



Challenges in Weaning from a Nasoenteral Tube in a Child with Craniofacial Anomaly

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Abstract

The purpose of this short communication was to promote reflection on the challenges of weaning from enteral diet, in a child patient with craniofacial anomaly. It approaches the fear and anxiety on the part of the child, who still does not present a favourable maxillomandibular and occlusal relationship to the performance of the functions of chewing and swallowing. It seeks to raise the impact of emotional insecurity of family members, guardians and caregivers in this process and the need for consensus among health team professionals regarding the time for this removal.

Keywords: Craniofacial Abnormalities; Child; Enteral Nutrition

Craniofacial anomalies are associated with great challenges; these starting from the diagnosis, at birth and during the entire rehabilitation process, with repercussions on growth and development, aesthetics, function, in the economic, social and emotional context of those affected. When we refer to children, the impact on quality of life, self-esteem, and resilience is directly associated

with the attitude of coping by parents, guardians, or caregivers, in addition to the team of health professionals involved in surgical and prosthetic interventions, and in the necessary therapies.

The anatomical and physiological characteristics such as neuromotor coordination impairments and craniofacial and structural

abnormalities frequently interfere with the acquisition of effective oral-motor skills which can in turn result in the development of potential feeding problems and swallowing dysfunction [1].

In some individuals, even in the face of an unfavourable condition for the performance of chewing and swallowing functions, in particular, there is an "adaptation" which enables the ingestion of food, without bronchoaspiration or other major impairments. However, when it comes to children and considering that chewing is a function learned and developed throughout life, there may be difficulties in digestion and absorption of nutrients.

When, in addition to the factors mentioned, there is a food selectivity on the part of the child, parenteral or enteral nutrition starts to be considered. There is limited information on therapeutic benefits and tube-related complications of pediatric nasoenteric (NE) tube feeding [2].

Nutritional support is indicated for patients with inadequate nutrition intake or manifestation of wasting and stunting [3]. Enteral feeding is more favorable than parenteral feeding in patients with a functioning digestive tract because the former can maintain gut integrity and prevent bacterial translocation [3].

Enteral tube feeding involves the artificial delivery of nutrition directly to the gastrointestinal tract without the need for swallowing. In temporary or short-term situations, this method is most commonly performed via an NG tube into the stomach but can be achieved via post-pyloric access with a nasoenteric (NE) tube (nasoduodenal or nasojejunal tube) into the proximal small bowel. Post-pyloric access is indicated in specific situations, such as severe gastrointestinal reflux disease (GERD) with a risk of aspiration, gastric emptying dysfunction, gastric outlet obstruction, acute pancreatitis, and previous gastric surgery precluding gastric feeding or in early postoperative feeding after major abdominal surgery [3,4].

When the time of use of the nasoenteric tube is not prolonged, the nutritional benefits are recognized. In the opposite direction, there is a growing fear of the child and his family members, responsible persons or caregivers about the possibility of feeding without this resource. And this point deserves further reflection: - When would be the opportune moment for this withdrawal? How to generate a feeling of confidence for the child regarding the possible advances without the tube?

Additional care must be taken for the period of prolonged use of the tube in infant patients with the possibility, even if reduced, of chewing and swallowing food, with good cognitive and organic conditions. Patients have reduced motivation to eat in response to hunger, aversion, motivation to eat in response to hunger, aversion and/or poor response to oral stimulation. If a child does not accept oral food, he/she is unable to associate food with hunger satisfaction [5].

Multiple therapeutic schemes have been described to rehabilitate the oral route, many of which are intensive multidisciplinary outpatient programmes with behavioural interventions [6].

In the context of what has been reported, the family, the carers or responsible persons also need to be worked on, to help in this process, believing and encouraging the child; which is not simple and can generate a lot of anxiety and doubts.

If oral feeding is feasible, the rehabilitation process advances, along with the autonomy and quality of life of these patients and their families. It is necessary to work, reinforcing the importance of this continued stimulus and not seeking for strong scientific evidence.

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