NHS
Vale of York
Clinical Commissioning Group

Referral Support Service

ENT

ENT20
Dysphagia (high dysphagia, above the sternal notch)

Definition

Difficulty swallowing in which the food or liquid has great difficulty in reaching the stomach or is regurgitated in full or in part.

High dysphagia: is difficult swallowing caused by mouth or throat conditions.

- Generally managed by the ENT teams when conservative management fails.

Low Dysphagia: is swallowing difficulties below the level of the cricoid bone or sternal notch from the oesphageo-gastric tract.

- Generally managed by gastroenterologists when conservative management fails.

Odynophagia is painful swallowing, more likely to due to infection, but globus can present with pain.

Exclude Red Flag Symptoms

- Dysphagia, with weight loss over age 55 is a red flag symptom: click here for list.
- If associated with stridor or sudden onset signs of obstruction - admit.
- Acute onset Dysphagia, associated with fever or systemic upset but normal examination - think **supraglottitis** or **epiglottitis**. Needs urgent flexible laryngoscopy.
- **Complete Aphagia** (inability to swallow food or fluids) - admit ENT or Medical depending on cause eg. Quinsy/ Epiglottitis - ENT. Lower aphagia - Medics.

Management

Establish the level of the dysphagia: High or Low.

- Above the sternal notch, sensitivity to the location of the dysphagia is usually quite accurate. If referral needed - ENT.
- Below the sternal notch, perception of dysphagia is harder to localise. If referral needed - GI.

Consider the Cause of Dysphagia:

Neurological: strokes, myasthenia gravis, Parkinson's Disease, Stroke and MS are amongst the many conditions which can cause dysphagia. End stage dementia will present with delayed swallowing and ultimately aphagia. Consider SALT input (with existing diagnosis).

Congenital or Developmental: cerebral palsy, Learning Disability, Cleft palate.

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Clinical Research & Effectiveness approved: Mar 2018
Date published: Mar 2018
Next Review: Sep 2024

Obstruction: varies from tonsillitis and self-limiting illnesses to oropharyngeal and oesophageal cancers. Pharyngeal pouch, oesophagitis, GORD and oral thrush can present with obstructive symptoms. Age, weight loss and risk factors should all be considered to establish referral route.

Soft tissue Disorders: Achalasia and Scleroderma. Combined management by GI and rheumatology.

Referral Information

Indications for referral

- A secondary care review with investigations is required for most cases of new onset dysphagia.
- Consider Urgency: 2WW if meets the criteria, urgent or routine may be appropriate.
- Based on location of dysphagia and possible cause: ENT/ GI/ Neurology

Information to include in referral letter

- Timeline and any progression
- Fluctuation or continuum of symptoms
- Location of dysphagia (patient reported)
- Only solids, or only fluids or both affected
- Any associated features (pain, regurgitation etc., as above)
- Relevant past medical/surgical history
- Anxiety symptoms, particularly if globus suspected.
- Current regular medication
- Risk Factors: any unintended weight loss/ smoking status/ alcohol intake/ employment

Investigations prior to referral

- Investigations need to be directed to likely cause:
    - Unintended weight loss: refer and complete blood profile
    - CXR (particularly if there is a cough for >4/52 and the patient is >50 years and/or a smoker)
- Consider some fresh baseline bloods, including FBC, LFTs, U&Es, TFT, ESR and Ferritin as a minimum.

Patient information leaflets/ PDAs

https://patient.info/health/difficulty-swallowing-dysphagia

References

https://patient.info/doctor/dysphagia
https://cks.nice.org.uk/gastrointestinal-tract-upper-cancers-recognition-and-referral

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Guide to causes of Dysphagia

Obstructive	Neurological	Others
Gastro-oesophageal reflux ± stricture Eosinophilic oesphagitis Other oesophagitis (eg, infection). Oesophageal cancer Gastric cancer Pharyngeal cancer Post-cricoid web (Paterson-Brown-Kelly syndrome) Oesophageal rings Foreign body (acute)	Cerebrovascular event or brain injury Achalasia Diffuse oesophageal spasm Syringomyelia or bulbar palsy Myasthenia gravis Multiple sclerosis Motor neurone disease Myopathy (dermatomyositis, myotonic dystrophy) Parkinson's disease and other degenerative disorders Chagas' disease	Pharyngeal pouch Globus hystericus External compression (eg, mediastinal tumour, or associated with cervical spondylosis) Calcinosis, Raynaud's disease, (o)esophageal dysmotility, sclerodactyly, telangiectasia (CREST) syndrome or scleroderma Oesophageal amyloidosis Inflammation - eg, tonsillitis, laryngitis.

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