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

MICROVASCULAR RECONSTRUCTION FOLLOWING REMOVAL OF HEAD AND NECK CANCER

WILLIAM LYDIATT, MD

Cancers of the head and neck arise in areas that are critical in terms of both form and function. Healthcare professionals that deal primarily with head and neck cancer patients acutely understand the importance of returning patients to as near normal form and function as possible. The advent of microvascular reconstruction has aided us greatly in this all important endeavor. This article will briefly review the history of microvascular reconstruction, some of the technical details important to its success, and the various options available for reconstruction.

The goal of the head and neck oncologic surgeon is complete removal of the cancer. Since these cancers arise in very critical areas removal of normal and vital structures may also be necessary. Surgeons have sought for hundreds of years to reconstruct and replace parts that have been removed because of cancer or trauma. Reconstructive options have included using adjacent tissues, various types of foreign tissues and also muscles that can be kept intact with their blood supply and moved to replace tissue that has been ablated.

Microvascular free flaps were first described in 1959, by Seidenberg, to reconstruct circumferential defects following removal of the entire throat using a segment of jejunum (small bowel). Many technical difficulties had to be overcome before this technique became widely available and the next 20 – 30 years saw tremendous advancement in the area of microvascular free flaps, including the improvement in operating microscopes and microvascular instrumentation particularly in the very small needles and thread used to sew the blood vessels back together. The thread is smaller than human hair and the needle also cannot be much bigger than the thread to avoid leakage from the hole. These technological advancements

helped to revolutionize head and neck reconstruction.

In general, the head and neck reconstructive surgeon must consider many factors in deciding which reconstructive method will be best for the patient. For example, the surgeon must consider what type of tissue will be removed and if a like tissue is available for replacement. When skin is removed, skin with similar texture and color is best.

If bone is removed, it is best to have bone for replacement. When a significant amount of tissue or muscle has been removed, replacement with a similar type, consistency and size of tissue is sought. The surgeon must consider the source of this tissue and what kind of disability will result when it is removed. This problem is called donor site morbidity. Generally, the surgeon seeks to take tissue that results in a relatively small degree of disability in order to reconstruct an area where the disability could be greater without the reconstruction.

The microvascular reconstruction of head and neck cancer defects requires much preoperative, intraoperative and post operative planning and coordination of care. This type of operation utilizes the concept of removing tissue from one portion of the body and completely severing it from any blood supply, thus creating a free tissue flap. The free tissue flap is then transferred to the area of need. The site where the flap is removed or harvested is called the donor site. The site where the flap is placed is called the recipient site. Often two surgical teams are utilized to decrease the amount of time the patient spends under anesthesia. Intraoperatively, after the patient is asleep in the operating room, the patient is positioned so that both surgical teams can operate safely and effectively at the same time. The ablative surgeon, or cancer surgeon, removes the cancer and gives an estimate as to the size of defect that will be needed for reconstruction.

Frozen sections, the technique of having a pathologist actually look at the margins of resection to make sure that cancer has been completely removed, are done before the reconstruction is performed to be as certain as possible that all cancer has been removed. Next the surgeons shape the free flap, particularly a bony reconstruction, to fit the necessary defect. This is called inseting the flap. The vascular supply is then reconstituted. Typically a branch of the external carotid artery is used to provide arterial inflow, bringing nutrient and oxygen rich blood into the flap, and the vein is connected to a major vein, such as the internal jugular vein to allow venous blood to return to the circulation. The time between clamping the vessel while harvesting the flap, which is the last thing done in harvesting, to when the clamps are released from the blood vessels in the neck and blood begins to return is called the ischemic time. Most flaps will tolerate ischemic times on the order of three or four hours but we seek to keep these times under two hours. Sewing the blood vessels generally requires some form of magnification either using an operating microscope or magnifying glasses.

Generally neck drains are used during and after surgery to

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COMING IN NOVEMBER, 2003

Sinus Malignancies
Lisa T. Galati, MD

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remove excess fluid and the small amounts of blood which continue to accumulate in the neck for several days. This helps to prevent wound complications. Antibiotics are also used to decrease the risk of wound infection. Many surgeons also use some kind of blood thinning agent to prevent blockage of the flap blood vessels.

A tracheotomy is often performed if there is concern about swelling and subsequent breathing problems. In many cases the tracheotomy tube can be removed after three to seven days depending on the swelling. Patients are encouraged to get out of bed as quickly as possible after surgery and begin walking. The exception is after a free fibula flap, when a skin graft is required to the lower leg. These grafts make walking in the first week after surgery somewhat more difficult and many surgeons prefer that patients stay with their legs elevated for at least five days.

In general, the advantages of microvascular free flaps include the ability to more closely approximate the needs of the defect, diminish the donor site morbidity, and allow excellent reliability and an unlimited arc of application. Postoperative radiation therapy has been shown both experimentally and clinically not to have a major negative impact on free flap survival. Advanced age in general is not a contraindication for the use of free flaps. Operative time may be longer using free flaps, however if the operation can be kept under approximately eight hours it does not seem to have a significant impact on the survival of the individual. In general, flap survival is on the order of 95%.

Types Of Free Flaps Available

There are many different tissues that can be used as free flaps. Several of the most commonly utilized flaps and their applications and advantages, as well as their donor site morbidity are described below. The four flaps that we will concentrate on are the fibula, radial forearm, jejunum and rectus abdominis.

Fibula

Cancers of the floor of mouth and tongue, particularly those that present at a more advanced stage, frequently involve the lower jaw (mandible). Loss of this vital bone creates a major functional and cosmetic deformity. The cartoon character Andy Gump was a cruel portrayal of just such an individual. This man tried unsuccessfully to sue the cartoonist Sidney Smith for damages attesting to the psychological impact this defect had on his self-image. Today it is rare for anterior mandible defects not to be successfully reconstructed. Mandibulectomy, or complete removal of a portion of the lower jaw or mandible, presents a huge problem because the tongue is anchored to the mandible and has very poor function without being fixed to the mandible.

While reconstruction can be performed using a bone tray, bar, or cadaver mandible, these have a much higher rate of failure due to infection and erosion. Pedicled flaps, meaning the blood vessels are kept intact and a muscle is brought up, (for example the pectoralis major muscle) have the disadvantage of being very bulky and not possessing bone.

In 1989, Dr. David Hidalgo reported on the use of a free fibular graft in an effort to improve mandibular reconstruction. This flap had been previously described approximately 15 years earlier for long bone defects. The fibula is a bone in the lower leg that does not support weight. It is approximately the same size as a small mandible, has an excellent blood supply and can be cut to shape it to the

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MICROVASCULAR continued from page 2 appropriate contour of the jaw. Dental implants can also be inserted to provide dental rehabilitation as well. The donor site morbidity is generally limited to use of a skin graft to replace some of the skin when that is needed for reconstruction. Wound healing problems and numbness of the portions of the foot can commonly occur.

Radial Forearm

Another extremely versatile and reliable flap is the radial forearm free flap. This flap consists of skin, subcutaneous tissue and a tough covering tissue called fascia along with the radial artery and accompanying veins. A variable amount of tissue can be removed from the under surface of the forearm, and a skin graft from the leg is then used to cover the donor site defect. The radial forearm free flap can then be used to reconstruct large soft tissue defects. This is frequently used to cover large skin defects where a local flap is not feasible, or large areas of the floor of the mouth. It is also used to reconstruct portions of the tongue because it allows more flexibility of the remaining tongue thus improving speech articulation and swallowing function. It can also be used to patch or rebuild portions of the throat following large resections of the larynx and pharynx, and it can be tubed to reconstruct total defects of the pharynx. This flap is very pliable and robust with a very high success rate. It can also be taken with part of the radius, one of the major lower arm bones, if bone is needed.

Complications associated with the radial forearm flap include exposure of the tendons of the arm, contracture or scarring with decreased strength and mobility of the fingers. When the bone is harvested, there is a 5% risk of fracture. Therefore, if possible, the non-dominant arm is used.

Preoperatively, the surgeon will often perform a test to make sure there is blood flow from both of the major arteries to the hand. This is called an Allen's Test. The surgeon will ask the patient to make a fist three times, then hold it tightly while the surgeon squeezes the wrist at the two pressure points which are the entries of the radial and ulnar arteries. The surgeon will then release the ulnar artery and watch the hand to make sure that it has return of color signifying flow through the ulnar artery. Some individuals only have flow through their radial artery and therefore removal of a flap is contraindicated, but this is unusual.

Rectus Abdominis

When more bulk is needed than the radial forearm can provide and a very large area of skin or soft tissue is needed the rectus abdominis free flap is an excellent choice. The rectus abdominis muscle is one of the paired muscles of the lower abdomen. Complications of this flap removal include hernias and a weakness of the lower abdomen. This flap provides a large amount of skin and subcutaneous tissue available with a single vascular anastomosis (connection).

Jejunum

As first described by Seidenberg, the jejunum, or middle portion of the small bowel, provides an excellent tube of healthy tissue that can be used to reconstruct total pharyngectomy defects. There is less need for a long suture line than a tubed radial forearm, however the morbidity of an abdominal operation can be more significant and troublesome than the radial forearm defect. Nonetheless, it still provides an excellent means for pharyngectomy reconstruction and is an important flap to have available.

Other Flaps

There are many other flaps which can be used

to do many of the same things as the four described above. Examples include the iliac crest flap which can also bring both soft tissue and bone for reconstruction of the upper and lower jaw. The latissimus dorsi, a large muscle from the back, can do similar things that the rectus abdominis can do although it does require some planning and patient positioning during the operation. There are also a number of other flaps similar to the radial forearm that incorporate skin and fascia.

Conclusion

The versatility of the microvascular tissue transfer affords excellent options from the reconstructive surgeon's standpoint to maintain as much form and function as possible. These reconstructions are major operations requiring technical expertise and resources. The required hospital stays are generally on the order of seven to twelve days and complications, although uncommon, can be significant.

Editor's Note: William Lydiatt, MD is Associate Professor of Otolaryngology-Head and Neck Surgery and a board-certified otolaryngologist-head and neck surgeon at the University of Nebraska Medical Center. Dr. Lydiatt is a co-author of the book entitled, Cancers of the Mouth and Throat: A Patient's Guide to Treatment.

SPOHNC NEEDS YOU!
 Become part of SPOHNC's new
NATIONAL SURVIVOR VOLUNTEER NETWORK (NSVN)

If you are a survivor of oral and head and neck cancer you know the importance of reliable information. You may also have gained strength and resolve from the support and encouragement of others who "walked in your shoes." If so, we invite you to share the wisdom you have gained from your personal experiences with others.

If you...

- are a survivor of oral and head and neck cancer
- have the desire to help others
- have good listening skills
- have good telephone communication skills
- have the ability to use a computer and to send email
- have a willingness to learn about different types of oral and head and neck cancer, their treatments and side effects of treatment as they affect quality of life
- are willing to participate in teleconference training calls
- are a member of SPOHNC

...then we encourage you to contact SPOHNC by
 phone at 1-800-377-0928 or by email at info@spohnc.org.

SPOHNC's goal is to have a minimum of two survivor volunteers in each state to provide up-to-date information and offer support and encouragement to fellow oral and head and neck cancer survivors.

WE LOOK FORWARD TO HEARING FROM YOU.

A TIME FOR SHARING

For twenty years I have been a firefighter/paramedic with the Arlington Fire Department. During my career I have had numerous occasions to provide assistance to people in their time of need. People have called 911 for my assistance with fire, medical, and hazardous materials emergencies. I have provided training to Arlington County, VA citizens on fire prevention, and medical emergency response. I took an active role in public education, first aid and CPR training. My job as an emergency healthcare provider gave me personal satisfaction and attachment to a group of individuals with remarkable dedication and commitment to service.

The fire department was where I worked and lived during 24-hour shifts away from my family. My wife and two young children learned the meaning of patience when the fire department work schedule prevented or delayed a school or social activity. I tried to balance my family priorities with my commitment to public service. I took pride in my job and the personal satisfaction it provided.

I was a four-sport athlete in high school and active in sports at college. My firefighting job demanded that I be physically fit and prepared to perform during times of fatigue. I was always active in my department's physical conditioning program of aerobics and strength training. The conditioning program became a positive routine and provided the extra energy I needed to perform my job and be active in my family's leisure pursuits. I prided myself in my body's ability to remain healthy and not to succumb to the many illnesses of those patients I was assisting.

In early 2001 my life was affected by two major events that occurred. First, I reached one of my career goals when I was promoted to a Fire/EMS Captain. Second, I was diagnosed with throat cancer.

I had developed a sore throat and sought treatment from my health HMO. On two visits physicians informed me that I should follow a dose of antibiotics and that the lump on the right side of my throat would diminish. On my third visit I was referred to an ENT and given a third dose of antibiotics. At the consultation with my ENT I was asked, "Are you a smoker?" I replied that I didn't smoke. "Are you a heavy drinker of alcohol?" I replied I was a social drinker. I was also asked after the physical examination, "Why did you wait so long before seeking treatment?" I replied that I had been seeking treatment for several weeks.

I was informed that my right tonsil

needed to be surgically removed. Five days after the surgery I was informed that I had squamous cell cancer and that I would need a second surgery called a radical neck dissection. I became numb in the office chair at being informed that I had cancer. My mind began to race and fill with multiple questions. How do I tell my wife, children, and family of my illness? How will my family make do without my income? Will I be able to continue in my current occupation? Why is this happening to me? I had made a great effort to keep my body in shape, why is it letting me down? Am I really faced with death or a life-altering decision?

I focused my energy researching the various treatments for my type of cancer. My wife, ENT and I decided the best course of treatment would be surgery followed by radiation treatment.

The second surgery left me weak with numbness of the face, shoulder and right arm. The pain and dryness in my throat was immense and thick phlegm choked me anytime I attempted to fall asleep. I slept very little while in the hospital. I was evaluated by a physical therapist who advised that I would need speech, occupational and physical therapy. "Why occupational therapy?" I asked. She stated, "You don't think that you are going to return to firefighting, do you? Have you considered another career?" I stared at her in disbelief.

I took three weeks to recover from surgery and then met with my radiologist to start radiation treatments. One month after surgery and during the first week of radiation treatments, I started to begin my personal physical rehabilitation with strength and aerobic exercises. It was frustrating to start at a level that would not tax my 10-year-old son. Still a day in the gym was another day that would bring me closer to regaining my strength.

The radiation treatments eventually wore me down. The constant fatigue, loss of appetite, burned skin and the difficulty in swallowing led to the end of my gym visits. I began to lose weight, muscle mass, and strength. In the later weeks of treatment, the trips to the radiation treatment became the focus of the day. I summoned all my strength just to drive the two miles to receive my radiation. My diet was primarily liquid due to difficulty in swallowing. I lost 40 pounds during my treatments and longed for the weekends to receive some respite from the burning on my neck and throat. I cannot describe the relief I felt on the last day of radiation with the hope of beginning a long recovery.

I tried to rest and recuperate, but I could only read so many hours a day and daytime television made me want to go back to work. I was ready to begin the recovery process. I started by walking and using 5 lb. barbells that I borrowed from my son. I was fortunate to have such a loving and supportive wife. She encouraged me to eat and to try multiple blender concoctions despite the pain of swallowing. She went to speak with a nutritionist and tried multiple food combinations to provide me nourishment.

I knew that I had a close, support group in my large family. They showed their support continuously as they pitched in to take care of family and domestic tasks that I couldn't perform. The emotional support was appreciated even more. Additionally, my fire department family changed my bandages, brought me meals and offered me encouragement and work news. It was this support network that helped me through a Spartan regimen of physical therapy. I approached my gym time of aerobics, strength and flexibility exercises as a day at work. Despite the occupational and physical therapists counseling towards another profession, I had made a decision that my goal was to pass the fire department physical exam and return to my previous occupation.

After being off work for six months, I was finally able to return. I successfully passed the rigorous fire department physical exam. My physician gladly signed my return to work release and went on to say that he was amazed at my tenacity and my family support. His last words to me were "You made my day. If at all possible, try not push too hard on your work schedule." He urged me not to work any overtime and suggested that I consider the business career that I trained for in college.

I returned to work on September 3, 2001. Eight days later my department responded to a hijacked airliner crashing into the Pentagon. We responded to the cries for help of victims caught up in the attack. My fellow firefighters performed admirably to assist the many people affected by this terrorist attack. I was proud of the efforts of my department's personnel to persevere in the rescue efforts despite the hazardous conditions. We worked two straight days before our crews were rotated. The emotions ran very high as we worked through the exhaustion. It was twenty-one days before we turned the scene over to the FBI. Fortunately, the Arlington Fire Department did not lose a single firefighter due to the plane

crash, building collapse, and fuel-fed fire that strained our department resources to the maximum.

The federal and local government learned a lot about the emergency response to the Pentagon. The need to establish cooperative response plans has led to my being assigned to the Pentagon as liaison officer. I have been busy the last two years assisting in developing response plans, training and facilitating a cooperative work effort between the Department of Defense and Arlington County. It has been quite a learning process, while

assigned to the “five sided building.” I am in a unique position as a firefighter assisting the Federal Government and military. I am thankful to have the opportunity to use my acquired fire and EMS skills to foster this collaborative effort to prepare for future manmade or natural disasters.

The two and a half years since diagnosis and surgery have been filled with the fear that every cancer patient knows. I have had my share of lumps, needle biopsies and the recurring thought that the cancer might be back. I have a new body with weakness that I

must learn to compensate for and use. I am fortunate that I can currently pursue a career and play ball with my son. I thank God for the blessings of my wife, children, and family. These blessings also include the many dedicated professionals at the Pentagon and the Arlington County Fire Department. God willing, I will take life one day at time and give love and also appreciate the love that I receive from others.

Gilbert Cook
Annandale, VA

Your Role As Strengthened Ally by MITCH GOLANT, PH.D.

The first time I met someone with throat cancer was when I was sixteen. In 1962, I worked on my father's parking lot in Downtown Los Angeles for my weekly allowance.

When I met Tommy, he was parking cars on the lot next door. He had been in the Navy in WW II (he'd lied about his age and joined at 16) and Korea. The way he'd “idle” away time on the ship was by playing chess and smoking cigarettes. I played chess. So, although he was 20 years older than me, we became chess buddies. And, I learned about his life.

Just after I graduated high school, I learned that Tommy had been diagnosed with throat cancer. Being his friend—and knowing he lived alone—I decided to visit him at UCLA Hospital and bring along my chess set. I wasn't prepared for the experience: Tommy couldn't speak except through a tracheal valve; swallowing and eating were painful as a result of surgery and treatment; he seemed thin, weak, and filled with despair. In many ways, the year I spent with Tommy during his recuperation and our playing chess, informed my personal and professional life.

As caregivers of a loved one with oral, head, and/or neck cancer, you must bear witness to the stress of your loved one not only coping with a life threatening illness, but also with an altered facial appearance and the loss or impairment of many everyday but profoundly important functions as a result of treatment. Witnessing your loved one's challenges can be overwhelming for you and can leave you both feeling isolated, alone, afraid, and at times powerless. These conditions are ripe for depression.

For many years, I facilitated support groups for cancer patients and their families at The Wellness Community (TWC) in Santa Monica, California. TWC is the largest non-

profit organization in the United States providing free psychological and emotional support for people with cancer and their families.

Discussions in TWC family groups often focus on how members can help loved ones with cancer fight for recovery without becoming overwhelmed by the burdens of caregiving. One group member, a woman of 62 whose husband was diagnosed with throat and mouth cancer, talked about how she became a “strengthened ally.”

“Once a week, I have lunch with friends,” Helen confided. “I see our granddaughter every Friday. I also visit our youngest son in college as often as possible. When I return from these outings, I feel renewed. That's when I can be a source of comfort to Bill. I'm happy to just hold him, if that's what he needs.” Helen's participation in a support group at TWC—being with others who share her plight—was also a source of strength.

Helen's strategies can work for you as caregiver to a cancer patient who is depressed. Unless you take care of yourself, you won't be at your most effective when it comes to helping your loved one. In fact, individuals who ignore their own needs for the sake of their ill loved one can experience “compassion fatigue” and “burnout.” And that can undermine their best efforts to help their loved one deal with the illness, especially if depression enters the picture.

What Is Depression?

Depression is a biological, psychological, and social illness affecting more than 18 million people. Clinical depression has two key components: profound sadness and hopelessness. Symptoms include changes in sleep patterns, loss of interest in daily activities and hobbies, appetite fluctuations, diminished

productivity, self-medication through alcohol or drug abuse, and thoughts of suicide. Although 90% of depressed people can be helped by a combination of medication and psychotherapy only 30% receive treatment.

While not everyone suffering from cancer experiences depression, sometimes the diagnosis itself can trigger a depressive episode. As you may know all too well, the side effects of treatment—chemotherapy, radiation, or surgery—with potential facial alterations and loss or impairment of the ability to eat, smell, taste, and speak can leave you and your loved one even more isolated and prone to depression.

Burnout

Burnout is the feeling of having reached the limits of your ability to cope. Unfortunately, burnout is common among caregivers, whether their loved one is suffering from a physical or mental illness. According to burnout expert, Dr. Herbert J. Freudenberger, you may be experiencing burnout if you have symptoms such as: headaches, insomnia, backaches, lethargy, lingering colds, gastrointestinal upsets or cardiovascular problems

Burnout also has emotional components. You may find yourself frustrated and angry, empty or sad, pessimistic, resentful, insecure, or depressed.

These are all expectable reactions to feeling stressed beyond endurance. But before you can be helpful to your loved one, you must know how to cope with your own situation.

Becoming A Strengthened Ally

As a strengthened ally, you provide aid and comfort through self-care and knowledge. You understand that a depressed loved one is

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NUTRITION SOLUTION TO GAIN STRENGTH AND RE-GAIN QUALITY OF LIFE

BY TRACY R. SMITH, PhD, RD, LD

“If he only would eat more, I know he’d gain the weight he needs to have the energy and strength to get better,” says a concerned wife speaking with her husband’s doctor. The husband tells his doctor, “I force myself to eat at times, just to make my wife less worried.” This scenario is typical of a condition known as “cancer-related weight loss.”

Weight loss due to cancer is different than weight loss from dieting and exercise. Many people go through life trying to lose weight and stay fit, but with cancer, weight loss isn’t desirable. You, or someone you know with oral, head or neck cancer may struggle with maintaining weight because of the nature and location of the cancer. Eating difficulties may result from treatment or may be associated with alterations in facial and neck appearance, and problems of speech, sight, smell, chewing, swallowing and taste perception.

It’s important for people diagnosed with cancer to maintain their weight in order to have the strength to help prevent complications and continue effectiveness of therapy. In fact, losing as little as five percent of body weight can adversely affect the response to cancer therapy. Slowing or stopping weight loss and rebuilding muscle provides the strength and independence to perform everyday functions and favorite activities.

Understanding Weight Loss

In addition to eating difficulties caused by tumor location, some cancers – especially solid tumors of the esophagus, head and neck – can cause metabolic changes that decrease weight, energy and strength. If metabolic problems are not addressed, simply eating more food or drinking conventional nutritional beverages may not be enough to prevent or reverse the loss of weight and muscle.

A therapeutic nutritional is available that has been clinically tested and may help people with cancer-related weight loss. In fact, a certain fatty acid has been found to play a positive role. EPA (eicosapentaenoic acid) is an omega-3 fatty acid that is effective in stabilizing weight loss in cancer survivors. Two grams of EPA, found in two servings of a therapeutic nutritional product, has been shown to help people with cancer build muscle, and in those who gained weight, increase strength. Increased physical and emotional strength provides the energy needed for what is important – eating well, interacting with family and friends, and performing daily activities.

It is critical that cancer survivors work with the health care team to identify and address all of the causes of weight loss. The earlier a person with cancer begins taking a therapeutic nutritional specifically designed to help normalize metabolism and promote weight gain, the easier it may be to maintain strength.

EPA Research

Clinical studies support EPA’s role in stabilizing weight loss. Several studies have been conducted with groups of pancreatic cancer patients who were rapidly losing weight. Researchers theorized that if these patients who typically experience rapid weight loss were able to gain weight, then the same results could be applied to patients with other types of cancer.

To maximize the benefit of EPA, research has shown it must be provided in combination with other nutrients - calories, protein, vitamins and minerals - to stabilize or even promote weight gain in cancer survivors. A clinical study among people with cancer showed that drinking two servings per day of an EPA-containing nutritional product as part of overall care promoted weight gain, helped build muscle,

improved quality of life, increased physical activity, and increased strength in those who gained weight. Some patients in the study who had been too weak to be active were even able to get out of bed and resume normal activity after eight weeks. The medical community is encouraged by the research and looks forward to further advancements.

Tips to Promote Good Nutrition

In addition to utilizing an existing therapeutic nutritional product with EPA, it also is important to eat a variety of foods, since lots of nutrients from many different sources are required to meet the physical and nutritional needs of cancer survivors. Survivors of oral, head or neck cancer should talk to the health care team to jointly create a flexible, personalized nutritional plan to adapt to ever-changing needs.

Here are some tips that may help alleviate the common problem of dry, sore and uncomfortable mouths and throats:

- ◆ Try moist and liquid foods such as soups and stews. They may be easier to chew and swallow.
- ◆ Try soft, cold foods such as ice cream, frozen fruit-juice bars, watermelon and grapes. They may feel and taste better than other foods.
- ◆ Thicken liquids to make swallowing easier. Use a nutritional beverage in smoothies or in other recipes.

Active Nutrition Care

Caregivers, family, friends and health care professionals have an opportunity to play an active role in helping people with cancer. By understanding the importance of nutrition in the treatment of cancer and applying useful strategies and tips, it’s possible to regain weight and reclaim quality of life. For more information and recipes, visit www.prosure.com/spohnc or call (800) 986-8502.

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terrified of being abandoned, and yet, may push you away. Still, there are many ways to revitalize your energy. The following will help you avoid burnout and become a strengthened ally:

1. *Get Support.* Join a support group or a chat room. Research shows that talking to people (whether in face-to-face groups or via the Internet) who share your problems reduces stress, decreases depression, and alleviates isolation.
2. *Educate Yourself.* Information is power. Understanding the course of cancer and depression, the possibility of relapse, the recommended treatments, and the side effects of medications can help you plan for the future.
3. *Keep a Journal.* That's where you can dialogue with yourself to vent frustrations and problem-solve without causing conflict.
4. *Maintain Friendships.* Helen's strategy of continuing contacts with friends and family despite her husband's illness is an inspiration.
5. *Preserve Routines.* Retain as much control over the routines of life as is reasonable.
6. *Continue with Hobbies.* Don't abandon favorite pastimes that always give you pleasure.
7. *Remember That Life Goes On.* You are a separate person and are entitled to enjoy your own life. Attend classes, start a hobby, go to a movie, make new friends.
8. *Learn to "Let Go."* Allow yourself to feel replenished by others' gestures—a card or a kind word left on your answering machine. Music, religious services, or a video can also help you recharge your batteries.
9. *Seek Respite.* Realize that you can't do it all. Allow others do some caring in your stead. Reach out to them.

10. *Attend to Your Physical Health.* Eat well and get enough sleep. Tend to any physical ailments that arise.

11. *Trigger the Relaxation Response.* Biofeedback, meditation, yoga, listening to music, even washing your car can relieve stress. By focusing on breathing, you trigger the mind-body connection.


12. *Deal with Frustration.* A short fuse can be a sign of burnout. If these suggestions have not worked, you may need more emotional support such as a support group or private therapist.

13. *Self-Care and Setting Limits.* Identify when you're feeling overwhelmed and be firm in delineating what you can and can't do. When you set limits, it's easier to seek respite, care for your health, maintain the patterns of your life, and let go.

Being a strengthened ally means having the ability to derive simple pleasures in the face of uncertainty. It means sharing your fears and struggles with someone you trust. And, it can also mean having faith in your loved one's ability to cope.

Through it all, a strengthened ally does what he/she can to learn from his/her mistakes and celebrate the small gifts that life bestows. This deepened awareness coupled with glimmers of hopefulness allows us to stand by the side of our ill, depressed loved ones and endeavor to make a difference.

Editor's Note: Los Angeles psychologist Mitch Golant, Ph.D. is The Wellness Community's VP of Research & Development and is the author of several books including What To Do When Someone You Love Is Depressed (Holt, 1998). The Wellness Community offers free professionally-facilitated face-to-face and online support groups for people with cancer as well as caregivers. Visit The Virtual Wellness Community at www.thewellnesscommunity.org for more information.



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