



REMARKS

1 General

- 1.1 Dysphagia can be classified by level (oropharyngeal or retrosternal) and aetiology (structural or functional).
- 1.2 Careful history taking often helps to differentiate the level of dysphagia and provides clues about the underlying aetiology, especially for oropharyngeal dysphagia.
- 1.3 Abnormalities of mid & lower oesophagus to gastric cardia may cause referred dysphagia to upper chest or pharynx. Therefore, the oesophagus and gastric cardia should also be assessed in patients with oropharyngeal dysphagia without attributable causes.

2 Barium swallow

- 2.1 Barium swallow and endoscopy are complementary to each other in assessing oesophageal strictures and tumours.
- 2.2 The length and the severity of stenosis are well demonstrated on barium swallow.
- 2.3 Barium swallow can detect motility disorders and it may be more sensitive to detect certain structural abnormalities such as oesophageal webs and rings.
- 2.4 Endoscopy allows biopsies to be taken and is more sensitive to detect mild reflux oesophagitis or other subtle oesophagitis.

3 Video-fluoroscopic swallowing study (VFSS)

- 3.1 VFSS focuses on evaluating the oral cavity, pharynx and cervical oesophagus to access for oral and pharyngeal swallowing phase abnormalities.

4 CT

- 4.1 CT can be used to assess extrinsic lesions and for tumour staging prior to surgery.

REFERENCES

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