

Reply by Feenay

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To the Editor:

Di Mario et al¹ state that the Learning Early About Peanut Allergy (LEAP) study intervention, which introduced peanut to high-risk infants between age 4 and 11 months, should not be described as “early introduction of peanut.”² They also believe a more accurate interpretation of the study results to be that peanut introduction should not be delayed beyond age 11 months because this increases the risk for peanut allergy.¹

What might be considered “early introduction” of foods is evolving as infant feeding practices change. The LEAP study enrolled its first participants in 2006; at that time, the median age of introducing peanut in the United Kingdom was 36 months, and so its introduction in the first year of life was considered early.^{3,4} LEAP consumers were advised to eat peanut in high amounts (6 g peanut protein per week). The deliberate introduction of peanut in high amounts between age 4 and 11 months differs from a recommendation simply not to delay its introduction. It appears that both the timing and the amount consumed are important to prevent the allergy.^{3,5}

Although the median age at study screening was 7.8 months, 19.7% (63 of 319) of the participants in the consumption group introduced peanut before age 6 months, and were thus going against current World Health Organization guidelines.² The optimal timing for the introduction of allergenic foods to prevent food allergy has not yet been defined; however, findings from the LEAP study indicate that sensitization to food allergens occurs as early as age 3 to 4 months. Seventy-six of 194 infants excluded from LEAP study participation at the screening stage had a peanut skin prick test wheal of above 4mm and were considered too high risk for the study.³ Of those enrolled, 15.3% (98 of 640) had a positive peanut skin prick test result at enrolment; sensitization to peanut was found to increase with age.^{3,6} Thus, the window of opportunity to introduce peanut to prevent the allergy may, in some high-risk infants, occur before the age of 6 months.

Interim guidelines on peanut introduction for allergy prevention in high-risk children have been published; further guidance is awaited once the results of other prevention studies are available.⁶

We agree that early feeding experiences are important. Efforts to introduce allergenic foods in infancy, in what may be a narrow time frame to prevent the allergy, will prove challenging for

carers where their infant shows disinterest, dislike, or food refusal. We have published details of the dietary advice provided to participant families on our study. No choking episodes were reported and the peanut-containing foods were largely well tolerated.

However, further research in this field should address practical questions of how best to introduce allergenic foods to ensure an adequate intake to achieve tolerance while supporting a “responsive feeding” approach.⁷We consider it reassuring that infants in the consumption group who were breast-feeding at enrollment continued to receive the benefits of breast milk as well as protection from the development of the allergy. We also showed that the introduction of peanut did not negatively impact growth or nutritional intake in infancy and early childhood.

Mary Feeney, MSc a,b; George Du Toit, FRCPCH a,b; Gideon Lack, FRCPCH a,b.

From a: the Department of Pediatric Allergy, Division of Asthma, Allergy and Lung Biology, King’s College London and b: Guy’s and St Thomas’ NHS Foundation Trust, London, United Kingdom. E-mail: gideon.lack@kcl.ac.uk.

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