Approach to Dysphagia

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Faculty Disclosure

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Objectives

- To review key points on history that can help narrow down the differential diagnosis in dysphagia
- To know when to worry about a patient with dysphagia
- To discuss what to do for a patient with dysphagia until they see GI
Step 1 – Oropharyngeal vs. Esophageal Dysphagia

- **Oropharyngeal**
  - Difficulty initiating a swallow
  - Coughing, choking, nasal regurgitation
  - Recurrent aspiration pneumonia

- **Esophageal**
  - Food gets stuck on the way down
  - Sensation of slow passage of food bolus

**Causes**
- Stroke, myasthenia gravis, brain tumour, Zenker’s diverticulum, cricopharyngeal bar, etc

**Test**
- VFSS (video fluoroscopic swallowing study) by a speech language pathologist

**Refer**
- Neurology or ENT

Step 2 – Mechanical vs. Motility Problem

- **Mechanical**
  - Mainly problem with solids
  - Intermittent or progressive
  - Frequency and duration of bolus impaction

- **Motility**
  - Problem with both solids and liquids
  - Usually progressive
  - May have associated chest pain
Step 3 – Useful Questions

- GERD – esophagitis, Schatzki’s ring, peptic stricture, cancer
- Asthma and allergies – eosinophilic esophagitis
- Bland regurgitation – achalasia
- Immunosuppression or steroid puffers – Candidal esophagitis
- History of radiation to chest or head and neck – stricture
- History of caustic ingestion
Step 4 - Red Flags

- Rapidly progressive dysphagia
- Weight loss
- Hematemesis
- Age older than 50 years
- Male
- Caucasian (adenocarcinoma)
- Black (squamous cell)
- Smoker
- Alcohol
- History of caustic ingestion
- Immunosuppression
- History of chemotherapy/radiation

Dysphagia

- Physical exam
  - Not much that you can examine
  - Check nutritional status, BMI
  - Cervical lymph nodes
  - Oral candidiasis

- Investigations
  - CBC and differential

Next step…

- If red flags present → urgent referral to GI

- If concurrent GERD symptoms and no red flags → trial of BID PPI x 4 weeks → if dysphagia resolves, scope may not be needed

- If not sure about severity of the problem and long GI wait time → upper GI series
Upper GI series says…

- “Reflux noted during study” does not automatically mean that the patient has GERD
- If radiologist says “reflux seen to proximal esophagus” then it is much more likely that the patient has GERD
- GERD alone, without obvious structural abnormalities on upper GI series, can cause dysphagia with solids

Upper GI series says…

- “Normal”
  … does not mean endoscopy will be normal

What to do until GI sees patient

- If patient has symptoms of GERD and/or significant reflux is seen on upper GI series, a trial of PPI is reasonable
- Tell patient to watch out for worsening dysphagia, weight loss, odynophagia, hematemesis, and let you know if they occur
Bottom line

- Almost all patients with dysphagia need a gastroscopy (at some point)

- History ± barium swallow will help determine whether the gastroscopy is urgent or not