MALAYSIAN ASSOCIATION OF SPEECH-LANGUAGE & HEARING (MASH)

Within Earshot

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INSIDE THIS ISSUE:

Editorial Note 1
President's Address 1
Feeding Disorders 2
Minimal Hearing Loss 4
Quote of the Month 4
A Parent's ABCs to a Clinician 5

Editorial Note

It's really exciting that the editorial team gets to continuously come out with new issues of WE. It's all due to the overwhelming support of MASH exec. comm. and also the members. This month's feature focus on pediatric issues; and so shoutouts to contributors of the month: Ms. Oo Kah Pheng, Mr. Saravanan Selanduray, and Ms. Pamela Thomas Joseph. You guys are the best! There will be celebrations this month. So to those celebrating, Happy Deepavali and Happy Eidul-Hajr!
As usual, drive safely and happy holidays!

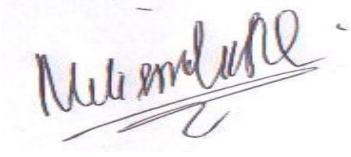
The President's Address

It's November already! We have had a fairly busy month with sifting through membership applications, liasing with our different portfolio heads on different issues; student, information management, medico-legal, professional issues and working on improving our administrative efficiency. That has been a full plate. And it will not satiate! There will always be more and better ways to do things and yes we need your input.

You would have received the Memorandum of support for the use of the term "speech-language pathology" as opposed to "speech-language therapy". We count on your full support. We hope to be able to update you on what has been happening, to plot direction for MASH and to harness your energy and enthusiasm and move forward in a definite direction.

We look forward to meeting as many of you as possible this upcoming meeting on Nov 20th. We hope for fuller participation from all members in the hopes that this will mean more membership advantages. Meanwhile for a start WE has been consistent and diligent! KUDOS! No mean feat. So to all of you out there who like to see WE grow, write, write, write, ….professional articles, professional impressions, thoughts, letters to the editor, information for the public which can be shared (on website), share your concerns, suggestions, whatever.

Till end November then.



In Focus: Feeding Disorders by Oo Kah Pheng, SLP

"My child just sits in front of the dining table for hours without picking up the spoon or food."
"My child rather suffer than eat. It is so difficult to put even one grain of rice into his mouth."
"My child just swallows everything that goes into the mouth. She does not even want to chew or bite the food."
"My child throws a tantrum to avoid food."

These are some of the signs and symptoms of feeding disorders. Many do not realize that this is a big issue. According to information provided by American Speech and Hearing Association (ASHA), approximately 25% of children experience feeding disorders.

What is feeding disorders?
We usually refer to the term 'feeding disorders" as a condition in which an infant or child is unable or refuses to eat, or has difficulty in eating. This unpleasant feeding experience can result in frequent sickness, failure to thrive, and even death.

Some common types of feeding disorders in infants or children:

1. Premature infants
Infants born prior to 32 weeks gestational age often encounter poor sucking skills. These babies are easily tired and may also have breathing difficulties due to the immaturity of their lungs. Besides that, their oral structure and throat muscles can be weak which may cause them to have low stamina for feeding. These babies may also show poor sleep-wake states, and they may have trouble communicating hunger cues.

2. Behavioral feeding issues
These children show tantrums during meal times. They may have some sensory issues at the hard palate or soft palate areas. They are usually picky with food: some children love crunchy food while others may like lumpy food. Some children do not know how to chew on the food that goes into their mouth.

3. Infant reflux
Infants who have increased muscle tone in the abdominal area, prematurity and those with low tone of internal organs usually have reflux issues. Reflux causes an uneasy feeling during feeding and may cause feeding issues at a later stage.

4. Oral motor structures
Infants who are born with cleft lip and palate may present with difficulties in production suction, slow weight gain and nasal reflux. Correct positioning and suitable feeding bottles/teats will help to ensure thin liquid is pushed into the pharynx and away from the nasal cavity.

Feeding Disorders (cont.)

Signs and symptoms of feeding disorders:

⇒ Refusal to eat or drink at all
⇒ Taking a longer time to finish one meal
⇒ Preference for certain texture, colour or type of food
⇒ Behavioral problems such as kicking, hitting or crying at every meal
⇒ Choke, gag or vomit during meal time
⇒ Poor weight gain
⇒ Does not like to chew on solid food by 18 months
⇒ Persistently drooling during meal time

Feeding tip:
Keep trying!
Sometimes children need more than 10 times exposure to accept new food!

Feeding tips:

⇒ Establish feeding routine regardless of the feeding issues.
⇒ Keep the feeding time short.
⇒ Always make sure to end the feeding session with happy ending
⇒ Taking regular breaks to burp may be necessary as your baby will likely swallow a lot of air while learning to feed.
⇒ Stroking the baby under the chin while feeding will sometimes help the feeding progress.
⇒ Ensure the child has good positioning during feeding.
⇒ Offer new food without pressure - sometimes letting them prepare the food together may help them to feel 'safe'.
⇒ Be a positive model to your child during meal time
⇒ Keep trying; sometimes children need more than 10 times exposure to accept new food.

Laugh-a-minute

A 5 year-old sister said to her 10 months-old brother: "You gotta learn to talk, Jeffrey — it's part of the aging process"

Patient: "I have this constant ringing in my ears. I think I have tinnitus."
Audiologist: "Does it sound like an 'eeeeeee' or a 'shhhhh'?"
Patient: "It's like the murmer of a thousand forgotten souls quietly lamenting past sorrows."
Audiologist: "Hmmm. I don't have a checkbox for that, sadly."

In Focus: Minimal Hearing Loss in Children

by Saravanan Selanduray, Audiologist

Audiologists are quite familiar with the non-medical management of hearing loss. However, things start to get a bit hazy when it comes to minimal hearing loss (MHL). Minimal hearing loss is a non standardized term that includes:-

i children with hearing thresholds worse than 16dB to 25dB; although some authors do include mild hearing loss levels in this category

ii high frequency hearing loss

iii unilateral hearing loss

The list is not exhaustive by any means.

We all know that hearing loss causes difficulty for a child to hear speech sounds especially in noisy environments. Various research done throughout the world has shown time and time again that children with minimal hearing loss are performing poorer than their peers in academic settings.

As parents become more aware of the impact of hearing loss on academic performance, we could expect to see an increase in numbers of children with minimal hearing loss being referred for hearing assessments in our clinics. As newborn hearing screening becomes more prevalent, we do expect to see more cases of unilateral hearing loss identified earlier and referred to the audiologist for diagnosis and management. The question that would be asked of the audiologist is, what do we do next?

For children with temporary hearing loss such as otitis media, this would be a straight forward referral to the ENT Surgeon for medical management. What happens if it is recurrent otitis media? More research is showing that there is a strong correlation between early recurrent otitis media and communication/ learning disorders in children. Would we recommend amplification if it is a permanent conductive hearing loss that can only be surgically treated when the child is older?

The problem gets more complicated with minimal sensorineural hearing loss as there is a school of thought that says children with MHL should only be managed if the hearing deteriorates, thus the advice to observe. However, as pointed out earlier, this may cause a lot of difficulties for the child to cope in classroom.

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Quote of the Month ~

It doesn't matter how many say it cannot be done or how many people have tried it before; it's important to realize that whatever you're doing, it's your first attempt at it. -Wally Amos

Minimal Hearing Loss (cont.)

So, I have asked a lot of questions. By now, you may be expecting me to give you an answer on what you could do with the children that you see in your clinic. Unfortunately, my experience and the reading that I have done to cope with similar cases have all shown me that no single management would be able to solve all MHL as they are each unique. However, I could share with you the most common solutions I would recommend and you would be able to decide if they are applicable to your cases.

a. Close monitoring of child's hearing status by thorough audiological assessment including electrophysiological evaluations where necessary.

a. Consideration of personal amplification including hearing aids or FM units for children who show considerable difficulty in discriminating speech including those with recurrent otitis media.

a. Counselling on communication strategies for the child including preferential seating in classroom.
Modification of classroom acoustics as they may benefit all the children in the classroom as studies constantly show that even children with normal hearing face difficulties in reverberating environments or rooms with poor signal to noise ratio.

As our screening and diagnostic technologies improve, more children with hearing loss are being identified earlier. As audiologists, we would be among the core team members to manage this deluge. New management techniques must be continuously adopted to help our clients and closer cooperation with other medical specialists must be taken to ensure this. There is no reasonable excuse to justify any child who has had his/her opportunity to learn and develop being deprived of it.

To submit articles or obtain advertising rates; please contact the editorial team at editorialwe@mash.org.my.

A Parent's ABCs to a Clinician

by Pamela Thomas Joseph, SLP

Allow mourning to take place.

Believe in my ability as a parent.

Create a loving atmosphere in which I can speak to you openly.

Dream about the possibilities we can achieve together.

Ensure evidence based approaches.

Forgive honest mistakes.

Give your heart and mind to each meet.

Help me understand what's going on.

Include me in all decisions.

Jot down our goals and progress-lest one of us forgets.

Kindly include my spouse and our other children.

Let me try a hand at therapy- I can.

Make me smile.

Notice improvements-even if it's small.

Openly discuss important matters.

Praise my child for his efforts.

Question.

Rely on a higher power than your earthly self.

Set achievable targets.

Talk to me if things are not going well.

Understand my family.

Venture beyond what you are comfortable with.

Welcome my thoughts and comments.

X-ray all possible approaches and alternatives.

Yank away negativity.

Zealously pursue the best.