Dysphagia Management

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Overview

- What is dysphagia?
- Why is it important?
- Causes of dysphagia in EOL Care
- Signs and symptoms
- Management strategies
Dysphagia: What is it?

- a disorder of swallowing
  - transfer of food from the mouth to the stomach

- aspiration: entry of material into the trachea, below the level of the vocal cords
Dysphagia: why is it important?

- malnutrition/under-nutrition
- dehydration
- choking
- aspiration pneumonia

- quality of life
- …a significant source of patient and family distress
Dysphagia

prevalence:

– 92/797 consecutive hospice patients (1/8, 11.7%)
– a series of 33 patients with clinical evidence of organic dysphagia associated with terminal malignant disease (tumours of the upper aerodigestive tract)
– over 80% of this group who underwent necropsy had locally obstructive lesions
– conservative treatment alone led to amelioration of dysphagia in approximately 60% of pts

Lancet, 1988
Problems/Reasons for Dysphagia:

- weakness, fatigue
- anorexia, cachexia
- pain
- nausea, vomiting
- xerostomia “dry mouth”
- infection
- anxiety – fear of choking
- taste, texture aversion
- reflux (Aviv et al., 2000)
- sensory problems
- physiological problems
- aging
- depression
- stomatitis, mucositis
- surgery, radiation
Dysphagia: Interrelated Factors

Grant & Riviera, 1995

- **Physiological:**
  - Nausea and vomiting, early satiety
  - Dysphagia, xerostomia

- **Psychological**
  - Anxiety, depression, fatigue

- **Social**
  - Hospitalization – loss of usual foods and companions

- **Decreased food intake can lead to decrease in nutritional status**
Assessment

- history
- clinical exam only (vs instrumental exam)
- patient’s “biography” and goals
- ongoing clinical re-evaluation
Signs and Symptoms

- weight loss, undernutrition
- dehydration
- coughing, choking
- weak cough/throat clear
- dysarthria, dysphonia
- wet, gurgly or breathy phonation

- drooling
- avoidance of certain foods, liquids
- respiratory problems
- effort, fatigue
- pain or discomfort
- sense of obstruction
- self-report: QoL
Family Perspectives

**weakness:** “you lose your strength, you’re a lot weaker than you would be if you were keeping your body fluids up”

**sickness:** “I know that you can get really sick when a person dehydrates. They stop their body functions”

**pain:** “it would be painful (to be dehydrated) because a body needs a certain amount of moisture”

McClement (2001-2002)

Behavior of families with a loved one in palliative care:
- Fighting back
- Letting nature take its course
- Pseudo-surrendering
Management Strategies

- Goals of treatment
- Aspiration pneumonia
- Xerostomia management
- Oral Care
- Treatment: compensatory techniques
- Tube-feeding
Goals of Dysphagia Treatment:

- Maintain oral intake/reduce need for tube-feeding
- Minimize hospital stay
- Relieve pain and symptoms
- Improve safety and efficiency of swallow
- Reduce risk of coughing/choking (aspiration pneumonia)
- QUALITY OF LIFE – support patient and family wishes
Aspiration Pneumonia

**Significant predictors for pneumonia:**

- multiple medical diagnoses (COPD, GI)
- current smoker
- tube feeding
- number of decayed teeth
- high # of medications
- dependent for feeding and/or oral care

Langmore et al., 1998
Specific Goals:  

**Minimize Aspiration**
- food, liquid
- reflux
- saliva, plaque

**Reduce Bacteria in the Mouth**
- dental care/oral care
- change meds/fluids if possible

Langmore et al. (2001)
Specific Goals (cont’d):

- Boost “Host” Resistance
  - tobacco reduction?
  - upright posture, movement
  - improve ability to cough and clear secretions
  - improve nutritional status
Xerostomia in Advanced Cancer

Davies, Broadley, & Beighton, 2001

- 120 pts completed MSAS, UWSFR
- average age: 66 yrs
- fourth most common symptom (78% of pts)
- associated with poor performance status
- ranked third most distressing symptom
  - 58% rated as “somewhat” to “very much”
Xerostomia in Advanced Cancer

Davies, Broadley, & Beighton, 2001

- severity correlated with severity of:
  - oral discomfort
  - difficulty chewing
  - mouth sores/discomfort
  - anorexia
  - difficulty speaking
  - dysphagia
  - dysphonia

- usual cause: medication (97.5%)
Xerostomia - Causes

- medications
- dry room air
- mouth breathing
- reduced talking, eating, saliva stimulation
- reduced thirst sensation
- dehydration
- reduced fluid intake
- radiation effects
- surgery
- infections
Xerostomia – medications

Davies, Broadley, & Beighton, 2001

- Opioid analgesics
- NSAIDs
- PPIs (e.g., Losec)
- Corticosteroids
- Diuretics
- Antidepressants
- Antipsychotic meds
- Antihistamines
- H2-receptor antagonists (e.g., Ranitidine)
- Benzodiazepines
- Beta-blockers
- Ca-channel blockers
- Other classes of drugs
Oral Care

- good oral hygiene
- frequent sips of water
- ice chips, frozen tonic water, pineapple
- sugarless candy or gum
- saliva substitutes
- humidification
- avoid alcohol-containing mouthwashes
Oral Care

Lee et al., Rousseau (1996); Guggisberg, Rapin, & Budtz-Jorgensen, 1990

treat oral infections

Pilocarpine 2.5-10 mg tid

mouth rinse:
- sodium bicarbonate - dilute
- sterile saline
- water

avoid lemon or glycerine swabs

keep lips moist
Oral Care

University of Manitoba
  – Community Dentistry Program
Safe Swallow Suggestions

- diet/texture modification
- thickened liquids
- bolus size
- self-feeding
- alter xerostomic meds

- humidification, oral lubricants
- mouth care
  - “symbolic feeding”
    - Miles (1985)
- feeding posture
- pain management
Treatment

Positioning

Postures and Manoeuvres:
- chin tuck
- head turn/tilt
- supraglottic swallow
- effort swallow
DVD

Feeding Dysfunction and Rehabilitation in the Elderly
Nutrition, Hydration, and Palliative Care

- Dehydration can reduce secretion production and coughing; ease respiration.
- Can reduce nausea, vomiting.
- Blood chemistry changes following terminal dehydration produce a natural analgesia.
- Decreased *desire* for food and liquids.
  - McCann et al., 1994.
- Reduced *need* for food and fluid.
  - Frederick, M.; AAHPM Bulletin; Fall, 2002.
Problems with Tube Feeds

aspiration, choking
pain, reflux
infection
agitation - physical restraints
also:
denied pleasure of eating
diminished human contact
(Finucane, Christmas, & Travis, 1999; Scott & Austin, 1994)
may be visible and/or uncomfortable
loss of control Scofield (1991); Segel & Smith (1995)
Appropriate Uses for ANH in Palliative Care

- Feeding tube in place and want to use it (e.g., in ALS, H-N cancer)
- Untimely or uncomfortable death may result without ANH
- When important to prolong life for important event (e.g., wedding, graduation)
- When tube/line is source of control or denial

McCamish & Crocker, 1993
Levels of Nutritional Intervention
McCamish & Crocker, 1993

- **dietary intervention**
  - any desired foods
  - modified texture or nutrient density
  - full meals and snacks

- **enteral supplements** (e.g., fatigue, malnutrition)

- **tube feeding**
  - supplement pt’s daytime but inadequate intake

- **parenteral nutrition** (and hydrodermoclysis)
DVD

Alzheimer’s Disease: Natural Feeding Techniques
Recommendations:

- decisions should be made jointly with team including patient and family
- aim for care in least restrictive environment
- present families with reasonable alternatives to tube feeding
- care should be consistent with patient’s previously expressed wishes
Recommendations:

- TF intervention with *specific goals and regular reassessment*
- stop TF if goals of therapy are not met

- JPM, 2000, 3(1), 1-3
- Finucane, Christmas, & Travis, 1999
- Segel and Smith, AJSLP, 1995
- McCann, 1999
- Aumann & Cole, 1991
Alternatives...

- Dysphagia management
- Dental/oral care
- Short trial with hand feeding
- Short trial with tube feeding with evaluation of outcome
- Discontinue/adjust non-essential medications (anticholinergic, xerostomic)
- Staff education
Silver Spoon Program
Musson et al., 1990

- Recruited community volunteers to feed patients
- Happy Hour – social activity with food and fluids
- Second Seating – altered schedule to give more time for dependent feeders
Alternatives...

- assistive devices
- body position, facilitation techniques
- finger foods, preferred foods
- reminders to swallow
- evaluation of other illnesses (e.g., depression)
- use of volunteers to hand-feed
- *family education/counseling*


- Finucane, Christmas, & Travis, 1999
- Abbasi & Rudman, 1994