MY EXPERIENCE OF LARYNGECTOMIES AND OESOPHAGEAL SPEECH

by

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The first Laryngectomy case I saw treated for oesophageal speech was a woman of some seventy odd years, and perhaps she was not a very fortunate subject for my first introduction - both her age and sex were against her. Her age because 70 is rather late in life to be forced to learn new habits, and her sex because I have since learned that women are more difficult cases than men. They do not take to it kindly. They are more sensitive. Their fashions are against them - the trachyotomy tube and the opening in the trachea is so conveniently camouflaged by man's collar and tie. The type of "voice" used in oesophageal speech is gruff and inclined to be harsh, which, though almost unnoticeable in a man, and at worst sounds like a very bad cold, in a woman is not attractive or natural-sounding and is rather 'disgusting', as my lady kept saying.

She had unfortunately discovered that the air in the buccal cavity could be used to her advantage before she came for Speech Therapy, and that by "spitting" out noiseless words and syllabus at people she could make herself understood.

Having resorted to this exaggerated use of the articulating organs it was all the harder for her to learn oesophageal speech. And particularly hard because she thought it all so 'disgusting'. She would sit and listen to the Therapist doing her level best, then she would shake her head and say "its disgusting", (two words that she could 'spit' out with very effective force!) But it was not nearly so disgusting as all the wheezing, coughing and spluttering noises she continually made through her tube.

Great efforts were made to interest her in the subject; to prove that it wasn't disgusting but really rather marvellous. To encourage her, former successful oesophageal speakers were called upon to come and help.

There were quite a few cases of which her Therapist was proud to boast, the most creditable of these being a young lawyer in his thirties. As a result of intrinsic carcinoma his larynx had to be removed. In a few weeks he had mastered oesophageal speech and within a few months, his health being quite recovered, he was back at the bar - where he is still carrying on most successfully. Few would suspect he was talking his way out of things without a "sound box"! He is perfectly intelligible, and not only does he speak well but

he has adjusted well to the situation and copes extremely competently and extremely politely with the inconvenience of his trachyotomy tube.

The lady of whom we were speaking gave up coming to the clinic. She was not well and was not happy. She preferred to go on in her old way, writing it down when she couldn't make herself understood. She lived alone, so had little need to talk. This was a big point - without the incentive to practise little is done, and without practise - particularly with this oesophageal speech - little is achieved.

Also to exonerate her from any blame, let it be said here that there appear to be three types of Laryngectomy cases.

1. Those that grasp the idea of oesophageal speech right away by going back to 5th form standards, and master it quickly.

2. Those that learn it slowly and surely but master it latterly.

3. Those that simply can not do it.

It is interesting to watch the various cases from the beginning. Immediately after the operation all they can do when visited in the wards is gesticulate - some shrug and frown, others grin and cock a thumb, according to their mood. Ten days after the operation they learn to belch to order. And from then on to articulate on the belch. Starting with syllables, working up to words and sentences and on to conversation. The length of time it takes to master this and develop it into a fine art, with improved tone - to the stage where they neither run out of air before they run out of words, nor do they run out of words before they've used all their air, depends on the ability of the individual.

Most of the work to acquire oesophageal speech should be done by the patient on his own. As much practise as possible should be done each day to achieve and better the sound. After practising the patient should come to the clinic for guidance, correction and further suggestions for more practise. Regular, fairly frequent visits are desirable to keep the patient up to the mark and to provide incentive for practise. The patient's health has to be watched as well. It is not always advisable to press the speech training, as it frequently causes dreadful flatulence and for this reason patients must be warned not to practise one hour before or after a meal.

Secondary growths are known to appear, and particularly if radium was the mode of treatment (rather than operation), the

wound is found to break down.

Another two very interesting cases I saw were a farmer and an ex-boxer.

The farmer was the younger of the two, being in his thirties, also, perhaps, a better class of person. He was a North countryman and had a farm in Yorkshire. He seemed shy and a little reserved.

The ex-boxer was a very jovial individual in his fifties. He was very pleased with himself and, indeed, had something to be pleased about. He was a great talker and told us all about it.

Both these men had had total Laryngectomies performed, followed by speech therapy. The ex-boxer had only had speech therapy over a period of weeks (6-9). The Yorkshireman had had speech therapy for a corresponding period of months, yet of the two the boxer was the better speaker.

There are probably several reasons for this, but it is partly accounted for by personality. He was a hearty type, not at all shy of making a fool of himself or of appearing conspicuous. The farmer was shy and more retiring, and more refined, which, interestingly enough, would appear to be a drawback - maybe in the long run he will benefit from it by having a more polished performance - but at the time it appeared that he was tenser, less free to experiment and therefore his efforts were inhibited.

A point greatly in the boxer's favour was that he lived in town and could conveniently attend therapy. Whereas the farmer, living in Yorkshire, had only visited London, I believe, three times for speech therapy, after the initial first week of treatment. In this, however, he served as a perfect example of results which may be obtained from practise.

These two men came especially one day to illustrate a talk on oesophageal speech. It was a great ordeal for them to appear on the stage before a hall packed with people, but in spite of the conditions and any 'nerves' they might have had, they spoke very well and could be heard and understood at the back of the hall without the aid of any microphone. I was most impressed with the ex-boxer and the way he kept stressing how fit and well he was. He was very happy and pleased with life and told us of all the exercise he took in a day - even to a light bit of sparring. This was interesting, as without a larynx it is impossible to take a break and close the glottis, holding the thoracic cavity braced, as we all do when effort is required of us.

The farmer too carried on his normal work without his larynx. His life was not much affected.

One last case you might like to hear of, is a man of about 60. He is a grocer and owns a shop. Another very proud and cheerful person. He had had speech therapy before I saw him and could now manage on his own. He had been taught by a different method, his tone was harsher and thinner than others I had seen treated, and he appeared to gulp air only as far as the pharynx instead of right into the stomach. He was perfectly intelligible and assured us he had no difficulty in serving his customers and making himself understood. He had not mastered a smooth flow of conversation, however, but spoke in gusts. He also gulped air in rather noisily.

There is a great tendency for all laryngectomies to make such a business of swallowing the air, and they wheeze, tense and strain, filling their lungs to capacity at the same time. It is hard for them to realise that any air taken in at the mouth must go into the stomach via the oesophagus, as there is nowhere else for it to go. The action of swallowing air is entirely independent of the action of breathing. Now there is no connection between their nose and mouth and their lungs.

It is important that they should not try too hard and should have perpetual encouragement. And it is amazing what can be achieved. The only sound that remains impossible for them is the h, for which they substitute g (as in gaan).

For those cases that cannot master oesophageal speech the laryngeal reed or artificial larynx is better than being inarticulate. But it is conspicuous, costly and requires careful handling lest air-blocks arise.