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Cow's milk protein allergy in infants: Myth busting to provide clarity in clinical practice

Cow's milk protein allergy (CMPA) remains one of the most commonly diagnosed food allergies in infancy, yet it is also one of the most misunderstood. Despite the availability of national and international guidelines, myths persist—among healthcare professionals, parents, and even within clinical pathways. These misconceptions can delay diagnosis, prolong symptoms, and contribute to unnecessary dietary restrictions or emotional distress.

As paediatric dietitians, we are often the first point of contact for families navigating the complexities of CMPA. Our role is not only to provide nutritional guidance but also to offer clarity, reassurance, and practical strategies that support behaviour change and improve outcomes. This article explores four persistent myths encountered in my clinical practice and offers evidence-based approaches to debunk them, drawing on my experience as well as current guidelines.

Myth 1

Infants with eczema are rarely allergic to cow's milk protein (CMP)

Eczema, or atopic dermatitis (AD), is frequently treated as a skin-only condition. However, in infants, especially those under 6 months, it may be a visible manifestation of an underlying food allergy, including CMPA. One of the most common misconceptions I encounter is the belief that eczema and food allergy are unrelated, particularly among general practitioners and non-specialist clinicians.

In practice, I regularly see infants with persistent, moderate to severe eczema who have undergone multiple courses of topical steroids with little improvement. Parents often arrive at the clinic feeling unheard and desperate for answers. They are not just seeking better creams; they are seeking clarity.

Studies show that approximately one-third of children with AD have a confirmed food allergy, and nearly half are sensitised to food allergens, with higher prevalence in severe cases.[1] We know that CMPA is a common culprit, particularly in infants with early-onset eczema, poor response to topical treatments, and co-existing gastrointestinal symptoms.[2]

What I look out for is the following, eczema onset before 3 months of age, poor response to emollients and topical steroids, gastrointestinal or respiratory symptoms, faltering growth, and a family history of allergy.

For breastfed infants, a 2-4 week maternal elimination of cow's milk protein may be trialled, ensuring nutritional adequacy through dietetic support.[3,4] For formula-fed infants, guidelines recommend a trial of up to 6-8 weeks may be needed in those with severe eczema[3] and the first line choice for these infants during the diagnostic elimination phase is an extensively hydrolysed formula (eHF).[3] However, in my experience amino acid-based formulas (AAF) seem to work best.

In my clinic, therefore, I often initiate AAF earlier in moderate to severe eczema cases. This approach has consistently led to faster symptom resolution, reduced reliance on topical steroids, and improved parental confidence. Once symptoms stabilise, a structured reintroduction confirms diagnosis, and a trial of eHF may be considered if appropriate.

Unsupervised elimination diets are common among families seeking answers online. I've seen children limited to fewer than 10 foods, resulting in worsening eczema, weight loss, and feeding aversion. Broad dietary restrictions without clinical supervision and unwarranted elimination diets can contribute to maternal nutritional deficits and even discontinuation of breastfeeding.[3] Dietitians are essential, therefore, to support families with targeted food elimination and reintroduction strategies.

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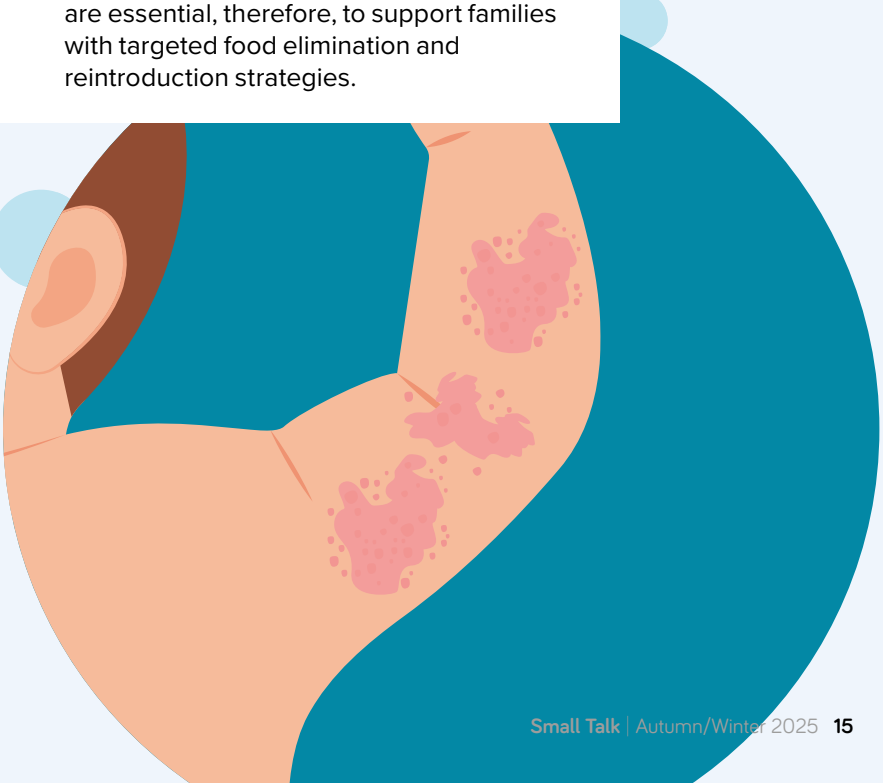


Myth 2

Lactose should be eliminated from the diet in children with CMPA

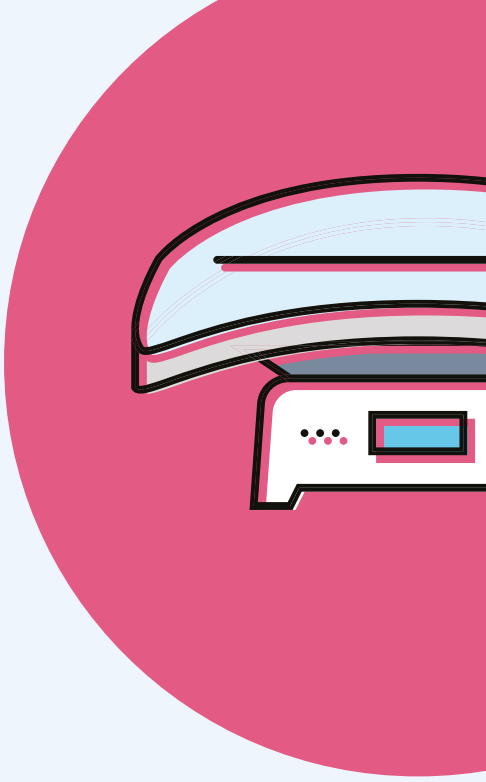
Another widespread myth is the belief that lactose must be removed from the diet of infants with CMPA. This stems from misinformation confusing CMPA with lactose intolerance – two distinct conditions with different mechanisms and therefore different management approaches.

CMPA is an immune-mediated reaction to milk proteins (casein and whey), while lactose intolerance results from lactase enzyme deficiency.[5] Primary lactose intolerance rarely occurs before the age of five years, while secondary lactose intolerance, often temporary, may occur due to viral gastroenteritis, giardiasis, cow's milk enteropathy (or CMPA).[5]

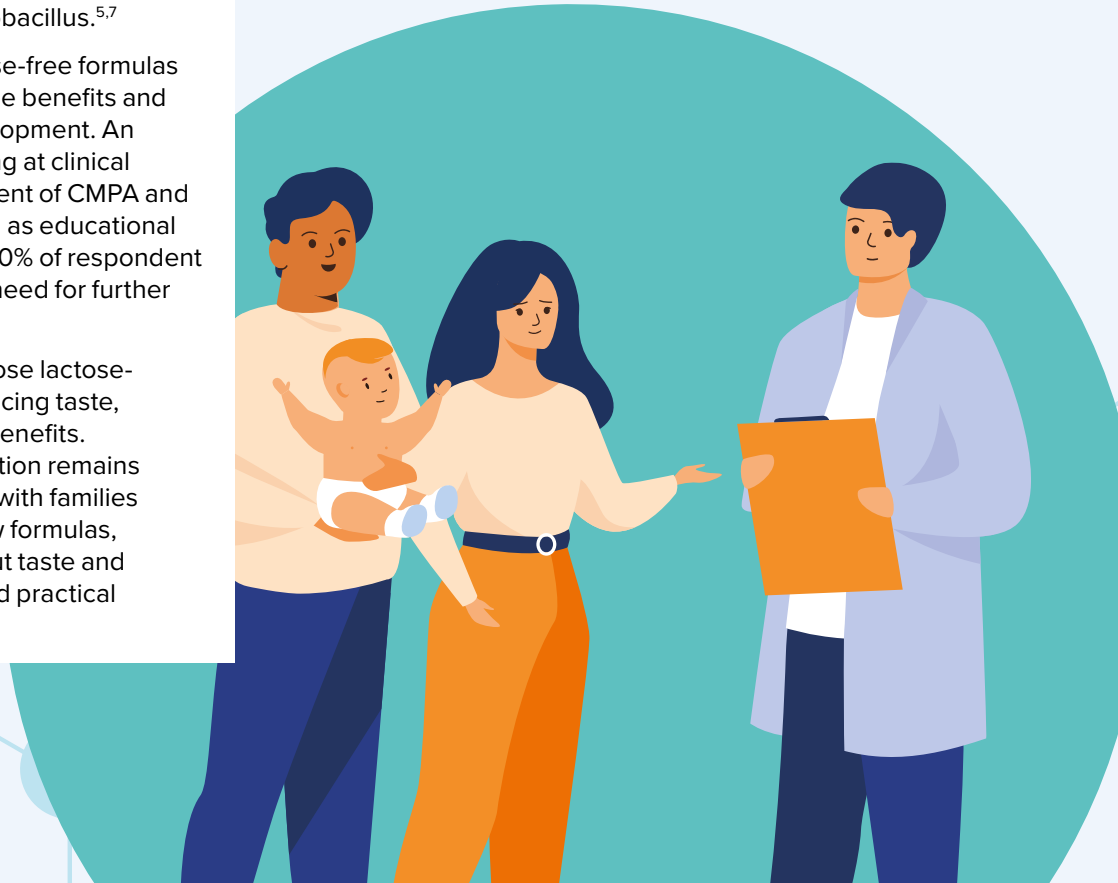
Breastmilk is full of lactose, being the largest solid component and plays several important roles in infant nutrition: it improves palatability[5] and potentially enhances nutrient uptake such as calcium,[6] and promotes the growth of some beneficial gut bacteria including species of Bifidobacterium and Lactobacillus.[5,7]

Over prescription of lactose-free formulas can deprive infants of these benefits and may delay tolerance development. An international survey looking at clinical practices in the management of CMPA and lactose intolerance as well as educational needs found that almost 80% of respondent clinicians recognised the need for further education and training.[8]

In my practice, I often choose lactose-containing formulas, balancing taste, tolerance and nutritional benefits. However, symptom resolution remains the priority. I work closely with families to gradually introduce new formulas, addressing concerns about taste and smell with reassurance and practical feeding suggestions.



> As dietitians, we play a vital role in offering clear, compassionate, evidence-based guidance to support both maternal and infant health



Myth 3

Infants gaining adequate weight are not allergic to cow's milk

A thriving infant is not necessarily a symptom-free infant. One of the most damaging myths I encounter is the assumption that adequate weight gain rules out CMPA. Parents often report being dismissed because their baby is growing well, despite persistent symptoms such as fussiness, reflux, or eczema.

Non-IgE-mediated CMPA, such as food protein-induced allergic proctocolitis (FPIAP) can present in infants who are growing normally.[9] In addition, in my experience infants with food protein-induced enterocolitis syndrome (FPIES), especially acute FPIES, can also present in well growing infants.

Therefore, the growth of an infant must be interpreted within the full clinical picture. A baby tracking along the 25th percentile who continues to show persistent symptoms should not be considered "fine" based solely on their weight. Symptom persistence may signal ongoing disease activity and warrants a structured evaluation.[10]

In my practice I emphasise that symptom resolution, not just growth alone, is essential when considering the diagnosis as well as management. In formula-fed infants, extensively hydrolysed formulas (eHF) and hydrolysed rice-based formulas (HRF) remain first-line options. However, in cases of ongoing, severe or complex allergies, I tend to opt for an amino acid-based formula (AAF), as I find that in some of these cases, it leads to quicker symptom relief with improved feeding outcomes. This is also important for the quality of life of the child and the family. Ultimately, formula choice should be individualised, taking into account the clinical presentation, nutritional needs, and family context.

Myth 4

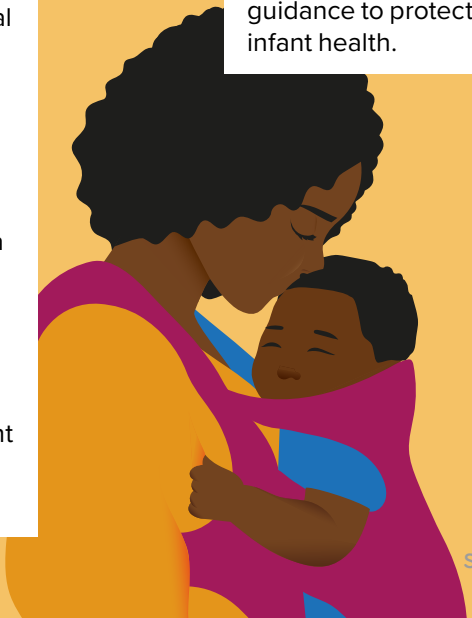
Should I stop breastfeeding if my baby has food allergies?

Despite growing awareness, many mothers are still advised to stop breastfeeding when CMPA is suspected. Others receive vague advice without structured support, leading to unsupervised elimination of multiple food groups leading to nutritional compromise.[3,4] CMPA can be effectively managed through maternal dietary exclusion while continuing with breastfeeding, provided the mother receives appropriate dietetic input.[3,4] Breastfeeding offers immunological, emotional, and nutritional benefits that should not be prematurely discontinued.

In my clinical experience, I assess the maternal diet along with the infants' symptoms, then guide targeted elimination of likely allergens. I support mothers with practical strategies to maintain nutritional adequacy of their own diet, including supplementation of calcium and vitamin D, and in some cases iodine and B12.

Stopping breastfeeding prematurely can lead to emotional distress for the mother, increased reliance on infant formula, and poorer outcomes for the child. It is well known that mothers of infants with CMPA report higher levels of anxiety and depression and tend to breastfeed for a shorter duration.[11,12]

As dietitians, we play a vital role in offering clear, compassionate, and evidence-based guidance to protect both the maternal and infant health.



Conclusion

CMPA is a multifaceted condition that requires clarity, empathy, and clinical precision. Dispelling myths is not just about correcting misinformation – it's about empowering families, improving outcomes, and restoring trust in the healthcare system. As paediatric dietitians, we are uniquely positioned to lead this through evidence-based practice, clear communication, and personalised support. By recognising and addressing these myths, we can ensure that infants receive timely, appropriate care, and that families feel supported throughout their (often difficult) journey.

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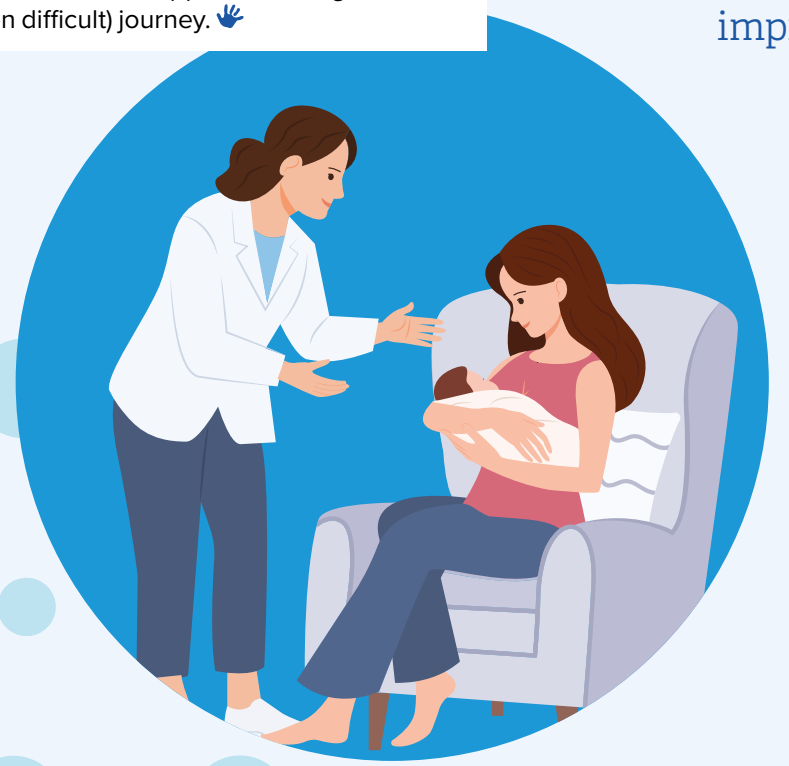

IMPORTANT NOTICE
Breastfeeding is best. AAF and eHF are Foods for Special Medical Purposes for the dietary management of cow's milk allergy (and Multiple Food Protein Allergies and other conditions where an amino acid based formula is recommended – for AAF only). They should only be used under medical supervision, after full consideration of the feeding options available including breastfeeding. They may be suitable for use as the sole source of nutrition for infants from birth, and/or as part of a balanced diet from 6-12 months. Refer to label for details.

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