

Comment on “Rethinking growth faltering in children: From anthropometrics to a biopsychosocial approach”

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Introduction

The recently published 2026 American Academy of Pediatrics (AAP) and North American Society for Pediatric Gastroenterology, Hepatology and Nutrition (NASPGHAN) clinical practice guideline on faltering weight represents an important advance in the terminology, diagnostic criteria, and clinical evaluation of growth faltering in children (1). Beyond these diagnostic refinements, the guideline also provides an opportunity to reconsider growth faltering within a broader biopsychosocial and family-centered framework. Growth faltering is a multidimensional clinical entity that requires the concurrent evaluation of medical, nutritional, developmental-behavioral, and social factors. In this letter, we discuss these dimensions in the context of current evidence and highlight the importance of integrating standardized growth assessment with individualized, family-centered clinical care.

This evolution is more than semantic. The 2017 National Institute for Health and Care Excellence (NICE) guidance reframed recognition of faltering growth around defined thresholds on WHO growth charts and favored graded clinical concern over any single cut-off (2). More recently, the 2026 AAP/NASPGHAN guideline formally replaced “failure to thrive” with “faltering weight” and anchored the diagnosis in z-score-based criteria rather than percentile—defining faltering weight as a weight-for-length or body mass index (BMI)-for-age below -1.65 z-score, a weight-gain velocity below -2 z-score in children younger than two years, or a decline of at least 1 z-score in weight, weight-for-length, or BMI (1). Consistent with this, current reference sources recommend assessing growth with WHO charts under two years of age and CDC charts thereafter, and using anthropometric z-scores in preference to the older, less precise percentile-based criteria (3,4). Importantly, these guidelines converge on a single clinical message that echoes the biopsychosocial perspective advanced here: diagnostic testing should be reserved for children with specific clinical concerns or persistent faltering, explicitly to curb the overuse of laboratory and imaging investigations (1,2).

Moving beyond the traditional approach to growth faltering, Tang et al. emphasized that the evaluation process must encompass a detailed medical and nutritional history, developmental assessment, parent-child interactions, and the psychosocial characteristics of the family (5). This perspective underscores that growth faltering cannot be evaluated based solely on anthropometric measurements, and that the child’s medical, nutritional, developmental-behavioral, and social characteristics must be considered collectively. Accordingly, integrating a biopsychosocial approach into clinical practice can support comprehensive clinical evaluation, thereby contributing to the reduction of unnecessary investigations and the enhancement of individualized care.

Supporting this view, Franceschi et al.(6) proposed a stepwise evaluation algorithm applicable to infants and toddlers. In this approach, the initial step comprises a detailed history, physical examination, and the assessment of serial growth charts, while laboratory investigations, imaging modalities, and specialist consultations are recommended for cases exhibiting red flag findings in the clinical history or physical examination. The presented flowchart offers a practical model that can aid in minimizing unnecessary laboratory testing and specialist consultations, particularly in cases of non-organic growth faltering. This staged logic is now mirrored at the guideline level: the 2026 AAP/NASPGHAN guidance similarly reserves laboratory testing, imaging, and endoscopy for children with focal clinical concerns or persistent faltering weight (1). Nevertheless, because the algorithm is derived from a single-center study and was evaluated exclusively in children aged two years and younger, it necessitates support from external validation studies conducted across diverse healthcare systems, in primary and tertiary care settings, and among broader age groups.

The social determinants of growth faltering also hold significant importance in the current clinical approach. Rabinowitz highlighted that food insecurity, in particular, is a critical factor to consider during the evaluation of growth faltering, noting that the term “failure” may induce feelings of guilt or inadequacy in families (7). Therefore, the evaluation should not be restricted

solely to the child's nutritional history; the family's economic circumstances, access to adequate and safe food, and health literacy must also be systematically assessed, and families identified with food insecurity should be directed to appropriate social support and nutritional services as an integral component of a family-centered, holistic approach. Importantly, addressing these social needs is distinct from using socioeconomic status as a diagnostic label: the 2026 AAP/NASPGHAN guideline explicitly advises against treating socioeconomic status as an assigned risk factor when diagnosing faltering weight (1), a distinction that helps direct support to families without stigmatizing them.

Alongside clinical research, Brady's personal narrative—authored from the dual perspective of a physician and a mother—draws attention to the psychosocial impacts of growth faltering on the family (8). Brady expressed that the persistent focus on her child's slow but consistent weight gain resulted in repetitive feeding interventions, specialist evaluations, and intense pressure regarding breastfeeding, while the child's developmental progress, overall health status, and the mother's psychological well-being were inadequately considered. Although this article does not present research data, it serves as a powerful reminder that parental experience and family-centered communication must not be overlooked in the assessment of growth faltering. Evaluating anthropometric targets in conjunction with the child's overall health, developmental trajectory, feeding function, and the psychosocial burden on the family—coupled with healthcare professionals tailoring their recommendations to individual family circumstances and avoiding accusatory communication—aligns with the contemporary understanding of family-centered care. This perspective suggests that while patient and family experiences do not replace an evidence-based medical approach, they should be regarded as an important and complementary component.

It also remains essential not to overlook organic causes. Hill emphasized that growth faltering is a significant clinical finding in infants and children with congenital heart disease (9). In this population, increased energy requirements, feeding difficulties, and inadequate energy intake can play a major role in the development of growth faltering. Consequently, the regular monitoring of weight, length/height, and growth velocity, along with a thorough assessment of nutritional status in children identified with growth faltering, is crucial.

Furthermore, data regarding the use of laboratory biomarkers advocate for a cautious approach. Ranasinghe et al. reported that while prealbumin can serve as an adjunctive biomarker in evaluating nutritional status, it can be significantly influenced by inflammation, infection, starvation, liver diseases, and other systemic conditions (10). Therefore, biomarkers such as prealbumin should not be utilized in isolation for diagnosing nutritional deficiency or for clinical decision-making; they must be interpreted in conjunction with the medical and nutritional history, anthropometric measurements, growth charts, and physical examination findings.

When these studies and guidelines are considered collectively, it becomes evident that the current literature prioritizes detailed clinical evaluation, serial growth monitoring, targeted diagnostic investigations in selected cases, and the assessment of social

factors in the management of growth faltering. Instead of implementing routine, broad-spectrum laboratory screenings for every child, this approach advocates for the individualization of investigations based on clinical history, growth patterns, and physical examination findings. Moreover, rather than focusing exclusively on numerical weight targets, the child's developmental status, feeding function, family circumstances, and the psychosocial needs of the parents must be taken into account.

In conclusion, current evidence—and now converging international guidance—demonstrates that evaluating growth faltering merely on the basis of deviations in growth charts or inadequate weight gain is insufficient. The stakes extend beyond the immediate weight trajectory: population-based cohort data link weight faltering in infancy to a higher risk of later childhood neurodevelopmental difficulties, underscoring the importance of early, holistic recognition (11). Adopting a biopsychosocial approach in clinical decision-making, applying standardized (z-score-based) diagnostic criteria alongside targeted diagnostic investigations, and strengthening family-centered care will contribute to both reducing unnecessary testing and improving long-term growth and neurodevelopmental outcomes in children. Additionally, this approach can foster the more efficient utilization of healthcare resources by mitigating unwarranted laboratory investigations and inappropriate referrals. It is imperative that future prospective and multicenter studies elucidate the impact of this holistic approach on clinical outcomes, quality of life, and the psychosocial well-being of families.

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