

Re: Confusing Recommendations Regarding Timing of Peanut-Based Foods to Low-risk Infants

As both pediatric advocates and formulators of the official American Academy of Pediatrics (AAP) policy “Breastfeeding and the Use of Human Milk,”¹ we are perplexed by the recent Perspectives article authored by Sicherer et al, “The Benefits of New Guidelines to Prevent Peanut Allergy.”²

The focus of our concern is the reprinting of a table from the guidelines previously published by the National Institute of Allergy and Infectious Diseases (NIAID)–sponsored expert panel³ and the statement by Sicherer himself, both of which imply policies regarding complementary feeding of peanut-based foods that are contradictory to official AAP policy. As a reminder, the 2012 Policy Statement of the AAP explicitly recommends that exclusive breastfeeding continues for ~6 months,¹ which has been a policy recommendation of the World Health Organization since 2002 and was reinforced by a 2012 Cochrane review.⁴

Thus, it is not clear what the justification is for the NIAID table that states in Guideline 3 that the earliest age of peanut introduction for infants who have no eczema or food allergy be “age appropriate and in accordance with family preferences and cultural practices.” This phrase seems to imply a license to feed peanut products before 6 months and stands in contrast to Guideline 2 for infants with mild-to-moderate eczema of introducing peanut only at ~6 months. As noted, this recommendation for infants without eczema or food allergy is in contradiction to official AAP policy.

More perplexing is Sicherer’s statement in discussing the recommendations for Group 3 infants (ie, those without risk factors) that “including this group in early introduction is expected to be safe and

contribute on a societal basis to peanut allergy prevention.” A simple reading of this statement, which is apparently justified by the statistic that 14% of children who become peanut allergic lack risk factors in infancy, is that all infants should be routinely exposed to peanut-based foods as early as 4 months. Clearly, this change in policy is not supported by the AAP, World Health Organization, or more recently by the Scientific Advisory Committee on Nutrition and the Committee on Toxicity of Chemicals in Food, Consumer Products, and the Environment of the UK National Health Service.⁵

We request clarification from Sicherer regarding the basis and authority for his recommendation regarding the timing of the introduction of peanut-containing foods to infants without risk factors. To most readers, early introduction in this context would mean earlier than 6 months. If we have misinterpreted the author’s intent, the fact that the text as quoted above has led to confusion is justification that there needs to be further elucidation and, as necessary, correction in writing.

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CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

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Authors’ Response

We thank Dr Eidelman and his colleagues for their comment on our Perspectives article,¹ which was written to discuss the recent AAP-endorsed “Addendum guidelines for the prevention of peanut allergy in the United States: Report of the National Institute of Allergy and Infectious Diseases-sponsored expert panel.”² We point out that the guidelines were a consensus document from representatives of 25 stakeholder groups, including the AAP (also with input from the Section on Breastfeeding). Briefly, Eidelman and colleagues believe from their reading of our review that we were indicating that infants with no known allergy risk factors (no eczema or any food allergy) be fed peanut at 4 to 6 months of age.

We confirm that the guidelines² do not suggest that infants with no risk factors (Guideline 3) ingest peanut at 4 to 6 months of age (which would broach the recommendation for exclusive breastfeeding to 6 months). The guidelines only suggest that infant-safe forms of peanut be introduced as early as 4 to 6 months for high-risk infants (Guideline 1), as described specifically in the guidelines (severe eczema, egg allergy, or both). The guidelines provide the rationale for this breach in

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