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Nightingale University

Dysphagia Management

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SECOND YEAR IN A ROW

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Dysphagia

1. Dysphagia, or difficulty swallowing, affects 15% of those 60+ years old
2. 40% of patients in assisted living, nursing homes, group homes, etc.
3. Swallowing is a complex task involving more than 50 pairs of muscles and several cranial nerves.
4. Impairment of swallow function increases risk of serious medical condition as well as results in concern for meeting adequate nutrition

Three Stages of Dysphagia

1. Oral Stage
2. Pharyngeal Stage
3. Esophageal Stage

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Oral Stage

Begins when the bolus enters the oral cavity and mixes with saliva to form a cohesive bolus.

Symptoms of Oral Stage Difficulty :

Decreased bolus management, inability to manage secretions, pocketing, difficulty chewing, leakage

Pharyngeal Stage

1. Begins when bolus is propelled to oropharynx and swallow reflex is triggered
2. The soft palate elevates to to prevent nasal regurgitation
3. Hyoid bone and larynx are pulled upward and forward and the vocal folds adduct.
4. The epiglottis retroverts and protects the airway.
5. The posterior tongue base propels the food through the pharynx along with peristaltic wave contraction of the posterior pharyngeal wall.
6. Symptoms of deficits include: coughing/choking while eating, wet vocal quality, Spiking high grade temp after meals, pain during swallow, nasal regurgitation, change in respirations during meals, frequent RLL pna

Esophageal Stage

1. As the food passes through the pharynx to the esophagus, the UES relaxes allowing food to pass through into the esophagus.
2. Peristaltic wave contractions continue to propel the food into the stomach.
3. The LES (juncture of esophagus and stomach) opens to allow the entry of the food into the stomach.
4. The LES then closes to prevent reflux.
5. Symptoms of Deficits: Reflux, strictures, Hiatal Hernia, complaint that food is “sticking in throat”

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Common Causes of Dysphagia

1. Neurological disorders such as CVA, TBI, Parkinson's Disease, etc.
2. COPD
3. Head and Neck Cancer
4. Esophageal Disorders
5. Trach/Vent
6. Dementia
7. Medications can cause xerostomia

Aspiration vs. Silent Aspiration

1. Aspiration is commonly followed by a cough or overt symptom. Silent Aspiration is without obvious reaction.
2. Many factors involved when assessing aspiration.
3. How the body processes the bacteria is of concern. Bacterial organisms CAN potentially cause pneumonia.

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The role of the SLP

1. The SLP evaluates the swallow and determines the deficits.
2. The SLP may recommend diet texture modifications and strategies
3. The SLP may recommend videofluoroscopic swallowing evaluation or referral to GI doctor or ENT.
4. The SLP may teach strategies to the patient, provide treatment or provide education to caregivers by teaching cueing strategies.

What can the SLP do to help?

1. The goal of the dysphagia eval is NOT TO DETERMINE IF A PERSON IS ASPIRATING OR NOT.
2. The goal is to determine how the person can eat safely by mouth.

What does the SLP determine?

1. Diet texture modifications
2. Level of supervision required
3. What compensatory strategies will be helpful to REDUCE the risk of aspiration
4. Whether treatment is warranted or implication of strategies

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Common confusion with dysphagia diets

1. Avoid mixed consistencies
2. Ice cream and jello are never allowed for those on thick liquid diets
3. Medications should be given in thick liquid or purees for those on thick liquid diets

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Treating Dysphagia

1. Once the deficits are determined, several treatment options are to be considered by the SLP
2. For decreased strength, exercises may be suggested.
3. Compensatory techniques may be implemented to decrease risk of aspiration.
4. Neuromuscular Electrical Stimulation-new treatment which allows the SLP to stimulate the musculature for swallowing. Patient must have intact neurons for swallow

Patients Appropriate for Dysphagia Treatment

1. Must be able to participate in therapy neurologically and retain strategies taught
2. Treatment includes training the patient, the family or both for strategy implementation
3. Patients with Dementia, poor cognitive function may only benefit from cueing by caregiver

Referrals to other professionals

1. If patient requires long term non oral nutrition, the SLP will refer to Dietician.
2. If Esophageal Stage disorders are determined, the SLP will refer to the GI physician who may refer back after intervention for the SLP to educate.
3. If adaptive equipment is necessary or positioning, the SLP may refer to OT.