Eating and swallowing dysfunctions manifest due to oral, lingual, pharyngeal and laryngeal movement disorders postoperatively, decreasing patient quality of life. When radiotherapy is performed for head and neck cancers, mucositis can cause pain, decreased lingual motor function, and delayed swallowing reflex, creating a risk of decreased eating and swallowing functions. Risks of aspiration pneumonia and respiratory complications can be reduced postoperatively in patients with thoracic esophageal cancer and head and neck cancers if eating and swallowing assessment and rehabilitation are performed (Recommendation: Grade B).

In the case of resection and reconstructive surgery for thoracic esophageal cancer and head and neck cancers, postoperative evaluation of swallowing function and determination of whether a risk of aspiration exists is important. Videofluoroscopic and videoendoscopic examination of swallowing are proactively used to evaluate swallowing functions (Grade B).

Oral intake can be resumed earlier if evaluation of the oral and swallowing functions and eating and swallowing rehabilitation are implemented in relation to dysphagia manifesting postoperatively in patients with tongue, oral, and pharyngeal cancer (Grade B). Selection of a suitable form of food and maintaining a suitable position during eating is thus important, as is nutritional management using a team-based approach.

Vocal and articulation training following surgery for tongue and oral cancer leads to improved speech intelligibility (Grade B). The electronic artificial larynx is the most widely used method for voice restoration following laryngectomy. Esophageal speech is a technique by which the patient draws air through the mouth into the upper esophagus, then creates sound by returning the air to the mouth. Compared with an electronic artificial larynx and esophageal speech, shunt speech is phonokinetically superior, enabling earlier resumption of vocal communication after surgery.