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Physical Therapy and Its Role in Head & Neck Cancer Rehabilitation

Nancy B. McGeough, MPT

Mary Ann Wilmarth, PT, DPT, MS, OCS, MTC, CERT. MDT

Often, when a patient receives medical treatments for head and neck cancer, there are some side effects that can be helped by physical therapy (PT). The scars will heal, but what about the muscle weakness, swelling, and pain? Physical therapy could help with some of these impairments.

It is vital that you, as the patient, and your medical team become excellent communicators in order to optimize your treatments and recovery and to have you return to your activities of daily living as quickly and seamlessly as possible.

What to Expect on Your First Physical Therapy Visit

Physical therapists complete full assessments prior to initiating any interventions. A complete history will be taken which will generally include questionnaires to outline baseline function and perceptions. Depending on the type of cancer remedying treatments you have undergone, the therapist will assess functioning of the musculoskeletal, neurological, cardiopulmonary, and integumentary systems (skin, and skin derivatives; (hair, nails, glands and receptors). The PT examination may include assessment of the following: neck, shoulder, and jaw, active and passive range of motion, muscle strength and flexibility, facial symmetry, edema, skin integrity particularly in the presence of radiation burns or scarring, cranial nerve testing, sensory testing, deep tendon reflexes, pain, posture, gait and balance, dexterity and coordination testing, the need for adaptive devices or orthotics, and work or recreational activity needs. While each examination is individualized to your specific status, it is important for you to contribute in the development of your personal physical therapy goals. Physical therapists help facilitate the healing process but the ultimate responsibility is up to you for follow through with the mutually established plan. Physical therapy involves rehabilitating the body as a whole, from lifting the arm to complex activity-related tasks to psychosocial

integration. Physical therapists look at the entire neuromusculoskeletal and systemic functioning of the person as a whole. If one part of the puzzle of the human body is affected, then this has an influence on the remaining functions of the body. It is important for both the therapist and the patient and family to recognize this during rehabilitation and establish reasonable treatment goals.

Treatment Interventions

The American Physical Therapy Association has published the *Guide to Physical Therapy Practice*. In accordance with this guideline, the therapist will evaluate the information gathered from the examination and synthesize and integrate it into an appropriate treatment plan. Evidence-based physical therapy interventions, those that have substantial research to support them are applied to the impairments commonly seen in the population of patients recovering from head and neck cancer treatments.

- **Range of motion (ROM):** All patients post surgery may need some form of ROM exercises, on their own and/or with a therapist. After Selective Neck Dissection (SND) or Modified Radical Neck Dissection (MRND), ROM may return quickly, but further interventions and facilitation may be required if the patient has had extensive surgery and/or radiation therapy. *Example: Look over the right and then the left shoulder for neck rotation; hold each for a minimum of 10 seconds.*

- **Mobilization/manipulation:** Joint mobilization/manipulations are performed by the therapist for the cervical spine (neck), thoracic spine (upper back), shoulder and upper extremity as necessary and determined with the assessment. This occurs when the accessory motions need to be increased in order to achieve full ROM and optimal functioning. *Example follow-up exercise: Use a towel and put under one arm, wrap around the back, and over the other shoulder, then tip your head in the opposite direction away from the towel. Go to tolerance and hold 20-30 seconds.*

- **Soft tissue mobilization (STM):** STM and manipulations are often done in conjunction with ROM exercises. Generally performed by the therapist, some mobilizations can become part of your home routine. STM includes deep tissue massage, transverse friction massage, trigger point release, and scar tissue remodeling with stretches for flexibility following STM interventions. Physical therapists use various techniques for manual treatment, all mainly focused on extensibility of the skin, connective tissue layers, muscles, tendons, ligaments, and joint capsules. *Example: Tip your right ear towards your right shoulder until you can feel a gentle stretch and hold for 20-30 seconds.*

- **Strengthening:** As ROM is restored, strengthening begins. It is important to maintain some level of cardiovascular fitness as well as general muscle strength, thus a walking routine and gentle isometric exercises may be a way to start. As your rehabilitation progresses, progressive resistance exercise (PRE) can be added, which may include free weights, resistance tubing, or adjustable weight machines. McNeely et al studied the effects of PRE in patients who had varying combinations of treatments for head and neck cancer. The authors reported a high

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adherence rate for the twelve week program and concluded that PRE for the shoulder and upper extremities was effective. The principles of exercise will be applied to your particular needs, incorporating intensity (how hard you work), frequency (how often you work), volume (how many repetitions), and mode of exercise (aerobic, isometric). An additional mode of strengthening that may be incorporated is proprioceptive neuromuscular facilitation (PNF), which involves manual input from your therapist to retrain functional movement patterns of the head, neck, and shoulder. *Example: Squeeze the shoulder blades together and lift extended arms behind the back.*

- **Posture training:** Ideal posture is when the ear canal, tip of the shoulder, hip, knee and ankle all fall in line with a lateral view. The therapist should observe the posture of the head on the neck and neck on the shoulder girdle. Head and neck posture influence other structures and reflect postural habits. Asymmetries are observed in both the sagittal and frontal planes. Forward head posture and rounded shoulders are particularly noted and may be due to elongated, weak scapular retractors, weak abdominal muscles, shortened suboccipitals and sternocleidomastoid muscle of the neck, shortened pectoralis major and minor and upper trapezius muscle and levator scapulae of the scapula. The “muscular imbalance patterns” according to Janda, describe the situation where some muscles become weak while others become tight losing their extensibility. Posture correction (general head posture, sitting, lying, sleeping, standing, eating, walking, and lifting and carrying items) and cognitive behavioral training have been shown to be effective in the management of myofascial pain (MFP) with limited jaw opening in a study by Komiyama A et al. Another study, by Wright EF et al indicated that posture training and self-management instructions are more useful for temporomandibular muscle disorders than self-management instructions alone. With ideal or neutral posture there is a balance of muscle length and tension, which results in improved functioning of the upper back, neck, jaw and arms. Postural exercises are always included in the treatment plan and are a part of the home exercise program. *Example: Chin tuck or axial extension exercise. Hold 5 seconds.*

- **Balance and gait training:** Interventions for balance and gait will be part of the treatment plan if the tumor is/was located on or near the spinal cord or in certain parts of the brain such as the cerebellum. Balance and gait may also be affected after prolonged periods of bed rest or a sedentary lifestyle. Balance and gait are complex tasks that require coordination, proprioception (position sense), muscle strength, ROM of the lower extremities, and neuromuscular control. Your therapist will guide you through this process. *Example: Stand near a counter to have support if you need it and balance on one foot. See how long you can do so and then compare to the other side. Goal is 1 minute on each side.*

- **Modalities:** Various modalities can be effective during rehabilitation. For example, electrical stimulation may be used to stimulate muscle fibers to prevent atrophy, coordinate co-contraction, or reduce pain (Transcutaneous Electrical Nerve Stimulation: TENS). Other modalities can include hydrotherapy, biofeedback, or laser treatment. Based on your individual impairment and contraindications of some modalities, the therapist will determine the modalities are right for each patient,

- **TMJ management:** For people with jaw pain and dysfunction, chewy and firm foods as well as biting into foods such as an apple, carrot or celery, are to be avoided and food should be cut into bite sized pieces and placed towards the molars for chewing. Exclusive unilateral chewing should also be avoided and emphasis should be on chewing on both sides or switching sides if possible. If chewing is painful, soft foods or a liquid diet are recommended. Yawning usually involves wide uncontrolled automatic opening of the jaw and thus, can be monitored and lessened

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by making a fist and gently placing it under the chin, flexing the head and neck, and positioning the tongue up on the roof of the mouth. It is best to avoid wide opening activities such as singing, prolonged dental work (take frequent breaks as necessary), and compression with resting the jaw on the hand, if it aggravates pain. Post-it notes or stickers can be tacked in several locations as reminders not to clench your jaw. Lipstick or lipstick with taste can be applied to increase awareness of lip biting or sucking. Jaw tensing when biting objects, pushing the tongue against the teeth, biting the cheeks or lips, and other habits should be avoided.

The rest position of the jaw is important and emphasizes keeping the teeth slightly apart and the masticatory muscles relaxed. The goal of the awareness exercises is to introduce good habits and to replace the poor habits, which may take up to two months to eliminate. In addition to exercises, a conscious effort with frequent daily practice is essential. Opening with the tongue lightly touching the roof of the mouth maintains hinge movement (rotation) and avoids anterior translation of the jaw, thus encouraging symmetrical opening. It is often helpful to perform the exercises in front of a mirror for visual feedback.

Deep diaphragmatic breathing is taught to patients with TMJ dysfunction as well as status post cancer treatments in order to help them to relax and be more in tune with their body and its reactions to stress. Sometimes a pain diary helps to review daily activities that exacerbate pain and modifications can be made accordingly.

Specific jaw exercises, as well as general aerobic and relaxation exercises, are recommended to the patient especially for myofascial problems. A daily walk, run, swim or other aerobic activity as well as relaxation including deep breathing are required for optimal results. Meditation, self-hypnosis, autogenics, and/or stress management techniques are to be investigated if the pain is related in any way to emotional or stress issues. Generally, every patient can benefit from the above-mentioned in terms of stress.

- **Edema management:** Lymphedema is treated with a special form of massage called manual lymph drainage (MLD). Therapists instructed in this technique attempt to stimulate lymphatic flow away from the affected area to healthy lymph nodes for drainage. It feels like very light pressure and involves stimulating several areas of the body including the contralateral neck, axillary area, and abdomen. You may be instructed to perform this massage on yourself as part of your home routine. MLD cannot be

performed over local infections and caution should be taken over the carotid sinus. You may also have to be fit for a custom compression garment depending on the severity and location of the edema. This condition is considered chronic because it can come and go if triggered by airplane travel, exhaustive exercise, restrictive clothing, or local infection.

- **Orthotic fabrication:** To prevent the shoulder blade from sticking out in the back, (scapular winging), a custom orthotic device may be fabricated for the patient. It will be strapped to the thorax to prevent the undesired motion and retrain supporting muscles. Kizilay et al report that use of the device two weeks after Radical Neck Dissection (RND) resulted in 72% of the patients being painfree after 3 months. Realigning the scapula with the clavicle and humerus led to improved functional gains, but not necessarily increased ROM. Success has also been seen with various taping techniques to accomplish this goal, however, with skin sensitivity this is not necessarily recommended. Each patient is assessed on an individual basis.

- **Home exercise program (HEP):** The therapist will work with you to develop a comprehensive HEP including exercises and self-mobilizations that are reasonable for you to do on a daily or otherwise noted basis. In addition, you will be advised regarding optimal postures, static and dynamic body mechanics, and ergonomics given your specific situation. Manual lymph drainage may require more frequent in clinic treatments, but otherwise, you can complete most of your physical therapy in the comfort of your own home.

Although the evidence with research and publications for physical therapy with patients having head and neck cancer is limited, all articles do advocate for physical therapy as an integral part of the treatment plan. A study by Cappiello et al, states that "physical therapy is mandatory to prevent shoulder pain and functional limitations." Others have shown that early physical therapy contributes to decreased shoulder complaints and improved QOL. Aside from the limitations in the head and neck, the shoulder dysfunction can often be more limiting with activities of daily living. Further controlled studies and case reports are necessary in this area. Specifically, there is a need for additional research regarding the efficacy of physical therapy on outcomes related to cancer treatments.

Quality of Life

Many studies have compared the functional outcomes in RND compared MRND or SND.

In most cases, when the spinal accessory nerve is preserved, patients had less pain and increased residual shoulder function, and therefore improved QOL. Kuntz and Weymuller completed a prospective study of 84 patients treated with varying combinations of radiation, surgery, and/or chemotherapy for head and neck cancer. Patients took a QOL survey before treatment, 6 months and 12 months post treatment. MRND and RND patients reported greater shoulder disability at 6 months than those with SND. However, by 12 months, the MRND and SND reported similar levels of recovery that were significantly greater than those who had RND. Terrell et al, found similar results. In addition, patients whose surgery spared the SAN (Spinal Accessory Nerve) also reported less pain.

Even just one of the impairments mentioned can have a profound impact on QOL. As defined by the American Cancer Society, QOL is qualified in four areas, social, psychological, physical, and spiritual. Physical therapy addresses primarily the physical aspect of QOL, but can also indirectly improve the other three areas. For example, meeting a physical goal improves self-esteem, reduces feelings of depression, and helps get you back to what you enjoy doing in life. Kuntz defined QOL in nine domains, namely, pain, appearance, activity, recreation/entertainment, employment, chewing, swallowing, speech, and shoulder disability. Regardless of how you define it, physical therapy addresses QOL needs.

Conclusion

Physical therapists are adept at rehabilitation of the neuromusculoskeletal system and strive to get you to meet your functional goals. They work closely with oncologists, neurologists, speech and language pathologists, occupational therapists, and dentists among others. It is definitely a team effort and although the patient is the center of the team, the physical therapist is an integral part as well.

Some controversy exists as to how quickly an exercise routine should be introduced. Often, fatigue limits daily functions and contact on radiated skin is irritating. However, the benefits of physical therapy clearly outweigh these discomforts and physical therapists can assist you with the intricacies of your rehabilitation. Ask your doctor if physical therapy would be right for you, chances are, it would be!

Editor's Note: Dr. Mary Ann Wilmarth is the Director of the Transitional Doctor of Physical Therapy Program as well as an Assistant Dean for Health within the College of Professional Studies at Northeastern University, Boston, MA. Dr. Wilmarth coordinates the doctoral capstone work for all of the students in the DPT program.

A TIME FOR SHARING...My ongoing adventure with dry mouth

In October of 2005, during an annual physical exam, the doctor found a lump on the left side of my neck. It proved to be cancerous and was removed in December of the same year along with one of my two major salivary glands. In February of 2006, I began 30 radiation treatments on both sides of my neck area lasting until March 21.

By March 21, 2006, my weight dropped from 174lbs. to 144lbs. (2 lbs. greater than my high school weight). All foods tasted different, usually bad. With almost no saliva, it was impossible to eat anything that needed chewing. All my meals were liquid from hot cereal to canned power drinks. Heightened sense of smell led to much difficulty in dealing with my wife's cooking and her breath both of which caused much gagging. I even asked her to stop kissing me. I could smell tulips across the room! Water tasted like metal. Rich Oberweiss eggnog tasted like soap.

My goals were to take in protein to rebuild lost muscle mass; eat carbohydrates for energy and weight gain; include fiber in my diet for regularity (I suffered from severe constipation during the last week of radiation treatments); and take vitamins & mineral supplements to help balance my diet.

During the first year after treatment, I was without saliva. I would get dizzy but never hungry, and with continued difficulty in swallowing, small frequent liquid meals were best – 5-6 per day. For the first few months my throat was very sore and the smell and taste of food would make me nauseous to the point of gagging. Water, even though tasting bad, was my friend. It needed to be tap fluoridated tap water, not purchased bottled water, to help compensate for the loss of saliva to protect my teeth. I carried a bottle of water with me at all times. Low sodium foods were essential. Hot or cold foods were a challenge for the first 3 months.

To protect my teeth and soothe my sore throat I would gargle and rinse my mouth several times a day with Biotene Mouthwash and brush my teeth after each meal with Biotene Dry Mouth Toothpaste (Costco has the best price for both these products). I also had my dentist prepare fluoride trays for my

upper and lower teeth. Just before retiring each evening I would apply a small amount of a 1.1% Sodium Fluoride Gel in each tray and insert the two trays on my teeth for a few minutes. With these procedures I hoped to mitigate my condition in the seventh age as described by the Bard (Shakespeare in As You Like It, "*Last scene of all, that ends this strange eventful history, is second childishness and mere oblivion – Sans teeth, sans eyes, sans taste, sans everything.*")

GNC has a product called, Real Gains with 108% of your daily protein requirement per serving (not counting what I added to it). I mixed this powder with whole milk, several scoops of rich ice cream and Benefiber. This combination filled two 8 oz glasses, one of which I had with breakfast and the other with the evening meal.

Early on, breakfast also included hot creamy cereals (with lots of honey). These included Malt O Meal, Cream of Wheat, Coco Wheat, and Oat Bran Cereal. Ground flax seed and wheat germ were added after a few months. Shortly thereafter I also added dried Goji berries while cooking the cereal. My breakfast drink of choice was prune juice. I took liquid vitamins, as I could not swallow pills.

During the day, I would also have a soft-boiled egg and Boost with Benefiber during along with high fat yogurt. Puddings, baby food and cream soups were recommended but did not work because of the terrible taste.

Mental distractions were a must at all meal times. During breakfast (always my biggest meal) I would indulge in reading the Chicago Sun Times with their ongoing reporting of the follies of Chicago, Cook County and Springfield politics. As bad as I felt, I could always get a good laugh from reading the newspaper. My evening meal (always my biggest challenge) was lightened by watching reruns of "Everybody Loves Raymond" *Laughter is a great healer.*

Prior to my treatment I lifted free weights 30 minutes, 5 days a week and walked for 30 minutes, 7 days a week. After treatment I was too weak for this regimen but gradually resumed these exercises between naps and philosophical musings sitting by my pond watching spring take hold and life

return to me and my backyard garden.

By the end of the first year (March 2007) I had gained back about 5 pounds. During the 2nd year, as my excessive sense of smell diminished and my throat healed I was able to try a wider range of foods. I began adding bananas, peaches, strawberries, and raspberries to breakfast and also ate them as a mid-afternoon snack. I was also able to consume soups with little or no salt, meat, and vegetables. Vegetables containing lots of liquid (tomatoes, lettuce, cucumbers, etc) became eatable with the help of a sip or two of water. Salad dressings added a little too much spice for my throat, however, eating a salad, while not particularly enjoyable, was beneficial to my well-being.

Toward the end of the year I began to eat dry cereal with lots of whole milk. Optimum Cereal from Trader Joes was my choice with 8g of protein and 44% of the daily fiber requirement. Topped with fruit, flax seed and wheat or oat germ it made for a hearty breakfast. I also learned how to drink decaffeinated tea and a low acid fruit juice to help wash down the cereal. Warmed stewed prunes (5) were also a daily breakfast item.

As I slowly expanded my diet, I used water in place of saliva (which was very slowly coming back) to help wash down my food. *This technique of washing down food with water became the turning point in the expansion of my diet.* It even allowed me to eat unsalted nuts (almonds were my preference) washing a mouthful down with a swallow or two of water. This, of course, was against everything mom had taught me – "Chew your food thoroughly before swallowing, young man." I do mom, but now since almost no saliva comes, I add a little water – and it works!

It was also later in the 2nd year that I discovered the magic of sugarless chewing gum. On my walks or any adventure out of the house I would always take along my bottle of water for my dry throat. One day in the late winter just before my morning walk, I tried chewing gum instead of bringing along my water bottle. Epiphany – I was able to chew the gum and it helped to produce some saliva!! I should have tried gum earlier. Chewing gum has now become a standard

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procedure on many of my adventures away from home.

By the end of the 2nd year I had gained an additional 5 pounds and my exercise regimen was up to 3 days of 30-minute free weights and 5 days of a 30-minute brisk walk.

During the third year, which I call the “Year of the Pancake”, I found myself able to eat syrup drenched pancakes (preferably blueberry) with a couple of eggs (sunny side up or scrambled), a plate of fruit and of course a large glass of water.

I gave up my afternoon yogurt for another shake – this one from Costco – Kirkland’s Weight Loss Shake – 10g of protein, 230 calories, 4g of fiber and vitamins galore. This together with an apple made for a good mid afternoon snack. I reduced my GNC Real Gains drink to 1 eight ounce glass in the evening as my breakfasts had now expanded to include prunes, Optimum Cereal topped with ½ banana and seasonal fruit (the more the merrier) a large glass of fruit juice (any kind I wanted), large cup of decaf green tea and my vitamin pills – which I could now swallow.

With the mastery of substituting water for saliva I could now eat a small portion of meat with my evening meal together with a little heated broccoli, cauliflower and carrots (mixed veggies purchased frozen from Costco) and an occasional sweet potato. Costco also had – Kashi TLC bars (140 calories, 4g fiber, 6g protein) and Mrs. May’s Trio bars (230 calories, 3g fiber, 6g protein) Together with an orange and Trader Joe’s Low Sodium Organic Tomato and Roasted Red Pepper Soup these bars became a good noontime meal. These bars also allowed me to venture eating out at restaurants with family and friends where as the past 2+ years, I dared not go. Most of the food was too dense or spicy for my taste and throat. Now I could try something and if I couldn’t eat very much of it I had my nutrition bar as backup. My wife and I re-entered the social scene, much to her relief and delight. I still had little interest in food and all alcoholic beverages were still off the menu; but we were seeing our friends in public, and it felt good.

My exercise regimen had now expanded to 5 days of free weights – 3 days for ½ hour and 3 days for 15 minutes – and 7 days for a 30 minute brisk walk. When outdoor con-

ditions became too icy I would resort to 20 minutes of brisk indoor aerobics.

During my October annual physical my weight was 157 lbs – same as my physical last October, and I still need belts to hold my pants up. Why exercise to overcome dry mouth and other side effects of radiation – one of which may be depression? Consider reading the “The benefits of movement” as found on the Mayo Clinic web site: www.mayoclinic.com/health/chronic. As tough as it may be to start an exercise program, your body will thank you.

After my radiation treatment ended, my doctors put me on a sleep medication (Ambien CR) and an anti depressant (Zoloft). The sleep aid helped a bit, but after a few episodes of finding the toilet seat up in the middle of the night I gave it up. No telling where I might end up next! The Zoloft was easier to give up as spring gave me the opportunity to walk and get on with some basic exercise. I began to feel emotionally better even while dreading any upcoming meal.

As I look back on my post radiation visits to my doctors, I’m aware that they were looking to treat more than just my physical being. However, I believed that it was important for me to take major responsibility for my own recovery. This was the key to my rehabilitation. As I began to feel better emotionally the dread of the upcoming meal slowly began to fade. Even now, in the 32nd month after the end of the radiation treatments, I’m still a bit nervous about taking on a new food item in my diet – but with each success my confidence grows. Keep trying – easy to say, much more difficult to do.

In this 3rd year I am now able to use regular toothpaste in the morning but still use Biotene at night along with my fluoride treatments. Whenever I get up at night to visit the bathroom I rinse my mouth out with Biotene. I am also now able to rinse my mouth out with Crest Pro Health Rinse. I visit the dentist every 6 months and all my check-ups have been favorable

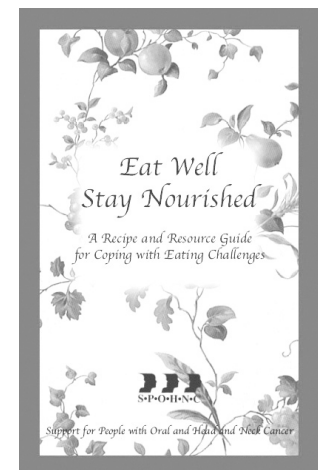
The successes I’ve enjoyed during my rehab can be contributed to many – the doctors, nurses and staff at Edwards Hospital were and are outstanding; my friends and family have made me feel very fortunate to be in their company; but most of all, my long suffering wife, Donna, truly deserves, the Nobel Prize for nursing/caring (if there is one). I was and am a very impatient man

– translation – bad patient. Time and again she would prepare a meal for me and I couldn’t or wouldn’t try it. She never lost her patience with me and kept encouraging me, while all this caring for her aged mother, who but for Donna’s help would not have enjoyed living in the independent living quarters she enjoyed before her passing last year.

I still have 4 months to go until the end of my 3rd year post radiation. In writing this synopsis of my adventure I have found it difficult to remember all the early difficulties I had – perhaps a good thing. Looking back though, provides me with a good benchmark to indicate how far I’ve come with this new body/life that cancer and related treatments have given me. I’m forced to make a healthier choice of foods resulting in a better body weight and a real sense of accomplishment. I still can’t drink wine or beer – stay tuned on this one. The radiation also effected my vocal cords and took away much of my projection capabilities. Thus I can no longer sing 2nd tenor in the Naperville Chorus, but as a bass I’ve now discovered where all the retired tenors go.

If I can ever figure out how to post this to my Face Book site I’ll update it as my adventure continues.

Garry Nelson
Naperville, IL
gjulian24@msn.com



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HEAD AND NECK CANCER NEWS

Doctors in the US and Netherlands Using Fast Rapid Arc Radiotherapy Technology to Help Fight Cancer are Now Treating Tumors of the Head and Neck

Technology Targets Tumors with Precise Image-Guided IMRT to Spare Healthy Surrounding Tissue

Doctors at cancer treatment centers in the United States and the Netherlands are now treating head and neck cancer using RapidArc™ radiotherapy technology from Varian Medical Systems (NYSE: VAR). RapidArc was used to deliver ultra-precise image-guided intensity-modulated radiotherapy (IMRT) significantly faster than was previously possible with conventional IMRT. The RapidArc treatment plans for these cases also did a better job of protecting surrounding normal tissues and organs.

“Traditional IMRT has been a gold standard for several years in radiotherapy when it came to avoiding healthy tissue and targeting the tumor mass,” said Ben Slotman, MD, PhD, professor and chairman of the Department of Radiation Oncology at the VU University Medical Center in Amsterdam, Netherlands. “We have been so satisfied with the faster treatment planning and the faster delivery with RapidArc that we plan to treat all of our head and neck IMRT candidates using this technology.”

Slotman and his colleagues recently treated a 46-year old male with throat cancer.

“The RapidArc plan showed better and more even tumor coverage, compared with a standard 7-field IMRT plan,” said Slotman. “With RapidArc, we were also able to spare more of the organs at risk than with IMRT,” he added. When treating a tumor in the head or neck it is important to avoid the highly sensitive organs nearby, such as the spinal cord, eyes, brainstem, and other vital areas of the central nervous system.

At the Center for Radiation Therapy of Beverly Hills, Henry Yampolsky, MD, recently used RapidArc to deliver an unusual unilateral neck tumor treatment that avoided the opposite half of the 68-year-old patient’s oral cavity, salivary glands, and neck.

The treatment involved immobilizing the patient for each of his daily treatments using an awkward mouth piece that immobilized the tongue. “A conventional treatment would have taken 15 minutes a day at least -- a long time to be immobilized in that way. With RapidArc, we had him in and out of there in less than five,” Yampolsky said.

“Compared with conventional forms of IMRT, RapidArc also helped us achieve better sparing of the healthy side of the patient’s neck,” said Yampolsky. “This was important to preserve his salivary function and as much of his oral cavity as possible.”

On the other side of the country, a gentleman with advanced throat cancer was able to keep his voice, thanks to RapidArc treatments. This 82-year-old patient had been enjoying an active lifestyle with his wife of 40 years, when

a lingering hoarseness led to the discovery of larynx cancer. “One treatment option was for him to have a laryngectomy, which would have removed his voice box, leaving him with no ability to speak and requiring him to breathe through a tracheostomy, which is a hole in the throat,” said Shawn H. Zimberg, MD, medical director of radiation oncology at Advanced Radiation Centers of New York. “Another option was a ‘larynx preservation’ course of radiotherapy.” Using RapidArc technology, Zimberg and his team were able to deliver a non-invasive radiotherapy treatment very quickly, and preserve this patient’s larynx and voice.

“Prior to his treatment, we compared two radiotherapy plans. One was for conventional IMRT and the other for a RapidArc treatment,” Zimberg added. “It was clear that the RapidArc plan was going to spare more of his normal tissues from radiation, reducing the likelihood of undesirable side effects. Clearly, being able to preserve his larynx while limiting the toxicity of his treatment has great potential for significantly improving the quality of life for this patient and his family after treatment is over.”

RapidArc radiotherapy technology has now been used for the treatment of prostate, head and neck, lung, brain, spine, bone, gynecological, and soft tissue cancers. The American Cancer Society estimates that 1.4 million new cancer cases will be diagnosed in the US in 2008, including over 35,300 cases of oral and throat cancer.

Noted Hopkins Scientist Says Research Indicates Need for Effective HPV Vaccine For Women And Men and a Simple HPV Screening Test

A call to explore a broader use of HPV (human papillomavirus) vaccines and the validation of a simple oral screening test for HPV-caused oral cancers are reported in two studies by a Johns Hopkins Kimmel Cancer Center investigator.

Leading HPV expert Maura Gillison, M.D., Ph.D., the first to identify HPV infection as the cause of certain oral cancers and who identified multiple sex partners as the most important risk factor for these cancers, reports her latest work in the November 3, 2008, journal *Clinical Cancer Research* and in a *Centers for Disease Control and Preven-*

tion (CDC) monograph. The CDC report on HPV-associated cancers appears on line November 3 and in the November 15, 2008, supplement edition of *Cancer*.

In the CDC report, believed to be the first and most comprehensive assessment of HPV-associated cancer data in the United States, investigators analyzed cancer registry data from 1998-2003 and found 25,000 cancer cases each year occurred at cancer sites associated with HPV infection. In additional analysis, Gillison and colleagues at the National Cancer Institute identified HPV infection as the underlying cause of

approximately 20,000 of these cancers.

Gillison and team found approximately 20,000 cases of cancer in the United States each year are caused by HPV infection. Oral cancers are the second most common type of HPV-associated cancers and are increasing in incidence in the U.S., particularly among men. Add to that anal, penile, vaginal, and vulvar cancers that are also linked to HPV infection, and Gillison says these cancers, when combined, equal the number of cervical cancers, the most common and well known of the cancers caused by HPV.

HPV continued on page 7

HPV continued from page 7

While about one-quarter of HPV-linked cancers occur in men, vaccines are currently approved only for use in girls and young women for cervical cancer prevention. "We need to have a more comprehensive discussion of the potential impact the HPV vaccine could have on cancer rates among men and women in this country," says Gillison, associate professor of oncology. "Currently available HPV vaccines have the potential to reduce the rates of HPV-associated cancers, like oral and anal cancers, that are currently on the rise and for which there are no effective or widely-applied screening programs." Gillison notes, however, that studies are needed to confirm that the vaccine effectively prevents HPV infections that lead to oral and anal cancers.

Gillison's findings were part of a project known as ABHACUS (Assessing the Burden of Human Papillomavirus-Associated Cancers). The data studied came from the CDC's National Program of Cancer Registries and the National Cancer Institute's Surveillance, Epidemiology, and End Results program. More than 80 investigators from across the country participated in the project, which addressed a variety of HPV-cancer associated issues, including racial disparity, economic impact, behavioral risk factors, and cancer mortality.

Other than prevention, early detection is held by cancer experts as the best way to control cancer. In the Clinical Cancer Research study, the first to track the disease and related oral infections over an extended period, Gillison found that simple "swish and spit" oral rinses can successfully track oral HPV infection over time. These findings open the door to a potential, non-invasive screening test to detect the disease and monitor for tumor recurrence. Head and neck cancer is the broad term for a variety of cancers of the oral cavity, including the tonsils, base of the tongue, and the side and back wall of the throat.

The study found that oral rinses successfully detected high-risk HPV infections in patients with HPV 16-positive head and neck cancers for up to five years after treatment for their cancer. Gillison says the findings indicate a high rate of persistent infection and reaffirms the connection between high-risk types of HPV and HPV-positive head and neck cancers.

In the study, the researchers used oral rinses to collect cells shed from inside the mouths of 135 head and neck cancer patients. The researchers genetically sequenced the DNA obtained from the rinses and tumor samples to identify those with HPV-positive cancers and determine the HPV type. There are approximately 120 types of HPV, but HPV 16 is one of the two most common associated with cancer.

The analysis revealed 44 patients with HPV 16-positive tumors and found that these patients were more likely to have continuing oral HPV 16 infections both before and after cancer treatment. While this study did not link the continued post-treatment infections to tumor recurrence, it was noted that patients with high-risk oral HPV infections prior to therapy, maintained high rates of infection after completing therapy. The team plans further, long-term research to determine if this continued infection leads to cancer recurrence.

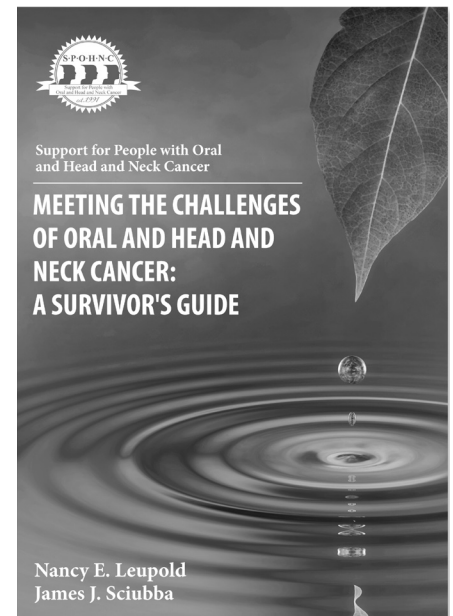
In 2000, Gillison identified HPV-positive head and neck cancer as a distinct subtype of the disease and linked it to improved survival.

"There is no question of cause," says Gillison. "It has now become a question of tracking the infection over time to identify those at risk of developing cancer or cancer recurrence."

Other researchers participating in the

study include Yuri Agrawal, Wayne M. Koch, Weihong Xiao, William H. Westra, Anna L. Trivett, and David E. Symer.

The research was funded by the Oral Cancer Foundation, the National Institute of Dental and Craniofacial Research, and the National Cancer Institute.



Meeting the Challenges of Oral and Head and Neck Cancer: A Survivor's Guide
\$24.99

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Holly Stephen

by

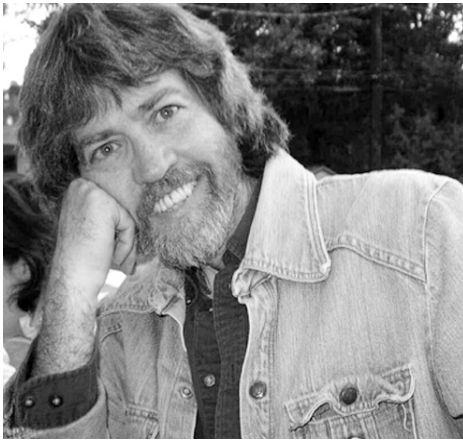
John & Deb Groves

David P. Wolk, MD

by

Karen Wolk

SURVIVORS IN THE NEWS



Tom Yohe is a cancer survivor. In addition to the support of his wife, Jeanne Marie, one of the reasons he credits for making a miraculous recovery after being diagnosed six years ago with a non-operable stage 4 tumor is the Head and Neck Cancer Support group at the Abramson Cancer Center. The support group “inspired him during the long treatment periods.” Tom continues to regularly attend meetings to “make suggestions, listen and simply ‘be there’ for others who are now at the beginning of the most frightening ordeal of their lives” and he adds, “I continue to get

occasional nuggets of helpful hints for myself as well.”

He is an original member of the Head and Neck Cancer Support Group which had its first meeting in October of 2000. Tom learned of the group from Susan Brodish, a former staffmember who was the first coordinator for the group, when he was in the hospital for his initial round of chemotherapy and radiation. He was hospitalized for the first week due to the 24 hour drip required for the chemo regimen he was undergoing, and as Tom tells the story, “it took some argument to be able to go as my chemo had to be changed in the middle of the meeting. They were not going to let me off the floor but I was insistent that this was very important. It turns out that Susan was an experienced chemo nurse, and we worked it out with the staff for her to change the bag.”

At the first meeting, Tom was the only attendee who was an inpatient and actively undergoing treatment.

As a result, he arrived wearing his hospital gown and in a wheelchair accompanied by a chemo drip. Right in the middle of the meeting, everyone stopped talking while Susan changed the bag. According to Tom, “no one batted an eye and then we continued

with our discussion.”

When asked why he insisted on going and why he still continues to attend the meetings after four years of being out of treatment, Tom says “I knew that I could not survive the coming ordeal without the help of other people, especially people who had been cancer patients like me — who could understand what it was I was going through from the patient side. I knew my survival chances were not great given what the physicians had shared with me, and I felt I needed every tool at my disposal.”

Tom continues, “I was convinced then, and even more convinced now, that a key element to surviving the disease, the treatment, and the aftermath is the support of people around you and people who have been through what I was going through and willing to listen and share. Medical science alone can only do so much, the remainder is still largely a mystery but it seems to me that ‘connectedness’ describes it as well as we can right now.”

*Courtesy of
Penn's Abramson Report
Volume 4, Issue 1, Winter, 2007.*

SURVIVORS RAISING AWARENESS

SAVE THE DATE: SATURDAY, MAY 9, 2009



Put on your walking shoes and join us on Saturday, May 9, 2009, rain or shine, as cancer survivors from chapters of SPOHNC, along with their families, friends and health-care professionals participate in SPOHNC to help raise awareness of oral and head and neck cancer. This will be the first annual **WALK SPOHNC** and everyone is invited to take part in this event. At precisely 10:00 AM as determined by local time zone, people, wearing SPOHNC T-shirts will begin walking in their communities in hopes of raising a deeper awareness of a difficult cancer.

Approximately 60,000 new cases of oral and head and neck cancer are diagnosed each year. This number includes the oral

cavity, the pharynx, paranasal sinuses and nasal cavity, the larynx, thyroid, and salivary glands as well as lesions of the skin of the face and neck and the cervical lymph nodes. Research also indicates that cancer in some areas of the head and neck is on the rise, especially in the younger population as a result of the human Papilloma Virus (HPV).

According to statistics of the National Cancer Institute, there are more than 500,000 survivors of oral and head and neck cancer living in the United States, many of whom continue to be plagued by the side effects of the disease and/or treatment throughout the United States. Many of these survivors are unaware of the resources that are now available to them.

So if you live within one of the areas mentioned in this announcement, come on

out and WALK SPOHNC. Come enjoy a few hours of camaraderie and bring your family and friends to help SPOHNC raise awareness of oral and head and neck cancer.

To find out more about WALK SPOHNC, please contact a chapter facilitator near you. Contact information can be found in the listing of chapters starting on page 9 of this newsletter. Come out and help us educate the public about a cancer that is often neglected until it has reached an advanced stage.

The chapters of SPOHNC that will be participating in this first annual walkathon include: Phoenix, AZ, Scottsdale, AZ, Indianapolis, IN, Kansas City, KS, Morristown, NJ, NJ/Philadelphia, Stony Brook, NY, and Syosset, NY.

LOCAL CHAPTERS OF SPOHNC FOCUS ON SPOHNC - SPOHNC-MINNEAPOLIS

Considering there is such a large need for a head and neck cancer support group you would think when you open the doors people would come.

That was not the case with the Minneapolis area chapter. In 2006 Colleen Martens Endrizzi, M.S., LLCC, CCC-SLP, and Nancy Newman, LPN, LLCC, both with the Three Rivers Clinic, saw the need and worked with National SPOHNC to start the Minneapolis chapter. Chuck Bartlett, a survivor, asked to assist when he read that a Minneapolis chapter was listed in the SPOHNC flyer. All three have shared in the facilitator duties.

Our first meeting looked promising with a half a dozen people attending. However we did not grow over the next many months. There were times we had only one or two attending.

We attempted to involve various doctors' offices and clinics without much success. We made flyers to distribute using both SPOHNC's publications and adding our own information. We obtained copies of the books SPOHNC published and gave them to several clinics. Again we had only minimal response.

Early in 2008, we learned that the University of Minnesota had its own head and neck cancer support group and decided to see how they were doing. Their group was more

than 10 years in the making and had more than a dozen people in their core group. However their noon meeting time was not convenient to many and several decided to attend our monthly Monday evening meetings. Getting both groups acquainted and exchanging our services was the beginning of growth for us. We now pass information between the two groups and attend each other's meetings and social gatherings.

In 2008, we had a medical professional give a presentation on managing the lymph system. We plan on having more presentations like this as we had a large number of attendees. Presentations such as this seems to answer many questions individuals have which may not be answered by their individual medical providers.

We now have a comfortable number of people (5-20) at most meetings and have assisted many who are going through head and neck cancer treatments and into the recovery process. We try to pair one of our chapter volunteers with new members to help with their specific needs. Several of our members have become SPOHNC volunteers and work outside our group helping others nationwide.

Obviously, we need to find ways to reach more people going through treatment and

recovery. Our biggest problem is the HIPPA law that prevents institutions from giving out names of people who are undergoing treatment.

Doctors are busy people and may not find time to read the information given to them about our group. Others don't fully realize the needs of their patients not only during treatment but also in the months and years to come in their recovery. Also some medical people feel we might give erroneous information. Consequentially not many doctors recommend our services to their patients. Our job here is to spread the word and educate the medical establishment about our chapter.

We look forward to whatever help we can give no matter how many come to the meetings and we see our primary mission to meet and support one on one during times of need and times of success. If one person is given hope, we have done our job. Success isn't in numbers at meetings but in discussions from the heart with each individual to promote healing of body and mind. That is our goal.

For more information contact:

Colleen M. Endrizzi:

952-545-0200: rivers3jvk@aol.com

Charles Bartlett: 952-461-2324

ARIZONA-PHOENIX

Banner Desert Medical Center

3rd Wednesday: 4:30 -6:30 PM

Keri Winchester, MS CCC-SLP 480-512-3627

Bette Denlinger, MA, RN 480-838-5194

beneden@cox.net

Dick Snider 480-895-6019

Rsnider326@aolcom

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

Les Norde 602-439-1192

elnorday@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

jhhiggins@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's Adventist Hospital

Last Tuesday: 6:30-8:00 PM

Jeanne Currey 303-778-5832

jeannecurrey@centura.org

CONNECTICUT-NORWICH

William W. Backus Hospital

Medical Office Building, MOB Conf. Rm.

3rd, Tuesday, 5:00-6:00 PM

Darlene Young, RN, OCN 860-892-2777

dayoung@wwbh.org

Kathy Gernhard, RN, OCN 860-892-2777

kgernhard@wwbh.org

DC-WASHINGTON

Lombardi Cancer Center

3rd Monday: 12:15-1:45 PM

Joanne Assarsson, MSW, LICSW 202-444-3755

assarssj@gunet.georgetown.edu

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/NW

Call for Location

4th, Thursday, 5:00 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

LOCAL CHAPTERS OF SPOHNC

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
2nd Monday: 6:00-7:00 PM
Carol Glavin, MSW, LCSW 352-371-8695
cflavin@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
The Wellness Community
3rd Wednesday, 7:00-9:00 PM
Gary Mallinchrodt 305-668-5900
gcme4@yahoo.com
Russell Nansen 305-661-3915

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

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

FLORIDA-SARASOTA
The Wellness Community
2nd Thursday: 5:30 PM
Julie O'Brien, LMHC 941-921-5539
julieobee@verizon.net
John Kleinbaum, Ph.D 941-921-5539
hope@wellness-swfl.org

FLORIDA-WELLINGTON
Wellington Cancer Center
4th Tuesday: 6:30-8:00 PM
Catherine DeStefano, RNC, OCN 561-793-6500
angelicaneil@bellsouth.nett

GEORGIA-ATLANTA
St. Joseph's Hospital
2nd Monday: 6:30-8:00 PM
John Sandidge 678-843-5585
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

GEORGIA-AUGUSTA
MCGHealth Children's Medical Center
Family Resource Center
1st Tuesday, 6:00-7:30 PM
Lori M. Burkhead, PhD, CCC-SLP
706-721-6100 lburkhead@mcg.edu
Leann Draganano
draganole@bellsouth.net

ILLINOIS-CHICAGO
Duchossois Ctr.for Advanced Medicine
4th Tuesday, 1:00 PM
Mary Herbert 773-834-7326
mherbert@medicine.bsd.uchicago.edu

ILLINOIS-MAYWOOD
The Cardinal Bernardin Cancer Ctr.
3rd Wednesday, 6:00-7:00 PM
Laura Morrell, LCSW 708-327-2142
lmorrell@lumc.edu

INDIANA-INDY-NORTH
Marion County Public Library
Lawrence Branch
Last 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

INDIANA-TERRE HAUTE
Hux Cancer Center
3rd Monday, 11:00 AM
Mary Ryan, SP 812-234-9584
Maryryan2@juno.com

IOWA-DES MOINES
Medical Oncology Hematology Assoc.
J. Stoddard Cancer Ctr., Suite 450
1st Wednesday, 5:30 PM
Jennifer Witt, RN 515-282-2921

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: 4:00 PM
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, OCW-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-ST. JOSEPH
Lakeland Healthcare
1st Monday, 5:00-6:00 PM
Jennifer Christopher, MA, CCC-SLP
269-428-2799
jchristopher@lakelandregional.org

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

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 314-268-7051
turcotte@slu.edu

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

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@atlantichealth.org
Catherine Owens, LCSW, OSW-C 973-971-5169
Catherine.Owens@atlantichealth.org

LOCAL CHAPTERS OF SPOHNC

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.co

NEW MEXICO-ALBUQUERQUE
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
jccicarelli001@nycap.rr.com
Norma Neapolitano 518-683-9518
nneapolitano@nycap.rr.com

NEW YORK-BUFFALO
Roswell Park Cancer Institute
3rd Tuesday: 4:30-6:00 PM
Amy Sumbum, SLP 716-845-4947
amy.sumbum@roswellpark.org
John Smaldino 716-845-4472
James.smaldino@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
Mount Sinai Medical Center
Third Tuesday, 3:00 PM
Stephanie Eisenman, LMSW 212-241-7962
stephanie.eisenman@mountsinai.org

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

NEW YORK-ROCHESTER
Strong Memorial Hospital
Luellen Resource Center, Patient Res. Ctr.
1st, Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW 585-276-4529
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
Christine Lantier 631-757-7905
clantier@optonline.net
Mary Ann Caputo 516-759-5333
mary.ann.caputo@sponhnc.org

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

NORTH CAROLINA-CHARLOTTE
Blumenthal Cancer Center
2nd, & 4th Thursday: 1:30-3:00 PM
Meg Turner 704-355-7283
meg.turner@carolinashhealthcare.org
Terri Painchaud 704-364-7119
Trappi6@yahoo.com

NORTH CAROLINA-CHAPEL HILL
Cornucopia House
3rd, Wednesday, 6:00 PM
Dave Gould 919-493-8168
dave.gould@da.org

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
2nd Thursday, 4:00 PM
Tom Wurz 440-243-6220
roe8@hotmail.com
Gwen Paull, LISW 216-476-7241
gwenpaull@fairviewhospital.org

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 550-269-8323
richard.boucher@hp.com

PENNSYLVANIA-HARRISBURG
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
bmrادish@wpahs.org

PENNSYLVANIA-YORK
Apple Hill Medical Center
2nd, Wednesday, 5:00 PM
Dianne S. Hollinger, MA, CCC-SLP
717-851-2601
Dhollinger@wellspan.org
Diane McElwain, RN, OCN, M.Ed 717-741-8100
dmcelwain@wellspan.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

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: 11:30-1:00 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

WISCONSIN-MILWAUKEE
Medical College of Wisconsin
Conference Rm. J, Rm. 1010
3rd, Thursday: 12:00-1:00 PM
Tammy Wigginton, MS, CCC/SLP 414-805-5662
wiggint@mcw.edu

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