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Solving Common Feeding Difficulties in Paediatrics: A Practical Approach

Québec City – Feeding difficulties in infants and children are extremely common and physicians need to identify specific types of feeding difficulties in order to counsel parents accordingly. Once identified, resolution of the feeding problem usually requires only a few practical strategies that are easy for parents to apply. In some cases, a nutritionally balanced supplemental product may be necessary to provide missing micronutrients and calories for optimal growth and development.

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Concerns about feeding difficulties are extremely common among parents and health care providers need to be able to identify the various types of feeding difficulties and counsel parents accordingly. Between 50% and 60% of parents report their child has some sort of feeding problem, according to several studies, Dr. Glenn Berall, Chief of Paediatrics, North York General Hospital, and Assistant Professor of Paediatrics, University of Toronto, Ontario, told delegates here at the CPS.

Four Facets of Poor Appetite, Other Feeding Difficulties

A "paediatrician-friendly" classification system of feeding disorders developed by Dr. Berall and colleagues describe 4 major symptom-related groups under the category of "poor appetite."

The first is poor appetite that is parental misperception. "Parents worry that their child is too small, smaller than all their peers, and interestingly enough, that is also true for some of the parents," Dr. Berall noted. The child may also have been born prematurely and not have the same growth potential as their peers. Even though physicians might explain to parents that the child is achieving satisfactory growth based on mid-parental height, "what you are worried about here is a feeding conflict because if parents are worried about what is going on and there really isn't a problem, they are going to intervene in a situation where it is not necessary and you end up with an endless conflict," Dr. Berall explained.

Poor appetite in a child who is otherwise alert, active and inquisitive is another common problem. "These children are more interested in playing and talking than feeding and they are easily distracted from feeding," Dr. Berall noted. In response, parents often try to entertain them as they feed but some may resort to force-feeding out of concern for their child, as these children are often underweight.

Poor appetite in a child who is apathetic and withdrawn may be a sign of possible neglect or abuse; alternatively, it may also be a sign of subtle developmental illness or psychiatric illness in the parent.

Poor appetite or refusal of food can also arise from serious organic pathology. Here, red flags may identify some but not all of these children and physicians must be very alert for conditions that present with more subtle symptoms such as celiac disease or food allergies.

Among children with other feeding difficulties, there are those who are highly selective eaters. "In these children, it's not so much a feeding difficulty as it is a sensory condition—they are sensitive to loud sounds, bright lights; they don't like tags on their clothing; they don't like walking barefoot on the grass or playing with sand or playdough," Dr. Berall explained. Highly selective eaters will limit the food they eat to a small select number of foods and they will demand specific presentations of that food. Once presented with accepted foods, they will quite happily eat the food but resist all others.

Lastly, there is the child with colic. "Inconsolable crying may interfere with successful feeding in a generally healthy infant under 4 months," Dr. Berall noted. The initiating event might be a normal physiological response but food sensitivity, constipation, reflux or a urinary tract infection may need to be excluded, he told delegates. Mothers of colicky babies often attempt to feed too often fearing hunger is causing the crying, he added. Children who cry at the sight of food, the bottle or the high chair and who resist feeding by crying, arching or refusing to open their mouth are classified with a fear of feeding problem. "This is the child who has had some kind of traumatic experience—they have choked on food, they have been intubated or nasogastric tube-fed—and have a lot of negative oral experiences so they are afraid of the feeding experience," Dr. Berall explained.

Continued

Physiological and Behavioural Consequences

If common feeding difficulties were of no physiological consequence, then reassurance would be all physicians would have to provide. But feeding difficulties can have consequences on growth. In a comparison of children with identified feeding problems to control children with no identified feeding problem, Wright et al. (*Pediatrics* 2007;120:e1069-e1075) showed that approximately 10% of children with the feeding problem were below the fifth percentile for weight gain at the age of 30 months vs. under 5% for children with no feeding problem.

"Picky eaters" may also not get the daily requirements of vitamin C and E intake and have lower protein, energy and fat intake as well as lower intakes of fruit and vegetables (*J Am Diet Assoc* 2005;105:541-8). An Israeli study (*J Am Acad Chil Adolesc Psychiatr* 2004;43:1089-97) also found that children with feeding disorders experienced significantly more negative touching and significantly less affectionate touching than children without feeding disorders—"so this is potentially a significant problem," Dr. Berall observed. The consequences of feeding problems can also extend beyond growth to emotional and cognitive limitations. In a study by Chatoor et al. (*Pediatrics* 2004;113:e440-e447), both picky eaters and children with infantile anorexia had a delay in their mental developmental index (MDI) relative to healthy eaters, even though MDI scores in all 3 groups were within the normal range. "Picky eaters are far more likely to be subjected to excessive parental anxiety and have behavioural problems including anxiety and depression, somatic complaints and even delinquency," Dr. Berall noted.

Tailored Approach

Registered dietitian Marie-Hélène Bourdages, CHUQ-CHUL, Québec City, Québec, stressed that each child needs to be managed using an approach that is tailored to fit the specific feeding difficulty. For children with poor appetite that is parental misperception, parents clearly need to be educated about what they can realistically expect in terms of growth for their child. "Paediatricians need to use growth charts and explain to parents where their child is on the chart," she told delegates. They must also highlight the importance of applying basic feeding principles for these children.

Parents of fundamentally vigorous children with a poor appetite must try and promote the child's appetite by increasing feelings of hunger and subsequent satisfaction from eating. To that end, parents need to provide 3 meals a day plus 1 afternoon snack and not allow "grazing" between meals. Moreover, the child should drink only water between meals. Parents must also minimize distractions during feeding. This may be accomplished by feeding the child in a high chair or at a table but for no longer than 30 minutes and using timeout to discourage disruptive feeding behaviours. If the child's growth is faltering, parents can supplement the child's normal diet with high-calorie foods or a 30 kilocalorie-per-ounce nutritionally balanced formula.

The apathetic and withdrawn child with poor appetite often responds positively to an enthusiastic and experienced feeder and is likely to need an inpatient admission to provide a positive feeding environment. Physicians also need to address causal factors for potential neglect including psychoneurosis in the mother, socioeconomic circumstances or neurological problems in the child.

Parents of highly selective eaters need to be reassured that the feeding difficulty is part of a broader sensory condition. "The fundamental principle is to tempt, not push," Bourdages indicated, "and they should model the consumption of new foods without offering it to the child." Parents also should supplement their child's diet either through a micronutrient supplement or a nutritionally balanced formula to address the risk of micronutrient deficiencies. For infants whose colic is interfering with feeding, calming strategies include having parents feed the child in a quiet room with dim lights and white noise. The child may also be comforted by swaddling and possibly by kangaroo-style skin-to-skin nursing. Parents can also try to bathe the child to help break the crying cycle.

As for the child who fears the feeding experience, mild cases may be desensitized by sleep feeding, when the child is sleepy enough to be less fearful. Parents may also try offering the child a cup or spoon instead of a bottle. "Children with severe food refusal require the use of a nutritionally complete and balanced product," Bourdages added. "For the tube-dependent child, referral to a multidisciplinary feeding disorders team would be the best strategy, if available."

Summary

Encountering parents whose child has feeding issues is commonplace in paediatric practice and those who care for children need to first identify the type of feeding problem the child is having before they can treat it. Most feeding difficulties can be solved with parental education and common-sense strategies. For many feeding difficulties, a nutritionally balanced supplement may help replace micronutrient deficiencies and potentially allay parental concerns that their child is not getting enough to eat. ☐

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