Pain has been defined as an unpleasant emotional and sensory experience associated with actual or potential tissue damage. It remains an ongoing challenge both for those who suffer from it and the clinicians who are working to control and manage it. Pain is a common symptom in patients with head and neck cancers (HNC), who account for about 3-5% of all cancers in the United States. The prevalence of these cancers is about 6% in males and 2% in females in developed nations while these figures are 8% and 4% for developing nations. These cancers have high prevalence rates in populations showing high tobacco and alcohol consumption and other smokeless non-tobacco products such as betel nut and paan.

One of the most feared complications in HNC is severe, intractable pain. Pain management in HNC is especially challenging due to the rich orofacial nerve supply along with extensive motor activity in the form of facial expressions, oral intake, chewing, swallowing, and speaking which can act as constant pain triggers. 85% of patients suffering from HNC report pain at the time of initial diagnosis and the majority of patients report pain to be the cause for seeking medical care. Pain was commonly reported due to tumor recurrence (35%), treatment sequelae (30%) and multiple factors (25%).

The occurrence of pain in head and neck cancers can be subdivided into acute and chronic pain.

ACUTE PAIN may be caused by:
- Disease: Invasion of bone, nerve, muscle, mucosal damage or from tumor pressure
- Cancer therapy: surgery, radiation therapy, and chemotherapy
- Oral/dental pain: mucositis, infection (e.g. yeast infections, Herpes Simplex Virus), neuropathy
- Unrelated conditions causing pain (e.g. myofascial pain i.e., pain from connective tissue that encases and layers the muscles, trauma)

CHRONIC PAIN may be caused by:
- Persisting/progression of the cancer
- Cancer therapy: surgery, radiation therapy, and chemotherapy causing:
  - Mucosal atrophy (wasting, degeneration or weakening of the lining of the mouth and throat,) xerostomia (i.e., abnormal dryness of the mouth resulting from decreased secretion of saliva)
  - Mucosal infection
  - Neuropathy
  - Temporomandibular (myofascial) disorders
  - Dental caries
  - Ill fitting appliances
  - Osteonecrosis/mucosal necrosis (i.e. premature death of bone or tissue cells)
  - Postherpetic neuralgia (shingles)
- Unrelated conditions causing pain

Mechanism of Pain
Due to Cancer of the Head & Neck
Cancer may compress and invade pain-sensitive structures and induce inflammation. Potential mechanisms of bone pain due to malignancy include periosteal (i.e., fibrous sheath covering bones) pressure and stretching, compression and invasion of nerves, damage to blood vessels, micro fractures, and muscle spasm. Inflammatory mechanisms can be activated by both cancer and cancer treatments and include release of certain proteins /chemicals that cause pain in the tumor environment such as inadequate oxygen supply. Tumors may themselves produce certain substances (cytokines and growth factors) that activate inflammation and pain pathways. Additionally, damage is caused by a number of highly reactive forms of oxygen that are potential sources of damage called “reactive oxygen species”.

These release mediators from tumor cells and cells in blood and immune cells resident in the affected tissue and nerve fibers causing inflammation leading to damage of the vascular lining releasing...
Mechanism of Pain Due to Surgery

Surgical options like radical and modified neck dissection seem to influence the post operative pain severity depending on sparing of the Spinal Accessory Nerve also called the XIth cranial nerve (CN) and the level of neck dissection. In addition, cancer-induced activation of “osteoclasts” - a cell that nibbles at and breaks down bone and is responsible for bone resorption (i.e., the loss and reabsorption) lower pH for dissolution of bone mineral.

Tissue inflammation also increases the circulation of certain enzymes that leads to production of substances (“bradykinin”) that produces and amplifies pain.

Tumor necrosis factor (TNF) a protein made by the white blood cells that kill cells appearing abnormal and stimulates autoimmune reactions like inflammation also plays a role in inflammation, neuropathic pain, and is a key mediator in mucositis.

Mechanism of Pain Due to Chemotherapy and/or Radiotherapy

Peripheral neurotoxicity (nerve damage) is common with a number of chemotherapeutic agents; including Platinum based agents which are used in the treatment of HNC. For example, Cisplatin induces a series of events in neuronal cells that leads to its death. Also, the taxanes (paclitaxel, docetaxel) may increase the risk of neurotoxicity when combined with platinum agents. Other agents used in cancer treatment (e.g. interferon, thalidomide) or in supportive care (e.g. amphotericin-B an antifungal) may also induce sensory neuropathies. Additive effects may occur from combinations of drugs.

Radiotherapy causes pain not only by causing direct tissue damage but also secondary to inflammation and radiation induced mucositis (RIM). Patients who undergo radiation report increased levels of cancer pain despite ongoing standard pain management protocols. Mucositis-related pain increases during radiation treatment, and typically resolves after completion of treatment. Mucositis ulcerations can become secondarily infected by oral bacteria causing worsening inflammation and more pain. To sum up, pain associated with mucositis is dependent on the degree of tissue damage, sensitization of pain receptors, and elaboration of inflammatory and pain mediators.

In addition to mucosal damage, radiation therapy damages bone and irreversibly damages the inner lining of the blood vessels throughout the radiated area. This may lead to chronic bone and soft tissue necrosis causing pain. As in mucositis this pain may also increase in the presence of infection.

Another cause for pain after radiation is spasms of the neck muscles presenting as neck and shoulder pain.

Mechanism of Pain Due to Surgery

Surgical options like radical and modified neck dissection seem to influence the post operative pain severity depending on sparing of the Spinal Accessory Nerve also called the XIth cranial nerve (CN) and the level of neck dissection. One study reported that patients who underwent surgery sparing CN XI noted better scores on PAIN MGMT.
PAIN MGMT. from page 2

the Head and Neck Quality Of Life pain domain and significantly less shoulder or neck pain compared to patients who had surgery sacrificing CN XI. Removal of all or parts of the jawbone is reported to cause sensory impairment with about 50% of these patients reporting regional increase in sensitivity to painful stimulus (“hyperalgesia”) or pain caused by a non-painful stimulus (“allodynia”) whereas 90% of patients who underwent surgical removal of the upper jaw bone (“maxillectomy”) reported persistent pain over a follow up period of 2-5 years. Patients undergoing surgery with adjuvant (i.e. supplemental) chemo or radiotherapy reported significant chronic pain and morbidity compared to those receiving chemo or radiotherapy alone. Apart from these, a specific pain syndrome associated with surgery in the parapharyngeal space (space outer to the pharynx and inner to the lower jaw bone) known as First Bite Syndrome may also complicate pain presentations in these patients. First Bite Syndrome (FBS) is proposed to involve a specific loss of nerve function causing hypersensitivity of the salivary gland cells which presents as severe, unremitting pain in the parotid region after the first bite of a meal.

Pain issues appear to have a significant impact upon the quality of life of HNC patients. In one study, the 5 year survival rates were seen to be 81.8% in patients with low post treatment pain scores whereas the rates were 65.1% in patients with high post treatment pain levels. Other symptoms reported to have a significant effect on the quality of life were dysphagia reported as significant symptom post radiotherapy by 82.5% patients. Ulceration of the oral and pharyngeal mucosa (mucositis) due to radiation treatment also impairs the ability of patients to take oral pain medications further aggravating the situation. Transdermal fentanyl and gabapentin (available in liquid formulation as well) are seen to bring significant relief in these patients.

Pain Management

Effective pain management by physicians and nurses requires knowledge about pain evaluation, treatment methods, and recent advances in the field of pain management. A comprehensive assessment of pain is a key component in effective management of pain and failure to do so is a common reason for inadequate pain relief. The history, physical examination, psychosocial assessment and diagnostic evaluation of the patient complement the pain specific assessment. The pain assessment includes identifying the location of pain which may correspond to the area of injured tissue or may represent referred pain.

Similarly, onset of pain, pattern of pain (acute, chronic, constant, intermittent, breakthrough or, incident pain), description of its characteristics whether neuropathic (burning, ‘pins and needles’, shock like, numb) or somatic (dull, achy, pressure like) – help strategize treatment modalities. Severity is used to judge the effectiveness of pain treatment methods. Clinicians often make use of various pain scales to help patients and/or their care givers to communicate/rate the severity of their pain and report to their treating clinicians. Alleviating factors, precipitating factors and associated symptoms aid in diagnosis and evaluation and selection of the treatment modalities. It is very important for the treating physician to obtain a history of the past treatment and response as inadequate relief may represent incorrect diagnosis or treatment of pain, disease progression, or therapeutic failure. The effect of pain on the patients and side effects from its treatment are also important to know.

Prevention & Management of Oral Mucositis

Development of strategies for the prevention and management of oral mucositis helps control the pain caused by it. Radiation shields are recommended during standard radiation therapy. Pretreatment oral/dental stabilization helps eliminate/prevent sites of infection and trauma. Other preventive measures include dental cleaning, good oral hygiene, saline mouth rinses, use of antibiotics, use of anti-inflammatory agents and biologic response modifiers such as granulocyte-colony stimulating factor and epidermal growth factor.

The core management of oral mucositis depends on palliative approaches by using a stepped protocol. The elements of this protocol include excessive sedation, constipation and their management should be provided. Patients should be cautioned about the risks and dangers of driving while taking opioids.

Cognitive and behavioral interventions such as relaxation, imagery, biofeedback, hypnosis, and transcutaneous electrical stimulation have been employed in the management of cancer pain with varying patient acceptance and efficacy. Use of subcutaneous Botulinum toxin A injections may help relieve chronic neuropathic pain following neck dissection.

Conclusion:
Optimal pain management starts with a thorough assessment. The goals of a thorough assessment are to understand the type of pain, ascertain its cause, consider the possibility that a specific pain syndrome is present, and formulate a management plan. Pain in the head and neck areas has a significant impact upon the quality of life and needs to be aggressively treated to prevent co-morbidities.

Systemic analgesics remain an important mainstay in pain management along with topical analgesics and anesthetics. Pain management including adjunctive pain medications are often underutilized in head and neck cancer-related pain syndromes. Novel approaches of potential interest are agents that affect neurotransmitters of pain. Biological response modifiers offer the potential for prevention and to speed healing. Oral care and continuing oral hygiene is recommended before and during cancer therapy. Whereas antimicrobial approaches have been shown not to prevent mucositis, there may be a positive effect on dental and gingival health and on candidiasis. Cooling the mouth and throat with ice chips is recommended for receiving short half life chemotherapy. Other approaches that require further study include low-energy lasers and anti-inflammatory medications.

In the end, successful pain management is a partnership between the patient and his/her caregivers and the treating interdisciplinary team where prompt and good communication holds the key to quality care.

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A TIME FOR SHARING

It sits there like a stain on the page... "Have you ever had cancer?" - and you want to be honest but it means having to wind back, like the calendar leaves flipping in the old black and white movietone clips. Backwards thru treatment, prognosis, diagnosis, tests that yielded small hints like pieces of coarse glass nearly buried in the sand. Where you were poked, prodded, and pierced beyond patience. And that moment, post surgery, when you rose sleepily out of anesthesia and the doctor said, “I’m sorry - but you have cancer.”

It was Rosh Hashanah. The first night of the first day of the Jewish New Year. I sat in the lobby waiting for my niece to come around with the car, surrounded front and back by family with my older brother pressing into my shoulder and repeating into my ear over and over again, “you’re going to be OK, you’ll get through this” and I push him away saying I just want to go home. I’m still groggy from the anesthesia, my eyes hurt, and the lights are too bright. Finally, they bundle me up and hustle me into the back seat, where I fall asleep on the way back home.

The next morning, outside of the meeting the ENT surgeon scheduled with an oncologist, I called my niece and asked her - told her - to tell me exactly what the diagnosis was. And as she spoke, it all fell away, the traffic suddenly stopped, the horns, the tires on asphalt, annoyed that you’ve blocked their way, the whole world goes dull and silent.

The words and diagnosis made their imprint. I had cancer. Then, slowly, the screen started to flicker again, and images and sounds rose up around me. I had cancer. Upstairs, the young oncologist sat in front of me, at a small round table, my wife taking notes, his students standing behind with hands clasped in front, when he said, “this is what you have and this is what we’re going to do.” That was all that I was interested in.

Virginia Woolf wrote of the relationship between the essayist and their essayistic personae: “Never to be yourself - and yet always.” That is what this question on the form, the same question asked over and over again, demands in contradiction. Because you can never really separate yourself from cancer. You can never “had” cancer. You are a survivor - but you are always a cancer patient. You can never remove yourself from that. Every cough, every twitch of a muscle, that mysterious itch, that bumpy growth on the side of your foot, always is put into the context of cancer. It’s right there, in that question on the form - so you answer the way you’ve been taught.

Who - Six doctors, including the initial ENT, an ophthalmic surgeon, two neuro-ophthalmologists, one neurologist, and an ENT surgeon, over nine months, could not diagnose why I was losing control of my left eye.

What - The double vision, the only symptom that came on suddenly on a Sunday morning. Multiple CAT scans and MRIs spoke of infection and some activity in the basal skull. But then the tour group moved on to more interesting sights.

When - Rising one morning early in February 2007.

Where - Treated in three different hospitals, including an ER where an intern fumbled with a piece of equipment in one hand, while reading the instructions that he held in the other.

Why - The only question that couldn’t be answered. The oncologist asked me if I was Asian since the rare cancer they found, in a place it wasn’t supposed to be, was so common in that part of the world. We had a good laugh at that since I’m made up of odd pieces of Russian and Polish immigrants who fled the poverty and anti-semitism in Europe. He asked if I ate a lot of Chinese food, since a high salt diet was another clue, but I told him only on Sundays with my family when we would order combination plates with crusty egg rolls and two choices of soup.

But he had a plan and he also had a determined patient constantly pushing him on schedule and information.

Between the time I was diagnosed and the time I started radiation, we met for further exams and discussions. I printed out illustrations found, showing the hollows of the skull with the outlines of small caverns and ledges. “Show me,” I said, “show me where it is.” Envisioning its placement was giving it an identity, a beaded pin on a map. I knew what it was - now I wanted to know where it was.

I went thru six weeks of treatment - four weeks of radiation treatments once a day, then two weeks twice a day. Along the road, I had two rounds of cisplatin and happily escaped a third. I counted them down one by one, fatigue setting in, my weight beginning to drop, my days spent sleeping until I was woken up to return to the lab. Until the final day, the last treatment, when I dressed, went out to meet my wife by the elevators, and said “Done.” And collapsed into her the way a child runs to the safety of the familiar.

The recovery was rougher than I thought, the radiation causing such intense inflammation along my sinuses and breathing passages that if I tried to lie down, I would immediately choke and struggle for air. So I learned how to sleep in a large club chair wrapped in comforters and a hooded sweatshirt, one of my dogs resting on my feet while the other lay at my side, watching me, not closing their eyes until mine did first.

I learned how to use my PEG tube, writing everything down in a journal, keeping an eye on both nutrition and...
Smoking During Radiation Treatments Reduces Chance of Overall Survival

Fairfax, Va. – Smokers who continue to smoke while undergoing radiation treatments for head and neck cancer fare significantly worse than those who quit smoking before therapy, according to a study in the February issue of the International Journal of Radiation Oncology-Biology-physics for Radiation Oncology (ASTRO).

Although the association between tobacco smoking and head and neck cancers has long been established, there had been little data until now showing whether continued smoking during treatment affects prognosis.

“I’ve always told patients, ‘You should really stop smoking,’ but I had no tangible evidence to use to convince them that they would be worse off if they continued to smoke,” Allen Chen, M.D., lead author of the study and residency training program director at the University of California, Davis, School of Medicine in Sacramento, Calif., said. “I wanted concrete data to see if smoking was detrimental in terms of curability, overall survival and tolerability of treatment. We showed continued smoking contributed to negative outcomes with regard to all of those.”

Chen and colleagues reviewed medical records of 101 patients with newly diagnosed squamous cell carcinoma of the head and neck who continued to smoke during radiation therapy and matched those patients to others who had quit prior to starting radiation therapy for their head and neck cancers. Matching was based on primary disease site, gender, smoking duration, stage of disease, radiation dose, other treatment (surgery and chemotherapy) and date of initiation of radiation therapy.

The researchers found that 55 percent of patients who had quit smoking prior to treatment were still alive five years later, compared with 23 percent of those who continued to smoke. The poorer outcomes for persistent smokers were reported for both patients who had surgery prior to radiation therapy and patients who had radiation alone. Similarly, Chen and his colleagues found that 53 of the patients who still smoked experienced disease recurrence, compared to 40 patients in the control group. Active smokers also experienced more complications of treatment, such as scar tissue development, hoarseness and difficulties with food intake.

Chen said additional research will be needed to explain these differences in outcomes for patients with head and neck cancers. One theory suggests that smoking deprives the body of much needed oxygen.

“Radiation therapy requires oxygenation for the production of free radicals, which attack cancer cells,” he said.

He also emphasized that their findings are based on an observational study, which does not establish a cause-effect relationship between smoking during radiation therapy and poorer outcomes. For instance, they were unable to determine with certainty the actual cause of death of each patient, and active smokers may be at higher risk of death from other medical problems such as heart disease, stroke and diabetes.

“Patients unable to quit may also have non-cancer-related medical and psychosocial problems that could possibly contribute to inferior survival.” Chen said.

“Those who continue to smoke even after a diagnosis of head and neck cancer are likely to be at higher risk for alcohol abuse, have less social support and have lifestyles associated with high-risk health behaviors. A diagnosis of cancer is emotionally devastating, and a lot of patients are reluctant to entertain the idea of smoking cessation. Many patients can’t or won’t connect the dots, and unfortunately, our data is showing that by continuing to smoke, they are more likely to gamble away the possibility of cure.”

 ASTRO is the largest radiation oncology society in the world, with more than 10,000 members who specialize in treating patients with radiation therapies. As the leading organization in radiation oncology, biology and physics, the Society is dedicated to improving patient care through education, clinical practice, advancement of science and advocacy. For more information on radiation therapy, visit www.rtanswers.org. To learn more about ASTRO, visit www.astro.org.
I am a Speech Pathologist who specializes in treating swallowing disorders in patients who have had oral, head and neck cancer. I am also the facilitator of our local SPOHNC support group in Fort Myers, Florida.

For the past 6 years my two English Bulldogs Daisy and Jazz have been going to work with me in our outpatient clinic. All the patients have grown to know and love the girls.

Daisy and Jazz provide moral support, distraction from pain and discomfort, have been proven to lower blood pressure and most of all provide love to all my patients as they undergo swallowing therapy. I will admit Daisy and Jazz are far more popular then I am, and that’s ok. When I see the smiles they bring to my patients’ faces that’s all that matters.

In March 2010, while petting Daisy, I felt a large lump on her cheek. Thinking it was an impacted tooth I took her to the Vet. After x-rays and two biopsies she was diagnosed with squamous cell carcinoma of the mandible. I was devastated.

Then in April, I took her to Tampa to see one of the best veterinarian surgeons in Florida and he performed a right mandibulectomy. I was truly amazed at the surgery. Her right jaw was removed and just soft tissue was left but to look at her you would never know she had surgery.

Her recovery was even more amazing. Daisy spent a week in the animal hospital in Tampa. The Vet said to keep her calm when I brought her home. That was impossible! She was so excited to see Jazz and me, and you couldn’t contain her.

A few weeks on pain pills, six weeks on soft food and 2 weeks off work; that was her total recovery. No chemotherapy or radiation. I was truly amazed.

After two weeks she would run to the car to make sure I didn’t leave her home. No special restrictions were needed. She could eat dry food, chew bones, run, enjoy playing in the mud and loved to work for milk bones.

Six weeks of soft food and she was fully recovered. It has been eight months now and she eats regular food, chews bones and still loves coming to work to make the patients smile. She did not have to undergo any chemo or radiation. She had a recent check up and the Vet said she’s just fine.

My patients are always amazed that she had the same cancer they did and recovered so remarkably. I think she is the most loved and spoiled dog I know.

My patient’s love both my dogs but Daisy is an inspiration to them. When I tell them her story they are amazed that a dog can get oral cancer and when they hear she has had a similar surgery to some of them they are even more surprised. She adores my patients and they adore her. She sits with them while they get their swallowing therapy, distracts them from their pain and discomfort and sometimes is silly and provides an example of how not to eat as she eats fast and drools.

All this unconditional love just for a belly rub and the occasional milk bone. The great news is Daisy remains cancer free, continues to provide tremendous joy and laughter in my life and the lives of the patients in our clinic and continues to love to go to work.

I’ve attached a photo so you can see how remarkable she looks. My patients encouraged me to share this lighthearted story with you in the SPOHNC newsletter.

Daisy and I love our jobs and love working with oral, head, neck cancer patients.
Returning to Work After Cancer

By Carolyn Messner, DSW, MSW, CD, LCSw-R, and Jessica Puma

This past decade has witnessed dramatic breakthroughs in the detection and treatment of cancer. Innovative methods of managing side effects of cancer treatments have made it possible for more individuals with cancer to work while receiving cancer treatment.

Many studies show that returning to work may contribute to cancer survivors’ emotional and financial well-being. Besides income, it provides satisfaction, social support, and the opportunity to interact with coworkers and colleagues. Continuing to work productively can be vital to your sense of well-being, as it is a reminder that you do have a life apart from cancer. Being a valued employee or trusted coworker may be a helpful distraction from the rigors of cancer treatments and follow up appointments.

Each workplace has its own unique culture. Choosing whether to tell your employer about your cancer is a personal decision. Many myths about cancer exist in our society, including the workplace. For instance, employers and coworkers may assume that you are not able to perform job responsibilities as well as before cancer. Sometimes, these misconceptions can lead to subtle or blatant discriminations. It is important to become familiar with the laws before deciding whether to disclose a cancer diagnosis.

The Americans with Disability Act requires that organizations with 15 or more employees comply with ADA guidelines. In order to take advantage of ADA protection, you must meet the ADA definition of “disabled person,” you must qualify for the job and be able to perform “the essential job functions,” and you must not pose a risk to your own or others’ health and safety.

The ADA recommends that any accommodation needed does not cause “undue hardship” to the employer. Flexible work hours to meet treatment schedules and doctors appointments are the most frequent workplace accommodation required by people living with cancer. If you require flextime, it is important to disclose your cancer diagnosis to a supervisor or Human Resources to be protected under the ADA. If no reason is given for frequent requests for flextime, you could risk jeopardizing your job security. For more information about the ADA, call (800) 514-0301 or visit www.ada.gov.

The Family and Medical Leave Act enables the person living with cancer, cancer survivors, and family members to take unpaid leave of up to 12 weeks within one calendar year. The FMLA applies to organizations with more than 50 employees. The employee must have worked with his or her employer for at least one year, and employers must continue health benefits during the leave. Leave does not have to be taken all at once but can be taken in blocks of time. To learn more about the FMLA, visit the Department of Labor website at www.dol.gov.

The Equal Employment Opportunity Commission is a federal agency that enforces the provisions of the ADA and the FMLA and assists citizens who feel that they have been discriminated against in the workplace. If you feel you are being treated unfairly, contact the EEOC at (800) 669-4000 or visit www.eeoc.gov.

5 Tips for Your Return to Work

1. Talk to your healthcare team about the practicality of returning to work. Discuss with your doctor the specific type of work you do, your workload, and your work hours, so that you and your doctor are able to make the most informed decision. If your oncologist supports your decision to return to work, obtain a letter on letterhead from your doctor saying it is safe for you to return to work, including any accommodations you may require.

2. Be realistic about your cancer, your energy and your work-life balance in transitioning back to work. Rehearse what you plan to say when asked how you are feeling. Brief, accurate information is likely to make colleagues feel more comfortable and encourage a supportive dialogue. It can also help dispel myths about cancer.

3. Plan for practical needs you may require to support your return to work. Consider a test run before returning to your workplace.


5. Be thorough and plan the details of your return to work so that you feel in control of how you will communicate with your workplace about your cancer and cope with your return to work.

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Editors Note: Dr. Carolyn Messner is Director of Education and Training at CancerCare and past president of the Association of Oncology Social Work. Jessica Puma is a freshman at Columbia University who spent her Prep for Prep Internship in the education department at CancerCare.

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We Want to Hear From You.

Do you have a story that you would like to share with others. Perhaps one that could help someone through his or her cancer journey?

Chris Leonardis is waiting to hear from you.
Please contact her at c.leonardis@spohnc.org or Call 1-800-377-0928, opt 4.

We look forward to sharing your story with our readers.

THANK YOU
ORAL, HEAD, AND NECK CANCER NEWS

March 09, 2011. Chapel Hill, NC - A UNC study released this week in the Journal of Clinical Oncology finds an increasing incidence of squamous cell carcinoma of the oral tongue in young white females in the United States over the last three decades.

A team of researchers from UNC Lineberger Comprehensive Cancer Center analyzed data from the National Cancer Institute’s Surveillance, Epidemiology and End Results (SEER) database and found that, between 1975 and 2007, the overall incidence for all ages, genders, and races of the disease was decreasing. However, the incidence of oral tongue squamous cell carcinoma rose 28 percent among individuals ages 18 to 44. Specifically, among white individuals ages 18 to 44 the incidence increased 67 percent. The increasing incidence was most dramatic for white females ages 18 to 44. They had a percentage change of 111 percent. Interestingly, the incidence decreased for African American and other racial groups.

Historically, oral tongue cancer has been strongly associated with heavy tobacco and alcohol use. Other epidemiological studies have related the decreasing incidence of oral tongue cancer in the United States to the decreased use of tobacco products. Though the UNC research team verified the known decreasing incidence of oral tongue cancer, they were surprised to observe an increasing incidence in young white individuals, specifically young white females.

“Lately we have been seeing more oral tongue cancer in young white women in our clinic. So we looked at the literature, which reported an increase in oral tongue squamous cell carcinoma in young white individuals but couldn’t find any information about gender-specific incidence rates, so we decided we should take a look at the SEER data,” said Bhisham Chera, MD, lead author on the study and assistant professor in the Department of Radiation Oncology.

Over the past decade an association between the human papilloma virus with squamous cell carcinoma of the tonsil and tongue has been observed. Patients with human papilloma virus associated oral squamous cell carcinoma are typically male, white, non-smokers, non-drinkers, younger in age and have higher socioeconomic status. The researchers at UNC have preliminarily tested the cancers of the oral tongue of their young white female patients and have not found them to be associated with the virus. Other institutions have also noted the absence of the virus in young females with oral tongue cancer. The UNC researchers have also anecdotally observed that these young white female patients are typically non-smokers and non-drinkers.

“Our findings suggest that the epidemiology of this cancer in young white females may be unique and that the causative factors may be things other than tobacco and alcohol abuse. Based on our observations and the published data, it appears that these cases may not be associated with the human papilloma virus. We are actively researching other causes of this cancer in this patient population,” he added.

Though the increasing rate of oral tongue cancer in young white females is alarming oral tongue cancer is a rare cancer, relative to breast, lung, prostate, and colorectal cancer. “Primary care physicians and dentist should be aware of this increasing incidence and screen patients appropriately,” states Dr. Chera. Oral tongue cancer is typically treated with surgery first followed by radiation and, in some cases, chemotherapy.

UNC study finds oral tongue cancer increasing in young, white females

UT MD Anderson Receives Grant for Study of Acupuncture in Cancer

Houston, March 22, 2011. The University of Texas MD Anderson Cancer Center has been awarded a grant to study whether xerostomia, a debilitating side effect caused by head and neck cancer radiation treatment, can be prevented when acupuncture is part of a patient’s treatment regimen.

The $2.7 million grant awarded by the National Cancer Institute (NCI) for the study of acupuncture in cancer received a perfect score from peer scientists evaluating grant proposals for NCI.

Lorenzo Cohen Ph.D, professor in MD Anderson’s Departments of General Oncology and Behavioral Science, received the funding. The research is in collaboration with MD Anderson’s Sister Institution, Fudan University Shanghai Cancer Center, in Shanghai, China.

Cohen estimates that xerostomia, also known as dry mouth, affects more than 80 percent of head and neck cancer patients undergoing radiation. The side effect can be debilitating for a patient’s quality of life, making it difficult to speak, eat, sleep and often results in taste changes.

“Saliva helps keep the oral cavity sterile and healthy,” said Cohen, who also is the director of MD Anderson’s Integrative Medicine Program. “It’s the initial step in food digestion, meaning patients with xerostomia may not be getting appropriate nutritional absorption from foods if they don’t have enough saliva to help the process,” said Cohen.

Acupuncture, which derives from traditional Chinese medicine, has been practiced around the world for thousands of years, and is used to relieve pain, treat infertility, and a host of other medical conditions. MD Anderson has offered acupuncture, when appropriate, to patients for pain or other cancer or treatment-related symptoms since 2004.

Numerous small studies suggest that acupuncture helps to treat radiation-induced xerostomia; however, none has examined its use to prevent the development of xerostomia.

“Previous studies, including research conducted at MD Anderson, examined acupuncture to treat xerostomia after it developed,” explained Cohen. “Our new research is unique because we’re incorporating acupuncture during radiation to see if we can prevent the condition in the first place and, should it develop, to try to diminish the severity.”

The Phase III randomized clinical trial will enroll 300 head and neck cancer patients receiving radiation treatment at either Shanghai Cancer Center or MD Anderson. Those enrolled in Shanghai will have nasopharyngeal carcinoma, a malignancy much less common in the United States.

Prior to undergoing radiation, patients will be randomized to receive either acupuncture (needles inserted at appropriate, selected points), sham acupuncture (real and placebo needles inserted at inactive points), or standard care. Subjective and objective assessments of xerostomia will be collected prior to, during and at the completion of therapy, as well as at three, six and 12 months post-radiation.

“Our goals are to determine if true acupuncture effectively prevents radiation-induced xerostomia, diminishes symptoms in those who have the condition, as well as determine if quality of life improves,” said Cohen. “Importantly, we’ll also try to understand the mechanisms behind acupuncture that help treat and prevent the condition. We’ll look at salivary constituents to see if anything specific changes the saliva – perhaps in terms of different proteins – to see why patients’ saliva flow increases due to acupuncture.”

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ARIZONA-PHOENIX
Comprehensive Cancer Ctr.
St. Joseph’s Hospital and Medical Ctr.
1st Tuesday: 5:30-7:30 PM Suite 650
Mary Schneider, Director 602-406-4756
mary.schneider@chw.edu
Barbara Chapman, RN, OCN 602-401-8131
bchapman@bannerhealth.com
Dick Snider, MD (ret.) 480-895-6019
rsnider326@aol.com

ARIZONA-SCOTTSDALE
Virginia G. Piper CA Center
3rd Thursday: 6:30-8:30 PM
Chris Henderson, MS, CCC-SLP 602-312-9226
chenderson2@shc.org
Sandy Bates, RN 480-838-5194
sandybates@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
jmlp@jmh.org

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

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

CALIFORNIA-PASO ROBLES
The Wellness Community
1st Tuesday: 6:00 PM
Pam Collins, Program Director 805-238-4411
pamela.collins@twccc.org

CALIFORNIA-SAN DIEGO
4S Ranch Library
1st Saturday: 12:00 noon
Valerie Targia 760-751-2109
vtargia@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-SANTA MARIA
Marion Rehab. Center
3rd Tues./Alternate Months
Aundie Werner, MS, CCC/SLP 805-739-3185
aundiew@email.com

CALIFORNIA-SANTA MARIA
The Cancer Resource Center of Community Memorial Hospital
Kathleen Horton 805-652-5459
khorton@cmhhospital.org

COLORADO-DENVER
Porter’s Adventist Hosptial
Cottonwood Springs Conf. Rm, 1st Fl.
Tuesday: 4:00 - 5:30 PM
Emily Glickman, MSW 650-722-5091
ejglickman@stanfordmed.org
Joan Fusco, LCSW 650-725-0562
jffusco@stanfordmed.org

CONNECTICUT-NEW HAVEN
Hospital of St. Raphael
2nd Tuesday 5:00 PM-6:30 PM
Vanna Dest, APRN 203-793-3131
vdest@srhs.org
Lori Ratchelous, MSW
lratchelous@srhs.org

CONNECTICUT-NEW LONDON
Lawrence & Memorial Hospital
Community Cancer Center
Waiting Room 1st. Thursday: 6:00 PM-7:30 PM
Catherine McCarthy, LCSW 860-444-3744
cmccarthy@lmhosp.org

CONNECTICUT-NORWICH
William W. Backus Hospital
Medical Office Building, MOB Conf. Rm.
2nd 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-GEORGETOWN
Lombardi Ca Ctr/Martin Marietta Conference Rm
3rd Monday: 1:45-3:00 PM
Joanne P. Lango, MSW
jANGLE@UWMC.EDU

DC-WASHINGTON
Washington Hospital Center
Washington Cancer Institute Room C1200
Last Thursday: 2:30-3:30 PM
Cynthia Clark, RD 202-877-3409
cynthia.d.clark@medstar.net
Christopher Bianca, LCSW
christopher.a.bianca@medstar.net

FLORIDA-FT MYERS
Gulf Coast Medical Center
Outpatient Rehabilitation Ctr.
4th Tuesday: 4:00-5:00 PM
Stacey Brill, MS, CCC-SLP 239-343-1645
stacey.brill@leememorial.org

FLORIDA-FTWALTHONBEACH/NW FL
Call for Location
4th Tuesday: 5:00 PM
Ryan Ennis, MA CCC-SLP 850-863-8275
rennis@white-wilson.com

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
2nd Monday: 6:00-7:00 PM
Monica Grey LCSW, LMT 352-222-8126
No calls after 5pm
monica.grey@cox.net

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

FLORIDA-MIAMI
The Wellness Community
3rd Wednesday: 6:00-8:00 PM
Gary Mallincho 305-668-9000
gmcmahon@yahoo.com
Russell Nansen 305-661-3915

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

FLORIDA-NAPLES
North Florida Rehabilitation Inst.
1st Wednesday: 3:00-4:30 PM
Karen Mott, MS, CCC-SLP 239-393-4079/karen.mott@nchmd.org

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

FLORIDA-SARASOTA
The Wellness Community
2nd Tuesday: 5:30-7:30 PM
Julie O’Brien, LMHC 941-921-5539
julieobee@verizon.net
John Klembaum, PhD 941-921-5539
hope@wellness-swfl.org

FLORIDA-WELLINGTON
Wellington Cancer Center
4th. Tuesday: 6:30-8:00 PM
Catherine DeStefano, RNC,OCN 561-753-8500
angelcancel@bellsouth.net

GEORGIA -ATLANTA
St. Joseph Hospital of Atlanta
Evelyn Trammell Voice & Swallowing Center
2nd Tuesday 1:00 PM
Tanya Duke 678-843-5866
tuduke@sjha.org

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

http://www.sphnc.org
E-mail-- info@sphnc.org
NEW YORK-ROCHESTER
Strong Memorial Hospital
1st Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW  585-276-4529
Sandra_Sabatka@URMC.Rochester.edu

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

NEW YORK-SYOSSET
NSLI-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@spohn.org

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

NORTH CAROLINA-ASHEVILLE
Call for additional information
Kathleen Godwin  828-692-6174
kgodwin@morrisbb.net

NORTH CAROLINA-
CHAPEL HILL/DURHAM
Cornacopia House
3rd Wednesday: 6:00 PM
Dave Gould  919-493-8168
dave.gould@dia.org

NORTH CAROLINA-
CHARLOTTE
Blumenthal Cancer Center
2nd & 4th Thursday: 1:30-3:00 PM
Meg Turner  704-355-7283
turner.carolinashealthcare.org
Terri Painchaud  704-364-7119
trapp6@yahoo.com

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

OHIO-DAYTON
The Chapel Room  One Elizabeth Place
2nd Monday: 6:00-8:00 PM
hdeneski@mindspring.com

OHIO-LIMA
St. Rita’s Regional Cancer Ctr.
Allison Rad/Onc. Ctr. Garden Conf Rm
3rd Tuesday of even month: 5:00 PM
Holly Metzger, LMSW  419-996-5606
hjmetzger@health-partners.org
Linda Glorioso  419-996-5616
ldglorioso@health-partners.org

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

OREGON-MEDFORD
Providence Medical Center
2nd Friday: 12:00-1:30 PM
Richard Boucher  503-269-8323
richard.boucher@hp.com

OREGON-THE WILLAMETTE VALLEY
Samaritan Regional Cancer Ctr.
2nd, Wednesday: 5:00-6:30 PM
Lisa Nielsen  541-757-8082
HNCSurvivor@comcast.net

PENNSYLVANIA-HARRISBURG
Health South Lab 3rd Tues: 6:30 PM
Joseph F. Brelsford  717-774-8370
jbrrelsford1@mmm.com

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

PENNSYLVANIA-NEW CASTLE
UPMC Jameson Cancer Center
Medical Arts Bldg Suite 104
3rd Thursday, 6:00-7:00 PM
Jeannie Williams, Patient Navigator
Becky Rainville, RN  724-656-5870

PENNSYLVANIA-PHILADELPHIA
Penn Med Perelman Ctr Advanced Med
1 W. Pavilion Pt % Fam Conf Rm
1st Wednesday: 9:30-11:00 AM
Micki Naimoli  856-722-5574
Tracy Lutenbach  215-662-6193
lutenbach@uphs.upenn.edu
Mia Benson Smith, MS  215-662-4641
mia.bensonsmith@uphs.upenn.edu

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

TENNESSEE-CHATTANOOGA
Memorial Hospital
1st Monday: 4:00-5:30 PM
Jeanne Richelson  423-894-9215
Jeanne1255@aol.com

TENNESSEE-NASHVILLE
Gilda’s Club Nashville
2nd Wednesday: 6:30-8:00 PM
Felice Apolinsky, LCSW  615-329-1124
felice@gildasclubnashville.org

TEXAS-DALLAS
Baylor Irving-Coppell Medical Center
2nd Saturday: 10:00 AM
Dan Stack  214-820-2608
danstack@aol.com

TEXAS-FORT WORTH
Moncrief Cancer Resources
2nd Wednesday: 3:30-5:00 PM
Marla Hathcoat, LMSW
817-838-4866
marla.hathcoat@moncrief.com

TEXAS-HOUSTON/TOMBALL
Tomball Regional Hospital
2nd Tuesday: 12:00 Noon-1:00 PM
Shelly Pepper, RN  281-401-5900
spepper@tomballhospital.org

TEXAS-McALLEN
Rio Grande Regional Hospital
3rd Tuesday: 6:00 PM
Stephanie Leal, MA,CCC,SLP
SAL1275@aol.com
Cheryl Lopez, MS, CCC, SLP
956-632-6426

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 of month: 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
Cynthia Gilliam  757-770-4190
beachdolphin@aol.com

WASHINGTON-SEATTLE
Evergreen Hospital Medical Center
Rad/Onc Conf Rm Green 1-245
2nd Wednesday: 6:30-8:00 PM
Kile Jackson 425-788-6562
kilejackson@hotmail.com

WASHINGTON-SEATTLE
Swedish Med Ctr. 1 E. Conf Rm
3rd Thursday: 6:00-7:30 PM
Susan (Sam) Vetto, BSN, RN, BC
206-341-1720  susan.vetto@vmmc.org
Joanne Fenn, MS, CCC-SLP
206-215-1770
joanne.fenn@swedish.org

WISCONSIN-MADISON
Univ. of Wisconsin Hospital
ENT Clinic Rm. G3/206
1st Wednesday: 11:30-1:00 PM
Rachael Kammer, MS, CCC-SLP
808-263-4896
rachael.kammer@surgery.wisc.edu

WISCONSIN-MILWAUKEE
Medical College of Wisconsin
Conference Rm. J, Rm. 1010
2nd Tuesday: 6:30-8:00 PM
Tammy Wigginton, MS, CCC-SLP
414-805-5662
twiggint@mcw.edu
SPOHNC would like to wish everyone a happy, healthy and relaxing Summer.

Enjoy.

Keep in touch.

Remember to share your stories for upcoming editions of News from SPOHNC.

See you in September!

info@sponhc.org
1-800-377-0928.

THANK YOU