



S•P•O•H•N•C

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

NOVEL THERAPIES IN SQUAMOUS CELL CARCINOMA OF THE HEAD AND NECK

EZRA E.W. COHEN, MD

The treatment of squamous cell carcinoma of the head and neck (SCCHN) is primarily stage based and stems from the usual and somewhat predictable behavior of this disease. Early stage disease (stage I or II) is treated with a single therapeutic modality – surgery or radiotherapy – with an expectation of high long-term survival rates. Intermediate stage disease (stage III) is often treated with surgery and radiotherapy although chemotherapy can be added in some instances. Locally advanced disease (stage IVa or IVb) should be treated with multi-modality therapy employing surgery, radiotherapy, and chemotherapy. Patients with recurrent or metastatic disease are often offered chemotherapy only for palliation. These paradigms have changed somewhat over the last decade to include a greater utilization of chemotherapy especially as part of initial treatment of stage III and IV disease in combination with radiotherapy. Nevertheless, overall survival rates remain at 50% while conventional chemotherapy can be fraught with serious side effects. The need for novel therapies in this disease is therefore blatant and prodigious.

Recent years have seen a dramatic increase in the number of novel agents in oncologic clinical trials and the approval of a few agents in specific diseases. Some of these agents have produced remarkable long-lasting results. Several agents have been utilized in SCCHN clinical trials with the epidermal growth factor receptor (EGFR) inhibitors leading the way. Other promising targets include tumor hypoxia (low oxygen) and angiogenesis (new blood vessel formation). This essay will discuss recent developments in SCCHN novel therapies.

EGFR

The EGFR is a member of a family of receptors that contain a section outside the cell (extracellular domain) and a portion inside the cell (tyrosine kinase domain). The extracellular domain is responsible for binding activating proteins, called ligands, which are secreted by cells into their environment. These ligands interact with the EGFR causing it to partner with one of its family members and activate the tyrosine kinase domain. This activation leads to a number of cellular events including growth, survival, and spread.

The most promising strategies employed thus far to target the EGFR have been antibodies and tyrosine kinase inhibitors (TKI). The antibodies bind to the extracellular domain, prevent ligand-receptor interaction, and cause breakdown of the receptor inside the cell. The TKI block the activating end of the receptor and thus do not allow the initiation of the downstream signaling cascade. These two drug classes also share a common side effect: an acne-like rash. In addition, the antibodies can infrequently cause allergic reactions while the orally administered TKI are associated with gastrointestinal toxicity, specifically diarrhea, nausea, and vomiting. In the great majority of patients with either type of inhibitor, the side effects are mild and manageable. While other methods of EGFR inhibition are being developed, both these approaches, antibodies and TKI, have already met with encouraging success in clinical trials.

Monoclonal Antibodies

There are at least five EGFR antibodies in clinical use as anti-cancer treatments. One of these, cetuximab, has already been approved for use in the United States for colon cancer and has shown promise in treating patients with SCCHN. In early trials, patients with incurable disease were treated with cetuximab and chemotherapy only after their disease progressed on the identical chemotherapy. In this patient population with ostensibly aggressive and resistant disease, cetuximab was still able to demonstrate an 11-12% response rate (significant tumor shrinkage) suggesting that it was able to provide benefit.

Recently, a single arm trial in patients who had failed first line chemotherapy was completed. In this study patients received cetuximab alone as second line therapy. Subjects who progressed on cetuximab alone were given the option to continue therapy with cetuximab in combination with chemotherapy. This study reported a 12% response rate and confirmed that cetuximab is effective as second line therapy in refractory SCCHN.

As these trials were showing promise, the Eastern Cooperative Oncology Group undertook a trial in previously untreated patients with recurrent or metastatic disease comparing cisplatin to cisplatin plus cetuximab. Indeed, the results of this trial showed that the addition of cetuximab was able to significantly improve response rate (23% vs. 9%) with a trend towards delaying disease progression.

The most significant impact of cetuximab in SCCHN, however,

THERAPIES continued on next

page



SUPPORT FOR PEOPLE WITH
ORAL AND HEAD AND NECK CANCER
S•P•O•H•N•C, INC.
P. O. BOX 53

BOARD OF DIRECTORS

Nancy E. Leupold, MS, President
James J. Sciubba, D.M.D, Ph.D., Vice President
Jean O. Cashin, Secretary
Walter E. Boehmler, Treasurer
Louis Frillmann
Karrie Zampini, CSW

MEDICAL ADVISORY BOARD

David M. Brizel, M.D. Duke University Medical Center	Herman Oliver, M.D., F.A.P.A. North Shore-LIJ Health System
Linda K. Clarke, MS, RN, CORLN Greater Baltimore Medical Center	David G. Pfister, M.D. Memorial Sloan-Kettering Cancer Center
David W. Eisele, M.D. University of California San Francisco	Jed Pollack, M.D. North Shore-LIJ Health System
Keith Heller, M.D., F.A.C.S. North Shore-LIJ Health System	James J. Sciubba, D.M.D., Ph.D. Johns Hopkins Medicine
Alex Keller, M.D., F.A.C.S. North Shore-LIJ Health System	Elliot W. Strong, M.D., F.A.C.S., Emeritus Memorial Sloan-Kettering Cancer Center
Jesus E. Medina, MD University of Oklahoma Health Sciences	Denise M. Vey Voda, M.A., D.D.S North Shore-LIJ Health System
Eugene N. Myers, M.D., F.A.C.S. University of Pittsburgh School of Medicine	Everett E. Vokes, M.D. University of Chicago Medical Center
David Myssiorek, M.D. North Shore-LIJ Health System	David P. Wolk, M.D., F.A.C.S. North Shore-LIJ Health System

Karrie Zampini, CSW

NEWSLETTER EDITOR

Nancy E. Leupold, MS

WEBMASTER

Barry Sebastian

News From SPOHNC is a publication of
Support for People with Oral and Head and Neck Cancer, Inc.
Copyright ©2004–2005

DISCLAIMER: Support for People with Oral and Head and Neck Cancer, Inc. does not endorse any treatments or products mentioned in this newsletter. Please consult your physician before using any treatments or products.

IN THIS ISSUE

A Time for Sharing.....	4
Jeffrey K. Perhach Foundation.....	6
Pat's Pantry Provençal.....	7

COMING IN FEBRUARY 2005

“Sentinel Lymph Node Biopsy For
Squamous Cell Carcinoma of the Oral Cavity”
Thom R. Loree, MD

THERAPIES continued from page 1

may be in its ability to augment the effects of radiotherapy. Experimental data has suggested that, upon exposure to radiation, cancer cells increase their expression of EGFR presumably as a protective mechanism. Therefore, inhibition of EGFR during radiation could have considerable merit. With that in mind, the Radiation Therapy Oncology Group tested the effect of adding cetuximab to radiotherapy in locally advanced SCCHN. Patients were treated either with radiation or radiation plus cetuximab. Confirming the results of earlier trials, the combination of cetuximab and radiotherapy was well tolerated. More importantly, however, the combination also conferred an advantage with respect to control of the tumor and survival. This proof of principle trial now justifies the study of adding cetuximab, and theoretically other anti-EGFR agents, to standard combination chemoradiotherapy regimens and comparing combination anti-EGFR/radiotherapy with chemoradiotherapy.

Tyrosine Kinase Inhibitors

The information regarding structure and function of cellular proteins coupled with the ability to synthesize complex molecules has given researchers the tools to inhibit a plethora of targets. Not surprisingly, there are a large number of agents that inhibit EGFR with high specificity. Two of these have been tested in SCCHN: gefitinib and erlotinib. In addition, studies utilizing agents that have the capacity to inhibit EGFR and related proteins (eg GW572016 and ZD6474) will begin in the near future.

Gefitinib

The principle studies with this agent have involved patients with recurrent or metastatic disease. The first study, completed by the University of Chicago Consortium, administered gefitinib alone at a dose of 500 mg per day. This trial reported a response rate of 11% in patients with refractory disease with a larger proportion realizing a clinical benefit. Interestingly, in a follow-up study in a very similar group of patients, gefitinib at a lower dose of 250 mg per day demonstrated minimal clinical activity with only one response in 63 patients. The 250 mg dose has been approved in the treatment of lung cancer after demonstrating equal activity as 500 mg in two randomized studies. It is possible that, in contrast to lung cancer, patients with SCCHN require the higher 500 mg dose to achieve benefit. Currently, a randomized trial is testing whether gefitinib can improve survival compared with chemotherapy (methotrexate) in patients with recurrent or metastatic disease.

Researchers are also studying whether gefitinib can add to the activity of conventional chemotherapy or other targeted agents. Encouraging reports combining it with cisplatin, docetaxel, and celecoxib suggest that these approaches are worth pursuing.

While studies in refractory patients lay the foundation for single agent activity of gefitinib, its impact in treating SCCHN will only be realized upon combination with radiotherapy in patients with locally advanced disease treated with curative intent. To that end, researchers have begun to add gefitinib to radiotherapy and chemoradiotherapy regimens. A study led by the University of Chicago is administering gefitinib with 5-fluorouracil, hydroxyurea, and radiotherapy and then continuing gefitinib as a single agent for an additional two years. This study is nearing complete accrual and

THERAPIES continued on page 3

THERAPIES continued from page 2
early results are anticipated in late 2004.

Similarly, investigators at the University of Colorado Cancer Center have combined gefitinib with radiotherapy. After demonstrating tolerability, the trial is now undertaking the next stage of incorporating cisplatin into the regimen. Clearly, the positive randomized data presented utilizing cetuximab (see above) and the apparent tolerability of TKI with chemoradiotherapy, will generate similar randomized trials with gefitinib and erlotinib.

Erlotinibs

Erlotinib has also been administered as a single agent in patients with recurrent or metastatic disease. The final results of this study have shown activity of this agent in SCCHN with a 4% response rate and, arguably more meaningful, a 6 month median survival which would compare favorably with conventional chemotherapy. Erlotinib is also being combined with chemoradiotherapy in an ongoing trial.

In an effort to target multiple pathways in cancer cells, the University of Chicago Consortium in conjunction with the National Cancer Institute is currently conducting a trial combining erlotinib with bevacizumab (see below). This study seeks to capture the benefit of inhibiting both EGFR and angiogenesis seen in preclinical models. In a preliminary report, this combination appears well tolerated and has produced a high rate of disease stabilization. Mature data should be available in early 2005. More information on this trial is available through the National Cancer Institute internet site: www.nci.nih.gov.

The Rash

As stated above, all EGFR inhibitors will produce a very similar acne-like rash. The rash is rarely serious and tends to dissipate over time. In addition to other cutaneous toxicities such as dry skin, nail changes, and brittle hair, the rash has been associated with improved outcome in SCCHN. This has been fairly consistently seen throughout different trials employing the varying agents. The association suggests that the rash is a clinical marker of benefit although it does not appear to be sufficient for response. That is, developing the rash does not guarantee a benefit although responses are rarely seen without onset of rash. The relationship is being further explored in clinical trials aiming to optimize benefit of the agents by escalating their doses until rash is seen.

TUMOR HYPOXIA

Although tumor hypoxia (low oxygen) is not a specific target per se since it is mediated by a large number of intracellular events and proteins, it is a process that is commonly present in SCCHN and is associated with worse outcome. It is estimated that 40-50% of SCCHN tumors will have some fraction that is hypoxic. Efforts to target hypoxia have aimed at increasing the oxygen in patients' blood, improving the oxygen carrying capacity of blood (usually by increasing hemoglobin), or altering radiation delivery. Recently, however, agents have entered clinical trials that specifically target hypoxic cells. One such agent, tirapazamine, is in late stage development in SCCHN.

Tirapazamine is a prodrug; that is, it requires conversion inside the cell to its active compound. This conversion can only occur in hypoxic cells, which forms the basis for its tumor specificity. Once converted, tirapazamine produces DNA damage that kills cancer cells. Tirapazamine has shown encouraging results in early clinical trials when combined with cisplatin and radiotherapy. Furthermore, its efficacy, not surprisingly, seems to be especially potent in tumors that are hypoxic. Currently, an international trial comparing cisplatin and radiotherapy with or without tirapazamine is nearing completion with results expected in 2006.

ANGIOGENESIS

Analogous to hypoxia, angiogenesis is not a specific target but a process that can be inhibited to curtail tumor growth. Angiogenesis, the formation of new blood vessels, is completely essential to tumor growth and spread. Early attempts to target angiogenesis met with profound enthusiasm that was likely premature. Nevertheless, recent trials have been heartening and the first anti-angiogenesis compound, bevacizumab, was approved in 2004 for the treatment of colon cancer.

Bevacizumab is an antibody directed against the vascular endothelial growth factor (VEGF). The VEGF protein is felt to be one of the most important growth factors for new blood vessels, sparking interest in it as a target in cancer therapy. In addition to the trial mentioned above combining erlotinib with bevacizumab, the agent has been combined with chemoradiotherapy. The addition of bevacizumab to 5-fluorouracil, hydroxyurea, and radiotherapy has proven feasible with

promising activity. A cautious note has been raised regarding the potential for blood clots and impairment of wound healing although it has been difficult to attribute these side effects to bevacizumab in non-randomized trials. Recently, a randomized trial has been initiated comparing 5-fluorouracil, hydroxyurea, and radiotherapy with or without bevacizumab that should establish the utility of this agent in SCCHN.

CONCLUSIONS

The era of targeted therapy in SCCHN has just begun with anti-EGFR agents proving successful at reducing tumor size and extending survival in certain settings. Similar prospects exist for agents targeting hypoxia and angiogenesis. There is little doubt that the exploding knowledge in cancer biology will produce even more therapies in the future. One challenge will be to find the agents that are truly effective. This will require an enormous effort from patients, researchers, and government.

Notwithstanding, the essential element that will dramatically improve treatment in this disease will be individualizing targeted therapy with respect to tumor biology. At this time physicians categorize tumors by their appearance under a microscope, their size, and their pattern of spread. This system allows estimates of prognosis and planning of treatment for each patient group, but it is profoundly inadequate when it comes to predicting the behavior of and best therapy for an individual's cancer. It is clear that every tumor, regardless of its location or appearance, is unique, but there are still biologic properties that different tumors will share. This is evident in the subset of patients that benefit from EGFR inhibitors. The connection between these tumors that render them sensitive, however, has not yet been fully elucidated. Nevertheless, we can envision a day when a patient's cancer will be classified by its biology and then treated with agents tailored to that unique biology. We are at the precipice of significant and exciting changes in cancer therapy that are just beginning to emerge and should prove vastly beneficial to patients in this devastating disease.

Editor's Note: Ezra E.W. Cohn, MD, is currently an assistant professor in the Department of Medicine at the University of Chicago. His research interests include development of novel therapies especially in the treatment of head and neck cancers.

A TIME FOR SHARING A Travel Journal...Part II

Two years after her treatment for cancer of the tonsil, Linda had another checkup. "No evidence of cancer." However, only two weeks later, she developed a sore throat that would not go away. Consequently, she had her first surgery for carcinoma of the tonsil. And now her story continues.

Right after my operation, my cousin Tom told me he had just been diagnosed with advanced lung cancer. This was a new form of hell. He was going through what I had gone through after the first diagnosis, only he was another person, very unlike me. Where I tend to be sad, he was angry. And as his cancer buddy, I was his designated coyote during this time. But anyone around such a person is liable to get seriously yelled at and emotionally whacked around. It is especially hard to handle questions and requests about final wishes, end scenes, death, assisted suicide, etc., even knowing that people must often think through such things. Finally I had no reserves left with which to recover from my own surgery. I went to Kaiser and explained that I had to have some help, and what I needed was an antidepressant of some sort to get me through this so I could help. I explained that I absolutely would not leave Tom to thrash through this situation alone, that I really was his coyote. And I lucked out: Prozac turned out to work for me, and in fact to counter a lifetime tendency to depression. And Tom's terrible weeks of therapy were successful; he is still symptom-free two years later. During that time our friendship has deepened incalculably; it has been amazing to have someone to really share the experiences with

So there was that year, and we both felt lucky to make it through to the blooming of the acacia trees again, those huge, fragrant masses of flowers that signal spring has come to Northern California. A wonderful spring! My daughter, Chey, was ecstatic to leave on her first road trip for the East Coast. Together with her good friends from college she headed east. She was going to work on Cape Cod all summer and then head to Morocco in the fall. The family wanderlust was lively in her bones. This was the year. of her deciding that I was going to be fine;

that she wasn't sure she wanted to go back to school—time for a change, adventure at the beginning of her life! And I was equally ecstatic. Now I would have time to do things I had wanted to do for years. Paint! Travel! One day Chey showed up at my door with a kayak for me.

The day after she got on the road, I got that tell-tale sore throat again. I took a round of antibiotics, just in case I had strep throat. The 10-day course would let me get used to this again. I didn't have strep throat. I had a further recurrence; in for a biopsy, and then my surgeon said he had a date opening up for surgery in three days, would I go? Later he would be on leave. Yes; anything to get it out sooner rather than later. He was pleased; told

...the oncologist thought the PET scan was just lighting up areas that were damaged by surgery, not showing new tumor growth. I looked at him in dumb astonishment. "So I can go to Morocco?" I asked. "Sure!"

me about this wonderful muscle in my chest he could take up to put in my throat so I could—probably—still talk and swallow. That shook me badly: not talk? not sing?

Final papers roused out and refurbished, phone numbers sent around for a fast phone network, friends marshaled, Chey told "Stay there, don't come back, I'll feel awful if you come back. Keep going! I love you." Neighbors for the cats, somewhere to go afterward, with a temporary tracheotomy as well as a feeding tube again. Three days in intensive care, a week in the hospital. The tracheotomy was hard; tapping on the edge of the phone when Chey called, writing notes to get help, frantic coughing and learning to use the suction machine; learning to clean and care for the tracheal tube before leaving the hospital. This time it was clear that the staff was hard-pressed to keep up with demands; several HMOs had folded, and Kaiser had taken on the job of providing health

care. It showed. And it was a little scary. I was very clear on the need to be my own health advocate, to keep my records as much as possible, to have friends who could help me research treatments, side effects, etc. My surgeon disappeared; other surgeons took his place. They told me that postsurgical biopsy had shown that the operation had achieved "clear margins"—no cancer currently left around the tumor site—but that there was a micrometastasis in one of the 10 lymph glands they had removed. That lymph gland was the one right in the midline of my jaw, which had been spared from the radiation. So perhaps the cancer was now all gone. Or not.

I have learned a lot. Cancer cells can be detected by a number of means, including X-ray (these detect tumors, or masses), biopsy (lab identification of cancer cells; full excisional biopsy is better than a mere needle biopsy, which can miss the cancer), CAT scan (3-D), and PET scan (finds places where sugar metabolism is high, as in healing wounds and growing tumors). None of these methods is error free. They need to be used with each other, and with experience. And the precancerous cells themselves may not show up. So I have had three occurrences (recurrences) of a primary cancer; and one micrometastasis. The first two times I was cleared of disease; but in fact there were cells ready to go bad that hadn't yet done so. Think about a head of cabbage: You know the outer leaves are going to go bad first. You can peel them off and it looks pretty good; but leave the cabbage alone and eventually the outer leaves are again going to go bad. Maybe I wasn't ready to know this, at first.

The tracheotomy took all my attention at first. It was scary to have a plug in my throat, and a suction machine under my bed, and huge amounts of suction tubes and sterile dressings, and uncertain instructions about everything. But two weeks later my trach incision had closed up, and I was beginning to eat solids; well, glop. I'm getting very good at gourmet glop. Summer squash pureed with butter, yum. Friends to die for, who let me creep into my bedroom in their house and nap, and wear their football-print boxer shorts, and make glop in the kitchen. A chiropractor who got his start in life by having his hand severed and

reattached, gave me free help with my increasingly stiff and painful shoulder. People are just amazing! I learned to kayak again, resting my right elbow on the edge of the boat and shoving the paddle forward with my left. I went out on the end of the Russian River on a glassy, still day when the pelicans were divebombing fish and beneath me the sea kelp trailed ghostlike through the shallows. Cormorants sat on the black rocks, the sunset painted the cliffs pink, the seals flopped out in a row on the inner curve of the sand barrier that always rises up to block the river's route to the wild ocean at the end of summer.

At the end of summer checkup, the doctor told me the PET scan could now be scheduled for me; the surgery had gone too fast to get it done.

The PET scan was easy, just a little fasting rest in a dark room, being scanned. I had brought a book, but they didn't want me to read, because they didn't want to raise my metabolism anywhere. (Ha! I could have told them I'm a hopeless bookaholic; with no book, I was likely to get the serious willies.) The PET scan results were given to me on the phone by a doctor who was not happy to be detailed to read them to me: I had lit up like a Christmas tree, all through the lungs, chest wall, and mediastinum. Basically, he said, there was nothing more the surgeons could do for me. It was now a time for chemotherapy. Palliative care. I am sorry to give you this news.

I froze. I think this is what cancer does to you, perhaps all long-term illnesses that may be fatal. They change your sense of time. For me, the time was now, and time had run out, and there was no more time. I was, now, dying. I responded like the lifetime introvert I am, and shut myself up inside myself. I could no more tell my daughter or my friends what was happening to me than if I had been struck speechless. This was my experience; completely mine; I could not share it, could not bear the dilutions and rehashings of normal human reactions. The thought of going public with this news was completely beyond me. I proceeded to work, to clean (always my response to stress) obsessively, to think. Finally, sitting in a laundromat, reading an old New Yorker for its cartoons, I found one that made me howl with laughter: An old-timer in Heaven is welcoming a newcomer, who is

shaking his head regretfully, exclaiming, "So much for antioxidants!"

This broke the black ice. I could then tell a friend here or there, and get some courage to tell Cheyenne. First I had to get confirmation. I got it, from another doctor who had read the report. In the middle of this my first surgeon called; Charlie had gone for a bone marrow transplant—he had leukemia. Charlie's daughter was exactly Chey's age. He had had no idea of what I had just learned. We were now both cancer patients—of the same doctor, as it turned out. Charlie thought the antioxidant joke was pretty funny too.

I called Chey, and said, "Look, I need some time to grow into this. I would be sad if you didn't get to Morocco. Go, and go early; when you come back I should be into chemo and needing help. But first, go, and have a great time!" Luckily, before she left, I was able to tell her that the oncologist thought the PET scan was just lighting up areas that were damaged by surgery, not showing new tumor growth. I looked at him in dumb astonishment. "So I can go to Morocco?" I asked. "Sure!"

So I did. If you go to Morocco, go see the D'jemma el Fna, the great town square of Marrakesh. Go see the storks nesting on the top of the red clay walls, and the camels, and the storytellers telling tales of Ali Baba in the night to enthralled crowds of all ages. Eat boiled acorns and snails, or fresh orange juice and dates, or mint tea and lamb tagine. Chey was my guide, we had adventures. We went to the blue city of Chefchaouen, and watched the cats of Casablanca meet the fishermen come up from the sea with wheelbarrowfuls of their catch. Each cat got a little fish to carry off.

I don't know where this story goes next. That is a good thing. Charlie died in February, of complications. Sometimes spring can't get here fast enough; you mourn for those who fall. It is now full spring, almost May, Chey is almost 21. I am glad to have had these five years. It's an ill wind that blows no good. Inshallah (God willing), I will go to China sometime soon. I have always wanted to see China.

Linda Purrington
Petaluma, CA



Helping to Raise Awareness of
Oral and Head and Neck Cancer

1-9 pins: \$6.50 each
10 or more pins: \$6.00 each
including shipping and handling



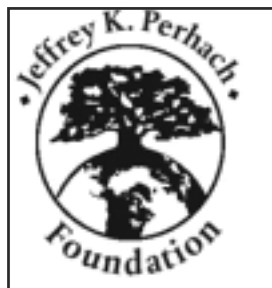
We Have Walked In Your Shoes,"
a three part resource for
Oral and Head and Neck
Cancer Patients
and their families

To order in English or Spanish
Call
1-800-377-0928

Visa, Mastercard and American Express
accepted by phone and mail
Visa and Mastercard
accepted at www.spohnc.org

*A Gift has been received
IN HONOR OF
Jeanna Richelson
by
Maurice & Jo Ann Richelson*

Jeffrey K. Perhach Foundation Golf Outing Helps Raise Awareness



The Jeffrey K. Perhach Foundation is a non-profit (501 (c) (3) organization dedicated to promoting oral

cancer awareness and early detection. The foundation was established as a tribute to the memory of Jeffrey K. Perhach, who lost his battle with oral cancer in early 2002 at the age of 35. His life as a loving husband, father, son, brother and friend, as well as his courage in the face of insurmountable odds, have inspired us to take action in the fight against cancer.

The foundation was created for many reasons but was truly inspired by one basic principal;

A considerable amount of time passed from when Jeff first complained about an apparent tooth abscess until he was diagnosed with oral cancer. Perhaps if we knew then what we all know now Jeff might still be with us. Therefore a fitting tribute to Jeff would be to reach

out and educate as many people as possible regarding the dangers of oral cancer and the importance of early detection in the hope of saving someone's life.

The Jeffrey K. Perhach Foundation is staffed by an all-volunteer board and faculty. Our overall goal is to develop several programs based on oral cancer awareness and early detection.

In 2003 the board of directors felt it would take two to three years to fully develop and fund these programs. Currently fund raising efforts primarily consist of the direct solicitation of general donations and public events such as an annual golf outing. In an effort to immediately comply with the foundation mandate of promoting oral cancer awareness and early detection the board of directors decided that partnering with a more established organization would be more efficient than expediting the development of any new program.

In early 2004, after careful consideration, it was determined that SPOHNC best represented the beliefs and goals of the Jeffrey K. Perhach Foundation. The board decided that for the next three years a portion of each year's net proceeds will be donated to SPOHNC in an attempt to

assist their efforts in promoting oral cancer awareness and early detection. Remaining proceeds will be used to continue the development of internal programs.

The Third Annual Jeffrey K. Perhach Memorial Golf Classic took place at Bunker Hill Golf Course in Princeton, New Jersey on Friday, October 1, 2004. It was a beautiful day for an outing in which 26 foursomes met the challenges of the golf course with enthusiasm and determination. Golfers were reminded of the mission of this outing with signs at each hole stating a fact related to oral and head and neck cancer, the Jeffrey K. Perhach Foundation and SPOHNC. Cooler bags, donated by Sommerset Valley Bank bearing the logos of the Jeffrey K Perhach Foundation and SPOHNC, were distributed to the guests. Dinner followed the shot-gun golf tournament with raffles sold for donated prizes. The third annual fundraiser was a successful event enjoyed by all.

For more information about The Jeffrey K. Perhach Foundation feel free to contact us:
Mail: 1 Mott Way, Flemington, NJ 08822
Contact: Joe Infante
Phone: (908) 284-6020
Web: www.jkpf.org
E-Mail: info@jkpf.org

SPOHNC TO PUBLISH COOKBOOK

For several years, we have published recipes in our newsletter from time to time. Our membership has been most receptive to this section of our newsletter and has often asked why we haven't published a cookbook just for oral and head and neck cancer survivors and their families. The time has now come and SPOHNC is looking into publishing a cookbook for distribution sometime in 2005. But to do this, we need your help. We need your favorite recipes for a cookbook for survivors with swallowing challenges. Over the years, many of you have found different ways of preparing foods to meet your individual eating needs. We are hoping that you will share your creative recipes with us so that we can share them with others.

Our plans are to include information about dysphagia (swallowing problems) as an introduction to the cookbook. There will be a section on tools and equipment as well as hints and techniques for preparing meals. Recipes will be categorized as appetizers, soups, vegetables, main dishes, sauces, beverages and desserts. We hope that this cookbook will add anticipation to daily eating, provide casual and practical advice and combine culinary proficiency with patient experience and need.

We are hoping for representation from as many different states and countries as possible. Just think, this cookbook could be an international cookbook for oral and head and neck cancer survivors.

You may send your recipes and "hints"

by email or mail. Please indicate the recipe category and title of the recipe at the top of your page, followed by a listing of ingredients and the method of preparation. If you would like to have your name to follow your recipe, please print it exactly as you would have it appear in our cookbook. Email your recipes to info@spohnc.org or send to SPOHNC, P.O. Box 53, Locust Valley, NY 11560-0053.

Please submit as many recipes as you wish. We will select one or more or all of your recipes to be included in the cookbook. If possible, please type them, or hand print for easy reading. So, send your recipes today! The sooner we receive your recipes, the sooner we can publish the cookbook. For more information, please call us at 1-800-377-0928.

MEMORIAL GIFTS
have been received
In Loving Memory of

Rebecca Vivian Fishman
by
Joanne Fishman

Oscar Heil
by
Manny & Mary Andala
Raul Andala
Stacie & David Court
Rob, Ria, Frits & Hanneke Dekkers
William & Christa Hyatt
Rev. Otto W. & Carole Immel
M/M Jenkins
Thomas & Lisette Mooney
Dr. Samuel & Sophia Jean Rowe
Don & Marian Teuton
Arlene Twomey

Mariano Lopez
by
Judith C. Lopez

Paul Robinson
by
Dorothy S. Arndt

Terrence Wiak, MD
by
Mary C. Wiak

James Woods
by
Perry M. Santos, MD



from **PAT'S PANTRY**
PROVENÇAL

Roasted Halibut with Potatoes

- | | |
|--|---|
| 12 Tbsp. olive oil | 2 lbs. potatoes (Yukon Gold
have a good texture. |
| 2 Tbsp. olive oil to grease
baking dish | 3 garlic cloves, minced |
| 15 oil cured black olives or
green olives, pitted | 2 halibut fillets, about 1 1/2 lbs. |
| | 1/4 cup finely chopped parsley |

Salt and pepper to taste

Preheat the oven to 400. Grease a 9x13 baking dish with the olive oil. Chop olives until fine. Slice the potatoes thinly. Place one third of them in the baking dish. Brush with a 3 Tbsp the olive oil and sprinkle on 1/3 of the garlic and 1/3 of the chopped olives. Repeat this process. Then top with the last third of the potatoes, 3 tsp olive oil, and season with salt and pepper. Set aside the rest of the garlic and olive oil. Cover the potatoes with foil and bake for 16-18 minutes, so that they begin to color. Remove the foil and bake about 10 minutes more, until lightly browned. Mix the remaining olive oil and garlic together. Dip the skinned fillets into the mixture. Season with salt and pepper. Place the fillets on top of the potatoes and sprinkle with the last 1/3 of the olives. Return dish to the oven for about 10-15 minutes, or until the fillets are flaky when tested with a fork. Sprinkle with parsley. To liquefy, blend with milk for desired consistency.

Tip: This dish is cooked with olive oil which is a Mediterranean ingredient and healthier than butter. You may substitute melted butter if you prefer.

MEMBERSHIP APPLICATION
SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER, INC.
Membership includes subscription to nine issues of *News From SPOHNC*

Name _____ Phone (____) _____

Address _____

Address _____

City _____ State _____ Zip _____

Please Check: Survivor ___ Friend ___ Health Professional (Specialty) _____

ANNUAL MEMBERSHIP

- \$25.00 individual \$30.00 family
 \$30.00 Foreign (US Currency)

CONTRIBUTIONS

- Booster, \$10+ Donor, \$50+ Sponsor, \$100+
 Patron, \$500+ Benefactor, \$1,000+ Founder, \$5,000+
 Leaders Circle, \$10,000+

Call 1-800-377-0928

to become a member and make a contribution by credit card or order on line at www.spoync.org

480-512-3636
 480-838-5194
 310-825-5707
 714-456-5235
 760-751-2109
 415-353-7982
 303-798-3041
 202-444-3755
 561-395-7100
 786-596-6951
 305-243-4952
 561-737-3699
 404-284-8045
 404-778-2369
 708-327-2042
 617-731-1703
 313-916-7578
 248-964-3430
 314-569-6569
 704-355-7283
 402-559-4676
 732-356-1939
 973-586-3522
 856-722-5574
 732-557-8270
 505-681-1917
 631-444-7678
 718-828-9243
 516-759-5333
 614-293-7042
 412-647-9127
 972-373-9599
 214-820-2608
 281-401-5900
 703-776-2813

PHONE

Denise Stats-Caldwell,CC
 Bette Denlinger
 Sabah Qasim, MSW
 Jennifer Higgins, MSW
 Valerie D. Targia
 Michele Francis, LCSW
 Henry V. Holdridge
 Joanne Assarsson, MSW
 Darci Lipson-McNally
 Annie Garcia-Montes
 Penny Fisher, RN
 Carmine Puleo
 Harmon Grotzky
 Arlene Kehir, RN
 Jenny Abrams, LSW
 Valerie Goldstein
 Amy Orwig, MSW
 Mary Plotz, ACSW
 Carol Murphy, SW
 Meg Turner
 Susan Stensland
 Bernadette Maszczak
 Howard Sakolsky
 Micki Naimoi
 Sherry Laniado, SW
 Anita Bryan
 Fran Tanzella
 Bob Barabarelli
 Nancy Leupold
 Vicki Henke, MSW
 Marilyn Hudak, RN
 Dan Stack
 Travis Maxwell
 Janet Kantenberg, LMSW
 Corrine Cook, CSW

COORDINATOR/FACILITATOR

ARIZONA--SCOTTSDALE (new)
 CALIFORNIA--LOS ANGELES-UCLA
 CALIFORNIA--ORANGE-UCL
 CALIFORNIA--SAN DIEGO
 CALIFORNIA--SAN FRANCISCO-UCSF
 COLORADO--DENVER
 DC--WASHINGTON-LCC
 FLORIDA--BOCA RATON
 FLORIDA--MIAMI
 FLORIDA--MIAMI-Mort Silverblatt Head and Neck
 FLORIDA--PALM BEACH (new)
 GEORGIA--ATLANTA, GA
 GEORGIA--ATLANTA-Emory
 ILLINOIS--MAYWOOD
 MASSACHUSETTS--BOSTON
 MICHIGAN--DETROIT-HFHS
 MICHIGAN--TROY
 MISSOURI--ST LOUIS (new)
 NORTH CAROLINA--CHARLOTTE
 NEBRASKA--OMAHA
 NEW JERSEY--BRIDGEMATER
 NEW JERSEY--MORRISTOWN
 NEW JERSEY--PENNSYLVANIA
 NEW JERSEY--TOMS RIVER
 NEW MEXICO--ALBUQUERQUE, (new)
 NEW YORK--LONG ISLAND EAST
 NEW YORK--MANHATTAN
 NEW YORK--SYOSSET
 OHIO--COLUMBUS
 PENNSYLVANIA--PITTSBURGH-UPMC
 TEXAS--DALLAS
 TEXAS--DALLAS
 TEXAS--HOUSTON/TOMBALL
 VIRGINIA--FAIRFAX-Heads Up!

SPOHNC CHAPTER

SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER (SPOHNC)



SUPPORT FOR PEOPLE WITH
 ORAL AND HEAD AND NECK CANCER
S•P•O•H•N•C, Inc.
 P. O. Box 53
 LOCUST VALLEY, NY 11560-0053

NON-PROFIT
 ORGANIZATION
 U.S. POSTAGE
 PAID
 LOCUST VALLEY, NY
 PERMIT NO. 28

Don't forget to
 send your recipes
 by mail or email

Support
 SPOHNC's Cookbook

See you in February 2005

News From SPOHNC
 is not published in
 January.