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S•P•O•H•N•C
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Reconstruction of the Jaw Affected by Osteoradionecrosis

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At a conventional dose that effectively kills cancer cells, radiotherapy has been associated with unavoidable and potentially debilitating complications for some oral and head and neck patients, one of which is osteoradionecrosis (ORN). The lower jaw bone, or mandible, is particularly susceptible to developing ORN because its high mineral content leads to absorption of higher doses of radiation. Radiation may cause injury and devitalization of the bone, making it highly susceptible to infection and impairing its capacity to heal.

Once radiation-induced injury is initiated in the mandible and the overlying soft tissues, ulceration and necrosis of the oral mucosa expose the underlying bone, resulting in the condition termed 'mandibular osteoradionecrosis.' The incidence of ORN in head and neck cancer patients varies from 4% to 37%. In spite of this, radiotherapy improves the likelihood of cure by minimizing the risk of cancer recurrence in the management of oral and head and neck cancer as a definitive treatment by itself, or combined with surgery in certain situations.

ORN typically occurs after a latent period following radiation, which may vary from a few months to several years, with the majority of cases occurring 6 to 22 months following treatment. The bone injury caused by radiation is of a persistent, progressive nature, and the risk of developing ORN can remain as high as 20% even 10 years after radiotherapy.

Predisposing Factors

Osteoradionecrosis of the mandible is caused by multiple factors. Jaw surgery performed within an irradiated field increases the risk significantly. Such surgical procedures are often crucial for achieving complete disease clearance during management of oral cancers, either as a way to gain access to the tumor site or to ensuring tumor-free margins. However, they may lead to an early onset of ORN by interfering with the blood circulation of the mandible. Other predisposing factors include:

- poor oral hygiene,
- chronic trauma by ill-fitting dentures,
- dental infections,
- decreased host immunity or,
- poor nutritional status.

Mandibular ORN worsens the quality of life in affected individuals by causing severe pain, jaw deformity, and infected, draining orocutaneous fistulae. It also compromises chewing, swallowing, retention of saliva, jaw opening, and efficient use of dentures. Extensive bone necrosis can lead to painful and persistent jaw fractures.

Prevention of ORN

Minimizing Dental Infections

Measures that minimize the risk of developing ORN are a critical component of comprehensive head and neck cancer treatment. A thorough dental evaluation for caries, periodontal disease, and tooth abscesses is critical to eliminate infectious sources that can lead to serious infections in irradiated mandibular bone with a poor blood supply. Any tooth that has the potential to become a source of infection or require extraction during the patient's lifetime should be extracted 2 to 3 weeks before radiotherapy. Following extraction, care is taken to close the mucosa and completely cover the exposed bone of the tooth sockets. Maintenance of meticulous dental hygiene, particularly in the postoperative period, along with daily fluoride treatment, is important to decrease risk of ORN.

Capacity to Heal

Poor nutritional status is frequently encountered in patients treated for head and neck cancer. It may play a role in perpetuation and worsening of mandibular ORN. Thus, strengthening the patient's immune system and ability to heal wounds by increasing nutritional intake through feeding gastrostomy tubes may be necessary to limit the development of ORN.

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Future Fundraiser

Skate4SPOHNC

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IN THIS ISSUE

Record Number of SPOHNC Chapters Serve Survivors

Support Groups Surpass 100 Mark in 2010

SPOHNC "Support for People With Oral, Head, and Neck Cancer," recently launched its 100th chapter to offer support, information and encouragement to help those diagnosed with oral, head, and neck cancer through their journeys of treatment and survivorship. There are now more than 100 SPOHNC Chapters providing help to individuals in 35 states.

The American Cancer Society estimates that 80,000 new cases of oral, head and neck cancer will be diagnosed in the United States in 2010. As new cases are increasing, the demand for services of support groups is also increasing.

According to SPOHNC Founder, Nancy Leupold, "Each year, thousands of individuals and their families look to SPOHNC to achieve their dreams of returning to health or well being. SPOHNC facilitators and chapter members are now available in more places across the country supporting them by offering their insights, knowledge and experience in local communities."

"As an oral cancer survivor, I understand the emotional and social

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Passion for the Mission

One Man Is Making A Difference for All of Us

One person can make a difference. Nowhere is that more evident than with the story of Skate4SPOHNC, which began in Dallas, Texas, as a day-long inline skating marathon to raise awareness of oral and head and neck cancer. On September 19, 2010, a new Skate4SPOHNC relay will take place, this time in honor of recently retired SPOHNC Founder Nancy Leupold.

In the late-2000s, Rick Agee, a tongue cancer survivor of two recurrences, wanted to enhance support for his local Mid-Cities chapter of SPOHNC. He decided to personally raise awareness by doing something he enjoyed—inline skating for fitness.

On September 20, 2009, Agee spent a grueling 7 hours circling the tracks at Richardson Grove Park for more than 60 miles (100 kilometers) on his skates. Throughout the day, friends skated, biked, ran, or walked with him, many donating to the effort. He raised $14,000 to fight our cancers. That first year, nearly 300 of Agee's friends, family, chapter members, and patients watched as he skated the course. An indescribable spirit prevailed at the track and in the marquees that dotted the field.

While he circled the tracks those hours, he thought about what events could take place in the future. He envisioned that Skate4SPOHNC in 2010 would continue raising awareness of oral and head and neck cancer. Months later he pulled together a small committee to plan the second event, this time dedicated to SPOHNC Founder and President Nancy Leupold. To read all about it—and make a donation to Rick's efforts to honor Leupold's legacy and to support SPOHNC's outreach programs—please log on to: skate4spohnc.org or go to the SPOHNC Web site at: www.spohnc.org.

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SPOHNC Founder and President Nancy Leupold

impact of the disease," says Leupold. "The main goal of treatment is to cure the patient of cancer. However, the physical, psychological, and psychosocial effects of the disease and its treatment must also be addressed." The psychosocial effects are the emotional and social issues that people with cancer often encounter which can greatly affect patients' well-being. "SPOHNC's work is vital to the survivor as it helps optimize patient care by providing essential, but often overlooked, services that complete an individual's cancer care plan," she adds.

These offerings include a comprehensive menu of personalized and essential services, including support groups, one-on-one matching program, education, and healthy lifestyle programs, to those affected by oral and head and neck cancers throughout the continuum of care. Both newly diagnosed patients and survivors call on SPOHNC support group facilitators and members as a vital source for information, insights, support and encouragement. In fact, every year, SPOHNC Chapters provide more than

- 1,000 meetings,
- 500 informational presentations and workshops,
- 2,500 attendees at support group meetings and special events.

Many people experience distress because of these cancers, but fewer take advantage of such personalized emotional and social support services. To ensure no one has to face this cancer alone, SPOHNC aims to ultimately develop additional support groups to be available to people in all 50 US states through the network of community-based centers, hospitals, oncology care groups and other non-profits, as well as online.

"SPOHNC is poised to provide support to the increasing number of persons who need it through its comprehensive and innovative offerings," says Executive Director, Mary Ann Caputo. "It is SPOHNC's goal to reach every individual affected by this devastating disease through our many resources."

Additionally, the SPOHNC organization is always working to expand its vital services to cancer patients and their loved ones through its National Volunteer Survivor Network, newsletter, Web site for online information, and its very successful publications. It is also exploring the use of novel technologies, such as FaceBook, to help extend the reach of these essential resources.

Many SPOHNC services are offered at no charge. Speaker sessions and workshops covering treatment and survivor issues are organized by local chapters, which usually meet on a monthly basis or more. We encourage individuals to become members of SPOHNC for an annual fee of $25.00 or $30.00 for families. With this membership individuals receive our very popular and informative newsletter, *News From SPOHNC*, published 8 times a year.

Contact a SPOHNC support group at any one of more than 100 chapters nationwide by visiting the SPOHNC Web site at www.spohnc.org or calling 1-800-377-0928.

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Management of ORN

The initiation and progression of ORN is facilitated by increased dose of external beam radiation. The dose (increase of external beam radiation over 50 Gy) and field of radiation should be planned with utmost care to minimize the risk of ORN. Along with these factors, the mode of radiation (external beam or radiation implants) has an impact on the severity of ORN. The use of more focused delivery techniques like brachytherapy (a form of internal radiotherapy in which radioactive material is surgically implanted into the tumor site) can limit the severity of ORN and is more responsive to conservative management than ORN in patients who undergo high-dose external beam radiation.

Early detection and initiation of treatment is important to arrest the progression of osteoradionecrosis. Conservative management is performed for early-stage ORN that includes irrigations, long-term antibiotics based on bacterial cultures, and debridement procedures like sequestrectomy for removal of minimal amount of necrotic debris if present. All these measures may be combined with hyperbaric oxygen (HBO) therapy. This therapy involves intermittent episodes of treatment with 100% oxygen at high atmospheric pressures. HBO is supposed to improve the healing capacity of tissues through increased oxygen delivery and better blood supply.

Failure of ORN to respond to conservative treatment within 6 months mandates active intervention. A foremost approach is to rule out local recurrence of cancer through biopsy. Even in the case of recurrent cancer, biopsy may not always detect it because the presence of gross inflammatory tissue may interfere with adequate tissue sampling. Thus radical surgical treatment is warranted, both in mandibular ORN cases nonresponsive to conservative measures like HBO, as well as severe cases of ORN with large areas of exposed and necrotic jaw bone, chronically draining fistula tracts, or jaw fractures.

Complete excision of the nonviable and necrotic bone is mandatory to initiate the healing process in ORN. The extent of bony resection is estimated preoperatively with a CT or MRI scan, and excision is done during an operation up to the point where healthy bleeding bone is encountered. The affected soft tissue around the necrotic bone also needs to be removed. After excision, a bony and soft-tissue defect is created, which requires correction by reconstructive surgery to restore function and facial harmony.

Reconstruction Options

Reconstruction is individualized to each patient. The reconstruction options depend on the severity, size, and site of the cancer. Options consist mostly of tissue rearrangement with local flaps, pedicle flaps, or free flaps. Various methods used to reconstruct the jaw include alloplastic materials, vascularized flaps, and re-vascularized free bone or soft-tissue flaps.

Alloplastic Devices

Alloplastic surgical material, such as titanium, is biocompatible and can be safely implanted into soft tissues. Titanium mandibular reconstruction plates are rarely used in patients treated for ORN because extrusion of the plate requiring its removal frequently occurs. However, the material may be used in cases where other reconstructive options do not exist. In this situation, a soft-tissue flap from the forearm

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Treatment of Depression in Patients With Oral and Head and Neck Cancer

KIM K. SOLBERG, M.D.

This is the second of two articles focusing on depression in patients with oral and head and neck cancer. In the April issue of News from SPOHNC, depression and considerations in diagnosis were described. This article describes treatment using the concept of the BIO-PSYCHO-SOCIAL MODEL.

It is important to emphasize that depression is very much treatable. There are different approaches to the management of depression, including many forms of psychotherapy and many medications. It is up to the psychiatric practitioner to develop a treatment plan tailored to the individual patient. Before a course of treatment may be decided upon, it is helpful to have a method to conceptualize or understand what the patient is going through. As a resident psychiatrist, I learned a time-honored method referred to as the BIO-PSYCHO-SOCIAL MODEL, which helps in this process.

The biology or BIO of the patient traditionally refers to brain chemistry and the patient's family history as factors in the development of depression. For instance, if a patient's mother had depression and responded to a certain antidepressant, it is more likely that the patient will respond to this same medication. In patients with oral and head and neck cancer, there are multiple biological considerations in treatment planning. The type of cancer as well as the location and stage of advancement at the time of diagnosis will determine what treatment is recommended. The recommendation may include surgery, radiation, and chemotherapy with predictable effects and side effects. Common side effects of the cancer treatment include pain and disfigurement, loss of speech, weakness, tiredness, insomnia, poor appetite and malnourishment.

All of these side effects may contribute to depression and should be addressed, as a part of the depression treatment. To illustrate this concept, consider that an antidepressant is not likely to help a patient whose pain is undertreated. Insomnia is common in medical patients in general and is a miserable condition that affects mood. Also, antidepressants are less likely to be effective in a patient who has lost considerable weight and is not eating well. Optimally, this aspect of the treatment will involve collaboration including the psychiatric provider with members of a multidisciplinary head and neck cancer management program.

The **psychological or PSYCHO** aspects of the evaluation and treatment include understanding the patient and the impact of the illness on his/her life. When someone has been diagnosed with a life-threatening and/or life-changing illness it is important to try to understand their personality style, especially in dealing with stressful situations. I believe that it is important to ask the patient what they know and believe about their illness. If a patient believes that their cancer is a punishment for past bad behavior, smoking, drinking, or otherwise, it is important to address this belief in some fashion. Similarly, a patient may believe that he or she is dying, even though they have been told that the cancer is treatable. This may have a profound negative affect on the patient's outlook and prognosis.

In oral and head and neck cancer patients, disfigurement and changes in ability previously taken for granted, such as swallowing and speaking, are especially challenging to adapt to on an emotional level. Patients whose self-esteem grew largely out of their outward appearance often have short- and long-term problems in adjusting. Finally, marital or family problems don't necessarily get better because of a life-threatening illness. Although psychotherapy or talk therapy is a very common recommendation in the treatment of depression, the cancer patient may be too ill, too tired, or too busy for this intervention in the midst of aggressive treatment. Because of each situation, the program's social worker may be in the best position to begin to address these issues. Support of the speech pathologist can also provide a lifeline to the patient who is struggling to adapt to changes in image and function.

The **SOCIAL aspect** of the BIO-PSYCHO-SOCIAL Model refers to the more practical aspects of the patient's life. Social workers in programs dedicated to the care of patients with oral and head and neck cancer are often the first care providers to address the emotional aspects of the patient's illness experience. Additionally, they identify and anticipate practical needs, which may be crucial in managing the patient's depression. These include transportation, obtaining medication and addressing family strain and unique family needs. The practitioner may write a prescription for a patient who doesn't have prescription coverage or can't afford the co-pay and will not be able to take the medication without funding arranged by the social worker. Often the social worker becomes a lifeline for the patient during treatment.

Alcohol and Drug Abuse Threaten Mental and Physical Health

Any discussion of treatment of depression would be deficient without mention of the fact that alcohol and some drugs are depressants. Abuse or even use of these substances must be evaluated and addressed starting with the initial evaluation process. Ongoing abuse may negatively impact mood, increase risk of cancer recurrence, and threaten the patient's health in general. Alcohol withdrawal and even delirium tremens are preventable complications, which present during hospitalizations after surgery. Any alcohol or drug use should be brought to the treatment team's attention.

In recent years, there has been an explosion in the number of antidepressants and psychotropic medications in general. In any patient, the choice of antidepressant often involves the avoidance of side effects, but conversely the exploitation of some side effects that may be beneficial. In general, medications that cause significant dry mouth should be avoided because such medications can worsen the effects of radiation-induced dry mouth and speech and swallowing problems. Amitriptyline (Elavil) is an example of such a drug.

Medication that causes sleepiness or sedation may be beneficial in patients who aren't sleeping well but problematic in those who are already tired. Mirtazapine

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A TIME FOR SHARING

"Cancer invades and destroys; an enemy from within. To fight it, our bodies must be cut, poisoned, and burned. We must endure pain. Side effects can be long-term and debilitating. Having cancer is like fighting a war against a cunning, ruthless enemy."—Rebecca Kohler, H&N cancer survivor, SPOHNC Oregon

"I was in such a misery and despair trying to win the battle with cancer. I hated cancer, and I hated how it changed my life."—cancer survivor

"Taking the warrior stance against my cancer is like trying to kill my body. My cancer is me. And since I started treating it as a part of my body instead of an outside invader, I have been much happier and less fearful."—cancer survivor

The devastation that oral and head and neck cancer causes to patients is certainly significant. Fear, anxiety, and depression are especially common among patients with these cancers, and this article aims to look at this issue. An informal survey by Rebecca and Brent Kohler of the Oregon SPOHNC support group of 20 persons revealed many members suffered from one or more psychiatric conditions such as anxiety, depression, or suicidal ideation (see above).

Yet only one person turned up who had received mental health services preventively during treatment. Another individual was prescribed an antidepressant at the same time as oxycontin because the doctor said, "You're gonna need this." The other 18 survivors had no mental health evaluations before, during, or after their treatment. Most received no queries specifically about their mental health throughout their entire course of treatment.

Who is responsible for the mental health of the cancer patient? Ultimately, it is the patient who is responsible.The **patient** must ask for help if he or she is anxious or depressed, suffers from panic attacks or insomnia, or has thoughts of suicide. On the other hand, patients are often overwhelmed by their physical symptoms. Pain, malnutrition, exhaustion, and medications can muddy their thinking. Further, being a cancer patient is a new experience, and they do not know how to identify when their feelings are "normal" or when they require professional help. Finally, a stigma still exists for mental health problems, and patients may be reluctant to admit they have issues. In short, many survivors will need professionals to aid them in identifying their mental health needs and arranging for therapeutic services.

Doctors and nurses and social workers can play an important role in helping patients identify their feelings and create and environment in which they feel comfortable talking about them. Simply asking open-ended questions like, "How are things going?" is not enough. Most patients will talk about their physical side effects before they will address any emotional ones. Instead, professionals should ask specific questions about mood, sleep, anxiety, depression, thoughts of suicide, etc. Also they should ask about social support, financial concerns, and other stressors in their lives. Mental health should be evaluated before, during, and after treatment. If patients have a history of psychiatric problems or chemical dependency, then refer them for mental health services at the outset of treatment. On a weekly basis, inquire about patients' emotional health as well as their physical.

Getting Ahead of Cancer for Mental Health

Finally, everyone should strongly encourage survivors and newly diagnosed patients to go to a SPOHNC meeting or call and ask for a one-on-one match with a mentor. They went through everything you are going through, and they made it. These are examples of the many benefits:

- Journeying with someone who has been there before is invaluable
- Being able to talk about the cancer experience with survivors is both comforting and inspiring
- Hearing the stories of survivors and telling your own is healing for all.

A variety of reasons exist for the increased rates of psychological effects in head and neck cancer patients, including arduous treatment regimens; surgery and complications that interfere with eating and talking; and having visible wounds left by the cancer, according to Dr. William J. Burke, M.D., a psychiatry professor from the University of Nebraska Medical Center. He is the lead investigator of a study designed to help head and neck cancer survivors get ahead of such problems.

Rebecca & Brent Kohler, Oregon

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(Remeron) may help with sleep, appetite, and anxiety. In general, the SSRIs (selective serotonin reuptake inhibitors) are the first-line medications in the treatment of depression. Fluoxetine (Prozac) was the first medication in this group. Citalopram (Celexa) and ecitalopram (Lexapro) have been studied and shown promise in prevention of depression in head and neck cancer patients. There are several other medications in the SSRI class. These medications do not help much with sleep but may be combined with one of many sleeping medications.

Another class of medications called the SNRIs (serotonin-norepinephrine-reuptake inhibitors) are also effective and well-tolerated antidepressants. Effexor (venlafaxine) and Cymbalta (duloxetine) are examples. Sometimes, novel medications such as methylphenidate (Ritalin) are tried in patients with depression, poor energy, and lack of appetite. A nice feature of this medication is, in patients who respond, it works quickly, often within days.

While it is not possible to give an exhaustive review in a newsletter format, I hope that this introduction will be helpful in understanding what is involved in the evaluation and treatment of depression in patients affected by oral and head and neck cancer. My hope is that increased awareness of depression and its treatment will result in more patients asking for and receiving help so that they feel better and adjust well.

Editor's Note: Dr. Solberg is a psychiatrist/ neurologist in Towson, MD.

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(pectoralis) region must be used to cover the titanium plate. If the portion of the mandible that forms the temporomandibular joint (condyle) must be removed, then reconstruction of the condyle and posterior mandible is possible with a titanium joint replacement prosthesis.

Vascularized Local and Pedicled Flaps
Local Flap: A local flap is a tissue rearrangement adjacent to the wound. To cover defects adjacent to the donor site area a local flap, consisting of skin and the underlying subcutaneous fat, is used.

Pedicle Flap: Pedicled flaps, which are composed of muscle and the overlying skin and subcutaneous fat, reconstruct *nonadjacent defects* that are farther away from the donor site region. Pedicle flap tissue is sutured into place at the recipient site.

In these cases, the blood supply to the flaps is preserved: they are vascularized flaps. Local and pedicled flaps, however, may not provide adequate blood supply to the irradiated tissue bed in cases of ORN, leading to poorer healing. Pedicled flaps have become less popular as more reliable revascularized flaps have been developed that also provide surgeons with the ability to customize the reconstruction to the defect. However, pedicled flaps continue to play a role in the management of patients afflicted with ORN, particularly when revascularized flaps fail.

Revascularized Flaps
Free Flap: A free flap is completely removed from its donor site and connected to an artery and a vein at the recipient site. Free flaps are more complicated because they require microsurgery.

This reconstructive surgery option involves the creation of a flap that is removed from the body, completely disconnecting the flap from its original blood supply at the donor site. This flap, freed from the donor site, is then transferred to the distant recipient site and is revascularized by re-establishing blood flow between the blood vessels of the flap and the recipient site. Revascularization of the free flap is achieved by sewing the ends of the blood vessels together (an anastomosis) under a microscope, thereby restoring the circulation.

Important factors that guide selection of the flap for reconstruction are the:

- size and location of bone and soft tissue defects,
- condition of the recipient bed,
- general health of the patient,
- patient's prognosis relative to his cancer.

Some patients may have undergone previous free flap reconstruction or neck dissection, which limits the number of adequate blood vessels for revascularization. In such situations, the surgeon may need to search for blood vessels on the opposite side of the neck or use a pedicled flap.

Microvascular reconstruction of jaw defects with a revascularized free flap is considered the standard of care for patients with advanced stage ORN. It not only restores continuity of the bony defect but also promotes healing by supplying healthy, nonirradiated soft tissue for coverage of the reconstructed jaw. The most commonly used free flaps for reconstruction of the jaw are comprised of bone and soft tissues such as muscle, fat and skin. The bony part of the free flap reconstructs the jaw while the muscle and skin provide healthy soft tissue for resurfacing the oral cavity and any external skin defects of the chin, cheek, or neck.

Bone-Containing Free Flap: The fibular free flap is the most widely used flap for the mandible. The fibula, one of the two bones in the lower leg, is a very reliable method of reconstructing lateral defects (lying on either side) of the jaw and can also be reshaped to reconstruct the curved U-shaped front portion. As a leg bone, the fibula does not support much body weight, so its removal has minimal effect on walking. The shin bone, or tibia, which has a greater role in weight-bearing activities, is left undisturbed. The new mandible formed by the transplanted fibular bone allows favorable placement of dental implants. These implants are tiny titanium screws that are gently inserted into the bone. These fixtures facilitate subsequent placement of implant-supported dental prostheses that are more stable than removable dentures and improve patients' ability to chew and swallow.

Use of a fibular free flap is recommended for reconstruction of the jaw when the estimated bone defect is greater than 5 cm. It remains useful for defects as large as up to 25 cm. The fibular flap has long blood vessels, thus decreasing the risk of flap failure because of inadequate blood flow. A careful evaluation is merited in patients with history of surgery, trauma or peripheral vascular disease of the lower legs prior to selection of a fibular flap; in such patients, other options like iliac crest or scapular free flaps should be considered for jaw reconstruction as discussed below.

Free flaps for mandibular reconstruction can be harvested from the scapula (shoulder blade), iliac crest (part of hip bone), or the forearm as well. The scapular and iliac crest flaps also provide bulky soft tissue for filling the space left by the resected jaw. The fibula and iliac crest serve as the best sources for bone and are correspondingly the preferred bone-containing flaps when dental implant placement is desired. In contrast, the radial forearm free flap is the best source of skin and soft tissues, which are thin, pliable and richly vascularized. Unfortunately, the indications for the radial flap are limited by the quality and quantity of bone that is available.

Free Soft-Tissue Flaps: Free soft-tissue flaps containing only muscle and skin can be harvested from the abdominal wall (rectus abdominis flap) or forearm (radial forearm flap). They are used in ORN patients who are poor candidates for a bone-containing free flap, for patients who require soft tissue resurfacing of the oral cavity for coverage of exposed mandibular bone, or when significant radiation-induced necrosis is present in soft tissue. The anterolateral thigh flap, a soft-tissue flap from the upper leg, has also become a popular choice for reconstruction of oral cavity defects resulting from cancer surgery or ORN.

Single-stage vs 2-stage Reconstruction
Microvascular reconstruction is usually performed immediately after excision of necrotic jaw bone in a single stage (during the same surgical procedure), but a 2-stage procedure is advocated as well by those who claim that it can achieve better healing. In the 2-step procedure, the necrotic bone is first removed and reconstruction is delayed until the oral mucosa is completely healed and chronically draining fistula tracts have resolved.

Complications Following Reconstruction
One of the challenges encountered with microvascular reconstruction is the extensive post radiation fibrosis and scarring around

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the blood vessels that may make dissection very difficult. Severely damaged irradiated tissues may increase the morbidity and failure rates associated with free flaps, resulting in infections, wound breakdown, and nonunion of the adjacent bone segments. By causing blood clot inside veins (venous thrombosis) and wound infections, the failure rate (reported to vary between 20%-33%) may also increase.

Therapy prior to such reconstruction is believed to promote formation of new blood vessels and reverse the delayed radiation changes in tissues, thereby decreasing the failure rate of free flaps in mandible and soft-tissue reconstruction for ORN. Another additional problem reported with free microvascular bone flaps is the difficulty in achieving the needed arch and size, which may lead to unsatisfactory dental prosthetic rehabilitation. To circumvent this problem, bone marrow grafts can be used to increase the bone volume. Certain surgical and dental techniques may also be used to compensate for the insufficient height of fibular and other bone flaps.

Conclusion

Advanced stage osteoradionecrosis of the mandible is a cause of significant morbidity for head and neck cancer patients. Radical resection followed by reconstruction is the treatment of choice for advanced stage ORN of the mandible in head and neck cancer patients. Although selection of an ideal technique for mandibular reconstruction continues to be a subject of intense debate, microvascular surgery as a single-stage surgical procedure is capable of achieving optimal results within a short hospital stay. Of the various bone-containing free flaps, reconstruction with the fibular flap has become the most effective way to enhance the quality of life in patients with ORN by eliminating pain, controlling local infections, improving functional status, and correcting facial disfigurement.

Editor's Note: Parul Sinha, M.B.B.S, M.S. is an otolaryngologist from New Delhi, India who has clinical and research interests that focus on oral cancer. Recently, Dr. Sinha published important research findings regarding the use of molecular analysis to confirm the adequacy of tumor resection for tongue cancer (Sinha P, Bahadur S, Thakar A, et al. Significance of promoter hypermethylation of p16 *gene for margin assessment in carcinoma tongue. Head & Neck. 2009;31:1423-1430.).*

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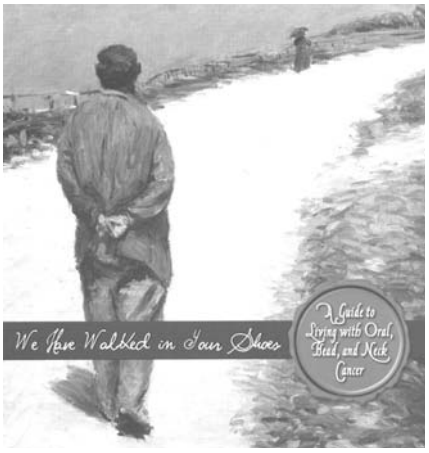

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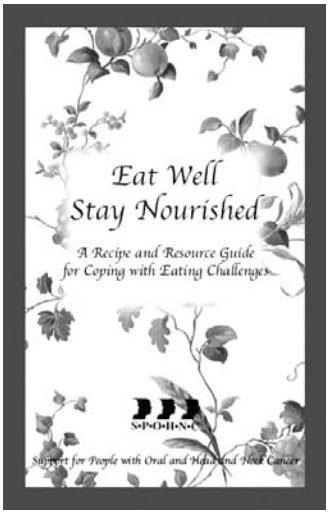

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SPOHNC CHAPTER NEWS

Arizona Experts Discuss Head and Neck Cancer Survival
by Keri Winchester, M.S., CCC-SLP

Oral and head and neck cancer strikes about 700 Arizonans each year. Although the numbers are not that great, the devastation to patients and their families is.

On April 13, in celebration of Oral and Head and Neck Cancer Awareness Week, 60 people attended a panel discussion on head and neck cancer sponsored by three local Arizona chapters of SPOHNC at the Chandler Regional Medical Center's Cancer Center. The discussion centered on "Living With Oral, Head, and Neck Cancer."

As one survivor put it, "Having head and neck cancer and surviving it opened my outlook on life that has made my life more full and has allowed me to help others."

Presently living with head and neck cancer are prominent film critic Roger Ebert and chef Grant Achatz from Chicago, and basketball coach George Karl of the Denver Nuggets. Head and neck cancer occurs in males three times as often as it does in females.

Many well known people have had oral and head and neck cancer in the past. Among the most famous are psychiatrist Dr. Sigmund Freud and President Grover Cleveland, who both had cancer of the palate. Secret surgeries were performed on the interior of the President's mouth, leaving no visible scars. A plate was made from tire rubber, which restored his speaking voice so well that when he re-appeared in public no one could detect that an operation had taken place. President Ulysses S. Grant was found to have squamous cell carcinoma after leaving office brought on by smoking 20 cigarettes a day for 22 years, according to his physician. Men who smoke have a 27-times higher rate of oral cancer than nonsmokers, says the World Health Organization.

Several physician experts in the field of head and neck cancer participated in the panel and shared information about the latest medical treatment and management of head and neck cancer. Dick Snider, M.D. retired, head and neck cancer survivor and co-facilitator of the Chandler and Phoenix chapters, served as moderator.

Speakers included:

- Glenn Rothman, M.D. Head and Neck Surgeon-The current role of surgery in the management of head and neck cancer; discussion of robotic surgical interventions.
- Herbert Hitchon, D.O. Radiation Oncologist – The current and future role of radiation oncology in the management of head and neck cancer.
- Rami Sarid, M.D. Medical Oncologist – The current role of various treatments for head and neck cancer as well as what the future may hold.
- Robert Price. D.D.S. Doctor of Dental Surgery – The role of diligent dental management before and after radiation therapy for oral and head and neck cancer.

The panel answered questions at the end of the program. "You have to make sure patients have the facts about what those who treat them can do," said Phoenix Chapter facilitator Kerri Winchester, S.L.P. At the same time, she said, "the discussion must be as honest as possible." If they don't have the realistic perspective to go along with the treatment, it won't be as successful."

Treatment of head and neck cancer patients is a multidisciplinary team effort, including a variety of specialty physicians and dentists, nurses, speech pathologists, mental health professionals and others. Fortunately, thanks to advances in medical treatments and plastic and reconstructive surgery techniques amazing things can be done to help paients with these cancers.

Spirit of Georgia

Bravos to the SPOHNC Chapter in Augusta, Georgia for also raising awareness and funds during Oral and Head and Neck Cancer Week with everyone participating in the second Annual Walkathon in May.

The event was planned by Head and Neck Cancer survivor Leann Dragano who serves as Chapter facilitator with Lori Burkhead, PhD, CCC-SLP. "We had to do this," says Dragano, "to show that the disease means something other than a cancer that devastates lives." She describes it as a "simple event" but a far-reaching demonstration of "determination to get the word out about oral and head and neck cancer and say you can survive this cancer ."

Gifts Have Been Received in Loving Memory of

Leslie Crump by Anonymous, Henry Deneski

Robert Klauber by
Sandra Campaniello, Michael Cannarozzi, Mark Cowitt, Jeff Ellner, Lynn Gormley, Susan Kennedy, Nina Klauber and Family, Carol Manske, Harvey Nosowitz, Elsa Paszek, Ronald Pollack, Bonnie Sawicki, Stanley Schrier, Robert Schwartzman, Margaret Siegle, Alfred Tuckman, Gary Turetsky, Judith Zipkin

Dorothy Lipari by Paula Heidt

William Edgar Robsky by
Allen Acker, Donald Daros, Judy Kostyk Hannon, Thomas Lane, John Livingston, Thomas McDowell, Theresa Miller, New England Golf Association, Inc, James Passier, PGA-Connecticut Section, Daniel Sullivan, John Walsh

SPOHNC is grateful for the generosity of its contributors. Thanks to your support, SPOHNC is able to maintain and extend its programs of education and support to cancer survivors, their families and friends.

CHAPTERS OF SPOHNC

ARIZONA-CHANDLER
Cancer Center at Chandler Reg. Med. Ctr.
1st. Wednesday, 5:30 – 7:30 PM
Monica Krise, MSW 480-728-3613
monica.krise@chw.edu
Dick Snider (ret.) 480-895-6019
rsnider326@aol.com

ARIZONA-PHOENIX
Banner Desert Medical Center
3rd. Wednesday: 4:30 -6:30 PM
Keri Winchester, MS, CCC-SLP
480-512-3627
Keri.Winchester@bannerhealth.com
Dick Snider (ret.) 480-895-6019
rsnider326@aol.com
Bette Denlinger, RN
beneden@cox.net

ARIZONA-PHOENIX
Comprehensive Cancer Ctr.
St. Joseph's Hospital and Medical Ctr.
1st.. Tuesday: 5:30-7:30 PM Suite 650
Mary Schneider, Director
602-406-3882
mary.schneider@chw.edu
Barbara Chapman, RN, OCN
602-401-8131 barbara.chapman@chw.edu
Dick Snider, MD (ret.) 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
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
Pam Collins, Program Director
805-238-4411
pamela.collins@twcccc.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

CALFORNIA-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
Joan Fusco, LCSW 650-725-0562
jfusco@stanfordmed.org
Jaime Laskowski, RN
jlaskowski@stanfordmed.org

CALIFORNIA-VENTURA
The Cancer Resource Center of
Community Memorial Hospital
Kathleen Horton 805-652-5459
khorton@cmhhospital.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 Ca Ctr/Martin Marietta Conference Rm
3rd. Monday: 1:45-3:00 PM
Joanne Assarsson, MSW, LICSW
202-444-3755
assarssj@gunet.georgetown.edu

DC-WASHINGTON
Washington Hospital Center
Washington Cancer Institute
Rooom C1200
Last Thursday: 2:00-3:30 PM
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 Cox, 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.
4th Tuesday, 3:00-4:00 PM
Stacey Brill, MS, CCC-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
850-863-8275
rennis@whitewilson.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
Monica Grey LCSW, LMT
352-222-8126 No calls after 9pm
monica.grey@cox.net

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: 6:00-8:00 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 Moss, MS, CCC-SLP
239-393-4079/Karen.moss@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

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
MCG Health 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 Dragano 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
Sabina Omercajic, MS, CCRP
847-570-1066
somercajic@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-FORT WAYNE
Lutheran Cancer Resource Ctr Ste 109
3rd Wednesday: 4:00-5:00
Susan Berghoff, RN, OCN
Mischa Story, RD 260-435-7959
lh.crc@lutheran-hosp.com

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, BSN, OCN
Stoddard Care Coordinator
515-241-3399 wittjl@ihs.org

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
Fernval@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
4th Thursday: 6:30 PM
Carrie Eriksen, LCS, 248-964-3430
CEriksen@beaumonthospitals.com

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

MISSOURI-COLUMBIA/MID-MO
Ellis Fishcl 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
Deborah S. Manne, MSN, RDH, RN, OCN
314-577-8880; mannedt@slu.edu
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@atlantichealth.org
Catherine Owens, LCSW, OSW-C
973-971-5169
Catherine.Owens@atlantichealth.org

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 Sumbrum, SLP 716-845-4947
amy.sumbrum@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

NEW YORK-NEW HYDE PARK
NORTH SHORE-LIJ Health System
Hearing and Speech Conf Rm, LL
Sharon Lerman, LCSW 718-470-8964
Lynn Gormley 516-628-1219
516-314-8897 lgormley1@optonline.net

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
NSLIJ-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@carolinashealthcare.org
Terri Painchaud 704-364-7119
Trappi6@yahoo.com

N 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
2nd. Thursday: 4:00 PM
Tom Wurz 440-243-6220
roe8@hotmail.com
Gwen Paull, LISW 216-476-7241
gwen.paull@fairviewhospital.org

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

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

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

OREGON-THE WILLAMETTE VALLEY
Samaritan Reg CA Cntr Library
2nd. Wednesday: 5:00-6:30 pm
Lisa Nielsen 541-757-9882
HNCSurvivor@comcast.net

PENNSYLVANIA-HARRISBURG
Health South Lab 3rd. Tues: 6:30 PM
Joseph F. Brelsford 717-774-8370
Jfbrelsford1@mmm.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-NEW CASTLE
UPMC Jameson Cancer Center
Medical Arts Bldg Suite 104
3rd Thursday, 6:00-7:30 PM
Jeannie Williams, Patient Navigator
Becky Rainville, RN 724-656-5870

PENNSYLVANIA-PHILADELPHIA
Penn Med Perelman Ctr Advanced Med
1 W. Pavilion Pt % Fam Conf Rm
1st Wednesday: 9:30-11:00 AM
Micki Naimoli 856-722-5574
Tracy Lautenbach 215-662-6193
lautenbach@uphs.upenn.edu
Mia Benson Smith, MS 215-662-4641
mia.bensonsmith@uphs.upenn.edu

PENNSYLVANIA-YORK
Apple Hill Medical Center
2nd. Wednesday: 5:00 PM
Dianne S. Hollinger, MA, CCC-SLP
717-851-2601 Dhollinger@wellspan.org
Diane McElwain, RN, OCN, M.Ed
717-741-8100 dmcelwain@wellspan.org

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
danrstack@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 of month: 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
Rad/Onc Conf Rm Green 1-245
2nd Wednesday: 6:30-8:00 PM
Kile Jackson 425-788-6562
kilejackson@hotmail.com

WASHINGTON-SEATTLE
Swedish Med Ctr. 1 E. Conf Rm
3rd. Thursday: 6:00-7:30 PM
Susan (Sam) Vetto, BSN, RN, BC
206-341-1720 susan.vetto@vmmc.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@humonc.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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