

CORRESPONDENCE

Reply to: Cost-Effectiveness of Using an Extensively Hydrolysed Formula Compared to an Amino Acid Formula as First-line Treatment for Cow Milk Allergy in the UK

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Editor,

With great interest we read the paper by Taylor et al. (1) about cost-effectiveness of two types of infant formula in case of cow's milk allergy (CMA). They compared cost-effectiveness of treatment with extensively hydrolysed formula (eHF) or amino acid formula (AAF) in two groups of infants. They used data from The Health Improvement Network (THIN) database. Infants with CMA younger than 1 year of age, diagnosed by a general practitioner, and marked in the THIN database by a certain read code were included in the study. It is not clear from the manuscript how CMA was defined. CMA seemed to be defined as symptoms suggestive of CMA and resolution of symptoms upon elimination diet.

We agree with the authors that the approach to the selection of patients from the THIN database is fundamental to this study. However, they state that the diagnosis of CMA is not clear in all cases. A clear definition of CMA is required to answer the research question and draw valid conclusions. Based on the results described by Taylor et al., we have concerns about the validity of diagnosis of CMA in their study.

First, prevalences based on perception of food allergy and not on objective measures are known to overestimate food allergy prevalences (2, 3). Therefore, according to international guidelines, diagnosis of CMA should be based on a food challenge, preferably: a double-blind, placebo-controlled food challenge (4). The current prevalence of CMA is unclear. Recent studies describe numbers between 1% and 17% (2, 3). This differs from the 2–3% given by the authors. Their observed prevalence seems to be in line with these studies. However, inclusion of patients in these studies differs markedly from the methods used in the study of Taylor et al. and cannot be compared. Second, 19% of the infants treated

with an AAF remained symptomatic. As AAF is based on amino acids and not derived from cow's milk protein it is considered a nonallergenic formula (5). Diagnosis of CMA should be questioned in these 19% when symptoms persist on AAF (6).

The authors also describe a percentage of 33% and 50% in both groups of infants with urticaria who also had anaphylaxis. However, in the discussion the percentage of children who had anaphylaxis was stated as 1% and 3%, respectively. The latter is more in line with our experience.

Finally, a high amount of healthcare visits can be explained by a short period of prescriptions of dietary formulas, which might be intrinsic to the healthcare system in the UK. Thus a difference in duration of prescriptions for the two formulas can be in part responsible for the higher costs for children treated with AAF (1). Adjusting for this difference is necessary.

In conclusion, it is certainly interesting to compare costs of eHF and AAF feeding in infants with CMA, especially because AAF is much more expensive. However, in this type of studies it is essential to have a clear definition of CMA in order to gain valid results. In our opinion a cost-analysis is unreliable when it is not based on international accepted criteria for the diagnosis and treatment of CMA.

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