



## **RADPLAT: A NEW WAY TO TREAT HEAD AND NECK CANCER**

K. THOMAS ROBBINS, M.D.

Researchers continue to look for better methods to treat cancer of the head and neck more effectively. Standard ways have significant disadvantages with regard to side effects and lack of effectiveness particularly for patients with advanced disease. Although surgery continues to be the most important modality, it is most reliable for patients with small lesions and must be combined with other modalities (usually radiation therapy) for more advanced disease. Unfortunately, the majority of patients fall into this latter category when the diagnosis is made. Furthermore, a significant proportion of patients with advanced disease are not suitable to undergo surgery either because the lesion is too large and involves important structures in close proximity to the cancer, or they are not medically fit to tolerate such lengthy procedures.

A second limitation to surgery for head and neck cancer is the loss of organ function that frequently results following removal of the tumor. Although substantial progress has been made in reconstruction techniques and overall rehabilitation, a significant proportion of patients are left with severe limitations in eating ability, speech, taste and smell.

To overcome these disadvantages of surgery, researchers have attempted to find alternate methods for treating advanced head and neck cancer using chemotherapy combined with radiation therapy. To date, the most promising results appear to have come from trials using chemotherapy agents given during radiation

therapy. This is called concurrent or concomitant chemoradiation. RADPLAT is one such protocol, which is proving to be extremely effective in terms of causing the tumors to melt away, preserving organ function, and possibly improving survival.

RADPLAT, also referred to as targeted chemoradiation, is a novel treatment developed specifically for patients with advanced cancer of the head and neck. It involves the use of the chemotherapy agent cisplatin, one of the most effective agents for this disease. What sets this treatment apart from other chemoradiation protocols is that the cisplatin is delivered directly to the tumor through very small catheters inserted in the arteries supplying blood to the tumor. The procedure is done by a radiologist specially trained to insert a long catheter through the large artery in the groin (femoral artery) and guide it upward through the aorta (the main artery of the body's torso) and into the neck artery (carotid artery). From there, a smaller catheter is fed through the initial one and guided by real time x-rays (fluoroscopy) to the dominant arterial supply of the tumor. Once the catheter is in place, cisplatin is ready to be infused rapidly into the cancer.

A second unique aspect of the chemotherapy infusion is the use of a second agent called sodium thiosulfate, which serves as a neutralizer or antidote to cisplatin. The thiosulfate is given as an intravenous infusion exactly at the same time the cisplatin is being rapidly delivered to the cancer. In this manner, the antidote is able to reach all of the other organs of the body before the cisplatin and thereby protect them against any possible side effects of the chemotherapy agent, which include potential effects on hearing and the kidneys. Theoretically, the use of the antidote also allows more cisplatin to be given before unacceptable side effects take place. This was proven to be the case when groups (cohorts) of patients were tested with increasing amounts of cisplatin. It was determined that cisplatin could be given safely to the majority of patients in amounts that were 5-10 times greater compared to protocols that use cisplatin in the more standard way (intravenous). Thus the RADPLAT protocol involves the use of cisplatin given through the artery (intra-arterial) in ex-

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extremely high doses (4 weekly infusions at 150 mg/square meter of body surface combined with intravenous thiosulfate).

Although tumors were found to respond to the extremely high dose schedule of intra-arterial cisplatin as described, the most potent effect of the drug delivery technique was achieved when radiation therapy was added to the regimen. With this schedule, radiation was administered over 7 weeks during which the cisplatin infusions were given on days 1, 8, 15, and 22. Referred to as the RADPLAT protocol, 213 patients with previously untreated advanced head and neck cancer received this at the University of Tennessee, Memphis between 1993 and 1998. Among the 189 patients who were able to complete the protocol and be re-staged, 90.5% of them had no evidence of any residual cancer remaining in the primary site (i.e. site of disease origin). Seventy percent of the patients also had complete resolution of the cancerous lymph nodes whereas all but 2 patients who had residual neck disease underwent neck surgery to successfully clear any remaining neck disease. In following these patients for 16-72 months (median 30 months), only 16 (8.2%) have developed a recurrence in the head and neck region whereas 35 (17.9%) have developed recurrences in distant organs. The projected 5 year survival estimates for this group of patients are 38.8% (overall) and 53.6% (cancer related). These results are promising when considered in the context of other types of treatment, particularly for those patients who had massive disease that was beyond the boundary for removal (unresectable). It is also significant that very few of the patients in this treatment program were required to undergo surgical removal of the cancer within the site of origin. Thus, 84 % of them had successful preservation of the organ/s or structure/s in which the cancer arose.

Unfortunately, chemoradiation is potentially toxic regardless of the specific type used. The RADPLAT protocol is no exception with 39% of patients experiencing one or more types of severe toxicity. However, most of these are self limiting, particularly severe mucositis which affects one

third of all patients. Most patients who go through the treatment experience some degree of fatigue, loss of appetite and weight loss. Approximately 20% of patients have such side effects as nausea and dehydration. Feeding tubes are often required to support them during this time interval. Hair loss is very uncommon. Upon completion of therapy, patients slowly recover such that the majority can resume their usual daily activities. Quality of life measurements done before, during and 6 months after therapy indicated that there was complete recovery in almost all categories (domains) scored by the patients.

Non-surgical therapy for head and neck cancer also may prove to be effective for preservation of organ function such as speech, swallowing, smell and taste. As mentioned previously, the RADPLAT treatment has been able to achieve a high rate of disease control above the collar bones (within the head and neck region). However, further analysis was required to determine whether this meant the organs preserved were functioning properly and serving some useful purpose for the patient. One specific analysis to assess function evaluated the ability of patients to eat. Patients were scored according to the following categories: 1) normal or nearly normal swallowing; 2) impaired swallowing requiring dietary alterations; 3) recreational oral intake possible, but tube feeding necessary for daily nutritional requirements; and 4) entirely dependent on tube feeding. The percentage of patients who reported normal swallowing declined during the RADPLAT treatment from 38% (18 patients) to 21% (10 patients) but increased during the next 18 months to 72% (34 patients). The requirement for a feeding tube was 13% (6 patients) among long term survivors.

With regard to speech and voice preservation, 2 analyses have been done: one for patients with laryngeal cancer; and another for patients with piriform sinus cancer which is located next to the voice box. The analysis for laryngeal cancer compared 36 patients with advanced primary disease (T3-4) treated with RADPLAT to a second group with T3-4 lesions who were treated

with surgery. Although survival was not significantly different between the 2 groups, 88% of the patients in the RADPLAT group had preservation of the larynx compared to 3/19 patients (16%) in the surgery group. Only 6/36 patients (17%) of the RADPLAT group had a poor voice while 19% were dependent on a feeding tube and 22% needed a tracheostomy. Thus there remains a small subset of patients who undergo chemoradiation for laryngeal preservation who have a suboptimal result with regard to voice and eating ability. The analysis of patients who received RADPLAT treatment for piriform sinus cancer showed similar results with 88% having organ preservation, 88% of whom had a fair to excellent voice, and 67% able to maintain their nutrition by oral intake.

The RADPLAT treatment has also proven to be very effective at controlling the associated cancer in the neck. Approximately 70% of patients have clinical evidence of neck disease at the time of diagnosis some of which was multiple (N2b) or very large (N2a and N3). A surprising outcome of the RADPLAT treatment is its ability to effectively shrink the nodal disease. Furthermore, among the patients who had incomplete resolution of the enlarged nodes, a subsequent neck dissection was effective at clearing the remaining lesions in virtually every patient. An additional feature of the neck treatment has been the use of conservation neck surgery as opposed to a radical operation. Thus the use of selective neck dissection has resulted in much less complications, minimal side effects such as severe fibrosis and shoulder pain, while disease control has remained very high.

It is common belief among head and neck surgeons that the presence of bone or cartilage invasion associated with head and neck cancer portends a worse prognosis and, if possible, the lesion should be treated with surgery followed by radiation therapy. Most oncologists are reluctant to treat such patients with chemoradiation unless the lesion is unresectable. Among patients treated with the RADPLAT protocol, this

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philosophy has not been followed and patients with bone or cartilage invasion have not been excluded. Recently this group was analyzed and compared to other RADPLAT patients with T4 disease. Surprisingly, there was no significant difference in complete response rate, recurrence rate, and overall survival between the 2 groups (unpublished data). Thus it appears that the RADPLAT treatment is potent enough to overcome such adverse factors as bone and cartilage destruction. These findings are also in keeping with other analyses, which have found no significant differences in outcomes between T3 and T4 lesions, and low versus high tumor volume.

The observation that bone destruction does not significantly alter the ability of RADPLAT to effectively clear disease has made it feasible to use this treatment approach for patients with extensive lesions invading the skull base. An analysis of patients with advanced sinus and nasal cancer showed effective disease control among patients who completed the treatment protocol, which in this case included surgical debridement 2 months post-radiation therapy. The treatment strategy has also proven to be effective for patients with ear cancer whose lesion has directly invaded the skull base.

While the RADPLAT treatment program at the University of Tennessee, Memphis is continuing to receive patients from all over the United States, a current effort is to encourage other centers to evaluate this approach through a multicenter trial sponsored by the National Cancer Institute. The goal of this study is to determine whether other centers can perform the treatment safely and obtain similar results to UT Memphis. As a result of this study, there are 10 centers across the USA currently participating in this project. Preliminary analysis indicates that the majority of patients have been able to receive the complete treatment and the complete response rate is extremely high and not significant different from the single center study. The RADPLAT treatment is also being pursued in Europe at the Amsterdam Cancer Center where 70 patients have completed therapy. Again, the results are very similar

to that of UT Memphis. The ultimate goal of the RADPLAT research efforts is to conduct a randomized trial and compare it to another treatment that others claim is better.

*Editor's Note: K. Thomas Robbins, M.D. is Professor and Chair of the Department of Otolaryngology - Head and Neck Surgery at the University of Tennessee, Memphis.*

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**RESOURCES****A Rendezvous with Clouds**

By Tim Fleming, M.D.

University of New Mexico Press, 1999

\$15.00. 233 pages.

Reviewed by Elizabeth Hadas

All of us who have been through the experience of cancer know that it can bring us unexpected gifts. I am a book publisher, so it is not surprising that one of great gifts that cancer and its aftermath brought me came in the form of a book: *A Rendezvous with Clouds*, by Tim Fleming, M.D., published in 1999 by Chaniisa Press in Santa Fe, New Mexico and reissued by the University of New Mexico Press, where I work as director and editor in chief

I was diagnosed early in 1998 with a squamous cell carcinoma that had metastasized from my left tonsil to the lymph nodes in my neck. I underwent a tonsillectomy, removal of all the lymph nodes on the left side of my neck, and five weeks of radiation after an arduous course of dental work. The treatment left me skinny, thirsty, and intensely interested in the nature of healing. I have always loved reading memoirs, but because I work in scholarly publishing, I don't have the chance to publish them. So I was startled, when one day in March 1999 I received a phone call from a physician in Santa Fe who had written a memoir and wanted to talk to me about it.

The minute I saw Dr. Fleming I knew he was gravely ill. He explained that he had always wanted to be a writer and had even taken time out from practicing medicine to work as a journalist. He had been treated as a young man for a rare neck cancer, a chemodectoma. It reappeared twenty-six years later, when he was forty-eight years old, and it was metastatic. Now fifty-four (my age), he had been fighting the cancer for five years, but he knew that he was losing the fight. He had long dreamed of publishing a book and decided to make that dream come true. But he was running out of time. The process of submitting a manuscript to a publisher, waiting

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## A TIME FOR SHARING

**M**y first experience with cancer was in 1992, when I was diagnosed with skin cancer on my nose. This cancer was treated only to recur again several times before being successfully treated with cutaneous micrographic surgery (MOHS surgery). But from that time on, I was indeed conscious of every little change on my nose. Consequently, it became a custom each morning, to look in the mirror for any new signs of skin cancers since they had a way of recurring every two years.

It was March 25<sup>th</sup>, 1998. No signs of recurring skin cancer. However while shaving that morning, I suddenly felt a lump in my neck about the size of an almond. I thought the lump was a swollen gland and that it would subside, but it didn't and after a week it became larger. I made an appointment for an examination with my ear, nose and throat doctor who is also a head and neck surgeon. Immediately following his examination, I was sent for a CT scan. A new chapter of living with cancer was about to begin.

Results of the CT scan revealed a 2cm enlarged lymph node adjacent to a large mass near my carotid artery. My doctor informed me that surgery to remove the lymph node and mass should be scheduled as soon as possible. Following the surgery on April 20<sup>th</sup>, 1998 at which time a large brachial clef cyst which was pressed against my carotid artery was removed, a biopsy of the lymph node was also done. The pathologist's report indicated that the lymph node contained metastatic squamous cell carcinoma.

My first thought was that the cancer of the nose had spread to the lymph nodes. But this was not the case. The cancer cells from the nose and the cancer cells from the lymph node were two different types.

My doctor whom I had known for fifteen years, informed my wife and me that he

had not seen any primary tumor visually and would need to do additional biopsies on the nasopharynx, larynx and tongue in order to determine the location of the primary tumor. These biopsies were done, however, they did not reveal the primary tumor. Consequently, the doctor told me that the appropriate course of action would be to radiate the entire neck, lymph nodes, some of my salivary glands, the nasopharynx and upper chest. I agreed to proceed and took a positive attitude that the radiation would kill the unknown primary. My wife and I prayed and prepared for radiation therapy. Preparing for radiation therapy with the simulator, the resin

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*I have a positive outlook. I don't dwell on my cancer and I don't ask "why me?" I educate myself about head and neck cancer through publications...*

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mask, CT Scans, etc. took several weeks. Then my therapy began.

In all I had thirty five radiation treatments at Clara Maass Medical Center. The staff treated me with compassion and encouragement. As was expected, I experienced all the side effects of treatment including difficulty in swallowing, dry mouth, thrush (yeast infections), loss of weight, nausea, etc. But my belief in God and my wife got me through. Being a Marine Corp veteran I can honestly say the ordeal was as tough as Boot Camp.

It is now almost two years since I com-

pleted my treatments. As a 54 year old survivor, I have a positive outlook. I don't dwell on my cancer and I don't ask "why me?" I educate myself about head and neck cancer through publications, and have follow-up examinations with my doctor every three months.

It seems that whatever the treatment plan, the side effects of treatment can be an ordeal, but as a cancer survivor, I have learned to cope. I have learned to live with dry mouth, some loss of taste, and some bleeding of my gums. After learning about dental management of head and neck cancer survivors in SPOHNC's newsletter, *News From SPOHNC*, (February, 1999), I attended a program about dental care at the Post Treatment Resource Program at Memorial Sloan-Kettering Cancer Center. I now know the importance of good regular dental care to prevent caries and osteoradionecrosis.

One of my positive New Year's resolutions for 1999 was to become a volunteer and try and help other cancer survivors get through their ordeal. Consequently, I joined an organization called Cancer Hope Network and speak via telephone and in person with head and neck cancer survivors and their families. I am also part of the "Survivor to Survivor" network of SPOHNC. When you are having difficulties coping with your cancer and side effects of treatment, there is nothing better than talking with a cancer survivor who has had similar experiences. It feels good to know you are not alone.

I would like to end my story with this reminder. If you spend time outdoors in the sun, be sure to use your sunscreen. Remember, skin cancer was my first experience with cancer.

Martin Kemp  
Clifton, New Jersey



## NEW ORAL CANCER SCANNER MAY HELP SAVE LIVES, STUDY SAYS

Computer-assisted analysis of oral tissues is highly effective for early detection of pre-cancerous and cancerous mouth lesions, and could have a dramatic impact on reducing oral cancer deaths, according to the cover story of the October 1999 *Journal of the American Dental Association*.

An estimated 30,000 new cases of oral cancer are expected to be diagnosed in the United States this year, according to the American Cancer Society. And despite treatment advances nearly 50 percent of people who have oral cancer die within five years. This year, an estimated 8,100 deaths are predicted in the United States.

"Early evaluation of oral precancerous lesions can have a dramatic impact on oral cancer mortality rates," said James J. Sciubba, D.M.D., Ph.D., for the U.S. Collaborative OralCDx study group.

The group, composed of researchers from throughout the nation, evaluated a computer-assisted method of analysis of oral brush biopsies for OralScan Laboratories, Inc., the manufacturer.

The collaborative group undertook the study to evaluate the sensitivity and specificity of OralCDx detection. A critical component of the detection is the use of computer-image analysis that has been adapted and optimized to detect tissue abnormalities unique to brush biopsy samples.

"Pre-cancers and early-stage oral cancers cannot be adequately identified by visual inspection and may easily be overlooked and neglected even by highly trained professionals with broad experience" explained

Dr. Sciubba, who also is professor of Oral and Maxillofacial Pathology, State University of New York at Stony Brook. "Thus, a method of detection at early, curable stages is crucial and may lead to a reduction in oral cancer morbidity and mortality rates."

The nationwide study compared results of the computer-assisted image analysis with those of scalpel biopsy of suspicious oral lesions, as well as using the computer-assisted analysis on oral lesions that appeared benign clinically.

Analysis kits supplied to investigators included an oral brush biopsy instrument, a pre-coded glass slide and data form.

Nine hundred forty-five patients were enrolled in the study conducted by dentists at 35 U.S. academic dental sites. Of the participants, 502 (53 percent) were women and 443 (47 percent) were men. Their ages ranged from 18 to 83 years.

Brush biopsy specimens were obtained from lesions from all regions of the oral cavity. The brush biopsy resulted in minimal or no bleeding and required no topical or local anesthetic. The tissue sample was then sent to a lab. A computer programmed to read the slide identified the most suspicious cells for a pathologist to evaluate.

"In 945 patients, computer-assisted analysis independently detected every case of histologically confirmed oral dysplasia and carcinoma. Every 'positive' result from the computerized analysis was subsequently confirmed by histology as abnormal or carcinoma," he said.

Also, in the study, 4.5 percent of clini-

cally benign-appearing lesions that would not have received additional testing or attention other than clinical follow-up, were identified through computer-assisted analysis as dysplasia or carcinoma.

The results of this study demonstrate that this type of testing can be reliably used on oral lesions with tissue abnormalities, the researchers concluded. More important, they said, the testing revealed unsuspected pre-cancerous and cancerous oral lesions.

The results of this multicenter trial demonstrate the potential value of computer-assisted image analysis as an adjunct to the oral cavity examination in identifying pre-cancerous and cancerous lesions at early stages, when curative therapies are most effective," Dr. Sciubba added. ■

*Editor's Note: James J. Sciubba, D.M.D., Ph.D., is presently Director of Dental and Oral Medicine in the Department of Otolaryngology-Head and Neck Surgery at Johns Hopkins Medical Center. Dr. Sciubba has been an active participant in the development and promotion of SPOHNC and serves as Vice President of the organization as well as a member of the Medical Advisory Board.*

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

## New Members Join Medical Advisory Board

Support for People with Oral and Head and Neck Cancer is pleased to welcome Drs. Eugene N. Myers, David G. Pfister and David M. Huchton to its Medical Advisory Board.

**Eugene N. Myers, M.D., F.A.C.S.**, is Professor and Chairman of the Department of Otolaryngology in the School of Medicine and Professor of Diagnostic Services at the School of Dental Medicine at the University of Pittsburgh in Pittsburgh, Pennsylvania. Dr. Myers is also Director of the newly established Oral Cancer Center which integrates the efforts and resources of the University of Pittsburgh Cancer Institute, the School of Medicine, the School of Dental Medicine, the Graduate School of Public Health, and the University of Pittsburgh Medical Center Health System. He is a member of the Board of Directors of the American Academy of Otolaryngology-Head and Neck Surgery and International Editor of *Otolaryngology-Head &*

*Neck Surgery Journal*. He is author, co-author and/or editor of many textbooks and more than 200 published articles. He lectures extensively on head and neck disease.

**David G. Pfister, M.D.**, is a medical oncologist at Memorial Hospital in New York. He trained at the Hospital of the University of Pennsylvania (internal medicine), Yale University School of Medicine/Yale-New Haven Hospital (clinical epidemiology), and Memorial Sloan-Kettering Cancer Center where he is presently co-leader of their Head and Neck Cancer Disease Management Team. He is also an Associate Professor of Medicine at Cornell University - Weill Medical College. Dr. Pfister is an expert in the management of cancers of the head and neck, with a special research interest in combined modality therapies and the development of therapies that preserve form and/or function. He has been a member of the Head and Neck Cancer Strategy Committee at the NCI since 1992. Dr.

Pfister is on the editorial board of *Critical Reviews in Oncology/Hematology*.

**David M. Huchton, M.D.**, is Assistant Professor in the Department of Otolaryngology-Head and Neck Surgery at Johns Hopkins School of Medicine. He is also Acting Division Director of Microvascular Reconstruction for Head and Neck Surgery. Dr. Huchton received training at the University of California, San Francisco School of Medicine and Johns Hopkins Hospital, Department of Otolaryngology-Head and Neck surgery. He is Board Certified in Head and Neck Surgery, General and Pediatric Otolaryngology and Plastic Surgery. Dr. Huchton's area of special interest is in the field of microvascular reconstruction. He has authored many published articles and has presented many lectures on the subject of microvascular reconstruction. ■

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for a decision, and then waiting for the book to be printed can take years. Tim Fleming didn't have years. So he made a wise decision to publish the book himself. When he came to see me, *A Rendezvous with Clouds* was already published and he had sold half the first printing. His friends had urged him to see if the book could reach a wider market through the University of New Mexico Press, the largest publishing company in the state.

I told Dr. Fleming that I was intensely interested in his book since I had also been treated for a head and neck cancer. This pale, wasted man who had come to seek my counsel suddenly turned into a healer. "Are you doing okay now? Head and neck cancers are so nasty, don't you think?" I promised to read his book immediately even though our press didn't ordinarily publish medical material.

It's a great book, and I called him the minute I finished it to tell him so. The first

third of the book is about the doctor's experiences in the Indian Health Service, where he worked with Hualapai and Havasupai people in Arizona. The middle is about his work as head of emergency medicine at St. Vincent's Hospital in Santa Fe. And the last section is about his own experience as a cancer patient. Dr. Fleming was not only a wonderful healer but also a talented writer who could tell great stories and make the reader laugh and cry and wonder. Even though it was completely different from the kinds of books university presses ordinarily publish, we agreed to distribute the remaining copies of the book. By the time we concluded the process of drafting a contract, Tim was too ill to sign it, but he knew that we loved *A Rendezvous with Clouds*. He died in April 1999, three weeks after I met him.

No sooner had Tim's son delivered the remaining copies of *A Rendezvous with Clouds* to our warehouse than I received a phone call from a friend of Tim's who was

organizing a memorial service. He asked if I would sell copies of the book at the service. This is the only time in my career that I have ever sold an author's book at his own funeral. For all I know, it's a first in the history of publishing. But it wasn't an ordinary funeral. It was held on a beautiful spring afternoon in the mountains outside Santa Fe. An amazing collection of people from the Indian Health Service, the state healthcare bureaucracy, and the University of New Mexico Medical School, as well as family, friends, and neighbors spoke about the good Tim had done and what he meant to them. I sold thirty-three copies of Tim's book, including one to a hiker who wandered into the service by mistake.

We soon sold out the first printing of *A Rendezvous with Clouds*, and now the University of New Mexico Press has reissued it. It's a joy for me to be able to spread the word to members of SPOHNC. ■

## A member writes...



info@spohnc.org

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

Dear SPOHNC

*I read with interest the letter from Jerry L. Runyon of Quincy, IL in your March, 2000 newsletter concerning xylitol. I, also, was a long time user of xylitol and was concerned when the production of the product ceased. After trying several substitutes, I now use Biotene gum which is available in general stores such as Wegman's and other supermarkets. After my third oral surgery when again a tumor and a portion of my mandible was removed, I was fitted with a dental prosthesis which has helped immeasurably in my ability to speak and conduct everyday activities and as most gums tend to stick to a prosthesis, however, Biotene gum does not.*

*There is also a Biotene toothpaste which I use that works very well for patients suffering from xerostomia.*

*Per the article, for Mr. Runyon and others who do not like chewing gum, there is a product called Salix Saliva Tablets which is a good alternative to continual gum chewing. At times, even though I have had severe xerostomia, I can go through a 24 hour period by just using Salix Saliva Tablets. If anyone is interested, the product can be purchased from Scandinavian Naturals, 13 W. Seventh St., Perkasio, PA 18944 (215-453-2505)*

... Sherwood Finn

Dear SPOHNC:

*I finally got relief from the mouth sores that resulted from radiation therapy. I've had 20 treatments with hyperbaric oxygen. I am now scheduled for surgery on my jaw and then 10 more treatments. After only 3 treatments with hyperbaric oxygen, I started to eat soups & stews. After 10 treatments I could eat soft foods and I'm now eating almost everything.*

... Roger



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ORAL AND HEAD AND NECK CANCER  
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