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Murray's Mumbles ... Musings from the President

My Best Laryngectomee Visit

Back in the spring of 1998 I was sitting in my living room bemoaning my fate. My ENT had just told me I had laryngeal cancer on the left true vocal cord and that I must undergo 25 sessions of radiotherapy and that would, in all probability, cure the cancer. It had been a long road to even reach this point. Most of our primary physicians see very little of this relatively rare cancer and therefore immediately think you have laryngitis, or some other common throat disorder, which is causing the hoarseness. Practically no general physician wants to think of carcinoma when a patient presents with the only symptom being a partial loss of voice. Of course, that's when the druggist becomes your best friend. You name it, penicillin, prednisone, Tetracycline and Erythromycin and I had them all. Of course I was still hoarse. I was finally referred to our Cancer Clinic and began radiation. It didn't work. Next step was a biopsy by a very good ENT physician who confirmed that I still had the big C and a total laryngectomy was required.

I went home still bemoaning my fate and the upcoming dramatic change in my vocal abilities. A knock on the door and there stood a tall, strapping man who put his right hand to his throat and said in a booming voice, "Hi Murray, I heard you need someone to talk to." And did I ever! This was the man. His name was Bob Diggon and he was then 75, a retired engineer from Shell Oil who had been a laryngectomee for over 20 years. What a great relief it was to hear him talk and his enthusiasm was boundless. His visit was just what I needed and it was "by the book". He explained my voice choices and showed me a TEP which he used. I couldn't believe that a small silicon tube could restore my ability to voice but Bob was living proof that it could. His visit was so uplifting it gave me a tremendous feeling of happiness and practically all the doubts that I had or imagined were gone. He was a miracle worker to me.

Bob explained that he was president of the Vancouver Laryngectomee Club and my good wife June and I were invited to meet other larys and their caregivers. Well, we appeared at the meeting about six weeks later and were met by at least 25 others in the same condition and of course their caregivers.
At the beginning of the meeting, Bob said, "Murray, you're speaking well and you're the youngest guy here". With that he proposed I become President of the Club. I was elected by acclamation and Bob smiled when he handed me the gavel.

Sadly, Bob passed away last year. I was so impressed by what his visit did for me that I have followed in his footsteps for the past 9 years and, at last count, have made over 130 visits both pre and post operation in the greater Vancouver area.

While it is unfortunate to have someone undergo this procedure, it gives me a great feeling if I have lessened some fears and convinced patients that their life will go on.

The very best to all, take care and stay well.

Murray Allan, argus@shaw.ca

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Complications when Laryngectomy is Accompanied by Total or Partial Glossectomy

by Alicia Meyers

University of Kansas Medical Center

Speech rehabilitation following total laryngectomy certainly requires specific expertise on the part of the treating speech-language pathologist (SLP). When a patient also undergoes removal of a portion or all of the tongue, along with the larynx, the rehabilitation process is even more unusual and challenging, both for the patient and the SLP. Fortunately, the combination of total laryngectomy and glossectomy (part or all of the tongue) is less common than total glossectomy plus surgical extension into the hypopharynx (i.e., lower part of the throat) or the esophagus (i.e., food tube).

However, certain tumors may require that the surgeon remove part of the base of the tongue or perhaps even some of the oral portion of the tongue. Total removal of the tongue (i.e., total glossectomy) along with total laryngectomy is necessitated less frequently than partial removal of the tongue plus laryngectomy. There are times when a large tumor of the tongue leads a surgeon to remove the tongue in total. In some of these cases, a laryngectomy may be done in an attempt to deal with the swallowing problems that may be left after removing the tongue (In leaving the larynx, there is a high likelihood of food and liquid spilling into the larynx, trachea and lungs). Although there is continuing debate about the merits of total glossectomy in general because of the large impact on quality of life, most surgeons continue to see it as a possible treatment approach for select patients. An SLP might only rarely have to work with a person that has a total laryngectomy plus partial or full glossectomy but must be ready to take on such cases.

Below is an overview of some concepts and issues with which an SLP must be familiar when working with individuals who have part or all of the tongue resected along with a total laryngectomy. It must be recognized at the outset that each person undergoing this combined procedure presents uniquely. With a total laryngectomy one can predict with a fair degree of certainty before surgery what structures will be removed and roughly what the surgical reconstruction will entail. With glossectomy plus laryngectomy, there is less certainty before surgery about how much and what tissues will need to be removed. There are also a number of surgical approaches and reconstruction options for tongue and floor of mouth defects. Below, some of the more common approaches and reconstructions for tongue resection and/or removal are briefly reviewed. The second portion of the paper deals more specifically with voice rehabilitation issues when a laryngectomy is combined with resection of the tongue.

Surgical Approaches and Reconstruction Options for Tongue Tumors
When dealing with just a tumor of the tongue, the surgeon has two broad choices for how to approach the tumor removal:

1) Through the mouth (transorally)
2) Through the neck or floor of mouth (transcervical). Sometimes a combination of these two approaches is used.

When there is a planned laryngectomy that also involves the tongue (often the tongue base), the approach usually is transcervical, although through-the-mouth may be added depending on extent and location of the tumor.

Reconstruction options for tongue resections will vary depending on the location, size and depth of the tumor, the patient's expectations and desires, the surgeon's expertise, and other factors. Each of the options carries certain advantages and disadvantages that also play a role in selecting the method of reconstruction. Some of the more common reconstructions include the following.

1) Open healing. Technically, this is not a reconstruction procedure. However, when the tumor resection is smaller and superficial on the tongue, the surgical defect may be left open to heal on its own. This is not likely to be the choice in our patients who also are undergoing total laryngectomy who more often have the base of the tongue or deeper tongue resections. At times, lateral tongue resections of a smaller and shallower size that are done these days using laser surgery are left for open healing. Of course, this is an approach that would only be used for partial and not total glossectomy.

2) Primary closure. When the surgical defect is small in terms of the surface area removed, but deep into the tongue, a surgeon may opt to suture together the edges of the surgical cut. This is referred to as primary closure and for the tongue it has been applied for small to moderate size tumors that project deeper into the tongue itself. If primary closure is attempted for a surgical defect that is too large in terms of the surface area (that is, the cut edges of the tongue are far apart from one another), there is more tension on the suture line and the remaining tongue may be restricted in its movement. SLPs are not likely to see patients with total laryngectomy plus partial glossectomy who have the tongue defect closed in this manner.

3) Regional Flaps. Surgeons talk about flaps for tongue defects quite often. A flap is tissue take from a donor site that is moved into the surgical defect created by the tongue tumor removal. Unless the surgeon specifies that it is a "free flap," the implication is that the flap of tissue is not totally disconnected from the donor site. Rather, the tissue retains an attachment from its original site so that it has a blood supply to help keep the tissue alive. When dealing with tongue defects that require a flap to replace the bulk of the excised tissue, the donor site is frequently the pectoralis major muscle. This is a large muscle of the upper chest. The flap of tissue that is taken usually includes the muscle as well as the skin tissue over the muscle. When taking the muscle from the chest and running it up through the neck and into the surgical defect in the tongue, the flap is referred to as "regional" rather than "local." Local flaps are usually smaller volumes of tissue that are closer to the surgery site. There is not a great choice for harvesting local flap tissue when trying to fill a tongue defect. The cheeks and lips don't generally have the bulk needed, plus the cosmetic and speech/swallowing problems that go along with such a local flap are not desirable. SLPs are likely to run into patients who have pectoralis major flaps for either fairly large oral tongue defects or oropharyngeal defects.

4) Free Flap. A free flap is a generic term that refers to tissues taken from outside the head or neck in which the blood vessels are severed at the donor site. The surgeon then moves the tissue to the surgical defect and "reconnects" the flap's blood supply and veins to the blood supply right at the surgical site (this is referred to as anastomosis of the veins and arteries). In this way, the transplanted tissue has a blood supply that can keep it alive in its new site. A typical donor site for surgical tongue defects is the patient's forearm. This is referred to as a "radial forearm flap." With an experienced surgeon, radial forearm flaps can be a reliable technique for closing tongue defects.

Surgeons are often adventurous and ingenious in their continued efforts to find the best ways to deal with surgical defects of the tongue. Various types of jejunal grafts are being tried for total glossectomy + laryngectomy cases along with other approaches. There is no standard approach for glossectomy + laryngectomy procedures at the present time. The uniqueness of individual cases makes standardization difficult and not necessarily desirable, if taken to an extreme.

There will always be a need to balance at least two principal competing aims: getting rid of the disease and maintaining as much function as possible. In the case of the glossectomy and laryngectomy patient, the functions of concern are swallow and speech related. The SLP must continue to stay well versed with the various types of surgical procedures and reconstructions that are available. In particular it is helpful to talk in detail with the ENT surgeons with whom they work most closely on such cases to learn when and why the surgeon opts for one approach over another.
The SLP can prepare to better serve the patients referred to them who undergo such surgeries.

**Voice Options Following Total Laryngectomy with Partial or Total Glossectomy**

The tongue is arguably the most important articulator. The extent and location of tongue resection, along with mobility of the tongue after the surgery (largely determined by how the surgical defect is filled) are major contributors to how understandable the person's speech will be, even when the larynx remains in place. When total laryngectomy and glossectomy are combined, the effects on speech production can be substantially more involved than when either surgery (larynx or tongue) is required on its own. Those with a total laryngectomy are usually required to be even more precise in their articulation following larynx removal in order to maximize intelligibility. Precise articulation, however, may be problematic after the tongue is surgically resected.

Although total glossectomy plus laryngectomy may be occurring less frequently today than in the past, given attempts at more conservative approaches, a few comments are in order. If such cases arise, the SLP must help the patient and surgeon decide which method of alaryngeal speech is most likely to meet the patient's daily needs. Although there are certainly case reports of patient's with total glossectomy + laryngectomy, of the three alaryngeal methods namely, artificial larynx, esophageal speech, and tracheoesophageal speech tracheoesophageal speech is considered by many to be the communication method of choice for such folks. Esophageal speech may be difficult for at least two reasons. First, the lack of the tongue as an articulator severely compromises intelligibility of speech (as it will for each of the three options). This lack of articulatory precision, along with the often quiet, hoarse sounding voice that is of short duration, can result in speech that is quite difficult to understand. Second, the tongue is often used to help inject air into the esophagus in order to generate the new esophageal voice. That is, folks are trained to press the tongue against the roof of the mouth or pharynx to squeeze air into the esophagus so that it can be returned to produce a voice. Alternatively, some esophageal speakers use the tongue to articulate certain speech sounds (e.g., t, d, k, g) more forcefully which also can force air down into the esophagus ("consonant injectors"). In either case, without the tongue, the patient's options for getting air into the esophagus are more limited. They could still use what is called the "inhalation method" (drawing air into the esophagus from the mouth as they inhale sharply through their stoma) or by pressing air down with the lips and cheeks. However, even if they can use these alternate means of getting air into the esophagus, the esophageal voice that is generated often is decreased in both loudness and duration. These changes in conjunction with the major articulatory deficits that come about when the tongue is removed totally are often too much for the patient to overcome and the resulting esophageal speech may be largely unintelligible.

An artificial larynx could be tried with a person who has had a total glossectomy + laryngectomy. However, there are problems in these cases that must be considered. Artificial larynx speech also requires sharper than normal articulation in order to make speech understandable. The technical terminology is that an artificial larynx user needs to generate greater air pressure in their mouth for stop consonants (p, b, t, d, etc.) and fricatives (s, z, sh, f, etc.). Following total glossectomy + laryngectomy, they may still be able to do this for sounds involving the lips, but not for sounds that involve the tongue if it is totally removed. Unfortunately, there are many more sounds involving the tongue than the lip. An intra-oral type of artificial larynx may also be ruled out if the person has excessive oral secretions, which often follow once the tongue is removed. The excess secretions may plug the tube too often to make it worthwhile. Even if this is not the case, the problem with being unable to articulate precisely remains.

Tracheoesophageal (TE) speech does not rely on the tongue for getting air into the esophagus for voice production as is the case for esophageal speech. In addition, the voice that is created is often louder and of greater duration than esophageal speech. The TE voice also is closer to normal laryngeal voice than either esophageal or artificial larynx speech which may make it less distracting and easier to process from the listener's perspective. The TE user also has the advantage of being able to generate some airflow through the mouth (from the trachea through the upper esophagus and into the throat) that can be used to create air pressure using the lips and teeth. This airflow into the mouth is not dependent on a tongue to compress the air in the oral cavity. The person may be able to learn compensatory use of the lips and teeth to help manipulate this available stream of air to make speech sounds. We can also try to teach the esophageal and artificial larynx user how to make such articulatory compensations but they do not have the advantage of this longer, stronger, and more consistent air stream.

The options for communication open up a bit more when dealing with total laryngectomy with only a partial glossectomy. Many might argue that TE speech remains the option of choice because the voice is closer to the laryngeal voice than the other two options. When a partial glossectomy is part of the situation, articulation is going to be affected regardless of the alaryngeal option that is chosen. So why not go with the one that has a voice that sounds the closest to a laryngeal voice and also the one that allows greater opportunity for building oral pressures and airflows to make speech sounds? There may not be a reason to shy away from TE speech and it should be given...
strong consideration. However, depending on the mobility of the remaining tongue and the location of the tongue defect, both artificial larynx speech and esophageal speech might be options as well.

Just recently I had the opportunity to talk with a woman who had a total laryngectomy and a fairly extensive lateral and "base of tongue" excision. She was an excellent esophageal speaker. She injected air into the esophagus by compressing her lips and cheeks (although she had enough tongue function also do a tongue press, I think, if she wanted to). Her tongue was functional enough to serve as a viable articulator. Her esophageal voice was strong. While she did have some slight articulatory imprecision on sounds involving the back of the tongue (k and g and to a lesser extent "sh"), her speech was quite intelligible. Again, with enough mobility of the mid and front portion of the tongue, many speakers can articulate precisely enough to use any of the three alaryngeal speech methods. Then the decision as to which option to pursue can move on to other considerations such as the sound of the voice source, the patient's preference or needs, and so forth.

Regardless of the decision made, the SLP must work to maximize the articulatory precision of the tongue. Folks who undergo total laryngectomy on it own need to be taught to articulate more precisely. However, this becomes even more important for the person who has the added burden of partial tongue excision. Work should focus on producing strong oral plosions and more audible frication on what are referred to as high pressure sounds (p, b, f, v, t, d, s, z, sh, k, g). If the tongue resection is such that a person is unable to place the tongue properly to produce a certain sound, attempts should be made to train an alternate method of producing the sound. For example, if the tongue surgery results in restriction of the tongue tip movement, but leaves some mid-portion of the tongue mobile, the person may be able to move the mid portion more forward against the palate to make more "forward tongue tip" sounds such as t, d, and s. There may not be an exact match acoustically or to the listener's ear when such compensatory articulations are trained. However, if the person consistently uses the compensatory speech pattern it is expected that those listeners who are familiar with the speaker are likely to accommodate to the speech difference and understand what is being said.

In addition to trying to train compensatory articulation maneuvers, attention should be given to other methods for trying to increasing the understandability of the speech. For example, basic communication strategies such as facing the listener and limiting background noise should become a normal part of the person's communication approach. Using more gestures and facial expression may be critical to helping convey meaning when the speech itself is less understandable than desired. Other good strategies to consider include having the speaker pay more attention to the listener's face to see if they look confused. If so, the laryngectomy speaker can know that they have to go back and repeat or rephrase what was just said. The laryngectomy + glossectomy speaker (either partial or total glossectomy) should be trained to utilize these alternate approaches to maximizing intelligibility. In some cases, alternate methods of communicating might have to be explored as a supplement (or in more extreme cases a replacement) to whatever verbal communication is possible. This could entail gesturing, writing, or using what are referred to as augmentative or alternative devices (e.g., picture boards, alphabet boards, electronic devices that allow a message to be typed on screen or spoken electronically).

Adding a partial or total glossectomy to total laryngectomy certainly makes speech rehabilitation more challenging. The SLP must be willing to explore a number of different means of increasing a person's communication effectiveness. Maximizing verbal communication should remain a primary goal and all three alaryngeal communication options should be weighed against the person's remaining abilities and desires.

While the nod may go to TE speech in many cases, the other two options might be viable or preferred in select patients. For all patients with total laryngectomy + glossectomy, training in compensatory strategies to maximize communication (more gestures, facing the listener, etc.) will be critical.
I'd like to respond to the CPR questions recently sent in to the WebWhispers email list. Many years ago, two of my Illinois laryngectomy friends underwent traumatic experiences involving lack of ability and knowledge about CPR. The lack of knowledge also applied to the local fire department staff. Both of my friends are from this area, still around, and can testify to the horrors they went through.

The first one, a lady whose husband had a heart attack shortly after she had undergone a laryngectomy, was unable to communicate at all. She hadn't wanted to use an electrolarynx (and there was no TEP at that time) and was not able to use the telephone (this was before there was such a thing as 911). She had to run to find a neighbor and by the time help came, he was gone. She did learn to use an electrolarynx and still uses it today.

The second one was a laryngectomized man who went shopping with his wife. Upon their return, while he was putting the car in the garage, she had a heart attack. He was unable to help her and by the time the paramedics came, she was gone.

I was involved on the Board of the IAL and this problem sparked a lot of concern, so we investigated the many avenues that could help us. We also heard from one of the Australian club members that, because of AIDS, many of the paramedics in that area were afraid to do "mouth to mouth" or "mouth to stoma" resuscitation, so many people were not attended to and died.

We found a solution in the form of a Pulmanex Ambu Bag, made by Life Design Systems, which could be used by and for everyone, even laryngectomees using a baby mask.

Many of the others who were involved in this endeavor are gone now. One of the goals of this project was to get the clubs to get their local paramedics and fire departments informed about the devices in addition to the members of the clubs so they would know what to do. I have one in my van and one in my home. It's been so many years since I got them, I'd almost forgotten about them.

I would be interested in knowing what was in the kit mentioned in the emails.

Frances Stack, Worth, IL
Celebrating 50 years (September 7th, 2005) as a laryngectomee

(Editor's note)

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Upcoming 2006 Regional Meetings of Interest

(1) Texas Laryngectomee Association (TLA) - Annual Conference
This year held 24-26 February at the Sofitel Hotel in north Houston, Texas, about 5 miles south of Houston Intercontinental Airport. Rooms are $79.00 per night and all food is included in the $75.00 Registration Fee. Featured speakers: Carla Gress, Jesse Hart, Elizabeth Durand, Candy Moltz, and Susan Reeves, etc. Further information and registration materials can be obtained from the TLA's web site: http://www.texastla.com/page3.html

(2) 28th Annual North Dakota Speech Seminar for Laryngectomees
21-22 April, Hilton Garden Inn, Grand Forks, North Dakota; Point of Contact: Fay McPhail, MA, CCC-SLP; Telephone: 701-780-2449; Email: fmcphail@altru.org

(3) Midwest Laryngectomee Conference
28-29 April, St. Joseph's Health Center, Kansas City, MO; Featured Speakers: Eric Blom, Ph.D., Dennis Fuller, Ph.D., Mary Jane Renner, M.S.W., and Shirley
Salmon, Ph.D. For additional information or to participate please Email CW Moreland at: dmoreland4@comcast.net or go to their web site: http://www.nu-voice.org/events.php

(4) Stanford University, Department of Otolaryngology TEP course
28-29 April. Guest faculty includes Dr. Yvonne Edels from Charing Cross Hospital in London, Dr. Frans Hilgers from the Netherlands, Dr. Donna Graville SLP at OHSU, Dr. Mark Singer from UCSF, and Dr. Minnie Graham from SFSU. Local faculty will include Dr. Ed Damrose, Margaret Coffey, Trish Woo Cavanaugh, Mary Ellen Rogers, Dr. Kris Izdebski, and Lillian Shiiba, PA.
Contact: Ann Kearney, Speech Pathologist, Stanford University, Department of Otolaryngology. (650) 736-0469, Email: AKearney@ohns.stanford.edu

Information on the Florida, California, New Jersey, and other related regional meetings will be available later in the year.

BETWEEN FRIENDS

Donna McGary

"That which does not kill us makes us stronger"

Moving On

I may have just turned a corner in this journey; if not actually turned the corner, peeked around far enough to see a wide avenue ahead. I had a moment just the other day when I thought of my voice not as a liability to be overcome but as a distinctive feature of my character - something to be proud of - something to be celebrated. I realized that no stranger who talks with me will soon forget me or my voice. I am unique.

Now I must make one caveat - obviously within our community, I am NOT unique nor even unusual. But within the larger world we are a small minority. And for one brief shining moment, it occurred to me there are advantages to being quite so unusual. People remember me and my voice. People notice me. That is not a small thing. When you reach middle age and you are a woman you start to become invisible. It does not matter how nicely you dress or how smart you look, you start slipping off the radar. I am not going to turn this into a feminist tirade"although I easily could"that isn't my point. It simply happens that we stop being cool and interesting and compelling because society tends to dictate otherwise. But, if you do decide you want to make people sit up and take notice, talk to them in a voice they do not expect nor can they forget. It took just one nice clerk at the grocery store that day to open my eyes. She was helpful, but no more so to me than anyone else, except I saw something in her eyes. It was neither compassion nor pity (something I am accustomed to or so I thought); it was curiosity and admiration. In that singular moment I realized how many times I may have misread both friends and strangers. I always thought that their compliments on my clarity of speech were well-meaning support and encouragement for my clumsy attempts at normalcy. It never occurred to me they might actually be telling the truth! I think back now and realize the times when I cannot make myself understood are infrequent and far outweighed by the times I have no trouble at all. I work with the elderly and with the exception of the very deaf, who quite frankly can't understand most of the staff, I am understood, well-respected and even loved. Some residents have even gone so far as to say that they can hear and understand me better than some of the other staff because I speak more slowly and distinctly. Mumbling is NOT an option with a Servox! Occasionally, a stranger may be taken aback for a moment but recovery is generally swift. And it occurs also to me now that people generally respond well to someone who is making a genuine effort to communicate with them. And I do that - because I have been self-conscious about my voice and my breathing/coughing situation, I look people in the eye and smile. I try to engage them, disarm them, if you will. In today's world, how rare is that! No wonder they respond.

A couple of years ago I was lamenting to someone - actually I was practicing "The 8th Deadly Sin" self-pity, if you
missed THAT column;) - the fact that I hadn't had a date since I got sick. My wise friend is an unrepentant radical liberal therapist who pulls no punches. He promptly e-mailed me back and basically said it was my own d*** fault. My voice, et al, wasn't the "deal breaker" when it came to men- it was my own bad attitude. I had lost my confidence. His novel suggestion was since I had just wrangled some power tools from my son as a Christmas present (don't ask- that was a monumental leap of faith on my son's part), I should prowl the aisles of Home Depot in my new tool belt, preferably in tight jeans, and pose questions to any men who caught my eye! I did NOT take his suggestion. In retrospect - perhaps I should have. I think I would lose the tool belt, but the tight jeans might work! Regardless, his point was well taken. It was my loss of confidence, not my loss of voice, that was the problem.

Today I went shopping with my son and his lovely wife at the very crowded LL Bean Outlet Store nearby. And I was unafraid, even bold to test my theory. It worked. I didn't get a date but that wasn't my purpose today. I just wanted to feel comfortable. I just wanted to be able to talk in a public place without feeling like a freak. I quickly realized that, if my voice attracted attention, as soon as I made eye contact and smiled, any awkwardness either of us felt dissipated as we all hunted for bargains and traded finds. There was one little girl, no more than three, who was watching me with the wide eyed solemnity so characteristic of that age. I knelt down and said "I have a problem with my throat so you can't hear my voice unless I use this [I showed her the Servox]. It kind of makes me sound like a robot, doesn't it?" Her whole face just lit up. Those beautiful eyes sparkled and, as she grinned, she leaned forward and laughed. "Nooool!" she exclaimed. She couldn't take her eyes off me after that and every time I caught her looking at me we smiled conspiratorially.

As I sat down tonight to write I thought of a family get-together this past Christmas when I used my Servox on maximum loud held up high as a buzzer to get everyone's attention. They all got a kick out of my ingenuity. I have been looking at this all wrong. I am not a freak. I am a survivor with a unique voice and a distinct perspective. I have found that which was lost and it is so much more precious because of the struggle. If I can charm store clerks, old men and little girls, can handsome middle-age men with youthful attitudes be far behind? I have to go now - I may dig out that tool belt after all!
I'll keep you posted.

REPORTS FROM ROBOCOP'S REPOSITORY
Or
News You Can Use ... by Officer Scott Bachman

Laryngectomees and Encounters with Law Enforcement Officers

Some time ago in a WebWhispers e-mail discussion I provided observations, personal and professional in nature, relating to contact with a Law Enforcement Officer (LEO). Were we not laryngectomees, or perhaps if I was not a police officer, these tips still should be considered. I realize many have opinions as to what they need do or say whenever there is contact with LEO and much of that may be from past experience or legal advice. What I offer is purely about safety, yours and mine both.

Motor vehicle stops are for the most part where many experiences occur with a LEO. Whether your definition of such activity is traffic/speed enforcement or traffic/speed "traps", either way when you are stopped there are things to consider, especially as a laryngectomee. When it comes to safety, be it Officer Safety or your own, a LEO has many things to consider as he pulls your vehicle over and approaches it.

The following are some Dos and Don'ts. They should help a laryngectomee consider how his/her actions are perceived in any contact with a LEO.

* Pull over as soon as safely possible when a LEO activates emergency equipment. Sudden stops or not pulling off the roadway sufficiently may create an unsafe situation. There have been many a news brief about those who impersonate LEO and how does a citizen treat that knowledge? If you have any doubt at all as to the validity of the LEO pulling you over there are several options which may assist you. Begin by slowing down, putting on your vehicle's hazard warning lights, maybe even waving your hand as you do so while looking for a well lit area. A legitimate LEO will at least realize that he has your attention. If you still have concerns use a cell phone and call 911 and identify where you are being stopped and by whom if known. Police dispatchers will either identify the unit stopping you or send another if there is doubt.
* During a legitimate traffic stop it is important that you make no sudden movements during the course of same. Despite all the suggestions one can make about time of day, type of vehicle, race, age, gender or any other descriptors, it is all about perceptions and what actions or activity a LEO perceives. Furtive movement is the LEO term for any suspicious or sudden movement which could escalate your encounter. It is best to simply to wait for the LEO to approach your vehicle, make a visual assessment and verbal contact before doing anything. My professional and personal favorite is to keep both hands on the steering wheel until that contact is made. Now, as laryngectomees the next step or two may present more issues. Certainly as good citizens and desiring a “break” from the LEO we want to do everything quickly and with purpose. NOT! Our first priority, as laryngectomees, is to communicate with the LEO, which could pose a problem for those using an electro-larynx or those not having any type of vocalization. Even those of us with TEP vocalization may need to use one hand if we are not using hands free options at the time. It is natural for us to use our hands to vocalize in most cases. This is where that “sudden movement” or worse, reaching for a black or silver metal object, our electro-larynx, can have grave consequences which need not be detailed here. Think about what you are reaching for regardless of what time of day it is. It doesn’t matter at that moment that you may have innumerably many grandchildren and hold the position of Elder or Deacon at your church! Yes, it can be that serious. Of course, if an electro-larynx is already around your neck and the LEO notices your neck is physiologically different than his own, things may get better. There are a variety of pocket cards and window decals provided by the IAL and the ACS which identify us as laryngectomees. That is a start. If one does not have any type of independent vocalization or does not have someone else in their vehicle an IAL wallet card or ready made laminated note indicating that you are a laryngectomee and/or cannot speak is real important. This card should be readily accessible or already visible to the LEO without necessarily having to go into a pocket, wallet/purse or glove box. Once that information is presented, the LEO should fully understand what he needs to do to further facilitate this contact and assist you as well (understanding that you need to write a response or have him try to read your lips). Those utilizing TEP or electrolaryngeal vocalization still need to ensure that their communications are clear and understood when answering questions. That may be difficult if there is a great deal of background noise such as other motor vehicles.

* Please remember that no matter what you believe relative to operating your motor vehicle a traffic stop is not the appropriate forum to debate it. The side of the road is not the place to hold court nor is it Traffic Court. I know that laryngectomees can be as vocally passionate as anyone else. I have had complaints suggesting “Officer Bachman yelled at me”. Well, that may be true and what’s the point? I digress. If you are “unlucky” and receive a citation you are still not guilty until proven otherwise. I would offer however that most speed violations that are RADAR, VASCAR or LIDAR initiated are rarely determined to be not guilty. I know few people who always drive the speed limit and if they do everyone else is passing them. Without getting into technical or legal details when LIDAR (Laser) enforcement, is utilized your vehicle may be “lit up” more than a mile away. If the LEO can put that little red light on your vehicle, it is over and long before you even know it! A question always posed is, “If I know I am guilty why should I go to court?”* BENEVOLENCE! Without knowing court procedures in the 50 states and Puerto Rico, most judges realize and understand that many defendants are good drivers and “outstanding” members of the community. Their desire is to keep your good driving intact as much as you do. After all, the LEO is only doing his job, right?

* Avoiding, or at least reducing your chances of being stopped for a speed violation is all about being aware of your environment as it relates to the posted speed limit and knowing, not simply guessing, what speed you are traveling.

* Although the previous recommendations have dealt exclusively with laryngectomees operating a motor vehicle, the same caveats should apply when encountering a LEO in person, especially during exigent circumstances. I cannot impress enough the concern regarding sudden movement(s) and specifically removing an electro-larynx from a pocket and/or having it in hand under reduced light or non-existent light conditions.

Once again I wish to offer these observations in general terms. They are not meant to offend or scare anyone nor suggest that every encounter with a LEO will be the same. Nothing is 100% these days so when you see the emergency lights of a police vehicle behind your own:

1. Don’t panic. Acknowledge you are aware of the LEO’s intentions by safely slowing down, using hazard lights or a turn signal as you find a location to move your vehicle to. Be aware that other vehicles may be doing the same thing when they see the emergency lights so consider that as well.
2. Be patient. Sit and wait. A LEO may not approach your car immediately. Keeping both hands on the steering wheel in an obvious non-threatening position is a plus.
3. Having the IAL or ACS orange card on display would indicate you have difficulty speaking.
4. Keep a pad and pencil available (always good to have). Use after permission is given.
5. If your electro-larynx is hanging around your neck, leave it there. Again, use after permission is given.
6. Practice in advance and find a couple of words that are easy to understand either by lip reading or hearing only the consonants that make sounds without an air supply... “Can’t Speak” ...can almost be heard without the vowels pronounced at all. Try it. Make the C sound as clearly as you can and add a distinct T sound at the end. Then make the S (hiss) and the P (pop) followed by the K sound. If any dialogue is difficult, point to your mouth, neck or stoma while shaking your head indicating “no”. If the LEO understands that much you most likely will not surprise him when using your finger or thumb to
occlude or the electro-larynx that is around your neck. With permission of course!

Happy Motoring!

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**Dutch's Bits, Buts, & Bytes**

(1) Printing Web Pages

**QUESTION:** When printing Web pages, the right-most inch or so of the screen content is frequently cut off when I print the page. I have tried closing out my Favorites bar or other menu type items that appear on the left side of the screen in order to be able to print the right edge, but this doesn't help. Got any suggestions?

**ANSWER:** Web pages are usually not designed with printing in mind. They don't adhere to standard margins and page sizes and, as a result, can often be difficult to print. This is the primary reason some sites offer a printer-friendly link for content that you may need to have a hard copy of.

If you want to see how a Web page will look when printed, just choose Print Preview under the File menu. One solution is to copy and paste the information from the site into a text editor like MSWord. Then you can format the page as you like and print it. Another approach is to change the printer settings so the page prints in landscape mode, or horizontally. In most cases, this will allow the full width of a Web page to print.

(2) Prior Planning Paid Off!

Last month's newsletter repeated my short article about taking care of one's "911 needs." Well, on Friday afternoon, 20 January, after experiencing weakness, dizziness, and almost passing out three times (but no chest pains or shortness of breath), I called the local EMT's and was transported to my local hospital. The EMT experience worked like a charm ... they showed up armed with the information I had previously provided them and all went smoothly and seamlessly. At the hospital, although no heart attack or similar activity was confirmed, they did assess possible abnormally low blood pressure and near syncope (loss of consciousness resulting from insufficient blood flow to the brain), and a "possible blood enzyme problem". They also suspected dehydration as a possible cause. After 48 hours of tests and observation, they discharged me on Sunday, 22 January around 4:00 PM and told me to stop taking the Altace (5 mg) that had been prescribed me earlier (to control hypertension). So, the "cardiac scare" aside, my prior coordination with my local 911 office paid great dividends in this case. They arrived at my home fully aware of what kind of "patient" awaited them. For those of you who have not done so, you might consider contacting YOUR local EMT/911 office in a similar manner. You never know when it might come in VERY handy!

( Please wish me luck when I check in for my "fistula repair surgery" on January 31st. This new fistula, located about 1 1/4" inch above the top of my stoma, developed suddenly last week - about 12 years AFTER my laryngectomy and about 13 years AFTER my pre-laryngectomy radiation treatments (6,000 Gy.). It is times like these when one thanks God for granting one a good sense of humor - the FUN never ends! )

(3) Food For Thought

My Dad was well known amongst his family, friends and associates for being able capture the "essence" of individuals he met in short, pithy, and often witty comments. One of my favorites was the following assessment of some folks' normal outlook on life: "They are great athletes ... they can throw a wet blanket 200 yards in any direction."

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Webmaster's Question of the Month

"I will be gone for a month and don't want to get WW Email while I am gone. What can I do?"

Easy!! You can do this YOURSELF. Just before you leave simply send a BLANK Email from the address you use for WW purposes to: webwhispers-vacation@mail-list.com. This will suspend WW mail delivery to your address. When you get back, simply send another BLANK Email from the address you use for WW purposes to the same address: webwhispers-vacation@mail-list.com. This will immediately put you back on distribution for WW mail.

ListServ "Flame Warriors"

Terms of Importance

flame
1. n. A hostile, often unprovoked, message directed at a participant of an internet discussion forum. The content of the message typically disparages the intelligence, sanity, behavior, knowledge, character, or ancestry of the recipient.
2. v. The act of sending a hostile message on the internet.

flame warrior
1. n. One who actively flames, or willingly participates in a flame war ... (Another Example Below) ...

ISSUES

Issues has an issue and she won't rest until it becomes your issue, too. Even when she's not talking about her issue, it's clear she would rather be talking about her issue. Something of a secular evangelist, her religion, her raison d'etre, her abiding passion is....well, her issue. Not exclusive to any ideological orientation, her issue could be the environment, abortion rights, raw foods, breast feeding, whatever. Her obsession, however, provides the key to defeating her in battle; she can't tolerate indifference, so if her thrusts are simply ignored she will rage, accuse, condemn, plead and finally, GO AWAY.
Welcome To Our New Members:
I would like to welcome all new laryngectomees, caregivers and professionals to WebWhispers! There is much information to be gained from the site and from suggestions submitted by our members on the Email lists. If you have any questions or constructive criticism please contact Pat or Dutch at Editor@WebWhispers.org.

Take care and stay well!
Murray Allan, WW President

We welcome the 31 new members who joined us during January 2006:

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<thead>
<tr>
<th>Name</th>
<th>City, State</th>
<th>Occupation</th>
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<tbody>
<tr>
<td>Linda Ayers</td>
<td>Plano, TX</td>
<td>Tracheal Stenosis</td>
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<tr>
<td>Tricia Baker</td>
<td>Channahon, IL</td>
<td>Caregiver</td>
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<td>John Christel</td>
<td>Cedarwood, NJ</td>
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<td>Cheri Gilbert</td>
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<td>Calvin Hash</td>
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<td>Ken Lawlis</td>
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<td>Julia Maclean</td>
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<td>Joyelle Rayan</td>
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<td>Donna Rosen</td>
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<td>Dave Suding</td>
<td>Ventura, CA</td>
<td>Vendor - TechneMed</td>
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<td>R. Robert Bailey</td>
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<td>Christine Gardner</td>
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<td>C.W. Manios</td>
<td>Macedon, Victoria, Australia</td>
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<td>Rick Riehl</td>
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<td>Peter Searls</td>
<td>William Whittle</td>
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<tr>
<td>Karen Ulmer</td>
<td>Baltimore, MD</td>
<td>Otolaryngology Nurse Specialist</td>
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<td>Bobby Westmoreland</td>
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<td>Cliff Baker</td>
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<td>Hillary Beck</td>
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<td>Amy Harms</td>
<td>Brandywine, MD</td>
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<td>Larry &amp; Joanne Hopkins</td>
<td>Plainwell, MI</td>
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<td>William MacDonald</td>
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WebWhispers is an Internet-based laryngectomee support group. It is a member of the International Association of Laryngectomees. The current officers are:
Murray Allan-----------------------------President
Pat Sanders---------------------VP - Web Information
Terry Duga------------------------VP - Finance and Admin.
Libby Fitzgerald.....VP - Member Services
Dutch Helms..........VP - Internet Services
Herb Simon.........Member, Board of Directors

WebWhispers welcomes all those diagnosed with cancer of the larynx or who have lost their voices for other reasons, their caregivers, friends and medical personnel. For complete information on membership or for questions about this publication, contact Dutch Helms at: webmaster@webwhispers.org

Disclaimers:
The information offered via the WebWhispers Nu-Voice Club and in http://www.webwhispers.org is not intended as a substitute for professional medical help or advice but is to be used only as an aid in understanding current medical knowledge. A physician should always be consulted for any health problem or medical condition.

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As a charitable organization, as described in IRS § 501(c)(3), the WebWhispers Nu-Voice Club is eligible to receive tax-deductible contributions in accordance with IRS § 170.

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