are cancer survivors. This is not because of cancer, but because the cancer diagnosis has precipitated a new spirituality

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SPOHNC and Cancer Care Co-host Teleconference, “Clinical Trials for Oral and Head and Neck Cancer”

More than 650 people from the United States, Canada, the United Kingdom, Brazil and China participated in the 4th oral and head and neck cancer teleconference, co-hosted by SPOHNC and Cancer Care through an educational grant from Bristol Myers Squibb Oncology and ImClone Systems Incorporated. This teleconference, entitled “Clinical Trials for the Oral and Head and Neck Cancer Patient” took place on Wednesday, October 30, 2002.

Margo Michaels, MPH, Chief of the Public and Survivor Education Section of the Office of Education and Special Initiatives at the National Cancer Institute began the program.

She defined clinical trials as research studies involving people. They are the final step in a long process beginning with preliminary laboratory research and animal testing. Clinical trials try to answer specific scientific questions to find better ways to prevent, detect and treat diseases or improve care for people with diseases such as cancer.

Only 2-3% of all cancer patients take part in clinical trials—far less than the number needed to answer the most pressing cancer questions quickly. It is also important to realize that clinical trials contribute to the knowledge of and the progress against cancer. Many of today’s most effective cancer treatments are based on previous clinical study results and with the progress made through clinical trials, people are living longer.

Everyone should have the option of participating in a clinical trial. A recent survey showed that most people with cancer were unaware or not sure that they could participate in a clinical trial. Most people in this survey said that they would have been willing to participate had they known more about the clinical trials available to them.

There are three phases of clinical trials—each seeking to answer the specific research questions. Clinical trials are not the “treatment of last resort.” They are not only for people with the most advanced disease but may also for people with early stage disease, as well.

Ms. Michaels concluded her presentation with a discussion of ways in which participants in clinical trials are protected including the informed consent process and the regulations and policies of the FDA and the Institutional Review Board. The costs associated with participation in a clinical trial were also discussed.

Dr. Barbara Conley, a medical oncologist and Chief of the Diagnostic Research Branch of the Cancer Diagnosis Program at the National Cancer Institute and a member of the Interdisciplinary Head and Neck Cancer Clinic was our second speaker.

Dr. Conley explained that one of the major reasons for conducting a clinical trial is to improve the survival rate of patients by using a different type of treatment. In addition, research is being conducted to determine the functional impairment of present treatments and how these functional impairments may be diminished. Quality of life studies are also being conducted. There are studies addressing locally recurring cancers as well as distant metastasis. Some head and neck cancers develop second primary tumors. Therefore, there are trials to determine how these tumors can be diagnosed early, how they can be prevented or how they may be treated.

In addition to treatment trials, there are other types of clinical trials including surgery trials. Diagnostic trials are trials in which the molecular features of the tumor or pre-malignant state are studied to see if they can predict what course the cancer or premalignant condition will take, or if they can predict response to therapy. There are also supportive care clinical trials and trials on new devices as well as treatment evaluation trials (quality of life).

The National Cancer Institute sponsors many clinical trials, however, trials are also sponsored by the pharmaceutical companies and the device manufacturers. Universities may also sponsor clinical trials.

Head and neck clinical trials listed on the NCI website are divided according to

anatomical sites, however, cancers from many head and neck sites may be included in the same trial. Currently, a search of the Cancer Trials website shows 59 trials for larynx, 65 for lip and oral cavity, 46 for the nasopharynx, 8 for the salivary glands and 65 for the oropharynx.

Most treatment trials for head and neck cancer are studying drugs or drugs and radiation. There are presently six phase III trials listed in the NCI database. There may be other phase III trials available, also, as pharmaceutical companies do not always list their trials with NCI. There are presently ten trials for symptomatic or supportive care, such as mucositis and difficulty in swallowing; three diagnostic trials and twenty trials using new drugs and vaccines specific for head and neck cancer. In addition there are also Phase I trials for head and neck cancer.

In summary, Dr. Conley suggested when searching for a clinical trial a patient should know the location of the cancer, the treatment that has been received as well as the stage of the cancer. It is also best to ask an expert opinion before entering a phase I trial.

Ms. Patty Delaney, Associate Director of the Cancer Liaison Program of the Office of Special Health issues, of the FDA was our third speaker. Ms. Delaney is a survivor of Hodgkin’s disease after participating in a phase III clinical trial fourteen years ago.

Ms. Delaney explained why it takes so long for a new cancer drug to be approved. There are three steps in the approval process; discovery, development and approval. As an example of the approval process, Ms. Delaney used the drug Herceptin, a cancer therapy for the treatment of breast cancer. She carefully explained the history of the development and eventual approval of this drug from the initial identification of a gene in 1979 to final approval of the drug in September 1998. In the case of Herceptin, discovery took 10 years, development took 9 years and FDA review and approval took 4 months for a total of more than 19 years.

The approval process of a drug involves multiple forces and pressures that are at work during the time that a drug must be shown to

be worth developing while assuring the safety and effectiveness of the drug. The process may involve the capitol markets, scientific discovery, corporate and scientific arguments, regulatory requirements, or sometimes, something as whimsical as chance or coincidence. In the case of Herceptin, all of these forces and pressures played a role.

The FDA has an important role in drug development and it is the FDA's exclusive responsibility to review and finally approve or disapprove a new drug application. The FDA staff of medical oncologists, chemists, statisticians and pharmacologists each reviews their sections of the new drug application and they meet as a team to discuss their findings. Frequently drug companies are asked for additional information to clarify their submission.

Once the FDA team has completed its review of the new drug application, the data on the drug is usually presented to an FDA advisory committee for their recommendation on the drug's worthiness for approval. FDA advisors are leaders in the practice of oncology and biostatistics. The FDA also has several programs that integrate patients into the FDA's role in drug development and approval.

In the past ten years, the FDA has taken many steps to reduce the length of time it takes for drug approval. Today, an application for a new agent, which may provide treatment for a life threatening disease where no other treatment exists, must be reviewed by the FDA and a decision made within a six month period. If an application for a new drug for a life threatening disease is similar to a treatment that is already on the market for that disease, the FDA must make a decision in no more than 12 months.

Our final speaker was Dr. David G. Pfister, Associate Attending Physician, Division of Solid Tumor Oncology, and Co-leader of the Head and Neck Cancer Disease Management Team, at Memorial Sloan-Kettering Cancer Center in New York. Dr. Pfister is also a member of the Medical Advisory Board of SPOHNC.

Dr. Pfister stated that primary site cancers with or without spread to the neck, are potentially curable with currently available therapies. In addition to the progress that has been made in terms of improving survival, functional and cosmetic outcomes have also

improved by avoiding major surgical procedures through the use of integrated chemotherapy and radiation approaches.

Unfortunately, the success rate is not 100 percent in all cases, particularly in the more advanced tumors and recurrent tumors. Thus, developing new agents that may improve the management of head and neck cancer is important.

Some drugs previously approved by the FDA that have shown activity in treating head and neck cancer are now in clinical trials in combination with "novel agents" that have demonstrated promise in early studies. Often this is done in the context of Phase I trials. These Phase I trials may be good options for patients with recurrent disease as they contain at least one drug with known activity.

A term commonly heard today is "targeted therapies." Historically, all agents were targeted for particular metabolic pathways; however, with a better understanding of the molecular basis for disease and what makes cancer cells "tick", "novel agents" can now be focused on a growing list of specific targets and pathways. One such pathway is that of the EGFR (epidermal growth factor receptor). EGFR is a protein receptor frequently found in head and neck cancers. This particular pathway is one that can be blocked with the intent of affecting tumor growth.

One way to interfere with this pathway is to target an antibody at this particular receptor. An example of such a targeted therapy is C225 or Erbitux. This agent is now going through Phase III clinical trials to determine potential benefits. Other agents that target this pathway include Irressa (ZD 1839) and Tarceva (OSI-774).

Another important target for cancer therapy is blood vessel development or angiogenesis. Blood vessel growth is important for the growth of tumors as well as the spread of tumors. Various angiogenic factors appear to facilitate the process of tumor spread. One such factor is VEGF (vascular endothelial growth factor). SU5416, is an example of an angiogenesis inhibitor that is directed at interfering with this process and preventing tumor growth.

Gene therapy is also an area of interest in clinical trials for oral and head and neck cancer. Basically, gene therapy is trying to exploit the genetic makeup of the cell. In this

respect, the tumor suppressor gene, p53, and the p53 pathway have been of particular interest. The general concept of gene therapy is that some genetic material packaged in a vector (a gene transfer system such as a virus) can facilitate the introduction of certain genetic material into the cell that will affect and selectively kill tumors without danger to the patient. Gene therapy is undergoing active investigation.

The COX 2 inhibitors, commonly used in the treatment of arthritis, are also being investigated. This class of drugs may play a role as potentially preventive agents of head and neck cancer as well as therapeutic agents.

Dr. Pfister suggested that when looking for particular studies and agents, the patient should talk with the principal investigator involved with the trial. This investigator may not be able to give any guarantees for a particular study, however, oftentimes the investigator will be able to provide information regarding anticipated side effects of treatment as well as responses or benefits in patients who share similar tumor types.

For more information about clinical trials for head and neck cancer, please visit the clinical trials page of the SPOHNC web site at www.spoync.org. Additional information may be found at www.cancer.gov and www.clinicaltrials.gov or by calling the National Cancer Information Service at 1-800-4CANCER.

To listen to the teleconference in its entirety, please visit the SPOHNC web site.

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that opens the door to a new understanding of self and others and God. Life has taken on new meaning, purpose, and value.

Editor's Note: Travis Maxwell is an Oncology Chaplain at Sammons Cancer Center at Baylor University Medical Center in Dallas, Texas where he has served since 1972. Chaplain Maxwell is a Board Certified Chaplain by the Association of Professional Chaplains. He is on the staff of the Virginia R. Cvetko Center at Sammons Cancer Center where he works with an interdisciplinary team to provide psychosocial/spiritual support for cancer patients and their families through several education and support programs. In addition, he is the staff-coordinator for several support programs, including a SPOHNC group for cancer patients and their families, and he is the coordinator for a visitation program for trained cancer survivors who visit with other cancer patients. ■

A TIME FOR SHARING ...Food For Thought

Film buff that I am, I was thrilled when my white count was finally high enough for me to go to the movies. But what a great disappointment it was to have to acknowledge that my post-treatment symptom of dry mouth prohibited me from eating popcorn. My constant companion, a bottle of water, only made the popcorn bland and soggy. Many times since, I have flirted with the concession counter, examining every chocolate-y, chewy, sugary or frozen item, only to retreat empty handed: too sweet, too hard, too dry, too sticky or too cold for my mouth and sensitive teeth. Gradually, I learned to accept the disappointment. My only remaining indulgence would be bottled water. Even at that, once at a small university theater, an usher collared me and insisted that I stash the bottle. With a pleading voice, I explained my chronic need; she became tongue-tied and apologetically permitted me to drink in the theater. Nowadays I march right into any theater, ignoring the sign that reads “No Outside Food or Beverages Permitted”.

On one emotionally rough day during my recovery, I treated myself to a matinee. The two hours spent in a dark space is always a consolation, allowing me to escape into some other life, into someone else’s story. The plan was to arrive early with plenty of time to find parking and grab a quick snack (I must refuel my depleted reserve system every couple of hours, or I can virtually collapse). But I underestimated the busy Solano Avenue shopping area where parking can be a competitive sport, and didn’t get a chance to get something to eat without missing curtain call. (One might say that I have my priorities backwards, but I don’t like to miss the beginning of a film.) When I finally arrived at the theater, I was greeted by the familiar buttery aroma from a ‘real’ popcorn machine. While standing about ten feet from the concession counter, knowing that there wasn’t anything available that I can sink my teeth into, but also knowing that my body will punish me later for not eating first, the strangest thing happened...I had an out of body experience. I shrunk into a tiny little person, looking up at a giant towering over

me. I recognized her right away. It was *me*, bending over and glaring down with radar eyes. The tall “me” shook her head slowly and admonished, “You can’t have any.” On the verge of tears, I clutched my purse, with *l’eau caché*, and shuffled into the already darkened theater.

At the very next cancer support group session, I recounted this story. The reactions from fellow patients and two therapists were surprisingly supportive. I had thought that my story was trivial, but they thought that it was very moving. They were all touched by it. Some even thought that I told the story eloquently. Everybody there had a reaction to share. I learned that the child in me sensed the loss and longed for something off limits, but the adult in me knew better. I also learned that I needed to allow myself time to grieve for the loss and to accept my post-cancer life “as is”, but I must continue to find creative ways to adapt.

Months later, at breakfast I had one of those cancer recovery eureka moments. My discovery was that the moisture from a bite of papaya enabled the chewing of hard crusty toast. The combination of the two made the papaya less acidic and the toast less dry. Armed subliminally with this new information, the next time I went to a matinee, I didn’t forget about the afternoon snack. But because going to the movie that day was a spontaneous decision, I had to bring the snack with me and concealed it in my tote bag with my other *caché*. It was early summer when fruit is bountiful, so I brought a mixed fruit salad of banana, peach and papaya.

The moment I entered the theater, some gentle force piloted me up to the concession counter. Somehow I knew that ‘today’ was the day to be adventurous. I ignored my inner voice questioning my action and ordered a small bag of popcorn. The concession staff dutifully offered me a bag twice the size for an extra dollar. I replied with a polite grin, my eyes blinking to hold back the tears from intermingled emotions and from being rattled by his offer. “No thanks,” I told him with a tremulous voice, “just a small one will do.” Then my intuition nudged at me, and I added emphatically, “...and you don’t need to fill it

up.” He looked at me peculiarly and proceeded to fill the bag. Who, in his or her right mind, would not want the popcorn overflowing at the top!

When the movie started, I sat alone in one of the front rows. I thought, “Great, I can eat my stash without being caught.” As the film rolled, I quietly laid out my picnic. In the darkness, with alternating bites of popcorn and fruit, I was able to finally enjoy what had been “off limits”. The juicy sweet fruit complemented the dry airy popcorn very well. Even though I only ate less than half the bag when I ran out of fruit, I had a delectable feast.

Feeling an enormous sense of accomplishment, I couldn’t wait to share the exciting news with my husband, Tracey. When the movie was over, I neatly packed the popcorn in my tote bag. Since I did not drive to the theater that day, home was a good thirty minutes away. I was too consumed with excitement that I did not want to wait that long. So I called him and asked him to come pick me up with the car without giving away any hint of my new found freedom. Ten minutes later, I sighted our little black Honda half a block away from the theater entrance.

Tracey picked me out from the crowd right away too. With his usual sense of fun and game, he blinked the head lights at me as if sending a Morse Code. I gyrated with both arms in the air signaling to him from the curb. If you knew me, you would know that I am a pretty reserved person when it comes to moving my body parts in public, especially when nobody else is dancing. But not this day! I was flying as high as a kite. When Tracey pulled up, he immediately caught wind of my excitement, and he said with a blithe smile, “You ate popcorn, didn’t you.” With a huge grin on my face and a tiniest bit of guilt for having indulged in something that had been forbidden, I nodded. We pulled away from the curb feeling euphoric about having marked another milestone in my journey towards healing from our year with cancer.

Pauline Chin
Berkeley, CA

New Members Join SPOHNC's Medical Advsiory Board

Support for People with Oral and Head and Neck Cancer is pleased to welcome Drs David M. Brizel and Everette E. Vokes to its Medical Advsiory Board.

David M. Brizel, M.D., Professor, Department of Radiation Oncology at Duke University Medical Center, Durham, North Carolina is a member of the American Society for Therapeutic Radiology and Oncology, the American Society for Clinical Oncology, the American College of Radiology and the Radiation Research Society among others. He has been a Principal Investigator in numerous research studies involving head and neck cancer with special expertise in the combination of radiotherapy and chemotherapy and in radioprotection. Dr. Brizel has been a visiting professor at the University of Pennsylvania, Yale University, Harvard Medical School and more recently at the University of Pittsburgh Medical Center and the Sun Yat Sen Cancer Center in Taipei, Taiwan. Dr. Brizel is the co-author of numerous articles and book chapters many

of which concern head and neck cancer.

Everett E. Vokes, M.D., John E. Ultmann Professor, Departments of Medicine and Radiation Oncology at the University of Chicago Medical Center and Director of the Section of Hematology/Oncology is a member of numerous professional organizations including the American Society for Clinical Investigation, American College of Physicians, American Society of Clinical Oncology, and the American Society for Head and Neck Surgery. He is also Chairman of the Radiation Therapy Oncology Group (RTOG), Head and Neck Medical Oncology Subcommittee. His honors include Member of the Advisory Board of the National Institute of Dental and Craniofacial Research (NIDCR), Best Doctors, Inc. 2001-2002 and The Castle Connolly Top Doctors: Chicago Metro Area, 2002. Dr. Vokes has authored and co-authored numerous articles concerning head and neck cancer and has also lectured extensively on this subject.■

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