

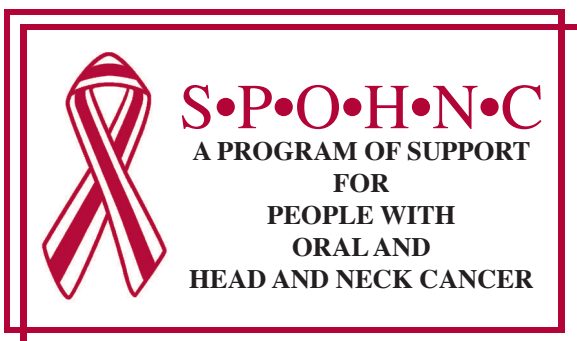
NEWS FROM S•P•O•H•N•C



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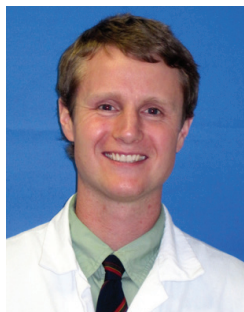


Transoral Robotic Surgery for Head and Neck Cancer

Matthew Pierce, MD, Jessica H. Maxwell, MD, MPH,
Bruce Davidson, MD, FACS

Introduction

Transoral Robotic Surgery (TORS) is a rapidly growing treatment modality for certain patients with head and neck cancer, specifically cancers of the oropharynx, including the tonsil and tongue base. Whereas many cancers of the head and neck are caused by a combination of tobacco and alcohol use, a majority of oropharyngeal cancers develop after a previous infection with the human papilloma virus (HPV). In fact, cancers of the oral cavity and larynx are declining with the decreased use of tobacco in society. However, the incidence of HPV-related oropharyngeal cancer has been steadily rising. With this rise in HPV-related cancer and the advent of TORS, surgical management has re-emerged as a valuable treatment option for select patients with oropharyngeal cancers.



Matthew Pierce, MD

Oropharyngeal Cancer

Currently, most oropharyngeal tumors (70-80%) harbor high-risk HPV, specifically types 16 and 18. HPV type 16 accounts for over 90% of HPV-related oropharyngeal cancers. Most adults in the United States have been exposed to HPV at some point during their lives through sexual activity. However, the vast majority of people with healthy immune systems who are infected with HPV will get rid of the virus within a year. Only a fraction of those people who continue to have latent HPV infection will then develop cancer. This transformation from HPV infection to carcinoma is thought to occur decades after the initial exposure.

HPV-related oropharyngeal cancer is distinct in its biology and clinical behavior compared to tobacco and alcohol-related head and neck cancer. Patients with HPV-positive oropharyngeal cancer tend to be younger and healthier and have an improved survival compared to those with HPV-negative oropharyngeal cancer. The excellent outcomes among patients with HPV-positive oropharyngeal cancer are related to the high responsiveness of these tumors to all types of treatment, including surgery and radiation.

Appreciating the current management of oropharyngeal cancer requires an understanding of the historical treatment of patients with these tumors. Prior to the early 2000's, advanced oropharyngeal cancer was managed by external surgical approaches, which often required cutting through the lower lip and jawbone in order to gain access to the cancer. Patients typically required a tracheostomy and a feeding tube as well. These surgical approaches were often disfiguring and involved significant surgical risks and complications. Following surgery, patients typically underwent post-operative radiation and/or chemotherapy. In order to improve functional outcomes without reducing survival, researchers investigated the role of combining chemotherapy and radiation therapy (chemoradiation) without surgery for patients with oropharyngeal cancer. This treatment modality consists of 6-8 weeks of radiation treatments, five days a week with simultaneous chemotherapy given at intervals during treatment. As a way to avoid extensive surgery, chemoradiation became a standard of care for the treatment of most patients with oropharyngeal cancer. Over time, chemoradiation was felt to cause fewer short term complications when compared to traditional surgery, but it was increasingly recognized to be associated with long term side effects.



Jessica H. Maxwell, MD, MPH

Recent changes in oropharyngeal cancer and in technology are impacting treatment options and decisions. First, patients with HPV-related oropharyngeal cancer tend to be younger with fewer health problems compared to HPV-negative cancer patients who are traditionally heavy smokers and drinkers. Second, the introduction of robotic resection in head and neck surgery has become a technologic advantage that provides more direct access to tumors of the oropharynx than the traditional surgical approaches. Transoral robotic surgery (TORS) now provides a less invasive approach to oropharyngeal surgery, and following surgery, there is the possibility of reducing or even avoiding additional treatment. Third, these HPV-related cancers are associated with a better prognosis; so long term survival is expected in most patients regardless of whether surgery or radiation is the initial treatment.

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NEWSLETTER EDITOR

Chris Traxler

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The risk of the side effects of treatment, particularly the late side effects, has now gained increased focus as treatment options are re-considered.

Transoral Robotic Surgery

Since its introduction in cardiothoracic surgery over 15 years ago, the Da Vinci robotic system has been utilized in many different surgical procedures by various surgical specialties including colorectal, gynecologic, urologic and general surgery. It was not until more recently that it was applied to the management of head and neck cancer. The technique was first described in cadaver and animal models in 2005 in order to prove safety and feasibility. The term TORS was coined by head and neck surgeons at the University of Pennsylvania. TORS was ultimately approved by the FDA in 2009 for select cancers of the mouth and throat. Since then, its use has spread rapidly throughout the country, providing a minimally invasive surgical alternative that reduces morbidity without compromising survival rates. In oropharyngeal cancer, TORS has also been shown to improve certain aspects of quality of life when compared to chemoradiation. Over the past few years, as training in TORS has increased and access to the robot has improved, many centers around the country have adopted this technology.

At this point it would be prudent to describe the robotic system itself as well as the general technique. The Da Vinci Si robotic system consists of two main components: the free standing robotic arms and a separate operative console where the surgeon sits. In TORS, there are three robotic arms positioned inside the patient's mouth. The center arm contains a small camera, which provides a wide angle, high definition picture of the surgical field. The two side arms use tools for grasping and cutting that are manipulated by the surgeon as an extension of his or her own hands. Occasionally there is misunderstanding about the robotic system, as people incorrectly believe that the robotic arms are programmed and move independently on their own, such as in automobile assembly lines. This is not the case with surgical robotic systems. The surgeon is 100% in control of the robotic arms at all times and the machine has no movement without real time direction from the surgeon. The technology translates the surgeon's hand movements into finer detail and magnifies the operative field with the high definition camera, allowing the surgeon to maneuver around corners and in tight spaces, such as in the oral cavity and throat.

The specific surgical technique employed by otolaryngologists differs slightly amongst each individual surgeon, depending on which procedure is being performed. However, the basic steps are generally the same. After a thorough discussion including the different treatment options and risks of the procedure, the patient is taken to the operating room where an anesthesiologist puts them to sleep and a breathing tube is inserted into the airway. The surgery begins with a metal retractor positioned in the patient's mouth to keep it open. The Da Vinci robot is then brought into the field and positioned near the head of the operating table so that the robotic arms can be easily positioned inside the oral cavity. An assistant sits at the head of the bed while the surgeon sits at the console to direct the instruments. There are a number of different instruments available, however in TORS these typically include a monopolar cautery (a knife that stops bleeding as it cuts) and a Maryland

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dissector (a grasping device). The advantage of using the robot is that the surgeon can see and use both instruments in a small space that may be otherwise out of view.

It is a universal paradigm that in all cancer surgery, the goal is to remove the entire tumor including a cuff of normal tissue. In traditional head and neck surgery, extensive surgery was required to expose the tumor enough to see and remove it. Robotic surgery provides that access without the extensive preliminary work and still provides the ability to remove the tumor completely. In TORS, bleeding is controlled with cauterization or surgical clips and the surgical wound is left open to heal over time. As will be discussed in more detail below, occasionally tumors prove even too elusive for our current robotic system.

Indications for TORS

There are many different indications for the use of TORS in the management of head and neck cancer. These relate to characteristics of both the cancer itself and the individual patient. The two most common cancer sites that are treated by TORS resection are the tonsil and the base of tongue. A small tonsil cancer can be removed using a technique known as radical tonsillectomy. This refers to surgery that removes the tonsil along with the muscle layer that lies deep to the tonsil. This is a wider resection than that done in routine tonsillectomy. Similarly, small base of tongue cancers can be resected using a TORS approach. Tonsil tumors that grow through the muscle layer noted above and base of tongue tumors that grow across the midline or extend forward into the oral tongue are usually considered to be too extensive to allow successful TORS surgery.

One growing indication for the use of TORS is among patients who present with cancer in the neck and no clear primary site in the throat. When these “cancers of unknown primary” presents in a lymph node in the neck, the source is often found in the pharynx. Typical sites of origin are the tonsils and the base of tongue (lingual tonsils). In order to find the primary cancer in these cases, a CT/PET scan (X-rays that look at the whole body) and exam under anesthesia have traditionally been used. Tonsillectomy is done as well since the cancers are often found deep in the tonsil tissue. The addition of TORS in these cases may provide two

advantages. One advantage is that if the cancer is found in the tonsil, conversion to a more radical surgery can be done in order to remove the tumor with clear margins. The other advantage is that the lingual tonsil tissue can be evaluated and resected by TORS, which is very difficult to do without TORS. When the application of TORS is considered in these unknown primary cancers, there are equipment and surgeon scheduling complexity that must be considered. More than one trip to the operating room may be required.



The goal of TORS is to obtain negative margins at the primary site. At this point, all patients also undergo surgery (non-robotic) to remove the lymph nodes in the neck that may harbor metastatic cancer. If a patient has a small tumor and TORS succeeds in obtaining clear margins and neck dissection confirms that no cancerous lymph nodes are present then no further therapy is required. On the other hand, patients with large tumors in the throat or extensive cancer in the neck are likely to require both chemotherapy and high dose radiation therapy whether surgery is done or not. The use of TORS in such a patient would not appear to provide any advantage in terms of the risk of recurrence or in reduced side effects from treatment, so the patient would be recommended to pursue chemoradiation alone with surgery only as a salvage treatment if needed.

The treatment decisions become complex when the patient presents with something in the middle of these two circumstances. In fact, most patients present with tumors that are between these two extremes. We STRONGLY SUPPORT a multidisciplinary approach to these patients. This may involve a tumor conference where surgeons, radiation therapists and medical oncologists come together to discuss new patients and to guide treatment decisions. A surgeon who is familiar with the advantages and limitations of TORS is essential in these conferences. In absence of a formal conference, the patient should be seen by head and neck specialists from the different

disciplines involved in the patient's care. Patients who are evaluated with all options in mind are likely to get the best care.

Limitations and Complications

Of course, as with any type of medical treatment there are always limitations and risks. With new technology, it is of paramount importance to assess the risk and potential complications of new procedures in order to keep patient safety the top priority. Careful selection of appropriate patients is crucial. We have described that some tumors are too large to resect in this way. However, even patients with small tumors may not be amenable to TORS. Patients may have limited mouth opening that does not allow enough access to attempt TORS. Other patients may have small tumors that lie at sites that are difficult to access using current robotic equipment. It is essential to have good access to the oral cavity and certain anatomical variations can prove too difficult even for TORS. These patients should be counseled on other alternatives. In the future, new equipment, such as a single, flexible arm robotic system, may provide the technology so that difficult to access tumors may be amenable to robotic resection.

The potential complications of TORS can be divided into intraoperative (during the surgery itself), perioperative (hours and days immediately following surgery) or late (weeks to months after surgery). Intraoperative complications include bleeding, swelling, and damage to surrounding structures such as teeth, gums and lips. Post-operative complications include bleeding, surgical site infection, difficulty swallowing and the possible need for a feeding tube. As with all surgical procedures, death is always a possible, but highly unlikely, risk. A recent study reported one surgical related death in 410 patients treated with TORS (De Almeida, JR, et al. *Oncologic Outcomes After Transoral Robotic Surgery: A Multi-institutional Study. JAMA Otolaryngology-HN Surgery.* 2015 Dec 141:12.). Patients who cannot discontinue blood thinners are at an increased risk of bleeding and may not be appropriate candidates for TORS. Late complications include persistent difficulty with swallowing and need for a feeding tube, recurrence of cancer and delayed healing. Patients who have had previous radiation should be counseled that they will likely

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have longer healing times. Currently, there are ongoing clinical trials incorporating TORS into the treatment paradigm for cancers of the head and neck and as more results become available our understanding of the indications and risks may change.

Conclusions

Ultimately, as our understanding of head and neck cancer has evolved, so has the technology to treat it. Whether in the screening, diagnosis or treatment of head and neck cancer, technological advances continue to improve outcomes while providing safe alternatives to traditional therapies. TORS is yet another tool among many that can be used to both diagnose and treat certain types of cancers in the head and neck. TORS offers a safe and efficient alternative to traditional open approaches allowing for more maneuverability and detail while maintaining excellent outcomes.

2016 - A New Year...and a New Venture

As 2016 brought some chilly winter winds and snowy days to SPOHNC's national office, it also brought a big change to our SPOHNC family. It is with sadness for us, but happiness for her, that we announce to you that our Chapter Administrator, Lisa Caracciola, has taken an exciting opportunity to return to her career in insurance.



We will miss our dear colleague and friend very much.

Lisa became a member of our SPOHNC family in 2009, and was an asset to our staff ever since. She

brought with her a kind and caring heart, and a special ability to ease the worries of a newly diagnosed patient or their family member who might call seeking information about SPOHNC programs, or some other type of assistance.

Ever patient and kind, Lisa always had a listening ear, and made every caller feel as though no one else mattered at that moment. Her apparent New York accent brought familiarity to many callers, while providing a topic of conversation and even entertainment, to others. She took it all with a laugh and a smile.

Editors Note: Matthew Pierce, MD is currently the Administrative Chief Resident in the Georgetown Otolaryngology Residency Program. Upon completing his residency in 2016, he will continue his training in a head and neck surgery fellowship at Yale.

Jessica H. Maxwell, MD, MPH is an Assistant Professor in the Department of Otolaryngology-Head and Neck Surgery at Georgetown University Medical Center and an Attending Surgeon at the Washington DC VA Medical Center. She completed her fellowship training in Head and Neck Surgical Oncology at the University of Pittsburgh Medical Center.

Bruce J. Davidson, MD, FACS is Professor and Chairman of the Department of Otolaryngology-Head and Neck Surgery at Georgetown University Medical Center and Chief of Otolaryngology at Medstar Georgetown University Hospital. His practice is focused in head and neck surgery and includes transoral robotic surgery.

She built some very special bonds with our Chapter Facilitators and Co-Facilitators, helping to grow the number of SPOHNC Chapters in the United States from 76 to more than 128 in the 7 years she was here. Lisa also had several special friends through SPOHNC – survivors who would call or send letter or postcards “just to say hello.”

It takes a very unique woman to do what Lisa did every day at SPOHNC. Juggling multiple tasks, answering the phones and even providing some much needed laughter in the office, she was a joy to work with. Though we will miss her very much, we know she will do great things, and will enjoy her new career path.

We wish you well Lisa, and thank you for all that you did for SPOHNC, and for those who you interacted with each and every day. Your heart is a big one, and it seems there was always room for more love, no matter what happened, every day.

*“They say that we
are all drops of water in the ocean
- but some of us sparkle.
You did...”*

~ Maggie D.

It Must Be Spring

*Hush, Can you hear it?
The rustling in the grass,
Bringing you the welcome news
Winter's day is past.
Soft, Can you feel it?
The warm caressing breeze,
Telling you the sticky buds
Are bursting on the trees.
Look, Can you see them?
The primrose in the lane,
Now you must believe it -
Spring is here again.*



Photo courtesy of PJ Jordan

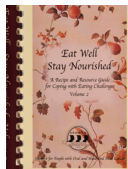
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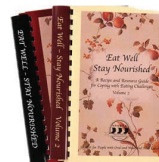
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Time for Sharing...This is My Story and I'm Sticking to it...Osteosarcoma

I am a retired federal law enforcement officer having retired in September 1996. In January 2012 I developed an abscess by tooth # 19 which was painless but irritable. I went to my dentist and was given a solution to clean the abscess for a couple of weeks. I returned to my dentist and she told



me that there was something wrong with tooth # 19 and that it needed to be extracted. On the same day a dental surgeon extracted tooth # 19 and prepared the gum area with bone graft for an implant which would occur four or five months later.

Two months later I began developing soft tissue bulge on the exterior side of the gum in the area where # 19 was extracted. The bulge did not hurt but it seemed hard. I contacted the surgeon's office and Amoxicillin was prescribed and appointment was made.

On May 11, 2012 the surgeon removed soft tissue mass/oral surgery and sent it to the lab. On May 17, 2012 the surgeon presented me with biopsy lab report – interpreted as a malignant bone tumor on the left mandible (jawbone): high-grade osteoblastic Osteosarcoma. I asked, “What is Osteosarcoma?” Needless to say, I was totally shocked. He recommended that I consult with a particular specialist and gave me his card. Osteosarcoma is very rare on a 65 year old man. I came home and informed my family of the diagnosis and that we would take it in stride and stay positive.

May 29, 2012 – I met with the specialist. He told me that his staff would make all arrangements for my appointments for an MRI of the head and neck and that it needed to be done as soon as possible since Friday, June 1 was the Cancer Tumor Board Meeting and he wanted to present my case to the Board.

On June 5, 2012, I decided to establish a support group of approximately 40 close friends and relatives via email and sent them

a “sequence of events” document that I had put together advising them of what was happening with me. This was Update # 1. The updates continued during the surgery and I continued them after I came out of my trauma. On June 6, 2012 I had a consultation with a Radiation Oncologist. He told me that radiation would take care of any remaining Osteosarcoma micro-organisms.

On June 7, 2012 Alice, Barbara and I met with my physician and his assistant. He reviewed CT scans, MRI and PET scans with us. He said that the sarcoma was running the length of much of the lower left side of the jaw. He said that Osteosarcoma is an aggressive form of cancer. The plan that my team came up with entailed surgery first to remove the sarcoma and reconstruct the jaw, a few weeks of recovery, then chemotherapy for 8 weeks or longer. Then depending on my health and strength after chemo ... radiation therapy may be the final step. My doctor said that the journey to cure this would be six months.

On June 14, 2012 I had a consultation with a Chemotherapy Oncologist. On June 14, 2012 I had a consultation with a specialist in Hand & Plastic Surgery. He said that the fibula to replace my left mandible will be from the right leg after he did his examination. He said that the jawbone has two angles and that after my surgeon removed the jawbone they would make sure the titanium plate fits the jaw area and then they would use the plate to measure the fibula.

On June 18, 2012 I met with my surgeon, where he gave me a complete picture of the surgery, possible complications and possible after effects. I had to sign the consent forms.

So what was going through my mind during this totally stressful period? I certainly was not blaming anyone for my condition. I had been asked by my doctor what I had been exposed to in my 65 years on this earth ... many chemicals including Agent Orange in Vietnam. The bottom line was, here I was in a condition that no one would ever want to be in, but in my mind, I had to remain totally positive about this situation. My daughter Patti asked me what my feelings were about the upcoming surgery. I told her that in my mind, I was going on a combat patrol and that

I knew I was going to be injured but could not imagine the extent of the injuries.

I have to say that the support I received from my wife Alice, daughters Barbara (and family) and Patti and all of my friends was tremendous, especially from Alice, Barbara and Patti and I will forever be in their debt. I firmly believe that you cannot get through a situation like this without great support. Most people do not realize what support is or does.

On June 22, 2012 Alice and Patti went with me to Sharp Memorial Hospital (and Barb), I checked-in at 5:20 AM for 7:20 AM surgery. I remember being prepped and taken in to the room where the surgery was to be performed. The last thing I remember was joking around with the anesthesiologist. I was informed later that the surgery lasted 15 ½ hours. I will forever be in debt to my physician and his surgical team. The Osteosarcoma was rated at stage “4”.

It was several days before I came to my senses after the surgery. They had me pumped up with so many pain killers that I was hallucinating like a mad man on all my ‘awake’ hours. They had performed a trachea on me so I could not speak. They gave me a pad and a pen to write what I wanted to say but couldn't see without my reading glasses. I would imagine that it was hilarious whatever I scribbled on the pad. I do know that Alice, Barb and Patti were constantly at my side. The hallucinations continued and that scared me from time to time. Finally after about a week, I had a conversation with my doctor, who told me that by now I should no longer be on any pain killers.

I thought about it that day, felt my face and neck and he was correct, nothing hurt. That evening I told my nurse that I didn't want any more pain killers. She gave me two Tylenol before my bedtime.

Shortly after I came to my senses, my surgeon came in to see me and told me that as far as he was concerned I was in remission effective the day of my surgery. He said, “I took it (the cancer) all out, I could see it.” He said that the bone (left mandible) looked like a shriveled pickle. A few days later, he came in and told me that he was looking at releasing me in a day or two. But then he detected an infection near the mandible

continued on page 8

continued from page 7

area. The infection was confirmed and now I could not be released until the infection was under control. In the meantime they installed a feeding tube and a PICK line for infusion of antibiotics when they released me from the hospital on July 16, 2012.

When I got home my weight was down to 165 (down from 195) and if I didn't take the seven cans of nourishment on a daily basis I would lose weight. I was feeling weak and feeble. I was also under the care of a dietician over the phone.

On August 14, 2012 I went in for my mask fitting before I began my radiation series. I began my radiation series on Thursday, August 23, 2012 and Chemo every Friday beginning August 24, 2012. I did 35 sessions of radiation and 7 sessions of Chemo and finished these treatments on Wednesday October 10, 2012. By that time I was all beat up, the inside of my mouth was in shambles and fortunately using the feeding tube as I could not eat anything orally.

My dentist's office took impressions of my teeth and made plastic trays that fit my teeth. Now, on a daily basis, before bedtime, I have to use NeutraMaxx 5000 Gel on the trays and place them on my teeth for approximately five minutes.

In September 2012 I attended my first SPOHNC meeting in San Diego, CA. On December 11, 2012 I met with Dr. Kossman who informed me of my upcoming Chemo treatments. He said I would have six sessions, one session every three weeks. Each session would consist of three days of Chemo.

On December 14, 2012 Dr. Mansfield told me the PET scan was clear...no cancer. On December 18, 2012 I went to Sharp Memorial Hospital to have a Chemo Port installed. On Tuesday, January 8, 2013 I began my first session of Chemo that consisted of a cocktail of anti nausea and hydration and 100 ml of Cisplatin plus 50 ml of Adria. I was advised that the Adria was the one that would cause the hair loss. The session began at 12:30 PM and ended at 5:30 PM. On Wednesday, January 9, 2013 I had an exact repeat of Chemo infusion as the day before.

On Thursday, January 10, 2013 I had a shorter session which consisted of the cocktail of anti nausea and hydration but the Chemo was only the 50 ml of Adria. On Friday, January 11, 2013 I had to go in for a shot to boost my immune system as my white blood cells were depleted by the Chemo. A blood test was done

and I had a visit with Dr. Kossman. He was monitoring my red blood count very closely.

On April 23, 2013 I went in for my sixth and final session of Chemo. On Friday I went in for the shot to boost my immune system and after the blood test ended up having to do another blood transfusion.

One thing I noticed around early May 2013 was that the bottom of my feet were feeling kind of funny, like I was losing my feeling at the bottom of my feet, and also the tips of my fingers on both hands were getting tingly. An estimated 30 to 40 percent of cancer patients treated with chemotherapy experience these symptoms - a condition called chemotherapy-induced peripheral neuropathy (CIPN). So what do you do about it? I do as Clint Eastwood said in one of his movies, "You live with it."

On June 10, 2012 my feeding tube was removed at Sharp Memorial Hospital. I saw Dr. Mansfield on December 16, 2013. He told me everything looked great. He ordered an MRI and a PET scan.

On March 3, 2014 I had an appointment with Dr. Mansfield. Prior to seeing him, his office did a CT scan of my head as he wanted to see how the bone had adhered on my jaw. Dr. Mansfield seemed very pleased (as was I). He said that I could do anything I wanted, that the bone was completely healed. He also told me that the PET scan was totally clear with no cancer showing anywhere in my body. He recommended that I see Dr. Harold Gulbransen, a dentist and specialist in prosthodontics. Dr. Gulbransen may be able to develop a denture for me for the area where the left mandible had been removed, teeth and bone. I told Dr. Mansfield that I had trouble reaching in between my cheek and teeth with my tongue. He said that he had taken out about 40 percent of my tongue during surgery. He said that the bulge I had on the outside of the gum by # 19 was also on the inside and into the tongue. That part of the tongue had to be removed as it had soft tissue sarcoma.

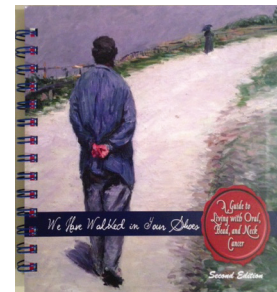
On March 19, 2014 my Chemo port was removed at Sharp Memorial Hospital. On March 27, 2014 I had my first appointment with Dr. Gulbransen.

After his examination, Dr. Gulbransen said the process would take about two months to build me a denture for my missing teeth where the left mandible was replaced.

Life goes on and I look forward to it ... I am very thankful to the Almighty God. Every day is a holiday and every meal is a feast! Semper Fi!

~ Arnoldo Flores
MrHDHawg@aol.com

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~ Valerie T.

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Chapter News

From the desk of Linda Clyne – Greenville, SC SPOHNC Chapter Facilitator, along with her husband, Bill, Survivor. Both of these amazing people are also volunteers for our National Survivor Volunteer Network – Bill as a patient match volunteer and Linda as



a caregiver match volunteer. “We had another GREAT meeting last night here in Greenville. We did a Valentine-themed Caregiver Appreciation Night. To better explain it, here is an excerpt from the reminder email I sent prior to the meeting:

February is the month for expressions of love, so the purpose of this meeting is to celebrate those who have loved us through some tough times. Please invite a family member, caregiver, friend, doctor, nurse, etc. -- anyone who really made a difference during your treatment and recovery -- and be ready to sing their praises to everyone in our group. Present them with a valentine, write a poem or share stories about their special acts of kindness...Be creative, be boring... It's not HOW you tell them that you appreciate them, just TELL THEM!

Refreshments will be served. Our very own “Italian Chef Extraordinaire” Matt G. is bringing homemade cheesecake. Thanks in advance, Matt! The generous folks at St. Francis are helping with decorations and utensils, we'll have coffee and cold beverages, and a special gift for all our invited guests.

I can't begin to tell you how nice it was last night. Not everyone brought a guest but everyone had a chance to tell about a person (or two or three) who were invaluable during their treatment and beyond. There was a very moving interaction that involved two of our Chapter attendees, one of whom has a daughter who is a patient, and the other is a pastor in our group who I knew would be the perfect “mentor” for the gentleman's daughter. The way this connection has changed a life is amazing; this is the kind of stuff that puts a face to God's grace.

Here are some photos. The woman standing is not a speaker, she is a sign-language interpreter who comes with one

of our hearing impaired attendees. We were going to take more of individuals with their guests, but we got busy talking -- and eating cheesecake, also not pictured! We wanted to do some sort of special gift for the guests at our

Valentine's celebration, but we didn't get the idea for the mugs until the last minute. Pictured are the front and back views. It's amazing what



even a non-artistic person can do online. They turned out GREAT! I ordered these on Saturday afternoon and had 20 delivered to our door Wednesday afternoon. We gave out 19 of them last night.

Some other cool things to report: Four of our members will be getting free massages next month, compliments of massage therapists in an “Advanced Oncology” class. It's all a part of the St. Francis Cancer Center, where we have been hosting our meetings.

We have an attendee in our group who works for a large financial services company. He approached me last night about doing a fundraiser with SPOHNC as a (partial) beneficiary. From what he told me, his office brings clients in every year for a big dinner, etc. and there is some sort a program whereby they raise money for selected charities. This year the Greenville Cancer Society is one and he would like SPOHNC to be another. More to come soon!

Yours truly, the “Queen of Technological Incompetence” managed to figure out how to start a Facebook page for SPOHNC - Upstate United! It's a closed group, and so far we have 8 members signed on. I've used it to post meeting announcements (in addition to the emails I send every member) and I've shared two recent FB posts from your site. The best use so far was when one of our members got a “clean bill of health” exam and posted the news on FB. Bill and I were sitting in a restaurant in Charleston (our first overnight trip to the east coast since moving here). In between courses I did a

quick check of my phone and saw the FB post about Walt's good news. At about the same time Matt (another member, the one who provided the divine cheesecake last night) saw it, too, and we had a short 3-way “like-fest” with messages of congratulation. Matt said last night he was as happy to read that message as if it had been his own. It is truly wonderful to see what a “family” we are becoming.

I am encouraging some attendees in our group to write “A Time for Sharing” pieces. If you ever talk to someone who is “considering” starting a chapter but not sure if all the hard work is worth it, you can send them our way. It is worth it!”

**Do you have a Story to Share?
Chapter News? Survivor News?**



SPOHNC is seeking GOOD NEWS every day, so share your special occasions, milestone celebrations, hobbies, book choices and anything else you find newsworthy.
Send them to info@spohnc.org

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April Is Oral, Head and Neck Cancer Awareness Month

SPOHNC is looking for news...and we want to promote YOU

April is Oral, Head and Neck Cancer Awareness Month. Have you thought about how you might raise awareness this year – with your Chapter, or in your Community? Would you like to see yourself, or your SPOHNC Chapter, featured in a future issue of “News from SPOHNC”?



Last year, lots of creative events took place, raising awareness of oral, head and neck cancer. There were Move to Music Exercise Classes, Oral Cancer Screenings, Awareness Displays at Community Health Fairs, Bake Sales, Taste Events and more! SPOHNC was pleased to feature those we heard about in the newsletter, on Facebook and on our website as well.

If you need ideas or help getting started, SPOHNC has educational materials to

share. We can get you well on your way to a successful event. SPOHNC is here to help. If you'd like to speak to someone who ran a successful event in the past, our Facilitators will be glad to connect with you. We can bring you together.

Let us know what's happening. We'll promote your event on our Facebook “group” and “page” and on our website. After your event, send us photos and a short piece about how you raised awareness of oral, head and neck cancer. We'll publish it in our newsletter, and feature you and your group on our website.

SPOHNC needs your help to promote awareness of oral, head and neck cancer and reach newly diagnosed patients and their families. We're all part of the April Oral, Head and Neck Cancer Awareness Campaign, so let's work together. Contact SPOHNC at info@spohnc.org, or at 1-800-377-0928, and we'll help you get started.

We're here for you – and we want to hear from you!

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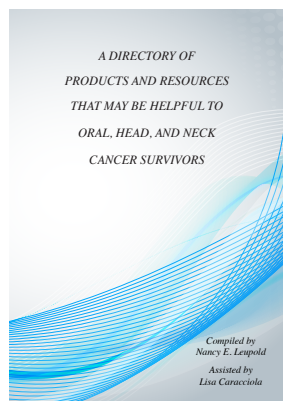
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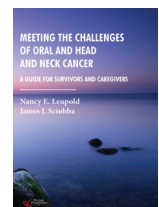
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