

Dysphagia in the Older Adult

September 25, 2019

Aida Wen, MD

Associate Professor

Department of Geriatric Medicine

John A. Burns School of Medicine

Shari Goo-Yoshino MS CCC-SLP

Instructor

Department of Communication

Sciences and Disorders

John A. Burns School of Medicine



Sponsored by



CATHOLIC CHARITIES
HAWAII
CIRCLE OF CARE FOR DEMENTIA



University of Hawaii
Center on Aging



This presentation was supported in part by the Geriatrics Workforce Enhancement Program (GWEP) DHS, DHHS, Bureau of Health Professions awarded to the Pacific Islands GEC. This is also supported in part by grant No. 90ADPI0011-01-00 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201, awarded to Catholic Charities Hawaii for the Alzheimer's Disease Program Initiative. Grantees undertaking projects with government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official policies from ACL, DHS, DHHS, or BHW.

HADI Hawai'i Alzheimer's Disease Initiative

A PROJECT OF THE UH CENTER ON AGING

www.hawaii.edu/aging/hadi

The speakers have no relevant financial relationships to disclose.

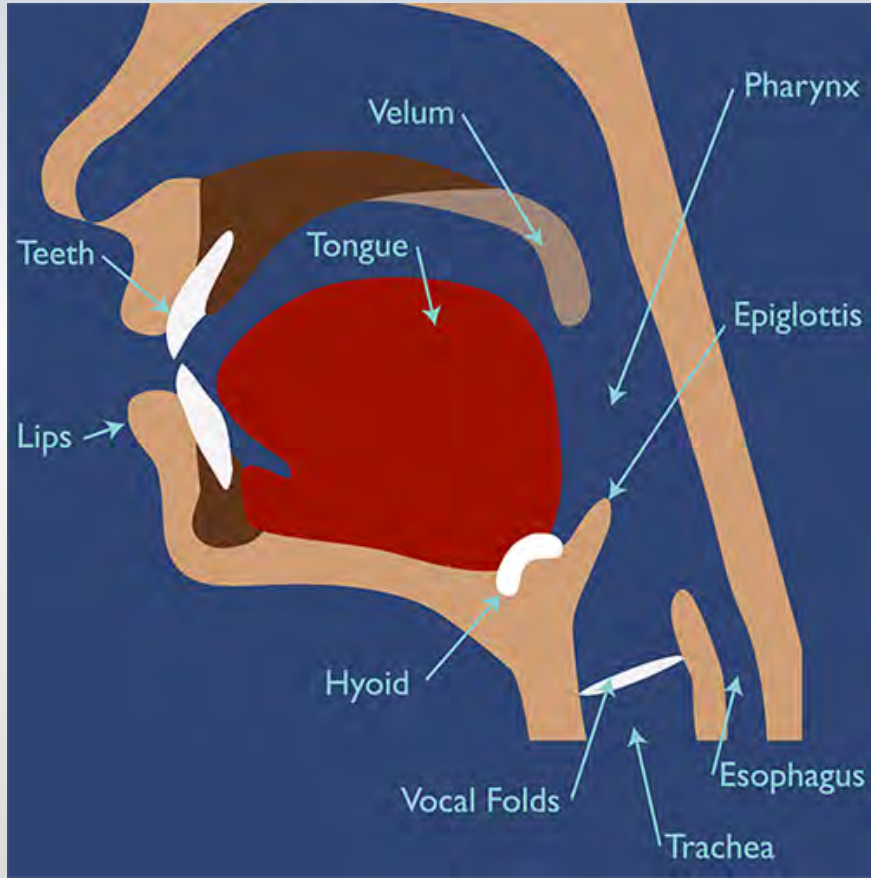
Learning Objectives

Identify	The common symptoms and causes of dysphagia in older adults
Explain	The indications and functional outcomes of swallow evaluations
Describe	The management and treatment options for dysphagia
Discuss	Issues regarding tube feeding for adults with dementia
Provide	Person-centered care to optimize safe, effective, and efficient swallowing for pleasurable participation in mealtime

Dysphagia (difficulty in swallowing)

- Highly prevalent among older adults living in assisted or nursing facilities (40-60%), related to dementia (13 to 57%), stroke (37 to 78%), and Parkinson's disease (35%-82%)
- Meal time difficulties: disinterest, selective eating, effort to swallow, early satiety, and fatigue
- Consequences: malnutrition and dehydration, aspiration pneumonia, chronic lung disease, choking, and mortality
- Compromised quality of life – life style changes
- Usually a symptom of other medical conditions

Oral and Pharyngeal Dysphagia



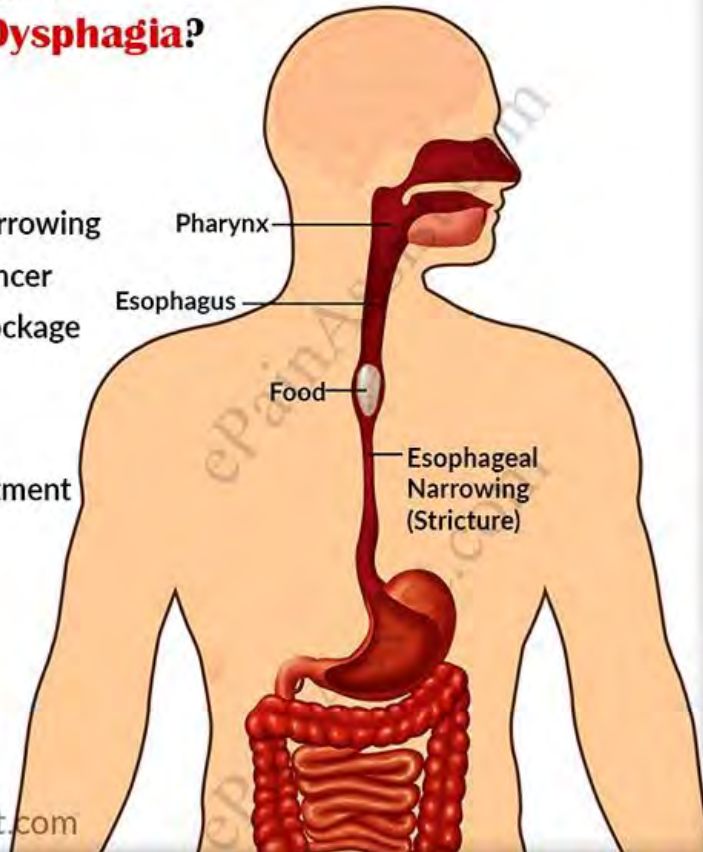
CAUSES

- Stroke, Dementia, Parkinson's, other neurological conditions
- Medications
 - Dry mouth (anticholinergic drugs)
 - Sedating drugs (psychotropic meds, opioids, sleeping pills, etc.)
 - Anorexia (donepezil, macrolide abx, etc.)
- Weakness and deconditioning
- Head and neck cancers

Esophageal Dysphagia

What can Cause Esophageal Dysphagia?

- Achalasia
- Spasms
- Esophageal Narrowing
- Esophageal Cancer
- Esophageal Blockage
- Esophagitis
- Scleroderma
- Radiation Treatment

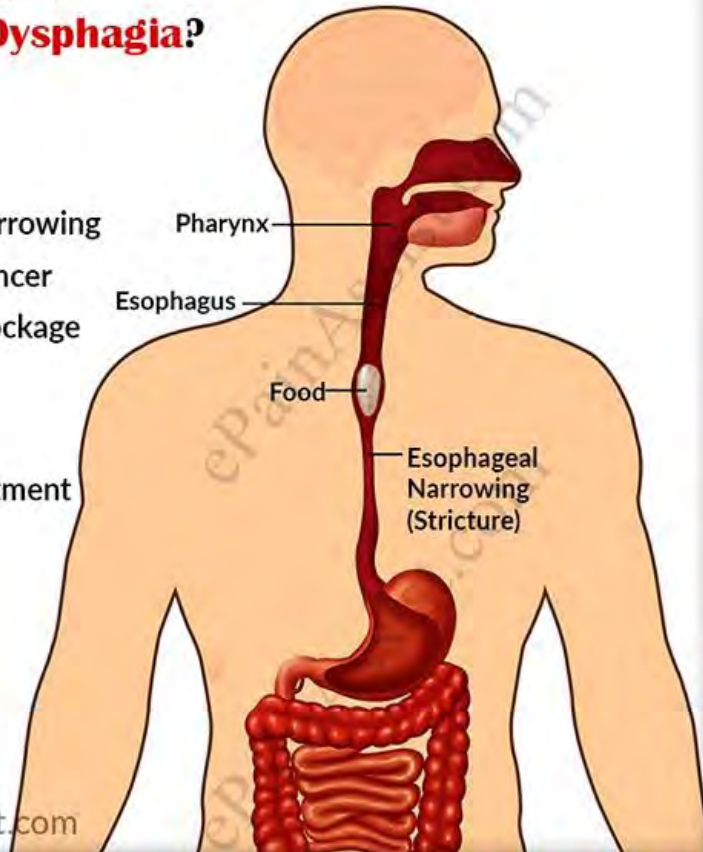


- ESOPHAGUS- trouble with food moving past the sphincters (upper and lower), trouble with peristalsis through the esophagus, reflux.
- Symptoms:
 - Pain with swallowing (odynophagia)
 - Unable to swallow
 - Feeling that food is stuck in your throat or chest behind your breastbone
 - Hoarse
 - Regurgitation (food backing up)
 - Frequent heartburn or feeling acid backing up into your throat
 - Having to cut food into smaller pieces or avoiding food because of trouble swallowing
 - Frequent respiratory problems (asthma), or infection

Esophageal Dysphagia

What can Cause Esophageal Dysphagia?

- Achalasia
- Spasms
- Esophageal Narrowing
- Esophageal Cancer
- Esophageal Blockage
- Esophagitis
- Scleroderma
- Radiation Treatment



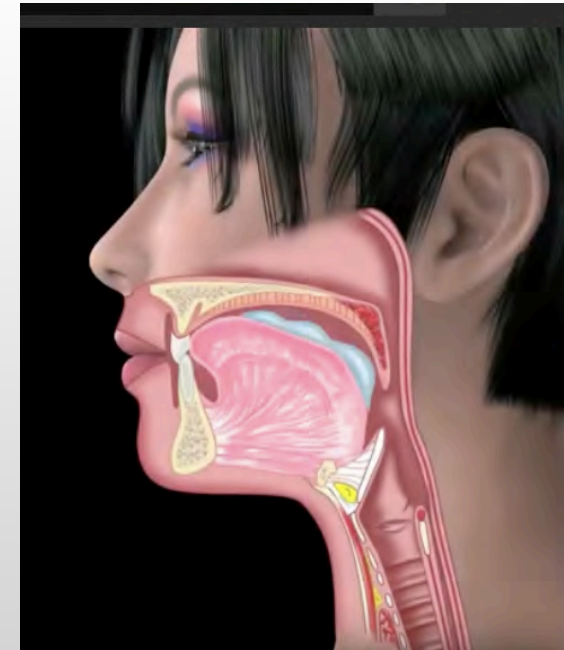
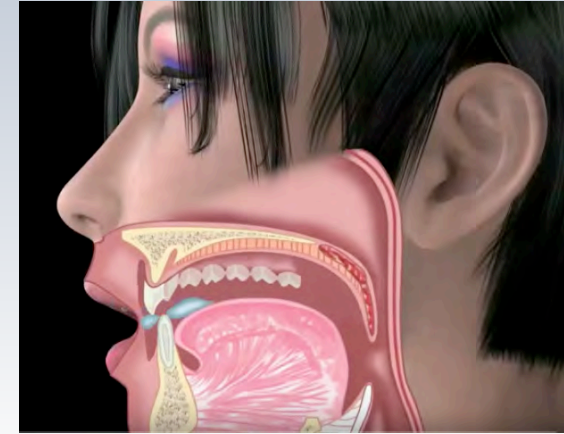
www.epainassist.com

CAUSES

- Achalasia
 - esophageal motility disorder
- Esophageal spasms
 - trigger foods, stress, GERD
- Mechanical problems
 - cancer, radiation treatment, stricture,
 - Barrett's esophagus (prevented by early treatment of GERD)
- Weakness and deconditioning

Overview of Normal Swallowing

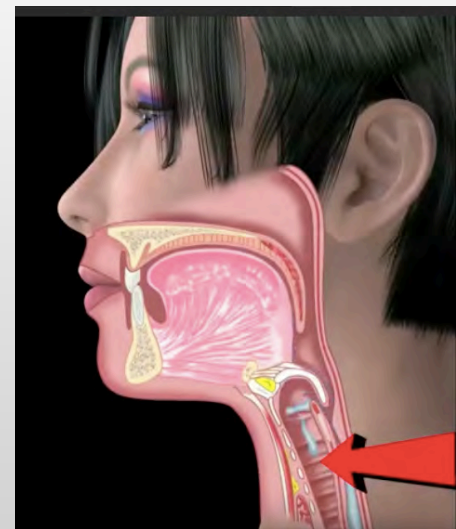
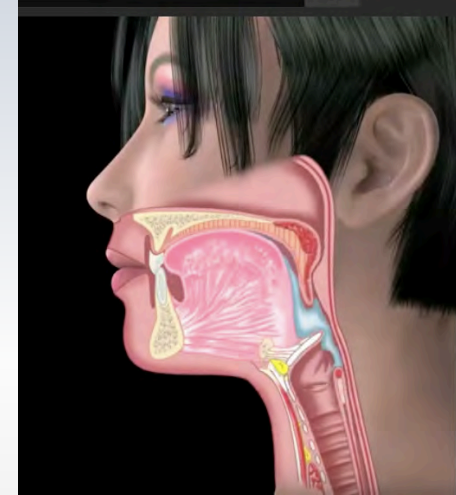
1st: Oral: Liquid and food enter the mouth and are manipulated, chewed, mixed with saliva, and transferred into the pharynx



Overview of Normal Swallowing

1st: Oral: Liquid and food enter the mouth and are manipulated, chewed, mixed with saliva, and transferred into the pharynx

2nd Pharyngeal: Food and liquid enters and passes through the pharynx -
Aspiration



Overview of Normal Swallowing

1st: Oral: Liquid and food enter the mouth and are manipulated, chewed, mixed with saliva, and transferred into the pharynx

2nd Pharyngeal: Food and liquid enters and passes through the pharynx -
Aspiration

3rd Esophageal: Passage of liquid and food through the esophagus and lower esophageal sphincter



General Symptoms And Signs Of Dysphagia

Coughing

Choking

Hoarse voice

Globus sensation

Involuntary weight loss and difficulty gaining weight

Recurring pneumonia, respiratory infection, or fever

Symptoms and Signs of Oropharyngeal Dysphagia

Coughing during or shortly after eating and drinking

Complaints of food "sticking" in the throat

Holding food or liquid in mouth

Prolonged chewing

Spill of food or liquid from the lips or nasal cavity

Food or liquid remaining in the mouth

Drooling

Dysarthria

Wet voice during or after swallow

Speech-Language Pathologist

Symptoms and Signs of Esophageal Dysphagia

Chronic coughing

Complaints of food "sticking" in the throat or chest

Pressure or burning in chest

Progressive difficulty in swallowing solids to liquids

Vomiting

Gastroenterologist

Non Instrumental - Clinical Swallow Evaluation



- Review of history and perception of the problem
- Examination of oral structures and function
- Assessment of swallowing
- Trials of compensatory or rehabilitative techniques

Non Instrumental or Clinical Swallow Evaluation Outcomes

- Diagnosis of **oral prep or oral** phase dysphagia
- Optimum food and liquid textures by mouth / Consider NPO
- Strategies to facilitate safe and efficient swallowing
- Counseling, education, and training
- Personalized treatment plan
- Referral for other services e.g., dietician, gastroenterologist
- Does NOT determine presence or absence of aspiration or pharyngeal phase dysphagia -> Indications for instrumental swallow evaluation

Indications for Instrumental Swallow Evaluation

- Symptoms or signs of pharyngeal phase dysphagia
- Uncertainty in safety and efficiency of swallowing for nutrition, pulmonary health, and airway safety (aspiration, choking)
- History of medical conditions associated with high risk for dysphagia and aspiration
- Previously identified dysphagia with a suspected change in swallow function that may change recommendations

Information guides management and treatment

Instrumental Swallow Evaluations - Video fluoroscopic Swallow Study/Modified Barium Swallow Study



- Provides direct visualization of **oral, pharyngeal, and upper esophageal structures and function**
- Assess swallow of food and liquid with barium
- Observe flow and clearance of materials from **mouth to entrance into esophagus**
- Determine influence of diet changes and compensatory strategies on swallow efficiency and safety

Instrumental Swallow Evaluations - Fiberoptic Endoscopic Evaluation of Swallow



- Provides direct visualization of **pharyngeal structures and function**
- Assess swallow of food and liquid
- Observe flow and clearance of materials through **pharynx**
- Determine influence of diet changes and compensatory strategies on swallow efficiency and safety

Instrumental Swallow Evaluation Outcomes

- Diagnosis of oral and **pharyngeal** phase dysphagia
- Detection of **aspiration**
- Optimum food and liquid textures by mouth / Consider NPO
- Strategies to facilitate safe and efficient swallowing
- Counseling, education, and training (**with biofeedback**)
- Referral for other services e.g., dietician, gastroenterologist
- Personalized treatment plan

Management and Treatment Options – Person-Centered Care

Restorative Exercises

Oral motor swallowing exercises
Expiratory muscle strength training

Feeding/Behavioral Strategies

Optimal alertness
Head and body positioning
Rate of feeding - Bolus size and placement
Swallow maneuvers

Counseling
Education
Training

Dietary Considerations

Appropriate texture
Preferred foods and drinks
Attractive - Proper temperature
Smaller, more frequent meals
Accessible snacks

Environmental Modifications

Maintain meal routines
Seating to improve posture
Calm environment - Reduce distractions
Support self-feeding – Consistent prompts
Pleasant exchanges – Optimize communication

Gastric Feeding Tubes

BENEFITS

- Easier, less time, ensure caloric intake
- Only benefits those NOT in the last stage of illness, such as:
 - acute stroke,
 - head trauma
 - critically ill with good chance of recovery,
 - Head and neck CA
 - ALS
 - young patients,
 - more functional patients.



RISKS

- Decreased QOL (isolation, decreased human contact, denied gratification of food, restraints)
- Nausea, Vomiting, Diarrhea
- Complications: Bleeding, Infection, Skin irritation, Leaking, Blocked, Falling out, Pulled out
- Increased risk for Pressure Ulcers
- More likely to get aspiration pneumonia
- More likely to get fluid overload

DOES NOT HELP IN END-STAGE DISEASE
(Alzheimer's, Parkinson's, Terminal cancer, CVA without improvement, PVS, poor prognosis)

- Prolong life, gain weight
- Prevent aspiration
- Healing of Pressure sores
- Improve functional status

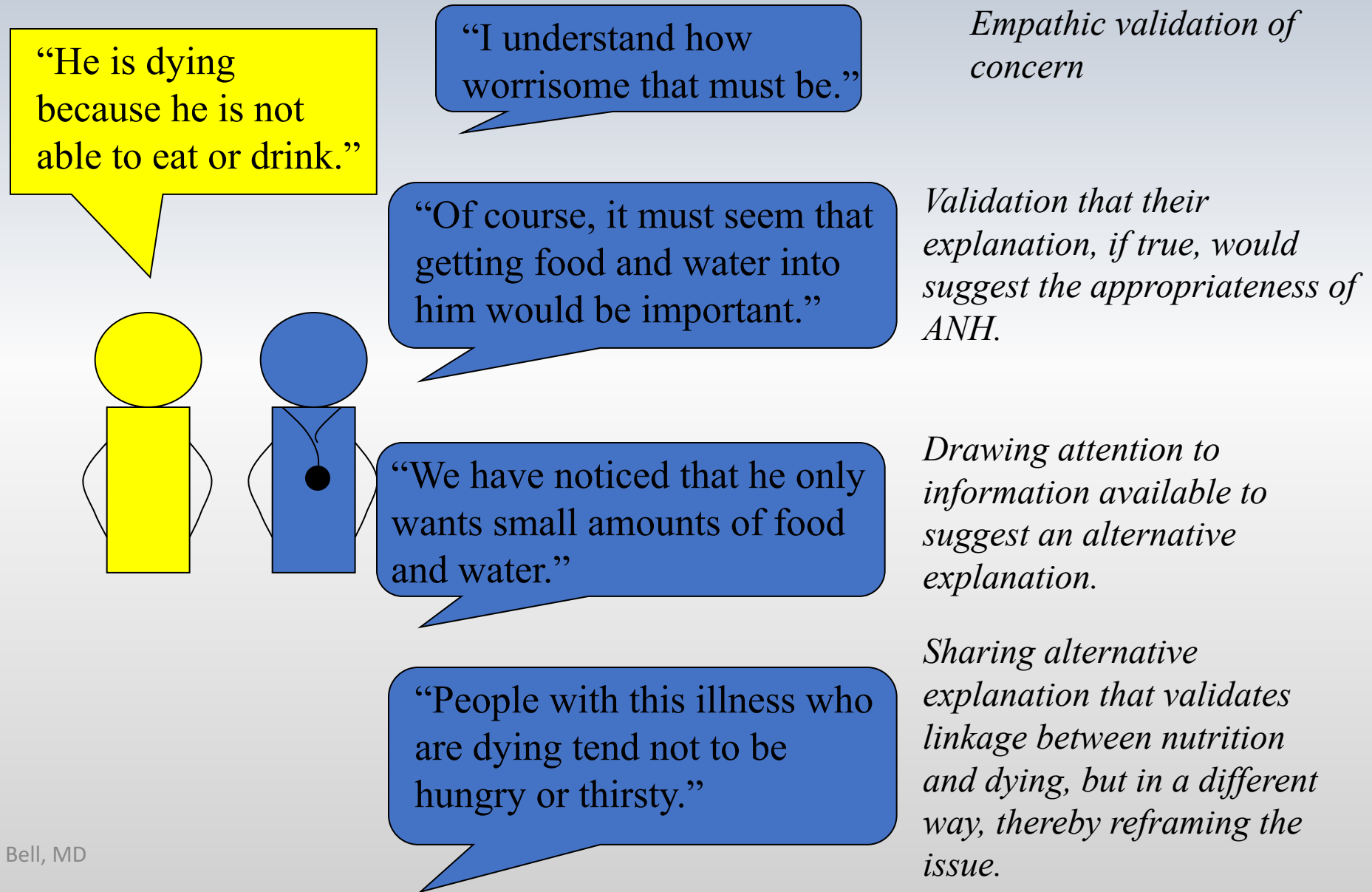
Decision making process

- Consider both the medical facts, and personal subjective elements
- A time-limited trial is always an option.
- The decision to either institute artificial feedings or to withhold them rarely needs to be made emergently.

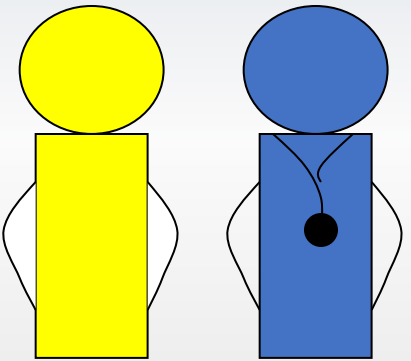
“I can’t just let her starve!”

- If the explanation, the clinician’s story, of why it is believed that ANH would not be beneficial is understood simply as an invalidation of the family’s stories, it will, quite reasonably, be rejected.
- Validate intent
- Try to reframe
- Suggest alternative interpretations in terms of their story line.

Reframing examples...



We can't let him starve to death, which can be prevented by artificial feeding.



You are right, if he were starving or thirsty and we could prolong his life through such feeding, that would make sense.

Validation of internal consistency of their story.

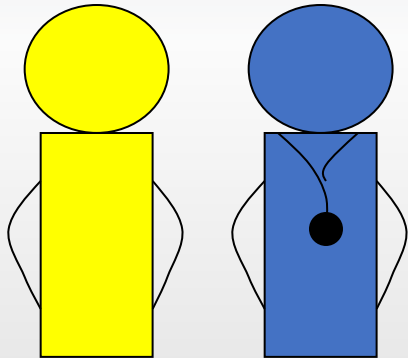
While it may seem like starvation, what is going on is somewhat different...

Suggest possible alternative interpretation.

It would be great if tube feeding worked that way. However, in other patients with this illness we have found that tube feeding does not make people live longer or feel better.

Share more info that suggests that ANH will not accomplish their goals, which are reasonable in and of themselves.

“So we’re just going to do nothing.”



Not at all! This is a time to pay special attention...

Acknowledge “need to nurture” and reframe current situation in terms of this.

He may not be able to eat or drink much, but is there some special food he really liked?

Involve family (facilitating nurturing) concretely in a new way – feeding for pleasure vs. calories.

At this stage dry mouth is a big problem. You could really help us care for him by giving...

Identify how family can be of help in paying special attention, thereby forming an alliance

Alternatives & Suggestions



Treat conditions that cause poor appetite:
constipation, depression, infection



Stop medicines that make
eating problems worse

Antipsychotics/ Antianxiety

Sleeping pills

Bladder Control meds

Alendronate

Donepezil



Dental Care



Careful Hand feeding, favorite foods for QOL feeding



Hospice referral



Other ways to show love (massage, read, music)

Feeding Tubes

Choosing Wisely[®]

An initiative of the ABIM Foundation

American Geriatrics Society



Leading Change. Improving Care for Older Adults.

Five Things Physicians and Patients Should Question

Don't recommend percutaneous feeding tubes in patients with advanced dementia; instead offer oral assisted feeding.

Careful hand-feeding for patients with severe dementia is at least as good as tube-feeding for the outcomes of death, aspiration pneumonia, functional status and patient comfort. Food is the preferred nutrient. Tube-feeding is associated with agitation, increased use of physical and chemical restraints and worsening pressure ulcers.

Choosing Wisely[®]

An initiative of the ABIM Foundation



Feeding tubes for people with Alzheimer's disease

When you need them—and when you don't

Most people in the last stage of Alzheimer's disease have difficulty eating and drinking. At this point, families may wonder if their family member with Alzheimer's needs a feeding tube.

Families want to do everything possible for someone who is ill. But they often get little information about feeding tubes. And they may feel pressure from doctors or nursing home staff, because feeding is simpler with a feeding tube.

But feeding tubes sometimes do more harm than good. Here's why:

Feeding tubes usually aren't helpful for severe Alzheimer's disease.

People with severe Alzheimer's disease can no longer communicate or do basic things. Chewing and swallowing is often hard. This can cause serious problems, such as weight loss, weakness, and pressure sores. Or food can get into the lungs, and cause pneumonia. So people often need help to eat.



In many cases, a decision is made to use a feeding tube. The tube may be put down the throat. Or it may be put through a small cut in the abdominal wall, into the stomach. The person is then given liquid nutrition through the tube.

Sources

Finucane TE, Christmas C, Travis K. Tube feeding in patients with advanced dementia: A review of the evidence. *JAMA*. 1999;282(14):1365-1370.

Gabriel SE, Normand ST. Getting the methods right – The foundation of patient-centered outcomes research. *N Engl J Med* [Internet]. 2012 Aug 30;367(9):787-90.

Teno JM, Feng Z, Mitchell SL, Kuo S, Intrator O, Mor V. Do financial incentives of introducing case mix reimbursement increase feeding tube use in nursing home residents? *J Am Geriatr Soc*. [Internet]. 2008 May;56(5):887-890.

Teno JM, Mitchell SL, Kuo SK, Gozalo PL, Rhodes RL, Lima JC, Mor V. Decision-making and outcomes of feeding tube insertion: A five-state study. *J Am Geriatr Soc*. [Internet]. 2011 May;59(5):881-886.

Palecek EJ, Teno JM, Casarett DJ, Hanson LC, Rhodes RL, Mitchell SL. Comfort feeding only: A proposal to bring clarity to decision-making regarding difficulty with eating for persons with advanced dementia. *J Am Geriatr Soc*. [Internet]. 2010 Mar;58(3):580-584.

Hanson LC, Carey TS, Caprio AJ, Lee TJ, Ersek M, Garrett J, Jackman A, Gilliam R, Wessell K, Mitchell SL. Improving decision-making for feeding options in advanced dementia: A randomized, controlled trial. *J Am Geriatr Soc*. [Internet]. 2011 Nov;59(11):2009-2016.

From JABSOM Department of Geriatric Medicine
Videos available in three languages

CAREGIVER EMPOWERMENT SERIES
DYSPHAGIA (SWALLOWING DIFFICULTIES) AND AGING



Caregiver
Video

Designed for caregivers helping someone with dysphagia, the 19-minute program includes information on the phases of dysphagia, esophageal reflux and lifestyle measures to manage it, aspiration risk reduction, dietary considerations, modifying food and liquid textures, dysphagia and dementia, and end of life concerns.



English, Chuukese, Ilocano and Samoan versions
can be viewed at: <http://geriatrics.jabsom.hawaii.edu/gwep>
or scan the QR code on the right.



For inquiries and copies, please contact:
Department of Geriatric Medicine
(808) 523-8461

Made possible by a grant from
The Health Resources and Services Administration (HRSA)
Geriatrics Workforce Enhancement Program

References

- Alagiakrishnan, K., Bhanji, R. A., & Kurian, M. (2013). Evaluation and management of oropharyngeal dysphagia in different types of dementia: A systematic review. *Archives of Gerontology and Geriatrics, 56*(1), 1–9.
- American Speech Language Hearing Association Adult Dysphagia <https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589942550§ion=Assessment>
- American Speech Language Hearing Association Dementia <https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935289§ion=Treatment>
- Aslam, M., & Vaezi, M. F. (2013). Dysphagia in the elderly. *Gastroenterology & Hepatology, 9*(12), 784–795.
- Baijens, L.W., Clave, P., Cras, P. et al (2016). European society for swallowing disorders—European Union geriatric medicine society white paper: Oropharyngeal dysphagia as a geriatric syndrome. *Clin Interv Aging, 11*, 1403–1428.
- Bath, P.M., Lee, H.S., & Everton, L.F. (2018). Swallowing therapy for dysphagia in acute and subacute stroke. *Cochrane Data Base of Systematic Reviews, 10*.
- Bell, C., & Goo-Yoshino, S. (2018). Chapter 10: Nutritional Issues and Swallowing in the Geriatric Population. In Cifu, D.X., Lew, H., & Oh-Park, M. (Eds.) *Geriatric Rehabilitation*. St. Louis, MO:Elsevier.
- Goyal & Shaker GI Motility On-Line <http://www.nature.com/gimo/contents/synopsis.html>
- Kalf, J. G., de Swart, B. J. M., Bloem B. R., & Munneke, M. (2011). Prevalence of oropharyngeal dysphagia in Parkinson's disease: A meta-analysis. *Parkinsonism Related Disorders, 18*(4), 311–315.
- Martino, R., Foley, N., Bhogal, S., Diamant, N., Speechley, M., & Teasell, R. (2005). Dysphagia after stroke: Incidence, diagnosis, and pulmonary complications. *Stroke, 36*(12), 2756–2763.
- van Hooren, M.R., Baijens, L.W., Voskuilen, S., Oosterloo, M., & Kremer, B. (2014). Treatment effects for dysphagia in Parkinson's disease: A systematic review. *Parkinsonism Relat Disord, 20*(8), 800–807.

Please complete the
online evaluation

Thank you