



# Office-based treatment of dysphagia



Naren N. Venkatesan, MD, Peter C. Belafsky, MD, PhD

*From the Department of Otolaryngology, Center for Voice and Swallowing, University of California—Davis, Sacramento, California*

## KEYWORDS

Dysphagia;  
 Esophagoscopy;  
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Dysphagia is a common symptom affecting many patients with several different causes. The use of thin, distal-chip, video esophagoscopes allows for a thorough evaluation and management of dysphagia in the office. Esophagitis should be recognized on endoscopy in addition to webs, rings, and strictures. Procedures to treat the cause of dysphagia can be performed in clinic with the use of topical anesthesia. Descriptions of how to perform procedures for dysphagia, including vocal fold medialization, diagnostic esophagoscopy, and esophageal procedures for intervention are reviewed.

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## Introduction

With the advent of thin, distal-chip, video esophagoscopes with a working port, the comprehensive evaluation and management of dysphagia from lips to stomach can now be performed in the clinic. Nearly 20% of the population experiences dysphagia, mostly as infrequent episodes while 3% report weekly occurrences.<sup>1</sup> The prevalence of dysphagia further rises to 50% in patients older than the age of 65 years.<sup>2,3</sup> The most common causes of dysphagia include gastroesophageal reflux, cricopharyngeus muscle dysfunction (CPMD), advancing age, progressive neurologic disease, and post-irradiation damage.<sup>4</sup> Given the high prevalence of dysphagia, it is essential for the otolaryngologist to have an advanced understanding of contemporary in-office esophageal procedures. Office surgery without anesthesia eliminates the risk of respiratory and cardiovascular complications of intravenous sedation<sup>5</sup> and is associated with cost savings exceeding \$5,000.00 per case. The purpose of this article

is to provide a beyond state-of-the-art review of office-based procedures for dysphagia.

## Diagnostic esophagoscopy

### Indications

The decision to perform esophagoscopy relies on patient history and extent of dysphagia. The 10-item eating assessment tool (EAT-10) is a validated self-administered symptom index for dysphagia symptoms of all etiologies. It is used in our center to assess initial patient symptom severity and to monitor treatment efficacy. Unlike symptoms of voice and laryngopharyngeal reflux (LPR), which are present in varying degrees in normal individuals, otherwise healthy persons do not experience dysphagia. An EAT-10 >2 (Table 1) is considered abnormal and is our most common indication for esophagoscopy.<sup>6</sup>

The American Society for Gastrointestinal Endoscopy and American College of Gastroenterology have established relative esophageal indications for esophagoscopy (Table 2).<sup>7,8</sup> Of these indications, dysphagia, bleeding, choking, chest pain, odynophagia, and weight loss are considered danger signs warranting expeditious examination. The extraesophageal indications for esophagoscopy (globose, throat clearing, hoarseness, and cough) are still

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**Address reprint requests and correspondence:** Naren N. Venkatesan, MD, Department of Otolaryngology, Center for Voice and Swallowing, University of California—Davis, 2521 Stockton Blvd, Suite 7200, Sacramento, CA 95817.

E-mail address: narennv@gmail.com

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**Table 1** Eating assessment tool-10

Item	0 = No problem, 4 = severe problem				
1. I have lost weight due to my swallowing disorder.	0	1	2	3	4
2. I cannot eat out due to my swallowing disorder.	0	1	2	3	4
3. I exert too much effort swallowing while consuming liquid foods.	0	1	2	3	4
4. I exert too much effort swallowing while consuming solid foods.	0	1	2	3	4
5. I exert too much effort while taking pills.	0	1	2	3	4
6. I feel pain during swallowing.	0	1	2	3	4
7. My swallowing condition impacts the pleasure I take while eating.	0	1	2	3	4
8. Food gets held (stuck) in my throat while swallowing.	0	1	2	3	4
9. I cough while I eat.	0	1	2	3	4
10. Swallowing creates tension on me (swallowing stresses me out).	0	1	2	3	4

being defined. The necessity for esophagoscopy in patients with signs and symptoms of LPR is uncertain. Data exist, however, that suggest extraesophageal symptoms better predict the presence of esophageal cancer than the typical esophageal symptoms of heartburn and regurgitation.<sup>9</sup> It is therefore our practice to screen the esophagus of patients we diagnose with LPR.

## Technique

Informed consent is obtained for all office esophagoscopy. Every examination is digitally recorded for later frame-by-frame playback and analysis. Office esophagoscopy is better performed if the patient has fasted for 3 hours before the examination. Although a full stomach is not a contraindication to the procedure, food in the stomach can exacerbate patient nausea and emesis and obscure the endoscopic view within the stomach. Patients are therefore requested to fast for 3 hours before the procedure. The patient is placed in the seated upright position. The nasal cavity is topically anesthetized and decongested. The outer diameter of a typical transnasal esophagoscope is approximately 5.3 mm (Olympus VISERA PEF-V, Olympus America, Center Valley, PA). This is approximately 30% larger than a typical laryngoscope. Thus, it is imperative to adequately anesthetize the nose to optimize patient comfort and increase the likelihood of a successful examination. We utilize 4 puffs of combination oxymetazoline 0.05% and lidocaine 4% nasal spray into the more patent nasal cavity.

**Table 2** Indications for esophagoscopy

Dysphagia or odynophagia	Choking
Esophageal ulcer	Treatment of bleeding lesions
Suspected neoplasm	Banding or sclerotherapy of varices
Esophageal stricture or obstruction	Biopsy of pathology
Removal of foreign bodies	Unexplained persistent vomiting
Management of achalasia	Esophageal reflux symptoms
Dilation of stenotic lesions	Despite medical therapy
Placement of a feeding tube	Anorexia and weight loss

In addition, the endoscope is continuously lubricated with 2% viscous Lidocaine gel (Roxane Laboratories, Columbus, OH) throughout the examination. Pharyngeal anesthesia is unnecessary for the most of patients. Patients with a significant gag reflex, however, are asked to gargle a teaspoon of the 2% lidocaine gel. The lidocaine gel can adhere to mucosal surfaces within the esophagus and make visualization during the examination more difficult. Copious irrigation once the endoscope is introduced into the esophagus can help clear the viscous medication. After nasal anesthesia has been applied, the endoscope is passed through the nasal cavity and positioned in the “home” position just above the epiglottis. Eye contact is made with the patient and a hand is placed on the shoulder (Figure 1). This endoscopist-patient contact is essential to alleviate patient anxiety and optimize comfort. The patient is then asked if they are “okay” and the patient is informed that, “We are going to have you swallow the camera. Imagine that it is a large piece of spaghetti. Close your lips and swallow hard.” The scope is advanced into the pyriform sinus and blindly advanced into the mid-esophagus as the patient swallows. The proximal esophagus is examined as the endoscope is withdrawn. Once the scope is introduced, eye contact is again made with the patient and a hand is placed on the shoulder. The esophagus is suctioned and the patient is given 30 seconds to get accustomed to having the



**Figure 1** Reassuring the patient while the scope is in “home” position. (Color version of figure is available online.)

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