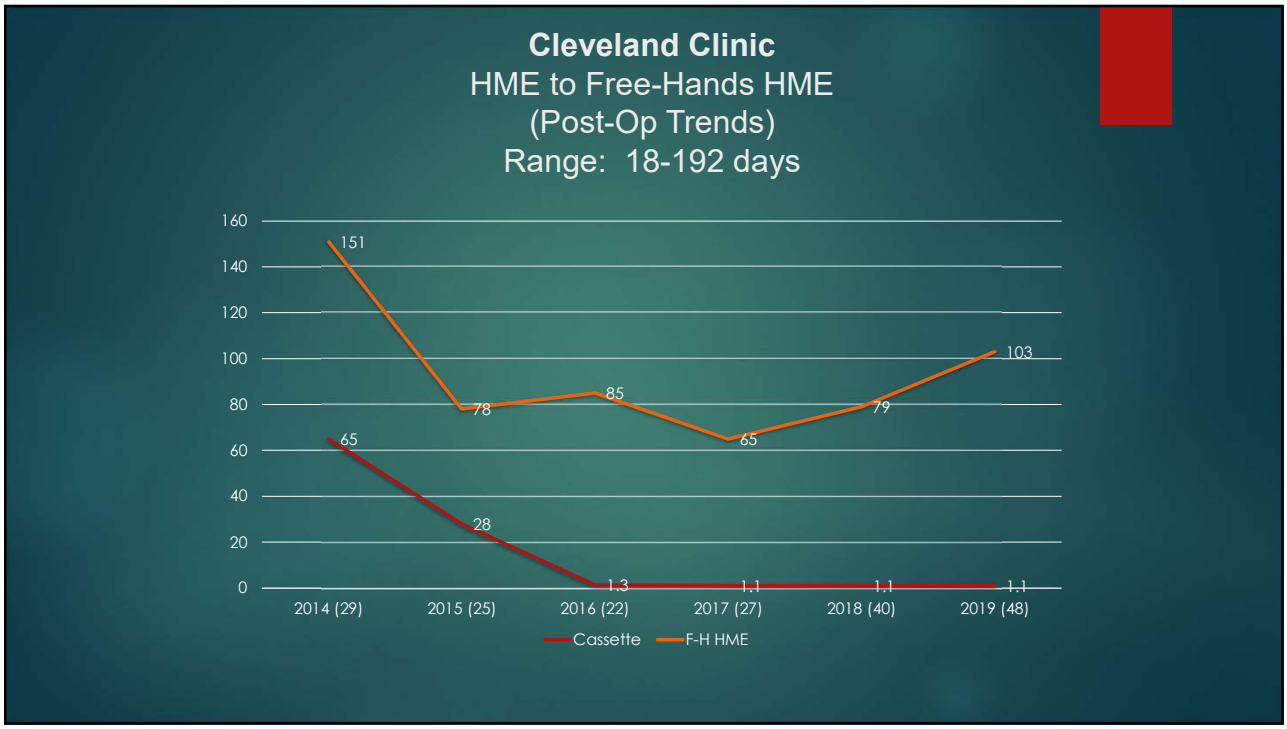

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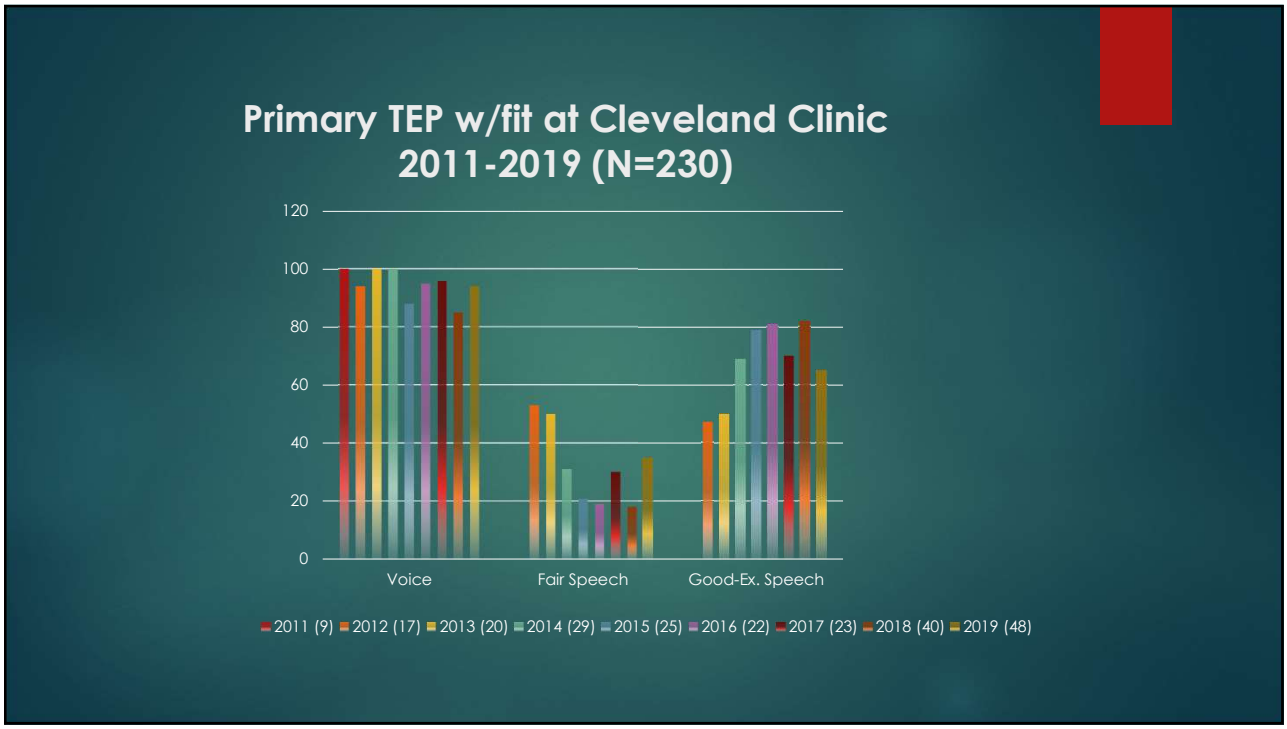
Joann Kmiecik, Cleveland Clinic,
Ronald van der Wildt, the Netherlands



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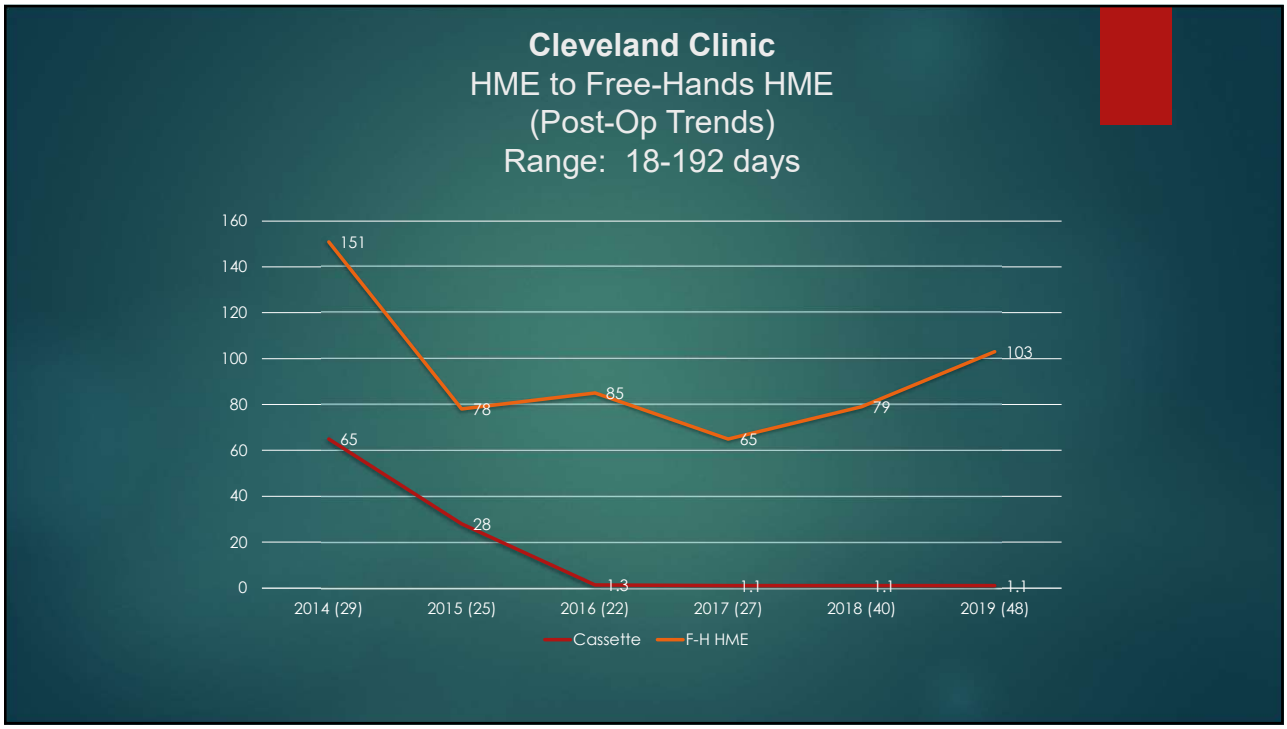
…..and next!

- With primary TEP and fit becoming routine, focus shifted to earlier HME use.
- Increased HME emphasis on out-pt service
- Late 2015, implementation of acute care HME protocol and post-op pulmonary rehabilitation kits following TL.

4



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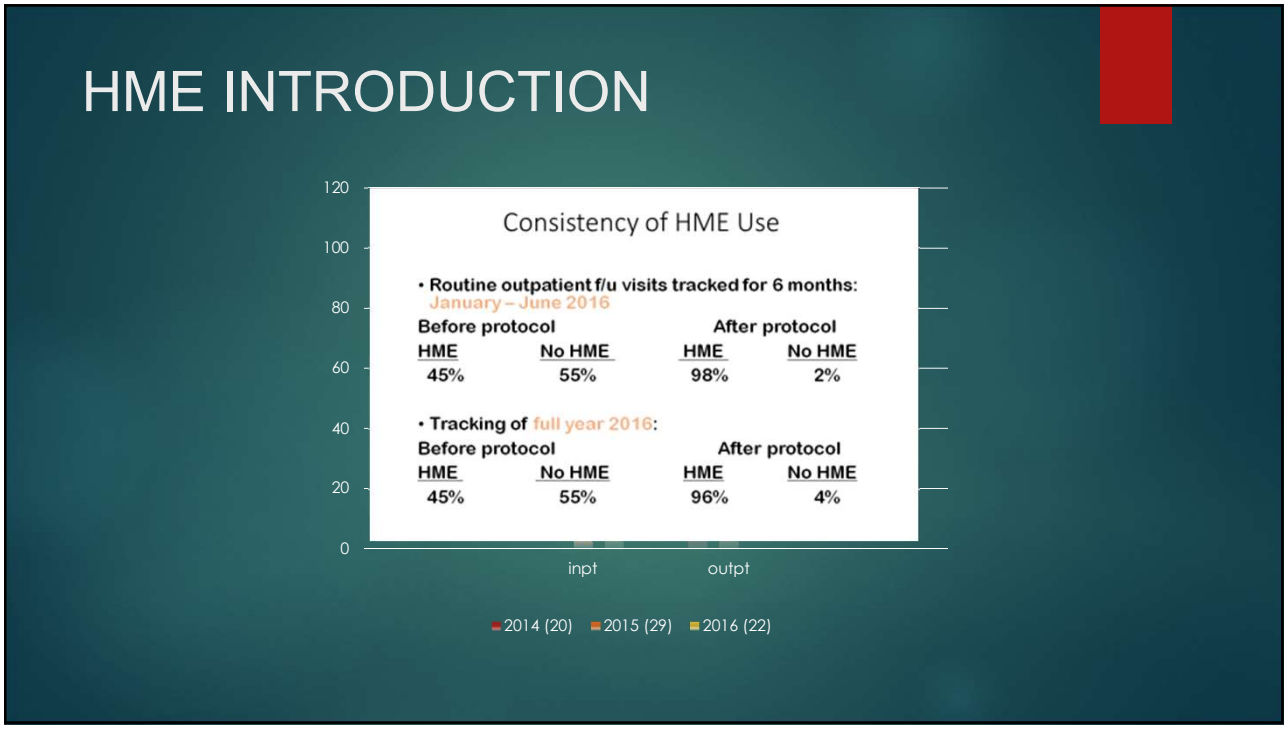

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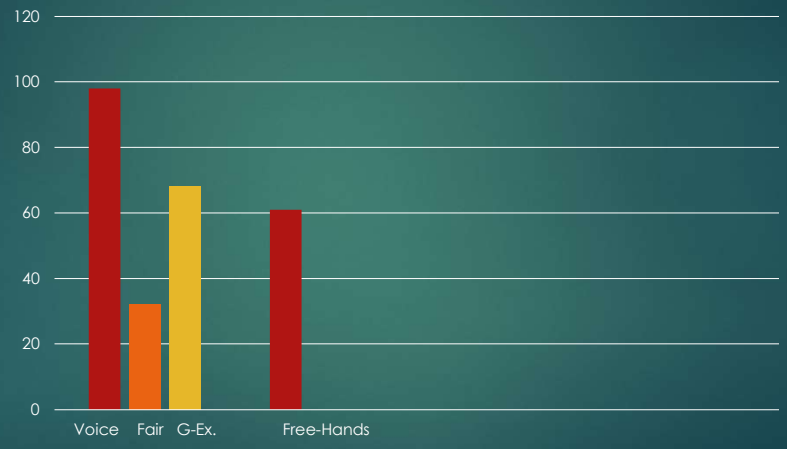
Primary TEP w/fit at Cleveland Clinic 2011-2019 (N=230)



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CC HME Protocol: Acute To Outpatient

- Dramatic improvement in HME use overall
- More TL/TEP patients using Free-Hands HME.
- More TL/TEP patients introduced to Free-Hands HME sooner
- Patients now have options for speech based on needs / activities each day

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Free-hands protocol of the Netherlands Cancer Institute (NCI)

Department of Head and Neck Surgery & Oncology
Amsterdam, The Netherlands

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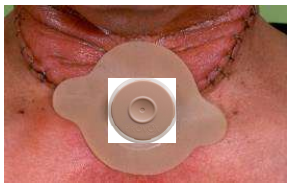
Background



Primary puncture (provox Fr22.5):

- Since 1988 method of choice in the NCI, giving earliest and best possible voice rehabilitation results, also long-term (> 30 yrs experience)*
- On the OR patients receive already an adhesive (optiderm) and HME (1995)

Secondary puncture:

Sequential: Planned 6-10 weeks post TLE (e.g., gastric pull-up)

*FJM Hilgers, KJ Lorenz, H Maier, CA Meeuwis, JDF Kerrebijn, V Vander Poorten, A-S Vinck, M Quer, MWM van den Brekel. Development and (pre-) clinical assessment of a novel surgical tool for primary and secondary tracheoesophageal puncture with immediate voice prosthesis insertion, the Provox Vega Puncture Set. Eur Arch ORL 2013; 270: 255 -62

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Post-operative period NCI

Primary puncture:

- Voice rehabilitation starts 10-12 days postoperatively
- Early feeding protocol (NG tube removal and start with oral feeding 2nd postoperative day)*
- Most patients leave the hospital in 2 weeks with a voice/oral intake

Full reimbursement

*Timmermans e.a., Predictive factors for pharyngocutaneous fistulization after total laryngectomy, *Ann Otol Rhinol Laryngol*. 2014.

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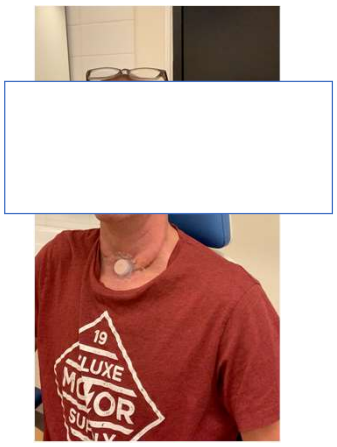
EXAMPLE:

- Primary puncture and primary fit is the fastest solution for restoring oral communication, also after flap reconstruction: patient < 3 weeks post-surgery



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During RT/CRT

- Weekly monitoring SLP
- Adhesive + HME during RT
- Skin problems –> switch to larytube
- Main goal
  - Check VP
  - Continuing speech rehab

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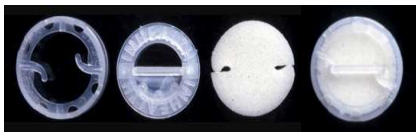
HF devices

- Advantages: hands are free, use of non-verbal communication, laryngectomy is less visible
- Approximately, start 3 months post-surgery
- When/who?
  - Good/relaxed voice with manual stoma closure
  - Anatomical conditions (hypotonicity/good seal)
  - Physical condition
  - Understanding of device
  - …



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FH use NCI – prospective multicenter study

- Data collection and follow-up (4 and 26 weeks):
  - -Structured questionnaires (four-scale answers)
  - -Visual Analog Scale to rate satisfaction
  - -Quality of life (EQ-5D-5L)
  - -Voice assessments
  - -Diary

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Method

- N = 40 (20 NCI; 20 UMCG) → 36 ♂ ; 4 ♀
- Mean age 63.6 years (SD± 8.91)
- Median post-surgical follow-up 74.5 months (range 3-317)
- At Baseline
  - Hands-free speech: 13/40 patients (33%)
  - No hands-free speech: 27/40 patients (67%)

L Lansaat et al. A prospective multicenter clinical feasibility study of a new automatic speaking valve for postlaryngectomy voice rehabilitation. EAORL. 2017; 274: 1005-1013

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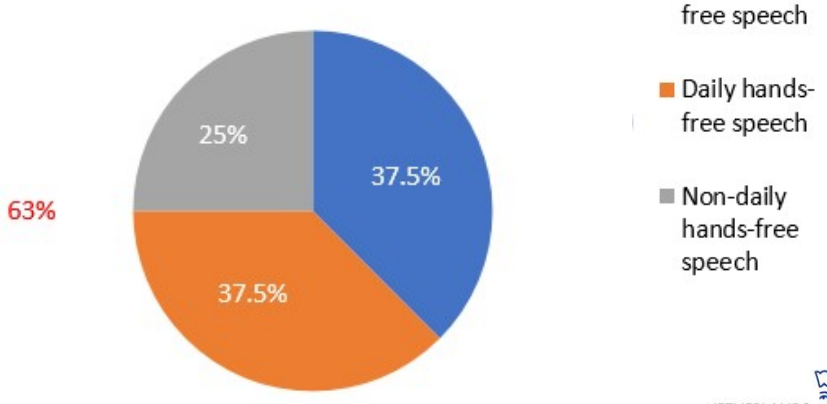
Compliance Flexivoice

- Use at 26 weeks follow-up (N=40)



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HF speech - disadvantages

- Adhesive gets loose/ leakage
- More tiresome compared to manual closure
- Less volume/ weaker voice
- Skin irritation/speaking resistance/annoying sound

Note: caution the patient not to use the FV during the night

Role of SLP **VERY IMPORTANT!**

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Case

- Larytube during the night because of shrinkage of the stoma.
- Flexivoice during the day ▸ leakage of adhesive
- Flexiderm + larytube with blue ring and flexvoice ▸ less forward movement ▸ less leakage
- The disadvantage: more coughing during manual closure

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