

COMMENT & RESPONSE

Cow's Milk Is Not Ideal for Children at Any Age

To the Editor Bodnar et al¹ promote cow's milk for children, including those at risk for health problems associated with milk consumption, and discourage the use of more healthful choices. They cite the 2019 report on healthy beverage consumption from Healthy Eating Research,² which contains short-sighted recommendations that take a toll on people of color, particularly African American individuals; is incomplete, misguided, and poorly referenced; and may do harm. The authors¹ ignore several reasons for concern about broadly recommending cow's milk, including its association with lactose intolerance symptoms and prostate and ovarian cancers, and its unnecessary load of saturated fat, cholesterol, and estrogens.

The loss of lactase enzymes after early childhood is the biological norm. Only among some White populations is lactase persistence common. The recommendation to consume cow's milk runs counter to the American Medical Association's recommendation that the US Department of Agriculture and US Department of Health and Human Services recognize that lactose intolerance is common among people in the US, especially those of color, and to clearly indicate in federal nutrition guidelines that dairy products are optional.³ To describe cow's milk as beneficial, or as the default beverage option, reflects racial bias that is presumably unintended but is nonetheless inappropriate and harmful.

Infants' nutritional needs are best met by their mothers' breast milk, which provides appropriate nutrition and helps build immunity. They should continue to receive breast milk or formula at least through their first 12 months. There is no need for infants to consume cow's milk. None of the studies referenced in the Healthy Eating Research report included analyses on absorption rates with soy milk. A study by Zhao et al⁴ confirmed that, with the current and most common fortification agent, calcium carbonate, calcium is absorbed at the same rate from soy milk as from cow's milk. Children who eat a healthful diet need no other beverage than water.

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Published Online: May 28, 2021. doi:10.1001/jamapediatrics.2021.1290

Conflict of Interest Disclosures: Ms Levin is employed by the Physicians Committee for Responsible Medicine and Barnard Medical Center in Washington, DC. Dr Barnard is an adjunct professor of medicine at the George Washington University School of Medicine, serves without compensation as president of the Physicians Committee for Responsible Medicine and Barnard Medical Center in Washington, DC, and has received royalties and honoraria for writing books and articles and giving lectures related to nutrition and health.

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In Reply We appreciate Levin and Barnard's interest in our Viewpoint¹ on recommendations for plant-based beverage intake in children aged 12 to 23 months. However, many of their concerns about the use of cow's milk are not relevant for this age group. For example, Levin and Barnard cite an association between cow's milk and cancers of the prostate and ovaries as well as an overload of saturated fat, estrogens, and cholesterol. An association between these cancers and use of cow's milk from 12 to 23 months has not been demonstrated in epidemiologic studies,^{2,3} and children younger than 2 years need adequate fat and energy to support growth and brain development.⁴

A major concern Levin and Barnard raised about the use of cow's milk was regarding lactose intolerance. We appreciate that lactose intolerance is a significant concern for many families of color with older children and for adult family members, and that lactose-free or lactose-reduced cow's milk may not be accessible to everyone. However, lactose intolerance is not a health concern for children younger than 2 years, including children of color.⁵ We agree that families with dietary patterns that do not include cow's milk, for health or other reasons, deserve evidence-based guidance about how to ensure that all of their children's nutrient needs are met. This is an important health equity issue, especially with children younger than 2 years, who have high nutrient needs relative to their intake.⁴

If cow's milk is not preferred by the family and children aged 12 to 23 months consume a high proportion of their beverage intake from plant-based sources, we recommended that assessment of dietary adequacy and guidance occur on an individualized basis between the family and a health professional with nutrition expertise.¹ Through this process, a family can weigh their individual preferences and situation, as well as the evidence that is available in conjunction with the other foods the child consumes, to decide if plant-based beverages or only water, plus healthy foods, are the right decision for their child. We also agree that guideline developers and professional organizations should create dissemination materials for health professionals and families that highlight different ways to adequately meet young children's nutrient needs. These materials should represent foods from a variety of cultures⁴ and include nondairy options. In our commentary, we also advocated for research to better inform evidence-based recommendations on the use of plant-based milk for children younger than 2 years going forward.

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Published Online: May 28, 2021. doi:10.1001/jamapediatrics.2021.1293

Conflict of Interest Disclosures: None reported.

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Supporting the Imperfect Use of Amplified Pain Syndrome

To the Editor Stigma in children with chronic pain is important because of its potential impact on health outcomes for patients and their families.¹ We applaud the focus on stigma in the article by Weisman and colleagues² but would like to share alternative views on the clinical use of the term amplified pain syndrome (APS). We agree that diagnostic labels can cause stigma, but even more problematic is how the diagnostic impression is communicated to patients and families. We argue that APS, while not perfect, provides an opportunity for clinicians to validate that the child's pain is real and can be modulated by environmental factors.³ The dichotomy that is perpetuated in medicine is that certain health conditions, such as chronic pain, are either exclusively medical or psychological in origin, which underappreciates the biopsychosocial etiology of chronic pain. This leads to misperceptions that the patient's pain is all in their head.

For many families, simply having a diagnosis or a name for their pain may be comforting, provide opportunities to find others who have similar experiences, find support in a safe haven among these peers, and learn from them. The prospect of learning more about this diagnosis may afford them hope. While we agree that APS has the potential to cause societal stigmatization and self-stigmatization, and perhaps should be stricken from our lexicon for the reasons Weisman and et al² describe, it is not the only diagnostic label that can cause stigma. Other diagnoses, such as medically unexplained physical symptoms or somatic symptoms

and related disorders may be similarly stigmatizing or even more so. A diagnosis of APS includes the concept that there is a biological sensitivity, putting it among the less stigmatizing diagnostic labels available.

Will erasing this term bring patients more clarity in mechanism or pathophysiology along with reducing stigma, or leave a void, making it more difficult for patients and families to understand, cope with, and treat their symptoms? Much of this may hinge on how a diagnosis is explained more than the diagnosis itself. We agree that further research is necessary to better understand chronic pain and its neurophysiology in pediatric patients, but would consider the imperfect label of APS acceptable at this time. No matter what label we use, the best approach will still require the education of ourselves, our colleagues, and the community because, as Titus Livius quipped, "We fear things in proportion to our ignorance of them."⁴

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Published Online: June 14, 2021. doi:10.1001/jamapediatrics.2021.1488

Conflict of Interest Disclosures: Dr Wakefield reports grants from National Institutes of Arthritis and Musculoskeletal and Skin Diseases. Dr Zempsky reports grants from the National Institutes of Health, US Department of Defense, Mayday Fund, and the Hartford Foundation for Public Giving, and is a consultant for Glycomimetics and GlaxoSmithKline and data safety monitoring board member for Lundberg. No other disclosures were reported.

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In Reply We thank Wakefield and colleagues for contributing their defense of the diagnostic label, amplified pain syndrome (APS). Nevertheless, their response reveals an ambivalence in their views. On the one hand, they agree with us that APS has the potential to stigmatize those so labeled; on the other hand, they see it as in some way validating the pain of a child or young adult. Surely such validation can be achieved through the clinician's honest expression of empathy and compassion.

Understandably, patients and those representing them often seek a name for their condition. However, as clinicians, we must always ensure that the names we offer to them have