Does Even Low-Grade Dysphonia Warrant Voice Center Referral?

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ABSTRACT

OBJECTIVE: Data regarding the referral of dysphonic patients to specialty voice clinics is limited. The objective of this study is to examine the relationship between low perceptual dysphonia severity and subtle laryngeal findings to discern if this can help guide referral.

METHODS: Charts of 94 patients presenting with a primary complaint of hoarseness to a single laryngologist over a one-year period at a tertiary care, interdisciplinary voice center were analyzed. Patients were stratified by clinician perceptual rating of dysphonia severity using the overall Grade score from the GRBAS (grade, roughness, breathiness, asthenia, strain) scale, and this was compared to their laryngeal findings on stroboscopy.

RESULTS: Forty-one patients had a Grade score of 0 or 1, of whom 85% had relatively subtle findings on stroboscopy.

CONCLUSION: Patients with a primary complaint of hoarseness but absent or only mild perceptual dysphonia may have subtle or occult laryngeal findings that may be easily missed. These patients may benefit from early referral to a specialty voice center.

INTRODUCTION

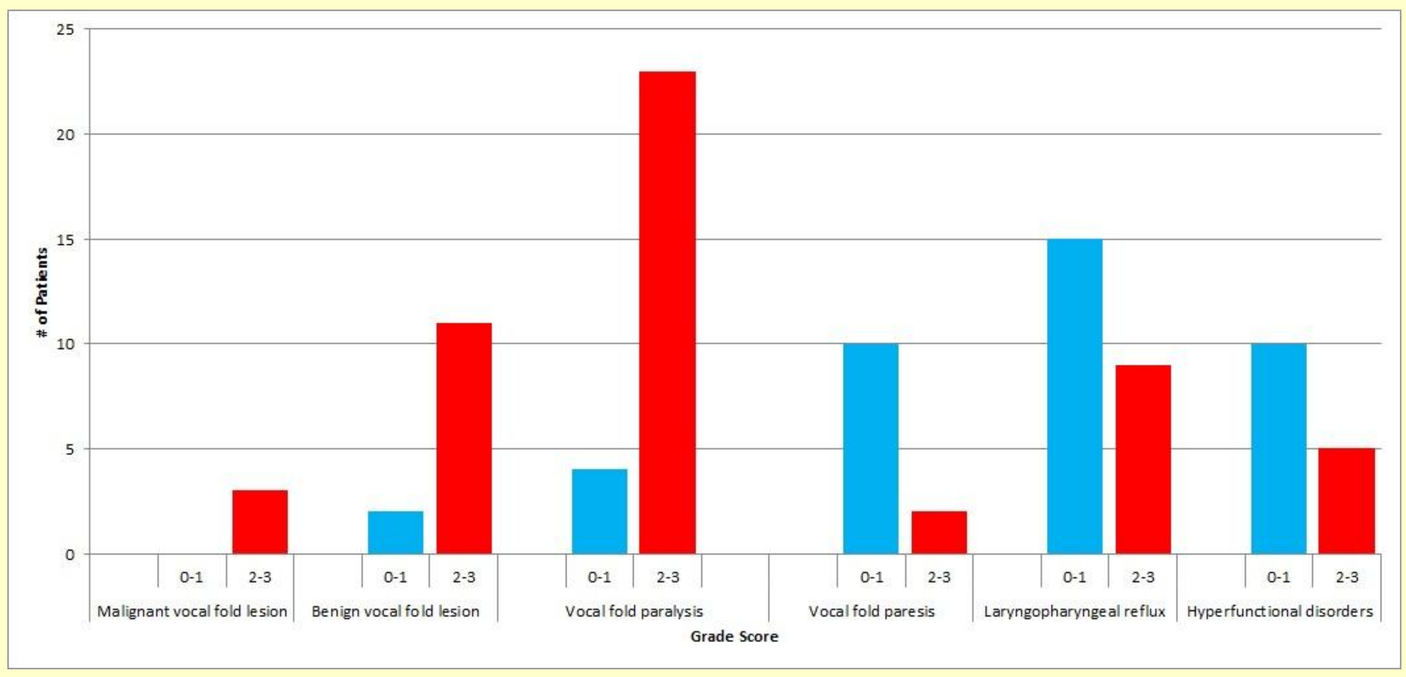
- Dysphonia is prevalent and complicated
  - Affects up to 1/3 of the U.S. adult population[1] during their lifetime
  - Causes a significant reduction in a patient's quality of life[2]
- Delayed diagnosis can lead to:
  - Inappropriate management
  - Progression of symptoms and disease
  - Patient dissatisfaction
- Data regarding referral to specialty voice clinics is limited

METHODS

- Retrospective chart review
- January to December 2015
- New patients with a chief complaint of hoarseness
- In-office evaluation by a single fellowship-trained laryngologist in conjunction with certified speech-language pathologist
- Multidisciplinary voice center
- IRB approval obtained
- Data points:
  - Demographic data
  - "Grade" score from GRBAS evaluation
  - Degree of voice use
  - Final voice diagnosis

RESULTS

- 94 patients
  - 47 men
  - 47 women
- Average age 60 years [range 31-88 years]
- Final voice diagnosis stratified by the "Grade" score from Grade/Roughness/Breathiness/Asthenia/Strain (GRBAS) scale
- 41 patients had perceptual dysphonia Grade score of 0 or 1, of whom 85% had subtle laryngeal findings on stroboscopy: vocal fold paresis; hyperfunctional disorders (spasmodic dysphonia, muscle tension dysphonia)
- Patients with moderate or severe perceptual dysphonia (meaning a Grade score of 2 or 3, respectively) tended to have more distinct structural or motion pathology on stroboscopic evaluation: benign/malignant lesion; vocal fold paralysis



DISCUSSION

- Patients with more severe perceptual dysphonia are evaluated by a physician sooner than those with milder perceptual dysphonia.
- Voice disorders that do not result from easily discernible masses/gross motion abnormalities associated with[3]:
  - multiple physician visits
  - diagnostic delay
  - delay in management
- Minimal perceptual dysphonia and no obvious structural findings on standard steady-light endoscopy = greater potential for misdiagnosis and mismanagement

CONCLUSION

- Absent or only mild perceptual dysphonia may be accompanied by subtle or occult laryngeal findings that may be missed on routine steady-light endoscopic evaluation
- Stroboscopy is a valuable tool in the evaluation of these patients however prevoius survey findings indicated that most generalists do not routinely utilize stroboscopy or feel comfortable interpreting findings
- Interdisciplinary voice evaluation with expert acoustic-perceptual evaluation and stroboscopy may be helpful in avoiding delays in diagnosis and management for these patients

REFERENCES

1. Cohen et al. Change in Diagnosis and Treatment Following Specialty Voice Evaluation: A National Database Analysis. *Laryngoscope*. July 2015;125(7):1660-66.
2. Keesecker et al. Patterns in the Evaluation of Hoarseness: Time to Presentation, etc. *Laryngoscope*. March 2015;125:667-673.
3. Sadoughi et al. Hoarseness Evaluation: A Transatlantic Survery of Laryngeal Experts. *Laryngoscope*. Jan 2014; 124:221-226.

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