



S•P•O•H•N•C

A PROGRAM OF SUPPORT
FOR
PEOPLE WITH ORAL
AND
HEAD AND NECK CANCER

THE WHEN AND WHY OF A TRACHEOTOMY

DAVID P. WOLK, MD

Tracheotomy is a surgical procedure that involves making a small incision in the front of the neck just above the sternal notch (breast bone) and introducing a curved breathing tube into the trachea (windpipe). The operation has many applications including relief of upper airway obstruction, provision of a safe and controlled airway in patients suffering from respiratory failure, and prevention of airway obstruction due to potential swelling following a major head and neck surgical procedure.

The operation has a long history, first described in 1500 B.C. and carried out by such diverse practitioners as Alexander the Great, Asclepiades, and Galen. Modern descriptions of tracheotomy were recorded in 1833, when Trousseau reported using the procedure to treat 200 patients with diphtheria, and in 1932, with a report by Wilson, describing its use in treating poliomyelitis patients.

Tracheotomy is a basic component of many different procedures to treat head and neck tumors. "Tracheotomy" can easily be confused with creation of a "tracheostoma", so it is important to describe the differences between the two procedures. Tracheotomy involves the creation of an opening in the front wall of the trachea and the placement of a breathing tube, called a tracheotomy tube, into the trachea. Tracheotomy is usually, but not always, temporary and can be reversed by simply removing the tube. The openings in the trachea and skin then close without additional surgery in two to six days.

Creation of a tracheostoma is quite different from tracheotomy and is performed in conjunction with a laryngectomy. The upper portion of the trachea is completely divided and removed with the diseased larynx. The cut end of the lower trachea is then curved forward and sewn to the skin as a complete circle. Tracheotomy then, is creation of an opening into the front wall of the trachea, while creation of a tracheostoma involves sewing the entire circumference of the cut trachea to the skin. Creation of a

tracheostoma is permanent and cannot be reversed.

To completely understand tracheotomy, knowledge of tracheal anatomy is essential. The larynx, or voice box, is located in the mid-portion of the neck and can be located by tracking the "Adam's apple." The larynx is the gateway to the trachea and opens and closes to allow breathing, coughing, and speech. The trachea is immediately below the larynx and proceeds downward from the larynx into the chest in a straight line in the middle of the neck. The trachea is 4-5 inches long connecting the larynx with the lungs and is half in the neck and half in the chest where it divides to form the right and left main-stem bronchi, which lead to the right and left lung, respectively. Supported by 15-20 horseshoe-shaped rings, the trachea is a rigid tube with a soft back wall. This back wall shares a common wall with the esophagus, or food tube, which carries food and liquids from the mouth to the stomach. The thyroid gland lies in front of and beside the trachea at the second through fourth tracheal rings. The nerves to the larynx, the recurrent laryngeal nerves, run alongside the trachea in a groove between the trachea and esophagus. Control of the vocal cords, critical to providing normal voice and breathing functions, is mediated through these nerves.

Patients who understand the process of tracheotomy will be better prepared to make the necessary post-operative life adjustments. In the early postoperative period, the patient's tracheotomy tube may be connected to a mechanical ventilator during which time the patient may be sedated. Following recovery of full capacity to breathe without assistance of a ventilator, the ventilator will be disconnected and the patient will breathe an oxygen/air mixture. During this period, to keep the airway clear, excessive secretions within the trachea will be suctioned by a nurse. As recovery progresses, the patient will notice that speech is not possible because most of the exhaled air will pass through the tracheotomy tube and not through the larynx. Knowledge of the tracheotomy tube will help explain why this happens.

Most surgeons prefer to use a "tube within a tube" design of the tracheotomy tube because the primary, or inner tube, can be removed for cleaning while the outer tube provides an airway until the inner tube is replaced. However, some patients will require an extra long tube because of anatomical conditions. These extra long tubes are usually a single tube design. All tracheotomy tubes used in the immediate post-op period have an inflatable balloon or cuff wrapped around the lower end providing an airtight seal of the tracheotomy tube in the trachea thus preventing leakage of the pressurized air from the mechanical ventilator and permitting controlled ventilation. When the ventilator is disconnected, the cuff is deflated to prevent excessive pressure on the inside of the trachea. Even though the cuff is deflated during this period, there is usually not enough room around it for air passage to generate a voice. As recovery proceeds, most surgeons will replace the "cuffed" tube with a cuffless one, to facilitate airflow and speech.

As recovery continues, the nursing staff will offer instruction in

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COMING IN FEBRUARY, 2002

Genetic Basis for Head and Neck Cancer

Development and Treatment

Bhuvanesh Singh, M.D.

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tracheotomy self-care. Coughing is difficult during this period because the vocal cords, which provide the mechanism for coughing, are by-passed by the tracheotomy tube. It is essential that the tube be cleansed of secretions to provide an adequate airway and access for suctioning. Mechanical suction provided by a vacuum pump is effective in removing excess secretions. The technique for its use is taught to the patient at the earliest appropriate time. Use of a normal shaving mirror is quite helpful in allowing accurate visualization of the suction process. The patient is then taught to remove and clean the inner tube of the tracheotomy, usually with a dilute solution of hydrogen peroxide and a nylon brush made for this purpose. The inner tube is then replaced and locked into place, a procedure that must be well understood to prevent dislodging of the inner tube during coughing.

Skin care at the tracheotomy site can be performed by the patient, again with the use of the shaving mirror. Crusts and secretions are best removed with a cotton-tipped applicator soaked in dilute hydrogen peroxide and then cleansed with water or saline. It is important to keep the collar of the tube, the part that fits against the skin, also clean of secretions and crusts to prevent local skin irritation/infection. Many surgeons prefer to place a gauze pad between the tube collar and skin, but such pads can harbor bacteria and cause skin irritations. I prefer not to use the gauze pads in this manner.

Most surgeons prefer to sew the tube to the skin during tracheotomy, but the stitches are removed after several days and replaced by tracheotomy ties that bind the tube to the neck. Originally made from cotton twill, the ties pass through the openings on the tube collar and are tied around the neck. Significant advances in tracheotomy tie design have produced Velcro-secured ties that are much easier to adjust for a perfect fit and are less likely to loosen. Tracheotomy ties should be kept clean and changed as necessary. Tie technique and care is also taught by the nursing staff.

If the patient goes home with the tracheotomy tube in place, the techniques of self-suctioning, saline installation and humidification are also taught. Humidification of inspired air is naturally carried out as air passes through the nasal passages. If the nasal passages are by-passed, as in the tracheotomy, an alternate method of humidification is needed to prevent drying of secretions and possible airway obstruction. The importance of keeping the secretions liquid to permit their removal by suctioning cannot be overemphasized. Home and bedroom humidification with electrical humidifiers and passive humidification with pans of water left on radiators are particularly effective. The technique of installation of several cc's of saline into the tracheotomy tubes followed by self-suction is an essential component of home and hospital management. The exact dose of saline is contained in a small, easily used plastic ampule available commercially. Self-suction using "clean" technique is taught by the nursing staff and is again facilitated by the use of the shaving mirror.

Although some patients will be discharged following surgery with the tracheotomy still in place, the preferred goal is to remove the tube before discharge. Prior to removing a tracheotomy tube, the surgeon may want to visualize the larynx with a mirror or a fiberoptic laryngoscope in order to assess the larynx for swelling and function to assure that the breathing passage will be adequate once the tube is removed. Following examination, the cuffed tracheotomy tube will be replaced by a non-cuffed tube, and the tube opening will be closed so that the patient can be observed breathing naturally via the nose

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and mouth. Most surgeons use a 24-hour observation period before finally removing the tube at the bedside in a painless procedure. Following tube removal, a gauze pad is placed over the opening and taped to the skin. Instructions are given to place a fingertip over the gauze pad to prevent air leaks when coughing or speaking. The tracheotomy opening closes spontaneously in 2 – 10 days without further surgery. Some patients with prolonged tracheotomy may experience lack of complete closure and may require a secondary surgical procedure.

There is no question that tracheotomy is a difficult experience for most patients, requiring adaptation to a whole new way of breathing, coughing, and speaking while the tube is in place. Eating is also affected because food aroma can no longer be sensed by the by-passed nasal passages. The complicated act of swallowing is also affected by the presence of the tracheotomy. The procedure is, however, a lifesaving component of head and neck surgery enabling patients to breathe during a period of post-operative swelling of the upper airway. Considerable judgment is exercised by the surgeon in evaluating patients for tracheotomy because some patients can be managed in the short term with post-operative endo-tracheal intubation. In this situation the breathing tube, which is inserted into the airway via the mouth and throat at the beginning of the operation, is left in place until the swelling resolves. It is then removed by the anesthesiologist and the surgeon.

The final point to remember in evaluating a tracheotomy is that in most cases a tracheotomy is a temporary situation designed to help the patient through the initial recovery phase of surgery. (An occasional patient may require a tracheotomy for longer periods of time.) Following removal of the tube, the patient can expect speech and swallowing functions to return towards normal with speech and swallowing therapy available to help achieve the best possible result.ⁿ

Editor's Note: David P. Wolk, MD, is Attending Physician in the Division of Head and Neck Surgery of the Department of Surgery at Long Island Jewish Medical Center in New Hyde Park, NY. He is also Associate Surgeon and Co-Chief of the Section of Head and Neck Surgery in the Division of Surgical Oncology at North Shore University Hospital at Manhasset, NY and an Assistant Clinical Professor of Surgery at Albert Einstein College of Medicine. Dr. Wolk is a staunch supporter of SPOHNC and has served as a member of SPOHNC's Medical Advisory Board for the past ten years.

Cancer Care, Inc. and SPOHNC Host Third Teleconference

On Friday, November 2, 2001 more than 650 people from the United States, Canada and the United Kingdom participated in a free teleconference entitled, "Living with Recurrent Oral and Head and Neck Cancer." This teleconference was made possible by educational grants from Matrix Pharmaceutical and was hosted by Cancer Care, Inc. and SPOHNC.

Barry Wenig, MD, Professor of Otolaryngology-Head and Neck Surgery at Northwestern University Medical School and Director of the Division of Head and Neck Surgery at Evanston Northwestern Hospital in Chicago, IL was the first presenter followed by Mr. Allen Levine, ACSW, Assistant Director of Social Service at Cancer Care, Inc.

Dr. Wenig began his presentation with a brief overview of the statistics of head and neck cancer. He pointed out that there are approximately 50,000 new cases of oral and head and neck cancer diagnosed each year which is a very small number compared to all cancers diagnosed in the United States. However, while there have been advances in the cure rate of other types of cancer, the cure rate for head and neck cancer has not changed substantially in the last fifty years. What has dramatically changed in the field of head and neck cancer is that an environment has been created in which surgeons are now able to successfully reconstruct patients, restoring basic functions such as speech and swallowing as well as improving cosmetic appearance. In addition, new treatment modalities have also been successfully identified, specifically combinations of chemotherapy with radiation therapy, resulting in less use of surgery. However, when considering the overall numbers, the survival rate has not significantly changed and that is because the new treatment modalities may have changed the biological process of the disease whereby patients no longer succumb to their primary tumors initially or to recurrence at the primary site. Rather, if the cancer returns it usually spreads within the region where it originated or spreads to a more distant site.

Dr. Wenig continued with a discussion of the symptoms of recurrence and the importance of regular follow-ups after treatment for head and neck cancer whether that treatment is surgery, radiation therapy or a combination of therapies. After the first year, chest X-rays, or CT Scans may be indicated to check the spread of the primary tumor or a second primary tumor in the lungs which occurs in

about 10% of all cases. A CT Scan or MRI may also be suggested to check on the original site of the tumor. Assuming that everything checks out OK, follow-ups continue and a repeat chest scan is done at the end of the second year. Follow-ups are of utmost importance for at least the first five years after treatment at which time the patient is considered "cured" and follow-ups may be reduced to once or twice a year.

If the patient has been diligent in his/her follow-ups and the physician has also been diligent in what is needed, most times a recurrence can be detected rather quickly after it recurs. The vast majority of these recurrences will occur within the first six to eighteen months after treatment. Therefore a patient diagnosed with squamous cell carcinoma of the head and neck area may be considered cured if there is no recurrence within the first two years.

If the cancer does recur, it will usually appear as a lump in the neck as this is the most common site of recurrence. It may also appear as an erosion in the skin of the neck or the patient may complain of pain in an undetermined site. Any of these symptoms may set off a chain of events to help identify the exact extent and involvement of the recurrence. A lump in the neck would be considered a regional recurrence as the primary tumor is usually identified in the oral cavity, the oropharynx or larynx. If the recurrence were to be in the primary site, it would be considered a local recurrence. A very small percentage of recurrences is considered distant spread. Metastasis is the spread of the cancer from the primary tumor where it originated to the distant site. In head and neck cancer recurrence is generally to the lymph nodes in the neck on either side and to other areas such as the lungs. It is very rare for a head and neck tumor to metastasize to the liver or brain.

Dr. Wenig briefly explained the concept of angiogenesis as a process by which new blood vessels are produced. Unless new blood vessels are produced to feed the tumor, another tumor will not develop. Tumors are clearly angiogenesis dependent diseases. Angiogenesis is absolutely essential for primary tumor growth, aggression and metastasis. Therefore, if the production of new blood vessels can be minimized, the tumors will not be fed and consequently will not spread or develop. However, to date, there has only been experimental information available and clinical TELECONFERENCE continued on page 6

A TIME FOR SHARING

The SPOHNC newsletter, which brings information to people with oral and head and neck cancer, has encouraged me to share the following story. This is a story of a world-class iron-man triathlon athlete diagnosed with throat cancer and how he recovered from his treatment to compete once again.

My husband, Richard, is 49 years old. He never smoked nor drank alcohol except for an occasional glass of wine. In October of 1999, he participated in the Hawaiian Ironman Triathlon World Championship in Kona, Hawaii. The race is televised on NBC each year. In this Triathlon, athletes from all over the world, swim 2.4 miles, cycle 112 miles and run a 26.2 marathon. To say Richard was in good shape would be an understatement.

However, without any warning, our family was led in a direction that we never imagined or dreamed of, and our lives were changed forever. In June of 2000 Richard was diagnosed with squamous cell carcinoma of the throat. The primary source was the left tonsil which had metastasized to the lymph nodes in the left side of his neck. It all began with a persistent scratchy throat. It felt just like the type of dry scratchy throat that one wakes up with in the morning. Sometimes it would go away and at times it would persist longer into the day. But never would it blossom into anything serious. When a close friend of ours passed away from a brain aneurysm, it got Richard thinking. "Why should I have a scratchy throat for months on end?"

Consequently, he went to his internist, Richard Andron, MD, who happens to be a training buddy of his. Thank God he is a very thorough doctor. He didn't feel there was anything to be concerned about, but suggested that Richard have a biopsy just to be sure. Unfortunately, the biopsy came back positive. The needle biopsy of a lymph node below the jaw line on his left side was also positive.

The course of treatment that was prescribed by Dr. Mark Urken, Chairman of Otolaryngology at Mt. Sinai Hospital in New York, and his colleague, Dr. Jack Dalton, radiation oncologist, was an extremely difficult regiment of six weeks of radiation twice a day including two in-hospital sessions

of chemotherapy for five days, 24 hours a day. This treatment was more brutal and devastating than we could ever have imagined. However, we discovered some things that were helpful throughout Richard's course of treatment. Richard found that taking a strong multi-vitamin throughout his treatment period helped to keep his energy levels up during the course of each day. He also found that taking flaxseed oil and Evening Primrose oil helped to keep the inflammation, due to radiation, manageable. However, it is important for each patient to check with his/her physician before taking any type of vitamins during treatment.

At the start of his treatment, Richard ate as much iron-rich food as possible. Foods such as red meat, tomatoes and spinach are good sources of iron. Foods rich in iron will help to keep the hemoglobin levels up. Richard also found that it was easier to swallow liquids with a thick consistency such as Kefer Yogurt Drink. He found this drink to be delicious and it is available in a variety of flavors. However, he stayed away from the banana flavor as this contains potassium which burned his irradiated throat. He also found that many of the liquid nutritional supplements caused his throat to burn. This was due to the high level of potassium found in the supplements. Consequently, we concocted our own supplement, which we call the Albom Protein Shake. It consisted of 16 oz. of White Wave Vanilla Soy Milk and one large scoop of Designer Protein combined in a blender. Designer Protein can be purchased in any GNC Vitamin Shoppe or other health food store. It is available in different flavors. Richard liked the French Vanilla flavor best.

When chemotherapy and radiation therapy were complete, Richard still had another hurdle to overcome. He underwent a neck dissection to remove the lymph nodes on the left side of his neck. Recovery from this meant that the little recovery he had made between treatment and the neck dissection would probably be lost and he would have to start at square one again. Needless to say Richard's iron-man body was decimated but his iron will prevailed. He never required a feeding tube nor did he ever stop his treatment throughout the six-week period.

Richard's recovery plan, post treatment

included Ensure High Protein oral supplement. Since his throat was still sore, he liked to drink an herbal tea called Throat Coat made by Traditional Medicinals. This tea is excellent for coating the throat. It can be purchased at health food stores. Another thing that helped to heal and coat Richard's throat was liquid vitamin E made by Solgar. He took a quarter to a half teaspoon every morning. It helped to coat and heal his throat. Not everyone can take this vitamin, so be sure to consult your physician. As a regular part of his recovery regimen, Richard continued to drink protein shakes to help heal and rebuild his body and he also ate foods rich in iron to maintain his hemoglobin levels.

Today Richard is cancer free. Since December of 2000 he has been back to his routine of running, biking and swimming. It took three months until he felt he was able to start training again. However, this past June 17, 2001, he participated in his first triathlon in Wycoff, New Jersey since his diagnosis. He came in first place in his age group and placed 19th out of a total of 750 participating athletes. Pretty amazing!

I thank God everyday for guiding us to two of the finest physicians and healers in the truest sense of the word. From the time of Richard's diagnosis and throughout his treatment and recovery, Dr. Mark Urken, Richard's head and neck surgeon and Dr. Jack Dalton, Richard's radiation oncologist, gave us the courage and strength to take on this challenge of facing cancer and learning to live through it. They showed compassion, sensitivity and understanding and accepted my husband as an individual with choices and options. Together with these physicians, we became a team. It was essential for our physicians to understand our fears and concerns about cancer, its treatment and recovery. Our hope for the future came largely as a result of our confidence and trust in our healers who displayed compassion, open mindedness, acceptance, availability, and the willingness to provide information.ⁿ

Robyn & Richard Albom
Ft. Lee, New Jersey.

Holiday Strategies for Family Caregivers

Ken Faulkner, M. Div.

The holidays provide unique challenges and opportunities for caregivers. The festive season that is upon us may yield great joy, but the potential for an increase in stress and frustration is very real. For this reason, caregivers need to be even more alert to ways they can help themselves and their loved ones during this special time of year.

Temper Your Expectations

One of the benefits of the holiday season is the time it provides for the reunion of family and friends and the strengthening of important relationships. During family gatherings, we have the occasion to express our love, enjoy each other's company, eat well, and celebrate bonds that have been forged over a lifetime.

These same gatherings, however, carry the potential for family members to revisit unresolved tensions, conflicts, and resentments. It's not uncommon for families to unite with expectations of peace and camaraderie only to find these intentions undermined by disputes and differences that have been simmering below the surface. For this reason, caregivers should try to anticipate potential tensions that may resurface over the holidays.

In light of these tensions, caregivers and their families may need to re-evaluate their expectations for how everyone will feel and behave. While everyone would love to have a Hallmark family holiday, this isn't always possible. Rather than strive for "the best holiday ever," it might be better to hope and plan for a "good enough" holiday.

Don't Get Overloaded

The holidays are full of extra activities—buying and giving gifts, going to parties, cooking fabulous dinners, and meeting the many social requirements of the season. Yet many caregivers struggle just to keep up with the everyday demands of caring for loved ones. On a practical level, what are some strategies that can make the

season less stressful?

- Make a conscious effort to simplify the holiday experience.
- Make sure family and friends understand what can realistically be expected of you. In a loving and sensitive way, let them know what you can and cannot do.
- Be more selective and realistic with your time. Try spending less time shopping for "just the right gift" for each member of your family. Or consider cutting back on the amount of cooking you do this year.
- Ask for additional help to meet those obligations you truly desire to fulfill.

Another strategy is to use the family gathering to evaluate the situation and discuss your loved one's well-being. The holidays may be the one time each year when all family members are together. Try to set aside some, extra time to discuss matters of concern to everyone. It may be time to determine future needs, anticipate problems and explore options for further assistance. If you decide the holidays are a good time for this discussion, let others know ahead of time.

- Be clear about the objective of the meeting and frame your request in a positive manner. A non-threatening way to approach others is to simply state, "Could we set aside some time to talk about this while we're all together?"
- If you find others hesitant to use holiday get-togethers for this discussion, don't force the issue. But do let them know you will need some time in the future to address these matters.
- Try not to let old tensions and issues overtake the meeting. The goal is to make the best possible decisions concerning your loved one's care. All other conflicts should be dealt with at another time.

Take Time For Yourself

Another strategy for a less stressful and more meaningful holiday is to use the season in a way that fulfills its original

purpose. Holidays were intended to be occasions of celebration and times for emotional and spiritual renewal. Much of this meaning has been lost in the frenzied activity of the modern holiday season. But with a little planning, personal renewal at the deepest levels is still possible.

Many find renewed hope and meaning through prayer, meditation, worship, or other rituals and the holidays abound with opportunities for these spiritual activities. Others find renewal by setting aside time for quiet reflection, reading or journaling. In these reflective moments, caregivers can take an inventory and contemplate ways to enrich the days and years ahead. Still others prefer spending time with special friends and loved ones to talk, laugh, reminisce, and celebrate the sustaining power of intimate relationships.

There are a variety of ways to experience holiday renewal. But they don't just happen. For caregivers, this may mean taking an additional respite from caregiving responsibilities—if only for brief periods of time. Consider the time you spend caring for yourself emotionally, physically, and spiritually as an investment that benefits not only you, but everyone around you. Self-care will reduce the stress and fatigue that can undermine this time of year.

Being a caregiver is a special responsibility. Make the holidays yet another way to help yourself in this important role.

Source

Family Care America

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For more detailed information on caregiving, please visit www.familycareamerica.com

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cal evidence has not yet been developed to support this concept.

What then, are the treatment options for the recurrence of squamous cell carcinoma of the head and neck? The more advanced the tumor is at the time of presentation, the greater the likelihood that the tumor will recur after multiple treatment modalities. There are indicators that tell us who may do better with salvage therapy in people with recurrent cervical cancer. These are people who did not originally have neck dissections, people who had negative margins after tumor removal and those who have a recurrence on the same side of the neck as the original primary site.

The treatment modalities that are available for recurrent head and neck cancer include chemotherapy, radiation therapy, and surgery. Chemotherapy has never been shown to be effective by itself for the treatment of recurrent head and neck cancer and is presently indicated only for palliative symptoms. Radiation therapy is generally used for primary treatment and most physicians prefer not to repeat this type of therapy. However, there are institutions in which radiation therapy is being given a second time and when combined with chemotherapeutic agents, the response rate has been very good with cure rates being reported as high as 20% in individuals who had advanced recurrent head and neck cancer. This combination of radiation therapy and chemotherapy has been successful in raising the cure rates to a very exciting level.

Surgery is also possible for the treatment of recurrent head and neck cancer. However, generally speaking, surgery is only valid for treatment of individuals who have very small recurrences. The larger the recurrence, the more structures involved, such as the carotid artery, the skull base, etc. and therefore surgery may not be an option.

There are also some experimental possibilities for treating recurrent cancer. Basically there are three options available. One of these is photodynamic therapy in which a dye is injected into the patient after which the dye is isolated into the tumor. Thereafter a laser light is directed at the tumor which activates the dye to destroy the tumor. This type of therapy is very effective, however it can only be used with superficial tumors with a depth of less than 1 centimeter.

Injectable gel technology, although still experimental, is another possibility for treating recurrent cancer. The leading chemotherapeutic agent, cisplatin, is being used in an injectable gel which is presently produced by

Matrix Pharmaceutical. This is basically an experimental protocol in which the gel containing cisplatin is injected directly into the tumor cell of patients with recurrent disease. North American and European studies have been conducted which have been promising. Studies in which systemic chemotherapy is given in addition to the injectable chemotherapeutic agents are also being conducted.

The last option is gene therapy where basically a gene, most commonly the p 53 gene, is injected into the tumor with the hope that it will have a cellular response to stop the growth of the tumor cells at a certain stage and thereby kill the tumor. Studies have been published concerning this type of therapy however, it is still very experimental.

Dr. Wenig concluded his presentation with a brief discussion of quality of life issues and the importance of good doctor/patient communication.

Mr. Allen Levine continued the discussion of doctor/patient communication emphasizing the importance of an open, honest communication with the physician, which may be difficult at times. Initially when a patient goes to his doctor, he/she may be feeling relatively healthy wanting to check out something that is bothering him/her. However, the physician may indicate that the symptoms need to be investigated further and therefore tests are ordered and the patient begins on a whirlwind of tests culminating with the physician's words, "You have head and neck cancer." In a very short period of time, the patient has gone from a somewhat healthy individual to a person diagnosed with cancer. A diagnosis of cancer is indeed devastating and overwhelming. This is a time when it is important to have a very open and honest discussion with the physician and/or the whole team that will be treating the patient including the nurses and social workers, and others who will be involved in the process of treatment for the patient. Understandably, this is a time when the patient is very nervous, upset and anxious making it difficult to have such a discussion.

Mr. Levine made several suggestions that may prove helpful when a patient finds himself in this stressful situation. 1. Before the appointment with your doctor, prepare a list of questions that you would like to have answered. Physicians appreciate having a list of questions prepared in advance. 2. Be sure that you write down the answers to your questions when they are given. If a patient is nervous he/she may forget the answers that the physician gave so it is important to write them

down. 3. Some physicians will allow the use of a tape recorder. Using a tape recorder is an ideal way to keep a record of what your doctor told you. You will now not only hear what the doctor says in the office, but you can also play it back at home to hear exactly what your doctor is recommending. 4. Bring a family member or a friend to your appointment. Having someone with you who is not emotionally involved is helpful in understanding what is being said in the doctor's office. Many times a patient, having so many things on his/her mind, misses some of the ongoing conversation. 5. If there is any type of language barrier, for example, if English is not the patient's first language, it is essential to have a competent interpreter who will be able to assist the patient in understanding the conversation with the physician.

Quality of life issues encompass many needs including basic needs, physical needs, financial needs, social needs, emotional needs and spiritual needs. How a patient meets these needs may determine his quality of life. Many questions arise regarding medical options and side effects of treatment. What type of support system does the patient have? Is he/she alone? Is there only one caregiver? Is the family supportive? Is insurance and transportation adequate? Are there special nutritional needs? Is there support in this area? Many new social and emotional feelings may arise based on the physical changes that may take place in one's body as well as his/her physical appearance.

Many times a head and neck cancer patient will feel very much alone as will the caregiver. For these reasons it is so important that the patient join an organization and find out as much as possible about the nature of the disease and also find someone with whom he/she can share feelings. When a patient speaks with other people who have "been there," he or she may come to realize that many of the personal feelings they are experiencing are similar to those of other survivors. However, for some people being part of a group is difficult. In such cases, a patient should seek out the assistance of a physician, a nurse, social worker or clergyman and share his/her feelings with this trained individual in hopes of getting needed support.

A brief question and answer period followed Mr. Levine's presentation.

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from PAT'S PANTRY
PROVENÇAL



Soup au Pistou (Pesto Soup)

Soup

- 1/2 cup dried navy beans and 1/2 cup dried red beans, soaked overnight and then boiled for one hour (or 1 1/2 cups each of canned beans)
- 1 1/2 cups fresh green beans, snapped and cut in 1 inch pieces
- 2 small zucchinis, cut in large cubes
- 1 or 2 med. potatoes, cut small
- 1/4 pound small curly noodles

Pesto Sauce

- 1/3 cup olive oil
- 1/3 cup chopped fresh basil
- 1 large fresh ripe tomato (skip, if tomatoes burn your throat)
- 1 clove garlic
- 1/4 cup Parmesan cheese, grated

Combine soup ingredients in a pot; add just enough water to cover. Bring to a boil. Simmer about 30 minutes until vegetables are tender. Add noodles and cook 7 minutes more. Make pesto by combining ingredients in a food processor to make a paste. Blend the soup and pesto together. Thin with water as needed.

Winter tip: This is a favorite fall dish, when our beans in Provence are fresh out of the garden, but you can use canned or dried beans. Dried beans will give you better flavor. This is a complete meal.

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