

European Society for Paediatric Gastroenterology, Hepatology and Nutrition Guidelines
for the Evaluation and Treatment of Gastrointestinal and Nutritional Complications in
Children with Neurological Impairment

Short title: ESPGHAN Guidelines for the Evaluation and Treatment of Gastrointestinal
and Nutritional Complications in Children with Neurological Impairment

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Abstract

Objectives: Feeding difficulties are frequent in children with neurological impairments and can be associated with undernutrition, growth failure, micronutrients deficiencies, osteopenia and nutritional comorbidities. Gastrointestinal problems including gastroesophageal reflux disease, constipation and dysphagia are also very frequent in this population and impact quality of life and nutritional status. There is currently a lack of a systematic approach to the care of these patients. With this report, ESPGHAN aims to develop uniform guidelines for the management of the gastroenterological and nutritional problems in neurologically impaired children.

Methods: Thirty-one clinical questions addressing the diagnosis, treatment, and prognosis of common gastrointestinal and nutritional problems in neurologically impaired children were formulated. Questions aimed to assess: 1) the nutritional management including nutritional status, identifying undernutrition, monitoring nutritional status, and defining nutritional requirements; 2) to classify gastrointestinal issues including oropharyngeal dysfunctions, motor and sensory function, gastroesophageal reflux disease, and constipation; 3) to evaluate the indications for nutritional rehabilitation including enteral feeding and percutaneous gastrostomy/jejunostomy; 4) to define indications for surgical interventions (e.g. Nissen Fundoplication, oesophago-gastric disconnection) and finally 5) to consider ethical issues related to digestive and nutritional problems in the severely neurologically impaired children. A systematic literature search was performed from 1980 to October 2015 using MEDLINE. The approach of the Grading of Recommendations Assessment, Development and Evaluation was applied to evaluate the outcomes. During two consensus meetings, all recommendations were

discussed and finalized. The group members voted on each recommendation using the nominal voting technique. Expert opinion was applied to support the recommendations where no randomized controlled trials were available.

Keywords: cerebral palsy, nutrition, gastrointestinal diseases

ACCEPTED

What is known

- children with neurological impairment have feeding and swallowing problems
- poor nutritional status is secondary to insufficient caloric intake
- the spectrum of the clinical conditions associated includes respiratory infections, gastroesophageal reflux and chronic aspiration
- the goals of the management is to improve the quality of life for both the child and family

What is new

- a number of feeding and oral-motor intervention strategies have been developed
- multiple approaches may be used in children with growth failure
- gastrostomy feeding may reduce aspiration but could exacerbate gastroesophageal reflux disease
- the impact of antireflux procedures in addition to gastrostomy is relatively unknown

Introduction

Gastrointestinal problems are frequent in children with neurological impairment (NI) and should be considered together with the evaluation of the nutritional status. The neurological impairment can affect the gastrointestinal system, most notably oral-motor function and motility. Dysphagia in NI children typically presents as feeding difficulties, extended feeding times, malnutrition, and/or a history of aspiration pneumonia. Dysmotility, hypotonia, and nonambulation can contribute to constipation or severe gastro-oesophageal reflux disease (GORD). Regular nutritional assessment is essential and identifies signs and symptoms related to malnutrition. One of the first and often most crucial decisions about nutritional management of NI children is whether or not to utilise non-oral methods (nasogastric tube-feeds or gastrostomy) of delivery to achieve an adequate intake. To date, although the morbidity of GI and nutritional problems are well known and the need for a careful multidisciplinary follow up is highlighted¹ no recommendations on the GI and nutritional management of infants and children with NI are available. Similarly, there is a lack of a systematic approach to the care of these patients through transition to adulthood.

In this consensus, we will consider NI as a heterogeneous group of disorders that primarily relate to the central nervous system, comprised of the brain and spinal cord, affecting an individual's speech, motor skills, vision, memory, muscle actions and learning abilities. As a proxy, we will also consider cerebral palsy (CP), as the major subgroup of the NI which is defined a group of permanent disorders of the development of movement and posture, causing activity limitation, that are attributed to non-

progressive disturbances that occurred in the developing fetal or infant brain².

Methods

Under the auspices of European Society of Gastroenterology, Hepatology and Nutrition (ESPGHAN), a working group (WG) consisting of selected members from the GI and Nutrition committees as well as experts in the field, including pediatric gastroenterologists and a pediatric surgeon, was formed in January 2015 to formulate current evidence-based clinical practice guidelines for the evaluation and treatment of GI and nutritional problems in children with neurological impairment. Clinical questions relevant for the evaluation and treatment of GI and nutritional problems in children with neurological impairment were formulated by the members of the working group after several rounds of e-discussion (Table 1). After the questions were formulated, the guidelines committee was subdivided into subgroups based on expertise of the individual members. Working group was subdivided into subgroups which focussed on different questions.

Questions were addressed using the results of systematic literature searches from 1980 to Dec 2015, and based also on expert opinions. The MEDLINE and Cochrane Database of Systematic Reviews were searched. Inclusion criteria were as follows:

1. Systematic reviews, prospective or retrospective controlled studies, prospective or retrospective cohort studies
2. Study population consisting of children aged 0–18 years.

3. The keywords used to identify relevant papers were neurological impairment and/or cerebral palsy, plus any of one of the following terms according to the topic covered: nutritional assessment, body composition, anthropometrics, growth charts, dysphagia, nutrition requirements, vitamins, minerals, micronutrients, oral motor dysfunction, dietetics, tube feeding, gastrostomy, jejunostomy, fundoplication, gastroesophageal reflux, constipation, ethics. Additional strategies for identifying studies included using these keywords to search studies included in the reference lists of review articles. All of the members of the working group were asked to search the literature with respect to their assigned topics and a common reference list and copy of each paper was made available for every participant. The levels and quality of evidence were assessed using the classification system of the Oxford Centre for Evidence-Based Medicine (<http://www.cebm.net>) (diagnostic and prognostic questions) and the GRADE system (therapeutic questions). Grades of evidence for each statement are based on the grading of the literature. If no therapeutic studies were found, we decided to define the quality of evidence as “very low.” Using the GRADE system, the quality of evidence was graded as follows³⁻⁸:

1. **High:** Further research is unlikely to change our confidence in the estimate of effect.
2. **Moderate:** Further research is likely to have impact on our confidence in the estimate of effect and may change the estimate.
3. **Low:** Further research is very likely to have an impact on our confidence in the estimate of effect and likely to change the estimate.
4. **Very low:** Any estimate of effect is very uncertain.

Each group of authors (each question was shared by at least two co-authors) systematically reviewed all the articles selected in the literature review, summarized the important findings in a tabular format graded the papers chosen in the literature review using the GRADE system. Both the summary tables of all the articles and their grading were sent to all the authors before they wrote their relevant sections. No professional librarian was involved in the process and, although the tables were reviewed during two face-to-face meetings, we did not perform a detailed down/upgrading of the level of evidence. We acknowledge that this is a deviation from the GRADE process. The table of the quality assessment of included studies is available in the online-only appendix. During the two face-to-face meetings, the qualities of the studies were reviewed and discussed before summary statements underwent voting and grading by the working group (Table 2).

Consensus meeting and voting

Two consensus meetings were held to achieve consensus on and formulate all recommendations. Each subgroup presented the recommendations during the consensus meetings, where they were discussed and modified according to the comments of the participants. The consensus was formally achieved through nominal group technique, a structured quantitative method. The ESPGHAN WG consisting of members of all the subgroups anonymously voted on each recommendation. A 9-point scale was used (1-strongly disagree to 9 -fully agree), and votes are reported for each recommendation. It was decided in advance that consensus was reached if >75% of the working group members voted 6, 7, 8, or 9. The consensus was reached for all of the questions. A

decision was made to present one algorithm (Fig. 1). The final draft of the guidelines was sent to all the committee members for approval in September 2016, and then critically reviewed by a multidisciplinary panel of the GI and nutrition committees as well as members of the council of ESPGHAN.

Recommendations

1. How to approach nutritional management in NI children?

Nutritional assessment and nutritional interventions in NI children are a challenge for physicians but should be part of the child's comprehensive care and rehabilitation. The aim is not only to advance weight and linear growth but also to secure improved physiological and functional capacity. Given that nutritional problems in this group of children arise from a variety of causes requiring one or more of multiple possible interventions (ie positioning, rehabilitation, diet modification, drugs) a multidisciplinary approach is required, including input from occupational therapists, psychologists, speech therapists, dietitians, physicians and nurses.

1: ESPGHAN WG suggests that nutritional evaluation and management should be performed by a multidisciplinary team ideally including as required a physician, dietitian, nurse, speech therapist, physical therapist, psychologist and occupational therapist

LoE Moderate,

GoR strong

VOTE: 9, 9, 9, 9, 9, 9, 9, 8, 9, 8, 8, 7, 9, 6, 9 (accepted)

2. What is the method for assessing nutritional status?

There are many ways to assess the nutritional status in children with NI, varying from simple to more complex methods. The methods can be divided into a) anthropometrics, b) body composition, c) methods for assessing bone status, and d) laboratory methods.

a. Anthropometrics

Anthropometric assessment is frequently used as the method for assessing the growth and nutritional status of NI children, but is more challenging than in typically developing children as most of measurements are shown to be invalid. Furthermore, specific reference standards, special norms are not available for NI children.

Weight measurements can be difficult to perform and several methods exist but there are no studies comparing the different methods. The commonly used methods are wheelchair scales, sitting scales and hoist scales⁹. Although reduced muscle mass may reflect undernutrition and immobility it may occur secondary to neurological disease and/or myopathy. The large study by Samson-Fang and Stevenson¹⁰ found weight for height [WFH] to be a poor indicator of low fat stores in children with CP (WFH < 10 th centile failed to identify 45% of children with severely depleted fat stores). On the other hand, finding a low body mass index (BMI) or WFH does not necessarily mean a low fat mass, but can also imply a low muscle mass, but high fat mass^{10, 11}.

Height measurements in children who can stand should take place using a stadiometer. Supine length could be a good alternative when a child can lie straight. A

significant proportion of children with neurodevelopmental disability however, is not able to stand upright and many have joint contractions, spasticity and/or scoliosis, making height measurements difficult¹². Alternative measurements for the assessment of height are segmental length measurements such as knee-heel length (KHL), tibia length and ulnar length, which can be assessed using sliding calipers. These measures were shown to have a high interrater reliability and to be highly repeatable and therefore may be used on their own to monitor growth¹³. Growth charts using these alternative measures have been developed which can be used to assess linear growth^{12, 14, 15}. There are several formulae available to estimate height from the segmental lengths^{12, 16, 17}, but the limits of agreement with recumbent length were found to be wide, usually in the range of ± 10 cm^{13, 18}.

2a: ESPGHAN WG recommends that the assessment of nutritional status in NI children should not be based solely on weight and height measurements

LoE Moderate

GoR strong

VOTE: 9, 9, 9, 9, 9, 9, 9, 8, 9, 8, 8, 7, 9, 6, 9 (accepted)

2b: ESPGHAN WG recommends that measurements of knee height or tibial length in NI children should be performed routinely in order to assess linear growth, when height cannot be measured

LoE strong

GoR strong

VOTES: 8, 9, 7, 8, 8, 9, 8, 8, 8, 9, 8, 8, 9, 7, 7, 9 (accepted)

Skinfolds and limb circumferences: measurement of limb circumferences such as mid upper arm circumference, upper leg circumference and calf circumference can easily be performed with a non-stretchable tape, but results lack specific information because they comprise bone, muscle and fat mass. Body fat can be estimated by the use of skinfold measurement usually at the biceps and triceps region of the mid upper arm by using a caliper. Assessment of mid-upper arm fat and muscle areas from triceps skinfold and mid-upper arm circumference measurements can be calculated using several equations¹⁹. In comparison with BMI, skinfold measurements are a more direct measurement of body fat, but their interpretation can also be challenging because children with NI tend to store fat more centrally (abdomen) than peripherally (skinfolds)¹¹.

2c: ESPGHAN WG recommends that the measurement of fat mass by skinfold thickness should be a routine component of the nutritional assessment in NI children

LoE moderate

GoR weak

VOTES: 9, 8, 8, 9, 8, 9, 9, 9, 7, 7, 7, 9, 6, 9, 9 (accepted)

b. Body composition assessment

Children with NI often need measures of body composition in order to assess nutritional status more accurately. Body composition refers to quantifiable components of the body including fat, water, protein, and bone²⁰. Whole body dual energy X-ray absorptiometry (DXA) has become the “gold standard” for the measurement of body composition²¹. If DXA can be obtained and interpreted with confidence then, it is the best way to ensure that a child’s fat stores are neither depleted nor excessive²². Skinfold thickness is easy to obtain and body fat can be calculated by using specific equations. The most widely used Slaughter et al.²³ equations are used in typically developed children, however, these equations do not take into account the different body composition of children with NI and tend to underestimate their body fat percentage²¹. Furthermore, several studies²⁴⁻²⁷ evaluated the accuracy of the Slaughter equation in the estimation of the body composition in children with NI. Three studies^{21, 25, 26} found that the use of Slaughter equation underestimated the percentage body fat compared to reference methods; another study²⁷ found good correlation, however, it included only a small number of participants. In order to improve the Slaughter equation, Gurka et al. derived new equations with a correction factor based on gender, race, size, pubertal status, and gross motor function level²⁶. These equations were assessed by 3 studies²⁸⁻³⁰. Two studies^{28, 29} found that percentage body fat derived from skinfolds using Gurka’s NI-specific equation was not significantly different from that measured by DXA. Although skinfold thickness is easy to obtain, it may not be as accurate in children with CP; reduced peripheral skinfolds may not necessarily mean low fat stores because children with CP store fat more centrally. Therefore, other methods are developed and evaluated,

mostly bioimpedancemetry (BIA). Four studies evaluated the role of BIA in the body composition assessment in children with CP^{27, 29-31} and found that BIA estimated body composition well when compared to standard methods (DXA, D2O).

c. Bone status assessment

Low bone mineralization is a serious problem in severe NI children, with mean z-scores ranging from -3.4 in the distal femur to -0.8 in the lumbar spine, a prevalence of bone mineral density (BMD) z-scores below -2 in over 70%, with an annual incidence of fractures of 4%. Significant determinants of low BMD are limited ambulation, feeding difficulties, previous fracture, anticonvulsant use, and lower fat mass³².

Bone health should be assessed in children with NI because of an increased risk of poor bone health resulting in fractures. BMD assessment by DXA is usually limited to lumbar spine and hip. However due to hip flexion contractures, in children with severe NI, it is mostly only lumbar DEXA measurements that are performed²⁰. There are data, however, which show that BMD of lumbar spine is not a predictive parameter for the fracture risk in children with NI³³. Therefore, some studies evaluated the BMD of the distal femur and found strong correlation between BMD Z-scores of this site and fracture history³⁴. The International Society for Clinical Densitometry recommends assessment of BMD at the lateral distal femur site in children with chronic immobilization, which is the most common fracture site in children with NI³². Other techniques have been used in children with NI, including quantitative computed tomography and quantitative ultrasound³⁵, however due to limited availability and lack of standardization they are not routinely used³⁶.

2d: ESPGHAN WG recommends the use of dual energy X-ray absorptiometry (DXA) scans to measure bone mineral density as part of nutritional assessment in NI children

LoE moderate

GoR weak

VOTES: 9, 8, 8, 7, 7, 8, 8, 8, 7, 7, 8, 6, 6, 8, 8 (accepted)

d. Laboratory parameters

Laboratory assessment can be performed, but there is no single marker representing good or poor nutritional status in children with NI (Table 3). Albumin and pre-albumin are not of much use as markers of undernutrition, because in general there is rarely a protein deficit, but more a caloric deficit is present³⁷. Lower values of serum albumin, prealbumin and retinol binding protein can be found³⁸, but routine measurements of prealbumin and albumin appear to be of little value and may lead to a false sense of security regarding the nutritional status of a child with NI. Children with NI often have lower mineral intakes than healthy children, which predispose them to having a poor micronutrient status. Few studies have evaluated the micronutrient status of children with NI³⁸⁻⁴² and the implications of various deficiencies on health outcome. These studies show that deficiencies for iron, zinc, copper, vitamin D, carnitine, folic acid and vitamin B12 are common with percentages ranging between 10-55%. Factors associated with low levels were found to be vitamin C intake (iron), use of anti-epileptics (carnitine, vitamin B12, folic acid, calcium and phosphorus), and reduced exposure to

sunlight (vitamin D). Tube feeding and the use of nutrition supplements were associated with higher concentrations of micronutrients in blood and serum⁴¹.

2e: ESPGHAN WG recommends the assessment of micronutrient status (e.g. vitamin D, iron status, calcium, phosphorus) as part of nutritional assessment of NI children

LoE moderate

GoR strong

VOTES: 5, 8, 8, 9, 8, 9, 9, 8, 8, 7, 7, 7, 9, 8, 8 (accepted)

3. How to identify undernutrition?

In general, there is no single, universally agreed definition of undernutrition in children, but criteria based on height-for-age, weight-for-height and body mass index (BMI)-for-age are commonly used^{43, 44}. Children can experience many illness-related factors contributing to undernutrition such as nutrient losses, increased energy expenditure, inflammation, decreased nutrient intake, or altered nutrient utilization⁴⁴. Moreover, for children with NI, no strict criteria to define undernutrition are in use due to the complexity and clinical variability among patients²². For clinical practice, in the absence of strict criteria for identification of undernutrition in NI children, it is important to look at the presence of warning signs of undernutrition, such as 1) physical signs of undernutrition such as decubitus, skin problems, poor peripheral circulation; 2) weight for age (z-score < -2); 3) triceps skinfold thickness < 10th centile for age and sex; 4) mid-

upper arm fat or muscle area < 10th centile; and 5) faltering weight and/or failure to thrive.

Growth charts

Standard growth charts may not be helpful for children with NI, whose growth patterns are often markedly different from the general pediatric population. The first CP specific growth charts were produced by Krick et al⁴⁵ who evaluated weight and stature of children with severe quadriplegia. Other studies produced centile curves for several other growth parameters, including weight, knee height, upper-arm length, mid-upper arm muscle area, triceps skinfold, and subscapular skinfold^{9, 46}. Day et al⁴⁶ constructed a series of height, weight, and BMI charts which were stratified by motor and feeding skills; they found that centiles of height and weight of patients with CP were close to those of the general population for the highest functioning groups with CP, but substantially different for those moderately or severely disabled children⁴⁶. The same group further developed growth charts stratified according to GMFCS level and tube feeding status, and described not only weight gain and growth, but also the W/A percentile at which point there is an increased risk of morbidity and mortality⁴⁷. These CP specific growth charts, however, describe growth which is not necessarily ideal as they include many children with other health conditions affecting growth, mostly malnutrition. Thus they cannot be considered as a measure of how this group of children should ideally grow⁴⁸. Furthermore, clinicians often need a growth chart that indicates ideal growth based on a standardised reference population, such as the World Health Organization (WHO) growth standards⁴⁹. Although there is no relevant data, authorities often recommend the use of WHO growth charts in children with NI in whom a reliable height

or a calculated height can be obtained up to 2 (or 5) years of age and in older children a relevant national growth chart should be used²².

Statement 3a: ESPGHAN WG suggests that the identification of NI children as undernourished should be based on the interpretation of anthropometric data

LoE high

GoR strong

VOTES: 8, 9, 7, 7, 9, 7, 9, 9, 9, 9, 7, 9, 9, 9, 9 (accepted)

3b: ESPGHAN WG does not recommend the use of CP-specific growth charts to identify undernutrition

LoE low

GoR weak

VOTES: 9, 7, 8, 7, 6, 8, 9, 9, 9, 8, 9, 8, 8, 9, 9 (accepted)

3c: ESPGHAN WG suggests the use of one or more of the following red flag warning signs for the identification of undernutrition in NI children:

- Physical signs of undernutrition such as decubitus skin problems, poor peripheral circulation

- **Weight for Age z-score < -2**
- **Triceps skinfold thickness < 10th centile for age and sex**
- **Mid-upper arm fat or muscle area < 10th percentile**
- **Faltering weight and/or failure to thrive**

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 9, 8, 9, 9, 8, 8, 9, 9, 8, 8, 9, 8 (accepted)

3d: ESPGHAN WG recommends the use of follow-up anthropometry (weight, linear growth and fat mass) in the monitoring of nutritional status of NI children

LoE moderate,

GoR strong

VOTES: 9, 9, 8, 9, 9, 9, 8, 9, 9, 9, 9, 9, 8, 9, 8 (accepted)

4. How often should nutritional status be monitored?

For infants, it is recommended to assess growth every 1–3 months and in older children the frequency of assessment may vary depending on their nutritional and health status⁵⁰. There is no data on the optimal follow up schedule for body composition assessment and this should be individually depending on risk factors and initial assessment. However, it is important to use same methods in order to have comparable values. For the assessment of growth velocity, the use of calculated heights based on segmental measures may be unreliable¹⁰. There is no consensus on the appropriate laboratory indices to be measured nor on how frequent this should occur.

4: ESPGHAN WG suggests that NI children have anthropometry at least every 6 months and micronutrients checked annually

LoE low

GoR strong

VOTES: 6, 8, 9, 9, 8, 7, 7, 8, 8, 9, 8, 7, 6, 9, 8 (accepted)

Nutritional Requirements (energy, proteins, fluids, micronutrients)

5. What are the requirements for energy intake in NI children?

The assessment of energy needs of the child with NI is difficult because there are no appropriate specific recommendations for this category of patients^{51, 1}. Dietary reference intake (DRI) overestimate energy needs, because of the severe growth delay and the decreased physical activity. Patients with NI have lower body fat, muscle mass, and protein^{46,52}. Energy intake is linked to mobility and activity level. There is an impact of NI in children on body growth and nutritional status, which becomes more marked in those with a greater degree of motor impairment. The major deficit is in energy intake⁵³.

Patients with NI require more energy for walking^{54,55}, while patients dependent on a wheel chair require 60-70% energy, compared to healthy children^{22, 56}. Compared with a reference population of age- and sex-matched typically developed children, 40 children with marked NI showed lower energy expenditure and high body fat content, particularly if they were enterally fed⁵⁷. Mean total energy intake was 60% of average energy allowance⁵⁸. The contribution of spasticity was around 10% of total energy expenditure. Children with spastic quadriplegic children were found to have a lower energy expenditure than unaffected children⁵⁹. Yet no correlation was found between energy

intake, the estimated average requirement, and anthropometric Z-scores. Increase in feeding difficulties correlates with successive decrease in nutritional status, in measurements of weight, body fat stores, and arm muscle mass⁶⁰. Published equations underestimate energy needs in non-ambulant children by ~22%. The greatest predictor of energy needs is fat-free mass, followed by ambulatory status⁶¹. Total energy expenditure to resting energy expenditure ratio is estimated to be 1.5 to 1.6 for normal activity, while can be as low as 1.1 in quadriplegic CP⁶².

Overestimation of energy needs can lead to being overweight, which is observed in 10% to 15% of children¹. There is a risk of overfeeding with enteral feeds due to a potential shift from negative to positive energy balance that enhances fat accumulation⁵⁷. Energy requirements must be individualized to take into account mobility, muscle tone, activity level, altered metabolism and growth. Indirect calorimetry may be useful for the assessment of these needs¹.

DRIs⁶³ is used to estimate calorie needs. Total energy expenditure is based on measurements of the doubly labelled water technique and is based on the needs of healthy children^{64,65}. The equations overestimate calorie requirements of the NI child even when used without the physical activity coefficient⁶⁴ or physical activity level⁶⁵ (PAL). The Schofield equation (Table 4) is reasonable in estimating calorie needs⁶⁶. Other special equations can be used (Table 5). These formulas are only a starting point and the effect of dietary intervention must be reassessed⁶⁷.

5a: ESPGHAN WG recommends the use of the dietary reference standards for typically developing children to estimate the caloric needs for NI children

LoE moderate,

GoR weak

VOTES: 8, 8, 8, 9, 9, 7, 8, 8, 7, 7, 8, 7, 6, 8, 9 (accepted)

5b: ESPGHAN WG recommends regular monitoring of body weight and fat mass as an indicator of energy requirements

LoE moderate

GoR strong

VOTES: 7, 7, 9, 9, 8, 9, 8, 9, 8, 9, 9, 7, 7, 8, 8 (accepted)

6. What are the requirements for protein in NI children?

Protein requirements for NI children are similar to the protein requirements of unaffected children^{66,68}. The DRIs are adequate for this group of children. Increased protein is needed if decubitus ulcers are present. Problems with protein intake may arise when calorie needs are low; it may be difficult to provide adequate protein in tube-fed children who require a very low calorie intake to prevent overfeeding. A higher protein formula or a protein supplement should be used with these children⁶⁶.

In preschool-aged children with NI the tube-fed, non-ambulant children have lower protein intakes compared with orally fed children⁶⁹. Schoendorfer et al. examined differences in protein intake and a variety of protein metabolism indices in children with

NI compared with controls⁷⁰. Despite all children consuming over recommended levels, children with CP had reduced levels of protein metabolic indices (albumin, creatinine and urate) versus controls. Data showed potentially greater protein metabolism issues in enterally fed children, compared with the other groups. Schoendorfer et al. reported decreased levels of albumin and urea in NI enterally fed group compared with NI orally fed and control group⁷⁰. The children with NI had reduced levels of plasma urate, as well as many with high-level cognitive impairment, when compared with typically developed children.

In severely undernourished patients the protein intake may be augmented to 2 to 2.4 g/kg/d⁵⁶. In one study, term and preterm infants fed with 120% of the recommended daily allowance showed an increased head circumference and corticospinal tract diameter⁷¹. Commercially available sip feeds (oral nutritional supplement) are an easy way to add proteins, with or without fibres and micronutrients⁵⁶. Dietary supplementation with glucose polymer and/or long chain triglycerides or use of hypercaloric or high density feed is required in poor nutrition or growth failure⁵⁹.

6a: ESPGHAN WG recommends the use of the dietary reference intake for protein in typically developing children to estimate the appropriate protein intake for NI children

LoE moderate

GoR strong

VOTES: 7, 8, 8, 8, 9, 9, 9, 8, 9, 8, 8, 8, 8, 8, 8 (accepted)

6b: ESPGHAN WG recommends the use of supplementary protein intake in specific clinical situations such as decubitus ulcers or in children with a very low calorie requirement

LoE moderate

GoR strong

VOTES: 9, 8, 7, 9, 8, 9, 9, 9, 9, 8, 9, 8, 8, 9, 9 (accepted)

7. What are the requirements for fluid in NI children?

NI children may have an impaired hydration status. Body composition is altered in NI children; a decrease in body cell mass accompanies an expansion of the extracellular fluid⁵⁹. One study showed that NI children (n=35, aged 9–13 years) had a reduction in salivary flow rate (50%), together with an increase in salivary (50%), plasma (3%), and urine osmolality (20%) versus a control group (n= 27 nondisabled children, aged 10–12 years). Salivary flow rate was negatively correlated with the salivary, plasma and urine osmolality whereas salivary osmolality correlated positively with plasma and urine osmolality⁷². Children with NI can present low salivary flow rate, pH and buffer capacity⁷². NI individuals appear to exhibit impaired hydration due to compromised oral motor function⁷³.

7: ESPGHAN WG recommends that careful attention should be paid to hydration status, as NI children are at risk of dehydration for a variety of reasons (e.g. inability to communicate thirst, drooling, unsafe swallow)

LoE moderate

GoR strong

VOTES: 9, 9, 9, 9, 8, 9, 9, 8, 9, 9, 9, 8, 8, 9, 9 (accepted)

8. What are the requirements for micronutrients in NI children?

The monitoring of micronutrient status in NI children may have a substantial and measurable impact on their nutritional adequacy, hospital costs, and future outcomes⁷⁴. Micronutrient deficiencies (calcium, iron, zinc, vitamins C, D, and E, selenium) are common, especially in children who are exclusively tube fed. Many NI children require less energy to avoid being overweight and, as a consequence of a reduced energy intake, their micronutrient intake can be less than their daily requirements. Essential fatty acid deficiency may also be related to suboptimal energy intake¹.

There was no difference in energy, protein, iron, zinc, copper or folate intake before and six months after gastrostomy placement⁷⁵. No change in Zn, Fe and Cu and in liposoluble vitamins were noticed in NI patient fed with or without fibre supplemented formula⁷⁶. Compared to a reference group, NI patients had low concentration of docosaenoic acid (DHA), linoleic acid and total n-6 fatty acids (FA), while arachidonic acid, eicosapentaenoic acid (EPA), n-3 FA concentrations were similar. After a 6 months supplementation of DHA, EPA and n-3 FA levels were higher than the reference group, while linoleic acid and total n-6 FA remained lower¹.

Iron

Children with disabilities are at greater risk of iron deficiency as their diets are often limited, especially if the diet is based largely on cow's milk. Only 46% of children

with disabilities achieved 100% of their recommended nutritional intake (RNI)⁵³. The increased incidence of iron deficiency anaemia in NI children with diets low in iron supports the conclusion that this is secondary to low iron intake and decreased iron absorption. Prepared liquid diets may include foods that are a poor source of iron (milk, cheese, cream, yoghurt, rice) or that inhibit iron absorption (vegetables, pulses, grains, cereals)⁷⁷. The recommended daily intake of iron is 10 mg/day in children (7-10 years), 12 mg/day adolescent males (15-19 years) and 15 mg/day in adolescent females (15-19 years)⁶⁵. In the treatment of iron deficiency in children with NI it is reasonable to provide iron supplementation as the first diagnostic and therapeutic measure in such patients. Endoscopic procedures should be postponed for a later stage, unless there are clinical or laboratory findings (such as faecal occult blood) suggestive of gastrointestinal blood loss⁷⁷.

8: ESPGHAN WG recommends use of the dietary reference intake for micronutrients in typically developing children to estimate the appropriate micronutrient intake for NI children

LoE moderate

GoR strong

VOTES: 9, 9, 8, 8, 9, 9, 8, 8, 9, 9, 7, 7, 6, 8, 9 (accepted)

GI issues (dysphagia/oral motor dysfunction, constipation, dysmotility as GORD)

9. Dysphagia/oral motor dysfunction: How to define it?

Oropharyngeal dysfunction (OPD) is defined by the presence of disturbances in one or more of the three phases of swallowing (oral, pharyngeal and oesophageal) and is very common amongst children with NI, with reported prevalences in excess of 90%^{78, 79}. In a study of 166 NI children the prevalence of dysphagia was 99% with 8% classed as mild, 76% moderate to severe, and 15% profound dysphagia. In agreement with other studies dysphagia appears to be positively correlated with the severity of motor impairment^{79,80,81,82}. The presence of OPD is often suggested by the clinical picture, the evaluation of which should include the feeding history from early infancy e.g. problems in sucking and swallowing⁷⁸. In a large study of children with NI, 27% of mothers of children referred for advice on their present swallowing difficulties stated that they did not recall any suckle feeding problems. This study suggested there was no association between the severity of present swallowing difficulties and whether infants had suckle fed well or experienced severe difficulties⁸³. In addition to swallowing dysfunction children with NI may display sialorrhea, coughing, multiple swallows, gurgly voice, wet breathing, gagging and choking as well as alterations in appetite, feeding difficulties and prolonged feeding times^{81, 84, 85}. Many of these symptoms are associated with dysfunction in the pharyngeal phase of swallowing, more significant OPD and poorer long-term prognosis.

The mainstay of evaluation of OPD has been the direct observation of meal times with or without the use of standardized and validated scoring systems. Although a number of scoring systems have been suggested to have good clinical utility including Eating and Drinking Ability Classification System (EDACS), the Schedule for Oral Motor Assessment (SOMA), Dysphagia Disorders Survey (DDS) and the Functional

Feeding Assessment (FFA), this remains to be validated in large high quality studies^{80, 82, 86-91}.

Lip functions play an important role in oral stages of feeding. Problems with incomplete lip-closure during swallowing, low lip and suction-pressure and prolonged delay between the suction and propelling stages have been described^{92, 93}. Furthermore, malocclusion of teeth may also contribute with preparation of food for swallowing⁹⁴.

9. ESPGHAN WG suggests considering oropharyngeal dysfunction in all NI patients even in the absence of obvious clinical signs and symptoms

LoE moderate

GoR strong

VOTES: 8, 9, 9, 9, 9, 8, 9, 8, 9, 9, 7, 7, 9, 9, 9 (accepted)

10. How to evaluate oral motor and sensory function?

Videofluoroscopy (VFS) remains one of the key investigations for the assessment of OPD with a number of studies supporting its utility to identify discoordinate pharyngeal motility and silent aspiration in the diagnostic work-up of children with neurodisability and to guide effective feeding strategies⁹⁵⁻⁹⁸. VFS may also be used to assess other parameters that relate to dysphagia and impaired feeding, including reduced lip closure, inadequate bolus formation, residue in the oral cavity, delayed triggering of pharyngeal swallow, reduced larynx elevation, coating on the pharyngeal wall, delayed pharyngeal transit time, multiple swallows⁹⁹. Although, ultrasound and electrophysiology

have been suggested as practical alternatives, or additional tests, to more established methods of assessment their utility still remains to be confirmed¹⁰⁰⁻¹⁰⁴. Although data on the use in OPD and in NI children is very limited, VFS has also been combined with high resolution oesophageal manometry to be more discriminating in identifying specific defects and potentially improve clinical utility¹⁰⁵. When there is a high suspicion of an abnormal pharyngeal phase of swallowing but the VFS is normal or where it is difficult to differentiate between upper oesophageal sphincter function and pharyngeal dysmotility, combined modalities (e.g. video-manometry) could be considered if appropriate equipment and expertise are available.

Gastrointestinal endoscopy is not routinely used in children with NI to investigate the cause for dysphagia. Fiberoptic endoscopy has been utilized to detect aspiration and penetration of the upper respiratory tract¹⁰⁶. The presence and nature of oesophageal dysmotility in NI is not well studied although studies utilising oesophageal 24-h pH monitoring and impedance as well as manometry have suggested it may be common in NI^{107, 108}. Most recently, impedance measurements have been used to detect alterations in flow characteristics of pharyngeal swallow that have the potential to predict to deglutitive aspiration risk¹⁰⁹.

10a: ESPGHAN WG suggests including both feeding history starting from early infancy as well as direct visual assessment of feeding carried out by appropriately trained professionals. Such professionals would generally consist of speech and language therapists but could include medical doctors, nurses, dieticians or GI physiologists trained or highly experienced in evaluating oropharyngeal function

LoE Moderate

GoR strong

VOTES: 9, 8, 8, 8, 9, 9, 9, 8, 9, 9, 9, 9, 9, 9 (accepted)

10b: ESPGHAN WG recommends the use of videofluoroscopy where there is suspicion of an abnormal pharyngeal phase of swallowing and/or concerns about aspiration. Where available this could be combined with high resolution oesophageal manometry to increase diagnostic yield

LoE low

GoR: weak

VOTES: 8, 9, 8, 9, 9, 8, 7, 7, 8, 9, 8, 9, 8, 9, 7 (accepted)

11. What is the treatment of oropharyngeal dysfunction?

Management of dysphagic children involves an appropriately skilled multidisciplinary team to support treatment strategies. A Cochrane review undertaken to examine the effectiveness of interventions for OPD in children with NI was only able to identify 3 randomised or quasi-randomised controlled trials. Overall, the review concluded that there was insufficient high-quality evidence to provide conclusive results about the effectiveness of any particular type of oral-motor therapy and larger-scale randomised trials were needed¹¹⁰.

Management should aim to optimize oral ingestion, where this has been shown to be safe, and address the behavioral expression of the many different pathologies causing OPD namely: (1) resistance to accepting food orally; (2) lack of energy and endurance to do the 'work' of eating; and (3) oral-motor disabilities resulting in an inability to produce the necessary motor skills for ingestion¹¹¹.

Modifications of feeds and feeding time

It is likely that a significant proportion of children with NI will be managed by modification of time allocated to feeding, posture, as well as feed consistency and content to provide safe feeding and limit complications such as aspiration. A cross-sectional, population-based cohort study comprising 99 children with NI (65 males, 35 females) aged 18 to 36 months showed that 39% of the children were on modified feed textures. Those with poorer gross motor function tended to receive a greater proportion of energy from fluids in their diets and fewer chewable foods compared to less affected children. Fluids, however, represented a texture most associated with OPD and being identified as unsafe¹¹².

Speech and language therapy

Speech and language therapy often forms the mainstay of treatment offered to children with neurodisability. Oral-sensorimotor therapies aim to improve the individual and combined functioning of the lips, cheeks, tongue and pharyngeal structures. Hirata and Santos performed a systematic review of the medical and speech therapy literature on the rehabilitation of OPD in children with NI spanning 1977-2010 and found a paucity of studies addressing the therapeutic rehabilitation of oropharyngeal dysphagia in children with cerebral palsy¹¹³. Compared to control treatments, sensorimotor interventions have

been variably shown to result in some improvement in eating and feeding time but not in drinking skills. Children appeared to maintain their weight but did not show catch-up growth¹¹⁴⁻¹¹⁷.

11: ESPGHAN WG suggests considering speech and language interventions in the treatment of NI children with oropharyngeal dysfunction, and/or where there is need for modification of the consistency of feeds

LoE Moderate

GoR strong

VOTES: 8, 8, 8, 8, 7, 8, 9, 7, 7, 9, 8, 9, 9, 8, 9 (accepted)

12. How to monitor oropharyngeal dysfunction?

In terms of long-term prognosis, the severity of OPD appears to remain relatively stable and gross motor function appears to be its best predictor¹¹⁸⁻¹²¹. Feeding data were collected from 23 NI children using parent questionnaires at 6-month intervals over 30 months. NI children with severe oral-motor involvement had marked and pervasive feeding difficulties, but this appeared to remain relatively stable over time¹¹⁹. Although disorders persist into adolescence, improvement has mainly been observed when only the oral phase of swallowing is affected. Involvement of the pharyngeal phase suggests further investigation is warranted¹²¹. The studies highlight the need for proactive screening of all young children with NI, including those with mild impairments, to improve growth and nutritional outcomes and respiratory health⁸⁰. Oral pharyngeal

dysfunction is one of the main factors for the reduction of oral food intakes and so a risk factor for undernutrition.

12: ESPGHAN WG recommends regular monitoring of growth and nutritional status in NI children with oral pharyngeal dysfunction

LoE low

GoR: weak

VOTES: 8, 9, 8, 9, 9, 8, 7, 6, 7, 9, 8, 8, 7, 8, 8 (accepted)

Gastro-oesophageal reflux disease

13. How to diagnose gastro-oesophageal reflux disease?

GORD is a problem commonly seen in NI children with reported incidence as high as 70%¹²²⁻¹²⁵. Due to the high frequency of GORD and fragility of this group of patients for whom investigations are more difficult to organize and perform than for typically developed children, a trial of proton pump inhibitors with careful clinical follow-up is acceptable¹²⁶. Esophagogastroduodenoscopy is the method of choice to diagnose esophageal involvement¹²⁷. Biopsies are important to identify or rule out other causes of esophagitis, and to diagnose and monitor Barrett's esophagus. Esophageal pH-metry is a valid quantitative measure of esophageal acid exposure. When combined with esophageal multichannel intraluminal impedance pH-metry can detect acid, weakly acid, and non-acid reflux episodes. Scintigraphy may have a role in the diagnosis of pulmonary aspiration. In patients with persistent gastric stasis and vomiting, upper GI barium swallow or abdominal ultrasound should be performed to exclude intestinal obstruction.

Patients with severe NI are at risk for development of superior mesenteric artery syndrome because of frequent scoliosis and malnutrition resulting in lack of retroperitoneal fat around the third part of the duodenum, which is thought to avoid compression by increasing the aortomesenteric angle¹²⁸.

13: ESPGHAN WG recommends use of objective measures for the diagnosis of gastro-oesophageal reflux disease (GORD) in NI children (oesophageal pH- or pH/multichannel intraluminal impedance monitoring, and/or upper gastrointestinal endoscopy). Given their high prevalence of GORD, a trial of proton pump inhibitors with careful clinical follow-up is acceptable management in this clinically fragile group of children

LoE low

GoR weak

VOTES: 9, 8, 7, 9, 9, 8, 5, 8, 6, 5, 6, 9, 8, 7, 8 (accepted)

14. How to treat gastro oesophageal reflux disease?

Treatment of GORD in children and adolescents consists of lifestyle changes, pharmacologic therapies and surgical treatment¹²⁷.

Lifestyle changes

Only a few small studies have evaluated the effects of nutritional intervention on GORD in children with NI. Miyazawa et al. studied the effect of food-thickener pectin on

GORD symptoms in 18 children with NI¹²⁹. High-pectin diet significantly decreased the reflux index, number of reflux episodes per day, duration of longest reflux and the number of reflux episodes. Vomiting episodes decreased with high-pectin formula and cough-score decreased with both concentrations of pectin. In a study by Khoshoo et al.¹³⁰, exclusively gastrostomy-fed NI children with gastro-oesophageal reflux were randomly assigned to receive either casein- or whey-based formula¹³⁰. A significant reduction in number of reflux episodes and duration of reflux was observed while consuming the whey-based formula. In addition, malnutrition itself seems to influence GORD in children with NI, as Campanozzi et al. noted a marked improvement of GORD in four out of nine children with NI after a 6-month feedig with hypercaloric diet and increase of body weight and BMI¹³¹.

Treatment with acid-suppression drugs is the main therapy in NI children with GORD. It is well accepted that proton pump inhibitors (PPIs) are superior to histamine-2 receptor antagonists (H2RAs) for both healing of erosive esophagitis as well as relief of GORD symptoms¹²⁷. Despite the fact that PPIs are very effective in reducing acid reflux and treatment of reflux esophagitis, they do not influence the volume of the reflux, the number of reflux episodes and the proximal extension of the reflux¹³². Therefore, some symptoms, like vomiting, usually persist despite PPI therapy¹³³, although one small prospective study documented a reduction in vomiting in NI children treated with PPI¹³⁴. Like in any other condition, special attention to side effects, especially when prolonged treatment is considered, is warranted (including pulmonary and digestive infections, as well as micronutrients malabsorption).

Kawai et al. studied the effect of the gamma-aminobutyric acid type B receptor agonist baclofen (0.7 mg/kg/day) on GORD in 8 NI children¹³⁵. The frequency of emesis significantly decreased, as well as the total number of acid refluxes and number of acid refluxes longer than 5 minutes. However, the percentage of total time of esophageal pH < 4 and esophageal acid clearance time were not significantly different when compared with pH-monitoring results before treatment. No adverse effects were observed, except for a slight reduction in muscle tone in one subject. The efficacy and safety of other prokinetic drugs, such as metoclopramide, domperidone, betanechol and erythromycin for GORD treatment in NI children have not been studied.

14a: ESPGHAN WG suggests modification of enteral nutrition (thickening of liquid enteral formulas, whey-based formulas) in addition to other therapeutic options of gastro oesophageal reflux disease in NI children

LoE very low

GoR weak

VOTES: 9, 8, 6, 7, 8, 8, 7, 7, 7, 6, 2, 8, 8, 7, 8 (accepted)

14b: ESPGHAN WG group recommends use of proton pump inhibitors as the first line treatment in NI children with gastro-oesophageal reflux disease

LoE strong

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 9, 7, 9, 8, 9, 9, 9, 7 (accepted)

14c: ESPGHAN WG recommends not to routinely use prokinetic agents in NI children with gastro-oesophageal reflux disease because of their weak efficacy and side effects. Their use may be considered, however, in uncontrolled gastro-oesophageal reflux disease

LoE moderate

GoR weak

VOTES: 7, 8, 9, 7, 9, 8, 9, 7, 7, 5, 6, 9, 9, 8, 8 (accepted)

15. How to monitor gastro-oesophageal reflux disease?

As severely neurologically disabled children can not adequately report symptoms such as pain and heartburn, and visible regurgitation and dysphagia are not necessarily caused by GORD, only objective diagnostic tests are reliable for monitoring whether GORD is successfully controlled by therapy or not. When long-term therapy for GORD is needed and stopping treatments such as PPI is considered potentially detrimental, multichannel intraluminal impedance (\pm combined with pH metry), if available, may assist in monitoring GORD.

15: ESPGHAN WG recommends the periodical re-evaluation of long-term therapy of gastro-oesophageal reflux disease in NI children

LoE weak

GoR strong

VOTES: 7, 9, 9, 8, 8, 7, 9, 9, 7, 5, 7, 9, 9, 8, 8 (accepted)

Constipation

16. How to diagnose constipation.

In patients with NI, constipation may be diagnosed through a careful history, symptoms-based, abdominal-rectal digital examination and colonic transit times. Constipation is significantly more common among children using medication known to slow intestinal motility, and in children who are tube fed¹³⁶. A digital rectal examination should be performed at least once when assessing constipation in children, because it is possible to evaluate perianal sensation, anal tone, size of the rectum, presence of an anal wink, and determine the amount and consistency of stool and its location within the rectum¹³⁷. In children without neurodevelopmental disorders, use of transabdominal ultrasound can be considered as non-invasive technique to assess the rectal filling state¹³⁸, but there are no studies concerning children with NI. If the diagnosis is uncertain an abdominal radiograph might be helpful. Colonic transit time assessment can be used as quantitative measure of constipation in NI. A transit time delay at the proximal segment of colon is the dominant finding that suggests alterations of the motility of the smooth muscle associated with the reduction of activity of the striated muscles of the anal

sphincter and/or of the pelvic floor. Brain abnormalities may play a role in colonic transit time delay as there is evidence that delayed colonic transit is more frequent in children with severe brain lesions¹³⁹.

16: ESPGHAN WG recommends diagnosis of constipation in NI children by a careful history, abdominal, perineal and if necessary rectal digital examination

LoE moderate

GoR strong

VOTES: 9, 9, 8, 8, 9, 9, 9, 8, 9, 9, 7, 7, 9, 9, 9 (accepted)

17. What is the treatment of constipation?

The treatment of constipation in NI children should conform to the standard for non-disabled children. The initial approach involves a fecal disimpaction before maintenance therapy, using enemas for 3 consecutive days and osmotic agents such as polyethylene glycol (1.5 g/kg/day) until the child performs a liquid and clear evacuation¹⁴⁰. More than 50% of NI children have chronic use of laxatives but they are less-responsive to treatment than typically developed children¹⁴¹. Fiber and fluid intakes are inadequate in 53% of NI children¹⁴². Modest relief of constipation with reduction of laxatives usage have been demonstrated by increasing fibre intakes to 17-21 g/day but high fibre intake may cause intolerance (flatulence, distension and bloating). Maintenance therapy requires use of osmotic laxatives such as lactulose (1-2 ml/kg/day) or polyethylene glycol (0.8 g/kg/day)¹³⁶. There have been reports of severe pneumonia due to aspiration of laxatives and therefore use of macrogol or liquid paraffin must be

provided with caution in NI children with high risk of aspiration¹³⁷. In refractory cases, hydro-colonic enema and antegrade continence enema (ACE) has been reported as an effective treatment option¹⁴³. The ACE procedure involves a surgically constructed conduit into the colon that allows the administration of antegrade irrigations. It is most often done as a laparoscopic cecostomy or placement of cecostomy by interventional radiology. Previous studies have shown that the ACE procedure is safe and effective in children with defecation abnormalities but limited information about long-term outcomes is available in NI children¹⁴⁴.

17a: ESPGHAN WG recommends in NI children with constipation to use standard treatments as in typically developing children, unless there is a risk of aspiration of polyethylene glycol or liquid paraffin

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 8, 8, 9, 9, 8, 9, 8, 7, 7, 9, 9, 9 (accepted)

17b: ESPGHAN WG suggests increasing fluid and fibre intake as an additional strategy to treat constipation in NI children

LoE low,

GoR weak

VOTES: 9, 8, 8, 7, 9, 7, 7, 8, 8, 8, 7, 7, 8, 9, 7 (accepted)

18. What other problems can contribute to feeding difficulties (ie dental, drowling, pain, orthopedics...)?

Dental

Children with NI have a high incidence oral/dental problems contributing to feeding difficulties. These include the stability of the jaws, lip tone and movement, and problems with biting including tonic biting and overbiting. Jaw instability limits graded opening and closure, impairing manipulation of food in the mouth and leading to poor bolus formation and swallowing difficulty. Jaw thrusting and retraction may cause difficulties taking food from a spoon, drinking, retaining and manipulating food within the mouth, bolus formation and safe and effective swallowing⁶⁷. NI children exhibit almost a 3-fold greater chance of having an occlusion abnormality¹⁴⁵. Bruxism, the habitual grinding of teeth is a common occurrence in people with NI. In extreme cases, bruxism leads to tooth abrasion and flat biting surfaces. Ortega et al¹⁴⁶ found that along with bruxism there were habits like pacifier-sucking, fingersucking, habit of biting objects and tongue interpositioning. Drooling of saliva, sialorrhea, appears to be the consequence of a dysfunction in the coordination of the swallowing mechanism, resulting in excess pooling of saliva in the anterior portion of the oral cavity and the unintentional loss of saliva from the mouth. Prevalence rates of sialorrhea in NI children are reported range from 10 to 58%¹⁴⁷. The lips and tongue also play an important role in effective feeding. The lips may be hypotonic, hypertonic or have a mixed tone with constant movement at rest. Poor lip control can cause leakage of food and fluids, resulting in

decreased intake and contributing to poor nutrition and dehydration. Poor tongue movements including thrusting may compromise the formation of the food bolus.

Orthopedic problems

Many NI children have trunk hypotonia. In an upright sitting position, therefore, the thoracic column becomes kyphotic and the cervical spine lordotic. Due to the problem of drooling the head of the child is often tilted backwards. The children therefore become lordotic in the cervical spine, which has a negative influence on the function of the pharynx during swallowing. Neck extension may hamper closure of the laryngeal vestibule. Many NI children undergo surgery for scoliosis. Apart from the routine problems post surgery, they may develop gastric dysmotility¹⁴⁸. The cause of this complication is not clear, but could be related to the continuous traction applied to the spine which may result in overstimulation of the sympathetic fibres. Sympathetic overstimulation may cause postprandial antral hypomotility and delayed gastric emptying leading to persistent nausea and recurrent emesis. Secondary malnutrition can further contribute to the gastrointestinal motility disorder.

18: ESPGHAN WG recommends that careful attention is paid to dental problems, general posture and orthopedic issues in NI patients, as these may contribute to feeding difficulties

LoE: moderate,

GoE: strong

VOTES: 9, 9, 9, 9, 8, 8, 9, 8, 9, 9, 8, 9, 9, 8, 8 (accepted)

Dietetic management and monitoring (other than enteral nutrition)

19. Which type of diet according to oral/gastric tolerance?

Oral feeding should be preferred in all children including children with NI. Feeding must be safe and so if severe oropharyngeal dysfunction (dysphagia, unsafe swallow) is associated with repeated pulmonary aspirations, pneumonias, dehydration and/or life threatening events then an early switch to (partial or full) enteral feeding is advocated (figure 1). The duration of a trial of oral feeding depends on the child's age and the severity of malnutrition. A follow-up period of 1-3 months is usually sufficient but infants and severely malnourished patients need to be seen more frequently. Older children should be seen at least annually^{1, 56}. The optimal energy content of oral feeds may differ according to type of the impairment, mobility of the patient, medication and other factors. In order to increase total energy content of meals without excessively increasing volume, additional fat or oils (e.g. high fat spreads), dry milk powders, cream or ice cream may be supplemented⁵⁶. Recommendations on fibre intake are the same as for typically developing children (age plus 5 g/d in children above 2 years of age).

Composition of the diet should be discussed with specialised feeding therapist/dietitians^{56, 149}. In cooperation with a feeding therapist/dietitian, it is reasonable to modify textures of food and thickness of fluids in order to ensure safe and efficient food intake.

19: ESPGHAN WG recommends using oral feeding in NI children if it is nutritionally sufficient, safe, stress-free and feeding time is not prolonged

LoE moderate,

GoR strong

VOTES: 9, 8, 9, 9, 9, 9, 8, 8, 9, 9, 9, 8, 9, 9, 9 (accepted)

20. Does Feeding times compete with rehabilitation?

In some children, attempts at oral feeding at any cost may lead to an excessive amount of time spent on feeding the child during the day, which in turn may lead to a lack of time left for other activities as rehabilitation, and severe impairment of the caregivers' quality of life (QoL). This occurs especially in children with chewing and swallowing dysfunction and affects up to 90 % of children with NI^{1, 53, 78, 150-156}. Some patients are able to feed themselves, but lack hand-mouth coordination and may eat slowly and spill part of food. Many of NI children with NI are not able to communicate hunger and satiety^{157, 158}. Usually, total feeding time during the day of between 3-6 hours or more than 30 min. per feed is considered as excessive^{50, 157, 159, 160}. ESPGHAN defines a feeding time > 4 to 6 h/day as one of the conditions for considering enteral nutrition support¹⁶¹. However, it should be taken into account that caregivers often overestimate the time spent feeding the child and also overestimate the child's caloric intake^{62, 78, 157}.

20: ESPGHAN WG recommends considering use of enteral feeding if total oral feeding time exceeds 3 hours per day

LoE low,

GoR weak

VOTES: 9, 8, 9, 8, 9, 9, 9, 8, 7, 9, 9, 5, 7, 8, 8 (accepted)

Enteral Nutrition (enteral tube feedings, percutaneous endoscopic gastrostomy/ jejunostomy)

21. Which sorts of enteral product to use?

The choice of enteral formula depends not only on the child's age, but also on its energy requirements and mode of enteral access. Most enteral feeds are designed to meet all essential nutrient requirements¹⁶¹. The initial feed of choice is usually a standard energy density (1.0 kcal/ml) polymeric feed. For children with an increased energy requirement or poor tolerance of large volumes of feed, a high-energy density formula (for example, 1.5 kcal/ml)^{162,1} or dietary supplementation with glucose polymers and/or long-chain triglycerides to increase calorie intake may be useful. The addition of modular nutrients, however, should be made with the help of a dietitian to ensure that the final composition of the diet is adequate and to avoid preparation errors. For severely undernourished children, additional protein (2.0 g/kg/d) and energy (additional 20 % increase in energy intake) may be required to promote 'catch up' growth^{163,50}. Before 12 months of age, an infant formula should be used¹⁶⁴. Most children will tolerate a polymeric formula, but some children may require a semielemental or elemental formula. Casein hydrolysates and amino acid-based formulas may be used in selected patients¹⁶⁴. In some countries an enteral feed specifically designed for tube-fed children with severe neurological impairment after nutritional rehabilitation is available: it is low-fat, low-calorie, high fibre, and micronutrient replete^{58,165}. Whey-based formulas may be beneficial in children with poor feed tolerance because of delayed gastric

emptying^{164,166,167}. Whey-based enteral formula has also been shown to significantly reduce acid gastroesophageal reflux episodes in children (but not infants) with severe NI and a 50 % whey formula significantly reduces gagging and retching in children with severe NI¹⁶⁸. Pureed food given via gastrostomy has been suggested to reduce gagging and retching in children following fundoplication surgery due to higher viscosity as well as different hormonal responses favourably affecting gastrointestinal motility¹⁶⁷. Concerns regarding the nutritional adequacy and safety of home-prepared tube feeds have been reported and even with the involvement of a dietitian, poor weight gain has been reported¹⁶⁷. Microbial contamination of enteral tube feeds can occur even with the use of commercial formulas^{169, 170}. Risk factors, however, include the environment and the manner in which the feed is prepared, poor attention to hygiene during handling, repeated topping up of the feed container and increasing feed-hanging times¹⁶¹. Commercially available ‘ready to hand’ closed enteral feeding systems are designed to limit handling procedures with the introduction of the giving set spike into the pack.

21a: ESPGHAN WG recommends using standard (1.0 kcal/mL) polymeric age-appropriate formula including fibre for NI children older than one year

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 8, 8, 8, 8, 8, 8, 8, 7, 7 (accepted)

21b: ESPGHAN WG recommends using a high-energy density formula (1.5 kcal/ml) containing fibre in cases of poor volume tolerance in NI children, provided hydration is carefully monitored

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 7, 7 (accepted)

21c: ESPGHAN WG recommends using human milk, a standard infant formula or nutrient dense infant enteral formula as clinically indicated in NI infants

LoE low,

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 9, 9, 8, 8, 8, 7, 6, 6 (accepted)

21d: ESPGHAN WG recommends using a low-fat, low-calorie, high fibre, and micronutrient replete formula for the maintenance of enteral tube feeding after nutritional rehabilitation in immobile NI children

LoE moderate,

GoR strong

VOTES: 9, 8, 8, 8, 8, 8, 8, 8, 8, 8, 8, 7, 7, 6, 6 (accepted)

21e: ESPGHAN WG recommends using a trial of whey-based formula in cases of gastroesophageal reflux, gagging and retching in NI children

LoE moderate,

GoR weak

VOTES: 9, 8, 8, 8, 8, 7, 7, 7, 7, 7, 6, 6, 6, 6, 5 (accepted)

21f: ESPGHAN WG recommends caution if pureed food is used for enteral tube feeding in NI children, because of concerns regarding nutritional adequacy and safety

LoE low,

GoR strong

VOTES: 9, 9, 8, 8, 8, 8, 8, 8, 7, 7, 7, 6, 6, 5, 4 (accepted)

22: Which modalities of EN to use (bolus/continuous)?

Enteral tube feeding can be administered as a bolus, intermittently or continuously. The choice of feeding regimen will be based on the child's enteral access, their activities, caloric needs, and tolerance to feeds¹. Continuous feeding is the preferred method in feeding intolerance. In continuous feeding the feed is delivered by dripping by gravity or assisted by an enteral feeding pump over a specified number of hours into a tube. In bolus feeding the nutritional product is administered over 15 to 30 minutes several times a day. Bolus feeding allows more freedom and may be more suitable to the

lifestyles of many families. The timing of bolus feeds is important to provide adequate opportunity for the development of hunger before oral meals. A child with high-caloric needs or with poor tolerance to volume may benefit from a combination of overnight continuous feeds with boluses during the day^{1, 56, 164}.

22: ESPGHAN WG recommends using a combination of nocturnal continuous feeds with daytime bolus feeds in children with high-caloric needs or poor tolerance to volume

LoE low,

GoR *weak*

VOTES: 9, 9, 9, 9, 9, 9, 9, 8, 8, 8, 8, 7, 7, 6, 5 (accepted)

23. Which type of tube (nasogastric, PEG) to use?

Intragastric access can be provided by either a nasogastric tube (NGT) or a gastrostomy, created surgically (preferably laparoscopic), radiology assisted or more usually a percutaneous endoscopic gastrostomy or PEG)¹⁷¹. Prospective randomised studies in children, comparing nasogastric with gastrostomy feeding in children are not available. In adults with swallowing difficulties, a Cochrane review showed that PEG was associated with a lower probability of intervention failure. PEG was found to cause less discomfort, to be more convenient and to interfere less with social activities. There was no significant difference in mortality rates between groups, nor in adverse events, including pneumonia related to aspiration. These results suggest that a gastrostomy may

be more effective and safe compared with NGT¹⁷². A prospective cohort study with a follow-up of 12 months of a cohort of 57 children with NI receiving a gastrostomy, showed a substantial increase in weight gain, improved health as reported by the parents and a significant reduction in feeding time with no increase in respiratory infections^{165, 57}. Common complications reported in this and other studies, are minor site infections and granulation tissue, occurring in 40–60% of patients. Peritonitis, tube migration, tube blockage, major site infections, buried bumper, colon perforation are far less common.

23: ESPGHAN WG recommends using a gastrostomy as the preferred way to provide intragastric access for long term tube feeding in NI children

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 9, 8, 8, 9, 9 (accepted)

24. What are the indications of jejunal feeding?

In cases where intragastric feeding is contraindicated because of severe gastric motility disorder, or severe GORD is not amenable to antireflux surgery, jejunal tube feeding can offer enteral access. A jejunal tube needs to be positioned distal to the Treitz ligament in order to prevent retrograde filling of a dysfunctioning stomach. Jejunal access can be provided by a nasojejunal tube, jejunal tube introduced through a gastrostomy, or surgical transcutaneous jejunostomy.

In patients who already have a gastrostomy, a jejunal tube can be introduced through the gastrostomy. However, these jejunal tubes frequently migrate back to the stomach. The mean functional duration of these tubes was found to be 55 days in adults and 39 days in children. Retrograde dislodgment of the jejunal extension tube, tube obstruction and mechanical failure have been described as the most common device-related complications¹⁷³.

Jejunal feeding is appropriate in patients with recurrent vomiting and/or tube feeding-related aspiration, severe gastroesophageal reflux and gastroparesis¹⁷⁴. The combination of gastric decompression via PEG and simultaneous jejunal nutrition was shown to provide clinical benefit in NI patients.

24: ESPGHAN WG suggests using jejunal feeding in cases of aspiration due to gastro oesophageal reflux disease, refractory vomiting, retching and bloating in NI children

LoE moderate,

GoR weak

VOTES: 9, 9, 8, 8, 8, 8, 9, 9, 8, 7, 7, 7, 5, 9, 9 (accepted)

25: When should tube feeding be started?

Tube feeding is indicated in cases of inadequate oral intake manifesting as insufficient weight gain or weight stagnation, evidence of low body-fat stores, low weight in respect to height/length, prolonged or stressful oral feeding, recurrent pulmonary

infections as sign of aspiration or food refusal which do not respond to non-invasive nutritional support^{1,56}.

25: ESPGHAN WG recommends using enteral tube feeding in cases of unsafe or inefficient oral feeding, preferably before the development of undernutrition

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 9, 8, 8, 7, 7, 5, 9, 9 (accepted)

Surgical interventions (Nissen fundoplication)

26. What investigations should be carried out prior to consideration for surgery?

NI children account for the great majority of GORD patients requiring anti-reflux surgery in the pediatric surgical field, but there have very few studies that have evaluated the GORD of NI patients prior to surgery in relation to the outcome¹⁷⁵. Careful evaluation of GORD is required before fundoplication since symptoms of GORD are often lacking (communication deficits) or non-specific (increased spasticity, seizures, pulmonary or laryngologic manifestations) or associated with other complications (inhalation, swallowing difficulties) in this high-risk population. Investigations are required before surgery to 1) confirm GORD 2) search for complications (oesophageal stenosis, Barrett's) 3) rule out differential diagnosis (ie eosinophilic esophagitis). The 24 h pH monitoring has been widely used to evaluate and quantify GORD, but is not able to be

detected non acid reflux. pH/impedancemetry has been established as a pH independent measurement tool which allows for the analysis of the movement, direction, and height attained by the bolus, making it possible to distinguish antegrade and retrograde bolus movement. The technique still has limitations: high cost, limited added value regarding therapeutic implications, and lack of evidence-based parameters for the assessment of GORD and symptom association in children. Assessing GORD could be difficult in cases of continuous enteral nutrition and/or PPI treatment. Upper gastrointestinal endoscopy with biopsies is required before surgery to search for esophagitis and Barrett's. NI patients are considered as a high-risk group for peptic esophagitis, Barrett's esophagus and esophageal adenocarcinoma. The utility of the upper gastrointestinal study to rule out anatomic abnormalities in the preoperative evaluation is questionable¹⁷⁶. There is no data on predictive value of high-resolution esophageal manometry on postfundoplication complications in NI patients. Abnormal gastric emptying, is frequent in NI children and may be assessed by using octanoic acid breath test or scintigraphy but its usefulness for deciding surgery or predict outcome after fundoplication has never been assessed. There is today no investigation that could predict failure, complication (ie dysphagia) of fundoplication or recurrence of GORD.

26: ESPGHAN WG recommends that upper gastrointestinal endoscopy with biopsies is performed before fundoplication in NI children. Other investigations (e.g. contrast studies, gastric emptying studies and pH+/- impedancemetry) may also be indicated

LoE low,

GoR strong

VOTES: 9, 8, 9, 9, 9, 9, 8, 9, 7, 5, 4, 9, 9, 9, 8 (accepted)

27. Should a fundoplication routinely be performed when a PEG indicated? (figure

1)

Among the children requiring PEG those with NI are more likely to require a subsequent antireflux procedure¹⁷⁷. One potential benefit of associating gastrostomy to fundoplication is to prevent inhalation and the respiratory complications of enteral feeding. However, infants with NI who underwent fundoplication at the time of gastrostomy placement did not have a reduced rate of reflux-related hospitalizations (including asthma, inhalation, GORD, pneumopathies) when compared with those who underwent gastrostomy placement alone¹⁷⁸. Antireflux surgery also has pitfalls and complications. There are no randomised controlled trials of fundoplication versus postoperative medication for children with NI and severe GORD undergoing gastrostomy¹⁷⁹.

Most of the publications on the relationship between PEG and GORD using pH/impedancemetry before and after PEG conclude that GORD is not aggravated by PEG^{180 181 182 183} although some studies showed that PEG increased GORD^{184, 185,186}. Another approach is to assess the outcome of GORD after PEG in NI children. In the experience of one of us only 16% of patients with a neurological disease, needed antireflux surgery at follow-up (unpublished data). In another study only 9% of patients requiring PEG underwent fundoplication 20 months after PEG¹⁸⁷. Even if we cannot rule out the responsibility of PEG worsening GORD, we hypothesize that the increased volume of food intakes following PEG placement could reveal or aggravate a preexisting

GORD. Routine fundoplication at the time of gastrostomy would unnecessarily expose a large proportion of NI children to antireflux surgery complications including gas bloat syndrome, dysphagia, and dumping syndrome.

27: ESPGHAN WG recommends that a routine antireflux procedure should not be performed at the time of PEG placement in NI children as it could add significant morbidity

LoE high

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 8, 9, 9, 7, 9, 9, 9, 8 (accepted)

28. What are the indications for fundoplication? (figure1)

In a retrospective cohort study on caregiver perceptions and complication rates in 122 NI patients that underwent fundoplication, the majority of caregivers indicated that surgery improved weight gain, chest infections, vomiting, and feeding tolerance. Although gagging and retching were common following surgery, a high percentage of caregivers reported improved nutrition, reflux-related symptoms, and high levels of satisfaction¹⁸⁸. NI children represent a special group of patients with increased risk for operative morbidity and postoperative failure and persistence/recurrence of GORD¹²⁷. As for normally developed children, antireflux surgery may be of benefit in children with confirmed GORD who have failed optimal medical therapy, who are dependent on medical therapy over a long period of time, who are significantly nonadherent with medical therapy, or who have life-threatening complications of GORD. Children with

respiratory complications including asthma or recurrent aspiration related to GORD are generally considered most likely to benefit from antireflux surgery when medical therapy fails. Given the morbidity and high failure rates of antireflux surgery in NI children, patients whose symptoms are well controlled on medical therapy may not derive additional benefit from antireflux surgery. In a systematic review, it was found that the need for reoperation in NI children was 15.4% in comparison with 7.0% in those without NI¹⁸⁹. Ferluga et al. concluded that there is poor or no evidence of effectiveness of fundoplication in treatment of nutritional problems¹⁹⁰. In NI patients, the potential benefit of fundoplication should be weighted against the risk of potential complications before surgery is decided upon¹⁹¹.

28: ESPGHAN WG recommends that fundoplication be considered in cases of failure of optimized medical therapy for gastro oesophageal reflux disease in NI children

LoE strong,

GoR *strong*

VOTES: 9, 9, 8, 9, 8, 8, 9, 6, 9, 8, 9, 8, 8, 8, 9 (accepted)

29. Are there surgical alternatives to fundoplication?

Total esophagogastric disconnection (EGD) and Roux-en Y esophagojejunostomy has been developed as a “once-and-for-all” effective therapy for GORD in NI patients. This strategy is, however, more invasive, requiring longer periods of rehabilitation¹⁹².

The advantage of laparoscopic Nissen fundoplication, in terms of both reduction of hospital stay and post operative peritoneal adhesions, reduces the indications for total esophago-gastric disconnection. This should be considered as primary surgical management of GORD only in special and complex clinical situations; in severe NI children needing repeated anti GORD surgery, EGD could represent the only opportunity of definitive resolution. Microgastria, in selected cases that cannot be treated with one of the gastric augmentation techniques, could also represent an indication for EGD¹⁹³.

29: ESPGHAN WG recommends restricting the indication for total oesophago-gastric disconnection and Roux-en-Y oesophagojejunostomy, as an alternative of classical anti-reflux surgery, to very selected cases in NI children

LoE weak,

GoR weak

VOTES: 9, 9, 8, 9, 8, 8, 9, 6, 9, 8, 9, 8, 8, 8, 9 (accepted)

Ethical issues related to digestive and nutritional problems in the severely handicapped

30. What is the effect of nutritional support on quality of life of children and caregivers?

The severity of the disease as well as the presence and severity of malnutrition both have an impact on Qol impairment. Gastrostomy feeding is effective in reversing malnutrition in children with NI and has positive effects on the Qol of the patients and the caregivers. Qol is often the most important outcome treatment for chronic conditions

such as NI¹⁹⁴. Children with NI have reduced health-related quality of life (HRQoL) and the degree to which it is reduced is related to the severity of their NI^{195, 196}. Almost 50% of children with NI are able to self-report their perceptions of their HRQoL. Healthcare professionals and parents should, therefore, rely on a proxy report only when the children are not capable of self-report, or to ascertain potential differences in perceptions between children and their parents¹⁹⁷. Nevertheless, for severely disabled children parent-proxy reported QoL are the only available data. Caring for a child with NI affects a parents physical well-being, social well-being, freedom, independence, family well-being and financial stability¹⁹⁸. Carers of children with NI have poor QoL, worse mental health, and higher burnout levels than controls¹⁹⁹. Parents often feel unsupported by the services they access²⁰⁰. Children with the most severe motor disability who have feeding tubes are an especially frail group, i.e. having the poorest health, the worst well-being, and using the most health-related resources²⁰¹. Previous qualitative studies have found issues of social isolation, difficulty in obtaining care, and high caregiving demands among parents of children with NI who are fed through a gastrostomy tube^{149, 202, 203}. Using a validated instrument for measurement of QoL, however, Sullivan et al found a significant improvement in the QoL of carers 6 and 12 months after insertion of a gastrostomy feeding tube in children with cerebral palsy²⁰⁴. A clear need for additional support for parents of children with a PEG has been identified that goes beyond simply meeting clinical need¹⁴⁹. Ongoing medical and psychosocial support is needed after initiation of nonoral feedings and is best provided through the collaborative efforts of the family and a team of professionals²⁰⁵.

30: ESPGHAN WG recommends that parents and/or caregivers are always involved in decision making especially around gastrostomy feeding

LoE high,

GoR strong

VOTES: 8, 9, 9, 9, 9, 9, 9, 8, 9, 9, 9, 9, 9, 9 (accepted)

31: Are there ethical issues in relation to nutritional support?

PEG feeding for reversing malnutrition in children with NI is a therapeutic intervention and as such is governed by standard ethical rules. The decision on initiation of the treatment is based on the likely net balance between advantages and disadvantages in order to promote the best interest of the individual patient. Similarly, to other treatments, informed and educated consent of the parents is an important ethical principle. PEG feeding is associated with several complications and is costly. Gastrostomy feeding has been shown to reverse malnutrition¹⁶⁵ and to reduce the number of feed-related choking episodes, vomiting, and chest infections⁵⁷. However, the decision-making process for parents is often difficult due to negative caregiver perceptions⁷⁵ and the gastrostomy tube placement is often delayed²⁰⁶. Fears about loss of normal eating, dependency on gastrostomy feeds and complications of the procedure can make parents accept this option only as a last resort²⁰⁰. Nonetheless, the majority of caregivers recognise improvement in the children following placement and the majority admit that they would have accepted an earlier placement of the gastrostomy tube if they had anticipated the overall outcome^{207, 208}. Obtaining parents' consent before initiating

PEG feeding is important ethical principle, similarly to any other medical intervention. The parents need to be given detailed information on the benefits, risks and alternatives of the treatment and also, enough time to retain the information in order to make a conscious decision. Health-care workers need to develop effective, family-centred, patient appropriate adherence strategies for gastrostomy fed children with NI. Furthermore, education and training on gastrostomy feeding both in hospital and in the community, helps the carers of patients to cope during the transition from oral to gastrostomy feeding while, continuing social support is essential in order to improve QoL of carers.

31: ESPGHAN WG recommends involvement of a professional ethicist to assist decision making in cases where invasive investigations or procedures (e.g. gastrostomy, fundoplication, parenteral nutrition) pose ethical dilemmas

LoE moderate,

GoR strong

VOTES: 9, 9, 9, 9, 9, 9, 9, 9, 8, 8, 9, 9, 8, 9, 9 (accepted)

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Supplemental Data

Table of grading and quality assessment of all papers reviewed for NI guidelines

(Supplemental Digital Content 1, Table, <http://links.lww.com/MPG/B24>)

References

1. Marchand V, Motil KJ, Nutrition NCo. Nutrition support for neurologically impaired children: a clinical report of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr* 2006;43:123-35.
2. Rosenbaum P, Paneth N, Leviton A, et al. A report: the definition and classification of cerebral palsy April 2006. *Dev Med Child Neurol Suppl* 2007;109:8-14.
3. Guyatt GH OA, Vist GE. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ* 2008;336:924-6.
4. Guyatt G, Oxman AD, Akl EA, et al. GRADE guidelines: 1. Introduction- GRADE evidence profiles and summary of findings tables. *J Clin Epidemiol* 2011;64:383-94.
5. Guyatt GH, Oxman AD, Kunz R, et al. GRADE guidelines: 2. Framing the question and deciding on important outcomes. *J Clin Epidemiol* 2011;64:395-400.
6. Balshem H, Helfand M, Schunemann HJ, et al. GRADE guidelines: 3. Rating the quality of evidence. *J Clin Epidemiol* 2011;64:401-6.
7. Guyatt GH, Oxman AD, Vist G, et al. GRADE guidelines: 4. Rating the quality of evidence--study limitations (risk of bias). *J Clin Epidemiol* 2011;64:407-15.

8. Hsu J BJ, Terracciano L, Kreis J, Compalati E, Stein AT, Fiocchi A, Schunemann HJ. Application of GRADE: making evidence-based recommendations about diagnostic tests in clinical practice guidelines. *Implement Sci* 2011;6:1748-5908.
9. Stevenson RD, Conaway M, Chumlea WC, et al. Growth and health in children with moderate-to-severe cerebral palsy. *Pediatrics* 2006;118:1010-8.
10. Samson-Fang LJ, Stevenson RD. Identification of malnutrition in children with cerebral palsy: poor performance of weight-for-height centiles. *Developmental Medicine and Child Neurology* 2000;42:162-8.
11. Kuperminc MN, Gurka MJ, Bennis JA, et al. Anthropometric measures: poor predictors of body fat in children with moderate to severe cerebral palsy. *Dev Med Child Neurol* 2010;52:824-30.
12. Stevenson RD. Use of Segmental Measures to Estimate Stature in Children with Cerebral-Palsy. *Archives of Pediatrics & Adolescent Medicine* 1995;149:658-62.
13. Haapala H, Peterson MD, Daunter A, et al. Agreement Between Actual Height and Estimated Height Using Segmental Limb Lengths for Individuals with Cerebral Palsy. *Am J Phys Med Rehabil* 2015;94:539-46.
14. Spender QW, Cronk CE, Charney EB, et al. Assessment of Linear Growth of Children with Cerebral-Palsy - Use of Alternative Measures to Height or Length. *Developmental Medicine and Child Neurology* 1989;31:206-14.

15. Hogan SE. Knee height as a predictor of recumbent length for individuals with mobility-impaired cerebral palsy. *Journal of the American College of Nutrition* 1999;18:201-5.
16. Chumlea WMC, Guo SS, Steinbaugh ML. Prediction of Stature from Knee Height for Black-and-White Adults and Children with Application to Mobility-Impaired or Handicapped Persons. *Journal of the American Dietetic Association* 1994;94:1385-91.
17. Gault LM, Kappers J, Carlin JB, et al. Height prediction from ulna length. *Developmental Medicine and Child Neurology* 2004;46:475-80.
18. Bell KL, Davies PSW. Prediction of height from knee height in children with cerebral palsy and non-disabled children. *Annals of Human Biology* 2006;33:493-9.
19. Frisancho AR. New Norms of Upper Limb Fat and Muscle Areas for Assessment of Nutritional-Status. *American Journal of Clinical Nutrition* 1981;34:2540-5.
20. Kuperminc MN, Stevenson RD. Growth and nutrition disorders in children with cerebral palsy. *Dev Disabil Res Rev* 2008;14:137-46.
21. Sullivan P. Measurement of body composition should become routine in nutritional assessment of children with cerebral palsy. *Dev Med Child Neurol* 2015;57:793-4.
22. Samson-Fang L, Bell KL. Assessment of growth and nutrition in children with cerebral palsy. *Eur J Clin Nutr* 2013;67 Suppl 2:S5-8.

23. Slaughter MH, Lohman TG, Boileau RA, et al. Skinfold equations for estimation of body fatness in children and youth. *Hum Biol* 1988;60:709-23.
24. Stallings VA, Cronk CE, Zemel BS, et al. Body composition in children with spastic quadriplegic cerebral palsy. *J Pediatr* 1995;126:833-9.
25. van den Berg-Emons RJ, van Baak MA, Westerterp KR. Are skinfold measurements suitable to compare body fat between children with spastic cerebral palsy and healthy controls? *Dev Med Child Neurol* 1998;40:335-9.
26. Gurka MJ, Kuperminc MN, Busby MG, et al. Assessment and correction of skinfold thickness equations in estimating body fat in children with cerebral palsy. *Dev Med Child Neurol* 2010;52:e35-41.
27. Liu LF, Roberts R, Moyer-Mileur L, et al. Determination of body composition in children with cerebral palsy: bioelectrical impedance analysis and anthropometry vs dual-energy x-ray absorptiometry. *J Am Diet Assoc* 2005;105:794-7.
28. Finbraten AK, Martins C, Andersen GL, et al. Assessment of body composition in children with cerebral palsy: a cross-sectional study in Norway. *Dev Med Child Neurol* 2015;57:858-64.
29. Oeffinger DJ, Gurka MJ, Kuperminc M, et al. Accuracy of skinfold and bioelectrical impedance assessments of body fat percentage in ambulatory individuals with cerebral palsy. *Dev Med Child Neurol* 2014;56:475-81.

30. Rieken R, van Goudoever JB, Schierbeek H, et al. Measuring body composition and energy expenditure in children with severe neurologic impairment and intellectual disability. *Am J Clin Nutr* 2011;94:759-66.
31. Azcue MP, Zello GA, Levy LD, et al. Energy expenditure and body composition in children with spastic quadriplegic cerebral palsy. *J Pediatr* 1996;129:870-6.
32. Bianchi ML, Leonard MB, Bechtold S, et al. Bone health in children and adolescents with chronic diseases that may affect the skeleton: the 2013 ISCD Pediatric Official Positions. *J Clin Densitom* 2014;17:281-94.
33. Henderson RC. Bone density and other possible predictors of fracture risk in children and adolescents with spastic quadriplegia. *Dev Med Child Neurol* 1997;39:224-7.
34. Henderson R. The effect of gastrostomy tube feeding on body protein and bone mineralization in children with quadriplegic cerebral palsy. *Dev Med Child Neurol* 2010;52:985.
35. Hartman C, Brik R, Tamir A, et al. Bone quantitative ultrasound and nutritional status in severely handicapped institutionalized children and adolescents. *Clin Nutr* 2004;23:89-98.
36. Cohen M, Lahat E, Bistritzer T, et al. Evidence-based review of bone strength in children and youth with cerebral palsy. *J Child Neurol* 2009;24:959-67.

37. Lark RK, Williams CL, Stadler D, et al. Serum prealbumin and albumin concentrations do not reflect nutritional state in children with cerebral palsy. *Journal of Pediatrics* 2005;147:695-7.
38. Tomoum HY, Badawy NB, Hassan NE, et al. Anthropometry and body composition analysis in children with cerebral palsy. *Clin Nutr* 2010;29:477-81.
39. Kalra S, Aggarwal A, Chillar N, et al. Comparison of micronutrient levels in children with cerebral palsy and neurologically normal controls. *Indian J Pediatr* 2015;82:140-4.
40. Sanchez-Lastres J, Eiris-Punal J, Otero-Cepedal JL, et al. Nutritional status of mentally retarded children in northwest Spain: II. Biochemical indicators. *Acta Paediatrica* 2003;92:928-34.
41. Hillesund E, Skranes J, Trygg KU, et al. Micronutrient status in children with cerebral palsy. *Acta Paediatrica* 2007;96:1195-8.
42. Takeda Y, Kubota M, Sato H, et al. Carnitine in severely disabled patients: relation to anthropometric, biochemical variables, and nutritional intake. *Brain Dev* 2015;37:94-100.
43. WHO. The WHO child growth standards. <http://www.who.int/childgrowth/standards> 2006.
44. Mehta NM, Corkins MR, Lyman B, et al. Defining Pediatric Malnutrition: A Paradigm Shift Toward Etiology-Related Definitions. *Journal of Parenteral and Enteral Nutrition* 2013;37:460-81.

45. Krick J, Murphy-Miller P, Zeger S, et al. Pattern of growth in children with cerebral palsy. *J Am Diet Assoc* 1996; 96:680-5.
46. Day SM, Strauss DJ, Vachon PJ, et al. Growth patterns in a population of children and adolescents with cerebral palsy. *Dev Med Child Neurol* 2007;49:167-71.
47. Brooks J, Day S, Shavelle R, et al. Low weight, morbidity, and mortality in children with cerebral palsy: new clinical growth charts. *Pediatrics* 2011;128:e299-307.
48. Stevenson RD, Conaway M. Growth assessment of children with cerebral palsy: the clinician's conundrum. *Dev Med Child Neurol* 2007;49:164.
49. Turck D, Michaelsen KF, Shamir R, et al. World Health Organization 2006 child growth standards and 2007 growth reference charts: A discussion paper by the committee on Nutrition of the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition. *J Pediatr Gastroenterol Nutr* 2013;57:258-64.
50. Kuperminc MN, Gottrand F, Samson-Fang L, et al. Nutritional management of children with cerebral palsy: a practical guide. *Eur J Clin Nutr* 2013;67 Suppl 2:S21-3.
51. Marchand V, Society CP, Committee NaG. Nutrition in neurologically impaired children. *Paediatrics & child health* 2009;14:395-401.
52. Arrowsmith FE, Allen JR, Gaskin KJ, et al. Reduced body protein in children with spastic quadriplegic cerebral palsy. *Am J Clin Nutr* 2006;83:613-8.

53. Sullivan PB, Juszczak E, Lambert BR, et al. Impact of feeding problems on nutritional intake and growth: Oxford Feeding Study II. *Dev Med Child Neurol* 2002;44:461-7.
54. Duffy CM, Hill aE, Cosgrove aP, et al. Energy consumption in children with spina bifida and cerebral palsy: a comparative study. *Developmental medicine and child neurology*. Volume 38, 1996:238-43.
55. Bandini LG, Schoeller Da, Fukagawa NK, et al. Body composition and energy expenditure in adolescents with cerebral palsy or myelodysplasia. *Pediatric research*. Volume 29, 1991:70-7.
56. Bell KL, Samson-Fang L. Nutritional management of children with cerebral palsy. *Eur J Clin Nutr* 2013;67 Suppl 2:S13-6.
57. Sullivan PB, Morrice JS, Vernon-Roberts A, et al. Does gastrostomy tube feeding in children with cerebral palsy increase the risk of respiratory morbidity? *Arch.Dis.Child* 2006;91:478-82.
58. Sullivan PB, Alder N, Bachlet AM, et al. Gastrostomy feeding in cerebral palsy: too much of a good thing? *Dev Med Child Neurol* 2006;48:877-82.
59. Andrew MJ, Parr JR, Montague-Johnson C, et al. Optimising nutrition to improve growth and reduce neurodisabilities in neonates at risk of neurological impairment, and children with suspected or confirmed cerebral palsy. *BMC Pediatr* 2015;15:22

60. Calis EA, Veugelers R, Rieken R, et al. Energy intake does not correlate with nutritional state in children with severe generalized cerebral palsy and intellectual disability. *Clin Nutr* 2010;29:617-21.
61. Walker JL, Bell KL, Stevenson RD, et al. Relationships between Dietary Intake and Body Composition according to Gross Motor Functional Ability in Preschool-Aged Children with Cerebral Palsy. *Annals of Nutrition and Metabolism* 2012;61:349-57.
62. Stallings VA, Zemel BS, Davies JC, et al. Energy expenditure of children and adolescents with severe disabilities: a cerebral palsy model. *Am J Clin Nutr* 1996;64:627-34.
63. Joint WHOFAOUNUEC. Protein and amino acid requirements in human nutrition. *World Health Organ Tech Rep Ser* 2007:1-265, back cover.
64. Otten JJ, Hellwig JP, Meyers LD, et al. *Dietary Reference Intakes: The Essential Guide to Nutrient Requirements*. National Academy of Sciences 2006:1345.
65. German Nutrition Society ANS, Society for Nutrition Research, Swiss Nutrition Association, . Referenzwerte für die Nährstoffzufuhr [Reference Values for Nutrient Intake]. 2008:1-240.
66. Mascarenhas MR, Meyers R, Konek S. Outpatient Nutrition Management of the Neurologically Impaired Child. *Nutrition in Clinical Practice* 2008;23:597-607.
67. Andrew MJ, Parr JR, Sullivan PB. Feeding difficulties in children with cerebral palsy. *Arch Dis Child Educ Pract Ed* 2012;97:222-9.

68. Walker JL, Bell KL, Boyd RN, et al. Validation of a modified three-day weighed food record for measuring energy intake in preschool-aged children with cerebral palsy. *Clin Nutr* 2013;32:426-31.
69. Walker JL, Bell KL, Boyd RN, et al. Energy requirements in preschool-age children with cerebral palsy. *Am J Clin Nutr* 2012;96:1309-15.
70. Schoendorfer N, Tinggi U, Sharp N, et al. Protein levels in enteral feeds: do these meet requirements in children with severe cerebral palsy? *Br J Nutr* 2012;107:1476-81.
71. Dabydeen L, Thomas JE, Aston TJ, et al. High-energy and -protein diet increases brain and corticospinal tract growth in term and preterm infants after perinatal brain injury. *Pediatrics* 2008;121:148-56.
72. Santos MTB, Batista R, Guaré RO, et al. Salivary osmolality and hydration status in children with cerebral palsy. *Journal of Oral Pathology & Medicine* 2011;40:582-6..
73. MT S, Batista R, Previtali E, et al. Oral motor performance in spastic cerebral palsy individuals: are hydration and nutritional status associated? *J Oral Pathol Med* 2012;41:153-7.
74. Schoendorfer N, Boyd R, Davies PSW. Micronutrient adequacy and morbidity: paucity of information in children with cerebral palsy. *Nutrition reviews* 2010;68:739-48.

75. Craig GM, Carr LJ, Cass H, et al. Medical, surgical, and health outcomes of gastrostomy feeding. *Dev. Med. Child Neurol.* 2006;48:353-60.
76. Guimber D, Bourgois B, Beghin L, et al. Effect of multifibre mixture with prebiotic components on bifidobacteria and stool pH in tube-fed children. *The British journal of nutrition.* Volume 104, 2010:1514-22.
77. Papadopoulos A, Ntaios G, Kaiafa G, et al. Increased incidence of iron deficiency anemia secondary to inadequate iron intake in institutionalized, young patients with cerebral palsy. *Int J Hematol* 2008;88:495-7.
78. Reilly S, Skuse D, Poblete X. Prevalence of feeding problems and oral motor dysfunction in children with cerebral palsy: a community survey. *J Pediatr* 1996;129:877-82.
79. Calis EA, Veugelers R, Sheppard JJ, et al. Dysphagia in children with severe generalized cerebral palsy and intellectual disability. *Dev Med Child Neurol* 2008;50:625-30.
80. Benfer KA, Weir KA, Bell KL, et al. Oropharyngeal dysphagia and gross motor skills in children with cerebral palsy. *Pediatrics* 2013;131:e1553-62.
81. Erkin G, Culha C, Ozel S, et al. Feeding and gastrointestinal problems in children with cerebral palsy. *Int J Rehabil Res* 2010;33:218-24.
82. Benfer KA, Weir KA, Bell KL, et al. Validity and reproducibility of measures of oropharyngeal dysphagia in preschool children with cerebral palsy. *Dev Med Child Neurol* 2015;57:358-65.

83. Selley WG, Parrott LC, Lethbridge PC, et al. Objective measures of dysphagia complexity in children related to suckle feeding histories, gestational ages, and classification of their cerebral palsy. *Dysphagia* 2001;16:200-7.
84. Waterman ET, Koltai PJ, Downey JC, et al. Swallowing disorders in a population of children with cerebral palsy. *Int J Pediatr Otorhinolaryngol* 1992;24:63-71.
85. Benfer KA, Weir KA, Bell KL, et al. Clinical signs suggestive of pharyngeal dysphagia in preschool children with cerebral palsy. *Res Dev Disabil* 2015;38:192-201.
86. Ortega Ade O, Ciamponi AL, Mendes FM, et al. Assessment scale of the oral motor performance of children and adolescents with neurological damages. *J Oral Rehabil* 2009;36:653-9.
87. Gisel EG, Alphonse E, Ramsay M. Assessment of ingestive and oral praxis skills: children with cerebral palsy vs. controls. *Dysphagia* 2000;15:236-44.
88. Benfer KA, Weir KA, Boyd RN. Clinimetrics of measures of oropharyngeal dysphagia for preschool children with cerebral palsy and neurodevelopmental disabilities: a systematic review. *Dev Med Child Neurol* 2012;54:784-95.
89. Skuse D, Stevenson J, Reilly S, et al. Schedule for oral-motor assessment (SOMA): methods of validation. *Dysphagia* 1995;10:192-202.
90. Reilly S, Skuse D, Mathisen B, et al. The objective rating of oral-motor functions during feeding. *Dysphagia* 1995;10:177-91.

91. Sellers D, Mandy A, Pennington L, et al. Development and reliability of a system to classify the eating and drinking ability of people with cerebral palsy. *Dev Med Child Neurol* 2014;56:245-51.
92. Lespargot A, Langevin MF, Muller S, et al. Swallowing disturbances associated with drooling in cerebral-palsied children. *Dev Med Child Neurol* 1993;35:298-304.
93. Chigira A, Omoto K, Mukai Y, et al. Lip closing pressure in disabled children: a comparison with normal children. *Dysphagia* 1994;9:193-8.
94. Miamoto CB, Ramos-Jorge ML, Pereira LJ, et al. Severity of malocclusion in patients with cerebral palsy: determinant factors. *Am J Orthod Dentofacial Orthop* 2010;138:394 e1-5; discussion 394-5.
95. Mirrett PL, Riski JE, Glascott J, et al. Videofluoroscopic assessment of dysphagia in children with severe spastic cerebral palsy. *Dysphagia* 1994;9:174-9.
96. Rogers B, Arvedson J, Buck G, et al. Characteristics of dysphagia in children with cerebral palsy. *Dysphagia* 1994;9:69-73.
97. Wright RE, Wright FR, Carson CA. Videofluoroscopic assessment in children with severe cerebral palsy presenting with dysphagia. *Pediatr Radiol* 1996;26:720-2.
98. van den Engel-Hoek L, Erasmus CE, van Hulst KC, et al. Children with central and peripheral neurologic disorders have distinguishable patterns of dysphagia on videofluoroscopic swallow study. *J Child Neurol* 2014;29:646-53.

99. Kim JS, Han ZA, Song DH, et al. Characteristics of dysphagia in children with cerebral palsy, related to gross motor function. *Am J Phys Med Rehabil* 2013;92:912-9.
100. Yang WT, Loveday EJ, Metreweli C, et al. Ultrasound assessment of swallowing in malnourished disabled children. *Br J Radiol* 1997;70:992-4.
101. Kenny DJ, Casas MJ, McPherson KA. Correlation of ultrasound imaging of oral swallow with ventilatory alterations in cerebral palsied and normal children: preliminary observations. *Dysphagia* 1989;4:112-7.
102. Casas MJ, McPherson KA, Kenny DJ. Durational aspects of oral swallow in neurologically normal children and children with cerebral palsy: an ultrasound investigation. *Dysphagia* 1995;10:155-9.
103. Casas MJ, Kenny DJ, McPherson KA. Swallowing/ventilation interactions during oral swallow in normal children and children with cerebral palsy. *Dysphagia* 1994;9:40-6.
104. Ozdemirkiran T, Secil Y, Tarlaci S, et al. An EMG screening method (dysphagia limit) for evaluation of neurogenic dysphagia in childhood above 5 years old. *Int J Pediatr Otorhinolaryngol* 2007;71:403-7.
105. Rommel N, Dejaeger E, Bellon E, et al. Videomanometry reveals clinically relevant parameters of swallowing in children. *Int J Pediatr Otorhinolaryngol* 2006;70:1397-405.

106. Bader CA, Niemann G. [Dysphagia in children with cerebral palsy--fiberoptic-endoscopic findings]. *Laryngorhinootologie* 2010;89:90-4.
107. Gustafsson PM, Tibbling L. Gastro-oesophageal reflux and oesophageal dysfunction in children and adolescents with brain damage. *Acta Paediatr* 1994;83:1081-5.
108. Tambucci R, Thapar N, Saliakellis E, et al. Op-24 Esophageal Baseline Impedance in Neurologically Impaired Children. *J Pediatr Gastroenterol Nutr* 2015;61:519-20.
109. Noll L, Rommel N, Davidson GP, et al. Pharyngeal flow interval: a novel impedance-based parameter correlating with aspiration. *Neurogastroenterol Motil* 2011;23:551-e206.
110. Morgan AT, Dodrill P, Ward EC. Interventions for oropharyngeal dysphagia in children with neurological impairment. *Cochrane Database Syst Rev* 2012;10:CD009456.
111. Gisel EG, Birnbaum R, Schwartz S. Feeding impairments in children: diagnosis and effective intervention. *Int J Orofacial Myology* 1998;24:27-33.
112. Benfer KA, Weir KA, Bell KL, et al. Food and fluid texture consumption in a population-based cohort of preschool children with cerebral palsy: relationship to dietary intake. *Dev Med Child Neurol* 2015;57:1056-63.

113. Hirata GC, Santos RS. Rehabilitation of oropharyngeal dysphagia in children with cerebral palsy: A systematic review of the speech therapy approach. *Int Arch Otorhinolaryngol* 2012;16:396-9.
114. Gisel EG, Applegate-Ferrante T, Benson JE, et al. Effect of oral sensorimotor treatment on measures of growth, eating efficiency and aspiration in the dysphagic child with cerebral palsy. *Dev Med Child Neurol* 1995;37:528-43.
115. Gisel EG, Applegate-Ferrante T, Benson J, et al. Oral-motor skills following sensorimotor therapy in two groups of moderately dysphagic children with cerebral palsy: aspiration vs nonaspiration. *Dysphagia* 1996;11:59-71.
116. Gisel EG. Effect of oral sensorimotor treatment on measures of growth and efficiency of eating in the moderately eating-impaired child with cerebral palsy. *Dysphagia* 1996;11:48-58.
117. Gisel EG. Oral-motor skills following sensorimotor intervention in the moderately eating-impaired child with cerebral palsy. *Dysphagia* 1994;9:180-92.
118. Benfer KA, Weir KA, Bell KL, et al. Longitudinal Study of Oropharyngeal Dysphagia in Preschool Children With Cerebral Palsy. *Arch Phys Med Rehabil* 2016;97:552-560 e9.
119. Clancy KJ, Hustad KC. Longitudinal changes in feeding among children with cerebral palsy between the ages of 4 and 7 years. *Dev Neurorehabil* 2011;14:191-8.

120. Tas SA, Cankaya T. An investigation of the relationship of drooling with nutrition and head control in individuals with quadriparetic cerebral palsy. *J Phys Ther Sci* 2015;27:3487-92.
121. Otapowicz D, Sobaniec W, Okurowska-Zawada B, et al. Dysphagia in children with infantile cerebral palsy. *Adv Med Sci* 2010;55:222-7.
122. Del Giudice E, Staiano A, Capano G, et al. Gastrointestinal manifestations in children with cerebral palsy. *Brain Dev* 1999;21:307-11.
123. Reyes AL, Cash AJ, Green SH, et al. Gastroesophageal reflux in children with cerebral palsy. *Child Care Health Dev* 1993;19:109-18.
124. Bohmer CJ, Klinkenberg-Knol EC, Niezen-de Boer RC, et al. The prevalence of gastro-oesophageal reflux disease based on non-specific symptoms in institutionalized, intellectually disabled individuals. *Eur J Gastroenterol Hepatol* 1997;9:187-90.
125. Bayram AK, Canpolat M, Karacabey N, et al. Misdiagnosis of gastroesophageal reflux disease as epileptic seizures in children. *Brain Dev* 2016;38:274-9.
126. Gangil A, Patwari AK, Bajaj P, et al. Gastroesophageal reflux disease in children with cerebral palsy. *Indian Pediatr* 2001;38:766-70.
127. Vandenas Y, Rudolph CD, Di Lorenzo C, et al. Pediatric gastroesophageal reflux clinical practice guidelines: joint recommendations of the North American Society for Pediatric Gastroenterology, Hepatology, and Nutrition (NASPGHAN)

- and the European Society for Pediatric Gastroenterology, Hepatology, and Nutrition (ESPGHAN). *J Pediatr Gastroenterol Nutr* 2009;49:498-547.
128. Neuman A, Desai B, Glass D, et al. Superior mesenteric artery syndrome in a patient with cerebral palsy. *Case Rep Med* 2014;2014:538289.
 129. Miyazawa R, Tomomasa T, Kaneko H, et al. Effects of pectin liquid on gastroesophageal reflux disease in children with cerebral palsy. *BMC Gastroenterol* 2008;8:11.
 130. Khoshoo V, Zembo M, King A, et al. Incidence of gastroesophageal reflux with whey- and casein-based formulas in infants and in children with severe neurological impairment. *J Pediatr Gastroenterol Nutr* 1996;22:48-55.
 131. Campanozzi A, Capano G, Miele E, et al. Impact of malnutrition on gastrointestinal disorders and gross motor abilities in children with cerebral palsy. *Brain Dev* 2007;29:25-9.
 132. Turk H, Hauser B, Breclj J, et al. Effect of proton pump inhibition on acid, weakly acid and weakly alkaline gastro-esophageal reflux in children. *World J Pediatr* 2013;9:36-41.
 133. Sullivan PB. Gastrointestinal disorders in children with neurodevelopmental disabilities. *Dev Disabil Res Rev* 2008;14:128-36.
 134. Cheung KM, Tse PW, Ko CH, et al. Clinical efficacy of proton pump inhibitor therapy in neurologically impaired children with gastroesophageal reflux: prospective study. *Hong Kong Med J* 2001;7:356-9.

135. Kawai M, Kawahara H, Hirayama S, et al. Effect of baclofen on emesis and 24-hour esophageal pH in neurologically impaired children with gastroesophageal reflux disease. *J Pediatr Gastroenterol Nutr* 2004;38:317-23.
136. Elawad MA, Sullivan PB. Management of constipation in children with disabilities. *Dev Med Child Neurol* 2001;43:829-32.
137. Veugelers R, Benninga MA, Calis EA, et al. Prevalence and clinical presentation of constipation in children with severe generalized cerebral palsy. *Dev Med Child Neurol* 2010;52:e216-21.
138. Burgers R, de Jong TP, Benninga MA. Rectal examination in children: digital versus transabdominal ultrasound. *J Urol* 2013;190:667-72.
139. Park ES, Park CI, Cho SR, et al. Colonic transit time and constipation in children with spastic cerebral palsy. *Arch Phys Med Rehabil* 2004;85:453-6.
140. Tabbers MM, DiLorenzo C, Berger MY, et al. Evaluation and treatment of functional constipation in infants and children: evidence-based recommendations from ESPGHAN and NASPGHAN. *J Pediatr Gastroenterol Nutr* 2014;58:258-74.
141. Pashankar DS, Bishop WP. Efficacy and optimal dose of daily polyethylene glycol 3350 for treatment of constipation and encopresis in children. *J Pediatr* 2001;139:428-32.

142. Fischer M, Adkins W, Hall L, et al. The effects of dietary fibre in a liquid diet on bowel function of mentally retarded individuals. *J Ment Defic Res* 1985;29 (Pt 4):373-81.
143. Rodriguez L, Flores A, Gilchrist BF, et al. Laparoscopic-assisted percutaneous endoscopic cecostomy in children with defecation disorders (with video). *Gastrointest Endosc* 2011;73:98-102.
144. King SK, Sutcliffe JR, Southwell BR, et al. The antegrade continence enema successfully treats idiopathic slow-transit constipation. *J Pediatr Surg* 2005;40:1935-40.
145. Oliveira AC, Paiva SM, Martins MT, et al. Prevalence and determinant factors of malocclusion in children with special needs. *Eur J Orthod* 2011;33:413-8.
146. Ortega AO, Guimaraes AS, Ciamponi AL, et al. Frequency of parafunctional oral habits in patients with cerebral palsy. *J Oral Rehabil* 2007;34:323-8.
147. Hegde AM, Pani SC. Drooling of saliva in children with cerebral palsy-etiology, prevalence, and relationship to salivary flow rate in an Indian population. *Spec Care Dentist* 2009;29:163-8.
148. Vande Velde S, Van Biervliet S, De Bruyne R, et al. Gastric dysmotility following orthopaedic scoliosis surgery in patients with cerebral palsy: a case series. *Neuropediatrics* 2010;41:182-5.

149. Brotherton AM, Abbott J, Aggett PJ. The impact of percutaneous endoscopic gastrostomy feeding in children; the parental perspective. *Child: Care, Health and Development* 2007;33:539-46.
150. Fung EB, Samson-Fang L, Stallings VA, et al. Feeding dysfunction is associated with poor growth and health status in children with cerebral palsy. *J Am Diet Assoc* 2002;102:361-73.
151. Krick J, Van Duyn MA. The relationship between oral-motor involvement and growth: a pilot study in a pediatric population with cerebral palsy. *J Am Diet Assoc* 1984;84:555-9.
152. Motion S, Northstone K, Emond A, et al. Early feeding problems in children with cerebral palsy: weight and neurodevelopmental outcomes. *Dev Med Child Neurol* 2002;44:40-3.
153. Thommessen M, Heiberg A, Kase BF, et al. Feeding problems, height and weight in different groups of disabled children. *Acta Paediatr Scand* 1991;80:527-33.
154. Thommessen M, Riis G, Kase BF, et al. Energy and nutrient intakes of disabled children: do feeding problems make a difference? *J Am Diet Assoc* 1991;91:1522-5.
155. Troughton KE, Hill AE. Relation between objectively measured feeding competence and nutrition in children with cerebral palsy. *Dev Med Child Neurol* 2001;43:187-90.

156. Somerville H, Tzannes G, Wood J, et al. Gastrointestinal and nutritional problems in severe developmental disability. *Dev Med Child Neurol* 2008;50:712-6.
157. Society CP. Nutrition in neurologically impaired children. *Paediatr Child Health* 2009;14:395-401.
158. Rempel G. The importance of good nutrition in children with cerebral palsy. *Phys Med Rehabil Clin N Am* 2015;26:39-56.
159. Gisel EG, Patrick J. Identification of children with cerebral palsy unable to maintain a normal nutritional state. *Lancet* 1988;1:283-6.
160. Sullivan PB, Lambert B, Rose M, et al. Prevalence and severity of feeding and nutritional problems in children with neurological impairment: Oxford Feeding Study. *Dev Med Child Neurol* 2000;42:674-80.
161. Braegger C, Decsi T, Dias JA, et al. Practical approach to paediatric enteral nutrition: a comment by the ESPGHAN committee on nutrition. *J Pediatr Gastroenterol Nutr* 2010;51:110-22.
162. Vernon-Roberts A, Wells J, Grant H, et al. Gastrostomy feeding in cerebral palsy: enough and no more. *Dev Med Child Neurol* 2010;52:1099-105.
163. Pencharz PB. Protein and energy requirements for 'optimal' catch-up growth. *Eur J Clin Nutr* 2010;64 Suppl 1:S5-7.
164. Nutrition in neurologically impaired children. *Paediatr Child Health* 2009;14:395-401.

165. Sullivan PB, Juszczak E, Bachlet AM, et al. Gastrostomy tube feeding in children with cerebral palsy: a prospective, longitudinal study. *Dev Med Child Neurol* 2005;47:77-85.
166. Brun AC, Stordal K, Johannesdottir GB, et al. The effect of protein composition in liquid meals on gastric emptying rate in children with cerebral palsy. *Clin Nutr* 2012;31:108-12.
167. Savage K, Kritas S, Schwarzer A, et al. Whey- vs casein-based enteral formula and gastrointestinal function in children with cerebral palsy. *JPEN J Parenter Enteral Nutr* 2012;36:118S-23S.
168. Fried MD, Khoshoo V, Secker DJ, et al. Decrease in gastric emptying time and episodes of regurgitation in children with spastic quadriplegia fed a whey-based formula. *J Pediatr* 1992;120:569-72.
169. Patchell CJ, Anderton A, MacDonald A, et al. Bacterial contamination of enteral feeds. *Arch Dis Child* 1994;70:327-30.
170. Patchell CJ, Anderton A, Holden C, et al. Reducing bacterial contamination of enteral feeds. *Arch Dis Child* 1998;78:166-8.
171. Gauderer MW, Ponsky JL, Izant RJ, Jr. Gastrostomy without laparotomy: a percutaneous endoscopic technique. *J Pediatr Surg* 1980;15:872-5.
172. Gomes CA, Jr., Andriolo RB, Bennett C, et al. Percutaneous endoscopic gastrostomy versus nasogastric tube feeding for adults with swallowing disturbances. *Cochrane Database Syst Rev* 2015:CD008096.

173. Committee AT, Kwon RS, Banerjee S, et al. Enteral nutrition access devices. *Gastrointest Endosc* 2010;72:236-48.
174. Dormann AJ, Huchzermeyer H. Endoscopic techniques for enteral nutrition: standards and innovations. *Dig Dis* 2002;20:145-53.
175. Ferluga ED, Sathe NA, Krishnaswami S, et al. Surgical intervention for feeding and nutrition difficulties in cerebral palsy: a systematic review. *Dev Med Child Neurol* 2014;56:31-43.
176. Novotny NM, Vegeler RC, Breckler FD, et al. Percutaneous endoscopic gastrostomy buttons in children: superior to tubes. *J Pediatr Surg* 2009;44:1193-6.
177. Novotny NM, Jester AL, Ladd AP. Preoperative prediction of need for fundoplication before gastrostomy tube placement in children. *J Pediatr Surg* 2009;44:173-6; discussion 176-7.
178. Barnhart DC, Hall M, Mahant S, et al. Effectiveness of fundoplication at the time of gastrostomy in infants with neurological impairment. *JAMA Pediatr* 2013;167:911-8.
179. Vernon-Roberts A, Sullivan PB. Fundoplication versus postoperative medication for gastro-oesophageal reflux in children with neurological impairment undergoing gastrostomy. *Cochrane Database Syst Rev* 2013:CD006151.
180. Grunow JE, al-Hafidh A, Tunell WP. Gastroesophageal reflux following percutaneous endoscopic gastrostomy in children. *J Pediatr Surg* 1989;24:42-4; Discussion 44-5.

181. Launay V, Gottrand F, Turck D, et al. Percutaneous endoscopic gastrostomy in children: influence on gastroesophageal reflux. *Pediatrics* 1996;97:726-8.
182. Razeghi S, Lang T, Behrens R. Influence of percutaneous endoscopic gastrostomy on gastroesophageal reflux: a prospective study in 68 children. *J Pediatr Gastroenterol Nutr* 2002;35:27-30.
183. Toporowska-Kowalska E, Gebora-Kowalska B, Jablonski J, et al. Influence of percutaneous endoscopic gastrostomy on gastro-oesophageal reflux evaluated by multiple intraluminal impedance in children with neurological impairment. *Dev Med Child Neurol* 2011;53:938-43.
184. Heine RG, Reddihough DS, Catto-Smith AG. Gastro-oesophageal reflux and feeding problems after gastrostomy in children with severe neurological impairment. *Dev Med Child Neurol* 1995;37:320-9.
185. Wheatley MJ, Wesley JR, Tkach DM, et al. Long-term follow-up of brain-damaged children requiring feeding gastrostomy: should an antireflux procedure always be performed? *J Pediatr Surg* 1991;26: 301-4; discussion 304-5.
186. Thomson M, Rao P, Rawat D, et al. Percutaneous endoscopic gastrostomy and gastro-oesophageal reflux in neurologically impaired children. *World J Gastroenterol* 2011;17:191-6.
187. Ponsky TA, Gasior AC, Parry J, et al. Need for subsequent fundoplication after gastrostomy based on patient characteristics. *J Surg Res* 2013;179:1-4.

188. O'Loughlin EV, Somerville H, Shun A, et al. Antireflux surgery in children with neurological impairment: caregiver perceptions and complications. *J Pediatr Gastroenterol Nutr* 2013;56:46-50.
189. Martin K, Deshaies C, Emil S. Outcomes of pediatric laparoscopic fundoplication: a critical review of the literature. *Can J Gastroenterol Hepatol* 2014;28:97-102.
190. Ferluga ED, Archer KR, Sathe NA, et al. AHRQ Comparative Effectiveness Reviews. Interventions for Feeding and Nutrition in Cerebral Palsy. Rockville (MD): Agency for Healthcare Research and Quality (US), 2013.
191. Mathei J, Coosemans W, Naftoux P, et al. Laparoscopic Nissen fundoplication in infants and children: analysis of 106 consecutive patients with special emphasis in neurologically impaired vs. neurologically normal patients. *Surg Endosc* 2008;22:1054-9.
192. Lansdale N, McNiff M, Morecroft J, et al. Long-term and 'patient-reported' outcomes of total esophagogastric dissociation versus laparoscopic fundoplication for gastroesophageal reflux disease in the severely neurodisabled child. *J Pediatr Surg* 2015;0:1828-32.
193. Kunisaki SM, Dakhoub A, Jarboe MD, et al. Gastric dissociation for the treatment of congenital microgastria with paraesophageal hiatal hernia. *J Pediatr Surg* 2011;46:e1-4.

194. Bjornson KF, McLaughlin JF. The measurement of health-related quality of life (HRQL) in children with cerebral palsy. *European Journal of Neurology* 2001;8:183-93.
195. Vargus-Adams J. Health-Related Quality of Life in Childhood Cerebral Palsy. *Archives of Physical Medicine and Rehabilitation* 2005;86:940-5.
196. Samson-Fang L, Fung E, Stallings VA, et al. Relationship of nutritional status to health and societal participation in children with cerebral palsy. *J. Pediatr.* 2002;141:637-43.
197. Varni JW, Burwinkle TM, Sherman SA, et al. Health-related quality of life of children and adolescents with cerebral palsy: hearing the voices of the children. *Developmental Medicine & Child Neurology* 2005;47:592-5.
198. Davis E, Shelly A, Waters E, et al. The impact of caring for a child with cerebral palsy: quality of life for mothers and fathers. *Child: Care, Health and Development* 2010;36:63-73.
199. Basaran A, Karadavut KI, Uneri SO, et al. The effect of having a children with cerebral palsy on quality of life, burn-out, depression and anxiety scores: a comparative study. *Eur J Phys Rehabil Med* 2013;49:815-22.
200. Craig GM, Scambler G, Spitz L. Why parents of children with neurodevelopmental disabilities requiring gastrostomy feeding need more support. *Dev Med Child Neurol* 2003;45:183-8.

201. Liptak GS, O'Donnell M, Conaway M, et al. Health status of children with moderate to severe cerebral palsy. *Dev. Med. Child Neurol.* 2001;43:364-70.
202. Thorne SE, Radford MJ, Armstrong EA. Long-term gastrostomy in children: caregiver coping. *Gastroenterol Nurs.* 1997;20:46-53.
203. Craig GM, Scambler G. Negotiating mothering against the odds: gastrostomy tube feeding, stigma, governmentality and disabled children. *Soc Sci.Med* 2006;62:1115-25.
204. Sullivan PB, Juszczak E, Bachlet AM, et al. Impact of gastrostomy tube feeding on the quality of life of carers of children with cerebral palsy. *Dev. Med. Child Neurol.* 2004;46:796-800.
205. Adams RC, Elias ER, Council On Children With D. Nonoral feeding for children and youth with developmental or acquired disabilities. *Pediatrics* 2014;134:e1745-62.
206. Mahant S, Jovcevska V, Cohen E. Decision-making around gastrostomy-feeding in children with neurologic disabilities. *Pediatrics* 2011;127:e1471-81.
207. Petersen MC, Kedia S, Davis P, et al. Eating and feeding are not the same: caregivers' perceptions of gastrostomy feeding for children with cerebral palsy. *Dev.Med.Child Neurol.* 2006;48:713-7.
208. Martinez-Costa C, Borraz S, et al. Early decision of gastrostomy tube insertion in children with severe developmental disability: a current dilemma. *J Hum Nutr Diet* 2011;24:115-21.

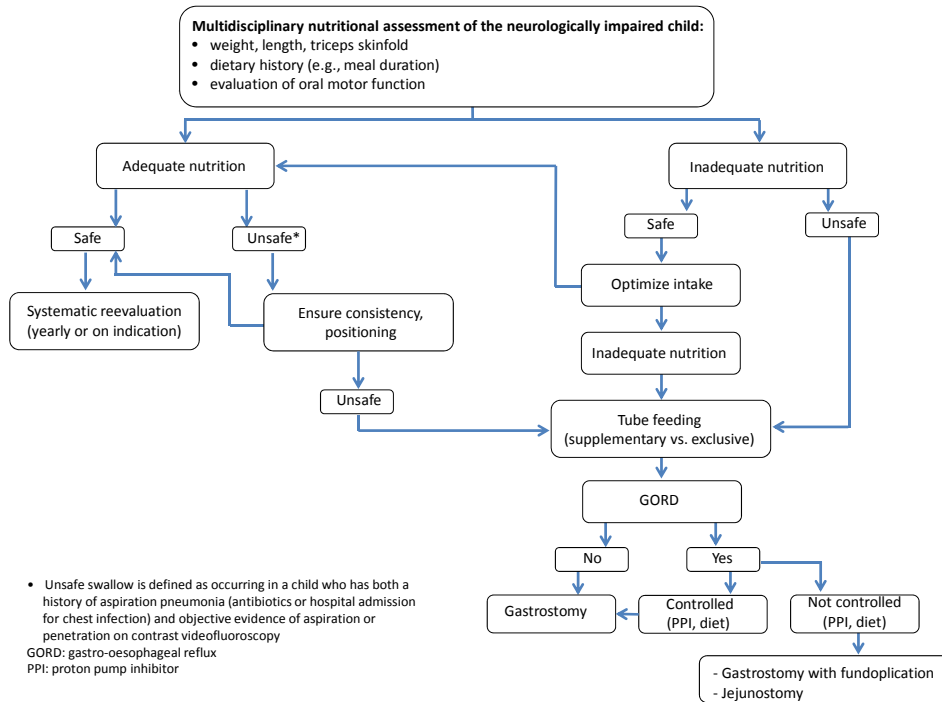


Table 1: Summary of the clinical questions

Number	Question
1	How to approach nutritional management in NI children?
2	What is the method for assessing nutritional status?
3	How to identify undernutrition?
4	How often to monitor nutritional status?
5	What are the requirements for energy in NI children
6	What are the requirements for protein in NI children?
7	What are the requirements for fluid in NI children?
8	What are the requirements for micronutrients in NI children?
9	Dysphagia/oral motor dysfunction: How to define it?
10	How to evaluate oral motor and sensory function?
11	What is the treatment of oropharyngeal dysfunction?
12	How to monitor oropharyngeal dysfunction?
13	How to diagnose gastro oesophageal reflux disease?
14	How to treat gastro oesophageal reflux disease?
15	How to monitor gastro oesophageal reflux disease?
16	How to diagnose constipation?
17	What is the treatment of constipation?
18	What other problem can contribute to feeding difficulties (ie dental, drowling, pain, orthopedics...)?
19	Which type of diet according to oral/gastric tolerance?
20	Does Feeding times compete with rehabilitation?
21	Which sorts of enteral product to use?
22	Which modalities of EN to use (bolus/continuous)?
23	Which type of tube (nasogastric, PEG) to use?
24	What are the indications of jejunal feeding?
25	When should tube feeding be started?
26	What investigations be carried out prior to consideration for surgery?
27	Should a fundoplication systematically performed when a gastrostomy indicated?
28	What are the indications for fundoplication?
29	Is there surgical alternative to fundoplication?
30	What is the effect of nutritional support on quality of life of children and caregivers?
31	Are there ethical issue in relation to nutritional support?

Table 2: Summary of recommendations

Number	Statements
1	ESPGHAN WG suggests that nutritional evaluation and management should be performed by a multidisciplinary team ideally including as required a physician, dietitian, nurse, speech therapist, physical therapist, psychologist and occupational therapist
2a	ESPGHAN WG recommends that the assessment of nutritional status in NI children should not be based solely on weight and height measurements
2b	ESPGHAN WG recommends that measurements of knee height or tibial length in NI children should be performed routinely in order to assess linear growth, when height cannot be measured
2c	ESPGHAN WG recommends that the measurement of fat mass by skinfold thickness should be a routine component of the nutritional assessment in NI children
2d	ESPGHAN WG recommends the use of dual energy X-ray absorptiometry (DXA) scans to measure bone mineral density as part of nutritional assessment in NI children
2e	ESPGHAN WG recommends the assessment of micronutrient status (e.g. vitamin D, iron status, calcium, phosphorus) as part of nutritional assessment of NI children
3a	ESPGHAN WG suggests that the identification of NI children as undernourished should be based on the interpretation of anthropometric data
3b	ESPGHAN WG does not recommend the use of CP-specific growth charts to identify undernutrition
3c	<p>ESPGHAN WG suggests the use of one or more of the following red flag warning signs for the identification of undernutrition in NI children:</p> <ul style="list-style-type: none"> - Physical signs of undernutrition such as decubitus skin problems, poor peripheral circulation - Weight for Age z-score < -2 - Triceps skinfold thickness < 10th centile for age and sex - Mid-upper arm fat or muscle area < 10th percentile - Faltering weight and/or failure to thrive
3d	ESPGHAN WG recommends the use of follow-up anthropometry (weight, linear growth and fat mass) in the monitoring of nutritional status of NI children
4	ESPGHAN WG suggests that NI children have anthropometry at least every 6 months and micronutrients checked annually
5a	ESPGHAN WG recommends the use of the dietary reference standards for typically developing children to estimate the caloric needs for NI children
5b	ESPGHAN WG recommends regular monitoring of body weight and fat mass as an indicator of energy requirements
6a	ESPGHAN WG recommends the use of the dietary reference intake for protein in typically developing children to estimate the appropriate protein intake for NI children.
6b	ESPGHAN WG recommends the use of supplementary protein intake in specific

	clinical situations such as decubitus ulcers or in children with a very low calorie requirement
7	ESPGHAN WG recommends that careful attention should be paid to hydration status, as NI children are at risk of dehydration for a variety of reasons (e.g. inability to communicate thirst, drooling, unsafe swallow)
8	ESPGHAN WG recommends use of the dietary reference intake for micronutrients in typically developing children to estimate the appropriate micronutrients intake for NI children
9	ESPGHAN WG suggests considering oropharyngeal dysfunction in all NI patients even in the absence of obvious clinical signs and symptoms
10a	ESPGHAN WG suggests including both feeding history starting from early infancy as well as direct visual assessment of feeding carried out by appropriately trained professionals. Such professionals would generally consist of speech and language therapists but could include medical doctors, nurses, dieticians or GI physiologists trained or highly experienced in evaluating oropharyngeal function
10b	ESPGHAN WG recommends the use of videofluoroscopy where there is suspicion of an abnormal pharyngeal phase of swallowing and/or concerns about aspiration. Where available this could be combined with high resolution oesophageal manometry to increase diagnostic yield
11	ESPGHAN WG suggest considering speech and language interventions in the treatment of NI children with oropharyngeal dysfunction, and/or where there is need for modification of the consistency of feeds
12	ESPGHAN WG recommends regular monitoring of growth and nutritional status in NI children with oral pharyngeal dysfunction
13	ESPGHAN WG recommends use of objective measures for the diagnosis of gastro-oesophageal reflux disease (GORD) in NI children (oesophageal pH- or pH/multichannel intraluminal impedance monitoring, and/or upper gastrointestinal endoscopy). Given their high prevalence of GORD, a trial of proton pump inhibitors with careful clinical follow-up is acceptable management in this clinically fragile group of children
14a	ESPGHAN WG suggests modification of enteral nutrition (thickening of liquid enteral formulas, whey-based formulas) in addition to other therapeutic options of gastro oesophageal reflux disease in NI children
14b	ESPGHAN WG group recommends use of proton pump inhibitors as the first line treatment in NI children with gastro-oesophageal reflux disease
14c	ESPGHAN WG recommends not to routinely use prokinetic agents in NI children with gastro-oesophageal reflux disease because of their weak efficacy and side effects. Their use may be considered, however, in uncontrolled gastro-oesophageal reflux disease
15	ESPGHAN WG recommends the periodical re-evaluation of long-term therapy of gastro-oesophageal reflux disease in NI children
16	ESPGHAN WG recommends diagnosis of constipation in NI children by a

	careful history, abdominal, perineal and if necessary rectal digital examination
17a	ESPGHAN WG recommends in NI children with constipation to use standard treatments as in typically developing children, unless there is a risk of aspiration of polyethylene glycol or liquid paraffin
17b	ESPGHAN WG suggests increasing fluid and fibre intake as an additional strategy to treat constipation in NI children
18	ESPGHAN WG recommends that careful attention is paid to dental problems, general posture and orthopedic issues in NI patients, as these may contribute to feeding difficulties
19	ESPGHAN WG recommends using oral feeding in NI children if it is nutritionally sufficient, safe, stress-free and feeding time is not prolonged
20	ESPGHAN WG recommends considering use of enteral feeding if total oral feeding time exceeds 3 hours per day
21a	ESPGHAN WG recommends using standard (1.0 kcal/mL) polymeric age-appropriate formula including fibre for NI children older than one year
21b	ESPGHAN WG recommends using a high-energy density formula (1.5 kcal/ml) containing fibre in cases of poor volume tolerance in NI children, provided hydration is carefully monitored
21c	ESPGHAN WG recommends using human milk, a standard infant formula or nutrient dense infant enteral formula as clinically indicated in NI infants
21d	ESPGHAN WG recommends using a low-fat, low-calorie, high fibre, and micronutrient replete formula for the maintenance of enteral tube feeding after nutritional rehabilitation in immobile NI children
21e	ESPGHAN WG recommends using a trial of whey-based formula in cases of gastroesophageal reflux, gagging and retching in NI children
21f	ESPGHAN WG recommends caution if pureed food is used for enteral tube feeding in NI children, because of concerns regarding nutritional adequacy and safety
22	ESPGHAN WG recommends using a combination of nocturnal continuous feeds with daytime bolus feeds in children with high-caloric needs or poor tolerance to volume
23	ESPGHAN WG recommendeds using a gastrostomy as the preferred way to provide intragastric access for long term tube feeding in NI children
24	ESPGHAN WG suggests using jejunal feeding in cases of aspiration due to gastro oesophageal reflux disease, refractory vomiting, retching and bloating in NI children
25	ESPGHAN WG recommends using enteral tube feeding in cases of unsafe or inefficient oral feeding, preferably before the development of undernutrition.
26	ESPGHAN WG recommends that upper gastrointestinal endoscopy with biopsies is performed before fundoplication in NI children. Other investigations (e.g. contrast studies, gastric emptying studies and pH+/- impedancemetry) may also be indicated
27	ESPGHAN WG recommends that a routine antireflux procedure should not be performed at the time of PEG placement in NI children as it could add significant

	morbidity
28	ESPGHAN WG recommends that fundoplication be considered in cases of failure of optimized medical therapy for gastro oesophageal reflux disease in NI children
29	ESPGHAN WG recommends restricting the indication for total oesophago-gastric disconnection and Roux-en-Y oesophagojejunostomy, as an alternative of classical anti-reflux surgery, to very selected cases in NI children
30	ESPGHAN WG recommends that parents and/or caregivers are always involved in decision making especially around gastrostomy feeding
31	ESPGHAN WG recommends involvement of a professional ethicist to assist decision making in cases where invasive investigations or procedures (e.g. gastrostomy, fundoplication, parenteral nutrition) pose ethical dilemmas

ACCEPTED

TABLE 3. Blood laboratory variables included in the assessment of neurologically impaired children (from ref. 41)

- Urea and electrolytes
- Creatinine
- Glucose
- Full blood count
- Haemoglobin, mean corpuscular volume, ferritin, iron
- Calcium, magnesium, phosphate
- Albumin or total protein
- Liver enzymes
- Vitamins A, B12, D, E,; folic acid
- PTH
- Zinc

PTH, parathyroid hormone

ACCEPTED

Table 4: The Schofield equation (from Schofield WN. Predicting basal metabolic rate, new standards and review of previous work. Hum Nutr Clin Nutr. 1985;39 Suppl 1:5-41).

	Age	Equation
Males	10-18	$((0.074 \times \text{wt}) + 2.754) \times 1000$
	18-30	$((0.063 \times \text{wt}) + 2.896) \times 1000$
	30-60	$((0.048 \times \text{wt}) + 3.653) \times 1000$
	Over 60	$((0.049 \times \text{wt}) + 2.459) \times 1000$
Females	10-18	$((0.056 \times \text{wt}) + 2.898) \times 1000$
	18-30	$((0.062 \times \text{wt}) + 2.036) \times 1000$
	30-60	$((0.034 \times \text{wt}) + 3.538) \times 1000$
	Over 60	$((0.038 \times \text{wt}) + 2.755) \times 1000$

ACCEPTED

TABLE 5: Equations for estimating energy requirements in children with neurological impairment

Method	Equation
Dietary reference intake standard for BEE	<p>Energy intake (kcal/d) = BEE × 1.1, where BEE is:</p> <ul style="list-style-type: none"> • Male: $66.5 + (13.75 \times \text{weight in kg})$ $+ (5.003 \times \text{height in cm}) - (6.775 \times \text{age})$ • Female: $65.1 + (9.56 \times \text{weight in kg})$ $+ (1.850 \times \text{height in cm}) - (4.676 \times \text{age})$
Indirect calorimetry	<p>Energy intake (kcal/d) = BMR × muscle tone × activity] + growth, where:</p> <ul style="list-style-type: none"> • Muscle tone = 0.9 if decreased, 1.0 if normal, and 1.1 if increased • Activity = 1.1 if bedridden, 1.2 if wheelchair dependent or crawling, and 1.3 if ambulatory. • Growth = 5 kcal/g of desired weight gain (normal and catch-up growth)
Height	<p>15 kcal/cm in children without motor dysfunction 14 kcal/cm in children with motor dysfunction who are ambulatory 11 kcal/cm in children who are not ambulatory</p>

from Andrew MJ, et al (ref 67)

BEE, basal energy expenditure; BMR, basal metabolic rate