Management of dysphagia

It is gratifying to see attention paid to the nutritional status of stroke patients with dysphagia, an often overlooked aspect of care. However, it is unfortunate that Hillel Finestone and Linda Greene-Finestone promulgate some of the misperceptions that abound in the area of managing patients with a swallowing disorder.

One of the most distressing errors, which often leads to inappropriate management, appears in the article title. Dysphagia cannot be “diagnosed.” Rather, it is a symptom of several hundred conditions and cannot be managed properly without identification of the source. Dysphagia has come to be discussed as though it were a disease in and of itself, which leads to the misconception that there is a standard approach to its management. This has in turn led to various inappropriate strategies for care, including some that contribute significantly to dehydration, as the authors have noted elsewhere. Where Finestone and Greene-Finestone refer to “overnight intravenous fluid administration,” it is to be hoped that they mean hypodermoclysis, the long-term hydration method of choice.

The case presented illustrates the most problematic of all issues associated with oropharyngeal dysphagia: aspiration. The patient in this case is described as having “pneumonia” in both lungs on the day of admission (also the day of insult). However, this is clearly a case of aspiration pneumonia, caused by inhalation of the reported vomiting, not bacterial pneumonia requiring antibiotics. Antibiotic therapy, as mentioned in the case description, might well be prophylactic against the secondary bacterial infection that often occurs but would not be effective for chemical pneumonitis. Secondary pneumonia is most often caused by aspiration of saliva, an event that also occurs in healthy adults and that is best avoided by scrupulous mouth care.

In the final section, “The case revisited,” the authors state that "Mr. B’s pneumonia is a strong indicator that aspiration occurred. His pneumonia is a probable sequela of aspirating saliva. Mr. B is not allowed to have anything by mouth when he is admitted to hospital.” Finestone and Greene-Finestone have missed the obvious at several levels. The patient’s “pneumonia” on admission was certainly the result of aspiration but could not have been due to aspiration of saliva (bacterial pneumonia). The solution is not to give him nothing by mouth but instead to identify the real cause of the problem and ensure scrupulous mouth care while maintaining good nutrition and hydration.

Of the remaining misperceptions, one in particular requires mention: there is no relation between the presence or absence of a gag reflex and the ability to swallow.

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Hilile Finestone and Linda Greene-Finestone\(^1\) offer many useful points in their article on dysphagia. However, it is disappointing that the technique and value of swallowing retraining\(^2\) are not mentioned.

Credit for recognizing that stroke victims may “forget” how to swallow, and can be retrained to do so, goes to Henry Heimlich.\(^4,5\) Both of his papers are well worth reading, as they document the pioneering of a new therapy. In brief, the technique of swallowing retraining is based on the idea that the reflex sequence of deglutition can be retaught if it is lost as a result of stroke. Heimlich’s original reports\(^4,5\) described patients being instructed in sucking, elevation of the larynx and coordination of those functions. People who have lost the ability to swallow for other reasons, such as disuse atrophy of the pharyngeal muscles, can also be retrained.

Over a period of years this mode of rehabilitation gradually became the domain of speech pathologists, and many physicians who care for stroke patients have unfortunately remained completely unaware of it. If there is swallowing dysfunction but no speech impediment, it is quite possible that a speech pathologist will not be consulted, and the patient may be unnecessarily consigned to permanent gastrostomy. As described in the article,\(^1\) swallowing function returns spontaneously in some cases. In others, it does not — but in some of those patients, it can be restored by retraining.

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Irene Campbell-Taylor is correct that dysphagia can be a symptom of a wide variety of conditions; however, our article\(^1\) specifically discusses dysphagia as a result of central neurologic conditions, in this case stroke, and we do not think that the context would be misconstrued by our audience.

Campbell-Taylor hopes that by the term “overnight intravenous fluid administration” we actually meant hypodermoclysis, which she characterizes as “the long-term hydration method of choice.” Hypodermoclysis\(^2\) is a fine method of hydration that unfortunately has not yet caught on to a significant degree in Canadian hospitals, and it would have been a good choice for fluid administration. However, given the typical evolution of dysphagia, fluids may not be required for a prolonged period, so it was not necessary to choose a long-term method.

Campbell-Taylor also emphasizes that aspiration pneumonia must be differentiated from aspiration pneumonitis. Mark\(^1\) distinguished these 2 entities but noted that “some overlap exists.” When a patient presents to the emergency department with a history of stroke, dysphagia and bona fide infiltrates on radiography, as in the case described, we feel that antibiotics would be indicated, especially given the “sick” state (hyperglycemia, hypertension) ex-

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