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Speech & Language Pathology

**Adult and Pediatric ENT
And specialty care for:**

Allergy (Shots & Drops)

Sinus Disease

Vocal Paralysis and Hoarseness

Swallowing Dysfunction

Recurrent Or Chronic Laryngitis

Spasmodic Dysphonia

Thyroid and Parathyroid

Disease

Head and Neck Cancers

On Site Services Include:

MRI, CT and X-ray

Full Audiology Department

The Voice Center

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Laryngopharyngeal Reflux Disease

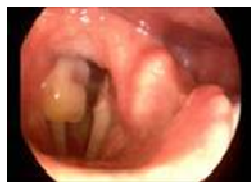
By Ramez J. Awwad, MD

"But I don't have heartburn..."

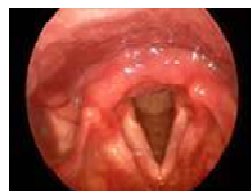
Laryngopharyngeal reflux disease (LPR) refers to the backflow of gastric contents into the upper aerodigestive tract. It is estimated that up to 10% of patients presenting to an otolaryngologist's office and up to 50% of patients with hoarseness have disease for which LPR is either the main cause or a significant aggravating factor. Despite the prevalence of this disorder, there still seems to be a lot of unanswered questions and confusion related to LPR.



Normal Larynx



Large vocal process granuloma secondary to LPR



Thickened true vocal cords, diffuse hyperemia, and posterior commissure hypertrophy



Pseudosulcus

LPR is distinct from gastroesophageal reflux disease (GERD). LPR is often called silent reflux, because the vast majority of patients with LPR don't have heartburn, the most common symptom of GERD. This is often quite puzzling for the patient. The most common complaints of LPR include frequent throat clearing, hoarseness, excessive mucus production, globus sensation, and chronic cough. LPR is not characterized by prolonged periods of acid exposure as is typically seen in GERD. The acid contact in LPR is short, but quite damaging to the sensitive laryngeal mucosa. Most clinicians believe that the major problem in GERD patients is lower esophageal sphincter dysfunction, whereas the primary defect in LPR is the upper esophageal sphincter.

Diagnosis

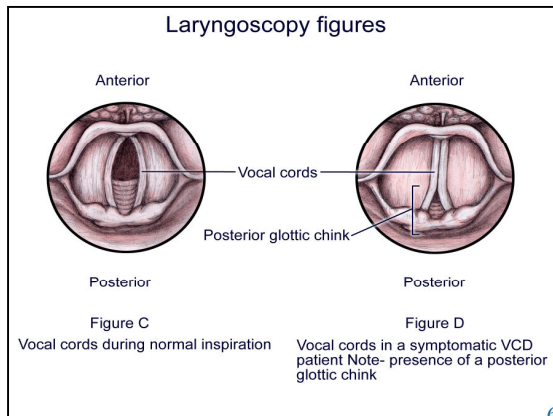
Most patients can be diagnosed on the basis of history and a good laryngeal exam. Capital Region Ear, Nose, and Throat utilizes state of the art videostroboscopy to closely examine the larynx. Typical findings in LPR include posterior commissure hypertrophy, subglottic edema (pseudosulcus), vocal fold edema, granuloma, diffuse hyperemia, and excessive mucus. If the diagnosis of LPR is in question, a 24 hour double probe pH probe study may be done.

Treatment

Treatment for LPR is similar to that of GERD, however, because the laryngeal mucosa is so sensitive to acid contact, it needs to be more aggressive and prolonged than that for GERD. In addition to lifestyle and dietary modifications, the American Academy of Otolaryngology recommends twice daily PPI therapy, to be taken 30-60 minutes before breakfast and dinner. The reason for the twice daily therapy is because none of the current PPIs suppress acid (pH < 4) for greater than 16.8 hours. The vast majority of patients will report symptomatic improvement within 2-3 months.

Vocal Cord Dysfunction (VCD)

Vocal cord dysfunction (VCD) is a laryngeal problem that causes the vocal folds to close during inhalation, which interferes with breathing. People with VCD say that their throat closes off and they struggle to breathe, which can be frightening. VCD episodes often occur with adolescents or young adults during activities like swimming or running.



Interestingly, many individuals affected by VCD are athletes who compete at very high levels. VCD is sometimes hard to diagnose and can be confused with asthma. In fact, it can occur with asthma in some cases.

VCD can be caused (triggered) by a number of things, including:

- Exercise
- Stress
- Reflux that irritates the larynx
- Upper respiratory infection
- Allergies
- Strong smells

VCD is treated with voice therapy that focuses on relaxation and breathing techniques that help open the throat. Recently, voice therapy techniques, like humming have even helped people manage VCD episodes. Since VCD is often related to irritation in the larynx, medication for acid reflux or allergies may help, too. It is important that a person with suspected VCD see their primary care doctor and work with an ENT and speech-language pathologist who can effectively assess and treat this laryngeal problem.

The Role of Speech-Language Pathology in an Ear, Nose and Throat practice

ENT practices that specialize in treating laryngeal problems employ a speech-language pathologist (SLP) to work with patients (adults and children) whose speaking voices are affected by disease or disorder. SLPs who work with people that experience voice disorders play several roles:

- Collaborate with the ENT and the patient on clinical decisions.
- Evaluate voice disorders, including the use of instrumentation to take objective measures of vocal function
- Conduct behavioral voice therapy, emphasizing the application of "physical therapy" for the voice.
- Perform laryngeal videostroboscopy.

Getting the Most from your Voice

By Jack Pickering, Ph.D., CCC-SLP

- It all starts with good posture. Sit up or stand up straight. When sitting, remember ninety degrees at the ankles, knees and hips.
- The power of your voice comes from your breathing. Inhaling moves your belly out; exhaling moves your belly in. Make the most of your exhaled air when you speak. Volume comes from breath support, not tension in your throat.
- Pitch is maintained and changed in your voice box. Stress and intonation are the ways you naturally change pitch to express yourself.
- Slow your rate and really articulate your sounds. Your mouth and your throat are a musical instrument – open them up. Don't mumble or muffle your words.
- Making voice is all about the balance between breathing, voicing, and articulating.