

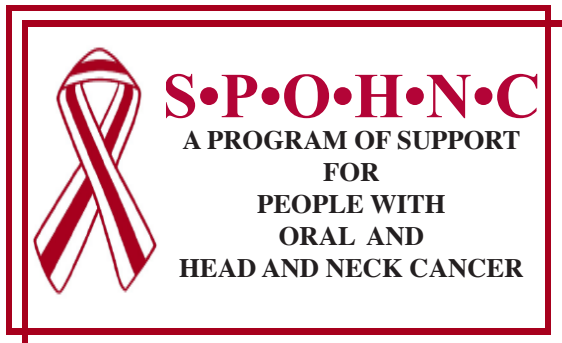
NEWS FROM S·P·O·H·N·C



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SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.

MAY 2009



Photodynamic Therapy Treatment of Early Oral and Laryngeal Cancers

MERRILL A. BIEL, MD PHD

Photodynamic therapy (PDT) is an FDA approved minimally invasive medical treatment modality that utilizes light in the presence of oxygen to activate photosensitizing agents that are relatively selectively concentrated in abnormal or neoplastic cells resulting in cell death. At the present time, PDT has been approved for clinical treatment in the United States, European Union, Canada, Russia and Japan. In the United States, the Food and Drug Administration approval has been given for the use of PDT in the treatment of Barrett's esophagus, obstructing esophageal carcinoma and early and obstructing tracheobronchial carcinoma using the photosensitizer Photofrin; actinic keratosis using the photosensitizer Levulan (aminolevulinic acid); and macular degeneration using the photosensitizer BPD. In the EU the above noted indications have also been approved in addition to the treatment of early head and neck cancers and palliative treatment of head and neck cancer using the photosensitizer Foscan; and treatment of basal and squamous cell skin cancers using the photosensitizer Metvix.

The method of PDT involves the use of a photosensitizing agent that is relatively selectively concentrated in abnormal or neoplastic cells. Depending on the type of photosensitizer, it may be injected intravenously, ingested orally, or applied topically. After application of the photosensitizer, the photosensitizer is relatively selectively retained by tumor cells so that after several hours to days, determined by the kinetics of the compound's distribution, there is more sensitizer in the neoplastic tissue than in the normal tissue. The photosensitizer is then activated with a specific

wavelength of light matching the absorption characteristics that are unique to that specific photosensitizer, usually using a laser. This results in tumor necrosis via several mechanisms including oxygen radical production as well as vascular shutdown to the tumor. Because there is less sensitizer in the adjacent normal tissue, only the neoplastic tissue necroses and the normal tissue is preserved. The advantage of PDT over the other conventional modalities of surgery, radiation and chemotherapy is that it is a minimally invasive treatment technique that lacks systemic toxicity yet results in selective tumor destruction with normal tissue preservation. This advantage is of particular importance for cancers of the oral cavity and larynx, where excessive tissue loss results in significant functional debilities that affect speech, swallowing and voice. In addition, since this is an entirely different process, the use of chemotherapy, ionizing radiation, or surgery does not preclude the use of photodynamic therapy. Also, unlike ionizing radiation, repeated applications of the photosensitizer and activating light treatments can be performed indefinitely.

Data are available for over 1500 patients treated with PDT using Photofrin, HPD, ALA or Foscan for the treatment of head and neck cancers. These patients include a mixture of presentations including primary, recurrent, and metastatic lesions. The predominant histology is squamous cell carcinoma, but other histologies treated include mucosal melanoma, Kaposi's sarcoma, adenocarcinoma, metastatic breast carcinoma, and adenoid cystic carcinoma. Fortunately in the last several years, the first multi-institutional clinical trials evaluating PDT treatment of head and neck cancers have been completed. These trials have demonstrated the efficacy of this minimally invasive therapy in the treatment of early oropharyngeal primary and recurrent cancers.

Early Stage Head and Neck Cancer: Photofrin-HPD based PDT

Patients with early stage cancers or early recurrences in the oral cavity and larynx (**Carcinoma in situ**, T1, T2) tend to have an excellent response to PDT. Of 518 patients treated with **Carcinoma in situ**, T1 or T2 cancers of the oral cavity, larynx, pharynx and nasopharynx, 462 (89.1%) obtained a complete clinical response after one PDT treatment. Laryngeal cancers, comprising 171 patients in this group, obtained a durable complete response rate of 89% with up to a sixteen year follow-up.

The largest series of patients treated has been reported by Biel, who treated 276 patients with early head and neck squamous cell carcinomas. Of these, 115 were early laryngeal tumors (Tis, T1, T2), 33 of which were radiation failures, treated with Photofrin 2mg/kg using a microlens fiber at 80 Joules/cm², 48 hours after Photofrin injection. All but ten patient (91%) obtained

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a durable complete response after a single PDT treatment (100% salvage) with follow-up to 201 months (mean 91 mos.). In addition, 113 patients with early carcinomas (Tis, T1, and T2) of the oral cavity, nasal cavity and nasopharynx and 48 patients with superficial T2-T3 carcinomas of the oral cavity were treated. All obtained a complete response after a single PDT treatment. With follow-up to of 6 to 202 months (mean 90 months), 106 of 113 (93.8%) patients with Tis-T2 carcinomas remained free of disease after a single PDT treatment (100% salvage) and 43 of 48 patients (89.5%) with superficial T2-T3 oral carcinomas remain free of disease after a single PDT treatment (100% salvage) with 6 to 128 month follow-up. Two of these patients however, recurred at the margins of the PDT treatment but were treated with limited laser resections of the recurrence and remain free of disease. Only one patient developed regional metastases 2 months post PDT.

**Early Stage Head and Neck Cancer:
 Foscan (mTHPC)-mediated PDT**

Second generation photosensitizers have the potential to improve the effectiveness of PDT by providing for greater tumor selectivity and deeper light penetration into tissue with the use of longer wavelengths of activating light. In addition, side effects such as the length of skin photosensitivity are reduced.

Foscan (mTHPC, Biolitec, Germany) is a potent second generation photosensitizer that is activated at 652nm light. To date, this is the only photosensitizer that has been evaluated in multiinstitutional trials for the treatment of primary oropharyngeal cancers and recurrent and second primary oral carcinomas. The trial evaluating Foscan PDT for the treatment of primary oropharyngeal cancers involved 114 patients with Cis-T2 oropharyngeal cancers. These patients received Foscan 0.15 mg/kg intravenously and underwent light activation at 652nm light at 20 J/cm² at 100mw/cm². Up to three light treatments were allowed under the protocol. A complete response rate of 85% (97/114) was achieved at completion of therapy. With two year follow-up there was an 77% complete response rate at 2 years with disease free survival of 89% and 75% at one and two years after PDT treatment respectively. This trial demonstrated complete durable response rates that are equivalent to those obtained with conventional therapies. The second trial evaluated Foscan PDT in 96 patients with recurrent or second primary carcinomas in the oral cavity. These patients demonstrated a 50% histologically confirmed complete response rate with a 79% survival rate at one year. Adverse events in these two trials consisted of pain at the treatment site, easily treated with oral analgesics and narcotics, and residual skin photosensitivity which lasted up to two weeks post Foscan injection. Both of these events were expected and manageable. These two clinical trials, the first multi-institutional PDT trials to be performed in the treatment of head and neck cancers, demonstrated that Foscan PDT results in cure rates that are equivalent to conventional therapy with less treatment associated morbidity, especially systemic toxicities.

**Early Stage Head and Neck Cancer:
 ALA-mediated PDT**

ALA-mediated PDT, a type of PDT, has been employed to treat a
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limited number of patients with oral superficial cancers and leukoplakia. In these trials with small numbers of patients there were a significant number of patients with partial responses to treatment. Also, transient liver function abnormalities occurred in all patients who received oral ALA administration. Due to the limited depth of accumulation of ALA and the limited penetration of 635nm light, tumors of greater than 2 mm depth were not consistently cured.

The present studies indicate the effectiveness of PDT in the treatment of specific anatomic areas in the head and neck. In particular, Cis and T1 carcinomas of the larynx appear to be particularly effectively treated with PDT. A literature review of control rates of various treatments for Cis of the vocal cord were as follows: Laser excision (104 patients) 20% initial failure rate requiring further therapy, 1% larynx lost; Vocal cord stripping (235 patients) 34% failure rate, 12% larynx lost; Radiotherapy (481 patients) 16% failure rate, 7% larynx lost. The literature demonstrated that surgical techniques to treat Cis are best limited to those patients where the Cis does not involve the anterior commissure or the bilateral vocal cords. The present clinical series demonstrates the efficacy of Photofrin-mediated photodynamic therapy as a curative treatment for Cis, T1 (85-92%) and T2 (72%) squamous cell carcinomas of the larynx. PDT for laryngeal carcinomas results in no glottic scarring as compared to conventional laser or surgical excision or vocal cord stripping. For recurrent carcinomas of the larynx that have failed conventional radiation therapy, PDT allows excellent voice preservation and may eliminate the need for partial or total laryngectomy. Also, PDT can be repeated without additional functional laryngeal compromise that can occur from repeated conventional laser surgery or cordectomy. Importantly, PDT treatment of primary T1 and T2 laryngeal carcinomas reserves radiation therapy for treatment of recurrences or of second head and neck primaries that may occur in these high risk patients.

The side effects of PDT treatment of laryngeal carcinomas is quite minimal as compared to conventional radiotherapy or surgery. PDT treatment is performed as a single outpatient procedure as compared

to 6 to 7 weeks of radiotherapy or the hospitalization associated with a partial or total laryngectomy. The photosensitivity of Photofrin is a temporary inconvenience not associated with systemic toxicity and is minimized by patient education and temporary changes in daily outdoor activities. The photosensitivity does however last for approximately 4 weeks.

Photodynamic therapy for treatment of T1 and T2 laryngeal carcinomas in the present series has cure rates that are comparable to if not better than that of conventional therapies with less morbidity of treatment. PDT should be considered as a reasonable option for the treatment of primary and recurrent Cis, T1 and T2 squamous cell carcinomas of the larynx.

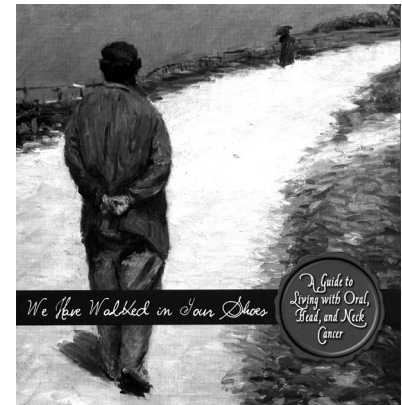
PDT also is effective in the treatment of Cis and T1 primary and recurrent carcinomas of the oral cavity including the palate, floor of mouth, nasopharynx and posterior pharyngeal walls. These results have been demonstrated in the multi-institutional Phase II Foscan PDT clinical trials and in single investigator Photofrin trials in which cure rates were comparable to those of conventional therapy with less morbidity.

Conclusion

Photodynamic therapy is an excellent modality for the treatment of primary and recurrent early and superficial carcinomas of the oral cavity and larynx. In order to further assess the effectiveness of this treatment on various areas within the head and neck, further standardized controlled studies are necessary. In addition, the development of new, more tumor-specific photosensitizing agents and light delivery systems will improve the effectiveness of this therapy. The present studies indicate that photodynamic therapy is an effective primary or alternative treatment modality for early carcinomas in the oral cavity and larynx.

Editor's Note: Merrill A. Biel, MD PhD is Director of Photodynamic Therapy Ear, Nose and Throat, Specialty Care of Minnesota and Medical Director, Head and Neck Oncology, Virginia Piper Cancer Institute, Abbott Northwestern Hospital in Minneapolis, Minnesota

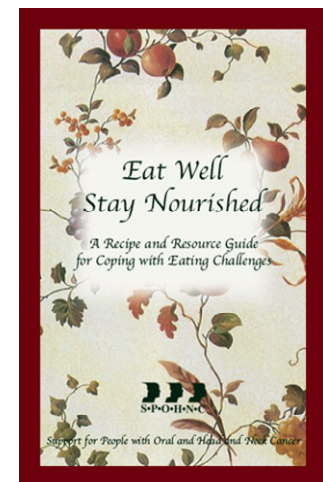
We Have Walked In Your Shoes, A Resource Guide to Living with Oral, Head and Neck Cancer



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.

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A TIME FOR SHARING... My Cancer Journey

I want to share my cancer journey for three reasons: individuals must research and pursue additional options; new treatment options become available frequently; and remission and/or improvement of a given disease is possible.

In March, 2004, I noticed a lymph node on the left side of my throat that had been enlarged for some time. Because I have always had sinus and hay fever problems, I was not overly concerned but thought I should go to a medical clinic near my home to ask for some antibiotics. After three rounds of antibiotics, four physicians, and one false biopsy, I was given a carcinoma diagnosis.

I was referred to a radiation oncologist who gave me the actual diagnosis of Stage III squamous cell supraglottic esophageal cancer. The location of the tumors made surgery impossible.

Prior to beginning the radiation treatments, a feeding tube, (PEG), would be inserted. A heartbreaking, sober, fearful feeling rushed through my wife and me as the radiation oncologist began to show us the x-ray, MRI and PET scan, and to draw the location of the tumors and the specific areas of my neck where the radiation therapy would be focused.

Additionally, I would need appointments to be fitted for the custom headgear, and for an oncologist for three chemotherapy treatments, a nutritionist and a dentist who specialize in cancer care. The radiation oncologist was caring, thorough and professional. Even though I thought my life had ended, I left with all of the appointments made and too stunned to even consider a second opinion.

We did some research on the web to locate others who had this same cancer and treatment, but we were unsuccessful. Support For People With Oral And Head And Neck Cancer (SPOHNC) was not able to provide new information, but added me to the mailing list.

The insertion of the PEG was not as easy as outlined. I recovered just in time to take the first chemo treatment prior to beginning the daily radiation treatments. The nausea began with the first chemo treatment and each treatment took longer because my body would not take it any faster.

When I went for the first radiation

treatment, and each time thereafter, swelling in the neck caused the headgear to be very painful. After the first radiation treatment, the nausea increased and I finally began using the PEG exclusively. Over-the-counter supplements recommended by the nutritionist also made me nauseated. My diet consisted of seven cans each of Jevity (a nutritional supplement), baby food and water for 17 months. My weight went from 165 lbs. to 125 lbs.

Even though the blood tests, MRI and PEG indicated I was in remission, I could not swallow. Approximately three months had passed, when I really began questioning the ear, nose and throat specialist and the radiation oncologist for additional ideas.

The radiation oncologist mentioned the names of several oncologists in the Otolaryngology Department at The University of Kansas Medical Center (KUMC). I was very fortunate to obtain an appointment with the director of the department. Finally, something good was happening. A laryngoscopy was inconclusive, but the otolaryngologist suggested that he and a gastroenterologist would perform an endoscopy to determine the size of the opening of the esophagus. Result: there was no opening. Scar tissue had closed it. A traumatic diagnosis!

However, these two exceptional physicians believed that a series of dilatations could possibly open the esophagus. However, after 12 dilatations I could only swallow small sips of liquid; no solid food. Several times during these procedures, my blood pressure dropped too low to continue.

We were asking all of the medical team for new options. The radiation oncologist casually mentioned a treatment he had just heard about called Neuromuscular Electrical Stimulation (NMES)/VitalStim. The speech pathologist at the hospital where he worked was using this procedure with people challenged by swallowing difficulties.

Coincidentally, the newsletter from Support For People With Oral And Head And Neck Cancer, Inc. (SPOHNC) came which contained a detailed article entitled "Esophageal Dilatation in the Head and Neck Cancer Patient by William J. Ravick, M.D. Dr. Ravick's article gave us renewed hope. We are very grateful for his expert knowledge. Nancy Leupold,

President of SPOHNC, was extremely gracious and referred me to the web to find a location that was using this procedure.

My otolaryngologist was familiar with the treatment, but had no definitive success stories at that time. (Since then, NMES/VitalStim is available when strictures occur in the esophagus.) However, my otolaryngologist immediately wrote the prescription for this procedure when I told him that the speech pathologist where I'd had radiology was trained in this method of treating head and neck cancer patients. Within six weeks the results of the combination of dilatations and electrical stimulations allowed me to swallow liquids and eat soft foods.

Now, even though my epiglottis is only one-fourth its original size, I can swallow most foods. I cut food into small bites and use many swallows of water with meals. My epiglottis, however, does not always close tightly thus allowing food to pass into the trachea which must be expelled.

I have been able to eat for the last eighteen months without a dilatation! The cancer has been in remission four years. Miracles from God and this special team of two physicians and nurses have returned a more normal life to me.

Without my gifted otolaryngologist, gastroenterologist, speech pathologist and radiation oncologist, I would not be swallowing solid foods. They have been extremely knowledgeable and professional, truly caring, kind, and considerate.

The nurse clinicians always returned calls immediately and were genuinely interested and helpful. The doctors and other healthcare professionals involved in my care, never appeared too busy to be helpful and to answer questions. These qualities are rare today. We were truly blessed to have received their care.

If anyone has questions, we are available at the following phone and e-mail addresses.

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HEAD AND NECK CANCER NEWS

Understanding Targeted Treatments

Until recently, cancer treatment was largely based on the location in the body where the tumor began, such as the lung or breast. Now, cancer treatment increasingly depends on specific factors of a person's tumor, such as gene mutations (changes) or proteins that are often characteristic of cancer cells, regardless of the original location of the cancer. A treatment that targets these faulty genes or proteins that contribute to cancer growth and development is called a targeted treatment. Unlike previous generations of cancer chemotherapies that were developed to interfere with cancer cells as they divide into new cancer cells, a targeted treatment is designed to turn off a signal that tells cells to divide or delay cell death.

Inside a Cancer Cell

Cells are the building blocks of every tissue in your body. There are many different types of cells, such as blood cells, brain cells, and skin cells, which have specific functions. Cancer begins when healthy cells begin to change and grow uncontrollably, forming a mass called a tumor. A tumor can be benign (noncancerous) or malignant (cancerous, meaning it can spread to other parts of the body). The change from a normal cell to a cancerous one is largely the result of specific mutations to genes that control cell division or delay the normal processes by which cells die. Learn more about the genetics of cancer.

By studying cancer cells and how they react to their environment, researchers are finding that specific gene mutations are related to the development of specific cancers. With this knowledge, they can develop drugs that correct or modify the changes in the cancer cell to stop or slow the growth of cancer.

For example, researchers learned that about 20% to 25% of all breast cancers have too much of a protein called human epidermal growth factor receptor 2 (HER2). A drug called trastuzumab (Herceptin) treats cancer by blocking HER2, but it is only effective for people with breast cancer whose tumors have HER2.

Outside of the Cancer Cell

Groups of cancer cells don't exist alone. The tumor is part of a larger network of tissues, lymph (a colorless fluid that carries lymphocytes, which are specialized white

blood cells), and blood vessels. When cancer spreads from one part of the body to another, it is because of cancer cells that have broken off from the main tumor and traveled through the blood or lymph system. Nearby blood vessels help feed the growing tumor.

Drugs can be developed against these events, too. One of the more successful approaches has been to target angiogenesis, the new blood vessel growth around a tumor. Targeted therapies such as bevacizumab (Avastin), lenalidomide (Revlimid), sorafenib (Nexavar), sunitinib (Sutent), and thalidomide (Thalomid) interfere with angiogenesis. Read more about angiogenesis and angiogenesis inhibitors to treat cancer.

Types of Targeted Treatments

Targeted treatments can be classified in the following ways:

* Monoclonal antibodies are substances that are made in the laboratory to block a specific target on the outside of cancer cells. Think of this as placing a protective plastic plug into an electrical socket to prevent electricity from flowing. These drugs are usually given intravenously (IV) because they are large compounds that are not absorbed well by the body. Examples include alemtuzumab (Campath-1H), bevacizumab, cetuximab (Erbix), panitumumab (Vectibix), pertuzumab (Omnitarg), rituximab (Rituxan), and trastuzumab. In one instance, a drug called tositumomab (Bexxar) is a monoclonal antibody used to deliver radiation to the tumor.

* Oral small molecules are given in the form of a pill that a patient takes by mouth because the body absorbs them better than monoclonal antibodies. These drugs usually block cancer processes in the inside of a cancer cell. Examples include dasatinib (Sprycel), erlotinib (Tarceva), gefitinib (Iressa), imatinib (Gleevec), lapatinib (Tykerb), nilotinib (Tasigna), sorafenib, sunitinib, and temsirolimus (Torisel).

* Proteasome inhibitors interfere with specialized proteins called enzymes that break down other proteins in the cell. A multiple myeloma drug, bortezomib (Velcade), is an example of this drug and is given by injection.

Matching patient to treatment

Recent studies show that not all tumors have the same targets, which may explain why a

targeted treatment doesn't work for each person. Because many of these treatments have some degree of side effects and because the cost of these treatments can be expensive, doctors are making efforts to match each patient to the most effective treatment whenever possible.

One example is HER2 and breast cancer. The American Society of Clinical Oncology (ASCO) and the College of American Pathologists recommend that all people with invasive breast cancer have their tumors tested for HER2. If a person's tumor has HER2, then treatment with drugs that target HER2, such as trastuzumab and lapatinib, can be effective. But, people whose tumors do not have HER2 do not benefit from these drugs. In other words, a targeted treatment doesn't work if the tumor doesn't have the target.

A similar situation exists for a gene called KRAS (pronounced kay-rass). This gene is mutated in about 40% of colorectal cancers. When this happens, the targeted therapies of cetuximab and panitumumab don't work. ASCO recommends that patients with metastatic colorectal cancer have their tumors tested for KRAS mutations, so that doctors can give their patients the most effective treatment and not expose patients to unnecessary side effects.

Challenges of Targeted Treatments

Although the idea of targeting a drug to a tumor seems straightforward, problems can arise when using this approach. For example, the target in the cancer cell may turn out not to be important, and the drug won't work. Or, the cancer may become resistant to the treatment, meaning it no longer works, even if it has previously. Finally, these drugs may still cause serious side effects, although the side effects are usually different than those seen with traditional chemotherapy. For instance, angiogenesis inhibitors are often associated with high blood pressure.

Although the development of targeted treatments is a breakthrough in cancer treatment, few cancers are cured with these drugs alone. People with cancer are still treated with a combination of surgery, chemotherapy, radiation therapy, and/or hormone therapy. As doctors gain more knowledge about specific changes in the cancer cell, more of these targeted treatments can be tailored to each person.

BOARD OF DIRECTORS ANNOUNCES NEW EXECUTIVE DIRECTOR



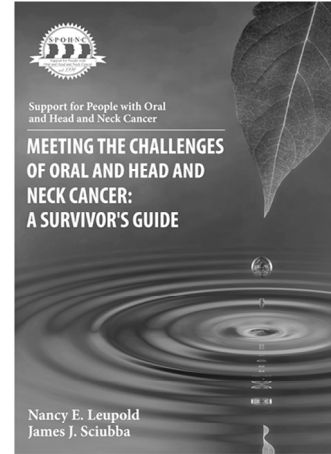
SPOHNC'S Board of Directors is pleased to announce the appointment of Teresa G. Piropato as Executive Director.

Well versed in non-profit organization management, she has served the non-profit community for three decades. Teri has provided public relations, marketing

communications and fund raising counsel for a variety of non-profits.

Teri served as the National Executive Director of the Cooley's Anemia Foundation and earlier was the first Executive Director of the New York State Grand Lodge Foundation, Order Sons of Italy in America. Formerly a member of SPOHNC's Board of Directors, Teri's professional affiliations include serving on the Board of Directors of the Women's Leadership Council, North Shore LIJ University Hospital; The Maurer Foundation for Women's Health Education; the Coalition Against Child Abuse & Neglect and the American Society of the Italian Legions of Merit.

"The opportunity to advocate for our patient population, partner with the Board, lead the staff, and build on SPOHNC's success will be a distinct honor," she said.



Meeting the Challenges of Oral and Head and Neck Cancer: A Survivor's Guide
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ORAL CANCER SURVIVOR GIVES BACK

Rose Gunter, an oral cancer survivor, accomplished singer, and producer, decided to give back to her community by using her talent and artistic abilities. She produced and directed what she calls "The Giving Back" concert series to benefit various cancer support groups throughout the community.

Rose's first "Giving Back" concert took place on January 29, 2009, at Mirelle's Restaurant in Westbury, NY, to benefit SPOHNC. To see and hear Rose sing and perform after radiation treatments was truly amazing especially for the oral and head and neck cancer survivors who attended the concert. One of the attendees commented, "Rose has the voice of Diana Krall, a famous jazz singer, and the personality of Louis Prima, a famous Italian singer from the swing era".

Many of her fellow musicians joined her by contributing to the evening's program. Members of the Stony Brook



& Syosset Chapters were thrilled to be able to share in the evening and give their support.

SPOHNC's Executive Director, Teresa Piropato, and Mary Ann Caputo, Outreach Administrator, were asked to speak about SPOHNC. Ms. Piropato spoke about SPOHNC's Outreach Programs. Ms. Caputo talked about our President, Nancy Leupold, who founded the organization and about SPOHNC's dedication to helping oral and head and neck cancer patients by

providing them with support and encouragement in their time of need.

Rose had invited her radiation oncologist, Dr. David Ebling, from Long Island Radiation Therapy, to join her on stage. She told the audience she would be forever grateful to Dr. Ebling and his staff who not only gave her the best treatment possible but made her feel as though she was part of a family. She was so honored that they came to the event.

It was a delightful evening, and Rose continues to give back to her community. She recently had another concert benefiting SPOHNC, and in June she will be the guest speaker at a joint meeting of the Syosset and Stony Brook, New York chapters. Rose is definitely an inspiration to all, especially to those who have traveled a similar cancer journey.

SURVIVORS IN THE NEWS CANCER SURVIVOR CELEBRATES WITH SPORT

by Austin Siegemund-Broka



Ginny Shoren's life was turned upside down when she was diagnosed with cancer of the tongue in 2001. "My whole life changed after that. Gratefully for me I had no idea of what lay ahead," she said. "The tests, the appointments, the doctors, the waiting — ignorance was bliss."

The road to recovery was long and often painful. The Herмосan underwent surgery to place bones and flesh from her leg into her jaw and tongue, and was forced to relearn tasks such as walking and talking.

Along the way she chose exercise as a way to help turn her life right-side up again. The 59-year-old Shoren competed in her sixth Danskin Women's Triathlon at the Disneyland Resort in Anaheim, CA.

Throughout the year more than 25,000 women are expected to participate in the triathlon series that emphasizes "finishing is winning." In Anaheim the women will swim a third of a mile, bicycle 10 miles and run or walk two-and-a-half miles.

Shoren competes with Team Survivor,

a nonprofit offshoot of the apparel maker Danskin, which is devoted to training women who have survived cancer or are fighting it. She credits Team Survivor with getting her back on her feet after her ordeal, as well as helping countless other women.

"Triathlons are one way for me to show that cancer is survivable," said Shoren. "Team Survivor has introduced me to women who have far more challenges than I, but when we stand together in the water, on a stage or at a finish line we are survivors, triathletes, and strong together."

In 2001 Shoren thought she had a wonderful life. She was celebrating 10 years of alcoholic sobriety with her husband Dave and children Kyle and Colleen. However: she'd also been a smoker for almost of her life, and one simple doctor's appointment changed her life forever.

"After seeing a great radiologist-oncologist, Tom Simko, in Torrance I decided to have treatment at UCLA. I was diagnosed with tongue cancer and from then on that's who I became - tongue carcinoma," Shoren said.

She underwent "free-flap" surgery in May 2001, in which doctors removed much of her jaw and tongue and replaced them with bones and flesh from her leg. With bones missing from her legs as well as major parts of her mouth replaced, Shoren set about relearning many of the basic tasks of life.

"Cancer took a lot from me, I had to relearn a lot of things," said Shoren. "I am the sum total of a lot of talented surgeons, dentists, speech therapists, physical therapists, friends that have loved me no matter what and family that has put up with me and the end results of all-of my bad habits."

In the early stages of her recovery she began to get involved in triathlons and other exercise opportunities. Her first triathlon was in Sacramento, where she managed to finish the run-walk portion amid hugs and cheering.

A fundraiser in conjunction with her cancer support group at Redondo's Wellness Center introduced her to Team Survivor, and

now she has competed in more than 20 triathlons with other cancer survivors.

"We are a group of cancer survivors who look at exercise and participation in team activities as a way to thrive while we survive," said Shoren.

Shoren also does presentations for groups of people who wish to quit smoking, and her recovery story can be heard alongside those of many other survivors on the website Livestrong.org.

"I talk to groups of people that are giving up smoking. I bring the yucky pictures to show how I quit and to tell them they don't have to do it that way. I have been given a lot, and I work a program that tells me to give back what I have in order to keep it," Shoren said.

The Danskin triathlon offers Shoren a chance to use the strength she has regained, and to demonstrate to others that cancer is beatable. For more information concerning the triathlon see Danskin.

Gifts Have Been Received in Loving Memory of

Peyton Belcher
by
Phyllis Hatfield

Dan Enright
by
Barbara Hurley

Jeff Jachim
by
Bette Denlinger
The Phoenix, AZ Chapter

Harv Jensen
by
Marlene C. Black
Virginia L Edwards
Steve Friedman
David & Eleanor Gee
Maria Sylvia M Jacobs
Kenneth C. Kirksey
Jennifer Mackey
F E & I M Muscarella
Hubert & SylvaPitters

Shirley J Hines
by
Charles E. Childs
Brett A. Ellison

Before Treatment: Coping With the Fear of Side Effects

The possibility of cancer treatment causing side effects that may make you sick and debilitated is a real fear you may experience. Feeling apprehensive about starting treatment for cancer can be even more overwhelming and harder to handle than the cancer diagnosis itself. Although cancer treatment can be associated with certain side effects, major advances have been made over the last decade and the majority of cancer treatments given today are well-tolerated.

Understanding your fears

It is normal to fear the unexpected and to anticipate that treatment will be difficult. In some circumstances though, the fears you may have can be so overwhelming that you would rather delay cancer treatment. It is important that you recognize and accept these feelings and identify the reasons why you are feeling anxious and afraid. Facing your fears will help you control your level of anxiety, so you can make educated decisions about receiving optimal treatment and consequently, the optimal benefit from your treatment.

- * Ask yourself what you are afraid of, and communicate your concerns to your doctor or nurse.
- * Certain side effects associated with treatment may or may not happen to you.
- * Many side effects related to cancer treatment are temporary, and there are many medications available today to help diminish these effects. Come up with a plan ahead of time on how certain side effects will be managed and seek support from your health-care team.
- * Don't be afraid to ask questions no matter how "silly" you may think they sound. Any unanswered questions you have will only contribute to your fears of not knowing what to expect.
- * The fear of having pain during treatment can be the most frightening. You may experience pain from the cancer itself or from the procedures associated with treatment. Pain management is a priority in the health-care profession today and the goal is achieving pain control and preventing pain from occurring. It is important that you communicate these concerns to your doctor or nurse and realize that they are aware and in tune to the concept that pain is different for everyone. The options available today to manage pain can be very effective. Individualized pain management

strategies can be developed by you and your doctor and tailored to meet your needs.

There may be other concerns that cause you emotional distress and may cause you to think about delaying treatment. These may include:

- * Fear of becoming dependent on others, especially if it involves child care
- * Fear of lifestyle changes
- * Financial concerns about requiring prolonged care if you experience side effects that are debilitating
- * Concerns about losing your job if the side effects cause prolonged illness

In order for your doctor or nurse to help you, they have to know what and how you are feeling. This means keeping the lines of communication open and making sure your needs are always addressed. Remember, there can be solutions, but you have to identify the problems first.

The following is a list of suggestions that may be helpful:

- * Be proactive, stay involved in your care, and give your input about initial treatment decisions. This will give you a sense of control and help you feel less anxious.
- * Try to stay positive and realize that treatment is meant to help you, not hurt you. Gather information on your cancer treatment and possible side effects, so you know the facts, not the fallacies.
- * Try some relaxation techniques, such as deep breathing, music therapy, and meditation, to try to alleviate some of your anxiety. When you are less anxious, you will be able to focus better and make more educated decisions.
- * Seek the support of your health-care team including your doctor, nurse, social worker, and realize that their goal is to help relieve symptoms and maintain good health and emotional well-being.
- * Ask to speak to others who have gone through the same treatments. Seek support groups that may be available in your local community where you can talk with others about how you are feeling. It may be beneficial to know you are not alone.
- * Stay focused on the present; don't get overwhelmed you with what could happen. This may help you overcome some of the fear and anxiety you are experiencing.
- * Ask a family member or friend to ac-

company you on your visit to the doctor to help support you when it is time to discuss treatment options. The less overwhelmed you feel, the more information you will be able to gather about your treatment.

* Talk with your family and loved ones ahead of time about your concerns and expectations of treatment. The help and support of family and friends makes the journey through cancer treatment more tolerable. Use their help and try to delegate responsibilities with children and household chores. This may help lighten the burden you feel about not being able to keep up with your responsibilities if you should experience side effects from treatment. Read Cancer.Net Feature: Supporting a Friend Who Has Cancer, Talking With Someone Who Has Cancer, and Family Life for more information.

* Talk with your employer ahead of time, so he or she knows what you will be going through. Perhaps there may be some adjustments that can be made to keep you working at a manageable pace after you begin treatment.

* Weighing the risk of treatment against not getting treatment at all may be helpful in putting things into a better perspective.

* Keep a journal, so you can get in touch with the issues that affect you on a personal level. Everyone experiences things in different ways, and your health-care team needs to know what your individual concerns are.

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LOCAL CHAPTERS OF SPOHNC

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
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-SAN FRANCISCO

UCSF Comprehensive Cancer Ctr.
3rd. Wed., 1:00-2:30 PM, Rm. H3805
Daphne Stuart, LCSW 415-885-7394
Daphne.stuart@ucsfmedctr.org

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

CALIFORNIA-VENTURA

The Cancer Resource Center Of
Community Memorial Hospital
Kathleen Horton, 805-652-5459
khorton@cmhhospital.org

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

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 Mallinchrout 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. C)

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@mccg.edu
Leann Dragano
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

IL-EVANSTON/HIGHLAND PARK

NorthShore University Health System

Call for location
2nd. Monday, 6:00-8:00 PM
Sabina Omercajic, MS, CCRP 847-570-1066
somercajic@northshore.org

ILLINOIS-MAYWOOD

The Cardinal Bernardin Cancer Ctr.

3rd. Wednesday, 6:00-7:00 PM
Laura Morrell, LCSW 708-327-2142
lmorrell@lumc.edu

LOCAL CHAPTERS OF SPOHNC

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.: 6:00-7:30 PM
Valerie Hope Goldstein 617-731-1703
Fernal@aol.com

MASSACHUSETTS-PEABODY
North Shore Cancer Center
2nd Tuesday: 5:30-6:30 PM
Mary Anne Macaulay, LICSW 978-573-5318
mma caulay@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 Eriksen, LCS, 248-964-3430
CEriksen@beaumont-hospitals.com

MINNESOTA-MINNEAPOLIS
Ridgedale Hennepin Area Library
1st. Monday: 7:00-9:00 PM
Colleen M. Endrizzzi 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; mandedt@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@atlantichhealth.org
Catherine Owens, LCSW, OSW-C 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.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 Sumbrum, SLP 716-845-4947
amy.sumbrum@roswellpark.org
Jim 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
mojica@chpnet.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

LOCAL CHAPTERS OF SPOHNC

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@sponhc.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/DURHAM
Cornucopia House
3rd. Wednesday, 6:00 PM
Dave Gould 919-493-8168
dave.gould@da.org

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
Tom Wurz 440-243-6220
2nd Thursday, 4:00 PM
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 650-269-8323
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

TEXAS-PLANO
Regional Medical Center at Plano
1st. Tuesday, 6:00-8:00 PM
Polly Candela, RN, MS
214-820-2608
Polly.Candela@baylorhealth.edu
Emily J. Gentry, RN
214-820-2608

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
2nd. 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
twiggint@mcw.edu

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of**

Rick Agee
by
Yvette Smith
Michael Williams

My mother,
Nina Kelly
by
Nina Kelly

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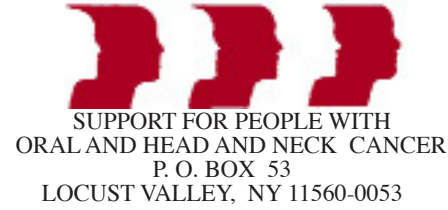
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your own experiences.*

The Next Issue of
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will be
September 2009

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

MEMBERSHIP APPLICATION

SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.



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City _____ State _____ Zip _____

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