



S•P•O•H•N•C

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

RECONSTRUCTION OF THE TONGUE

ERIC GENDEN, M.D., F.A.C.S.

The tongue is one of the most complex organs in the human body. It is responsible for speech, articulation, chewing and swallowing. In spite of the years of research done to explain the dynamic movement of the tongue, its function remains a fascination to scientists who are perplexed by the tongue's unique ability to twist and turn in a coordinated fashion to produce the complex sounds associated with spoken language.

What causes cancer of the tongue? The oral tongue is one of the most common sites afflicted with head and neck cancer. In most cases, risk factors like tobacco and alcohol use are the most common causes of cancer. Poor dental hygiene and persistent oral irritation in association with a rough tooth surface has been linked to the development of oral malignancy; however, these are less common causes. There are a growing number of younger patients and patients that have no history of alcohol or tobacco use. This has led many investigators to consider environmental carcinogens such as mouth wash and food preservatives; however, there is a paucity of evidence to support these theories. Other theories including genetic predisposition, have been proposed. Future work in genetic mapping will likely reveal such genetic links.

What is the best method to treat tongue cancer? Unlike other areas of the head and neck, surgical therapy represents the most effective method for the treatment of oral tongue cancer. While there are select areas within the head and neck region that are amenable to radiation therapy, the functional morbidity and efficacy of radiation to the oral tongue is poor. As a result, the treatment of tongue cancer often necessitates removal of a portion, or in some cases the entire tongue. The amount of the tongue removed during such

an operation is largely dependant on the size of the tumor and the ability to obtain tumor- free margins. The "margin" is the disease free tissue surrounding the tumor. During a cancer resection, the pathologist works intimately with the surgeon during the course of the operation to sample and examine all of the tissue around the tumor to assure that there is no tumor within the peripheral margin. Meticulous assessment of the tumor margins and negative margins has a significant impact on the outcome and survival.

How does removing a portion of the tongue impact a patient's ability to eat and communicate? For many years, surgical management of tongue cancer meant that patients were left with devastating defects. In most cases, patients were unable to communicate and in some cases, they were unable to eat by mouth. Patients were often left with open defects, and in some cases skin grafts were used to resurface the defect. It was not until after World War II that surgeons developed local and regional skin flaps wherein adjacent tissues could be transferred into the oral cavity to reconstruct defects of the tongue. Skin from the cheek and forehead were routinely used for oral cavity reconstruction; however, the outcome was poor and the patients were often functionally incapacitated. In the early 1980's, work done at our institution led to the introduction of the pectoralis myocutaneous flap. This innovative flap allowed for a paddle of skin and muscle to be transferred from the chest wall up to the head and neck region for reconstruction of the tongue. The introduction of this flap was revolutionary and considered one of the most significant innovations in head and neck reconstruction. For the first time, patients with extensive defects of the oral cavity could be reconstructed with a flap from the chest wall. Initially, the pectoralis flap seemed to provide the tissue necessary for reconstruction of extensive tongue defects. Over the ensuing years it became clear that the initial excitement eventually waned as surgeons looked for a more ideal method for reconstruction. The bulky nature of the pectoralis flap was sufficient for patching large head and neck defects but because the tissue is bulky and tethered to the chest wall, the functional outcome was suboptimal.

What are the options for reconstructing the tongue? In the early 1980's, microvascular reconstruction was introduced. Similar to organ transplantation, microvascular reconstruction is a technique where tissue from one area on the body is transferred to another area of the body. Using microvascular surgery, the blood supply to the transferred tissue is re-established. Tissue from the arm, leg, stomach and back can be transferred to the head and neck region. Once there, the artery and vein of the transferred tissue can be connected with an artery and vein in the neck, not unlike a transplant. This tissue can be used to reconstruct a tongue, jaw, or

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COMING IN APRIL 2006

“A Vital Link: Oral Health During Cancer Therapies”
(Head and Neck Radiation and/or Chemotherapy)
Susan Calderbank, DMD

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the voice box. The introduction and subsequent refinement of such techniques has resulted in astonishing functional results that have had an immeasurable impact in head and neck reconstruction and quality of life for head and neck cancer patients. Patients suffering from tongue cancer can undergo life saving surgery and during the same operation undergo a microvascular reconstruction that provides tissue to rebuild the tongue such that it is similar to the native tongue. In many cases the nerves of the transferred skin can be reconnected providing sensation to the new tongue and near-normal function. The transferred tissue provides the bulk necessary to form speech patterns and it is free to move with the remaining tongue muscle to optimize articulation. While there are many areas of the body that can provide tissue for microvascular reconstruction, the skin of the forearm is the most ideal. The skin of the forearm provides a source of thin and pliable tissue that can be used to reconstruct the complex three-dimensional anatomy of the tongue and floor of mouth. The skin can be harvested and designed to specifically match the tongue defect to provide an ideal reconstruction. Work at our medical center has revolutionized the success of reconstruction by demonstrating that the transferred tissue can be re-sensitized to provide patients with sensation. Such innovations have resulted in improved functional results as well as an improvement in quality of life.

Microvascular reconstruction requires extensive training and a dedicated team of physicians, nurses, and surgeons. This approach provides patients with a multidisciplinary team dedicated to all facets of reconstruction, recovery and rehabilitation. The surgical procedure is only a small part of the process. The process is started by a review of each patient case in the Multidisciplinary Tumor Board where the head and neck oncology team meet with medical oncologists, radiation oncologists, pathologist, and a large group of support staff including a prosthodontist, speech therapist, and others. Each patient case is carefully reviewed and discussed. Based on the expertise of the group and the current standard of care, a treatment plan and plan for reconstruction is established.

The options for treatment and reconstruction are then carefully explained to the patient. During surgery, after the tumor has been removed, the defect is carefully assessed. There are several options for free flap reconstruction of the tongue; and based on the defect, the needs of the patient, and the patient’s preferences, a donor site is chosen and the flap is harvested. The microvascular surgery used to reattach the blood vessels of the flap into the neck is performed under high powered magnification. The sutures used for the vessel repair are barely visible without magnification.

Once surgery has been completed, the patient is monitored carefully in the intensive care unit. Although rare, the small vessels nourishing the flap may clot at any time. A core of highly skilled nurses and doctors monitor the flap reconstruction every hour watching for changes in blood flow. If there is any sign that the blood flow is compromised, the patient is immediately transferred to the operating room for exploration. The success rate for microvascular surgery at our institution is nearly 99%; however, every patient is carefully monitored.

Following the initial recovery, patients are often evaluated by the team dentist, speech therapist, and physical rehabilitation

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team. In most cases, seven days after surgery, the patient begins swallowing therapy with the careful help of the speech and language therapist. The entire team works in a coordinated fashion to maximize recovery and provide the patient with all the tools necessary to achieve a full recovery. Although patients are usually able to eat and speak 7 to 10 days after surgery, it often takes several weeks before they are comfortable with the reconstruction. Intense therapy can provide patients with the training to develop normal speech and eating. Many of the patients function as if they never had surgery while others have a slight detectable dysarthria (articulation problem).

The advances in tongue reconstruction have provided patients with the opportunity to maintain their self expression after extensive surgery. Where patients were once forced to live with debilitating defects, microvascular reconstruction has provided surgeons with an irreplaceable tool.

What does the future hold for reconstruction of the tongue? As a result of work done at

The Mount Sinai School of Medicine, techniques in tongue reconstruction have become refined to the point that many patients are able to function normally after undergoing a near total glossectomy. Most patients are able to speak with only a minor deficit and most can eat a regular diet. Since the introduction of microvascular surgery, there has been a concentrated effort on refining head and neck reconstruction. This has been a challenge largely because the complex functions associated with the organs of the head and neck are difficult to replicate. Transplantation has been an area of increased interest among head and neck surgeons. In addition to experimental work done in tongue transplantation, experimental transplantation of the trachea, thyroid, and parathyroid glands has proved promising. Recently, the first successful larynx (voice box) transplant was performed.

Because the complex movement of the tongue is difficult to replicate using flap techniques, transplantation may represent a viable alternative. Experimental success in tongue transplantation is promising

however immunosuppression remains a challenge. Our group, and others, has shown that transplantation clearly has a role in the future of head and neck reconstruction.

In caring for head and neck cancer patients, the quality of a patient's life is as important as the quantity of one's life. As we develop surgical, radiation, and chemotherapeutic protocols to improve survival in cancer patients, it is important not to forget that survival and quality of life often go hand and hand. Reconstructive techniques such as microvascular free flap reconstruction provide patients with the opportunity to eat, speak, and enrich the quality of life following head and neck cancer surgery. Microvascular reconstructive surgery provides patients the opportunity to enjoy the benefits of speech and eating without compromising an opportunity for cure.

Editor's Note: Eric M. Genden, M.D., F.A.C.S., is Chairman of the Department of Otolaryngology and Head and Neck Surgery and Immunobiology, at Mount Sinai School of Medicine, New York, NY.



Introgen Therapeutics, Inc. Announces Oral Health Alliance with Colgate-Palmolive Using Introgen's Molecular Therapies

In early November of 2005, Introgen Therapeutics, Inc. announced an alliance with Colgate-Palmolive Company to develop and potentially market oral health care products. The terms of the alliance call for the development of specialized formulations of Introgen's molecular therapies targeted at pre-cancerous conditions of the oral cavity and oral cancer. Research and development activities in the alliance will be conducted by Introgen and will focus on oral formulations of Introgen's molecular therapeutics employing tumor suppressors such as p53, mda-7, and FUS1. Introgen academic collaborators are conducting a phase 1/2 clinical study using INGN 234, a mouthwash formulation

delivering the p53 tumor suppressor for oral cancer prevention in patients diagnosed with leukoplakia, a pre-cancerous condition that can lead to oral cancer. Leukoplakia is usually diagnosed by dentists and, according to the journal, "Practical Periodontics and Aesthetic Dentistry", occurs in approximately 3 percent of the adult population. "We are enthusiastic about the opportunity to apply Introgen's molecular agents to develop oral care products with Colgate-Palmolive," stated David G. Nance, Chief Executive Officer of Introgen. "We believe future commercial applications of therapeutic genes will include topical formulations such as those developed for oral use under the alliance

with Colgate. The tissues lining the oral cavity may be particularly well suited and accessible targets for molecular therapies that can arrest abnormal cell growth without harming normal cells. We believe that repair of damaged cells and safe elimination of malignant or pre-malignant cells from the mouth could represent important therapies for dentists, oral health professionals and oncology specialists to prevent and treat oral diseases. We expect to investigate new formulations of oral rinses, gels or other topically applied products under the Colgate alliance." Excluded from the alliance with Colgate are Introgen's current portfolio of cancer product candidates, i.e. ADVEXIN, INGN 241, INGN 225, and INGN 401.

A TIME FOR SHARING

It was February 9, 2005 when, after days of having a problem with my tooth and gum, I went to see my oral surgeon. After sitting down in the chair (we all love to hate) he told me that the tooth and gum problem was something he could take care of; however, there was a lesion at the back of my tongue that needed to be biopsied. Waiting twelve days for the results of the biopsy was agonizing. It was February 21, President's Day, when I called the surgeon and spoke to his nurse. She explained that the doctor never gave results over the phone and that I would need to come in to see him that day. After telling her that we just had a foot of snow, she replied, if not today then definitely tomorrow. That made me even more worried. My wife and I proceeded to dig out the car and drive over to the doctor's office.

We arrived at his office (a 15-minute drive) 45 minutes later. We were greeted by his nurse and escorted right into the examining room. When the doctor came in I could see on his face that the news he was about to give me, was not good. He proceeded to explain that the biopsy came back with a diagnosis of squamous cell carcinoma. He told me that I needed to make an appointment with a head and neck surgeon immediately and recommended someone in New York City. My wife and I thought that it might be a good idea to find someone on our plan that was more local and affiliated with a good hospital where we live. I called and made an appointment with a local surgeon who had more than 30 years experience as a head and neck surgeon.

On Feb 23rd we went to the local surgeon. When we sat down in his office and explained to him why we were there he said he needed to examine me. After spending less than 5 minutes with me, he said "let's talk in my office". He proceeded to tell me, as he was drawing me a picture, that I had the worst case of head and neck cancer he had ever seen and that, even if I had surgery, at the best I would maybe have 2 years to live. He could not do the surgery because it was too complicated for him and said I should go to New York City and see another surgeon. He then told me that I should go home, write out my will, get all my papers in order, say goodbye to everyone

and hope for the best. My wife and I were stunned. We said goodbye to the doctor and walked out of the office hysterical. The first thing I did was call my son who works in one of those good "city hospitals" and asked him to find me a doctor quick. He told me, "I will call you back in 5 minutes". When he called back he told me he had just the doctor I needed and that he was the best in his field. He said the doctor had been working with the most advanced procedures for head and neck cancer. He made an appointment for me to see the doctor on Friday afternoon and would meet me there.

It was Friday February 25, 2005; 3:00 P.M. at the doctors office in New York City. The head and neck surgeon came into the examining room and greeted me with a big smile (made me feel better already) and proceeded to examine the area. The examination took all of 2 minutes. He sat down in his chair and told me that he was about to explain all the details of the surgery and that it might take a while, so I should hold all the questions until the end as he might answer most of them in his explanation. He started off by telling me that I would be just fine; (I cried.) that he does this same type of surgery 3-4 times a week; and that most people have a full recovery. He explained that the tumor and the surrounding area of the tumor needed to be removed including the lymph nodes on the left side of my neck. This would mean that close to three quarters of my tongue would have to be removed, but that area can be reconstructed using the inner part of my wrist. What he would do is take muscle, tendons and an artery from my wrist (a free-flap transfer) and reconstruct the portion of my tongue that he would remove. I was amazed to say the least. He squeezed both my wrists so he could check blood flow to see which arm would provide "optimum results". Well my luck! It was the right wrist and yes I'm a "righty". A small price to pay to get my life back.

The surgeon explained I would need to have a complete physical, a PET scan and a CT scan before surgery. He needed to know if the cancer had spread to my lymph nodes or any other organs. He was right, he did answer almost all my questions except one. That

question was, "Why was I so blessed to find such a great doctor". I could answer that myself- because God is good, as my old and dear friend, who I worked with for so many years, always told me. Now I believe her even more. The surgeon proceeded to tell me he was going on a 10-day cruise, and that I would be his first surgery when he returned fully rested on Mar. 7th. I would like you to know that my son, who found this great doctor for me, only started to work for this hospital a few months before. Also more reason to believe.

Well the time had come. It was the morning of March 7th. After a sleepless night I went to the hospital with my wife and son. I sat and waited to be called with a pager, (the same as you get when waiting for a table at a restaurant). When I was called, I went through all the normal things to prepare for a surgical procedure; except, you don't realize how cold the hospital is until you get that gown and that's all you have on. Well they told me that they needed to transport me to the surgical floor and my family would be waiting for me there when the surgery was over. Yes I was scared to death, but I was so confident in my doctor it relieved some of my fear. Leaving my family was very hard. With hope in my heart they took me to the surgical floor where I met all the doctors, and I mean all seven of them, yes seven. All made me feel confident that everything was going to be all right.

I didn't remember anything about the surgery; however, my wife told me that I was in such pain that they had to strap me down so I wouldn't pull out any of the IV's that were literally all over my body. I needed my pain managed so my wife spoke to my son and my son knew the person in charge of palliative care to come down and speak with the doctors. The palliative care staff managed the pain so as to allow the patient to wake from the anesthesia with minimal discomfort. When I awoke I had a tracheotomy and was hooked up to a respirator. My surgeon had told me that most of my pain would not be in my mouth but in my wrist and arm at the site of the free-flap transfer. He was right. My arm was in a splint and then a soft cast immobilized on a pole. To add to my discomfort, the doctor

then told me he needed to remove and re-insert the nasal feeding tube because it was in my lung instead of my stomach. They tried 3 times without success. They called a company that had a new technique to insert the tube. The special tube had a camera on the end. They would "see" the path into my stomach from the picture the camera relayed to a monitor. Just another added attraction to my stay. Oh, in addition, the residents would come every 2 hours and prick my new tongue to check the circulation (Was that a lot of fun!).

The next thing I remember was being moved from ICU to the "step down unit" where a nurse is dedicated to caring for three or four patients. I was in that unit for about two days with IV's and a trach and the most unbelievable dedicated nurses I have ever met. When my surgeon came in to see me (that was the first time I remember seeing him after surgery) he touched my hand and said "everything went well, and you should be fine". I felt a miracle had happened, but I could not forget what the first doctor had told me. I kept saying to myself, "Oh God, thank you for giving me a second chance at life." They soon moved me to a private room and then I knew I was on my way out of the hospital sooner than later.

On Monday morning my wife came to my room at 9AM and we both waited on pins and needles for the speech pathologist to arrive to test my ability to swallow. The On-call doctor had removed the feeding tube in preparation for the "big event". When the speech pathologist arrived, she gave me a glass of water. I had no problem drinking it; in fact, I could have drunk a gallon. The applesauce went down with no problem, also, and I asked for more. I never cried over a meal before, but this one I did. Well everything went well and I was leaving the hospital.

It was Monday March 14, a very good day for me. My wife and one of my best friends came to take me home. Just feeling the air outside made me count my blessings. Very shaky, but able to walk with the help of everyone. I went home to an incredible amount of get well wishes from everybody I know. I had so many flowers I could have started my own botanical garden. The phone never stopped ringing that day; everyone wanted to hear how I was doing. There was shock when I talked to some of the people calling, because

they never thought in a million years that I would be able to speak so well after such a complicated operation. I had people crying on the other end of the phone. Then I started to cry, also.

For days after my return home, I felt very weak. We contacted the Visiting Nurse Services. They had a nurse come and evaluate my condition and start the needed services they thought I should have. A visiting nurse came four days a week to change the dressings on my arm and wrist. I also had a skin graph that needed attention. This skin graph was on the upper part of my right leg. This skin was needed to cover the parts of my wrist that were needed for the reconstruction of my tongue.

I also had a speech therapist come three times a week, and an occupational therapist began coming three or four times a week, too. The speech therapist helped me with exercises for movement of my tongue and for articulating specific speech sounds. She left me many exercises to do on my own. The occupational therapist worked on exercises to help me get the strength back in my wrist and forearm. They were very painful to do. I had very little movement in my wrist and arm because of the extensive surgery. In the beginning I thought I would never be able to use my right arm again. This was very scary. I worked very hard day in and day out with all the exercises. Persistence and perseverance were the keys to my healing.

Ten days post op I went to see my surgeon and my best friend for life. He examined me and told me he got a "clean cut" which meant that the tumor, and all the cancer from the surrounding site had been removed. He explained that no cancer was found in the lymph nodes. Consequently, I would not need radiation. What a present to give me! (Chemotherapy was never an option with my type of cancer). So I walked away with ONLY (really) the surgery needed. My surgeon told me I would need a PET scan and CT scans every three months. If I stayed clean of cancer for two years the chances of it not coming back were very good.

I continued with three months of visiting nurse services, speech therapy, occupational therapy, and some of the most tiring days I ever had. I never thought that things I took for granted could become the hardest things to accomplish. For example, something as simple as opening a bottle, or eating lunch. It took

me 40 minutes to finish a bowl of soup because my hand hurt so much just lifting up the spoon. Well, with perseverance, I succeeded in doing what was necessary to get back to a normal life. After Memorial Day I decided I was going back to work part time a few hours a day.

June 6th I returned to work part time. What a great feeling it was to get back to work with the people I so enjoy working with. For days and weeks I must have told my story a thousand times (I'm sure Jerry, my co-worker and good friend, was getting tired of hearing the story but never once told me that). The feeling that I had was of disbelief. Why do I say that; because on Feb. 21st when the dentist told me that this lesion was cancerous, I thought my life was coming to an end, and now here it was less than four months later.

On June 16th I had an appointment with my surgeon. I sat in the office again waiting for this agonizing exam (don't get me wrong I think it's the thought of the exam and not the exam itself). In came my smiling doctor. After the exam, he told me that I was looking very well, and that everything was great. Deep breath! He wanted me to schedule a PET scan and a CT scan, which I did. Another agonizing 10 days went by waiting for the results hoping and praying that the radiologist would find absolutely nothing and I could have somewhat of a normal summer. Well the results came back clean. Hawaii here I come! Yes, we planned this trip before my diagnosis and I was optimistic that I would be ok. On July 24th we were off to Maui. I'm so glad we didn't cancel our trip.

Three months later, on September 15th, I was back at my surgeon's office for my 6-month exam. I worry weeks before every exam thinking of what the exam will show; how the test results will come out; and if my life will ever be the same after hearing what the doctor will say. Well my surgeon came in smiling again. I must add that in my 55 years of life I've seen many doctors (as I'm sure we all have), but here was a doctor with the finest credentials in this profession who also has the greatest personality you would ever want in a doctor.

My surgeon examined me and again told me that I looked wonderful and there was no reason to see me before Feb. 06. I sat there in shock for I thought I would have to come

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WITH CANCER, TREATMENT IS ONLY PART OF THE PICTURE

JANE E. BRODY

More than 10 million people in the United States are cancer survivors, and their numbers increase daily. Many are considered cured. Some are still in treatment and one day may — or may not — be counted among the cured. Others are living with advanced disease.

But nearly all have similar needs:

- ◆ A need to know about and cope with the physical and emotional consequences of cancer and its treatment, including current challenges to quality of life and delayed health effects.
- ◆ A need to know when to worry and when not to worry about symptoms that could signal a recurrence or a new cancer.
- ◆ A need for reliable information and assistance on matters like diet, exercise and smoking cessation that may improve survival chances.
- ◆ A need to deal with employment and insurance problems related to their medical histories.

Such needs inspired a panel of the National Academies this to call for major improvements in follow-up care for cancer patients, who are too often left to struggle on their own with serious cancer-related matters.

Making a Plan

“Successful cancer care doesn’t end when patients walk out the door after completion of their initial treatments,” said Dr. Sheldon Greenfield, director of the Center for Health Policy Research at the University of California, Irvine, who led the committee.

Patients need to have a “survivorship care plan” that provides information critical to proper long-term care, including the exact cancer diagnosis, a detailed list of treatments received and the potential consequences of those treatments.

“Cancer can be considered a chronic disease, in part because of the serious consequences and persistent nature of some of cancer’s late effects,” the committee said. This suggests that cancer survivors, like other patients with chronic diseases, need a plan for optimal functioning.

The committee’s findings are spelled out in a 500-page book, “From Cancer Patient to Cancer Survivor: Lost in Transition,”

produced by the Academies’ Institute of Medicine and National Research Council. Their recommendations were endorsed by the American Society of Clinical Oncology, which represents 20,000 cancer treatment specialists, but it could take years for doctors to carry out the measures nationwide.

For now, there are steps that cancer survivors can take on their own to enhance their knowledge and improve their medical, emotional and social well-being. If patients cannot do this for themselves, then someone who can serve as the patient’s advocate — a family member or friend — should do it for them.

A friend who just had surgery for breast cancer asked me how she could improve her diet or exercise habits and what supplements she should take to ward off a recurrence. In advance of further treatments, she also wanted to know how her appearance and sex life would be affected, now and in the future, by the various choices of postsurgery drugs and radiation.

In the next 12 months, more than 211,000 women who learn they have breast cancer will face similar questions, but few will know how to get reliable answers.

Many will go through life feeling as if the sword of Damocles hangs over their heads. I recognize the feeling. Although I have every reason to believe I was cured of breast cancer six years ago, I do worry whenever I get a new symptom that I can’t explain, like a pain in my ribs, a suspicious bruise, soreness in my breast. Could it mean my disease has recurred or spread?

Waiting for Warnings

I was never told what to look out for. Nor was I told that hardening and extreme sensitivity of breast tissue could be a lasting consequence of radiation therapy. How many breast cancer survivors now taking an aromatase inhibitor like Arimidex know that their risk of developing osteoporosis and fractures is increased as a result, and what they can do to reduce that risk?

When faced with a life-threatening illness, most patients readily accept their physicians’ treatment recommendations no matter how dire the potential consequences.

Only later do they wonder if something might have been done, say, to preserve their fertility or virility or to prevent lymphedema, chronic swelling of a limb after lymph node removal.

Patients have a right to know beforehand if surgery planned for head and neck cancer is likely to affect their ability to speak, swallow or breathe, or, for patients with prostate cancer, what their chances are of experiencing incontinence or erectile dysfunction as a result of surgery or radiation therapy.

It’s not that knowing possible side effects is likely to prompt cancer patients to reject life-saving treatment. Rather, a prepared patient is better able to deal with such life-disrupting consequences. On the other hand, a patient who will gain only a short period of time from a debilitating therapy may choose not to be treated.

Writing It Down

At the time of diagnosis, through the course of treatment and after treatment is completed, patients or their advocates should come equipped to ask questions and record answers when meeting with their physicians. They should leave with a written record that includes these items:

The precise nature of the cancer, including its pathological type and stage, indicating its aggressiveness, scope and likelihood of spreading.

The treatments received, including the type and extent of surgery or radiation treatments, and a complete list of chemotherapeutic drugs and medications to prevent relapse, along with their possible long-term effects.

A monitoring program to check for the late effects of treatment, like heart damage, thyroid disorders or bone marrow disease.

A follow-up plan to check for a recurrence or the appearance of a second cancer.

A list of symptoms that might indicate recurrence or spread of the cancer.

Advice about diet and exercise that can help improve stamina and immune defenses and counter post-treatment depression, and referral, if needed, to a smoking cessation program.

A list of self-help groups for emotional

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SHARING continued from page 6 every 3 months for the first year. He told me that I was doing so well there was no reason to see me before my one year anniversary; however, if I had any problems I was to come in sooner. I was ecstatic.

So here I am, writing "A Time for Sharing" more than 11 months post-op and I'm back to work full time. I also started up a chapter of SPOHNC in Westchester, NY. I'm continuing to produce my local cable TV show that I have been doing for 10 years, and most of all I'm happier than I have ever been in my life. I never thought it was possible. I have to say I owe my life to many people, my wonderful and caring wife and my best friend for almost 34 years; my son, who looked after me and found a miracle doctor for me; my daughter who I hold so close to my heart; my grandson who by just thinking of his beautiful face gave me strength to go on; and all those friends and family members who were always there for me in my time of need; and of course, without saying, my head and neck surgeon. Without him, I don't know what kind of life I would have had. So God bless him, so that he can continued to do for others what he did for me.

Yes the winter is hard on my arm and wrist. It doesn't like the cold weather and it tells me so. I look at life in a whole different way. But I'll leave you with one thought that I have every day of my life: A positive attitude and hope for good health is essential for recovery.

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CANCER continued from page 6 and sometimes practical support, friendship and understanding of the problems of cancer survivors. The diagnosis of cancer often becomes a "teachable moment" — a chance to persuade people to change habits that might have contributed to their disease or that may impede their recovery.

Many cancer patients and survivors continue to smoke because they believe it is too late to quit, but cessation of smoking can reduce treatment complications, improve survival chances and reduce the risk of a second cancer, as well as the risk of developing heart and lung disease.

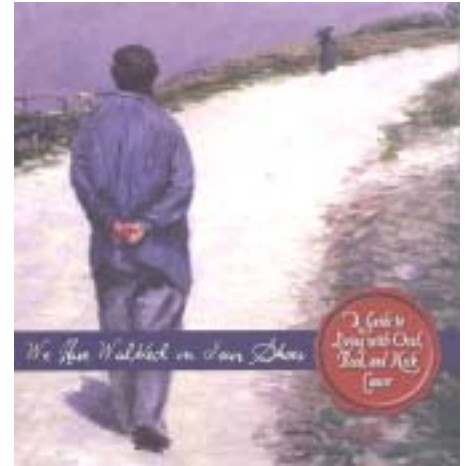
Likewise, survivors should be encouraged to be active. An increase in physical activity enhances their vigor and vitality, cardiopulmonary fitness and overall quality of life and counters post-treatment depression, anxiety and fatigue.

For significantly overweight patients, better diets emphasizing fruits, vegetables, whole grains and lean protein can improve survival among those with breast and prostate cancer.

As for unconventional remedies, the new report cites potential benefits from massage, imagery, relaxation training and participation in support groups, but notes that other measures, like phytoestrogens for breast cancer survivors on anti-estrogen medication, can be harmful.

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