Laryngectomy information sheet
(for healthcare providers)

This information sheet has been produced to help healthcare professionals who may not be familiar with laryngectomees. More information can be found on the NALC (www.laryngectomy.org.uk) or NTSP websites (www.tracheostomy.org.uk).

What is a laryngectomy?

A laryngectomy involves surgical removal of the larynx (voice box), usually as treatment for cancer of the larynx. The remaining trachea (wind pipe) is brought to the front of the neck as an end stoma. The mouth, nose and upper airways are no longer connected to the lungs. All breathing, ventilation and oxygen delivery can only occur via the stoma in the neck. Bed-head signs are available to display this information.

Humidification & suction

The humidification normally provided by the upper airways is lost. Laryngectomees need continuous artificial humidification of air or oxygen inspired via the neck stoma. This can be achieved using various stoma covers or protectors. Any oxygen administered *must* be humidified. Cough effort can also be reduced or less effective. Regular suction may be required and should *always* be available.

TEP valve

Communication

Laryngectomees have lost their 'voice box'. Artificial speech is possible via an 'electolarynx' which vibrates the neck externally, oesophageal speech ('burping' swallowed air) or via a Tracheo-oEsophageal Puncture (TEP) valve. The TEP valve allows expired gas to be forced into the oesophagus, facilitating speech.

Anaesthesia

There are no contra-indications to anaesthesia with a laryngectomy. For general anaesthesia, the laryngectomy stoma can be intubated with a tracheostomy tube, specialist laryngectomy tube (eg. Montadon tube shown here) or an endotracheal tube. Supplemental humidified oxygen via an open stoma can be delivered via a 'trachy-mask.' The TEP valve should be left in situ. Emergency management algorithms and further resources are available from NALC and NTSP.