Eating and aspirating
Two cases, two outcomes
Lots of questions...

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Dysphagia in cervical spinal cord injury

Incidence - 31% - 41%

Significant **Risk factors** - presence of tracheostomy

Potential risk factors - age, mechanical ventilation (weaker evidence)

No significant evidence for other factors incl. Surgical intervention, level of injury, completeness of injury

(Data from systematic review of literature by S. Minshall (pending publication))

Problems with quality of evidence base :

Observational design studies only (case control, cohort)

Significant variation in quality and population characteristics - no meta analysis possible

Lack of consistent and comparable definitions of dysphagia

Range of methods of identification of dysphagia, not all used objective measures leading to potential underestimation (silent aspiration)

Lack of data about **patient outcomes**

Case study 1

Male, Age 47

Fall from ladder August 2012

C4 complete tetraplegia.

Respiratory failure 3 days later - intubation and ventilation

Sputum retention problems in ITU twice daily chest physio

Commenced cough assist with vent in referring ITU

Speech, language and cognition normal

Admitted to SIU Mid January 2013 eating and drinking - no NG

Case study 1….

Continued twice daily chest PT and CA

Weaning with VFB commenced March 2013 within 6 days - 5 hours vent free.

Four weeks later weaning stopped due to sputum load.

1st SLT ax March - BSE suggests pharyngeal dysphagia ; pt opting to eat and drink whilst awaiting video

Video fluoroscopy demonstrates mild but consistent aspiration on primary and clearing swallow for all fluids and diet consistencies.

Trial NBM (Tic tac habit)

Continue CA - Twice daily, less manual therapy

Case study 1….

PEG insertion, SLT input with exercises.

Once daily chest physio Re-commenced weaning - cautiously

Chest deterioration, ? mouth stick giving increased saliva, ? tic tacs

September ’13 repeat videofluoroscopy - ISQ

Chose to eat and drink accepting risks

Needing CA - Twice daily (but not PT)

Discharged home ventilated 18 hours, carers using Nippy Clearway 2x daily

Recurrent CI but otherwise well

Case study 2.

Male Age: 65

Fall down stairs September 2014 #C1-3 resulting in C3 ASIA A

Admitted SIU Jan 2015 PEG in situ

(R) LL consolidation treated with ABx, confused, DNAR discussed and agreed, for ward based care only.

Consolidation resolved, improved orientation, remained confused, chest variable

Assessed end Feb - will need Home ventilation

Case study 2...

Speech and language function intact but cognitive / behavioural overlay

Jan/ Feb - steady improvement up to normal fluids and soft/normal diet

March - acute deterioration in swallow (?cause, CT head clear)

Videofluoroscopy showed aspiration pre, peri, post swallow on all consistencies

weak or absent cough response

Episodes of NBM and dysphagia therapy but expressing wish to eat and drink

Case study 2...

Some improvement in swallow function however refused modification of diet and fluids.

Swallow variable. Eating and drinking accepting risks.

Worsening swallow and obvious aspirations

Nursing staff using cough assist post oral intake

Complications:

Capacity Variable, Poor eyesight difficult to engage

Crisis management, repeated antibiotics, ceilings of care

Re- settlement, finding place to manage desaturations - RIP

Issues and questions:

Informed decision making - we need more data on short and long term impacts/outcomes of dysphagia in this population

Mental capacity assessments with variable presentation

Amount of chest care - workload for physiotherapists and nursing staff ; impact on patient

Legal issues and Nursing issues

- Are we harming patients by orally feeding them?
- Stress of crisis management

Should we have limited IV ABx earlier ?

Questions for the expert panel…

Could or should we have limited IV or any antibiotic use earlier ?

Would it be feasible to do a prospective data collection across units?

Are tic tacs really dangerous ?