Biggest Threat to Lary Health and Safety


Parts 1 and 2 can be read at TheIAL.com under Publications-The IAL News. Especially if you have not read Part 1, please do. It is important. Parts 1, 2, and 3 report(ed) on a survey of over 45 speech therapists and a half dozen MDs.

The threat to laryngectomee health mentioned by the majority was: “A lack of basic knowledge of laryngectomees and their changed anatomies and their breathing by medical professionals (such as confusing tracheostomy vs. laryngectomy), and subsequent inability to provide appropriate treatment. These professionals include pulmonologists, respiratory therapists, primary care physicians, nurses, anesthesiologists, SLPs, and ENT MDs.” In one study of 12 hospitals, 26 laryngectomees died as a result.

Part 1 stated that laryngectomees can minimize the chances that medical professionals will injure them and even cause their deaths. Recommendations included:

1. **Identify yourself** through bracelets and necklaces, cards carried in wallets or purses, notifying first responders ahead of time, using car window stickers, and others.
2. **Learn how your breathing worked before you became a laryngectomee and how it now works.** Know that you are a total neck breather.

The article also stated that the air reaching our lungs is now dirtier, drier, and cooler.

It described ways to improve our breathing by urging us to wear a stoma cover 24/7, maintain an indoor humidity level of between 40-55%, and listed ways to maintain a good flow of mucus (which is essential for healthy lungs and windpipe.) It concluded with a quote and the advice to never allow medical personnel to put an oxygen or anesthesia mask over your mouth and nose, or a tube down your throat, without questioning them on whether they understand you are a laryngectomee and total neck breather and not a trach patient.

It is a sad fact, but laryngectomees (and their loved ones/caregivers) must stand guard and advocate for themselves and loved ones until they are certain that medical personnel who will provide treatment understand our changed breathing systems.

Part 2 discussed the second most frequent answer to the question about laryngectomee health and safety - depression. Clinical depression and less serious forms were discussed and recommendations made.

Part 3, the final one in the series, deals with other important threats to laryngectomee health and safety. The original question asked in the survey was:

“Aside from (larynx cancer) recurrences and new primary cancers, what do you think is the biggest threat to laryngectomee health and safety?”

Recurrences of larynx cancer and the development of new cancers are a major threat to laryngectomees. The chance of larynx cancer returning after treatment depends on the type of cancer, location, stage, and the effectiveness of treatment. Recurrence is most likely to occur in the first two to three years. Being five years free from a recurrence is taken as an indication that a return of the original larynx cancer is highly unlikely.

The recommended schedule for follow-up visits to your ENT doctor following laryngectomy is once per month the first year. Every 2-4 months the second year, every 4-8 months the third year, and once per year thereafter. Keep those appointments, and report any changes. This is your first defense against a recurrence or new cancer.

The chances of developing a new primary cancer depends, in part, on the cause of the larynx cancer. If the lary was a smoker other parts of the anatomy were also exposed to the chemicals in tobacco. The development of lung
Cancer is not unusual in laryngectomies who smoked and/or were heavy drinkers. The combination of the two increases the risk significantly. Many larys who were smokers will be scheduled for an annual chest x-ray.

However, if you smoked at least one pack a day for 30 years, or 2 packs for 15 years, are age 55-80, and if you stopped smoking less than 15 years ago there is a different recommendation. The Centers for Disease Control recommend that you have a LOW DOSE CT scan every year until you are more than 15 years since you stopped smoking or you turn 80. CT scans are much more accurate in detecting lung cancer than x-rays in early stages when they are more successfully treated. If you meet the requirements stated above, ask your doctor if you should receive an annual LOW DOSE CT-scan (a yearly regular CT-scan would expose you to too much radiation.)

*Lung infections* can be very dangerous for laryngectomies. Untreated pneumonia can be life threatening. Wearing the most effective stoma covers 24/7 helps prevent lung infections. The more effective stoma covers are those which cause all of the incoming air to be filtered, such as the Heat/Moisture Exchange filter (HME). Other types of covers have varying degrees of protection. Some larys increase the effectiveness of their square foam stoma covers by doubling them.

The color of mucus can indicate a lung infection. If mucus is no longer transparent or white but has a green or yellow coloring it probably means an infection. See your doctor immediately. These infections are usually effectively treated with antibiotics.

Although they are fairly rare, a mucus plug is capable of being deadly. Under normal circumstances, mucus moves upwards from the lungs and through the windpipe (trachea) by microscopic waves of hair-like cilia to our throats where we can cough the mucus out. But especially if our mucus becomes dried out and thickens the cilia may no longer be able move mucus upwards. If enough accumulates mucus can form a plug which blocks the movement of air. It can cause the collapse of a lung.

Some new laryngectomies are sent home from the hospital with a suction machine to be used to vacuum out mucus and prevent plugging. Laryngectomies can also reduce the chance of the formation of a mucus plug by keeping their flow of mucus thin and watery. This can be done by staying well hydrated, maintaining an indoor humidity of 45-55%, wearing a Heat/Moisture Exchange filter, squirting sterile saline water into their stomas and then coughing it out. Some use saline "pink bullets" to squirt down into the stoma, others may use a saline spray.

Some laryngectomies experience shrinking of their stomas (stoma stenosis, micro-stoma). If the stoma is too small it can effect the movement of air into the lungs making it harder to breathe. The solution for many is to wear a lary tube or button at least part of the day to stretch out the stoma.

Another problem for some laryngectomies is the formation of granulation tissue, especially around the TEP prosthesis. The tissue growth is the body’s attempt to heal an unnatural opening.
Granulation tissue can be removed in the ENT MD’s office. An extreme case of stoma stenosis may require surgical revision (stoma plasty) to enlarge it.

Another problem for some laryngectomees is the shrinking (stenosis) of the esophagus (feeding tube) making it difficult to swallow. The solution for many is to have their esophagus stretched (dilated) by their ENT MD. A few laryngectomees can self-dilate using what is called a “bougie”

For those laryngectomees who were treated with radiation there can be long term complications including the formation of “fistulas” (holes that may not heal on their own). Carotid arteries can be damaged, and, in extreme cases, radiation can contribute to the development of another cancer.

We laryngectomees need to educate ourselves. There are relatively few of us so we may encounter medical professionals who have never treated a lary and who mistake us for trach patients. There are many things we can learn and do to protect ourselves. (Compiled by David Blevins)