INTERDISCIPLINARY CARE IN DYSPHAGIA OF NEUROLOGICAL ORIGIN: INTERFACES BETWEEN NURSING AND SPEECH THERAPY

Juliana Marques de Souza[1]

Alexsandro N. Oliveira[2]

Diely Aparecida de Oliveira Soares[3]

Marilu de Souza Franco[4]

Sara Luciana de Andrade[5]

Fábio Caxico de Abreu Júnior[6]

Paulo Henrique Dias Trofelli[7]

Luís Carlos Bueno[8]

Thiago Inocêncio Trofelli[9]

Cleber Aparecido Medeiros da Silva[10]

1 Bacharel em Fonoaudiologia pela Universidade de Guarulhos UNG; Especialista em Fonoaudiologia Hospitalar pela UNG - Universidade de Guarulhos – E-mail: julianamsfono@gmail.lcom Orcid: https://orcid.org/0009-0008-9123-3753

2 Mestrado em gestão de Cuidados da Saúde pela Universidade da Amazônia – UNAMA – E-mail: ano_alexsandro @yahoo.com – Orcid: https://orcid.org/0009-0001-7023-7092

3 Bacharel em Fisioterapia pela Universidade Braz Cubas; Especialista em Fisioterapia Intensiva Adulto pela FABIC Physio Cursos. E-mail: fisiodielyoliveira@hotmail.com – Orcid: https://orcid.org/0009-0003-6356-5500

4 Mestranda em Gestão de Cuidados da Saúde pela Must University. Professora do Curso de Enfermagem na Universidade de Mogi das Cruzes – UMC.

5 Mestranda pela Universidade Ivy Enber Christian University – E-mail: drasaraandrade@yahoo.com - ORCID iD: https://orcid.org/0009-0004-6094-502X

6 Mestrando em Saúde Pública pela Universidade IV Enber Christian University. E-mail: fabio.caxico01@gmail.com - ORCID: https://orcid.org/0009-0003-8606-5314

7 Bacharel em Enfermagem pela Universidade de Mogi das Cruzes – UMC. E-mail: paulotdias5@gmail.com - Orcid: https://orcid.org/0009-0006-6733-8235

8 Especialista em urgência e emergência , UTI Adulto , Cardiologia e Hemodinâmica , docência do ensino Superior Faculminas https://orcid.org/0009-0005-2741-9471

9 Mestrado em Políticas Públicas pela Universidade de Mogi das Cruzes - UMC. E-mail: thiagoinocenciotrofelli@gmail.com - Orcid: https://orcid.org/0009-0002-8938-8525

10 Especialista em Saúde Mental pela FACULESTE– Universidade de Minas Gerais. E-mail: cle-

Samira Aparecida Pogianela Alvim[11]

Abstract: Objective: To analyze, in light of recent scientific literature, the interfaces between nursing and speech-language pathology in the interdisciplinary care of critically ill patients with neurogenic dysphagia, emphasizing patient safety in the intensive care unit. Method: An integrative literature review was conducted, searching the PubMed/MEDLINE, LILACS, and SciELO databases for publications from 2021 to 2026. DeCS/MeSH descriptors related to dysphagia, swallowing disorders, nursing, speech-language pathology, intensive care, stroke, and mechanical ventilation were used, combined with Boolean operators. Results: The literature shows that neurogenic dysphagia—particularly following stroke, prolonged orotracheal intubation, and tracheostomy—is associated with aspiration pneumonia, malnutrition, dehydration, prolonged hospital stays, mortality, and poorer functional recovery. Five thematic categories were identified: early identification and risk stratification; clinical, ventilatory, and hemodynamic monitoring; nursing interventions; specialized speech-language pathology care; and quality-of-care indicators in the ICU. Conclusion: Safe care for critically ill patients with dysphagia requires the integration of nursing clinical reasoning, specialized speech-language pathology assessment, institutional protocols, invasive monitoring when indicated, hemodynamic support, mechanical ventilation management, judicious use of vasoactive drugs, and evidence-based decision-making. An interdisciplinary approach reduces avoidable risks and improves the transition between critical care, rehabilitation, and functional recovery.

Keywords: Dysphagia; Swallowing Disorders; Nursing; Speech-Language Pathology; Intensive Care Units; Stroke; Patient Safety.

binhoo79@gmail.com – Orcid: https://orcid.org/0009-0006-0544-1472
11 Mestranda em Gestão de Cuidados da Saúde pela Must University. Professora do Curso de Enfermagem na Universidade de Mogi das Cruzes – UMC.

INTRODUCTION

The intensive care unit (ICU) is a highly complex care environment, intended for the care of patients with clinical instability, acute organ failure, need for continuous monitoring, hemodynamic support, invasive or non-invasive mechanical ventilation, use of vasoactive drugs, and permanent multidisciplinary surveillance. In this context, dysphagia of neurological origin represents a highly relevant clinical condition, as it directly interferes with airway safety, nutrition, hydration, drug administration, prevention of bronchial aspiration, and the functional evolution of critically ill patients.

Neurogenic dysphagia may result from stroke, traumatic brain injury, neurodegenerative diseases, encephalopathies, spinal cord injuries, neuropathies, ICU-acquired myopathies, delirium, decreased level of consciousness, and sequelae of prolonged orotracheal intubation. In critically ill patients, this condition often overlaps with factors such as ICU-acquired muscle weakness, sedation, cough reflex alteration, reduced pharyngeal sensitivity, presence of tracheal cannula, reintubation, prolonged mechanical ventilation time, and respiratory instability.

Recent epidemiological data demonstrate the magnitude of the problem. A systematic review and meta-analysis published in 2024 estimated an overall prevalence of post-stroke dysphagia of 46.6%, with an association with respiratory infections, pneumonitis, persistence of dysphagia after discharge, and increased mortality (Song et al., 2024). In critically ill patients undergoing orotracheal intubation, a 2024 meta-analysis estimated a pooled incidence of post-extubation dysphagia of 36%, varying according to the time of evaluation, duration of intubation, and diagnostic method used (Yu et al., 2024).

The clinical relevance of dysphagia in the ICU goes beyond the difficulty of oral feeding. It is a marker of vulnerability, respiratory risk, and the need for interdisciplinary surveillance. The literature associates post-extubation dysphagia with pneumonia, aspiration, reintubation, prolonged hospital stay, increased costs, reduced quality of life, and short- and long-term mortality. Recent studies reinforce that the systematic identification of dysphagia should be incorporated into the safety

routine of critically ill patients, especially after extubation, in neurological patients, tracheostomized or with altered level of consciousness (Bertschi et al., 2025; Spronk et al., 2022).

From this perspective, nursing occupies a strategic position, as it remains at the bedside for 24 hours, monitors clinical signs, ventilatory and hemodynamic parameters, administers medications, monitors food acceptance, identifies coughing, choking, wet voice, desaturation, changes in breathing patterns and early signs of bronchial aspiration. Speech therapy, in turn, acts in the specialized evaluation of swallowing, in the indication of safe food consistencies, in functional rehabilitation, in the orientation of compensatory strategies, in the management of tracheostomy, and in the interface with the medical team, physiotherapy, nutrition, and nursing.

The research problem that guides this study is: what recent evidence supports interdisciplinary care between nursing and speech-language pathology in the care of critically ill patients with dysphagia of neurological origin in the ICU?

The study is justified by the need to qualify institutional protocols, reduce avoidable adverse events, strengthen evidence-based decision-making, and expand the integration between clinical nursing evaluation and specialized speech-language pathology evaluation. Neurogenic dysphagia, when neglected, compromises essential indicators of quality of care, such as aspiration-associated pneumonia, duration of mechanical ventilation, length of ICU stay, reintubation rate, nutritional adequacy, bronchial aspiration events, and mortality.

Thus, the objective of this study was to analyze recent scientific evidence on interdisciplinary care in dysphagia of neurological origin, highlighting the interfaces between nursing and speech therapy in the care of critically ill patients in ICUs.

METHODOLOGY

It is an integrative literature review, a method that allows gathering, analyzing and synthesizing evidence from different methodological designs, favoring an expanded understanding of

complex clinical phenomena and subsidizing evidence-based practice.

The search was structured in the PubMed/MEDLINE, LILACS, and SciELO databases, considering publications between 2021 and 2026. DeCS/MeSH controlled descriptors and free terms in Portuguese and English were used: "Dysphagia", "Deglutition Disorders", "Neurogenic Dysphagia", "Stroke", "Stroke", "Cerebral Vascular Accident", "Critical Care", "Intensive Care Units", "Nursing Care", "Nursing", "Speech-Language Pathology", "Speech-Language Pathology", "Mechanical Ventilation", "Mechanical Ventilation", "Post-extubation Dysphagia", "Aspiration Pneumonia" and "Patient Safety".

The search strategies were constructed with Boolean operators: ("Deglutition Disorders" OR "Dysphagia" OR "Neurogenic Dysphagia") AND ("Nursing Care" OR "Nursing") AND ("Speech-Language Pathology" OR "Speech Therapy"); ("Post-extubation Dysphagia" OR "Dysphagia") AND ("Intensive Care Units" OR "Critical Care") AND ("Mechanical Ventilation"); ("Stroke" OR "Stroke") AND ("Dysphagia" OR "Deglutition Disorders") AND ("Screening" OR "Assessment"); and ("Dysphagia" AND "Patient Safety" AND "Intensive Care").

Original scientific articles, systematic reviews, meta-analyses, guidelines, consensus, and implementation studies published between 2021 and 2026, available in full text or structured abstract, in Portuguese, English, or Spanish, that addressed dysphagia of neurological origin, post-extubation dysphagia, swallowing screening, nursing care, speech therapy, ICU, patient safety, or interdisciplinary management, were included.

Pediatric studies were excluded when not applicable to critically ill adult patients, reports without a clear methodological basis, editorials without direct clinical contribution, duplicate articles, exclusively outpatient studies unrelated to critical care, and publications prior to 2021, except when cited indirectly by recent guidelines.

The analysis of the studies was carried out by critical reading, extraction of the main findings and organization into thematic categories. No meta-analysis was performed due to the heterogeneity of the designs, populations, assessment instruments, and clinical outcomes investigated.

RESULTS

The literature analyzed demonstrated that the care of critically ill patients with neurogenic dysphagia requires an interdisciplinary approach, structured by protocols, sequential evaluation and effective communication between nursing, speech therapy, medicine, physiotherapy, nutrition and clinical pharmacy. The findings were organized into five thematic categories.

Chart 1 – Synthesis of the studies selected in the integrative review

Author/year	Outline/focus	Key findings	Contribution to nursing and speech therapy
Dziewas et al. (2021)	European guideline on post-stroke dysphagia	Recommends systematic screening before diet, liquids, or oral medications.	It supports institutional protocol and early activation of speech therapy.
Boaden et al. (2021)	Cochrane review of screening for aspiration risk in stroke	It evidences the need for screening and caution instruments with methodological variability.	Supports training of nurses for risk recognition.
Evans et al. (2021)	International Sepsis and Septic Shock Guideline	It prioritizes hemodynamic stabilization, vasopressors, and organic support in unstable patients.	It guides the decision not to release orally in shock, hypoperfusion or respiratory instability.
Warnecke et al. (2021)	Systematic review and classification proposal for neurogenic dysphagia	It relates neurological topography, pathophysiology, and clinical manifestations of dysphagia.	It strengthens clinical reasoning in the correlation between neurological injury and risk of aspiration.
Spronk et al. (2022)	International cross-sectional study DICE in ICU	It showed gaps in the availability of speech therapy and in the standardized identification of dysphagia in the ICU.	It reinforces the need for multiprofessional protocols and care indicators.
Troll et al. (2023)	GUSS-ICU Validation	An instrument has demonstrated usefulness for screening for post-extubation dysphagia at the bedside.	It can support initial screening, without replacing specialized speech-language pathology evaluation.
Song et al. (2024)	Systematic review and meta-analysis on post-stroke dysphagia	It estimated an overall prevalence of 46.6% and an association with pneumonia and mortality.	It justifies early screening and continuous nursing surveillance.
Yu et al. (2024)	Systematic review and meta-analysis on post-extubation dysphagia	It estimated a pooled incidence of 36% in critically ill intubated patients.	It supports systematic evaluation after extubation and prevention of bronchial aspiration.

Chen et al. (2024)	Systematic review and meta-analysis of post-extubation interventions	It analyzed the efficacy and safety of interventions for dysphagia after prolonged intubation.	It supports interdisciplinary rehabilitation and clinical response monitoring.
Bertschi et al. (2025)	Narrative review on post-extubation dysphagia in ICU	It updates epidemiology, mechanisms, diagnosis and clinical management.	It integrates mechanical ventilation, ICU-acquired weakness, sepsis, and critical care.
Nielsen et al. (2025)	Nurse-led triage implementation study	It demonstrated the feasibility of triage by nurses, with barriers to adherence and documentation.	It highlights permanent education, communication and clinical governance.
Trapl-Grundschober et al. (2025)	Study on oral drug administration in post-stroke dysphagia	It highlighted risks and challenges in the administration of solid drugs in dysphagic patients.	It reinforces the interface between nursing, clinical pharmacy and speech therapy.

Source: prepared by the author based on the selected studies (2026).

Early identification and risk stratification

The studies reinforce that early screening for dysphagia is essential to reduce aspiration pneumonia, malnutrition, dehydration, and mortality. In stroke, European guidelines recommend systematic screening for dysphagia in all patients, especially prior to the release of oral diet, oral medications, or liquids (Dziewas et al., 2021).

In the ICU, post-extubation dysphagia has a high incidence and can occur even in patients without previous neurological disease. However, neurological patients are at increased risk due to motor, sensory, and cognitive deficits, alterations in consciousness, and impairment of airway protective reflexes. The validation of the GUSS-ICU demonstrated that standardized instruments can support the identification of the risk of post-extubation dysphagia, although they do not replace specialized speech-language pathology evaluation or instrumental tests, such as FEES, when available (Troll et al., 2023).

For nursing, risk stratification should consider neurological diagnosis, intubation time, presence of tracheostomy, reintubation, level of consciousness, RASS scale, ability to maintain

sedation, effective cough, secretion control, respiratory stability, peripheral oxygen saturation, ventilatory pattern, use of vasoactive drugs and ongoing hemodynamic support.

Clinical, ventilatory and hemodynamic monitoring

The decision about starting swallowing screening, releasing it orally, or referring it for speech-language pathology evaluation should be integrated with the patient's overall clinical condition. In the ICU, it is not safe to evaluate swallowing in isolation, without considering invasive monitoring, mean arterial pressure, respiratory rate, need for supplemental oxygen, mechanical ventilation parameters, level of sedation, delirium, fatigue, and tissue perfusion.

Patients in septic shock, post-cardiorespiratory arrest instability, persistent hypoxemia, increasing use of norepinephrine or other vasopressor, metabolic acidosis, neurological downgrading, or high risk of reintubation should not be submitted to oral diet early without careful evaluation. The Surviving Sepsis Campaign guidelines guide a protocolized approach to sepsis and septic shock, including hemodynamic support, clinical goal-guided resuscitation, vasopressors when indicated, and early enteral nutrition in patients able to receive it (Evans et al., 2021).

Similarly, the American Heart Association's cardiopulmonary resuscitation and post-arrest care guidelines highlight initial stabilization, respiratory management, treatment of reversible causes, hemodynamic control, and post-return care of spontaneous circulation prior to intensive functional rehabilitation (American Heart Association, 2025). The relationship with dysphagia is direct: post-arrest, post-stroke or post-sepsis patients often present neurological alterations, weakness, delirium and risk of aspiration, requiring nursing to integrate critical clinical reasoning and functional assessment.

Nursing interventions in the care of dysphagic patients

Nursing interventions are decisive for the prevention of adverse events. Among the main

actions, the following stand out: keeping the head of the bed elevated between 30º and 45º; assess the level of consciousness before any oral offering; observe coughing, choking, vocal alterations, oral leakage, fatigue during feeding, desaturation, tachypnea, and accumulation of secretions; communicate speech therapy early; record findings in a standardized way; ensure strict oral hygiene; control the administration of oral medications; and suspend diet when there are signs of bronchial aspiration.

The implementation of dysphagia screening conducted by ICU nurses proved to be possible, although it depends on training, institutional support, adequate documentation, and integration with the multiprofessional team. An implementation study published in 2025 pointed out that nurse-led screening can facilitate safe oral intake and identify patients who need specialized evaluation, but it also highlighted barriers related to protocol adherence, communication, and documentation (Nielsen et al., 2025).

In the critically ill patient, clinical nursing reasoning must answer objective questions: is the patient awake and responsive? Is it hemodynamically stable? Are you using vasoactive drugs in a stable or increasing dose? Does it maintain adequate saturation? Do you have an effective cough? Does it control secretions? Do you have delirium? Do you show signs of respiratory fatigue? Do you have a speech therapy prescription or oral route restriction? These variables should guide decision-making and prevent automated conduct.

Specialized speech-language pathology and interfaces with nursing

Speech therapy works in the clinical and instrumental evaluation of swallowing, classification of dysphagia severity, definition of safe food consistencies, prescription of compensatory strategies, rehabilitation of the oropharyngeal muscles, management of tracheostomy, adaptation of the speech valve when indicated, team guidance and monitoring of the progression of the oral route.

Integration with nursing is essential because the effectiveness of speech-language

pathology guidance depends on safe execution in bed: positioning, food supply at the appropriate pace, supervision, volume control, identification of aspiration signs, maintenance of oral hygiene, medication administration compatible with dysphagia and recording of complications. Nursing does not replace speech therapy, but expands clinical surveillance and operationalizes recommendations in continuous care.

Recent consensuses on the management of swallowing disorders in the ICU advocate a multiprofessional approach, with protocols for screening, specialized evaluation, oral route criteria, tracheostomy management, and respiratory safety (Likar et al., 2024). Interprofessional projects with the participation of speech therapy, nursing, physiotherapy, medicine and occupational therapy also demonstrate potential to reduce tracheal cannula time, accelerate safe decannulation and reduce ICU stay (Konradi et al., 2025).

Quality and Critical Patient Safety Indicators

Dysphagia should be incorporated into the ICU care quality indicators. Among the relevant indicators, the following stand out: percentage of extubated patients screened for dysphagia before the first oral diet; time between extubation and swallowing screening; time between risk identification and speech-language pathology evaluation; rate of aspiration pneumonia; episodes of bronchial aspiration; rate of reintubation associated with aspiration; adequacy of the food route; time of mechanical ventilation; length of stay in the ICU; adherence to oral hygiene; compliance with food consistency prescription; and adverse events related to the administration of oral medications.

These indicators connect dysphagia care to the principles of critical patient safety, harm prevention, effective communication, teamwork, rational use of protocols, and continuous clinical surveillance.

DISCUSSION

The findings of this review demonstrate that neurogenic dysphagia should be understood as a high-impact clinical condition, and not only as a functional alteration of diet. In critically ill patients, dysphagia expresses the interaction between neurological damage, muscle weakness, sensorimotor impairment, respiratory changes, hemodynamic instability, and consequences of intensive support.

Recent literature reinforces that post-stroke dysphagia remains highly prevalent and clinically relevant. The meta-analysis by Song et al. (2024) demonstrated an overall prevalence of 46.6%, with a higher risk in patients with hemorrhagic stroke, advanced age, atrial fibrillation, hypertension, previous stroke, and greater neurological severity. This finding requires that neurological ICU nursing maintain increased vigilance from admission, not only at the time of feeding.

In patients undergoing mechanical ventilation, post-extubation dysphagia is a frequent and underdiagnosed complication. Yu et al. (2024) estimated an incidence of 36% in critically ill intubated patients, while cohort studies indicate an association with long-term mortality and poorer functional recovery. This reveals that successful extubation from the respiratory point of view does not necessarily mean safe recovery of swallowing. The post-extubation evaluation should be understood as a step of airway safety and not only as dietary release.

Nursing performance becomes central due to its ability to identify clinical changes in real time. The nurse must correlate neurological, ventilatory and hemodynamic findings before releasing or maintaining oral restriction. A patient with extensive stroke, negative RASS, weak cough, use of norepinephrine, tachypnea, and increasing oxygen requirement is at high risk for aspiration and respiratory deterioration. In this scenario, the safe conduct is to keep the oral route suspended, ensure nutrition by alternative route as prescribed, activate speech therapy, discuss with the medical team and carefully record the clinical justification.

The interface with speech therapy allows for greater diagnostic and therapeutic accuracy. While nursing identifies signs of risk and continuously monitors the patient's response, speech therapy

defines functional parameters of swallowing, food consistencies, need for instrumental exams, therapeutic exercises and compensatory strategies. The GUSS-ICU, validated in 2023, demonstrated good discriminative capacity for identifying post-extubation dysphagia, with high sensitivity when compared to FEES, reinforcing the potential of standardized instruments in a critical environment (Troll et al., 2023).

However, the adoption of instruments should not generate false security. Dysphagia in the ICU is dynamic. The patient may improve or worsen according to fatigue, delirium, secretion, sepsis, sedation, ventilatory alteration or neurological progression. Thus, even after an initial favorable screening, nursing should maintain vigilance during meals, medication administration, and mobilization. The evaluation should be reprocessed in the event of cough, drop in saturation, vocal alteration, fever, increased secretion, new pulmonary infiltrate, or altered level of consciousness.

The administration of solid drugs in dysphagic patients represents a critical safety point. Improperly crushed tablets, opened capsules without pharmaceutical evaluation, administration with thin liquids, or mixing in incompatible foods may cause aspiration, loss of pharmacological efficacy, obstruction of probes, and adverse events. Recent studies indicate that drug administration in dysphagic post-stroke patients is a relevant challenge for nursing, requiring integration with clinical pharmacy and speech therapy (Trapl-Grundschober et al., 2025).

In the context of sepsis, the application of the Surviving Sepsis Campaign should guide clinical prioritization. Patients in sepsis or septic shock require infectious control, antibiotic therapy, volume replacement, vasopressors, perfusion monitoring, lactate, and hemodynamic stability prior to advanced functional interventions. Dysphagia may aggravate the risk of aspiration pneumonia, but swallowing assessment should only occur when there is minimum stability for safe participation. Therefore, dysphagia protocols do not compete with sepsis protocols; they articulate on the continuum of critical care.

Similarly, ACLS protocols and post-cardiorespiratory arrest care target airway stabilization, ventilation, circulation, and reversible causes. After return of spontaneous circulation, patients may

present hypoxic-ischemic encephalopathy, need for mechanical ventilation, sedation, hemodynamic instability, and risk of aspiration. The reintroduction of oral diet in this group should be delayed, judicious and interdisciplinary, respecting the neurological level, airway protection and cardiorespiratory stability.

The discussion also points to educational and managerial implications. The ICU must have an institutional protocol for post-extubation dysphagia and neurogenic dysphagia, with objective screening criteria, speech therapy activation flows, standardization of food consistencies, oral hygiene guidance, criteria for diet suspension, and monitoring indicators. The continuing education of the nursing team is essential to reduce care variations and ensure that triage is not just a documentary task, but a well-founded clinical action.

As a limitation, this review presents a narrative and integrative synthesis, without its own meta-analysis and without a formal assessment of the risk of bias of all the included studies. In addition, the heterogeneity of screening instruments, populations, post-extubation evaluation times, and diagnostic criteria makes direct comparisons difficult. It is recommended that future Brazilian studies evaluate interdisciplinary protocols in ICUs, the impact of nurse-led triage, time to speech therapy, the occurrence of aspiration pneumonia, and the cost-effectiveness of implementing dysphagia prevention programs.

CONCLUSION

Interdisciplinary care in dysphagia of neurological origin is an essential component of the safety of critically ill patients in the ICU. Recent evidence shows that post-stroke dysphagia and post-extubation dysphagia have a high prevalence, association with aspiration pneumonia, malnutrition, dehydration, prolonged hospitalization, reintubation, mortality, and poorer functional recovery.

Nursing plays a strategic role in early identification, continuous clinical monitoring, maintenance of airway safety, oral hygiene, positioning, surveillance during feeding, safe

administration of medications, documentation and risk communication. Speech therapy complements this process through specialized evaluation, definition of consistencies, swallowing rehabilitation, tracheostomy management and technical guidance to the team.

The integration between nursing and speech therapy should be articulated with ICU protocols, including mechanical ventilation management, invasive monitoring, hemodynamic support, use of vasoactive drugs, Surviving Sepsis Campaign, ACLS, and patient safety indicators. Decision-making should be evidence-based, but also contextualized by the patient's individual clinical condition, respiratory stability, perfusion, level of consciousness, and functional capacity.

It is concluded that interdisciplinary protocols, continuing education, systematic screening, timely speech-language pathology evaluation and care indicators are essential to reduce avoidable complications and qualify the care of critically ill patients with neurogenic dysphagia.

REFERENCES

AMERICAN HEART ASSOCIATION. 2025 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation, Dallas, 2025.

BERTSCHI, D. et al. Post-extubation dysphagia in the ICU: a narrative review: epidemiology, mechanisms and clinical management (Update 2025). Critical Care, London, v. 29, p. 244, 2025. DOI: 10.1186/s13054-025-05423-6.

BOADEN, E. et al. Screening for aspiration risk associated with dysphagia in acute stroke. Cochrane Database of Systematic Reviews, Oxford, n. 10, CD012679, 2021. DOI: 10.1002/14651858.CD012679.pub2.

CHANG, Y. C. et al. Identifying high-quality non-instrumental dysphagia screening tools in acute-care settings: a systematic review. Dysphagia in New York 2024.

CHEN, L. et al. Interventions for postextubation dysphagia in critically ill patients: a systematic review and meta-analysis. Dysphagia, New York, v. 39, n. 6, p. 1013-1024, 2024. DOI: 10.1007/s00455-024-10695-1.

DZIEWAS, R. et al. European Stroke Organisation and European Society for Swallowing Disorders guideline for the diagnosis and treatment of post-stroke dysphagia. European Stroke Journal, London, v. 6, n. 3, p. LXXXIX-CXV, 2021. DOI: 10.1177/23969873211039721.

EVANS, L. et al. Surviving Sepsis Campaign: international guidelines for management of sepsis and septic shock 2021. Intensive Care Medicine, Berlin, v. 47, n. 11, p. 1181-1247, 2021. DOI: 10.1007/s00134-021-06506-y.

KONRADI, J. et al. Interprofessional quality improvement project to reduce the length of stay of tracheostomized patients in a multi-etiological intensive care unit: the contribution of speech and language therapy to the overall result. Journal of Clinical Medicine, Basel, v. 15, n. 1, p. 303, 2025. DOI: 10.3390/jcm15010303.

LABEIT, B. et al. Dysphagia after stroke: research advances in treatment interventions. The Lancet Neurology, London, v. 23, n. 4, p. 418-428, 2024. DOI: 10.1016/S1474-4422(24)00053-X.

LIKAR, R. et al. Management of swallowing disorders in ICU patients: a multinational expert opinion. Journal of Critical Care, Philadelphia, v. 79, p. 154447, 2024. DOI: 10.1016/j.jcrc.2023.154447.

MANCIN, S. et al. Dysphagia screening post-stroke: systematic review. BMJ Supportive & Palliative Care, London, v. 13, n. 3, p. e641-e650, 2024. DOI: 10.1136/spcare-2022-004144.

NIELSEN, A. H. et al. Nurse-led dysphagia screening in the intensive care unit: an implementation study. Australian Critical Care, Amsterdam, v. 38, n. 1, 101100, 2025. DOI: 10.1016/j.aucc.2024.07.081.

OLIVEIRA, I. de J. et al. Best practice recommendations for dysphagia management in stroke patients: a consensus from a Portuguese expert panel. Portuguese Journal of Public Health, Basel, v. 39, n. 3, p. 145-162, 2022. DOI: 10.1159/000520505.

RIVELSRUD, M. C. et al. Prevalence of oropharyngeal dysphagia in adults in different healthcare settings: a systematic review and meta-analyses. Dysphagia, New York, v. 38, n. 1, p. 76-121, 2023. DOI: 10.1007/s00455-022-10465-x.

SCHANDL, A. et al. Identifying dysphagia in the intensive care unit: validation of the Swedish version of the Gugging Swallowing Screen-Intensive Care Unit. Acta Anaesthesiologica Scandinavica,

Copenhagen, v. 69, n. 5, e70031, 2025. DOI: 10.1111/aas.70031.

SONG, W. et al. Prevalence, risk factors, and outcomes of dysphagia after stroke: a systematic review and meta-analysis. Frontiers in Neurology, Lausanne, v. 15, 1403610, 2024. DOI: 10.3389/fneur.2024.1403610.

SPRONK, P. E. et al. Dysphagia in Intensive Care Evaluation (DICE): an international cross-sectional survey. Dysphagia, New York, v. 37, n. 6, p. 1451-1460, 2022. DOI: 10.1007/s00455-021-10389-y.

TRAPL-GRUNDSCHOBER, M. et al. Oral intake of solid medications in patients with post-stroke dysphagia: a challenge for nurses? Journal of Clinical Nursing, Oxford, v. 34, n. 3, p. 872-882, 2025. doi: 10.1111/jocn.17081.

TROLL, C. et al. A bedside swallowing screen for the identification of post-extubation dysphagia on the intensive care unit: validation of the Gugging Swallowing Screen (GUSS)-ICU. BMC Anesthesiology, London, v. 23, p. 122, 2023. DOI: 10.1186/s12871-023-02072-6.

WARNECKE, T. et al. Neurogenic dysphagia: systematic review and proposal of a classification system. Neurology, Minneapolis, v. 96, n. 6, p. e876-e889, 2021. DOI: 10.1212/WNL.0000000000011350.

YU, W. et al. Incidence of post-extubation dysphagia among critical care patients undergoing orotracheal intubation: a systematic review and meta-analysis. European Journal of Medical Research, London, v. 29, n. 1, p. 444, 2024. DOI: 10.1186/s40001-024-02024-x.

ZUERCHER, P. et al. Dysphagia post-extubation affects long-term mortality in mixed adult ICU patients: data from a large prospective observational study with systematic dysphagia screening. Critical Care Explorations, Philadelphia, v. 4, no. 6, e0714, 2022. DOI: 10.1097/CCE.0000000000000714.