

THE IMPORTANCE OF PROPER DENTAL CARE FOR HEAD AND NECK CANCER PATIENTS

ALAN B. SHEINER, D.D.S.

The oral cavity, one of the most complex and visible organ systems in the body, is invariably compromised as a result of treatment for head and neck cancer. Whether the malignancy is to be treated by surgery, radiation therapy, chemotherapy or a combination of these modalities, the function, if not also the form, of the oral cavity will be impacted. Therefore, it is vital that every head and neck cancer patient be evaluated by a dentist who is trained and experienced in the unique problems and circumstances that accompany this type of cancer.

In theory, every dentist should be well versed in the management and care of the irradiated head and neck patient. Unfortunately, this subject has not been stressed in dental school. Even if the dentist had some instruction, his or her clinical experience would have been quite limited. A real life example of this is a lady irradiated for a parotid gland tumor. Her general dentist provided her with fluoride applicators, but unfortunately this practitioner did not appreciate the importance of using a neutral pH fluoride gel. The acidulated fluoride gel, normally used when a dentist or hygienist gives a fluoride treatment, literally ate into the surfaces of this woman's porcelain crowns. Now, in addition to having a dry mouth from radiation, she also has multiple crowns with surfaces like sandpaper. Needless to say, these expensive restorations could not be salvaged and required replacement. In short, the dentist remembered that radiated patients should have

daily fluoride treatment. He just did not have a genuine understanding of how to accomplish the task properly.

The most common and profound side effects of irradiation to the head and neck region are: dry mouth (since the major salivary glands are almost always damaged by the therapy), post-irradiation dental caries (a preventable situation), the risk of osteoradionecrosis (non-healing chronic bone death in irradiated bone which has a compromised blood supply) and trismus, (an inability to open the mouth fully).

The radiation-induced dry mouth syndrome can be treated with an artificial saliva substitute. It can also be treated through the use of medication (e.g. Salagen) or chewing gum (e.g. Biotene), or saliva stimulating lozenges (e.g. SALIX) to maximize the output of whatever salivary capacity the patient still possesses. The post-irradiation dental decay or caries can be prevented through conscientious daily use of custom made fluoride applicator trays and neutral pH fluoride gel, scrupulous oral hygiene, and routine follow-up care by a dentist. One of the most disheartening situations encountered is that of the patient who decides to stop his/her fluoride therapy and later presents with a toothache along with rampant post-radiation caries. This situation need not have occurred at all, if someone had taken the time to explain to the patient that fluoride therapy is a permanent regimen, not one that is adhered to only during active radiation treatment. Of course, the patient himself/herself must maintain conscientious follow-up and be committed to its importance.

The concomitant risk of osteoradionecrosis (ORN) can likewise be minimized or eliminated by a little foresight on the part of the clinician treating the patient. Unfortunately, there are occasions when ORN occurs spontaneously following irradiation. In those instances, careful, insightful and knowledgeable management is crucial to control and to limit the potentially devastating ramifications. No one ever wants to remove a tooth from irradiated bone or perform surgery on irradiated bone, lest ORN occur and become unmanageable. If ORN, despite all best efforts, does occur, the patient should immediately see a dentist or oral and maxillofacial surgeon trained and experienced in the care and management of the head and neck cancer patient.

Once a patient is irradiated, the blood supply to the treated area is compromised forever. It will not return. We all need blood to heal from any type of injury. When a tooth is removed, the blood clot that forms in the socket is, in turn "organized" by

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COMING IN MARCH, 2001

Patients Decision Making in Cancer of the Larynx

Gregory T. Wolf, M.D.

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new tissue as the wound heals. Almost everyone knows of someone who has suffered a "dry socket." This is a slang term for a tooth extraction site where the blood clot spontaneously aborts, leaving exposed bone. This exposed bone necroses (dies) and is painful. Fortunately in most cases, this is a self-limiting condition, which resolves with minimal treatment. However, the radiated patient may be left with the exposed bone without the promise of resolution, since there is less blood supply for healing.

Unfortunately, I have had experience with this type of situation. A patient who had a tooth removed from an irradiated mandible by an uninformed dentist came to see me. When I saw this patient, the bone had eroded down to a small artery, which was bleeding quite profusely. Fortunately, once the bleeding was controlled, the area healed; however, a very tense and potentially devastating episode occurred which could have been prevented.

Trismus is the inability to fully open the mouth. This side effect can be minimized, if not prevented altogether, by doing specific exercises even before radiation therapy has begun. These exercises simply involve opening the mouth as wide as is comfortable. This maximum comfortable opening is measured using a tongue depressor or popsicle stick, held up vertically like a ruler against the open front teeth. This should be done in front of a mirror, so you can make a mark on the tongue depressor at the level of the biting edges of the top teeth and bottom teeth. You can then hold up this marked tongue depressor against the teeth, and this is the amount of opening you should strive to achieve 5-6 times per day, ten openings per set. Opening and closing the mouth can prevent the fibrotic changes, which cause trismus. Once these fibrotic changes occur, they are very difficult, if not impossible, to resolve. Most patients do not know what to do on their own. They need experienced professionals to guide them. And by the way, even if you do not like to eat very thick hero sandwiches, just visualize how difficult it would be to brush the tongue side of your lower back teeth..... a rather important task considering the vulnerability to post-radiation caries.

The ability to open the mouth is also needed for the insertion of an obturator (prosthesis) if surgery necessitates removal of part of the upper jaw. In order for these prostheses to function, they must be of certain dimensions to obturate, or "fill up" the defect left by the resection. It is difficult if not impossible to fit a two inch prosthesis into a mouth which will only open one inch!

Should every cancer patient be seen by a knowledgeable dentist? Even those patients with dentures? Well fitting, well made dentures use saliva as a seal to keep them in place. Saliva also acts as a lubricant to prevent irritation to the mucosa. Sometimes the relatively benign dry mouth from medications, such as anti-histamines, can also cause denture problems. The permanent and profound dry mouth caused by radiation can even render a patient completely incapable of using dentures at all. A well-intentioned

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dentist may think to provide a "soft liner" for this patient. Unfortunately, the soft liner does not wet as well as hard plastic. It drags on the tissue and acts more like an abrasive on sensitive mucosa. While this irritation might be annoying to the unsuspecting denture patient, the more troubling problem lurking beneath the surface, is the prospect of ORN, if bone is exposed. Edentulous patients also need to be aware that anything which causes a break in the mucous membrane and exposes bone, can lead to ORN. They need to be careful!

For people with normal dentitions, dental evaluation prior to radiation is critical. Any teeth in the field of radiation which are likely to require removal, or any anticipated gum surgery in the radiated area is best completed 2-3 weeks prior to radiation treatment. The radiation oncologist may or may not call this to the attention of the patient: consequently, the patient must be aware. No one wants to perform dental surgery in an irradiated field, if it can be prevented. However, if it becomes apparent that some invasive procedure is required, it is absolutely critical that the patient be in the care of a practitioner experienced in the management of irradiated patients.

Patients treated with chemotherapy have a special set of situations. Aside from oral lesions that may develop during therapy, the most pressing concerns are related to blood counts...specifically platelets and white blood cell counts. Platelets are necessary for blood clotting: white cells, to counter and prevent infection. The dentist must be aware of both, since there is a time lag after administration of chemotherapy, when these counts can be depressed to extremely low levels. If the platelets are too low, even cleaning someone's teeth or giving an injection of local anesthetic can be a problem. Likewise, both the quantity and quality of the white cells are important. Sometimes the patient requires antibiotic coverage prior to dental care. In short, the dentist must be aware of these special circumstances, in

order to safely and effectively care for the patient.

If surgery is the treatment modality and part of the upper jaw is removed, a maxillofacial prosthodontist, as a member of the multidisciplinary team, should be consulted early on. Sometimes, the patient is not seen until after surgery, but obviously pre-surgical planning is the most advantageous. Ideally, the patient should have the benefit of surgical obturator placement in the operating room during the resection. Once the resection is completed, this prosthesis is either wired into place or retained with clasps. With this in place, the patient is able to speak and take fluids by mouth once he is awake. After approximately one week, this prosthesis is removed and a transitional prosthesis is placed. Ultimately, a definitive (final) obturator prosthesis is provided. Again, the importance of a skilled maxillofacial prosthodontist for these procedures cannot be stressed enough.

Where does one locate this kind of dental specialist? A maxillofacial prosthodontist is a D. D. S. or D.M.D. who has completed a residency and fellowship, usually in a hospital based program, and who is trained thoroughly in the diagnosis and treatment of complex situations concerning the design, construction and fitting of dental restorations and prosthetic restorations after cancer surgery or traumatic injuries, as well as in general dental management of cancer patients. This specialist is best suited to deal with all the problems present in head and neck cases. If another specialty is needed, the prosthodontist will also know who else is experienced in dealing with the comprehensive needs of head and neck patients.

Sources for finding doctors in this field are The American College of Prosthodontists and The American Association of Hospital Dentists. Your medical oncologist, surgeon, or radiation oncologist may also be able to refer you to a knowledgeable practitioner. You might consider contacting the alumni office of major medical centers such as Memorial Sloan-Kettering

in New York, M.D. Anderson in Houston, Texas, The Mayo Clinic in Rochester, Minnesota, and Roswell Park in Buffalo, New York. These centers can provide you with names of alumni from their training programs, who practice near your home. Many V.A. Hospitals also have provided training ground for maxillofacial prosthodontists.

Oral management for cancer patients may be considered medically necessary treatment, since the ensuing problems are unique to cancer, which is a medically driven situation. In almost all cases, you will need to argue the point with your insurance carrier, but again the properly trained dentist will have had plenty of experience in this arena, as well. It has been the experience of this author that persistent, focused claims usually succeed. Insurance companies are essentially uninformed of the special circumstances involved in treating head and neck cancer patients. Most carriers are receptive once these special circumstances are clearly articulated and understood. You will need to be committed and tenacious.

In summary, the list of special needs and potential oral complications of head and neck cancer patients are numerous, indeed. Dental health can significantly affect the quality of life and overall health of "normal" patients, according to founders of the Mayo Clinic and the U.S. Surgeon General. It is of utmost importance to keep your dental health to optimum levels; not only are potentially devastating complications at issue, but quality of life post cancer treatment, as well. Good oral care can be trying, both emotionally and physically, however, a positive mental outlook can work wonders.

Editor's Note: Alan B. Sheiner, D.D.S. is a Diplomate of the American Board of Prosthodontics and has been in private practice in New York City for over twenty years. He has extensive experience in oro-dental management for cancer patients undergoing radiation therapy, chemotherapy, maxillofacial resections, reconstructive surgery, and bone marrow transplant therapy. Dr. Sheiner is a Clinical Assistant Professor at The Mount Sinai School of Medicine.

A TIME FOR SHARING

It was August, 1997, the sunshine of my life. I was twenty-seven years old and seven months pregnant with my first child. I couldn't wait for the baby's birth in October. I also couldn't wait for the end of the stuffiness, clogged ear and nasal voice I'd recently developed. I would also be glad when the lump on my neck disappeared. It was becoming unsightly, not to mention annoying. Soon I would have relief from all the unpleasantness and hopefully receive a gift from God. Little did I know that God had other plans in store for me.

Shortly before I became pregnant, I had developed horrible sinus problems and trouble hearing from my left ear. I had always had earaches as a child so I assumed that they were giving me trouble again. I had been seeing a local otolaryngologist who prescribed everything from pills to nose spray to ear cleanings to rid me of my stuffiness. In February 1997, I opted for minor surgery where a small tube was placed in my ear. It worked beautifully. I could finally hear. My doctor told me to come back in 6 months so he could see if the tube had fallen out naturally (as it should have). Unfortunately, it was not long before my ear became clogged again. I just assumed it was pregnancy related. However, in August, after much hesitation, I decided to visit the doctor again and have him do a quick check just to make sure the tube had fallen out and that if it had not, to be sure it would remain safe during the rigors of labor and delivery. During that visit that I casually mentioned the lump on my neck (he had missed it). It was at that moment, alone in the office and very pregnant, that I received the devastating news. It appeared that I might have cancer.

DIAGNOSIS

After a CT scan revealed a cancerous tumor, my local physician diagnosed me with what he thought might be a type of lymphoma. He was about to biopsy the lump on my neck, when my family contacted other medical sources and I went for a second opinion at Memorial Sloan Kettering Cancer Center. It didn't take very long for the head and neck surgeon to make a diagnose; stage III cancer of the nasopharynx. He did not feel that it was necessary to biopsy the lump in my neck as he felt it was a node responding to the foreign cancerous cells in my body. I was told that my cancer was a very rare cancer, but curable and that treatments would have to start right away.

A nasal biopsy (sans anesthesia due to the pregnancy) revealed a squamous cell carcinoma that would respond to a combination of radiation and chemotherapy. Since I was young and otherwise healthy, I would be getting the strongest radiation dose possible. I would lose function of my salivary glands and would need to use

nightly fluoride trays forever, possibly. I might also lose my hair, temporarily, and I might suffer from some of the side effects of treatment such as nausea, vomiting, and diarrhea. It was suggested that I have a feeding tube to help me sustain nutrition. Oh, and did I mention that I would have to deliver my baby right away?

DELIVERY

It was funny how the focus of my existence, just a few days earlier, had now become a "back burner" issue for the most part. The doctors were now both concerned and challenged with the care of two lives...my baby's and mine. I was given steroid shots to increase my unborn child's lung capacity. And then in the 35th week of my pregnancy, after five days in labor, my baby was born. God does work in mysterious ways. In spite of all my experiences of the weeks past, I was fortunate enough to deliver a 6 lb. baby boy. Other than his premature arrival, he was in perfect health and absolutely beautiful. He spent a mere week at the neonatal unit. And he would be the sole focus of my next 5 months of hell.

TREATMENTS

I brought my son home on a Friday and started treatments that following Monday. I began with Cisplatin, a chemotherapy drug that was given twice during my radiation therapy (on the first and twenty-second day of radiation treatments). I also had six weeks of radiation (weekends off) with doses twice a day during the last two weeks. Receiving the radiation didn't hurt, but the side effects were delayed and I developed serious (but temporary) burns on my neck. I also became extremely tired from the doses (again temporary). Additionally, I had three cycles of chemotherapy (a combination of 5FU and Cisplatin) around the clock for one week at a time a month after completing radiation therapy. I had a temporary port placed in my upper chest to pump the medicine through my body. This port allowed me to go home for the week rather than stay in the hospital. Chemo affects everyone differently. Unfortunately, I was quite sick from it. I took the anti-nausea drugs but nothing seemed to help. By the beginning of the second week however, the nausea calmed down and I began to feel much better.

Thanks to my new baby, I was feeling good emotionally. I figured I could handle the chemo but it was not in the cards. The first night I became violently ill. My mom was going to move in to help me with the baby but instead, I moved back to my parents' home. My husband's company was very generous in giving him time off, but he still had to work. So my father took me to the hospital for treatments every day for six weeks. My mother took total care of my son those 5 months. I wanted to remain strong and

independent during all this, but I just couldn't do it alone. I will always thank God for my family.

Half way through my radiation cycle, I was advised to get a feeding tube. As each week passed, I could barely eat and soon I could hardly speak. After my second dose of chemo during the radiation cycle, I needed the tube more than ever. For the next few months, I basically lived on a liquid diet of Ensure.

I finished the last of the chemo in early February 1998 (ironically one year to the date after the placement of the tube in my ear). Oddly enough, I started to loose some hair on top of my head a month *after* I completed chemotherapy. I was told this would happen but, other than some hair loss where the radiation was beamed (and where it was not visible), I thought I had escaped more hair loss. I did not loose all my hair however, and consequently, I never got a wig, but I did get one of those funky short haircuts (luckily they were in style).

PEACE and RESOLUTION

It has been over three years since my diagnosis. Each time I have visited my four doctors at MSKCC I have been given a clean

bill of health. I get a yearly CT scan and periodic blood tests. And I wait for that five-year mark when they say I am "cured". Oh and by the way, I had another baby just 14 months after finishing treatments. I was uncertain if the chemo would prevent me from becoming pregnant again (not that the doctors ever said that but you know the stupid things people say). I went full term this time, (actually I was overdue!) and now I have two healthy, beautiful sons.

I am eternally grateful for a second chance, and for having had this experience. I now have a different outlook on life, one in which I embrace each day and each moment fully. I am thankful for my wonderful family, and guardian angels who created that moment back in August 1997 in which I went to the doctor for a routine checkup. Most importantly, I am grateful for my two wonderful children, the first who got me through this horrible ordeal, the second who was a reward from God. I guess somebody up there really likes me.

*Lillian Corbett
Florham Park, NJ*

ADDICTIONS AND CANCER

by Todd Whitmer

Mary was 38 years old and recovering from oral cancer. Having been diagnosed with early stage squamous cell carcinoma, Mary's treatment had been successful. She was feeling the regeneration and gratitude for life that accompanies cancer recovery. She was full of hope and enthusiasm. Mary smoked two packs of cigarettes a day.

Mary had, of course, been strongly warned to quit smoking. Over the last two years warnings had come from all directions: her family doctor, her oncologist, her dentist. Even more significantly, her husband had been asking, even begging, her to quit for the last five years. And, in a most heartfelt plea, her six-year old daughter's words, "Mommy, please stop smoking those cigarettes."

Mary had attempted to quit many times. She found herself sneaking cigarettes, feeling guilty, quitting again, and then starting again. Frustrated in this one area of her life, Mary felt like a failure. Perhaps her cancer and her smoking problem were some type of punishment from God. She wondered... is this some unconscious deathwish?

Bill, her husband, had also been a smoker for years but had now cut back to an occasional cigarette.

Addiction is indeed devastatingly powerful. As an addiction specialist, I am always amazed at the lengths people will go to continue their use of alcohol and other drugs. Nicotine, of course, is a drug. Acting on the central nervous system it produces both sedating and stimulating effects. Of all of the drugs of abuse, including heroin, nicotine kills more people annually.

Nicotine dependency is perhaps the most powerful addiction. Most people who smoke are nicotine dependent. The drug, nicotine, is highly addictive, and the drug delivery system (smoking) significantly adds to the addictive factor. Smoking a drug is the fastest way for the drug to enter the system; faster than injecting or snorting. That is why even though crack and cocaine are essentially the same, crack, which is smoked, is more addictive than cocaine which is often inhaled in powder form. Since the nicotine is already in vapor form, the drug goes directly to the brain, providing an instantaneous drug affect feedback system.

Smoking, obviously, presents an incredible risk for anyone recovering from oral, head or neck cancer. If one is unable to stop smoking in the face of cancer recovery, addiction is most likely

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present. For many, it may be hard to believe that someone who has experienced the pain, fear and trauma of cancer would continue to smoke or drink alcohol. That is the power of an addictive disease. This is the same disease that takes a successful athlete back to cocaine, even though his career is threatened. This is the disease that takes drinking drivers back on the highway even though they know the consequences that may follow. This is the same disease that ends marriages because the addicted spouse continues to drink.

Treatment of addictions has made many positive strides over the last ten years. At Caron, we know addiction is a chronic, progressive and potentially fatal disease that responds well to treatment; and in the majority of cases, most people seeking treatment find recovery. However, we also recognize the denial aspects of addiction. Someone like Mary, intelligent and obviously successful, will continue to deny and repress her addiction.

The National Council on Alcoholism has developed guidelines for assessing alcoholism. These guidelines apply to all of chemical addictions. The NCA states that if an individual meets any one of following four criteria, addiction is most likely present:

1. Withdrawal symptoms when not using the drug. Withdrawal from nicotine leaves smokers irritable, tense and sometimes depressed. Withdrawal is connected to tolerance, the need for more and more of the chemical to achieve the same results. Withdrawal from alcohol includes nervousness, tremors and, in the more progressed stages, life-threatening seizures.

2. Using the drug even though previous use has led to major life consequences. Examples include: the drinker who continues to consume alcohol even though he has previous major marriage-threatening arguments; the person who has had an accident while driving-under-the-influence and has been arrested, but continues to drink and drive; and of course, the smoker, like Mary, who continues to smoke even though smok-

ing-related illnesses are life threatening.

3. Negative affects on a significant area of life, such as family, work, school, vocation resulting from the use of alcohol, nicotine or other drug. The honor roll student, for instance, whose drinking affects her studying and her collegiate aspirations.

4. Previous unsuccessful attempts at stopping the substance use. As an addiction counselor, when someone comes to my office and says that they have tried to quit smoking and could not, I make the probable assumption of addiction. On the average, individuals who are nicotine dependent will have five or six attempts at quitting smoking before they are successful.

Anyone concerned about his or her alcohol, nicotine or other drug use should contact an addictions specialist. Most states have accreditation processes for addiction counselors. These specialists are trained and credentialed in the assessment and

Smoking and/or substance abuse, following serious illness, can be related to coping with the trauma brought on by the illness.

treatment of alcoholism and drug addiction. Addiction treatment involves recognizing and understanding the problem and developing and implementing a recovery plan. In many cases a period of inpatient treatment is the best first step in a recovery plan. At Caron Foundation in Wernersville, Pennsylvania we treat more than 6,000 patients each year.

A major component of addiction treatment is family involvement. As in most diseases, families are affected; although with addiction, families often play an unintended enabling role. Involving the family in the recovery processes greatly improves recovery outcomes. In Mary's case,

her husband Bill attended family sessions and realized that much of his life had been revolving around Mary's illness and her continued smoking. He recognized the futility of hiding her cigarettes, begging her to stop smoking and calling her physician with day-by-day reports of her continued smoking. Through counseling he was able to refocus on his own life and let go of his desire to control and change the situation. This in turn, reduced pressure on Mary. Now, instead of reacting to Bill's attempts to control her smoking, she was able to take more personal initiative.

Smoking and/or substance abuse, following serious illness, can be related to coping with the trauma brought on by the illness. Recovery, then, must assist patients in finding other coping mechanisms. Often dealing with the loss issues related to the illness is a significant part of the recovery plan.

The twelve-step program of Alcoholics Anonymous and its related programs such as Nicotine Anonymous, Narcotics Anonymous and Families Anonymous are the foundation of most recovery programs. SPOHNC, as a self-help organization, shares similarities to the self-help groups that have been so successful in helping people with addiction problems. Like SPOHNC, AA offers peer support and connection – essential qualities of any illness recovery program.

Through a comprehensive and individualized treatment program, Mary has been able to stop smoking. Her cancer recovery continues, and her connections with her husband and daughter are strong and true. Significantly, her appreciation of her new cancer free and drug free life has brought her meaning and great joy.

Editor's Note: Todd Whitmer is Senior Executive Officer at Caron Foundation, a nationally recognized alcohol and drug treatment facility in Wernersville, PA. Mr. Whitmer holds an MS degree in Training and Organization Development from St. Joseph's University in Philadelphia and is an adjunct faculty member of Immaculata College. He has worked in the addiction and behavioral health field for the last 25 years with positions as a clinician, clinical director, trainer and workshop leader, Employee Assistance Professional and administrator.

SPOHNC-BOSTON

Twenty-one people braved tropical downpours to attend SPOHNC-BOSTON's first meeting, held November 14 at Massachusetts General Hospital. It was an emotional but uplifting experience as patients shared stories and helpful tips from their experiences with head and neck cancer.

The weather for meeting #2 on December 12 wasn't much better - but neither icy temperatures, gale force winds nor holiday shopping kept the group from turning out for a question and answer session with Dr. Mark Varvares, head and neck surgeon at Massachusetts Eye and Ear Infirmary. Dr. Varvares compared head and neck cancer to an "orphan" disease because of the comparatively small number of persons affected by it, and urged those present to contact their government representatives to demand more research funding. He shared his optimism over head and neck surgical reconstruction procedures developed over the last decade, as well as research into the molecular basis of the disease, which should eventually lead to better treatments. Everyone in the group had a chance to ask Dr. Varvares questions during this most helpful session.

For more information about SPOHNC-BOSTON, please call Valerie at (617) 731-1703 or e-mail Fernval@aol.com.



from PAT'S PANTRY PROVENÇAL

Lamb Casserole

- | | |
|---|-------------------|
| 1 1/2 lbs. lamb --chops or shouler or shanks with bone | 1 tomato |
| 3 carrots | 1 clove garlic |
| 2 turnips | 2 Tbls. olive oil |
| 1 stalk celery | 1 bay leaf |
| 2 onions | 1/2 tsp. thyme |
| 3 potatoes | parsley |
| | salt to taste |
| 1 cup uncooked angel hair pasta or couscous grains or bulghur wheat berries | |

Chop the vegetables and put the meat, vegetables, salt and herbs in a stewpot. Cover with water and bring to a boil. Simmer for 1 hour. Add the pasta or couscous and cook 10 minues more. Blend with the cooking juice and add milk as needed.

February's Tip: Lamb is considered a red meat, like beef. Cardiac patients shouldn't eat it too often, but it is good for protein. If you don't find it in the supermarket ask for it. I have found that they always have some in back. And ask for the bones, too, which will add flavor to your stock. Just don't try to blend up the bones!

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