



**S•P•O•H•N•C**

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

## **CAROTID MANAGEMENT IN HEAD AND NECK SURGERY**

**JOHN M. TRUELSON, M.D.**

The potential for loss of the carotid artery always presents difficult decisions for both the patient and surgeon. The right and left two carotid arteries are the primary arteries in the neck that provide the blood flow to the brain, but it is sometimes necessary to sacrifice one of them because of rupture or tumor involvement. A tumor may either surround or invade the carotid, or the artery may spontaneously begin bleeding because of invasion, weakness in the wall or infection. Carotid invasion is most likely in patients who have previously received radiation and/or surgery. Radiation induces changes in the wall of the carotid artery that weaken it, making it more likely to rupture, while surgery disrupts natural tissue planes and barriers. Regardless of the pathology, the question of disease extent, treatment of tumor and whether to reconstruct the carotid artery must be faced.

### **Carotid Rupture**

One of the carotid arteries may rupture spontaneously, without warning, but it will usually be “announced” by a “herald bleed” – a significant bleeding episode that stops spontaneously. The bleeding may occur from the neck or mouth due to a fistula, an abnormal connection of the throat with the contents of the neck. Prior radiation alone may be the only risk factor, but generally rupture occurs in previously radiated patients who also have a current neck infection, fistula or recurrent tumor. When a carotid

rupture occurs, it can be a catastrophic event, which may result in death in a few minutes. It is therefore important for both the patient and surgeon to correctly interpret any spontaneous bleeding.

In a stable patient, a preoperative assessment can be done, but there are times when carotid ligation/sacrifice must be done emergently. Abrupt ligation of one carotid artery, in patients who have had no evaluation of the cerebral blood flow, has resulted in stroke or death in as many as 42% of cases in some reviews. Because of this high incidence of complications, the blood flow to the brain should be studied preoperatively if possible.

### **Evaluation of Cerebral Blood Flow**

The brain receives blood from four primary sources: right and left carotid arteries and right and left vertebral arteries. These four arteries are all interconnected at the base of the brain in a network of vessels called the “Circle of Willis”. Each carotid supplies its side of the brain, but has a variable amount of collateral flow to the opposite hemisphere.

The normal range of cerebral blood flow (CBF) is maintained by autoregulation of the cerebral blood flow – the blood vessels in the brain are able to regulate the pressure and flow to the brain, separate from the systemic blood flow. However, with significant hypotension (low blood pressure) as in the case of blood loss, autoregulation is lost and CBF fluctuates with arterial blood pressure. It is generally accepted that CBF must decrease to less than half its normal level before brain effects are seen. The longer that blood flow is diminished, the worse the cerebral damage will be and the less likely function will return to normal. Preoperative tests have been developed based on this understanding of CBF, and will be discussed in the next section. It is also important to maintain systemic blood pressure post operatively when the carotid has been ligated or occluded, even with a normal post-treatment neurologic status. Neurologic symptoms and even stroke may develop in patients after carotid ligation/occlusion when the systemic blood pressure drops. Anticoagulants may also be needed to prevent blood clot in the carotid artery system after occlusion or ligation.

In the case of sudden rupture, intraoperative assessment may be necessary. After occlusion/ligation of the carotid, the section of the artery still in continuity with the cerebral blood vessels is called the carotid stump. Carotid stump pressure is generally regarded to be a useful measure of adequate collateral cerebral blood flow from other arteries supplying blood to the brain when

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**COMING IN FEBRUARY, 2004**

IMRT and its Role in Head and Neck Cancer: A Summary  
Thomas Yang, MD, Gokhan Ozyigit, MD, K. S. Clifford Chao, MD

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the carotid is occluded. Intraoperative EEG (Electroencephalogram) may also be useful in determining whether blood flow is adequate.

**Trial Balloon Occlusion of the Carotid Artery**

Optimally, a preoperative test should be able to assess blood flow to the region of the brain at risk after carotid ligation. While other methods have been tried, trial balloon occlusion (TBO) of the carotid is the standard method of assessing cerebral blood flow because it elicits neurologic signs in patients who cannot tolerate occlusion. TBO is performed during angiography of the arteries supplying the brain. The angiographic catheter is passed from a groin artery into the carotid artery and a balloon is blown up to occlude the carotid for 15-30 minutes. During this time, the patient is continuously observed and the balloon is released in the event of development of neurologic deficits. If TBO is tolerated, then the patient has passed the test and has a lower likelihood of stroke as a result of carotid sacrifice.

In association with TBO, we use a cerebral blood flow scan to demonstrate visually the actual blood flow into the brain. While the balloon is expanded, occluding the vessel, a radioactive tracer is injected into a peripheral vein in the arm. The tracer will enter the brain, but not by the route of the occluded carotid. A brain scan is then performed to show the amount of tracer that has made its way to the side of the brain where the carotid has been occluded. The two sides of the brain are then compared, and if there is a significant difference, it may indicate poor collateral blood flow from other arteries. Patients are generally categorized into three categories based on TBO and CBF scan results:

1. High risk: failed TBO, no CBF scans done
2. Moderate risk: passed TBO, inadequate CBF scan
3. Low risk: passed TBO, adequate CBF scan.

TBO is usually done in a controlled situation, wherein the patient has no physiologic stress on blood pressure, heart or lungs. Even when the patient passes the TBO/CBF scan, a cerebrovascular event (stroke) may still occur if the blood pressure is not maintained, a blood clot forms in the carotid stump or if the TBO is a false negative.

**Surgical Management**

In head and neck surgical patients, there are issues other than the question of carotid flow and the TBO/CBF scan results. The first and most obvious is tumor recurrence, since the recurrence rates vary from 30%-100%, depending on which study is reviewed. Another problem is that cancer patients have often been treated with radiation and/or chemotherapy, increasing the likelihood of infection, fistula or rupture of any graft reconstructing the carotid artery. On the positive side, neck tumors may slowly compress the carotid, allowing collateral blood flow to develop. It has been shown that slow therapeutic occlusion of the carotid artery over 8 days or longer in patients with vascular problems in the brain such

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as aneurysms results in a much lower incidence of neurologic damage.

A third problem is the difficulty in reconstructing the internal carotid artery. One of the better ways of reconstructing the cerebral blood supply is bypassing the sacrificed portion of the carotid with a branch of the carotid artery. This is often done in neurosurgical patients, but cannot be done when the entire carotid is sacrificed. Veins and artificial materials have also been used successfully, though arteries are the best donor material. Generally, vein grafting has been performed in moderate or high risk patients, while low risk patients are usually treated without grafting. When it is certain that the carotid will be resected, preoperative permanent occlusion of the artery is probably safer, since there is little risk of blood pressure fluctuations and the patient will have time to develop collateral blood flow prior to surgery.

The last issue is whether the carotid needs to be resected at all. Tumors that, on CT scan, appear to simply abut the carotid, seldom invade the carotid wall. On the other hand, the carotid is more likely to have actual invasion when the tumor surrounds more than 180° of the circumference of it on a CT scan; in fact if the tumor surrounds or encroaches 270° of the carotid circumference, the artery is actually involved by the tumor in up to 83% of the cases.

Some surgeons feel that all carotids must be reconstructed. However, the risk of stroke from complications of carotid reconstructive surgery are probably as high as the possibility of stroke from carotid sacrifice, even with low risk TBO/flow scan results. With this added to a previously radiated neck, low patients may be better off with no reconstruction.

## Long Term Results of Carotid Resection

Most of the information available regarding long term follow-up of patients with carotid resection comes from studies of patients having intracranial aneurysms or other problems of blood supply unrelated to cancer. Three studies indicate that patients

have a 25 times greater incidence of stroke than the general population. In one very large study of cerebral aneurysm patients treated with carotid occlusion, 29% of patients suffered some degree of neurologic symptoms after occlusion. Of those having symptoms, 79% occurred in 48 hours and 10% within the next 48 hours. Five patients had late symptoms at 6 months, 11 months, 12 months, 18 months and at 4 years. It is difficult to apply these exact statistics to head and neck cancer patients for the same reasons discussed earlier. Patients may have slow occlusion of the artery, and the TBO/flow scan results assist in determining which patients to reconstruct. Patients are also relatively older, often having risk factors for arteriosclerosis (such as smoking, high blood pressure) making it difficult to determine the true cause of any cerebral blood flow problems. Last, patients with carotid involvement have a poor chance of survival due to the advanced tumor, precluding any meaningful long term survival analysis.

## Summary

Patients with malignant tumors that are advanced enough to require resection of the carotid artery generally have a poor prognosis – due to likelihood of cancer recurrence as well as potential for stroke. Fortunately, preoperative testing lessens the likelihood that stroke will occur by helping decide which patients should have the carotid artery reconstructed. Hopefully, in the future we will find ways to treat these tumors without surgery. Research protocols are continually being devised in an attempt to cure these advanced tumors with a variety of modalities. Until that day comes, the mainstay of treatment is surgical resection.

*Editor's Note: John M. Truelson, M.D. is Associate Professor in the Department of Otorhinolaryngology, University of Texas Southwestern Medical Center at Dallas. Dr. Truelson is also the Chairman of the Division of Head and Neck Surgery.*

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## A TIME FOR SHARING

I woke up today looking back at an experience that changed my life. It has been a year since surgery. Like many reading this, I was diagnosed with a head and neck cancer; Adenoid Cystic Carcinoma was the name of my adversary.

In the spring of 2002, I began to notice a lump under my jawbone while I was shaving. It was not noticeable when I went for my annual physical two months earlier. I returned to the doctor with little concern, but an open mind. History had taught me to check problems quickly, not to be afraid of trainers or doctors, heed the doctor's orders and get back into the game quickly.

Yes, the game. I have been a professional ice hockey official in the minor leagues for the past eight years. Throughout that time I have skated with a cracked ankle, bruised ribs, a mild concussion, stitches in my face and many aches and pains that come with getting hit by a frozen rubber disk at speeds in excess of 80 miles per hour. I have seen a fair amount of what many may call setbacks: asthma as a child and young adult, an ankle injury in early adulthood which would force me to stop jogging and running 2 marathons (26.2 miles) a year, a lifestyle I enjoyed immensely. I had to quit running or face walking with a cane for the rest of my life.

At that point I returned to a sport I played in my youth. In my early thirties I took to the ice like I was back in Michigan on the ponds when I was six. I began to officiate amateur games to gain time on the ice and improve the skills fifteen years took away. Luck and desire landed me in the minor leagues and allowed dreams to come true. I realized that I was too old, too small, and too slow to move up the ranks, but I was enjoying hockey in ways that I never thought could happen. Returning to training camp (yes! Just like the players we go through training camp every year) the last eight seasons and skating with kids in their twenties who have far greater dreams and aspirations that could land them in the highest levels of hockey in the world, is a thrill and a challenge. I must admit, as I get older, it is much more a challenge than a thrill.

In 2002, I was 41 and coming closer to my 42nd birthday, which is significant in my family. You see, my oldest brother lost a short battle with lung, liver and pancreatic cancer when he was 42, a little more than 10 years ago. The time frame between diagnosis and the end of his life was 3 months. For my two other, older brothers, their 42nd birthdays were milestones to pass as well as time to wonder, reminisce and ask "what if"? It was now quickly my turn. In May when the initial treatment by my family doctor did not yield the desired results, I was sent to an oncologist. I will not bore you with that part of the story, as it is all too familiar to many of us with biopsies, surgery, bad news, more bad news, uncertainty, etc. My cancer was found in my salivary gland. The gland was removed causing nerve damage, losing sensation and taste on the left side of my tongue, which will not return. Where my story may vary from most is not that they didn't get all the cancer, nor that they were looking into radical surgery involving removing my jaw bone or cutting from inside my mouth to gain access to the cancer that was left, but into another option called neutron radiation which is offered limitedly in the United States.

The options I was given were Seattle, Washington, or as my doctor half jokingly said, Detroit, Michigan. Little did he know I had family and friends in Detroit. After consulting with family, it was brought to my attention that if Detroit offered high tech solutions, they should be at the forefront of knowledge on my condition. Since my doctor was weighing the options for treatment, I decided to fly to Detroit and get a second opinion. I worked out a schedule and in July of 2002, brought my slides, CT's, MRI's, surgery reports and my doctor's files to Michigan for a one day whirlwind visit which introduced me to four highly skilled professionals and their associates. My niece went with me for support, why, I will never know, as she has seen such situations turn from bad to worse with her father when she was in high school. We did make light of it though when people thought she might be my trophy

wife and we played along grinning at each other like newlyweds. After getting additional biopsy tests back and looking at my paperwork, they concluded that they could indeed help me. I went back to Texas and gathered up my things and made plans to move to Michigan for eleven weeks. I went through radiation with my head bolted down to a table, markings and maps drawn on a mask. After two weeks of the high-powered neutron radiation treatments, I heard great news. The rest of the radiation treatment was the more common proton radiation protocol that could be administered in Texas. I again quickly gathered my things and moved back to the Dallas area I have called home for more than twenty years. My family wondered if it were the last time they would see me. The cancer experiences in our family were not success stories. I lost my father, brother and then my mother to cancer in less than two years.

Another new doctor, another hospital and another mask were in store for me when I landed. The great thing about this experience was the fact that from my family doctor all the way through my new doctors in Ft. Worth all shared notes, documentation, emails and phone conversations with each other. I truly had a team working for me.

I went through the typical reactions to radiation: loss of appetite, blisters in my mouth, things tasting different, sore throat, loss of weight and energy, and most of all, uncertainty.

When I arrived back to the Dallas/Ft. Worth area and was picked up by another official, he looked at me and noticed, but didn't have the heart to say, that I looked like my spirit was broken. He suggested that we get onto the ice and call a game together in the adult recreation leagues and maybe the ice would do me well. Although it was true, I was skating as soon as the doctor gave me permission (10 days after surgery), I was taking it easy. Later, my doctor found out that when I said I went skating, that I was in game situations where I could get hit with the puck or in the middle of two highly charged combatants wanting to prove who was

tougher. He and I differed as to what "taking it easy" meant, but he encouraged me to lead what I had as a normal life prior to surgery. When I returned to Texas, I returned to the ice.

Another local amateur official, who knew my plight, was coaching in a game and kept yelling at me that I did not belong on the ice. He repeated his protest to the point that players on his bench asked if I was that poor of an official? His response was "no", then commented that I was going through cancer treatments and that I should not waste my energy and take care of myself. Little did he know that this was the best medicine for me.

I worked out as much I as I could, getting on the ice two to four times a week. Granted, I saw my performance get worse and worse, but I didn't need to get to a competitive level for a couple of months. I called the minor League offices to inform them of my situation and they told me to take my time and get back to health and worry about hockey later. They were supportive, very supportive. My low point in treatment came over the Labor Day

weekend in September. I had lost 30 pounds, 10 in one week. I was weak, dehydrated and wondering if I was going to get better. I was given IV's before the weekend and the Tuesday following the holiday. I knew training camp was the 1st weekend in October and I wondered if I was going to attend. I wondered if I could even skate at a competitive level again and began thinking about retirement. This floated in my mind while I worked very hard to workout.

October came. I was out of radiation for a whole 2 weeks when I walked into training camp. I did well enough to make the squad and continued to work hard throughout the winter to gain my stamina back. The beginning of the season I was so weak that I had to prepare for a day or two before each game. I drank enough Ensure and Boost to feel waterlogged (about 6 or more cans a day). I would have to take some time off after games to recoup as well. I couldn't do two games in back to back nights. It did not deter me though. People still believed in me enough to give me

a chance and to work through my situation. I did not want to let them or myself down. By the close of the season, I had done 5 games in an eight-day stretch. My eating got better and I walked away from the season knowing that I was not what I had been in previous seasons but at least I had hope and I was on my way to leading a normal life.

I am happy to say that now I have put on some weight. The cancer does not stream through my mind on a daily basis and remind me of the road that was chosen for me in the peak of my life. I cannot forget and I still have permanent changes, which affect me daily, but they will not keep me down. I look forward to training camp this October with less uncertainty and with only the worry of being 43 in a young man's game.

*Tim Zemens*

Arlington, TX 76012

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## "Survivor To Survivor"

Hello,

My name is Craig. I had radiation to the neck area for squamous cell cancer in 2000. Soon after completing treatment, I developed a rash over my entire body and found that I became allergic to almost everything. The doctors all say my auto immune system went "haywire" due somehow to the radiation, but they cannot explain it.

I have been on Prednisone since about April 2001, and of course that is NOT good. I am seeing a dermatologist, trying to get off this medication, but it is not hopeful.

My sensitivity seems to be getting worse and taking higher doses of Prednisone seems to be the only answer. However, I have been told that Prednisone and most other drugs used to control this kind of rash, can eventually do a great deal of harm to my body.

I am really trying to keep up a good attitude and maintain my faith, but I need some help and encouragement. Is there anyone else who has this condition? Do you know what caused it? What are you doing about it?

**ACTION:** If you have any suggestions for Craig, please send an email to [info@spohnc.org](mailto:info@spohnc.org) or call 1-800-377-0928.

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**SPOHNC NEEDS YOU!**  
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### **NATIONAL SURVIVOR VOLUNTEER NETWORK (NSVN)**

If you are a survivor of oral and head and neck cancer you know the importance of reliable information. You may also have gained strength and resolve from the support and encouragement from others who "walked in your shoes." If so, we need you to share the wisdom you have gained from your personal experiences with others.

If you...

- are a survivor of oral and head and neck cancer
- have the desire to help others
- have good listening skills
- have good telephone communication skills
- have the ability to use a computer and to send email
- have a willingness to learn about different types of oral and head and neck cancer, their treatments and side effects of treatment as they affect quality of life
- are willing to participate in teleconference training calls
- are a member of SPOHNC

...then we encourage you to contact SPOHNC by phone at 1-800-377-0928 or by email at [info@spohnc.org](mailto:info@spohnc.org).

SPOHNC's goal is to have a minimum of two survivor volunteers in each state to provide up-to-date information and offer support and encouragement to fellow oral and head and neck cancer survivors.

**WE LOOK FORWARD TO HEARING FROM YOU.**

## Survivor Competes in Hawaii Ironman Triathlon

**M**ore than 1500 athletes from 48 countries participated in the 25<sup>th</sup> Anniversary Ironman Triathlon World Championship held in Kailua-Kona, Hawaii on October 18, 2003. This contest is considered to be one of the toughest one day tests of physical endurance in the world.

The first of the now world famous contests was held in Hawaii in 1977 when 15 men competed to determine whether swimmers or runners were the most physically fit. The challenge combined the Waikiki Roughwater Swim with the Around the Oahu Bike race, followed by the Honolulu Marathon. Twelve of the fifteen men finished the race.

Richard Albom, a survivor of head and neck cancer, recently competed in the 2003 Hawaii Ironman Triathlon. In this contest, athletes swim 2.4 miles, cycle 112 miles and then run a 26.2 marathon. This was not Richard's first time in this Triathlon. He had participated in October of 1999 at the age of 49 prior to his diagnosis of throat cancer in June of 2000.

Richard has been an inspiration to many cancer survivors. He was diagnosed with squamous cell carcinoma of the left tonsil that had metastasized to the lymph nodes in the left side of his neck. His case is remarkable in that he had both radiation and chemotherapy followed by a neck dissection to remove lymph nodes. However, throughout his treatments, his "iron will" prevailed and by December of 2000 Richard was back to his routine of running, biking and swimming. ("A Time for Sharing," *News From SPOHNC*, Winter 2001)

This year, Richard once again qualified for the Hawaii Ironman Triathlon. Not only did he finish the 25<sup>th</sup> Anniversary Ironman Triathlon World Championship, but he completed the contest in 11 hours and 32 minutes making him the 28<sup>th</sup> most physically fit person in the world for his age group. For his accomplishments in fighting cancer and competing in the Triathlon, Richard was awarded a new Volkswagon SUV for his use for the next 2 years.

CONGRATULATIONS, RICHARD!

## Debunking Cancer Myths: An Interview With a Mayo Clinic Specialist

By Mayo Clinic Staff

As advances in the detection, diagnosis and treatment of cancer have increased, you may have discovered more opportunities to learn the facts about this disease. Yet some misleading ideas about cancer and cancer treatment still persist. Timothy Moynihan, M.D., a cancer specialist at Mayo Clinic, Rochester, Minn., helps debunk some of the most common misconceptions and explains the truth about them.

### **A positive attitude is all you need to beat cancer.**

Although many popular books on cancer talk about fighters and optimists, there's no scientific proof that a positive attitude gives you an advantage in cancer treatment or improves your chance of being cured.

What a positive attitude can do is improve the quality of your life during cancer treatment and beyond. You may be more likely to stay active, maintain ties to family and friends, and continue social activities. In turn, this may enhance your feeling of well-being and help you find the strength to deal with your cancer. A positive attitude may also help you become a more informed and active partner with your doctor during cancer treatment.

### **If we can put a man on the moon, we should have a cure for cancer by now.**

Cancer actually includes a large group of diseases. Each can be caused by many different factors. Despite advances in diagnosis and treatment, doctors still have much to learn about what triggers a cell to become cancerous and why some people with cancer do better than others.

In addition, cancer is a moving target. Cancer cells may continue to mutate and change during the course of the disease. This may lead to the cancer cells no longer responding to the chemotherapy drugs or radiation treatments that were initially given.

Finding the cure for all cancer is, in fact, proving to be more complex than mastering the engineering and physics required for spaceflight.

### **Drug companies and the Food and Drug Administration (FDA) are blocking or withholding new cancer treatments..**

Going through cancer treatment is never easy. Even when things are going well, it's natural to become frustrated and wish for a magic bullet to cure your cancer. You might even wonder if such a treatment is available but being withheld.

That's not the case. Your doctor and the FDA, which must approve new drugs before they can be marketed, are your allies. As such, they make your safety a high priority. Unfortunately, scientific studies to determine a cancer treatment's safety and effectiveness take time. That may create the appearance or lead to reports that effective new treatments are being blocked. However, the thorough testing required has kept many unsafe and ineffective drugs from being used in the United States.

Hiding or withholding an important treatment advance would be difficult because the public has many ways to access medical information. In addition to verbal, print, video and electronic means, you may even gain access to information about experimental treatments by participating in a clinical trial.

If you still believe a cure is purposefully being withheld, ask yourself why a doctor may choose to specialize in cancer research. Oftentimes doctors go into cancer research because they have a family member or friend affected by the disease. They're just as interested in finding a cure as anyone else, for exactly the same reason — it affects them personally. They hate to see a loved one in pain and don't wish to lose this person. They also want to spare others what they have gone through.

As to suggestions that organizations keep cures a secret because they would otherwise lose their source of funding, human nature makes this scenario highly unlikely. It is indeed an unusual human being who would pass up the prestige associated with finding a cure in order to keep funds flowing to a research organization.

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## NATIONAL SURVIVOR VOLUNTEER NETWORK: AN UPDATE

Readers of our October 2003 newsletter will remember seeing our notice (please see reprint on page 5) seeking volunteers willing to become part of the National Survivor Volunteer Network (NSVN). We invited readers to join us in creating a network of survivors of oral and head and neck cancer willing to lend their encouragement and support to others via telephone and email.

The October newsletter was mailed throughout the United States and the response has been excellent. We have also had

responses to the announcement that was posted on our web site at [www.spohnc.org](http://www.spohnc.org). It has indeed been our pleasure to speak with many wonderful and compassionate people eager to help others.

Though our network is growing stronger and more cohesive as the weeks go by, we still need more volunteers, especially volunteers from the states west of the Mississippi.

In addition to our Survivor Volunteers, we are fortunate to have Consultant Volunteers. These volunteers are nurses and social workers who have worked with oral and head and neck cancer patients. They will address any concerns or questions that our Survivor Volunteers may have after being contacted by patients.

If you would like to share the wisdom you have gained from your personal experiences as an oral head and neck cancer survivor and have the ability to use a computer and send email, please call us at 1-800-377-0928 or email inquiries to: [info@spohnc.org](mailto:info@spohnc.org). We also invite nurses and social workers to contact us as well.

We would love to speak with you and answer any questions you may have about participation in the network and what it may entail.

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*IN HONOR OF*

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by  
Pamela S. worth*

\*\*\*\*\*

*Dr. Barry Rasgon  
by  
Jane Mancina*

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