SAnt with identification of a possible delay by reviewing developmental milestones. Most general pediatricians do this routinely. For example, being able to grab and transfer an object is a milestone at about 5 months of age. Some infants develop this fine motor skill at 4 months or 6 months, so sometimes delays are within a reasonable time frame.

Be aware of who is at high risk for delayed development. Consider pregnancy, labor and delivery, and birth history. Did the infant have any acquired illnesses during the first few months of life? There could be a set-up in utero for subtle presentations in the first few years of life.

If you suspect that an infant or toddler is experiencing developmental delay, close monitoring is warranted. Have the patient return sooner and more frequently than you would otherwise with routine well-child visits.

If a suspected delay becomes more prominent, consider referral to a subspecialist. When to refer a patient for further evaluation can be subjective, but it is better to err on the safe side. As a general rule, if the child is more than 3 months behind in any developmental area, referral is warranted. A concern for me is that some pediatricians tend to underplay a possible developmental delay for too long. Telling concerned parents to “just give it some time” can be dangerous, particularly if suspicion about a true clinical delay are ultimately confirmed.

Early diagnosis and identification of the cause for the delay increase the likelihood it can be corrected or treated more effectively. Seizure, congenital brain abnormality, and metabolic disorder are potential etiologies for developmental delay.

Remember to assess the four general areas of infant and toddler development: gross motor skills, fine motor skills, language, and social interaction. The delay or delays demonstrated by an individual child guides the patient’s management. For example, an infant with gross motor deficits could benefit from consultation with a physical therapist. A toddler with fine motor delay could improve with the assistance of an occupational therapist.

Speech therapy might be warranted, as well, depending on the age of the child. At around 18 months, for example, most toddlers display significant gains in language and socialization skills. Always keep autism in mind with speech and socialization delays—this is a big area of concern today.

Ask yourself if the child has a global delay or a specific delay. The more global the delay, the more I worry about brain involvement. If an infant presents with low muscle tone, try to determine if the brain, spinal cord, nerve, and/or muscle systems are involved. Deficits in each system necessitate different treatment approaches.

When performing a physical examination, look for an asymmetrical head or dysmorphic appearance. If the child does not look like the rest of the family—for example, has a small jaw, a small head, or rotational ears—the developmental delay could have a genetic basis.

We know a lot more about genetic causes now than we did even just 5 years ago, in part because microarray assessment allows us to detect genetic microdeletions.

Although some general pediatricians can and do order diagnostic tests and imaging to confirm delayed development, many rely on a subspecialist for further work-up of the child. Often subspecialists do an MRI scan after initial screening and examination. Metabolic laboratory tests are also useful for screening and diagnosis.

Be careful about what I call “scam” treatments. For example, some families might consider trying bariatric oxygen, stem cell treatments, or vitamin thera- pies. While omega 3 fish oil supplements may not hurt the child, they are not necessarily helpful either.

Follow these patients regularly for progress to guide families and determine appropriate treatment over time.