NEWS FROM

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THE IMPACT OF HEAD AND NECK RECONSTRUCTION ON THE QUALITY OF LIFE FOR PATIENTS WITH HEAD AND NECK CANCER

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Since the introduction of the surgical management of head and neck cancer in the mid 17th century, surgeons have been preoccupied with reconstruction. This is largely because defects of the head and neck incurred during surgical removal of tumors can be devastating functionally and aesthetically. In the mid 19th century, it was discovered that surgical resection of tumors including the oral cavity, the skin, and the voice box, could result in a high cure rate and patients often survived their disease. However, the defects sustained during the surgical management of these cancers were often so debilitating that the patients were left unable to speak, sometimes unable to eat, and commonly inhibited in their desire to socialize. As a result, many of these patients became reclusive and withdrawn. Suicide rates were reported as high as 12%. Patients would commonly withdraw from family members, friends and the work place. Surgeons recognized this dilemma and early in the 20th century focused a great deal of energy on reconstructive efforts in an effort to improve form, function, and aesthetics.

Initially, many of the reconstructive efforts were focused on covering open defects. This was because the resection required in order to treat a patient with head and neck cancer commonly resulted in an extensive defect that was not compatible with life. Segments of soft tissue, referred to as "flaps", were transferred into the defect to provide coverage of the wound. During the course of World War I, surgeons in the battlefield developed techniques for the management of battlefield injuries and a great deal was learned about soft tissue flap reconstruction. Skin grafts and a compendium of local and regional flaps were introduced as a result of the war time experience.

The Second World War was marked by an increase in the number of extremity as well as head and neck injuries. Surgeons were forced to further develop reconstructive techniques that were reliable and appropriate for large head and neck injuries. The introduction of regional flaps, including the forehead flap and the scalp flap, provided tissue for coverage of small and medium sized defects. In the 1960's, many of the soft tissue flaps developed in the battle field were applied to patients with head and neck cancer. Although these flaps were an improvement, the results were often disappointing because many of the flaps contained only soft tissue, which was not appropriate for reconstruction of complex defects, which really required hard and soft tissue for complete reconstruction.

In the 1970's, the concept of "quality-of-life" was introduced and it was related to a patient's outcome following surgery. There were some investigators who felt that quality of life was an individual experience that was nearly impossible to quantify. Others, however, proposed assessment tools to better understand the qualities that make a person's life worth living. Head and neck cancer has been highly studied because of the well-documented effect on speech, eating, and socialization. While quality of life is a unique entity, we know that there are certain attributes, including those previously mentioned, that have impact on a patient's happiness and desire to live. As surgical techniques improved during the 1970's and early 1980's, patients began to demand more than just a cure. Disease-free survival slowly improved and patients with head and neck cancer were living longer; many of them were surviving their illness. The focus on quality-of-life gained increasing attention. The introduction of several quality-of-life assessment tools provided ablative surgeons and reconstructive surgeons with a method to measure a patient's happiness and functionality.

Until the 1980's, most head and neck reconstruction was achieved by transposing tissue adjacent to the head and neck into an ablative defect which required coverage. Unfortunately, while many of these techniques filled in the ablative defect, they often resulted in tethering, scarring, and a sub-optimal functional result for eating and speaking. Although the wounds were covered with skin flaps, patients were rarely pleased with their ability to speak clearly, eat a regular diet, or achieve an acceptable cosmetic result.

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COMING IN APRIL
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William J. Ravich, M.D.

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In the early 1970's, technological advances lead to introduction of free tissue transfer, ushering in a new era in reconstructive surgery.

Free tissue transfer involves transplanting tissue from a distant site in the body to the head and neck region. In 1959, the technique was first introduced when a defect of the esophagus was reconstructed by transplanting a segment of the bowel to the head and neck region. The artery and the vein feeding the transplanted segment of bowel were then connected to an artery and vein in the neck using microsurgical techniques. While exciting, free tissue transfer did not become popular until the late 1970's and early 1980's when improved microsurgical instruments and the operating microscope were introduced.

Over the 1980's, a number of different donor sites, (areas from which tissue could be transferred) were introduced. In the early 1980's, new donor sites such as the lower leg, the stomach and the back were introduced. Bone could be transferred from the lower leg and hip, while muscle and skin could be transferred from the arms, legs, and back. Today, there are more than 25 different donor sites that have been described. Tissue, including bowel, bone, skin, muscle, and a combination of these tissues (referred to as composite flaps), can be transferred from different areas in the body up to the head and neck region. This technique provides the ability to transpose the bone for reconstruction of the upper and lower jaws, muscle for reconstruction of the deep tissues in the neck, and skin for reconstruction of the tongue, the oral cavity, and the lining of the face and neck. Once transferred the tissue is often able to be shaped to mimic the original contour of the region in need of reconstruction.

More recently, investigators and surgeons have focused on providing sensory re-innervation and movement to the transposed tissues. Today, reconstruction of the tongue not only involves transferring tissue from one part of the body to the head and neck, but efforts are often made to re-innervate the tissue so that it has sensory capability. While we are unable at this time to provide taste, the ability to simply sense food in the mouth has had a significant improvement on patients eating, swallowing and speaking.

In the 21st Century, it is no longer acceptable to patch the defect. Patients' demand both functional and aesthetic reconstructions. Reconstruction of the upper and lower jaws exemplifies the progress that has been made in head and neck reconstruction. While just 10 years ago, reconstruction of the upper and lower jaw was rarely accomplished, today, it is routine that reconstructive teams at major head and neck cancer centers use fibula bone, iliac crest bone, and scapula bone to reconstruct both the upper and lower jaws. Bone and soft tissue can be transferred at the time of the tumor removal or in a secondary process for reconstructive use after the initial management of the cancer. The transplanted bone is fixed to the adjacent bone in the remaining jaw using small titanium plates. The transferred tissue is revascularized by being microscopically anastomosed (a surgical procedure in which blood vessels are joined) to recipient vessels in the neck. Over the course of six weeks the

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transferred tissue heals to the adjacent upper or lower jaw. Once this has occurred, dental implants can be placed into the new bone and dental rehabilitation can be achieved. In many of these patients, dental implants are placed into the new bone providing stability for implant-borne dentures. In other patients, the bone provides an infrastructure for a tissue-borne denture, not unlike a typical denture retained with oral adhesives.

Dental rehabilitation has had a significant impact on function, both as it related to chewing and speech. The restoration of dentition following ablation and reconstruction has provided patients with the ability to speak more clearly, as well as to eat a normal diet. Additionally, the innervation of free flaps for reconstruction providing sensation to the oral cavity has provided patients the ability to sense food in the mouth and, therefore, improve their ability to chew and swallow the food. It is clear that free flap reconstruction of the head and neck has had a significant and positive impact on the quality of life of patients who experience cancer in this location.

While many of these patients are treated during the initial time of surgical treatment of the tumor, some patients require secondary reconstruction. We have found that there is a large population of patients treated over the past 50 years who have sustained defects of upper and lower jaw, tongue, neck and larynx. Many of these patients are not aware of the contemporary techniques being used in head and neck reconstruction. However, of those who are aware, many have now come forward requesting secondary head and neck reconstruction. There is no procedure that is more satisfying than one which helps a patient who has had compromised speech and swallowing from an ablative procedure in the past, to now develop normal speech, swallowing and aesthetics. Contemporary techniques in head and neck reconstruction have provided an excellent tool for patients to undergo secondary reconstruction and achieve an improvement in their quality of life.

Figure 1

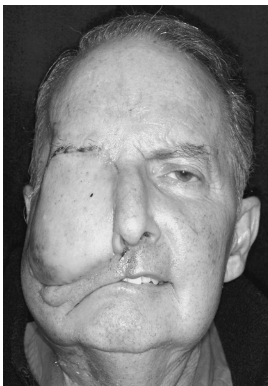

Figure 2

Figure 1 demonstrates a middle-aged patient who sustained a mid-face and orbital defect. Originally the patient had undergone a reconstruction with a soft tissue flap. When he presented to our center, he requested a reconstruction that would provide him with the bone and tissue necessary to achieve dental rehabilitation with implants and teeth, and prosthetic restoration of the eye, and palatal reconstruction. The initial reconstruction (Figure 1) demonstrates the placement of soft tissue to cover the defect.

The second stage provided the patient with the bone and soft tissue necessary to achieve dental restoration and prosthetic reconstruction of the orbit (Figure 2). This particular patient represents what can be achieved through the use of free tissue transfer and a multidisciplinary approach. A combination of free tissue, aesthetic sculpting, and prosthetic restoration can provide a patient with an excellent functional and aesthetic result.

While techniques, such as free tissue transfer, provide miraculous results for patients who have suffered head and neck ablative defects, there are several organ systems that remain a challenge for head and neck reconstruction. This includes the voice box, the tracheal airway, and the tongue. Future efforts will focus be focused on head and neck transplantation. Recent success with laryngeal and tracheal transplantation as well as experimental success with tongue transplantation will herald in an era that will undoubtedly change the face of head and neck reconstructive efforts. New developments in immunosuppression will eventually provide patients with a history of head and neck cancer the opportunity to undergo organ transplantation with restoration of the trachea, voice box, and one day - the tongue.

Head and neck cancer and the defects sustained during the management of head and neck cancer are unique because they have such tremendous impact on a patient's organs of self expression. In no other area of the body does a defect so significantly impact the patient's quality of life. In particular, head and neck cancer can devastate a patient's ability to communicate and maintain relationships, as well as, their ability to eat, see, smell, taste, speak and hear.

Reconstruction of the head and neck provides patients with the opportunity to once again eat, speak, swallow, and socialize. Techniques, such as free tissue transfer and multidisciplinary care of the head and neck cancer patient has provided patients with a quality of life that was not possible, in the not so distant past. However, it cannot be stressed enough that this is a multi-disciplinary approach. It requires an experienced team of physicians, including surgeons, radiation oncologists, medical oncologists, radiologists, prosthodontists, dentists, oral-maxillofacial surgeons, and speech language pathologists. Working together, the results can be astonishing and the impact on life cannot be understated.

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A TIME FOR SHARING

November 2006 marked the end of my first five years. Five years after treatment is a major milestone. As my chemotherapist so felicitously put it when he was trying to calculate my chances after treatment. "If you make five years, you will die of something else."

At the time, I thought his statistical citation was rather grisly. Today I am able to appreciate not only that the time and manner of my death are unknowable but I look forward to the future with less fear having already looked over the chasm. My walk with cancer was not pleasant but it has helped me to understand that the path we travel is not a circle. We cannot keep coming back to the same place. Life is change, each day is different.

A paradox of cancer is that while every story is unique it tells of events that almost define a strange commonality. Until this generation, a confirmed diagnosis usually was a predictor of fatality. The patient had little information, little understanding and little hope. Now most doctors and the internet offer boundless facts. Informed choices are possible and survival statistics improve every year.

I received my diagnosis on November 5, 2001. Three weeks later I had my first appointment at Memorial Sloan Kettering Cancer Center. This was an extraordinary time to land in New York City. An analogy between my health and the tragedy that had so recently hit the city should not, of course, be overdrawn. We had both been hit, and hit hard, by an unexpected invader. Still I believe that I was able to gain strength and courage from the examples that surrounded me.

There is no telling why any one person gets cancer in general or squamous cell tongue cancer in particular. There are certain known genetic factors. There are irrefutable correlations between behaviors like smoking and throat cancer. Still there remains the mystery why some get it and others do not. There is no value in asking the unanswerable question of "why me" or beating yourself up with the accusation that "I did this to myself." No one deserves cancer, so don't shoulder any blame. The past is gone. You are, at least partially, responsible for your own future. We all can work on that equally, one day at a time without recriminations on the past.

Being of Two Minds

Cancer treatment is a bit like a ride in a contemporary space capsule. Most of the decisions are made by the professionals on the ground. The astronaut is not really steering the ship. Still your choices can make or break the success of the mission. The patient is challenged to simultaneously maneuver two vehicles in his or her head.

One is where to go for treatment and what plans, decisions and actions are needed to get there. This involves all the assignments of regular life plus the added details of the cancer. There is the constant making of mental lists and plans for today, tomorrow and beyond while trying to remember everything that you have been told.

The other wheel being turned is emotional. Along side all the planning and ruminating, lies the present. The conscious and the subconscious engines are constantly racing. We feel. Cancer is scary. It is important not to lose traction. Help is available through friends, counselors, loved-ones, books and mindfulness courses. Some doctors can talk with you about the emotional and or, if you prefer, the spiritual side of the fight for life. Other doctors cannot or will not. The patient needs to pay conscious attention to the psyche while battling the cancer.

Choosing Treatment

Although every cancer experience is different there are many commonalities. Most people when they are first diagnosed with any type of cancer suddenly realize that they know nothing about the biggest event in their life. Ignorance is not a happy state. We all have different abilities and taste for gathering knowledge. Some of us freeze and find reassurance in the belief that the doctor knows best. Others find comfort by wrapping themselves in blankets of information. A balance is needed and that requires some organized effort on the part of the patient and his or her family.

There is a great payoff to getting a second opinion and learning as much as possible about your cancer and the various forms of treatment. The internet and SPOHNC can bring the latest in comprehensive information to the smallest town. Treatment protocols in North American hospitals are roughly similar and based on widely published studies but they are not all the same. Some lean more towards surgery, different types of radiation regimes are offered and the personalities of the medical staff are different. Many insurance policies will allow you to choose the treatment center.

There are many decisions to make in the difficult and hurried days after receiving a cancer diagnosis. Sometimes there are options as to where you will receive treatment. It is important to meet, interview and quiz the team - surgeon, chemotherapist and radiation oncologist. You will be putting your life into the hands of these people. You need to feel confident in their abilities and as comfortable as possible with their personalities.

Ultimately you do have to put total trust in your doctor but that faith will be stronger if it is based on a choice that you made guided by facts and your own intuition. At a minimum there should be one doctor on the team who makes you feel strong, who seems to always have the time to consider your fears and take your worries as important. No hospital or doctor can promise success but you will do better if you feel in your gut that you made the right choice. Usually with throat cancers, time is significant but not so critical that you have to take the first unexamined option.

Preparing for Treatment

There are many things that the patient can do to help win the fight. If there is any thread that runs continuously through the stages of diagnosis, treatment and recovery it is to keep calm. Of course, that is easier said than done but it helps to recognize and to accept that all things will change. It may be helpful to begin each day or each troubled hour with a meditation that change is ever present, that everything is impermanent. If you can really believe in the perpetual nature of change, you may find it easier to stay calm than if you are trying to tightly hold on to a past that has left while you were reaching for the handle.

Your doctors will give good advice and there is a lot of common wisdom to be followed. From my experience, readings and conversations with patients and doctors I would like to mention a few specifics that do not get much attention but might help make your voyage a safer and easier one.

PEG Tube

Staying physically healthy is important. The greatest challenge for head and neck patients is getting enough to eat. The doctor's job is to kill the cancer. Your job is to be well enough to withstand the attack.

I strongly recommend getting a feeding (PEG) tube inserted as soon as possible and before the beginning of radiation. The procedure involves threading a line down the throat to insert a valve in the stomach wall. This is easier to do before the throat has been singed with radiation burns. The procedure is done under total anesthesia and is, therefore, relatively painless.

After three weeks, radiation burns and the changes in the chemistry of the mouth make ingesting food increasingly difficult. Solid food can become impossible to chew and swallow. Protein shakes and smoothies are a viable alternative for several weeks but they become increasing difficult to consume by mouth. I have talked with patients who reported spending an hour or more painfully working to spoon a bowl of thin soup past their painful throat. Eventually some cannot even sip clear liquids.

The average person with average health can stand to lose up to ten percent of body weight without losing strength and vitality. Losing more is dangerous. It is very difficult to do your part in fighting the cancer if you are increasingly weak. Hospitalization may be required. The treatment may simply be less effective. The greater danger is in becoming so weak that the course of treatment needs to be interrupted or discontinued. Radiation and chemotherapy are given under standard protocols. It does not work to have a bit now and another bit later. Strength is needed to withstand the intentional attack. Good nutrition is necessary to preserve strength. The average adult needs two or three thousand calories per day depending on your size and metabolism. A feeding tube is the only guarantee of getting good and sufficient nutrition.

The arguments against the feeding tube need to be confronted. It is not costly. The procedure and the nutrients are covered by insurance. It is not unsightly because the tube is fully concealed by ordinary clothing. Feeding – "eating" – is not gross and disgusting. The canned liquids are inserted into the tube with a plastic syringe while standing at the kitchen sink. The burnt mouth can not enjoy food, so there is no loss of taste. The tube can be cleaned in privacy just like any other body washing. It is not painful and in most cases, it is not permanent. It takes the throat two to four months to heal after completing the course of radiation. The return to mouth eating can be gradual until the tube is no longer necessary. The removal is a simple ten-minute office visit.

Resistance to having the feeding tube and struggling to eat add an unnecessary burden to the fight. Get it early and use your energy in better ways. At the least, talk to your doctor.

Get to Know the Radiation Techs

It is a collaborative effort to get the patient through radiation and periodic infusions of chemotherapy. The effects are cumulative and very debilitating. The normal course of radiation for head and neck cancers is five days per week for six to eight weeks. Some protocols call for sessions twice per day. Getting radiated is like fighting a boxing match. The blows in each round may be the same but the beating gets worse and worse as the fight moves along. You need all the trainers in your corner.

Beyond the three medical captains there is an army of people responsible for your care. Some you will never meet, such as the physicist who works the math for the radiation program, the lab worker who mixes the chemo-cocktail or the nurses who assist the surgeon while you are deep under anesthesia.

Often overlooked or taken for granted is the team of technicians who prepare and place you under the beam of the accelerator. They are all professionals and want to do a good job. They work very hard without getting much obvious credit. They are humans subject to the stresses of the job and their private lives. Make an effort to know the radiation techs. Express your appreciation. Try to muster a sincere hello each day. Your efforts will be repaid with kindness, affection and better attention to the deadly machine that they are wielding.

Accepting Radiation

The daily preparation for head and neck radiation involves being snapped into position with a molded mask and being told not to move. "Be still" are the last words from the radiation tech as he/she leaves the room for safety from the invisible but lethal beams. You wonder what that really means. Is blinking not allowed? Is it alright to swallow? And what about scratching that maddening itch? Clearly you are the target and hopefully the accelerator is aimed precisely at the cancer. Being still for twenty to forty minutes doesn't come naturally to most people.

Coping with the actual radiation is not won with active struggle. I think that there is value to cultivating a sense of quiet acceptance of the situation and the moment. This is popularly called mindfulness. It is a training of the mind not to be thinking about what was or what will be, but to focus on the here and now and experience it without preconception or prejudice. Radiation, as such, doesn't hurt but the claustrophobia can be excruciating and the dramas that the whirling brain can create are the source of the worst pain. The greatest terror is that which we create with our own imagination.

The most helpful technique to stay in the moment and to keep your mind from racing away is to concentrate on the breath. It can be as simple as counting each in-breath and each out-breath. You can bring your entire focus onto the in-breath and the out-breath. You can be still while you just breathe and keep your thoughts away from the past, the future and the faint whine in the radiation room.

Many hospitals offer a wonderful short course on "mindfulness". The mental training and discipline are helpful in the management of pain and dealing with stress and anxiety. Most simple mindfulness courses teach the basics of Eastern meditation without the religious context. It may be impossible to completely will away pain and depression but they can become easier to face if you can lose some of the fear that comes naturally to all of us facing the invasion of cancer.

Massage after Completing Radiation

With or without surgery, the side effects of treatment can be substantial. Unfortunately the patient has little control over the collateral damage. The goal is to kill the cancer and simply hope for the best. Radiation is a severe attack on the muscles, tendons and connecting tissues in the neck. A return to normalcy means regaining full mobility. It is important to do the simple exercises recommended by the hospital – look up, look down, look left and right – it is like doing the hokey-pokey with your head. My experience is that it is a good idea to supplement the exercises with a periodic deep massage.

Beyond increasing mobility, massage is a way of bringing the patient back to full emotional good health. The cancer resided somewhere deep inside the throat, the neck and tongue. It is natural to feel alienated from your body and, especially, the neck area. The kind human touch of massage can help rebuild the connection between mind, body and heart that is necessary to return to life with confidence and vitality.

John Conover
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Nutrition Highlights: Focus on Fiber

By Jennifer Thompson, RD, LD, CNSD

Did You Know?

In January of 2005, the Food Guide Pyramid was replaced by MyPyramid. If you only remember the Four Food Groups and have never heard of the Food Guide Pyramid, then keep reading. The USDA released new and updated dietary guidelines based on the latest scientific evidence available. You can go to www.mypyramid.gov and check it out after you finish reading this article. Information can also be found in the back of the SPOHNC cookbook, "Eat Well, Stay Nourished." The website allows each person to individualize the guidelines for himself. The biggest changes were the recommendations on the amounts of fruits and vegetables to be consumed each day. The suggested amount depends on the caloric intake of the individual. The recommendation for a person who eats 2000 calories per day would be a daily intake of 2 cups of fruit and 2 ½ cups of vegetables. You may be thinking, "What was the old recommendation?" It dealt with servings for each category of food with an average of 5 servings of fruits and vegetables. Does the "Five-a-Day" campaign sound familiar? The new guidelines embrace a more objective measurement device than servings so that people will be able to better understand. The rationale being that it is harder for people to distort a cup than a serving. Another change to the guidelines regards grains. There is now a specific recommendation for whole-grains of at least three ounces per day or half of the total number of grains consumed. The old pyramid stated 6-11 servings of grains, but what constituted a serving was a mystery to most people. An ounce is a precise measurement and is often found on the nutrition labels. One ounce of a grain equals one slice of store-bought bread or ½ cup of pasta or rice.

Why is it important?

By following these guidelines, a person should be able to meet his fiber needs for the day. Technically, the 2005 Dietary Guidelines state a person should eat 14 grams of fiber per 1000 calories. An easier way to remember is 25-30 grams per day. The average American intake is 15 grams per day (Env). Clearly there is a disconnect between knowledge and application.

Take a look at your current fiber intake by keeping track of what you are eating over a 3-day period. Do NOT jump from 10-12 grams of fiber per day to 25-30 grams of fiber. Instead, make slow increases in the amount of fiber you eat by increasing 2-3 grams at a time. Give your body 3-4 days to adjust to the new increase before increasing the amount again. If you are currently not eating any fruits or vegetables, then focus on including them in your diet. Start with consistently eating one fruit & one vegetable a day for a week. Then, work on increasing that number to two and then three and so on until you reach your personal goal.

Now that you know… Let's look at ways to accomplish this in a realistic setting. Generally, you will get more fiber when you eat whole grains, beans, legumes, nuts, fruits and vegetables. See Tables 1-4 for the fiber contents of specific foods.

Diana Dyer, MS, RD, the author of "A Dietitian's Cancer Story," suggests the following: eating 1 ½ cups of fruits and/or vegetables at each meal and/or eating fruits and vegetables as snacks. Personally, I eat at least 2-3 pieces of fruit at lunchtime which would equal 1 ½ to 2 cups of fruit. At dinner is where I eat my vegetables. My favorite vegetable is a large bowl (approximately 2 cups) of fresh spinach with toasted sliced almonds and dried cranberries, topped with Ken's Raspberry Walnut Vinaigrette. You need to find the right combination that works for you.

It is very important for you to increase your fluid intake at the same time as you are increasing your fiber intake. If you fail to drink more, then you will be more likely to be constipated instead of having easier bowel movements.

Review of Day's Intake

Let's use the following dietary intacke to evaluate the fiber content. We will see where it stands and see what changes need to be made.

Breakfast	Amount of Fiber
2 eggs, scrambled	0
8 oz (1 cup) 2% milk	0
2 pieces of wheat toast (with 2 t. butter)	1.6 gms per slice (of 100% whole wheat)
2 pieces bacon	0
Lunch	
Peanut Butter & Jelly Sandwich	1.6 grams per slice of bread & 2 gms from 2T. PB
8 oz (1 cup) 2% milk	0
1 cup baby carrots	4 gms
Snack	
1 cup yogurt (8 oz)	0
½ cup pretzels	1
Dinner	
4 oz. roasted chicken (no skin)*	0
Steamed vegetables	2 gms per 1/2 C.
8 oz. 2% milk	0
½ c. brown rice	1.7 gms
1 c. ice cream	0
TOTAL	**16 gms**

Analysis: the current day's intake is above the average but still has room for improvement. We only need to find 9 more grams to meet the low end of the target range. Some easy additions to consider:

- Add 1/3 cup All-Bran to yogurt at the afternoon snack for 8.5gms fiber OR
- Substitute a fruit smoothie (for the milk at one of the meals) made with ½c. frozen strawberries (2gm), ½c. frozen blueberries (1.7gm), ¼c. wheat germ (4gm), and orange juic (add as much as needed for desired consistency) for ~8gms fiber. (You can always make a bigger amount of the smoothie and drink it at several of the meals. OR
- Add ½ cup of black-eyed peas to dinner for 8.5 gms fiber.

Look at the various foods listed in the tables if these suggestions do not appeal to you. Experiment with the foods that are appealing and will also add more fiber to your diet.

If your diet is limited by consistency, then try blenderizing foods like the smoothie recipe above. Many vegetables and beans/legumes work well mashed up. The fiber remains but is in a more tolerable form. Plus, you can add butter and even protein powder as needed to boost the calories and protein content. Another option for those who need a limited consistency is the following recipe:

- All Natural Laxative (from *Eating Well Through Cancer)*

1 ¼ C. unprocessed bran	1 T. Molasses or honey
1 C. prune juice	1 C. applesauce

Mix & store in a covered container in the fridge for up to 7days. Stir before taking. Take 2 T. every night as needed. Provides 2 gms fiber per serving.

There are some medicines that will make it more difficult for you to experience regular bowel movements. Some of the worst medications are those used to treat pain. Some examples are lortab, hydrocodone, and oxycontin. The extent to which these medicines will cause constipation depends on the amount used. Increasing the fiber in your diet may not prove successful. Laxatives may be needed to correct the problem. The recipe above would be worth trying if you want to avoid pills. Another non-traditional route might be herbal teas that contain senna leaf. Word of caution with any herbs—have your doctor or dietitian look at the ingredient list to rule out any known interactions with medicines you are taking. If your doctor does not know, then ask to speak with a dietitian.

If you absolutely cannot increase your fiber intact through the foods you are eating, then look into the various fiber supplements available in stores. You are probably familiar with name brands like Metamucil, Senokot, Fibercon, and Citrucel. A new one you may have noticed is called Benefiber. Many of the supplements are a combination soluble and insoluble fiber, the latter serving to stimulate bowel movements while the former serves to absorb fluid in your intestines and add bulk to your stool.

Caution: If you are still using a feeding tube to provide your nutritional needs, be careful when putting fiber down the tube. Remember to flush the tube well before and after you put anything in it. Also make sure the fiber is well-mixed into the liquid and there are no clumps. If your tube gets clogged, call your doctor's office.

A Final Word

There are easy answers and then there is reality. It is easy to sit here and read how to add more fiber into your diet. It is more difficult to actually do what is suggested. My challenge to you is to start somewhere. Take one tip given in this article and over the next month work on making it part of your daily routine. Once you have transformed that suggestion into a habit, start on another one. Your body will thank you.

Editor's Note: Jennifer Thompson, RD, LD, CNSD is a clinical dietitian in the Blood & Marrow Transplant Unit at Baylor University Medical Center in Dallas, TX. Ms. Thompson was previously a clinical dietitian covering lung transplant & thoracic surgery patients as well as head & neck cancer patients at Brigham & Women's Hospital in Boston, MA.

Table 1 Beans and Lentils

Food, Standard Amount	Dietary Fiber (g)
Navy beans, cooked, ½ cup	9.5
Kidney beans, canned, ½ cup	8.2
Split peas, cooked, ½ cup	8.1
Lentils, cooked, ½ cup	7.8
Black beans, cooked, ½ cup	7.5
Pinto beans, cooked, ½ cup	7.7
Lima beans, cooked, ½ cup	6.6
White beans, canned, ½ cup	6.3
Chickpeas, cooked, ½ cup	6.2
Great northern beans, cooked, ½ cup	6.2
Soybeans, mature, cooked, ½ cup	5.2
Green peas, cooked, ½ cup	4.4
Soybeans, green, cooked, ½ cup	3.8
Peas, edible-podded, cooked, ½ cup	2.5

Table 2 Grains

Food, Standard Amount	Dietary Fiber (g)
Bran ready-to-eat cereal (100%), ½ cup	8.8
Barley, whole, ¼ cup dry	8.0
Wheat Bran, ¼ cup	6.3
Wheat Germ, ¼ cup	4.0
Bulgur, cooked, ½ cup	4.1
Rolled oats, ½ cup dry	4.1
Oat bran, raw, ¼ cup	3.6
Shredded wheat ready-to-eat cereals, ~1 oz.	2.8-3.4
Whole-wheat spaghetti, cooked, ½ cup	3.1
Oat bran muffin, 1 small	3.0

Table 3 Fruits

Food, Standard Amount	Dietary Fiber (g)
Pear, raw, 1 small	4.3
Raspberries, raw, ½ cup	4.0
Strawberries, 1 cup	3.9
Blackberries, raw, ½ cup	3.8
Stewed prunes, ½ cup	3.8
Figs, dried, ¼ cup	3.7
Dates, ¼ cup	3.6
Apple with skin, raw, 1 medium	3.3
Banana, 1 medium	3.1
Orange, raw, 1 medium	3.1
Kiwi, 1	2.6
Blueberries, ½ cup	1.7

Table 4 Vegetables/Nuts

Food, Standard Amount	Dietary Fiber (g)
Artichoke, globe, cooked, 1 each	6.5
Sweet potato, baked, with peel, l med.	4.8
(no peel, boiled)	3.9
Mixed vegetables, cooked, ½ cup	4.0
Potato, baked, with skin, 1 med.	3.8
Pumpkin, canned, ½ cup	3.6
Spinach, frozen, cooked, ½ cup	3.5
(fresh, 1 cup yields ~2gms)	
Almonds, 1 oz	3.3
Brussels sprouts, frozen, cooked, ½ cup	3.2
Sauerkraut, canned, solids, liquids, ½ cup	3.0
Tomato paste, ¼ cup	2.9
Winter squash, cooked, ½ cup	2.9
Broccoli, cooked, ½ cup	2.8
Greens (Collards, Turnip), cooked, ½ cup	2.7-2.5
Okra, frozen, cooked, ½ cup	2.6

ORAL, HEAD AND NECK CANCER NEWS

Study Shows Aspirin May Reduce Risk of Head and Neck Cancer

According to the American Cancer Society, the estimated incidence for oral, head and neck cancer in 2007 (oral cavity, oropharynx, hypopharynx, salivary glands, nasopharynx and larynx) is 45,740 new cases or 3% of all cancers. The National Cancer Institute reports that 85% of these cases of head and neck cancer are associated with tobacco use. These statistics do not include cancer of the thyroid, eye and orbit and skin.

In an article published in November of 2006, in the *Archives of Otolaryngology Head and Neck Surgery,* a group of researchers at Roswell Park Cancer institute in Buffalo, NY reported on a hospital-based case-control study that included individuals who had received medical services at the NCI-Designated Comprehensive Cancer Center. During the period from 1982 to 1998, 529 patients with head and neck cancer and 529 hospital control subjects matched by age, sex and smoking status were selected for the study. The frequency and duration of aspirin use of these two groups was classified and reported.

"ASA (Acetylsalicylic acid - commonly known as aspirin) has been shown to inhibit a pathway that is associated with inflammation which is a contributor to many cancers, including lung, head and neck, colon and esophageal" stated Mary E. Reid, an assistant professor of oncology at Roswell Park and a co-author of the study, "Many of these cancers are also associated with smoking. By inhibiting some of the enzymes that promote inflammation, encourage uncontrolled cell growth, and depress the immune response, such as COX-2, known to increase pre-malignant lesions, ASA may slow the processes." Dr Reid also mentioned that there have been many studies evaluating ASA and other cancer sites, including lung, esophagus and colon, the main trials being in colon and esophageal cancer. The National Cancer Institute is presently sponsoring several trials for head and neck cancer patients using other NSAID agents (non-steroidal anti-inflammatory drugs) that inhibit these pathways.

The case group consisted of patients with primary head and neck cancers and no other concurrent primary cancer and no history of malignancy. Cases included carcinoma of the nasopharynx, oral cavity, oropharynx, hypopharynx, larynx and salivary glands. The control group consisted of 529 subjects selected from a pool of 6828 eligible individuals without any diagnosis or history of malignant conditions or benign tumors.

It should be noted that there are some limitations to be considered in interpreting the results of this study. All subjects involved were patients at Roswell Park Cancer Institute, which may not be representative of the general population. However, the characteristics of the case and control groups did show that the distribution of risk factors in the study population were comparable to the well-established results noted in the literature. In addition, to minimize bias of selected subjects from a particular population, the control subjects were randomly selected from a pool of 6,828 eligible individuals.

Results from this study support the hypothesis that aspirin use is associated with a reduced risk of head and neck cancer. In this study, long-term use of aspirin showed a statistically significant 25% reduction in risk of head and neck cancer among some patients. The reduction in risk was observed across all six primary tumor sites studied with a comparatively higher risk reduction for head and neck squamous cell carcinomas, notably oral cavity and oropharyngeal cancers. The study also showed that the most significant risk reduction, 33%, was in the group of subjects who were moderate smokers or moderate drinkers, while individuals who were heavy smokers or drinkers showed no reduction in risk of the disease. The study also demonstrated that the reduction in risk of moderate smokers and drinkers was greater in women than in men.

"There are some risks to taking ASA on a regular basis" said Dr. Reid, "Not everyone can take ASA. Common side effects of this agent are stomach upset and bleeding. People with a history of bleeding disorders, ulcers and stroke are not candidates for daily ASA. These same people cannot take ASA for heart attack prevention."

Although the results of this study are promising, randomized placebo controlled clinical trials with intermediate biological endpoints are needed to confirm the association between aspirin and risk reduction of head and neck carcinoma and to determine an optimal target population for aspirin chemoprevention. Dr. Reid reported that researchers at Roswell Park are in the process of proposing a small NCI-sponsored trial to look at the effect of ASA on biomarkers in head and neck cancer patients.

MEMORIAL GIFTS have been received

In Loving Memory of

Al Burillo
by SPOHNC-SCOTTSDALE
****

Joan "Toots" Busa
by
Jane Davidson, The Delelee Family, James & Christine Raguse, Hannah Nishimoto & Randi Woodrow, Penny Wright
****

Jeanette Decampo
by SPOHNC-PHOENIX
****

James J. Lewis, DDS
by Curt & Audrey Myers
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Peter Mallahan
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Robert L. Randal
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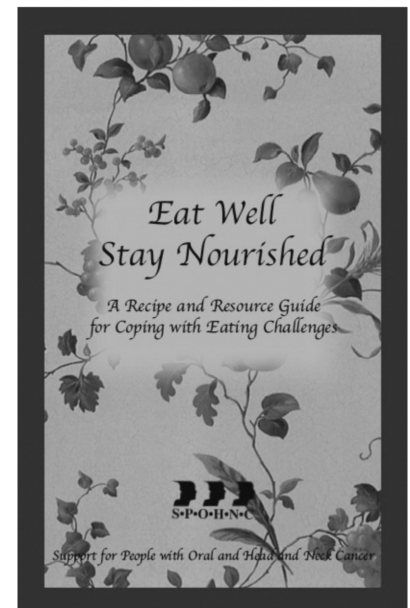
Andrea Upah
by SPOHNC-PHOENIX



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CLINICAL CANCER ADVANCES 2006

Major Research Advances in Cancer Treatment, Prevention, and Screening

HEAD AND NECK CANCER

Cancers of the head and neck—those affecting the nose, mouth, tongue, throat, and larynx—are usually treated with a combination of surgery, chemotherapy, and/or radiation therapy. In the past year, several studies identified new treatment regimens that could slow the growth of head and neck cancers and improve survival for these patients, without causing significant additional side effects. Head and neck cancers have traditionally been very difficult to treat, and these studies represent some of the most significant advances in the management of head and neck cancer in decades.

MAJOR ADVANCE

CETUXIMAB PLUS RADIOTHERAPY IMPROVES SURVIVAL FOR HEAD AND NECK CANCER PATIENTS

A multinational study found that adding the drug cetuximab (Erbitux) to high-dose radiotherapy in patients with locally advanced head and neck cancer slowed cancer growth and prolonged survival, compared with patients who received radiotherapy alone. Cetuximab is a monoclonal antibody that targets the epidermal growth factor receptor in cancer cells, which stimulates cancer cell growth and repair. The time it took for cancer to progress was significantly longer in the cetuximab group: 24.4 vs. 14.9 months. Patients in the cetuximab group also lived longer: 49 vs. 29.3 months. Moreover, the addition of cetuximab produced relatively mild side effects, including an acne-like rash and local reactions to the drug infusion.(1) Cetuximab was approved for the treatment of metastatic colorectal cancer in combination with chemotherapy in 2004. Following publication of this study, the FDA this year approved the drug for use in combination with radiation therapy to treat squamous cell cancer of the head and neck, making it the first drug to be approved for this disease in 45 years. Additional studies are now underway to compare a regimen of cetuximab, platinum-based chemotherapy, and radiation vs. radiation and chemotherapy alone (another commonly-used treatment regimen for this group of patients).

OTHER NOTABLE RESEARCH

ADDING DOCETAXEL TO STANDARD TREATMENT FOR ADVANCED HEAD AND NECK CANCER PROLONGS SURVIVAL

An international, multicenter phase III study showed that patients with locally advanced head and neck cancer who received initial ("induction") chemotherapy that included docetaxel (Taxotere) were 30% less likely to die than patients who received the standard induction therapy (cisplatin and 5-fluorouracil, or PF). All patients in the study had squamous cell carcinomas, which represent about 90% of head and neck cancers. The tumors were all advanced and were located in the larynx, pharynx, or oral cavity.

In the study, 538 patients were randomized between the two treatments. Induction therapy was followed by ongoing chemotherapy and radiation, and for some patients, surgery. Patients were followed for an average of 41.9 months. Researchers found that overall survival for the group at three years was 62.1%, compared with 48.1% for the control group. The majority of late side effects were related to radiation therapy. This trial represents the first large multicenter effort to show that the addition of docetaxel to induction therapy, when followed by chemoradiotherapy, improves survival.(2)

CHEMOTHERAPY AND "RE-IRRADIATION" AFTER SALVAGE SURGERY SLOWS CANCER GROWTH

This study showed that giving the chemotherapy drugs 5-fluorouracil and hydroxyurea with additional radiation therapy to patients who underwent "salvage" surgery for second head and neck cancers or head and neck cancers that had returned extended the time it took for their cancers to grow by 60%, compared with patients who had no treatment after salvage surgery. "Salvage" surgery is the term used to describe surgery to remove cancerous tissue after a tumor has returned, or a new cancer has developed in an area previously treated for cancer. All of the patients had previously received radiation therapy for head and neck cancer. Overall survival did not significantly differ between the two groups.(3)

These data are the first to compare the effectiveness of such "re-irradiation" and chemotherapy in patients with head and neck cancer following salvage surgery. The additional treatment was not associated with significant side effects.

REFERENCES

1. Bonner JA, Harari PM, Giralt J. Radiotherapy plus cetuximab for squamous cell carcinoma of the head and neck. *N Engl J Med. 2006;354:567-78.*

2. Posner MR, Hershock D, Le-Lann L, Devlin PM, Haddad RI. Scientific Special Session: Docetaxel added to induction therapy in head and neck cancer. Presented at: American Society of Clinical Oncology Annual Meeting; June 2-6, 2006; Atlanta, Georgia.

3. Janot F, De Rancourt D, Castaing M, et al. Re-irradiation combined with chemotherapy after salvage surgery in head and neck carcinoma: A randomized trial from the GETTEC and GORTEC groups. *J Clin Oncol.* 2006; 24:18s(abstr 5508).

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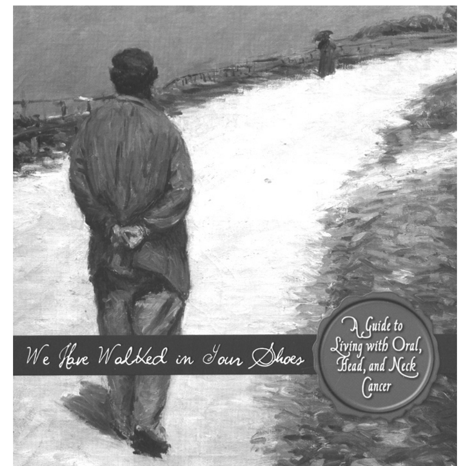

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LOCAL CHAPTERS OF SPOHNC

FOCUS ON SPOHNC - NEW JERSEY-PENNSYLVANIA

In August of 1997, I was diagnosed with insulin dependent diabetes. I scheduled an appointment with an endocrinologist at the University of Pennsylvania Hospital in Philadelphia to get a second opinion. In the meantime, I discovered two large lumps on the left side of my neck. Two months after my initial diagnosis of diabetes, I got to see a new endocrinologist. During my examination, I told him about the lumps on my neck. He immediately scheduled an appointment for me with a head and neck surgeon at the U of Penn. During this examination, it was determined that I had squamous cell carcinoma in my neck. Soon after, I had a radical neck dissection followed by 35 radiation treatments.

All through my treatments I asked my doctors and nurses and anyone else who would listen, "Do you have a head and neck support group?" The answer was always "NO". "We have just a general cancer support group". The closer I became with my health care team, the more questions I asked. Some they answered and some they didn't. Being a persistent person, I felt it was very important that a support group be started for head and neck cancer patients at the U of Penn hospital. My husband, Ben, wajust as persistent as, I regarding such a group

I called SPOHNC and spoke with Nancy Leupold. She gave me the encouragement to keep working on the hospital to get a group started and she gave me some suggestions as to how the doctors could help to get the group underway. She was such an inspiration to me, and I will be forever grateful to her and her staff.

My persistence paid off. And in October of 2000 a head and neck cancer support group was started. The Abramson Family had made a large donation to the U of Penn Cancer Center. As a result, there were monies available to provide us with an administrative person and a social worker along with a room to use in the hospital. At the first meeting, three survivors and their mates along with the two employees from the Abramson Cancer Center met to discuss our experiences. "Thank God we are still here."

The NJ-PA Chapter of SPOHNC has grown considerably since that first meeting. At the present time, we have about 63 members from newly diagnosed patients to 15-year survivors. Doctors, dentists, nurses, nutritionists, spiritual staff and other professionals address our group, which meets on the first Wednesday of each month. Every three or four months group members share their experiences. Nancy has visited our support group twice since we began. And my husband, Ben, is always there to support me and our members.

To all the SPOHNC chapters facilitators let me add, "It does get easier". " Being there to listen is the best support we can give our members".

The Abramson Cancer Center has written several articles about our group. We have often been told that by far, NJ-PA-SPOHNC is the best support group at the hospital.

Micki Naimoli
Founder & Facilitator

****

ARIZONA-PHOENIX
Banner Desert Medical Center
3rd Wednesday: 5:30 PM
Keri Winchester, MS, CCC-SLP 480-512-5604
Keri.Winchester@bannerhealth.com

ARIZONA-SCOTTSDALE
Virginia G. Piper CA Center
3rd. Thursday: 6:30-8:30 PM
Bette Denlinger, MA, RN - 480-838-5194
betneldenlin@cs.com
Sally Kaszilek
skazilek@yahoo.com

ARKANSAS-LITTLE ROCK
Baptist Health Medical Center
2nd Thusday: 7:00 PM
Cathy Peralta - 501-202-1703
cathy.peralta@baptist-health.org

ARKANSAS-NORTHWEST
NWA Cancer Support Home
3rd. Saturday: 10:00 AM-12:00
Jack Igleburger - 479-876-1051/586-4807
tmplnjak@cox.net

CALIFORNIA-LOS ANGELES-UCLA
UCLA Med. Pla., Rad/Onc Conf. Rm. B-265
1st Tuesday: 6:30-8:00 PM
Sabah Qasim, LCSW - 310-825-5707
sakmal@mednet.ucla.edu
Pam Hoff, LCSW--310-825-6134
phoff@mednet.ucla.edu

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

CALIFORNIA-PASO ROBLES
The Wellness Community
1st Tuesday: 6:00 PM
Kenda Kellawan - 805-238-4411
kenda.kellawan@wellnesscommunityhope.org

CALIFORNIA-SAN DIEGO
Valerie Targia - 760-751-2109
valtargia@yahoo.com

COLORADO-DENVER
Porter's Adventist Hospital
Last Thursday: 6:30-8:00 PM.
Virgil Holdridge - 303-798-3041
virgil126@juno.com
Jeanie Curry - 303-778-5832

DC-WASHINGTON
Lombardi Cancer Center.
3rd Monday: 12:15-1:45 PM
Joanne Assarsson, MSW, LICSW - 202-444-3755
assarssj@gunet.georgetown.edu

FLORIDA—BOCA RATON
Boca Raton Community Hospital.
1st Tuesday: 4:00-5:00 PM
Laura Moon, MSW - 561-955-5897
lmoon@brch.com

FLORIDA-ENGLEWOOD
Englewood Community Hospital
3rd. Thursday: 10:30-12:00 PM
Joseph Bauer - 941-474-0099

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
2nd Monday: 6:00-7:00 PM
Carol Glavin, MSW, LCSW - 352-371-86
CGlavin@gru.net
No calls after 9:00 PM, please

FLORIDA-MIAMI
Baptist Hospital
1st Wednesday: 5:30 PM
Annie Garcia-Montes - 786-596-6951
anniegm@baptisthealth.net

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

FLORIDA-SARASOTA
The Wellness Community
2nd. Thursday: 5:30 PM
Joseph Bauer - 941-474-0099
John Kleinbaum, Ph.D.--941-921-5539
hope@wellness-swfl.org

GEORGIA-ATLANTA
St. Joseph's Hospital
2nd Monday: 6:30-8:00 PM
John Sandidge - 404-851-5585
johnsandidge@msn.com

GEORGIA-ATLANTA-Emory
Winship CA Institute (Bldg. G)
Last Monday: 6:30-7:30 PM
Arlene S. Kehir, RN - 404-778-2369
Arlene.Kehir@emoryhealthcare.org

ILLINOIS-CHICAGO
Duchossois Ctr.for Advanced Medicine
2nd Tuesday: 9:30-10:30 AM
Robyn Egan - 773-834-2470
regan@medicine.bsd.uchicago.edu

LOCAL CHAPTERS OF SPOHNC

ILLINOIS-MAYWOOD
The Cardinal Bernardin Cancer Ctr.
3rd. Wednesday alternate mo.: 6:00-7:00 PM
Marilyn Myles - 708-327-2061
mmyles@lumc.edu

INDIANA-INDY NORTH
Marion County Public Library
Lawrence Branch
3rd. Tuesday: 7:00-9:00 PM
John Groves - 317-872-6674
Jgroves14@comcast.net

INDIANA-INDY SOUTH
St. Francis Education Center
1st. Thursday: 7:00 PM
Janice Leak, MSN, APRN-BC, AOCN
317-782-7604
Janice.Leak@ssfhs.org

KANSAS-KANSAS CITY
Univ. of Kansas Hospital
2nd & 4th Wednesdays: 4:00 - 5:00 PM
Mary Moody - 913-588-3630
mmoody@kumc.edu
Dorothy Austin, RN, OCN - 913-588-6576
daustin@kumc.edu

LOUISIANA-BATON ROUGE
American Cancer Society
2nd to last Tuesday: 6:30 PM
Krystal k. Sauceman, RN - 225-572-7943
KKS.BR@yahoo.com

MARYLAND-BALTIMORE-JHMI
Johns Hopkins – Greenspring Station
2nd. Wednesday: 7:00-8:30 PM
Kim Webster - 410-955-1176
Kwebst@jhmi.edu
Dwayne Arehart: 717-615-7464

MASSACHUSETS-BOSTON
Massachusetts General Hospital,
One Tuesday each mo.: 6:30-8:00 PM
Valerie Hope Goldstein - 617-731-1703
Fernval@aol.com

MICHIGAN-DETROIT
Henry Ford Hospital
Josephine Ford Cancer Ctr. Rm. 2038D
1st Wednesday: 11:30 AM
Amy Orwig, MSW - 313-916-7578
aorwig1@hfhs.org

MICHIGAN-TROY
Wilson Cancer Resource Center
4th Thursday: 6:30 PM
Suzanne Frantz, RN, CNOR - 586-228-2309
sfrantz@beaumonthospitals.com

MINNESOTA-MINNEAPOLIS
The Lymphedema Center
4th Monday: 7:00-9:00 PM
Colleen M. Endrizzi - 952-545-0200
rivers3jvk@aol.com

MISSOURI-ST. LOUIS
David C. Pratt Cancer Center
4th Wednesday/alternate months
10:00-11:30 AM
Carol Murphy, LCSW - 314-251-6569
murpck@stlo.mercy.net

MONTANA-BOZEMAN
Bozeman Deaconess Hospital
3rd. Thursday: 12:00 Noon-1:00 PM
Doug Stiner - 406-586-0828
nancydoug@theglobal.net
Wendy Gwinner, LCSW--406-585-5070
wgwinner@bdh-boz.com

N. CAROLINA-CHARLOTTE
Blumenthal 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

NEBRASKA-OMAHA
Methodist Cancer Center
1st Friday: 3:00 PM.
Susan Stensland - 402-559-4420
sstensland@nebraskamed.com

NEBRASKA-OMAHA
Nebraska Medical Center
3rd Friday: 3:00 PM
Susan Stensland - 402-559-4420
sstensland@nebraskamed.com

NEW JERSEY, LONG BRANCH
Leon Hess Cancer Center
The Goldsmith Wellness Center
2nd Thursday: 7:00-8:00 PM
Becky Kopke, RN, BSN, OCN - 732-923-6473
BKopke@SBHCS.com
Anita M. Pfisterer, MSW, LSW - 732-923-6961
ampfisterer@aol.com

NEW JERSEY, MORRISTOWN
Morristown Memorial Hospital
3rd Wednesday: 1:30 PM
Howard Sakolsky - 973-586-3522
hesakolsky@aol.com

NEW JERSEY/PENNSYLVANIA
University of Pennsylvania Hospital
1st Wednesday: 9:30-11:00 AM
Micki Naimoli - 856-722-5574
Stefanie Washburn - 215-615-0536
Stefanie.washburn@uphs.upenn.edu

NEW JERSEY-TOMS RIVER
Community Medical Center
Last Thursday: 3:00 PM
Sherry Laniado, MSW, LCSW - 732-557-8
slaniado@sbhcs.com

NEW MEXICO-ALBUQUERQUE
Christ Unity Church
3rd Friday: 4:30-5:30 PM
Anita Bryan - 505-681-1971
anitabeach2@yahoo.com

NEW YORK-MANHATTAN
Beth Israel Head and Neck Institute
4th Tuesday: 1:30-3:30 PM
Jackie Mojica - 212-844-8775
jmojica@chpnet.org

NEW YORK-ROCHESTER, NY
Strong Memorial Hospital
1st. Thursday: 4:00-5:30 PM
Sandra E. Sabatka, LMSW - 585-275-4631
Sandra_Sabatka@URMC.Rochester.edu

NEW YORK- EAST SETAUKET
Stony Brook Physicans
1st. Wednesday: 7:30-9:00 PM
Dennis Staropoli - 631-682-7103
Den.star@hotmail.com

NEW YORK-SYOSSET, NY
NSLIJ-Syosset Hospital
2nd Thursday: 7:30-9:00 PM
Nancy Leupold - 516-759-5333
nleupold@spohnc.org

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd Thursday: 7:00 PM
Mark Tenzer - 914-472-3397
tenzer1@optonline.net

OHIO-CLEVELAND
Cuyohoga County Public Library
2nd Saturday: 10:00 AM
Tom Wurz - 440-243-6220
TomRoe8@adelphia.net

OHIO-COLUMBUS
The James Cancer Hospital &
Solove Research Institute
1st. Monday: 3:30-5:30 PM
Vicki Heinke, LISW - 614-293-7042
Vicki.Heinke@osumc.edu

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

PENNSYLVANIA-MECHANICSBURG
Health South Lab
Every 3rd. Month/3rd. Tues.: 6:30 PM
Joseph F. Brelsford - 714-774-8370
Jfbrelsford1@mmm.com

TEXAS-DALLAS
Baylor Irving-Coppell Medical Center
2nd Saturday: 10:00 AM
Dan Stack - 972-373-9599
danrstack@aol.com

TEXAS-DALLAS
Cvetko Ctr. at Sammons Cancer Ctr.
2nd Tuesday: 11:00 AM-12:30 PM
Jack Mitchell - 972-496-6561
jackmitchell5225@aol.com
Travis Mitchell - 214-820-2608
travism@BaylorHealth.edu

TEXAS-FORT WORTH
Moncrief Cancer Resources
2nd Wednesday: 3:30-5:00 PM
Valerie Oxford, MSSW
817-927-6364/838-4863
Valerie.Oxford@moncrief.com

TEXAS-HOUSTON/TOMBALL
Tomball Regional Hospital
2nd. Thursday: 12:00 noon-1:30 PM
Lynda Tustin, RN - 281-401-5900
ltustin@tomballhospital.org

VIRGINIA-CHARLOTTESVILLE
Dept. of Forestry Building, Suite 800
Last Thursday: 12:00 noon-1:00 PM
Vikki Bravo - 434-982-4091
vsb4n@virginia.edu

VIRGINIA-FAIRFAX
Inova Fairfax Hospital, Radiation/Oncology
2nd Wednesday: 5:30-7:00 PM
Corine Cook, LCSW - 703-776-2813
Corinne.cook@inova.com

WISCONSIN-MADISON
Univ. of Wisconsin Hospital
ENT Clinic Rm. G3/206
1st. Wednesday: 11:30-1:00 PM
Rachael Kammer, MS, CCC, SLP
608-263-4896
Kammer@surgery.wisc.edu

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