FEES vs. MBS

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FEES vs. MBS

- They are just tools for the evaluation of swallowing
- They are as good as what your clinical question is
- They should not be used to confirm your bedside diagnosis

Aspiration

- 25-57% of aspiration events before the swallow
- 44 – 65% of aspiration events after the swallow
- 7 – 9% of aspiration events during the swallow

(Colodny,2001; Smith et al., 1998)

FEES vs. MBS

- MBS no longer the Gold Standard
- The safety of nasendoscopy has been well established
- The more instrumentation available, the more benefit to our patients.

Case 1

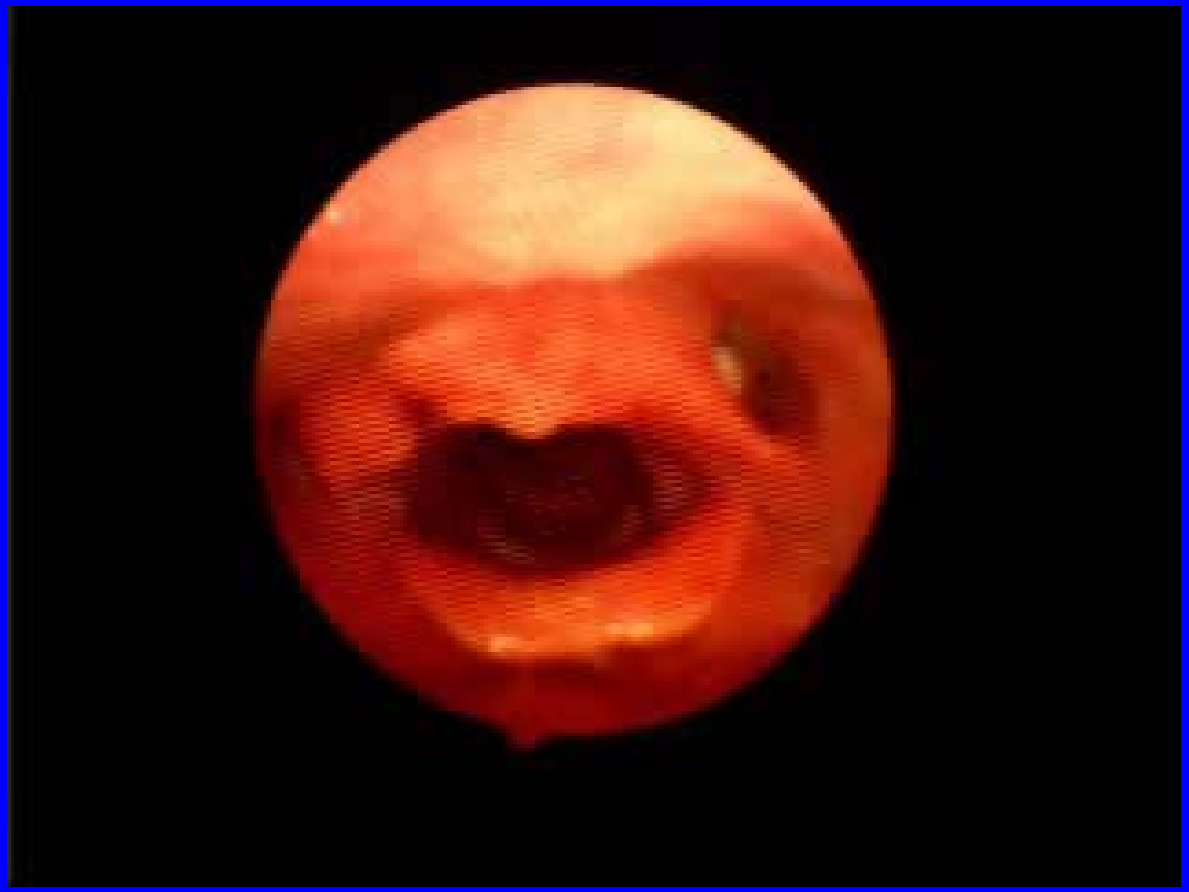
Supracricoid Partial laryngectomy with Cricohyoidoepiglottopexy (CHEP)

Case 1

Case 1

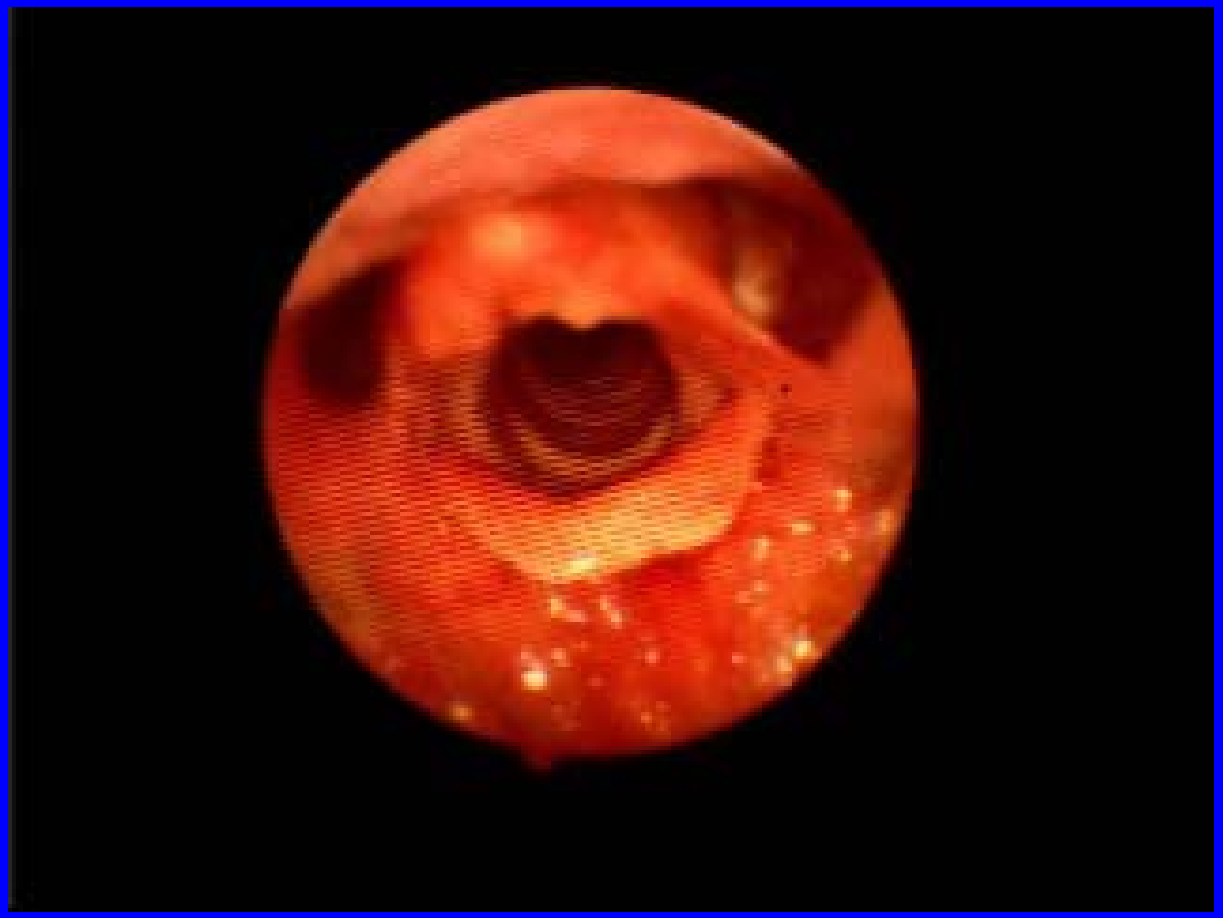
- 75 y.o. male
- SCPL with CHEP with preservation of both arytenoids (Jan 2005)
- Received no direct dysphagia Tx post op.
- Multiple MBS revealed severe dysphagia
- Nasendocopy by ENT revealed frozen larynx
- Evaluation by me 18 months later revealed that pt. had not learned to move structures post op.
- Pt. benefited from visual biofeedback via nasendoscopy.

Case 1 Initial evaluation



s/p SCPL CHEP two arytenoids

Case 1 Post visual biofeedback



s/p SCPL CHEP two arytenoids

Case 2

Long Uvula

Case 2

- 54 yo male
- No contributing medical history
- Complained of frequent gagging and choking during eating and also without eating
- Treated by PCP with reflux meds for 6 weeks without success
- Evaluated by SLP via MBS
  - Normal swallow

Case 2 Cont'd…

- Self referred to the swallowing center
- Based on symptoms a FEES was conducted
- Findings as follows:
  - Unusually long uvula

Conclusions

- Clinicians must:
  - have comprehensive knowledge of the available instrumentation and their limitations
  - take advantage of the instrumentation available to be considered a good diagnostician .
  - account for all factors that may influence outcome.
  - Understand that dysphagia is more than just aspiration.

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