

# Rigid Endoscopes and the Clinical Swallowing Evaluation: Current Practices and Views of Practitioners

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## INTRODUCTION

- ❖ Dysphagia (difficulty swallowing) frequently occurs as a result of strokes, head and neck cancer, trauma, or degenerative neurologic illnesses (Langmore, 2001; Logemann, 1998). It can cause pneumonia, malnutrition, and dehydration leading to higher medical costs and decreased quality of life. It is essential that these consequences be prevented or minimized to the extent possible. Detection of dysphagia is imperative.
- ❖ Clinical swallowing evaluations (CSEs) are done routinely by speech language pathologists (SLPs) for patients with suspected dysphagia. The CSEs are non-instrumental evaluations designed to detect dysphagia and to determine the need for further testing. Because CSEs do not utilize instruments to capture images of the swallowing structures and functions, it is impossible to diagnose dysphagia with CSEs alone (Steele, 2014). Furthermore, it has been shown that 40% of the most experienced clinicians do not accurately detect silent aspiration during CSEs.
- ❖ Accuracy of detecting dysphagia and determining the need for further testing has been demonstrated by using rigid endoscopes to capture views of the pharynx (throat) and larynx before and after swallows of foods and/or liquids (Curtis, Laus, Yung, & Courey, 2016). However, the use of rigid endoscopes for this purpose is rarely considered. Given the importance of discovering the presence of dysphagia and the valuable information rigid endoscopes provide, more needs to be known regarding views and attitudes of practitioners.

## PURPOSE

- ❖ The purpose of this study was to query SLPs (practitioners) who evaluate patients for dysphagia about their use, attitudes, and thoughts regarding the use of rigid endoscopes as a part of CSEs in order to learn more about preferences and practices.

## METHODOLOGY

- ❖ Participants consisted of SLPs/practitioners who specialize in dysphagia evaluation and treatment who are current members of the American Speech Language Hearing Association (ASHA) and members of ASHA's special interest group 13 (SIG 13). SIG 13 is an online community for SLP's/practitioners who specialize in dysphagia services.
- ❖ A 22-item questionnaire was developed using Survey Monkey. To recruit participants, an electronic invitation with a link to the survey was posted to the SIG 13 community site. After one week, the electronic message was re-posted in order to gain more participants. The survey was closed after 3 weeks. Data were processed and analyzed with the necessary tools in Survey Monkey and Microsoft Excel (2016).

## RESULTS

### 35 QUESTIONNAIRES WERE COMPLETED

#### Gender

Male: n = 9 (25%)  
Female: n = 26 (75%)

#### Years Practiced

Range: 1 to 40 years  
Mean: 15.65 years  
SD: 9.49  
Median: 14.5

#### Age

Range: 30 to 69 years  
Mean: 43.41 years  
SD: 9.48  
Median: 42

#### Frequency of CSEs

Never: n = 0 (0%)  
Seldom: n = 1 (3%)  
Half: n = 1 (3%)  
Usually: n = 14 (40%)  
Always: n = 19 (54%)

#### Trained in Rigid Laryngoscopy

n = 21 (40%)

#### Rigid Endoscopy Available Where They Work

n = 18 (51%)

#### Supervisor/Trainer Never Considered Use of Rigid Endoscope for CSEs

n = 31 (92%)

One Practitioner Reported Using the Rigid Endoscope During CSEs 40 to 60% of the Time

## DISCUSSION

- ❖ Results of this study provide insight regarding the scant use of rigid endoscopes during CSEs. Key points are as follows:
  - ❖ Of the 35 respondents, only 21 of them had ever been trained in rigid endoscopy.
  - ❖ Only 18 of the 35 respondents had rigid endoscopes available to them where they worked.
  - ❖ Of the 35 respondents, 31 of them had never been exposed to the use of rigid endoscopy for CSEs when being trained for dysphagia by their supervisors.
  - ❖ Of the 4 practitioners who had been exposed during their training, 3 of them did not carry on the practice beyond training
  - ❖ Only 1 practitioner reported using the rigid endoscope during CSEs 40% to 60% of the time.

## CONCLUSION

- ❖ The majority of SLPs/practitioners who participated in this study are not using the rigid endoscope during CSEs. While some of this is related to personal and professional preferences, much of it may be due to lack of exposure during education and training for dysphagia. Given the positive impact the use of rigid endoscopes could have as shown by prior research, perhaps it is time to add its use to education and training programs. We recommend it become an integral part of CSEs and trained accordingly to students and current practitioners alike. It is imperative that dysphagia be detected early and this is one more tool that could be used in this effort.

### Selected References

- Curtis, J. A., Laus, J., Yung, K. C., Courey, M. S. (2016). Static endoscopic evaluation of swallowing: Transoral endoscopy during clinical swallowing evaluations. *Laryngoscope*, 126(10), 2291-2294. doi: 10.1002/lary.25828
- Langmore, S. E. (2001). *Endoscopic evaluation and treatment of swallowing disorders*. New York, NY, Thieme
- Logemann, J. A. (1998). *Evaluation and treatment of swallowing disorders* (2<sup>nd</sup> ed.). Austin, Texas: Pro-ed.
- Steele, C. M. (2014). The blind scientists and the elephant of swallowing: A review of instrumental perspectives on swallowing physiology. *Journal of Texture Studies*, 46(3), 122-137. doi: 10.1111/jtxs.12101



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