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S•P•O•H•N•C

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

HEAD AND NECK CANCER IMAGING

VAL J. LOWE, MD

Imaging of head and neck cancer is a major component of the evaluation of patients with head and neck cancer. Imaging information tells surgeons and radiation oncologists what structures are involved so that they are as prepared as possible when they perform surgery or radiation therapy. Imaging studies can also guide physicians as to how far the tumor has spread to other areas of the body. Tumors that have spread to local lymph nodes or to distant sites may warrant different types of treatment. The information about the spread of cancer from the original site to other sites plays a large role in determining the prognosis for the patient.

The single most important factor in patient assessment, treatment planning, and survival prognostication is accurate staging. Staging is a description of the extent of tumor spread. The current staging guidelines in use for head and neck cancer are from the 1997 manual of the American Joint Committee on Cancer. Staging involves an accurate assessment of tumor at the primary site (T), regional lymphatic metastases (N), and distant metastases (M). Each primary tumor has a unique propensity for local and regional spread and these must be appreciated when evaluating head and neck cancer patients.

Evaluation of the patient begins at the first consultation with a physical examination. This includes direct visualization of the primary tumor either through the mouth or nose or by using office endoscopy. This technique employs a flexible viewing tube that allows the physician to see many areas of the head and neck. Next, the neck is palpated to determine the presence of cervical lymph node enlargement. Lymph nodes less than 1 cm in diameter are not reliably appreciated on physical exam. General physical appearance and body build, such as obesity or short necks, may make this assessment problematic, too. The next phase of the evaluation consists of a pathologic diagnosis (direct biopsy of the tumor or a needle biopsy of a neck mass) and/or anatomic imaging if the neoplastic process is not visualized, palpable or accessible.

The most commonly used imaging modality for head and neck cancer is computed tomography (CT) with intravenous iodinated contrast. Lymph nodes greater than 1 cm in diameter or with central necrosis are considered abnormal and suspicious for metastasis. The obvious shortcoming to this approach is that the determination of metastasis is based on anatomic criteria alone and excludes the possibility of early nodal metastases, which have failed to enlarge the lymph node. Positron emission tomography (PET) has therefore been used by many centers. It may improve the detection of lymph node spread of cancer.

Standard assessment for distant metastases in head and neck cancer, which is uncommon for patients presenting with a new tumor, can include chest xray and liver function blood tests. CT of the chest or abdomen are most commonly used to evaluate abnormalities found on the preceding two studies. PET imaging can also help greatly in this regard.

Second primary disease (either synchronous or metachronous) is an important issue in the evaluation of head and neck cancer patients. These lesions are usually in the head and neck, lung, or esophagus. Synchronous lesions are defined as the discovery of a second primary within 6 months of the diagnosis of the first. Metachronous primaries are discovered at an interval greater than six months. This risk is likely due to underlying molecular or cellular abnormalities of many of the cells lining the upper aerodigestive tract mucosal lining which have resulted from long term exposure to other predisposing factors such as marijuana, betel nut chewing, human papilloma virus infection, epstein-barr virus (EBV) infection, gastroesophageal reflux disease or chronic and excessive mouthwash (alcohol containing) use. The standard approach to head and neck cancer to rule out a second primary has been operative endoscopy (laryngoscopy, bronchoscopy, esophagoscopy). Improved office endoscopy and CT (neck and

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COMING IN MARCH, 2003
The Role of the Dental Hygienist in the Detection of Oral Cancer
Stephanie Bossenberger-James, RDH, MS

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chest) has resulted in a decrease in operative endoscopy. The precision of whole body PET may prove useful for synchronous second primary detection and for surveillance for metachronous lesions.

All head and neck cancer patients are at risk for recurrence. The more advanced the stage of the head and neck cancer at presentation, the greater the risk for recurrence. Most recurrences occur in the first 24 months following therapy for head and neck cancer. Later occurring lesions (lesions at different locations and with distinct histology) are probably second primaries. Local recurrences can present many challenges, but when detected early, can often be re-excised. Re-excision will further compromise any pre-existing dysfunction (speech, voice, swallowing, or airway) and will negatively impact on quality of life.

Regional recurrences can present in the non-treated neck, the operated neck, the irradiated neck, or a neck that has had both treatments. Carotid artery involvement is a significant issue in this population and can result in stroke or death from acute arterial hemorrhage. Treatment for these recurrences can include re-operation, re-irradiation (external beam or implant), chemotherapy (with palliative intent), or comfort measures and support.

Distant metastases occur more commonly in patients in the context of disease recurrences than at initial presentation and may be as high as 20%. The lungs are the most common sites of distant recurrence. Prior to embarking on therapy of locally recurrent disease, distant disease recurrence should be excluded, as it would obviate the need for any attempt at curative resection of locally recurrent disease.

Head and neck cancer patients require long-term surveillance for recurrence and are only deemed “cured” after five years of being disease-free. The traditional approach to this includes serial physical exams, annual chest x-rays and liver function tests. Other tests (CT or MR) are ordered when physical exam findings or patient complaints arouse a suspicion for recurrent or second primary neoplasm. Data suggest that PET may serve as a post-treatment surveillance tool for detecting new disease at a subclinical level or earlier than other means.

Details of CT and MRI

Radiological assessment of head and neck cancer has largely depended on the demonstration of anatomical changes in the head and neck as an indication of tumor involvement. Computed tomography and magnetic resonance imaging (MRI) have both been used with similar success in evaluating head and neck cancer in this regard. CT imaging depends on different tissue density. MRI depends on differences in water content between different tissues. Distortion of normal anatomy as seen on these images can imply the presence of tumor. Tumor size can be measured accurately. Destruction of bone or cartilage seen on CT can be an indication of tumor involvement. Nevertheless, CT only has marginal sensitivity to detect such involvement and it cannot be

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ruled out when tumors are in close proximity to bone. Demonstration of enlarged nodes, indications of possible great vessel involvement and cartilage or bone destruction can all help assess the overall stage and resectability of a tumor.

The anatomic information as obtained from CT and/or MRI although extremely helpful, does have some limitations. Identification of small volumes of tumor can be difficult in areas such as the larynx or base of tongue. These can sometimes be seen on physical examination of the regions but still may not be clearly seen on the imaging tests. The tests may still be helpful to assist in identifying cancer that may have spread to other areas. Also, post-treatment scans can be made difficult by the anatomic changes caused by surgery and/or radiation. These changes in anatomy are often impossible to distinguish from tumor that might be recurring. As normal anatomic structure is a key to interpreting these images, once surgery has altered normal structure definition, the accuracy of the images is diminished. Radiation therapy can induce changes in tissue structure that makes it feel different as well as look different on CT or MRI. These changes also hamper the interpretation of the images. The best chance for identification of tumor recurrence is to compare one CT done after completion of therapy to another completed at a later date. Changes between these two post therapy scans may allow identification of a developing recurrence of cancer. After a recurring tumor has grown substantially, it may become more obvious but it certainly would be preferable to know about tumor recurrence as early as possible.

Cross sectional imaging with CT and MRI both are useful and can be complementary to one another for evaluation of head and neck lesions. There are, however, situations when one imaging method may be preferred over the other. The longer scan acquisition times with MRI can be an impediment particularly in sick people, those short of breath, or those who are unable to be still during the image acquisition. In imaging the larynx, CT can be considered the imaging method of choice as normal motion may be more likely to hamper MRI. The multiplanar capabilities of MRI are especially helpful in assessment of complex lesions, including those that involve the skull base, bone involvement and those that may involve perineural tumor spread. MRI is also likely to be more sensitive in detecting bone involvement than CT.

Details of PET Imaging

PET imaging of head and neck cancer depends upon the increased metabolism and rapid cell proliferation of head and neck neoplasms. In the 1930's, malignant cells were shown to have increased glucose metabolism. The largest PET experience with head and neck neoplasms has been with florodeoxyglucose (FDG). Greater than 90% of these tumors have a squamous cell pathology which demonstrates high levels of glucose metabolism. Various other tumors such as adenoid cystic tumors and adenocarcinomas demonstrate elevated levels of glucose metabolism but at times not to the extent of squamous cell tumors.

FDG PET imaging is performed in the fasting state to minimize competitive inhibition of FDG uptake by glucose. The effect of diabetes on the uptake of FDG is not fully elucidated but elevated serum glucose levels may result in decreased FDG accumulation in cancer cells.

Primary tumor staging with PET will likely contribute little over conventional staging in most patients with the possible exception of unknown primaries. Standard tumor staging using CT and physical exam with endoscopy will provide more anatomic information that is important to tumor staging than what can be provided by PET. In around 5% of cases, however, the primary may not be identified by standard techniques. Some of these primaries become obvious as the patient is followed over time. Others are thought to spontaneously regress while most are never diagnosed by conventional means. Following these clinical evaluations, PET may identify the unknown primary in about 20-50% of cases as reported by several authors. There is some evidence that PET should only be performed after clinical assessment because routine panendoscopy and physical exam will identify some small lesions that may not be seen by PET.

Many medical centers have described the high accuracy of FDG-PET in local nodal staging of head and neck cancer. All studies have shown PET to be equivalent or superior to anatomic methods of nodal staging. In a study by Adams, et al, about 1400 lymph nodes were sampled in 60 patients and PET had a 10 percent advantage over either CT, MRI or US in sensitivity for local nodal disease. The specificity was also 10% higher for PET. The authors showed highly statistically significant differences in the performance of these modalities. Metastatic disease to distant regions is not common with head and neck cancer. This may relate to earlier detection of head and neck cancer due to obvious symptoms. It will likely be rare for PET to identify metastatic disease in initial staging that will impact a large proportion of patients due the low incidence (probably < 5%).
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Conclusion

A variety of imaging methods are available to assess head and neck malignancy. These methods can be complementary although each has its strengths and weaknesses. Cross sectional imaging with CT and MRI provide detailed anatomic information essential for treatment planning. New methods of metabolic imaging such as FDG PET are being actively developed and may make a significant contribution to the management of head and neck cancer as well.

Editor's Note: Val J. Lowe, M.D., is an Associate Professor of Radiology at Mayo Clinic, Rochester, MN. Dr. Lowe has been performing PET imaging with PET for the past 11 years and has a particular interest in head and neck cancer imaging. Dr. Lowe is a diplomat of the American Board of Nuclear Medicine. He completed a full year of fellowship training exclusively in PET imaging at Duke University. Prior to being asked to join the Mayo Clinic, Dr. Lowe was the Director of the PET Imaging Center at St. Louis University. ■

A TIME FOR SHARING .

My story starts about fifteen years ago when I was first diagnosed with leukoplakia on the side of my tongue. Five different times, over a period of several years, my doctor would remove it…and, the diagnosis was always dysplasia. The sixth time this happened it was cancer. For this he just removed the cancer and got clean margins around the area.

Then five days before Christmas, 1999, my doctor, told me I would have to face surgery for the seventh time. This was the worst, with cancer on the base of my tongue and in my lymph nodes.

Three days later, my husband, Jack, and I went to talk everything over with my physician. He told me about the surgery, recovery and that I would need radiation. I felt such a sense of relief that I *only* needed radiation. I just knew I could handle that…No Big Deal!!! Later I found out, because of the area affected, it *was* a big deal!

Everything was happening so fast, I felt confused, numb, scared, angry, and some degree of denial. Never mind the fact we are in the week before Christmas, which is supposed to be a happy, exciting time…not a time when you get the news that YOU have cancer, need surgery, need radiation, and that your full time job is going to be "eating". How does it fit into my box of life much less CHRISTMAS? It doesn't!!!

When Jack and I left the doctor's office we stopped by the mall to get a gown and robe to wear in the hospital. Trying to find a parking place was practically impossible, and everyone was hustling and bustling to get their last minute Christmas shopping done. Don't they understand *I have CANCER.* How can the world go on when my world has just blown up right in front of me!

I was able to celebrate Christmas, putting aside the events of the week and what was to come, because God was holding me in the palm of His hand. My Christmas Holiday was shorter than planned, but I had three great days with family.

Tuesday, December 28th, I checked in the hospital and had surgery which included removing one-forth of my tongue and the lymph nodes on the right side of my neck. I was in the hospital for a week, which included bringing in the New Millennium. How exciting is that! Jack and I spent New Year's Eve watching television bringing in "Y2K" from Australia and ending up in downtown Dallas. We were able to stay awake until midnight and then off to sleep we went. Happy New Year!!!

During my two week post-op check up with Dr. Preskitt we talked about radiation and going to the Radiation Oncologist. It was a very hard and emotional conversation…I started to cry and told him I wasn't sure if I had the energy to climb that mountain. He told me it was like I had just been hit with a hammer, and I needed time to process all that had just happened. He reminded me that my full time job is eating and the only way I would heal from surgery and make it through radiation is through good nutrition…they had feeding tubes for people who don't eat. Well!!! I am NOT going to do that!!! I left pretty burdened down, confused, and very scared.

...I thought I was supposed to be back to "normal" after several months of recovery, but that was not happening. People in the group shared their personal experiences and I learned it takes a year, two years, or however long YOU need to get your life back after cancer.

I was trying to understand all of this in my confused and scared mind. I got very angry with God to the point that I was not "speaking" to Him, thinking I was a bad person, and, that I must have done something to deserve this. If God *really* loved me how could He have allowed this to happen to me. I was *trying* to make sense of this, when in fact there is no way to understand when bad things happen to good people.

It finally came time to meet with the Radiation Therapy Department. My Radiation Oncologist told me everything that was going to happen…the preparation for radiation, and then what would happen to me physically. He showed me the mesh mask that would be fitted for me to wear during treatment.

Reality was hitting pretty close to me now. I felt so overwhelmed and I was beginning to put myself on autopilot. This really can't be happening to me. My world was upside down and I don't know anything except I am confused and wonder where is God and His love?

To help me work through the process of my daily treatments, 35 in total, I decided to check off each day with stickers on my calendar. I used hearts matching the color of socks I wore for the month of February, and flower stickers for March. My socks became a trademark for me with my treatment team. They couldn't wait to see what design I had on my socks each day. Somehow, someway each of us has to get our identity from something…for me it was socks.

By the end of week three of treatment, eating was getting very difficult. My throat was very sore and raw, my saliva was getting thick and my mouth continued to get drier. I had to sleep sitting up because of the thick saliva, so I was not sleeping well. I felt like I might choke and it was easier to breathe when I was sitting up.
By the middle of week four, I was not able

to eat or drink anything so I talked to my doctor about getting the PEG, feeding tube, put in. Friday was "the day". I felt much better and could continue on knowing that I can rest my mouth and throat now. The pressure is off and all I have to do it just "tube it"!!!

Week six found me very tired... emotionally, physically, mentally and spiritually. I was to the point that even trying to talk made me gag so bad that I had to quit talking too. Not being able to eat or talk is something strange to experience, because I took them so much for granted, but they are a gift and should be cherished.

One particular day I was gagging so bad and physically exhausted to the core. I was ready to give up and just sit down and die, but my precious husband and three children and five grandchildren needed a wife, mother and grandmother. I couldn't do that to them, so I kept moving and put another Ensure in the tube. I also knew that God was meeting me DOWN where I was. I was angry and could not reach out to Him, so God had to come to me, which He was faithful to do.

Finally, March 17th, St. Patrick's Day came, and my treatment was over. I was glad for it to be over, but it was very scary. There was a lot of security in going to treatment and seeing those wonderful people everyday, even though radiation was making me sicker by the day.

Over the next several months I began to get stronger and tried to eat soft foods. For me this was the most difficult thing to overcome. With each piece of food I decided to try, I would just stare at it for about twenty or thirty minutes to get the nerve up to put it into my mouth. Baby bites, baby steps, I finally reached a place where I knew I could survive without my feeding tube. The day I got it out was the most liberating feeling...I was able to survive on my own, not depending on anything…just me!

The next important thing I did was join a support group for people with all types of cancer at Baylor Medical Center, Dallas. I thought I was supposed to be back to "normal" after several months of recovery, but that was not happening. People in the group shared their personal experiences and I learned it takes a year, two years, or however long YOU need to get your life back after cancer. We are all individuals, so I was able to relax and just let the process move at its own pace.

After not "speaking" to God for over a year, I was able to recommit myself to Him and know that He loves me and was not shaken by my attitude or anger toward Him. From the beginning my pastor assured me that God loved me and would be with me through this whole ordeal, and that many people would be praying for me. He also said God was big enough to handle my anger. Now I know this is true…God is who He says He is…God Is Love!

Pam Hess
Dallas, Texas

WORDS THAT HEAL by M. K. Key, Ph.D.

Upon hearing oneself diagnosed with "cancer," the word knocks you breathless—a momentary interruption of life force. You begin to talk to yourself about the dilemma you're in: "I'm dead," "I will suffer painful treatments," "I will lose everything," "It's over." In this stunned pause, a person looks to their interior belief system and to others for an explanation—searching for the WHAT and the WHY ME of this cruel pronouncement. From this moment forward, every "word" will shape the Diagnosed's view of themselves and their state of health.

People will tell you that ATTITUDE is everything in this healing process. WORDS are how that attitude is shaped; words spoken to oneself, relayed to others and heard from others in the patient's surroundings. This is the language of healing.

Speaking to Oneself

Those who are emotionally lost do not often speak. The first words spoken internally are most likely negative, as with most change that is thrust upon a person, not of their choosing. The internal dialogue is usually one of hopelessness, loss, fear, anger and helplessness. I can remember retreating with my diagnosis of cancer, and resigning myself to doing nothing at all. Let Nature take its course. It was the apathy of shock and depression. That is the first response to uninvited cruelty; the second response is where the power lies. I had to crawl out of my self-constructed cave, really a dungeon, by first owning my health situation and then allowing others to lift me up. I had to speak a language about myself that would empower me to heal.

My first physical evidence to the world of my trouble was speaking "I have cancer" out loud, practicing ownership. I chose distant and safe recipients on whom to practice and gauge a response—a bus driver, a pharmacist, a shop-keeper—all the while, drawing the notion closer and closer to me. Of course, my immediate family knew, but we did not speak extensively of it. We operated with tacit knowledge, moving in ways that would indicate it but not name it. Slowly and deliberately, I uttered new phrases about myself, seeking affirmations of my aliveness and choosing my approach to life and to this challenge:

- "I am a student. I will learn everything I can about this disease."
- "I am a soldier. I will march steadily and respond to good direction."
- "I am a mother and I will be here for my child. How I react to this teaches her everything about how to deal with adversity."

WORDS continued on next page

WORDS continued from previous page

♦ "I am loved and I will be loved, despite any outcome."
♦ "I will not be ruled by fear. I have danced with death before, so let's have another go."
♦ "I will choose caregivers who empower me."
♦ "This cancer will not run my life. I have important things to do."

Here is another example of healthy self-talk from Carolyn Shull, shared with me over the Internet (e-mail dated 3/7/02):
♦ "The only way out, is through."
♦ "If my time is going to be cut short, I've got to start giving love away like a flood."
♦ "It's only taking some tissue, never my dignity and never my laughter."
♦ "I'll just take it one minute at a time."
♦ "Nothing turned out as bad as I anticipated."
♦ "How surprising people can be! So much love in my direction, and I never knew."
♦ "Never, never, never give up!"

Part of owning the situation through expression can come from writing or journaling. Research indicates that people who do this have better health outcomes—writing is an effective and modulated release of emotion. Putting emotions into words reduces anxiety and depression and enhances immune function (Researcher Bruce E. Compas, personal communication, 9/17/02). I began to write about my experience in the form of Progress Notes and used e-mail lists to inform an ever-widening pool of Concerned Others. My network of other cancer patients and close friends became my most important healers.

The Healing Language of Others

Language is creative. The feedback or bounceback from others builds ideas that form into possibilities that shape actions. The most helpful thing that people did for me when hearing of my diagnosis was to speak to my strength.

From other cancer patients:
♦ "You're tough. You'll survive."
♦ "We will hold you up."
♦ "We are always right here."
♦ "You don't have to wear that wig. You are beautiful just as you are."
♦ "This is no big deal. You can do it."
♦ "Ready to kick some cancer butt?"

From friends:
♦ "Your spirit and your strength will prevail."
♦ "No one could handle this with more style than you."
♦ "You have such a deep spiritual life. God has been gracious in His gifts to you."
♦ "You will teach us how to do this."
♦ "You are the healthiest person I know."
♦ "I admire the way you've taken charge of this."
♦ "If I get this, you're the person I'm calling."

There occurred in my mind a shift from Powerless to Powerful, aided by my language and theirs.

I tuned in to every statement made to me in this vulnerable time. Yet I learned to sift through, take the helpful and deflect what would have harmed me. I noticed that I sought out optimists, people who had upbeat ideas. And avoided the "oh, ain't it awful" types. I constructed my own network of associates who could speak a language I wanted to echo...who had words that inspired me. "Inspired" means literally "to breathe life into." I lived for, I hungered to inhale, the good word.

In Retrospect

One of the most powerful learnings in this cancer journey was that my language created an energy field with others that surrounded me as well. In other words, I needed the positive spirit of people around me to elevate myself, and I got that feeling back through projecting it. Give what you need and you will receive it back in multitudes.

My language and theirs brought about a collaborative healing environment that took me from despair to joy and mastery. And so, I hope, for them as well. This is a journey full of lessons. Let ours be to speak to each others' strength, health and well-being with words that heal.

Editor's Note: M. K. Key, Ph.D.is author, speaker, educator and consultant to organizations. She brings her background as a psychologist and healthcare provider to her experience as a breast cancer patient. She has served on the faculty of Vanderbilt University and is associated with a team at the VU Medical Center, exploring the phenomenon of "chemo-brain." You can reach her at <keyassocs@mindspring.com> or 1-888-655-3901■

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SPOHNC Web Site Receives Award

Health Improvement Institute

Support for People with Oral and Head and Neck Cancer (SPOHNC) is pleased to announce that its web site at www.spohnc.org is a winner of the 2002 Aesculapius Award of Excellence. This Award of Excellence is given each year to encourage excellence in health communication and promotion. Other recipients of the 2002 Award of Excellence for health-rlated WWW sites included Consumer Health Interactive, North American Menopause Society, Rodale, Inc., National Institute on Alcohol Abuse and Alcoholism, The National Cancer Institute and GMMB. We are indeed honored to receive this award and to be among such distinguished recipients.

The award, established by the Health Improvement Institute, a non profit, tax-exempt organization based in Bethesda, Maryland, is dedicated to promoting excellence in informing consumer lifestyle choices and health care decisions. This year marks the eleventh year of the annual awards competition. It is named for the ancient Greek God of healing, Aesculapius.

Aesculapius Awards of Excellence are given to producers of health-related radio and television PSAs (public service announcements) and World Wide Web sites that Health Improvement Institute judges consider excellent in communicating health information to the public. Each year, judges choose one PSA and one Web site from among excellent sites to receive the top prize – the Aesculapius Award. Winners of the Aesculapius Award receive an elegant engraved brass commemorative plaque. In addition, all winners of the Aesculapius Award of Excellence receive a certificate proclaiming their award and the Health Improvement Institute Aesculapius Award logo to use in publicity materials and to display on their web site. Improvement Institute announces winners of the Aesculapius Awards competition in a national media release and on the World Wide Web.

SPOHNC extends its sincere appreciation to Web Master, Barry Sebastian, whose dedication and management of SPOHNC's web site has made it deserving of the Aseculapius Award of Excellence.■

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