MBS / FEES
Course Objectives

• Know the normal anatomy of swallowing
• Know the normal physiology of swallowing
• Enumerate different etiologies of oropharyngeal dysphagia
• Be able to do bedside assessment (KKUH visit)
• Interpret MBS and FEES procedures
• Write MBS and FEES reports
• Put a short-term and long-term treatment plan
Modified Barium Swallow (MBS-VFSS)
MBS vs. Barium Swallow (BS)

1. Amount of material.
2. Type of material.
4. Views of study.
5. Purpose of the study.
Rationale

1- Study the anatomy and the physiology of the oral preparatory, oral, pharyngeal, and cervical esophageal stages of deglutition.

2- Define management and treatment strategies that will improve the oropharyngeal dysphagia patient’s swallowing safety or efficiency.

Positioning of the patient

Lateral view

1- The oral and pharyngeal transit times.
2- Location of stasis of the bolus along the vocal tract from anterior to posterior.
3- Analysis of patterns of lingual movement.
4- Gross estimate of the time elapsed before the swallowing reflex triggers.
5- Estimate of the amount of vallecular residue, and the amount of material aspirated per bolus, as well as the reason for the aspiration.

Lateral view

Positioning of the patient (Cont.)

Antro-posterior view

1- Symmetry in function, particularly of the vocal folds.

2- Viewing residues such as collection of material in the valleculae and residue in the pyriform sinuses.

3- Examine the residue in the pharynx after the swallow, comparing the two sides.

4- Provide a clear picture of vocal fold movement by tilting the patient's head backwards and ask him to vocalize a continuous "ah" and a rapidly repetitive /a/a/a/.

New MBS Chair
Positioning of the patients in MBS

Before

Now
MBS Chair (KKUH)
MBS Equipment (KKUH)
Food presentation

The patient is asked to swallow three swallows of each of the following:

(a) 3 ml, 5 and 10 ml **thin liquid** (20% barium sulfate [prontobario H.D.®] and 80% water);
(b) 3, 5, and 10 ml **thick liquid** (50% barium and 50% water);
(c) 3, 5, 10 ml **semisolid** (pudding mixed with barium powder) and
(d) ¼ of a **cookie** (coated with pudding + barium powder)

**Thin liquid** (20% barium sulfate [prontobario H.D.®] and 80% water) [1:4]

**Thick liquid** (50% barium and 50% water) [1:1]

**Semisolid** (pudding mixed with barium powder)

**cookie** (coated with pudding + barium powder)
Ready made consistencies
Normal MBS/ Lateral view
Measuring parameters

1- Range of structural movement

2- Duration of bolus movement; transit times

3- Oropharyngeal Swallow Efficiency [OPSE]

4- Coordination of pharyngeal swallow events
Penetration-Aspiration Scale (Rosenbek et al, 1996):

1 = Material does not enter the airway.

2 = Residue ABOVE TVF, patient expels it.
3 = Residue ABOVE TVF, patient does not sense it.
4 = Residue ON TVF, patient expels it.
5 = Residue ON TVF, patient does not sense it.

6 = Residue BELOW TVF, patient expels it.
7 = Residue BELOW TVF, patient does not expels it despite effort.
8 = Residue BELOW TVF, no effort to expel it.

Modified Barium Swallow checklist

<table>
<thead>
<tr>
<th>Stage of Swallowing</th>
<th>Thin liquid (1 Ba x 4 water)</th>
<th>Thick liquid (1 Ba x 1 water)</th>
<th>Semisolid (pudding-Ba)</th>
<th>Cookie</th>
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<tbody>
<tr>
<td></td>
<td>300</td>
<td>600</td>
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<td>5000</td>
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<tr>
<td>Lateral view</td>
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<tr>
<td>I. Oral Phases:</td>
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<tr>
<td>1. Reduced lip closure</td>
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<td>2. Poor mandibular movement</td>
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<td>3. Poor bolus formation</td>
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<td>4. Poor tongue movements:</td>
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<td>- rotary movements</td>
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<td>- tongue-to-palate contact</td>
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<td>- A-P movement</td>
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<td>- repetitive A-P movements</td>
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<tr>
<td>- tongue thrust</td>
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<tr>
<td>5. Oral residue: *</td>
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<tr>
<td>- anterior sulcus</td>
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<td>- lateral sulcus</td>
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<td>- dorson of the tongue</td>
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<tr>
<td>- % oral residue</td>
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<td>6. Premature swallow:</td>
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<td>7. Piecemeal deglutition:</td>
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<td>8. Oral transit time: **</td>
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<td>9. Pharyngeal Phase:</td>
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<tr>
<td>1. Nasal regurgitation</td>
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<td>2. Swallowing initiation: ***</td>
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<td>3. Pharyngeal delay time: ###</td>
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<td>4. Reduced velar elevation</td>
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<td>5. BOT-PTR contact</td>
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<td>6. Reduced laryngeal elevation</td>
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<td>7. Ant. hyolaryngeal excursion</td>
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<td>8. Reduced laryngeal closure</td>
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<td>9. ULES (oropharyngeal opening)</td>
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<td>10. Penetration: %</td>
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<td>- before - during - after</td>
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<tr>
<td>11. Aspiration: %</td>
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<td>- before - during - after</td>
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<tr>
<td>12. Pen. / Asp. Scale</td>
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<tr>
<td>- cough resp. to pen-asp.</td>
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</tbody>
</table>

Penetration-Aspiration Scale (Rosenbek et al., 1996):  
1- no residue; 2- mild coating; 3- moderate; 4- severe

Post-swallow residue:  
1- normal; 2- mild delay; 3- moderate delay; 4- severe delay; 5- absent.

** Oral transit time: from initiation of posterior bolus movement to arrival of the bolus head at ramus ramus of the mandible.

*** Swallowing initiation:  
- no pen-asp.: 1% = 10 %; 2% = 20 %

# Cough response:  
- present, 1- weak; 2- absent

# Pharyngeal delay time:  
- From bolus head passing ramus to onset of anyngeal elevation.
Modified Barium Swallow checklist

<table>
<thead>
<tr>
<th>Stage of swallowing</th>
<th>Thin liquid (1 Ba x 4 wtr)</th>
<th>Thin liquid (1 Ba x 1 wtr)</th>
<th>Semisolid (pudg+ba)</th>
<th>cookie</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3cc</td>
<td>6cc</td>
<td>10cc</td>
<td>cup</td>
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<tr>
<td>Pharyngeal stage (cont.)</td>
<td></td>
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</tr>
<tr>
<td>Pharyngeal residue</td>
<td>base of tongue</td>
<td>post. pharyngeal wall</td>
<td>valleculae</td>
<td>aryepiglotic folds</td>
</tr>
<tr>
<td>Pharyngeal transit time</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>OPSE score</th>
<th>%</th>
<th>% of bolus swallowed</th>
<th>Total swallow duration</th>
<th>OPSE Score</th>
<th>Mean OPSE Score</th>
<th>i - for bolus volume</th>
<th>i - for bolus consistency</th>
<th>Total OPSE Score</th>
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<tbody>
<tr>
<td>i - for bolus volume</td>
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<tr>
<td>Total degree of impairment</td>
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</table>

Degree of Impairment:
- Mean degree of impairment
- i - for bolus volume
- i - for bolus consistency
- Total degree of impairment

Anterior - Posterior view:
1. alignment of the mandible :
2. symmetry of bolus movement :
3. symmetry of pooling in oral cavity :
4. symmetry of vallecular stasis :
5. symmetry of stasis in pyriform sinus :
6. degree of vocal fold adduction :
7. height of the vocal folds : equal / unequal

Trial Therapy: 

Comments:

Recommendations:

Diet:

Swallowing posture:

Swallowing maneuver:

Others:
Follow up

Depends on the patient’s medical diagnosis, anticipated rate of recovery, and prognosis.

1- Questionnaires (SWAL-QOL/ DHI/ EAT-10 tool/ patients’ compliance)

2- MBS
Abnormal MBS
Poor lip seal (Oral spillage)

Premature spillage
Diffuse bolus
(poor oral manipulation)
Piece meal deglutition
Penetration

During swallowing

With open airway
Aspiration

Posterior aspiration
Residues
MBS Report

Swallowing Disorders Clinic – KKUH
Modified Barium Swallow (MBS) Report

Name: [Name Redacted]
Diagnosis: D.M., HTN., CVA, Dysphagia, Al-imam
Age: 75 yrs.
Gender: Male.
MRN: [Redacted]
Date: 21/11/2011

Pharyngeal phase:
- Delayed initiation of pharyngeal swallow with 2 ml thick/thick liquid that lead to posterior penetration with 3 ml thin liquid.
- Pulsing in valleculae and pyriform sinuses before swallow 3 ml thin liquid / 3 ml thick.
- Transient penetration during swallow 3 ml thin / 3 ml honey thick liquid due to incomplete airway protection.
- Penetration during swallow 3 ml honey thick liquid due to incomplete airway protection.
- Posterior post-swallow penetration with residues of 3 ml thin / 3 ml honey thick liquid.
- One episode of overt aspiration before swallow 3 ml thick liquid in attempt to wash residues was detected.
- Aspiration could not be ruled out due to the study limitations.
- Residues in valleculae due to decreased base of tongue retraction and extrinsic pyriform sinuses & UES due to decreased pharyngeal squeeze & incomplete swallowing excursion with all volumes of liquids and increased volumes of purees; these put the patient at risk of post swallow aspiration.
- No significant difference found when lemon was used.

Impression:
- Moderate oral severe pharyngeal Neurogenic dysphagia characterized by decreased oral control and manipulation, delayed initiation of pharyngeal swallow, incomplete airway protection, decreased base of tongue retraction & decreased pharyngeal squeeze.
- Study limitations: Reduced study reliability due to improper positioning and patient’s inability to follow commands along with his drowsiness.

Recommendations:
1. Short-term alternative mean of nutrition.
2. Pures in top for pleasure and therapy purposes under strict swallow precautions that are already explained to the family.
3. Risks of oral feeding already explained to the family.
4. Monitor chest condition & VS, in case of any temperature spikes or chest complications noticed stop any form of oralf feeding and seek medical advice.
5. F.U in 3 weeks in OPD will be provided.
6. F.E.E.S procedure in N.A.A to rule out aspiration.

Written by:
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Revised by:
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Consultant Phoniatrik
Superviser, Swallowing Disorders Clinic

7-Apr-15

Swallowing Course/ MBS & FEES
Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
History of FEES
Various instrumental techniques have been developed to investigate dysphagia.

Among them, videoflouroscopic evaluation of swallowing (VFES) is said to be the ‘gold slandered’ because it investigates oral, pharyngeal, and esophageal phases of swallowing.
However, there are many conditions in which VFES is difficult to undertake. So, there must be additional methods that can help in these situations.
Flexible nasopharyngolaryngoscopy was introduced to Otorhinolaryngology in 1968 (Sawashima and Hirose, 1968). It first appeared in clinical practice in the 1970s (Williams et al, 1975). Significant technologic improvements were developed in 1980s.

Endoscopic evaluation of swallowing was first described by Langmore et al (1988).

They called it “Fiberoptic Endoscopic Evaluation of Swallowing” (FEES). It investigates mainly the pharyngeal phase of swallowing.

In 1998, Aviv and colleagues described the **FEESST** procedure (**Fiberoptic Endoscopic Evaluation of Swallowing with Sensory Testing**).

FEESST augments FEES by directly testing sensation in the laryngopharynx through air pulses delivered via a fibroscope with a channel.

Initially, FEES was indicated only when MBS was not available. Today, it is widely used worldwide as a standard tool for diagnosing and treating dysphagia (Langmore, 2001).

Technique
(1) Positioning:
- Ambulatory patients: seated upright.
- Bed-bound patients: bedside, with the head of the bed raised to 45 degrees.
- Infants and children: gentle restraint.

(2) Oral & neck examination.

(3) Introduction of the fiberoptic pharyngolaryngoscopy.

(4) Introduction of dyed liquids and foods.

(5) Patient / Family counseling.
Bedside FEES

Fiberoptic endoscopic evaluation of swallowing (FEES®) examination protocol (Susan E. Langmore, Ph.D., 2004) in Endoscopic evaluation of oral and pharyngeal phases of swallowing. GI Motility online (2006)
Bedside FEES

Fiberoptic endoscopic evaluation of swallowing (FEES®) examination protocol (Susan E. Langmore, Ph.D., 2004) in Endoscopic evaluation of oral and pharyngeal phases of swallowing. GI Motility online (2006)
Normal FEES (Thin fluid dyed blue)
Indications & Advantages
Indications (ADVANTAGES) of FEES:

1. Transportation to Radiology is difficult, eg on ventilator.
2. Positioning for fluoroscopy is difficult, eg neck halo.
3. Exposure to radiation is risky, eg pregnant.
4. No time limit.
5. Visualization and assessment of velopharyngeal valve (hypernasality) or larynx (eg, vocal fold paralysis, GERD (LPR)).
6. Anatomic changes (color image), eg s/p head and neck surgery, s/p neck trauma, s/p neurological insult.
Indications (ADVANTAGES) of FEES (cont.):

7. Assessment of integrity of airway protection.
8. Compromised pulmonary clearance (conservative exam).
9. Severe dysphagia (conservative exam).
10. NPO for prolonged period (conservative exam).
12. Assessment of sensation.
14. Educational tool (patient, family).
Disadvantages
Disadvantages of FEES:

1. Whiteout obscures view DURING the peak of swallowing (BUT: 0.5 sec., 7 %).

2. Lack of view in rapid chain swallowing in infants during bottle feeding (BUT: slow motion).

3. Limited information about oral and esophageal stages.

4. Possible discomfort with endoscope passage (BUT: local anesthetic).

5. Possible gagging / vomiting (BUT: decrease as exam. progresses).
Protocol
FEES protocol of evaluation (Langmore, 2004):

I. Anatomic and physiologic assessment

II. Assessment of food and liquid swallowing

III. Assessment of therapeutic interventions

I. Anatomic and physiologic assessment:

- **Velopharyngeal valve:**
  - Soft palate movement:
    - Symmetric, Deviated to: Rt. Lt.
    - Degree: 0 (immobile) 1 2 3 (normal) 4
  - Lateral pharyngeal wall movement:
    - Rt. 0 (immobile) 1 2 3 (normal) 4
    - Lt. 0 (immobile) 1 2 3 (normal) 4
  - Posterior pharyngeal wall movement:
    - Degree: 0 (immobile) 1 2 3 4
  - Passavant’s ridge: present absent
  - Velopharyngeal Gap:
    - Shape: coronal sagittal circular others:
  - Vocal folds:
    - Color: pearly white red white
    - Vascular markings: few increased ectasia
    - Gap (max. width posteriorly in mm):
    - Swellings: site size shape edge surface color
    - Deviation of the glottis: none, direction: Rt Lf degree:
    - Gross mobility (adduction/abduction):
      - normal restricted: Rt Lf
      - fixed: Rt Lf
- Ventricular folds:
- Other laryngeal structures:
- Secretions:
  - Amount:
    - Site:
- Base of tongue:
- Laryngopharyngeal sensory testing:
- Tracheostomy:
- NG tube:

II. Assessment of swallowing:

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Intake of Thin Liquid</th>
<th>Intake of Thick Liquid</th>
<th>Intake of Semisolid (pudding)</th>
<th>Intake of Solid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spillage during holding the bolus #</td>
<td>&lt;5cc 10cc cup</td>
<td>&lt;5cc 10cc cup</td>
<td>&lt;5cc 10cc cup</td>
<td>&lt;5cc 10cc cup</td>
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<tr>
<td>2. Swallowing initiation **</td>
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<td>3. Post-swallow residue ***</td>
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<td>4. Penetration – Aspiration scale #</td>
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<td>5. Relation of aspiration to swallowing **</td>
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Sites:

# Penetration – Aspiration scale (Rosenbek et al, 1996):

1. Doesn’t enter airway.
2. Enters airway / above vocal folds / ejected.
3. Enters airway / above vocal folds / not ejected.
4. Enters airway / contacts vocal folds / ejected.
5. Enters airway / contacts vocal folds / not ejected.
7. Enters airway / below vocal folds / not ejected despite effort.
8. Enters airway / below vocal folds / no effort.

## Relation of aspiration to swallowing:

0. No aspiration, 1. Before the swallow, 2. During the swallow, 3. After the swallow.

Findings:

Recommendations:

- Diet:
  - Swallowing posture:
  - Swallowing maneuver:
  - Others:
  - K. Maki
I. ANATOMIC AND PHYSIOLOGIC ASSESSMENT:

(1) Velopharyngeal valve closure:
   - Say: /i/ , /s/.
   - Dry swallow.

(2) Larynx and hypopharynx:
   - Appearance.
   - Symmetry.
   - Abnormality.
I. ANATOMIC AND PHYSIOLOGIC ASSESSMENT (Cont.):

(3) Secretions and swallow frequency:
   - Amount.
   - Location.
   - Frequency of dry swallow.

(4) Tongue:
   - Base of tongue; Say: /sal/ , /mal/.
I. ANATOMIC AND PHYSIOLOGIC ASSESSMENT (Cont.):

(5) Pharyngeal muscles:
- Say: strained /iː/.

(6) Laryngeal (vocal fold) functions:
- Respiration.
- Phonation.
- Airway protection; Hold breath to the count of 7, cough, clear throat.
I. ANATOMIC AND PHYSIOLOGIC ASSESSMENT (Cont.):

(7) Laryngopharyngeal sensory testing:

- Lightly touching pharyngeal walls or aryepiglottic folds.
- Air-pulse stimulator (FEESST).
II. ASSESSMENT OF SWALLOWING FOOD AND LIQUID:

❖ All foods/liquids are **dyed with food colorings**.

❖ Consistencies:
  - Thin liquid (water, milk, …).
  - Thick liquid (thick juice, …).
  - Puree (pudding consistency, yoghurt, …).
  - Soft solids, Hard solids.
II. ASSESSMENT OF SWALLOWING FOOD AND LIQUID (Cont.):

- **Amount:**
  - < 5 mL if patient is medically fragile.
  - 5 mL (1 teaspoon).
  - 10 mL.
  - 15 mL (1 tablespoon).
  - From cup, straw, consecutive swallows.
❖ **Cardinal Parameters:**

1- Pooling of *secrections*.

2- **Premature spillage** during holding the bolus.

3- Swallowing initiation (*Pharyngeal trigger*).

4- Post-swallow *residue*.

5- Laryngeal *penetration* (entry of material into the laryngeal vestibule *above* the level of the true vocal folds).

6- Tracheal *aspiration* (entry of material *below* the level of the true vocal folds); before, during, or after the swallow.
Secretions Score (Langmore, 2001):

0 = Mucosa are moist (Normal).
1 = Secretions in valleculae, lateral channel, pyriforms.
2 = Secretions in laryngeal vestibule transiently or cleared by the patient.
3 = Secretions in laryngeal vestibule throughout examination and not cleared by the patient.

Residue
Residue
Residue
Residue
Penetration
Penetration
Aspiration
Aspiration
Aspiration
Aspiration
Aspiration
III. RESPONSE TO THERAPUTIC INTERVENTIONS:

BEHAVIOR RE-ADJUSTMENT SWALLOWING THERAPY (BRAT) can include:

- Dietary modification.
- Postural techniques.
- Swallowing maneuvers.
65 years old male patient S/P cervical disectomy for cervical prolapse (C3 and C4). After the operation he started to experience swallowing difficulty and weakness on the right side of the body. Brain MRI revealed left capsular infarction. FEES revealed:

- Grade III out of IV coronal closure of Velopharyngeal valve.
- Fair pharyngeal movements with squeeze test. Poor posterior tongue movement.
- Both vocal folds are freely mobile.
- Complete vocal folds coaptation during phonation.
- Residues were noticed in the valleculae, lateral pharyngeal walls with all consistencies. These residues increase with the increase of the consistencies (i.e. from fluids to solids). However, these residues were eliminated with multiple dry swallows.
- Penetration with liquids (during swallowing) occur with bolus > 5 ml and with semisolids (post-swallow). However, this penetration was ejected by the patient and no aspiration was detected with any consistency.

**Opinion:**
Oro-pharyngeal dysphagia: pharyngeal weakness.

**Recommendations:**
- Reassurance.
- Small bolus volumes with controlled effortful swallows followed by multiple dry swallows.
- Masakows exercise to improve posterior tongue movement.
- Follow up after 2 months.

**M. Farahat**
Consultant of Communication and Swallowing disorders
FEES Vs VFES (MBS)
<table>
<thead>
<tr>
<th></th>
<th>Defines Anatomy</th>
<th>Detects Aspiration</th>
<th>Quantifies Aspiration</th>
<th>Detects Etiology</th>
<th>Availability</th>
<th>Cost*</th>
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<tbody>
<tr>
<td>MBS</td>
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<td>++</td>
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<td>+</td>
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<td>3</td>
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<td>FEES</td>
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**Bedside**

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<th>Defines Anatomy</th>
<th>Detects Aspiration</th>
<th>Quantifies Aspiration</th>
<th>Detects Etiology</th>
<th>Availability</th>
<th>Cost*</th>
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<tr>
<td>Evaluation</td>
<td>-</td>
<td>±1</td>
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<tr>
<td>Scintigraphy</td>
<td>-</td>
<td>++</td>
<td>++</td>
<td>-</td>
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</table>

*Order from least to most expensive

1 Can detect actual aspiration in patients with tracheotomies
“The critical findings of dysphagia were detected as often with FEES as with MBS” (Langmore et al, 1991; Willging et al, 1996; Wu et al, 1997; Kaye et al, 1997; Crary abd Baron, 1997; Leder et al, 1998; Longemann et al, 1998; Perie et al, 1998).

“The underlying causes of these findings usually can be determined by using either tool” (Langmore, 2001).
## Unique findings

### Only MBS
- visualizes bolus during height of the swallow
- Oral phase (esophageal phase)
- Tongue retraction
- UES opening
- Laryngeal elevation, extent of aspiration
- Submucosal changes (osteophytes, metal plates from surgery, etc.).

### Only FEES
- Secretions
- Sensation
- Surface anatomy
- Mucosal abnormalities (edema, erythema)
- Effect of altered anatomy on bolus flow and airway protection
- Glottic closure
- Path of the bolus clearly
- Location of bolus within the hypopharynx.

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Fiberoptic endoscopic evaluation of swallowing (FEES®) examination protocol (Susan E. Langmore, Ph.D., 2004) in Endoscopic evaluation of oral and pharyngeal phases of swallowing. GI Motility online (2006)

7-Apr-15

Swallowing Course/ MBS & FEES
CONCLUSION: Whether dysphagic outpatients have their dietary and behavioral management guided by the results of MBS or of FEESST, their outcomes with respect to pneumonia incidence and pneumonia-free interval are essentially the same.

The Agency for Health Care Policy and Research (AHCPR, 1999) indicated that **MBS is not the gold standard in dysphagia assessment.**

Indeed, there is no gold standard in the field of oropharyngeal dysphagia because neither tool has been shown to be superior.

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*Agency for Health Care Policy and Research, Diagnosis and Treatment of Swallowing Disorders (Dysphagia) in Acute-Care Stroke Patients. Summary, Evidence Report/Technology Assessment: Number 8, March 1999.*
FEES in Treatment
FEES can guide dysphagia treatment:

1. **During** the procedure by applying the therapeutic interventions.

2. **Education tool** for the patient and the family.

3. **Biofeedback tool** in dysphagia therapy sessions.

4. **Re-evaluations** to monitor improvements.
FEES guides dysphagia treatment

Fiberoptic endoscopic evaluation of swallowing (FEES®) examination protocol (Susan E. Langmore, Ph.D., 2004) in Endoscopic evaluation of oral and pharyngeal phases of swallowing. GI Motility online (2006)
Pediatric FEES
Causes of Pediatric Dysphagia (Feeding and Swallowing Disorders):

(1) Structural … Craniofacial syndromes, …
(2) Neurogenic … Arnold-Chiari malformations, …
(3) Cardiac … Congenital heart diseases, …
(4) Respiratory … Bronchopulmonary dysplasia, …
(4) Behavioral … Food aversion, …
(5) Inflammatory … GERD, …
(6) Metabolic … Fructose intolerance, …
(7) Others … Prematurity, …
“Pediatric FEES is a relatively new and effective diagnostic method to add to and to complement the current armamentarium of techniques for evaluation of pediatric dysphagia” (Miller et al, 1994; Willging et al, 1996; Langmore, 2001).

Pediatric FEES
Pediatric FEES

- Time-consuming (usually more than adult’s).
- Requires assistance to stabilize the child.
- Pediatric nasopharyngolaryngoscope.
- Requires knowledge of normal pediatric swallowing anatomy and physiology.
- Parents can bring the child’s usual food and utensils.