

respective analysis of 120 patients assessed by videofluoroscopy. *Clin Otolaryngol* 1993;18:303-7.

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Hillel Finestone and Linda Greene-Finestone¹ offer many useful points in their article on dysphagia. However, it is disappointing that the technique and value of swallowing retraining^{2,3} are not mentioned.

Credit for recognizing that stroke victims may “forget” how to swallow, and can be retrained to do so, goes to Henry Heimlich.^{4,5} Both of his papers are well worth reading, as they document the pioneering of a new therapy. In brief, the technique of swallowing retraining is based on the idea that the reflex sequence of deglutition can be retaught if it is lost as a result of stroke. Heimlich’s original reports^{4,5} described patients being instructed in sucking, elevation of the larynx and coordination of those functions. People who have lost the ability to swallow for other reasons, such as disuse atrophy of the pharyngeal muscles, can also be retrained.

Over a period of years this mode of rehabilitation gradually became the domain of speech pathologists, and many physicians who care for stroke patients have unfortunately remained completely unaware of it. If there is swallowing dysfunction but no speech impediment, it is quite possible that a speech pathologist will not be consulted, and the patient may be unnecessarily consigned to permanent gastrostomy. As described in the article,¹ swallowing function returns spontaneously in some cases. In others, it does not — but in some of those patients, it can be restored by retraining.

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Hillel Finestone and Linda Greene-Finestone¹ note that “if the risk of aspiration is high, enteral nutrition (tube feeding) should be provided.” Unfortunately, there is little evidence to support the implication that enteral nutrition through a tube reduces the risk of aspiration pneumonia. Tube feeding does not afford protection against aspiration of oropharyngeal secretions, which may be colonized. The incidence of aspiration pneumonia is similar in subjects fed by nasogastric tube, gastrostomy or postpyloric tube.²⁻⁶ None of the cited studies compared the incidence of aspiration pneumonia among subjects receiving enteral nutrition with that among patients fed intravenously.

Finestone and Greene-Finestone¹ identify complications of enteral nutrition in their online Appendix 2,⁷ noting that several of these may be life-threatening. There appears to be a need for good quality-of-life studies of stroke subjects with dysphagia randomly assigned to various feeding and hydration techniques. As the authors have already shown,⁸ such studies are made more difficult by the spontaneous recovery of swallowing in almost two-thirds of subjects within 2 to 4 months.

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[One of the authors responds:]

Irene Campbell-Taylor is correct that dysphagia can be a symptom of a wide variety of conditions; however, our article¹ specifically discusses dysphagia as a result of central neurologic conditions, in this case stroke, and we do not think that the context would be misconstrued by our audience.

Campbell-Taylor hopes that by the term “overnight intravenous fluid administration” we actually meant hypodermoclysis, which she characterizes as “the long-term hydration method of choice.” Hypodermoclysis² is a fine method of hydration that unfortunately has not yet caught on to a significant degree in Canadian hospitals, and it would have been a good choice for fluid administration. However, given the typical evolution of dysphagia, fluids may not be required for a prolonged period, so it was not necessary to choose a long-term method.

Campbell-Taylor also emphasizes that aspiration pneumonia must be differentiated from aspiration pneumonitis. Marik³ distinguished these 2 entities but noted that “some overlap exists.” When a patient presents to the emergency department with a history of stroke, dysphagia and bona fide infiltrates on radiography, as in the case described, we feel that antibiotics would be indicated, especially given the “sick” state (hyperglycemia, hypertension) ex-