Approach to Dysphagia

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Faculty Disclosure

- **Faculty:** Adriana Lazarescu
- **Relationships with commercial interests:**
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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

Step 1 – Oropharyngeal vs. Esophageal Dysphagia

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

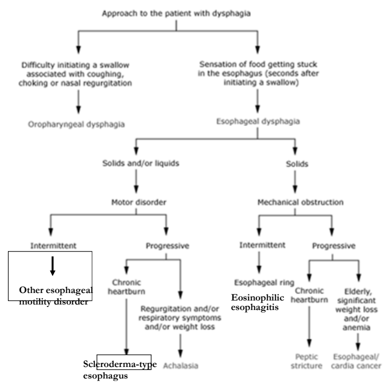
Step 3 – Useful Questions

- 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

Causes of esophageal dysphagia

Mechanical lesions
Intrinsic
Benign tumors
Caustic esophagitis/stricture
Diverticula
Malignancy
Peptic esophagitis/stricture
Eosinophilic esophagitis
Pill esophagitis
Post surgery (laryngeal, esophageal, gastric)
Radiation esophagitis/stricture
Rings and webs
Extrinsic
Aberrant subclavian artery
Cervical osteophytes
Enlarged aorta
Enlarged left atrium
Mediastinal mass (lymphadenopathy, lung cancer, etc.)
Post surgery (laryngeal, spinal)
Motility disorders
Achalasia
Chagas' disease
Diffuse esophageal spasm
Hypertensive lower esophageal sphincter
Nonspecific esophageal motility disorder
Nutcracker esophagus
Scleroderma
Functional
Functional dysphagia

UpToDate



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