

Oral myofunctional performance during food introduction to preterm infants followed up in an outpatient clinic

Desempenho oromiofuncional na introdução alimentar de crianças prematuras acompanhadas em um ambulatório de *follow-up*

Desempeño oromiofuncional durante la introducción de la alimentación complementaria en lactantes prematuros atendidos en un ambulatorio de seguimiento

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Abstract

Objective: To evaluate oral myofunctional performance during the introduction of food to premature infants, followed up at an outpatient clinic. **Method:** Descriptive, observational, cross-sectional, quantitative study, conducted with 45 premature infants at 6 months of corrected gestational age. The study assessed orofacial motor skills during food introduction with the Orofacial Myofunctional Evaluation Protocol with Scores-extended (reduced version). Inclusion criteria were premature infants, 6 months of

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corrected age, who used an orogastric tube, without neurological or syndromic alterations, who stayed in a neonatal intensive care unit, with preserved oral feeding. Variables were analyzed using descriptive statistics and Fisher's Exact test. **Results:** The evaluated infants' gestational age ranged from 27 to 36 weeks and 1 day, and their birth weight ranged from 435 to 3160 g. The average length of hospital stay was 19 days, and the average length of orogastric tube use was 25 days after birth until weaning to oral feeding. Gestational age, birth weight, length of tube use, and length of stay in the neonatal intensive care unit were not statistically significantly associated with the oral myofunctional assessment, despite the high number of alterations in all groups. **Conclusion:** The children evaluated had a high incidence of oral motor alterations, compromising their performance during food introduction, regardless of their birth condition. This highlights the need for early and continuous speech-language-hearing follow-up.

Keywords: Complementary Feeding; Deglutition; Mastication; Premature Infant; Child.

Resumo

Objetivo: Avaliar o desempenho oromiofuncional na introdução alimentar de crianças prematuras atendidas em um ambulatório de *follow-up*. **Método:** Estudo descritivo, observacional, transversal e quantitativo, com uma amostra de 45 crianças prematuras aos seis meses de idade gestacional corrigida. Utilizou-se o protocolo Avaliação Miofuncional Orofacial com Escores Expandido Lactentes (versão reduzida) para avaliar motricidade orofacial na introdução alimentar. Os critérios de inclusão foram: crianças prematuras, com seis meses de idade corrigida, que fizeram uso de sonda orogástrica, sem alterações neurológicas ou síndromicas, permanência em unidade de terapia intensiva neonatal e uso de via de alimentação oral preservada. As variáveis foram analisadas por meio de estatística descritiva e teste Exato de Fisher. **Resultados:** As crianças avaliadas apresentaram idade gestacional entre 27 e 36 semanas e um dia, com peso ao nascer de 435 g a 3160 g. A média de permanência de internação foi de 19 dias, e média de 25 dias de uso de sonda orogástrica após nascimento até o desmame para via oral de alimentação. Não houve associação estatisticamente significativa entre as variáveis de idade gestacional, peso ao nascer, tempo de uso de sonda e tempo de internação em unidade de terapia intensiva neonatal com a avaliação oromiofuncional, embora o quantitativo de alterações tenha sido elevado em todos os grupos. **Conclusão:** Crianças avaliadas apresentaram elevada incidência de alterações motoras orais comprometendo o desempenho na introdução alimentar, independente das condições ao nascimento, evidenciando a necessidade de acompanhamento fonoaudiológico precoce e contínuo.

Palavras-chave: Alimentação complementar; Deglutição; Mastigação; Prematuro; Criança.

Resumen

Objetivo: Evaluar las funciones alimentarias en niños prematuros atendidas en Centro de Salud de *Follow-up*. **Método:** Estudio descriptivo, Observacional y cuantitativo, con una muestra de 45 niños prematuros a los seis meses de edad gestacional corregida. Se utilizo el protocolo Evaluación Multifuncional Orofacial con Escalas Expandidas para Lactantes (versión reducida) para evaluar motricidades orofacial durante la introducción alimenticia. Los criterios de inclusión fueron: Niños prematuros, con seis meses de edad corregida, que hicieron uso de sonda orogástrica, sin alteración neurológica o con síndromes, permanencia en unidad de terapia intensiva neonatal y uso de vía alimenticia oral preservada. Las variables fueron analizadas por medio de estadísticas descriptivas y prueba exacta de Fisher. **Resultados:** Los niños evaluados presentaron edad gestacional entre 27 y 36 semanas y un día, con peso al nacer de 435 g a 3160 g. La media de permanencia de internación fue de 19 días, y media de 25 días de uso de sonda orogástrica después del nacimiento hasta el destete para vía oral de alimentación. No hubo asociación estadísticamente significativa entre las variables de edad gestacional, peso al nacer, tempo de uso de sonda y tempo de internación en la unidad de terapia intensiva neonatal con el rendimiento alimentario, aunque el cuantitativo de alteraciones haya sido elevado en todos los grupos. **Conclusiones:** Niños evaluados presentaron elevada incidencia de alteraciones en la función y desempeño alimenticio independiente de las condiciones al nacimiento, destacando la necesidad de acompañamiento fonoaudiólogo precoz y continuo.

Palabras clave: Alimentación complementar; Deglución; Masticación; Prematuro; Niños.

Introduction

Scientific advances in neonatology in recent decades have brought about a significant transformation in the care provided to newborns, resulting in a notable increase in the survival rate of children with a history of prematurity, low birth weight, and serious complications. However, as increasingly premature and smaller babies manage to survive, challenges arise related to the morbidities they may face during their development¹.

Premature newborns are those born before 37 weeks of gestational age (GA). They are categorized into four groups according to the World Health Organization (WHO): extremely preterm (below 28 weeks), very preterm (between 28 and 31 weeks and 6 days), moderately preterm (32 to 33 weeks and 6 days), and late preterm (between 34 and 36 weeks)². These children are at a higher risk of overall developmental impairment compared to those born at term³.

The most frequently observed morbidities in these cases include neurological, cognitive, linguistic, auditory, visual, and behavioral changes¹, and feeding difficulties⁴. Thus, adequate nutrition for premature infants is crucial for their development, as it not only promotes healthy growth but also strengthens the bond between the mother and child, highlighting its biopsychosocial importance⁵.

The feeding process for newborns begins with the recommendation of breastfeeding. If this is not possible, modified milk formula is used, recommended to be exclusive until 6 months, without the need to introduce other foods². From the sixth month onwards, in addition to breast milk, other foods should be part of the child's meals, including varied food groups, based on unprocessed or minimally processed foods, without the addition of processed foods. Food choice is fundamental to providing adequate, healthy nutrition and forming good eating habits, which begin in the first years of life⁶.

At 6 months of age, the child is expected to have developed the reflexes necessary for swallowing, such as the reduction of tongue protrusion, the visual desire for food, head support, and trunk control, which facilitate picking up food with a spoon. Moreover, deciduous teeth begin erupting, which facilitates chewing. With this, the child further develops their palate and begins to establish

food preferences, which is why this is an opportune age for introducing food^{6,7}.

The Brazilian Ministry of Health⁶ highlighted the importance of introducing complementary food to premature infants at 6 months of corrected GA to ensure neurological, cardiac, respiratory, and gastrointestinal maturation, as their absence hinders the absorption and digestion of nutrients. Thus, corrected GA ensures the time for developing readiness signs and oral and sensory skills for a safe offering without any risk of pulmonary aspiration, with adequate coordination of chewing, swallowing, and breathing⁷.

Therefore, this study aimed to evaluate the oral myofunctional performance in the introduction of food to premature infants, correlating it with the degree of prematurity, weight, length of use of the feeding tube, and hospitalization at birth.

Material and methods

This is a descriptive, analytical, observational, cross-sectional quantitative study, conducted in an outpatient clinic for at-risk and high-risk newborns at the Lauro Wanderley University Hospital/EBSERH.

Before starting the research, approval was obtained from the hospital's Human Research Ethics Committee, linked to the Federal University of Paraíba, under opinion number 6.293.052.

The study sample consisted of 45 premature infants at 6 months of corrected GA.

A medical history survey was previously applied to obtain information for the inclusion criteria, investigating data on identification, pregnancy, risk factors, complications during childbirth, length of stay in the neonatal intensive care unit (NICU), general health status, and maternal complaints regarding breastfeeding, language, or hearing.

The children included in the research met the following inclusion criteria: prematurity, absence of neurological or syndromic changes, prior use of an orogastric tube after birth, NICU stay, and preserved oral feeding.

Birth weight was classified according to the guidelines of the Brazilian Ministry of Health⁸, as follows: normal, equal to or greater than 2500 g; low weight (LBW), 1500-2499 g; very low weight (VLBW), 1000-1499 g; and extremely low weight (ELBW), less than 999 g.

The children's parents/guardians who agreed to participate in the study signed an informed consent form. The infants were filmed at the time of the assessment for later analysis and notes on the Orofacial Myofunctional Evaluation Protocol with Scores-extended (OMES-E) for Infants (6-24 months)⁹, used to assess orofacial motor skills during the food introduction test at 6 months of corrected age.

OMES-E Infants, according to the sample's age range, was applied in the reduced version, which analyzes orofacial characteristics and behaviors. They were measured from direct observation in a single consultation by a speech-language-hearing pathologist responsible for the service and a speech-language-hearing undergraduate student who accompanied the appointments; then, both analyzed the filming done at the time of the assessment. The protocol was previously applied in the outpatient clinic's routine, observing weaknesses for application in the study population to ensure test reliability.

A score was assigned on an ordinal scale for analysis of the results, where the numbers 4, 3, 2, and 1 corresponded to normal, mild, moderate, and severe alteration, respectively. When evaluating lip behavior, "They seal or partially seal the oral cavity without apparent effort" should be interpreted as normal; "They seal the oral cavity with marked contraction", as a mild alteration; "They seal the

oral cavity with reduced contraction", as a moderate alteration; and "They do not seal the oral cavity (do not fulfill the function)" as a severe alteration.

In some items of the protocol, the 4-point scale was not followed, such as "swallowing efficiency," for which the scale has 3 points, and "other behaviors and signs of alteration" during swallowing and chewing, which has 2 points, indicating present (1) and absent (2). The results were added to the other scores assigned to these functions.

The study authors considered the result abnormal when the child had abnormal results in four items, given that the protocol has not yet defined a cutoff.

The data were analyzed descriptively through absolute and percentage frequencies for discrete variables and the mean, standard deviation (mean $\pm$ SD), and median for numerical variables. Fisher's Exact test assessed the association between two categorical variables. The decision of the statistical tests used a 5% significance level.

Results

The study population consisted of 45 children (24 females and 21 males).

Table 1 presents the descriptive data of the clinical characterization of the study sample regarding gestation, delivery, and hospital stay.

Table 1. Clinical characterization of the study sample (N = 45)

Variable	n (%)
Total	45 (100.0)
Gestational risks ⁽¹⁾	
Hypertension	13 (28.8)
Diabetes	13 (28.8)
Placental abruption	4 (8.9)
Urinary tract infection	8 (17.7)
Cytomegalovirus	1 (2.2)
Cervical insufficiency	2 (4.4)
Anemia	3 (6.7)
Cancer, HIV/AIDS, rheumatic fever, cervical shortening, hemorrhage, consanguinity, rubella, syphilis, uterine rupture ⁽²⁾	15 (33.3)
Childbirth	
Cesarean delivery	36 (80)
Normal birth	9 (20)
Sex	
Males	21 (46.7)
Females	24 (53.3)
Gestational age	
Extremely preterm (less than 28 weeks)	2 (4.4)
Very preterm (28 weeks to 31 weeks and 6 days)	17 (37.8)
Moderately preterm (32 weeks to 33 weeks and 6 days)	8 (17.8)
Late preterm (34 weeks to 36 weeks and 6 days)	18 (40.0)
Birth weight (g)	
Up to 999 (ELBW)	5 (11.1)
1000 to 1499 (VLBW)	13 (28.9)
1500 to 2499 (LBW)	17 (37.8)
2500 or more (normal)	10 (22.2)
ICU length of stay (days)	
Up to 6	13 (28.9)
7 to 19	21 (46.7)
20 or more	11 (24.4)
Length of tube use (days)	
Up to 7	12 (26.7)
8 or more	33 (73.3)

(1) There was a sample with more than one occurrence, totaling a number greater than the sample size; (2) each risk occurred only once per child; (3) ELBW: extremely low birth weight, VLBW: very low birth weight, LBW: low birth weight.

The evaluated children's GA at birth ranged from 27 weeks to 36 weeks and 4 days. The main gestational risk conditions were hypertension and gestational diabetes.

Birth weight ranged from 435 to 3900 g, with a mean of 1776 g. The mean length of NICU stay

was 17 days. All children were fed through an orogastric tube (OGT) in the first days of life, for a mean of 23 days.

Table 2 describes the clinical data prior to the food introduction test.

Table 2. Feeding data for children at 6 months of corrected gestational age (N = 45)

Variable	n (%)
Total	45 (100.0)
Previous feeding	
Exclusive breastfeeding	9 (20)
Breastfeeding + expressed breastmilk	1(2.2)
Breastfeeding + formula	11 (24.4)
Formula	23 (51.1)
Infant cereal	1 (2.2)
Signs of readiness ⁽¹⁾	
Being interested in food	32 (71.7)
Holding the neck up	43 (95.5)
Controlling the trunk	21 (46.6)
Lack of tongue protrusion	3 (6.6)
Harmful habits ⁽¹⁾	
Pacifier	25 (55.5)
Thumb sucking	1 (2.2)
Bottle	36 (80)
Refusal	8 (17.8)

(1) There was a sample with more than one occurrence, totaling a number greater than the sample quantity.

Regarding the type of feeding prior to food introduction, early weaning was observed in 36 infants (80%). Furthermore, 37 mothers of study children (82.2%) reported some harmful habits, such as pacifier and bottle use and thumb sucking.

Regarding the signs of readiness, although the

vast majority (43; 95.5%) could hold their neck up, more than half (24; 53.3%) of the children evaluated lacked trunk control.

Table 3 describes the oral patterns and signs of alteration identified with OMES-E Infants reduced version⁹ during the food introduction test.

Table 3. Description of the oral myofunctional assessment of the sample during food introduction (N = 45)

Variable	n (%)
Total	45 (100.0)
Lip behavior	
They seal or partially seal the oral cavity without apparent effort	27 (60)
They seal the oral cavity with marked contraction	10 (22.2)
They seal the oral cavity with reduced contraction	6 (13.3)
They do not seal the oral cavity	2 (4.4)
Tongue behavior	
Normal	26 (57.8)
Mild alteration	11 (24.4)
Moderate alteration	2 (4.4)
Severe alteration	6 (13.3)
Signs of alteration ⁽¹⁾	
Movement of the head or other parts of the body	5 (11.1)
Residues in the oral cavity	12 (26.7)
Food spillage	9 (20)
Tension in the facial muscles	
Exaggerated gag reflex.	10 (22.2)
Cough	4 (8.9)
Swallowing	
Single or once-repeated swallowing per bolus	25 (55.6)
Twice-repeated swallowing	4 (8.9)
Multiple swallowing attempts (three or more repetitions)	16 (35.6)

(1) There was a sample with more than one occurrence, totaling a number greater than the sample quantity.

Also, 15 children (44.1%) presented some degree of alteration in oral cavity sealing, and 13 (38.2%) had some alteration in tongue behavior.

Table 4 describes the myofunctional evaluation of the children associated with the degrees of prematurity, birth weight, OGT length of use, and NICU length of stay.

Table 4. Oral myofunctional assessment based on the length of the orogastric tube use, length of stay in the neonatal intensive care unit, birth weight, and gestational age of the study children (N = 45)

Variable	Oral myofunctional assessment			p-value
	Abnormal n (%)	Normal n (%)	Total n (%)	
Total Group	37 (82.2)	8 (17.8)	45 (100.0)	
Length of OGT use (days)				$p^{(1)} = 0.661$
Up to 7	9 (75.0)	3 (25.0)	12 (100.0)	
8 or more	28 (84.8)	5 (15.2)	33 (100.0)	
Length of NICU stay (days)				$p^{(1)} = 0.615$
Up to 6	11 (84.6)	2 (15.4)	13 (100.0)	
7 to 19	18 (85.7)	3 (14.3)	21 (100.0)	
20 or more	8 (72.7)	3 (27.3)	11 (100.0)	
Birth weight (g)				$p^{(1)} = 1.000$
Up to 999 (ELBW)	4 (80.0)	1 (20.0)	5 (100.0)	
1000 to 1499 (VLBW)	11 (84.6)	2 (15.4)	13 (100.0)	
1500 to 2499 (LBW)	14 (82.4)	3 (17.6)	17 (100.0)	
2500 or more (normal)	8 (80.0)	2 (20.0)	10 (100.0)	
Gestational age				$p^{(1)} = 0.558$
Extremely preterm	2 (100.0)	-	2 (100.0)	
Very preterm	13 (76.5)	4 (23.5)	17 (100.0)	
Moderately preterm	8 (100.0)	-	8 (100.0)	
Late preterm	14 (77.8)	4 (22.2)	18 (100.0)	

Caption: GA: gestational age; OGT: Orogastric Tube; NICU: neonatal intensive care unit; ELBW: extremely low birth weight; VLBW: very low birth weight; LBW: low birth weight.

(1) Fisher's Exact Test.

Oral myofunctional performance was not significantly associated with the variables analyzed. However, quantitatively, a high number of abnormal results were observed in all variables. The frequency of oral myofunctional alterations were as follows: 28 children (84.8%) using OGT for more than 8 days; 18 children (85.7%) with a length of stay from 7 to 19 days; 14 children (82.4%) with LBW; and a higher incidence of late preterm infants (14; 77.8%) with abnormal oral myofunctional performance.

Discussion

Determining the ideal time for food introduction is widely discussed in the pediatric field, with diverse standpoints among child nutrition authori-

ties, as specialized institutions have established different parameters based on specific criteria.

A study¹⁰ suggested introducing solid food from the third month of GA, based on the acquisition of early motor skills; however, it highlighted that it may be unsafe for premature infants. The European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) recommended introducing food from the fourth month of GA, depending on the case¹¹. In contrast, the Italian societies of neonatology, pediatrics, and pediatric gastroenterology adopt a multifactorial approach, proposing introduction between the fifth and eighth month of chronological age, based on neuromotor development, taste maturation, and readiness to accept food textures¹². The WHO¹³ recommended the introduction of complementary foods from 6 months of chronological age, main-

taining breastfeeding until 24 months, as the gold standard for infant feeding, which is the source followed in Brazil.

However, since these are premature infants, it is understood that the start of complementary feeding will depend on their systemic maturity. Thus, corrected GA is used as a parameter¹⁴, although other factors such as the coordination of chewing, swallowing, and breathing must also be considered to ensure the efficiency and safety of this process^{7,15}.

The early introduction of complementary foods, before the corrected age, can shorten breastfeeding, increase the risk of nutritional disorders (obesity and malnutrition), anemia, deficiencies (iron and vitamin A), food intolerance, allergies, and other complications¹⁶.

Only 20% of children were exclusively breastfed at 6 months of corrected age (Table 2). These results are far below those mentioned in the literature¹⁷, which showed a prevalence of 45.8% in exclusive breastfeeding during this period before food introduction.

Several studies¹⁸⁻²⁰ indicated that offering exclusive breastfeeding with food introduction at 6 months of corrected age led to a lower tendency to food refusal when respecting this period.

Trofino and colleagues¹⁹ observed a higher proportion of premature children with signs of feeding difficulties, highlighting that they may be 3.6 times more likely to develop signs of feeding difficulties than children born at term. This corroborates the current study, which found that most children had signs of alterations during feeding.

Research²¹ using a questionnaire to screen the perception of parents of premature children highlighted a percentage of 73.7% with reports of children with at least one defensive behavior during meals. The most frequent were refusal to open their mouth (42.1%), followed by food selectivity (28.9%) and refusal to feed (26.3%). Food refusal (44.4%) had a greater association with artificial feeding ($p = 0.033$). The study²¹ stated that prior feeding with formula increases the chances of children having difficulties with complementary feeding by 41%, compared to exclusive breastfeeding and mixed feeding.

Therefore, breastfeeding should encourage the introduction of safe and healthy food, although there is much variation in the age at which complementary foods are first offered. Greater attention

should be paid in the case of prematurity, as other factors may be present.

It is important to highlight that motor development milestones such as holding the head up, sitting up, and bringing the hand to the mouth are important for the development of the feeding process²². According to a study²³, these predictive factors for the introduction of complementary feeding in premature newborns are significantly influenced by GA.

This research observed that most did not show any sign of readiness for feeding, which may indicate immature motor development at 6 months of corrected GA. Therefore, premature children may have a greater tendency towards the risk of inefficient feeding performance.

Although the literature²⁴ describes that readiness for oral feeding naturally improves with the maturation of premature infants, the implementation of an oral stimulation program tends to significantly accelerate this process, promoting faster preparation for oral feeding.

The assessment of premature newborns in this study identified alterations in oral and functional structures, which directly impacted food introduction (Table 3). This was demonstrated by inadequate lip seal, altered tongue mobility, lack of trunk control, food spillage, muscle tension, and inefficient swallowing. These findings show how orofacial motor immaturity, frequently observed in premature infants, can compromise the posture and neuromuscular control necessary for safe and effective feeding²⁵.

Moreover, it is known that premature newborns may have been exposed to harmful sensory stimuli, such as orotracheal intubation, upper airway aspiration, and prolonged use of a feeding tube as an alternative feeding route. Hence, oral feeding is introduced late, which may impair oral skills, suggestive of inefficient food introduction^{27,28}.

Another study²⁶ investigated preterm infants and subdivided them into two groups, both with complaints about feeding difficulties, identified by alterations in sensorimotor aspects of feeding. However, the group of preterm infants born after 32 weeks had a lower incidence of discomfort during food intake than the group under 32 weeks, whose frequency of oral motor alterations during feeding was higher with both pureed and solid foods, as well as alterations in lip seal during swallowing and signs suggestive of laryngeal penetration or

aspiration. These data corroborate the present study, which also verified alterations in lip seal and inefficient swallowing (Table 3).

Furthermore, the present study found a high percentage of abnormal results in the oral myofunctional performance of children with a NICU stay longer than 7 days. This suggests that the length of hospitalization may be associated with a higher occurrence of oral dysfunctions, which may be justified by the deficit in sensory stimulation during the critical period of development²⁹. Pires et al.²³ identified a direct correlation between prolonged hospital stay and delay in the introduction of complementary foods, especially solids and semi-solids, in premature infants.

The signs of altered oral patterns observed in the evaluated children, such as exaggerated gag reflex, food spillage, cough, and food residue in the oral cavity, are considered important, as they interfere with the sensory ability of the oral cavity for adequate feeding performance. However, a high number of premature infants had oral myofunctional alterations, regardless of GA, which may have been caused by harmful sensory stimuli at birth.

Table 4 showed a high percentage of oral myofunctional alterations in premature infants in the four prematurity classifications and with different birth weights. However, no significant association was found between prematurity, weight, and the assessment.

Regarding birth weight, the children varied between 80% to 90% of orofacial myofunctional alterations among the groups of premature infants, even with variations in weight, evidencing that the risk remained high even among premature infants with relatively higher weight. Therefore, weight was not significantly associated ($p = 1.000$) with the assessment but showed a high percentage of alterations in feeding functions in LBW premature infants (Table 4). This may be an important warning sign, indicating possible health or developmental problems in the stages of child development. This was demonstrated by the WHO¹³, which highlighted feeding difficulties due to both prematurity and other problems such as LBW and gastrointestinal discomfort.

Authors³⁰ observed that the shorter the tube feeding use associated with intervention (early stimulation), the better the feeding performance, and that prematurity, developmental delays, and early stimulation directly impact feeding perfor-

mance. This is related to the assessment of oral structure and function in this study population, since alterations in these structures affect oral myofunctional performance during the introduction of complementary feeding.

Regarding prematurity, this study showed a high incidence of abnormal results in all study groups, regardless of the children's GA. This corroborates studies^{20,27} that observed a higher percentage of feeding difficulties in preterm than full-term children, which can occur as complementary feeding is introduced¹⁹.

This demonstrates the importance of continuous care programs for premature children, with an emphasis on the systematic assessment of feeding skills and the implementation of evidence-based practices to promote adequate feeding development. These efforts are fundamental to improving the quality of life and minimizing the risks of long-term impairments.

Accordingly, the professional's direct assessment made this study more scientifically sound, distinguishing it from others¹⁹⁻²² that used a screening method based on parent-report questionnaires.

This study demonstrated the importance of outpatient follow-up in this population. However, future studies should use larger samples, as the small sample size in this study limited the statistical association between variables. Nevertheless, it demonstrated the importance of speech-language-hearing follow-up in evaluating and guiding the family as they introduce complementary food to children, as numerous risk factors can make family members and caregivers insecure about food introduction, hindering the entire feeding process during early childhood.

Conclusion

This study demonstrated through direct assessment that premature infants, even when clinically stable at 6 months of corrected GA, have a high incidence of oral myofunctional alterations, regardless of GA, birth weight, length of feeding tube use, or NICU stay, reinforcing the multifactorial nature of feeding difficulties in premature infants.

The findings highlight the importance of early, direct, thorough assessments to identify risk signs for alterations in oral myofunctional performance during food introduction at 6 months of corrected GA. This reinforces the clinical relevance of

speech-language-hearing intervention during this developmental period, with the professional's role in the multidisciplinary team of a follow-up clinic to assist in the oral myofunctional development of patients assisted in this service.

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