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Dysphagia in Patients with Dementia: What's the SLP to Do? - Part 1

Amber Heape, CScD, CCC-SLP, CDP

Moderated by:
Amy Natho, MS, CCC-SLP, CEU Administrator, SpeechPathology.com

continued

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- Call 800-242-5183
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- 3+ years SLP Professional Experience Required
- Contact Amy Natho at anatho@SpeechPathology.com

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Course Objectives

The learner will be able to:

1. Identify characteristics that differentiate presbyphagia and dysphagia.
2. Describe polypharmaceutical side effects related to swallowing in older patients with cognitive decline.
3. Describe the evidence regarding feeding tubes for patients with end-stage dementia.

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Step 1

- Understand normal vs. disorder!

CONTINUED

Presbyphagia

- Declines of swallow associated with normal aging
- Normal changes are not considered a disorder
- Secondary factors (disease or other health factor) increase risk of significant dysphagia

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Dysphagia

- Disordered swallowing
- May lead to
  - Aspiration
  - Modified diets
  - Weight loss
  - Inability to maintain nutrition/hydration
    - Malnourished patients are 3 times more likely to have infection and twice as likely to develop pressure ulcers (Avelino-Silva and Jaluul, 2017)
  - Placement of alternate nutrition/hydration

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Normal Aging- Motor Function

- Decreased strength of lips, tongue, mandible, pharynx, and larynx
- Xerostomia leading to inability to form a cohesive bolus
- Some delay in onset of pharyngeal swallow, with penetration into the vallecula
- Decreased lingual and pharyngeal strength (may require multiple swallows to clear vallecular space)
- UES opening may not fully relax (causing food, pills, etc. to “get stuck”)
- Esophageal peristaltic wave weakened (presbyesophagus)

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Normal Aging- Sensory Function

- Decrease in taste and smell
- Reduction of saliva secretion
- Decreased sensitivity and thinning of vocal folds (may lead to inability to fully protect airway during swallow)

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Other Normal Changes in Aging

- Changes in dentition
- Change in nutritional requirements
  - Vitamin D deficiency (less outdoor time)
  - Calcium (bone health)
  - Protein (muscle mass)
  - Nutritional supplements to maintain weight
- Lower activity level= less caloric intake needs

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Conditions that May Lead to Dysphagia:

- Neurological Disorders
  - Static or Acute: CVA, SLN Palsy
  - Progressive: ALS MS, PSP, Myasthenia Gravis, Alzheimer's
- Cancer
  - Tumor, radiation, chemotherapy
- Pharyngeal disorders
  - Zenker's Diverticulum, Cervical Osteophytes
- Gastroesophageal disorders
  - Hiatal hernia, esophageal stricture, Barrett's esophagus
- Chronic Conditions:
  - Diabetes, COPD, Arthritis, ESRD, Hypothyroidism

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Additional Factors- Drug Induced Dysphagia

- Dysphagia due to Side Effects
  - Xerostomia
  - Decreased taste
  - Decreased appetite
  - Constipation
  - Metabolic issues (absorption)

CONTINUED

Additional Factors- Drug Induced Dysphagia

- Dysphagia Due to the Drug Therapy Itself
  - Xerostomia
  - Damage to the mucosa (radiation, chemo drugs)
  - Immunosuppressants leading to viral or fungal infections
  - High dose corticosteroids may lead to muscle wasting
  - Narcotic pain medications or muscle relaxers cause decreased voluntary muscle control and awareness due to depressed CNS
  - Antipsychotics or Neuroleptics can cause movement disorders

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Additional Factors- Drug Induced Dysphagia

- Esophageal Injury
  - Largely caused when person lays down too quickly after taking medication before the primary peristaltic wave has completed or not enough hydration was provided during administration
  - Medications remain in the esophagus and cause irritation and localized injury

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Social/Emotional Factors in Dysphagia

- Decreased motivation or enjoyment for eating due to social isolation
- Activity limitations, increased effort and time to eat, embarrassment
- Financial problems that impair ability to maintain nutrition
- Physical limitations that prevent preparation of food
- Depression leading to fatigue, globus sensation
- Anxiety about chewing/swallowing issues

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Interactive Review Question

Which of the following is NOT a primary sensory characteristic in presbyphagia?

A. Decrease in taste
B. Decrease in smell
C. Reduced saliva secretion
D. Stronger sensitivity of vocal folds leading to increased airway protection during swallow.

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Step 2

- Understand stages of decline in dementia and associated characteristics

CONTINUED

Dementia: Stages of Decline

- Early Dementia (around GDS 4)
- Moderate Dementia (GDS 5)
- Moderate/Severe Dementia (GDS 6)
- Late (End-Stage or Severe) Dementia (GDS 7)

CONTINUED

Dysphagia in Early Dementia

- Visual field= 14-24 inches (Tristani, 2011)
- Awareness of deficits
- Depression may lead to decreased (or increased) intake for nutrition/hydration
- Eating still a highly social activity
- Patient can clearly express preferences
- Early dysfunction of taste and smell
- Mild attention impairment

CONTINUED

Dysphagia in Moderate Dementia

- Visual Field= 7-14 inches with perceptual deficits (Tristani, 2011)
- Wandering or restlessness
- Requires assistance for oral care
- Decreased attention span leading to decreased nutrition/hydration
- Leaves table during meal
- May require verbal cues to redirect or complete meal
- Texture aversion
- Increased stasis post-swallow ("saving for later")

CONTINUED

Dysphagia in Moderate/Severe Dementia

- May use fingers instead of utensils or use utensils incorrectly
- May easily become overwhelmed by too much food or too many containers present
- Decreased judgment (excess bite size or attempting to eat nonedibles)
- Pours liquids onto foods
- Takes food from others
- Wants to eat junk food/ dessert only
- Over-chewing or over manipulation, pocketing food
- Tongue pumping

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Dysphagia in Severe Dementia

- Stage lasts from 6 months to 2 years
  - About 1/3 of patients diagnosed with dementia will live to progress into the advanced/end stage (Gillick, 2001)
- Loss of interest in eating, dysphagia are prevalent (Goldberg and Altman, 2014)
- Visual field with limited perceptual abilities and only up to about 7 inches from midline (Tristani, 2011)
- Oral apraxia and oral acceptance deficits
- Loss of speech is common, so patient cannot express needs verbally

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Dysphagia in Severe Dementia

- Patient is dependent for oral care, increasing risk of aspiration pneumonia
- Often requires positioning assistance
- Textural issues
- Most patients lose self-feeding ability, requiring assistance
  - With cognitive deficits, this may become a “scary” experience
  - Oral acceptance issues

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Key Point

- Dementia is a progressive condition that is terminal, though progression varies by patient

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Interactive Review Question

Which of the following statements about dysphagia is true of many patients with moderate dementia?

A. They may require verbal cues for redirection during meal
B. They may exhibit restlessness during mealtime
C. You may see increased stasis post-swallow or delayed swallowing of small amounts of stasis.
D. All of the above

CONTINUED

Step 3

- Consider medical/treatment options after thorough assessment

CONTINUED

Interactive Question

- When a patient has late stage dementia and associated dysphagia, do you consider yourself:
  - Pro-PEG
  - Anti-PEG
  - or does it depend on the situation?

CONTINUED

Medical Options

- Supplemental Nutrition/ Hydration
  - IV
  - Oral
  - NG/PEG
- Temporary or Permanent?
- What expectations are you trying to achieve?
- Risk vs. Benefit

CONTINUED

Tube Feeding in Advanced Dementia- Review of the Evidence

- There is no current evidence to demonstrate that long-term survival rates for patients with dementia who undergo PEG placement are any higher than those who refuse the PEG; nor is quality of life higher (Sampson et.al, 2009)
- Some evidence suggests that median survival rate is worse with the PEG (Goldberg and Altman, 2014) or that they are equal (Murphy and Lipman, 2003)

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Risks of Tube Feeding in Advanced Dementia

- Approximately 1/3 of residents in SNFs with advanced dementia have feeding tubes (Sampson, Candy, & Jones, 2009)
- Complications with the PEG in approximately 2/3 of patients (Malmgren et.al, 2011)
  - 39% with aspiration complications post-PEG

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Why do Patients/Families Choose Tube Feeding?

- Moral, ethical, religious reasons
- Fear of "starving" the loved one
- Poor practitioner education
- "Listening" to the doctor
- It's presented as a choice (for or against), without other options
- There are also cultural, familial, and geographical influences

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Advanced Directives

- POA- Person who makes decisions for the patient in the event of incapacitation
  - May be financial or healthcare POA
- Living Will - legal document that outlines patient's wishes in medical scenarios
- HIPAA Authorization
  - RP information will be in chart
- Do Not Resuscitate Order (DNR)
  - Usually indicated on outside and inside of chart with a special indicator sticker

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4 Major Ethical Questions

1. What is the true purpose of intervention? (medical indication)
2. What are the patient's wishes or preferences? (may be written or verbal, depending on severity)
3. How do these decisions affect the patient's quality of life?
4. Are there any legal, financial, religious, scientific, or emotional constraints that may hinder this intervention?

CONTINUED

Next Week…

- Evaluation and Interventions for patients with dementia and dysphagia
- External modifications that may benefit patients with dysphagia and dementia
- Strategies for counseling patients and their families

CONTINUED

Thank you for your attention and participation!