Dysphagia:

Dysphagia, or difficulty in swallowing, is a common complaint, and can be caused by any lesion in the mouth, pharynx or oesophagus that disturbs the normal sequence of coordinated muscle activity, or any other lesion that could have a negative effect on muscular function. This would include Central Nervous System (CNS) lesions. A variety of symptoms can present as dysphagia, some more sinister than others. It is therefore of utmost importance to know the range of symptoms that could be classified as causes of dysphagia.

Discussion:

Because of the range of diseases that can cause dysphagia, it is important to establish the exact symptoms, as this is a clear indication of severity. Oropharyngeal lesions may give rise to a feeling of swallowing over an object. Pharyngo-oesophageal lesions initially cause a feeling of something in the throat, followed at a later stage by dysphagia. Oesophageal lesions are responsible for difficulty in swallowing solids, with food eventually sticking in the throat. CNS lesions are difficult to diagnose and manage, but generally patients would struggle with fluids as opposed to solids.
Questions to include in history taking are as follows:
Type of sensation and nature of symptoms, e.g. Solids vs.fluids
Duration of problem, progression of symptoms
Regurgitation associated with dysphagia
Associated symptoms that could indicate a more sinister problem, e.g. Weight loss, hoarseness, otalgia in presence of a normal ear, aspiration pneumonia, neck mass, regurgitation of food or drink.
Once this has been established, an ENT examination should follow, with emphasis on the following: oral cavity, pharynx or larynx. If a lesion is noted, malignancy should be considered, therefore histopathological examination of tissue samples is mandatory.
A thorough neck examination should then be performed, to establish the possibility of neck nodes that could harbour metastatic disease. If a node is palpated, it may only be examined via a fine needle aspiration biopsy (FNA).
Special investigations range from a barium swallow, video fluoroscopy to a direct oesophagoscopy. Important to note is that a normal barium swallow may not exclude pathology and a direct oesophagoscopy could reveal abnormalities.
Dysphagia may be divided into acute and chronic, and the history is usually very helpful.
Acute causes: Inflammatory lesions, e.g. Tonsillitis, pharyngitis
Aphthous ulcers
Foreign bodies/ ingestion of caustic substances
Chronic causes: Neuromuscular disorders, e.g. Motor neuron disease, Multiple sclerosis, Myasthenia gravis
Intrinsic lesions, e.g. Neoplasia, pharyngeal pouch, strictures, achalasia
Extrinsic lesions, e.g. Thyroid lesions, Aortic aneurism
Systemic causes, e.g. Scleroderma
Psychosomatic, e.g. Globus pharyngeus

Treatment:
Neuromuscular: Associated with a high risk of aspiration, often overcome by performing a cricopharyngeal myotomy.
Neoplastic: Common sites are the piriform fossa, postcricoid region and oesophagus. Treatment options include surgery and radiotherapy.
Pharyngeal pouch: Hernia of pharyngeal mucosa through the upper and lower portions of the inferior constrictor. Surgical excision with or without cricopharyngeal myotomy.
Oesophagopharyngeal stricture: Depending on cause, could be benign or malignant. Malignancy must be excluded by biopsy. Benign disease is usually due to reflux, causing excessive fibrosis and stricture formation. Reflux should be controlled, and dilatation can be considered. Surgical correction in severe cases.
Achalasia: Abnormal oesophageal muscular tone, seen during swallowing. Regurgitation may be common. Surgery to divide the cardiac sphincter, as dilatation is not successful
Extrinsic lesions: Treatment of cause, e.g. Thyroid pathology.
Psychosomatic causes: Associated with anxiety, complains of lump in the throat. In patients with no sign of anxiety, a barium swallow should be done to exclude malignancy. If no other pathology exists, the patient should be reassured.

Summary:
If symptoms persist, investigate further, Barium swallow should at least be performed.
Use a directed line of questioning.
Acute vs. chronic dysphagia on history, suspect foreign bodies in children.
If symptoms persist, do an oesophagoscopy.
Strictures should be biopsied to exclude malignancy.
Globus pharyngeus patients might need further investigation to exclude other causes.
If reflux is present, this should also be treated.