

SUBSPECIALIST CONSULT

The Infant/Toddler With Delayed Development

Start with identification of a possible delay by reviewing developmental milestones. Most general pediatricians do this routinely. For example, being able to grab and transfer an object is a milestone at about 5 months of age. Some infants develop this fine motor skill at 4 months or 6 months, so sometimes delays are within a reasonable time frame.

Be aware of who is at high-risk for delayed development. Consider pregnancy, labor and delivery, and birth history. Did the infant have any acquired illnesses during the first few months of life? There could be a setup in utero for subtle presentations in the first few months of life.

If you suspect that an infant or toddler is experiencing developmental delay, close monitoring is warranted. Have the patient return sooner and more frequently than you would otherwise with routine well-child visits.

If a suspected delay becomes more prominent, consider referral to a subspecialist. When to refer a patient for fur-

ther evaluation can be subjective, but it is better to err on the safe side. As a general rule, if the child is more than 3 months behind in any developmental area, referral is warranted.

A concern for me is that some pediatricians tend to underplay a possible developmental delay for too long. Telling concerned parents to “just give it some time” can be dangerous, particularly if suspicions about a true clinical delay are ultimately confirmed.

Early diagnosis and identification of the cause for the delay increase the likelihood it can be corrected or treated more effectively.

Seizure, congenital brain abnormality, and metabolic disorder are potential etiologies for developmental delay.

Remember to assess the four general areas of infant and toddler development: gross motor skills, fine motor skills, language, and social interaction. The delay or delays demonstrated by an individual child guides the patient’s management. For example, an infant with gross motor

deficits could benefit from consultation with a physical therapist. A toddler with fine motor delay could improve with the assistance of an occupational therapist.

Speech therapy might be warranted, as well, depending on the age of the child. At around 18 months, for example, most toddlers display significant gains in language and socialization skills. Always keep autism in mind with speech and socialization delays—this is a big area of concern today.

Ask yourself if the child has a global delay or a specific delay. The more global the delay, the more I worry about brain involvement. If an infant presents with low muscle tone, try to determine if the brain, spinal cord, nerve and/or muscle systems are involved. Deficits in each system necessitate different treatment approaches.

When performing a physical examination, look for an asymmetrical head or dysmorphic appearance. If the child does not look like the rest of the family—for example, has a small jaw, a small head, or rotational ears—the developmental delay could have a genetic basis.

We know a lot more about genetic

causes now than we did even just 5 years ago, in part because microarray assessment allows us to detect genetic microdeletions.

Although some general pediatricians can and do order diagnostic tests and imaging to confirm delayed development, many rely on a subspecialist for further work-up of the child. Often subspecialists do an MRI scan after initial screening and examination. Metabolic laboratory tests also are useful for screening and diagnosis.

Be careful about what I call “scam” treatments. For example, some families might consider trying bariatric oxygen, stem cell treatments, or vitamin therapies. While omega-3 fish oil supplements may not hurt the child, they are not necessarily helpful either.

Follow these patients regularly for progress to guide families and determine appropriate treatment over time. ■

DR. SCHUB is section chief of neurology at Children’s Healthcare of Atlanta at Scottish Rite, and in pediatric neurology private practice in Atlanta. He had no relevant financial disclosures. E-mail him at pdnews@elsevier.com.



BY HOWARD S. SCHUB, M.D.

Failure to Thrive Symptom Demands Multifaceted Exam

BY BETSY BATES

LAS VEGAS — Think of failure to thrive as a symptom, not a disease, Dr. Carol D. Berkowitz suggested.

Defined as growth that is not progressing at the expected rate, failure to thrive is diagnosed on a continuum, when a child’s arc of growth slips by two major percentiles on a growth chart, she said at a seminar on practical pediatrics sponsored by the American Academy of Pediatrics.

Regular assessment of a child’s height, weight, body mass index, and dentition (the “poor man’s bone age”) are critically important in making the diagnosis.

Then, it’s the pediatrician’s job to get to the root of the problem, which is possible about 95% of the time, said Dr. Berkowitz, professor of clinical pediatrics at the University of California, Los Angeles.

The first question is whether failure to thrive exists at all in a given patient. Children’s growth is stepwise, and those destined to be constitutionally short may at times look like they are falling behind.

“Measure the parents,” said Dr. Berkowitz. “No one admits to being under 5 feet tall.”

Next, be like Willie Sutton, the famous bank robber. Go where the money is, she advised. With failure to thrive, “a lot of money is in the birth history.”

Obviously, questions begin with a review of gestational age and birth weight. Simple prematurity may instill a false sense that a child is not growing at the expected rate; this growth should catch up by age 2 years.

Children with Down syndrome or other genetic syndromes would similarly be expected to grow at their own rate, plotted on their own growth curves.

But the birth history can reveal more subtle clues to growth delay as well, explained Dr. Berkowitz. Tight intervals between pregnancies (ideal spacing is 2.5-4 years) may have had an impact on the child’s in utero growth.

A history of maternal miscarriages prior to the child’s birth may point to genetic issues missed during

newborn evaluations, and may raise questions about lingering maternal depression. “Ask, ‘Was this a planned pregnancy?’” Statistics show that half of all pregnancies are unplanned, but it may be valuable to know about lingering ambivalence on the part of the mother, who may be struggling to take care of a child who was not wanted, she said.

The question with the most “bang for the buck” involves maternal exposure to cigarettes, alcohol, and drugs during pregnancy, said Dr. Berkowitz.

“The answer you get depends on how you ask it,” she cautioned. Rather than posing a yes-no question, she asks a question about quantity, with the presumption of an affirmative reply: “So, what drugs did you take?” or “How much did you smoke?”

If a mother says she cut way back on drinking, Dr. Berkowitz might ask, “Like a 6-pack on the weekend?”

If fetal alcohol syndrome is suspected, she might ask to see a child’s kindergarten picture, because fetal alcohol syndrome facies may not be as evident in the maturing face of an older child.

Not uncommonly, a medical issue such as thyroid malfunction will drive failure to thrive.

Severe eczema, extreme allergy-restricted diets, and even profound asthma can interfere with a child’s calorie intake. In the case of a patient who had a chest wall deformity, simple energy output was to blame. He was taking 80 breaths a minute. “He was burning calories just breathing,” she said.

Some of the toughest cases to diagnose are not related to organic issues, but to the environment. In a chaotic household or a homeless family, the child may not be fed.

Other times, environmental deprivation may be an

outgrowth of maternal depression, misperceptions of the child as being ill or mentally retarded, or even the hostile singling out of one child for neglectful care, “as great a risk to the child as intracranial hemorrhage,” said Dr. Berkowitz.

Children removed from their homes by social services may not be free from environmental deprivation, she added, recounting the case of a 39-month-old child who appeared thin and wasted, despite her foster mother’s insistence that she was a voracious eater. In this case,

simple observation was useful.

The child gobbled small bags of peanut butter crackers available in the clinic, but was prevented from eating more by the foster mother, who insisted that they be saved “for later.” When the child at one point reached for the foster mother’s hand, a staff member saw the foster mother yank her arm away.

When a child is in foster care, “be vigilant,” she said. “Do not assume it’s a good match.”

Anytime a caregiver reports a huge caloric intake and no weight gain in the absence of diarrhea, “be wary,” Dr. Berkowitz said. The history may be confabulated, or caregivers may be preparing formula incorrectly, with too much water.

Nutritional consultants can help to devise a plan for supplemental calories, assuming that the problem is organic or practical and not deeply entwined with environmental limitations of the family.

But when a child’s failure to thrive is due to failure to care, the prognosis is poor without a change in environment. Fortunately, even very deprived children are likely to rebound quickly when placed in a loving environment with plenty of food, she said. ■

Disclosures: None was reported.

The question with the most ‘bang for the buck’ involves maternal exposure to cigarettes, alcohol, and drugs during pregnancy. ‘The answer you get depends on how you ask it.’