



REVISTA DE GASTROENTEROLOGÍA DE MÉXICO

www.elsevier.es/rgmx



REVIEW ARTICLE

Position statement of the Latin American Dysphagia Society for the management of oropharyngeal and esophageal dysphagia during the COVID-19 pandemic[☆]



C. Manzano-Aquihuatl^{a,b}, R. Tobar-Fredes^{c,d}, M.R. Zavala-Solares^{b,e}, D. Salle-Levy^{f,g},
R. Imamura^{h,l}, R. Morales-Fernández^{a,i}, L. Ojeda-Peña^{a,j}, D. Parra-Reyes^{a,k},
P. Santoro^{h,l}, V. Ton^{m,n}, O.E. Trujillo-Benavides^ñ, M.A. Vargas-García^{a,o}, A.M. Furkim^{a,p,*}

^a Sociedad Latinoamericana de Disfagia (The Latin American Dysphagia Society)

^b Sociedad Mexicana de Disfagia, Mexico City, Mexico

^c Sociedad Chilena de Deglución y Alimentación, Santiago, Chile

^d Departamento de Fonoaudiología, Universidad de Chile, Santiago, Chile / Unidad de Fonoaudiología, Hospital del Trabajador, Santiago, Chile

^e Escuela de Altos Estudios en Salud, Universidad La Salle México, Mexico City, Mexico

^f Academia Brasileira de Disfagia, Sao Paulo, Brazil

^g Departamento de Disfagia de la Sociedad Brasileira de Fonoaudiología, Brazil

^h Academia Brasileira de Laringología y Voz, Brazil

ⁱ Instituto Nacional de Rehabilitación Pedro Aguirre Cerda, Santiago, Chile

^j Asociación Paraguaya de Disfagia, Asunción, Paraguay

^k Sociedad Peruana de Disfagia, Lima, Peru

^l Hospital de las Clínicas de la Facultad de Medicina de la Universidad de Sao Paulo, Sao Paulo, Brazil

^m Asociación Argentina de Disfagia, Buenos Aires, Argentina

ⁿ Departamento de Endoscopia Hospital General de Zona No. 42. Instituto Mexicano del Seguro Social, Mexico City, Mexico

^ñ Departamento de Endoscopia Hospital General de Zona No. 42. Instituto Mexicano del Seguro Social, Ciudad de México, Mexico

^o Departamento de Fonoaudiología, Universidad Metropolitana, Barranquilla, Colombia

^p Universidad Federal de Santa Catarina, Curso de Fonoaudiología, Florianópolis, Brazil

Received 13 March 2021; accepted 5 August 2021

Available online 29 December 2021

KEYWORDS

COVID-19;
Dysphagia;
Oropharyngeal;

Abstract

Introduction: The SARS-CoV-2 virus that causes the COVID-19 disease is transmitted through the inhalation of droplets or aerosols and inoculation via the oronasal or ocular routes, transforming the management of swallowing disorders into a challenge for healthcare teams, given their

[☆] Please cite this article as: Manzano-Aquihuatl C, Tobar-Fredes R, Zavala-Solares MR, Salle-Levy D, Imamura R, Morales-Fernández R, et al. Posicionamiento de la Sociedad Latinoamericana de Disfagia para el manejo de la disfagia orofaríngea y esofágica durante la pandemia COVID-19. Rev Gastroenterol Méx. 2022;87:63–79.

* Corresponding author at: Universidade Federal de Santa Catarina – UFSC Rua Campus Reitor João David Ferreira Lima, s/n, Trindade, Florianópolis (SC), CP: 476, CEP: 88040-900, Brazil. Tel.: +55 48 996006078.

E-mail address: ana.furkim@gmail.com (A.M. Furkim).

Esophageal;
Suggestions

proximity to the aerodigestive tract and the high probability of aerosol generation during patient evaluation and treatment.

Aim: To provide essential guidance for Latin American multidisciplinary teams, regarding the evaluation and treatment of oropharyngeal and esophageal dysphagia, at the different levels of healthcare. The position statement was formulated for the purpose of maintaining medical service continuity, in the context of a pandemic, and minimizing the propagation and infection risks of the virus.

Methods: Thirteen experts in swallowing disorders were summoned by the Latin American Dysphagia Society to formulate a series of clinical suggestions, based on available evidence and clinical experience, for the management of dysphagia, taking the characteristics of Latin American healthcare systems into account.

Results: The position statement of the Latin American Dysphagia Society provides a series of clinical suggestions directed at the multidisciplinary teams that manage patients with oropharyngeal and esophageal dysphagia. It presents guidelines for evaluation and treatment in different contexts, from hospitalization to home care.

Conclusions: The present statement should be analyzed by each team or healthcare professional, to reduce the risk for COVID-19 infection and achieve the best therapeutic results, while at the same time, being mindful of the reality of each Latin American country.

© 2021 Published by Masson Doyma México S.A. on behalf of Asociación Mexicana de Gastroenterología. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

PALABRAS CLAVE

COVID-19;
Disfagia;
Orofaringea;
Esofágica;
Sugerencias

Posicionamiento de la Sociedad Latinoamericana de Disfagia para el manejo de la disfagia orofaríngea y esofágica durante la pandemia COVID-19

Resumen

Introducción: El virus SARS-CoV-2, que causa la enfermedad COVID-19, se transmite por inhalación de pequeñas gotas o aerosoles e inoculación por vía oronasal u ocular, lo cual hace del manejo de la deglución para los equipos de salud un desafío, dada su proximidad al tracto aerodigestivo y la alta probabilidad de generar aerosol durante la evaluación y tratamiento de los pacientes.

Objetivo: Brindar orientación esencial a los equipos de salud multidisciplinarios de Latinoamérica para la evaluación y tratamiento de la disfagia orofaríngea y esofágica en los diferentes niveles de atención en salud. Este posicionamiento fue realizado con el propósito de mantener la continuidad de los servicios médicos en el contexto de una pandemia y minimizar los riesgos de propagación y contagio del virus.

Métodos: Con base en la evidencia disponible y la experiencia clínica alcanzada hasta la fecha, 13 expertos en deglución convocados por la Sociedad Latinoamericana de Disfagia formularon una serie de sugerencias clínicas para el manejo de la disfagia, considerando las características de los sistemas de salud latinoamericanos.

Resultados: El posicionamiento de la Sociedad Latinoamericana de Disfagia brinda a los equipos multidisciplinarios una serie de sugerencias clínicas para el manejo de personas con disfagia orofaríngea y esofágica y ofrece lineamientos para su evaluación y tratamiento en diferentes contextos, desde la hospitalización hasta la atención domiciliaria.

Conclusiones: Este posicionamiento debe ser analizado por cada equipo o profesional de la salud, para reducir el riesgo de contagio por COVID-19 y lograr los mejores resultados terapéuticos, considerando siempre la realidad de cada país latinoamericano.

© 2021 Publicado por Masson Doyma México S.A. en nombre de Asociación Mexicana de Gastroenterología. Este es un artículo Open Access bajo la licencia CC BY-NC-ND (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

Introduction

The World Health Organization declared the COVID-19 disease a global pandemic in March of 2020. In Latin America, as

of mid-June of 2021, a total of 35,672,198 positive COVID-19 cases have been confirmed, accounting for 20% of the infected population worldwide. Unfortunately, 1,228,677 of those patients have died¹. The disease produced by SARS-

CoV-2 is highly transmissible, requiring clinicians to modify their practices and protocols for safety reasons. COVID-19 disease impacts the functioning of the respiratory system and is a risk factor for developing dysphagia in certain groups, such as the elderly, patients with pre-existing lung conditions, and patients with other comorbidities². Conditions are exacerbated in patients that require prolonged periods of ventilation (more than 72 h), increasing the risk of dysphagia after extubation³. Therefore, it is not surprising that the incidence of dysphagia in COVID-19 patients can be as high as 80% in persons that required ventilatory support, and close to 30% in those that did not^{4,5}.

Considering the abovementioned data, all healthcare professionals (HCPs) that are part of the dysphagia treatment team must take all the necessary measures to minimize the risk of contagion, recognizing that the treatment of dysphagia includes procedures that can lead to the production of droplets and aerosols, as well as to contact with the virus^{6–8}. Therefore, the timing of the evaluation of dysphagia and the indication of treatment will most likely differ from the norm⁶, especially regarding the implementation of different procedures, in an effort to maintain the continuity of care and optimize patient turnover at the different hospitals and health facilities⁹.

The present position statement is a proposal for promoting the safety of the multidisciplinary team treating oropharyngeal and esophageal dysphagia, in the context of the COVID-19 pandemic. The aims of this statement are: (1) to provide essential guidance related to the diagnosis and rehabilitation of oropharyngeal and esophageal dysphagia and (2) to provide a guide for the multidisciplinary team working with COVID-19 patients that present with different clinical complexities of dysphagia (i.e., critical care patients, hospitalized patients, outpatients, patients receiving home care, and patients receiving telehealth services), to help reduce the risk of transmission of SARS-CoV-2.

The Latin American Dysphagia Society (LADS) formulated this position statement, with respect to clinical management, in the context of a crisis that is still present in several countries in the region, based on currently available information. Because the information is continuously developing, the statements contained herein are not evidence-based clinical practice guidelines and may require future evaluation and revision. Finally, the statements must be put into context, based on the characteristics of the health system of each country, access to resources, and the prevalence of COVID-19.⁹

⁹ Not only patients infected with SARS-CoV-2 need care. As the pandemic continues, many institutions and medical societies have suggested postponing non-emergency medical care, which has led to a marked reduction in outpatient care^{10–16}. As a result of this, the diagnosis and treatment of other progressive diseases related to COVID-19 have been delayed, which has had an impact on morbidity, mortality and treatment costs for these patients^{17–19}. As the incidence curve improves, it will be necessary to consider resuming the care of elective patients considering the challenges related to the safety of patients and health care professionals (HCPs), as well as the availability of personal protective equipment (PPE).

Methods

The board of directors of the LADS summoned 13 experts to participate in formulating the position statement. The participants were from Argentina, Brazil, Chile, Colombia, Mexico, Paraguay, and Peru, the countries that, as of March 2021, formed part of the dysphagia society. Each expert met the following criteria: (a) at least 10 years of experience in the treatment of dysphagia, (b) postgraduate training in dysphagia, and (c) currently working at a clinic, hospital, or academic institution. The multidisciplinary approach was favored by the participation of speech language pathologists, phoniatrists, gastroenterologists, and otolaryngologists.

The methodology previously described in similar documents was used^{6,20} and the statements were supported by recommendations, consensuses, and evidence available at the time, taking care to adapt them to the different scenarios that exist in Latin America. At a first meeting, and in accordance with the area of expertise of each participant, the sections were assigned for the bibliographic search, the summarization of the evidence collected, and the drafting of the recommendations for the first round of voting. The bibliography was available to all the participants. The recommendations were sent to the participants by means of an electronic survey system. The response options for each recommendation were: "I agree", "I disagree", and "text modification", and the round of voting was carried out on October 19, 2020.

The participants had a final meeting on a virtual platform on October 21, 2020, to know the results of the survey and vote again, if necessary. Agreement of 80% was required for a recommendation to be established. Recommendations that did not reach 80% agreement were put to a vote, after making the suggested text modifications, and recommendations that had 80% approval were automatically accepted. Each section provides a summary of the evidence and the subsequent recommendations. No system was employed to classify the quality of the evidence. The final version of the document was reviewed and approved by all the participants.

Personal protection and prevention measures

The SARS-CoV-2 virus is transmitted by inhalation of drops or aerosols²¹, or by contact and subsequent inoculation via the oronasal or ocular routes. It is highly transmissible, a situation that implies strict control, with respect to prevention measures and personal protection for the health team and towards patients²², which includes correctly putting on and taking off personal protection equipment (PPE)²³. Both clinical and instrumental swallowing evaluations are considered aerosol-generating procedures (AGPs), because they involve interventions for assessing cough, phonation, the functioning of sphincter mechanisms, and pressures at the aerodigestive crossroads, for the protection of the airway^{6–8}. Such interventions tend to involve an exposure time of more than fifteen min and a distance of less than 1.80 m, increasing the risk of transmission²⁴.

For hospital wards of patients with suspected or confirmed COVID-19, maintaining negative pressure, with a

minimum of 6–12 air exchanges per hour, is recommended, and if that is not possible, they should maintain a ventilation rate of at least 160 L/s²⁵. The doors of the rooms should be kept closed the majority of the time. The air in those rooms must be exhausted directly to the outside or filtered through a high-efficiency particulate air (HEPA) filter, before recirculation²⁵.

The PPE for AGP practices includes an N95 mask, covered by a disposable surgical mask, eye protection, a cap, disposable gloves, and a gown. An acrylic mask and shoe covers are optional. Because PPE goes by different names in each Latin American country, Table 1 shows a list of the corresponding synonyms. Whether Levels 1, 2, or 3 of PPE should be used, depends on the viral load status of the patient, local and institutional regulations, and the epidemiological situation of the specific region.

The following recommendations are suggested:

- a) To perform the swallowing assessment, the use of PPE that includes all the elements for practices that generate droplets and aerosols is suggested.
- b) Each professional must be adequately trained in the use of PPE, according to the protocols established by the health center.
- c) The elements and instruments used in the practices must be disposable or properly disinfected after each use.
- d) It is important to categorize the different procedures by risk and correlate the risks with the viral load (Table 2).

Considerations for the clinical assessment of swallowing

In patients with confirmed COVID-19, postponing the clinical evaluation of swallowing in patients with dysphagia is recommended. Patients are predisposed to coughing during the procedure, and it is even more frequent in the context of their concomitant respiratory conditions⁷.

However, there are situations in which the procedures cannot be deferred because of patient needs and health center requirements, particularly those with great demand for high-complexity care beds in areas with an elevated prevalence of COVID-19 in the population. Thus, direct care should be reduced to cases in which the swallowing specialist, together with the team, estimates the predominance of benefits over risks²⁵. In such cases, the clinical evaluation of swallowing can be carried out, in compliance with strict standards that enable the protection of the HCP and reduce the spread of the virus, using screening tests as an initial option.

Dysphagia screening

In the context of the pandemic, swallowing clinicians should share tasks related to swallowing management with the health team. Training other professionals (nurses, respiratory therapists, or non-specialist physicians) in the use of those tools, receiving additional instructions from the outside²⁶, reduces the number of HCPs that are exposed to SARS-CoV-2 and enables rational PPE use. It is always important to remember that the results obtained through the screening tests are useful for providing general recom-

mendations to the health team, but not for planning the rehabilitation of dysphagia or its pathophysiology.

Using the following detection instruments, which are commonly described in the literature and easily applicable in the Latin American context, is suggested: the Volume-Viscosity Swallow Test (V-VST)²⁷, the Yale Swallow Protocol²⁸, the Repetitive Saliva Swallowing Test (RSST)^{29,30}, and the Gugging Swallowing Screen (GUSS)³¹.

Clinical assessment

The clinical assessment of swallowing must include the examination of the cognitive and communicative states, posture, and the oropharyngolaryngeal and respiratory systems. It is important to collect as much information as possible about the patient's respiratory status, the use of supports to improve ventilation (oxygen and mechanical ventilation, among others), and the support of the multidisciplinary team, so that the patient's tolerance to weaning, oxygen saturation stability, and respiratory rate can be checked²⁶. There must be special considerations for patients with tracheostomy^{9,26}.

Therefore, the following suggestions are recommended:

- a) Check the availability of the PPE to be used. If PPE is limited, consider deferring the assessment.
- b) If it does not interfere with the procedure, the patients should continue to wear PPE (goggles, masks). If that is not possible, make the necessary adjustments to the evaluation protocol.
- c) If the same HCP provides services to patients that are negative for SARS-CoV-2, as well as to patients that are positive, the negative patients should be treated first.
- d) Minimize exposure time, limiting the evaluation sessions to the bare essentials, ideally 15 min or less.
- e) Keep a physical distance of at least 1.5 m between the HCP and the patient, when feasible, during the interview and cognitive-communication assessment.
- f) A distance of 1.5 m should be kept during the orofacial motor exam, moving closer only for evaluating the intraoral structures and making the strength assessment.
- g) Do not evaluate voluntary cough, unless absolutely necessary.
- h) If the patient can ingest liquids and/or food independently, allow him/her to do so, if the patient's cognitive and communicative performance allows him/her to adequately follow the instructions.
- i) If the patient cannot ingest liquids and/or food independently, stay at the patient's side.
- j) Always choose the foods and/or liquids that are the most appropriate for the estimated condition of the patient, avoiding the generation of reflex cough or the need for aspirating the oral cavity (or the tracheostomy tube, if present).
- k) Individually analyze the relevance and benefits of performing procedures with a high risk of aerosolization in patients with tracheostomy, such as deflation of the cuff, the use of a speaking valve, or subglottic air flow.

Table 1 Table of synonyms for personal protective equipment.

The United States	Argentina	Brazil	Chile	Colombia	El Salvador	Spain	Honduras	Mexico	Nicaragua	Paraguay	Peru	Portugal	Venezuela
HAIR NET, MEDICAL CAP	GORRO QUIRÚRGICO	TOUCA	GORRO QUIRÚRGICO, COFIA	GORRO QUIRÚRGICO	GORRO QUIRÚRGICO	GORRO DE CIRUGÍA	GORRO QUIRÚRGICO	GORRO QUIRÚRGICO	GORRO DE ENFERMERÍA	GORRO QUIRÚRGICO	GORRO QUIRÚRGICO	TOUCA CIRÚRGICA	GORRO QUIRÚRGICO
GOGGLES	ANTIPARRAS	ÓCULOS DE PROTEÇÃO	ANTIPARRAS	MONOGAFAS	GOGGLES	GAFAS	LENTE DE PROTECCIÓN, LENTE DE SEGURIDAD	GOGGLES/LENTE DE PROTECCIÓN	GAFAS/LENTE	ANTIPARRAS	LENTE PROTECTORES	ÓCULOS DE PROTEÇÃO	LENTE PROTECTORES
FACE VISOR	MASCARA FACIAL	PROTECTOR FACIAL	ESCUDO FACIAL	CARETA	CARETA	VUSERA	CARETA	CARETA	PROTECTOR FACIAL/CARETA	PROTECTOR FACIAL	PROTECTOR FACIAL, MÁSCARA FACIAL	VISEIRA	CARETA
SURGICAL FACE MASK	BARBIJO QUIRÚRGICO	MÁSCARA CIRÚRGICA	MASCARILLA QUIRÚRGICA, MASCARILLA DE PROCEDIMIENTO, MASCARILLA 3 PLIEGUES	TAPABOCAS CONVENCIONAL	MASCARILLA	MASCARILLA QUIRÚRGICA	MASCARILLA QUIRÚRGICA	CUBREBOCAS/CUBREBOCAS TRICAPA	MASCARILLA QUIRÚRGICA/MASCARILLA DE LIGAS/CUBREBOCAS	TABAPOCA QUIRÚRGICA	CUBREBOCAS O TAPABOCAS	MÁSCARA CIRÚRGICA	TAPABOCAS
FFP2 MASK, FFP3 MASK	BARBIJO FFP2, BARBIJO FFP3	MÁSCARA FFP2, MÁSCARA FFP3	MASCARILLA FFP2, MASCARILLA FFP3	MASCARILLA FFP2, MASCARILLA FFP3	MASCARILLA FFP2, MASCARILLA FFP3	MASCARILLA FFP2, FFP3	MASCARILLA FFP2, MASCARILLA FFP3	MASCARILLA FFP2, MASCARILLA FFP3/CUBREBOCAS TIPO CONCHA	MASCARILLA	MASCARILLA FFP2, MASCARILLA FFP3	MASCARILLA FFP2, MASCARILLA FFP3	MÁSCARA FFP2/MÁSCARA FFP3	TAPABOCAS FFP
N95 MASK	BARBIJO N95	MÁSCARA N95	MASCARILLA N95	MASCARILLA N95	MASCARILLA N95	MÁSCARA DE PROTECCIÓN N95	MASCARILLA N95	MASCARILLA N95/ N95 TIPO CONCHA	MASCARILLA	MASCARILLA N95	MASCARILLA N95	MÁSCARA N95	TAPABOCAS N95
PAINT PROJECT RESPIRATOR	MASCARILLA DE PINTOR	MÁSCARA RESPIRATORIA PARA PINTURA	RESPIRADOR DE MEDIO ROSTRO	RESPIRADOR FACIAL	RESPIRADOR	MEDIA MASCARILLA	MASCARA DE PINTURA, MASCARA ANTIGAS	RESPIRADOR/RESPIRADOR CON FILTRO	MEDIA MASCARA	RESPIRADOR	RESPIRADOR CON DOBLE FILTRO 3M	RESPIRADOR	RESPIRADOR
POWERED AIR-PURIFYING RESPIRATORS	RESPIRADORES PAPR Y DE AIRE SUMINISTRADO	RESPIRADOR PURIFICADOR DE AIRE	EQUIPO MOTOR VENTILADO	RESPIRADORES PURIFICADORES DE AIRE	RESPIRADOR	RESPIRADOR PURIFICADOR DE AIRE CON BATERÍA	RESPIRADOR CON AIRE PURIFICADO	RESPIRADOR/RESPIRADOR PURIFICADOR	RESPIRADOR	RESPIRADOR	RESPIRADOR PURIFICADOR COMPLETO	RESPIRADOR PURIFICADOR DE AIRE MOTORIZADO	RESPIRADOR

Table 1 (Continued)

The United States	Argentina	Brazil	Chile	Colombia	El Salvador	Spain	Honduras	Mexico	Nicaragua	Paraguay	Peru	Portugal	Venezuela
ISOLATION GOWN	DELANTAL	AVENTAL DESCARTÁVEL SEM MANGA	PECHERA	BATA DE AIS-LAMIENTO	DELANTAL	DELANTAL DESECHABLE	DELANTAL	DELANTAL/ MANDIL	DELANTAL	DELANTAL DE PROTECCIÓN	DELANTAL	AVENTAL P LÁSTICO	DELANTAL
APRON LONG SLEEVED, DISPOSABLE GOWN	CAMISOLÍN	CAPOTE	PECHERA DELANTAL QUIRÚRGICO	BATA QUIRÚRGICA	GABACHON	BATA DE EPPI	BATA QUIRÚRGICA	BATA QUIRÚRGICA/BATA	BATA	BATA QUIRÚRGICA	BATA QUIRÚRGICA	BATA CIRÚRGICA DE USO ÚNICO	MONO QUIRÚRGICO, MONO QUIRÚRGICO COMPLETO
MEDICAL PROTECTING GOWN, MEDICAL ISOLATION GOWN	TRAJE DE PROTECCIÓN	MACACÃO DE PROTEÇÃO COM CAPUZ	BUZO DE PAPEL, OVEROL, TRAJE TYVEK	TRAJE DE AIS-LAMIENTO PROTECTOR	TRAJE	MONO EPPI	TRAJE DE BIOSEGURIDAD	TRAJE DE PROTECCIÓN/OVEROL	TRAJE DE PROTECCIÓN	EQUIPO DE PROTECCIÓN PERSONAL, MAMELUCO	TRAJE DE PROTECCIÓN COMPLETO, MAMELUCO	FATO DE PROTEÇÃO COM CAPUZ	TRAJE DE PROTECCIÓN
RUBBER GLOVES, DISPOSABLE GLOVES	GUANTES	LUVAS DE PROCEDIMIENTO	GUANTES DE PROCEDIMIENTO	GUANTES	GUANTES	GUANTES	GUANTES	GUANTES	GUANTES	GUANTES	GUANTES DESCARTABLES	LUVAS	GUANTES
PROTECTIVE BOOTS, SHOE COVER	CUBREBOTAS	PROPÉ	CUBRECALZADO, CUBREZAPATOS	POLAINAS	ZAPATERAS	POLAINAS O PEUCS	CUBREBOTAS, CUBRECALZADO	CUBREBOTAS	CUBREBOTAS	CUBREBOTAS	CUBREBOTAS	COBRE-PÉS, CAPAS PARA SAPATOS LONGAS	BOTAS QUIRÚRGICAS

Table 2 Risk and viral load categorization table.

Epidemiological condition	Phenotype	Social issues	Summary of swallowing assessment and therapy recommendations
Intensive care unit Hemodynamic and respiratory stability	24 to 48 h post-extubation		Assessment: Minimize exposure time, limiting evaluation sessions to what is essentially necessary, ideally 15 min or less. During the orofacial motor exam, maintain a physical distance of 1.5 m, approaching only for assessments of intraoral structures and strength. Swallowing screening that can be performed: <ul style="list-style-type: none"> • Repetitive Saliva Swallowing Test (RSST).^{21,22} • The Yale Swallow Protocol.²³ • The Toronto Bedside Swallowing Screening Test (TOR-BSST).²⁴
	Alert Medically stable Continuous monitoring Enteral tube feeding		
Subacute	Patient referred to the intermediate care unit, requiring monitoring but no vital support	Medical social worker must manage the necessary conditions for discharge	Assessment: <ul style="list-style-type: none"> • Clinical evaluation of swallowing can be performed • During the orofacial motor exam, maintain a physical distance of 1.5 m, approaching only for assessments of intraoral structures and strength. • The Volume-Viscosity Swallow Test (V-VST) can be used.²⁵ • If the patient is able to ingest liquids and/or food on his/her own, allow the patient to do so, if his/her cognitive and communicative performance enables instructions to be adequately followed. • In the event that the patient cannot ingest liquids and/or food on his/her own, stay at the patient's side. • Always choose those foods and/or liquids that presumably are the most appropriate for estimating the patient's safest swallowing performance, avoiding the generation of reflex cough or the need for oral aspiration (or through the tracheostomy tube, if present) • Analyze the relevance and benefits of performing procedures with a high risk of aerosolization in patients with tracheostomy, such as deflation of the cuff, the use of a speaking valve, or subglottic air flow, on a case-by-case basis. • Instrumental Assessments (VFSS or FEES) can be performed to determine swallowing functional and structural indemnity, according to the clinician and health team. • Therapy: <ul style="list-style-type: none"> • Dysphagia intervention, in this context, should aim to achieve oral feeding safely, in the shortest time possible, preparing the conditions for discharge and collaborating with bed cycling. • Adapt the different treatment techniques aimed at minimizing associated complications, such as aspiration pneumonia, thus providing an opportunity early for lower medical complexity. • Prepare and implement an oral hygiene plan that reduces the risk of aspiration pneumonia. • Implement an augmentative alternative communication system (AACs) to favor patient communication. • Preparation for discharge should consider telemedicine monitoring and assess the patient's feeding performance at home.
Home care	Patient at home with sequelae associated with COVID-19	Difficulties to isolate inside the house COVID- positive family member Older adult living alone Decreased autonomy Poor support network	<ul style="list-style-type: none"> • Reduce the number of face-to-face visits, to limit the risk of contagion, without making the patient feel emotionally isolated or abandoned. • Survey the patient and the household members about the onset of symptoms or signs that may represent suspected or positive COVID-19 cases. • Assess and consult the clinical threshold for home care (decannulation process, nasogastric tube passage process, gastrostomy, or the oral route) • Incorporate and train the family member or main caregiver on how to maintain routine care

*In all procedures, healthcare professionals (HCPs) must use Level 3 personal protective equipment (PPE).

Acoustic analysis of swallowing

The acoustic analysis of swallowing, or cervical auscultation (CA)³², is an important procedure, in the context of the pandemic, that can be performed rapidly, minimizing the risk of contagion^{2,6,23}. In practice, the sequential relation of swallowing physiology should be kept in mind³³, as well as interference in the uptake of sounds that may occur due to the respiratory repercussion of COVID-19 and the presence of continuous or discontinuous transmission noise and aggregates, which can make analysis difficult^{34,35}.

Therefore, the following considerations are suggested for CA use:

- Use CA when it is strictly necessary.
- Whenever possible, each patient should be designated his/her own equipment and it should not be shared. Otherwise, isolate the equipment with an examination glove and disinfect it immediately, according to the local protocol.
- The HCP must stand to the side of or behind the patient. Do not stand facing the patient at the time of the test.
- If the CA is carried out digitally, generate the graphic-acoustic analysis outside of the consultation room, to minimize contact with the patient.

Dysphagia scales

Dysphagia severity scales are instruments used within the diagnostic process, to help identify risk, as an instrument to maintain a common language between HCPs, and a parameter to control the effectiveness of rehabilitation. Said scales have been proposed in several studies, but consensus criteria are not always used³⁶, and so the selection of a particular scale should be made, according to the characteristics and resources of each hospital, clinic, or healthcare center. It is important for the health team to be familiar with those scales, facilitating clinical decision-making and their subsequent implementation.

Considerations for instrumental assessment of swallowing

All instrumental assessments of swallowing are considered AGPs and should be elective procedures. However, the patient's condition sometimes makes it impossible to defer the study. For example, COVID-19 patients, especially those that underwent endotracheal intubation after extubation in the intensive care unit (ICU), may need those procedures the most^{37,38}.

General suggestions for instrumental assessment are:

- The decision to indicate instrumental assessment procedures should be based on the risk-benefit analysis for each patient.
- Perform COVID-19 testing (polymerase chain reaction [PCR]) prior to the procedure, whenever possible.
- Wear full PPE, regarding all patients that have a positive test or are untested, prioritizing patients with nutritional

deterioration due to dysphagia and in whom the result is relevant for making decisions about their management.

- Strict use of PPE (masks [FFP2, N95, or higher], eye protection, a long-sleeved apron, and gloves).
- Carry out the procedures with the minimum number of HCPs. Only the personnel that is essential for carrying out the evaluation should be present.
- Allow sufficient time between patients, for disinfecting and sterilizing the equipment.

Fiberoptic endoscopic evaluation of swallowing (FEES)

High levels of viral load have been identified in the oral and nasal cavities. Therefore, oropharyngeal manipulation represents a high risk of infection, by activating the cough or vomiting reflexes. In that context, the following specific recommendations are suggested^{37,39}:

- Postpone follow-up endoscopic exams and screenings, if possible.
- Use the video recording system whenever possible, because adequate physical distance from the patient can be maintained and the study can be reviewed several times, to better understand the swallowing disorder.
- Perform the FEES in an airborne infection isolation room (AIIR), or a room with adequate ventilation, according to the AGP regulations at each health service. Use a negative pressure room, if available.

Videofluoroscopic swallow study (VFSS)

Before conducting the examination, a clinical reevaluation is proposed. Videofluoroscopy should be ordered, only if the oral route remains unsafe. Videofluoroscopy is preferred over FEES, in COVID-19-positive patients or COVID-19-suspected cases⁴⁰. Nevertheless, when oral feeding is possible, videofluoroscopy should only be performed in patients at high risk of aspiration/malnutrition. Specific recommendations for the procedure are:

- Prior instructions must be given to the patient and the multidisciplinary support team, for carrying out an examination in the shortest time possible.
- Allow self-administered food/liquids during the test, whenever possible⁴¹.
- The use of scales, such as the Rosenbek Penetration-Aspiration Scale (PAS)^{42,43} and the Dysphagia Outcome and Severity Scale (DOSS), are recommended for analyzing the videofluoroscopy findings⁴⁴.
- The exam should be carried out in large rooms, with remote access to screens, whenever possible.
- Use an IQAir HealthPro (Incen AG) with a HEPA class H13 filtration system, if possible, for the configuration of the radiology room, to evacuate particles in the air and prevent viral transmission through droplets and aerosols generated by episodes of coughing, during videofluoroscopy^{25,39}.

High-resolution esophageal manometry

Motility tests and functional disorders are generally not urgent and can be scheduled and planned well. Like FEES and videofluoroscopy, esophageal manometry is considered a high exposure risk for HCPs because it is an AGP. There are few reports in the literature on this procedure, in the context of the COVID-19 pandemic⁴⁵, but based on the information available, we propose the following suggestions:

- a) When placing the probe, cover the patient's mouth with a modified surgical mask.
- b) Do not perform the procedure on a patient that has tested positive for COVID-19. The procedure can be postponed until a negative test is obtained. In the interim, the patient can be referred for an esophagogram, if pending.
- c) The catheter or probe is regularly cleaned, according to the material and protocol of each laboratory, but it is specifically recommended to add cleaning with a cloth, using disinfectants, such as 70% alcohol or a sodium hypochlorite solution.

Esophageal endoscopy

As is the case with the previously described exams, esophagogastroduodenoscopy is a procedure with a high risk for contagion of COVID-19, for both HCPs and patients, due to exposure to respiratory or gastrointestinal secretions^{46,47}. In times of COVID-19, and according to the clinical and epidemiological risks, all the protection recommendations mentioned above, for patients and HCPs during the performance of endoscopy, should be followed.

Swallow therapy

Swallowing specialists must participate in the clinical decision-making process of the health team, even in patients that are medically unstable. That includes providing information to the healthcare team, indirect management of dysphagia, through instructing team members, and direct treatment.

The characteristics of each healthcare center must always be considered. Indeed, in most Latin American health centers there are few swallowing specialists, if any at all. Therefore, implementing a triage to organize the provision of services, according to existing resources and the needs of each patient, is suggested. Said planning must take into account the incidence of consciousness and cognition, determining treatment candidates on a daily basis, as well as the types of patients and the frequency of the intervention, according to the expected recovery of the patients.

Patients in intensive care units

Patients with COVID-19 that have been admitted to an ICU, especially those of advanced age with underlying diseases, such as hypertension, chronic heart and lung diseases, diabetes, and obesity, have more complications and require long periods of orotracheal intubation^{48–50}. Orotra-

cheal intubation can cause dysphagia due to a decrease in oropharyngeal and laryngeal sensation, lesions and edema in the swallowing structures, atrophy of the oropharyngeal muscles, cognitive disturbances, and respiratory-swallowing incoordination⁵¹. In addition, various neurological manifestations associated with COVID-19 disease have been described, including alterations in dependent functions of the central and/or peripheral nervous system⁵². This is seen in a clinical context, when cognitive, motor, and respiratory fluctuations are frequent, and such changes should be monitored by the swallowing specialist and healthcare team²⁶.

The achievement of re-functionalization of the sphincters and aerodigestive tract pressures, in patients that have undergone prolonged intubation or long periods of tracheostomy, requires a treatment process⁹. For this to occur, an early approach to the swallowing function is essential; the tone and motility of the oropharyngolaryngeal structures and the swallowing respiratory synchrony tend to recover through such an approach⁵³. Early approach aims to transfer the patient to a lower-complexity room, as soon as possible, in preparation for discharge.

The following suggestions are made for managing ICU patients:

- a) The patient's condition must be stable (with or without external support), allowing interventions with a low generation of respiratory and/or hemodynamic changes.
- b) Adapt the different rehabilitation techniques to minimize complications, such as aspiration pneumonia⁹.
- c) Prepare and implement an oral hygiene plan that reduces the risk of aspiration pneumonia^{9,54}.
- d) Defer any procedure that requires deflation of the tracheostomy cuff. Postpone it until the patient is considered negative or when the benefits to the individual outweigh the risks of the intervention⁵⁰.
- e) Implement an augmentative alternative communication system (AACs), to favor patient communication, facilitating the patient's ability to deliver information about his/her swallowing condition.

Non-critical hospitalized patients

In this context, the aim of dysphagia treatment should be to safely achieve oral feeding in the shortest time possible, preparing the conditions for discharge, and collaborating with the bed cycle. Preparation for discharge should take telemedicine monitoring into account, to assess the performance of the patient's feeding at home. As mentioned above, instrumental assessments should be performed to determine swallowing functionality and structural compensation, only when the benefits outweigh the risks.

In-office swallowing therapy

In Latin America, most of the public health agencies have suggested the suspension of elective outpatient care, limiting patient interactions to emergency cases only, as a preventive or mitigating measure against the advance of the SARS-CoV-2 virus. Outpatient clinic staff must consider every patient as a suspected COVID-19 patient and manage the

correct use of PPE. That precaution is particularly essential, when planning actions that generate aerosols⁵⁵.

Specific recommendations for in-office treatment are listed below:

- a) Upon discharge, recovered patients should be encouraged to continue with care, preferably by telemedicine.
- b) Carry out a telephone survey, prior to admission of the patient/caregiver, to verify the presence of signs or symptoms of COVID-19.
- c) Teams that treat dysphagia in COVID-19-positive patients should not be the same teams that treat elective outpatients.
- d) In outpatient care, the intervals between consultations should be optimally programmed, with respect to the time needed to disinfect the environment, between each appointment.

Swallowing therapy in home care settings

In home care settings, the HCP must take the standard precautions, regarding his/her transportation to the patient's home. For their part, the patient and his/her family should take the same precautions, as well as create a sanitizing room in the house for the HCP. The World Health Organization has created guidelines for the HCP in the home care scenario. Those recommendations were adapted to the dysphagia intervention, as follows⁵⁶:

- a) Be informed about the onset of symptoms or signs that could indicate suspected or positive COVID-19 cases, with respect to the patient or family members in a home care setting.
- b) Avoid attending to a home care patient after a hospital shift.
- c) Comply with the local transport regulations for going to the patient's house.
- d) Promote telehealth to minimize the risk of SARS-CoV-2 transmission.
- e) Assess and consult the clinical threshold for home care (decannulation process, nasogastric tube passage process, gastrostomy, or oral route).
- f) Incorporate and train the family member or principal caregiver, so that he/she can maintain routine care.
- g) Reduce the number of face-to-face visits, to limit the risk of contagion, without making the patient feel emotionally isolated or abandoned.

Medical and surgical procedures for dysphagia

Medical centers have chosen to close clinics and outpatient procedures to mitigate the impact of the disease for the following reasons: precaution, protection of patients and HCPs from exposure to disease, and limited resources. Elective procedures and surgeries have been postponed, to preserve existing supplies and allocate them to the care of patients infected with COVID-19^{57,58}. Within that framework, the LADS has established a series of suggestions for the more frequent medical procedures in dysphagia.

As general recommendations, all patients, even asymptomatic ones, should have a PCR test for SARS-CoV-2, one

or two days before the procedure. Procedures should be postponed in positive patients until their performance is deemed safe. Unfortunately, due to the low sensitivity of PCR for diagnosing COVID-19 in pre-symptomatic patients, a negative result does not mean that preventive measures against infection can be suspended, even in asymptomatic patients, and so adequate PPE use must be strictly adhered to. In addition, closed-circuit suction systems with an antiviral filter and negative pressure operating rooms should be used, whenever possible.

Specific recommendations for each procedure are outlined below:

Botulinum toxin

As a non-emergency medical procedure, the application of botulinum toxin to the salivary glands has been postponed in several countries. As a result, controlling hypersalivation in patients that need said applications, to contain recurrent aspiration pneumonia, has become particularly difficult⁵⁹. Therefore, the LADS suggests the following recommendations for the treatment of hypersalivation:

- a) Patients that are stable, with the use of anticholinergic drugs, may continue clinical treatment.
- b) Intraglandular botulinum toxin application in patients with hypersalivation should only be prescribed in cases that present with side effects or no response to anticholinergic drugs.

General precautions for surgical procedures

The following recommendations are suggested for surgical procedures:

- a) When deciding to intervene surgically in a dysphagic patient, in times of COVID-19, the possible benefits and risks of the surgery must be weighed, including the risk of transmission to the patient, as well as to the HCP, during both the procedure and the postoperative period.
- b) The surgical staff should be as small as possible⁶⁰.
- c) The use of an electric or ultrasonic scalpel can promote aerosol formation, and therefore, should be avoided. When necessary, they should be simultaneously used with a vacuum coupled to a HEPA filter system⁶¹.
- d) Local-regional anesthesia should be preferred whenever possible, as it reduces the number of AGPs (i.e., intubation and extubation of the patient)⁶².

Esophageal dilations

The recommendations for esophageal dilations are the same as those described for endoscopic procedures.

Cricopharyngeal myotomy

Despite being a simple procedure, patients that undergo cricopharyngeal myotomy generally require postoperative rehabilitation for a relatively long period of time. Thus, the procedure should be avoided, if possible, due to the

potential risk of SARS-CoV-2 spread during rehabilitation⁶. On the other hand, in the dysphagic patient with a clear indication for such a procedure, myotomy may be a better alternative than tracheostomy, which has a higher risk of aerosolization⁶⁰.

For Zenker's diverticulum, open surgery should be preferred in patients known to be positive for COVID-19, whereas endoscopic approaches may be considered for patients with a negative PCR test. The latter approach should be considered for elderly patients or those with comorbidities, as it requires less surgical time and shorter hospital stay^{63–65}. Some surgeons use an intraesophageal balloon as an aid, during the anatomical location of muscle fibers of the upper esophageal sphincter^{66,67}. That maneuver should be avoided in patients with COVID-19, to minimize the risk of exposure to potentially infected mucosa.

Gastroesophageal reflux

The risk of developing gastroesophageal reflux disease (GERD) is increased in critically ill patients, by the presence of nasogastric tubes, the dorsal decubitus position, and high dose sedation, among others. GERD affects laryngeal sphincter function and increases the risk of aspiration. Chronic GERD can contribute to the development of postintubation dysphagia⁴¹.

Proton pump inhibitors (PPIs) remain the first-line drugs in the pharmacological treatment of GERD. Prokinetic agents can accelerate gastric emptying, increase resting pressure of the lower esophageal sphincter, or increase esophageal clearance of refluxed contents. Combination therapy of a PPI plus a prokinetic agent should be considered in patients with GERD and delayed gastric emptying.

Artificial nutrition

Nutritional treatment is key in critical patients with COVID-19, to avoid malnutrition, with the aim of reducing mortality and exacerbation of the clinical condition. The LADS has established the following suggestions for its use:

Enteral tubes

Enteral nutrition is recommended in patients with COVID-19 that do not meet their requirements through oral intake and/or cannot utilize the oral route⁶⁸ due to dysphagia, neurological/respiratory status, or to other associated comorbidities.

There is no evidence demonstrating that the direct placement of nasoenteral tubes is a risky procedure for HCPs. However, the risk is inferred because tube placement stimulates the patient's oropharynx and pharynx, causing coughing and a possible increase in secretions and aerosols⁶⁹. Consequently, nasojejunal, nasogastric, and nasoduodenal tube placement should be performed by non-endoscopic methods due to the increased risk of COVID-19 transmission (unless the nasojejunal or nasoduodenal position is strictly required).

There is no evidence that a patient receiving enteral nutrition at home during the COVID-19 pandemic should modify his/her treatment.

Gastrostomy

Percutaneous endoscopic gastrostomy (PEG) has been established as a treatment option for patients with transient or permanent dysphagia due to neurological disorders. It may be required in cases of COVID-19, in which patients cannot meet their nutritional requirements over long periods of time.

The placement of a percutaneous gastrostomy tube, guided by endoscopy, is generally an elective procedure. The recommendations are the same as those previously described for endoscopy.

Telemedicine in swallowing rehabilitation

As noted throughout the present document, the use of telemedicine should be promoted as a safe way to provide care for patients with dysphagia. To reduce bias, the telemedicine clinical assessment of swallowing should be combined with quantitative measures, such as self-perception questionnaires and the use of clinical scales, which, in combination with the medical history and clinical observation, can provide the necessary information for better dysphagia management. Procedures must be adapted, heeding the following suggestions:

- a) Prior to the telemedicine clinical evaluation of swallowing, the HCP must make sure that food and fluids are available to the patient, provide the patient with standardized food consistencies, use food coloring to improve visibility, and utilize a colored tape placed at the thyroid level, to visualize laryngeal elevation during swallowing.
- b) The active participation of caregivers is mandatory, especially in patients with cognitive difficulties or motor interference. Good communication between the clinician and the caregiver facilitates treatment adherence⁷⁰.
- c) In-person patient assessment should only be carried out in emergency situations that cannot be postponed. The decision to have face-to-face treatment should be made after a team discussion or when the use of telemedicine prevents the patient from achieving an adequate condition of health.
- d) Inadequate selection of the type of technology to be used, insufficiently trained HCPs, and patients with digital illiteracy can be limitations of telemedicine. All those variables must be considered and compensated for creatively.

Finally, to support clinicians during the evaluation, diagnosis, and treatment processes, we have proposed an algorithm that includes the general considerations regarding the management of swallowing disorders (Fig. 1). To correctly apply the algorithm, in the context of the COVID-19 pandemic, the HCP must be familiar with all the suggestions proposed in the present article.

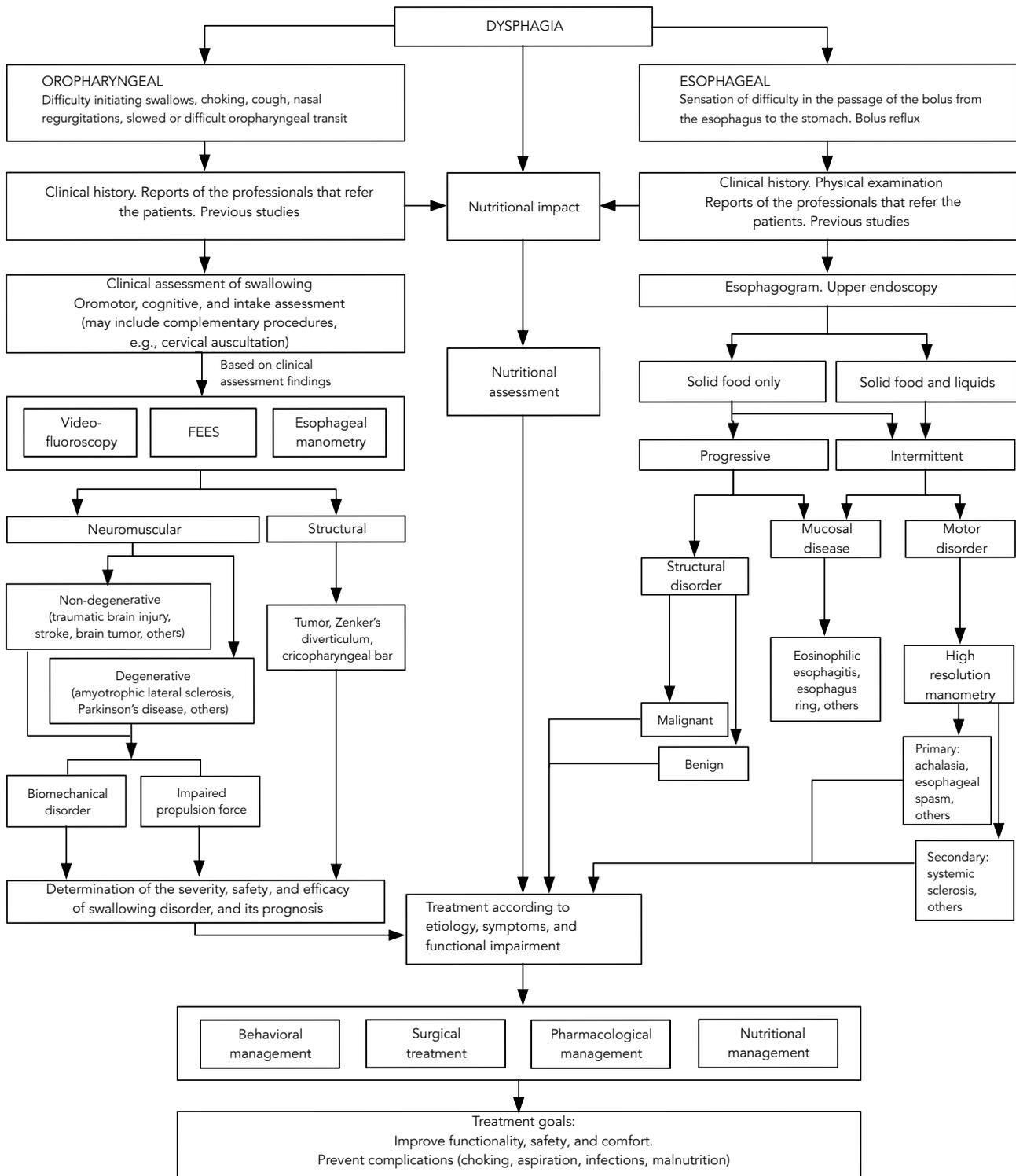


Figure 1 Algorithm with general considerations for the interdisciplinary management of oropharyngeal and esophageal dysphagia.

Limitations

The suggestions proposed herein are based on the international literature available on the subject and no system for assessing the evidence was employed. Said recommendations are based on clinical experience, given that the

ever-increasing knowledge produced during the pandemic will provide more robust information on the subject. Not all the Latin American countries are represented by the authors, but it is our hope that more countries join the society in the coming years, enriching all future updates of the position statements of the LADS.

Table 3 Legal considerations for the protection of healthcare professionals, in the context of COVID-19, are available in some Latin American countries.

Country	Organizations	Legal framework	Recommendations
Argentina	Department of Health and Social Development, Superintendent of Health Services, Argentina <i>Asociación Argentina de Disfagia (AAD)</i>	Health personnel protection program against the COVID-19 coronavirus pandemic. National interest. Law No. 27548. (BO 06/08/2020). Decree of necessity and emergency DNU 2020 367 APN PTE Art 1 - The COVID-19 disease produced by the SARS-CoV-2 coronavirus will be presumptively considered a professional disease -not listed- according to section 2 subsection b) of Article 6 of Law No. 24557, with the benefits provided in Law No. 24557 and its amending and complementary regulations. Special benefits for the personnel of the Health sector, the Armed Forces, National Security, and others. Decree 788/2020. National interest. Electronic or digital prescriptions. Law 27,553.	Guide and recommendation of the <i>Asociación Argentina de Disfagia</i> for the care of patients during the COVID-19 pandemic (March, 2020). -Guide and recommendation for speech therapy and in-hospital management of dysphagia during the COVID-19 pandemic. ASALFA. Volume 67, No. 2, August 2020- ISSN-1668–9402 -Recommendations for patients in situations of their last days/hours of life and for exceptional cases with COVID-19- MINSAL- Argentinean Scientific Community Forum.
Brazil	Department of Health (National Council of Health), Brazil	Technical Opinion No. 128/2020, which provides the guidelines for healthcare workers, in the scope of health services, during the Public Health Emergency of National Importance due to Coronavirus Disease - COVID-19. https://conselho.saude.gov.br/recomendacoes-cns/1103-recomendac-a-o-no-020-de-07-de-abril-de-2020	Recommendations for professional health workers, regarding health personnel protection against the COVID-19 coronavirus pandemic.
Chile	Department of Health, Chile	Resolution MINSAL FONASA No. 204, dated March 24, 2020, Circular Letter IP No. 7, of the Health Providers Administration, dated April 13, 2020, and other applicable regulations.	<i>Sociedad Chilena de Medicina Intensiva, (SOCHIMI)</i> Phonoaudiology and Occupational Therapy Division. <i>Sociedad Chilena de Pediatría.</i> <i>Colegio de Fonoaudiólogos de Chile.</i> <i>Sociedad Chilena de Fonoaudiología (SOCHIFO)</i>
Colombia	Department of Health and Social Protection, Colombia <i>Asociación Fonoaudiológica Colombiana de Disfagia Orofaringea y Motricidad Orofacial</i>	Resolution 666 of 2020, through which the general biosafety protocol is adopted to mitigate, control, and carry out the proper management of the coronavirus pandemic. Resolution 502 of 2020: Guidelines for the provision of health services during the containment and mitigation stages of the Sars-CoV-2 (COVID-19) pandemic. Resolution 2654 of 2019, through which the national provisions for telehealth and the practice of telemedicine are established.	Speech Therapy Guidelines for Patient Care with COVID-19. National Consensus of Speech Therapists. Guidelines for the management of the positive COVID patient, in the hospital and at home. <i>Asociación Fonoaudiológica Colombiana de Disfagia Orofaringea y Motricidad Orofacial</i>
Mexico	Department of Health, Mexico <i>Asociación Mexicana de Comunicación, Audiología, Otoneurología y Foniatria (AMCAOF)</i> <i>Sociedad Mexicana de Disfagia (SOMEDI)</i> <i>Asociación Mexicana de Terapeutas en Comunicación Humana (AMTCH)</i> <i>Asociación Mexicana de Labio y Paladar Hendidado y Anomalías Craneofaciales (AMLPH)</i> <i>Sociedad Latinoamericana de Neurogastroenterología (SLNG)</i>	Internal algorithms for COVID-19 care by the Mexican government.	The <i>AMCAOF</i> , <i>AMTCH</i> , <i>SOMEDI</i> , and <i>AMLPH</i> have issued recommendations, guidelines, and positions regarding swallowing, voice, speech, and language diagnostic and rehabilitation procedures during the COVID-19 pandemic.
Paraguay	<i>Asociación Paraguaya de Disfagia</i>	Law No. 6524/2020 declaring a state of emergency in the entire territory of the Republic of Paraguay, in the face of the pandemic declared by the World Health Organization due to COVID-19 or the coronavirus and establishing administrative and financial measures. Publication date: 03-26-2020.	Biosecurity guidelines in the field of speech audiology in the framework of the COVID-19 pandemic, for the incorporation of professional activities in Paraguay

Table 3 (Continued)

Country	Organizations	Legal framework	Recommendations
		Decree No. 3475/2020 by which the Department of Public Health and Social Welfare is authorized to coordinate the plans and actions of the health sector, in the framework of the health emergency declared in the face of the risk of the spread of coronavirus (COVID-19) in the national territory. Law No. 5482/2015 creates the National Telehealth Program, which is under the control of the Department of Public Health and Social Welfare and aims to provide support to the Public Health System. https://www.bacn.gov.py/descarga/4465/20151217121453.pdf	Ambulatory Medical Care Biosafety Guidelines Recommendations of the <i>Asociación Paraguaya de Disfagia</i> for the care of patients during the COVID-19 pandemic, through expert consensus (June, 2020).
Country	Organizations	Legal framework	Recommendations
Peru	<i>Asociación Peruana de Disfagia</i>	Urgency Decree No. 025-2020, Emergency measures to strengthen the health surveillance and response system (March 11, 2020); Supreme Decree No. 012-2020-SA, Actions for the prevention, control, diagnosis, and treatment of coronavirus – COVID-19 (April 1, 2020); Ministerial Resolution No. 268-2020-MINSA; Recommendations for the proper use of masks and respirators (May 8, 2020); Ministerial Resolution No. 447-2020-MINSA Recommendations on the use of Face Shields (July 1, 2020).	Recommendations for the care of patients with dysphagia in times of COVID-19, document formulated by the consensus of the multidisciplinary team, in the care of dysphagia patients (April 2020).

Legal framework and ethical challenges

It is important to be familiar with the guidelines for providing care to patients with COVID-19 in the different countries of Latin America, as developed by their respective departments of health, and with those contained in the position statements of local health organizations (Table 3).

Conclusions

The present position statement was developed to provide immediate guidance for the multidisciplinary dysphagia care team during the pandemic. The authors included recommendations related to the use of PPE, as well as to the diagnosis, treatment, and rehabilitation of oropharyngeal and esophageal dysphagia, to reduce the risk of contagion and spread of the virus in the environment. These recommendations are based on clinical experience, given that, at present, scientific evidence is still limited, and the development of knowledge about the pandemic will be a continuous learning experience.

The publishing of international clinical experience, utilizing the scientific method, will enable us to know more about the evolution of patients that present with sequelae after having had COVID-19 infection.

Note for special considerations

In both oropharyngeal and esophageal dysphagia, if there are negative studies in the diagnostic algorithm, the possibility of gastroesophageal reflux disease should be ruled out as a condition, through either a therapeutic test and/or a pH monitoring study^{71,72}, and biopsies of the esophageal mucosa should be performed in patients with dysphagia, to rule out eosinophilic esophagitis^{73,74}. When complementary studies are normal or negative, consider the possibility of

functional dysphagia (after exclusion of globus, xerostomia, odynophagia)^{75,76}.

Financial disclosure

No financial support was received in relation to this work.

Conflict of interest

Carlos Manzano, Rodrigo Tobar-Fredes, Deborah Salle Levy, Rui Imamura, Rodrigo Morales Fernández, Liz Ojeda Peña, David Parra Reyes, Patricia Santoro, Valeria Tona, Omar Edel Trujillo Benavides, Miguel Vargas García and Ana Maria Furkima declare that they have no conflict of interest. Monica Rocío Zavala Solares has given lectures at Medtronic.

Acknowledgments

Special thanks to Adrian Castillo-Allendes, Francisco Contreras-Ruston, Lady Cantor, Juliana Codino, Marco Guzman, Celina Malebrán, Axel Pavez, Thays Vaiano, Fabiana Wilder and Mara Behlau, authors of the article, "Voice therapy in the context of the COVID-19 pandemic"; recommendations for clinical practice that were the source of inspiration and motivation for this article by the Latin American Dysphagia Society (LADS). We also wish to thank the members of the scientific committee of the LADS from different countries. Special appreciation to Ioko Inamoto (Japan), Pere Clavé (Spain), and Luis F. Riquelme (the United States) for their expert feedback on this document. The present article is a posthumous tribute to all those who have passed away in the course of carrying out their professional duties, especially to the multidisciplinary HCPs of Latin America for their dedication, vocation, courage, and sacrifice.

References

1. WHO Coronavirus (COVID-19) Dashboard [Internet]. World Health Organization. [Accessed 21 June 2021]. Available from: <https://covid19.who.int/>.
2. Coutts KA. Dysphagia services in the era of COVID-19: are speech-language therapists essential? *S Afr J Commun Disord*. 2020;67:e1–6, <http://dx.doi.org/10.4102/sajcd.v67i1.709>.
3. Bhatraju PK, Ghassemieh BJ, Nichols M, et al. Covid-19 in critically ill patients in the Seattle region – case series. *N Engl J Med*. 2020;382:2012–22, <http://dx.doi.org/10.1056/NEJMoa2004500>.
4. Leite VF, Rampim DB, Jorge VC, et al. Persistent symptoms and disability after COVID-19 hospitalization: data from a comprehensive telerehabilitation program. *Arch Phys Med Rehabil*. 2021;102:1308–16, <http://dx.doi.org/10.1016/j.apmr.2021.03.001>.
5. Osbeck Sandblom H, Dotevall H, Svennerholm K, et al. Characterization of dysphagia and laryngeal findings in COVID-19 patients treated in the ICU—an observational clinical study. *PLoS One*. 2021;16:e0252347, <http://dx.doi.org/10.1371/journal.pone.0252347>.
6. Kimura Y, Ueha R, Furukawa T, et al. Society of swallowing and dysphagia of Japan: Position statement on dysphagia management during the COVID-19 outbreak. *Auris Nasus Larynx*. 2020;47:715–26, <http://dx.doi.org/10.1016/j.anl.2020.07.009>.
7. Bolton L, Mills C, Wallace S, et al. Aerosol generating procedures, dysphagia assessment and COVID-19: a rapid review. *Int J Lang Commun Disord*. 2020;55:629–36, <http://dx.doi.org/10.1111/1460-6984.12544>.
8. Workman AD, Welling DB, Carter BS, et al. Endonasal instrumentation and aerosolization risk in the era of COVID-19: simulation, literature review, and proposed mitigation strategies. *Int Forum Allergy Rhinol*. 2020;10:798–805, <http://dx.doi.org/10.1002/alr.22577>.
9. Tobar-Fredes R, Briceño Meneses B, Fuentealba Miranda I, et al. Consideraciones clínicas para fonoaudiólogos en el tratamiento de personas con COVID-19 y traqueostomía. Parte I: Deglución. *Rev Chil Fonoaudiol*. 2020;19:1–12. Available from: <https://doi.org/10.5354/0719-4692.2020.60185>
10. Mehrotra A, Chernew M, Linetsky D, et al [Accessed 21 June 2021]. Available from: <https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits>, 2020.
11. Kowalski LP, Sanabria A, Ridge JA, et al. COVID-19 pandemic: effects and evidence-based recommendations for otolaryngology and head and neck surgery practice. *Head Neck*. 2020;42:1259–67, <http://dx.doi.org/10.1002/hed.26164>.
12. Cheng X, Liu J, Li N, et al. Otolaryngology providers must be alert for patients with mild and asymptomatic COVID-19. *Otolaryngol Head Neck Surg*. 2020;162:809–10, <http://dx.doi.org/10.1177/0194599820920649>.
13. ENT UK [Accessed 21 June 2021]. Available from: A graduated return to elective ENT within the COVID-19 pandemic [Internet]; 2021. p. 6–20 <https://www.entuk.org/sites/default/files/A%20Graduated%20Return%20to%20Elective%20ENT%20within%20the%20COVID%2C%20new%20version.pdf>
14. Givi B, Schiff BA, Chinn SB, et al. Safety recommendations for evaluation and surgery of the head and neck during the COVID-19 pandemic. *JAMA Otolaryngol Head Neck Surg*. 2020;146:579, <http://dx.doi.org/10.1001/jamaoto.2020.0780>.
15. Lavinsky J, Kosugi EM, Baptistella E, et al. An update on COVID-19 for the otorhinolaryngologist – a Brazilian Association of Otolaryngology and Cervicofacial Surgery (ABORL-CCF) Position Statement. *Braz J Otorhinolaryngol*. 2020;86:273–80, <http://dx.doi.org/10.1016/j.bjorl.2020.04.002>.
16. Patel ZM, Fernández-Miranda J, Hwang PH, et al. Letter: precautions for endoscopic transnasal skull base surgery during the COVID-19 pandemic. *Neurosurgery*. 2020;87:E66–7, <http://dx.doi.org/10.1093/neuros/nyaa125>.
17. American Academy of Otolaryngology-Head and Neck Surgery, Available from: Guidance for Return to Practice for Otolaryngology-Head and Neck Surgery-Part One [Internet]; 2020. p. 1–9 https://www.entnet.org/wp-content/uploads/2021/04/guidance_for_return_to_practice_part_one_update_070120.pdf
18. Hanna E. How fragile we are. *Head Neck*. 2020;42:1355–60, <http://dx.doi.org/10.1002/hed.26366>.
19. Kutikov A, Weinberg DS, Edelman MJ, et al. A war on two fronts: cancer care in the time of COVID-19. *Ann Intern Med*. 2020;172:756–8, <http://dx.doi.org/10.7326/M20-1133>.
20. Remes-Troche JM, Valdovinos-Díaz MA, Viebig R, et al. Recomendaciones para la reapertura y reinicio de actividades de las Unidades de Neurogastroenterología ante la pandemia por COVID-19. Posicionamiento de la Sociedad Latinoamericana de Neurogastroenterología. *Rev Gastroenterol Mex*. 2020;85:428–36, <http://dx.doi.org/10.1016/j.rgmx.2020.07.001>.
21. Ong SWX, Tan YK, Chia PY, et al. Air, surface environmental, and personal protective equipment contamination by severe acute respiratory syndrome Coronavirus 2 (SARS-CoV-2) from a symptomatic patient. *JAMA*. 2020;323:1610, <http://dx.doi.org/10.1001/jama.2020.3227>.
22. World Health Organization [Accessed 21 June 2021]. Available from: [www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](http://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it), 2019.
23. Brodsky MB, Gilbert RJ. The long-term effects of COVID-19 on dysphagia evaluation and treatment. *Arch Phys Med Rehabil*. 2020;101:1662–4, <http://dx.doi.org/10.1016/j.apmr.2020.05.006>.
24. Bourouiba L. Turbulent gas clouds and respiratory pathogen emissions: potential implications for reducing transmission of COVID-19. *JAMA*. 2020;323:1837–8, <http://dx.doi.org/10.1001/jama.2020.4756>.
25. Ku PKM, Holsinger FC, Chan JYK, et al. Management of dysphagia in the patient with head and neck cancer during COVID-19 pandemic: practical strategy. *Head Neck*. 2020;42:1491–6, <http://dx.doi.org/10.1002/hed.26224>.
26. Miles A, Connor NP, Desai RV, et al. Dysphagia care across the continuum: a multidisciplinary Dysphagia Research Society Taskforce Report of service-delivery during the COVID-19 global pandemic. *Dysphagia*. 2021;36:170–82, <http://dx.doi.org/10.1007/s00455-020-10153-8>.
27. Clavé P, Arreola V, Romea M, et al. Accuracy of the volume-viscosity swallow test for clinical screening of oropharyngeal dysphagia and aspiration. *Clin Nutr*. 2008;27:806–15, <http://dx.doi.org/10.1016/j.clnu.2008.06.011>.
28. Warner HL, Suiter DM, Nystrom KV, et al. Comparing accuracy of the Yale swallow protocol when administered by registered nurses and speech-language pathologists. *J Clin Nurs*. 2014;23:1908–15, <http://dx.doi.org/10.1111/jocn.12340>.
29. Oguchi K, Saitoh E, Mizuno M, et al. The repetitive saliva swallowing test (RSST) as a screening test of functional dysphagia. Normal values of RSST. *Jpn J Rehabil Med*. 2000;37:375–82, <http://dx.doi.org/10.2490/jjrm1963.37.375>.
30. Persson E, Wårdh I, Östberg P. Repetitive saliva swallowing test: Norms, clinical relevance and the impact of saliva secretion. *Dysphagia*. 2019;34:271–8, <http://dx.doi.org/10.1007/s00455-018-9937-0>.

31. Trapl M, Enderle P, Nowotny M, et al. Dysphagia bedside screening for acute-stroke patients: the gugging swallowing screen. *Stroke*. 2007;38:2948–52, <http://dx.doi.org/10.1161/STROKEAHA.107.483933>.
32. Frakking TT, Chang AB, O'Grady K-AF, et al. The use of cervical auscultation to predict oropharyngeal aspiration in children: a randomized controlled trial. *Dysphagia*. 2016;31:738–48, <http://dx.doi.org/10.1007/s00455-016-9727-5>.
33. Vargas-García MA. Perfil espectrográfico de deglución normal en adultos. *Nutr Hosp*. 2018;36:412–9, <http://dx.doi.org/10.20960/nh.2173>.
34. Campos NG, da Costa RF. Alterações pulmonares causadas pelo novo Coronavírus (COVID-19) e o uso da ventilação mecânica invasiva. *J Health Biol Sci*. 2020;8:1–3, <http://dx.doi.org/10.12662/2317-3076jhbs.v8i1.3185.p1-3.2020>.
35. Zenteno D, Vera R, Perillán J, et al. Ventilación mecánica prolongada en tiempos de pandemia/COVID-19. *Neumol Pediatr*. 2020;15:346–50, <http://dx.doi.org/10.51451/np.v15i2.64>.
36. da Silva RG, Motonaga SM, Cola PC, et al. Estudo multicêntrico sobre escalas para grau de comprometimento em disfagia orofaríngea neurogênica. *Rev Soc Bras Fonoaudiol*. 2012;17:167–70, <http://dx.doi.org/10.1590/S1516-80342012000200011>.
37. Castillo-Allendes A, Contreras-Ruston F, Cantor Lady, et al. Terapia de voz en el contexto de la pandemia covid-19; recomendaciones para la práctica clínica. *J Voice*. 2020;35:808.e1–12, <http://dx.doi.org/10.1016/j.jvoice.2020.08.018>.
38. Ministério da Saúde, Brasil [Accessed 21 June 2021]. Available from: Protocolo de manejo clínico para o novo coronavírus (2019-nCoV) [Internet]; 2020. p. 6–28 <http://portaldeboaspraticas.iff.fiocruz.br/biblioteca/protocolo-de-manejo-clinico-para-o-novo-coronavirus2019-ncov/>
39. Soldatova L, Williams C, Postma GN, et al. Virtual dysphagia evaluation: Practical guidelines for dysphagia management in the context of the COVID-19 pandemic. *Otolaryngol Head Neck Surg*. 2020;163:455–8, <http://dx.doi.org/10.1177/0194599820931791>.
40. Fritz MA, Howell RJ, Brodsky MB, et al. Moving forward with dysphagia care: implementing strategies during the COVID-19 pandemic and beyond. *Dysphagia*. 2021;36:161–0149, <http://dx.doi.org/10.1007/s00455-020-10139-6>.
41. Frajkova Z, Tedla M, Tedlova E, et al. Postintubation dysphagia during COVID-19 outbreak-contemporary review. *Dysphagia*. 2020;35:549–57, <http://dx.doi.org/10.1007/s00455-020-10139-6>.
42. Rosenbek JC, Robbins JA, Roecker EB, et al. A penetration-aspiration scale. *Dysphagia*. 1996;11:93–8, <http://dx.doi.org/10.1007/BF00417897>.
43. Borders JC, Brates D. Use of the penetration-aspiration scale in dysphagia research: a systematic review. *Dysphagia*. 2020;35:583–97, <http://dx.doi.org/10.1007/s00455-019-10064-3>.
44. O'Neil KH, Purdy M, Falk J, et al. The dysphagia outcome and severity scale. *Dysphagia*. 1999;14:139–45, <http://dx.doi.org/10.1007/PL00009595>.
45. Aoyagi Y, Ohashi M, Funahashi R, et al. Oropharyngeal dysphagia and aspiration pneumonia following coronavirus disease 2019: a case report. *Dysphagia*. 2020;35:545–8, <http://dx.doi.org/10.1007/s00455-020-10140-z>.
46. Ing EB, Xu QA, Salimi A, et al. Physician deaths from corona virus (COVID-19) disease. *Occup Med*. 2020;70:370–4, <http://dx.doi.org/10.1093/occmed/kqaa088>.
47. Soetikno R, Teoh AYB, Kaltenbach T, et al. Considerations in performing endoscopy during the COVID-19 pandemic. *Gastrointest Endosc*. 2020;92:176–83, <http://dx.doi.org/10.1016/j.gie.2020.03.3758>.
48. Cummings MJ, Baldwin MR, Abrams D, et al. Epidemiology, clinical course, and outcomes of critically ill adults with COVID-19 in New York City: a prospective cohort study. *Lancet*. 2020;395:1763–70, [http://dx.doi.org/10.1016/S0140-6736\(20\)31189-2](http://dx.doi.org/10.1016/S0140-6736(20)31189-2).
49. Intensive Care National Audit & Research Centre, 1089:1–28. [Accessed 21 June 2021]. Available from: www.icnarc.org/DataServices/Attachments/Download/4db14011-e51a-eb11-912b-00505601089b, 2020.
50. Freeman-Sanderson A, Ward EC, Miles A, et al. A consensus statement for the management and rehabilitation of communication and swallowing function in the ICU: a global response to COVID-19. *Arch Phys Med Rehabil*. 2021;102:835–42, <http://dx.doi.org/10.1016/j.apmr.2020.10.113>.
51. Macht M, Wimbish T, Bodine C, et al. ICU-acquired swallowing disorders. *Crit Care Med*. 2013;41:2396–405, <http://dx.doi.org/10.1097/CCM.0b013e31829caf33>.
52. Sharifian-Dorche M, Huot P, Oshero M, et al. Neurological complications of coronavirus infection; a comparative review and lessons learned during the COVID-19 pandemic. *J Neurol Sci*. 2020;417:117085, <http://dx.doi.org/10.1016/j.jns.2020.117085>.
53. Brodsky MB, Huang M, Shanholtz C, et al. Recovery from dysphagia symptoms after oral endotracheal intubation in acute respiratory distress syndrome survivors. A 5-year longitudinal study. *Ann Am Thorac Soc*. 2017;14:376–83, <http://dx.doi.org/10.1513/AnnalsATS.201606-550C>.
54. Cavalcante-Leão BI, de Araujo C, Basso I, et al. Is there scientific evidence of the mouthwashes effectiveness in reducing viral load in Covid-19? A systematic review. *J Clin Exp Dent*. 2021:e179–89, <http://dx.doi.org/10.4317/jced.57406>.
55. Organización Mundial de la Salud, 68. [Accessed 21 June 2021]. Available from: <https://apps.who.int/iris/handle/10665/332638>, 2020.
56. Organización Mundial de la Salud, 5. [Accessed 21 June 2021]. Available from: <https://apps.who.int/iris/handle/10665/331528>, 2020.
57. Sifuentes-Rodríguez E, Palacios-Reyes D. COVID-19: the outbreak caused by a new coronavirus. *Bol Med Hosp Infant Mex*. 2020;77:3854, <http://dx.doi.org/10.24875/BMHIM.20000039>.
58. Levy DS, De Almeida ST. Disfagia infantil. *Thieme Revinter Publicações*; 2018. p. 273.
59. Abboud WA, Nadel S, Hassin-Baer S, et al. Ultrasound-guided botulinum toxin injections into the salivary glands for the treatment of drooling. *Isr Med Assoc J*. 2019;21:116–9. PMID: 30772963.
60. Menegozzo CAM, Arap SS, Mariani AW, et al. Standardization of elective tracheostomies at the Central Institute of the Hospital das Clínicas in São Paulo during the COVID-19 pandemic. *Rev Col Bras Cir*. 2020;47:e20202574, <http://dx.doi.org/10.1590/0100-6991e-20202574>.
61. Kulcsar MAV, Montenegro FLM, Santos ABO, et al. Recommendations for head and neck surgical procedures during the COVID-19 pandemic. *Clinics*. 2020;75:e2084, <http://dx.doi.org/10.6061/clinics/2020/e2084>.
62. Macfarlane AJR, Harrop-Griffiths W, Pawa A. Regional anaesthesia and COVID-19: first choice at last? *Br J Anaesth*. 2020;125:243–7, <http://dx.doi.org/10.1016/j.bja.2020.05.016>.
63. Dauer E, Salassa J, Iuga L, et al. Endoscopic laser vs open approach for cricopharyngeal myotomy. *Otolaryngol Head Neck Surg*. 2006;134:830–5, <http://dx.doi.org/10.1016/j.otohns.2005.12.030>.

64. Case DJ, Baron TH. Flexible endoscopic management of Zenker diverticulum: the Mayo Clinic experience. *Mayo Clin Proc.* 2010;85:719–22, <http://dx.doi.org/10.4065/mcp.2009.0663>.
65. Ho AS, Morzaria S, Damrose EJ. Carbon dioxide laser–assisted endoscopic cricopharyngeal myotomy with primary mucosal closure. *Ann Otol Rhinol Laryngol.* 2011;120:33–9, <http://dx.doi.org/10.1177/000348941112000105>.
66. Zaninotto G, Ragona R, Briani C, et al. The role of botulinum toxin injection and upper esophageal sphincter myotomy in treating oropharyngeal dysphagia. *J Gastrointest Surg.* 2004;8:997–1006, <http://dx.doi.org/10.1016/j.gassur.2004.09.037>.
67. Kos MP, David EF, Klinkenberg-Knol EC, Mahieu HF. Long-term results of external upper esophageal sphincter myotomy for oropharyngeal Dysphagia. *Dysphagia.* 2010;25:169–76, <http://dx.doi.org/10.1007/s00455-009-9236-x>.
68. Stachowska E, Folwarski M, Jamiot-Milc D, et al. Nutritional support in coronavirus 2019 disease. *Medicina.* 2020;56:289, <http://dx.doi.org/10.3390/medicina56060289>.
69. Sturrock BR, Fanning SJ, Khan M, et al. Should nasogastric tube insertion during the COVID-19 pandemic be considered as an aerosol-generating procedure? *Br J Hosp Med.* 2020;81:1–6, <http://dx.doi.org/10.12968/hmed.2020.0307>.
70. Mattei A, Amy de la Bretèque B, Crestani S, et al. Guidelines of clinical practice for the management of swallowing disorders and recent dysphonia in the context of the COVID-19 pandemic. *Eur Ann Otorhinolaryngol Head Neck Dis.* 2020;137:173–5, <http://dx.doi.org/10.1016/j.anorl.2020.04.011>.
71. Huerta-Iga F, Bielsa-Fernández MV, Remes-Troche JM, et al. Diagnosis and treatment of gastroesophageal reflux disease: recommendations of the Asociación Mexicana de Gastroenterología. *Rev Gastroenterol Mex.* 2016;81:208–22, <http://dx.doi.org/10.1016/j.rgmex.2016.04.003>.
72. Gyawali CP, Carlson DA, Chen JW, et al. ACG clinical guidelines: clinical use of esophageal physiologic testing. *Am J Gastroenterol.* 2020;115:1412–28, <http://dx.doi.org/10.14309/ajg.0000000000000734>.
73. Dellon ES. Eosinophilic esophagitis. *Gastroenterol Clin North Am.* 2013;42:133–53, <http://dx.doi.org/10.1016/j.gtc.2012.11.008>.
74. Dellon ES, Gonsalves N, Hirano I, et al. ACG clinical guideline: evidenced based approach to the diagnosis and management of esophageal eosinophilia and eosinophilic esophagitis (EoE). *Am J Gastroenterol.* 2013;108:679–92, <http://dx.doi.org/10.1038/ajg.2013.71>, quiz 693.
75. Aziz Q, Fass R, Gyawali CP, et al. Functional esophageal disorders. *Gastroenterology.* 2016;136:78–79, <http://dx.doi.org/10.1053/j.gastro.2016.02.012>. S0016–5085.
76. Baumann A, Katz PO. Functional disorders of swallowing. *Handb Clin Neurol.* 2016;139:483–8, <http://dx.doi.org/10.1016/B978-0-12-801772-2.00039-4>.