Dysphagia in the Older Adult

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<th>Identify</th>
<th>The common symptoms and causes of dysphagia in older adults</th>
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<td>Explain</td>
<td>The indications and functional outcomes of swallow evaluations</td>
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<td>Describe</td>
<td>The management and treatment options for dysphagia</td>
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<td>Provide</td>
<td>Person-centered care to optimize safe, effective, and efficient swallowing for pleasurable participation in mealtime</td>
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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

- **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

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

<table>
<thead>
<tr>
<th><strong>Symptoms and Signs of Oropharyngeal Dysphagia</strong></th>
<th><strong>Symptoms and Signs of Esophageal Dysphagia</strong></th>
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<tr>
<td>Coughing during or shortly after eating and drinking</td>
<td>Chronic coughing</td>
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<tr>
<td>Complaints of food &quot;sticking&quot; in the throat</td>
<td>Complaints of food “sticking” in the throat or chest</td>
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<tr>
<td>Holding food or liquid in mouth</td>
<td>Pressure or burning in chest</td>
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<td>Prolonged chewing</td>
<td>Progressive difficulty in swallowing solids to liquids</td>
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<td>Spill of food or liquid from the lips or nasal cavity</td>
<td>Vomiting</td>
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<tr>
<td>Food or liquid remaining in the mouth</td>
<td><strong>Speech-Language Pathologist</strong></td>
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<tr>
<td>Drooling</td>
<td><strong>Gastroenterologist</strong></td>
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<td>Dysarthria</td>
<td></td>
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<tr>
<td>Wet voice during or after swallow</td>
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Adapted from Bell, C. & Goo-Yoshino, S. (2018)
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

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

**Feeding/Behavioral Strategies**
- Optimal alertness
- Head and body positioning
- Rate of feeding - Bolus size and placement
- Swallow maneuvers

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

**Counseling Education Training**
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)

**NO BENEFIT**
- 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.

Slide Credit: Christina Bell, MD
Reframing examples…

“He is dying because he is not able to eat or drink.”

“I understand how worrisome that must be.”

“Of course, it must seem that getting food and water into him would be important.”

“Empathic validation of concern”

“Validation that their explanation, if true, would suggest the appropriateness of ANH.”

“We have noticed that he only wants small amounts of food and water.”

“Validation that their explanation, if true, would suggest the appropriateness of ANH.”

“People with this illness who are dying tend not to be hungry or thirsty.”

“Drawing attention to information available to suggest an alternative explanation.”

“Sharing alternative explanation that validates linkage between nutrition and dying, but in a different way, thereby reframing the issue.”
We can’t let him starve to death, which can be prevented by artificial feeding.

Validation of internal consistency of their story.

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

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

Suggest possible alternative interpretation.

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

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.
“So we’re just going to do nothing.”

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

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

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

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

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

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

Slide Credit: Christina Bell, MD
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

Feeding tubes for people with Alzheimer's disease
When you need them—and when you don't

Source:
From JABSOM Department of Geriatric Medicine
Videos available in three languages
Caregiver Empowerment Series
Dysphagia (Swallowing Difficulties) and Aging

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

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References


Goyal & Shaker GI Motility On-Line http://www.nature.com/gimo/contents/synopsis.html


Please complete the online evaluation

Thank you