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A 12-month-old With Dysphagia and Cough

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ABSTRACT

Oropharyngeal dysphagia is a dysfunction of the oral and pharyngeal phase of swallowing and can be caused by a variety of disorders. Swallowing dysfunction can allow laryngeal penetration or aspiration of small volumes of food or liquids. Infants with dysphagia may present with a history of feeding difficulties; choking episodes during feedings; and chronic symptoms, such as coughing, wheezing, or stridor. This case presentation involves a 12-month-old infant with a history of dysfunctional swallowing and coughing during feeds.

Keywords: chronic cough, dysphagia, feeding problems, laryngeal cleft, pediatric

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CASE PRESENTATION

A 12-month-old girl presented to her primary care provider (PCP) accompanied by her parents with chief complaint of choking episodes during feedings. The parents indicated that the child has had gagging and coughing during feedings since early infancy, particularly with liquids, along with occasional emesis during these episodes. In addition, they reported snoring and stridorous breathing when the child was lying supine. At 2 months of age, the patient was diagnosed by her PCP as having gastroesophageal reflux (GERD) and laryngomalacia, based on clinical symptoms. She was treated with ranitidine, but with no clinical improvement. At 4 months of age, her formula was changed to a reduced-lactose, milk-based formula, which slightly improved the severity of symptoms. Because the patient was gaining weight and had no history of recurrent infections, no further evaluation was performed. During the 12-month well-child visit, the PCP observed the patient drinking from a sippy cup and noted abnormal oral movements and a delayed swallow trigger, followed by a choking and coughing episode. The PCP referred the patient to a speech therapist for further clinical evaluation.

The patient's medical history was unremarkable; the mother reported that the child was born at 37 weeks and pregnancy was uncomplicated. There was no previous history of hospitalization or surgery. Medications included lansoprazole daily for GERD. Immunizations were up to date and the patient had no known medication or food allergies. The mother denied any pertinent family history. The child lived with both parents and her maternal grandmother. All family members smoke, but reportedly outside of the home. The child did not attend daycare. She met normal developmental milestones and was in the 80th percentile for weight, 90th percentile for height. Her current diet consisted of stage 2 and 3 baby foods and some table foods with liquids via bottle and cup.

Review of systems revealed no unexplained fevers, weight loss, or rashes. The child has had infrequent upper respiratory infections and uncomplicated otitis media, but no history of pneumonia, accidental ingestion, or foreign-body aspiration. The mother denied any episodes of apnea, cyanosis, edema, or hearing or speech concerns. The patient has had occasional vomiting with the choking episodes, as well as frequent problems with constipation, but no difficulties with urination.

Physical exam showed a healthy-appearing, alert, and well-nourished child. She was afebrile with normal vital signs. Her skin was pink, warm, and dry without rash. Further examination revealed a normocephalic infant with facial symmetry, normal tone, and no drooling. Oral examination showed normal mobility of the tongue, an intact palate, and 1^{+} tonsils. The child's heart rate was regular with no murmurs. Her respirations were unlabored with clear breath sounds. Abdominal examination revealed a soft and nontender abdomen with normal bowel sounds and no hepatosplenomegaly and/or masses.

Upon referral, the speech therapist performed a feeding evaluation of the patient. Abnormal oral motor movements and discoordinated swallow was noted. The speech therapist recommended a modified barium swallow (MBS) to thoroughly assess the integrity of her swallow function. Swallow was observed using videofluoroscopy with various consistencies of liquids. With all consistencies (puree, thin liquid, nectar-thick liquid, and honey-thickened liquid), the patient demonstrated signs of oropharyngeal dysphagia, including poor oral control of bolus, inconsistent mouth closure, tongue thrusting, gagging, and atypical tongue thrust movements, in attempt to perform anterior to posterior transit of bolus. Swallows of puree consistency were discoordinated but without penetration or aspiration. Swallows of all liquid consistencies resulted in multiple episodes of aspiration. Immediate coughing after swallows was observed.

Questions to consider:

1. What further diagnostic tests should be considered?
2. What are the possible differential diagnoses?
3. Based on the information, what is the possible diagnosis?
4. What are the possible treatment options available?
5. What is the recommended follow-up for this individual?

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