South East London Guideline for the Management of Cow's Milk Allergy and Prescribing of Hypoallergenic Formula in Primary Care

Summary: These guidelines aim to improve the identification, treatment and management of cow's milk allergy (CMA) in infants and children with a focus on primary care. The guidelines should be implemented to promote and facilitate standardised evidenced-based practice including the appropriate use of hypoallergenic formula (HF).

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Abbreviations

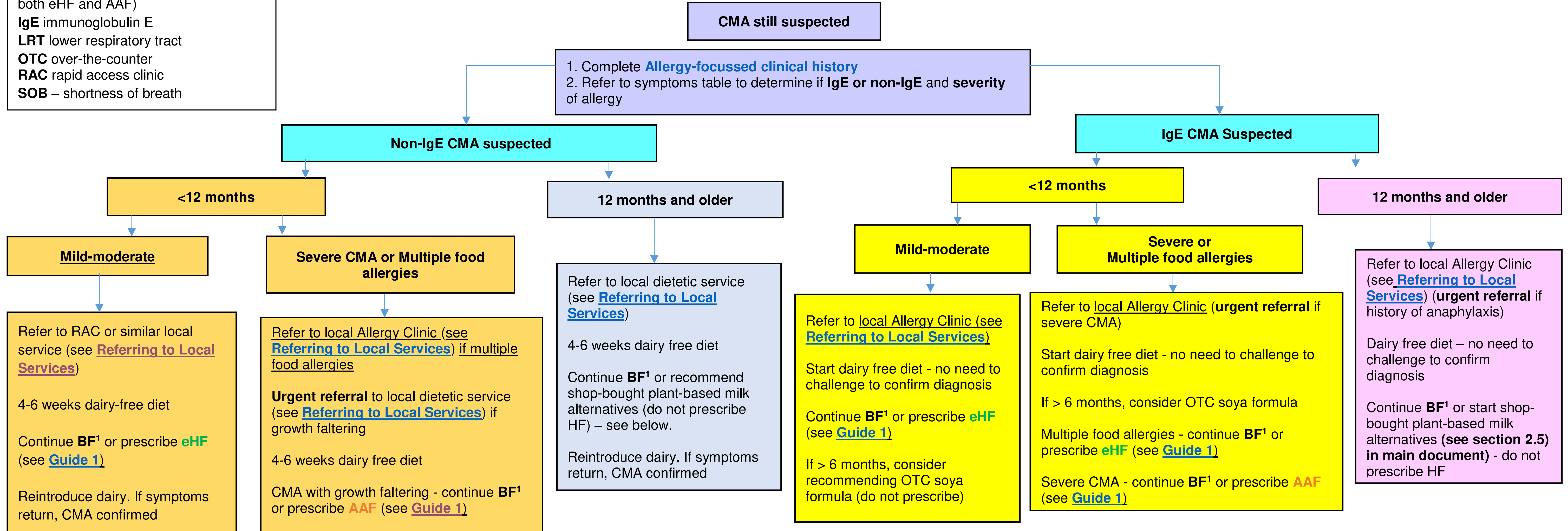
Abbreviation used	Meaning
AAF	amino acid formula
ACBS	Advisory Committee on Borderline Substances
BF	breastfeeding
CMA	cow's milk allergy
eHF	extensively hydrolysed formula
GORD	gastro-oesophageal reflux disease
GP	general practitioner
HCP	healthcare professional
HF	hypoallergenic formula (includes both AAF and eHF)
IgE	immunoglobulin E
LRT	lower respiratory tract
NEC	necrotising enterocolitis
OTC	over-the-counter
PSD	prescribing support dietitian
RAC	rapid access clinic
SEL	south east London
SOB	shortness of breath
URT	upper respiratory tract

NHS

Abbreviations:
CMA cow's milk allergy
BF breastfeeding.
eHF extensively hydrolysed formula
AAF amino acid formula
HF hypoallergenic formula (includes both eHF and AAF)
IgE immunoglobulin E
LRT lower respiratory tract
OTC over-the-counter
RAC rapid access clinic
SOB – shortness of breath

1. Algorithm 1: Diagnosis and Management of Cow's Milk Allergy Quick Reference for GPs

[1]**Protect, promote and support breastfeeding.** Maternal dairy free diet is **not** recommended if no symptoms when exclusively breastfeeding



Symptoms table to determine if IgE or non-IgE and severity of allergy

Non-IgE CMA (symptom onset: 2-72 hours)		**IgE CMA** (symptom onset: minutes – 2 hours)	
Mild – Moderate	**Severe**	**Mild – Moderate**	**Severe**
Pruritus Erythema Atopic eczema		Pruritus Erythema Urticaria Flaring of persistent atopic eczema	
GORD Diarrhoea Blood/mucous in stools Abdominal pain Infantile colic Feeding difficulties Constipation	Faltering growth	Angioedema Oral pruritus Extreme colicky abdominal pain Vomiting Diarrhoea	Faltering growth
Cough, chest tightness, wheezing, or SOB		Nasal itching, sneezing, rhinorrhoea, or congestion Cough, chest tightness, wheezing, or SOB	Anaphylaxis

Volume Tables:

1. Volume required if mixed-fed (Based on daily intake of formula as reported by carer)

oz/day	ml/day	g/28 days
10oz	300ml	1600g
14oz	400ml	2000g
17oz	500ml	2400g
20oz	600ml	2800g
24oz	700ml	3200g
27oz	800ml	3600g
30oz	900ml	4000g
33oz	1000ml	4400g
36oz	1100ml	4800g

2. Volume required if exclusively formula fed

Age	g/28 days
0-3 months	4000g
3-6 months	5200g
6-9 months	4000g
9-12 months	3200g
12-14 months	2400g

Shop-bought plant-based milk alternatives suitable for >12 months:
Soya-, oat-, coconut- and pea-based drinks enriched with calcium.
Not suitable:
Rice-based milk alternative, organic and low-calorie varieties (e.g. "light")
See section 2.5 in main document for further information.

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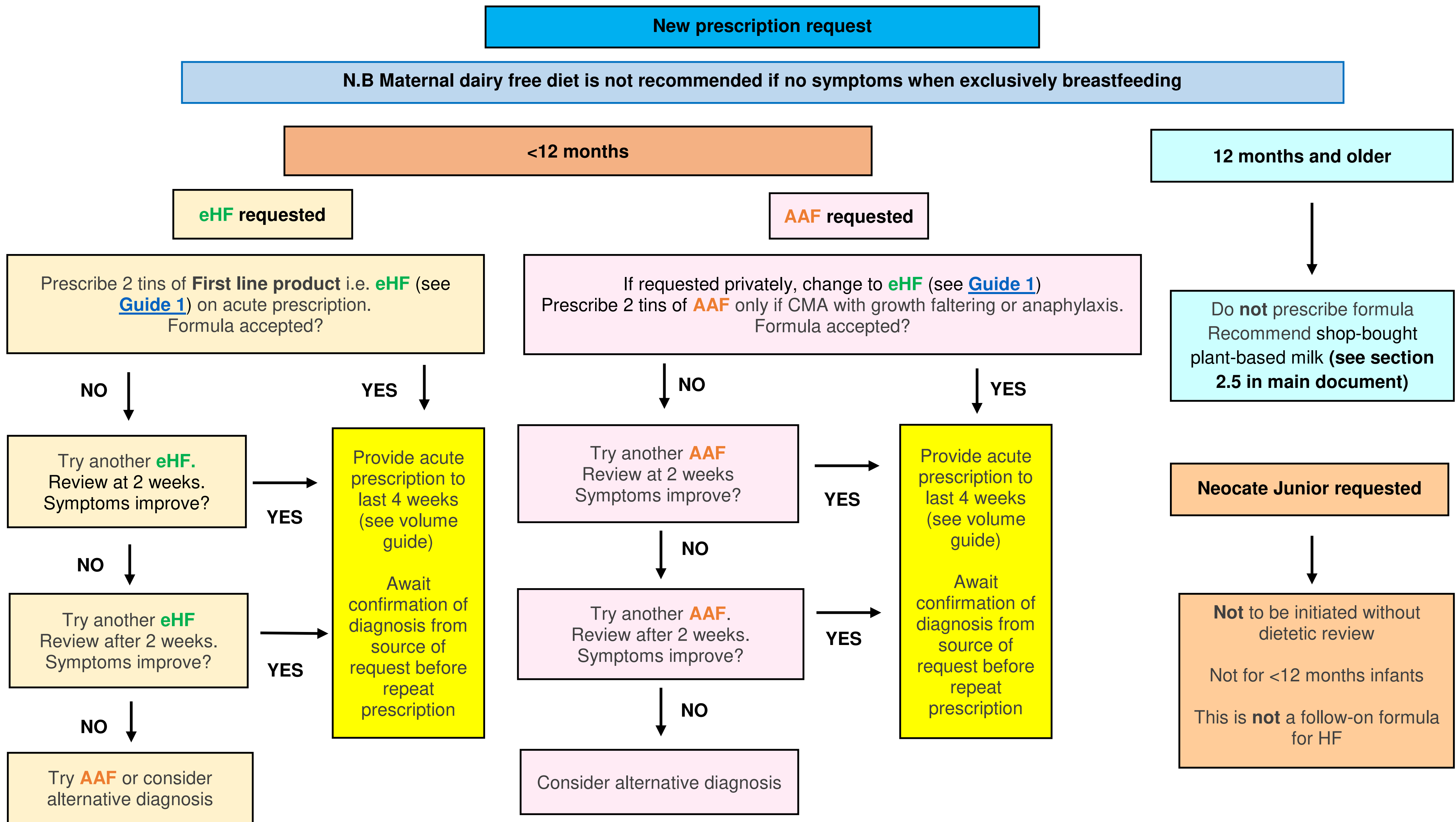
Algorithm 2: Guide for Prescribing Hypoallergenic Formula for GPs and Pharmacists



OTC products (do not prescribe) - Soya formula, Lactose-free formula, Anti-reflux formula, Comfort formula, Carobel

Repeat prescription request

EMIS prescription template review guide

- Ensure it has been documented on prescription request letter that diagnosis of CMA has been confirmed before providing repeat prescription. If no confirmation of diagnosis has been provided, contact request source.
- Add: next **review date** (review prescription against volume based on age or intake every 3 months) and **prescription end date** within dosage instruction (Date when patient is 14 months of age)
- Adjust volume:
  1. Volume recommendation from dietitian letter
  2. If not available, use volume recommendation (see Guide 1) based on age/ intake
- Child should transition from formula to an appropriate shop-bought plant-based milk **(see section 2.5 in main document)** from 12 months of age
- Stop prescription if:
  - tolerating dairy in diet
  - >14 months of age: unless advised by dietitian (check recent dietetic letter)

Neocate Junior

Prescription review process

1. Review 3 monthly until prescription is no longer required.
2. Check to ensure that dietetic review has been completed within the last 6 months (check latest dietetic correspondence letter) and re-refer if no evidence of dietetic input within the last 6 months.

Refer to dietetics service if dietetic input not yet received as all infants with suspected/confirmed CMA should receive dietetic support. See Referring to Local Services

Contact SEL Prescribing Support Dietitians gst-tr.prescribingsupportdietitians@nhs.net **if:**

- Unsuccessful transition onto shop-bought plant based milks at 14 months of age despite giving advice on transition
- Patient with active HF prescription has been discharged from local dietetics service due to DNA or not making contact
- Any other HF prescription queries

Volume Guide:

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14oz	400ml	2000g
17oz	500ml	2400g
20oz	600ml	2800g
24oz	700ml	3200g
27oz	800ml	3600g
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33oz	1000ml	4400g
36oz	1100ml	4800g

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HF hypoallergenic formula (includes both eHF and AAF)
IgE immunoglobulin E
OTC over-the-counter
RAC rapid access clinic
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Section 1

1.1 Introduction

Cows' milk allergy typically presents in the first year of life and affects approximately 1% of infants in the UK[1], with a lower likelihood in exclusively breastfed infants[2]. Most children outgrow non-immunoglobulin E (non-IgE) mediated allergy within 1 year of diagnosis, while IgE-mediated CMA may be outgrown later[1].

The majority of infants with non-IgE CMA are managed in primary care, there is evidence of significant variation in practice (such as over interpretation of symptoms therefore resulting in over diagnosis of CMA[1] and inappropriate prescribing of hypoallergenic formula), frequent delays in diagnosis and sub-optimal management of infants with a suspected CMA. This has resulted in poorer quality of life for families, high numbers of GP visits (average of 9 weeks with numerous GP visits before child was diagnosed correctly with CMA) and therefore delay in initiation of appropriate diet[3].

The cost of HF prescribed in 2020/2021 was ≥£1.3 million in South East London (SEL), with 63% of this spend attributed to amino acid based formula (AAF). Only 64% of all HF prescriptions were for extensively hydrolysed formula (eHF), while NICE recommends that eHF is tolerated by 90% of CMA patients[4]. The implication of which suggests there is potential to significantly reduce spending on hypoallergenic formula with more appropriate prescribing as AAF is twice as expensive as eHF.

1.2 Scope

This guideline aims to support health care professionals in the current clinical management of CMA (consistent with the international Milk Allergy in Primary Care iMAP guidelines[5]), best practice for prescribing hypoallergenic formula within SEL primary care and referral guidance to paediatric dietetic and allergy clinics within SEL secondary care.

This guideline is designed for use by general practitioners (GPs), medicines optimisation teams, acute and community dietitians, health visitors, pharmacists and any other health care professionals involved in the care of infants and children who may present with CMA.

A Prescribing Support Dietetic (PSD) service has been commissioned across SEL. The service is part of the Medicine Optimisation work stream to support primary care teams. The goal of this service is to ensure appropriate prescribing of hypoallergenic formula (HF) in line with ACBS prescribing criteria and SEL guidelines and, for patients who do meet prescribing criteria, that they are prescribed the most clinically appropriate formula and provided with appropriate dietetic support.

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Section 2: Clinical guideline

2.1 Breastfeeding and Support

Most women can successfully breastfeed their infant but will benefit from **help and support** to achieve this. Any mother that wishes to breastfeed but is having difficulties or needs support should be referred to their local health visiting teams or breastfeeding support team. It is rare that breastfeeding would need to stop for infants with CMA. Every effort should be made to support and encourage the continuation of breastfeeding where it is clinically safe and the mother is in agreement. Breastmilk is the ideal source of nutrition for infants. The prevalence of CMA in exclusively breastfed babies (0.5%) is much lower than formula fed babies[2].

CMA related symptoms often present at a similar time to more common infant conditions such as colic and reflux (usually in the first few weeks/ months after birth). This period also coincides with mothers trying to establish breastfeeding with their babies. In the first instance, it is important to refer mothers who present their babies with feeding issues for assessment and support on breastfeeding. This will ensure breastfeeding technique is optimised and the more common childhood conditions such as colic, reflux and constipation are addressed with first line treatment.

Table 1: Contact details for health visiting teams and breastfeeding support across SEL boroughs

	Health Visiting Teams	Breastfeeding Support
Bexley	Bexley 0-4 Children's Public Health Service	Refer via email or phone: 0300 330 5777 bromh.bexley0to19@nhs.net
Bromley	Bromley 0-4 years Public Health Service	Refer via email or phone: 0300 330 5777 bromh.bromley0to19@nhs.net Bromley Breastfeeding groups
Greenwich	Greenwich 0 to 4 years Health Visiting service 020 8161 0530 Bromh.greenwich0to4admin@nhs.net/ bromh.cat@nhs.net	Refer via email: bromh.greenwichinfantfeedingteam@nhs.net
Lambeth	Lambeth & Southwark Health Visitor teams 020 3049 5300 gst-tr.spahealthvisitingservicelambeth@nhs.net	Refer via email: referralsbreastfeedingservice@gstt.nhs.uk Breastfeeding support for Lambeth & Southwark
Lewisham	Lewisham Health Visitors 020 3049 1873	Refer via email: lg.breastfeedingvirtualhubs@nhs.net Breastfeeding hubs in Lewisham
Southwark	Lambeth & Southwark Health Visitor teams 020 3049 8166 gst-tr.spahealthvisitingservicesouthwark@nhs.net	Refer via email: gst-tr.southwarkbreastfeedingreferral@nhs.net Breastfeeding support for Lambeth & Southwark

Useful resources for parents and health professionals:

- www.firststepsnutrition.org
- https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/breastfeeding-resources

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2.2 Treatment of common childhood conditions

Key Message
• Approximately 40% of infants in the UK have reported reflux[6], 15% in England are affected by eczema[7], 15% and 21% worldwide have constipation[8] and colic[9] while <1 % of infants in Europe are affected by CMA[1] • Symptoms of being unsettled, irritable, colic, reflux or constipation may be due to feeding techniques – refer to health visiting team or infant feeding team for assessment and support. • Patients with one non-IgE symptom **(Table 2)** and no family history of atopy, should be advised to trial 1st line treatment for the symptom for at least 2 weeks before suspecting CMA. • Consider CMA if patients present with one or more CMA related symptoms and immediate family history of atopy. • **Do not** prescribe anti-reflux formula, lactose free formula, soya formula or 'comfort' formula.

1st line treatment for common childhood conditions without family atopy	• Constipation: NICE Knowledge summary: Constipation in children[10]
	• Gastro-oesophageal reflux disease (GORD): NICE Guidelines (NG1): Gastro-oesophageal reflux disease in children and young people: diagnosis and management[6].
	• Colic: NICE Knowledge summary: Colic – infantile[11].
	• Atopic eczema: NICE Guidelines (CG57): Atopic eczema in under 12s: diagnosis and management[12].
	• Lactose intolerance: a condition which occurs as a result of a deficiency of the lactase enzyme in the intestine (not CMA). Symptoms occur as a result of lactose malabsorption and include abdominal distension, abdominal pain and diarrhoea.
	  o Secondary lactose intolerance is a temporary phenomenon, which results from injury to the gut wall following acute gastroenteritis. This usually resolves within a 2-4 weeks.
	  o Primary lactose deficiency is uncommon in Western Europe and is very rare in infants[13]. It is due to a decline in activity of the lactase enzyme, which can occur at varying rates, from a few months of age.

Formula available OTC	The following products may be considered to address the conditions above – **do not prescribe.** They are similar in price to normal formula. Anti-reflux formula Lactose free formula 'Comfort' formula

Resources for parents	• **Reflux:** www.livingwithreflux.org/ includes a Facebook support page
	• **Colic:** CRY-SIS support group: www.cry-sis.org.uk Helpline number: 08451 228 669 (9.00-22.00 daily)
	• **Eczema:**
	  • Short videos explaining difference between emollients, steroids etc. https://www.guysandstthomas.nhs.uk/our-services/dermatology/dermatology-videos.aspx
	  • Practical advice on eczema care plan, application of emollient, bathing etc. https://www.itchysneezywheezy.co.uk/EczemaVideos.html
	  • Eczema society factsheets https://eczema.org/information-and-advice/eczema-booklets-factsheets/factsheets/

Referrals required	• Secondary care specialists as per NICE guidelines • Refer to health visiting/infant feeding team for breastfeeding assessment and support • Refer to health visiting/infant feeding team for bottle feeding support See **Referring to Local Services**

2.3 Diagnosis and Management of Cow's Milk Allergy

Step 1: Presentation

Key Message
• The immune response to cow's milk protein can be subdivided into IgE and non-IgE CMA • Diagnostic pathway is different for suspected non-IgE (Step 2a) and IgE CMA (Step 2b) • Diagnosis for suspected non-IgE CMA is a two-step process (1. Elimination diet for at least 4-6weeks. 2. Reintroduce dairy to confirm or exclude CMA) • Patients with one non-IgE symptom and no family history of atopy – trial 1st line treatment for the symptom (for at least 2 weeks) before suspecting non-IgE CMA

Allergy Focused Clinical History

Completing an allergy focussed clinical history is a key step in appropriately diagnosing CMA. The **Allergy-Focused Clinical History form** should be used to help determine whether the patient is presenting with suspected IgE or non-IgE CMA, and is also required for referral to SEL Telephone Non IgE-mediated CMA Rapid Access Clinic (RAC).

When completing an allergy focused clinical history ensure the following is considered:

- Does the patient have a history or immediate family history of atopy? This increases likelihood of food allergy.
- Examine the child to check for signs of allergy-related morbidities e.g. atopic eczema.

Table 2: Presenting symptoms that may be associated with CMA[14]

Presentation	**Non-IgE** (Symptom onset: 2-72 hours)		**IgE** (Symptom onset: minutes – 2 hours)	
	Mild – Moderate	**Severe**	**Mild – Moderate**	**Severe**
Skin	Pruritus Erythema Atopic eczema		Pruritus Erythema Urticaria Angioedema: commonly of the lips, face and around the eyes Flaring of persistent atopic eczema	
Gastrointestinal	Gastro-oesophageal reflux disease (GORD) Loose or frequent stools Blood and/or mucous in stools Abdominal pain Infantile colic Food refusal or aversion Constipation – especially soft stools with excess straining Perianal redness	Faltering growth with at least one or more mild – moderate symptoms	Angioedema of the lips, tongue and palate Oral pruritus Extreme colicky abdominal pain Vomiting Diarrhoea	Faltering growth with at least one or more mild-moderate symptoms
Respiratory (usually in combination with other symptoms)	Lower respiratory tract (LRT) — cough, chest tightness, wheezing, or shortness of breath (SOB)		LRT— cough, chest tightness, wheezing, or SOB Upper respiratory tract (URT) — nasal itching, sneezing, rhinorrhoea, or congestion (with or without conjunctivitis)	Anaphylaxis involving respiratory and/or cardiovascular system signs and symptoms

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Step 2a: Diagnostic pathway for suspected non-IgE CMA

Key Messages
• Refer all suspected non-IgE CMA patients to dietetics (see **Referring to Local Services**) • Diagnosis is a TWO-STEP process: elimination diet for 4-6 weeks and reintroduction of dairy to confirm or exclude CMA • Only advise maternal dairy-free diet if you suspect that child is reacting to cow's milk proteins transferred via breastmilk. • Provide acute prescription only before diagnosis is confirmed • Severity of symptoms determine type of HF to prescribe Patients over 1 year: do not prescribe hypoallergenic formula

Diagnostic Two-step process	Refer all suspected non-IgE CMA patients to RAC for diagnosis and management advice 1. Trial of strict dairy exclusion (4-6 weeks) • Exclusively breastfed fed: maternal dairy-free diet • Mixed-fed/exclusively formula fed: hypoallergenic formula and strict dairy-free diet for infant • Advise maternal dairy-free diet if exclusively breastfeeding or if mixed fed infants' symptoms do not improve on extensively hydrolysed formula i.e. you suspect that child is reacting to cow's milk proteins transferred via breastmilk • Patients over 1 year: advise dairy free diet and shop-bought plant based milk alternatives as main drink • Refer to 2.4 Dairy free general advice **(see Section 2.4)** 2. Reintroduce dairy after 4-6 weeks using iMAP Home Challenge[15] • CMA confirmed if symptoms return after reintroduction of dairy • CMA excluded if no change or no return of symptoms after reintroduction of dairy
Prescription (for infants under 1 year of age only)	• Prescribe HF if patient is exclusively formula or mixed-fed. o Mild-moderate symptoms: eHF o Severe symptoms: AAF • See **Guide 1** for product names and refer to Section 3: Prescribing Guideline • Use **Guide 2** for support for transition onto HF • First acute prescription: 2 tins to establish acceptance • If accepted: second acute prescription to last the 4 weeks trial
Volume guide	• Exclusively formula fed: use volume guide according to age or intake. Refer **Guide 1** • Mixed fed patients: Ask parent for their total intake per day to determine the volume to prescribe.
Resources for parents	GP Infant Feeding Network - iMAP home reintroduction, CMA information sheet for parents, CMA information sheet for exclusively breastfed infant[15]
Referral	• Patients under 1 year of age: Telephone Non IgE-mediate CMA RAC (see **Referral Form for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic** and **Pathway for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic**) • Patients over 1 year of age: refer to local dietetic service (see **Referring to Local Services**)

Step 2b: Ongoing management for confirmed Non-IgE CMA

Key Messages
1. Only provide repeat prescription if diagnosis is confirmed (iMAP home reintroduction)[15] 2. Add review date to prescription template on electronic record (3 monthly) 3. Add prescription end date to 'dosage instruction' (date when patient is 14 months of age) 4. Dairy reintroduction should be initiated after patient has been symptom free for 6 months or when infant is 9-12 months (iMAP milk ladder)[15] 5. Patients with persistent allergy to cow's milk protein at 12 months old can transition onto shop-bought plant-based milk alternative **(see Section 2.5)** 6. Stop prescription when it is noted that patient tolerates dairy (cow's milk and milk products)

Ongoing management	• SEL CMA RAC will advise on: - Dairy-free weaning - Dairy reintroduction after 6 months or when infant is 9-12 months (iMAP milk ladder)15 - Transition onto shop-bought plant based milk alternative at 12 months • Infant should be on a dairy-free diet until 9-12 months of age or for at least 6 months • Patients with persistent allergy to cow's milk protein at 12 months old can transition onto plant-based milk alternative **(see Section 2.5)** in place of formula provided there are no concerns raised regarding growth or parental concerns regarding nutritional adequacy of diet. • Re-refer to dietetics (see **Referring to Local Services**) if concerns are raised in this regard
Prescription	Provide a repeat prescription for HF only if diagnosis is confirmed (iMAP home reintroduction)[15]
Referral	• Refer to local dietetic team (see **Referring to Local Services**) if concerns raised regarding growth and/or nutritional adequacy of diet.

Step 3a: Diagnostic pathway for suspected IgE CMA

Key Message
1. Refer all suspected IgE CMA patients to allergy clinic (see **Referring to Local Services**) 2. for appropriate testing and management 3. Diagnosis does not require home reintroduction of dairy 4. Only advise maternal dairy-free diet if you suspect that child is reacting to cow's milk proteins transferred via breastmilk 5. Severity of symptoms determine type of HF to prescribe 6. Patients over 1 year: do not commence hypoallergenic formula

Diagnostic	Appropriate tests in specialist allergy service. Suspect IgE CMA when symptoms **(hyperlink Table 2)** occur within 0-2 hours of exposure to dairy. Do not advise home reintroduction of dairy to confirm diagnosis.
Medical treatment	• Exclusively breastfed: Strict maternal dairy-free diet **(see Section 2.4)** • Mixed fed/exclusively formula fed: prescribe HF and recommend dairy-free diet for infant. • Only advise maternal dairy-free diet if exclusively breastfeeding or if mixed fed infants' symptoms do not improve on extensively hydrolysed formula i.e. you suspect that child is reacting to cow's milk proteins transferred via breastmilk • Patients over 1 year: advise dairy free diet and shop-bought plant based milk alternatives as main drink

Prescription (exclusively formula fed or mixed fed)	Acute prescription: 2 tins to establish acceptance. If accepted: prescribe ongoing
	• Prescribe HF if patient is exclusively formula or mixed-fed.
	  ○ Mild-moderate symptoms: eHF
	  ○ Severe symptoms: AAF
	• See **Guide 1** for product names and refer to Section 3: Prescribing Guideline
	• Use **Guide 2** for support for transition onto HF
	• First acute prescription: 2 tins to establish acceptance

Volume guide	• Exclusively formula fed: use volume guide according to age or intake • Mixed fed patients: Ask parent for their total intake per day to determine the volume to prescribe • Refer to **Guide 1** for volume guide according to age/intake
Resources for parents	Allergy UK[16] Anaphylaxis Campaign[17] Provide a management plan to carers. Templates for management plans are available on the British Society for Allergy and Clinical Immunology (BSACI) website[18]
Referral	Specialist Allergy Service to confirm diagnosis with appropriate tests and provide support for ongoing management. Bromley GPs should also refer to Bromley Health Dietetics Bexley GPs should also refer to Darent Valley Dietetics Please see **Referring to Local Services** for contact details and how to refer to the above services.

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Step 3b: Ongoing management for confirmed IgE CMA

Key Message
1. GPs/pharmacists to review prescription every 3 months and end prescription by 14 months of age unless otherwise advised by Allergy Dietitian 2. Patients with persistent allergy to cow's milk protein at 12 months old can transition onto a shop-bought plant-based milk alternative **(see Section 2.5)** in place of formula 3. Stop prescription when it is noted that patient tolerates dairy (cow's milk and milk products)

Ongoing management	• Strict dairy-free diet. Allergy team will provide advice for reintroduction of dairy in controlled setting where appropriate • Allergy dietitian will provide advice for milk free weaning and transition onto plant based milk alternative • Patients with persistent allergy to cow's milk protein at 12 months old can transition onto a shop-bought plant-based milk alternative in place of formula provided there are no concerns raised regarding growth or nutritional adequacy of diet.
Prescription	Refer to Section 3: Prescribing Guideline and **Guide 1**
Volume guide	• Exclusively formula fed: use volume guide according to age or intake • Mixed fed patients: Ask parent for their total intake per day to determine the volume to prescribe Refer to **Guide 1** for volume guide according to age/intake

2.4 General recommendations for dairy-free diet

The dietary recommendations for children with CMA vary depending on their feeding regime. Breast milk is the ideal nutrition for infants with CMA and any decision to initiate an elimination diet must include measures to ensure that breastfeeding is actively supported.

Table 3: General recommendations for dairy-free diets

Exclusively breastfed	Exclusively formula-fed or mixed-fed	Taking solids
• Recommend exclusive breastfeeding for 26 weeks (6 months), with continued breastfeeding up to 2 years and beyond[19]. • Only recommend maternal dairy-free diet if it is clear that the child is symptomatic following breastmilk ingestion • Milk alternatives for dairy free mothers: soya, oat, coconut, pea, nut based milks fortified with calcium (and iodine and vitamin B12 if maternal diet is predominantly plant-based) • Mothers should be advised to meet daily calcium (1250mg/d) and vitamin D (10mcg/d) requirements, which usually requires additional calcium and vitamin D supplementation • Consider additional maternal soya exclusion if the infant remains symptomatic (but symptoms have partially improved). Seek advice from a paediatric dietitian (see **Referring to Local Services**)	• Replace cow's milk formula with an appropriate HF (see **Guide 1**). • For mixed-fed infants, if symptoms occurred only with the introduction of top-up formula feeds, replace these with HF top-ups and the mother can continue to consume foods containing cows' milk protein. • For mixed-feeding, refer mother to local specialist/additional breastfeeding support **(see Section 2.1)** for support with return to exclusive breastfeeding or increased breastmilk if this is mother's choice.	• Exclude all dairy and dairy products from the child's diet and recommend a suitable milk alternative. • Soya formula (purchased over-the-counter – do not prescribed) can be recommended for infants between 6-12 months, but if this is not tolerated (suggesting soya allergy) an appropriate HF should be prescribed. Infants who have been tolerating soya formula at < 6 months can continue this after 6 months of age. • Introduce milk free solids no earlier than 17 weeks. • Consider additional soya exclusion if the child remains symptomatic (but symptoms have partially improved). Seek advice from a paediatric dietitian (see **Referring to Local Services**)

2.5 Shop-bought plant-based milk alternatives

At 6-12 months, soya formula is suitable as an alternative formula, provided the child is not allergic to soya[20]. This should be purchased over the counter and **not prescribed.**

Plant-based milk alternatives with added calcium are suitable to be added into food from 6 months of age. Most children can safely transition onto these milk alternative in place of formula from 12 months of age, provided they are eating well and growing well. Re-refer to dietetics (see **Referring to Local Services**) or consult with the prescribing support dietetic service if concerns are raised regarding growth and/or nutritional adequacy of the diet for bespoke support for this transition.

The transition should only take a few days for these patients but an allowance of prescription formula up to 14 months of age should be sufficient for those who take longer to adopt the change.

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Suitable plant-based milk alternatives	Unsuitable plant based milk alternatives
We recommend products containing a minimum of 40kcal, 1g protein and 120mg calcium per 100ml made from plant-based sources such as (provided not allergic to): Soya Oat Coconut Pea	Organic varieties "Light" varieties Rice milk is not suitable for children under 5 years of age Mammalian milks such as goat or sheep milk

Benefits of transitioning onto plant-based milk alternatives

- Helps to normalise diet as much as possible – plant-based milk alternatives are ready to use.
- The majority of these products contain more calcium compared to HF, and most soya-based options contain more protein than HF.

Useful tips for transitioning

- Prompt introduction of plant based milk alternatives during the weaning stage (i.e. adding into cereals, porridge, mashed potatoes and puddings) is likely to support acceptance of taste when transitioning from formula to plant based milk at 12 months.
- If a straight swap from formula to a plant based milk alternative is not successful, introduce it gradually over several days as tolerated.
- The Department of Health and Social Care recommends that babies from birth to 1 year should have a daily supplement containing 8.5 to 10mcg of Vitamin D throughout the year if they are breastfed or having less than 500ml formula daily[21].
- Children aged 1 to 4 years old should be given daily supplement containing 10mch of vitamin D throughout the year[21].

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Section 3: Prescribing Guideline

Please refer to Figure 2 and **Guide 1** for a quick guide to support appropriate prescribing of hypoallergenic formula in SEL.

Prescribing of hypoallergenic formula (HF) is governed by the Advisory Committee on Borderline Substances (ACBS). ACBS advice takes the form of its 'recommended list' which is published as Part XV of the Drug Tariff. It is essential that all prescriptions for hypoallergenic formula are made following clinical guidelines to ensure that they meet specific ACBS criteria, are clinically appropriate, and that first-line management for presenting symptoms has been trialled if non-IgE CMA is suspected.

3.1 Healthcare Professionals involved in the prescribing of HF

It is important that prescriptions for HF are **started**, **reviewed** and **stopped** appropriately in order to provide best clinical practice, reduce the potential risk of compromising the nutritional status of the child and avoid unnecessary cost.

The following healthcare professionals may be involved in the prescribing of hypoallergenic formula:

- GP
- Pharmacists (please refer to prescription review guide for pharmacists in Figure 2)
- Acute or community paediatric dietitian
- Acute or community paediatrician
- Health visitor
- Consultant paediatrician or dietitian in private practice
- Prescribing support dietitian

It is recommended that all healthcare professionals (HCPs) involved in a prescription take responsibility for ensuring that the prescription is clinically appropriate, and that it is reviewed and stopped when appropriate. It is recommended that any HCP requesting an NHS prescription for HF from the patient's GP should provide an end or review date for the prescription. Please refer to **Letter 1** for a recommended letter template for dietitians initiating prescriptions for hypoallergenic formula.

Please refer to the South East London NHS and Private Interface Prescribing Guide[22] for prescription requests received from private health care professionals.

3.2 How to start a prescription for HF

3.1.1 Initial acute prescription (trial)

- **Extensively hydrolysed formula (eHF)** should be used **first-line** for mild-moderate CMA, as **90% of infants with CMA should tolerate eHF**[4].
- It is recommended that only **1 x 800g tin/2 x 400g tins** is/are prescribed initially until formula is accepted to avoid waste.
- If non-IgE CMA is suspected:
  - Review 1 week later and provide a second **acute** prescription to last 4 weeks if the formula is accepted symptoms improve, then refer to either the Telephone Non-IgE Cow's Milk Allergy Rapid Access Clinic if criteria met (see **Referral Form for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic** and/or **Pathway for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic**) or similar local service (see **Referring to Local Services**) for support with confirming the diagnosis for re-challenge.
  - Refer to **Guide 1** for recommended volumes to prescribe as a **4 week trial**. It is recommended that you ask the infant's parent/carer about their current daily formula consumption to guide the volume required.
  - **Second line option:** Patients who only partially respond to a trial of two different eHFs for a total of at least 4 weeks can be progressed to amino acid formula (AAF).
  - The dietitian may request another **acute** prescription to last until the challenge can be completed.

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- If IgE CMA is suspected (immediate reactions), provide a repeat prescription once patient is showing a response to the formula. There is no need to complete a milk challenge.
- AAF should only be prescribed for patients whose symptoms do not resolve after at least 4 weeks of eHF, first-line for severe IgE-mediated CMA (anaphylaxis), faltering growth (with symptoms of CMA). Only 10% of infants with CMA should require management with AAF[4].
- To improve acceptance, advise the parent/carer to mix the HF with their usual formula initially to introduce the taste **only if non-IgE CMA is suspected (do not recommend mixing for suspected IgE-mediated CMA).** Please refer to **Guide 2**. Note that improvement in symptoms will only be seen once the patient is exclusively on HF therefore do not include this transition period in the trial period.

3.1.2 Repeat prescription

- A **repeat** prescription for HF should only be provided once the diagnosis of non-IgE CMA has been confirmed using the iMAP Home Challenge. A letter should be provided by the dietetic service to request this. Please see **Letter 1** for the recommended letter template for requesting prescriptions.
- The exception is if IgE CMA is suspected. In these cases a repeat prescription should be prescribed once accepted and symptoms improve. There is no need to complete a milk challenge.
- Recommended age-related volumes for repeat prescriptions are outlined in tables 3 and 4. These tables are included in the recommended letter template for dietitians (**Letter 1**).
- Some children may require larger quantities e.g. faltering growing. Review recent correspondence from the paediatric dietitian.

See Guide 1 for hypoallergenic formulas which can be prescribed.

3.3 Reviewing prescriptions for HF

- It is recommended that volumes prescribed are reviewed by the GP/pharmacist every 3 months in order to ensure that the prescription meets the needs of the patient. Use tables 3 and/or 4 as a guide for reviewing volumes prescribed.
- It is recommended that the HCP requesting the prescription (e.g. paediatric dietitian) provides a prescription end date on their correspondence. See **Letter 1** for an example of a recommended prescription request letter template.
- The GP/pharmacist should also record the prescription end date and review date on their electronic record system, and request a prescription end date from the requesting HCP if this was not provided.
- In rare cases, where is a need for the prescription to continue beyond 14 months, this need should be reviewed at least every 6 months by a paediatric dietitian. If there is no review within 6 months, the prescription should be stopped.
- It is recommended that the parent/carer is provided with support for transitioning to an appropriate shop-bought plant-based milk alternative with added calcium from 1 year, until cow's milk is tolerated. Please refer **section 2.5**. If the child has non-IgE CMA, they should be provided with support on the iMAP Milk Ladder to reintroduce dairy back into the diet.

Patients discharged from dietetic services due to non-attendance/cancellation:

- **GP/pharmacists:** Review and stop or change prescription according to these guidelines.
- **Dietitians**: It is recommended that discharge letters from SEL dietetic service include the following statement: "If this patient has a prescription for formula, their prescription may be changed/discontinued according to SEL Guidelines if contact not made within 2 weeks of receiving this letter."
- Please see **Letter 2** for an example of a recommended discharge letter template.

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3.4 Stopping Prescriptions for HF:

Prescription for HF should be stopped when:
• It has been made apparent to the GP/pharmacist/dietitian that the patient tolerates dairy (cow's milk and milk products). • Diagnosis of non-IgE CMA has been excluded following iMAP Home Challenge i.e. symptoms did not return after reintroduction of cow's milk protein • Non-IgE CMA is suspected but parent/carer has failed to engage with dietetics to have diagnosis confirmed e.g. parent/carer does not attend dietetic appointment or fails to make contact • The child is **14 months** of age or older and there has been no correspondence from a paediatric dietitian or paediatrician with instructions to continue the prescription in the last 6 months e.g. growth faltering or concerns regarding nutritional intake. • ***Please note that Neocate Junior® is a high calorie amino acid-based supplement. It is not a follow-on formula for AAF and should only be prescribed if a paediatric dietitian has provided written justification. Again, this needs to be reviewed at least every 6 months by a paediatric dietitian in order to continue the prescription. Patients should not be discharged from dietetic services until Neocate Junior® is no longer required.*** • Other products indicated for children older than 12 months e.g. Nutramigen 3 with LGG® are not recommended. Children older than 12 months should transition onto plant based milk alternatives or continue with their formula (e.g. Nutramigen 1 with LGG®).

3.5 Formulas not to be prescribed

The following products can be purchased over the counter at a similar price to that of standard formula therefore the SEL CCG does **not** support prescribing of these products. The pharmacist or prescribing support dietitian reserves the right to stop these prescriptions and advise the parent/carer to purchase them over the counter. The following products are **not** suitable for infants with CMA (except for soya formula).

- Soya formula (suitable for CMA from 6 months only, if soya is tolerated)
- Lactose-free formula
- "Anti-reflux" (pre-thickened) formula
- "Comfort" or "H.A" formula

3.6 Inappropriate prescribing of HF

Table: Inappropriate use of hypoallergenic formula and actions to take

Scenario	Action	Justification
Patient with suspected non-IgE CMA has a prescription for HF but diagnosis is not confirmed.	Refer to Telephone non-IgE mediated cow's milk allergy rapid access clinic if criteria are met (see **Referral Form for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic** and/or **Pathway for Telephone Non IgE-mediated Cow's Milk Allergy Rapid Access Clinic**)/ local dietetic service (see **Referring to Local Services**). Stop prescription if appointment is not attended or parent/carer declines input.	Prescription cannot be considered clinically appropriate.

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Prescription volume for HF exceeds what is recommended for age.	Reduce prescription to age-appropriate volume or review volume required with parent/carer. Refer to volume guide in **Guide 1**.	Excessive volumes incur unnecessary cost and may lead to waste. Patient intake may exceed what is recommended for age and may compromise nutritional intake e.g. from solid food.
Patient has a prescription for soya, lactose-free, "anti-reflux" (pre-thickened), "comfort" or "H.A" formula.	Stop prescription. Parent/carer is advised to purchase product from supermarket or pharmacy (over-the-counter).	These products are available commercially at a similar cost to that of standard formula. SEL CCG does not support their prescription.
Patient has a prescription for HF and is older than 14 months. There is no correspondence from a paediatric dietitian justifying a need to continue HF beyond 1 year.	Stop prescription for HF and recommend transition to a shop bought plant-based milk alternative Refer to **section 2.5** for recommended products. Refer to the local dietetic service (see **Referring to Local Services**) if there are any nutritional concerns e.g. growth concerns or restricted diet.	Children with CMA can transition to a plant-based milk alternative with added calcium, provided they are growing well and their nutritional intake is otherwise sufficient i.e. cow's milk is the only food requiring substitution.
Patient has a prescription for Neocate Junior® without clear justification from a paediatric dietitian.	Stop prescription and change to previously prescribed HF if patient is under 2 years. Refer to local dietetic service (see **Referring to Local Services**) for review.	Neocate Junior® is not a follow-on formula for AAF. It is a high energy amino acid supplement indicated only for children with CMA with growth faltering and/or unable to meet nutritional requirements with an appropriate cow's milk substitute.
Patient has a prescription for Neocate Junior® that was requested by a paediatric dietitian but there has been no dietetic review for more than 6 months.	Refer to local dietetic service for review. Do not issue prescription until the need for the prescription has been reviewed.	Prescription cannot be considered clinically appropriate.
Patient has a prescription for AAF due to having a history of necrotising enterocolitis (NEC) with subsequent malabsorption. They are now older than 6 months.	Refer to local dietetic service (see **Referring to Local Services**) for advice on reintroduction of cow's milk protein using the iMAP Milk Ladder. Stop prescription for AAF and recommend transition to a shop bought plant-based milk alternative if patient is older than 12 months and growing and eating well. Refer to **section 2.5** for recommended products.	Patients with a history of NEC requiring AAF are managed as non-IgE CMA. They are likely to acquire tolerance to cow's milk proteins from 6 months after commencing AAF or from weaning age.

Key Messages

- Ensure non-IgE CMA diagnosis is confirmed before providing a repeat prescription using iMAP Home Challenge: https://gpifn.org.uk/imap/
- Soya, lactose-free, "anti-reflux" (pre-thickened) and "comfort formulas"/"H.A" should be purchased OTC and not prescribed
- Neocate Junior® is not a follow-on formula for AAF
- eHF should always be prescribed first-line for mild-moderate CMA for at least 4-6 weeks (90% CMA infants/children should tolerate)
- Stop all HF prescriptions by 14 months unless otherwise recommended by a dietitian
- Review volumes of formula prescribed every 3 months.

References

1. Schoemaker, A.A., Sprikkelman, A.B., Grimshaw, K.E., Roberts, G., Grabenhenrich, L., Rosenfeld, L., Siegert, S., Dubakiene, R., Rudzeviciene, O., Reche, M. and Fiandor, A., 2015. Incidence and natural history of challenge-proven cow's milk allergy in European children–EuroPrevall birth cohort. *Allergy*, 70(8), pp.963-972.
   Available at:
   https://onlinelibrary.wiley.com/doi/pdf/10.1111/all.12630?casa_token=4LIM7zuH4wgAAAAA:Gf0KkJg34ZNoTYbWhf8CB6dZK4UxJ1xR8LcsX988R7DiH9QpOLs4gfz8yFldrjD9mSI5FeBBet_hVw
   Accessed on 11 April 2022.
2. Høst, A., Husby, S. and Østerballe, O., 1988. A prospective study of cow's milk allergy in exclusively breast-fed infants: incidence, pathogenetic role of early inadvertent exposure to cow's milk formula, and characterization of bovine milk protein in human milk. *Acta Pædiatrica*, 77(5), pp.663-670.
   Available at: https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1651-2227.1988.tb10727.x?casa_token=Oxr_fxkUrC0AAAAA:16YRf9edzGf0VuyQ2FqXerJHh6hS5ucvmUZAbvnVR5LvoQ88eILyplZIPxHG2DBX4DTMI4uIodqT6w
   Accessed on 11 April 2022.
3. Lozinsky, A.C., Meyer, R., Anagnostou, K., Dziubak, R., Reeve, K., Godwin, H., Fox, A.T. and Shah, N., 2015. Cow's milk protein allergy from diagnosis to management: a very different journey for general practitioners and parents. *Children*, 2(3), pp.317-329.
   Available at: https://www.mdpi.com/2227-9067/2/3/317
   Accessed on 11 April 2022.
4. Høst, A., Koletzko, B., Dreborg, S., Muraro, A., Wahn, U., Aggett, P., Bresson, J.L., Hernell, O., Lafeber, H., Michaelsen, K.F. and Micheli, J.L., 1999. Dietary products used in infants for treatment and prevention of food allergy. Joint statement of the European Society for Paediatric Allergology and Clinical Immunology (ESPACI) Committee on Hypoallergenic Formulas and the European Society for Paediatric Gastroenterology, Hepatology and Nutrition (ESPGHAN) Committee on Nutrition. *Archives of disease in childhood*, 81(1), pp.80-84.
   Available at: https://adc.bmj.com/content/archdischild/81/1/80.full.pdf
   Accessed on 11 April 2022.
5. Fox, A., Brown, T., Walsh, J., Venter, C., Meyer, R., Nowak-Wegrzyn, A., Levin, M., Spawls, H., Beatson, J., Lovis, M.T. and Vieira, M.C., 2019. An update to the Milk Allergy in Primary Care guideline. *Clinical and translational allergy*, 9(1), pp.1-7.
   Available at: https://ctajournal.biomedcentral.com/articles/10.1186/s13601-019-0281-8
   Accessed on 11 April 2022.
6. National Institute for Clinical Excellence, 2015. Gastro-oesophageal reflux disease in children and young people: diagnosis and management. NICE guideline [NG1].
   Available at: https://www.nice.org.uk/guidance/ng1/chapter/1-Recommendations#diagnosing-and-investigating-gord
   Accessed on 11 April 2022.
7. de Lusignan, S., Alexander, H., Broderick, C., Dennis, J., McGovern, A., Feeney, C. and Flohr, C., 2021. The epidemiology of eczema in children and adults in England: A population-based study using primary care data. *Clinical & Experimental Allergy*, 51(3), pp.471-482.
   Available at: https://onlinelibrary.wiley.com/doi/pdf/10.1111/cea.13784
   Accessed on 11 April 2022.
8. Levy, E.I., Lemmens, R., Vandenplas, Y. and Devreker, T., 2017. Functional constipation in children: challenges and solutions. Pediatric health, medicine and therapeutics, 8, p.19.
   Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774595/
   Accessed on 11 April 2022.
9. Vandenplas, Y., Abkari, A., Bellaiche, M., Benninga, M., Chouraqui, J.P., ÇokuĐraþ, F., Harb, T., Hegar, B., Lifschitz, C., Ludwig, T. and Miqdady, M., 2015. Prevalence and health outcomes of functional gastrointestinal symptoms in infants from birth to 12 months of age. *Journal of pediatric gastroenterology and nutrition*, 61(5), p.531.
   Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4631121/
   Accessed on 11 April 2022.
10. National Institute for Health and Care Excellence Clinical Knowledge Summaries – Constipation in children (revised November 2020)
    Available at: https://cks.nice.org.uk/topics/constipation-in-children/

Not to be used for commercial or marketing purposes. Strictly for use within the NHS.

Accessed on 11 April 2022.
11. National Institute for Health and Care Excellence Clinical Knowledge Summaries – Colic – Infantile (revised June 2017).
Available at: https://cks.nice.org.uk/topics/colic-infantile/
Accessed on 11 April 2022.
12. National Institute for Health and Care Excellence, 2007. Atopic eczema in under 12s: diagnosis and management. Clinical guideline [CG57].
Available at: https://www.nice.org.uk/guidance/cg57
Accessed on 11 April 2022.
13. Heine RG, AlRefaee F, Bachina P, De Leon JC, Geng L, Gong S, Madrazo JA, Ngamphaiboon J, Ong C, Rogacion JM. Lactose intolerance and gastrointestinal cow's milk allergy in infants and children–common misconceptions revisited. World Allergy Organization Journal. 2017 Dec; 10(1):1-8.
Available at: https://link.springer.com/article/10.1186/s40413-017-0173-0
Accessed on 11 April 2022.
14. National institute for Health Care Excellence Clinical Knowledge Summaries - Cow's Milk Allergy in Children (revised August 2021).
Available at: https://cks.nice.org.uk/topics/cows-milk-allergy-in-children/
Accessed on 11 April 2022.
15. GP Infant Feeding Network: Supporting Tools for the iMAP Algorithms available at: https://gpifn.org.uk/imap/.
Accessed on 11 April 2022.
16. Allergy UK factsheets.
Available at: https://www.allergyuk.org/information-and-advice/conditions-and-symptoms/469-cows-milk-allergy.
Accessed on 11 April 2022.
17. Anaphylaxis Campaign patient information available at: https://www.anaphylaxis.org.uk/living-with-anaphylaxis/care-and-medication/
Accessed on 11 April 2022.
18. British Society for Allergy and Clinical Immunology (BSACI) website.
Available at: https://www.bsaci.org/professional-resources/resources/paediatric-allergy-action-plans/
Accessed on 11 April 2022
19. World Health Organization. Global strategy for infant and young child feeding. World Health Organization; 2003.
Available at: https://www.who.int/publications/i/item/9241562218
Accessed on 11 April 2022.
20. Luyt D, Ball H, Makwana N, Green MR, Bravin K, Nasser SM, Clark AT. BSACI guideline for the diagnosis and management of cow's milk allergy. Clinical & Experimental Allergy. 2014 May: 44(5):642-72.
Available at: https://www.bsaci.org/wp-content/uploads/2020/09/Milk-guideline-pdf.pdf
Accessed on 8 April 2022.
21. Davies DS, Jewell T, McBride M, Burns H (2012). Department of Health and Social Care. Vitamin D-advice on supplements for at risk groups: Correspondence.
Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213703/dh_132508.pdf
Accessed on 4 May 2022.
22. South East London Integrated Medicines Optimisation Committee (SEL IMOC). (2019). *South East London NHS and Private Interface Prescribing Guide.*
Available at: https://selondonccg.nhs.uk/wp-content/uploads/dlm_uploads/2021/09/NHS-and-Private-Interface-Prescribing-Guide-2019-21.pdf
Accessed on 11 April 2022
23. National institute for Health and care excellence. Faltering growth: what is it? Last revised June 2018.
Available at: https://cks.nice.org.uk/topics/faltering-growth/background-information/definition/
Accessed on 11 April 2022.
24. Royal college of paediatrics and child health UK-WHO growth charts 0-4 years.
Available at: https://www.rcpch.ac.uk/resources/uk-who-growth-charts-0-4-years
Accessed on 11 April 2022.

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