MAJOR ADVANCES IN RECONSTRUCTIVE SURGERY OF THE HEAD AND NECK
MARK L. URKEN, MD, FACS

Surgical treatment of tumors of the head and neck is similar to that of tumors elsewhere in the body, in that the goals of treatment are to remove the tumor in its entirety while preserving the form and function of the region. Surgery in the head and neck, however, differs from other regions in a number of fundamental ways. The head and neck is very visible and alterations in the appearance of a person’s face or neck are very difficult to hide. This is quite different from patients who undergo surgery for tumors of the lung, breast, prostate or gastrointestinal tract who are readily able to camouflage the scars of surgery as well as to hide the loss of these anatomic parts. There is also much greater redundancy of such structures as the lung or bowel so that loss of a portion of these organs can be readily compensated by the remaining parts. This is not the case in such regions as the mouth and throat where loss of even small portions may lead to a critical disturbance in function such that a patient may be rendered dependent on a tracheostomy tube for breathing or a gastrostomy tube for nutrition.

A discussion of surgery for tumors of the head and neck centers around four fundamental issues: 1. What anatomic parts are involved by the tumor and therefore require removal to obtain clear margins around the disease; 2. What factors exist that would lead to an impairment in wound healing; 3. What is the best surgical approach to obtain exposure of the tumor to achieve an optimal and safe removal of the tumor while leading to the least alteration in form and function; 4. What is the best method to reconstruct the missing anatomic parts to restore the appearance as well as the physiologic function.

Our ability to evaluate the extent of a tumor has been greatly enhanced through a number of advances in imaging techniques such as CT scans, MRI, and arteriography. Many different factors have been identified as being important to successful wound healing. Some of these factors can be successfully influenced through preoperative nutritional replacement and surgical technique, while others such as radiation, are more difficult to overcome. Surgical access to difficult areas of the head and neck has been greatly influenced by innovative approaches, which have been critical to such disciplines as cranial base surgery. However, the aspect of head and neck surgery which has undergone the most dramatic change over the past two decades has been in head and neck reconstruction. This will be the topic of the remainder of this discussion.

Historical Perspectives:
The advances in reconstructive surgery which have occurred over the past 30 years are far greater than those that occurred during the first half of this century. In the 1960’s, reconstructive surgeons were restricted to the use of skin from the back of the neck and shoulder (nape of neck flap), from the forehead (forehead flap) and the upper chest wall (the deltopectoral flap). The use of these flaps usually resulted in multistaged procedures, prolonged hospitalizations, and potentially catastrophic consequences resulting from rupture of the carotid artery. In addition, the quality of the reconstruction was limited by the narrow range of tissue that was available.

The era which followed, took place in the mid to late 1970’s and continued into the mid 1980’s. During this period, it was discovered that muscles on both the front and back of the chest wall (the pectoralis major, trapezius, latissimus dorsi) could serve as carriers of skin from these regions in a very safe and highly

Please see RECONSTRUCTIONon next page

<table>
<thead>
<tr>
<th>In This Issue</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>3</td>
</tr>
<tr>
<td>A Time For Sharing</td>
<td>4</td>
</tr>
<tr>
<td>FYI: Understanding Prognosis and Cancer Statistics</td>
<td>5</td>
</tr>
<tr>
<td>New Tools to Help you Quit Smoking</td>
<td>6</td>
</tr>
<tr>
<td>Pansy</td>
<td>7</td>
</tr>
</tbody>
</table>
**The Mouth**

The impact of the loss of a portion of the lower jaw on the appearance and function of patients with oral cancer was perhaps the most recognized stigma which characterized head and neck surgery throughout the majority of this century.

Microvascular surgery has provided a solution to this problem through the transfer of bone with a rich blood supply from such sites as the hip (iliac bone), the shoulder blade (scapula) and the lower leg (fibula). Removing bone from these donor regions does not lead to significant functional or aesthetic impairment. In addition, soft tissue flaps can be harvested with the bone to restore the missing soft tissue portions of the defect. The rich vascular supply of this bone allows it to survive and heal to the remaining portions of the lower jaw, much like a fracture heals following a traumatic injury. The success of this form of reconstruction has been enhanced by applying advances in technology permitting rigid fixation of the bony segments for rapid bone healing and the use of dental implants. It is the latter innovation which allows oral cancer patients to wear dentures that are supported by implants which are inserted into the reconstructed jaw. This form of dental restoration provided a major leap forward in the level of function that could be achieved. We have restored well over one hundred oral cancer patients with implant-borne dentures in our series of 240 patients who have undergone microvascular reconstruction of the lower jaw.

In addition to the functional improvement, the transfer of vascularized bone for mandibular reconstruction has had a significant impact on the decisions regarding disease management. With reduced concern regarding the functional and aesthetic impact of taking larger segments of the mandible in order to achieve generous margins around the cancer, the incidence of positive bone margins has been reduced to 1.8% in our series. In addition, the condition of mandibular osteoradionecrosis, which involves the destruction of the jaw bone following radiation therapy, can be effectively treated through removal of the diseased bone and primary reconstruction using the techniques described.

Soft tissue reconstruction of the mouth has also been greatly influenced by the transfer of thin skin flaps from such sources as the forearm. This thin, pliable tissue can be used to preserve the mobility of the tongue which is so vital to postoperative function. In addition, sensory restoration can be achieved by transferring the dominant sensory nerve that supplies the skin when it is located in the forearm, and attaching that nerve to an appropriate sensory nerve in the neck. With this technique, the patient regains the ability to perceive stimuli applied to the skin following transfer to the mouth. By providing relief from the numbness which would otherwise exist, patients are able to enjoy an enhanced level of functional recovery. Unfortunately, the special sense of taste cannot be restored with this technique, however the results of using “sensate flaps” in reconstructing the mouth and throat of well over 100 patients have been very encouraging.

While bony reconstruction of the lower jaw occupied much of our attention in the early years of head and neck microvascular surgery, we have also applied the same techniques to patients whose tumors involve the upper jaw. Although tumors of the hard palate are less common than tumors of the lower jaw, the surgery can be equally disabling. Through the transfer of vascularized bone flaps and the use of dental implants, such patients can be successfully restored to the extent that they can avoid the use of bulky and socially awkward prostheses which were previously the only solution for this problem.

**The Larynx (Voice Box)**

Although there has been a shift in the treatment paradigms for management of malignant cancers of the voice box and hypopharynx (region adjacent to the larynx), surgery remains an important form of therapy. This highly specialized region relies greatly on the fine coordinated movements of the vocal cords in order to produce voice, maintain an adequate...
“Fatigue” Is a Medical Condition For People with Cancer: Don’t Ignore It!

For most people, “fatigue” is a temporary condition—something you feel after you wash the kitchen floor, or mow the lawn, and that goes away if you take a quick nap. But for cancer patients, fatigue is a common medical condition. For someone with cancer, fatigue can be chronic (meaning it doesn’t go away), and can severely affect their health and quality of life.

Unfortunately, many cancer patients don’t talk to their doctor about fatigue, because they don’t understand exactly what it is, or think that feeling tired from cancer or cancer treatment is “normal.”

What Is Fatigue?

No one would be surprised to think of weakness or exhaustion as signs of fatigue. But there are other, less obvious indicators, too. “I just don’t feel like myself” is a common statement made by cancer patients, especially if they are undergoing chemotherapy. Pain in your legs, or difficult climbing stairs or walking short distances, are both signs of fatigue. Fatigue can mean being short of breath after only light activity, like cooking a meal or taking a shower.

Fatigue can also affect the way you think and feel—it can cause you to have difficulty concentrating, lose interest in your pastimes, and make you impatient. If any of these are true, you may be suffering from fatigue as a medical condition.

What Causes Fatigue?

One of the most common causes of fatigue is chemotherapy treatment. Chemotherapy can lower the number of red cells in your blood, which carry oxygen throughout your body and give you energy. Having fewer red blood cells means that your body gets “out of breath” when you do something even mildly strenuous. Chemotherapy (or general cancer pain) can also disrupt your eating or sleeping habits, both of which can result in fatigue.

Talk To Your Doctor

If you feel fatigue (or think you do), talk to your physician, nurse, or caregiver. Your medical team can provide you with helpful information to improve fatigue, or prescribe medications to treat any physical conditions (like anemia due to chemotherapy) that can be the cause of it.

In addition, there are several things you can do to lessen your fatigue, or help your medical team treat it.

What Can You Do On Your Own?

Everyone’s experiences with fatigue and treatments are different. Some people can return to work or normal activity, while others cannot. Regardless of the severity of your fatigue, the ten tips can help you lessen your fatigue, or assist you in treating it:

1. Take several short naps or breaks, rather than one, long rest period.
2. Plan your day so that you have time to rest.
3. Take short walks or do some light exercise if possible—some people find this decreases their fatigue.
4. Try easier or shorter versions of the activities you enjoy.
5. Eat as well as you can, and drink plenty of fluids.
6. Ask your family or friends to help you with tasks you find difficult or taxing.
7. Keep a diary of how you feel each day. It can help you identify patterns, and assist your medical team in treating it.
8. Join a support group, or seek help from an oncology social worker or counselor—sharing your feelings with others can ease the burden of fatigue, and you can often learn coping hints from talking about your own situation.
9. Cultivate interests that can be less strenuous, like listening to music or reading.
10. Finally, remember that you don’t have to do everything—save your energy for things you find most important.

Conclusion

Advances in reconstruction of the head and neck continue to be made at a feverish pace. Our ability to relieve the suffering of patients with tumors in the head and neck as well as to restore their ability to lead enjoyable and productive lives, is far greater in 1999 than it was a mere five years ago. There are many more advances that have been made in this field than could be described in this communication.

With the first transplantation of a human larynx having been successfully accomplished, the avenue for head and neck organ transplantation will undoubtedly gain momentum in the next millennium. At Mount Sinai, we have been engaged in research investigating tracheal transplantation for patients with injuries or tumors of the windpipe that force them to wear a tracheostomy tube in order to sustain their breathing. With continued research in this field, there will undoubtedly be breakthroughs which reduce the amount of medication as well as the ultimate necessity for immunosuppression in order to avoid the rejection of an organ transferred from another human donor.

Editor’s Note: Mark L. Urken, MD, FACS is Chairman of the Department of Otolaryngology of the Mount Sinai School of Medicine, Chief of Head and Neck Surgical Oncology, and Director of the Microvascular Fellowship and the Microvascular Research and Training Laboratory.

© 1998, Cancer Care, Inc.

Don’t Ignore It!
A TIME FOR SHARING

During the summer of 1997, my family moved to Guangzhou, China, which is a two hour train ride from Hong Kong. We enjoyed our first year living abroad getting to know the Chinese people and their culture. We made weekend trips to the cities of Guilin, Yangshou and Beijing. My husband, our three daughters ages 10, 9 and 3 and I walked on the Great Wall of China in May 1998. We also had the opportunity to visit Thailand, Singapore and the Philippines. Life was great, but that would soon change in June, 1998.

It started with the discovery of “tongue ulcers” after a family trip to the beach. In late July of 1998, I happened to be visiting friends in Cincinnati, Ohio and decided to go see my former internist to see if she could tell me what the oval white patch was under the left side of my tongue.

My doctor admitted she didn’t know what it was and did tests for herpes and fungus. She told me if the tests came back negative I should go see an ENT doctor. By the time the results came back, I was already headed back to China. Since I had no pain from this white lesion I decided to return to China with my daughters and make an appointment with an ENT doctor in Hong Kong. In late August I made the two hour train ride into Hong Kong to meet with an otolaryngologist. He said he thought I had leukoplakia and to use a mouthwash and a denture cream that he prescribed. I was not confident with what he said and went home to see what I could find on the Internet about leukoplakia. Unfortunately, I found very little information.

The lesion was still under my tongue several weeks later, so I made an appointment in Hong Kong with another doctor. It happened that I was going into Hong Kong to pick-up my parents who were arriving to spend two weeks with us in Asia. I saw the ENT doctor who suggested that I see his friend, a dentist. The dentist proceeded to send me to an oral surgeon. When I saw the oral surgeon he suggested that a biopsy be done. I started to take out my date book to schedule an appointment when he said, “Oh no we can do it now!” I didn’t want it done then for my parents were arriving in a few hours and we were all going to Bali two days later.

Knowing what an ordeal it was to get to Hong Kong from Guangzhou I decided to go ahead with the two biopsies. We never discussed what he expected to find and I was just glad that he was going to cut the entire lesion out. In my mind the lesion was finally gone and there was going to be a resolution to this nagging problem.

One week later, after returning to Guangzhou from a wonderful family trip to Bali my husband’s secretary called. She said that a doctor in Hong Kong had been trying to reach us for two days and we needed to call him right away. I called the doctor in Hong Kong and what he told me changed my life forever. He said that one of the biopsies showed I had cancer! He told me not to get too upset; that we had caught the cancer early. He wanted my husband and me to come to Hong Kong immediately and meet with him.

We made an appointment to see him the next day. Now I had to tell my parents that their 33 year old daughter had cancer. My husband and I repacked and took the last train of the day back to Hong Kong. For the next 20 hours until we met with the doctor I tried not let my imagination run wild.

We met with the oral surgeon on Wednesday October 7, 1998 and he gave us the news that I had squamous cell carcinoma of the tongue. Oddly enough the lesion I had been going to doctors about for the past 3 months was only pre-cancerous. The cancer was farther back on my tongue and I never saw it. We were in shock; I had never smoked and drank very little alcohol. Why was this happening? The doctor proposed that he remove 25% of my tongue in a wedge shape on the left side.

Here we were in a foreign country faced with a decision of whether I should have the surgery here or go back to the United States. After much debate and discussions with physicians back in the US we decided that I would have the surgery in Hong Kong. My parents would stay in China caring for our daughters and I would have the surgery two days later. I spent two nights in the hospital and one night at a hotel. On the third day, although I was weak, I made the 2 hour train ride back to Guangzhou to recover. I must say although the first few days were rough I was surprised at how fast I bounced back. By the second week my speech began to improve. I was thrilled. At my four week checkup the oral surgeon said I should consider this a just “a bad memory.” He would see me in three months.

While I was recovering I began searching the Internet and e-mailing all my friends back in the US trying to find information about oral cancer. After sifting through all the information I was able to find, I decided that I needed a second opinion regarding my case. Everything that I was reading said that I was at risk for a new primary and that prevention was the key.

My husband and I agreed that I would travel back to the US and consult with a team of head and neck cancer doctors. I saw the team in mid November. It was their recommendation that I return to the US so that I could participate in a retinoid acid study. They also said I needed monthly follow-up. More importantly I needed to stay away from second hand smoke and alcohol and any type...
of a polluted environment.

At this point my husband requested a transfer back to the United States. I returned to China to prepare our household for the move. In January 1999 I returned to the US with my youngest daughter to have the monthly follow-up and to start looking into participation in a study. We spent three weeks living with my parents. Then my husband and two other daughters came to visit for 10 days. During this time my husband was able to secure a transfer back to Ohio that would take place five weeks later. This was good news. Our family would be together again. But now I needed to find all new doctors.

My husband and I met with four different doctors. After much debate and with each doctor having his own opinion about my case, it was finally decided that I would not participate in a retinoid acid study.

I am currently receiving monthly follow-up with an ENT doctor, taking a variety of vitamins to help boost my immune system and trying to eat a cancer free diet. I am participating in the Wellness Community to help me deal with the stress and anxiety of having had cancer. I have an oncologist who is my guardian angel, and who says I should be asking "Why me?"

Some would say our family has been though a lot, and we have. But having had cancer has allowed me to slow down and take a break from my "professional" career as a volunteer. It has allowed me to put myself and my family first. It has taught my daughters that cancer and death are not synonymous. It has given me the gift to truly appreciate the smell of a fresh cut Christmas tree, the sparkle of the sun shining on an icicle and the beauty of knowing that each day is a gift and that is why it’s called the present!

My current doctor has told me I can look at this cancer two ways; that my cup is half empty and the cancer can return or that my cup is half full and I am cancer free today. I choose my cup to be half full! I am sad that I had the cancer but I am not sorry for the lessons it has taught me.

Cassie Camacho
Mason, Ohio

Understanding Prognosis and Cancer Statistics

It is natural for anyone facing cancer to be concerned about what the future holds. Understanding the nature of cancer and what to expect can help patients and their loved ones plan treatment, anticipate lifestyle changes, and make quality of life and financial decisions. Cancer patients frequently ask their doctor or search on their own for statistics to answer the question, "What is my prognosis?"

Prognosis is a prediction of the future course and outcome of a disease and an indication of the likelihood of recovery from that disease. However, it is only a prediction. When doctors discuss a patient’s prognosis, they are attempting to project what is likely to occur for that individual patient. The doctor may speak of a favorable prognosis, if the cancer is expected to respond well to treatment, or an unfavorable prognosis, if the cancer is likely to be difficult to control.

A cancer patient’s prognosis can be affected by many factors, particularly the type of cancer the patient has, the stage of the cancer (the extent to which the cancer has metastasized, or spread), or its grade (how aggressive the cancer is or how closely the cancer resembles normal tissue). Other factors that may also affect a person’s prognosis include the patient’s age and general health or the effectiveness of treatment.

Statistics are also used by the doctor to help estimate prognosis. Survival statistics indicate how many people with a certain type and stage of cancer survive the disease. The 5-year survival rates are the most common measure used. They measure the effect of the cancer over a 5 year period of time. Survival rates include persons who survive 5 years after diagnosis, whether in remission, disease-free, or under treatment. It is important to understand that statistics alone cannot be used to predict what will happen to a particular patient because no two patients are exactly alike.

Patients and their loved ones face many uncertainties when dealing with cancer. For some, coping is easier if they know the statistics; for others, statistical information is confusing, fearful, and too impersonal to be of use. The doctor who is most familiar with the patient’s situation is in the best position to discuss a patient’s prognosis and to help interpret what the statistics may mean for them.

If patients or their loved ones feel they want to know prognostic information, they should talk with the doctor. At the same time, it is important for patients to understand that even the doctor cannot tell them exactly what to expect; in fact, a patient’s prognosis may change over time if the cancer progresses, or if treatment is successful.

Seeking prognosis information and understanding statistics can help some patients reduce their fears as they learn more about what their prognosis means for them. It is a personal decision and the patient’s choice about how much information to accept and how to deal with it.

Source
National Cancer Institute

F.Y.I.
NEW TOOLS TO HELP YOU QUIT SMOKING

Cigarette smoking kills more than 400,000 Americans each year. It plays a role in the leading causes of death—cancer, heart disease, and lung diseases—and accounts for $50 billion of annual health care expenditures. Quitting lowers the risk of getting and dying of these illnesses. So why do people continue to smoke despite such devastating consequences?

Giving up cigarettes is harder than giving up heroin, according to people recovering from these addictions. With every puff from a cigarette, a smoker inhales 4,000 chemicals, many toxic and one-nicotine-highly addictive. Within seconds, nicotine unleashes a flood of brain chemicals (including dopamine, norepinephrine, and serotonin) that causes the smoker to feel alert and a sense of pleasure. Because the body adjusts to and craves heightened levels of these chemicals, some people experience intense withdrawal symptoms when trying to quit smoking. Irritability, difficulty concentrating, anxiety, and depression are common.

On top of the physical addiction, psychological, behavioral, and environmental factors make quitting smoking especially hard. A smoker may come to associate cigarettes with enjoyable experiences like socializing with friends or the cup of coffee that starts her day every morning. Or she may smoke to calm her nerves during stressful situations. While giving up cigarettes requires a tremendous amount of determination, sheer willpower is often not enough. Only about 5% of those who quit “cold turkey” are successful. The good news is that many cessation aids are available and-used alone or together-can dramatically increase a smoker’s chance of putting out that last cigarette.

NICOTINE REPLACEMENT THERAPY

Pharmaceutical nicotine administered via chewing gum, skin patch, nasal spray, or inhaler serves as a substitute for the nicotine in cigarettes. It lessens both the craving for and the withdrawal symptoms from the drug. A smoker trying to quit may use nicotine replacements anywhere from a few weeks to a few months, depending on the level of addiction. During that time (there is a suggested duration of use for each product), the dose is gradually tapered. Studies evaluating different nicotine replacement therapies show that they all work about equally well and yield roughly twice the success rate of a placebo.

Heavy smokers (people who smoke more than 20 cigarettes a day) often require higher doses of nicotine for a longer time than those who don’t smoke as much. They may also benefit from using more than one nicotine replacement therapy at a time or adding a different cessation aid—some form of social support or an antidepressant.

Nicotine gum tends to work best for lighter smokers. It can be purchased over the counter (OTC) in 2-mg and 4-mg doses (a piece of the 2-mg gum delivers about the same amount of nicotine as a cigarette). It should not be chewed like normal gum. Chew it slowly, until you feel a mild tingling. Then place it between your gum and cheek for a few minutes. Continue this process for half an hour, then discard the gum. Many people find they need 10 to 15 pieces a day during the first week after quitting.

Transdermal nicotine patches, which deliver nicotine through the skin, can be bought OTC as well. Use a dose that corresponds to the number of cigarettes you smoke. For example, if you are a pack-a-day smoker, you may want a patch that delivers 21 or 22 mg of nicotine over 24 hours. Likewise, if you smoke two packs or more daily, you might require a patch that delivers 42 to 44 mg of nicotine a day. Minor skin irritation can occur, so don’t apply them to the same spot every time.

Available by prescription only, nicotine nasal spray delivers a strong dose of nicotine into the nostril, where it is absorbed very quickly. This rapid delivery method may help heavy smokers. Headaches, watering eyes, and nasal/throat irritation are not uncommon in the first few days of use, but these effects generally wear off within the first week. The newest nicotine replacement—available by prescription—is a nicotine inhaler. It resembles a cigarette holder and delivers about 4 mg of nicotine. As the device can be held and inhaled like a cigarette, this might be the best choice for those who enjoy the ritual of smoking.

WHEN NICOTINE IS NOT ENOUGH

Despite their usefulness, nicotine replacement therapies don’t work for everyone. Interestingly, nicotine seems to matter more to men than to women. In most of the studies evaluating nicotine replacements, men do better than women. In addition, women with a low motivation to quit relapse more quickly than women who are very determined. Similarly, smokers with a history of depression tend not to do as well using nicotine replacement therapies alone. These findings imply that a certain percentage of smokers trying to break the habit may need some form of behavioral intervention, such as individual counseling or participation in a smoking cessation group.

“Research shows that nicotine replacement therapy increases the chance of success, but the best results are achieved in conjunction with behavioral therapy,” explains Dr. Maxine Stitzer, a professor of psychiatry at Johns Hopkins. “In therapy, people learn to avoid being around cigarettes, smokers, and things that trigger their desire for a cigarette.” Dr. Stitzer suggests that smoking is often a way of coping with an emotional problem. That is, a smoker might light up out of boredom or after getting into an argument. Therapy can address these underlying issues and offer alternative ways of dealing with them. Group and individual therapy are equally beneficial, Dr. Stitzer says. She recommends finding a program that extends for two months. “The hardest time is those first two weeks after quitting,” she says. “If you can go for two weeks without a cigarette, you have a much better chance at long-term abstinence than someone who cannot.”

Antidepressants are yet another option. Bupropion (Zyban), by affecting some of the same neurotransmitters as nicotine, reduces both nicotine cravings and withdrawal symptoms during cessation attempts. A recent study revealed that 23% of those taking bupropion, compared with 12% of those taking a placebo, were smoke-free after one year.

SMOKING continued on page 7

SPOHNC http://www.spohnc.org E-mail-- info@spohnc.org
SMOKING continued from page 6

That’s about the same long-term success rate as that seen with the nicotine replacement therapies. Interestingly, people taking bupropion did not gain as much weight as those taking a placebo. So bupropion might be a good cessation aid for smokers concerned about gaining weight after quitting. Another antidepressant-nortriptyline (Aventyl, Pamelor)- has been found to be an effective stop-smoking tool, although it is not approved for this purpose.

Finally, research indicates that combining therapies may be the most effective way to quit smoking. While the patch and bupropion used individually are more effective than a placebo in helping people to quit smoking after a month, the two used together achieve the greatest cessation rate, likewise, adding some form of counseling or behavioral therapy to drug therapy can increase a smoker’s chance of quitting for good.

Reprinted with permission from the JohnsHopkins Medical Letter Health After 50 ©Medletter Associates, 1999.

To order a one year subscription, please call 800-829-9170

Pansy: A Survivor with Attitude

“Difficult times can help you to grow”

S•P•O•H•N•C

SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER
MEMBERSHIP APPLICATION FOR PATIENTS, HEALTH PROFESSIONALS AND FRIENDS
Membership includes subscription to nine issues of News From SPOHNC

Name____________________________________ Phone (________)_________________
Address______________________________________________________________________
City____________________State____________________Zip____________

Please Check:   Survivor ____Friend ____Health Professional (Specialty) ______________________

ANNUAL MEMBERSHIP
$20.00 individual       $30.00 family
$30.00 Foreign (US Currency)

CONTRIBUTIONS
Booster, $10+ ____  Donor, $50+ ____  Sponsor, $100+ ____
Patron, $500+ ____  Benefactor, $1000+ ____  Founder, $5000+ ____

Please send checks (tax-deductible as permitted by law) to S•P•O•H•N•C, Inc., P.O. Box 53, Locust Valley, NY 11560-0053
SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER
S•P•O•H•N•C, INC.
P. O. BOX 53
LOCUST VALLEY, NY 11560-0053

PRESIDENT
Nancy E. Leupold
VICE PRESIDENT
James J. Sciubba, DMD, PhD
SECRETARY
Jean O. Cashin
TREASURER
Walter E. Boehmler

BOARD OF DIRECTORS
Walter E. Boehmler
Jean O. Cashin
Louis Frillmann
Nancy E. Leupold
James J. Sciubba, DMD PhD
Karrie Zampini, CSW

MEDICAL ADVISORY BOARD
Kenneth L. Halpern, D.D.S.
Keith Heller, M.D.
Alex Keller, M.D.
Joan Levy, M.A.
David Myssiorek, M.D.
Herman Oliver, M.D.
Jed Pollack, M.D.
James J. Sciubba, DMD, PhD
Elliot W. Strong, M.D.
Denise M. Vey Voda, D.D.S.
David P. Wolk, M.D.

NEWSLETTER EDITOR
Nancy E. Leupold

CALL 1-800 4-Cancer or your local American Cancer Society.
To find out if there is a support group in your area.

For information, counseling or reservations, please call 212 717-3527.
Rockefeller Research Laboratories, 400 East 67th Street, New York, NY
Memorial Sloan-Kettering Cancer Center
Post-Treatment Resource Program
Will meet on Thursday, May 12, 1999 at 2:30 P.M.
For Head and Neck and Oral Cancers
A Resource Program for People Treated
Moving Forward

For more information and directions, please call S•P•O•H•N•C at (516) 759-3333.
Reservations necessary.
Syosset, NY 11791
225 South Oyster Bay Road
Syosset Public Library
May 13, 1999
Will meet on the second Thursday of the month - 7:00 P.M.
Support for People with Oral and Head and Neck Cancer

S•P•O•H•N•C
NON-PROFIT ORGANIZATION
U.S. POSTAGE PAID
LOCUST VALLEY, NY
PERMIT NO. 28