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"It is amazing how much crisper the general experience of life becomes when your body is given a chance to develop a little strength." (Duff, 2005)

Introduction

Pediatric undernutrition is a clinical syndrome well recognized as a precursor to an array of health problems in the pediatric population (Kessler & Dawson, 1999). Undernutrition may result from insufficient access to calories, or it may be due to the infant's inability to ingest adequate nutrition (Rielly et. al., 1999). The latter is typically classified under the umbrella label of 'failure to thrive' (FTT). The diagnostic criteria for FTT in infancy and early childhood are continuously evolving as the medical community establishes accepted definitions and signs of this syndrome (Kessler & Dawson, 1999). Currently, diagnosis is based on the presence of 'wasting', a term used to describe a sudden deficit in weight-for-age or weight-for-height measurements, as compared to norm-based growth charts, and its correlation with weight measurements below the 5th percentile (Boswinkel & Mamula, 2003). The diagnosis of FTT is also closely tied to its known etiology; historically, the most-accepted etiological categories are organic versus non-organic failure to thrive (Kessler & Dawson, 1999). For some infants, there is a known organic cause of their FTT (e.g.; genetic or congenital abnormalities, endocrine deficiencies, disease). However, for others, there is no one characteristic or medical sign concentrated enough as to be considered the root cause of the syndrome (Kessler & Dawson, 1999; Reilly et. al., 1999). There has been a strong debate surrounding this dichotomy for many years; some professionals feel that most cases of non-organic failure to thrive (NOFTT) have a neurodevelopmental etiology that is too minute to detect with standard testing, and therefore the term 'non-organic' is inappropriate (Reilly et. al., 1999; Rams(h)-0.957164(.)-roph e , 200

methods. The specific feeding details derived from the SOMA results are very valuable to clinicians working with NOFTT infants. Nevertheless, the lack

dysfunction, and therefore a label of ‘non-organic’ is misleading.

c c on All subjects were referred by a ‘health visitor’ from child-health clinics within a defined low SES inner-city area, and were previously known to have a form of FTT. This method of sampling presents two weaknesses: the referral source (i.e.: health visitor) was not defined, nor was their clinical expertise reported, as well as the homogeneity of the sample which renders the results less transferable to the general population. The study also had a relatively small sample size (n=9), however the authors were able to match their controls based on a number of relevant variables, therefore increasing the power of their results by controlling for moderators.

M n ‹'oc d - The procedure involved a semi-structured interview with the mother, a video-recorded meal in the home during which the researcher was inconspicuously present, and the presentation of the FAS following the meal. The authors reported the stringent criteria under which they devised their FAS, including a standardized presentation of the varied food categories (liquids, purees, semi-solids, firm-solids). They also developed different versions of the scale for infants 9-12 months and 13-15 months in order to control for the natural development of oral-motor control. While data was not provided, the authors presented a thorough explanation of the conceptual basis of the tool. The scoring of the FAS was done primarily from video, however the researcher recorded specific moments of OMD that he/she felt would not be visible on the videotape. This likely strengthened their ability to detect minute aspects of OMD. Moreover, the researchers were blinded to the subject’s group (case vs. control), thereby reducing the potential for expectation bias. In general, this study provides compelling evidence with regard to the specific feeding difficulties of NOFTT infants, albeit from a homogeneous small sample size.

Conclusions

The reviewed research highlights a number of critical factors when considering the feeding and swallowing capabilities of infants with NOFTT. There are, however, numerous limitations in the research methodology that must be considered if implementing the results in a clinical capacity. Foremost, the recurrent issue of a non-reliable assessment tool when studying the feeding and swallowing habits of infants with NOFTT presents as a major global weakness of these studiesudis su-365(a)-2.644sses 5(n)5.0732(o)-7.00166(r)-5.0012956603(i)0.3142( )-257.0

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