

# WebWhispers

Sharing Support Worldwide  
Throat Cancer and Laryngectomy Rehabilitation

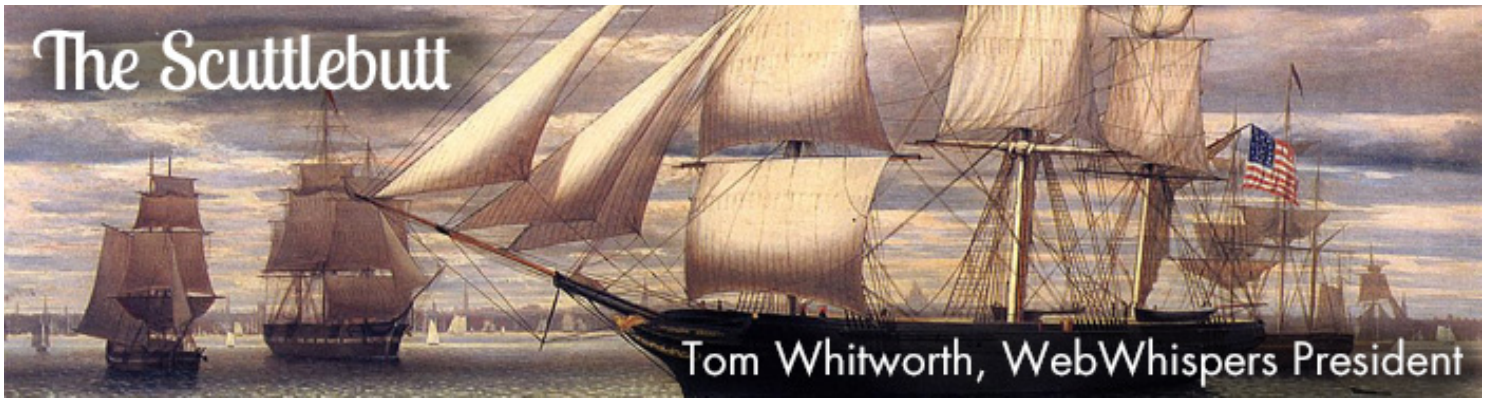


## November 2017

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**FEEDBACK**



## You Can't Do That!

Practice makes perfect. Yeah, right? Well, at least practice makes better, most of the time. You may remember my column last month about getting out of my box, like never before. There was nothing to lose, not really, and everything to gain, including possibly some things I wasn't even looking for. The success at networking really has changed me and my laryngectomy has actually enhanced my ability to do it well. Notice I said "my laryngectomy". I own it and I claim it. It is not who I am but it surely is an integral part of me. I should add that the networking activity appears to be paying off.

As a child, I remember my dad being a true disciplinarian. Hopefully, my mother would handle anything and tell him she had when she informed him about it. I guess that happened a lot, because when I thought she was done, I never heard from Daddy about it. Each of those days were good ones. On a fishing bank or from a boat, he was the sweetest person I will have ever known the day I leave this life. He coached and taught my older brother and me as if he were training us for life, in general. He was! He was not one for advice. Daddy's way was to have you talk to him and make your own decision based mostly on what you alone said out loud to him. I think that is what most therapists have us do. I also think it is effective. In my case with Daddy, he always spoke last after I told him of my decision. He ended those conversations by telling me that I could do anything and that if he wanted me to do something and do it well, all he had to do was to tell me I could not do it.

We are often told "you can't do that" or "you can no longer do it". The ...no longer do it... got on my nerves so badly, I passed that on the roadside on my way to doing things I never felt totally comfortable with in the first place. Does this make me any better than a single one of you? Hell, no! It does not. Yet, I do think I am a better version of me. Join me on this ride. Embrace it and hold on to the handlebars!

***Enjoy, laugh, and learn,***  
***Tom Whitworth***  
***WebWhispers President***



**“Over the many years I have spent on this journey I've heard many people say that their laryngectomy has actually changed their lives for the better, while others may consider it the ultimate tragedy. So, while searching for a question for this month I thought I'd ask; "If they came up with an implanted artificial larynx (no immune suppression drugs required) would you consider that option?" I'm assuming that our long time survivors will respond differently than our newbies but maybe you will surprise me.” Jack Henslee**

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At my age, 81 years young, and being in good health I would try it for no other reason as a test case. Hopefully get the bugs out for the youngsters so they could have more of a normal voice.

**Bob Bauer - Hayward, CA  
Class '08**

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Since it has been over 9.5 years post surgery, and since I have a very good voice with my TruTone Emote EL and since I'm over 74 years old, I don't think I would opt for an implant no matter how good it was. Another surgery on this old neck is something I would not want. Now if I were younger and thinking about going back to work, I would have to give it some consideration.

**Tom Olsavicky - Newport News, VA  
2008 Laryngectomee**

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My name is Lisa O and I'm from Chicago. I had my total laryngectomy August 28 of this year (2017) -- So I cannot speak with ANY authority or experience, whatsoever.

But I do know one thing for sure...this IS a journey. This IS changing my life, daily. I believe change is good and my life gets better daily! It's different. I'm learning some new skills and/or honing the ones I've got. It's all

good. If it's not good, I'm going to ask for guidance to seek out the good. Life is meant to be joyous not just for me but for others as well. Live, Love, Laugh!

That's my story as a new newbie -- and for, now I'm sticking to it.

**Best regards,  
Lisa O'Farrell – Chicago, IL  
Aug, 2017**

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In a heartbeat! I had my operation in March 2016.

**Joe Rook – Holladay, UT**

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Given the choice I would certainly consider the option of an artificial larynx implant. This would allow me to return to a larger range of fly fishing without the issue of the "hole in the throat", which limits me to bank fishing, and I would hopefully be able to sing again. Unfortunately, what's otherwise been done could not be undone such as hypothyroidism and peripheral neuropathy but this would be outweighed by the benefits.

**Dave Hughes, Sun Lakes, Az.  
May 2010**

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Though I don't consider my situation a "tragedy," of course I'd get an artificial larynx if it were possible. I guess some have justified their situation by convincing themselves it's the "best thing that ever happened to them" because they've become better people, got closer to god, learned to live in the moment, whatever. But while it's not the worst thing, there's no reasonable way to consider it the best either. Thanks for asking!

**Andrea Braun - St Louis, MO  
Lary since 7/16**

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In response to the speaking out question, would I consider having an artificial larynx if one could be implanted without the need for anti-rejection drugs. My answer is that I would consider the implant. There are many factors to consider.

First, would the implant take the place of having a stoma. If the really were no stoma, then I would be more interested. I miss swimming and would enjoy the ability to enjoy water more fully.

I would also consider the quality of voice allowed by the implant. Quality and volume are important. I enjoy engaging in theater and miss acting.

Cost, of course is also an issue. But all in all, I would look into it.

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**Terry Duga – Indianapolis, IN  
Class of 1995.**

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Yes definitely, been following the progress of Implants and a long way to go, but they will get there in the end.

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**Fred Simpson – Boston, UK**

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I would do it immediately. Class of 2005 and use the TEP rather well.

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**Jerry Shoul - Joppa, MD  
2005**

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My thought.

Some people get a laryngectomy because their epiglottis is not functioning well enough to keep food and drink away from the lungs.

If the ENT can't fix that. How would a new Larynx be installed without the epiglottis.  
I think it would be a very risky operation for most older folks as well as the younger ones.

I would choose not to have it. I'd rather have little lips around my stoma that could open and close, so I could go swimming safely underwater. and I could close those little lips to talk thru my TEP ... No occlusion.

Just my thought

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**Bob Megrey - Brunswick, Ohio  
8/2011**

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I have just turned the corner on 5 years as a laryngectomy patient. I have used a TEP for 4.5 years and have had very few problems. The biggest mishap was being given a valve of the wrong width (correct length) and I never noticed this. I walked around for 3 months with a leaking valve and never really noticed, I noticed when I developed a very bad chest infection which led to other things that basically took months to heal. I change my own valve, have no problems with Candide, the valve lasts about 6-8 months and I have two valves that I revolve.

By and large I find the situation very manageable and being comfortable I would not change the status quo. Later on when older it might get difficult to manage the changing of the valves so perhaps then an implanted voice valve could be useful. But as my surgeon says "if it works, don't change anything".

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**Serge Droogmans – Newcastle, UK  
2012**

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In a heartbeat I would go for the transplant.... I miss my voice, it has been well over 8 years since I lost it, but, I want to be able to laugh again, to smell like I used to, and to speak normally, like a real person... that would be the best thing... I can only imagine it..

**Lynn Foti - Akron, Ohio**  
**May 2009**

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What qualifies one to be a long time survive or? When I was first diagnosed with stage 4 cancer I thought was a death notice. Now that I'm still on the sunny side of the grass I consider myself a long time survivor. I wouldn't hesitate five seconds to get in line for an artificial larynx implant.

**Johnnie Dontos - Woodway , WA**  
**11/15**

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Wow, that is a fantastic question! I'm sure the answers will vary with how long one has been a Laryngectomy. And how many problems we had going through with this whole new life style!  
As for me, I'm coming up on my 16th year, I'm used to my prosthesis and I use a finger to speak. Would I go with a new Larynx? NO! I'm fine with how I am right now. I think that it comes down to vanity. I'm fine with my neck and my voice.  
It is great to be an old Laryngectomy!

**John Haedtler - New Mexico, USA**  
**2001**

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I don't think I would opt for the artificial larynx. And my reason is I have metastatic laryngeal cancer now, so my lifetime is limited. Also it would be another major surgery, which at age 62, could be too much. I have managed to get along in life, and I use an EL. I presently work full time, I have some problems with people understanding me, but I get by. And as my ex-girlfriend once said, "You didn't talk that much before your surgery, so it's not that much different after your surgery".

**Scott Sysum - Concord, CA**  
**Lary Aug 2008**

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**Next Month's Question:**  
**What methods, products or equipment do you use for stoma care?**

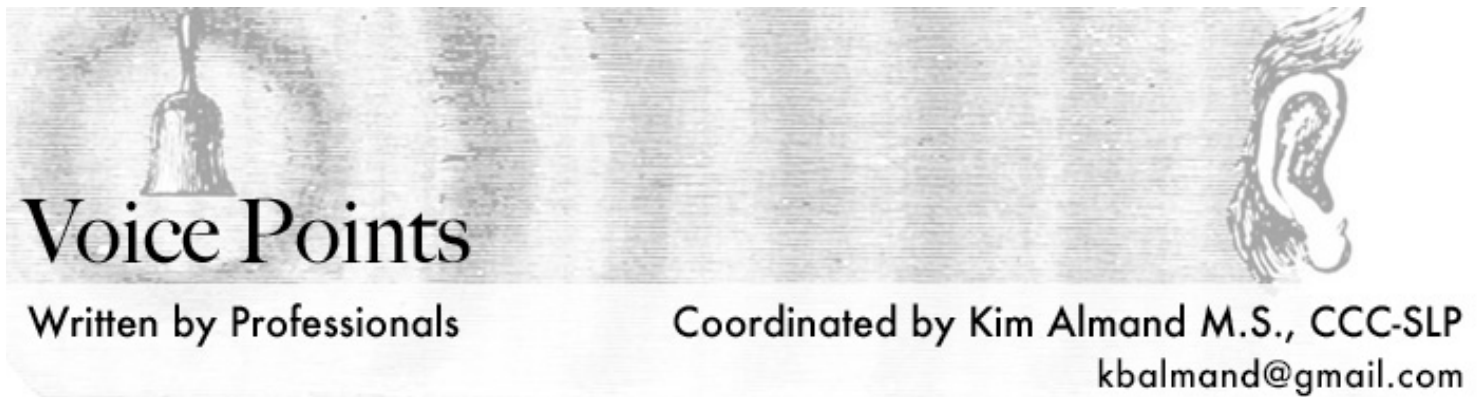
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Thank you for your submissions. Edits are used for length, clarity and to keep comments on subject of the month.

Staff of Speaking Out



Even if you do not have a tracheoesophageal voice prosthesis (TEP), please consider reading the following information as it may be relevant to you and/or someone you know. Ruel and Huber have provided a thorough description of reflux and biofilm, two terms discussed with increasing frequency in the general media and especially in the medical and laryngectomy fields. Due to the large amount of education provided herein, this month's article will be continued in December's Voice Points column. Check back next month for Part 2 and the conclusion of this article, along with some helpful reflux management and prevention strategies.

Wishing all my colleagues, friends and members of WebWhispers a happy Thanksgiving and holiday season! A heartfelt thank you for your ongoing support and contributions to make this column a success.

**Voice Prosthesis Failure: The Impact of Reflux and Biofilm**  
**Part 1 of 2**  
**Brienne Ruel and Kathleen Huber**

Have you ever woken up in the middle of the night with a sour taste in your mouth? Or felt a burning sensation in your chest after a meal, sometimes accompanied by a smelly burp or two? You may be experiencing pharyngeal reflux. Pharyngeal reflux is a result of food contents or acid traveling backwards from the stomach, into the esophagus and into the throat, or the pharynx. Total laryngectomees are known to have a higher incidence of reflux. Reasons for this include resection and reconstruction of anatomical structures, loss of nerve function, changes to esophageal motility or reduction in natural reflux barriers in the tissue, and pressure differences in the esophagus that can contribute to backflow or regurgitation of stomach

acid. Both reflux and biofilm accumulation are hypothesized to play a role in voice prosthesis failure. Biofilm is a term used to describe a slimy layer of bacteria that colonizes along the surface of foreign material within the body, such as a silicone tracheoesophageal voice prosthesis. If you use a tracheoesophageal voice prosthesis as your means for expressive communication, both reflux and/or biofilm may negatively affect your voicing ability and may even reduce the lifespan of your device. In this article, we aim to summarize how reflux and biofilm interact with the tracheoesophageal voice prosthesis and puncture site (TE tract), and offer some suggestions for management.

We know that leakage through and around the voice prosthesis and difficulty voicing are complications of voice prosthesis use. Evidence of reflux and leakage around the voice prosthesis have been noted in the literature. This also correlates with the authors' clinical experience for leakage around (versus leakage through) the prosthesis and tracheoesophageal voice production difficulty, although there are few reports of tracheoesophageal voicing difficulty solely attributed to reflux. Studies looking at reflux in the total laryngectomy population are limited, but those available attribute reflux to possibly enlarging the tracheoesophageal tract as well as to the formation of fistulae, or additional passageways between the trachea and the esophagus (Hutcheson et al. 2012, Kress et al. 2014).

Let's talk anatomy. The cricopharyngeus is a muscle at the top of the esophagus, which relaxes in order to allow food and liquid to pass into the esophagus and the cricopharyngeal segment acts as the vibratory source during tracheoesophageal voice production. One of the leading causes of voice prosthesis failure is at the level of the cricopharyngeal segment, wherein spasms or stenosis (narrowing) can occur, with one potential aggravator cited as being reflux. In a retrospective chart review, Pattani and colleagues (2009) attempted to find a link between reflux and voice prosthesis failure. For their study purposes, Pattani et al. excluded identifiable causes of voice prosthesis failure in their group including cricopharyngeal stenosis/spasm, stomal stenosis, fungal infections, and fistulae. They identified patients based on difficulty voicing and producing intelligible speech with their voice prosthesis. All 22 patients included were treated with aggressive anti-reflux medication (2 doses per day for 2-3 months). Their results indicated that 77% of patients had a positive response to the anti-reflux therapy, as judged by improvement in voicing, ability to produce intelligible speech and elimination of granulation tissue. While they found benefit with pharmaceutical reflux management, they could not ultimately determine if the reflux itself had any impact on the tracheoesophageal tract or voice prosthesis.

Another potential complication with voice prosthesis failure that is loosely associated with the presence of reflux is the development of granulation tissue, or ulcerative tissue. This is concerning as the granulation tissue, depending on location or size, can enlarge the tracheoesophageal tract, occlude the lumen of the prosthesis or cause pain or discomfort of the surrounding tissue.

What if I have leakage around the prosthesis? Degradation of the puncture tract tissue can lead to enlargement of the tract and issues with leakage around the prosthesis or reduced voicing ability. Lorenz (2010) reported an incidence of 48% leakage around the prosthesis, which was much higher than prior findings of 6% to 39% (Op de Coul, et al. 2000, Malik et al. 2007, Hilgers et al. 2008). They identified risk factors for leakage around as hypertension, diabetes, post-operative radiation, trauma during prosthesis replacement and severe reflux.

Does the lifespan of my voice prosthesis change if I have reflux? Yes, it appears so. Boscolo-Rizzo (2008) found that those without reflux had a device life span of 215 days, whereas those with reflux achieved a voice prosthesis lifespan of only 126 days. Lorenz et al. (2010) reported grossly similar findings with more specificity, indicating an average voice prosthesis lifespan of 263 days for those without reflux. For those with reflux without leakage around their device, the average device lifespan was 187 days and for those with reflux and leakage around their prosthesis, the average lifespan was only 48 days. In contradiction, however,



Hancock et al., (2013) reported an average device lifespan of 208 days for the Provox prosthesis. Of those on anti-reflux medication, voice prosthesis lifespan was 193 days whereas those without anti-reflux medication enjoyed a prosthesis lifespan of 206 days. Interestingly, they reported that 86% of their participants were on regular anti-fungal medication, thus they did not control for isolating only *Candida* (yeast) or only reflux as the sole contributor to voice prosthesis failure. They reported the primary reason for failure and replacement was leakage through, followed by difficulty voicing. Comparison of these studies indicates that while reflux seems to have an impact, more investigation is needed.

So why is it that some patients require more frequent TEP changes than others? Elving et al., 2002 compared patients with frequent (less than 4 months of wear) versus infrequent (greater than 9 months of wear) voice prosthesis replacement by analyzing the biofilm composition found along the esophageal aspect of the voice prosthesis post-removal. Their results indicate that not all bacteria are created equal; rather, the presence of specific types of bacteria may play a greater role in the early failure of the silicone voice prosthesis. Specifically, the presence of the bacterial strains *R dentocariosa* and *S aureus* promote adherence and the colonization of yeast, such as *C albicans I* and *C tropicalis*. This relationship in turn forms the dreaded biofilm layer along the esophageal aspect of the voice prosthesis and leads to valve failure, resulting in increased airflow resistance and/or leakage through the prosthesis.

Does the amount of radiation I had matter? Yes. Elving et al., 2002 and Ackerstaff et al., 1999 found remarkable variation across individuals concerning the lifetime of indwelling silicone voice prostheses; so why the heterogeneity? "The causative factors for these extreme differences in prosthesis lifetimes are not entirely known, but it has been suggested that irradiation dose, volume of irradiated salivary gland tissue, residual salivary flow rate, time passed after irradiation or insertion of a prosthesis, surgical or drug therapy, and prosthetic tooth replacement are involved," (Elving et al., 2002; p. 202). Their group also found that patients who had a history of radiation dose of greater than or equal to 60 Gray had consistently shorter device lifespans, and Boscolo-Rizzo et al., 2008 found similar results.

It has been suggested that since the bacterial strains *R dentocariosa* and *S aureus* seem to lay the groundwork for the colonization of yeast, which then ultimately leads to prosthesis valve failure, administration of selected antibiotics or salivary peptides may help to exclude these bacteria from the oral microflora. This reduces the risk for developing the bacterial base that is needed for the yeast to colonize. So, rather than taking an antimycotic (which is used to combat yeast colonization), suppressing the growth of the *R dentocariosa* and *S aureus* bacteria strains on the esophageal aspect of the silicone prosthesis may, in turn, reduce the colonization of the yeast that will ultimately lead to valve failure (Millsap et al., 2001; Palmer et al., 1993; Elving et al., 2002).

Since biofilm has been identified as one of the primary contributors to voice prosthesis failure, what can you do to combat it from colonizing in the first place? Studies have been conducted comparing voice prostheses coated with certain metal mixtures or altered chemical compositions compared to untreated voice prostheses with some promising results. However, often attached to this technology is a hefty price tag, so for our purposes, the focus is on biofilm prevention strategies. Probiotics have been found to combat the growth of yeast, specifically the strains *L. lactis 53* and *S. thermophilus B* (Free et al., 2001), which can be found in such foods as buttermilk, certain cheeses and yogurt. Alternatively, your physician may prescribe you an antifungal medication. However, it is important to follow diligently the directions outlined by your physician, as one of the risks associated with taking prophylactic antifungal medication is developing a resistance to specific strains. Lastly, Perez-Giraldo et al., 1997 found that the supplement N-acetylcysteine reduced the development of biofilm with certain strains of *S. epidermidis*.

*Disclosures: We have no financial relationship with any company that manufactures voice prosthesis or related devices and furthermore the references cited herein were chosen without bias toward any company*

*product mentioned in the included literature.*

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## Abandon ship? If Only!

Would I take an artificial laryngeal implant if there was no risk? Absolutely!

Nowadays I speak with an EL. I get by, but my speech is slow and laborious and sounds harsh, slurred and robotic. I'd love to be able to chat easily again, laugh out loud, talk in hushed tones when someone is sick or upset, say a phrase of endearment without it sounding like a joke, sing or chant at a ceremony, chatter to my neighbour's dogs as I scratch their ears, comment on a film without interrupting everyone in the cinema, guide a meditation session, ask for something in a shop without turning heads all around, offer English lessons at a refugee camp nearby, swim in the sea, help a stranger in distress without giving them the shock of my robotic voice, use my hands as I speak, murmur sweet-nothings to a loved one, say hello while shaking hands ... the list goes on. Yes, I would be first in the queue for a laryngeal implant.

One of the few times I'm grateful for the EL is when I have to speak to a group. I can feel very nervous, and dread this showing in my voice. Ever since laryngectomy I can reassure myself that no matter how much I'm shaking inside, none of that will show – the mechanical drone sounds the same no matter how I feel. It's like wearing a mask. Nobody sees 'the real me'!

I also have to admit that, deep down, I'm a happier and better person for having had a laryngectomy. The benefits have come from learning to accept and live with something I really don't want. That journey stripped away some level of delusion, like the thought: 'I am an OK person because I can speak normally'. I never even knew I was harbouring that thought until I lost my voice and found myself scared to go out in public. Losing my voice isn't really the problem – it's the niggling thought that I'm a lesser person for having lost it.

Luckily that thought rarely appears. Much of the time, I'm just getting on with life as I always did. But now, pondering Jack's Speaking Out question, an unpleasant feeling stirred within, telling me that this 'new me' is not who I want to be. As I write this, a sweep of bitter sensations are being generated in the middle of my spine. They sweep upwards to grip my right shoulder, dig into the back of my neck and seep into my tongue and jaw and cheekbones. The sensations carry the message of sorrow and dejection.

What I've learned to do is to let the sensations and my mood do their own thing. Not to interfere. Not to try to cheer myself up or talk myself out of feeling bad. To trust that, so long as I acknowledge how I'm feeling during the process, I will cheer up naturally when the sensations and moods have run their course. Not only will I cheer up, I'll learn something valuable too and feel better able to live with laryngectomy.

This is the practice of mindfulness, and it's the way I've learned to accept laryngectomy and live with it as happily as I can. Allowing thoughts and emotions come to the surface, do their thing, trusting that I'll be a stronger person for having borne with them.

Just now, as I felt the stinging sensations I felt almost paralysed by grief. It was the sense of having lost some essential part of myself, and that life could never be the same again. I took a few minutes to let all this sink in, let the feelings flow through. Gradually, the mood lightened. I remembered that, contrary to my worst fears, the 'new me' has been treated really well everywhere it went. My friends and family have never hinted that I'm any less of a person now than before laryngectomy.

This kindness isn't to be taken for granted. Only a few generations ago, disability was something to be feared, and disabled people were often hidden away, shunned. Many probably died of neglect. I know this from the story of my grandmother's brother who had a lame leg and was never allowed to visit because he would 'show her up' among her new neighbours. And nowadays, pregnancies are regularly terminated if the fetus has a physical disability. How many would survive if it was known they had no vocal chords?

Although our humanity has wonderful aspects, we also inherit tribal instincts, and my fears of being 'a lesser person' probably stem from an instinctive terror of being rejected because of being different, not functioning as well as the normal person. Fear and grief are very closely connected. In his wonderful book "A Grief Observed" which recounts the days and weeks following the death of his wife, C.S. Lewis starts by saying "No one told me grief was so like fear". As he works his way through his new fearful world, he comes to terms with his loss and begins to find joy in her memory.

So too, as I acknowledged my grief just now, what emerged was a sincere appreciation for NOT having been rejected or treated badly. I felt a surge of gratitude for the fact that I've been welcomed, cared for and respected as much if not more than before laryngectomy. I felt good about myself too, proud to have such a good family and so many kind friends, to live in a society that accepts people with disability.

Laryngectomy has taught me many invaluable lessons like this. Every time it brings me down a dark tunnel of fear, grief or dejection, I come out the other side a wee bit wiser. I am a happier person, deep down, for

having learned the hard lessons it teaches. So I'm glad I wasn't given an artificial larynx at the start of my journey. But if I could keep the wisdom learned from almost five years as a lary, then I would very happily take an artificial larynx now. When it comes to the choice between the hard lessons from laryngectomy and the joy of easy conversation, I would take the easy way out any day. Life will always find some way to teach us hard lessons!

Yes, I'm sorry to tell you, I would abandon all you wonderful WebWhisperers and jump ship in a jiffy!

But this is all pie in the sky, as there is no artificial larynx in the offing. So Webwhispers will have me on board for as long as this body holds together. I'm glad to have found the good ship WW and have your good company for the voyage. Avast me hearties!



## What's In A Voice?

One of the many benefits of being your editor is getting to read all the comments and columns as they come in. They are always interesting and frequently inspiring. This month was no exception. The Speaking Out question, would you go for a larynx transplant if it were available and didn't require anti-rejection meds seemed pretty straightforward to me at first. Who wouldn't want a "normal voice" again? But as your answers started coming in I realized it was more complicated.

Aside from the obvious issue of the surgical procedure itself which would surely be long and complicated, there was the issue of recovery and the challenges of learning to use this new artificial larynx. If we are staying somewhere within the realm of possibility and not indulging in "magical thinking" learning how to use this new voicebox would be akin to learning to talk all over again, only harder. Maybe closer to the arduous rehabilitation that amputees must go through in order to learn to walk on prostheses but significantly more complicated since we would need to learn, along with our new device, how to talk, swallow and breathe in that smooth choreography that we all took for granted in our old life.

Add to all that the fact that no medical procedure is ever going to have the guarantee of a 100% success rate, one would need to be mightily motivated to even have a chance at having that "normal voice" again.

That got me thinking about what we go through now in order to voice. One option that fewer and fewer

people exercise these days is esophageal speech largely because it takes so much time, patience and lots of practice to achieve success. That is why I included one of Elizabeth Finchem's many excellent tutorials on ES for this month's column "From The Archives". For those who are willing and able to master ES it can provide a natural sounding voice, hands-free and no devices or supplies to pay for and manage. But there is an element of luck- you do have to have the right anatomical requirements and you need to be sufficiently motivated, disciplined and have considerable perseverance. I encourage you all to read Elizabeth's column- she is a tireless champion and teacher of ES.

But back to the artificial larynx and another issue presented itself to me. Given all that we might be willing to go through for this new "normal voice" what would it sound like? Our old voices were unique; the timbre (tone), intensity, pitch, and range all varied from individual to individual depending on our anatomy. That is separate from language, speech dialects & patterns and accents all of which we still retain now regardless of our voicing method (assuming we have one at all. Not everyone uses speech to communicate). But the sound of our voice was determined largely by the vocal cords and our surrounding anatomy. I am simplifying here and I'm sure some of our SLPs are shaking their heads at my layperson's fumbling/bungling of the science of voicing but it's probably close enough for this discussion!

Think of the remarkable advances that have been made in prosthetic limbs. Some of those track and field athletes are truly remarkable and while those legs run and jump like "normal legs", even better some say, they don't look like normal legs. They are beautiful, sculptural masterpieces of technology but their beauty is different from the "original" masterpiece of bones, muscles, sinews and flesh. I suspect our imagined new voices would be just as different and perhaps even just as easily identifiable as not an "original factory/body part".

Even if this new voice technology did sound remarkably human and "normal" it still would not, in all likelihood sound like our old/original voice. A w met new people they would come to identify that new voice as us, since it would be the only voice they had ever heard, just as folks do now; only those who knew us before would know the difference, as would we ourselves.

I wonder if perhaps that really is the crux of the matter. Our human voice is an important part of how we define ourselves; it is what sets us apart from other creatures. Birds sing, wolves howl, people talk. Losing one's voice IS huge. And there are some losses in life which are irreplaceable. Coming to terms with those inevitable losses is a significant part of the human experience. Some of us do it better than others and we each have to make the very personal decision, over and over again, as to what we can change and that which we must accept. I think it is what each of us were grappling with as we pondered this month's Speaking Out question. I am not a religious person but I have an old framed prayer on my wall that came from my Nana's house and it seems particularly relevant.

*Dear God, give us strength to accept with serenity the things that cannot be changed. Give us courage to change the things that can and should be changed. And give us wisdom to distinguish one from the other.*

*~Reinhold Niebuhr, 1892-1971,*

*2nd generation American*

*Taught Applied Christianity at Union Theological Seminary, NYC*

# Bits, Bytes and No Butts!



**Frank Klett**

## **New Threats, Chromebooks**

Since Microsoft debuted Windows 10 there has been a rather unexpected increase in the adaptation of competitive operating systems. Consumers have been buying up Google's Chromebooks at a brisk rate...not only for the alternative operating system but the affordability.

Chromebook is a term adapted to define a laptop computer as one that has a Google-developed Linux operating system. While it may resemble your Windows PC it is a different and very inexpensive alternative. The typical Windows PC carries with it a licensing fee charged by Microsoft for the use of its software...this can add from \$100 up to the cost of your new PC. Chromebooks do not have that cost and therefore are less expensive from the outset.

One of the single greatest differences with the Chrome OS is that your interaction with your PC is through the Chrome browser and no other. This may seem somewhat restrictive, however most users quickly adapt to the user-friendly Chrome interface.

One of the cost reductions which has become very popular with all the manufacturers is the use of the cloud for storage as opposed to large hard drives. Consumers have, as a whole, accepted this approach to reducing costs since they have many options open to them if they do want more local storage.

For the typical casual user with the need to check and send email, catch up on the news, update Facebook and shop online they soon find that a Chromebook meets all their needs for a much lower cost than a Windows PC.

Amazon's number one selling laptop for the past two years has been the Chromebook line...with an average cost of \$249.

Chromebooks are currently made by Toshiba, Asus, Acer and HP. As you can imagine this low pricing has led to many folks purchasing the Chromebook for the kids, for a second PC, in place of a tablet, for the family student, and just plain because.

So I turned to our resident expert to express his thoughts and he has done that in a very readable way:



[http://askbobrankin.com/is\\_2015\\_the\\_year\\_you\\_buy\\_a\\_chromebook.html?awt\\_l=9NLwJ&awt\\_m=lfK3ZjfFXuP6SL](http://askbobrankin.com/is_2015_the_year_you_buy_a_chromebook.html?awt_l=9NLwJ&awt_m=lfK3ZjfFXuP6SL)

Another review comes to us from MakeUseof:

<http://www.makeuseof.com/tag/acer-c720-chromebook-review-giveaway/>

Now all the news on the Chromebook is to bring you the even better news. Microsoft has felt the heat from the Chromebooks and from the cheaper tablet market...losing market share mainly because the added cost of its software licensing. To help offset this cost differential Microsoft reached a deal with its hardware partners to reduce their cost of licensing in return for a dedicated product design on their part reducing the overall cost to be equal or better than the Chromebook's. Hence we now have sub \$300 Windows laptops hitting the market and going head to head with them in pricing and in most cases offering a full featured Windows 8.1 product. The consumer can only win in this arrangement, whether they decide to buy the Chromebook or an inexpensive Windows laptop.

HP and Microsoft got together to come up with the Stream. In fact, recouping some of the low-end laptop market is so important to Microsoft, the company worked with HP to price the Stream to undercut the most popular Chromebooks, which are typically \$250 to \$350. The HP Stream 11 runs a full version of Windows 8.1 yet costs only \$200. But wait, there's more: It also comes with a free year of Office 365.

And finally for the video of the month this item gives us a grand tour of a Google data center. I must say that I will never search for an item again without recalling everything it takes to give me my answer. If you have purchased or have considered buying one why not stop in the WW Forum and open a discussion on it. Sharing your thoughts with your fellow larys can go a long way in helping with your personal experiences.

For those that use Internet Explorer you had until January 12, 2016 for either update to IE 11 or find an alternative web browser. As of January 12th Microsoft no longer provide support for Internet Explorers earlier than 11. After this date the issue will not be functionality but of security. Planning now for an update or alternate browser will avoid problems down the road since most websites will not support any IE earlier than IE 11.

For more information read on with Bob Rankin:

[http://askbobrankin.com/internet\\_explorer\\_11\\_or\\_bust.html](http://askbobrankin.com/internet_explorer_11_or_bust.html)

Text Neck is a somewhat new and just recently diagnosed condition caused by...you guessed it, holding one's head in a downward position for a long period of time...no, not caused by smoking! There are actual studies being conducted to help identify and hopefully resolve the issues that are arising from our new technologies. The following article from CNET provides more info. You can even find apps to help you through this pain in the neck!

<http://www.cnet.com/how-to/how-to-avoid-text-neck/>

For those of you who may be wondering what some of the technical jargon means here are some basics for you. Windows 10 refers to the operating system they have designed and built which can tell your hardware how to perform its functions. If you are an Apple or Chromebook user then you have a totally different operating system and none of this applies to you...unless you are considering a change in the near future.

Your access to the INTERNET is through your browser. Your browser may be Internet Explorer, Safari,

Firefox , Chrome, or any one of many various browsers that are available. Your browser along with your operating system allows you to interact with the INTERNET and "browse" the web. The only important thing in choosing an operating system or browser is how well it meets you needs and your comfort level.

You can have multiple browsers installed but you can only have one operating system (for simplicity here I am not going into dual boot systems).

[http://www.davescomputertips.com/learning-computers-browsers/?utm\\_source=wysija&utm\\_medium=email&utm\\_campaign=Weekly+Recap+Newsletter](http://www.davescomputertips.com/learning-computers-browsers/?utm_source=wysija&utm_medium=email&utm_campaign=Weekly+Recap+Newsletter)

For our social media folks here are some thoughts to keep you safe online.

"Social engineering is by far the most common form of malware delivery and the sad truth is, despite untold warnings, people continue to fall for even the simplest of lures to click on that malicious link or open that malicious attachment. Continue reading at:

[http://www.davescomputertips.com/malware-bait-will-we-ever-learn/?utm\\_source=wysija&utm\\_medium=email&utm\\_campaign=Weekly+Recap+Newsletter](http://www.davescomputertips.com/malware-bait-will-we-ever-learn/?utm_source=wysija&utm_medium=email&utm_campaign=Weekly+Recap+Newsletter)

And the latest threat we are being warned of is called KRACK. "The alarming flaw was nicknamed KRACK - short for Key Reinstallation Attack. Basically, this is how it works. An attacker can capture data from a nearby WPA2 protected Wi-Fi network by impersonating it and cloning its MAC address (a MAC address is a Wi-Fi gadget's unique network identifier). Gadgets connecting to the original router can then be forced to connect to the attacker's clone network first. Before the flaw was discovered, WPA2 clients were protected from this switcheroo since unique keys are required to encrypt each block of data. Simply put, the keys from the real and the fake network won't match, making the switch impossible." Courtesy of Kim Komando.

KRACK is a very technical subject and mainly related to the bad guys' ability to access your data via your modem. To learn more about it and how to defend yourself from it follow this link:

<https://www.komando.com/tips/425117/how-to-prevent-a-krack-attack-on-your-wi-fi>

Mike R. reminds us that all WebWhispers members are invited to join the WebWhispers Facebook Group, our home on Facebook. We are a warm, caring support group of larys, caregivers and SLPs who help you adjust to life after laryngectomy. To join our Facebook Group, send a friend request to one of our admins, plus a PM on Facebook Messenger telling us you are a WebWhispers member. Our admins are Anne Rinaldi Ammenti, John Isler, William Cross at william.cross.752 and Shmuel Mitchell.

Mike R, VP Website Information, WebWhispers, Inc. (Shmuel Mitchell on Facebook)

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*[Editor's Note] Elizabeth Finchem wrote "Practically Speaking" for several years, often sharing her expert advice and training tips for esophageal speech. If you scroll down through the index linked here: <http://www.webwhispers.org/news/WotWIndex.asp> and start back in 2006 you will see her columns listed if you would like more information on ES as well as another of her interests- assuring larys that they could still enjoy being in and on the water safely. She is a wealth of information on living the lary life to the fullest.*



## More on Esophageal Speech

Practically speaking, we are still on the topic of esophageal speech, but here are two exercises that will serve you well, no matter which method of speech you use. One is a tongue exercise, and the other one, I call 'sigh/swallow', will relax the neck and shoulder muscles and clear the mouth for speech.

1. TONGUE EXERCISE: It is important that you do this in front of a mirror so you have the visual cues. Stick out your tongue as far and as straight as you can. Be certain that it isn't going off to one side; that it is 'centered'. Next, try to curl your tongue up to touch the tip of your nose, hold, and then slowly move it back to 'center'.

Then try to bend your tongue down to touch your chin, and back to 'center'.

Go next to your right cheek as far as you can stretch, and back to 'center'.

Finally, go to the left cheek as far as you can stretch, and back to 'center'.

The first time you will only do one or two sets of this exercise to strengthen and flatten you tongue for more flexibility and better articulation. This will also help with water going up your nose because the back of your swollen tongue can close off and force fluid up your nose instead of allowing fluid to go over the back of the tongue and down the hatch as it should. The tongue is the strongest muscle we have, and as laryngectomees we really give this muscle a work out...especially with esophageal speech.

2. SIGH/SWALLOW: Take a deep breath, hold it, and pull your shoulders up toward your ears and hold that tensed position. As you lower your shoulders and exhale slowly you will feel the warmth as the blood rushes back into the relaxed muscles. Then take a moment to gather up the saliva in your mouth to swallow at least twice to completely clear your mouth before you resume speaking.

This process I call 'sigh/swallow' describes two steps we can use to relax and clear in an exaggerated way privately, or as simply as sighing in public during a brief pause when speaking. When using esophageal speech it is essential that the neck and shoulder muscles stay relaxed, as opposed to the tightening we used with lung air for speech. The extra benefit of the swallowing is that the cricopharyngeus sphincter must open to swallow. When it opens it will allow any excess air in the esophagus to escape; perhaps in a series of little burps, or one long 'ahhh'. With the excess air pressure reduced it is easier to resume speaking esophageally, and should also reduce the uncomfortable build up of air going to the stomach.

In answer to the eternal question: Where does the air come from for ES?

Basically there are three methods of getting air into the esophagus:

1. GLOSSAL PRESS: This means lightly pressing your tongue up against the roof of your mouth. This action will put the air that is always in your mouth under enough pressure to guide it toward the back of your mouth until it enters the sphincter at the top of your esophagus. You are just tucking a little air in before you open your mouth to say, "ah". This happens as quickly as you can blink your eyes. Please note: I did not suggest that you swallow air. If you hear a 'klunk' you are probably forcing too much air in and it will soon become unmanageable.

Nor should you 'double pump' to make sure you have enough air to say several words. A friend of mine named Chuck double pumped for

this reason for a few years before I finally convinced him that all he had to do is say, "Chuck" without using glossal press first. The 'ch' provided all the air he needed to say his name. The double pump, plus the 'ch' consonant injection put in more air than he could manage for fluent ES.

2. CONSONANT INJECTION: As you begin working with consonants such as p, t, or k, add vowels, for example 'p-ah', 'p-ie', 'p-oh', etc. You may wonder how this works. Remember? "For every action there is an opposite and equal reaction"? So, if you pucker your lips to make a "P-ah" sound with your hand in front of your lips you can feel the air pass over your fingers. At that moment the same amount of air is headed backward inside of your mouth, past the cricopharyngeus sphincter, and down into the top of your esophagus. Please don't wait to use it for sound. Catch it before it heads south. You can increase the air pressure in your mouth, if you need to, by holding your lips in the 'P' position a little longer before popping your 'p' sound.

Just for fun, take a moment to put your lips together. There will be enough air in your mouth to move it from one cheek to the other, and back again. Now, continue to keep your lips together and press your hands against your puffed out cheeks. If you have healed enough, you may feel the air go back into your esophagus. (You may see the air as it speeds down your esophagus in the mirror.) The air might come out between your lips like a Bronx Cheer, or it could go up and out of your nose. Your tongue position controls the direction it will take. Experiment! Blow out a candle, blow up bubble gum, and then try your luck blowing up a balloon with the air in your mouth. Keep your lips around the end of the balloon, and pinch the neck of the balloon closed while you draw the air up into your nose by dropping your lower jaw like a bellows. Yes, you can, and you will probably be able to smell as well. These are all great exercises for your tongue muscle.

3. INHALATION: This does not refer to inhaling air into your lungs. Instead it is a method that allows air to be drawn into your esophagus. With your mouth open and tongue down, raise the soft palette as you would to 'gasp in surprise', or 'yawn'. You will hear a "click" sound when the sphincter pops opens. That sound indicates that air has entered your esophagus. It is like opening a vacuum sealed container. When the sphincter opens a vacuum is broken and air has been drawn down into your esophagus, and you're ready to say "ah". It may not be a very loud "ah", but it is audible. You can repeat this continuously until you master it. This method is the air intake technique that fluent esophageal speakers use, especially when beginning with a vowel.

Air for esophageal speech travels into the mouth and should go no lower than about where your larynx used to be before it returns in a figure 8 loop. Blowing out with lung air for ES, or when using an EL, will result in stoma blast. This distracting sound also tightens your neck and shoulder muscles. It makes enough noise to override your ES voice. There is also the worry that you are blowing more than air into the face of your listener.

Another distraction is the intrusive 'k' when speakers use the back of their tongue to say a vowel; i.e. KI, KA, KL, instead of IAL. However, for the 'h' sound you can take air into your mouth with glossal press or inhalation, and the air return and sound will begin at the back of the tongue. If you stop short of touching the soft palette, as you move the back of the tongue as if to say, 'he, he, he', or ha,ha,ha. When you master this technique you can say, 'Harry has hair on his head.'...without a "intrusive k".

I'll close with a story about 'bad actors': double pumping, klunking, stoma blast, and intrusive 'k', to name a few. The Director of the Voice Institute and several of us decided as a 'unit' to attend the IAL "Masquerade" Meet & Greet at the New Orleans Annual Meeting in 1992 dressed as "Uninvited Guests". Our plan was to remain silent and have folks guess what each one of us represented? I borrowed white sheets from hotel housekeeping and designed costumes, arranging each sheet in an individual way. (The sheets were returned unharmed.) During our break that afternoon a few of us walked to Ben Franklin's and bought props: a bicycle horn & tire pumps, construction paper, and masks of course. It was so much fun. We won a prize for best group costume. LOL I recall I went as 'double pump' because I could manage both bicycle tire pumps (one on each hip) and keep my sheet together. No pun intended.

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