Societies' proceedings

DISCUSSION OF PAPERS OF DR. MILLER AND MISS WARNER
SECTION OF LARYNGOLOGY, ROYAL SOCIETY OF MEDICINE
6 MARCH 1970

Mr. Maxwell Ellis thanked the President for asking him to open the discussion, even though at a moment's notice, as it was a rare pleasure to hear two such excellent papers and presentations with so much of interest in each. Both speakers had shown good sense coupled with good sensibility in their discussion of a disability causing so much distress to the patient concerned. Excision of the larynx and thus the deprivation of normal speech produced an emotive disability which early on had been dubbed a mutilation, a name which has stuck. All efforts to remedy the condition are to be welcomed.

He was delighted to learn that Dr. Miller uses a vertical midline incision for laryngectomy and hoped that this will support the efforts the speaker had been making for over twenty years to convert laryngologists to a simpler and more rational surgical approach. One of the many advantages was the flexibility of the method so that unforseen or reparative procedures were easily accommodated, and the Asai technique described by Dr. Miller illustrates this point.

The speaker was troubled by the length of trachea which seemed to be necessary. He had always believed that transection of the trachea immediately below the cricoid cartilage risked stomal recurrence. Has this occurred in any of Dr. Miller's cases?

Did the saliva leak into the trachea at night when the patient was not using his finger to control the pharyngo-tracheal opening?

The continuous use of one hand in producing the voice is a disadvantage, but of course this must be weighed against the advantage of thereby obtaining a good and intelligible voice. The two good cases demonstrated in the film undoubtedly had better voices than would normally be obtained by the more conventional oesophageal speech technique; nevertheless a patient with a good oesophageal voice was better off, as he would not normally wear a laryngectomy tube and would have both hands free. This seemed to indicate that an Asai technique might be a useful second string method in cases where oesophageal speech was poor. Dr. Miller has shown how this can be achieved technically and the speaker believed it might prove a useful conception.

The age of the patient and the economic need to develop a good voice were important factors. Elderly patients rarely acquired good oesophageal voices, but younger ones, often stimulated by the need to return to work, were usually successful in developing reasonable and often excellent voices. Temperament was another factor and patients who had an optimistic outlook or a combative spirit were more likely to succeed. Dr. Miller's cases also showed this selective success. The Asai method might suit patients of frail mentality and old patients

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who were not arthritic and who did not mind the limitation of one-handedness.

The speaker was interested to learn that irradiation was not necessarily a deterrent. Most of his own cases would have been given a full therapeutic dose of irradiation in the first instance and he thought that radionecrosis of the tracheal cartilages and soft tissue morbidity would be built in hazards in such patients. No doubt an Asai modification in some would be successful, but perseverance with conventional oesophageal speech methods or the provision of an artificial larynx seemed better alternatives.

Almost every word spoken by Miss Warner had his enthusiastic support. The case of post-laryngectomy speech therapy had never been put better or more gracefully. He wondered whether Miss Warner had had any experience of an artificial larynx buzzer fitted into the roof of the mouth or into an upper denture. This seemed to him a distinct advance, but his practical experience was negligible. Had Miss Warner anything to add?

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