Dysphagia

Peter C. Belafsky, MD, PhD, MPH

Dysphagia refers to problems with swallowing and is common after head and neck cancer treatment. Dysphagia can be related to a range of swallowing problems from a mild problem of types of liquid or food getting stuck in the throat or chest progressing to a life-threatening problem with complete inability to safely consume anything by mouth. Individuals with head and neck cancer have a very high rate of dysphagia and a comprehensive understanding of the causes, treatments, and preventative strategies is beneficial to all head and neck cancer patients, survivors, and caregivers.

Consequences of dysphagia include malnutrition, dehydration, aspiration (liquid or food entering the airway), pneumonia, pulmonary abscess (collection of pus in the lung) and even death. Aspiration pneumonia caused by dysphagia is one of the most common causes of death among head and neck cancer survivors. Because of the potential severity of these outcomes, it is essential to be able to identify the signs and symptoms of swallowing problems. The ten-item Eating Assessment Tool (EAT-10) is a validated self-administered survey instrument to document the severity of swallowing difficulty. An EAT-10 greater than 1 suggests you perceive significant swallowing problems. If you complete the EAT-10 and your score is greater than one, you should consult a swallowing specialist and be evaluated for a potentially significant swallowing problem. Another widely used, validated self-administered survey instrument is the MD Anderson Dysphagia Inventory (MDADI). The MDADI assesses how you view your swallowing ability and how it influences your quality of life.

There are numerous reasons for swallowing problems in patients with head and neck cancer. The most common cause of swallowing problems after head and neck cancer treatment is the damaging effects of radiation. Radiation kills tumor cells but also damages normal surrounding blood vessels, muscles, and nerves. Muscles that have been damaged by radiation become fibrotic (stiff) and do not function well. If an individual has fibrotic muscles in the pharynx (throat) that do not function properly, it can become progressively more difficult to pass food from the mouth into the stomach. Food that remains in the throat without entering the esophagus can pass into the lungs (aspiration) and may cause pneumonia and possibly death. Nearly half of patients with advanced stage head and neck cancer who have been treated with radiation may aspirate. The radiation can also damage nerves in the head and neck. If the nerves in your neck are affected by radiation, you may lose the ability to sense when liquid or food is entering your airway, which means you may not be aware that you are aspirating. Such “silent aspiration” is extremely dangerous and has a very high likelihood of causing lung complications, such as pneumonia. If an individual has any signs or symptoms of dysphagia, it is urgent to get a swallowing evaluation by a trained clinician to rule out the presence of aspiration. A speech-language pathologist (SLP) is a clinician with expertise in the assessment and treatment of swallowing problems.

An evaluation of your swallowing function may include any combination of endoscopy or fluoroscopy to adequately identify the swallowing problem(s) and identify appropriate treatment. Endoscopy involves using an endoscope to view the structures of the neck involved with swallowing and how they are functioning. Fluoroscopy uses a continuous X-ray to examine how the mouth, throat, and esophagus (tube that transports liquid and food into your stomach) are functioning.

The damage caused by radiation can be divided into acute (early) and chronic (late) effects. Acute effects of radiation include radiation-induced mucositis (inflamed mouth or throat lining), dermatitis (inflamed skin) and myositis (inflamed muscle). These effects usually subside within 3-6 months following the end of treatment. Late effects of radiation include lymphedema (swelling of tissue due to the blockage of lymph tissue), nerve and blood vessel injury, and muscle fibrosis. The net effect of this damage causes nerves to function improperly and muscles to become fibrotic (stiff) and weak. The late effects can be permanent and may continue to cause progressive swallowing dysfunction throughout an individual’s lifetime. The combined use of chemotherapy with radiation increases the damaging effects of radiation and intensifies swallowing problems in head and neck cancer patients and survivors.

Another cause of dysphagia in patients with head and neck cancer is stenosis (narrowing) of the region between the lower
The best treatment for dysphagia in patients with head and neck cancer is prevention. Swallowing exercise(s) administered during therapy can contribute to the development of a robust swallow and decrease the frequency of aspiration. Early consultation with a speech pathologist can facilitate an exercise program (Part-I). A swallow evaluation with a video barium swallow or a fluoroscopic swallow study should be performed to assess the swallowing mechanism and the presence of a stricture or stenosis. The ultimate goal of rehabilitation is to achieve a successful swallow and to return the patient to a normal diet. A multidisciplinary approach is essential to achieve the best results. The role of the speech pathologist in the treatment of head and neck cancer is to facilitate safe swallowing and prevent aspiration. The speech pathologist should be involved in the rehabilitation process from the outset and continue to monitor the patient's swallowing throughout the course of treatment. A swallow evaluation should be performed at the end of radiation therapy to assess the patient's swallowing function and to determine if a swallow Peterson is necessary. If a swallow Peterson is necessary, the speech pathologist should be involved in the rehabilitation process from the outset and continue to monitor the patient's swallowing throughout the course of treatment. A swallow evaluation should be performed at the end of radiation therapy to assess the patient's swallowing function and to determine if a swallow Peterson is necessary. If a swallow Peterson is necessary, the speech pathologist should be involved in the rehabilitation process from the outset and continue to monitor the patient's swallowing throughout the course of treatment.
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throughout the course of radiation therapy by a trained speech-language pathologist (SLP) can lessen or prevent swallowing problems during radiation therapy and later in life. There are numerous challenges that patients face before the initiation of radiation therapy. The acceptance of a new cancer diagnosis, the need for pre-surgical and pre-radiation counseling, laboratory tests, and imaging studies, the coordination of financial, familial, and employment responsibilities, all represent barriers to the timely start of swallowing therapy at the initiation of radiation treatment. Despite these challenges, swallowing therapy and exercise should remain a top priority to all patients beginning treatment for head and neck cancer. An iPhone app has been developed as an adjunct or companion approach to swallowing exercise therapy. The iSwallow app is available as a free download from the iTunes store and is designed to be used under the supervision of a trained swallowing clinician.

Radiation therapy and chemotherapy can cause mucositis (inflammation) of the tissues of the mouth and throat. Mucositis can cause pain and decrease the desire, comfort, and pleasure of eating. Mucositis typically resolves within a couple of months following the completion of radiation. It is imperative that patients continue to eat and stay nourished and well-hydrated during this difficult time. Sometimes swallowing becomes so difficult and painful that non-oral feeding through a feeding tube may be recommended. Patients who can avoid having a feeding tube and who continue to swallow throughout the course of treatment, even if painful or uncomfortable, typically have less swallowing problems in the future. If swallowing problems develop, patients should discuss swallowing problems with their physician who may be able to prescribe medication or alternative treatment to make swallowing less painful and uncomfortable.

The damaging effects of chemotherapy and radiation can continue throughout an individual’s lifetime. Scarring and fibrosis can progress for decades after the completion of treatment. Dietary and nutrition recommendations as well as ongoing swallowing exercises prescribed by a speech-language pathologist (SLP), can be beneficial and are recommended in the course of follow up care for patients treated for head and neck cancer.

Even with careful diagnosis and state-of-the-art treatment, a significant percentage of persons with swallowing problems secondary to the effects of head and neck cancer remain profoundly disabled. There are very ambitious research programs to offer hope to the millions of suffering individuals. Ongoing research includes a swallowing disorders awareness campaign (http://www.youtube.com/watch?v=MrbEUDO6SSU) and programs available through national organizations. Research projects include the testing of behavioral (exercise-based) therapies, innovative surgical treatments (for example, an innovative medical device to mechanically open the upper esophageal sphincter, http://news.cnet.com/8301-27083_3-20024189-247.html), and medical therapies, such as the use of stem cells to improve tongue strength and function. Research studies are also underway that evaluate the effectiveness of computer-assisted technology to help deliver swallowing therapy. A great deal of progress has been made in the development of evaluation and treatment methods and technologies over the past 20 years. The continued advocacy and support by our head and neck survivors, spouses, and caregivers will lead to an effective plan of future development and testing of these novel and necessary approaches toward improvement in swallowing and quality of living.

Editors Note: Peter C. Belafsky, MD, PhD, MPH, is an Associate Professor and the Director of The Center for Voice and Swallowing at the University of California at Davis (www.ucdvoice.org) and is on the board of the National Foundation of Swallowing Disorders as Medical Advisor, and the Dysphagia Research Society (www.dysphagiaresearch.org). Dr. Belafsky’s primary clinical interests are the comprehensive diagnosis and management of voice, swallowing, and airway disorders. As Medical Director of the Voice and Swallowing Center at UC Davis, Dr. Belafsky treats a wide array of laryngeal and esophageal disorders.
TIME FOR SHARING... Cancer Changes Everything

My name is Ed Steger. I was diagnosed in mid 2005 at age 53 with stage III/IV squamous cell carcinoma at the base of my tongue. I didn’t smoke or drink. I am HPV negative. The journey has not been easy. Surprisingly enough, I have had some wonderful opportunities I wouldn’t have had, had life gone as planned. Here’s my story.

Cancer History

When diagnosed, I was at the peak of my career. I worked for a large firm as a program manager implementing large-scale information technology projects with contract values in the hundreds of millions of dollars. I traveled extensively worldwide and when required, worked seven days a week, 12 to 14 hours a day. I considered myself a turn-around specialist; turning programs that were in trouble into a success. I loved my work.

In April 2005, I became increasingly concerned by two lymph nodes under my left jaw; each had grown to the size of a hot dog. I had my first clinic visit with a physician at the cancer center closest to my home. Two days later I had a fine needle aspiration. Two minutes later I was given the diagnosis; the diagnostic physician reentered the exam room and said, “you have cancer.” I was shocked. There was no, “let’s run some additional tests, let’s get a second opinion”; it was a definitive no-holds-barred diagnosis. A few days later I met my new physician, a cancer specialist, surgeon, and researcher. He recommended Intensity-Modulated Radiation Treatment (IMRT) followed by a left side neck dissection.

I’ll sum up the 18 months following my 36 IMRT treatments: I had four rapid recurrences, six surgeries, and eight different chemotherapy regimens. I’m not going to dwell on this period, but will provide some highlights. In mid-2006 I had a 12 hour surgery. Without this surgery, my surgeon said I would be dead by year end. The surgeons removed a large tumor at the base of my tongue, my left side lower jaw bone, a 7 by 2.5 inch section of nerve, tissue, and muscle in my upper esophagus, and a piece of my soft palate. My jaw bone was replaced by my tibia bone from my right leg; the esophageal tissue was replaced by tissue from my right lower leg. My lower leg tissue was repaired by a skin graft from my thigh. I spent two days in the ICU. I was sure I was going to die; every breath was unbelievably difficult. I couldn’t talk; I could barely communicate. I begged my wife to stay and watch over me. She didn’t leave my side for 48 hours. My sister, then my brother, and then my aunt came into town to help relieve my wife from her 24 x 7 vigil. A week after I left the ICU, I left the hospital to recuperate at home. I had a feeding tube, bladder catheter, and tracheotomy. I was a mess.

Fast forward five months. I had no tubes in me. I was exercising daily and had regained most of my stamina. My speech impediment was moderate and I had taught myself – with the help of dedicated swallowing therapists - to consume liquids orally. I had just planned a three day golf trip to the Monterey Peninsula with seven friends. I went on short term disability the day of my 12 hour surgery five months earlier and was now feeling well enough to go back to work. A few days before our golf outing I had a PET scan and clinic visit. The diagnosis was grim. I had five inoperable tumors in my oral cavity. I was stunned. My surgeon was stunned and disappointed. All that work; not just by me, but by my family, friends, and medical team. My surgeon recommended that I begin palliative care, which is done to make someone comfortable with the dying process, but does not treat the illness. I did two things: 1) I went on my golf outing, and 2) I asked my surgeon if there were any other options. He set an appointment for me to meet with my oncologist.

The next two years are a bit of a blur; I spent the vast majority of the time either in bed exhausted from the chemo drugs or getting IV treatments at the cancer center. My chemotherapist put me on debilitating doses of Taxol, Cetuximab, Cisplatin, Tarceva, Carboplatin, and GEMZAR. Seven months after being diagnosed with five inoperable hot spots, all five hot spots had disappeared; one new tumor was now detectable in my lymph nodes under my right-side jaw. The challenge was my cancer kept coming back; this was my fourth recurrence in 18 months. My luck, if one can call it that, changed in mid 2007.

On December 26, 2006 the Wall Street Journal published a story titled, “One Man’s Chronicle of his Duel with Death.” It was a story about Andy Martin who was starting his third year at Tulane University School of Medicine when he learned that he had a very rare, lethal cancer called sinonasal undifferentiated carcinoma, or SNUC. Realizing that little was known about SNUC, the medical student started doing his own research. He then devised a unique and ambitious project to study and grow his own tumor cells in the lab in the hopes of finding an effective treatment. Andy Martin died before his cells became viable in the lab.

This story stuck with me and is a factor in saving my life. I began asking my medical network about applying what Andy Martin had attempted in the hope of finding a cure for my cancer. I know what some of you are thinking, personalized medicine, ho hum. But, this was in 2007, before “personalized medicine” was in vogue. It was akin to showing someone an operational color 90 inch flat screen TV in the days of black and white television. Over the next six months my medical team took my tumor cells, grew them in the lab, and then applied different chemotherapy agents to my cells to find one that would be effective. In the lab setting, the ‘standard of care’ chemos agents killed only a small percent of my cancer cells. An experimental cancer agent (Zactima - ZD6474) killed almost all my cancer cells. My medical team was unable to obtain this experimental cancer agent for clinical purposes, but they were able to simulate it with two FDA-approved drugs, Avastin and Tarceva. I had 11 Avastin treatments spaced three weeks apart. I took a daily Tarceva pill. My cancer recurrences stopped. October 2012 marked my fifth year with no evidence of disease (NED) and about 3 years ago I was reclassified as being in remission.

Twice I had been given a short term death sentence; the most recent was in late 2006, six years ago. I’ll say it again, I’m still here. I began a blog in 2007 at www.hncancer.blogspot.com; it has 200 posts and documents my cancer journey.

Second Chance at Life

Although I’ve been living with cancer since early 2005, it was only within the past year that I had an epiphany: I actually do have a second chance at life! Not a “time
Having a shorter term outlook on projects
Harming relationships with a few people
Assuming the next conversation I have
Always wanting to have my affairs in
Feeling anxious about my contribution to

Having had my own pain during the past

Giving back and making a difference

Giving back and making a difference
B.C. - Before Cancer - I always loved my
job. My educational background was in
math and computer science. My professional
work added experience in project/program
management, process engineering and change
management. What I loved most about my
work was making a difference, making it
quickly, and putting it to work. This drive
worked very well for my clients and staff. I
built business enterprises that changed the
way large organizations operated and, with
my team, made those organizations more
efficient, more effective, and more successful.

Fast forward to A.C. - After Cancer.
Drewing on this love for making a positive
impact, I was invited a year ago to become
a patient research advocate volunteer at my
cancer center. It’s taken awhile to begin to make
a contribution in this role, but I’m beginning
to see where my strengths and efforts may
contribute to advances in the fight against
cancer.

In September 2012, I expanded my
volunteer efforts by being nominated for
and accepting the position as President of
the National Foundation of Swallowing
Disorders (www.NFOSD.com). I was
diagnosed with severe dysphagia (i.e., a
swallowing disorder) following my major
surgery. It’s a chronic condition. I’ve heard
estimates of 50% of head and neck cancer
patients suffering from dysphagia as a by-
product of their disease and treatment. I
look forward to giving back in this area.

Continuing to learn

Three years ago, as I began to believe I would
continue to live, I developed a renewed interest
in learning about the larger world and became
a lover of reading. I now read one to two non-
fiction books a month - many on the subject of
health care, and a few historical books.

I read articles of interest in daily and
periodic publications. Topics range from
cancer research and personalized medicine,
to public and global affairs. I’ve also recently
started taking a few college-level courses in
new areas of interest - writing and science.
For instance, earlier this year I completed a
college-level biology course. About 90% of
the course was online, which fits well with
my post-cancer disabilities and my preferred
style of learning. We met in person for a lab
once a month. It was fascinating to me – no
doubt influenced by my journey - and the
instructor was terrific. She made learning
fun and did everything possible to provide
an environment where students willing to
put in the effort could learn the material.
I found it challenging, which added to the
allure. Eventually, I believe it may allow me to
contribute more (or in a different way) in my
cancer center volunteer activities. If it does,
that will be a bonus.

Being more empathetic
and compassionate

I understand what empathy and compassion
are and believe I have always had these traits,
but in a more limited way. As a result of
my personal cancer experience, I feel these
emotions at a deeper level. It’s one thing to
know someone is in pain; it’s completely
different to actually feel that pain.

Having had my own pain during the past
seven years, I can more easily feel what others
in similar circumstances may be experiencing.
I have also had some wonderful role models
who showed me empathy and compassion during
this cancer journey. I still have a ways to go,
but I do believe it has made me a better person.

Forgive

My journey has also led me to want to be
more forgiving of others. It’s one more area
where reinventing myself is making me a
better person. This includes being more patient
and more accepting. It does not mean I am
lowering my expectation of others or myself;
but I am ‘letting go’ of the trivial. It sounds
simple enough but it takes thought and effort.
This, like the other changes I’m trying to make in
my “second chance” life, is a work in progress.

Cancer Changes Everything

I have a different view on my life and on
myself. There was a four year period from
early 2006 to late 2009 where my life hung
in the balance over and over again. With four
recurrences, six surgeries, and a constant feed
of toxic chemotherapy, I developed a form of
post traumatic stress syndrome (PTSD). I’m
not a hypochondriac, but I do fear, maybe
even expect, another recurrence - even after
five years with no evidence of disease. The
impacts include:

- Having a shorter term outlook on projects
- Always wanting to have my affairs in
- Harmful relationships with a few people
- Feeling anxious about my contribution to
- Assuming the next conversation I have

This doesn’t stop me from enjoying life,
playing golf, going on an occasional vacation,
or trying to make that positive contribution;
but, having lived through this journey,
everything is different.

Conclusion

I write about the insight I’ve gained in
this journey with the hope that you’ll take
something away from my experience. I have
come to feel that as long as I’m here, I want
To look forward to what tomorrow may bring.
I encourage you to discover how you want
to live your life, whether it’s your ‘second’
chance or your first, whether it’s being
proactive in making a positive difference,
helping a friend in need, contributing to the
needs of your community, or any other path
which gives your life meaning.

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A thankful heart is not only the greatest virtue, but the parent of all other virtues.

- Cicero

Chocolate Mousse

2 c. heavy cream
¼ c. powdered sugar
6 oz. semi-sweet chocolate finely chopped
1 tsp. vanilla

In a small heavy saucepan bring ½ c. heavy cream to a simmer. Remove from heat, stir in chocolate & cover. Set aside for 5 minutes then stir till smooth. Transfer chocolate to large bowl. In another bowl beat remaining 1½ c. cream w/ sugar & vanilla till soft peaks form. Fold 1/3 of whipped cream into chocolate mixture. Gently fold in remaining whipped cream. Spoon into individual custard cups & refrigerate. Makes 5 servings.

Lynda Holler

Hank Deneski, Survivor of oral, head and neck cancer, polio and prostate cancer, and Facilitator of the Dayton, Ohio SPOHNC Chapter Support group was recently awarded with the Champions of Hope, Person of Inspiration Award, by the Miami Valley Hospital Foundation. Hank was nominated by SPOHNC Executive Director, Mary Ann Caputo, and SPOHNC Outreach Administrator, Chris Leonardis, in recognition of his dedication and commitment to our organization, and for all of his efforts in raising awareness of oral and head and neck cancer, and supporting patients and their families in their cancer journey and beyond. In the application sent to the nominating committee, the following words appeared – and were echoed in the invitation to this prestigious event:

“Oral, head and neck cancer is an extremely debilitating and devastating disease. For those who are going through it, there is nothing that compares to the emotional support of someone who has walked in their shoes. Hank’s willingness to share that experience with others is what makes him so special.”

Truer words were never spoken.

The awards ceremony took place on Wednesday, September 19, 2012 at the Miami Valley Hospital in Dayton, Ohio, where more than 300 guests enjoyed an evening of cocktails and hors’deuvres, while honoring some of the Dayton area’s “standout” citizens, which also included a Survivor Honoree, a Medical Professional Honoree and a Caregiver Honoree as well.

Hank has been the facilitator of the Dayton Ohio chapter of SPOHNC since 2006. He is also a volunteer for our National Volunteer Survivor Network since 2007, and has helped countless patients and their families along the difficult journey that comes with oral, head and neck cancer.

Hank’s beautiful award – entitled “Solidarity” means complete unity, as of purpose or feeling. It speaks of passion and dedication and of higher purpose. When people work together or come together with a common goal, they are elevated by the truth of their goals and by the strength of their best intentions. The Champions of Hope Award captures the power of individuals coming together in the form of a flame.

Pictured here is Hank, with his lovely wife Lil, who celebrated his honor with their family in attendance. It was a beautiful evening, honoring remarkable people and their achievements in the fight against cancer. Congratulations Hank!

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Alice Chiou, Sang Lee,

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Oct. 1, 2012 - Determining the optimal treatment course and predicting outcomes may get easier in the future for patients with head and neck squamous cell carcinomas (HNSCCs) with the use of an investigational imaging agent. Research published in the October issue of *The Journal of Nuclear Medicine* shows that positron emission tomography (PET) imaging with 3'-deoxy-3'F-18-fluorothymidine (18-F-FLT) during treatment and early follow-up has the potential to predict therapeutic responses and identify patients needing close follow-up to detect persistent or recurring disease.

Typically, tumor response to therapy is monitored by assessment of tumor size change by anatomic imaging modalities. While several studies have shown that F-18-fluorodeoxyglucose (FDG) PET may be used to assess response, the agent may produce false-positive findings. Authors of the study “Usefulness of 3'-Deoxy-3'F-18-Fluorothymidine PET for Predicting Early Response to Chemoradiotherapy in Head and Neck Cancer” sought to determine if F-18-FLT, a recently introduced imaging agent, would also be useful in predicting response to therapy for HNSCCs.

“In experimental models, reduced FLT uptake preceded reduced FDG uptake, suggesting that decreased cell proliferation precedes changes in glucose metabolism,” noted Hiroshi Hoshikawa, MD, lead author of the study. “However, there are few clinical studies comparing FLT-PET and FDG-PET findings for radiotherapy.”

In the study, 28 patients with HNSCCs underwent F-18-FLT and F-18-FDG PET imaging prior to treatment with radiation therapy, four weeks after the start of therapy and five weeks after the conclusion of therapy. Uptake of both of the agents was measured in primary and metastatic lesions.

During the radiation therapy, F-18-FLT uptake disappeared in 34 of 54 lesions (63 percent); the negative predictive value was 97 percent. F-18-FDG uptake also had a high negative predictive value (100 percent) during radiation therapy, but only nine lesions (16 percent) showed absence of FDG. In addition, the specificity and overall accuracy of F-18-FLT were significantly higher than F-18-FDG PET both during and after radiation therapy. These findings indicate that F-18-FLT PET is more useful for assessing early loco-regional clinical outcomes and helpful for avoiding unnecessary radical surgery.

“With the development of new molecular imaging agents, it’s now up to clinical researchers to utilize them to assess the characteristics of malignant tumors and their therapeutic response to chemotherapy, radiotherapy and molecular targeting therapy,” said Hoshikawa. “We hope that our findings will be helpful in understanding the significance of F-18-FLT-PET.”

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<td>Kathryn Cramer LMSW, CCHT 570-881-6247 <a href="mailto:sccsowork@hotmail.com">sccsowork@hotmail.com</a></td>
</tr>
<tr>
<td>PENNSYLVANIA-HARRISBURG</td>
<td>PinnacleHealth Fox Chase Regional Cancer Center</td>
<td>2nd Wednesday: 6:00 PM</td>
<td>Debra Winer, Nurse Navigator 717-724-6772 <a href="mailto:dwwiner@pinnaclehealth.org">dwwiner@pinnaclehealth.org</a></td>
</tr>
<tr>
<td>PENNSYLVANIA-MONROEVILLE</td>
<td>Inter Community Cancer Center</td>
<td>Last Friday of the month: 3:00 - 4:00 PM</td>
<td>Beth Madrishin 412-856-7740 <a href="mailto:bmadrishin@wpahs.org">bmadrishin@wpahs.org</a></td>
</tr>
<tr>
<td>PENNSYLVANIA-PHILADELPHIA</td>
<td>Penn Med Perelman Ctr Advanced Med</td>
<td>1 W. Pavilion Pt Fam Conf Rm</td>
<td>Monday: 9:30-11:00 AM</td>
</tr>
<tr>
<td>PENNSYLVANIA-NEW CASTLE</td>
<td>UPMC Jameson Cancer Center</td>
<td>Medical Arts Bldg Suite 104</td>
<td>Tuesday: 6:30-8:00 PM</td>
</tr>
<tr>
<td>PENNSYLVANIA-PP</td>
<td>711-711</td>
<td>1 W. Pavilion Pt Fam Conf Rm</td>
<td>Monday: 9:30-11:00 AM</td>
</tr>
<tr>
<td>PENNSYLVANIA-UPMC</td>
<td>Pittsburgh Cancer Center</td>
<td>Wednesday: 5:00 PM</td>
<td>Tracy Lautenbach MSW, LMSW, COSW-1C 215-662-5374/lautenbach@uphs.upenn.edu</td>
</tr>
<tr>
<td>PENNSYLVANIA-YORK</td>
<td>Apple Hill Medical Center</td>
<td>2nd Wednesday: 5:00 PM</td>
<td>Dianne S. Hollinger, MA, C-SCP 717-812-5850 <a href="mailto:dhollinger@wellspan.org">dhollinger@wellspan.org</a></td>
</tr>
<tr>
<td>SOUTH CAROLINA- CHARLOTTE</td>
<td>Carolinas HealthCare System</td>
<td></td>
<td>Wednesday: 5:30-7:00 PM</td>
</tr>
<tr>
<td>SOUTH CAROLINA- CHARLOTTE</td>
<td>Carolinas HealthCare System</td>
<td></td>
<td>Thursday: 6:00-7:30 PM</td>
</tr>
<tr>
<td>SOUTH DAKOTA-RAPID CITY</td>
<td>Rapid City Regional Hospital, Rushmore Room</td>
<td>3rd Monday:</td>
<td>6:30 - 7:30 PM</td>
</tr>
<tr>
<td>TENNESSEE-CHATTANOOGA</td>
<td>Memorial Hospital</td>
<td>1st Monday:</td>
<td>4:55-5:30 PM</td>
</tr>
<tr>
<td>TENNESSEE- NASHVILLE</td>
<td>Gilda’s Club Nashville</td>
<td>4th Monday:</td>
<td>6:00 - 7:30 PM</td>
</tr>
<tr>
<td>TEXAS-DALLAS</td>
<td>Baylor Irving-Coppell Medical Center</td>
<td>2nd Saturday:</td>
<td>10:00 AM</td>
</tr>
<tr>
<td>TEXAS-FORT WORTH</td>
<td>Moncrief Cancer Institute</td>
<td>2nd Wednesday:</td>
<td>3:30-5:00 PM</td>
</tr>
<tr>
<td>TEXAS-HOUSTON/TOMBALL</td>
<td>Tomball Regional Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TEXAS-McALLEN</td>
<td>Rio Grande Regional Hospital</td>
<td>3rd Tuesday:</td>
<td>6:00 PM</td>
</tr>
<tr>
<td>TEXAS-PLANO</td>
<td>Regional Medical Center at Plano</td>
<td>4th Wednesday:</td>
<td>6:00-8:00 PM</td>
</tr>
<tr>
<td>VIRGINIA- CHARLOTTESVILLE</td>
<td>Dept. of Forestry Building, Suite 800</td>
<td>Last Thursday of month:</td>
<td>11:30-1:00 PM</td>
</tr>
<tr>
<td>VIRGINIA- FAIRFAX</td>
<td>Inova Fairfax Hospital Radiation/Oncology</td>
<td>2nd Wednesday:</td>
<td>5:30-7:00 PM</td>
</tr>
<tr>
<td>VIRGINIA- NORTFOLK</td>
<td>Sentara Norfolk General Hospital</td>
<td>3rd Monday:</td>
<td>7:00 PM</td>
</tr>
<tr>
<td>VIRGINIA- RICHMOND</td>
<td>Massey Cancer Ctr, Thalimeter Room</td>
<td>2nd and 4th Wednesday:</td>
<td>2:00-3:30 PM</td>
</tr>
<tr>
<td>WASHINGTON-Seattle</td>
<td>Evergreen Hospital Medical Center</td>
<td>Radi/One Conf Rm Green 1-245</td>
<td>2nd Wednesday:</td>
</tr>
<tr>
<td>WASHINGTON-Seattle</td>
<td>Swedish Med Ctr 1E Conf Rm</td>
<td>3rd Thursday:</td>
<td>6:00-7:30 PM</td>
</tr>
<tr>
<td>WISCONSIN-MADISON</td>
<td>Univ. of Wisconsin Hosp. - ENT Clinic Rm, G3/206</td>
<td>1st Wednesday:</td>
<td>11:30-1:00 PM</td>
</tr>
<tr>
<td>WISCONSIN-MILWAUKEE</td>
<td>Medical College of Wisconsin - Conf.Rm, N, 3rd Fl.</td>
<td>2nd Tuesday:</td>
<td>1:00-1:00 PM</td>
</tr>
</tbody>
</table>

**SPOHNC** P.O. Box 53 Locust Valley, NY 11560-0053 1-800-377-0928
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Call 1-800-377-0928

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- $25.00 Booster
- $50.00 Sponsor
- $100.00 Donor
- $500.00 Patron
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City_________________________________________State________________Zip________________________

Please Check:   Survivor ____Friend  ____Health Professional (Specialty)  _______________________________________________

First time member__________  Returning member________

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

Best wishes from
SPOHNC
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Happy Thanksgiving

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