****

**BARTS HEALTH NHS TRUST VIDEOFLUOROSCOPY ASSESSMENT REPORT**

|  |  |  |
| --- | --- | --- |
| **Name:**  | **DOB:**  | **NHS Number:**  |
| **Date of assessment:**  | **Radiologist:**  | **Managing SLT:**  |
| **Relevant Medical History:**  |
| **Reason for Referral:**  |
| **Current nutritional Intake:**  |
| **Current Communication:**  |

**IMPRESSION AND SUMMARY OF FINDINGS**

|  |
| --- |
| If this is a repeat study – comment on comparison with previous study and whether any change etc.If additional factors are taken into account in formulating the management plan, they should be noted here – eg impulsiveness, candidacy for therapy or use of compensatory strategies etc. |
| **Recommendation:*** Food/Fluids
* NBM/ non-oral/oral/ mixed.
* Management strategies re swallow
* Management strategies re maximising voice quality
* Management strategies re voice prosthesis selection
* Arrangements for review.
* Procedure for therapy
* Other investigations / interventions
 |
| **Plan:**  |

**ASSESSMENT FINDINGS IN DETAIL:**

|  |  |
| --- | --- |
| **Consistencies trialled:**  | **Bolus presentation:** Able to follow all instructions and was self-feeding. |
| **Views:** Lateral, Lateral-oblique & Antero-posterior | **Contrast:** Omnipaque, Baritop liquid and Bartitop powder.  |
| **Anatomical features/ Abnormalities:** * Stoma identified at
* pseudo-valleculae
* Upper anastomosis viewed at
* Lower anastomosis
* Peristalsis commences at
* Flap reconstruction (identify type)
* Anastomosis identified at - (identify level of spine)
* Hypothesised myotomised area from identified at (identify level of spine)
* Peristalsis commences at (identify level of spine)
* Reconstructed segment identified at (identify level of spine)
 |
| **General:** * consent
* standing/seated
* Oxygen
* follow all instructions provided ?
* Positioning
* Anatomy – comment on any structural abnormality seen on the initial view – eg. osteophytes, post-Sx ‘metalwork’, any abnormally thickened structures etc

**Oral Stage:** * lip and tongue ROM/apparent strength
* palatal movement/elevation
* glossopalatal seal
* bolus formation, manipulation and AP transfer,
* timeliness and cohesiveness of transfer
* post-swallow oral residue, awareness of this, success in spontaneously clearing, success in clearing with prompting
* premature spillage secondary to poor oral control

**Pharyngeal Stage:** * pre-swallow pharyngeal pooling (“to the level of \_\_\_\_\_\_\_\_\_”)
* timing/site of swallow trigger and any variability in this within or across textures
* any nasal backflow?
* BOT to PPW approximation
* Bolus flow and maximum dilation
* Any anatomical obstruction/stricture
* Post swallow residue – where? awareness? ability to clear spontaneously or with prompting?
* Aspiration (via TEP) – when? On which texture(s)? Estimated amount/severity? Airway response? Effectiveness of cough – reflexive/ prompted ?
* Effect of compensatory strategies (or put in separate box below)
* Any fatigue effect

**A-P view:*** symmetry of swallow, residue etc

**Oesophageal stage (if appropriate):** * flow through proximal oesophagus
* any hold up, backflow, presence of osteophytes etc
* tertiary contractions

**Voicing*** Air insufflation catheter inserted transnasally via XX nostril, with tip observed at (identify level of spine)
* Oxygen introduced at 0.5, 1, 1.5, 2 and 2.5 l/min
* Voice prosthesis in situ at (identify level of spine)
* Vibratory source/segment visualised at (identify level of spine)
* Describe vibration and voicing at each volume of O2 trialled (e.g. audible, tonic, hypotonic, hypertonic, mixed tonicity, spasmodic)
* Any muscle activity on voicing?
* Any focal areas of narrowing on voicing? Does the area distend at all?
* Optimal voice quality / maximum tonicity was achieved with …. O2
 |
|  |  |

c.c. Medical notes, SLT file and patient copy.