

Correspondence

Low-risk infants may still benefit from allergenic food consumption

To the Editor:

We greatly appreciate the published findings by Perkin et al¹ and agree these data should further inform infant feeding guidelines. However, to best interpret these outcomes with respect to food allergy prevention recommendations, we find it helpful to review study definitions and study design nuances of both the Learning Early about Peanut (LEAP) and Enquiring About Tolerance (EAT) trials.^{2,3} We believe the conclusion that low-risk infants do not benefit from allergenic food introduction is overstated.¹

The meaning of “early” introduction in LEAP, EAT, and clinical practice varies.^{2–8} LEAP recruited high-risk infants at age 4 to 11 months to test a peanut introduction strategy versus avoidance for the prevention of peanut allergy.² However, in the EAT study, an “early” strategy called for allergenic food introduction beginning at age 3 months, whereas the “standard” introduction group began allergenic food at age 6 months.³ The EAT study did not meet its primary end point in intention-to-treat analyses (due at least in part to high protocol nonadherence), and some have interpreted this to mean that infant allergenic food consumption does not prevent food allergy in the general population. This conclusion is not supported, because the comparator groups were in effect “earlier than early” by the LEAP inclusion criteria, versus a time point within the LEAP criteria and younger than the mean age of introduction in the LEAP cohort (7.8 months).^{2,3}

In addition, the comparator groups in the EAT study differed not just in the timing of allergenic food introduction but also in the degree of consumption. As reported, the study protocol *permitted* introduction of allergenic foods in the standard group, whereas the early introduction group was *required* to consume 6 allergenic foods.³ Thus, any reduction in food allergy incidence due to the relative timing of allergenic food introduction must be interpreted with caution, because this could have been confounded by differential allergenic food exposure. For example, a family could have been adherent to the standard introduction protocol, but in fact not had pursued allergenic food consumption. A question therefore remains for EAT—are reductions in food allergy incidence attributed to timing of food introduction specifically at 3 months, or to the fact that only this group was required to consume allergenic food? Conversely, the lack of statistically significant effect sizes between the comparator groups in some subgroup analyses does not disprove the benefit of infant allergenic food introduction in low-risk populations, because this may be subject to type II error (especially given high nonadherence). In fact, there was an important, though

nonstatistically significant, difference in peanut allergy between early and standard groups in those with mild eczema (0.9% vs 4.5%; $P = .21$), and small reductions in food allergy in those without visible eczema (2.3% vs 3.5%; $P = .30$).¹

Raising these points is not meant to diminish the benefits of allergenic food introduction in high-risk groups, but rather to highlight that infant allergenic food consumption may still be beneficial in low-risk groups. Even small changes in food allergy incidence in low-risk groups can amount to a large absolute number of food allergy cases prevented on a population level.⁹

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