

Fig. 1

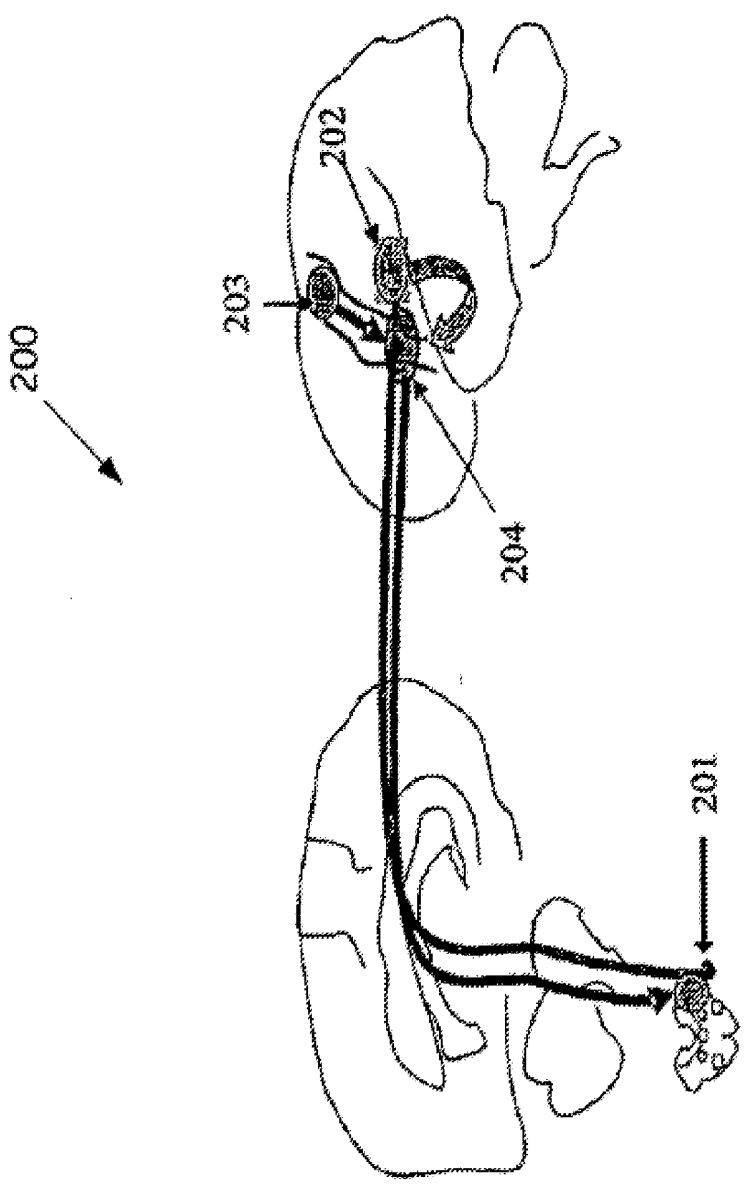


Fig. 2

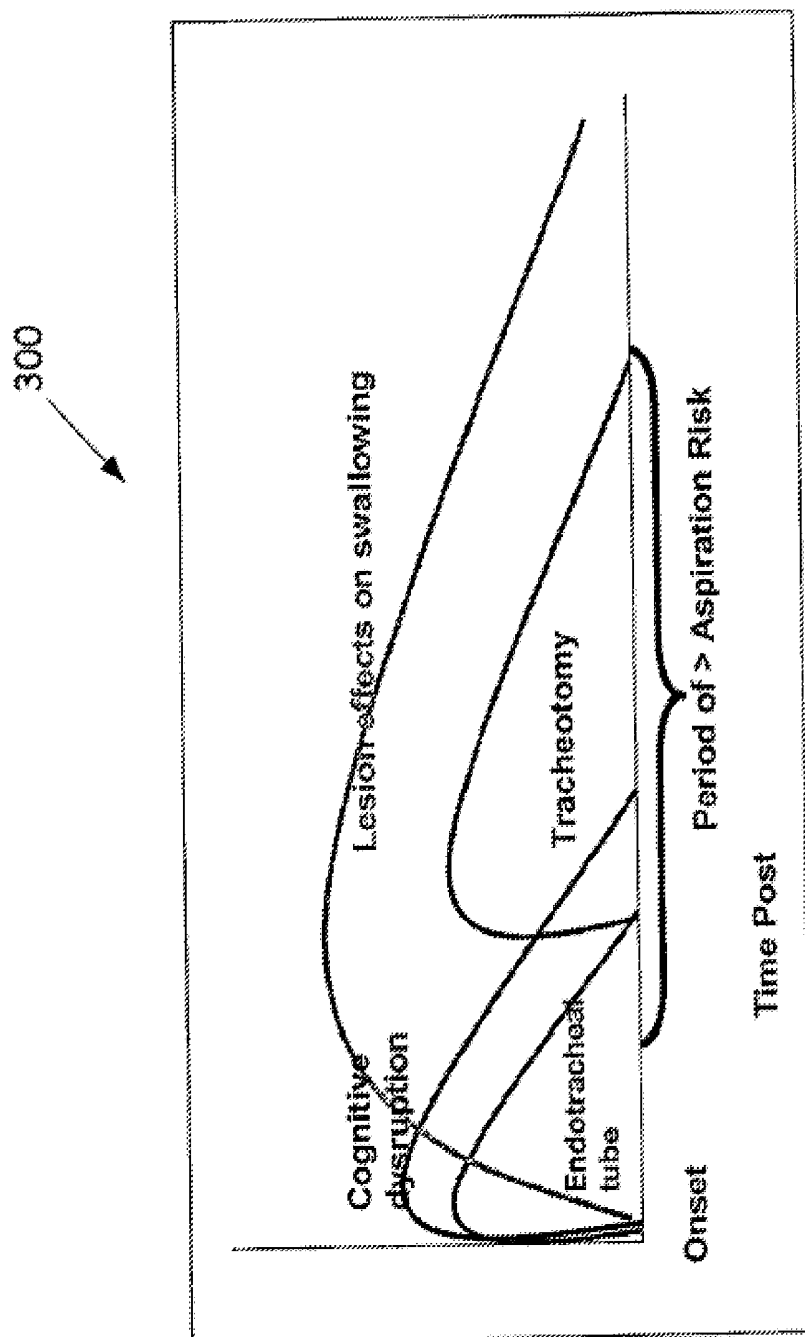


Fig. 3

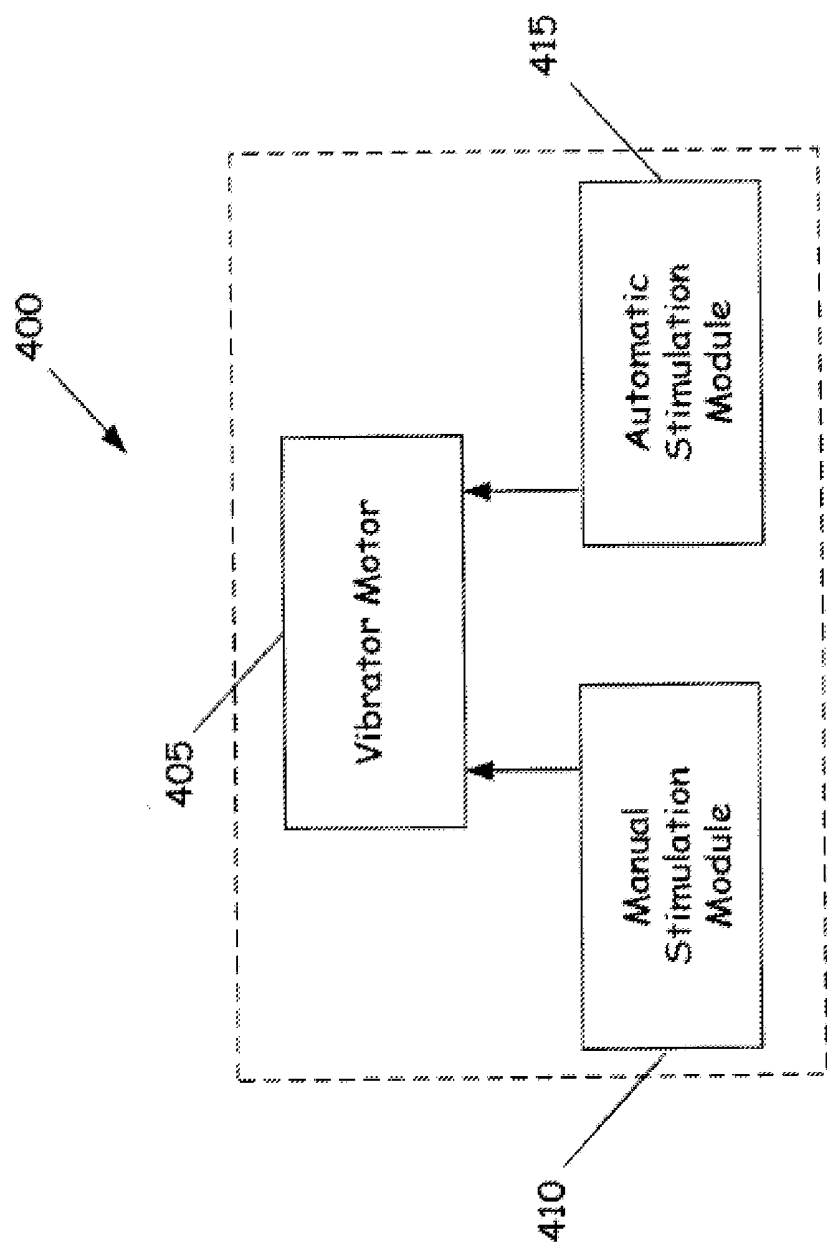


Fig. 4

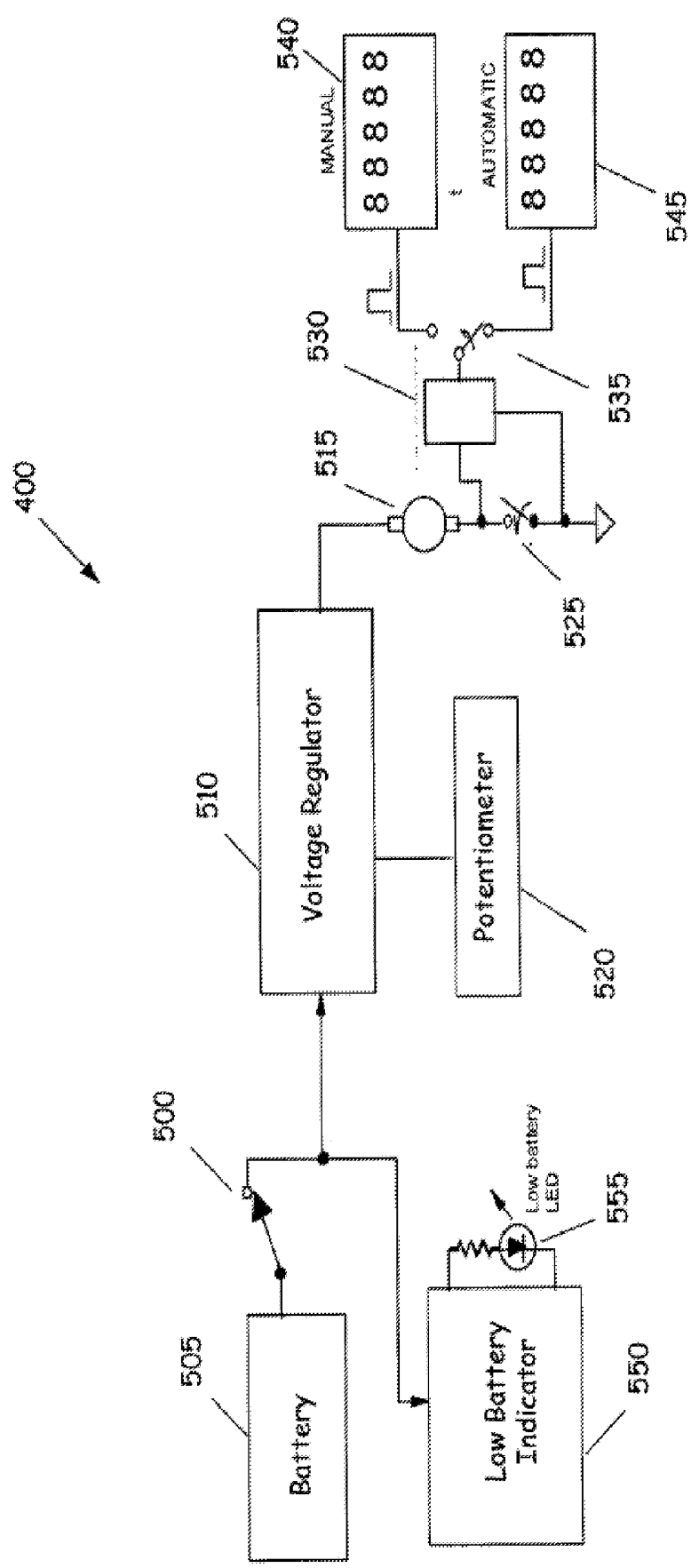


Fig. 5

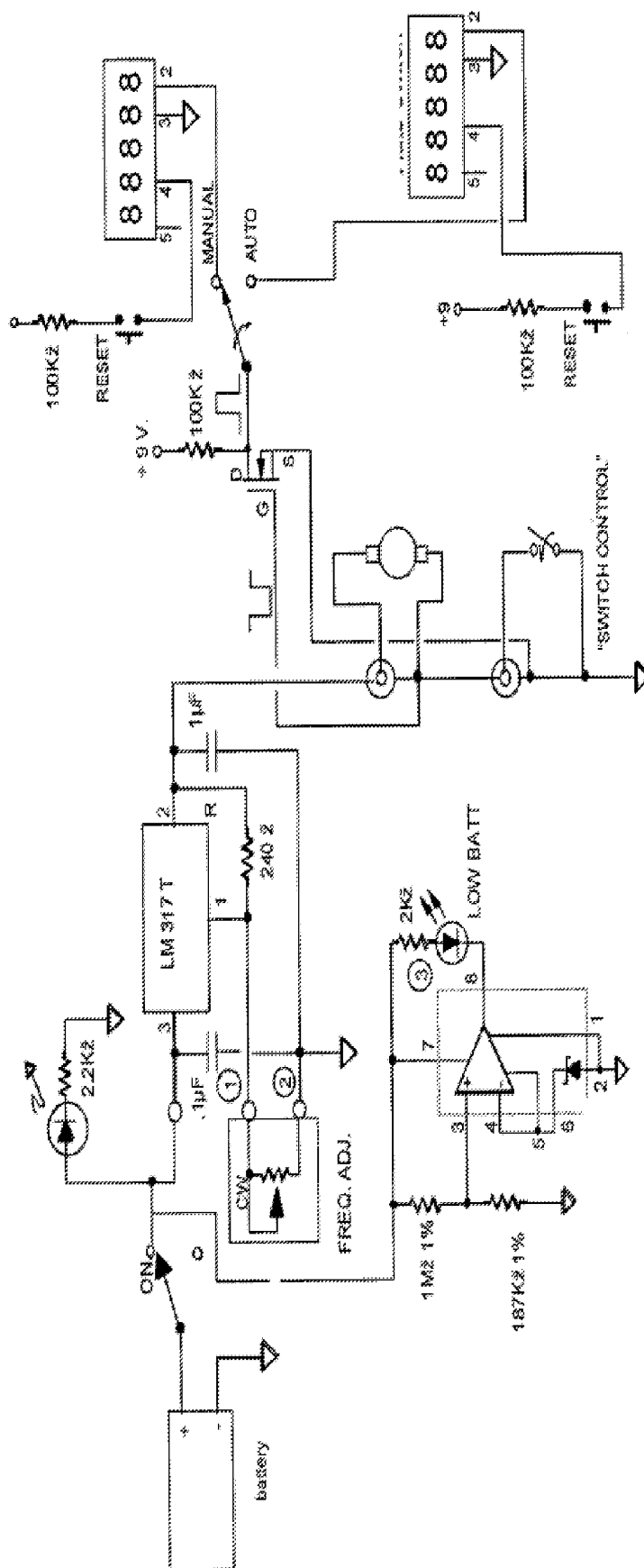


Fig. 6a

600

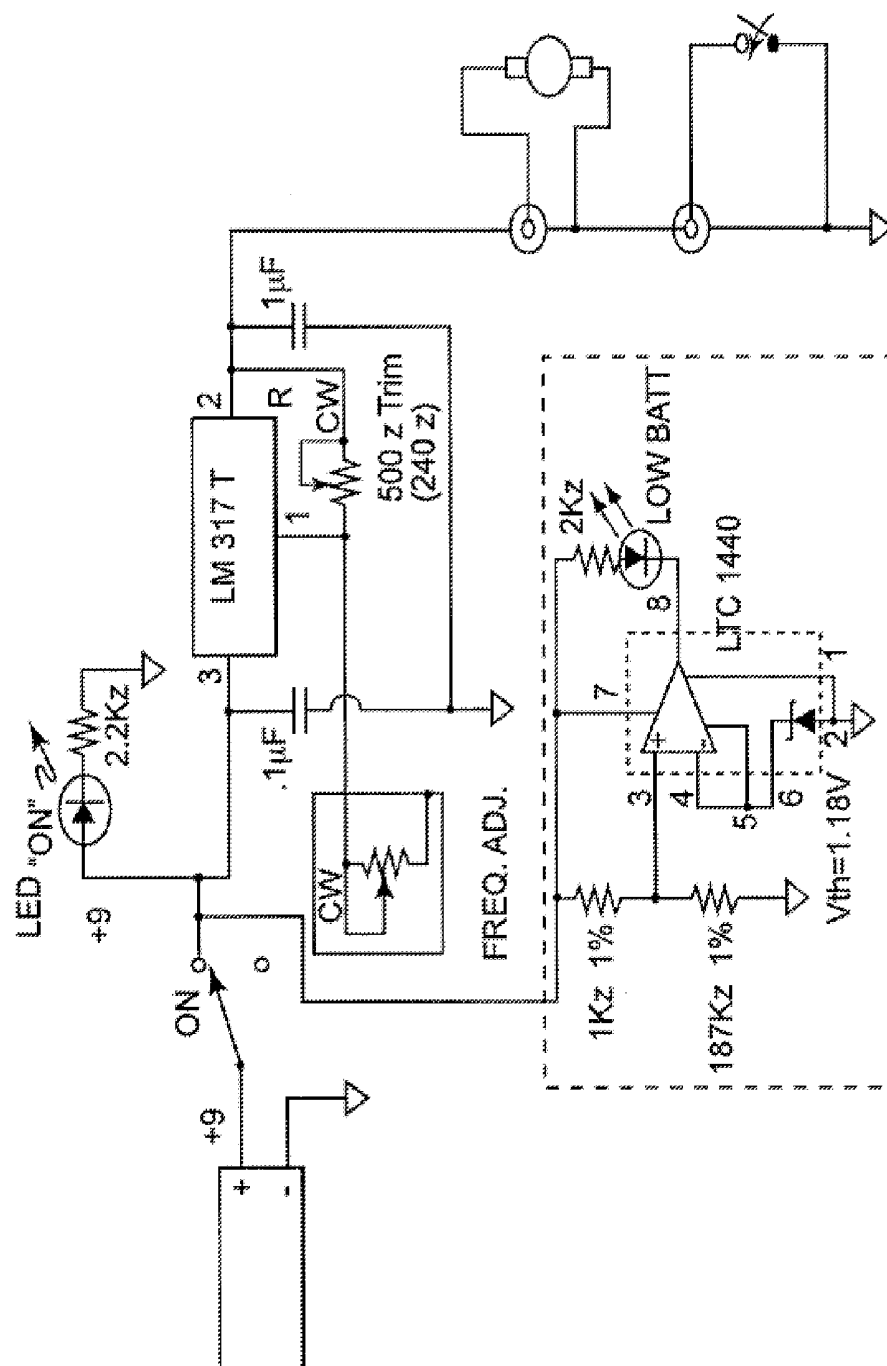


Fig. 6b

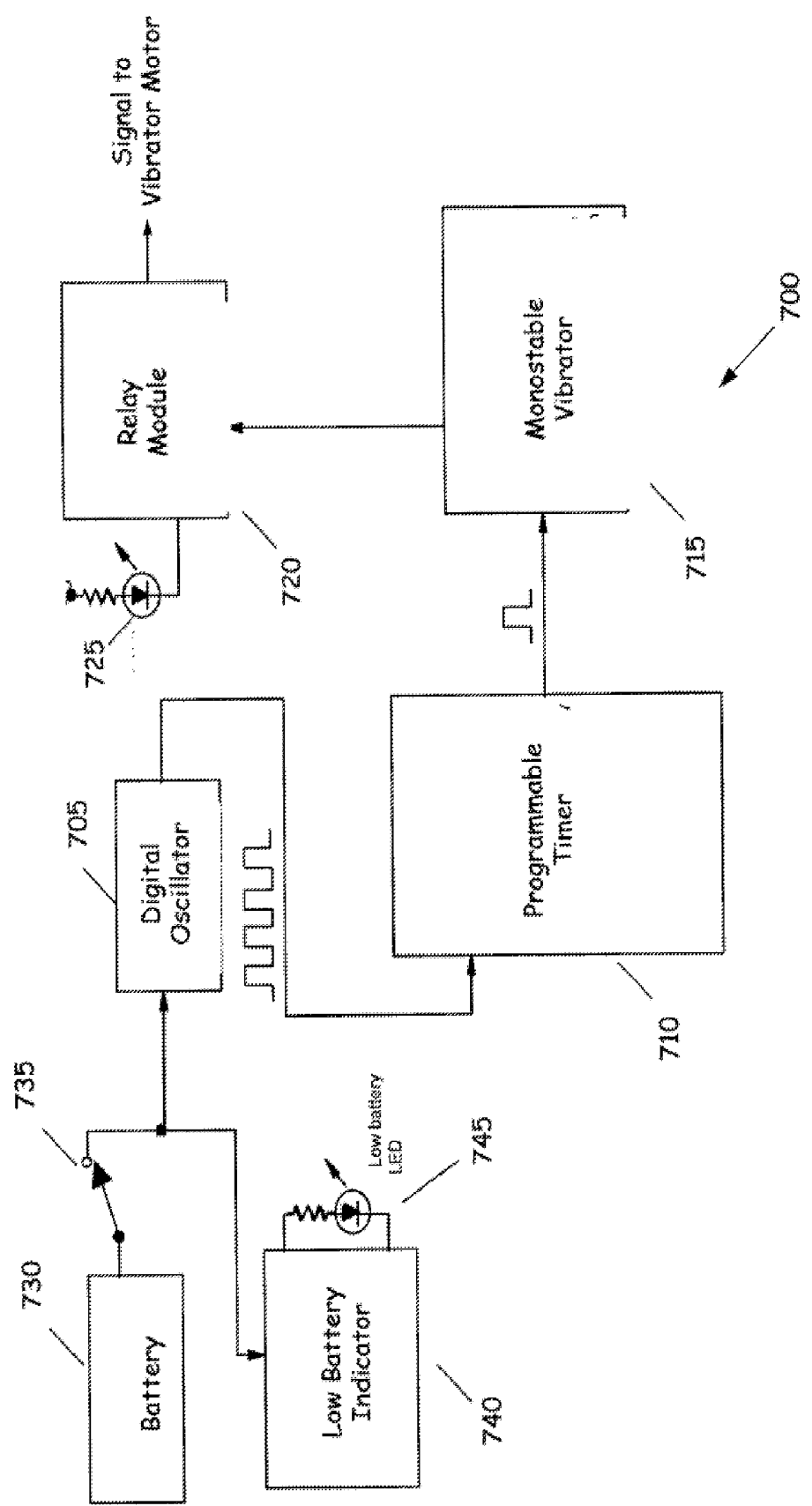


Fig. 7

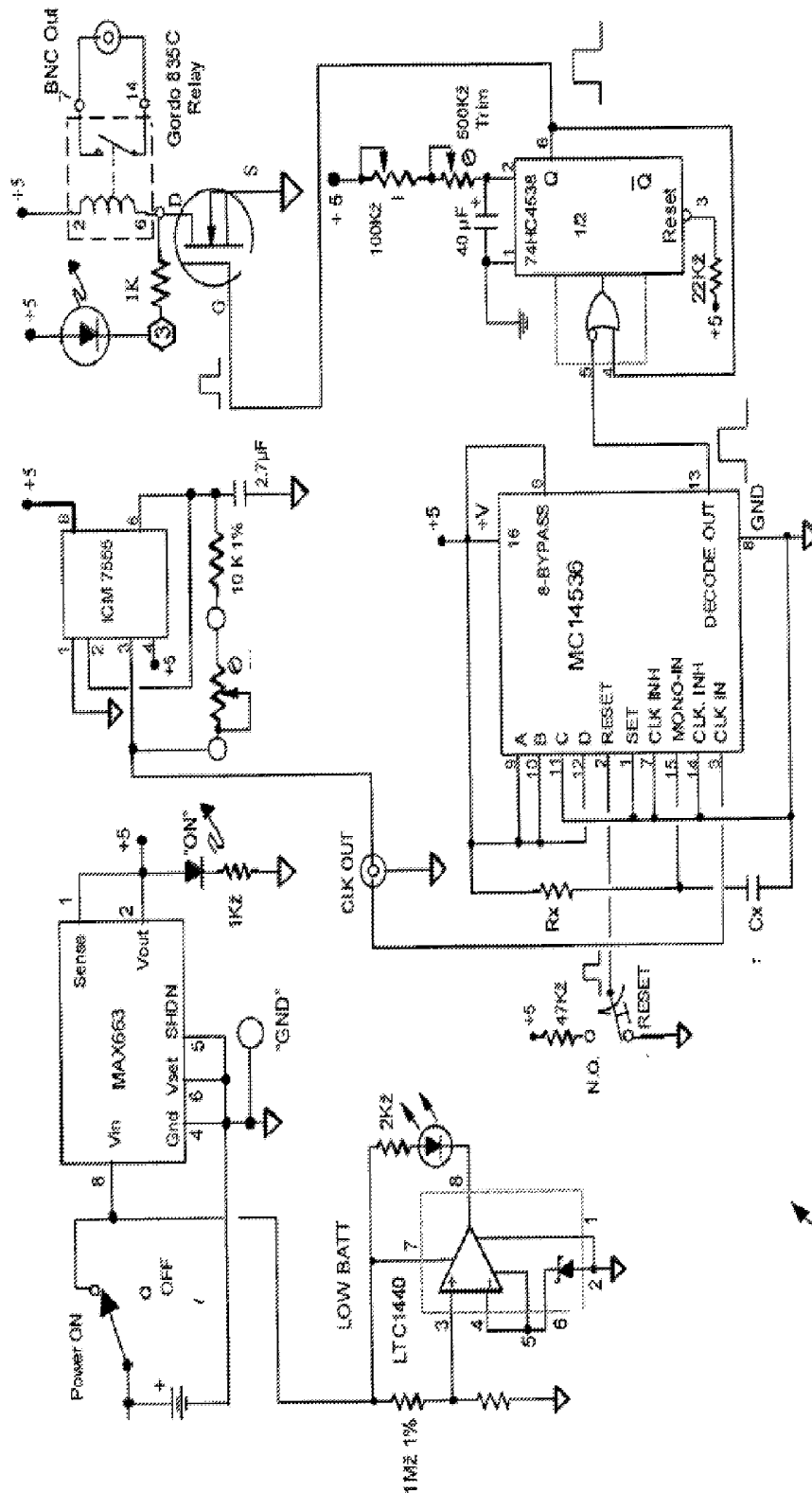


Fig. 8a

800

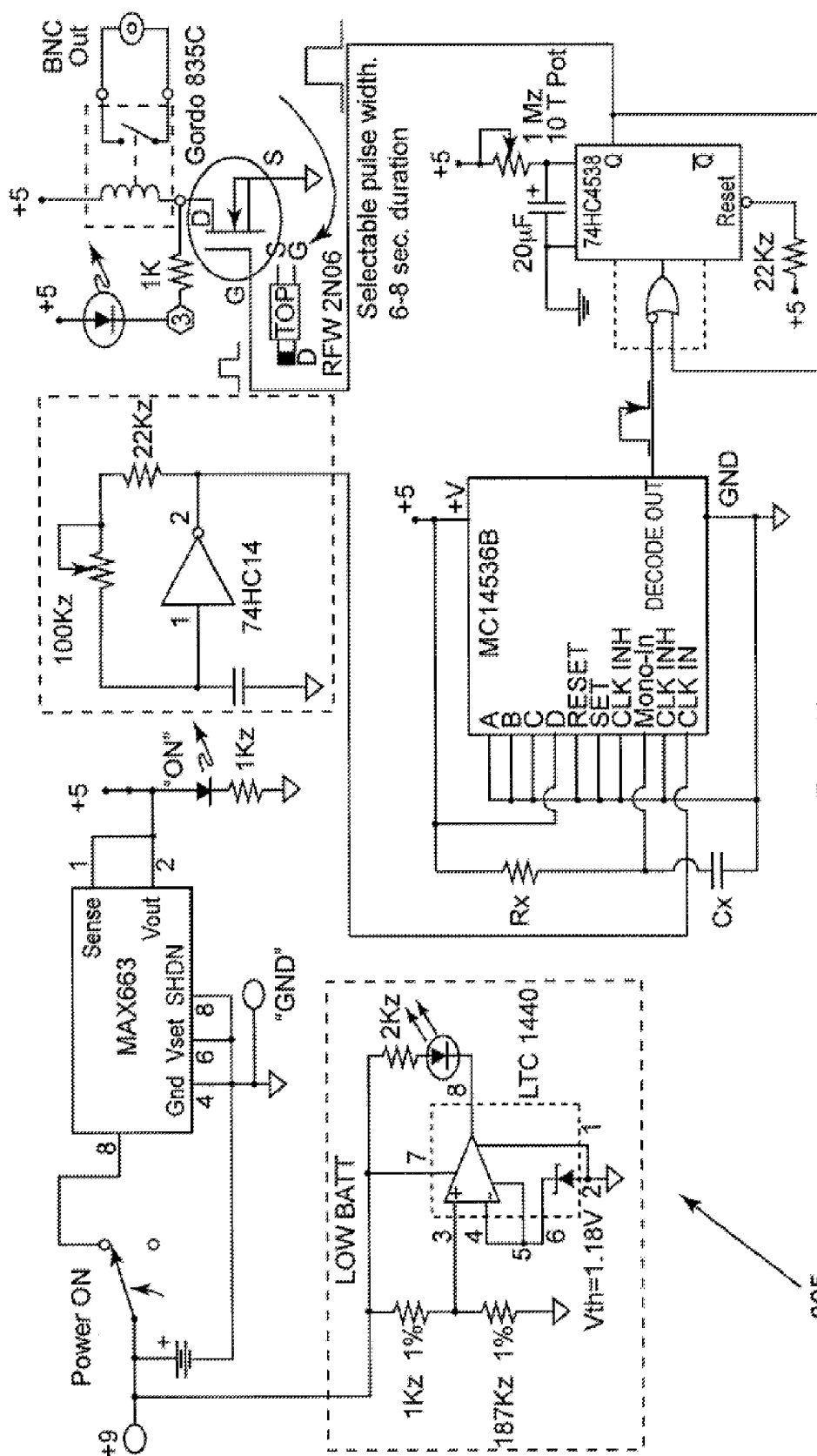


Fig. 8b

805

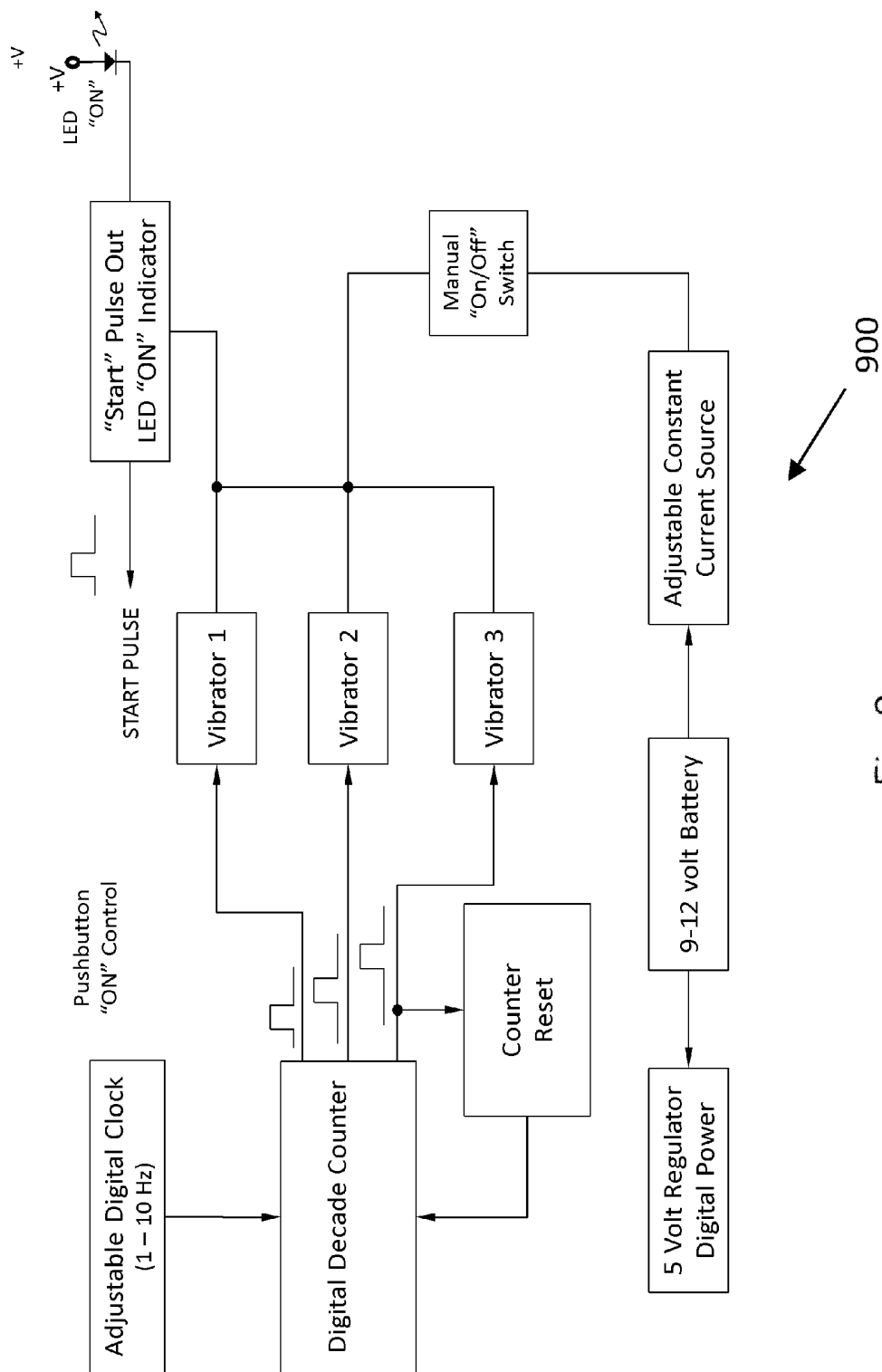


Fig. 9

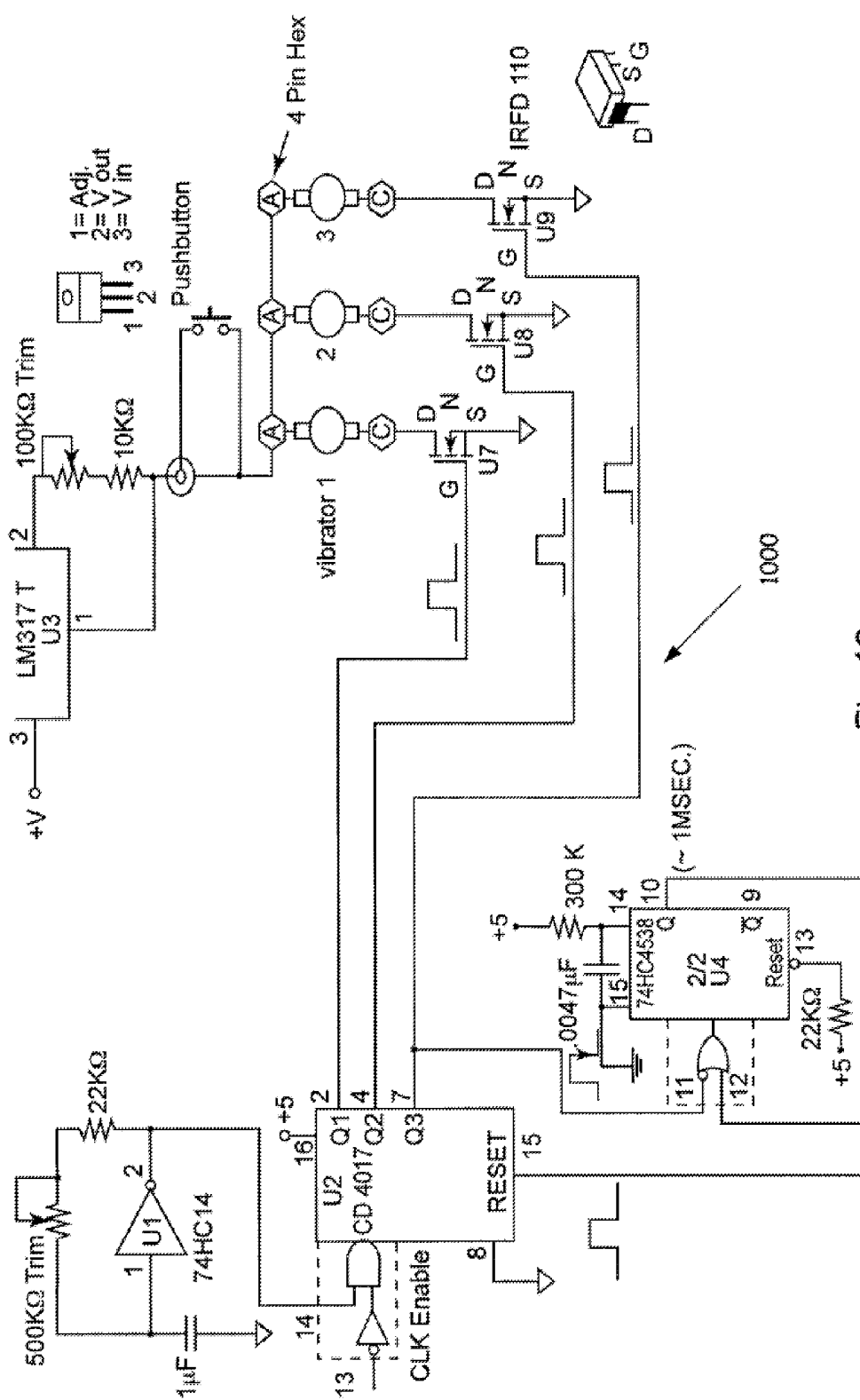


Fig. 10

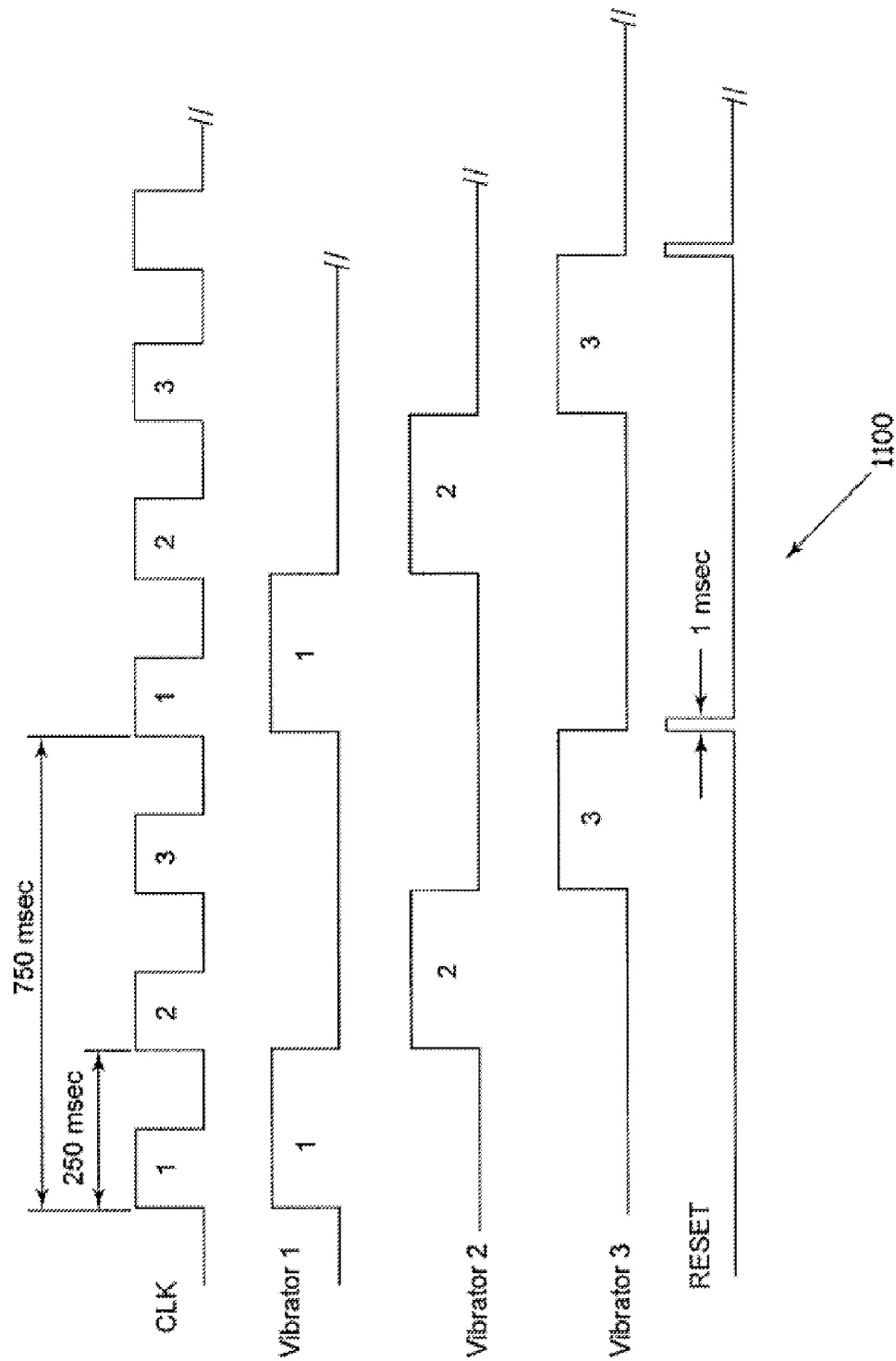
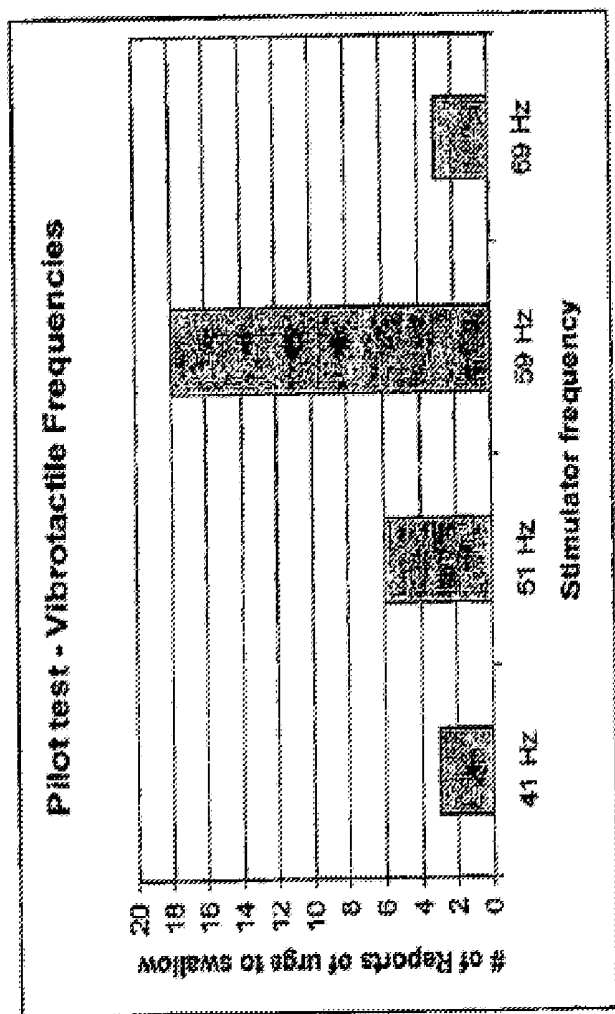
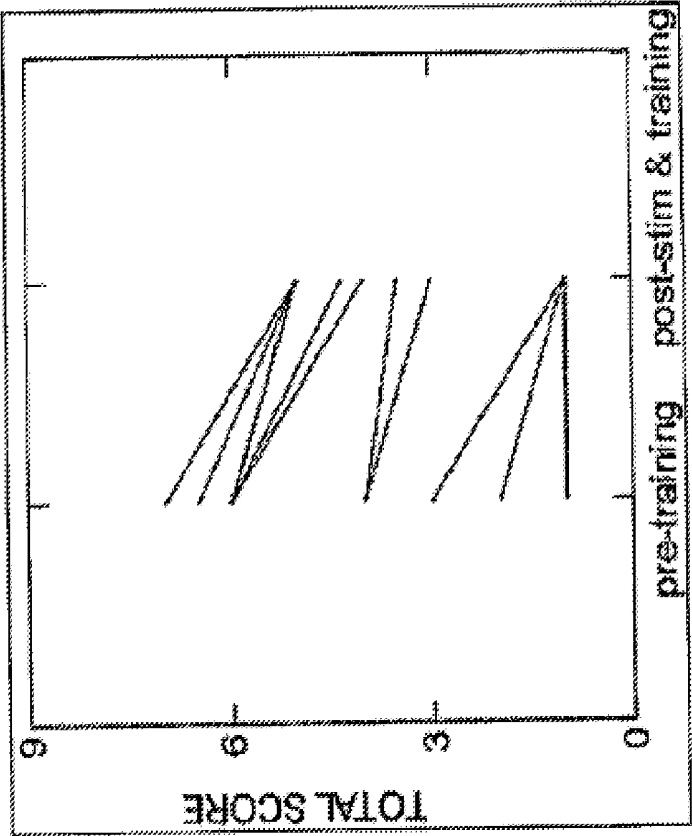


Fig. 11



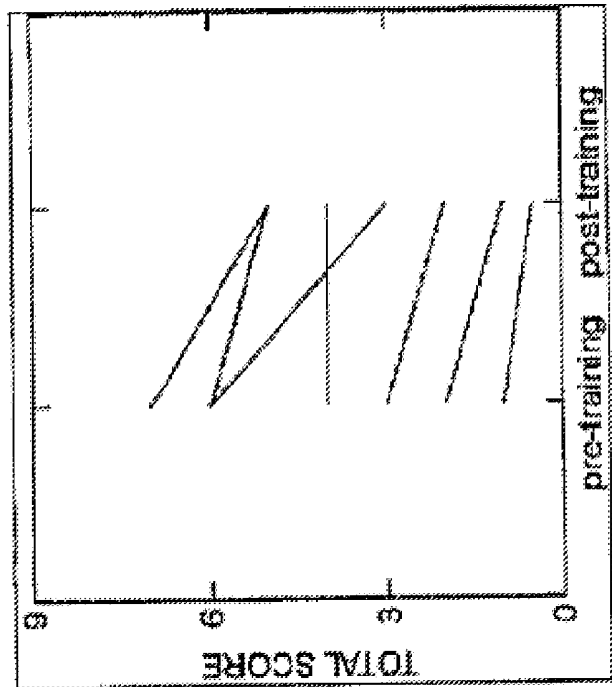
1300

Fig. 13



$t=6.285, p\leq 0.00025$

Fig. 14



$t=3.33, p=.0025$

Fig. 15

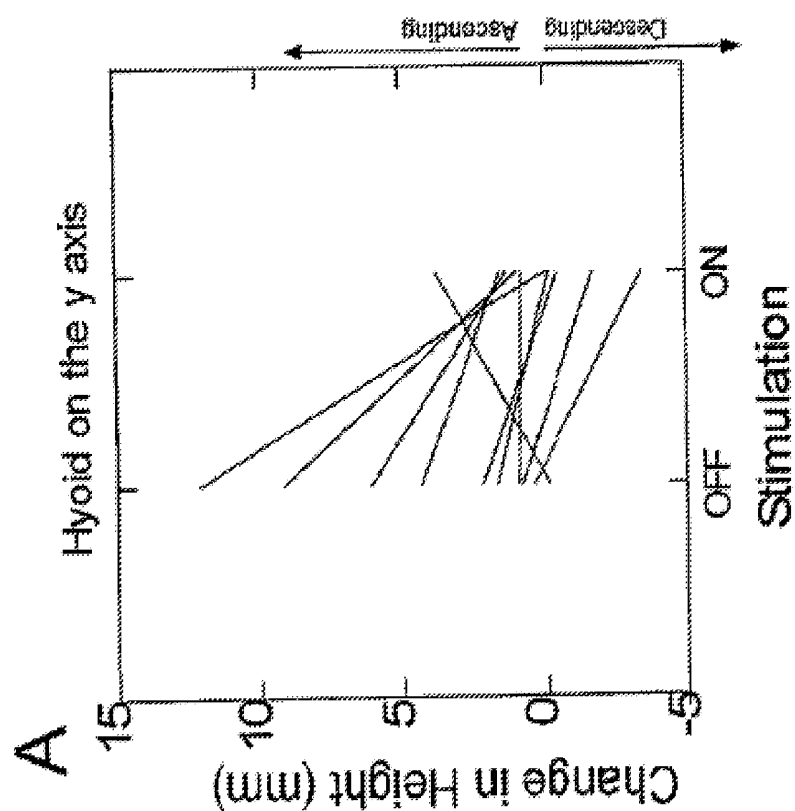


Fig. 16

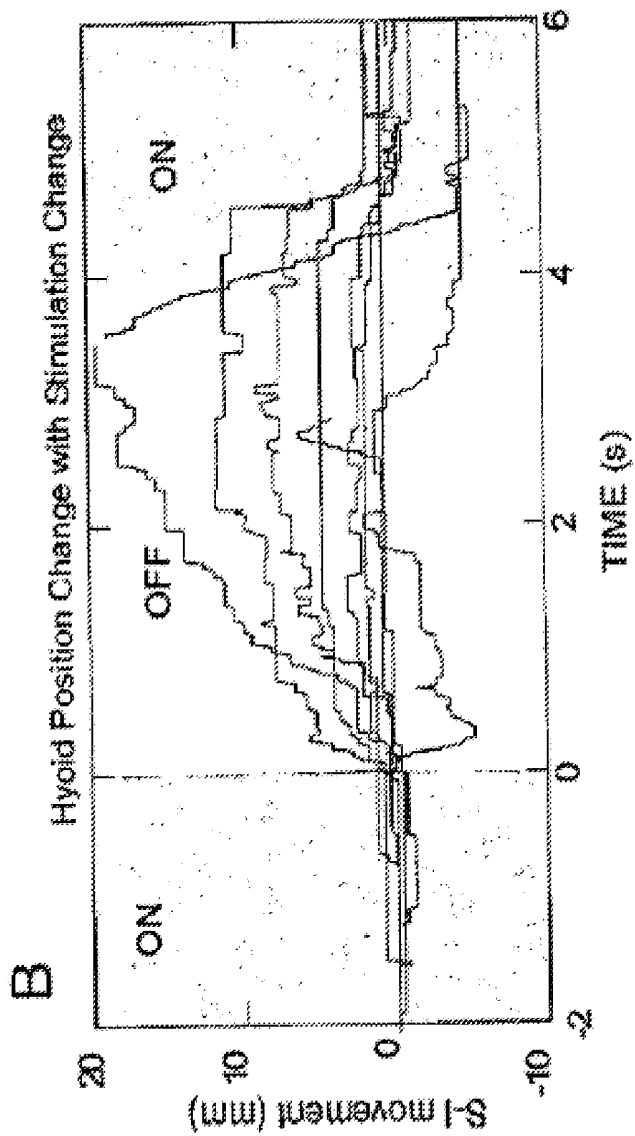


Fig. 17

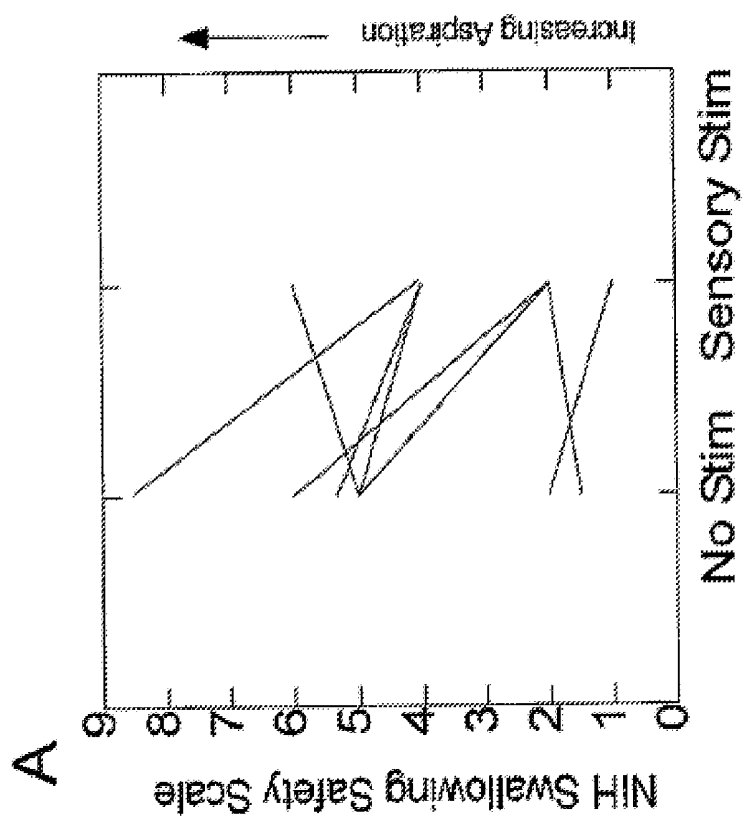


Fig. 18

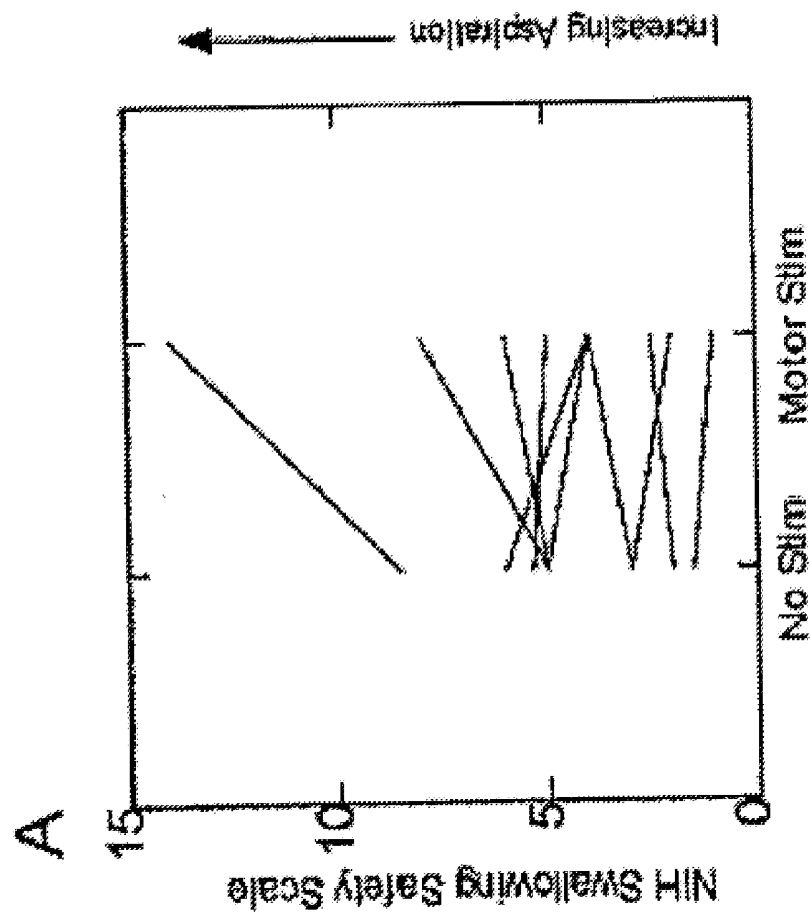


Fig. 19

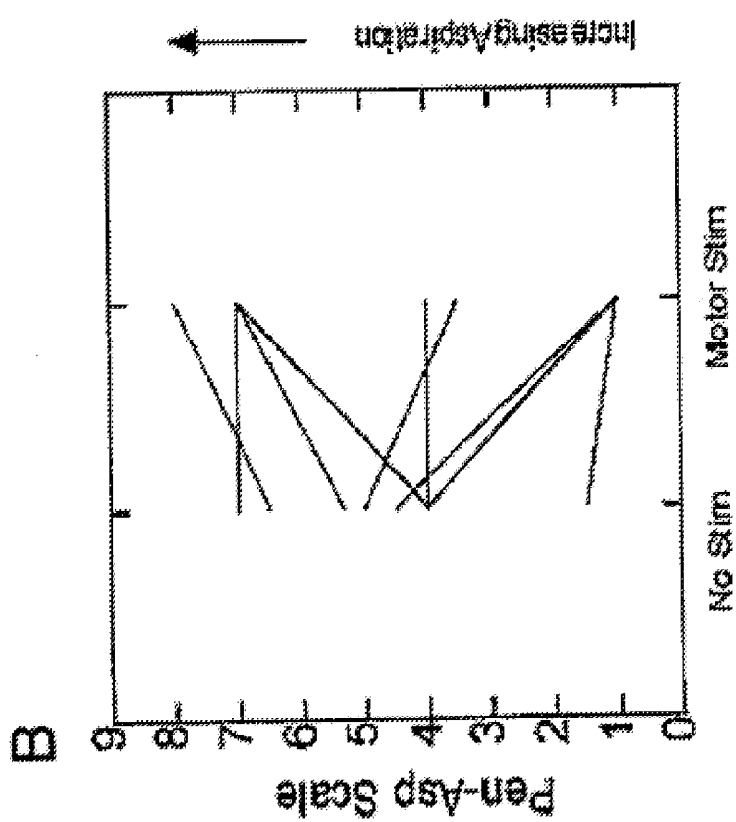


Fig. 20

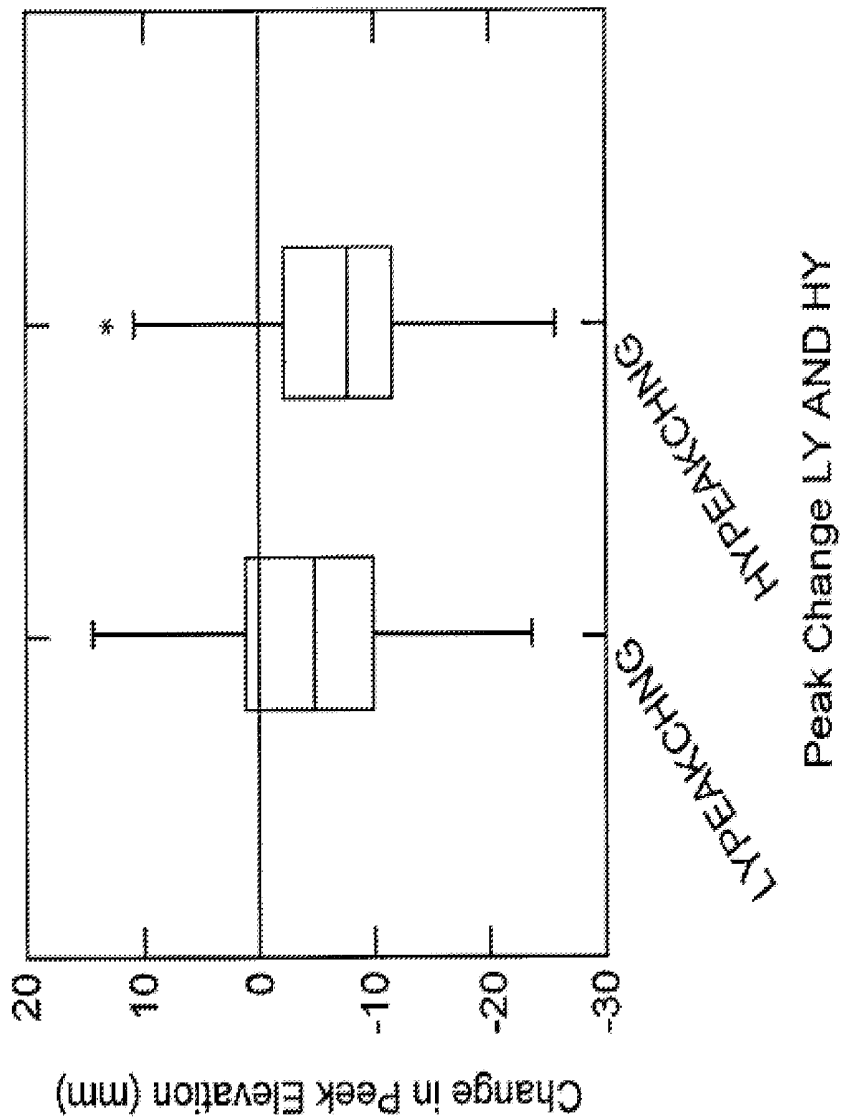


Fig. 21

SYSTEMS AND METHODS FOR RECOVERY FROM MOTOR CONTROL VIA STIMULATION TO A SUBSTITUTED SITE TO AN AFFECTED AREA

CROSS-REFERENCE TO RELATED APPLICATIONS AND INCORPORATION DATA

[0001] This application is a continuation of U.S. patent application Ser. No. 12/211,633, filed Sep. 16, 2008, issuing on Mar. 5, 2013 as U.S. Pat. No. 8,388,561, which is hereby incorporated by reference in its entirety. U.S. patent application Ser. No. 11/993,094, filed Dec. 19, 2007, PCT Patent App. No. PCT/US2006/025535, filed Jun. 30, 2006, U.S. Prov. Patent App. Ser. No. 60/695,424, filed Jul. 1, 2005, U.S. Prov. Patent App. Ser. No. 60/787,215, filed Mar. 30, 2006, and PCT Patent App. No. PCT/US2007/007993, filed Mar. 30, 2007, are all hereby incorporated by reference.

STATEMENT OF RIGHTS TO INVENTION MADE UNDER FEDERALLY SPONSORED RESEARCH AND DEVELOPMENT

[0002] The work performed during the development of this application utilized support from the National Institutes of Health. The United States government has certain rights in the invention.

TECHNICAL FIELD

[0003] The present disclosure relates generally to systems and methods for treating and managing neurological disease comorbidities. More specifically, the present disclosure relates generally to systems and methods for treating and managing diseases and disorders affecting the muscles of the neck and/or pharynx.

BACKGROUND

[0004] A wide range of neurological diseases and disorders exist that are not well addressed by present medical technology. Among these, dysphagia (a swallowing disorder that affects the central nervous system thereby weakening neuromuscular control and effectively reducing the ability to properly swallow) is a particularly life threatening disorder placing persons at risk of aspiration pneumonia. Patients at risk of aspiration pneumonia have a 17% survival rate over three years (Pick et al., 1996). Estimates are that over 7 million persons in the U.S. have dysphagia as a result of neurological diseases or disorders such as stroke, traumatic brain injury, brain tumors, Parkinson's disease, multiple sclerosis (Humbert, Lynch and Ludlow, in preparation 2008) and other neurological diseases and over 300,000 persons develop a swallowing disorder as a result of a neurological disease or disorder in the United States each year. Over 50% of patients with neurological diseases or disorders are at risk of aspiration pneumonia because of loss of central nervous system control of their swallowing resulting in either delayed or reduced elevation of the hyolaryngeal complex, which does not allow them to prevent food or liquid from entering the airway (Lundy et al., 1999). Normally the hyoid and larynx are raised by about 20 mm during swallowing producing an inversion of the epiglottis and assisting with opening of the upper esophageal sphincter.

[0005] Frequently, patients having dysphagia require 24-hour attention to prevent aspiration and ensure that the passage of food and/or fluids, particularly saliva, into the

respiratory system is minimized. It has previously been shown that glass rod pressure stimulation to the faucial pillars in the mouth can trigger swallowing (Pommerenke, 1927) while chemical blocks of laryngeal sensation severely impair volitional swallowing in normal adults (Jafari, Prince, Kim, & Paydarfar, 2003). Pharyngeal stimulation can initiate laryngeal closure and elevation for swallowing in animals (Jean, 1984), while laryngeal stimulation will trigger a swallow (Nishino, Tagaito, & Isono, 1996). In humans, when sensory stimulation of the oropharynx is presented during a period separate from swallowing, it enhances cortical activity in the swallowing regions (Fraser et al., 2003; Hamdy et al., 2003; M. Power et al., 2004; Lowell et al., 2008), but does not benefit subsequent swallowing in dysphagic patients (M. L. Power et al., 2006). These approaches to stimulation, however, generally involve the placement of a device or probe into the oral cavity which interferes with eating food and liquids and can alter oral sensory function in patients already having oral sensory deficits.

[0006] Accordingly, there is a need for therapeutic methods and a device for enabling those who are afflicted with dysphagia or other conditions or disorders that affect the ability to properly swallow without interfering with oral function or altering oral sensory function.

SUMMARY

[0007] A device and methods for treating a subject with dysphagia or other neurological disease, neurological disorder, neurological injury, neurological impairment or neurodegenerative disease that affects voluntary motor control of the hyoid, pharynx, larynx, oropharyngeal area, is disclosed. The device and methods of the invention can also be used to treat a subject with a speech disorder.

[0008] A device of the invention generally comprises a vibrotactile stimulator for applying at least one stimulus to the outside surface of a subject's neck. The at least one stimulus comprises a vibrational stimulus, an auditory stimulus, a temperature stimulus, a visual stimulus, an olfactory stimulus, a gustatory stimulus, or a combination thereof. The vibrotactile stimulator comprises at least a vibrational transducer; a manual stimulation module to manually engage the vibrational transducer; an automatic stimulation module to automatically engage the vibrational transducer; and a manual counter and/or an automatic counter for determining the number of times the manual stimulation module and/or the automatic stimulation module is engaged.

[0009] In an embodiment, the vibrational transducer produces a wave having a frequency of about 50 Hz to about 70 Hz. In certain embodiments, the vibrational transducer produces a wave having a frequency of 59 Hz. In an embodiment, the automatic stimulation module comprises an automatic timer. The automatic timer can include an automatic clock to initiate the onset of the automatic stimulation module; an adjustable clock to initiate the automatic stimulation module at an adjustable interval of about 0.5 s to about 30 minutes; and an adjustable timer that allows for setting the duration of stimulation of about 100 ms to about 10 s.

[0010] A device of the invention also generally comprises a connector for attaching the vibrotactile stimulator to an outside surface of the subject's neck. The connector can be adjusted by an adjustment mechanism for positioning a contact section of the vibrotactile stimulator substantially over the subject's larynx. A device of the invention also generally comprises a switch control communicatively connected to the

vibrotactile stimulator to selectively engage the manual stimulation module and the automatic stimulation module.

[0011] A device of the invention can also include one or more physiological sensors electrically coupled to the vibrotactile stimulator; a swallowing receptor comprising a piezoelectric stretch receptor; a battery, contained within the vibrotactile stimulator, acting as a power supply for the device; and a control box for selecting one or more of the stimulus mode, stimulus type, stimulus rate, and stimulus amplitude. The physiological sensors can include movement sensors, temperature sensors, skin color sensors, hematocrit sensors, oxygenation sensors, and blood pressure sensors. In one example embodiment, a swallowing receptor comprises a piezoelectric accelerometric movement sensor.

[0012] A device of the invention can also include a digital clock generator for producing an initial clock signal having a first frequency range; a digital decade counter for receiving the initial clock signal and producing sequential pulses having a second frequency range; and a motor responsive to the sequential pulses for producing vibrations on the subject's larynx, having a third frequency range. In an embodiment, the initial clock signal is adjustable and comprises a frequency. In an embodiment, the frequency of the clock signal comprises about one signal every 3 minutes to about one signal every 30 minutes. In an embodiment, the second frequency range is about 1 Hz to about 10 Hz, or about 20 Hz to about 75 Hz, or about 30 Hz to about 60 Hz with durations of about 10 ms to 500 ms. In an embodiment, the third frequency range is about 15 to about 200 Hz or between about 20 and about 100 Hz. The motor can include a planetary gearbox. In an embodiment, the motor produces a vibrational frequency of about 50 Hz to about 70 Hz.

[0013] Methods for treating a subject with dysphagia or other neurological disease, neurological disorder, neurological injury, neurological impairment or neurodegenerative disease that affects voluntary motor control of the hyoid, pharynx, larynx, oropharyngeal area, or hyolaryngeal complex disorder with a device of the invention is also disclosed. The methods of the invention can also be used to treat a subject with a speech disorder.

[0014] In one aspect, methods for inducing a swallowing reflex in a subject to prevent drooling and/or aspiration of the subject's own secretions are disclosed. The secretions can be saliva and/or mucus. The methods generally comprise applying a device of the invention to an outside surface of the subject's neck substantially over the subject's larynx and configuring an automatic timer to activate the vibrotactile stimulator to induce the swallowing reflex. In an embodiment, activation of the vibrotactile stimulator produces vibrations at a frequency of about 40 Hz to about 70 Hz and applies pressure of about 1 psi to about 14 psi to the subject's neck during an onset period. In an embodiment, the onset period comprises about 10 ms to about 1.5 s, about 50 ms to about 750 ms, or about 100 ms to about 500 ms. In an embodiment, an automatic timer of the device of the invention is configured to activate the vibrotactile stimulator at an interval of about once every 3 minutes to about once every 30 minutes.

[0015] In another aspect, methods for identifying a subject at risk of aspiration from their own secretions are disclosed. The methods generally comprise applying a device of the invention to an outside surface of the subject's neck substantially over the subject's larynx; downloading data from the vibrotactile stimulator after a period of use of the device by the subject; and analyzing to data to determine if the subject

is at risk of aspiration from their own secretions. The subject activates the device to induce volitional swallowing and the device records the data to allow a health professional to determine if the subject is at risk.

[0016] In yet another aspect, methods for monitoring patient compliance with a training or therapy regime are disclosed. The methods generally comprise applying a device of claim 1 to an outside surface of the patient's neck substantially over the patient's larynx, wherein the patient activates the device to induce volitional swallowing; downloading data from the vibrotactile stimulator after a period of use of the device by the patient; and analyzing to data to determine the patient's compliance with the training or therapy regime.

BRIEF DESCRIPTION OF THE DRAWINGS

[0017] FIG. 1 is an example system incorporating a device for use in volitional swallowing retraining.

[0018] FIG. 2 is an example diagram illustrating the neural circuitry involved in the concurrent use of hand control and substitute sensory stimulation to enhance volitional swallowing.

[0019] FIG. 3 is a graph depicting conceptualization of events post brain injury.

[0020] FIG. 4 is a general block diagram of a vibrotactile stimulator according to principles of the present disclosure.

[0021] FIG. 5 is a more detailed block diagram of the vibrotactile stimulator of FIG. 4.

[0022] FIG. 6a is an example circuit diagram of the vibrotactile stimulator of FIG. 5 including a manual and an automatic counter.

[0023] FIG. 6b is an example circuit diagram of the vibrotactile stimulator of FIG. 5 without a manual and an automatic counter.

[0024] FIG. 7 is an example automatic timer circuit block diagram.

[0025] FIG. 8a is example circuit diagram of the automatic timer circuit as shown in FIG. 7.

[0026] FIG. 8b is an alternative example circuit diagram of the automatic timer circuit as shown in FIG. 7.

[0027] FIG. 9 is an alternative embodiment of a vibrotactile stimulator of the present disclosure.

[0028] FIG. 10 is an example circuit diagram of the vibrotactile stimulator shown in FIG. 9.

[0029] FIG. 11 is a diagram depicting a clock based sequential vibrator control as implemented with the vibrotactile stimulator of FIG. 9.

[0030] FIG. 12 is a diagram of the controller box for the vibrotactile stimulator as shown in FIG. 9.

[0031] FIG. 13 is a plot illustrating that vibratory stimulation to the skin over the throat at about 59 Hz produces the most frequent reports of an urge to swallow.

[0032] FIG. 14 is a graph showing individual patient pre-training baseline Total Score without stimulation or button press training representing the degree of risk of aspiration during swallowing and post-training Total Score following button press training for coordinating swallowing with intramuscular stimulation. An increased score represents a greater risk of aspiration during swallowing.

[0033] FIG. 15 is a graph showing individual patient pre-training baseline swallowing NIH safety score at baseline before button press training (an increased score represents a greater risk of aspiration during swallowing and post-training). Total Score following button press training for coordi-

nating swallowing. FIG. 15 shows that button press training alone can improve swallowing safety as the Total Score reduced significantly.

[0034] FIG. 16 shows post training mean values for each participant during off and on stimulation conditions. Lowering of the hyoid position on the y axis in the neck is shown with high levels of electrical stimulation on the neck.

[0035] FIG. 17 depicts the traces of hyoid position during high electrical stimulation “on”, then stimulation turned “off” followed by stimulation “on” for each of the participants in the study. High levels of electrical stimulation on the throat area lowers the hyoid bone when stimulation is “ON.” The hyoid is only able to return to a normal position in the neck when stimulation is “OFF”. Because of this action, high motor levels of electrical stimulation interfere with the usual elevation of the hyoid bone which is required for swallowing.

[0036] FIG. 18 is a presentation of individual patient reductions in aspiration seen in comparison with swallowing without stimulation versus swallowing with low levels of electrical stimulation at approximately 2 milliamps (mA) applied on the throat. This shows that sensory levels of stimulation enhance swallowing safety.

[0037] FIG. 19 shows a line graph showing individual participants rating during the stimulated and non-stimulated swallows at motor levels of stimulation on the NIH Swallowing Safety Scale. This graph is auto scaled to the range of the data in the condition. Therefore FIG. 19 is on a larger scale than FIG. 20. FIG. 19 shows that high motor levels of electrical stimulation (>8 mA) do not benefit swallowing in some patients with swallowing disorders.

[0038] FIG. 20 shows a line graph showing individual participant ratings during stimulated and non-stimulated swallows at motor levels of stimulation on the NIH Penetration-Aspiration scale (Rosenbek et al., 1996). FIG. 20 is auto scaled to the range of the data in the condition. Therefore the FIG. 16 is on a larger scale than FIG. 20. FIG. 20 shows that high motor levels (>8 mA) of stimulation do not benefit swallowing.

[0039] FIG. 21 is a plot of measured peak elevation of the larynx (LYPEAKCHNG) and the peak elevation of the hyoid bone during swallowing (HYPEAKCHNG) in normal volunteers from Humbert et al. (2006) with electrical surface neuromuscular stimulation demonstrating that motor levels of surface electrical stimulation (8 mA or greater) reduce hyolaryngeal elevation during swallowing in healthy adults.

DETAILED DESCRIPTION

[0040] The present disclosure relates generally to systems and methods for treating and managing neurological disease co-morbidities and disorders affecting the volitional control of muscles that are involved in raising and lowering the hyoid/larynx and/or pharynx in the neck. Systems and methods that produce deglutition stimulation and vocalization stimulation and/or combinations of these are disclosed. In general, these types of stimulation may be volitionally coordinated and controlled electrically, mechanically, chemically or biologically. For example, in accordance with principles of the present disclosure, the combined use of button press training with simultaneous vibratory pressure stimulation on the neck region of the larynx is employed to facilitate voluntary control of swallowing. This method and systems of the disclosure are particularly useful for treating and managing subjects having dysphagia.

[0041] Others have attempted providing stimulation to areas that are reduced in sensory function to enhance swallowing in patients with dysphagia (Park, O'Neill, & Martin, 1997), and in normal volunteers (Theurer, Bihari, Barr, & Martin, 2005). For example, the device disclosed by Theurer et al. requires that a dental plate be constructed and placed over the lower teeth. This device interferes with mouth closing and therefore makes it difficult for patients to control liquid in their mouth. Electrical stimulation of the faucial pillars in the mouth requires a probe to be placed in the mouth, making it impossible for patients to swallow such that this method can only be used at a time separate from asking the patient to swallow (Fraser et al., 2003; Hamdy et al., 2003; M. Power et al., 2004). Therefore, placement of devices into the oral cavity is not optimal as such devices will interfere with eating food and liquids and alter the oral sensory function in patients (Theurer, Bihari, Barr, & Martin, 2005) who already have oropharyngeal sensory deficits (Hagg & Larsson, 2004; Aviv, Sacco, Mohr et al., 1997; Setzen et al., 2003).

[0042] One important aspect of the present disclosure is that the device of the invention is applied to an exterior surface of the throat area and not inside the mouth or the pharynx. A device placed inside the mouth or the oropharynx will interfere with eating. For example, the device disclosed by Park et al., (Park, O'Neill, & Martin, 1997) covers the mucosa in part of the mouth or the roof of the mouth thereby interfering with normal sensation for controlling the movement of the food or liquid in the mouth using sensory feedback between the tongue and the roof of the mouth.

[0043] Many patients with dysphagia already have oral sensory deficits (Logemann, 1993; Logemann et al., 1995). Providing stimulation to regions that are already impaired in sensation can be expected to provide less sensory facilitation of volitional and reflexive swallowing than sensory stimulation to unaffected areas. Therefore, the present disclosure is aimed at providing simultaneous sensory facilitation to areas unaffected by sensory deficits such as the skin overlying the throat area and the vibratory sensors in the musculature and cartilages in the throat area and the thyroid cartilage in particular. Vibratory stimulation of the thyroid cartilage and the sternothyroid muscle has already been shown to have powerful effects on voice (Loucks, Poletto, Saxon, & Ludlow, 2005). The methods and systems of the present disclosure differ from other previous approaches in that the patient initiates the stimulation themselves immediately prior to swallowing and such stimulation is to an area that will not interfere with oral and pharyngeal movement and sensation during swallowing.

A. Stimulator Systems and Devices

[0044] Referring now to FIG. 1, an example system 100 incorporating a device in accordance with the principles of the present disclosure is shown. More specifically, FIG. 1 depicts a device for treating dysphagia or a speech disorder. For example, in general, a band 101 may be wrapped around the neck for dysphagia treatment. The band 101 may include a vibrator 102 such that the vibrator 102 may be positioned over the larynx to provide sensory stimulation. In certain embodiments, a designated contact section 120 of the vibrator 102 is positioned to be in contact with the outside of a subject's throat over the larynx. Additionally, the band 101 can include an adjustment mechanism 125 for tailorable positioning of the contact section 120 over the subject's larynx. Upon activation of an actuator 103, such as a button, switch or other

equivalent actuator communicatively connected to vibrator 102, on a utensil 104, such as a spoon, fork, or knife, held by the subject 105, the vibrator 102 is engaged and transmits vibrational energy to the throat and the larynx. Actuator 103 can be covered when not in use. In an embodiment, actuator 103 may be a button in a small cover that is reversibly slid over the top of a spoon handle or spoon handle shaped mount. Alternatively, the actuator 103 can be independent of the utensil. Thus, in one embodiment, actuator 103 is a remote switch that may or may not be physically connected to the stimulating device.

[0045] In certain embodiments, a device to control one or more vibrator operating can be provided. For example, a control box (not shown) having appropriate switches, knobs, or dials can be provided to set a stimulus type, a stimulus rate (set or increasing) and/or a stimulus amplitude (set or increasing). Additionally, the control box can include features to determine stimulus duration. For example, the control box can be configured to allow for stimulation for a specific duration of time upon activation of actuator 103 or as long as actuator 103 is depressed. In one example embodiment the duration of stimulation is about 6 seconds to about 25 seconds.

[0046] Referring still to FIG. 1, instructions can be provided to the subject 105 for practice of initiating the sensory stimulation immediately prior to the subject's 105 own initiation of a motor act such as swallowing. The initiation may be coordinated by viewing on a display screen 106 a movement feedback signal 107. The movement feedback signal 107 can be provided, for example, by a piezoelectric or pressure sensor 108 also contained in the neck wrap 101, which can be displayed on a display screen 106 when the motor movement begins. In one example embodiment, a piezoelectric accelerometric movement sensor is contained in the neck wrap 101. The signal 109 from the button 103, initiating sensory stimulation, can be presented on the same display screen 106 for the subject 105 and a trainer to observe when the actuator 103 was activated for sensory stimulation in relation to the onset of the motor act or swallow. In this manner, the subject can learn to optimize the timing of the sensory switch to occur about 600 ms to about 200 ms prior to the onset of their motor act of swallowing. It will be appreciated that actuation of the vibrator 102 via the actuator 103 may be accomplished via a hardwired connection or wireless telemetry. Similarly, communication between the movement sensor and the (display may be hardwired or by wireless telemetry to relieve the subject 105 from the hardwired devices.

[0047] Without wishing to be bound by any one theory for this embodiment, it is believed that such motor training produces concurrent brain activation due to sensory input that induces a central pattern generator in the patient's brain stem that produces the related effect of swallowing. It will be appreciated to those skilled in the art that this principle is applicable to many other neurological impairments, their associated motor act habituations and related sensory stimulations. Accordingly, the scope of the methods and systems of the present disclosure will be applicable to that a large variety of patients having various diseases and disorders.

[0048] Referring now to FIG. 2, an illustration 200 of the neural circuitry involved in the concurrent use of hand control and substitute sensory stimulation to enhance volitional swallowing is shown. More specifically, FIG. 2 illustrates the neural circuitry in using hand control 203 to trigger volitional

swallowing 204 along with simultaneous sensory stimulation 201 which goes to the cortex 202. This is implemented after button press training described above with respect to FIG. 1. Elicitation of the swallowing reflex and safety in swallowing is dependent upon sensory feedback 201 to the brain from sensory mechanoreceptors in the upper airway. If sensory input is withdrawn, persons feel that they can no longer swallow and are at significant increase of aspiration during swallowing (Jafari et al., 2003). The neural circuitry enhances cortical motor control 202 of swallowing coincident with substitution of sensory input 203 from stimulation of the throat area to trigger brain stem circuitry to trigger reflexive swallowing 204 simultaneous with volitional swallowing.

[0049] Referring now to FIG. 4, a general block diagram of a vibrotactile stimulator 400 is shown according to principles of the present disclosure. The vibrotactile stimulator 400 can be used in example system 100. In certain embodiments, the vibrotactile stimulator 400 is pressed against the outside surface of subject's throat to stimulate the larynx such that with coordination, the vibrotactile stimulator 400 can be used to enhance volitional control of swallowing.

[0050] As described previously with reference to FIG. 1, the vibrotactile stimulator 400 may be secured or connected to a connector or a band that can be subsequently wrapped around the subject's neck. In this manner, a designated contact section of the vibrotactile stimulator 400 can be positioned on the subject's neck to stimulate the throat and larynx. Additionally, the connector can include an adjustment mechanism for a fine adjustment of the contact section over the subject's larynx. In certain embodiment, the adjustment mechanism shifts the position of the vibrotactile stimulator 400 within a circle having an area of about 0.01 to about 10 cm²; about 0.25 to about 5 cm², or about 0.5 to about 2.5 cm².

[0051] In general, the vibrotactile stimulator 400 includes a manual stimulation module 410 operatively configured to allow a user to manually operate the vibrotactile stimulator 400 by pressing, or otherwise activating, an external actuator that communicatively connected to the vibrotactile stimulator 400. In general, the actuator can engage a vibrational transducer to transmit energy to a subject's larynx. In one embodiment, the actuator is a pushbutton ON switch that when pressed, or activated, energizes a vibrator motor 405 that vibrates at a desired frequency a periodic pressure wave that can transmit vibrational energy to the subject's larynx. In one embodiment, when the ON switch is released the vibration produced by the vibrator motor 405 is terminated. There is no delay between pressing the ON switch and the vibration to the throat area. In use, the manual stimulation module 410 may be engaged during activities such as eating, drinking, and swallowing to prevent aspiration with patients having dysphagia.

[0052] Additionally, in the example embodiment, the vibrotactile stimulator 400 includes an automatic stimulation module 415 operatively configured to automatically energize the vibrator motor 405. In certain embodiments, the automatic stimulation module 415 enables the subject or caregiver to programmably define vibrator motor 405 operating parameters such as duration, vibrational frequency, and amplitude. For example, the automatic stimulation module 415 can function to periodically energize the vibrator motor 405 to induce swallowing throughout the course of a day, thereby reducing saliva aspiration (and in general for saliva control) for subjects afflicted with dysphagia, for subjects with neurological disorders who have uncontrolled drooling, and for subjects with cerebral palsy who have uncontrolled drooling. In a

preferred embodiment, the automatic stimulation module **415** includes an automatic timer circuit to facilitate the periodical energizing of the vibrational motor **405**, as described in further detail below. In one aspect, the automatic timer provides for continuous practice throughout the day, which is required for rehabilitation of speech and/or swallowing disorders (Ludlow et al., 2008; Robbins et al., 2008). Automatic stimulation occurring at regular intervals of one every 3 minutes to one every 30 minutes will induce regular swallowing to eliminate drooling.

[0053] It will be appreciated to those skilled in the art that components of the vibrotactile stimulator **400** as described in the present disclosure may be implemented via hardware and/or software techniques. For example, the vibrotactile stimulator **400** may include a printed circuit board (PCB). The PCB may comprise a plurality of discrete electrical components such as transistors, capacitors, inductors, resistors and functional integrated circuitry such as a processor, a memory element, such as read-only memory (ROM) and/or random access memory (RAM), a field programmable logic array (FPGA) **1320**, and input/output circuitry.

[0054] Referring now to FIG. 5, an example vibrotactile stimulator block diagram is shown as a possible implementation of the vibrotactile stimulator of FIG. 4. In general, upon engagement of a power switch **500**, a battery **505** supplies power to a three terminal voltage regulator **510**. In the embodiment as shown, the voltage regulator **510** is used as an adjustable current source to control vibrator motor **515** vibrational frequency. In practice, this may be accomplished by utilizing an external adjustable potentiometer **520**.

[0055] Further, a switch control **525**, such as a pushbutton, switch or other equivalent actuator is provided to enable the user to selectively engage the manual stimulation module **410** or automatic stimulation module **415**. In certain embodiments the switch control **525** is communicatively connected to an external actuator such as a control box or a spoon. In the example embodiment, the switch control **525** is manipulated to electrically load a switch interface **530** such that a count select mechanism **535** is actuated. In this manner, a manual counter **540** is enabled when the user operates the vibrotactile stimulator **400** in the manual mode, and an automatic counter **545** is engaged when automatic stimulation is employed, as described further below. In a preferred embodiment, the automatic stimulation module **415** may be implemented with an automatic timer circuit such that the switch control **525** can be controlled by the automatic timer circuit to actuate the count select mechanism **535**, thereby engaging the automatic counter **545** and energizing the vibrator motor **405**.

[0056] In the example embodiment the counters **540**, **545** are internally mounted to the vibrotactile stimulator **400**. The manual counter **540** records the total number of times a subject engages the manual stimulation module **410**. In a similar manner, the automatic counter records the number of times the automatic stimulation module **415** is engaged. Subsequently, the counters **540**, **545** may be interrogated, or equivalently read, and reset manually after the total number of counts are recorded. In alternative embodiments, a wireless data interrogation using one of many technologies, such as Blue Tooth, may be performed to transfer the information to an external application. The quantitative information provided by the counters **540**, **545** may provide, for example, an investigator or caregiver quantitative information regarding patient compliance and information regarding the effectiveness of the vibrotactile stimulator **400**. As patient compliance

is generally low, around 50% (Portone et al., 2008), it is important to the rehabilitation process to identify poor compliance particularly in the management of dysphagia, a life threatening disorder. Identification of poor compliance allows the therapist to intervene to assure proper use of the device by the patient and their caregivers.

[0057] In certain embodiments, the manual counter **540** and the automatic counter **545** can be provided with their own internal power supplies so that cumulative counts are not lost when the power switch **500** is disengaged. Additionally, the vibrotactile stimulator **400** may include a low battery indicator **550** such that if the battery **505** voltage drops below a specified voltage level an indicator specifying that event is generated. In the example embodiment an LED "Low Battery" indicator **555** comes on.

[0058] Referring now to FIG. 6a, a circuit diagram **600** is shown illustrating one embodiment of a vibrotactile stimulator block diagram of FIG. 5. It will be appreciated to those skilled in the art that example circuit diagram **600** is only an example circuit architecture and that the vibrotactile stimulator **400** may be implemented via any suitable architecture. In the example embodiment both passive and discrete electrical components are chosen such that component attributes and tolerances fit a known specification. An alternative example circuit diagram **605** of the vibrotactile stimulator block diagram of FIG. 5 is shown in FIG. 6b.

[0059] Referring now to FIG. 7, a block diagram of an automatic timer circuit **700** shown. In general, the automatic timer module is communicatively connected to the vibrotactile stimulator **400** as shown in FIG. 4. As previously mentioned, the automatic timer circuit **700** may actuate the count select mechanism **535**, thereby engaging the automatic counter **545** and energizing the vibrator motor **405** for a predetermined period of time. In the example embodiment the automatic timer circuit **700** comprises of a digital oscillator **705** having an adjustable oscillating frequency of about 2.2 Hz to about 28 Hz. The output signal of the digital oscillator **705** is routed to a programmable timer **710** set to divide the periodic digital input signal by 4096. The input clock frequency from the digital oscillator **705** to the programmable timer **710** will determine when an output pulse is generated. In the example embodiment, the output pulse period may be generated in a range from about 3 to about 30 minutes. Subsequently, the programmable timer **710** output pulse triggers an adjustable monostable multivibrator **715**. An output pulse width of the adjustable monostable multivibrator **715** sets the "On" time for the vibrator motor **515** (as shown in FIG. 5) by energizing a relay through a transistor switch. In the example embodiment, the transistor switch and relay control is integral to relay module **720**. An LED **725** indicates that the relay has been activated, which is used to energize the vibrator motor **515** in the automatic mode. In an example embodiment, the selected time period may be about 5 to about 15 seconds.

[0060] In general, the automatic timer circuit **700** is powered by a battery **730** or other equivalent power source and a power switch **735**. Additionally the automatic timer circuit **700** may also include a low battery indicator **740** such that if the battery **730** voltage drops below a specified voltage level an indicator specifying that event is generated. In the example embodiment an LED "Low Battery" indicator **745** comes on. It will be appreciated that the battery **730**, the power switch **735**, the low battery indicator **740** and the LED **745** may be used to power the vibrotactile stimulator **400** as shown in FIG. 5.

[0061] Referring now to FIG. 8, a circuit diagram **800** is shown illustrating a one embodiment of the automatic timer circuit as shown in FIG. 7. It will be appreciated to those skilled in the art that example circuit diagram **800** is only an example circuit architecture and that the automatic timer circuit **700** may be implemented via any suitable electrical architecture. Additionally, in the example embodiment both passive and discrete electrical components are chosen such that component attributes and tolerances fit a known specification. An alternative example circuit diagram **805** of the automatic timer circuit as shown in FIG. 7 is shown in FIG. 8b. In certain embodiments, the manual counter **540**, the automatic counter **545**, and the automatic timer circuit **700** can be incorporated into a single functional counter and timer module that is mounted internally and communicatively connected to the vibrotactile stimulator **400**.

[0062] Referring now to FIG. 9, an alternative embodiment of a vibrotactile stimulator **900** is shown. In general, the vibrotactile stimulator **900** is a battery-powered device that sequentially activates one or more small DC vibrator motors as described herein. An adjustable digital clock can set the timing for separate events. The clock frequency can be adjusted between about 1 and about 10 Hz. This clock, in conjunction with a digital decade counter, generates sequential pulses that control the individual vibrators "On" and "Off" duration. At the end of the pulse cycle, a short reset pulse is generated to reset the decade counter and begin the next cycle of pulses.

[0063] A subject can control the vibrotactile stimulator **900** by pressing an external pushbutton "ON" switch. The switch will also activate an LED indicator light and will generate a digital pulse that can be used for coordinating various recording devices. When the button is released, the vibration pulses will stop. Preferably, there is no perceived delay between pressing the "On" switch and the first vibration to the throat.

[0064] Referring now to FIG. 10, a diagram of an example circuit **1000** of the vibrotactile stimulator **900** as shown in FIG. 9 is depicted. Additionally, FIG. 11 is a diagram **1100** depicting a clock based sequential vibrator control as implemented with the vibrotactile stimulator **900** of FIG. 9. Further still, FIG. 12 depicts a diagram of the controller box **1200** for the vibrotactile stimulator **900** as shown in FIG. 9. The controller box **1200** may set one or more vibrotactile stimulator **900** operating parameters. For example, an operating parameter may include a stimulus type, a stimulus rate (set or increasing) an amplitude (set or increasing), or a combination thereof. Additionally, the control box may be configured to allow for stimulation for a specific duration upon activation of the button or as long as the button is depressed. In an embodiment, the duration of stimulation is about 2 seconds to about 6 seconds.

[0065] Referring now to the vibrator motor as utilized in the vibrotactile stimulator **900** as shown in FIG. 9 and in the vibrotactile stimulator **400** as shown in FIG. 4. In operation, a vibrator motor vibrating frequency of about 30 Hz to about 60 Hz is particularly effective in eliciting the swallowing reflex. The vibrator motor may be a low voltage DC motor with a planetary gearbox utilized to generate the effective frequency.

[0066] In operation the gearbox reduces the output rotation per minute (RPM) to the desired range and increase the available torque. An eccentrically loaded mass is attached to the output shaft to generate the vibration. The mass weight can be changed to increase or decrease the vibration amplitude. In an

embodiment, a lightweight, sealed aluminum tube encapsulates the motor assembly. Further, in certain embodiments the vibrator motor may utilize a sleeve shaft for the output shaft. In alternative embodiments the vibrator motor may utilize a ball bearing shaft for the output shaft.

[0067] In use, one or more vibrator motors can be placed on the front of the neck over the region of the thyroid cartilage. The one or more vibrator motors may be held in place by a rigid/semi-rigid holder or one or more straps. The vibrators may be arranged on the inside of the holder to suit the neck dimensions of the individual patient/user. An elastic strap may be attached to the outside of the holder and is wrapped to attach in the back of the patient/user's neck to hold the holder in place. A small, battery powered portable box connects to the button that is pressed to drive the vibrators. In preferred embodiments, the device is supplied to the patient/user who is trained in its use by a speech-pathologist or other professional with knowledge of swallowing, speech or voice disorders.

[0068] The stimulation device of the invention can be covered by a disposable cover, such as a plastic or a cloth cover. Stimulators may be contained within a stretchable device such as a wrap with Velcro and is adjustable for individual patient bodies. Vibrator and electrical stimulators are preferably positioned close to the skin. In another embodiment, the stimulation device of the invention includes one or more sensors of physiology, such as temperature, skin color, hematocrit, oxygenation, blood pressure and the like. In an embodiment the device reports results by a display and or by electromagnetic transmission and monitors and/or records swallowing events. For example, a device of the present invention can monitor the presence (and optionally depth) of a swallowing event via a piezoelectric stretch receptor or other sensor on or in the band around the neck, and/or at the surface over the larynx. (See Holzer and Ludlow, 1996; Burnett et al, 2005).

B. Methods and Uses

[0069] The systems and devices of the invention can be used to treat a number of conditions and disorders including, but not limited to, stroke, cerebral hemorrhage, traumatic brain injury, dysphagia, post surgery to brain, Parkinson's disease, multiple sclerosis, birth defects, ALS, cerebral palsy, CNS injury, supranuclear palsy, and any other neurological disease, neurological disorder, neurological injury, neurological impairment or neurodegenerative disease that affects voluntary motor control of the hyoid, pharynx, larynx, oropharyngeal area, or hyolaryngeal complex. Neurological impairments that are contemplated include reflex actions that involve interactions between afferent and efferent paths, at the spinal cord or in the brain stem, as well as higher order interactions in the primary motor cortex of the hemispheres. The systems and methods of the present disclosure apply to patients who have lost or partially lost the ability to voluntarily control motor functions but also to patients who were born with birth defects that have prevented them from having voluntary motor control, such as cerebral palsy. The systems and methods of the present disclosure are also applicable to treating various speech motor control disorders such as stuttering and laryngeal dystonia.

[0070] The term "motor control" as used herein refers to the ability to control muscle activity at will. For instance, in one embodiment, the invention is applicable to the ability to swallow at will. Thus, patients with dysphagia, which is the complete or partial loss of the ability to swallow, can be treated

with the methods of the present invention. In an embodiment, the disease or disorder reduces or delays motor control of swallowing and/or results in delayed or reduced elevation of the hyolaryngeal complex, which does not allow the patient to prevent food or liquid from entering the airway.

[0071] The methods of the invention generally comprise stimulating a substitute site for the area with a system or device according to the invention, thereby triggering the motor control of the affected area. The term “recovering” as used herein includes within its meaning obtaining the ability to volitionally control motor functions. “Volitionally” as used herein means at the will of the patient. A “substitute site” as used herein means an area of the body that is capable of eliciting a desired reflex but is not a sensory region that is able to elicit reflex in impaired patients.

[0072] Subjects are often not responsive to stimulation in the oral and pharyngeal cavities but remain sensate to vibratory stimulation to the areas of the human head which include anatomical structures (e.g., muscles, nerves or connective tissue) that work in concert to affect deglutition. By providing sensory stimulation to sensate areas on the throat, substitute stimulation can be used to enhance the volitional elicitation of swallowing. For example, patients with dysphagia following neurological disease usually have sensory loss in the oropharyngeal area (Aviv et al., 1996; Aviv, Sacco, Mohr et al., 1997; Aviv, Sacco, Thomson et al., 1997) which is normally required to be sensate in order to elicit safe swallowing without aspiration in normal volunteers (Jafari, Prince, Kim, & Paydarfar, 2003). The present invention uses sensory triggering in “substitute sites” to enhance the elicitation of reflex and volitional swallowing, such as stimulation of afferents from the laryngeal area contained in the superior laryngeal area (Jean, 1984), (Dubner, Sessle, & Storey, 1978), (Dick, Oku, Romaniuk, & Cherniack, 1993; Ootani, Umezaki, Shin, & Murata, 1995).

[0073] Basic studies suggest that the second order neurons excited by afferents in the superior laryngeal nerve are selectively excitable at particular frequencies (Mifflin, 1997) and that stimulation around 30 Hz may be preferred for exciting the swallowing system in the brainstem (Dubner, Sessle, & Storey, 1978). Patients are often not responsive to stimulation in the oral and pharyngeal cavities but remain sensate to vibratory stimulation to the throat area including the skin and laryngeal cartilages underlying the skin. Thus, the throat is a substitute site and by providing sensory stimulation to the throat, enabling swallowing “at will” or volitional swallowing may be elicited.

[0074] The site for stimulation can be adjusted depending upon the desired motor control. One of skill in the art, such as a treating physician or other allied health professional with experience with the disease causing the motor impairment will readily understand where to locate the stimulation. In an embodiment, the affected area is the area of the body responsible for swallowing, speech, or voice. In an embodiment, the affected area is the oropharyngeal area. In an embodiment, the substitute site is the area of the throat over the larynx. In an embodiment, the recovered motor control is volitional swallowing.

[0075] By providing a vibratory stimulus to the patient’s neck area, mechanoreceptors in the skin will be activated providing feedback to the brain stem and brain to assist with triggering voluntary initiation of swallowing, speech or voice. At greater vibration amplitudes, mechanical stimulation induces movement of the thyroid cartilage and of the

extrinsic and intrinsic laryngeal muscles in the region including: the platysma, the sternohyoid, the sternothyroid, the thyrohyoid, cricothyroid and the thyroarytenoid muscles. Some of these muscles contain muscle spindles. The muscle spindle afferents can provide sensory feedback to the central nervous system to assist with triggering voluntary initiation of the muscles for swallowing, speech and voice initiation.

[0076] In one embodiment, the stimulation is asserted immediately before a volitional attempt to move or carry out the physiological impaired function, such as swallowing or speaking. In an embodiment, the stimulation comprises an onset period in which the stimulation is asserted about 1 second to about 10 seconds before, about 0.1 second to about 1 second before, about 0.2 second to about 0.5 second before, or about 0.2 second to about 0.4 second before the volitional attempt. The stimulation may also be asserted at the same time as the volitional attempt. Preferably the stimulation of the affected body part is made via a system or device according to the present disclosure before the volitional attempt.

[0077] The sensory modality for stimulation includes but is not limited to vibratory stimulation, pressure stimulation, auditory stimulation, temperature stimulation, visual stimulation, electrical stimulation, olfactory stimulation, taste stimulation, and combinations thereof. The stimulation may be controlled electrically, mechanically, chemically, biologically or by any other method known to the skilled artisan. In an embodiment, the stimulation is vibratory, tactile, pressure, or a combination thereof. In an embodiment, the stimulation is vibro-tactile. In an embodiment, vibration stimulation is combined with another stimulation, such as electrical skin surface stimulation (same timing or different).

[0078] Vibratory stimulation desirably is applied at a frequency of about 1 to about 100 Hz, about 5 to about 70 Hz, about 30 to 60 Hz, about 50 to about 60 Hz, about 55 to about 60 Hz, or about 58 to about 60 Hz. In an embodiment, the pressure and/or electrical stimulation desirably is applied at a frequency of about 50, about 51, about 52, about 53, about 54, about 55, about 56, about 57, about 58, about 59, or about 60 Hz. The amplitude of vibration preferably may be, for example, about 1 micron to about 2 mm. Amplitudes of about 100 micron to about 1 mm are useful. In an embodiment, the vibrator produces a sequential wave of pressure across bars (such as 1 to 5 oblong bars) at about 0.5 to about 30 times per second, and more preferably about 2 to about 25 times, more preferably about 5 to about 10 times per second. Desirably the pressures are about 1 psi to about 14 psi with rise times of about 2 ms to about 500 ms and more desirably rise times of about 4 to about 150 ms.

[0079] Electrical stimulation, if used, should be applied at a rate of 30 Hz at low levels of less than about 2 mA over a small area of 1 cm² or 25 mA over a large area (about 10 cm²) or greater, or less if the area is smaller (less than about 10 cm²), such as about 0.01 to about 10 mA, about 0.1 to about 7 mA, about 0.5 to about 5 mA, or about 1-3 mA to assure only sensory stimulation is occurring and not resulting in muscle contraction. Levels that do not exceed about 10 mA, about 7 mA, about 5 mA, about 4 mA, about 3 mA, and more desirably about 2 mA, are particularly useful. In an embodiment, the electrical stimulation comprises biphasic pulses (about 50 to about 300 microsecond pulses for example) of about 1 to about 5 mA of current at about 15 to about 60 Hz. When electrical stimulation is utilized care must be taken to assure that muscle contraction is not occurring as stimulation of

muscles in the throat area pull the hyoid downward and interfere with swallowing (Humbert et al., 2006; Ludlow et al., 2007).

[0080] In a preferred embodiment applicable to all stimulation types (pressure, vibration, electrical, etc) the amplitude of the stimulation (measured as energy output or more directly as electrical current or vibration displacement etc) and/or the rate of the stimulation pulse increases during the swallowing activity. In another embodiment the duration of stimulation is set to the average measured, or expected duration of the patient's swallow. In another embodiment, the stimulation lasts as long as the swallow is perceived to occur, or as long as a switch is activated. However, to prevent central adaptation to the stimulation, the stimulation will only be turned on by the patient when swallowing and will remain off when the patient is not swallowing.

[0081] As disclosed herein, the patient that can activate a system or device of the invention stimulates their throat over the larynx thereby eliciting reflex swallowing. In an embodiment, the stimulation is vibratory, tactile, pressure, or a combination thereof. In an embodiment, the stimulation is vibrotactile. In an embodiment, the patient controls the stimulation via an actuator communicatively connected to the stimulator. The vibrotactile stimulate of the system and methods of the present invention provides substitute sensation to assist with eliciting swallowing while training the patient to volitionally control swallowing to substitute for their loss of reflexive swallowing. A system according to the present invention, can train the patient to press a button, switch or other equivalent actuator communicatively connected to the stimulator immediately before wanting to swallow thereby providing an alternate sensory input via vibrotactile stimulation (or other similar sensory modalities) to the throat area to enhance volitional control of swallowing of saliva.

[0082] The swallowing retraining systems and methods of the present disclosure provides patients and their caregivers the opportunity to practice volitional swallowing early in the post extubation period. FIG. 2 illustrates the neural circuitry in using hand control **203** to trigger volitional swallowing **204** along with simultaneous sensory stimulation **201** which goes to the cortex **202**. This is implemented after button press training described above with respect to FIG. 1. Elicitation of the swallowing reflex and safety in swallowing is dependent upon sensory feedback **201** to the brain from sensory mechanoreceptors in the upper airway. If sensory input is withdrawn, persons feel that they can no longer swallow and are at significant increase of aspiration during swallowing (Jafari et al., 2003). The neural circuitry enhances cortical motor control **202** of swallowing coincident with substitution of sensory input **203** from stimulation of the throat area to trigger brain stem circuitry to trigger reflexive swallowing **204** simultaneous with volitional swallowing. By practicing motor onset with a device that provides an alternative sensory input to the brain, such as vibrotactile stimulation, the patient can regain volitional swallowing control readying them to swallow safely first with their own saliva and later to ingest small amounts of food in a controlled volitional fashion. By providing volitional control over swallowing the patient can substitute voluntary swallowing for their loss of reflexive swallowing.

[0083] The automatic timer of the systems and devices of the inventions can be used to stimulate the initiation of swallowing on a regular basis to prevent drooling and/or aspiration of the patient's own secretions. In such a configuration, a

device of the invention is not dependent upon manual activation by the patient and can be set to initiate swallowing without a user input at a predetermined or variable interval. For example, the automatic timer can be configured to initiate swallowing of saliva to prevent aspiration of secretions from drooling during sleeping. Methods for automatically stimulating swallowing on a regular basis or set interval generally comprise applying a device of the invention to an outside surface of the subject's neck substantially over the subject's larynx and configuring an automatic timer to activate the vibrotactile stimulator to induce the swallowing reflex. In an embodiment, activation of the vibrotactile stimulator produces vibrations at a frequency of about 40 Hz to about 70 Hz and applies pressure of about 1 psi to about 14 psi to the subject's neck during an onset period. In an embodiment, the onset period comprises about 10 ms to about 1.5 s, about 50 ms to about 750 ms, or about 100 ms to about 500 ms. In an embodiment, an automatic timer of the device of the invention is configured to activate the vibrotactile stimulator at an interval of about 1 to about 5 minutes.

[0084] In one embodiment, an automatic timer is configured to activate the vibrotactile stimulator once every 3 minutes to about once every 30 minutes for a durations of about 10 ms to about 20 s during which pulsed stimulation is produced at vibrations of about 1 to 300 Hz lasting about 200 ms to about 10 s to induce the swallowing reflex, wherein activation of the vibrotactile stimulator is pulsed at a particular rate and lasts for a particular interval produces vibrations at a frequency of about 40 Hz to about 70 Hz and applies pressure of about 1 psi to about 14 psi to the subject's neck during an onset period.

[0085] A device according to the present disclosure can be configured with a counter and timer system to aid in monitoring a patient's use of the device. For example, the counter and timer system can be used to determine or measure frequency of use including how often the patient uses the device, which mode the patient uses, how long and when the device is stimulated, and the like. The data generated by the counter and timer system can be used, for example, to determine compliance with a training or therapy regime. Such data can be used to modify a treatment or training program and/or can alert caretakers to a risk of drooling or aspiration of secretions due to limited use of the system.

[0086] Methods for identifying a subject at risk of aspiration from their own secretions generally comprise applying a device of the invention to an outside surface of the subject's neck substantially over the subject's larynx; downloading data from the vibrotactile stimulator after a period of use of the device by the subject; and analyzing to data to determine if the subject is at risk of aspiration from their own secretions due to limited use. The subject activates the device to induce volitional swallowing and the device records the data to allow a health professional to determine if the subject is at risk, due to limited use.

[0087] Methods for monitoring patient compliance with a training or therapy regime generally comprise applying a device of claim **1** to an outside surface of the patient's neck substantially over the patient's larynx, wherein the patient activates the device to induce volitional swallowing; downloading data from the vibrotactile stimulator after a period of use of the device by the patient; and analyzing to data to determine the patient's compliance with the training or therapy regime.

[0088] For dysphagia treatment, a band may be wrapped around the neck, with an inflatable balloon(s) positioned over the larynx. Upon activation (e.g. by a switch, such as a button) by the user (one who wears the device, or under orders from the wearer) the balloon inflates and puts pressure on the larynx. A controller box is contemplated that may be set to the stimulus type, the stimulus rate (set or increasing) and amplitude (set or increasing) parameters and whether the duration would be set or stay for 2 to 6 seconds or as long as the button is pressed. In an embodiment, the device that stimulates the substitute site is a pressure applying device that attaches to the body by, for example, a Velcro, strap, rubber band, belt, bandage, garment, ace bandage, wire, string, piezoelectric band or film, and/or combination of these or by any other method known in the art.

[0089] For instance, the stimulating device may include a contact pressure builder such as a balloon, inflatable tube that inflates to a desired pressure or volume. The art of blood pressure monitors includes devices and methods that may be used as part of the device of the present invention. Preferably a neck wrap is used that positions the pressure applying device to the throat area above the larynx and is adjustable via VELCRO® or any other adjustment means. A small point such as an area as small as about 0.02 square centimeter on the throat over the larynx may be pressed, although larger areas of, for example, about 0.1 to about 10 cm², about 0.25 to about 5 cm², about 0.5 to about 2.5 cm² areas may be used. A desirable area is a 2 cm circle. In a preferred embodiment, at least about 25%, about 35%, about 50%, about 75%, about 85%, about 90%, about 98% or more of the total pressure (calculated as an integrated sum measurement of pressure times surface area) is placed on the throat over the larynx cartilage and not over surrounding muscle. In another embodiment, such selective pressure is achieved, to obtain satisfactory results. In another embodiment, vibratory energy similarly is selectively confined on the throat over the larynx versus the surrounding muscle. In some embodiment, less than about 50%, about 25, about 10%, about 5% or even less pressure is applied to neck muscles. In some embodiments, the stimulation may be cold, vibration, heat, and/or low levels of electrical stimulation capable of inducing a sensory stimulus but not high enough to induce muscle contraction, that condition or disorders or a combination thereof.

[0090] The systems and devices of the present disclosure can be used in methods for treating impairment of reflexive swallowing due to intubation. Many patients are intubated to maintain the airway for ventilation, including following loss of consciousness due to brain injury or stroke or following coronary artery bypass graft. As the patient recovers cognitive function, extubation of the endotracheal tube occurs. At this point it has been found that the swallowing reflex is reduced (de Larminat, Montravers, Dureuil, & Desmonts, 1995). FIG. 3 shows a conceptualization 300 of events post brain injury, placing patients at high risk of aspiration post extubation with tracheotomy due to reduced afferent stimulation in the upper airway and restricted oral intake, limiting return of reflexive swallowing.

[0091] There are most likely several factors contributing reduced swallowing reflex associated with intubation. First, sensory feedback from the upper airway to the brain is reduced due to changes in the sensory function of the mucosa in the upper airway possibly as a result of injury to the mucosa by the endotracheal tube, and sensory organs of nerve endings supplying those organs due to the pressure of the endotracheal

tube on the mucosa or resultant edema in the upper airway. In some patients tissue granulation/ulceration occurs when the endotracheal tube has been in place for prolonged periods (over one week). Upon extubation such patients often receive a tracheostomy to provide an adequate airway. It has been shown that during this period following extubation that the normal swallowing reflex is reduced in patients increasing their risk of aspiration of their own saliva (de Larminat, Montravers, Dureuil, & Desmonts, 1995).

[0092] In addition to loss of the swallowing reflex, when such patients have a tracheotomy, their sensory input to the upper airway is further reduced because of a lack of air flow through the hypopharynx. In addition, such patients are often placed on a restricted oral intake to prevent aspiration. As a result of their “nothing per oral” (NPO) status, such patients are not swallowing and may be fed through a nasogastric tube or long-term by enteric means for several days or weeks. All of these factors reduce reflexive swallowing. During this period, the methods of the invention can enhance volitional swallowing.

[0093] The present invention can provide volitional control for patients with motor control disorders affecting speech and voice. Persons who stutter usually have difficulty with speech initiation and have speech “blocks” when the patient undergoes a loss of volitional control over the laryngeal muscles in particular. This loss of volitional control is manifested as delay in voluntary initiation of muscle contraction or vocal fold movement or an interference due to chronic laryngeal muscle contractions or sustained vocal fold closure. Several studies have suggested that adults who stutter may have increased thresholds to kinesthetic or vibratory stimulation during speech (De Nil & Abbs, 1991). The device and methods of the present invention can enhance vibratory sensory input to persons who stutter. Recent research has shown that persons who stutter have delays in their onset of vocal fold vibration during speech. The present invention increases vibrotactile input to the central nervous system in persons who stutter thereby enhancing their volitional control for speech. When a mechanical displacement is applied to the larynx according to the methods of the invention, it stimulates proprioceptors in the strap muscles, producing a reflexive sternothyroid muscle contraction (Loucks et al., 2005). Because extrinsic laryngeal muscles have a high muscle spindle density, stretch or vibratory stimuli applied to the larynx will serve to enhance muscle activity in this region.

[0094] The present invention can provide enhanced volitional control for patients with Spasmodic Dysphonia and Laryngeal Dystonia. Spasmodic dysphonia is a laryngeal focal dystonia, which produces voice abnormalities during speech similar to stuttering. These patients have particular difficulties initiating voicing during speech (Bielamowicz & Ludlow, 2000; C. L. Ludlow, Baker, Naunton, & Hallett, 1988; C. L. Ludlow & Connor, 1987; C. L. Ludlow, Hallett, Sedory, Fujita, & Naunton, 1990) and are often slow to initiate laryngeal muscle activity and have problems maintaining vocal fold vibration during speech. Many focal dystonias have associated sensory abnormalities, with reduced cortical responses in the somatosensory area (Bara-Jimenez, Catalan, Hallett, & Gerloff, 1998; Bara-Jimenez, Shelton, Sanger, & Hallett, 2000) including spasmodic dysphonia (Haslinger et al., 2005). By providing increased vibratory stimulation to the laryngeal area according to the methods of the invention,

input to the cortical somatosensory region will enhance volitional voice control for speech in persons with spasmodic dysphonia.

[0095] In prior methods for treating stuttering, many devices have been developed to provide altered auditory input, auditory masking or delayed or frequency altered feedback of the speaker's speech to them. Examples include the Edinburgh Masker, Delayed Auditory Feedback by Phonic Ear, Pacemaster, the Casa Futura System, the Vocaltech, the Fluency Master®, and SpeechEasy®. The VocalTech® device includes a vibrator applied to the throat of the user. A microphone picks up the user's voice and then provides both an auditory feedback signal and a vibration to the throat to alter feedback during speech.

[0096] Various embodiments of the present invention differ both in concept and in function from prior systems in that the patient/user presses a button to initiate vibrotactile stimulation to aid their ability to initiate speech/voice onset. In such embodiments, the vibratory signal is initiated before the patient attempts to initiate speech and will aid in their volitional control of speech initiation. The VocalTech® device for example only detects speech after it has started and can only be triggered by the patient/user's own speech. The VocalTech® device utilizes a feedback of the patient/user's speech and no other inputs. Therefore if the patient is unable to initiate speech and/or voice, the vibratory signal cannot be initiated. The lack of initiation of the vibratory signal is further exacerbated as there is a delay between the onset of the patient's speech and the onset of the vibratory and auditory feedback. Therefore the VocalTech® device is unable to enhance the patient's ability to onset speech as it is dependent upon the speaker being able to initiate speech. In contrast, the device and the system of the present disclosure assists patients with speech initiation as the vibratory stimulus precedes the person's speech initiation by enhancing mechanical sensory input to cortical control centers for speech. Other auditory masking or delayed or frequency altered feedback devices such as SpeechEasy® also alter or delay the speaker's acoustic speech signal and also require that the speaker is able to initiate speech before the feedback can occur. Therefore these other devices differ both in concept and function from the present invention.

[0097] In one embodiment, the present invention is a portable device that can be supplied to adults who stutter and persons with dysphonia to provide stimulation before speech to enhance triggering and controlling voice onset and maintenance for speech. The device of the present disclosure can be used in everyday speaking situations. Patients could purchase the device to use in everyday life to enhance volitional control while speaking.

C. Kits

[0098] The present disclosure also relates to kits that include at least one stimulating device of the present disclosure, a container for the device, and instructions for using the device. In an embodiment, the kit comprises a device of the invention that is adapted to be placed in contact with an affected body part, such as the larynx, a container for the device, a switch activated by a patient, and instructions for using the device. The instructions desirably include at least one instruction corresponding to one or more method steps disclosed herein. In an embodiment, a power supply such as a battery is contained within the stimulating device. In an embodiment, disposable covers are included that cover the

stimulator during use. In an embodiment the stimulating device includes at least one pump that increases pressure within a chamber such as balloon(s) or tube(s). The device further may include a pressure, stretch, volume, power or other sensor to monitor pressure exerted by the device. In an embodiment the device further includes a switch for setting the amount of desired pressure or movement and/or low levels of electrical stimulation on the skin to increase sensation in the skin in the region overlying the larynx. Switches also may exist for setting frequency and or amplitude of the stimulation.

EXAMPLE

[0099] The present disclosure may be better understood with reference to the following example. This example is intended to further illustrate the invention and its underlying principles but is not intended to limit the scope of the invention. Various modifications and changes may be made to the embodiments described above without departing from the true spirit and scope of the disclosure.

Example 1

[0100] This example demonstrates that low levels of sensory stimulation to the throat area in patients with severe chronic pharyngeal dysphagia enhances their ability to swallowing safely while high levels of electrical stimulation that activate throat muscles do not enhance swallowing in these patients.

[0101] Although surface electrical stimulation has received increased attention as an adjunct to swallowing therapy in dysphagia in recent years (Freed, Freed, Chatburn, & Christian, 2001; Leelamanit, Limsakul, & Geater, 2002; Park, O'Neill, & Martin, 1997; Power et al., 2004), little is known about the effects of transcutaneous stimulation on swallowing physiology. It has been hypothesized that electrical stimulation may assist swallowing either by augmenting hyo-laryngeal elevation (Freed, Freed, Chatburn, & Christian, 2001; Leelamanit, Limsakul, & Geater, 2002) or by increasing sensory input to the central nervous system to enhance the elicitation of swallowing (Park, O'Neill, & Martin, 1997; Power et al., 2004).

[0102] When electrical stimulation is applied to the skin or oral mucosa at low current levels it activates the sensory nerve endings in the surface layers providing sensory feedback to the central nervous system. With increased current amplitude, the electric field may depolarize nerve endings in muscles lying beneath the skin surface (Loeb & Gans, 1986) and may spread with diminishing density to produce muscle contraction.

[0103] When electrodes are placed in the submental region, therefore, the current density is greatest at the skin surface, and diminishes with depth through the platysma underlying the skin and subcutaneous fat (Sobotta, 1990). Accordingly, as the current is increased in amplitude, increasingly deeper muscles may be recruited, albeit with less efficiency. Such muscles include the anterior belly of the digastric, which can either lower the mandible or pull the hyoid upward depending upon whether the mouth is held closed. Deeper still are the mylohyoid and geniohyoid muscles, which pull the hyoid bone upward and toward the mandible, respectively. These muscles are much less likely to be activated by surface stimulation, however, because of their greater depth.

[0104] Similarly when electrodes are placed on the skin overlying the thyroid cartilage in the neck, the current will be greater at the skin with less intensity to the underlying platysma muscle with further reduction to the underlying sternohyoid and omohyoid muscles (Sobotta, 1990), which pull the hyoid downward and backward towards the sternum. The electrical field strength would be even further diminished if it reaches the deeper thyrohyoid muscle, which brings the larynx and hyoid together and the sternothyroid muscle, which lowers the larynx towards the sternum. Given that the sternohyoid muscle is larger and overlies the thyrohyoid and sternothyroid, we previously found that high levels of surface electrical stimulation on the neck could pull the hyoid downward interfering with the ability of normal volunteers to raise the larynx toward the hyoid bone as occurs in normal swallowing (Humbert et al., 2006). In fact, in some healthy volunteers high intensity surface electrical stimulation reduced swallowing safety as it allowed liquid to enter the vestibule (Humbert et al., 2006).

[0105] In VitalStim® Therapy (Wijting & Freed, 2003) electrodes are simultaneously activated over the submental and laryngeal regions on the throat, with the aim of producing a simultaneous contraction of the mylohyoid in the submental region (to elevate the hyoid bone) and the thyrohyoid in the neck (to elevate the larynx to the hyoid bone). However, because these muscles lie deep beneath the anterior belly of the digastric, sternohyoid and omohyoid muscles, we hypothesized that simultaneous transcutaneous stimulation with two pairs of electrodes at rest would cause: 1) the hyoid bone to descend in the neck (due to sternohyoid muscle action); 2) the hyoid bone to move posteriorly (due to the omohyoid muscle activity); and, 3) the larynx to descend (if current activates either the sternohyoid or sternothyroid muscles). Further, we hypothesized that in severe chronic dysphagia: 4) when the same array is used at low levels of stimulation just above the sensory threshold, sufficient for sensation but without muscle activation, patients' swallowing might improve due to sensory facilitation; while 5) at higher levels required for motor stimulation, the descent of the hyoid might interfere with swallowing causing increased penetration and aspiration.

[0106] Methods

[0107] Participant selection criteria included: chronic stable pharyngeal dysphagia, at risk for aspiration for 6 months or more, a score of 21 or greater on the Mini-Mental State Examination (Folstein, Folstein, & McHugh, 1975), a severely restricted diet and/or receiving nutrition through enteric feeding, and medically stable at the time of the study. To be included for study, all participants had to demonstrate a risk of aspiration for liquids on videofluoroscopy during the screening portion of the study.

[0108] Procedures

[0109] Participants were administered informed consent, and had to correctly answer 10 questions to demonstrate that they understood the content of the consent before participating. VitalStim® electrodes (Chattanooga Group, Hixson, Tenn., #59000) and the VitalStim® Dual Channel Unit were used for the study. Two sets of electrodes were used; the top set was placed horizontally in the submental region over the region of the mylohyoid muscle above the hyoid bone (FIG. 16). The bottom set was placed on the skin over the thyroid cartilage on either side of the midline over the region of the thyrohyoid muscle medial to the sternocleidomastoid muscle. This electrode array was recommended as effective during certification training of the first two authors (Wijting & Freed,

2003). A ball bearing with a diameter of 19 mm was taped to the side of the neck for measurement calibration.

[0110] After familiarizing the participant with the device, the sensory threshold, which was the lowest current level at which the participant reported a "tingling" sensation on the skin, was identified. Stimulation at the sensory threshold level did not produce movement on videofluoroscopic recordings and was the lowest level at which participants sensed the stimulation on the skin. Movement was first observed when participants first reported a "tugging" sensation, usually around 7 or 8 mA. The maximum motor level was the highest current level a participant could tolerate without discomfort during stimulation on the neck. The sensory and motor levels independently for each set of electrodes was determined. The VitalStim® device cycles automatically from "on" to "off" to "on" again for 1 second every minute. Because the change in stimulation is ramped, this cycling process takes up to 4 s. For the stimulation at rest trials, the participant was told to keep their teeth clenched to prevent jaw opening and the stimulation was simultaneously set at the maximum tolerated levels for both sets of electrodes. When the stimulation duration reached 55 s, videofluoroscopy was turned on and we recorded the fluoroscopic image on S-VHS videotape while the participant was in the resting position and the device automatically cycled from "on", to "off" and then "on" again. The examiner pressed a button at the time of stimulation offset to place a visible marker on the videotape.

[0111] During the videofluoroscopic screening examination, we determined which volume, either a 5 or 10 ml of liquid barium bolus, was more challenging and put a participant at risk of aspiration for use during testing. During testing, between one and three swallows were recorded in each of the following conditions in random order: 1) with no stimulation, 2) with both electrode sets on at the sensory threshold level and 3) with both sets at the maximum tolerated stimulation level. Stimulation remained on before, during and after the stimulated swallows. The videotaped recordings included an auditory channel for documentation and a frame counter display for identifying when stimulation changed.

[0112] Because radiation exposure during this study was administered for research purposes only and was not for necessary medical care, the Radiation Safety Committee limited us to a short exposure time per participant for the total study. Therefore, depending on radiation exposure time in each part of the study, we were only able to conduct between one and three trials per condition in addition to stimulation at rest for each of the participants.

[0113] Movement Analysis

[0114] The video of each trial was captured off-line using Peak Motus 8, a 2D motion measurement system (ViconPeak, Centennial, Colo. 80112). The system was equipped with a video capture board at -60 fields/s (-30 frames/s) and a frame size of 608x456 pixels. The radius of the ball bearing (9.5 mm) was used for all measurement calibrations in the horizontal and vertical directions. An investigator used a cursor to identify the points on the most anterior-inferior corner of the second and fourth vertebra on each video frame and a straight line was drawn between these two points to define the y axis. When either the second or fourth vertebra was not visible, the bottom anterior-inferior corner of the first and third vertebrae were used in the same fashion. A line perpendicular to the y axis at the anterior-inferior corner of the lower vertebra served as the x axis. The x and y coordinates for all points were determined in mm relative to the anterior-inferior corner

of the second vertebra serving as the origin with anterior and superior points being positive and posterior and inferior points being negative for direction of movement of the hyoid. Four points were marked for each frame, the anterior-inferior points of the two interspersed vertebrae, the anterior inferior point of the hyoid bone and the most posterior and superior point in the subglottal air column (to track the position of the larynx).

[0115] The time series plots of the x and y points of the hyoid bone and the y coordinate of the larynx were exported from Peak Modus into Microsoft Excel and then into Systat 11 (Systat Software, Inc., Richmond, Calif.) for analysis. The frame when the stimulation cycled from “on” to “off” was added to the file and used to sort measures into stimulation “on” and stimulation “off”. All of the position data were then corrected to place the starting position at zero on both the x and y axes for each subject and then the mean hyoid (x,y) and larynx (y) positions were computed for the stimulation “on” and stimulation “off” conditions for each subject.

[0116] Dysphagia Ratings

[0117] Four experienced certified speech pathologists initially examined the screening videotapes of randomly selected subjects to decide on a rating system. After assessing several swallows with the Rosenbek Penetration-Aspiration Scale (Rosenbek, Robbins, Roecker, Coyle, & Wood, 1996) (Pen-Asp) it was noted that many of the participants who were on enteric feeding because of their risk of aspiration could score within the normal range, a score of 1 on this scale. This occurred when no penetration or aspiration occurred even though there was severe residual pooling in the pyriform sinuses and none of the bolus entered the esophagus. These participants regurgitated any residual material back into the mouth after a trial, not swallowing any of the liquid but scoring as normal because no material entered the airway. Because scores of 1 on the Pen-Asp scale were at ceiling (normal) and would not allow measurement of improvement, this scale could only measure a worsening in swallowing in these patients. Therefore, another scale was developed that did not have a ceiling effect.

[0118] The NIH Swallowing Safety Scale (SSS) captured the abnormalities seen in this patient group, which involved pooling and a lack of esophageal entry with and without penetration and aspiration. When scoring a swallow, a score of 1 was assigned for the occurrence of each the following abnormalities: pooling in the vallecula, penetration into the vestibule from the hypopharynx, pooling in the pyriform, and back up penetration from the pyriform into the laryngeal vestibule. The amount of the bolus material entering and clearing from the upper esophagus was rated as 3 if none entered, 2 if a minimal amount entered, 1 if a moderate amount entered and 0 if all of the bolus was cleared through the upper esophagus. In addition, the total number of aspirations in each swallowing sample were counted. Only normal swallows received a total of 0 on this scale and the maximum score could reach as high as 13 depending upon the number of aspirations or other abnormalities in bolus flow that occurred in a single swallow.

[0119] All four speech pathologists viewed each videofluoroscopic recording without knowledge of condition and came to a consensus on all noted behaviors and the Pen-Asp rating before assigning the scores. After repeating ratings on 21 trials to establish reliability, differences in ratings of the same swallow were noted and a set of uniform rules were developed to be followed in assigning scores. These rules were subse-

quently used to assign ratings to each of the trials in this study. Another set of 18 trials was then repeated to determine the measurement reliability.

[0120] Statistical Analyses

[0121] To determine the reliability of the position measures, two examiners measured the position for the hyoid on the x and y axes and larynx on the y axis on each frame and then computed means for each during both the stimulated and non-stimulated conditions on 4 of the 10 subjects. The output of the General Linear Model Systat 11 (Systat Software, Inc., Richmond, Calif.) was used to calculate the mean square differences for the within and between subject factors. The Intraclass Correlation Coefficient (ICC) was computed by taking the mean square difference between subjects and subtracting the mean square difference within subjects and then dividing the result by the sum of the mean square difference between subjects and the mean square difference within subjects (Fleiss, 1999).

[0122] To determine the reliability of the ratings made using the Pen-Asp Scale and the NIH-SSS, ICCs were computed between the two sets of ratings on each scale from the first 21 trials that were reanalyzed. To identify the items that were unreliable, Cohen's Kappa was computed for the two sets of ratings of each component item of the NIH-SSS using Systat 11 (Systat Software, Inc., Richmond, Calif.). After developing rules for scoring those items that had low reliability, ICCs were computed on the second set of repeated ratings for both the Pen-Asp Scale and the NIH-SSS.

[0123] To address the first hypothesis that the hyoid bone would descend in the neck with maximal levels of stimulation at rest, a one-sample directional t-test was used to test for a lowering of the hyoid bone on the y axis between “off” and “on” stimulation. To address the second hypothesis that the hyoid bone would move posteriorly, a one-sample directional t-test was used to test for a retraction of the hyoid bone on the x axis in the “off” and “on” stimulation conditions within subjects. To determine if the larynx descended during stimulation, a one-sample directional t-test was used to test for a lowering of the subglottal air column between the two conditions.

[0124] To determine if swallowing improved due to sensory levels of stimulation, one-sample directional t-tests were used to test participants' mean changes in ratings between non-stimulated swallows and stimulated swallows within participants on the Pen-Asp scale and the NIH-SSS with a Bonferroni corrected p value of $0.05/2=0.025$. Finally, to determine if swallowing worsened during maximum levels of motor stimulation, one-sample directional t-tests were used to test participants' mean changes in ratings between non-stimulated swallows and stimulated swallows within participants on the Pen-Asp Scale and the NIH-SSS with a Bonferroni corrected p value of $0.05/2=0.025$. Pearson correlation coefficients using a Bonferroni corrected p value of 0.025 for statistical significance were computed between both the participant's mean initial severity on the Pen-Asp scale and the NIH-SSS and changes in mean ratings during the sensory stimulation to determine if participant characteristics predicted the degree of benefit. Similarly, Pearson correlation coefficients were computed between the extent to which the hyoid was pulled down in the neck during stimulation at rest and the change in participants' mean ratings for swallowing on the Pen-Asp scale and the NIH-SSS using a Bonferroni corrected p value of 0.025 for statistical significance.

[0125] Results**[0126] 1. Participants**

[0127] All 11 participants had chronic long-standing dysphagia (Table 1). Their disorder was either subsequent to a CVA in six (>6 months post), post craniotomy for a benign tumor in two (2 and 4 years post) or post traumatic brain injury in two (2 and 3 years post). Only one patient had a chronic progressive neurological disease, Parkinson disease of >20 years with dysphagia for more than 2 years duration.

[0128] Ten of the 11 participants participated in the stimulation at rest trials; one did not because of time constraints. During swallow stimulation trials, one of the participants had severe aspiration on an initial swallowing trial and for safety reasons the study was discontinued for that participant. Therefore, we were able to include ten participants in the motor stimulation swallow trials. Because of time constraints, two of the participants did not participate in the low sensory levels of stimulation, leaving 8 participants in the study.

[0129] 2. Measurement Reliability

[0130] The ICC for the movement of the hyoid bone on the y axis in the on and off stimulation conditions were 0.99 and 0.94 respectively and for hyoid movement on the x axis were 0.94 and 0.87. The ICCs for the larynx on the y axis in the stimulation “on” and “off” positions were 0.58 and 0.66 respectively indicating much less reliability on these measures. Because the movement of the larynx was extremely small, ranging from a mean position of 0.4 mm in the stimulation “on” to 0.18 mm in the “off” condition, measurement variability contributed to the variance on this measure.

[0131] 3. Movement Induced by Stimulation at Rest

[0132] To address the first hypotheses, a one-tailed directional t-test comparing the mean position between “off” and “on” stimulation conditions demonstrated a significant lowering of the hyoid position on the y axis ($t=-2.523$, $df=9$, $p=0.016$) (see FIG. 16). In FIG. 17 the individual tracings of hyoid movement in each of the patients is shown when the stimulator is turned “on” and then “off” and then “on” again showing elevation of the hyoid bone when the stimulator is turned “off”. To address the second hypothesis that the hyoid bone would move posteriorly with stimulation at rest, a directional t-test comparing the mean positions in the “off” and “on” stimulation conditions within subjects was not significant ($P=0.102$, $df=9$, $p=0.460$). Similarly, a directional t-test found no descent in laryngeal position on the y axis during stimulation ($t=-0.696$, $df=9$, $p=0.748$).

[0133] 4. Reliability of Ratings on the Pen-Asp and NIH SSS

[0134] After the first set of 21 repeated ratings, the ICC was 0.965 on the Pen-Asp scale and 0.764 on the NIH-SSS. Because of concerns about the reliability of the NIH-SSS, we implemented more detailed judging rules for each item where disagreement occurred. A second set of 18 reliability measures using the new judging rules resulted in an ICC for the NIH-SSS that was 0.925, demonstrating adequate reliability when using the scale once the judging rules were developed and implemented.

[0135] 5. Effects of Low Sensory Stimulation Levels During Swallowing

[0136] Due to time constraints only eight of the ten participants completed the sensory condition. To address the fourth hypothesis that swallowing improved with sensory levels of stimulation, one-sample directional t-tests were computed to compare mean change in ratings between non-stimulated

swallows and stimulated swallows within participants. The results were not significant on the Pen-Asp Scale ($t=-0.336$, $df=7$, $p=0.373$) but were significant on the NIH-SSS ($t=-2.355$, $df=7$, $p=0.025$) using a Bonferroni corrected p value of $0.05/2=0.025$. This is shown in FIG. 18. Six of the eight of the participants showed a reduction on the NIH-SSS with sensory stimulation during swallowing while five of the eight participants showed a reduction on the Pen-Asp scale.

[0137] 6. Effects of Motor Stimulation Levels During Swallowing

[0138] To address the fifth hypothesis that the risk for aspiration and swallowing safety worsened during stimulation, one-sample directional t-tests were computed to examine mean change in ratings between non-stimulated swallows and stimulated swallows within participants. The result was not significant on either the Pen-Asp Scale ($t=-0.363$, $df=9$, $p=0.637$) or on the NIH-SSS ($t=-0.881$, $df=9$, $p=0.201$) at a Bonferroni corrected p value of $0.05/2=0.025$. On the NIH-SSS scale, five of the ten participants had increased risk with motor levels of stimulation (FIG. 19), while on the Pen-Asp equal numbers of participants increased or decreased with motor levels of stimulation (FIG. 20).

[0139] 7. Relationship Between Severity of Dysphagia and Changes in Swallowing with Stimulation

[0140] The Pearson correlation coefficient between participants' initial severity on the Pen-Asp scale and change in swallowing with sensory stimulation was not significant ($r=0.142$, $p=0.737$). Similarly, participants' initial severity and change in swallowing with sensory stimulation on the NIH-SSS ($r=0.701$, $p=0.053$) was not significant using a Bonferroni corrected a value of 0.025 for statistical significance. A Pearson correlation coefficient between both the participants' initial severity on the Pen-Asp scale and change in swallowing with motor stimulation was not significant ($r=-0.501$, $p=0.140$), nor was the correlation between participants' initial severity on the NIH-SSS and change in swallowing with motor stimulation ($r=-0.190$, $p=0.599$), using a Bonferroni corrected a value of 0.025 for statistical significance.

[0141] 8. Relationship of Movement during Stimulation at Rest with Changes in Swallowing with Stimulation

[0142] Pearson correlation coefficients were computed between the extent to which the hyoid was pulled down in the neck during stimulation at rest and the change in swallowing on the Pen-Asp and the NIH-SSS using a Bonferroni corrected a value of 0.025 for statistical significance. No significant relationship was found between the degree of improvement on the NIH-SSS and the degree to which the hyoid bone was depressed during motor levels of stimulation at rest ($r=-0.388$, $n=9$, $P=0.302$). The improvement in the Pen-Asp scale during motor stimulation was significantly inversely related to the degree to which the hyoid bone was depressed during motor levels of stimulation at rest ($r=-0.828$, $n=9$, $p=0.006$). The relationship demonstrated that those with the greatest hyoid depression at rest had the greatest reduction on the Pen-Asp scale during motor levels of stimulation while swallowing.

[0143] Discussion

[0144] One purpose of this study was to determine the physiological effects of surface electrical stimulation on the position of the hyoid and larynx in the neck. We had predicted that when both the submental and laryngeal electrode pairs were stimulating at the participants' maximal tolerated levels, that the hyoid bone would be pulled downward, most likely due to stimulation of the sternohyoid muscle. The data sup-

ported this hypothesis; all but two of the participants had depression of the hyoid bone by as much as 5 to 10 mm during stimulation at rest (FIGS. 6A and 6B). We also predicted that the hyoid bone might be pulled posteriorly; however, limited anterior-posterior movement occurred in the hyoid bone. Three participants had hyoid anterior movement, by as much as 5 mm in one case, while the others had minimal movement in the posterior direction. Whereas minimal ascending movement (2-3 mm) occurred in the larynx in two participants, none of the other participants experienced any appreciable laryngeal movement (FIG. 6D) and the 2-3 mm changes were potentially due to measurement variation. To summarize these findings, the only appreciable motoric effects of surface electrical stimulation was to cause the hyoid bone to descend in the neck, producing movement in the opposite direction from that required for swallowing.

[0145] These results suggest that when surface stimulation was applied to the neck at rest, stimulation was either too weak or not deep enough to stimulate axons innervating the muscles that produce hyoid and laryngeal elevation such as the mylohyoid and the thyrohyoid muscles respectively. No change in laryngeal position was observed with surface stimulation at rest.

[0146] Another purpose of this study was to determine the immediate effects of surface stimulation on swallowing in participants with chronic pharyngeal dysphagia. Based on previous use of sensory stimulation in the oral and pharyngeal cavities to augment patients' volitional control of swallowing (Hamdy et al., 2003; Park, O'Neill, & Martin, 1997), we compared sensory levels of electrical stimulation just above the participants' sensory threshold for detecting a tingling sensation on the skin, and found a significant improvement during swallowing on the NIH-SSS scale (FIG. 18). The improvement on the NIH-SSS tended to be related to higher initial scores; that is the more severely affected patients were those who had the greatest improvement with stimulation. Because the NIH-SSS captures pharyngeal pooling and failed esophageal entry in contrast with the Pen-Asp scale, which only measures aspiration and penetration, sensory stimulation may be somewhat helpful in those patients who have reduced ability to clear the bolus from the airway.

[0147] Based on the expected lowering of the hyoid with motor levels of stimulation, we hypothesized that the group would have increased penetration and aspiration during swallowing with motor stimulation. No group change in aspiration was noted on either scale with motor levels of stimulation. When the degree of improvement on the Pen-Asp scale with motor levels of stimulation was examined relative to the degree of hyoid depression, we found an unexpected relationship indicating that patients with the greatest hyoid depression during motor levels of stimulation at rest had the greatest improvement during swallowing with the same levels of stimulation. When the hyoid was depressed with stimulation, a patient probably experienced a greater resistance to hyo-laryngeal elevation during swallowing. Perhaps those patients who felt a greater downward pull on the hyoid, when stimulation was turned on at maximal levels, made a greater effort to elevate the hyo-laryngeal complex when swallowing in an attempt to overcome the effects of the stimulation. It could also be the case that those patients who had greater residual power in their hyo-laryngeal muscles would have not only experienced greater hyoid descent with stimulation but could also have greater residual power that they could recruit

for hyo-laryngeal elevation to counteract the stimulation induced descent during swallowing.

[0148] This study also addressed the immediate physiological effects of the use of surface electrical stimulation at rest and during swallowing. This study suggests that electrical stimulation should be used judiciously dependent upon a patient's type and degree of difficulty with swallowing. In those patients who already have some ability to raise the hyo-laryngeal complex, hyoid depression with stimulation may serve as "resistance" during therapy. On the other hand, if a patient is unable to produce any hyo-laryngeal elevation, and therefore would not be able to resist the hyoid depression induced by stimulation, stimulation might put such a patient at greater risk of aspiration as the hyo-laryngeal complex is held down during swallowing. This may have occurred in some of the more severely affected patients who increased in severity on the Pen-Asp and NIH-SSS with motor levels of stimulation, while those less impaired did not change (FIGS. 19 and 20).

[0149] In this study, both submental and laryngeal pairs of electrodes were used simultaneously as is recommended for VitalStim® Therapy. It is likely that the simultaneous stimulation resulted in hyoid lowering because the stronger stimulation to the more superficial and larger sternohyoid and sternothyroid muscles overcame any action that might have been induced by stimulation of the mylohyoid muscle in the submental region or the thyrohyoid muscle beneath the sternohyoid in the throat region. Some have proposed using submental stimulation alone to activate the anterior belly of the digastric and the mylohyoid muscles to pull the hyoid bone upward. However, elevation of the hyoid bone without simultaneous stimulation of the thyrohyoid to raise the larynx would leave the larynx down resulting in further opening of the vestibule and increased risk of aspiration. Only if the mylohyoid and thyrohyoid muscles are activated together, without contraction of the sternohyoid, would both the hyoid and larynx be raised together as has previously been shown with intramuscular stimulation (Burnett, Mann, Cornell, & Ludlow, 2003). This cannot be achieved using surface stimulation, because the larger sternohyoid muscle overlies the thyrohyoid and pulls the hyoid downward.

[0150] The finding that the group as a whole improved with sensory levels of stimulation alone on the Pen-Asp scale was unexpected. Previous research has shown that stimulation of the anterior and posterior faucial pillars was most effective stimulation for eliciting a swallow reflex in normal persons (Pommerenke, 1927). Although not studied physiologically, stroking the throat region is known to assist with the spontaneous elicitation of swallowing in infants and some mammals. Stimulation of either the glossopharyngeal or the superior laryngeal nerves has been shown to elicit swallowing in animals (Jean, 1984) and bilateral chemical blockade of the superior laryngeal nerves disrupts swallowing in normal humans (Jafari, Prince, Kim, & Paydarfar, 2003). It has not been observed that sensory stimulation to the surface of the throat would reflexively trigger a swallow in adults; however, sensory levels of electrical stimulation on the skin in the throat may facilitate volitional triggering of swallowing in dysphagia. These results suggest that low levels of electrical stimulation on the skin might be beneficial in some patients. Because such low levels of electrical stimulation were not observed to induce hyoid depression, we posit that none of the patients would be put at increased risk for aspiration using lower sensory levels of stimulation. Before surface electrical stimulation is used, the patients should be carefully screened to determine whether they would be placed at increased risk of aspiration with a procedure that lowers the hyoid.

TABLE 1

Participant Characteristics and Surface Electrical Stimulation Levels							
Subject	Sex	Age	Etiology	Time post onset (years)	Status	Sensory Threshold Upper/Lower Electrode (mA)	Motor Threshold Upper/Lower Electrode (mA)
1.	M	66	hemorrhage in veterobasilar circulation	2.5	PEG, bilateral sensory loss, pooling, previous aspiration pneumonia	3.5/2.0	8.0/8.0
2.	M	66	Parkinson disease	20 years duration, Severe dysphagia 2+ years	PEG for 2 years, swallowed own secretions Recurrent pneumonias	6.0/2.5	10.0/10.0
3.	M	76	Stroke	1	PEG unable to handle secretions Aspiration pneumonia X 3, normal sensation	4.0/2.0	14/7.0
4.	M	78	Brain stem stroke	5	PEG, frequent aspiration pneumonias, sever reductions in UES relaxation, normal sensation	7.0/7.0	14/14
5.	F	47	Left occipital and brain stem stroke	3	PEG, unable to handle secretions	3.0/4.0	10/10
6.	M	25	closed brain surgery	2	Bilateral sensory loss Aspirations on liquids, bilateral sensory loss	3.5/6.0	16.6/13.0
7.	M	48	Cerebellar hemorrhage with craniotomy	2	PEG, Unable to handle secretions, aspiration pneumonia, pooling, Normal sensation	3.0/2.5	18.0/18.0
8.	F	44	Subarchnoid hemorrhage left vertebral artery	2	Tracheostomy PEG tube Normal sensation bilateral Pooling of secretions	4.0/2.0	12.5/9.5
9.	M	45	Traumatic brain injury	3	Chokes on saliva, eats soft foods, drooling, Bilateral sensory loss	3.0/4.0	18.0/16.0
10.	M	61	Left hemisphere stroke	.5	PEG, Inable to handle secretions, Normal sensation on left, pooling, BOTOX ® in UES	1.5/4.0	13.0/13.0
11.	M	47	Craniotomy for brain stem tumor	4	Severe aspiration, multiple aspiration pneumonias Bilateral sensory loss	1.5/1.5*	14/18

*Couldn't study effects of either sensory or motor stimulation during swallowing due to severe aspiration.

REFERENCES

[0151] References not listed specifically can be found in the literature by a search for the authors. U.S. application Ser. No. 10/529,401 entitled Methods and Devices for Intramuscular Stimulation of Upper Airway and Swallowing Muscle Groups filed on Mar. 28, 2005, is incorporated by reference in its entirety. The references found in that patent application are relevant and incorporated by reference with respect to the details of stimulating devices and method which are contemplated for use in embodiments presented here.

[0152] All references cited herein are hereby incorporated by reference in their entirety.

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- [0210] While specific embodiments of the subject invention have been discussed, the above specification is illustrative and not restrictive. Many variations of the invention will become apparent to those skilled in the art upon review of this specification. The full scope of the invention should be determined by reference to the claims, along with their full scope of equivalents, and the specification, along with such variations.
- [0211] Unless otherwise indicated, all numbers expressing quantities of ingredients, reaction conditions, and so forth used in the specification and claims are to be understood as being modified in all instances by the term "about." Accordingly, unless indicated to the contrary, the numerical parameters set forth in this specification and attached claims are approximations that may vary depending upon the desired properties sought to be obtained by the present invention.
- What is claimed is:
1. A device comprising:
 - a stimulator configured to apply at least one stimulus to the outside surface of a neck of a subject;
 - a switch configured to selectively engage between
 - a manual mode in which the stimulator is configured to apply the at least one stimulus upon volitional activation by the subject, and
 - an automatic mode in which the stimulator is configured to apply the at least one stimulus at an interval; and
 - a first counter configured to determine either
 - a number of applications of the at least one stimulus in the manual mode, or
 - a number of applications of the at least one stimulus in the automatic mode.
 2. The device of claim 1, further comprising a second counter configured to determine either the number of applications of the at least one stimulus in the manual mode, or the number of applications of the at least one stimulus in the automatic mode, the configuration of the second counter opposite the configuration of the first counter.
 3. The device of claim 1, wherein the at least one stimulus comprises a vibrational stimulus, a pressure stimulus, an auditory stimulus, a temperature stimulus, a visual stimulus, an olfactory stimulus, a gustatory stimulus, or a combination thereof.
 4. The device of claim 1, wherein the at least one stimulus comprises vibratory stimulus.
 5. The device of claim 4, wherein the vibrating stimulus is at a vibrational frequency between about 1 Hz and about 100 Hz.
 6. The device of claim 4, wherein the vibrating stimulus is at a vibrational frequency between about 5 Hz and about 70 Hz.
 7. The device of claim 4, wherein the vibrating stimulus is at a vibrational frequency between about 30 Hz and about 60 Hz.
 8. The device of claim 4, wherein the at least one stimulus comprises pressure stimulus applied to the outside surface of the neck of the subject.
 9. The device of claim 9, wherein the stimulator is configured to apply pressure of about 1 psi to about 14 psi to the neck of the subject.

10. The device of claim 1, wherein a duration of the at least one stimulus is between about 2 seconds and about 6 seconds.

11. The device of claim 1, wherein the interval is between about 3 minutes and about 30 minutes.

12. The device of claim 1, wherein the at least one stimulus is configured to induce a swallowing reflex of the subject.

13. The device of claim 1, wherein the at least one stimulus is configured to initiate speech of the subject.

14. The device of claim 1, further comprising a physiological sensor.

15. The device of claim 14, wherein the physiological sensor is selected from the group consisting of movement sensors, temperature sensors, skin color sensors, hematocrit sensors, oxygenation sensors, and blood pressure sensors.

16. A method for monitoring subject compliance with a training or therapy regime, the method comprising analyzing data from the device of claim 1 after a period of use of the device by the subject:

17. The method of claim 16, further comprising manually interrogating the first counter.

18. The method of claim 16, further comprising manually resetting the first counter.

19. The method of claim 16, further comprising remotely interrogating the first counter.

20. The method of claim 16, further comprising remotely resetting the first counter.

* * * * *

专利名称(译)	用于通过刺激到替代部位到受影响区域从马达控制恢复的系统和方法		
公开(公告)号	US20130225954A1	公开(公告)日	2013-08-29
申请号	US13/777907	申请日	2013-02-26
当前申请(专利权)人(译)	美利坚合众国政府作为代表局局长, HEALT系		
[标]发明人	LUDLOW CHRISTY LESLIE MORGAN NEWLIN DOLD GEORGE LOWELL SOREN DIETRICH BURNS KATIE		
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IPC分类号	A61H23/00 A61B5/00 A61B5/0205		
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摘要(译)

公开了用于治疗患有吞咽困难或其他神经疾病, 神经系统疾病, 神经损伤, 神经损伤或影响自主运动控制的舌, 咽, 喉或口咽区域的受试者的装置和方法。本发明的装置通常包括用于向受试者的颈部的外表面施加至少一种刺激的振动触觉刺激器; 用于将所述振动触觉刺激器附接到所述受试者的颈部的外表面的连接器, 以及可通信地连接到所述振动触觉刺激器以选择性地接合手动刺激模块和/或自动刺激模块的开关控制器。通过本发明的装置刺激受试者的喉部区域的外表面刺激受试者的吞咽反射。

