



STEREOTACTIC RADIATION AND HEAD AND NECK CANCER

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Head and neck cancers present a challenging spectrum of disease to the treating oncologist. Not only is control of tumor and cure important, but also, the need for organ preservation and function. Thus the goal of the oncologist is to cure the head and neck cancer patient with minimal cosmetic alteration while preserving the ability to swallow, speak and articulate normally. To achieve these objectives, a number of treatment strategies have evolved, primarily the development of therapies integrating chemotherapy with radiation and limited surgery. When treating the primary site with radiation, a balance must be established in delivering a dose that yields a high likelihood of tumor control but that does not prohibitively exceed the tolerance of the surrounding organs that are necessarily included in the field. With advances in computer-based treatment planning systems, radiographic imaging, application of new radiobiologic concepts and the incorporation of radiosensitizing chemotherapy agents, impressive advances have been made in achieving this balance, often termed the "therapeutic ratio."

Multiple methods to deliver radiation have been used to optimize the therapeutic ratio above that which is offered by conventional techniques. Brachytherapy is the actual placement of radioactive sources in the tumor. Three-dimensional conformal radiation uses sophisticated treatment planning and Cat Scan (CT) imaging. Heavy particle radiation (such as protons and neutrons) offers unique advantages in dose deposition. Intensity modulated radiation involves the actual regulation of beam strength. Stereotactic radiation delivers highly focused radiation to the tumor using rigid immobilization techniques, three dimensional treatment planning and dose delivery. Although all of these methods have been used in the

treatment of head and neck cancer, the purpose of this article will be to explore the place of stereotactic radiation.

SRS versus SRT

The foremost advantage of stereotactic radiation is that it allows delivery of tightly shaped (conformal) radiation around the tumor, thereby sparing surrounding organs. In discussing the role of stereotactic radiation, one must distinguish between stereotactic radiosurgery (SRS) in which one large dose of radiation is delivered, from stereotactic radiotherapy (SRT) during which multiple smaller doses are given over a prolonged period (i.e. fractionated radiation). The benefit of SRT is that it allows the repair of normal tissue between fractions, increasing radiation tolerance so that a higher total dose can be delivered to the tumor increasing its tumor-killing effectiveness. The advantage of SRS is that all imaging (e.g. CT scan or MRI), planning and treatment are completed in a one-time treatment session and radiation is delivered with the highest precision of all current radiation delivery techniques. Whether SRS or SRT is applied for a particular tumor depends on the clinical judgment of the physician.

Importance of Treatment Setup

Both techniques require the use of a special frame (stereotactic frame) placed over the lower half of the head to create a three-dimensional localizing system which orients the computer to the exact location of the tumor and adjacent normal tissue. Immobilization techniques are distinctly different whereby the stereotactic frame in SRS requires invasive fixation to the skull to ensure maximal precision. In SRT the frame is attached less invasively with the use of plastic masks and devices such as mouthpieces/neck straps/nose guards. Given the difference in technique, the margin for error is smaller for SRS (approximately 2-3 millimeters (mm) total) compared to that of SRT (about 4-5 mm). Both compare favorably to conventional methods where margins of up to 20mm are needed for adequate treatment of the tumor.

Gamma-Knife versus Linear Accelerator Based Treatment

Two methods of delivering stereotactic radiation involve 1) the use of radioactive cobalt sources or 2) the generation of radiation by a machine called a linear accelerator (Linac). The method of radioactive sources was pioneered first and called the "Gamma knife" device. The modern version is a helmet containing 201 cobalt radioactive sources, each of which can be independently controlled to deliver radiation, permitting significant flexibility in treatment planning. The device is used solely for the purpose of delivering SRS although efforts have been made to expand its use to SRT. Basic advantages of the Gamma knife include the ease of treatment planning, the ability to treat irregularly shaped tumors with great conformality (i.e. the radiation is shaped tightly around the tumor) and an extensive clinical experience. Disadvantages include its cost, its restricted use

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COMING IN MAY, 2001
Swallowing Disorders
Bonnie Martin-Harris, Ph.D., CCC-SLP

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only for SRS rather than conventional treatment or SRT, its limited availability and the need for greater maintenance.

Linear accelerator (Linac) based systems are an effective alternative. Linac-based systems are widely available since standard linear accelerators used for general radiation treatments may be easily converted for stereotactic radiation, an important economic consideration for many centers. Several Linac-based techniques have been developed. By far, the most common technique involves the use of a rotating cylindrical collimator (a radiation beam-shaping device) which moves in an arc around a point in the tumor. Two or three arcs of radiation are typically used. Another method uses multiple, stationary beams positioned at carefully selected angles and each precisely designed to encompass the projection of the tumor shape (e.g. Brainlab system). Typically, about 10 fields are used. Yet another technique involves a combination of the previous two (Peacock system). The cylindrical collimator technique ideally treats round tumors whereas the multiple beam field method is better suited for irregularly shaped lesions.

Indications for Stereotactic Radiation

Stereotactic radiation is best applied towards tumors that are suitably sized (usually less than 4 cm), non-mobile and well seen on imaging. The tumors must be clearly defined to be adequately treated by the sharp fall-off in dose distribution which increases the dose difference between the tumor and surrounding normal tissue. The tumor must also be small enough to allow both high conformality and dose uniformity. The size of the tumor is especially important in cases of SRS in which a single large radiation dose delivered to a large volume will increase the risk for treatment-related complications. In addition, tumors are also selected because of their location near critical organs which would be at high risk for severe damage if treated with conventional techniques. Such structures include spinal cord, brainstem, temporal lobe, optic nerve, optic chiasm, retina and mandible.

Stereotactic radiation may be used as primary treatment or boost treatment after conventional radiation. Head and neck tumors often require treatment to both the primary site and draining regional lymph nodes which prohibit the use of stereotactic radiation alone given the limited area and precision of the method. However, in conjunction with conventional methods, these sites could be boosted with SRT/SRS. Also, it can be applied for localized recurrences in previously treated fields. Depending on the tumor type, the benefit from radiation may involve elimination of tumor (as in malignant disease), prevention of tumor growth (especially benign tumors such as paragangliomas, meningiomas) or obliteration of vascular malformation and neural pathways (acoustic neuromas).

Treatment Planning Process

Critical to the delivery of quality stereotactic radiation is the need for an experienced multidisciplinary team comprised of a radiation oncologist, neurosurgeon, radiologist, physicist and oncology nurse. In general, a patient receiving SRS can expect to spend the entire day undergoing treatment planning and delivery. After an appropriate preparatory regimen (pre-medications and diet restriction), the patient arrives early in the morning at which time the stereotactic head frame is put in place by the neurosurgeon. The patient is sedated

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during this time as the headframe is fixed to the skull under topical anesthesia. The patient is then brought to the radiology department at which point the appropriate imaging study is performed. This consists of a CT scan and may also include an MRI or angiogram. MRI can often better define the tumor volume, which in some cases may not even be visualized on CT. Current treatment planning systems allow for the fusion of various imaging studies such as CT scan and MRI. The imaging study is crucial to accurately shape the radiation three dimensionally so that it conforms to the tumor.

The patient is scanned with the head frame so that it is simultaneously imaged with the patient's tumor and anatomy. The data is transferred to the treatment planning program. This process allows a three-dimensional spatial coordinate system to be created which permits accurate visualization of the target and relevant critical normal structures. As importantly, the radiation dose absorption can be accurately calculated using the CT data.

While the patient rests with the head-frame in place, the radiation oncologist and physicist proceed with treatment planning. The tumor volume and adjacent critical structures (especially, spinal cord, optic structures and brainstem) are outlined. Using a "beam eye's view" technique, the number and angle of beams are selected through a trial and error process to optimize the dose to the tumor. Several criteria are used to evaluate the quality of each potential treatment plan including the uniformity of dose, the volume and total dose received by the nearby normal organs. Once a plan is approved, a series of quality assurance checks are conducted. The tolerance of setup error is no more than 1 millimeter. After the proper measures are completed, the patient is brought in for treatment. Depending on the number of beams selected, the treatment delivery time is usually about 15-45 minutes and well tolerated. Upon completion, the head frame is quickly removed and after a period of observation, the patient is sent home.

Patients undergoing SRT experience a similar treatment planning process except that the stereotactic frame is placed using less invasive methods. Again, the patient undergoes the appropriate imaging study with the head frame in place. In contrast to the SRS process, radiation is not delivered the same day since the treatment setup is easily repeated. The patient's fractionated radiation will begin upon treatment planning completion.

Side Effects of Treatment

In general, treatments are well tolerated. The patient will not experience any uncomfortable sensations while the radiation beam is on. The risk for complications depends primarily on the location of the tumor, any previous history of symptoms associated with it, the total dose given and any history of previous radiation. For most patients, common complications are the result of inflammatory swelling of the irradiated area that can lead to headaches, seizures, nausea and vomiting. However, pretreatment medications such as steroids or anti-nausea medications reduce the risk for such complications. On rare occasions, the swelling persists despite a long course of steroids due to permanent injury of the brain tissue that may ultimately require surgical removal. Temporary hair loss will likely result in treated areas. Side effects involving strength, sensation and vision may occur if too high a dose is delivered. With regard to surgical complications, the patient is at low risk for infection of the screw insertion sites, cerebrospinal fluid leak or bleeding.

Results

Most cases treated with stereotactic radiation have been with intracranial tumors (tumors within the skull) especially arteriovenous malformations, metastatic brain tumors and primary brain tumors such as meningioma, acoustic neuroma and glioma. To a lesser extent, extra-cranial head and neck tumors have also been treated with stereotactic radiation and comprise mainly base of skull tumors, nasopharynx cancer, nasal cavity/paranasal sinus tumors, ocular tumors and localized recurrent head and neck tumors. The majority of these lesions are unresectable because of the prohibitive associated morbidity. Given the highly selected population with often the least favorable prognoses, it is difficult to assess the outcome of these patients compared to standard treatment. In many cases, no other treatment options are available. Stereotactic radiation of the above have yielded promising results. It is clear that radiosurgical boost will increase the local control of brain metastases as compared to standard whole brain radiation. Large national studies are underway which will evaluate the role of SRS as a boost to conventional treatment for glioblastomas and brain metastases.

The experience with extracranial tumors is limited but encouraging. Treatment of recurrent base-of-skull and nasopharynx cancers in which most were previously irradiated have shown reasonable response rates with minimal added toxicity. However, the followup has been too short to fully document the chronic toxicities and the patient population too heterogenous to determine clearly its efficacy. As more centers apply this technique to the primary and recurrent tumor setting, the subsets of tumors that will benefit from this modality will be better defined.

Limitations of Stereotactic Radiation

The primary disadvantages of stereotactic radiation include the small margin for error, and tumor size limits as well as increased daily setup time and increased labor intensity. Although highly conformal doses can be delivered with stereotactic radiation, the tumor must be well-defined on imaging. If the actual tumor extent is beyond what is visualized on imaging, then the risk for missing the target increases.

Lesions greater than 4 cm are more difficult to treat because the dose fall-off is not as sharp so surrounding tissues receive a higher dose. For example, if a large irregularly shaped lesion were to be treated using the linac-based arcing method with a large cylindrical collimator, excessive amounts of normal tissue would be treated. Finally, only lesions located above the stereotactic frame may be treated because there are no markers of orientation at the level of the frame itself. Thus, the lowest extent of the target can reach only to about the level of the upper portion of the mouth or lower jaw. Extracranial lesions such as small nasopharynx cancers or base-of-skull tumors are therefore ideal targets, but not lesions below the stereotactic frame such as larynx or hypopharynx tumors. Moreover, lesions located too close to the optic chiasm or optic nerve (closer than 2-3mm) increase the risk for visual complications, especially in the gamma-knife technique where large hotspots are standard.

Conclusion

SRT/SRS adds an important dimension in the treatment of head and neck cancers. It allows highly precise delivery of radiation to STEREOTACTIC continued on page 7

Advance Directives: Health Care Proxies by Andrea S. Barber, Esq.

Introduction

Although no one likes to think about it while one is feeling strong and healthy, in the future there may come a time when serious, important and even critical decisions about one's health care will be necessary. By planning for the tough times ahead, we can insure that our wishes will be respected. Several legal documents, collectively called "advance directives," can provide a framework for decision making should we become incapable of making decisions for ourselves. The corner stone of these advance directives is the health care proxy.

What is a health care proxy? A health care proxy is a legal document that appoints another person as your "agent" or "attorney in fact" to make decisions regarding your care in the event you become incapacitated and lose the ability, either temporarily or permanently, to make appropriate decisions regarding your health care. The proxy can have broad powers and can apply to all medical situations, or it can be limited and spell out specific instructions or situations. The health care proxy is fully recognized in New York state; however, some states may limit its applicability in certain situations.

Why should I have a health care proxy?

Anyone and everyone, regardless of age or medical status, who wants to be sure that future health care decisions are made by a person they know and trust if they are unable to make the decisions for themselves, should have a health care proxy. A health care proxy applies to all situations when you do not have the ability make decisions about your health care. The health care proxy keeps you in control by acknowledging your wishes about all aspects of your health care.

When does the health care proxy take effect?

The health care proxy becomes effective only when, as determined by a physician, you are unable to make appropriate decisions for yourself. Until that time, or after a period of temporary incapacity has passed, you are in charge of making your own health care decisions.

Does the health care proxy ever expire?

No. Unless you revoke it, your health care proxy will remain current until your death. If you wish, you may include language in

your health care proxy that will terminate it on a particular date or if certain events occur.

Who can I appoint as my health care agent? Anyone you trust to make responsible, appropriate decisions on your behalf over the age of 18, can be your health care agent. However, it is wise to appoint a person that lives nearby as they will be more accessible should they be called to act. It is also advisable to appoint an alternate agent should your first choice of agent be unavailable or unable to act for whatever reason.

What if I change my mind? The health care proxy is simple to revoke should you wish to do so. The easiest way is to complete a new document. The most current health care proxy will always govern. Be sure to notify all interested parties that a new one is in effect and provide copies as needed. If you choose your spouse as your health care agent and you become legally separated or divorced, the appointment is automatically cancelled, as a matter of law. Periodic reviews of all your estate planning documents are important to ensure that the documents you have executed are still in accordance with your wishes.

What decisions can be made by my health care agent?

Unless limited in the proxy, your agent will have the power to make any and all treatment decisions that you would have made if you had the ability to decide for yourself. Your agent can make decisions on whether or not you should receive treatment, choose between different treatment options, and even decide if certain treatments should be halted.

Can my health care agent be legally liable for decisions made?

No. If made in good faith your health care agent will not be held liable for decisions made on your behalf, nor will he/she be responsible in any way for the cost of your care just because he/she is making the decisions.

How do I create a health care proxy? Appointing a health care agent is a serious and important decision. The best way to start is to discuss it with your family, close friends, physician, clergy and legal counsel. These people can help you understand the decisions

that may need to be made in the future based on your current health status as well as help you sort out your own personal feelings and attitudes about certain forms of treatment. Although it is not necessary to have an attorney complete a health care proxy, it is advisable to consult with one as part of an integrated estate plan.

How many copies of my health care proxy can/should I have?

You may execute as many copies of your health care proxy as you need. Be sure your health care agent (and substitute agent) has a copy as well as your physician and attorney. You may also wish to give copies to other family members or close friends. If you are admitted to a hospital or nursing facility you should make sure they have a copy as well. Another good idea is to carry a card in your wallet stating the existence and location of your health care proxy.

Is the health care proxy the same as a living will?

No. A living will is another type of advance directive that allows you to provide instructions and state your attitudes about specific types of health care treatment. Generally, it is used to state your wishes in writing about life-sustaining treatment in the event you suffer from a terminal illness and cannot make your wishes known. In contrast the health care proxy appoints a person you trust, who knows your feelings and wishes, to make these types of decisions for you should you be unable. Unlike a living will, a health care proxy does not require you to contemplate and make decisions about future medical treatment as the health care agent that you appoint can weigh options and make decisions you could not have anticipated. However, it is advisable to have both a health care proxy and a living will. The living will can speak for you in situations when your appointed health care agent is unavailable. The living will can also guide the decisions of your health care agent and physician and help both to better understand your feelings about certain types of treatment. ■

Note: This article is based on New York State law and is intended for informational purposes only. It should not be construed as legal advice. Do not attempt to interpret or apply any law without the aid of a licensed attorney in your jurisdiction.

Editor's Note: Andrea S. Barber, Esq., is an attorney with a solo practice concentrating on elder law, estate planning and administration. She is located in Huntington, New York. She may be contacted at 631-271-2961.

A TIME FOR SHARING Shane's Mission

I had no symptoms! There was no reason to suspect that anything was wrong!

On the 18th of April 1996, my four and one-half year old grandson, Shane, and I were viewing our throats in a hand held mirror. On April 24th he was to have his tonsils removed and he was curious. When I went to put the mirror away, again, out of curiosity, I opened my mouth as wide as I could, in front of the mirror and took a look. I was totally surprised by what I saw. What I saw looked like a pale pink piece of cauliflower protruding from far back on the left side of my throat! I didn't panic! But I sure thought it was rather suspicious looking. I spoke to my husband about it and he agreed. My only thought was that it must be some kind of infection on my tonsil. I didn't feel ill, so I decided to wait a couple days to see if it would disappear.

Two days later one of my daughters came to have lunch with us. I asked her to look in my throat. She said, "Mom, I think you better make an appointment with your doctor as soon as possible." I called and was told that I couldn't have an appointment for two weeks! By now I was beginning to feel two weeks would be a lengthy wait. A nurse spoke to me and suggested I gargle with salt and warm water! I couldn't believe doing that would help at all.

Finally, the office made an appointment for me for the next day. The office staff would "squeeze me in." The nurse practitioner located the growth but had no idea what it could be. She immediately made an appointment for me to see the ear, nose and throat surgeon in the same building.

On April 24th I saw an ENT surgeon. At first this physician could not see the growth. He had me point to it with a long swab. Once he saw it he remarked that it was the size of a small plum. He was anxious to take a biopsy. He said there was a good chance that it was cancerous and would have to be removed. Since I was going to the hospital to see Shane after my examination, the doctor had me carry the biopsy tissue, in a vial, in a plain brown paper bag to the lab at the hospital.

The official diagnosis was given to me in the surgeon's office on April 30th. The following day I was scheduled to have a CT scan. I saw the doctor two more times and had a complete physical, a chest x-ray, and

blood tests in preparation for the surgery on May 8th. The growth on the salivary gland was growing rapidly.

During the operation, the back of my lower left jaw along with a piece of the base of my tongue, the tonsil, and the tumor were removed. Also a piece of the muscle in my upper left shoulder was taken out and put into my jaw to make a new "hinge" so that I could open and close my mouth and eventually chew again. I already had no teeth in that area (I had a partial). A feeding tube was inserted through my nose and when I awoke a temporary trach was in place. The trach stayed in for two weeks while I was in the hospital but I went home with the feeding tube in place for another two weeks. The operation took seven and a half hours.

At home I used nutritional supplements five times a day. After the tube was removed I graduated to jarred baby foods and other soft or mashed foods because my denture no longer fit and I did not have much saliva to help me swallow.

On June 5th I was back in the operating room. This time it was on the right side of my neck. I had a neck dissection to remove eleven lymph nodes. One was found to be cancerous. I was in the hospital less than 24 hours after the three hour surgery. I wanted to go home very much as it was my husband's and my 17th wedding anniversary on June 8th.

On July 15th I went to have the first of 33 radiation treatments. The last one was September 5th, 1996. I had to take a few days break twice because my throat became so sore and I became so fatigued. But now it is more than four years since my cancer was diagnosed. I have no new problems. My strength has returned along with my appetite. I have "dry mouth" to some degree but my lips are the driest. There are a few foods that are difficult for me to eat without gravy or a sauce, such as breads, crackers and cake. I lost about ten pounds and have gained most back.

I often wonder if I would still be here if it hadn't been for Shane. Everyday I thank God for him.

Leone Locke
Concord, New Hampshire

LOCAL CHAPTERS OF SPOHNC

SPOHNC-MIAMI, FL

SPOHNC-MIAMI has been meeting each month since November of 2000 at Baptist Hospital. This chapter of SPOHNC meets at 5:30PM on the first Wednesday of the month.

There is a speaker for the first 15 minutes of each meeting, followed by a discussion among the attendees. As a result of discussions at our support group meetings, all head and neck cancer patients at Baptist Hospital in Miami are now seen by a speech pathologist prior to treatment for head and neck cancer.

For more information, please contact Marsha Braunstein, RN at 305-596-6566

SPOHNC-BOCA RATON, FL

SPOHNC-BOCA RATON held its first meeting on Tuesday, March 6, 2001.

This cancer support group meets on the first Tuesday of each month from 3:00 PM to 4:00 PM in the Education Center of the Boca Raton Community Hospital. Meetings are open to anyone in the community who would like to attend.

To learn more about SPOHNC-BOCA RATON, please contact Darci Lipson-McNally, MSW, LCSW at 561-395-7100 ext. 4501



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Looking for Laughter in all the Wrong Places by Scott Burton

When my wife, Cheryl, and I first got the news that my tumor was malignant I don't recall having a reaction of any kind. No sense of utter defeat or that of a life wasted, or even the determined made-for-TV movie expression of "Cancer has a new enemy and its name is Scott Burton." Actually, in all honesty, I do believe, since my doctors confidently told me there was a 98% chance that this was a benign, giant cell tumor, my first thought at being told otherwise was something akin to "Man, I hit the lottery (sort of)." It turned out to be a high grade osteo sarcoma that tends to strike in the age group of 16-25 (I was 30 at the time). The treatment required not only the removal of the tumor, which was inside my femur, but part of the bone itself. It was, of course, replaced with a new one (it's a loaner).

I had spent the previous eight years of my life as a comic and juggler on the comedy circuit, in clubs and performing at corporate events around the country. It is my job to make people laugh. People of every slice of life, every demographic group... it's my job to take them away from whatever is going on in their lives at the time and make them feel that everything is still okay (at least for the length of my show).

As a comic, you learn to survey your situation before you react. You learn that nothing is outrageous—especially when looked at with a different perspective. And, as you're generally living from job to job with little or no security, you learn to be prepared for, and accept, most any situation. Albeit, cancer is the last thing you expect. Cancer, for a comic, is the heckler in the back of the room who's been drinking and won't listen to reason, who screws up your timing and simply won't sit down and shut up.

I learned quickly through other cancer patients who's zest for life seemed heightened with their battles, that looking for humor in our situation is not simply a diversion but, rather, vital to our healing. Perhaps I had a head start due to my profession, but most every survivor I've encountered knows that the humor is there. Humor surrounds us no matter what we are going through. It abounds in life itself! That is a simple fact. It is only our situation that clouds our perception to *see* the humor. When we see through the situations that we *all* battle in everyday life, we see that they, too, are merely a part of living a human life. We can then see the humor even in the

most dire circumstances.

It comes down to this: it's just my life. This IS my life, cancer and all. And *all* life is worthwhile and embraceable. It's just that now it's a little different. The rest of it involves doing what we need to do when a situation comes that requires action. That, I suppose, is the essence of living one day at a time. It's no longer an imaginary life in which you create goals and envision your future. This is accepting what is given to you now and finding your contentment there.

That is not to say we didn't talk about my battle with deep seriousness. It has to come out somehow, sometime. You just have to make sure it comes out at the *right* time, say, with your spouse at home as opposed to in line at the bank.

"Yes sir, you need to make a deposit?"

"Please hold me, I think I have a disease!!"

I think what put the news of my cancer into perspective was knowing deep in my heart just how many millions of people struggle with cancer every day. I knew I was certainly not alone in my battle, not to mention I'd joined quite an esteemed group of *true* survivors (though I think we'd all be happier if the group's dues weren't so darned steep). I found that we all must, and do, go through tremendous trials in life. Be it cancer or any other horror disease, perhaps some form of abuse, mental or physical, or even dysfunctional families, the trials are countless. *We all* have a cross to bear. Who am I to not have to deal with these genuine pains of human existence?

Part of it comes down to fears and how we handle them. Fear is a constant...for all of us. Fear is what sets us off in search of humor. I remember once walking into the darkened room of my, then, two year old son as he cried and bounced urgently in his crib. He looked up at me and said, "I'm scared." Thinking I was there to take away all his fears I said, "What are you scared of Matthew?" And with a look of true concern he said, "Rhinos." I picked him up and held him. I smiled and thought, "And I think *I* have problems." Fear, whether real or imagined, is still fear and humor gives us the tools to combat it.

My greatest fear was the loss of my humanity. In knowing what one has to go through and eventually look like because of chemotherapy, I simply did not want those around me to treat me as if I wasn't human anymore. I was foolishly determined to go through my chemotherapy without a hitch.

Contrary to what the nurses told me, I thought, if I tried real hard that I could possibly keep my hair (Will power? Two-sided tape? I don't know *what* I was thinking).

Fear is okay. Fear is natural. But fear without acceptance hurts. Fear of letting go. Until we do let go, our lives are bound by our desire to control and direct it. Once we do let go and let our life be what it is (even if it's not exactly what we expect) we are more prepared and excited for it.

It was after my second week in chemo that I realized that I would not only go bald, but that I would lose every stitch of hair on my body, leg hair, nose hair, eyebrows... It hit me after about three months that I no longer qualified as a mammal! That's when I knew that, aside from the very real pains and danger, there was real and genuine humor in my circumstance.

I believe I had exercised my sense of humor from the very beginning, but eventually I knew the humor was not just for my benefit but for those around me as well. Those who don't know it's okay to laugh at even the hardships in life. Humor put them at ease and assured them that, although I look considerably different, I am still the same person I had always been. My mind still knows the truths I've always known. My mouth spoke the same words. My heart bled the same way (Anti-clotting drugs notwithstanding). I could show them that whether this is just a trial in life or I am soon to pass on, I am vital right now.

Cancer, for survivors, has become another step towards knowledge. A true knowledge. Most of us can well acknowledge that we all, someday, must die (except, perhaps, the board of directors of the Cryogenics League of America). Cancer is a crash course in coming to grips with mortality. It may sound odd, but not all people are fortunate enough to have that. And what they don't know is that once you see the profound seriousness in life, you can truly recognize the deep humor and beauty of it is well.

And once you can laugh *with* life, your defense meter goes down and your joy meter goes up. That's when you realize your life, regardless of the circumstances or how soon it must end, is a full one. ■

*Editor's Note: Scott Burton, a cancer survivor, speaks nationally on humor and humanity in the cancer battle. His book on cancer and humor is **A Life in the Balance**. Visit his website at www.sburton.com Email: scott@sburton.com*

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STEREOTACTIC from page 3

small/medium tumors with sharp dose gradients between target and adjacent normal organs. This allows highly conformal treatment but necessitates rigid immobilization and precise targeting. Future improvements will include the application of beam intensity modulation which will add a completely new degree of freedom for treatment planning and even more conformal delivery of treatment. Newer immobilization and localization techniques will develop which will be less invasive and allow larger field sizes and other areas to be treated. Also, incorporation of new imaging techniques such as the PET scan, which images the metabolic activity of the tumor, will refine the target margins. The improvement in the therapeutic ratio resulting from stereotactic radiation is especially important because of the interest in exploring dose-escalation for radiation in head and neck cancer as well as the trend for incorporating new biologic agents and radiosensitizing chemotherapy with radiation. Such research approaches may yield excessive toxicity if the radiation is not carefully delivered. ■

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from **PAT'S PANTRY**
PROVENÇAL

Minestrone Soup

- 1 lb. ground beef or stew beef or steak
- 1 16 oz. can lima beans
- 1 large onion, cut up
- 3 carrots
- 2 stalks celery
- 2 tomatoes or a small can (8 oz.) chopped tomatoes
- 2 cloves garlic
- 1 teaspoon sage
- salt to taste
- 1/4 lb. angel hair pasta or couscous grains
- 1/2 cup grated Parmesan cheese
- Water as needed

Crumble or chop the meat. Chop vegetables. Put everything in the stewpot except the pasta and cheese. Bring to a boil and simmer for 1 hour. Add the pasta or couscous and simmer 1/2 hour more or until the vegetables are cooked and the meat is tender. Blend with milk and grated Parmesan cheese.

April's Tip: Minestone Soup is an excellent source of vitamins. Look at all those vegetables. Here in Provence they tell us to eat at least 10 vegetables/fruits per day!

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