

## 1: Differences in Assessment and Management of Adult and Pediatric Dysphagia

*Dysphagia is an alarm symptom that warrants prompt evaluation to define the exact cause and initiate appropriate therapy. It may be due to a structural or motility abnormality in the passage of solids or liquids from the oral cavity to the stomach.*

Chin down flexion " used when there is a delay in initiating the swallow; this allows the valleculae to widen, the airway to narrow, and the epiglottis to be pushed towards the back of the throat to better protect the airway from food. Chin down flexion " used when the back of the tongue is too weak to push the food towards the pharynx; this causes the back of the tongue to be closer to the pharyngeal wall. Head rotation turning head to look over shoulder to damaged or weaker side with chin down " used when the airway is not protected adequately causing food to be aspirated ; this causes the epiglottis to be put in a more protective position, it narrows the entrance of the airway, and it increases vocal fold closure. Lying down on one side " used when there is reduced contraction of the pharynx causing excess residue in the pharynx; this eliminates the pull of gravity that may cause the residue to be aspirated when the patient resumes breathing. Head rotation to damaged or weaker side " used when there is paralysis or paresis on one side of the pharyngeal wall; this causes the bolus to go down the stronger side. Head tilt ear to shoulder to stronger side " used when there is weakness on one side of the oral cavity and pharyngeal wall; this causes the bolus to go down the stronger side. While still holding their breath they are to swallow and then immediately cough after swallowing. This technique can be used when there is reduced or late vocal fold closure or there is a delayed pharyngeal swallow. Super-supraglottic swallow - The patient is asked to take a breath, hold their breath tightly while bearing down, swallow while still holding the breath hold, and then coughing immediately after the swallow. This technique can be used when there is reduced closure of the airway. Effortful swallow - The patient is instructed to squeeze their muscles tightly while swallowing. This may be used when there is reduced posterior movement of the tongue base. This technique may be used when there is reduced laryngeal movement or a dis-coordinated swallow. JoAnne Robbins , developed a device in which patients perform isometric exercises with the tongue. Some patients require a soft diet that is easily chewed, and some require liquids of a thinned or thickened consistency. The effectiveness of modifying food and fluid in preventing aspiration pneumonia has been questioned and these can be associated with poorer nutrition, hydration and quality of life. For example, removing distractions like too many people in the room or turning off the TV during feeding, etc. Oral sensory awareness techniques Oral sensory awareness techniques can be used with patients who have a swallow apraxia, tactile agnosia for food, delayed onset of the oral swallow, reduced oral sensation, or delayed onset of the pharyngeal swallow. This type of therapy has been used in a clinical setting for many years in Physical Therapy. Its use for oropharyngeal dysphagia has received much attention in recent years and is now the most researched treatment intervention in dysphagia therapy.

### 2: Evaluation and Treatment of Swallowing Impairments - - American Family Physician

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Nancy Swigert for volunteering her time to develop this article on swallowing disorder basics for teens and adults. Teens with developmental disabilities or chronic conditions, like cerebral palsy, may continue to present with swallowing problems throughout their life. New onset of dysphagia in teens or younger children might occur as a result of a choking episode. Sometimes an isolated incident of choking on food will cause a fear of swallowing. The child may begin to avoid foods they have previously eaten without difficulty. They may limit the food and liquids they will eat to the extent that they are not receiving adequate nutrition and hydration. The child or teen will likely not be able to make the connection between the choking episode and the current restrictions he is imposing on himself. The speech-language pathologist and physicians performing the assessment can then recommend intervention for the teen. This may include a referral to a psychologist to help the teen deal with the developed fear of eating. Second only to children ages , teens and young adults ages experience the most traumatic brain injuries http: One of the results of a traumatic brain injury TBI can be dysphagia. Depending on the location and extent of the injury, the dysphagia can be severe. Adolescents can experience dysphagia related to esophageal problems. The teen may experience gastroesophageal reflux, which occurs when stomach acid backs up into the esophagus. Other problems that can occur in the esophagus are esophagitis and esophageal spasm. Esophagitis is inflammation in the esophagus and can be caused by persistent reflux. Esophageal spasm can feel like chest pain. It may be caused by reflux or may be related to stress http: Dysphagia usually occurs after the adult has already been diagnosed with a neurological disorder. However, difficulty swallowing can sometimes be the first sign of a neurological disorder http: Adults may fail to report swallowing problems to their physicians, but because it may be a sign of a more serious problem, the difficulty should be reported. Dysphagia can also occur as a result of an injury to the nervous system such as a head injury, spinal cord injury, or stroke. There is an increased risk of pneumonia in patients with stroke who have dysphagia. Spinal cord injuries can also cause swallowing problems. There are at least seven cranial nerves controlling over thirty muscles involved in eating and safely swallowing. For example, the hypoglossal nerve sends impulses to almost every muscle in the tongue. The front, middle and back parts of the tongue and the sides of the tongue perform complex movements for drinking, chewing and swallowing. The trigeminal nerve controls the movements of the jaw for biting and chewing. Nerves like the facial and vagus are responsible for sensation and movement in the throat to protect the airway. Many different things can damage cranial or peripheral nerves, and when that happens swallowing problems can result. The cancer may have been in the mouth, particularly if the tongue was affected, or the throat. Laryngeal cancer can have a big impact on swallowing because the larynx serves as the main airway protector during swallowing. Dysphagia may be caused by the presence of the tumor in the mouth or throat. It can also occur after surgery has removed the tumor and parts of the mouth or throat. Dysphagia can also be a result of the radiation therapy used to cure the cancer. Over time, radiation therapy causes the tissues in the area to become less flexible. This means that the structures that need to move in a coordinated fashion to allow the individual to chew and swallow may move more slowly, or may not move at all. This type of dysphagia, called late-effects dysphagia, comes on slowly so that sometimes the problem is not noticed until the point that it may be very difficult to change. Individuals who are undergoing chemo-radiation therapy benefit from learning swallowing exercises to practice on a daily basis to try and prevent this late-stage dysphagia from developing.

## 3: BMJ Best Practice

*Overview. This book introduces background information and procedural overviews needed to assess swallowing disorders in adults in addition to offering detailed protocols for administering the assessment.*

To this end, an examination of oral-motor and laryngeal mechanisms is critical. The anterior neck is inspected and palpated for masses. Dysphonia abnormal voice and dysarthria abnormal speech articulation are signs of motor dysfunction of the structures involved in oral and pharyngeal swallowing. The thyroid cartilage is gently mobilized by manual distraction to either side. Laryngeal elevation is evaluated by placing two fingers on the larynx and assessing movement during a volitional swallow. The oral cavity and pharynx are inspected for mucosal integrity, masses and dentition. The soft palate is examined for position and symmetry during phonation and at rest. The gag reflex is elicited by stroking the pharyngeal mucosa with a cotton-tipped applicator or tongue depressor. A gag reflex can be elicited in most normal persons. However, absence of a gag reflex does not necessarily indicate that a patient is unable to swallow safely. Indeed, many persons with an absent gag reflex have normal swallowing, and some patients with dysphagia have a normal gag reflex. The pulling of the palate to one side during gag reflex testing indicates weakness of the muscles of the contralateral palate and suggests the presence of unilateral brain-stem bulbar pathology. The patient should also be observed during the act of swallowing. At a minimum, the patient should be watched while he or she drinks a few ounces of tap water. In normal persons, swallowing is initiated promptly, and no significant amount of material is retained after a swallow. Drooling, delayed swallow initiation, coughing, throat clearing or a change in voice quality may indicate a problem. After the swallow, the patient should be observed for a minute or more to see if there is a delayed cough response. One study showed that a water swallow test in patients who had a stroke identified 80 percent of those subsequently found to be aspirating based on radiographic studies. The patient eats and drinks these foods while radiographic images are observed on a video monitor and recorded on videotape. Ideally, the VFSS is performed jointly by a physician typically a radiologist or physiatrist and a speech-language pathologist. The VFSS demonstrates anatomic structures, the motions of these structures and the passage of the barium-food bolus through the oral cavity, pharynx and esophagus Figure 5. Lateral projection of the videoprint of a videographic swallowing study showing aspiration of liquid barium. For example, some, but not all, patients with poor bolus control experience less aspiration with thick liquids e. Patients with poor pharyngeal contraction usually have more pharyngeal retention with thickened liquids and chewed solid foods than with thin liquids. The results of the VFSS make it possible to design an individualized diet. This diet would include foods that could be eaten and swallowed safely by a particular patient. For example, tucking the chin neck flexion or holding the breath before swallowing may reduce aspiration. Turning the head toward the weak side may improve pharyngeal clearance by deflecting the bolus to the strong side in a patient with unilateral pharyngeal weakness. These techniques include altering the position of the head, neck and body relative to gravity, modifying the method of feeding or teaching the patient to voluntarily contract particular muscles during the act of swallowing. The effectiveness of these maneuvers may be tested during fluoroscopy. Electromyography is indicated in patients with motor unit disorders, such as polymyositis, myasthenia gravis or amyotrophic lateral sclerosis. However, it can identify aspiration and pharyngeal retention after the swallow.

## 4: Assessment of Dysphagia in Adults

*Impaired swallowing, or dysphagia, can cause significant morbidity and mortality. Swallowing disorders are especially common in the elderly. The consequences of dysphagia include dehydration.*

Dysphagia Assessment and Treatment Planning: A Team Approach, Fourth Edition is an ideal resource for dysphagia courses in speech-language pathology graduate programs. The unique value of this book is its multidisciplinary approach. Too often, speech-language pathologists function clinically with insufficient interaction with, or understanding of, the roles of other professionals involved with their patients. This text incorporates information pertinent to the roles, tools, and views of a multidisciplinary dysphagia team, including physicians, speech pathologists, nurse specialists, and dietitians, who work together on a daily basis. In this fourth edition, the organization has changed, with chapters concerned with assessment techniques coming first, and material addressing special populations comprising the latter portion of the text. This reflects what is likely a more typical approach to dysphagia in graduate courses concerned with the topic and one that complements teaching of the subject matter. Updates to the fourth edition include: The treatment chapter Chapter 10 has been updated to reflect the current status of therapeutic approaches previously considered in treating dysphagic patients. Chapters dealing with nursing Chapter 11 and nutrition Chapter 12 have been updated to incorporate the latest recommendations in nursing care and dietary considerations for patients experiencing dysphagia. The pediatrics chapter Chapter 13 has been expanded to address specific problems and needs not only of infants but also the entire spectrum of childhood. A chapter devoted to the esophagus Chapter 14 addresses new information on the management of esophageal disorders, including the novel double-balloon dilation of the UES and a device for manually opening the upper esophagus. Chapters addressing special populations, including neurogenic disease Chapter 15 and head and neck cancer Chapter 16, incorporate the latest information regarding dysphagia and approaches to treatment pertinent to each group. A brand-new addition to the book is Chapter 18, which addresses dysphagia associated with alterations to the spine as a consequence of either disease or surgery. Please note that ancillary content such as documents, audio, and video, etc. Elsevier Health Sciences Format Available: Information on Dysphagia for Otolaryngologists in this issue of Otolaryngologic Clinics: Among topics presented are: Guest Editor Kenneth Altman of Mount Sinai, whose expertise, clinical work, and teaching is focused on laryngology, leads the group of expert physicians in this issue. This comprehensive manual provides a clinical, yet practical, approach to treating tracheostomized and ventilator-dependent patients. Its organizational structure is conducive to learning, as information builds on itself progressively from chapter to chapter. Emphasis is also placed on individualizing treatment and assessment protocols. Find Your eBooks Here€¹.

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**Esophagus** The esophagus is a muscular tube that connects your mouth and your stomach. Rings of muscle sphincters in the upper and lower portions contract and relax to allow food and liquid to pass. Difficulty swallowing dysphagia means it takes more time and effort to move food or liquid from your mouth to your stomach. Dysphagia may also be associated with pain. In some cases, swallowing may be impossible. But persistent dysphagia may indicate a serious medical condition requiring treatment. The causes of swallowing problems vary, and treatment depends on the cause. Symptoms Signs and symptoms associated with dysphagia may include: Having pain while swallowing odynophagia Being unable to swallow Having the sensation of food getting stuck in your throat or chest or behind your breastbone sternum Drooling Bringing food back up regurgitation Having frequent heartburn Having food or stomach acid back up into your throat Unexpectedly losing weight Coughing or gagging when swallowing Having to cut food into smaller pieces or avoiding certain foods because of trouble swallowing When to see a doctor See your doctor if you regularly have difficulty swallowing or if weight loss, regurgitation or vomiting accompanies your dysphagia. If an obstruction interferes with breathing, call for emergency help immediately. Request an Appointment at Mayo Clinic Causes Swallowing is complex, and a number of conditions can interfere with this process. However, dysphagia generally falls into one of the following categories. Some of the causes of esophageal dysphagia include: Muscles in the wall of your esophagus may be weak as well, a condition that tends to worsen over time. This condition produces multiple high-pressure, poorly coordinated contractions of your esophagus, usually after you swallow. Diffuse spasm affects the involuntary muscles in the walls of your lower esophagus. A narrowed esophagus stricture can trap large pieces of food. Tumors or scar tissue, often caused by gastroesophageal reflux disease GERD , can cause narrowing. Difficulty swallowing tends to get progressively worse when esophageal tumors are present. Sometimes food or another object can partially block your throat or esophagus. Older adults with dentures and people who have difficulty chewing their food may be more likely to have a piece of food become lodged in the throat or esophagus. A thin area of narrowing in the lower esophagus can intermittently cause difficulty swallowing solid foods. Damage to esophageal tissues from stomach acid backing up into your esophagus can lead to spasm or scarring and narrowing of your lower esophagus. This condition, which may be related to a food allergy, is caused by an overpopulation of cells called eosinophils in the esophagus. Development of scar-like tissue, causing stiffening and hardening of tissues, can weaken your lower esophageal sphincter, allowing acid to back up into your esophagus and cause frequent heartburn. This cancer treatment can lead to inflammation and scarring of the esophagus. Oropharyngeal dysphagia Certain conditions can weaken your throat muscles, making it difficult to move food from your mouth into your throat and esophagus when you start to swallow. You may choke, gag or cough when you try to swallow or have the sensation of food or fluids going down your windpipe trachea or up your nose. This may lead to pneumonia. Causes of oropharyngeal dysphagia include: Sudden neurological damage, such as from a stroke or brain or spinal cord injury, can affect your ability to swallow. A small pouch that forms and collects food particles in your throat, often just above your esophagus, leads to difficulty swallowing, gurgling sounds, bad breath, and repeated throat clearing or coughing. Certain cancers and some cancer treatments, such as radiation, can cause difficulty swallowing. Risk factors The following are risk factors for dysphagia: People with certain neurological or nervous system disorders are more likely to experience difficulty swallowing. Complications Difficulty swallowing can lead to: Malnutrition, weight loss and dehydration. Dysphagia can make it difficult to take in adequate nourishment and fluids. Food or liquid entering your airway when you try to swallow can cause aspiration pneumonia, because the food can introduce bacteria to the lungs. When food becomes impacted, choking can occur. If food completely blocks the airway, and no one intervenes with a successful Heimlich maneuver, death can

occur. Early detection and effective treatment of GERD can lower your risk of developing dysphagia associated with an esophageal stricture.

## 6: Assessment Of Dysphagia In Adults | Download eBook PDF/EPUB

*Dysphagia is pervasive in the adult and aging populations, and associated with a wide variety of diseases and disorders. Clients with dysphagia face significant health and psychosocial challenges inherent in a swallowing disorder.*

**Print Diagnosis** Your doctor will likely perform a physical examination and may use a variety of tests to determine the cause of your swallowing problem. **X-ray with a contrast material barium X-ray.** You drink a barium solution that coats your esophagus, allowing it to show up better on X-rays. Your doctor can then see changes in the shape of your esophagus and can assess the muscular activity. Your doctor may also have you swallow solid food or a pill coated with barium to watch the muscles in your throat as you swallow or to look for blockages in your esophagus that the liquid barium solution may not identify. You swallow barium-coated foods of different consistencies. This test provides an image of these foods as they travel through your mouth and down your throat. The images may show problems in the coordination of your mouth and throat muscles when you swallow and determine whether food is going into your breathing tube. A visual examination of your esophagus **endoscopy.** A thin, flexible lighted instrument endoscope is passed down your throat so that your doctor can see your esophagus. Your doctor may also take biopsies of the esophagus to look for inflammation, eosinophilic esophagitis, narrowing or a tumor. **Fiber-optic endoscopic swallowing evaluation.** Your doctor may examine your throat with a special camera and lighted tube endoscope as you try to swallow. **Esophageal muscle test manometry.** In manometry muh-NOM-uh-tree , a small tube is inserted into your esophagus and connected to a pressure recorder to measure the muscle contractions of your esophagus as you swallow. **Treatment** Treatment for dysphagia depends on the type or cause of your swallowing disorder. **Oropharyngeal dysphagia** For oropharyngeal dysphagia, your doctor may refer you to a speech or swallowing therapist, and therapy may include: Certain exercises may help coordinate your swallowing muscles or restimulate the nerves that trigger the swallowing reflex. You may also learn ways to place food in your mouth or to position your body and head to help you swallow. **Esophageal dysphagia** Treatment approaches for esophageal dysphagia may include: For a tight esophageal sphincter achalasia or an esophageal stricture, your doctor may use an endoscope with a special balloon attached to gently stretch and expand the width of your esophagus or pass a flexible tube or tubes to stretch the esophagus dilation. For an esophageal tumor, achalasia or pharyngoesophageal diverticulum, you may need surgery to clear your esophageal path. **Difficulty swallowing associated with GERD** can be treated with prescription oral medications to reduce stomach acid. You may need to take these medications for an extended period. If you have eosinophilic esophagitis, you may need corticosteroids. If you have esophageal spasm, smooth muscle relaxants may help. **Severe dysphagia** If difficulty swallowing prevents you from eating and drinking adequately, your doctor may recommend: A special liquid diet. This may help you maintain a healthy weight and avoid dehydration. **Surgery** Surgery may be recommended to relieve swallowing problems caused by throat narrowing or blockages, including bony outgrowths, vocal cord paralysis, pharyngoesophageal diverticulum, GERD and achalasia, or to treat esophageal cancer. Speech and swallowing therapy is usually helpful after surgery. The type of surgical treatment depends on the cause for dysphagia. **Laparoscopic Heller myotomy**, which is used to cut the muscle at the lower end of the esophagus sphincter when it fails to open and release food into the stomach in people who have achalasia. Your doctor inserts a lighted tube endoscope into your esophagus and inflates an attached balloon to gently stretch and expand its width dilation. Alternatively, your doctor may pass a flexible tube or tubes of different diameters instead of a balloon. The doctor can also insert a metal or plastic tube stent to prop open a narrowing or blockage in your esophagus. Some stents are permanent, such as those for people with esophageal cancer, while others are temporary and are removed later. **Request an Appointment at Mayo Clinic** **Clinical trials** Explore Mayo Clinic studies testing new treatments, interventions and tests as a means to prevent, detect, treat or manage this disease. **Lifestyle and home remedies** If you have trouble swallowing, be sure to see a doctor and follow his or her advice. Also, some things you can try to help ease your symptoms include: **Changing your eating habits.** Try eating smaller, more-frequent meals. Be sure to cut your food into smaller pieces, chew food thoroughly and eat more slowly. Trying foods with different textures to see if some

cause you more trouble. Thin liquids, such as coffee and juice, are a problem for some people, and sticky foods, such as peanut butter or caramel, can make swallowing difficult. Avoid foods that cause you trouble. Avoiding alcohol, tobacco and caffeine. These can make heartburn worse. Depending on the suspected cause, your doctor may refer you to an ear, nose and throat specialist, a doctor who specializes in treating digestive disorders gastroenterologist or a doctor who specializes in diseases of the nervous system neurologist. What you can do Be aware of pre-appointment restrictions. List your symptoms, including any that may seem unrelated to the reason for which you scheduled the appointment. Write down key personal information, including major stresses or recent life changes. List all medications, vitamins and supplements you take. Write down questions to ask your doctor. For dysphagia, some basic questions to ask your doctor include: What are other possible causes? What tests do I need? Is this condition temporary or long lasting? I have other health conditions. How can I best manage them together? Do I need to restrict my diet? Are there brochures or other printed material I can have? What websites do you recommend? What to expect from your doctor Your doctor is likely to ask you a number of questions, including: When did your symptoms begin? Have your symptoms been continuous or occasional? Does anything seem to improve your symptoms? What, if anything, appears to worsen your symptoms? For example, are certain foods harder to swallow than others? Do you have difficulty swallowing solids, liquids or both? Do you cough or gag when you try to swallow? Did you first have trouble swallowing solids and then develop difficulty swallowing liquids? Do you bring food back up regurgitate after swallowing it? Do you ever vomit or bring up blood or black material? Have you lost weight? What you can do in the meantime Until your appointment, it may help to chew your food more slowly and thoroughly than usual. Over-the-counter antacids also may help temporarily.

### 7: Dysphagia - Symptoms and causes - Mayo Clinic

*Ethics and Standards Committee Page 2 Guidelines for assessment and management of patients with Dysphagia Introduction Speech-language therapists involved in the management of dysphagia are required to.*

### 8: Oropharyngeal dysphagia - Wikipedia

*The two major instrumental assessment procedures for dysphagia, the video-fluoroscopic examination and the fiberoptic endoscopic evaluation of swallowing (with transnasal passage of a flexible laryngoscope), are described in detail, with schemas and visualization pictures.*

### 9: Dysphagia - Diagnosis and treatment - Mayo Clinic

*For evaluation of dysphagia, your doctor will perform a physical examination and use a variety of tests to determine the cause of your swallowing problem. These tests could include a barium swallow x-ray, an upper endoscopy (EGD), or an esophageal muscle test (manometry).*

*PTEN and NDUF8B aberrations in cervical cancer tissue S. M. Hsieh . [et al.] The life and works of Charles Lamb. The social functions of avoidances and taboos among the Zulu Masters of the Big House Section III: Contexts and variations ; 5. Creative language and social context ; 6. Creativity, discourse Analytical psychology its theory and practice Congress and its members Measurement and Meaning in Economics Food in Shakespeare (Literary and Scientific Cultures of Early Modernity) Years of the aging Soviet leaders Low back pain syndrome Path to priesthood Imperialism, race, and resistance Juvenile delinquency in Maine . Tomba 2 The Evil Swine Return Ups and downs on the ocean Jerome embraces the Ascetic Life 30 Today I will nourish my inner martyr The experience of politics: you and American Government. And Eternity (Incarnations of Immortality) Dont be surprised! Prophecies of the Bible Shadow falls book 3 Indigenous Peoples: Ethnic Minorities and Poverty Reduction Methodology for analytical toxicology Tom Glazers Treasury of Songs for Children Selecting target areas Basic Technical Mathematics and Basic Technical Mathematics with Calculus, Students Solutions Manual Water: the wonder of life Initial business considerations Cities and Urban Life (2nd Edition) Eyewitness Travel City Map to San Francisco Juvenile delinquency a sociological approach 10th edition Learning to Become a Person of Influence About This Booklet A Conversation With Harris Seldon (Occasional Paper, 116) The selected poetry of rainer maria rilke stephen mitchell Brett Weston Dianne Nilsen 5. Secondary features 138 Logitech professional presenter r800 manual*