11th UK SWALLOW RESEARCH GROUP CONFERENCE

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5TH + 6TH FEB 2026

EDGBASTON PARK HOTEL, BIRMINGHAM

UKSRG Sponsors 2026

UKSRG – Day 1

Thursday 5th February 2026

Time	Session/Speaker	Location/Subject
08.00 - 09.00	**Registration & tea/coffee**	**Exhibitor Space**
09.00 - 09.15	**Welcoming address** Justin Roe	**Fry Suite**
09.15 - 10.45	**Artificial Intelligence**	**Fry Suite**
	(1) Joseph Alderman	The risk of algorithmic bias, the way AI is regulated, and the opportunities if we get this right.
	(2) Alberto Martin-Martinez	Embedding a Systematic and Universal Artificial Intelligence Screening Method for Oropharyngeal Dysphagia in a hospital setting.
	(3) Andrea Bandini	Developing AI-based methods to automate the analysis of videofluoroscopy.
	(4) Anais Rameau	AI in dysphagia: Where are we now and what is next? (Virtual)
10.45 - 11.15	**Tea/coffee & poster viewing**	**Exhibitor Space**
11.15 - 12.45	**Critical care**	**Fry Suite**
	(5) Eileen Kelly	Oral and suprahyoid muscle wasting and dysphagia in critically ill patients
	(6) Sarah Edney	The impact of hypoxic ischaemic encephalopathy on feeding in the NICU and beyond
	(7) Carol Gilmore	An early intervention programme for infants with diaphragmatic hernia on NICU – a service evaluation
	(8) Prof Brendan McGrath	The impact of airflow on swallowing in mechanically ventilated tracheostomy patients – The SEACtV project
	(9) Ella Terblanche	Exploring the nutritional challenges of survivors of critical illness - the patient perspective
12.45 - 13.45	**Lunch, networking & poster viewing**	**Exhibitor Space**
13.45 - 14.15	**Free paper session 1**	**Fry suite**
	Martina Guido	Determining the Value of Bulbar (Genioglossus) Electromyography in the Assessment of Dysphagia in Children
	Jodi Allen	Quantitative muscle ultrasound as an assessment and phenotyping tool in neuromuscular dysphagia
	Nicola Martindale	Implementing the free water protocol in the acute stroke unit setting: Focus groups to explore how to overcome perceived barriers.
14.15 - 15.15	**Breakout workshops**	

	(10) Margaret Coffey and Chadwan Al-Yaghachi	**Fry Suite** High Resolution Manometry- introduction
	(11) Marloes Lagarde and Mari Viviers	**Breakout Room 1** Paediatric ultrasound
	(12) Roganie Govender	**Breakout Room 2** Behaviour change in dysphagia rehab
	(13) Paula Leslie	**Breakout Room 3** Writing for publication
15.15 - 15.45	**Tea/coffee & poster viewing**	**Exhibitor Space**
15.45 - 16.15	**Free paper session 2**	**Fry Suite**
	Rachel Sylla	Is there value in intensive dysphagia therapy six months after radiotherapy? A service evaluation of Swallowing bootcamp
	Kelly Weir	Eating and Drinking Function in individuals with cerebral palsy across the lifespan – Does function change with time?
	Sally Archer	Boosting confidence at the bedside: Supporting speech and language therapy students to offer mealtime assistance
16.15 - 17.30	**Gastroesophageal considerations**	**Fry Suite**
	(14) Sheraz Marker	LINX vs Fundoplication (GOLF) study
	(15) James O'Hara	LPR - an evidence review and the TALGITS Trial
	(16) Kornilia Nikaki	The use of high resolution manometry in the diagnosis of paediatric oesophageal dysphagia
17.30 - 17.45	**Closing remarks**	**Fry Suite**
19.00 – Late	**Conference dinner sponsored by PENTAX** **Restaurant**	PENTAX® MEDICAL

Poster presentation day 1 (Thursday 5th February 2026)		
Submitting author	**Title**	**Poster number**
Jodi Allen	Reliability and measurement agreement of quantitative muscle ultrasound (QMUS) for assessing swallowing-related muscle pathophysiology	1
Helen Heer	What are the challenges of completing dysphagia therapy in a NHS community setting?	2
Sally Morgan	Creating a toolkit for families of children who need assistance with eating and drinking: Safe Efficient and Enjoyable Mealtimes (SEEM Study) – current progress	3
Kelly Weir	Current protocols for paediatric Videofluoroscopic Swallow Studies– A survey of Practice in Australia and New Zealand	4
Caroline Smith	Developing a Core Outcome Set for oropharyngeal dysphagia screening services in hospitals: A modified Delphi study	5
Fay Pickles	A feasibility study investigating the accuracy and viability of ultrasound versus fibreoptic nasendoscopy in detecting impairments of vocal fold mobility in patients with neurological disease	6
Alison Felton	Use of point of contact laryngeal ultrasound (POCUS) to identify vocal cord paresis in high-risk cardiac infants prior to dysphagia assessment.	7
Alison Keys	Artificial Intelligence in Videofluroscopy and Fibreoptic Endoscopic Evaluation of Swallowing analysis: A Scoping Review	8
Anne Breaks	Feeding and Swallowing Outcomes in Infants and Children with Spinal Muscular Atrophy Type 1 Treated with Disease-Modifying Therapies: Real Life Experiences	9
Faye McLoughlin	Does bolus volume modulation reduce penetration-aspiration scores when compared to viscosity modulation alone, in videofluoroscopy?	10
Anna Joyce	Assessment of post-extubation dysphagia in Critical Care-do blanket referrals uncover it?	11
Sambavy Nerminathan	Severe sensori-motor pharyngeal dysphagia in a profoundly deaf patient following major trauma.	12
Victoria Thomas	Oral feeding outcomes of infants born with Oesophageal Atresia at discharge from hospital: a two centre study.	13
Catherine Cawley	A service evaluation of a new FEES service: exploring changes in restrictive oral intake practices for acute inpatients with dysphagia.	14

UKSRG – Day 2

Friday 6th February 2026

Time	Session/Speaker	Subject
08.00 – 08.30	**Registration & tea/coffee**	**Exhibitor Space**
08.30 – 09.45	**Palliative Care**	**Fry Suite**
	(17) Rob George	Palliative care: setting the scene
	(18) Laura Chahda	Shared Decisions, Meaningful Support: Navigating Dysphagia in Palliative Care
	(19) Dharinee Hansjee	Eating and Drinking with Acknowledged Risk
09.45 – 10.15	**Free Paper Session 3**	**Fry Suite**
	Jodi Allen	A cross-sectional study exploring the alignment between patient-reported and biomechanical dysphagia outcomes in myotonic dystrophy type1 (DM1)
	Roganie Govender	Feasibility of a cluster-randomised swallowing prehabilitation trial (SIP SMART2) within the NHS cancer care pathway
	Yuki Yoshimatsu	Supporting Decision-making around Eating and Drinking with Acknowledged Risks in older adults – A mixed methods study of the experiences of clinicians in Japan and the UK
10.15 – 10.45	**Tea/coffee & poster viewing**	**Exhibitor Space**
10.45 – 11.15	**Free Paper Session 4**	**Fry Suite**
	Louise Bax	Significance of Elevated Pharyngeal Constriction Ratio in Infancy in Predicting Feeding Outcomes
	Elizabeth Montgomery	Investigating the Relationship Between Laryngeal Oedema and Dysphagia Severity Following Extubation and Tracheostomy
	David Smithard	Swallowing and Ageing: An Internet based study
11.15 – 12.15	**Breakout workshops**	
	(20) Margaret Coffey and Chadwan Al-Yaghachi	**Fry Suite** High Resolution Manometry paediatrics, clinical cases and biofeedback
	(21) Jodi Allen and Joan Ma	**Breakout Room 1** Ultrasound Adults
	(22) Roganie Govender	**Breakout Room 2** Behaviour change
	(23) Paula Leslie	**Breakout Room 3** Writing for publication

12.15 – 13.15	**Lunch, networking & poster viewing**	**Exhibitor Space**
13.00 – 13.15	**AGM**	**Optional**
13.15 – 14.30	**Respiratory**	**Fry Suite**
	(24) Lee Bolton	Practical recommendations for swallowing and speaking during NIV in people with neuromuscular disorders
	(25) Sabrena Lee & Shevonne Waines (parent speaker)	'The experiences and views on feeding and swallowing from parents of children who use long-term ventilation'
	(26) Ricardo Jose	The Impact of Reflux and Aspiration on Respiratory Infection and Lung Disease"
14.30 - 15.00	**Tea/coffee & poster viewing**	**Exhibitor Space**
15.00 – 16.30	**Impact of dysphagia**	**Fry Suite**
	(27) Susan Guthrie	Supporting people with mental health conditions (Virtual)
	(28) Lindsey Collins	Supporting people with dementia
	(29) Tracy Lazenby- Paterson	How intellectual disability complexifies dysphagia diagnosis and management
	(30) Sonja Jacobs	Su Feeding premature infants: Supporting parents beyond discharge
16.30 - 17.00	**Final remarks and prizes** Justin Roe Prize	**Exhibitor Space**
		This year we are running a competition to win **FREE** registration for the 2028 UKSRG conference! Visit our partner stands and complete the competition form – remember to get your form stamped at each stand! Once complete submit your form at the UKSRG reception desk to be in with a chance of winning this great prize!

Poster presentation day 2 (Friday 6th February 2026)		
Submitting author	**Title**	**Poster number**
Alex Stewart	Determining inter-rater reliability, concurrent validity and responsiveness of the Children's Eating and Drinking Activity Scale	1
Roganie Govender	A process evaluation of the SIP SMART2 swallowing prehabilitation cluster-randomised pilot trial	2
Natalie Raven Morris	Utilising the Diagnostic Criteria of Paediatric Feeding Disorder: Updated Clinical Findings from a Population-based Cohort Study	3
Kate Taylor	Outcome measures for mealtime and swallowing difficulties in people with dementia: a scoping review	4
Gemma Clunie	Do head and neck cancer patients describe Quantitative Muscle Ultrasound as an acceptable addition to their care?	5
Sally Morgan	A content analysis of UK Mealtime Information Sheets used by Speech & Language Therapists working with children with dysphagia who need mealtime assistance	6
Jacqui Benfield	Is Respiratory Muscle Strength Training safe and feasible to deliver in stroke? A scoping review of the literature.	7
Anna Creagh Chapman	The implementation of Pharyngeal Electrical Stimulation (PES) in Adult Critical Care Unit at a major trauma hospital: Procedures, challenges and learnings	8
Nicole Tomitz	Swallowing Kinematics in Older Adults	9
Katie Irwin Crosby	Evidence based management of dysphagia in Huntington's disease: A scoping review	10
Sarah Morgan	Secretions, Cough, Impaired Ventilation- why they matter in the management of dysphagia in individuals with spinal cord injury (SCI). Consideration for the Speech and Language Therapist (SLT)	11
Kate McGlinchey	A Speech and Language Therapy (SLT) pilot quality improvement project (QIP): Dysphagia identification and management within inpatients on a Respiratory Support Unit (RSU) requiring Non-Invasive Ventilation (NIV) for an Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD).	12
Sarah McNally	Evaluating the use of the Eating Assessment Tool-10 (EAT-10) in Speech and Language Therapy (SLT) assessment of oropharyngeal dysphagia (OD) in inpatients with Chronic Obstructive Pulmonary Disease (COPD).	13
Aarthi Madhavan	Facilitating Assessment of Swallowing and Sensory Function in Adults with Down Syndrome through Visual Supports	14
Himali De Silva	Respiratory health outcomes of children with Down Syndrome following dysphagia management: A service evaluation	15

UKSRG Committee Members:

Prof Justin Roe MBE (Chair)
Dr Grainne Brady (secretary)
Mr Chad Al Yaghchi
Dr Jacqui Benfield
Dr Lisa Everton
Prof Paula Leslie
Grace McCormack
Sue McGowan
Rebecca Murphy
Anita Smith
Alison Smith
Dr Christine Smith
Dr David Smithard
Dr Alex Stewart
Prof Sarah Wallace OBE

Speaker Biographies

Picture	Speaker
	**1. Joseph Alderman** Joe is an NIHR academic clinical lecturer in anaesthetics and intensive care based at the University of Birmingham, UK. His research focuses on data-driven predictive models and risk scores which are used throughout healthcare – how can we ensure these tools are safe and effective for everyone? He also leads research into algorithmic bias and fairness, including the STANDING Together initiative, which created international recommendations to improve the way data is used when developing AI health technologies.
	**2. Dr Alberto Martin-Martinez** 'Nurse and postdoctoral researcher at the Laboratorio de Fisiologia Digestiva del Hospital de Mataró. Associate Professor at the Autonomous University of Barcelona. Researcher at the Instituto de Salud Carlos III (ISCiii) (CIBERehd). My main research lines are: a) Massive minimal interventions in elderly patients with oropharyngeal dysphagia and b) Improvement of the diagnosis of oropharyngeal dysphagia by systematic screening with Machine Learning."

3. Assistant Professor Andrea Bandini

Andrea Bandini is an Assistant Professor of Bioengineering at the Interdisciplinary Research Center "Health Science" at Scuola Superiore Sant'Anna (Pisa, Italy). He is also an Adjunct Scientist at the KITE Research Institute – UHN (Toronto, Canada). Dr. Bandini earned his PhD in Bioengineering from the University of Bologna (Italy) in 2016. His research lies at the intersection of biomedical engineering, speech-language pathology, artificial intelligence (AI), and computer vision. He develops and validates cutting-edge, multimodal technologies that are redefining how speech and swallowing impairments are assessed and monitored, particularly in individuals affected by neurological and neurodegenerative conditions.

4. Dr Anais Rameau

Dr. Anaïs Rameau is an associate professor and the current Chief of Dysphagia and Director of New Technologies in the Department of Otolaryngology at Weill Cornell Medical College. She has focused her scientific endeavors on the integration of novel technologies in the diagnosis and treatment of voice and swallowing disorders with the ultimate goal of decreasing cost of care, improving accessibility of specialized health services and detecting pathologies early. Much of her current focus is on the development of a bedside aspiration acoustic screening tool using artificial neural networks in the recognition of the “wet” voice, characteristic of patients with severe deglutitive disorders, funded by the National Institute on Aging prestigious Beeson Award. She is also a co-investigator on the Voice data generation project of the Bridge to AI initiative of the NIH Common Fund. She is leading the development of a silent speech wearable device for patients with limited phonation, and is actively researching the application of computer vision to automate diagnosis in video-laryngoscopy, a project funded by the American Laryngological Association. She is an alumna Young Leader of the French American Foundation.

5. Eileen Kelly

Eileen qualified as a Speech and Language Therapist from the National University of Ireland, Galway in 2014. Since then, she has worked internationally as a Speech and Language Therapist in adult acute care in Ireland, Australia, United Arab Emirates and the UK. Her clinical and research interests are in critical care, focusing on the management of swallowing and laryngeal injury post intubation.

Since 2019, Eileen has worked as a Speech and Language Therapist at the Adult Critical Care Unit of the Royal London Hospital. Her clinical and research interests are in critical care, focusing on the management of swallowing and laryngeal injury post intubation. Eileen completed a MSc from Trinity College Dublin in 2021, specialising in adult acquired dysphagia. In 2024, she completed an NIHR pre-doctoral fellowship investigating the role of ultrasound in assessing oral and suprahyoid muscles and developing a PhD proposal. Eileen commenced her Clinical Research Doctoral Fellowship, funded by Barts Charity, in 2025 and is focusing on the evaluation of muscle wasting and dysphagia in critically ill patients. Her PhD is hosted by Barts Health and Queen Mary University of London.

6. Sarah Edney

Sarah is a clinical academic speech and language therapist specialising in neonatology and infant feeding. For the past 10 years, she has been an active researcher focusing on feeding disorders following neonatal brain injury. She is nearing completion of her doctoral studies and will soon be establishing the first neonatal speech and language therapy service for the Liverpool Neonatal Partnership.

7. Carol Gilmore

Carol Gilmore is a Clinical Specialist Speech and Language Therapist with expertise in neonatal and paediatric dysphagia. She currently leads

	the development of a sustainable NICU SLT service at Galway University Hospital and is undertaking a Professional Doctorate in Health at the University of Bath, where her research examines the prevalence and long-term impact of oral aversion in infants following NICU admission.
	**8. Professor Brendan McGrath** Brendan qualified from the University of Sheffield and trained initially in general medicine in the UK and Australia. He returned to specialise in Anaesthesia & Intensive Care Medicine, appointed as a consultant at Wythenshawe Hospital (Manchester University Foundation Trust) in 2009. Brendan's research interests in patient safety and airway management led to the initiation of the UK National Tracheostomy Safety Project, collaborating widely in developing educational resources. Brendan helped to develop the Global Tracheostomy Collaborative in 2012, bringing together international expertise from Harvard to Melbourne with the goal of improving care everywhere. Brendan has led several domestic and international quality improvement projects, device development studies and research programs, improving the safety and quality of care. Outside of medicine, Brendan is entertained by a young family, attempts to support Liverpool FC whilst living near Old Trafford, and tries to ride his road bike when it isn't raining (too hard).

9. Ella Terblanche

Ella is an award-winning critical care dietitian, researcher and leader with over 20 years of clinical, academic and national strategic experience. She was honoured with an MBE in 2021 for services to Dietetics and the NHS. She is proven expert at translating evidence into practice, leading large-scale workforce transformation projects, and advancing critical care nutrition research. Ella's currently undertaking a PhD focused on improving nutritional recovery for survivors of critical illness. She has a strong publication record, experience as investigator on NIHR multicentre portfolio studies, and a passion for building a research active dietetic profession.

10. Dr Margaret Coffey and Mr Chadwin Al – Yaghachi

Dr Margaret Coffey

Dr Margaret Coffey is a Clinical Academic Speech and Language Therapist with extensive experience in the evaluation and treatment of dysphagia. Margaret has developed her clinical skills working in recognised centres of excellence in both the UK and the USA. She currently works at Imperial College Healthcare Trust in London, UK and is an honorary Senior Clinical Lecturer at Imperial College London, UK. Margaret is a Royal College of Speech and language Therapists designated national clinical advisor.

Margaret is especially interested in the evidence based use of instrumental swallow evaluation tools including FEES to evaluate and manage swallowing function after head and neck cancer. She was one of the first SLTs in the UK to be awarded a prestigious National Institute of Health Research (NIHR) Clinical Doctoral Fellowship pioneering the use of FEES as a swallow evaluation tool for people with laryngectomy. Margaret was also one of the first SLTs to be awarded a NIHR Advanced Fellowship to continue her post-doctoral work on an early-stage clinical trial investigating the feasibility of an exercise-based intervention to

	improve swallow function for people with laryngectomy. Margaret has published in leading peer reviewed journals and regularly provides teaching and organises courses aimed at promoting evidence based clinical care. She has contributed to national clinical guidance including the RCSLT FEES and HRM position papers and competency frameworks and the UK Multidisciplinary Head and Neck Cancer guidelines. Margaret was recognised by the Royal College of Speech and Language Therapists (RCSLT) with a fellowship in 2021. Margaret was also awarded an honorary MBE in the Queen's Birthday Honours in 2022 for services to Speech and Language Therapy.
	**Mr Chadwan Al Yaghchi** Mr Chadwan Al Yaghchi is a consultant laryngologist at the National Centre for Airway Reconstruction, Imperial College Healthcare, London. He manages the full spectrum of laryngeal disorders with specialist interest in airway stenosis and complex dysphagia. He completed his higher surgical training in Ear Nose and Throat in the London North Thames regional rotation and laryngology training at Charing Cross Hospital. Mr Al Yaghchi holds a PhD in Molecular Oncology from Queen Mary's University of London studying oncolytic viruses in head and neck cancers. In addition, he has an active clinical research program in voice, airway and swallowing disorders. He published multiple book chapters, 30 peer-reviewed articles and is currently the Laryngology Section editor of Scott-Brown's Otolaryngology textbook. Mr Al Yaghchi is a founding member of the British Laryngological Association and the honorary treasurer. He is a board member of the UK Swallowing Research Group and Vice General Secretary of the European Laryngological Society.

11. Dr Marloes Lagarde and Dr Mari Viviers

Dr Marloes Lagarde

Marloes Lagarde, PhD is a speech language pathologist and researcher within the neuromuscular center of the Amalia Children's hospital of the Radboud university medical center in the Netherlands. In 2022 she finished her PhD on the use of instrumented measurements in the diagnosis of pediatric dysphagia. Her research focuses on the application of ultrasound within speech-language pathology diagnostics and treatment. She is supervisor of a PhD student, who is currently studying the natural history of dysarthria and dysphagia in Duchenne Muscular Dystrophy and Myotonic dystrophy type 1.

Dr Mari Viviers

Mari is currently the Clinical Lead: Paediatric speech and language Therapist at Imperial College NHS Healthcare Trust. She completed her PhD in infant feeding with a specific focus on neonatal dysphagia in premature and high-risk infants. She currently holds NIHR BRC post-doctoral fellowship funding with Imperial College London where she is an Honorary Clinical Research Fellow in the Human Performance Lab. Her current post-doctoral research focuses on the use of ultrasound to assess sucking, swallowing and laryngeal function in infants and children. Mari has presented nationally and internationally at various conferences on the topics of neonatal and paediatric dysphagia. In addition, she has numerous peer-reviewed journal publications on neonatal dysphagia, and early intervention. She has also authored multiple chapters in textbooks. She currently serves on the RCSLT London PDCEN committee and as research chair of the research working group in the RCSLT Neonatal CEN

12. Associate Professor Rogaine Govender MBE

Roganie is a consultant clinical-academic SLT at University College London Hospital and an Associate Professor at UCL, Division of surgery & Interventional Science. She is currently AHP representative on the British Association of Head and Neck Oncology Council, serves on the European Society of Swallowing Disorders (ESSD) research group and an active member of the Royal College of Speech & Language Therapists contributing to national guidelines and policies for the profession.

Roganie's research interest centres around swallowing, cancer prehabilitation and health behaviour change within pre/rehabilitation interventions. She has won multiple fellowships from the NIHR over the last 10 years enabling her training in mixed methods research and clinical trials. She recently led on a pilot cluster-randomised multicentre trial of swallowing prehabilitation in people with head and neck cancer. This was one of the first AHP-Led clinical trials to support the NIHR Associate Principal Investigator Scheme helping to build capacity for AHP leadership and engagement with clinical trials.

13. Professor Paula Leslie

I support clinicians in research and training for complex decision-making, ethics, end of life and vulnerable populations. I have taught professional writing and scientific presentation skills for over two decades. I am a member of the American Society for Bioethics & Humanities, American Speech-Language Hearing Association (ASHA) SIGs in swallowing disorders and geriatrics, and founder member of UKSRG. I am proud to be a Fellow of the Royal College of Speech and Language Therapists and a Fellow of ASHA, and currently work for the NICE External Assessment Group, NHS Northern Medical Physics and Clinical Engineering Directorate.

14. Professor Sheraz R. Markar PhD (Imperial), PhD (Karolinska), FRCS, MSc, MA

Sheraz is a Professor of Upper Gastrointestinal Surgery and Director of Surgical Interventional Trials Unit, Nuffield Department of Surgery, University of Oxford and Consultant Oesophago-Gastric Surgeon.
Sheraz qualified in Medicine from Cambridge University in 2007. He undertook his academic and surgical training in Cambridge, London, Seattle, Stockholm and Oxford, including NIHR Doctoral Research & Clinical Trials Fellowship and NIHR Academic Clinical Lectureship. He has completed two PhD degrees, at Imperial College London developing a breath test for oesophago-gastric cancer and at Karolinska Institutet, Sweden, concerning complex statistical modelling of surgical outcomes from oesophagectomy. He has a strong academic and clinical interest in the management of benign and malignant upper gastrointestinal disease, with over 300 publications. He is a member and chair of several surgical committees including International and European Society for Diseases of the Esophagus and has received several research awards including the Royal College of Surgeons Hunterian Professorship 2020 and United European Gastroenterology Rising Star 2019. He is the Royal College of England surgical specialty lead for oesophageal and gastric cancer.
The focus of Sheraz's research and surgical practice in Oxford is the design and implementation of challenging trials, surgical quality assurance and integration of novel technology, to improve the clinical outcomes for patients with benign and malignant oesophageal and gastric disease.

15. Mr James O'Hara

James O'Hara is a clinical academic ENT surgeon, with interests in head and neck surgery and dysphagia….but he is interested in researching anything in ENT! As part of the team in Newcastle, James has helped deliver trials showing that PPIs are ineffective for throat symptoms, that adult tonsillectomy is clinically and cost effective, and that septoplasty is clinically and cost effective. He leads the Trial of Alginates in Throat Symptoms, which should be reporting over the next few months. He is the academic chair for BACO 2026 and is the ENT specialty research lead within the RCS England. James is always keen to hear from anyone who wants any guidance on how to conduct research. Email on James.O'Hara@newcastle.ac.uk

16. Dr Kornilia Nikaki

Dr Kornilia Nikaki is a Consultant in Paediatric Gastroenterology at Great Ormond Street Hospital, with sub-specialisation in the field of Neurogastroenterology. Dr Nikaki graduated with Honours from University of Thessalia, Greece in 2006 and since pursued training in General Paediatrics and later on in Paediatric Gastroenterology, Hepatology and Nutrition in the UK. Dr Nikaki was awarded a PhD from Queen's Mary University of London in 2022 on work performed in the Wingate Institute of Neurogastroenterology on paediatric gastroesophageal reflux disease (GORD). She has served as the Chair of Gastroenterology at BSPGHAN between 2021 and 2024 and is an active member of the ESPGHAN Motility working group.

17. Professor Rob George MA MD Cantab FRCP Lond FRCP Edin FRCGP(Hon) FRCPathME

I started my career in General and Respiratory Medicine before pioneering HIV & non-cancer palliative care. Since then, I have worked in all its settings: teaching hospitals, DGHs, and NHS and voluntary hospices.
Having retired from full-time clinical work, I continue to practice at Guy's and St Thomas' NHS Foundation Trust and Greenwich & Bexley Hospice.
I have been President of the Association for Palliative Medicine of Great Britain and Ireland, an elected Councillor for the RCP London and Secretary of their Committee on Ethical Issues in Medicine. I chair the Speciality Certificate Exam Board for Palliative Medicine and have sat on RCP working parties reporting on palliative care and Prolonged Disorders of Consciousness. I have advised various UK government departments on end-of-life issues.
I am a clinical academic with a particular interest in the Philosophy and Ethics of Care. I was Senior Lecturer in Bioethics at University College London before gaining a personal chair at the Cicely Saunders Institute at King's College London. He has around 150 publications that reflect my interests.
I am a cyclist, foodie and wine bibber. My children and most of his grandchildren have given medicine a wide berth.

18. Dr Laura Chahda

Dr Laura Chahda is a senior speech-language pathologist and researcher, with a clinical and academic focus on swallowing, communication, and cognitive changes in adult and elderly populations. Passionate about palliative care, she pursued death studies before completing her speech pathology qualifications. Her award-winning research has contributed to redefining speech-language pathology's role in end-of-life care in Australia. An adjunct research fellow at Victoria University (Melbourne, Australia), she continues to practice in acute, community and palliative care, striving to improve clinical practices, mentor future professionals, and

	advocate for enhanced swallowing management in vulnerable populations.
	**19. Dr Dharinee Hansjee** Dharinee Hansje is programme lead and an academic portfolio lead at the University of Greenwich. She is a national advisor for dysphagia (dementia). Her special interest lies in eating drinking and swallowing difficulties in older people and she has published extensively in this area. She has delivered national and international presentations on the development of guidance on eating and drinking with acknowledged risks (EDAR) and is lead author for the RCSLT multi professional guidance. Dharinee was awarded an RCSLT fellowship in recognition of her work in this area of care. She is currently completing her doctoral thesis on the subject of EDAR.
See Number 10	**20. Dr Margaret Coffey and Mr Chadwan Al-Yaghachi**
	**21. Dr Jodi Allen and Dr Joan Ma** **Dr Jodi Allen** Dr Jodi Allen is a clinical specialist speech and language therapist at The National Hospital for Neurology and Neurosurgery in London. She specialises in swallowing and motor speech disorders caused by progressive neurological and neuromuscular disease. Jodi completed her NIHR-funded PhD in 2025, investigating the multidimensional profile of dysphagia in Myotonic Dystrophy Type 1. Her research used instrumental assessments including muscle MRI, ultrasound and videofluoroscopy, alongside clinical and patient-reported measures. She chairs the international ultrasound speech and language therapy working group and has authored several peer-reviewed publications on ultrasound applications in this field.

	**Dr Joan Ma** Joan is a Senior Lecturer in Speech and Hearing Sciences and a member of the Clinical Audiology, Speech and Language Research Centre at Queen Margaret University. She leads the Swallow Vision project (www.swallow-vision.com), which focuses on developing the technology and the evidence base in supporting the clinical translation of ultrasound in different areas of speech and language therapy, including Ultrasound Evaluation of Swallowing (USES) and laryngeal ultrasound. She is a member of the International Ultrasound Working Group and received funding from the Royal Society of Edinburgh for the ultrasound project. Joan is also the Women in Research Champion at QMU and an Associate Academic Lead for REF 2029.
See Number 12	**22. Associate Professor Roganie Govender MBE**
See Number 13	**23. Professor Paula Leslie**
	**24. Lee Bolton** Lee is currently the Speech and Language Therapy Service Manager and Professional Lead at NHS Western Isles. Before relocating to the beautiful Outer Hebrides, he was the Clinical Lead SLT at Royal Brompton and Harefield hospitals in London where he developed a specialist interest in swallowing disorders associated with complex respiratory and cardiothoracic conditions. During this time, he became an Improvement Leader Fellow with the NIHR Applied Research Collaborative North West London, leading a project to improve the earlier identification and management of Swallowing and Voice Outcomes after Cardiac and Lung Surgery (SVOCALS-QI). Prior to this, Lee completed a Pre-doctoral Fellowship at Imperial College Healthcare Trust. His study explored the feasibility of a methodology for investigating swallowing during and after an acute exacerbation of COPD using FEES. He has presented nationally and internationally and has been an invited guest lecturer on swallowing and communication disorders and rehabilitation at Brunel University, Trinity College Dublin, and the University of West London. He has published peer-reviewed

	articles on dysphagia in respiratory and cardiothoracics and has contributed to several professional body publications for the RCSLT, British Thoracic Society and Intensive Care Society. In recognition of his contributions to the profession during the pandemic, Lee was awarded a Fellow of the RCSLT.
 	**25. Sabrena Lee & Shevonne Waines (parent speaker)** **Sabrena Lee** Sabrena Lee is a speech and language therapist who has worked at Evelina London Children's Hospital for the last seven years. Prior to this, she worked across various tertiary children's hospitals in Australia specialising in the area of paediatric feeding. Sabrena completed an NIHR Pre-doctoral Clinical Academic Fellowship in 2022 where she completed research on the feeding and swallowing needs of children who receive long-term ventilation. She hopes to continue completing research with patients and their families in this topic area in the future. **Shevonne Waines (parent speaker)** Shevonne Waines is the mother of an 8-year-old boy with long-segmented tracheal stenosis, left pulmonary artery sling, and anal atresia. He spent his first 15 months in hospital and continues to rely on tracheostomy ventilation. Drawing on her background as an Occupational Therapist, Shevonne helped him learn to eat a regular diet, eliminating the need for gastrostomy by age 4, and taught him to communicate with Makaton after vocal cord palsy until his voice returned at age 5. Shevonne is self-employed as an Occupational Therapist, Expert Witness, and Makaton Tutor, working around Henry's care needs. She manages a team of 11 staff through a direct payment (PHB) to ensure Henry's safety and mainstream school attendance, which averages 94%. Shevonne supports families in similar situations and shares her experience with WellChild and Great Ormond Street Hospital through fundraising and speaking at national events. She also works with her local university through co-production, helping health and social care

	students understand life for families like hers and raising awareness of the challenges long-term ventilation (LTV) can bring in all aspects of life.
	**26. Dr Ricardo Jose** Dr Ricardo José is a Consultant in Respiratory Medicine at the Royal Brompton Hospital and an Honorary Associate Professor at University College London's Centre for Inflammation and Tissue Repair. He completed his medical degree at the University of Pretoria, holds a Diploma in Anaesthetics from the Colleges of Medicine of South Africa, a Postgraduate Certificate in Public Health from the University of Manchester, and a PhD in respiratory infection, inflammation and immunity from UCL. Dr José's has particular expertise in the management of complex chest infections, bronchiectasis, airway disease and pulmonary complications of cancer therapy.
	**27. Dr Susan Guthrie** Principal Speech and Language Therapist (SLT) & Clinical research lead, Leeds and York Partnership Trust; Honorary research fellow School of Healthcare, University of Leeds. I have many years experience working with adults who have mental health and/or learning disabilities in both community and hospital settings. I am currently working as a research lead and clinician, based in Leeds and York PFT with adults with mental health conditions. My research publications explore risk of choking and dysphagia experienced by adults with learning disabilities and mental health conditions. I am interested in scoping the role of SLT in mental health and promoting awareness of the impact and value of SLT. This includes SLT role in assessment and intervention for communication difficulties. Recent research My PhD study explored the nature of mealtimes and choking incidents experienced by adults on inpatient mental health wards. This was

	collaborative research and highlighted the voices of inpatients (link to summary: 'me at mealtimes - patient stories'). My interest in communication includes inclusive research with people who have communication or cognitive difficulties. I am interested in accessibility in research including creative and inclusive forms of dissemination. Collaborations & activities RCSLT clinical advisor (mental health and dysphagia), chair of UK network #SLTsinMH. I sit on relevant RCSLT workgroups including shared decision making and capacity assessment work group. I am passionate about supporting clinicians into research and developing SLT evidence base.
	**28. Associate Professor Lindsey Collins** Lindsey is an Associate Professor at the University of Bradford and a registered Speech and Language Therapist who specialises in working with people living with dementia. She has been responsible for developing specialist Speech and Language Therapy services within several UK NHS Mental Health Trusts prior to commencing her current role. Lindsey has a particular interest in supporting people living with dementia who experience eating, drinking and swallowing difficulties, which has been the focus of her PhD and post-doctoral research. Lindsey is also passionate about supporting others to develop skills to engage meaningfully with people living with dementia and enhance well-being. Within the University of Bradford's Department of Applied Dementia Studies, Lindsey leads on the development, delivery and evaluation of person-centred dementia care consultancy and training packages for health and social care organisations throughout the UK and internationally.
	29. Tracey Lazenby – Paterson Tracy is a Speech and Language Therapist specialising in eating, drinking and swallowing disorders in adults with intellectual disabilities in NHS Lothian. She is an RCSLT Professional Adviser in ALD Dysphagia and Chair of the

	Scottish SLT Dysphagia Clinical Excellence Network. She is a founding member of the Swallowing Perspective Advocacy and Research Collective (SPARC), whose research aims to progress person-centred and knowledge-based practice. Tracy also works in the private sector providing medico-legal expert witness reports for choking investigations. Her professional and research interests are in the changing evidence base about texture and viscosity modification, and ethical considerations in the assessment and management of risk in dysphagia.
	**30. Sonja Jacobs** Sonja is a Speech and Language Therapist (SLT) at Barth Health NHS Trust, with over 25 years of experience supporting children with eating, drinking and swallowing difficulties, and their families, in community services. She is the recipient of a NIHR Doctoral Clinical Academic Fellowship and is currently pursuing a PhD at Queen Mary University of London. Passionate about empowering families, Sonja has a particular interest in shared decision-making for babies and children with complex eating, drinking and swallowing needs. Her PhD research explores the experiences of parents feeding their premature infants after hospital discharge and co-designing a resource to support families during this critical transition.

Abstracts

Free papers Thursday 5th February 2026

Determining the Value of Bulbar (Genioglossus) Electromyography in the Assessment of Dysphagia in Children

Martina Guido[1], Melissa Pritchard[2], Eleanor Conway[2], Alex Stewart[2]

[1]University College London, London, United Kingdom. [2]Great Ormond Street Hospital, London, United Kingdom

Abstract

Background: Genioglossus electromyography (gEMG) is used to identify bulbar palsy as a cause of dysphagia in children. Previous studies have demonstrated association between abnormal gEMG findings and poor feeding outcomes. However, the relevance of abnormal gEMG to dysphagia severity and trajectory of swallow function is unknown. This study compared videofluoroscopy swallow study (VFSS) and functional feeding outcomes in children for those with normal and abnormal gEMG outcomes.

Methods: This was a five-year retrospective case note review, single-centre service evaluation. Demographic, medical history, and outcome data were collected. VFSS outcomes: presence/absence of aspiration, penetration, and residue at first and last VFSS. gEMG results: normal/abnormal. Functional outcome: Children's Eating and Drinking Activity Scale (CEDAS). Non-parametric statistical tests were used to identify group differences.

Results: Data were collected for 35 participants (20 males). Fifteen had abnormal gEMG. No significant differences found in gender between gEMG groups or age at gEMG or first VFSS. Children with abnormal gEMG were significantly older at last VFSS (median 7.73 years vs 3.50 years p = 0.02). No significant differences in VFSS outcomes or CEDAS at either VFSS.

Discussion: Those with abnormal gEMG did not have different pattern of aspiration, penetration or residue compared to those with normal gEMG at first or last VFSS. However, older age at last VFSS for those with abnormal gEMG suggests longer time to improvement. This is an important finding regarding prognosis. Future research with larger numbers would be valuable to confirm this finding.

Quantitative muscle ultrasound as an assessment and phenotyping tool in neuromuscular dysphagia

Jodi Allen[1,2], Tom Parry[1], Caroline Waszkiewicz[2], Christina Smith[3,4], Roganie Govender[5], Sue Mallett[1], Stuart Taylor[1]

[1]University College London Centre for Medical Imaging, London, United Kingdom. [2]The National Hospital for Neurology and Neurosurgery, University College London Hospitals, London, United Kingdom. [3]University College London Division of Psychology and Language Sciences, London, United

Kingdom. [4]NHS Lothian, Edinburgh, United Kingdom. [5]University College London Division of Surgery & Interventional Science, London, United Kingdom

Abstract

Current dysphagia phenotyping focuses on biomechanical function while neglecting disease-specific pathophysiology. This limits treatment selection in conditions like myotonic dystrophy type 1 (DM1), where dysphagia may result from central nervous system impairment, peripheral muscle pathophysiology, or both. We integrated biomechanical and muscle pathophysiology assessments to characterise DM1 dysphagia phenotypes.

Ninety-four adults with DM1 were recruited from across the UK (July 2023 to August 2024). Participants underwent videofluoroscopic swallowing study using the Modified Barium Swallow Impairment Profile and quantitative muscle ultrasound (QMUS) of five swallowing-related muscles (geniohyoid, anterior digastric, masseter, temporalis, and tongue). Participants were stratified by MBSImP oral and pharyngeal sum score tertiles. QMUS echogenicity and thickness were converted to sex-, age-, and BMI-adjusted z-scores and compared between tertiles. Sample size was calculated based on geniohyoid muscle changes as the primary outcome.

Median age was 45 years (IQR 38,52); 52 were female. Muscle pathophysiology patterns varied by dysphagia type and severity. For pharyngeal dysphagia, median geniohyoid echogenicity z-scores decreased across tertiles: 2.60 (IQR 2.25, 2.79; n=22), 2.34 (1.48, 3.05; n=38), and 1.73 (1.43, 2.31); n=30), while thickness was reduced in tertiles 1-2 (medians -1.09 and -1.06) but less affected in tertile 3 (-0.40). All oral dysphagia tertiles showed elevated geniohyoid echogenicity (2.18- 2.30) and reduced thickness (-1.01 to -1.07). Results for remaining muscles, including the tongue (z-scores near zero) will be presented.

QMUS indicators of altered muscle pathophysiology were associated with biomechanical dysphagia in DM1, but the relationship was not universal, potentially indicating multifactorial dysphagia mechanisms beyond muscle pathophysiology alone.

Implementing the free water protocol in the acute stroke unit setting: Focus groups to explore how to overcome perceived barriers.

Nicola Martindale[1], Sabrina Eltringham[1,2], Elizabeth Lightbody[3], Sue Pownall[1], Craig Smith[4,5]

[1]Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield, United Kingdom. [2]Sheffield Hallam University, Sheffield, United Kingdom. [3]University of Central Lancashire, Preston, United Kingdom. [4]University of Manchester, Manchester, United Kingdom. [5]Manchester Centre for Clinical Neurosciences, Salford Royal Hospital, Northern Care Alliance NHS Trust, Manchester, United Kingdom

Abstract

Background: The free water protocol (FWP) is a management approach for people who aspirate thin fluids. Individuals continue to drink water and follow strict guidelines to minimise consequences of aspiration. A national survey of stroke professionals identified barriers to the implementation of the FWP in acute stroke.

Methods: Five online focus groups explored ways to overcome identified barriers related to: concerns around risks of aspiration and consequences, complexity of patient selection, training, oral care, staff workload and turnover and lack of clear guidelines. Stroke professionals from across the UK with >6 months experience were invited; some but not all used the FWP routinely. Focus groups were transcribed and analysed using the Consolidated Framework for Implementation Research.

Results: Speech and language therapists (n=8), nurses (n=4) and support staff (n=2) from 5 NHS acute stroke units took part. A key theme included training, with benefits of MDT involvement in the provision as well as receipt of training to increase shared responsibility. Content of training to include oral care as well as management of red flags and roles and responsibilities. A rolling training program was suggested to address staff turnover. Other suggestions included developing a protocol with clear eligibility criteria, multimodal communication amongst the MDT and ways to improve accuracy of recording water intake.

Discussion: Findings from these focus groups informed national workshops, where an implementation strategy was codesigned with stakeholders. This strategy will be trialled in a feasibility study on an NHS acute stroke unit in the next phase of this research.

Is there value in intensive dysphagia therapy six months after radiotherapy? A service evaluation of Swallowing bootcamp

Caitlin Reilly[1], Lucy Tennant[1], Rachel Sylla[1], Megan O'dell[1], Joanna Lawson[1], Mary Lee[1], Roganie Govender[2]

[1]University College London Hospital, London, United Kingdom. [2]UCL, London, United Kingdom

Abstract

Background: Swallowing bootcamp is a high intensity rehabilitation programme using bolus-driven exercises to support swallowing recovery following treatment of head and neck cancer. This service development project explored whether an intensive Bootcamp programme warrants further resource investment within the SLT team at a tertiary head and neck centre.

Methods: Eligible participants presenting with dysphagia 6-18 months post chemo/radiotherapy were offered participation, with 8 agreeing. The programme comprised baseline VFS; 12 60-minute sessions offered 3 times weekly for 4 consecutive weeks; post-treatment VFS; review appointments at 3, 6, 12 months. Data was collected on patient reported outcomes (MDADI, distress thermometer, SWAL-CARE, interview), functional outcomes (PSS-HN, FIGS, MIO, gastrostomy dependence), and instrumental swallow assessment measures (DIGEST, PAS). Results were analysed using descriptive statistics and content analysis.

Results: No significant change was seen on DIGEST and PAS scores pre and post Bootcamp. However, functional and patient-reported outcomes improved and were sustained at 12 months. MDADI scores reflected an improvement in swallow-related quality of life, with reduced dependence on enteral feeding. Results of content analysis demonstrated participant satisfaction with bootcamp programme, specifically the rapport with clinicians over the block, improved swallowing, and increased knowledge about managing dysphagia.

Discussion: This project demonstrates the value of intensive swallow rehabilitation programs to maximise swallow outcomes. We were able to complete this project because of additional funding. Our results support the case for increased clinical capacity to offer this kind of intensive programme on a regular basis to a wider head and neck patient population beyond radiotherapy.

Eating and Drinking Function in individuals with cerebral palsy across the lifespan – Does function change with time?

Kelly Weir[1,2], Lisa Moshovis[3], Marie Blackmore[4], Monica Cooper[2], Katherine Langdon[5], Andrew Wilson[5], Noula Gibson[5], Thuy Frakking[6], Robert Ware[7]

[1]The University of Melbourne, Melbourne, Australia. [2]The Royal Children's Hospital, Melbourne, Australia. [3]Ability WA, Perth, Australia. [4]The Kids Institute, Perth, Australia. [5]Perth Children's Hospital, Perth, Australia. [6]Gold Coast Health, Southport, Australia. [7]Griffith University, Brisbane, Australia

Abstract

Two thirds of children with CP have oropharyngeal dysphagia(OPD) and 1/3 will require modified texture diets/fluids, and/or tube feeding to support nutrition. Little is known about the progression/deterioration of dysphagia to guide surveillance and timing of swallowing-mealtime reviews. This project aimed to describe the clinical presentation of swallowing skills across time, and whether age or key transition periods are associated with changes in swallow function. We conducted a retrospective study reviewing 530 mealtime evaluations from 113 customers attending a community-based disability service in Western Australia. Customers with CP with mealtime plans in six age bands (0-12 months; 1-3, 4-8, 9-12, 13-17 and 18+ years) were included. Data extracted from client records included age, sex, cerebral palsy type, motor function assessed on the Gross Motor Ability Classification System(GMFCS), comorbidities, swallowing assessment results and classification using the Children's Eating and Drinking Activity Scale(CEDAS). Preliminary analysis of 90 customers/patients and 294 mealtime evaluations included 53(59%) males, mean age 5.3±4.3 years. The majority were aged 1-3y(40%) and 4-8y(28%), with GMFCS levels II(23%), IV(29%) or V(27%). As motor ability decreased, so did children's eating and drinking ability. As age increased, the difference between GMFCS I and V got further apart ($p<0.001$), suggesting children with GMFCS I improved eating-drinking ability, whilst those with GMFCS V(more severe) did not. Our study provides foundational knowledge about the progression of OPD in individuals with CP over a large age period informing future service delivery.

Boosting confidence at the bedside: Supporting speech and language therapy students to offer mealtime assistance

Sally Archer[1], Elizabeth Farrell[2], Valentine Olds[2]

[1]Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom. [2]University College London, London, United Kingdom

Abstract

Background: Hospital mealtimes are a crucial point of care yet patient support is compromised by clinical pressures and staffing shortages[1]. Enabling SLT students to assist with mealtimes aligns with the RCSLT Eating, Drinking and Swallowing Competency Framework[2] and may enhance care. However students often lack confidence in this area[3] .This study aimed to design and evaluate an intervention to prepare students for mealtime support.

Methods: Consecutive SLT students on placement at an NHS Hospital over 6 months completed a questionnaire rating statements from 0 (low) to 10 (high) about preparedness, confidence, knowledge and skills in assisting with mealtimes and providing suggestions for improvement. A resource was created, piloted and trialled with subsequent students and median (IQR) questionnaire scores compared pre-post intervention with the Mann-Whitney U test.

Results: Eight students completed the pre-intervention questionnaire. Their feedback informed development of a resource covering ward orientation, personnel, practical tips, feeding and trouble-shooting. After launch, questionnaire scores were compared for the next eight students. Scores improved significantly across all questions pre-post intervention ($p<0.05$); preparedness – 4/10 (3.3 – 5) to 9/10 (8.0-10.0), confidence -3.5/10 (2.8-4.3) to 9.0/10 (7.9-9.3), skills - 4.0/10 (3.8-5.0) to 8.0/10 (8.0 – 9.6), knowledge - 5.0 (4.0 -6.5) to 10.0 (8.9 – 10.0). All reported the resource was helpful and mealtime assistance built confidence for ward work.

Discussion: A targeted educational tool improved SLT students' preparedness and competency for supporting mealtimes. The resource is now embedded in practice and shared with other professions aiming to improve patient experience. Future work is exploring patient feedback about mealtimes.

Poster abstracts Thursday 5th February 2026

1. Reliability and measurement agreement of quantitative muscle ultrasound (QMUS) for assessing swallowing-related muscle pathophysiology

Jodi Allen[1,2], Tom Parry[1], Carmel Evans[3], Quezada Gabriella[4,2], Christina Smith[5,6], Roganie Govender[7,3], Sue Mallett[1], Stuart Taylor[1]

[1]University College London Centre for Medical Imaging, London, United Kingdom. [2]The National Hospital for Neurology and Neurosurgery, University College London Hospitals, London, United Kingdom. [3]University College London Hospitals, London, United Kingdom. [4]Queen Margaret University Division of Speech and Hearing Sciences, Edinburgh, United Kingdom. [5]University College London Division of Psychology and Language Sciences, London, United Kingdom. [6]NHS Lothian, Edinburgh, United Kingdom. [7]University College London Division of Surgery & Interventional Science, London, United Kingdom

Abstract

Quantitative muscle ultrasound (QMUS) is a promising tool for detecting changes in swallowing-related muscle pathophysiology. Establishing robust measurement reliability and agreement parameters is essential for its successful translation from research to clinical practice. We assessed QMUS reliability and measurement agreement in healthy controls and patients with muscle pathology to enable clinicians to confidently distinguish true pathological changes from measurement error.

Sixty-three healthy controls and ninety-four participants with myotonic dystrophy type 1 (pwDM1) underwent QMUS of five swallowing-related muscles (geniohyoid, anterior digastric, masseter, temporalis, and tongue). Inter- and intra-investigator reliability for muscle structure (echogenicity) and size (thickness) was assessed for both: (1) image acquisition and measurement, and (2) measurement alone, in subsets of 20% of controls and 10% of pwDM1. We calculated intraclass correlation coefficients (ICC) and Bland-Altman plots with 95% limits of agreement (LoA) for echogenicity and thickness measurements.

Controls had a median age of 43 (IQR 30, 56; 32 females) and pwDM1 had a median age of 45 years (IQR 38, 52; 52 females). Geniohyoid echogenicity demonstrated ICC ranges of 0.73-0.99 in controls and 0.80-0.97 in pwDM1 across all four measurement contexts, with corresponding 95% LoA of ±23 and ±34 grayscale units (scale 0-255) respectively. Thickness measurements showed ICC ranges of 0.07-0.83 in controls and 0.37-0.74 in pwDM1, with 95% LoA of ±3.8mm and ±4.4mm respectively. Bland-Altman plots revealed distinct patterns across the remaining muscle groups.

The need to improve measurement agreement will depend on the smallest difference required to detect meaningful change in muscle pathophysiology.

2. What are the challenges of completing dysphagia therapy in a NHS community setting?

Helen Heer

Sheffield Hallam University/ Leeds Community Healthcare, Sheffield/ Leeds, United Kingdom

Abstract

Background: NHS care to community settings is at the forefront of the government's 10 year plan. Dysphagia is a common complication following neurological or respiratory conditions, as well as being common amongst a frail and elderly population. For clinicians working in a NHS community setting dysphagia therapy can be a considered option for intervention, however anecdotally this is rarely considered. This service review was completed as part of the NIHR Integrated Clinical Academic Programme Internship, to look at the challenges of implementing dysphagia rehabilitation in a NHS community setting.

Methods: An online survey to clinicians within the service, followed by semi-structured interviews. Reflective thematic analysis was then used to code and themes produced from the data. Patient and public engagement was sought from patients that the author was working with.

Results: The service was a largely young, white British, female service, catering for patients with neurological, respiratory and frail conditions for communication and swallowing difficulties.

Workforce was split 50/50 for the length of time of being a registered clinician – 2-8 years; 8-15+years. Clinicians had been dysphagia trained between 2 and 34years.

Clinician's confidence levels for use dysphagia therapy was variable.

Three themes emerged:

Three themes emerged:

- Clinical confidence & a Reliance on the 'familiar
- Significant Pressures with the Service.

- Significant Demand on the Service

- Low Morale

- Lack of Creativity

- Receptiveness for the Therapeutic Intervention.

Discussion:

- Dysphagia therapy is not at the forefront of clinical intervention in this community setting.
- Reduced clinical confidence was significant.

Patients were not appropriate for a therapeutic intervention.

3. Creating a toolkit for families of children who need assistance with eating and drinking: Safe Efficient and Enjoyable Mealtimes (SEEM Study) – current progress

Sally Morgan[1], Kathleen Mulligan[1,2], Kelly Weir[3,4], Katerina Hilari[1]

[1]City St George's, University of London, London, United Kingdom. [2]East London Foundation Trust, London, United Kingdom. [3]University of Melbourne, Melbourne, Australia. [4]The Royal Children's Hospital Melbourne, Melbourne, Australia

Abstract

Background: The abilities and experiences of family-carers providing mealtime assistance to children with dysphagia and how Speech & Language Therapists (SLT) work with them are unknown. This PhD will develop a prototype resource to support SLT-family-carer joint working.

Methods: Following the MRC framework for complex intervention development's 'develop intervention' stage four studies were delivered:

1: Systematic literature review: Best research evidence:

2: Survey of UK SLT clinical practice: Clinical expertise

3: Qualitative family mealtime study: Patient and/or carer values

4: Synthesis through co-design with family-carers and SLTs

Outcomes: Study A: Great study heterogeneity was found e.g., setting, participants, interventions and outcomes. Some results had a positive effect, but variability prevented a recommendation of any specific approach. Publication under review.

Study B: One hundred and forty participants described minimal validated assessment use. Reported mealtime recommendation practice focussed on supporting family-carer's knowledge, skills and risk awareness with less mention of other potential aspects e.g., emotion, restricted resources. Practice constraints was evident with high documentation variability. Covid-adaptation article published, main publication under review.

Study C: Delivered 2024. Six diverse family-carers described confidence in their knowledge, skills and risk awareness alongside personal problem-solving when SLT recommendations did not match their child or family's needs or context. Analysis ongoing.

Study D: Underway August-October 2025. Some core resource principles evident from outset e.g., co-designed, accessible.

Discussion: A limited research evidence base, limited SLT published research uptake e.g. assessments, and the context of constrained services indicates a resource may be beneficial supported by careful consideration regarding adoption.

4. Current protocols for paediatric Videofluoroscopic Swallow Studies– A survey of Practice in Australia and New Zealand

Kelly Weir[1,2], Julie Bettle[2], Sree Vidya Metlapalli[1], Brittany Ng[1], Melody Ou[1], Madeline Stockdale[1], Thuy Frakking[3]

[1]The University of Melbourne, Melbourne, Australia. [2]The Royal Children's Hospital, Melbourne, Australia. [3]Gold Coast Health, Southport, Australia

Abstract

Whilst the Videofluoroscopic Swallow Study(VFSS) is commonly used for evaluating dysphagia/aspiration in children, there is currently no standardised paediatric protocol, leading to

significant practice variability. We aimed to understand current practice variation in conducting paediatric VFSS across Australia and New Zealand(ANZ). We conducted an online survey of speech pathologists/therapists undertaking paediatric VFSS. Participants were asked 71 questions about demographics and current VFSS protocols/practices. Of 52/71 valid responses, most were Australian(90%), female(98%), aged 30-39 years(33%) or 40-49 years(31%) with a bachelors degree (65%), and working in a tertiary paediatric hospital(69%). Pre-VFSS clinical feeding evaluations were required(88%) although only 46% had a specific protocol in use. Water-soluble contrast was used more frequently than barium or both contrasts, with infants consuming thin fluid formula(63%), breastmilk(67%) or other thin fluid(37%). Acquisition rates included 15 frames-per-second (fps, 79%), and 30 fps(31%). Lateral view was used most frequently, and oesophageal sweep 40-50% across age groups. Dose reduction measures included monitoring screening time(92%), collimation(60%), limiting magnification(63%), ALARA principles(90%), and radiation badges(75%). Standard VFSS analysis rating tools(79%), including the Penetration-Aspiration Scale(98%) were used. Whilst there was minimal use of quantitative measures(up to 12%), most used descriptive measures of sucks-per-swallow(29%), and swallows to clear(29%). Practice variation and minimal use of quantitative measures suggest further research and training is required to determine best practice protocols and support implementation of quantitative measures into paediatric VFSS practice.

5. Developing a Core Outcome Set for oropharyngeal dysphagia screening services in hospitals: A modified Delphi study

Caroline Smith[1], Lizelle Bernhardt[2,1], Valerie Bryant[3], Dharinee Hansjee[4], Lynn MacDiarmid[2], Paresh Parmar[5], David Smithard[6], David Wright[1]

[1]University of Leicester, Leicester, United Kingdom. [2]Leicestershire Partnership NHS Trust, Leicester, United Kingdom. [3]PPI Co-applicant, Leicester, United Kingdom. [4]University of Greenwich, London, United Kingdom. [5]London North West University Healthcare NHS Trust, London, United Kingdom. [6]Lewisham and Greenwich NHS Trust, London, United Kingdom

Abstract

Background: Oropharyngeal dysphagia (OD) affects around 50% of older adults admitted to hospital, but is not routinely screened for on 'care for the older person' wards. OD screening can reduce mortality risk and hospital stay. To inform the evaluation of a planned nurse-led OD screening service, and standardize outcome reporting in related research, this study aimed to develop a Core Outcome Set (COS) for hospital-based OD screening.

Methods: Following a modified Delphi approach, a long list of potential outcomes from three previously developed OD COSs and a systematic review of OD screening trials. This was sent out to nurses, speech and language therapists (SLT), pharmacists, senior hospital staff, researchers and patients over two rounds of Delphi questionnaires to identify those deemed most important. A 90-minute online consensus workshop was then held to finalise the COS.

Results: Outcomes were identified and sent out to participants in the Delphi questionnaires. 34 stakeholders completed round one and 28 completed round two. After round two, 30 outcomes were rated 'Important' to include and 24 did not reach consensus to include or exclude. 13 stakeholders in the consensus workshop agreed on the final COS: mortality, aspiration pneumonia, choking, medication intake, patient's experience with the service, swallowing-related quality of life, hospitalisation & proportion of patients referred to (SLT).

Discussion: This study developed the first COS for evaluating OD screening services in hospital settings. Adoption of this COS will facilitate consistency in outcome measurement, evidence synthesis and translation of research into clinical practice.

6. A feasibility study investigating the accuracy and viability of ultrasound versus fibreoptic nasendoscopy in detecting impairments of vocal fold mobility in patients with neurological disease

Fay Pickles[1], Caroline Waskiewicz[1], Simon Grobler[1], Claire Slinger[2], Aoife Stone-Ghariani[1], Jonathan Fishman[3], Jodi Allen[1]

[1]The National Hospital For Neurology and Neurosurgery, University College London Hospitals NHS Trust, London, United Kingdom. [2]Lancashire Teaching Hospitals NHS Foundation Trust, Preston, United Kingdom. [3]Royal National Throat, Nose and Ear Hospital, University College London Hospitals NHS Trust, London, United Kingdom

Abstract

Impairments of vocal fold (VF) mobility can occur in up to two-thirds of patients with neurological disease. Accurate diagnosis is essential for targeted treatment however gold-standard evaluation via fibreoptic nasendoscopy (FNE) can be costly, invasive, and subject to delays. We explored the accuracy and viability of speech and language therapist (SLT)-led ultrasound (US) to diagnose impairments of VF mobility compared to FNE.

Patients with suspected impairment of VF mobility were recruited by their treating SLT at a tertiary neurological hospital (August 2023-2024). Three SLTs underwent 5 hours of expert and self-directed US training. Patients underwent one FNE and two US examinations by two independent, blinded SLTs (rating 1 and 2). The assessment protocol included seven tasks including phonation, cough, and Valsalva. US images were scored by the SLT responsible for image acquisition and FNE scored by a blinded ENT consultant. The pre-determined scoring system included: 0 (normal movement), 1 (partial movement), 2 (no movement), or unable to score.

Twenty patients were recruited, and one withdrew due to FNE intolerance. Of the 38 complete sets of US images, one was not recorded and seven had insufficient image quality for scoring. True positive rate (sensitivity) was 4/7 (57%) for both rating 1 and 2. True negative rate (specificity) was 6/7 (85%) for rating 1 and 7/8 (87.5%) for rating 2. Inter-rater agreement as well as factors preventing image scoring will be shared.

US shows potential for ruling out impairments of VF mobility. Enhanced training programmes may improve US accuracy and viability.

7. Use of point of contact laryngeal ultrasound (POCUS) to identify vocal cord paresis in high-risk cardiac infants prior to dysphagia assessment.

Alison Felton, Harriet Edwards, Christopher Thompson, Jessica Green

Alder Hey Children's NHS Foundation Trust, Liverpool, United Kingdom

Abstract

Background: There have been increasing reports of vocal cord screening in high-risk cardiac infants over the last 10 years in both Australia and the USA. Early identification of vocal cord paresis is important as it has been associated with swallowing dysfunction, need for tube feeding, increase in aspiration events and resulting poor growth. Recurrent nerve injury also means that subsequent surgery in the right side of the neck such as for extra-corporeal membrane oxygenation cannulation (ECMO) may put the patient at risk of contra-lateral nerve injury, resultant bilateral cord injury and potential tracheostomy.

Methods: A prospective blinded assessor study was undertaken in infants under one year of age undergoing high risk cardiac surgery or ECMO who have been extubated for more than 12 hours. Inter-rater reliability of results determined between PICU clinician, ENT and Radiologist. Videofluoroscopy was conducted in identified high risk infants.

Results: Of the 67 eligible patients 21 had radiology scans, 51 had POCUS assessment, 12 underwent ENT assessment and 32 Speech and Language Therapy (SLT) assessments were undertaken (17 with additional videofluoroscopy).

Discussion: Identification of vocal fold paresis should be determined in a timely manner to minimize dysphagia related morbidity and promote appropriate length of stay in hospital. A robust pathway is required to ensure appropriate dysphagia management and mitigate the risks of silent aspiration in this high-risk group.

8. Artificial Intelligence in Videofluroscopy and Fibreoptic Endoscopic Evaluation of Swallowing analysis: A Scoping Review

Alison Keys[1], Orla Duffy[1], Rosalind Rogers[1], Clare Rainey[2]

[1]Ulster University, Belfast, United Kingdom. [2]University College Cork, Cork, Ireland

Abstract

Background: Oropharyngeal dysphagia occurs across a wide range of conditions and healthcare settings and is associated with increased healthcare resource use and cost. Early screening, instrumental assessment, and swallowing therapy can reduce this risk. The gold-standard diagnostic tools are the Videofluoroscopic Swallow Study (VFSS) and Fibreoptic Endoscopic Evaluation of Swallowing (FEES). However, subjective interpretation can lead to variability in diagnosis and treatment planning. The integration of artificial intelligence (AI) into VFSS and FEES presents an opportunity to enhance clinical decision-making, diagnostic precision, and workflow efficiency.

Aim: To conduct a scoping review of the literature evaluating the performance of AI systems developed for swallow phase analysis in VFSS and FEES.

Methods: A systematic search was conducted following the PRISMA-ScR guidelines. After applying inclusion and exclusion criteria, 18 studies were selected.

Results: The analysis showed advancements in AI models for VFSS, particularly in detecting and segmenting the pharyngeal phase, bolus and hyoid bone tracking, and penetration-aspiration events.

In contrast, fewer studies have explored AI applications in FEES, which have primarily focused on aspiration-penetration detection, residue analysis, laryngeal adductor reflex, and anatomical segmentation There was significant variability in model architectures, training methods, testing protocols, and performance metrics across both modalities.

Conclusion: Although progress has been made, a fully automated end-to-end AI tool for VFSS and FEES has not yet been developed. Nonetheless, AI holds potential to support clinical decision-making and improve diagnostic accuracy and efficiency. Standardising reporting metrics and methodologies would facilitate comparison across studies and accelerate the clinical implementation of AI tools.

9. Feeding and Swallowing Outcomes in Infants and Children with Spinal Muscular Atrophy Type 1 Treated with Disease-Modifying Therapies: Real Life Experiences

Anne Breaks, Lesley Baker

Evelina London Childrens Hospital, London, United Kingdom

Abstract

Background: Spinal muscular atrophy (SMA) type 1 causes severe motor and bulbar weakness, often resulting in aspiration and dependence on enteral feeding. Disease-modifying therapies (nusinersen, onasemnogene abeparvovec, risdiplam) have improved survival and motor outcomes, but their effects on feeding and swallowing remain less clear.

Objective: To describe early feeding and swallowing outcomes in children with SMA type 1 treated with disease-modifying therapies.

Methods: This retrospective observational study includes infants and children with genetically confirmed SMA type 1 receiving disease modifying therapies. Data collected include feeding route (oral, partial oral plus enteral, tube-fed), videofluoroscopic swallow study (VFSS) findings where available, and clinical swallowing observations. Descriptive analysis is being undertaken.

Results: Data collection is ongoing. Preliminary observations suggest heterogeneity in feeding outcomes. Some children appear to maintain safe oral intake, while others remain partially or fully tube fed. VFSS has been performed in a subset, demonstrating variable findings. Full results will be available by the time of the presentation.

Discussion: Early results indicate heterogeneity in feeding outcomes among SMA type 1 patients receiving disease modifying therapies. VFSS is not consistently undertaken, limiting direct comparisons. These findings highlight the need for standardised swallowing assessment and longitudinal monitoring.

Conclusion: Feeding and swallowing outcomes remain variable. Interim results highlight the importance of standardised swallowing assessments and ongoing multidisciplinary care, and suggest persistent risk of feeding difficulties in a subset of patients. Ongoing data collection will clarify long-term trajectories and inform best practice.

10. Does bolus volume modulation reduce penetration-aspiration scores when compared to viscosity modulation alone, in videofluoroscopy?

Faye McLoughlin[1,2], Jacqueline Benfield[3,4]

[1]Northern Care Alliance, Bury, United Kingdom. [2]Calderdale and Huddersfield Foundation Trust, Halifax, United Kingdom. [3]University of Nottingham, Nottingham, United Kingdom. [4]Derbyshire Health Services Foundation Trust, Derby, United Kingdom

Abstract

Background: Thickened fluids are the most common compensatory intervention recommended for thin fluid dysphagia; other interventions have minimal evidence bases. This analysis attempted to identify if bolus volume modulation (BVM) reduces penetration or aspiration compared to cup sips in patients with post stroke dysphagia.

Method: We retrospectively analysed data taken from stroke patients who underwent videofluoroscopy (VFS) as part of their routine in-patient care, over 18 months. PAS were determined by a VFS trained speech and language therapist based on assessments at 15 frames per second, with boli of 40% w/v barium (prepared to match IDDSI Levels 0-4).

Patients were initially trialled on their most recently recommended viscosity or, thin fluids if NBM. If PAS >2 then BVM, by either Drinkrite cup (DR) or teaspoon (same consistency), was trialled. Patients included, if they were trialled with a cup sip and at least one BVM intervention.

Comparisons were made between initial cup sip, teaspoon and DR sip of the same consistency.

Results: Related-Samples Wilcoxon Signed Rank Tests were completed comparing each parameter.

Wilcoxon signed-rank tests showed that use of teaspoons elicited a statistically significant reduction in PAS when compared to sips, for inpatients with dysphagia following a stroke ($p < 0.001$). There was nil statistical difference with cup sips compared to use of DR.

Discussion: Initial analyses show that BVM via teaspoon reduce the risk of penetration/aspiration in the majority of patients. DR reduce this risk in some, but not the majority and would benefit from further research.

11. Assessment of post-extubation dysphagia in Critical Care- do blanket referrals uncover it?

Anna Joyce, Aoife Byrne, Dr Patrick O'Sullivan

St. Vincent's University Hospital, Dublin, Ireland

Abstract

Background: Post extubation dysphagia (PED) is common, with incidence reported to increase with duration of intubation (Scheel et al 2016). Intubation for ≥48 hours is independently predictive for PED (Malandraki et al 2016). Complications are serious; increased length of stay, pneumonia and increased morbidity (Macht 2011).

Early identification of PED is paramount to providing optimal assessment and management. Prior to this study, need for PED assessment was determined by nursing staff or medical team, based on identification of signs or risks of dysphagia, often during oral trials.

Method: A retrospective review of usual PED service delivery over three months was completed. A blanket referral system for PED was established. Swallow-related outcomes from blanket referrals were compared to usual practice. Outcomes examined included dysphagia severity and time to initial assessment (IA) and oral intake.

Results: Prior to blanket referrals, average time to referral was 2.5 days. IA was completed within 24 hours of extubation for 65% with blanket referrals, compared to 28% without.

Dysphagia severity was measured by Functional Oral Intake Scale. PED was observed in 87% of blanket referrals, and 76% through usual referral pathway. 60% were unable to commence oral intake post IA after blanket referral, compared to 68% with normal practice. Average days to oral intake decreased with blanket referrals from 5.5 to 3.8.

Discussion: The results show that blanket referrals enabled earlier dysphagia assessment and management in this vulnerable cohort. Further, it supports its use going forward to facilitate safe & timely transition to oral intake after extubation.

12. Severe sensori-motor pharyngeal dysphagia in a profoundly deaf patient following major trauma.

Sam Nerminathan, Anna-Liisa Sutt Vowden

Barts Health NHS Trust, London, United Kingdom

Abstract

Background: A 26 year-old female admitted via helicopter following a road traffic accident with polytrauma including TBI and cervical spine fractures. She had been profoundly deaf from birth with laryngomalacia requiring a tracheostomy until the age of 3.

Method: This is a single, complex case study of severe sensori-motor dysphagia.

Results: She was extubated on day 10 and reviewed by SLT within one day. Following initial FEES and videofluoroscopy, a period of intense swallow rehabilitation commenced targeting hyolaryngeal movements and airway closure. Effortful swallow with ice chips was used the most, whilst EMST was partially successful reliant on external support. Patient had 4 instrumental assessments in total, and was discharged from hospital on day 47 having L0 and L7.

Discussion: Accessing the major trauma rehabilitation pathway was complicated due to profound deafness. One particular BSL translator was able to develop good rapport, however booking a consistent translator was impossible. Reliance on emotional family members to support communication during rehabilitation was inappropriate but unavoidable, leading to poor EMST technique: she could not hear the auditory feedback from equipment. Deafness also impacted the accuracy of endoscopy findings by SLT/ENT (unable to engage in speech tasks vs VF palsy).

Swallow rehabilitation was further limited by the reduced neck movements from posterior fixation of cervical spine, preventing Shaker manoeuvre.

Conclusion: A complex dysphagia presentation that was challenging to rehabilitate due to pre-morbid factors impacting the patient's capacity to engage with SLT. Despite maximum efforts and good swallow outcomes, equitable care was not delivered.

13. Oral feeding outcomes of infants born with Oesophageal Atresia at discharge from hospital: a two centre study.

Victoria Thomas[1], Sophie Phillips[2], Jeri Yap[1], Louise Edwards[3,1]

[1]Leeds Teaching Hospitals NHS Foundation Trust, LEEDS, United Kingdom. [2]Cambridge University Hospitals NHS Foundation Trust, Cambridge, United Kingdom. [3]University of Lancashire, Preston, United Kingdom

Abstract

Background: Oesophageal atresia (OA) is a rare, complex condition that can impact on early feeding experiences of infants [1].

The need for longer-term studies in this population has recently been highlighted [2] and a review of feeding outcomes in older children with a delayed OA repair has been reported [3]. Clinical data on the nature of early feeding experiences, outcomes and relationship to prematurity have not previously been reported.

Methods: Retrospective record review of infants born with OA admitted to two surgical NICUs in the UK between September 2023 and August 2024. Data was analysed using a joint protocol including demographic, surgical, speech and language therapy (SLT) input and outcomes.

Results: 20 infants across the two sites met inclusion criteria.

Prematurity

Extremely preterm: 5%

Very preterm: 15%

Moderate-late preterm: 35%

Term: 45%

Timing of repair

Immediate repair: 55%

Delayed repair: 45%

No infants who had a delayed repair achieved total oral feeding by discharge.

There was a trend for improved feeding outcomes with greater gestational age at birth.

Conclusions: OA significantly impacted on the achievement of total oral intake and families' feeding goals at point of hospital discharge.

Delayed primary anastomosis appeared to impact on infants' progress with oral feeding and prematurity was noted to increase the risk of being fully tube dependent.

This review has clinical implications for the approach and timing of feeding support for infants with OA in neonatal settings and highlights the role of SLT in the neonatal intensive care unit and beyond.

14. A service evaluation of a new FEES service: exploring changes in restrictive oral intake practices for acute inpatients with dysphagia.

Catherine Cawley1, Dr. Claire Mills2,3, Dr. Jen Pearson4

1Royal United Hospital, Bath NHS Foundation Trust, Bath, United Kingdom. 2Royal Brompton & Harefield Hospitals, Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom. 3Leeds Institute of Health Sciences, University of Leeds, Leeds, United Kingdom. 4School of Health and Social Wellbeing, University of the West of England, Bristol, United Kingdom

Abstract

Background: Dysphagia management often includes the use of restrictive practices, such as 'nil-by-mouth' (NBM), thickened liquids and texture-modified diets. These practices are intended to reduce the choking and aspiration risk but may have unintended effects. We aimed to explore the impact of flexible endoscopic evaluation of swallowing (FEES) on changing restrictive practice established through clinical swallowing evaluations (CSEs).

Method: We conducted a retrospective service evaluation of a new FEES service on consecutive adults receiving FEES from March 2023—March 2025 at a district general hospital. Data were analysed descriptively.

Results: FEES were conducted on 130 patients with a median time from admission to FEES of 13 days, and 2.5-days from referral to FEES.

Following FEES, the median FOIS change score was +1. Fifty-three percent (n=69/130) showed positive change scores, 42% (n=55/130) had no change, with 78% (n=43/55) remaining NBM/water only due to aspiration risk. There was a reduction in recommendations for NBM (16%; n=21/130), thickened fluids (68%; n=11/16), modified diets (50%; n=16/30), and 29% (n=37/130) commenced oral diet.

Discussion: Post-FEES, over half of patients received less restrictive recommendations compared to CSE. These findings suggest FEES may support safer, less restrictive dysphagia practices. However,

spontaneous recovery could have contributed to the observed changes. Future research should explore earlier use of FEES to reduce oral intake restrictions.

Free papers Friday 6th February 2026

A cross-sectional study exploring the alignment between patient-reported and biomechanical dysphagia outcomes in myotonic dystrophy type1 (DM1)

Jodi Allen[1,2], Tom Parry[1], Caroline Waszkiewicz[2], Christina Smith[3,4], Roganie Govender

[5,6], Mallet Sue[1], Stuart Taylor[1]

[1]University College London Centre for Medical Imaging, London, United Kingdom. [2]The National Hospital for Neurology and Neurosurgery, University College London Hospitals, London, United Kingdom. [3]University College London Division of Psychology and Language Sciences, London, United Kingdom. [4]NHS Lothian, Edinburgh, United Kingdom. [5]University College London Division of Surgery & Interventional Science, London, United Kingdom. [6]University College London Hospitals, London, United Kingdom

Abstract

Studies in myotonic dystrophy type 1 (DM1) consistently demonstrate poor association between patient-reported dysphagia symptoms and swallowing impairments identified through instrumental assessment. This disconnect, potentially reflecting disease-related anosognosia or reduced symptom awareness, complicates clinical assessment and may lead to underdiagnosis of dysphagia. We investigated relationships between biomechanical dysphagia severity and patient-reported symptoms.

Ninety-four adults with DM1 were recruited from across the UK to a tertiary neuromuscular centre (July 2023 to August 2024). During the same visit, participants completed the Sydney Swallowing Questionnaire (SSQ), and Swallowing Quality of Life Questionnaire (SWAL-QOL), followed by a videofluoroscopic swallowing study using the Modified Barium Swallow Impairment Profile (MBSImP). Participants were stratified into three dysphagia severity groups based on MBSImP oral and pharyngeal sum score tertiles for comparison of symptom scores. Descriptive and graphical analysis were used.

Median age was 45 years (IQR 38, 52); 52 were female. MBSImP oral and pharyngeal scores ranged 3-17 and 1-23, respectively. SSQ scores (range 20-1096) increased across pharyngeal dysphagia tertiles: median 152 (IQR 57,270; n=22), 194 (78, 398; n=39), and 350 (183, 663; n=31). SWAL-QOL swallowing symptom scores (range 0-100) decreased across tertiles: 68 (46,86), 65 (38,86), and 43 (30,59). SSQ also increased across oral dysphagia tertiles (medians 136, 224, 264) and SWAL-QOL decreased (medians 68, 57, 46). Individual questionnaire items will be presented, highlighting those with poor sensitivity for detecting differences in dysphagia severity.

These findings suggest that limitations in measurement sensitivity, rather than anosognosia, may explain previously observed disconnect between patient-reported and instrumental measures.

Feasibility of a cluster-randomised swallowing prehabilitation trial (SIP SMART2) within the NHS cancer care pathway

Roganie Govender, Jiunn Wang, Louise Marston, Elena Pizzo, Stuart Taylor, Irwin Nazareth

UCL, London, United Kingdom

Abstract

Background: Swallowing prehabilitation may help to mitigate some of the negative effects of head and neck cancer (HNC) treatments on people's ability to eat and drink. This study assessed the feasibility of delivering the SIP SMART (Swallowing Intervention Package: Self-Monitoring, Assessment, Rehabilitation Training) intervention in a two-arm cluster randomised pilot trial to minimise contamination; NHS hospital sites were the unit of randomisation.

Methods: Trained clinicians at the intervention sites delivered the manualised SIP SMART intervention, whilst standard care was provided at care as usual (CAU) sites. In both arms, all eligible adult patients newly diagnosed with Stage II-IV HNC receiving curative treatment within a multidisciplinary setting were invited to participate. Primary outcomes related to feasibility of recruitment and collection of clinical and health economic data at baseline, four, 12 and 24 weeks after treatment.

Results: Twelve hospitals expressed interest and six were randomised (50%) and provided data to the point of study completion. Patient recruitment across all sites (n=76) reached the target, although two sites fell short of their individual targets. The proportion of people with HNC recruited vs those eligible for each arm was 39% (95%CI 29, 49) for SIP SMART group and 55% (95%CI 43,66) for CAU. The end point data at 24 weeks were completed for 50% (95%CI 33,67) for SIP SMART and 78% (95%CI 62,89) for CAU.

Discussion: Whilst feasible, a future trial could be optimised for efficiency in set-up and follow-up data collection based on these findings and the accompanying process evaluation study.

Supporting Decision-making around Eating and Drinking with Acknowledged Risks in older adults – A mixed methods study of the experiences of clinicians in Japan and the UK

Yuki Yoshimatsu[1], Dharinee Hansjee[2], Marianne Markowski[2], Ryan Essex[2], Tadayuki Hashimoto[3], Hiroyuki Nagano[4], David Smithard[2]

[1]Guy's and St Thomas' NHS Foundation Trust, London, United Kingdom. [2]University of Greenwich, London, United Kingdom. [3]Brigham and Women's Hospital, Boston, United States. [4]Tenri Yorozu Hospital, Tenri, Japan

Abstract

Introduction: Older patients are often restricted from oral intake due to feared risk of aspiration. Eating and Drinking with Acknowledged Risks (EDAR) is an alternative process enabling comfort and autonomy. While UK has national guidance on EDAR, other ageing societies do not. To understand

the experiences of healthcare professionals in EDAR decision-making and explore optimal interventions, we conducted a mixed-methods study comparing Japan and the UK.

Methods: First, we interviewed 12 healthcare professionals (doctors, nurses and speech therapists) on their experiences of EDAR in older adults and analysed thematically. Extracted themes informed the development of a survey, distributed among healthcare professionals in both countries.

Results: The qualitative phase revealed three themes: 1. healthcare professionals/healthcare systems, 2. priorities in decision-making, 3. relationship with family/patient. Decision-making was shaped by a complex combination of individual, structural and cultural factors. In Japan there was a greater likeliness to defer decision-making and to side with families' wishes when they differed from patients.

The quantitative phase involved 1452 participants (Japan 1058, UK 394). UK-based respondents reported significantly higher levels of confidence ($\beta = 2.358$, SE = 0.137, $p < 0.001$), greater likelihood of supporting EDAR ($\beta = 1.633$, SE = 0.148, $p < 0.001$), and less difficulty in undertaking EDAR ($\beta = -1.970$, SE = 0.173, $p < 0.001$). Experience and training were associated with higher confidence. Regarding future interventions, a guiding framework and education were rated as beneficial.

Conclusions: Current guidance is not sufficient; education and training are essential to enable EDAR in older adults.

Significance of Elevated Pharyngeal Constriction Ratio in Infancy in Predicting Feeding Outcomes

Louise Bax[1,2], Anna Miles[1]

[1]University of Auckland, Auckland, New Zealand. [2]Starship Child Health, Auckland, New Zealand

Abstract

Videofluoroscopic swallow studies (VFSS) provide information about current swallow function. Little is known about how VFSS measures such as pharyngeal constriction ratio (PCR) predict feeding trajectory. This study explored feeding trajectory at 5yrs old in children with and without impaired PCR in infancy.

50 infants (<12mths) with 'impaired' PCR (>0.2cm^2) were consecutively extracted from a prospective database of ~1000 children referred for VFSS due to feeding concerns at one children's hospital. 50 age and gender-matched infants with 'normal' PCR (<0.2cm^2) were extracted for comparison. Medical records were reviewed for the first 5yrs of life. Feeding outcomes were compared between groups.

Children with impaired PCR were more likely to aspirate on their first VFSS than children with normal PCR ($p<.001$). 25% of children had no diagnosis at time of first VFSS. Children with impaired PCR were more likely to have received a neurological, genetic or anatomical diagnosis by 5yrs old (e.g. cerebral palsy, Trisomy21, cleft palate, laryngomalacia) ($p<.05$). Children with impaired PCR had five times longer duration of enteral tube feeding and two times more VFSS and hospital admissions than children with normal PCR ($p<.001$).

Elevated PCR is associated with aspiration in children. Elevated PCR in infants <12mths old may present as an early clinical marker of severity and trajectory of dysphagia with longer enteral tube feeding and more hospitalisations in the first 5yrs of life. This preliminary research may guide speech-language therapy and dietetic services, multidisciplinary decision-making and family counselling. Further research exploring PCR in disease-specific populations is warranted.

Investigating the Relationship Between Laryngeal Oedema and Dysphagia Severity Following Extubation and Tracheostomy

Elizabeth Montgomery[1], Jackie McRae[2]

[1]St George's Hospital, London, United Kingdom. [2]City St George's University, London, United Kingdom

Abstract

Background: Laryngeal injury, particularly oedema, is a frequent complication following prolonged intubation and tracheostomy in critically ill patients, often contributing to post-extubation dysphagia. Despite its prevalence, the impact of laryngeal oedema on swallowing function remains underexplored.

Method: A retrospective study was conducted on 46 patients referred for Fibreoptic Endoscopic Evaluation of Swallowing (FEES) over 12 months at a large teaching hospital with three intensive care units comprising 62 beds. All participants had undergone intubation for over 24 hours and were either extubated or received a tracheostomy. Swallowing function was assessed using validated scales including the Penetration-Aspiration Scale, Yale Pharyngeal Residue Severity Rating Scale, and New Zealand Secretion Severity Rating Scale. Laryngeal oedema was rated using the Patterson Oedema Scale.

Results: Laryngeal oedema was present in 71.7% of patients, with the highest prevalence in the arytenoids (69.6%) and pyriform sinuses (52.2%). Pearson's correlation coefficients were calculated to determine the strength and direction of associations between variables. A positive correlation was found between oedema severity and pyriform sinus residue, indicating impaired bolus clearance in patients with more pronounced oedema. Additional correlations were identified between oedema severity and impaired secretion management and swallowing safety, suggesting a clinically significant relationship.

Conclusion: Laryngeal oedema post-intubation and tracheostomy may contribute to dysphagia severity, particularly in regions critical to airway protection and bolus clearance. These findings highlight the importance of further research to assess the behaviour of laryngeal oedema over time and whether targeted treatments can have a positive impact on dysphagia symptoms.

Swallowing and Ageing: An Internet based study.

David Smithard[1,2], Trevor Thompson[3], Paula Leslie[4], Adrian Slee[5], Rotem Perach[6], Ian Swaine[2]

[1]Care of Older People, Queen Elizabeth Hospital, Lewisham and Greenwich NHS Trust, Woolwich, United Kingdom. [2]Centre for Active Exercise and Rehabilitation, University of Greenwich, Eltham,

London, United Kingdom. [3]Centre for Chronic Illness and Ageing, University of Greenwich, Eltham, United Kingdom. [4]NICE External Assessment Group, Northern Medecal Physics and Engineering, Newcastle-upon-Tyne NHS Trust, Newcastle-upon- Tyne, United Kingdom. [5]Division of Medicine Faculty of Medical Sciences University College London, London, United Kingdom. [6]School of Social Sciences, University of Westminster, London, United Kingdom

Abstract

Increasing age is associated with comorbidities and complications including frailty, sarcopenia and swallowing problems. We conducted a questionnaire based internet study investigating the associations between increasing age and swallowing speed (TWST), reported swallowing difficulties (4QT), frailty (FRAIL), sarcopenia (SARC-F) and appetite (SNAQ).

Method: Snowball recruitment was used. Participants were asked for their consent and had to have no history of dysphagia, had no medical history that could result in dysphagia and >18 years of age. Ethics approval was granted by the University of Greenwich. Regression analyses were conducted to study relationships of variables against increasing age.

Results: 251 people completed the study, 161 (64.2%) identified as female, mean age 48 (20-87) years, reported backgrounds were 75.3% white and 14.7% Asian. Asthma was the most commonly reported comorbidity (20.3%). Linear regression found increasing age to be associated with increased swallowing time ($p=0.002$), but not with appetite score. Logistic regression found age was associated with an increased odds of both SARC-F scores ≥ 1 (OR = 1.03, $p=0.004$) and 4QT scores ≥ 1 (OR=1.03, $p=0.015$), but not with frailty using the FRAIL questionnaire ($p=0.379$).

Discussion: Results confirm our previous findings in a Chinese population: swallowing speed decreases with age and is associated with reported swallowing problems and probable sarcopenia. Frailty and appetite were not correlated which may not be surprising as this was a fit community-based population. Limitations include no detail of the total population sampled and that those taking apart were self-selected.

Poster abstracts Friday 6th February 2026

1. Determining inter-rater reliability, concurrent validity and responsiveness of the Children's Eating and Drinking Activity Scale

Ericka Joinelle Mantaring[1], Sheung Yu Sylfiana Wong[1], Michelle McInerney[1], Vicky Thorpe[2], Alex Stewart[1,2]

[1]Department of Language and Cognition, UCL, London, United Kingdom. [2]Department of Speech and Language Therapy, Great Ormond Street Hospital for Children, London, United Kingdom

Abstract

Background: The Children's Eating and Drinking Activity Scale (CEDAS) is a clinician-rated outcome tool measuring functional eating and drinking skills for children aged 0-18 years. The tool has established face validity but lacks further psychometric evaluation. The aim of this study was to determine inter-rater reliability, responsiveness and concurrent validity.

Method: Inter-rater reliability was assessed using an online questionnaire completed by Speech and Language Therapists (SLTs) working in hospital and community settings in the UK, Ireland, Australia and New Zealand. Participants (n=39) applied the CEDAS to 12 vignettes. Inter-rater reliability was calculated using Krippendorff's Alpha.

The CEDAS was applied retrospectively to consecutive Speech and Language Therapy (SLT) referrals at a single hospital (n = 85, median age 11.2 months, range 1 week - 17 years 1 month). Responsiveness was assessed by comparing median CEDAS scores at referral, after initial SLT assessment and discharge. The Functional Status Scale (FSS) feeding domain was used to evaluate concurrent validity.

Results: Inter-rater reliability was excellent (Krippendorff's $\alpha = 0.927$). The CEDAS was responsive to change, with expected score increases between referral and discharge ($Z = -4.37$, $p < .001$), and initial assessment and discharge ($Z = -3.23$, $p < .001$). Strong concurrent validity was established with the FSS (R_2 -.77 to -.99, $p < .003$).

Discussion: The CEDAS demonstrates excellent inter-rater reliability when used by SLTs. The tool is responsive to change in an acute hospital. Concurrent validity with the FSS supports construct validity. These results support use of the CEDAS in clinical or research practice.

2. A process evaluation of the SIP SMART2 swallowing prehabilitation cluster-randomised pilot trial

Roganie Govender[1], Gemma Clunie[2], Irwin Nazareth[1], Cecilia Vindrola-Padros[1]

[1]UCL, London, United Kingdom. [2]Imperial College Healthcare NHS Trust, London, United Kingdom

Abstract

Background: Prehabilitation has been recommended in the Getting It Right First-Time guidelines for delivery of quality care in head and neck cancer (GIRFT 2025). SIP SMART is a swallowing prehabilitation intervention recently conducted at 6 NHS sites as part of a pilot trial assessing feasibility outcomes. An accompanying process evaluation was undertaken to determine: 1) barriers and facilitators at participating hospital sites that may impact the main trial; 2) whether the chosen method to assess fidelity is achievable and acceptable to clinicians delivering the intervention; 3) patient and clinician views and experiences of participating in the trial.

Methods: Mixed and multiple methods were used to provide a nuanced picture of barriers and facilitators that could affect trial outcomes and implementation. Data sources included focus groups, 1:1 interviews, observations and field notes; and documentary evidence. The Consolidated Framework for Implementation Research (CFIR) was used as a deductive approach enabling charting of data in a matrix to undertake a case (site) and construct (CFIR variables) analysis.

Results: All CFIR domains had some influence on the trial including intervention characteristics, inner setting (hospital sites), outer setting (anything outside the hospital site that impacted outcomes and implementation), individuals involved, and the implementation process itself. Constructs within the inner setting was most pertinent in distinguishing best performing from worst performing sites.

Discussion: This study provides a template example for other dysphagia researchers seeking to optimise swallowing interventions prior to larger effectiveness trials, by demonstrating how data may be captured and analysed to make evidenced changes.

3. Utilising the Diagnostic Criteria of Paediatric Feeding Disorder: Updated Clinical Findings from a Population-based Cohort Study

Natalie Morris[1], Hannah Daw[1], Lucy Bates[1], Richard Horniblow[2]

[1]The Feeding Trust, Birmingham, United Kingdom. [2]University of Birmingham, Birmingham, United Kingdom

Abstract

Objectives: Paediatric Feeding Disorder (PFD) is common but underdiagnosed in the UK. While current diagnostic criteria offer a useful framework, inconsistent application in clinical settings contributes to under-recognition and variable care. This study aimed to assess the utility of these criteria in a UK context, clarify how PFD presents in practice, and support more accurate diagnosis and early intervention.

Methods: In this observational cohort study, 51 children diagnosed with PFD were evaluated against the established diagnostic criteria. Each case was assessed across the four diagnostic domains: medical, nutritional, psychosocial, and feeding skill-related impairments. The aim was to identify the prevalence and pattern of clinical features across these domains.

Results: Skill-based and medical difficulties were the most prevalent. All participants exhibited feeding skill impairments, and 96% had a co-occurring medical condition. Psychosocial challenges were identified in 51% of cases, while 20% had a diagnosed nutritional deficiency. Most children

presented with overlapping impairments across multiple domains, reinforcing the complexity of PFD presentations.

Conclusion: This is the first UK study to highlight the predominance of skill-based deficits in PFD. Findings support the need for refinement of diagnostic criteria, with increased emphasis on medical and feeding skill-related components. Results also highlight the importance of a comprehensive, multidisciplinary assessment that includes functional evaluation of feeding skills and the influence of medical conditions. These insights can guide earlier identification and improved care for children with PFD in UK clinical practice.

4. Outcome measures for mealtime and swallowing difficulties in people with dementia: a scoping review

Kate Taylor[1,2], Gemma Cartney[3], Lisa Everton[2,4]

[1]Lincoln University, Lincoln, United Kingdom. [2]Nottingham University Hospitals NHS Trust, Nottingham, United Kingdom. [3]Queen Margaret University, Edinburgh, United Kingdom. [4]University of Nottingham, Nottingham, United Kingdom

Abstract

Background: People with dementia frequently experience mealtime and swallowing difficulties which have a huge impact on health status and quality of life. Intervention studies in this area are poor quality due to inconsistent outcome measures. Effective, validated outcome measures are essential to ensure quality interventions to improve patient outcomes. This is an under researched area and in need of further investigation, especially considering an ageing population and an increasing number of people with dementia. The aim of this scoping review is to map the existing evidence on instruments that have been created or used as outcome measures to evaluate mealtime and swallowing difficulties in people with dementia.

Method: This scoping review was done in compliance with the PRISMA-ScR following the Joanna Briggs Institute scoping review framework. Five databases were searched with key terms relating to the concepts of “dementia”, “swallowing difficulty” and “outcome measure”.

Results: After removing duplicates, 1508 articles were screened, leaving 45 eligible papers for review. Preliminary findings show that over 15 different outcome measures have been used to measure mealtime or swallowing difficulties in people with dementia.

Discussion: The findings show that the Edinburgh Feeding Evaluation in Dementia Scale is the most frequently used validated measure of mealtime difficulties but it does not measure swallowing. There is a need for validated outcome measures specifically for swallowing difficulties in dementia in order to inform evidence based interventions and improve quality of care for patients.

5. Do head and neck cancer patients describe Quantitative Muscle Ultrasound as an acceptable addition to their care?

Gemma Clunie[1,2], Jodi Allen[3,4], Margaret Coffey[1,2], Jonathan Bernstein[1], Dorothy Gujral[1], Alison McGregor[2]

[1]Imperial College Healthcare NHS Trust, London, United Kingdom. [2]Imperial College London, London, United Kingdom. [3]National Hospital for Neurology and Neurosurgery, London, United Kingdom. [4]University College London, London, United Kingdom

Abstract

Background: Head and neck cancer (HNC) treatment modalities vary, but radiotherapy is often the sole option or used adjuvant to chemotherapy and surgical approaches. Cumulative injury to tissues leads to significant morbidity relating to swallowing and speech function. There is limited understanding of the quantification of muscle changes, and the treatment options for swallowing and speech. We consider whether quantitative muscle ultrasound (QMUS) is an acceptable adjunct to HNC patients given its potential for quantifying muscle pathophysiology.

Methods: Following ethical approval and consent, we are recruiting patients with HNC undergoing curative radiotherapy/chemoradiotherapy treatment to investigate the feasibility and acceptability of QMUS, protocol available here: https://doi.org/10.1186/ISRCTN14681287. Participants complete an acceptability questionnaire based on the theoretical framework of acceptability model (TFA). Analysis includes descriptive statistics and content analysis.

Results: Thirteen consecutive participants (12:1 male: female) have been recruited with research ongoing. Key findings related to the acceptability of QMUS for patients with HNC show that 100% of participants feel QMUS is beneficial, comfortable, painless and straightforward. All felt it was worth the time required in the context of multiple appointments and complex care planning.

Discussion: Despite the additional time burden, participants in this study to date have reported that QMUS is an acceptable addition to their treatment, providing valuable insights to its potential use in a HNC population for SLTs. Further results from this study will determine the feasibility and value of QMUS to SLTs in terms of developing tailored assessment and rehabilitation protocols for HNC patients based on muscle pathophysiology.

6. A content analysis of UK Mealtime Information Sheets used by Speech & Language Therapists working with children with dysphagia who need mealtime assistance

Sally Morgan[1], Kathleen Mulligan[1,2], Kelly Weir[3,4], Katerina Hilar[1]

[1]City St George's, University of London, London, United Kingdom. [2]East London Foundation Trust, London, United Kingdom. [3]University of Melbourne, Melbourne, Australia, Melbourne, Australia. [4]The Royal Children's Hospital Melbourne, Melbourne, Australia

Abstract

Background: When working with people with Learning Disabilities and dysphagia the NHS has recommended that Speech & Language Therapists (SLTs) create a mealtime information form (NPSA, 2017). This outlines assessment recommendations in simplified steps to inform family- or paid-carers on how to meet a person's mealtime needs and requirements.

Methods: This study explored UK SLTs usage of mealtime information forms when working with school-aged child with dysphagia. As part of an ethically approved practice survey, SLT participants

(n=102) uploaded anonymised documentation (2021). Submitted documents were screened with duplicates removed and then qualitatively analysed (content analysis).

Results: Fifty-nine documents were uploaded providing 39 mealtime information sheets (n=37 participants). Two duplicates were identified (n=4 participants) alongside multiple adapted versions e.g., full oral vs 'tasters'. Twenty-eight unique templates were identified. These had 19 different terms or name e.g. Eating & Drinking/Feeding/Mealtime Plan/Information/Guidelines alongside different formats: n=23 colour, n=20 symbols/icons, n=19 2-pages, and approach: n=5 first person language. Greater agreement was found on recommendation topic: n=28 texture (n=27 IDDSI terminology), positioning n=26, utensils n=22. However, the heading sections differed e.g.: 'Things to look out for/Red flag signs/Stop immediately if/Signs of aspiration/!'.

Discussion: Mealtime information forms appear to be common within UK practice. Despite similarity in sectional style and some recommendation topics, there is heterogeneity in title, format and content. This variation, lack of common language and approach may impact effectiveness e.g., communication between professionals and carers and at transition points.

NHS Patient Safety Agency (2007) Problems Swallowing?

7. Is Respiratory Muscle Strength Training safe and feasible to deliver in stroke? A scoping review of the literature.

Virginia Brinkley[1], Waiza Kadri[2], Gwenllian Wilkinson[3], Elizabeth Boaden[4], Jacqueline K Benfield[5,6]

[1]Norfolk Community Health and Care NHS Trust, Norwich, United Kingdom. [2]London Northwest University Healthcare, London, United Kingdom. [3]Stroke Trials Unit, School of Medicine, University of Nottingham, Nottingham, United Kingdom. [4]Stroke Research Team, School of Health, Social Work and Sport, University of Central Lancashire, Preston, United Kingdom. [5]Centre of Rehab and Ageing research, School of Medicine, University of Nottingham, Nottingham, United Kingdom. [6]Derbyshire Community Health Services NHS Trust, Derby, United Kingdom

Abstract

Background: Respiratory muscle strength training (RMST) may have promise to improve airway protection during swallowing. One RMST intervention suggests acute stroke and hypertension as contraindications for use due to a Valsalva effect which can increase blood pressure and heart rate. We aimed to understand whether it is safe and feasible to deliver RMST in the stroke population.

Methods: The search strategy was developed with a university librarian. The primary reviewer searched databases including Medline, Web of Science, Embase and grey literature for any full text papers in English reporting the use of RMST in adults with a stroke diagnosis. Using Covidence, two independent reviewers screened, firstly titles and abstracts and then full text to determine final eligibility. Discrepancies were discussed and clarified, and a third reviewer resolved uncertainties. A pre-designed tool was used to extract data from eligible papers including age of participants, time post stroke, inclusion/exclusion criteria, type and parameters of intervention, safety events and feasibility or acceptability data. Subgroup analysis exploring different interventions and protocols at different stages post stroke will be conducted if there is sufficient data.

Results: Searches found 794 references, after duplicates 445 were screened for inclusion. 381 were excluded from title and abstract, leaving 64 for full text review. Data extraction and synthesis will be completed on the final 38 eligible studies by October 2025.

Discussion: Results will inform whether there is sufficient safety data in the literature to enable use of different types of RMST with different cohorts of the stroke population.

8. The implementation of Pharyngeal Electrical Stimulation (PES) in Adult Critical Care Unit at a major trauma hospital: Procedures, challenges and learnings

Anna Creagh Chapman, Anna-Liisa Sutt Vowden, Eileen Kelly, Robyn Cary, Sambavy Nerminathan

Barts Health NHS Trust, London, United Kingdom

Abstract

Background: Pharyngeal electrical stimulation (PES) is an innovative treatment for severe swallowing difficulties in neurologically-impaired patients. It works by providing electrical stimulation to the inside of the pharynx to promote neuroplasticity (Schefold et al., 2020). Our SLT team recently obtained funding to be able to implement PES in the Adult Critical Care Unit for 30 patients.

Aim: To explain the procedures and challenges that were encountered in implementing Pharyngeal Electrical Stimulation (PES), and to share learnings for those who may be interested in implementing PES, or other innovative treatment, in their own trust.

Methods: Qualitative and quantitative data will be gathered from the local SLTs and multidisciplinary staff involved in implementing PES. This will be obtained through surveys and interviews. Data will be collected on barriers and facilitators with initial and ongoing funding, governance at different levels, and implementation. These data are expected to be finalised well in advance of the RCSLT conference.

Results: Common themes will be identified and grouped. Learnings and future recommendations will also be presented.

Discussions: The implementation of new interventions has its challenges; we hope sharing our experiences can inform and inspire others who are interested in doing the same. SLTs should explore charity options in addition to hospital funding in order to obtain innovative interventions for patients with communication and/or swallowing problems.

9. Swallowing Kinematics in Older Adults

Nicole Tomitz[1], Kristine Galek[1], Ed Bice[2]

[1]University of Nevada, Reno, Reno, United States. [2]IOPI Medical, Woodinville, United States

Abstract

Purpose: As life expectancy increases, individuals are expected to spend extended time in old age. Currently, there is limited information available on typical swallowing patterns or sip volumes in older adults, highlighting the need to establish normative data for clinical utility. Normative reference values for swallowing have been established for adults aged 21-82 (Steele et al., 2023). The study aimed to establish normative sip volumes and swallowing reference values for adults over 69 for speech-language pathologists to use as a reference in their swallowing assessments of older adults.

Method: Sip volume and kinematic swallowing measurements were collected from 40 adults aged 69-98 (mean age: 80). Participants underwent a standard videofluoroscopic swallow study (VFSS) with no aspiration. Comfortable sips of thin and mildly thick liquids were measured pre- and post-consumption to determine sip volume. Three trained raters analyzed the VFSS recordings to determine kinematic measurements by consensus for swallow reaction time, time to laryngeal vestibule closure, duration of laryngeal vestibule closure, and duration of upper esophageal sphincter (UES) opening.

Results: We present updated VFSS reference percentile tables, stratified by consistency, for swallowing timing kinematics for older adults. The sip volume results indicate that older adults take, on average, larger sips than those under 69, regardless of liquid consistency.

Conclusion: These updated reference values contribute to the current literature by including the demographic of older adults. The findings underscore the need for future research to refine swallowing reference values by decade to enhance clinical utility for speech-language pathologists.

10. Evidence based management of dysphagia in Huntington's disease: A scoping review

Katie Irwin Crosby[1,2], Julie Regan[1], David Denton[3]

[1]Trinity College, Dublin, Ireland. [2]Bloomfield Mental Health Services, Dublin, Ireland. [3]Bloomfield Hospital, Dublin, Ireland

Abstract

Background: Individuals with Huntington's disease face often challenges with swallowing. There is a gap in the literature regarding what interventions are most effective for managing dysphagia as the disease progresses within this cohort.

Objective: This study aims (i) to examine what interventions have been investigated across the disease trajectory and (ii) to determine what outcome measures are being used to capture the impact of dysphagia interventions on swallowing and quality of life (QoL) of individuals and their caregivers.

Methods: A scoping review will be conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta Analysis extension for scoping reviews (PRISMA-ScR) (Tricco et al., 2018). CINAHL, EMBASE, MEDLINE, Web of Science, ProQuest Dissertations & Theses and trial registry Clinicaltrials.gov electronic databases will be searched using two search strings (*Dysphagia and Huntington's disease*) without any date or language restrictions. Full-text articles of any study design were included if participants with a diagnosis of HD received an intervention aimed at

improving eating, drinking and swallowing. Studies involving those with co-morbidities which could cause dysphagia and secondary research will be excluded. Search findings will be exported to an online platform (www.covidence.org). Two independent reviewers will assess articles for eligibility and will extract relevant data and categorise it according to type of interventions.

Results: 2066 articles were found. These were screened and reviewed by two independent authors. Articles focusing on dysphagia interventions were then categorised.

Conclusions: Findings will guide future research on dysphagia management in HD.

11. Secretions, Cough, Impaired Ventilation- why they matter in the management of dysphagia in individuals with spinal cord injury (SCI). Consideration for the Speech and Language Therapist (SLT)

Sarah Morgan, Aimi Forrest

North West Regional Spinal Injuries Centre, Mersey and West Lancashire Teaching Hospitals NHS Trust, Merseyside, United Kingdom

Abstract

Background: The incidence of SCI is estimated at 4,400 cases per year in the UK. Most receive acute care in their local hospital awaiting transfer to a SCI centre. Waiting times can be significant with SLTs working in non-specialist settings treating these patients. Individuals with cervical SCI have an incidence of dysphagia between 8-80%, along with significant challenges in secretion management, ventilation and cough effectiveness due to respiratory muscle paralysis and autonomic dysfunction. Respiratory complications remain the leading cause of mortality and morbidity. Mechanical ventilation via tracheostomy is often indicated. Dysphagia pathophysiology is not clearly understood but a defining feature is silent aspiration. This can impact on ability to ventilate and worsen secretion burden.

Method: A retrospective case series of patients from a UK SCI centre. An overview of changes in physiology, principals of secretion clearance, ventilation management and swallowing will be discussed.

Results: 3 patients who failed weaning attempts at the admitting hospital are discussed. Age range: 21-62, male, SCI level: C4-8 A-D, all ACDF to C6-7. Pre-admission: 3/3 NBM. 2/3 had FEES. 2/3 ventilated via tracheostomy, 1/3 tracheostomy. 3/3 cuff inflated. SCIC: 3/3 had FEES. Return to oral intake and decannulation were achieved in all.

Discussion: SLTs working in SCI should understand the underlying pathophysiology, and complex interplay between SCI and swallowing. Key considerations include early FEES, assessment of cough and augmentation techniques, assessment of secretions, and an appropriate ventilation strategy. Physiologically led interventions within an MDT context can alter trajectory and support SLT in dysphagia management.

12. A Speech and Language Therapy (SLT) pilot quality improvement project (QIP): Dysphagia identification and management within inpatients on a Respiratory Support Unit (RSU) requiring Non-Invasive Ventilation (NIV) for an Acute Exacerbation of Chronic Obstructive Pulmonary Disease (AECOPD).

Kate McGlinchey[1], Lorna Dodenhoff[1], Camilla Dawson[1,2,3]

[1]Queen Elizabeth Hospital Birmingham, Birmingham, United Kingdom. [2]Leeds Beckett Univerity, Leeds, United Kingdom. [3]University of Birmingham, Birmingham, United Kingdom

Abstract

Background: We present a QIP highlighting the importance of SLT input and instrumental assessment when identifying and managing dysphagia in AECOPD patients with acute NIV requirements.

Method: Appropriate patients were identified via MDT electronic referrals or via SLT RSU screening. SLT then completed a bedside swallow assessment and the EAT -10 (Eating Assessment Tool), to identify any overt symptoms of dysphagia and/or patient concerns of dysphagia.

Patients identified as having signs of, or who reported concerns of, dysphagia (n=15) then had a Fibreoptic Endoscopic Evaluation of Swallowing (FEES). Consistent outcome measures were used, including the Penetration-Aspiration Scale (PAS) and the Yale and Murray rating scale. These rating scales indicate the presence of laryngeal penetration and/or aspiration, alongside the quantity and location of residue and secretions.

Results: 80% (n=12) of the FEES cohort (n=15) presented with laryngeal penetration and/or aspiration. 50% (n=6) of those who demonstrated laryngeal penetration and/or aspiration on FEES presented with diminished sensation. This was indicated by no reflexive response to matter penetrated to the level of the vocal folds or below. 20% of the total FEES cohort (n=3) demonstrated silent aspiration on FEES .

Discussion: This QIP demonstrates the prevalence of laryngeal penetration, aspiration and associated insensitivity in a small cohort of this population, and the requirement for targeted instrumental assessment of swallowing to objectively assess for dysphagia in this population.

13. Evaluating the use of the Eating Assessment Tool-10 (EAT-10) in Speech and Language Therapy (SLT) assessment of oropharyngeal dysphagia (OD) in inpatients with Chronic Obstructive Pulmonary Disease (COPD).

Sarah McNally, Sally Archer

Guys and St Thomas' NHS Foundation Trust, London, United Kingdom

Abstract

Background: OD is common in COPD and increases the likelihood of severe acute exacerbations (AECOPD), a leading cause of UK emergency admissions[1]. The EAT-10 is considered a useful swallow screen for AECOPD inpatients[2]. However its role in dysphagia management with this cohort remains unclear. Our aim is to establish if EAT-10 scores correlate with SLT assessment and aid management of inpatients with COPD.

Methods: Data collected on all inpatients with a COPD history referred to SLT over 6 months at St Thomas' hospital, London. Patients with other diagnoses/events affecting swallowing were excluded. Included patients completed the EAT-10 during initial SLT assessment. Scores were compared to SLT findings and management. Validated scales (Dynamic Imaging Grade of Swallowing Toxicity DIGEST[3] and Penetration-Aspiration Scale PAS[4]) rated videofluorscopies with blinding.

Results: 71 patients were referred to SLT; 4 were included and remained on intake after initial assessment. Median EAT-10 was 12 (range 0-30). All underwent videofluoroscopy after median 4.5 days (range 1-6). DIGEST rating ranged from mild - severe impairment. Median PAS was 8 (range 2-8). EAT-10 did not correlate with PAS/DIGEST. Three patients safely commenced intake post-videofluoroscopy. The remaining patient had a PAS 8 and a DIGEST rating of severe but scored 0 on EAT-10 (indicating no impairment).

Discussion: In this small cohort, the EAT-10 did not correlate with gold standard swallowing assessment or aid decision-making. Investigating the specific dysphagia profile of inpatients with COPD is challenging; patients are complex with multiple other potential causes for dysphagia. Larger sample research is required.

14. Facilitating Assessment of Swallowing and Sensory Function in Adults with Down Syndrome through Visual Supports

Aarthi Madhavan, Nicole Etter, Sophie Wolf, Krista Wilkinson

Pennsylvania State University, University Park, United States

Abstract

Background: People with Down syndrome (DS) demonstrate a striking increase in prevalence of dysphagia (13.6% vs. 2.5% in non-disabled peers) and aspiration pneumonia as a cause for mortality. Accurate assessment for individuals with DS can be challenging when task completion relies on comprehension of verbal instructions. This presentation will describe visual communication support strategies developed within a larger research study to enhance assessment of swallowing and somatosensation for individuals with DS.

Methods: An established evidence base supports the use of augmentative and alternative communication (AAC) in medical service delivery. In this project, we aimed to harness AAC to promote participants' ability to respond independently and to reduce challenges associated with comprehension of verbal instructions. Researcher-clinicians with expertise in AAC and dysphagia collaboratively designed visual supports to enhance understanding, participation, and task completion of swallowing and related assessments. These methods have been successfully used with 18 adult participants with DS. Visual supports used include video modeling, low technology visual supports, and Talking Mats to provide rich data regarding participant preferences with independent expression.

Results: Our observations and participant feedback suggest that integration of AAC supports for swallowing and related assessments enhances and supports participation for individuals with DS. Many participants referenced the visual aids as key to their understanding of what to expect and do during assessments.

Discussion: Practical strategies can improve understanding and engagement in swallowing assessments for individuals with DS. Using multi-sensory modalities may support accurate assessments and functional outcomes for many populations, including those with intellectual disabilities (IDD).

15. Respiratory health outcomes of children with Down Syndrome following dysphagia management: A service evaluation

Himali de Silva[1], Neekita Shah[2], Narad Mathura[1], Christina Smith[3]

[1]Guy's and St Thomas' NHS Trust, London, United Kingdom. [2]Central London Community Healthcare NHS Trust, London, United Kingdom. [3]Department of Clinical Neurosciences, Edinburgh, United Kingdom

Abstract

Background: Children living with Down Syndrome (clwDS) have a 50-80% risk of dysphagia. Over half of them aspirate silently on instrumental swallow evaluations. Respiratory illness is prevalent and the primary cause of hospitalisation and mortality for clwDS and can result from aspiration. Speech and language therapists use cervical auscultation (CA) to detect subtle audible wet pharyngeal sounds (SAWPS) which can be indicative of oropharyngeal dysfunction. CA is used to identify children requiring further swallow evaluation using VideoFluoroscopy Swallow Study for targeted dysphagia management.

Method: In an urban NHS community Trust, a retrospective service evaluation was carried out for referrals for clwDS received during 2012-2017. The study examined the respiratory health outcomes three years after dysphagia management. Children were classified into three groups based on timing of intervention: Early, Late or No-intervention. Medical comorbidities commonly associated with DS and dysphagia were also reviewed.

Results: 42 children were included in the study. Children who received dysphagia assessment and management by 12 months old (Early) did not develop any Lower Respiratory Tract Infections (LRTI) post intervention. Children whose dysphagia management was commenced after 12 months old (Late) or those who had No-intervention developed more LRTI over the three-year period. Children with at least one additional comorbidity showed a trend for developing more respiratory illnesses.

Discussion: The results suggest that early identification and management of dysphagia in clwDS is associated with reduced incidence of respiratory illness. The presence of prematurity, cardiac, gastrointestinal, or respiratory comorbidity may indicate greater risk to respiratory health.