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Profile of Demand for Speech-Language Pathology Services in an Oncology Intensive Care Unit

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Abstract

Introduction: The practice of SLP therapy in the intensive care unit (ICU) has as a main objective the evaluation and rehabilitation of swallowing and communication. Dysphagia is an alteration that most solicits the presence of the speech-language pathologist in the ICU. The objective of this study is to characterize the profile of the patient treated by SLP in an ICU of an oncology hospital. **Material and methods:** A retrospective study in which patients of both sexes were included, without age restriction, subject to an assessment with SLP therapy in the ICU between 2000 and 2006. Excluded were patients not evaluated by worsening clinical profile or the non-authorization of patient's health plan. The data collected included that of the bedside SLP evaluation protocol of the institution. **Results:** Evaluated were 78 patients, a majority male (64.1%), with an oncologic diagnosis of a tumor in the head and neck (25.6%) or pelvic region (25.6%). The predominant treatment was surgical (48.7%). During evaluation, 73.1% used an alternative feeding pathway and 47.4% presented clinical signs suggestive of aspiration. Dysphagia was diagnosed in 61.5%, with 75.6% referred to SLP therapy. **Conclusion:** The profile of patients evaluated by a SLP team in a hospital oncology ICU is heterogeneous with respect to gender, location of the tumor and treatment carried out. Most presented dysphagia with signs of aspiration, use of alternative pathway and need for SLP therapy, but with good evolution of the same.

Keywords: deglutition disorders; rehabilitation; intensive care units

Introduction

Speech-language pathology is continuously growing within the hospital environment with the relatively recent performance of this specialty, mainly in semi-intensive and intensive care units.¹

In the hospital, the speech-language pathologist joins a multi- and interdisciplinary team with goals of prevention, diagnosis and rehabilitation, acting seamlessly and defining the most appropriate course of speech-language therapy treatment.^{1,2}

The interdisciplinary team consists of professionals from various health specialties and areas, such as: nursing,

physiotherapy, intensive care physicians, nutrition and referring physicians. The consonance between team members is essential to avoid contradictory information and courses of treatment, ensuring a positive link and mutual trust with the patient. Professionals need to be attentive to information that the patient is ready to receive so they can process it effectively. Responsibility falls to the speech-language pathologist in the form of diagnosis,

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evaluation, orientation and treatment of pre-existing and/or sequelae-related disorders to oral communication or the feeding of patients.³

The speech-language pathologist should be knowledgeable of the patient's clinical history, medical diagnosis, lung and gastroenterological conditions, cognitive state, clinical and psychosocial limitations, as well as information obtained from the physician, nurse and family or caregiver.²

The intensive care unit (ICU) is the place where the patient continuously has their vital functions monitored, so it is of the utmost importance that the speech-language pathologist have specific knowledge about some of the procedures performed, as well as normality values and/or changes that are referenced through monitoring equipment.¹

Speech-language pathology in the ICU is included in several areas, including neonatal, pediatric, coronary, burns, trauma and oncology ICUs.

The potential effects of cancer and its treatment result in various changes that vary in frequency of occurrence, severity and complexity. The prevalence of dysphagia symptoms increases with age, and particularly, in the treatment of central nervous system, head and neck and aerodigestive tract tumors.⁴ An ICU in an oncology hospital presents unique characteristics in relation to general ICUs because it enables the admission of patients who do not have space in other units by ethical issues of the constant need of turnover by lack of beds.⁵

In a study conducted in an oncology hospital, it was observed that among the 24 patients with central nervous system tumors submitted to SLP evaluation, 41% reported dysphagia as the most frequent alteration.⁶

Most head and neck tumors occur in the upper aerodigestive tract, mainly in the mouth, pharynx and larynx that have fundamental structures for the performance of the basic functions of chewing, swallowing and speech production. Swallowing disorders are considered by patients as the most devastating, interfering with their quality of life.⁴

Dysphagia is one of the SLP alterations that solicit the presence of the speech-language pathologist in an emergency ICU, due to serious complications that may influence the patient's state of health. Thus, the speech-language pathologist assists in the prevention and reduction of pulmonary and/or nutrition and hydration complications of the patient.^{1,2}

The experienced speech-language pathologist in this area can contribute significantly within a multiprofessional team in an ICU by rehabilitating swallowing and promoting health with a greater quality

of life. In addition to physiological aspects, there are psychological ones as well, because the moment of feeding is pleasurable, not only for the ingestion of food, but by the social act itself and by all that is generated around that time.² The late identification of swallowing alterations can determine the occurrence of serious pulmonary complications associated with aspiration, which could be prevented that if from the beginning of the hospital admission, the patient would be adequately evaluated and preventive measures imposed.⁷

ICU patients have difficulty with communication in situations where they are not able to speak, for example, in the need of respiratory support, such as mechanical ventilation. This situation can render an impact on the patient's active participation in treatment and in the healing process.⁸

Therefore, the speech-language pathologist also has a key role in the evaluation and rehabilitation of patients with communication difficulties in the ICU.

Generally, the performance of speech-language pathologists in the ICU is still not fully recognized by intensive care professionals and physicians in general because it is something still relatively recent in our field. Alterations should be clinically identified early to prevent an increase in morbidity and mortality, thereby reducing bed occupation time and hospital costs.²

Speech-language pathology in the ICU works as much in maintaining life, as it prevents complications, as it does in the quality of life. This allows the patient to return to feeding through their mouth, maintaining adequate nutritional support, and provides necessary adjustments for alterations in communication.¹

Controversy between speech-language pathologists about concepts, objectives, methods and performance priorities in the hospital consists of a field yet to be defined. One of the first steps to define performance is the characterization of its population.

Thus, the goal of this study is to characterize the profile of the patient treated by SLP in an intensive care unit of an oncology hospital.

Material and Methods

Included were patients of both sexes, without age restriction, admitted in the pediatric and adult ICU during the period January 2000 to December 2006, which were referred to and evaluated by the Speech-Language Pathology Department of Hospital A.C. Camargo during hospitalization. Exclusion criteria consisted of patients admitted in the ICU that had not been evaluated by

the SLP Department for several reasons, including: non-authorization of patient's health plan and/or family, suspension of SLP evaluation by medical staff due to the worsening of clinical profile, and ICU discharge before SLP evaluation.

Patients underwent speech-language therapy intervention through referrals from several medical departments or the ICU during the period mentioned above. All patients presented possible SLP sequelae as a result of cancer and/or its treatment.

This retrospective study was conducted by a survey of 122 eligible patient records accompanying the history, clinical evolution and speech-language therapy intervention during the ICU stay. A survey was conducted of all data appearing in SLP evaluation protocol through a data record, which consists of data related to demographic, pathological and clinical-therapeutic variables of each patient, in addition to the description of all SLP evaluation data. For the definition and elaboration of this record, the bedside SLP evaluation protocol was considered, used by the speech-language pathology department of the institution.

After the collection of data and database population, descriptive tables were elaborated with all data found in the protocols of evaluation and/or patient records. A high rate of the incomplete filling in of some items contained in the protocol was observed and attributed to the impossibility of investigating these items at the time of the evaluation, due to the noncooperation of the patient, cognitive changes, lowering of the level of consciousness or no medical authorization to perform a specific procedure due to immediate postoperative or clinical complications. Thus, added by researchers was the option "NA" (no action) on all questions of protocol evaluation.

After analyzing the data collected in the data records, a descriptive statistical analysis was made of all variables contained in the data records. These variables are described in the form of tables that have the number of occurrence or absolute frequency, as well as the relative frequency of occurrence in each category.

Results

In this study, 122 patients were identified by patient records to have been referred to the Speech-Language Pathology Department of A.C. Camargo hospital during the period determined in the study. Of these, 78 patients were evaluated by a SLP team in the intensive care unit (ICU) and fulfilled the inclusion criteria.

The results of this study are presented in Tables 1 to 4.

The tables describe, respectively, the demographic characteristics of the population studied and the treatment

Table 1 - Demographic characteristics and treatment (n=78)

Variable	Category	Freq. (%) or measures
Sex	Male	50 (64.1)
	Female	28 (35.9)
Age(years)	Min.-max.	0.1-94
	Median	66.5
	Mean $\pm$ standard deviation	57.3 $\pm$ 26.8
Education	Semi-illiterate	26 (33.3)
	Elementary complete	20 (25.6)
	High school incomplete	2 (2.6)
	High school complete	14 (17.9)
	Superior incomplete	2 (2.6)
	Superior complete	14 (17.9)
Profession	Student	7 (9.0)
	Salesperson	5 (6.4)
	Retired	21 (26.9)
	In home	11 (14.1)
	Others	34 (43.6)
Location of Tumor Base	Head and neck	20 (25.6)
	Pelvis	20 (25.6)
	Central nervous system	8 (10.3)
	Thorax	8 (10.3)
	Esophagus	2 (2.6)
	Abdomen	5 (6.4)
	Blood tissue	3 (3.8)
	Breast	2 (2.6)
	Skin	1 (1.3)
	Others (without oncologic diagnosis)	4 (5.1)
Treatment performed	Cx	38 (48.7)
	RxT	9 (11.5)
	QT	5 (6.4)
	Cx + RxT	6 (7.7)
	Cx + QT	6 (7.7)
	Cx + RxT + QT	5 (6.4)
	RxT + QT	3 (3.8)
	Others (clinical support)	4 (5.1)

Legend: Freq.: frequency

Table 2 - General clinical characteristics (n=78)

Variable	Category	Freq. (%) or measures
Aspiration history	No	34 (43.6)
	Yes	44 (56.4)
Tracheostomy	No	58 (74.4)
	Yes	20 (25.6)
	metallic	2 (2.6)
	plastic	18 (23.1)
Cuff	No	60 (76.9)
	Filled	18 (23.1)
	No	46 (59.0)
	Yes	32 (41.0)
Feeding	OP exclusive	10 (12.8)
	AFP	57 (73.1)
	NET	50 (64.1)
	NGT	4 (5.1)
	OGT	1 (1.3)
	Jejunostomy	2 (2.6)
	AFP +OP	6 (7.7)
	PPN	5 (6.4)
Behavior characteristics	Alert	43 (55.1)
	Debilitated	9 (11.5)
	Cooperative	42 (53.8)
	Non-cooperative	10 (12.8)
	Posture/positioning inadequate	2 (2.6)
	Others	5 (6.4)
	NA	2 (2.6)

Freq.: frequency; OP: oral pathway; AFP: alternative feeding pathway; NET: nasoenteral tube; NGT: nasogastric tube; PPN: rolonged parenteral nutrition; OGT: orogastric tube

performed, the general clinical characteristics of the patient at the time of SLP evaluation, the SLP evaluation given, and the diagnosis, suggested course of treatment and evolution of the patient.

Table 1 demonstrates the results in reference to the characterization of the sample with regard to demographic, clinicopathological and treatment data.

In Table 2, we note the presence of a history of aspiration prior to the referral to SLP evaluation, as well as a high referral level of nontracheostomized patients. More than half of patients referred were using an alternative feeding pathway at the time of the evaluation.

In Table 3, a high number of the option “NA” was observed. More than half of patients presented clinical

Table 3 - Characteristics of bedside SLP evaluation (n=78)

Variable	Category	Freq. (%) or measures
Clinical signs of aspiration	Yes	40 (51.2)
	No	19 (24.4)
	NA	19 (24.4)
	Absent	22 (28.2)
Aspiration	Present	29 (47.4)
	Before	1 (1.3)
	During	12 (15.4)
	After	24 (30.8)
Execution of therapeutic tests (cleaning maneuvers and protection of airways)	NA	27 (34.6)
	Yes	27 (34.6)
	No	16 (20.5)
	NA	35 (44.9)
Effectiveness of maneuvers (n=27)	Yes	10 (37)
	No	3 (11.1)
	Partial	12 (44.5)
	NA	2 (7.4)
Possibility of silent aspiration	No	12 (15.4)
	Yes	35 (44.9)
	NA	31 (39.7)
	Normal	13 (16.7)
Vocal quality	Rough	24 (30.8)
	Breathy	13 (16.7)
	Wet	13 (16.7)
	Others	18 (23.1)
	NA	19 (24.4)
	Intelligible	17 (21.8)
	Partially intelligible	15 (19.2)
	Intelligible with attention	18 (23.1)
Speech intelligibility	Unintelligible	2 (2.5)
	NA	26 (33.4)
	Normal	26 (33.3)
	Altered	16 (12.8)
	Lng receptive	6 (7.7)
	Lng expressive	10 (12.8)
	NA	36 (46.1)

Freq.: frequency; Lng: language; NA: non action

Table 4 - SLP diagnosis, suggested course of treatment (n=78)

Variable	Category	Freq.(%) or mea- sures
SLP diagnosis	Functional deglutition	14 (17.9)
	Dysphagia	48 (61.5)
	Mechanical oropharynge	19 (24.4)
	Neurogenic oropharynge	21 (26.9)
	Mechanical pharynx	5 (6.4)
	Neurogenic pharynx	3 (3.8)
	Organic dysphonia	20 (25.6)
	Dysarthrophonia	3 (3.8)
	Aphasia	1 (1.3)
	Absence of oral communication	6 (7.7)
	Others	5 (6.4)
Suggested course of treatment	NA	5 (6.4)
	Evaluation objective of swallowing	12 (15.4)
	SLP	59 (75.6)
Therapy	Orientations	27 (34.6)
	mean of sessions	1.73
Evolution of general clinical profile	Stable	23 (29.5)
	Regular	22 (28.2)
	Good	33 (42.3)
	Stable	4 (5.1)
	Regular	41 (52.6)
ICU discharge without SLP discharge	Good	33 (42.3)
	Yes	56 (71.8)
	No	7 (9)
	Death	15 (19.2)

Freq.: frequency

signs of aspiration, such as coughing and choking, at the time of the evaluation, with most of these at risk for silent aspiration.

Table 4 shows dysphagia as a predominant disorder in the patients studied, most with neurogenic etiology. After evaluation, almost 60% of the patients were referred to SLP treatment, and of those, a majority presented good evolution to speech-language therapies.

Discussion

In the survey of patient record and protocol evaluation, 122 patient records were reviewed, of which 78 were eligible for the study. We noted that many patients were referred to SLP evaluation by the ICU (43 patients), but had not been evaluated at this location for different reasons, among them: non-authorization of the family for the procedure, which is necessary for carrying out the SLP evaluation as a routine service; non-authorization by the health care plan, since most refuse to include SLP services in their table of approved procedures; suspension of evaluation by medical staff due to a general worsening of the clinical profile; ICU discharge before SLP evaluation, with the patient subsequently evaluated by the team in a room of the ward. On some evaluation items, we observed a high percentage of responses in the option "NA", demonstrating the difficulty to completely evaluate a critical patient in the intensive care unit.

With regard to the epidemiological findings, it was noted that most patients evaluated and treated by the SLP department were males (64%), with a median age of 66.5 years. It is known that due to factors related to lifestyle habits, the incidence of cancer is greater in males in the world, nevertheless, the estimate of the Brazilian National Cancer Institute (INCA) of new cases of cancer in Brazil in the year 2008 is 231,860 new cases for males and 234,870 for females, this being the tendency. According to the case studied, we see a greater number of cases diagnosed with pelvic and head and neck cancer. Previous studies indicate that head and neck cancer occurs more frequently in males and in the age groups above 50 years of age,⁹ which corresponds with our findings.

The education level was a finding consistent with Brazilian reality, in which a large proportion of the population is illiterate or semi-literate. These data also have repercussions in the diagnosis, treatment and prognosis of cancer. The socioeconomic and cultural level affects the cancer prognosis, with one of the main reasons being the lack of information for patients about the disease and the difficulty of access to the Brazilian health system.⁹ According to European modalities, the best way to avoid a high incidence of cancer is the carrying out of primary and secondary prevention. The deficiency of primary prevention is the main reason for the lack of awareness regarding the health of the population (consequences of cigarettes, fat-rich diets and low physical activity) and the late introduction of secondary prevention contributes to increased mortality rates for patients with cancer.¹⁰

Most referrals (66 patients, 84.6%) were executed by the adult ICU. Regarding the location of the primary tumor, 20 patients (25.6%) were diagnosed in

the head and neck region and 20 patients (25.6%) in the pelvic region. The location of the tumor and treatment modality, despite being diverse, influences the request of SLP services. It is known that the first action of SLP therapy in patients with cancer was in the treatment for head and neck tumors, because these directly affect the organs responsible for swallowing and communication functions.

Normally, these patients are admitted to the ICU in the immediate postoperative period and do not remain admitted in this treatment unit for long, except in cases of postoperative complications and comorbidities. These patients are referred to SLP evaluation when, after discharge, are readmitted for various factors, such as worsening health, tumor recurrence and pneumonia. In our study, we noted that referral of patients diagnosed with head and neck tumors occur this way. Currently, the start of SLP intervention is early and the systematization of referrals is improving every day. Ideal SLP care should begin in the preoperative period, in the case of head and neck tumor treatment.¹¹

The speech-language pathologist, in addition to advising the patient and their families about the possible changes in speech arising from the surgical procedure, can start SLP rehabilitation with tactile thermal oral stimulation, without flavor and volume, to avoid infection or irritation in the region manipulated during surgery. This treatment teaches the patient to manipulate saliva better, aiding in the rehabilitation of swallowing. In some cases, the placement of a tracheostomy tube during surgery is necessary. Some authors report that dysphagia presents an intimate relationship with a tracheostomy because the simple presence of the tracheostomy tube can cause aspiration, altering mainly during the pharyngeal swallowing phase.^{12,13}

The treatment carried out until the time of referral was surgical for 38 patients (48.7%), although well described by the literature are other treatment options (radiotherapy and/or chemotherapy), which can also bring damage to swallowing and communication functions, mainly in head and neck tumors when performed in association. The presence of large fibrosis of the cervical musculature, through the swallowing reflex, reduces laryngeal elevation, food buildup in the vallecula and the superior esophageal sphincter, leading to the occurrence of dysphagia.¹⁴

Most patients evaluated by the SLP department, while they were in the ICU, were referred by intense care physicians. The objective of the referral was the evaluation of swallowing in 74 patients (95%), which can be justified by the fact that the patients admitted to the

ICU presented critical and unstable symptoms, which therefore demand specific care, such as the importance to returning to safe oral feeding. Rehabilitation of communication in these cases is also important because it contributes to the execution of proposed exercises and maneuvers during the rehabilitation of swallowing. We must remember that the SLP rehabilitation process consists of working together to improve aspects related to the rehabilitation of swallowing and communication functions.

The sequelae arising from the surgical treatment of head and neck cancer involve changes in the structures of the stomatognathic system (mouth, tongue, teeth and lips, among others), leading to important changes of feeding, chewing, swallowing and speech articulation.¹⁵ However, the process of SLP rehabilitation consists of working together to improve aspects related to the rehabilitation of swallowing and communication functions.

Often, the presence of the tracheostomy tube is regarded as justification for the action of the speech-language pathologist, not only to evaluate the safety of oral feeding, but also the risk of bronchoaspiration of saliva and secretions. We noted a low number of tracheostomy-referred patients in our study, with only 20 patients (25.6%) in 7 years. In a current study conducted at this institution, we note that this profile has been modified, observing 36.5% of tracheostomy patients evaluated by speech-language pathology in the ICU in the year 2007 alone.

Dysphagia is an alteration that can generate complications aside from malnutrition and the potential for tracheal aspiration and may endanger the life of the patient. For many patients, feeding becomes difficult, leading to malnutrition, dehydration, pulmonary complications, and mainly endangerment to the quality of life.^{16,17} In a study conducted with patients after encephalic vascular accidents admitted into the ICU, dysphagia was observed as a predictive factor of the onset of pneumonia.¹⁸

The oral pathway is unquestionable the preferred pathway of nutrition. As a consequence, when faced with the impossibility of using this pathway due to numerous diseases and clinical and surgical conditions, the speech-language pathologist aids in the definition of the safest feeding pathway, as well as the type, volume, temperature and consistency of diet, the use of utensils and potential risks of bronchoaspiration.¹⁹

In case of the need to use an alternative feeding pathway, such as with nasointestinal tube (NET) and gastrectomy, the speech-language pathologist acts in rehabilitating the swallowing of these patients, thus

allowing the early return to a safe oral pathway. In our study, we observed that 57 patients (73%) using an alternative feeding pathway, with 50 (64%) of these with a nasoenteral tube. There is preliminary evidence that the NET alone interferes in swallowing physiology²⁰. This result is expected, considering that patients admitted in an intensive care unit, for the most part, present a serious clinical profile inhibiting oral intake. These data could be modified if the course of treatment related to feeding takes into account the early work of the speech-language pathologist within this context.

In the clinical practice of the ICU, the medical team usually liberates a diet orally to the patient, and only upon the occurrence of episodes of coughing/choking or bronchoaspiration, opts for an alternative feeding pathway and only then solicits SLP evaluation. This also justifies a finding related to the history of aspiration in a studied population, where 44 patients (56.4%) presented a prior history of aspiration before SLP attendance. In our study, we observed a high number of patients who used a NET as a feeding pathway. Currently, there is greater dialog between the professionals who work with dysphagia patients in an effort to opt for gastrectomy in cases where a greater period of an alternative feeding pathway is needed. Gastrectomy, most of the time percutaneous endoscopic, should be the pathway of choice when the time of enteral nutrition is more than six weeks, since we know of the interference of the NET in swallowing.¹⁹ ICU patients have a higher risk of aspiration and aspiration pneumonia for being in a supine position, with factors such as gastroparesis, presence of a nasogastric tube, use of narcotics and neuromuscular blockers associated with this risk.⁷

In relation to the presence of clinical signs of aspiration in patients evaluated, we observe that these signs varied from the exit of food by tracheotomy, coughing, choking, dysphagia, and stasis, and some patients present more than one sign. The option "exit of food by tracheostomy tube" was regarded as a clinical sign, as it appeared as one of the items of "clinical signs of aspiration" in the protocol. We believe that the output of food by tracheotomy is already in itself an indication of laryngotraqueal aspiration, since the concept of aspiration is the presence of saliva secretion or food below the level of the vocal folds before, during or after swallowing.¹²

In the bedside clinical evaluation, the parameters used to show the occurrence of aspiration are often subjective. In this study, we observed that of the 78 protocols analyzed, 37 (47.4%) contained the information of the occurrence of aspiration. This alteration can be proven through the exit of secretion and/or

foods by tracheostomy tube, functional evaluation of swallowing using food dye coloring or through exams of complementary objectives. In the sample collected, only 20 patients (25.6%) had tracheostomies and none of them had any kind of objective exam of swallowing, with the finding related to aspiration justified through the clinical evaluation of swallowing, where many times the changes observed can be correlated and the occurrence of laryngeal aspiration can be concluded. Faced with all these considerations, we believe that following the completion of the bedside clinical evaluation, the responsibility falls to the speech-language pathologist experienced in characterizing the type of alteration and the occurrence, or lack thereof, of aspiration, having to conduct the beginning of speech-language therapy. This conduct was the choice for 59 patients (75.6%) in our study.

The use of cleaning maneuvers and/or airway protection was demonstrated to be limited. Probably, this occurred due to a number of factors, among which was the impossibility of execution due to the critical clinical profile of the patient, the altered state of alertness and the socio-cultural level, which also makes understanding the requested tasks difficult. We can also consider that a majority of the population in our study presented a median age within the age group of 66 years, and it is known that the older the patient is, the harder it is for the patient to understand the implementation of these maneuvers. The maneuvers were considered partially effective when there were only minimizing signs of stasis, penetration and/or aspiration.

In relation to vocal quality, the Speech-Language Pathology Department of Hospital A.C. Camargo routinely uses the Grade, Roughness, Breathiness, Asthenia and Strain (GRBAS) scale²¹ for the subjective classification of dysphonia. However, the protocol for the evaluation of admitted patients makes adaptation necessary since patients, in addition to the parameters analyzed by GRBAS, may present other vocal alterations, such as wet and gurgly vocal quality. In cases where the classification of vocal quality is unable to be performed (unrated/no action), we believe that with the use of a tracheostomy tube with an uninflated cuff, the altered alert status and cognitive level do not permit vocal evaluation. The occurrence of the alteration of loudness, a psychophysical feeling related to intensity, was observed in 30 patients (38.4%) and the maximum phonatory time in 23 patients (29.5%), which can be justified by physical debility of most of the patients in the ICU, leading to a reduction of pulmonary support, which altered these parameters. The maximum phonatory time is one of the parameters that is easiest to obtain respiratory

measurements, as it can be employed both as a means of diagnosis and monitoring the evolution of the therapy of dysphonic patients.²²

As to the SLP evaluation, we noted that 48 patients (61.5%) had the diagnosis of dysphagia, with 19 patients (24.4%) characterized as mechanical oropharynge dysphagia and 21 patients (26.5%) as neurogenic oropharynge dysphagia. Critical patients represent a population with multiple risk factors for aspiration, and the identification of swallowing alterations can aid in detecting patients with a high risk of aspiration, preventing pulmonary complications such as aspiration pneumonia.⁷ Therefore, we believe that knowledge of the profile of the patient admitted in the ICU facilitates the monitoring and SLP performance improvement in this environment.

Conclusion

It can be concluded that the profile of patients evaluated by a SLP team in a hospital oncology ICU was mostly male, subjected to surgical treatment that evolved with dysphagia resulting from various factors, with a history of aspiration, need for tracheotomy, the lowering of the general clinical profile and modification of the anatomy and physiology of the stomatognathic system. Most of the nourishment was with an alternative pathway, presenting rough vocal quality; patients were referred to SLP therapy and had an SLP evolution which was considered good.

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