Editorial

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Food Refusal in Children

Ravi BK*

Department of Clinical Nutrition, Sri Ramachandra University, Chennai, India

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***Corresponding author:**
Ravi BK

Kundhala@rediffmail.com

Department of Clinical Nutrition, Sri Ramachandra University, Chennai, India.

Tel: 044-4592 8500

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Editorial

Nowadays, children are on the binges where they want to eat what they want. They are becoming picky eaters and eating only certain food. They are refusing to eat good food. Food refusal need not be considered a medical issue in certain situation. An illustration which often comes to my mind in dealing with food refusal helps one to understand the non-medical cause.

A child was refused by her mother to wear a new dress for the grand party at school as it was specifically bought for a family wedding in the mother's home town the following week end. The only way the child thought of exhibiting her displeasure was by refusal to eat not only breakfast but also was adamant not to carry the lunch prepared by her mother. At school the child happily fed herself from her friend's lunch box. Not knowing this the mother was upset that the child did not eat even the dinner. A phone call from the friend revealed the fact that the child was not starving. The mother though moved was firm to teach the child a lesson that refusal to eat does not solve problems.

A child is growing normally and has normal energy level though he/she is not eating the expected diet, there is probably little to worry about. It is important to remember that in the early childhood period, it is time for child's development where he/she is growing very fast and not even required a lot of calories.

Food refusal in younger children and infants, especially refusing to begin to take solids, is usually a different matter.

According to the experts, it is suggested that solid diets should be started for an infant after six months onwards. In the starting, cereals can be given to the child as the solid diet which can be mixed with the breast milk, formula or water and the diet should be fed with the spoon not in the bottle. Feeding of the solid diet can be initiated with the one tablespoon of an iron-fortified rice cereals at one feeding and the amount can be increased to 3-4 tablespoons slowly at the interval of one or two times each day.

If an infant refuses to take the cereal with a spoon when first introduced, then just wait a week or two and try again. Not all children are ready to begin solids at the same time.

If the child is refusing to take solids by the seven or eight months, then an evaluation with a pediatrician is mandatory. If the child is otherwise growing and developing normally, then his refusing to take solids may very well be normal, but it is important to rule out other disorders, so that treatment, if necessary, can be started.

An assessment is especially important if a child is not gaining weight (failure to thrive) and developing normally, or if he coughs, chokes, gags, or vomits during feedings, which may indicate that he is aspirating during feedings and can lead to recurrent respiratory problems.

A child can refuse to take solids due to many common reasons which may include dysphagia (difficulty swallowing), but are not limited to:

Gastro esophageal reflux: Children with this condition will usually spit up a lot, which can lead to esophagitis and pain when swallowing, causing irritability.

Oral motor dysfunction: Can lead to aspiration and recurrent pneumonia, especially in children that cough or gag when eating.

Food aversion disorders: This usually occurs in children with a chronic medical problem, who may have been hospitalized at a young age, requiring help breathing with a ventilator, intravenous nutrition or tube feedings.

Neuromuscular disorders: Such as cerebral palsy can cause trouble swallowing.

Obstruction: delayed gastric emptying or other gastrointestinal obstruction

Achalasia: An uncommon condition, especially in younger children, in which the muscles of the esophagus do not work properly, so that foods do not move through the esophagus to the stomach normally.

Many other anatomical and neuromuscular disorders can also cause dysphagia.

A thorough evaluation by a pediatrician, with special attention

to the child's growth and development, is usually required for children with dysphagia. If the child is growing and developing normally and has good weight gain, then it is not unreasonable to wait a week or two and continue to try and feed small amounts of solids.

Additional testing may be required if the child has dysphagia and he is not growing and developing normally, or if he is not improving after a period of watchful waiting.

Further evaluation is usually with a speech pathologist or occupational therapist, who can observe how the child swallows, or attempts to swallow, foods of different consistencies. These specialists are usually part of the early childhood intervention programs that are available in most areas.

The most common test performed for children with swallowing difficulties is a video swallow or video fluoroscopy, which is a type of barium swallow. In this test, barium with different consistencies is given to the child to drink. X-rays are then taken to see if the barium is swallowed or aspirated. This test is usually done with the assistance of a speech pathologist that can observe and look for swallowing abnormalities.

Treatments for dysphagia depend on the underlying cause. Reflux is usually treated with an antacid. Food aversion and oral motor dysfunction is usually treated by a speech pathologist and/or an occupational therapist.

Treatments include changing the position the child is in when he feeds, and offering foods with different consistencies. The speech pathologist will also attempt to desensitize the child to having solid foods in his mouth, especially if he seems hypersensitive to having things in his mouth. Special adaptive feeding devices may also be used.

Refusal to eat is therefore a problem related to multiple issues and treatment should be based on understanding root cause. It needs special handling so that it does not adversely affect the child. Nutritionists have to work with allied team members to handle certain issues. The age of the child plays a prominent role in planning strategies for treatment. Effective and timely interventions are required in some cases, whereas thorough observation is sufficient to deal with the root cause in most cases.