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Republication de : The Bedside Clinical Examination as a key element of the swallowing assessment during the COVID 19 Pandemic[☆]



Dear editor in chief, in a recent issue of the European Annals of Otorhinolaryngology, Head and Neck Diseases [1], eminent exponents of the French Society of Otorhinolaryngology, Head, Neck Surgery and of the French Society of Phoniatics, presented careful devised guidelines of clinical practice for the management of

[☆] Cet article a fait l'objet d'une première publication dans les *European Annals of Otorhinolaryngology, Head and Neck Diseases*. Nous le republions ici dans les pages des *Annales Françaises d'Otolaryngologie*, son titre jumelé. Avec autorisation de l'éditeur. Pour la citation veuillez utiliser la référence de la première parution : *European Annals of Otorhinolaryngology, Head and Neck Diseases*, 138 (4) (2021) 313. <https://doi.org/10.1016/j.aforl.2020.06.029>.

swallowing disorders and dysphonia during the COVID 19 Pandemic.

The authors recommend to consider all patients as potentially positive, due to not absolute reliability of the tests used for the SARS-Cov-2 detection, and rightly underline the high risk of contamination from droplets emitted by the patient during instrumental diagnostic procedures such as flexible endoscopy. Consequently, they recommend running swallowing assessment only in case of emergency, postponing the majority of investigations, possibly using a teleconsultation.

While agreeing with all the recommendations of caution indicated in the guidelines, we believe that in several patients, according to literature, the evaluation of swallowing cannot be postponed, in particular in dysphagic post-extubation patients [2] and in neurodegenerative patients suffering from severe dysphagia [3].

Considering the inopportunity to move the patient to other wards to undergo radiological examination and the need to reduce the number of endoscopic evaluations, we transitory made the clinical (bedside) swallow examination (BSE) the key element of the swallowing assessment process. The BSE is performed by our speech-therapists according with the American Speech-Language-Hearing Association recommendations. Only conscious and collaborative patients are examined. The evaluation is focused on the observation of voice and articulation quality, head-neck control and posture, cough strength, oral phase functionality, hyolaryngeal excursion during dry swallowing and finally on the identification of signs and symptoms of penetration and/or aspiration, such as throat clearing or coughing before, during and after the swallow of different textures of fluids and semisolid foods. In our preliminary experience, BSE allowed us to restore oral nutrition to 35 out of the 43 examined subjects, limiting oral intake to semi-solid and semi-liquid food in 22 cases. Eight subjects were referred to endoscopic examination. Due to lack of an instrumental reference test, it is not possible to evaluate the reliability of our data, it must however be considered the volume viscosity test alone reach a sensitivity of 0.94 [4].

Finally, we are aware that also BSE exposes to saliva droplets produced by coughing, however the speech pathologist, unlike the ENT or Phoniatician who performs endoscopy, can defend himself wearing not only a protective mask, but also a shield for face. Right now, no one out of the four speech therapists involved in the BSE in two large hospitals from our city, showed symptoms of COVID 19 infection.

Disclosure of interest

The authors declare that they have no competing interest.

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**Republication de : Isolated Dysphagia: It could be the tip
of the iceberg of a bigger problem**[☆]

Dear editor in chief,

We would like with this letter to reinforce the idea that the assessment of a patient with dysphagia requires a high degree of suspicion regarding its origin, since in fact it can only represent the initial manifestation of a bigger problem.

A 70-year-old man, with smoking habits, but previously autonomous and without major health problems, was admitted to the emergency department due to acute respiratory distress after eating. He was stabilized and otorhinolaryngology observation was requested. Nasofibrolaryngoscopy was performed, which showed a foreign body occupying the entire glottic region (Fig. 1). Under visualization, the foreign body was removed using forceps from foreign bodies through the oral cavity. A clear reduction in mucosal sensitivity was observed, with no coughing or vomiting reflex during airway manipulation. After stabilization and a better exploration of the clinical history, it was possible to notice that there was a history of dysphagia with about one year of evolution, for solids, and loss of five pounds in three months, without any more associated symptoms. To investigate the cause of dysphagia, he was observed by neurology, with suspicion of Lambert Eaton Myasthenic Syndrome (LEMS), confirmed by the presence of antibodies against voltage-gated calcium channels and electrophysiological tests. Computed Tomography in combination with Positron Emission Tomography Scanning revealed a nodule in the right upper lobe, and lung needle biopsy confirmed a small cell lung carcinoma.

The LEMS is an autoimmune-mediated (paraneoplastic or primary auto-immune) neuromuscular junction disorder, characterized by typical clinical triad: proximal muscle weakness, autonomic features, and areflexia [1]. Fig. 2 shows a schematic representation of the LEMS pathophysiology. In this work we report a rare and scarcely described presentation, an acute upper airway obstruction, as the tip of the iceberg for the diagnosis of LEMS.

In fact, symptoms of LEMS are usually slowly progressive, sometimes with years of evolution. Wirtz et al., in an analysis of 227 published cases, showed that the most frequent presentation symptoms are leg weakness (60%), generalized weakness (18%),

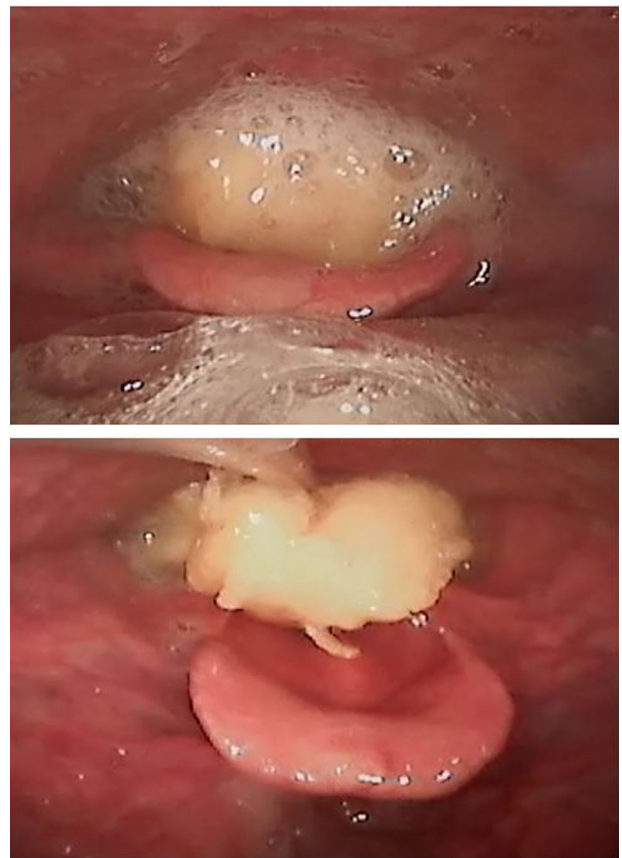


Fig. 1. Image captured by nasofibrolaryngoscopy. Foreign body observed in the glottic region of the larynx (orange), significantly compromising airway permeability.

muscle pain or stiffness (5%), dry mouth (5%), arm weakness (4%), diplopia (4%), and dysarthria (2%) [2]. Only in advanced stages of the disease there is an involvement of the oculobulbar muscles [2]. Particularly in relation to dysphagia, it can occur in 24–34% of patients with LEMS, although rarely occur during the initial manifestation of the disease [3].

With this case, we reinforce the idea already reported by Guruprakash et al. [4] and Payne et al. [5], who described two isolated cases of dysphagia, which later showed to be associated to LEMS. Therefore, isolated dysphagia, even with long duration (over 1 year), may be the initial manifestation of myasthenic syndromes, even when they have an associated tumor at their origin.

In conclusion, recognizing LEMS and others neuromuscular disorders swiftly is important, especially because the treatment entails addressing the underlying etiology. This particular case reinforces the few cases already described in the literature mentioned and emphasizes the importance of considering isolated dysphagia as a clinical presentation of LEMS and other myasthenic syndromes, requiring a high level of suspicion to be possible an early diagnosis and to be able to orchestrate a systematic and multidisciplinary approach.

Disclosure of interest

The authors declare that they have no competing interest.

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