

Dysphagia

Dysphagia is defined as difficulty in swallowing. It is usually associated either with pharyngeal or oesophageal disease^[1]. There is a spectrum of possible aetiologies (see links in table under Aetiology, below), from self-limiting illness (eg, tonsillitis) to carcinoma. It may occur with odynophagia – painful swallowing.

Presentation

Symptoms

Important information

NB: steady worsening of dysphagia over a few weeks in an older patient suggests malignancy.

- As well as the feeling of food sticking in the gullet, patients with oesophageal disease may have other symptoms. These range from discomfort to severe pain, with the patient nearly always unable to locate the obstruction accurately.
- Regurgitation, vomiting, coughing and choking are common.
- Men with new onset of alarm symptoms (loss of weight with worsening dysphagia) have an increased likelihood of a diagnosis of cancer, especially in those aged over 65^[2]. A positive predictive value of 9.0% has been found in this age group.

Aetiology

- The most common lesions within the oesophagus are inflammatory strictures from reflux or tumours.
- A long history of heartburn is usually associated with an inflammatory stricture.

- In Westernised countries, eosinophilic oesophagitis is thought to affect between 40 and 55 per 100,000 population - similar to the numbers affected by Crohn's disease^[3] .
- Idiopathic achalasia presents with dysphagia for solids and also regurgitation of a bland-tasting material that has never entered the stomach. It occurs in 1-2/100,000, most commonly seen in mid-adult life, and is caused by impaired neural control of the distal oesophagus^[4] .
- Impairment of oropharyngeal swallowing function and abnormal laryngeal findings have been noted in patients with severe COVID-19 treated in intensive care units^[5] .

Obstructive

- Gastro-oesophageal reflux ± stricture.
- Eosinophilic oesophagitis.
- Other oesophagitis (eg, infection).
- Oesophageal cancer.
- Gastric cancer.
- Pharyngeal cancer.
- Post-cricoid web (Paterson-Brown-Kelly syndrome).
- Oesophageal rings.
- Foreign body (acute).

Neurological

- Cerebrovascular event or brain injury.
- Achalasia.
- Diffuse oesophageal spasm.
- Syringomyelia or bulbar palsy.
- Myasthenia gravis.

- Multiple sclerosis.
- Motor neurone disease.
- Myopathy (dermatomyositis, myotonic dystrophy).
- Parkinson's disease and other degenerative disorders.
- Chagas' disease.

Others

- Pharyngeal pouch.
- Globus hystericus.
- External compression
(eg, mediastinal tumour, or associated with cervical spondylosis).
- Calcinosis, Raynaud's disease, (o)esophageal dysmotility, sclerodactyly, telangiectasia (CREST) syndrome or scleroderma.
- Oesophageal amyloidosis.
- Inflammation - eg, tonsillitis, laryngitis.

Investigations^[1]

- FBC and erythrocyte sedimentation rate (ESR) should be taken.
- Barium swallow and/or endoscopy with biopsy should usually be performed.
- Laryngoscopic examination may be helpful if a pharyngeal cause is suspected.
- In patients with severe COVID-19, the swallowing function should be assessed as a standard procedure, preferably at an early stage, before initiation of oral intake. Fibreoptic endoscopic evaluation of swallowing is preferred due to the high incidence of pooling of secretion and risk of silent aspiration^[5].
- MRI scanning may also be required before any surgery is considered - eg, if there is oesophageal carcinoma.

- Endoscopic ultrasonography can assist with staging in oesophageal carcinoma.
- Videofluoroscopy is the radiological investigation of choice when 'difficulty swallowing' rather than 'food sticking' is the presenting symptom and/or aspiration is suspected. However, fiberoptic endoscopic evaluation of swallowing (FEES) may be preferred if a less invasive approach is required, there are concerns about aspiration, repeated examinations are needed, or an assessment of swallowing using real food is required^[6].
- If the patient has no supra-oesophageal symptoms, negative barium swallow, negative FEES findings, and clinical evidence of oesophageal dysphagia, they should be referred to a gastroenterologist for a barium video-oesophagogram. This assesses both the anatomy (strictures or tumour) and motility function of the esophagus (such as achalasia).

Management

When to refer^[7]

Important information
If cancer is a possibility - offer urgent direct access upper gastrointestinal endoscopy (to be performed within two weeks)^[7].

General

The patient may need to chew well or liquidise food.

There is insufficient evidence currently to support the efficacy of dietary modification, swallowing manoeuvres, surgical interventions, enteral feeding or intravenous immunoglobulin for the treatment of chronic neuromuscular conditions^[8]. Patients with neurological problems (eg, cerebrovascular injury) may benefit from an early Speech and Language Therapy assessment^[9].

Eosinophilic oesophagitis may be treated with dietary modification, topical steroids, leukotriene antagonists and other drugs, and endoscopic dilation^[3].

Surgical

Definitive treatment depends on cause:

- Strictures may be managed with endoscopic dilation (either using bougies or inflatable balloons).
- If oesophageal carcinoma is diagnosed, staging will dictate whether curative surgery (for example, oesophagectomy) and chemotherapy are appropriate ^[10] .
- The overall five-year survival rate is 20–25% for all stages. Not surprisingly, lymph node involvement equates with a poorer prognosis. A study of 1,085 patients who underwent oesophagectomy showed a 4% operative mortality rate and a 23% survival rate. For patients who had pre-operative chemoradiotherapy, the prognosis improved to 48% ^[11] .
- In oesophageal carcinoma, palliative relief of dysphagia can be achieved with:
 - Repeated dilatation
 - Stent replacement ^[12]
 - Laser photocoagulation
 - Injection of sclerosants
- Brachytherapy can be a useful alternative or adjunct.
- Surgical myotomy and endoscopic injection of the sphincter with botulinum toxin are occasionally used for some aetiologies.

Complications

- [Malnutrition](#); nutritional support is often needed prior to treatment.
- [Aspiration pneumonia](#) may occur.
- Perforation may occur iatrogenically.

Further reading

- [Acute stroke pathway](#); NICE, July 2014
- [Transcutaneous neuromuscular electrical stimulation for oropharyngeal dysphagia in adults](#); NICE Interventional procedures guidance, December 2018
- [Tadavarthi Y, Hosseini P, Reyes SE, et al](#); Pilot Study of Quantitative Methods for Differentiating Pharyngeal Swallowing Mechanics by Dysphagia Etiology. *Dysphagia*. 2021 Apr;36(2):231-241. doi: 10.1007/s00455-020-10123-0. Epub 2020 May 14.
- [Triggs J, Pandolfino J](#); Recent advances in dysphagia management. *F1000Res*. 2019 Aug 29;8. doi: 10.12688/f1000research.18900.1. eCollection 2019.

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