



**S•P•O•H•N•C**

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

## **VIRTUAL ENDOSCOPY AND SURGICAL SIMULATION FOR HEAD & NECK CANCER**

MARVIN P. FRIED, M.D., F.A.C.S.,  
BABAK SADOUGHI, M.D.

Imaging is a fundamental component of the management of head and neck cancer. Although clinical examination and other non-radiological studies play critical roles in the decision-making process, it is usually on the additional imaging findings that the final therapeutic decisions rely.

Computer technology advances and multimedia developments have been greatly beneficial to modern imaging devices, and non-invasive radiology is an increasingly attractive field of research for physicians and scientists. This research is pursued in several directions: on one hand, developing new core technologies and concepts of image acquisition, such as positron emission tomography (commonly referred to as "PET-Scan") and other sophisticated nuclear medicine studies; on the other, updating longstanding technologies such as computerized tomography ("CT-Scan") or magnetic resonance imaging ("MRI") by integrating recent enhanced applications into them, as seen with open MRI units or fluoroscopy, which are state-of-the-art devices allowing a surgeon to update the patient's images while the surgery is being performed. This article outlines the usefulness of virtual laryngoscopy and surgical simulation as real future applications of currently implemented imaging technologies, to improve the management of patients with tumors of the head and neck.

### Current Laryngeal Assessment

The assessment of tumors of the pharynx and the larynx ("voice box") currently follows a very standardized sequence. First, the patient's past general medical history is taken in the physician's office, and all relevant data pertaining to the present symptoms are recorded. The patient then undergoes clinical examination, including mirror (indirect) laryngoscopy (voicebox inspection) and/or fiberoptic (direct) laryngoscopy. At this point, depending on what is observed, further studies can be ordered by the physician, such as: stroboscopic examination, to assess the mobility of the vocal cords; functional tests, e.g. acoustic or aerodynamic, to assess the functionality of the voice box; neurophysiologic studies, to assess the correct transmission of signals from the nerves to the voice box. Sometimes a more thorough examination is required in the operating room, under general anesthesia, to access the size and location of a tumor or to harvest biopsies to better typify the lesion. Radiology and all its modalities are the most frequently required studies. Indeed, specialized imaging of the head and neck allows a unique view of the deep layers that neither palpation, nor even examination under general anesthesia can estimate in a more than approximate way. The increasing precision and quality of current imaging studies make them very reliable and accurate, and sometimes even allow to anticipate the nature of a lesion by its radiologic characteristics before conducting specimen pathology studies, although the latter always remain mandatory to characterize a tumor as benign or malignant. However, radiology is not useful if not correlated with a comprehensive clinical and/or operative examination.

### Limitations of Current Endoscopy

Endoscopy is a two-dimensional observation of the inner surface of the oral, pharyngeal, and laryngeal cavities, thus reflecting mere surface abnormalities. When a suspect lesion is found, the depth of invasion can sometimes be difficult to assess, since the layers lying beneath the surface (mucosa) are not seen through. When a tumor is bulky, its own structure may hinder further visualization. When the majority of the tumor is hidden in the deeper tissue, and only revealed by the presence of minimal mucosal disease, its actual growth extent may be hard to tell even though the cavities are easy to access and visualize. The presence of narrowing (stenosis) in the cavities, whether or not caused by the tumor, is also an obstacle to realizing a thorough examination, as well as hindering access.

### Visualization Challenges of the Head and Neck

Despite major advances and undeniable usefulness in studying head and neck lesions, imaging also has its drawbacks. One of them is the complexity of the anatomy of the neck, not only in the number and variety of the structures encountered, but also in their

See ENDOSCOPY on next page



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**WEBMASTER**

**Barry Sebastian**

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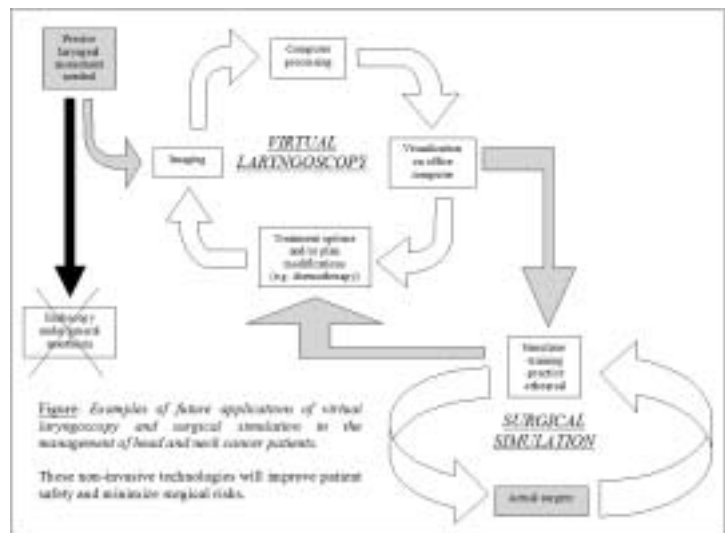
*News From SPOHNC* will return in SEPTEMBER

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critical functions: for instance, the carotid arteries supply the blood flow to the head and brain; the vagus nerve conducts the breathing signal from the brain to the respiratory muscles, etc.

Moreover, many structures pass back and forth through multiple radiographic slices, and the pathology itself may cause unpredicted distortion of the images, in an area where free cavity (lumen) is usually already limited. A thorough knowledge of anatomy is therefore essential to identify any abnormality. Correct interpretation of imaging studies of the head and neck therefore requires specific expertise and broad experience in order not to jeopardize the vital functions of this complex area.

The above assertions provided the basis for the creation of patient-specific three-dimensional models for visualization, which would combine the benefits and reduce the drawbacks of both endoscopic and radiographic techniques. Such a project needed the close collaboration of experts from various fields to conduct computer science-based research in the setting of a clinical environment: software and biomedical engineers working together with physicians (such as otolaryngologists, neurosurgeons, orthopedic surgeons, neurologists, or pulmonologists) to run a surgical planning laboratory, where imaging data are post-processed to create the needed types of 3D reconstruction, among which virtual laryngoscopy. This was done in the Department of Radiology at the Brigham and Women’s Hospital, Boston, Massachusetts.



Virtual Endoscopy and Surgical Simulation

Virtual endoscopy of the larynx, or virtual laryngoscopy, has a number of positive aspects. Unlike regular endoscopy, it is non-invasive, does not require hospitalization or general anesthesia, and bears no more danger to the patient than that of the imaging acquisition technology used to obtain it. The presence of the patient is in fact not required once the image acquisition is complete, the task then becoming purely analytic. Using computer data processing, the physician is able to browse the virtual larynx as many times as required and from all needed angles, on a regular office computer screen without having the patient present.

There are additional reasons to favor the implementation of  
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virtual laryngoscopy for pre-operative assessment of a patient with head and neck cancer. Indeed, the technological resources used allow sophisticated enhancements: patients could greatly benefit, for example, of merging multiple imaging methods, such as CT, MR or PET, to reach a far higher level of accuracy in the assessment of the tumor, and subsequently, in its treatment plan. The latter would also be improved in the surgical planning laboratory by the use of surgical simulation: downloading patient-specific data into a simulation device, in order to rehearse the planned procedure in a virtual reality environment. The trajectory to target tissues would be studied, and problem areas, such as ones where the tumor lies next to a blood vessel or a nerve, located. This would help the surgeon not only safely identify the possible risks of surgery, but also anticipate problem-solving issues and practice in advance, in order to make the actual procedures shorter, safer, and overall more successful.

Virtual laryngoscopy would also be a valuable tool to measure response after initial treatment, such as chemotherapy. The analysis allowed by computerized imaging is precise enough to directly measure the reduction of tumor size and help determine further treatment options.

The maintenance of digital information is also very suitable for data sharing purposes. Physician-to-physician consultation becomes faster, as the constantly increasing bit rate and speed of online networking systems allows easy exchange of large amounts of data between office computers. Physician-to-patient communication becomes more visual and user-friendly with the use of realistic 3D virtual models, for instance by displaying a virtual mockup of the patient's anatomy on a computer screen, to describe the lesion and comment the treatment options, in a more practical manner than the current narrative and somewhat abstract one. Teaching and training surgical residents will also undoubtedly take advantage of these endeavors, since younger generations of physicians are already well versed into the use of computers and informatics for many of their daily tasks.

### Challenges of Virtual Endoscopy

Virtual endoscopy is an emerging area

of biomedical research, and is still in need of proper validation. Large-scale prospective studies have to be conducted to define the actual strengths and weaknesses of the concept, and to set evidence-based guidelines for the time and cost involved.

There are technological challenges to resolve as well, such as defining the precise abnormality on the scan images, or distinguishing the lesion from surrounding normal tissue, as well as improving the resolution, realism, and precision of the system. It is already anticipated that once perfected and validated, virtual endoscopy will also become the standard first-line investigation method for many other specialties where research has been very active in the field, e.g. gastro-intestinal medicine (virtual colonoscopy), gynecology (virtual hysteroscopy), cardiology (virtual coronary artery endoscopy), pulmonology (virtual bronchoscopy), or urology (virtual cystoscopy).

### Surgical Simulation: Our Experience with the Endoscopic Sinus Surgery Simulator

In 1996, the endoscopic sinus surgery simulator (ES3) was developed by the conjunct efforts of the Department of Defense and Lockheed Martin, Inc., directly based on flight simulation technology, and four prototypes were built. One of these devices, consisting of virtual reality simulators that reproduce the conditions of an actual endoscopic sinus surgery procedure, is housed in the Department of Otolaryngology at Montefiore Medical Center. It allows training for various levels of experience, and permits surgical trainees to enhance their understanding of spatial relationships, hand-eye coordination and their performance of maneuvers in space in the sinus anatomy. The ES3 includes the full spectrum of common surgical instruments in its virtual reality environment, and has unique capabilities of voice recognition and activation, operating room environment simulation, or response to medication. Virtual reality is enhanced by tactile force feedback response. The overall result is one of the most advanced and realistic surgical simulators to date.

The ES3 is programmed to teach surgical technique for routine procedures, and has many additional educational

features, such as labeled anatomic structures, surgical hazards, unexpected complications, vascular injury and hemorrhage.

Over the last years, several core validation studies were performed on the ES3, using such various subjects as medical students, otolaryngology residents or skilled sinus surgery attending physicians, and a standardized training curriculum was created with the elaboration of manuals and multimedia material.

Recent ongoing studies are assessing the predictive validity of the ES3, to demonstrate that the knowledge gained on the simulator transfers to the operating room on actual patients. Flight simulators have proven an average transfer rate of 50%, which means that an hour spent by a pilot on a simulator spares half an hour in the air. The rate of transfer of the ES3 is still to be determined, and is under study through our current "Virtual Reality to Operating Room" (VR to OR) protocol.

We envision future developments for virtual reality coupled to surgical simulation, as a tool to identify and reduce surgical errors. Increasing technical sophistication and incorporation of patient-specific data will allow the users of next generation simulators to "preview" surgery and practice it the same way jet fighter pilots have "mission rehearsals".

The applications in head and neck cancer are numerous and very promising. In the future, surgeries are likely to be planned in a way that will be safer and more efficient than ever before. Patient follow-up and evaluation will be minimally invasive, yet more precise and instructive than at present.

We anticipate that the final rewards of these major evolutions will be the improvement of the duration and quality of life of head and neck cancer patients, along with major changes in the basic concepts of surgical education.

*Editor's Note: Dr. Marvin Fried is the Professor and University Chairman of the Department of Otolaryngology at Montefiore Medical Center, of the University Hospital of the Albert Einstein College of Medicine in New York City. Dr. Babak Sadoughi is a research fellow, collaborating with Dr. Fried in the Department of Otolaryngology's Surgical Simulation Center at Montefiore Medical Center.*

# A TIME FOR SHARING

During the Christmas season of 1998, (my absolute favorite time of year), whilst hanging the balls, decking the halls, and cooking up a storm for my annual parties, I felt an olive-sized lump on the right side of my neck. With some trepidation, I planned to get it checked out right after the holidays.

At the beginning of January, I started feeling sick. My GP, diagnosed an infection, put me on strong antibiotics, and ordered blood tests. Over the next three months, I came down with sore throats, ear infections, and the flu twice. I pointed out the lump during separate visits to two different ENT specialists. They both assured me that it was connected to the infections.

Despite their reassurances, that strange lump made me anxious, and my gut kept telling me to find out exactly what was causing it. Finally, after three months, and four doctors' misdiagnoses, a friend recommended a physician who specialized in diseases of the head and neck. Gently, but firmly, this physician told me that he needed to do a biopsy. I asked him later, if he had known what it was from the start and he acknowledged that from all the signs, he had been almost sure it was a malignant tumor in my right tonsil. The biopsy proved him right! It was stage III, squamous cell carcinoma of the tonsil.

But where did it come from? It's still a mystery since I'm not a smoker/drinker. My purpose in sharing my story with you is to illustrate the importance of finding the right doctor. Within the next two weeks, my surgeon performed a right tonsillectomy, including half of my palate, followed by a neck dissection. Because of the metastases to the neck, he couldn't predict whether the neck dissection would be radical, or modified. Fortunately, it turned out to be modified, and I went home to recuperate for six weeks before radiation. Little did I know that the painful surgeries and subsequent neuropathy, paled in comparison to the symptoms caused by my radiation **treatment.**

After an initial consultation, my

radiation/oncologist prescribed dental treatment to fix any problems, and remove two teeth in the radiation field. I don't know why this caused me such emotional distress, but it did. Physically it was far less traumatic than either surgery. But, finally, the dam burst. It was the outpouring of every emotion I had suppressed – trying to be strong, and hiding the ice-cold face of fear behind a mask of normalcy. Knowing that I was going to lose perfectly good teeth, that I had taken care of my whole life, sent me into a tailspin. Only my poor cat was home at the time, he watched, in wide-eyed fascination as I roamed the house wailing like a wounded animal.

Everyone tolerates radiation differently. From what I had read, I expected about a two-week grace symptoms and it was downhill from there. The six-week course of radiation ended up lasting nine, because of two necessary pauses in treatments. One weekend, my throat closed completely, causing dehydration. A couple of weeks later, I was hospitalized again with a blood clot in my leg, which was unrelated to the radiation.

Having to go every day for more radiation, and getting progressively sicker, was daunting, to say the least. I put myself on autopilot, to get through it one day at a time. I viewed guided imagery videos and tapes, which were very helpful. I feel that humor is so important in a stressful situation, so I watched corny old movies, and comedy sitcoms. I was too fatigued to laugh out loud, but I know that if I laughed in my mind, it would count. I forced myself to eat because I was losing a lot of weight, and I was petite before the treatments. I lived mostly on food that would slide down easily, my neighbor's lovely organic eggs, and my own nutrition-dense milkshakes. I didn't want my burned skin to break open, so every night I pierced a vitamin E capsule and applied it to the burned area and every other day after treatment I used Aloe Vera gel.

After the last treatment, the feeling of sheer relief was overwhelming. However,

the awful sore throat, burning mouth tissues, nausea, and fatigue plagued me for about three months. Then, from complete exhaustion, and just lying around feeling sorry for myself, the change was sudden and dramatic. From one week to the next, it was as though a veil lifted and most of my old energy returned.

The saliva situation is still not as comfortable as I would like, but ongoing acupuncture treatments have certainly worked for me. I eat almost anything that's not nailed down, (can you believe even salsa and chips) and enjoy an occasional glass of wine.

I started the San Diego Chapter of SPOHNC because at the time of my diagnosis, I found it very difficult to find information on my type of cancer. What little I did find was all gloom and doom. At that time, SPOHNC had not evolved into the huge, wonderful organization it is today. (Thank you, Nancy) It had only three chapters nationwide, and a limited website. I certainly didn't find any anecdotal help anywhere. So, today it is a pleasure to help people, who contact me. It's reassuring to hear from someone, who has been through the same dark tunnel, and come out smiling at the other end.

My husband and I play singles tennis for an hour every day. It's not a pretty sight, but it keeps the juices flowing, and my shoulder loose, besides, I take secret delight in making him run back and forth in hot pursuit.

If someone had told me then how well I would feel today, I would never have believed them. It has been a gradual, healing process both physically, and emotionally. I am living proof that you can survive the trauma of cancer, and return to a happy life. And, if sometimes I sound like the AFLAC DUCK, THAT'S OKAY, SHE'S CUTE!

*Valerie Targia*  
Escondido, CA

## Antioxidant May Have Adverse Effects in Head and Neck Cancer Patients

Sarah L. Zielinski

Journal of the National Cancer Institute  
jncimedia@oupjournals.org

Alpha-tocopherol (vitamin E) supplementation may have unexpected adverse effects on the occurrence of second primary cancers and on cancer-free survival in patients with head and neck cancer, according to a new study in the April 6 issue of the "Journal of the National Cancer Institute".

Studies have found an association between low dietary intake of antioxidants and an increased risk of cancer, but trials that have tested the cancer-preventive effects of antioxidant supplementation have had mixed results. Two of the most studied vitamins have been alpha-tocopherol (vitamin E) and beta-carotene, a precursor of vitamin A.

To determine whether antioxidant supplementation could reduce the risk of second primary cancers in head and neck cancer patients, Isabelle Bairati, M.D., Ph.D., of the Université Laval in Québec City, Québec, and colleagues conducted a multicenter, double-blind, placebo-controlled, randomized trial among 540 patients with stage I or II head and neck cancer who had been treated with radiation therapy between

1994 and 2000. Participants received supplementation with alpha-tocopherol and beta-carotene or a placebo during radiation therapy and for the next 3 years. (Beta-carotene supplementation was discontinued about 1 year into the trial because results from a different large trial found an increased incidence of lung cancer among smokers receiving beta-carotene.) Participants were followed for a median of 52 months.

Compared with patients given a placebo, patients who received alpha-tocopherol supplements had a higher rate of developing a second primary cancer during the period of supplementation but a lower risk of a second primary cancer after supplementation ended. Overall, the proportion of participants free of a second primary cancer after 8 years of follow-up was similar in both groups of patients. The rate of having a recurrence of the head and neck cancer or a second primary cancer was also higher during supplementation among patients receiving alpha-tocopherol than among patients receiving placebo but lower after supplementation had ended.

"This cancer chemoprevention trial was conducted in a population of patients at high risk of second primary cancers. There is some concern about the generalization of the study results to individuals in the general population who are at low risk of a first primary cancer. Nevertheless, our results suggest that caution should be advised regarding the use of high-dose alpha-tocopherol supplements for cancer prevention," the authors write.

In an editorial, Edward S. Kim, M.D., and Waun Ki Hong, M.D., of the University of Texas M. D. Anderson Cancer Center in Houston, review the current state of the use of antioxidants for cancer chemoprevention. "The field of chemoprevention still remains an exciting area of research, yet many challenges are ahead," they write. "Risk stratification factors must become more specific and scientific. This, in turn, will allow us to treat the patient in a more biomarker-integrated approach. Only then will we be able to discover that elusive 'golden apple' of chemoprevention."

## CHAPTERS OF SPOHNC

### ARIZONA-PHOENIX

Keri Winchester  
480-512-8040  
Keri.Winchester@bannerhealth.com  
Banner Medical Center  
3<sup>rd</sup> Wednesday, 5:30 PM

### ARIZONA-SCOTTSDALE

Bette Denlinger  
480-838-5194; betneldenlin@cs.com  
Virginia G. Piper Cancer Center  
2<sup>nd</sup> Thursday, 6:30-8:30 PM

### CALIFORNIA-LOS ANGELES-UCLA

Sabah Qasim, LCSW  
310-825-5707; sqasim@mednet.ucla.edu  
Pam Hoff, LCSW: 310-825-6134  
UCLA Med. Pla., Rad/Onc Conf. Rm. B-265  
1<sup>st</sup> Tuesday, 6:30-8:00 PM

### CALIFORNIA-ORANGE, UCI

Jennifer Higgins, MSW,

714-456-5235; jhiggins@uci.edu  
UCI, Chao Family comprehensive CA. Ctr.  
1<sup>st</sup> Monday, 6:30-8:00 PM.

### CALIFORNIA-SAN DIEGO

Valerie Targia; 760-751-2109  
valtargia@yahoo.com

### CALIFORNIA-SAN FRANCISCO-

Michele Francis, LCSW  
415-353-7982  
michele.francis@ucsfmedctr.org

### COLORADO-DENVER

Virgil Holdridge  
303-798-3041  
Email: virgil126@juno.com  
ACS Office, Conference Room C  
1<sup>st</sup> Tuesday, 5:00-7:00 PM.

### DC-WASHINGTON

Joanne Assarsson, MSW, LICSW  
202-444-3755

assarssj@gunet.georgetown.edu  
Lombardi Cancer Center.  
3<sup>rd</sup> Monday, 12:15-1:45 PM

### FLORIDA—BOCA RATON

Darci McNally, LCSW  
561-637-7216; DMcNally@brch.com  
Boca Raton Community Hospital.  
1<sup>st</sup> Tuesday, 3:00-4:00 PM,

### FLORIDA-GAINESVILLE

Gail Adorno  
352-265-0680 ext. 87638  
Adorngf@shands.ufl.edu  
Winn Dixie Hope Lodge  
2<sup>nd</sup> Monday, 6:00 PM to 7:00 PM

### FLORIDA-MIAMI

Annie Garcia-Montes  
786-596-6951; annieb@baptisthealth.net  
Baptist Hospital  
1<sup>st</sup> Wednesday, 5:30 PM

## FLORIDA-MIAMI

Penny Fisher, MS,RN, CORLN  
305-243-4952; pfisher@med.miami.edu  
Marty Mash: mashmarty@hotmail.com  
UM/Sylvester at Deerfield Beach, Ste. 100  
2 nd Tuesday, 1:30 PM-3:00 PM

## FLORIDA-WEST PALM BEACH

Carmine Puleo  
561-737-3699 631-226-0604  
cptess453@aol.com  
JFK Comprehensive Cancer Center  
3<sup>rd</sup> Thursday , 2:00 PM.

## GEORGIA-ATLANTA

Harmon Grotsky  
404-284-8045  
H26C30@aol.com  
St. Joseph's Hospital  
2<sup>nd</sup> Monday, 6:30-8:00PM

## GEORGIA -ATLANTA

Arlene Kehir, RN  
404-778-2369 Arlene\_Kehir@emory.org  
Winship Cancer Institute (Bldg. G)  
Last Monday, 6:30-7:30 PM

## ILLINOIS-CHICAGO

Robyn Egan  
773-834-2470  
regan@medicine.bsd.uchicago.edu  
Duchossois Ctr.for Advanced Medicine  
2<sup>nd</sup> Tuesday, 9:30-10:30 AM

## ILLINOIS-MAYWOOD

Barrett Gray  
708-327-2339; abgray@lumc.edu  
The Cardinal Bernardin Cancer Ctr.  
3 rd. Wednesday alternate mo., 6-7 PM

## MASSACHUSETTS-BOSTON

Contact: Valerie Hope Goldstein  
617-731-1703; Fernval@aol.com  
Massachusetts General Hospital,  
One Tuesday each mo, 6:30-8:00 PM

## MICHIGAN-DETROIT

Amy Orwig, MSW  
313-916-7578;  
aorwig1@hfhs.org  
Henry Ford Hospital  
1<sup>st</sup> Wednesday 1:30 PM.

## MICHIGAN-TROY

Suzanne Frantz, RN, CNOR  
586-228-2309  
sfrantz@beaumont-hospitals.com  
David C. Pratt Cancer Center  
4th Wednesday, alternate mo. 10:00-11:00AM

## MISSOURI-ST. LOUIS

Carol Murphy, LCSW  
314-251-6569; murpck@stlo.mercy.net  
David C. Pratt Cancer Center  
4th Wednesday/alternate months,  
10:00-11:30AM

## NORTH CAROLINA-CHARLOTTE

Meg Turner  
704-355-7283  
meg.Turner@carolinashealthcare.org  
Blumenthal Cancer Center  
2<sup>nd</sup>. & 4<sup>th</sup> Thursday, 1:30-3:00 PM.

## NEBRASKA-OMAHA

Susan Stensland  
402-354-5890  
sstensland@nebraskamed.com  
Methodist Cancer Center  
1<sup>st</sup> Friday 3:00PM.  
Nebraska Medical Center  
3<sup>rd</sup> Friday, 3:00 PM

## NEW JERSEY/PENNSYLVANIA

Micki Naimoli  
856-722-5574  
University of Pennsylvania Hospital  
1<sup>st</sup> Wednesday, 9:30-11:00 AM.

## NEW JERSEY, MORRISTOWN

Howard Sakolsky,  
973-586-3522; hesakolsky@aol.com  
Morristown memorial Hospital  
3 rd Wednesday, 1:30 PM

## NEW JERSEY-TOMS RIVER

Sherry Laniado, MSW, LCSW  
732-557-8270;  
slaniado@sbhcs.com  
Community Medical Center  
Every Wednesday, 1:00PM.

## NEW MEXICO- ALBUQUERQUE, NM

Anita Bryan  
505-681-1971; anitabeach2@yahoo.com  
Christ Unity Church,  
3<sup>rd</sup> Friday, 4:30-5:30 PM

## NEW YORK-LONG ISLAND

Fran Tanzella, RN  
631-444-7678  
ftanzella@notes.cc.sunysb.edu

## NEW YORK-LONG ISLAND

Nancy Leupold  
516-759-5333  
nleupold@spohnc.org  
NSLIJ-Syosset Hospital  
2<sup>nd</sup> Thursday, 7:00-9:00 PM

## NEW YORK-MANHATTAN

Jackie Mojica  
212-844-6876  
jmojica@chpnet.org  
Fax: 212-844-6976  
Beth Israel Head and Neck Institute  
4<sup>th</sup> Tuesday 1:30 – 3:30 PM.

## OHIO-COLUMBUS

Vicki Heinke, MSW  
614-293-7042; heinke-1@medctr.osu.edu  
James CA Hosp./Solove Research Institute  
1<sup>st</sup> Monday of each month

## PENNSYLVANIA-HARRISBURG

Debra Witwer  
717-691-3235  
dwitwer@oakwoodradonc.com  
Oakwood Center  
Last Wednesday, 6:30 PM

## PENNSYLVANIA-PITTSBURG

Marilyn Hudak, RN  
412-648-6527  
hudakme@msx.upmc.edu  
UPMC Montefiore Hospital

## TEXAS-DALLAS

Dan Stack  
972-373-9599  
danstack@aol.com  
Baylor Irving-Coppell Medical Center  
2<sup>nd</sup> Saturday, 10:00 AM

## TEXAS-DALLAS

Jack Mitchell  
972-496-6561; jackmitchell5225@aol.com  
Cvetko Ctr. at Sammons Cancer Ctr.  
2<sup>nd</sup> Tuesday, 11:00 AM-12:30 PM

## TEXAS-HOUSTON/TOMBALL

Marti Hosford, RN, CCN  
281-401-5900  
mhosford@tomballhospital.org  
Tomball Regional Hospital  
4th Tuesday, 12:00 noon-1:30 PM

## VIRGINIA-CHARLOTTESVILLE

Vicki Bravo  
434-982-4091; vsb4n@virginia.edu  
UVA Medical Center  
Last Thursday of each month  
12:00 noon-1:00 PM

## VIRGINIA-FAIRFAX

Corrine Cook, CSW  
703-776-2813; corrine.cook@inova.org  
Inova Fairfax Hospital  
2nd Wednesday, 5:30-7:00 PM

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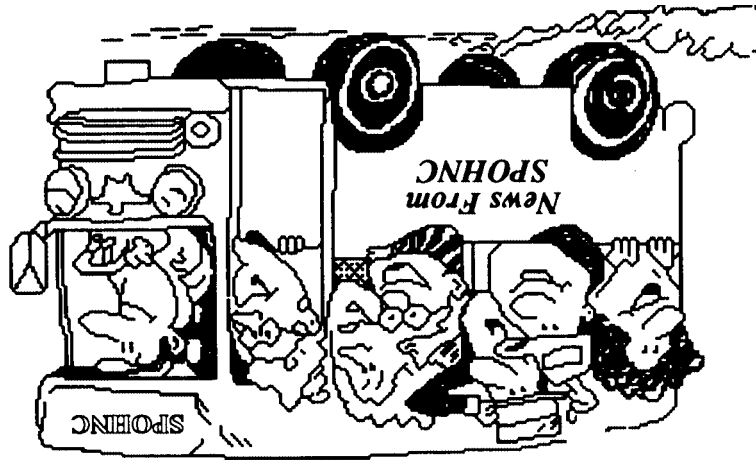
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January 1, 2005 to May 11, 2005

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*News From SPOHNC Goes on Vacation*



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