



INFANCY (Birth–12 months)

HEAT Clinical Practice Guideline Recommendations and Supporting Evidence

Section 1. Early Identification

BLUE BOXED AREA = Culturally Appropriate Recommendations

CLINICAL PRACTICE	RATIONALE AND REFERENCE
<p>HISTORY</p> <p>1. Document and annually update a three-generation family health history, including: overweight, hypertension, diabetes mellitus, gestational diabetes, coronary heart disease (CHD) before 55 years in men and 65 years in women, smoking and passive smoke exposure, gestational age and birth weight of the child, and parent self-report of height, weight, and educational level.</p>	<p>HISTORY</p> <p>1. Knowledge of family risk factors associated with overweight and its co-morbid conditions allows the clinician to evaluate risk of overweight in subsequent generations. The American Heart Association (AHA), National Heart, Lung, and Blood Institute (NHLBI), American Academy of Pediatrics (AAP), and others agree that the identified conditions in adult family members represent risk of overweight and its co-morbidities (5, 6, 8, 22, 23, 26, 27, 33, 38, 58, 59, 60). Infants classified as Large-for-Gestational-Age (LGA) or Small-for-Gestational-Age (SGA) are more likely to become overweight in childhood (26). Maternal overweight and low income status are strongly associated with increased risk of childhood overweight (6, 16). The powerful effect of maternal overweight and other risk factors on the development of adiposity in childhood allows for directed preventive efforts to the most vulnerable populations.</p>
<p>a. Pay particular attention to a history of maternal diabetes, including gestational diabetes, because this condition places all exposed infants, especially those of Native American mothers, at significant risk of overweight.</p>	<p>a. Exposure to intrauterine diabetes was a risk factor for the development of obesity and diabetes in Pima Indian children. Lower rate of Type 2 diabetes was found in Pima Indians who were exclusively breastfed (Culture Ref: 16).</p>
<p>MEASUREMENT</p> <p>2. Perform accurate length, weight, and head circumference* measurements at least at each well child visit from 6 to 18 months of age. *(This is an appropriate measurement for these visits although it is not relevant to overweight.)</p>	<p>MEASUREMENT</p> <p>2., 3. The Centers for Disease Control and Prevention (CDC) growth charts released in 2000 are recommended by the AAP as the best growth charts to use in practice. Plotting of growth measures on appropriate growth charts allows the practitioner to identify changes in growth trends and provide appropriate intervention. Visual representation of growth patterns aids parents in understanding their child's growth (6, 17, 38).</p>
<p>3. Perform assessment of risk of overweight:</p> <p>a. Document weight for length on the 2000 CDC growth chart from birth to 23 months of age.</p>	<p>a. Weight for length, not body mass index (BMI), is recommended by the CDC to judge overweight in infancy (13).</p>
<p>b. Monitor infants birth to 6 months of age for early rapid weight gain, a particularly strong risk factor for African American and Hispanic infants.</p>	
<p>c. Document on the problem list weight-for-length percentiles $\geq 85^{\text{th}}$% or early, rapid weight gain in the first 6 months of life.</p>	<p>c. (17).</p>
<p>EDUCATION</p> <p>4. Educate parents about their child's growth pattern, clearly identifying risk status for overweight when early, rapid infant weight gain or weight-for-length measurements $\geq 85^{\text{th}}$% occurs.</p>	<p>EDUCATION</p> <p>4. Parents who understand their child's growth patterns and their significance will be more likely to retain good lifestyle behaviors and change those that are unfavorable to their child's growth and wellness (1, 9, 17, 38, 53).</p>