Dysphagia

Dysphagia is defined as difficulty in swallowing. It is usually associated either with pharyngeal or oesophageal disease. There is a spectrum of possible aetiologies (see links in table under Aetiology, below), from self-limiting illness (eg, tonsillitis) to carcinoma. It may occur with odynophagia - painful swallowing.

Presentation

Symptoms

- As well as the feeling of food sticking in the gullet, patients with oesophageal disease may have other symptoms. These range from discomfort to severe pain, with the patient nearly always unable to locate the obstruction accurately.
- Regurgitation, vomiting, coughing and choking are common.
- Men with new onset of alarm symptoms (loss of weight with worsening dysphagia) have an increased likelihood of a diagnosis of cancer, especially in those aged over 65. A positive predictive value of 9.0% has been found in this age group.

Aetiology

- The most common lesions within the oesophagus are inflammatory strictures from reflux or tumours.
- A long history of heartburn is usually associated with an inflammatory stricture.
- In Westernised countries, eosinophilic oesophagitis is thought to affect between 40 and 55 per 100,000 population - similar to the numbers affected by Crohn's disease.
- Idiopathic achalasia presents with dysphagia for solids and also regurgitation of a bland-tasting material that has never entered the stomach. It occurs in 1-2/100,000, most commonly seen in mid-adult life, and is caused by impaired neural control of the distal oesophagus.

<table>
<thead>
<tr>
<th>Obstructive</th>
<th>Neurological</th>
<th>Others</th>
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<tbody>
<tr>
<td>Gastro-oesophageal reflux ± stricture</td>
<td>Cerebrovascular event or brain injury.</td>
<td>Pharyngeal pouch.</td>
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<tr>
<td>Other oesophagitis (eg, infection).</td>
<td>Diffuse oesophageal spasm.</td>
<td>External compression (eg, mediastinal tumour, or associated with cervical spondylosis).</td>
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<tr>
<td>Oesophageal cancer.</td>
<td>Syringomyelia or bulbar palsy.</td>
<td>Calcinois, Raynaud's disease, (o)esophageal dystmotility, sclerodactyly, telangiectasia (CREST) syndrome or scleroderma.</td>
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<tr>
<td>Gastric cancer.</td>
<td>Masthenia gravis.</td>
<td>Oesophageal amyloidosis.</td>
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<td>Oesophageal rings.</td>
<td>Myopathy (dermatomyositis, myotonic dystrophy).</td>
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<td>Foreign body (acute).</td>
<td>Parkinson's disease and other degenerative disorders.</td>
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<td>Chagas' disease.</td>
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Investigations

- FBC and erythrocyte sedimentation rate (ESR) should be taken.
- Barium swallow and/or endoscopy with biopsy should usually be performed.
- MRI scanning may also be required before any surgery is considered - eg, if there is oesophageal carcinoma.
- Endoscopic ultrasonography can assist with staging in oesophageal carcinoma.
- Videofluoroscopy is the radiological investigation of choice when ‘difficulty swallowing’ rather than ‘food sticking’ is the presenting symptom and/or aspiration is suspected.
- Oesophageal motility studies (require swallowing a catheter containing a pressure transducer) are useful when oesophageal spasm is suspected.
Management

If cancer is a possibility - all cases need urgent assessment under the ‘two-week rules’ (Department of Health guidelines for urgent referral).[5]

General
The patient may need to chew well or liquidise food.

There is insufficient evidence currently to support the efficacy of dietary modification, swallowing manoeuvres, surgical interventions or enteral feeding for the treatment of chronic neuromuscular conditions.[6] Patients with neurological problems (e.g. cerebrovascular injury) may benefit from an early Speech and Language Therapy assessment.[7,8]

Eosinophilic oesophagitis may be treated with dietary modification, topical steroids, leukotriene antagonists and other drugs, and endoscopic dilation.[4]

Surgical
Definitive treatment depends on cause:

- Strictures may be managed with endoscopic dilation (either using bougies or inflatable balloons).
- If oesophageal carcinoma is diagnosed, staging will dictate whether curative surgery (for example, oesophagectomy) and chemotherapy are appropriate.[9]
- Overall, the five-year survival of patients with oesophageal carcinoma ranges from 15-25%.[9]
- In oesophageal carcinoma, palliative relief of dysphagia can be achieved with:
  - Repeated dilatation
  - Stent replacement[10]
  - Laser photoocoagulation
  - Injection of sclerosants
- Brachytherapy can be a useful alternative or adjunct.
- Surgical myotomy and endoscopic injection of the sphincter with botulinum toxin are occasionally used for some aetiologies.

Complications

- Malnutrition; nutritional support is often needed prior to treatment.
- Aspiration pneumonia may occur.
- Perforation may occur iatrogenically.

Further reading & references

- Transcutaneous neuromuscular electrical stimulation for oropharyngeal dysphagia; NICE Intervventional Procedure Guidance, May 2014
- Acute stroke pathway; NICE, July 2014
- 1. Dent J, Holloway RH and Neale G; Oxford Textbook of Medicine, 4th Edition
- 5. Referral for suspected cancer; NICE Clinical Guideline (2005)
- 7. Management of patients with stroke: Identification and management of dysphagia; Scottish Intercollegiate Guidelines Network - SIGN (June 2010)

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