An Approach to Parotid Tumors
Andrew C. Urquhart, FACS

Salivary glands have an important function in human physiology. Their main purpose is to produce saliva. There are 3 paired groups of major salivary glands. These include the parotid, submandibular and sublingual glands. There are over 600 minor salivary glands within the mouth and oral cavity. These minor salivary glands are very small and difficult to see. They cover the smooth mucosal surfaces of the mouth and throat.

The major salivary glands are divided into lobules. These lobules connect through a series of ducts which flow together and form a single larger duct. Saliva is produced in the glands and flows through these smaller ducts which end in the single larger duct, draining into the mouth. Saliva is released in response to food, facilitates swallowing, and forms part of the initial process of digestion with the release of certain enzymes. The secretion of saliva is controlled by what is termed the autonomic (involuntary) nervous system. Any obstruction in the ducts will result in obstruction to the outflow of saliva with subsequent swelling of the gland. This article will focus on tumors of the parotid gland because the overwhelming majority of salivary gland tumors occur in this gland.

The parotid gland is the largest of the major salivary glands. These are paired glands with one on either side of the face, just in front of the ear. The saliva that is produced drains into the mouth through a small tube or duct, called Stensen’s duct. This duct opens into the mouth, in the cheek near the 2nd upper molar tooth. The gland is shaped like a pyramid, with the point extending into the depth of the neck and the broad base extending over the outside of the cheek and neck. Posteriorly it overlaps the large muscle in the neck called the sternocleidomastoid muscle. Below and deeper to the gland is a muscle called the digastric muscle which is usually identified at the time of surgery. As mentioned, the tip of the pyramid forms the deeper part of the gland and extends towards a small structure called the styloid bone. The facial nerve lies just on top of this bone. The facial nerve is extremely important as it controls voluntary facial movement. Movement of the face is an integral part of human interaction with facial expression. One may be familiar with paralysis of the face which is occasionally seen in patients that have had a stroke. The facial nerve originates in the brain stem and travels through the temporal bone which contains the inner and middle ear structures. The nerve exits this bone through a small hole in the mastoid bone which lies just behind and below the ear. It immediately enters the parotid gland where it divides the gland into the larger superficial lobe and the smaller, deep lobe. The nerve then divides into 5 branches which supply the muscles of the face. The majority of the gland is formed by the superficial lobe, while the deep lobe is much smaller. Tumors arise most commonly in the superficial lobe. While a growth or enlargement of the superficial lobe (which forms the broad base of the “pyramid”) can be seen or felt in front of and below the ear, the deep lobe cannot be felt and enlargement of this area may extend into the throat or oropharynx, by expanding an anatomical region, called the parapharyngeal space. This may present as swelling or fullness in the region of the tonsil.

There are many processes that can affect the parotid glands, including infectious conditions such as parotitis (bacterial or viral, such as mumps), obstructed salivary gland due to stones in the duct, granulomatous conditions such as sarcoidosis, enlargement with certain conditions associated with rheumatoid arthritis, and certain medications. These conditions usually involve the entire gland which is diffusely enlarged and may be tender. They may involve both sides of the face, giving the patient a “chipmunk” appearance. No discreet, small lump can be felt. While these conditions require medical intervention, we are more concerned about localized swellings or lumps in the gland. Most of these localized lumps will be tumors of the parotid gland with the majority occurring in the superficial lobe of the gland.

Clinical Evaluation
Tumors of the parotid gland can be either benign or malignant. Fortunately most of these tumors (estimated up to 85%) are benign. They usually present as a painless mass or lump just in front of or below the ear. This is usually something that the patient notes incidentally; in men, often during shaving. These lumps are usually painless, so one should always be concerned about the possibility of a malignant parotid tumor if the mass is painful. The facial nerve, which moves the face, extends through the parotid gland. If there is weakness associated with the nerve (usually presenting as a facial droop or difficulty in moving the face on that side) a malignant tumor should be strongly suspected. Generally tumors of the parotid gland form a well localized mass or lump although occasionally the entire gland may be enlarged and involved with the tumor. If there is extension beyond the gland, with attachment to the surrounding structures including the underlying muscles or overlying

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Skin, this will result in decreased mobility of the lump and may even cause it to be “fixed” or immobile. This is usually indicative of a malignancy with a poor prognosis.

Lymph nodes in the neck can be felt when enlarged and while they may occur in benign inflammatory conditions, their presence should make one suspicious of a malignant tumor of the parotid gland. This has implications with regards to the extent and type of surgery required to remove the parotid gland and lymph nodes. As mentioned, tumors of the deep lobe may occasionally present as a swelling in the mouth or throat in the region of the tonsils, without any visible swelling or mass on the outside.

The evaluation of a suspected tumor of the parotid gland requires a detailed history. This should include how long the mass has been present, any associated pain, discomfort with eating, any drainage in the mouth, change in size, any lesions of the skin or scalp and any weakness of the face. Most of these tumors present in a fairly consistent way with a mass in front of or below the ear. Once the clinical diagnosis is made, further testing needs to be considered, depending on the physician’s clinical findings and patients underlining medical condition and preferences. Understanding that most tumors of the parotid gland are benign is important. The most common benign tumor, called a benign mixed tumor or pleomorphic adenoma is firm, but well localized. Moreover, there is a common, benign tumor called a Wharton’s tumor which is more prevalent in elderly men and may be bilateral. This tumor is soft and sometimes cystic. In some older patients, particularly those with underlying medical conditions, reassurance and observation may be enough. However, the majority of patients with tumors of the parotid gland need further evaluation and testing.

Further Testing

In the past, physicians were so confident with the diagnosis of a classical benign parotid tumor that no further testing was felt necessary before proceeding to surgery. This has changed, however, and most centers would recommend a CT scan as an initial evaluation. An MRI scan, which may be more expensive and difficult for the patient to undergo is also an excellent way to view the parotid gland. While clinical judgment plays an important role in decisions regarding the diagnosis and further treatment, imaging is very helpful. Certainly if there is any suspicion of invasion of surrounding structures or lymph nodes in the neck, the CT scan will help to define the extent and location of the disease as well as deep extension. Choosing between an MRI and CT scan, may depend on the physician’s preference and availability. Generally CT scans are more helpful with evaluating bone involvement while MRI scans are superior for imaging of the soft tissues. Both modalities should include the entire neck, to exclude lymphadenopathy. Ultrasonography is relatively easy and cost effective to perform. While it may differentiate a solid from a cystic lesion, CT or MRI is the recommended diagnostic test of choice for fine detail.

Fine needle aspiration biopsy (FNAB) is a good diagnostic tool, particularly when cytopathologists are immediately available and comfortable in interpreting the slides. There are some who favor performing an FNAB on all parotid masses, because cytology will assist in counseling and planning the extent of surgery, particularly if a malignant tumor is diagnosed. Those who oppose using it routinely feel that it is not always completely reliable and seldom changes what needs to be done; remove the parotid gland surgically. Part of the reasoning for this is that although most parotid tumors are benign, the most common benign tumor called a “benign mixed tumor” or pleomorphic adenoma.
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may occasionally become malignant over time, resulting in many surgeons recommending surgery either way. Warthins tumors, mentioned earlier, do not undergo malignant changes and certainly observing these, particularly in elderly patients with underlying medical problems is a reasonable option. While the general feeling is that most tumors of the parotid gland should be removed, cytology may be beneficial in patients with findings suggestive of malignancy or in some patients where a benign diagnosis is expected and surgery would be avoided due to factors such as comorbid medical disease, advanced age or patient preference. When the FNAB is suspicious for malignancy, it is very helpful in preoperative counseling of the patient; planning for a larger procedure to include a possible neck dissection and to discuss the potential increased risk of injury to the facial nerve. The possible need for post-operative treatment including radiotherapy would be discussed. The FNAB is performed in the office, with minimal discomfort. A fine needle is placed through the skin, into the underlying tumor and a small amount of tissue is aspirated back into a syringe. This is then viewed under a microscope by a pathologist with a diagnosis usually available within a few hours. As mentioned, if malignancy is suspected, it may change the surgeon’s surgical approach. In older patients particularly, with a benign diagnosis of a Whartin’s tumor, watchful waiting may be the correct option.

Surgery

Once the diagnosis of a tumor of the parotid gland is established, with a combination of clinical, radiological and cytological information, the plan is usually to proceed with surgery. While a superficial parotidectomy is a relatively safe procedure, it should be performed by a surgeon with adequate experience who feels comfortable performing the operation. While rare and usually minor, some of the complications can be devastating, particularly transaction or injury to the facial nerve. This will result in weakness or even complete paralysis of that side of the face. While temporary mild weakness may occasionally occur from traction and dissection on the nerve, this should recover completely. Complete transaction of the nerve is highly unusual and should not occur, unless the patient has a high grade malignancy with direct facial nerve involvement. Other minor complications include numbness of the ear, which will always occur because the nerve supplying feeling to the ear lies on the parotid gland and needs to be removed with the surgery. Patients occasionally develop drainage of saliva around the incision called a fistula or collection of serous fluid under the flaps, called a seroma. These usually resolve spontaneously with minimal sequela. A small number of patients develop Frey’s syndrome, also known as gustatory sweating. This occurs many months after the surgery and is related to the autonomic nerves (nerves that we have no control over) that regulate the production of saliva getting mixed up with the nerves that control sweating of the skin. The resultant effect is sweating around the surgical site which occurs with meals. It is usually a minor inconvenience, but when severe, treatment options are available. Cosmetically, the incision usually heals very well and blends into the natural skin lines. Occasionally there may be a slight concavity where the tumor and parotid gland were, that may be obvious to the discerning eye.

The surgery is undertaken under general anesthesia and usually takes approximately 1½ to 2 hours. Many surgeons use a facial nerve monitor during the case which may help with identifying and dissecting the facial nerve trunk and its peripheral branches. While it may be helpful, nothing can take the place of a surgeon’s ability and experience in performing parotid surgery. The surgery performed should be done in a meticulous, bloodless fashion. The facial nerve needs to be treated very delicately as any irritation or unnecessary trauma to it can result in temporary post-operative weakness. Very clear and specific landmarks are used to identify the trunk of the facial nerve which is in a constant position. After the procedure a small drain may be placed into the wound. The patient may go home later that day or the following morning. Most patients experience minimal discomfort and usually return for follow up 7 to 10 days after the surgery. At this time definitive pathology should be available with further recommendations. As mentioned earlier, most of these tumors are benign, consisting of either benign mixed tumors (pleomorphic adenoma) or Warthins tumors. In both of these cases, no further treatment is required and with recurrence being extremely unlikely, no further follow up is required. It is, however important to emphasize that an adequate resection be performed initially, particularly with the benign mixed tumors, as simple excision or inadequate resection will result in the tumor recurring. This can result in revision surgery in the future with increased risk to the facial nerve. Fortunately with a planned appropriate surgery, this should be extremely rare.

The situation with malignant tumors is more complex. Generally, the surgeon and patient should be aware of the possibility of malignancy before the surgery. This is due to the clinical appearance of the tumor, lymphadenopathy and cytology from the fine needle aspiration biopsy, or as occasionally may be required, a formal biopsy in the line of a proposed parotid incision. It is important to be aware that one is dealing with a malignancy before surgery particularly for planning and the extent of surgery required. In some situations further imaging studies including a PET scan may be required. A PET scan is helpful in identifying areas of higher metabolic activity, usually indicating cancer. This is helpful in identifying spread of cancer to the neck and even the rest of the body such as the lungs. While this is not common in parotid cancer, it certainly may occur in the more aggressive cancers and impact the treatment and surgery planned. Generally there are 2 types of cancer of the parotid gland; low grade and high grade. Low grade cancers include low-grade mucoepidermoid carcinoma and acinic cell carcinoma. High-grade cancers include adenoid cystic carcinoma, high-grade mucoepidermoid carcinoma, malignant mixed tumors and carcinoma ex-pleomorphic adenoma. The reason to differentiate the grade is important, because high grade cancers tend to be more aggressive and are associated with higher recurrence rates at the surgical site and a tendency to metastasize. Adenoid cystic carcinoma has a tendency to spread along nerves (perineural spread) with a high rate of recurrent disease. High grade cancers usually require more extensive surgery, including neck dissection. Post-operative radiotherapy is usually required as well. Chemotherapy does not generally form part of the treatment in parotid cancers, but may be incorporated as part of a study or investigative protocol.

Editors Note: Dr. Urquhart is an Otolaryngologist/Head and Neck surgeon at the Marshfield Clinic in Wisconsin - one of the largest private multispecialty clinics in the country. He underwent medical training in South Africa and the United Kingdom and fellowship training at the University of Pittsburgh in Head and Neck Oncologic surgery with Dr. Eugene Myers, and is also a member of the American Society of Head and Neck surgeons and an established author who has contributed many articles to Head and Neck Surgery literature.

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A TIME FOR SHARING

My name is Bob Hyams. I’ll soon celebrate my 76th birthday and just this April, my wife Sheila and I celebrated our 50th wedding anniversary. In 2005 the odds of my survival to this date seemed very slim.

In late July of 2005, at the insistence of my wife, I visited an ear, nose and throat (ENT) specialist. My voice had been hoarse for about six weeks, due to, I thought, my usual summer allergies. The doctor examined my throat and said “one of your vocal chords is paralyzed.” He called in another doctor, who verified that the vocal chord was indeed paralyzed. The doctor told me that this could be caused by a virus, or it could be cancer.

When this happened I was a content, healthy, retired, overweight 69 year-old. Life can really change very quickly. The next few weeks were spent at White Plains Hospital getting a CT scan, a sonogram, and a biopsy of my thyroid gland which up until that time, other than being a little sluggish, had never given me any trouble.

The biopsy showed that I had Anaplastic thyroid cancer, which is a particularly rare and aggressive type. The cancer had damaged a nerve which controlled the vocal chord, causing it to become paralyzed.

With the diagnosis I’d been given, it was vital to treat the cancer as quickly as possible. My family and I were pretty much in shock at this point, although my wife had decided not to tell me that the prognosis for this type of cancer is not good. My son David, through his work, had contacts in the health care field. He asked these contacts who they would recommend, and they recommended a doctor who had recently joined the Head & Neck Cancer group at Beth Israel Hospital. When I mentioned his name to the doctor at White Plains Hospital who had done my scan and sonogram, he said he was a top man in the field.

We (David, myself and Sheila) met with my doctor and his associates at Beth Israel Hospital. They decided that the tumor should be removed as soon as possible. My doctor delayed his vacation so he could perform the surgery. At 6:00 p.m. on August 22nd, about three weeks from my ENT visit, I was sedated, and that was the last thing I remember until I woke up in the recovery room, with a headache and minus my cancerous thyroid. The operation went very well, and the next day I left the hospital for home.

The next weeks were spent at home healing from the operation. I was wearing a fentanyl patch and taking Oxycodone to control pain. Large doses of steroids helped to keep down the swelling in my throat. My routine began at 5:00 a.m. each day, when I would get up from the chair where I slept, sitting up, so that I could breathe more easily.

After an ice-cold drink to numb my throat, I took Oxycodone, steroids and whatever other medications I needed. In order to drink, I had to mix liquids with a thickener, or else I could not swallow them.

Now that the cancer was removed, the next step was to ensure that it didn’t recur. An aggressive course of treatment was recommended, utilizing radiation of the cancerous area, combined with chemotherapy. We met the radiologist who would be supervising the radiation, and an oncologist, who would be monitoring my condition with blood tests, etc. Both doctors could not have shown more consideration to me and my family, or more patience in answering our questions. Meanwhile my dentist prepared plastic molds of my teeth which would be filled daily by me with a fluoride gel to strengthen my teeth against damage caused by the radiation. The radiologist referred to the initial radiation treatments as “the honeymoon,” indicating that not much in the way of sores in the mouth or throat occurred until later treatments. I was lucky in that my “honeymoon” didn’t end – I was spared the sores that frequently accompanied radiation treatments.

The treatments: a screen mesh mask was made which would fit over my face. A small dot was tattooed on my chin as a reference point for the radiation. The treatments took place twice a day, three days a week, for six weeks (36 treatments in all). Each session took about thirty minutes. I would lay down on a table under the radiation machine and the mask was placed over my face and locked in place so that my head would not move. With my arms at my side, I pulled on cords to pull my shoulders down to expose my neck to the radiation. I brought along some nice classical CDs which the techs played while I was being radiated.

I was given chemotherapy once a week for five weeks. The nurses and techs that treated me in radiation and chemo could not have been nicer. Maybe because so many of the people, especially in chemo, were so sick, the nurses there were especially gentle and patient. I think it takes a special type of person to be a nurse in chemo. It may seem trivial in the “big picture”, but every nurse and tech who took blood or did an IV was as considerate and careful as they could be. When you are going through cancer treatments, anything that is done to make you more comfortable is greatly appreciated.

I was lucky that the chemo never made me feel ill, although it did make me feel weak. I felt well enough to drive myself from Westchester to Beth Israel (14th Street). Besides, it was safer than letting my wife drive.

I would see my team of doctors regularly, and they were very pleased with my recovery. We consider ourselves very fortunate to have found such excellent doctors as well as wonderful people. Not that my recovery was without setbacks. Shortly after my treatment ended I developed pneumonia and spent some time in White Plains Hospital. Later on, after going off the heavy steroids, I broke out in a head-to-toe rash (like a boiled lobster). It seems that the steroids, which suppress allergic reactions, had been masking an allergy to one of my medications. The rash cleared up, but at this time I was very weak. Also, heavy steroid use over time can cause diabetes and it did. I take medication for diabetes, and my blood sugar is well under control. My doctor said it may disappear altogether.

When my treatment was completed, I began a series of PET scans to make sure I was cancer free. These were full body scans, which I took every three months, for several years. The interval was later increased to every six months. Then a year apart and finally, this year no more PET scans.

I still see my surgeon periodically for a check up. He also monitors a tracheostomy which I got in May of 2010 during a heart operation for an aortic valve replacement and
a bypass. The trache I will need for the rest of my life, and though it is sometimes a pain in
the neck (a little trache humor), the maintenance
is not difficult. I have learned to be pretty
adaptable over the last six and a half years.

I have always been an optimist which I
think has helped me and my family get through
the illness. Wonderful doctors and a loving and
supportive family made rough and sometimes
depressing times easier to handle. Thanks
to my children Michelle, Alan, David and
their spouses and especially my wife Sheila,
who took great care of me and never showed
anything but faith that I would get through
this okay.

So how has this changed me? I have a
voice like “the Godfather.” I am no longer
overweight (50 pounds lighter) but still content,
and with an increased appreciation of every day.
Seeing my children and grandkids and friends,
listening to classical music, which I love, or
seeing a movie – all things I took for granted,
now give me greater enjoyment. I feel lucky
and so grateful. It’s good to be alive.

Bob Hyams

Chapter Happenings

Recently, several SPOHNC BOSTON
group members had their photos displayed
in an exhibit at the Art Institute of Boston.
Photography student Zoe Isaac took candid
shots of the group members in their homes as
part of her graduate thesis showing people of
different ages and walks of life dealing with
various forms of cancer. “It’s important to me
to appreciate the struggles that people dealing
with cancer have gone through and to celebrate
every triumph along the way,” Zoe said. “I’ve
met so many wonderful people through this
project and I hope to meet many more, as I plan
to continue this project indefinitely.”

SPOHNC’s 20th Anniversary Conference
& Celebration of Life was an inspiring,
educational and amazing way to spend the
weekend. For those of you who attended,
we’ve loved hearing your comments,
reading your e-mails, and receiving all the
wonderful photos you’ve sent. So many
of our SPOHNC friends from across the
country came together and it was exciting
to see our chapter support group members
meeting other group members, NSVN
volunteers meeting their matches face to
face for the first time and listening to the
information given to attendees about the
latest treatments and pertinent information
about oral, head and neck cancer.

Some comments and e-mails from
attendees have included: “Great experience
– met many caring, helpful people,” “thank
you so much for a wonderful conference and
for providing such great information,” “very
well organized and executed – thanks!” and
“very impressed by the organization, quality
of presenters and the entire experience.”

There were so many wonderful
questions posed by audience members, to
the medical professionals who presented
on Saturday that we regretfully weren’t
able to get to all of the questions in one
day. Thanks so much to all of you who
participated. Be sure to read future issues
of News from SPOHNC, for the answers
to many of those questions, as we ask the
medical professionals who attended the
event to share their thoughts and expertise
with you, our readers. We want to provide
you with the information you have been
looking for!

The October issue will contain lots
of information about the Conference,
speakers, day by day happenings and plenty
of pictures, so if you weren’t able to attend,
you can still feel almost as if you were there
with us. We missed you, and we hope to
see you all at our 25th Anniversary – which
will be here before you know it!

Check our website at www.spohnc.org
for articles, information and more photos
as well. If you’re on Facebook, check our
page shortly for photos – many of which
were sent to us by Conference attendees.

SNAPSHOT!
SPOHNC’s 20th Anniversary Conference
and Celebration of Life

Thanks to SPOHNC BOSTON
group member Rob Littlefield
for allowing us to share his photo.
SPOHNC TASTE EVENTS CREATE A CULINARY BUZZ ACROSS THE COUNTRY

Kansas City, KS – On April 25, 2012 the University of Kansas Cancer Center’s SPOHNC Chapter Support group held their third Annual Tasting Event. Year number three brought along some additional committee members, along with some new ideas, to make the event even better than the year before.

Many of our past participating restaurants and chefs returned to the event, enthusiastic and on board with delicious offerings for our guests to enjoy. New group participants also brought along new restaurants, and our 200 attendees were treated to a fabulous event, with so many new, delectable dishes, and so much to offer. It was a lovely evening.

The Cancer Center courtyard provided a beautiful backdrop for our guests, and the background music provided by a local DJ enhanced the atmosphere just enough. He even thanked us for letting him be involved!

We invited local community oncology organizations to join us and bring displays and materials to promote awareness of oral, head and neck cancer. We were pleased to welcome the American Cancer Society, Cancer Action, Turning Point and Gilda’s Club. Missy’s Boutique, a good friend of the Cancer Center, brought along wigs and a variety of jewelry and other gift items to display for our guests.

Chris Lominska, a radiation oncologist who works with oral, head and neck cancer patients, was one of our guest speakers this year. His presentation included a great deal of information concerning HPV and head and neck cancer, and was a great vehicle for raising awareness at the event. Susie Cable, survivor and member of the Kansas City SPOHNC Chapter Support group, shared her journey, speaking about her tongue cancer and bringing the reality of her cancer experience to life through words.

The event was truly a grass roots effort as group members rolled up their sleeves to volunteer for set-up, clean-up and everything in between. Talk about dedication? One of our group members had surgery for a recurrence only a week before the event, but still came to volunteer and direct traffic for event parking as he has in the past. Amazing!

Once again, our Tasting Event awarded us a great opportunity to bring awareness to Kansas City, while affording our survivors, patients and their families the chance to show support and celebrate for one another.

Long Island, NY - On April 22, 2012, the combined Long Island, NY Chapters (Syosset, Stony Brook, and New Hyde Park) presented their third annual Tasting Event. It was timed to coincide with Oral, Head and Neck Cancer Awareness Month. A rousing success, the event brought together survivors, families, friends, and community for a fun, delicious evening, which raised approximately $15,000. About 200 attendees feasted on an abundance of food generously donated by 45 restaurants and bakeries. A variety of pasta dishes were donated including many chicken, beef, and Mediterranean specialties, as well as an array of delicious desserts. This year’s selections were so abundant, that the buffet line just seemed to be never ending! In addition, many Chapter support group members made their own culinary contributions to the event by bringing along some homemade goodies for tasting. Sal’s yummy “survivor soup”, Helene’s ratatouille and a few other delicacies brought something very special to the evening. For the second year in a row, the event was held at the Stuart Thomas Manor, a beautiful catering hall in Farmingdale, L.I. Their staff was most helpful and gracious, as always. Musical entertainment was provided by Knomad, a local band invited to the event by survivor and local SPOHNC Chapter Co-Facilitator, Madelyn Walsh. Knomad was a hit, as they donated their time and talent for the evening. Dr. David L. Schwartz, from North Shore LIJ Health Systems, spoke to the audience, giving all the attendees, survivors and their families, food for thought.

The evening was dedicated to the memory of Michael Henderson, a member of the Syosset group, who fought his cancer with determination and a positive outlook and was an inspiration to all. Michael lost his battle with cancer, after a long and very brave journey. Michael’s widow, Nathalie, invited to the event, gave a beautiful and poignant story about Michael, noting how SPOHNC was very supportive to both of them. She also brought along some beautiful potted plants to present to all survivors who attended, in recognition of their own hard work and determination.

Madelyn Harper-Walsh, Syosset group Co-Facilitator did a fine job as emcee of the evening as she welcomed our special guests and attendees. Many members and families collected an amazing number and assortment of donated gifts of goods and services, which were raffled off in a Chinese auction presided over cheerfully and efficiently by Lisa Caracciola, Chapter Administrator at SPOHNC. Members Helene Mangones and the Harper-Walsh family assembled a particularly generous variety of contributed prizes. There was something for everyone – restaurant gift certificates, Mets tickets, cosmetics, jewelry, lamps, and many other beautiful items provided for lots to look at and choose from for raffle participants. There was also a 50/50 cash prize raffle, for those who preferred to carry home less bulky items!

This event not only was a very effective fundraiser for SPOHNC, while promoting awareness, but it was an opportunity for all to share an evening of fun and experiences.

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and to celebrate life. Many thanks to all for a job well done.

Rochester, NY - The James P. Wilmot Cancer Center at the University of Rochester Medical Center was happy to host the Rochester, New York’s SPOHNC Chapter Support groups third annual Tasting Event on April 19, 2012. As guests arrived, they were welcomed by the beautiful sounds of music as one of our members, Vincent S., a former vocal music teacher, played the grand piano.

Dr. Hong Zhang, Assistant Professor in Radiation Oncology, served as Mistress of Ceremonies and gave an inspirational definition of “Being a Survivor.” Her words resonated with many patients and their families. Support group member, Lisa M., said “I liked knowing my doctor was here and called us all survivors: because there were days you didn’t think you could get through it.” Nurses, social workers and speech therapists participated in the event and the participants thoroughly enjoyed visiting with their care team in a relaxed atmosphere – much in contrast to the atmosphere while undergoing treatment.

The event featured delicious cuisine from a dozen local chefs/restaurants, with an emphasis on dishes that were appropriate for those with eating and swallowing difficulties. We were excited to watch the chef from Highlands Living Center, as he showed off his acute culinary skills while flambéing Artichoke French tableside! All agreed that the food was wonderful and we extend our continued appreciation to the chefs and businesses that donated their time and delectable dishes.

Joining us this year were community partners from the American Cancer Society, Hope Lodge/Hospitality House, Gilda’s Club of Rochester and Western New York Wellness, all of whom were on hand to answer questions and provide information to participants about their programs. The evening culminated with a lively raffle of prizes comprised of gift certificates to local restaurants and stores, and also books and gift baskets.

Karen Miltner, a reporter from the Rochester daily newspaper, the “Democrat & Chronicle,” covers the local food/beverage and restaurant industry and interviewed Vincent S. She blogged about the Tasting Event and later followed up with a lengthy front page feature article about his experience, “Cancer Patient RedisCOVERS Joys of Eating.” The newspaper’s online version of the story also included video and photography captured at our Tasting Event, as well as at Vincent’s home. We are grateful to Vincent for sharing his story in such a public way and for Ms. Miltner’s sensitive way of relaying it. It certainly helped to promote awareness about SPOHNC and our local chapter!

The overall experience was captured by one of the care partners; Margaret B., who said “Everyone was so nice and accommodating. These events are a nice change from our sometimes difficult moments.” Don L., a survivor said “Had a discussion with a man who is to undergo a laryngectomy soon and he seemed glad to meet a survivor-me!” In our opinion, that is what this event is all about . . . celebrating the journey and connecting with fellow travelers.

Cleveland, OH – “Celebrate Food & Life!” The Cleveland Chapter of SPOHNC held its first annual Taste Event & Wellness Fair this year – “Celebrate Food & Life!” The event focused on food and wellness as one navigates the cancer process and works through recovery.

The American Cancer Society graciously offered our group the space to hold our event, and the location midway between the east and west sides of Cleveland made the setting ideal. The sun was shining as balloons, flowers and banners decorated the space and the day was all about “health and healing” for patients, families and caregivers.

Our attendance goal for the first year was 75 or so, but with the support of our three major medical centers; University Hospitals, The Cleveland Clinic and Metro Health System, we welcomed more than 130 guests, including many medical professionals from all three hospital systems.

Area chefs, food services and health food stores embraced our event and guests were treated to a fabulous array of delicious foods to enjoy. Chefs and food service personnel engaged with attendees, providing menu and food preparation advice as well as demonstrations. A separate room full of health and wellness professionals from all three Cleveland area medical systems and other area cancer patient support centers provided valuable advice and direction for patients dealing with Oral, Head and Neck Cancer and the effects of the treatments. We couldn’t have asked for a better group of food service and health and wellness professionals to participate in our first event and help those challenged through this cancer...in body, mind and spirit.

Other highlights of the day included three surgeons – one each from the three participating medical systems – offering words of advice and encouragement to patients and families, a fabulous silent auction well supported by local businesses and a strolling violinist who mingled with guests and surely enhanced our festive atmosphere. A wonderful afternoon was had by all those who planned, participated in and attended, and we look forward to continuing the tradition we began with this year’s event.

Our goal for the inaugural “Celebrate Food & Life!” was to help raise awareness of Oral, Head and Neck Cancer and be a measure of support to those patients and families who are journeying through the cancer process. We sincerely hope that our first annual event provided this and through our sharing of stories and experiences that everyone came away with some measure of “hope in healing” within their cancer journey. We look forward to next year, and plans have already begun for another wonderful event.
HEAD AND NECK CANCER NEWS

Researchers Identified Markers That Predict Progression of Oral Lesions to Cancer

PHILADELPHIA — A group of molecular markers have been identified that can help clinicians determine which patients with low-grade oral premalignant lesions are at high risk for progression to oral cancer, according to data from the Oral Cancer Prediction Longitudinal Study published in Cancer Prevention Research, a journal of the American Association for Cancer Research.

“The results of our study should help to build awareness that not everyone with a low-grade oral premalignant lesion will progress to cancer,” said Miriam Rosin, Ph.D., director of the Oral Cancer Prevention Program at the BC Cancer Agency in Vancouver, British Columbia, Canada. “However, they should also begin to give clinicians a better idea of which patients need closer follow-up.”

Oral cancers are a global public health problem with close to 300,000 new cases identified worldwide each year. Many of these cancers are preceded by premalignant lesions. Severe lesions are associated with a high progression risk and should be treated definitively. However, the challenge within the field has been to distinguish which low-grade lesions are the most likely to progress to cancer.

In 2000, Rosin and colleagues used samples of oral premalignant lesions where progression to cancer was known to have subsequently occurred in order to develop a method for grouping patients into low-risk or high-risk categories based on differences in their DNA. In their current population-based study, they confirmed that this approach was able to correctly categorize patients as less or more likely to progress to cancer.

They analyzed samples from 296 patients with mild or moderate oral dysplasia identified and followed over years by the BC Oral Biopsy Service, which receives biopsies from dentists and ENT surgeons across the province. Patients classified as high-risk had an almost 23-fold increased risk for progression.

Next, two additional DNA molecular risk markers called loss of heterozygosity were added to the analysis in an attempt to better differentiate patients’ risks. They used the disease samples from the prospective study, and categorized patients into low-, intermediate- and high-risk groups.

“Compared with the low-risk group, intermediate-risk patients had an 11-fold increased risk for progression and the high-risk group had a 52-fold increase in risk for progression,” Rosin said.

Of patients categorized as low-risk, only 3.1 percent had disease that progressed to cancer within five years. In contrast, intermediate-risk patients had a 16.3 percent five-year progression rate and high-risk patients had a 63.1 percent five-year progression rate.

“That means that two out of every three high-risk cases are progressing,” Rosin said. “Identifying which early lesions are more likely to progress may give clinicians a chance to intervene in high-risk cases, and may help to prevent unnecessary treatment in low-risk cases.”

For more information about the AACR, visit www.AACR.org.

“Keep your face toward the sunshine and the shadows will fall behind you!”

Walt Whitman
<table>
<thead>
<tr>
<th>State/Region</th>
<th>Location</th>
<th>Contact Information</th>
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<tbody>
<tr>
<td>Illinois-Maywood</td>
<td>The Cardinal Bernardin Cancer Ctr.</td>
<td>3rd Wednesday: 6:00-7:00 PM</td>
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<tr>
<td>Indiana-Port Wayne</td>
<td>St. Luke’s Cancer Resource Ctr.</td>
<td>3rd Tuesday: 4:00-5:00 PM</td>
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<tr>
<td>Indiana-Indianapolis</td>
<td>Riley Hospital for Children</td>
<td>Last Monday: 6:00-7:00 PM</td>
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<tr>
<td>Indiana-Fort Wayne</td>
<td>St. Joseph Hospital</td>
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<td>Indiana-Terre Haute</td>
<td>Hux Cancer Center</td>
<td>3rd Tuesday: 4:30 PM</td>
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<tr>
<td>Iowa-Des Moines</td>
<td>Iowa Methodist Medical Center</td>
<td>Suite 450</td>
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<tr>
<td>Kansas-Kansas City</td>
<td>Univ. of Kansas Medical Center</td>
<td>2nd &amp; 4th Wednesdays: 4:00-5:00 PM</td>
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<tr>
<td>Louisiana-Baton Rouge</td>
<td>Cancer Services of Greater Baton Rouge</td>
<td>2nd Monday: 6:00-8:00 PM</td>
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<td>Louisiana-New Orleans</td>
<td>St. Peter’s RC Church</td>
<td>2nd Tuesday: 5:30-6:30 PM</td>
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<tr>
<td>Minnesota-Minneapolis</td>
<td>Hennepin/Southdale Library</td>
<td>1st Monday: 6:00-9:00 PM</td>
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<tr>
<td>Missouri-St. Louis</td>
<td>St. Louis University Hospital</td>
<td>4th Friday: 10:00 AM - 12:00 noon</td>
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<td>Montana-Bozeman</td>
<td>Bozeman Deaconess Hospital</td>
<td>3rd Thursday: 12:00 Noon - 1:00 PM</td>
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<td>Nebraska-Omaha</td>
<td>Methodist Cancer Center</td>
<td>Meets Quarterly</td>
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<td>New Jersey-Princeton</td>
<td>University Medical Center</td>
<td>1st Tuesday: 6:00-7:30 PM</td>
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<td>New Jersey-Somerville</td>
<td>Steeplechase Cancer Center</td>
<td>3rd Wednesday: 6:00-7:30 PM</td>
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<td>New Jersey-Toms River</td>
<td>Community Medical Center</td>
<td>Last Thursday: 3:00 PM</td>
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<tr>
<td>New Mexico-Albuquerque</td>
<td>Roswell Park Cancer Institute</td>
<td>3rd Tuesday: 4:30-6:00 PM</td>
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<td>New York-Albany</td>
<td>Albany Medical Center</td>
<td>3rd Tuesday: 7:00-9:00 PM</td>
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<td>New York-Buffalo</td>
<td>Roswell Park Cancer Institute</td>
<td>3rd Tuesday: 4:30-6:00 PM</td>
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<td>New York-Manhattan</td>
<td>Beth Israel Head and Neck Institute</td>
<td>4th Tuesday: 2:00-4:00 PM</td>
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<td>New York-Manhattan</td>
<td>Mount Sinai Medical Center</td>
<td>3rd Tuesday: 5:00 PM</td>
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<td>New York-Manhattan</td>
<td>NYU Clinical Cancer Center</td>
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<td>New York-Middletown</td>
<td>Orange Regional Medical Center</td>
<td>Community Education Center</td>
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<td>New York-New Hyde Park</td>
<td>North Shore-LIJ Health System</td>
<td>Hearing and Speech Center</td>
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<td>New York-Rochester</td>
<td>Strong Memorial Hospital</td>
<td>Luellen Resource Center, Pat. Res. Ctr.</td>
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**CHAPTERS OF SPOHNC**

P.O. Box 53
Locust Valley, NY 11560-0053
1-800-377-0928
NEW YORK-STONY BROOK
Ambulatory Care Pavilion
1st Wednesday: 6:45-8:15 PM
Dennis Stropoli 631-682-7103
den.star@hotmail.com

NEW YORK-SYOSSET
NSLI-Syosset Hospital
2nd Thursday: 7:30-9:00 PM
Alice Stein 516-764-1571
alicestein28@gmail.com
Madelyn Harper-Walsh 516-753-0923
lyn.SPOHNC@yahoo.com

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd Thursday: 7:00 PM
Mark Tenzer 914-584-6151
tenzer1@optonline.net

NORTH CAROLINA-ASHVILLE
Call for additional information
Kathleen Godwin 828-692-6174
tenzer1@optonline.net

NORTH CAROLINA-CHAPEL HILL/DURHAM
Cornucopia House
3rd Wednesday: 6:00 PM
Dave Gould 919-493-8168/jmorton44@gmail.com

NORTH CAROLINA-CHARLOTTE
Blumental Cancer Center
2nd & 4th Thursday: 1:30-3:00 PM
Meg Turner 704-355-7283
meg.turner@carolinashealthcare.org
Terri Painchaud 704-364-7119
trappi6@yahoo.com

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Deborah.Heim@uchealth.com
Angie Keith 513-475-7366
Angie.Keith@ucphysicians.org

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
2nd Thursday: 4:00 PM
Gwen Paul, LSW 216-476-7241
gwpaul@ccf.org

OHIO-DAYTON
The Medical Center at Elizabeth Place
One Elizabeth Pl. - West Lobby - The Chapel Room
2nd Monday: 6:00-8:00 PM
Hank Dennis 970-832-2677
wohnc@emailink.net

OHIO-JIMA
St. Rita’s Regional Cancer Ctr.
Allison Rad/Onc. Ctr. Garden Conf Rm
3rd Tuesday of even month: 5:00 PM
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Linda Glorioso 419-996-5616
lglorioso@health-partners.org

OKLAHOMA-TULSA
Hardesty Public Library
1st Tuesday: 6:30 PM
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Bertriggin@att.net

OREGON-MEDFORD
Providence Medical Center
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SOUTH CAROLINA-OF THE UPSTATE
Ambulatory Care Pavilion
1st & 3rd Tuesday: 6:00 - 7:30 PM
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felice@gildasclubnashville.org

SOUTH DAKOTA-RAPID CITY
Rapid City Regional Hospital
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Kathryn Cramer LMSW, CCHT
248-789-1234
KathrynCramerLMSW@gmail.com

TEXAS-FORT WORTH
Baylor All Saints Hosp.- Joan Katz Conf. Room
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Marla Hatcoat, LMSW 817-838-4866
marla.hatcoat@moncrief.com

TEXAS-HOUSTON-TOMBALL
Tomball Regional Hospital
TBA

TEXAS-MCALLEN
Rio Grande Regional Hospital
3rd Tuesday: 6:00 PM
Stephanie Leal, MA, CCCC, SLP
SAL1275@aol.com

TEXAS-PLANO
Regional Medical Center at Plano
4th Tuesday: 6:00-8:00 PM
Polly Candela, RN, MSN 214-820-3595
Polly.Candela@baylorhealth.edu
Emily J. Gentry, RN 214-820-2608

VIRGINIA-CHAPEL HILL/DURHAM
St. Rita’s Regional Cancer Ctr.
1st Monday: 6:00-7:30 PM
Corinne Cook, LCSW 919-843-5213
Corinne.cook@inova.com

VIRGINIA-NORFOLK
Sentara Norfolk General Hospital
3rd Monday: 7:00 PM
Cynthia Gilliam 757-770-4190
beachdolphin@aol.com

VIRGINIA- RICHMOND
Massey Cancer Ctr. Thalhimer Room
2nd and 4th Wednesday 2:00-3:30 PM
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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@vmc.org
Joanne Fenn, MS, CCCC-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
608-263-4806/Kammer@surgeru.wisc.edu
Peggy Wiederholt, RN 608-265-3044
wiederholt@humonc.wisc.edu

WISCONSIN-MILWAUKEE
Medical College of Wisconsin
Conference Rm. N, 3rd Floor
2nd Tuesday: 12:00 - 1;00 PM
Mary Brawley, MA, CCCC-SLP 414-805-5635
mary.brawley@froedterthealth.org
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