



A SASS MINUTE

GERD Considerations & Oropharyngeal Dysphagia

The following is a position statement developed by SASS Associates Holly Blankenship, Travis Camp, Jessica Scott, and Matthew Ward. This collaborative effort was born out of their experiences seeing patients for FEES studies and their desire to better understand GERD and its relationship to oropharyngeal dysphagia. We commend them for their efforts.

Position Statement

Gastro-esophageal reflux disorder (GERD) is a common condition—impacting up to 28% of adults in the United States (El-Serag et al., 2014). While the diagnosis and treatment of GERD fall outside the standard scope of practice for speech-language pathologists (SLPs), reflux can cause significant respiratory complications and often complicates the diagnosis of oropharyngeal dysphagia at bedside. Treatment of known or suspected dysphagia by altering diet texture or liquid viscosity can significantly reduce quality of life and may exacerbate reflux. Hence, screening for dysphagia should include a thorough review of the patient’s history that includes common symptoms of reflux. Treatment for oropharyngeal dysphagia should not begin prior to completing an instrumental (VFSS or FEES) assessment of swallowing. Any signs concerning undiagnosed or poorly controlled reflux warrant a physician consultation.

GERD: The reflux of gastric contents from the stomach into the esophagus and maybe into the pharyngeal spaces resulting in problem symptoms or complications. Refluxed content may be acidic or alkaline, liquid or gaseous. Its frequency and duration of episodes as well as the destination of the refluxed material affects its impact. (Lee & Goldstein, 2015)

Position Evidence and Support

Roughly, 40% of adults in the United States report weekly GERD symptoms, and 10% experience GERD weekly or daily (Bajwa et al., 2011). GERD can cause coughing during or after meals, and it is a common cause of chronic cough. In fact, GERD may present only with a cough—and no other GI symptoms—in up to 75% of cases (Irwin & Richter, 2000). Even further complicating the clinical picture for clinicians seeking to diagnose dysphagia at bedside, there is a correlation between reflux and many chronic or recurrent respiratory conditions: pneumonia, bronchitis, COPD, asthma, and pulmonary fibrosis (Bajwa et al., 2011).

At bedside, dysphagia screenings—whether completed by speech-language pathologists or other medical professionals—rely heavily on coughing during oral intake as an indicator of possible laryngeal penetration or aspiration. However, only 29% of SLPs report using a statistically valid tool to evaluate dysphagia (Carnaby & Harenberg, 2013). Therefore, any medical condition that can cause coughing is likely to confound bedside evaluations.

SASS Assesses for You!

In medical settings, there is often a systemic urge to treat a cough—as the hallmark of aspiration—at bedside without imaging. In short, SLPs are often tasked with eliminating or reducing frequent coughing with meals, when drinking, or when taking medications. However, attempting to ameliorate a symptom, without knowing its cause, is problematic at best. Moreover, when SLPs are consulted, a common intervention is diet texture modification or liquid viscosity alteration, and up to 30% of long-term care residents receive thickened liquids and mechanically altered diet textures (Castellanos et al., 2004). Thickened liquids are known to slow digestion (Cichero, 2013), which may exacerbate reflux. Thus, treating a cough, of unknown origin, with traditional swallowing intervention may prove futile and could ultimately cause harm.

The rate of pneumonia from prandial aspiration remains relatively low, and continuing to eat and drink orally, even when significant laryngotracheal aspiration is observed via FEES or VFSS, is poorly correlated with the development of pneumonia (Abdelhamid et al., 2016; Andersen et al., 2013; Beck et al., 2018; Bock et al., 2017; Feinberg et al., 1996; Hines et al., 2010; Loeb et al., 2003; Santos et al., 2021; Speyer et al., 2010). While trace aspiration of food and liquid may cause pneumonia or other complications, morbidity and mortality for gastric aspiration (due to reflux or emesis) are high—accounting for 30-40% of all acute respiratory distress-related mortality (Acosta-Herrera et al., 2014).

FEES Helpful Hints:

- 1) Only you discuss the planned study with your patient, not PT, RT, OT, nursing, or the chaplain.**
- 2) ALWAYS do the “Q-Tip Test” to see how well your patient will tolerate the procedure.**
- 3) Look beyond just aspiration & penetration in the SASS reports. Consider hydration & nutrition needs & your patient’s quality of life. Is an altered diet the right or the best choice?**

GERD Considerations after FEES

If patient history or changes in the soft tissue are concerning for unknown or poorly controlled reflux, physician consultation is warranted. Further, if aspiration of esophageal or gastric contents is witnessed during FEES, medical staff should be informed immediately.

While there is a poor correlation between prandial aspiration and pneumonia, aspiration of esophageal or gastric contents can have dire consequences. Thus, the reduction or elimination of prandial aspiration alone should not be the singular focus of recommendations based on FEES results. When making recommendations, clinicians should weigh the risks of any proposed intervention that could exacerbate GERD. Therefore, diet texture modifications and liquid viscosity alterations should be made with equal regard for their impact on quality of life, nutrition, hydration, and the possibility of exacerbating underlying medical conditions such as GERD.

(The complete Reference List is available upon request.)

Did you know . . .

- . . . thicken liquids may coat tablets and capsules and slow their time and place of release in the digestive tract?**
- . . . hyoid-larynx elevation is NOT the first event of swallow onset initiation?**
- . . . the actual incidence of pneumonia is less than 15% in patients who aspirate?**
- . . . the lower respiratory system is NOT sterile and is home to the same pathogens found in the mouth?**
- . . . honey thick liquids reduce aspiration risk the most, but also results in the highest incidence of pneumonia?**
- . . . physicians order imaging studies to help deliver correct diagnoses and treatment plans? Why not SLPs?**

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