

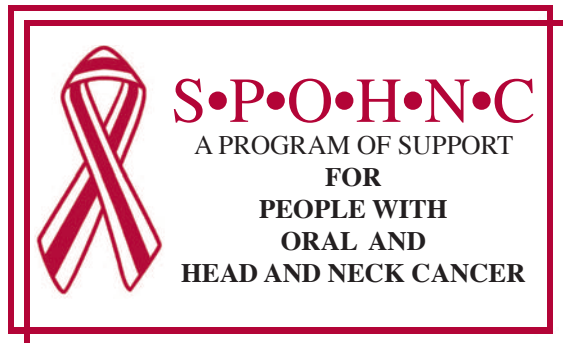
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Recurrent Head and Neck Cancer Treatment Options and Management Strategies

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Local and regional recurrence of cancer of the head and neck is a challenging and complicated problem. It also has many different forms, and arises in a variety of circumstances. A cancer can recur in the original primary site (local), or it can recur in the neck (regional). It can recur in the region that was originally treated, or in an area nearby the original treatment. It can recur at the primary site and the neck simultaneously.

A cancer can recur soon after the original cancer, or months to years later. Obviously, all of these situations are different. Therefore, an essential principle of management of recurrent head and neck cancer is that it requires a personalized treatment plan. It also requires significant clinical expertise.

Patients with recurrent cancer have all had prior treatment. Previous surgery, radiation therapy, or both, adds significantly to the complexity of retreatment. Prior chemotherapy could impact on the potential role of this modality for the management of recurrence. Functional outcome and quality of life are essential features, and must be incorporated into the management strategy. Finally, patients may have other conditions, such as diabetes, heart disease, lung disease, kidney disease, or other medical issues which will have a great impact on their ability to undergo further treatment. Therefore, all patients with recurrent head and neck cancer should be evaluated by a multi-disciplinary team with expertise in surgery, radiation oncology, and medical oncology, with access to specialized expertise in head and neck imaging and pathology.

In general, the treatment of choice for recurrent head and neck cancer has been surgery. Due to the nature of the situation, proper surgery often requires appropriate reconstruction, in an attempt to optimally restore form and function. However, the loss

of a major organ is sometimes unavoidable. Many patients with recurrent larynx cancer will require a total laryngectomy. Patients with recurrent cancers near the eye may require the removal of the eye in order to achieve an adequate operation. These management options require patients and their families to think long and hard about the balance between saving life and preserving quality of life.

Radiation therapy has become increasingly important in the management of recurrent head and neck cancer. We have learned that it is safe to re-irradiate some patients who have had prior radiation therapy. This requires meticulous attention to treatment techniques, and all attempts to minimize the dose of radiation to the normal organs near the tumor. Specifically, concerns about the spinal cord, mandible, brain and brainstem, skin, carotid artery, as well as other vital structures, call upon the radiation oncologist's ability to maximize the dose to the tumor and to minimize the dose to normal organs. Special radiation delivery techniques such as intensity modulated radiation therapy, brachytherapy, intraoperative radiation therapy, and stereotactic radiosurgery can all play a role.

While every patient is different, one of the general principles that has emerged is that the best outcomes are achieved with combinations of surgery, radiation and chemotherapy. Therefore, many institutions have adopted treatment protocols that combine these approaches. The goal is to intensify the treatment while minimizing the damage to normal tissue.

A clinical example can illustrate some of the principles at hand. A recent patient presented with a recurrent tumor of the base of tongue and recurrent tumor spread in the neck. This patient had had 3 prior operations, 2 courses of radiation therapy and 2 courses of chemotherapy. He had recurrent disease both at the primary site (base of tongue) and his neck. As mentioned above, the principle of management is that a combination of surgery, radiation therapy and chemotherapy offers this patient the greatest opportunity for survival and disease control.

The patient was evaluated by experts in radiation oncology, medical oncology, and head and neck surgery. All imaging studies were reviewed with experts in head and neck radiology so that the exact extent of disease could be assessed. Pathology was reviewed and recurrent head and neck cancer was documented. The patient was discussed at a weekly head and neck tumor conference, where all complex cases are presented and reviewed by the entire team of experts in treatment, but also attended by specialists in nursing, supportive care, nutrition, and pain management. It was decided that this patient could undergo a series of procedures that would ultimately result in a full course of re-treatment to all the involved areas.

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The patient was brought to the operating room and the recurrence in his left neck was removed. At the time of surgery, intraoperative radiation therapy was delivered. The patient was treated in a special operating room equipped with radiation therapy capability. In this way, a high dose of radiation could be delivered directly into the tumor bed during the operation. This minimizes the radiation dose to the surrounding normal organs, and has been a key ingredient to this type of protocol for recurrent disease.

After the radiation was completed, the surgery was completed with a reconstructive procedure that closed the neck using a procedure called a free-flap. This consists of fresh muscle and skin that was moved from another part of the body and connected to the neck and its blood supply. This free flap was essential, as it brought fresh tissue that had never been irradiated. After several weeks of healing, additional radiation therapy was delivered to the neck. This is a daily treatment using a highly conformal approach called intensity modulated radiation therapy (IMRT). IMRT allows the radiation oncologist to deliver radiation that is literally sculpted to encompass the area of recurrent tumor, and which minimizes dose to the surrounding organs. This radiation was made possible by the free-flap reconstruction which brought non-irradiated tissue with a fresh blood supply to the neck. By planning and delivering radiation beams to go through this free-flap, additional treatment was delivered to the neck, with minimal complication. Chemotherapy was given with the radiation further intensifying the treatment. This treatment was delivered over 5 weeks.

The recurrence of base of tongue was managed with a combination of external beam radiation therapy plus brachytherapy. Brachytherapy is a form of radiation therapy that involves the implantation of radioactive seeds directly into a tumor. In the case of a patient with tongue cancer, this is an innovative way to deliver a high dose of radiation directly into the tumor, and minimize the dose to the surrounding normal organs which have been exposed to prior radiation treatment. Also, this helps to avoid the surgical removal of the base of tongue, which would result in significant impact on quality of life, especially speech and swallowing. This brachytherapy procedure was done at the same time as the neck surgery. The follow-up external beam radiation therapy was done in combination with the treatment of the neck (described above) using the IMRT approach, thus comprehensively completing the treatment program.

Chemotherapy has become increasingly important in the management of advanced head and neck cancer. In this regard, its use in the recurrent disease setting has also become increasingly important. Chemotherapy can act both as an augmentation to the local effects of radiation therapy, and as an independent agent that can reduce the risk of cancer spread to organs outside the head and neck, like the lungs, bones or liver. Its exact role in the management of recurrent head and neck cancer remains unclear. However, due to its established role in the management of locally advanced disease, it is only natural for it to be incorporated in the management of recurrent disease.

The two major applications are induction chemotherapy and concomitant chemotherapy. Induction chemotherapy consists of the use of multiple chemotherapeutic drugs prior to any local treatment

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(surgery or radiation therapy). The concept behind induction chemotherapy is the hope that the chemotherapy will induce significant regression of the known disease, as well as have an effect on any tumor cells that may have spread to distant organs. Concomitant chemotherapy/radiation therapy is the use of chemotherapy simultaneously with radiation therapy. The most common drug used for this purpose is cisplatin. A combination of cisplatin and radiation therapy is commonly used in locally advanced head and neck cancers. Therefore, it is logical to consider this combination in the recurrent disease setting. There is clear evidence that concomitant chemotherapy/radiation therapy can improve tumor control and potentially reduce the risk of distant spread to other organs. In this patient, the concomitant approach was used. In other patients, new drugs, new drug combinations,

and novel biological compounds, are often considered as part of a clinical trial. Finally, targeted biological agents are also being investigated in the setting of recurrent head and neck cancer.

Conclusion

With the complexities of recurrent disease management, treatment must be personalized to the individual circumstance in the individual patient. Nowadays, advances in surgery, radiation therapy, and chemotherapy, have allowed for novel and innovative strategies to be used in patients with recurrent head and neck cancer. Advances in imaging have allowed a better assessment of the extent of the tumor, thus allowing the treating physicians the opportunity to tailor the surgery and radiation therapy to the exact anatomical areas that are involved. New drugs and biological agents are being

tested and used for patients with recurrent cancers. As previously mentioned, a patient is wise to seek advice and management from a specialized head and neck cancer team, so that the most current and sophisticated modalities can be used. Participation in clinical trials should be encouraged. The good news is that many patients with recurrent head and neck cancer can enjoy long term survival with a reasonable quality of life.

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Caregivers Corner...10 Practical Tips From Highly Effective Caregivers

This month we are going to look at some practical ways to handle the stress of caregiving. Many of these ideas have been gathered through my own experience as a cancer caregiver, as well as from my practice of working with caregivers.

1. Take time for yourself. Schedule some quiet time away from cancer, cancer, cancer. Practice blocking out worry, even for 10 minutes. Sit or walk in a special location, imagining a sign that says, "No worry allowed." This is your "worry-free" appointment with yourself.
2. Create some distractions, such as working with puzzles, crosswords, computer games, knitting, cards, music, yoga. Activities that have a rhythmic mechanical repetition are helpful and soothing.
3. Create a support system. Find someone who will serve as your cheerleader and your encourager. Someone who will lean over the balcony, waving his/her arms as you run the race below in the arena, shouting, "You can do this. Keep pressing forward. Easy does it. First things first. You are stronger than you think."
4. Cry and laugh. These are all natural stress-buster activities. Find something to laugh about every day. It reduces stress, increases the heart rate and muscle activity, and releases feel-good chemicals into the brain. Even a smile can produce a moment of pleasure. Sometimes a good cry can discharge stress and bring relief.
5. Open up your horizon a bit. Caregiving can create a narrow, lonely, and shrinking world. Talk to someone at least once a day about anything other than cancer. Step outside and just look at the sky, even for a minute. Pray.
6. Learn to walk in beauty. Take notice of our natural world and the miracles of sunlight, fluttering leaves, bright flowers, floating clouds, a squirrel skirting across the grass, rain, thunder, a gentle breeze, morning dew, fountain sprays, the rhythm and rotation of daylight and darkness with the promise of a new sunrise every morning.
7. As you walk, imagine energy and light traveling from your feet up into your mind, with each step visualizing its slow and healing course of travel through your legs, abdomen, torso, shoulders, and arms. Breathe in peace deeply and breathe out distress, counting to five each time. Imagine opening your heart and releasing musical notes, filling the air around you as you exhale. Practice.
8. Keep a journal of "Tiny Gratitudes." Gratitude is the number one positive emotion. Remember that life's greatest gifts sometimes arrive in small packages. Miracles really are everywhere when

we look for them. Become a detective and look for and find the little things — the tiniest moment of beauty, the tiniest blessing, the tiniest thing for which to be grateful. Count your pulse or that of your loved one ... and be grateful.

9. Use positive self-talk. "I can cope. I am being held up by God. I can do this. Others have done it before me and I can do it, too. I've been through tough times before."
10. Join a support group. You don't have to go through this alone. I facilitate a weekly psycho-educational support group called "I've Got Feelings, Too!" at M. D. Anderson Cancer Center. This group is designed to help broaden a caregiver's perspective and horizon. Assuming the role of caregiver can be shocking and distressing. This group provides a cushion of support from fellow comrades going through similar experiences in the war against cancer.

A support group can help a caregiver organize the chaos in his/her head, sort through feelings, and direct goals and behaviors in ways that may not have been considered.

Editor's Note: Phyddi Tacchi, RN, CNS, LMFT, LPC is a Psychiatric Advanced Practice Nurse in the Department of Psychiatry at the University of Texas M. D. Anderson Cancer Center in Houston, Texas.

A TIME FOR SHARING... My Cancer Journal: 2009

On March 09, 2009, as I was washing my hands in front of the ladies room mirror at work, I yawned and suddenly I noticed a growth on the left side of my tongue. I made an appointment with an Ear, Nose, and Throat doctor (ENT) for the next day. As soon as the doctor saw the growth he felt that it needed to be looked at by a specialist because he, "had never seen this type of growth before and this might be one for the books." He told me, "You could be a case study." At that point, I just viewed the strange growth as an inconvenience that was interrupting my busy work schedule.

Timing Is Everything.

I was able to get an appointment with the specialist on March 19th. In the meantime, the thing in my mouth was growing rapidly. When I saw the specialist, he originally felt that this was probably a pyogenic granuloma, which is a common, benign growth, but he biopsied it to confirm his diagnosis. I was still thinking: one ambulatory surgery and I would be back at work; no real changes to my life. I had never smoked, abused alcohol, chewed tobacco, or been exposed to secondhand smoke. Since neither my parents nor my husband ever smoked, I had no reason to suspect the growth could be something else.

The growth was atypical in many ways. It grew rapidly, getting bigger and bigger each day and the tip was showing signs of necrosis, or tissue death. It was not adhering to my tongue but rather growing parallel to it. It was getting so big that I was joking with my son-in-law that he better watch it since I was becoming "the mother-in-law with the forked tongue!" By March 27th it was becoming difficult for me to eat, my speech was affected, and swallowing was difficult as well. The extraction was scheduled for March 30th as an outpatient procedure, and my family and I were becoming concerned because the pathology results continued to be inconclusive. As I was waiting to be wheeled into the operating room, I was told that the pathologist saw traces of cancer but so far had been unable to

determine what type of cancer. Without an exact cancer diagnosis, my surgeon did not feel it was prudent to remove the growth. Since I was already prepped for surgery, a tracheotomy was done because the growth was starting to affect my breathing. And I would need it once I had the extraction. So there I was, sitting in the pre-op room believing that I had a noncancerous growth, that I was going to have a procedure, go home after a few hours, and get back to my life. Suddenly, I had to deal with the shock of being diagnosed with cancer, still not knowing which type, and with having a tracheostomy. My first thoughts were, "this cannot be happening to me!" I felt like putting my head down and crying but realized that would mean I was giving into the disease.

Luckily, my oldest daughter ("the doctor"), who is a neonatologist and my medical advocate, was with me. She maintained her calm demeanor and advised me to agree to the tracheostomy. I had to trust her, after all her father and I had invested thousands of dollars in her education! While inserting the tracheotomy, my surgeon decided to remove about two-thirds of the tumor (it was no longer a growth!) to facilitate my eating and breathing. Also, he would have additional tissue samples to send to the pathologist for testing. I stayed at the hospital for 5 days and the pathological results were still inconclusive.

My Busy Schedule

I was released to go home on April 3rd and that same night, at 10:00 pm, the hospital called my daughter to tell her that the results finally had come in and I had "spindle cell variant squamous cell carcinoma." It was just my luck to have a cancer variant that was difficult to diagnose and a tumor that was atypical. Because of the size of the tumor, it was designated as Stage III Tongue Cancer. As scary as this all sounded, and since ignorance is bliss, I was confident that we would set a date for the operation, remove it, do some radiation, and then my life would go on as if there were no

interruptions. I was still focused on getting this done quickly, so that I could go back to work. I might not have mentioned this, but I work for an accounting firm and it was our busy **tax season**. I had no time for this nonsense! I also omitted the fact that our daughter "the doctor" was 8½ months pregnant.

We scheduled the operation for April 14th after meeting with a plastic surgeon who was going to handle the reconstruction of my tongue. It was, of course, inevitable that 2 days before my surgery, my daughter went into labor and on Easter Sunday our beautiful third grandson was born. Going to the hospital to visit them and holding this beautiful gift, I realized how blessed we were and I made a silent promise to him that I would fight with every ounce of my fiber to be around and love him and be part of his life for a very long time.

The surgery lasted approximately 8 hours, followed by a 2-week stay in the hospital. The reconstruction team used tissues from the inside of my cheek to rebuild my tongue. To ensure that blood was flowing to my "new, improved tongue," part of my cheek remained attached to my tongue, with tissue going between my teeth. (This brought a totally new meaning to the phrase "tongue in cheek"). All who saw me, the nurses, the doctors, my family, would tell me that I looked great. On the other hand, when I looked in the mirror I saw a "Quasimodo" look-alike: a disfigured face looking back. I could neither speak, nor eat, which as far as I'm concerned, is a curse for a Greek woman! Again, I was extremely lucky to have my second daughter, "the lawyer," take the time to be my voice and to be helpful with the little details that arise with everyday hospitalization.

Difficult Days

I went home with my tongue still attached to my cheek through my teeth—unable to chew, barely able to speak, and in pain. Percoset, my new friend, helped me through these difficult days. This was when my husband realized that his caregiving would

become an essential part of my recovery, and he stepped up to the plate. He tried to have me drink Ensure, but I still had some taste buds and the taste made me gag. He took it upon himself to emulsify any and every meal that he cooked for himself. I had brown liquid that was pork roast and mashed potatoes; white liquid that was steamed fish with vegetables, etc, etc. He truly became the "Iron Chef" of emulsified and liquid foods! Each and every day, whether I could eat or not, he insisted that I join him for dinner. This was the only time when he would not allow me to stay in bed or on the couch. I love to eat and there I was, smelling and watching him eat things that I used to enjoy. During those times I hated him with every fiber of my body, and I sat there wishing I could magically make him disappear. In retrospect, I realize that this was a great strategy for forcing me to get as much nutrition as possible to the point where I could partake in the great meals he was preparing.

My Daily Fare of Radiation

Since the cancer was stage III the doctors decided that I should have aggressive daily radiation for 6 weeks. In mid-May, in an outpatient procedure, the plastic surgeon detached my tongue from my cheek and advised me that I could now eat anything I liked. What a joke that was! My tongue was swollen and painful, I would choke if I tried to eat even yogurt, and the doctor had the sense of humor to tell me that I could eat! Obviously *he* never had a glossectomy. Thank you Percoset, you will always be special to me!

On May 18 I started radiation. The first week was extremely difficult. I am borderline claustrophobic, and having a face mask immobilize me on the table was extremely confining and uncomfortable. Even though sessions only lasted about 15 to 20 minutes, each felt like a lifetime. I love the beach and I have travelled all over the world. To control the panic I was feeling I tried to visualize walking and swimming at a different beach each time. The mind is powerful thing, and I learned to control the panic I felt. While I was treated the technicians piped some music into the room. I realized that my sessions were lasting about 5 songs. So I developed the habit of singing the songs in my head and was thrilled when I heard the third song finish because I knew the session was more

than halfway done. I also would like to point out that the radiologist, the nurses, and the radiation therapists were terrific. They truly tried to be compassionate, kind, and supportive every day. Those were difficult days, but the staff played a big part in my ability to handle those difficult days.

The side effects of radiation are brutal. Until you experience it, you do not realize how debilitating it is. I refused to have a feeding tube. I considered it a weakness and a form of surrender to the disease. I insisted that I would continue to eat, or rather slurp, whatever my husband placed in front of me. Each week eating became more difficult, but I was determined not to lose too much weight. I survived on protein shakes, my husband's gourmet (!) slurpees, and what my doctors called the "Mangones diet": hummus mixed with babaghanoush (eggplant dip). I ate bucketfuls of the mixture, and it provided me with the protein and fiber I needed to keep my strength. I also felt that I had to return to work. The psychological impact of being inactive for 3 months was starting to affect me. I was starting to feel sorry for myself. Luckily my employers were extremely understanding, and allowed me to return on a part time basis in June.

It was not an easy time for me. Not wanting to be exposed to mass transit with a radiation-compromised immune system, I drove each day. Some days the return trip was so bad that I considered stopping at a hotel on the way home, calling my family and telling them to come get me. I was so exhausted physically but kept pushing myself to go on, one mile at a time. I used different landmarks on the way and kept focusing on reaching each one of them, without thinking of the total distance.

I was also not prepared for some of the other side effects of radiation. I was lucky that my skin tolerated the radiation better than most (maybe my exposure to the Mediterranean sun had something to do with it!). The mucositis, the inability to swallow even my saliva, the thrush, the loss of my taste buds and

the total exhaustion I felt made me wish I did not agree to the radiation therapy. I kept bargaining with my radiologist to reduce the number of sessions, but to no avail! Those were tough days, and it got a lot worse before things started to get better. Two weeks after the radiation ended I could not eat anything at all. And then, lo and behold, one day about 3 weeks after the end of radiation I woke up (a total of 35 lbs lighter) and felt like half a human being. Each and every day I felt better and stronger.

Counting My Blessings

It is now one year since my surgery. Eating is still difficult at times, but I eat what I can and enjoy every morsel of it. My taste buds came back and as long as I sip water with my meals, I can enjoy a variety of food. Speaking can also occasionally be difficult, but everyone understands my speech. My energy is back. I need to have a bottle of water with me at all times and my mouth and tongue do not feel like they used to before the surgery. However, I consider myself blessed and lucky. We had a rough 2009 but some wonderfully positive things happened to our family that I focus on (remember my little grandson?) rather than on my cancer experience.

It is also important to point out that this journey humbled me. The support I had, and still have, from so many people was so unexpected. There is no doubt in my mind that all these gestures of love and support helped me recover. They made me stronger and enabled me to fight. No one that goes through something like this journey should have to do it alone. That is why I decided to join SPOHNC with the hope that I would be able to give back to others the support that I found around me. As a wise man told me: "Yesterday is the past, tomorrow is the unknown, but today is the present." I have learned to enjoy each and every one of the presents I get and be thankful for them!

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Chemotherapy-induced Peripheral Neuropathy

It usually starts in the hands and/or feet and creeps up the arms and legs. Sometimes it feels like a tingling or numbness. Other times, it's more of a shooting and/or burning pain or sensitivity to temperature. It can include sharp, stabbing pain, and it can make it difficult to perform normal day-to-day tasks like buttoning a shirt, sorting coins in a purse, or walking. An estimated 30 to 40 percent of cancer patients treated with chemotherapy experience these symptoms, a condition called chemotherapy-induced peripheral neuropathy (CIPN).

CIPN is one of the most common reasons that cancer patients stop their treatment early. (See box for a list of drugs that can cause CIPN.) For some people, the symptoms can be mitigated by lowering the dose of chemotherapy or temporarily stopping it, which diminishes the pain within a few weeks. But, for other patients, the symptoms last beyond their chemotherapy for months, years, or even indefinitely.

"Peripheral neuropathy can be an incredibly debilitating side effect," explained Dr. Ann O'Mara, head of NCI's Palliative Care Program in the Division of Cancer Prevention. "We can't predict who will come down with it or to what degree they will get it. So there are a lot of questions around this issue, in terms of preventing and treating it."

Outside of clinical trials, CIPN symptoms are commonly managed in a manner similar to other types of nerve pain—that is, with a combination of physical therapy, complementary therapies such as massage and acupuncture, and medications that can include steroids, antidepressants, anti-epileptic drugs, and opioids for severe pain. But these therapies have not demonstrated true efficacy for CIPN, and virtually all of the drugs to treat peripheral neuropathy carry side effects of their own.

Life with Neuropathy

Cynthia Chauhan is a patient advocate who is very active in the cancer community. She participates with several boards and committees that advise NCI-sponsored clinical trial groups, including the North Central Cancer Treatment Group and the Southwest Oncology Group, and she is co-chair of the Patient Advocate Working Group

for the Translational Breast Cancer Research Consortium. She is also very familiar with the burden of peripheral neuropathy and the shortcomings of current treatments.

A two-time cancer survivor, Ms. Chauhan lives with peripheral neuropathy that arose spontaneously—called idiopathic neuropathy—nearly 15 years ago. Her symptoms include shooting pains, fiery numbness, and tingling in her hands and feet, as well as a lack of sensitivity to temperatures. Her mother developed chronic CIPN during her treatment for stage IV ovarian cancer and, because of the pain, has terrible difficulty sleeping. "But without the drugs that caused her neuropathy, she would not have survived," Ms. Chauhan said. "So she uses that knowledge to balance the negative aspects.

"I'm an optimist by nature," Ms. Chauhan continued. "I like to focus on what I have, rather than what I don't have, and I can still walk and use my hands—I'm an artist, so my hands are important to me. That I can still use them is very positive." She has tried several medications for her neuropathy, and all of the systemic drugs caused unbearable side effects.

Today she manages her pain with Lidoderm patches and the practice of guided imagery and meditation, which she says function mostly as distractions for the pain. "Nothing ever stops it. It's a 24-7 issue with me. I know that drugs work for some people, and if you can find effective medications under the care of a really knowledgeable physician, that's great," she said. "But more basic and translational research is critical for those of us who are living with the condition."

Chemotherapy Drugs Associated with CIPN

Platinum compounds (cisplatin, carboplatin, oxaliplatin)
Vincristine
Taxanes (docetaxel, paclitaxel)
Epothilones (ixabepilone)
Bortezomib
Thalidomide
Lenalidomide

Understanding the Pain

NCI's Symptom Management and Health-related Quality of Life Steering Committee, of which Ms. Chauhan is a member, met in Rockville, MD, last year to discuss these issues. This steering committee is one of several that advise NCI as it works to improve the efficiency of clinical trials so that proposed treatment hypotheses can be translated more quickly into new screening, treatment, and prevention options for patients.

What actually causes CIPN, on the cellular and tissue level, is still largely a matter of speculation. There is evidence that nerves can become sensitized because the concentration of salts in the fluid surrounding them changes, or because the channels that use these salts to trigger nerve impulses become dysfunctional. These or other changes may actually damage the structure of nerves. Because the underlying etiology may vary according to the chemotherapy agent and from patient to patient, more research with animal models is needed, in addition to clinical trials, to try to define the causes of CIPN and identify means to prevent or alleviate it, said Dr. Charles Loprinzi, the Regis Professor of Breast Cancer Research at the Mayo Clinic in Rochester, MN, who chaired the steering committee meeting.

"We need a multi-pronged approach," he explained. "If we can better understand what causes CIPN in animals and which antidotes might be helpful for preventing and treating it, that doesn't necessarily mean that [the antidotes] will be exactly the same in humans, but it will allow us the opportunity to screen promising compounds. Ones that successfully alleviate the symptom profiles in animals can be advanced to clinical trials in humans."

Getting the Right Measures

"I've been very lucky not to develop this before now, actually...It's likely just a side effect of the chemotherapy treatment (Taxol) that I've been receiving for the past 10 weeks. And that's why we're taking a break from chemo this week," Dr. Susan Niebur wrote in 2007 of her experience with peripheral neuropathy on her blog [Toddler Planet](#), where she documents her experience

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as a mother and survivor of inflammatory breast cancer.

“Hopefully the week off will allow my system some time to recover and the pain to diminish. Already, my legs are responding more to me (no more wheelchair!) and I can feel my left foot. My right foot and leg, up to the knee, are still tingling and painful to the touch, but I hope that will also resolve in the next few days.” More than 2 years after finishing her chemotherapy, Dr. Niebur still has some residual neuropathy in her right foot and occasionally in her hand, but she wrote in an e-mail that it’s primarily a numbness now, “and a bother more than anything else.”

Patient-reported outcomes (PROs) during and after chemotherapy, such as those Dr. Niebur described, will be an important part of future research on CIPN. A tool that was developed by NCI and that is routinely used to record adverse effects from cancer treatment in clinical trials, the CTCAE, “is not adequate to help us fully understand this condition,” said Dr. Loprinzi. “As opposed to having a health care provider summarize the symptoms of a patient, it is much preferred to have patients more directly record their symptoms.”

PROs commonly include substantially more detailed and accurate information for a variety of symptoms. The steering committee identified several tools, including a 20-item patient questionnaire called the EORTC-QLQ-CIPN20, which appear to better capture this level of information.

Clinical Research Ahead

Several new agents have shown positive effects in pilot studies in patients with CIPN or neuropathy related to diabetes or HIV, and the steering committee has recommended that some of the more promising of these be pursued in larger placebo-controlled randomized clinical trials. Some of these trials are already enrolling patients, while others are still in the planning stages. More information about these trials can be found on NCI’s Web site.

For treating the pain associated with CIPN, agents that appear promising include the antidepressants duloxetine, and venlafaxine, which are both serotonin/norepinephrine-reuptake inhibitors. Another promising agent is a topical compound of the muscle-relaxant baclofen, the antidepressant

amitriptyline, and the analgesic ketamine.

For preventing the onset of CIPN, the committee recommended further clinical testing of intravenous calcium and magnesium, which reduced CIPN symptoms by approximately half compared with a placebo in one trial involving patients receiving oxaliplatin; a peptide called glutathione, which is thought to bind to heavy metals and has shown promise in small trials in patients who are treated with platinum chemotherapies; acetyl-L-carnitine, a substance that was effective in animal models and in patients with diabetes and HIV; and the antioxidant alpha-lipoic acid.

Pharmacogenomic studies will also, it is hoped, help guide the identification of patients who are more or less likely to develop CIPN. One such study is being planned at the Mayo Clinic to determine how a variation in genes that control taxane and carboplatin metabolism may affect a person’s risk of getting CIPN.

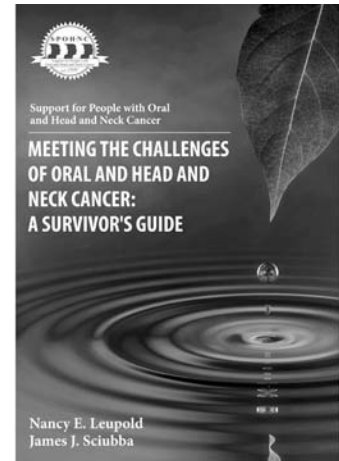
“I’m a relatively conservative person, in terms of how I practice medicine and research,” said Dr. Loprinzi. “But I’m excited about this area. We’re just starting to tap it. Over the next few years, as study results become apparent, I’m reasonably confident that one or two, or possibly more, of these agents will be shown to be beneficial for patients.”

—Brittany Moya del Pino

Courtesy of the
NCI Bulletin Vol 7. No. 4.

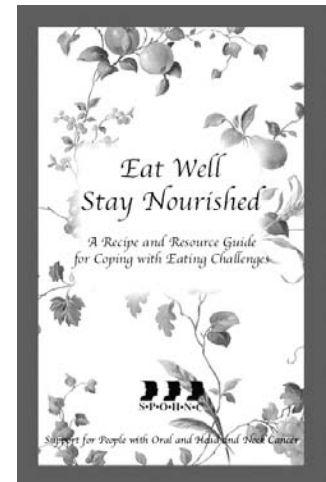
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HEAD AND NECK CANCER NEWS

Accelerated Radiation Therapy Reduces Toxicity in Patients With Advanced Head and Neck Cancers

Using an accelerated, shorter course of radiation therapy for patients with advanced head and neck cancer allows doctors to reduce the amount of chemotherapy, thus reducing toxicity, according to a study presented at the Multidisciplinary Head and Neck Cancer Symposium in Phoenix on February 25.

Between July 2002 and May 2005, this multi-institutional randomized phase III trial analyzed 721 patients with stage III-IV carcinoma of the oral cavity, oropharynx, hypopharynx or larynx, with 360 receiving accelerated radiation and 361 receiving standard radiation with two and three cycles of cisplatin, respectively.

After a median follow up of 4.8 years, the overall survival of accelerated radiation patients versus standard radiation patients was 59 percent and 56 percent respectively. Disease-free survival rates were 45 percent

and 44 percent respectively and local-regional failure and metastasis rates were also very similar at 31 and 28 percent and 18 and 22 percent, respectively.

“Accelerated fractionation concurrent with two doses of high dose cisplatin has the potential to reduce toxicity related to the chemotherapy regimen by not exposing patients to a third cycle,” said, Phuc Felix Nguyen-Tan, MD, assistant professor of radiation oncology at CHUM Notre-Dame in Montreal, who presented the study.

Reference: “*A Phase III Trial to Test Accelerated versus Standard Fractionation in Combination with Concurrent Cisplatin or Head and Neck Carcinomas (RTOG 0129): Report of Efficacy and Toxicity.*” Presented at the Multidisciplinary Head and Neck Cancer Symposium, Phoenix, February 25, 2010. Abstract 18.

Larynx Preservation Treatments Result in Low Incidence of Severe Voice Disability, Nutritional Problems

Head and neck cancer patients receiving induction chemotherapy followed by radiation to preserve their larynx have a low-risk of severe voice disability and almost half experienced no eating or swallowing problems, according to a first of its kind study presented February 25 at the 2010 Multidisciplinary Head and Neck Cancer Symposium.

Total larynx removal with permanent tracheotomy is the current standard treatment for patients with cancer of the larynx. While larynx preservation using chemotherapy followed by radiation is an effective treatment, the functional results are often not reported and the quality of life for these patients remains unknown.

Researchers at the Hopital Bretonneau in Tours, France, the Centre Hospitalier in Lorient, France, the Centre Paul Papin in Angers, France, the Institut Gustave Roussy in Villejuif, France, and the Institut Sainte Catherine in Avignon, France, observed 213 patients who received induction chemotherapy using cisplatin and 5FU without (PF) or with docetaxel (TPF) followed by radiation

and evaluated the quality of the voice, the nutritional function, and the quality of life.

After 61 months of follow up, the laryngo-esophageal dysfunction free-survival was 28 percent when averaging the PF arm and the TPF arm. Voice disability was low for 57 percent of patients, with only 15 percent experiencing severe voice disability. Forty percent of patients had no eating or swallowing problems at all and 8 percent required a feeding tube.

“For cancer patients receiving treatment to their larynx, it is important to preserve the organ, but it is more important to preserve the function of this organ,” Gilles Calais, MD, lead author of the study and a radiation oncologist at the Hopital said. “This is the first study that analyzes not only the preservation rate but also the preservation of the function of the larynx and the esophagus.”

Reference: “*Induction Chemotherapy Followed by Radiation for Larynx Preservation. Functional Results of the Gortec 2000-01 Randomized Trial.*” Presented in the plenary session, Multidisciplinary Head and Neck Cancer Symposium, Phoenix, February 25, 2010. Abstract 1.

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ARIZONA-CHANDLER
Cancer Center at Chandler Reg. Med. Ctr.
1st. Wednesday, 5:30 – 7:30 PM
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monica.krise@chw.edu
Dick Snider 480-895-6019
rsnider326@aol.com

ARIZONA-PHOENIX
Banner Desert Medical Center
3rd. Wednesday: 4:30 - 6:30 PM
Keri Winchester, MS, CCC-SLP
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Keri.Winchester@bannerhealth.com
Dick Snider 480-895-6019
rsnider326@aol.com

ARIZONA-SCOTTSDALE
Virginia G. Piper CA Center
3rd. Thursday: 6:30-8:30 PM
Chris Henderson, MS, CCC-SLP
602-312-9226
chenderson2@shc.org
Bette Denlinger, RN
betneldenlin@csc.com
480-838-5194
Sandy Bates, RN
zoomomof6@cox.netd
Les Norde 602-439-1192
elnorday@cox.net

ARKANSAS-NORTHWEST
NWA Cancer Support Home
3rd. Saturday: 10:00 AM-12:00 PM
Jack Igleburger 479-876-1051/586-4807
tmplnjak@cox.net

CALIFORNIA-LOS ANGELES-UCLA
UCLA Med. Pla., Rad/Onc
Conf. Rm. B-265
1st. Tuesday: 6:30-8:00 PM
Pam Hoff, LCSW 310-825-6134
phoff@mednet.ucla.edu

CALIFORNIA-ORANGE-UCI
Chao Family Comprehensive CA Ctr.
1st. Monday: 6:30-8:00 PM
Jennifer Higgins, MSW 714-456-5235
jhiggins@uci.edu

CALIFORNIA-PASO ROBLES
The Wellness Community
1st. Tuesday: 6:00 PM
Kenda Kellawan 805-238-4411
kenda.kellawan@wellnesscommunityhope.org

CALIFORNIA-SAN DIEGO
4S Ranch Library
1st. Saturday: 1:00 PM
Valerie Targia 760-751-2109
valtargia@yahoo.com

CALIFORNIA-SAN FRANCISCO
UCSF Comprehensive Cancer Ctr.
3rd. Wed., 1:00-2:30 PM, Rm. H3805
Daphne Stuart, LCSW 415-885-7394
Daphne.stuart@ucsfmedctr.org

CALIFORNIA-SANTA MARIA
Marion Rehab. Center
3rd. Tues./Alternate Months
Aundie Werner, MS, CCC/SLP
805-739-3185
aundiew@mail.com

CALIFORNIA-STANFORD
Stanford Cancer Center
1st Tuesday: 4:00 - 5:30 PM
Jan Porter, LCSW 650-725-4765
jporter@stanfordmed.org
Ann Kearney, MA, CCC-SLP 650-736-0469
akearney@ohns.stanford.edu

CALIFORNIA-VENTURA
The Cancer Resource Center of
Community Memorial Hospital
Kathleen Horton 805-652-5459
khorton@cmhshospital.org

COLORADO-DENVER
Porter's Adventist Hospital
Cottonwood Springs Conf. Rm, 1st. Fl.
Last Tuesday: 6:30-8:00 PM
Jeanne Currey 303-778-5832
jeannecurrey@centura.org

CONNECTICUT-NEW LONDON
Lawrence & Memorial Hospital
Community Cancer Center
Waiting Room 1st Thursday 6:00 PM-7:30 PM
Catherine McCarthy, LCSW
860-444-3744
cmccarthy@lmhosp.org

CONNECTICUT-NORWICH
William W. Backus Hospital
Medical Office Building, MOB Conf. Rm.
3rd. Tuesday: 5:00-6:00 PM
Darlene Young, RN, OCN
860-892-2777
dayoung@wwbh.org
Kathy Gernhard, RN, OCN
860-892-2777
kgernhard@wwbh.org

DC-GEORGETOWN
Lombardi Cancer Center.
3rd. Monday: 12:15-1:45 PM
Joanne Assarsson, MSW, LICSW
202-444-3755
assarssj@gunet.georgetown.edu

DC-WASHINGTON
Washington Hospital Center
Washington Cancer Institute
Call for Additional Information
Cynthia Clark, RD 202-877-3498
cynthia.d.clark@medstar.net
Christopher Bianca, LCSW
Christopher.a.bianca@medstar.net

FLORIDA-BOCA RATON
Boca Raton Community Hospital.
1st Tuesday: 4:00-5:00 PM
Laura Moon, MSW 561-955-5897
lmoon@brch.com

FLORIDA-ENGLEWOOD
Englewood Community Hospital
3rd. Thursday: 10:30AM-12:00 noon
Joseph Bauer 941-474-0099

FLORIDA-FT MYERS
Gulf Coast Medical Center
Outpatient Rehabilitation Ctr.
Call for Additional Information
Stacey Brill, SLP 239-343-1645
stacey.brill@leememorial.org

FLORIDA-FTWALTONBEACH/NW FL
Call for Location
4th. Thursday: 5:00 PM
Ryann Ennis, MA CCC-SLP
850-863-7580
ryann.ennis@hcahealthcare.com
Shannon Leach, MA, CCC-SLP
850-362-9200
sleachslp@yahoo.com

FLORIDA-GAINESVILLE
Winn Dixie Hope Lodge
2nd Monday: 6:00-7:00 PM
Carol Glavin, MSW, LCSW
352-371-8695
cfglavin@cox.net
No calls after 9:00 PM, please

FLORIDA-LECANTO
Robert Boissoneault Oncology Institute
3rd Wednesday: 11:30 AM-1:00 PM
Patrick Meadors, PhD, LMFT
352-342-1822
pmeadors@rboi.com

FLORIDA-MIAMI
The Wellness Community
3rd. Wednesday: 7:00-9:00 PM
Gary Mallinchrodt 305-668-5900
gcme4@yahoo.com
Russell Nansen 305-661-3915

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

FLORIDA-NAPLES
NCH Healthcare System/Downtown
1st. Wednesday: 3:00-4:30 PM
Karen Spina, MS, CCC-SLP
239-393-4079/Karen.spina@nchmd.org

FLORIDA-OCALA
Robert Boissoneault Oncology Institute
1st. Monday: 11:00 AM-12:00 Noon
Patrick Meadors, PhD, LMFT
352-342-1822
pmeadors@rboi.com

FLORIDA-SARASOTA
The Wellness Community
2nd. Thursday: 5:30 PM
Julie O'Brien, LMHC 941-921-5539
julieobee@verizon.net
John Kleinbaum, PhD 941-921-5539
hope@wellness-swfl.org

FLORIDA-WELLINGTON
Wellington Cancer Center
4th. Tuesday: 6:30-8:00 PM
Catherine DeStefano, RNC,OCN
561-793-6500
angelicaneil@bellsouth.net

GEORGIA-ATLANTA
St. Joseph's Hospital
2nd. Monday: 6:30-8:00 PM
John Sandidge 678-843-5585
jsandidge@sjha.org

CHAPTERS OF SPOHNC

GEORGIA-ATLANTA-EMORY
Winship CA Institute (Bldg. C)
Last Monday: 6:30-7:30 PM
Arlene S. Kehir, RN 404-778-2369
Arlene.Kehir@emoryhealthcare.org

GEORGIA-AUGUSTA
MCGHealth Children's Medical Center
Family Resource Center
1st. Tuesday: 6:00-7:30 PM
Lori M. Burkhead, PhD, CCC-SLP 706-721-6100
lburkhead@mcg.edu
Leann Dragan
draganole@bellsouth.net

ILLINOIS-CHICAGO
Duchossois Ctr. for Advanced Medicine
4th. Tuesday: 1:00 PM
Mary Herbert 773-834-7326
mherbert@medicine.bsd.uchicago.edu

IL-EVANSTON/HIGHLAND PARK
NorthShore University Health System
Call for location
2nd. Monday: 6:00-8:00 PM
Tina Gremore, PhD 847-570-2039
tgremore@northshore.org

ILLINOIS-MAYWOOD
The Cardinal Bernardin Cancer Ctr.
3rd. Wednesday: 6:00-7:00 PM
Laura Morrell, LCSW 708-327-2042
lmorrell@lumc.edu

INDIANA-INDY-NORTH
Marion County Public Library
Lawrence Branch
Last Tuesday: 7:00-9:00 PM
John Groves 317-872-6674
Jgroves14@comcast.net

INDIANA-INDY-SOUTH
St. Francis Education Center
1st. Thursday: 7:00 PM
Janice Leak, MSN, APRN-BC, AOCN
317-782-6704
Janice.Leak@ssfhs.org

INDIANA-TERRE HAUTE
Hux Cancer Center
3rd Tuesday: 4:30 PM
Mary Ryan, SP 812-234-9584
Maryryan2@juno.com

IOWA-DES MOINES
Iowa Methodist Medical Center
Suite 450
1st. Wednesday: 5:30 PM
Jennifer Witt, RN 515-282-2921

KANSAS-KANSAS CITY
Univ. of Kansas Hospital
2nd & 4th Wednesdays: 4:00 - 5:00 PM
Mary Moody, LMSW 913-588-3630
mmoody@kumc.edu
Dorothy Austin, RN, OCN 913-588-6576
daustin@kumc.edu

LOUISIANA-BATON ROUGE
Cancer Services of Greater Baton Rouge
3rd Wednesday: 4:00 PM
Krystal K. Sauceman, RN 225-572-7943
Ksauceman@gmail.com

MAINE-AUGUSTA/CENTRAL
Harold Alfond Center for Cancer Care
Call for Additional Information
Therese Berniger, SLP-CCC 207-872-4051
therese.berniger@mainegeneral.org

MARYLAND-BALTIMORE-GBMC
Milton J. Dance Head & Neck Center
Physicians Pavilion East Conf. Ctr.
3rd. Tuesday: 7:00 PM
Dorothy Gold, LCSW-C, OCW-C 443-849-2980
dgold@gbmc.org

MARYLAND-BALTIMORE-JHMI
Johns Hopkins – Greenspring Station
2nd. Wednesday: 7:00-8:30 PM
Kim Webster 410-955-1176
Kwebste@jhmi.edu
Dwayne Arehart 717-615-7464
arehart@dejazzd.com

MASSACHUSETTS-BOSTON
Massachusetts General Hospital,
One Tuesday each mo.: 6:00-7:30 PM
Valerie Hope Goldstein 617-731-1703
Fervnal@aol.com

MASSACHUSETTS-DANVERS
MGH Northshore Cancer Ctr.
2nd Tuesday: 5:30-6:30 PM
Mary Anne Macaulay, LICSW 978-882-6002
mmacaulay@partners.org

MICHIGAN-DETROIT
Henry Ford Hospital
Josephine Ford Cancer Ctr. Rm. 2038D
1st Wednesday: 11:30 AM
Amy Orwig, MSW 313-916-7578
aorwig1@hfhs.org

MICHIGAN-ST. JOSEPH
Lakeland Healthcare
1st. Monday: 5:00-6:00 PM
Jennifer Christopher, MA, CCC-SLP
269-428-2799
jchristopher@lakelandregional.org

MICHIGAN-TROY
Beaumont Hospital
Wilson Cancer Resource Center
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Carrie Eriksen, LCS, 248-964-3430
CEriksen@beaumont-hospitals.com

MINNESOTA-MINNEAPOLIS
Hennepin/Southdale Library
1st. Monday: 7:00-9:00 PM
Call before for confirmation
Colleen M. Endrizzi 952-545-0200
rivers3jvk@aol.com
Charles Bartlett 612-220-5449

MISSOURI-COLUMBIA/MID-MO
Ellis Fishel Cancer Center
2nd. Wednesday: 5:30-7:00 PM
Laura M. Neal, MSW, MPH, LCSW
573-884-1509
neallm@health.missouri.edu

MISSOURI-ST. LOUIS
St. Louis University Cancer Center
4th. Friday: 10:00 AM - 12:00 noon
314-577-8880; mannedt@slu.edu
Deborah S. Manne, MSN, RDH, RN, OCN
Cathy Turcotte, RN, MSN 314-268-7051
turcotte@slu.edu

MONTANA-BOZEMAN
Bozeman Deaconess Hospital
3rd. Thursday: 12:00 Noon-1:00 PM
Doug Stiner 406-586-0828
nancydoug@theglobal.net
Wendy Gwinner, LCSW 406-585-5070
wgwinner@bdh-boz.com

NEBRASKA-OMAHA
Methodist Cancer Center
1st. Friday: 3:00 PM.
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

NEBRASKA-OMAHA
Nebraska Medical Center
3rd. Tuesday: 12:00 noon
Susan Stensland 402-559-4420
sstensland@nebraskamed.com

NEW JERSEY-LONG BRANCH
Leon Hess Cancer Center
The Goldsmith Wellness Center
2nd. Thursday: 7:00-8:00 PM
Becky Kopke, RN, BSN, OCN
732-923-6473
BKopke@SBHCS.com
Anita M. Pfisterer, MSW, LSW
732-923-6961 ampfisterer@aol.com

NEW JERSEY-MORRISTOWN
Morristown Memorial Hospital
3rd. Wednesday: 1:30 PM
Edie Boschen, RN, APN-c, OCN
973-971-4144
Edie.Boschen@atlanticealth.org
Catherine Owens, LCSW, OSW-C
973-971-5169
Catherine.Owens@atlanticealth.org

NEW JERSEY-PHILADELPHIA
University of Pennsylvania Hospital
1st Wednesday: 9:30-11:00 AM
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Tracy Lautenbach 215-662-6193
lautenbach@xrt.upenn.edu
Mia Benson Smith, MS 215-662-4641
mia.bensonsmith@uphs.upenn.edu

NEW JERSEY-TOMS RIVER
Community Medical Center
Last Thursday: 3:00 PM
Sherry Laniado, MSW, LCSW 732-557-8270
slaniado@sbhcs.co

NEW MEXICO-ALBUQUERQUE
Anita Bryan, 505-681-1971
Anitabeach2@yahoo.com

NEW YORK-ALBANY
Gilda's Club
3rd Thursday: 7:00-9:00 PM
Joseph Ciccarelli 618-882-9742
jciccarelli001@nycap.rr.com
Norma Neapolitano 518-683-9518
nneapolitano@nycap.rr.com

NEW YORK-BUFFALO
Roswell Park Cancer Institute
3rd. Tuesday: 4:30-6:00 PM
Amy Sumbum, SLP 716-845-4947
amy.sumbum@roswellpark.org
Jim Smaldino 716-845-4472
james.smaldino@roswellpark.org

NEW YORK-MANHATTAN
Beth Israel Head and Neck Institute
4th. Tuesday: 1:30-3:30 PM
Jackie Mojica 212-844-8775
jmojica@chpnet.org

NEW YORK-MANHATTAN
Mount Sinai Medical Center
3rd. Tuesday, 3:00 PM
Stephanie Eisenman, LMSW 212-241-7962
stephanie.eisenman@mountsinai.org

NEW YORK-MANHATTAN
NYU Clinical Cancer Center, 11th flr
1st. Tuesday: 2:00 PM
Carole Wind Mitchell, RN 212-731-6002
carole.mitchell@nyumc.org

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NEW YORK-ROCHESTER
Strong Memorial Hospital
Luellen Resource Center, Pat. Res. Ctr.
1st. Thursday: 4:30-6:00 PM
Sandra E. Sabatka, LMSW
585-276-4529
Sandra_Sabatka@URMC.Rochester.edu

NEW YORK-STONY BROOK
Ambulatory Care Pavilion
1st. Wednesday: 7:30-9:00 PM
Dennis Staropoli 631-682-7103
den.star@hotmail.com

NEW YORK-SYOSSET
NSLJ-Syosset Hospital
2nd. Thursday: 7:30-9:00 PM
Christine Lantier 631-757-7905
clantier@optonline.net
Mary Ann Caputo 516-759-5333
mary.ann.caputo@spohnc.org

NEW YORK-WESTCHESTER
White Plains Hospital Cancer Center
2nd. Thursday: 7:00 PM
Mark Tenzer 914-328-2072
tenzer1@optonline.net

NORTH CAROLINA-ASHVILLE
Call for additional information
Kathleen Godwin 828-692-6174
kgodwin@morrisbb.net

NORTH CAROLINA-
CHAPEL HILL/DURHAM
Cornucopia House
3rd. Wednesday: 6:00 PM
Dave Gould 919-493-8168
dave.gould@da.org

NORTH CAROLINA-CHARLOTTE
Blumenthal Cancer Center
2nd. & 4th Thursday: 1:30-3:00 PM
Meg Turner 704-355-7283
meg.Turner@carolinashalthcare.org
Terri Painchaud 704-364-7119
Trappi6@yahoo.com

NORTH CAROLINA
HENDERSONVILLE/WNC
Pardee Health Ed. Ctr. Blue Ridge Mall
2nd Tuesday: 5:00-6:30 PM
Kathleen Godwin 828-692-6174
kgodwin@mchsi.com

OHIO-CLEVELAND
Cleveland Clinic at Fairview Hospital
Tom Wurz 440-243-6220
2nd. Thursday: 4:00 PM
roe8@hotmail.com
Gwen Paull, LISW 216-476-7241
gwen.paull@fairviewhospital.org

OHIO-LIMA
St. Rita's Regional Cancer Ctr.
The Allison Rad/Onc. Ctr.
Garden Conference Room
3rd. Tuesday of even month: 5:00 PM
Holly Metzger, LMSW
419-996-5606
hjmetzer@health-partners.org
Linda Glorioso 419-996-5616
ltglorioso@health-partners.org

OHIO-DAYTON
The Chapel Room
One Elizabeth Place
Hank Deneski 937-832-2677
2nd. Monday: 6:00-8:00 PM
hdeneski@mindspring.com

OKLAHOMA-TULSA
Hardesty Public Library
1st. Tuesday: 6:30 PM
Christine B. Griffin, RN 918-261-8858
Beritgriffin@cox.net

OREGON-MEDFORD
Providence Medical Center
2nd. Friday: 12:00-1:30 PM
Richard Boucher 650-269-8323
richard.boucher@hp.com

PENNSYLVANIA-HARRISBURG
Health South Lab
3rd. Tues: 6:30 PM
Joseph F. Brelsford 717-774-8370
Jfbrelsford1@mnm.com

PENNSYLVANIA-MONROEVILLE
Inter Community Cancer Center
Last Friday of month: 3:00 - 4:00 PM
Beth Madrishin 412-856-7740
bmadrish@wpahs.org

PENNSYLVANIA-YORK
Apple Hill Medical Center
2nd. Wednesday: 5:00 PM
Dianne S. Hollinger, MA, CCC-SLP
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Diane McElwain, RN, OCN, M.Ed
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TENNESSEE-CHATTANOOGA
Memorial Hospital
1st. Monday: 4:00-5:30 PM
Jeanna Richelson 423-894-9215
Jeanna1255@aol.com

TEXAS-DALLAS
Baylor Irving-Coppell Medical Center
2nd Saturday: 10:00 AM
Dan Stack 972-373-9599
danstack@aol.com

TEXAS-DALLAS
Cvetko Ctr. at Sammons Cancer Ctr.
2nd Tuesday: 11:00 AM-12:30 PM
Jack Mitchell 972-496-6561
jackmitchell5225@aol.com

TEXAS-FORT WORTH
Moncrief Cancer Resources
2nd. Wednesday: 3:30-5:00 PM
Valerie Oxford, MSSW
817-927-6364/838-4863
valerie.oxford@moncrief.com

TEXAS-HOUSTON/TOMBALL
Tomball Regional Hospital
2nd. Tuesday: 12:00 Noon-1:30 PM
Lynda Tustin, RN 281-401-5900
ltustin@tomballhospital.org

TEXAS-McALLEN
Rio Grande Regional Hospital
3rd. Tuesday: 6:00 PM
Stephanie Leal, MA, CCC, SLP
SAL1275@aol.com
Cheryl Lopez, MS, CCC, SLP
956-632-6426

TEXAS-PLANO
Regional Medical Center at Plano
1st. Tuesday: 6:00-8:00 PM
Polly Candela, RN, MS
214-820-2608
Polly.Candela@baylorhealth.edu
Emily J. Gentry, RN
214-820-2608

VIRGINIA-CHARLOTTESVILLE
Dept. of Forestry Building, Suite 800
Last Thursday: 11:30-1:00 PM
Vikki Bravo 434-982-4091
vsb4n@virginia.edu

VIRGINIA-FAIRFAX
Inova Fairfax Hospital,
Radiation/Oncology
2nd. Wednesday: 5:30-7:00 PM
Corinne Cook, LCSW
703-776-2813
Corinne.cook@inova.com

VIRGINIA-NORFOLK
Sentara Norfolk General Hospital
3rd. Monday: 7:00 PM
Helen Grathwohl 757-487-2624
agrath3004@aol.com

WASHINGTON-SEATTLE
Evergreen Hospital Medical Center
Call for Additional Information
Kile Jackson
425-788-6562
kilejackson@hotmail.com

WASHINGTON-SEATTLE
Virginia Mason Cancer Institute
Correa C Conference Rm.
3rd. Thursday: 6:00-7:30 PM
Susan (Sam) Vetto, BSN, RN, BC
206-341-1720
susan.vetto@vmc.org
Joanne Fenn, MS, CCC-SLP
206-215-1770
joanne.fenn@swedish.org

WISCONSIN-MADISON
Univ. of Wisconsin Hospital
ENT Clinic Rm. G3/206
1st. Wednesday: 11:30-1:00 PM
Rachael Kammer, MS, CCC, SLP
608-263-4896
Kammer@surgery.wisc.edu
Peggy Wiederholt, RN 608-265-3044
wiederholt@humcon.wisc.edu

WISCONSIN-MILWAUKEE
Medical College of Wisconsin
Conference Rm. J, Rm. 1010
3rd. Thursday: 12:00-1:00 PM
Tammy Wigginton, MS, CCC/SLP
414-805-5662
twiggint@mcw.edu

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