Proposed guidance for laryngectomy surgery during the COVID-19 pandemic

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To: UK head and neck multidisciplinary teams

BAHNO recognises that the management of many patients with cancer will have to be modified and sometimes delayed during the current COVID-19 crisis. One particular group that will cause management dilemmas are those patients with advanced and potentially-airway obstructing laryngeal and hypopharyngeal cancers.

Emergency airway management

- We refer members to the recent ENT UK tracheostomy guidance https://www.entuk.org/tracheostomy-guidance-during-covid-19-pandemic
- Tracheostomy is preferable to debulking procedures given the potential for high-volume aerosol contamination.

Choice of treatment

- As with all head and neck cancers during this crisis patients planned for curative treatment should be prioritised according to need, availability of alternative treatment options and potential for cure
- The laryngectomy procedure itself and all patients who are laryngectomised are significantly aerosol-generating. Therefore avoid performing a laryngectomy unless deemed absolutely necessary
- Many patients with advanced cancers will be suitable for radiotherapy. Of the proportion who recur locally some will be suitable for salvage laryngectomy at a time when the current COVID-19 situation has improved
- Surgery should be avoided in patients with advanced disease and a poor overall chance of survival.

The laryngectomy / laryngectomy-pharyngectomy procedure

- COVID-19 testing must be performed before a tracheostomy and certainly before laryngectomy is performed. Two tests over an interval period would provide more definitive results
- Do not perform a laryngectomy in a COVID-19 positive patient. Intubate or perform a tracheostomy to alleviate airway obstruction and wait for the patient to become COVID-19 negative before further definitive treatment
- All patients should be managed peri-operatively on the assumption that they may be COVID-19 infected - full PPE and FFP3 respirators are necessary for all theatre staff
- Avoid a primary tracheoesophageal puncture to reduce the associated risks in the immediate and short-term recovery period. A secondary TEP can be performed at a later date
- Avoid microvascular free flaps where possible
- For patients requiring pharyngeo-laryngectomy avoid a circumferential resection which will allow for pedicled flaps such as pectoralis major or SCAP flaps
- Consider, when primary pharyngeal closure is possible, an augmentation myofascial flap in cases at higher risk of fistula.

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