

Fussy eating in children: when should we worry?

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Fussy eating is common in childhood, and a frequent cause for stress in parents. It can start as early as two months with the disappearance of the sucking reflex. Data suggests introducing solid, lumpy food no earlier than from six months onwards, or children are more likely to develop fussy eating habits.

Babies six to 12 months are usually open to eating anything that is offered, and fussy eating usually starts just after turning one and peaks at around 20 months of age, mainly with the introduction of food that leaves a bitter aftertaste, such as vegetables.

However, it is important to persist and keep offering them non-sweet and non-fat food in this crucial developmental window, to prevent future fussy eating. Tongue protrusion may be a problem in babies refusing food, but this is considered a normal initial physiological reaction to solids and can be overcome with persistence. Thus many parents may think their child is fussy, when, they are showing normal, age-appropriate behaviours.

The first consideration is growth: it is imperative to do an accurate anthropometry and establish their percentiles both for height and weight. The next thing to consider is nutrition, and good growth may not necessarily mean good nutrition.

Review of grazing habits and beverage consumption through a typical day is important, and aim to reduce all sugar containing drinks, including fruit juices, especially at least 30 minutes prior to mealtimes. Go through different food groups which can have specific nutritional value, such as milk/dairy providing the calcium requirements of the body, meat being a good source of zinc and iron.

Specific vitamin deficiencies, for example vitamin A, C or B12, arising from a restrictive diet, can give rise to distinct conditions.

If either growth or nutrition seem to



be affected, further investigations may be warranted.

When to suspect more serious issues

Pattern recognition is paramount, always suspect eosinophilic esophagitis (EoE) in a child with atopy, food allergies and frequent vomiting.

However, children may present with a wide range of symptoms and signs including reflux, regurgitation, coughing, food refusal, poor sleep and vomiting in the younger child; to abdominal pain, swallowing difficulties, retrosternal pain, drinking excessive water at mealtimes and food bolus obstruction in the older child.

Peripheral blood eosinophilia and/or raised total IgE level may be seen but not universal. Children with a past history of cow's milk protein allergy and autistic children are more prone to having EoE. A high index of suspicion and prompt referral for a gastroscopy with biopsies can lead to an early diagnosis and effective, tailored management in these children.

Paediatric feeding disorder (PFD) is defined as impaired oral intake that is not age-appropriate, and is associated with medical, nutritional, feeding skill, and/or psychosocial dysfunction. If suspected, an early referral to a specialist and subsequent involvement of a multidisciplinary team is warranted.

Evaluation by a speech therapist, possibly with a videofluoroscopy may be appropriate. A dietician must be involved if malnutrition is suspected, and high calorie supplementation is deemed necessary. Psychosocial impact on feeding may be significant and should be appropriately assessed by professionals. A paediatric gastroenterologist must be involved to determine the need for bloods, imaging, endoscopy for example, and these children often need long-term monitoring and follow up at a multidisciplinary feeding clinic.

Community management

In primary care, the focus should be on evaluation and interventions, rather than investigations. After initial evaluation of growth and nutrition, and as long as EoE or PFD is not suspected, there are several strategies that can be implemented, mainly with a view to promote appetite and increase the range of food groups offered in the diet and supplementing vitamins and minerals to ward off any nutritional deficiencies.

Interventions include increasing the gap between mealtimes to


Key messages

- Evaluating growth and nutrition is the first step in assessing children with fussy eating; good growth may not mean good nutrition
- Most children do not need investigations in primary care. Commonsense behavioural interventions are the cornerstone of management in the community
- A low index of suspicion and early referral is warranted in suspected eosinophilic esophagitis and/or paediatric feeding disorder.

stimulate appetite, cutting down on fruit juices and other beverages between meals, encouraging cereals with fortified vitamins, minerals, and iron, administering multivitamins (tablets rather than gummies as gummies have little iron or zinc) and calcium fortified orange juice in children who refuse milk and dairy products.

Cyproheptadine is used as an appetite stimulant with good success but should always be used in conjunction with other strategies. Food logs are not recommended as

this has been shown to cause more parental anxiety. Dietary recall is more pragmatic. A high calorie supplement in these children is not recommended as it may further promote fussy eating. Bribery may also be an effective strategy, as long as the incentive is not another food group, for example dessert for eating some vegetables, as studies have shown this may make matters worse.

Commonsense behavioural interventions to successfully expand the variety of food groups in the diet and nutritional supplementation remain the cornerstone of managing this common but challenging issue. 

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