



RADIATION THERAPY OF HEAD AND NECK TUMORS

JAMES R. WONG, M.D.
EDIE BOSCHEN, MA, RN, OCN

Historicly written medical documentation of treatment for head and neck cancer reveals that surgical intervention has been, and continues to be, the mainstay. While surgical techniques improved, new instruments and approaches have been developed to control these tumors. However, despite other improvements, surgical treatment of head and neck cancers may lead to both physical and/or functional disfigurements that require creative minds to develop facial and oral prostheses as well to correct these problems.

Roentgen's discovery of the "x-ray" in 1896, offered a different approach to head and neck cancers and subsequently lead to organ-sparing types of treatment. The x-ray was produced in a glass cathode-ray tube, and then aimed at the involved body part. This discovery had implications for local control and relief of pain for those suffering with cancer. Understanding this elementary device soon led to knowledge to regulate exposure, which had certain adverse effects to skin, tissues, and nearby organs, if used improperly. With this discovery, the field of radiation therapy was born.

In 1898, the Curies discovered a natural radiation source, radium. This advancement led to the technique of applying a radiation source directly on the tumor. This was accomplished by exposing the tumor through surgery, or placing the radium in a body cavity with needle "implant." Today this radiotherapy procedure, where the radiation source is contained in a sealed, metal container is known as "brachytherapy."

As technology evolved, and radiation was delivered with deeper penetration (orthovoltage), the resultant destruction of normal tissue needed to be controlled. Over time, physicists were able to define various objective measurements of radiation, accounting for time and distance of the radiation treatment. Those established measurement terms were "milliamperage" and "kilovoltage." World War II and the atomic bomb provided new information and technology for high-powered treatment machines (megavoltage) delivering "teletherapy." In the intervening years, the science of radiotherapy has seen the evolution of ever more powerful machines, and various generations of so-called linear accelerators. With the advent of computer resolution, radiation therapy entered yet another era of computer driven technologies enabling it to be administered with a high degree of safety.

The most common form of radiation used today is known as ionizing radiation. It is usually produced by a linear accelerator. The object of radiation is to destroy the tumor cells while sparing as much normal tissues as possible. For most tumors, this is accomplished by directing high energy waves of photons or electrons at the tumor and the draining lymph nodes, and then avoiding as much normal tissue as well. Consideration in achieving a favorable result depends on tumor size, nearby critical organs or tissues, and known radiosensitivity of the tumor.

The body's cells, including cancer cells, are continually in a state of repair and reproduction. Cancer cells are constantly dividing while most normal cells do not. When radiation is directed at these cancer cells, cell division is interrupted, and cell death occurs. Daily treatments are given to ensure that the cancer cells are continually exposed to ionizing radiation, at the same time allowing for the repair of normal tissue.

Before using radiation on the patient, films are taken and a design session is performed. This session may usually last from 30 minutes to two hours, and is known as the "simulation." The radia-

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 tion oncologist, physicist, and therapist check all markings, blocks, and positions to ensure that the dose is precisely calculated and directed only to the area of involvement. Treatment begins once the simulation has been approved, and the calculations checked and rechecked.

The number of treatments for head and neck cancer is determined by several factors. For treatment aiming for cure, a dosage of at least 6000 cGy (or rad) is needed. The daily dose is usually 180-200 cGy per day, and is derived by understanding the amount of radiation a given area can tolerate with minimal tolerable effects. For these cancers, "standard" treatments are directed at "cure," and are given daily, usually lasting for 7-8 weeks. There are newer regimens such as hyperfractionation, which is administered twice daily or combined chemo-radiation, which is chemotherapy given at the same time with radiation. These regimens are used with the goal of improving the chance of cure and often, to avoid major functional losses from surgery. These regimens are also used for larger tumors that are considered inoperable.

It is necessary to try to protect normal structures from the effects of radiation. By carefully studying x-rays and CT scans, the physicist and radiation oncologist are able to produce an image and plan that minimizes the exposure of surrounding tissue that does not need radiation. Using computers, a precise area is defined for treatment, and the remainder is "blocked." Heavy metallic "blocks" are made that conform to that computer image. When the block is placed in the external beam radiation machine, it serves to shield uninvolved areas from radiation. When treating with radiation, it is essential that the treatment area be identical each time the patient is treated. To eliminate movement of the head, plastic molds are created. These molds

serve to immobilize the head and neck region, allowing reproducible accuracy. In order to protect or displace vital structures of the mouth, a "stent" may be used. The stent serves to push certain structures, such as the

weeks after radiation treatment. Patients who use alcohol and tobacco, or have poor oral hygiene are at higher risk of these effects. Although these effects are usually unavoidable, the patient and staff can manage them by working together to implement interventions. The most common effects are associated with the comfort and normal function of the mouth and throat. The mucosa, or the lining of the mouth, is very radiosensitive, often becoming inflamed, swollen, dry, or ulcerated with radiation. These effects can make eating difficult and undesirable to the patient, as well as being generally uncomfortable. Scrupulous oral hygiene and vigilant monitoring by the patient, care giver, and dietitian can help relieve the serious outcomes of pain, infection, and malnutrition (Table I/II). During this time, the patient may need to use liquid or powder nutritional supplements to maintain his/her weight and good health. Xerostomia (dry mouth) is a common side effect if the salivary glands are in the radiation fields. Salagen® and Ethyol® (Amifostine) are two newer medications that may lessen this problem in some patients.

A very important consideration prior to radiation therapy is dental management and bringing the oral cavity dentition to a state of optimum health. The patient should see a dentist who is familiar with the special oral problems and situations which may arise as a result of radiation treatments to the head and neck region. This dentist will then tailor a treatment plan appropriate for the patient. Custom gel-applicator trays may be fabricated for the patient's daily use to help prevent cavities. Dental care after radiation must be continuous as radiation can cause rampant tooth decay. Unfortunately, there are many patients

receiving radiation therapy who are never told about the importance of dental care prior

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TABLE I
MOUTH CARE

HELPFUL HINTS:

- See a dentist before beginning radiation therapy
- Brush teeth after each meal, using a soft, even-bristle brush with bland toothpaste
- Rinse mouth 3 times or more daily, using salt and baking soda rinse, or an aniplaque solution at room temperature
- Use a pulsating water device with warm water with a mixture of baking soda and salt, aimed at the teeth, not the gums
- If a denture wearer, wear only when necessary, not at night
- Increase fluid intake
- Use a humidifier
- Suck on hard, sugarless candies
- Use mouth moisturizing gels
- Keep the lips lubricated with petrolatum or lip balm
- Use fluoride trays, if recommended by the radiation oncologist or dentist

TABLE II
DIETARY INSTRUCTIONS:

HELPFUL HINTS

- Choose soft, moist foods
- Moisten foods with gravies, broth, butter
- Increase fluid intake
- Keep food bite-sized
- Blenderize food, or use baby foods

AVOID:

- Very hot, or very cold foods and beverages
- Scratchy" foods, such as pretzels, crackers or nuts
- Spicy or very salty foods, such as canned soups, vinegar, salsa, ketchup
- Alcoholic beverages
- Strongly minted candies or toothpaste
- Fumes, such as ammonia, household cleaners, paints, gasoline

tongue, out of the radiation field.

Patients receiving radiation to the head and neck area experience a number of side effects. Most side effects will begin 2-3

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to and following treatment. As a result, severe damage to the patient's teeth or dentition may occur.

The skin is another organ that is subject to changes during treatment. The skin may appear initially reddened. Later, the reddening may intensify to the point of the skin sloughing in that radiation field, similar to severe sunburn. Regular observation for skin changes is necessary to prevent the latter damage. There may be times that the patient will need to be placed on a radiation "break" for a few days, to allow the normal tissues time to repair. The radiation patient may use healing lotions approved by the staff.

Most patients undergoing radiation therapy will experience fatigue at some point during their treatment. The causes of fatigue include the stress of making daily treatments, anxiety, anemia, the use of chemotherapy during radiation treatment, and the effect of the build-up of waste products from the breakdown of cancer cells. Patients can usually manage fatigue by responding to their body's need for sleep and rest. Fatigue usually improves steadily after treatment is completed.

Patients may continue to take all of their previous medications during their radiation therapy but, of course, it is important to consult the treating physician which drugs may interfere with the radiation. Generally, patients may continue taking a multivitamin, but it is wise to consult with a dietitian if other supplements are being used. A note of caution: Currently, many patients take natural or complementary products and it is prudent to consult with your caretakers that these products do not contain excessive antioxidants which may interfere with the radiation.

Head and neck cancers may be treated with radiation alone, or in combination with chemotherapy. In certain tumors, the presence of chemotherapeutic agents can sensitize the cancer cells to react more to the radiation therapy. When both treatments are used together, the patient needs to be observed very carefully for side effects, espe-

cially side effects involving blood counts and the breakdown of the oral linings. During this time, white blood cells and platelets may become lower than normal. When the white cell count decreases, the chance of infection increases. If the platelets become low, the body has more potential for bleeding and this is especially important with the breakdown of the oral linings. Monitoring the blood count closely can prevent these more serious complications.

If severe nutritional problems are anticipated, especially with simultaneous chemotherapy and radiation, placement of a gastrostomy tube early in the course of treatment should be considered.

Head and neck cancer has undergone tremendous changes in the past decades. Much improvement will continue to occur in the years to come, especially in this era of ever-changing and better computer technologies. At the present time, the good news of all these treatments is that head and neck cancers are very curable, despite many unpleasant side effects. We look forward to the time when such side effects are eliminated or significantly minimized.

Editor's Note: James R. Wong, MD is Chair of the Department of Radiation Oncology at Morristown Memorial Hospital in Morristown, New Jersey. Previously, Dr. Wong was Assistant Professor of Radiology at the NY Hospital, Cornell Medical College where he specialized in the treatment of nasopharyngeal cancer, gastrointestinal cancer, head and neck cancer, brain tumors, and prostate cancer. In addition to Dr. Wong's current duties, in 1998, he was appointed Associate Clinical Professor of Radiation Oncology at Columbia University, College of Physicians and Surgeons.

Edie Boschen MA, RN, OCN is Nurse Clinician in the Department of Radiation Oncology at the Carol Simon Cancer Center of Morristown Memorial Hospital, Morristown NJ.

Third Annual Head and Neck Cancer Awareness Week April 17-23, 2000

The Yul Brynner Head and Neck Cancer Foundation, Inc. located in Nashville, Tennessee, announces the Third Annual Head and Neck Cancer Awareness Week to be held on April 17-23, 2000. This annual event is dedicated to the education, rehabilitation, support, early diagnosis and prevention of head and neck cancer. Many activities are planned for this week in Nashville.

Other communities nationwide will be observing this week, also. We hope that through the help of patients, health care personnel and the general public that we can finally make a difference in the awareness, education, treatment prevention and cure of head and neck cancer. For more information, please call 615-343-9725

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A TIME FOR SHARING

Being a dermatologist, I am familiar with the problems that head and neck cancer patients experience due to radiation. In my medical practice I have been consulted on various complications resulting from radiation therapy such as secondary fungal infections, ulcerations, and bacterial and viral infections. Often I would listen compassionately to patients describing their difficulties in swallowing, sleeping, eating and speaking. Therefore when I was informed that I was to receive head and neck radiation I felt I understood the numerous restrictions and discomforts in daily living that would follow my therapy. However, despite 32 years of active practice, I never fully appreciated the all the difficulties that head and neck cancer patients endured in their daily lives until I became a patient and walked in their moccasins.

I was diagnosed with squamous cell cancer of the left tonsil and underwent a modified radical neck dissection on May 9, 1997 at the Hospital of the University of Pennsylvania, in Philadelphia. Radiation therapy was to follow. One month prior to my surgery, the university had been approved to participate in a study to observe the effect of a drug called Ethyol® (amifostine). In previous clinical trials, Ethyol® had been successful in reducing the incidence of severe radiation-induced xerostomia (dry mouth) by protecting the salivary glands from radiation therapy. Knowing the changes in my life style that would result from radiation, I volunteered to participate in the Ethyol® study in the hope of minimizing the known side effects. I was fortunate to be chosen by protocol random selection. My first question concerning this protocol was..... If "Ethyol® protects the salivary glands from radiation, will it also prevent the desired damaging effects of radiation on the tumor? Previous stud-

ies had shown that the drug concentrated 100 times more in salivary glands than in other tissue. Hence the protective effect on tumor cells seemed negligible.

I was given the medication through a "PICC Line" (an intravenous catheter) on the inner surface of my right upper arm prior to each radiation treatment, throughout the seven weeks of 6600 Gy. In addition, I had one hour of intravenous fluids prior to receiving the medication and radiation therapy each day. Hence I was in the waiting area about one hour and forty

*Only those who
have walked in
my moccasins
can know*

five minutes daily, which gave me the opportunity to me become acquainted with many patients as they came in and out of the waiting area each day. During this time, I was able to observe the effects of radiation on head and neck cancer patients, not only from the viewpoint of a patient, but also from the viewpoint of a physician. Although the primary side effects of the use of Ethyol® are nausea, vomiting and low blood pressure with dizziness, I was fortunate not to experience any of these side effects.

During radiation therapy I experienced the same damaging effects of radiation to my mouth and throat as my fellow patients not on Ethyol® but to a much lesser degree. I lost my taste at the end of the second week. Although most of my fellow patients were experiencing severe side effects at the second and third week, my severe side effects from radiation did not begin until the fifth week. At that time, I experienced difficulty

sleeping at night. Each night I would need to lubricate by mouth hourly. By 3AM I was wide awake with the urge to urinate all the water I had consumed. Not being able to sleep at night, I exhausted by midday.

I remember that the first swallow of fluid in the morning were pure torture. It would take 45 minutes to swallow a bowl of diluted oatmeal even with the use of narcotics. My diet consisted primarily of soups and high calorie liquid food supplements. I lost 35 pounds during the seven weeks of radiation. Although side effects of radiation therapy that I experienced were similar to those of other patients, they were to a lesser extent. As I sat in the radiation waiting area daily I spoke with many of the head and neck patients. Of course many of us compared and joked about our discomforts from radiation during our daily meetings. In my discussions with my fellow patients all had ulcerations. I had no ulcerations and the mucositis that I experienced was much less. I was able to eat and speak better than any head and neck patient that I met at the center. Some of the patients not on "amifostine" had feeding tubes because of their inability to swallow.

I suddenly realized how much better I was doing than my fellow patients when on the fifth week I began to show outward signs of radiation including weight loss, weakness and the inability to speak above a whisper. As I walked into the waiting room with my weak shuffle and my head down, my fellow patients who had joked with me daily in the waiting area said, "Phil, You can't go down. You're the one who has been holding us up all these weeks".

Definitely, the side effects of radiation therapy that I experienced were milder than those experienced by other patients. But the long term effects, in my opinion, are even more dramatic. And from a patient's point of view, rather spectacular. My recovery from treatment was markedly improved in six

weeks. I was eating foods with gravy and sauces and playing golf twice a week. By six months I was eating most foods even those without gravy or sauces. I am now 30 months post radiation and I can eat all food including breads and bagels without dunking. I never realized that most patients who have had radiation to the head and neck area have difficulty eating bread until one day when I joined two ladies for breakfast who I had known who had experienced similar surgery and radiation therapy. As I approached their table from the cafeteria line their eyes were wide in amazement. And as they looked at my tray they both in unison exclaimed, "Phil..... YOU CAN EAT A BAGEL."

There are a few foods that continue to irritate my tongue and cheeks such as vinegar, even in Ketchup and mustard, and black pepper. My speech is 80% of normal. I can even sing in church although my range is

more limited now. I rarely walk with a water bottle unless I am on a long plane ride or expect to be away from a water source for more than 90 minutes.

Teeth often become decayed after head and neck radiation because the pH change causes high bacteria count. It is recommended that irradiated patients use fluoride applicators daily which I did for one year. Because of the prophylactic surgical removal of molars and movement of teeth it was necessary for me to have dental braces for 15 months. During that time, I was not permitted to use fluoride for 7 months because it would remove the glue holding the braces in place. During this period and to the present time I have had no cavities and I attribute this to the rebound of my salivary glands due to "amifostine". Since removal of the braces I have returned to using fluoride applicators every other day.

I would like to bring several points to your attention. "Amifostine" is now available for patients who are to start radiation to the head and neck. This medication will not help if your radiation has been completed. Ethyol® can only be of help if given prior to radiation therapy. Hence patients about to receive radiation therapy to the head and neck should discuss this adjunct to therapy with their radiation oncologist. One patient's successful response to therapy, such as mine, does not prove definite efficacy for all patients treated. Although this medication does not destroy the cancer or increase survival, it may increase the patient's ability to produce a more adequate supply of saliva and improve the quality of life after radiation.

Philip LoPresti, MD
Mt. Laurel, New Jersey



New Frontiers: A Symposium for People Treated for Head, Neck & Oral Cancers and their Family and Friends

The Post Treatment Resource Program and the Head and Neck Service of Memorial Sloan-Kettering Cancer Center are pleased to sponsor *New Frontiers: A Symposium for People Treated for Head, Neck and Oral Cancers and their Family and Friends*, on Friday, March 31, 2000. This symposium will take place at the Hoffman Auditorium in the Memorial Sloan-Kettering Cancer Center at 1275 York Avenue in New York City. It will commence at 9:30 AM and continue until 3:30 PM. There is no charge to attend this special event, however, registration is required. Please call 212-717-3532 to register.

The focus of the day will be on the

medical and psychological concerns of head, neck and oral cancer survivors. This symposium will help the individual negotiate his/her journey as a cancer survivor and offer practical and current information provided by a multidisciplinary health care team.

The morning sessions of the symposium will address medical issues, research and treatment. The afternoon sessions will focus on the topics of health maintenance and quality of life. In addition, there will be a "Stories of Survivorship: A Panel Discussion." This part of the program will feature the personal stories of cancer survivors.

The purpose of this special symposium is to offer survivors, friends and family members current information on the advances in the treatment and research of head, neck and oral cancer. The day is designed to provide information and support. All are welcome.

Written by
Constance H. Genson
and
Karrie Zampini

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How To Deal With The Depression Associated With Medical Problems

by Robert H. Phillips, Ph.D

Virtually everyone who has been diagnosed with a medical problem has experienced depression. It is so common that it has been nicknamed the “common cold” of emotional problems. It can be described as an extremely unpleasant feeling of unhappiness and despair, ranging from mild (feeling discouraged and downhearted) to severe (feeling utterly hopeless, worthless and unwilling to go on living).

Depression doesn't just affect the person with the medical illness. Family members, too, can suffer from this emotional problem. They may worry about the illness, its affect on the family, changes in lifestyle... among many other things.

How Do You Know If You're Depressed?

You may be depressed if you're experiencing any of the following:

- Are you feeling excessive amounts of sadness, despair, discouragement, or melancholy?
- Are you unable to eat (and this problem has nothing to do with the medical condition or its treatment)?
- Are you sleeping either too much or too little?
- Do you feel totally withdrawn from social activities?
- Are you crying more often than usual?
- Do you brood about the past and feel hopeless?
- Are you experiencing excessive amounts of irritability or anger?
- Do you feel inadequate and worthless?
- Are you unable to concentrate on virtually anything in your life (e.g. work, family, or other interests)?
- Do you have little or no interest in sex or intimacy?

Any of these can be symptomatic of depression. The more of them you experience, the more likely it is that you are depressed and should take some action to help yourself.

What Causes Depression?

First of all, remember that a certain amount of depression is normal in anyone's life. We all experience ups and downs. If we never experienced some of the downs, how could we fully appreciate the ups!?! But the depression that needs to be treated often starts with one specific thing- one upsetting event or occurrence. Certain events- traumatic experiences such as losing a loved one, being diagnosed with a chronic medical problem, requiring major surgery, or being fired from a job- can lead anyone into a depression. This may lead to a kind of chain reaction, where you feel worse and worse. When depression becomes more than just the “normal downs,” then it must be attended to. Nipping it quickly in the bud can keep it from becoming much worse. Anger that is bottled, or kept inside, can also lead to depression. Because the anger is such an intense emotion, you may “shut down” in an attempt to keep yourself from experiencing these terrible feelings. In a small per-

centage of cases, depression may be caused by biochemical deficiencies- a chemical imbalance in the body.

Other contributors to depression in people with medical problems include an unsatisfied need for control, fear of the future, problems involving other people, or changes in lifestyle.

How Can You Cope With Depression?

Can anything be done to alleviate depression? Of course! There are many effective coping strategies that can help you deal with depression. Let's discuss some specific suggestions for ways that you can alleviate depression.

☐ **Distinguish between what you can change and what you can't.** It can be very helpful to make a list of all the things that are depressing you. You may feel there'll be at least fifty items! But in actuality, you'll probably start running out of ideas after six or seven. Next, divide this list into two more lists: first, those things that you can do something about and, second, the things you can't do anything about. Set out to do something about those items in the first list, and work on your thinking regarding those items in the second list.

☐ **Work on your thinking.** Negative, unpleasant thoughts can create difficulties for you. The difference between being happy and unhappy is not whether or not you experience negative thoughts. Rather, the difference is determined by how successful you are at dealing with any negative thoughts you do have. You may want to learn how to restructure (or reword) negative thoughts by turning negatives into realistic positives. This is called “cognitive restructuring.” Identify and reword your negative thinking. Replace words that are inappropriate and counterproductive with more positive and realistic ones.

☐ **Project the constructive thoughts of others into your thinking.** What happens if your thinking is so negative that you have difficulty coming up with positive ways to reword your statements? Ask yourself what others might say if you presented your thought to them. This may give you some ideas. If necessary, ask of those around you. Why do that? You can compare yourself with any person with regard to any characteristics. There will always be people who are better than you, as well as people who are worse than you, no matter what their characteristics. Remind yourself of this when you find yourself automatically getting into comparisons. Use this as a reason not to continue the comparison. Just concentrate on being you.

☐ **Have a family powwow.** Since all family members are affected if someone in the family is ill, it can be very helpful for them to be able to share how they feel. And improved family relationships and support can be important in alleviating depression. A family meeting and discussion can help you improve constructive communication within the family. For this technique to work best,

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DEPRESSION continued from page 6
all available family members should be included. Give each person a predetermined amount of time (start with five minutes) to share feelings, gripe, air grievances- even cry. However, the intent of any communication must be constructive. No one else should interrupt. Reactions are permissible, but only after each person has had his or her few minutes. Just getting together to discuss feelings can bring family members closer together.

The strategies and techniques that are most effective in dealing with depression can also be effective in preventing you from becoming depressed. Unfortunately, this doesn't mean that you'll never again feel depressed. It may happen. Anticipate it, so that if it does recur, you won't completely fall apart. And if this feeling does come back, won't it be good to know that you *can* do something to help yourself?

Editor's Note: Dr. Robert H. Phillips is a licensed psychologist and the founder and director of the Center for Coping on Long Island, NY. He can be reached at (516) 822-3131. The web site of the Center for Coping is at www.coping.com.



P.O. Box 53
Locust Valley, NY 11560-0053

Dear SPOHNC:

A few years back you published my story in your newsletter. I had radiation treatment to my neck for an unknown primary tumor and have now been cancer-free and healthy for almost ten years. When I last wrote you, I described my dental regimen and stated that I had found that using gum with XYLITOL sweetener had done wonders for stimulating my saliva output and helping me maintain excellent dental health. At that time, the product I was us-

A member writes...

ing was called XYLIFRESH gum. I'm sorry to say that it is no longer in production. The gum I now use is called Ford Extreme Xylitol Gum and I purchase it at a health food store. I still prefer the former, but this is also working just fine. Since I really don't like to chew gum (ironic isn't it?) I have a piece of it under my tongue every waking hour. It has truly been a wonder drug for me. There may be other XYLITOL sweetened products that help, but I'm not aware of any other gums. Please consider using this information in a future newsletter. If I can be of any assistance, please don't hesitate to contact me.

Sincerely,
Jerry L. Runyon
Quincy, IL

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