

SMALLTALK

PAEDIATRIC NUTRITION MAGAZINE FOR HEALTHCARE PROFESSIONALS

THE CLARITY ISSUE

Communication, change, and cutting through misinformation



SCC4547



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Autumn/Winter 2025

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Theresa Cole
Medical Affairs Manager



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Paediatric Dietitian, Cystic Fibrosis

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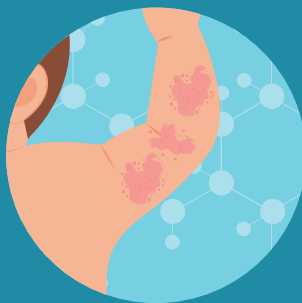


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Welcome

to the Autumn/Winter edition of Small Talk

This latest edition is all about clarity – whether that's in how we communicate with families, adapt to change, or challenge misinformation in our clinical practice. We're thrilled to bring you a vibrant collection of articles that reflect the depth and diversity of paediatric dietetic practice across the UK and Ireland.

We open with two standout articles. Anna Groom's "Importance of health coaching to improve communication" offers a powerful reflection on how coaching techniques can transform our conversations with young people, helping them become active participants in their care. In "Cow's milk protein allergy in infants: Myth busting to provide clarity in clinical practice", Nishti Ismail tackles common misconceptions with evidence and empathy, helping us support families with confidence and precision.

Sustainability is a growing priority in healthcare. In "A call to action – the need for a sustainable paediatric dietetic movement", Dr Luise Marino challenges us to think boldly about our environmental impact- from recycling medical nutrition packaging to reimagining hospital food systems for plant-forward diets. It's a powerful reminder of our collective responsibility, and an article that is both urgent and inspiring.

In "From tertiary centre to tiny island – navigating allergy guideline application across settings", Ailsa McHardy shares

her experience of delivering allergy care in remote and rural communities, reminding us that flexibility and context are essential to good practice.

We also feature a compelling case study by Niamh Brosnan: "A case of oral aversion in an Infant with congenital heart disease", which follows baby Kate's journey through complex feeding challenges and the role of Infatrini in supporting her growth and recovery.

And finally, Raquel Enciso Serradilla invites us behind the scenes in "A Day in the Life of the Nutricia Resource Centre". From quirky queries to orangutans with milk allergies, it's a fun read that celebrates the team's dedication.

We hope this issue brings clarity, insight and inspiration. Thank you for being part of the *Small Talk* community.

Warm wishes,

Theresa

Theresa Cole
Editor, *Small Talk*

If you have any feedback, questions for our next edition or ask the expert, or would like to contribute to our next edition, we'd love to hear from you.

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DIARY DATES

2025

16–18 OCTOBER

British Society for Allergy and Clinical Immunology (BSACI)

Annual Conference

WHERE: International Convention Centre in Wales

23–25 OCTOBER

European Academy of Allergy and Clinical Immunology

EAACI/ PAAM 2025 Pediatric Allergy Matters: Inspiring Insights for Every Family

WHERE: Palma de Mallorca, Spain

2026

23 JANUARY

British Society for Allergy and Clinical Immunology (BSACI)

Global Allergy Online Symposium 2026

WHERE: Online

5 MARCH

Northern Ireland Nutricia Congress

WHERE: Belfast, Northern Ireland

25–27 MARCH

British Society of Paediatric Gastroenterology, Hepatology and Nutrition

40th Annual Meeting

WHERE: Leeds, UK

9–11 APRIL

13th International Conference on Nutrition and Growth

WHERE: Prague, Czech Republic



A DAY IN THE LIFE OF

the Nutricia Resource Centre



“Working collaboratively is a vital part of the role”

Here at the Nutricia Resource Centre, we have a small but mighty team of six dedicated Dietitians, Nutritionists and Food Scientists. As part of the Medical Affairs team of over 30 Dietitians and Nutritionists, we are the go-to hub for timely and accurate information for all things Nutricia product related.

Our mission? To support both Health Care Professionals (HCPs) and patients with evidence-based and practical information to support clinical decision making and the usage of Nutricia products.

After a morning cup of coffee to kick-start the day, we begin with checking the inbox to see what's come in overnight. Alongside emails, we also take phone calls, so there's always something to jump on. We get queries from a wide range of people, from Dietitians, Nurses and Pharmacists to patients or carers and prioritise them based on clinical urgency and complexity. We are now able to respond to emails in an average of just under five hours, meaning HCPs can typically expect to hear back from us on the same or next day.

As Resource Centre Specialists, we have developed a wide range of expertise to answer queries ranging from product composition, allergens, formulations, clinical usage scenarios, dietary suitability through to wholesale and stock queries. We always stick to clear, evidence-based information and make it clear that we can't give personal or clinical advice, but we're here to support people in using Nutricia products confidently and safely in close collaboration with their HCP. We are confident in knowing our remit and boundaries when handling queries. Therefore, if something is beyond our expertise, we quickly escalate our query to our Medical Affairs team for further expert input. Where appropriate, we signpost to helpful resources such as the Dietetic App or patient information materials.

Working collaboratively is a vital part of the role. We regularly engage with colleagues from Medical Affairs, Product Development, Nutricia Homeward and Quality Assurance. This teamwork ensures the responses we provide are consistent, accurate, and in line with the most up-to-date guidance. Whether cross-

checking allergen processes with manufacturing sites or checking a clinical query with Medical Affairs, these partnerships help us maintain confidence and trust with HCPs and patients alike. Sharing knowledge and learning from each team allows us to continuously improve how we deliver support and handle enquiries.

Our goal is to make HCPs' lives easier by supporting them and their patients – whether it's a question about product suitability, preparation, or something more technical, we're happy to help. Even if a query falls outside our remit, we'll always do our best to signpost you to the right place. Think of us as your trusted first point of contact with Nutricia, here to connect you quickly and accurately with the answers you need – or simply talk things through if you need reassurance.

Every day brings a mix of weird and wonderful queries that keep our work interesting and rewarding. The Resource Centre is more than a helpdesk – it's a hub of expertise, collaboration, and support. So, whatever your question, big or small, don't hesitate to reach out – that's exactly what we're here for. 🙌

Q&A

Now for a look behind the scenes with a quick Q&A with the team:

How have you seen The Resource Centre change over the years?

Simeon Ramet,
Head of Medical Affairs:

🗨️ In the 20 years I've been involved in the Resource Centre, the breadth of the queries has become wider with an expanding range, but also how people contact us. When I first started it was mainly phone calls and very few emails, now it's the other way around! Allergens have become a common theme today versus 15-20 years ago, driven by increased awareness and the growing number of individuals affected by food allergies. What's not changed is our desire to answer as quickly as possible and to ensure the caller, whether a consumer or HCP, has the best information at their fingertips.

What changes do you expect in the future for the Resource Centre?

Lauren Farley,
Senior Medical Affairs Manager:

🗨️ With the speed of digital advancements, the future will likely bring new technologies to our systems and improve the efficiency of information gathering. This could complement the valuable expertise (and more human touch!) of our Resource Centre Specialists.

What's the most unusual query you've received?

Raquel Enciso Serradilla,
Resource Centre Specialist:

🗨️ We have had some wonderfully unexpected queries about using our products in the animal kingdom. From chimpanzees sipping Fortisip to orangutans with milk allergies thriving on Neocate, and even a horse being tube-fed Nutrison – it seems our feeds have caught the attention of more than just humans!

NUTRICIA RESOURCE CENTRE

The Nutricia Resource Centre's expert team of Dietitians and Nutritionists can help healthcare professionals, patients and their caregivers to access a wide range of support, including:

- NUTRITIONAL, CLINICAL AND PRACTICAL INFORMATION AND GUIDANCE ABOUT NUTRICIA PRODUCTS
- SUPPORT RESOURCES, SERVICES AND TOOLS FOR HCPS AND PATIENTS
- PRODUCT EVIDENCE
- NUTRICIA EDUCATION

GET IN TOUCH

with the Nutricia Resource Centre:

✉ resourcecentre@nutricia.com
☎ 01225 751098 (HCPs)
☎ 03457 623653 (patients)

www.nutricia.co.uk/hcp/contact-us

NUTRICIA DIETETIC APP

For more useful product information, resources and tools for clinical practice, as well as Resource Centre contact information, access the Nutricia Dietetic App by using the QR code.



GET INVOLVED

YOUR VOICE MATTERS: EXPLORING DIETETIC PRACTICE IN PAEDIATRIC NEURODISABILITY

Nutricia wants to hear your voice – we're keen to learn about your experiences managing children with Neurodisability.

Your insights matter.

This is your opportunity to share valuable clinical perspectives that could help shape future support for patients and healthcare.

Quick and easy to complete.

The survey takes just 5-10 minutes – scan the QR code to get started and make your voice count!



**ANNA GROOM**Specialist Diabetes Dietitian & Associate Clinical Lead,
Young Person, Pump and Technology lead

Importance of health coaching to improve communication



When I graduated from university and started my first job I felt so proud and important, I was a Registered Dietitian, a fully-fledged health care professional. I left the nest and embarked on my new career feeling confident in my knowledge to support people, both on the ward and in outpatient clinics. I progressed through basic grade (now band 5) rotations but all the Continued Professional Development (CPD) offered was clinical i.e., supporting continued learning of medical conditions and dietary approaches – until I moved into a senior II post (now band 6) which specialised in obesity. Here I attended motivational interviewing and behaviour change courses – understanding the stages of change highlighted to me that not everyone was ready to change when they came to see me. At the time I didn't fully appreciate the complex reasons that might influence a person's readiness for change – surely reducing their cholesterol and losing weight was the most important thing to them? – because the Doctor (and now me) had told them so. Plus, we had completed an in-depth diet history and I had highlighted all the changes they could make and created a goal list, summarising what we had discussed and agreed on the next appointment. Offering solutions to required lifestyle and dietary change was my job, and that was why people came to see me – for my expertise and advice on what diet they needed to follow. I was quite happy with the way I worked, and I achieved success and got good feedback.

“With a passion for supporting behaviour change I jumped at the chance of attending a health coaching course”

A new opportunity

But then, ten years into my career I was offered the opportunity to attend a health coaching course. With a passion for supporting behaviour change I jumped at the chance and got my place – not really knowing what it was, nor what impact it would have on me, both personally and professionally. At this stage I was leading a paediatric diabetes dietetic service, running clinics and patient education groups and supporting the development of an insulin pump service. The course was a 2 day training programme with a couple of weeks in between to practice my new skills. I was immediately thrown into the world of feeling consciously incompetent. I was being asked to trial structuring my conversations in a different way, to veer away from my known biomedical model and utilise tools and techniques initially observed in coaching conversations between industry and sport. I had never considered myself as a coach, not really seeing the similarities between setting goals for diabetes control and setting fitness and performance goals. It was a real opportunity to stop and reflect on my communicating style and appraise what worked, and honestly consider what didn't. Finally, I was understanding the psychological principles of behaviour change and what supports developing a consistent healthy and productive relationship between clinician and patient.

“It was a real opportunity to stop and reflect on my communicating style and appraise what worked and what didn't”

Health coaching

Health coaching is: 'Helping people gain and use their knowledge, skills and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals.'¹

In simple terms, health coaching is a specific approach used by health and care professionals to raise awareness about their own health, and take more control of their health and wellbeing, which is particularly effective in supporting positive behaviour change. Using a health coaching approach encourages the clinician to consider the wider determinants of health, not just concentrate on the long-term condition. This is especially relevant when working with young people with diabetes – whether it be type 1 or type 2 diabetes; using a holistic approach encourages young people to be aware of their current situation and helps them create ways to support their health with increased responsibility.

Health coaching includes not only the framework for different conversations, but it encourages self-reflection by practitioners. It's not asking us to put ourselves in our patients' shoes but reflecting on what makes us set certain goals, or achieve/not achieve goals, what gets in the way from an internal or external point of view in our daily work, and how this may be similar to the interferences our patients may have.

Developing relationships and self-reflection

So, what should we consider when reviewing our professional relationship and communication style with our young people in clinic? The first thing has to be trust and rapport. How can we expect a young person to disclose information about their life if they do not feel they can trust us? Relationships can have high trust and low rapport – such as dropping your child off at school to a teacher you don't know; or low trust but high rapport – such as having a great amusing conversation with someone but not trusting them to look after your pet when you are on holiday. Then there are relationships with high trust and high rapport – these are the game changer conversations which have high potential to make good behaviour change. But what exactly is rapport? It does not just mean being friendly, it means being honest, empathic and open, being transparent with your intentions and framing conversations within the boundaries of time or content. When asked the definition of rapport the English dictionary states "relationship, connection" – but good rapport takes time and genuine listening and interest.

Spending time on goal setting

What else is important in a good conversation that promotes positive change? ...Goal setting...When providing clinical supervision to colleagues and encouraging a coaching approach, it is now always high on my list to discuss the who, what, where, when and why of goal setting. Considering working with patients, who's goal it is that we are working towards? I know I have targets to meet, and my service has targets. My goal is to help the young person achieve the lowest possible HbA1c that will reduce the likelihood of them developing co-morbidities associated with their diabetes, and I also need to ensure that the young person has had their 8 care processes completed and address any unusual/abnormal results. But what are the young person's goals? What influences their desire to set goals, what is their experience of goals, who influences and supports them in working towards and meeting their goals? What has been their experience of setting goals with other clinicians and health care professionals. Having an open honest conversation about their short-term and long-term goals during their appointment is essential. It enables us as clinicians to align our goals and work together rather than in different directions.

Once I've established good rapport and had time to listen to the young person's goals, it's then time to move onto the motivational interviewing part. This is the part that is most different to my previous ways of working. Previously I would have offered lots of ideas on what I thought would be good dietary changes and activities – some of which may have landed well and others not so well. But my style now is to give some simple challenges, for example, what is the one thing that you would find easiest to change right now? What could be possible now? What are the different ways in which the young person could achieve their goal / make a change? By asking these questions it assumes that the young person has the potential to solve, or at least identify, some ways to change. Previously I would jump in – but allowing the space and time for the young person to really think...and then think a bit deeper about their goals helps them create solutions themselves, which is increasing their intrinsic motivation to change. This is a much more powerful way of supporting sustainable behaviour change – it's that "ah ha"/light bulb moment.

Health coaching includes not only the framework for different conversations, but it encourages self-reflection by practitioners

Considering the patient perspective

As part of writing this I thought I would not only reflect on my own thoughts about my journey to developing and enhancing my communication style, but also ask a young person their thoughts. This young person has two auto immune conditions – type 1 diabetes and coeliac disease. Navigating dietary change for type 1 diabetes is a challenge in itself – learning about carbohydrate counting, glycaemic index, glycaemic load and insulin dosing via injection and using an insulin pump. Having their blood glucose data visible to me as their clinician feels like “big brother” where I can identify straight away good/poor compliance; when boluses were missed, inaccurate carbohydrate counting, forgotten basal doses etc., no other condition requires this level of tracking and questioning. Plus, every three months they have an HbA1c test – checking how they have managed, the frowns when it increases and the “its better but still not quite there” comments. On top of this for this patient is the diagnosis of coeliac disease – further dietary manipulation and yet another blood test to monitor compliance. Having multiple self-managed lifelong conditions is challenging enough, without additional challenges from health care professionals who continuously ask to *try a little harder*.

“Once I’ve established good rapport and had time to listen to the young person’s goals, its then time to move onto the motivational interviewing part”



So I asked the young person a few questions

How important is it to you to have a good relationship with your diabetes team, when it comes to managing your diabetes? “A good relationship with my diabetes team is really important to me. Managing a long-term condition like type 1 diabetes can be challenging at times, and having a supportive team makes a big difference. It helps me feel more comfortable asking questions, being honest about what I’m finding difficult and staying engaged in my care.”

How would you describe Anna’s communication style? “Anna’s communication style is calm, clear and genuinely caring. She takes the time to listen and respond in a way that feels personal and supportive. She explains things in a way that makes sense, without being overwhelming, and always makes me feel heard.”

Does Anna’s communication style/technique differ from other health professionals you have been supported by? If it does, how does it differ? “Yes, it definitely does. With previous clinicians, I often felt like I wasn’t really being heard, there didn’t seem to be much care or understanding. It felt quite detached. But with Anna, it’s completely different. She’s consistent, kind and always there when I need help. It’s clear she genuinely cares and wants to support in any way she can.”

How does Anna support you (if you feel she does) with managing your diabetes and coeliac disease? “Anna supports me by looking at both conditions together and helping me manage how they affect each other. She understands the realities of living with them day to day, and gives advice that’s practical and achievable. She’s someone I know I can reach out to if I’m struggling and always responds with care and guidance.”

What would you say is a barrier to forming a rapport with your health care team? “Not feeling listened to is the biggest barrier. If a health professional seems rushed, uninterested, or overly focused on numbers rather than how I’m actually doing, it’s really hard to build trust or feel comfortable being open with them.”

How would you like your diabetes/ health care professional team to speak with you/support you? “I’d like them to be open, kind and collaborative, to speak with empathy and take time to understand what’s going on beneath the surface. Managing a condition like this isn’t just about ticking boxes, it’s about real life.”

As a clinical lead I am often encouraged to focus on the data, activity and outcomes – but how often do we get feedback on our communication style and technique? The words we choose, our tone of voice and our body language are so impactful on the outcome of the conversation, and the likelihood of a young person’s continued engagement. So, if there is only one thing you take away from reading this article, it would be to rethink how you word your questions or how you offer support to your patients – then that’s a win for me. 🙌

Reference

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NISHTI ISMAIL
Specialist Paediatric Dietitian
at Nishti's Choice

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 eczema³ 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.

“As paediatric dietitians, we are often the first point of contact for families navigating the complexities of CMPA”

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.

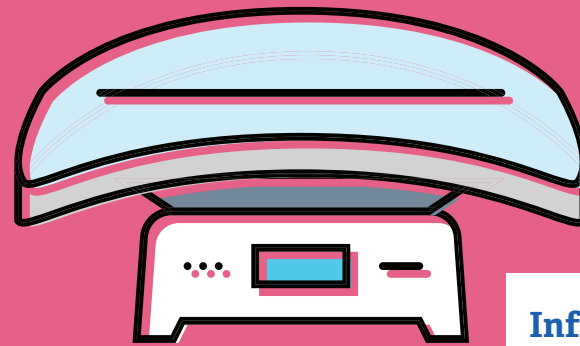
CMPA is an immune-mediated reaction to milk proteins (casein and whey), while lactose intolerance results from lactase enzyme deficiency.⁵ Primary lactose intolerance rarely occurs before the age of five years, while secondary lactose intolerance, often temporary, may occur due to viral gastroenteritis, 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 palatability⁵ 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. 🙌

“Dispelling myths is not just about correcting misinformation – it's about empowering families, improving outcomes, and restoring trust”

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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.



THIS INFORMATION IS INTENDED FOR HEALTHCARE PROFESSIONAL USE ONLY

NUTRICIA

For the dietary management of formula-fed infants with Cow's Milk Allergy (CMA)

NO.1 FOR GOOD REASONS...



IMPORTANT NOTICE: Breastfeeding is best. Aptamil Pepti 1 is a Food for Special Medical Purposes for the dietary management of Cow's Milk Allergy. It should only be used under medical supervision, after full consideration of the feeding options available including breastfeeding. 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. For enteral use only. Refer to label for details.

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CMA: Cow's Milk Allergy; EHF: Extensively Hydrolysed Formula.

Accurate at time of publication: September 2025

🍼 CMA symptom resolution in 97% of infants¹

😊 Best tasting²⁻⁴

£ Lowest price⁵

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DR LUISE MARINO
Clinical Academic Paediatric Dietitian

A call to action – the need for a sustainable paediatric dietetic movement

What is global warming?

Global warming is primarily caused by increased greenhouse gas (GHG) emissions.¹ The Paris Agreement (2015) a legally binding international treaty signed by 196 countries and entities, aimed to reduce GHG emissions, and global warming to below 2°C compared with pre-industrial levels. Despite this multilateral climate change process, global temperatures are expected to exceed the 1.5°C threshold by 2030 and 2°C by 2050², leaving us four summers to affect change.³ The rise in temperature is predicted to affect the most vulnerable within society including children, as they will have less resilience to rising temperatures and infectious disease. Extreme weather is also likely to lead to animal and plant extinctions, water and crop failures increasing food prices, poverty and mass displacement arising from uninhabitable land.⁴

But what does the climate emergency have to do with healthcare?

A key tenant of healthcare ethical practice is non-maleficence (i.e., first do not harm), with healthcare professionals including dietitians, acting as advocates for health across the life course.⁵ In spite of this, the healthcare sector contributes 4.4% of global net emissions and is the fifth-largest annual emitter of GHGs⁶, with the northern hemisphere healthcare organisations contributing 56% of the total healthcare climate footprint.⁷ The healthcare sectors impact on the climate emergency is multifaceted, and is exacerbated by a dependence on fossil fuels and inadequate waste disposal practices for medication (including medical nutrition), medical and food waste, much of which is sent to high temperature incineration creating GHG emissions.^{8,9}

NHS Green plan

The Health and Care Act 2022 made the Green Plan a statutory requirement (i.e., a legally binding commitment) for National Health Service (NHS) organisations, with a bold ambition to achieve a net zero target by 2040.¹⁰ Most of the NHS carbon footprint comes from scope three,¹⁰ comprising of 62% supply chain, 24% delivery of care, plus 10% staff commute and patient-visitor journeys.¹¹ Although there is considerable opportunity for impactful sustainability projects, much relies on voluntary action by organisations and individuals which may be insufficient to enable change. Legislative refinement to the plastic packaging tax (2022) would help compel change in healthcare, i.e., reviewing healthcare exemption for the so-called plastic tax as this would help to drive circularity in terms of reuse and recycling of virgin plastic and high value polyethylene terephthalate (PET), high density polyethylene (HDPE), low density polyethylene (LDPE) and propylene plastic (PP) used in medical nutrition.¹²⁻¹⁵ Dietitians have an important role to play as sustainability advocates for legislative change – we need to find our voices as we have individual and collective power as trusted nutrition healthcare professionals.¹⁶

How does sustainability make healthcare professionals (HCP) and dietitian feel?

A recent survey of paediatric intensive care unit staff, suggests HCP feel psychological distress and disempowered when it comes to effecting change within their own organisation; and that conflicts with clinical priorities making it difficult to prioritise sustainability initiatives (Verbruggen¹⁷, personal communication). Other surveys, report a high level of HCP interest in sustainability, but lack of knowledge on how to make changes within a clinical setting.¹⁸ However, all is not lost, as any type of action is better than inaction. Several systematic reviews suggest HCP, including dietitians are embracing change, but there is still a long way to go.^{8,19}

How can individual dietitians effect change?

Behaviour change is difficult²⁰, while knowledge and awareness are not the strongest drivers of change; it requires a combination of capability, opportunity and motivation (i.e., the COM-B framework).²¹ The best projects support change by providing physical opportunities to enable the change to happen (i.e., providing a recycling box for empty enteral feeding bottles).²²

In practice – how can you make a difference where you work?

Here are two small change ideas that will make a big difference. Imagine the impact if all of us took on these two actions in 2026 – imagine how much GHG emissions we could save by reusing or recycling plastic packaging, not to mention the financial savings.

1 Recycling – medical nutrition bottles and ancillaries

One of the barriers to recycling enteral, oral nutrition supplement bottles, bottle lids and other plastic components is infection control. However, there is no evidence to suggest used enteral feed bottles pose an infection control risk, especially in dry waste streams.²³ Another barrier is time and space.¹⁷ Yet within adult critical care recycling of medical nutrition bottles has been achieved, taking recycling rates from 0% to around 50%, with significant reductions in carbon emissions along with financial savings.^{23,24} Medical nutrition companies including Nutricia are developing partnerships to promote reuse and recycling.²⁵ In collaboration, Nutricia has developed a step-by-step guide for implementing a medical nutrition packaging recycling project: 25 which is summarised here in 10 steps.

“The NHS is full of exciting initiatives, and as paediatric dietitians we have the potential to make a big difference”

Project 1:

Ten steps to sustainable recycling

Work with the leadership team within your department, green team, medical nutrition company, ward staff, estates team, families and children.

- 1 Create your project team** – who is the lead, what support outside of the NHS do you need (i.e. waste contractor)
- 2 Agree the scope of the project** – hospital wide or patients in their own home?
- 3 Build a shared purpose** – where are you now, how will you get there?
- 4 Review data on usage** – which wards use the most product and how much is currently recycled?
- 5 Scope out areas for an initial pilot** – go big if you can
- 6 Identify champions of the project** – to remind clinical staff to recycle medical nutrition packaging i.e., single use enteral feed syringes
- 7 Ideally count how much is being recycled** – run a competition – ask your hospital charity to sponsor prizes
- 8 Report your findings** – carbon savings and financial savings
- 9 Keep learning** – ask for feedback – make changes
- 10 Inspire others** – share your findings – be generous, share your plans

12%
of the total food waste generated in the UK²⁹ is produced by 1,297 NHS hospitals and 515 private hospitals

2 Reducing waste – tackling food waste

With one in six plates of hospital food wasted²⁶, approximately 50% of the total waste generated on the ward comes from food.^{27,28} Despite the use of food and drink standards, it is estimated the 1,297 NHS hospitals and 515 private hospitals produce 12% of the total food waste generated in the UK.²⁹ This equates to 1.1 million tonnes of food waste per annum²⁹, producing 1,543kilo tonnes of carbon dioxide emissions (CO2e), approximately 6% of total NHS emissions per annum²⁶, with an NHS waste management cost of £230m per annum.²⁹ Although there are exciting examples of change in the UK, for example sustainable procurement for patient and staff meals, bolder changes could be made.^{30,31}

Project 2:

Plant-forward diets

There is a move for plant-based diets by default within the hospital setting, with animal protein being available on request only.³² Unfortunately many NHS hospitals have demonstrated little commitment to moving to plant-based meals, suggesting issues with implementation or barriers to change amongst staff and patients.³⁰

In paediatrics, the use of a plant-forward diet where whole-grains, fruits, vegetables, nuts and legumes (i.e., beans and lentils) are eaten in larger amounts with reduced amounts of animal protein³⁷ may be a more acceptable first step.^{9,33-35} A nurse led study reported putting these plant-based dishes at the top led to a four-fold increase in these meals being chosen.³⁶ Information sharing with housekeepers and ward staff around plant-forward or plant-based meals is also essential.³⁷⁻⁴³ This ensures frontline staff serving food can talk positively about plant-based meals.^{44,45} For example, if frontline staff convey disgust about the meals even with non-verbal cues, this may be negatively received by children and their families.⁴⁶

Practical strategies for paediatric dietitians to implement within their hospital system

Create your project team

- 1** Identify where and what food is being wasted
- 2** Using free on-line tools tracking water, carbon emissions and cost savings e.g., NHS recipe bank <https://foodplatform.england.nhs.uk> and Food Pro Cool <https://coolfoodpro.net>
- 3** Estimate packaging waste – what could be reused or recycled?

Identify changes

- 1** Advocate for plant-forward inclusive recipes – using NHS recipe bank for inspiration
- 2** Encourage “meat free Mondays” – give clear health benefits and CO2e savings
- 3** Remove negative labels from meals i.e., vegetarian, vegan or meat free
- 4** Share changes with staff, patients and families – to prevent unintended consequences (i.e. families buying animal-protein meals)⁴⁷ or food waste increasing with plant-based dishes.⁴⁸



When did healthcare become so disposable?

Modern medicine including medical nutrition support, is wasteful; and 85% of materials are discarded rather than reused or recycled.⁴⁹ The NHS is full of exciting initiatives, and as paediatric dietitians we have the potential to make a big difference. We are known for being innovative thinkers, but we must now be bold – think big and challenge the current status quo about why items cannot be recycled or reused. Together we could start a sustainable paediatric dietetic movement – we have just four summers left so time is of the essence. 



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*MIMS online. Available at www.mims.co.uk (accessed July 2025). †Market comparison of preterm formula (July 2025). 1. Boehm, et al. Arch Dis Child Fetal Neonatal Ed. 2002;86:F178–81. 2. Knol, et al. Acta Paediatr. 2005;94(449):31–3. 3. Mihatsch, et al. Acta Paediatr. 2006;95(7):843–8.

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A case of oral aversion in an infant with congenital heart disease (CHD)

Case presentation

A one-week-old baby girl (baby Kate) was referred to me on admission to the Paediatric Intensive Care Unit (PICU) for nutrition support.

Clinical history

Baby Kate was born via elective caesarean section due to breech position at 39 weeks. She was in the Special Care Baby Unit for one day with a hypoglycaemic episode and discharged home at 3 kg (9th-25th centile). She was discharged on a combination of breastmilk and Aptamil 1 First Infant Milk formula. However, at 1 week of age she presented to the emergency department with reduced feeding, lethargy and was very pale. On assessment she had a high heart rate, low oxygen saturation and was hypothermic. She was worked up for sepsis and started on triple antibiotics, then transferred to the PICU, where she was referred to me for dietetic assessment.

Examinations

An echo was performed which showed a postnatal diagnosis of a hypoplastic arch, coarctation of the aorta and a ventricle septal defect (VSD). These are a collection of congenital heart defects which usually present in newborns with symptoms such as poor feeding, lethargy and weak pulse in the lower limbs. It requires surgical repair as early as possible. A staged surgical approach was used; where she first had surgery to repair her coarctation of the aorta and a pulmonary arterial band placed – a temporary procedure to help limit the blood flow so that the heart can send more blood to the rest of the body. The VSD was not repaired at this stage, as the surgeons wanted her to be at least 6kg (when the heart is larger it is safer to operate on).

Diagnosis

Congenital heart disease (CHD): hypoplastic arch, coarctation of the aorta, and a ventricle septal defect.

Dietetic assessment/management plan

On my first assessment, Kate's weight in PICU was 3 kg (9th-25th centile). She was on total parental nutrition (TPN) for a period post op, then slowly weaned off and restarted back on expressed breastmilk through a nasogastric tube (NGT). Her nutritional requirements were estimated to be approximately 96-120 kcal/kg/day which are the requirements of a 1-2-month-old infant.¹ During this time Kate's mother became very unwell and was admitted to hospital. Unfortunately, she was unable to continue breastfeeding or express her milk, so Kate was worked up to 150 ml/kg/day of Aptamil 1 First Infant Milk, which provided 99 kcal/kg.

Kate was slow to get back to full oral feeds, requiring the NGT for top ups. She was reviewed by a Speech and Language Therapist (SLT), and it was felt that she just needed time to build up her oral skills. She was discharged home from hospital at 3 weeks of age with the NGT. Her weight at discharge was 2.96 kg (2nd-9th centile), a drop of one centile since birth.

First follow-up appointment

One week post discharge, Kate was 4 weeks old and weighed 3.04 kg (2nd centile). She had only gained 110 grams the previous week, despite taking 99 kcal/kg/day of standard formula. Her expected weight gain was approximately 180-200 grams/week. **Dietetic advice:** I advised to add 50% Infatrini to her standard infant formula to bring the calories up to 120 kcal/kg/day – meeting the higher end of the recommendations by Scientific Advisory Committee on Nutrition (SACN) for a 1-2-month-old infant.¹

Second follow up appointment

Kate was now 6 weeks old and, following the initiation of Infatrini, had gained ~200 grams/week – her weight was now close to the 9th centile. At this time, her parents' main concern was that she had an increase in phlegmy spit ups. They did not feel it was formula related and reported that Kate was drinking less orally and needing the NGT more often. I felt that there was no need to further increase Infatrini at this point, as she was growing well and tracking for both weight and length on the 9th centile. I recommended that they continue 50% Aptamil 1 formula and 50% Infatrini, and to go to Kate's GP to assess reasons for phlegm. Kate was subsequently diagnosed with a lower respiratory tract infection and started on antibiotics.

Weekly review appointments

I reviewed Kate weekly either by telephone or face to face. After her respiratory infection, her parents took her to the GP again who diagnosed her with oral thrush, possibly the result of being on the antibiotics. During my review, her parents reported gagging and retching when the bottle was offered and having to use the NGT for most feeds, which caused significant parental stress.

Advice from the SLT was to avoid bottle feeds until her oral thrush completely resolved to reduce the risk of further feeding aversions. Kate's weight was now 4.5kg and she was tracking above the 9th centile. Her feed volume needed to be increased to maintain her weight above the 9th centile, but her parents didn't want to do this as they felt this would worsen her phlegm.

Dietetic advice: I decided to switch to 100% Infatrini to help reduce her total fluid volume (110 ml/kg/day = 110 kcal/kg/day). At subsequent follow-ups, Kate continued to gain weight but refused to take feeds orally. The SLT felt that she had developed oral feeding aversion.

Joint dietetic and speech and language appointments

A joint SLT and dietitian assessment was carried out when she was 17 weeks old. Kate was still gagging on bottle feeds. On assessment, she showed good head control, was able to sit supported and was accepting tasters from her fingers to her mouth. Following a discussion with her medical team, it was recommended to start early weaning with smooth purées on hands/toys etc. Kate enjoyed this very much and her parents were advised to start offering



them via the spoon. Kate continued on full Infatrini feeds via her NGT to maintain her growth and nutritional status. She was well hydrated and growing on 100 ml/kg/day (100 kcal/kg/day) which is ~104% of SACN requirements.¹

We reviewed Kate one month later when she was 5 months old. Kate had progressed very well with tasters; she was very accepting of the spoon, taking more than 5 teaspoons of smooth purée, twice a day. Her parents were very pleased but felt she was too full from the NGT feeds to progress with her oral intake. At this point, Kate was growing well and was tracking between the 9th-25th centile for weight and length. **Dietetic advice:** I advised switching back to standard infant formula to allow her appetite to develop. Kate had a target weight for surgery, so weight gain was still the main priority. Therefore, I advised to make up purées using Infatrini at least 3 times/day, to maximise the calories from her spoon feeds.

At the time of her final surgery, Kate had been weaned down to 450ml/day of standard formula via NGT, with an additional 200ml Infatrini as spoon feeds throughout the day. Post VSD repair, she continued to gain weight and progress with her spoon feeds.



Discussion

Babies with CHD are more likely to have feeding problems.² CHD increases the chance of a baby having symptoms of reflux and vomiting, because their gastric emptying tends to be slower than non-CHD babies. They can also be at risk of malnutrition and growth failure, influenced by factors such as feeding challenges, insufficient caloric intake and inefficient nutrient absorption and utilisation.³ Furthermore, oral aversion in infants with CHD is a well-recognised and complex issue that can further impact on the infants feeding pattern, growth and overall development.⁴

“Babies with CHD are more likely to have feeding problems”

IMPORTANT NOTICE
Breastfeeding is best. Infant milk is suitable from birth, when babies are not breastfed. We advise that all formula milks be used on the advice of a doctor, dietitian, pharmacist or other professional responsible for maternal and child care. Foods for Special Medical Purposes, such as Infatrini, should only be used under medical supervision. Infatrini is used for the dietary management of disease related malnutrition and growth failure in infants and young children. It is suitable as a sole source of nutrition for infants from birth and young children up to 18 months of age (or <9kg). Refer to label for details.

Conclusion/learnings

Babies with CHD will often have increased nutrition requirements.³ This means they commonly need a nutrient dense formula like Infatrini. It’s important however, to consider each infant individually. Some cardiac babies may need 100% nutrient dense formula (NDF) in order to maintain fluid restrictions and help with reflux, vomiting and growth, while others may just need part NDF mixed with a standard formula, to achieve growth.

This case highlights the importance of case-by-case discussions and some of the complexities that can present when dealing with CHD babies. The use of fortified breast milk or a NDF, like Infatrini, can help achieve good weight gain while maintaining fluid restrictions and hydration. Finally, this case highlights the benefit of joint dietitian and SLT sessions when tube weaning in a baby with oral aversions. By combining knowledge and expertise, we can achieve better outcomes for these babies, especially when moving from tube feeding to solids. 🙌

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scGOS/lcFOS: short chain galacto-oligosaccharides / long chain fructo-oligosaccharides; 2'-FL: 2'-fucosyllactose
[†] MIMS UK & Ireland, August 2025. Product can be provided to patients upon the request of a Healthcare Professional. They are intended for the purpose of professional evaluation only. Ypreclinical data; ^ study in healthy term infants receiving a formula with GOS only (control) or GOS plus either 0.2g/L or 1.0g/L 2'-FL and compared to a breastfed reference group; *post hoc analysis of the control group and the 0.2g/L 2'-FL formula group from the Marriage et al. 2015 study. **Nutricia Innovation Data on file (August 2025).
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From tertiary centre to tiny island – navigating allergy guideline application across settings



In my 15-year career as a dietitian, I have been fortunate and privileged to work across a range of different clinical settings. My two most recent NHS roles were in one of the country's leading Paediatric Tertiary Centres and in a remote Scottish island community. Combined, these roles helped me develop skills in providing the best possible paediatric allergy care in the context of the available resources.

There are many different UK and international best-practice guidelines for the management of children with cow's milk allergy (CMA), with similarities and some differences. Whilst guidelines serve as a foundation to our practice, their interpretation, and implementation in the clinical setting, requires flexibility and a context-dependent approach.

Guidelines and their limitations

As clinicians we can focus heavily on guidelines. However, the intricacies and slight differences between guidelines on allergy remind us of the importance of keeping the family we are supporting as the primary focus. In my practice I apply guidance in the context of the individual child and their family situation.

The challenges these families face are significant, and much of what is asked of them can feel daunting. For example, when asking families to reintroduce cow's milk (either via breastmilk or standard formula) to confirm a CMA diagnosis, or by taking the bold step of checking for tolerance acquisition at 9-12 months of age. While the tertiary centre often has better facilities to address these needs, access to frequent and approachable healthcare professionals, such as those available in a remote setting can be as valuable, if not more, for families.

Allergy rates and remote and rural challenges

Remote and rural populations face a unique set of healthcare challenges, specifically in paediatric allergy care. This includes difficulty accessing specialist care due to distance, weather and transport constraints.¹ Whilst working in the remote and rural setting I experienced firsthand the limited access to skin-prick testing (SPT), with a SPT service from the closest specialist centre visiting only once a year. For urgent cases, there was the option to refer patients into the regional specialist service, requiring very significant travel distances for appointments. At a point in allergy care where we are moving towards more proactive management, aiming for earlier food challenges for tolerance acquisition, the absence or limited acute paediatric services in many remote regions can make 'cautiously bold' decisions more challenging.

Applying guidelines in urban vs rural settings

The examples below demonstrate how geography may influence care-planning, even in the context of the same clinical experience and use of the same guidelines.

The stark contrast between these highlights differences in the approach that is needed. For many of us, our clinical practice is somewhere between the rural and tertiary setting, thus it is essential that we interpret guidelines in a context-specific way. We should also bear in mind that the support families feel they receive may be the single most valuable thing, rather than the clinical intricacies of the allergy treatment itself.

What it boils down to

Framing clinical decisions by considering the risks of doing *something*; e.g. the risk associated with asking a family to trial cow's milk at home, versus doing *nothing*; e.g. the risk associated with an additional 6 months wait for a SPT, really helped me navigate work in the remote and rural setting.

Our nearest Specialist Allergy multi-disciplinary team (MDT) service and the allergy nurses in particular, were hugely supportive. This reaffirmed that communication with colleagues in other centres is absolutely key in the delivery of good patient care. I met the allergy nurses socially when they visited the annual SPT clinic – this was among the most useful things I did in my time as a remote and rural dietitian, allowing us to establish a good working relationship which was of huge benefit over the following months.

Having worked across a range of settings, I believe that excellent allergy care is achievable for children in all communities. Its success hinges on excellent intra-centre communication, a supportive wider team of colleagues, and decision-making processes which are bold when in the patient's best interest. The differences we see in allergy guidelines remind us that a patient-centered, flexible approach is needed. 🙌

Guideline recommendation	Urban setting considerations 	Remote and rural setting considerations 
The home challenge to test tolerance acquisition	Acute paediatric care is generally accessible for families in the event of a severe reaction, including high-dependency/intensive care.	Limited or no access to acute paediatric care – in the event of a severe reaction or need for respiratory support the child would need to be airlifted.
Introduction of allergens in an infant with severe atopic eczema	SPT is likely to be available and accessible; access to specialist acute paediatric care quickly if needed.	Longer time to arrange and travel for SPT; time could increase the risk to the infant of developing a food allergy; home introduction risks a reaction with limited local resources to manage this.
A formula-fed infant has not responded to the extensively hydrolysed formula (eHF) and requires an amino acid formula (AAF) or hydrolysed rice formula (HRF) trial	I will likely be able to obtain a supply of the formula the same day and arrange for an ongoing supply.	There may not be availability of these formulas locally; delivery may take time. During winter months, or spells of poorer weather, island ferries may be cancelled affecting supplies.

Reference

1. Health, Social Care and Sport Committee. RCGP Scotland response: Healthcare in Remote and Rural Areas consultation. [Online]. Available at: www.rcgp.org.uk/getmedia/eb01ba6c-3271-449d-9c0e-53d2e478d4a3/RCGP-Scotland-response-to-Healthcare-in-Remote-and-Rural-Areas-consultation.pdf.

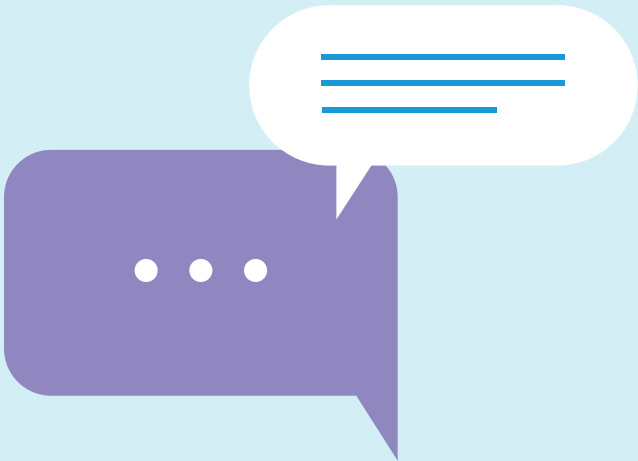


Up2Date

In this edition of Up2date, we present some recent surveys carried out by student dietitians in Ireland which echoes a concern around the need for clearer communication and support for caregivers as well as the need for more practical advice and education.

Whether navigating cow’s milk allergy, disorders of gut-brain interaction, or the complex journey of preterm infants, these studies highlight a recurring theme – caregivers are often left feeling confused, anxious, unsupported, and underinformed.

As paediatric dietitians, we are uniquely positioned to support families when it comes to nutritional issues. By advocating for better education with a consistent, practical approach, we can help families feel more confident and empowered in their feeding decisions.



Evaluating weaning guidance provided to a sample of caregivers of infants diagnosed with cow’s milk allergy (CMA)¹

The aim of this study was to look at the advice received by caregivers on weaning their infant on to solid foods when diagnosed with CMA.

A cross-sectional online survey with a 21-item questionnaire was distributed via an Irish parenting platform, targeting caregivers of infants (aged 4-30 months) with a current or previous diagnosis of CMA.

Results – there were 124 valid responses. The mean age of infants was 14 months with 53% in the 6-12 month range. The primary diagnosing clinicians were general practitioners (GPs) (34%, n = 42) and Paediatricians (35%, n = 43). Although 76% (n = 93) of the caregivers had received advice on when to start the introduction of solid foods, only 40% (n = 49) were given specific advice on introducing typically allergenic foods. 69% of caregivers (n = 85) reported the need for more information on weaning, and 84% (n = 104) reported that they felt more anxious about the weaning journey due to their infant’s diagnosis. 76% of caregivers (n = 95) described the experience as ‘Difficult’ or ‘Very Difficult’.

It was concluded that a gap existed in the provision of practical weaning guidance to caregivers managing infants with CMA, leading them to seek alternatives, and with high levels of anxiety. Training of health care

professionals using evidence-based resources that promote a diverse diet with optimal nutrition is needed for these infants.

Parental perspectives on the diagnosis and management of common disorders of gut-brain interaction (DGBI) in infants in Ireland²

The aim of this study was to explore parental perspectives on the diagnosis and management of the most common DGBIs (reflux, colic and constipation) in infants up to one year of age.

An online survey with a 36-item questionnaire was distributed via an Irish parenting platform.

Results – of the 355 parents recruited most were female (91%) aged between 25-34 years (56%), having attended third level education (78%). 42% of respondents reported that their infant experienced one of the three disorders (reflux, colic or constipation); 39% reported two disorders and 19% reported three disorders. **Reflux** was most commonly reported, affecting 73% of infants (n=258), followed by constipation (57%, n=170) then **colic** (48%, n=199). 36% of those with reflux were diagnosed by a general practitioner (GP) and 40% of these reported receiving no treatment. 47% of GPs and 49% of Paediatricians initiated medications as a treatment. 19% were diagnosed by a public health nurse (PHN) and 27% were diagnosed by a parent (38% and 60% respectively received no treatment). 56% of those

with **constipation** were diagnosed by a parent with 37% receiving no treatment. However, 36% reported using “other treatment”, including diet (prunes, fibre, additional water), exercise, massage and warm baths. 38% of those with colic were diagnosed by a GP, 31% by a parent and 22% by a PHN. Most Health Care Professionals (HCPs) did not treat colic; only 31% of GPs and 34% of PHNs suggested a change of formula for these infants. Meanwhile 31% of those diagnosed by a parent used some medication.

It was concluded that inconsistent approaches are used by HCPs (and parents) to diagnose and manage common DGBIs. And despite guidelines recommending nutritional approaches before medications, this was not consistently followed. HCP and parents need to be educated on how to better manage infants with DGBIs.

An investigation into the experiences of parents of preterm infants in Ireland³

The aim of this study was to investigate the challenges parents of preterm infants face throughout the preterm journey.

An online survey with a 39-item questionnaire was distributed via an Irish parenting platform.

Results – of the 154 parents recruited over 3 years the majority were female (90%) with 54% aged between 35-44 years. 82% of the preterm infants were classified as Low Birth Weight. 68% of

parents reported an unexpected delivery (with less than one week’s notice), with 51% receiving less than 24 hours’ notice. 32% reported at least one week’s notice (of expected delivery). Among those with expected deliveries, 34% felt they did not receive adequate information before the birth. The information parents felt they needed was about the Neonatal Intensive Care Unit (NICU), education about preterm infants, and emotional support. Commonly reported health challenges included respiratory, jaundice, feeding issues, growth and cardiac issues. Parent reported challenges included emotional distress, separation from their infant, disruption to family, difficulties with healthcare professionals and feeling generally unsupported.

It was concluded that potential challenges exist for both preterm infants and their parents, while support and education is recommended to improve the preterm journey.

References

- 1. Twomey Z et al. 2025¹ Abstract – submitted.
- 2. Morrissey S et al. 2025.¹ Abstract – submitted.
- 3. Morrissey S et al. 2025.¹ Abstract – submitted.

i. Technological University Dublin, Ireland.

IMPORTANT NOTICE

Breastfeeding is best. Infant milk is suitable from birth, when babies are not breastfed. Follow-on milk is only for babies over 6 months, as part of a mixed diet and should not be used as a breastmilk substitute before 6 months. We advise that the use of formula milks and the decision to start weaning should be made only on the advice of a doctor, dietitian, pharmacist or other professional responsible for maternal and child care. based on baby’s individual needs. Refer to label for details.

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†Compliant patients consumed >75% of their prescribed ONS.

**Order can be provided to patients upon the request of a Healthcare Professional. They are intended for the purpose of professional evaluation only.

1. Hubbard, et al. Eur J Pediatr. 2020;179(9):1421-30. 23-079 Date of publication: June 2024 © Nutricia 2024

NUTRICIA
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Ask the Experts

Ask The Experts

Do you have a question for our expert?

Email resourcecentre@nutricia.com and your question might be answered in our next edition!



Dr Luise Marino
Clinical Academic Paediatric Dietitian

Q. What are your key recommendations for setting up a sustainable paediatric dietetic movement?



1. Choose a project:

- Medical nutrition reuse/recycle – dedicated nutrition recycling boxes?
- Food waste – smaller portions?
- Plant-based meals – first choice on a menu?

2. Plan – what does success look like, what will you measure and how will you evaluate it – carbon emissions, cost savings, both?

3. Find key players for the team – waste management, leaders and operational teams

4. Think big – start in one or two areas, scale up quickly

5. Pick a launch date, work backwards – and be ambitious

6. Set up a competition and communicate it e.g., on social media, internal comms

7. Report your findings, including what went well and how you overcame challenges – inspire others, be generous, share your plans.



Anna Groom
Specialist Diabetes Dietitian & Associate Clinical Lead, Young Person, Pump and Technology lead

Q. How do you approach patient misinformation in your clinic? Do you have a specific approach you find effective?



If a young person has obtained misinformation, it typically tells me they have been researching/ discussing their condition outside their appointment. In this case, I would explore where they found the information and what made them look for it. It highlights motivation and their understanding of their diabetes / condition. I would then ask them to tell me more about what they think about the information and how they feel it could help them. I would then ask permission to compare this information to my/ another clinician's advice and review the differences. Together we would discuss the positive or negative attributes of the information source and how it could affect them.

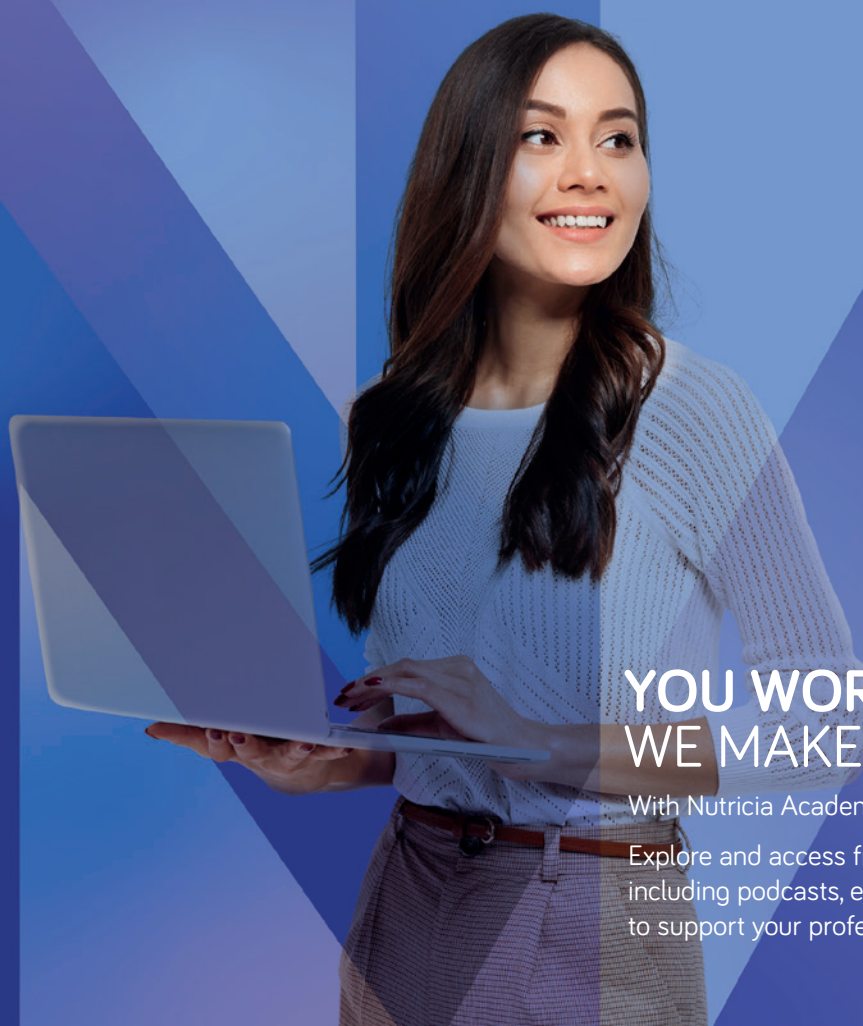


Lauren Farley
Senior Medical Affairs Manager – Resource Centre

Q. How can Nutricia help healthcare professionals (HCPs) to reduce plastic waste?



The Nutricia Resource Centre can help HCPs and patients navigate resources, guidance and support a change in behaviour with a “Reduce – Re-use – Recycle” approach to medical nutrition. We can share information on recycling our product packaging, and reducing waste and signpost to the Nutricia.co.uk and nutriahomeward.co.uk websites for information on our sustainability commitments. For example, easy to use pictorial guides and videos explaining giving set use reduction, online ordering for Nutricia Homeward patients and using reusable bottles for tube feeding. We also have a range of resources to inspire HCPs interested in driving local sustainability initiatives. As the Resource Centre is led by a team of expert dietitians and nutritionists, we can also help dietitians to interpret and apply our sustainability guidance, giving more clarity to clinical judgment decisions in specific patient scenarios.



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