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Gastro-oesophageal reflux and feeding: the speech and language therapist's perspective

Sue Strudwick*

Maple Children's Centre, Kingston Hospital, Wolverton Avenue, Kingston, Surrey, KT2 7QD, UK

Abstract

Babies and children with gastro-oesophageal reflux often have significant feeding difficulties. The symptoms of reflux are described, including the higher risk of aspiration. Babies can present with motor and sensory feeding disorders and can quickly develop aversive reactions to the feeding process. This effect can be long-term, and speech and language therapists use various techniques to provide babies and young children with positive sensory experiences to reduce aversion and promote successful oral feeding. Advice on grading the introduction of textures to the child's diet, messy play and advice on communication and interaction will also form part of the feeding plan. The stress on the parents will be discussed. Research shows that a truly collaborative multidisciplinary approach is likely to be the most successful, encompassing the nutritional, medical, psychosocial and developmental aspects of the child.

Keywords: Gastro-oesophageal reflux; Speech and language therapist; Sensory disorders; Parental stress; Multidisciplinary

1. Introduction

Gastro-oesophageal reflux is a major factor in many children with long-term and short-term feeding difficulties. Reflux can occur in all children, but premature babies and children with neurological impairments are most prone [1]. It is important to consider the variety of symptoms that can indicate the presence of reflux, the impact on feeding at all stages of feeding development, the stresses that the family suffers and the advantages of therapeutic intervention.

* Tel.: +44-2085-467711x2595; fax: +44-2085-411648.
E-mail address: sstrudwi@kingstonhospital.nhs.uk (S. Strudwick).

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1.1. Symptoms included

Vomiting (frequent or not); refusal of food; starting to feed then breaking off; playing with the teat in the mouth without sucking; fighting before the feed starts and then giving in and feeding; refusal to start feeding again after winding; screaming in pain during feeding; arching of the back when feeding; feeding better when asleep or less alert; gagging before the feed starts; showing dysphagia and uncoordinated oral–motor patterns; having hoarseness/wheeziness; showing signs of aspiration, including coughing, choking, apnoea; having persistent phlegm. The baby is at higher risk of aspiration with an oedematous pharyngeal and laryngeal area.

2. Long-term impact on feeding

- The baby can present with failure to thrive. In my experience, if there is no weight loss, the reflux symptoms are frequently left untreated or conservatively treated until the situation deteriorates.
- Some babies show panic as food enters the oral cavity and this can last well after the reflux has been controlled medically.
- Persistent food refusal is very common, and it can prove very difficult to introduce solids and develop a positive interest in food.
- Children who have suffered from reflux have often developed both an oral and a tactile hypersensitivity and will not touch food or certain other textures, such as sponges, sand or water.
- As a result of this sensitivity, children are unable to move on in their feeding development to more challenging textures, and they are then later unable to develop the skills to be able to cope with lumpy food as stated in Northstone et al.'s [2] research.
- Children may be left with a legacy of selective eating and a restricted diet.

3. Stress on the family

Parents report that they suffer extreme stress with a baby with reflux. Feeding predominates their lives and they are unable to carry on with normal social activities. For instance, the baby may need a very quiet, calm environment in which to feed, and this means that he/she always has to be fed at home. Children with special needs will not be able to attend hydrotherapy sessions and other specialist activities because of their vomiting. Some of the babies' development is delayed as a result of not being put down on the floor because of fears of aspiration from vomiting. Most children with reflux cannot be fed by other members of the family or other carers, and can only tolerate being fed by their regular feeder.

Most parents report that the support they received was insufficient to cope with all the difficulties that reflux brings, and this is especially true for those families with other siblings. Another cause of stress that parents report is that health professionals do not listen to them and do not take the situation seriously. Many parents are told not to be concerned,

as their baby is not losing weight or will ”grow out of it”. If this is the case, the abnormal feeding pattern is likely to continue for many months or years. This often alters the mother/child relationship, which impacts on both the child's development and the family dynamics. In addition, these parents often have many hospital appointments or admissions, which is another cause for stress. The long-term impact on feeding can lead to multiple worries. Most parents feel they have failed. Feeding is central to the nurturing process, and when this breaks down, it undermines the very core of the parenting role.

4. The speech and language therapist's role

Our role initially involves observing a feed at home. Very few professionals actually observe a feed and rely on reports from the parents. This often leads to an underestimation of the impact of the reflux on the feeding process, of the abnormal feeding pattern and of the destructive influence these problems inflict on the family. The speech and language therapist will then assess the child's feeding skills and development, and evaluate whether the child is at the expected developmental level in terms of oral–motor skills, types of food offered and communicative/interactive feeding behaviour. Utensils and environment can be adjusted as can the position of the baby, all of which may help.

Advice on communication and interaction will also form part of the feeding plan. A core part of our intervention will be to reduce aversion to the feeding process through positive oral stimulation and food play at the appropriate developmental level. This is obviously contingent on the reflux being managed medically. As feeding develops, the speech and language therapist can adjust the introduction of solids and grade transitions to more challenging textures appropriately, together with dietetic advice.

But the most important role that we have is to support parents in the home as part of the multidisciplinary team. Research by Batchelor [3] has shown that effective intervention for children with failure to thrive or faltering growth should involve work within the home and a truly collaborative, multidisciplinary approach.

In conclusion, in order to assess and treat these children effectively, the multidisciplinary team must collaborate to provide intervention that includes the nutritional, medical, psychosocial and developmental aspects of the child with reflux.

References

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