

## **Oropharyngeal Dysphagia in the Critically Ill Patient: An Addition and Subtraction Challenge**

**Ana María Tobón Espinosa<sup>1</sup> and Julián Rondón-Carvajal<sup>2\*</sup>**

<sup>1</sup>Speech Therapist, María Cano University Foundation, Medellín, Colombia

<sup>2</sup>Internist, IPS Universitaria - León XIII, Health Services, University of Antioquia, Medellín, Colombia

**\*Corresponding Author:** Julián Rondón-Carvajal, Internist, IPS Universitaria - León XIII, Health Services, University of Antioquia, Medellín, Colombia.

**Received:** September 17, 2021; **Published:** October 12, 2021

Swallowing is defined as a complex motor and reflex act whose objective is to transport the food bolus from the mouth to the stomach, with sensitive and motor responses, modifiable by alterations in the stimulus, in the volume of the food and the characteristics of the food bolus. Likewise, oropharyngeal dysphagia is diagnosed when there is difficulty in the oral preparation or containment of solids and/or liquids, with or without difficulty in safely initiating swallowing or propulsion of the bolus through the pharynx, unlike esophageal dysphagia [1], where a mechanical component derived or not from disorders in the innervation of the esophageal muscle fibers prevails.

There are warning signs that can make us suspect the presence of a swallowing disorder and that, depending on the patient's situation, may not be expressed by the patient in critical health conditions for different reasons: compromise of the mental sphere, negative effect of sedative-analgesic drugs, neurological sequelae (as in the case of patients with a history of stroke), among others. Some of them are listed below [2].

<b>Manifest signs</b>	<b>Silent signs</b>
Dysphagia	Laryngeal throat clearing (vocal clearing)
Nasal regurgitation	Avoidance of certain foods
Coughing during food intake	Prolongation of mealtime
Unintentional weight loss	Frequent lower respiratory infections
Remains of food in the mouth after swallowing	Changes in respiratory pattern after swallowing
Drooling	Recurrent dysphonia

**Table 1**

The evaluation and rehabilitation of oropharyngeal dysphagia in the critical patient setting is based on instrumental clinical evaluations whose main objective is to detect and address it by means of screening tests, oriented on three scales [2,3]:

1. Estimate the probability of aspiration in the patient.
2. To indicate the need for evaluation of swallowing mechanics in high-risk patients.
3. To determine the safety of swallowing before initiating oral intake in patients with transient alternate feeding routes (enteral, parenteral).

Clinical strategies (protocols: EAT -10, V-VST - Volume viscosity, PARD, cervical auscultation) and instrumental strategies (pulse oximetry, FEES, videofluoroscopy of swallowing) have been described; the former include self-assessment questionnaires, of verbal analogical type, being useful not only for diagnosis but also for follow-up in terms of rehabilitation by phonoaudiology [4]. This is of interest for the clinician, taking into account that according to some studies dysphagia has a prevalence close to 40% in patients older than 60 years, being an entity usually underdiagnosed.

Likewise, in the intensive care unit setting, dysphagia, including post-extubation dysphagia (PED), is a constant concern, a matter of addition and subtraction in terms of length of stay and mortality. Previous studies, most of which were limited by study design, patient selection and/or limited number of patients, reported contradictory and inconsistent results regarding the incidence of post-extubation dysphagia [3,4]. In fact, incidence rates ranged from 3 to 62%. Moreover, PED persisted until ICU discharge in more than 80% of cases and more than 60% of patients with impaired swallowing in the ICU were still dysphagic at hospital discharge, which has an impact on morbidity and mortality, with an excess all-cause mortality at 90 days of 9.2%, according to some registries [5].

It is then urged to be more active in the parallel processes of rehabilitation of the critically ill patient, highlighting the comprehensive approach to their care that includes, of course, the strengthening of the biophysical mechanisms involved in such a noble and necessary act for human enjoyment and survival as feeding.

### Bibliography

1. Philpott H., *et al.* "Dysphagia: Thinking outside the box". *World Journal of Gastroenterology* 23.38 (2017): 6942-6951.
2. Abdel Jalil AA., *et al.* "Approach to the patient with dysphagia". *The American Journal of Medicine* 128.10 (2015): 1138e17-23.
3. McGinnis CM., *et al.* "Dysphagia: Interprofessional Management, Impact, and Patient-Centered Care". *Nutrition in Clinical Practice* 34.1 (2019): 80-95.
4. Altman KW. "Dysphagia evaluation and care in the hospital setting: the need for protocolization". *Otolaryngology-Head and Neck Surgery* 145.6 (2011): 895-898.
5. Zuercher P., *et al.* "Dysphagia in the intensive care unit: epidemiology, mechanisms, and clinical management". *Critical Care* 23 (2019): 103.

**Volume 8 Issue 11 November 2021**

**©All rights reserved by Ana María Tobón Espinosa and Julián Rondón-Carvajal.**