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NEWS FROM SPOHNC

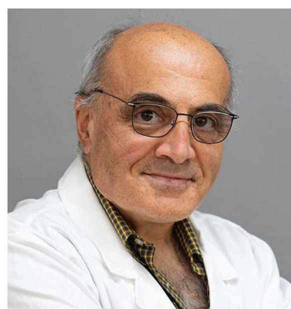
SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER | EST. 1991

S•P•O•H•N•C
A PROGRAM OF SUPPORT FOR PEOPLE WITH ORAL AND HEAD AND NECK CANCER

The Use of Hyperbaric Oxygen Therapy in Head and Neck Cancer Patients

Ziad K. Mirza, MD, CPE, CMD, FACP, MBA, ABIM, ABPM/UHM

Hyperbaric Oxygen Therapy (HBOT) is a non-invasive method of delivering pressurized oxygen to treat different ailments including those in individuals suffering from consequences of head and neck cancer therapy. This involves breathing oxygen at high pressures which helps oxygenate hypoxic tissue by diffusion of supersaturated blood into tissues lacking adequate oxygenation. It also creates oxygen free radicals that enhance cellular signaling leading to tissue regeneration, mobilization of stem cells, and formation of new blood vessels, helping limit the effects of inflammation, and helping fight infection. When indicated, HBOT should always be used as an adjunct to appropriate medical and surgical care; it is rarely a stand-alone therapy.



Treatment of head and neck cancer often includes radiation therapy (RT) that is used to alter the DNA within cancer cells, thus leading to cell death. Advances in RT include intensity modulated radiation therapy or volumetric modulated arc therapy. Despite such modalities that deliver high dose RT to well-demarcated areas of the body, healthy tissue can still be affected leading to post-operative complications of RT. These include death of bone known as osteoradionecrosis (ORN), death of salivary gland tissue leading to decreased salivation (xerostomia) resulting in greater risk of oral trauma and dental infections, and death of cartilaginous tissue, such as that found in the larynx (chondroradionecrosis). Other complications include non-healing of ulcers at the site of radiation. Most of these complications occur 6 months to 2 years after the initial RT and are therefore referred to as Delayed Radiation Injury (DRI). Around 5-15% of patients who receive radiation develop delayed radiation injury. The risk of radiation injury increases along with radiation dosage, adjunctive chemotherapy, age at the time of initial treatment, size of the initial tumor, the presence of infection over the site, any prior ischemic (low oxygen) event involving the affected area, smoking, and the presence of any metabolic disorders, such as diabetes. Radiated tissue becomes more compromised with time and the risk of complications increases as more time elapses.

HBOT is FDA approved to treat several conditions that occur in head and neck cancer individuals. These conditions include DRIs as well as other pertinent conditions such as ORN, compromised flap/graft, chronic refractory bone infection and necrotizing infection. Surgical intervention in the field of the RT may lead to non-healing surgical ulcers. Such conditions may require further surgery with a flap or graft placement. HBOT has been shown to help reverse the effect of radiation and improve the healing process, thus minimizing the risks associated with further surgery. Radiation injuries typically take longer to heal in comparison to other conditions because of poor vascularity, cellularity, and oxygenation to the area.

Hyperbaric oxygen therapy can be delivered in two different kinds of chambers: the mono-place and the multi-place. The mono-place chamber treats one patient at a time and is compressed with 100% oxygen. The patient lies flat inside a large transparent tube with the possibility of viewing a television screen located outside the chamber. If needed, medical equipment – such as blood pressure machines, intravenous pumps, and cardiac monitors, can be used with attachments through the chamber door. The multi-place chamber, on the other hand, is a larger unit with multiple patients being treated at the same time while a medical attendant is also inside the chamber. The multi-place chamber is compressed with medical air that is 21% oxygen, and the patient wears a hood that delivers 100% oxygen during treatment. The patient is usually sitting on a chair or bench and may be able to stand up or stretch his/her legs if needed. In the multi-place chamber, the patient can be closely monitored for such things as blood pressure and cardiac function while inside the chamber. Some minor medical procedures can also be performed inside the chamber while the patient is breathing 100% oxygen. Both types of chambers are effective in treating patients.

Typical treatment time is about 90 minutes per session at 2 to 3 atmospheric pressures – the equivalent of diving between 33 feet and 66 feet of sea water. The public needs to be informed that

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inflatable home chambers, as well as devices that deliver topical oxygen therapy, sometimes marketed as hyperbaric oxygen therapy, do not deliver the therapeutic effect that is being discussed in this article.

The gold standard for treatment is still based on the work of Dr. Robert E. Marx, who studied the therapeutic effects of hyperbaric oxygen therapy on patients with active ORN. His protocol recommended that all patients receive 30 treatments initially, after which they are evaluated for potential minor bone scraping or debridement. After any necessary bone removal, 10 additional follow-up treatments are indicated. In Marx's study, patients who did not improve after 40 total treatments underwent major surgery followed by an additional 10 treatments for a total of 50 treatments. Under this protocol, Dr. Marx successfully managed 268 cases of active ORN. In many of these cases, 68% specifically, 50 treatments of hyperbaric oxygen therapy were required. His protocol remains valid today despite a few subsequent studies that did not adhere to the same principles defined by Dr. Marx in his original trial, but have been successful as well.

Dr. Marx also studied the effect of hyperbaric oxygen therapy as a prophylactic or preventative measure on patients who received radiation therapy in need of dental extractions. He was able to prove that 20 hyperbaric treatments given prior to extractions on irradiated patients, followed by 10 treatments after tooth removal led to a decrease in the incidence of ORN. This was a small prospective randomized study involving only 37 patients. The patients that received hyperbaric oxygen therapy were less likely to develop ORN with the risk decreasing from 29.9% for those who were not treated, to 5.4% for those who received HBOT. This prophylactic treatment with hyperbaric oxygen therapy, as a modality to prevent ORN, is used by 78% of hyperbaric providers in the United States today, although all insurance companies do not cover it.

Another well-studied side effect of radiation aside from bone injury is soft tissue injury. In a controlled non-randomized study involving 160 patients, the risk of patients developing wound infection dropped from 24% to 6% in those receiving HBOT. Additionally, the risk of wound dehiscence or breakdown for those patients who received HBOT decreased from 48% to 11%, while the risk of delayed tissue healing decreased from 55% to 11%. Furthermore, in a retrospective study, Dr. John Feldmeier showed that there was a 60% complication rate from surgery in radiated fields out of which 87% healed with HBOT.

A recent article published in 2020 concluded that HBOT is a valid adjunctive treatment option in the management of indicated conditions in the head and neck region. A review article in the same year published in the *Clinical and Translational Oncology* recommended HBOT for prevention of osteonecrosis after tooth extraction, treatment of ORN, as well as prevention of the loss of implants in irradiated bone. Doses greater than a cumulative radiation effect of approximately 120 Gy standard fractionation led to a high degree of dental implant failure (citation: Granstrom G. Osseointegration in irradiated tissues. Experience from our first 100 treated patients. *J Oral Maxillofac Surg*. 1996;63:579–585). HBOT has been shown to act as a stimulator of dental implant osseointegration by increasing new bone apposition at the implant interface, increasing overall bone turnover, and increasing the

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blood supply to irradiated bone (citation: King MA, Casarett GW, Weber DA. A study of irradiated bone: I. histopathologic and physiologic changes. *J Nucl Med*. 1979;20:1142–1149. The oxygen delivered through HBOT may act synergistically with growth factors to help stimulate further bone growth (citation: Resnik, RR. Misch's Contemporary Implant Dentistry. 4th edition. 1993; 255.). In addition to improving prosthetic outcomes, HBOT has also been shown to improve quality of life measures, including subjective improvement of radiation induced xerostomia.

Other benefits of hyperbaric oxygen therapy in patients with head and neck cancer not receiving radiation therapy, include treatment of chronic refractory osteomyelitis and necrotizing soft tissue infection. Chronic refractory osteomyelitis not related to prior radiotherapy is a bone infection that persists over a period of 4 to 6 weeks despite appropriate antibiotic therapy and surgical debridement. Treatment for chronic refractory osteomyelitis requires at least 30 hyperbaric treatments and may increase to 50 treatments. Necrotizing soft tissue infections can be produced by several organisms that can cause accelerated tissue necrosis over a short period of time. Patients with such infections heal faster and have fewer complications when hyperbaric oxygen therapy is combined with antibiotics as an adjunct to treatment. Patients with necrotizing infections may require 20 HBOT treatments with the first 10 given twice a day with a four-hour break in between treatments to effectively limit the spread of infection. It is important to note that hyperbaric oxygen therapy should be given in conjunction with appropriate antibiotic therapy for these patients.

Finally, some patients undergoing treatment for head and neck cancer may require a tissue flap or a soft tissue graft over the affected area to optimally restore functionality and esthetics. Periodically, a flap or graft may become compromised shortly after surgery due to the poor healing potential of irradiated tissue. Hyperbaric oxygen therapy can be used in such cases to avert the risk of surgical failure of the flap or graft. Treatment should be initiated as soon as possible, with such patients requiring twice a day treatment for the first 10 treatments for a total of 20 treatments. If the graft or flap fails, and the surgeon is contemplating another graft or flap, hyperbaric oxygen therapy can be used to prepare for such a reparative procedure. Patients should receive 20 treatments before and 10 treatments after the proposed surgery.

Hyperbaric oxygen therapy is a relatively safe modality with an overall complication rate of 83 per 10,000 treatments. Most complications are related to the pressure and its effect on areas of the body that contain air, such as the middle ear, sinuses, and the lungs. Increasing the pressure during treatment (barotrauma) produces a decrease in volume in these locations and vice versa when pressure is decreased. This change in pressure and volume translates into the potential for barotrauma to middle ear, sinuses, and lungs. Injuries to the middle ear may require placement of tympanic membrane tubes that can be removed after therapy is discontinued.

Other complications are related to the fact that hyperbaric oxygen therapy increases blood pressure by causing vasoconstriction or narrowing of the arteries. This leads to an increase of the cardiac workload by 35%. Patients with congestive heart failure can decompensate quickly and might not be able to tolerate hyperbaric oxygen therapy. High levels of oxygen can also lead to seizure activity during hyperbaric oxygen treatment. This is usually a self-limited event and does not carry any risk of long-term seizure activity after hyperbaric therapy is completed. Patients who develop a seizure while being treated will require more air breaks and a decrease in the pressure at which they are being treated. Hyperbaric oxygen therapy can also affect the eyes in several ways including maturing of cataracts and changes in the shape of the lens leading to refractory vision problems. The latter is a reversible effect with resolution over several weeks after stopping hyperbaric oxygen therapy. Patients with claustrophobia can be pretreated with anti-anxiety medications.

Oxygen under pressure puts the need for fire safety front and center. The risk of fire can be fully averted if all the safety measures are taken. Patients should wear cotton clothing; gowns are provided prior to treatment. No battery-operated devices are allowed in the chamber with exception to medical devices that have been tested such as pacemakers and cardiac defibrillators. No cosmetics are allowed, and patients are told not to use such products prior to treatment. No newspapers, tobacco products, lighters, or vaping pens are allowed in the chamber. Patients are usually grounded using a wristband that is connected by a wire to the ground connector on the hyperbaric chamber. Patients are allowed to have an approved bottle of water or juice and a urinal if needed while in the chamber.

The question of hyperbaric oxygen therapy and its effect on cancer care is a valid one and merits further research. What we know so far is based on retrospective data analysis showing that hyperbaric oxygen therapy does not enhance the growth of active cancerous cells. The reason is that cancerous cells are thought to have cellular signaling that differ from cells with normal physiology. Patients who are receiving active chemotherapy might have to wait before receiving hyperbaric oxygen therapy. This waiting time is usually due to the chemotherapy drug that is used and its half-life. The minimum wait time required is 4 to 5 half-lives of the drug with exception to bleomycin for which a whole year is required due to the risk of pulmonary toxicity.

Contraindications of hyperbaric oxygen therapy can be classified as absolute or relative in nature. There is only one absolute contraindication, untreated pneumothorax, which is defined as a puncture in the lung with air trapping in the chest wall. Relative contraindications include advanced congestive heart failure, claustrophobia, active chemotherapy, seizure disorder, advanced chronic obstructive lung disease, bullous lung disease, active smoking, fever, chronic sinus congestion and pregnancy.

Further research is needed to study the effect of hyperbaric oxygen therapy as an adjunct modality in treating cancer patients prior to radiation and/or chemotherapy. The possibility that hyperbaric oxygen therapy can sensitize the cancerous cells making them more responsive to chemo and/or radiation therapy has been proven in animal models. More research is needed on human subjects.

In summary, patients with head and neck cancer who received radiation therapy should understand that complications from radiation may persist over the patient's lifetime and may worsen as time passes. The effect of these complications may be averted,

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minimized, or even treated with hyperbaric oxygen therapy. Complications from any surgical interventions in a irradiated field, including invasive dental work or surgical reconstruction, should be discussed with the surgeon and an appropriate hyperbaric-trained physician prior to any intervention.

Hyperbaric oxygen therapy is a safe therapeutic modality that requires a daily time commitment over several weeks with adherence to the safety measures aforementioned. Many patients seem to be unaware of the availability or the need for such therapy, and not all physicians are trained on this science that is still developing.

Editors Note: Dr. Ziad K. Mirza is the Chief Medical Officer of MVS Wound Care & Hyperbarics. Board certified in hyperbaric medicine and internal medicine, Dr. Mirza has nearly 2 decades of experience in the delivery of Hyperbaric Oxygen Therapy (HBOT). In addition to his responsibilities with MVS Wound Care & Hyperbarics, Dr. Mirza serves as Medical Director of several nursing homes in the Greater Baltimore area.

Dr. Mirza is also certified in Undersea Medicine, and holds certifications for Physician Executive, and Medical Director for Long-Term Care. He completed his residency in Internal Medicine at Good Samaritan Hospital, Baltimore, MD, and received his M.D. from American University of Beirut in Beirut, Lebanon.

Dr. Mirza holds the following Society Memberships (Current & Past): American Medical Association, American College of Physicians, American Society of Internal Medicine, Undersea and Hyperbaric Medical Society, American College of Physician Executives, American Medical Directors Association, American Board of Quality Assurance Utilization Review.

He has been the Medical Director of the GBMC Wound Care Center and Hyperbaric Oxygen Unit, in Towson, MD from 2012-2016, and the Co-Medical Director of the GBMC Wound Care Center and Hyperbaric Oxygen Unit in Towson, MD from 2010-2012.

Dr. Mirza was voted Baltimore Magazine Top Doctor 2014 – 2020: Hyperbaric Medicine, and he currently serves on the Board of the National Institute of Health, in Washington D.C.

For questions about this article Dr. Mirza can be reached at zmirza@mvswoundcare.com.

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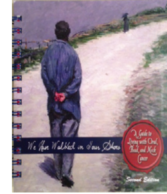

We Have Walked In Your Shoes: A Guide to Living With Oral, Head and Neck Cancer

by Nancy E. Leupold & James J. Sciubba, DMD, PhD

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Photo courtesy of PJ Jordan, NSVN Volunteer and Outstanding Photographer!

A Time for Sharing...

Life After Laryngectomy: One Survivor's Story

As readers of this newsletter well know, being diagnosed with head/neck cancer is devastating and to undergo a total laryngectomy is life changing. It is important to know that, as incomprehensible as it might seem at diagnosis, life does not end after a laryngectomy … it can be as or more rich and fulfilling. In this article, Steve Cooper shares his laryngectomy journey, including returning to work.

Initial Diagnosis

Steve made an appointment with an ENT to see why his voice was hoarse. It had been hoarse for some time but he figured it would just get better. When it hadn't, in December of 2018, Steve went to an ENT, who performed a laryngoscope. On reviewing the results, the doctor thought there was some kind of "paralysis" of one of the vocal chords. He then referred Steve to another specialist more familiar with that type of issue, but never sent the laryngoscope video. Thus, the new ENT asked to do another scope. She had an associate in the exam room. According to Steve, when the scope was fully inserted, she turned to the other doctor saying: "Do you see that?" and the mood in the room immediately changed. She retracted the scope, looked at the video again and said "I see something that concerns me and I want to refer you to another doctor for a better look". Sensing the somber mood, Steve asked if it was cancer. He was told this was indeed a concern but that's why she felt the need to take a better look. Two days later, Steve was back in the office. This time he was seen by an head and neck cancer surgeon who took a small tissue sample which confirmed that Steve had Stage 4 Squamous cell carcinoma of the vocal cords. After a PET Scan was done, the doctor informed Steve that he would need a Total Laryngectomy, followed up with several weeks of radiation treatments.

Initial Reaction

Steve's says his initial reaction to being told he had cancer was shock. He was devastated. He reports the few weeks after his diagnosis were a bit of a blur. Initially he told the doctor he wasn't going to have the surgery and would rather let the cancer run its course. Steve had a home-based business as a Wholesale Food Broker. Although email is an important form of communication in his business, his primary role was in purchasing and sales. Often the best way to "close a deal" was by simply picking up the phone. Steve feared that he would lose the ability to effectively communicate. For that reason, he thought his career was over. He reports it was a very depressing time, which led him to his initial thoughts about refusing surgery. The doctor proceeded to explain that if he chose that route, he "would suffer and die a very painful and gruesome death." It was the thought of putting his family through that, of his wife losing her lifelong partner and his kids losing their father that was the primary reason Steve decided to agree to the surgery.

Preparation

When asked how prepared Steve felt for surgery he stated "we are really NEVER fully prepared for surgery. The fears and emotions consume our thoughts every day and night". With that said, Steve did the single greatest thing a person facing a TL could do. Before surgery, he connected with laryngectomees and, specifically, a local laryngectomee. It is commonly agreed that meeting with, and talking to, other laryngectomees prior to surgery extremely helpful in gaining some insight into the process and outcome. It helps pre surgical patients see that they can lead full and productive lives post-surgery.

Surgery

During Steve's surgery, in addition to his larynx, over 30 lymph nodes were removed. Fortunately, the general margins were clear and every lymph node tested 100% negative for cancer. It was strictly confined to his larynx. Chemotherapy and radiation were not needed. The surgery was a success and the results were good. Steve would have CT scans every 3 months for the first 2 years, then every 6 - 12 months for the next 3 years. At the 5-year mark, if scans remained clear, he would be considered "cured"! (NOTE: this is Steve's experience and is not necessarily representative of what individual patients may face).

Post Surgery

Steve was a Wholesale Food Broker for over 40 years. As noted above, he feared that after the surgery, his career would be over. However, Steve was answering emails on day 5 from his hospital bed. He could only work one or 2 hours before getting very tired. He reports he did notice that it was a bit difficult to concentrate and that he had to re-read emails 2 or 3 times before hitting send. For the first few months, communication was difficult and extremely frustrating and depressing at times. He was using an Electrolarynx but, due to swelling, lymphedema and being a novice EL user, it was a bit difficult to be understood. During those few months, he relied on others in his company to make calls for him and did as much as possible via email. However, as soon as Steve was starting to be understandable with an EL, he forced himself to make phone calls when it was necessary. He found this was helpful in getting more proficient with using an EL and to get over his feeling of the stigma of what his voice might sound like. To his surprise, although there were several weeks of downtime, he has fully returned to the same business with the same abilities as before. In fact, he reports that many customers and vendors actually seem kinder now. As it turned out, Steve says the most difficult part post surgery was not work related. It was trying to deal with the insurance company and get the supplies he needed. Having someone else calling the insurance company was frustrating. Steve knew best what supplies were needed and what the obstacles were. It actually took fighting with his health insurance company for 7 months and only when he threatened to file a complaint with the insurance commissioner in his state did they finally agree to purchase directly from the vendors that sold the supplies. Even once they agreed, it still took almost 3 additional months for the insurance company to get the paperwork finalized.

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What would it have been helpful to know?

When Steve was asked what did he wish his medical team had shared with him prior to surgery he replied "I wish my medical team was more informative about what's ahead". Their primary concern was getting rid of the cancer. In hindsight, there wasn't enough attention given to the "whole patient" and tips and techniques to combat the emotional issues. Also, he expressed a desire for a better mechanism to get pre-approval with the insurance carriers for required supplies. "Once you've had the surgery and can't communicate at first, it's impossible to argue your case with the insurance companies." This only compounded the frustration of trying to get badly needed supplies. When he speaks now to pre surgery patients, he makes these aspects part of his focus.

Biggest Impact

Steve feels strongly that the biggest impact in becoming a laryngectomee is emotional. Physically, he healed fairly quickly but believes emotional aspects can last a lifetime. As he states, "Our voices are our personality. When we lose our voice, we lose a part of ourselves. Until we regain a way of communication, it takes a toll. We can be angry and resentful, especially to those closest to us." There were a few times that Steve says he just fell apart, crying uncontrollably and completely debilitated. It was a very dark period in his recovery. Steve stresses the importance of post laryngectomy patients to seek help from a psychologist, psychiatrist, a pastor or anyone trained in dealing with depression. Also, diet, exercise and developing hobbies or staying active is very important as well. Steve says on the positive side, it did change his perspective of what's important in life. He feels he learned to "not sweat the small stuff" and to focus on what's truly important; health, family and friends. Also that we only have so many days on this earth… Spend each one wisely! Steve's advice for someone facing a laryngectomy is never just assume that you won't be able to work again. Make a plan! Tell others that you may be out of commission for a short period of time. Assign tasks to others. Let them run with them, don't try to micro manage. And keep in mind that many laryngectomees actually find a new and different career after surgery, so there are many possible scenarios that lay ahead.

The Path Forward

Prior to surgery, Steve was only occasionally involved in community volunteering activities. After surgery, he became committed to helping others that are faced with having a laryngectomy. As a result, he is a board member of the International Association of Laryngectomees, a board member of the Laryngectomee Club of Montgomery County (MD), a board member of the Governor's Advisory Board for Telecommunications Relay in Maryland and a past board member of WebWhispers, Inc. He is also a peer-to-peer mentor for SPOHNC and several other programs. Steve regards his biggest "achievement" as meeting other pre and post laryngectomy patients, holding himself as an example and leaving them with the comfort in knowing that they will be OK, we can lead full and productive lives after a Total Laryngectomy, and they too can "do this".

Stacey Brill MS CCC-SLP
SPOHNC Ft. Myers, FL
Chapter Support Group Facilitator

News You Can Use

Good news! Each household in the U.S. can now have four free COVID-19 at-home tests shipped directly to their home at no cost! All you need to do is visit COVIDtests.gov and enter your contact information and mailing address.

The tests are rapid antigen "at-home" or "self" tests — not PCR tests which require a lab drop-off. The "at-home" or "self" tests can be taken anywhere and give results within 30 minutes.

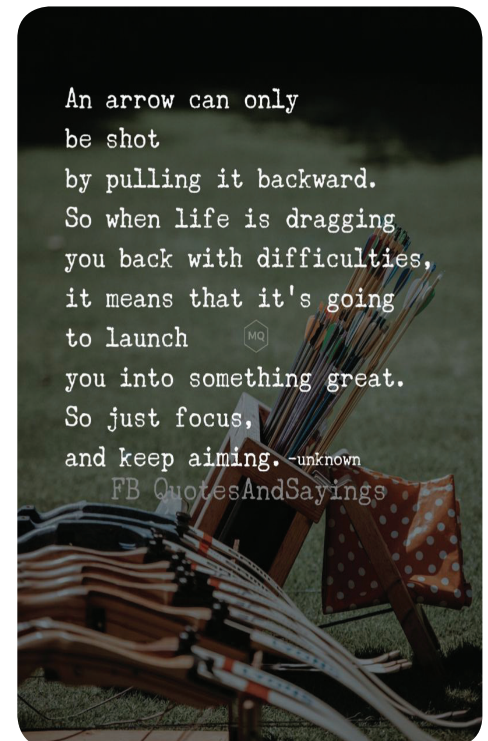
Guard against scammers trying to steal your personal information. When ordering tests, use the official, secure government website: https://COVIDtests.gov.

Watch out for phone scammers, too. If you get a phone call requesting information so that free at-home tests can be mailed to you, hang up — it's a scam!

Remember: Medicare pays for COVID-19 tests performed by a lab, such as PCR or antigen/rapid tests, at no cost to you when the test is ordered by an authorized health care professional. Those in a Medicare Advantage Plan should check with their plan to see if their plan offers coverage and payment for at-home tests.

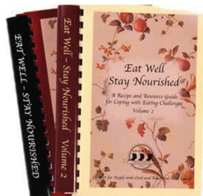
"Thank you for all you do!"

~ Eileen



Eat Well Stay Nourished
A Recipe and Resource Guide
for Coping With Eating Challenges
compiled by Nancy E. Leupold, Founder, in memoriam

SPOHNC is offering a great bargain for its Eat Well Stay Nourished Vol. One and Vol. Two Cookbooks… Buy One Get One (BOGO).



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Fancy February Recipes from “Eat Well Stay Nourished A Recipe and Resource Guide For Coping With Eating Challenges”

Compiled and Edited by Nancy E. Leupold, Founder, in memoriam

Raspberry Rice Smoothie *(from Volume One)*

½ c. cooked brown or white rice
1 ripe banana
1 c. frozen raspberrries in syrup
1 c. flavored yogurt
1 to 2 tsp. honey

Combine all ingredients in a blender and blend until smooth. Serves 2. *379 calories/serving.*

~ Martha V., NY

Cinnamon French Toast *(from Volume Two)*

½ c. milk
¼ tsp. vanilla extract
2 eggs
4 slices cinnamon swirl bread
Maple syrup (optional)
Blueberries (for topping, optional)

Heat oven to 350 degrees. Spray an 8 x 4 inch bread pan or other small pan with vegetable cooking spray. Mix together milk, vanilla extract and eggs. Tear bread into small pieces and place in blender or food processor. Pour egg mixture over bread pieces and process until mixture is smooth. Pour into a pan. Bake for 30 to 35 minutes until knife inserted in the center comes out clean. Cool for 5 minutes. Cut into squares. Serve with maple syrup, and blueberries, if desired. Yields 2 servings. *305 calories/serving.*

~ Staff at UPMC, PA

Elliot Strong, MD
in memoriam

SPOHNC was deeply saddened to learn of the passing of longtime Medical Advisory Board member, and friend to SPOHNC, Dr. Elliot W. Strong, in December, at the age of 91. A well-known and highly revered member of the head and neck cancer healthcare community, Dr. Strong will be missed by colleagues, former patients and all who knew him.

Dr. Strong graduated with honors from Tufts College in 1952 and from Tufts University School of Medicine in 1956. He was an intern and resident in surgery at Hartford Hospital in Connecticut from 1956-1961. On completion of his training, he was appointed to the staff of the Head and Neck Service, Department of Surgery at Memorial Sloan-Kettering Cancer Center. In 1969, he became Chief of the Head and Neck Service, a position he held until 1992.

Dr. Strong served on many committees, including the Society of Head and Neck Surgeons, the American Radium Society, the American Cancer Society, the Society for Surgical Oncology, and the American College of Surgeons. He was co-program chair for the first two international head and neck conferences and was the first president of the New York Head and Neck Society from 1979-1981. He was also president of the Society of Head and Neck Surgeons from 1980-81, and president of the American Radium Society from 1989-1990. He was Chairman of the Head and Neck Contacts Program at the National Cancer Institute, where he led the most expensive and extensive research study of the impact of chemotherapy on head and neck cancer to date. While Dr. Strong was dedicated to serving his profession, he was most devoted to his patients. When he stepped down from Chief of Head and Neck Surgery, hundreds of his patients attended his reception and thanked him for his dedication and extraordinary care.

Upon his retirement in 1999, Dr. Strong brought his energy to his family's church, where he served in many capacities including as Ruling Elder, Chair of the Building and Grounds Committee, tree-hauler at the annual Christmas Tree Sale, and painter of anything needing painting. Dr. Strong was a family man, and in his retirement, he was able to make the transition to enjoying life as a Dad, a role he enjoyed tremendously.

On behalf of SPOHNC's Board of Directors, Medical Advisory Board, staff and our SPOHNC family of newly diagnosed patients and survivors, we extend our deepest sympathies to Dr. Strong's loving family. We thank him for his years of dedicated service to SPOHNC. We know his memory will live on in your hearts, and the hearts of the patients and survivors whose lives he touched along the way. May God bless him.

SPOHNC, The THANC (Thyroid, Head and Neck Cancer) Foundation, NFOSD (National Foundation of Swallowing Disorders), HNCA, and many others are pleased to share the recording of the Xerostomia EL-PFDD Meeting, held on Thursday, August 19, 2021. (Learn more about dry mouth)

View the recording at https://www.youtube.com/watch?v=0diX2-naOH4

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Our February Champions of Hope

Chuck and Jody Bartlett

SPOHNC Minneapolis, MN Chapter Facilitators

Chuck and Jody Bartlett are two very important members of our 30+ year old, longstanding SPOHNC family. They have both been instrumental in providing hope, help and support for patients, survivors and caregivers for many years.

Chuck joined our National Survivor Volunteer Network in 2007 after being diagnosed with tonsil and thyroid cancer in 1998. Chuck has been matched with many newly diagnosed patients over the years, and Chuck and Jody have facilitated the SPOHNC Minneapolis, Minnesota Chapter support group for many years, encouraging and providing hope and information for those who came to them seeking help, and a listening ear from those who have travelled a similar journey.

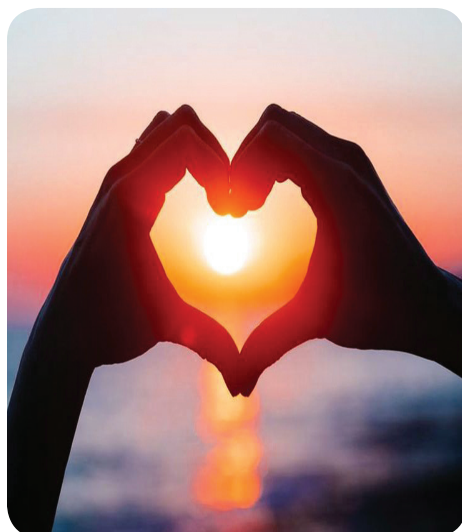
Chuck and Jody's group are a tight knit one, and their meetings are not only supportive, but informative as well. The Bartlett's are great at securing speakers for their monthly support group meetings, and have had guests who covered topics from immunotherapy, to dental issues, lymphedema and beyond. Each month, their group members come away from their meeting with renewed hope of a brighter future, fueled by the energy of the family that the Minneapolis group has become.

SPOHNC Minneapolis is not just all about information though – they do like to have a little fun! For the last 9 years, the group has hosted an annual Potluck Supper at Thanksgiving time, hosted by group members Mike and Else Sevig. The photos shared with SPOHNC show a warmth and camaraderie that can't be described in words. There is also a story about White Castle hamburgers at the event, which we have yet to get to the bottom of, but we remain curious!

SPOHNC Minneapolis, MN has also participated in Awareness events over the years where they have hosted a table with information about SPOHNC, oral head and neck cancer and their support group. The table is staffed by volunteers from the group, who happily greet visitors and provide information about the support they offer. They have also participated on the University of Minnesota's Annual Head and Neck Conference as well. Chuck and Jody always go above and beyond, creating flyers and materials for their event tables, and for their support group meetings as well. They were even kind enough to take a nighttime drive to Eagan, Minnesota last year, to photograph the Sperry Tower, which was lit up in SPOHNC's colors for April Oral, Head and Neck Cancer Awareness Month. Thanks for your awesome photography skills as well - the list is endless!

Chuck has participated on several patient panels, and even attended SPOHNC's 20th Anniversary Conference and Celebration of Life, here in New York, in 2012. Although we were hoping to meet both members of this dynamic duo, Jody was unable to attend. Though we were sad, we were grateful to Chuck for making the long trip, solo. It was wonderful to finally meet him!

SPOHNC is forever grateful to Chuck and Jody Bartlett, and it is our pleasure to honor them both as our ***February 2022 Champions of Hope.*** Thank you, Chuck and Jody, from the bottom of our hearts, for all that you do!!!



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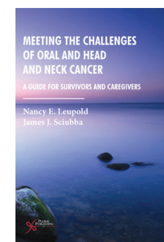

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Survivor News

In 2014, SPOHNC received a call from Gary and Laura Dumm. Gary was about to undergo a laryngectomy, and Laura, his wife, was about to become Gary's caregiver throughout his cancer journey. Like everything else they do in life, this couple did it all…together.

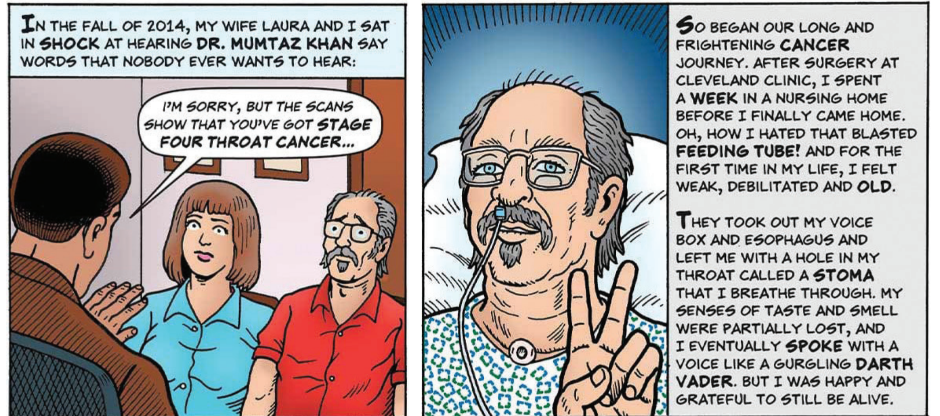
SPOHNC was able to connect Gary and Laura with Frank and Carrie Marcovitz, through the National Survivor Volunteer Network matching program, to guide them along their cancer journey. The two couples have stayed in contact over time.

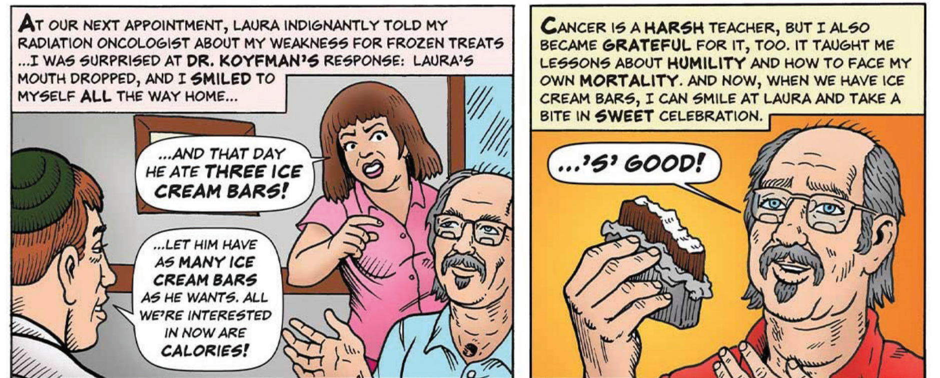
In 2021, Gary and Laura Dumm celebrated 50 years of marriage and making art. The Dumm's are renowned artists. Gary is a cartoonist and Laura is a pop art painter. They work separately but love to collaborate on many different projects.

One of their most recent collaborations was for a project of The Cleveland Clinic, for their magazine, which can be found at https://magazine.clevelandclinic.org/2021-100-stories. As the Clinic celebrated its centennial, they put together a piece called 100 Stories. The Dumm's shared their cancer journey in a very unique way!

JUST WHAT THE DOCTOR ORDERED!

BY GARY DUMM & LAURA DUMM





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Keep your SPOHNC membership current. Enjoy all 8 issues of "News from SPOHNC"

Also remember if you have moved, or changed your email address or phone number, be sure to contact SPOHNC at 1-800-377-0928 or email us at info@spohnc.org to let us know.

SPOHNC Wants to Hear From You!

Share your exciting news, and important or memorable occasions with SPOHNC.

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CHAPTERS OF SPOHNC

Contact SPOHNC at 1-800-377-0928 for Chapter information & Facilitator contact information.

PLEASE NOTE: Many Chapters are not holding meetings in person at this time due to COVID-19.

Many groups have found other creative ways to support one another during this time of need.
Please call to SPOHNC at 1-800-377-0928 to find out more information.

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~ Tom H.

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so you can connect with a survivor or caregiver to support you

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so you can be informed

Contact us at 1-800-377-0928
or at info@spohnc.org

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