

Questions/Answers Katlyn McGrattan Webinar
Dr. Brown's Medical 12/19/17

Q1: I find that babies we recommend nectar thick liquids for are unable to get it out with a Level 1 nipple. Any suggestions? I know your recommendations appear to be using the level 3 during the MBS but a level 1 at the bedside.

A1: *You raise a very important, and clinically frustrating point! To clarify, the study I referenced in the webinar determined a level 3 nipple was required to express nectar liquids (Varibar barium) at the same flow rate as thins via level 1. This being said, it's well appreciated that there remains high variability in thickening regimens used bedside, making it so a bedside nectar may be very different in viscosity than barium. For infants that are old enough and do not have medical complications of the gut, we use 0.5tsp modified corn starch thickener/ 30mL formula via L3 as a starting point. Of course, depending on formula and infant deficits we sometimes need to increase/decrease viscosity/flow rate.*

Q2: How do you down load presentation to print?

A2: *I have provided a PDF.*

Q3: What is the name of the course? It was difficult to understand.

A3: *I'm not sure I understand your question fully. The course I referenced relating to the videofluoroscopic swallow study is called the Modified Barium Swallow Impairment Profile (MBSImP). The pediatric one that is not available yet is the BabyVFSSImP. I also referenced the conferenced which is the Charleston Swallowing Conference at Northwestern University.*

Q4: If you use the Dr. Brown's product in your MBS's, do you then expect the family to go out and purchase a new bottle system to use with the baby? That is a huge expense and many of my families can not afford to do so. Is there any help available to them? And what if the baby doesn't like the Dr. Brown's nipple?

A4: *You raise a great point. The bottle and nipple that we use during the procedure is provided to the family after its use, so that helps in part. While we do appreciate buying additional bottles is an undesirable expense, after review of the evidence and discussion with our medical team, we concluded that this expenditure was necessary to effectively treat the impairment. As I am sure you are well aware, there is tremendous variability in the field of pediatric dysphagia, making it very difficult to achieve the desired treatment effect. Based on the evidence and our clinical experience with using the Dr. Brown's system for infants with dysphagia, the removal of one component of this variability and the flexibility in flow rates enables us to overcome one of these barriers and improve care. Although any cost is undesirable, the cost of purchasing a few bottles is very little compared to lost days of work, medications, office visits, and*

hospitalizations that all can occur if dysphagia is not effectively treated. All of that said, for some families this is not a realistic cost and therefore we have worked to get some small, internal grants that allow us to provide very low-income families with bottles when needed.

Q5: Thank you for this presentation, it was very interesting. I'm wondering if, with regard to your description of changes in swallowing physiology throughout a VFSS, if the infants drank for 1:30 consecutively when these changes were observed? Thank you!

A5: *Thank you for the feedback! To answer your question, yes, infants included in the initial pilot study for change in swallow all drank uninterrupted for 01:30 (ie. We gave bottle and did not remove, pace, apply an intervention until that protocol period ended). They were, however, able to take suck-burst breaks independently as long as they were not abnormally prolonged. I hope that helps clarify!*