Vocal Variability Post Swallowing in Individuals with and without Oropharyngeal Dysphagia

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Abstract

Introduction Voice modification after swallowing may indicate changes in the transit of the bolus.

Objective The aim of this study is to verify the use of perceptual voice analysis to detect oropharyngeal dysphagia.

Study Design Case series.

Methods Twenty-seven patients with dysphagia as diagnosed by videofluoroscopy and 25 without were evaluated. The sustained vowel /a/ was recorded before this exam and after swallowing different consistencies (pasty, liquid and solid). For the voice evaluation, the GRBAS scale (grade, roughness, breathiness, asthenia and strain) and the parameter “wet voice” were used. Three judges blinded to study group and time of emission performed voice analysis.

Results Individuals with dysphagia showed significant decrease in grade of voice and asthenia and increase in strain after swallowing pasty substances, differing from individuals without dysphagia who showed no modification of the parameters after swallowing. The wet voice parameter showed no difference after swallowing in both study groups.

Conclusion The decrease in grade and asthenia and increased strain are indicative of a swallowing disorder, indicating increased vocal strain to clean the vocal tract of food. The modification of vocal production after swallowing proved to be a trusted resource for detection of swallowing disorders.

Keywords ► deglutition disorders ► voice quality ► deglutition ► voice ► oropharyngeal dysphagia

Introduction

Swallowing, a stomatognathic function, is characterized by a complex mechanism that requires the involvement of many structures that must be coordinated to occur effectively. The main functional condition that needs to be considered is the ability to protect the lower airway through elevation, laryngeal closure and protective reflexes, such as coughing.1 When starting the pharyngeal phase of swallowing, three events occur: laryngeal elevation through the contraction of the supraboid muscles; lowering of the epiglottis, which reduces the space of the laryngeal inlet; and vocal fold adduction, operating in glottal closure, which is an additional mechanism that reduces exposure of the lower airway.1–3

The main diagnostic method to evaluate swallowing dynamics is videofluoroscopy, also known as “videodeglutogram” or dynamic examination of swallowing. Considered the reference standard for evaluation and diagnosis of changes in this function, it consists of swallowing food with barium, allowing the visualization of the process by dynamic X-ray machine,
which shows the path traversed by the material swallowed. In this exam, the exact course taken by the food can be precisely identified, as well as the areas where the process does not occur efficiently; it is possible to view a deposit of contrasted material in places with changes in motility.4,5

Although videofluoroscopy is the standard for diagnosis, it is not easy to access for patients with swallowing disorders, besides having restrictions on its indication. Therefore, clinical evaluation is routinely used for detection of swallowing disorders and determination of treatment.6,7 This method consists of several steps that, when taken together, describe the swallowing changes according to the characteristics presented by the patient, thus allowing the determination of therapeutics.5,7,8

One of the aspects considered in the clinical evaluation is laryngeal function, which requires assessment of the anatomical conditions of the region, evaluated by palpation and aspects of mobility and its functional capacity, evaluated by changes in vocal production after swallowing. Altered vocal production after swallowing has been considered a leading indicator of inefficiency of the process, because stasis of food in the laryngeal-pharyngeal cavity during swallowing is commonly observed in patients with dysphagia.9,10 The presence of food in this region can alter the space of the vocal tract, modifying voice quality.11 Although this parameter is routinely evaluated in clinical protocols, few studies have analyzed its reliability for detection of dysphagia, indicating possible bias of this method when indicating a change in swallowing. Moreover, studies do not compare voices of individuals with and without swallowing disorders, which could determine whether this modification can actually be attributed to a disturbance of this function or it occurs for all subjects immediately after swallowing.

This study aimed to: (1) investigate the reliability of the protocol used; (2) check whether significant change occurs in the perceptual assessment of voice after swallowing in individuals with oropharyngeal dysphagia; and (3) compare significant changes related to voice quality in the group with dysphagia compared with the control group.

Methods

Design and Sample

This study presents a descriptive cross-sectional prospective comparison between subjects with and subjects without oropharyngeal dysphagia aiming to verify changes of voice production after swallowing. The study was approved by the Ethics Research Committee under protocol 293.856.

Men and women 18 years or older capable of continuous voice production for at least 4 seconds and swallowing at least one of the consistencies in the evaluation (pasty, liquid and solid) were included. The study sample was divided into two groups: individuals with (G1) and individuals without (G2) oropharyngeal dysphagia. Subjects who were diagnosed with swallowing disorder by videofluoroscopy composed G1 and were stratified according to the score in the dysphagia severity scale from 1 to 5, signifying severe to discrete dysphagia. Individuals in G2 showed no swallowing disorders and scored 7 on the scale used, compatible with normality.12

Pairing by sex and age was performed, with a difference of up to 5 years between pairs. Individuals with tracheostomy, organic-functional and organic vocal fold lesions, or injury of laryngeal nerves causing vocal fold paralysis were excluded. Subjects who had surgical removal of tumor and tissues involved in the swallowing process and all those individuals cognitively unable to respond to the protocol were also excluded.

Fifty-two individuals, 27 (14 men and 13 women) in G1 and 25 (12 men and 13 women) in G2, were evaluated, with mean ages of 71.07 for men and 76.69 for women in the first group and 68.05 and 78.53, respectively, in the second group. The evaluations performed yielded 201 vocal recordings, including 101 in G1 and 100 in G2. The difference in the number of recordings between groups was due the greater number of subjects in G1; the number of recordings was also less than expected due to the impossibility of evaluating some consistencies due to limitations of bolus preparation and oropharyngeal dysphagia.

Procedures

All study participants underwent evaluation of vocal production before and after a sequence of swallows during videofluoroscopy, using three consistencies of foods evaluated in the following order: pasty, liquid and solid. For the recording of vocal productions, the digital recorder DVR-Powerpack 576.BK (Powerpack, China) with external microphone was used. Before the exam, subjects were asked to perform a deep inspiration followed by emission of vowel /a/ in the usual tone of voice; if the emission lasted at least 4 seconds, it was considered valid. The same instructions were made for evaluations performed after swallowing each food consistency tested in the exam.

Videofluoroscopy

Videofluoroscopy examinations were performed with the Siemens Axion Icons R100 fluoroscopy (Siemens, USA) model coupled to an image recording system in a computer, which allows further detailed analysis of the exam. During the examination, subjects remained seated and images were captured in the lateral and anteroposterior positions, with upper and lower limits ranging from the oral cavity to the stomach.

The examinations were performed by evaluating pasty, liquid and solid consistencies prepared, respectively, as follows: yogurt-type petit sisse with liquid barium (Bariogel®, Brazil) at a ratio of 1:1 (20 mL of yogurt to 20 mL of barium); distilled water with liquid barium (Bariogel®) at a ratio of 1:1 (40 mL of water to 40 mL of barium); and bread soaked in liquid barium (Bariogel®).

Based on the dysphagia severity scale,12 the degree of dysphagia was determined on each subject and used to allocate subjects into their study groups. Individuals with functional swallowing (a score 6 on the scale) were excluded because they were considered to have neither normal swallowing nor dysphagia, which could compromise data analysis. The examination data were only used to include subjects in
each study group and will not be described in detail here. Nevertheless, it should be noted that 18 (66.6%) subjects had grade 5 dysphagia, 5 (18.51%) had grade 4, 1 (3.70%) had grade 3, 3 (11%) had grade 2 and 0 (0%) had grade 1, demonstrating that the majority of the sample had mild to moderate oropharyngeal dysphagia.

Perceptual Analysis of Vocal Quality

At the end of data collection, voice recordings were given to three judges with clinical experience in voice analysis and evaluation of swallowing. The perceptual analysis was classified using the GRBAS scale (grade, roughness, breathiness, asthenia and strain).13 The three judges received an instructional guide with the objectives and procedures of analysis to be performed. Values were assigned on a scale from 0 to 3 (no change, mild alteration, moderate alteration and severe alteration, respectively) to the parameters described in the protocol. In addition, the wet voice feature was included in perceptual assessment because it is commonly attributed to the vocal production of individuals with dysphagia after swallowing. The judges were blinded to the information and evaluation results of patients. Moreover, they were not informed about which recordings occurred before or after swallowing or to the subject’s study group to maintain the reliability of the data and to not influence these aspects in the analysis. The recordings were sent in stages, with each stage not containing more than one recording of each subject, so evaluators could not compare samples.

Statistics

The data collected were analyzed using descriptive statistics and statistical tests, arranged in tables. The Kolmogorov-Smirnov test was used to test the normality of the data. To measure the reliability of the protocol used, we applied Cronbach’s alpha to measure the correlation between judges. Moreover, the means of the results obtained from the judges for each variable evaluated were calculated. The comparison of the voice emission before and after swallowing of each consistency was performed using the t test for paired samples for variables with normal distribution and the Wilcoxon U test for variables with non-normal distribution. Maximum level of significance of 5% was adopted and the statistical software used for data analysis was SPSS version 20.0.

Results

- Table 1 shows the reliability of the protocol used, GRBAS scale and wet voice in various stages of evaluation by the three judges. Cronbach’s alpha coefficient demonstrated a good correlation between the answers provided by evaluators for all times.
- Table 2 shows a significant decrease only in the voice grade after swallowing pasty food and - Table 3 demonstrates a significant decrease in the aspect of asthenia and increased strain after swallowing pasty food in individuals with oropharyngeal dysphagia.
- Table 4 presents the data before and after swallowing on the G2 of variables with significant vocal change in the G1. Through the Wilcoxon U test, a statistical difference in voice modification after swallowing was not observed in G2.

Table 1 Compatibility between judges in the application of GRBAS scale and wet voice at each moment of evaluation

<table>
<thead>
<tr>
<th>Moment of evaluation</th>
<th>Number of items evaluated</th>
<th>Cronbach’s alpha</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before swallowing</td>
<td>6</td>
<td>0.898</td>
</tr>
<tr>
<td>After swallowing pasty food</td>
<td>6</td>
<td>0.882</td>
</tr>
<tr>
<td>After swallowing liquid food</td>
<td>6</td>
<td>0.872</td>
</tr>
<tr>
<td>After swallowing solid food</td>
<td>6</td>
<td>0.863</td>
</tr>
</tbody>
</table>

Table 2 Emission before and after swallowing of each consistency in individuals with oropharyngeal dysphagia (Student t test)

<table>
<thead>
<tr>
<th></th>
<th>G</th>
<th>R</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>1.98</td>
<td>0.75</td>
<td>1.55</td>
</tr>
<tr>
<td>After swallowing pasty food</td>
<td>1.77</td>
<td>0.69</td>
<td>1.38</td>
</tr>
<tr>
<td>p</td>
<td>0.008*</td>
<td>0.134</td>
<td>&gt; 0.999</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>1.94</td>
<td>0.074</td>
<td>1.51</td>
</tr>
<tr>
<td>After swallowing liquid food</td>
<td>1.8</td>
<td>0.54</td>
<td>1.61</td>
</tr>
<tr>
<td>p</td>
<td>0.146</td>
<td>0.439</td>
<td>&gt; 0.999</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>1.93</td>
<td>0.68</td>
<td>1.44</td>
</tr>
<tr>
<td>After swallowing solid food</td>
<td>1.79</td>
<td>0.49</td>
<td>1.52</td>
</tr>
<tr>
<td>p</td>
<td>0.267</td>
<td>0.581</td>
<td>0.928</td>
</tr>
</tbody>
</table>

Abbreviations: B, breathiness; G, grade; R, roughness; SD, standard deviation.

*p < 0.05.
Discussion

The same anatomical structures are involved in phonation and swallowing, especially in the laryngeal region, which is responsible for the main execution of these functions [14]. Some studies have been conducted to identify vocal parameters that can contribute to detection of oropharyngeal dysphagia.

Vocal production is initiated by the exhalation of air, which passes through the vocal folds in adduction position, producing a sound that is modified by the vocal tract that features the voice of each individual. The length and diameter of the vocal tract, ranging from the vocal folds to the nasal cavity, the placement of structures, such as the tongue and lips, as well as the permeability of the paranasal sinuses modify the sound produced by the vocal folds, making the voice of each person unique due to anatomical peculiarities.

Thus, anatomical or functional modifications in these structures, as well as the presence of food in the pharyngolaryngeal cavity in cases of oropharyngeal dysphagia, can lead to perceptual changes in the usual voice.

The results of this study helped confirm that perceptual parameters commonly evaluated for vocal characterization may vary after swallowing in individuals with oropharyngeal dysphagia. This is not observed in subjects without this change, which is of fundamental importance in clinical applicability. Furthermore, judges were compatible on the assignment of the observed features, as shown in Table 1. Perceptual analysis needs to have high compatibility in intra- and interevaluators so that the data are reliable compared with the real vocal production.

A proviso should be made for the wet voice parameter added to the protocol in this study, which will be discussed later.

Voice grade depends on the perception of the evaluator and consequently, previous experiences in voice analysis is necessary to assign a gravity score based on a set of vocal characteristics perceived as variations of normality.

Table 3 Emission before and after swallowing of each consistency in individuals with oropharyngeal dysphagia (Wilcoxon U test)

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th></th>
<th>S</th>
<th></th>
<th>Wet voice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>IR</td>
<td>Median</td>
<td>IR</td>
<td>Median</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.66</td>
<td>0–2.3</td>
<td>0.66</td>
<td>0–2</td>
<td>0.3</td>
</tr>
<tr>
<td>After swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pasty food (n = 27)</td>
<td>0.011a</td>
<td></td>
<td>0.028a</td>
<td></td>
<td>0.142</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.66</td>
<td>0–2.3</td>
<td>0.5</td>
<td>0–2</td>
<td>0.16</td>
</tr>
<tr>
<td>Liquid food (n = 26)</td>
<td>0</td>
<td>0–2</td>
<td>0.33</td>
<td>0–2.3</td>
<td>0.33</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.71</td>
<td></td>
<td>0.077</td>
<td></td>
<td>0.345</td>
</tr>
<tr>
<td>After swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solid food (n = 21)</td>
<td>0.33</td>
<td>0–2</td>
<td>0.33</td>
<td>0–2.6</td>
<td>0.33</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.428</td>
<td></td>
<td>0.586</td>
<td></td>
<td>0.444</td>
</tr>
</tbody>
</table>

Abbreviations: A, asthenia; IR, interquartile range; S, strain.

*p < 0.05.

Table 4 Emission before and after swallowing of each consistency in group 2 (Wilcoxon U test)

<table>
<thead>
<tr>
<th></th>
<th>G</th>
<th></th>
<th>A</th>
<th></th>
<th>S</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>IR</td>
<td>Median</td>
<td>IR</td>
<td>Median</td>
<td>IR</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.66</td>
<td>0.3–2.3</td>
<td>0</td>
<td>0–1</td>
<td>0.33</td>
<td>0 to 2.3</td>
</tr>
<tr>
<td>After swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pasty food (n = 25)</td>
<td>0.357</td>
<td>0–2</td>
<td>0</td>
<td>0 to 0.6</td>
<td>0.33</td>
<td>0–2</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.6</td>
<td>0.3–2.3</td>
<td>0</td>
<td>0–1</td>
<td>0.3</td>
<td>0–2.3</td>
</tr>
<tr>
<td>Liquid food (n = 25)</td>
<td>1</td>
<td>0.3–2.3</td>
<td>0</td>
<td>0–1</td>
<td>0.3</td>
<td>0–2.3</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.406</td>
<td></td>
<td>0.167</td>
<td></td>
<td>0.439</td>
<td></td>
</tr>
<tr>
<td>After swallowing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solid food (n = 25)</td>
<td>0.6</td>
<td>0.3–2.3</td>
<td>0</td>
<td>0–1</td>
<td>0.3</td>
<td>0–2.3</td>
</tr>
<tr>
<td>Before swallowing</td>
<td>0.646</td>
<td></td>
<td>0.428</td>
<td></td>
<td>0.586</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: A, asthenia; G, grade; IR, interquartile range; S, strain.
use of this parameter in the evaluation of dysphagia allowed
the identification of changes in the oropharyngeal transit of
pasty food, with a decrease in severity of grade, even in a
blinded analysis. It was noted that this modification only
occurs for this consistency and was not modified for other
consistencies evaluated. The viscosity of the pasty food
permits it to adhere to the pharyngolaryngeal structures
when there are changes in motility, as observed in imaging
studies.22,23 The presence of food in the pharyngolaryngeal
cavity acts as a voice modifier and changes voice character-
istics during the sound passage produced by the vocal folds
over the vocal tract. The obstruction at any point in the vocal
tract, as commonly accomplished by the lips and tongue
during speech, changes the formants that compose the voice,
giving more bass or treble according to the position of these
structures.18,24 Thus, the stasis of pasty food modified speech
and decreased the aspects considered not normal and re-
duced the evaluator’s perception of the grade of alteration,
which can be associated with changes in the sound wave
cau sed by the presence of food.11 Nevertheless, the changes
related to swallowing liquids and solids are not able to change
this perception. The consumption of liquid is a benefi-
cial resource for vocal production as it reduces the salivary
viscosity and decreases dryness of the tract after long-term
use, with little immediate benefits perceived aurally.25 In case
of change in motility for this consistency, no impact occurs on
the voice after swallowing when there is no adherence of the
material in the tract modifying the passage of sound. So as
observed in a previous study, the use of liquid food for voice
variability evaluation after swallowing shows little sensitivity
because there is no immediately perceptible voice modifica-
tion even in cases of tracheal aspiration.16 In solid swallow-
ing, it is believed that this change will not occur once the food
causes a mechanical obstruction, leading to discomfort due to
prolonged transit time of food, which affects effective breath-
ing; phonation is performed only when there is clearance of
the tract after conducting multiple swallows26,27 as observed
in the tests performed.

Beyond the modification of voice grade, the parameters of
vocal effort also changed after swallowing. During the per-
ceptual analysis, the judges characterized the voice by assign-
ing a marker of vocal effort.13,21 Individuals with vocal asthenia showed a decrease in this
aspect after swallowing, consequently verifying higher
strain; those who already had vocal strain had an increase of
this parameter. The vocal strain is caused by the increased
resistance of the vocal tract during passage of expiratory air,
performed in an attempt to compensate for structural
changes or a lack of balance between air and vocal muscle
use during phonation, with excessive muscular effort during
emission.18,28 This effort also occurs during coughing, when
the muscles contract abruptly to expel a foreign body.29 When
there is food residue in the tract, phonation occurs with more
effort to keep the usual voice pattern, because the food causes
obstruction, demonstrating that the increased vocal strain
is associated with the attempt to maintain a normal pattern of
speech and withdrawing food deposited in the tract.11,14

Although there is scarce literature about the use of voice
modifications to evaluate dysphagia, it is based primarily on
clinical identification of the presence of wet voice after
swallowing.30,31 Although commonly described as being a
characteristic of voice in which there is a change in the usual
pattern after swallowing, no features describe this variability
in the literature, as opposed to the concepts of other vocal
classifications observed.11,16,21 This aspect complicates the
standardization of analyses made by professionals in the area,
because it involves subjective characterization with little
scientific background. No significant change in this parameter
before and after swallowing was observed in this study. As
discussed in previous studies, this vocal characterization is
sensitive and it is not always possible to identify individuals
with alterations; the subjectivity and lack of standardization
cause poor reproducibility between evaluators, reflecting a
poor diagnostic prediction for dysphagia.11,16

Despite the important findings presented in this study, it is
necessary to point out some limitations, among them, the
sample size. Other authors who studied this method of
evaluation also had this same difficulty concerning the lim-
itations of the patients, because participation and integrity of
oropharyngeal structures are necessary. In addition, the use
of gold standard methods for evaluation are restricted to
individuals who have conditions to accomplish such evalu-
ation.11,14–16 Even with this limitation, the results corroborate
previous studies and demonstrate that this method of evalu-
sion shows specificity to differentiate individuals without
swallowing disorder.16,31

Further studies should be conducted to confirm our data to
better standardize the use of voice assessment as a method of
identification for oropharyngeal dysphagia. Other data ob-
tained from this same sample demonstrating the use of
parameters of vocal self-perception, acoustic voice analysis
and comparison between voice modifications and video-
fluoroscopic examination will be presented in other publica-
tions to probe studies in this area.

Conclusion

Based on the data presented in this study, after swallowing
pasty food, individuals with dysphagia decreased the
grade of vocal alteration and increased strain, with no
change in these vocal parameters for individuals without
swallowing disorder, demonstrating its specificity for clin-
cal use in the detection of oropharyngeal dysphagia.
Nevertheless, the use of the wet voice parameter was not
found to contribute to indicating this disorder, requiring
further studies and standardization like other vocal
parameters used in this study to allow a reliable evaluation
for clinical applicability.

References

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swallow: a meta-behavioral response to aspiration. Respir Physiol