# SMALLTALK

PAEDIATRIC NUTRITION MAGAZINE FOR HEALTHCARE PROFESSIONALS

## MANAGING COMPLEXITY

Practical feeding support and shared decision making in complex paediatric conditions


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**18** Managing oral intake in children with Cystic Fibrosis and Cerebral Palsy

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Spring/Summer 2026

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# Welcome

## to the Spring/Summer edition of Small Talk

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As paediatric healthcare professionals, your practice sits at the intersection of complex clinical needs, evolving evidence and close partnerships with families. This Spring/Summer 2026 edition of Small Talk focuses on **practical feeding support and shared decision making in complex paediatric conditions**, bringing together evidence-based insights and real-world experience to support your clinical practice.

In this issue, Jumana Ahmed explores the **advantages of early allergen introduction in high-risk infants**. You'll also find an in-depth introduction to a new evidence-based toolkit developed by the FEEDS toolkit team at Newcastle University, designed **to support shared decision making with parents of children with eating, drinking and swallowing need**s.

We reflect on innovation and progress in paediatric nutrition as **Fortini reaches its 25-year milestone** – Simeon Ramet revisits its journey and ongoing role in nutritional support. Meghan Vickery shares a clinical case, highlighting the **challenges faced by children with cerebral palsy that impact their nutritional status**, and how oral nutritional supplements and multidisciplinary team working can support children at different stages of their journey.

Our co-editor, Jacqueline Lowdon, goes on to consider **practical strategies for managing oral intake in children with cystic fibrosis and co-existing neurodisabilities**. Focusing in on preterm nutrition, Catherine Casewell reviews **key emerging trends in breast milk fortification**, highlighting their implications for evolving clinical practice.

We also step outside the clinic to learn about a '**Day in the Life**' of a Danone sustainability manager as Jess Ainley shares her experiences and explains how environmental considerations are increasingly shaping healthcare and nutrition.

Our regular **Diary Dates** and **Up2Date** sections complete the edition, keeping you informed with concise highlights to support your ongoing professional practice.

We hope this issue provides practical insights you can apply across the diverse and complex care settings you work in every day.

Best wishes

*Vicky & Vicki*

**Vicky Furmidge-Owen & Vicki Evans**
Editors, *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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NUTRICIA ACADEMY
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**JUMANA AHMED**
Specialist Paediatric Dietitian

# Advantages of early allergen introduction in high-risk infants

Around 3-6% of children in the Western world are thought to be affected by food allergy,[1] and the prevalence is on the rise. In England, food allergy prevalence is thought to have doubled from 2008 to 2018. However, it appears to have plateaued since 2014,[2] which may be linked to changes in recommendations around allergen introduction into children's diets.

Historically, prevalence of food allergy has been lower in areas where it is common practice to introduce allergens into an infant's diet at an early age, such as the Middle East, Asia and Africa. In contrast, prevalence increased in countries where government guidance stated that allergens, like peanut and tree nuts, should be avoided during pregnancy and early infancy up until more recently (e.g. the UK, USA and Australia).

There is now growing evidence to suggest that early allergen introduction in infants, especially those at high risk, is preventative against developing food allergy later in life. High-risk infants include those with eczema, a family history of allergy or existing food allergies.[3,4]

Two landmark studies led to a change in UK guidance in 2018:

- **The Learning Early About Peanut Allergy (LEAP) study**[3] aimed to determine whether early introduction of peanuts into the diet of high-risk infants (those with severe eczema and/or egg allergy) could prevent peanut allergy. Infants who were introduced to peanuts between 4-11 months of age and consumed them regularly had a lower incidence of peanut allergy at 5 years of age compared with those who avoided peanuts for the first 5 years of life.
- **The Enquiring About Tolerance (EAT) study**[4] showed a significantly lower prevalence of peanut allergy in infants who had been breastfed and introduced to peanuts prior to 6 months of age, versus infants who were exclusively breastfed until 6 months of age and introduced to allergenic foods thereafter.

## What are the current recommendations?

Guidance from the UK National Health Service (NHS) and the Scientific Advisory Committee on Nutrition (SACN) for the general population recommends exclusive breastfeeding for the first 6 months of life and introducing allergenic foods, like egg and nuts, once weaning starts around 6 months of age. The guidelines emphasise that deliberately delaying the introduction of allergens beyond 6-12 months of age may increase a child's risk of developing food allergies.[5,6]

Like the NHS, the British Society of Allergy and Clinical Immunology (BSACI) recommends exclusive breastfeeding for the first 6 months of life, but gives specific guidance that high-risk infants, such as those with eczema or an existing food allergy, may benefit from the early introduction of allergens (like egg and peanut) from around 4 months of age, alongside other complementary foods.[7]

There is now growing evidence to suggest that early allergen introduction in infants, especially those at high risk, is preventative against developing food allergy later in life.

## How should allergens be introduced into an infant's diet?

Before commencing the introduction of solids, it is important to ensure that the child is developmentally ready to do so. They should have good head control and be able to sit up unsupported. Puréed vegetables, cereals (e.g. baby rice/porridge) and fruit should be introduced first, before attempting to introduce allergens.

BSACI recommends introducing allergens in the order shown in Table 1.

Allergens should be introduced one at a time into the diet, when a child is well, in the first half of the day and ideally at least 2 hours before a nap (to allow sufficient time to assess for any possible reactions). A small portion size (e.g. a quarter to a half of a teaspoon) should be given initially, which can then be increased daily over 3-4 days until the child can tolerate a portion size equivalent to the size of their palm. The next allergen can then be introduced.

For parents adopting a more 'baby-led weaning' approach, allergens can be offered as finger foods, e.g. strips of omelette/pieces of well-cooked scrambled egg or smooth peanut butter on rice cakes.

Whilst introducing allergens early is important, it is crucial to ensure that these allergens are then included in the diet regularly, so that the child remains tolerant of them. Introducing the allergens early and then failing to maintain regular exposure could, in fact, increase a child's risk of developing an allergy to this food. A heaped teaspoon of peanut butter a few times a week should be sufficient to maintain tolerance.[3]

Ideally, all of these allergens should be introduced before 12 months of age. However, for those infants at high risk of developing food allergy, evidence suggests the greatest preventative effect is achieved through allergens being introduced within a 'window of opportunity' between the age of 4 and 6 months.[7]

**Table 1:** Allergens to be introduced and how to introduce them

| Allergen | How to introduce |
|---|---|
| Egg  | Use British Red Lion-stamped eggs. Introduce boiled egg, omelette/scrambled egg blended with formula milk or mashed into a purée of foods that are already tolerated. |
| Peanut  | Smooth peanut butter (ideally 100% nut butter without added salt/sugar) can be added to purées, porridge etc. Alternatively, puffed peanut snacks can be ground and added to the same foods.<br><br>Whole nuts, crunchy nut butters, or crushed nuts are not suitable for infants under the age of 5 years and should be avoided as they are a choking hazard. |
| Tree nuts  | Includes cashew, almond, hazelnut, walnut. Pure, smooth nut butters should be used where available, or the nut can be finely ground to a powder and added into purées/family foods. Again, whole or coarsely chopped nuts should be avoided. |
| Cow's milk  | If a child has been exclusively breastfed, cow's milk can be introduced via dairy yoghurt (look for no added sugar options) or fresh cow's milk mixed into porridge or mashed potato. |
| Wheat  | Can be introduced using cereals like wheat bisks, bread, pasta, cous cous, bulgar wheat etc. |
| Sesame  | Introduce using tahini (sesame paste) mixed into veg/fruit purées or porridge, or choose hummus (if child is already tolerating chickpea). |
| Fish/seafood  | Aim to try at least one white fish (e.g. cod/sea bass) and one oily fish (e.g. salmon). Prawn or crab are often the easiest way to introduce shellfish. These can be puréed either on their own, with vegetables, or mashed potato. |

*Table adapted from BSACI's Preventing food allergy in your baby: A summary for parents*[7]

Considering ethnic/cultural preferences when advising on early allergen introduction is key. In some cultures, it is not common practice to begin weaning prior to 6 months of age, therefore clear education around the benefit of early allergen introduction in high-risk infants versus the risks of delayed allergen introduction is important within these groups. There are also some cultures where nuts are not frequently used in everyday foods, so advice will need to be given on how the nuts can be incorporated into traditional foods. Interpreters should be used to address language barriers where appropriate.

It is also important to acknowledge financial circumstances when giving advice on introducing allergenic foods. Branded pure nut butters, for example, can be expensive. Many supermarkets now offer their own brand 100% nut butters which can be a more affordable option. Nuts can also be ground using a pestle and mortar or a rolling pin – a food processor is not essential.

## Tips for introducing allergens where a child is 'picky'

- Mix the allergenic food into a tolerated food that the child likes to eat regularly, e.g. mashed potato, a tomato-based pasta sauce, yoghurt, or pancakes.
- Repetitive exposure is key – it can take 10-15 exposures to a new food/flavour before it is accepted.
- Peanut puff crisps can be a good method for introducing peanuts into the diet if peanut butter is not tolerated. They can however have a high salt and sugar content, so should be used sparingly for infants.
- Once the individual nuts have been introduced and tolerance has been confirmed, a nut mix powder/mixed smooth nut butter can be made and added to everyday foods to avoid having to give each nut separately, multiple times a week
- For maintaining nut exposure in older children who are picky, consider adding crushed nuts to meatballs/burgers, mixing into breadcrumbs to coat chicken/fish, or using nut butters in homemade muffins and biscuits.

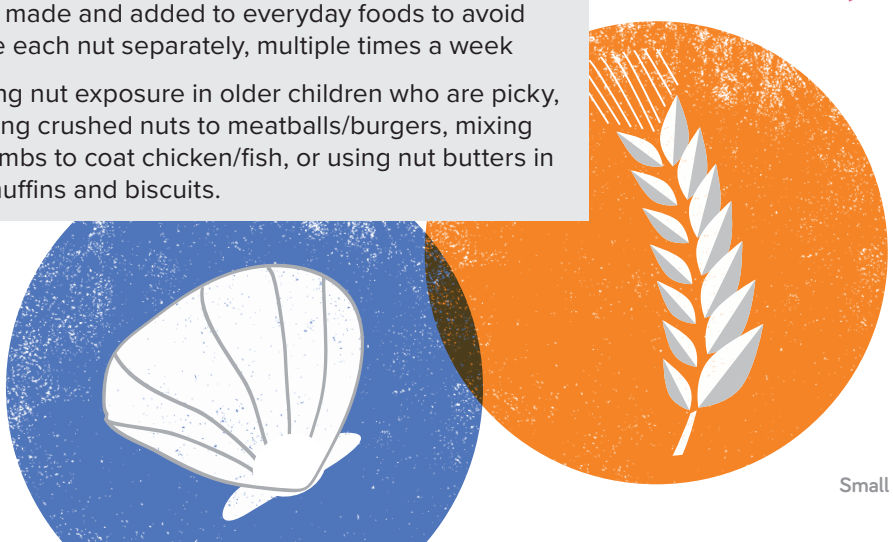
## How can I help anxious parents to introduce allergenic foods into their child's diet?

Parental anxiety around introducing allergens is very common, especially where there is a family history of food allergy, or if the child has eczema. Whilst delaying allergen introduction might feel more comfortable to a parent, it is important to discuss the risks of delaying their introduction.

Anxiety often arises where a parent or a sibling has an existing food allergy. Whilst an immediate family history of food allergy can put the child at greater risk of developing food allergy, this allergy will not necessarily be inherited by the child directly. If one of the child's parents has an allergy to the food being offered, it can be helpful for someone else to lead on the introduction of this food, such as the other parent, a grandparent, or another trusted family member.

Providing advice on how to minimise cross-contamination at home, e.g. thorough hand washing, wiping down surfaces properly and using separate cutlery/crockery to serve the allergenic foods, can help families to feel more prepared if a parent/sibling is allergic to the food being offered.

> "Considering ethnic/cultural preferences when advising on early allergen introduction is key."



## What happens if the child reacts to an allergen?

Children may react when first introduced to a new allergen. Most infants will not present with a life-threatening reaction, but they may develop hives/an urticarial rash (raised, bumpy rash), vomiting or swelling of their lips, face or eyes. As per the British National Formulary (BNF), an over-the-counter antihistamine can be given if required.

If the child has had an IgE-mediated (immediate) reaction to the allergen (see Table 1 below), they should be referred to their local Paediatric Allergy Clinic. The allergen should not be given to the child again until they have seen an Allergy Specialist.

Children with suspected non-IgE mediated food allergy, such as delayed cow's milk allergy, should ideally be referred to their local Community Paediatric Dietitian service for support with conducting a formal exclusion diet. The suspected allergenic food should be removed from the diet for around 2-4 weeks to see if symptoms improve, and then should be re-introduced to see if symptoms worsen again.[8]

> Whilst introducing allergens early is important, it is crucial to ensure that they are then included in the diet regularly to maintain tolerance.

It is uncommon for infants to have severe reactions affecting the airways, breathing or consciousness; however, if any symptoms of this nature do occur, emergency medical assistance should be sought immediately.

Often, when a child has reacted to one allergenic food, they are mistakenly advised to avoid all other allergenic foods. Whilst this might appear to be the 'safer' option, it may actually increase this child's risk of developing allergies to other foods. It is therefore important that parents proceed with introducing other allergenic foods with the help of an Allergy Specialist.

There are some contraindications, e.g. if a child has reacted to cashew, then pistachio should not be subsequently introduced as there is cross-reactivity to the structure of the proteins of these two nuts. Similarly, if a child has reacted to walnuts, then pecans should be avoided.

Some children with cow's milk allergy will also react to soya. However, a child should only avoid soya if they develop symptoms when consuming it, e.g. soya yoghurt, soya milk, edamame etc.

**Table 2:** Presentation of IgE-mediated reactions

| IgE-mediated reactions | |
|---|---|
| **Timing** | Usually occur within 30 minutes of ingesting the allergenic food, but can occur up to 2 hours afterwards |
| **Symptoms** | **Mild-moderate symptoms include:**<br>• Itchy skin rash/hives<br>• Vomiting<br>• Swelling of lips, face, eyes<br>• Abdominal pain<br>**Severe symptoms (known as anaphylaxis):**<br>**Airways**<br>• Persistent cough<br>• Hoarse voice/cry<br>• Difficulty swallowing<br>• Swollen tongue<br>**Breathing**<br>• Difficult/noisy breathing<br>• Wheezing<br>**Consciousness**<br>• Persistent dizziness<br>• Pale or floppy<br>• Suddenly sleepy<br>• Collapse/loss of consciousness |

## Are there any groups of children where this approach would not be recommended?

Whilst infants with eczema are at high risk of allergy and hence would benefit from early allergen introduction, it is important that uncontrolled eczema (i.e. widespread, itchy, or weeping eczema) is treated with the help of a specialist before allergens are introduced.[7] Uncontrolled eczema can make it difficult to assess skin reactions when allergenic foods are introduced.

Caution should also be taken when considering early allergen introduction in infants born prematurely. Introducing solids at the age of 4 months (actual age and uncorrected) is not usually suitable for a preterm infant, as they are unlikely to be developmentally ready. Once the infant has demonstrated good head control and is able to coordinate movements from their hands to their mouth, weaning can commence.

## Conclusions

Early allergen introduction in an infant's diet, particularly in high-risk infants, is key to preventing food allergy. Paediatric Dietitians play a pivotal role in facilitating timely allergen introduction, helping to address parental anxiety around introducing allergens, and advising on practical ways to ensure regular exposure to allergenic foods once they have been introduced.

### Useful resources:

- BSACI – Preventing food allergy in higher risk infants: guidance for healthcare professionals
- BSACI – Preventing food allergy in your baby: A summary for parents
- NHS Start for Life – www.nhs.uk/start-for-life/baby/weaning/safe-weaning/food-allergies

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# Expert-led nutritional care for Lionel, **when it mattered most**

- **The UK's No.1 preterm formula** with the widest, most nutritionally tailored range[1,2]
- Promotes feeding tolerance and helps reduce infection risk[3-5*]
- Aligned with ESPGHAN principles on neonatal nutrition[6]
- Nutriprem HMF supports breastfeeding during early infancy[7†]

Patient images shown are of real patients, using photographs of themselves as preterm infants

**Halal & Kosher**


Scan the QR code to learn more about the Nutriprem range

# NUTRIPREM

**60 years of partnership** in preterm care

*Nutriprem 1 & 2 are the only preterm formulas in the UK to contain prebiotic oligosaccharides[2] which have been shown to reduce the risk of infection[4,5]
†Nutriprem Human Milk Fortifier supports preterm infant growth and preserves breastfeeding during early infancy[7]

**IMPORTANT NOTICE:** Breastfeeding is best. Nutriprem Human Milk Fortifier, Nutriprem Protein Supplement, Hydrolysed Nutriprem, Nutriprem 1 and 2 are Foods for Special Medical Purposes for the dietary management of preterm and low birthweight infants. They should only be used under medical supervision, after full consideration of the feeding options available, including breastfeeding. Hydrolysed Nutriprem, Nutriprem 1 and 2 are suitable for use as the sole source of nutrition for preterm and low birthweight infants. Nutriprem Human Milk Fortifier and Protein Supplement are not suitable for use as the sole source of nutrition. Refer to label for details.

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HMF: Human Milk Fortifier; ESPGHAN: European Society for Paediatric, Gastroenterology, Hepatology and Nutrition.

**MEGHAN VICKERY**
Specialist Paediatric Dietitian

# Dietetic management of a child with cerebral palsy

## Clinical history and diagnosis

Amelia moved into our area and started at a local school for children with disabilities. Amelia has bilateral spastic dystonic cerebral palsy (CP) with a Gross Motor Function Classification System (GMFCS) Level 4. She was born premature and has a severe learning disability. Amelia can sit unsupported and move by commando crawling. She often bounces in her chair and loves swimming. Amelia has had long standing growth concerns and her weight has always been on or below the 0.4th centile. She can feed herself some finger foods, but she is mostly spoon-fed.

## Initial assessment

I met Amelia when she was 6.5 years old alongside her Speech and Language Therapist (SLT). She weighed 16.3kg (0.4th centile) and her supine length was 103.4cm (0.4th centile). It can be challenging to accurately measure length in children with neurological impairment (NI) due to hypertonia and scoliosis. ESPGHAN advise not to use height and weight measurements alone to assess nutritional status in children with a NI.[1] When seeing Amelia, she appeared underweight; therefore, I felt her length was an underestimation.

Amelia had a good appetite and enjoyed mealtimes. She would eat three meals and snacks per day. Mealtimes often took a long time, and it could be difficult to identify the volume of food eaten due to the amount of food spilled. Amelia would consistently drink less than her fluid requirements.

She suffered with constipation and was using an osmotic laxative to support regular bowel movements. She would become dysregulated if she was hungry and during transitions – food and nursery rhymes helped to regulate her.

## Dietetic and SLT plan

SLT advised that Amelia was able to manage majority of textures providing she had support to eat. Her diet recommendations are the International Dysphagia Diet Standardisation Initiative (IDDSI) Level 0 fluids (thin fluids) and Level 7 foods (regular easy to chew) – see Figure 1.[2] We aimed to achieve catch up growth, so I advised food fortification including an oral nutritional supplement (ONS); in this case, neutral Fortini Compact Multi Fibre* (MF). Her family would add this to her breakfast and mix through suitable meals, for example pasta, mash potato and curry. The aim was to increase energy intake but not increase food volume.

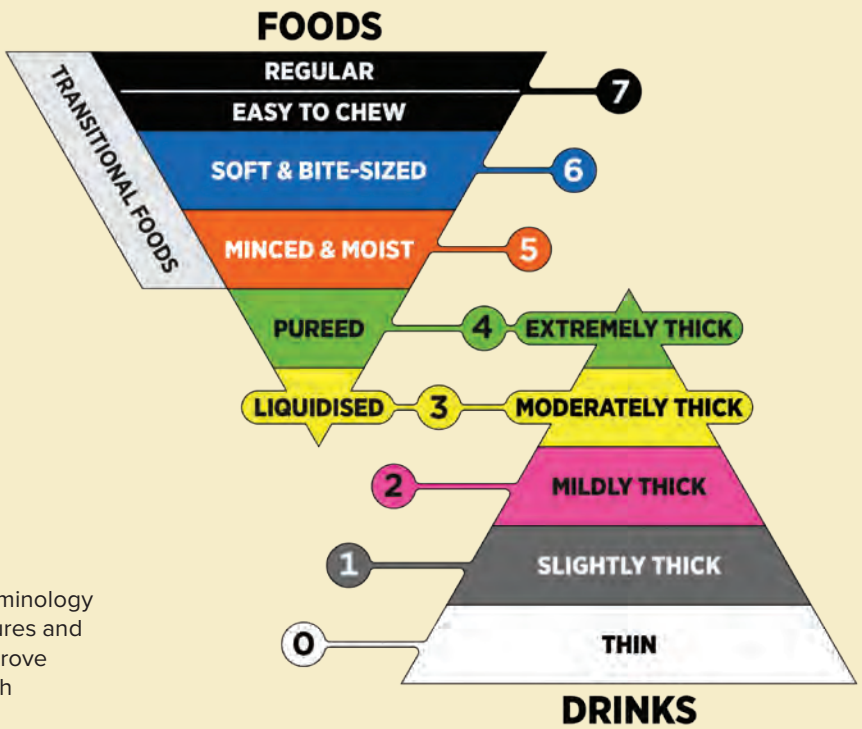
## Initial follow up

6 months later (7 years old) Amelia weighed 17.1kg (0.4th centile), meaning her growth continued to track. Her length was 119cm (25-50th centile); this appeared more accurate compared to her initial length.

## Third review

Amelia's family moved home and she became fussier with her foods. She began to refuse meals unless they were her favourites and she would only eat snacks in school. She started to struggle with some sickness, particularly in the evenings. Her food intake was meeting approximately 60% of her estimated energy requirements for catch up growth. I recommended two bottles of Fortini Compact MF* to meet her energy deficit. This helped to improve her weight. At 7 years 3 months she weighed 19.3kg (>2nd centile).

**Figure 1:** The IDDSI Framework




Providing a common terminology for describing food textures and drink thicknesses to improve safety for individuals with swallowing difficulties.

## Unexpected change

Amelia became unwell and subsequently developed an aversion to drinking. This resulted in a nasogastric tube (NGT) being passed. She was only eating snacks – therefore her feeding regime aimed to meet her fluid requirements and 80% of energy requirements via four bolus feeds throughout the day.

Initially, Amelia struggled with sickness and nausea and was commenced on domperidone and omeprazole which helped significantly.

With time and encouragement, Amelia started to eat and her feeding plan became much more flexible. She would still have a top-up feed before bed and extra depending on her food intake during the day. Amelia's feeding plan continued to meet her fluid requirements.

## Ongoing management

Amelia continues to be weighed in school monthly. She has a NGT for fluid top-up only. She continues to have three-monthly dietetic appointments, and her family contact us if they have any concerns.

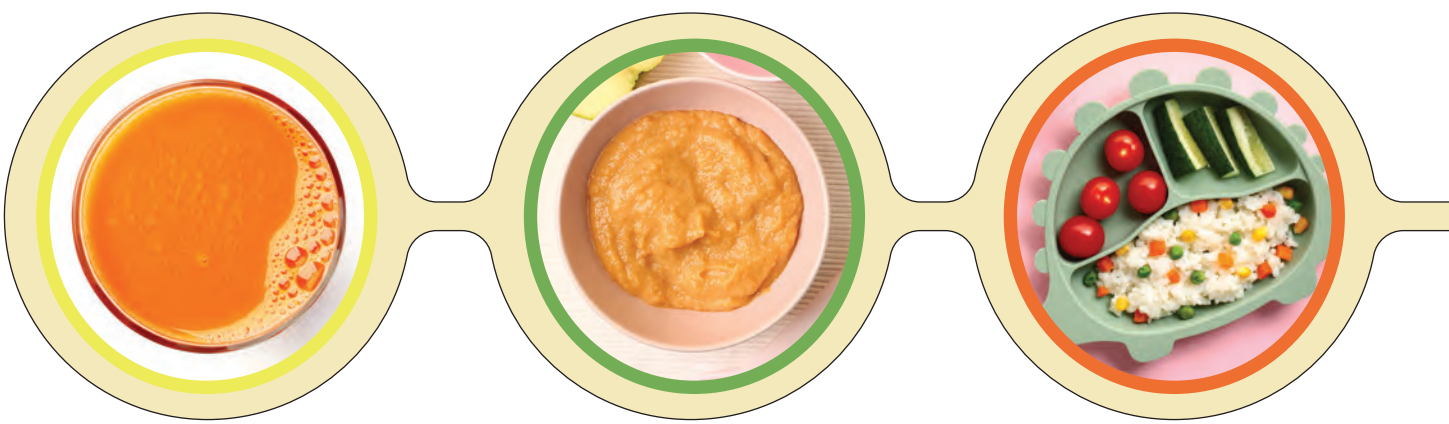
She is not having any ONS currently as she is eating well at home and school. Amelia's family have a small supply to use when she attends a different setting, as this can reduce her food intake.

Children with CP are at greater risk of malnutrition[3] and there are many factors that contribute to this – Table 1 highlights the factors that affect Amelia.

**Table 1:** Factors affecting Amelia's growth and oral intake

| Factor | Description related to Amelia |
|---|---|
| **Physical Activity Level** | Has hypertonia which can lead to involuntary movements.<br>She cannot walk but does enjoy bouncing and commando crawling.<br>These factors can make it difficult to quantify energy expenditure. |
| **Dysphagia** | Foods need to be a safe consistency for her to swallow efficiently. |
| **Food preferences** | Will sometimes refuse foods if they are not her favourite foods. |
| **Gastrointestinal symptoms** | Constipation<br>Reflux |
| **Changes in routine/ environment** | Her appetite and food acceptance can reduce with uncertain changes. |
| **Dysregulation** | Foods, such as chocolate buttons, can help calm situations. |

> It is important to choose an ONS that is suitable for the child and that can be flexible in how it is used.



## Discussion and practice points

92% of children with CP have significant gastrointestinal symptoms and constipation is common in children with NI.[1] ESPGHAN advise to increase a child's fluid and fibre intake to support regular bowel movements.[1] Abnormal muscle tone can increase a child's energy expenditure up to 10%[1], which impacts a child growth if energy requirements are not met orally. Compact ONS, and those containing fibre, can benefit children suffering with these symptoms. For Amelia, Fortini Compact MF* helped increase the energy density of her food to meet her energy demands and provided some fibre to support regular bowel movements.

Amelia significantly enjoys mealtimes and loves her favourite foods (chocolate buttons). It is crucial to support enjoyment of food and quality of life alongside meeting nutritional needs.

It is important to choose an ONS that is suitable for the child and that can be flexible in how it is used. Think outside of the box:

- What can it be added to?
- Can it be given in small, frequent doses?
- Would the individual prefer it frozen or warm?

ONS must meet the child's modified diet recommendations from SLT. This is to ensure eating is safe but also efficient.[1]

Finally, working alongside key professionals is essential to support a child holistically. In Amelia's case, I work alongside her school nurse, SLT and a paediatrician. Children often follow different routines in different settings; therefore, a plan needs to factor these differences in.

## Conclusion

In conclusion, there are many factors that contribute to nutritional status for a child with CP. ONS can be beneficial in meeting energy demands when a child struggles to meet them with diet alone.[1,3] A child-centred plan that can adapt and evolve throughout a child's journey is the key to success.

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3. *Silva, et al. Rev Paul Pediatr. 2023;42:e2022107.*




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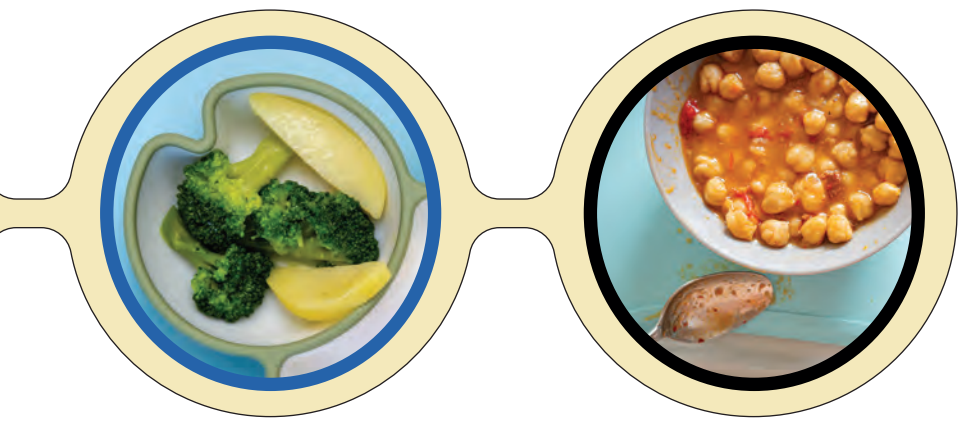

**SIMEON RAMET**
Head of Paediatric Medical Affairs

# Fortini – A millennial now reaching a quarter of a century


In **2001**, the world was welcoming iTunes, the iPod, the launch of Wikipedia, Harry Potter's first appearance on the big screen, and Shrek's immortal line, *"That'll do, Donkey"*. But while headlines focused on these milestones, something equally transformative was happening in paediatric nutrition: Fortini was launched! This represented Nutricia's first comprehensive oral nutritional supplement (ONS) designed specifically for children with, or at risk of, faltering growth.

For these children, achieving and maintaining adequate nutritional status is fundamental to improving clinical outcomes and long-term health. ONS have been shown to support catch-up growth, enhance nutritional status, and reduce susceptibility to infection.[1] Reflecting this evidence base, NICE guidelines recommend the use of ONS in infants and children whose faltering growth persists despite food-based strategies.[2]

The launch of Fortini in the early noughties (now approaching a quarter of a century old!) was a significant innovation milestone. It was specially formulated to meet the unique metabolic needs of paediatric patients; higher energy requirements, appropriate protein composition, and the right balance of micronutrients, in a product designed to taste appealing to young patients. And, while today's packaging benefits from advanced design techniques, the original brightly coloured Fortini cartons at the time were every bit as pioneering as the product inside.

As Fortini started to grow and play catch-up to more established brands at the time, the addition of our MF6™ fibre blend quickly followed. Fortini Multi Fibre became the first-line ONS product for many, as fibre intakes were – and in many cases still are – poor in children.[3] Fortini Multi Fibre still contains the unique patented MF6™ blend of soluble and insoluble fibre which has been shown to help maintain gut health.[4]

In 2007, during a focus group, dietitians relayed feedback from parents expressing the need for a Fortini option that was designed to taste neutral, like milk, and one that could be added easily to foods or used as a plain option. From that initial idea, Fortini Multi Fibre Unflavoured was developed and subsequently brought to market in record time.

Developing an ONS for children designed to have a neutral milk taste was a significant technical challenge; however, the result speaks for itself. Today, it remains an excellent product with remarkable versatility.


> ONS are clinically important when food-first strategies aren't enough, supporting catch-up growth and improving nutrition.

As Fortini grew up, consumer trends were fast influencing Foods for Special Medical Purposes and smoothies were (and still are) all the rage by the late-noughties. Fortini wanted to spread its appeal into the new world and Fortini Smoothie was launched in two fruity flavours. They were unique in the ONS space as they combined 15% real fruit with a tangy flavour to boot; Fortini was now a teenager coming of age.

Many Fortini users have complex needs and take ONS for extended periods of time, so it's important for Nutricia to keep innovating and ensuring there's a product for everyone. This is particularly evident in children with complex neurodisabilties who struggle to eat, drink and maintain their nutritional status. Our German market gave us a semi-solid scene setting about the needs of these children and the concept was further refined into Fortini Creamy Fruit, launched in 2014. A real fruit containing product that can be used as a taster for children with minimal intakes, or to be used as a dessert style product to help children avoid flavour and taste fatigue.

In the late noughties, Fortini's older sibling, Fortisip Compact, had already revolutionised the adult ONS market. Using a special type of protein, Nutricia were able to squeeze 300kcal from a 200ml bottle into a 125ml bottle. Taking this technology into paediatrics, Fortini Compact Multi Fibre was the first 'Compact' Paediatric ONS to hit the market in 2017 and came along with some new flavour technology to enhance the taste to new heights.

Evidence from a randomised controlled trial showed a 37% higher compliance rate with the compact product versus the 200ml option, as well as improved nutritional intake from both ONS and everyday food within just four weeks, securing its place as a noteworthy addition to the Fortini range.[5] Fortini has always been synonymous with helping to support catch-up growth in children but at the same time as maximising everything a child can eat. At Nutricia, we recognise that a 'food first' approach is fundamental in managing faltering growth, supporting both adequate nutrient intake and healthy eating habits. However, when achieving adequate energy and nutrient intake through food alone becomes challenging, paediatric specific ONS can play an important supportive role, helping to close nutritional gaps without displacing food.

Fortini is also highly versatile, allowing it to be added to everyday meals and recipes to increase energy and nutrient density while maintaining familiar flavours and textures. This approach helps ensure children receive the energy and micronutrients they need, while keeping food at the centre of their nutritional management.

As you can see, Fortini's come a long way – the old packaging here may look outdated, but the characters on every bottle also became a way of children identifying which product they wanted. To reward kids who took their prescribed amount daily, we had Wallace and Gromit's Reward scheme that has now been updated into the All Stars Club. It's a really successful way to encourage children to follow their nutrition plan and have some fun and reward along the way.

Fortini's heritage now spans 25 years and it's been launched in more than 30 countries, supporting children worldwide. As Shrek famously said to his friend: 'You know, Donkey, sometimes things are more than they appear.'

**Fortini All Stars Club** is an engaging way to support children in taking their Fortini ONS, with fun rewards to collect along the way.

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**IMPORTANT NOTICE**
All products shown here are Foods for Special Medical Purposes and must be used under medical supervision. See individual product labels and datacards for more information.

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NUTRICIA ACADEMY
Feed your mind

# “All gone”

*This bottle did contain Fortini Compact Multi Fibre*


# Nutritionally complete (d)

## The best ONS is one that children can finish

With its low volume, energy density and great taste, Fortini Compact Multi Fibre significantly improves growth compared to standard ONS, within just 4 weeks.[1*]

**37%**

**Higher**

**compliance rates** with Fortini Compact Multi Fibre[1*†]

**45%**

**Higher**

**mean total energy intake** with Fortini Compact Multi Fibre[1*]

**32%**

**More**

**patients achieved their primary dietetic goal** with Fortini Compact Multi Fibre[1†]


## Free sample**

Order a free sample direct to your patient’s home

ONS: oral nutritional supplement

**This information is intended for Healthcare Professionals only.**

**IMPORTANT NOTICE:** Fortini Compact Multi Fibre is a Food for Special Medical Purposes for the dietary management of disease related malnutrition and growth failure in children from one year onwards, and must be used under medical supervision.

*Standard Paediatric ONS is 1.5kcal/ml, 200ml. Standard ONS group received Fortini Multi Fibre®/Nutricia, Fortini®/Nutricia or Paediasure Plus®/Abbott.

†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.

**Date of publication: February 2026.**

NUTRICIA
Fortini

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Clinical Specialist Paediatric Dietitian,
Cystic Fibrosis

# Managing oral intake in children with Cystic Fibrosis and Cerebral Palsy

## Introduction

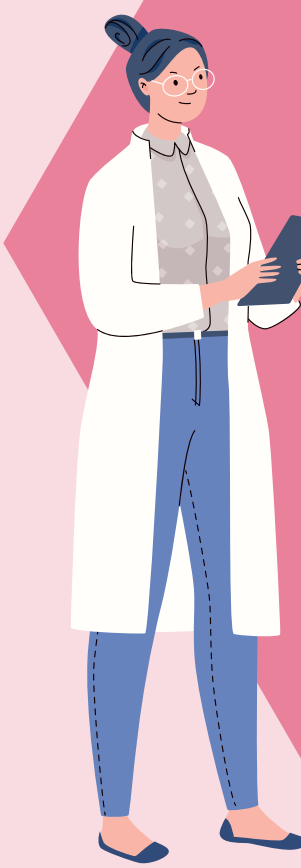
Cystic Fibrosis (CF) and neurological conditions are both life-long, often requiring intense treatment burdens. A concurrent neurological diagnosis can pose unique challenges in the clinical management of CF care.

CF has, historically, been associated with a substantial and advancing multisystem pathology. This comes with a burdensome treatment regimen, complex psychosocial challenges and reduced life-expectancy.[1]

For children with CF (cwCF) who also have a concurrent neurological diagnosis, such as Cerebral Palsy (CP), complex and overlapping challenges will present, especially respiratory health, mobility and nutritional care.

There has also been a transformative change in the management of many, though not all, people with CF (pwCF). Life expectancy is increasing, largely driven by the introduction of newborn screening (NBS), multidisciplinary care and nutritional support, along with rigorous screening and optimisation of comorbidities (e.g. diabetes).[2] More recently, the introduction of cystic fibrosis transmembrane conductance regulator modulators (CFTRm) has brought significant benefits, such as a significantly increased life expectancy, for those who are eligible, and are able to tolerate and access them.[1,3] Consequently, there is now more attention on the complexities of ageing.[4] Managing an ageing CF population along with a concurrent neurological diagnosis will pose new challenges and priorities for pwCF, their families and their healthcare teams.

In cwCF and CP (cwCF/CP) there are several areas with overlapping dietetic concerns, such as growth, nutritional requirements and gastro-intestinal (GI) issues. In this article, we are going to look at patient scenarios for cwCF/CP.



## Children with CF and CP

Tables 1 and 2 demonstrate the key aspects of CF and CP.

**Table 1:** Key aspects of Cerebral Palsy

| |
|---|
| **Causes:**<br>Results from abnormal brain development or damage, often during pregnancy, childbirth, or early infancy. |
| **Symptoms:**<br>Spasticity, hypotonia, jerky or uncontrolled movements, poor coordination.<br><br>A spectrum of respiratory, nutritional and digestive complications, including respiratory infections, aspiration, constipation, gastro-oesophageal reflux disease (GORD). |
| **Types:**<br>Spastic (most common, stiff muscles), Dyskinetic (uncontrolled movements), Ataxic (balance issues), and mixed types. |
| **Associated conditions:**<br>Motor issues, learning disabilities, epilepsy, hearing, vision, or speech difficulties. |
| **Management:**<br>Multidisciplinary team (MDT) approach, including physiotherapy, occupational and speech therapy, dietetics.<br><br>Medication and/or surgery to help manage symptoms and improve function and quality of life (QoL). |

**Table 2:** Key aspects of Cystic Fibrosis

| |
|---|
| **Causes:**<br>Genetic Mutation: Caused by mutations in the CF transmembrane conductance regulator (CFTR) gene on chromosome 7.<br><br>Autosomal Recessive: Must inherit two copies of the defective gene, one from each parent. |
| **Mechanism:**<br>The faulty gene causes the CFTR protein to malfunction, disrupting the movement of salt (chloride) and water in and out of cells, leading to thick, viscous mucus. |
| **Symptoms:**<br>Most children are diagnosed via NBS, some may be diagnosed in later life.<br><br>***Respiratory:*** Persistent cough with thick mucus, wheezing, shortness of breath, frequent lung infections, nasal polyps, chronic sinusitis.<br><br>***Digestive/Nutritional:*** Majority are pancreatic insufficient (PI), requiring pancreatic enzyme therapy (PERT) to help treat and prevent steatorrhoea, chronic constipation, abdominal pain, poor weight gain and slow/faltering growth. Fat soluble vitamin supplementation also required. |
| **Associated conditions:**<br>***CF-Related Diabetes (CFRD):*** Damage to the pancreas reduces insulin production.<br><br>***Liver Disease:*** Blocked bile ducts leading to cirrhosis.<br><br>***Osteoporosis/Osteopenia***.<br><br>***Infertility:*** Affects most men (absent vas deferens) and reduces fertility in women. |
| **Treatments:**<br>Although no cure, treatments have improved life expectancy.<br><br>***Airway Clearance:*** Techniques and devices (e.g. vibration vests, PEP masks) to loosen and cough up mucus.<br><br>***Medications:*** CFTRm: Targeting specific genetic mutations to improve protein function. Antibiotics, mucus thinners, bronchodilators.<br><br>***Nutritional Support:*** PERT, vitamin supplements (A, D, E, K).<br><br>***Lifestyle:*** Regular physical exercise. |

## Key considerations

### Respiratory challenges

Children with CF and CP are at significant risk of severe respiratory infections. The combination of thick mucus in CF and impaired clearance mechanisms (due to motor deficits) in CP can lead to chronic lung infections. Repeated infections can increase energy requirements.

### Aspiration risk

Serious respiratory illness in children with CP (cwCP) results from several contributing factors. Oropharyngeal dysphagia, GORD and seizures all increase the risk of aspiration, further complicating lung health. Aspiration can cause respiratory illness due to bacteria being present in the aspirate or chronic inflammatory responses in the lungs. Signs of aspiration include choking, coughing and changes to breathing and voice, but it can also be silent, which is detected using a video fluoroscopy.

Scoliosis is associated with severe gross motor impairment and other comorbidities, and is another risk factor because it reduces lung capacity.[5,13] If aspiration is suspected, it is essential that it is investigated and appropriate treatment initiated.

### GI symptoms

Aside from dysphagia, common overlapping considerations in CF and CP are GI issues. In cwCF it's important to also consider potential PI, steatorrhea and abdominal pain. In cwCF/CP, the overarching priorities of supporting nutritional status, growth and QoL need to be carefully navigated. Up to 92% of children with CP have significant digestive issues which can reduce intake and further impact nutritional status, for example GORD, retching, vomiting and constipation.[18]

Figure 1 outlines the assessment and management of children with neurological impairment.

> In cwCF/CP, the overarching priorities of supporting nutritional status, growth and QoL need to be carefully navigated.

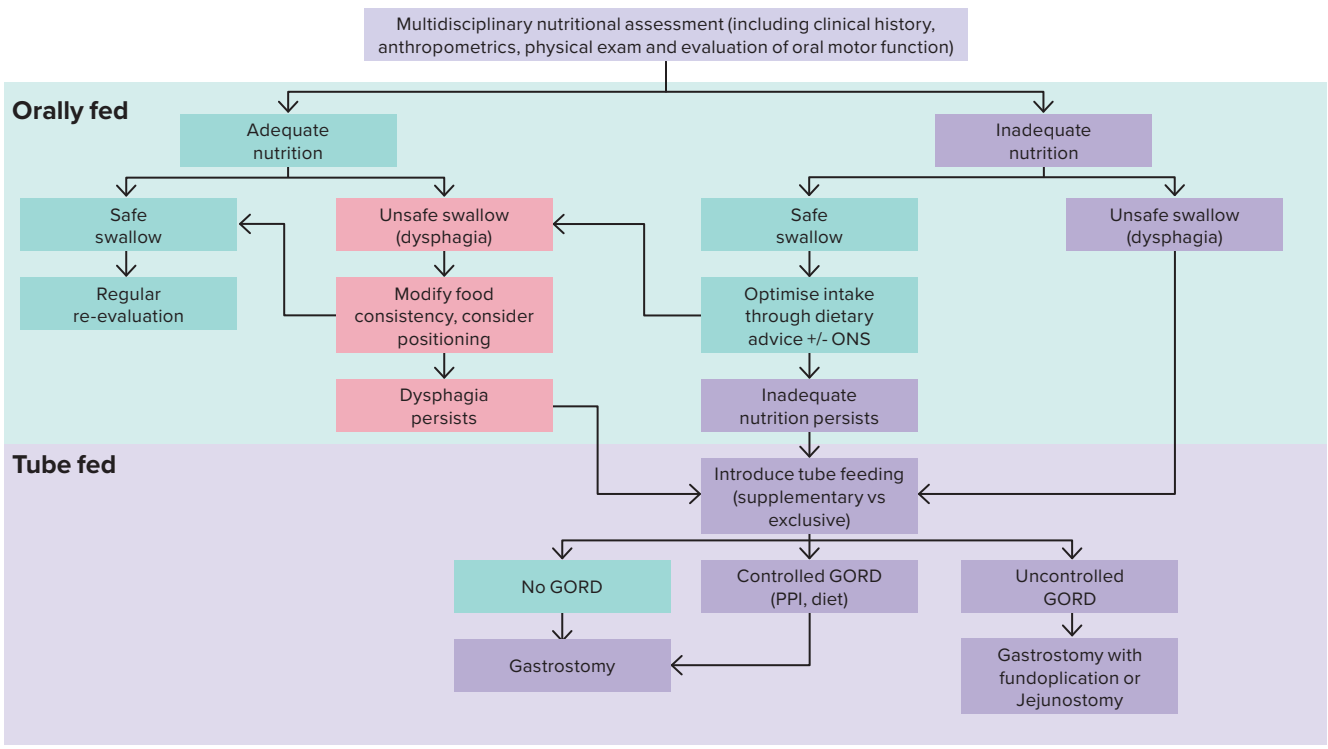



**Figure 1 :** Nutritional management of children with neurological impairment, adapted from Romano et al, 2019.[6]

GORD: Gastro-oesophageal Reflux Disease, ONS: Oral Nutritional Supplement, PPI: Proton Pump Inhibitor.

## Growth assessment

If the child can stand, standard growth charts should be used, whereas measuring growth can be challenging if they are unable to stand. Segmental measurements are reliable and valid to obtain an estimated height, calculated from ulna length, knee height and tibial length.[7]

Assessment of undernutrition/malnutrition in cwCF/CP should not be based on CP-specific growth charts. CwCP often have a low body size (both height and weight) and so a different composition from neurologically developed children. According to ESPGHAN, signs of malnutrition include a weight for age that is 2 standard deviations below the mean and fat mass measurements (triceps skin fold, arm muscle area) below the 10th percentile.[6]

Body mass index (BMI) has long been identified as an independent predictor of mortality in CF and was endorsed for clinical evaluation in cwCF.[8,9] BMI became the defining standard, recommending children and young people (2 to 20 years) maintain a BMI at or above the 50th percentile. However, with improved treatments, CF is moving from a condition associated with undernutrition to one increasingly associated with appropriate nutritional status and overnutrition.[10] BMI does not distinguish between fat mass (FM) and fat free mass (FFM), or lean body mass (LBM), which reflect different health status - the focus is now on body composition.

Bio-electrical impedance (BIA) is recommended to assess body composition in cwCF and is non-invasive.[11] A study of cwCP has also highlighted that standard measures, like BMI, may not adequately reflect nutritional risk, especially in those with greater motor impairment.[12] A comprehensive assessment of body composition is recommended to guide individualised, function-based nutritional strategies.[12]

Assessment should also include measurement of bone mineral density and micronutrients, both routinely recommended in CF, as well as other signs of malnutrition (e.g. skin condition, pressure areas).[11]

## Energy requirements

Many cwCP have decreased energy requirements compared to neurotypical children, and these differences increase with impairment severity. For example, wheelchair bound cwCP reportedly have 60-70% of the energy requirements of neurotypical children, but any physical activity should be considered.[13,25]

ESPGHAN recommends using dietary reference standards for typically developing children to estimate the energy requirement for cwCP.[6] As energy expenditure is based on basal metabolic rate, which is strongly influenced by body size and composition (especially FFM), this may overestimate energy needs due to the low weight and height of many cwCP and variation in FFM (muscle tone).

For cwCF, energy requirements were set at 120%-200% of the recommended energy intakes.[14] With the changing landscape in this new era of CFTRm, energy requirements have yet to be defined. Therefore, growth parameters are still the best method for assessment.

As a starting point, choose a method to calculate requirements. If growth is appropriate, this should be considered as a success. Growth should be monitored 3-6 monthly, depending on the age of the child; more frequently if it falters.

## Protein requirements

There is no evidence to suggest that protein needs of cwCP differ. Protein requirements for typically developing children are therefore recommended.[6] If undernourished, additional protein (along with energy) may be required to promote 'catch-up' growth, e.g. up to 2.0 g/kg per day of protein and an additional 20% increase in energy intake.[15]

## Micronutrients

In cwCF, ESPGHAN recommendations for micronutrients for CF should be followed.[11] CwCF/CP can be at risk of micronutrient deficiencies, particularly calcium, iron, zinc, vitamins C, D and E, and selenium,[18] especially if tube fed.[6] Starting with the requirements for typically developing children is recommended.[6]

## Nutritional management

Both conditions can impact weight gain. CF causes digestive issues and nutrient malabsorption, while CP can involve feeding and swallowing difficulties and digestive issues, necessitating specialised diet plans.

There is no evidence to show whether optimising nutritional intake in young people with CP prevents respiratory illness. However, in people without CP, there is evidence that insufficient nutrition leads to weakened immune responses.[16]

If cwCP have poor nutritional status, dietitians should look to optimise nutritional intake whilst managing the risk of aspiration and digestive issues.[17]

Children with CF and neurological conditions will fall into one of several categories of nutritional support, depending on symptoms. Nutritional status, the ability to consume adequate quantities of food and fluids, and pulmonary aspiration risk all affect the type of nutritional support required. Impaired swallowing, poor co-ordination of breathing with swallowing during meals, and GORD all contribute to the requirement for nutritional support and impact the route of feeding. GI symptoms, including constipation, retching and vomiting, can further complicate management. The level of support required is dynamic, depending on how either condition develops. ESPGHAN has published a useful guide to support decision-making.[18]

Options include:

- Oral intake with food texture modifications
- Oral intake with food fortification and oral nutritional supplements (ONS)
- Oral intake plus enteral tube feeding (ETF)
- All nutrition by tube and nil by mouth (NBM).

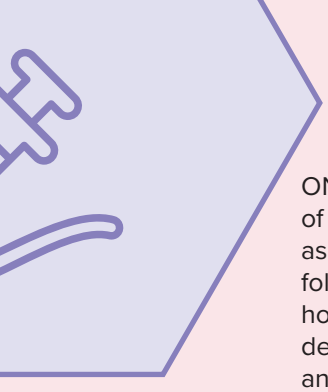
The first option, where possible, should involve oral nutritional support, aiming to increase the energy, protein and micronutrient content of the diet. The trial of oral intake will also depend on the child's age and severity of malnutrition.[6]

The decision to modify the diet and/or use of non-oral feeding methods is individual, depending on a wide range of factors. Firstly safety, with the risk of aspiration and respiratory disease discussed, allowing families to make a fully informed decision. Other factors for consideration are growth, weight gain and QoL.

Food texture modification needs to be assessed in conjunction with a speech and language therapist using the International Dysphagia Diet Standardisation Initiative (IDDSI) classification. As respiratory symptoms are common in cwCP, especially at mealtimes, it is important to consider the risk of respiratory illness associated with pulmonary aspiration regularly.[5]

If faltering growth is an issue, food fortification and ONS have an important role to play. As well as the standard ranges, other options include compact varieties for smaller volumes, higher density requirements and fibre options. Fibre recommendations for cwCP are in line with typically developing children.[18]

> Children with CF and CP face overlapping respiratory, nutritional and feeding challenges that demand a highly individualised MDT approach.



ONS can significantly contribute to the intake of micronutrients (and potentially fibre) as well as additional energy and protein. An initial follow-up in 1-3 months is usually sufficient; however, the length of time to trial an ONS depends on age and nutritional status. Infants and those with a poorer nutritional status will need to be reviewed more frequently.[19] If nutritional status continues to be of concern, ETF should be considered.

Nutritional goals are for optimal growth and nutritional status, but it can be a fine balancing act. For those who can eat but require supplementary tube feeding, allowing the child to eat what they want may provide enjoyment and add to QoL. However, food choices may not always be the most nutritious, leading to nutritional imbalances. For example, if less ETF is given and poor nutrient dense foods consumed, nutritional depletion may become an issue. If the full prescribed ETF is given and the child is allowed to eat high energy but poor nutrient dense foods, then excess weight gain may occur. Feeding should not be stressful for the child or family or take excessive amounts of time to the exclusion of other activities, e.g. a maximum of 30 mins per feed. If families are spending many hours a day trying to feed their child it can significantly impair QoL, and this is often when the option to tube feed is decided.[20]

Whatever route and regimen are used, families need to be supported with options to explore different feeding scenarios.

## Considerations for ETF

Indications for ETF include:[19,20]

- unable to meet nutritional requirements orally, despite oral nutritional support
- more severe undernutrition
- significant feeding and swallowing dysfunction (with a risk of pulmonary aspiration) or stressful oral feeding sessions/prolonged feeding times.

ETF may be used solely (for those with an unsafe swallow) or to supplement oral intake. The choice of access for ETF will depend on the clinical status of the child but is usually gastrostomy. Nasogastric tube feeding (NGT) should only be used acutely until a gastrostomy can be placed. Post-pyloric feeding, such as a jejunostomy tube, is another alternative if gastrostomy feeding is not tolerated, e.g. with GORD.

### Methods of feed delivery

ETF can be administered in several ways: bolus, intermittently, or continuously, using an ETF pump. For example, some children may be able to eat during the day and have a top-up feed overnight or during the evening. Combination feeding is another option, with overnight continuous feeds and boluses during the day to provide sufficient nutrition. This method is suggested by ESPGHAN for children with high calorie requirements but poor volume tolerance.[6] Some families only give bolus feeds during the day as and when required, depending on the child's intake for that day.

### Choice of feed

Many commercial enteral feeds are available, including polymeric, semi-elemental and elemental formulas, tailored for different age groups. They vary in energy density, fibre, macronutrient and micronutrient content, osmolarity and packaging.

For increased energy requirements or fluid restriction, a high-energy formula may be useful. Lower-energy formula feeds are available for reduced requirements.

Fibre-containing enteral feeds are recommended, especially if diarrhoea or constipation are experienced.[21] Feeds with dietary fibre have been shown to have potential beneficial effects for the prevention of both diarrhoea and constipation.[22] CwCF would also benefit from a fibre-containing feed, as it is well established that they can have low fibre intakes.[23] In cwCP, insufficient fluid intake may predispose to constipation, especially for those who tend to choke, dribble or vomit. Also, for children with masticatory and swallowing difficulties, a puréed diet may be insufficient to stimulate active peristalsis in the bowel.

> Managing both conditions can be demanding on families, highlighting the need for comprehensive support services.

### Special considerations

Where scoliosis is present, especially in moderate to severe cases, this can press on the stomach and other digestive organs, as the unnatural spinal curve reduces torso space, leading to digestive discomfort, GORD, constipation, bloating and nausea. If volume tolerance is an issue, a higher energy formula may be preferred.

Blenderised food is increasingly being used by parents for their tube-dependent children. To date, there is little published evidence on the potential health benefits or risks of this practice and the best way to use it.[6] The child's needs should be carefully considered. Commercial feeds containing food-derived ingredients are available, providing a potential suitable alternative, so long as the foods used are not contraindicated.

Whey-based formulas may be beneficial in children with poor feed tolerance due to delayed gastric emptying and GORD.[18,24] Peptide-based formulas are often introduced when standard polymeric whole-protein feeds are not tolerated. These are also available in higher energy options.

Medium-Chain Triglyceride (MCT) feeds are indicated if there are malabsorption issues. As MCTs are absorbed directly into the portal vein, bypassing typical fat digestion, they require less PERT. This can be helpful in tube fed cwCF, especially if NBM, and the PERT must be administered via the tube.

## Summary

Dietetic care for cwCP and CF requires an individualised approach to provide adequate macro and micronutrients, fibre and fluids, alongside regular assessment to help ensure optimal growth is achieved. A safe eating experience is essential with any impairment supported. This requires the MDT working with family members to ensure a collaborative approach. Managing both conditions can be demanding on families, highlighting the need for comprehensive support services.

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NUTRICIA ACADEMY
Feed your mind

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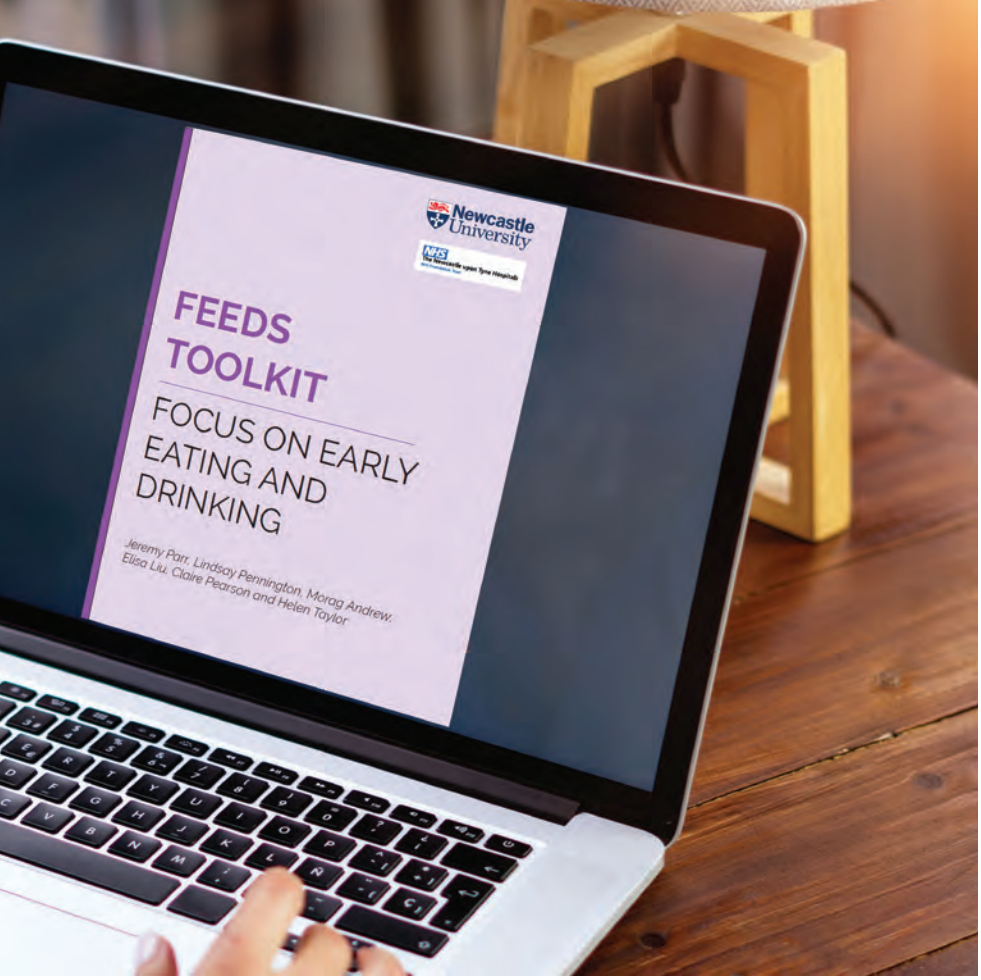
# Introducing the new evidence-based resource for shared decision-making with parents of children with eating, drinking and swallowing needs




> Parents stressed the importance of having a Toolkit of interventions that a healthcare professional could introduce them to – the FEEDS Toolkit.

Children with eating, drinking and swallowing (EDS) difficulties as part of a neurodisability or neurodevelopmental condition often face significant challenges with nutrition, growth, and mealtime participation. Inadequate nutrition can affect growth, hydration, energy levels, and overall health and development. There may be specific concerns about swallow safety, sensory-based feeding challenges, or gastrointestinal and respiratory health. Parents report stress related to EDS, and anxiety about what the future may hold, whilst navigating potentially complex care pathways, limitations in services offered, and waiting lists that may delay the support needed.

These difficulties can affect many aspects of family life. Difficulties engaging in mealtimes at home and elsewhere can impact quality of life for children and their families. For example, mealtime challenges can result in families being unable to eat outside of the home or affect wider family willingness to help care for a child around mealtimes, leading to reduced social networks or support for a child and their family.

Families report a lack of reliable information about EDS difficulties and interventions, and would value access to reliable resources. Shared decision making is an important part of personalised care and intrinsic to our professional standards.[1] Accessible resources are required to facilitate this.

The **FEEDS Toolkit** was developed to address this gap. Co-produced by parents and a multidisciplinary team (MDT) of speech and language therapists (SLTs), paediatricians, a dietitian and a clinical psychologist, the FEEDS Toolkit brings together evidence-based interventions for early feeding difficulties in a format designed to support collaborative, personalised care.

This article explores the clinical context for the FEEDS Toolkit, the evidence behind it, and how it can support MDT working. It also draws on parent and professional experiences from a small quality improvement (QI) evaluation within a Trust, that provides initial evidence of its feasibility, acceptability and utility in routine practice. More than 200 healthcare professionals from over 40 NHS Trusts have now been trained in FEEDS Toolkit use. At the end of the article there is information for those interested in being trained to use the FEEDS Toolkit with subsequent free access to the materials.

## Evidence for resources to support shared decision-making

The *Focus on Early Eating, Drinking and Swallowing* (FEEDS) Review looked at what EDS interventions are available and can be delivered at home by parents of young children with neurodevelopmental conditions.[2] Through an evidence review, surveys and workshops with parents and professionals, the study identified **evidence-based interventions** addressing both physical and non-physical (e.g. sensory and behavioural) issues for children with EDS difficulties.

Parents and professionals agreed that they needed a Toolkit to bring together all the information to support shared decision-making. This led to a core multidisciplinary team of SLTs, paediatricians, a dietitian and a clinical psychologist, alongside local parents and professionals, co-producing the Toolkit. Participating parents had varied experiences and backgrounds. The professionals included a range of allied health professionals and education staff supporting pupils with EDS difficulties in school. Feedback from parents and professionals informed all aspects of the Toolkit, including the content, organisation, and visuals. Further work has described how intervention use varies by neurodevelopmental diagnosis and professional role, and how this informed the Toolkit's development.[3]

## What is the FEEDS Toolkit?

The FEEDS Toolkit is designed to support shared decision-making by helping families understand the rationale behind interventions and how to implement them safely and effectively at home. The Toolkit is an A4, full-colour booklet designed for ease of use. It includes:

- **Intervention summaries:** evidence-based approaches drawn from the FEEDS Review, for example, 'Enhancing Diet', 'Scheduling of Meals' and 'Graded Exposure to New Food'.
- **Background context:** key considerations about paediatric EDS and early feeding.
- **Visual aids:** diagrams, icons, and illustrations.
- **Reproducible action plan templates:** for completion by parents and professionals working together.

## Introducing the Toolkit to a family

During the co-production process, parents stressed the importance of a professional introducing the Toolkit to families, ensuring shared decision-making personalised to each child. Parents can be directed to the interventions most relevant to their child, or most useful sections of information in the Toolkit. Using the Toolkit, parents and healthcare professionals can jointly agree and prioritise which interventions to use at any given time and create a personalised action plan.

Parents and professionals have highlighted that timing is important; for example, some families may feel unable to engage with the Toolkit effectively at certain times in their child's health journey. However, it can help structure conversations, clarify options, and support parents to feel more confident and informed.

> Parents described the Toolkit as helpful, reassuring and easy to use.

## Supporting broader conversations

Parents agreed that the Toolkit should be kept by families to aid discussions and share information with other healthcare professionals and caregivers. For example, parents have told us the Toolkit has helped them explain their child's needs to other family members and nursery/school settings, supporting more consistent implementation of strategies across home and education environments. It can also support professionals working with a holistic approach, for example by providing an overview of different interventions from different disciplines. It may also help with multi-disciplinary working and accountability between different professionals when there are clear aims and interventions written down for a child, especially if these are accessible to everyone supporting a particular child.

In the words of a dietitian who took part in our quality improvement (QI) evaluation (see below) "*The action plan including dietitian advice and SLT advice was a nice way of referring back to current goals and interventions. As a dietitian, you often get asked for advice from SLT, so the action plan helped*".

## Toolkit user experiences from our NHS quality improvement (QI) evaluation

The aim was to explore whether parents and professionals used the Toolkit, found it easy to understand, and felt it supported shared decision-making around EDS interventions.

We used a **mixed-methods** approach of **pre- and post-Toolkit questionnaires** for parents and professionals, and **semi-structured interviews**.

Participants included **three SLTs** trained in the FEEDS Toolkit, who used the Toolkit with **six parents** from six families. We also interviewed some of the professionals who had worked as part of each child's MDT: a dietitian and a play specialist. The children all had mixed physical and non-physical EDS difficulties, neurodisability conditions, and received support from multiple healthcare and education professionals.

## What we found

Questionnaire responses indicated that the Toolkit helped to increase parents' understanding of interventions that may be appropriate for their child, and their satisfaction with their level of involvement in selecting interventions. SLTs reported that parents' understanding of EDS interventions, participation in decision-making, and satisfaction with and implementation of strategies increased following Toolkit use.

Parents and professionals together reported that:

- information in the Toolkit was **useful** and **easy to understand**
- they all used the Toolkit to varying degrees, with some using it regularly
- most would like to **continue using** the Toolkit in the future.

Parents described the Toolkit as helpful, reassuring and easy to use. One parent commented:

*"Just the little things we've been able to put in place have really made a big difference."*

Another parent valued being able to revisit the information:

*"I could check how we were implementing interventions, read more about what might help, and then ask the SLT."*

Professionals found the Toolkit to be a valuable resource to support structured personalised care. They appreciated having *"all the information in one place"* and felt it helped formalise feeding plans and make strategies more "*concrete*" for families. One clinician noted, *"I really like the content,"* while another said it was *"very useful"*.

Professionals thought that timing was key; introducing the Toolkit too early, especially before a discussion about a neurological or neurodevelopmental condition, could overwhelm families. Overall, clinicians valued the Toolkit but emphasised the need for tailored use and professional guidance.

## What this means

Overall, parents and health professionals found the Toolkit easy to understand and helpful in joint decision-making around interventions for eating and drinking. The FEEDS Toolkit is unique and low cost, and this NHS evaluation shows it is **feasible** to use in NHS services, **acceptable** to parents and professionals, and considered **useful**. Most participants thought they would continue to use the Toolkit in the future.

## Tips for using the Toolkit with parents:

- **Take a little time to introduce the Toolkit**, explaining what it is, why it might be useful and how you and they can use it together.
- **Direct parents to the relevant section(s)** for them at that time. Make it clear they do not have to read it cover to cover.
- **Highlight or write down page numbers** with parent carers in the Toolkit itself: there are blank note pages and action plans you can use. Action plans can be added to a child's health record.
- **Keep a printed Toolkit with you** to share with a parent during appointments.

After introducing the Toolkit to one parent, they emailed the SLT afterwards with a list of ideas to discuss and the following feedback:

*"I just want to say that this booklet is amazing....it's really got me looking and thinking about everything. This is going to be great for parents!... I can't wait to see what progress we can all make together. It's got me really excited again!"*

## Training and access

The FEEDS Toolkit is available through a low-cost two-hour online training course. This is open to all professionals involved in shared decision-making around EDS. Individuals from a range of disciplines and from more than 50 UK and international organisations have already been trained, including more than 40 NHS Trusts. We are producing additional supporting content over time: an infographic for professionals is already available.

We are also seeking collaboration opportunities, including translation partnerships to broaden accessibility, and collaborations for clinical evaluation studies, so please contact us to find out more.

**Elisa Liu and Lindsay Pennington, SLTs**

**Morag Andrew and Jeremy Parr, Consultant Paediatricians**

Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle University

FEEDS@newcastle.ac.uk

## Find out more

Learn more about the FEEDS Toolkit training: **go.ncl.ac.uk/FEEDStraining**

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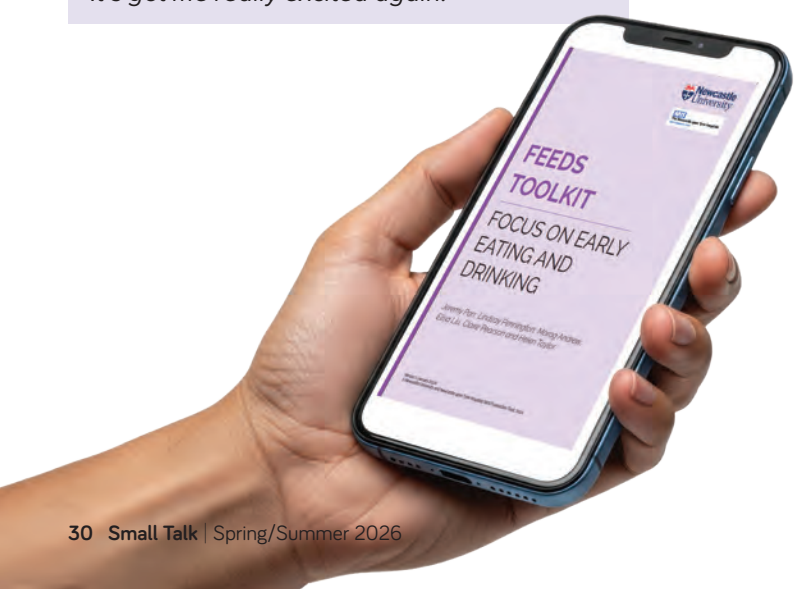


**CATHERINE CASEWELL**
Specialist Paediatric/Neonatal Dietitian/Lead Neonatal Dietitian

# A summary of key 2025-2026 trends in breast milk fortification

## Introduction

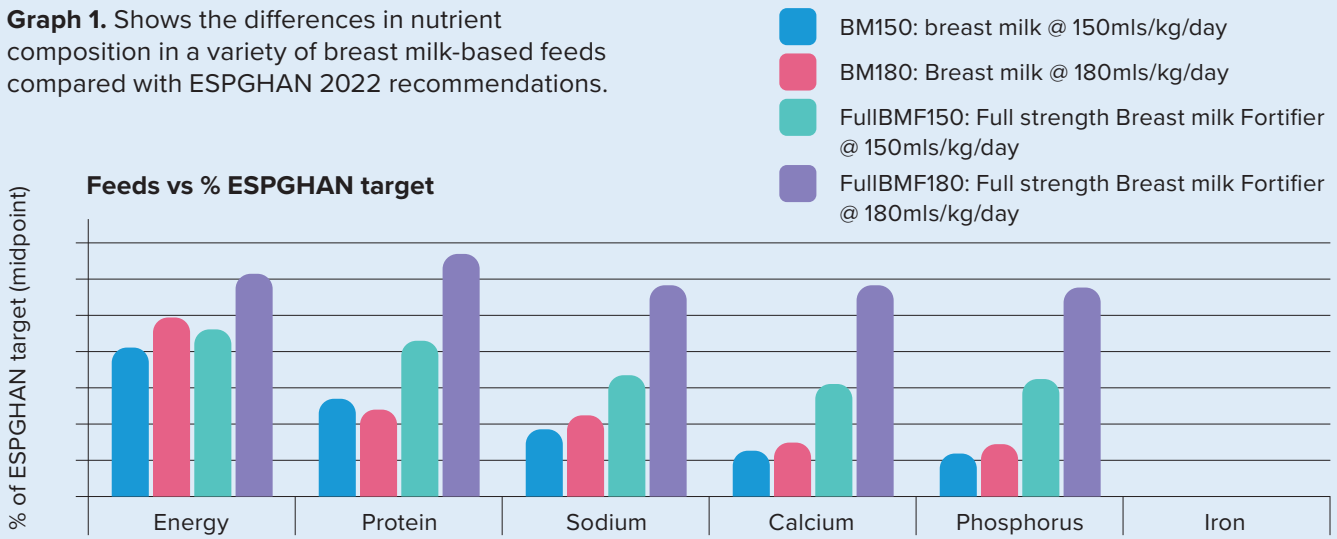
Breast milk is the best choice for feeding premature infants; however, it is well documented that it does not meet the higher nutritional requirements of the preterm infant unless fully fortified (Graph 1). Many studies are currently examining the composition of Breast Milk Fortifier (BMF) and feeding strategies to optimise both long- and short-term outcomes for preterm infants.[1-3]

## Fortification matters!

Fortification with BMF is recommended for all infants born <32 weeks. Its benefits have been demonstrated in supporting with:[4,5]

- Optimal growth velocity
- Bone mineralisation
- Neurodevelopment
- Reduced complications (e.g. necrotising enterocolitis (NEC), sepsis, feeding intolerance).

**Graph 1.** Shows the differences in nutrient composition in a variety of breast milk-based feeds compared with ESPGHAN 2022 recommendations.




ESPGHAN: European Society for Paediatric Gastroenterology, Hepatology & Nutrition

## How is BMF used?

- Expressed breast milk is usually fortified using pre-measured sachets (e.g., one sachet per 25-50ml), though some units follow their own protocols.
- Neonatal staff or parents mix the BMF in line with Family Integrated Care (FiCare) principles and local guidelines.
- Babies generally receive it until they maintain adequate growth, or as directed by hospital policy.

**Recent UK research has focused on three areas of fortification:**

# 1.

### Nutrient source: Human milk-derived fortifiers (HMDF) vs standard cow's milk-based products.

Evidence shows lower NEC risk with higher maternal breast milk intake and with donor milk instead of formula, prompting interest in whether an exclusive human milk diet (EHMD) might offer added protection.[1-3] In the UK, BMF (or human milk fortifier, HMF) is currently made from hydrolysed cow's milk protein, meaning infants remain exposed to cow's milk proteins even without formula. Concerns about NEC risk have encouraged further research into EHMDs.[6] Several UK clinical trials have now examined nutrient source in BMF, which are summarised in Table 1.

**Practical considerations:**

- Bovine fortifiers can support adequate growth in infants < 32 weeks[11,12]
- Liquid fortifiers dilute the quantity of breast milk received[13]
- Liquid fortifiers may further reduce maternal milk intake
- Human-derived fortifiers are significantly more expensive and not widely available in the UK[14]
- More UK specific evidence is needed on short and long term outcomes of human milk-based fortifier.

**Table 1:** A summary of the findings for recent UK studies on BMF

| Study | Year | Authors | Summary of Findings |
|---|---|---|---|
| **Human vs bovine fortifier body composition randomised controlled trial (RCT)[7]** | 2022 | Uthaya et al | Body composition & growth: A direct comparison of human-derived vs bovine fortifier showed no meaningful differences in MRI measured Fat Free Mass (FFM) or Fat Mass at term. Anthropometrics were not different between the groups. Nutrient intakes were matched for the study. |
| **Early human milk fortification RCT[8]** | 2023 | Salas et al | Human milk diets fortified soon after birth in infants born extremely preterm do not increase FFM accretion at term-equivalent age. Early provision of fortified human milk within the first 96 hours after birth may increase length gain velocity and reduce declines in head circumference-for-age z scores from birth to 36 weeks' Post Menstrual Age (PMA). |
| **PUFFIN: Human-based fortifier vs standard cow's milk-based fortifier[9]** | 2023 | Berrington et al | No detection of reduced gut inflammation as measured by faecal calprotectin in HMF compared to cow's milk-based fortifier but weight gain was slower. Of potential clinical importance. |
| **PREMFOOD body composition analysis[4]** | 2025 | Mills et al | Early human-based fortification (from day 2) did not increase FFM at 36 weeks PMA, but improved length velocity and reduced head circumference z-score decline. NEC and Spontaneous Intestinal Perfusion rates were low and similar between fortified and unfortified groups, with no significant differences in adverse events observed. |
| **Protein enriched fortifier RCT[10]** | *2021* | Salas et al | Infants receiving higher-protein fortifier showed significantly greater FFM and weight gain at term-equivalent age reflecting enhanced lean-tissue deposition. Length and head-circumference z-scores were also improved |

# 2.

## Feeding strategies:

- **Increasing use of individualised (targeted) fortification**
  UK neonatal units are gradually moving away from standard 'one size fits all' fortification toward individualised or targeted approaches. Growth parameters are increasingly used to adjust BMF dosing to better match infant requirements. Breast milk analysers are widely used in the USA, but UK uptake is unknown, and evidence is still emerging. Targeted fortification may improve growth velocity, optimise nutrient intake, and reduce risks of under- or over- feeding.[15-17]
- **Fortification of donor milk**
  Many UK Neonatal units are following the 2025 British Association of Perinatal Medicine (BAPM) *Donor Human Milk Framework* which recommends using pasteurised donor milk when maternal milk is unavailable.[18] Internationally, some centres use higher fortifier concentrations for donor milk (e.g., 6 sachets/100ml vs 4 sachets/100ml for maternal milk), producing "donor milk at 26kcal" and "maternal milk at 24kcal".[14]

**Practical considerations:**

- Establish unit- or network-based guidelines which include a more individualised fortification
- Optimise fortification of Donor Human Milk (DHM) as well as Mum's Own Milk (MOM)
- Consider adoption of milk analysis tools and targeted fortification but consider:
  - Breast milk composition varies within and between mothers
  - Individualised fortification is labour intensive.

# 3.

## Clinical outcomes beyond growth

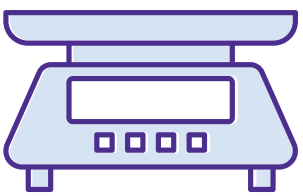
- Research is exploring effects on neurodevelopment, feeding tolerance, NEC risk, inflammation, and long-term outcomes to improve digestive tolerance and target nutrient profiles.[19]
- Innovations are emerging in neonatal BMF studies, including adding probiotics, prebiotics, and synthetic human milk oligosaccharides (HMOs). These may enhance gut health, immunity and reduce risk of infection.[20,21]

**Practical considerations:**

- These developments signal a move toward increasingly personalised, microbiome-aware fortification approaches designed to optimise growth and support healthier long-term outcomes.

## Summary

This article has outlined key 2025-2026 developments in breast milk fortification for preterm infants. While breast milk remains the optimal feeding choice, it requires fortification to meet the nutritional needs of very preterm babies. It highlights recent UK research comparing human-derived and cow's milk-based fortifiers, early versus delayed fortification, and impacts on growth, body composition and NEC risk. Emerging trends include increasing use of individualised or targeted fortification, optimising donor milk fortification and exploring additives such as probiotics and HMOs.



> While breast milk is the foundation of preterm nutrition, fortification strategies are key to optimising growth and long-term outcomes.

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**3.** *Sullivan, et al. J Pediatr. 2010;156(4):562-7.*

**4.** *Mills, et al. Nutrients. 2025;17(8):1366.*

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**9.** *Berrington, et al. J Pediatr Gastroenterol Nutr. 2025;80(2):336-44.*

**10.** *Salas, et al. Pediatr Res. 2022;91(5):1231-7.*

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**13.** *Kim, et al. J Pediatr Gastroenterol Nutr. 2015;61(6):665-71.*

**14.** *Hair, et al. Breastfeed Med. 2016;11(2):70-4.*

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**19.** *Belfort, et al. Semin Fetal Neonatal Med. 2017;22(1):42-8.*

**20.** *Underwood. J Pediatr Surg. 2019;54(3):405-12.*

**21.** *Puccio, et al. J Pediatr Gastroenterol Nutr. 2017;64(4):624-31.*


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# A DAY IN THE LIFE OF

## a Danone sustainability manager


> **Sustainability isn't just a professional focus for me – it's a personal passion as well.**

I've been part of Danone for two and a half years now, but my journey in sustainability spans over thirteen years, mostly within retail and food and drink brands. What drew me to my current role was the opportunity to join a B Corp certified, purpose-driven company operating at scale, where the potential for meaningful impact is truly significant.

Sustainability isn't just a professional focus for me – it's a personal passion as well. On a business level, embedding sustainable practices and working to reduce our environmental impact is essential for ensuring continued growth and meeting the evolving needs of our customers and consumers. Personally, I've always felt a deep connection to nature and a motivation to protect the environment, which influences me every day in my work. Our Danone Impact Journey provides a comprehensive framework across three pillars to guide our progress.

My role at Danone involves collaborating across all product categories to improve sustainability performance in line with our Danone Impact Journey goals (Figure 1), with a focus on our 'preserve and regenerate' nature pillar and supporting targets on packaging recyclability, sustainability and circularity. There's no such thing as a typical day for me; my work ranges from exploring and implementing product-specific improvements to reduce environmental impact, to embedding new and existing packaging sustainability regulations, like Extended Producer Responsibility, and representing Danone in key external partnerships and forums such as WRAP's UK Plastic Pact.

In the healthcare sector, I'm especially proud of our progress in switching to reusable ancillaries and cutting down plastic waste. By working closely with hospitals, healthcare professionals, and patients, we have introduced a reusable container for mixing and feeding. In 2024, this allowed us to reduce single-use containers by 15%, saving 18 tonnes of plastic. Sheffield Children's Hospital was an early adopter, achieving a reduction in container use of over 70%. This has allowed us to reduce and manage waste whilst ensuring we continue to support people and communities.

*"As a Homeward nurse in the Sheffield paediatrics team, I support families to reduce plastic use by switching to reusable bottles and using one giving set per 4 hours. This has been positive and fulfilling, with families reporting significant benefits in home storage and environmental impact. I have received such positive feedback from families; it has been so rewarding."*
**Elaine Memmott-Richardson**
Nutricia Homeward Enteral Nurse, Danone UK & Ireland

We're also driving plant-based innovation in healthcare – we upgraded the protein blend in our Nutrison Energy Multi Fibre* adult tube feed with more plant-based proteins, lowering the carbon footprint by 18% while maintaining patient tolerance. This is a great example of how we are leading the change in medical nutrition, aiming for better patient outcomes alongside lower environmental impacts.

We are also always looking for the best ways to share information and drive progress with our partners. One recent example of a partnership project was between Nutricia and The Newcastle Hospitals NHS Trust to educate healthcare professionals on recycling medical nutrition packaging. This has resulted in increased recycling rates and the creation of template posters, brochures and other materials showcasing how to dispose of different products' empty packaging, which other NHS Trusts can also use: (see 'Further Resources' below).

This year I also enjoyed working on our Danone Impact Journey progress report for the UK & Ireland, which captures our sustainability progress throughout the year and highlights case studies of our work, just like the ones I have shared in this article. The report is available on our Nutricia website if you want to check it out!


Of course, working in a large, complex organisation with many stakeholders brings its own challenges, and one of the biggest is bringing everyone along on the journey to maximise the impact of our projects and innovations. However, sustainability is so important to us at Danone, and I feel proud to contribute to this in my job.

We can only achieve our goals by working in partnership with our suppliers, our customers and our patients, so we are always interested to hear any ideas or new initiatives you want to share.

**Contact our Nutricia Resource Centre if you have any ideas to share: resourcecentre@nutricia.com**

***IMPORTANT NOTICE**
Nutrison Energy Multi Fibre is a Food for Special Medical Purposes for the dietary management of disease-related malnutrition in patients with higher energy needs and must be used under medical supervision.

Carbon footprint for Nutrison Energy Multi-Fibre 1L certified by the Carbon Trust.

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**Figure 1:** The Danone Impact Journey Pillars


## FURTHER RESOURCES

To learn more about Danone's Sustainability Goals and download the progress report, please visit: **www.danone.com/gb/en/sustainability.html**

More information on the recycling initiative at Newcastle and downloadable templates for your Trust to use can be found at: **www.nutricia.co.uk/hcp/where-we-specialise/tube-feeding/reducing-plastic-in-enteral-feeding/recycling-project-for-medical-nutrition-packaging.html**

We also have an informative recorded webinar from Dr Luise Marino exploring the role of paediatric dietitians in achieving the NHS Green Plan – you can watch it here: **www.nutricia.co.uk/hcp/academy/faltering-growth-in-infants-and-children/exploring-the-role-of-paediatric-dietitians-in-achieving-the-nhs-green-plan.html**

# Up2Date

**RAQUEL ENCISO SERRADILLA**
Resource Centre Specialist,
Nutricia Resource Centre

## The evolution of nutritional care in children with food allergies – focus on cow's milk allergy

**Meyer R. et al.** *J Hum Nutr Diet. 2025;38(1):e13391.*

Cow's milk allergy (CMA) remains one of the most challenging paediatric food allergies, and this review highlights how diagnosis and dietary management have shifted over the last decade. Advancements have been made in existing diagnostic tests for IgE-mediated CMA, and some new promising tests are being developed, whilst little has changed for non-IgE-mediated CMA. Symptoms of the latter are often controversial, overlapping with other common childhood conditions, which makes careful history taking and structured elimination and reintroduction essential to avoid overdiagnosis.

Management has also evolved beyond simple avoidance. The authors discuss the debate over the prevalence of CMA in breastfed infants, emphasising the need to support breastfeeding and avoid unnecessary maternal elimination diets. Advances in the hypoallergenic formulas available for formula-fed infants are also discussed, including plant-based options and the addition of pre, pro and synbiotics. Attention has shifted towards dietary diversity and microbiome modulation during complementary feeding as a target to prevent atopic disease.

Nutritional concerns, such as poor growth and feeding difficulties are well recognised, but rising obesity rates among children with CMA and micronutrient deficiencies beyond calcium and vitamin D (notably iodine) highlight the need for individualised dietetic support.

Inspired by early allergen introduction studies, a more active approach to managing CMA has emerged; with early baked milk inclusion, the use of milk ladders and, in some cases, oral immunotherapy (OIT). These strategies aim to support tolerance development, reducing the need for prolonged avoidance, although more data are needed regarding their risks and benefits.

Overall, the review reflects a field moving toward more nuanced, active and individualised care for children with CMA.

## Different paths, one goal: milk ladders in IgE- and non-IgE-mediated CMPA

**Wiszniewska, et al.** *Nutrients. 2025;17(24):3816.*

What if the journey back to cow's milk didn't have to feel like guesswork? This narrative review revisits the milk ladder – a stepwise reintroduction of cow's milk proteins – through a fresh lens, showing how a tool once reserved for non-IgE-mediated cow's milk protein allergy (CMPA) is now being cautiously adapted for IgE-mediated cases as well.

Heated and baked milk products may accelerate the development of tolerance because of their reduced allergenicity; however, the authors highlight how even small recipe or heating differences can significantly alter protein structure. This makes consistency crucial and raises important safety considerations as children progress up the ladder.

Rather than providing rigid rules, the authors encourage clinicians to reflect: Who is the right candidate? How far can the ladder safely extend? And what does "safe" really mean when allergenicity can shift with just a few degrees of heat?

Emerging strategies – such as early low-dose exposure and carefully supervised oral immunotherapy – are beginning to reshape how clinicians think about restoring milk tolerance. The review concludes that while milk ladders offer a promising route toward expanding dietary options and supporting tolerance, their use requires thoughtful patient selection and structured, well-supervised implementation to ensure safety and effectiveness.

## International survey on enteral nutrition, supplementation and probiotic practices for preterm infants

**Klingenberg, et al**. *Arch Dis Child Fetal Neonatal Ed. 2026;Feb 12: fetalneonatal-2025-329670.*

Feeding preterm infants remains a complex and often debated aspect of neonatal care. This large international survey – covering 185 neonatal units across 15 high-income countries on three continents – illustrates how approaches to enteral nutrition have evolved over the past decade.

A previous survey conducted in 2010 revealed substantial variation in feeding practices. The current survey, carried out in 2023-2024, examines contemporary practices for infants born at <32 weeks' gestation and compares them with the 2010 findings.

The authors report that access to donor human milk (DHM) has improved markedly, driven by the expansion of milk banks, and is now high across all regions. However, the timing of initiation and advancement of enteral feeds continues to vary. Compared with 2010, more units now begin feeding earlier, with most NICUs initiating feeds on day 1 or 2 for extremely preterm infants – particularly in Central and Northern Europe, where this has become standard practice. In contrast, only around half of units in the UK/Ireland, Canada and Southern Europe start feeds on day 1.

Breast milk fortification is now considered standard care in most regions except a few areas of the UK and Ireland, typically using cow's milk-based fortifiers, although practices around when to start and stop fortification remain highly variable. Human milk-derived fortifiers are rarely used. The survey also highlights wide variation in cytomegalovirus (CMV) screening practices. Probiotic use is common, with 66% of preterm infants receiving them, though the specific preparations used and the criteria for initiation differ considerably between units.

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# Ask The Experts

**Do you have a question for our experts?**

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

## Jumana Ahmed
Specialist Paediatric Dietitian

### Q. What would happen if a child who has been introduced to an allergen, e.g. peanut in infancy, stops eating that allergen regularly?

Early and regular peanut intake in infancy has been shown to reduce the risk of peanut allergy in childhood and maintain this protection into early adolescence. In the LEAP Trio follow-up study,[1] around 500 children from the original LEAP trial[2] were reassessed at age 12 after both the early consumption group and the avoidance group had avoided peanuts between ages 5 to 6 and then eaten peanuts freely thereafter. Peanut allergy prevalence at age 12 was measured via oral food challenge.

The findings were clear: children who consumed peanuts regularly from infancy to age 5 remained protected against peanut allergy years later, even without consistent peanut intake between ages 6 and 13.

The study also suggests a possibility that if peanut exposure is not maintained after early introduction, some risk of developing allergy later in childhood may still exist. More evidence is needed to understand this fully, and it is not yet known whether these findings apply to other allergens.

*1. Du Toit, et al. NEJM Evid. 2024;3(6):EVIDoa2300311.*
*2. Du Toit, et al. NEJM. 2015;372(9):803-13.*

## Elisa Liu
Highly Specialist Speech and Language Therapist, Paediatrics and Neonates

### Q. Which professionals should introduce the FEEDS Toolkit, and when?

Any member of the child's care team trained in the FEEDS Toolkit may introduce and offer to use it with families they support, working within their own clinical competencies. Professionals should take time to explain its purpose, how it can be used, and guide parents to the most relevant sections for their child. It is helpful to emphasise that the Toolkit does not need to be read in full. Each family will need to decide if, or when, they might find it helpful.

The most appropriate timing for introducing the FEEDS Toolkit will vary depending on each family's circumstances, the child's needs, and the professionals involved. It is for children with an acknowledged neurodevelopmental or neurological condition, and recognised eating, drinking and swallowing (EDS) difficulty, for which parents/carers are seeking support. It is designed to facilitate families and professionals discussing their aims and shared decision-making about interventions. Once the Toolkit has been introduced, it remains with the family. The wider multidisciplinary team are informed about it, so they can also refer to it with the family.

## Catherine Casewell
Specialist Paediatric Dietitian

### Q. How should neonatal units balance standard versus individualised breast milk fortification to optimise growth, neurodevelopment and necrotising enterocolitis (NEC) risk in preterm infants?

- Neonatal units should have their own unit-wide or network-wide guidelines for the use of breast milk fortifier (BMF) for all very preterm/very low birth-weight infants.
- Making standard multi-nutrient fortification of human milk the default for all very preterm infants once feeds are established, regardless of the use of maternal breast milk or donor human milk (DHM).
- Using individualised (adjustable or targeted) fortification selectively, focusing on infants with poor growth, those who receive higher quantities of donor human milk (DHM), or those who are vulnerable.
- Keeping NEC prevention, inflammation and long-term outcomes, including neurodevelopmental strategies, centred on human milk strategies (maximising MOM, using DHM instead of formula, and using cautious feeding protocols with BMF).
- Continue to encourage the use of "BMF Boosts" post-discharge to improve growth outcomes in the longer-term.

# DIARY DATES 2026

## 2 JUNE

**Nutricia Enteral Feeding Essentials 2026**

**WHERE:** Mercure St. Paul's Hotel & Spa, Sheffield

## 3–6 JUNE

**European Cystic Fibrosis Conference**

**WHERE:** Lisbon, Portugal

## 12–15 JUNE

**EAACI Congress**

**WHERE:** Istanbul, Turkey

## 24–27 JUNE

**ESPGHAN 58th Annual Meeting**

**WHERE:** Lille, France

## 21–24 JULY

**Nutrition Society Conference**

**WHERE:** Newcastle University, UK

## 24–27 SEPTEMBER

**European Academy of Paediatric Societies (EAPS) Congress**

**WHERE:** Athens, Greece

## 11–13 OCTOBER

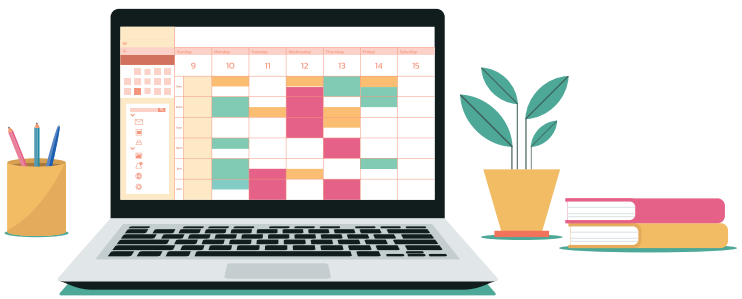
**BSACI Annual Conference**

**WHERE:** ICC, Newport, Wales

## 19–21 NOVEMBER

**EAACI FAAM**

**WHERE:** Utrecht, Netherlands



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## HAVE YOU READ OUR PREVIOUS EDITIONS?

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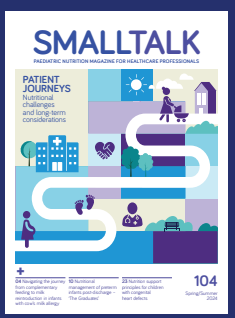
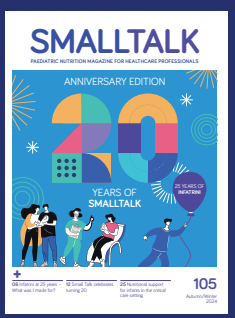



**Spring/Summer 2024**

- Childhood cancer survivorship
- Complementary feeding in cow's milk allergy




**Autumn/Winter 2024**

- Tube feeding considerations
- Nutritional support for infants in critical care settings


**Spring/Summer 2025**

- Artificial intelligence in dietetics
- Feed intolerance in neurological impairment


**Autumn/Winter 2025**

- Sustainability in dietetics
- Navigating allergy guidelines across settings

THIS INFORMATION IS INTENDED FOR HEALTHCARE PROFESSIONAL USE ONLY

NUTRICIA | ALLERGY

For the dietary management of formula-fed infants with
**Cow's Milk Allergy (CMA) and Multiple Food Protein Allergies**

# NO.1 FOR GOOD Reasons...


**NEW BETTER VALUE 420G TIN[1*]**

- Fast symptom relief in as little as 3 days[2]
- Leading AAF on prescribing guidelines[3]
- 40+ years of CMA expertise[4]

Prescribe Neocate LCP,
**the UK's No. 1 AAF**[5]

**IMPORTANT NOTICE:** Breastfeeding is best. Neocate LCP is a Food for Special Medical Purposes for the dietary management of Cow's Milk Allergy, Multiple Food Protein Allergies and other conditions where an amino acid-based formula is recommended. 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 under one year of age. Refer to label for details.

*Increase in powder volume from 400g to 420g, providing 5% more product for the same price.

1. Data on file: Comparison of UK Neocate LCP 400g tin vs UK Neocate LCP 420g tin, MIMS, January 2026. 2. De Boissieu, et al. J Pediatr. 1997;131(5):744-7. [Infants with CMA. Non-cutaneous symptoms (e.g. vomiting, diarrhoea) and improved eczema]. 3. Data on file: Discovery, Reporting Dashboard, National Overview; medicines management analysis. [Accessed February 2026]. 4. Neocate LCP was launched in 1983. 5. IQVIA data, December 2025, Moving Annual Total (MAT), volume AAF market share (UK).

CMA: Cow's Milk Allergy; AAF: Amino Acid-based Formula.

Accurate at time of publication: February 2026

Scan to learn more