Dementia and Dysphagia

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Overview

• 7,918 individuals turn 65 daily
• 330 individuals turn 65 per hour
• 10 million baby boomers will develop dementia
• Every 71 seconds someone is dx with AD
• Midcentury every 33 seconds someone will be dx with AD
• 67.8% have dementia in ALF
• 34% of the 67.8% have significant behavioral symptoms associated with the dementia
• 27% moderate to severe dementia

MMSE and Function in the Home

• 21-26
  • Keeping appointments (ie., doctor etc.)
  • Meal Preparation
  • Toileting
  • Medication management
  • Other high level sills

• 20-24
  • Safety in the home
  • Use of appliances in the home
  • Dressing, grooming, selecting clothes to wear
  • Toileting
  • Communication
  • Eating alone in the home

• Below 20
  • Eating
  • Sleeping
  • Instrumental behaviors
  • Grooming
  • Sensation
  • Communicating, dates and trends
### Depression-Rating Scale (BCRS)*

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<td><strong>Axis I: General Apathy</strong></td>
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1. No objective or subjective evidence of defect in concentration.
2. Subjective decrement in concentration ability.
3. Minor objective signs of poor concentration (e.g. inattention, driftiness).
4. Definite concentration deficit for periods of time (e.g. rated deficit on each of 4 tests, frequent difficulty in calculations, within 2 months).
5. Marked concentration deficit (e.g., giving wrong telephone number at errands (2 tests)).
6. Frequent or continuous difficulty in concentration task. Frequently begins to count forward when asked to count backward. From 10 to 1.

### Memory-Rating Scale (BCRS)*

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1. No objective or subjective evidence of defect in recent memory.
2. Subjective impairment only (e.g. forgetting names more than friends).
3. Deficit in recall of specific events student-own detalles (e.g. German grammar, dates, addresses).
4. Cannot recall major events of previous weekend, social events, names of family, friends.
5. Deficit in recall of scents, friends, schools, date.
6. Loss of memory, may not know names, President, current events.
7. Occasional loss of some events, labor or role of current duties, weather, etc.
8. Loss of memory of most recent events.

### Past Events-Rating Scale (BCRS)*

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2. Subjective impairment only (e.g. recalling two or more primary school exams).
3. Some gaps in past exam; specific questioning likely to reveal at least one childhood memory or two childhood friends.
4. Chat not deficit (e.g. surname recall most of the patient’s past more than the patient). Cannot recall childhood friends or former teachers but knows the names of most schools attended. Conveys chronology in tracing personal life.
5. Deficit in memory of past events, possessions, etc. (e.g. unable to name one’s high school cafeteria).
6. Gaps in past events sometimes noted (e.g. events of school attended).
7. No memory of past.
### Axis IV: Orientation

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- No deficit in awareness for time, place, identity of self or others.
- Subjective impairment only.
- No deficit in time, place, if one or more, if 2 days.
- Any deficit in time, place, day of week, if 3 days.
- Any deficit in month or year or both, if 2 months.
- Inadequate to month and year or month and season, if 3 months.
- Inadequate to month, year, or both, if 4 months.

- Any deficit in time, place, if 2 days.
- Any deficit in month, if 3 months.
- Any deficit in year, if 4 months.
- Any deficit in month and/or year or both, if 5 months.
- Any deficit in any aspect, if 6 months.

- Any deficits in time, place, day of week, if 1 day.
- Any deficit in time, place, if 2 days.
- Any deficit in month or year or both, if 3 months.
- Any deficit in month, year, or both, if 4 months.

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### Axis V: Functioning and Self-Care

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- No difficulty, either subjectively or objectively.
- Subjective complaints of forgetting location of objects.
- Subjective work difficulties.
- Decreased job functioning evident to coworkers.
- Difficulty traveling to new locations.
- Decreased ability to perform complex tasks (e.g., planning dinner for guests, handling finances, marketing, etc.).

- Requires assistance in choosing proper clothing.
- Requires assistance in feeding, and/or toileting, and/or bathing, and/or ambulating.
- Requires constant assistance in all activities of daily life.

= Total Score

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= Total Score
Normal Swallowing

"Wake up. The cat's got your teeth."
What is Dysphagia?

**Dysphagia** is an impairment in the swallowing function that may occur anywhere from the mouth to the stomach (Perlaman, 1997).

_Dysphagia Causes Pneumonia_

Prevalence of Dysphagia

- Mainly associated with advanced aging
- The incidence is approximately 44% in the geriatric population and is associated with significant morbidity and mortality
- Noted to result in weight loss, poor nutrition, dehydration, decubitus, social isolation, aspiration pneumonia and even death
- Approximately 58% of the 50% caseload in home health are dysphagia patients
- Over the past decade, the number of hospitalized elderly Medicare beneficiaries admitted to the hospital with a dx of aspiration pneumonia has increased 93.8%.

Overview of Normal Swallow

- 2400 swallows/day avg.
- 3 stages:
  - Oral Preparation
    - Requires lip closure
    - Jaw elevation, depression and rotary movements
    - Anterior tongue control
    - Posterior tongue elevation to close off airway from oral
  - Oral Transit
    - Sending the bolus from the anterior to posterior
  - Pharyngeal
    - Involuntary neurological event that elevates the larynx and closes off the airway.
Oral Prep and Oral Phase

**Normal Oral Prep and Oral Phases:**
- Food preparation
- Hand to mouth
- Food is bitten off or taken from a utensil
- Liquids are sipped via cup or sucked through a straw
- Oral manipulation/mastication
- Bolus formation
- Bolus propulsion
- Oral Transit

Pharyngeal Phase

**Normal Pharyngeal Phase:**
- Soft Palate elevates
- Tongue base makes contact with pharyngeal wall
- Hyolaryngeal excursion initiates
- Breathing momentarily stops
- Airway closes
- Vocal cords close
- Epiglottis inverts
- Muscles of the pharynx contract
- Upper esophageal sphincter (UES) opens
Normal Laryngeal Dysphagia

Normal Laryngeal Elevation:
- Normal laryngeal elevation should be approximately 2 cm in men and 1.5 cm in women, with some reduction of 1 to 3 mm over the age of 80.

Airway Protection

(Loewens, J.L., Liss, J.M., & Sciortino, K.L.)

Pharyngeal Phase consists of several events for airway closure:
1. Velopharyngeal Closure
2. Inversion of the epiglottis over the laryngeal entryway
3. Anterior and superior hyoid displacement
4. Closure of the true and false vocal folds
5. Progressive pharyngeal contraction
6. Opening of the UES

Geriatric Swallowing Evaluation Summary

- Age changes to swallow
- Diagnoses:
  - (How are diagnoses impact swallow and at what age)
  - Personal History
  - Environment
  - Medication Review
  - Weight Loss, malnutrition, dehydration
  - Respiratory (SOB)
  - Change in Temperature
- Structural Assessment:
  - May want to recommend MBS for CA patients
  - Cranial Nerve Assessment
  - Oral care issues
  - PEG Tube
    - tube positioning, family support, oral care, length of PEG placement, etc.
  - Cognition
  - Oral
  - Pharyngeal
  - Aspiration:
    - Before/During or after the swallow
    - Symptoms of aspiration (Patient Aims);1 have to explain during evaluation for us to find...
Dementia and Dysphagia

Think Beyond Aspiration
- Aspiration
- Choking
- Tracheostomy
- Malnutrition
- Dehydration
- Weight loss
- Wound
- Pressure Ulcer
- Chronic Respiratory Illness
- PEG or J-Tube
- Confusion
- Death
Aspiration in Dementia

- **Aspiration is only one symptom of dysphagia**
- **60% of aspiration is silent aspiration**
- **68% of CVA pts have silent aspiration**
- **Common Signs and Symptoms of Aspiration:**
  - Coughing during or after eating
  - Feeling of food “sticking in throat”
  - Runny Nose
  - Watery Eyes
  - Gurgled Vocal Quality
  - Loss of Weight
  - Dehydration
  - Temperature increases associated with meals and intake

Dementia and Dysphagia

- **People with cognitive impairment develop Dysphagia**
- **Dementia residents exhibit:**
  - Changes in behavior during meals
  - Sensory loss affecting ability to eat, swallow, follow treatment strategies
  - Motor loss affecting ability to initiate swallow
- **Primary cause of dysphagia in dementia = intellectual impairment**

Dysphagia and Dementia

- **Sensory damage** can disrupt the process of bolus organization, mastication and Oral Transit.
- **Motor damage** caused by dementia can disrupt airway closure and pharyngeal movement.
- Due to Sensory and Motor Damage dementia patients demonstrate aspiration, silent aspiration, bronchiectasis, dehydration, weight loss, and starvation
**Sensory Considerations**

- The degree to which sensory information activates motor response remains uncertain
- SLPs are encouraged to probe the effects of heightened sensory input with strong smell and taste (as well as texture and temperature) information to increase the opportunity for persons with dementia to recognize, interpret and react to the bolus
- 1000s of Sensory Receptors in the anterior oral mucosa
  - Chemoreceptors (taste, smell, pain)
  - Mechanoreceptors (touch, kinesthesia)
  - Thermoreceptors (temperature, pain).

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**Early Stage Dementia: Effects on swallowing, nutrition and hydration**

*Tristani (2015)*

- Mild Cognitive Impairment
- Depression
- Taste and smell dysfunction
- Awareness of cognitive deficits
- Attention - Mildly impaired
- Distracted intermittently throughout the meal
- Medications and polypharmacy
- Decreased nutrition and hydration due to MCI and depression

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**Middle Stage Dementia: Effects on swallowing, nutrition and hydration**

*Tristani (2015)*

- Wandering
- Motor restlessness
- Assistance needed for adequate oral care
- Cognitive based dysphagia
- Attention - Moderately impaired
- Distracted periodically throughout the meal
- Texture aversion
- Medications and polypharmacy
- Is it possible to forget to eat??
Advanced/Late/End Stage Dementia: Effects on swallowing, nutrition and hydration
Tristani (2015)
- Cognitive Based Dysphagia
- Dependence on oral care
- Oral apraxia
- Oral acceptance deficits
- Oral preparatory deficits
- Attention - Mod-severely impaired-often distracted
- Texture aversion
- Medications and polypharmacy
- Pharyngeal phase deficits and aspiration

Advanced/Late/End Stage Dementia: Effects on swallowing, nutrition and hydration
Tristani (2015)
- Over chewing
- Severe myoclonus
- Twitching in oral musculature
- Self-feeding ability is lost Individuals become dependent on others for meal consumption

Summary of Dysphagia and AD
- Dysphagia in early stage AD:
  - Delayed pharyngeal swallow; reduced lingual movement
- Dysphagia in mid-stage AD:
  - Reduced oral prep., pharyngeal clearance, UES opening, (+) asp
- Dysphagia in late-stage AD:
  - Increased aspiration pneumonia, leading to death
Oral Prep and Oral Phase

Deficits in Oral Prep and Oral Phase:
- Prolonged chewing and pocketing
- Open mouth posture
- Oral Residue post swallow
- Increased food prep time
- Excessive manipulation time
- Lingual pumping
- Difficulty forming the bolus
- Difficulty throwing the bolus
- Oral residue post swallow

Pharyngeal Phase

Pharyngeal Phase Deficits:
- Pharyngeal delay difficulty triggering the swallow
- Laryngeal penetration: Material enters the top of the airway but does not drop below the vocal cords.
- Aspiration
- Silent Aspiration
- Pharyngeal residue: Material remains in the throat post swallow

Dysphagia Management For Dementia Patients
Current Treatment for Dysphagia

- Compensation interventions
- Feeding Tubes
- Diet modifications
- Oral Care
- Feeding Techniques
- Positioning

Feeding Tube Myths

- Prevent Malnutrition: No improvement of nutritional markers
- Maintain Skin Integrity: ↑ risk for pressure ulcer formation
- Prevent Aspiration Pneumonia: Never shown to ↓ aspiration pneumonia incidence
- Improve Quality of Life: May ↑ suffering and discomfort
- Functional Status and Survival: Never shown to ↑ life span

PEG Tubes - 78% SLPs Believe

- Outcomes data does not support this belief that PEG tube feeding reduces the risk of aspiration pneumonia (Finucane et al., 1999).
Diet Modifications:

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<th>Diet Level</th>
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<tr>
<td>NDD Level 1: Dysphagia/Purred</td>
<td>All foods must be pured and thinned (if necessary) to a pudding-like consistency. It must be lump-free or no chewing is required.</td>
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<tr>
<td>NDD Level 3: Dysphagia/Mechanically Altered</td>
<td>All foods are soft, not texturized, and easily chewed. Meals are pureed and served with gravy or sauce. Cooked cereals, corn meal and self-porridge, meats and fish, and eggs are allowed. Some chewing is required.</td>
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<tr>
<td>NDD Level 5: Dysphagia/Advanced</td>
<td>Swallowed soft, slightly moistened foods that can be cut easily into bite-size pieces. Dry breakfast cereals must be well moistened and meats must be tender. Lettuce can be served if shredded.</td>
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<tr>
<td>NDD Level 6: Regular</td>
<td>No restrictions.</td>
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National Dysphagia Diet (NDD) - Textures

Oral Care
- Conduct after each meal
- Make it a focus of your treatment
- Make it a goal
- Quality of Life
- Diet compliance from patient
Common Difficulties with Eating and Drinking

- Reduced interest in food and drink
- Appetite
- Forget to eat and drink
- Increase in meal time requirement
- Cough and choke with intake
- Refuse food
- Weight loss
- Dysphagia
- Impaired sense of smell

Feeding Devices in Dementia

- Provale Cup
- Maroon Spoon - Use with feeding problems such as poor lip closure, tongue, throat and oral hypersensitivity
- Soft Spoon - Use with patients who bite down
- Flexi-Cut Cup - Can be squeezed gently to change the shape of the cup lid.
- Nosey cup
- 3 section plate
- Infant spoons

Optimal Task Presentation

- Early Stage Dementia – 14 – 24 inches
- Middle Stage Dementia – 7-14 inches
  - With visual perceptual deficits
- Late Stage Dementia – 7 inches from the midline
  - Significantly diminished visual perceptual processing
The Feeding Experience – General Feeding Tips

• Make sure patient is ready to eat
• Provide quiet, inviting environment
• Promote calm
• Sit at eye level
• Use boundaries
• Take time
• No garnishes
• Serve promptly
• Offer liquids throughout day
• Assure dignity

Tips for Encouraging Intake

• Ensure proper temperature of foods
• Use finger foods
• Small portions
• More intake in morning
• Add sweetener
• Ethnic/culturally appropriate foods
• Alternate food choices
• Tell patient meal is paid for

Feeding Devices in Dementia

• Treatment Techniques
  • The coated spoon
  • Cold, metal spoon presentation
  • Adaptive equipment
  • Patient routine adaptations - timing of meals
  • Capitalize on patient routine at PLOF
  • Alternate hot - cold
  • Diet texture modification
Treatment Techniques

- Timing, readiness, latency techniques
- Use of distraction
- Tactile, visual, verbal cues & modeling
- Behavioral strategies
- Finger foods
  - When it is difficult to use a utensil
  - When it is helpful to ambulate and eat
  - When in doubt - COMBINE

Treatment Techniques

- Visual cues and written reminders
- Limit the number of utensils
- Use one-step directives for cueing and encouraging PO
- Dining area should be in a home like environment – dining room etc.
- Serve larger portions at breakfast to maintain weight
- Offer liquids and water consistently throughout the day
- Patients can be tempted to eat more with sweetener added

Treatment Techniques

- Increase number of finger foods
- Alternate hot, cold, sweetener, and alternate with spicy foods, add ketchup, mustard, salt, pepper (if medically appropriate)
- Tell concerned patients “their meal is paid for” and included in a “meal club”
- Do not use garnishes or decorations or meal tray slips, as they are easy picked up and eaten.
- Use boundaries by using place mats or square tables to reduce interest in another persons meal
Compensation Techniques for Dysphagia

Appropriate Positioning
- Chin Tuck
- Head Rotation
- Rotation and Chin Tuck
- External Pressure to the Cheek
- Labial and Chin Support

Multiple Swallows

Supportive Feeding in Dementia

General Feeding Techniques:
- Try chin tuck (may need to support head in this position with rolled towels)
- Use a small spoon to avoid putting too much food in the mouth at once
- Watch/feel for the swallow; do not give more food or drink until they have swallowed
- Remind the person to chew each mouthful thoroughly
- Touch the person’s lower lip to stimulate opening the mouth
- Massage the throat to stimulate the swallow reflex
- Use one-step directives for cueing and encouraging PO
- Oral care after each meal
- Ensure the person remains sitting in an upright position for at least 30 minutes after each meal

Feeding Techniques: Concentration Deficits

Feeding Techniques:
- Plan any exercise for about 1 hour before mealtime
- Verbalize each step of the eating process
- Physically place utensils in hand
- Play the same soft music at every meal, sit in the same chair at every meal, etc.
- Clear room of distractions, when possible
- Make sure that food and utensils are visible
- Move yourself to maintain eye contact with the person, while stating that it is now mealtime
- Describe each food item to the person (i.e., “Here we have some green Jell-O”)

9/21/2011
Feeding Techniques: Combative/Throws Food

- Schedule aerobic activity prior to mealtime
- Remove the item that was thrown
- Consider using suction cups to affix dishes to table
- Stand or sit on non-dominant side
- Provide only one food at a time
- Reward good mealtime behavior
- Provide a calm environment for mealtime
- Do not show any response to the person’s combative behavior—remain calm
- Tell the person that you need him/her to stop behaving in this way
- Re-approach at a later time

Feeding Techniques: Chews Constantly

- Empty Spoon Technique
- Provide soft foods that require less chewing
- Offer small bites
- Touch the individual’s jaw as a reminder that he/she is making chewing motions
- Some people can follow verbal cues, such as “still,” in between bites of food (i.e., “Chew still. Open up. Chew still.”)

Feeding Techniques: Eats Quickly

- Encourage the person to set utensils down between bites
- Offer food items one at a time
- Offer foods that require more chewing
- Use small utensils
- Divide foods in half, offer one half at a time, and ask if the person would like some more food before providing it
- Attempt to engage the person in conversation between bites to make them more aware of the meal
- Describe each food item to the person or ask them to describe it to you
- Try to assess degree of hunger and serve between-meal snacks, if necessary
### Feeding Techniques: Eats Slowly

<table>
<thead>
<tr>
<th>Feeding Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide verbal cues (i.e., &quot;Take a bite.&quot; &quot;Chew.&quot; &quot;Swallow.&quot;)</td>
</tr>
<tr>
<td>Use insulated dishes to maintain appropriate temperature</td>
</tr>
<tr>
<td>Remind the person of what is planned after the meal</td>
</tr>
<tr>
<td>Remove any distractions from the room</td>
</tr>
<tr>
<td>Do not allow the person to become overwhelmed by providing too much variety at one meal or by providing too large of portions</td>
</tr>
<tr>
<td>Make sure that meals are appropriately spaced and are not served too close together</td>
</tr>
</tbody>
</table>

### Feeding Techniques: Forgets to Swallow

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Verbally remind the person to swallow</td>
</tr>
<tr>
<td>Feel for swallow after each bite</td>
</tr>
<tr>
<td>Stroke larynx upward</td>
</tr>
<tr>
<td>Try using prompts—some people can learn &quot;prompts&quot; to remind them to swallow, such as a hand squeeze or a light tap on the arm</td>
</tr>
</tbody>
</table>

### Feeding Techniques: Poor Attention and Plays with Food

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Provide finger foods</td>
</tr>
<tr>
<td>Cover dishes and only uncover one at a time</td>
</tr>
<tr>
<td>Only serve one food at a time</td>
</tr>
<tr>
<td>Watch for patterns in behavior (does the person play with food more when tired, overwhelmed, etc.) and modify daily routine, as necessary</td>
</tr>
<tr>
<td>Gently pull the person's hand away from the meal and clearly say &quot;no&quot;</td>
</tr>
<tr>
<td>Wipe the person's hands off every time that food is touched, rather than using utensils</td>
</tr>
<tr>
<td>Verbally remind the person that this is mealtine and that it is time to eat</td>
</tr>
</tbody>
</table>
Feeding Techniques: Patients with Paranoia

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Provide a consistent routine</td>
</tr>
<tr>
<td>Do not mix medicines into food</td>
</tr>
<tr>
<td>Explain what each food item is</td>
</tr>
<tr>
<td>Prepare foods in front of the person (sometimes necessary) or allow them to</td>
</tr>
<tr>
<td>assist in preparation, if possible</td>
</tr>
<tr>
<td>Do not serve new food items; try to stick to the familiar</td>
</tr>
<tr>
<td>Keep foods as simple as possible, avoiding complicated casseroles, etc.</td>
</tr>
</tbody>
</table>

Care Delivery Model for Dementia: Multidisciplinary

Medical Social Work

Physical Therapy

Occupational Therapy

Speech-Language Pathology

Skilled Nursing

Medical Social Work