

FEEDING DISORDERS CLINIC

QA OBSERVATIONS ON FAILURE TO THRIVE REFERRALS

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METHODS

- A Systematic review of all referrals to Robert Warner MD Center's Feeding Disorders Clinic from 10/07 to 6/08
- Demographics, associated diagnoses and outcomes
- Focus on FTT and treatment methods

Feeding Disorders Clinic

- Began in late 1980s – Brian Rogers, MD
- Modeled on Kennedy Krieger clinic, to include therapeutic feeding observations
- Previously at 936 Delaware and at outreach schools (Aspire, CHC, Heritage, Cantalician, DDSO sites). Now in WCHOB only (in D1 and Tanner 6 clinics)
- Staffed by Developmental Peds, PNP, Nutrition, OT, SL, and Social Work
- *Transdisciplinary approach*

Strengths

- Team effort
- Capable of analyzing medical and developmental issues together with family dynamics – with the goal of normalizing growth, nutrition and feeding behaviors.
- Connections with school programs and therapists in the community.
- Strong PMD referrals.

Weaknesses

- Time intensive evaluation
- Parenting styles and cultural differences often limit the changes we can expect.
- Medical issues are often covered by other providers – with potential conflicts of advice and medical opinion.

Opportunities

- Growing care for Autism Spectrum Kids with overselectivity
- Failure to thrive care
- Continued need for the care of premies, children with true neurological dysphagia and for otherwise medically complex

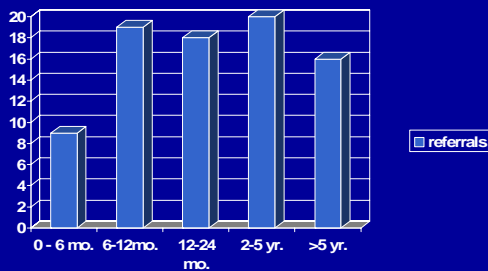
Threats

- Follow-up: Feeding and growing are emotionally threatening to parents and suggestions for behavior change fall on the parents as well as the child
- Public knowledge of clinics availability
- Staff availability

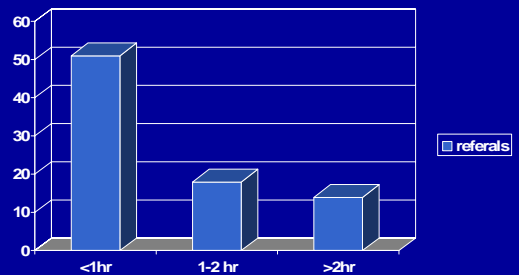
Recent referrals

- From 10/2007 to June 2008
- 83 referrals to FDC
 - 60 from community PMDs
 - 11 from WCHOB or SOCH primary care
 - 9 from EI or therapists (via PMD)
 - 3 from others
- New patients usually seen Thursday AM

Age of referrals



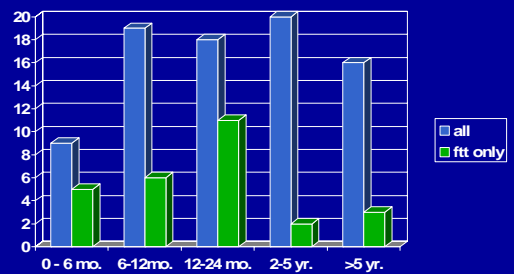
Distance of referrals



FTT – Pediatric Undernutrition

- Why worry?
- Specific nutrient deficiencies associated with lower cognitive outcomes
 - Iron, iodide
- Low weight itself not necessarily a risk to cognition but Bayley MDI 10 points lower for the picky eaters and infantile anorexics in Chatoor's 2004 report – compared to healthy eaters
- Lifelong food battles do not lead to healthy teen and adult eating habits (anecdotal)

Age of FTT referrals



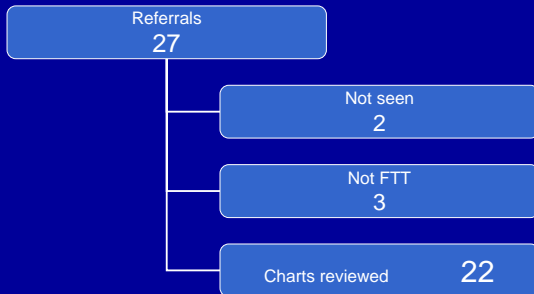
Failure to thrive referrals

- Telephone intake of FTT or weight concern
- 27 referrals in 8 months
- Prioritized by age for prompt visit

FTT chart reviews

- Clinical question
 - How many came?
 - Were they truly underweight?
- Of the underweight:
 - What other diagnoses were present?
 - Was GERD or food allergy a major issue?
 - Did they improve?
 - Were community services available or accessed when appropriate?

Results



Underweight – Other Diagnoses

Prematurity	5	• Seizures	1
Genetic	2	• "colitis"	1
Hypothyroid	1	• ADHD	1
RTA	1	• GERD	8
Iron deficient anemia	1	• Motor Delay or CP	1
		• Spinal cord anomaly	1

FTT and GERD

- 8/22 GER diagnosed – 36%
- 8 medicated (H2 blocker or PPI) 36%
- No metaclopramide
- 6 more had symptoms supporting a scintiscan – results pending

FTT follow-up

- Because of recent sampling
 - 4 are still due for first follow-up
 - 9 did not follow-up, did not schedule, did not get ordered tests done nor change to other clinics
- Results of the remaining 9
 - 3 improved and d/c –developmental and informal f-up
 - 6 continuing in follow-up
 - 5 improved or kept up on weight/ height (not resolved yet)
 - 1 worse (renal pt)
- 8/9 (89%) improved, but only 50% fully treated

Case History #1 - WD

- Toddler with FTT – possibly organic background – with behavioral sequelae
- Weight near 50% for 3 mo, then tapering to the 5th by 9 months (83% IBW), keeping up at 12 mo (81% IBW)

Clinical vignette WD

- Male, Referred by PMD at 12 months for FTT
- BTT and adenoidectomy at 8 months, after many antibiotics
- GERD presumed at 3 months by emesis – started omeprazole at 3 mo. added ranitidine at 4 mo. Then, PPI changed to lansoprazole at 5 mo. Either Breast fed or Alimentum
- NM scintiscan negative for reflux at 8 mo., 17% emptying time
- “Bland diet” prescribed by ENT

WD

- At 12 ½ mo, seen for team eval, choking on stage 3, refusing many stage 2, on Alimentum 24 oz day and only 4 oz juice
- Grazing, fed constantly and pressured, coerced to eat, overstuffing mouth until he chokes
- Advised on appetite promotion techniques and reducing mealtime stress. Now will sit in high chair and is advancing self feeding to a developmentally appropriate level

WD follow-up

- At 16 mo., Weight still < 5%ile (79% IBW) Had seen Allergy, cleared for Pediasure, only on lansoprazole
- Feeding behaviors improved – no gagging choking or overstuffing. Parents using a schedule and a high chair and reporting much less stress. Beginning to self-feed with cup and spoon
- Further follow-up expected

What is feeding therapy in FTT?

- Assess for sensory/oral-motor deficits
- Rule out pharyngeal swallow problems
- Evaluate self feeding skill - motor and psychological
- Evaluate mealtime environment
 - Physical
 - Social
 - Temporal
- Set goals with caregivers – short term

Feeding Behavioral techniques

- Background
 - Irene Chatoor MD – psychiatry
 - “Food Rules” aka “food guidelines”
 - Promotion of appetite
 - Stress reduction
 - Guidance on parental behaviors

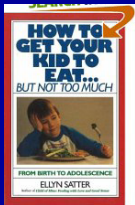
Food Rules

- Scheduled meals and snacks
- No food or drink in between meals
- Seated for all meals & snacks w/o distractions
- Neutral caregiver – no pressure to eat
- 30 minutes per meal or snack
- Clean-up at the end

Food rules – What parent has to do

- Act neutral – respect the child's autonomy
- Read and respond to the child's cues –
 - Refusal, Acceptance, stress, fullness, medical
- Expect variation in food volume and choices.
- Maximize calories with the foods that child eats most efficiently.

Parent resources: Ellyn Satter books



Summary

What might work for FTT.

- Early referral
- Early recognition of GERD
- Involvement of therapists who have experience in feeding
- Shorter term goals and follow-up – with social support of parents
- Keeping a developmental perspective on the child's abilities and the family role

Improvement Plan

- Involvement of therapy services
 - OT or speech evaluation prior to clinic may be helpful to prepare the family and reduce the time in clinic
 - Outpatient OT with collaboration with EI therapists (when appropriate)
- Observation: 22 referrals
 - Of the 9 lost to follow-up only 3 had developmental services in EI or school
 - Of the 9 who came (so far) 7 were in EI and one had parents with medical concerns

Improvement Plan - Medical

- Note - A VFSS was necessary only once – but reflux studies in 14/22
- Further study of medical issues - what is optimal lab work, imaging or consultations needed?
 - (Ex: IDA, celiac and IBD screens)
- Support Communication from PMDs
 - Please send the whole growth chart and labs
- Quicker follow-up for family support
- Rebuild EI and school support for nutrition
 - Educational conference in planning stages