

That's not what I saw! : Explaining discrepancies in swallowing assessments

Elizabeth Thrush, M.S., CCC-SLP
The Reading Hospital and Medical Center

PSHA Convention 2010

- ❖ Introduction: Why is understanding discrepancies important?
 - Assessment
 - Treatment

- ❖ Potential discrepancies:
 - Clinical assessment vs. VFSS
 - Clinical or instrumental assessment vs. another clinician's VFSS
 - Caregiver reports vs. clinical assessment

- Clinical assessment vs. VFSS
 - Feeding factors
 - Self- vs. caregiver-feed

 - Cued (volitional) vs. automatic swallow

 - Single vs. consecutive sips

 - Presentation order
 - Positioning factors
 - Reclining vs. upright

 - Chin tuck

 - Head back

- Bolus factors
 - Carbonation
 - Temperature
 - Taste
 - Viscosity
 - Barium vs. plain
 - Volume
 - ◆ Other bolus size considerations
- Clinical or instrumental assessment vs. another clinician's VFSS
 - Differentiating impairments
 - Swallow delay vs. decreased oral containment vs. normal function
 - Unilateral pharyngeal bolus transit – pharyngeal weakness vs. unilateral epiglottic deflection
 - Normal vs. abnormal
 - Food over base of tongue to valleculae before the swallow
 - Liquid to valleculae or pyriform sinuses before swallow initiation
 - Transient penetration
 - Small amount of pharyngeal residue/coating

- Other considerations
 - Esophageal screening done?
 - Realtime judgments/interpretation vs. tape review
 - Number of trials given
- Caregiver reports vs. clinical assessment
 - Distractions
 - Patient status (e.g., lethargy, agitation, confusion, fatigue, meds, disorder characteristics, acute illness, etc.)
 - Which side to stand on (with unilateral weakness or neglect)
- Pediatric considerations
 - Positioning
 - Breastfeeding vs. bottle feeding vs. cup feeding
 - Breastmilk vs. formula
 - Nipple type/cup type
 - State (e.g., sleepy, frightened, crying)
- Clinical applications
 - What to do when encountering discrepancies
 - ◆ List possible causes
 - ◆ Direct questions regarding history

