Introducing the Reflux Finding Score (RFS)

The next objective measure for FEES that we will be sharing is the **Reflux Finding Score.** The RFS is an eight-item index designed to assess clinical severity base on laryngoscopic findings in order to identify possible laryngopharyngeal reflux (LPR). The laryngoscopic markers that are used include subglottic edema, ventricular obliteration, erythema/hyperemia, vocal fold edema, diffuse laryngeal edema, posterior commissure hypertrophy, granulation tissue and thick endolaryngeal mucus. The ratings vary, including present vs. absent, partial vs. complete and mild-severe. Each item is scored individually and added together to create a total score. The score totals range from 0 (normal) to 26 (most severe), with a score of 7 or greater being indicative of LPR.

Multiple research studies have shown high agreement between raters, demonstrating **high inter- and intra-rater reliability** of the RFS. Studies have also shown high correlation with confirmed LPR as demonstrated by double probe pH monitoring. It has been shown to be useful as an initial assessment in the diagnostics of LPR as well as a post-treatment assessment to demonstrate improvement of LPR.

How is the RFS used in our reports?

We have a table that is included in the objective section of the report. It lists the anatomical findings, individual scores, and total score. There is also a statement that a total score above 7 being indicative of LPR. At times, we may not include the RFS if it is not relevant to the case.

How does this information help you clinically?

Prevalence of LPRD and GERD have increased greatly over the years due to diet changes and more sedentary lifestyles. As SLPs we see patients with symptoms of reflux regularly. We are often the first professionals to see these patients because they are referred for their symptoms of dysphagia, globus sensation, throat clearing and hoarse voice. We may not be able to readily treat LPR or esophageal dysphagia, but we can provide education and direct the patient to the appropriate healthcare specialty. With this information you can provide the appropriate education and discharge the patient from services rather than continuing to treat an unknown physiologic impairment without access to instrumentation.

If a patient has a high RFS, I will often encourage the SLP to complete the **Reflux Symptom Index** (RSI) as well. The RSI is a 9 item questionnaire that is designed to rate reflux symptom severity over a period of time. The rating is from 0 (no problem) to 5 (severe problem) with a maximum total score of 45. A score higher than 13 demonstrates a likelihood of LPR. It correlates highly with the RFS in providing further indication of LPR. Having these two items to demonstrate likelihood of LPR is often much more effective in getting the appropriate referrals for the patient rather than our clinical exam alone.

It is well known that instrumental swallow studies are necessary to appropriately diagnose dysphagia. In cases with pharyngeal and esophageal dysphagia symptoms, FEES can be very helpful. We can rule-out pharyngeal dysphagia or assess for presence of pharyngeal dysphagia

due to primary esophageal dysphagia. We can visualize esophageal backflow and see indications of PES dysfunction. FEES can enable us to see what happens between the swallow (i.e. esophageal backflow) and allows us to give extended PO trials in order to elicit the patient's typical symptoms on exam. These are often tasks that cannot be completed on an MBSS. FEES does have limitations in that it cannot visualize the esophagus directly, but we are able to make references to esophageal dysphagia and provide referrals to the appropriate medical professional.

In summary, not only can FEES be an effective tool in assessing for pharyngeal dysphagia, it can also assess for the likelihood of esophageal dysphagia and LPR with use of the Reflux Finding Score and other markers. If you would like more information on the RFS, please see the resources below.

References

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