Supportive care after Total Laryngectomy.


This study investigated the apprehensions, social, sexual and financial problems in patients after total laryngectomy (TL) and the impact of attending laryngeal club on these problems. A total of 125 patients completed a questionnaire covering the social, sexual and financial impact (job status) on their lives after TL. The majority of patients expressed apprehensions and showed some social problems after TL, especially in the initial phase which improved either with passage of time or after attending Laryngectomy Club. The main problem was financial uncertainty (74%), with severe financial impact faced by 55 (44%) patients due to loss of job. This was followed by regrets over loss of voice (67%). Patients appeared less concerned about losing family support (18%) and facing social rejection 12%. Only 5% of patients feared losing sexual relationship with their spouse. The authors conclude that the Laryngectomy Club serves as a useful platform to interact and share experiences. Regular attendance at the club could help the patient recover from depression and lead a better life.


To bridge the transition from hospital to home and to support self-management during rehabilitation after total laryngectomy (TL) an online self-care education program was developed in the Netherlands. The program provides general information about laryngeal cancer, and the functional changes after TL as well as voice prosthesis care, speech and smell rehabilitation. The program was evaluated through patient satisfaction surveys. Out of the thirty-eight laryngectomized patients who used the program, most (66%) were satisfied. Satisfaction was significantly associated with (higher) educational level and health literacy skills. No significant association was found with gender, age, marital status, employment status, Internet use/literacy, treatment modality, time since total laryngectomy, and quality of life. The authors concluded that the online self-care education program can support early rehabilitation.
Voice Rehabilitation after Total Laryngectomy.


This study assessed surgical parameters that correlate with voice quality after total laryngectomy (TL). Voice and speech outcomes of 76 tracheoesophageal patients’ speech were related to details of their surgical procedure (taken from surgical reports and patient records). The authors found that differences in voice outcome after TL are related to variables like radiotherapy, neurectomy, neck dissection, and reconstruction procedures. Results suggest that narrower pharynges and/or more superiorly located neoglottic bars are associated with better voice quality. Patients with pharyngeal lumen reconstructions (i.e., by Pectoralis Major flaps and (tubed) gastric pull-ups) have the poorest voices. They also suggested that neurectomy as part of the TL procedure may be favorable.


The introduction of voice prostheses for laryngectomized patients has significantly improved the voice related quality of life (V-RQOL) in such patients. This study assessed the V-RQOL and impact of socioeconomic status by using two questionnaires: Voice handicap index (VHI) and V-RQOL. Seventy-one patients, using TEP voice completed the questionnaires. The majority (76.1%) had minimal voice handicap with approximately only 4% having a serious voice handicap. On V-RQOL, approximately 17% had excellent scores and 40.8% scored very good. Patients within a lower socioeconomic group had better V-RQOL than those in a high socioeconomic group.
Pulmonary Rehabilitation after Total Laryngectomy.


Self-ventilating tracheostomy and laryngectomy patients have significantly altered pulmonary physiology as the normal conditioning and filtration of inhaled air in the nose and pharynx are bypassed, allowing unconditioned air to enter the trachea directly. Heated humidification and HMEs are the most common methods of artificial humidification for these patients. A systematic review was conducted to determine which method is more effective in preventing pulmonary complications in self-ventilating tracheostomy and laryngectomy patients. They concluded that HMEs are the preferred choice of humidification due to reduction of pulmonary complaints, better patient compliance and improvements in relevant quality of life aspects.


This study documents how laryngectomized patients get accustomed to using an HME (both XtraMoist and XtraFlow) and attachments. Thirty patients, who previously did not use an HME, were followed for twelve weeks. In general, patients reported that it took them 6 days to get used to the HME. In the first two weeks, the majority of patients (63%) reported less coughing while 43% of patients reported some discomfort of HME use, such as increased breathing resistance. After six weeks patients were generally accustomed to the breathing resistance and over 96% reported after 12 weeks of HME use that breathing was equal or less strenuous compared to breathing through an open stoma. Although over 80% used an adhesive as attachment (Provox® Optiderm, Regular, Flexiderm, XtraBase and StabiliBase), in the first weeks of HME use, patients tended also to use either a LaryTube or LaryButton. The results of this study provide healthcare professionals with valuable information on HME use and can assist them in managing patient expectations and compliance.