



S•P•O•H•N•C

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

SINUS MALIGNANCIES

LISA T. GALATI MD

Malignant tumors of the sinuses are rare, accounting for less than one percent of head and neck cancers. Tumors in these air-filled spaces around the nose cause very few symptoms at first, which is why many are at an advanced stage at the time of diagnosis. Delayed diagnosis and location of these tumors near vital structures (for example, the brain, eyes and major blood vessels) can make successful treatment difficult.

Early stage, or small, sinus malignancies usually are asymptomatic, making detection difficult. Small tumors cause symptoms if they are located near sinus openings, which drain into the nose, and cause obstruction. Symptoms are similar to sinusitis, and many patients are treated for months with antibiotics and decongestants before receiving a more thorough head and neck examination.

Larger sinus tumors may extend into the eye, nasal cavity, or mouth. Resulting symptoms can mimic those caused by benign conditions (allergies, sinusitis, tooth decay), causing a delay in diagnosis. Patients often seek treatment for poorly fitting dentures (from spread of the tumor through the hard palate or roof of the mouth), loose teeth, or nasal congestion before being diagnosed with a sinus cancer.

Certain occupations, such as leather tanning, nickel mining, and carpentry, are associated with an increased risk of developing sinus malignancies. Squamous cell carcinoma of the sinuses is associated with cigarette smoking. Thorotrast is a dye that was used until the 1960's for x-ray studies of the maxillary sinus. The dye was injected into the sinus. It remains in the sinus for years and has been directly linked to cases of maxillary cancer.

Most patients are diagnosed between the ages of 40 and 60. The most common symptoms at the time of diagnosis are one-sided nasal obstruction, nose bleeds, double vision from orbit (eye) invasion, or headache.

Tumors of the maxillary sinus can also invade the maxillary branch of the trigeminal nerve, which gives sensation to the cheek, and cause numbness. Extension into the brain can lead to personality changes, confusion and headaches.

On physical examination, a nasal mass may be seen filling the nasal cavity. Involvement of the nasopharynx (the very back of the nasal cavity) may cause blockage of the Eustachian tube, which drains the ear into the back of the nose. This blockage can lead to build-up of fluid behind the eardrum, which is visible on physical examination. Fluid behind the eardrum can also cause hearing loss.

Complete evaluation of sinus malignancies, prior to treatment planning, must include radiologic studies to determine the extent of disease and biopsy. Radiologic studies are also important in checking for metastatic (distant) disease. Cat scan (CT) is very useful in evaluating erosion of bone. Since the sinuses are encased in bone and lie in close proximity to the skull, bone erosion is very common in malignancies of the sinuses. MRI is useful in evaluating extension of cancer along nerves and can help differentiate between fluid in the sinus and tumor. Chest x-ray is important in identifying lung metastases.

Biopsy of the tumor is necessary to make the diagnosis of malignancy. Biopsy can be performed under general anesthesia in the operating room, or if the tumor is easily visible, in the office. The first step in office biopsy procedure involves numbing the area with a nasal spray and injection of a local anesthetic. Next, the tumor is viewed with the aid of a nasal endoscope. At this point a small piece of tumor can be removed, and any bleeding is controlled with pressure (insertion of a medicine-soaked cotton ball) or cauterization.

Although there are many types of sinus cancers, the most common type is squamous cell carcinoma (SCCa). SCCa is the most common head and neck cancer and its relationship to smoking is well known. Most SCCa's of the sinuses are treated with a combination of surgery and radiation. Some sinus SCCa's, particularly those of the maxillary sinus, may be treated with radiation alone. Adenocarcinoma, melanoma, sarcomas (cancer arising from the bony sinus walls) and lymphomas are other malignancies found in this region. Lymphoma, unlike the others, is not treated with surgery, but chemotherapy and/or radiation.

Surgery for sinus malignancies can range from minimally invasive endoscopic surgery to combined procedures in which

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COMING IN DECEMBER
Carotid Management in Head and Neck Surgery
John M. Truelson, MD

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the otolaryngologist-head and neck surgeon must work with neurosurgeons and reconstructive plastic surgeons. Very small tumors with easily seen boundaries can be removed through the nostril with the aid of an endoscope.

More invasive sinus cancer surgery requires incisions along the nose, eyelid or gumline. Incisions on the face are carefully placed in hard to see creases and the cosmetic results are usually excellent.

The Caldwell-Luc procedure is used to excise cancers that are contained within the maxillary sinus and is performed through an incision in the upper gum. A medial maxillectomy enables the surgeon to remove tumors of the ethmoid sinuses through an incision called a lateral rhinotomy (along the line between the cheek and the side of the nose). In some cases, a medial maxillectomy can also be performed through a degloving approach, which is done without any facial incisions. In this surgery an incision is made in the gumline under the upper lip, which is lifted up to expose the ethmoid and maxillary sinuses. Removal of a portion of the hard palate in some cases requires fitting of a special denture to restore normal speech and swallowing.

More radical surgery for sinus malignancies may include removal of an involved eye (orbital exenteration) or craniotomy, which provides access to tumors that extend into the cranial cavity. Although most patients find loss of the eye the most distressing part of sinus cancer surgery, there are several painless reconstruction options that provide an excellent cosmetic appearance. An orbital prosthesis can be worn behind the eyelids, or a prosthesis which covers the entire eyelid area can be easily worn when attached to eyeglasses. These intricately carved prostheses are custom made and match the uninvolved eye.

The complications of sinus cancer surgery include significant bleeding, cerebrospinal fluid (CSF) leak, infection and cranial nerve damage. Life-threatening bleeding is rare, but can occur if an artery is in spasm during surgery and therefore doesn't bleed during the surgery. Hours later, when the artery relaxes, hemorrhage can occur. Return to the OR and cauterization or ligation of the artery is necessary and some patients will require transfusion. CSF leak may occur during skull base surgery for sinus malignancies. If a leak is detected, treatment includes patching of the site, bed rest, and/or spinal drain.

Survival for sinus malignancies ranges from 20-40% 5 year survival for large tumors to as high as 80-90% for early stage tumors. The rarity of these tumors does not warrant routine screening; however, patients with seemingly common sinus complaints and risk factors for sinus cancer or who are not improving after treatment should undergo a thorough examination by an otolaryngologist-head and neck surgeon. Only then can sinus malignancies be detected earlier and be more curable.

Editor's Note: Lisa T. Galati, MD is board certified in otolaryngology and presently serves as Associate Professor in the Division of Otolaryngology at the Albany Medical Center, Albany, NY. Dr. Galati's research activities and publications have focused on head and neck disease, and her clinical practice focuses on head and neck carcinoma.

A TIME FOR SHARING

It began sometime in late February of 2002 with an irritation on the right side of my mouth near the base of my tongue. It felt like a slight case of swollen glands. For quite a while I just ignored it, but, it just didn't go away.

And then I realized that it was the same sensation I had felt when I was first diagnosed with oral cancer in 1996. Consequently, I made an appointment with the ENT Clinic at the Veterans Affairs Hospital in Baltimore, Maryland. I had several appointments and each time I went to my appointment the doctors saw nothing that could cause the discomfort. Soon the discomfort became real pain. I was given pain medication but it was not solving the problem. Finally I convinced the doctor to perform a biopsy of the affected area since nothing seemed to be helping. Prior to the biopsy, I had a CT scan and an MRI, but, nothing showed abnormal. The biopsy was done and we waited for the results. However, the pain persisted.

Finally, on June 7, 2002 we received the results of the biopsy: positive for cancer. I could have told them that three months before and as a matter of fact I tried on several occasions, however, everybody kept saying they couldn't see anything. I even pointed out where the pain was located, but, still nothing could be seen. Surgery was now necessary and it was scheduled for June 20, 2002.

On June 20th I reported to the Surgery Clinic. My wife, Sandi, and my step daughter, Tina, were by my side. That morning, the cancerous tumor, half the size of a golf ball, was removed. Early the next morning, I was given some type of juice to swallow. Fortunately, I was able to swallow it and so I was discharged from the hospital. I was told that I would be on a liquid diet for at least a week.

It seemed that we had finally solved the mystery of the "unknown cause of pain." We had discovered what it was, removed it and now all that remained was the recovery process. How fortunate I was to have Sandi by my side. She stood by me every minute during this difficult time. Without her I don't really know what I would have done. She is, without a doubt, the greatest wife

any man could ever hope for and not only that, she is also the greatest friend I have ever had.

Not quite four weeks later, I was still having some difficulty swallowing solid food. Some swelling in the gland area occasionally gave me pain. However, I was able to speak more clearly although it was necessary to speak rather slowly. I was also able to drink some root beer and Dr. Pepper and I had my first cup of coffee since before the surgery...tasted good, too.

I soon returned to my job and to seeing the many co-workers who had shown such concern during my absence.

I had several follow-up appointments at the ENT Clinic and then had a meeting with a radiation oncologist to determine if radiation therapy would be necessary. Having had radiation therapy for my first bout of cancer, I was hoping that it would not be necessary again. As it turned out, I was told that further radiation could be dangerous to my jaws. Consequently, it was decided that there would be no further treatment; however, upon further examination of my throat, the doctor saw some sort of ulcer in the right tonsil area and I was directed to go back to the ENT Clinic for a thorough exam. A doctor examined the area and probed the inside of my throat and also used a suction device to clear away the affected area. I was advised to gargle with salt water and return in one week to determine if another biopsy was necessary.

I kept my appointment with the ENT Clinic on August 6th, and after examination, a biopsy was done. Tissue was removed from the affected area for analysis. I was still unable to swallow any solid foods, and now there was quite some discomfort from the biopsy.

On August 16, 2002 Sandi and I were back at the ENT Clinic to get the results of the biopsy. This time when the doctor examined my mouth and throat he said that everything looked good and that the biopsy was negative...no more cancer was evident. Needless to say, those words were like music to our ears. Now we could go on with our lives. The doctor ordered a consultation with a speech therapist to help with my swallowing problem.

It was a welcome relief to get a clean bill of health from that nasty disease and to survive cancer, again. For this, I must give the Lord His due. Sandi and I, along with my family members and numerous friends, did a lot of praying for my deliverance from this cancer. Before we left the house on the 16th to go to the VA Hospital Sandi led us in a prayer and on the way there I had this indescribable special feeling that everything was going to come out good. I had faith that God was not going to let us down this time; that He was going to see us through it all.

In view of everything that I have been through; nearly drowning as a child in the Mississippi River, having my throat cut as a teenager, being wounded in combat while fighting in the Korean War, being in a near fatal car accident, surviving parachute training, having two open heart surgeries and now having two cases of cancer, I feel somehow that the Lord is keeping me around for some particular reason. I only wish He would reveal to me what that reason is. Maybe it is to witness to others the way He has been looking out for me all these years and I have been doing that. Every day I thank the Lord for all the blessings He has bestowed on me like allowing me to stay here on this earth, giving me such a wonderful wife as Sandi, giving me two sons that I am extremely proud of and a wonderful family and friends that are priceless. I have lived a very full life. I have seen and done things very few other people have ever done or could even think about doing, so, if I were to die today, I'd die a very wealthy man. Maybe not financially, but, there is more to life than money.

I am writing this the day after Thanksgiving, 2002 and I am thankful that I am able to do so. I am still unable to eat most solid foods; however, yesterday I was able to eat some mashed potatoes and gravy along with some of Sandi's delicious dressing. I couldn't partake of any turkey but I was extremely satisfied with what I could eat. I have no idea when I will ever be able to eat solid food again or when I will have complete use of my tongue, but, I am hopeful. I can speak a lot more clearly

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COMMON EMOTIONAL DISORDERS OF HEAD AND NECK CANCER

ROGER B. GRANET, MD

Cancer poses such a major challenge to one's being, both physically and psychologically, that is hardly surprising to find the disease associated with a variety of emotional disorders. In their way, these conditions are further manifestations of cancer. And like those other manifestations, the emotional disorders that often accompany the disease can be treated very effectively. Psychiatrists and other mental health professionals have access to a wide variety of therapeutic techniques and medications that work well to alleviate the troubling symptoms of emotional disorder and allow the individual to live much more normally and fully.

It is important to understand that emotional reactions to cancer occur across a continuum. Experiencing serious sadness and anxiety on learning that one has cancer is usual and expected, and does not add up to disorder. The difference between that normal reaction and an emotional disorder like adjustment disorder, and then again between adjustment disorder and major depression, is largely a matter of how severe the emotional symptoms are, how long they last, and how profoundly they interfere with an individual's ability to function in family, social, work, or school situations.

This article describes the principal disorders likely to accompany cancer. And the central point is that although psychological distress is frequent, treatment is dramatically beneficial.

Adjustment Disorder

Adjustment disorder stands in a midpoint between normal coping on the one hand and major emotional disorder, particularly depression and anxiety, on the other. It is something of a normal reaction that goes over the top.

Adjustment disorder always arises in reaction to a clear, identifiable stressor that occurred no more than three months before the onset of the symptoms. Cancer, of course, is just such a stressor. The individual reacts to the stressor in a way that causes noticeable distress in some basic activity, causing difficulty in work, family and personal relationships, hobbies, or the enjoyment of life, in-

cluding sexuality. Usually adjustment disorder will resolve on its own within six months of the time the stressor ends or is removed. But if the stressor continues, as is the case with cancer, then the condition can also last indefinitely. The symptoms of adjustment disorder vary. Sometimes they tend toward depression and make themselves known as periods of sadness, teariness, feelings of hopelessness, and the like. They can also tend toward anxiety - nervousness, worry, rapid heart rate or sweaty palms for example. Often depressive and anxious symptoms are mixed, with the individual nervous, sleepless and sad, for example. Conduct as well as mood and emotions may be disturbed. For example, a woman who usually loves to go shopping recreationally may find herself so immobilized by alternating sadness and anxiety that she cannot even imagine heading off to the mall.

Adjustment disorder is usually treated with psychotherapy. In some cases, medication is used as well.

Generalized Anxiety Disorder

Everyone experiences anxiety to one degree or another. It's the butterflies-in-the-stomach, cotton-in-the-mouth, sweat-in-the-palms feeling that arises when you're waiting for the dentist, looking down the barrel of a mugger's pistol, or picking up the phone to call the oncologist about the latest MRI results. Anxiety serves a purpose over the short term: It mobilizes the body for sudden action at a time when danger or threat loom. But anxiety that hangs on and becomes both constant and chronic is a serious emotional problem.

Even under the best of circumstances, anxiety tends to peak at each stage of the cancer cycle. Studies of head and neck cancer patients, for example, show that anxiety increases when the tumor is found, peaks just before surgery and continues high thereafter, then declines slowly over the first year of survivorship.

The expected anxiety of the cancer cycle becomes a disorder requiring treatment when its symptoms become overwhelming. These symptoms fall into four areas:

- *Apprehensive expectation*: Uncontrolled worry.

- *Motor tension*: Trembling, twitching, or feeling shaky; muscle tension, aches or soreness; restlessness; lack of stamina.

- *Autonomic nervous system hyperactivity*: Shortness of breath, increased heart rate, sweating or cold clammy hands, dizziness, dry mouth, frequent urination, hot flashes or chills, trouble swallowing or a lump in the throat (globus hystericus).

- *Vigilance*: Feeling keyed up, strong startle response, difficulty concentrating, trouble sleeping, irritability

What distinguishes generalized anxiety disorder from adjustment disorder with primarily anxious symptoms is severity and duration. Simply, generalized anxiety disorder is worse and it lasts longer.

Anxiety responds well to psychotherapy, which is often combined with medication. In addition, relaxation techniques, such as medication or medical hypnosis are effective as an adjunct treatment.

Major Depression

Depression is something like the blues to the extreme. While everyone hits low points that usually last only a few days, major depression is a bottomless pit that goes on and on. It is an abnormal, persistent mood state characterized by sadness, melancholy, slowed mental processes, and changes in such physical patterns as eating and sleeping. While feelings of being blue or down usually improve on their own after a few days, the change in mood goes on and on in major depression.

Medically, depression is defined as the daily presence for two weeks of at least five of the following nine symptoms. One of the symptoms must be either melancholy mood or loss of pleasure:

1. Melancholy mood or sadness (sometimes experienced as apathy or irritability for most of the day).
2. Loss of pleasure in practically all activities, particularly ones the person previously enjoyed (referred to as anhedonia),
3. Disturbed appetite, or either weight gain or loss..
4. Disturbed sleep, particularly an inability to sleep through the night (insomnia).

5. Slowed or agitated physical activity.
6. Fatigue or very low energy, often leading to a diminished or nonexistent sex drive.
7. Feelings of worthlessness, low self-esteem, or guilt.
8. Difficulty concentrating and thinking.
9. Morbid or suicidal thoughts or actions.

Rarely, in very severe cases, depressed people may develop psychotic symptoms, including false perceptions (hallucinations), such as hearing voices that tell them to hurt themselves and false beliefs (delusions), such as believing that they deserve to be harmed.

The difference between adjustment disorder with depressive symptoms and major depression is, as with anxiety, a matter of degree and duration. In adjustment disorder, symptoms are likely to be a mood of continuing sadness that makes one less interested in social contacts and interferes with work or school. Depression is more of the same, only worse. The sadness is severe, sleeping difficulty is usually pronounced, weight is lost or gained suddenly, and the impairment of functioning may be so profound that the individual can hardly work or take part in ordinary daily activities. Some people are so immobilized by depression that they literally cannot get out of bed in the morning. The more severe the depression, the more likely are suicidal thoughts. Plans to harm oneself are not a sign of terminal cancer. Rather, they signal severe depression, even in people who are in the late stages of disease.

Depression is remarkably treatable. Psychotherapy, medication, or a combination of the two are used.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) most recently entered the general vocabulary after returning combat veterans from the Vietnam War found themselves incapable of coping with daily life and often experienced battlefield flashbacks so vivid that they thought they had returned to the fighting in Southeast Asia. PTSD in cancer is the same disorder, with the disease substituting for the incoming fire of combat. In each case, a trauma that threatens death or serious injury occasions a series of specific symptoms. Typically, the disorder begins within three months of the trauma, but onset may be

delayed for six months or longer. Severity and duration vary. The disorder is considered acute if symptoms have been present for three months or less, chronic if for more than three months.

The most prominent sign of PTSD is the re-experiencing of the traumatic event. These thoughts are intrusive, recurring, and distressing. They can come in a number of forms: disquieting flashbacks (vivid recollections of the trauma), amnesia (in which the person forgets where he or she is), nightmares, or powerful emotional reactions to small cues associated with the trauma, such as news reports on cancer or the smell of disinfectant in a physician's office. Because the thoughts and flashbacks associated with the trauma are so unpleasant, the individual with PTSD tries to avoid any person or situation associated with it. This is accompanied by a numbing of feelings, which may lead the individual to block out certain aspects of the memory of the trauma, feel uninterested in pleasurable activities, and avoid social contact. Finally, an individual with PTSD is highly aroused and vigilant. Sleep is difficult, concentration often impossible, anger or irritability constant. The normal startle response is highly exaggerated and extreme.

Treatment of PTSD consists of both psychotherapy to increase awareness of the underlying emotions and beliefs and often medication to alleviate the symptoms. The disorder is quite common among cancer patients, although it is often overlooked. If the condition is recognized promptly, the outlook for treatment is very good.

Panic Disorder

Psychiatrists list fourteen possible symptoms of a panic attack, of which four or more must be present:

1. Sudden extreme nervousness which seems to come "out of the blue"
2. Palpitations, pounding heart, or accelerated heartbeat (tachycardia)
3. Sweating
4. Trembling or shaking
5. Feeling short of breath or smothering
6. Feelings of choking
7. Pain or discomfort in the chest
8. Distress in the abdomen or nausea
9. Feeling dizzy, light-headed, faint or unsteady

10. A sense of unreality, as if events are happening in a movie or dream, or depersonalization, as if they are happening to someone else.

11. Fear of losing control or going crazy.
12. Fear of dying, typically by heart attack or stroke.
13. Numb or tingling hands or feet.
14. Chills or hot flashes.

Panic attacks come on very suddenly, peak within seconds to minutes, then fade. Usually the whole experience lasts no more than ten or fifteen minutes.

One panic attack is not enough to support a diagnosis of panic disorder. Attacks have to be repeated and recurring, although no precise number in a given period of time has yet been specified. It matters, too, how the individual reacts to panic attacks. In true panic disorder, at least one attack prompts worry about subsequent attacks for a month or more. In addition, the individual with panic disorder reshapes his or her life to avoid situations where panic attacks seem more likely. In many individuals this develops into what is known as agoraphobia, a fear of public, open spaces like schools, shopping malls, and sports stadiums.

Although unpleasant, a single panic attack is not dangerous. However, repeated, untreated panic attacks may increase the risk of cardiovascular disease, such as high blood pressure (hypertension) or abnormal heart rate and rhythm (arrhythmia). Treatment usually consists of both psychotherapy and medication, and it provides excellent outcomes.

Cancer creates frequent emotional distress. However with sophisticated application of psychotherapy and, at times, medication, no one needs to suffer psychologically. Modern psychiatric intervention assures relief and hope.

EDITOR'S NOTE: Dr. Granet is Clinical Professor of Psychiatry at Weill Medical College of Cornell University, Consultant in Psychiatry at Memorial Sloan-Kettering Cancer Center and Attending Physician at New York Presbyterian and Morristown Memorial Hospitals. He is the author of numerous articles, chapters and books including, If You Think You Have Depression, (Dell, 1998), and Why Am I Up, Why Am I Down: Understanding Bipolar (Dell, 1999) and most recently of Surviving Cancer Emotionally: Learning How To Heal, (John Wiley & Sons, 2001) from which this article is adapted. Dr. Granet maintains a private practice in Morristown, New Jersey.

Head and Neck Resources on the Internet 2003

ENGLISH

Head and Neck Cancer Home Page (National Cancer Institute)

http://www.cancer.gov/cancer_information/cancer_type/head_and_neck/

Oral Complications of Chemotherapy and Head/Neck Radiation (patient version)

<http://cancer.gov/cancerinfo/pdq/supportivecare/oralcomplications/patient/>

Oral Complications of Chemotherapy and Head/Neck Radiation (health professional version)

<http://cancer.gov/cancerinfo/pdq/supportivecare/oralcomplications/HealthProfessional>

Nutrition in Cancer Care (patient version)

<http://cancer.gov/cancerinfo/pdq/supportivecare/nutrition/patient/>

Nutrition in Cancer Care (health professional version)

<http://cancer.gov/cancerinfo/pdq/supportivecare/nutrition/HealthProfessional>

Metastatic Squamous Neck Cancer with Occult Primary (patient version)

<http://www.cancer.gov/cancerinfo/pdq/treatment/metastatic-squamous-neck/Patient>

Metastatic Squamous Neck Cancer with Occult Primary (health professional version)

<http://www.cancer.gov/cancerinfo/pdq/treatment/metastatic-squamous-neck/HealthProfessional>

Oral Health, Cancer Care and You: Fitting the Pieces Together (NOHIC)

<http://www.nohic.nidcr.nih.gov/campaign/index.html>

SPANISH

Complicaciones orales de la quimioterapia y la radioterapia a la cabeza y cuello (patient version)

<http://www.cancer.gov/espanol/pdq/cuidados-medicos-apoyo/complicacionesorales/>

Complicaciones orales de la quimioterapia y la radioterapia a la cabeza y cuello (health professional version)

<http://www.cancer.gov/espanol/pdq/cuidados-medicos-apoyo/complicacionesorales/healthprofessional>

Nutrici3n (patient version)

<http://cancer.gov/espanol/pdq/cuidados-medicos-apoyo/nutricion/patient/>

Nutrici3n (health professional version)

<http://cancer.gov/espanol/pdq/cuidados-medicos-apoyo/nutricion/healthprofessional>

C3ncer escamoso metast3sico del cuello con tumor primario oculto (patient version)

<http://www.cancer.gov/espanol/pdq/tratamiento/escamoso-metastasisico-del-cuello/Patient>

C3ncer escamoso metast3sico del cuello con tumor primario oculto (health professional version)

<http://www.cancer.gov/espanol/pdq/tratamiento/escamoso-metastasisico-del-cuello/HealthProfessional>

Courtesy of the Cancer Information Service (CIS)

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now, but some words just won't come out right. However, I can be understood and that is what is important. Of course singing is completely out of the question at this point.

My advice to others who may be faced with a similar situation to mine, is to have someone near to you to give you comfort and offer moral and spiritual support. I was fortunate to have Sandi by my side. However, I do want to say that not only does the patient suffer the pain and agony of the disease, but those close to him/her are also suffering in a different way. Place your trust in the Lord and let Him do His will. If I can be of support to others, I am more than willing to be contacted via email at: cvsxmian@aol.com.

Charles V. Christian
Dundalk, Maryland



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“Survivor to Survivor”

Two years ago I had surgery followed by six and a half weeks of radiation therapy for treatment of nasopharyngeal cancer. Although both surgery and radiation therapy were difficult, I recovered and can speak and eat normally, so I was lucky. However, since my recovery from radiation therapy, I have developed a sore on my tongue and on my lower lip. These sores always appear in the same place and seem to be cyclical, every 2-3 weeks. If I am lucky they will heal for 4 weeks before they return.

I have seen my surgeon, dentist, dermatologist, oncologist and radiologist, none of whom have been able to provide any suggestions to help rid me of these sores. Is this a fairly common thing to have happen? What do other survivors do about it?

My mouth care is immaculate; floss, brush and water-pik after every meal; use nystatin swish and swallow when it gets bad, sometimes use Peridex. Also brush at night with Prevident...so is there anything else anyone could suggest. Thanks for your time....Annie

ACTION: If you have any suggestions for Annie, please send an email to info@spohnc.org or call 1-800-377-0928.

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 from others who “walked in your shoes.” If so, we need 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.

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