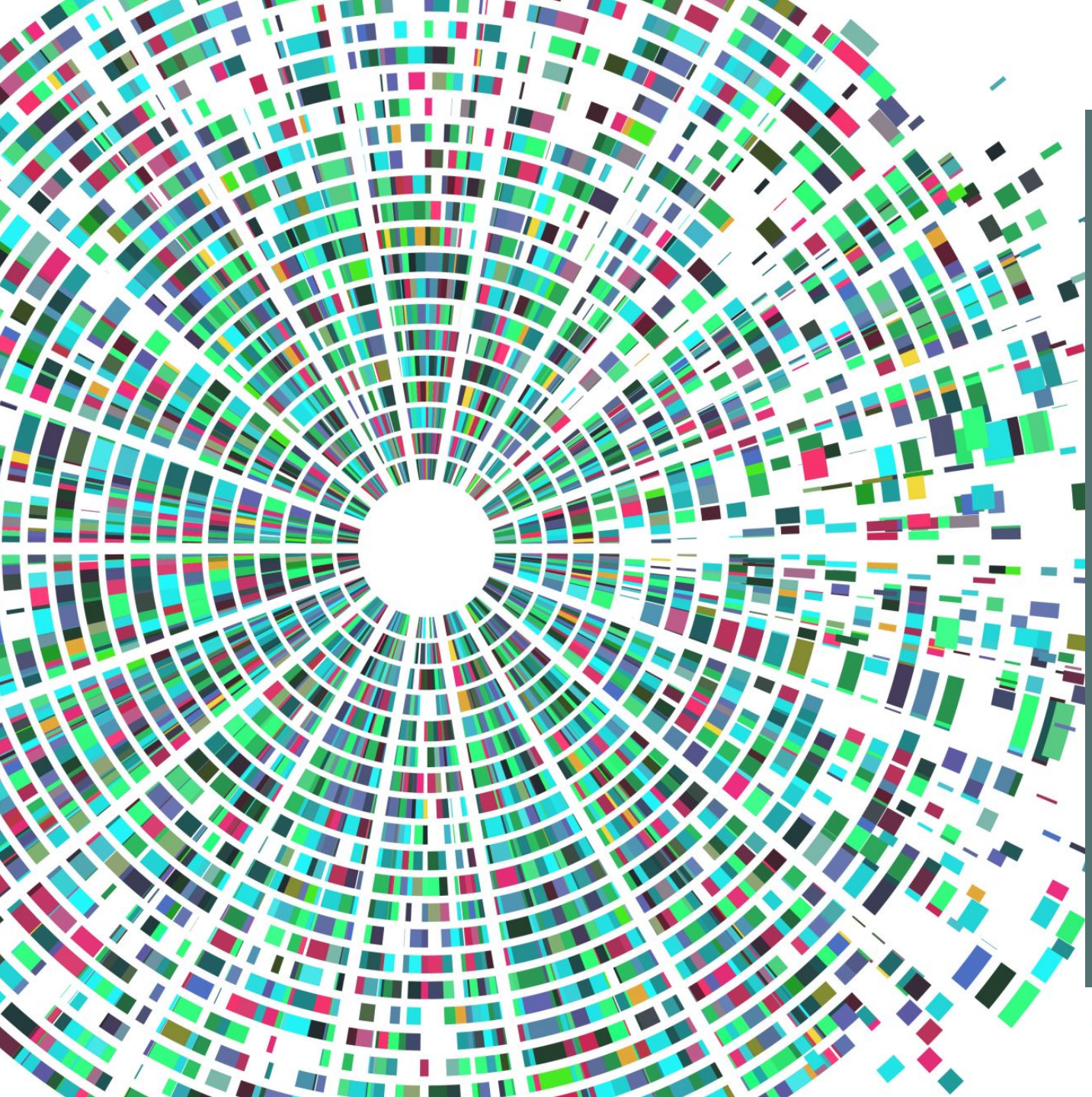


PEDIATRIC FEEDING AND SWALLOWING DISORDERS: IT'S NOT BEHAVIORAL

Brianna Miluk, MS, CCC-SLP, CLC

DISCLOSURES

- Non-financial: Brianna is a volunteer ambassador for Feeding Matters. Brianna is also the co-founder and secretary of the Miluk Forward Foundation. She co-hosts the podcast The Feeding Pod and runs the Instagram page @pediatricfeedingSLP

- Financial: Unfortunately, Brianna has no relevant financial disclosures ;)

ABOUT ME

- Located in Greenville, SC
- MS from Marshall University
  - First taste of pediatric feeding and swallowing
- I married my high school sweetheart
- I am working on becoming a BCS-S
- I love nerding out on all things PFD and teaching, so please don't be afraid to reach out so we can chat!
  - briannamiluk.slp@gmail.com

LEARNING OUTCOMES

DESCRIBE THE FOUR MAIN AREAS OF A PEDIATRIC FEEDING DISORDER

IDENTIFY SIGNS/SYMPTOMS THAT PRIORITIZE REFERRALS TO SPECIFIC DISCIPLINES (E.G. ENT, GI)

APPLY FEEDING AND SWALLOWING STRATEGIES FOR TREATMENT TO CURRENT CASELOAD

DID YOU KNOW?

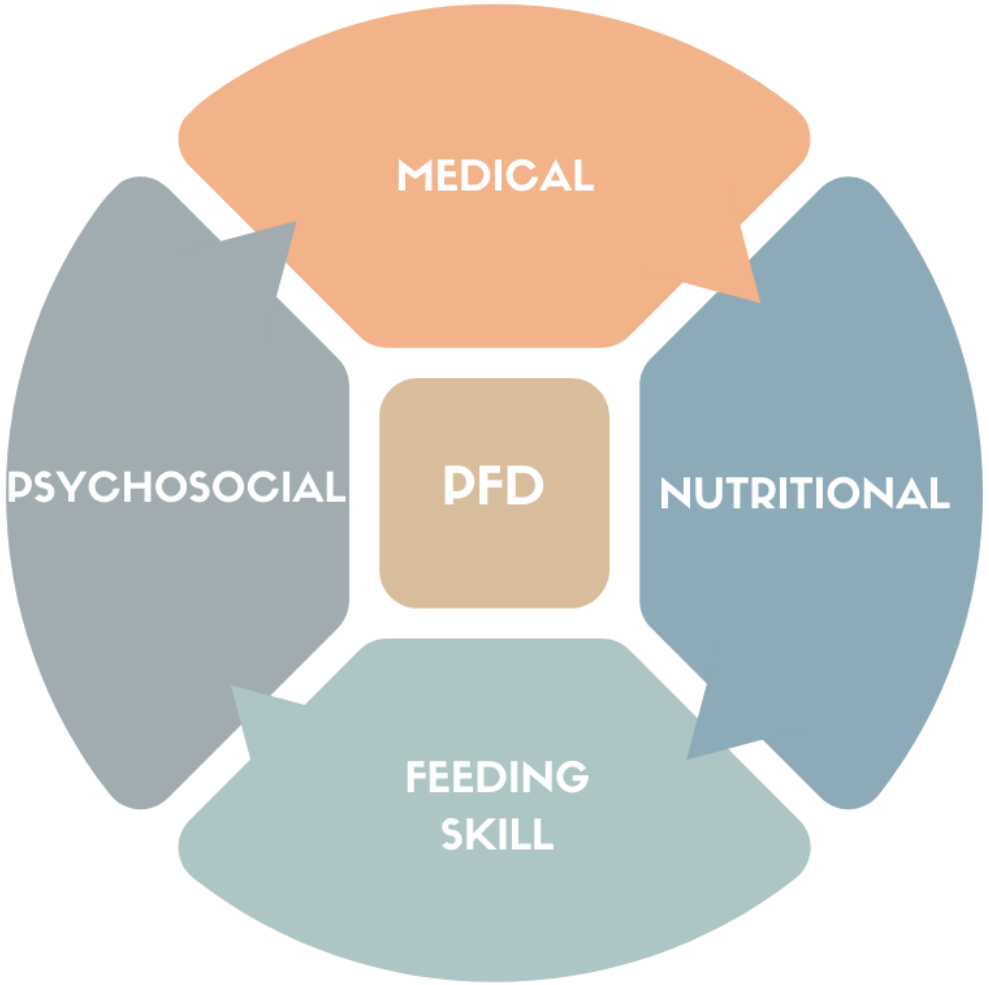
Up to **1 in 23 children** under 5 years are diagnosed with a pediatric feeding disorder?

AND

97.42% of children referred for a behavioral feeding program, had an underlying medical issue(s) interfering with feeding!

WHAT IS A PFD?

- Impaired oral intake that is not age-appropriate, associated with medical, nutritional, feeding skills, and/or psychosocial dysfunction
- U.S. Centers for Disease Control and Prevention (CDC) has officially approved PFD to be a stand-alone diagnostic code (R code) in the next edition of the U.S. International Classification of Diseases (ICD) on October 1, 2021



FOUR DOMAINS OF PFD

MEDICAL

Impaired structure/function of the gastrointestinal, cardiorespiratory, and neurological systems are frequently associated with dysphagia

NUTRITIONAL

Restricted quality, quantity, and/or variety of beverages and foods consumed, placing them at risk of malnutrition, overnutrition, micronutrient deficiency or toxicity, and dehydration

FEEDING SKILL

Altered feeding experiences due to illness, injury, or developmental delay

PSYCHOSOCIAL

Factors within the child, caregiver, and the feeding environment

QUESTION TIME

SLP'S ROLE

- Assessment, diagnosis, and treatment
  - Clinical/educational services
  - Prevention and advocacy
  - Education
  - Administration
  - Research
- Experience in adult swallowing disorders does not qualify an individual to provide swallowing assessment and intervention for children.

COMPREHENSIVE EVALUATION

- Case History
- Assessment of physical, social, behavioral, and communicative development
- Structural assessment of the face, jaw, lips, tongue, hard and soft palate, oral pharynx, and oral mucosa
- Functional assessment of swallowing ability
- Assessment of behavioral factors, including but not limited to (a) acceptance of pacifier, nipple, spoon, and cup and (b) range and texture of developmentally appropriate foods and liquids tolerated.
- Assessment of consistency of skills across the feeding opportunity
- Impression of airway adequacy and coordination of respiration and swallowing
- Assessment of developmentally appropriate secretion management
- Assessment of modifications in bolus delivery and/or use of rehabilitative/habilitative or compensatory techniques
- Consideration for interventions and **referrals**

CASE HISTORY

- Caregiver Concerns
- When did difficulties begin?
- What do you hope to achieve through treatment?

CASE HISTORY

- Pregnancy and Birth History
- Medical Diagnoses
- Medications
- Surgeries, procedures, hospitalization
- Specialists

CASE HISTORY

- Digestion
- Sleep
- Allergies
- Sensory
- Developmental Milestones

FEEDING HISTORY

- At birth
- Changes
- Age of Introduction
- When did difficulties begin?
- Current Feeding Status
- Management of Secretions
- Additional Questions/Information

FEEDING MODE AND SCHEDULE

- Enteral Feed or Oral
- Frequency Intervals
- Length of Meals
- Modified Diet

ORAL FOOD AND DRINK INTAKE

- Bottle
- Open cup
- Straw
- Fed by others
- Self-feeds – finger feeds or with utensils

DIET CONSISTENCY AND TYPES

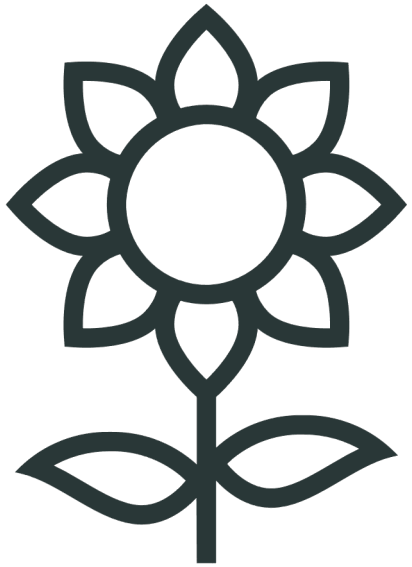
- Food groups
  - Fruits, vegetables, grains, proteins, dairy
- Textures
  - Crunchy, chewy, pureed, cold, hot, etc.

STRUCTURES AND FUNCTION

- Oral/Facial
- Neurology
- Gastrointestinal
- Respiration/Airway/Swallowing
- Genetics
- Gross and Fine Motor

OBSERVATIONS

- Feeding trials
- Caregiver/child led
- Modifications/strategies



BREAK TIME!

RED FLAGS FOR REFERRAL

- Neurology
- Developmental Pediatrician
- Gastroenterology
- Allergist
- ENT
  - Pulmonologist
  - Cardiologist

RED FLAGS FOR REFERRAL

- Genetics
- Endocrinology
- Craniofacial team
- Dietitian
- Psychologist/Counselor
- Physical Therapy
- Occupational Therapy
- Lactation – CLC or IBCLC
- Instrumental – FEES or MBSS/VFSS

HOW TO MAKE REFERRAL

- Make connections
- Find out how they prefer to receive communications
- Send to specialist AND pediatrician
- Include reasons why and most recent progress note (and any other relevant documentation)

BUILD YOUR TEAM

- Be a human… honestly
- Reach out
- Lunch and learn – COVID friendly
- Don't be afraid!
- Share your contact information
- Find out how they prefer – I have some that seriously prefer text updates while others want documents faxed.
    - Of course, always clarify means of communication approved with family and HIPPA compliant

GOALS OF INTERVENTION

Support	Support safe and adequate nutrition and hydration
Determine	Determine the optimum feeding methods and techniques to maximize swallowing safety and feeding efficiency
Collaborate	Collaborate with family to incorporate dietary preferences
Attain	Attain age-appropriate eating skills in the most normal setting and manner possible (e.g. mealtimes with family)
Minimize	Minimize the risk of pulmonary complications
Maximize	Maximize the quality of life
Prevent	Prevent future feeding issues with positive feeding-related experiences to the extent possible, given the child's medical situation

2

TREATMENT PHILOSOPHIES

Responsive Feeding

Experience-dependent neuroplasticity

Interdisciplinary Collaboration

RESPONSIVE FEEDING

Autonomy

Competence

Relatedness

RESPONSIVE FEEDING

- Innate Intrinsic Motivation
- Caregiver attunement to the child and assessment of cues
- Avoidant behaviors are viewed as reactions/responses
- Behavioral feeding therapy tactics are potentially problematic

EXPERIENCE-DEPENDENT NEUROPLASTICITY

- Relearning
  - Limit the severity of the initial injury to minimize loss of function
  - Reorganize the brain to restore and compensate for function that has been compromised or lost
- Compensatory strategies
  - Adaptive or maladaptive
- Changes in learning processes

EXPERIENCE DEPENDENT NEUROPLASTICITY: 10 PRINCIPLES

1. Use it or Lose it
2. Use it and improve it
3. Specificity
4. Repetition matters
5. Intensity matters
6. Time matters
7. Salience matters
8. Age matters
9. Transference
10. Interference

INTERDISCIPLINARY COLLABORATION

- Encompasses all aspects of PFD for assessment and treatment
  - Medical – GI, ENT, PCP, ENT, genetics, neuro, pulmonology, sleep medicine
  - Nutritional – Dietitian
  - Feeding Skill – SLP, OT, PT
  - Psychosocial – Social worker, counselor, psychologist
- Most children will need a combination
- If you do not find out the underlying WHY, treatment will not be successful

CASE STUDIES

Case K

Case D

Case B

CASE K

- Born @ 30 weeks; 44 day NICU stay
- Now: 4 years old
- Refuses all solid food. Only drinks Pediasure from bottle. Will lick crackers/cookies, but does not take any bites
- Started as soon as they introduced solid foods
- Inadequate oral motor skills
- Had adenoids removed, but still snores and has trouble sleeping
- Environment allergies, asthma, eczema
- Coughs a lot, gags, and almost always leads to vomiting
- Always congested/"has a cold"
- Hits, kicks, yells, throws food, cries, and spits when caregivers attempt to get him to eat solid food

CASE D

- Born 38.5 weeks
- Now: 10 months old
- Hospital stay for bronchiolitis at 2 weeks old
- H/o respiratory infections
- Tongue and lip ties released by ENT as recommended by IBCLC
- Snoring while sleeping, went away short time after release, but it is back
- Coughing on liquids and solids
- Gagging and vomiting
- Anterior loss with bottle
- Refuses any solids except smooth purees
- Difficulty drinking from straw and open cup

CASE B

- Born 33 weeks; Grade 4 hemorrhage at birth
- Now: 2 years 1-month-old
- Spastic quadriplegia cerebral palsy
- Medications: ranitidine for reflux, Flovent inhaler daily
- Constipation
- Vomits after eating
- Poor weight gain
- Wakes up a lot at night
- Drooling, bites and chews non-food items
- Drinks from bottle or sippy cup; no straw or open cup
- Eats purees and some chewable solids, such as veggie sticks and spaghetti O's
- Swallows whole, pocketing
- Mealtimes 45-60 minutes
- Supplements with 1 Carnation mixed with ice cream and whole milk
- Already see: ENT, Neuro, Pulmonology, Neurosurgeon, Ophthalmology, OT, and PT

QUESTIONS

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