FOREWORD

Laryngeal carcinomas comprise about 2% of all cancers but close to 45% of those affecting the head and neck. Male smokers between 45 and 75 years of age are at highest risk, although the percentage of affected women has been rising for some years now. A diagnosis of laryngeal cancer triggers an existential crisis for patients and their families; if it is left untreated, a patient's life expectancy approximates 12 months. Then, of course, there are the challenges of coping with the loss of voice, diminished smell and taste, altered swallowing, and needed changes in daily living habits, vocation, and family roles.

The first reported amputation of a human larynx was described by Billroth in 1873. A year later, the ill-fated efforts to restore this patient's voice was reported by Gussenbauer. Since that time, few areas of cancer management and rehabilitation have experienced more significant advances than that of laryngeal cancer, especially during the past decade and a half. To bring us up to date on these advances, I asked Steve McFarlane and Tom Watterson of the University of Nevada Medical School in Reno to serve as guest editors for this issue of *Seminars in Speech and Language.*

Drs. McFarlane and Watterson assembled a multidisciplinary team of prominent, experienced clinicians, and together they describe how they provide laryngectomees with a new voice, help them adjust to anatomical and functional losses, and execute the surgical and medical treatment of laryngeal cancer. Although additional research and clinical trials are needed, the prospects for further advances in the medical management of laryngeal carcinoma that will require less anatomical mutilation and the maintenance of natural voice production seems to be an achievable goal in the not too distant future.

In introducing a 1986 issue of *Seminars in Speech and Language* on this topic, the editor, William H. Perkins, noted that it was an "exciting time" for clinicians who work with laryngectomized patients. It still is.

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