

# گزارش موردی یک کودک مبتلا به دیسفاژی دهانی با منشأ سرخجه مادرزادی

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## چکیده

**مقدمه:** بیمار دختری است که حاصل حاملگی فول ترم و روش سزارین بوده است. از ابتدا مشکلاتی در تغذیه و بلع داشت. میکروسفالی او قابل توجه بود و به موازات آن تاخیر در رشد و نمو (growth, development) نیز در همه مراحل رشد دیده می‌شد. در بررسی‌های انجام شده سی‌تی‌اسکن طبیعی و آزمایشات مویید سندرم سرخجه مادرزادی بوده است. در سن ۵ سالگی به دلیل مشکلات زیادی در تغذیه و کمبود وزن به کلینیک گفتار درمانی ارجاع داده شد. در ارزیابی feeding مشخص شد که عملکردهای chewing و biting را دارا نیست و بلع او نیز غیر طبیعی است. رژیم غذایی او به چند ماده خاص غذایی محدود بود که تنها از طریق مکیدن انجام می‌شد. طول مدت تغذیه در هر وعده غذایی حدود یک ساعت بود که در این مدت به دفعات دچار آسپیراسیون و حالت تهوع می‌شد.

زیرسیستمهای گفتاری شامل تنفس، آواسازی، تولید و تشدید و در نتیجه گفتار او طبیعی (متناسب با سن و جنس) بود. به تشخیص آسیب‌شناس گفتار و زبان، مشکل اصلی او دیسفاژی دهانی بود. بنابراین برنامه درمانی او که شامل تمرینات دهانی - حرکتی، درمانهای مایوفانکشنال، آموزش والدین و روشهای اصلاح رفتار بود به مدت سه ماه، دو بار در هفته اجرا شد.

**نتایج:** پس از سه ماه برنامه درمانی منظم و همکاری خانواده، مهارتهای biting و chewing ایجاد شده، جایگزین مکیدن شد. آسپیراسیون و حالت تهوع در طول تغذیه از بین رفت. طول مدت تغذیه از یک ساعت به نیم ساعت کاهش و تمایل او به خوردن مواد غذایی متنوع افزایش یافت.

**بحث:** نتایج این بررسی نشان داد که ترکیبی از تمرینات دهانی - حرکتی، درمانهای مایوفانکشنال، آموزش والدین و روشهای اصلاح رفتار می‌تواند در درمان دیسفاژی دهانی مفید و مؤثر باشد.

**کلیدواژه‌ها:** تمرینات دهانی - حرکتی، دیسفاژی دهانی، مشکل تغذیه.

## تشکیل انجمن فیزیوتراپی سالمندان ایران

رشد سالمندی در جهان به گونه‌ای است که تا سال ۲۰۲۵، هشتصد میلیون سالمند در جهان وجود خواهد داشت که بیشترین رشد آن در کشورهای در حال توسعه خواهد بود. در حال حاضر در ایران حدود چهار میلیون و پانصد هزار نفر سالمند وجود دارد. فیزیوتراپیست‌ها به علت دانش، مهارت و تجارب منحصر به فردی که در این زمینه دارند دارای جایگاه محوری در اقدامات سلامتی مرتبط با سالمندان هستند. در سومین کنگره بین‌المللی (International Association of Physiotherapists IPTOP Working with Older People) که در استانبول برگزار گردید با مسؤلین IPTOP هماهنگی به عمل آمد که این زیر گروه در ایران نیز تشکیل گردد و نماینده این انجمن در ایران معرفی گردد. انجمن با ارتباط با سایر انجمن‌ها و نهادهای مرتبط داخلی و بین‌المللی، برنامه‌ریزی‌هایی را در سطح ملی تدارک دیده، در زمینه برگزاری سمینارها، کنگره‌ها، انجام تحقیقات، مداخله در سیاست‌گذاری‌های کلان، اطلاع رسانی از طریق رسانه‌ها و ... اقدام خواهد نمود. با توجه به نیاز شدید جامعه به وجود یک انجمن منسجم و دارای دیدگاه‌های علمی «انجمن فیزیوتراپی سالمندان ایران» که زیر شاخه‌ای از «انجمن فیزیوتراپی ایران» می‌باشد، تأسیس گردیده است. خواهشمند است در صورت تمایل جهت عضویت در انجمن با دفتر گروه فیزیوتراپی دانشگاه علوم پزشکی اصفهان تماس حاصل فرمایید.

### اعضای هیئت مدیره انجمن:

آقای دکتر عبدالکریم کریمی - عضو هیأت علمی دانشگاه علوم پزشکی اصفهان  
آقای احسان قاسمی - عضو هیأت علمی دانشگاه علوم پزشکی اصفهان  
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# Oral-Motor Management of Oral Dysphagia following Congenital Rubella Syndrome: Report of one case

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## Abstract

The efficacy of oral-motor management for treatment of oral dysphagia was investigated in a 5 year-old child with severe problems in feeding and weight-loss subsequent to congenital rubella syndrome. A complete assessment, revealed that she has disorder in biting, chewing, bolus gathering and initiation of swallowing. Therefore, making the biting and chewing, reduction of aspiration in feeding, improvement of drinking function, the elimination of hypersensitivity, and reduction of feeding time were established as the main goals of the therapy. After three months of treatment program consisted of oral-motor and swallowing management, myofunctional therapy, and behavioural procedures, the main goals of the therapy were obtained. The results of the present study demonstrated that the combination of oral-motor practices, myofunctional therapy, parent training, and behavioural procedures could be useful in the treatment of the oral dysphagia.

**Key Words:** oral-motor management, feeding Disorders, oral dysphagia

## Introduction

Many congenital birth syndromes can cause alterations of the orofacial structures and subsequently dysphagia (1).

Rubella is typically a subclinical or mild exanthematous infection of children and adults. The infant may have physical and mental abnormalities such as cataract, congenital heart disease, deafness, microcephaly or psychomotor retardation.

In this study, congenital rubella syndrome caused multiple defects. The case was selected for reporting because of her unique features and multiple disability such as low vision and fine motor disorders especially in oral movement which affects her ability to chew, manipulate the bolus in the mouth and swallowing. This study reported the child's feeding before intervention and after three months oral-motor treatment.

## Case Report

The subject was a five years old girl with severe problems in feeding result in weight-loss (13 Kg.) subsequent to congenital rubella syndrome. She was followed from birth up to the time of the study by a qualified paediatrician. Clinical diagnosis of congenital rubella syndrome was established with the blood exam.

Medical history of the patient revealed that she was delivered by Caesarean section due to full term period. Her Apgar was normal but she was small for gestational age. Her eyes had

microphthalmia, Coloboma, and strabismus and were observed after the examination she had hypogenesis of retina. Her vision test result was 0.3. She had microcephaly but the CT scan of her brain was normal.

During an informal cognitive assessment (e.g. visual and auditory perception and receptive vocabulary) and interview with parents, it was revealed that there is a mild delay in cognition development.

After the complete oral-motor examination done by a qualified speech language pathologist, it was revealed that she had oral dysphagia with the following signs: disorders in biting, chewing, bolus gathering, and initiation of swallowing. Furthermore, she had the signs of gastroesophageal reflux (GER) include: irritability, inability to tolerate large feeds, early satiation and frequent vomiting (2).

The most important findings of the clinical examination of this patient were as follows:

In feeding history, this data was obtained:

- The patient was dependent on others for feeding.
- Increased oral tactile sensitivity with these signs: extreme sensitivity to touch either in or around mouth; food refusal; withdrawal or facial grimacing; intolerance to some of food textures.
- She never bites and chews any edible materials.
- Excessive duration of meal-time about one hour.
- She felt fatigue and lethargic during the feeds.

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- The patient did not use her tongue adequately to form and move a bolus; therefore, she used her fingers to displace it in the mouth.

- She had several aspirations during the feeds.

In oral motor examination, the following information was obtained:

- The strength and range of motion of the lips, tongue and jaw were poor and without any coordination.

- The tongue and jaw movements were not separated.

- Her speech was normal for her age.

- Speech subsystems such as breathing, phonation, articulation and resonance were normal.

- Most of her teeth were decayed and some of them were repaired.

### **Results**

A three months treatment program was performed by a Speech-Language Pathologist two times per week. These programs consisted of oral-motor and swallowing management, myofunctional therapy procedures (3) and behavioural procedures such as positive and negative reinforcement for the treatment of food refusal. Parent training was an important part of the program.

Following improvements were obtained after the treatment:

- Biting and chewing patterns.

- Appropriate oral movements for feeding

- Elimination of hypersensitivity.

- Elimination of aspiration during the feeding.

- Elimination of behavioural problems during the meal time.

- Reduction of feeding time since 1 hour to 40 minutes. (10-30 minutes is best (4)).

- Increasing tolerance for textures.

- Improving of swallowing of the liquids continuously.

### **Conclusion:**

Making the biting and chewing, reduction of

aspiration in feeding, improvement of drinking function, the elimination of hypersensitivity, and reduction of feeding time were established as the main goals of the therapy.

The results of the present study indicates that the combination of oral-motor practices, myofunctional therapy, parent training, and behavioural procedures could be useful in the treatment of oral dysphasia.

The results imply that team different professionals – medical and behavioural are required.

The core interdisciplinary team may include a physician, nurse, nutritionist, speech language pathologist and occupational therapist (1)

In cases of paediatric dysphagia, the SLP is treating children who have yet to acquire normal eating skills. The goal of dysphagia assessment and treatment with children is to aid in the development of skills needed to keep the child safe and well nourished (5).

The oropharyngeal stage of deglutition begins with contraction of the tongue and striated muscles of mastication. The muscles work in a coordinate fashion to mix the food bolus with saliva and propel it from the anterior oral cavity into the oropharynx, where the involuntary swallowing reflex is triggered. (6). Because of weakness of oral structures in this patient, the oral stage of swallowing was impaired, but her speech was normal for her age, because the muscle strength necessary for speech is less than that required for swallowing(1).

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