Electrical Stimulation in Treatment of Pharyngolaryngeal Dysfunctions

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Key Words
Neuromuscular electrical stimulation · Dysphonia · Dysphagia · Dyspnoea · Laryngeal dysfunction

Introduction

Electrical Stimulation/Electric Currents
The idea to use electric currents in a healing context is not new. Wall-paintings of the ancient Egyptians suggest that electricity from an electric catfish had already been used in ancient medicine [1]. Records of Scribonius Largus, a doctor in the Roman Empire, state that ‘piscine electrotherapy’, namely a live black torpedo, was used for pain treatment. It was said that this therapy cured one of Tiberius’ freemen [2]. In the 19th century utilization of electrical energy in therapy re-emerged as an alternative to physiotherapy.

Today neuromuscular electrical stimulation (NMES) is well established in medicine. Even though its muscle strengthening effect in normal muscles is still under debate, there seems to be a lot of support regarding its effectiveness in strengthening weakened musculature, especially in combination with voluntary activity [3]. The term NMES is sometimes used to describe indirect muscle stimulation, where a muscle contraction is achieved due to stimulation of the innervating nerve [4]. In this article, however, we will use it generically [3] to describe stimulation of the nerve-muscle entity, i.e. direct as well as indirect muscle stimulation. We will also include electric stimulation to modify sensibility if per-
formed to enhance muscle activity, even though such stimulation could be classified as sensory stimulation.

In general three main frequency ranges of electric currents are distinguished. Currents with frequencies above 100,000 Hz have no stimulation effects and are used to warm the tissue in thermotherapy. In the low frequency range, up to 1 kHz, each pulse of sufficient intensity and duration can generate a muscle contraction [3]. In the so-called medium frequency range, exceeding 1 kHz, not all phases of currents can create a muscle contraction.

In paretic muscles electrostimulation aims to condition the muscle to prevent fibrosis and maintain flexibility until reinnervation occurs [5] and should be commenced as soon as possible. For denervated muscles, the best results seem to be achieved with vigorous isometric muscle contractions to the point of fatigue 2 to 3 times a day. All the denervated muscle fibres must be activated and isometric contractions are said to be more effective than isotonic [3].

**Larynx Functions and Swallowing**

The larynx represents an intersection between the airway and digestive tracts. It most importantly functions to protect the airways during swallowing and allows air passage during respiration, respectively. Furthermore it is the source of phonation [6].

Many articles investigated the effectiveness of NMES as a treatment for dysphagia. In this article we will review the benefit of NMES in the treatment of three laryngeal dysfunctions, such as dysphonia, dyspnoea and dysphagia, in order to give an overview regarding the current state of knowledge in these fields of research.

**Methods**

A literature search using PubMed according to current guidelines (www.prisma-statement.org) using the following key words was conducted: ‘electric AND/OR electrical stimulation AND dysphonia OR dyspnea OR deglutition OR dysphagia OR laryngeal’.

The initial search resulted in a total of 356 hits. Only publications in English and German were included. After excluding multiple hits, articles with a different (topical) focus, implants or investigation on muscles other than the throat or neck or not in human adults, 6 case reports, 11 reviews, 43 prospective clinical trials, 3 retrospective trials and two meta-analyses were identified. (One meta-analysis was identified during the initial literature search. The second meta-analysis was published and included during the review process of this article.) Additional studies were identified from the references of the identified articles.

**NMES for Dysphonia and Dyspnoea**

Dysphonia and dyspnoea may result from e.g. vocal fold paresis resulting from recurrent laryngeal nerve paresis, vocal fold bowing, spasmodic dysphonia and muscle tension dysphonia.

Apart from traditional voice therapy NMES alone or in combination with voice exercises has been used for more than 40 years [7–9].

**Vocal Fold Paresis**

Vocal fold pareses can be a sequela of central or peripheral nerve damage. Several studies investigated the effect of transcutaneous NMES on unilateral [10–12] and/or bilateral [13] vocal fold paresis, others tried more invasive forms of application, such as needle electrodes placed in the middle portion of the laryngeal abductor muscle [12]. Ptok and Strack [10, 11] and Dahl and Witt [13] compared the effectiveness of conventional voice therapy in comparison with electrical stimulation-supported voice exercise. Both groups found superior therapy results in the NMES groups regarding voice parameters, such as vocal fold irregularity [10, 11] and maximum phonation time [10, 11] or regeneration rates [13] and enhancement periods [13]. Zeal aer et al. [12] found that the magnitude of electrically induced vocal fold abduction during inspiration was comparable to the spontaneous movement on the unimpeled side.

**Vocal Fold Bowing**

In dysphonic patients laryngoscopy sometimes reveals vocal fold bowing either on one side or bilaterally. Mechanisms of vocal fold bowing are presumed but unknown [14, 15]. It may stem from insufficient vocal fold muscle tension or degeneration of tissue in the vocal fold [14]. Treatment of vocal fold bowing usually involves laryngeal augmentation or thyroplastic medialization [14]. However, the effectiveness of voice therapy [14, 16], as well as behavioural voice therapy with adjunctive NMES delivered transcutaneously to the cricothyroid muscles and the superior laryngeal nerves has been suggested. LaGorio et al. [14] reported positive results regarding mean phonation times, voice handicap index values and glottal closure as a result of NMES. Mean phonation time for sustained phonation of the vowel [i:] increased significantly and post-stimulation voice handicap index values, relative to pre-stimulation values, tended towards significance. Also, glottal closure during phonation was said to improve and supraglottic compression decreased following stimulation. Improvements were still present or enhanced during a follow-up evaluation.
Spasmodic Dysphonia

When suffering from spasmodic dysphonia the patients’ voice sounds as if being strangled. The underlying pathomechanism is unclear. Ludlow et al. [17] suggest a central disinhibition of laryngeal responses to sensory input for adductor spasmodic dysphonia. Nowadays, the intralaryngeal injection of botulinum toxin (Botox) is the therapy of choice [18]. Several studies investigated the effects of NMES on adductor [17] as well as abductor [18] spasmodic dysphonia [19], all of which have used invasive electrodes, such as needle [17, 19] and hooked wire electrodes [18] applied to the region of the recurrent laryngeal nerve [19], superior laryngeal nerve [17], or the two laryngeal adductor muscle groups (thyroarytenoid muscles and lateral cricoarytenoid muscles) [18]. At least some studies suggested that NMES potentially improves voice quality in patients with spasmodic dysphonia [18, 19].

Muscle Tension Dysphonia

Muscle tension dysphonia is characterized by a change in voice quality and may result from a misuse of the voice. Organic factors resulting from such a misuse can involve nodules, phonation fissures, inflammation and oedema [20]. Therapeutic procedures usually involve voice therapy; however, surgical procedures might be necessary in certain cases. Guirro et al. [21] found that transcutaneous electrical nerve stimulation (a subtype of NMES) resulted in a decrease in hoarseness, the level of dysphonia and laryngeal injuries as well as relief of pain in women with nodules or bilateral mucus thickening and phonation fissure.

Other

Some studies also focused on the effects of NMES in healthy individuals [22, 23]. Among others, differences in fundamental frequency and relative sound level (not significant [23]) were found.

Dysphagia

Swallowing is a vital mechanism and comprises the passage of foods and liquids as well as saliva from the oral cavity to the stomach. Aspects of the swallowing mechanism also serve to protect the lower respiratory tract from aspiration [24]. Four phases can be distinguished: anticipatory phase, oral phase, pharyngeal phase, and oesophageal phase.

Functional dysphagia therapy [25] is generally based on three components: restitution, compensation and adaptation. Restitution aims to fully or partially restore function and is based on stimulation (thermal, tactile), mobilization (pressure-resistance tasks) and motion exercise (labial, lingual exercise), to facilitate desired actions and inhibit unwanted movements. Compensatory strategies are chosen to improve remaining functions or replace swallowing dysfunctions. Swallowing manoeuvres (e.g. easy or effortful breath-holding, effortful swallow or Mendelsohn manoeuvre) or changes in posture (e.g. chin-tuck, head rotation) are commonly used to facilitate swallowing. Adaptation is concerned with adjusting the surrounding to the needs and abilities of the dysphagic patient by means of consistency modification of foods and liquids, adjuvants, and so forth.

NMES and Dysphagia

Studies using NMES to treat dysphagia seem to be incommensurable due to various electrodes and electrode placements, varying stimulation protocols, different aims regarding the outcome/achievements, varying study protocols and, most importantly, conflicting results from various studies.

Electrodes and Electrode Placements

For electrode placement the anterior neck can be divided into an upper submental region and a lower throat region. The upper region lies between the mandible and the hyoid bone, the lower region represents the area below the hyoid. Depending on the positioning of the electrodes and the current intensity, there is variation in how far the electrical current spreads in the tissue. The most superficial muscles will be reached first. With increasing intensity the current passes deeper into the tissue and stimulates deeper muscle layers [26]. Placement of electrodes in the upper region is thought to support laryngeal elevation during deglutition. Placing the electrodes below the hyoid can either help vocal fold closure or stimulate the antagonistic muscles which lower the larynx.

The platysma, in both regions, is the most superficial muscle, which as part of the facial muscles tightens the skin and is not involved in swallowing. In the submental region, the anterior belly of the digastric muscle lies directly underneath the platysma. It can raise the hyoid when teeth are occluded. The mylohyoid muscle and geniohyoid muscle (deeper than the mylohyoid) are situated underneath the digastric muscle. The mylohyoid muscle raises the hyoid upwards to the mandible; the geniohyoid muscle moves the hyoid in an upward and anterior direction. When stimulated, these muscles support elevation of the hyoid [26].

In the anterior neck region the first muscle beneath the platysma is the sternohyoid muscle. This muscle pulls the hyoid down towards the sternum. Underneath the ster-
nohyoid lies the omohyoid muscle, which moves the hy-
roid downwards and laterally. Laryngeal elevation is only
achieved by stimulating the thyrohyoid muscle, which is
situated underneath these muscles [26].

The current may be applied directly into the muscle
through bipolar needle electrodes [27], an intraluminal
bipolar ring electrode catheter inside the pharynx [28], or
transcutaneously by electrodes on the skin directly above
the muscle [3].

Stimulation Protocols
Regarding studies in the field of NMES and dysphagia,
implementation of a uniform stimulation protocol con-
cerning the duration of each session, the total number of
sessions or parameters of the electric currents has not
been achieved.

Aims regarding the Outcome of NMES Application
Numerous studies have been undertaken during the
initial – acute – phase after stroke. Therefore spontaneous
remission cannot be ruled out as contributing to a pattern
of results in a given study. In general the application of
NMES in dysphagia therapy aims to improve laryngeal
elevation (e.g. [26, 29]), improve glottal closure (e.g. [11,
14]), improve/evoke reflex triggering (e.g. [30, 31]), re-
duce aspiration (e.g. [32–35]), reduce spasticity (e.g.
[36]), and increase quality of life (e.g. [37, 38])

Study Protocols
Published studies concerned with NMES and dyspha-
gia can be roughly classified into two groups: those in-
cluding patients and those including healthy volunteers.
While the former investigate therapeutic effects, the latter
use NMES to study the central/peripheral control mecha-
nisms and pathways of swallowing.

Conflicting Results
Several studies have reported a positive effect of NMES
in the treatment of dysphagia (e.g. [39–44]). Others [36,
45] suggested a negative effect of electric stimulation on
hyolaryngeal elevation [46, 47] or found no significant
differences between traditional therapeutic methods and
NMES [48–53].

Studies Evaluating NMES in Dysphagic Patients
Many of the studies investigating the effect of NMES
in the treatment of dysphagia compared swallowing abil-
ity and the occurrence of penetration and aspiration be-
fore and after therapy as indicators of the effectiveness of
the therapeutic procedure [29, 32, 34, 37, 39–44, 48, 49,
51–60 amongst others, see tables 1, 3 for an overview].
Some studies, especially the earlier ones, were criticized
regarding their study designs [29, 32, 34]. Freed et al. [34],
for example, in their first evaluation of the VitalStim®
device, did not elucidate specific treatment effects and no
randomization was applied. Furthermore spontaneous
regeneration was not controlled for. The number of ther-
apeutic sessions between the two treatment conditions
was found to be unequal.

Most studies used a transcutaneous form of current
application, others [51] stimulated intraorally or used a
catheter for pharyngeal simulation [61] (see table 1 for an
overview regarding the different results and stimulation
protocols of studies investigating NMES in dysphagic pa-
ients).

In 2007 a meta-analysis was conducted on 7 studies,
including 255 patients with dysphagia of multiple aetiolo-
gies, to examine the effects of NMES in improving clinical
swallowing ability. The analysis showed a statistically sig-
nificant, summary effect size supporting the use of NMES
in the rehabilitation of adult patients with dysphagia with
a mean improvement of 20% in swallowing performance
following treatment [62]. The authors stated themselves,
however, that most of the studies included in the meta-
alysis showed severe methodological flaws, such as un-
blinded observers, no randomization to conditions, or
the absence of a control group. A more recent meta-anal-
ysis [38] investigating 7 studies comparing NMES versus
traditional therapy suggests that in all patient groups, ex-
cept for stroke patients, NMES was more effective than
traditional therapy. In post-stroke dysphagia patients the
effectiveness of NMES and traditional therapy were com-
parable. Similar results had previously been reported in a
review by Clark et al. [63].

Numerous case reports on patients with various types
of dysphagia also suggest great improvements in swallow-
ing functions [64–69]. From the 25 studies [29, 32, 34,
37–44, 48, 49, 51–62] identified in this literature search,
18 reported positive results for NMES treatment of dys-
phagia (table 1).

Studies regarding the Influence of NMES on
Swallowing Mechanisms in Healthy Subjects
Various studies investigated the influence of NMES on
swallowing mechanisms in healthy subjects (see table 2
for an overview), such as laryngeal elevation [38], vocal
fold closure [27, 70] and swallowing frequency [71]. Also
different stimulation conditions were investigated, e.g.
different electrode placements [72, 73], stimulation con-
ditions [71] or stimulation currents [46].
<table>
<thead>
<tr>
<th>Clinical trial/meta-analysis</th>
<th>Year</th>
<th>Design</th>
<th>Result NMES +/-o</th>
<th>Patients or healthy individuals</th>
<th>Electric current electrode placement</th>
<th>Electric current means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
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</thead>
<tbody>
<tr>
<td>Freed et al. [34]</td>
<td>2001</td>
<td>post-/pre</td>
<td>+</td>
<td>patients: post-stroke</td>
<td>I: either side of the midline above lesser horns of the hyoid bone; II: either side of the midline, one electrode placed above lesser horns of hyoid bone, second placed over the thyroid</td>
<td>VitalStim: 1 h/day transcutaneous videofluoroscopy, swallowing function scale</td>
<td>thermal tactile therapy</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Leelamanit et al. [29]</td>
<td>2002</td>
<td>post-/pre</td>
<td>+</td>
<td>patients: pharyngeal dysphagia of different aetiologies (n = 23)</td>
<td>2 electrodes are placed over the submandibular gland, one on each side, 3rd electrode (ground electrode) placed at ear lobe</td>
<td>VitalStim: high voltage electrical stimulator (EMG + stimulation): twin peak with a ramp at the beginning, 60 Hz, 4 h/day until improvement</td>
<td>otolaryngological examination, VFSS and modified descriptive scale, weight monitoring</td>
<td>level B, non-randomized clinical trial</td>
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<tr>
<td>Blumenfeld et al. [32]</td>
<td>2006</td>
<td>retrospective trial, pre-/post</td>
<td>+</td>
<td>patients: different aetiologies (n = 80)</td>
<td>applied to thyroid muscle (horizontal placement just above thyroid notch)</td>
<td>VitalStim: fixed pulse rate of 80 Hz and fixed pulse duration of 700 μs, intensity: motor response</td>
<td>swallowing difficulty scale</td>
<td>TDT level B, clinical cohort study</td>
</tr>
<tr>
<td>Kiger et al. [48]</td>
<td>2006</td>
<td>pre-/post</td>
<td>o</td>
<td>patients: different aetiologies (n = 22)</td>
<td>4 electrodes aligned vertically on neck, I: just above, II: just below thyroid notch</td>
<td>VitalStim treatments</td>
<td>videofluoroscopy or fibre-optic endoscopy</td>
<td>TDT level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Power et al. [51]</td>
<td>2006</td>
<td>post-/pre</td>
<td>o</td>
<td>patients: post-stroke (n = 16)</td>
<td>oral stimulation oral</td>
<td>0.2 Hz</td>
<td>videofluoroscopy: laryngeal closure (initiation and duration), pharyngeal transit time, penetration aspiration scale</td>
<td>sham-controlled level A, randomized controlled trial</td>
</tr>
<tr>
<td>Shaw et al. [54]</td>
<td>2007</td>
<td>post-/pre</td>
<td>+</td>
<td>patients with mild to moderate dysphagia, patients with most severe dysphagia not sufficiently improved</td>
<td>4 different placements</td>
<td>VitalStim: 1 h/session</td>
<td>modified barium swallow</td>
<td>level B, clinical cohort study</td>
</tr>
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</table>
Table 1. (continued)

<table>
<thead>
<tr>
<th>Clinical trial/meta-analysis</th>
<th>Year</th>
<th>Design</th>
<th>Result NMES +/-o</th>
<th>Patients or healthy individuals</th>
<th>Electric current</th>
<th>Means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ludlow et al. [39]</td>
<td>2007</td>
<td>pre-/post</td>
<td>+ reduction of aspiration and penetration only with sensory stimulation at rest, with greatest improvements correlated with greater hyoid depression during stimulation at rest</td>
<td>patients: chronic pharyngeal dysphagia of different aetiologies (n = 11)</td>
<td>I: horizontally in submental region, over region of the mylohyoid muscle; II: over thyroid on either side of midline</td>
<td>videofluoroscopy: hyoid movement, subglottic air column position</td>
<td>no stimulation</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Carnaby-Mann and Crary [40]</td>
<td>2008</td>
<td>pre-/post</td>
<td>+</td>
<td>patients: chronic dysphagia of different aetiologies (n = 6)</td>
<td>4 electrodes vertically on midline of anterior neck</td>
<td>swallowing ability, no functional oral intake, gain in body weight, patient perception and kinematics of swallowing</td>
<td>no level B, case-controlled study</td>
<td></td>
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<tr>
<td>Oh et al. [55]</td>
<td>2007</td>
<td>pre-/post</td>
<td>+ changes in swallowing function correlated with cortical reorganization (TMS)</td>
<td>patients: post-stroke (n = 8)</td>
<td>anterior belly of digastric and thyroid muscles</td>
<td>videofluoroscopy, Dysphagia Outcome and Severity Scale, TMS</td>
<td>no level B, non-randomized clinical trial</td>
<td></td>
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<tr>
<td>Bülow et al. [49]</td>
<td>2008</td>
<td>pre-/post</td>
<td>o</td>
<td>patients: postacute stroke (3 months after stroke, n = 25)</td>
<td>one set on each side of the throat, 2 electrodes placed just above the level of thyroid notch on thyromusculature</td>
<td>videographic swallowing evaluation, nutritional status, oral motor function, self-evaluation (visual analog scale)</td>
<td>TDT level A, randomized controlled trial</td>
<td></td>
</tr>
<tr>
<td>Lim et al. [41]</td>
<td>2009</td>
<td>pre-/post</td>
<td>+</td>
<td>patients: post-stroke (n = 36)</td>
<td>I: submentally, II: between thyroid cartilage</td>
<td>thermal tactile stimulation</td>
<td>level A, randomized controlled trial</td>
<td></td>
</tr>
<tr>
<td>Ryu et al. [56]</td>
<td>2009</td>
<td>pre-/post</td>
<td>+</td>
<td>patients: head and neck cancer (n = 46)</td>
<td>I: horizontally above thyroid notch, II: parallel, just below notch</td>
<td>clinical dysphagia scale, functional dysphagia scale, ASHA national outcome measurement system, MDADI</td>
<td>sham + TDT</td>
<td>level A, randomized controlled trial</td>
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</table>
**Table 1.** (continued)

<table>
<thead>
<tr>
<th>Clinical trial/ meta-analysis</th>
<th>Year</th>
<th>Design</th>
<th>Result NMES +/-/o Patients or healthy individuals</th>
<th>Electric current electrode placement</th>
<th>current application</th>
<th>Electric current protocol</th>
<th>Means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permsirivanich et al. [57]</td>
<td>2009</td>
<td>pre-/post design</td>
<td>+ post-stroke (n = 23)</td>
<td>transcutaneous</td>
<td>1 h/day, 5 days/week, 4 weeks</td>
<td>FOIS</td>
<td>TDT</td>
<td>level A, randomized controlled trial</td>
<td></td>
</tr>
<tr>
<td>Bogaardt et al. [58]</td>
<td>2009</td>
<td>pre-/post design</td>
<td>+ patients: multiple sclerosis (n = 25)</td>
<td>transcutaneous</td>
<td>Myomed 134: 30 Hz with a phase duration of 200 μs, ramp-up time: 0.5 s, hold time: 5 s, ramp-down time: 0.1 s, 2 sessions of 20 min/ per week for 3 weeks</td>
<td>transnasal flexible endoscopy</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
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<tr>
<td>Pattani et al. [59]</td>
<td>2010</td>
<td>pre-/post design</td>
<td>+ due to increase in saliva production patients: head and neck cancer (n = 5)</td>
<td>transcutaneous</td>
<td>E-stim: pulse width of 80–100, 4–30 mA saliva production, dysphagia questionnaires</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
<td></td>
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<tr>
<td>Jayasekeran et al. [61]</td>
<td>2010</td>
<td>pre-/post design</td>
<td>+ healthy subjects with virtual lesion (n = 13) and stroke patients (n = 50)</td>
<td>pharyngeal</td>
<td>catheter for pharyngeal stimulation (<em>Pha genera</em>) stimuli: 0.2-ms pulses, 280, 5 Hz, 75% of maximal tolerated, 10 min, once a day for 3 days</td>
<td>videofluoroscopy, dysphagia severity rating scale</td>
<td>sham</td>
<td>level A, randomized controlled trial</td>
<td></td>
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<tr>
<td>Lin et al. [37]</td>
<td>2011</td>
<td>pre-/post design</td>
<td>+ patients: nasopharyngeal carcinoma (n = 20)</td>
<td>transcutaneous</td>
<td>700 macro-sec at maximum tolerance, 15 sessions of 1 h each, 3 times/week</td>
<td>videofluoroscopy, penetration-aspiration scale, oral transit time, pharyngeal transit time, pharyngeal delay time, hyoid bone movement, stasis of pyriform sinuses, quality of life questionnaire</td>
<td>home rehabilitation program</td>
<td>level B, randomized controlled trial</td>
<td></td>
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<tr>
<td>Verin et al. [43]</td>
<td>2011</td>
<td>pre-/post design</td>
<td>+ patients: chronic neurologic disorders (n = 7)</td>
<td>submental sensitive NMES: submental region lateral to midline</td>
<td>transcutaneous</td>
<td>TENS</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
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<tr>
<td>Beom et al. [52]</td>
<td>2011</td>
<td>pre-/post design</td>
<td>– both groups showed reduced scores after treatment, no difference between groups patients: brain injury (n = 28)</td>
<td>suprahypoid muscles, submental, reference electrodes at midpoints between bilateral mandibular angle and chin</td>
<td>transcutaneous</td>
<td>60 Hz of 500 μ duration with intermittent stimulation (1 s on, 1 s off), 30 min/day, 5 days/ week for 4 weeks</td>
<td>VFSS + Videofluoroscopic Dysphagia Scale, ASHA NOMS swallowing scale (ASHA level)</td>
<td>TDT</td>
<td>level B, pilot study, non-randomized clinical trial</td>
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<tr>
<td>Clinical trial/ meta-analysis</td>
<td>Year</td>
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<td>Result NMES +/-o</td>
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<td>Electric current electrode placement</td>
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<td>Park et al. [44] 2012</td>
<td>pre-/post design</td>
<td>+</td>
<td>patients: post-stroke (n = 20) above infrahyoid muscles</td>
<td>transcutaneous</td>
<td>hyolaryngeal excursion, maximal width of the upper oesophageal sphincter opening, penetration-aspiration scale</td>
<td>sensory stimulation</td>
<td>level A, randomized controlled trial</td>
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<tr>
<td>Heijnen et al. [53] 2012</td>
<td>pre-/post design</td>
<td>o all groups showed significant improvements</td>
<td>patients: Parkinson’s disease (n = 88) suprahyoid muscles transcutaneous VitalStim at motor level (cycles off for 1 s every minute)</td>
<td>quality of life: SWAL-QOL and MDADI, single-item Dysphagia Severity Scale, FOIS</td>
<td>TDT vs. sensory vs. motor (three groups), 13-15 treatment sessions of half an hour each, on 5 consecutive days/week within a period of 3–5 weeks</td>
<td>level A, randomized controlled trial</td>
<td></td>
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<tr>
<td>Long et al. [42] 2013</td>
<td>pre-/post design</td>
<td>+</td>
<td>patients: nasopharyngeal carcinoma (n = 60) NMES + balloon dilatation: 1: midline, 1 mm above thyroid notch, 2: superior to first, 3: 1 mm below thyroid notch, 4: inferior to 3rd</td>
<td>transcutaneous VitalStim + balloon dilatation, 4 months</td>
<td>water swallow test, VFSS</td>
<td>TDT</td>
<td>level A, randomized controlled trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baijens et al. [60] 2012</td>
<td>comparison of 3 electrode positions</td>
<td>o</td>
<td>patients: Parkinson’s disease (n = 10) 1: submental, 2: paralaryngeal, 3: combination of 1 and 2</td>
<td>transcutaneous VitalStim: single session</td>
<td>temporal, spatial, and visuoperceptual variables</td>
<td>healthy controls + sham</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carnaby-Mann and Crary [62]</td>
<td>meta-analysis</td>
<td>+</td>
<td>7 studies, dysphagic patients of multiple aetiologies (n = 225) muscles of the throat and neck</td>
<td>transcutaneous multiple multiple multiple</td>
<td>level A, meta-analysis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 2. Overview of studies investigating NMES in healthy subjects

<table>
<thead>
<tr>
<th>Clinical trial/ meta-analysis</th>
<th>Year</th>
<th>Design/aim</th>
<th>Result NMES +/–/o</th>
<th>Patients or healthy individuals</th>
<th>Electric current electrode placement</th>
<th>Current application</th>
<th>Electric current protocol</th>
<th>Means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnett et al. [27]</td>
<td>2003</td>
<td>comparing single, bilateral, and combined muscle stimulation + paired muscle stimulation exceeds single muscle stimulation in larynx elevation</td>
<td>healthy men (n = 15)</td>
<td>muscles of the throat and neck; NMES electrode placement on the anterior neck</td>
<td>transcutaneous electrodes</td>
<td>multiple 200-μs biphasic pulses, 20 Hz lasting 1–2 s</td>
<td>videotaping of thyroid prominence movement</td>
<td>no</td>
<td>treatment (crossover)</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Suiter et al. [46]</td>
<td>2006</td>
<td>crossover design</td>
<td>o</td>
<td>healthy subjects (n = 10)</td>
<td>multiple 1 mm above thyroid notch, 2: just superior to first, 3: 1 mm below thyroid notch, 4: just below third</td>
<td>transcutaneous 10×1 h NMES, 80 Hz, intensity ‘grabbing sensation’</td>
<td>surface EMG at baseline and after each condition for 5-ml water swallows</td>
<td>no</td>
<td>treatment (crossover)</td>
<td>level B, randomized controlled trial</td>
</tr>
<tr>
<td>Humbert et al. [71]</td>
<td>2008</td>
<td>ten different electrode placements</td>
<td>– NMES on submental and neck regions does not produce immediate true vocal fold adduction, one position might even increase true vocal fold opening</td>
<td>healthy subjects (n = 27)</td>
<td>transcutaneous VitalStim</td>
<td>fibre-optic nasolaryngoscopic record-</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Park et al. [70]</td>
<td>2009</td>
<td>pre-/post design</td>
<td>+ increased hyoid bone excursion immediately after treatment</td>
<td>healthy subjects (n = 16)</td>
<td>transcutaneous</td>
<td>Microstim: 30 Hz, 600 μs, 20 min/day, at motor threshold, 2 weeks, effortful swallows every 10 s</td>
<td>electromyographic activity (gastric muscle), hyoid bone excursion</td>
<td>sensory stimulation</td>
<td>level A, randomized controlled trial</td>
<td></td>
</tr>
</tbody>
</table>
Table 2. (continued)

<table>
<thead>
<tr>
<th>Clinical trial/ meta-analysis</th>
<th>Year</th>
<th>Design/aim</th>
<th>Result NMES +/–/o</th>
<th>Patients or healthy individuals</th>
<th>Electric current electrode placement</th>
<th>Electric current current application</th>
<th>Means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim and Han [76]</td>
<td>2009</td>
<td>movement with/without stimulation</td>
<td>– movements significantly smaller during NMES</td>
<td>healthy subjects (n = 12)</td>
<td>suprathyroid muscles</td>
<td>transcutaneous</td>
<td>hyolaryngeal movement vocal fold stimulation (5-ml barium swallows)</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Furuta et al. [73]</td>
<td>2012</td>
<td>comparing types of currents and frequencies</td>
<td>+ interferential current (sensory, 50 Hz) increased number of swallows</td>
<td>healthy men (n = 9)</td>
<td>I: submental region, IE: level of laryngeal prominence along anterior ridge of the sternocleidomastoid muscle</td>
<td>transcutaneous</td>
<td>swallowing sound, swallowing reflex: number of swallows</td>
<td>5-min control period</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Humbert et al. [74]</td>
<td>2013</td>
<td>adaptive motor learning</td>
<td>+ evidence of motor learning found for some conditions</td>
<td>healthy adults (n = 9)</td>
<td>infrathyroid muscle</td>
<td>transcutaneous</td>
<td>peak hyoid and laryngeal movement during VFS for 5-ml swallows</td>
<td>no-perturbation: sensory-only</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Burnett et al. [75]</td>
<td>2005</td>
<td>synchronizing stimulation with swallowing; testing for motor adaptation</td>
<td>o no adaptive changes in amplitude, duration, relative timing of activity for either muscle</td>
<td>healthy adults (n = 9)</td>
<td>hyolaryngeal muscle</td>
<td>bipolar hooked-wire electrodes</td>
<td>timing, amplitude, duration, or relative timing of activity for either muscle</td>
<td>no</td>
<td>level B, non-randomized clinical trial</td>
</tr>
<tr>
<td>Takatsuj et al. [31]</td>
<td>2012</td>
<td>evoking the swallowing reflex by electrical stimulation</td>
<td>+ swallowing reflex triggered multiple times during 30 s of stimulation, onset latency became shorter with increasing frequency</td>
<td>healthy adults (n = 10)</td>
<td>electrode on flexible coil spring tube placed against posterior wall of pharynx</td>
<td>pharyngeal ‘catheter’</td>
<td>electromyogram from suprathyroid muscles, latency, number of swallowing reflexes evoked</td>
<td>level B, non-randomized clinical trial</td>
<td></td>
</tr>
<tr>
<td>Tsukano et al. [72]</td>
<td>2012</td>
<td>influence of electrical stimulation on the number of voluntary repetitive swallows</td>
<td>+ number of swallows increased especially with laryngo-, oro-, and nasopharyngeal stimulation</td>
<td>healthy men (n = 14)</td>
<td>nasal cavity, nasopharynx, oropharynx, laryngopharynx</td>
<td>surface electrodes attached to the (manometry) catheter via a trigger generator, which placed five channels of electrodes</td>
<td>latency, number of swallowing reflexes evoked, manometric recording</td>
<td>with/without stimulation</td>
<td>level B, non-randomized trial</td>
</tr>
</tbody>
</table>

+ = Positive; – = negative; o = neutral (based on reported effects). Level of evidence in accordance with Siwek [86].
Whereas Suiter et al. [46] compared three different conditions of stimulation and found no significant differences comparing EMG measurements taken from the anterior neck (1 mm superior to the thyroid notch and a second electrode positioned immediately superior to the first), other studies reported positive effects, such as Park et al. [70] who found that hyoid bone excursion showed an increase in their experimental group immediately after treatment. Also investigating hyoid movement, Burnett et al. [27] found that paired muscle stimulation exceeded individual/single muscle stimulation significantly. The results indicated also that no one muscle or muscle pair achieved the greatest elevation in all individuals, leading to the assumption that the extent of movement depended on the area of the muscle the stimulation had been applied to [27]. The theory of adaptive motor learning was investigated by Humbert et al. [74] as well as Burnett et al. [27] in order to investigate whether the hyolaryngeal movement adapts to the presence of a persistent perturbation resulting from the stimulation at motor level. Evidence of motor learning was found for a couple of conditions by Humbert et al. [74], but no significant changes were found by Burnett et al. [75].

Humbert et al. [71] compared ten different electrode placements and concluded that surface electrical stimulation to the submental and neck regions does not produce immediate true vocal fold adduction adequate for airway protection during swallowing. It was also put forward that NMES might even worsen swallowing activity by reducing swallow-related movements [71].

Turning to the question of different stimulation currents Furuta et al. [73] found that interferential current stimulation at the sensory threshold significantly increased the number of swallows and that pure alternating current stimulation failed to. The results led to the assumption that interferential current stimulation or low-frequency, modulated kilohertz alternating current stimulation might be an alternative stimulation mode in the treatment of dysphagia.

Regarding swallowing frequency, the number of swallows increased significantly by applying NMES to the laryngo-, oro- and nasopharynx [73] and the onset latency of the swallowing reflex seemed to become shorter with increasing stimulation frequency (up to 30 Hz) [72].

Ten studies [27, 31, 46, 70–76] were identified in this literature search. Six of these reported positive results in relation with NMES and swallowing (table 2).

**NMES Studies regarding Cerebral Representation, Reorganization and Excitability**

Longitudinal studies involving neurologic patients confirmed deglutition-related cortical changes and reorganization. Diseases in which there is degeneration of the upper and lower motoneuron showed decreasing cortical excitability [27, 31, 46, 70–76], whereas lesions beyond the upper motor neuron, e.g., bulbospinal muscle atrophy, typically result in an increase of the cortical representation of swallowing [77].

During the rehabilitation of stroke two processes might take place; either a restitution of impaired functions of the damaged hemisphere, or, more typically, functional reorganization processes of the unimpaired hemisphere, e.g. increase in motor representation of the pharynx [77].

Several studies investigated the effects exerted by NMES on the cerebral representation of swallowing [77, 78] (see table 3 for an overview). Some reported that input patterns associated with enhanced excitability (pharyngeal stimulation 5 Hz, 10 min) induced stronger cortical activation [79–83]. When applied to acutely dysphagic stroke patients, corticobulbar excitability is increased mainly in the undamaged hemisphere, which correlates strongly with improvement in swallowing function [79].

Stimulating the pharynx at a frequency of 5 Hz is also said to result in increased cortical excitability and an expansion of the cortical area representing swallowing for up to 60 min following stimulation [79]. All of the identified studies [79–84] reported positive results on cortical excitability or reorganization in relation with NMES (table 3).

Effects of sensitive submental transcutaneous NMES were investigated by Fraser et al. [79, 80], Power et al. [81], Gallas et al. [82], Doeltgen et al. [83] and Hamdy et al. [84]. Even though results from Gallas et al. [82] suggested an improvement in the subjective swallowing rating and swallowing reaction time with a decrease in aspiration and residue, no modification of the motor pharyngeal cortical area was identified via transcranial magnetic stimulation. Doeltgen et al. [83], however, reported that 80-Hz NMES increased the motor-evoked potential amplitude at 30 and 60 min after NMES, but only after a specific stimulation procedure. Similarly, Power et al. [81] reported that faucial pillar stimulation at 5 Hz decreased corticobulbar excitability and enhanced swallow response time, whereas stimulation at 0.2 Hz increased excitability without lengthening the response time. No modification could be found for 1 Hz and sham stimulation.
<table>
<thead>
<tr>
<th>Clinical trial/ meta-analysis</th>
<th>Year</th>
<th>Design</th>
<th>Result NMES +/−/0</th>
<th>Patients or healthy individuals</th>
<th>Electric current</th>
<th>Means of measurement</th>
<th>Control</th>
<th>Evidence level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hamdy et al. [84]</td>
<td>1998</td>
<td>pre-/post stimulation</td>
<td>+ motor cortex excitability and area of representation for the pharynx increased for at least 30 min after stimulation</td>
<td>healthy individuals (n = 8)</td>
<td>pharynx</td>
<td>pharyngeal stimulation (Phagenesis)</td>
<td>focal TMS (before, immediately and 30 min and 1 h after stimulation)</td>
<td>no</td>
</tr>
<tr>
<td>Fraser et al. [79]</td>
<td>2002</td>
<td>pre-/post stimulation</td>
<td>+ input patterns associated with enhanced excitability (5 Hz, 75% of max tolerated intensity, 10 min) induced stronger cortical activation</td>
<td>stroke patients (n = 16) and healthy individuals (n = 8)</td>
<td>pharynx</td>
<td>pharyngeal stimulation (Phagenesis)</td>
<td>TMS, pharyngeal EMG</td>
<td>no</td>
</tr>
<tr>
<td>Fraser et al. [80]</td>
<td>2003</td>
<td>pre-/post stimulation</td>
<td>+ 5 Hz electrical stimulation resulted in increased cortical excitability and expansion of the cortical area up to 60 min after stimulation</td>
<td>healthy individuals (n = 8)</td>
<td>pharynx</td>
<td>pharyngeal stimulation (Phagenesis)</td>
<td>TMS</td>
<td>no</td>
</tr>
<tr>
<td>Power et al. [81]</td>
<td>2004</td>
<td>pre-/post stimulation</td>
<td>+ stimulation at 5 Hz decreased corticobulbar excitability and enhanced swallow response time, whereas 0.2 Hz increased excitability without lengthening response time</td>
<td>healthy individuals (n = 10)</td>
<td>oral: faucial pillars</td>
<td>finger mounted electrode assembly for faucial pillars</td>
<td>TMS, EMG (pharyngeal catheter), videofluoroscopy</td>
<td>no</td>
</tr>
<tr>
<td>Gallas et al. [82]</td>
<td>2010</td>
<td>pre-/post design</td>
<td>+ improvement in subjective swallowing rating and swallowing reaction time, decrease in aspiration and residue no modification of motor pharyngeal cortex identified</td>
<td>patients: &gt;8 weeks after stroke (n = 11)</td>
<td>submental</td>
<td>transcutaneous</td>
<td>videofluoroscopy, pharyngeal motor evoked potentials, Dysphagia Handicap Index</td>
<td>no</td>
</tr>
<tr>
<td>Doeltgen et al. [83]</td>
<td>2010</td>
<td>pre-/post stimulation</td>
<td>+ 80 Hz NMES increases the motor evoked potential (MEP) amplitude at 30 and 60 min after NMES only after 60 repetitions of 4-second event-related trains</td>
<td>healthy individuals (n = 10)</td>
<td>submental</td>
<td>transcutaneous</td>
<td>event-related protocols (volitional contraction or swallowing) using TMS</td>
<td>no</td>
</tr>
</tbody>
</table>

+= Positive; −= negative; o = neutral (based on reported effects); TMS = transcranial magnetic stimulation; EMG = electromyography. Level of evidence in accordance with Siwek [86].
Discussion

Limitations of This Paper

Having only used PubMed as a search engine to identify studies in relation with NMES and dysphagia, dysphonia or dyspnoea further, possibly valuable studies may have been missed. Furthermore only free-text words were used, where the use of MESH terms might have identified more studies.

Due to length restrictions of this article not all of the identified studies are discussed in the text, where studies with exemplar results were chosen. Tables 1–3 give an overview of the results.

Conclusion

Regarding basic science studies it appears reasonable to assume that NMES can modulate swallowing directly and/or by interfering with (central) control and execution mechanisms. In this case, NMES may offer hope for better therapeutical effects. Several clinical studies indicate a benefit of percutaneous and possibly invasive electrical stimulation approaches in the treatment of dysphonia. These findings are also very relevant for dysphagia therapy: they show that vocal fold closure is modifiable by NMES due to muscle weakness and even due to paresis.

Up to now, there have generally been three approaches in NMES for dysphagia. Oropharyngeal stimulation was applied via palatal prostheses which deliver electrical stimulation bilaterally to the faucial pillars, via electrodes mounted on a gloved finger or by an intraluminal pharyngeal catheter. Oropharyngeal stimulation has been shown to be relatively successful in modulating the swallowing reflex and corticobulbar excitability [81]. The application of transcutaneous stimulation is very difficult due to limited muscle specificity. A number of studies have been performed using this stimulation approach, but the effectiveness is still debated as a result of major methodological flaws in the study protocols [79–81, 85]. Intramuscular stimulation, just as the previously mentioned approaches, has shown, some promising results [85]. Due to different stimulation protocols and the various underlying pathological conditions, a comparison of the current literature appears to be difficult. Furthermore spontaneous recovery may have occurred in patients treated with NMES.

There is also no consensus as to which type of current and parameters should be used, the exact timing of stimulation or electrode placement. Regarding the question whether NMES should be used in therapy for dysphagia and dysphonia, it can be concluded that considering the studies discussed, no side effects have been described. It can therefore be used in the therapy of laryngeal paresis, submental muscle support, enhancement of infrathyroidal resistance or to support sensory input. In combination with traditional therapy methods, NMES offers better and faster therapy effects. However, further well-implemented studies regarding the effectiveness and efficiency of NMES as a therapeutic approach in the treatment of dysphonia and dysphagia are needed.

Disclosure Statement

None declared.

References

Electrical Stimulation for Pharyngolaryngeal Dysfunction


