Here we meet Claire Slinger, Consultant Respiratory Speech and Language Therapist. Claire is part of the Airways MDT at the Chest Clinic in Royal Preston Hospital.

We would be interested to know more about your path to becoming a speech and language therapist. What attracted you to this role in the NHS?

I initially became aware of one of the roles of Speech and Language Therapy during my post as an Assistant Neuropsychologist, during a training course in Cognitive Neuropsychology. A session by a Speech & Language Therapist immediately captured my interest.
I was very interested in the ability to both assess a patient, and then provide therapy to improve function, and that the impact that this can have on patients and families/loved ones.

I later Specialised in Clinical Voice disorders and Head and Neck Oncology, and this was the start of my appreciation on the role of the larynx and upper Airway for people's quality of life, and that it is mostly when people experience difficulties with laryngeal and upper airway function that you really appreciate is importance. After all, we use the Larynx for eating & drinking, voicing, airway protection airway clearance and it has a role in breathing, and even lifting, so all very important functions.

How did you become involved in respiratory medicine?

I was really attracted to this area after I gained an appreciation of how important getting an accurate diagnosis of upper Airway dysfunction (ILO or Chronic Cough) can often be a long journey for patients. But, once that diagnosis is secured, we are able to work with them to help them to manage that condition. What what really drew me in, was the speed that this was possible, if the patient is ready to accept the diagnosis and is ready for therapy. We do see this speed of improvement when working with Voice disorders, but with patients with Upper Airway disorders, this felt even more impactful, as symptoms can be extremely debilitating, and patients can have high health care utilisation and morbidity from both their symptoms and a high pharmacological burden. To be able to contribute to the assessment and management of upper Airway dysfunction and ultimately quality of life is a complete privilege that I never take for granted.
As assessment is undertaken as part of the Multi-Disciplinary Team, we have a strong foundation on which to thoroughly assess the patient holistically, to make sure we get accurate diagnoses, and to help identify other conditions, such as Airways diseases and comorbidities, to help make sure the patient is as optimised as much as possible for the best outcome for them.

You are part of a strong multi-professional team. Who are the other members of the Airways MDT?

The Airways and Severe Asthma Team for our service comprises of Consultant Respiratory Physicians, two of whom Specialise in Asthma and one who Specialises in Chronic Cough. We also have 2 Speech and Language Therapists, 2 Respiratory Physiotherapists, a Clinical Psychologist who is dedicated to our service and 2 Asthma nurse Specialists.

The importance of the role of MDT assessment and management of upper Airway dysfunction is highlighted in the most recent iteration of the Royal College of Speech & Language Therapists Upper Airways Position Statement. This has been updated to highlight recent developments in this area, and is intended as a supporting resource for service commissioning and delivery, as well as acting as a clinical resource for SLTs working or interested in working in this area.

Your role is so varied, could you outline a typical week?

Assessment: Once a week we have "1-stop clinic", where the whole MDT will see patients that have been triaged accordingly. For our

patients, they are seen for an initial assessment with one of the Respiratory Physicians, as well as undergoing assessments on the day to help in the differential diagnosis. This typically will involve the patient having tests such as Full Pulmonary Function Tests, reversibility, Impulse oscillometry, fractional exhaled nitric oxide (FeNO), bloods, imaging (if indicated). The patient is seen with the available results of these tests for a joint detailed case history with SLT and Respiratory Physician. Then, they attend for a Provocation Diagnostic Laryngoscopy.

Diagnosis: The current gold standard for diagnosis of Inducible Laryngeal Obstruction is a provocation diagnostic Laryngoscopy. In our (and most other), Specialist Centres, this is performed by the SLT, in the presence of the Respiratory Physician to systematically assess the upper Airway, to try to provoke typical symptoms in patients with the laryngoscope in situ, so symptoms can be correlated with what we see on Laryngoscopy.

We look for what the larynx does at baseline during breathing (In ILO it is the inspiratory breath we are most interested in, looking to see if the vocal folds, or the supraglottic area narrows by anything above 50% in the presence of symptoms). If we see this, we can start to show the patient why this will have the potential to affect their breathing, and how they can "reverse" it, using the SLT techniques to open up the upper airway and vocal folds.

The thing that often strikes me when we are able to diagnose ILO, is that patients quite often feel a sense of relief that their symptoms have been understood and that the diagnosis of ILO correlates with their symptoms. Often patients will say "I have said for years this is not just Asthma."

Management: Once a patient has obtained a diagnosis of ILO, and the team are clear that other Airways diseases, such as Asthma & Bronchiectasis are optimised, SLT intervention can begin. This is multi-faceted, but typically will involve education around their condition (ILO or Chronic Cough), upper Airway hygiene, Psychoeducation and demonstrating to the patients techniques to control the upper airway to both prevent and relieve their symptoms. Patients typically have between 2-4 sessions, and will have a therapy laryngoscopy, so that they can see if their larynx is responding in real-time with biofeedback, and feel reassured that the larynx does respond when they apply the airway control techniques.

Education/Awareness: A large part of the role is to educate fellow professionals from primary, secondary and tertiary level about the existence of upper Airway dysfunction, how to spot it, and when to refer for specialist assessment.

Unfortunately, ILO in particular has not made it to "prime time" as yet, so there is still a way to go before it is widely recognised and accepted as a diagnostic entity. There is an emerging body of evidence, particularly around exercise-induced laryngeal Obstruction (EILO). However, there is a lack of prospective quality randomised studies in the literature with standard endpoints. The relatively recent consensus nomenclature which suggests Inducible Laryngeal Obstruction is definitely a step in the right direction to align professionals in the terminology for ILO. The European Respiratory Society and European Laryngological Society have issued a joint statement on this.

Perhaps you can you share your experience with a particular patient?

A female patient in her 50's who was having severe symptoms of throat "shutting down" over several years, so much so that it was significantly affecting her physical and mental health, as standard treatments were not working. Her symptoms were also so severe, she struggled, and was very mindful of what she could eat, as this would trigger off her symptoms. She was seen for a 1-stop assessment, and underwent lung function, bloods, FeNo and reversibility, which showed

no objective evidence of asthma, alongside a clinical history of non-response to inhaled therapies. A diagnostic laryngoscopy performed the same day confirmed that she did have ILO, and a management plan crafted that day, including SLT for ILO started.

As she was very motivated for therapy, she very quickly applied the techniques successfully, and further therapy sessions evidenced that she felt much more reassured regarding the nature of her condition, that she felt less anxious and depressed, and that she felt that even if she were to have another episode, that she would be able to manage it and control it with SLT techniques.

Speech and language therapists are increasingly part of respiratory teams. How do you see the profession developing within respiratory?

As awareness grows, I would envisage that more dedicated SLTs will be working within Respiratory teams, with more centres developing this model of working. One of the challenges for this is funding and resource. It is hoped that the RCSLT position statement will help, as this advocates that SLTs working in the area of upper airway should be working as part of the MDT; a key recommendation from the RCSLT (2021) states "SLTs working in upper airway disorders are members of a specialised respiratory multidisciplinary team (MDT), and it is recommended they should be commissioned as such."

With access to SLT supervision from experienced clinicians, it is hoped that more and more SLTs will take up the torch of working with this very rewarding caseload.

The recent upsurge of interest from SLTs keen to work in the field of the Upper Airway ideally needs to be matched with a vision from Respiratory teams as to the added value of SLTs in their teams. It is hoped this will be helped by guidance such as the ICS/BTS joint guidance for Respiratory Support Units, which acknowledges the role of the MDT and SLTs as part of this; working with patients with Complex Respiratory conditions in a RSU environment. The RCSLT has put forward a position statement which sits within the guidance.

Additionally, the NHSE service specification document for Severe Asthma services, acknowledges the importance and impact of the role of SLTs within the Severe Asthma service.

The BTS has been very supportive in recognising the role of SLTs in Respiratory, adding them to the membership category, and encouragement of the involvement of SLT in professional activities.

The hosting of a poster discussion session at the Winter BTS meeting in 2019 on Complex breathlessness and chronic cough, was very well received and attended by members.

Are there opportunities for you to contribute to quality improvement and research?

I aim to undertake at least 2-3 small projects a year for submission to Winter BTS meeting. Generally, these reflect key themes, or address key clinical or patient questions around ILO assessment and management and to aim to contribute in a small scale to the general understanding of ILO.

In addition, we also currently are working alongside trainees and Clinical Sports Science students with research projects and final year dissertations to contribute to their training. The project for the Clinical science student is looking at the utility of the use of IOS in the assessment for ILO.

As an MDT Respiratory department, we are currently involved in a "Big Room" project, using flow-coaching methodology to look at transformation of our current Respiratory High Care unit in our Trust. This is in acknowledgement of the importance and

impact of such units, as was seen on our unit during the Covid-19 pandemic. RSUs have been put forward as a model of good practice.

Do you have any particular advice for SLT colleagues considering a role in respiratory?

Identify and get to know key stakeholders in your clinical area and Trust. Use resources, such as the RCSLT position paper, the NHSE Severe Asthma Service specification and the BTS/ICS guidance to show business managers and clinicians the added value of SLTs in the Respiratory MDTs. The use of health economic data that is published, can be used, along with patient stories, again to show worth. The RCSLT have produced a very informative factsheet on upper airway disorders.

Attending some respiratory clinics, and joint case discussions, alongside some pilot projects to "prove worth" may also prove useful. It can take a very long time to get services established, but once you have made those links it will be invaluable for the patients.

I would also suggest the use of the Network of Professional Advisor SLTs in Upper Airway Disorders, held by the RCSLT.

What do you see as the benefits of connecting with respiratory organisations like BTS?

There are multiple benefits, including access to educational opportunities, such as the short courses, being able to attend and participate via submitted abstracts to the Winter BTS. I have had the great pleasure and honour of presenting at 2 Summer BTS events: Short course in Complex Breathlessness and a round table discussion this year which took the form of an Asthma MDT.

Contact details

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