

Disfagia e ictus

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Caso
clínico

2



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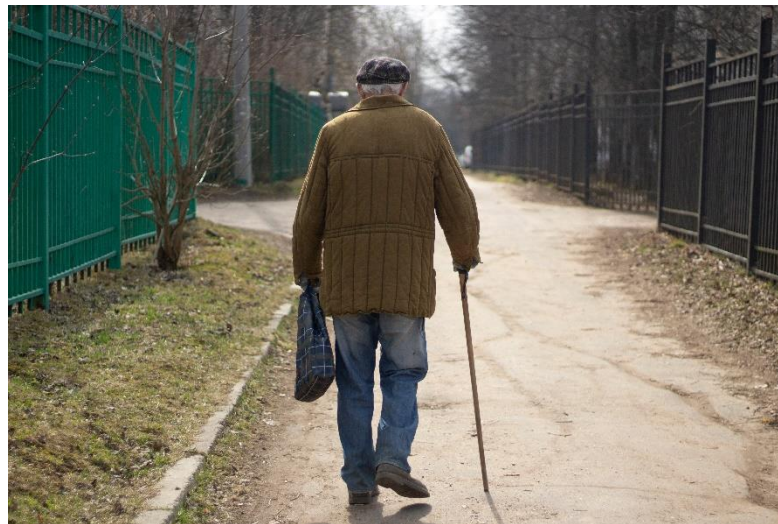
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01 Historia clínica

Perfil del paciente

- ▶ Varón de 89 años que consulta por disminución de la fuerza en hemicuerpo derecho y disartria al despertar (9:30 h).
- ▶ Visto por última vez el día anterior a las 22:30 h, asintomático.
- ▶ Niega cefalea, vómitos, dolor torácico, disnea o fiebre.





Disfagia e ictus

Antecedentes personales

- ▶ Hipertensión arterial.
- ▶ Dislipemia.
- ▶ Diabetes mellitus tipo 2 de unos 15 años de evolución, con buen control (última HbA_{1c} 7,3% hace 6 meses) y sin complicaciones microvasculares previas.
- ▶ Ictus en arteria cerebral media (ACM) izquierda en 2011, sin secuelas.
- ▶ Hipertrofia prostática benigna.
- ▶ IQx: artroplastia de cadera izquierda en 2006.

Tratamiento habitual

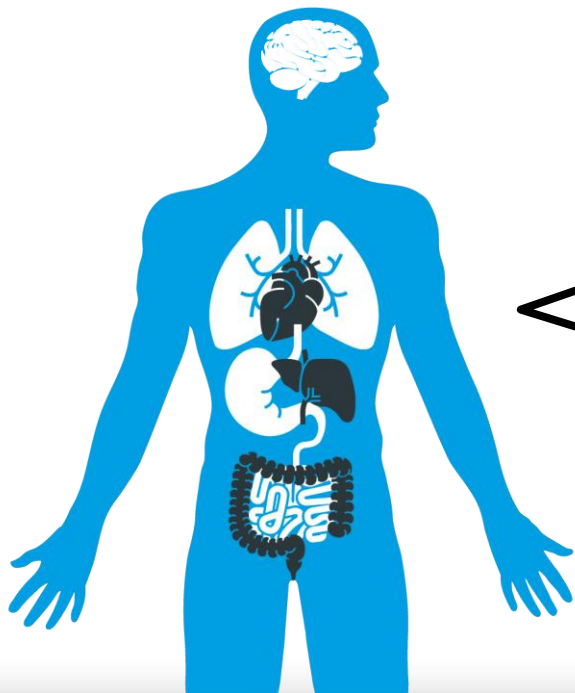
- ▶ Valsartán/hidroclorotiazida 160/12,5 mg: 1 comp./día.
- ▶ Amlodipino 5 mg: 1 comp./día.
- ▶ Atorvastatina 20 mg: 1 comp./día.
- ▶ Insulina Lantus: 16 UI /día.
- ▶ Metformina/sitagliptina 1.000/50 mg: 1 comp./12 h (no lo está tomando).
- ▶ Doxazosina 4 mg: 1 comp./día.

Situación sociofamiliar

- ▶ Viudo, vive con una cuidadora 24 h.
- ▶ Único familiar: un sobrino.
- ▶ Independiente para las actividades básicas de la vida diaria (ABVD).
- ▶ Sin deterioro cognitivo.
- ▶ Camina con apoyo.



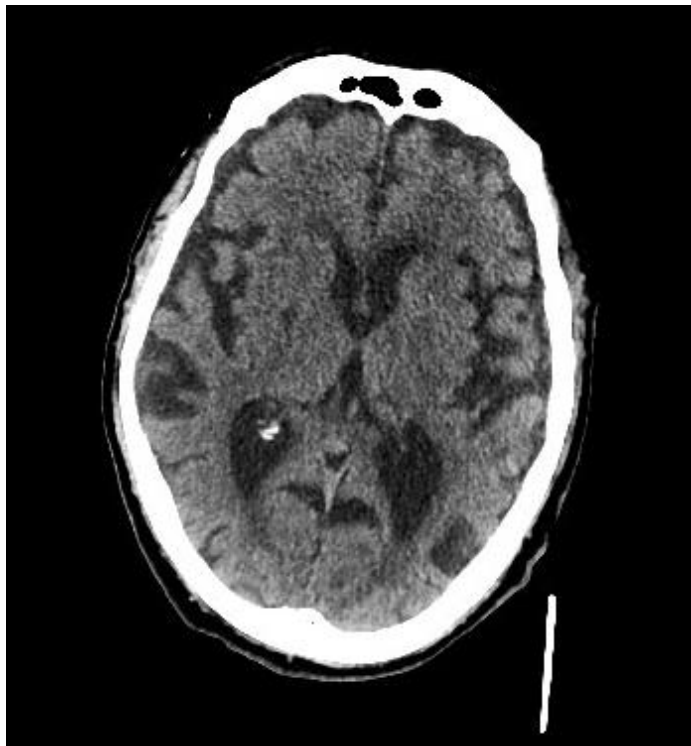
02 Exploración física y pruebas complementarias



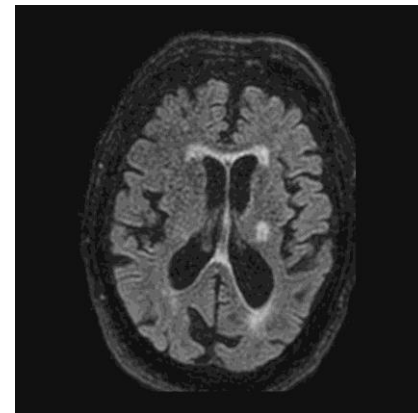
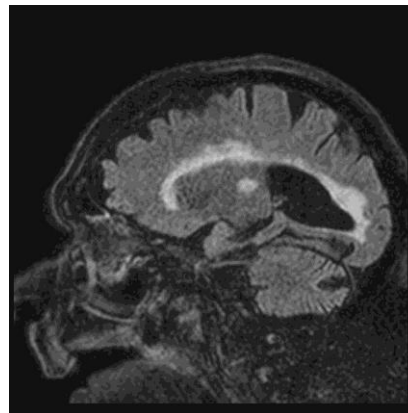
- ▶ Consciente y orientado. Glasgow 15. Marcada disartria sin aparente afasia que imposibilita la anamnesis. Parálisis del nervio facial derecho. Discreta desviación de la lengua a la derecha. Resto de los pares craneales sin alteraciones. Debilidad de MID (4/5) y MSD (3/5 proximal y 2/5 distal). Sin alteraciones de la sensibilidad. No disimetría.
- ▶ PA, 161/98 mmHg; FC, 72 lpm; SpO₂, 92% (FiO₂ 0,21). Glucemia capilar, 364 mg/dL.
- ▶ ACR: rítmica, sin soplos. MVC con subcrepitantes bibasales.



Disfagia e ictus



TAC cerebral

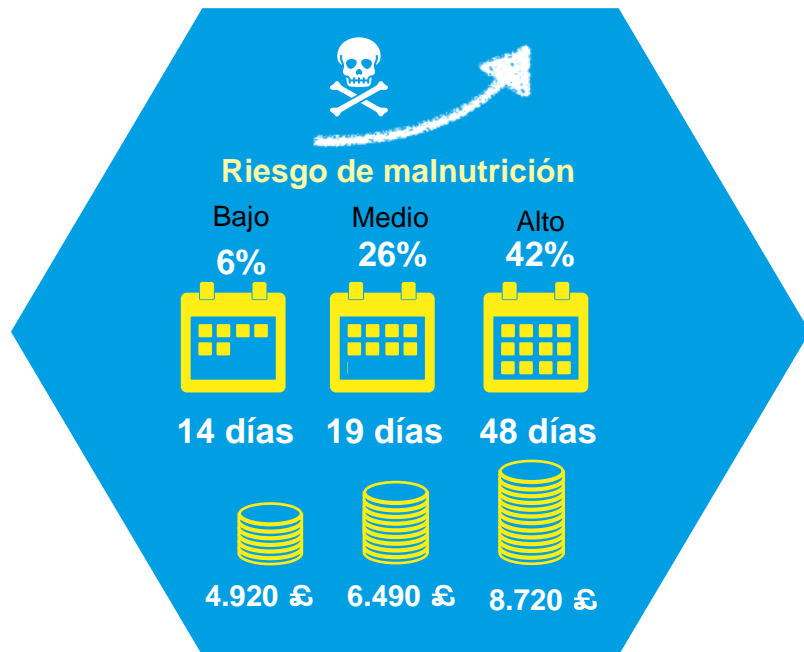


RM cerebral

- ▶ Análisis al ingreso: HbA_{1c}, 8,3%; creatinina, 1,14 mg/dL (FG estimado CKD-EPI 63 mL/min/1,73 m²); PCR, 24 mg/dL; CT, 178 mg/dL; cHDL, 48 mg/dL; Tg, 123 mg/dL.
- ▶ 24 horas después del ingreso, nos avisan para valoración y tratamiento nutricional.



03 Exploración nutricional



Adaptada de: J Stroke Cerebrovasc Dis. 2016; 25(4): 799-806.

Supervivencia y estado nutricional

- ▶ A todo paciente ingresado en las primeras 48 h.
- ▶ Método de cribado: MUST, NRS-2002...
- ▶ Si resulta negativo, repetir semanalmente.



Disfagia e ictus



ESPEN guideline clinical nutrition in neurology

Rosa Burgos, Irene Bretón, Emanuele Cereda, Jean Claude Desport, Rainer Dziewas, Laurence Genton, Filomena Gomes, Pierre Jesús, Andreas Leischker, Maurizio Muscaritoli, Kalliopi-Anna Poulia, Jean Charles Preiser, Marjolein Van der Marck, Rainer Wirth, Pierre Singer, Stephan C. Bischoff

6.1. Clinical Question 31: Which stroke patients should be screened and assessed for dysphagia?

Recommendation 52:

A formalized **screening for dysphagia** should be performed in all stroke **patients as early as possible and before oral intake**.
Grade of recommendation B — strong consensus (95% agreement)

Recommendation 53:

All stroke patients failing the dysphagia screening or demonstrating symptoms of or risk factors for dysphagia should be evaluated with a **more thorough assessment** of swallowing function as early as possible.
Grade of recommendation B — strong consensus (100% agreement)



Viscosidad →

LÍQUIDO

NÉCTAR

PUDIN



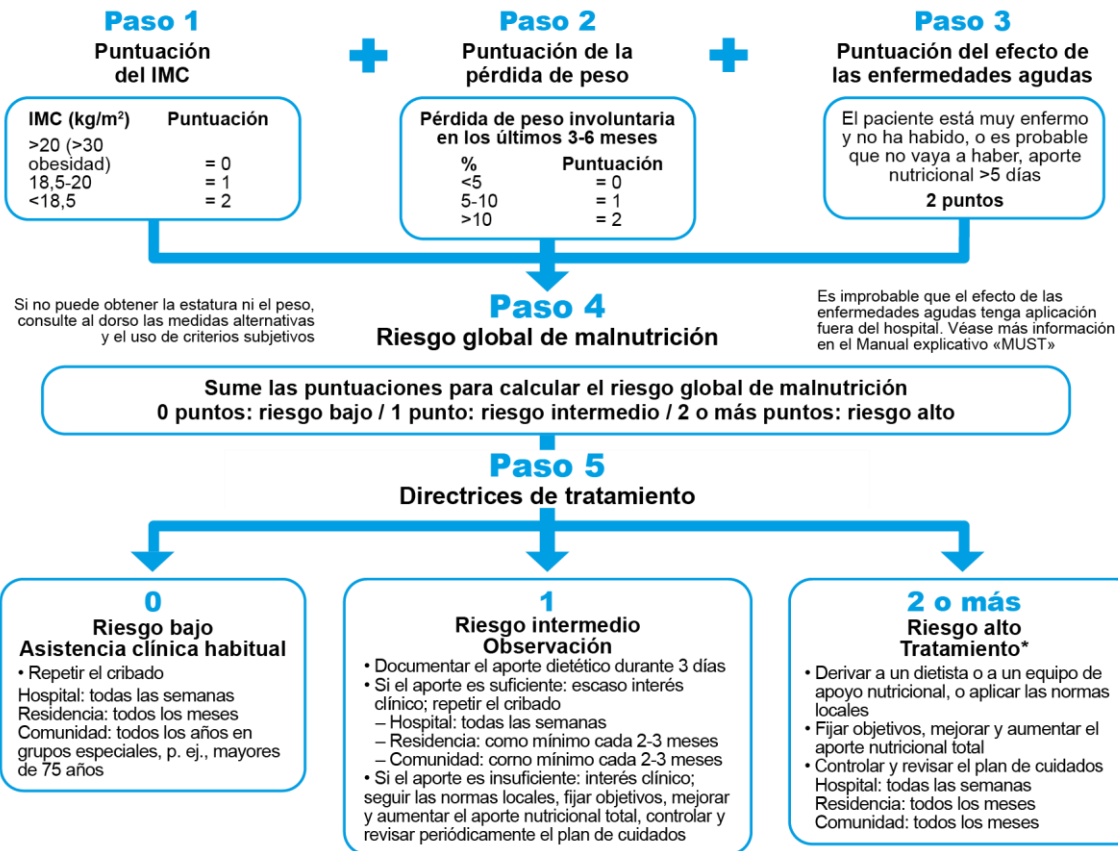


Disfagia e ictus

- ▶ Los familiares desconocen el peso o la talla previa.
- ▶ Dieta sólida previa al ingreso.
- ▶ Sin uso de espesantes (tampoco en el ictus previo).

Exploración antropométrica:

- ▶ Peso estimado: 73,5 kg; talla estimada: 167 cm; IMC: 26,3 kg/m².
- ▶ Circunferencia braquial: 30 cm; talón-rodilla: 52 cm
- ▶ Requerimientos estimados: GET 2.045 kcal; requerimientos de proteínas: 95 g/día.



*Salvo que sea perjudicial o no se espere ningún beneficio del apoyo nutricional, p. ej. En caso de muerte inminente.
Extraída de: Malnutrition Universal Screening Tool. © BAPEN 2003.



Disfagia e ictus

VISCOSIDAD	NÉCTAR			LÍQUIDO			PUDDING		
	ALTERACIONES O SIGNOS DE SEGURIDAD								
	5 ml	10 ml	20 ml	5 ml	10 ml	20 ml	5 ml	10 ml	20 ml
TOS	X								
CAMBIO DE VOZ									
DESATURACIÓN DE OXÍGENO	X						X		
	96% a 90%						96% a 92%		
	ALTERACIONES O SIGNOS DE EFICACIA								
	5 ml	10 ml	20 ml	5 ml	10 ml	20 ml	5 ml	10 ml	20 ml
SELLO LABIAL									
RESIDUO ORAL									
DEGLUCIÓN FRACCIONADA	X						X		
RESIDUO FARÍNGEO									



Conclusión: No puede emplearse la vía oral

#TexturasDeTranquilidad



Disfagia e ictus

- ▶ Cambios por pulsioximetría:
4,6% si hay aspiración;
1,4% si no hay aspiración
(precisión del pulsioxímetro:
1,8%).
- ▶ Permite detectar
aspiraciones silentes.

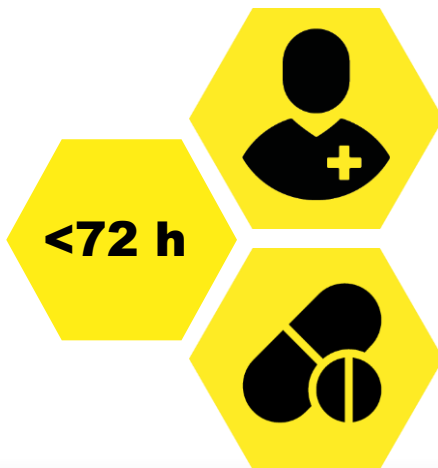




04 Diagnóstico y tratamiento

Recommendation 63:

Patients with prolonged severe dysphagia after stroke that presumably last for more than 7 days should receive early (not more than 72 h) enteral tube feeding. Grade of recommendation: GPP – strong consensus (100% agreement)



Research article

Open Access

Do nasogastric tubes worsen dysphagia in patients with acute stroke?

Rainer Dziewas*†, Tobias Warnecke†, Christina Hamacher, Stefan Oelenberg, Inga Teismann, Christopher Kraemer, Martin Ritter, Erich B Ringelstein and Wolf R Schaebitz

Abstract

Background: Early feeding via a nasogastric tube (NGT) is recommended as safe way of supplying nutrition in patients with acute dysphagic stroke. However, preliminary evidence suggests that NGTs themselves may interfere with swallowing physiology. In the present study we therefore investigated the impact of NGTs on swallowing function in acute stroke patients.

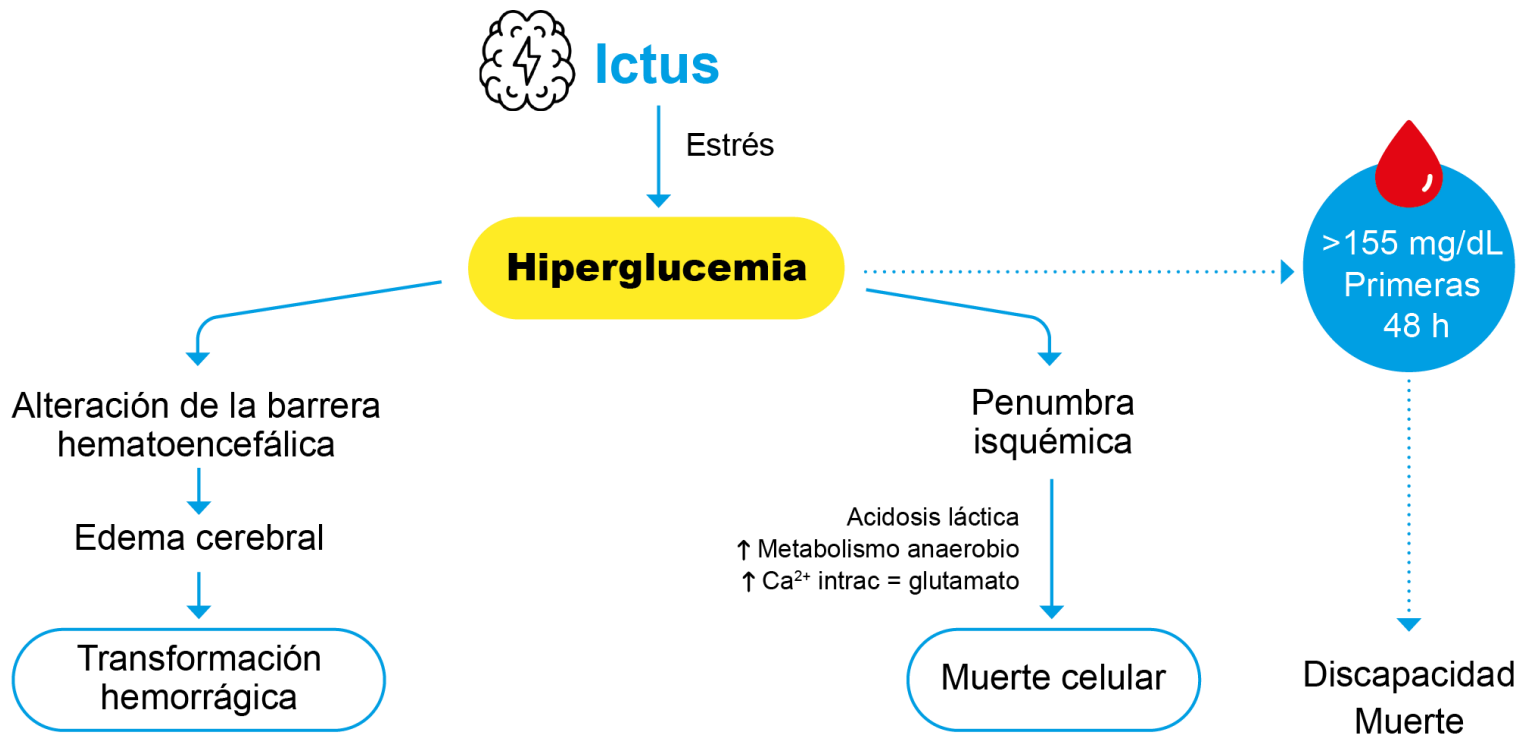
Methods: In the first part of the study the incidence and consequences of pharyngeal misplacement of NGTs were examined in 100 stroke patients by fiberoptic endoscopic evaluation of swallowing (FEES). In the second part, **the effect of correctly placed NGTs on swallowing function** was evaluated by serially examining 25 individual patients with and without a NGT in place.

Results: A correctly placed NGT did not cause a worsening of stroke-related dysphagia. Except for two cases, in which swallowing material got stuck to the NGT and penetrated into the laryngeal vestibule after the swallow, **no changes of the amount of penetration and aspiration were noted with the NGT** in place as compared to the no-tube condition. Pharyngeal misplacement of the NGT was identified in 5 of 100 patients. All these patients showed worsening of dysphagia caused by the malpositioned NGT with an increase of pre-, intra-, and postdeglutitive penetration.

Conclusion: **Based on these findings, there are no principle obstacles to start limited and supervised oral feeding in stroke patients with a NGT in place.**



Fisiopatología de la hiperglucemia en el ictus agudo





05 Seguimiento y evolución



▶ FASE 1



▶ FASE 2



▶ FASE 3



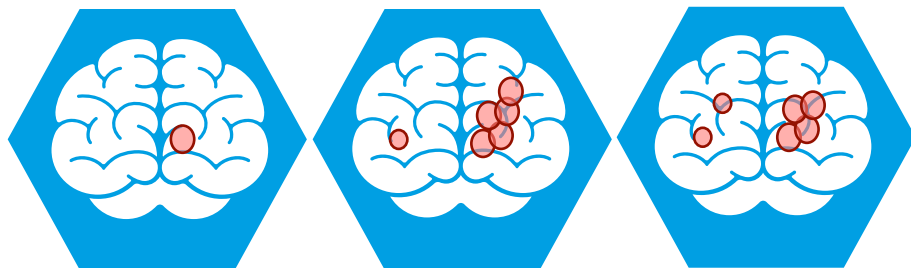
▶ FASE 4

- ▶ SNG con Novasource® Diabet Plus a 81 mL/h con buena tolerancia
- ▶ MECV-V tras 3 días: alta seguridad



Disfagia e ictus

Representación faríngea cortical



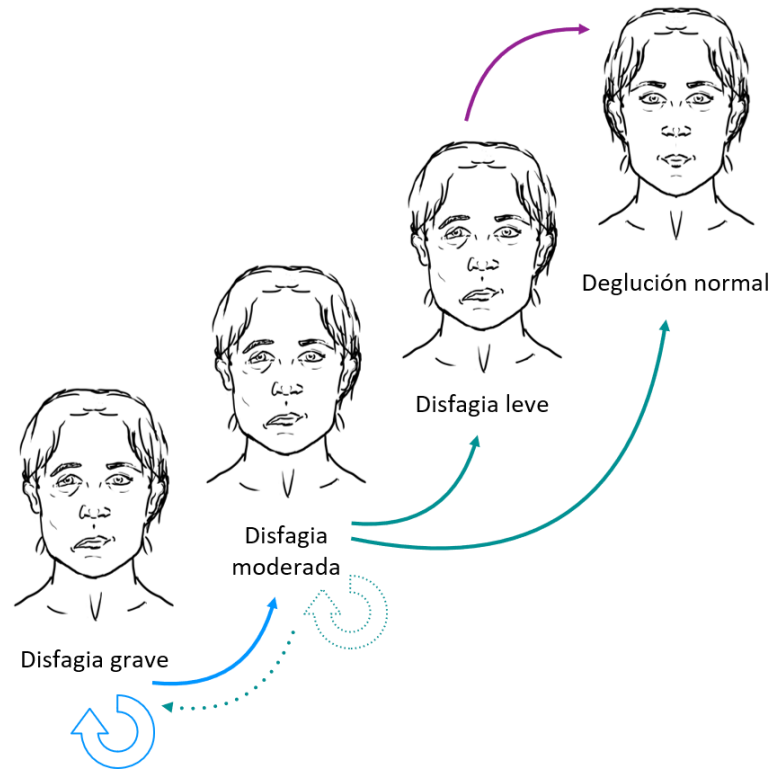
Tras ictus
CON disfagia

1 mes

3 meses

Neuroplasticidad

Reorganización del hemisferio contralateral





Disfagia e ictus



▶ FASE 1

- ▶ SNG con Novasource® Diabet Plus a 81 mL/h con buena tolerancia
- ▶ MECV-V tras 3 días: alta seguridad



▶ FASE 2

- ▶ MECV-V a los 15 d: pudin seguro (fracciona toma 10 mL)
- ▶ Iniciamos dieta disfagia tx CB 29,5 cm (2%pp)



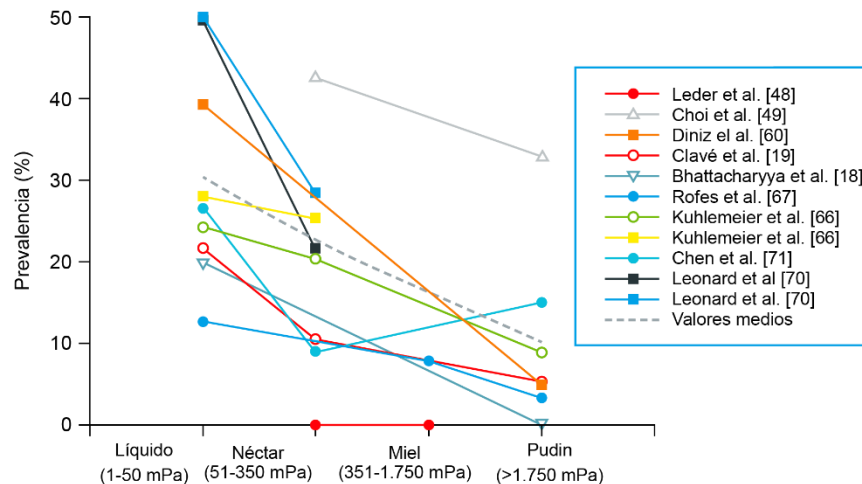
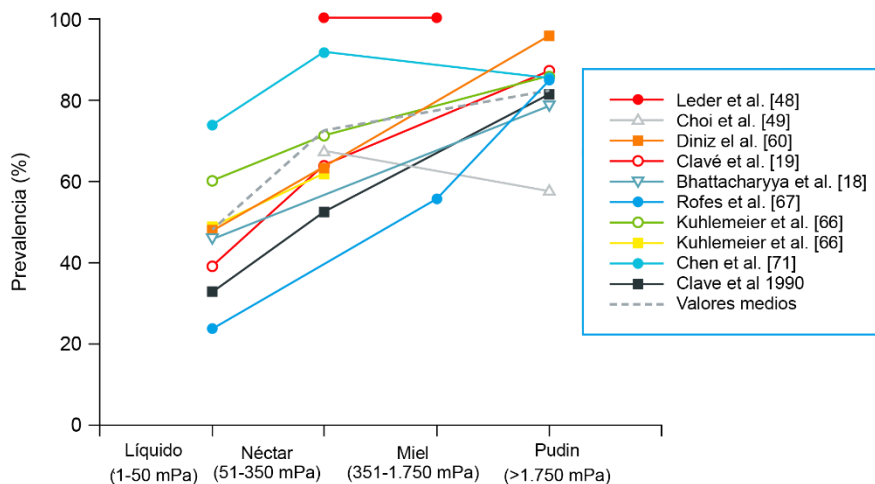
▶ FASE 3



▶ FASE 4



Viscosidad y seguridad en la deglución





Disfagia e ictus



▶ FASE 1

- ▶ SNG con Novasource® Diabet Plus a 81 mL/h con buena tolerancia
- ▶ MECV-V tras 3 días: alta seguridad



▶ FASE 2

- ▶ MECV-V a los 15 d: pudín seguro (fracciona toma 10 mL)
- ▶ Inicia dieta disfagia tx CB 29,5 cm (2%pp)



▶ FASE 3

- ▶ Dieta disfagia tx + Resource® Diabet Dense 2 ud
- ▶ Se retira NE por SNG
- ▶ MECV-V (alta): miel 10 mL
- ▶ Cita en CC.EE. en 2 m



▶ FASE 4

- ▶ CC.EE. (2,5 m): dieta disfagia tx (**líquidos néctar**)
- ▶ MECV-V: néctar y líquido sin alta seguridad (fracciona 20 mL)
- ▶ CB 30,3 cm
- ▶ HbA_{1c} 6,2%



06 Conclusiones

- ▶ Es necesario identificar a los pacientes con disfagia y desnutrición tras un ictus (cribado y valoración).
- ▶ Debemos evitar la hiperglucemia en el ictus agudo.
- ▶ Reevaluar periódicamente la disfagia.
- ▶ Optimizar la situación nutricional y evitar que el paciente se desnutra. Infradiagnóstico...



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