NECK DISSECTIONS
The Different Types and Indications

JESUS E. MEDINA, M.D.

Treatment of the regional lymph nodes is an integral component of the management of patients with squamous cell carcinoma (SqCC) of the head and neck region. For several decades, since the beginning of this century, surgical treatment of cervical metastases consisted of the radical neck dissection as described by Crile in 1906. During the past twenty years, significant changes have occurred in the treatment of the neck. As a result, today, the radical neck dissection is not the only operation used for the surgical treatment of the neck, and surgery is not the only treatment for every patient with cervical lymph node metastases.

Many terms have been used to describe the different neck dissections. Reading and hearing terms such as radical, modified, functional, limited can be confusing. Thus, I believe the reader’s understanding of the treatment of cancer of the head and neck would be enhanced by a systematic discussion of the different types of neck dissections, the proper nomenclature currently recommended to describe them, and their current indications.

The American Academy of Otolaryngology-Head and Neck Surgery, Inc. and the American Head and Neck Society have sanctioned the current classification of neck dissections, presented in Table 1. This classification standardized the names used for the various modifications of the radical neck dissection, thereby reducing the confusion that existed for many years when various names were used to refer to the same operation.

The classification is based, primarily, on the lymph node groups of the neck that are removed, and secondarily, on the anatomic structures that may be preserved, such as the spinal accessory nerve, the internal jugular vein and the sternocleidomastoid muscle. It also relies on the acceptance of a uniform nomenclature for the lymph node groups of the neck in groups or levels I through V (Figure 1).

This classification separates neck dissections into four categories: Radical, Modified Radical, Selective, and Extended.

Radical Neck Dissection consists of the removal of all five lymph node levels of one side of the neck including the sternocleidomastoid muscle which is a large muscle in the neck, the internal jugular vein which is a major blood vessel through which blood returns

![Fig. 1. The different lymph node levels or groups of the neck.](image-url)

Table 1. Classification Of Neck Dissections

<table>
<thead>
<tr>
<th>RADICAL</th>
<th>MODIFIED RADICAL</th>
<th>SELECTIVE</th>
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<tr>
<td>Lateral</td>
<td>Supraomohyoid</td>
<td>Posterior</td>
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<tr>
<td>Posterolateral</td>
<td>Anterior</td>
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<td>EXTENDED</td>
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from the head to the heart, and the spinal accessory nerve which controls movement of one of the major shoulder muscles.

This type of neck dissection is currently indicated in the following circumstances:
- When there are multiple, large nodes at different levels in the neck.
- When there are multiple, matted nodes.
- When there is a single, large node (> 6-8 cm) in upper/mid neck.
- Occasionally, when an ill-advised open biopsy of a cancer in a neck node has been performed.

Modified Radical Neck Dissection consists of modifications of the radical neck dissection that were developed with the intention of reducing the morbidity of this operation by preserving one or more of the following structures: the spinal accessory nerve, the internal jugular vein or the sternocleidomastoid muscle. Like the radical neck dissection, the modified radical neck dissection removes all five nodal levels in one side of the neck. The three neck dissections that can be included in this category differ from each other only in the number of neural, vascular, and muscular structures that are preserved. Therefore, it has been suggested that these neck dissections be subclassifying into 3 types (Table 2): Type I in which only “one” structure, the spinal accessory nerve, is preserved. Type II in which “two” structures, the spinal accessory nerve and the internal jugular vein are preserved and Type III in which all “three” structures, the spinal accessory nerve, the internal jugular vein and the sternocleidomastoid muscle are preserved.

Many surgeons, particularly in Europe, perform these neck dissections when metastases to the neck nodes are highly probable but can not be detected by palpation or radiographs - that is when the neck is staged N0 (No regional lymph node metastasis). In North America, the main indication to perform these operations is the presence of palpable lymph node metastases, especially when they are multiple, relatively small, i.e. less than 3 – 4 cm, and are not fixed to the underlying structures. The modified radical neck dissection Type III is clearly the operation of choice for patients with thyroid cancer, who have palpable lymph node metastases in the neck.

Table 2.
Classification of Modified Radical Neck Dissections

| Type I: | Spinal accessory nerve preserved |
| Type II: | Spinal accessory nerve preserved and internal jugular vein preserved |
| Type III: | Spinal accessory nerve, internal jugular vein and sternocleidomastoid muscle preserved |

Selective Neck Dissection consists of the removal of only the lymph node groups that are at highest risk of containing metastases, according to the location of the primary tumor. The spinal accessory nerve, the internal jugular vein and the sternocleidomastoid muscle are preserved.

The selective neck dissections are increasingly accepted for the surgical treatment of the neck nodes when the neck is staged N0. These neck dissections are based on the following observations:
- a) Lymph node metastases are found in predictable regions of the neck, depending on the site of the primary tumor. For example, for cancers of the oral cavity, the nodes that are most likely to contain metastases are those in levels I, II, and III; for cancers of the pharynx and larynx, the nodes at risk are those in levels II and III.
- b) These operations are as effective as the more extensive radical and modified radical neck dissections, when the neck is staged N0.
- c) The morbidity associated with these operations is minimal and potentially reversible.

There are four operations in this category of selective neck dissections:

The lateral neck dissection consists of the en-bloc removal of the nodes in levels II, III and IV. It is currently indicated in patients with tumors of the larynx and pharynx staged T2-T4 N0. Since the lymphatic drainage of these regions is such that metastases are frequently bilateral, the operation is often done on both sides of the neck.

The supraomohyoid neck dissection consists of the en-bloc removal of the nodes in levels I, II and III. It is the preferred procedure for the surgical management of patients with cancer of the oral cavity. The procedure is performed on both sides of the neck for patients with cancers of the anterior tongue and floor of the mouth. A bilateral dissection is performed when the lesion is located at or near the midline.

Postoperative radiation is utilized when metastases are found in multiple nodes or when a tumor in the lymph nodes has broken through the capsule of the lymph nodes (extra-capsular spread).

The anterior neck dissection consists of the removal of the lymph nodes in front and around the trachea, in the low, anterior aspect of the neck. This type of neck dissection is done alone in the treatment of thyroid cancer. It is also done in combination with other types of neck dissection – a lateral neck dissection for example – when treating certain cancers of the larynx or pharynx.

The posterolateral neck dissection is currently done almost exclusively for the treatment of malignant melanoma of the posterior lateral aspect of the neck or the scalp.

Extended Neck Dissection is the term used when a given neck dissection is “extended” to include either lymph node groups or structures of the neck that are not routinely removed, such as the retropharyngeal nodes or the carotid artery.

In summary, today, head and neck surgeons have a variety of neck dissections that can be used for different and specific situations. In patients with cancer and in whom the lymph nodes in the neck are not palpable, the selective neck dissections are effective and leave the patient few, if any, sequelae. In patients in whom the nodes are already enlarged, it is possible to remove these nodes without always having to do radical surgery.

Editor’s Note: Jesus E. Medina, M.D. is the Paul and Ruth Jonas Professor and Chair of the Department of Otorhinolaryngology at the University of Oklahoma Health Sciences Center.
A Time for Sharing

In 1988, I received a heart transplant. Solid organ transplant recipients become quite ill from time to time due to being immunosuppressed. Consequently, there are many horror stories out there worse than mine, so consider the following for information purposes only, not a trip in self admiration.

The beginning is easily memorable, it was New Year’s Eve day 1997. I was in a non-transplant hospital having the 4th biopsy of my vocal cord area trying to find the cause of an ongoing hoarseness. The previous 3 excursions down my throat with a sharp knife had resulted in the tissue samples being symptomatic of cancer, but not really cancer - yet. As the doctor left the OR he told my wife, Sue, that he hadn’t seen any cancer this time either.

Normally, one can walk right out of the hospital after such surgery, but this time unfortunately somebody (more like a “jerk”) had administered some atropine to this transplant patient, a definite “no, no.” My heartbeat nearly stopped in a condition known as heart block. Fortunately, my chief transplant (Tx) coordinator was available and she arrived with the head “electrical” heart man from the transplant hospital where I’m followed. I was admitted to the hospital for 2 days observation on a heart monitor. The heart rate returned to normal over night, but not realizing that atropine had been administered, the “wire” doctor was convinced I needed a pacemaker and kept me there another day. (An angiogram was performed shortly thereafter showed the heart was fine. I now kid the “wire guy” that he’s like the proverbial street watch salesman only in his case it’s pacemakers pinned inside his trench coat.)

Four days later the final pathology report came back. The lab report said Stage 3 cancer of the larynx. The doctor’s quote was, “The good news is that there doesn’t appear to be any invasion of the cartilage, the less than good news is that Stage 3 cancer of the larynx always calls for surgery.” This meant a total laryngectomy. Outside of going very much berserk, one of the first of many things I thought of was there goes fishing. If one has a stoma and falls overboard, it would be all over very quickly.

Condensing the story just a bit - The head Tx coordinator at Henrico Doctors Hospital made a presentation to the Tumor Board of the hospital on my behalf. Rather than surgery, the Board concluded that it would be worth a try to use radiation and chemotherapy in combination, with the concept fully understood by me that if at certain points in the process, there was no reduction, or any increase in the tumor size, I would have to undergo surgery immediately. Due to my transplant recipient status, they were also very careful to point out that they had no history or statistics, or really even proven procedures to go on in my case.

The chemo was infused over two separate one week stays in the hospital with a three week interval between. After each week long infusion of chemo, a CAT Scan was performed. After the second week long infusion the CAT Scan showed an apparent 62% reduction, and thus the radiation program was started in addition to weekly chemo injections in the doctor’s office.

While in the hospital there was really no noticeable effect from the chemo, but there sure was later on. The “truck” hit about two days after I came home from the second infusion. For about two weeks I only occupied Point A, the bed, or Point B, the Lay-Z-Boy chair, dressed for all occasions in pajamas. Travel between the two points was carefully monitored with at least one rest stop and a cane in use at all times. Showers had to be taken while seated in a lawn chair, a most unproductive method.

The chemo early on affected the blood flow to the heart in a complicated way that essentially created acute hypotension, or low blood pressure and dizziness. A couple of times, before I realized the problem for what it was, I simply passed out right where I happened to be, say in the middle of a street passed out.) I then headed toward the door of the P.O. only to realize as I got to the handicapped entrance railing that I was about to be very dizzy. I simply latched onto the railing and again rested, this time I guess with head down.

Almost immediately a lady came by and asked if I was all right and should she call the Rescue Squad. I responded that I was fine, but thought to myself that I must be making some sort of scene here in the center of town, so I relaunched the body toward the entrance door. I made it through the door, and then thought, I’ll just back up here and lean against the wall. I missed the wall by 3 feet and sort of cork-screwed to the floor. In so doing I realized I was bending my ankle in a direction that would just never work, but there was absolutely nothing I could do about it in my fog.

I was very correct in my instant diagnosis, the ankle was smashed to pieces. The Rescue Squad was called and I was off to the local emergency clinic, followed by a trip back to the hospital. It was just a bit convenient that I had already been scheduled for surgery the next day to remove the shunt through which they applied the chemo, as it had become infected, not a happy situation for a Tx recipient. So, that surgery went ahead as planned and then the following day an orthopedic mechanic literally screwed and plated my ankle back.

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http://www.spohnc.org

E-mail-- info@spohnc.org
The Role of Physical Therapy in the Rehabilitation of Patients with Oral and Head and Neck Cancer by Kristen Henderson, PT

Introduction
A patient’s recovery following oral and head and neck surgery can be long and arduous and can be easily compounded by multiple complications. Most oral, head and neck cancer survivors will recover from varied physical limitations within one year of treatment. However, despite the likelihood of an eventual return to normalcy, patients enduring neck dissections may face many possible physical challenges. A physical therapist can play an important role in helping a survivor to meet these challenges and to overcome many limitations. The importance of physical therapy cannot be underestimated in the recovery of patients following oral and head and neck surgery.

Case Study:
KM is a sixty-eight year old female with a history of smoking four packs of cigarettes a day for thirty years. KM quit smoking in 1992 but nonetheless was diagnosed several years later with cancer of the jaw (squamous cell carcinoma of the right mandibular alveolus) in addition to cancer of the left floor of mouth. Because of the invasiveness of KM’s cancer, she had to have surgery right away. KM’s first surgery was in early 1999 when her cancerous jaw and floor of the mouth were removed and bilateral selective neck dissections were performed. KM’s jaw was reconstructed with muscle and bone tissue harvested from her left calf (left fibular free-flap reconstruction). The patient remained in the intensive care unit for almost a week.

Her physicians felt she was ready to begin physical therapy on post-op day seven. Despite the fact that KM had not been out of bed in seven days, she was able to get out of bed and walk four feet with moderate assistance of two people and a walker on her first day of therapy. KM learned to lightly touch her left foot to the floor instead of putting full weight on it. This allowed for healing of her left fibular free flap graft. Initially, KM found walking to be painful, but she found that the more she walked, the quicker her pain decreased. In addition to walking, KM was given a gentle stretching and strengthening exercise program for the left foot to help increase ankle flexibility and to decrease pain and swelling.

KM continued to progress with her walking, and by the end of two weeks of therapy, she was able to walk 300 feet. In addition, she spent several hours a day sitting in a chair performing her leg exercises as instructed by her therapist. About this time, it was determined that KM’S free-flap reconstruction was no longer viable. As a result, additional surgery was necessary. This time KM had muscle and bone taken from her left shoulder blade for reconstruction of the jaw (left scapular osteocutaneous free-flap reconstruction). Four days after surgery, KM resumed physical therapy. In addition to a slightly painful left leg, KM’s left arm had to be immobilized in a sling when she was out of bed. Walking became a challenge, as she could no longer use the walker.

KM persevered and maintained a positive outlook. In addition to her daily therapy routine, her surgeon said she could start gently exercising her left arm. However, her surgeon suggested that head, neck and right arm exercises be postponed to allow for optimal healing. KM eventually went to a Sub-Acute Unit to continue with intensive therapy, and eventually her surgeon allowed her to begin exercises for her head, neck and both arms.

KM was in the hospital for a total of twenty-eight days, of which she received physical therapy for seventeen of those days, sometimes twice a day. Despite all of the complications related to her cancer and hospitalization, she was able to return home and was living independently within just four months. "I can do just about anything I want to do except to lift my left arm over my head.” stated KM. She no longer needed a walker and began taking daily walks around her neighborhood. When I last spoke with her on the phone, she requested my address so that she could send me pictures of her home which she is currently redecorating!

Rehabilitation
The neck is filled with nerves, small muscles and blood vessels which often cannot be avoided during surgery; thus the more invasive the surgery, the more likely the physical disability. Invasion of musculature may lead to disability such as postural malalignment of the head and shoulders, which can cause inability to do something as easy as looking up or lifting the arms overhead. Facial paralysis and the inability to chew or swallow affect many patients. If bone is taken from the fibula for jaw replacement, the donating extremity may limit walking ability immediately post-operatively. Likewise, if muscle and skin are taken from a forearm, the donating extremity may have limited use post-operatively.

If there is not sufficient exercising of the neck and extremities post-operatively, a patient may develop frozen shoulder syndrome some six months later and experience an inability to lift the arms overhead. This patient may also have significant shoulder pain. Or, the patient may experience an inability to look up or turn the head from side-to-side accompanied by significant neck pain. In the aftermath of surgery, physical therapy can gradually return the muscles to a normal level of functioning and can prevent long-term disability.

Within several days of reconstructive surgery, it is important for the patient to walk and to sit up in a chair for several hours a day. The physical therapist can provide the appropriate walking equipment, if needed, to help improve the patient’s walking ability.

It is important to begin gentle exercises for the neck and extremities once the surgeon gives his/her approval. The physical therapist can provide and monitor these
exercises. As well as assure the patient of results. Exercises for the head and neck may include gentle forward bending of the head, backward bending, turning of the head from side to side, and lowering of the ear towards the shoulder on alternating sides. If a patient has facial paralysis from facial nerve palsy or from nerve resection, the physical therapist can provide facial exercises such as puckering of the lips as if to kiss, smiling wide, wrinkling of the nose or forehead and opening the mouth wide.

Arm exercises are a must for the patient, too, as shoulder weakness is common following oral, head and neck surgery. The physical therapist can instruct patients on shrugging of the shoulders, lifting of each arm out to the side or in front and squeezing of the shoulder blades in back. The same is true if bone and tissue have been harvested from an arm or leg. For example, if tissue is harvested from an arm, then in addition to the arm exercises described above, wrist and elbow exercises need to be added to the patients exercise program. The most effective exercises for this type of surgery are gentle bending of the wrist up and down and side to side, bending of the elbow up and down (with emphasis on straightening the elbow as far as is painlessly possible), and turning of the palm towards the ceiling and then down towards the floor alternately. If tissue is harvested from a lower extremity, then hip, knee and ankle exercises need to be added to the patient’s daily therapy regimen, specifically ankle circles, ankle pumps, and gentle ankle stretching.

If a patient has difficulty beginning an exercise program, it may be helpful to begin the exercises with the patient lying flat in bed, thus eliminating the force of gravity on the patient’s extremities. If a patient cannot fully perform the facial exercises, he/she can learn to use a hand to assist the facial muscles to move (best done in front of a mirror). If a patient cannot lift an arm up, even if lying flat in bed, he/she may be instructed to use the opposite arm to assist. Of special note: It is always important for the patient to exercise within his or her “pain-free” range, as over zealous exercisers tend to have more complications following surgery.

The patient should try to perform five to ten repetitions of the appropriate exercises, two to three times a day, for six to eight weeks (sometimes longer), unless otherwise indicated by the patient’s surgeon. If the patient has had recent radiation therapy, then it is best to postpone exercises for a couple of weeks to allow for optimum healing. The same is true if infection or poor healing of the surgical site becomes evident. Following oral, head and neck surgery, most patients may have driving and lifting restrictions and should consult their physicians for detailed instructions following surgery.

Summary

Advances in modern medicine can replace a cancerous jaw and effectively repair and hide scarring with good cosmetic effects. However, preventing muscle atrophy and long-term disability requires hard, persistent work from the patient with the guidance of a physical therapist. Working through the physical discomfort following surgery, and accepting the rigorous job of physical rehabilitation, most patients feel that being able to lift an arm overhead to wave good-bye or to do such things as redecorate a home or play a game of golf is worth the effort and hard work.

Editor’s note: Kristin Henderson is an acute care physical therapist specializing in rehabilitation of general surgery and head and neck cancer patients at Vanderbilt University Medical Center, Nashville, TN

SHARING continued from page 3

Together. That was on Friday. On Monday I was discharged and told to go home and keep my leg elevated. I followed orders to the tee. Sue did the driving to radiation treatments with me lying like a “poached out-of-season deer” in the back seat.

Time passed and it was May 26th, my birthday, a date now celebrated only by my disability insurance company as another year closer to the date they can stop sending money. Radiation was completed and I was due for the Biggie CAT Scan, the one that would indicate success or failure of the therapy. Just after the scan I mentioned to the Tx Coordinator that if I were a doctor I would be willing to bet that I had phlebitis (blood clot) in my left leg. An immediate ECHO of the leg showed a clot from ankle to thigh. So much for obeying orders and keeping the leg up! Yep, back into the hospital for another full week this time on blood thinners!

Fortunately, the CAT scan showed a radical reduction in the tumor, leaving just an indiscernible small mass, which could have been scar tissue, or cancer cells now dead, but not absorbed yet by the body. The really good news came later, in early August, when surgical biopsy of 5 areas showed no sign of cancer.

As to the patient. He has some neat scar patterns on his right shoulder and left ankle. His lower face and neck are swollen due to the permanent effect of the radiation (gosh no more neckties!). He has no saliva, which may be the most annoying side effect. Ninety-five percent of head hair was lost, only to be eventually replaced by curly salt and pepper steel wool - coarse grade. And his voice consists of one paralyzed vocal cord caused by the cancer, and another that just flaps in the breeze. The result is sort of an absolutely non-sexy, raspy, loud whisper that even the maker finds annoying.

Friends kid me that from now on when I go through airport security I will trip the alarm with my ankle. The Doctor said, “No way, but we’ll give you a card just in case.” On my first trip, I tripped every alarm in the airports both going and coming! I just whipped out my card, which only made them more suspicious. From now on I’m destined to be just another gray-haired terrorist, who can’t spit.

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Finding the WEB Sites  By Edward F. McCartan

Where in the World Wide Web is it? Where among the currently estimated 800 million pages on 2.8 million sites is the information we need on cancer, research, health, and nutrition? Not to worry; we don’t have to deal with that many pages. Only about 6% cover scientific and educational material (85% contain commercial content, in case you want to go shopping). That’s only about 164,000 sites to search. But it’s not as hard as it seems. Remember, the mysterious Internet that everybody wants to “get on” is a network of millions of computers all over the world that provides the contents, or pages, that make up the Web.

The first step in finding information is to access the Internet through your computer. To do this you must have an Internet Service Provider (ISP) that will furnish you with the necessary software to connect to the Internet. Along with this service, you must also have a modem connected to a telephone line. Many computers come with a modem installed internally. Older computers may use an external modem that can easily be installed.

Included in the software provided by your ISP will be a browser. Browsers allow you to access the information on the “Net.” Two popular browsers are Netscape Navigator and Communicator and Microsoft Internet Explorer. There are many other browsers available also. Most come on discs from which the program is loaded into the computer. The exception is MSN Internet which is integrated into Windows, and is currently the operating system on most new computers. It does not have to be used, however; any of the many other browsers offered by ISPs can be used.

It is estimated that there are over 5,000 Internet service providers in the United States. The most popular, in terms of speed and reliability, are AOL (America Online), AT&T WorldNet, MSN Internet, and CompuServe. Other popular ISPs include EarthLink Network, Flashnet, GTE, IBK MediaOne, Prodigy, and NetCom. More information can be found in Web Directories, available in bookstores or computer stores. Also, newspapers and magazines sometimes carry ads for small, inexpensive local providers, such as Galaxy Internet Services, Access 1, or OnePine Internet, in the New York area.

The first step in searching for cancer information is to activate the provider by clicking on the icon and signing on (each individual has a password). If the address or URL (Universal Resource Locator) of a cancer-related web site is known, enter it in the space provided (keyword box) and click on Search or Find. The addresses begin with www.; then the name of the site followed by a period, then either com, org, gov, or net. Usually, the result of the search will be a list of related sites or subjects.

Finding information about SPOHNC by doing a search using www.spohnc.org will result in many titles depending on which Internet Service Provider and browser you are using. For example, AOL with its browser, will find 22 titles, Mindspring using Hotbot will find 24 titles. One of the first titles that will be shown will be a direct link to SPOHNC’s homepage. Access to the information is gained by clicking on the title.

The web site address of the American Cancer Society is www.cancer.org. Searching for this site brings up many choices. Most of the titles in the early listings are about breast cancer and nutrition; useful information, but not specific to head and neck cancer. Calling up Cancer Care’s site at www.cancercareinc.org will bring you titles, dealing with support, breast cancer, and links to other web sites. If useful web pages are found, they can be saved or printed out.

It can be frustrating to try and find head and neck information this way, even though other useful information is available. Another way to search is by subject matter. Instead of keying in a web site address, enter the subject matter; in this case, head and neck cancer. One provider responds with 1,772,228 titles. A lot of these are irrelevant to a survivor’s search; the relevant ones usually appear at the beginning of the list. A shorter list can be found by being more specific; entering cancer of the larynx, for example. This can result in some 300,000 entries. Searches can be made even more specific by using search engines.

Search engines collect information from millions of web pages, index it and allow you to search their indexes. Some of the larger ones are: AltaVista, Excite, HotBot, Lycos, WebCrawler, Infoseek and Yahoo. There are also specialized search engines that deal with specific subjects. All of these are accessed in the usual way: www.yahoo.com, for example. A more thorough search can be achieved by resorting to meta-search engines. These are sites that combine the information in the regular engines. Some of these engines are: DogPile, MetaCrawler, and MetaSearch. MetaCrawler responds to cancer, head and neck with 39 titles, most of which have to do with support organizations (SPOHNC shows up here).

A direct way to get to a specific web site is to go to the location box or address box which can be found at the top of your browser’s screen. There you will find the letters http:// followed by a web address. Erase the existing address and type in the URL of the web site you want to visit. Press return, enter or go.

The sheer volume of information on the Web may seem overwhelming at first, but once a relevant site or page has been found, it does not have to be searched for again. Internet providers usually offer a facility called Bookmark, Favorites, or something similar. By clicking on the name on the tool bar, a menu is brought up which enables the searcher to save that particular page or pages by adding it to the menu. Then the page can be brought up at any time by going back to the menu. Thus, each searcher can build up a file of relevant information that is easily accessible on screen or in printed form.

DISCLAIMER: Support for People with Oral and Head and Neck Cancer, Inc. does not endorse any treatments or products mentioned in this newsletter. Please consult your physician before using any treatments or products.
In Memoriam

We extend our condolences to the family and friends of the following member of SPOHNC

Richard Jasieczek

Memorial Contributions from the following have been received in memory of Richard Jasieczek.

NYSEG/Quarter Century Club, James F. Gillooly and Robert T. Portorsnik, Robert and Cheryl Williams, Robert McCall, Jon C. Lochner, Delores F. Jessick.

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