

Your Guide to Head and Neck Cancer

Head and Neck Associates of Orange County

You're in the right place

Our surgeons are some of the best in the business

Choosing Head and Neck Associates of Orange County means you have top-notch providers working in collaboration with some of the best radiation oncologists, radiologists, medical oncologists, and rehabilitative services in the region!

"Peace is the result of retraining your mind to process life as it is, rather than as you think it should be." Wayne W. Dyer

Before going further, know that we are available should you have questions after reviewing the information here.

Head and Neck Associates Main Line (949) 364-4361 Extension 1140 for Shannon (Dr. Luu's medical assistant) Extension 1106 for Rachel (Dr. Bredenkamp's medical assistant) Extension 2204 for Jackie (Dr. Well's medical assistant) Extension 1169 for Juanita (Dr. Mundi's medical assistant)

Mission Hospital Head and Neck Cancer Nurse Navigator Alice Daugherty (949) 226-4178

About our Nurse Navigator



Alice Daugherty is a registered nurse with dedicated training and certification in cancer care. She provides advocacy for our head and neck cancer patients. She often meets or talks with our new cancer patients, helping them through the initial diagnosis and workup, facilitating appointments for their radiology and biopsies, as well as collating their health records to present their cases at our multidisciplinary tumor board. Alice ensures our cancer patients have worry-free hospitalization and follows them through discharge and even at home!

"Be kind, for everyone you meet is fighting a harder battle." Plato

Table of Contents

Cover 1

Introduction and important contact information 2

About our Nurse Navigator 3

Workup 5

Gastrostomy tube 6

Dental oncology consult 8

Radiation, medical oncology and rehabilitation service 9

Surgery 11

Your provider may have ordered any or all of the following workup:

US-guided biopsy: This scan uses an ultrasound probe to fine a mass underneath the neck skin, which helps to guide the placement of a needle to biopsy tissue. This obtains tissue for diagnosis by pathology.

CT scan: This scan is necessary for looking at the anatomy of the head and neck region, and is often necessary to obtain modeling information from your jawbone in order to design custom plates that may be needed for your surgery

PET/CT: This scan uses specially labeled glucose injected into your body to look for spread of a cancer into other parts of your body, a process called metastasis. Information from this scan may change the treatment options available to you.

MR angiogram or CT angiogram of the lower extremities: Your reconstructive surgeon may need to see if blood vessels in your legs are healthy enough so that he can safely transfer bone and skin from your calf region to reconstruct tissues in the mouth.

Frequently asked questions:

Is the radiation from the scans dangerous?

The radiation used is of a nominal dosage, and the benefits obtained from getting the xrays and scans is of extreme importance in staging and treating your cancer.

Is this covered by my insurance?

Our staff will submit requests to your insurance in order to get any tests and x-rays approved by your insurance. This does take some time; we work to get the tests approved as fast as possible. However, it may take up to one week to get approval from your insurance company.

Your provider may have asked that you undergo gastrostomy tube placement

After doing extensive surgery in the head and neck region, there may be significant swelling and the tissue must be allowed to heal adequately before allowing the area to be exposed to food and liquid. Your provider may recommend that a gastrostomy tube be placed. This involves a short procedure to insert a feeding tube through the skin of your abdomen into your stomach. This allows your providers to give you nutrition while your surgical site is healing. Furthermore, if you get radiation to the head and neck, it may cause a lot of throat irritation which makes swallowing difficult.



Frequently asked questions

Are there any alternatives to the gastrostomy tube?

In some cases, your surgeons can insert a temporary feeding tube through your nose going into your stomach. Sometimes this is a good option if you only need to avoid

eating anything by mouth for a short amount of time. The downside is that it is a visible tube that sometimes accidentally comes out, or can irritate the nose and cause sinusitis.

How long will I need the gastrostomy tube?

We typically recommend planning on at least 6 months for the feeding tube. This doesn't necessarily mean you won't eat anything by mouth AT ALL for 6 months, but if you require radiation therapy after surgery, it usually won't start until about 6 to 8 weeks AFTER your surgery and will last 6 weeks. During that time, your throat may be very sensitive from the radiation, making eating difficult. It's useful then to have that gastrostomy tube to give yourself the extra nutrition to beat your cancer! Once your providers are confident that the cancer is in remission based on clinical examination and/or x-rays, we can set you up for removal. Remember, it's tricky to try to "re-insert" a gastrostomy tube if you've already had one and it's decided you need another one if we remove it too early. So it's a better idea to leave it in until we are SURE it's safe to take it out!

Dental Oncology consultation

Your provider may ask you see a dental oncologist for several reasons:

Fabrication of a dental occlusal splint: the dental oncologist may be asked to make a type of "retainer" that your teeth fit into for use during your surgery. It helps when your surgeons are reconstructing your jaw, because it will help to keep your teeth biting together in the correct orientation.

Fabrication of an immediate surgical obturator (ISO): if part of your palate and teeth have to be removed, such as in a maxillectomy surgery, the dental oncologist will make a type of "retainer" that clicks into your remaining teeth and fills the defect from the surgery, in order to prevent food and liquids from going into your nose and sinuses when you eat, and to provide support for your facial anatomy.

Fabrication of a facial prosthesis: the dental oncologist may be asked to recreate anatomy with use of advanced prosthetic material. For example, your dental oncologist can make a new "ear" to replace one that might be removed during ear cancer surgery.

Dental "clearance." Any diseased teeth should be extracted and your dental health should be maximized with fluoride trays, etc. prior to radiation to your head and neck.



This surgical prosthesis creates the upper teeth and fits into the mouth like a denture

Radiation oncology referral

A radiation oncologist will use external beam radiation, carefully dosed to the appropriate regions with cancer and to any lymph nodes in your neck, to either cure cancerous disease or to remove any microscopic residual cancer cells left behind after surgery.

Medical oncology referral

A medical oncology uses chemotherapy, which is intravenous medicine, to kill cancerous cells. This is often done together with radiation therapy.

Speech and language pathology, nutrition, genetics referrals

Our treatment often affects the way people speak and swallow. This is understandable as we do surgery on the mouth, throat, tongue, and other structures that are intimately involved in the way we eat food! Research suggests that a strong swallow preservation program instituted early in your cancer treatment will help maximize your swallowing outcomes. Your providers may also ask you to see a nutrition expert for counseling on optimizing your caloric intake. A genetic counselor sometimes is needed if your cancer is thought to be associated with other syndromes.

Frequently asked questions:

How long is radiation therapy?

A course of radiation therapy typically lasts 6 to 7 weeks, and involves sessions of about 15 minutes a day from Monday through Friday

Do I really need radiation and chemotherapy?

For advanced head and neck cancers, combined therapy using both surgery and radiation is recommended most often. Chemotherapy may also be recommended in addition to radiation therapy. This often depends on how advanced your cancer is on analysis of the pathology from the surgery. For example, if there is some residual cancer left behind or if the cancer seems to invade the edges of the lymph node to which it spread, chemotherapy is typically added to the radiation therapy to increase the chance of cure.

What are some side effects of radiation and chemotherapy?

Radiation can cause reddening of the skin like a sunburn, and irritation in your throat and mouth, which can lead to problems swallowing. It can also lead to long-term dryness of the throat. Chemotherapy can cause neuropathy, as well as nausea, and sometimes hearing loss. These side effects are best discussed when you meet with the radiation and medical oncology physicians.

Surgery

While details of your surgery vary based on the location of the cancer, let's look at an example of an oral cancer originating from the gums overlying your jaw.

In this scenario, your surgeons may need to remove the affected gums and lining of your mouth, the underlying jawbone, lymph nodes in your neck, and then reconstruct this with bone and skin from your leg (called a "free flap").

After removing the cancer, the surgeons will graft the "free flap" from the leg into the mouth, securing the bone to a titanium plate that most often is permanently left in place. The free flap blood vessels are sewn to blood vessels in your neck so the free flap has adequate blood supply and helps the tissue survive. It is like having a "transplant" of tissue from one part of your body to the head and neck region!

This CT model shows that the surgeons are planning to remove the red part of the right jawbone to get rid of the cancer; it is this section that needs to be replaced with the "free flap" bone to restore anatomy and function!



In this case below, the surgeon is taking a rectangle of skin along with the underlying fibula bone to reconstruct the defect in the oral cavity





Frequently asked questions

Will there be a scar?

Any incision of the skin will leave a scar. However, our surgeons use meticulous plastic surgery techniques to close incisions to make sure the healing is as cosmetically appealing as possible.

What happens when you take my lymph nodes? Don't I need them? Once lymph nodes are removed, there is sometimes some subtle swelling in the region long-term because of less efficient lymphatic drainage. This typically improves over time, and your surgeons may refer you to lymphatic physical therapy to make this better. Patients aren't susceptible to more infections because lymph nodes are removed, and patients function normally without them.

If you take my leg bone, do you replace it?

The fibula bone your surgeons use for jawbone reconstruction is the smaller of two bones in the leg (the tibia is the larger one). The fibula typically bears 5 to 10 percent of the weight of the leg, and the only muscle to purely insert on the fibula is the flexor hallucis (which flexes the big toe).

You will be in a cast if tissue is harvested from your forearm or from your leg for about a week. Once you have healed from the flap surgery (in about a month), you will have full use of your extremity. Physical therapy may make your recovery even faster!

What are risks of free flap surgery?

Besides standard surgical risk of scarring, infection, bleeding, there are very rare risks of damage to the arm or leg from which the flap is harvested. Some patients report mild permanent swelling of the extremity. If the fibula flap is used, some patients have mild "foot drop" with inability to fully dorsiflex their foot, but this is extremely rare! The risk of the flap "dying" from an infection during the hospitalization or from a blood clot in the blood vessels is very low. In fact, it is closer to 0 percent than it is to 2 percent of the time. If it happens, additional surgery may be necessary.

How long will I be in the hospital?

Hospitalization after major head and neck surgery (especially surgeries that involve a free flap) is usually between 7 to 14 days, the early part of which is spent in an intensive care unit. Depending on how well the patient is doing, the patient can either go home or to a nursing facility temporarily after the surgery for additional wound care. Upon discharge to home, your providers may set up a home nurse to come help with wound care if needed for a few weeks.

How long is the surgery?

Surgery can last from anywhere from 4 to 8 hours, and sometimes even longer depending on the complexity of the case.

Will I be awake after surgery?

Our surgeons will do their best to allow to you to "wake up" the night of your surgery. We have very few patients who need to remain completely sedated on a ventilator after surgery.

Do you do this surgery often?

Absolutely. Our surgeons have been doing this surgery for many years, and our expertise and experience is akin to that found in tertiary academic centers.

Why choose your center versus a tertiary academic center, then? Academic centers are excellent centers of care for teaching, surgery, and research. This means they are obligated to train resident physicians to do surgery and to manage patients afterwards. This is often the reason patients don't see their main surgeon more than once or twice during the hospitalization. With our group, only fully licensed, board-certified physicians will DIRECTLY manage your care. That means there are no residents (trainee physicians) closing your cosmetically sensitive incision, and there are no residents managing your care postoperatively. Our critical care physicians and hospitalists, as well as other specialists, are ALL attending (senior) physicians who have completed residency training. It is not uncommon for our large cases to finish in a fraction of the time it takes at a tertiary care center because there are no residents trying to "learn" how to do the surgery during a case. A two hour thyroidectomy done elsewhere can often be done in one hour with our surgeons, and a large cancer with free flap reconstruction can finish in the early afternoon versus in the early evening. Saving a patient literally HOURS of anesthesia means safer surgery!