

Dysphagia

By CLARISA E. CUEVAS, MD

Dysphagia is defined as difficulty in swallowing. It is a symptom that can be due to a defect in the mouth, oropharynx, or esophagus. It can also be the result of a motor disorder or mechanical obstruction.

To determine the area of defect, we must evaluate all stages of swallowing. It all begins with suckling. The lips must be able to form a tight seal as the tongue is displaced posteriorly. The glottis closes to guard the airway, and the soft palate rises to close the nasopharynx as the cricopharyngeal muscles relax. The food then passes to the back of the pharynx. Solids require coordinated actions requiring appropriate jaw movements and teeth alignment. Salivary secretions lubricate the food as it passes through the mouth into the pharynx and then the esophagus.

Abnormalities in any phase can interrupt successful swallowing. It is abnormalities of the muscles involved in the ingestion process, their innervations, strength or coordination causing intermittent dysphagia in infants and children. Cerebral palsy, Arnold-Chiari malformation, myelomeningocele, congenital myotonic dystrophy, and other myopathies, as well as cricopharyngeal achalasia, can present as dysphagia.

Esophageal disease is a common cause of swallow dysfunction. Sudden dysphagia in the younger child should be evaluated immediately and a foreign body should be ruled out. Eosinophilic esophagitis often presents as a swallow dysfunction and feeding refusal with or without choking. Candida pharyngitis or esophagitis can cause difficulty in swallowing. Gastroesophageal reflux with esophagitis or ulcerations can result in choking and difficulty with both liquid and solid bolus. Idiopathic achalasia often presents with difficulty in swallowing liquids and solids. A history of tacheoesophageal atresia or fistulae suggests stricture formation and a motility problem.

The clinical presentation varies. In the younger child, it often presents with respiratory signs and symptoms combined with feeding refusal. The older child can have fits of coughing, nighttime drooling, and refusal of their favorite foods. A

choking episode with food bezoar impaction is the most common presentation in the adolescent patient.

Careful examination of oral, pharyngeal, laryngeal, and esophageal anatomy and function are important during the evaluation of children with dysphagia. Three basic approaches are utilized:

Radiographic studies: (a) upper gastrointestinal series will help identify anatomic or structural abnormalities such as strictures, vascular anomalies of the esophagus, fistulae and masses. Images of the coordination of movement of bolus through the oropharynx and esophagus can help identify motility dysfunction, chaliasia or achaliasia; (b) modified barium swallow with a speech or occupational therapist can identify oropharyngeal dysfunction.

Direct visualization with a fiberoptic endoscope will help in both the identification of the problem and in removal of a bezoar, foreign body, or therapeutics with botulin toxin or pneumatic dilation for achaliasia.

Motility studies are indicated for the evaluation of esophageal peristalsis. A 24-hour study can help when GERD is suspected.

The therapeutic modalities vary depending on the cause for the dysphagia. At our GI for Kids clinic, we coordinate care with speech therapy and occupational therapy in the case of oropharyngeal problems. Recommendations for treatment of both achaliasia (Botox/dilatations) and chaliasia (H2 antagonist/PPIs) are given. Treatment and follow-up are provided so as to prevent recurrence of the problem particularly in the case of Eosinophilic esophagitis. Inhalers, PPIs, and esophageal dilation are needed throughout the year. While dysphagia requires a complex evaluation, in most cases we have complete resolution of the medical problem.

Clarisa E. Cuevas, MD, is a board-certified pediatric gastroenterologist with GI for Kids, PLLC, in Knoxville, Tenn.



www.giforkids.com • 865.546.3998