SLP's Role in Management of Type III/IV Laryngeal Clefts

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Where the world comes for answers

Pre-operative feeding evaluation

- Generally NPO given high risk for aspiration
- Therapeutic oral stimulation and developmentally supportive cares, as medically appropriate
- Anticipatory guidance for the family

Post-operative Oral Feeding Advancement

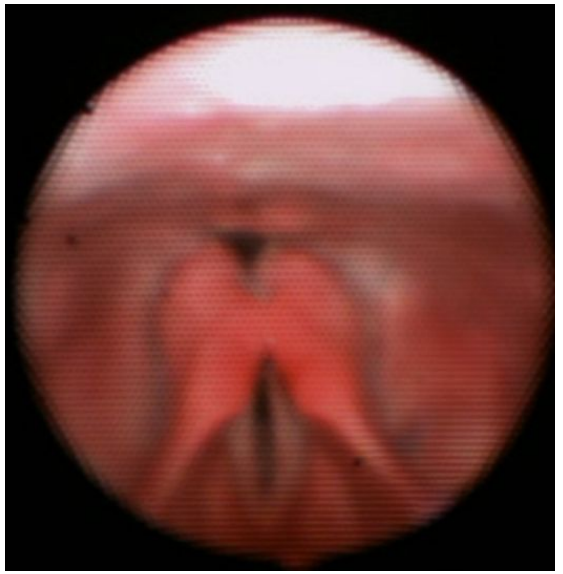
- Considerations
  - Co-morbidities and associated risk factors
  - Complexity of surgical course and status of cleft repair (residual cleft; tracheostomy)
  - Gastric tolerance
  - Pulmonary status
  - Readiness cues and secretion management
  - *Family's goals of care*

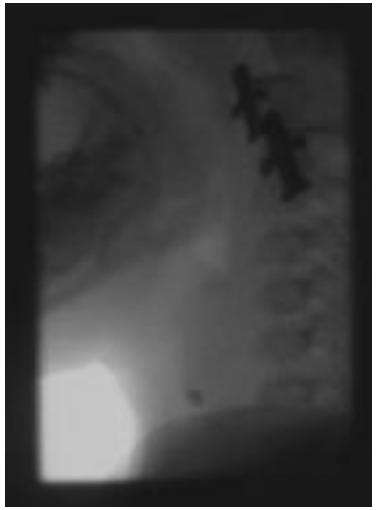
Instrumental Assessment

- Essential to fully understand swallowing physiology and oral feeding safety for this population given the high risk for *silent* aspiration (Velayutham et al, 2017)

- Use to guide plan of care, recognizing that this is not the "full picture"

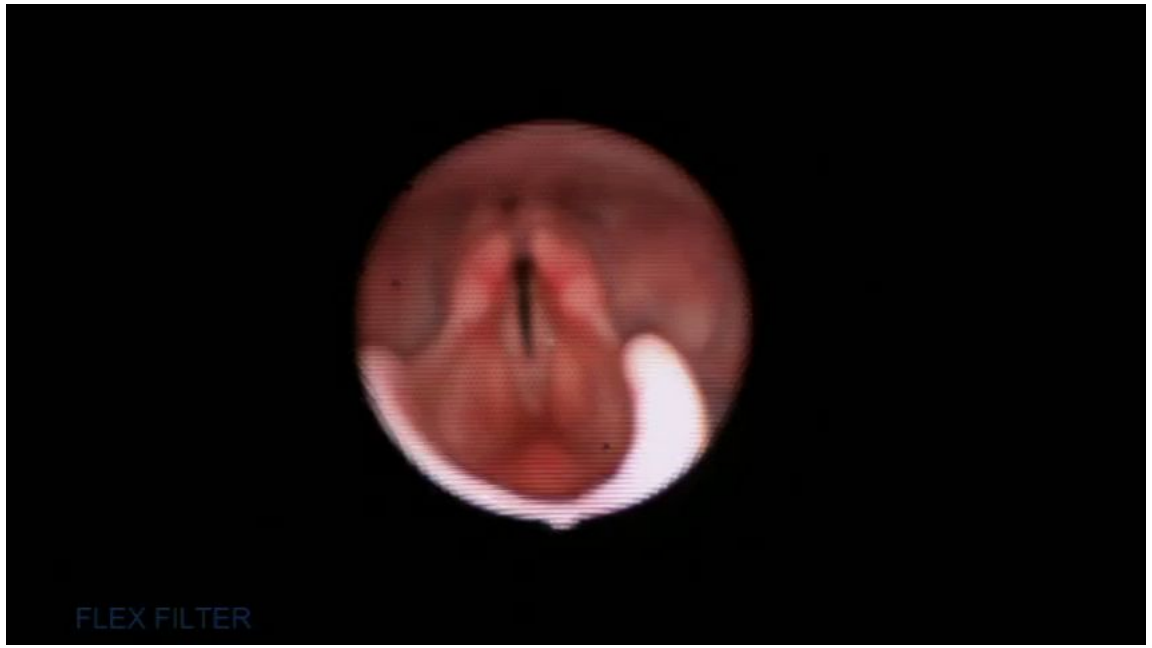
- FEES vs. VFSS





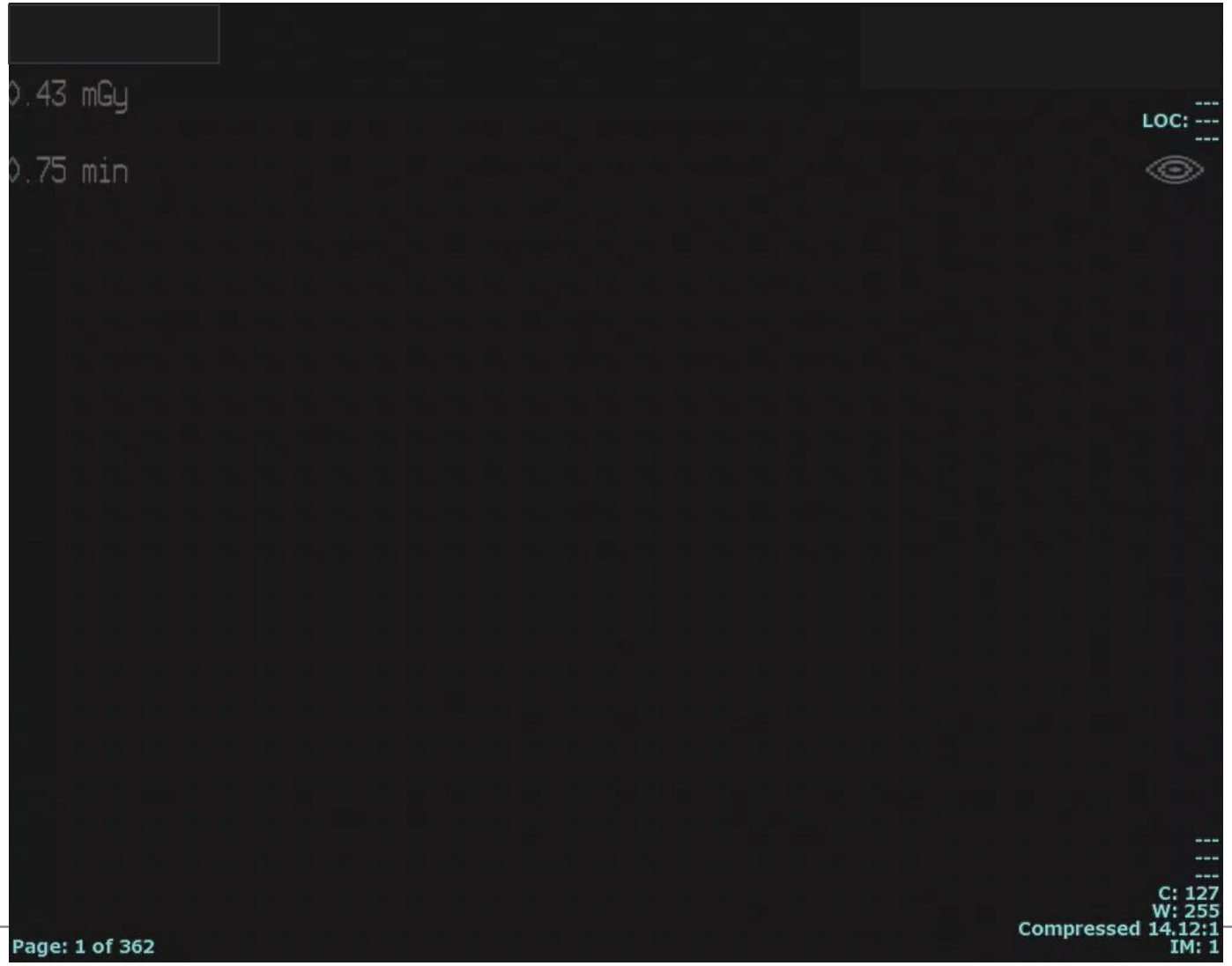
Fiberoptic Endoscopic Evaluation of Swallowing

- Allows for visualization of laryngeal vestibule, interarytenoid region, vocal fold mobility
- Does NOT allow for visualization of the distal repair site



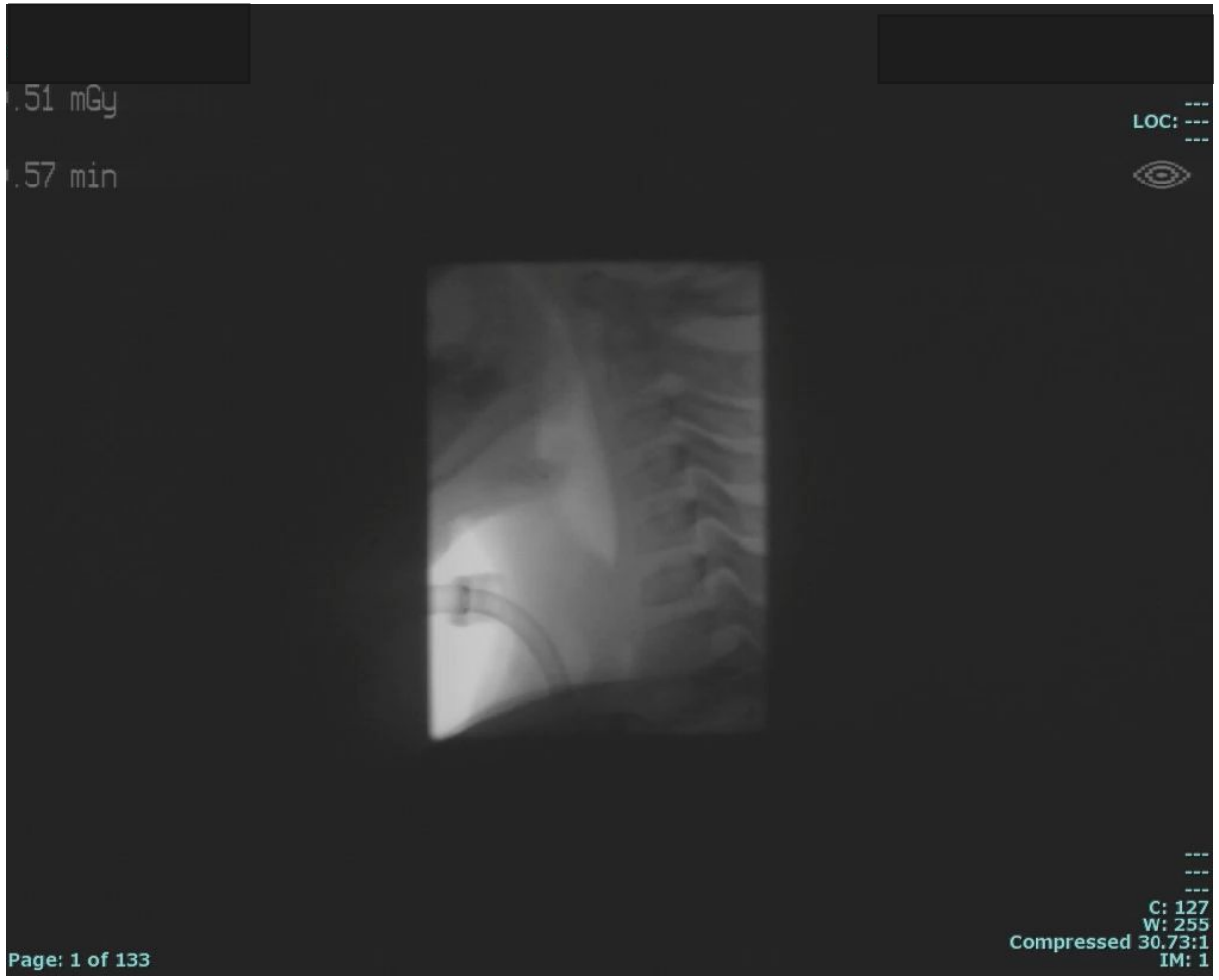
Videofluoroscopic Swallow Study

Allows for visualization of oral, pharyngeal, and upper esophageal phases of swallowing, including distal repair site



Clinical Progression

- Interdisciplinary collaboration to support progression of oral feeding, considering not only instrumental findings but also clinical presentation
    - Clinical and instrumental findings may differ – due to mucosal redundancy, optimal positioning, and minimal distractions
    - Consider “sick plan” for oral feeding due to known increased risk during periods of illness
    - Serial clinical assessments to guide progression and determine frequency of instrumental assessments



Case Studies

- Underlying cardiac defects status post repair
- Type IV cleft with residual type II cleft
- Severe tracheobronchomalacia (unrepaired)
- Tracheostomy dependence
- Vomiting and feeding difficulties with GJ-tube dependence

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VFSS overall reassuring – aspiration with thin liquid but not with mildly thick or solids

- No unifying diagnosis or significant comorbidities
- Type III cleft with residual type I cleft
- No acute illnesses or inhalers in past year
- GJ-tube dependence

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VFSS concerning for possible fistulous tract
-aspiration with all liquids but not solids or puree

Recommendations guided by family goals of care, psychosocial considerations, clinical presentation, and global status

Summary

- Instrumental assessment is essential, with VFSS being preferred to visualize full repair
- Consider clinical symptoms/status with instrumental findings
- Primary feeding plan with modifications during periods of illness
- Close monitoring of progress and for changes in status
- *Meeting the patient and family where they are at*