

Correspondence

Does giving infant formula to prevent cow's milk allergy hinder breast-feeding?

To the Editor:

We read with interest the article by Sakihara et al,¹ which argued that daily consumption of at least 10 mL of cow's milk-based infant formula (CMF) between the ages of 1 and 2 months prevents infant milk allergy without competing with breast-feeding. However, we are concerned that this regimen might discourage breast-feeding and harm breast-fed infants.

Early introduction of supplemental formula greatly increases the risk of early cessation of breast-feeding and is therefore not recommended.^{2,3} Sakihara et al¹ argue that the intervention did not hinder breast-feeding because the breast-feeding continuation rate at age 6 months was not significantly different between the intervention and control groups. However, the vast majority of infants in their study received infant formula soon after birth, before the intervention period. This likely reflects the routine introduction of infant formula at hospitals, which conflicts with international recommendations.^{2,3} We suspect that if the study had been conducted in hospitals where infant formula was supplied only when medically indicated, the intervention might have adversely affected breast-feeding outcomes.

Furthermore, the study did not assess the health risks of nonexclusive breast-feeding. Studies have confirmed the benefits of exclusive breast-feeding.³ Thus, before advising caregivers to give infant formula to breast-fed infants, the risks of nonexclusive breast-feeding should be evaluated. A possible reduction in the incidence of cow's milk allergy is insufficient justification to introduce infant formula, because breast-feeding improves a wide range of health outcomes and is often dose-responsive.⁴ In Sakihara et al's study,¹ the caregivers in the intervention group were asked to add only a small amount of formula; however, about half gave more than 200 mL of CMF daily to their babies. In addition, even after the intervention period, most caregivers in the intervention group continued giving more than 40 mL of infant formula per day.¹ Therefore, because caregivers might provide a substantial amount of infant formula even when recommended

to give "limited" amounts for a short period, the risks of nonexclusive breast-feeding should be assessed.

Finally, the study findings may not pertain to infants breast-fed exclusively since birth. In Sakihara et al's study, more than 90% of infants received CMF within 3 days of birth. Previous studies indicate that early exposure to CMF is a risk for cow's milk allergy.⁵ Indeed, none of the 31 infants who avoided CMF in the first 3 days of life developed cow's milk allergy in Sakihara et al's study.¹ Therefore, we conclude that CMF should not be given to prevent cow's milk allergy, especially to exclusively breast-fed infants.

In summary, advising caregivers to continue daily CMF supplementation may hinder breast-feeding. In addition, the health risks of nonexclusive breast-feeding may outweigh any favorable effect on cow's milk allergy and might even increase the incidence of such allergy. In light of the known benefits of breast-feeding, future studies should attempt to identify strategies that prevent cow's milk allergy without sacrificing those benefits.

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