

Feeding Disorders and Failure to Thrive in infancy. The role of the pediatrician

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Feeding disorders and failure to thrive in infancy

- Not a rarity, frequency in community samples is around 3% of open population of infants
- In hospital samples it may account for 5% of admissions to hospital.
- Parents with psychosocial problems and difficult circumstances visit pediatrician more often, as well as emergency room

Failure to thrive

- “organic” failure to thrive vs. “non-organic” failure to thrive
- Cartesian distinction between mind and body
- In reality cases are not as “pure”, i.e. only psychosocial and “only organic”.

Failure to thrive

- Many cases have a mixture of biologically-based problems and psychosocial , concomitant issues.
- Multidirectionality of causes, psychosocial to organic and organic to psychosocial, plus influence of environment, culture, circumstances

Growth Stunting

- Growth stunting is not a rarity
- In “developing countries” it may reach a frequency of 40 or 50% of all children if not more
- Often, problems are ascribed to ethnic or genetic factors, e.g. the mother is short or the father is short.

What is the role of the pediatrician

- Promote health
- Impart information
- Provide support to the health of the baby and for parents in their role as parent
- Proactive rather than reactive
- Diagnosis of problems
- Intervention for problems

What is the area of the pediatrician?

- The body and the mind (emotional life, cognitive development, social development) etc. of the child
- Need to expand focus to include :
 - Relational factors
 - Psychosocial context
 - Cultural context

Myths about failure to thrive in infants

- “the child has to be underweight, I.e. under the 3rd percentile”
- “ it is caused mostly by maternal deprivation”
- I.e. neglect on the part of the mother
- The only cause is psychosocial when a disease has been ruled out. E.g. malabsorption syndromes, digestive conditions, etc.

Myths about feeding young children

- “all children are born with an equipment to suck and breastfeed” if given a chance
- “children know intuitively how much to eat, and later on, what variety of foods they need”
- “all children respond in a typical manner” (vs. the uniqueness of each child’s behavioral repertoire and responsiveness)

Concepts on infant feeding

Much of infant feeding is culturally determined, rather than “scientific”

Different cultures value various foods and practices, e.g. “kiss-feeding” or “pre-chewing” the food for the infant

Feeding is an ability that has a developmental line, i.e. a progression in part determined by the environment.

Concepts of feeding

- Children tend to prefer sweet foods and foods with more “fat content”
- Children tend to prefer the easier way of feeding, if given a chance e.g. bottle vs breastfeeding
- Feeding is a strongly social activity, influenced by imitation, modeling, interpersonal play

Concepts of feeding

- The feeding situation is best not turned into a battle of wills or moment of tension
- Children vary in their ability to concentrate on the act of feeding or eating
- Children vary in their ability to tackle different textures, volumes, flavors, odors, and the skills required to self-feed later on.

Failure to thrive

- Determined by multiple factors :
 - Factors in the child him or herself
 - Factors in the parent (beliefs, practice, technique)
 - Physical factors (sensorimotor organization, sensory integration, motor coordination, ability to be organized behaviorally)
 - Cultural and family factors (transgenerational)

Failure to thrive

- Determined by diminished intake of calories per kg of body weight
- At first 100 to 120 kcal/kg of body weight
- Weight under 3rd percentile or
- Weight going down in the growth curves at least two standard deviations from original path
- Weight for age (other measures)

Failure to thrive and feeding disturbance

- Feeding difficulties should be considered separately from failure to thrive
- A child may have feeding difficulties but not fail to thrive
- A child may fail to thrive without having feeding difficulties
- Often feeding diff . And FTT go together

Factors in the child

- Sensory integration abilities
- Ability to suckle and suck
- Ability to focus
- Ability to regulate states (I.e. awake vs asleep)
- Sensitivity in the mouth, mucosa, skin, to postures, motion, sound, visual stimuli, etc.

Factors in the child

- Developmental “crises”
- Going from one state to another
- E.g. from liquid foods to semisolids or purees
- From semisolids to solid foods
- From being feed to self feeding
- From no choice to choice, in foods, textures, ec.

Role of the pediatrician

- Detection of early feeding difficulties
- Detection of early organizational difficulties
- Monitoring weight gain and stature gain
- Assessing condition of the parent infant relationship and maternal status (e.g. maternal depression)

Role of the pediatrician

- Detection of 'ALARM SIGNS'
- E.G. Excessive crying,
- Sleeping difficulties
- Difficulties maintaining an alert state
- Hypertonicity, hyperreactivity, hyporeactivity
- Difficulties with low muscular tone

Role of the pediatrician

- Detecting maternal depression
- (tiredness, vague and chronic pains, malaise, sleeping difficulties, etc.)
- Detecting difficulties in caring for the baby
- Detecting difficulties in “reading “ the baby

Intervention by pediatrician

- Diagnosing contributing elements
- Neurological organization of the infant
- Contributing biological factors
- Providing information about caloric needs, individuality of the infant, feeding techniques
- Empathizing with parents of difficult child

Intervention by pediatrician

- Providing emotional support
- Providing practical guidance and suggestions
- Monitoring and encouraging
- Consultation and referral when complex problems
- Continue to be a part of the “caretaking team”