Cancer patients face many challenges – and one of the more frustrating clinical challenges is when their disease (or its treatment) causes facial paralysis. Tumors of the parotid gland, and skin cancers that invade the facial nerve are the most common cancer related causes of facial paralysis.

Facial paralysis – weakness of the facial muscles responsible for eye blinking and facial expression – can be partial or complete. It is absolutely devastating to patients. In most cases of facial paralysis, one side of the face is affected and the other is spared. As a result, the appearance of the face is asymmetric. This asymmetry is accentuated whenever any facial expression is demonstrated. So, smiles are uneven, one side of the face droops and eyebrows don’t match. The eye is dry and irritated without a blink reflex, the nose can be blocked, and the mouth droops and drools. Thankfully, we have found that there are answers. Almost all patients with facial paralysis have great options to help them feel and look better.

Complete vs. Incomplete Paralysis

“Complete” facial paralysis means that on the involved side there is no movement at all. There is no tone, and one side of the face has zero movement. These cases are more serious, because if the complete paralysis persists, the facial nerve and muscles on that side of the face will eventually lose their ability to function again. In “incomplete” paralysis, there is diminished movement, but there is some movement. There is a tone to the muscles that protects them from wasting away and becoming useless. There is really no rush to perform any particular procedure. The options to treat complete facial paralysis are usually different than the options to treat incomplete paralysis.

Relevant Anatomy and Functions

The facial nerve (“Cranial Nerve 7”, or, CNVII), has a very important job, and that is to control all of the muscles of the face. The right and left facial nerves normally always work together, to control the raising and lowering of eyebrows, blinking of eyelids, smiling, grimacing, kissing, much of speaking, etc. All emotions that we ever experience are expressed through movements of our face working simultaneously on both sides. During conversation, the facial expressions give subtle but important information to the other person or people we are speaking with. In some cases our facial expression even changes somewhat the meaning of the words we say. The facial nerve has other important functions too, in addition to controlling the movement of the facial muscles. These include lubricating our eyes through the release of tears (and eye blinking), stimulating the flow of saliva into our mouths to help with eating and even slightly modifying how we hear loud sounds. When the facial nerve is injured, this complex system is disrupted, resulting in significant problems of two types. First, the function declines. There is a real danger of the surface of the eye developing problems from chronic dryness. Speech and swallowing can be affected, and breathing through the nose on the involved side can be obstructed. The second, and perhaps even more important problem, is the visible facial deformity. The face on the affected side droops and sags, appearing lifeless and immobile. This deformity is distracting to others, and interferes with one’s ability to communicate with others. In the end, what really causes anxiety and distress in the patient is two things. First, the face looks odd and uneven. Second, they are unable to smile. The ability to smile is something we all take for granted. When this is taken away, it is really a tough thing to adjust to. The majority of patients with complete facial paralysis will say that more than anything, they want to be able to smile again.

The Facial Nerve and Cancer

The facial nerve starts in the brain stem, and travels through the bones of the skull until it exits, just below the ear. It then passes through a large gland that makes saliva. This is called the parotid gland. It travels through this gland, branching as it does into many finer filaments. From there it enters the muscles of facial expression to allow them to move. Tumors can grow in the parotid gland – both benign and malignant. Thus, these tumors and the surgery to remove them can result in injury to the facial nerve. Cancers from other areas can also damage the facial nerve - including the skull base, and from the skin.
FACIAL PARALYSIS continued from page 1

Dryness of the Eye and the Importance of Eye Protection

This is the most important medical concern of facial paralysis. The inability to blink normally may be also accompanied by a diminished tear production. If the surface of the eye remains dry for extended periods, severe damage can occur that can threaten one’s vision.

It is imperative that a patient with facial paralysis employ a regimen of eye lubrication and protection. This must be started right away, and continued indefinitely. It is very important to see an ophthalmologist for regular checkups. There are a variety of procedures that can be effective to protect and soothe the eye, however, they do not take the place of lubrication regimens.

Treatment Options

Patients who undergo surgical removal of tumors that involve the facial nerve may undergo simultaneous reconstruction. For example, when the parotid gland is removed for a cancer that involves the facial nerve, the missing tissue can be replaced with a technique called free tissue transfer. Tissue is taken from another area - the thigh, for example – and used to restore the shape of the face, and replace any missing skin. The tissue survives well because it is connected to blood vessels in the neck or face. This is done with the help of a microscope. In addition, small platinum weights are often added to the upper eyelid to help it close. A simultaneous temporalis tendon transfer can be done to hold up the corner of the mouth, and restore the ability to smile. Nerve grafting can also be performed at the same time as the cancer surgery. The resected facial nerve is replaced with a nerve graft.

Many cancer patients need radiation therapy after the surgery. Nerve grafts in place can still work well, even if radiation occurs. The temporalis tendon transfer also works well to suspend the tissues of the face after radiation. However, radiation does result in a lower likelihood of the tendon transfer producing a meaningful smile.

Complete Facial Paralysis - Reinnervation Options

(can be used in cases of complete paralysis of less than one year’s duration)

This means that procedures are done in an attempt to “reawaken” the facial nerve, to allow the use of the patients natural smiling and blinking muscles. In cases of complete paralysis, there is a window of opportunity to accomplish this. When the nerve is significantly injured and the face paralyzed, the muscles exist without the normal stimulation they typically receive. The muscles start to atrophy, losing muscle tone and mass. Ultimately, scarring (fibrosis) of the junctions of the nerve branches and muscle occurs. Eventually, the muscles lose their ability to ever move, and waste away. This window of opportunity to reinnervate existing facial muscles of expression is probably about one year.

Repair of the Transected (Cut) Nerve

In cases where the facial nerve is severed as a result of surgery, the nerve can be sutured back together under a microscope using meticulous technique. This is the best option in this scenario, however, if the facial nerve is transected, it is currently impossible to achieve normal facial nerve function. Good symmetry at best can often be achieved, but there will be some noticeable asymmetries seen with movement.

FACIAL PARALYSIS continued on page 3
The reinnervation options described above are not always spontaneous, but it can be accomplished. There are different techniques used to transfer this muscle. Some surgeons take a slip of the muscle from the temple and swing it down over the cheek bone to connect to the corner of the mouth, which may cause a small bulge over the cheek. There is also an alternative, minimally invasive procedure known as the “T3”, or temporalis tendon transfer, where part of a muscle that inserts into the jaw is detached, and stretched down to the corner of the mouth. This takes practice and is not always spontaneous, but it can be accomplished.

Free Tissue Transfer
Microvascular free tissue transfer involves the transplantation of tissue (skin, muscle, bone) from one area of the body to another distant site. It requires complete detachment of the tissue. The blood supply must therefore be re-established into the “flap” of tissue. This requires the suturing of the artery and veins of the transplanted tissue to connect them to arteries or veins in the face or neck. It is a technically advanced procedure that requires highly specialized expertise. The muscle most commonly used for facial reanimation is the gracilis muscle. This delicate muscle is in the thigh, and its removal typically produces minimal effects in the leg.

The procedure is often performed in two stages. In the first stage, a cross face graft is performed as described above. This provides a way to grow one or more branches of the facial nerve from the normal side of the face over to the paralyzed side. After the first stage, a prolonged waiting period allows time for the facial nerve to grow across the face through the cross face nerve graft. This takes up to a year. In the second stage, the gracilis muscle is transplanted from the leg to the face. This requires a stay in the hospital for several days. Microvascular free tissue transfers can fail if a clot forms in the artery or vein. At advanced centers, this failure rate is about 5%.

Static Procedures

Browlift
Most patients with complete facial paralysis develop drooping of the eyebrow. This can obstruct vision somewhat, and also create a very noticeable asymmetry. Browlifts can be very effective to help with this. There are a variety of brow lifting procedures, and they may be performed on just the paralyzed side, or if desired, on both sides.

Upper Eyelid Loading
It is often not possible to restore a normal blink in facial paralysis. Thus the upper eyelid, while it opens normally (this is controlled not by the facial nerve but by another cranial nerve), it cannot blink nor even close completely. Upper eyelid loading involves the placement of an eyelid weight – gold, or more recently platinum chains – so when one relaxes the eye, it can more completely close. A true blink is not restored, but eye protection (particularly while sleeping) is improved.

Lower Eyelid Procedures
The paralyzed lower eyelid may become displaced inferiorly (lid retraction) or turn away from the eye (ectropion). This can contribute to eye exposure problems and discomfort. A number of procedures exist to elevate and/or tighten the lower eyelid to improve function.
FACIAL PARALYSIS continued from page 3

improve its position. These included lateral canthopexies, medial canthopexies and other procedures.

Static Slings
A simple and safe strategy to suspend the sagging tissues of the face, slings can lift the corner of the mouth and drooping nose. A number of materials are used – either the patients own tissue such as fascia lata (tissue from the leg) or commercially available skin substitutes such as acellular dermis.

Chemodenervation
This involves the use of Botox or Dysport to constrain the activity of specific facial muscles. The goal is to improve facial symmetry, and it is performed for two reasons. First, to suppress synkinetic movement. These are the uncontrolled movements that often exist after a facial nerve injury, once the nerve has had a chance to heal. The other is to suppress movement on the other side of the face, in an attempt to make the face more symmetric. These injections are quick and easy to perform, as an outpatient, the effects begin in a few days, and last typically for three to four months.

Cosmetic Procedures
Many patients with facial paralysis benefit from additional procedures to help make them look more youthful, attractive, and symmetric. These include eyelid surgery, face and neck lift, volume restoration (fat transfer, injectable fillers), and other procedures.

Facial Symmetry
The process by which human beings perceive the faces of others is a funny thing. We all encounter faces all day long, and virtually never pay attention to asymmetries that all faces have. Yet they are there, and once pointed out, one can typically see them fairly easily. Our brains are designed to ignore facial asymmetry in others, until it becomes markedly asymmetric. This is a really important observation for patients with facial paralysis. For other deformities such as scars, or skin cancers, it is not the asymmetry that stands out - it is the tumor or scar that is seen. However, with facial paralysis it is not the paralysis that others see, as they do not readily perceive which side is dysfunctional. What they notice is simply that the two sides of the face don’t match well enough. This is very important for patients with facial paralysis and their surgeons to understand. There are no magical cures for facial paralysis. However, knowing that the human brain is designed to ignore facial asymmetry up to a point, is an advantage. Both sides of the face can be addressed – from top to bottom - and there are many options to improve symmetry. The result is often dramatic improvement.

Editors Note: Dr. Byrne is board certified in facial plastic surgery by both the American Board of Otolaryngology and the American Board of Facial Plastic and Reconstructive Surgery and is a leading authority on nasal surgery (rhinoplasty), rejuvenation of the aging face (facelift, necklift, blepharoplasty, browlift, etc.), skin cancers, and the treatment of facial paralysis (facial reanimation).

In addition to his clinical practice, Dr. Byrne serves as the Director of the Division of Facial Plastic and Reconstructive Surgery in the Department of Otolaryngology-Head and Neck Surgery at Johns Hopkins Medicine. He also directs the Johns Hopkins Fellowship Program in Facial Plastic and Reconstructive Surgery within the Department of Otolaryngology-Head and Neck Surgery.

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A TIME FOR SHARING... Laugh ‘Til It Heals!

Cancer is a laughing matter? Who knew? Diagnosed with Stage III, metastatic breast cancer nineteen years ago, laughter was the last thing on my mind. Yet immediately, I witnessed a phenomenon: when friends and family learned I had cancer, they didn’t know what to say or what to do. Not wanting to say the “wrong thing,” they often ended up saying nothing, causing me to feel isolated and alone.

I started receiving “silent gestures of support.” Cards came in the mail: people sent flowers; others dropped meals at my door. But I quickly discovered humor was a great connector of people. And I wanted people around me. I started drawing cartoons about my cancer experience. If someone sent me flowers or dropped off food, I would send them a thank-you note, using a cartoon. Guess what happened? They picked up the phone and called me! Finally—a voice!

Humor is a great connector of people. It puts people at ease, being light-hearted or making fun of something you’ve just experienced (flying wigs was a big one for me). Everything changes.

Your breathing level changes; blood flow changes; muscle tension is reduced. Stress goes down. Physicians such as Lee Berk, M.D., O. Carl Simonton, M.D., and Patch Adams proved laughter provides physiological benefits, such as increasing natural killer cell activity—the body’s natural fighter for viruses and tumors; increasing T-cell activity; and reducing cortisone levels which tend to suppress the immune system.

Not convinced you can get your daily dose of laughter while going through treatments? Read on and see how these cancer patients got a belly full.

Warning: Humor May Be Hazardous to Your Illness!

Dear Cancer Club,

Surgery for acinic cell carcinoma of the parotid gland (salivary gland cancer) left me with an 8” incision along my neck, held together with metal staples. I went to sleep as Ms. McCutcheon and woke up Ms. McFrankenstein. My ex-boyfriend offered me a couple of bolts to complete the look. (You can tell why he’s an ex.) Since then, I’ve had a remarkable recovery. I owe my life to my surgeon, whom I’ve since nominated for knighthood.

I took about three weeks off work to recover from surgery and didn’t start radiation until nearly eight weeks later. Given that I was only 34 years old and healthy (cancer aside), I was determined to keep working throughout the five weeks of radiation therapy. This arrogance was challenged after day two of treatments, when during a conference call at the office, I suddenly lost 90% of the moisture in my mouth.

Lest you have any doubt, saliva is essential to conversation. You never appreciate the value of saliva until the moment you have none.

With me, it was like a form of torture. Thank God I happened to have a bottle of water on my desk or I might have had to use sign language to tell my colleague to finish the call on my behalf. I can laugh about this now, and actually laughed pretty soon after it happened. I chalke it up to yet another learning experience: always have a bottle of water handy during treatment. I’m convinced I’ll be carrying around a water bottle—much like a security blanket—until my salivary glands are back to normal.

Ann M.

Vancouver, British Columbia, Canada

Dear Cancer Club,

In the spring of 1994, the day after I broke the sound barrier as a Navy pilot, I was diagnosed with an almost invisible form of a cancer called amelanotic malignant melanoma on the left ear. Soon after this diagnosis, I had the jugular vein, the trapezoid muscle, the salivary gland and about 200 lymph nodes surgically removed from the left side of my face and neck. The surgeon also removed most of my left ear.

When I finally got home from the hospital, my face and head were wrapped up tight like a mummy. Our twins, Brian and Christie, were only six years old. As soon as they saw me for the first time, they cried out “Mummy-Daddy... Mummy-Daddy!” My name became Mummy-Daddy. It would crack me up whenever I heard them say it. And even though at times it seemed almost too painful to laugh, I learned it only seemed that way, but laughter can break down any barrier, especially pain. I stayed Mummy-Daddy for quite some time.

The doctors would not perform any plastic surgery on me until I had survived a year. Exactly one year later, a wonderfully gifted plastic surgeon reconstructed my left ear from one of my ribs that he removed, and also from a large piece of my groin.

The operation was a complete success—even you can’t imagine what happens to my ear now when my wife kisses me goodnight!

Bill G.

Orange Park, FL

Dear Cancer Club,

My funny episode was at work. I own a small shop with flags, banners and windsocks. I was taking a windsock off the floor for a customer when another sock hanging from a battery-operated spinner got caught in my wig, spinning and spinning until it was wrapped up in all my plastic hair!

I removed my wig, took down the spinner from the ceiling, and carefully removed the metal. I thought I was going to wet my pants, I was laughing so hard! The customer ignored the entire thing. Ovarian cancer. Cancer free eight months and counting!

Terri H.

Cincinnati, OH

Dear Cancer Club,

Four months after my surgery, I attended a support group where they displayed prostheses. One woman spoke up and said she simply used a shoulder pad in her bra and that helped a lot. I liked that idea.

The following Saturday night I was invited to a friend’s house and thought this would be the perfect time to try the shoulder pad. We played board games, watched a movie, and then moved to the table to play cards. On his way over to the table, Jim leaned over to the floor and said, “Did someone lose a shoulder pad?” I was
laughing so hard that I had to tell them where it came from. Now I use safety pins.

Gwen M.
Columbus, OH

So next time you’re sitting in your chemo chair, lying on the radiation therapy table, or just getting ready to take a nap, don’t forget to laugh! ™

Christine Clifford, CSP, is CEO/President of The Cancer Club (www.cancerclub.com) and the author of eight books. She is a nineteen year cancer survivor, and speaks internationally on finding humor in the cancer journey. Don’t forget to laugh! ™

cristine@cancerclub.com

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SURVIVOR NEWS

You may remember the Sharing Story in our April 2013 issue – My Story – written by Frank Marcovitz. Frank recently underwent two surgeries - the most recent one was to reconstruct his esophagus. He is such an inspiration, and kept his sense of humor and Iron Man mentality throughout it all. We’re thrilled to report that Frank came through everything with flying colors, has regained some of his voice, and is now able to eat as well. Prior to his surgery, Frank made up a Memo to Staff, and distributed it to his healthcare team upon arrival at the hospital. He recently shared it with us, so we’d like to share it with you. Talk about the importance of a sense of humor in recovery?

IMPORTANT NOTICE - MEMO TO STAFF

COMING SOON

TO AN OPERATING ROOM NEAR YOU

(Date to be determined)

LET’S FIX FRANK’S THROAT – PART III

Starring:
Jatin Shah as THE DOC
Dr. McCarthy as STITCHES
Dr. Broad as SLEEPY
Special Guest Appearance by Frank Marcovitz as THE PATIENT

Notes for this performance:

• Please be sure to have a steady supply of warm blankets.
• A big fluffy pillow.
• Sheets that actually FIT the bed. More comfort for me, less work for you!!
• It’s baseball season, or more accurately – Yankee season. It would be nice if I could have the YES channel – it would help in my recovery!!
• Last time I looked, the TV in the lounge was missing. Could you arrange for it to be replaced? I think MSK can splurge to buy a new one. There are lots of good buys at Costco.
• Talking about the lounge, how about sprucing it up? You know I like to dance – how about adding a dance floor, disco ball, strobe lights, and a stereo? Wouldn’t that be fun??
• I like the Julliard dancers and the chefs from the Ritz Carlton. Please arrange to have them visit during my stay.
• A number of you have had trouble reading my handwriting. After spending a total of 31 days at MSK during the past few years, I would think you would have gotten the hang of it by now. If not, take a course in Egyptian hieroglyphics. The writing is similar.
• When the going gets hard, be ready to grab a suppository!!
• Please inform my fellow patients on the 17th floor, that the left lane is the fast lane. I hate when I have to knock over the slowpokes when doing laps!!
• For the lovebirds on the 17th floor – you know who you are, the ones with the fiancés and boyfriends: You’ll have a lifetime to spend with them. Right now, the focus is on ME, ME, ME!!! Besides, when was the last time they brought you chocolate and candy covered pretzels to work??!
• Remember, pain and I don’t get along – keep that in mind when you are with me.

As always, your help in my care and recovery is so important and I am so grateful. See you soon.

Lots of Love,
Frank Marcovitz

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Humor
is a prelude
to faith
and laughter
is the beginning
of prayer.

~ Reinhold Niebuhr

Visit the SPOHNC website at www.spohnc.org
HEADCANCERNEWS
Head and Neck Cancer Survivors Reported Not Seeking Mental Health Services

(dailyRx News) Long-term treatment can affect how cancer survivors manage in the world. The fancy phrase for this is “psychosocial functioning.” A recent study looked at how head and neck cancer survivors get along after treatment.

Depression is not uncommon among head and neck cancer survivors, researchers found in this new study. However, not many of the survivors in the study sought help for their depression with either antidepressants or therapy. Physicians could assist by screening for psychosocial problems because depression is very treatable, according to one expert. “If you’re feeling blue, ask for help.”

Allen M. Chen, MD, of the University of California, Davis, and now of the David Geffen School of Medicine at the University of California, Los Angeles, led this study. Dr. Chen and colleagues were looking at the rates of depression among head and neck cancer survivors who had received radiation therapy to treat the disease.

“The treatment of head and neck cancer can lead to devastating impact on psychosocial functioning due to the many important structures located in the head and neck region,” Tobenna Nwizu, MD, a solid tumor oncologist with the Taussig Cancer Institute at Cleveland Clinic, told dailyRx News. “Functions like speech, swallowing, taste and salivation can all be affected,” said Dr. Nwizu, who was not involved in this study. Treatment can also affect appearance, cause dry mouth and increase the risk of aspiration (sucking food into the airway), according to the authors.

For this study, the researchers asked 211 head and neck cancer survivors to complete a questionnaire. The University of Washington Quality of Life instrument was used to assess the rates of depression. Study members were all disease-free, and none had a history of mental health issues prior to their cancer diagnosis.

One year after treatment was completed, 17 percent of survivors reported being “somewhat depressed” or “extremely depressed.” Among three-year survivors, 15 percent said they felt depressed, as did 13 percent of those who were five years out from treatment. Of those who reported depression, 6 percent of one-year survivors, 11 percent of three-year survivors and 0 percent of five-year survivors reported taking antidepressants.

Very few survivors reported receiving psychotherapy and/or counseling. Only 3 percent of one-year survivors, 6 percent of three-year survivors and 0 percent of five-year survivors said they were getting help from mental health professionals for their depression.

“This study shows the need to screen for depression in patients treated for head and neck cancer, as depression can adversely affect a patient’s quality of life, and is easily treatable,” said Dr. Nwizu, who is a dailyRx Contributing Expert. He added that economic factors, social support and other medical conditions, “which could all have an effect on a patient’s psychosocial well-being, were not accounted for in the study.”

The authors said a number of things may have influenced the survivors’ choices not to seek help for their depression, including lack of insurance, financial barriers, lack of follow-up care, not having a primary care physician and the perceived social stigma of mental illness.

HPV Viruses Linked To Growth In Oral Cancers

8/12/2013 - While the annual report on the status of cancer in this country indicated a decline in the incidence and death rates of all cancers combined, some particular cancers did not fare that well. HPV-related cancer of the throat is one of them.

You don’t have to explain that to Dr. Robert I. Haddad, the disease center leader of the Head and Neck Oncology Program at Dana-Farber Cancer Institute. “I see two patients a week for HPV-related head and neck cancer,” he explained. “It’s very common and now the number one cause of oropharyngeal cancer.”

Oropharyngeal cancer affects the throat, back of the tongue & tonsils. For HPV-associated cancers, it trails only cervical cancers in number & medical experts predict that if the current trend continues, these oral cancers will move to first place. More than 50 percent of the cases are caused by HPV 16.

According to the Centers for Disease Control and Prevention (CDC) almost 12,000 new cases are confirmed each year, & men bear the brunt of the illness at 80 percent of the diagnoses. The rate of occurrence in white and black males is similar, according to the latest CDC data. Although the statistics are clear, the reasons for the uptick are less so. Haddad agrees. “It is difficult to pinpoint the reason for increased incidence of oral cancer,” he said.

Some clinicians blame oral sex. A 2012 CDC report on the prevalence of oral sex found that roughly two-thirds of males and females aged 15-24 had engaged in oral sex, & cited birth control as a reason. Indeed, non-coital sex prevents pregnancy, but not sexually transmitted diseases. Even more puzzling is the description of patients diagnosed with throat cancer. The typical patient is now a non-smoker & non-drinker male in his mid- 40s or early 50s. At one time, oral cancers were more commonly attributed to heavy smoking, especially when combined with heavy drinking. Victims were generally in their 60s.

There are no FDA-approved tests to detect HPV infections in men. Nor are there screening methods similar to Pap smears to find cell changes caused by HPV infections of the throat, but that does not mean one should not be vigilant. There are tell-tale signs. A sore throat & difficulty swallowing are two of them. A lump in the neck or enlarged tonsils is another. “The lump should bring you into the doctor’s office right away,” cautioned Haddad. Doctors often rely on dental hygienists & dentists to spot the problem. “They are in a unique position to examine the mouth,” Haddad explained. “We rely on them to be the first line of detection.” Prevention is key. “We talk about not smoking & drinking to prevent oral and other types of cancer,” he said. “We have to emphasize vaccination as well.”

Although there has been no research on the impact of HPV vaccination on throat cancer, Haddad argues there is little reason to believe it will not affect HPV-related oral cancer as well. Yet the vaccination rate, especially among males, is very low. “Many parents think this is taboo and are uncomfortable having it done,” explained Haddad. HPV-related throat cancer is treated by surgery, chemotherapy and radiation and depends on the stage of diagnosis. The good news is that the treatment works well. According to the American Cancer Society, oropharyngeal cancers that contain HPV DNA tend to have a better outlook than those without HPV.

Still, treatment comes with long-term side effects. “The treatment is difficult and can affect speech,” Haddad explained. People have difficulty with dry mouth. Anxiety and depression are common. “Many people will be cured, but it won’t be easy,” he warned.
**CHAPTER HAPPENINGS**

Send us your stories. We'll share them in an upcoming issue.

Since our last issue of “News from SPOHNC” in May, we’re very excited to share the news that our SPOHNC Chapters have continued to grow. With international interest, and the possibility of new chapters developing in Canada and in Sweden, SPOHNC now welcomes new Chapters in Lancaster, PA, Englewood, NJ, Hattiesburg, MS, Topeka, KS, Houston, TX, St. Paul, MN, Springfield, IL, and Hot Springs, AK. It’s amazing how groups begin. Below is just one story of a new chapter - Hot Springs AK, facilitated by Barb Conway and Dick Antoine.

Barb Conway is the Mercy Hospital Nurse Navigator that initiated a support group for oral, head and neck cancer patients. Joni James and Curt Anderson were members of the Arkansas Northwest chapter four years ago. They relocated to Hot Springs and Curt started working at Mercy Hospital, where he met Barb. Joni joined their group for support. Curt became an advocate for their group to become a SPOHNC chapter. Curt contacted Jack & Temple Igleburger, the Facilitators of Arkansas Northwest, and the rest, as they say, is history!

Dick Antoine, local radio personality and a Hot Springs dynamo, is a Marketing Consultant and knows everyone in the business community in Hot Springs. Dick is also a four-year survivor of oral, head and neck cancer and co-facilitates the group. He interviewed SPOHNC Founder, Nancy Leupold, and Jack & Temple on his radio show the day after they attended the bi-monthly meeting at Mercy Hospital.

**IN MEMORIUM**

SPONHC wishes to extend its most heartfelt condolences to the family of Trisha Appelhans, an inspiring, beautiful young woman, a mother, wife, daughter and a friend to many.

Trisha was a volunteer for our National Survivor Volunteer Network match program since 2006, always willing to support others and listen to their concerns, keeping a positive attitude as she offered her help to so many. She was also a very active member of our SPOHNC Facebook group, sharing messages of hope and encouragement even as she fought her own brave battle. Her bright spirit, her smile and her kindness will be remembered by those whose lives she touched so deeply.

We will miss Trisha always, and will continue to keep her husband Matt, her beautiful children and her family and friends in our prayers.

**“Like” SPOHNC on Facebook**
## CHAPTERS OF SPOHNC

Contact SPOHNC at 1-800-377-0928 for Chapter information & Facilitator contact information

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SPOHNC  http://www.spohnc.org  E-mail-- info@spohnc.org
## CHAPTERS OF SPOHNC

Contact SPOHNC at 1-800-377-0928 for Chapter information & Facilitator contact information

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SPOHNC Facilitator Testimonial...

“When you come to the support group, we’re encouraging. We don’t sit around and talk about our cancer, we talk about what we can do to help someone else.”

~ Karen C. - Chapter Facilitator, Birmingham, AL

ATTENTION!

SPOHNC Chapter Facilitators -

If your meeting location, day and time, or contact information has changed, please be sure to let us know. Also, please share any events you may have organized or participated in.

Call SPOHNC at 1-800-377-0928, x2 or e-mail us at info@spohnc.org.

SPOHNC Chapter Group Member Testimonial...

“Coming to the meetings gives me a sense of accomplishment – to see how all of my friends are doing and making progress.”

~ Ray G.

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PENNYSYLVANIA-NEW CASTLE
PENNYSYLVANIA-PHILADELPHIA/ACCP
PENNYSYLVANIA-PHILADELPHIA/HUH
PENNYSYLVANIA-YORK
SOUTH CAROLINA-OF THE UPSTATE
SOUTH DAKOTA-RAPID CITY

TENNESSEE-CHATTANOOGA
TENNESSEE-NASHVILLE
TEXAS-CHARLOTTESVILLE
TEXAS-FAIRFAX
TEXAS-NORFOLK
TEXAS-PLANO

VIRGINIA-CHARLOTTESVILLE
VIRGINIA-FAIRFAX
VIRGINIA-NORFOLK
WASHINGTON-SEATTLE/EHMC
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