

RED FLAGS FOR FEEDING: DIAGNOSES & CONDITIONS THAT AFFECT FEEDING

- **Unable to hold head upright and control torso (trunk):**

The entire digestive system, including the mouth, is designed to be used while sitting upright. Children who cannot control their head and neck muscles will not develop advanced feeding skills, such as biting and chewing. They may be able to eat some amounts of strained, pureed, and soft solid foods. If head control improves over time, feeding skills can also improve. Children who lack trunk control cannot develop the hand and arm skills to self feed.

- **Limited Cognition**

Children with limited cognition may not progress beyond pureed foods even if they have the physical ability to do so. This is because the development of biting and chewing skills requires awareness and motivation, qualities that may be absent in children with cognitive impairments. In some cases, children may learn to bite and chew but at older ages than usual.

- **Tracheostomies.**

Tracheostomy tubes can interfere with eating because swallowing is uncomfortable with the tubing in place. Some children may drink fluids but refuse solids. Others may eat pureed solids but refuse foods with more texture. A rare few will be able to eat regular food textures while the tube is still in place. Once the tubing is removed and the tracheostomy has been allowed to close, children can catch up in their feeding skills.

- **Prematurity.**

Prematurity predisposes many children to have oral sensitivities and difficulty transitioning to foods with more texture. Consistent mealtime routines, de-sensitization techniques, sensory diets, and behavioral psychology strategies are very effective in overcoming these problems.

- **Reflux.**

Moderate to severe reflux can interfere with food intake and cause failure to thrive. If reflux lasts long enough, children learn to associate eating with pain and discomfort, and start avoiding food- a behavioral feeding problem. Our feeding team recommends aggressive medication management for reflux, so that poor growth and behavioral feeding problems can be prevented or minimized.

- **Prolonged Tube Feeding.**

Naso-gastric tubes (NG tubes-from the nose to the stomach) should be used for no longer than 6-8 weeks or aversions to oral eating may develop. After 6-8 weeks, we recommend placement of long term feeding tubes (gastrostomy and jejunostomy tubes, usually called “G” and “J” tubes). Although these may seem more invasive than NG tubes, G and J tubes interfere with eating much less than NG tubes. And G and J tubes can be easily removed when no longer needed.

Often, G and J tubes are placed when there are already longterm medical or feeding problems. Therefore, they are by definition, ‘red flags’ for feeding. Any child who has had an NG tube, G or J tube for more than a few months may need a structured feeding plan to promote oral eating or to maintain a certain amount of oral eating.

- **Down Syndrome.**

Children with Down syndrome can develop functional oral skills, but these skills usually emerge later than usual. Oral skill development is connected to gross motor skill development. Children with Down syndrome often do not start walking until 24-36 months. When they do start walking, they can also progress in their feeding skills. Counsel parents to be patient with feeding until then.

- **Cerebral Palsy (CP).**

Cerebral palsy can range from mild to severe. Moderate to severe cases usually cause children to have oral-motor limitations. Some children can keep up with their calorie needs through oral eating while their bodies are small. But as they grow and require additional calories, their oral skills can no longer keep up with their nutrient needs. At this point, supplementation with nutrition formulas or high calorie homemade beverages may be needed to add more calories, or a G tube (see feeding tubes above) may be needed to provide additional calories.

Individuals with CP can experience a decline in feeding skills in any decade of life, including adulthood.

- **Autism Spectrum Disorders (ASD).**

Some children with these diagnoses find eating to be distressing or uncomfortable. Consequently, they limit the kinds and amounts of foods they eat. This is called “food selectivity.” Sensory de-sensitization within a structured behavioral feeding plan (plus anti-anxiety medications in some cases) are very effective treatments for children with mild to moderate food selectivity. Children with severe food avoidance and selectivity will do best in in-patient feeding programs.

- **Prader-Willi Syndrome (PW syndrome).**

Children with PW syndrome start out with low tone, poor feeding, and failure to thrive. By age 3-4, brain changes cause them to never feel full after meals. They begin to overeat and will become overweight very quickly if measures are not taken to control their eating. Behavioral feeding strategies will help, but these children will have a lifelong struggle with food. Kitchens, refrigerators, and cabinets often have to be locked. Strict diets may need to be followed.

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