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Voice Humanism and the Soul

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Abstract

In 1873, Bill roth performed the first Total Laryngectomy (TL). For almost a century little thought was given to the adverse social and psychological effects of the procedure. The alternative was life versus death as no other therapeutic alternatives were available if life was to be preserved.

Keywords: Voice Humanism; Emerging patient; Voice quality; Quality of life

Introduction

In 1873, Bill roth performed the first Total Laryngectomy (TL). For almost a century little thought was given to the adverse social and psychological effects of the procedure. The alternative was life versus death as no other therapeutic alternatives were available if life was to be preserved.

Yet, in the fullness of time, emerging patient experiences would ultimately document the more than consequential ill effects TL had on human existence thus negating the concept of beneficence that once existed relative to the procedure in a great many instances. I will explore the intricacies of the human voice as it relates to Quality of Life (QOL) and the current alternatives to TL. I will further opine on physician reticence to change relative to a future that includes primary transplantation for selected primary malignancy.

The human larynx is a complex organ. The vibrations produced and subsequently fine-tuned by the cavities in the head, lead to a unique footprint for each individual. Voice quality is a signature recognizable and identifiable by almost all knowing a person in most circumstances. In its most nuanced interpretation, it is arguably the most beautiful musical instrument ever produced, giving rise to a Pavarotti, Botticelli etc. Its intonations contribute to what we know as humanism via the expression of joy, happiness, grief, sadness, terror and more.

The larynx has important physiological functions as well. It is the inlet for respiratory function and protects the airway from aspiration during deglutition. It is sentinel for developing an effective cough.

Some laryngeal malignancies require total extirpation, leaving patients with a large tracheostoma. Human voicing is lost in the process. Air no longer traverses the nasal passages leading to a loss of smell and, as such, a diminution of taste. Showers and swimming are best avoided and lifting becomes more difficult. Yet many still consider the larynx to be a non-vital organ. The consideration of laryngeal transplantation for cancer has been seeded by studying the residue of said organ's extirpation.

Jack was 60 years of age, had a 20-pack year history of smoking and presented with hoarseness, odynophagia and mild stridor. A T4 laryngeal malignancy (large and partially obstructing) at the time required a total laryngectomy. Preoperatively, the potential physiologic and psychological changes he would or could experience were discussed at length. There was no evidence of depression. Alternatives for oral communication moving forward were stressed. His postoperative course was uneventful. Forty-eight hours after his discharge he committed suicide. His first night home during intercourse he coughed and the mucous emitted from the stoma in his neck covered his wife's chest. He was devastated. A welcome home party planned for his second night evolved into a jocular discussion of the robotic quality of his speech produced by his electrolarynx. Some suggested he now would be known as robot man. The next day he jumped off bridge and drowned. Never again this author would the larynx be considered a non- vital organ.

The disparities that exist unfairly between men and women are unfortunately far more evident when it comes to living with a laryngectomy. In my practice the divorce rate following the procedure is far greater for women. Even troubled marriages prior to male laryngectomy survived with women feeling compelled to provide care. This psychosocial phenomenon, in all probability was part of

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the calculus for five women patients under my care choosing death rather than laryngectomy after all other options had been considered and rejected. Two would have been classified as very bad deaths. Not one, as death approached, when queried said in retrospect that they would have chosen otherwise. When asked if conservation or transplantation surgery had been an option would that have been considered - all responded affirmatively.

My original intent for this paper was to focus on the impact laryngeal transplantation could have on life's quality, thereby in part mitigating the down side reality of some decrease in survival. My research was to be summarized as an evolving canvas rather than dwelling on specific research efforts. Yet those considerations lead to recalling Jack's story. It was the personal devastation associated with his laryngectomy that lead to exploring the consequences of such in more detail. An additional germane consideration, that of surgeons' reluctance to accept change, will also be discussed. Recall as a reference the decade plus lag in accepting the concept that gastric ulcers could have a medical cure rather than surgical -proton pump inhibitors versus the prior gold standard of vagotomy and pyloroplasty.

Studying bioethics can have a profound impact on processing for surgeons that are introspective. For some it leads to being less concrete and far more philosophical. Questions explored regarding death and humanism are often a stimulus for significant reflection. It isn't that we agree with all positions taken. It's the overall approach that led to equating the loss of the human voice in part to a loss of humanism conceptually making TL far more disruptive. Is it in reality a beneficent procedure if we don't strive to do better and also acknowledge nonmaleficence? What follows will chronicle the psychosocial and physical effects of the procedure such as the current data suggest. Then the medical and surgical efforts to preserve the human voice will be briefly chronicled as a prelude to why the human voice really matters- humanism, the soul and for some the perception of what lies beyond. This rendering records an academic surgeons' journey toward a more comprehensive understanding of humanism and death and, as such, richer perceptions of bioethical principles and the Hippocratic Oath.

There is relatively little science in the discussion that follows and, as data a driven science-based surgeon, this paper will be a first. For me science has always been a foundation whose boundaries exist only to be exceeded, not cautiously but boldly. As such non acceptance by "noted experts" to innovative concepts has been irrelevant. Robert Frost in The Road Not Taken has written about 2 roads that diverged in the woods, one less travelled by which is the one that has always resonated with me and that has made all the difference.

Delving more into the psychosocial aspects of laryngectomy will optimistically help prioritize the acceptance of other innovative surgical procedures and ultimately transplanting for primary laryngeal cancer. Addressing surgeons' reticence to change will give insight as to the anticipated negative responses as the program matures.

Laryngeal cancer, as with any malignancy, has a profound psychological impact on all at the time of diagnosis. Many of the initial concerns regarding laryngeal cancer are followed with the realization that fundamental daily life functions will be permanently lost following TL. Unfortunately, relatively little attention has been given to some of the most devastating side effects of this procedure. Strojan and Zwitter write "laryngectomy is among the most mutilating treatments of cancer [1]. It brings with it physical incapacity and social stigmata in many instances to an already marginalized subset of the population. The majority of the patients with laryngeal cancer have a squamous cell pathology, the precursors for which are smoking and drinking. Both have been associated more often with the disadvantaged and a decreased ability to cope [2,3]. After discussions with many spouses, it became clear that most patients coming from a more privileged societal environment also have some element of depression. Further altered behavioural patterns, reticence to engage, increased isolation, demanding much more of spouses etc., not only persisted but tended to increase over years unless intervention occurred.

The real incidence of suicide remains questionable, as is that of self-destructive behaviour leading to death (persistent consumption of alcohol and smoking). These need further investigation. Designing rigorous studies to address these considerations more scientifically are essential. What percentage of this population who were gainfully employed return to their prior positions and what percentage of those who did were successful in maintaining such? Are those socially advantaged better able to adapt? Certainly, better access to counselling would on the surface seem to be of benefit. However, is it? The not-so-subtle rejections in the upper levels of society could ultimately prove to be more devastating than for the disadvantaged. A study by Souza et al suggests the latter to be true [4]. The study of 95 predominantly male patients were described as coming primarily from a low educational level in Brazil. The lower levels of speech quality correlated with an overall perception of a reduced quality of life. Clearly better speech quality is the sentinel factor affecting life following total laryngectomy. The latter correlated with my patient base. However, beyond a year post surgery adaptation was seemingly better for the Souza cohort than for my patient populace. The latter supporting our contention that the underserved, with just another intrusion on an otherwise compromised life, have had to adapt to so much adversity that this is just one more incident. In short, the disadvantaged have poorer coping skills but a lifetime of adapting often to substandard conditions.

An article on TL published April 2021 evaluated 46 published papers [5]. The first conclusion, that the strength of the evidence from them is weak, correlates with our impression that most such articles lack scientific rigor. The second conclusion, that the QOL for TL patients was worse than that of the male normative population, should have been a forgone conclusion. Further publications comparing women's responses after TL to those of men found women to have far more difficulty with acceptance and, as such, most rate their QOL as fair to poor.

Having a psychiatric background prior to becoming a head and neck surgeon, I attempted to mitigate the adverse consequences of TL for my patients with personal counselling sessions. Although there was some benefit, it became clear that my efforts weren't sufficient. More effort must be directed to hospital supported programs involving physical therapists, occupational therapists, psychologists, social workers, family counselors and physicians if a meaningful QOL is to be re-established. The head and neck service at Pittsburg has established a physician led clinic incorporating the latter for all patients post debilitating head and neck procedures. The reviews to this point have been positive and a few other institutions have followed suit.

As a stop gap measure more than a decade ago, I began suggesting Lexapro for all patients facing major head and neck oncologic

procedures. A well-designed placebo-controlled study would be essential to verify efficacy. As a rule, I disregard personal observational efforts, acknowledging the potential for bias. Yet, a significant number of the patients tried the medication and the difference in the incidence of depression and actual improvement in affect, pre and postoperatively, was notable to those interacting with them regularly.

In summation of what has been presented so far and what resonates most with me is the thoughtful sobering insight penned by a physician who had a TL. I was overwhelmed by daily tasks and the new reality I faced. I was mourning the many losses I experienced which included my voice, my wellbeing and the need to accept many permanent defects." He acknowledged experiencing "creeping depression [6].

It became clear that alternatives to TL were needed and would be accepted if maintaining human voicing was possible. Three scenarios currently exist: Chemo-Radiation (CR) therapy for cure, more aggressive partial laryngeal surgery and immediate transplantation post TL. The latter is beyond the scope of this paper but will be addressed in the future.

In the landmark Veterans Laryngeal Cancer Study Group trial, nonsurgical laryngeal preservation included induction Chemotherapy (CT) followed by Radiation Therapy (RT). It was compared to TL followed by RT for advanced laryngeal cancer. The nonsurgical arm for responders to initial CT offered survival rates similar to the surgical RT arm [7]. A later trial showed concomitant chemo RT to have improved laryngectomy free survival [8] The latter initiated a sea change in management for more than a decade. We also adapted this approach eschewing TL whenever possible. More trials ensued using newly minted chemotherapy combinations. CT and RT in combination remain the first consideration for many in the head and neck cancer orbit today. Yet evaluation of larger cohorts of patients and separating out the T4 laryngeal malignances rather than grouping T3 and T4 together suggested that T4 lesions had a poorer survival with CT/RT than TL [9]. Then more information began to surface regarding the complications as years passed. The concept that the debilitating acute effects of the treatment regimen [Chemo RT] would subside once treatment was completed proved to be incorrect. There was an increase in the need for tracheotomy in some. Swallowing was problematic for many because of pharyngeal scarring and subsequent stenosis. Taste suffered and mouth dryness was debilitating. Neck fibrosis limited motion and pain syndromes developed. Decreased hearing associated with CT as well as decreased foot sensation for some lead to balance issues. Then there was the very problematic development of RT related chondronecrosis. Forty percent of those so treated still recurred and, when salvage surgery was required post CT RT, the surgery was far more challenging and associated with significant increases in surgically related complications. Given the QOL considerations for both approaches, some surgeons again are reconsidering initial aggressive partial and total laryngectomy.

John Kirchner's epic anatomic sectioning and study of multiple larynges removed surgically with squamous cell cancer defined patterns of spread previously unidentified [10] After spending hours reviewing his slides, I reconsidered some of the surgically recommended anatomic limits accepted as requiring TL finding them too conservative. In our current paradigm, and that of a few European surgeons, removing 90 plus percent of the larynx with extended boundaries in properly selected cohorts is doable safely without increasing recurrence. Further, these resections could be increased to include segments of the cricoid cartilage and trachea. It is now possible to design personalized operative procedures based on patterns of growth. The latter has been rejected out of hand by some- to technically difficult, not portable, cancer would recur etc. A few worldwide accepted extended modifications and the results were as hoped. Larynges were preserved in far greater numbers for those able and willing to perform the procedures. It has as yet not been widely accepted. Even in the most aggressive resections, admittedly hoarse, but never the less human quality voices are attainable with normal respiration, swallowing, salivary flow, taste and smell. Importantly most patients maintain a sense of wellbeing.

An accomplished and noted Hollywood screen writer was one of the first of my patients to accept this paradigm. His appearance on his first visit was unkempt looking and he acted like so many of the underserved presenting with laryngeal cancer. He was clearly under the influence of alcohol during his consultation. Yet at the time that he was preeminent in his field. He had seen a noted academic laryngologist who recommended CT RT. Yet he sought alternatives for managing his advanced laryngeal malignancy. After removing 90% of the larynx and performing the requisite reconstruction, his in hospital recovery was unremarkable. He was very satisfied with his hoarse quality voice. No adjuvant treatment was recommended despite close margins. He gave up smoking, alcohol and drugs subsequently choosing to go on TV to let the public know that this type of surgery was feasible. He later chronicled his life's journey including his bout with laryngeal cancer in 2 books- Hollywood Animal and Cross Bearer and remains tumor free for almost 2 decades.

Years later one of my last patients for extended transoral microsurgery was a member of an iconic band. All prior consulting laryngologists recommended CT RT. The effects of the latter on his voice quality, in particular an inability to reach his highest register, would have ended his career. The surgery went as hoped with one margin being knowingly close as increasing it would have had an adverse effect on voice quality. With the close pathologic margins, his manager sought multiple opinions as how to proceed. In a conference call all the consultants recommended adjuvant CT RT. Further all stated if the latter didn't occur recurrence, was a certainty. Now 8 years later and cured with surgery alone, he continues to perform.

Resistance to change among surgeons remains as problematic today as when these considerations were first voiced. It remains inexplicable that so many are unable to expand their horizons when something as individual and human as voice production is at stake. They lack the understanding of the impact and association of how much the human voice contributes to humanism. Is it ethical to dismiss out of hand something so fundamental when preservation techniques exist? Authoritarianism has long defined the surgical persona which often interferes with the principal of beneficence, often precludes consideration of non-maleficence and in this instance at times prevents preservation of the organ that contributes more than any other to humanism with perhaps the exception of the brain.

Expanding on the latter, humanism is at the core of a total being. Although the term itself acknowledges the potential and agency of who we are, it also represents an evolutionary construct of the soul. In many religions, philosophical and mythological traditions the soul is the incorporeal essence of a living being [10]. Further it has been intimated that repair of human souls may require more sensitivity than care of the human body. In my philosophical and ethical construct, preservation or repair of whatever leads or contributes to

humanism, the human voice being a cornerstone of such, enhances the soul. Some believe the soul is the lasting embodiment of what we represent when we die. For them and us, nurturing humanism by preserving voice, thereby enhancing the soul is a worthwhile effort.

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