



S•P•O•H•N•C
A PROGRAM OF SUPPORT
FOR
PEOPLE WITH
ORAL AND
HEAD AND NECK CANCER

Precision-Oriented Radiotherapy for the Treatment of Head and Neck Cancer

STEVE P. LEE, M.D., PH.D.

Introduction

Radiation is a powerful tool for cancer treatment. It works by delivering focused energy (i.e., *dose*) to destroy or disrupt chemical bonds within the genetic material (DNA) of a cell. Consequently the cell loses its capability to reproduce and leads eventually to its death. In principle, the chance of controlling such tumor growth with radiation increases with the amount of dose it receives. Unfortunately, radiation particles cannot distinguish normal cells from cancerous ones, and damage to normal tissues might occur if care is not taken to precisely localize the dosage onto the intended target while limiting the dose to normal structures and organs. This is of particular importance for cancers of the head and neck, which often mingle with or abut important normal structures that might be similarly sensitive to radiation damage.

In a traditional radiotherapy approach, the volume to be covered by radiation is relatively broad and the total dose given is consequently restricted due to the rather unsophisticated technology in either delineating the true three-dimensional (3-D) extent of the tumor that may be irregular in shape or ensuring the precise delivery of the radiation dose. If the dose is escalated to increase the chance of tumor control, negative side effects may ensue due to excessive damage of the normal organs. If the dose is lowered to spare normal tissues, the tumor recurrence rate may be unacceptably high due to inadequate dose.

A good example is a nasopharynx or oropharynx tumor, for which the irradiated volume usually covers both the primary site and the draining lymph nodes adjacent to the salivary glands. After the treatment, patients may thus experience significant dry mouth permanently. Other critical structures which may cause the treating physicians to curtail the radiation dosage include cranial nerves, optic apparatus, brain stem and spinal cord. Even temporary side effects such as inflammation of the

oral and pharyngeal linings, sore throat and swallowing difficulty could be so debilitating that patients may have a difficult time completing the course of treatment in a timely manner.

Clearly, there would be a therapeutic benefit if one could identify the precise anatomic extent of the patient's cancer and possess the technical ability to tailor the radiation dose to conform tightly around the tumor while avoiding the surrounding normal tissues. Thanks to modern advances in computer technology, significant progress in such *precision-oriented radiotherapy* (PORT) techniques has been made. PORT is now available in the treatment of many malignancies, including head and neck cancer.

Prerequisites of Precision-Oriented Radiotherapy

Precision-oriented radiotherapy begins with the accurate localization of tumor targets as well as normal structures that are to be protected. The first prerequisite of PORT is thus accurate diagnostic imaging. Once the target volume is delineated, the aim of PORT is to deposit high dose within the volume and as little dose as possible outside. Unfortunately, the limiting resolution of typical radiological studies such as computer tomography (CT) or magnetic resonance imaging (MRI) remains to be of the order of about half to one centimeter. This means that as many as a billion tumor cells may be spared inadvertently by PORT, due to its nature of rapid dissipation of dose beyond the edge of the intended treatment volume.

Intuitively, PORT should be indicated whenever tumor irradiation involves substantial chance of normal tissue damage. It might hence be readily accepted when planning radiation treatment that attention to precision is always beneficial. However, sometimes a certain degree of deliberate *imprecision* might be necessary by allowing a generous treatment margin around the intended target volume. This stems from the fact that even if PORT were attained to "perfection", it might at best substitute surgical resection for which one would still face the dreadful limitation a cancer surgeon typically encounters: uncertainty in the *microscopic* extent of the tumor. One may say that PORT is therefore analogous to an invisible knife, and such a sharp "dissection" instrument is much less forgiving in comparison with traditional radiotherapy if "geographical miss" occurs. Note that a malignant tumor is often infiltrative with tentacles not unlike the legs of crabs (thus the term *cancer* – the sign of a crab), the extent of which often remains inconspicuous clinically. This is especially true for many head and neck cancers for which relatively porous channels (e.g. nasopharyngeal cancer transgressing through skull base) or anatomical paths (e.g. lymphovascular or peri-neural invasion) exist to allow easy tumor spread. As far as cancer cells are concerned, physicians should remember that *we can kill what we can see, but it is often what we cannot see that kills the patient*, and getting too "cute" in tailoring treatment volume coverage might be dangerous.

PORT continued on page 2



SUPPORT FOR PEOPLE WITH
ORAL AND HEAD AND NECK CANCER
S•P•O•H•N•C, INC.
P. O. BOX 53
LOCUST VALLEY, NY 11560-0053

BOARD OF DIRECTORS

Nancy E. Leupold, MA, President
James J. Sciubba, D.M.D., Ph.D., Vice President
Jean O. Cashin, Secretary
Walter E. Boehmler, Treasurer
Maria DeMarco Begley, Esq.
Teresa G. Piropato
Wayne Smith
Karrie Zampini, LCSW

MEDICAL ADVISORY BOARD

David M. Brizel, MD Duke University Medical Center	David G. Pfister, MD Memorial Sloan-Kettering Cancer Center
Linda K. Clarke, MS, RN, CORLN Beebe Medical Center	Jed Pollack, MD Long Island Radiation Oncology
David W. Eisele, MD, FACS University of California San Francisco	James J. Sciubba, DMD, PhD Greater Baltimore Medical Center
Bonnie Martin-Harris, PhD, CCC-SLP Medical University of South Carolina	Elliot W. Strong, MD, FACS, Emeritus Memorial Sloan-Kettering Cancer Center
Alex Keller, M.D., FACS North Shore-LIJ Health System	Denise M. Vey Voda, MA, DDS North Shore-LIJ Health System
Eugene N. Myers, MD., FACS Univ. of Pittsburgh School of Medicine	Everett E. Vokes, MD University of Chicago Medical Center
David Myssiorek, MD, FACS New York University	Randal S. Weber, MD, FACS MD Anderson Cancer Center

Karrie Zampini, LCSW
Fighting Chance, Sag Harbor, NY

NEWSLETTER EDITOR

Nancy E. Leupold, MA

WEBMASTER

Barry Sebastian

News From SPOHNC is a publication of
Support for People with Oral and Head and Neck Cancer, Inc.
Copyright ©2007-2008

DISCLAIMER: Support for People with Oral and Head and Neck Cancer, Inc. does not endorse any treatments or products mentioned in this newsletter. Please consult your physician before using any treatments or products.

IN THIS ISSUE

A Time for Sharing.....	6
Executive Director Position Available.....	5
Head and Neck Cancer Studies.....	8
Local Chapters of SPOHNC: Focus on Phoenix, AZ.....	10

**THE NEXT ISSUE OF
NEWS FROM SPOHNC
WILL BE SEPTEMBER, 2008**

PORT continued from page 1

PORT is thus indicated only if the treating radiation oncologist possesses the confident knowledge – though often by educated guess – of the likely microscopic extent of tumor involvement. Such judgment is facilitated initially by appreciating the *macroscopic* extent of the tumor via diagnostic imaging, as well as the statistical knowledge of the likely sites at risk for microscopic spread.

With the help of diagnostic imaging, the 3-D shapes of target volumes and surrounding normal structures are obtained during a process called *simulation*. Such anatomic information is registered electronically and fed into a treatment planning system. A professional team of radiation oncologists, physicists or dosimetrists (who specialize in radiation treatment planning) then design the treatment fields by trying to encompass the radiation dose over the desired target volume while sparing the normal tissues. Since tumors are usually irregular in shape but the basic volume assumed by each radiation beam as it is emitted from the source is often very simple such as a cube or a cylinder, an additional “beam-shaping” device is needed to modify the radiation dose coverage. Traditionally, devices such as metal blocks have been constructed manually and customized for individual patients, and the treatment planning has been rather rudimentary with a dose distribution (*dosimetry*) calculation in 2-D space used as a basis for extrapolation into an idealized 3-D display. When CT-based imaging technique became available and adapted for simulation, more reality-based 3-D oriented *conformal radiotherapy* (CRT) became common practice. Still, because of the laborious ways of constructing customized blocks and other cumbersome beam-modifying devices, the number of radiation fields employed for each patient case remains quite limited and as a consequence the volume irradiated often involves much normal tissues.

Fortunately, new computer technology has been developed in the last decade to allow for very slick 3-D based precision oriented treatment by using machine-driven beam-shaping devices called *multileaf collimators* (MLC). A target volume is basically sliced into numerous contiguous sections by the computer one beam-path at a time, each bounded by a pair of metal leaflets with a width measuring from a few millimeters to a centimeter. Within each slice the dose delivered is calculated for the corresponding target volume the radiation beam traverses. During the treatment, these automated MLCs move swiftly to ensure that the dose coverage tightly conforms to the target, much like the old manually-made metal blocks were designed to do but in a much quicker and efficient fashion. Thus, precise dosimetric determination for any irregularly shaped tumor target or normal tissue in 3-D is feasible, and tools are available for planning physicists and dosimetrists to maximize the therapeutic benefit by a repetitive and interactive process of optimization – all done in lightening speed by the computer. The rapid movement of MLCs can alter the intensity of the radiation beam and allow for a much greater ability to tailor and shape the way radiation dose is deposited in both the target volume and normal tissues.

The era of PORT has thus arrived, but it assumes several divergent forms since different technical and commercial development paths have taken place that result in various approaches for the same goal. In general, PORT has been developed along two separate paths: first, with the attempt to limit patient set-up uncertainty due to motion and other technical factors, and second, with the exploitation of computer technology to help treatment plan optimization.

PORT continued on page 3

PORT continued from page 2

Stereotactic Treatment Techniques

Even if a dosimetry plan is established perfectly according to the locations of the tumor and normal tissues based on the imaging results from the initial simulation, PORT loses its meaning if the positions of these structures deviate during actual treatment because of set-up uncertainty or patient motion. Thus to immobilize patient during irradiation becomes crucial, especially for tumors in the brain or the head and neck. In particular, for relatively few and small tumors, there may be a need to *ablate* such lesions precisely with exceptionally high and focused dose using the so-called *stereotactic radiosurgery* (SRS). Stereotactic techniques were originally developed by neurosurgeons to locate brain lesions with pinpoint accuracy using a 3-D coordinate system with reference to a rigid frame attached to the patient's skull. It is used in radiation oncology when high-dose radiation is indicated to substitute invasive surgical resection (thus the term *radio-surgery*). Commercially available systems can be distinguished along the two different ways of radiation production, but the original purposes and the ultimate clinical results are similar. For systems such as Gamma Knife®, about 200 Cobalt-60 radioisotope sources emitting gamma rays (identical to x-rays) are oriented in a hemispherical fashion or other similar geometrical pattern, and focused on a central point where the lesion target will be placed. The second way of producing such focused radiation is via a linear accelerator (LINAC) that generates an x-ray beam from a single electronic source that can be rotated or moved around a central focus. Well-known commercial x-ray systems include Cyberknife®, X-knife®, Novalis® and other similar configurations. SRS has gained wide popularity among neurosurgeons and radiation oncologists to treat mainly central nervous system tumors (both benign and malignant) and at times functional targets to combat neurophysiological disorders such as trigeminal neuralgia. Characteristically, feasible SRS targets must be small (usually 3 cm or less in diameter), and the number of lesions to be treated must be few (usually 4 or less). Its use for head and neck tumors is usually limited to situations where additional “boost” beyond conventional radiation treatment or salvage for local recurrence might be beneficial.

For most head and neck malignancies, the size of primary tumor is typically larger than what SRS can accommodate, and more importantly its edges are often mingled with

normal tissues. In such cases, stereotactic technique can be combined with the biological advantages of *fractionation*, the process of repeating relatively small dose of radiation in many “fractions” over a long period of time. In this manner, normal tissues may be spared better than the fast-growing malignant tumors, thus therapeutically more beneficial. When used in such a way, the stereotactic treatment is truly a form of radiation therapy, i.e. one that is based on sound *biological* principles, and thus is more appropriately categorized as *stereotactic radiotherapy* (SRT). This is often done using removable body-fixation frames for reproducing a specific patient position over multiple daily treatments.

Certain general guidelines might thus be given regarding selection of SRS vs. SRT. Whenever an aggressive tumor is found located in close proximity to a critical normal tissue, SRT would probably be more beneficial than SRS since the advantage of fractionation can be exploited. On the contrary, if there is not much biological difference - as far as the response to fractionated irradiation is concerned - between the tumor and the surrounding normal tissue (a benign or low-grade lesion usually fits such criteria), SRS may be the treatment of choice, serving as a surgical tool. SRS is thus better suited for benign tumors such as meningiomas and acoustic neuromas, where a single large dose of radiation has a good chance of ablating the tumor, and the risk of microscopic disease spread is nonexistent. We should reiterate that SRT will in general have a theoretical biological advantage over SRS for most malignancies. SRS is often favored for logistic reasons rather than biological considerations per se. Perhaps due to the wide acceptance of SRS, or because SRT is simply a more tedious procedure, clinicians might develop a tendency to minimize the number of fractions for patient treatment. Only with genuinely precise treatment is it safe to do so; by spatially segregating tumors from normal tissues one can then zoom in to treat the former without too much concern of deleterious biologic effect over the latter (i.e., with PORT like SRS, the advantage of fractionation radiobiology might be justifiably ignored due to relatively little involvement of normal tissues).

Intensity Modulated Radiation Therapy (IMRT)

Treatment planning for precision-oriented radiotherapy can be optimized with the use of

computers. This method consists of inverse *planning*, in which the physicist feeds the anatomic information of tumors and normal organs at risk into the computer and specifies the desired outcome with dose constraint for each structure of interest. The computer then searches for the best solution to achieve the goal. The answer will dictate how the treatment machine might adjust (or “modulate”) the radiation beam intensity in an automated fashion by moving the MLCs (beam shaping devices) rapidly across the irradiated target, while constantly avoiding the normal organs. Such a technique is thus called *intensity modulated radiation therapy* (IMRT). This is in contrast to the traditional process of *forward planning*, when physicists literally had to guess and input beforehand which basic set of beam-field arrangements (each with arbitrarily chosen level of uniform intensity) might produce a good dosimetric result, and then finalize on an acceptable plan only after some trials and errors. The difference can be quite remarkable, since the computer-generated IMRT plan allows for a much higher dose within the target and a more conformed dose distribution around the irregular tumor border, while the adjacent normal tissues receive relatively little dose. With the availability of IMRT, one can consider escalating the total radiation dose to the tumor as high as possible and look forward for improvement in the chance of local tumor control, meanwhile minimizing normal tissue side effects.

For head and cancer cancers, IMRT is fast gaining wide acceptance worldwide. Higher dose can be given via IMRT as a “boost” to the primary tumor bed *sequentially* after a course of radiation therapy aimed at a broader coverage of the head and neck region. This follows the traditional practice of the “shrinking-field technique,” with the dosages of various structures (including the tumor) prescribed to commonly accepted values among different practitioners. More often now, IMRT is used from the very beginning of the treatment course with the so-called *simultaneous integrated boost* (SIB) technique. For each fraction of treatment, the *subclinical* (undetected but perceived to be microscopically present) spread of cancer cells in the broad head and neck area is treated to a relatively lower dose, while the primary tumor is irradiated *simultaneously* with a higher dose. Because of this unorthodox approach, the total dose received at any structure of interest and

PORT continued on page 4

PORT continued from page 3

its subsequent clinical effect can vary widely depending on the fractionation schemes used. It is therefore less meaningful to use total *physical* doses for inter-comparison of treatment results using different SIB techniques. Instead, some sort of quantitative *biological* correction is usually needed. Furthermore, IMRT has the potential of introducing dose inhomogeneity *within* a specific structure because of intensity modulation. The biological and clinical consequence due to such effect is still not very well understood, since clinicians have traditionally been trained to be familiar with the consequences of only homogeneous dose distribution across an anatomic object. These issues are at the forefront of clinical radiation oncology research currently, and the art of implementing IMRT is continually being refined.

One of the pitfalls of IMRT is the lack of uniform treatment planning approach among different radiation oncologists or physicists. The computer-assisted inverse planning process introduces way too many dosimetric variables for individuals to manipulate in unison. As a consequence, different planner can result in very different treatment plan. Furthermore, treatment planning software and delivery hardware also vary widely from center to center, thus patients can rarely transfer their radiotherapy care freely without suffering some kind of miscommunication in the technical details. From radiobiological consideration, different levels of physical dosage per fraction cannot be added simply to predict the ultimate clinical consequences. Therefore, unless absolutely necessary, it is not advisable for any IMRT patient to switch doctors or treatment facilities once the treatment begins.

While avoiding excessive dose to the normal tissues, IMRT allows precise dose delivery to the target typically via more beam paths, in effect spreading extremely small amounts of dose to a wider area of the body as compared to the conventional forward-planned 3-D CRT. Thus, while the total dose received at the designated organs at risk may be minimized, the *integral dose* - total dose deposited in the whole body - might still be significant. The health hazard of such pervasive low dose, in particular the induction of second malignancies, remains uncertain and debatable. It might take a few more years, even decades, before it can be determined if this poses any long-term risk. Regardless of the quantitative risk, ways to minimize the integral dose should be ben-

eficial and are being developed by modifying the existing PORT techniques or using entirely different technologies.

Image Guided Radiation Therapy (IGRT) and Adaptive Radiation Therapy (ART)

Image guided radiation therapy (IGRT) is a recent development in radiation oncology beyond IMRT and SRS/SRT. Just like the stereotactic techniques, IGRT is preoccupied with precise tracing of the radiation target in order to compensate for motion uncertainty. An example is to implement *respiratory gating* for tumors in the trunk during each fraction of irradiation by synchronizing the treatment field coverage precisely over a tumor that moves with the patient's respiration. Another frequent application of IGRT is for prostate cancer, since the prostate gland can move slightly (mostly depending on the content of the rectum behind it) from day to day through the long course of radiation therapy. These internal soft-tissue structures that ordinarily will escape radiographic detection can be illuminated if, say, metal seeds could be inserted beforehand as "fiducial markers."

Fortunately, for head and neck cancer, target motion is of relatively low concern since the currently existing immobilization devices for the head are generally adequate and the tumors are often fixed to internal structures. Once simulation is performed and the target is identified, its location will often be assumed to be constant in relation to the surrounding bones. When IGRT is used, one needs only to check the bony landmarks within the skull for position verification before proceeding with daily irradiation.

On the other hand, bulky tumors of the head and neck often shrink readily during the long course of radiation and chemotherapy treatment. The anatomic uncertainty is thus introduced not because of patient motion or set-up error, but the significant anatomic deviations of relevant internal structures due to the progressive change of the tumor bulk (or the patient's significant weight loss). To keep track of this dynamic situation and issue appropriate countermeasure as frequently as possible, *adaptive radiation therapy* (ART) is indicated. The aim of this therapy is to modify sequentially in time the original treatment plan based on the initial simulation scan and the subsequent daily image verification, using sophisticated mathematical algorithm

for mitigation of the geometrical incongruities and variations, without actually repeating the laborious simulation and treatment planning. Active research in this regard is on going.

Other Techniques of PORT

Radiation particles other than x-rays (or photons) used for PORT include protons and heavy ions such as alpha particles (helium nucleus) or carbon anions. These particles are characterized by the so-called *linear energy transfer*—(LET), a quantity measuring the rate of energy loss per length of path. Heavy ions have high LET and thus are "densely ionizing," in comparison with the low-LET photons that are "sparsely ionizing." Particle therapy, especially using protons, is making news headlines nowadays due to the recent commercialization of its use in several nationally known cancer centers.

Protons have a level of LET similar to photons, thus no significant biological advantage (measured as *relative biological effect*, RBE) over high-energy photons or electrons (another kind of radiation commonly used in all radiation oncology centers). A proton beam, however, has a special physical property of releasing very little energy as it traverses into tissue until a fixed depth is reached where almost all the dose is deposited (called a "Bragg peak"). The depth of this dose peak can be manipulated electronically to coincide with the target by varying the energy of the protons. Thus, proton radiation has the dosimetric advantage when treating a deep-seated tumor next to a critical normal structure. Heavy ions have both high LET and the presence of a Bragg peak. If utilized properly, they possess both the physical and biological advantages as the PORT particle of choice for highly "radioresistant" tumors, as long as normal tissue tolerance is also respected (a lesson learned painfully from past research trials using another high-LET particle, neutrons). Both proton and heavy-ion treatment planning may be done in an inverse manner, with intensity modulation amounting to "dose painting." Such may represent the most sophisticated form of PORT, although many technical details remain to be worked out and is under intense investigation at a few treatment centers worldwide. The main disadvantage is their extremely high cost of production and operation.

Another form of PORT is implant (brachy-PORT continued on page 5

PORT continued from page 4

therapy), which has been practiced by radiation oncologists for decades. It involves the manual or machine-driven placement of radioactive sources that emit extremely short-ranged radiation within the tumor volume, usually temporarily over single or multiple sessions. The main advantage of brachytherapy is its relatively low dose to the rest of the patient's body since no external radiation beam traversing the body is involved. Its disadvantages mainly stem from the fact that it involves invasive procedures with operative risks similar to surgery (risks of anesthesia, bleeding, infection, etc.). With the popularity of external beam treatment using IMRT, brachytherapy for head and neck cancer is becoming a rarity and should be performed by experienced hands in selected centers of excellence.

Functional Image Guided PORT

The recent developments of functional imaging studies like *positron emission tomography* (PET) or *magnetic resonance spectroscopy* (MRS) imaging have allowed physicians to consider dose escalation to metabolically-active or radiation-resistant spots within a tumor to help raise the local tumor control rate. These sophisticated imaging techniques may unite modern molecular biology to clinical radiation oncology using IMRT or particle beams for dose painting purpose. As it stands today, much remains to be researched before their clinical application becomes routine.

Even though PORT such as SRS can be used at times to substitute for real surgical resection, a fundamental tenet in surgical oncology still needs to be observed: that is, partial tumor resection (tumor debulking, equivalent to partial radiation field coverage of the tumor) is rarely helpful. Thus, it is important to ensure that the radiation field coverage of the lesion be as complete, with adequate margins, as possible. It is crucial that radiographic imaging be used to help clinicians delineate precisely the extent of the tumor. In fact, functional imaging studies may likely augment the efficacy of PORT better if they could help detect previously unseen tumor edges rather than, or in addition to, identifying metabolically active spots within a tumor.

Conclusion

Because of the technical complexity involved, planning for PORT takes time and requires patience and skill. Since the process involves

judgmental call to weigh the balance between tumor dose escalation vs. minimizing normal tissue damage, a certain art of the trade is at display by the treating doctors and physicists. For any patient, it is crucial to allow the radiation oncology team sufficient time to plan the treatment carefully, rather than urging them to rush through at the possible expense of suboptimal planning. Such minor time delays to ensure the best planning outcome is a worthy investment despite the possible tumor progression during the waiting period. For head and neck cancers, much preparation is usually required including dental evaluation and prophylaxis, construction of intraoral shielding device if indicated, and medical oncology consultation with possible insertion of deep vein catheter or gastrointestinal feeding tube. Once the radiation treatment commences, it is also prudent to avoid significant interruption of the planned therapy schedule since, from clinical radiobiological teaching, cancer cells can exhibit the treatment-induced phenomenon of accelerated growth as overall time course gets prolonged. Despite the use of PORT, treatment induced acute toxicities (e.g. skin irritation, sore throat or swallowing difficulty) are still expected to occur but fortunately are transient, since the dose planned is tailored to limit predominantly permanent late effects (e.g. dry mouth or nerve damage). A strong personal will of the patient is usually required to finish the entire course of prescribed treatment, and psychosocial support from family and friends is also helpful. Frequently, a team approach involving professional healthcare staff makes a significant difference in ensuring a favorable therapeutic outcome.

With the advent of computer technology, PORT techniques like SRS, SRT, or IMRT have certainly fulfilled the goal long-held by radiation oncologists to deliver adequate dose for tumor control while minimizing toxicity to the normal tissues. PORT is thus inherently beneficial, but with the technological improvement its cost has also escalated. This also applies to many new chemotherapy or molecular-targeted drugs. With specific regard to PORT, the ultimate fruition is the *local control* of the tumor, which may or may not lead to the enhancement of survival rate for which the determining factor is the often unknown extent of microscopic disease throughout the patient's body (i.e. *metastasis*). In the case of patients having known systemic metastasis, treatment by PORT can also provide meaningful alleviation of local

symptoms and thereby improve quality of life. Above all, there is no cure by systemic therapy without the simultaneous control of local tumors, and PORT may be used to supplement chemotherapy for such purpose, particularly if the tumors are few in number but too large to be controlled by drugs alone. The general question is to what extent our society should bear the financial burden as the cost of the high-tech cancer treatment continues to skyrocket. Furthermore, the equal accessibility for patients with less ability to pay will remain a hot political item to deal with. The recent surge of many well- and lesser known institutes to build proton or particle treatment facilities (each requiring tens to hundreds of million dollars) will likely push these issues to repeated public debates in medical meetings as well as political gatherings.

Editor's Note: Steve P. Lee, M.D., Ph.D, is the Interim Chair of the UCLA Department of Radiation Oncology and Associate Professor of Radiological Sciences at the David Geffen School of Medicine at UCLA. Dr. Steve Lee was the 2007 recipient of the Physician of the Year Award presented by the UCLA Medical Enterprise during National Nurses Week. He was selected unanimously by the selection committee from among many qualified and deserving candidates.

**Gifts Have Been Received
in Loving Memory
of**

Elizabeth "Liz" Hernandez

by
Susan Malfa and
The Bravo Ad Sales Group/NBC Universal

Roger Jonsson

by
Patty Lee
Lesley Mongelluzzi & Family

Ed Kaneko

by
Jim and Cari Crisman
Antoinette Green
Ted & Kate Gregory
Edwin & Frances Kurata
Airma, Kelly & Max LeGere
Mr. & Mrs. Barry Luck
Charlene Simpson
Morris & Lecretta Trueman

Arnold Pastel

by
Denise Pastel

Orrin G. Sumner

by
Joan S. Sumner

A TIME FOR SHARING

A little over a year ago I wished I was dead. Life was unbearable. My body had been violated. Parts of me were carved away. Parts of me were burnt. My mouth was filled with huge, yellow sores. Other parts were redirected and I had been turned inside-out. Each morning I silently railed at the Angel of Death for not coming to take me in yet another night spent at the edge of sleep, unable to dream because of the pain medication.

I'm Janet Wilder. I'm 61 years old, a small and feisty Jersey Girl now living in way-the-heck-south-Texas. I have always been healthy. I have always been a marathon talker, raconteur, seminar deliverer and a loud and tuneless singer.

In the summer of 2004 my tongue began to feel sore near the lower, left rear molar. I saw a dentist. He didn't see anything wrong. I saw a doctor. He didn't find anything wrong. Six months later the spot was still sore. I saw another dentist and asked that he file down my tooth. He didn't find anything sharp. I went to another doctor. He didn't find anything wrong. I tried yet a third dentist and all he wanted to do was charge me thousands of dollars to do work in other places of my mouth. I went back to the second dentist and the filing commenced. By May of 2006, I was wearing a temporary crown and my tongue really, really hurt.

While accompanying my husband to his doctor visit, he mentioned that I had been complaining about a sore on my tongue. He suggested I show it to the physician and "get some medicine" for it. The doctor looked into my mouth, turned pale and declared that there was no medicine for it. He immediately sent me to the ENT across the street. Because I was in pain the doctor took me in immediately. He donned a glove, felt my tongue, looked into my mouth with a flashlight and pronounced: "you have cancer". Just like that. No dramatics like in the TV shows. No "lets take a biopsy and see what comes back". Just those three dreaded words: "you have cancer." The doctor felt it was small and localized and called it stage I squamous cell carcinoma.. He took a sample for a biopsy, gave me some pain killers and a prescription for lidocaine gel, set up a CT scan and told me that I would just need the surgery since it was small and early.

The scan was clean. I was unhappy about having part of my tongue carved away, but small and early are encouraging words. I went

in for the surgery. When I awoke in the recovery room the ENT was at my side. "I'm so sorry," he said. "The tumor was bigger than we expected. I had to take half of your tongue. You have had a hemi-glossectomy." I managed a garbled "will I ever talk" and made myself cry. He assured me that my speech would improve when the swelling went down. The half tongue that was left felt like two tongues, it was so swollen.

At my first post-op visit the ENT suggested radiation and possibly chemotherapy. The size of my tumor had put it into the stage III category. Protocols must be observed. There was a possibility that a microscopic cancer cell was floating around in my body and it must be killed before it attacked me.

I visited the local medical oncologist, a prince of a man who agreed with my preference for quality of life not quantity of life. He didn't think I needed chemo, but made me a second appointment to see him after I'd seen the radiation oncologist. I also got onto the internet and learned about the ravages of head and neck radiation. I was scared. I'm a hard-core claustrophobic and just the thought of wearing the mask terrified me. I was willing to take my chances with that microscopic cell but the family, meaning well, insisted I embark on the treatment. As anyone who has been through radiation knows, the cure can be worse than the disease.

I was not impressed with the radiation oncologist. Not that he wasn't a good doctor but that it didn't appear they had the resources to deal with the side effects. The nurse handed me a little booklet about side effects and told me to make an appointment to be fitted for the mask. I told my husband that I wasn't going to get radiation. He wanted to hear what the medical oncologist had to say. We saw him and he agreed with me about head and neck radiation at the local facility. They are a good facility for breast cancer, prostate cancer, colon cancer, but if they see one head and neck cancer a year it's a big deal. He made an appointment for me at the University of Texas MD Anderson Cancer Center in Houston, Texas, one of the top three head and neck cancer centers in the country.

The medical oncologist at MDA was a little unhappy that my ENT had not done a neck dissection but he sent me to the radiation oncologist. I had a PET scan which was clear and I was scheduled for radiation therapy. They

sent me to their dentist who x-rayed my teeth and declared I would be losing some of them.

We live five hours south of Houston and we needed a place to stay during the six weeks of radiation and the planning visits before it began. We had a motor home and found a campground close to the hospital that had special rates and a shuttle bus for campers. We brought our little dog with us and towed our Honda Civic behind the motorhome so we would have a daily driver.

The morning I was supposed to see the dentist to have an unknown number of teeth pulled, our little dog died. She was nine years old and had some heart problems for which she was medicated, but her death was unexpected. The dentist pulled three lower teeth. Two directly to the left of the front teeth and the next to the last molar on the right.

A few days later I saw the oncological dentist who made a stent for me to wear during radiation that would protect salivary glands and tissue that did not need to be radiated. He also made my fluoride trays and directed me to start using them as soon as I started radiation.

The radiation team knew of my claustrophobia and I was given Ativan before the mask making and simulation. I also took one before each treatment. Even with the drugs, I could barely tolerate the mask.

I went through the horrors of radiation. My mouth hurt, I could barely swallow, my neck was red, raw and weeping, but we drove the car home every weekend and I took great comfort in being there, even if it was just for a few days. I was holding my weight using Slim Fast so I cancelled the insertion of the feeding tube.

By the last two weeks I was heavily medicated with morphine and methadon in liquid form. The patch did not work and I was allergic to the adhesive. I had a variety of swishes and was religious about my baking soda rinses. Pain could be killed long enough for slow sipping of canned nutrition and water. My taste buds went away, but before they left they got weird and everything tasted vile. Everything that went into my mouth had to be room temperature.

Because I had no treatment on Labor Day, I was to double up on that Thursday. I had my treatment in the morning and then I was to see the radiation oncologist for my weekly clinic visit. I complained that my stomach hurt. I had a fever so they sent me to the emergency room

where they sent me for an x-ray. A doctor came in and told me that my colon had ruptured and that I needed to have surgery immediately. This with only 4 more radiation treatments to go.

I awoke from the surgery with a colostomy. The surgeon called it a “double barrel” because both ends of the colon had been brought to the surface. The pain medication had slowed down my digestive system and there were large pieces of stuff stuck to the wall of my colon. Other stuff moved through the “normal” way (if you can call 8 Sennakot S a day “normal”) and while it was passing through it pushed the hard stuff right through the wall of my colon.

This was much more than I had bargained for. All of this to defeat a hypothetical microscopic cancer cell? I’m a fighter and there must have been a spark left somewhere within me because when my radiation oncologist appeared at my bedside a few days after surgery to encourage me to finish the last four treatments, I agreed. I finished them as an in-patient. After a week, they sent us home to our motorhome.

I spent one night there and was back in the hospital the next afternoon. My temperature had begun to rise. The emergency room doctor looked at my incision that stretched from navel to the bottom of my abdomen and decided that part of it was infected. He took out the staples and left a six inch long by three inch deep red, angry gash in my stomach. Then he showed me how to pack it with gauze dipped in saline solution and cover it with dry gauze. He assured me it would heal from the inside out. We didn’t believe him.

I was admitted to the hospital again for dehydration. By that time my mouth was so bad and my spirits so low that I was anorexic. I asked for the feeding tube. They looked at my shrinking abdomen with the huge appliance covering two pieces of colon and the enormous gaping wound and said: “where would we put it?” I spent another week in the hospital.

Don’t ask how I managed to survive. I just did. After two weeks we got permission to return home so we hitched up and left. I do not sleep when taking opiates. I doze and awaken in a series of very short naps, but no REM sleep. I was already off the morphine and had finished the tapering-down program on the methadon, but still not sleeping. I was depressed. I only wanted to die. When the last of the drugs left my system, I managed to sleep for a few hours at a time and that’s when I started to get better. I now recognize that I was sleep deprived.

Two and a half months after the colostomy, I convinced the gastric surgeon to reconnect me. The surgery was painful, leaving me with yet another open wound to care for. My body, though starting to make a comeback from the depths of hell, did not have the resources for a speedy recovery. It took me four months to recover.

It has been 18 months since my hemiglossectomy and a little more than a year since the second gastric surgery. I have gained back some of the weight I lost, climbing from 98 pounds to 113. I’d like to give back 5. I have my old energy back and I have no evidence of cancer. I still have some issues with my bowels, but everything is under control and I will be starting to go to the gym soon. There are things I will never be able to eat again, but there are plenty of things I can enjoy. I’m not missing any tastes, though I still can’t tolerate hot or cold foods and only the first bite of ice cream tastes good. The rest only feels good. I have a partial denture and just got permission from my dental oncologist to get some veneers as long as no work goes below the gum line.

My ENT and my radiation therapist are astounded by how well my speech has recovered. My voice has power and range though I lisp. I’m very conscious of it, though others say they barely notice it. A few nights ago I went with my husband as moral support to an audition for our local community theater. I read for a part just to see if I could, even though the director was looking for “diction.” I got a part! My husband says it will give me confidence. I’m a little scared, but I’ve been scared worse.

It is mid-December as I write this and I am thinking that in this season of miracles, I am one.

Postscript: I was a great success in the community theater play. Everyone understood me and I gained the confidence I lacked in my own speech ability. Most people didn’t even notice my speech imperfections. I don’t know if I’ll ever perform in another play, but I do recognize that I have overcome a problem that was more in my mind than in my mouth. All that I needed was someone else’s confidence in me.

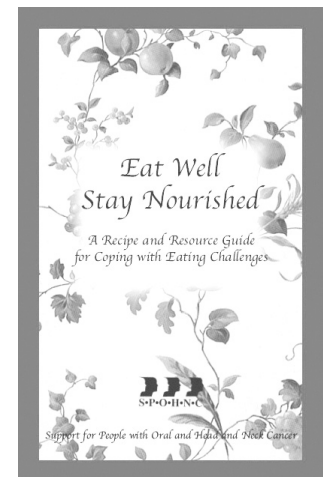
I have now started going to the gym 5 days a week. On Mondays, Wednesdays and Fridays I take classes in water aerobics, Body Pumping® and Pilates®. On Tuesdays and Thursdays I take a Yoga class and on Tuesday nights I am learning to belly dance, though I shall never, ever, do it publicly. I am working on restoring the physical strength that a year and a half of

illness took from my body. I am even getting some strength back in the abdominal muscles that were carved up like a Jack-O-Lantern for the two gastric surgeries.

Before this is published, I will have participated in a local American Cancer Society Relay for Life. I’ll have walked not only for myself but for all the other cancer patients I’ve met either in person or through many of the support boards on the Internet.

I still have a little over three years before I can be “cured” but for right now, I’ll settle for being a chatterbox with no evidence of disease.

Janet Wilder
San Benito, Texas



Eat Well – Stay Nourished: a Recipe and Resource Guide for Coping with Eating Challenges

SPOHNC’S resource guide and cookbook of more than 200 pages provides support and encouragement to people with eating challenges. This book contains special pages of information about swallowing problems and nutrition, cancer journeys of survivors, and suggestions and “Tips from the Pros” (SPOHNC’s members and head and neck cancer survivors).

This recipe and resource guide is certain to be a valuable asset to oral and head and neck cancer patients as well as caregivers and health care professionals involved in their care. The cost of this guide is \$17.50 plus \$2.50 for shipping and handling. To order, call 1-800-377-0928 or order online at www.spohnc.org.

Capecitabine and Docetaxel Combination Therapy Appears Effective in Advanced Head and Neck Cancer

by Shazia Qureshi

PARIS, FRANCE -- February 8, 2008 - Combination therapy with capecitabine and docetaxel showed a partial response in 38.5% of patients with advanced head and neck cancer, according to findings from a study reported here at the 19th International Congress on Anti-Cancer Treatment (ICACT).

Docetaxel and capecitabine previously have been shown to be useful drugs in the treatment of head and neck cancer," said the study's lead author, Joan Manel Mañé, MD, Medical Oncologist, Hospital de Cruces, Bilbao, Spain, who presented the study in a poster session on February 7. For this reason, her team conducted a study to evaluate the combination of these two drugs in nonselected patients with advanced or metastatic head and neck cancer.

Dr. Mañé and colleagues enrolled 33

patients with a mean age of 60 years who presented with squamous-cell locally advanced or metastatic (M1) head and neck cancer. One patient was female. The cancer was local in 49% of patients, local and M1 in 36% of patients, and M1 in 15% of patients. Of those patients whose cancer was staged as M1, the main site of the metastasis was the lungs in 76.5% of patients, lymph nodes in 11.8%, bone in 5.9%, and soft tissue in 5.9% of patients.

The treatment regimen consisted of 75 mg/m² of docetaxel on day 1, and capecitabine at a dose of 950 mg/m² every 12 hours on days 2 to 14. Patients received this combination therapy every 3 weeks for a mean of 4 treatment cycles (range 1-7).

The researchers were able to evaluate treatment response in 26 of the patients. A complete response was seen in 7.7% and a

partial response in 38.5% of patients. In addition, 34.6% of patients achieved stable disease and 19.2% had disease progression.

The findings also showed that median time to progression was 21 weeks (95% confidence interval [CI] 17.5-24.2). Median overall survival was 39.8 weeks (95% CI 32.4-47.4).

The most commonly occurring severe adverse events in the study patients included neutropenia, febrile neutropenia, mucositis, and asthenia. Two patients suffered toxic deaths.

Combination therapy with capecitabine and docetaxel appears to be effective in first-line treatment of advanced head and neck cancer and should be evaluated in larger studies, Dr. Mañé concluded.

EXECUTIVE DIRECTOR POSITION AVAILABLE

SPOHNC is currently looking for an Executive Director. We are seeking highly qualified applicants for this position. The successful candidate will serve as chief liaison to contributors, pharmaceutical companies and government agencies; report directly to the Board of Directors; directly supervise staff; and provide overall leadership and strategic direction to ensure maximum program effectiveness and impact. Specifically, essential job functions will include:

- Assisting with the development and implementation of the annual budget.
- Raising adequate funds to permit the organization to carry out its mission.
- Overseeing the Outreach Program: The National Survivor Volunteer Network (NSVN); Chapter Development; and Message Board
- Development of SPOHNC's national newsletter.
- Maintaining a working knowledge of significant developments and trends in the field of oral and head and neck cancer.

Candidates should have the following knowledge, skills, and abilities:

- Demonstrated ability to fundraise.
- Leadership/management role in a non-profit organization.

- Strong administrative, project management, communication and writing skills.
- Ability to travel and work in excess of 40 hours per week or on weekends when essential.
- Bachelors degree, Masters degree or above in a relevant field.

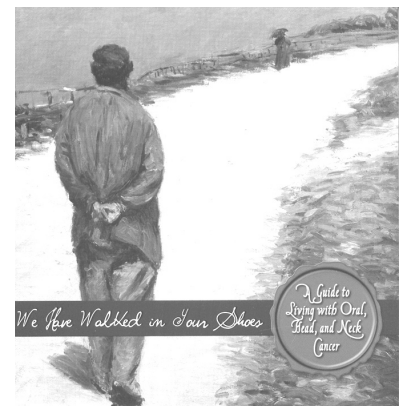
Interested candidates should submit, via email (Microsoft Word compatible attachments) a cover letter, resume summarizing interest, qualifications and experience, salary history, a brief writing sample stating why he/she is interested in this position, and the names and contact information of three professional references.

Please send all materials to:

Nancy E. Leupold
President & Founder of SPOHNC
nleupold@spohnc.org.

For more information, please call:
Nancy Leupold at 1-800-377-0928.

This position will be available as of January 1, 2009 with a training period beginning in October, 2008.



We Have Walked In Your Shoes, A Resource Guide to Living with Oral, Head and Neck Cancer

This book contains basic information about oral and head and neck cancer and provides resources for patients and families. It is not intended to replace any information and or recommendations made by health care professionals. It is designed to help you get the answers you need. It summarizes the most common advice on living with oral and head and neck cancer, provides you with resources if you want more information, and offers practical tips as well as weekly and monthly calendars to help you track your treatment. This book is free.

Visit www.spohnc.org to order.

For large orders, please call
1-800-377-0928.

(This book was made possible through the
generous support of
Bristol-Myers Squibb & ImClone Systems)

LOCAL CHAPTERS OF SPOHNC

FOCUS ON SPOHNC-Phoenix, AZ

For many years before SPOHNC Phoenix originated, the speech pathologists at Banner Desert Medical Center heard from oral, head and neck cancer patients about the need for a support group in the east valley.

Denise Stats-Caldwell, speech pathologist, contacted SPOHNC National in late 2003. She was paired with Bette Denlinger, a registered nurse, certified health education specialist and nasopharyngeal cancer survivor. In February 2004, they partnered to form the first Arizona chapter of SPOHNC. The first meeting was at Banner Desert Medical Center in Mesa, Arizona. The group was small, with 5 attendees. The meeting space was equally small and designed for "business," not comfort. Despite the accommodations, the small group bonded and grew.

In 2005, Denise found her family and commitments growing and her colleague, Keri Winchester assumed the co-facilitator position. At the same time the group itself was growing and acquired new space at

the hospital. It was a comfortable space that helped the group to feel like they were "visiting," not conducting business. Our meetings are loosely structured. Members have time to sign in, visit and enjoy refreshments. They then share their stories, victories, and challenges or ask questions of the group as a whole. We allow for "one-on-one" time at the end of the meeting. We have a yearly holiday gathering that is a purely social opportunity for members to mingle and celebrate life.

In 2007 we averaged 26 attendees including survivors and their co-survivors (spouses, family members, neighbors, siblings, friends). Just in the month of November we welcomed 40 attendees.

We have obtained speakers based on the interest of our members. Professional speakers have included a Psychiatrist, Oncology Counselor, Endodontist, Acupuncturist, Radiation Oncologist, Oncology Nurse and Registered Dietician. We have featured topics such as advanced directives, trismus

and nutritional supplements.

Over the years members have attended each other's weddings, retirement parties and funerals. They share golf games or get together to cheer on their teams during football season. They interact via emails, phone calls and letters. They laugh and cry together. The "veterans" uplift the newly diagnosed and the newly diagnosed survive to become the ones to carry on the uplifting. This happens because the group has become a family. One of our favorite quotes is "If you look at what you do not have in life, you don't have anything, if you look at what you have in life, you have everything."--Author Unknown. Our meetings are held on the 3rd Wednesday of every month from 4:30-6:30 PM.

For More information, please call:
Keri Winchester, MS CCC-SLP
480-512-3627
email: keri.winchester@bannerhealth.com.

ARIZONA-PHOENIX

Banner Desert Medical Center
3rd Wednesday: 4:30 -6:30 PM
Keri Winchester, MS, CCC-SLP 480-512-5604
Keri.Winchester@bannerhealth.com

ARIZONA-SCOTTSDALE

Virginia G. Piper CA Center
3rd. Thursday: 6:30-8:30 PM
Bette Denlinger, MA, RN 480-838-5194
beneden@cox.net
Chris Henderson, MS, CCC-SLP
602-312-9226
chenderson2@shc.org
Sandy Bates, RN
zoomomof6@cox.net

ARKANSAS-NORTHWEST

NWA Cancer Support Home
3rd. Saturday: 10:00 AM-12:00 PM
Jack Igleburger 479-876-1051/586-4807
tmplnjak@cox.net

CALIFORNIA-LOS ANGELES-UCLA

UCLA Med. Pla., Rad/Onc Conf. Rm. B-265
1st Tuesday: 6:30-8:00 PM
Pam Hoff, LCSW 310-825-6134
phoff@mednet.ucla.edu

CALIFORNIA-ORANGE-UCI

Chao Family Comprehensive CA. Ctr.
1st. Monday: 6:30-8:00 PM
Jennifer Higgins, MSW 714-456-5235
jhiggins@uci.edu

CALIFORNIA-PASO ROBLES

The Wellness Community
1st Tuesday: 6:00 PM
Kenda Kellawan 805-238-4411
kenda.kellawan@wellnesscommunityhope.org

CALIFORNIA-SAN DIEGO

Valerie Targia 760-751-2109
valtargia@yahoo.com

CALIFORNIA-STANFORD

Stanford Cancer Center
1st Tuesday: 4:00 - 5:30 PM
Jan Porter, LCSW 650-725-4765
jporter@stanfordmed.org
Ann Kearney, MA, CCC-SLP 650-736-0469
akearney@ohns.stanford.edu

COLORADO-DENVER

Porter Adventist Hospital
Last Tuesday: 6:30-8:00 PM
Jeanne Curry 303-778-5832
Jeannecurry@centura.ocr

DC-WASHINGTON

Lombardi Cancer Center.
3rd Monday: 12:15-1:45 PM
Joanne Assarsson, MSW, LICSW 202-444-3755
assarssj@gunet.georgetown.edu

SPOHNC has received a donation given by Janet Anderson
In Honor of Eileen Gobbo

FLORIDA-BOCA RATON
Boca Raton Community Hospital.
1st Tuesday: 4:00-5:00 PM
Laura Moon, MSW 561-955-5897
lmoon@brch.com

FLORIDA-ENGLEWOOD
Englewood Community Hospital
3rd. Thursday: 10:30-12:00 PM
Joseph Bauer 941-474-0099

FLORIDA-FT. WALTON BEACH
Ft. Walton Beach Medical Center
3rd Wednesday: 4:00 PM
Ryann Ennis, MA CCC-SLP 850-863-7580
ryann.ennis@hcahealthcare.com
Shanon Leach, MA, CCC-SLP 850-863-7580
shannon.leach@hcahealthcare.com

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
2nd Monday: 6:00-7:00 PM
Carol Glavin, MSW, LCSW 352-371-8695
cfiglavin@cox.net
No calls after 9:00 PM, please

FLORIDA-LECANTO
Robert Boissoneault Oncology Institute
3rd Wednesday: 11:30 AM-1:00 PM
Patrick Meadors, MS 352-342-1822
pmeadors@rboi.com

FLORIDA-MIAMI
UM/Sylvester at Deerfield Beach, Ste.100
2nd. Tuesday: 1:30 PM-3:00 PM
Penny Fisher, MS, RN, CORLN 305-243-4952
pfisher@med.miami.edu
Marty Mash
mashmarty@hotmail.com

FLORIDA-OCALA
Robert Boissoneault Oncology Institute
1st Monday: 11:00 - 12:00 Noon
Patrick Meadors 352-342-1822
pmeadors@rboi.com

FLORIDA-ORLANDO
MD Anderson Cancer Center
2nd Thursday: 2:00 - 3:00 PM
Dana Nolon, MS, LMHC, NCC
321-841-6087

FLORIDA-SARASOTA
The Wellness Community
2nd. Thursday: 5:30 PM
Joseph Bauer 941-474-0099
John Kleinbaum, Ph.D 941-921-5539
hope@wellness-swfl.org

GEORGIA-ATLANTA
St. Joseph's Hospital
2nd Monday: 6:30-8:00 PM
John Sandidge 404-851-5585
jsandidge@sjha.org

GEORGIA-ATLANTA-EMORY
Winship CA Institute (Bldg. G)
Last Monday: 6:30-7:30 PM
Arlene S. Kehir, RN 404-778-2369
Arlene.Kehir@emoryhealthcare.org

ILLINOIS-CHICAGO
Duchossois Ctr.for Advanced Medicine
2nd & 4th Tuesdays
Mary Herbert 773-834-7326
mherbert@medicine.bsd.uchicago.edu

ILLINOIS-MAYWOOD
The Cardinal Bernardin Cancer Ctr.
3rd. Wednesday alternate mo.: 6:00-7:00 PM
Marilyn Myles 708-327-2061
mmyles@lumc.edu

INDIANA-INDY-NORTH
Marion County Public Library
Lawrence Branch
3rd. Tuesday: 7:00-9:00 PM
John Groves 317-872-6674
Jgroves14@comcast.net

INDIANA-INDY-SOUTH
St. Francis Education Center
1st. Thursday: 7:00 PM
Janice Leak, MSN, APRN-BC, AOCN
317-782-6704
Janice.Leak@ssfhs.org

KANSAS-KANSAS CITY
Univ. of Kansas Hospital
2nd & 4th Wednesdays: 4:00 - 5:00 PM
Mary Moody, LMSW 913-588-3630
mmoody@kumc.edu
Dorothy Austin, RN, OCN 913-588-6576
daustin@kumc.edu

LOUISIANA-BATON ROUGE
Cancer Services of Greater Baton Rouge
3rd Wednesday: 12:00 noon
Krystal K. Sauceman, RN 225-572-7943
survivorbr@yahoo.com

MARYLAND-BALTIMORE-GBMC
Milton J. Dance Head & Neck Center
Physicians Pavilion East Conf. Ctr.
3rd. Tuesday, 7:00 PM
Dorothy Gold, LCSW-C, OCN-C
443-849-2980
dgold@gbmc.org

MARYLAND-BALTIMORE-JHMI
Johns Hopkins – Greenspring Station
2nd. Wednesday: 7:00-8:30 PM
Kim Webster 410-955-1176
Kwebste@jhmi.edu
Dwayne Arehart 717-615-7464
darehart@dejazzd.com

MASSACHUSETTS-BOSTON
Massachusetts General Hospital,
One Tuesday each mo.: 6:30-8:00 PM
Valerie Hope Goldstein 617-731-1703
Fernval@aol.com

MASSACHUSETTS-PEABODY
North Shore Cancer Center
2nd Tuesday: 5:30-6:30 PM
Mary Anne Macaulay, LICSW 978-573-5318
mmacaulay@partners.org

MICHIGAN-DETROIT
Henry Ford Hospital
Josephine Ford Cancer Ctr. Rm. 2038D
1st Wednesday: 11:30 AM
Amy Orwig, MSW 313-916-7578
aorwig1@hfhs.org

MICHIGAN-TROY
Beaumont Hospital
Wilson Cancer Resource Center
4th Thursday: 6:30 PM
Carrie Erikson, LCS, 248-964-3430
CErikson@beaumont-hospitals.com

MINNESOTA-MINNEAPOLIS
Ridgedale Hennepin Area Library
1st Monday: 7:00-9:00 PM
Colleen M. Endrizzi 952-545-0200
rivers3jvk@aol.com
Charles Bartlett 952-461-2324

MONTANA-BOZEMAN
Bozeman Deaconess Hospital
3rd. Thursday: 12:00 Noon-1:00 PM
Doug Stiner 406-586-0828
nancydoug@theglobal.net
Wendy Gwinner, LCSW 406-585-5070
wgwinner@bdh-boz.com

MISSOURI-ST. LOUIS
St. Louis University Cancer Center
4th Friday: 10:00 AM - 12:00 noon
Deborah S. Manne, MSN, RDH, RN, OCN
314-577-8880; mannedt@slu.edu
Cathy Turcotte, RN, MSN 314268-7051
turcotte@slu.edu

NEBRASKA-OMAHA
Methodist Cancer Center
1st Friday: 3:00 PM.
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

NEBRASKA-OMAHA
Nebraska Medical Center
3rd Tuesday: 12:00 noon
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

NEW JERSEY-LONG BRANCH
Leon Hess Cancer Center
The Goldsmith Wellness Center
2nd Thursday: 7:00-8:00 PM
Becky Kopke, RN, BSN, OCN 732-923-6473
BKopke@SBHCS.com
Anita M. Pfisterer, MSW, LSW 732-923-6961
ampfisterer@aol.com

NEW JERSEY-MORRISTOWN
Morristown Memorial Hospital
3rd Wednesday: 1:30 PM
Edie Boschen, RN, APN-c, OCN 973-971-4144
Edie.Boschen@atlantichhealth.org
Catherine Owens, LCSW 973-971-5169
Catherine.Owens@atlantichhealth.org

NEW JERSEY-PHILADELPHIA
University of Pennsylvania Hospital
1st Wednesday: 9:30-11:00 AM
Micki Naimoli 856-722-5574
Stefanie Washburn 215-615-0536
Stefanie.washburn@uphs.upenn.edu

NEW JERSEY-TOMS RIVER
Community Medical Center
Last Thursday: 3:00 PM
Sherry Laniado, MSW, LCSW 732-557-8270
slaniado@sbhcs.com

NEW MEXICO-ALBUQUERQUE
Christ Unity Church
3rd Friday: 4:30-5:30 PM
Anita Bryan 505-681-1971
anitabeach2@yahoo.com

NEW YORK-ALBANY
Gilda's Club
3rd Thursday: 7:00-9:00 PM
Joseph Ciccarelli 618-882-9742
jciccarelli001@nycap.rr.com
Norma Neapolitano 518-683-9518
mneapolitano@nycap.rr.com

NEW YORK-BUFFALO
Roswell Park Cancer Institute
3rd Tuesday: 4:30-6:00 PM
Amy Sumbrum, SLP 716-845-4947
amy.sumbrum@roswellpark.org

NEW YORK-MANHATTAN
Beth Israel Head and Neck Institute
4th Tuesday: 1:30-3:30 PM
Jackie Mojica 212-844-8775
jmojica@chnpnet.org

NEW YORK-MANHATTAN
NYU Clinical Cancer Center, 11th Floor
1st Tuesday: 2:00 PM
Carole Wind Mitchell, RN 212-731-6002
carole.mitchell@nyumc.org

NEW YORK-ROCHESTER
Strong Memorial Hospital
1st Thursday: 4:00-5:30 PM
Sandra E. Sabatka, LMSW 585-275-4631
Sandra_Sabatka@URMC.Rochester.edu

NEW YORK-STONY BROOK
Ambulatory Care Pavilion
1st Wednesday: 7:30-9:00 PM
Dennis Staropoli 631-682-7103
den.star@hotmail.com

NEW YORK-SYOSSET
NSLIJ-Syosset Hospital
2nd Thursday: 7:30-9:00 PM
Nancy Leupold 516-759-5333
nleupold@spohnc.org

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd Thursday: 7:00 PM
Mark Tenzer 914-328-2072
tenzer1@optonline.net

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
Tom Wurz 440-243-6220
TomRoe8@adelphia.net
Gwen Paull, LISW 216-476-7241
gwenpaull@fairviewhospital.org

OHIO-COLUMBUS
The James Cancer Hospital &
Solove Research Institute
1st Monday: 3:30-5:30 PM
Vicki Heinke, LISW 614-293-7042
Vicki.Heinke@osumc.edu

OHIO-KETTERING
Kettering Medical Center
2nd Monday: 2:00-3:00 PM
Rae Norrod, MS, RN, AOCN, CNS
937-395-8115
rae.norrod@khnetwork.org
Hank Deneski: wohnc@earthlink.net

OKLAHOMA-TULSA
Hardesty Public Library
1st Tuesday: 6:30 PM
Christine B. Griffin, RN 918-261-8858
Beritgriffin@cox.net

OREGON-MEDFORD
Providence Medical Center
2nd Friday: 12:00-1:30 PM
Richard Boucher 650-269-8323
richard.boucher@hp.com

PENNSYLVANIA-MECHANICSBURG
Health South Lab
3rd Tues: 6:30 PM
Joseph F. Brelsford 717-774-8370
jfbrelsford1@mmm.com

PENNSYLVANIA-MONROEVILLE
Inter Community Cancer Center
Last Friday of the month: 3:00 - 4:00 PM
Beth Madrishin 412-856-7740
bmrashid@wpahs.org

TEXAS-DALLAS
Baylor Irving-Coppell Medical Center
2nd Saturday: 10:00 AM
Dan Stack 972-373-9599
danrstack@aol.com

TEXAS-DALLAS
Cvetko Ctr. at Sammons Cancer Ctr.
2nd Tuesday: 11:00 AM-12:30 PM
Jack Mitchell 972-496-6561
jackmitchell5225@aol.com
Travis Maxwell 214-820-2608
travism@BaylorHealth.edu

TEXAS-FORT WORTH
Moncrief Cancer Resources
2nd Wednesday: 3:30-5:00 PM
Valerie Oxford, MSSW
817-927-6364/838-4863
Valerie.Oxford@moncrief.com

TEXAS-HOUSTON/TOMBALL
Tomball Regional Hospital
2nd Thursday: 12:00 Noon-1:30 PM
Lynda Tustin, RN 281-401-5900
ltustin@tomballhospital.org

VIRGINIA-CHARLOTTESVILLE
Dept. of Forestry Building, Suite 800
Last Thursday: 12:00 Noon-1:00 PM
Vikki Bravo 434-982-4091
vsb4n@virginia.edu

VIRGINIA-FAIRFAX
Inova Fairfax Hospital, Radiation/Oncology
2nd Wednesday: 5:30-7:00 PM
Corinne Cook, LCSW 703-776-2813
Corinne.cook@inova.com

VIRGINIA-NORFOLK
Sentara Norfolk General Hospital
3rd Monday: 7:00 PM
Helen Grathwohl 757-487-2624
agrath3004@aol.com

WISCONSIN-MADISON
Univ. of Wisconsin Hospital
ENT Clinic Rm. G3/206
1st Wednesday: 11:30-1:00 PM
Rachael Kammer, MS, CCC, SLP 608-263-4896
Kammer@surgery.wisc.edu
Peggy Wiederholt, RN 608-265-3044
wiederholt@humonc.wisc.edu

Call 1-800-377-0928 to become a member and make a contribution by credit card or order on line at www.spohnc.org

- ANNUAL MEMBERSHIP**
- \$25.00 individual
 - \$30.00 family
 - \$30.00 Foreign (US Currency)
- CONTRIBUTIONS**
- Booster, \$15+
 - Donor, \$50+
 - Sponsor, \$100+
 - Patron, \$500+
 - Benefactor, \$1,000+
 - Founder, \$5,000+
 - Leaders Circle, \$10,000+

Please Check: Survivor Friend Health Professional (Specialty)

 City _____ State _____ Zip _____

 Address _____

 Address _____

 Name _____ Phone (_____) _____

MEMBERSHIP APPLICATION
 SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.
 Membership includes subscription to eight issues of *News From SPOHNC*

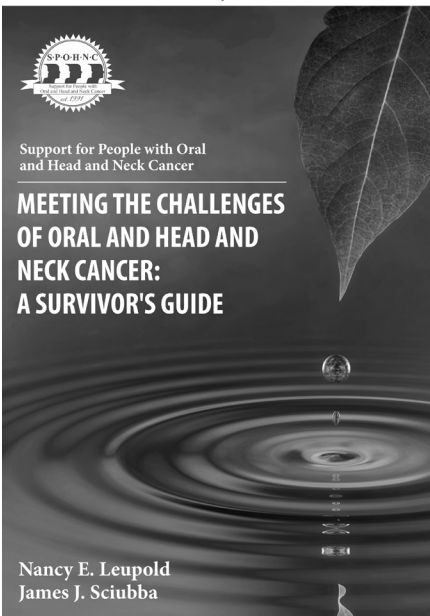
SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER (SPOHNC)



SUPPORT FOR PEOPLE WITH
 ORAL AND HEAD AND NECK CANCER
 P. O. BOX 53
 LOCUST VALLEY, NY 11560-0053

NON-PROFIT
 ORGANIZATION
 U.S. POSTAGE
 PAID
 LOCUST VALLEY, NY
 PERMIT NO. 28

LIMITED TIME ONLY
ORDER NOW GET 10% off
 Discount code: AP302
www.spohnc.org



Cost of book: \$24.99 US plus S&H