



S•P•O•H•N•C

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

A VITAL LINK: ORAL HEALTH DURING CANCER THERAPIES (HEAD AND NECK RADIATION AND/ OR CHEMOTHERAPY)

SUSAN CALDERBANK, DMD

How about something that you, a cancer patient, can control? Something essential for your care? Something that needs to be part of your protocol, but often remains under the radar. Hopefully the following information can help patients become strong advocates for proper oral care during cancer treatment. Current estimates reveal that one in every two males and one in every three females will develop cancer. Statistics show that of those patients receiving chemotherapy 40-50% will develop treatment related oral side effects. If the treatment of choice is a stem cell or bone marrow transplant, this figure jumps to 75-90%. When head and neck radiation is the treatment modality and the oral cavity is in the field of radiation, virtually all of these patients develop oral complications. These treatment induced oral side effects are the number one reason that patients have to temporarily discontinue or stop their treatment protocols.

The prevention and management of oral complications greatly enhance a patient's chance of survival and ensures a better quality of life during and after treatment.

Two key issues stand out: the prevention or reduction of oral side effects and the maintenance of a patient's quality of life. Treatment plans must address these components of the cancer patient's overall care. These two key parts are simultaneously the most important and yet the most neglected aspects of treatment planning for these patients. They are not often discussed within the scope of a physician's oncology residency program and when

they are, they are not emphasized. Yet, when a cancer patient who is actively under treatment dies from an infection, it is estimated that 56% of the time the infection originates in the mouth.

In 1989, The National Institutes of Health held a Consensus Development Conference entitled The Oral Complications of Cancer Therapies: Diagnosis, Treatment and Prevention. Once the Conference's consensus development statement is published, this becomes part of our national standard of care. The number one recommendation of the conference was that every cancer patient should receive a pretreatment oral evaluation and any potential sources of infection be eliminated *before* initiating cancer treatment. Sadly, 15 years later, this recommendation is largely not followed.

Dental professionals have been schooled in the concept of prevention from the first day of professional training. Prevention of dental decay and periodontal or gum disease is the benchmark of a successful dental practice. When dental professionals are an integral part of the cancer management team, the treatment induced side effects can be greatly diminished or prevented. The concept of damage prevention as opposed to damage control is one that certainly applies to the cancer patient.

The notion of "Quality of Life" is a frequently mentioned topic in health care circles these days, but it often seems to bypass patients actively receiving cancer therapy. This issue only comes to the forefront when the patient begins to physically decline. The frightening diagnosis of cancer often leads a patient down an aggressive path of treatment that is solely focused on the eradication of the malignancy with little regard to the "*rest of the patient.*" Physicians are so cancer focused that the side effects of the treatment are seen as an inevitable sequelae of what they hope will be a victory. In the ensuing battle, the patient's quality of life is frequently compromised. Unless dental professionals are involved at the *pretreatment level*, oral health for the cancer patient will never receive the important recognition that is needed.

BACK TO BASICS

In order to grasp the severity of the potential oral side effects of cancer therapy, one needs to have a basic understanding of the oral tissue. At the most basic level, chemotherapy is designed to poison the cancer cells, and radiation is designed to kill the cancer cells by producing internal cellular damage. Both of these treatments are effective and both also harm normal, healthy tissue. All too often cancer patients think that their treatment is like a magic bullet aimed at the cancer cells and destroying only the cancer cells. Chemotherapy is designed to stop the most rapidly

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COMING IN MAY 2006
The Role Of The Medical Oncologist
In The Treatment of Head And Neck Cancer
Bhoomi Mehrotra, MD

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dividing cells, i.e. the cancer cells. In a healthy individual, the most rapidly dividing cells are the lining cells of the oral cavity and the upper esophagus. This is because in normal every day life these cells are lost or sloughed off due to chewing and eating hard or scratchy foods. When a patient receives chemotherapy, there is a direct and harmful effect on the mouth tissues. These tissues become thinned, inflamed and may also ulcerate. Once the tissue ulcerates, the normal mouth microorganisms (bacteria, fungi and viruses) are allowed to enter the bloodstream and go throughout the body. These chemotherapeutic drugs also have a direct effect on the vascular, inflammatory and healing responses of these tissues. These ulcerations and associated inflammation are called *mucositis* and they are the first and the most common oral side effect. Hot and spicy foods should be avoided as well as those foods which may scrape the inside of the mouth. Alcohol and carbonated beverages may also irritate the mouth. Mouth ulcers can occur as soon as 8-10 days following the beginning of chemotherapy. Ulcerations caused by radiation are very similar and carry the same risk of leading to a systemic infection. They also have the same precautions as far as eating and drinking.

Oral infections are also very common in the cancer patient when the ability to fight infection is lost as the white blood cell count drops. By far the most common infection is the fungal infection which is characterized by redness of the tissue, a burning sensation and a white coating most frequently found on the tongue. Viral infections are becoming increasingly more common and can be very destructive. Those patients who experience frequent cold sores or "fever blisters," or who have had shingles or recent chicken pox, should consult with their physician concerning anti-viral therapy during their cancer treatment. An intensive oral hygiene program including brushing, flossing and rinsing with an antimicrobial rinse is essential to lower the number of bacteria and other organisms in the mouth.

It is common knowledge that chemotherapy drugs target the cells in the bone marrow that produce white blood cells (infection fighters) and platelets (those cells which make the blood clot). Therefore, infections in these patients are not only unpleasant side effects, they can develop into life threatening situations. The increased risk of infections and the possibility of extensive bleeding episodes present grave risks to those requiring dental care once cancer treatment is started. This is another reason why dental care must be done *ahead of time*. Full cooperation between the dentist and the oncologist has a direct impact on patient safety.

Few patients are as damaged by treatment as head and neck radiation patients. In addition to burning on the skin, when the oral cavity is in the field of radiation, *permanent* damage may be done to the salivary glands and to the jaws opening and closing mechanism. If the salivary glands are damaged, the resultant dry mouth can be oppressive. The ability to eat and speak correctly may be effected. Moisturizing Gel (Oral Balance) gives patients tremendous relief and can be applied to irritable tissue. The simple use of a solution of baking soda and water is often successful in eliminating the burning sensation caused by more acidic saliva.

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Fluoride (sodium fluoride 5,000 parts per million) as directed by a dentist will help to prevent the rampant decay experienced by head and neck radiation patients. Patients should always use soft toothbrushes! When the temporomandibular joint or jaw hinge is in the field of radiation, stretching the mouth open as wide as possible 10X-3X per day can eliminate the "frozen" jaw joint. It is essential to understand that the side effects of head and neck radiation last a lifetime! In spite of strategies employed such as use of fluoride over the counter products to control the devastating radiation side effects, it is a fact that radiation patients are normally only compliant with the use of these strategies for 12-18 months. They need to be educated to realize that it is necessary to be compliant for the rest of one's life in this regard!

BACK TO THE FUTURE

Following the Consensus Development Conference, the 1990's should have been the decade during which the new standard of care was implemented for the cancer patient. Unfortunately, this has not occurred. Reasons often cited for this deficiency include oncologist apathy, lack of adequate training in residency programs concerning this topic, delay of treatment for the patient, lack of patient education and lack of reimbursement.

Now is the time to go "back to the future" and get it right! The potential for oral side effects always exist and the results of these oral side effects can often be devastating and life threatening. Their occurrence is most often related to the present state of the oral cavity (i.e. patients with existing tooth and gum disease are more likely to encounter treatment related oral side effects.)

It is the standard of care that all patients who will be undergoing cancer therapy receive a prior dental evaluation. Two concepts that are mandatory to focus on at this stage are patient education and the education of the primary care giver. The cancer patient will usually arrive at the dental office confused, apprehensive and wishing to be most anywhere else! A comprehensive orientation program will

convert the above patient into a knowledgeable and compliant patient. It will also give the primary care giver the tools to keep the patient motivated during the course of treatment. The thought process that must be communicated to the patient is that the control of the oral environment is the only area truly under the patient's control. They have limited control over how they got the cancer, limited control over the cancer treatment protocol, no control over the activity of the cancer cells and no control over how their bodies will respond to treatment. Patients are made aware that they can control the cleanliness of their mouths, restrict the amount of sugar they eat, and add fluoride to their daily routine. Adherence to the proposed maintenance schedule enables the patient to continue with good nutrition in a pain free manner. Control over this aspect of a patient's life is essential to a patient whose life is otherwise out of control.

The procedures that would follow this orientation phase would include:

1. A thorough history including medication use
2. A full cleaning and examination to detect any potential source of infection
3. The restoration or extraction of any tooth that might become a source of infection. In the case of an extraction, one must wait 14-21 days before beginning cancer treatment.
4. The removal of any sharp edges on dentures, partials, and teeth.

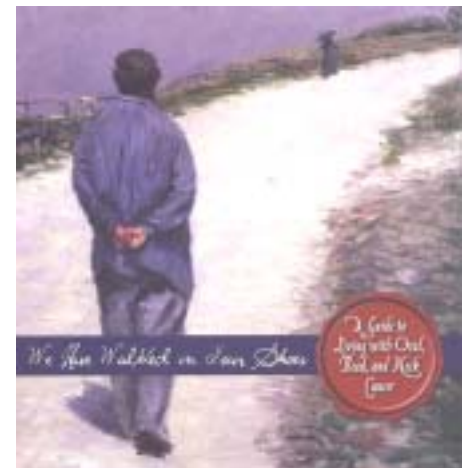
Cancer patients also require frequent recall appointments, often in a weekly format. This will enable the dental practitioner to troubleshoot areas before major symptoms develop. These visits are usually very short in duration. They are important in the prevention of uncontrolled infections and the evaluation of patient compliance.

MAKE THE FUTURE HAPPEN

Oncologically-related dentistry is just another aspect of preventative dentistry. It is of utmost importance that it becomes an integral part of the cancer patient's treatment plan. Public education programs regarding this topic must be developed in

conjunction with the in-service education of all cancer healthcare personnel. Not only is the dental care of the cancer patient the current standard of care, it is the *moral and ethical* responsibility of the healthcare provider to ensure that all cancer patients receive this essential service.

Editor's Note: Susan Calderbank, DMD, currently in private practice in Greenville, Pennsylvania. In addition to being a staff dentist at the University of Pittsburgh Medical Center/Horizon Campus, Dr. Calderbank is an associate professor at the University of Pittsburgh School of Dental Medicine.

NOW AVAILABLE

"We Have Walked In Your Shoes, A Resource Guide to Living with Oral, Head and Neck Cancer"

This book contains basic information about oral and head and neck cancer and provides resources for patients and families facing a diagnosis of this type of cancer, its treatment, rehabilitation, and recovery. It is not intended to replace any information and/or recommendations made by health care professionals. It is designed to help you get the answers you need. It summarizes the most common advice on living with oral and head and neck cancer, provides you with resources if you want more information, and offers practical tips as well as weekly and monthly calendars to help you track your treatment.

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1-800-377-0928.

A TIME FOR SHARING

The Importance Of Early Detection

It was 5:15 PM, March 22, 2005 and I had just returned from dinner to start my evening hours, when my office manager handed me the fax from the Oral Pathology Department at Temple University. My diagnosis from the previous Friday's biopsy was Squamous Cell Carcinoma. I was shocked! This can't be happening to me, I'm a dentist with no risk factors. I was 59 years old. As it turned out, it was a good thing I am a dentist. Someone else might have ignored the non healing sore.

I had noticed the ulcer and it hadn't been painful. I'm not sure how long it was there before I realized it wasn't going away. I thought maybe it was caused by that new cinnamon flavored toothpaste I recently started using. So, I waited a week or two before asking my oral surgeon to do the biopsy. Neither of us suspected cancer. It was just an ulcer.

The next 11 days were a whirlwind of appointments. I picked up my slides from Temple University and brought them to the Fox Chase Cancer Center. My newly found surgeon, the Chief of Head and Neck Surgery, wanted his pathologist to read the slides. Several days later, my wife and I met with the surgeon. It was his opinion that since I had apparently found the cancer so early, the treatment of choice was a partial glossectomy and a modified neck dissection. I was lucky that the surgeon had a cancellation in his schedule and my surgery was planned for the next week. The radiation oncologist would later confirm, "No radiation and no chemo"!

Pre-op testing and meetings with the radiation oncologist, physical therapy and speech therapy departments took up a full day. Those 11 days are a complete blur now, but somehow I got through them and still kept a full schedule treating my patients until the night before surgery.

When the word about my cancer got out to my local dental community, I was contacted by a colleague, who told me about a tongue cancer survivor, Eva Grayzel Cohen. Eva had been told by her dentist, oral surgeon and the pathologist that read

her biopsy slides that she did not have cancer. Approximately 2 years later she was diagnosed with stage 4 squamous cell carcinoma. I had several phone conversations with Eva prior to my surgery. Her positive attitude and upbeat comments, made me feel much calmer going into surgery.

The morning of the surgery was spent with my wonderful and supportive family. My two adult children joined my wife and me waiting for the OR to become available. The 3 hours of surgery were easy for me. For those waiting, it's always more difficult.

I was released from the hospital 3 days after surgery. The surgical pathology report was excellent. The tongue tissue removed during surgery showed no cancer cells. All 30 lymph nodes were clear.

I spent the next 7 days trying to figure out how I was ever going to eat solid foods again and to speak normally. I slept and dozed on and off most of the time. During that time I was nursed back to health by my loving wife. Family, friends, colleagues and some of my office team members visited and helped me pass the time. Drinking a bottle of Ensure took half a day and it took an hour to get down 2 teaspoons of Tylenol with codeine. My first bite of solid food was quiche. Yes, real men do eat quiche and it sure was good. It's amazing how I never felt hungry until that first taste of solid food on day 10.

Due to the neck dissection, my left arm and neck had limited range of motion. I knew everyone was lying to me when they said I sounded normal. To me I sounded like I had marbles in my mouth when I spoke. With the help of my wonderful physical and speech therapists at Fox Chase, it took about 3 months to regain full range of motion in my arm and neck and to start speaking normally. I went back to work in 3 and a half weeks with a reduced schedule. Although I was working slower than usual, I was able to resume a full schedule the next week.

I have previously mentioned Eva Grayzel Cohen and how much she helped me

prior to surgery. Eva, who is a world known storyteller, www.evagrayzel.com, has devoted part of her web site to early detection of oral cancer (see the links to [Red Balloon Group](#) and [For Dentists & Hygienists](#) – Click Here). She speaks publicly about it, whenever she can. She was featured in two videos made by the American Dental Association a few years ago when they had a campaign stressing early detection. She was also the keynote speaker at the ADA's annual session that year. Eva did a video about oral cancer with the Surgeon General at that time, Dr. Richard Carmona. Links to these videos are on her website.

After about 10 days I started feeling well enough to sit at my computer and I found and joined the Oral Cancer Foundation and began participating in their on-line forum. As stated on their website, the Oral Cancer Foundation is a national public service, non-profit entity designed to reduce suffering and save lives through prevention, education, research, advocacy, and support. It was started by Brian Hill, an oral cancer survivor who had a strong dental background as the owner of Implant Support Systems Inc., a dental implant manufacturing company.

Around the same time I also found and joined SPOHNC and spoke with Nancy Leupold. I suggested that she contact Eva Grayzel to be the keynote speaker at SPOHNC's 15 Year Anniversary Celebration, this coming August.

Through the OCF website forum, I was soon contacted by another tongue cancer survivor, Barbara Boland, a dental hygienist from Philadelphia. Like me, Barbara was lucky to be a dental professional. She was told twice that what she had under her tongue was nothing, but she knew enough to pursue a diagnosis. She had a brush biopsy done and soon received the diagnosis of squamous cell carcinoma. Barbara is currently working for a dental practice management company. Since her cancer, she has developed a presentation for dentists to teach them how to do better oral cancer

screenings. She does this free of charge for those dental practices that use the services of her employer, as well as many other dentists and hygienists in other practices.

Until I joined the OCF forum and also started reading the SPONHC newsletter, I really had no concept as to how lucky I was. I emailed and phoned many people I met in the forum and I quickly saw what others were going through after surgery, radiation and chemotherapy. And, after seeing what both Eva and Barb were doing about promoting the importance of early detection, I decided that I too, had to make early detection awareness a major part of my life and career. If it could happen to me, a dentist with no risk factors, it could happen to anyone.

I decided that the first place to start was in my office. Soon after returning to work, I arranged for Barb to do her presentation in my office. I also invited Eva to tell her story and to meet Barb. We are a large practice of 3 general dentists, 4 specialists and a staff of 24. Her presentation helped us to upgrade our clinical oral cancer screening techniques, add the ViziLite exam and Oral CDx biopsy to our procedures. Although we had always done oral cancer screenings, we were never as thorough as we are now, thanks to Barb. All patients are now encouraged to have a ViziLite exam once a year.

After Barb and Eva met, a plan soon evolved to further increase the awareness of the importance of oral cancer screening in the dental office. They have a promotional brochure at the printers and are in the process of developing their website, www.sextetscreening.org, 6 steps to a thorough oral cancer screening. Their goal is to "...educate the general public about thorough oral cancer screenings, and signs of early oral cancer, which is very curable with early detection."

It wasn't too long after my return to work that my office manager and I thought it would be a good idea to reach out to the community by getting an article in the local newspaper. I could tell my story and what we were now doing in the office for oral cancer screenings and the importance of early detection. With the help of a patient, who is a reporter for The Bucks County Courier Times, we were contacted by their

health reporter. After an interview, they ran the story on July 17th, 2005. <http://www.phillyburbs.com/pb-dyn/news/111-07172005-515499.html>. It was also about this same time that we updated our office website, www.kwhdental.com, with a page about early detection of oral cancer.

Prior to the American Dental Association's annual session in Philadelphia this past October, I had made contact with their videographer and arranged a meeting with him to tape an interview. I had told him my story and he said that in his 15 years with the ADA, no dentist had ever contacted him about a personal experience with oral cancer. He made no promises, but he hoped that the interview could be used in some future ADA campaign about early detection.

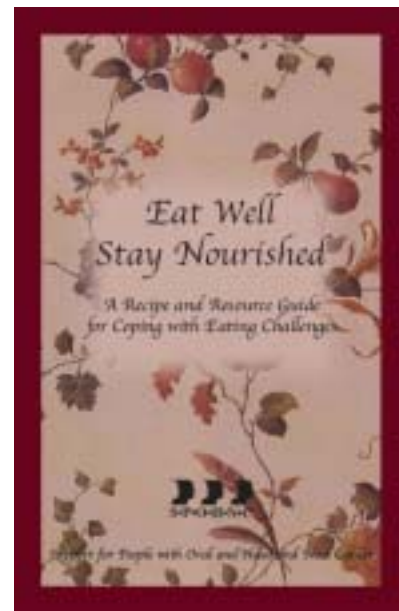
For the past several years my wife and I have been participating in the fund raising effort for the American Cancer Society's Relay for Life. In addition, this coming year, my plan is to set up a booth with volunteers from my office and do free oral cancer screenings and provide literature about oral cancer for the relay participants.

As I write this article, I am approaching my one year surgery anniversary. On April 6th, 2005 no one could have convinced me that I would be so close to a full recovery. It's remarkable that only some minor effects remain. Considering that a 2 cm radius section was removed from my tongue, only a small divot remains on the left lateral border. There is some numbness and loss of taste in that area. The scar on my neck from the removal of the lymph nodes has faded. My cheek and neck are still numb along the incision area and will probably remain that way. These are surely a small price to pay for becoming a survivor.

There is never a day that goes by, that I don't think about my experience with cancer. Being a dentist and an oral cancer survivor puts me in a unique position. I intend to continue to use my experience with oral cancer to try to increase the awareness that early detection can save lives. The general public and the dental profession both need education in this area.

Jerry Wilck
Yardley, PA
wilckdds@kwhdental.com

A NEW RESOURCE FOR ORAL AND HEAD AND NECK CANCER SURVIVORS



"Eat Well – Stay Nourished: a Recipe and Resource Guide for Coping with Eating Challenges" is a resource book of more than 200 pages providing support and encouragement to people with eating challenges. This book contains special pages of information about swallowing problems and nutrition, cancer journeys of survivors, and suggestions and "Tips from the Pros" (SPOHNC's members and head and neck cancer survivors).

Under a decorative, full color hard cover you will find a helpful resource including the special pages, and more than 270 recipes, each with nutritional information, that have been contributed by cancer survivors, caregivers, friends, and health care professionals. The black spiral binding with the title in white, makes this book easy to find on a shelf.

This recipe and resource guide is certain to be a valuable asset to oral and head and neck cancer patients as well as caregivers and health care professionals involved in their care. The cost of this guide is \$17.50 plus \$2.50 for postage. Please call SPOHNC at 1-800-377-0928 to order or order online at www.spoHnc.org.

FDA APPROVES ERBITUX® (CETUXIMAB) FOR TREATMENT OF HEAD AND NECK CANCER

– First and Only Approved Monoclonal Antibody for Squamous Cell Carcinoma of the Head and Neck –

New York, NY & Princeton, NJ – March 1, 2006 – ImClone Systems Incorporated and Bristol-Myers Squibb Company announced today that the U.S. Food and Drug Administration (FDA) has approved ERBITUX® (Cetuximab), an IgG1 monoclonal antibody, for use in the treatment of squamous cell carcinoma of the head and neck. Designed to inhibit the function of the epidermal growth factor receptor (EGFR) – a molecular structure linked to tumor growth – ERBITUX is the first and only monoclonal antibody to be approved for the treatment of head and neck cancer.

With this approval, ERBITUX is now indicated for use in combination with radiation therapy for the treatment of locally or regionally advanced squamous cell carcinoma of the head and neck (SCCHN) and as a single agent in recurrent or metastatic SCCHN where prior platinum-based chemotherapy has failed. These indications are based on a Phase III study – one of the largest studies ever conducted in head and neck cancer patients – that demonstrated a survival and locoregional control advantage when ERBITUX was added to radiation therapy, and a Phase II study, where ERBITUX therapy alone reduced tumor size.

“This is an important milestone as ERBITUX is the first FDA approved therapy for head and neck cancer patients in more than 30 years,” said Kie-Kian Ang, M.D., Ph.D., Professor, Radiation Oncology, Deputy Chair, Radiation Oncology, Deputy Division Head, Radiation Oncology, The University of Texas M. D. Anderson Cancer Center, Houston, Texas. “For patients with locally or regionally advanced disease, ERBITUX in combination with radiation therapy has demonstrated a clinically significant improvement in survival and locoregional control.”

In a pivotal, international, randomized Phase III trial of 424 patients with locally regionally advanced squamous cell carcinoma of the oropharynx, hypopharynx or larynx with no prior therapy, the addition of ERBITUX to radiation (n=211) when compared to radiation alone (n=213) resulted in a 9.5-month improvement in median duration of locoregional control [24.4 months versus 14.9 months, p=0.005, hazard ratio, 0.68, 95% Confidence Interval (0.52-0.89)]. ERBITUX was dosed weekly, starting one week before radiation and for the duration of radiation therapy. The median number of ERBITUX doses administered in the clinical study was eight (1-11 infusions). Results also showed a 19.7-month improvement in median survival [49.0 months versus 29.3 months, p=0.03, hazard ratio, 0.74, 95% Confidence Interval (0.57-0.97)].

Another principal trial was a single-arm, multicenter, Phase II trial studying the effects of ERBITUX as a single-agent treatment. The study analyzed 103 patients with recurrent or metastatic SCCHN not suitable for further local therapy and who had failed platinum-based chemotherapy. ERBITUX was administered until disease progression or unacceptable toxicity. The median number of doses was 11 (range 1-45 infusions). Patients demonstrated a clinically meaningful objective response rate of 13 percent (95% Confidence Interval 7%-21%). The median duration of response was 5.8 months (range 1.2-5.8 months).

Pretreatment assessment for evidence of EGFR expression is not required for patients with squamous cell carcinoma of the head and neck.

“This approval is a significant advancement for ImClone Systems and its partners,” said Joseph L. Fischer, Interim Chief Executive Officer, ImClone Systems

Incorporated. “We continue to support a broad, evidence-based development plan for ERBITUX with the goal of fully demonstrating the therapy’s potential in treating human cancers.”

“ERBITUX represents an important new option for potentially thousands of patients fighting head and neck cancer, a serious disease for which there is significant unmet medical need,” said Peter R. Dolan, Chief Executive Officer, Bristol-Myers Squibb. “These new indications for ERBITUX are another step forward in our company’s commitment to helping patients with cancer, and building on our decades-long legacy of researching, developing and providing innovative anti-cancer therapies to patients around the world.”

This is the second indicated tumor type for ERBITUX, previously approved by the FDA for use in combination with irinotecan for patients with EGFR-expressing metastatic colorectal cancer who are refractory to irinotecan therapy and as a single-agent for the treatment of EGFR-expressing metastatic colorectal cancer in patients who are intolerant to irinotecan therapy. The effectiveness of ERBITUX for the treatment of EGFR-expressing metastatic colorectal cancer is based on objective response rates. Currently, no data are available that demonstrate an improvement in disease-related symptoms or increased survival with ERBITUX for the treatment of EGFR-expressing metastatic colorectal cancer.

ERBITUX was granted approval by SwissMedic in December 2005 for use in combination with radiation in the treatment of patients with previously untreated advanced head and neck cancer. A similar marketing application was recommended for approval by a European Medicines Agency scientific advisory panel.

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Editor's Note: According to the FDA (www.fda.gov) commonly reported side effects of Erbitux were infusion reactions (fever, chills), skin rash, fatigue/malaise, nausea. The common side effects associated with radiation such as sore mouth, trouble swallowing, and radiation skin changes were similar in frequency in patients receiving Erbitux plus radiation and those receiving radiation alone.

Additional Resources:

1. "Radiotherapy plus Cetuximab for Squamous-Cell Carcinoma of the Head and Neck" James A. Bonner, M.D., Paul M. Harari, M.D., Jordi Giralt, M.D., Nozar Azamia, Ph.D., Dong M. Shin, M.D., Roger B. Cohen, M.D., Christopher U. Jones, M.D., Ranjan Sur, M.D., Ph.D., David Raben, M.D., Jacek Jassem, M.D., Ph.D., Roger Ove, M.D., Ph.D., Merrill S. Kies, M.D., Jose Baselga, M.D., Hagop Youssoufian, M.D., Nadia Amellal, M.D., Eric K. Rowinsky, M.D., and K. Kian Ang, M.D., Ph.D. New England Journal of Medicine 2006; 354:567-578, Feb 9, 2006.

2. Phase III Randomized Trial of Cisplatin Plus Placebo Compared With Cisplatin Plus Cetuximab in Metastatic/Recurrent Head and Neck Cancer: An Eastern Cooperative Oncology Group Study: Barbara Burtness, Meredith A. Goldwasser, William Flood, Bassam Mattar, Arlene A. Forastiere. Journal of Clinical Oncology, Vol 23, No 34 (December 1), 2005; pp. 8646-8654

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