Pediatric nutrition—What's new?

The new BC Pediatric Nutrition Guidelines[1] introduce a holistic, family-centred approach to feeding children aged 0–6 years, focusing as much on *how* to feed as *what* to feed. The introduction draws attention to important social and cultural determinants of eating, such as food insecurity and nontraditional diets.

Nutrition is one of the most important modifiable determinants of health. At birth, the brain's potential for change with minimal intervention is almost infinite. Early feeding can influence epigenetic changes, neuroendocrine pathways, and behavioral patterns that establish the trajectory for lifelong eating, metabolism, and weight; it is critical that we empower patients with good information from the very start.

Responsive feeding

A key principle emphasized in the guideline is responsive feeding, which involves responding to children's cues for hunger and fullness in developmentally appropriate ways without pressuring or overt restriction. Responsive feeding can be operationalized using a division of responsibility—parents decide what to offer and children decide if and how much to eat. Babies should be fed on demand and gradually transitioned toward regularly scheduled snacks and family mealtimes. Parents can be reassured that children's appetites and tastes vary and develop over time, eating more at some times than others, and parents may need to offer a new food up to 15 times or more before children accept it. Responsive feeding promotes autonomy and allows children to retain their natural ability to recognize internal cues for fullness and hunger. This, in turn, is linked to healthy eating habits, self-regulation of food intake, lower rates of malnutrition, and a more consistent growth trajectory across the lifespan.

Nonresponsive feeding, such as bribing, coaxing, forcing, or using food for boredom, distraction, reward, or punishment, is associated with picky eating, emotional eating, growth faltering, and weight acceleration. Excessive restriction of higher-fat, sugary, or processed foods can adversely affect self-regulation and inadvertently lead to over- or underconsumption. Parents can offer these foods in moderation as part of family meals or celebrations to help children experience them as a normal part of eating, not as forbidden foods. Eating together with available adults and making mealtimes an enjoyable social experience, free of distractions (such as screens), is associated with healthier eating habits and improved mental well-being.

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Growth monitoring

The guidelines include an important new section on routine growth monitoring and its potential to cause anxiety and undermine responsive feeding when parents or providers place too much emphasis on weight. Given its lack of evidence in relation to long-term health benefits, providers should exercise caution when interpreting routine growth monitoring. Providers should use only proportional (weight-for-length and body mass index), not age-based, measures to avoid overdiagnosing short or tall children as under- or overweight, respectively. They should also recognize that infants' and children's weight fluctuates normally over time; the smooth lines of growth charts are population averages and don't reflect how individual children grow. During their first 2 to 3 years, children often cross percentile lines as they transition from their intrauterine-determined weight to their genetically determined future weight. Primary care providers should be mindful of their own anxiety and understand that for otherwise healthy and asymptomatic babies who are shifting percentiles, a period of watchful waiting is often appropriate.

A few more tips from the guidelines

- Introduce allergenic foods (e.g., peanut butter, seafood, soy) around 6 months and offer them frequently as some of the first foods, especially for babies with a family history of atopy or allergy. Parents need only wait 3 to 4 hours between introducing different foods.
- Introduce high-iron foods first (e.g., meat, fish, eggs, legumes, iron-fortified cereal).
- Avoid all honey (even pasteurized) until 1 year of age due to the risk of infant botulism.
- Encourage water for thirst between meals and milk only with meals (maximum 2 cups per day) to avoid overconsumption of milk, which can displace other foods and contribute to iron deficiency.
- Avoid sweetened beverages, including juice, sweetened milks, and nutritional supplement drinks, before age 2; energy drinks should be avoided for all children, especially before age 4.

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the meantime, these vaccines are commercially available for purchase in the private market. ■

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- Plant-based beverages (e.g., soy, oat, and almond milks) are not nutritionally equivalent to dairy milk and are not recommended before age 2. Soy-based formula is an acceptable alternative to dairy formula for vegan infants and others.
- Full-fat cow's or goat's milk can be introduced at 9 to 12 months (once infants are eating a wide variety of solids) and continued until 24 months.
- Providers are encouraged to use neutral and nonjudgmental language rather than talking about healthy, unhealthy, or junk foods. ■

—Ilona Hale, MD, FCFPC
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and cautions that "how you perform the physical exam, and how often you perform it, can change over time and become overly limited without you realizing the impact on patients."[2] Performing a physical exam can also increase patients' confidence in the physician and validate that they have been heard.

If you have questions about your patients with workplace injuries/illnesses and would like to speak with a physician at WorkSafeBC, please contact us through the RACE app at www.raceconnect.ca/race-app. ■

—Harvey Koochin, MD
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