



S•P•O•H•N•C

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

A PATIENT'S GUIDE TO TONGUE CANCER

PETER HAN, MD & LOUIS B. HARRISON, MD

Introduction

The tongue is the part of the mouth that assists in swallowing, chewing, speech, and taste. It is a muscular organ that consists of two contiguous parts: the oral tongue and the base of tongue. The oral tongue is the portion in the mouth that is easily visible and mobile. The base of tongue is the segment connected behind the oral tongue, and is immobile and not easily visible. The head and neck is categorized by different anatomical regions. The oral tongue is part of the oral cavity, and the base of tongue is part of the oropharynx. Unfortunately, cancer can occur in the tongue like any other site. Overall, cancer of the head and neck region accounted for approximately 3% of all cancer diagnosis in 2004. According to the American Cancer Society, there was a predicted estimate of over 29,000 cases of cancer in 2005 to occur in the oral cavity and pharynx in the United States. Males are typically afflicted twice as often as females, and more commonly over 50 years old. Over 7,600 cases were projected to occur in the tongue. However, significant advancements in treatments and technology have been made to treat tongue cancer more effectively.

Risk Factors

It is impossible to accurately predict who will get cancer. There are however, known risk factors, which have been linked with the development of cancer. The major risks constitute life styles habits, which include the use of tobacco and alcohol consumption. Tobacco usage can consist of smoking cigarettes or pipes, chewing tobacco or snuff use. There is no safe tobacco. There is also evidence that the combination of alcohol and tobacco significantly increases the risk of cancer over that which is caused by either one alone. In addition, there is some evidence of hereditary conditions, nutritional deficiencies, poor dental hygiene and even viral infection; specifically the human papillomavirus may be linked to the development of cancer.

Signs and Symptoms

Unfortunately, cancer in the head and neck region is not always detected early. The cancer usually has to become large enough to alter normal function or anatomy prior to its recognition. However, lesions in the oral tongue are generally more easily visible and noticeable, potentially allowing for earlier detection. Some of the signs and symptoms of cancer in the oral tongue may include non-healing sore, tongue mass, pain, bleeding, and difficulty with speech and/or swallowing. Cancer in the base of tongue is usually more insidious due to its location in the back of the mouth. Therefore, cancer in this site usually presents with more advanced disease. In addition to symptoms mentioned earlier, patients may notice difficulty chewing, a new lump in the neck or ear pain. Unexplained weight loss can also be a sign of underlying cancer. Occasionally, tongue cancer can be preceded by patchy white or red discoloration in the tongue. If a person experiences such symptoms, it is important to follow up with one's physician for a complete examination.

Screening

There are no specific guidelines for oral cavity and oropharynx cancer screening as developed for other cancer sites including colorectal, breast, and cervix. Therefore, it is important to undergo a routine complete physical check up with your physician and your dentist for complete oral care and examination. This is especially true for those who use tobacco and/or alcohol.

Patterns of Spread

Oral tongue cancers tend to grow within the tongue itself, and can become quite large. It is not uncommon for disease to extend onto the adjacent floor of the mouth. Spread to the lymph nodes in the neck is also common. The overall risk of lymph node spread relates to the size of the tumor in the tongue as well as its depth of invasion into the tongue, itself. The larger the tumor, and the deeper it invades, the greater the risk of spread to the neck.

Base of tongue cancers also spread within the tongue itself. Since the base of tongue is adjacent to the tonsils and just above the larynx (voice box), tumors can spread and involve these structures. Extension into the oral tongue from the base, and vice versa, can also occur. Spread to the lymph nodes in the neck is extremely common even for very small base of tongue cancers. Overall, about 80% of patients have spread to the lymph nodes on one side of their neck, and about 20% manifest lymph nodes in both sides of the neck.

Work up

Once a cancer has been diagnosed, the extent of the disease must be determined through a process known as staging. Physicians that are experienced in the treatment of head and neck cancer typically do the evaluation and treatment. The work up includes a complete history and physical with a detailed and comprehensive head and neck examination. An examination under anesthesia may also be required

See CANCER on next page



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IN THIS ISSUE

A Time for Sharing.....4
Understanding & Managing Head & Neck Lymphedema.....5

COMING IN WINTER, 2005
“Chemotherapy-Related Fatigue,
Memory and Thinking Changes”
Stewart B. Fleishman, MD

CANCER continued from page 1

allowing the physician to evaluate and biopsy areas that cannot be reached with an awake patient. During the procedure, fiberoptic technology is available to help visualize the lesion and to rule out the presence of a co-existing second malignancy. Radiological imaging is essential for determining the extent of disease. Tremendous technological advancements have been made on various imaging modalities to assist in the determination of disease extent. CT (computed tomography) and MRI (magnetic resonance imaging) are two different types of imaging studies that help define the tongue cancer and visualize the extent of disease. A newer technology called a PET scan (positron emission tomography) can provide functional information of one's body that complements the anatomical information provided by CT and MRI. Specifically, one can visualize how metabolically active a certain region of your body is. Typically, cancer is more active than normal, non-cancerous adjacent tissue. The higher cell activity demands a higher amount of energy for fuel. A PET scan converts this information into a picture. In addition, it is also possible to combine the findings of a PET scan with that of a CT to more accurately determine the specific site of cancer. Once the workup has been accomplished, the extent of the tumor can be determined or staged with the use of the American Joint Committee on Cancer staging manual guidelines. The stage of the tumor is broken up into three categories: T stage (1-4) defines the extent of the primary tumor, N stage (0-3) defines the involvement if any of neck disease, and M stage (0-1) defines the presence or absence of distant spread. The combination of these factors determines the overall “stage” of the cancer and the prognosis of the patient. The TNM stage plays a significant role in the creation of treatment recommendations for patients.

Dental Care

Dental hygiene and evaluation prior to treatment are an important step to ensure proper oral care and avoidance of unnecessary post-treatment interventions especially if radiation therapy is part of the cancer management. Good oral hygiene and habits are crucial to optimize treatment tolerance and a lasting quality of life. Patients who are planned to undergo radiation therapy treatments should undergo complete dental evaluation by a dentist/oral surgeon who is experienced in head and neck cancer and radiotherapy. The patient may typically need to use daily a custom designed fluoride tray to provide additional fluoride treatment to one's teeth for the prevention of caries. Ideally, the use of a soft toothbrush with fluoride toothpaste is recommended after every meal and at bedtime. In addition flossing is also important to maintain healthy gums and teeth.

Tongue Cancer Management

Treatment strategies have evolved markedly over time. The various treatment options available include surgery, radiation therapy, and chemotherapy. Tongue cancer management should be coordinated through a multi-disciplinary team collaboration to optimize the cure and overall quality of life. Ideally, this team should be led by surgeons, radiation oncologists and medical oncologists all of whom should see the individual patient and agree to a plan of action prior to the initiation of treatment. Other members of the team should include dentists, nurses, nutritionists, speech therapists and social workers.

Radiation therapy is less likely to be understood by the public as opposed to surgery and chemotherapy. Radiation therapy is primarily

CANCER continued on page 3

CANCER continued from page 2

the medical use of radiation to treat regions that contain and may harbor cancer cells. Broadly, this can be divided into two categories: external beam radiation therapy and brachytherapy. External beam radiation therapy typically is emitted from a machine called a linear accelerator directed to specific regions in the body.

The delivery of external beam radiation therapy can also have several approaches. The radiation therapy can be delivered once a day or more over a course of several weeks to optimize potential radiation effectiveness due to biological factors. Treatment planning technology has also advanced sharply with the use of commercial software in conjunction with the patient's CT scans. The radiation treatment can be "mapped" out onto the patient's 3-dimensional image allowing for a more accurate targeting of radiation to specific areas in the head and neck. This also minimizes exposure to adjacent sites to lessen the potential side effects. There has also been tremendous interest in the use of IMRT (intensity modulated radiation therapy), which is a specific treatment planning approach. This entails sophisticated computer assisted 3-dimensional plan, which allows for more precise treatment delivery. With any delivery system, the radiation beam is painless during the actual treatment. However, there is an overall potential cumulative effect that accounts for the symptoms seen during the radiation treatments. These symptoms are usually temporary.

The second category is brachytherapy, which involves the direct implantation of radiation directly into the tumor. Under anesthesia, multiple catheters are surgically implanted into the tongue covering the region of the tumor in addition to a temporary breathing tube in the neck. These temporary catheters are loaded with radioactive sources, which stay inside for hours or days, and deliver the total dose of radiation required. Upon completion of the brachytherapy, all the catheters and radiation sources are removed from the patient. Overall, the optimal delivery of the radiation therapy may consist of either one or a combination of both external beam radiation therapy and brachytherapy. Our approach has typically been to incorporate both techniques allowing a high therapeutic dose of radiation therapy to the cancer to ensure better local control and minimize potential side effects.

Strategy for Oral Tongue Cancer

The management of oral tongue cancer can

be broadly divided into two parts. For early stage lesions, either surgery or radiation therapy as single treatment type or in combination is possible. However, for small lesions, it is preferable to utilize a single type of therapy to minimize the potential treatment side effects, inconvenience and minimize long-term complications. For various reasons including time, patient convenience, and avoidance of long term potential side effects, primary surgical excision is generally preferred as the initial treatment with typically good function of the remaining oral tongue. Surgical resection for small tumors provides good local control. However, patients who are not good surgical candidates, refuse surgery, or are likely to experience significant functional loss secondary to the surgical defect, should receive radiation therapy for the primary treatment. Brachytherapy, as described earlier, may potentially be an integral part of the radiation treatment program for such patients.

For locally advanced tumors, patients would likely need to undergo a combination of both surgery and radiation therapy to obtain optimal control. Reconstruction of the surgical defect is also available depending upon extent of resection. Various tissues from the patient's own body can be used to help reconstruct organs. Surgical techniques including the use of a non-essential muscle in the forearm for the tongue or a bone from the leg for a portion of the jaw are available. The addition of chemotherapy with the drug cisplatin during radiotherapy in the postoperative setting improves the likelihood of cure for patients who are at high risk of recurrence. This benefit has been demonstrated in large cooperative group clinical trials in both the United States and Europe. Depending upon the response, the patient may be able to undergo brachytherapy and possible neck dissection if there is neck disease present without undergoing surgical resection to the tongue. Patients need to have locally advanced tongue lesions that would initially need to undergo a total or near total resection of the tongue to be eligible. In addition, at least one course of the chemotherapy will entail its administration into the feeding artery of the tumor to allow for higher concentrated dose at the tumor site. The treatment is under study and is not the typical standard regimen for oral tongue cancer. Overall, the treatment needs to be tailored for each patient's illness.

Strategy for Base of Tongue Cancer

The treatment of base of tongue cancer has evolved to incorporate organ and function preserving strategies with treatment goals of optimal cure rates and quality of life. Typically, radiation therapy is the primary treatment strategy for the management of base of tongue cancer. This approach has led to the improvement of quality of life with the patient maintaining maximal functional capability. Similar to the approach in oral tongue cancer, the overall strategy can be divided into two parts. For early staged lesions, patients can undergo radiation therapy without chemotherapy. In our institution, the radiation treatment program typically entails incorporation of external beam radiation therapy and brachytherapy. In our experience in addition to other reported studies including those from Paris and Stanford and Long Beach, CA, local control rates that incorporated brachytherapy are in the 85-90% range.

For locally advanced cancers, chemotherapy is given in conjunction with the external beam radiation. Many studies have demonstrated an advantage to the use of simultaneous chemotherapy in conjunction with the radiation therapy for select patient population. This usually consists of patients presenting with stage III and IV diseases. A large French Head and Neck study group was recently reported revealing a local control and survival improvement with the use of simultaneous chemotherapy and radiation therapy for patients with oropharynx cancer that included base of tongue cancer. Our initial experience without chemotherapy has also been encouraging with local control rates from 80-100% for locally advanced lesions. It is likely that with chemotherapy, the results would be more encouraging for advanced diseases. Our recent unpublished review of our patients revealed that patients with locally advanced tumors (T4) had a three year calculated local control rate of 73% and overall survival of 88% with the use of external beam radiation therapy with simultaneous chemotherapy, and brachytherapy. As mentioned earlier, the use of IMRT has led to some encouraging findings. Reports from Washington University and University of San Francisco revealed a high local and neck control ranging from 88-94% for mostly locally advanced tumors including base of tongue with IMRT. IMRT may be particularly useful for helping to preserve salivary gland function which is typically severely impaired after conventional radiotherapy.

CANCER continued on page 6

A TIME FOR SHARING *My Journey Continues*

Update 8.6.04 Hi All, Once again thanks so much for your continued support via visits, cards, calls, e-mails, prayers and little gifts. You are all very creative and I truly appreciate everything. We have 3 weeks of treatments down and 3 to GO. So far so good. The tumor at the base of my tongue has been reduced over 55% and the lymph nodes in my neck are down 50% which is a very good sign that the treatments are working. I have had only minimal weight loss to date of 7 lbs. I'm still able to eat all foods, however when they say you will lose your taste buds from radiation treatments they are not kidding, I no longer have an insatiable appetite! All foods taste the same, like CARDBOARD! But eating is so important to staying strong and building back my blood counts that I just sit and smile and say if this all that I need to cope with it's not too bad in the bigger picture. They said by December that the taste buds should start to return, so I have that going for me, which is nice. I know in my last update I said I would stay away from people with colds. I didn't do such a good job with that and I caught a pretty nasty sore throat which made it tough to swallow the better part of last week. The doctors wouldn't give me anything for it because they didn't want my blood count to be effected for my next chemo infusion which is set for Monday 8.9.04. Then on Thursday 8.12.04 I will start to go to radiation twice a day 6-8 hours apart for the balance of my treatments which end on 8.27.04. This has been a Great Life Experience for me. I have learned so much about myself and the wonderful people that surround me. Some of the quotes I have been reading tell me, "You can't begin to imagine how your mind and body can handle what is placed in front of you." They are so right! I leave you with this quote:

"Although the world is full of suffering,
It is also full of the overcoming of it."
--- Helen Keller

Update 8.19.04 Hi All. Five weeks down and 1 to GO! Its been a couple of weeks since my last update, lots of positive things have been happening. I had my final chemo treatment on Aug. 9th and again with only minor side effects of a queasy stomach, tingling fingers and toes and some ringing in my ears. But all in all I came through chemo as good as it gets. I still get liquid infusion

twice a week to help flush out the toxic chemo from my kidneys. The meds are unbelievable! Ok, last time I wrote that my tumor was down 55% it has now been reduced to over 80% at the base of my tongue and doctors expect it will dissolve completely by the time treatments are complete. The lymph node on the side of my neck is also still reacting to treatments and is down about 70% which is good. They are hitting the lymph node area on my neck with less radiation then at the back of my tongue to help with scarring in case they do need to do surgery on the lymph nodes, I have a follow-up appointment on Sept. 28th for them to make that decision. The two-a-day radiation treatments are going very well. Both the soreness inside my throat and on my skin surface has been great with only minor irritation. I'm still able to eat CARDBOARD!; I'm sorry, SOLID FOODS, without the aid of pain meds which really has everyone very happy. My appetite is still low due to the lack of taste buds and I am now down 17 lbs since July 19th. The disappointing thing about the taste buds is that I really would like to eat some ICE CREAM but have no interest in it at all. Some one pick Joe Kelley and Tom Kuharski off the floor. Yes, Chris Urso said NO to ICE CREAM! I look forward to the day that I can eat again for pleasure. Until then, keep your fingers and toes away from my plate because I wouldn't know if I were eating them. Again I would like to say thanks to everybody for your continued support via visits, cards, gifts, e-mails and prayers, family, friends and faith continue to be our strength. I leave you with this funny sports quote a friend, Mick Trexler, sent me.

"If I were a bettin man, my money
would be on you!"--- Pete Rose

Update 9.6.04 Hi all, I will call this update NO PAIN, NO GAIN! My treatments ended on schedule August 27th and I made it almost completely through the treatments before the pain of swallowing really kicked in, which the doctors said was amazing. Also the skin on my neck had not started to blister until the last day. You could feel the heat coming off the neck. It looked funny because you could see the lines where it stopped. The last 2 weeks I have been sleeping most of the day away and probably only spoke a total of 1 hour during that time, (Colette said that was an act of GOD. She has enjoyed the peace

and quiet.) The hardest challenge to date has been having to "psych" myself up swallow the pain meds which allow me to eat. I had made a promise to the doctors and to myself that I would continue eating solid foods no matter what to avoid needing a feeding tube (THAT WAS NOT A OPTION IN MY BOOK). Many of you who stopped by to visit, sat with me at the table while I took an hour to eat that bowl of home made soup that my great friends and family have been making for me, Thanks so much for your support. My appetite is still low due to the lack of taste buds and I am now down 25 lbs since July 19th. That was the PAIN part! OK enough of that crap, tell us about the GAIN! I had my last doctor's visit on August 26th and his early, by the naked eye examination showed the primary tumor at the base of my tongue was GONE! The lymph node on the side of my neck has been reduced to the point where he could not feel it anymore, which was better than expected originally. I now had an 80% chance of not having to have a dissection. When I see the doctor's on September 28th they will use the PET scan and CAT scan to make the final determination regarding the surgery. This was all great news to hear and really helped me live with the discomfort of the last 2 weeks. The other good news is today I stopped taking the pain meds to see how I can tolerate the swallowing, So far, not too bad. That's it for now, thanks again for the e-mails, cards, gifts, visits and most all the continued prayers for my complete recovery. I will leave you with this quote.

" There are really only TWO ways to approach life: as a victim or as a gallant fighter.
You must decide if you want to ACT or REACT.
Deal your own cards or play with a stacked deck.
And if you don't decide which way to play with life, it always plays with you."
---Merle Shain

Update 9.28.04 Hi all. It's been a couple of weeks since my last update. My treatments ended on 8.27 and I have been rehabbing. I'm happy to report that I am eating again without pain meds and the skin on my neck has recovered nicely from the blistering. I have regained a lot of my strength back. I would say I'm at about 90% to 95%. My weight loss

has pretty much leveled off this week and I'm down about 30 pounds since July 19 when treatments started. Colette and I met with the head & neck surgeon at Fox Chase today; I wish I had some better news to report. The CAT scan came back a little abnormal and the PET Scan showed 3 small hot spots in the neck area. So I will be going back on Friday for them to do an ultrasound and (FNA) Fine Needle Aspiration of the areas. Keep your fingers crossed that the hot spots are from leftover radiation, which is possible. I would think, that after this, we will be looking at a neck dissection. While I would agree I'm not out of the fire yet, I feel lucky that I still have additional options due to technology that is out there for me and other cancer patients. The good news is nothing else in my body showed up with cancer and the doctor did concur with the radiation oncologist that my primary tongue base tumor is gone. I again would like

to thank everyone for their prayers, e-mails, visits and cards; you can't imagine how important they are.

Update 10.8.04 Hello to all. **I'm Back!** I have some GREAT news to report. After a long week of waiting for the results of my ultrasound and FNA biopsies, Colette and I just learned that the biopsies came back NEGATIVE on both sides of my neck. Neck surgery is not necessary at this time but a follow-up PET and CAT scan will be done in 3 months. I expect the doctor will release me and I'll be able to return to work on 10.18.04, I look forward to returning to work. Thanks again for all your continued prayers, cards, call, visits and gifts.

Update 06.09.05 Work is GREAT! Been traveling around the country, weekly for some time now. To date I still do not have my taste buds back and VERY limited saliva, but keeping this all in perspective, a small inconvenience to live with, based on my initial

diagnosis and prognosis. I just came back from my follow-up visit with the radiation oncologist who told me all is clear. I am still cancer free. One more year of visits every 2 months and then I will be considered somewhat out of the woods for any reoccurrence of the cancer.

September, 2005. I continue to do just fine. And I end this diary with the hope that my story will help others with similar situations to better understand that there are options and hope for you. Don't try and go it alone and try and laugh daily. I tried to look at every test and doctor's visit with anticipation of a **CURE** versus **FEAR** of what they might find. I truly believe that if you can stay focused on **TODAY** you can handle the obstacles placed in your path.

Christopher Urso
Toms River, NJ

UNDERSTANDING AND MANAGING HEAD AND NECK LYMPHEDEMA

By Bonnie B. Lasinski, MA, PT, CLT-LANA

Lymphedema is swelling in a body part that is caused by a disruption/malfunction/abnormal development of the lymphatic pathways that normally assist the body in removing lymph fluid from that area. This swelling or "edema" can cause pain, changes in the skin and subcutaneous tissues, limit normal muscle and joint movement, and alter body image. Lymphedema is most commonly seen in the extremities, but it can occur in the head, neck, abdomen, and genitalia.

The lymphatic system is part of our body's immune system. Lymph vessels transport lymph fluid which contains water, proteins, fat cells, white blood cells, cancer cells, bacteria, and waste products of cell metabolism that collect in the tissues of the body. Lymph fluid contains special white blood cells called macrophages that function to destroy and break down fat, bacteria, viruses, cell debris, etc. These macrophages are the infection fighters of the body and can destroy bacteria that can cause serious infection. Lymph fluid is transported in lymph vessels that pass through a series of lymph nodes that filter and concentrate the lymph, which is then transported in other lymph vessels that eventually connect with the large veins in the neck.

Another critical function of the lymphatic system is the transport of blood proteins (these normally leak out of the blood capillaries into

the tissue spaces) back into the central circulation. These proteins are large in diameter and do not fit into the smaller pores in the walls of the veins. The cell walls of the lymphatic capillaries are made up of special cells with edges that overlap forming a sort of "sliding door" that can open wide enough for large diameter molecules like these proteins to enter the lymph vessels. These cells are connected to the surrounding tissues with small very fine "thread-like" filaments that act as "guide wires, to open and close these cell walls. That is why heavy pressures and shearing pressures applied to the skin of a lymphedematous area can damage these fine connecting filaments and cause the delicate lymphatic capillaries to collapse causing further disruption to lymph drainage. In fact, anything that damages the skin (sunburn, infection, irritation from chemicals) can damage these delicate lymphatic vessels and trigger swelling.

Approximately 24 liters of fluid moves into our body tissues in a twenty-four hour period. Ninety percent of that fluid volume is transported back to the heart by the veins. Ten percent (2 liters per day) can only be transported by the lymphatic system. The body can "play" with this fluid to maintain fluid balance in the body so that despite the amount of fluid a person drinks, despite the temperature/humidity level and the individual's activity level, despite the amount of salt the person ingested that

day, the body is neither swollen nor dehydrated.

What does all this mean to the person who has had surgical removal and/or radiation of lymph vessels/nodes? Every lymph vessel eventually connects (directly or indirectly) to a lymph node. When a lymph node is removed or treated with radiation its function is lost/ impaired and the area of skin and subcutaneous tissue that was drained by that regional lymph node now has difficulty transporting the lymph fluid from that area.

When too much fluid remains in the tissues, the skin stretches and the area swells. There is pressure from the stagnant fluid on nerves, muscles, skin, and blood vessels in the area. Oxygen has difficulty diffusing through the area due to the extra fluid in the tissue spaces. We all know that living tissue needs oxygen to survive and maintain health.

When lymphedema occurs, the macrophages – those infection fighting white blood cells – don't work properly – scientists are not sure why – but they don't work in the area that is swollen. This is a perfect set up for infection to develop and to progress rapidly – an area that is deprived of oxygen and has poorly working infection fighting capability is ripe for a bacterial takeover! The infection that can develop in a lymphedematous area is called "cellulitis" meaning an infection in the cells/tissues. How

LYMPHEDEMA continued on page 6

LYMPEDEMA continued from page 5

do you know whether you have "cellulitis"? The skin of the face/neck may be warm, red, painful, or mottled/blotchy – a rash or pimples can develop. The area can swell suddenly. You may develop swelling/redness/heat/pain inside your mouth. Any of these signs can represent an infection and you should have them checked out by your physician immediately to minimize complications. If your physician is not available you should go to a hospital emergency room and advise them that you had surgery/radiation of lymph nodes in your face/neck and think that you have an infection/cellulitis. This information will help them to evaluate your situation.

So what does all this mean to an individual who has had lymph nodes removed or radiated to treat head/neck cancer? Does it mean that they will definitely develop lymphedema? No it doesn't, but it means that they are always at some risk to develop it as the years progress. Some people are lucky enough to develop collateral lymphatic pathways that take over from the pathways that were surgically removed or damaged by radiation.

There are precautions that individuals at risk should follow to decrease the risk of de-

veloping lymphedema. Meticulous skin care and oral hygiene are very important. Avoid using harsh chemicals/soaps/astringents/de-pilatories on the face/neck. An electric razor is safer for shaving than a regular blade that can cause small nicks/cuts in the skin and trigger an infection. Clean the heads of the razor after each use. If you do shave with a blade razor, use disposables and discard after each use. Check with your dentist/periodontist on the best way to keep your teeth and gums clean while reducing the risk of bleeding from the gums. Talk to your physician/dentist about taking an oral antibiotic before teeth cleaning/periodontal work to reduce the risk of developing an infection after these procedures. The human mouth is full of bacteria (good and bad) and any opening in the skin/gums provides a portal of entry for bacteria. If the face/mouth/neck has been irradiated then the lymphatic system in that area is impaired and the ability to prevent infection in that area is reduced.

Muscle contraction helps to move lymph fluid. Gentle stretching/contracting of the muscles of the face/neck/upper body along with deep breathing exercises can improve lymph drainage. Facial/neck exercises can

help the different layers of tissue in those areas glide more freely allowing for better lymph flow. Changes in pressure in your upper body (thorax – where your lungs are) created when you do breathing exercises help to move lymph as well. That is why breathing and postural exercises are so important. These are not difficult to do and they can really help you to feel better. Simple changes in your posture/positioning in chair/bed may also contribute to improved comfort/sleep that can translate into better energy for you!

Some might say that this is too much information about a condition that might never develop. To them I say that knowledge is power. It is always better to be aware and informed about potential problems so that if they do develop, they are recognized and addressed immediately.

Editor's Note: Bonnie B. Lasinski, MA, PT, CLT-LANA is the Clinical Director of Lymphedema Therapy in Woodbury, NY. Ms. Lasinski is an active member of the International Society of Lymphology and the Oncology Section of the American Physical Therapy Association, a board member of the National Lymphedema Network and the Lymphology Association of North America. For more information

CANCER continued from page 3

Neck Disease Management

The overall treatment strategy to manage the primary site must also incorporate the treatment of potential disease in the neck. This may include surgery or a radiation therapy approach +/- in conjunction with chemotherapy. Regarding cancer of the oral tongue, the patient will likely undergo a neck dissection to excise known or occult neck disease since surgery is the preferred initial method for controlling oral tongue cancer. Depending upon the pathological findings of surgery, additional therapy can be considered to address potential remaining occult oral tongue or neck disease.

Since radiation therapy is typically used for management of base of tongue cancer, the external beam radiation therapy would also be used to target the neck for known or potentially occult neck disease during the same radiation treatment program. There is controversy relating to the need for neck dissection for patients presenting with lymph nodes in the neck after undergoing radiation therapy +/- chemotherapy with apparent complete clinical resolution of the neck

disease. Although the patient may appear to have no palpable or even radiological evidence of disease in the neck, there is still no exact test to determine if there are any occult viable cancer cells in the neck. A strategy that is incorporated at our institution includes the use of external beam radiation therapy +/- chemotherapy followed by an interstitial brachytherapy to the base of tongue cancer site and a planned neck dissection for select patients. The initial dose of external beam radiation therapy can be modified to a lesser dose since surgical neck dissection is planned. This method appears to provide an ongoing excellent regional control of the neck in addition to local control at the primary site. A published review of our patients revealed only one neck recurrence out of 51 neck dissections after undergoing radiation therapy and chemotherapy. During the planned neck dissection, patient may undergo insertion of the brachytherapy catheters performed under a single operation.

Closing

The treatment of tongue cancer usually incorporates a multidisciplinary team

consisting of a head and neck surgeon, radiation oncologist, medical oncologist, radiologist, pathologists, dentists, reconstructive surgeons and skilled nursing care. In addition, a nutritionist, pain specialist, and speech and swallow therapist can provide crucial roles to treatment tolerance and recovery. Close communication between the patient and the treating physicians with an understanding of the treatment strategy, expected side effects and recovery period are essential to overall treatment success and outcome.

Editor's Note: Peter Han, MD is Attending Physician in the Department of Radiation Oncology at Beth Israel Medical Center and St. Luke's Roosevelt Hospital Center, New York, NY

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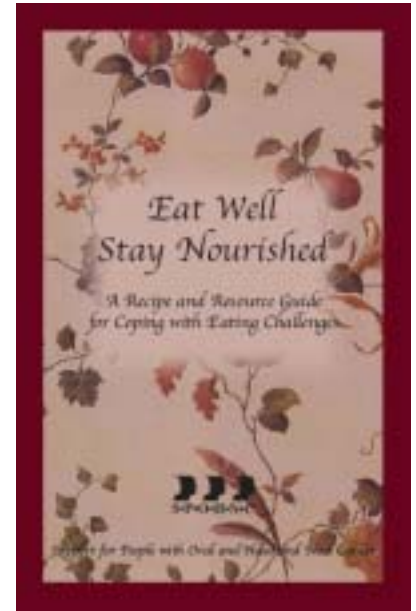
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