

Chapter 50

Voice Restoration after Total Laryngectomy

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Loss of voice is the greatest disability for most patients after total laryngectomy. Although the presence of a tracheostoma and the associated anterior neck deformity pose a cosmetic and functional deformity, it is loss of a normal speaking voice that is most debilitating to the patient, both functionally and emotionally. As a result of the severity of this disability and its effect on social interaction, efforts to rehabilitate the voice after total laryngectomy have been made almost since the first laryngectomy was performed more than a century ago.

Acoustic signals that are interpreted as voice are a complex compilation of varying frequencies created by a number of anatomic structures. The larynx is responsible for the fundamental vibratory frequency of the sound produced, as well as the associated interruptions and alterations in airflow. Airflow is created by expiratory lung volume, and the complexities of articulated speech and resonance are produced in the air passages superior to the larynx. Therefore, any means that can approximate normal vibratory airflow function proximal to the articulators has the possibility of resulting in understandable speech. All forms of speech rehabilitation after laryngectomy rely on this principle.

TYPES OF SPEECH REHABILITATION

Speech rehabilitation after total laryngectomy can be subdivided into three major categories:

1. Esophageal speech
2. Prosthetic artificial oscillators
3. Tracheopharyngeal shunts or fistulas

Esophageal Speech

Esophageal speech is a learned technique in which air is swallowed ("injected") into the esophagus and then allowed to escape through the pharynx. Appropriate tensing of the pharyngeal walls during expiratory airflow

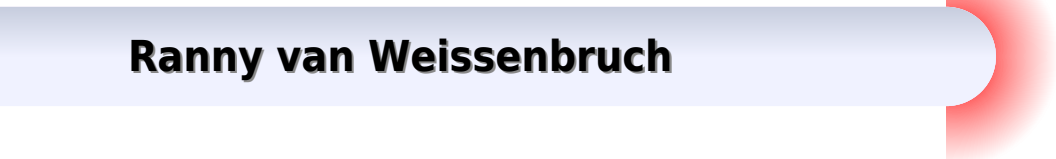
results in vibration of the pharyngeal walls, which creates sound. Esophageal speech is typically of lower pitch than normal speech frequencies because of characteristics of the pharyngeal wall. The advantages of this technique are that it requires no surgical procedure, prosthesis, or cumbersome hand motions. However, few patients who have undergone laryngectomy are able to achieve usable esophageal speech, and fewer than one in five achieve speech acceptable for social interaction. Extensive training is required by most people, and individuals vary widely in their ability to use this training to rehabilitate their speech; nonetheless, despite recent advances it remains useful for those who are able to master it. A few patients are able to use esophageal speech as their sole speech modality, but most retain other forms of speech as a backup.

Prosthetic Oscillators

Electronic devices supplying vibration into the oral cavity will permit speech, albeit monotone and machine-like. This is clearly the easiest method to use and, for many patients, remains their sole form of speech after total laryngectomy. The devices can be divided into two types: those that cause the pharyngeal wall to vibrate and result in secondary vibration of the air column and those that cause vibrations within the oral cavity via a connecting tube (Fig. 50-1). One (and perhaps more) of the instruments available commercially can be modified to permit either vibration of the oral cavity tissues externally or entrance of vibrating air into the oral cavity. As in many other skills, speech production by these techniques is learned by experience, and patients vary widely in their ability to develop useful communication. An externally applied device will not be satisfactory in a patient whose pharynx has been reconstructed with bulky flaps or who has undergone radiotherapy because of the increased rigidity of the tissues and resistance to vibration.

Voice Restoration After Total Laryngectomy

Ranny van Weissenbruch



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