

SAMPLE: ADULT DYSPHAGIA
(Space down seven spaces)

April 10, 2006

MODIFIED BARIUM SWALLOW STUDY WITH VIDEOFUOROSCOPY

NAME:	Matt Lauer	D.O.B.:	02/11/34
ADDRESS:	11780 Greenwood Ct. Mobile,, AL 36587	AGE:	72
PHONE:	(334)-XXX-XXX	D.O.E.:	04/04/06
		REFERRAL:	Dr. Sebelik
		PATIENT #:	LAUER0000

STATEMENT OF THE PROBLEM

Mr. X, age 70, was seen on an outpatient basis at the University of South Alabama Medical Center for a modified barium swallow study with videofluoroscopy. This study was recommended after a non-instrumental evaluation of swallowing on April 1 was unable to assess the safety of Mr. X's swallow. Accordingly, in consultation with Dr. Sebelik, a modified barium swallow study was recommended. Mr. X had expressed lack of confidence in his ability to swallow as well as some discomfort after a jaw resection in September, 2005.

HISTORY INFORMATION

Mr. X was initially seen at the USA Speech and Hearing Clinic on April 1, 2206, for a preliminary swallow evaluation. His primary complaint was intermittent difficulty with swallowing including an inability to hold foods in his oral cavity. Mr. X has been able to tolerate water for the past few weeks, but he has felt uncomfortable trying to swallow other consistencies.

EVALUATION RESULTS

ORAL EXAMINATION: An oral examination was completed to determine structural adequacy for swallowing. Mr. X's mouth was noted to be asymmetrical at rest. While the left side appeared to have good range of motion, the right side was impaired when he was asked to smile as well as purse his lips. Range of motion was poor for the tongue, particularly for the tongue tip. Mr. X exhibited little lateral or vertical movement of the tongue. (It should be noted that Mr. X reported soreness in and around his mouth.) The elevation of the soft palate appeared to be symmetrical and within normal limits during phonation. Mr. X presented with a hyperactive gag reflex. Mr. X has no teeth and does not wear dentures.

SWALLOWING EVALUATION

Mr. X was viewed while sitting in a chair with a right lateral view and followed by an anterior to posterior view. Material was administered from a spoon as well as a straw. Mr. X also sipped straight from a cup. Consistencies used were thin and thick liquids, pudding, chopped meat and cookies. His current intake is mainly through a nasogastric tube.

Oral Preparatory/Oral Phase: Mr X achieved adequate lip seal. Anteriorly, Mr. X exhibited poor tongue mobility. However, the posterior portions of the tongue appeared to demonstrate appropriate tongue to palate contact. Reduced anterior-posterior and lateral movement of the tongue was noted. With thin liquids in particular, Mr. X was unable to hold thin liquids in the oral cavity leading to premature entry of part of the bolus into the pharynx. This material usually filled the valleculae space until the pharyngeal swallow occurred.

Pharyngeal Phase: Mr. X's pharyngeal swallow reflex was normal and usually cleared the material pooled in the valleculae space prior to the swallow. Mr. X did complain of material being stuck in his throat after swallowing the cookie. The exam indicated some small residue of this material on the posterior pharyngeal wall. A small amount of stasis was noted in the valleculae space after the swallow. Penetration was evidenced in the laryngeal vestibule, but lateral pharyngeal wall contraction appeared to clear the bolus consistently. No reflexive cough

was noted in response to the small amount of penetration. However, this was cleared with the swallow. A chest x-ray performed after the swallow study did not show any aspiration.

Compensatory Posture/Positioning/Maneuvers: No specific maneuvers were taught during the procedure. However, Mr. X appeared to use a spontaneous chin tuck when he had more difficulty with a swallow. Also, food placement was best on the left side of his mouth.

LANGUAGE/VOICE/FLUENCY: Informal assessment of language, voice and fluency yielded normal results. Mr. X's pitch and loudness were considered appropriate for his age and gender.

ARTICULATION: Mr. X's articulation was informally assessed and his speech was considered intelligible.

HEARING: No hearing testing was done at this evaluation session. Mr. X was noted to respond appropriately at normal conversational intensity.

IMPRESSIONS/PROGNOSIS

Mr. X presented with a difficulty in the oral stage of swallowing, typified by poor lingual range of motion. Penetration was noted in the laryngeal vestibule only with thin liquids; however, no aspiration was noted. He demonstrated a safe and primarily efficient swallow on all other consistencies. His ability to use compensatory strategies and residual functioning of the swallow mechanism present a positive prognosis for improvement.

RECOMMENDATIONS

1. Mr. X should follow up with Dr. Sebelik regarding the results of this evaluation.
2. It is recommended that Mr. X continue oral intake and incorporate new consistencies into his diet (e.g., thick materials such as pudding, milkshakes, creamed or mashed vegetables).
3. It is recommended that Mr. X alternate thin liquids and solids frequently to assist in clearing residual material from the pharynx.
4. Food should be positioned on the left side to avoid pocketing of material in the right lateral cheeks.

Amy Wilson, B.S..
Graduate Student Clinician

Martha Bailey, M.S., CCC-SLP
Clinical Supervisor

cc: Mr. X
Dr. Sebelik