sensitive to milk. Most of the children who were sensitized to milk were also sensitized to egg (88%), but 33% of the children were only sensitized to egg. The SCORAD scores were higher at baseline for children with both milk and egg sensitivity (mean ± standard deviation [SD]: children with normal specific IgE (SCORAD = 17 ± 10), children with milk-specific IgE only (SCORAD = 18 ± 10), children with egg-specific IgE only (SCORAD = 20.5 ± 12) and children with both egg and milk sensitivity (SCORAD = 23.1 ± 12). Sensitization to milk and egg was more common in children with more severe AD at all time points of the study. The RAST level, particularly for egg, was strongly related to the severity of AD. Sensitization to egg or milk at the beginning of the study was associated with a higher rate of persistence of AD at 18 months. In children with negative specific IgE at baseline, only 57% had active AD at the end of the study, versus 84% of the egg-sensitized and 67% of the milk-sensitized subjects who had persistent AD at the 18-month time point. AD improved on average throughout the 18-month study, however, children in whom sensitization to milk increased had significantly less improvement and egg-sensitized children had deterioration of their AD.

Conclusions. The authors found an association between severity of AD and sensitization to egg or to milk. They further conclude that sensitization to milk, and, in particular, to egg is a negative predictor for severity of AD and persistence of AD.

Reviewers’ Comments. This study demonstrated an association between the severity and persistence of AD with milk and/or egg sensitization. Other studies have shown that food-allergic children will have improvement in their AD if placed on an elimination diet. The authors acknowledge that they did not address other contributors to AD severity such as environmental trigger, infections, skin care regimens and irritants. They also note that they did not track the specific diets of these children, but speculate that the children with food sensitivity and more severe AD would be more likely to remove offending foods from their diet than the other group. This study further emphasizes the importance of evaluating children with AD for food sensitivity, particularly in patients with moderate to severe AD.

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INTERPRETATION OF COMMERCIAL FOOD INGREDIENT LABELS BY PARENTS OF FOOD-ALLERGIC CHILDREN

Purpose of the Study. Food allergen avoidance is the mainstay of current therapy for food allergy and food-allergic consumers depend on the ingredients labels of the commercial products. This study sought to determine the accuracy of label reading among parents of food-allergic children.

Study Population. Parents of food-allergic children followed at the food allergy referral center.

Methods. Parents of children on restricted diets were asked to review a group of 23 food labels taken from widely available commercial products. For each label, each parent/parent pair was asked to indicate whether the product was safe for the allergic child and, if it was not, which foods restricted from the child’s diet were in the product.

Results. There were 91 participants. Peanut was the most commonly restricted food (82 children), followed by milk, egg, soy, and wheat (60, 45, 27, and 16 children, respectively). Identification of milk and soy was the most problematic: only 4 (7%) of 60 parents correctly identified all 14 labels that indicated milk, and only 6 (22%) of 27 parents correctly identified soy protein in 7 products. Peanut was correctly identified in 5 products by 44 (54%) of the 82 parents restricting peanut. Wheat (10 labels) and egg (7 labels) were correctly identified by most parents (14/16 and 42/45, respectively). Correct label identification was associated with prior instruction by a dietitian.

Conclusions. With current labeling practices, most parents are unable to identify common allergenic food ingredients. These results strongly support the need for improved labeling with plain-English terminology and allergen warnings as well as the need for diligent education of patients about reading labels.

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ALLERGY TO SOY FORMULA AND TO EXTENSIVELY HYDROLYZED WHEY FORMULA IN INFANTS WITH COW’S MILK ALLERGY: A PROSPECTIVE, RANDOMIZED STUDY WITH A FOLLOW-UP TO THE AGE OF 2 YEARS

Purpose of Study. To evaluate the cumulative incidence up to the age of 2 years of allergy or other adverse reactions to soy formula and to extensively hydrolyzed formula in infants with confirmed cow’s milk allergy.

Study Population. The study group was comprised of 170 children with cow’s milk allergy (99 boys and 71 girls) with a mean age at the time of diagnosis of 7 months (range: 2–11 months). All the patients had their diagnosis confirmed by double-blind, placebo-controlled challenge (DBPCFC) except for 4 patients with a history of an anaphylactic reaction to cow’s milk and positive immunoglobulin (IgE) antibodies to this protein.

Methods. Infants with documented cow’s milk allergy were randomly assigned to receive either a soy formula (Soija Tutteli, Valio Ltd, Valio, Finland) or an extensively hydrolyzed formula (Peptidi Tutteli, Valio Ltd, Valio, Finland). If there was a clinical suspicion that the formula caused symptoms, a DBPCFC with the formula was performed. The children were followed to the age of 2 years, and soy-specific IgE antibodies were measured at the time of diagnosis and at ages 1 and 2 years.

Results. An adverse reaction to the formula was confirmed by challenge in 8 patients (10%; 95% confidence interval: 4.4%–18.8%) randomly assigned to soy formula and in 2 patients (2.2%; 95% confidence interval: 0.3%–7.8%) randomly assigned to extensively hydrolyzed formula. Adverse reactions to soy were similar in IgE-associated and non–IgE-associated cow’s milk allergy (11% and
INTERPRETATION OF COMMERCIAL FOOD INGREDIENT LABELS BY PARENTS OF FOOD-ALLERGIC CHILDREN

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