EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

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HEAD AND NECK SURGERY / LARYNGECTOMY

The treatment of cancers of the head and neck involves a careful evaluation of the patient to determine the type and extent of the malignancy. The health care providers and staff of ENTACC work closely with our patients in order to ensure that these tests are completed in a timely fashion.

The tests may include some or all of the following: CT scans, used to evaluate the extent of the cancer; PET scans, used to evaluate the presence of metastatic disease; ultrasounds and MRIs may also be useful; in-office endoscopies and biopsies (which may include FNA or fine needle aspirate biopsies or an actual open biopsy, in which a portion of the tissue is removed). Your surgeon will determine which of these studies are appropriate.

For one (1) week prior to surgery, you should not take any aspirin or aspirin containing drugs, nor any ibuprofen or ibuprofen containing drugs. Examples of these include Advil (Motrin), Naprosyn (Naproxen), or Fiorinal. Also, supplements which should be avoided include Vitamin E capsules, omega 3 (fish oil), or glucosamine chondroitin. If you are required to be on any of these medications, discuss this matter directly with your ENTACC provider before stopping. If you are on Coumadin (Warfarin), Aspirin, or Plavix, please discuss with the prescribing physician about how to adjust this medication prior to your surgical procedure.

In addition to the above and depending upon the type and extent of malignancy, your ENTACC physician may refer you to other specialists in radiation therapy or chemotherapy. Again, this decision will be based upon the nature and extent of the malignancy. Prior to your head and neck surgery, a feeding tube (PEG tube) is usually placed in your stomach for feeding purposes during the healing process. This ensures that you receive adequate nutrition in the postoperative period. Generally these tubes are removed you are able to achieve normal nutritional intake by mouth.

Surgery is performed as an inpatient in the hospital. Drains are kept in place postoperatively in order to ensure that the wounds heal without any accumulation of fluid. They are removed when an acceptable level has been achieved, normally about two or three days postoperatively. . Patients are generally discharged from the hospital within five to seven days and have their sutures removed between 10 and 14 days. At around this time, oral feedings are resumed for patients who have had laryngectomies or lower throat reconstructive procedures.

If radiation therapy is required, this usually is begun about six weeks postoperatively. Frequently the determination as to whether or not radiation therapy is required will not be made until postoperatively when the final pathology report on the tissue removed has been reviewed.

In other circumstances, the decision is made preoperatively. If radiation is required as an adjunctive treatment for your cancer, therapy generally will begin about six weeks postoperatively. The type and length of radiation therapy will be determined in consultation with a radiation therapist. If chemotherapy is required as well, it will either start at the same time or after completion of radiation therapy.

Unfortunately patients who have head and neck surgeries have a high risk of developing a second primary cancer in the aerodigestive tract. For this reason and because cancers can recur, it is necessary that patients are followed closely by their surgeon for an extended period (usually in excess of five years). During this time your head and neck surgeon will determine whether additional diagnostic studies may be required in order to ensure that there is no recurrence of your malignancy.

Because there is such a high correlation between the use of tobacco and head and neck cancers as well as the excessive use of alcohol, it is recommended that all patients who have head and neck cancers abstain absolutely from cigarettes and use alcohol in extreme moderation postoperatively and throughout the remainder of their life.

LARYNGECTOMY, PARTIAL OR COMPLETE: SPECIAL CONSIDERATIONS

Laryngectomy surgery may involve removal of the entire voice box or removal of only a portion of the voice box with reconstruction. If the malignancy involves the vocal cords, you may also be evaluated by a speech therapist to aid in vocal rehabilitation.

If you have had a total laryngectomy performed, while you are in the hospital, you will be instructed on how to care for your stoma (the new hole in the neck for breathing purposes). This care will continue throughout your life. If you have a total laryngectomy, your surgeon may insert an indwelling voice prosthesis at the time of surgery or may determine that this is better inserted at a later date. If such a prosthesis is not inserted, you will work with a speech therapist in the immediate postoperative period to begin the use of your electrolarynx (artificial voice device).

For those laryngectomy patients who have not had an indwelling voice prosthesis inserted at the time of surgery, this may be done at a later date. Once adjunctive therapy (radiation and/or chemotherapy) is completed, your physician may determine that you are a satisfactory candidate for insertion of the prosthesis which is usually inserted under general anesthesia as an out-patient.