

Paediatric Feeding Disorder

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Abstract

Pediatric feeding disorders (also termed avoidant/restrictive food intake disorders) are conditions in which a child avoids eating or limits what or how much he or she will eat. This leads to problems including weight loss, nutritional deficiency, need for nutritional supplements, or problems with daily functioning. These disorders often limit a child's ability to participate in normal social activities such as eating with others, and disrupt family functioning.

Introduction

Feeding is a complex process that requires interaction of the central and peripheral nervous systems, oropharyngeal mechanism, cardiopulmonary system, and gastrointestinal (GI) tract with support from craniofacial structures and the musculoskeletal system. This coordinated interaction requires acquisition and mastery of skills appropriate for a child's physiology and developmental stage. In children, feeding occurs in the context of the caregiver-child dyad [1]. A disruption in any of these systems places a child at risk for a feeding disorder and associated complications. Often, more than 1 system is disrupted, contributing to the development and persistence of pediatric feeding disorders (PFDs) [2]. Hence, effective assessment and treatment of PFDs require the involvement of multiple disciplines. The lack of a universally accepted definition has, however, hindered collaborative care [3]. (Figure 1)

- Medical factors
- Nutritional factors
- Feeding skill factors
- Psychosocial factors
- Psychosocial Dysfunction

Causes

For most children, there is not just one thing that causes a feeding disorder. Most often, it is a combination of factors [4].

Things that can contribute to the development of a feeding disorder include:

- Child temperament (slow to adapt, easily over-stimulated)
- Pain or discomfort with feeding (from things like reflux and allergy)



Figure 1: Shows the Pediatric Feeding Disorder.

Negative experiences with feeding (pain, coughing, vomiting or gagging during feeding)

Negative experiences related to the mouth (history of NG tubes, oral procedures, being on a ventilator, surgeries)

Slow emptying of the stomach

Poor oral motor skills (dysphagia)

Low muscle tone or high muscle tone

Developmental delays

Certain developmental disabilities, such as autism spectrum disorder [5].

Anxiety

ADHD

Sensory differences (hypersensitivity to taste, smell, texture)

Chronic health problems (ear infections, frequent respiratory infections, dental problems, seizures)

Parent-child conflict, parental anxiety

Diagnosis

Depending on the child's history and current problems, the evaluation may include some or all of the following:

Review of medical history, growth pattern, developmental history, and current symptoms

Assessment of dietary intake by a registered dietician [6].

Evaluation by a physician or nurse practitioner with expertise in feeding and feeding disorders

Evaluation of feeding behaviors by a clinical psychologist [7].

Evaluation of oral motor skills, chewing and swallowing by a speech-language pathologist

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Special tests to evaluate swallowing, such as a barium swallow or endoscopic assessment [8-9]

Evaluation by a pediatric gastroenterologist to determine if problems of the GI tract (GE reflux, constipation, delayed emptying, or other GI disorders) are contributing to feeding problems[10]

Evaluation of motor skills, posture, and sensory issues by a pediatric OT or PT

Blood work to evaluate nutrition status or to screen for medical conditions that can contribute to feeding problems.

Vaccination is disease-specific

Immune responses are very specific, and that is the reason we need to have a specific vaccine for each. The immune system responds separately to each pathogen it encounters. It cannot be 'overloaded' by giving the full range of currently available vaccines or by having multiple antigens in one vaccine. A healthy immune system can generate hundreds of millions of T and B cells, each of which targets one particular antigen. However, pathogens can sometimes overwhelm the immune response. Vaccines give the immune system a head start by allowing it to learn and remember what a pathogen looks like, providing valuable protection against aggressive pathogens.

Pre-formed antibodies provide immediate protection

It takes around 7–21 days after being vaccinated to generate an effective immune response in healthy individuals. Most vaccines work by switching on a person's immune system to make the antibodies, cytokines and memory cells needed to protect against infection. However, this kind of active immune response takes 7–21 days to fully develop. Sometimes, in the case of overwhelming and dangerous infections, an unwell person may receive pre-formed antibodies as part of their medical treatment to prevent or combat the infection. These either come from healthy blood donors or are produced in a laboratory, as they can act much more quickly to help the person fight off the infection. This is known as 'passive immunisation'. However, these antibodies don't stay in the body for very long—it is better to make antibodies through being vaccinated wherever possible.

Conclusion

These proposed diagnostic criteria for PFD use a conceptual

framework that goes beyond disease-oriented or unilateral diagnostic paradigms, defining PFD as restricted oral intake that is not age appropriate and leads to dysfunction in at least one of 4 closely related, complementary domains. Adoption of this definition by healthcare professionals from all disciplines will establish a common terminology that could have widespread impact on clinical practice, education, research, and advocacy.

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Conflicts of interest

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References

1. Bratteby LE, Garby L, Groth T, Schneider W, Wadman B (1968) Studies on erythro-kinetics in infancy XIII The mean life-span and the life-span frequency function of red blood cells formed during foetal life. *Acta Paediat Scand* 57-311.
2. OskiFA, Naiman JL (1966) Hematologic problems of the newborn. W B Saunders Company Baltimore 19-66.
3. Smith CA (1959) The physiology of the newborn infant. 3 Charles C Thomas Publisher Philadelphia.
4. Guest GM, Brown EW (1957) Erythrocytes and hemoglobin of the blood in infancy and childhood III Factors in variability statistical studies. *Mer J Dis Child* 93-486.
5. Gairdner D, Marks J, Roscoe (1952) Blood formation in infancy Part I The normal bone marrow. *Arch Dis Child* 27-128.
6. Sturgeon P (1950) Volumetric and microscopic pattern of bone marrow in normal infants and children. *Pediatr* 7-577.
7. Sturgeon P (1951) Volumetric and microscopic pattern of bone marrow in normal infants and children. *Pediatr* 7- 642.
8. Sturgeon P (1951) Volumetric and microscopic pattern of bone marrow in normal infants and children. *Pediatr* 7- 774.
9. Glaser K, Limarzi L, Poncher HG (1950) Cellular composition of the bone marrow in normal infants and children. *Pediatr* 6-789.
10. Garby L, Sjölin S, Vuille J (1963) Studies on erythro-kinetics in infancy III Disappearance from plasma and red cell uptake of radioactive iron injected intravenously *Acta Paediat Scand* 52-537.