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GSHA Pre-convention
Presentation

Why are we doing, what we are doing?

Dispelling Prevalent Myths in Dysphagia Assessment and Treatment

Relevant Financial Disclosures

- The Georgia Speech-Language Hearing Association is providing me lodging during the convention and attendance at the Annual Convention
- I am currently employed as the Agency Administrator for Integra Rehabilitation
- I provide Flexible Endoscopic Examination of Swallowing (FEES) for Integra Rehabilitation's contracted customers.
- Integra Rehabilitation is a sponsor of events at this convention, including this presentation.

Relevant Non-Financial Disclosures

- Past-President of GSHA and have held various other positions both elected and appointed within the organization since 2004
- Recently appointed the StAMP (State Advocates for Medicare Policy) for the state of GA

This presentation started in 1997 while I was a student at Valdosta State University...



It started in my motor speech disorders class...

- ✓ We learned about this illness that some people have called "dysphagia"
- ✓ We were introduced to altered diets, thickening liquids, and some really odd utensils
- ✓ We talked about this "technique" for making your swallowing better called Thermal Tactile Stim
- ✓ Chin Tucks and Modified Barium Swallow Studies were in there somewhere as well

Oh, and by the way...

EVERYTHING we got about swallowing and swallowing disorders was presented over the course of about three 2 ½ hour classes.

BUT something hooked me!

So I did my externship at a Skilled Nursing Facility

- I had a great experience with a great CF supervisor
- LOTS and LOTS of dysphagia
- I did not have a clue what I was doing
- MDs did not like to give orders for "swallow studies".
- I remember one MD made the comment that "dysphagia was just something that SLPs made up in order to bill Medicare."



After my clinical fellowship I took a job with Integra Rehabilitation...



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- I was continuing to get my feet wet and seeking out mentors for dysphagia.
- I took a job traveling between five skilled nursing facilities doing mainly dysphagia therapy.
- I was changing diets, teaching chin tucks, meeting with families, doing what I thought was "good" therapy.

I really was hungry to learn more and so I threw myself into reading literature and attending CEUs

- My very first CEU course was Deep Pharyngeal Neuromuscular Stimulation (don't judge me)
- At a course with Nancy Swigert in the early 2000's, she made a huge impression on me as she talked about how Flexible Endoscopic Examination of Swallowing would one day become more wide spread and available.
- It started sinking in that being able to get a "visualization" was important



I thought I was a good therapist BUT I felt like something was missing...

In 2007, I decided that I HAD to get experience with videofluoroscopy and that I wanted to get experience with a different population. So, I resigned full time with Integra and took a job with Meadow's Memorial.

For about a year, I learned and performed videofluoroscopy in addition to hospital, outpatient, and SNF work...

- Regularly saw PCU, acute care, outpatient, and skilled nursing unit patients
- Got tons of experience and cemented my professional focus on swallowing disorders
- Knew that swallowing and swallowing disorders was what I wanted to do
- ...and in particular, I liked doing videofluoro, treating dysphagia, and being involved with radiology.
- Doing MBSs at the hospital is when it clicked...
- I realized you simply can't do therapy that is beneficial if you don't have good visualizations

What is the history of SLPs and Swallowing Disorders?

- SLPs have been involved with "feeding and swallowing" since the 1930s
 - Initially with oral motor disorders in children with cerebral palsy
 - Typically these interventions occurred in conjunction with speech disorders only
 - A pattern of involvement with children and adults with developmental disorders was the norm for decades
 - These children and adults were managed

(CONT)

Our history continued...

- The unique combination of skills made us the ideal profession to address swallowing issues in developmentally delayed/disordered populations population.

We utilized clinical assessment and skills from –

- Special Education
- Neurology
- Otolaryngology
- Behavioral Psychology

It is like speech-language pathologists were “made” to address swallowing disorders!

(CONT)

History continued...

- Our evolution over the 60’s, 70’s, and 80’s was noticed and encourage by various organizations and government entities.

- We started branching out into acquired disorders and treating more of the population, both children and adults
- We started to become professionals of REHABILITATION vs HABILITATION
- Much of the work that would transition us into adult rehabilitation occurred in the Veteran Administration system and one of the first recognized pioneers in swallowing was George L. Larson, Ph. D., SLP

- Dr. Larson worked in the Seattle VA system and brought clinical insight into developing protocols and treatments for those with acquired swallowing disorders

(CONT)

History continued...

- While Larson was definitely a pioneer, there is no doubt that Jeri A Logemann, Ph. D., SLP brought us into the modern era.

- She “invented” imagining and systematic approaches to swallow interventions

- Larson was described as having an “artistic and intuitive” approach while Logemann’s approach was systematic and intuitive.

- The development of the MBSS (modified barium swallow study) and descriptions of what normal and abnormal swallowing looked like cemented the SLP profession firmly as the preferred provider of dysphagia services

Miller RM and Groher ME: Speech-language pathology and dysphagia: a brief historical perspective. Dysphagia. 1993;8(3): 180-4



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In 1987, President Ronald Reagan signed into law the first major revision of the federal standards for nursing home care since the 1965 creation of both Medicare and Medicaid 42 U.S.C.1396r, 42 U.S.C. 1395i-3, 42 CFR 483. The landmark legislation changed forever society's legal expectations of nursing homes and their care. Long term care facilities wanting Medicare or Medicaid funding are to provide services so that each resident can "attain and maintain her highest practicable physical, mental, and psycho- social well-being." Omnibus Budget Reformation Act of 1987

<http://www.ncmust.com/doclib/OBRA87summary.pdf>

Affects of opening services more broadly for SLPs...

1. Mostly positive! Rehabilitation and maintenance was an expectation in our SNFs and hospital settings. Yippee!!!
2. Expanded the job market for SLPs and there was a spike in demand for dysphagia services. Yippee!!!
3. Unfortunately, practices were not always based on research, literature, or best practices. Boo.
4. Many SLPs providing services simply were not up to date with best practices. Boo.



The Rise of Corporate Long Term Care Providers came to be...

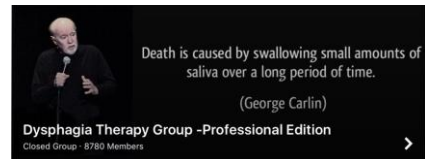
- In speaking with several SLPs that were practicing during the 70's, 80's and early 90's in healthcare settings, it became clear that providing services was a little like the Wild West during that time.
- No limits or caps on payment
- No consistent oversight initially
- Seemingly unlimited therapy
- No real measure of what was "good" dysphagia care
- No real measure of what was outcomes

"We had to have a speech or language impairment to treat swallow. It was basically diet modification. I had a class in college but that was back in the day of cine radiography. We learned from the Logemann book, but we were basically told we would probably only see swallow problems to treat in kids with CP.

1989 is when we could treat swallow without speech disorder. Then it was Johnny bar the door. We were told (by our employers) to keep patients on for 6 months for diet monitoring. It was nuts."

"I'm 66. I worked in a Rehab Center for TBI from 1982-1993. I'm not really sure when we started to do swallowing Evals. I did not have a course in it. But mostly we did just clinical Evals and fed people small amounts of puréed. We did though start doing MBS studies at a hospital near by. Even with Level 3 (ranchos scale). Most of our patients had G-tubes that were lower level. But we did 'stim feelings' and trained the family right away because that was the biggest thing with the mothers- if they could eat, they'd get better was their thinking, it gave the families something to do and they felt better then about the situation. We did lots of sensory stim programs and 'feeding' was part of that. My facility was one of 6 in the USA for a long time. We had lots of people from Canada and from all over the country. While we did work on swallowing in a sense it wasn't all that sophisticated back then. Although a few of us did go to see Jeri Logemann; and we did thermal stim, etc."

I posed a question on Facebook...



The question was simply this...

What practices do you see going on in the world of dysphagia that are erroneous, but despite being inaccurate are still provided?

In other words... What myths about dysphagia assessment and treatment do you see perpetuated?

The post got an amazing response. Many myths, much erroneous information, and outright misinformation was discussed...

- Almost 300 separate responses were posted...
- Many misconceptions and myths were hashed about, but they tended to focus on...
- How we evaluate and make decisions about our patients.
- What therapy techniques do and do not work
- What role visualizations should play in our decision making

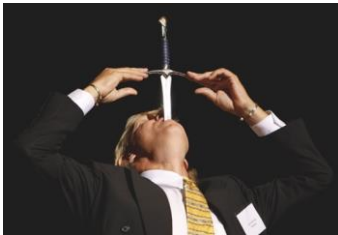
#1

My patient doesn't have a gag reflex or it is very weak. They are unsafe to eat an oral diet and can't swallow safely.

A "Gag Reflex" is an inaccurate and unreliable sign of underlying dysphagia

- Decreased "gag reflex" may occur in conjunction with swallowing problems in some individuals. It means absolutely nothing in other individuals.
- How do you know if a person's "gag reflex" is decreased if you never measured how prominent their gag was prior to becoming sick or impaired?
- There is a range of potential malfunctions in the "gag reflex". Patients can become hypofunctional or they could be hyperfunctional. Again, what was their baseline?
- The literature is all over the place on what the gag does and does not tell us. Basing decisions about swallowing management on just how the clinician perceives the "gag reflex" is unfair to the patient.

Early Assessments of Dysphagia and Aspiration Risk in Acute Stroke Patients [Oshiro JJ, Sumo M, Boyd G. Stroke. 2003; 34: 1252-1257](#) Published online before print April 3, 2003; doi: 10.1161/01.STR.0000083202.61490.85



Ramsey DJC, Smithard DG, and Kalra L. Early Assessments of Dysphagia and Aspiration Risk in Acute Stroke Patients. *Stroke*. 2003; 34: 1252-1257

#2

My patient has a right lower lobe pneumonia. They definitely are aspirating food and drink.

RLL Pneumonia's are not universally related to the inhalation of food.

- Aspiration produces pneumonitis in gravity dependent parts of the lung
- Not all aspiration is food related. Normal secretions can be a source of aspiration.
- How the patient is positioned can affect where gravity pulls aspirated material whether it is food or secretion related.

Coyle J. Pulmonary Systems and Diseases. ASHA Convention. 2007

#3

In order to screen patients for silent aspiration, look for “watery eyes and a runny nose” during meals.

Let's put an end to this one... it is simply not true!

- The phenomenon of having nasal discharge and watery eyes during or after meal intake is call "gustatory rhinitis"
- There are several types of rhinitis, but "gustatory rhinitis" is caused by stimulation of sensory nerves and results in the nasal drip and tearing of the eyes we as SLP are so often asked to use as an indication of a swallowing problem.
- ASPIRATION HAS NOTHING TO DO WITH IT!!!

J Allergy Clin Immunol. 1989 Jan;83(1):110-5. Gustatory rhinitis: a syndrome of food-induced rhinorrhea. Raphael G(1), Raphael MH, Kaliner M.

Copied and pasted from SIG13, 1/23/15:

"There is absolutely, positively, no scientific evidence that a runny nose (rhinorrhea) or "watery eyes" are signs of aspiration, and most especially, silent aspiration." -Dr. James Coyle

Brenda's Video

#4

I have a dementia patient that is getting pneumonia over and over again. They could probably benefit by ceasing PO intake and using a Gtube to decrease their risk.

"Aspiration is one of the most important and controversial complications in patients receiving enteral nutrition, and is among the leading causes of death in tube-fed patients due to aspiration pneumonia."

Management of Feeding Tube Complications in the Long-Term Care Resident. Friday, September 5, 2008 - 17:54 Author(s): Shai Gavi, DO, MPH, Jennifer Hensley, MD, Frank Cervo, MD, Catherine Nicastrì, MD, and Suzanne Fields, MD Issue Number: [Volume 16 - Issue 4 - April, 2008](#)

"A demented patient with eating difficulty can present formidable clinical challenges. We believe that a comprehensive, motivated, conscientious program of hand feeding is the proper treatment. If the patient continues to decline in some clinically meaningful way, tube feeding might be considered as empirical treatment; however, all who help make the decision should be clearly informed that the best evidence suggests it will not help."

Tube Feeding in Patients With Advanced Dementia: A Review of the Evidence Thomas E. Finucane; Colleen Christmas; Kathy Travis *JAMA*. 1999;282(14):1365-1370 (doi:10.1001/jama.282.14.1365)

#5

In my facility, we regularly change our residents diets that have swallowing difficulty to thickened liquids. If their swallow is really bad, we use honey and pudding thick liquids to help keep them as safe as possible.

Thicker is not necessarily better...

- Use of thickened liquids should be assessed visually, not just arbitrarily prescribed to patients.
- In the frail elderly or frail "very sick" population, dehydration is a very real concern...
- In my opinion, those on thicker viscosities should be screened often and regularly to assure that they are absolutely needed
- We have to consider what we are "preventing" when using thickened liquids of any kind and in particular VERY thick liquids that are far removed from thin.
- Is the cure worse than the disease?

Consider what you are trying to accomplish with thickened liquids...

- Aspiration is not the only determining factor in who gets pneumonia
- Increase in "behaviors" and acting out
- Restrictive diets often result in power struggles among staff, caregivers, the clinician, and the patient
- The American Speech-Language Hearing Association guides that we are responsible for other aspects of diet changes beyond just "preventing aspiration"
- What is the point of stopping aspiration if we only substitute it with other problems. Clear Lungs, failing kidneys?

<http://www.gcripal.org/2015/01/do-thickened-liquids-help-people-with-dysphagia.html>

#6

Straws should just be banned for the sick and elderly... they lead to aspiration in those with swallowing problems.

SLPs hate straws... But is it hatred warranted?

- There is no direct research that indicates that straw use alone raises the risk of aspiration across the board for patients with dysphagia. There is research that indicates aspiration is volume dependent and "liquid type" dependent.
- Straws can be tools to increase function, let's not arbitrarily disregard their use out of misinformation passed down from SLP to SLP.
- In my professional experience, while evaluating with FEES and MBSS, in some patients straws increase risk, BUT in other patients they increase functional ability.
- "No straws" has been wildly over interpreted and is often enforced as a matter of bad policy in hospitals, SNFs, etc....

https://www.researchgate.net/profile/Steven_Leder/publication/47730127_Silent_aspiration_risk_is_volume-dependent/links/53cf96730cf27fe53e814a4.pdf

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3780773/>

#7

The chin tuck is my go to compensatory strategy and any medical professional should know to recommend the chin tuck when a patient is coughing at meals.

The “chin tuck” can make the swallow worse...

- Utilizing the “chin tuck” or “chin down” posture with out visualizing it on either FEES or MBSS can put the patient at risk of aspiration
- Before we have patient’s staring down throughout a meal and doing odd things that disrupt the social aspects of eating, we better make sure it is necessary
- We aren’t even sure how to accurately do this posture... descriptors of what it is vary across the literature
- We should train across disciplines to not arbitrarily recommend this posture with out testing it on videofluoroscopy

“To Chin Tuck, or Not to Chin Tuck? That is the Question” By Karen Sheffler, MS, CCC-SLP, BCS-S of SwallowStudy.com

#8

A great alternative for nectar thickened liquids is carbonated beverages... carbonated beverages make a great substitute when patients don’t like the thickened stuff!

Thin liquids are thin liquids... there is not evidence to support “substituting” carbonated thin liquids for nectar liquids arbitrarily. There is evidence that certain patients with sensory based dysphagia MAY benefit from carbonation to elicit a more timely swallow. Test this response with a visualization, preferably FEES in order to assess the response directly.

Bulow, M., Olsson, R., & Ekberg, O. (2003). Videoradiographic analysis of how carbonated thin liquids and thickened liquids affect the physiology of swallowing in subjects with aspiration on thin liquids. *Acta Radiologica*, *44*(4), 366-372.

Krival, C. R. (2007). *Effects of carbonated vs. Thin and thickened liquids on swallowing in adults with neurogenic oropharyngeal dysphagia.*. University of Cincinnati. Retrieved from http://rave.ohiolink.edu/etdc/view?acc_num=ucin1186623264

Sdravou, K., Walshe, M., & Dagdilelis, L. (2012). Effects of carbonated liquids on oropharyngeal swallowing measures in people with neurogenic dysphagia. *Dysphagia*, *27*(2), 240-250.

Nixon, T. S. (1997). Use of carbonated liquids in the treatment of dysphagia. *Network: A Newsletter of Dietetics in Physical Medicine and Rehabilitation*.

#9

I hope my patient isn't aspirating and doesn't fail his swallow test (modified barium swallow study or FEES).

Neither test's purpose is to "detect aspiration"...

- FEES and the MBSS are essential in the determination of WHY someone is aspirating. Aspiration is the consequence of a malfunctioning system.
- Never would a Physical Therapist do any exam just to watch the patient fall down.
- When patients aspirate on an MBSS or FEES many more factors go into determining if they remain safe for PO intake
- What did the aspirate? How much? How often? What is the general health of the patient like.

Ashford, J.A. (2013). FEES: Instrumental Dysphagia Assessment Training Manual. Nashville, TN: Author

Langmore, S. (2001). Endoscopic Evaluation and Treatment of Swallowing Disorders. New York: Thieme

Clinical utility of the modified barium swallow. *Dysphagia*, 2000 Summer;15(3):136-41. Martin-Harris B1, Logemann J.A, McMahon S, Schieicher B, Sandidge J.

#10

My clinical experience, training, and particular swallow examination allows me to make accurate determinations about the underlying cause and severity of my patients dysphagia... so there.

CSE (Clinical Swallow Exam) vs An Instrumental

- Clinicians must examine their own long held beliefs to make sure they have incorporated new insights from emerging scientific literature
- Most importantly, clinicians must be willing to let go of beliefs and familiar actions that are no longer sufficient to meet the demands of clinical practice.
- In other words, "Change is Good"
- Simply put: All studies that compare the CSE to FEES/MBSS determine that the CSE alone misses a high rate of those that are aspirating.
- The CSE doesn't do the job it claims to do.

Hoffman L. Prologue: Improving clinical practice from the inside out. *Lang Speech Hear Sw Schools*. 2014;45:88-91.

Leder SB, Suiter DM, and Warner HL. Advantages & Disadvantages of CSE Compared with Simultaneous FEES. *ASHA Convention 2015*

