Troubleshooting and FAQ Guide

Prof Dr Michiel van den Brekel

Biography

Michiel WM van den Brekel, MD PhD, graduated "cum laude" from the Medical Faculty of the University of Leuven (Belgium) in 1987. He did his Ph.D. at the Free University and wrote a thesis on "Imaging and Histophathology of Neck Node Metastases". He was the first to study the value of ultrasound guided aspiration cytology in neck nodes. After his Otolaryngology-residency at the Free University in Amsterdam he did a Head and Neck Fellowship at the Netherlands Cancer Institute and the University of Toronto, Mount Sinai Hospital. Since 1997 he works as a head and neck surgeon at the Free University Hospital and since 2000 in the Netherlands Cancer Institute in Amsterdam where he was chairman from 2009 until 2023. In 2011 he was appointed as Professor at the University of Amsterdam. His clinical research focuses on translational medicine, rehabilitation as well as imaging of head and neck cancer patients. He (co-)authored over 350 peer-reviewed papers and chapters.

Question:

What are the positive effects of using adhesives and HMEs immediately after surgery with laryngectomized patients?

Answer:

HMEs can replace external humidification, which has been proven to be better tolerated and is more effective. Starting directly post-surgery is important to avoid open stoma breathing with no resistance and to teach the patient on the use of HMEs

Question:

What short and long-term positive impacts have you noticed within your patients since introducing this pathway?

Answer:

If you start early, patients will accept the breathing resistance better. Also, pulmonary complaints are diminished and sleeping is better. Avoiding open stoma breathing is also more hygienic for the HCPs.

Question:

Are there any factors that would stop you from using this pathway with some of your patients?

Answer:

When a patient needs artificial ventilation on the ICU, normal adhesives and HMEs are not possible.

Samina Kea-Kiyani

Biography

Samina Kea-Kiyani is a registered oncology nurse with 14 years of experience, specializing in head and neck oncology at the Antoni van Leeuwenhoek hospital. In addition to her work as an oncology nurse, Samina has been a practice coach for the past 3 years, guiding nurses through various educational trajectories. Her dedication to providing the best possible care for patients, combined with her passion for mentoring and supporting colleagues, has made her a valuable asset in both.

Question:

In which circumstances would you also introduce external humidification?

Answer:

When a patient has thick, tenacious mucus in the trachea, nebulization with NaCl 0.9% can be performed.

Question:

Do you always start with the Home HME or are there any pulmonary comorbidities that would alter the HME that you select for your patients?

Answer:

Home HME is always used as the standard starting

point. Go HME is only used when the patient is actively mobilizing, such as using a stationary bike or experiencing severe shortness of breath. This is an exception, as HMEs are typically not switched. The choice of HME is not dependent on any pulmonary conditions.

Question:

Can you use a barrier cream underneath the adhesive?

Answer:

The Provox skin barrier wipe can be used around the edges and surrounding skin to provide a film barrier to protect the skin.

Question:

When might you choose a laryngectomy tube rather than an adhesive?

Answer:

Larytube with a ring that can be placed in the adhesive baseplate when the stoma opening is too narrow and the airway needs to be secured. Additionally, a larytube may be selected if the surrounding skin is dry or damaged and an adhesive baseplate cannot be placed. The larytube is then secured using a strap or laryclips.

Question:

When a patient requires oxygen support how do you facilitate this, whilst continuing to use an HME?

Answer:

Digitop with a free hands filter is used. Up to 10 liters of oxygen can be administered through this filter with the digitop.

Prof Dr Thomas Rustemeyer

Biography

Thomas Rustemeyer is professor in dermato-allergology and occupational dermatology at the Department of Dermatology-Allergology at the Amsterdam University Medical Centers, Netherlands. He is supervisor of immunological research of the University, and he is active in supervising patient's care and research addressing fundamental immunological and translational research topics. He is (co)author of more than 300 publications and editor of several textbooks. He is member and/or chairperson of various national and international societies active in dermato-allergology, immunology and occupational health, including governmental and regulatory affairs.

Question:

How soon after surgery can you use adhesives, is it safe to use a hydrocolloid adhesive over sutures and staples?

Answer:

If we think about classical wound care, the hydrocolloid has been developed to improve wound care. You can place it on top of wound sutures or staples and the hydrocolloid will help to keep the wound dry and to prevent infection. This can be done directly after surgery, and the benefit of doing this is that the skin is still sterile and not greasy and there is therefore a lower risk of infection.

Question:

Antibiotic ointments are widely used post-operatively but make it difficult to use an adhesive. Is it necessary to use an antibiotic ointment after surgery?

Answer:

Antibiotic ointments are not needed post-operatively, as surgery is carried out in a sterile environment and the wounds are closed. The hydrocolloid adhesive is an effective alternative, absorbing moisture and keeping the wounds dry.

Question:

When do you recommend removing the hydrocolloid adhesive?

Answer:

Look through the adhesive and if it is soaked with exudate, you know it is time to remove and then it will be easy to remove because it has lost its adhesive capacity, and therefore much easier to peel off.

Acknowledgment

We would like to thank Prof Dr Michiel van den Brekel, Samina Kea-Kiyani and Prof Dr Rustemeyer for reviewing the content of this clinical practice guidance and for their valuable comments.

Any recommendations in this educational material are a general guide for best practice, to be implemented by qualified healthcare professionals subject to clinical judgement and availability of healthcare resources.

The information presented should not be considered medical advice for specific conditions. A patient's individual circumstances and preferences should always be considered and clinical practice should be in accordance with the principles of protection, participation and partnership.