



S•P•O•H•N•C

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

SMOKING CESSATION FOLLOWING DIAGNOSIS OF HEAD AND NECK CANCER

JAMIE S. OSTROFF, Ph.D.

It is well known that the best way to prevent cancers of the head and neck region is to avoid smoking. Approximately 85% of new cases of head and neck cancer are associated with a history of tobacco use. Many patients who started smoking when they were very young, and perhaps unaware of the dangers of long-term use, often wonder whether there is any benefit to quitting smoking after cancer diagnosis. "After all, isn't the damage already done?" In fact, it is never too late to quit smoking. When compared to patients who continue smoking, studies have demonstrated that patients who quit smoking following the diagnosis of head and neck cancer are less likely to have a recurrence of their disease or a second primary cancer. They also experience fewer treatment-related side effects and have a longer period of survival. In addition to the clear physical benefits of quitting, for most patients there are also strong mental health benefits to quitting following diagnosis. In response to the fear and uncertainty commonly associated with a cancer diagnosis, patients describe that quitting enhances their sense of personal control, mastery, and self-esteem.

Given these compelling reasons for quitting, it is not surprising that most head and neck cancer patients who smoke, do, in fact, quit smoking at or shortly after diagnosis. Research has shown that nearly 65% of patients who were smoking at the time of diagnosis report abstinence following diagnosis of head and neck cancer. The subgroup who continue to smoke seem to be those patients who are diagnosed with early stage disease, heavily nicotine dependent, less knowledgeable about the benefits of smoking cessation, likely to live with family members who are active smokers, and those who experience heightened psychological distress and report heavy use of alcohol.

As most smokers know, the road to quitting is rarely a straight path. Patients vary in their readiness to quit smoking following diagnosis. While most patients express a strong interest in quitting

for good, many patients have made multiple attempts to quit followed by a disappointing resumption of smoking. Experts agree that smokers often need to practice quitting. That is, with each attempt, smokers can learn more about strategies for dealing with barriers for quitting and long-term abstinence. Identifying effective strategies for coping with urges to smoke will help a smoker to become more self-confident in his/her ability to best meet the challenges of smoke-free daily living.

For many head and neck cancer patients, learning to cope with the stress of diagnosis and treatment is essential for achieving smoking abstinence. Some patients are not able to concentrate on efforts to quit smoking until they have begun the process of physically and emotionally recuperating from their treatment. Quitting smoking takes teamwork and health care providers are an important part of the overall game plan. They will have answers to questions about the likely benefits of quitting and the risks of continued smoking. They will also have advice about effective strategies for quitting and managing symptoms of nicotine dependency and provide assistance in locating written self-help materials, support groups and local professional resources to help the patient along the way.

Getting ready to quit smoking requires preparation. First, smokers need to weigh the pros and cons of smoking and decide that the benefits of quitting outweigh the benefits of smoking. Then, smokers need to set a quit date. While there is rarely a best time to quit, setting a specific date helps one to get organized for making this important health change. Before quitting, smokers should also develop alternate plans for dealing with urges and cravings to smoke.

Strategies such as avoiding common smoking triggers or cues, drinking water, using deep breathing relaxation exercises, seeking support from ex-smokers or caring family and friends, and rewarding oneself for achieving progress toward one's overall goal have been shown to be particularly helpful. There is no one way to quit smoking and a smoker may experience some trial and error until he/she develops a plan that will work. Fortunately, there are many resources available to help patients quit and maintain abstinence (e.g., written pamphlets, smoking cessation support programs offered in your local community, the Cancer Information Service at 1-800-4-CANCER, *quitlines*, the health psychologist at your hospital, etc).

Patients often have many questions about quitting smoking following cancer diagnosis. The following are a few of the most common concerns expressed:

Q: I am embarrassed to tell my doctor that I am smoking after my surgery. What if he/she gets angry with me?

A: Chances are that your physician and nurse realize how hard it can be to quit smoking and have counseled patients who have struggled to quit. Letting your health care team know that you continue to smoke allows them to help you to identify smoking cessation programs and resources in your area. While your physician may be disappointed to hear of your continued smoking because of his or her strong belief about the health benefits of quitting, you will

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COMING IN APRIL, 2003

Oral Cancer: An Overview
 James J. Sciubba, DMD, PhD

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probably be more comfortable to ask for assistance in smoking cessation than to be anxious about your physician's reaction to discovering your smoking during your follow-up visits.

Q: I've heard about medications for smoking cessation. Can cancer patients use them?

A: There are now several FDA approved medications that have been proven to be effective in managing nicotine withdrawal symptoms and in promoting long-term smoking abstinence. There are five options for nicotine replacement therapy (NRT)—transdermal patch, gum, nasal spray, inhaler and lozenge. Some of these are available only by prescription and others are available over the counter at your pharmacy. Essentially all forms of NRT allow the smoker to quit smoking and gradually reduce the amount of nicotine so as to reduce the frequency and severity of nicotine withdrawal symptoms (i.e. cravings, irritability, difficulty concentrating). Another FDA approved medication is Zyban (Bupropion SR) which is a non-nicotine medication available by prescription from your doctor. There are also many other medications that are currently being tested to see if they are safe and effective. Your physician can help you to choose the smoking cessation medication that is best for you. Many head and neck cancer patients find that these medications provide for a “kinder and gentler” quitting experience leading to the best chances for achieving and maintaining long-term smoking cessation.

Q: Ever since my cancer diagnosis, my family and friends have been nagging me to stop smoking. My smoking has become a source of much conflict in my family. Any suggestions?

A: Cancer diagnosis is a traumatic event for patients and their families. Well-intentioned family members are often frustrated by how difficult it can be to quit smoking. Family support can be enormously helpful in both encouraging you to quit, helping you to deal with nicotine cravings and congratulating you for successes along the way to achieving abstinence. Think about how your family members can help you and then let them know your preferred type of assistance. Getting them on your team, will help you to be a winner.

Q: When I returned home from the hospital, I hadn't had a cigarette in 10 days. I was somewhat surprised how easy it was to quit while I was in the hospital for my surgery. Now that I am feeling better and back to my old routines, I find that I am having frequent cravings for a cigarette and have started bumming cigarettes from friends and co-workers. What should I do?

A: Some patients find that it is easier to quit while they are in the hospital. After all, hospital regulations do not permit smoking. Patients often report being too sick to smoke and there are many reminders of the health risks of tobacco use. The longer time since diagnosis and treatment, the more important intrinsic motivation becomes in maintaining abstinence. Now may be a good time to review your personal reasons for quitting. Even something quite simple like writing down the top three reasons for quitting on a note card can help remind you of your goal when your motivation and confidence are low.

Q: I am so upset about my cancer diagnosis that I find myself smoking even more than usual. It seems like a vicious cycle-the more I'm upset, the more I smoke, the more I'm upset. Since smoking provides both pleasure and comfort to me during this difficult time would it be better to wait until I'm feeling stronger emotionally before I quit?

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A: Quitting smoking following cancer diagnosis is probably both the best and worst of times to quit. It is the best of times in that you are probably highly motivated to restore your physical health and prevent further disease. In addition, you are likely to have extensive support for quitting that will include your health care team, former patients, family and friends. On the other hand, patients often report high levels of stress, sadness and fear, particularly shortly after cancer diagnosis. Some patients find that they may need to seek additional support to deal with concerns related to cancer. Many patients find that cancer forces them to brush up on old ways and perhaps, learn some new ways, of dealing with stress and difficult decisions. For others, counseling and medications may be helpful in reducing emotional distress and in addressing quality of life issues. Quitting smoking following cancer diagnosis represents an important step in your overall health care and in efforts to restore physical and psychological well-being after cancer diagnosis.

Q: *My cancer diagnosis was truly a wake-up call for me and I'm pleased to say that I've been smoke-free since my surgery and hospitalization. But, I have a husband and young adult daughter who are current smokers and I'm very worried about their health. Should I speak up?*

A: More than most people, you are keenly aware of the dangers of continued smoking and the benefits of cessation. More than likely, you also understand the challenges of becoming motivated to quit, and then being able to follow through with a quit plan that combines behavioral strategies and proven medications. You can set a great example for others in your family! Research has shown that when a family member is diagnosed with cancer, family members often re-evaluate their health lifestyles and those who smoke often consider smoking cessation. In order to help your loved one move from contemplation to action, you may want to review the benefits of smoking cessation and make recommendations for how they can devise a quit plan that will work for them. Family support and encouragement can go a long way in helping to motivate loved ones to join you in making a commitment to protecting their health and well-being.

Editor's Note: Jamie S. Ostroff, Ph.D. is Assistant Attending Psychologist and Director of the Smoking Cessation Program at Memorial Sloan-Kettering Cancer Center in New York City. ■

Tips From the Pros

Nancy,

My name is Hal Holley. I am a survivor of squamous cell carcinoma in the base of my tongue and my jaw. Yes, I was a smoker for way too long. I lost my tongue and part of my jaw. But I consider myself lucky. I'm still alive, I still work, and I am still active. Other than difficulty speaking and a rather frightening appearance, I'm OK.

Recently, I found some software that speaks what I type. It also has facilities for pre-recorded phrases, sentences, and sounds. It helps me a great deal in communicating. My doctor, Dr. John O'Brien in Dallas, suggested that I pass along the source of the software to you. Perhaps some members of SPOHNC will find it as useful as I do.

The software is free to anyone who needs it. It was written by a man whose brother lived with A.L.S. Chip died last year, but his brother Jack is committed to supporting and improving the software as a sort of memorial to Chip. The net address is www.chipspeaking.com. The software can be downloaded from there or Jack will mail

you a copy free of charge. A great guy in anybody's book.

Hope this is helpful to someone.

Hal

Dear Friends:

I celebrated my third anniversary as a survivor of squamous cell carcinoma of the left tonsil on Super Bowl Sunday, 2003. Although I am doing quite well, I still have some problems with thick ropery saliva.

I found that Toms Natural Mouthwash of Maine does a great job of clearing the thick saliva from my mouth and throat. This product can be purchased over-the-counter at pharmacies such as CVS.

Papaya juice is also helpful, but it must be 100% juice, not nectar. The enzymes in the juice help to cut through the thick saliva. Papaya juice can be purchased in your local supermarket..

Virgil Holdridge
Denver, CO



Please Welcome
SPOHNC-SAN FRANCISCO-CA
at UCSF

First meeting
Thursday, March 6, 2003, 4:00 PM
Third Floor Conference Room
UCSF Comprehensive Cancer Center
1600 Divisadero St.
(between Post & Sutter)

For information, please contact:
Barbara Buckley, LCSW

415-885-7623
email: barbara.buckley@ucsfmedctr.org

Please Welcome
SPOHNC-DETROIT-MI
at HFHS

Meeting on
Wednesday, March 5, 2003
1:30 PM
Henry Ford Hospital
Clara Ford Pavillion, 2nd Floor
Room 236

For information, please contact:
Amy Orwig, LSW

313-916-8101
email: aorwig1@hfhs.org

Dental Care for Patients Diagnosed with Oral and Head and Neck Cancer

Patients diagnosed with oral and head and neck cancer are commonly treated with surgery, radiation therapy and chemotherapy or a combination of these modalities. Radiation therapy and/or chemotherapy may be part of a patient's treatment, prior to, or subsequent to, surgical resection of the tumor. It is of utmost importance that the patient sees a dentist with expertise in dental care for irradiated patients prior to initiation of radiation and/or chemotherapy. Medically necessary oral care that includes diligence and adherence to proper treatment planning strategies prior to, during, and after cancer treatment can prevent or reduce the incidence and severity of oral complications, enhancing both patient survival and quality of life.

How will radiation and chemotherapy affect my mouth?

Radiation and chemotherapy are used to treat cancer because they kill cancer cells. However, in addition to destroying cancer cells, radiation to the head and neck area and chemotherapy can harm normal cells, including cells in the mouth, salivary glands, jawbones and oropharynx. Patients receiving radiation therapy to the head and neck area will be at risk for developing certain problems including dry mouth, (xerostomia), changes in taste, rampant tooth decay ("cavities"), mucositis, oral and systemic infections and nutritional compromise. Your dentist can help you to establish a program of treatment to help prevent or reduce the severity of these problems.

Why is it necessary to see a dentist before beginning radiation and chemotherapy?

A dentist, familiar with dental care for irradiated patients, is an important member of the multidisciplinary team that will be treating your cancer. By seeing your dentist several weeks prior to beginning radiation and/or chemotherapy, you may be able to prevent some of the serious mouth problems that may arise as a result of your treatment. It is important that your mouth

be as healthy as possible prior to beginning radiation and/or chemotherapy.

Will my visit to the dentist be a routine examination?

Yes, but in addition, a decision must be made concerning the long term care of the teeth and their supporting structures.

Will I need to have any teeth pulled before having radiation and chemotherapy?

Probably not, if your teeth are healthy. The majority of patients will be able to retain most, if not all, of their teeth. To accomplish this, a vigorous program of hygiene, prevention and recall visits to the dentist and dental hygienist must be adhered to on a permanent basis.

How long after seeing my dentist can I begin cancer treatment?

In cases where tooth extractions are necessary, two to three weeks should elapse, when possible, prior to beginning radiation therapy. This will allow sufficient early healing to occur prior to treatment. Where dental extractions are not indicated or necessary, a few days should elapse to allow for any preparation of dental devices or further procedures by the dental provider.

What type of oral health regimen will my dentist suggest?

Emphasis will be on daily prevention strategies including practicing scrupulous oral hygiene, daily topical fluoride applications and dietary considerations.

What are fluoride applicators? How are they used?

Fluoride applicators are similar to sports mouth guards. They are fitted to the individual mouth and are used to provide a neutral pH fluoride gel to the teeth on a daily basis.

The fluoride helps to protect the enamel covering of the teeth and helps to prevent cavities. This regimen should be part of an irradiated patient's lifelong oral care. The applicators are filled with a prescription fluoride gel and are placed in position over the teeth after brushing and

flossing are complete. The applicators remain in position for a designated amount of time after which they are removed and cleaned. Excess gel may be spit out, but it is important that the patient does not rinse or drink for thirty minutes or more.

When my cancer treatment is complete, can I resume a regular dental routine?

Essentially yes, however, the frequency of recall visits may be greater for you than for someone who has not been previously treated for oral and head and neck cancer.

Must I continue with a dentist who has expertise with irradiated patients or can I resume my checkups with my family dentist?

Your family dentist is probably qualified to monitor and intervene when appropriate within the context of prior dental and cancer treatment history. However, you should be assured that your dentist is familiar with patients that have received radiation treatments to their head and neck region, in particular to the mouth and jaw. This is particularly important if you require extractions or periodontal work.

Will I be able to wear my dentures?

Yes, in all likelihood.

What is trismus?

Patients who have had facial surgery or radiation treatment may experience stiffness in some or all of the muscles that open and close the mouth thereby restricting the opening of the mouth and affecting one's ability to eat, speak and maintain good oral hygiene. This condition, known as "trismus", is a relatively common occurrence that can be minimized if patients are willing to do specific exercises prior to, during, and following radiation treatment.

What is osteoradionecrosis?

Osteoradionecrosis (ORN) is a necrosis or death of the bone of the mandible (lower jaw) or maxilla (upper jaw) when these areas

are directly in the field of radiation. The blood flow restriction and localized bone destruction caused by radiation leads to poorly nourished bone that often responds unsatisfactorily to infection, trauma and wounds, including tooth extractions and bone/periodontal surgery. Although it usually occurs in the mandible (lower jaw) it can also occur in the upper jaw. Osteoradionecrosis may also occur following brachytherapy (radiation implants).

Must I take any precautions if I need to have any periodontal work done or have a tooth extracted?

If there has been prior radiation therapy involving the jaws, great care must

be exercised by an experienced clinician. A second opinion by a dentist experienced with the effects of radiotherapy may be necessary. The use of preoperative hyperbaric oxygen therapy may be indicated in such cases.

What is hyperbaric oxygen therapy?

Hyperbaric oxygen (HBO) involves breathing of pure oxygen within a pressure chamber. This allows the blood level of oxygen to be substantially increased, thus raising tissue oxygen levels and therefore, promoting healing and helping to eliminate infection.

Is hyperbaric oxygen therapy always necessary when an invasive procedure must be done?

Not necessarily. Much depends upon the clinical circumstances and must be

considered on a case-by-case basis. Be sure to discuss this matter with your dentist prior to any invasive procedure.

What is the best way to insure a life-long healthy mouth?

Scrupulous dental care must begin prior to receiving radiotherapy and/or chemotherapy and continue for life. Most *critical* is a well-informed and consistently motivated patient partnering with a similarly well-informed dental team.

Editor's Note: The foregoing information is from Part III of the SPOHNC Patient Information Folder. This information is not intended to replace any information and/or recommendations made by health care professionals. ■

A TIME FOR SHARING My Millennium Misfortune

It was Saturday, the 25th of March 2000. I had been working in my garden and stopped to have lunch. As was my custom, prior to having lunch, I gargled. Much to my dismay, when I cleared my throat and spit, I saw a considerable amount of fresh blood.

The following Monday I had a consultation with my physician. During that consultation, I related my Saturday experience after which he examined my throat and immediately made arrangements for me to see an ENT physician that same afternoon. My throat was scoped and revealed a large tumor on my left tonsil, which extended to a small area at the back of my tongue and down the side of the throat. The ENT doctor made an appointment for me to have a fine needle biopsy of my neck. Nothing showed. He then arranged for me to have a biopsy under sedation at the local hospital.

Stage 4 squamous cell carcinoma. How could that be? Only three months before, I had my annual physical and there was no indication that anything was wrong. I was never aware of any growth in my throat, nor were there problems with swallowing or hoarseness. The bleeding

episode was the first indication that I might have a serious problem.

Several weeks later, I met with the ENT doctor to discuss my options of treatment. The doctor's recommendation was surgery. He explained every detail of the surgery and all the possible side effects. Surgery would be quite extensive and involve cutting through my jawbone and some muscles to remove the tumor. Reconstructive surgery would also be extensive and recovery could be lengthy. We discussed all possible side effects of the surgery including disfigurement, speech difficulties with the possibility of the loss of my voicebox, the inability to eat and swallow solid foods, and of course, the possibility of death.

I decided I needed a second opinion. The new ENT physician was associated with our large medical school. This doctor made the very same recommendation, with all the same possible results. I then consulted with a radiation oncologist and a medical oncologist. They discussed radiation with chemotherapy as an option. After several meetings with these doctors, I decided that I would go with a combination of radiation and chemotherapy

The recommended treatment came from a study being conducted at Duke University Medical Center, which involved 52 treatments of radiation, involving approximately a 2 minute "zap" on the right side, left side and my throat area just under my chin. It was described as an accelerated and aggressive assault on the tumor, since it was a stage 4. The radiation oncologist informed me of the percentages for recovery and explained all the possible side effects. She gave me all the possible scenarios, including the survival rate, especially for a man my age (74 at the time). She also gave me a printout of the Duke study. My wife and I read as much as we could find on the subject. This was a tremendous help in preparing us for what was to come. Treatment began on May 1, 2000.

I was admitted to the hospital on this day to start a week of chemotherapy around the clock and radiation twice a day. After the fourth day, a feeding tube was inserted into my stomach as I had lost the ability to taste, and swallowing had become impaired. I was losing weight and growing weaker each day. My weight before cancer had been 192. I lost approximately 20 pounds that very first week. Fortunately SHARING continued on page 6

SHARING from page 5

my weight has fluctuated between 172 to 180 lbs., the recommended weight for my size. The feeding tube proved to be a godsend as my energy and stamina greatly improved.

During this first week of hospitalization my oncologist also ordered a "port" to be inserted in my right arm. This receptacle was surgically buried into my upper right arm in order to access all the chemicals that were being administered during this week, alleviating my becoming a pincushion for the needed injections.

I was discharged from the hospital after the first week of treatment and then continued with radiation therapy twice a day as an outpatient, Monday thru Friday. The tumor on the left side was given a very heavy dose of radiation and disappeared early into the treatment. However, treatment continued as scheduled by the study to insure that any unseen radical cells were not present.

During this time the port was taken out and reinserted in my arm on three different occasions due to different malfunctions, two of which involved the formation of blood clots. This was a bit scary. To dissolve potential clots, I was treated with a medication administered by small needle injection into my stomach muscle.

Fortunately, I was only sick (vomiting, etc) two days during my treatments. This resulted from a double dose of chemo the last two days of my second stay in the hospital. I had no loss of hair on my head, however the cheek area of my face became as smooth as a baby's bottom. I didn't have to shave much during this time.

My wife chose to stay with me around the clock, during both stays in the hospital. She kept a daily journal of the schedules, activities, procedures and treatments so that we would stay informed and know pretty much what to expect each day. This was a good mental exercise for us. My attitude was positive and my spirits were pretty good. My family, friends and church friends continued to pray for me and sent many "get well wishes." We received so much encouragement.

Our third son's wedding took place in Boston the last week of my scheduled treatment. Much to my disappointment I

was not able to attend. Way back at the beginning of all this, our three other sons made a video of my toast to be shown at the rehearsal dinner. Our oldest son's wife is a nurse and she insisted on staying here in Virginia with their two children to take care of my needs and injections so that my wife, Jackie, could attend the wedding. I was to be our son's best man, just as I had been for his three brothers at their weddings, but since this was not to be, my wife and eldest son flew up for the three days of celebration and this son was my stand-in as best man. Cell phones are really great, as the groom and brothers called frequently to keep me tuned in on the many activities. My son called just before walking down the aisle.

I am an aviculturist by hobby. I raise waterfowl, pheasants, peafowl and chickens. I also raise show racers (pigeons), which I "show" up and down the east coast. I have two lofts to maintain as well as pens and a pond. During the time of my treatments and recovery, I was fortunate that my sons and a good fellow aviculturist friend were able to do the necessary chores associated with my hobby. I also enjoy vegetable and flower gardening. This hobby was curtailed a bit. However, I did go out every evening after returning home from the hospital and enjoyed a little digging in a small garden. A friend came several times during the summer to help and he did the tilling, which was more than my strength would allow at the time.

I tell this to encourage anyone diagnosed with cancer to keep as busy and interested as you can while undergoing the physical and mental challenges of the disease. I am presently 76 years old and since retiring in 1987 I have always had a daily work schedule for these long standing interests. I did not let cancer slow me down much. My wife cared for the birds the weeks we were not in the hospital. Later in the summer, I took over, wearing a surgical mask to keep from breathing the feather dust, etc. I was truly a happy man to be back with my feathered friends and my usual routine although with some limitations.

At the time of the diagnosis, I was told that this type of tumor was usually found

in patients who are heavy into alcohol and smoking. I stopped smoking "cold turkey" at age 37 and a 6-pack of beer is probably consumed socially for over a period of a couple of years. So, so much for that theory, however, they did say the early years of smoking could have possibly been the start of some radical cells.

As I approach my third anniversary, I continue with my regular check-ups and all is well. During my recovery period, I did get new teeth, though I am still on a liquid diet and using a feeding tube. It will be a RED LETTER DAY when I am off the peg and I can once more eat food with much gusto and joy. Scar tissue in the esophagus, restricting the passage of food is the ongoing problem.

Jackie and I continue to be hopeful that there is a viable solution or help for my swallowing problem that is not yet known to us or to our doctors. I truly believe there must be an answer out there somewhere and that I will once again be able eat solids and swallow naturally so that I can rid myself of this added appendage (peg). Other than that, I am able to see each day in good health, with my daily routine and other activities. Jackie and I bowl once a week with the senior league, and I continue to host avicultural meetings in my back yard under a tent, once or twice a year, with approximately 50 to 70 attendees. My activities are great fun and give me much pleasure and exercise.

Overall, I must say that I was blessed with a team of great physicians and nurses at Henrico Doctors' Hospital, both on the floor and the infusion team. This team was very supportive and encouraging and very efficient. I credit these dedicated professionals, my wife and family with my relatively smooth ride thru it all. I had a PET scan, CAT scan, MRI, BONE scan and ultrasound of my vital organs in 2002. All tests reported clean.

Jackie and I look forward to SPOHNC's newsletter and thank Nancy and SPOHNC for all the work they put into this publication.

Mel Nunnally
Mechanicsville, VA



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from PAT'S PANTRY
PROVENÇAL

Tarragon Zucchini Egg Dish

- | | |
|----------------------------------|--------------------------|
| 2 lbs. zucchini squash | 2 mint leaves (optional) |
| 4 eggs | 1 Tbs. butter |
| 1/3 cup sour cream | 2 Tbs. olive oil |
| 1 tsp. tarragon leaves (chopped) | Salt and pepper to taste |

Milk

Cut the zucchini squash into lengthwise strips,. Steam squash until soft, about 10 minutes. Next saute strips lightly in the oil and butter for 3-5 minutes, turning on all sides. Puree the zucchini strips in the food processor. Add eggs and beat. Add sour cream, tarragon and mint (optional). Season with salt and pepper. Place mixture in buttered pyrex baking dish. Back 20 minues at 350 degrees. Cool slightly. Puree again adding milk to desired consistency.

Serve with poached or baked salmon which has also been pureed.and blended with milk.

March's Tip: Always choose the smallest zucchinis available. Be sure they are firm. Smaller zucchinis have more flavor!

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