Early Detection, Diagnosis, and Staging

Detection and Diagnosis

Catching cancer early often allows for more treatment options. Some early cancers may have signs and symptoms that can be noticed, but that is not always the case.

- Can Laryngeal and Hypopharyngeal Cancers Be Found Early?
- Signs and Symptoms of Laryngeal and Hypopharyngeal Cancers
- How Are Laryngeal and Hypopharyngeal Cancers Diagnosed?

Stages and Outlook (Prognosis)

After a cancer diagnosis, staging provides important information about the extent of cancer in the body and anticipated response to treatment.

- How Are Laryngeal and Hypopharyngeal Cancers Staged?
- Survival Rates for Laryngeal and Hypopharyngeal Cancers by Stage

Questions to Ask About Laryngeal and Hypopharyngeal Cancer

Here are some questions you can ask your cancer care team to help you better understand your cancer diagnosis and treatment options.

- How Are Laryngeal and Hypopharyngeal Cancers Staged?
- Survival Rates for Laryngeal and Hypopharyngeal Cancers by Stage
- What Should You Ask Your Doctor About Laryngeal or Hypopharyngeal Cancer?
Can Laryngeal and Hypopharyngeal Cancers Be Found Early?

Screening is testing for diseases like cancer in people without any symptoms. Screening tests may find some types of cancer early, when treatment is most likely to be effective.

But for now there is no simple screening test for laryngeal and hypopharyngeal cancers. These cancers are often hard to find and diagnose without complex tests. Because the cancers are not common, and the tests require specialized doctors, neither the American Cancer Society nor any other group recommends routine screening for these cancers.

Still, many laryngeal and some hypopharyngeal cancers can be found early. They usually cause symptoms, such as voice changes, which are described in “Signs and symptoms of laryngeal and hypopharyngeal cancers” Talk to your doctor if you have any of these symptoms. Many of the symptoms of laryngeal and hypopharyngeal cancers are more often caused by less serious, benign (non-cancerous) problems, or even other cancers. Still, it is important to see a doctor to find out what is causing your symptoms. The sooner the cause is found, the sooner it can be treated, if needed.

- References
See all references for Laryngeal and Hypopharyngeal Cancer

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Signs and Symptoms of Laryngeal and Hypopharyngeal Cancers

In most cases, laryngeal and hypopharyngeal cancers are found because of the symptoms they cause.
Hoaerness or voice changes

Laryngeal cancers that form on the vocal cords (glottis) often cause hoarseness or a change in the voice. This can lead to them being found at a very early stage. People who have voice changes (like hoarseness) that do not improve within 2 weeks should see their health care provider right away.

For cancers that don’t start on the vocal cords, hoarseness occurs only after these cancers reach a later stage or have spread to the vocal cords. These cancers are sometimes not found until they have spread to the lymph nodes and the person notices a growing mass in the neck.

Other symptoms

Cancers that start in the area of the larynx above the vocal cords (supraglottis), the area below the vocal cords (subglottis), or the hypopharynx do not usually cause voice changes, and are therefore more often found at later stages.

Symptoms of these cancers may include:

- A sore throat that does not go away
- Constant coughing
- Pain when swallowing
- Trouble swallowing
- Ear pain
- Trouble breathing
- Weight loss
- A lump or mass in the neck (due to spread of the cancer to nearby lymph nodes)

Many of these symptoms are more likely to be caused by conditions other than laryngeal or hypopharyngeal cancer. Still, if you have any of these symptoms, it is very important to have them checked by a doctor so that the cause can be found and treated, if needed.

References

See all references for Laryngeal and Hypopharyngeal Cancer

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How Are Laryngeal and Hypopharyngeal Cancers Diagnosed?

Laryngeal and hypopharyngeal cancers are usually found because of signs or symptoms a person is having. If cancer is suspected, tests will be needed to confirm the diagnosis. Diagnosis in people without symptoms is rare and usually accidental (because of tests done to check other medical problems).

Exams and tests for laryngeal or hypopharyngeal cancer

If you have signs or symptoms that suggest you might have a cancer of the larynx or hypopharynx, your doctor will recommend one or more exams or tests.

Medical history and physical exam

Your doctor will ask you about your symptoms, possible risk factors, family history, and other medical conditions. A thorough physical exam can help find signs of possible cancer or other diseases. In particular, your doctor will pay close attention to your head and neck, looking for abnormal areas in your mouth or throat, as well as enlarged lymph nodes in your neck.

Examination by a specialist

If your doctor suspects a cancer of the larynx or hypopharynx, you will be referred to an ear, nose, and throat (ENT) doctor, also known as an otolaryngologist, who will do a more thorough exam of the head and neck area. This will include an exam of the larynx and hypopharynx, known as laryngoscopy, which can be done in 2 ways:

Direct (flexible) laryngoscopy: For this exam, the doctor inserts a fiber-optic laryngoscope  a thin, flexible, lighted tube through the mouth or nose to look at
the larynx and nearby areas.

**Indirect laryngoscopy:** In this exam, the doctor uses special small mirrors to view the larynx and nearby areas.

Both types of exams can be done in the doctor’s office. For either type of exam, the doctor may spray the back of your throat with numbing medicine to help make the exam easier.

Patients with laryngeal or hypopharyngeal cancer also have a higher risk for other cancers in the head and neck region, so the nasopharynx (part of the throat behind the nose), mouth, tongue, and the neck are also carefully looked at and felt for any signs of cancer.

**Panendoscopy**

Panendoscopy is a procedure that combines laryngoscopy, esophagoscopy, and (at times) bronchoscopy. This lets the doctor thoroughly examine the entire area around the larynx and hypopharynx, including the esophagus and trachea (windpipe).

This exam is usually done in an operating room while you are under general anesthesia (asleep). The doctor uses a rigid laryngoscope to look for tumors in the larynx and hypopharynx. Other parts of the mouth, nose, and throat are examined as well. The doctor may also use an endoscope to look into the esophagus or a bronchoscope to look into the trachea (windpipe).

Your doctor will look at these areas through the scope(s) to find any tumors, see how large they are, and see how far they have spread to surrounding areas. The doctor might also remove (biopsy) small tissue samples from any tumors or other abnormal areas using special instruments operated through the scopes.

**Biopsies to diagnose laryngeal and hypopharyngeal cancers**

In a biopsy, the doctor removes a sample of tissue to be looked at under a microscope. It is the only way to confirm the diagnosis of laryngeal or hypopharyngeal cancer. There are different types of biopsies.

See **Testing Biopsy and Cytology Specimens for Cancer** to learn more about
different types of biopsies, how the tissue is used in the lab for disease diagnosis, and what the results will tell you.

**Endoscopic biopsy**

The larynx and hypopharynx are deep inside the neck, so removing samples for biopsy can be complex. Biopsies of these areas are done in the operating room while you are under general anesthesia (asleep), rather than in a doctor's office. The surgeon uses special instruments through a rigid laryngoscope (or other type of endoscope) to remove small tissue samples.

**Fine needle aspiration (FNA) biopsy**

This type of biopsy is not used to remove samples in the larynx or hypopharynx, but it may be done to find the cause of an enlarged lymph node in the neck. A thin, hollow needle is placed through the skin into a mass (or tumor) to get cells for a biopsy. The cells are then looked at under a microscope. If the FNA finds cancer, the pathologist (doctor examining the samples with a microscope) can often tell what type of cancer it is. If the cancer cells look like they might have come from the larynx or hypopharynx, an endoscopic exam and biopsy of these areas will be needed as well.

If the FNA does not find cancer, it only means that cancer was not found in that lymph node. Cancer could still be present in other places. If you are having symptoms that might be from a laryngeal or hypopharyngeal cancer, you could still need other procedures to find the cause of the symptoms.

FNA biopsies may also be useful in some patients already known to have laryngeal or hypopharyngeal cancer. If the person has a lump in the neck, an FNA can help determine if the mass is due to spread of the cancer. FNA may also be used in patients whose cancer has been treated by surgery and/or radiation therapy, to help find out if a neck mass in the treated area is scar tissue or if it is a return (recurrence) of the cancer.

**Imaging tests**

Imaging tests use x-rays, magnetic fields, or radioactive substances to create pictures of the inside of your body. Imaging tests are not used to diagnose laryngeal or hypopharyngeal cancers, but they may be done for a number of reasons both before and after a cancer diagnosis, including:
To help look for a tumor if one is suspected
To learn how far cancer may have spread
To help determine if treatment has been effective
To look for possible signs of cancer recurrence after treatment

**Computed tomography (CT) scan**

The CT scan (also known as a CAT scan) uses x-rays to produce detailed cross-sectional images of your body. Instead of taking one picture like a standard x-ray, a CT scanner takes many pictures of the part of your body being studied as it rotates around you. A computer then combines these pictures into an image of a slice of your body. Unlike a regular x-ray, a CT scan creates detailed images of the soft tissues and organs in the body.

This test can help your doctor determine the size of the tumor, if it is growing into nearby tissues, and if it has spread to lymph nodes in the neck. It may also be done to look for spread of cancer to the lungs.

A CT scanner has been described as a large donut, with a narrow table in the middle opening. You will need to lie still on the table while the scan is being done. CT scans take longer than regular x-rays, and you might feel a bit confined by the ring while the pictures are being taken.

You may be asked to drink 1 to 2 pints of a liquid called *oral contrast* before the test. This helps outline the digestive tract so that certain areas are not mistaken for tumors. You may also receive an IV (intravenous) line through which a different kind of contrast dye (*IV contrast*) is injected. This helps better outline other structures in your body. Some people are allergic to the dye and get hives, a flushed feeling, or, rarely, more serious reactions like trouble breathing and low blood pressure. Be sure to tell your doctor if you have any allergies or have ever had a reaction to any contrast material used for x-rays.

**Magnetic resonance imaging (MRI) scan**

MRI scans use radio waves and strong magnets instead of x-rays. The energy from the radio waves is absorbed and then released in a pattern formed by the type of tissue and by certain diseases. A computer translates the pattern into a very detailed image of parts of your body. A contrast material may be injected just as with CT scans, but it is used less often.

Because it provides a very detailed picture, an MRI scan may be done to look for
spread of the cancer in the neck. These scans can be very useful in looking at other areas of the body as well.

MRI scans are a little more uncomfortable than CT scans. First, they take longer – often up to an hour. Second, you have to lie inside a narrow tube, which is confining and can upset people with claustrophobia (a fear of enclosed spaces). Newer, more open MRI machines can sometimes help with this if needed, although the images may not be as sharp in some cases. MRI machines make buzzing and clicking noises, so some centers provide earplugs to help block this noise out.

**Barium swallow**

This is often the first test done if someone is having a problem with swallowing. For this test, you drink a chalky liquid called barium to coat the walls of the throat and esophagus. A series of x-rays of the throat and esophagus is taken as you swallow. The barium can help show abnormal areas in the throat.

**Chest x-ray**

A chest x-ray may be done to see if the cancer has spread to the lungs. If any suspicious spots are seen on the chest x-ray, a CT scan of the chest may be needed to get a more detailed picture.

**Positron emission tomography (PET) scan**

For a PET scan, a form of radioactive sugar (known as fluorodeoxyglucose or FDG) is injected into the blood. The amount of radioactivity used is very low. Cancer cells in the body grow quickly, so they absorb large amounts of the radioactive sugar. After about an hour, you will be moved onto a table in the PET scanner. You lie on the table for about 30 minutes while a special camera creates a picture of areas of radioactivity in the body. The picture is not finely detailed like a CT or MRI scan, but it provides helpful information about your whole body.

A PET scan may be used to look for possible areas of cancer spread, especially if there is a good chance that the cancer is more advanced. This test can also be used to help tell if a suspicious area seen on another imaging test is cancer or not.
Some newer machines can do both a PET and CT scan at the same time (PET/CT scan). This lets the doctor compare areas of higher radioactivity on the PET with the more detailed appearance of that area on the CT.

For more information on these tests, see Imaging (Radiology) Tests.

**Other tests**

Other types of tests may be done as part of a workup in people diagnosed with laryngeal or hypopharyngeal cancer. These tests are not used to diagnose the cancer, but they may be done to see if a person is healthy enough for other treatments, such as surgery or chemotherapy.

Blood tests are often done to check liver and kidney function, as well as to help evaluate your overall health before treatment. Blood tests are also needed if you are getting chemotherapy because chemo can affect the levels of blood cells in the body.

If surgery is planned, you might also have an electrocardiogram (EKG) to make sure your heart is functioning well. Some people having surgery also may need tests of their lung function. These are known as pulmonary function tests (PFTs).

- References
See all references for Laryngeal and Hypopharyngeal Cancer

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**How Are Laryngeal and Hypopharyngeal Cancers Staged?**

The stage (extent of spread) of laryngeal or hypopharyngeal cancer is one of the most important factors in selecting treatment options and estimating a person’s outlook (prognosis). Laryngeal and hypopharyngeal cancers are staged based on
the results of exams, imaging tests, endoscopies, and biopsies, which are described in “How are laryngeal and hypopharyngeal cancers diagnosed?”

If you have laryngeal or hypopharyngeal cancer, ask your cancer care team to explain the stage of your cancer in a way that you understand. Knowing all you can about the stage can help you take a more active role in making informed decisions about your treatment.

The TNM staging system

A staging system is a way for members of the cancer care team to sum up the extent of a cancer’s spread. The most common system used to describe cancer stages is the American Joint Committee on Cancer (AJCC) TNM system. For laryngeal and hypopharyngeal cancers, the TNM system is based on 3 key pieces of information:

- **T** stands for tumor (its size and how far it has spread within the larynx or hypopharynx and to nearby organs).
- **N** stands for spread to nearby lymph nodes in the neck. (Cancers often first spread to lymph nodes, which are bean-sized collections of immune system cells.)
- **M** is for metastasis (spread to distant organs). These cancers most often spread to the lungs, although they may also spread to the bones, liver, or other organs.

**T groups for laryngeal and hypopharyngeal cancers**

The T group describes how far the cancer has spread within the larynx or hypopharynx and to any nearby structures. This is based on the results of exams such as laryngoscopy and on any imaging tests of the area, such as CT or MRI scans. Higher T group numbers mean more advanced spread.

The T group of laryngeal cancer also depends on the movement of the vocal cords. The doctor will watch the vocal cords with an endoscope or special mirrors while the person makes certain sounds. If the vocal cords move normally, the cancer probably has not affected deeper tissues. If a vocal cord isn’t moving normally (vocal cord fixation) it can be because cancer is growing into it.

The features used to assign the T group of laryngeal cancer are based on the area of the larynx involved (supraglottis, glottis, or subglottis). The T groups for
hypopharyngeal cancer differ from those for cancer of the larynx.

**T groups common to all laryngeal and hypopharyngeal cancers**

**TX:** Not enough information available to stage the tumor

**T0:** No tumor can be found

**Tis:** Carcinoma in situ. The cancer cells are only growing in the inner lining layer (the epithelium) of the larynx or hypopharynx, with no cancer growing into the underlying connective tissue. (Very few hypopharyngeal and larynx cancers are found at this early stage.)

**T groups for supraglottic cancer**

For cancer of the supraglottis (the area above the vocal cords), the T group is based on how many different parts (or sites) of the larynx the cancer has reached and how far outside the larynx the cancer has spread. The 5 subsites of the supraglottic part of the larynx are:

- The false vocal cords (or ventricular bands)
- Arytenoids
- Suprahystoid epiglottis
- Infrahystoid epiglottis
- Aryepiglottic folds

Vocal cord movement is also considered. When the vocal cords do not move normally it often means that the cancer is growing into them and is therefore more advanced.

**T1:** The vocal cords move normally and the tumor is only in 1 subsite of the supraglottis.

**T2:** The tumor is in at least 2 subsites of the supraglottis (or glottis). The vocal cords still move normally.

**T3:** One or both of the following applies:

- The tumor is only in the larynx but has caused a vocal cord to stop moving.
- The tumor is growing into nearby areas such as the postcrioid area, paraglottic space, pre-epiglottic (in front of the epiglottis) tissues, or the inner
part of the thyroid cartilage (firm tissue that separates the thyroid gland from the front of the larynx).

**T4a:** The tumor is growing through the thyroid cartilage and/or is growing into tissues beyond the larynx (such as the thyroid gland, trachea, esophagus, tongue muscles, or neck muscles). This is known as *moderately advanced local disease*.

**T4b:** The tumor is growing into the tissue in front of the spine in the neck (the prevertebral space), surrounds a carotid artery, or is growing down into the space between the lungs. This is also known as *very advanced local disease*.

**T groups for glottic cancer**

These cancers start in the glottis – the part of the larynx that includes the vocal cords.

**T1:** The tumor is only in the vocal cord(s). The vocal cords move normally.

**T2:** One or both of the following applies:

- The tumor is growing into the supraglottis and/or subglottis.
- The vocal cords do not move normally.

**T3:** One or more of the following applies:

- The tumor is only in the larynx but has caused a vocal cord to stop moving.
- The tumor is growing into the paraglottic space.
- The tumor is growing into the inner part of the thyroid cartilage (firm tissue that separates the thyroid gland from the front of the larynx).

**T4a:** The tumor has grown through the thyroid cartilage and/or is growing into tissues beyond the larynx (such as the thyroid gland, trachea, esophagus, tongue muscles, or neck muscles). This is known as *moderately advanced local disease*.

**T4b:** The tumor is growing into the tissue in front of the spine in the neck (the prevertebral space), surrounds a carotid artery, or is growing down into the space between the lungs. This is also known as *very advanced local disease*.

**T groups for subglottic cancer**

These cancers start in the subglottis – the part of the larynx below the vocal cords.
**T1:** The tumor is only in the subglottis.

**T2:** The tumor has grown from the subglottis to the vocal cords, with normal or reduced vocal cord movement.

**T3:** The tumor is growing only in the larynx but has caused a vocal cord to stop moving.

**T4a:** The tumor is growing through the cricoid or thyroid cartilage and/or is growing into tissues beyond the larynx (such as the thyroid gland, trachea, esophagus, tongue muscles, or neck muscles). This is known as *moderately advanced local disease*.

**T4b:** The tumor is growing into the tissue in front of the spine in the neck (the prevertebral space), surrounds a carotid artery, or is growing down into the space between the lungs. This is also known as *very advanced local disease*.

**T groups for hypopharyngeal cancer**

Spread of cancer within the hypopharynx is described based on the size of the tumor and how many areas (subsites) of the hypopharynx are involved by the cancer. The 3 subsites of the hypopharynx are the:

- Pyriform sinuses
- Lateral (side) and posterior (back) hypopharyngeal walls
- Pharyngo-esophageal junction (where the throat and esophagus meet)

**T1:** The tumor is only in 1 subsite of the hypopharynx and it is 2 centimeters (cm) (about ¾ of an inch) across or smaller.

**T2:** One or more of the following applies:

- The tumor in in 2 or more subsites of the hypopharynx.
- The tumor is in 1 subsite plus an area nearby.
- The tumor is more than 2 cm but not more than 4 cm (about 1½ inches) across, and the vocal cords move normally.

**T3:** One or more of the following applies:

- The tumor is larger than 4 cm across.
- The tumor is affecting the movement of vocal cords.
- The tumor has grown into the esophagus.
**T4a:** The tumor is growing into the cricoid or thyroid cartilage, hyoid bone, thyroid gland, or the strap muscles or fat in front of the larynx. This is known as *moderately advanced local disease.*

**T4b:** The tumor is growing into the space in front of the spine in the neck, surrounds a carotid artery, or is growing down into the space between the lungs. This is also known as *very advanced local disease.*

### N groups for laryngeal and hypopharyngeal cancers

The N groups are based on spread of the cancer to nearby (regional) lymph nodes and on the size of the nodes. These groups are the same for all laryngeal and hypopharyngeal cancers:

**NX:** The lymph nodes cannot be assessed (information not available).

**N0:** There is no evidence the cancer has spread to the lymph nodes.

**N1:** The cancer has spread to a single lymph node on the same side of the neck as the tumor. The lymph node is not larger than 3 cm (about 1¼ inch) across.

**N2:** Separated into 3 sub-groups:

- **N2a:** The cancer has spread to a single lymph node on the same side of the neck as the tumor. The lymph node is larger than 3 cm but not larger than 6 cm across.
- **N2b:** The cancer has spread to 2 or more lymph nodes on the same side of the neck as the tumor. None of these lymph nodes is larger than 6 cm across.
- **N2c:** The cancer has spread to lymph nodes on the side of the neck opposite the tumor or on both sides of neck. None of these lymph nodes is larger than 6 cm across.

**N3:** The cancer has spread to at least 1 lymph node that is larger than 6 cm across.

### M groups for laryngeal and hypopharyngeal cancers

The M groups for all laryngeal and hypopharyngeal cancers are the same:

**M0:** The cancer has not spread to distant sites.
M1: The cancer has spread to distant sites.

Stage grouping

Once the T, N, and M groups have been assigned, this information is combined to assign an overall stage for the cancer. This process is called stage grouping. Stage grouping rules are the same for all cancers of the hypopharynx and the supraglottic, glottic, and subglottic areas of the larynx.

Stage 0: Tis, N0, M0

Stage I: T1, N0, M0

Stage II: T2, N0, M0

Stage III: T3, N0, M0, OR T1 to T3, N1, M0

Stage IVA: T4a, N0 or N1, M0, OR T1 to T4a, N2, M0

Stage IVB: T4b, Any N, M0, OR Any T, N3, M0

Stage IVC: Any T, Any N, M1

In general, patients with lower stage cancers tend to have a better outlook for a cure or long-term survival.

- References
  See all references for Laryngeal and Hypopharyngeal Cancer

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Survival Rates for Laryngeal and Hypopharyngeal Cancers by Stage
Survival rates are often used by doctors as a standard way of discussing a person's prognosis (outlook). Some patients with cancer may want to know the survival statistics for people in similar situations, while others may not find the numbers helpful, or may even not want to know them. If you do not want to know the survival statistics for laryngeal and hypopharyngeal cancers, stop reading here and skip to the next section.

The 5-year survival rate refers to the percentage of patients who live at least 5 years after their cancer is diagnosed. Of course, many of these people live much longer than 5 years.

Five-year relative survival rates, such as the numbers below, assume that some people will die of other causes and compare the observed survival with that expected for people without the cancer. This is a more accurate way to describe the prognosis for patients with a particular type and stage of cancer.

To get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. Improvements in treatment since then may result in a better outlook for people now being diagnosed with these cancers.

The rates below are based on the stage of the cancer at the time of diagnosis. When looking at survival rates, it’s important to understand that the stage of a cancer does not change over time, even if the cancer progresses. A cancer that comes back or spreads is still referred to by the stage it was given when it was first found and diagnosed, but more information is added to explain the current extent of the cancer. (And of course, the treatment plan is adjusted based on the change in cancer status.)

These numbers are from the National Cancer Data Base, based on patients diagnosed in 1998-1999, and published in 2010 in the AJCC Cancer Staging Manual, Seventh Edition (see the “References: Laryngeal and hypopharyngeal cancer detailed guide.” For laryngeal cancers, survival rates differ based on which part of the larynx the cancer started in (supraglottis, glottis, or subglottis).

### Supraglottis (part of the larynx above the vocal cords)

<table>
<thead>
<tr>
<th>Stage</th>
<th>5-year relative survival rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>59%</td>
</tr>
<tr>
<td>II</td>
<td>59%</td>
</tr>
<tr>
<td>III</td>
<td>53%</td>
</tr>
<tr>
<td>IV</td>
<td>34%</td>
</tr>
</tbody>
</table>
Glottis (part of the larynx including the vocal cords)

- Stage
- I 5-year relative survival rate
  - 90%
- II
  - 74%
- III
  - 56%
- IV
  - 44%

Subglottis (part of the larynx below the vocal cords)

(These numbers are less accurate because of the small number of patients.)

- Stage
- I 5-year relative survival rate
  - 65%
- II
  - 56%
- III
  - 47%
- IV
  - 32%

Hypopharynx

- Stage
- I 5-year relative survival rate
  - 53%
- II
  - 39%
- III
  - 36%
- IV
  - 24%

Survival rates are based on previous outcomes of large numbers of people who had the disease, but they cannot predict what will happen in any person’s case. Many other factors can affect a person’s outlook, such as their general health and how well the cancer responds to treatment. Your doctor can tell you how the numbers above apply to you, as he or she is familiar with your situation. If you have any questions about the stage of your cancer or how it affects your treatment, do not hesitate to ask your doctor.

- References
See all references for Laryngeal and Hypopharyngeal Cancer

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What Should You Ask Your Doctor About Laryngeal or Hypopharyngeal Cancer?

It is important to have frank, open discussions with your cancer care team. They want to answer all of your questions, no matter how minor they might seem. For instance, consider these questions:

- Where is my cancer located?
- Has my cancer spread beyond where it started?
- What is the stage of my cancer, and what does that mean?
- Do I need other tests before we can decide on treatment?
- Are there other doctors I need to see?
- How much experience do you have treating this type of cancer?
- What treatment choices do I have?
- Are you aware of any clinical trials I might be eligible for?
- What do you recommend and why?
- What is the goal of the treatment?
- What are the chances my cancer can be cured with treatment?
- How quickly do we need to decide on treatment?
- What should I do to be ready for treatment?
- How long will treatment last? What will it involve? Where will it be done?
- What risks or side effects that I should expect? How long are they likely to last?
- How will this treatment affect my voice? If my larynx is removed, what are the options for restoring my voice?
- How will treatment affect my daily activities?
- What can we do if the treatment doesn’t work or if the cancer recurs?
- What type of follow-up will I need after treatment?
- Where can I find more information and support?

Along with these sample questions, be sure to write down some of your own. For instance, you might want more information about recovery times so that you can...
plan your work or activity schedule. Or you may want to ask about getting a second opinion.

- References
See all references for Laryngeal and Hypopharyngeal Cancer

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