

# NEWS FROM S•P•O•H•N•C



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SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER

SEPTEMBER 2008



## CARCINOMA OF THE TONSIL AND OROPHARYNX

RODRIGO BAYON, M.D.  
BARRY L. WENIG, M.D., M.P.H., F.A.C.S.

### Epidemiology

Cancer of the oropharynx is an uncommon disease with only about 5,000 cases being diagnosed annually in the United States. Recent studies have shown that the overall rate of oropharyngeal cancer has remained stable (1.5 per 100,000 people) in the United States. However, it now accounts for a larger percentage of all head and neck malignancies, rising from 17% to 22% over the last twenty years. A change in demographic characteristics has also been noted. Head and neck cancers have traditionally been diagnosed in the age group of 60 years or older. However, recently more and more cases are presenting in the third, fourth and fifth decades of life. A subset of these patients does not have the risk factors classically associated with head and neck carcinomas, with a role for viral infection being postulated. While traditionally a disease seen primarily in men, recent trends show a significant change in the ratio of males to females developing head and neck malignancies

Many lifestyle, environmental and genetic factors are implicated as important etiologic agents in the development of carcinomas of the upper aerodigestive tract. Tobacco, in the form of cigarettes, pipe, cigar or the smokeless variety, is implicated in a specific dose-response relationship. Alcohol has been demonstrated to be not only an independent risk factor, but it also creates a synergistic effect with tobacco. The mechanism for this synergy is thought to be related to alcohol's irritant effect on the mucosa, which increases the permeability of the carcinogens found in tobacco. Radiation therapy, often used to treat head and neck malignancies, is known to induce mucosal cancers of the upper aerodigestive tract.

In recent years, there has been a growing association between the human papilloma virus (HPV) and oropharyngeal cancers. Human papilloma virus has been previously shown to be an important risk factor in development of cervical cancer in women. However, increasing evidence has demonstrated a role for HPV in head and neck malignancies. The overall prevalence is estimated to be anywhere from 11% to 44%. However, its impact in the oropharynx is much higher, with HPV markers found in up to 50% of tongue base cancers and 20-100% of tonsillar cancers. The mechanisms by which this virus induces changes that result in cancers are still being evaluated.

### Anatomy and Physiology of the Oropharynx

The oropharynx is the anatomic space directly behind the oral cavity. With regard to head and neck malignancies, the most important structures found within the oropharynx include the soft palate above, the palatine arch and tonsils laterally and the base of the tongue below. The tonsil itself is made up of lymphoid tissue that fills the tonsillar fossa and is covered by a layer of mucous membrane. The free surface varies considerably in appearance and is made up of a large number of crypts that often act as locations where food may get trapped. The retromolar trigone which is the area overlying the ascending ramus (a portion of bone) of the mandible is technically located within the posterior oral cavity and not within the oropharynx. However, tumors in this region behave in a manner similar to those of oropharyngeal origin yet those arising in the retromolar trigone tend to be of more advanced staging at presentation due to direct mandibular involvement.

The oropharynx plays an important role in the proper function of multiple processes in the human body. The soft palate allows for proper speech production by regulating the amount of air that escapes through the nose. In addition, it prevents regurgitation of liquids and food into the nose during swallowing. The tongue base is also an integral part of the swallowing mechanism along with the pharyngeal walls, which serve to propel food into the esophagus. Dysregulation of these mechanisms can impact speech, swallowing and protection of the airway.

### Evaluation of Oropharynx Cancer

Early tumors of the oropharynx are remarkably asymptomatic with the tumor often reaching a considerable size before any symptoms appear. The earliest complaints are usually related to a feeling of vague discomfort and soreness in the throat. Pain, either localized to the throat or radiating to the ear, remains the most common presenting symptom. A large percentage of patients may present with an asymptomatic neck mass. Symptoms such as hoarseness, weight loss, difficulty in swallowing and difficulty in opening the mouth often indicate progression of the cancer to a more advanced stage.

Patients presenting with any combination of these symptoms

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should be referred to a qualified head and neck surgeon. A thorough history and physical examination is essential to identify the source of the problem and to help in the staging and treatment planning. The exact location, size and extent of tumor must be noted at this time. The neck must be palpated to evaluate the possibility of cervical metastases and even direct tumor extension into the neck. Studies have demonstrated that between 45% and 78% of patients with oropharyngeal tumors have neck metastases at the time of presentation and up to 20% will have bilateral metastases. Direct visualization will readily identify the majority of cancers. Indirect mirror or fiberoptic examination is often a helpful adjunct in identifying the inferior extent of the tumor. Trismus or difficulty in opening the mouth, decreased mobility of the tongue on protrusion and loss of sensation over the chin are all indicators of deep muscle or bone involvement.

As the tumor is usually readily accessible at the time of physical examination, a biopsy may be performed at that time. If there is concern for neck metastasis, a fine needle biopsy of the suspicious neck mass may be performed as well. If surgery is to be performed, this complete evaluation known as triple or pan-endoscopy can be carried out at that time. This procedure is essential even if surgery is not considered as a treatment option since approximately 10 - 15% of malignancies are multicentric in nature.

Prior to initiating treatment, it is extremely useful to obtain radiographic evaluation. Plain radiographs are of little utility in the head and neck, although chest radiographs have been standard of care to evaluate for lung involvement. Spiral CT of the chest, however, is now becoming a routine part of the work up. CT scan or MRI are essential tools in evaluating tumor size and stage and are in many ways complementary with regards to the information that is obtained. Routinely a CT scan of the neck with intravenous contrast is ordered to evaluate both the primary site as well as evaluate for the presence of neck metastasis. However, in the oropharynx details are often obscured by artifact created by dental fillings. In this setting, MRI provides more insight into the extent of the cancer. In addition, MRI is more sensitive in evaluating the degree of soft tissue involvement, including the degree of prevertebral muscle invasion, involvement of nerves and the extent of tongue involvement by tumor. Bony invasion however is best evaluated with CT. Both CT and MRI are equally useful in determining the involvement of cervical lymph nodes.

Positron Emission Tomography (PET) has become another tool used by the head and neck surgeon to evaluate cancers. This study uses a radioactive sugar injected intravenously to detect cancer cells, which take up this sugar more avidly than normal cells. Studies looking at head and neck cancers have demonstrated that this is not cost effective in the initial work up. However it does provide useful information in the setting of questionably enlarged lymph nodes as well as the evaluation of recurrent/persistent disease, distant metastasis or occult primary cancers.

**Treatment of Oropharynx Cancer**

Therapeutic options are a function of staging of the tumor, the presence or absence of associated disease, the psychological attitude of the patient and family, the philosophy of the treating physician and the facilities that may be available. Optimal treatment requires an interdisciplinary approach with the participation of a head and neck surgeon, medical

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oncologist, radiation oncologist and speech-language pathologists.

Early stage tumors are usually treated with a single modality, and can be handled equally successfully by either radiation therapy or surgery alone. The surgical alternatives for early lesions include resection either through an intraoral approach or, more aggressively, using a mandible sparing approach such as a lateral or transhyoid pharyngotomy or a mandible splitting procedure. The boundaries of the intraoral approach have been pushed with the advent of trans-oral laser surgery. This technique allows for a wider field of resection, intraoperative examination of margins to assure clearance of disease, and avoids the morbidity of more extensive approaches. However, it is currently practiced only by a select group of head and neck surgeons in the United States.

Advanced stage lesions often involve the mandible due to its close proximity. Traditionally, advanced stage disease requires multimodality treatment with surgery and radiation in some combination. The surgery may either be mandible sparing or may require sacrifice of a portion of the bone with the neck being addressed with either approach. If a portion of the mandible is resected along with the tumor and neck contents, this is called a composite resection.

Much of the morbidity and deformity that once was associated with these procedures has been reduced with advances in reconstruction of these defects. A wide variety of reconstructive options are available to close the surgical defects and allow for improved form and function. The introduction of free tissue transfer, where tissue is harvested from a distant site such as the leg, abdomen or forearm, has revolutionized reconstructive surgery. This not only allows for better reconstructive outcomes but also allows surgeons to perform a more complete resection without fear of inability to reconstruct the ensuing defect. After surgery, postoperative radiation therapy is given to enhance the chance of cure and consists of 5 sessions per week over a six to seven week period.

Recently, attention has been given to organ sparing therapy which combines the use of chemotherapy and radiation therapy. This unique approach has been reported to have success that rivals that of the more traditional surgery-radiation therapy without the deforming nature of surgery that is often an integral part of cancer treatment. Multiple prospective trials

have demonstrated an equal or improved rate of failure and disease free survival. However, these same studies have also demonstrated a high rate of toxicity and complications associated with concurrent chemotherapy and radiation which rival or exceed that of surgical intervention.

#### The Future

Research in the field of head and neck oncology continues to develop new ways of treating, and hopefully one day preventing cancer. Advances in technology are allowing surgeons to access and treat disease more aggressively in less invasive and deforming ways. Robotic surgery has been widely accepted in other fields including urology and cardiothoracic surgery. The introduction of trans-oral robotic surgery holds promise and is currently being employed at a select number of institutions. In addition, as understanding of the genetics and molecular biology of tumors becomes better understood, alternatives to traditional chemotherapeutic agents are being developed. This includes the use of agents to block specific molecular receptors known to be important to the growth of tumor cells and creation of cancer vaccines. Lastly, the recent development of an HPV vaccine for prevention of cervical cancer in women has potential application for the prevention of cancers of the oropharynx. Clinical trials are currently being developed to investigate its use in head and neck cancer.

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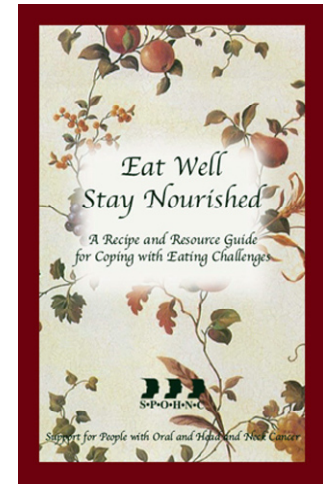
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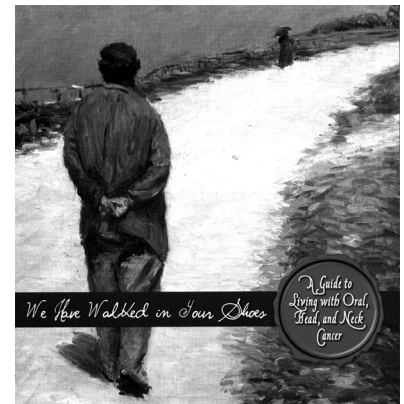
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## A TIME FOR SHARING...A Second Chance

When we were kids and things didn't work out quite as we thought they should, the situation was easily rectified by simply declaring, "Overs" or "Do-Over" and that gave us another chance to achieve success. Wasn't that a great way to take a bad situation and turn it around to our liking?

How often in this life are you honestly given a second chance? Wouldn't it have been wonderful when you received your cancer diagnosis if you could have just declared, "OVERS!". Stop right there and do it over. Do it over till they get it right. Do it till you get a negative biopsy report, a clean scan, no sign of a lump, no tumor and no problem.

Well we now know, life just isn't that simple. You can't turn the clock back and you can't undo what has been done by nature. You have to accept it, with all the consequences, and make the best of it. We all go through those series of emotions linked to a cancer diagnosis which include denial (not me), questioning (why me), self-pity (woe is me), guilt (what did I do to deserve this), bargaining, sadness and possibly the most significant of all, the realization of our own mortality.

We are forced to face our mortality. It comes home to us in an unabashedly clear manner. Possibly for the first time in our lives, we come face to face with the grim reaper. In the past, we've discussed death, what we think it may be, what it would be like, how it would come to us and perhaps, even joked about what we would do when the day came. Now, we are coldly faced with the fact and we lose our jovial attitude when you meet it face to face or mano y mano.

Having gone down into the bowels of hell and back, we survive. We have suffered the course of treatment and we've come out the other side, often times stronger than when we entered. We have WON. We whipped it and we stayed on this side of the grass in the process. What a feeling of accomplishment? What joy? What a second chance to be afforded?

Yes, a second chance. This is our do-

over; when all the trials and challenges of cancer are behind us and we have time to reflect. Reflect on what we have endured, reflect on our life B.C. (Before Cancer), and reflect on just how fleeting life can be. What we once feared, we now contemplate. What was once an event for the future, is suddenly brought into the present.

How do you recognize your second chance? Once you've come to grips with the totality of your situation, you notice things you never noticed before. You appreciate things anew that heretofore you took for granted. You now see the beauty in every sunrise and sunset, you marvel at the dew on the grasses, you are amazed at the blooming of a flower, you hear birds singing that you never noticed before, a baby's babble brings you joy, you love more deeply and you appreciate more spiritually.

### *Live wide and deep, my friends, and enjoy every minute of your Second Chance.*

Sentimental is now one of your personality attributes.

We often become keenly aware of and highly sensitive to the whole of our existence and the value of life and the living. We rejoice in our family and we realize how treasured our friends are. Very little is taken for granted or taken at face value anymore. Everything has a much deeper meaning and we marvel at the complexities of the world and our relationships.

For a lot of survivors, the change is magical. It's as if they are re-born, their whole personality changes. They are more tolerant, less on the edge, smile more often, cry a bit easier, laugh much harder and love more fiercely. They realize the value of a friendly gesture, a sparkling smile, a warm handshake, an honest hug, a comforting word and a cheery attitude.

For some, it's using the nice china plates and crystal glasses for an ordinary dinner.

It's wearing that suit coat to church that you've been saving for a special occasion. It's a lady wearing that expensive scent to the supermarket that she's been saving for a special night out. It's an attitude to not put off, hold back or save anything. It's live for the moment and you enjoy the moment you live. It's being more spontaneous and acting from your heart. It's living life to its fullest and wringing every bit of pleasure out of it.

So if you're one of us who are fortunate enough to have earned a second chance, make the most of it. Put your challenges and memories behind you and revel in the dawn of your second chance. Love like you've never been hurt, sing like there's no one listening, dance like there's no one watching and live like it's heaven on earth.

In the words of the humorist, Evan Esar, "We can't do much about the length of our lives, but we can do plenty about its width and depth".

Live wide and deep, my friends, and enjoy every minute of your Second Chance.

Larry Menkhoff  
Arlington, Texas

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**David I. Rosenthal, MD, F.A.C.R.**  
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Dr. Rosenthal was awarded the degree of Fellow of the American College of Radiology on May 18, 2008 in Washington, DC.

## SURVIVORS IN THE NEWS HELP FOR THE LONG HAUL

### Throat Cancer Survivor Starts Support Group After Getting Help From Man In Virginia



Richard Boucher sits with his dog, Olive, at his Jacksonville home, talking about the support group he helped organize for people recovering from oral, head and neck cancers.,,.,*Jamie Lusch*

Bill Kettler, February 18, 2008: There's no "good" place to get cancer, but Richard Boucher discovered some places are worse than others.

Boucher was just 44 and living in California when doctors discovered advanced cancer in his throat. They bombarded him with radiation to kill the cancer cells and poisoned them with chemo. They also removed cancerous lymph glands and muscle tissue in his neck.

"Any diagnosis of cancer is life changing," he says, sitting in the kitchen of his Jacksonville home. "But head and neck cancers are particularly complicated because they grow so quickly."

Physicians often have to treat such cancers aggressively, and the side effects can be devastating because so many critical body structures that affect quality of life are in the head and neck. Patients often lose the ability to swallow. Some lose all or part of their jaw or suffer other disfigurement. Many struggle with huge volumes of mucus as the body tries to repair damage caused by the drugs and radiation. Some never regain their sense of taste, or the ability to swallow.

"The treatment itself is a source of despair," Boucher says. "The radiation gave me the worst sore throat you can imagine. Eating

became a totally joyless exercise.

"By the end of my last radiation treatment I was absolutely at the end of my rope," he says. "I couldn't do another one."

Doctors gave Boucher a 30 percent to 50 percent chance of surviving back in 2000 when he was diagnosed. He beat the odds and drew strength along the way from a man in Virginia, who had survived a similar cancer.

"Being able to communicate with a survivor was a wellspring of solace," Boucher says. "George was a font of advice for how to deal with the many side effects of treatment, and he was incredibly generous with his time."

Boucher met George through an organization known as SPOHNC — Support for People with Oral and Head and Neck Cancer Inc. When he moved to Southern Oregon he was surprised to discover there wasn't a local SPOHNC chapter, so he decided to organize one.

"I started the group because the support I had from a survivor was profoundly helpful," he says. "I owe a debt to that guy in Virginia, and I'm paying it forward."

The group meets the second Friday of every month at Providence Medford Medical Center. There's a presentation on some aspect of treatment or recovery, and patients share their stories.

"The need was definitely there," says Kimberly Morley, an oncology nurse at Providence. "The treatment for head and neck cancers is so significant that support and ongoing care is really necessary."

"What's neat about the group is there are survivors and people in treatment," Morley says. "Someone who's in treatment can see those who are three or six months out (after treatment) or a year, or three years or five years

#### "Survivors in the News"

Have you had a story appear in your local newspaper or magazine at sometime in the past? Send us a copy of the article with or without a photo or direct us to the newspaper's web site. We will contact the newspaper for reprint permission and include your story and photo in our new section of the newsletter.

or 10 years out, and they can see there's hope for recovery."

Doctors and nurses often attend the meetings, and answer questions from patients. "We're in the periphery," Morley says, "but they find that very supportive." Boucher says the group gives hope to people who are in treatment.

"It's important to see you can survive throat cancer," he says. "When you get a diagnosis like that it's easy to let despair rear its ugly head, and despair can be fatal."

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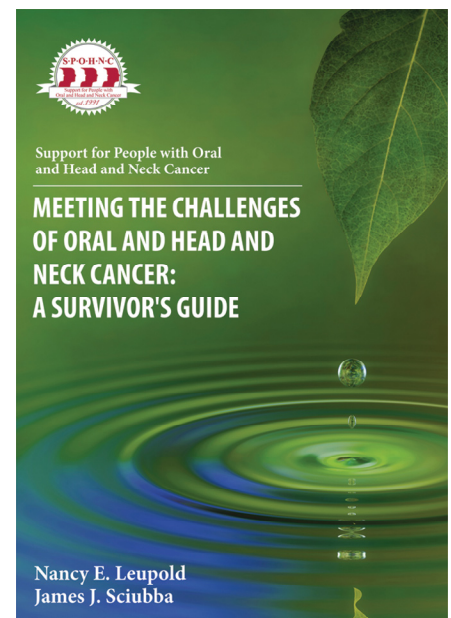
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**Bonnie Martin-Harris, PH.D.** is Professor in the College of Medicine, Department of Otolaryngology-Head and Neck Surgery, College of Health Professions, Department of Communication Sciences and Disorders, and College of Dental Medicine at the Medical University of South Carolina directs the MUSC Evelyn Trammell Institute for Voice and Swallowing. Her expertise in voice and swallowing disorders is evident in her research, clinical and educational roles at regional, national, and international levels. Dr. Martin-Harris chairs the Specialty Board for Board Recognition in Swallowing and Swallowing Disorders, and is President of the Dysphagia Research Society. Dr. Martin-Harris's clinical and research interests are focused in the areas of laryngeal and pharyngeal dynamics during swallowing, respiration and vocalization. She is Associate Editor of the *Journal of Speech-Language-Hearing Research*, an Editorial Board member for the *Dysphagia Journal* and *Bulgarian Journal of Communication Disorders* and also serves as a content reviewer for numerous medical and communication journals. She is a national lecturer, and has published chapters and articles in the areas of aerodigestive tract function and disorders. She is a Fellow of the American Speech Language and Hearing Association (ASHA), recipient of Honors from the South Carolina Speech-Language-Hearing Association (SCHA), and associate member of the Academy of Otolaryngology-Head and Neck Surgery and the American Head and Neck Society.



**Randal S. Weber, M.D., FACS**, is an internationally recognized head and neck surgeon and expert in the treatment of patients with head and neck cancer. He is Professor and Chair of the Department of Head and Neck Surgery at The University of Texas, M.D. Anderson Cancer Center in Houston, Texas. After earning his medical degree, he completed a surgery internship at the National Naval Medical Center in Bethesda, Maryland, and residencies in surgery and otolaryngology at Baylor College of Medicine in Houston. He received specialized training in head and neck surgical oncology at M. D. Anderson Cancer Center and later joined the M. D. Anderson faculty, with a joint appointment at Baylor College of Medicine. He served as Professor and Vice Chair of the Department of Otorhinolaryngology-Head and Neck Surgery at the Hospital of the University of Pennsylvania from 1996 to 2003 and then returned to M. D. Anderson to accept the post as Chairman. In addition to maintaining a busy surgical practice, Dr. Weber is active in clinical research and is closely involved in training young physician-scientists. He is a prolific author in head and neck medicine and a sought-after lecturer both nationally and internationally. He is on the editorial boards of several international journals, including *Cancer*, *Journal of Clinical Oncology*, and *Head & Neck*. Dr. Weber has consistently been named one of America's Top Doctors by the Castle Connolly Guide. His clinical interests are non-melanoma skin cancer, thyroid cancer, and therapeutic strategies for organ preservation.

### *Gifts Have Been Received in Loving Memory*

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## HEAD AND NECK CANCER NEWS

### Acupuncture Reduces Pain and Dysfunction in Head and Neck Cancer Patients after Neck Dissection

NEW YORK, NY, May 31, 2008. New data from a randomized, controlled trial found that acupuncture provided significant reductions in pain, dysfunction, and dry mouth in head and neck cancer patients after neck dissection. The study was led by David Pfister, MD, Chief of the Head and Neck Medical Oncology Service, and Barrie Cassileth, PhD, Chief of the Integrative Medicine Service, at Memorial Sloan-Kettering Cancer Center (MSKCC). Dr. Pfister presented the findings today at the annual meeting of the American Society for Clinical Oncology.

***“Acupuncture can control a number of distressing symptoms, such as shortness of breath, anxiety and depression, chronic fatigue, pain, neuropathy, and osteoarthritis.”***

...Barrie Cassileth, PhD

Neck dissection is a common procedure for treatment of head and neck cancer. There are different types of neck dissection, which vary based on which structures are removed and the anticipated side effects. One type - the radical neck dissection - involves complete removal of lymph nodes from one side of the neck, the muscle that helps turn the head, a major vein, and a nerve that is critical to full range of motion for the arm and shoulder.

“Chronic pain and shoulder mobility problems are common after such surgery, adversely affecting quality of life as well as employability for certain occupations,” said Dr. Pfister. Nerve-sparing and other

modified radical techniques that preserve certain structures without compromising disease control reduce the incidence of these problems but do not eliminate them entirely. Dr. Pfister adds, “Unfortunately, available conventional methods of treatment for pain and dysfunction following neck surgery often have limited benefits, leaving much room for improvement.”

Seventy patients participated in the study and were randomized to receive either acupuncture or usual care, which includes recommendations of physical therapy exercises and the use of anti-inflammatory drugs. For all of the patients, at least three months had elapsed since their surgery and radiation treatments. The treatment group received four sessions of acupuncture over the course of approximately four weeks. Both groups were evaluated using the Constant-Murley scale, a composite measure of pain, function, and activities of daily living.

Pain and mobility improved in 39 percent of the patients receiving acupuncture, compared to a 7 percent improvement in the group that received usual care. An added benefit of acupuncture was significant reduction of reported xerostomia, or extreme dry mouth. This distressing problem, common among cancer patients following radiotherapy in the head and neck, is addressed with only limited success by mainstream means.

“Like any other treatment, acupuncture

does not work for everyone, but it can be extraordinarily helpful for many,” said Dr. Cassileth. “It does not treat illness, but acupuncture can control a number of distressing symptoms, such as shortness of breath, anxiety and depression, chronic fatigue, pain, neuropathy, and osteoarthritis.”

“Cancer patients should use acupuncturists who are certified by the national agency, NCCAOM [National Certification Commission for Acupuncture and Oriental Medicine], and who are trained, or at least experienced, in working with the special symptoms and problems caused by cancer and cancer treatment,” she added.

Acupuncture, a component of Traditional Chinese Medicine, originated more than 2,000 years ago. Treatment involves stimulation of one or more predetermined points on the body with needles, heat, pressure, or electricity for therapeutic effect. A report published by the Centers for Disease Control (CDC) indicated that more than 8 million Americans use acupuncture to treat different ailments. Acupuncture is being used in the palliative care of cancer to alleviate pain and chronic fatigue and to reduce postoperative chemotherapy-induced nausea and vomiting.

*The study was funded in part from a grant by the National Cancer Institute. In addition to Drs. Pfister and Cassileth, other MSKCC contributors to the study include: Dr. Andrew Vickers, Dr. Gary Deng, Ms. Jennifer Lee, Mr. Donald Garrity, Dr. Nancy Lee, Dr. Dennis Kraus, Dr. Ashok Shaha, and Dr. Jatin Shah.*

### Quality of Life Predicts Cancer Survival, U-M Study Finds Assessment Could Help Identify More Aggressive Head and Neck Tumors

ANN ARBOR, Mich. — Head and neck cancer patients who reported lower physical quality of life were more likely to die from their disease, according to a new study from the University of Michigan Comprehensive Cancer Center. The findings could mean that identifying patients with poor quality of life could also identify patients with particularly aggressive tumors.

“Low quality of life may have value in screening patients for recurrence. By identifying patients with poor quality of life, we may also be able to identify early on those who have particularly aggressive tumors,” says lead study author Carrie A. Karvonen-Gutierrez, M.P.H.,

research associate at the U-M School of Public Health and the VA Ann Arbor Healthcare System.

Results of the study appear in the June 1 issue of the *Journal of Clinical Oncology*. The researchers surveyed 495 people at four hospitals who had been diagnosed with head and neck cancer within the previous two years. Participants responded to questions about physical and emotional quality of life, including pain, eating and swallowing, speech and emotional well-being.

The researchers found that general physical health and quality of life issues were highly

associated with survival. And in particular, patients who reported difficulty with pain, eating and speech were significantly less likely to survive. The researchers suggest that pain and declines in other physical quality of life measures could be a marker for cancer recurrence.

“Our findings validate the concept that doctors have long recognized: that persistent or increasing pain is a worrisome clinical finding. Perhaps in the future, quality of life data will be routinely collected in a standardized way, and trends in pain scores will trigger more aggressive examinations for cancer

U-M STUDY continued on page 8

## Take a Bite Out of Trismus - Early Detection and Treatment of Limited Mouth Opening Associated with Radiotherapy

Lori Burkhead PhD, CCC-SLP

When embarking on radiotherapy for oral, head or neck cancer, the focus is usually on the details of treatment and cure rather than the possible side effects. Nevertheless, there are a host of side effects that may occur and can impact individuals to differing degrees. One possible side effect of radiotherapy is trismus, or limited mouth opening. This is thought to be due to fibrosis, which is a change in tissues from radiotherapy that causes the muscles to stiffen. This condition has been reported to affect approximately half of patients who have undergone radiotherapy (with or without chemotherapy) to the mouth or upper throat.

An obvious problem encountered with trismus is a limitation on what one is able to eat. Mild trismus might limit someone from being able to bite into a sandwich or an apple. Severe trismus might interfere with taking even small bites of food from a spoon or fork and can even hinder one's ability to speak clearly. In addition, limited mouth opening can interfere with practicing good oral hygiene, which is important to maintain throughout treatment. Adequate mouth opening is essential for the physician to thoroughly examine the oral cavity, a vital part of cancer surveillance.

Pain may accompany the stiffness that limits jaw opening or might even cause it. A common reaction to pain is guarding. This is a natural reaction to limit movement and increase muscle tension in an attempt to lessen or avoid pain. Unfortunately, this can start a vicious cycle. When movement is limited voluntarily, this can

actually lead to more stiffness and muscle shortening that can, in turn, limit function and result in more pain and dysfunction. The best way to keep things moving is quite simple...just keep moving!

Doing at least some sort of range-of-motion exercises for the jaw is better than doing nothing; however, there is one type of exercise that has been shown to be most effective for treating trismus. This exercise is called passive range-of-motion. During passive range-of-motion, muscle that is being stretched is relaxed and the joint is mobilized to stretch the muscle passively (e.g., relaxing the mouth and manually opening the jaw). This is different than active range-of-motion, where in one uses the muscle to move the joint (e.g., opening the mouth as



wide as possible). Passive range-of-motion can be achieved with a device called the Therabite® Jaw Motion Rehabilitation System™ (Atos Medical). This device was designed specifically to provide a passive stretch to jaw-moving muscles. While one may use a stack of tongue depressors or other objects between the teeth or gums to hold the jaw open, research studies have shown that the more progressive and even pressure applied during the passive stretch

that is provided with a Therabite yields greater mouth opening in a shorter amount of time.

The key to combating trismus is early identification and treatment. Mouth opening may be limited prior to treatment due to tumor bulk or pain. Once treatment begins, mouth opening may improve as the tumor size decreases only to then get worse as muscle fibrosis sets in. On the other hand, some may have normal mouth opening that worsens with the onset of fibrosis from radiotherapy. In either case, jaw range-of-motion should be monitored carefully. Normal mouth opening in adults is approximately the same as three fingers held together between the upper and lower teeth, or 5 centimeters. Any departure from normal range-of-motion should be reported to the physician and a passive range-of-motion exercise regimen should be instituted as soon as possible. This is usually done with a Physical Therapist or Speech-Language Pathologist.

Radiotherapy is an effective method for fighting oral, head and neck cancers, but is often accompanied with some lingering side effects. Although trismus can be a frustrating consequence that accompanies radiotherapy, the negative impact of it can be minimized or even eliminated with early identification and treatment. As with any treatment, self-education and awareness is key.

*Editor's Note: Lori Burkhead PhD, CCC-SLP is Assistant Professor in the Department of Otolaryngology at the MCG Center for Voice and Swallowing Disorders, Medical College of Georgia.*

### U-M STUDY continued from page 7

recurrence," says study author Sonia A. Duffy, Ph.D., R.N., a research scientist at the VA Ann Arbor Healthcare System, associate professor of nursing at the U-M School of Nursing and research assistant professor of otolaryngology at the U-M Medical School.

"While patients are monitored and screened after cancer treatment, small recurrences of cancer may be difficult to detect, even with standard imaging techniques. But, for example, small islands of cancer near a nerve can cause substantial pain before the cancer is detected on routine examination or imaging scans," says study author Jeffrey Terrell, M.D., associate professor of otolaryngology at the U-M Medical School.

The next question for the researchers is to understand whether treatments that improve quality of life can improve survival.

"Although it is not yet clear how the association works between survival and quality of life related to head and neck pain, it is clearly advantageous to minimize pain for patients. And, if in doing that, the chance of cancer recurrence or patient survival is improved, the effort is worthwhile, regardless of why these factors are related. Patients want improved quality of life after cancer treatment—whether it be to improve survival or simply to improve everyday living and feel better," Duffy says.

Based on their findings, the study authors recommend routine quality of life assessments

of patients with head and neck cancer, before treatment and again after six months, one year and two years.

Additional study authors were David L. Ronis, Ph.D., associate research scientist at the U-M School of Nursing and research scientist at the VA Ann Arbor Healthcare System; Karen E. Fowler, research associate at the U-M Medical School and VA Ann Arbor Healthcare System; and Stephen B. Gruber, M.D., Ph.D., H. Marvin Pollard Professor of Internal Medicine at the U-M Medical School.

*Funding for the study was from the Department of Veterans Affairs, GlaxoSmithKline through the Managed Care Forum, and the National Cancer Institute. Reference: Journal of Clinical Oncology, Vol. 26, No. 16, June 1, 2008*

## LOCAL CHAPTERS OF SPOHNC

### FOCUS ON SPOHNC-UCLA

The UCLA (Los Angeles Chapter of SPOHNC) Head and Neck Support Group started in the Fall of 2000. The group was formed as a joint effort between radiation oncology (outpatient/social worker) and the hospital surgical unit (inpatient/social worker) for head and neck patients.

It was the patients from radiation oncology and surgery that motivated the start of this group. Their personal journeys were very different from the other types of cancer we treat. Some of the patients were experiencing overwhelming challenges such as, disfiguring surgeries, placement of feeding tubes, difficulty with swallowing, dental and speech problems, and the side-effects from chemotherapy and radiation. They needed a forum to voice their concerns, fears and hopes.

The format of the group was structured as an educational and support group.

We are fortunate to hold this group meeting at a University Medical Center.

During the year, we draw upon our excellent physicians and auxiliary medical professionals to come and share their expertise. We have had speakers from our Head and Neck Surgery Division, the Swallowing Clinic, Speech Therapy, Physical Therapy, Nutrition, East/West Medicine, Maxillofacial Dentistry, Medical and Radiation Oncology, and Psychiatry. It has been enormously helpful for these patients to have the opportunity to ask questions and learn about different modalities that might help them with the side-effects of treatment and the quality of life issues.

However, the true teachers, are the remarkable patients that come each month. They have validated each other's feelings and given hope to those who feel scared and vulnerable. They have been resources for products, given tips for how to travel with a feeding tube, shared eating techniques and recipes to enhance nutrition. We have a growing number

of patients who are going through concurrent treatments of radiation and chemotherapy. The support group has helped these new patients with "their" road maps on how to navigate this life changing event. They are beacons of courage, inspiration, and caring support—not unlike Randy Pausch, (pancreatic cancer) who has taught the nation about his life philosophy in the "Last Lecture" given at Carnegie-Mellon.....one can be a Tigger or an Eeyore!

Flyers are sent out monthly to various departments in our hospital, to the local VA hospital, and to other community hospitals. Group members also receive a reminder about the date and if there will be speaker, or a general meeting. The group is held in the Department of Radiation Oncology, on the first Tuesday of every month, 6:30-8:00 pm.

Contact: Pamela Hoff, LCSW, 310-825-6134 for more information.

\*\*\*\*\*

#### ARIZONA-PHOENIX

Banner Desert Medical Center  
3<sup>rd</sup> Wednesday: 4:30 -6:30 PM  
Keri Winchester, MS, CCC-SLP  
480-512-5604  
Keri.Winchester@bannerhealth.com

#### ARIZONA-SCOTTSDALE

Virginia G. Piper CA Center  
3<sup>rd</sup>. Thursday: 6:30-8:30 PM  
Bette Denlinger, MA, RN 480-838-5194  
beneden@cox.net  
Chris Henderson, MS, CCC-SLP  
602-312-9226  
chenderson2@shc.org  
Sandy Bates, RN  
zoomomof6@cox.net

#### ARKANSAS-NORTHWEST

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

#### CALIFORNIA-LOS ANGELES-UCLA

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

#### CALIFORNIA-ORANGE-UCI

Chao Family Comprehensive CA. Ctr.  
1<sup>st</sup>. Monday: 6:30-8:00 PM  
Jennifer Higgins, MSW 714-456-5235  
jhiggins@uci.edu

#### CALIFORNIA-PASO ROBLES

The Wellness Community  
1<sup>st</sup> Tuesday: 6:00 PM  
Kenda Kellawan 805-238-4411  
kenda.kellawan@wellnesscommunityhope.org

#### CALIFORNIA-SAN DIEGO

Valerie Targia 760-751-2109  
valtargia@yahoo.com

#### CALIFORNIA-STANFORD

Stanford Cancer Center  
1<sup>st</sup> Tuesday: 4:00 - 5:30 PM  
Jan Porter, LCSW 650-725-4765  
jporter@stanfordmed.org  
Ann Kearney, MA, CCC-SLP  
650-736-0469  
akearney@ohns.stanford.edu

#### COLORADO-DENVER

Porter's Adventist Hospital  
Last Tuesday: 6:30-8:00 PM  
Jeanie Curry 303-778-5832  
jeannecurry@centura.org

#### CONNECTICUT-NORWICH

William W. Backus Hospital  
3<sup>rd</sup>. Thursday, 12:00-1:00 PM  
Darlene Young, RN, OCN 860-892-2777  
dayoung@wwbh.org  
Kathy Gernhard, RN, OCN 860-892-2777  
kgernhard@wwbh.org

#### DC-WASHINGTON

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

#### FLORIDA-BOCA RATON

Boca Raton Community Hospital.  
1<sup>st</sup> Tuesday: 4:00-5:00 PM  
Laura Moon, MSW 561-955-5897  
lmoon@brch.com

#### FLORIDA-ENGLEWOOD

Englewood Community Hospital  
3<sup>rd</sup>. Thursday: 10:30-12:00 PM  
Joseph Bauer 941-474-0099

#### FLORIDA-FT. WALTON BEACH

Ft. Walton Beach Medical Cancer  
3<sup>rd</sup> Wednesday: 4:00 PM  
Ryann Ennis, MA CCC-SLP 850-863-7580  
ryann.ennis@hcahealthcare.com  
Shanon Leach, MA, CCC-SLP 850-863-7580  
shannon.leach@hcahealthcare.com

#### FLORIDA-GAINESVILLE

Winn Dixie Hope Lodge  
2<sup>nd</sup> Monday: 6:00-7:00 PM  
Carol Glavin, MSW, LCSW  
352-371-8695  
cflavin@cox.net  
No calls after 9:00 PM, please

## FLORIDA-LECANTO

Robert Boissoneault Oncology Institute  
3<sup>rd</sup> Wednesday: 11:30 AM-1:00 PM  
Patrick Meadors, MS 352-342-1822  
pmeadors@rboi.com

## FLORIDA-MIAMI

UM/Sylvester at Deerfield Beach, Ste. 100  
2<sup>nd</sup>. 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-OCALA

Robert Boissoneault Oncology Institute  
1<sup>st</sup> Monday: 11:00 - 12:00 Noon  
Patrick Meadors 352-342-1822  
pmeadors@rboi.com

## FLORIDA-ORLANDO

MD Anderson Cancer Center  
2<sup>nd</sup> Thursday: 2:00 - 3:00 PM  
Dana Nolon, MS, LMHC, NCC  
321-841-6087

## FLORIDA-SARASOTA

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

## FLORIDA-WELLINGTON

Wellington Cancer Center  
4th. Tuesday, 6:30-8:00 PM  
Catherine DeStefano, RNC, OCN  
561-793-6500  
angelicaneil@bellsouth.net

## GEORGIA-ATLANTA

St. Joseph's Hospital  
2<sup>nd</sup> Monday: 6:30-8:00 PM  
John Sandidge 404-851-5585  
jsandidge@sjha.org

## 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  
2<sup>nd</sup> & 4<sup>th</sup> Tuesdays  
Mary Herbert 773-834-7326  
mherbert@medicine.bsd.uchicago.edu

## ILLINOIS-MAYWOOD

The Cardinal Bernardin Cancer Ctr.  
3<sup>rd</sup>. Wednesday 6:00-7:00 PM  
Marilyn Myles 708-327-2011  
mmyles@lumc.edu

## INDIANA-INDY-NORTH

Marion County Public Library  
Lawrence Branch  
3<sup>rd</sup>. Tuesday: 7:00-9:00 PM  
John Groves 317-872-6674  
Jgroves14@comcast.net

## INDIANA-INDY-SOUTH

St. Francis Education Center  
1<sup>st</sup>. Thursday: 7:00 PM  
Janice Leak, MSN, APRN-BC, AOCN  
317-782-6704  
Janice.Leak@ssfhs.org

## KANSAS-KANSAS CITY

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

## LOUISIANA-BATON ROUGE

Cancer Services of Greater Baton Rouge  
3<sup>rd</sup> Wednesday: 4:00 PM  
Krystal K. Sauceman, RN 225-572-7943  
survivorbr@yahoo.com

## MARYLAND-BALTIMORE-GBMC

Milton J. Dance Head & Neck Center  
Physicians Pavilion East Conf. Ctr.  
3<sup>rd</sup>. Tuesday, 7:00 PM  
Dorothy Gold, LCSW-C, OCW-C  
443-849-2980  
dgold@gbmc.org

## MARYLAND-BALTIMORE-JHMI

Johns Hopkins – Greenspring Station  
2<sup>nd</sup>. Wednesday: 7:00-8:30 PM  
Kim Webster 410-955-1176  
Kwebste@jhmi.edu  
Dwayne Arehart 717-615-7464  
darehart@dejazzd.com

## MASSACHUSETTS-BOSTON

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

## MASSACHUSETTS-PEABODY

North Shore Cancer Center  
2<sup>nd</sup> Tuesday: 5:30-6:30 PM  
Mary Anne Macaulay, LICSW  
mmacaulay@partners.org 978-573-5318

## MICHIGAN-DETROIT

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

## MICHIGAN-TROY

Beaumont Hospital  
Wilson Cancer Resource Center  
4<sup>th</sup> Thursday: 6:30 PM  
Carrie Erikson, LCS, 248-964-3430  
CErikson@beaumont-hospitals.com

## MINNESOTA-MINNEAPOLIS

Ridgedale Hennepin Area Library  
1<sup>st</sup> Monday: 7:00-9:00 PM  
Colleen M. Endrizzi 952-545-0200  
rivers3jvk@aol.com  
Charles Bartlett 952-461-2324

## MISSOURI-ST. LOUIS

St. Louis University Cancer Center  
4<sup>th</sup> Friday: 10:00 AM - 12:00 noon  
Deborah S. Manne, MSN, RDH, RN, OCN  
314-577-8880; mannedt@slu.edu  
Cathy Turcotte, RN, MSN 314-268-7051  
turcotte@slu.edu

## MONTANA-BOZEMAN

Bozeman Deaconess Hospital  
3<sup>rd</sup>. 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

## NEBRASKA-OMAHA

Methodist Cancer Center  
1<sup>st</sup> Friday: 3:00 PM.  
Susan Stensland 402-559-4420  
sstensland@nebraskamed.com

## NEBRASKA-OMAHA

Nebraska Medical Center  
3<sup>rd</sup> Tuesday: 12:00 noon  
Susan Stensland 402-559-4420  
sstensland@nebraskamed.com

## NEW JERSEY-LONG BRANCH

Leon Hess Cancer Center  
The Goldsmith Wellness Center  
2<sup>nd</sup> 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  
3<sup>rd</sup> Wednesday: 1:30 PM  
Edie Boschen, RN, APN-c, OCN  
973-971-4144  
Edie.Boschen@atlanticealth.org  
Catherine Owens, LCSW 973-971-5169  
Catherine.Owens@atlanticealth.org

## NEW JERSEY-PHILADELPHIA

University of Pennsylvania Hospital  
1<sup>st</sup> 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  
732-557-8270  
slaniado@sbhcs.co

## NEW MEXICO-ALBUQUERQUE

Anita Bryan, 505-681-1971  
Anitabeach2@yahoo.com

## NEW YORK-ALBANY

Gilda's Club

3<sup>rd</sup> Thursday: 7:00-9:00 PM  
Joseph Ciccarelli 618-882-9742  
jciccarelli001@nycap.rr.com  
Norma Neapolitano 518-683-9518  
nneapolitano@nycap.rr.com

## NEW YORK-BUFFALO

Roswell Park Cancer Institute  
3<sup>rd</sup> Tuesday: 4:30-6:00 PM  
Amy Sumbtrum, SLP 716-845-4947  
amy.sumbtrum@roswellpark.org

## NEW YORK-MANHATTAN

Beth Israel Head and Neck Institute  
4<sup>th</sup> Tuesday: 1:30-3:30 PM  
Jackie Mojica 212-844-87  
jmojica@chpnet.org

## NEW YORK-MANHATTAN

Mount Sinai Medical Center  
Third Tuesday, 3:00 PM  
Stephanie Eisenman, LMSW  
212-241-7962  
stephanie.eisenman@mountsinai.org

## NEW YORK-MANHATTAN

NYU Clinical Cancer Center, 11th Floor  
1<sup>st</sup> Tuesday: 2:00 PM  
Carol Wind Mitchell, RN 212-731-6002  
carol.mitchell@nyumc.org

## NEW YORK-ROCHESTER

Strong Memorial Hospital  
1<sup>st</sup>. Thursday: 4:00-5:30 PM  
Sandra E. Sabatka, LMSW 585-275-4631  
Sandra\_Sabatka@URMC.Rochester.edu

## NEW YORK-STONY BROOK

Ambulatory Care Pavilion  
1<sup>st</sup>. Wednesday: 7:30-9:00 PM  
Dennis Staropoli 631-682-7103  
den.star@hotmail.com

## NEW YORK-SYOSSET

NSLIJ-Syosset Hospital  
2<sup>nd</sup> Thursday: 7:30-9:00 PM  
Nancy Leupold 516-759-5333  
nleupold@spohnc.org

## NEW YORK-WESTCHESTER

White Plains Hospital Cancer Center  
2<sup>nd</sup> Thursday: 7:00 PM  
Mark Tenzer 914-328-2072  
tenzer1@optonline.net

## NORTH 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

## OHIO-CLEVELAND

Cleveland Clinic at Fairview Hospital  
2<sup>nd</sup> Thursday: 4:00 PM  
Tom Wurz 440-243-6220  
roe8@hotmail.com  
Gwen Paull, LISW 216-476-7241  
gwenpaull@fairviewhospital.org

## OHIO-COLUMBUS

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

## OHIO-KETTERING

Kettering Medical Center  
2<sup>nd</sup> Monday: 2:00-3:00 PM  
Rae Norrod, MS, RN, AOCN, CNS  
937-395-8115  
Rae.Norrod@khnetwork.org  
Hank Deneski: wohnc@earthlink.net

## OKLAHOMA-TULSA

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

## OREGON-MEDFORD

Providence Medical Center  
2<sup>nd</sup> Friday: 12:00-1:30 PM  
Richard Boucher 650-269-8323  
richard.boucher@hp.com

## PENNSYLVANIA-HARRISBURG

Health South Lab  
3<sup>rd</sup> Tues: 6:30 PM  
Joseph F. Brelsford 717-774-8370  
Jfbrelsford1@mmm.com

## PENNSYLVANIA-MONROEVILLE

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

## PENNSYLVANIA-YORK

Apple Hill Medical Center  
2<sup>nd</sup>. Wednesday, 5:00 PM  
Dianne S. Hollinger, MA, CCC-SLP  
717-851-2601  
Dhollinger@wellspring.org  
Diane McElwain, RN, OCN, M.Ed  
717-741-8100  
dmcelwain@wellspring.org

## TEXAS-DALLAS

Baylor Irving-Coppell Medical Center  
2<sup>nd</sup> Saturday: 10:00 AM  
Dan Stack 972-373-9599  
danstack@aol.com

## TEXAS-DALLAS

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

## TEXAS-FORT WORTH

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

## TEXAS-HOUSTON/TOMBALL

Tomball Regional Hospital  
2<sup>nd</sup>. 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  
2<sup>nd</sup> Wednesday: 5:30-7:00 PM  
Corinne Cook, LCSW 703-776-2813  
Corinne.cook@inova.com

## VIRGINIA-NORFOLK

Sentara Norfolk General Hospital  
3<sup>rd</sup>. Monday: 7:00 PM  
Helen Grathwohl 757-487-2624  
agrath3004@aol.com

## WISCONSIN-MADISON

Univ. of Wisconsin Hospital  
ENT Clinic Rm. G3/206  
1<sup>st</sup>. Wednesday: 11:30-1:00 PM  
Rachael Kammer, MS, CCC, SLP  
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