Dysphagia

see Bedside dysphagia screen.

Esophageal dysphagia is almost always caused by disease in or adjacent to the esophagus but occasionally the lesion is in the pharynx or stomach. In many of the pathological conditions causing dysphagia, the lumen becomes progressively narrowed and indistensible. Initially only fibrous solids cause difficulty but later the problem can extend to all solids and later even to liquids. Patients with difficulty swallowing may benefit from thickened fluids if the person is more comfortable with those liquids, although, so far, there are no scientific study that proves that those thickened liquids are beneficial.

Although recombinant human Bone morphogenetic protein 2 is effective in promoting arthrodesis, many physicians avoid using it in Anterior Cervical Spine Surgery due to concern for increased incidence of dysphagia, significant pre-vertebral swelling, and airway compromise. Pilot studies have shown that the local application of depomedrol may decrease the incidence of postoperative dysphagia.

A study provides Level of evidence 1 that locally administered depomedrol on a collagen sponge significantly decreases postoperative dysphagia incidence and magnitude following anterior cervical spine fusion using low-dose rhBMP-2¹⁾.

Etiology

see Dysphagia after anterior cervical discectomy.

Anterior cervical osteophyte.

Diffuse Idiopathic Skeletal Hyperostosis.

Dysphagia may manifest as the result of autonomic nervous system pathologies including stroke and ALS, or due to rapid iatrogenic correction of an electrolyte imbalance.

Severe dysphagia and odynophagia are post-ACDF complications. In most instances they are attributable to prevertebral soft-tissue edema accompanied by inflammatory responses such as fever and an increase in the white blood cell count and in C-reactive protein. In other cases these anomalies are elicited by hematoma not associated with inflammation ².

Diagnosis

Emerging evidence exists to support the use of US as an adjunct to clinical assessment of swallowing and laryngeal function in the neonatal and pediatric population. A paucity of evidence to support the use of the US in the assessment of sucking exists. Further research is needed to establish evidence-based assessment and analysis protocols as well as development of paediatric data ³⁾.

Case reports

A case of a foramen magnum meningioma highlights the importance of the neurologic exam when evaluating a patient with dysphagia. A 58-year-old woman presented with an 18-month history of progressive dysphagia, chronic cough, and 30-pound weight loss. Prior gastroenterology and laryngologic workup were unrevealing.

Her neurologic examination revealed an absent gag reflex, decreased sensation to light touch on bilateral distal extremities, hyperreflexia, and tandem gait instability. Repeat esophagogastroduodenoscopy was normal, whereas laryngoscopy and video fluoroscopy revealed marked hypopharyngeal dysfunction. Brain magnetic resonance imaging demonstrated a 3.1 x 2.7 x 2.9 cm foramen magnum mass consistent with meningioma. The patient underwent neurosurgical resection of her mass with near complete resolution of her neurologic symptoms. Pathology confirmed the diagnosis of a WHO grade I meningothelial meningioma.

CNS pathology is an uncommon but impressive cause of dysphagia. The case demonstrates the importance of a thorough neurologic survey when evaluating such a patient ⁴⁾.

1)

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