1. Failure to thrive (FTT) in a child is defined as ‘lack of expected normal physical growth’, ‘failure to gain weight’ or ‘lack of growth’.
2. The internationally accepted objective consensus definition for FTT is based on two measurements, taken at least two weeks apart, to confirm nutritional growth delay.
3. Weight-for-age, weight-for-height and height-for-age, used in our growth charts and health booklets, are the acceptable parameters to assess for FTT.
4. In infants, a daily weight gain that is less than expected for their age may already be suggestive of FTT.
5. FTT is suspected when a single measurement showing weight percentile is markedly discrepant from the other parameters (height or head circumference); for example, when weight-for-height is < 10th percentile.
6. Children who are the shortest in their kindergarten classes for two consecutive years should always be investigated for FTT.
7. Some normal children may experience ‘catch-down’ growth, where growth decreases by ≤ 2 major percentiles between six and 18 months of age to match their genetic programming and then begins to follow new, lower percentile curves.
8. Children may have more severe and prolonged ‘catch-down’ growth, growing along a low growth percentile curve and having a low preadolescent growth rate and delayed pubertal development.
9. Children who experience ‘catch-down’ growth typically will not experience ‘catch-up’ growth when they go through puberty, resulting in shorter adult stature.
10. Children with constitutional growth delay should be thoroughly evaluated with further scans and hormonal blood tests at regular intervals.
11. The projected adult height of children is independent of their parental heights, and is only influenced by nutritional and environmental factors in their childhood.
12. For children with constitutional growth delay, it is more accurate to use bone age, rather than chronological age, to determine their projected height.
13. Children with familial short stature have bone age consistent with their chronological age and require no further evaluation.
14. Malnutrition or inadequate caloric intake is not among the top three common causes of FTT in Singapore over the last decade.
15. Malnutrition or inadequate caloric intake firstly affects the child’s weight, then head circumference and, lastly, height.
16. The family doctor working in the community is best placed to detect FTT in children when they present for illnesses or health monitoring.
17. The family doctor may need to refer the child or family to a paediatrician, a dietitian or social services, as appropriate, to deliver holistic care.
18. Age-appropriate, nutritional counselling for parents or carers, including advice on food preparation, might be required for management of FTT.
19. Evidence supports the use of authoritative feeding styles for fussy eaters.
20. If a child is not taking or unable to take a nutritionally complete milk formula, physicians should consider checking for iron deficiency.