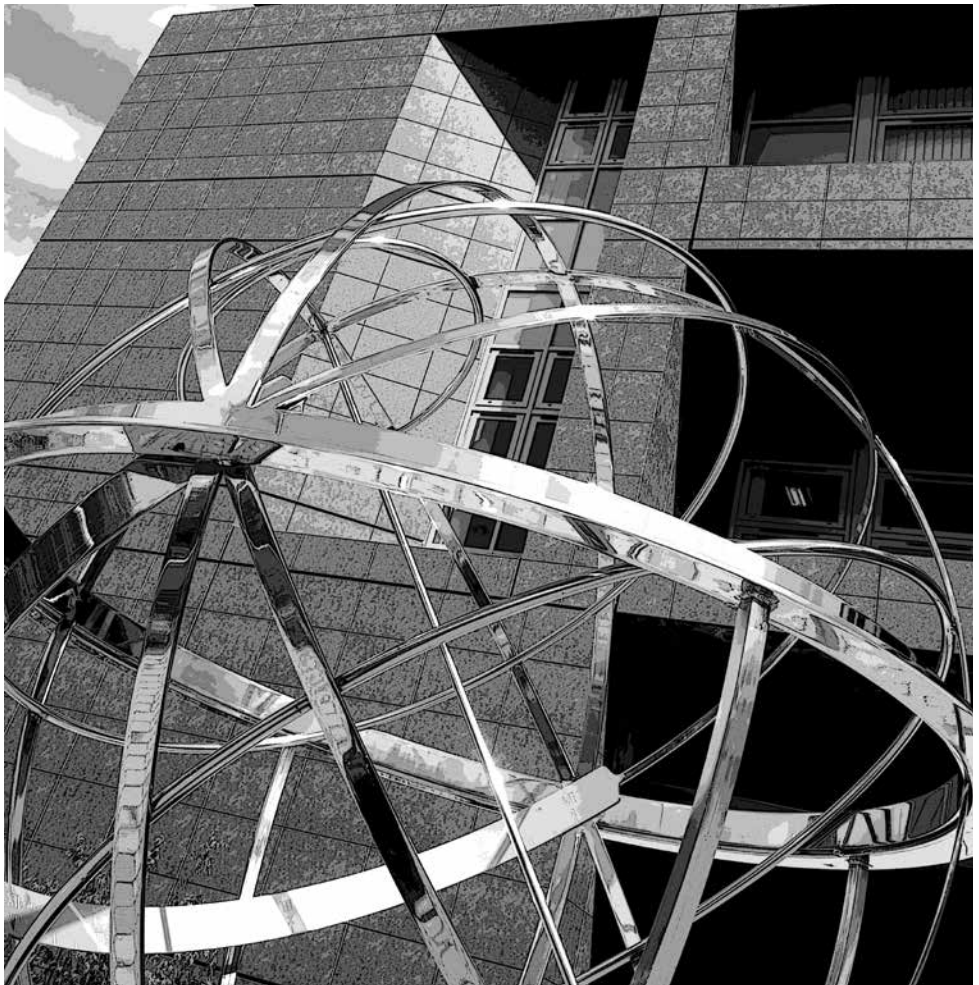


Oxford Centre for Head and Neck Oncology

Major head and neck operation with reconstruction

Information for patients



Introduction

This booklet has been written as a guide to give you information about your major head and neck surgery with reconstruction. This may include one or a combination of the following operations:

- hemi-glossectomy: removal of half the tongue
- total-glossectomy: removal of all the tongue
- hemi-mandibulectomy: removal of part of the jawbone
- tonsil resection: removal of tonsil and area around it that may be affected by cancer
- tongue-base resection: removal of the tumour from the back of the tongue
- floor of mouth resection: removal of the tumour from under the tongue.

The information aims to answer the questions most commonly asked by patients. If you need more detailed information your healthcare team will be happy to help. We hope that you and your family will find the information both helpful and reassuring.

When will I be admitted for surgery?

You will be asked to come to a pre assessment appointment before your surgery. This is so that we can assess your fitness to have a major operation.

Usually, you will be admitted either on the day of the operation, or the afternoon before, but this can vary if you have other medical conditions which mean you need to come in earlier. You are likely to need to stay in hospital for 2-3 weeks after the operation.

What is a major head and neck operation with reconstruction?

The aim of the operation is to remove the primary tumour. In order for the Surgeon to be able to get to the tumour, it is often necessary to make a cut through your jawbone. This will be repaired at the end of the operation with a metal plate and screws.

Removing the tumour and a margin of healthy tissue will leave a gap. This needs to be sealed to enable you to speak and swallow. To fill this gap, the Reconstructive Surgeons will move healthy tissue, with blood vessels attached, from another part of your body (for example, your forearm). This is called a 'flap' and sometimes this contains soft tissue only, but sometimes may contain bone. The blood vessels of the flap are connected to blood vessels in your neck.

The site where the flap was taken from will then be repaired, sometimes with a skin graft from another place on your body. The flap needs to be monitored very closely after the surgery to make sure that it has a good blood supply.

You will have a urinary catheter inserted to monitor how much urine you are producing. You will also have two or three drainage tubes coming out through your skin which are used to remove any excess fluids. These are likely to be in your neck and where the flap was taken from. These drains will be removed a few days after the operation. There will be a number of stitches and clips that are used to close the wounds in your skin; these will usually be removed a week after the operation.

During your operation you will also have lymph nodes removed. This is carried out in an operation called a neck dissection. We will give you a separate booklet to explain this part of your operation.

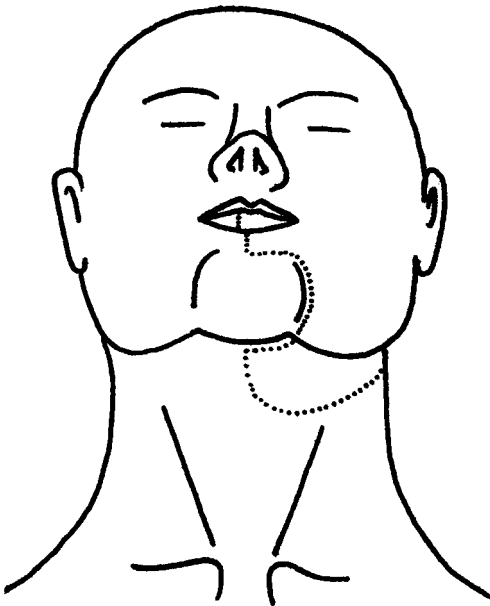
To protect your airway, it may be necessary to insert a tube

to help you breathe. This is called a tracheostomy tube and goes from your windpipe through your skin to the outside of your neck. This tube will remain in for about a week after the operation or until the swelling subsides and you can breathe comfortably through your nose or mouth. Your nurse or physiotherapist will use a fine tube to regularly remove any chest secretions from the tracheostomy tube.

Once the operation is finished, you will spend the first 24 hours on the Intensive Therapy Unit (ITU). You will be connected to various drips, drains and tubes so you can be closely monitored. You will then be transferred back to the ward.

If you have had bone taken from your leg to create a 'flap', you will need to wear a supportive boot and use a crutch for a few weeks, to help the wound recover.

Will I have a scar?



Yes, but the scar will vary from person to person. It may run from your bottom lip, around your natural chin contour, underneath your chin and extend onto your neck. These scars will usually fade to thin lines over time.

If it is necessary to remove one of the large muscles from your neck, your neck will look a little flatter on this side.

Will I have any pain?

During the operation the nerve supply to the skin will be affected and will leave an area of numbness on your neck. This means that you may not have as much pain as you expect after the operation. To help control your pain you will have a hand held button to push, which will give you a measured dose of pain relief medication. This system is known as patient controlled analgesia (PCA) and your nurse will show you how it works.

How will I talk?

If you have a tracheostomy, the tracheostomy tube will prevent air from moving through your voice box, so you will temporarily be unable to speak. You will be encouraged to speak once the tube is removed. You might find that using a pen and paper and non-verbal communication, such as nodding or shaking your head, will be helpful in the first week. Long term effects to your speech will depend on the extent of the operation. Your health care team can advise you about how your operation is likely to affect your speech.

Will I be able to eat and drink?

After the operation you will not be allowed to eat or drink while everything is healing. During this time (at least 7-10 days) you will be fed through a tube into your stomach. The Dietitian will talk to you about the type of tube feed you may need and answer any questions you may have.

You may need to have an X-ray test called a barium swallow. This involves drinking or having a chalky liquid made of barium-based solution put down through your feeding tube. It is used to check if your wounds are completely healed inside, and also to check

how well you can swallow. The barium helps to show up any leaks on the X-ray pictures.

The Speech and Language Therapist will give you advice about the safest and easiest textures of food and drink to start with. Food may be soft or pureed in texture and drinks can be thickened with special thickening powder. Your mouth and throat may be sore initially, so we usually suggest smooth bland foods. As time goes on you will hopefully progress to more normal food and drinks. However, this can take time. The operation is likely to affect your sense of taste, particularly if the surgery involves your tongue.

The Dietitian will advise you on your nutritional needs and will reduce your tube feed as you start to drink and eat more. Sometimes, long-handled cutlery or a special beaker can be helpful to move food or drink to the back of your mouth.

What are the problems that may occur?

Flap failure:

There is a small risk that the blood supply to the flap may become restricted during or after the operation. If this happens, further surgery may be required to either get the blood supply going again, or in a few cases, to replace it with a new flap from another part of your body. If you need to have a new flap made, the Reconstructive Surgeon will explain how this will be done before the operation.

Infection:

There is a risk of infection associated with any surgery. This could include a wound or chest infection. Antibiotics are usually given to prevent this from happening.

Numb skin:

As mentioned previously, the skin on your neck may be numb after the surgery. This will improve over time, but you should not expect it to return to normal.

Haematoma:

Sometimes the drainage tubes can become blocked, causing blood to collect under your skin and form a clot (haematoma). If this happens, further surgery may be required to remove the clot and replace the drains. If this happens we would need to keep you in hospital longer than originally planned.

Hypoglossal nerve:

Very rarely this nerve, which makes your tongue move, also has to be removed due to the position of the tumour. If this needs to be done, you will find it difficult to move your tongue to one side and it can interfere with your swallowing. If this happens, you may find that your speech can be less clear.

Marginal mandibular nerve:

This nerve is a branch of the facial nerve which supplies the facial muscles. The nerve is at risk of being damaged during the operation, but the Surgeons try hard to protect it. If it is damaged you will find that your lower lip will be a little weak. This will be most obvious when you are smiling. The Speech and Language Therapist can suggest exercises and strategies that will help improve the strength in these muscles.

Will I need any other sort of treatment?

You will be given the results (histology) of the operation about two weeks after the surgery. The aim of the operation is to remove all the cancer and a margin of healthy tissue around the edge, to reduce the risk of cancer cells being left behind. This is not always possible due to the position of the cancer,

and because we are not always able to see tiny microscopic cancer cells that may have begun to form in some of the normal tissue. The laboratory will be able to see these cells under a microscope from the samples taken during the operation. These results, together with other factors, will help the doctors to decide whether you need any additional treatment, such as radiotherapy.

Questions or further information

If you have any questions or concerns, or need any further information, then please contact the:

Head and Neck Cancer Specialist Nurses

Tel: 01865 234 346 (Monday to Friday, 8.00am to 4.00pm)

You will also be given the Specialist Nurses leaflet which contains information on websites and local support groups that you may find helpful.

If you have a specific requirement, need an interpreter, a document in Easy Read, another language, large print, Braille or audio version, please call **01865 221 473** or email **PALSJR@ouh.nhs.uk**

Compiled by Head & Neck Oncology Team
February 2015
Review: February 2018
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