

Editorial

The vocal cords, dysphonia and phonosurgery may arguably be the glamour areas in laryngology. However, let us not forget the other physiologic function subserved at the same anatomic level. The larynx is situated at the crossroads of the passages for air and food. A wrong turn can lead to aspiration. This and other issues can lead to the spectrum of swallowing disorders.

Swallowing is a complex process involving multiple organs and intricate nervous control. It is described in four stages *viz* oral preparatory, oral, oropharyngeal and esophageal. The lips, oral cavity, oropharynx, hypopharynx, cricopharyngeal sphincter and esophagus all form a system of tubes and valves, which guide the bolus of food smoothly down into the lower gastrointestinal (GI) tract.¹ A host of local anatomic or central neurological/neurosurgical pathologies can affect this smooth flow. The end result is 'dysphagia', the umbrella term given for the many issues that can affect a normal swallow.

Depending on the severity of the problem, the person afflicted with dysphagia usually ends up with a nasogastric tube or a PEG-feeding tube. Either way, the quality of life is greatly, sometimes depressingly, affected. In the past, no thought was given to this; the patient would meet his/her end without any attempt to eat normally for months to years.

Management of this issue has progressed by leaps and bounds in the last decade or so. As otolaryngologists, we are used to viewing and evaluating the larynx. So, we can also examine anything going wrong in the adjoining area. It is natural but that the ENT surgeon becomes a key person in the evaluation of patients with swallowing disorders. However, the health care personnel in this field has evolved. The speech language pathologist (SLP), preferably with special training in swallowing disorders, is now considered the central figure.

Two investigations are now mandatory in cases of swallowing disorders. These are flexible endoscopic evaluation of swallowing (FEES) and videofluoroscopic study of swallowing (VFSS). They complement each other in terms of areas visualized and type of pathology assessed.² The former is essentially a routine per-nasal flexible laryngoscopy, which is done by the laryngologist. Added on is the process of giving various types of food boluses and visualizing their progress at the hypopharyngeal and laryngeal level.³ The latter is a radiological modality, involving the ingestion of barium of various consistencies, and recording the video of its progress down the entire pathway of the swallow process. A trained SLP, with the help of the laryngologist, analyses the findings of the above and decides on the therapy strategies, including the possibility of removal of the nasogastric tube, if present. It must be underscored here that this subject is necessarily a multidisciplinary one. Most patients would be from the departments of neurology and neurosurgery. There is the need for an endoscopy and a radiology suite. Hence, it is better suited at the institutional level. There is a genuine need for elite centers and trained personnel for the management of swallowing disorders.

As laryngologists, we are bound to pay due attention to this 'subspecialty'. Many a patient, in his/her last days, would yearn to be able to taste and eat their food, valuing it even more than the ability to breathe nasally. Let us strive to help them attain this for as long as possible.

REFERENCES

1. Logemann JA. Anatomy and physiology of normal deglutition. In: Berman D, editor. Evaluation and treatment of swallowing disorders. 2nd ed. Texas: Pro.ed;1998. p. 23-36.
2. Kelly AM, Drinnan MJ, Leslie P. Assessing penetration and aspiration: How do VFSS and FEES compare? *Laryngoscope* 2007;117: 1723-1727.
3. Langmore SE. Endoscopic evaluation of oral and pharyngeal phases of swallowing. *GI Motility Online* 2006. Available at: Nature.com.



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