



# WebWhispers

Sharing Support Worldwide



## Whispers on the Web

A Monthly OnLine Newsletter for WebWhispers



September 2008

Name Of Column	Author	Title	Article Type
News Views	Pat Sanders	Casey Cooper Award-Mike Rosenkranz	News & Events
VP	Lisa M. Proper	A Complete Examination	Education-Med
Between Friends	Donna McGary	Quests, Kings, Rings & Dreams	Experiences
Practically Speaking	Elizabeth Finchem	What's Your Story	Experiences
A Scottish Accent	Rosalie Macrae	The Tail Of The Snail	Experiences
My Neck Of The Woods	Paul From Alabama	Aunt Bella	Experiences
Travel With Larys	Terry Duga	IAL 2008	Experiences
New Members	Michael Csapo	Welcome	News & Events



2008 Casey Cooper Award Winner  
Mike Rosenkranz

Mike Rosenkranz had his surgery in January 1999, found and joined WebWhispers in October of that year.

He has quietly volunteered or accepted work on various assignments through these years. His answers were filled with humor and he has always had a way of making sense out of nonsense and smoothing out some rough roads!

Examples of the way Mike handles being a "lary"

"We all nose our nose is our best friend. It'll run for us till it drops. I nose the right way to call someone is the way that someone wants to be called. I will spell lary with an "r" or, if someone wants to use "rr", I nose I will still understand that it is a reference to our being a member of the "hole in the neck" gang. And if someone wants to use "rrr" that's okay with me, too, but I must tell you it would look noseitably redundant."

"I don't have a handicap. I just have a hole of distinction. And to clarify your statement about our being nuts, you do not, I repeat, do not have to be nuts to be a member in good standing. But this is in reference to a nutty sense of humor. So, everyone, take a deep breath, lighten up, and stay that way. We only come this way once. Might as well enjoy it.

Sheldon Mitchell Rosenkranz

The nut with the hole of distinction"

"When I went in for surgery, and I was lying on the table, with a filter over my stoma and my Servox in my hand (which I had demanded I be allowed to take to the OR with me), a nurse attempted to put the oxygen hose in my nose. When I used the Servox to tell her it wouldn't do me much good there because I breathed through my stoma, a completely

baffled look came over her face and she went to get a supervisor to tell her where to put it. I felt like telling her where she could put it but I was too much of a gentleman to do so."

"A few months later, we had the FLA Spring Fling, my daughter, Susan, wrote a skit which included the following lines:

THERE'S THE NURSES WHO GIVE OXYGEN

WE'VE MET A FEW OF THOSE

NO MATTER WHAT YOU SAY TO THEM

THEY SHOVE IT UP YOUR NOSE"

In, March 2001, when we had our first WebWhispers cruise, Mike accepted the back-up moderator position for whenever Dutch and Pat were not available.

"Dear Dutch, Just got home, checked my schedule, and the only two things I have scheduled that week are my New Voice Club meeting and a 9 a.m. doctor's appointment on the 24th with a doctor who is always prompt. Per your instructions, I pondered, but there wasn't too much to ponder about. I'll be happy to fill in for you and Pat. Enjoy your cruise".

Mike

When given instructions that first time he filled in as moderator, he responded:

"Pat. You had already touched on that a few weeks ago, when you mentioned no one knew you were moderating until in one instance, you signed your name. So I guess what I will do is what you did, when in doubt, I'll sign your name. (lol) Mike"

This has gone on through the years every time he was asked to be on a committee or to take another job with us, such as managing and keeping control of our WW Forum with its member list, bulletin board, and chat room, which he has done now for some years.

Mike's local club appreciates him highly for his contributions there and Mike has been a pleasure to work with at WebWhispers. He has held a steady hand and a humorous thought for us all and is someone our members could emulate. He is a leader by example.

And, he is our 2008 Casey Cooper Award winner.

Well deserved.

*Enjoy,*  
Pat W Sanders  
WebWhispers President

**VoicePoints written by professionals  
Coordinated by Lisa Proper, MS-CCC-SLP, BC-NCD-A, BRS-S**

**([LisaMProper@comcast.net](mailto:LisaMProper@comcast.net))**

**[© 2008 Lisa Proper]**

## **The Essentials of a Complete Examination**

*Lisa Proper, MS CCC SLP; BCNCD-A; BRS-S*

A complete Speech Pathology examination of a laryngectomee patient or any patient for that matter begins with a comprehensive medical history. In an ideal world, we have all the medical records at our finger tips and alert, cooperative patients and families. However, as we know, this is not always the case and many times, complete information is not available or there is reluctance or inability to provide the necessary information. The information gained from a comprehensive history is invaluable and may ultimately be the key to a diagnosis and eventual treatment. However, not only the information gained from this process is valuable, but to us as speech pathologists, the notations and essentially evaluation of the patient that occurs during the interview process may be the best evaluation we will have of the patient's conversational abilities.

When reviewing the neurological literature, Speech Pathologists and Neurologists alike state that 90% of the ultimate outcome or neurological diagnosis depends on the patient's history. In fact, a well renowned neurologist was quoted to say that "Nearly all clinical neurological diagnosis is based on speech - either its content or it manner of expression". That realization and sometimes makes speech pathologists run from the area of differential diagnosis in motor speech disorders. A dear friend said to me that she would no way want such a responsibility. But yet, speech pathologists do have this burden, like it or not. Yes, I realize this is a column on laryngectomee rehabilitation and not neurological speech pathology, however, I have found that using this premise for all patients, is key to ultimately providing the best patient care. Why not use the best and most comprehensive information we have across disciplines?

Additionally, sitting down with a patient and spending some extra time on the history at the beginning of the encounter generally shows the patient that you are interested in them personally and are trying your best to help them. Speech Pathologists are well aware of the pertinent medical information and key facts that are necessary to obtain, therefore, I will not address this area. However, I will remind the professional of some specific questions and areas addressed in the Motor Speech Area, many by Joseph Duffy, Ph.D., in his book Motor Speech Disorders. One of the most important issues is to try to get all the information you can from the patient, not solely from the family or care giver.

Even if the patient is non communicative, always address your questions to the patient by looking and speaking directly to the patient as opposed to the family. Do not allow the family to answer the question if the patient is trying to communicate with you. This is actually easily accomplished if presented in the correct manner. What has personally worked for me is that I allow the family to complete the answer the first time, I thank them for the information and tell them that the information that they can provide is most valuable. However, I then state that it is very important for me to hear what the patient has to say and to hear what they have to say first for many reasons: Some of the questions can only be answered by the patient as they are the only one who can "feel" the problem, the patient's perceptions may be different from their observations, and it is most important for me to

observe how they communicate, try to communicate or experience their lack of attempt to communicate.

When I ask the next question to the patient, and after the patient responds, I then make certain to turn to the family and ask something like "Is there anything you would like to add to this and/or do you observe the same?" This scenario seems to assure the family that their input is indeed important and will be heard and appears to gratify even the most "talkative" family member in a positive manner. Crucial information needed from the patient is a very detailed description of the problem that they are seeking medical attention for and the patient's perception of the problem (if any).

It may be necessary for the Speech Pathologist to engage in multiple questions to obtain a clear understanding of the specific patient and/or family complaints. It is also beneficial to establish a clear onset of the problem and any differences noted in this by the patient and family. One should determine if the problem is stable, if it has continually worsened, improved or even become normal. Complete questioning regarding swallowing and chewing must occur with all laryngectomee evaluations. One should also ascertain if there are any external forces that have an effect on the patient's complaint, i.e. medication or alcohol as well as environmental changes. At this point, if the problem is even remotely suspected to be anything other than laryngectomee related issues, the case history would proceed to include further questioning as we would question patients with motor speech disorders, such as any noted changes in facial appearance; change in facial expression; difficulty controlling one's emotions, etc. By the end of the case history interview, you will have been able to establish the appropriate course of action for the laryngectomee evaluation.

By not completing such a thorough diagnostic interview, you may miss crucial information and therefore, possibly conclude your session by misdiagnosing and mistreating the patient. Something none of us wants to occur.

Unfortunately an in-depth case history interviewing process, although simple and relatively short, does not always occur and speech pathologists are not the only profession who misses this opportunity, physicians do as well. A case in point, and in fact the reason for this article, was a patient, whom I had the privilege of seeing approximately one year ago. A laryngectomee presented to my office for evaluation regarding what was described as a relatively new onset of difficulties with his voice prosthesis. The gentleman had been using a patient changed voice prosthesis for more than fifteen years. Although he cared for his device on his own while in site, his son removed and inserted the device for him.

The only other significant past medical history was that of a CVA approximately 8 years prior which left him with only mild residual weakness in one of his extremities. The patient had a similar problem with his voice prosthesis approximately two years prior to the current problem. The outcome of this deficit was reportedly a "partially closed" esophageal opening, with successful opening of the closure occurring within the MD office. The family was fairly confident that he was having the same difficulty. The only medical history information available was that provided by the patient and family as the patient was relatively new to the local area and they brought no reports from outside sources. However, the patient had reportedly seen two Otolaryngologists and two speech pathologists, some more than one time. The speech pathologists told him there was nothing wrong with the prosthesis while the ENTs recommendations were to see a speech pathologist. I was his 7th medical visit regarding this problem over the past 2-3 months. The complaints were primarily "difficulty with the prosthesis" and that the patient "could no longer be heard" as reported on the medical history sheet.

The patient was initially seen in the Otolaryngology procedure room as this is where prosthesis' were managed. The medical history was taken. Initially, the family provided most of the medical information as the patient would gesture that he could not talk. The patient's own description of the problem was simply "can't talk". During the history interview, the patient did attempt further communication on two occurrences, however, speech intelligibility was poor and his communication trials were not successful. I continued to attempt to engage the patient to provide his own information; however, he was reluctant due to his "difficulties" and his ineffectiveness. Additionally, he declined to communicate any way other than verbally. However, getting the information specifically from the patient is extremely important in all medical case history interviews and this area was continually attempted throughout the actual examination process and therefore was not complete at this interviewing stage.

As I stated earlier the patient made approximately 3 attempts at communication during the interview. One of the phrases was understood, two were not. However, during these communication attempts the patient was noted to have relatively consistent TE voice with easy onset, but with low volume, short utterances and a "breathy" quality.

Manual tension to the anterior neck was attempted during one of these attempts to determine if voicing could be improved in order to assist the interviewing process. This palpitation resulted in either no change or worse vocal quality, by reducing easy onset and increasing patient apparent strain with voicing while the quality remained breathy and low in volume. Articulation was poor, however, the family insisted, that this was due to the voice problem and not a true articulation/speech problem as he had the same symptoms during the previous prosthesis difficulty.

The medical history interview also inquired about swallowing function for which the family denied problems; however, they did state that they believed that the patient may have been taking more time to eat a meal than he once did. The patient agreed that it took him more time to eat but he also believed there were other problems, which I was unable to distinguish due to his poor speech intelligibility. Throughout the interview, the family continued to insist that if I would just take the prosthesis out, I would see the problem. They also continued to remind me that all the other Speech Pathologists removed the prosthesis immediately and they did not understand why I was asking so many questions and not focusing on the prosthesis. I do believe I eventually had to point out to the family that despite previous immediate removal of the prosthesis by other SLPs, the patient was still having the problem and I was determined to find the cause of his current communication abilities and that "all the questions" should help me and help the patient.

After the primary portion of the interview was concluded, the prosthesis was visually and manually inspected. It appeared to be in excellent shape and condition. The size appeared adequate. The tracheal tissue was healthy and appeared well hydrated. The valve opened easily with light touch and voicing onset was always immediate with easy onset. To this clinician, the prosthesis did not appear to be the primary concern, although voicing difficulties were noted, the patient's speech intelligibility deficits were significantly more worrisome, despite the fact of all the reports to the contrary. Therefore, at this time, I moved the patient and family out of the procedure room and into my speech pathology office, without removing the prosthesis. Needless to say, the family was quite annoyed with me; however, the patient was not. (As a side, I did remove the prosthesis once the rest of the examination was completed to assure the patient and family of my findings.)

I proceeded to evaluate this individual with a comprehensive motor speech/swallowing assessment. When I initiated the exam, the patient's family stated that everyone had "looked at his mouth" and apparently had found no concerns. As my comprehensive motor speech/swallowing examination continued, it was reported that the patient had only peripheral exams of the oral mechanism and not such a comprehensive examination as I was performing; the family skepticism appeared to lessen.

As all SLPs know the aim of a motor speech examination is not only to determine weaknesses and deficits but also to provide a diagnosis. An "oral peripheral/mechanism exam" does not nor is it a thorough examination of the mechanism. The oral peripheral exam essentially looks at structure, some range of motion elements and possibly some aspects of strength depending on the examiner. This is far from comprehensive and I wonder why this is even still taught as anything other than a screening procedure. While a complete article on the W's of the Motor Speech Exam is beyond the scope of the article and this web site, a very brief refresher of the basic differences is necessary to remind all those SLPs who don't routinely provide this type of examination. The Motor Speech/Swallowing Exam has three essential components according to Duffy. One is a comprehensive case history which we have briefly touched upon. The other two components of a motor exam are to identify the salient and confirmatory features of the patient's verbal/vocal patterning. Salient features are those characteristics that contribute most directly and influentially to the speech diagnosis. Confirmatory features are those signs OTHER than speech characteristics and salient features which confirm the salient features findings. The salient features that need to be evaluated are that of strength; speed; range; steadiness; tone and accuracy/inaccuracy. EACH of these parameters must be address with each mechanism that focuses on speech and/ or voice. Those components are obvious but many; cheeks, lips, tongue, velopharyngeal mechanism, laryngeal/alaryngeal mechanism, respiration, posture as well as exam of oral-facial reflexes and overall facial appearance. Evaluation of these mechanisms in combination then allows for assessment of articulation; speech accuracy; voicing proficiency, and prosody. Although, not all of the salient features can be evaluated within the office on all components, more than most can. Think about it, 6 features, 7 plus single mechanisms. This is not a short cursory exam of the oral mechanism. Although, this more comprehensive exam does take longer than the cursory peripheral exam, it is surprising that the extra time is minimal, especially for an experienced SLP. And the payoff is tremendous,

allowing accurate and appropriate diagnostic information being achieved by the SLP. What about the inexperienced SLP? Maybe one with less experience is unable to come to a diagnosis, but one should hopefully know there is something not quite right and know that the patient needs additional medical help to assist in the diagnosis and eventual treatment. The help may be a physician or another SLP who is qualified in Motor Speech diagnosis.

So what about the patient that inspired this topic? Despite the apparent TEP voicing difficulties, the patient was able to engage in all aspects of the examination including the speech and voicing portions. Deficits were noted in both salient and confirmatory features consistent with mixed flaccid and spastic dysarthria which are deficits of both the upper and lower motor neuron systems. Truthfully, the actual speech diagnosis of this gentleman was quite challenging in terms of applying speech and laryngeal terms to an alaryngeal mechanism. Although I was confident in my findings, I also stated this fact in my diagnostic impressions. I can envision how an SLP with less experience than I in both laryngectomy and differential diagnosis in motor speech may not be able to establish such an actual diagnosis. However, had just one the SLPs performed this exam, or had one of the ENTs looked just a little further, it would have been evidently clear that this gentleman's problems were not that of a prosthesis failure or problem.

Why did it take 7 visits to five different MDs/SLPs to figure this out? Was the failure with the exam itself with insufficient tests provided? Were the impressions of the exam provided inaccurate, due to the severity of some of the deficits, this conclusion is doubtful. Or was the failure earlier than the exam? Was the failure at the beginning, the first essential component of any exam, the medical history interview? Was family insistence into the problem allowed to control the health providers thought process? Was there a lack of attempts in engaging the patient to allow him to speak for himself? Were assumptions made based on the information provided? Any thorough diagnostician should never assume. The reason for the failure will never be known. What is known is that this failure should have never occurred.

At this time I would like to add a point about the role of assumption in diagnosis. As previously stated, assuming does not have any role in diagnostics. I had the good fortune to learn this early in my training, although I certainly didn't see it as "good fortune" at the time. During my graduate training, there was a professor who had the reputation of asking such questions on her tests that "no one ever knew enough material to earn a 100% grade". When I received a test back, I looked over the test and found my information was all correct, yet I only received a 97%. The professor had taken off 3 points because I used the words "Assuming you mean .....". There was a note to me in the margins that read "never assume". As you can imagine, I was more than a little mad and went to her for an explanation, as I was assured that it was her fault. After all, she was the person who didn't write the question clear enough to be adequately understood for me to be certain that I was answering the correct question! The professor kindly pointed out to me, that I will most undoubtedly have patients who will provide such explanations, and it was my job to clarify the intended meaning by asking more questions. Had I asked the question of her during the test, instead of assuming, I would have received the all illusive perfect score. A good lesson for a young diagnostician to learn, an even better lesson all diagnosticians should heed.

I could end this article here, but if the reader is anything like me, I am sure you want to know the outcome. Therefore, once again, back to the subject of the patient. After completing the exam, and before I provided the results to the patient, the patient grabbed my arm and said with bright eyes and a sigh of relief "Thank you so much". He then stated that he felt as if he had not been able to push with his tongue and wondered if this was a weakness. (Incidentally, I was able to understand him better at this point of the exam due not only to increased familiarity but predominately because I trained him in rate modification intervention during the exam procedure for which he rapidly utilized as he saw the positive results the strategy provided). I then proceeded to explain the findings to the patient and the family indicating the possibility of neurological involvement and the absolute need for evaluation by a neurologist. After this, I also removed the prosthesis, and examined several scenarios with the prosthesis out of the fistula tract to demonstrate that there was no problem with the prosthesis. The patient was grateful as appeared the wife, however, the son appeared skeptical, therefore, I asked one of our ENTs to visit with the patient at which time I briefly demonstrated some of the significant findings, the ENT also recommended to the patient and family that he see a neurologist. The patient was offered an appointment at our clinic and declined. He was then given a list of neurologists in his local area. Approximately 5 weeks later, the patient's wife called me and said the ENT wanted me to see the patient again. I inquired about the neurological exam; the patient had not seen nor made an appointment for a neurologist. I was then extremely frank with the patient's wife about the

EXTREME need for a neurological consultation and that I would not be able to see him for the same problem until he saw a neurologist. Two weeks later, I received a call from the patient's new neurologist. He was most appreciative of my comprehensive exam and report on this patient, and sadly, the patient's medical diagnosis was the one I feared, Amyotrophic lateral sclerosis (ALS) or Lou Gerig's Disease, a fatal progressive neurological disease.

This patient's case demonstrates the absolute need for clinician objectivity and thoroughness. A look outside the box is always necessary when determining a diagnosis. A TEP problem may not be a TEP problem and a clear concise, unassuming case history interview and evaluation are absolute musts in all populations, including laryngectomy. The previous health care providers in this case didn't know the cause of the problem, and even when the determination was made that there was no problem with the prosthesis itself, no one persevered to assist this patient.

Perhaps, the experienced among us need to be the ones to step up and say "call me whenever you're not sure". And the inexperienced among us, don't pretend; know and set your limitations and never ever assume.



## On Quests and Kings, Rings and Dreams

The Lord of the Rings is right at the top of my list of guilty pleasures. I have read the book, in its entirety (it is a misnomer to call it a trilogy...it is one book with three parts) at least four times. I saw the movies in the theaters – and I NEVER go to the movies- have watched them on TV and on DVD- and am, as I write this, watching them once again on TV. If I could find my Tolkien collection in the boxes of books I have yet to unpack, I would be happily anticipating yet another extended visit to Middle Earth.

When the first movie, Fellowship of the Ring, was released in December of 2001, we were all feeling that the world was a much darker and more dangerous place than we had realized. My own personal experiences mirrored that of the larger world; life had been turned upside down and seemed, at times, as if it would never right itself. I was visiting my parents over the holidays and since, at the time, I was frequently tethered to a misting machine, I had plenty of time to re-read LOTR again, in anticipation of going to the movies with my Dad. I wore a pain patch, was on a heavy duty codeine cough medicine and not entirely sure I could even make it through the movie, but

we were going to try. I didn't go out much in those days and this "date" was a big deal. Armed with a bag of paraphernalia, including a baggie with a wet washcloth to breathe through, if necessary, I caught sight of myself in the hall mirror. With my cape, multitudinous scarves and waist length grey hair flying, I looked liked Mrs. Gandalf! I managed to croak, "one ring to rule them all" and we were headed out on our own quest.

It was a success. I managed to keep the coughing at bay with the washcloth and a few judicious swigs from my "flask" of cough medicine. My Dad hadn't read the book in years (we share a love for those sword and sorcery tales) but I was able to refresh his memory regarding the difference between a mountain troll and Balrog, as well as discussing the finer points of the dubious genealogy of the Urak-hai.

By the time I headed out to "Return of the King" with my son and daughter-in-law (the passion for the genre MAY be genetic), I was long off the pain patch, had put the compressor in storage, and kicked my codeine habit cold turkey LOL! That is another story, however. I no longer croaked, I now buzzed. I had cut my hair and was down to just one scarf and a bottle of water. I accidentally leaned into my Servox as we were getting to our seats and it buzzed loud enough to startle the kids in front of us. We all just laughed.

Frodo and Sam's adventure out of the Shire and back again had taken them 11 months, mine three times that. And while eight of the original companions lived to see the return of the king and the coming of the time of men, all were irrevocably changed. As Gandalf said of Frodo's injury by the Nazgul sword "There are some wounds which never heal."

I suspect it is like that for all of us. Our journeys may not have been the epic battle between good and evil that the inhabitants of Middle Earth experienced, but they are our journeys...the ones we have been given to live and to tell about.

"It's like in the great stories, Mr. Frodo, The ones that really mattered. Full of darkness and danger they were and sometimes you didn't want to know the ending because how could the end be happy? How could the world go back to the way it was when so much bad had happened? But in the end, it is only a passing thing, the shadow. Even darkness must pass. A new day will come and when the sun shines, it will shine all the clearer. Those are the stories that stay with you, that meant something, even if you were too small to understand why. But I think, Mr. Frodo, I do understand. I know now. Folks in those stories had plenty of chances to turn back, only they didn't. They kept going, because they were holding on to something.

What are we holding on to, Sam?

That there's some good in this world, Mr. Frodo, and that it's worth fighting for."



## What's Your Story?

You know, it's the one that faithful listeners will recognize as your personal mantra. It's the one that you know by heart and repeat like a thumbnail biography. Certain triggers will set the stage for another "telling" of it. Disappointment, abuse, rage, hurt, loss, all serve as reminders.

Certainly some of the same facts and parts of our story will be repeated in some context as these experiences have become the fabric of our lives.

There was a moment for me in 1984 while attending an Actors Institute Seminar in LA when I was stunned to be stopped by the Presenter with, "Wait...that's your 'story', now tell us who you really are". In that moment alone on stage, I felt like the 5th grader who was called upon by my Math teacher to explain a problem on the blackboard, "without using my hands" as I told her how to solve it. To sum up ourselves in a public statement is not an easy task. The acting coach wanted me to introduce the elephant in the room, my voice, and how that had become a part of me.

In the early 80's during a conversation about laryngectomee rehabilitation and life changes, a well known SLP said to me, "laryngectomees bring their baggage with them". I really hadn't thought about it in just that way. It was a fairly self-explanatory statement. He was right. Whatever we had going on in our lives pre-op is still a part of it. If we had a problem, it will need to be dealt with eventually. I have observed this in persons dealing with addictions, and some married couples who had problems enough to separate, and felt it necessary to try to come together again during the laryngectomy pre & post op stages. The empathy and generosity were there, but the original problems were also still there.

Tea and sympathy is a good book title, but having sat through years of such sessions, I can tell you it can be very frustrating for the willing listener. In the case of my mother-in-law the tea & sympathy sessions included a package of Fig Newton cookies and a pile of wadded up, tear- filled tissues. While my future husband was away in the Army, I would visit his parents and much younger sister, who had polio. The stories always traveled the same route. From her mother's early death to the need for her to work outside the home to support her disabled father and her younger sister. "What a poor Christian she must be" and "how God punished her by giving her only daughter polio" were always stated loud enough for her little daughter to hear. No amount of positive thinking and reasoning could turn that boat around in conversation. No matter how often we would review her list of repeated worries to demonstrate that most of them never did come true. Her most often repeated worry was "what would she do if her husband died before she did? Whatever would she do?" She lived for another fifteen years after his death and she was always well taken care of by her daughter and family.

My point about advice and reasoning is this. It is generally Mars vs. Venus – we women vent, or think out loud to clarify the problem. We need to be heard. We accept suggestions. Men frequently assume we want them (or somebody else) to solve our problem for us. Oftentimes, that is not at all what we want. It is in the telling of the situation that we work out our own solution after considering all options. The listener gets bent out of shape and I can understand why. Because we don't' take their "advice".

It is maddening to repeat the steps one might take toward solution, and all we get back is the same script, word for word, with no evidence of a willingness on their part to make changes. Same recipe and ingredients: same results. Luckily my SLP was well trained to watch for such signals early in my rehabilitation. Rather than try to be my speech therapist, and my counselor as well, she referred me to a trusted psychologist she knew to be a very good family counselor. Our insurance program would pay for such care. So I took the leap of faith with the hope that he could help me sort through the minutia that was troubling me a lot. How kind he was to work with me while I was trying my best to learn how to use my heavy, loud electro-larynx. My neck was healing from three surgeries, terribly swollen and hard as a tabletop. I didn't have any feeling in my neck yet, so I couldn't tell if the head of the electro-larynx was flush with the skin for clearly intelligible sound. I soon learned to tell by the muffled buzzing sound I was making if the head of the electro-larynx was wandering away from my skin with my movement, or if it was caught on my scarf.

Even though I was 42 then, there were many things I had to learn as I developed new problem solving skills. Several important books were recommended, and they did change the way I saw life around me. One could say my "truth" shifted. One of the most important lessons I learned during those sessions came from a statement meant to evaluate what the counselor had learned about me. He said, you "are the most responsible person I ever met". I was taken back by his tone as well as his words. I thought "responsible" was a good thing. I didn't know then how that leads to "enabling", but I learned. Not all at once. In fact I am still working on that problem, but I think I recognize the pattern sooner. .

In the beginning, progress seemed slow but sure. I describe it as being similar to an onion that was peeled back in layers...one problem at a time. I gave my mother back her "stuff" to deal with. No more tears when she called to rattle my chain over the phone. The in-laws had to find a place of their own nearby. Preparing daily meals for 10-12 people was a bit too much for me then. I can recall trying to explain to them that I was in a fight for my life that would take everything I had to win, and I couldn't take care of everyone else at same time. Next I dealt with my oldest son and his fiancée who needed to be told that I was not a hypochondriac, but recovering from laryngectomy surgery, cancer, and radiation. All these years later I cannot imagine standing up for myself like this with my fledgling electro-larynx voice, but I remember the moment with photographic clarity. It was a benchmark for both my personal growth, and total laryngectomee rehabilitation. Step by step I was able to make small changes. Some say I re-invented myself. Same me, it was just time to grow into the person I was always meant to be. There was a sense of "urgency" to get on with the rest of my life and purpose. I just didn't know exactly what it was then, but I could feel I was moving in the right direction. Remember, I had prayed..."I wonder what this adventure is going to be about?" I always end the adventure prayer with, "Thy will be done".

Why am I sharing such personal information this time? Mainly, to encourage those who can identify with what I've covered this month to seek professional guidance. Telling the same sad tale without solution has no ending. Tears help, but they are a short term release. There is no goal, or accountability to mark progress and well being. As with other professionals, you may need to seek a second opinion if you have a problem with the person you are working with. Insurance of all sorts will cover this care. It pays to ask, and not shrug off this assistance by assuming it won't work.

WebWhispers works because we invite you to tell us, "What's Your Story?"

**Elizabeth Finchem**



## The Tale Of The Snail.....

by Rosalie Macrae

It is a well-known bit of homespun philosophy that in all walks of life when one door closes, another one opens. It is a nasty bit of update that nowadays the other opening door is where Security have escorted you off the premises. I would rather think, being an optimistic soul, that you *might* find a key to the creaky gate of a place where the air is purer and nobody stabs you in the back.. When you lose your voice, after the initial shock--- oh goodness yes, it *is* high on the Richter scale of trauma unless you are an insensitive clod--larys can find themselves in situations which border, at times, on the surreal. They just seem to develop when you are larynx-less. You could be chucked out of the church choir but offered the job of turning the pages for the pianist . A nice job for a limelight case. People look at you, bathed in soft candlelight, when they are bored with the song.

Which leads me to a few days back when a young chef on the cusp of fame--he was on local telly, which is a very big deal around these parts, a bit thin on the ground for celebrities---whispered in my ear that he had prepared just the meal for a lary. 'Un grand surpris, madame!'. This chef, Sean, has a twirly moustache of the type not usually sported by a farmer's son from a swamp in the middle of nowhere. But he is half French, his maternal granny coming from Marseilles, and the locals accept his little ways.

It was a special occasion. My favourite grand-daughter has been accepted by a good university to study philosophy and textiles. A slightly Mickey Mouse combination of subjects. Plato and Polystyrene. These were the only courses with places left. Like her grandmother, she is no genius, but full of guile. She will probably present a very good dissertation about Freudian complexes which could arise if you cannot afford to wear pure silk and have to wear synthetics. Whatever. She was awarded a very helpful government grant, and my son is ecstatic. He can see the light at the end of the alimony tunnel. He had arranged a splendid meal for the family at a pub in the fens near Cambridge. The meal would be digested before the bank wrote a cool letter about the overdraft. Unauthorised.

Thoughtfully, he had explained on the phone that his mother had swallowing difficulties with lots of things but was always partial to a nice plate of chicken soup and some ice-cream. He knows that I know my place. Slurping soup at the end of the table so that people don't talk across me, surrounded by a nest of napkins.

Sean had other ideas. Would his mother please test a new recipe for a special porridge which he had learned about at a place called The Fat Duck. The owner/chef is a genius called Heston Blumenthal who has a real laboratory adjoining the kitchen, and works out recipes on a blackboard to get the chemicals right. As one does. So far nobody had volunteered to taste Sean's rendering, snails being the main ingredient. The British are funny

like that. But my son assured him that his mother would tackle anything as long as there was no gristle or fat. He said I had porridge for breakfast, but nothing exotic. Usually with bananas as opposed to gastropod---the posh name of the snail.

My meal was borne in. High Noon on a silver platter. Snail porridge with Joselito ham, and shaved fennel.. Joselito is the truffle equivalent of ham, made from a happy breed of rare, black-footed pigs fed on acorns. Snuffled not slurped. The fennel had been shaved to look like an octopus. Sean said he had not been very successful at sculpting snails.



What do you think of his result then? Everyone put down their steak knives and asparagus shoots and became spectators, as quiet as I usually am of necessity when eating. Yes, I have already used the word slurping, Mavis. Sean said that he had bred the snails specially on their favourite leaves. They were a dainty size, not big like the French escargots. His were subtle. Gently simmered in garlic butter, with a lid on the pan to preserve the livid snail green.

It was indescribably delicious. A culinary heaven. I would get the recipe and freeze bags of it. But as I spooned it down my gullet there was a terrible rush of reality. The laryngectomy operation had left me with normal hunger pangs, but an abnormally small stomach. If overloaded, it rejects without warning and spews out with projectile force. In direct firing line was the other grandmother, a bit aspish at the best of times because I am two weeks younger, sitting across the table in a fetching shade of black, and a creamy pearl choker. The mere thought of green speckles on her decolletee made me gulp. My son froze. Gulps usually spelled disaster. He vaulted the length of the table (poetic license) and dragged, I mean steered me casually, to the loo. This Ladies was called Eve's Place and I got there in time. No loss of face in front of the ould biddy.

Back at the table, the talk had now slithered from snails to caterpillars. Why had they disappeared from cabbages? Something sinister going on, it had been decided. My granddaughter started to look panicky as an uncle remembered taking out his 'top set' when he found one lurking under a lettuce leaf. Her new boyfriend was expressionless, but slightly pink with a hint of green around his youthful gills.

The champagne arrived before the conversation reached slugs, surely the next logical topic on the chat menu. I was going to relate how I laid a trail of salt round the sitting-room floor to discourage a recent invasion of slug thugs after treading on one barefoot. Me, not the slug. They were saved this saga by the arrival of a silver spray of crystallized rose petals placed in front of Georgia, the college girl. Compliments of the chef. Organic roses, of course, from the pub garden and, said Sean to me, "Your snails had that great flavour because they feed on....rose leaves".

No surprises there.... They call it re-cycling.



## Aunt Bella

Have any of you got a legend in your family?....I don't mean a character, although my Aunt Bella was certainly that, but she is legend in these parts.....Everyone it seems I run into here in town that's over the age of 7 has an Aunt Bella story and some of them from people who say they knew Aunt Bella and saw her do some of the crazy things she was famous for even though I know that some of them weren't even born yet by the time Aunt Bella had already died, which was in 1959...She was like that, you just wanted to be able to say you saw her do some of the things she did or that you knew her or God forbid, you saw her driving down the road onetime headed straight for you.....:)

Now she was famous for a vast array of let us say, eccentric behavior, but the thing she most famous for was her driving skills or the lack there of...And included in the word "driving", I include, parking a car, closing a door when you do park it, driving on the wrong side of the road, driving in the middle of the road and one time driving on the sidewalk....Yes Aunt Bella had some funny ideas about all those activities and how to do them.....

Let me tell you just a few Aunt Bella stories off the top of my head.....The one I find the most interesting is the one I've heard from the most people over the years, how she parked her car downtown or anywhere else for that matter....Now Aunt Bella owned a clothing store, The Fair Store, right in the middle of town and she ran it with my grandfather, Isadore....Now my grandfather always opened the store and later on Aunt Bella would show up to work....and when she did she'd park right in front of the store, whether she had a parking place or not and if she did have a parking place available the car wasn't always let us say, parked...let me explain.....OK, you got a corner, on one side of the corner you got a parking place that goes right up the corner and on the other side of the same corner you got another parking place that goes right up the corner itself.....you know right angles....but in my Aunt Bella's mind she saw 3 parking places where the rest of the population of Piedmont saw only 2....She drove around the corner exactly half way and just stopped....Where the two streets and parking places came together at the corner, my Aunt Bella saw an opportunity to park.....So there she left her car and walked into the store ready to work.....

Now other times when there was a parking place, you know a normal one, an actual one, she didn't park in it really, she aimed the front end of the car toward the curb until she hit it and then just got out with that little Pomeranian dog from Hades wrapped in her left arm.....oh, and with the back end of her car sticking out in the middle of the road!!!.....

Now Piedmont had a cracker jack police force back in them days, but bank robberies and shootouts were in short supply so they always had time to come into the store and ask Aunt Bella for her car keys and so they could move her car to a let us say, a less dangerous place.....:)

Now sometimes she closed the door to the car when she 'parked' it and sometimes she didn't, but she had an excuse I guess, well in her mind I reckon she did....You see she had this little Pomeranian dog, and it was the peskiest little beast ever put on this earth but Aunt Bella loved it and wherever Aunt Bella went, well the 'dog was

sure to go'...She drove with that little dog in her left hand, the dog licking Aunt Bella's face the entire time she was behind the wheel and with her other hand she was, I wouldn't characterize it as driving really, more like with her other hand she pointed the car in the general direction she wanted to go....but never the less, she frequently left her car door open.....Grown men that were young men or even kids back then told me of seeing Aunt Bella's car door being open and them walking over and closing it, shaking their heads and grinning at the same time.....:)

Now this leaving the door open had some unintended consequences a couple of times, once a pulpwood truck swung around that corner I was telling you about and took Aunt Bella's car door clean off, which goes to show you how far out into the street she must have been parked in the first place for that big old pulpwood truck swinging around the corner to take her door off!!!

Let me say this, from what I can gather all of the cars that Aunt Bella owned over the years, all had more than one drivers side front door during their colorful and dangerous existence.....:)

Now if some of you think I'm just making this up, let me tell you something, I got photographic proof!!!!.....:) You see a buddy of mine I told you about the other day, Kenny Grissom, Dot Grissom's boy, well he gave me this CD with all these old pictures of downtown Piedmont over the years, from the 30's, 40's, 50's and 60's.....Well one of the pictures shows my Grandaddy's and Aunt Bellla's clothing store, The Fair Store, its been in our family since 1911 and in the same place for 85 years....Now take a look at the picture that goes with this little story, the one up top, imagine my surprise when I see one of Aunt Bella's old cars, this one an Oldsmobile or a Buick I think, parked with its back end half way in the street.....and look at the 3 old men standing on the corner, looking in utter disbelief at the way she parked the car!!!...I rest my case.....:) I can't begin tell you how Kenny and me laughed and laughed when we figured out what the picture was.....

My uncle told me this little story, they were paving a street in town onetime and there was a flagman in the road, well down the street comes Aunt Bella and the flag man has to jump out of the ways to keep from getting run over.....Well Aunt Bella goes wherever she's going and drives back the same way she came and nearly runs over the flag man AGAIN!!!!.....I understand the flagman in question found a new and less dangerous vocation.....:)

A lady friend of mine whose husband was a dentist for years here told me this about Aunt Bella and our little town back in them days....This lady was a young mother back then and in the summer time on her street all the kids played in the front yards or even in the streets, the lady told me that most of the mothers would sit on the front porches or front steps and watch their kids while they played....Now when Aunt Bella was seen coming down the street in her big old Chrysler all the young mothers would run out into the yards and gather up their kids until Aunt Bella passed, just as a precautionary measure.....:)

Now luckily nobody ever got hurt or even got a scratch during all these driving 'incidents', not Aunt Bella and not some innocent bystander, but for the life of me I don't see how....Well except the flagman and he wasn't hurt really, Aunt Bella just scared him to death.....:)

Now I saved the best story for last, the story about the bicycle.....You see Aunt Bella lived on this little side street that only had a few houses on it....Her next door neighbor's little daughter had a bicycle like most little girls do and Aunt Bella ran over it....of course she didn't even know she did it.....And when the next door neighbor who really liked Aunt Bella told her the next day about her running over her daughter's bicycle, Aunt Bella said,"Well she really shouldn't leave it in the drive way" and the next door neighbor said," Aunt Bella, the bicycle wasn't in the driveway, it was in our front yard"!!!!.....That fellow gardeners was my Aunt Bella.....

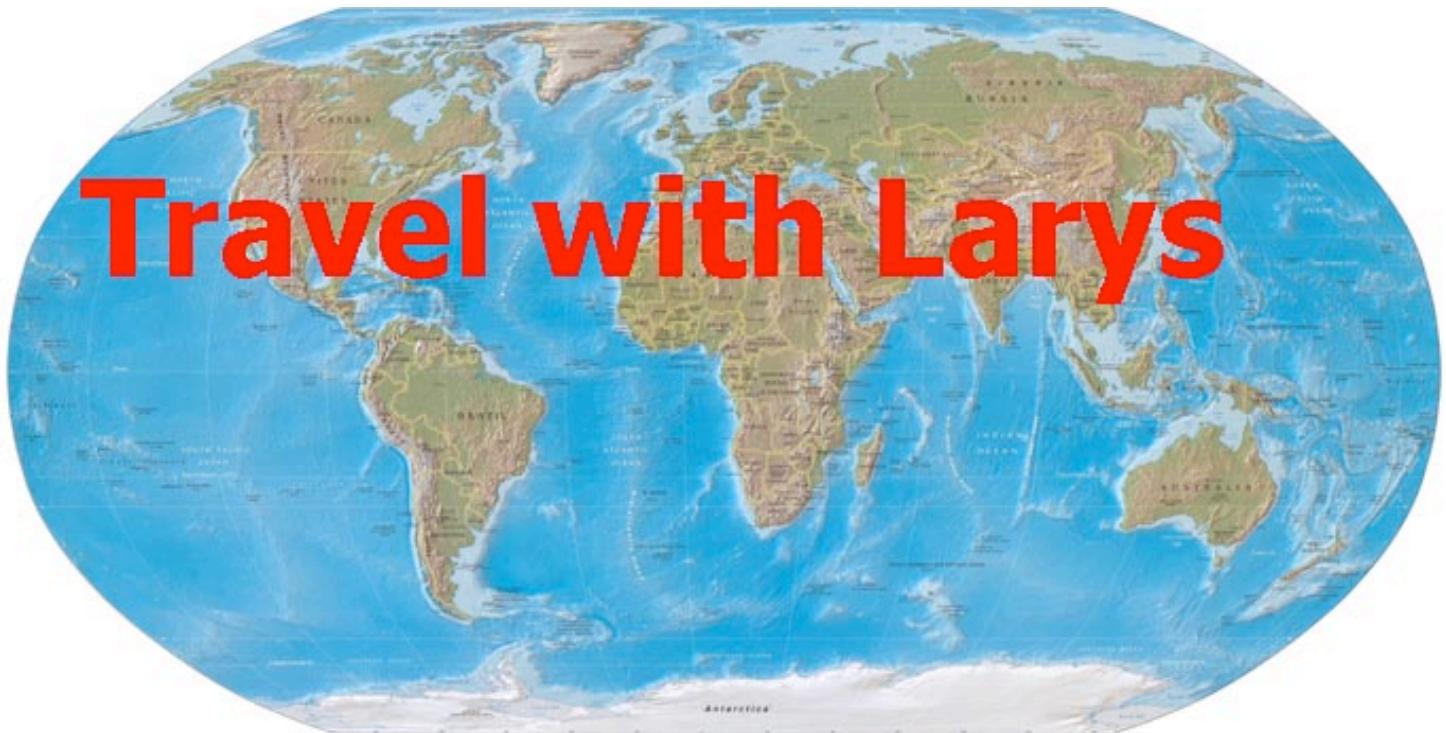
#### Addendum:

Aunt Bella had a sister, Aunt Sophie, she wasn't let us say anymore adept at driving and its related activities than Aunt Bella was.....Well about 1965 some of my buddies and me were driving to this lake where we were going swimming.....We're driving down the road and coming straight for us in the middle of the road is big old Buick, two tone, brown and beige and behind the wheel is this little silver haired old lady.....Now one of my buddies hollers out,"Who in the world is that manic driving in the middle of the road"?

I kinda swallowed hard and said,"Oh that's my Aunt Sophie"...."She doesn't uh, well she, she ah....doesn't drive that well.....:)

Now after everything I've told you, all the stories, all the first hand accounts, even photographic evidence.....there's just one thing that puzzles me and has puzzles me for years, there's no way, I mean NO way my Aunt Bella could have ever passed a drivers test so that leads me to my final thought about my Aunt Bella and her driving....WHO IN GOD'S NAME WAS THE LAW ENFORCEMENT OFFICER WHO GAVE AUNT BELLA A DRIVERS LICENSE IN THE FIRST PLACE?.....:)

*Paul from Alabama  
Monday, June 23, 2008*



## IAL 2008

*Terry Duga*

OK, so I wasn't going to attend the meeting in Little Rock. It was set for Labor Day weekend, flights to Little Rock are expensive and the hotel was costly. Also, I had been to Little Rock on business twenty some years ago, and was not impressed (it has improved since then – a lot).

Then came the invite from Bruce Medical to attend their reception for the Voice Institute at the Clinton Presidential Library (a/k/a "The Double Wide." Now, I am not the one that gave it this moniker. A close personal friend who is a die in the wool democrat called it that. He claims that the locals gave it that name. I don't know if that is true. I do hope it is.) Anyway, Bruce puts on a great reception, so given that and the WW dinner, I took a look a schedules. Southwest had decent, though not super, rates if I flew in Wednesday and back on Friday (the rates soared if I stayed to Sunday). This also allowed me to drive to Ohio on Saturday for my standing trip to visit friends over the

Labor Day weekend.

Driving to the airport, I was struck by how many people are on the Indianapolis roads a little before six in the morning. I got a great parking spot in long term parking, right by the shuttle pick up kiosk. Got to the terminal and the nice lady at the counter took care of my bags. I didn't even need to mess with the e-ticked machine.

I am liking Southwest more and more. The plane was on time. It flew from Indy to Midway Airport in Chicago. There I switched planes (Midway has places to plug in your laptop while waiting for a plane). Then from Midway to St. Louis then to Little Rock (it seems that there are not real direct ways from Indy to Little Rock). My bag was waiting for me as I approached the luggage carousel. I called the hotel and had them send the courtesy van (heck, I am paying their prices, let them provide me with service). A short ride later, and Peabody here I am.

I run into Richard Najarian as I check in and Jahn from Fahl. The mood starts to rise. My room is very nice. Then I descend to the second floor to find my peeps. Pat is at the WW table with Mike Rosenkranz, this year's Casey Cooper Award Winner. They have the table set and ready to go. I register for the IAL and get my tag and goodie bag. I am ready to go.

I greet Caryn Melvin. Things get happier. I start the picture taking process.

I learn that Joanne Fenn is here from Seattle. I am happy. I haven't seen her since the IAL in Anaheim (and drinking into the wee hours with Bwana Jim Lauder). She is looking for a seat in the banquet, but the time has passed for buying seats. Pat sends her to Bwana Jim.

Mary Jane Renner is there waiting for the good people from InHealth to show. We chat. Tina Long comes up and shares a rumor about me that makes me laugh (no I won't share it further, just know that it is absurd).

I am happier that I decided to come for at least a short while.

Pat and I go to the Hotel restaurant for lunch. Burgers. They are good, but their idea of medium and mine differ. Our waiter, however, is outstanding. He earns an extra tip.

At the appointed hour, we gather by the front door. Bruce Medical, again, has blinky rings to be used as a symbol of invitation. A bus/trolley takes us to the Clinton Library. It is of modern architecture, and OK it may not be a double wide per se, but may follow manufactured housing (trust me, there is a difference between the two, but it is sort of technical).

The library is actually very well put together. I have never been to a presidential library, so it is interesting. The reception in one flight below the entrance, but is partially outside. There are tables and a buffet inside, and outside on the patio there are more tables and a very nice bar. I have a drink. After all, I want to be sociable. There are cheeses and fruit outside to snack on. Appetizers are distributed. I am drawn to the bacon wrapped scallops. Mmmmmmmmm, bacon. I know it is not kosher, but bacon does make things better (this is not my original saying, but it is true).

The evening is very pleasant. I get to help Richard Najarian conduct the drawing for door prizes. I think that everyone leaves a winner.

After returning to the hotel, I sit with Joanne Fenn, Bob and Lesley Herbst and Ronald Leclair, the IAL's new webmaster, for a final cocktail. We are all movie buffs and discuss many films.

Thursday morning I rise and go to the opening ceremonies. Dr. Eric Blom (my SLP) gives the key note address. He covers the history of the voice prosthesis, from the first recorded self puncture by an unknown laryngectomee in the '30s to today. He tells how he and Mark Singer developed the Blom-Singer prosthesis and the puncture method. He brings us to today and a new model he is testing that should be more resistant to leakage. He then tells us of a new project he is undertaking to allow people who are on ventilators to speak.

At 11 in the morning, the Peabody Ducks make their parade to the duck fountain in the lobby. Karen Griffin has been selected to be the guest duck mistress. She is bubbling with excitement. At the stroke of 11 she is taken into service. She rides the elevator to the balcony level and the ducks join her in the elevator. They march from the elevator along a red carpet to the fountain. Karen makes a great duck mistress (but she does not threaten them with orange sauce).

Pat and I go exploring for lunch. The young man at the door gives us directions to a local restaurant with home cooking. We head off and find Dave's Home Cooking. It is not fancy, but wow. Pat and I have fried pork chops. Pat has green beans and yams as sides, I have green beans and mac and cheese. I am in heaven. Not fancy, but really, really, really good.

Back at the hotel, I go to my room and play on the Internet for a while and then work on this report (Pat expects it by Friday night when I get home, or Saturday, at worst, so it can be fit into place on Monday, and I know better than to disappoint the "Golden Goddess"). Then back to see people.

I shower and dress for the dinner. I have written the VIP checks (fourteen of them this year) and get my part of the dinner ready. A little after six, it is show time.

People are already outside of the room waiting for the bar to open. I muse that laryngectomees can tend to be an impatient lot. The bar opens at 6:30 (the time printed in the IAL meeting is off by half an hour). The waiters pour wine, distribute beer and give out soft drinks. There is a nice cheese platter for noshing. I take a wine cork for use in my lead up to the toast of Dutch. The room is nice. Libby has made center pieces that feature ducks and cattails in painted Styrofoam. They look quite nice.

Jim Lauder tries to work out the seating of extra people. He has paid for two tables and is the only one with some leeway to accommodate latecomers. The Peabody, inexplicably, is not flexible in allowing us to add diners without a substantial penalty, which we will not pay. (What should you learn from this? Next year plan ahead and heed our reminders to sign up for the banquet early.)

Libby gives a short grace. The food will not be cold!

Dinner starts with a salad of quality greens, cole slaw that has a light dressing and red skinned potato salad, fried chicken, meaty barbecue spare ribs, and sautéed catfish. Hush puppies, rolls and some vegetables fill out the bill. There is also a cobbler for desert. Iced tea and coffee make the rounds.

As the dinner ends, the program begins. Libby reads the names of our members who departed since the last banquet. Bob Herbst rings the bell. The rope detaches from the clapper. Bob gamely continues moving the clapper by hand to not miss a beat.

I then rise. I give some history about how ten years ago WW was an emerging entity which was just starting to have a presence. At the IAL meeting in Indianapolis, we placed a red "WW" on our name tag so we could put faces with names. We held the first, non official, WW dinner there. I was given the task of finding a place. We met

at the Embassy Suites, a block or two from the hotel in which the IAL was meeting. We had a quiet area of the restaurant to sit and talk. There were about 33 of us, and the restaurant gave separate checks (those waiters really treated us right). Of the people there, only Wayne Baker, Elizabeth Finchem and I were the only ones who were at that dinner and this one. Oh, by the way, the Embassy, like the Peabody, had ducks in the lobby. Go figure.

I hold up the wine cork and tell the audience to ask Wayne Baker what it was that he and Jewell Hoffman "invented" during that meeting. I don't know if anyone did ask Wayne, but afterwards, he did remember.

Then I tell how at the end of the dinner, we toasted Dutch, who while not physically with us, was there in spirit. I commented that Dutch was with us in spirit today and was watching over us. He had probably just finished several chocolate deserts, and was certainly enjoying an ice cold glass of Stoli. We toasted his memory.

Then the recognitions began. Mike Rosenkranz was awarded the Casey Cooper Laryngectomee of the Year award. His daughter took pictures as he graciously accepted. It will hold many Werthurs. Jack Henslee was given a special humanitarian award for his work with laryngectomees in Costa Rica.

Recognition is given to Ed Chapman, Gary and Vicki Metz, Tammy Wigginton, and Randy Weinke. InHealth and Bruce Medical are thanked for their support of the banquet. Tom and Dorothy Lennox and Luminaud received a certificate of appreciation for their support of WW. Tom and Dorothy Lennox of Luminaud received a certificate of appreciation for their support of WW. InHealth also is thanked for the continuation of the Dutch Helms Travel Grant. This year, the thousand-dollar grant is split between Roger Silberman and Jean Frank who are both attending the voice institute. Diane Davis is given the "Candle of Hope" recognition for her positive attitude.

I get to give Jan Lewin a certificate of our appreciation for her lecture regarding Dutch at last year's IAL meeting and for her great lectures on the last cruise. She was surprised.

Then came "Final Fun With Bwana Jim." I presented Jim Lauder and Lauder Enterprises, Inc., with a certificate of appreciation for underwriting the Edmund Lauder Support Fund, which allows us to give a \$100 grant to all WW members who attend the voice institute.

Then the dinner ends and people disperse.

I get to sign off to pay the bill. My last official action. Joanne Fenn, Richard Najarian and I have a final night cap in the lobby bar. Then it is off to my room to pack and get ready to fly home on Friday morning.

I find that I am glad that I decided to make an abbreviated trip to the meeting. Getting to see everyone in a relaxed setting has been fun.

As I finish this in the Midway Airport in Chicago, I think of the generosity of our supporters. Thanks to InHealth and Bruce Medical, our members are able to enjoy the meal at a reduced, hopefully affordable cost. We work hard to keep the cost of the banquet down, but prices keep rising. Bruce medical also supplies the pre dinner drinks. This, again, helps keep member's costs down. InHealth, in establishing and continuing the Dutch Helms Travel Grant not only honors Dutch's memory, but also gives some major support to members who wish to attend the meeting, but have financial limitations. Lauder's generosity in funding the Edmund Lauder Support Fund encourages members to attend the VI regardless of their personal financial needs

We are truly blessed.

I think I am looking forward to next year's meeting.



WW Table being readied



Mike and Pat helping out at table



Werthers and spray bottles at WW table



In the lobby



Lorens Gran, Tom Herring and Torbourn



Mike receiving C-C Award



Ducks leaving Peabody pool



Time for a trolley ride



Clinton Library Grounds



## Welcome To Our New Members:

I would like to extend a "Warm Welcome" to our most recently accepted laryngectomees, caregivers, vendors, and professionals who have joined our WebWhispers community within this past month. There is a great wealth of knowledge and information to be accessed and obtained from our website, email lists, and newsletters. If ever there should be questions, concerns or suggestions, please feel free to submit them to us from the "Contacts"

page of our website.

Thanks and best wishes to all,

Michael Csapo

VP Internet Activities  
WebWhispers, Inc.

**We welcome the 42 new members who joined us during August 2008:**

Fred A. Baity  
Acworth, Ga

Wayne Benton  
Mohave Valley, AZ

Roxana Bombillar - (Caregiver)  
Buenos Aires, Argentina

James (Jim) W. Booth  
Zephyrhills, FL

Manuel D. Bustillos Jr - (Caregiver)  
Williamsburg, VA

Stephanie Bustillos - (Caregiver)  
Williamsburg, VA

Joyce Cole  
Mishawaka, IN

Raymond Douglas  
Hampton Bays, NY

Donna Amatulli Favia - (Caregiver)  
Munster, IN

Charles Fritzsche  
Riverside, CA

Nick Guiditta  
Wolcott, CT

Vivian Vanden Hogan -  
(Caregiver)  
Appleton, WI

Steve Jara - (SLP)  
Philadelphia, PA

Roni Jensen - (caregiver)  
Sanger, TX

Robert Jones  
Hazel Green, AL

Hakan Kantar  
Ýstanbul, Kartal, Turkey

Barry Charles Kline  
Philadelphia, PA

Frank Kopacz  
Philadelphia, PA

Arthur Kronsperger  
Bellevue, NE

Cathy Kuhler  
Petaluma, CA

LeRoy Lewis III  
Lake Jackson. TX

Dr.Mani - (Medical Member)  
Chennai, India

Marilyn Massey  
Sherrills Ford, NC

Michael May  
Kingsport, TN

Janelle Miller  
Tripp, SD

Mike Mullery Jr.  
West Chester, PA

Elmer R. Nichols Jr.  
Lakehurst, NJ

Amy M. Pasley - (Vendor)  
West Allis, WI

Janice Reed - (Caregiver)  
Hazel Green, AL

Isabella Margarita Rosnes - (SLP)  
Winston Salem, NC

Wayne A. Rupert

George Sedgwick

Michael D. Smith Sr.

Otisville, NY

Blackburn, UK

North Augusta, SC

Paul Streble Sr.  
Underwood, INMike Swayze  
Bellville, Ontario, CANSteve Walker - (Returning Member)  
Etowah, NCChristine Wallace - (Caregiver)  
Gulf Shores, ALDarrell Wallace  
Gulf Shores, ALMary Wallace - (Caregiver)  
Elberta, ALDave Walsh  
Whittier, CAHeidi Janelle Wenmoth - (SLP)  
Franklin, PACharles L. Winn  
Southlake, TX

**WebWhispers is an Internet based support group. Please check our [home page](#) for information about the WebWhispers group, our email lists, membership, or officers.**

**For newsletter questions, comments or contributions, please write to [editor@webwhispers.org](mailto:editor@webwhispers.org)**

**Managing Editor - Pat Wertz Sanders  
Editor - Donna McGary**

**Disclaimer:**

The information offered via WebWhispers 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. The statements, comments, and/or opinions expressed in the articles in Whispers on the Web are those of the authors only and are not to be construed as those of the WebWhispers management, its general membership, or this newsletter's editorial staff.

**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.**

**© 2008 WebWhispers**

**Reprinting/Copying Instructions can be found on our [WotW/Journal Index](#).**

Copyright © 2008 WebWhispers.org