Complete Summary

GUIDELINE TITLE

Failure to thrive as a manifestation of child neglect.

BIBLIOGRAPHIC SOURCE(S)

Block RW, Krebs NF. Failure to thrive as a manifestation of child neglect. Pediatrics 2005 Nov;116(5):1234-7. [26 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Failure to thrive

GUIDELINE CATEGORY

Evaluation
Management
Treatment

CLINICAL SPECIALTY

Family Practice
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Dietitians
Nurses
Occupational Therapists
Physician Assistants
Physicians
Speech-Language Pathologists

GUIDELINE OBJECTIVE(S)

To provide a guide for the assessment, management, and support of children with failure to thrive (FTT) as a manifestation of child neglect

TARGET POPULATION

Infants and children with failure to thrive

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation

1. History (family and medical)
2. Physical examination
3. Feeding observation
4. Home visit
5. Laboratory and radiologic testing
6. Assessment of risk factors for failure to thrive secondary to neglect

Management/Treatment

1. Period of observation including hospitalization, if needed
2. Referral to occupational therapy and/or speech therapy, as needed
3. Reporting any maltreatment to the applicable child protective services
4. Foster care placement

MAJOR OUTCOMES CONSIDERED

Weight gain

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Assessment

Most children with failure to thrive (FTT) can be assessed by a general pediatrician with the help of professionals in other disciplines. The clinical evaluation for FTT should include a comprehensive history, physical examination, feeding observation, and a home visit by an appropriate health professional. For breastfed infants, an observation of feeding should include an evaluation of the mother's breastfeeding technique and the infant's response to feeding and be conducted by a professional specifically trained in lactation counseling and assessment. Laboratory and radiologic studies are frequently unnecessary. A multidisciplinary approach involving nursing, social services, and dietetics personnel is essential when children with FTT fail to recover and sustain normal growth velocity after treatment interventions.

History

A thorough review of the child's family history should include genetic conditions, growth histories, endocrine disorders, caregivers' knowledge of normal growth and development, family function, eating patterns, types of food available in the home, and family stressors. The child's parents should be queried about personal history of abuse, eating disorders, psychopathology, alcohol use, drug use, domestic violence, and stress; their social skills, nutritional beliefs, and positive assets also should be considered in the evaluation.

The child's medical history should include a general review of systems, current medications, allergy history, feeding history, 72-hour dietary record, gastrointestinal symptoms, travel history, feeding routines, feeding skills, time required to feed, behavior during feedings, sleep patterns, developmental history, daily routine, gestational and prenatal history, and history of organic disease. Information obtained from all child care providers should include a history of eating patterns, interactions, social skills, responses to the providers, and family concerns.

Physical Examination

The physical examination should include documentation of past and present growth parameters, including head circumference, using appropriate growth charts. General examination should include a search for major and minor anomalies, careful neurologic examination, assessment of suck-swallow coordination, and observation of the child's developmental skills and responses and interactive behaviors with parents and examiners.

Feeding Observation

A feeding observation can be performed in the office but is enhanced as part of a home visit. Feeding behavior, the child's oral interest or aversion, and parent-

child interactions before, during, and after feeding should be observed and recorded.

Laboratory Testing

When history, comprehensive physical examination, feeding observations, and home visitation do not reveal an obvious cause of FTT, laboratory testing may be performed to rule out organic disease and ascertain nutritional deficits. Testing should be performed if there are concerns arising from the history or physical examination; however, the yield of positive laboratory data are <1%.

Recognition of FTT Secondary to Neglect or Abuse

The risk factors that should alert the pediatrician to the possibility of neglect as the cause of FTT include:

- Parental depression, stress, marital strife, divorce
- Parental history of abuse as a child
- Mental retardation and psychological abnormalities in the parent(s)
- Young and single mothers without social supports
- Domestic violence
- Alcohol or other substance abuse
- Previous child abuse in the family
- Social isolation and/or poverty
- Parents with inadequate adaptive and social skills
- Parents who are overly focused on career and/or activities away from home
- Failure to adhere to medical regimens
- Lack of knowledge of normal growth and development
- Infant with low birth weight or prolonged hospitalization

Moreover, concerns of abuse or neglect should be raised during the course of intervention and monitored if the following become evident:

- Intentional withholding of food from the child
- Strong beliefs in health and/or nutrition regimens that jeopardize a child's well-being
- Family that is resistant to recommended interventions despite multidisciplinary team approach

Treatment and Management

FTT in the young infant and toddler must be considered a medical emergency if the growth curve documents weight <70% of the predicted weight-for-length. Guidelines on management of less severe cases of FTT are listed in the *Pediatric Nutrition Handbook* from the American Academy of Pediatrics. Because early malnutrition can have severe deleterious effects on early brain development, prompt recognition of severe cases is essential. After resolution of urgent, life-threatening medical conditions, the priority in an evaluation of FTT is a period of observation of at least several weeks to monitor intake, output, growth, feeding style, interactions, and infant/child characteristics. Historically, this has taken

place in a hospital but may be better situated in a home environment, possibly including a foster home, until the cause of the FTT is determined.

Despite current economic and managed care constraints, inpatient care is justified for a child with severe FTT and/or if abuse or neglect is suspected. In contrast to other children, a child with FTT secondary to neglect may eagerly eat in the protective and predictable hospital environment. Liberal intake and above-average weight gain observed in the hospital support a diagnosis of neglect as an underlying cause of the FTT. When appropriate, pediatricians should advocate for inpatient care with managed care plan personnel, because hospitalization has been shown to significantly improve outcome in some cases. However, FTT needs to be considered a chronic process, and interventions need to be long-term.

Severely malnourished children may be anorectic and weak. The institution of adequate caloric intake may be difficult. Moreover, institution of increased feedings may initiate significant metabolic problems, known as refeeding syndrome. Guidelines for diagnosis and management of this condition are available elsewhere. Nutritional guidance and occupational and/or oral-motor evaluation by a speech therapist regarding effective feeding techniques are invaluable. Parents should be involved in all aspects of the treatment program and should be provided with support and education, empowering them to fulfill the care plan.

Suspicion of child maltreatment must lead to a report to the appropriate child protective services agency. The pediatrician must adequately document interventions that have been attempted, specific instructions to parents, evidence of parental understanding of the instructions, evidence of parental understanding of the potential adverse consequences to the child, and evidence of parental failure to adhere to nutritional and feeding recommendations. Intervention by child protective services agencies may increase parental compliance or allow for additional support services such as child care, counseling, and home visitation. If aggressive interdisciplinary intervention fails to correct the weight to safe levels (>80% of predicted weight-for-length) and maintain weight gain, then placement in foster care may be the only alternative. Education and training of foster parents regarding feeding and the importance of close social interaction are mandatory. The involvement of the pediatrician during all phases of protective service intervention is essential.

Guidance for the Pediatrician

1. Pediatricians are encouraged to recognize that child neglect is among the many causes of FTT.
2. Pediatricians are strongly encouraged to consider child abuse and neglect and to report cases of FTT that do not resolve with appropriate interventions.

Conclusions

FTT usually can be evaluated by the office-based pediatrician with minimal laboratory tests and medical interventions. However, for infants with FTT who are suspected to be victims of abuse and neglect, aggressive multidisciplinary intervention is required in either an inpatient or outpatient setting. Close follow-up from a multidisciplinary team and home visitors who are respectful and supportive

of the family are important components of assessment and treatment. FTT as a consequence of abuse or neglect must be considered in families with profiles indicating a high risk of abuse and in families that consistently fail to adhere to the recommended interventions or are unable to maintain a safe environment for their child.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Accurate and adequate assessment, management, and treatment of failure to thrive due to child neglect

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Block RW, Krebs NF. Failure to thrive as a manifestation of child neglect. Pediatrics 2005 Nov;116(5):1234-7. [26 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Nov

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

GUIDELINE COMMITTEE

Committee on Child Abuse and Neglect
Committee on Nutrition

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: Robert W. Block, MD; Nancy F. Krebs, MD

Committee on Child Abuse and Neglect, 2004-2005: Robert W. Block, MD, *Chairperson*; Roberta A. Hibbard, MD; Carole Jenny, MD, MBA; Nancy D. Kellogg, MD; Betty S. Spivak, MD; John Stirling, Jr, MD

Liaisons: Joanne Klevens, MD, MPH, Centers for Disease Control and Prevention; David Corwin, MD, American Academy of Child and Adolescent Psychiatry

Staff: Tammy Piazza Hurley

Committee on Nutrition, 2004-2005: Nancy F. Krebs, MD, *Chairperson*; Jatinder J.S. Bhatia, MD; Frank R. Greer, MD; Melvin B. Heyman, MD; Fima Lifshitz, MD; Robert D. Baker, Jr, MD, PhD

Liaisons: Sue Ann Anderson, PhD, RD, Food and Drug Administration; Donna Blum-Kemelor, MS, RD, US Department of Agriculture

Staff: Pamela Kanda, MPH

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Policy Web site.

Print copies: Available from American Academy of Pediatrics, 141 Northwest Point Blvd., P.O. Box 927, Elk Grove Village, IL 60009-0927.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on January 27, 2006. The information was verified by the guideline developer on February 15, 2006.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx .

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 11/3/2008