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

Oral Complications of Radiation Therapy: The Dentists Role

ERIC G. D'HONDT D.D.S.

In 2003 there were an estimated 27,700 newly reported cases of oral-pharyngeal cancer in the United States resulting in an estimated 7,200 deaths. Many of the patients treated for these types of cancers will receive head and neck radiation as part of their treatment. The goal of radiation therapy is to eradicate the tumor without causing significant damage to normal tissues. Currently, many of the radiation techniques used in the treatment of head and neck cancers have serious and detrimental side effects to the oral cavity (Table 1). Oral complications of head and neck radiation have been cited as the single most common cause of interruption and discontinuation of treatment regimens for cancer patients. Therefore, these complications can have the potential to adversely affect treatment outcomes, cancer prognosis and quality of life.

To help manage the oral complications associated with head and neck radiation a dentist should be involved as an integral part of the treatment planning team. Unfortunately, dentists are oftentimes overlooked. This can be a result of physicians and patients not understanding the role of dentists or dentists not feeling comfortable treating head and neck cancer patients due to lack of education. Dentists need to be involved in all aspects of cancer therapy including treatment planning for patients prior to the start of radiation treatment and during radiation treatment, and follow-up with patients after treatment is completed.

TABLE 1 Oral Complications of Head and Neck Radiation

Xerostomia: Dryness of mouth as a result of reduced or absent salivary flow which increases the risk of infection and dental disease and compromises speaking, chewing and swallowing

Infection: Viral, bacterial, or fungal resulting from xerostomia and/or damage to mucosa

Mucositis/stomatitis: Inflammation and ulceration of mucous membranes associated with pain

Dental decay: Rapid decay and/or erosion of the tooth as a result of changes in both quality and quantity of saliva. Increases lifetime risk of dental decay

Taste alterations: Changes in taste perception, ranging from unpleasant to tasteless.

Functional disabilities: Impaired ability to eat, speak and swallow.

Nutritional compromise: Poor nutrition secondary to eating difficulties cause by mucositis, dry mouth, trismus or infection.

Trismus: Loss of elasticity/scarring of chewing muscles that restricts normal ability to open the mouth.

Osteoradionecrosis (ORN): Blood vessel compromise and destruction of bone exposed to therapeutic doses of radiation resulting in a decreased ability to heal if traumatized with increased susceptibility to infection

Source: National Institutes of Health

Prior to the start of radiation therapy a full dental and oral examination should be scheduled. During this visit, a full series of x-rays should be taken to identify any potential pathology, decay, gum disease or infected teeth. A dental cleaning and all necessary fillings should be completed. Dental impressions are also needed for the fabrication of custom fluoride trays to be used during radiation. The dentist should also use this opportunity to discuss with the patients the potential side effects of head and neck radiation. (Table 1).

Teeth that are infected or have the potential to become infected during or after treatment need to be addressed. If traditional dental treatments (i.e. root canals) cannot be completed prior to the start of treatment, or if the tooth cannot be saved, it must be removed prior to the start of treatment. This is important because of the potential for osteoradionecrosis if the tooth has to be removed following radiation therapy. Osteoradionecrosis is a very serious potential complication of head and neck radiation that can occur when a tooth is removed in an area that has been irradiated.

The pretreatment evaluation also gives the dentist and patient the opportunity to discuss the oral complications that can be expected or avoided during treatment. There are multiple

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COMING IN OCTOBER, 2004

“Reconstructive Surgery for the Narrowing of the Throat
Following Nonsurgical Therapy of Laryngopharyngeal Primary Cancers”

Mark L Urken, MD, FACS

ORAL COMPLICATIONS continued from page 1

treatment modalities, both prescription and non-prescription, that can help minimize the complications of radiation therapy (Table 2). The success of these medications and products varies depending on the person and dose of radiation received but most patients find them helpful. Please note that there are other modalities that are available that may also be helpful

During treatment, patients should perform normal oral hygiene at least twice a day. As radiation treatment progresses, oral hygiene may become painful as a result of xerostomia and mucositis. A

TABLE 2. Medications and Products For Patients Undergoing Radiation Therapy

Rx Fluoride: In custom trays filled with prescription 1.1% neutral sodium fluoride gel. Worn for 5 minutes each night prior to bedtime. Nothing to eat or drink following.

Rx Chlorohexidine rinse: Antimicrobial rinse used twice a day AS TOLERATED. Has a high alcohol content that may irritate tissues.

Rx Stanford Mouthwash (Nystatin/Tetracycline/ Hydrocortisone/Chlorpheniramine): Antimicrobial. Pain associated with mucositis

Rx KBX rinse (Kaopectate, Benadryl, Xylocaine): For pain associated with mucositis

Rx Gelclair rinse: For pain associated with mucositis

Xylitol products: gums and candies which promote saliva flow that do not cause decay

Physical therapy: to help with elasticity of the chewing muscles and to maintain opening.

supersoft toothbrush is recommended in these situations. Prescription mouth rinses (KBX, Stanford, Gelclair) can be prescribed by your dentist and used as needed to help coat the mucosa and soothe the pain caused by mucositis. Custom fluoride trays should be worn every night for 5 minutes prior to bedtime. It is important not to eat or drink after using the trays. The fluoride will help protect the teeth and make them more resistant to decay. Recall appointments with the dentist should be scheduled at least every 3 months. This more frequent recall interval allows dentists to assess how the oral cavity is responding to radiation treatment and make suggestions for treatment.

Following the completion of treatment, patients can expect some of the side effects of radiation to improve. Some patients may notice an improvement in mucositis and return of taste within a few weeks. This will improve their ability to speak, eat, and swallow. Trismus, the inability to open the mouth, takes longer to improve. The muscles that open and close the mouth lose elasticity and can take months to regain full function. Physical therapy can be helpful both during and after treatment to maintain muscle function and opening.

The most permanent side effect of radiation therapy is xerostomia. The salivary glands are extremely sensitive to

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SCIENTIFIC DATA RELATED TO HEAD AND NECK CANCER PRESENTED AT ASCO'S ANNUAL MEETING IN JUNE 2004

New Orleans, June 5, 2004. A large international phase III study has found that adding the drug, cetuximab (Erbix), to radiation therapy can nearly double the median survival in patients with head and neck cancer that has not spread to other parts of the body.

James A. Bonner, MD., Chairman of the Department of Radiation at the University of Alabama at Birmingham, and Merle M. Salter professor of radiation oncology, presented the findings at the 40th Annual Meeting of the American Society of Clinical Oncology on June 5, 2004. "The use of cetuximab and radiation therapy may become an excellent choice of therapy for this group of patients," said Dr. Bonner, the study's principal investigator. "Future studies should be performed to examine combinations of chemotherapy, radiation therapy, and cetuximab."

Head and neck cancers account for three to four percent of all cancers in the United States. Cancers of the head and neck comprise several sites including the nasal cavity, the sinuses, oral cavity, nasopharynx, oropharynx and other sites in the head and neck region. Most of these cancers begin in squamous cells found in the lining of structures in the head and neck. Standard treatment options for locally advanced head and neck cancer include radiation therapy, chemotherapy combined with radiation treatment, or surgery followed by radiation and/or chemotherapy plus radiation for patients whose tumors can be surgically removed.

Many head and neck cancer cells overexpress (make too much of) a protein called the epidermal growth factor receptor (EGFR), which may help cancer cells to grow more aggressively. One targeted therapeutic approach includes the agent cetuximab, which is a monoclonal antibody that attaches to and blocks EGFRs. Early studies suggested that treatment with cetuximab would boost the effectiveness of radiation therapy in patients with head and neck cancer. Erbitux is currently approved for the treatment of advanced colorectal cancer and is presently in several clinical trials to evaluate its efficacy in the treatment of other cancers.

A total of 424 patients in the United States and Europe were enrolled in this study. All had tumors in their tonsils, tongue, or voicebox that may have involved lymph nodes but had not spread to other parts of the body. Patients were randomly assigned to receive either radiation therapy alone or radiation plus weekly cetuximab. Patients were followed up for a median of just over three years.

Results of the trials indicated that median survival for patients treated with cetuximab was 54 months, compared with 28 months for patients who received radiation therapy alone. Fifty-seven percent of the cetuximab-treated patients survived for three years, compared with 44 percent of those in the radiation-only group. The researchers concluded that the addition of Erbitux to high-dose radiation therapy significantly improves survival compared to high-dose radiation therapy alone in the treatment of locally advanced head and neck cancer.

Mucositis (inflammation in the mouth), causing pain and difficulty swallowing, is a common side effect of radiation therapy for head and neck cancer. In this study, patients in both groups suffered from this side effect in roughly equal numbers. "It is particularly encouraging that the increase in survival achieved with cetuximab was attained with no worsening of radiation-induced adverse effects," said Bonner. Patients treated with cetuximab suffered more frequently from a skin rash on the face and body, but this did not appear to reduce the effectiveness of the treatment.

The addition of chemotherapy to radiation has also previously been shown to improve outcomes in patients with locally advanced head and neck cancer, says Scott Saxman, M.D., of the National Cancer Institute's Cancer Therapy Evaluation Program. Follow-up studies will be necessary to determine the relative benefit of cetuximab compared to chemotherapy, he adds, and to determine whether combining cetuximab with chemotherapy will provide even greater benefit.

New Orleans, June 6, 2004—Data presented today from a Phase III clinical trial involving 303 head and neck cancer patients showed that Ethiol (amifostine) reduced the incidence of moderate-to-severe dry mouth (xerostomia) in patients receiving radiation therapy for their disease. The data also showed that two years after treatment, patients treated with Ethiol retained the ability to produce saliva. Further, the data showed no evidence of tumor protection for the 24-month period of the study. The data were presented today at the American Society of Clinical Oncology's (ASCO) 40th Annual Meeting.

"We found that two years after treatment, amifostine continues to diminish xerostomia induced by radiation therapy for head and neck cancer without evidence of any compromise in the efficacy of the radiotherapy," said David M. Brizel, MD, Professor of Radiation Oncology, Duke University Medical Center and principal investigator of the study.

Xerostomia is the medical term for chronic and severe dry mouth. It is a debilitating and sometimes permanent condition caused by a reduction in salivary gland function, commonly caused by radiation therapy to treat cancer of the head and neck region. The salivary glands are very sensitive to radiation and may be exposed during treatment resulting in a reduction in the production of stimulated and unstimulated saliva in the mouth.

The Phase III clinical trial was conducted at 40 centers in North America and Europe. Patients were randomized to one of two groups: group 1 (the control group) received 1.8 to 2.0 gamma rays (Gy) of radiation to treat their cancer; group 2 were given the same dose of radiation, but also received Ethiol by intravenous infusion 15 to 30 minutes prior to each of their radiation treatments. Both groups received treatment for five to seven weeks for a total dose of 50-70 Gy. The Ethiol group received the drug at 200 milligrams per meter squared (mg/m²).

Xerostomia was assessed at 12, 18 and 24 months after radiotherapy by Radiation Therapy Oncology Group (RTOG) criteria. Radiotherapy efficacy was assessed by

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A TIME FOR SHARING Cycling and Cancer – The First Cancer Experience

Cycling had been an integral part of my life since I began cycling seriously in Plano, Texas in 1984. The spring of 1996 in Atlanta was no different from previous springs. I had been putting in a ton of training miles in preparation for the summer and had achieved a high level of fitness. All of my plans for the summer changed suddenly when, one week after completing the 1996 Bike Ride Across Georgia, I discovered a tumor on the base of my tongue.

The diagnosis was a stage III squamous cell carcinoma with metastasis to an adjacent lymph node. Up until that time, I had assumed that cancer was not a disease of highly fit, health-conscious people. My perceptions quickly changed. I did not know at the time of my diagnosis if I would be able to return to a normal and healthy life, or if I would even survive. I also did not know that cycling would play a key role in my return to fitness and health, or that another cyclist and cancer survivor, who happened to be from Plano, Texas, would inspire my return.

An aggressive treatment regimen that included three cycles of chemotherapy (Cisplatin and 5-FU) and twice daily radiation for 31 days had drained my energy, and my weight had dropped from 170 to 148 pounds. I had continued to ride during my treatment. My oncologist was very surprised when I asked him if I could ride my bike with my chemo pump attached to my infusion port. After replying "God love you!", he went running down the hall of the medical complex shouting, "You are not going to believe what Mr. Chambers just asked me!" He seemed to be quite pleased that I was trying to maintain a normal and active life in the midst of coping with a serious illness.

As I was recovering from the effects of the disease and the treatment, I wondered if I would ever again have the stamina to complete the Six-Gap Century in the north Georgia mountains, a 100 mile ride with over 10,000 ft. of vertical climbing. As my weight and energy began to return, I was on the bike more and riding a little stronger, but still nowhere near the fitness level required to complete Six-

Gap. In the summer of 1999, after watching Lance Armstrong win the Tour De France, I decided that if Lance could win the Tour after cancer treatment, I could ride Six-Gap.

That summer I joined a local bike club in the Chicago area, Velo Club Roubaix. I got dropped a lot on the club training rides during that first summer, but the next summer I was hanging on longer and getting stronger and fitter. During the summer of 2001, I was training and riding 200 miles per week in preparation for Six-Gap, and I was no longer being dropped on the club training rides.

In the fall of 2001 I rode Six-Gap again for the first time since 1995. I completed the ride in 6 hours and 10 minutes, only 10 minutes longer than my previous, fastest time of 6 hours. It was an unbelievable feeling to complete Six-Gap. I felt a great sense of accomplishment in finishing the ride that day, five years after wondering if I would ever complete the ride again. It also felt great to have achieved the same level of fitness and stamina that I had experienced before cancer.

I have been able to sustain my fitness and stamina, and completed Six-Gap in 2002 and 2003. I also completed el Tour de Tucson in 2001 and 2002, riding with the Platinum group in el Tour. The 2001 el Tour was a special event for me because it occurred at my five-year post-treatment anniversary. In the 2002 el Tour, I was fortunate to start the ride with the cyclists in the VIP group, including Robbie Ventura, Greg LeMond, Jeannie Longo, and the T-Mobile women's team. Six years earlier I wondered if I would survive, and there I was at the starting line of el Tour with some of the top cyclists in the world.

Role Reversal and Shared Experiences – Cancer Returns (but does not recur)

After I returned from el Tour in November of 2001, my wife, Kathy, discovered a knot in her neck and a growth of tissue on her tonsillar fossa. When I felt the knot in her neck and saw the growth, I felt that same sense of dread that I had experienced five years earlier. The enlarged lymph node and the abnormal tissue

growth were ominous signs. I tried to be optimistic and assure her that it was probably just a benign re-growth of her tonsillar tissue, but deep down, I had the feeling that this all looked too familiar.

How could this be happening? Oropharyngeal cancer is not a common form of cancer and it usually occurs in smokers. How could two non-smokers in the same family end up with throat cancer? We hoped that the enlarged node and growth were benign anomalies, but when the growth and node were surgically removed and the biopsy performed, the diagnosis was cancer. The doctor had told us that if the growth and nodes were cancerous, he would perform a neck dissection and remove the adjacent lymph nodes.

When Kathy returned from recovery after her neck dissection, the doctor came to see us to discuss the results of the surgery. We already knew what we would hear since she now had a scar that extended from behind her ear to mid-throat. The diagnosis was a stage III squamous cell carcinoma with metastasis to an adjacent lymph node. We had heard that diagnosis before and could not believe that we were hearing it again.

As Kathy recovered from her surgery, we began preparing for the next steps of her treatment. Since the metastasis in her lymph nodes had been aggressive, Kathy's team of doctors recommended that her treatment include a clinical trial of chemotherapy combined with radiation therapy. After she recovered from her surgery, she had a PEG tube put into her stomach so that she could maintain adequate nutrition during her treatment. I did not have a PEG tube during my treatment and lost a significant amount of weight as a result.

After her diagnosis, I told her that I thought shared experiences were important for spouses but that I also thought she was taking it a bit too far. Another thing I shared with her was that this would be the first time when she couldn't say to me "But you don't know how I feel!" because I knew exactly how she felt, and how she would feel undergoing and

recovering from aggressive radiation treatment to her head and neck.

The weeks of chemotherapy and radiation treatment passed and she began experiencing the extreme pain of sores in her mouth. It was extremely difficult watching and sharing in her suffering. She had been there for me during my treatment and I wanted to encourage her and support her so she could complete her treatment and be restored to health and vitality. I was amazed at her strength and courage as

she, with the help and support of many friends, completed all of her chemotherapy and radiation treatments on schedule.

Kathy has just celebrated her two-year post-treatment anniversary with no sign of recurrence at the primary site. Our shared experiences have brought us together and strengthened our bond and our commitment to each other. We have had very meaningful and emotional experiences over the past few years participating in the American Cancer

Society Relay for Life, initially as survivor and caregiver, and recently as survivor/caregiver and survivor/care-giver. We have also had the opportunity to share our experiences with and encourage others who have had to cope with similar cancers. There is nothing quite like talking to someone who has been there.

John Chambers
Libertyville, IL

Maintaining Your Emotional Health

By Dale E. Theobald, PhD, MD

About 25 percent of people who have cancer have emotional reactions (usually depression or anxiety) that can be disabling. One of the most emotionally disabling things about cancer is giving into the assumption that you should feel bad. It is true that cancer and cancer treatments are accompanied by many symptoms.

Fatigue is the most common symptom. At some time in the course of treatment, nearly 90 percent of people who have cancer will have fatigue. Pain is less frequent and depends more on where the cancer is located. Nausea is a common but actively treated symptom also. All of that is the bad news.

The good news is that in the last ten years, remarkable progress has been made in cancer symptom management. Fatigue has been studied extensively. We know about anemia of cancer and how that causes fatigue. We know how to treat fatigue—such as with mild aerobic exercise.

Pain is better understood now. Old myths about addition and pain medicine are being dispelled. People are encouraged to tell their caregivers about their pain and not to suffer in silence.

Nausea can be short-term and related to treatment or it can be chronic. The underlying causes are understood treatments that are more effective are available.

All of these are symptoms that a cancer survivor may experience. When untreated, they can affect a person's activity level, quality of life and emotional well-being. While these symptoms can be tough problems, there is a lot

that the survivor and his or her caregivers can do.

Tell your caregivers (loved ones or treatment team) how you feel. Sometimes people feel it is a sign of weakness to admit that they are depressed, worried or experiencing pain. These are all natural things that happen. It is not being weak. Caregivers or the treatment team must be aware of problems before they can help.

Often survivors are afraid of distracting the doctor from the care of their cancer. Don't hold back. If you feel that you cannot talk about these issues with your doctor, identify someone else on the treatment team. Learn to work with your treatment team. It is easy to feel overwhelmed at the doctor's office or clinic. Prepare for your visits. Make a list of questions. Don't leave until they are answered. Effective use of these visits will pay big dividends.

Educate yourself. The more you know the better. Learn about your illness. Learn about the treatments and what the side effects might be. One of the hardest things to handle emotionally is the unexpected. If you understand that you may have fatigue or some other symptom and that it is related to something specific, it is often easier to accept and work through it.

If needed, ask for professional help. There is now an abundance of studies telling us that emotional reactions can be effectively treated. Again, your treatment team needs to know if these reactions are a problem.

Think about joining a support group. Some people do very well in support groups

and benefit greatly. Other people are more private and don't like support groups. Do what works best for you.

Keep a journal or diary. Emotions and physical symptoms vary widely during cancer and cancer treatment. It is often helpful to be able to look back to last week or last month so see how you were feeling. This information can also be helpful to your treatment team. Another benefit is that you may learn a great deal about yourself by writing down your thoughts and feelings and then looking back over them in quiet moments.

Keep up or start wellness behaviors. It is never too late to cultivate and strengthen good health behaviors. Learn about and practice good nutrition. Reduce the use of alcohol and tobacco. If possible, mild aerobic exercise is also good. You may need to exercise under the supervision of a trained professional so that no harm is done.

The bottom line: Don't say, "I have cancer, so I should feel bad." Speak up and work with your caregivers and cancer care team!

Editor's Note: Dale E. Theobald, PhD, MD, is a psychiatrist and director of the Quality of Life Program for Community Cancer Care in Indianapolis, IN. He is also an assistant clinical professor of psychiatry at the Indiana University of Medicine. Dr. Theobald was recently appointed as a Distinguished Fellow of the Psychiatric Association and holds an endowed chair of Clinical Research in Oncology Symptom Management by the Methodist Health Foundation of Indianapolis.

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locoregional tumor control, progression-free survival and overall survival. In addition, quality of life was assessed by a patient benefit questionnaire with eight questions scored from 1 (severe negative impact) to 10 (no impact).

Ethylol significantly reduced the incidence of moderate-to-severe (Grade \geq 2) xerostomia at each follow-up visit. At 24 months, only 20 percent of Ethylol patients had Grade \geq 2 xerostomia versus 36 percent in the control group (p=0.002). Ethylol also significantly increased the percentage of patients who could produce meaningful quantities of saliva (>0.1 grams) at 24 months (76 percent in the Ethylol group versus 56 percent in the control group (p=0.01).

In the study, tumor control, progression-free survival and overall survival at each follow-up visit were not significantly different between treatment groups. At 24 months, overall survival was 72 percent in the Ethylol group versus 67 percent in the control group (p=0.184). Mean overall scores for the patient benefit questionnaire tended to improve with Ethylol. At 24 months, patients in the Ethylol group scored their quality of life at 7.24 versus 6.87 in the control group (p=0.229).

Ethylol is a cytoprotective agent used to reduce some toxicities associated with cancer chemotherapy and radiotherapy. Specifically, this drug is an intravenous organic thiophosphate agent indicated to reduce the incidence of moderate-to-severe xerostomia in patients undergoing post-operative radiation treatment for head and neck cancer, where the radiation port includes a substantial portion of the parotid glands. Ethylol is also indicated for the reduction of cumulative renal toxicity associated with repeated administration of cisplatin in patients with advanced ovarian cancer or non-small cell lung cancer (NSCLC).

New Orleans, June 5, 2004. A multidrug chemotherapy regimen consisting of cisplatin, fluorouracil (5-FU) including the drug docetaxel (Taxotere) was given before radiation in a phase III study of patients with inoperable head and neck cancer. The results of this study indicated extended patients' survival by about four months, with fewer side effects, compared to standard therapy in patients with nonresectable locally advanced squamous cell carcinoma of the head and neck.

Patients are sometimes given

chemotherapy before other treatment, when it is thought that giving the drugs first may improve the effectiveness of the treatment that follows. This strategy is known as neoadjuvant chemotherapy. For patients with inoperable head and neck cancer, however, previous studies have not identified a neoadjuvant chemotherapy regimen that extended patients' lives.

The trial, conducted by The European Organization for Research and Treatment of Cancer (EORTIC) conducted the study led by principal investigator Jan B. Vermorcken, M.D., Ph.D., of the University of Antwerp in Belgium. "Previous studies had not shown any survival benefit with other neoadjuvant chemotherapy regimens, said Dr. Vermorcken. Dr. Vermorcken presented the findings at the ASCO meeting in New Orleans.

The study involved 358 patients with inoperable head and neck cancer whose tumors had spread to lymph nodes in the neck. Patients were randomly assigned to receive standard chemotherapy with the drugs cisplatin and 5-fluorouracil or the cisplatin and 5-fluorouracil plus docetaxel. After chemotherapy, both groups of patients also received standard radiation therapy.

After a median follow-up period of 32 months, patients treated with docetaxel survived for a median of 18.6 months, compared with 14.5 months for patients who received the standard platinum-based chemotherapy. In addition, patients in the docetaxel group lived for a median of 12.7 months before their disease progressed, compared with 8.4 months for standard-therapy patients. More patients in the docetaxel group than in the standard therapy group (67.8 percent vs. 53.6 percent) responded to treatment.

Fewer patients treated with docetaxel suffered side effects such as nausea, vomiting, and stomatitis (mouth sores). In addition, fewer patients in the docetaxel group died from adverse reactions to chemotherapy. "Nonresectable, locally advanced head and neck cancer has a very poor prognosis, with a 5-year survival of less than 10%" said Dr. Vermorcken. "This data is quite compelling. I think it will change the standard of care."

Head and neck cancer is the 7th most frequently occurring cancer worldwide with about 500,000 new cases each year or about 6% of the incidence of all cancers. About

60,000 new cases are reported annually in the United States.

Previous randomized trials involving patients with advanced head and neck cancer have suggested that chemotherapy is most effective when administered concurrently with (at the same time as) radiation, notes Scott Saxman, M.D., of the National Cancer Institute's Cancer Therapy Evaluation Program. Further study will be necessary, he says, to determine whether adding docetaxel concurrently with platinum-based chemotherapy and radiation is feasible and, perhaps, even more beneficial.

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radiation and once irradiated they do not usually regain function. Unfortunately, there is still no effective treatment for radiation-induced salivary gland dysfunction. Patients will need to keep their mouth lubricated by drinking adequate amounts of water. Sugarless candies and mints containing xylitol are also effective in keeping the mouth moist and have an anti-cavity effect. Medications, such as pilocarpine and cevimiline, can also be prescribed but may have unpleasant side effects.

Following up regularly with a dentist after the completion of radiation therapy is essential. Regular cleanings, x-rays, and examinations are imperative because of the increased risk of decay secondary to decreased levels of saliva. Patients should continue to use fluoride trays at night and must maintain meticulous oral hygiene. It is also important that patients be aware of the potential complications of having teeth extracted in the field of radiation. Hyperbaric oxygen treatments should be considered before and after a tooth is removed to reduce the possibility of osteoradionecrosis.

Radiation therapy for head and neck cancer can be a difficult treatment. The oral complications of head and neck radiation oftentimes are the most debilitating aspect of treatment. A dentist with experience in

treating irradiated patients, can be a great resource in helping to manage the side effects of treatment and to prevent further complications.

Editor's Note: Eric G. D'Hondt, D.D.S. is a partner of Greenwood Dental Associates of Greenwood Village, CO. He is a faculty member of the University of Colorado School of Dentistry in the Department of Applied Dentistry. Dr. D'Hondt has co-authored many articles related to dental care for oral and head and neck cancer and has lectured on these topics as well.


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