

A Symptom That's Hard To Swallow: Dysphagia Management In Multiple Sclerosis

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Background:

Swallowing difficulties (dysphagia) in Multiple Sclerosis (MS) are known to impact on respiratory health, nutrition and quality of life. Dysphagia is caused by damage to several structures including the brainstem, cerebellum, corticobulbar tracts and cranial nerves (Calcagno et al., 2002). Dysphagia in MS is clinically challenging to manage given the complex relationship between relapse and recovery, respiratory function and cough, cognition, fatigue and physical disability. Speech and Language Therapists therefore must provide patient-centred dysphagia management.

Aims:

The themes for this project were taken through running a specialist SLT MS outpatient clinic, whereby patients were referred for initial dysphagia assessment and follow-up management. The aim was to identify themes and clinical considerations in dysphagia management in MS.

Cognition

Those with severe cognitive impairment were unable to implement safe-swallow strategies which put them at further risk of aspiration.

Several patients had poor awareness of their dysphagia and were observed to be impulsive while eating or drinking, while others consistently denied swallowing difficulties, yet on observation demonstrated consistent overt signs of aspiration while eating or drinking.

Physical impairments

Patients with greater physical impairment and thus reduced mobility regularly presented with a more severe dysphagia. Those reliant on others for feeding are at increased risk of aspiration (Langmore, 1998).

Dysphagia severity is known to correlate with EDSS score (Poorjavad, 2010), which suggests that swallow assessments should be considered for patients with more severe physical impairments.

Chest History

Multiple patients presented with a history of recurrent chest infections which required either oral antibiotics or hospital admissions. This highlighted the impact of dysphagia for these patients, and often contributed towards the need for an instrumental assessment (e.g. Videofluoroscopy). GPs were often advised to prescribe a specific antibiotic for aspiration pneumonia, rather than Community Acquired Pneumonia (CAP).

Cough

Cough strength was assessed in some patients using Peak Cough Flow (PCF). Patients with a PCF of less than 180l/min are known to have reduced ability to clear chest secretions (Chatwin, 2018) (and thus food/fluid residues from their pharynx). Patients with spasticity were regularly observed to demonstrate reduced cough strength, further impacting the risk of their dysphagia.

Fatigue

Patients with MS experienced swallow fatigue during mealtimes, which can result in a more severe dysphagia at the end of a meal, compared with the beginning. Patients were often advised to adopt a 'little and often' approach to eating, rather than 3 large meals per day. It was recommended for some patients to adapt their food consistency throughout the day, depending on their fatigue levels (e.g. normal diet in the morning and soft/mashed in evening).

Conclusion:

Weight History

Low BMI and unexplained weight

loss was a key indicator for the need

to further assess their swallow.

Patients regularly reported eating

"normally" however further

questioning often highlighted how

patients did not finish their portion,

or experienced coughing episodes

and then discontinued their meal. A

referral to a dietician was regularly

made, and at times gastrostomy was

discussed due to low body weight

and severe dysphagia.

The above themes highlight the clinical complexity of dysphagia management in Multiple Sclerosis. Those with moderate-severe dysphagia were often affected by more than one of the above factors, emphasising that dysphagia management can be clinically challenging and multi-factorial. Clinicians must adopt a holistic approach in the assessment and management of dysphagia in order to provide patients with high quality, patient-centered care.