

The Silent Risk: Why Swallowing Evaluation Matters in Myositis

“They watched me drink some water and said I was fine.”

I hear a version of that sentence constantly from patients, and it's the sentence this article exists to challenge.

If you fell, injured your leg, went to the doctor to find out what was wrong, and the doctor simply looked at you and said, “I bet it's broken, let's put a cast on it,” you would leave and never see that provider again.

Just like your doctor, speech-language pathologists don't have x-ray vision. There are things that simply cannot be identified from the outside. Let's talk about the importance of an objective swallow study.

Silent aspiration: the problem with watching

Aspiration is the entry of food, liquid, medication, or saliva into the airway. Most people assume it always announces itself: coughing, choking, visible distress. It doesn't. In silent aspiration, material enters the airway and the protective cough reflex simply doesn't work. No cough. No choking. No throat clearing, nothing. Just bacteria-laden material quietly reaching the lungs, raising the risk of aspiration pneumonia.

Silent aspiration is well documented in neuromuscular conditions, and patients with myositis are squarely in the risk group. This is why symptom checklists and bedside impressions, valuable as starting points, cannot exclusively rule out the problem. The patient who “seems fine” may not be.

When to evaluate

The triggers are clearer than most patients are told: an EAT-10 score of 3 or higher, any new or worsening swallowing symptoms, unexplained weight loss, coughing or choking when eating or drinking, throat clearing at meals, wet vocal quality, and recurrent pneumonia.

What real evaluation looks like

Two instrumental studies actually visualize the swallow, and both are gold standard.

The Modified Barium Swallow Study (MBSS) is videofluoroscopy, a live X-ray. The patient eats and drinks barium-coated foods and liquids while the team watches the swallow in real time across the mouth, throat, and esophagus, identifying exactly where function breaks down and whether material enters the airway.

The Fiberoptic Endoscopic Evaluation of Swallowing (FEES) involves passing a thin camera through the nose for a direct view of the throat and airway while the patient eats real food. No radiation means no time limit, so the clinician can observe swallow fatigue throughout a full meal. For a disease defined by muscle fatigability, that is not a small advantage.

The right evaluation for you is the one that is available in your area.

The ask

For patients: you don't need to wait for someone to offer. "I'd like a referral for a swallow study, either a FEES or an MBSS" is a complete, reasonable request. If you're dismissed: "Dysphagia in myositis is a recognized clinical complication. I'd like this documented and addressed during this visit."

For clinicians and advocates: build the swallowing question into routine myositis care. Ask about mealtime changes at every visit. Screen with the EAT-10. Refer to a speech-language pathologist for a detailed evaluation if the score is 3 or greater. The cost of asking is minutes; the cost of missing silent aspiration is hospitalizations, weight loss, global decline, and a change in quality of life.

The value of a repeat study

As we discussed earlier, if you fell and hurt your leg, you would get imaging to determine the best course of treatment. However, if you hurt your leg three months ago and then hurt it again yesterday, your provider wouldn't use your X-ray from three months ago to treat you today.

If symptoms have changed, if eating and drinking are harder, if you are in a disease flare, if you have lost global strength, or if you have had pneumonia, or if you just feel different, getting an additional swallow study to determine what your swallow looks like today is imperative.

Using old imaging is about as helpful as pretending we have X-ray vision.

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