FEES vs. MBS

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FEES vs. MBS

They are just tools for the evaluation of swallowing
They are as good as what your clinical question is
They should not be used to confirm your bedside diagnosis
Aspiration

25-57% of aspiration events before the swallow

44 – 65% of aspiration events after the swallow

7 – 9% of aspiration events during the swallow

(Colodny, 2001; Smith et al., 1998)
FEES vs. MBS

MBS no longer the Gold Standard
The safety of nasendoscopy has been well established
The more instrumentation available, the more benefit to our patients.
Case 1

Supracricoid Partial laryngectomy with Cricohyoidoepiglottopexy (CHEP)
Case 1
Case 1

75 y.o. male
SCPL with CHEP with preservation of both arytenoids (Jan 2005)
Received no direct dysphagia Tx post op.
Multiple MBS revealed severe dysphagia
Nasendoscopy by ENT revealed frozen larynx
Evaluation by me 18 months later revealed that pt. had not learned to move structures post op.
Pt. benefited from visual biofeedback via nasendoscopy.
Case 1

Initial evaluation

s/p SCPL CHEP two arytenoids
Case 1  Post visual biofeedback

s/p SCPL CHEP two arytenoids
Case 2

Long Uvula
Case 2

54 yo male

No contributing medical history

Complained of frequent gagging and choking during eating and also without eating

Treated by PCP with reflux meds for 6 weeks without success

Evaluated by SLP via MBS
  – Normal swallow
Case 2

Cont’d…

Self referred to the swallowing center

Based on symptoms a FEES was conducted

Findings as follows:

– Unusually long uvula
Conclusions

Clinicians must:

- have comprehensive knowledge of the available instrumentation and their limitations
- take advantage of the instrumentation available to be considered a good diagnostician.
- account for all factors that may influence outcome.
- Understand that dysphagia is more than just aspiration.


