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Feeding Complications of Reflux

Frequently Asked Questions (FAQ)

One common link among many children seen for feeding difficulties is a history of gastro-esophageal reflux, the backward movement of food or liquid into the esophagus, pharynx, and/or oral mechanism. Although some children with feeding problems have never been diagnosed with reflux, they often present with clinical symptoms such as arching, hard, audible swallows while the child is playing or otherwise engaged (not eating); eye reddening and subtle color changes associated with feeding; and fussiness while eating or immediately following a feeding. Some children also present with volume limiting, food selectivity, texture aversion and oral tactile defensiveness. Reflux can generally be treated with medications and clinical interventions, but in the most severe cases may require surgical intervention.

If my child has never been diagnosed with reflux, do I need to be concerned?

If your child presents with feeding complications identified in the list above she may have reflux. If a child “spits up” frequently, it is easy to identify reflux. Unfortunately, some children have “silent reflux”. That is, reflux that occurs with out spit up therefore we need to identify reflux by using other more subtle cues.

Why is it so important to rule out reflux?

It is important to rule out reflux and other gastrointestinal problems promptly because they can interfere with typical feeding development. Even very young infants with reflux will quickly learn to associate feeding with the painful, burning sensation, which results from reflux. This can lead to complete or partial food refusal. Second, although the area is new to researchers, current findings indicate that reflux in infants and children may alter the child’s sensory perception pathways, making it difficult for the child to tolerate sensory input, especially tactile stimulation. As a result, hypersensitivity to tactile stimulation will be evident not only in the child’s avoidance of certain textures touching his body, but also in his avoidance of different textures in his mouth. Children who do not mouth objects miss out on an important means of exploring their world and will often lag in the development of the oral sensori-motor skills required for feeding. In addition, these children often have difficulty transitioning from smooth, pureed baby foods to foods with increased texture, such as chunky baby food (stage 3 baby food), mixed textures or crackers and other table foods. Their hypersensitivity to textures in their mouth often leads to a gag reaction or even vomiting when presented with these textured foods.

What is hypersensitivity?

Hypersensitivity means to be overly sensitive and is characterized by aversive reactions to non-threatening factors in the environment. Hypersensitivity can evidence itself in a variety of ways. In addition, one or more sensory systems may be involved including taste, smell, auditory, visual, tactile and vestibular.

What does hypersensitivity have to do with eating?

The most obvious choice for which the sensory system would impact feeding is taste. Some children prefer very bland tasting foods while others, often children who experience gastro esophageal reflux, prefer stronger tasting or spicy foods. However, children often decide they will or will not eat a certain food based on the way it smells, looks or feels. Frequently, children who are overly sensitive to foods will present with aversive behaviors to the taste, sight, smell or touch of these foods. Some of these behaviors may include turning away, removing the offending food, grimacing, crying, gagging and even vomiting. Children with significant sensory defensiveness to foods often eliminate many types of food from their diet and live off of only a few different foods everyday.

What can I do if I notice that my child seems hypersensitive?

In order to address a child’s oral hypersensitivity, one must first work through hypersensitivity to touch and textures on his body. For example, you can play with your baby in a sensory box of uncooked beans or rice, encouraging her to put her hands and feet in the rice, or you can help your child to finger-paint with pudding or

baby food. You can also play in the sandbox, the grass, exposing her to different textures on her body and her face. Bath foam, shaving cream and bath paints are other fun sensory bath experiences. The brushing program may benefit your child and can be explained by your therapist. As the child's tactile defensiveness decreases, the clinician and parents can begin to stimulate the child's mouth. This may be accomplished by encouraging the child to mouth toys (vibrating toys are especially effective), by using a toothbrush or Nuk massage brush to play in the child's mouth, or for very young babies, by allowing the child to suck on your finger. For children who are above the age of 8 months and have not transitioned to textured baby foods or soft table foods, small amounts of finely ground graham cracker crumbs are added to his smooth pureed foods in order to gradually increase the amount of texture tolerated in his food. As tolerated, either the size or the amount of crumbs is increased, but not both at once. It is important that a therapist trained in pediatric dysphagia monitors this progression, ensures that all GI issues are being addressed and aids in creating a program specifically for your child.

My child is limiting food choices. What do I do now?

It is important to continue to offer your child a variety of foods, but just as important that you don't force her to eat it. Keep in mind that it may take up to seven non-threatening presentations of a new food for a typical child to even try it. Keep in mind that if she doesn't like certain textures of food, chances are she doesn't like to touch these textures, as well. Encourage her to become familiar with the texture of the food she is avoiding by presenting that texture in a tactile experience such as the activities described above. In addition, to help decrease hypersensitivity around her mouth, start exposing her face to a variety of textures. Play peek-a-boo games with washcloths (wet, dry, cold, warm) with the goal of having her tolerate facial massage. Use vibrating toothbrushes to tickle and massage her cheeks. Often, when a child begins to feel comfortable with new textures on her skin, she will become more daring at trying new foods and tastes.

How do I know my child is hypersensitive to foods?

Some parents assume their child is "just picky." It is very important to first, observe her behaviors when food is presented. How does she react? Hypersensitive children are often extremely cautious when presented with any type of food. What happens when new foods are presented? Will she accept it or does she only like one type of food (sweet, light colored, crunchy, soft)? Does she mind being messy or touching new textures? Will she make strange faces or grimaces at the feel of a new food?

What if my child is hyposensitive and is able to swallow large pieces of food whole?

The other extreme of hypersensitivity is hyposensitivity. Hyposensitivity means that a child's sensory system needs more sensory input for processing. These children may have just experienced a hard fall or banged into the corner of a table and not even complain about it. They may not feel drool on their face, food on their lips or in their cheeks. Hyposensitive children often enjoy oral stimulation and frequently place toys or objects in their mouths. Their gag reflex is often hypo responsive as well. A hypo responsive gag response is particularly dangerous if a child is able to swallow large pieces of food. The protective gag reflex is not active and the risk of airway and esophageal obstruction is significant. Other complications may include constipation and malabsorption. Treatment recommendations often include reducing textures to puree and then reintroducing the textures as chewing is established and the gag reflex is reinstated. Please refer to our FAQ on swallowing food whole.