



**S•P•O•H•N•C**

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

## **Reconstructive Surgery For The Narrowing of the Throat Following Nonsurgical Therapy of Laryngopharyngeal Primary Cancers**

MARK L URKEN, MD FACS

The increased popularity of utilizing radiation therapy alone or in combination with chemotherapy for primary malignancies of the upper aerodigestive tract, while an established practice, has produced secondary problems with less established solutions. (The aerodigestive tract consists of combined organs and tissues of the respiratory tract and the upper part of the digestive tract including the lips, mouth, tongue, nose, throat, vocal cords, and part of the esophagus and windpipe). The goal of "organ preservation therapy" is to not only preserve the structure of the upper aerodigestive tract but also to preserve its function. Swallowing without aspiration is critical to the success of this approach.

The ability to maintain oral nutrition can be compromised both during and after therapy, with a small number of patients requiring permanent gastrostomy tubes (feeding tubes in the stomach) to maintain nutritional support. In some patients, a modified barium swallow demonstrates discoordination of the swallowing mechanism which is likely due to fibrosis (scarring) of the muscles of the oral cavity and the throat. Many patients experience a significant period of gastrostomy tube dependency during and after therapy which can result in a deconditioning (weakening) of the swallowing mechanism. This deconditioning phenomenon may respond to a period of swallowing therapy in order to determine how much of the normal mechanism can be restored and how much is permanently damaged.

In a small but growing number of patients there may be an acquired anatomic abnormality that involves a narrowing or complete

obstruction of the swallowing passage. While there is considerable experience in correcting a narrowing of the pharyngoesophageal segment (throat and upper esophagus) after a total laryngectomy, the restoration of swallowing with the larynx in place is a relatively new problem about which very little has been written. The presumed causes of this condition include the following:

1) the long term nasogastric tube placement resulting in chronic irritation and loss of the mucosa (lining of the throat) with resultant scar formation of this region leading to a narrowing or complete obstruction of the inlet (entrance) to the upper esophagus

2) the treatment of tumors of this region with radiation and chemotherapy often leading to severe mucositis which involves a process of loss of the normal mucosal lining and then healing through ingrowth of new lining. This process results in a risk of stenosis (marked narrowing) or complete obstruction.

3) the regression of a primary tumor with the healing being somewhat haphazard. If the primary tumor is located at the inlet to the upper esophagus or in the immediately adjacent region, then as that tumor responds to treatment, a significant portion of the lining of the region is destroyed and heals with a scar. As a result of this process, there will undoubtedly be a decrease in the size of the swallowing channel.

4) Chronic gastroesophageal reflux (GERD) which may lead to the same type of mucosal irritation noted above and result in loss of the lining of this region and subsequently closure of the throat.

The area of the inlet to the cervical esophagus (also known as the upper esophageal sphincter) is unique for several reasons. It is the narrowest part of the upper swallowing tract. It is the only portion which is bounded by a rigid structure in the back, the vertebrae, and in the front, cartilage of the voice box, resulting in compression of the esophagus. The muscle at the opening of the esophagus is always contracted and only opens as food passes through, requiring relaxation of the muscle. All of these anatomic peculiarities contribute to the development of a circumferential scar formation (stricture) in the swallowing tract if loss of the mucosa results from either chronic irritation/inflammation or tumor regression.

### **Patient Evaluation**

Any patient who develops post treatment dysphagia (swallowing difficulties) requires a thorough evaluation to determine the cause(s) and the optimal form of intervention. The appropriate point in time in order to carry out that evaluation is determined by the recovery of the patient and the degree of healing of the mucosa of the mouth and throat. A combination of upper endoscopy and a barium swallow x-ray is usually required to define the extent of the problem and to determine if a stricture has developed. However the physician and the patient must be aware of this problem developing and the consequences of ingesting barium or another contrast medium, gastrografin, which may go into the upper airway and the lungs

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COMING IN NOVEMBER, 2004

“Reirradiation for Head and Neck Cancer”

Sharon Spencer, MD

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(aspiration) through the larynx (voice box) if the inlet to the upper esophagus is obstructed.

Flexible fiberoptic esophagoscopy (examining the swallowing passage with a lighted tube) is usually an effective way to evaluate the problem. The endoscopist must be wary of the friable (delicate) nature of the lining of this region and the potential for puncturing the wall of the esophagus. Under no circumstances should a dilatation be performed before the extent and degree of the problem is well defined. The fragile nature of the lining of the region due to radiation exposure makes dilation (stretching with instruments) a risky form of intervention.

#### Classification of the extent of the Stenosis (Closure)

The extent of the narrowing and obstruction must be defined in order to determine the optimal method for surgical restoration and to determine the prognosis for functional recovery if the continuity of the swallowing tract is restored. The majority of patients with stenoses in this region have involvement of the upper esophagus and throat. I have chosen to classify limited stenoses of the cervical esophagus as class I. If the narrowing extends to the hypopharynx (lower throat) it becomes a class II stenosis. Extension to the oropharynx (upper throat) results in a class III designation. If the narrowing extends of the swallowing tract extends to the lower esophagus, below the level of the collar bone, then a class IV designation is given.

The determination of the lower extent of the narrowing in a patient with complete obstruction requires that retrograde esophagoscopy be performed by passage of a flexible scope through the opening in the stomach for the gastrostomy tube up to the level of the neck to define the lowest point of narrowing. This is a procedure which is usually performed in the operating room at the time that surgical repair is to be performed. If the esophageal tube is narrow or obstructed as far down as the chest, then replacement of the esophagus within the chest will be required through the use of a gastric pullup (elevation of the stomach into the chest and sewing it to the throat.). The technique of using a colon (large bowel) and surgically repositioning it is an alternative approach.

#### Surgical Intervention

The goal of surgery is to restore the continuity of the upper aerodigestive tract with well vascularized lining which can be either a skin flap or mucosa obtained from either the small intestine (a free jejunal flap) or from the greater curvature of the stomach. The latter can be harvested with a segment of tissue called the greater omentum, thus producing a compound “gastro-omental flap”. The advantage of this form of reconstruction is that the greater omentum has unique healing properties and is thin and pliable tissue which can be draped over critical structures in problem wounds. Both jejunal and gastro-omental flaps are transferred using microvascular techniques and carry the added benefit of bringing not only well vascularized epithelium but also the lubricating properties of the mucosa which is both normal to the region and helpful in overcoming the dryness in the upper aerodigestive tract (xerostomia) that is a product of the radiation effect on the salivary glands. The effect of dryness not only impacts patient comfort through producing the parched sensation in the oral cavity and the pharynx, but it contributes greatly to the excess thickness of the secretions which makes it difficult for the patient to swallow.

Finally, by bringing lubrication into the upper aerodigestive tract,

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it helps with the propulsion of food through the region.

Another major added benefit of the gastro-omental flap is the ability to transfer the greater omentum into the neck which is a very important adjunctive procedure which enhances the wound healing effect that is impaired as a result of the prior treatment. Referred to as the "policeman of the abdomen" the addition of the greater omentum to the mucosa of the greater curvature of the stomach represents an extremely attractive feature of this composite free flap.

The use of cutaneous (skin) flaps which can be tubed to create a circumferential lining for the conduit, offer the distinct advantage of being harvested from the arm or the leg without the need for disturbing the normal anatomy of the abdomen. However, these skin flaps are often too bulky and fail to bring in tissue with the desired lubricating properties.

One other very important factor that must be addressed in this surgery is the repositioning of the voice box into a more favorable location in relation to the base of tongue. The larynx often becomes frozen in position after radiation therapy and that lack of movement in an upward and forward direction contributes to the development of aspiration symptoms. Suspension of the larynx from the anterior aspect of the mandible (jaw bone) accomplishes, in a static fashion, what the movement of the larynx produces in a dynamic way during normal swallowing. Laryngeal suspension not only tucks the opening to the airway up underneath the tongue base, but it also pulls it away from the posterior wall of the throat and helps to statically open the entrance to the esophagus.

The avoidance of complications is critical to achieving the desired outcome after surgery. A wide enough opening which is located in a dependent position in the throat is critical to ensuring that future narrowing does not occur.

The integrity of the recurrent laryngeal nerves must be preserved in order to ensure not only a normal voice but also to make certain that the protective sphincteric mechanisms of the larynx are preserved. Finally, meticulous microvascular technique must be employed to ensure flap survival. *If that is not achieved then the patient is at risk of being made worse by this procedure.*

Paying additional attention to wound healing is very important and helps to avoid the development of a postoperative pharyngo-cutaneous fistula (leak) of saliva which could

compromise the vascular pedicle and lead to flap failure.

### Postoperative Management

At the time of surgery, a feeding tube is usually placed to ensure that enteral nutrition is restored very quickly after the surgery. That tube is often placed into the jejunum (J tube). Postoperatively patients do not resume swallowing until the tracheostomy tube is removed and the patient is deemed to be handling their secretions well. A barium swallow or a modified barium swallow is often helpful to reassess the anatomy of the region after reconstruction. Swallowing exercises are initiated in the second week after surgery to begin reconditioning of the swallowing tract to help overcome the period of inactivity. Patients do not usually start swallowing for a period of 3 to 4 weeks after surgery. They must commit to work with a speech therapist in order to optimize their function after reconstruction of the swallowing tract.

### Functional Outcomes

After surgery, the anticipated goals can be prioritized in the following way. The patient experiences a relief of coughing and choking as a result of secretions being successfully diverted away from the larynx and the bronchial tubes. Prior to reconstruction, these patients often experience respiratory difficulties due to the chronic low grade aspiration which leads to recurrent tracheitis (inflammation of the windpipe). The inability to drink liquids leads to slowing or stoppage of secretions in the throat which often produces significant malodor and patient discomfort. The ability to drink liquids is the next tier of functional recovery. This carries with it the extremely important benefit of allowing the patient to resume rehydration of the upper aerodigestive tract to help to overcome xerostomia and to help to cleanse the secretions which accumulate in this region. Finally the highest level of functional recovery is for the patient to resume eating soft and solid food and eliminate the dependency on nutrients administered through the feeding tube. The achievement of each of these goals leads to a progressive enhancement in the quality of life of these patients who have often suffered for considerable periods of time after treatment of their cancers.

Predicting how far a patient will progress is often quite difficult due to the considerable

number of factors which can impact on the recovery of function. The defect classification scheme introduced above helps to stage the extent of anatomic impairment that the treatment has produced. However the amount of deconditioning of the swallowing mechanism and the degree of discoordination that has been produced from the radiation is difficult to quantify in advance of restoring continuity of the upper aerodigestive tract that allows these parameters to be evaluated by the use of a modified barium swallow or through the use of FEES (Functional Endoscopic Evaluation of Swallowing).

Perhaps the most difficult aspect of this surgery is the acceptance by the patient of the uncertainty of not knowing the degree to which the restoration of the upper aerodigestive tract will result in functional improvement. The majority of patients in our series have noted improvement according to the criteria noted above. However the inability to predict the outcome may lead to disappointment and in the worst case scenario, the necessity for a functional laryngectomy to be able to resume oral nutrition. It is important for the patient to understand the various levels of improvement noted above and also to understand that if a total laryngectomy were to be needed, that it would likely require that exact same reconstruction described above due to the need to restore the normal size of the swallowing tract.

*Editor's Note: Dr Mark Urken is the Professor and Chairman of the Department of Otolaryngology at Mt. Sinai Medical Center in New York. He is also the director of head and neck oncology and an attending in the Derald Ruttenberg Cancer Center. He has been a member of the faculty at Mt. Sinai for 18 years and Chairman for the past decade. He has been recruited to take a new position in the fall of 2004 at Beth Israel Medical Center, New York, where he will assume the position of Director of Head and Neck Surgery in the Continuum Cancer Center of New York and Director of Head and Neck Surgery in the Department of Otolaryngology at Beth Israel. In addition he will be Co Director of the Institute for Head and Neck and Thyroid Cancer. He is the Medical Director of the THANC Foundation which is dedicated to promoting education and research in thyroid and head and neck cancer.*

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## A TIME FOR SHARING

After two years of unrelenting stress with our older daughter, my husband John and I made the painful decision to enroll her in a therapeutic school in another state. John took her there on October 17, 2001. That same day while stopped at a red light I rubbed my neck and was surprised to discover a large knot. When I got home I went next door and asked our neighbor, a doctor, what this could be. He asked if I had a cold or sore throat and I told him that I did not. Trying to make me feel better he said, "Now Kathy, do you know the incidence of head and neck cancer among non-smokers?" He was quite stunned when I replied yes I did — that John had been diagnosed with squamous cell carcinoma on the base of his tongue five years earlier. Then my neighbor got out a flashlight and looked into my mouth. "There it is," he said. "Your tonsil is infected." I just stared back and replied, "I don't have tonsils." My tonsils were removed when I was a child. Yet, there where my right tonsil had been was this "clustery-looking thing."

My sister, who is a dental hygienist, assured me that tonsil re-growth was not uncommon. The next day I saw an ENT doctor. The "thing" didn't seem to interest him at all. He told me that I had a sinus infection, prescribed an antibiotic, and said if the knot had not gone down in 10 days to come back for a CT scan. Nothing changed so I returned for a scan and was told to also schedule a needle biopsy. However, this doctor would be away for the next three weeks. I didn't want to wait so I made an appointment with another doctor who looked at the results of the scan and sent me to the Head and Neck Department at Loyola University Hospital for a needle biopsy that very afternoon. On the 45-minute drive to Loyola, I looked over the report and was shocked to discover that lymphoma was suspected.

At Loyola I had three needle biopsies — all were clear. Yes, they were clear as far as lymphoma was concerned. To diagnose squamous cell carcinoma a section of the growth would have to be taken. It was suggested that I go home and think about whether I wanted to have the knot and growth removed or if I wanted to just "watch it" for a while. I didn't have to think. I wanted both out as soon as possible. The doctor at Loyola thought this a wise decision and so surgery was set for three weeks later on November 29, a few days after Thanksgiving.

On the day of surgery I was given all sorts of forms to sign. I noticed one was for consent to perform a neck dissection, if necessary.

I remember asking what in the world was a neck dissection and being told that this was just a formality. A neck dissection was done IF there was cancer — which "of course" mine was not.

After surgery I woke to find John's face very near mine. I asked him if there was just a little band-aid where the knot had been. Imagine my surprise to see the anxious expression on his face as he told me no and instead I discovered a myriad of pumps and tubes coming out of my "dissected" neck!

Everyone, including my surgeon, was in a complete state of shock and disbelief. How could two NON-blood related, NON-smokers within the same household have the same cancer? That question has never been answered. Some think a virus could have been the cause — maybe I had the virus all along and the stress I was under finally kicked it in. Environmental? If so then what would this mean for our children? Others won't speculate and some just say it's something we will never know. In any event, John says that we have carried togetherness a bit too far. We are quite the phenomenon in oral cancer circles.

After having gone through this with John, I had more than a good idea of what I was facing. John quickly became my encourager, my mentor, and my inspiration as I embarked upon this challenging, and hopefully not final, chapter of my life. My new focus was getting through life one day at a time — sometimes a moment at a time. I was blessed in having a wonderful support system of friends who were there to provide meals, encouragement, and rides to Loyola. I felt completely enveloped in the prayers of family and friends living all over the world.

Thankfully, my oncologist did not give me the option of whether or not to get a feeding tube. He TOLD me that I would get one and it would be there if I needed it. So, a few days before Christmas I was given the "gift" of this unwanted appendage and decided to embrace this "pain in my side." I drew a face on "it", tied a small ribbon around "it's neck," and named it "Chuckie." Within weeks Chuckie became my new best friend! And it didn't take long for me to obtain new awe and admiration for John (who had NOT had a feeding tube). I remember watching him suffer so much as he forced himself to swallow food. Sometimes it would take hours for him to get down a bowl of soup — each swallow accompanied by a painful groan. As bad as the idea of a feeding tube sounded, it was a godsend.

Treatment began on Monday, January 7, 2002. The schedule was: chemo on Mondays and radiation Monday through Friday every week for six and a half weeks. I made the decision to participate in a clinical trial, which involved the use of the chemotherapy drug docetaxel along with radiation therapy. I was willing to try anything to avoid the sickness that John experienced with cisplatin.

As an artist I immediately turned to my creative energy as a means of coping with this experience. Right from the beginning I had John take photos of me. I decided that if I lived through this I would create a visual body of work to express my emotions. I wanted the photos taken as a record of this event and so that I could see the gradual metamorphosis of my face. John took over 75 photos, which document the entire period. I also kept a journal, which I now find quite useful as a source of reference when I communicate with others who are going through treatment. I am currently working on a series of paintings titled, "In Character." The paintings are of me depicted as different characters: Bride of Frankenstein, Van Gogh, Hannibal Lecter, Marcel Marceau, etc. Each was done for a specific reason. So far there are 12 paintings in the series. I plan on doing more self-portraits and other works made from items that I kept which include feeding bags, empty medicine bottles, my radiation mask, mouth guards, and even old "Chuckie"! In the past year I have spoken to several organizations, women's groups, and college classes about this series. My lectures include information on oral cancer and what motivates an artist to use personal experience in creating a body of work. I show enlarged prints of specific photos, which were used as references for some of the paintings. I also discuss the paintings: why I did each one and what it represents. For me, art is a form of communication and a vessel for expressing emotion, be it pain or healing.

My faith in God has sustained me throughout this trial and through so many other trials in my life. Sometimes I am amazed at the things we endure on this earth. I believe that we can use these dark times to bring light into the lives of others — that we should not waste these experiences but use them to offer hope and encouragement to those facing similar circumstances.

Many of you read my husband John's story in last month's newsletter and know the

importance that bicycling played in his treatment and recovery. John joined a Chicago area bike club in 1999. One of the members is a U.S. Postal team rider. In December 2001 I wrote a letter to this team member telling him John's story and inquiring about the possibility of getting an autographed photo of Lance Armstrong (cancer survivor and six time winner of the Tour de France) to give to John on his 50th birthday the following February.

I never heard back so I assumed that it wasn't possible. Then February came and John received a phone call from this dear man who had just returned from training with the team in Spain. Before going to Spain he had also heard about MY cancer and so he shared both of our stories with Lance. John and I were completely surprised to receive an autographed U.S. Postal team jersey that read: "To the Chambers family: Never give up! Lance Armstrong." Like John

and so many other people affected by cancer, Lance Armstrong has inspired me, too. In fact, one of my self-portraits is titled "Me As Lance Armstrong." In it I am wearing the yellow jersey!

*Kathy Chambers*  
Libertyville, IL

*Comment: To view the "In Character" series please visit Kathy's website at <http://members.aol.com/kathyduzart/>*

**FYI**

## Oral Mucositis Can Interrupt Head and Neck Cancer Therapy New Clinical Trial To Evaluate Medicated Oral Rinse

Radiation therapy, in combination with surgery or chemotherapy, is a frequently recommended treatment for patients with head and neck cancer. Many people tend to focus on getting to the radiation center on a daily basis which can be a tiring and time consuming process. Others may be afraid of possible chemotherapy side effects. Many people are unprepared for one of the most common head and neck cancer therapy side effects involving the mouth area: oral mucositis, also commonly referred to as mouth sores.

Oral mucositis can cause severe discomfort for people who receive radiation therapy. It usually begins with inflammation in the mouth that causes a burning sensation and can progress to very painful, ulcer-like sores. Mucositis has been cited as the most bothersome side effect in patients receiving radiation. These mouth sores can make it

difficult to talk, eat, drink, and smile. In addition, severe oral mucositis may force people to temporarily stop their cancer treatment in order to provide time for the sores to heal. The interruption in treatment prevents patients from receiving the full and immediate benefits of the therapy.

Currently, there is no Food and Drug Administration (FDA)-approved drug or therapy to prevent oral mucositis. Many people use over-the-counter medications and mouth rinses to relieve pain; others change their diets to avoid irritating foods. However, these approaches have not been proven to decrease the chance of getting mucositis. In some instances, physicians may prescribe a "magic mouthwash" to provide temporary relief from the pain. It is important to note that individual physicians or pharmacists create their own version of these "magic mouthwash"

solutions; there is no standard formula.

In an effort to address the need for an FDA-approved treatment, a major pharmaceutical company is sponsoring a Phase III clinical research study. This study is designed to evaluate the safety and efficacy of a medicated oral rinse for head and neck cancer patients to prevent or lessen radiation-induced oral mucositis. Volunteers are needed to test whether the medication under investigation may reduce the chance of getting or reducing the severity of oral mucositis. This may permit uninterrupted radiation therapy.

People who participate in clinical studies receive high quality care, close monitoring of their condition, and evaluation at the end of treatment.

If you are about to receive radiation therapy to your head and neck region and are interested in learning more about this study, please visit [www.headandneckcancer.com](http://www.headandneckcancer.com).

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## NATIONAL SURVIVOR VOLUNTEER NETWORK

SPOHNC's National Survivor Volunteer Network (NSVN) is steadily growing with new volunteers as well as new callers. Our volunteers are enthusiastic and eager to be of support to others knowing full well the challenges that other survivors may be facing.

At the present time, we have more than 90 Volunteers who have submitted detailed applications to SPOHNC enabling our Network Administrator, Janine Cortese, to make the best matches possible with survivors looking for someone who has had similar experiences to their own. Once a volunteer submits his/her application, he/she is sent a binder containing articles about different types of oral and

head and neck cancer, treatment, nutrition, side effects, supportive care products, etc.

On April 21<sup>st</sup> of this year, SPOHNC held its first "Volunteer Training Teleconference." More than 90% of our Survivor Volunteers participated. Following the teleconference the National Survivor Volunteer Network was activated: as of that day SPOHNC was ready to match callers with our volunteers.

As of September 18<sup>th</sup>, we have made 70 matches. Feedback from both parties has been very positive. Callers are very grateful to be able to talk to someone who understands what they are experiencing. Volunteers are pleased that they are able to support and encourage others.

We encourage callers and volunteers to keep us informed regarding their exchanges

and share anything that concerns them. Thus far, the reports have been very positive.

Although at this point in time, some of our volunteers may not have been called to help, they will be in the near future. Everyone is a vital part of the network and we thank all our volunteers who remain on call.

If you would like to volunteer to be part of NSVN or would like to speak with one of our volunteers, please call Janine at 1-800-377-0928 or email her at [JCortese@ix.netcom.com](mailto:JCortese@ix.netcom.com).

Together, SPOHNC and NSVN are working to fulfill our mission of meeting the needs of oral and head and neck cancer patients. We are here to be of service to survivors, family, friends and others.

## Pain Management for Head and Neck Cancer

Vivek T. Maholtra, MD

For many cancer patients, pain is the caller whose knock at the door is feared and dreaded. It arrives without welcome, acts without permission, and lingers for an unknown time. While pain demands respect, it need not merit fear. Better understanding, newer therapies and novel thinking have made it easier to treat pain.

With its myriad of nerves traveling through multiple nooks and crannies, understanding the anatomy and physiology of the head and neck area can be maddening. Fortunately, when thinking of pain and its causes in head and neck cancer, there are really only 2 causes of pain and 2 types of pain. Pain can be from either the tumor itself or as a consequence of the therapies we use to fight it. Each of these can cause 2 types of pain: nociceptive (“normal”) pain or neuropathic (“nerve”) pain. What we do as pain physicians is dictated by identifying the cause and the type of pain.

Tumors need space; but, the head and the neck are so tight that even small tumors easily encroach upon essential structures. These structures can be bone, muscles or nerves. Pushing on bone and muscle causes nociceptive pain, a type that is often described as a pressure, ache, throbbing, “or just plain pain.” It is familiar to many as it resembles pains that most people have felt through their lives. When encroachment upon nerves occur, descriptions change and may include the words “burning,” “pins and needles,” “or shooting.” Some may describe gentle touching, wind, or water as causing pain. This “neuropathic pain” is unfamiliar to most and is the result of disordered transmission of pain impulses along nerves, much like a short circuiting. Neuropathic pain is often more distressing to people as it is a “weird” type of pain, not easily described to nor understood by friends and family members. Treatment of this type of pain requires approaches distinctly different from nociceptive pain.

Treating cancer requires aggressive maneuvers that include surgery, radiation or chemotherapy. While these treatments are aimed at the tumors themselves, they often can cause damage to non-cancerous structures as well. Most often the structures damaged by surgery, radiation and chemotherapy are nerves resulting from scarring, radiation damage (neuritis) or chemo-induced neuropathies. While

some may complain of nociceptive pain, most pain that arises from treatment is neuropathic.

Fortunately, one need not sit back and take it. As aggressive as one is about fighting cancer, so too can one aggressively fight pain. For nociceptive pain, a stepwise approach developed by the World Health Organization (WHO) and referred to as the WHO ladder is used. Simple is best; thus, the initial treatment employs non-narcotics such as NSAIDs. (Non Steroidal Anti-Inflammatory Drugs)

Simple things like ibuprofen, naproxen or newer agents such as celecoxib, rofecoxib (COX-2 inhibitors) are often chosen. These act to relieve chemicals, produced by the pressure of the tumor, that sensitize pain structures. They help stop pain at the source of the tumor itself. NSAIDs are particularly effective when tumor is encroaching upon the bone, as are other non-narcotic agents called bis-phosphanates (usually administered once per month intravenously). When NSAIDs are not enough, we must venture into narcotic country. Step 2 of the WHO ladder recommends the use of weak narcotics (often coupled with acetaminophen). These include familiar trade names such as Vicodin (hydrocodone and acetaminophen), Darvocet (propoxyphene and acetaminophen), and Tylenol with codeine. Yes, if there are *weak* opioids, there must be *strong* opioids. These form step 3 of the ladder and include oxycodone (sometimes used in forms such as Percocet and Endocet); Hydromorphone (Dilaudid) and the classic Morphine. If pain relief is achievable but requires frequent pill intake, long acting agents are employed. These are slow-release pain medications that trickle pain medications into the body over time. The medicine is made to do the work of dosing and not the person. Some of the most commonly used medicines for this purpose are Fentanyl patches, slow-release oxycodone (Oxycontin), and slow-release morphine (MS Contin, Kadian and Avinza).

But, what about nerve pain? Yes, the nociceptive medications can be used, but most feel they do not completely remove the pain and “only take the edge off.” More often, drugs that attempt to prevent the “short-circuiting” of nerve pain are more effective.

Most of these medications have traditionally been used to treat depression and epilepsy. Much as antidepressants (e.g., amitriptyline, nortriptyline) and anticonvulsants (e.g., gabapentin) calm nerves for depression and seizures, they are also effective in calming nerve dysfunction in neuropathic pain. The doses used for pain are different and do not contribute much to an anti-depressant effect. These are not immediately acting medications but do require from one to several weeks to become effective. They are often started at lower doses and require upward adjustment. Once they do work for neuropathic pain, they are more effective than opioids and substantially reduce pain. Even still, people may have “attacks” of pain that require a fast-acting medication. Thus, these slow neuropathic medications are coupled with fast acting opioids to at least “deadend” the attacks until the neuropathic medications can become effective.

Sometimes, a tumor may push upon the bone and a nerve resulting in both nociceptive and neuropathic pain. In these situations, both a nociceptive medication, like an opioid, is coupled with a neuropathic medication. However, there are single medications that can act on both types of pain. And like all else, they come in a weak and strong flavor, tramadol (Ultram) and Methadone, respectively. Yes, that was methadone you read. It’s not just for drug abusers, it’s actually a novel pain medication with unique properties and one that is used frequently in cancer pain. When other medications are ineffective, methadone can provide unparalleled relief, particularly when the pain is mixed. It works like an opioid for nociceptive pain while also quieting neuropathic pain, sometimes in a faster fashion.

Few things in life come free, so too is it with pain relief. Relieving pain may sometimes be accompanied by unwanted side effects. Often, what is being achieved is a balance of pain relief and side effects. When the pain persists and side effects dominate, sometimes the only solution is to rotate medications. One of the more life impinging side effects of these medications is constipation; however, with vigilant attention to regularity, it is possible to achieve a balance.

PAIN continued on page 7

## PAIN from page 6

But, what if medications are not sufficient, or side effects are too great? This is when novel treatments such as nerve blocks, pumps, and nerve stimulators are considered. These approaches attempt to relieve the pain without using additional medications or creating side effects. They are more invasive and thus are reserved for situations when simpler methods fail. They may not replace medications entirely; but, may assume some percentage of pain relief and allow for a reduction of other medications and relief of side effects. Every person is different and every situation is different; thus, there is no single best treatment.

Having head and neck cancer and pain is more than simply about cancer pain. The diagnosis changes a person and the suffering and anguish that is felt is more than physical pain. No amount of medicine or interventions alone can improve life quality. It is essential, imperative, and sensible to seek emotional help in the form of support groups, therapists and psychiatrists. So too, is it important to be part of physical therapy programs. The body and the self are scarred from the cancer and the treatments. Pain should not be viewed and feared as an unwelcome guest, but as the reliable friend tapping one's shoulder warning that "something's up" and there is work to be done.

*Editor's Note: Vivek T. Malhotra, MD is an anesthesiologist with expertise in pain management. Dr. Malhotra has dual appointment in the Pain Services of the Department of Anesthesiology and the Department of Neurology at Memorial Sloan Kettering Cancer Center in New York.*

## SPOHNC SELECTED CHARITY BY NEIMAN MARCUS DIRECT

Neiman Marcus, the specialty retailer with a 97 year history of offering spectacular gift selections to their many dedicated customers, unveiled the 2004 Christmas Book in Dallas on Tuesday, September 28<sup>th</sup>.

Once again the Christmas book is filled with the most amazing assortment of unique and imaginative and dreamy holiday offerings available in any one place. Neiman Marcus remains committed to helping customers make dreams come true, particularly during the holiday season.

First published in 1926 as a 16 page catalogue, the Neiman Marcus Christmas Book was originally intended as a Christmas card to its best customers. Building each year on that heritage, the book has retained its personal touch while evolving into a relied-upon source of suggestions for customers committed to giving unique and dramatic gifts to their loved ones.

In keeping with its long-standing tradition and dedication to philanthropy, this holiday season, Neiman Marcus has chosen Support for People with Oral and Head and Neck Cancer as this year's featured charity. A portion of the proceeds of certain items in the Christmas Book will go to this organization, which helps survivors and their families get

the support and resources they need and to spread the much-needed word on early detection and prevention. Every year, 60,000 people face the life-threatening and disfiguring effects of cancers of the oral cavity, head, and neck. Often overlooked, these types of cancers can be physically, emotionally, and financially overwhelming. SPOHNC is committed to meeting the needs of oral and head and neck cancer patients and to developing awareness of a rare disease.

This year, the Neiman Marcus Christmas Book will be distributed to more than 2 million homes in the United States and around the world. In addition, the Neiman Marcus website, [www.neimanmarcus.com](http://www.neimanmarcus.com), will feature the entire Christmas Book on-line, making it possible for customers who have not received a book to order holiday gifts directly from the site.

SPOHNC is indeed honored to be the charity selected by Neiman Marcus this year. It is our hope that through the Neiman Marcus 2004 Christmas Book that SPOHNC and Neiman Marcus will be able to make a difference in raising awareness of oral and head and neck cancer in hopes of early detection of this rare cancer that may lead to cure.

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