Identifying Vulnerable Patients: Role of the EAT-10 and the Multidisciplinary Team for Early Intervention and Comprehensive Dysphagia Care

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There is under diagnosis and low awareness of dysphagia, despite that the condition is modifiable and poorly managed symptoms diminish psychological well-being and overall quality of life [1]. Results of a landmark pan-European survey reveal that a large percentage of elderly in formal care settings who suffer from swallowing problems do not receive proper diagnosis (60%) and timely treatment (66%). Meanwhile, symptoms related to eating/drinking being painful, stressful, burdensome, and no longer pleasurable are common. Namely, 55% experience ‘food sticking in the throat or choking on food’, 46% suffer from ‘persistent cough or sore throat’ related to an inability to swallow liquids, and nearly 40% report ‘inability to swallow liquids’ and ‘loss of appetite’. While eating and drinking are normally social and pleasurable experiences, 55% of respondents report that swallowing problems have ‘made life less enjoyable’. The added ‘embarrassment’ and ‘anxiety or panic during mealtimes’, experienced by 37% and 41%, respectively, of patients because of swallowing difficulties, can lead patients to ‘avoid eating with others’, which was reported by 36% of respondents. All of these psychological factors may lead to reduced fluid and nutritional intakes, and increased risk of malnutrition and dehydration. Clearly, individuals with unmanaged dysphagia suffer a loss of the pleasure of eating.

Frontline clinicians are in a unique position to be alert to the high prevalence of swallowing difficulty among elderly, evaluate and identify those who need intervention, and assure that individuals receive appropriate care [2]. Proper diagnosis and treatment of oral-pharyngeal dysphagia involves a multidisciplinary healthcare team effort and starts with systematic screening of at-risk patients. The presence of a medical condition such as acute stroke, head and neck cancer, head trauma, Alzheimer’s disease, Parkinson’s disease, pneumonia or bronchitis is adequate basis for predicting high risk and the need for evaluation [3].
**Fig. 1.** The EAT-10, a validated dysphagia screening tool.
Systematic screening of dysphagia and resulting malnutrition among at-risk older adults is justified in an effort to avoid pneumonia and is recommended by clinical practice guidelines [3]. Screening serves to facilitate targeted referral of persons at dysphagia risk to dysphagia specialists for further assessment and to initiate appropriate interventions. In principle, a good screening tool will be quick, easy, and validated [4]. A validated
screening tool for dysphagia is available, the EAT-10 (fig.1) [5]. The tool was specifically designed by a multidisciplinary group to address the clinical need for a rapidly administered and easily scored questionnaire to assess dysphagia symptom severity [5]. An EAT-10 score >3 is abnormal and indicates the presence of swallowing difficulties [5]. The EAT-10 is rapidly self-administered and can be completed in <2 min [5]. Analogous results were observed among patients from acute care, long-term care, and primary care settings, that the EAT-10 is useful as a self-administered test, easy to understand for the majority (95.4%) of patients, quick to perform having a mean completion time of <4 min, and able to differentiate patients at risk for dysphagia from those with a normal swallow [6].

Systematic screening as part of a comprehensive care protocol (fig.2) enables multidisciplinary teams to more effectively manage the condition, reduce the economic and societal burden, and improve patient quality of life [7]. In fact, care settings with a systematic dysphagia screening program attain significantly better patient outcomes including reduced cases of pneumonia (by 55%) and reduced hospital length of stay [8].

References