



**S•P•O•H•N•C**

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

## **FINE NEEDLE ASPIRATION OF NECK MASSES**

JONAS T. JOHNSON, M.D

### **Introduction**

Fine needle aspiration biopsy (FNAB) is widely used to help in the diagnosis of abnormal masses. It is especially applicable to evaluation of lumps in the neck because these masses are often close to the skin, allowing the physician to feel (palpate) them. Under these circumstances the FNAB can be accomplished with local anesthesia in the physician's office. FNAB should be considered a diagnostic test. The accuracy of the test will depend upon the ability to acquire representative cells from the mass in question. The cells obtained must be of sufficient quality and quantity to allow the cytopathologist to identify them. As is the case with all medical tests, there does exist the possibility of false positive interpretation, false negative interpretation, and non-diagnostic findings.

The practice of cytopathology is best reflected in the example of the PAP smear. Cells are scraped off and spread onto a glass slide, stained and then interpreted by the cytopathologist. The use of a fine needle to obtain cells differs from the PAP smear in as much as the cells must be broken off the mass in question and then aspirated into the inside of the needle. They are then expelled from the needle using a syringe onto a glass slide. Physicians recognize that fine needle aspiration provides the pathologist with only cells without an opportunity to interpret the relationships of the cells to one another and to other normal or surrounding tissues. Therefore, FNAB may be inadequate to make some diagnoses that require that the whole tissue be submitted to the pathologist.

In the past, core needle biopsy, a percutaneous (through the skin) procedure that involves removing small samples of tissue

using a hollow "core" needle, has been successfully employed thus allowing the pathologist a bigger piece of tissue to examine. However, it is infrequently used in the head and neck because it is more painful, it may be associated with bleeding or injury to vital structures and there have been reported incidents in which the needle tract was seeded with tumor. These problems rarely or never happen with FNAB.

### **Indications**

FNAB may be appropriately used in almost any soft tissue mass. It is generally not used in bone because the needle cannot perforate the bone. Additionally, FNAB is rarely used in vascular masses because all you would predictably obtain would be blood.

### **Thyroid Nodules**

The greatest experience with FNAB is in the diagnosis of thyroid nodules. The accuracy is well over 90%. In every instance, it is necessary that the needle aspiration actually acquire cells for the cytopathologist to be able to render an interpretation. When blood is obtained, the cells of importance might be so diluted as to make them unidentifiable. A good aspirate can usually be interpreted to be in one of four categories.

1. Normal/Benign
2. Malignant/Cancer
3. Follicular/Suspicious
4. Non Diagnostic

Patients with benign aspirates can be safely followed. Progression of the nodule (increasing size or new symptoms) should provoke reevaluation. Aspirates interpreted as malignant should undergo appropriate treatment. Aspirates interpreted as follicular or suspicious generally require biopsy. In the case of thyroid malignancy, thyroid lobectomy is required. The removal of the entire nodule with surrounding thyroid tissue then allows the pathologist a better opportunity to render a final diagnosis. Non-diagnostic aspirates generally require further evaluation. This could be repeat aspiration, close follow up, or removal of the nodule.

### **Salivary Gland Nodules**

Fine needle aspiration of a mass in a salivary gland (parotid, submandibular gland) is frequently employed. A wide variety of pathologies, which may occur in the salivary glands, and the relative rarity of these conditions make interpretation of the cytopathology more difficult. In experienced hands, accuracy of salivary gland is above 85%. Both false positives (calling something cancer when it is not) and false negatives (calling something benign when it is cancer) do occur and emphasize the

FNAB continued on next page



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COMING IN OCTOBER, 2003  
Microvascular Reconstruction Following  
Removal of Head and Neck Cancer  
William M. Lydiatt, MD

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importance of recognition that FNAB is only a test and does not in and of itself establish the diagnosis. I recommend that the sacrifice of a normal vital structure such as the facial nerve should not be undertaken based on FNAB alone. The needle biopsy results are often best corroborated by a biopsy before performance of a deforming procedure is planned.

**Lymph Nodes**

FNAB is commonly used to help the clinician to focus his evaluation and diagnostic approach to identify the cause of an enlarged lymph node. Benign hyperplastic (enlarged) lymph nodes may be secondary to inflammation. Often the inflammation is non specific and unidentified. In general, benign enlargement of the lymph nodes is far more common in children and young adults than in older adults. Cancer may exist in a lymph node either as a metastasis from another source (a primary) coming from another site or a tumor originating in a lymph node that may be a lymphoma. A common example would be Hodgkin's disease.

When a patient presents with an enlarged lymph node, it is appropriate for the doctor to locate the site of infection or tumor. FNAB may focus on that inquiry. Once again the doctor must be continually alert to the fact that the FNAB is only a test. Both false positives and false negatives exist. Some low-grade lymphomas may look very similar to the cells found in a benign lymph node. Special techniques are required to establish the diagnosis of a lymphoma based upon needle aspiration. Accordingly, an actual biopsy may be appropriate and required in many circumstances.

On occasion, FNAB will result in the aspiration of cyst fluid. This should be interpreted with caution because some metastatic cancers result in development of a cystic cavity in the middle. The presence of the cyst fluid dilutes the aspiration enough as to make it difficult for the pathologist to identify the cancer. Accordingly under most circumstances, the cyst should be removed. This, of course, allows the pathologist an opportunity to see the entire lesion.

**Technique**

FNAB is almost always accomplished on an outpatient basis. Masses that can be readily felt (palpated) can be localized with the hand. When the abnormality in question cannot be adequately palpated, some form of needle guidance may be required. This is frequently encountered when an abnormality is found on a scan, which was not otherwise appreciated by either the physician or the patient. Under these circumstances, the FNAB can be achieved by using either ultrasound or CT guidance. The abnormality is then localized and the needle is directly inserted into the mass under such guidance.

The skin overlying the intended aspiration is generally anesthetized with lidocaine. The mass is then immobilized with the hand and a needle is passed into it. Generally, the needle needs to be moved in a to and fro direction to break off some cells which can be aspirated with negative pressure into the inside of the needle. Most physicians do a minimum of two or three passes.

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Contamination with blood is generally an indication that the specimen will be non-diagnostic and should be repeated. Between aspirates and at the complication of the procedure, the needle site is compressed gently for five to ten minutes. This is similar to the procedure performed after taking a blood sample. A bruise or bleeding is unusual and even a band-aid may often be unnecessary.

Once the physician has obtained some cells (a specimen), they should be quickly expelled onto a glass slide. A thin layer of cells is obtained by rubbing two slides together, which are then quickly fixed in an appropriate solution and stained.

The slides are then transported to the pathologist. A stain will be performed which enhances the pathologist's ability to interpret his findings. Under ideal circumstances, a verbal report should be available within a few hours. Transcription of a written report will often add a day or two.

#### Consumers Beware!

FNAB has been developed and refined to serve as an important test in the evaluation of soft tissue masses. It may not be a substitute for a biopsy. The provisional diagnosis rendered by FNAB should be consistent with the clinical findings. Errors are relatively unusual, but may be due to inadequate sampling of the mass. Recall that only a few cells are taken out with the needle biopsy. Under some circumstances, the sample may be obtained from the wrong portion of the tumor. Additionally, some pathology may not be evident on FNAB. Accordingly, it is essential that the findings of the FNAB be consistent with the clinical situation. A regular biopsy may be required before the patient and his physician can be confident in the diagnosis and subsequent therapeutic choices.

*Editor's Note: Jonas T. Johnson, M.D. is a professor in the Departments of Otolaryngology and Radiation Oncology at the University of Pittsburgh School of Medicine. Dr. Johnson is also a professor in the Department of Oral and Maxillofacial Surgery at the University of Pittsburgh School of Dental Medicine. He presently serves as Vice Chairman of the Department of Otolaryngology.*

## Cancer Trials Support Unit (CTSUS): A Web Based System That Offers Efficient and Effective Tools for Clinical Trials Management

In 1996, the National Cancer Institute (NCI) and its Board of Scientific Advisors convened the Clinical Trials Program Review Group to evaluate NCI-sponsored, extramural clinical trial programs. Based on the Review Group's recommendations, the NCI created a pilot project called the Cancer Trials Support Unit (CTSUS).

The CTSUS aims to increase physician and patient access to Phase III cancer treatment trials, most of which are led by the Clinical Trials Cooperative Groups. One of the ways the CTSUS accomplishes this is through providing cross-Group access to selected Phase III NCI-sponsored trials. This means Cooperative Group members are able to enroll eligible patients for any CTSUS trial that is not available through their own Cooperative Group. Currently, the CTSUS has 40 active studies and 40 studies in development. Initially, the CTSUS protocol menu included protocols from 5 disease areas – gastrointestinal, genitourinary, lung, breast, and adult leukemia; however, the CTSUS has expanded to include other diseases such as melanoma, head & neck, multiple myeloma, and some rare cancers.

Beginning May 18, 2002, the CTSUS opened its protocol menu to qualified medical, radiation, and surgical oncologists and hematologists within the USA who are not Cooperative Group members. The new policy allows cancer patients anywhere in the USA to participate more easily in advanced (Phase III) treatment trials. More information can be accessed on the public side of the CTSUS web site (<http://www.ctsus.org>).

A unique aspect of the CTSUS is its foundation in the web. All CTSUS members have access to protocols, protocol-specific forms, and patient educational materials on the members' side of the CTSUS web site (<http://members.ctsus.org/>). Protocol-specific materials that are provided on-line include the following: IRB submission

application template, protocol overview, protocol-specific time and events schedule, protocol instructions, a pocket-sized protocol card that outlines the eligibility requirements and treatment plan and Patient Education Pages (PEPs) that explains patients options for treatment in a patient-friendly language.

An important benefit of the CTSUS has been the availability of several web-based educational offerings. These training programs and tools can facilitate the enrollment of patients on CTSUS trials. The CTSUS offers an on-line educational program that can be accessed via the public side of the web site (<http://www.ctsus.org>) called *eCourse*. This program provides both novice and experienced research staff with a convenient method of learning about participation in clinical trials through the CTSUS. A CTSUS process checklist is also available on the web site as an easy-to-follow flowsheet that provides instructions on how to successfully register and enroll a patient via the CTSUS. A Frequently Asked Questions (FAQ's) link offers answers to common questions about the CTSUS.

Also, the CTSUS offers a Patients Page on the public side of the web site. This page contains resources specifically for patients seeking information about cancer and available clinical trials, including links to: NCI web sites that offer disease-specific, treatment, and support information for patients, information on health insurance with links to many of the major providers, a printable list of all currently active protocols on the CTSUS menu, Cooperative Group web sites, and protocol abstracts from the National Cancer Institute's PDQ database, including access to patient and health professional versions of the abstracts.

For more information, visit the CTSUS web site at [www.ctsus.org](http://www.ctsus.org), contact the CTSUS Help Desk at 1-800-823-5923 or by email at [CTSUSContact@westat.com](mailto:CTSUSContact@westat.com).

## A TIME FOR SHARING

Whenever it comes, a cancer diagnosis has to be one of life's rudest interruptions. For me, the bad news came at the end of what had been the biggest and best year of my life, a year of profound, powerful and long-awaited change for my husband and me. And in that sense, hearing that I had cancer seemed like more than a rude interruption to my new life. It seemed like awakening from a wonderful dream into a terrible reality.

In January, 2000, after years of frustrating failures and dashed hopes, my husband and I were poised at last to become parents—and not just once, but twice! That month, we would bring home our first child, a beautiful 13-month-old girl, born in the People's Republic of China. And less than eight weeks later, I would give birth to our second child, another healthy girl.

"A toddler and a newborn!" people would exclaim to us. "Wow, is your life going to change!"

We knew it, and we welcomed the change. By spring, we were plunged deep into the daily realities of parenthood—diapers and two a.m. feedings, first smiles and first steps, story books and sticky kisses.

As summer deepened, we hit our stride, enjoying neighborhood walks with our two-seat stroller. "Are they twins?" passers-by would ask, before they had a chance to peer beneath the sunshade and see a bright-eyed Asian tot and a sleeping blonde baby. "Well, sort of," we would answer, enjoying the quizzical looks we'd get when we would add, "They actually came seven weeks apart."

Fall brought singular pleasures—apple picking with our one-year-old, tiny Halloween costumes for both girls, a Thanksgiving that found us more thankful than we had ever been in our lives.

And as the winter holidays approached, we anticipated the joys which that season, too, would bring—perhaps more to an eager pair of first-time parents than to their Christmas-uninitiated children. Even a slight toothache at the lower right rear of my mouth didn't bother me too much. I had once had a cracked molar that produced the same sensation, and since I had a routine dental visit approaching in January, I decided to live with the mild pain.

The sensations and discomfort increased,

however, and on December 17<sup>th</sup>, our wedding anniversary, I peered into a mirror to see if I could find the tooth that might be causing the problem. When I lifted my tongue, I was shocked to see a pattern of white, curd-like patches on its underside. My first thought was that I had thrush. I was still nursing our infant, and I had read that nursing mothers and their babies could pass the fungal infection back and forth to each other. But why had I never seen any signs of thrush in my daughter? And why would the infection be in my mouth?

I called our family doctor for an appointment at the first of the year, and spent that Christmas painting the patches with tea-tree oil and other over-the-counter antifungals. I had a nagging bad feeling about the whole thing, but put it aside to celebrate Christmas and our older daughters second birthday, her first with us.

"It sure looks like thrush," said our family doctor at my appointment on January 3<sup>rd</sup>. That was welcome news to me—a fungal infection was something I could cope with. But my doctor remained serious. "There's no reason that a healthy young woman should have oral thrush unless she is seriously immune-compromised," he told me, adding that he wanted me to have a complete blood count, plus tests for HIV, Hepatitis C.

I awaited the results of those tests without much anxiety, actually. We had had the same workup as part of our fertility testing and the results had always revealed excellent health. But the sense that something was indeed wrong continued to mount, particularly as the prescription anti-fungal medicines had no affect on the white patches in my mouth. My right ear began to ache, too.

In late January, as my family doctor contemplated our next step in diagnosing and treating the problem, I went to the routine dental cleaning and exam I had scheduled months before. Not wanting to surprise the dentist, I told him that I had oral thrush, and that I was under a doctor's care for it. "They've ruled out everything scary," I added, wanting to reassure him in case he was concerned that I was HIV-positive." His exam took several minutes, after which he leaned back with a concerned look on his face. "Exactly what scary things did they rule out?"

he asked. "Did they do a biopsy?"

Those questions marked the beginning of my foray into the world of cancer diagnosis and treatment. The dentist explained that the white patches on my tongue were likely not the root problem—of far greater concern, in his view, has a thick, hard lump on the underside of my tongue and extending on the floor of my mouth. "If I were you," he said, "I would have a biopsy of that lump immediately. Please don't wait."

I didn't. I tore back to my family doctor and insisted he refer me to an ENT for the biopsy. That procedure was scheduled for two weeks later. I occupied the wait by reading up on oral cancer, at least in my calmest and most mature moments. But I also panicked a great deal and railed against a universe that would give me what I had wanted for so long—two beautiful daughters—only to threaten to take me away from them after less than a year.

And I worried. Would my husband be able to raise our girls alone if he had to? How badly would it affect my girls to grow up without a mother? "Don't buy trouble," many advised me. "Wait and see what the doctor says." I came to hate that advice—so easy to give when one isn't facing the specter of cancer.

My reading and research told me that a cancer diagnosis was a strong possibility, so when the news came, three days after my biopsy on February 16, 2001, I wasn't really surprised. In fact, I was a little relieved. Knowing was so much better than being in limbo.

My husband and I swung into action. We interviewed a few surgeons and radiation oncologists, setting on a head and neck surgeon we trusted completely, at a large university medical center down state. My surgery was scheduled, and we were told that the results of the surgery—in particular, the neck dissection and pathological exam of my lymph nodes—would determine whether and what kind of follow-up treatment I would need. One positive node and I would add a thirty-day course of radiation to my cancer battle plan.

We arranged for child care and for time off work for both of us. And before dawn one

March morning, I kissed my sleeping girls and we made the three hour drive downstate for my surgery.

I awoke from the nine-hour surgery on Saturday, March 10—my younger daughter's first birthday. Thank goodness that a physician friend of mine had earlier taken the time to explain that I would find myself in intensive care for a few days and that I would be on a ventilator for a time and festooned with tubes leading from nearly every quarter of my body. My surgeon had glossed over these "details," perhaps because they seemed minor to him.

I spent two days or so focused on nothing but recovering from the surgery. A tracheotomy prevented me from talking, and painkillers kept me pretty groggy, but friends and family visited and kept me company. By the third day, feeling more human, I shifted my focus to the results due in from pathology.

Had the cancer spread? If so, how far? My husband had explained that the surgery went well, yielding "clean margins" all around, but I knew the pathologist would have more to say.

One evening my surgeon appeared, smiling. "I have good news for you," he told my husband me. "Your lymph nodes are all clear!" My husband and I embraced, I cheered silently—still prevented from speaking by the trach—and mouthed a heartfelt thank-you to my surgeon.

After that, I fixed on one goal: getting home to my girls and being there for them until they were grown. My surgeon explained that my odds of a recurrence were as low as we could hope, but still not negligible. Close monitoring would be necessary to catch any regrowth or secondary tumors early. And part of my skin graft had failed, creating a speech

impediment that necessitated therapy and will eventually call for another surgery. But I knew in my heart that I was headed exactly where I wanted to go, back home, back to a life where potty training and a perennially stretched budget awaited me. What could be better?

Now, two years-plus past my diagnosis, I am still vigilant about my health, and probably always will be. Through diet and exercise I've lost thirty pounds and have a new appreciation for taking care of myself. But in other ways, I've slipped completely back into familiar and comforting patterns of life as a wife, a mom a sister, a daughter, a friend and a coworker. My life is indeed back to wonderfully normal. It's as though I can look around me on any given day and say, "Where was I before I was so rudely interrupted?"

*Lissa Hunt*  
South Bend, IN

## Cancer Care 101: Treating the Illness, Treating the Person By Martin L. Rossman, MD

You can't know where life will take you, but you can commit to a direction.

—Wendell Berry

### Introduction

The way you use your mind can make a huge difference in what happens to you; the evidence points to effects that range from improving your emotional well-being to reducing adverse effects of treatments, to surviving, even thriving, through the experience.

For the past thirty years I have helped people with cancer harness the power of their minds to fight their disease, find their strengths, make the best of treatments, and meet the challenges a significant illness brings. While many of the skills you will learn have other uses in life, my focus is to use them to meet the challenges of cancer.

Cancer is many diseases, and the first thing most newly diagnosed people need to know is that having cancer does not mean they will die from it. More than 50 percent of cancers diagnosed today are curable through conventional medicine alone, and as many cancer patients get well as succumb to their illnesses. While you are alive you have hope, and you have options. You have will, imagination, and powerful natural healing abilities within you that you can stimulate by the use of your mind.

In cancer care there are two complementary goals of treatment. One, the usual medical goal, is to kill cancer cells and tumors, or reduce their numbers and their ability to grow, reproduce, and spread (metastasize). The other, perhaps best called the healing goal, is to support the well-being and resistance of the patient. Here I use resistance to stand for all the mechanisms, known and unknown, that protect us from the development and dissemination of cancer.

Conventional medical care for cancer has for many years concentrated on destroying tumors without paying much attention to supporting the patient as a whole person, with innate healing capacities. Until recently, most people put themselves in the hands of an oncologist (cancer specialist) and did what they were told. While you almost certainly need a good oncologist to prescribe and monitor your medical treatment, there is often much more to surviving cancer.

Charles Smith, M.D., is a prominent urologist who specialized for years in treating men with prostate cancer, and then developed aggressive prostate cancer himself. After going through treatment, he wrote: "Cancer

is not just a lump in your body that can be cut out or killed by radiation or drugs. It alters every aspect of your life. Time and time again patients would tell me this. Some would even say that, in the end, it was the best thing that ever happened to them."

Dr. Smith points to a major problem with the conventional approach to cancer. While it aggressively attempts to eliminate cancer cells, it does little or nothing to promote the health, vitality, and well-being of the person who is fighting that cancer. A poorly nourished, poorly supported person with cancer, overwhelmed by emotions, is likely to have a much more difficult time than one who is better nourished, better supported, and better balanced emotionally.

Years ago I moved into a new house with my wife and infant daughter. Next to the back windows around the baby's room there were a number of ailing bushes. Not being much of a gardener, I called one in. A leather-skinned fellow looking twice his actual age said that the bushes had four different infestations and needed to be sprayed with four different chemical pesticides. When I asked him if they were toxic, he lit up a cigarette and looked at

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me as if I was from Mars. "Nah," he said, drawing deeply on his smoke, "I've been using them for years and they haven't bothered me none."

Having a small child, I got a second opinion from an organic gardener, a pleasant young man who carefully examined the plants and their environment. He agreed completely with the diagnoses made by the first gardener, but his approach to treating them was quite different. He said, "These plants are pretty sick, but they haven't been well cared for in some time. Let's give them what they need and see what they can do on their own." He then showed me how to prune the deadwood, aerate the soil, fertilize the plants, and get them on a regular watering schedule. In four months the bushes had regained their health and threw off the infections themselves. The next year, they even produced beautiful blossoms.

The difference between the approaches of these two gardeners is a perfect analogy for a strictly medical versus an integrated approach to cancer care. The plants may still have needed pesticides if they weren't able to recover themselves, but they would probably have needed smaller doses and fewer than the first gardener recommended. In the same way, you may well benefit from medical and surgical treatment, but you are likely to do much better with all therapies if your basic needs are attended to as well.

Supporting your innate healing abilities can only help you make the best use of any treatment you choose, and, alternatively, neglecting them is likely to make it more difficult for any treatment to work. As the second gardener said to me, "You know, if these plants don't get regular water and proper nutrients, all the pesticides in the world won't be able to cure them."

Supporting your health and eliminating your disease are two complementary approaches to healing that support and strengthen each other. In my experience, neither one works as well as both together.

You can use this analogy to see if there are any changes in your life that would support your own healing more effectively. Is there "dead-wood" in your life — areas where you put energy that does not produce something of value to your well-being? Can you eliminate any of it? Are there pests and parasites that can be picked off? Are you giving yourself good nutrition and enough water on a regular basis?

Is there an appropriate balance of light (joy) and shade (rest) for you? What could you do to make that balance more enjoyable for yourself?

Supporting your health makes it easier to tolerate treatments that can sometimes be difficult, and that in turn increases the likelihood that the treatments will work as desired. Methods of supporting your health and enhancing resistance to cancer generally fall into three categories: (1) nutritional support, ranging from improvement of diet to sophisticated individualized programs of nutritional supplementation with vitamins, minerals, herbs, essential fatty acids, and natural biological response modifiers; (2) mind-body approaches, ranging from support groups to counseling, to meditation, stress reduction, and guided imagery practices, and body-mind practices such as yoga, chi gung, tai chi, Jin Shin Jyutsu; and (3) systematic approaches with time-honored healing systems, such as traditional Chinese medicine or Ayurvedic medicine.

While the methods differ, their goal is the same — supporting and stimulating the vitality and function of the innate healing systems of the body, mind, and spirit. This idea is an ancient one, which perhaps we lost sight of in our enthusiasm for what modern medical treatment might be able to do. In traditional Chinese medicine this is known as fu zheng therapy. Fu zheng translates as "supporting the righteous." In China, fu zheng is not the sole therapy for cancer, but it is a useful complement to both traditional and modern means to eliminate tumors and cancer cells. Many studies have shown that good nutrition, herbs, acupuncture, and mind-body approaches are all effective in reducing adverse effects from conventional treatments, and very likely in improving treatment results.

*Editor's Note: Martin L. Rossman, M.D., is the co-founder and president of the Academy for Guided Imagery and is on the faculty of the medical school at the University of California, San Francisco. He is the author of Guided Imagery for Self-Healing and Fighting Cancer from Within: How to Use the Power of Your Mind For Healing, from which the foregoing is an excerpt. For more information please visit [www.fightcancerwithin.com](http://www.fightcancerwithin.com)*

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## In Tribute to a Charter Member of SPOHNC



Julianna Clyne (Bobbie)

On September 10<sup>th</sup> 1991, nine survivors of oral and head and neck cancer gathered together to share their experiences and help one another cope with their diagnoses and cancer treatments. Bobbie Clyne was one of these original nine members of Support for People with Oral and head and Neck Cancer.

Bobbie had attended other cancer support groups, but she felt "at home in the SPOHNC group. It felt good to be part of a group of people with similar problems and receive moral support, information and camaraderie," she said.

Bobbie continued to be an active participant at SPOHNC meetings through May of 2003. She was an inspiration and a friend to all who knew her in person, by phone and by email. She was an example of a survivor who offered others the moral support, information and camaraderie that she once sought. On June 22, 2003, Bobbie Clyne lost her fifteen year battle with cancer. She will always be remembered for her smiling face, her words of encouragement and the love she gave to all.

SPOHNC has indeed lost a very dear friend.

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