FEEDING BASICS

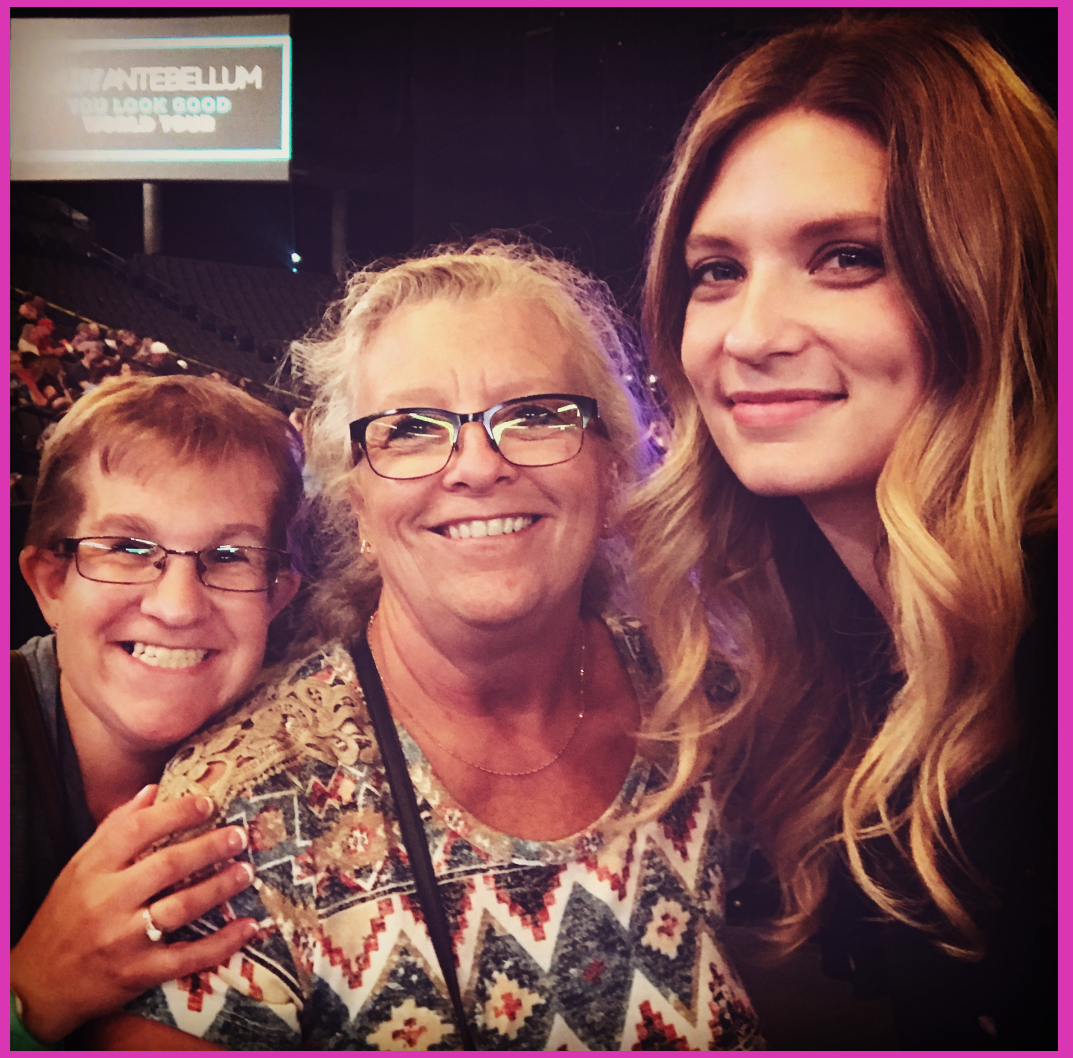
Nikki Page OTD, OTR/L

ABOUT ME:

- Creighton University: Doctorate of Occupational Therapy
- Pediatric and feeding practice since graduation in 2010
- Feeding team member at Children's Hospital Omaha for 5 years.

Children's
HOSPITAL & MEDICAL CENTER

MY WHY...



WHAT DOES A FEEDING THERAPIST DO?

- Evaluates oral motor skills for intake of developmentally appropriate foods and liquids
- Assesses a child's oral skill for intake
- Assesses a child's pharyngeal (swallow skill) for intake
- Evaluates and treats children birth to 21 years
- Can be a speech therapist or occupational therapist
- Helps to identify route issues with feeding related to: Oral Skill; Swallow Skill; Behaviors; Sensory Processing; Meal Routines/Structure
- Can complete Modified Barium Swallow Studies (MBS) AKA: Deglutition, Swallow Study, Video Fluoroscopic Swallowing Exam

NORMAL FEEDING DEPENDS ON THE SUCCESSFUL INTERACTION OF A CHILD'S HEALTH, DEVELOPMENT, TEMPERAMENT, EXPERIENCE, AND ENVIRONMENT. DISRUPTING ANY OF THESE SYSTEMS PLACES A CHILD AT RISK FOR PEDIATRIC FEEDING DISORDER. - FEEDINGMATTERS.ORG

WHAT IS ORAL DYSPHAGIA:

- Any disruption in the oral phase of the swallow.
- This could include disruptions related to: sucking, moving food around in your mouth, consolidating food in your mouth into food ready for swallow, chewing, and the act of moving food from the front of your mouth to the throat for swallow.

WHAT IS PHARYNGEAL DYSPHAGIA:

- Disruptions in the process of the swallow at the throat level.
- Could lead to aspiration. Aspiration is when food or liquid enters the airway. Airways may not be protected from aspiration for a number of reasons.

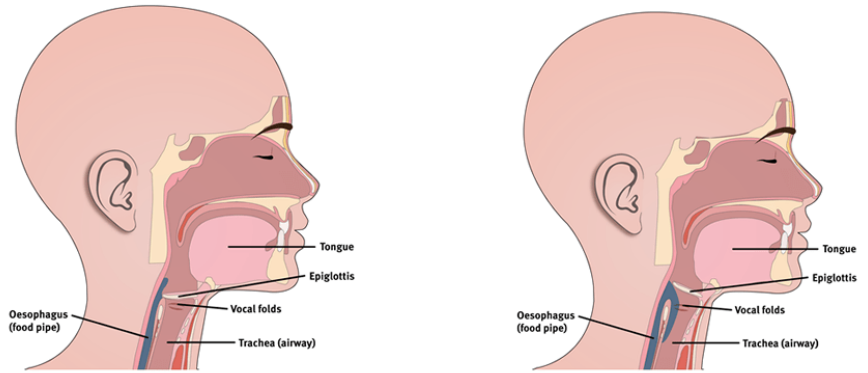


Figure 1: Normal Swallow vs Aspiration. Retrieved from https://www.childrenshealth..qld..gov.au/fact-sheet-swallowing-difficulties-children/

ANATOMY

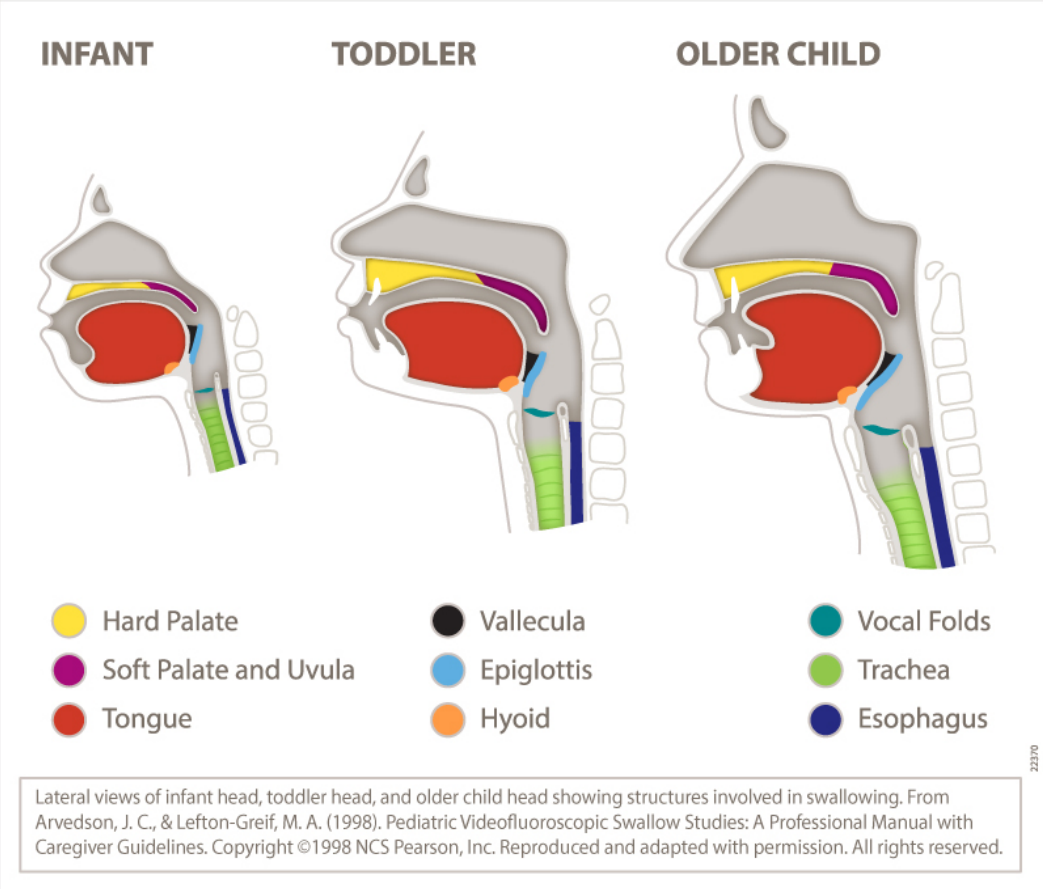


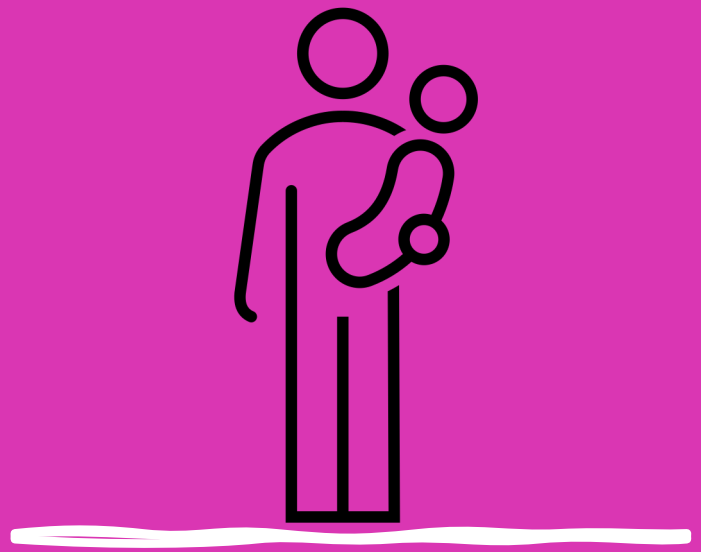
Figure 1: Growing child's anatomy. Retrieved from: ASHA.org

HOW DOWN SYNDROME CAN IMPACT FEEDING:

- Anatomical differences in the mouth and throat can alter a child's progression with oral intake and safety of swallow.
- Small and narrow upper jaw and/or a high palatal arch: Creates a smaller oral cavity space for tongue. (This is often why the tongue may appear larger.)
- Low muscle tone and weak oral facial muscles: Impacts a child's strength, endurance, and coordination for successful oral intake and safe swallow.
- Low muscle tone overall: Impacts a child's ability to demonstrate postural control for intake.

Cheng, Yiu, Leung Chapter Entry Published August 17th 2011

GENERAL FEEDING DEVELOPMENT (BIRTH TO 2 YEARS)



BIRTH TO 4 MONTHS

- In Utero: Sucking and swallowing observed in the womb
- At birth: Automatic reflex patterns (rooting, gag). Shows hunger cues with opening mouth, fingers to mouth, rooting, tongue is moving in a suckling pattern.
- 3 months: Suckling and tongue extension/retraction motions.
- 3-4 months: Begins to have increased head, neck, and trunk control. Feedings often become more spaced out.

Smith; Chapter Entry; Occupational Therapy for Children 2005

4-6 MONTHS

- Liquids and purees are typically initiated.
- Jaw movements become more variable. Vertical chewing/munching.
- Sitting control with support improves

Smith; Chapter Entry; Occupational Therapy for Children 2005

6-9 MONTHS

6-8

- Begins to develop tongue side to side motion
- May start meltable solids (dissolvables like puffs)
- Eating lumpy and mashed table foods

8-9

- Can practice cup and straw; Primary is still bottle or breast for nutrition
- Soft solids start; Increasing skill with jaw and chewing

Smith; Chapter Entry; Occupational Therapy for Children 2005

10-12 MONTHS

- Is starting to self feed with utensils
- Rotary chew begins
- Crunchy and more dense textured solids are being consumed
- Foods transition into being more of a primary source of nutrition at 12 months

Smith; Chapter Entry; Occupational Therapy for Children 2005

12-24 MONTHS

- Regular food schedule (Children's promotes 3 meals a day with am and pm snack.)
- Increasing skills with oral awareness (May overstuff)
- 24 months: The hope is to be eating all table foods with functional oral motor skill and be transitioned to successful oral intake of liquids by transitional cup.

Smith; Chapter Entry; Occupational Therapy for Children 2005

MEDICAL FACTORS TO CONSIDER

- Prematurity
- Cardiac Conditions
- Neurological Impact
- Gastrointestinal Disorders
- Craniofacial Anomalies

PICKY FEEDING

- Sensory Processing and Sensory Integration: "refers to the way the nervous system receives messages from the senses and turns them into responses." - www.spdstar.org
- Impact on oral intake? Food refusals. Picky eaters.
- Strategies: Play with foods; Model interaction; Mix preferred foods together; Mix a preferred with a non preferred; Make subtle changes to foods and grade interaction.

BEHAVIORAL FEEDERS

- Relates to the behaviors of obtaining and consuming foods.
- Can be both sensory and behavioral.
- Strategies: Structure; Goodbye bowl; Getting children involved in making choices with meals.

WHAT HAPPENS WHEN YOU COME TO SEE SOMEONE LIKE ME...

- Parent interview
- Oral exam
- Observation of meal/snack
- Recommendations are made
- Treatment is set up if necessary

HOW CAN YOU FIND US?

- Down Syndrome Clinic: 1st, 3rd, and 4th Tuesdays of the month at Children's from 12:45 to 5pm
- Ask your physician for a referral to clinic or to have a feeding evaluation via our outpatient rehab department.

QUESTIONS?

- Thank you so much for having me! -Nikki Page, OTD, OTR/L