

How to build a patient report based on VFSS

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Courtesy of the Asklepios Stadtklinik Bad Tölz

SLP VFSS report

Challenges with VFSS :

- Analysing VFSS is very challenging (this applies for all radiologic/ instrumental diagnostic procedures).

4 reporting errors:

- Overreporting (false positive) – knowledge of normative data including age related changes is essential
- Perception errors (false negative) – not identifying pathology
- Errors of interpretation – a symptom is correctly identified but the underlying cause is not
- Errors of communication – findings are correct but way of communication is inadequate

[Nightingale et al. 2012]

SLP VFSS report

Challenges with VFSS report writing:

- Missing standards and non-uniform language
- Differentiate clearly between objective findings and interpretation leading to the overall assessment
- Report on *spontaneous* reaction of patient and its efficiency
- List all *compensatory techniques* with intended goal and comment on efficiency

eg.:

- pre-swallow pooling or leaking
- hyolaryngeal excursion or superior-anterior hyoid-larynx movement

[Brodsyk 2012]

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eg.: Pre-swallow pooling can be objectively seen on VFSS – the underlying cause (eg. delayed initiation of pharyngeal swallow) is an interpretation

[Brodsyk 2012]

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eg. Patient spontaneously reacted with insufficient cough to aspiration

[Brodsyk 2012]

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eg.: swallow with chin tuck to prevent pre-swallow pooling and aspiration -> pooling could be reduced but aspiration still occurred

[Brodsyk 2012]

SLP VFSS report

Content of VFSS report:

- Indication and medical diagnosis
- Listing of contrast agent, consistencies and volumes trailed
- Morphological abnormalities
- Diagnostic summary that identifies the underlying pathophysiology causing observed symptoms

Suggestion of diagnostic summary [Huckabee]:

„Patient presents with [*..which phase..*] dysphagia characterized by [*..biomechanical abnormality..*] resulting in [*..symptoms..*].“

[Daniels et al. 2019]

SLP VFSS report

Content of VFSS report:

- **Spontaneous** clearing reaction (eg. cough, throat clear, dry swallow) and effectiveness
- **Compensatory** techniques trialed and effectiveness
- Recommendations regarding:
 - Mode of intake of food, fluid and medication – including compensatory techniques if applicable
 - Rehabilitative therapies
 - Other diagnostic procedures
 - Re-Evaluation if applicable

SLP VFSS report

If a VFSS report does not list the morphological or physiological reasons for observed symptoms and misses to report implemented compensatory techniques and their effectiveness, the VFSS as such is incomplete [Logemann, 1998].

SLP VFSS report example

Contrast agent:

Visipaque 320: 50ml

Barium used

Administered bolus during VFSS:

5 x 1 tsp liquid

2 x 1 sip

3 x 1 tsp puree

1 x 1 bite bread

Overall assessment:

Videofluoroscopy of swallowing conducted on 29.08.2024 showed severe pharyngeal phase dysphagia characterized by reduced hyolaryngeal excursion resulting in reduced tilting of the epiglottis and reduced opening of the pharyngoesophageal segment (PES). This in turn lead to severe post-swallow residue in the pharynx and post-swallow aspiration with in parts silent aspiration on fluids, penetration with puree that cleared on swallow, no passage of solid bolus through PES, despite spontaneous multiple swallow attempts with redirection of the bolus back from pharynx into oral cavity, followed by expectoration.

Additionally, there was suspicion of reduced pharyngeal stripping/ approximation of the base of the tongue with the posterior pharyngeal wall and/ or mis-sequencing of pharyngeal movement.

SLP VFSS report example

Compensatory techniques:

- Throat clearing and expectoration was largely efficient.
- Chin tuck did not increase safety/ efficiency in a relevant way
- Head turn to left – not efficient
- Head turn to right lead to a more efficient and safe bolus passage

Recommendations:

- Nutrition: self-feeding purree with right head turn
- Fluids: tsp fluids with right head turn
- Intensive swallow therapy focusing on skill training using sEMG and BiSSkiT Software as adjunct – as well as skill training by working on swallowing solids using right head turn followed by throat clear and expectoration
- If symptoms stay stable pharyngeal manometry would be indicated
- VFSS re-evaluation to adapt treatment content