At a conventional dose that effectively kills cancer cells, radiotherapy has been associated with unavoidable and potentially debilitating complications for some oral and head and neck patients, one of which is osteoradionecrosis (ORN). The lower jaw bone, or mandible, is particularly susceptible to developing ORN because its high mineral content leads to absorption of higher doses of radiation. Radiation may cause injury and devitalization of the bone, making it highly susceptible to infection and impairing its capacity to heal.

Once radiation-induced injury is initiated in the mandible and the overlying soft tissues, ulceration and necrosis of the oral mucosa expose the underlying bone, resulting in the condition termed ‘mandibular osteoradionecrosis.’ The incidence of ORN in head and neck cancer patients varies from 4% to 37%. In spite of this, radiotherapy improves the likelihood of cure by minimizing the risk of cancer recurrence in the management of oral and head and neck cancer as a definitive treatment by itself, or combined with surgery in certain situations.

ORN typically occurs after a latent period following radiation, which may vary from a few months to several years, with the majority of cases occurring 6 to 22 months following treatment. The bone injury caused by radiation is of a persistent, progressive nature, and the risk of developing ORN can remain as high as 20% even 10 years after radiotherapy.

Predisposing Factors
Osteoradionecrosis of the mandible is caused by multiple factors. Jaw surgery performed within an irradiated field increases the risk significantly. Such surgical procedures are often crucial for achieving complete disease clearance during management of oral cancers, either as a way to gain access to the tumor site or to ensuring tumor-free margins. However, they may lead to an early onset of ORN by interfering with the blood circulation of the mandible. Other predisposing factors include:

- poor oral hygiene,
- chronic trauma by ill-fitting dentures,
- dental infections,
- decreased host immunity or,
- poor nutritional status.

Mandibular ORN worsens the quality of life in affected individuals by causing severe pain, jaw deformity, and infected, draining orocutaneous fistulae. It also compromises chewing, swallowing, retention of saliva, jaw opening, and efficient use of dentures. Extensive bone necrosis can lead to painful and persistent jaw fractures.

Prevention of ORN
Minimizing Dental Infections
Measures that minimize the risk of developing ORN are a critical component of comprehensive head and neck cancer treatment. A thorough dental evaluation for caries, periodontal disease, and tooth abscesses is critical to eliminate infectious sources that can lead to serious infections in irradiated mandibular bone with a poor blood supply. Any tooth that has the potential to become a source of infection or require extraction during the patient’s lifetime should be extracted 2 to 3 weeks before radiotherapy. Following extraction, care is taken to close the mucosa and completely cover the exposed bone of the tooth sockets. Maintenance of meticulous dental hygiene, particularly in the postoperative period, along with daily fluoride treatment, is important to decrease risk of ORN.

Capacity to Heal
Poor nutritional status is frequently encountered in patients treated for head and neck cancer. It may play a role in perpetuation and worsening of mandibular ORN. Thus, strengthening the patient’s immune system and ability to heal wounds by increasing nutritional intake through feeding gastrostomy tubes may be necessary to limit the development of ORN.

Future Fundraiser
Skate4SPOHNC
See Story on page 2
Record Number of SPOHNC Chapters Serve Survivors
Support Groups Surpass 100 Mark in 2010

SPOHNC “Support for People With Oral, Head, and Neck Cancer,” recently launched its 100th chapter to offer support, information and encouragement to help those diagnosed with oral, head, and neck cancer through their journeys of treatment and survivorship. There are now more than 100 SPOHNC Chapters providing help to individuals in 35 states.

The American Cancer Society estimates that 80,000 new cases of oral, head and neck cancer will be diagnosed in the United States in 2010. As new cases are increasing, the demand for services of support groups is also increasing.

According to SPOHNC Founder, Nancy Leupold, “Each year, thousands of individuals and their families look to SPOHNC to achieve their dreams of returning to health or well being. SPOHNC facilitators and chapter members are now available in more places across the country supporting them by offering their insights, knowledge and experience in local communities.”

“As an oral cancer survivor, I understand the emotional and social

RECORD continued on next page

Passion for the Mission
One Man Is Making A Difference for All of Us

One person can make a difference. Nowhere is that more evident than with the story of Skate4SPOHNC, which began in Dallas, Texas, as a day-long inline skating marathon to raise awareness of oral and head and neck cancer. On September 19, 2010, a new Skate4SPOHNC relay will take place, this time in honor of recently retired SPOHNC Founder Nancy Leupold.

In the late-2000s, Rick Agee, a tongue cancer survivor of two recurrences, wanted to enhance support for his local Mid-Cities chapter of SPOHNC. He decided to personally raise awareness by doing something he enjoyed—inline skating for fitness.

On September 20, 2009, Agee spent a grueling 7 hours circling the tracks at Richardson Grove Park for more than 60 miles (100 kilometers) on his skates. Throughout the day, friends skated, biked, ran, or walked with him, many donating to the effort. He raised $14,000 to fight our cancers. That first year, nearly 300 of Agee’s friends, family, chapter members, and patients watched as he skated the course. An indescribable spirit prevailed at the track and in the marquees that dotted the field.

While he circled the tracks those hours, he thought about what events could take place in the future. He envisioned that Skate4SPOHNC in 2010 would continue raising awareness of oral and head and neck cancer. Months later he pulled together a small committee to plan the second event, this time dedicated to SPOHNC Founder and President Nancy Leupold. To read all about it—and make a donation to Rick’s efforts to honor Leupold’s legacy and to support SPOHNC’s outreach programs—please log on to: skate4spohnc.org or go to the SPOHNC Web site at: www.spohnc.org.
impact of the disease,“ says Leupold. “The main goal of treatment is to cure the patient of cancer. However, the physical, psychological, and psychosocial effects of the disease and its treatment must also be addressed.” The psychosocial effects are the emotional and social issues that people with cancer often encounter which can greatly affect patients’ well-being. “SPOHNC’s work is vital to the survivor as it helps optimize patient care by providing essential, but often overlooked, services that complete an individual’s cancer care plan,” she adds.

These offerings include a comprehensive menu of personalized and essential services, including support groups, one-on-one matching program, education, and healthy lifestyle programs, to those affected by oral and head and neck cancers throughout the continuum of care. Both newly diagnosed patients and survivors call on SPOHNC support group facilitators and members as a vital source for information, insights, support and encouragement. In fact, every year, SPOHNC Chapters provide more than

- 1,000 meetings,
- 500 informational presentations and workshops,
- 2,500 attendees at support group meetings and special events.

Many people experience distress because of these cancers, but fewer take advantage of such personalized emotional and social support services. To ensure no one has to face this cancer alone, SPOHNC aims to ultimately develop additional support groups to be available to people in all 50 US states through the network of community-based centers, hospitals, oncology care groups and other non-profits, as well as online.

“SPOHNC is poised to provide support to the increasing number of persons who need it through its comprehensive and innovative offerings,” says Executive Director, Mary Ann Caputo. “It is SPOHNC’s goal to reach every individual affected by this devastating disease through our many resources.”

Additionally, the SPOHNC organization is always working to expand its vital services to cancer patients and their loved ones through its National Volunteer Survivor Network, newsletter, Web site for online information, and its very successful publications. It is also exploring the use of novel technologies, such as FaceBook, to help extend the reach of these essential resources.

Many SPOHNC services are offered at no charge. Speaker sessions and workshops covering treatment and survivor issues are organized by local chapters, which usually meet on a monthly basis or more. We encourage individuals to become members of SPOHNC for an annual fee of $25.00 or $30.00 for families. With this membership individuals receive our very popular and informative newsletter, News From SPOHNC, published 8 times a year.

Contact a SPOHNC support group at any one of more than 100 chapters nationwide by visiting the SPOHNC Web site at www.spohnc.org or calling 1-800-377-0928.

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Management of ORN

The initiation and progression of ORN is facilitated by increased dose of external beam radiation. The dose (increase of external beam radiation over 50 Gy) and field of radiation should be planned with utmost care to minimize the risk of ORN. Along with these factors, the mode of radiation (external beam or radiation implants) has an impact on the severity of ORN. The use of more focused delivery techniques like brachytherapy (a form of internal radiotherapy in which radioactive material is surgically implanted into the tumor site) can limit the severity of ORN and is more responsive to conservative management than ORN in patients who undergo high-dose external beam radiation.

Early detection and initiation of treatment is important to arrest the progression of osteoradionecrosis. Conservative management is performed for early-stage ORN that includes irradiations, long-term antibiotics based on bacterial cultures, and debridement procedures like sequestrectomy for removal of minimal amount of necrotic debris if present. All these measures may be combined with hyperbaric oxygen (HBO) therapy. This therapy involves intermittent episodes of treatment with 100% oxygen at high atmospheric pressures. HBO is supposed to improve the healing capacity of tissues through increased oxygen delivery and better blood supply.

Failure of ORN to respond to conservative treatment within 6 months mandates active intervention. A foremost approach is to rule out local recurrence of cancer through biopsy. Even in the case of recurrent cancer, biopsy may not always detect it because the presence of gross inflammatory tissue may interfere with adequate tissue sampling. Thus radical surgical treatment is warranted, both in mandibular ORN cases nonresponsive to conservative measures like HBO, as well as severe cases of ORN with large areas of exposed and necrotic jaw bone, chronically draining fistula tracts, or jaw fractures.

Complete excision of the nonviable and necrotic bone is mandatory to initiate the healing process in ORN. The extent of bony resection is estimated preoperatively with a CT or MRI scan, and excision is done during an operation up to the point where healthy bleeding bone is encountered. The affected soft tissue around the necrotic bone also needs to be removed. After excision, a bony and soft-tissue defect is created, which requires correction by reconstructive surgery to restore function and facial harmony.

Reconstruction Options

Reconstruction is individualized to each patient. The reconstruction options depend on the severity, size, and site of the cancer. Options consist mostly of tissue rearrangement with local flaps, pedicle flaps, or free flaps. Various methods used to reconstruct the jaw include alloplastic materials, vascularized flaps, and revascularized free bone or soft-tissue flaps.

Alloplastic Devices

Alloplastic surgical material, such as titanium, is biocompatible and can be safely implanted into soft tissues. Titanium mandibular reconstruction plates are rarely used in patients treated for ORN because extrusion of the plate requiring its removal frequently occurs. However, the material may be used in cases where other reconstructive options do not exist. In this situation, a soft-tissue flap from the forearm

RECONSTRUCTION continued on page 6
Treatment of Depression in Patients With Oral and Head and Neck Cancer

KIM K. SOLBERG, M.D.

This is the second of two articles focusing on depression in patients with oral and head and neck cancer. In the April issue of News from SPOHNC, depression and considerations in diagnosis were described. This article describes treatment using the concept of the BIO-PSYCHO-SOCIAL MODEL.

It is important to emphasize that depression is very much treatable. There are different approaches to the management of depression, including many forms of psychotherapy and many medications. It is up to the psychiatric practitioner to develop a treatment plan tailored to the individual patient. Before a course of treatment may be decided upon, it is helpful to have a method to conceptualize or understand what the patient is going through. As a resident psychiatrist, I learned a time-honored method referred to as the BIO-PSYCHO-SOCIAL MODEL, which helps in this process.

The biology or BIO of the patient traditionally refers to brain chemistry and the patient’s family history as factors in the development of depression. For instance, if a patient’s mother had depression and responded to a certain antidepressant, it is more likely that the patient will respond to this same medication. In patients with oral and head and neck cancer, there are multiple biological considerations in treatment planning. The type of cancer as well as the location and stage of advancement at the time of diagnosis will determine what treatment is recommended. The recommendation may include surgery, radiation, and chemotherapy with predictable effects and side effects. Common side effects of the cancer treatment include pain and disfigurement, loss of speech, weakness, tiredness, insomnia, poor appetite and malnourishment.

All of these side effects may contribute to depression and should be addressed, as a part of the depression treatment. To illustrate this concept, consider that an antidepressant is not likely to help a patient whose pain is untreated. Insomnia is common in medical patients in general and is a miserable condition that affects mood. Also, antidepressants are less likely to be effective in a patient who has lost considerable weight and is not eating well. Optimally, this aspect of the treatment will involve collaboration including the psychiatric provider with members of a multidisciplinary head and neck cancer management program.

The psychological or PSYCHO aspects of the evaluation and treatment include understanding the patient and the impact of the illness on his/her life. When someone has been diagnosed with a life-threatening and/or life-changing illness it is important to try to understand their personality style, especially in dealing with stressful situations. I believe that it is important to ask the patient what they know and believe about their illness. If a patient believes that their cancer is a punishment for past bad behavior, smoking, drinking, or otherwise, it is important to address this belief in some fashion. Similarly, a patient may believe that he or she is dying, even though they have been told that the cancer is treatable. This may have a profound negative affect on the patient’s outlook and prognosis.

In oral and head and neck cancer patients, disfigurement and changes in ability previously taken for granted, such as swallowing and speaking, are especially challenging to adapt to on an emotional level. Patients whose self-esteem grew largely out of their outward appearance often have short- and long-term problems in adjusting. Finally, marital or family problems don’t necessarily get better because of a life-threatening illness. Although psychotherapy or talk therapy is a very common recommendation in the treatment of depression, the cancer patient may be too ill, too tired, or too busy for this intervention in the midst of aggressive treatment. Because of each situation, the program’s social worker may be in the best position to begin to address these issues. Support of the speech pathologist can also provide a lifeline to the patient who is struggling to adapt to changes in image and function.

The SOCIAL aspect of the BIO-PSYCHO-SOCIAL Model refers to the more practical aspects of the patient’s life. Social workers in programs dedicated to the care of patients with oral and head and neck cancer are often the first care providers to address the emotional aspects of the patient’s illness experience. Additionally, they identify and anticipate practical needs, which may be crucial in managing the patient’s depression. These include transportation, obtaining medication and addressing family strain and unique family needs. The practitioner may write a prescription for a patient who doesn’t have prescription coverage or can’t afford the co-pay and will not be able to take the medication without funding arranged by the social worker. Often the social worker becomes a lifeline for the patient during treatment.

Alcohol and Drug Abuse Threaten Mental and Physical Health

Any discussion of treatment of depression would be deficient without mention of the fact that alcohol and some drugs are depressants. Abuse or even use of these substances must be evaluated and addressed starting with the initial evaluation process. Ongoing abuse may negatively impact mood, increase risk of cancer recurrence, and threaten the patient’s health in general. Alcohol withdrawal and even delirium tremens are preventable complications, which present during hospitalizations after surgery. Any alcohol or drug use should be brought to the treatment team’s attention.

In recent years, there has been an explosion in the number of antidepressants and psychotropic medications in general. In any patient, the choice of antidepressant often involves the avoidance of side effects, but conversely the exploitation of some side effects that may be beneficial. In general, medications that cause significant dry mouth should be avoided because such medications can worsen the effects of radiation-induced dry mouth and speech and swallowing problems. Amitriptyline (Elavil) is an example of such a drug.

Medication that causes sleepiness or sedation may be beneficial in patients who aren’t sleeping well but problematic in those who are already tired. Mirtazapine

DEPRESSION continued on next page
A TIME FOR SHARING

“Cancer invades and destroys; an enemy from within. To fight it, our bodies must be cut, poisoned, and burned. We must endure pain. Side effects can be long-term and debilitating. Having cancer is like fighting a war against a cunning, ruthless enemy.”—Rebecca Kohler, H&N cancer survivor, SPOHNC Oregon

“I was in such a misery and despair trying to win the battle with cancer. I hated cancer, and I hated how it changed my life.”—cancer survivor

“Taking the warrior stance against my cancer is like trying to kill my body. My cancer is me. And since I started treating it as a part of my body instead of an outside invader, I have been much happier and less fearful.”—cancer survivor

The devastation that oral and head and neck cancer causes to patients is certainly significant. Fear, anxiety, and depression are especially common among patients with these cancers, and this article aims to look at this issue. An informal survey by Rebecca and Brent Kohler of the Oregon SPOHNC support group of 20 persons revealed many members suffered from one or more psychiatric conditions such as anxiety, depression, or suicidal ideation (see above).

Yet only one person turned up who had received mental health services preventively during treatment. Another individual was prescribed an antidepressant at the same time as oxycontin because the doctor said, “You’re gonna need this.” The other 18 survivors had no mental health evaluations before, during, or after their treatment. Most received no queries specifically about their mental health throughout their entire course of treatment.

Who is responsible for the mental health of the cancer patient? Ultimately, it is the patient who is responsible. The patient must ask for help if he or she is anxious or depressed, suffers from panic attacks or insomnia, or has thoughts of suicide. On the other hand, patients are often overwhelmed by their physical symptoms. Pain, malnutrition, exhaustion, and medications can muddy their thinking. Further, being a cancer patient is a new experience, and they do not know how to identify when their feelings are “normal” or when they require professional help. Finally, a stigma still exists for mental health problems, and patients may be reluctant to admit they have issues. In short, many survivors will need professionals to aid them in identifying their mental health needs and arranging for therapeutic services.

Doctors and nurses and social workers can play an important role in helping patients identify their feelings and create and environment in which they feel comfortable talking about them. Simply asking open-ended questions like, “How are things going?” is not enough. Most patients will talk about their physical side effects before they will address any emotional ones. Instead, professionals should ask specific questions about mood, sleep, anxiety, depression, thoughts of suicide, etc. Also they should ask about social support, financial concerns, and other stressors in their lives. Mental health should be evaluated before, during, and after treatment. If patients have a history of psychiatric problems or chemical dependency, then refer them for mental health services at the outset of treatment. On a weekly basis, inquire about patients’ emotional health as well as their physical.

Getting Ahead of Cancer for Mental Health

Finally, everyone should strongly encourage survivors and newly diagnosed patients to go to a SPOHNC meeting or call and ask for a one-on-one match with a mentor. They went through everything you are going through, and they made it. These are examples of the many benefits:

• Journeying with someone who has been there before is invaluable
• Being able to talk about the cancer experience with survivors is both comforting and inspiring
• Hearing the stories of survivors and telling your own is healing for all.

A variety of reasons exist for the increased rates of psychological effects in head and neck cancer patients, including arduous treatment regimens; surgery and complications that interfere with eating and talking; and having visible wounds left by the cancer, according to Dr. William J. Burke, M.D., a psychiatry professor from the University of Nebraska Medical Center. He is the lead investigator of a study designed to help head and neck cancer survivors get ahead of such problems.

Rebecca & Brent Kohler, Oregon

DEPRESSION

Continued from page 4

(Remeron) may help with sleep, appetite, and anxiety. In general, the SSRIs (selective serotonin reuptake inhibitors) are the first-line medications in the treatment of depression. Fluoxetine (Prozac) was the first medication in this group. Citalopram (Celexa) and escitalopram (Lexapro) have been studied and shown promise in prevention of depression in head and neck cancer patients. There are several other medications in the SSRI class. These medications do not help much with sleep but may be combined with one of many sleeping medications.

Another class of medications called the SNRIs (serotonin-norepinephrine-reuptake inhibitors) are also effective and well-tolerated antidepressants. Effexor (venlafaxine) and Cymbalta (duloxetine) are examples. Sometimes, novel medications such as methylphenidate (Ritalin) are tried in patients with depression, poor energy, and lack of appetite. A nice feature of this medication is, in patients who respond, it works quickly, often within days.

While it is not possible to give an exhaustive review in a newsletter format, I hope that this introduction will be helpful in understanding what is involved in the evaluation and treatment of depression in patients affected by oral and head and neck cancer. My hope is that increased awareness of depression and its treatment will result in more patients asking for and receiving help so that they feel better and adjust well.

Editor’s Note: Dr. Solberg is a psychiatrist/ neurologist in Towson, MD.

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RECONSTRUCTION from page 3

(pectoralis) region must be used to cover the titanium plate. If the portion of the mandible that forms the temporomandibular joint (condyle) must be removed, then reconstruction of the condyle and posterior mandible is possible with a titanium joint replacement prosthesis.

Vascularized Local and Pedicled Flaps

Local Flap: A local flap is a tissue rearrangement adjacent to the wound. To cover defects adjacent to the donor site area a local flap, consisting of skin and the underlying subcutaneous fat, is used.

Pedicle Flap: Pedicled flaps, which are composed of muscle and the overlying skin and subcutaneous fat, reconstruct nonadjacent defects that are farther away from the donor site region. Pedicle flap tissue is sutured into place at the recipient site.

In these cases, the blood supply to the flaps is preserved: they are vascularized flaps. Local and pedicled flaps, however, may not provide adequate blood supply to the irradiated tissue bed in cases of ORN, leading to poorer healing. Pedicled flaps have become less popular as more reliable revascularized flaps have been developed that also provide surgeons with the ability to customize the reconstruction to the defect. However, pedicled flaps continue to play a role in the management of patients afflicted with ORN, particularly when revascularized flaps fail.

Revascularized Flaps

Free Flap: A free flap is completely removed from its donor site region and connected to an artery and a vein at the recipient site. Free flaps are more complicated because they require microsurgery.

This reconstructive surgery option involves the creation of a flap that is removed from the body, completely disconnecting the flap from its original blood supply at the donor site. This flap, freed from the donor site, is then transferred to the distant recipient site and is revascularized by re-establishing blood flow between the blood vessels of the flap and the recipient site. Revascularization of the free flap is achieved by sewing the ends of the blood vessels together (an anastomosis) under a microscope, thereby restoring the circulation.

Important factors that guide selection of the flap for reconstruction are the:

- size and location of bone and soft tissue defects,
- condition of the recipient bed,
- general health of the patient,
- patient’s prognosis relative to his cancer.

Some patients may have undergone previous free flap reconstruction or neck dissection, which limits the number of adequate blood vessels for revascularization. In such situations, the surgeon may need to search for blood vessels on the opposite side of the neck or use a pedicled flap.

Microvascular reconstruction of jaw defects with a revascularized free flap is considered the standard of care for patients with advanced stage ORN. It not only restores continuity of the bony defect but also promotes healing by supplying healthy, nonirradiated soft tissue for coverage of the reconstructed jaw. The most commonly used free flaps for reconstruction of the jaw are comprised of bone and soft tissues such as muscle, fat and skin. The bony part of the free flap reconstructs the jaw while the muscle and skin provide healthy soft tissue for resurfacing the oral cavity and any external skin defects of the chin, cheek, or neck.

Bone-Containing Free Flap: The fibular free flap is the most widely used flap for the mandible. The fibula, one of the two bones in the lower leg, is a very reliable method of reconstructing lateral defects (lying on either side) of the jaw and can also be reshaped to reconstruct the curved U-shaped front portion. As a leg bone, the fibula does not support much body weight, so its removal has minimal effect on walking. The shin bone, or tibia, which has a greater role in weight-bearing activities, is left undisturbed. The new mandible formed by the transplanted fibular bone allows favorable placement of dental implants. These implants are tiny titanium screws that are gently inserted into the bone. These fixtures facilitate subsequent placement of implant-supported dental prostheses that are more stable than removable dentures and improve patients’ ability to chew and swallow.

Use of a fibular free flap is recommended for reconstruction of the jaw when the estimated bone defect is greater than 5 cm. It remains useful for defects as large as up to 25 cm. The fibular flap has long blood vessels, thus decreasing the risk of flap failure because of inadequate blood flow.

A careful evaluation is merited in patients with history of surgery, trauma or peripheral vascular disease of the lower legs prior to selection of a fibular flap; in such patients, other options like iliac crest or scapular free flaps should be considered for jaw reconstruction as discussed below.

Free flaps for mandibular reconstruction can be harvested from the scapula (shoulder blade), iliac crest (part of hip bone), or the forearm as well. The scapular and iliac crest flaps also provide bulky soft tissue for filling the space left by the resected jaw. The fibula and iliac crest serve as the best sources for bone and are correspondingly the preferred bone-containing flaps when dental implant placement is desired. In contrast, the radial forearm free flap is the best source of skin and soft tissues, which are thin, pliable and richly vascularized. Unfortunately, the indications for the radial flap are limited by the quality and quantity of bone that is available.

Free Soft-Tissue Flaps: Free soft-tissue flaps containing only muscle and skin can be harvested from the abdominal wall (rectus abdominis flap) or forearm (radial forearm flap). They are used in ORN patients who are poor candidates for a bone-containing free flap, for patients who require soft tissue resurfacing of the oral cavity for coverage of exposed mandibular bone, or when significant radiation-induced necrosis is present in soft tissue. The anterolateral thigh flap, a soft-tissue flap from the upper leg, has also become a popular choice for reconstruction of oral cavity defects resulting from cancer surgery or ORN.

Single-stage vs 2-stage Reconstruction

Microvascular reconstruction is usually performed immediately after excision of necrotic jaw bone in a single stage (during the same surgical procedure), but a 2-stage procedure is advocated as well by those who claim that it can achieve better healing. In the 2-step procedure, the necrotic bone is first removed and reconstruction is delayed until the oral mucosa is completely healed and chronically draining fistula tracts have resolved.

Complications Following Reconstruction

One of the challenges encountered with microvascular reconstruction is the extensive post radiation fibrosis and scarring around the reconstructed area. Reconstruction continued on next page.

SPOOHNC http://www.spohnc.org E-mail-- info@spohnc.org
the blood vessels that may make dissection very difficult. Severely damaged irradiated tissues may increase the morbidity and failure rates associated with free flaps, resulting in infections, wound breakdown, and nonunion of the adjacent bone segments. By causing blood clot inside veins (venous thrombosis) and wound infections, the failure rate (reported to vary between 20%-33%) may also increase.

Therapy prior to such reconstruction is believed to promote formation of new blood vessels and reverse the delayed radiation changes in tissues, thereby decreasing the failure rate of free flaps in mandible and soft-tissue reconstruction for ORN. Another additional problem reported with free microvascular bone flaps is the difficulty in achieving the needed arch and size, which may lead to unsatisfactory dental prosthetic rehabilitation. To circumvent this problem, bone marrow grafts can be used to increase the bone volume. Certain surgical and dental techniques may also be used to compensate for the insufficient height of fibular and other bone flaps.

Conclusion

Advanced stage osteoradionecrosis of the mandible is a cause of significant morbidity for head and neck cancer patients. Radical resection followed by reconstruction is the treatment of choice for advanced stage ORN of the mandible in head and neck cancer patients. Although selection of an ideal technique for mandibular reconstruction continues to be a subject of intense debate, microvascular surgery as a single-stage surgical procedure is capable of achieving optimal results within a short hospital stay. Of the various bone-containing free flaps, reconstruction with the fibular flap has become the most effective way to enhance the quality of life in patients with ORN by eliminating pain, controlling local infections, improving functional status, and correcting facial disfigurement.

Sources


SPOHNC CHAPTER NEWS

Arizona Experts Discuss Head and Neck Cancer Survival
by Keri Winchester, M.S., CCC-SLP

Oral and head and neck cancer strikes about 700 Arizonans each year. Although the numbers are not that great, the devastation to patients and their families is.

On April 13, in celebration of Oral and Head and Neck Cancer Awareness Week, 60 people attended a panel discussion on head and neck cancer sponsored by three local Arizona chapters of SPOHNC at the Chandler Regional Medical Center’s Cancer Center. The discussion centered on “Living With Oral, Head, and Neck Cancer.”

As one survivor put it, “Having head and neck cancer and surviving it opened my outlook on life that has made my life more full and has allowed me to help others.”

Presently living with head and neck cancer are prominent film critic Roger Ebert and chef Grant Achatz from Chicago, and basketball coach George Karl of the Denver Nuggets. Head and neck cancer occurs in males three times as often as it does in females.

Many well known people have had oral and head and neck cancer in the past. Among the most famous are psychiatrist Dr. Sigmund Freud and President Grover Cleveland, who both had cancer of the palate. Secret surgeries were performed on the interior of the President’s mouth, leaving no visible scars. A plate was made from tire rubber, which restored his speaking voice so well that when he re-appeared in public no one could detect that an operation had taken place. President Ulysses S. Grant was found to have squamous cell carcinoma after leaving office brought on by smoking 20 cigarettes a day for 22 years, according to his physician. Men who smoke have a 27-times higher rate of oral cancer than nonsmokers, says the World Health Organization.

Several physician experts in the field of head and neck cancer participated in the panel and shared information about the latest medical treatment and management of head and neck cancer. Dick Snider, M.D. retired, head and neck cancer survivor and co-facilitator of the Chandler and Phoenix chapters, served as moderator.

Speakers included:
• Rami Sarid, M.D. Medical Oncologist – The current role of various treatments for head and neck cancer as well as what the future may hold.

The panel answered questions at the end of the program. “You have to make sure patients have the facts about what those who treat them can do,” said Phoenix Chapter facilitator Kerri Winchester, S.L.P. At the same time, she said, “The discussion must be as honest as possible.” If they don’t have the realistic perspective to go along with the treatment, it won’t be as successful.”

Treatment of head and neck cancer patients is a multidisciplinary team effort, including a variety of specialty physicians and dentists, nurses, speech pathologists, mental health professionals and others. Fortunately, thanks to advances in medical treatments and plastic and reconstructive surgery techniques amazing things can be done to help patients with these cancers.

Spirit of Georgia

Bravos to the SPOHNC Chapter in Augusta, Georgia for also raising awareness and funds during Oral and Head and Neck Cancer Week with everyone participating in the second Annual Walkathon in May.

The event was planned by Head and Neck Cancer survivor Leann Dragano who serves as Chapter facilitator with Lori Burhead, PhD, CCC-SLP. “We had to do this,” says Dragano, “to show that the disease means something other than a cancer that devastates lives.” She describes it as a “simple event” but a far-reaching demonstration of “determination to get the word out about oral and head and neck cancer and say you can survive this cancer.”

Gifts Have Been Received in Loving Memory of

Leslie Crump by Anonymous, Henry Denesi

Robert Klauber by Sandra Campaniello, Michael Cannarozzi, Mark Cowitt, Jeff Ellner, Lynn Gormley, Susan Kennedy, Nina Klauber and Family, Carol Manske, Harvey Nosowitz, Elsa Paszek, Ronald Pollack, Bonnie Sawicki, Stanley Schrier, Robert Schwartzman, Margaret Siegle, Alfred Tuckman, Gary Turetsky, Judith Zipkin

Dorothy Lipari by Paula Heidt

William Edgar Robsky by Allen Acker, Donald Daros, Judy Kostyk Hannon, Thomas Lane, John Livingston, Thomas McDowell, Theresa Miller, New England Golf Association, Inc, James Passier, PGA-Connecticut Section, Daniel Sullivan, John Walsh

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<td>Call for additional information, Kathleen Godwin, 828-692-6174</td>
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<tr>
<td>PENNSYLVANIA-HARRISBURG</td>
<td>Health South Lab 3rd Tues, 6:30 PM, Joseph F. Brelsford, <a href="mailto:Jfbrs@mm.com">Jfbrs@mm.com</a></td>
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<tr>
<td>VIRGINIA-CHARLOTTESVILLE</td>
<td>Dept. of Forestry Building, Suite 800, Vikki Bravo, 434-982-4091</td>
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<tr>
<td>NORTH CAROLINA-CHARLOTTE</td>
<td>Blumenthal Cancer Center, 1 W. Pavilion Pt % Fam Conf Rm, 717-777-8370</td>
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<tr>
<td>PENNSYLVANIA-MONROEVILLE</td>
<td>Inter Community Cancer Center, Beth Madrishin, 412-856-7740, <a href="mailto:bmadrishin@wpahs.org">bmadrishin@wpahs.org</a></td>
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<tr>
<td>VIRGINIA-FAIRFAX</td>
<td>Inova Fairfax Hospital Radiation/Oncology, 757-487-2624, <a href="mailto:Corinne.cook@inova.com">Corinne.cook@inova.com</a></td>
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<tr>
<td>NORTH CAROLINA-ASHVILLE</td>
<td>Call for additional information, Kathleen Godwin, 828-692-6174</td>
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<tr>
<td>PENNSYLVANIA-NEW CASTLE</td>
<td>UPMC Jameson Cancer Center, 3rd Thursday, 5:00-7:30 PM, Jeannie Williams, Becker</td>
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<tr>
<td>VIRGINIA-FAIRFAX</td>
<td>Sentara Norfolk General Hospital, 2nd Wednesday, 6:30-8:00 PM, Kile Jackson, 425-788-6562</td>
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<tr>
<td>N CAROLINA-HENDERSONVILLE/WNC</td>
<td>Pardee Health Ed. Ctr. Blue Ridge Mall, Kathleen Godwin, 828-692-6174</td>
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<tr>
<td>PENNSYLVANIA-PHILADELPHIA</td>
<td>Penn Med Perelman Ctr Advanced Med, 1 W. Pavilion Pt % Fam Conf Rm, 717-851-2000</td>
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<tr>
<td>OHIO-CLEVELAND</td>
<td>Cleveland Clinic Fairview Hospital, 2nd Monday, 6:00-8:00 PM, Gwen Paul, LISW</td>
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<tr>
<td>TENNESSEE-CHATTANOOGA</td>
<td>Memorial Hospital, 19.5 Memorial Hospital, 615-451-5555, <a href="mailto:jeanell1325@aol.com">jeanell1325@aol.com</a></td>
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<tr>
<td>OHIO-DAYTON</td>
<td>The Chapel Room One Elizabeth Place, Hank Denesi, 937-832-2677, 2nd Monday, 6:00-8:00 PM, <a href="mailto:hdenesi@mindspring.com">hdenesi@mindspring.com</a></td>
</tr>
<tr>
<td>TEXAS-DALLAS</td>
<td>Baylor Irving-Coppell Medical Center, 10th Floor, 972-373-9599, <a href="mailto:danstack@aol.com">danstack@aol.com</a></td>
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<tr>
<td>OHIO-LIMA</td>
<td>St. Rita’s Regional Cancer Ctr., Allison Rd/Onc. Ctr. Garden Conf Rm, 419-996-5606</td>
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<tr>
<td>TEXAS-DALLAS</td>
<td>Cvetko Ctr. at Sammons Cancer Ctr., 1200-12:30 PM, Cvetko, 1200-12:30 PM, Cvetko</td>
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<tr>
<td>P.O. Box 53</td>
<td>Locust Valley, NY 11560-053, 1-800-377-0928</td>
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</table>
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