

MANAGEMENT OF INTRACTABLE ASPIRATION

Episode 34.1

DIAGNOSIS

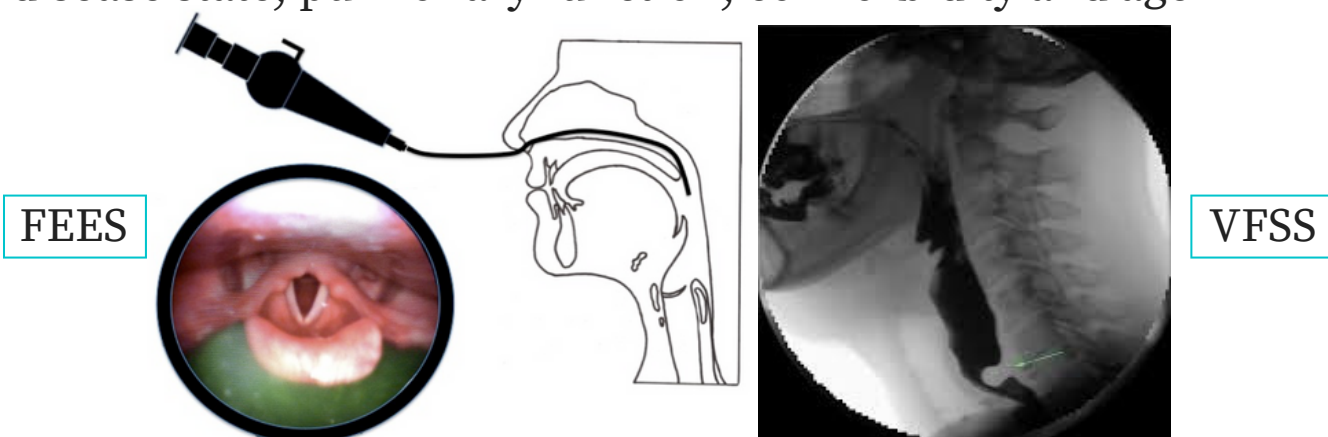
- Aspiration is often unrecognized or masked and identified by presence of sequelae
 - Recurrent PNA, excessive secretions after tracheostomy, weight loss
- Etiologies:
 - Neuromuscular: ALS, MS, stroke, CN deficits (CN IX, X), Parkinson's
 - After oropharyngeal or laryngeal surgery
 - After treatment of H&N cancer with organ preservation protocol
- Disturbance in any phase of swallowing contributes to aspiration (oral, pharyngeal, and/or esophageal phases)

TRACHEOSTOMY & STROKE

- Tracheostomy is long associated with aspiration: loss of glottic closure reflex and elevated subglottic pressures during swallowing
- Stroke causes sensory loss
- Age and underlying disease further confounds both causes

EVALUATION

- History and physical exam. **If acute, may present with stroke symptoms (loss of gag, loss of sensation on ipsilateral face / contralateral limbs, ipsilateral Horner's syndrome, ataxia)**
- Evaluate for dysphagia: FEES (flexible endoscopic evaluation of swallowing), barium swallow
- Quantify aspiration: Modified barium swallow (aka. VFSS - videofluoroscopic swallowing study)
- Evaluate clinical effects of aspiration. Consider underlying disease state, pulmonary function, co-morbidity and age



TREATMENT

NONSURGICAL

- NPO and alternate route of feeding (G-tube) or dietary modifications
 - Optimize pulmonary function. Intubate if in failure
- Inflate tracheostomy cuff and give pulmonary toilet
- Control reflux, oral care

SURGICAL

- Goal: separate the airway and food passages
 - Vocal cord medialization
 - Myotomy
 - Laryngectomy
 - Glottic closure
 - Laryngeal stenting
- Tracheoesophageal diversion