

Relationship between self-reported symptoms and the possibility of dysphagia before first geriatric consultation

Relação entre autorrelato de sintomas e possibilidade de disfagia antes da primeira consulta geriátrica

Relación entre el autorreporte de síntomas y la posibilidad de disfagia antes de la primera consulta geriátrica

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Abstract

Introduction: Aging is associated with a higher prevalence of dysphagia. **Objective:** To identify, associate, and correlate self-reported symptoms and the possibility of dysphagia in older adults at a geriatric outpatient clinic before their first consultation. **Material and method:** An observational, cross-sectional study, approved by the Research Ethics Committee (number 5.530.009), conducted between September 2022 and August 2023 at a university hospital. Data were obtained through medical record analysis and the application of the Eating Assessment Tool (EAT-10) and the Oropharyngeal Dysphagia Screening for the Elderly in a Hospital Setting (RaDI-H). Comorbidities were assessed using the Charlson Comorbidity Index (CCI). Descriptive and inferential statistical analyses were performed using Fisher's exact and

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Spearman's correlation tests. **Results:** A total of 56 (100%) patients participated, with a predominance of females (n=43; 77%) and a median age of 75 years. Most presented comorbidities (n=39; 69.7%), primarily with a weight of 1 (n=35; 89.7%), such as mild diabetes without complications (n=17; 43.5%) and probable sarcopenia (n=33; 58.9%). All patients (100%) were on oral intake; swallowing and respiratory complaints were observed in 6 patients (10.7%), and voice/speech complaints in 4 (7.1%). Self-reported symptoms indicative of dysphagia were present in 15 patients (27%), and the possibility of dysphagia in 11 (20%), with a significant association and a strong positive correlation. **Conclusion:** In this study, 27% of the elderly, before their first consultation with a geriatrician, presented self-reported symptoms indicative of dysphagia, and 20% showed a possibility of dysphagia. There was a significant association and a strong correlation between the protocols, indicating that higher self-report scores correspond to a greater possibility of dysphagia.

Keywords: Deglutition; Deglutition Disorders; Aged; Mass Screening; Speech, Language and Hearing Sciences.

Resumo

Introdução: O envelhecimento está relacionado à maior prevalência de disfagia. **Objetivo:** Identificar, associar e correlacionar o autorrelato de sintomas e a possibilidade de disfagia em idosos atendidos em um ambulatório de geriatria antes da primeira consulta. **Material e método:** Estudo observacional e transversal, aprovado pelo Comitê de Ética em Pesquisa (número 5.530.009), realizado entre setembro/2022 e agosto/2023, em um hospital universitário. Os dados foram obtidos por meio da análise de prontuários e aplicação do *Eating Assessment Tool* (EAT-10) e do Rastreamento de Disfagia Orofaringea em Idosos em ambiente hospitalar (RaDI-H). As comorbidades foram baseadas no Índice de Comorbidade de Charlson (ICC). Foram realizadas análises estatísticas descritivas e inferenciais por meio dos testes exato de Fisher e de Spearman. **Resultados:** Participaram 56 (100%) pacientes, com prevalência do sexo feminino (n=43; 77%) e mediana de idade de 75 anos. A maioria apresentava comorbidades (n=39; 69,7%), principalmente com peso 1 (n=35, 89,7%), como diabetes leve sem complicações (n=17; 43,5%) e provável sarcopenia (n=33; 58,9%). Observou-se 100% de alimentação via oral, queixa de deglutição e de alterações respiratórias em 6 pacientes (10,7%) e queixas de voz/fala (n=4; 7,1%). Houve autorrelato de sintomas indicativos de disfagia (n=15; 27%) e possibilidade de disfagia (n=11; 20%), com associação e correlação positiva forte. **Conclusão:** Neste estudo, 27% dos idosos, antes da primeira consulta com geriatra, apresentaram autorrelato de sintomas indicativos de disfagia e 20% apresentaram possibilidade de disfagia. Houve associação e forte correlação entre os protocolos, indicando que maiores escores de autorrelato correspondem à maior possibilidade de disfagia.

Palavras-chave: Deglutição; Transtornos de Deglutição; Idosos; Programas de Rastreamento; Fonoaudiologia.

Resumen

Introducción: El envejecimiento está relacionado con una mayor prevalencia de disfagia. **Objetivo:** Identificar, asociar y correlacionar el autorreporte de síntomas y la posibilidad de disfagia en adultos mayores atendidos en un centro ambulatorio de geriatría antes de la primera consulta. **Material y método:** Estudio observacional y transversal, aprobado por el Comité de Ética en Investigación (número 5.530.009), realizado entre septiembre de 2022 y agosto de 2023 en un hospital universitario. Los datos se obtuvieron mediante el análisis de historias clínicas y la aplicación del *Eating Assessment Tool* (EAT-10) y del Rastreo de Disfagia Orofaringea en Ancianos en ambiente hospitalario (RaDI-H). Las comorbidades se basaron en el Índice de Comorbilidad de Charlson (ICC). Se realizaron análisis estadísticos descriptivos e inferenciales mediante las pruebas exacta de Fisher y de Spearman. **Resultados:** Participaron 56 (100%) pacientes, con prevalencia del sexo femenino (n=43; 77%) y una mediana de edad de 75 años. La mayoría presentaba comorbidades (n=39; 69,7%), principalmente con peso 1 (n=35; 89,7%), como diabetes leve sin complicaciones (n=17; 43,5%) y probable sarcopenia (n=33; 58,9%). Se observó un 100% de alimentación por vía oral; se registraron quejas de deglución y alteraciones respiratorias en 6 pacientes

(10,7%) y quejas de voz/habla en 4 (7,1%). Hubo autorreporte de síntomas indicativos de disfagia (n=15; 27%) y posibilidad de disfagia (n=11; 20%), con una asociación significativa y una correlación positiva fuerte. **Conclusión:** En este estudio, el 27% de los adultos mayores, antes de la primera consulta con el geriatra, presentaron autorreporte de síntomas indicativos de disfagia y el 20% presentó posibilidad de disfagia. Hubo asociación y una fuerte correlación entre los protocolos, lo que indica que mayores puntuaciones de autorreporte corresponden a una mayor posibilidad de disfagia.

Palabras clave: Deglución; Trastornos de la Deglución; Adultos Mayores; Programas de Cribado; Fonoaudiología.

Introduction

Aging is an irreversible process characterized by structural and functional changes associated with several comorbidities that negatively affect bodily function, as well as emotional, economic, and social aspects¹. In this context, advanced age is one of the factors associated with a higher prevalence of dysphagia, which is considered a multifactorial geriatric syndrome. This condition is characterized by changes such as the gradual loss of muscle strength and reduced sensitivity of structures involved in swallowing, impairing the safe and efficient transport of food to the stomach and consequently increasing health risks for older adults²⁻⁷.

The prevalence of dysphagia among older adults is strongly associated with an increased risk of pneumonia and mortality, particularly among the oldest individuals². In this population, the presence of sarcopenia, frailty, immobility syndrome, dementia, stroke, urinary incontinence, pressure ulcers, delirium, and falls significantly increase the risk of oropharyngeal dysphagia². A 2022 meta-analysis reported that the prevalence of dysphagia among community-dwelling older adults, assessed using water swallow tests, ranged from 12.14% to 30.52%. In contrast, among institutionalized older adults, it could reach up to 58.69%, depending on the assessment method employed³.

The presence of systemic diseases increases the likelihood of dysphagia in older adults by 2.47-fold. The conditions most frequently associated with dysphagia include diabetes mellitus, myocardial infarction, stroke, dementia, and head and neck cancer¹. In recent years, sarcopenic dysphagia has received increasing attention, as the relationship between sarcopenia and oropharyngeal dysphagia may increase older adults' vulnerability to complications such as aspiration and malnutrition⁴. Given

this scenario, the implementation of validated subjective tools for self-perception and identification of possible dysphagia in older adults is essential, since heterogeneity in diagnostic methods may lead to an underestimation of its true prevalence^{3,4}.

Although dysphagia is an important health issue, its prevalence among older adults may be underreported due to the widespread belief that swallowing difficulties are a natural consequence of aging. Complaints such as coughing during or after liquid intake or meals and the sensation of food sticking in the throat are often omitted during medical consultations, hindering early diagnosis and delaying treatment^{8,9}. Furthermore, dysphagia assessment should be comprehensive and not limited to patient self-report, especially in older populations, who may present cognitive and sensory limitations related to aging that impair the recognition and perception of swallowing disorders³.

Screening is a simple and rapid strategy for identifying the possibility of dysphagia during the initial consultation, enabling early speech-language pathology intervention with greater potential to reduce healthcare costs, improve functional outcomes, and positively impact quality of life^{5,7}. Several instruments can be used for dysphagia screening, including questionnaires, water swallow tests, and multiple-consistency swallowing tests, all of which can be quickly administered in outpatient settings⁵.

This study is justified by the scarcity of research investigating the presence of swallowing-related signs and symptoms that can be identified before the first geriatric consultation. It is hypothesized that, at this initial stage, older adults may self-report symptoms suggestive of dysphagia and present a possibility of dysphagia, even in the absence of specific complaints, thereby enabling early referral for speech-language pathology assessment.

Therefore, this study aimed to identify, examine associations, and determine correlations between self-reported symptoms suggestive of dysphagia and the possibility of dysphagia in older adults attending a geriatric outpatient clinic before their first consultation.

Materials and Methods

This was an observational cross-sectional study, as no intervention was performed by the researchers on the variables investigated, and data were collected at a single time point while patients were awaiting their first outpatient consultation with a geriatrician. The cross-sectional design was chosen because it allows the identification and assessment of associations and correlations between signs suggestive of dysphagia and the possibility of dysphagia among older adults attending the outpatient clinic at a single clinical moment, in accordance with the study objective, without the intention of establishing causal relationships or clinical diagnoses. The study was approved by the Research Ethics Committee of the institution under protocol number 5,530,009. Data collection was conducted at the Geriatrics Outpatient Clinic of a university hospital between September 2022 and August 2023.

Older adults awaiting their first outpatient consultation with a geriatrician were eligible for inclusion, regardless of diagnosis. Patients who were unable to understand or respond to the questions and/or instructions, as well as those undergoing speech-language therapy, were excluded.

Clinical and demographic data were obtained through medical record review, including age group, sex, comorbidities, gastroesophageal reflux disease, probable sarcopenia, feeding route, and complaints related to voice, speech, respiratory alterations, and swallowing. The Eating Assessment Tool (EAT-10) and the Screening for *Rastreamento de Disfagia Orofaringea em Idosos no ambiente hospitalar* (RaDI-H) protocols were administered at a single time point. Comorbidities were analyzed using the Charlson Comorbidity Index (CCI), which is routinely used by the geriatrics service. All participants received prior information regarding the study and provided written informed consent.

To minimize the risk of bias, all protocol questions were administered directly to participants in the form of an interview while they awaited

their consultation with the geriatrician. Whenever necessary, doubts were clarified by the principal investigator, who has experience in dysphagia assessment and the administration of self-report instruments. No data collection occurred during the geriatric consultation itself, as the study focused on the patient's perspective at that specific moment.

The EAT-10 was originally developed to identify dysphagia risk and symptoms, document baseline dysphagia severity, and monitor treatment outcomes. In the present study, it was used to assess the self-report of symptoms suggestive of dysphagia^{10,11}. The instrument consists of ten simple questions, can be administered rapidly, and does not require visual analog scales or complex scoring formulas^{10,11}. It demonstrates excellent internal consistency, reproducibility, and criterion-based validity, with sensitivity and specificity of 0.82 and 0.63, respectively¹². Because it can be administered by different healthcare professionals, it facilitates referrals for speech-language pathology assessment, contributing to early multidisciplinary intervention, reduced treatment costs, and improved quality of life. A score of ≥ 3 indicates self-reported symptoms suggestive of dysphagia and the need for formal swallowing assessment.^{10,11}

RaDI-H^{13,14} is a screening protocol designed to identify the possibility of dysphagia in hospitalized older adults. It consists of nine easy-to-administer questions addressing swallowing-related symptoms and complaints. Response options for each item are “no,” “yes,” or “do not know.” When a positive response is provided, symptom frequency is further investigated using the options “sometimes” or “always.” Scores range from 0 to 2 points per item (“no” = 0; “yes” = 2; “sometimes” = 1; “always” = 2; “do not know” = 2). The total score ranges from 0 to 18 points. A score of ≥ 4 is considered positive, indicating the need for referral for diagnostic swallowing assessment¹³.

The ICC¹⁵ is an instrument in which points are assigned according to the presence of specific diseases, and the resulting score is associated with patient prognosis, particularly mortality risk. Nineteen clinical conditions are included and weighted as follows: weight 1 (acute myocardial infarction, mild liver disease, uncomplicated diabetes mellitus, chronic pulmonary disease, congestive heart failure, peripheral vascular disease, connective tissue disease, cerebrovascular disease, dementia, and peptic ulcer disease); weight 2 (moderate-to-

severe renal disease, hemiplegia, diabetes with complications, solid tumor, lymphoma, and leukemia); weight 3 (moderate-to-severe liver disease); and weight 6 (metastatic cancer and Acquired Immunodeficiency Syndrome [AIDS]). The final score is obtained by summing the weights of all comorbidities present, with higher scores indicating lower expected survival¹⁵.

Probable sarcopenia was assessed using the *Strength, Assistance in walking, Rise from a chair, Climb stairs, and Falls* (SARC-F)¹⁶ screening tool, which identifies individuals at risk of sarcopenia through questions regarding muscle strength, need for assistance when walking, difficulty rising from a bed or chair, difficulty climbing stairs, and falls during the previous year. Because the administration of this questionnaire is part of the routine clinical practice of the outpatient clinic, data regarding probable sarcopenia were obtained directly from medical records.

Data were entered into a database created using Microsoft Excel® and subsequently analyzed statistically. The sample was classified as non-parametric according to the Kolmogorov–Smirnov normality test. Descriptive and inferential statistical analyses were performed for all study variables. Associations were analyzed using Fisher's Exact Test, and correlations between protocol scores were

assessed using Spearman's Rank Correlation Test. A significance level of 5% ($p \leq 0.05$) was adopted. Correlation coefficients were interpreted as follows: <0.3 (weak correlation), ≥ 0.3 to <0.6 (moderate correlation), ≥ 0.6 to <0.9 (strong correlation), ≥ 0.9 to <1.0 (very strong correlation), and $r = 1.0$ (perfect correlation).

Results

At the first consultation, 59 patients were identified, of whom 56 were included and 3 were excluded: 1 (33.3%) because they were undergoing speech-language therapy and 2 (66.7%) due to difficulties in comprehension. There was a predominance of female participants ($n = 43$; 77%). Age ranged from 61 to 93 years, with a median age of 75 years. A high frequency of comorbidities was observed ($n = 39$; 69.9%). All participants ($n = 56$; 100%) were fed orally. Complaints related to swallowing, respiration, and voice/speech were reported by 6 (10.7%), 6 (10.7%), and 4 (7.1%) participants, respectively. Probable sarcopenia was identified in 33 patients (58.9%), and only one participant (1.8%) reported gastroesophageal reflux disease (Table 1).

Table 1. Characterization of clinical/demographic variables of elderly patients seen before their first consultation at a geriatrics clinic (n=56)

Variables	n (%)
Age group	60–70 years
	15 (26.7)
	71–80 years
	29 (51.7)
	>80 years
	12 (21.5)
Sex	Female
	43 (77.0)
	Male
	13 (23.0)
Disease/CCI	Yes
	39 (69.7)
	No
	17 (30.3)
CCI comorbidities	Acute myocardial infarction
	5 (12.8)
	Uncomplicated diabetes mellitus
	17 (43.5)
	Congestive heart failure
	3 (7.6)
	Chronic pulmonary disease
	4 (10.2)
	Peripheral vascular disease
	1 (2.5)
	Connective tissue disease
	5 (12.8)
	Cerebrovascular disease
	5 (12.8)
	Dementia
	2 (5.1)
	Moderate/severe renal disease
	6 (15.3)
	Diabetes mellitus with complications
	4 (10.2)
	Solid tumor
	1 (2.5)
	Moderate/severe liver disease
	2 (5.1)
Gastroesophageal reflux disease	Yes
	1 (1.8%)
	No
	55 (98.2%)
Probable sarcopenia	Yes
	33 (58.9%)
	No
	23 (41.1%)
Oral feeding	Yes
	56 (100%)
Voice and speech complaints	Yes
	4 (7.1%)
	No
	52 (92.9%)
Respiratory complaints	Yes
	6 (10.7%)
	No
	50 (89.3%)
Swallowing complaints	Yes
	6 (10.7%)
	No
	50 (89.3%)

Abbreviation: CCI = Charlson Comorbidity Index.

Regarding the Charlson Comorbidity Index (CCI), 35.8% (n = 14) of the patients presented multimorbidity, which could include conditions with the same or different weights. Among those who scored on the index, diseases classified as weight 1 predominated (n = 35; 89.7%), particularly uncomplicated diabetes mellitus (n = 17; 43.5%). Weight 2 conditions were present in 11 patients (28.2%), with moderate-to-severe renal disease being the most prevalent (n = 6; 15.3%). Weight 3 conditions, corresponding to moderate-to-severe liver disease, were identified in two patients (5.1%). No diseases classified as weight 6 were observed.

A total of 39 patients (69.7%) scored on the CCI. The total score, calculated as the sum of the weights assigned to each condition, was distributed

as follows: score 1 (n = 22; 56.4%), score 2 (n = 7; 17.9%), score 3 (n = 7; 17.9%), score 4 (n = 2; 5.2%), and score 5 (n = 1; 2.6%). The mean CCI score was 1.79, with a median of 1 and a range from 1 to 5 points.

For the EAT-10, the mean score was 1.91, with a maximum score of 16 points and a standard deviation of 3.46. For the RaDI-H, the mean score was 1.42, the maximum score was 10 points, and the standard deviation was 2.41. Both instruments presented a minimum and median score of 0 points.

Self-reported symptoms suggestive of dysphagia were identified in 15 patients (27%), whereas the possibility of dysphagia was identified in 11 patients (20%). All patients classified as having a

possibility of dysphagia also reported symptoms suggestive of dysphagia. The results demonstrated

a significant association between these two variables (Table 2).

Table 2. Frequency and association between self-reported symptoms suggestive of dysphagia and the possibility of dysphagia in older adults assessed before their first consultation at a geriatric outpatient clinic (n = 56)

Possibility of Dysphagia	Self-reported Symptoms			p-value
	Present n (%)	Absent n (%)	Total n (%)	
No	4 (7%)	41 (73%)	45 (80%)	0.001
Yes	11 (20%)	0 (0%)	11 (20%)	
Total	15 (27%)	41 (73%)	56 (100%)	

Fisher's Exact Test.

A strong positive correlation was observed between self-reported symptoms suggestive of dysphagia and the possibility of dysphagia ($r = 0.719$; $p < 0.001$).

Discussion

Swallowing difficulties in older adults are frequently not reported by patients, resulting in the underdiagnosis of dysphagia, despite the importance of thorough investigation. Identifying the possibility of dysphagia is essential to prevent complications, optimize functional outcomes and quality of life, and reduce the duration and costs of hospitalizations, as it enables earlier and more effective interventions^{3,7,17}.

Among the findings, the higher frequency of individuals aged 71 to 80 years deserves attention, as this age group is associated with greater vulnerability to swallowing disorders⁴. This finding is consistent with the literature, which demonstrates a progressive increase in dysphagia prevalence with advancing age, particularly after 75 years¹⁸. Several physical and metabolic changes occur during aging, including sarcopenia, delayed laryngeal vestibule closure, upper esophageal sphincter dysfunction, and increased esophageal stiffness, making older adults more susceptible to malnutrition, dehydration, and pulmonary complications^{2,3,5,18}.

The predominance of women at the first consultation highlights sex-related differences in health-seeking behavior. It reinforces the need for strategies aimed at encouraging men to take a more active role in managing their own health. Women generally appear to be more attentive to their health

and well-being, whereas men are often more reluctant to seek professional assistance, possibly due to social and cultural values that associate masculinity with self-sufficiency¹⁹. Consequently, men may be underrepresented in outpatient healthcare services, potentially contributing to delayed diagnosis and management of conditions such as dysphagia in this population.

The high prevalence of comorbidities observed in this study reinforces their role as important determinants of dysphagia among older adults. Evidence from meta-analyses indicates a multimorbidity prevalence of 42.4% among adults, with a strong association with advancing age²⁰. In older populations, this prevalence may reach 67.8% and is associated with increased mortality risk, functional decline, reduced life expectancy, and the progressive accumulation of chronic diseases²¹. In this context, the presence of comorbidities and multimorbidity, particularly when associated with functional impairment, contributes to an increased possibility of dysphagia due to their impact on musculoskeletal, cardiometabolic, and cognitive systems¹.

The predominance of diabetes mellitus in the sample is noteworthy, as this condition is associated with manifestations that may compromise swallowing function. Complaints such as xerostomia and altered taste perception, resulting from changes in salivary composition in diabetic patients, may impair mastication and swallowing⁸. Furthermore, diabetes-related neuromuscular alterations may reduce tongue and lip motor function, leading to decreased endurance and increased muscle fatigue⁹. Sensations of food sticking in the throat and cough-

ing after swallowing are also frequently reported by this population⁸.

Evidence indicates that diabetes is present in a substantial proportion of hospitalized older adults and that a considerable number of these individuals exhibit signs of dysphagia²². In this context, a multidisciplinary approach provides comprehensive care, promoting not only efficiency but also swallowing safety and improved quality of life.

Regarding CCI scores, patients with scores above 3 have a lower likelihood of maintaining oral feeding²³. It is believed that, although comorbidities may be present, the clinical decision to recommend an alternative feeding route in older adults depends on multiple factors related to the patient's overall clinical condition and multidisciplinary team assessment. Even when oral feeding is maintained, multimorbidity may mask the possibility of dysphagia, particularly in the absence of swallowing-related complaints or symptoms, thereby delaying clinical investigation. Such delays may allow silent progression of swallowing impairment, exposing patients to numerous health risks.

The small number of patients reporting gastroesophageal reflux disease (GERD) may be related to incomplete or inconsistent information documented in medical records. GERD is highly prevalent among older adults and represents the most common disease of the digestive tract. Clinical manifestations include acid regurgitation, heartburn, burning sensation, belching, dysphagia, hoarseness, and chronic cough. Approximately two-thirds of older adults with GERD present dysphagic symptoms due to acid exposure of the oral cavity, pharynx, and larynx, resulting in pain and discomfort during swallowing²⁴. Aging-related physiological changes in the digestive system, such as reduced upper esophageal sphincter pressure, impair the anti-reflux barrier and contribute to the increased prevalence of GERD in this population²⁴.

Medications commonly used by older adults, including nonsteroidal anti-inflammatory drugs and benzodiazepines, may reduce sphincter pressure, contributing to the development or worsening of GERD. Salivary secretion, which functions as a protective barrier for the esophageal mucosa, is also compromised with aging, affecting approximately 25% of older adults and intensifying GERD symptoms²⁴.

The findings revealed probable sarcopenia in more than half of the sample. Loss of muscle mass

and strength affects multiple bodily functions, including reductions in tongue strength and range of motion, as well as diminished strength of other swallowing-related muscles and intraoral pressure, impairing bolus propulsion^{4,25}. The association between sarcopenia and dysphagia worsens patients' clinical conditions, and approximately one-third of older adults with dysphagia also present sarcopenia, increasing the risk of nutritional and functional complications²⁵. Furthermore, reduced oral function and dysphagia are important features of frailty in older adults, reflecting a complex interaction of pathophysiological mechanisms that contribute to adverse outcomes in this population^{6,7}.

Voice and respiratory complaints, identified in part of the sample, are relevant indicators of possible dysphagia, given the interdependence of phonatory and swallowing systems. Both depend on the integration of pressure, myoelastic, and aerodynamic mechanisms to function effectively and safely, coordinating simultaneously with respiration to ensure lower airway protection²⁶. Dysphonia is a common condition among older adults, with prevalence rates reaching up to 27.79%²⁷. Glottic insufficiency, often resulting from muscle weakness, is characterized by reduced ability to achieve adequate glottal closure and generate sufficient subglottic pressure, compromising cough effectiveness and consequently increasing the risk of aspiration²⁸.

Given the close relationship between swallowing and voice, which share anatomical structures and physiological mechanisms, glottic insufficiency directly affects vocal production and may result in hoarseness, breathiness, vocal instability, and reduced vocal intensity. Moreover, this dysfunction impairs lower airway protection, negatively affecting swallowing efficiency in older adults²⁸.

Poor coordination between respiration and swallowing considerably increases the likelihood of penetration and/or aspiration, making patients more susceptible to aspiration pneumonia. The complexity of these systems highlights the importance of carefully investigating reported complaints and correlating them with each patient's clinical condition to enable early intervention when dysfunction is suspected²⁷.

Swallowing-related complaints during the first medical consultation were identified in nearly 11% of participants. However, 27% reported symptoms suggestive of dysphagia, suggesting that many

individuals may perceive certain signs as a natural consequence of aging and therefore underestimate or ignore them. Self-reported symptoms suggestive of dysphagia may reach 24.1% among hospitalized older adults³. In long-term care facilities, prevalence estimates range from 16% to 69.6%²⁹. In southern Brazil, approximately one in every twelve patients reports symptoms suggestive of dysphagia¹⁹. These findings reinforce the importance of dysphagia screening to enable early intervention and reduce the clinical and functional consequences associated with aging that may substantially compromise quality of life.

The prevalence of possible dysphagia observed in this study is consistent with findings from another investigation in which possible dysphagia was identified in 21.5% of older adults residing in nursing homes³⁰. This proportion increases to 43.1% among patients admitted to acute medical units²². These findings emphasize the importance of incorporating dysphagia screening into routine outpatient care.

All patients identified as having possible dysphagia also reported symptoms suggestive of swallowing impairment. However, not all participants who reported symptoms were classified as having possible dysphagia by the screening protocol. Although causal relationships cannot be established due to the subjective nature of the instruments used, a significant association and strong positive correlation were observed between the variables, suggesting that poorer self-reported swallowing symptoms are associated with a greater likelihood of dysphagia. These findings support the incorporation of systematic screening instruments into the initial geriatric assessment, a stage at which patient complaints and healthcare needs are expected to be identified and appropriate referrals determined. It should be emphasized that the absence of self-reported complaints does not exclude the possibility of dysphagia, reinforcing the need for validated screening methods to avoid compromising early detection and timely clinical management.

Overall, the findings highlight the relevance of self-reported symptoms suggestive of dysphagia as a promising tool for early screening in older adults. Furthermore, the association between self-reported

symptoms, comorbidities, and probable sarcopenia underscores the vulnerability of this population to dysphagia-related complications. The presence of voice and respiratory complaints also suggests the need for a comprehensive clinical approach that systematically includes swallowing assessment. Therefore, integrating symptom self-report and dysphagia screening into routine geriatric consultations may contribute to earlier diagnosis, more effective interventions, and improved quality of life among older adults receiving outpatient care.

It is important to note that the relatively small sample size was primarily due to the reduction in the number of appointments available at the geriatrics outpatient clinic and the fact that data collection was conducted at a single hospital, both of which represent important study limitations. In addition, the cross-sectional design and exclusive use of subjective self-report and screening instruments preclude the establishment of dysphagia diagnoses or causal relationships among the investigated variables. The subjective nature of the instruments may also have influenced the magnitude of the observed associations, while the absence of clinical and/or instrumental diagnostic methods limits the validity of the findings. Nevertheless, identifying swallowing-related symptoms and conducting dysphagia screening during the first consultation may facilitate early interventions capable of minimizing functional, social, and emotional impairments, thereby directly improving quality of life among older adults. Based on the present findings, both the EAT-10 and RaDI-H appear to be valuable tools for routine outpatient and hospital practice, supporting effective screening and follow-up of older populations.

Conclusion

In this study, 27% of older adults reported symptoms suggestive of dysphagia before their first consultation with a geriatrician, and 20% presented a possibility of dysphagia. A significant association and a strong positive correlation were observed between the protocols, indicating that higher self-reported symptom scores were associated with a greater possibility of dysphagia.

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