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6



Prediction of aspiration in dysphagia using logistic regression: oral intake and self-evaluation

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ABSTRACT

Objectives

Oropharyngeal dysphagia (OD) has a major influence on health in general and health-related quality of life (HR-QoL) in particular. The gold standard assessments for OD, especially for aspiration in OD, are fiberoptic endoscopic evaluation of swallowing (FEES) and videofluoroscopy (VFS), but not all patients have access to such procedures. Therefore, the current study built a prediction model to forecast aspiration in patients with OD on the basis of common self-evaluation questionnaires and oral intake status.

Methods

A consecutive series of 111 patients with confirmed diagnosis of OD was measured according to a standardised protocol using the following tools: the Swallowing Quality of Life Questionnaire (SWAL-QOL), the Dysphagia Handicap Index (DHI), two self-report visual analogue scales which measure the severity and the impairment of the swallowing problem on everyday social life as experienced by the patient, the Eating Assessment Tool 10 (EAT-10), the Functional Oral Intake Scale (FOIS) and subsequently FEES (the gold standard). Penalised logistic regression was carried out to predict aspiration. The performance of the resulting models was evaluated by constructing receiver operating characteristics (ROC) curves and computing areas under the curve (AUC).

Results

The final model showed an AUC of 0.92, indicating excellent performance.

Conclusion

This study shows that it may be possible to accurately predict aspiration in oropharyngeal dysphagia by a non-invasive and non-instrumental assessment protocol including oral intake status and self-report questionnaires on functional health status and HR-QoL.

INTRODUCTION

Oropharyngeal dysphagia (OD) has a major influence on health in general and notably on health-related quality of life (HR-QoL)[1-3]. OD is known to negatively influence social life; patients may no longer enjoy eating and drinking, and may avoid social activities[1]. In turn, OD can cause dehydration and malnutrition[2, 4]. Moreover, OD has economic consequences; Bonilha et al.[5] calculated that the costs for OD in stroke patients were \$ 4510 per patient per year. For all of these reasons, detecting OD and optimising its care is increasingly important.

Aspiration or silent aspiration in severe OD can cause aspiration pneumonia and, when accompanied by malnutrition and dehydration, can lead to hospitalization, IC admission or even death[2, 4]. The gold standards for detecting aspiration and silent aspiration are videofluoroscopic (VFS) and fiberoptic endoscopic evaluation of swallowing (FEES). While both have a high sensitivity and specificity[6], they are invasive, may be burdensome for the patient and are expensive. Moreover, these gold standards are not generally available in clinical settings such as a nursing home or general practice. Screening for OD can be performed in various ways such as by trial swallows using water or substances with different viscosities, by oxygen desaturation or by cough elicitation[7, 8]. Screening should be sufficiently sensitive and specific but also easy to administer without extensive training[7]. When patients fail the screening, further assessment of OD is recommended. Numerous assessments are available to evaluate OD in further detail. Each one is focussed on certain domains such as functional health status (FHS), health-related quality of life (HR-QoL) or oral intake. Two commonly used FHS questionnaires are the Eating Assessment Tool (EAT-10)[9] and the Sydney Swallow Questionnaire (SSQ)[10], and a common HR-QoL questionnaire is the Swallowing Quality of Life questionnaire (SWAL-QOL)[11]. Self-evaluation questionnaires such as the Dysphagia Handicap Index (DHI)[12] include items on both HR-QoL and FHS. Some measures have several subscales and over 40 items (e.g., SWAL-QOL), whereas others consist of a single visual analogue scale on swallowing function[13] or a single ordinal scale on oral intake (e.g., Functional Oral Intake Scale or FOIS)[14].

The presence of aspiration is the most critical clinical sign in patients with OD. However, the literature[15, 16] reveals a moderate to low correlation between self-evaluation questionnaires and aspiration as determined by FEES or VFS. Also, oral intake as assessed by the FOIS shows weak correlations with aspiration[14].

Predictive modelling entails developing a mathematical tool that generates an accurate prediction[17]. Several studies on dysphagia have used predictive modelling to forecast swallowing problems based on various criteria: for example, dosimetric parameters in radiotherapy[18, 19], tumour size and location[19], VFS parameters[20] or cervical

auscultation[21]. The predicted outcome of the models ranged from radiotherapy-induced dysphagia[18, 19] to persistent dysphagia after stroke[20] and presence of aspiration[21]. The predicted outcome of most studies was dysphagia, though not differentiating between dysphagia with or without aspiration. To the best of our knowledge, no models thus far have used individual or combined self-evaluation questionnaires on FHS and/or HR-QoL in OD for predicting aspiration.

Clinicians often employ patient self-evaluation in daily clinical practice and recognise the importance of early detection of aspiration when working with patients with OD. With their co-operation, predictive modelling using questionnaires as predictors and aspiration as the outcome becomes an option. The possibility of collaboration led to the design for the current study: the purpose was to build a predictive model that could forecast aspiration in patients with OD using oral intake status and commonly used self-evaluation questionnaires on FHS and HR-QoL.

METHODS

Patients

The study included a consecutive series of patients with OD who visited the outpatient clinic of the department of Otorhinolaryngology and Head and Neck Surgery of the Leiden University Medical Centre. Patients were included if they (1) were at least 18 years old and (2) were not suffering from severe cognitive problems. All had a confirmed diagnosis of OD based on FEES examination by an experienced ENT specialist or speech-language pathologist (SLP). This study was approved by the local Medical Ethical Committee.

Measures

As part of standard care at the outpatient clinic of the department of Otorhinolaryngology and Head and Neck Surgery, all patients completed several self-evaluation questionnaires during the week prior to their FEES exam. The following standardised protocols were used (listed in order of administration).

1. The *SWAL-QOL*[11, 22, 23] is a 44-item questionnaire on HR-QoL. It is considered to be the gold standard for measuring HR-QoL in OD[24]. The *SWAL-QOL* consists of ten subscales (Burden, Eating duration, Eating desire, Food selection, Communication, Fear, Mental health, Social functioning, Fatigue and Sleep) and one symptom scale (14 items, among which coughing, choking, gagging and drooling)[25]. The minimum and maximum scores on each subscale range from

- 0 to 100: not impaired to extremely impaired HR-QoL, respectively.
2. The *DHI*[12] measures FHS as well as HR-QoL. This 25-item questionnaire concerns the effect of OD on Physical (9 items), Functional (9 items) and Emotional (7 items) aspects of patients' lives. Each item is scored as 0, 2 or 4, with higher scores meaning more severe disability. The total score ranges from 0 to 100. The DHI has one additional question about the severity of a patient's swallowing problem ranging from 1-7 (Severity question: 1 normal, 7 severe problem).
 3. Each of two concise self-report 100-mm *Visual Analogue Scales (VAS)*[13] measures a certain aspect of swallowing. One concerns the severity of the swallowing problem as experienced by the patient (Severity: FHS), whereas the other measures the perceived impact of the swallowing problem on everyday social life (Impairment: HR-QoL). Higher scores indicate greater impairment (range 0 - 100).
 4. The *EAT-10*[9] is a short 10-item self-administered questionnaire[8]. Although predominantly regarding FHS, it also includes some HR-QoL items [26]. Each one is rated on a five-point scale (0-4); the summed score ranges from 0 to 40 (higher scores are more abnormal). A sum of ≥ 2 [27] or ≥ 3 [9] is considered abnormal.
 6. The *Functional Oral Intake Scale (FOIS)*[14] registers actual oral intake. The scores range from 1 (nothing by mouth) to 7 (total oral diet with no restrictions). During a patient's visit to the outpatient clinic, the FOIS was completed by the clinician.

Subsequently, FEES was performed according to a standardised protocol[28]. Patients were offered three swallow trials of three different consistencies (nine trials maximum): methylene blue dyed water (thin) or applesauce (thick) in portions of 10 mL and three bite-sized crackers with a fixed weight of 3.3 g (solid). In the event of aspiration, the trial of that particular consistency was stopped. FEES examinations were performed with a XION chip-on-the-tip flexible nasendoscope (Berlin, Germany). Results were recorded with RVC Clinical Assistant (Baarn, the Netherlands), a medical archive and image viewer. Recordings were rated by consensus among two SLPs using the Penetration Aspiration Scale (PAS)[29]. FEES results were dichotomised into no aspiration (PAS score 1-3) or aspiration (PAS scores 4-8)[30]. If the patient aspirated during any of the (maximum of) nine trials with any of the three consistencies, he or she was considered an aspirator in this study. All patients were categorised either as aspirating or not.

Statistical analysis

Logistic regression was used to predict the outcome (dichotomous variable: aspiration present/absent). Model performance was evaluated by constructing receiver operating characteristics (ROC) curves and computing areas under the curve (AUC). In order to

objectively evaluate whether individual questionnaire items contributed to prediction, a penalised version of logistic regression was used on all items. To that end, a variant of the LASSO regression was applied, namely the elastic net. LASSO allows to simultaneously perform model selection and estimation, whereby variables not contributing to prediction are removed from the model. A penalty parameter determines how many variables are retained. This parameter is chosen automatically by a cross-validation procedure. AUC and *glmnet* packages in R version 3.4.0 were used for all analyses[31].

RESULTS

Patient characteristics

One-hundred-eleven patients were included from June 2014 till November 2015 (Table 1). Sixty-seven subjects (60%) were male with a median age of 65 years (IQR 58-71) compared to 44 (40%) female subjects with a median age of 67 years (IQR 52-74). Medical diagnoses included head and neck cancer (36%) and neurological disorders (37%) such as stroke, Parkinson's disease, multiple sclerosis and myotonic dystrophy. The remaining patients (27%) had diagnoses like general weakness due to other diseases, cricopharyngeal muscle hypertrophy or epiglottitis. The median FOIS score for the total group was 6 (IQR 4-7), so most patients had an oral intake with some restrictions.

Descriptive statistics

Table 2 displays the descriptive statistics for the SWAL-QOL, DHI, VAS and EAT-10. The median scores on the SWAL-QOL subscales were Burden 38 (IQR 13-75), Eating duration 38 (IQR 0-75), Eating desire 67 (IQR 33-92), Food selection 63 (IQR 25-75), Communication 75 (IQR 38-88), Fear 75 (IQR 56-94), Mental health 55 (IQR 35-85), Social functioning 55 (IQR 30-85), Fatigue 58 (IQR 33-75) and Sleep 75 (IQR 38-88). The median SWAL-QOL symptom score was 61 (IQR 46-71). The median DHI total score was 48 (IQR 28-64) and the additional DHI Severity question showed a median of 5 (IQR 4-6). The median VAS scores on Severity and Impairment were 51 (IQR 30-80) and 55 (IQR 30-85) mm, respectively. The EAT-10 had a median score of 15 (IQR 8-23).

FEES showed no aspiration in any of the nine trials using three different viscosities (thin, thick, solid consistency) in 90 (81%) patients. A group of 21 (19%) patients aspirated on at least one swallow trial.

Table 1. Subject characteristics

	Total group	111
Number of subjects [n (%)]	Male (%)	67 (60)
	Female (%)	44 (40)
Age in years [Med (IQR)]	Total group	66 (56-72)
	Male	65 (58-71)
	Female	67 (52-74)
Medical diagnosis [n (%)]	Head and neck cancer	40 (36)
	Neurological disorder	41 (37)
	Other	30 (27)
FOIS ¹ [Med (IQR)]		6 (4-7)

1 Range 1 – 7: ‘Nothing by mouth’ to ‘Total oral diet with no restrictions’.

Prediction modelling

To build prediction models, first two sets of variables (A and B) were specified a-priori (Table 3). In a second, exploratory step, automatic variable selection was used to choose the prediction model.

Pre-specified variables

The first set of variables (A) in the logistic regression model was selected on the basis of the literature and clinical experience. Six subscales of the SWAL-QOL (HR-QoL) were considered of lesser importance to oropharyngeal dysphagia and, therefore, excluded: Communication, Fear, Mental health, Social functioning, Fatigue and Sleep[32]. The remaining subscales, namely Burden, Food selection, Eating duration and Eating desire, and the Symptom scale of the SWAL-QOL were included, as were the DHI total subscale scores (Functional, Physical and Emotional subscales) and both VAS scales on swallowing (Severity and Impairment)[13]. As coughing is considered a clinically relevant symptom of aspiration, item 9 of the EAT-10 (I cough when I eat) was also listed [33]. Lastly, the FOIS was added to include information about oral intake. This prediction model yielded an AUC of 0.862.

The second set (B) included fewer variables: the subscale Food selection of the SWAL-QOL, the DHI subscales (Functional, Physical and Emotional), item 9 of the EAT-10 and the FOIS. Both VAS scales and the remaining SWAL-QOL subscales were excluded. This reduced model obtained an AUC of 0.852.

The first analysis using set A identified a non-linear association between the gold standard and the Symptom scale of the SWAL-QOL, which led to the inclusion of a quadratic term for the Symptom scale score. Based on this second model, an AUC of

0.874 was found. Because the Symptom scale score was not included in set B, this prediction model remained unchanged.

Score X =

$$\begin{aligned}
 & 18.6591708 + (0.0007031 * \text{SWAL-QOL Burden}) + (0.0326739 * \text{SWAL-QOL Food Selection}) \\
 & - (0.0219832 * \text{SWAL-QOL Eat duration}) + (0.0081344 * \text{SWAL-QOL Eat desire}) - \\
 & (0.2093808 * \text{SWAL-QOL Symptom}) + (0.0020425 * \text{SWAL-QOL Symptom Squared}) + \\
 & [(0.6740265 * \text{DHI item 1p score 2}) + (3.5526187 * \text{DHI item 1p score 4})] - [(19.2522260 * \text{DHI} \\
 & \text{Severity Question score 2}) - (36.8925068 * \text{DHI Severity Question score 3}) - (19.3098857 * \\
 & \text{DHI Severity Question score 4}) - (19.9454640 * \text{DHI Severity Question score 5}) - \\
 & (18.4990410 * \text{DHI Severity Question score 6}) - (15.9065488 * \text{DHI Severity Question score} \\
 & 7)] - (0.0363491 * \text{VAS Severity}) + (0.0428708 * \text{VAS Impairment}) + [(4.6092903 * \text{EAT10 item} \\
 & 9 \text{ score 1}) + (4.3063001 * \text{EAT10 item 9 score 2}) + (3.6040778 * \text{EAT10 item 9 score 3}) + \\
 & (1.8982514 * \text{EAT10 item 9 score 4})] - (0.4016869 * \text{FOIS})
 \end{aligned}$$

The inverse logistic function of the final score X indicates the chance of aspiration:

$$P_{\text{aspiration}} f(x) = 1/(1 + \exp(-x))$$

Automatic variable selection

The first penalised logistic regression included all available variables. Based on this regression, certain variables were added to sets A (model 2) and B (model 1). For the first set of variables (A), the DHI additional question on severity (Severity question) and the DHI item 1p ('I cough when I drink') were added. For the second set (B), the squared Symptom scale score was added in addition to the two DHI items (Severity question and item 1p). This yielded AUCs of 0.922 for set A and 0.915 for set B.

Table 3 provides an overview of the included variables and the results per prediction model by showing per item the odds ratio, 95% confidence interval and p-value. Figure 1a-e presents ROC figures and AUC outcomes per model. The following formula predicts the presence of aspiration in an individual subject based on the penalised logistic regression model (model 3) using the first set of variables A with an AUC of 0.922:

Thus, to determine the chance of aspiration in an individual with OD, the following scores need to be entered in the formula:

- SWAL-QOL: subscales Burden, Food Selection, Eat Duration, Eat Desire and Symptom score (ranging from 0 to 100);
- DHI: Item 1p and Severity question. In the formula variables are included per score

Table 2. Descriptive analysis of patient self-evaluation questionnaires (n=111): SWAL-QOL, Dysphagia Handicap Index (DHI), Visual Analogue Scales (VAS), EAT-10.

Questionnaire ¹	(Sub)scale	Range scale	Median (IQR)
SWAL-QOL	Burden	0-100	38 (13-75)
	Eating duration	0-100	38 (0-75)
	Eating desire	0-100	67 (33-92)
	Food selection	0-100	63 (25-75)
	Communication	0-100	75 (38-88)
	Fear	0-100	75 (56-94)
	Mental health	0-100	55 (35-85)
	Social functioning	0-100	55 (30-85)
	Fatigue	0-100	58 (33-75)
	Sleep	0-100	75 (38-88)
	Symptom score	0-100	61 (46-71)
DHI	Physical	0-36	16 (10-22)
	Functional	0-36	20 (10-28)
	Emotional	0-28	10 (4-18)
	Total score	0-100	48 (28-64)
	Severity question	1-7	5 (4-6)
VAS	Severity (FHS)	0-100	51 (30-80)
	Impairment (HR-QoL)	0-100	55 (30-85)
EAT-10	Total score	0-40	15 (8-23)

¹ Higher scores indicate higher degree of disability.

for item 1p (score 0, 2 or 4) and for Severity question (score 2 to 7; not 1). These variables include binary numbers (present = 1; absent = 0); For example, if item 1p is scored 2, the section of the formula relating to item 1p is completed as follows: $(0.6740265 * 1) + (3.5526187 * 0)$;

- VAS: Severity and Impairment (score 0-100);
- EAT10: item 9. In the formula variables are included per score for item 9 (score 1, 2, 3 or 4). These variables are expressed as binary numbers (present = 1; absent = 0);
- FOIS (score 0-7).

Next, to determine the chance of aspiration, the inverse logistic function of the final score *X* needs to be calculated.

Table 3. Overview of included variables and results per prediction model.

	Model 1			Model 2			Model 3 (LASSO)				
	Set A (figure 1a) AUC 0.862	Set B (figure 1b) AUC 0.852	Set A (figure 1c) AUC 0.874	Set A (figure 1d) AUC 0.922	Set B (figure 1e) AUC 0.915	OR	95% CI	P-value	OR	95% CI	P-value
(Intercept)	NA	NA	NA	NA	NA	0.52	NA	1.00	NA	NA	1.00
SWAL-QOL Burden	0.99	0.96-1.02	0.39	0.99	0.96-1.01	0.31	1.00	0.97-1.03	0.96		
SWAL-QOL Food selection	1.02	0.99-1.05	0.14	1.02	1-1.04	0.06	1.03	1.00-1.07	0.05	1.04	1.00-1.07
SWAL-QOL Eating duration	1.01	0.98-1.03	0.67	1.00	0.97-1.03	0.97	0.98	0.94-1.01	0.21		
SWAL-QOL Eating desire	1.00	0.98-1.02	0.96	1.00	0.98-1.02	0.98	1.01	0.98-1.04	0.57		
SWAL-QOL Symptom	0.99	0.94-1.03	0.57	0.82	0.66-1.01	0.06	0.81	0.61-1.07	0.14		
SWAL-QOL Symptom squared				1.00	1.00-1.00	0.06	1.00	1.00-1.00	0.10	1.00	1.00-1.00
DHI Subscale Physical	0.95	0.86-1.05	0.33	0.96	0.87-1.05	0.34	0.95	0.86-1.05	0.31	0.90	0.80-1.02
DHI Subscale Functional	1.04	0.94-1.16	0.41	1.05	0.96-1.15	0.29	1.04	0.94-1.16	0.44	1.11	0.99-1.24
DHI Subscale Emotional	1.03	0.91-1.15	0.67	1.07	0.97-1.18	0.17	1.01	0.89-1.13	0.92	1.02	0.91-1.14
DHI item 1 p ¹ score 2				1.96	0.28-13.98	0.50	2.79	0.41-19.11	0.30		
DHI item 1 p ¹ score 4				34.90	1.91-638.76	0.02	46.57	2.87-756.22	0.01		
DHI Severity Question ² score 2				0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF
DHI Severity Question ² score 3				0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF
DHI Severity Question ² score 4				0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF
DHI Severity Question ² score 5				0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF
DHI Severity Question ² score 6				0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF

DHI Severity Question ² score 7	0.00	0.00-INF	1.00	0.00	0.00-INF	1.00	0.00	0.00-INF	1.00
VAS Severity	0.99	0.96-1.03	0.76	0.99	0.95-1.03	0.73	0.96	0.91-1.02	0.21
VAS Impairment	1.01	0.98-1.05	0.45	1.02	0.98-1.06	0.44	1.04	0.99-1.10	0.14
EAT10 item 9 ³ score 1	33.87	3.70-310.01	0.00	30.25	3.78-241.77	0.00	100.41	3.05-3300.58	0.01
EAT10 item 9 ³ score 2	15.82	1.62-154.72	0.02	16.05	1.86-138.56	0.01	28.15	2.29-346.29	0.03
EAT10 item 9 ³ score 3	47.62	4.42-513.04	0.00	51.11	5.42-481.70	0.00	80.10	5.83-1100.82	0.00
EAT10 item 9 ³ score 4	26.80	2.41-298.47	0.01	33.04	3.39-321.76	0.00	35.89	2.75-469.06	0.01
FOIS	0.72	0.49-1.07	0.11	0.70	0.48-1.02	0.06	0.69	0.45-1.06	0.09

¹DHI item 1p: cough when I drink (score 1- 3: never, sometimes, always). ²DHI: Patient self-rated severity of dysphagia (score: 0-7; normal to severe problem).

³EAT-10 item 9: I cough when I drink (score: 0-4; no problems - severe problems).

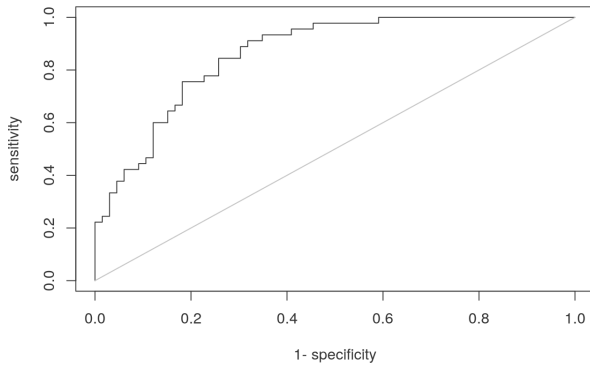


Figure 1a. *ROC Model 1* Variable set (A) included the following variables: SWAL-QOL subscales Burden, Food selection, Eat duration, Eat desire and Symptom scale, DHI subscales (Functional, Physical and Emotional), VAS scales (Severity and Impairment), EAT-10 item 9 ('I cough when I eat') and FOIS. AUC 0.862.

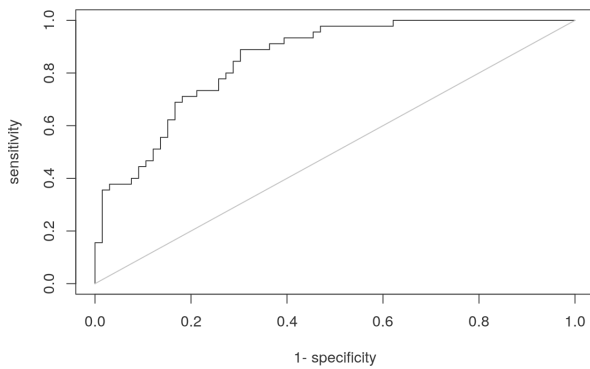


Figure 1b. *ROC Model 1* Variable set (B). Reduced model to SWAL-QOL Food Selection, DHI subscales (Functional, Physical and Emotional), EAT-10 item 9 ('I cough when I eat') and FOIS. AUC 0.852.

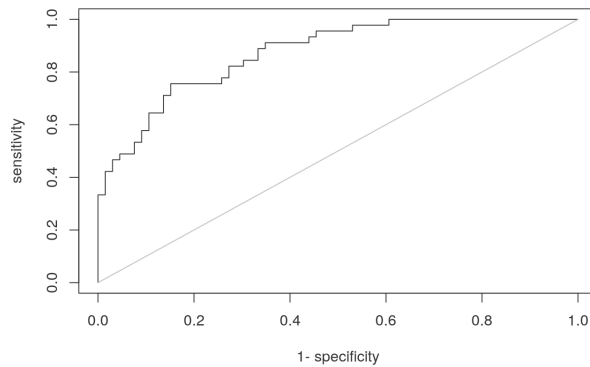


Figure 1c. *ROC Model 2* Variable set (A), included the following variables: SWAL-QOL subscales Burden, Food selection, Eat duration, Eat desire, Symptom scale and Symptom scale squared, DHI subscales (Functional, Physical and Emotional), VAS scales (Severity and Impairment), EAT-10 item 9 ('I cough when I eat') and FOIS. AUC 0.874

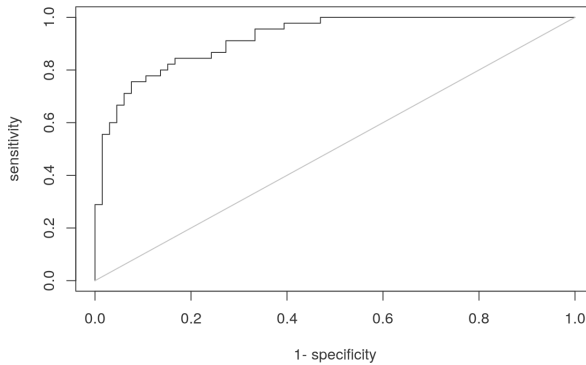


Figure 1d. ROC Model 3 Variable set (A) included the following variables: SWAL-QOL subscales Burden, Food selection, Eat duration, Eat desire, Symptom scale and Symptom scale squared, DHI item 1p ('I cough when I drink'), DHI Severity Question, VAS scales (Severity and Impairment), EAT-10 item 9 ('I cough when I eat') and FOIS. AUC 0.922

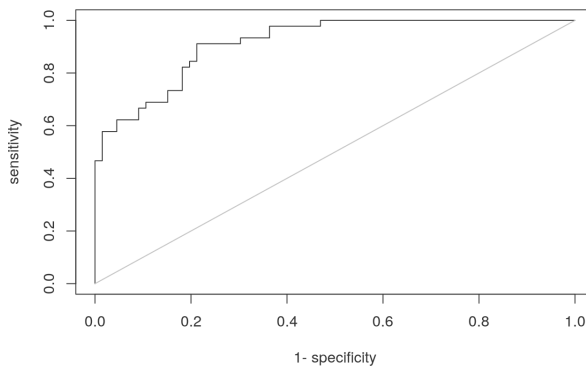


Figure 1e. ROC Model 3 Variable set (B) included the following variables: SWAL-QOL subscales Food selection and the Symptom scale squared, DHI subscales (Functional, Physical and Emotional), DHI item 1p ('I cough when I drink'), DHI Severity question, EAT-10 item 9 ('I cough when I eat') and FOIS. AUC 0.915

DISCUSSION

The purpose of this study was to build a prediction model for aspiration in patients with OD using common self-evaluation questionnaires and patients' oral intake status. Logistic regression modelling is the preferred method for this[34]. Herein, the number of parameters tested determines the size of the study population needed[35]. Both clinical experience and prior knowledge from the literature may be used to limit the number of predictors in such models. The variable selection was based on these assumptions. Good accuracy was found [36], i.e. AUC of 0.86 and 0.85 for variable sets A and B, respectively. Subsequently, LASSO regression showed excellent accuracy, i.e. AUC of 0.92 for selection of variables from both sets A and B. The resulting formula may be used in the future as a guide to predict aspiration in patients with OD. This study has some limitations. Firstly, the subjects had high FOIS scores, i.e. no functional impairments in oral intake or only mild impairments. This may have influenced our findings and the generalisability of the results. In view of that possibility,

a consecutive series of patients was included to avoid selection bias. As such, our population forms a representative sample of persons visiting an outpatient clinic for dysphagia in an academic hospital setting. Secondly, only details on the LASSO regression model using the set of variables A are presented here. However, as the AUCs were almost equal for both sets (A and B) when using LASSO regression modelling, the option of using set B in daily clinics might be considered as well. Clinicians may prefer to use DHI subscales rather than adding the SWAL-QoL subscales and VAS scales on Severity and Impairment. Future studies may consider such clinical preferences when building regression models. Thirdly, external validation of the findings in another group of patients with OD was not performed. Nonetheless, all predictive models showed good to excellent accuracy with all $AUC \geq 0.85$ and AUC exceeding 0.92 when using LASSO regression. Even though no great differences are expected when other groups of patients with OD are included, it may be interesting to compare the current results with those from future studies in other populations with OD. Casting the net wider might reveal similarities or discrepancies in study outcomes; to what degree our predictive model can be generalised to other patient populations remains to be evaluated in follow-up research. Our model can be considered a first step towards the assessment of aspiration risk in patients with OD using oral intake and self-report questionnaires only. The high accuracy of the final prediction model seems to make this a very promising avenue.

These findings are relevant for clinical practice and underscore the importance of self-reported evaluations in the clinical assessment of patients with OD. Until now, these questionnaires were used to measure concepts such as FHS and HR-QoL. They were not used for decision-making; specifically, they were not used to determine whether a patient with dysphagia was at risk for aspiration. The current study suggests that in the absence of gold standard measures, an accurate risk assessment can be performed on the grounds of combined oral intake and self-reported FHS and HR-QoL. Possibly, future studies may address the usefulness of the current assessment protocol in clinical settings such as nursing homes or general practices where access to VFS or FEES may still be limited, in contrast to the widespread availability in tertiary centres nowadays. Furthermore, the use of a non-instrumental assessment protocol to identify aspiration in patients with OD may reduce costs in healthcare.

CONCLUSIONS

This study shows that aspiration in patients with OD may be predicted by a cost-effective, simple and non-invasive assessment protocol including oral intake status

and patient self-evaluation questionnaires on FHS and HR-QoL. A predictive model was built using data from a consecutive series of patients at an outpatient clinic of a tertiary care centre. This model may be used to predict aspiration in patients with OD.

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REFERENCES

1. Eslick, G.D. and N.J. Talley, *Dysphagia: epidemiology, risk factors and impact on quality of life--a population-based study*. *Aliment Pharmacol Ther*, 2008. **27**(10): p. 971-9.
2. Martino, R., et al., *Dysphagia after stroke: incidence, diagnosis, and pulmonary complications*. *Stroke*, 2005. **36**(12): p. 2756-63.
3. Speyer, R., *Oropharyngeal dysphagia: screening and assessment*. *Otolaryngol Clin North Am*, 2013. **46**(6): p. 989-1008.
4. Garcia-Peris, P., et al., *Long-term prevalence of oropharyngeal dysphagia in head and neck cancer patients: Impact on quality of life*. *Clin Nutr*, 2007. **26**(6): p. 710-7.
5. Bonilha, H.S., et al., *The one-year attributable cost of post-stroke dysphagia*. *Dysphagia*, 2014. **29**(5): p. 545-52.
6. Fattori, B., et al., *Comparison between videofluoroscopy, fiberoptic endoscopy and scintigraphy for diagnosis of oro-pharyngeal dysphagia*. *Acta Otorhinolaryngol Ital*, 2016. **36**(5): p. 395-402.
7. Kertscher, B., et al., *Bedside screening to detect oropharyngeal dysphagia in patients with neurological disorders: an updated systematic review*. *Dysphagia*, 2014. **29**(2): p. 204-12.
8. Speyer, R., et al., *Psychometric properties of questionnaires on functional health status in oropharyngeal dysphagia: a systematic literature review*. *Biomed Res Int*, 2014: p. 458678.
9. Belafsky, P.C., et al., *Validity and reliability of the Eating Assessment Tool (EAT-10)*. *Ann Otol Rhinol Laryngol*, 2008. **117**(12): p. 919-24.
10. Dwivedi, R.C., et al., *Validation of the Sydney Swallow Questionnaire (SSQ) in a cohort of head and neck cancer patients*. *Oral Oncol*, 2010. **46**(4): p. e10-4.
11. McHorney, C.A., et al., *The SWAL-QOL and SWAL-CARE outcomes tool for oropharyngeal dysphagia in adults: III. Documentation of reliability and validity*. *Dysphagia*, 2002. **17**(2): p. 97-114.
12. Silbergleit, A.K., et al., *The Dysphagia handicap index: development and validation*. *Dysphagia*, 2012. **27**(1): p. 46-52.
13. Heijnen, B.J., et al., *Neuromuscular electrical stimulation versus traditional therapy in patients with Parkinson's disease and oropharyngeal dysphagia: effects on quality of life*. *Dysphagia*, 2012. **27**(3): p. 336-45.
14. Crary, M.A., G.D. Mann, and M.E. Groher, *Initial psychometric assessment of a functional oral intake scale for dysphagia in stroke patients*. *Arch Phys Med Rehabil*, 2005. **86**(8): p. 1516-20.
15. Andrade, M.S., et al., *Correlation between swallowing-related quality of life and videofluoroscopy after head and neck cancer treatment*. *Codas*, 2017. **29**(1): p. e20150175.
16. Pedersen, A., et al., *Swallowing outcome measures in head and neck cancer--How do they compare?* *Oral Oncol*, 2016. **52**: p. 104-8.
17. Kuhn, M. and K. Johnson, *Applied Predictive Modeling*. 2016, New York: Springer-Verlag New York. 600.
18. De Ruyck, K., et al., *A predictive model for dysphagia following IMRT for head and neck cancer: introduction of the EMLasso technique*. *Radiother Oncol*, 2013. **107**(3): p. 295-9.
19. Langendijk, J.A., et al., *A predictive model for swallowing dysfunction after curative radiotherapy in head and neck cancer*. *Radiother Oncol*, 2009. **90**(2): p. 189-95.

20. Han, T.R., et al., *The prediction of persistent dysphagia beyond six months after stroke*. *Dysphagia*, 2008. **23**(1): p. 59-64.
21. Frakking, T., et al., *Aspirating and Nonaspirating Swallow Sounds in Children: A Pilot Study*. *Ann Otol Rhinol Laryngol*, 2016. **125**(12): p. 1001-1009.
22. McHorney, C.A., et al., *The SWAL-QOL outcomes tool for oropharyngeal dysphagia in adults: I. Conceptual foundation and item development*. *Dysphagia*, 2000. **15**(3): p. 115-21.
23. McHorney, C.A., et al., *The SWAL-QOL outcomes tool for oropharyngeal dysphagia in adults: II. Item reduction and preliminary scaling*. *Dysphagia*, 2000. **15**(3): p. 122-33.
24. Timmerman, A.A., et al., *Psychometric characteristics of health-related quality-of-life questionnaires in oropharyngeal dysphagia*. *Dysphagia*, 2014. **29**(2): p. 183-98.
25. Rosenbek, J.C. and H.N. Jones, *Dysphagia in movement disorders*. 2008, United Kingdom: Plural Publishing.
26. Cordier, R., et al., *Evaluating the Psychometric Properties of the Eating Assessment Tool (EAT-10) Using Rasch Analysis*. *Dysphagia*, 2017. **32**(2): p. 250-260.
27. Rofes, L., et al., *Sensitivity and specificity of the Eating Assessment Tool and the Volume-Viscosity Swallow Test for clinical evaluation of oropharyngeal dysphagia*. *Neurogastroenterol Motil*, 2014. **26**(9): p. 1256-65.
28. Baijens, L.W., et al., *FEES protocol derived estimates of sensitivity: aspiration in dysphagic patients*. *Dysphagia*, 2014. **29**(5): p. 583-90.
29. Rosenbek, J.C., et al., *A penetration-aspiration scale*. *Dysphagia*, 1996. **11**(2): p. 93-8.
30. Steele, C.M. and K. Grace-Martin, *Reflections on Clinical and Statistical Use of the Penetration-Aspiration Scale*. *Dysphagia*, 2017.
31. R Development Core Team, *R: A language and environment for statistical computing*. 2017: Vienna, Austria.
32. Speyer, R., et al., *Quality of life in oncological patients with oropharyngeal dysphagia: validity and reliability of the Dutch version of the MD Anderson Dysphagia Inventory and the Deglutition Handicap Index*. *Dysphagia*, 2011. **26**(4): p. 407-14.
33. Miles, A., et al., *Comparison of cough reflex test against instrumental assessment of aspiration*. *Physiol Behav*, 2013. **118**: p. 25-31.
34. Mucho, R., *[Logistic regression: a useful tool in rehabilitation research]*. *Rehabilitation (Stuttg)*, 2008. **47**(1): p. 56-62.
35. Courvoisier, D.S., et al., *Performance of logistic regression modeling: beyond the number of events per variable, the role of data structure*. *J Clin Epidemiol*, 2011. **64**(9): p. 993-1000.
36. Hanley, J.A. and B.J. McNeil, *The meaning and use of the area under a receiver operating characteristic (ROC) curve*. *Radiology*, 1982. **143**(1): p. 29-36.