



European Society for Swallowing Disorders

ESSD Position Statements:

Oropharyngeal Dysphagia in Adult Patients

The Statements were drafted by expert panels which included the chairs of the corresponding sessions at the **2nd ESSD Congress, Barcelona 25 October 2012** prior to the congress and were debated and corrected at the end of each session. The statements were endorsed by the Acadèmia de Ciències Mèdiques de Catalunya I les Balears, CIBERehd - Instituto de Carlos III, AIAQS and ESPEN.

The **aim** of the statements is to provide a consensus on best practice and the state of the art, unify criteria and identify best clinical practice among the different healthcare centers and professionals working with patients with oropharyngeal dysphagia (OD).

More details will be available on www.myessd.org.

General Position Statements: Common Statements for all Stages and Patients

- Reliable, feasible, validated tools must be used to measure, screen, assess, diagnose and treat dysphagia.
- The WHO International Code of Diseases (ICD) and International Classification of Functioning, Disability and Health (ICF) for dysphagia must be included in the medical report of every patient (see glossary).
- Health care practitioners involved in dysphagia should have specific training, and have good knowledge and experience on how to use different techniques.
- Dysphagia should be managed by multidisciplinary teams (see glossary).
- International definitions and terminology and standardization of textures and nutritional adaptations for fluids and solids are urgently needed.

Position Statement on the Standardization of Clinical Methods for Screening and Assessment of OD

- Clinical screening is defined as an evaluation that recognizes clinical signs of OD and identifies those patients at risk of OD, the purpose being to determine whether a



European Society for Swallowing Disorders

person's swallow is likely to be impaired and a detailed assessment of swallow therefore indicated. Clinical screening can be done by medical and/or nursing staff with basic training in the screening tool. Screening should be noninvasive and simple and to have been proven reliable, valid and feasible in the clinical environment.

- Clinical assessment is defined as a comprehensive evaluation of the efficiency and safety of swallow by health care professionals with specific training, the purpose being to determine presence, severity and mechanism of the swallow impairment. This provides the necessary information for devising a management plan. A water test is recommended, with the possible incorporation of pulse-oximetry and different viscosities, or other validated methods.
- All inpatients at risk for OD (such as neurological and elderly patients) should be kept nil per os until their swallowing ability is screened using a reliable and valid screening tool. Screening identifies patients at risk for dysphagia and prioritizes patients for full assessment. Screening should be performed as soon as the patient is awake and alert.
- Specific assessment should be performed for specific diseases.

Position Statement on the Standardization of Diagnostic Methods – Videofluoroscopy (VFS) and Fiberoptic Endoscopic Evaluation of Swallowing (FEES)

- Patients whom clinical assessment reveals are likely to suffer from OD or poor airway protection should undergo an instrumental examination, either VFS or FEES.
- VFS and FEES should be performed in a standardized way, preferably with the patient in an upright position. VFS should always include lateral projection of the oral cavity, pharynx, and oesophagus.
- A standardized protocol is essential for both VFS and FEES; however individually designed examinations are necessary for some patients.
- The diagnostic test should focus on the patient's worst swallow to reveal dysfunction or morphologic abnormalities that can explain the patient's symptoms.
- The instrumental test should also determine methods by which the impairment might best be remedied.



European Society for Swallowing Disorders

- The procedure should include manoeuvres and postures where necessary as well as the use of different viscosities and textures including, if deemed safe, thin liquid, puree and soft solid. The best test materials are those similar to the food and liquid the patient normally eats and drinks. Cultural differences should be taken into account (water, carbonated liquids, milk, juices, coffee, tea may be used).
- A VFS should be performed by an expert in dysphagia together with a radiologist. The competence of both specialists is necessary. VFS should be performed at a capture rate of at least 25 frames per second.

Position Statement on Nutritional Complications in Patients with OD

- Patients with OD are at risk of malnutrition and nutritional status should be screened and monitored regularly. Validated and reliable nutritional risk screening tools should be used as recommended by the Council of Europe.
- Methods for clinical assessment of nutrition need to be validated and reliable. The minimum data to be incorporated are weight, height, weight changes over time and dietetic assessment.
- Hydration status must be assessed in patients with OD, as dehydration is one of the most common silent complications.
- In malnourished OD patients, the efficiency and the safety of swallowing must be assessed in order to decide the route to provide specialized nutritional support (oral, enteral or mix). The continued need for adapted nutritional support should be reviewed regularly.
- Diagnosis of malnutrition, the severity and the type must be reported in the patient's medical history using the ICD and ICF code.

Position Statement on Respiratory Complications in Patients with OD

- Aspiration pneumonia (AP) is a serious complication of OD. One of the main causes is the aspiration of colonized oropharyngeal material mainly from the oral cavity to the lungs. Poor oral health and oral diseases such as caries or periodontal disease are closely related to oropharyngeal colonization by respiratory pathogens. When these pathogens are aspirated and the immune status of the patient is impaired, an AP can be contracted.



European Society for Swallowing Disorders

- Some risk factors such as poor oral health, malnutrition, smoking, dry mouth and polymedication facilitate oropharyngeal colonization and should be avoided. For example, poor oral hygiene may lead to oropharyngeal bacterial colonization by respiratory pathogens. Keeping the oral cavity clean can reduce the incidence of AP.
- The implementation of a structured dysphagia programme in a hospital setting can reduce the rate of pneumonia and need for antibiotics.
- The diagnosis and treatment of AP can be improved by early identification of patients who are at risk of aspiration using easy and reliable screening tools, by applying a standardized oral healthcare program in hospitals and nursing homes and an appropriate diet adaptation of fluids and solids.

Position Statement on Behavioral Treatments and Rehabilitation

- All patients diagnosed with OD should have individualized and evidence-based dysphagia treatment according to best available information.
- The evidence base for behavioral treatments and swallowing rehabilitation is currently limited and requires more, high quality research.
- Evidence-based individualized treatments include bolus texture modifications and postural adjustments alongside stimulation-based therapies - all of which require further cost-benefit analysis.

Position Statement on Dietary Management, looking for a consensus

- Food and beverages for dysphagia management need to be safe, attractive, and provide adequate nutrition/hydration.
- All health care providers need specific training to note and report signs that may indicate the presence of dysphagia.
- All individuals who are prescribed texture modified foods for dysphagia management require a nutrition referral and regular reviews to routinely check food and fluid intake and ensure optimal nutrition/hydration management.
- Active treatment of dysphagia is advocated to improve nutritional outcomes.
- Consistent terminology improves patient safety and communication.
- All patients need to be adequately educated on the options and rationale for dietary/nutrition management to facilitate best informed choices and management decisions.



European Society for Swallowing Disorders

- A variety of texture modified foods/modified fluid consistencies should be offered/provided to promote enjoyment and encourage intake.

Position Statement on OD Management in Older Persons

- Older persons are at risk for OD due to a variety of factors (aging, neurodegenerative disease, dementia, frailty, pneumonia, impaired functional status, acute conditions, poly medication) and should undergo screening for dysphagia and nutrition/hydration concerns.
- Screening of older persons should be disease-specific when possible (validated questionnaires for Parkinson's Disease, screening of patients with dementia etc.).

Position Statement on OD in Patients with Neurodegenerative Diseases

- OD is a common and potentially life threatening problem in patients suffering from neurodegenerative diseases.
- Due to the heterogeneous entities leading to neurodegeneration, interdisciplinary, holistic patient management has to be tailored to their specific symptoms and needs. However, there is a need to standardize clinical guidelines for patients with neurodegenerative diseases in order to allow early detection and appropriate management of OD.
- Adequate nutrition (oral /non-oral) deserves special interest. There is a lack of consensus over if and when PEG is indicated. Ethical considerations have to be addressed.

Comment: The demographic situation in the western world and improved health care will increase the population of the elderly. Diseases with progressive dementia will therefore become more common and, among other things, represent a challenge for adequate dysphagia management.



European Society for Swallowing Disorders

Screening, Diagnosis and Treatment of Oropharyngeal Dysphagia in Stroke Patients

The Statements were drafted by an expert panel which included the faculty of the **Precongress Course on Oropharyngeal Dysphagia in Stroke Patients, 2nd ESSD Congress, Barcelona 25 October 2012** and were debated and corrected during the last session of the course. Participants included the Acadèmia de Ciències Mèdiques de Catalunya I les Balears, CIBERehd - Instituto de Carlos III, AIAQS and ESPEN.

The **aim** of the statements is to provide a consensus on best practice and the state of the art, unify criteria and identify best clinical practice among the different healthcare centers and professionals working with patients with oropharyngeal dysphagia.

More details are available on www.myessd.org.

- Statement on Screening. All acute stroke patients should be kept nil per os until their swallowing ability is screened, by trained health care professionals, using a reliable and valid screening tool. Screening should be completed as soon as the patient is awake and alert. Screening identifies patients at risk for dysphagia and prioritizes patients for a full assessment.
- Statement on Diagnosis. OD can be diagnosed in stroke patients by using validated clinical assessment methods and, if appropriate, instrumental exploration protocols such as VFS and FEES. A formalized assessment for dysphagia should be performed on all stroke patients as soon as possible after failed screening and before oral intake. The diagnosis and grading of OD should be reported using validated scoring systems and ICD and ICF codes in the medical report of every patient.
- Statement on respiratory complications. Pneumonia is a frequent complication in the first days following stroke. Pneumonia following stroke is associated with greater mortality and long-term impairment. The presence of oropharyngeal dysphagia and aspiration correlates with the highest relative risk of stroke-associated pneumonia (SAP). The implementation of a structured dysphagia program in a hospital setting can reduce pneumonia rates and antibiotic use.
- Statement on nutritional complications and dehydration. Patients with OD should be screened for nutritional risk upon admission. Further assessment of nutritional status and hydration must be performed and appropriate treatment provided to prevent



European Society for Swallowing Disorders

deterioration of nutritional status and complications. Nutrition experts should be involved in the management of OD. Furthermore, international guidelines based on clinical evidence need to be developed using standardized dysphagia diet terminology (liquids and solids).

- Statement on standards of treatment Diagnosis of OD should be directly linked to appropriate compensatory, protective and rehabilitative procedures. For example: Nutritional recommendations should be systematically implemented including adaptation of texture of solids and fluids and patients educated on the options and rationale. Bolus modification and postural adjustments should form part of minimal treatment protocol.

As the evidence for behavioral treatments and swallowing rehabilitation is currently limited, higher quality, controlled research is required.

- Statement on prognosis, institutionalization and follow up All patients receiving modified texture diets or enteral feeding for OD require reassessment of their swallow and nutritional status usually the first week and maximum 2 to 3 months thereafter during the first year and then at least every 6 months thereafter. The severity of the swallowing impairment and the rate of improvement may alter the reassessment schedule.

Monitoring should include patients in long-term care institutions.

- The multidisciplinary dysphagia team A dysphagia program should involve a trained core team composed of physicians, nurses, swallowing and/or speech and language therapists, and experts in nutrition. Ideally there should be a dysphagia team in each general hospital and long-term care facility.
- Statement on Guidelines These position statements should be developed into future guidelines following evidence-based research that demonstrates their validity.

ESSD recommendations:

- ESSD advocates an open access policy for training programs for health care practitioners and will promote educational activities.
- ESSD promotes evidence-based classification and description of the levels of adaptation for solids and fluids.



European Society for Swallowing Disorders

- The ESSD promotes research in evidence-based behavioral treatments and swallowing rehabilitation.
- International definitions and terminology and standardization of textures and nutritional adaptations for fluids and solids are urgently needed. ESSD will promote the development of a consensus on definitions and standardization of textures and nutritional adaptations for fluids and solids between nutritional companies, scientific associations and other stakeholders.

Abbreviations

- AP: Aspiration Pneumonia
- ESSD: European Society for Swallowing Disorders
- FEES: Fiberoptic Endoscopic Evaluation of Swallowing
- H&N cancer: Head and Neck cancer
- ICD: International Classification of Diseases.
- ICF: International Classification of Functioning, Disability and Health
- NPO: Non Per Oral
- OD: Oropharyngeal Dysphagia
- SAP: Stroke Associated Pneumonia
- VFS: Videofluoroscopy

Glossary

- Efficacy of swallow: the patient's ability to ingest all the calories and water he/she needs to remain adequately nourished and hydrated. Pathogenesis of impaired efficacy is related to alterations in bolus propulsion caused by a weak muscular tongue squeeze associated to sarcopenia and weakness [2].
- Safety of swallow: the patient's ability to ingest all required calories and water with no respiratory complications. Pathogenesis of impaired safety is related to a delay in several physiologic protective reflexes in oropharyngeal reconfiguration (mainly laryngeal vestibule closure) caused by a slow neural swallow response and is associated with several risk factors such as aging, neurodegenerative diseases, confusion, dementia, and drugs [2].



European Society for Swallowing Disorders

- ICD codes: The International Statistical Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems.
- ICF codes: The International Classification of Functioning, Disability and Health, known more commonly as ICF, is a classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: a list of body functions and structure, and a list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors.

References

[1] Robbins J, Langmore S, Hind JA, Erlichman M. Dysphagia research in the 21st century and beyond: proceedings from Dysphagia Experts Meeting, August 21, 2001. J Rehabil Res Dev. 39(4):543-8; 2002.

[2] Rofes L, Arreola V, Almirall J, Cabré M, Campins L, García-Peris P, Speyer R, Clavé P. Diagnosis and management of oropharyngeal Dysphagia and its nutritional and respiratory complications in the elderly. Gastroenterol Res Pract. 2011; pii: 818979; 2011.

[3] ICD and ICF Codes

<http://www.who.int/classifications/icd/en/>

<http://www.cdc.gov/nchs/icd.htm>

<http://www.who.int/classifications/icf/en/>

<http://www.cdc.gov/nchs/icd/icf.htm>