Dysphagia

Disclaimer

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Background

About dysphagia

Dysphagia, or difficulty in the act of swallowing (often with a sensation of hold-up of the swallowed bolus), is usually divided into pharyngeal (upper) and oesophageal (lower) causes.

Using plain language is helpful when assessing patients to diagnose serious causes e.g., “heartburn most days for 3 weeks or more”, or “food sticking when swallowing”.

Quick links

- I-PACED Oesophageal and Gastric Cancers Resource Card
- Oesophagogastric Cancer: Optimal Care Pathway
- Oesophagogastric Cancer: What to Expect

Red flags

- Sudden onset complete dysphagia
- Inability to swallow
- Dysphagia with difficulty in breathing or stridor
- Dysphagia caused by a foreign body or solid food

Assessment

Acute obstruction

1. Determine the cause of the obstruction e.g., food bolus or foreign body such as chicken or fish bone.
2. Determine whether the patient can swallow saliva.
3. In the acute situation, general practice X-rays are not useful and may delay referral and treatment. If appropriate, any X-rays will be performed in secondary care.

Dysphagia

1. Take a history:
   - Ask about symptoms and risk factors for oesophageal, gastric, and throat cancer. Record smoking history, alcohol intake, and medications.
Review medications

- There are approximately 160 known medications that list dysphagia as a potential adverse effect.
- Dysphagia may be an adverse effect of the drug, a complication of the drug’s therapeutic action, or represent a medication-induced mucosal injury.
- Examples of medications that can cause dysphagia:
  - Antipsychotic or neuroleptic medications – extrapyramidal reactions may impair swallowing
  - Anticonvulsants – may cause drowsiness and motor incoordination, both of which may affect swallowing.
  - Xerostomia (dry mouth) can occur with angiotensin-converting enzyme inhibitors, antiarrhythmics, anticholinergic medication, antiemetics, antidepressants, antihistamines and diuretics
  - Oesophageal mucosa irritation may be induced by:
    - orally ingested bisphosphonates, doxycycline, iron supplements, non-steroidal anti-inflammatory agents (NSAIDs) and potassium chloride.
    - swallowing medications in a supine position.
    - taking medications immediately before bedtime.
    - taking medications without enough fluid.

Risk factors for esophageal and gastric cancer

Oesophageal adenocarcinoma or squamous cell carcinoma:
- Age
- Male gender
- Barrett’s oesophagus
- Smoking
- Obesity
- Gastro-oesophageal reflux
- Caustic injury
- Alcohol
- Achalasia

Gastric cancer:
- Age
- Helicobacter pylori (H. pylori)
- Previous partial gastrectomy
- Smoking
- Pernicious anaemia
- Family history
- Race (Asian descent)

Consider using the Oesophago-gastric Cancers Risk Assessment Tool to assist in determining the likelihood of cancer in patients aged > 55 years given specific symptoms and signs.
**Oesophago-gastric Cancers Risk Assessment Tool**

Refer patients for urgent or routine gastroenterology referral if probability of cancer is > 5% (red section).

![Risk Assessment Table](image)

Symptoms

Symptoms of oesophageal and gastric cancer:
- Persistent epigastric pain or dyspepsia (heartburn most days for ≥ 3 weeks)
- Pain on swallowing
- Food bolus obstruction (food sticking when swallowing)
- Unexplained weight loss
- Haematemesis or melaena
- Early satiety (feeling full after eating)
- Unexplained nausea and bloating
- Unexplained anaemia

Symptoms of pharyngeal and laryngeal cancer:
- Hoarseness
- Difficulties swallowing
- Pain on swallowing
- Throat pain

• Assess whether true dysphagia, globus or odynophagia.

Odynophagia

Odynophagia is pain in swallowing, usually caused by irritation of the inflamed oesophageal mucosa.

Causes include:
- infections e.g., candida, herpes simplex virus (HSV), cytomegalovirus (CMV)
- chemical e.g., drug induced, radiation, Crohn’s disease, dermatological causes, severe reflux
- xerostomia – check medication causes, Sjogren syndrome
- oesophageal and throat cancers.

Globus

• Globus is non-painful lump or fullness in the throat with unimpaired food bolus transport.
• Alleviated by eating and/or drinking fluid.
• Most noticeable with swallowing saliva.
• Globus is a common symptom associated with anxiety and should not be confused with dysphagia.

True dysphagia

True dysphagia is difficulty with the act of swallowing.
• Determine the location of symptoms:

Location
Consider the following signs to help determine the location of the obstruction:

• Oral:
  o Difficulty controlling food, liquid, or saliva in the mouth
  o Drooling
  o Food getting stuck in the mouth
  o May report taking a long time to chew food and avoiding certain foods

• Pharyngeal:
  o Delayed or difficulty initiating swallowing and may be associated with coughing, choking or nasal regurgitation
  o May have unexplained chest infections (aspiration pneumonia)
  o May need to swallow repetitively to clear hypopharynx
  o May feel that food gets stuck at neck level
  o May have wet or ‘gurgly’ voice
  o If hoarseness, dysphonia, and dysphagia, consider throat malignancy or muscular dystrophies

• Oesophageal – discomfort or obstructive symptoms a few seconds after swallowing

• If oral or pharyngeal, consider possible causes including neurological or structural.

Pharyngeal dysphagia causes
• Often have a neurological basis e.g., Parkinson's disease, multiple sclerosis, previous stroke, motor neurone disease.
• Consider a pharyngeal pouch. May have regurgitation of food on lying down, even hours after eating.
• May be caused by a local tumour in the pharynx.

• If oesophageal, consider whether structural or motor disease causes.

Oesophageal dysphagia – structural or motor disease
• Determine whether solids, liquids, or both are a problem.
• Assess whether the symptoms are intermittent, nonprogressive, or progressive.
• Structural causes:
  o Progressive dysphagia is usually caused by cancer or a stricture.
  o Intermittent symptoms are more likely to be due to an oesophageal ring.
  o Strictures or webs are likely to be slower in onset and associated with reflux oesophagitis.
  o Eosinophilic oesophagitis is associated with atopy, or asthma in young adults.
• Motility causes:
  o Progressive dysphagia is seen with achalasia and scleroderma.
  o Intermittent symptoms are more likely to be due to spasm or other motility disorders.
2. Examination:

- Examine head and neck, including looking in the mouth, checking for lymphadenopathy and thyroid enlargement.
- Perform **neurological examination**.

**Neurological examination**

- Check cranial nerves, looking for muscle weakness, spasticity, tongue atrophy, facial asymmetry, sensory changes.
- If abnormal examination, consider possible causes such as motor neurone disease, Parkinson’s disease, multiple sclerosis, stroke.

- Check swallowing

**Check swallowing**

- Ask patient to dry swallow first.
- Then ask the patient to drink a glass of water. Watch how the patient swallows.
- Look for struggling behaviours e.g., effortful transfer from oral cavity, multiple swallows per bolus, reflexive coughing triggered.
- If dysphagia is associated with a CVA, consider swallowing screening as per Stroke guidelines.

- Examine hands and skin, looking for Raynaud’s phenomenon, scleroderma, dermatomyositis.

3. Investigations:

- Do not delay referral to wait for investigation results.
- If oral or pharyngeal, arrange FBE, ferritin, creatinine kinase (CK), CRP, ANA, thyroid tests. Consider modified barium swallow.
- If oesophageal, no investigations are usually required prior to referral. Barium swallow may be considered.

**Management**

Most patients with dysphagia require specialist assessment to determine the cause and appropriate intervention.

**Referral**

- If acute or total obstruction, call **000** for ambulance and transfer to the nearest Emergency Department.
- If foreign body ingestion or obstruction, refer for immediate hepatobiliary referral or admission.
- If suspected oesophageal or gastric cancer with new onset or rapidly progressive dysphagia or epigastric pain (> 2 weeks):
  - arrange urgent gastroenterology or hepatobiliary referral and write “high suspicion of cancer” on your referral.
• refer to specialist services with multidisciplinary team care approach.
• Arrange specialist referral depending on suspected cause or support required:
  • If oral or pharyngeal cause is suspected, arrange urgent ENT referral.
  • If a neuromuscular problem is most likely, consider urgent or routine neurology referral and arrange speech pathology assessment.
• For patients and families awaiting results or specialist review for suspected oesophageal or gastric cancer, consider referral to Cancer Council Victoria for advice and support.

Information
For health professionals

Further information
• Cancer Council Australia:
  • Clinical Practice Guidelines for the Diagnosis and Management of Barrett’s Oesophagus and Early Oesophageal Adenocarcinoma
  • I-PACED Oesophageal and Gastric Cancers Resource Card
  • Optimal Care Pathway for People with Oesophagogastric Cancer: Quick Reference Guide
  • RACGP – Dysphagia and Aspiration (Silver Book)
  • Western Australia Diagnostic Imaging Pathways – Dysphagia

For patients
• Cancer Council Australia – Oesophagogastric Cancer: What to Expect
• Patient – Difficulty Swallowing: Dysphagia
• St George Swallow Center – Living With Dysphagia

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