EVALUATION OF DYSPHAGIA IN HYDERABAD KARNATAKA REGIONR. B. Chapparbandi¹, Farha Naaz Kazi², Muhammad Kazim Ali³**HOW TO CITE THIS ARTICLE:**

R. B. Chapparbandi, Farha Naaz Kazi, Muhammad Kazim Ali. "Evaluation of Dysphagia in Hyderabad Karnataka Region". Journal of Evolution of Medical and Dental Sciences 2014; Vol. 3, Issue 48, September 29; Page: 11585-11588, DOI: 10.14260/jemds/2014/3517

ABSTRACT: Deglutition is the process by which fluid or food is passed from mouth to stomach and this term is used interchangeably with swallowing. The range of divergent causes of dysphagia necessitates careful investigation not only of structures readily involved in swallowing but also many systemic and far remote processes, thus resulting in early diagnosis and cure. This study was undertaken to identify the prevalence and various etiological conditions causing dysphagia in Hyderabad Karnataka region.

KEYWORDS: Dysphagia, Upper GI endoscopy, Esophagus

INTRODUCTION: Eating and drinking are basic human pleasures and problems associated with swallowing can impact dramatically upon the quality of life. Dysphagia is defined as difficulty in swallowing which may affect any part of swallowing pathway from mouth to stomach.¹ It may be ranging from a mere local discomfort to a total hold up to the passage of food.

Approximately half of the patients with dysphagia are seen in ear, nose and throat clinics. The otolaryngologist should know how to diagnose this condition. Swallowing disorders are usually symptoms of underlying complex diseases. Aside from the risk of asphyxiation through choking, swallowing disorders can also be a direct cause of morbidity and mortality as a result of aspiration of food, liquid and possibly refluxed gastric acid contents causing bacterial infection or tissue damage.²

Here we present a study to evaluate the etiological factors of various conditions causing dysphagia in all age groups, to evaluate age wise distribution, sex wise distribution of incidence of various conditions causing dysphagia in our region, to study the various pathological variants of conditions and various investigative procedures available for early diagnosis.

METHODOLOGY: This study was conducted on cases who presented to our outpatient department with symptoms of dysphagia over a period of two years from October 2009 to September 2011. It was a prospective study involving a group of patients with dysphagia selected on simple random basis. Patients presenting with odynophagia and foreign bodies in aerodigestive tract were excluded from the study. The data was collected on the basis of detailed history, systemic examination and ENT examination. Specific investigations like flexible fiberoptic endoscopy, direct laryngoscopy or radiological investigations like barium swallow and CT scan were performed and the data was tabulated.

RESULT: In the period under review cases were evaluated for dysphagia by taking a careful history, clinical examination, radiographic and laboratory investigations including upper GI Endoscopy and the diagnosis was established. 48 patients (96%) had dysphagia for solids, 28 had dysphagia for both solids and liquids and 02 patients had dysphagia for liquids only. On clinical examination by indirect laryngoscopy, a lesion was noted in 24 patients, 20 patients had normal study and in 06 patients IDL could not be done as the patients were not cooperative.

ORIGINAL ARTICLE

The investigations that were undertaken include upper GI Endoscopy (43 patients), Barium Swallow (34 cases), Direct Laryngoscopy (28 cases), chest X-ray (20 cases), CT scan (7 cases) and other blood investigations. The site involved were esophagus in 22 cases, larynx in 12 cases, and hypopharynx in 08 cases, CNS in 06 cases and oral cavity in 02 cases.

The etiology for dysphagia included carcinoma esophagus (11), carcinoma larynx (10), carcinoma hypopharynx (08), cerebrovascular accident (05), esophageal candidiasis (03), stricture (02), oral malignancy (02); TB of upper aerodigestive tract (02), esophageal web (02), drug induced esophageal ulcer (01), extrinsic compression (01), scleroderma (01), achalasia cardia (01) and myasthenia gravis (01).

Type of dysphagia	Number	Percent
For solids	48	96
For Solids and liquids	28	56
For liquids	02	04

Table 1

On IDL examination	Number	Percent
Lesion noted	24	48
Normal study	20	40
IDL not possible	06	12

Table 2

Investigation	Number	Percent
Upper GI Endoscopy	43	86
Barium Swallow	34	68
Direct Laryngoscopy	28	56
Chest X-ray	20	40
HB<10mg%	09	18
CT scan	07	14
Others	03	06

Table 3

Others: MRI, Tensilon test and Barium meal

Site	Number	Percentage
Esophagus	22	44
Larynx	12	24
Hypopharynx	08	16
CNS	06	12
Oral cavity	02	04

Table 4

ORIGINAL ARTICLE

Etiology	Number	Percentage
Carcinoma esophagus	11	22
Carcinoma larynx	10	20
Carcinoma hypopharynx	08	16
Cerebrovascular accident	05	10
Esophageal candidiasis	03	06
Stricture	02	04
Oral malignancy	02	04
TB of upper aerodigestive tract	02	04
Esophageal web	02	04
Extrinsic compression	01	02
Drug induced esophageal ulcer	01	02
Scleroderma	01	02
Achalasia cardia	01	02
Myasthenia gravis	01	02

Table 5

DISCUSSION: Dysphagia is a common problem and evaluation should start with careful history taking, to guide subsequent diagnostic testing and management. Dysphagia needs to be distinguished from odynophagia which means painful swallowing.³ It can be divided into oropharyngeal and esophageal pathologies.⁴ Oesophagoscopy is usually the investigation of first choice to exclude an obstructive lesion.

Many techniques are currently available for assessing dysphagia which includes upper GI endoscopy, barium swallow, barium meal, CT scan, etc. The commonest and most effective investigation is flexible fiberoptic endoscopy. It has been called 'milk nasendoscopy'⁵, and was first described by Langmore et al⁶. The commonest cause for dysphagia in present series was malignancy of upper aerodigestive tract, most common being the esophagus. The most common non- malignant cause for dysphagia in this series was cerebrovascular accidents.

Barium swallow showing tracheoesophageal fistula

Barium swallow showing Achalasia cardia

ORIGINAL ARTICLE

Upper GI endoscopy showing tracheoesophageal fistula with stricture

REFERENCES:

1. Elfy B Chevetton. Causes of Dysphagia: In: Scott-Brown's Otorhinolaryngology, Head and Neck Surgery. Michael Gleeson, George G Browning, Martin J Burton, Ray Clarke, John Hibbert, Nicholas S Jones et al(Eds). 7th Ed; London: Hodder Arnold; 2008; 153: p. 2025-36.
2. Susan Standring; Head and neck In Grays Anatomy 40th Ed., Elsevier Churchill Livingstone, London, 2008; P499-595.
3. Jason F. Vollweiler, Michael F Vaezi. The Esophagus: Anatomy & Physiology & Diseases. 4th Ed. Cummings Otorhinolaryngology, Head & Neck Surgery, Elsevier Mosby, Pennsylvania; 2005: p.1837
4. Thadeus L Trus, Jeffery H Peters; Maingot's Abdominal Operations. 11th Ed, Mc Graw Hill; 2007: p. 223
5. Wilson PS, Hoare TJ, Johnson AP. Milk naso endoscopy in assessment of Dysphagia. The Journal of Laryngology and Otology, 1992; 106: 525-27.
6. Langmore SE Schatz K, Olson N. Fiberoptic endoscopic examination of swallowing safety – a new procedure. Dysphagia, 1988; 2: 216-19.

AUTHORS:

1. R. B. Chapparbandi
2. Farha Naaz Kazi
3. Muhammad Kazim Ali

PARTICULARS OF CONTRIBUTORS:

1. Professor and HOD, Department of ENT, M. R. Medical College, Gulbarga.
2. Post Graduate cum Resident, Department of ENT, M. R. Medical College, Gulbarga.
3. Post Graduate cum Junior Resident, Department of ENT, M. R. Medical College, Gulbarga.

NAME ADDRESS EMAIL ID OF THE CORRESPONDING AUTHOR:

Dr. R. B. Chapparbandi,
Room No. 10, Department of ENT,
Basaveshwar Hospital, Sedam Road,
Gulbarga.
Email: drrbchapparbandi@gmail.com

Date of Submission: 09/09/2014.

Date of Peer Review: 10/09/2014.

Date of Acceptance: 22/09/2014.

Date of Publishing: 27/09/2014.