



S•P•O•H•N•C

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

AN ORAL CANCER OVERVIEW

JAMES J. SCIUBBA, D.M.D., PH.D.

Cancers of the head and neck region, aside from skin cancer, are dominated by oral cancer, specifically squamous cell carcinoma. For purposes of this discussion the oral cavity will include the lips, buccal mucosa, anterior two-thirds of the tongue, floor of mouth, hard palate, and gum tissues or gingiva in both the upper and lower jaws.

INCIDENCE

In comparison to other cancers, those affecting the head and neck region are uncommon with an annual incidence of approximately 45,000 cases in United States, with new oral cancer cases numbering approximately 29,000 cases annually. Men are more frequently affected with oral cancer than women with both incidence and mortality higher in African-American men versus other subsets of the population. Oral cancer is highly associated with excessive use of alcohol and tobacco with the combined effect of alcohol and smoking being multiplicative. The overall risk of developing oral cancer as well as other forms of head and neck cancer is as much as 200 times greater for heavy smokers and drinkers than for those who do not engage in those habits. Other risk factors that may play a role in oral cancer development include viral infection, prior radiation to the area, dietary factors and genetic susceptibility.

ETIOLOGY / CAUSE

The actual cause or etiology of oral cancer at the cellular level is attributed to a phenomenon termed multistep carcinogenesis which may be defined as a set of intermediate steps or stages of altered cell behavior within the oral cavity. The multistep process, more specifically, represents a series of genetic events that are caused by the risk factors noted above that ultimately lead to the development

of invasive cancer. The genetic alterations or events are driven by numerous molecular mutations within a family of genes known as tumor suppressor genes. The presence of faulty tumor suppressor genes within cells comprising the oral mucous membrane lining ultimately lead to proliferation or growth in unregulated fashion thus in turn leading to tumor formation.

CLINICAL PRESENTATION

In the vast majority of cases, oral cavity cancer is preceded by a series of early clinical alterations leading to production of signs and symptoms that may be vague or subtle. Often times this type of cancer can be diagnosed in early stages of development prior to evolution into invasive disease or an advanced stage of presentation. The early phases of cancer development within the oral cavity as well as other areas of the aerodigestive tract proceed through stages of dysplasia or altered precancerous tissue characteristics that are reflective of the molecular and genetic changes previously stated. So-called noninvasive squamous carcinoma or in-situ carcinoma represents the stage of cancer immediately prior to invasion and, when treated appropriately is easily curable.

From a clinical perspective a common cancer precursor lesion is reflected by surface changes where a white patch or a combination of red and white patchy alterations may be noted. The white patch designation is termed leukoplakia, best defined as a white patch that cannot be rubbed off and cannot be given a specific diagnosis simply by visual examination. Importantly, the term leukoplakia refers only to a clinical naked eye view of altered oral mucosa. The presence of leukoplakia does not indicate that a cancer or precancer is also present. The relevance of leukoplakia to the clinician and to the patient relates to its clinical identification. The identification of leukoplakia should lead to the performance of a representative biopsy of the altered tissue so that a pathologist can carefully evaluate the tissue and the cells comprising the tissue and further determine whether the alterations are benign, premalignant or malignant. The pathological diagnosis will guide the best approach for treatment or management of the specific problem.

TREATMENT

As stated many times in the past and more recently in the literature, the key to improved treatment success relative to oral cancer resides in its early diagnosis. New approaches to early diagnosis are currently being developed by researchers. When small cancerous lesions are identified early in their evolution [T-stage 1 and T-stage 2], cure rates are very high with treatment tending to be less complicated and extensive than for more advanced disease. Early head and neck cancer, that include T-stage 1 and T-stage 2 lesions, are identified in approximately 30 to 40 percent of patients. Within this context overall five-year survival rates range from 60 percent to over 90 percent,

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COMING IN APRIL, 2003

Complementary and Alternative Medicine
 Georgia M. Decker MS, RN, CS-ANP, AOCN, CN

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depending upon the site and depth of the lesion and possible alterations or overexpression of certain genetic markers. The major public health concern relative to oral cancer is for advanced local-regional disease T-stage 3 or T-stage 4. Unfortunately, advanced oral cancer is present in over 50 percent of patients at the time of initial diagnosis. Such patients are generally managed with combination therapy including complete surgical excision and postoperative radiation therapy.

Cases of advanced oral cancer that are deemed to be unresectable, have generally poor prognoses with five-year survival rates no better than 20 percent. In such cases, chemotherapy and radiation therapy have a role in attempting to establish and obtain local control. Previously, radiotherapy alone was used for palliative therapy, but more recently effective chemotherapy regimens have been defined and are now employed with encouraging results. Many experimental treatment protocols are currently underway to define combinations of drugs used in association with radiation therapy, which may be effective in producing improved local control results. It has become clear that in the recent past combined chemotherapy and radiotherapy does produce a distinct survival advantage over either radiotherapy alone or chemotherapy alone.

The mainstay of oral cancer treatment remains complete surgical excision. The concept utilized by surgeons that should be understood by patients and their families is complete wide surgical excision with adequate margins of resection are critical in order to achieve local control of disease. The goal of surgery is to obtain margins with no evidence of cancer. When this is accomplished, the incidence of local recurrence is less than 15 percent for t-stage 1 lesions, but for much larger t-stage 4 lesions, the incidence of local recurrence approaches 50 percent.

Numerous references have been made to the stage of oral cancer, which may best be defined as a composite representation of the measured size of the cancer, the presence or absence of local spread or metastasis to lymph nodes in the neck and the presence or absence of cancer at distant sites such as the lung. The nuances and complexities of staging are beyond the scope of this brief review. It is fair to say, however, that the higher staged tumors carry with them a less optimistic prognosis and often times a more complex treatment plan.

An important consideration in oral cancer management relates to whether or not there is evidence of enlarged lymph nodes in the neck, usually on the same side where the oral cancer is located. Upon finding enlarged lymph nodes that are suspicious for or are more consistent with metastatic disease, the surgeon may indicate that a neck dissection is necessary. In cases where there is no evidence of enlarged lymph nodes or metastatic disease in the neck, or the so-called N₀ neck, controversy remains as to whether or not an elective neck dissection should be performed. Because a majority of patients with a clinically negative neck will not have cancer cells with metastasis to neck lymph nodes, some may consider an elective neck dissection as excessive treatment. Thus identification of this group of patients with clinically and radiographically negative neck evaluations is of vital importance. Some surgeons recommend an elective neck dissection only if the risk of undetected metastatic disease to neck lymph nodes exceeds 20 percent. It has been shown that a sparing approach to treating the neck area along specific

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lymphatic drainage areas that follow a predictable path is effective surgical therapy.

An important principle of management concerns reconstruction and rehabilitation of any surgically created deficits. Many individuals with oral cancer face significant functional as well as psychological problems associated with the diagnosis and treatment of their cancer. Difficulties may be encountered with swallowing, speech function and general cosmetics or appearance subsequent to surgical removal of the tumor. Restoration of swallowing and speech following surgery will include proper surgical reconstruction and post-operative rehabilitation. Both are critical to re-establishing functionality and quality of life. Specific reconstruction procedures can be offered by reconstructive surgeons as well as by maxillofacial prosthodontists as the initial step in the overall return to form and function. Lower jaw or mandibular defects can be managed by tissue transfer including bone from other sites of the body or with use of metal reconstruction plates in association with soft tissue grafts. Upper jaw or maxillary defects, in particular those involving the hard palate, can be managed with removable appliances called obturators which close off any communication between the mouth and the nose and sinus cavities. Obturators allow swallowing and speech function to be carried out successfully while avoiding nasal regurgitation and hypernasal speech quality.

When radiation therapy is necessary subsequent to surgery or as primary therapy without surgery, most patients will receive their radiation by external means, usually by way of a linear accelerator. Most hospitals and institutions in the United States utilize conventional linear accelerator therapy. Treatment is done on a 5 times per week basis or so-called fractions. Five fractions per week ranging from 180 to 200 centigray are delivered to a total dose of approximately 6600 to 7000 centigray over 6 to 7 weeks. Many recent advances in delivery of radiation therapy to the oral cavity and head and neck area also include conformal beam therapy, image modulation therapy (IMRT) and hyperfractionation therapy. Each technique has its advantages and indications.

Critical to understanding the role of radiation therapy in oral and head and neck cancer management relates to both the acute

and long-term complications of this form of management. While the cancer cells themselves are more susceptible to the effects of the radiation therapy in comparison to normal tissue, which is also in the field of the radiation, there are certainly adverse effects on normal tissue that must be understood by the patient.

Acute radiation-related complications will include radiation mucositis, a soreness of the oral mucous membranes as well as the mucous membranes of the throat. In addition, painful swallowing, difficult swallowing, radiation-induced skin burn or radiation dermatitis, hoarseness, if the larynx or voice box is in the path of radiation, and importantly, decreased salivary gland function causing variable degrees of mouth dryness or xerostomia. It should be noted, however, that patients may react differently to radiation therapy and thus radiation-related side effects will vary with each individual patient.

It is crucial that all patients scheduled to receive radiation therapy to the oral and head and neck region be screened and evaluated by their dental practitioner in advance of the therapy. This allows appropriate pre-therapy intervention to be performed in an effort to eliminate or reduce the chances of radiation-related complications. All necessary dental treatment must be completed as soon as possible to avoid any delay in the initiation of radiation treatment.

The longer-term or late effects of radiation therapy may include a dry mouth and difficulty opening the jaws or trismus, scarring beneath the skin and mucous membranes, thyroid gland dysfunction, swallowing dysfunction or development of a condition known as osteoradionecrosis. The latter condition is generally preventable by working with members of the dental team including the dental hygienist and dentist as well as the radiation therapist or radiation oncologist. As a general rule the severity of the early or acute complications relates to the daily individual doses of radiation therapy while the degree of late or chronic complications relates more to the overall or total dose of radiation given rather than by the daily individual dose or fraction.

The diagnosis, management and long-term follow-up of patients with oral cancer requires a team of individuals including the family practitioner, and dentist and dental

hygienist, head and neck surgeon, radiation oncologist, medical oncologist, maxillofacial prosthodontist, speech therapist, and physical rehabilitation specialists. The patient must participate in his/her own care by eliminating the consumption of alcohol and smoking which may contribute to decreased treatment success or the development of new tumors. In addition follow-up visits must be maintained with all involved caregivers in an effort to maintain vigilance and assure optimal quality of life subsequent to diagnosis and treatment.

Editor's Note: James J. Sciubba, DMD, PhD, is currently the Director of Dental and Oral Medicine at The Johns Hopkins Medical Center. He is a Professor of Otolaryngology, Dermatology and Pathology at The Johns Hopkins School of Medicine and is active in Oral Pathology, Oral Medicine and Hospital Dentistry within the Johns Hopkins Medical Institutions. Dr. Sciubba was instrumental in the founding of SPOHNC and continues to be a strong supporter of this organization.

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A TIME FOR SHARING Secretary to a Special Cancer Patient

Secretaries have always fascinated me. They are powerful people. They can let you in to see the boss or keep you out by clever maneuvers and yet they are loyal to their bosses supporting their ideas, following their leads and doing only what their bosses would direct or desire. Secretaries may present a thought or action for the boss' consideration; however, they will ultimately do what the boss wishes.

I have never wanted to be a secretary. I have too many ideas of my own that I want to project; too many tasks I consider important; too many times I want to be boss.

This was the mind-set I had when my husband discovered he had throat cancer. Our life plans were going smoothly. Lee had completely remodeled our ten-room house, room by room-nineteen years of hard work. We had it up for sale, and our new apartment waited. There were only a few improvements to make there. Meanwhile, the list of places we wanted to travel to grew longer each day.

Our plans changed. Our vacation was postponed and I became a secretary. My medical background was slight, praise the Lord. Dealing with our primary care doctor and administration personnel called for a secretary's organizational skills, always keeping in mind that the boss, my husband, needed to feel in control.

The health care system is fragmented and it took a calm secretary (me) to get answers from a distant health care administrator. She was firm; this was a daily experience for her. Lee needed to come in for a preliminary physical exam that afternoon, so Monday morning he could go to the hospital for a "procedure". I learned procedure is a generic term for what they needed to do to Lee's body. After Monday's trip to the hospital, there was another doctor's visit. Wednesday we went to another hospital, for another procedure. This was coupled with daily radiation treatments and soon to be added chemotherapy treatments. I wrote the schedule out in chronological order, gave it to Lee to log in his daily planner and waited for the next influx of run-arounds.

Another facet of my new job was to be

the support person. I gladly rode and after drove with Lee to all of his appointments. I had plenty of time to pray while I waited. For probably the first time in my life I had to guard my thoughts. I like to talk a lot, and Lee needed to be quiet. My voice is naturally loud. Lee needed softer tones. I tend to race with ideas. I had to slow down. My encouragement had to allow for frustration, anger and bewilderment, enough for the both of us

Projects were in the mix but now they had to be tempered with patience. My "boss" was a workaholic, always thinking, planning or doing. Now he was forced to stop and rest. Protection became my job. I reassured him waiting was okay. I tiptoed around him at naptime and raced to answer the telephone calls. I double checked the appointment times and suggested plans that would make the trips smoother. I respected Lee for he kept it all together and as usual thought and planned just as a boss would.

Another facet: plan for the unplanned. The radiation therapy department called and asked us to come in early; unfortunately, our already scheduled appointment was running late. We had decided to eat a good meal before radiation, now we had to rush from one appointment to the other, no time for that meal. I packed a few things to eat but they were the wrong things and now Lee had more reason to be upset. I was gaining respect for the secretary that could plan for the unplanned and I hoped to develop that talent sooner than later.

There was one skill I brought to the job...talking on the telephone. Most of my past calls had been welcomed. All my new ones were not. For instance, we got to the oncologist to find out Lee had no referral from the primary care doctor. When I called the HMO, I got "Good Morning, may I put you on hold?" Click. No, you may not; we have only ten minutes before the boss sees the doctor the first time. I stayed on hold. They don't even have easy listening music in the background, but thank God, they don't have that annoying voice that comes on every ninety seconds and says, "Your call is

important to us." So after a minute or two I hung up and called back. That went on four or five times. Finally the referral that was supposed to be faxed earlier was sent. Then another call was necessary. This time my husband-boss needed blood work done in a day's notice. There were two fax numbers for that data, one hospital (different from the one we had gone to yesterday) and an adjusted chemotherapy appointment with little time to drive fifteen miles.

Most secretaries don't have to have nutritional degrees. I don't have one either; however, my boss doesn't feel like eating but he must. He has a list of suggested foods but won't tell me which ones appeal to him. Maybe he doesn't know himself. I planned one thing for lunch. He wanted another. No problem. I went to the produce store and got an inspiration. He liked it and we added sweet potatoes to our menu. It was only a matter of time before mouth feeding became impossible and Lee used the tube implanted in his stomach. That was a big adjustment for him, but he recognized the nourishment value and the necessary energy boost. I ate things I knew Lee wouldn't miss-like tuna fish and chicken. We ate at separate times. It worked better that way. The fun and social aspect was gone for both of us. We believed it was only temporary and that all our future meals would take on a higher degree of thankfulness.

Routine? What secretary doesn't want to settle into a routine? Lee and I wished for one. We ran from doctor to doctor, from hospital to hospital. We hoped that when we got the preliminaries out of the way life would become simple again-just chemotherapy every morning and radiation every afternoon. There was some mention of a visiting nurse thrown into our desire for an uninterrupted few hours. After all, new contraptions needed attention. I tried to develop the skill of paying attention to the details. Probably not a bad skill but one I was not acquainted with. I am a "Reader's Digest" sort of person.

But I did become semi-skilled at medical marvels. Thank God Lee could still do most of the things for himself. I was queasy around

needles and I forgot important things like the alcohol wipes. We were glad when the port came out. That meant chemotherapy was over, even if the port did come out unconventionally and prematurely. It fell out while Lee was showering and I was fifteen miles away working on the house move. This secretary moved with speed and clarity of purpose and God cleared traffic so I could get home. Lee was very calm although somewhat concerned. The doctor's visit told us everything would be okay.

As a secretary, I had to stay on top of things. An appointment made Friday had to be verified. And if I forgot (which I did) I needed to call and sound confident. Thank God the doctor's office was accommodating and they were able to schedule the necessary blood work. The mail came, bringing upsetting news. A large hospital bill "they" say we are responsible for. I told myself, "Don't panic, just ask the right person."

Sensibility is a big asset for any secretary. I think secretaries like to do things that will help their bosses. I had one such opportunity and I was happy with my ingenuity. Lee's feeding tube was 14-16 inches long. It got in the way of everything. For a while he had it pinned to a shoestring that was tied around his neck. As his neck received more radiation, it became more tender and the shoestring became an irritant rather than an aid. What could keep the tube intact and not cause an irritation? One day, I found myself in the lady's department of a local discount store. There was the answer—a soft stretchable tube top, popular with teenagers, perfect to tuck a feeding tube into. It worked. I bought a second one and Lee washed them when he showered. They were drip dry. It was a small investment with a big reward. I wore a smile that day, knowing I had done a good thing.

Days have gone by and we are in a routine except for the exceptions. The radiologist called, could we come in earlier? The road to travel was slow or obstructed by construction. The beach trip back home was gone because we had moved in the middle of all this. We substituted a lake drive, not bad but not the ocean view. The apartment was overcrowded and the progress was slow. Lee doesn't have the energy. That's okay. We have

all the time in the world. I have plenty of things to sort out, file away, and throw away.

My biggest job is to be there when my boss wants me. That is my biggest challenge. I always wanted to be the boss. Now, I wait. I help. I stand around trying to understand what he says. Talking is hard for him now and listening is not one of my big skills. One thing however, even though I don't listen well, Lee has a habit of speaking behind my back or when the television is too loud or when I am just not paying attention. I know I really need to work on my listening skills. However, secretly I wish he would help a little more.

There is one thing I have learned. Our core personalities do not change much. Lee has never been the most positive thinker and just at the time he needs that positive atmosphere all around him, he just doesn't have it. I give all I can, however we all know that what is most important is what you say to yourself. I stand in the gap for Lee with constant prayer and I ask others to lift him up. I don't know how tough the treatments are on his mind. I know it is the toughest, roughest, hardest thing he has ever done. Having said that, Lee has been remarkably strong, brave and honest. Again, these are parts of his core personality that have not changed but have been challenged to the highest degree.

As a secretary, I have learned to give my boss his own space, his own room. Still it is awkward. We have moved from a large spacious house to a small apartment so we are still adjusting. We dance around each other. He is not talking much now. Sometimes he motions for me to sit by him and we are together. I still miss him. I want to dance with him.

That brings up another issue. I have an exception in my job description. Secretaries in the traditional sense are not allowed to touch their bosses. That would be highly unprofessional. However, my covert job description includes touching. It isn't much; holding his hand on the ride home from radiation or softly touching his shoulder before I say goodnight. As we watch television together, I put my pillow as close to his as I can. I confess my kisses are impassionate touches on the forehead, all the rest of his face hurts. There will be better days.

Driving is one of my duties and it probably terrifies Lee more than anything else I do. We have different thinking, budgeting, and driving styles. I know he has valid points and I have tried to incorporate his suggestions into my style. Sometimes I do, sometimes I don't. However, I do think of his reasoning and he is right. Hopefully I'll be a better driver. All I can say is I drove him safely for thirty-five trips to radiation and other appointments.

My boss made new contacts; the other patients in the waiting rooms, the doctors and support personnel. Every professional was professional, however his/her patience and concern was unique. You sensed a genuine caring from each and everyone. That was certainly a plus in Lee's case. The other patient's faces became familiar, the stories similar and the task the same. Everybody's situation was different, however, it had an underlying goal—get through the treatments and move on. The most impressive prevailing mood was "we are connected by this mystery and we care for each other." When Lee finished his treatments, our exit was grateful. We wished the others in the waiting room God's speed in their recovery and said our good-byes. We knew we would always feel some connection.

Lee's radiation treatments are over. We have gone home for him to heal. My secretary duties are over for the most part. I hope I do not have to do this job again, however, I am in the marriage forever and who knows what life brings.

I have told this story from my point of view, not Lee's. He is the one who has taken the radiation treatments day after day. He is the one who has unanswered questions to deal with. He is the one talking to himself about this whole experience. He is the one who needed a secretary.

While helping Lee rebuild the house we sold, I have added many titles to my life resume: apprentice roofer, plumber and mechanic. Now I can add secretary. This has been my most serious job and I am not eager to do it again.

As I pack away my supplies, I think of all the other secretaries, "hired" unexpectedly, doing the best they can, May God bless everyone.

Ann Lemos
West Palm Beach, FL

Federal Employment and Health Insurance Laws That Affect People Living with Cancer

By Barbara Ullman Schwerin, Esq.

The Cancer Legal Resource Center [CLRC], a joint program of Loyola Law School and the Western Law Center for Disability Rights, was founded in 1997 and provides information and education on all types of cancer-related legal issues for persons with cancer, their family and friends, caregivers, employers and others impacted by the disease.

The CLRC has assisted more than 23,000 people since its inception. Many callers are helped through the CLRC's telephone assistance line, staffed primarily by Loyola Law School students under the supervision of CLRC's legal staff. Additionally, the CLRC conducts 60-80 workshops annually in the cancer community, including cancer support groups, in service training for health care professionals, conferences, health fairs and other activities. The CLRC also has a volunteer panel of attorneys and other professionals who provide more in-depth counsel when needed. The CLRC is primarily California based; however, a significant percentage of callers come from outside of California, with the CLRC finding local resources for these callers. The CLRC's services are free.

The CLRC responds to questions in many areas of law. The following is a brief overview of the federal employment and health insurance laws affecting persons with cancer.

The Americans with Disabilities Act

In 1990, Congress passed the Americans with Disabilities Act [ADA]. The ADA is a wide-ranging law, prohibiting discrimination in all areas of the employment process. It was designed to level the playing field in the employment arena—so that people would not be denied jobs, or the benefits of jobs, simply because they had a disability.

The ADA applies to private employers with 15 or more employees. It also applies to employment agencies, labor organizations and local and state governments. The ADA provides protection to a "qualified individual with a disability." **An individual must be both disabled and qualified.**

An individual with a disability under the ADA is an individual with a physical or

mental impairment that substantially limits a major life activity. The major life activity can be, among other things, caring for oneself, walking, talking, seeing, breathing, or working. A person may also have a disability if she has a record of an impairment or is regarded as having an impairment. The impairment that substantially impacts a major life function must be severe, not temporary, and must produce a permanent or long-term impact.

In determining whether an impairment is substantially limiting, the impairment must be looked at in its corrected, or mitigated, state. Therefore, one must look at the employee's present condition, including whether the employee has already had surgery and where the employee is in his/her treatment program. One must look at the medications that may control the person's impairment, and also look at the side effects of the treatment, including the side effects of radiation and chemotherapy.

If the person's cancer is completely or substantially controlled through surgery, radiation and chemotherapy, the person may not have a qualifying disability under the ADA because they cannot show a substantial impact on a major life function. However, the person may be protected under one of the other two prongs of the ADA; namely, that they have a history of an impairment or are treated as having an impairment.

To be entitled to protection, the employee must also be a "qualified individual." This means the employee must be able to perform the essential functions of the job with or without a reasonable accommodation. Some examples of reasonable accommodations include a flexible schedule, reassignment to a vacant position, a light duty position, or possibly an extended period of leave time. Each situation is to be assessed on an individualized basis, including whether the reasonable accommodation would be an undue hardship for the employer. The ADA provides suggestions for reasonable accommodations. This list is not exhaustive and a discussion about reasonable accommodations is meant to be a dialogue between the employee and employer and

based upon the specific type of job and company involved.

The ADA can also provide protection for individuals looking for new jobs. Prospective employees applying for new jobs, do not need to disclose their medical conditions unless they need reasonable accommodations for the application or interview process. Applicants need not reveal their disabilities when applying even if they believe they will need accommodations on the job. If a person has a visible impairment, the prospective employer can ask the potential employee how they would perform the job function, and ask them to demonstrate.

If a person receives a conditional job offer based upon undergoing a medical examination, such an examination must be required of all employees in the same job category. The offer cannot be rescinded unless the medical examination indicates that the person cannot perform the essential functions of the job with or without a reasonable accommodation or that the person would pose a direct threat to himself or others. Finally, any requests for reasonable accommodations under the ADA are to be kept confidential. They should be kept in a separate, locked file that is kept separate and apart from a person's personnel file.

The Family and Medical Leave Act

There are other laws that may provide protections to employees in the workplace. The ADA can work hand in hand with another law, the Family and Medical Leave Act [FMLA]. The FMLA provides for a person to take up to 12 weeks of unpaid medical leave to care for a seriously ill spouse, parent or child. It also allows for up to 12 weeks of unpaid leave for the serious medical condition of the employee. Although unpaid, this is job-protected leave, which means the employee returns to the same or an equivalent position. This law also requires the employer to keep an employee's benefits intact.

The FMLA applies to employers with 50 or more employees. Covered employees must have been employed at least a year and have worked a minimum of 1,250 hours in that year. Sometimes, a person will need



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more than the 12 weeks of unpaid leave provided by the FMLA. In that case, a person may be able to take an extended period of leave time as a reasonable accommodation under the ADA after exhausting the 12 weeks of FMLA leave. Additionally, there may be state laws that provide protections equal to or greater than the ADA or FMLA

Health Insurance

There are also recent changes in health insurance laws that provide ways for people to keep their health insurance or obtain new health insurance even after being diagnosed with cancer. COBRA is a federal law that applies to employers with 20 or more employees and is a way for persons to keep their group health insurance if they leave their job or have reduced hours. COBRA is generally available for 18 months. During this time, the employee pays up to 102% of

the entire applicable employee rate. (the health insurance premium plus 2% for administrative costs).

Another law, the federal Health Insurance Portability and Accountability Act [HIPAA], provides protection for people going from one group health insurance plan to another. The employee receives "creditable coverage" for the time they have had health insurance. They take this creditable coverage with them when they go to a new employer and this time is credited towards any pre-existing condition exclusions. HIPAA also limits the amount of time that a pre-existing condition can be imposed [maximum 12 months; some states are less]. Also, there are limits on how far back an insurer can look at an applicant's health history for purposes of imposing a pre-existing condition exclusion. This law also permits a person to go from a group health plan to an individual health plan if they meet certain conditions. Again, as with employment laws, there may be laws in your state that provide greater protections.

How to Get Assistance

Please contact the Cancer Legal Resource Center at 919 S. Albany St., Los Angeles, CA 90015 or call 213-736-1455. Our Fax number is 213-736-428 and email address is clrc@majordomo.lls.edu. Please visit our web site at www.wlcdr.org.

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 congratulate him and wish him well.*

Editor's Note: Barbara Ullman Schwerin, Esq. is the Director of the Cancer Legal Resource Center and an Adjunct Professor of Law at Loyola Law School in Los Angeles, California.

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