

NEWS FROM S•P•O•H•N•C



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S•P•O•H•N•C
A PROGRAM OF SUPPORT
FOR
PEOPLE WITH
ORAL AND
HEAD AND NECK CANCER

THYROID CANCER

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Mark L. Urken M.D.

Thyroid cancer is the most rapidly increasing malignancy in the United States. The intent of this article is to provide information about thyroid cancer, its risks, symptoms, diagnosis, management and follow-up care.



The thyroid gland is located in the midline of the front of the neck below the Adam's apple and above the collar bone. The gland is in the shape of a butterfly with 2 equal sides, the right and the left lobes, that are joined by the isthmus. In most individuals, the thyroid cannot be seen or felt. Behind the thyroid gland and resting directly on its surface are 4 *parathyroid* glands, which make

parathyroid hormone, that also plays a significant role in regulating the level of calcium circulating in the body.

The thyroid gland is comprised of 2 main types of cells: thyroid follicular cells and C cells (parafollicular cells). The follicular cells absorb iodine from the bloodstream to produce thyroid hormone, which helps to regulate the body's metabolism. *Hypothyroidism* occurs when there is a low level of thyroid hormone causing decreased body metabolism, producing symptoms of: fatigue, weight gain, feeling cold and lack of energy. *Hyperthyroidism* occurs when there is a high level of thyroid hormone and can harmfully elevate the body's metabolism and cause an irregular or elevated heartbeat, anxiety, diarrhea, hunger, weight loss, feeling too warm and difficulty sleeping. The pituitary gland is located at the base of the brain and produces *thyroid-stimulating hormone* (TSH), which regulates the amount

of thyroid hormone released by the thyroid gland. The C cells produce calcitonin, a hormone that regulates how the body uses calcium.

Types of Thyroid Cancer

Various types of tumors can develop in the thyroid gland. At times, the orderly process of normal cell death and growth is altered and an overdevelopment of cells creates a *nodule*. Thyroid nodules can develop at any age, however, they are more common in adults. When the thyroid gland is evaluated with an ultrasound machine, nearly half of all adults are found to have a thyroid nodule that is too small to feel. Most thyroid nodules, approximately 90-95%, are benign, however, 1 in 20 are cancer.

The majority of thyroid nodules are cysts containing a stored form of thyroid hormone called colloid. Solid nodules are more likely to be cancer, albeit, the majority of these are also benign. The presence of several large nodules in the thyroid is generally a benign condition known as a *multinodular goiter*. Benign nodules often do not require treatment unless they become very enlarged or cause symptoms.

Papillary carcinoma and *follicular carcinoma* are the 2 most common types of thyroid cancer. These tumors develop from thyroid follicular cells and are known as *well differentiated cancers*.

Papillary carcinoma makes up about 80 percent of thyroid cancers and typically grows very slowly. In many instances, papillary carcinoma can spread to the lymph nodes in the neck. If diagnosed early, this cancer can be successfully cured.

Follicular carcinoma makes up about 10 percent of all thyroid cancers and tend not to spread to the lymph nodes in the neck. The prognosis for follicular carcinoma is also quite favorable, though not as good as that of papillary carcinoma. If diagnosed early, this cancer can be successfully treated.

The other types of thyroid cancer occur less frequently and include medullary thyroid carcinoma and anaplastic carcinoma.

Medullary thyroid carcinoma (MTC) makes up about 4 percent of thyroid cancers and develops from the C cells of the thyroid gland. These cancers produce an abnormally high level of calcitonin in the blood. This cancer can spread to lymph nodes in the neck, the lungs, or the liver. Since medullary cancers do not absorb radioactive iodine, which is often used for the treatment of papillary and follicular cancer, the prognosis is not as favorable. Familial MTC is genetic, and can occur in multiple generations of a family, often developing in children and can be found linked to other types of tumors.

Anaplastic carcinoma makes up about 2 percent of thyroid cancers. It is also known as *undifferentiated carcinoma*. Although this tumor begins in follicular cells of the thyroid, under the microscope the cancer often appears very different from thyroid

THYROID CANCER continued on page 2

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IN THIS ISSUE

A Time For Sharing.....5
 SPOHNC's 20th Anniversary.....7
 Head & Neck Cancer News.....8
 Local Chapters of SPOHNC.....9

COMING IN APRIL 2012

“HPV and Oral and Head and Neck Cancer”
 Dr. Sara Pai

THYROID CANCER continued from page 1

cells. This cancer usually occurs in older persons, grows very rapidly, invades surrounding structures in the neck and spreads very quickly. Anaplastic carcinoma has a poor prognosis and is difficult to treat.

Statistics about Thyroid Cancer

In the United States, it is estimated there will be 48,020 individuals newly diagnosed with thyroid cancer in 2011, with approximately 36,550 women and 11,470 men affected¹. Thyroid cancer is the seventh most commonly diagnosed malignancy in females. The SEER (Surveillance Epidemiology and End Results) Cancer Statistics Review compiled by the National Cancer Institute showed that the number of people in the United States with thyroid cancer, known as prevalence, on January 1, 2008 was approximately 458,000¹.

Over the past two decades, the incidence of thyroid cancer has increased at a higher rate than other cancers in the body. It is thought this is partly due to an improved ability to detect early thyroid disease, including smaller cancers, with an increased use of the ultrasound machines. However there is also an increased number of larger thyroid cancers being detected².

The overall 5-year relative survival for thyroid cancer from 2001-2007 is reported as 97.2%¹. The death rate from thyroid cancer is very low compared to most other cancers and has been relatively stable for several years. It is estimated that approximately 1,740 men and women will die of cancer of the thyroid in 2011¹.

Risk factors for thyroid cancer

Research has identified certain risk factors that increase the chance of developing thyroid cancer. The risk factors that are known include:

- Exposure to high levels of radiation is a known risk factor for papillary and follicular thyroid cancer. Sources of high radiation include radiation fallout from a nuclear power plant accident and also some medical treatments.
- Individuals exposed to radiation incidents, such as the Chernobyl accident in 1986, have been shown to have a significantly higher risk for thyroid cancer, particularly if they were children at the time of exposure. Adults living close to Chernobyl in 1986, or who played a role in the cleanup after the accident, also have had a higher rate of thyroid cancer.
- An exposure to head and neck radiation treatments is a risk factor for thyroid cancer, particularly in children. From the 1920s to 1950s, children were at times treated with radiation for conditions that are not currently treated with radiation such as acne, enlarged tonsils or adenoids, or an enlarged thymus gland. Formal radiation therapy has and is currently used for some cancers in children including neuroblastoma, sarcoma, lymphoma and Wilms tumors. Research has shown that some individuals who have received such treatments have developed thyroid cancer. An exposure to head and neck radiation as an adult has a lower risk of leading to a thyroid malignancy.
- Although the reasons are not understood, women are about 3 times more likely than men to develop thyroid cancer. Thyroid cancer can develop at any age, however, there is an increased risk among women older than 40-50 years old and men older than 50 years old.
- Iodine is a substance commonly found in iodized (table) salt or shellfish. In areas of the world where there is low

THYROID CANCER continued on page 3

THYROID CANCER from page 2

iodine in the diet there is an increased risk for follicular thyroid cancer. In the United States, most individuals have enough iodine in a regular diet.

- Having a first-degree relative such as a parent, sibling or child with a differentiated thyroid cancer has been shown to increase the risk of developing papillary and follicular thyroid cancers.

An estimated 20 percent of medullary thyroid carcinomas (MTCs) are associated with the inheritance of an abnormal *RET* gene. This can occur alone in *familial medullary thyroid carcinoma* or with other cancers as a *multiple endocrine neoplasia (MEN) syndrome*. In addition to MTC, in *MEN* the other tumors can include pheochromocytomas, parathyroid gland tumors, or neuromas. If there is an abnormality of the *RET* gene, which can be detected with a blood test, there is a very high risk of other family members developing MTC.

Symptoms of Thyroid Cancer

Often there are no symptoms associated with early thyroid cancer. As thyroid cancer grows, however, the following signs and symptoms may develop:

- A swelling or nodule in the front or the side of the neck
- Hoarseness
- Difficulty swallowing (dysphagia)
- Difficulty breathing (dyspnea)
- Blood in the sputum (hemoptysis)

However, commonly, these signs and symptoms are not due to thyroid cancer. An individual with such findings should seek the care of a physician so a diagnosis can be made and treatment, if needed, can be started.

Attention to thyroid cancer signs and symptoms at an early point is the best way to diagnose and treat this disease at the point when the chance for cure is optimal. Many early thyroid cancers are identified during a routine physical examination or if a patient asks their physician about a neck nodule or lump that has recently developed. Uncommonly, thyroid cancers can go unnoticed until they reach an advanced stage. An ultrasound or other imaging of the neck completed for a different health problem often diagnoses a nodule in the thyroid.

Diagnosis of Thyroid Cancer

Laboratory tests can help to identify whether the thyroid is working normally by testing the blood level of thyroid-stimulating hormone (TSH). However, the levels of TSH and thyroid hormone (T3 and T4) are generally normal in thyroid cancer. If there is a suspicion or family history of medullary thyroid cancer (MTC), physicians can evaluate for an abnormally high level of calcitonin in the blood.

A biopsy is the best method to diagnose thyroid cancer. Cells from the suspicious nodule are removed and evaluated under a microscope. A *fine needle aspiration (FNA)* biopsy is most frequently performed to see if a thyroid nodule is benign or malignant. The accuracy of this test is improved when carried out under ultrasound guidance.

An FNA biopsy can be completed in a physician's office or a radiology department. A thin needle will be placed directly into the nodule to withdraw a few cells. This process is generally repeated a few times to take a sample from multiple areas of the nodule. In general, a biopsy is done on all thyroid nodules that are larger than 1 centimeter.

If a diagnosis cannot be made from FNA biopsy, the physician may elect to complete a surgical biopsy known as a *lobectomy*, in which the lobe that contains the suspicious nodule is removed in the operating room under anesthesia. Follicular thyroid cancer cannot be diagnosed accurately by FNA so a surgical biopsy is usually required to make the diagnosis.

Ultrasound: An ultrasound, or sonogram, uses sound waves to create an image of parts of the body. Sound waves are directed at the thyroid gland and a computerized screen will detect echoes as the waves are reflected off the thyroid to give an image of the gland. The ultrasound identifies nodules in the thyroid and shows their size and shape and also if a nodule is solid or filled with fluid. In some instances, an ultrasound will be used to guide a needle biopsy of a suspicious nodule if the nodule is too small to be felt. An ultrasound of the neck may be useful in telling if cancer has spread to enlarged lymph nodes in the neck.

Radioiodine scan: Patients with differentiated thyroid cancer (papillary and follicular cancer) can be evaluated with a radioiodine scan, only after the thyroid

gland has been removed. A small amount of radioactive iodine (called I-131) in a pill form is swallowed and enters the blood stream. After a short period of time, the radioiodine is absorbed by thyroid cells anywhere in the body and a *whole-body scan* is used to evaluate if thyroid cancer is possibly present or has spread to other parts of the body such as other organs or bone.

Staging: Following the determination of the size of a cancer and if it has spread, the extent or *stage* of a patient's thyroid disease is determined. The stage is an important factor in selecting the best treatment options for a particular patient, and to provide a prediction for the chance for cure.

Expected Survival

A survival rate is a rough estimate of an individual's outlook or prognosis for being alive at a set amount of time after the diagnosis of a disease. These rates are based upon previous outcomes of a large number of patients who had the disease, but cannot provide an exact prediction of what may occur in any one case. Multiple other factors can also affect prognosis including age and other health factors.

A 5-year survival rate will indicate the percentage of patients who are alive at least 5 years after their cancer treatment. Commonly, many individuals with thyroid cancer will live well beyond 5 years and most are cured of their disease. A 5-year *relative survival rate* will account for the fact that some individuals may die of other causes over the subsequent 5 years and is a more accurate way to describe the prognosis for patients with cancer.

The following survival data is based upon the 2010 7th edition of the American Joint Committee on Cancer (AJCC) Cancer Staging Manual^{3,4}.

Papillary thyroid cancer (based on patients diagnosed between 1998 to 1999)

Stage	5-Year Relative Survival Rate
I	near 100%
II	near 100%
III	93%
IV	51%

THYROID CANCER continued on page 4

THYROID CANCER from page 3

Follicular thyroid cancer

Stage	5-Year Relative Survival Rate
I	near 100%
II	near 100%
III	71%
IV	50%

Medullary thyroid cancer (based on patients diagnosed between 1985 and 1991)

Stage	5-Year Relative Survival Rate
I	near 100%
II	98%
III	81%
IV	28%

Treatment of thyroid cancer

The choice of treatment will generally depend upon the type of thyroid cancer (papillary, follicular, medullary or anaplastic), and factors that are specific to the cancer as well as factors that are specific to the patient, such as their age and other medical conditions.

The treatment options for thyroid cancer may include: surgery, radioactive iodine treatment, thyroid hormone therapy, external beam radiation therapy and chemotherapy. The vast majority of patients with differentiated thyroid cancer are treated with surgical removal of the thyroid gland, and often the regional lymph nodes. In select cases, the decision to administer radioactive iodine is based on the postoperative determination of the stage of the disease. Only in rare instances are patients treated with external beam radiotherapy and chemotherapy.

Surgery

The main treatment in nearly every case of thyroid cancer is surgery, except for some anaplastic thyroid cancers. Once a thyroid cancer is suspected or diagnosed based on biopsy, a surgeon will remove all or part of the thyroid gland. A total thyroidectomy is

most commonly performed in conjunction with the removal of lymph nodes located in the central area of the neck. If thyroid cancer has spread to nearby lymph nodes in the neck then the lymph nodes are removed along with the thyroid gland at the time of surgery. This is uniformly done in the treatment of medullary thyroid cancer. In differentiated (papillary or follicular) thyroid cancer, enlarged lymph nodes are often removed when they are believed to contain cancer. In select circumstances the surgeon may not know that a thyroid nodule is cancer and that diagnosis may not be able to be established on frozen section. The performance of a lobectomy for diagnostic purposes may leave open the question of whether a completion thyroidectomy should be performed at a second operation. That decision is made based upon a number of factors related to the stage and the patient's overall health.

In almost all instances there is a small remnant of thyroid tissue that remains following surgery that can be eliminated with radioactive iodine. After total thyroidectomy, the patient will be dependent upon a daily dose of thyroid hormone (levothyroxine).

Perioperative Risks and Side Effects:

Potential risks of thyroid surgery include:

- Temporary or permanent voice changes: this can occur if the nerves to the vocal cords are stretched or damaged during surgery.
- Temporary or permanent hypocalcemia: the parathyroid glands, attached to the thyroid, regulate the level of calcium in the blood. Removal or damage to these glands will require the patient to take calcium and vitamin D, either temporarily or permanently.
- Radioactive iodine (radioiodine) therapy: Radioactive iodine (I-131) therapy is used as an additional form of treatment for differentiated papillary and follicular thyroid cancers. When a large enough dose of radioactive iodine (RAI), also known as I-131, is administered, it can destroy the thyroid gland and any other thyroid cells (including cancer cells) that take up iodine, with little effect on the rest of the body.

Conclusions:

The most common forms of thyroid cancer are successfully treated with a combination of surgery and radioactive iodine. In addition, patients are most often placed on a slightly higher dose of thyroid hormone in order to achieve the goal of suppression of TSH. One of the unique features of thyroid cancer management is the ability to monitor a patient's clinical course by measuring the biomarker, *thyroglobulin*, which is only produced by thyroid cells that are malignant. Rises in thyroglobulin often indicate a recurrence of disease that may require further diagnostic efforts and therapy. Despite the very high cure rates for differentiated thyroid cancer, there is a requirement to monitor patients throughout their lives due to the risk of delayed emergence of either recurrent or metastatic disease.

Editors Note: Dr. Mark L. Urken is the Director of Head & Neck Surgical Oncology for the Continuum Cancer Centers of New York, & Professor of Otolaryngology- Head & Neck Surgery in the Department of Otolaryngology at Albert Einstein College of Medicine. He is the Co-Director of the Institute for Head & Neck & Thyroid Cancer at Beth Israel Medical Center. He is also the President & Medical Director of the THANC Foundation, which he founded in 2003.

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SHARING STORY...Maggie & Daniel - Part Two

I started going to the Cancer Support Group in Homewood during the last week of March. Every Tuesday night I would meet with from five to eight cancer patients most of whom were still battling their cancer. I still go most Tuesdays. I FOUND THAT I WASN'T ALONE WITH MY FEARS AND DEALING WITH PROBLEMS CAUSED BY MY CANCER TREATMENTS. I met two wonderful women there, both battling breast cancer. They kind of adopted me and made sure that I was invited to and attended all the social functions put on by the group so that I could overcome the social stigma that I thought existed.

I then started going to a SPOHNC support group at the University of Chicago, which meets the last Tuesday of every month. The people in this group were all oral, head and neck cancer survivors. Through the people I met there in the group, and the resources offered by SPOHNC, I came to realize that although I now had some limitations, I was no different than thousands of other survivors with the same cancer.

By March 2010, I was not totally recovered in all aspects of my life, but I was no longer sinking in my boat of despair and bailing like a crazed man. I found myself at sixty-one years of age desperately wanting a relationship with a woman. I have never been married nor do I have any children, but having gone through this "vale of tears" by myself, I wanted very badly to connect with someone with whom I could share the rest my life. I went on an Internet Dating Service called Christian Mingle in March of 2010, putting only some basic information. I would not post a picture. I had no photographs of me after my cancer journey and since I was changed so much I would not put a photo of me before cancer. If I found someone to connect with, I wanted her from the start to know the real but changed me. I went to counseling sessions at Illinois Masonic Hospital where I found the help I needed, to overcome the last fear I had – that a total stranger would not or could not be interested in me because of my appearance. I finally posted a passport photo, completed my survey and waited for the results.

I had gotten very far away from my core Christian beliefs before my journey with cancer began, but there is nothing like looking into the void of eternity to bring one back to one's childhood belief in God. I sincerely believe that God showed me His grace and mercy by

giving me three miracles. The first miracle was surviving oral cancer. (All my doctors had believed that I was terminal, yet now after four and a half years I am still cancer free from my head to my toes.) The second miracle was my emotional and spiritual healing. I've been able to move from being in a state of despair to now actually looking forward to meeting new people and doing new things even with my limitations. And the third miracle is a woman named Margaret Ann Jensen Olson.

After I posted the rest of my story and photo on Christian Mingle, six women replied to my initial contact. Only one of them kept up an ongoing email relationship. That was Maggie Olson. Maggie, as she is known to



her friends (who are countless), is a most amazing woman. She is a devoted Christian woman, a wonderful mother to four adult children and grandmother to four granddaughters. She is a professor at the University of Wisconsin. She is an amateur violinist and artist. She can beat my pants off at pool and Hearts. She has an extremely dry sense of humor that she loves to tease me with.

At this point of the story, I turn the floor over to Maggie.

Daniel and I first connected in March of last year – the day before my birthday. We emailed at first, and quickly started emailing every day. After about two weeks of daily emails he finally got up the nerve to tell me about his "limitations". He was so afraid that after he told me about the permanent effects of his treatment I would run the other way. He said that when he had told other women, all he had heard back was silence. My response to him was, "You will not hear silence from me, Daniel!"

By mid-May he had captured my heart and he asked if he could call and talk to me on the telephone. He was a nervous wreck! He warned me that due to his dry mouth he sounded a bit like he had a sock stuffed in his mouth and that he might have to ask me to repeat myself due to his hearing loss. Yet even before he called, he made arrangements to come to visit me in Wisconsin in June. When I mentioned that

he seemed a bit sure of himself, he replied, "Confidence is my middle name!"

We finally met in person at the end of June, spending the day together in Madison. I was excited, but also very nervous! Here was a man that I had fallen in love with without ever seeing him in person! How were we going to relate to each other face to face? The day was wonderful, but not without its challenges for me.

As we sat across the table from each other in the park after having a picnic I experienced a mixture of emotions. I was looking at a man who had no teeth, and whose hearing was impaired. I felt like I knew the inner man, but I was now faced with the outer man. I had been telling him for several months that his limitations did not matter to me at all; now I knew that they DID matter. The question was could I find a way to get past them? Could we really make this relationship work?

The day after our first meeting in Madison, I shared with Daniel that I had been telling my girlfriends all about our first date. "It was a date, wasn't it?" I said. "NO!!! It wasn't a date! I didn't even buy you dinner!!!" On his drive back to Chicago it had dawned on him that he had never even THOUGHT about feeding me dinner. After his experience with oral cancer, he just never gets hungry and only eats now because he knows he must eat to live! After asking me if I'd ever seen "The Little Shop of Horrors" (I had to Google it) we have come up with a plan: when we are out and about together and I get hungry, I am to say to him, "Feed me, Daniel, FEED ME!" Then he will realize that it's time to eat, whether he is hungry or not.

In July, Daniel asked me to marry him; we were engaged in September. For a variety of reasons we have not yet set a date. I have had my moments of doubt and uncertainty. It really hit me hard the first time he came to Wisconsin for the weekend and we attended worship in Wausau; he had warned me about how his hearing loss affects him when in a crowd, but I got first-hand knowledge when introducing him to my friends before and after the service and I realized that he missed much of the conversations. After he went back to Chicago I realized that I was struggling with all that his limitations would mean for our social life.

I find it very interesting that God brought us together. I believe we will be wonderful life partners. There will be challenges, for sure.

I have no guarantees that his cancer will not return (although his doctors say that the chances are extremely slim) – but HE has no guarantee that I won't get cancer! (My older sister is a breast cancer survivor and my younger sister is currently getting radiation treatments for breast cancer, and her 18 year old daughter Claire was diagnosed with alveolar rhabdomyosarcoma in June 2010.)

Daniel sometimes struggles with survivor guilt and he has also had episodes of PTSD brought on by news of Claire's condition. I know that when she dies Daniel is going to take it very, very hard. But he is willing to TALK about what he is feeling and to get professional help if he needs it.

I have come to realize that all his wonderful qualities more than make up for the challenges we will face. He is alive! That is a miracle. And his experience with cancer has changed him into a man of great compassion and patience. I love that about him. He has his priorities straight. He is now easy-going and calm. He lives a life of gratitude. He is generous and eager to help anyone who needs it. He is looking forward to ministering to people with life-threatening illnesses in the Wausau area after he moves here. He is able and willing to talk about his emotions, which he feels very deeply. He is a wonderful communicator, has a terrific sense of humor and is very endearing. And he loves me with all his heart. I am very proud of this man, and so very grateful that God spared his life and brought us together. He is my hero!

Daniel Milkovich
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Margaret Olsen
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**Hope is
an adventure,
a going forward,
a confident search
for a rewarding
life.**

~ Dr. Karl Menninger

Take the Breaking Through Survey Today



If you haven't already done so, please read below and take the survey, which will provide important information for a study of patients with breakthrough pain.

Dear Friends of SPOHNC,

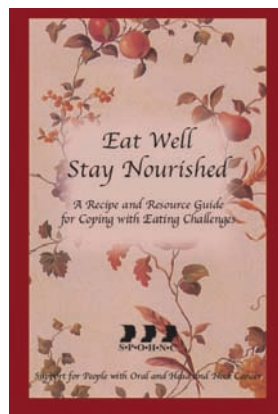
Many individuals with oral, head and neck cancers experience constant, background pain related to their cancer. On top of this background pain, many also experience brief, intense and sudden flares of pain called breakthrough pain in cancer (BTPc). Even though BTPc can have an extremely debilitating effect on an individual's quality of life, it continues to be a poorly understood and highly under-diagnosed condition.

In light of this, Support for People with Oral, Head and Neck Cancer (SPOHNC) is joining forces with other cancer advocacy groups to support a new educational campaign called Breaking Through: Voices of Breakthrough Pain in Cancer Patients. An integral part of this campaign is a nationwide survey to better understand patient experiences with BTPc.

Since many of you may have experienced BTPc, we urge you to participate in this survey and support SPOHNC in this important initiative. Please also encourage and direct members of your support groups to take this survey. Your collective insights will be valuable in identifying barriers that deter people from discussing pain with their oncologists and developing educational programs.

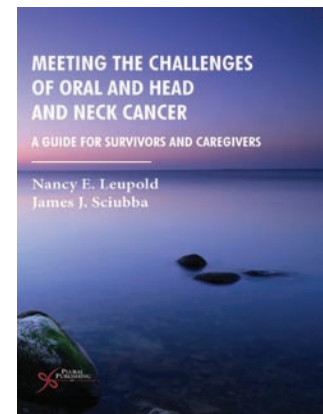
To participate in the survey, visit our website at www.spohnc.org, or go to:

<https://www.visioncriticalsurveys.com/skin/breakingthrough/SPOHNC.html>



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**SUPPORT FOR PEOPLE WITH
ORAL AND HEAD AND NECK CANCER (SPOHNC)
20TH ANNIVERSARY CONFERENCE AND CELEBRATION OF LIFE
NEW YORK LAGUARDIA AIRPORT MARRIOTT
August 10th - 12th, 2012**



SATURDAY ~ AUGUST 11, 2012
SPOHNC Registration/Information
7:30 AM – 10:00 AM

CONTINENTAL BREAKFAST
7:30 AM – 8:40AM

Opening Remarks
8:45 AM

Nancy E. Leupold, Survivor, President and
Founder of (SPOHNC) Support for People with Oral and
Head and Neck Cancer

James J. Sciubba, DMD, PhD, Moderator
Vice President of SPOHNC

Guest Honoree, Gene Monahan
Survivor, Retired NY Yankees Head Athletic Trainer

New Treatments for Head and Neck Cancer

Dennis Kraus, MD, Head and Neck Surgeon
Memorial Sloan - Kettering Cancer Center

Christine Chung, MD, Medical Oncologist
Sidney Kimmel Comprehensive Cancer Center-Johns Hopkins

Refreshment Break with Exhibitors

David Brizel, MD, Radiation Oncologist
Duke University Cancer Institute

The Role of a Patient Navigator
Joanne Stein, RN, Nurse Navigator
Fox Chase Cancer Center

BUFFET LUNCH

Key Note Presentation:
Self Love...The All Time Greatest Healer
Denise DeSimone,
Survivor, Author and Inspirational Speaker

Clinical Trials for Head and Neck Cancer
Bettie Steinberg, PhD, Researcher, Investigator
North Shore /LIJ Health Systems

Refreshment Break with Exhibitors

**Speech & Swallowing Function in Patients
with Head & Neck Cancer**

Jan Lewin, PhD
UT MD Anderson Cancer Center

Quality of Life for Head and Neck Cancer Survivors

Dorothy Gold, MSW, LCSW-C, OSW-C
Greater Baltimore Medical Center

**SPOHNC'S ANNIVERSARY
RECEPTION AND ENTERTAINMENT**

Comedian

Stewie Stone, Survivor, Brooklyn, NY
Headlined in Las Vegas, Atlantic City, New York

Music

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Voted the #1 Band on Long Island

SUNDAY ~ AUGUST 12, 2012
SPOHNC Registration/Information
7:30 AM – 9:00 AM

Opening Remarks
8:30 AM

Nancy Leupold, Survivor,
President & Founder of SPOHNC

BUFFET BREAKFAST

How Far Have We Come in 20 Years

James J. Sciubba, DMD, PhD
Vice President of SPOHNC

Salute to Volunteers, Making a Difference

Mary Ann Caputo,
Executive Director of SPOHNC

Salute to Survivors

All Survivors of Oral and Head and Neck Cancer
Mary Ann Caputo,
Executive Director of SPOHNC

Closing Remarks

Nancy E. Leupold, Survivor
President & Founder, SPOHNC

HEAD & NECK CANCER NEWS

The following news releases are taken from studies presented at the Multidisciplinary Head and Neck Cancer Symposium, sponsored by AHNS, ASCO, ASTRO and SNM.

Newer radiation technology improves head and neck cancer patients' long-term quality of life

Phoenix, AZ - January 26, 2012- Intensity modulated radiation therapy, or IMRT, is a highly specialized form of external beam radiation therapy that allows the radiation beam to better target and conform to a tumor. It is a newer treatment that has become widely adopted for treating head and neck cancer. Prior studies have shown that IMRT decreases the probability of radiation therapy related side effects, including dry mouth and chewing and swallowing problems, but no study has been conducted to measure long-term quality of life in head and neck cancer patients treated with various forms of radiation therapy.



Investigators from the University of California, Davis, School of Medicine, prospectively administered the University of Washington Quality of Life instrument, a standardized, previously validated questionnaire that patients complete after radiation therapy, to 155 patients undergoing treatment for cancers of the head and neck and analyzed the scores over time. Fifty-four percent of patients were initially treated with IMRT and 46 percent were treated with non-IMRT techniques.

The researchers showed that the early quality of life gains associated with IMRT not only are maintained but become more magnified over time. At one-year post-treatment, 51 percent of IMRT patients rated their quality of life as very good or outstanding compared to 41 percent of non-IMRT patients. However, at two-years after treatment, the percentages changed to 73 percent and 49 percent, respectively. Also, 80 percent of patients treated with IMRT reported that their health-related quality of life was much better or somewhat better compared to the month before developing cancer. In contrast, only 61 percent of patients treated by non-IMRT techniques felt similarly.

Although the researchers acknowledged that quality of life is somewhat of a subjective concept, they nonetheless believe their findings support the widespread use of IMRT for head and neck cancer.

“Hopefully, these results provide some reassurance to patients that radiation therapy using contemporary techniques in the hands of expert specialists can maintain their function and long-term quality of life, while still curing them of cancer,” Allen Chen, MD, lead author of the study and director of the radiation oncology residency training program at the University of California, Davis School of Medicine in Sacramento, Calif., said. “Radiation therapy for head and neck cancer is without a doubt an intensive process and very intimidating to most patients. Folks think about the prospects of six to seven weeks of radiation and naturally expect the worst. It is nice to know that technological advances have made the treatment much more tolerable than in the past.”

Allen Chen, M.D.

Oral temperature changes in head and neck cancer patients predicts side effect severity

Phoenix, AZ - January 26, 2012- Mucositis, or mouth sores, is a common side effect of chemoradiotherapy for head and neck cancer that is painful and can be very severe. Physicians cannot predict which patients will have mild mucositis or severe mucositis that would require narcotic pain medication, nutritional support and/or feeding tubes.

Researchers in this study hypothesized that using sensitive thermal imaging technology to measure temperature changes of less than one-tenth of a degree early in treatment could predict the severity of mucositis later in treatment. This knowledge could allow for early intervention and potential changes in therapy using a technology that is simple, harmless and non-invasive.

Patients receiving chemoradiotherapy underwent baseline and weekly thermal imaging of their oral mucous membranes. All patients displayed an increase in temperature and severe mucositis was found in 53 percent of patients.

“If we could predict which patients were going to suffer the greatest toxicity, we could proactively make changes to their care that could ameliorate or prevent side effects,” Ezra Cohen, MD, lead author of the study and co-director of the head and neck cancer program at The University of Chicago in Chicago, said. “Ultimately, we could identify the patients at higher risk of severe complications from treatment.”



Ezra Cohen, M.D.

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CHAPTERS OF SPOHNC

ARIZONA-CHANDLER
Cancer Center at Chandler Reg. Med. Ctr.
1st Wednesday: 5:30 – 7:30 PM
Monica Krise, MSW 480-728-3613
monica.krise@chw.edu
Dick Snider, MD (ret.) 480-895-6019
rsnider326@aol.com

ARIZONA-PHOENIX/MESA
Banner Desert Medical Center
3rd Wednesday: 4:30 -6:30 PM
Keri Winchester, MS, CCC-SLP
480-412-3627
Keri.Winchester@bannerhealth.com
Dick Snider, MD (ret.) 480-895-6019
rsnider326@aol.com
Bette Denlinger, RN
beneden@cox.net

ARIZONA-PHOENIX
Rad/Onc Waiting Room
St. Joseph's Hospital and Medical Ctr.
1st Tuesday: 5:30-7:30 PM
Mary Schneider, Director
602-406-3882
mary.schneider@chw.edu
Barbara Chapman, RN, OCN
602-406-4756
barbara.chapman@dignityhealth.org
Dick Snider, MD (ret.) 480-895-6019
rsnider326@aol.com

ARIZONA-SCOTTSDALE
Virginia G. Piper CA Center
3rd Thursday: 6:30-8:30 PM
Chris Henderson, MS, CCC-SLP
602-312-9226
chenderson2@shc.org
Les Norde
602-439-1192/
elnorday@cox.net

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

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

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

CALIFORNIA-SAN DIEGO
4S Ranch Library
1st Saturday: 12:00 noon
Valerie Targia
760-751-2109
valtargia@yahoo.com

CALIFORNIA-SANTA MARIA
Marion Rehab. Center
3rd Tues./Alternate Months
Aundie Werner, MS, CCC/SLP
805-739-3185
aundiew@mail.com

CALIFORNIA-STANFORD
Stanford Cancer Center
1st Tuesday: 4:00 - 5:30 PM
Mike Bonar, LCSW 650-725-0929
mbonar@stanfordmed.org

CALIFORNIA-VENTURA
The Cancer Resource Center of
Community Memorial Hospital
4th Thursday: 6:00 - 7:30 PM
Kathleen Horton 805-652-5459
khorton@cmhhospital.org

COLORADO-DENVER
Porter's Adventist Hospital
Twin Peaks Conf. Rm.
Last Tuesday: 6:30-8:00 PM
Jeanne Currey 303-778-5832
jeannecurrey@centura.org

CONNECTICUT-NEW HAVEN
Hospital of St. Raphael
2nd Tuesday: 5:00 PM-6:30 PM
Vanna Dest, APRN 203-789-3131/vdest@srhs.org
Lori Ratchelous, MSW/lratchelous@srhs.org

CONNECTICUT-NEW LONDON
Lawrence & Memorial Hospital
Community Cancer Center
Waiting Room - 1st Thursday: 6:00 PM-7:30 PM
Catherine McCarthy, LCSW 860-444-3744
cmccarthy@lmhosp.org

CONNECTICUT-NORWICH
William W. Backus Hospital
Medical Office Building, MOB Conf. Rm.
3rd Tuesday: 5:00-6:00 PM
Darlene Young, RN, OCN 860-892-2777
dayoung@wwbh.org
Kathy Gernhard, RN, OCN 860-892-2777
kgernhard@wwbh.org

DC-GEORGETOWN
Lombardi Ca Ctr/Martin Marietta Conference Rm
3rd Wednesday: 1:45-3:00 PM
Joanne Assarsson, MSW, LICSW 202-444-3755
assarssj@gunet.georgetown.edu

DC-WASHINGTON
Washington Hospital Center
Washington Cancer Institute, Room C1200
3rd Wednesday: 1:45-3:30 PM
Cynthia Clark, RD 202-877-3498
cynthia.d.clark@medstar.net
Christopher Bianca, LCSW
Christopher.a.bianca@medstar.net

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

FLORIDA-FT MYERS
Gulf Coast Medical Center
Outpatient Rehabilitation Ctr.
4th Tuesday: 3:00-4:00 PM
Stacey Brill, MS, CCC-SLP 239-343-1645
stacey.brill@leememorial.org

FLORIDA-FTWALTONBEACH/NW FL
Call for Location
4th Thursday: 5:00 PM
Shannon Leach, MA, CCC-SLP 850-362-9200
sleachslp@yahoo.com
Ryann Ennis ryann02@live.com

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
1st Monday: 6:00-7:00 PM
Monica Grey LCSW, LMT
monica.grey@cox.net
352-222-8126
no calls after 9PM

FLORIDA-LECANTO
Robert Boissoneault Oncology Institute
4th Monday: 2:00PM
Wendy Hall, LCSW, AHCP/352-572-0106
whall@rboi.com

FLORIDA-MIAMI
The Wellness Community
3rd Wednesday: 6:00-8:00 PM
Janny Rodriguez 305-668-5900/janny321@gmail.com
Russell Nansen 305-661-3915

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

FLORIDA-NAPLES
NCH Healthcare System/Downtown
1st Wednesday: 3:00-4:30 PM
Karen Moss, MS, CCC-SLP 239-393-4079
Karen.moss@nchmd.org

FLORIDA-OCALA
Robert Boissoneault Oncology Institute
1st Monday: 11:00 AM-12:00 Noon
Amy Roberts, LCSW 352-732-0277/aroerts@rboi.com

FLORIDA-SARASOTA
The Cancer Support Community
1st Wednesday: 2:00 - 3:30PM
Julie O'Brien, LMHC 941-921-5539
julieobee@verizon.net
John Kleinbaum, PhD 941-921-5539
hope@wellness-swfl.org

FLORIDA-TAVARES
Florida Hosp. Cancer Inst. Waterman Conf. Room
2nd Thursday: 4:00pm-5:30pm
Julie B. Arcaro 352-253-3600/arcarobj@yahoo.com
Georgeann Bjornson georgeann.bjornson@ahss.org

GEORGIA-ATLANTA
St. Joseph Hospital of Atlanta
Evelyn Trammell Voice & Swallowing Center
2nd Tuesday: 1:00 PM
Tanya Duke 678-843-5586/tduke@sjha.org

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

GEORGIA-AUGUSTA
MCG Health Children's Medical Center
Family Resource Center
1st Tuesday: 6:00-7:30 PM
Lori M. Burkhead Morgan, PhD, CCC-SLP
706-721-6100
lburkhead@georgiahealth.edu
Leann Dragano draganole@bellsouth.net

GEORGIA-COLUMBUS
Columbus Public Library
3000 Macon Rd.
2nd Monday: 6:00-7:30 PM
Wanda Hodge 706-442-1768/whodge50@gmail.com

ILLINOIS-CHICAGO
Duchossois Ctr. for Advanced Medicine
4th Tuesday: 1:00 PM
Mary Herbert 773-834-7326
mherbert@medicine.bsd.uchicago.edu

IL-EVANSTON/HIGHLAND PARK
NorthShore University Health System
Call for location
2nd Monday: 6:00-8:00 PM
Sabina Omercajic, MS, CCRP 847-570-1066
somercajic@northshore.org

CHAPTERS OF SPOHNC

ILLINOIS-MAYWOOD
The Cardinal Bernardin Cancer Ctr.
3rd Wednesday: 6:00-7:00 PM
Laura Morrell, LCSW 708-327-2042
lmorrell@lumc.edu

INDIANA-FORT WAYNE
Lutheran Cancer Resource Ctr Ste 109
3rd Wednesday: 4:00-5:00
Susan Berghoff, RN, OCN
Mischa Story, RD 260-435-7959
lh.crc@lutheran-hosp.com

INDIANA-INDY-NORTH
Marion County Public Library
Lawrence Branch
Last Monday: 6:00-8:00 PM
John Groves 317-872-6674
jgroves14@comcast.net

INDIANA-TERRE HAUTE
Hux Cancer Center
3rd Tuesday: 4:30 PM
Mary Ryan, SP 812-535-2587
Maryryan2@juno.com

IOWA-DES MOINES
Iowa Methodist Medical Center
Suite 450
1st Wednesday: 5:30 PM
Jennifer Witt, RN, MSN, OCN
Stoddard Care Coordinator 515-241-3399
wittjl@ihs.org

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

LOUISIANA-BATON ROUGE
Cancer Services of Greater Baton Rouge
3rd Wednesday: 4:00 PM
Ester Sachse 225-927-2273
esachse@cancerservices.org

MAINE-AUGUSTA/CENTRAL
Harold Alford Center for Cancer Care
Therese Berniger, SLP-CCC 207-872-4051
therese.berniger@mainegeneral.org

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

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

MARYLAND- LIBERTYTOWN
St. Peter's RC Church- Parish Center
2nd Wednesday: 2:00-3:30pm
Judith Churco 301-631-8159
judyduster@aol.com

MASSACHUSETTS-BOSTON
Massachusetts General Hospital
One Tuesday every other month: 6:00-8:00 PM
Valerie Hope Goldstein
617-726-0651
vgoldstein@partners.org

MASSACHUSETTS-CAPE COD
Fallmouth Hosp-Clark Cancer Center
Rad/Onc Conference Room
3rd Thursday: 2:00 - 3:30 PM
Jeffrey A. Gaudet, LCSW, OSW-C
508-862-7571
jgaudet@capecodhealth.org

MASSACHUSETTS-DANVERS
MGH North Shore Cancer Ctr.
2nd Tuesday: 5:30-6:30 PM
Mary Anne Macaulay, LCSW
978-882-6002
mmacaulay@partners.org

MICHIGAN-ST. JOSEPH
Lakeland Healthcare
1st Monday: 5:00-6:00 PM
Lisa Sutton MA, CCC-SLP
269-428-2799, x2997
lsutton@lakelandregional.org

MINNESOTA-MINNEAPOLIS
Hennepin/Southdale Library
1st Monday: 6:45-9:00 PM
Colleen M. Endrizzi
952-545-0200
colmartens@gmail.com
Charles Bartlett 612-220-5449

MISSOURI-ST. LOUIS
St. Louis University Cancer Center
4th Friday: 10:00 AM - 12:00 noon
Cathy Turcotte, RN, MSN
314-268-7015
turcotte@slu.edu

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

NEBRASKA-OMAHA
Methodist Cancer Center
Meets Quarterly
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

NEBRASKA-OMAHA
Nebraska Medical Center
Meets Quarterly
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

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

NEW JERSEY-MORRISTOWN
Morristown Memorial Hospital
3rd Wednesday: 1:30 PM
Edie Boschen, RN, APN-c, OCN 973-971-4144
Edie.Boschen@atlantichhealth.org
Catherine Owens, LCSW, OSW-C 973-971-5169
Catherine.Owens@atlantichhealth.org

NEW JERSEY-PRINCETON, UMC
Med. Arts Building, Adm. Conf. Rm.
3rd Wednesday: 12:00-1:00 PM
Amy Heffern 609-575-7949
aheffern@mac.com

NEW JERSEY-SOMERVILLE
Steeplechase Cancer Center
3rd Wednesday: 6:00-7:30 PM
Kelly Harth, MSW, RYT-500
908-343-8247/ kharth161@comcast.net

NEW JERSEY- SPARTA
Sparta Cancer Center-Suite 250
1st Friday: 1:30-3:00pm
Nina Sullivan, RN, BSN OCN 973-729-7001
sccexam@hotmail.com
Kathryn Cramer, LMSW 570-504-7200
sccswork@hotmail.com

NEW JERSEY-TOMS RIVER
Community Medical Center
Last Thursday: 3:00 PM
Sherry Laniado, MSW, LCSW 732-557-8270
slaniado@barnabashealth.org

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

NEW YORK-ALBANY
ACS Hope Club
3rd Thursday: 7:00-9:00 PM
Kathy Rosbrook 518-758-1333
okroz@aol.com

NEW YORK-BUFFALO
Roswell Park Cancer Institute
3rd Tuesday: 4:30-6:00 PM
Amy Sumbrum, SLP 716-845-4947
amy.sumbrum@roswellpark.org
Jim Smaldino 716-845-4472
james.smaldino@roswellpark.org

NEW YORK-MANHATTAN
Beth Israel Head and Neck Institute
4th Thursday: 2:00-6:00 PM
Jackie Mojica 212-844-8775
jmojica@chpnet.org

NEW YORK-MANHATTAN
Mount Sinai Medical Center
3rd Tuesday: 3:00 PM
Margot Wankoff, LMSW 212-241-7962
margot.wankoff@mountsinai.org

NEW YORK-MANHATTAN
NYU Clinical Cancer Center, 11th fl
1st and 3rd Thursday: 2:00 PM
Christine Nolin, LCSW/ 212-731-5141
christine.nolin@nyumc.org

NEW YORK-NEW HYDE PARK
NORTH SHORE-LIJ Health System
Hearing and Speech Conf Rm, LL
3rd Thursday: 6:30 PM - 8:00 PM
Sharon Lerman, LCSW 718-470-8964
Lynn Gormley 516-628-1219 / 516-314-8897
lgormley1@optonline.net

NEW YORK-ROCHESTER
Strong Memorial Hospital
Luellen Resource Center, Pat. Res. Ctr.
1st Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW 585-276-4529
Sandra_Sabatka@URMC.Rochester.edu

CHAPTERS OF SPOHNC

NEW YORK-STONY BROOK
Ambulatory Care Pavilion
1st Wednesday: 6:45-8:15 PM
Dennis Staropoli 631-682-7103
den.star@hotmail.com

NEW YORK-SYOSSET
NSLIJ-Syosset Hospital
2nd Thursday: 7:30-9:00 PM
Alice Steiner 516-764-1571
asteiner28@aol.com
Madelyn Harper-Walsh 516-753-0923
lyn.SPOHNC@yahoo.com

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd Thursday: 7:00 PM
Mark Tenzer 914-584-6151
tenzer1@optonline.net

NORTH CAROLINA-ASHVILLE
Call for additional information
Kathleen Godwin 828-692-6174
kateyes928@aol.com

NORTH CAROLINA-
CHAPEL HILL/DURHAM
Cornucopia House
3rd Wednesday: 6:00 PM
Dave Gould 919-493-8168 /dave.gould@da.org

NORTH CAROLINA-CHARLOTTE
Blumenthal Cancer Center
2nd & 4th Thursday: 1:30-3:00 PM
Meg Turner 704-355-7283
meg.turner@carolinashealthcare.org
Terri Painchaud/704-364-7119
Trappi6@yahoo.com

OHIO-CINCINNATI
Call for date and location
Deborah Heim, MSN, ANPBC, AOCNP
513-584-4794
deborah.heim@uchealth.com
Angie Keith 513-475-7366
Angie.keith@ucphysicians.com

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
2nd Thursday: 4:00 PM
Gwen Paull, LISW 216-476-7241
gwpaul@ccf.org

OHIO-DAYTON
The Medical Center at Elizabeth Place
One Elizabeth Pl. - West Lobby - The Chapel Room
2nd Monday: 6:00-8:00 PM
Hank Deneski 937-832-2677
wohnc@earthlink.net

OHIO-LIMA
St. Rita's Regional Cancer Ctr.
Allison Rad/Onc. Ctr. Garden Conf Rm
3rd Tuesday of even month: 5:00 PM
Holly Metzger, LMSW 419-996-5606
hjmetzer@health-partners.org
Linda Glorioso 419-996-5616
ldglorioso@health-partners.org

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

OREGON-MEDFORD
Providence Medical Center
2nd Friday: 12:00-1:30 PM
Richard Boucher 650-269-8323

PENNSYLVANIA- DUNMORE
Northeast Radiation Oncology Center
Last Thursday of the month: 5:30-7:00PM
Kathryn Cramer LMSW, CCHT
570-881-6247 scsocwork@hotmail.com

PENNSYLVANIA-HARRISBURG
Health South Lab
3rd Tuesday: 6:30 PM
Joseph F. Brelsford 717-774-8370
jfbrelsford1@mmm.com

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

PENNSYLVANIA-NEW CASTLE
UPMC Jameson Cancer Center
Medical Arts Bldg Suite 104
3rd Thursday: 6:00-7:00 PM
Jeannie Williams, Patient Navigator
Becky Rainville, RN 724-656-5870

PENNSYLVANIA-PHILADELPHIA
Penn Med Perelman Ctr Advanced Med
1 W. Pavilion Pt Fam Conf Rm
1st Wednesday: 9:30-11:00 AM
Micki Naimoli
856-722-5574
Tracy Lautenbach
215-662-6193
lautenbach@uphs.upenn.edu

PENNSYLVANIA-YORK
Apple Hill Medical Center
2nd Wednesday: 5:00 PM
Dianne S. Hollinger, MA, CCC-SLP/ 717-812-5850
Dhollinger@wellspon.org
Diane McElwain, RN, OCN, M.Ed 717-741-8100
dmcelwain@wellspon.org

SOUTH CAROLINA - OF THE UPSTATE
44 W. Avondale Drive
1st Sunday: 2:00pm-3:30pm
Martha Miller 864-232-6334
marthamiller@hotmail.com
Mindy Hurley 864-232-6334
melindahurley123@yahoo.com

TENNESSEE-CHATTANOOGA
Memorial Hospital
1st Monday: 4:15-5:30 PM
Jeanna Richelson
423-894-9215
Jeanna1255@aol.com

TENNESSEE- NASHVILLE
Gilda's Club Nashville
4th Monday:6:00 - 7:30 PM
Felice Apolinsky, LCSW
615-329 1124
felice@gildasclubnashville.org

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

TEXAS-DALLAS
The New Svetko Center, Suite 200
2nd Tuesday: 11:00 AM-12:30 PM
Jack Mitchell 972-346-4297
jackmitchell5225@aol.com

TEXAS-FORT WORTH
Baylor All Saints Hosp.- Joan Katz Conf. Room
2nd Wednesday: 3:30-5:00 PM
Marla Hathcoat, LMSW 817-838-4866
marla.hathcoat@moncrief.com

TEXAS-HOUSTON/TOMBALL
Tomball Regional Hospital
TBA

TEXAS-McALLEN
Rio Grande Regional Hospital
3rd Tuesday: 6:00 PM
Stephanie Leal, MA,CCC,SLP
SAL1275@aol.com
Cheryl Lopez, MS, CCC, SLP
956-632-6426

TEXAS-PLANO
Regional Medical Center at Plano
4th Tuesday: 6:00-8:00 PM
Polly Candela, RN, MS 214-820-2608
Polly.Candela@baylorhealth.edu
Emily J. Gentry, RN
214-820-2608

VIRGINIA-CHARLOTTESVILLE
Dept. of Forestry Building, Suite 800
Last Thursday of month: 11:30-1:00 PM
Vikki Bravo 434-982-4091, vsb4n@virginia.edu
Gordon Putnam, M. Div. MA, Gp4d@virginia.edu

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

VIRGINIA-NORFOLK
Sentara Norfolk General Hospital
3rd Monday: 7:00 PM
Cynthia Gilliam 757-770-4190
beachdolphin@aol.com

WASHINGTON-SEATTLE
Evergreen Hospital Medical Center
Rad/Onc Conf Rm Green 1-245
2nd Wednesday: 6:30-8:00 PM
Kile Jackson 425-788-6562
kilejackson@hotmail.com

WASHINGTON-SEATTLE
Swedish Med Ctr. 1 E. Conf Rm
3rd Thursday: 6:00-7:30 PM
Susan (Sam) Vetto, BSN, RN, BC
206-341-1720 susan.vetto@vmmc.org
Joanne Fenn, MS, CCC-SLP 206-215-1770
joanne.fenn@swedish.org

WISCONSIN-MADISON
Univ. of Wisconsin Hospital
ENT Clinic Rm. G3/206
1st Wednesday: 11:30-1:00 PM
Rachael Kammer, MS, CCC, SLP
608-263-4896
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Medical College of Wisconsin
Conference Rm. N, 3rd Floor
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