Swimming, snorkeling, breathing, smelling, and motorcycling after total laryngectomy

LANDIS, Basile Nicolas, et al.
ected using immunocytochemistry on lymph node tissue in a prospective study of 10 patients with Kikuchi’s disease (6). Acute parvovirus infection should be considered in the differential diagnosis of patients with rash, polyarthropathy, and lymphadenopathy.

Leonard B. Johnson, MD
Anita Pasumarthy, MD
Louis D. Saravolatz, MD
Division of Infectious Disease
Department of Internal Medicine
St. John Hospital and Medical Center
Detroit, Michigan


SWIMMING, SNORKELING, BREATHING, SMELLING, AND MOTORCYCLING AFTER TOTAL LARYNGECTOMY

To the Editor:
Total laryngectomy, the only curative therapy for extensive laryngeal cancer, is associated with substantial physical disability and psychological effects. Apart from the loss of voice, there are other consequences associated with breathing through the tracheostoma, such as an increased risk of tracheopulmonary infection, suffocation by intrusion of a foreign object, and water aspiration. In addition, there is total or partial loss of smell (1). Although anosmia after laryngectomy is considered by most to be due to the lack of nasal airflow, surgical interference with sensory feedback mechanisms from the larynx to the olfactory system may be involved (2). We report the case of a 68-year-old man who underwent total laryngectomy for recurrent cancer.

Before surgery, the patient was an active swimmer and a passionate motorcyclist. A few months after surgery, he presented with two self-made devices for living assistance. The first was a larynx bypass fabricated from his diving equipment (Figure, A and B), which allowed him to snorkel, swim, smell, and breathe through the nose. The device was made of a plastic diving tube connected to the tracheostoma, and it was fixed in a waterproof manner with a metallic pipe coupling. A snorkel could also be connected instead of the mouthpiece. Testing with “Sniffin’ Sticks” (Burghart, Wedel, Germany) (3) showed that olfaction improved from hyposmia (23.5 points) without the larynx bypass, to normosmia (33.5 points) with the device (scale of 0 to 48 points; anosmia <16 points, normosmia >31 points), supporting the suggestion that hyposmia after laryngectomy is due to the nonfunctioning nose (4) rather than postsurgical neuronal modification.

The second device (Figure, C), a metallic tea strainer fixed by a ribbon around the neck, served as a protective aid during motorcycling. It prevented insects from entering the tracheostoma, as well as occlusion of the tracheostoma by clothing. As most patients face a difficult rehabilitation program after laryngectomy, physicians should be aware of potential, simple ways of improving quality of life after surgery (5).

Basile N. Landis, MD
Roland Giger, MD
Jean-Silvain Lacroix, MD, PhD
Pavel Dulguerov, MD
Clinique et Policlinique d’ORL et de Chirurgie Cervico-Faciale
Hôpitaux Universitaires de Genève
Geneva, Switzerland

Letter to the Editor

Figure. Computed tomographic scan of the abdomen revealing lymphadenopathy with central necrosis near the head of the pancreas (arrows).
Figure. Larynx bypass (A) and snorkeling device (B) made by patient from diving tubes, and modified tea strainer (C) for tracheostoma protection.