Infant Feeding – allergies, intolerances, & the evidence; hardly ever black & white

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030511

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Aim of this workshop

- To give you a treatment pathway that enables you to practice with confidence.

- How do we do this with current evidence available?

- Research Evidence + Clinical Practice = Better Practice
- Separating the black & white from the grey

Most diet therapy is based on:

- Known *physiology of the condition*
  - as that knowledge increases diet therapy benefits e.g diabetes, inborn errors of metabolism
- Known *content of foods*
  - related to condition e.g. various nutrients

… We know the physiology of some symptoms eg reflux, but *that physiology* does not help us decide which foods to change

We need the *physiology of the mechanism whereby those symptoms arise* - unknown

- In **allergy** we have the mechanism & allergy tests do inform practice with clinical trials
- In **FODMAPS** we have a mechanism & a hypothesis - re what foods affect gut function
- In **food intolerance** we do <u>not</u> have the physiology of the mechanism - it is known to be pharmacological & to be complex

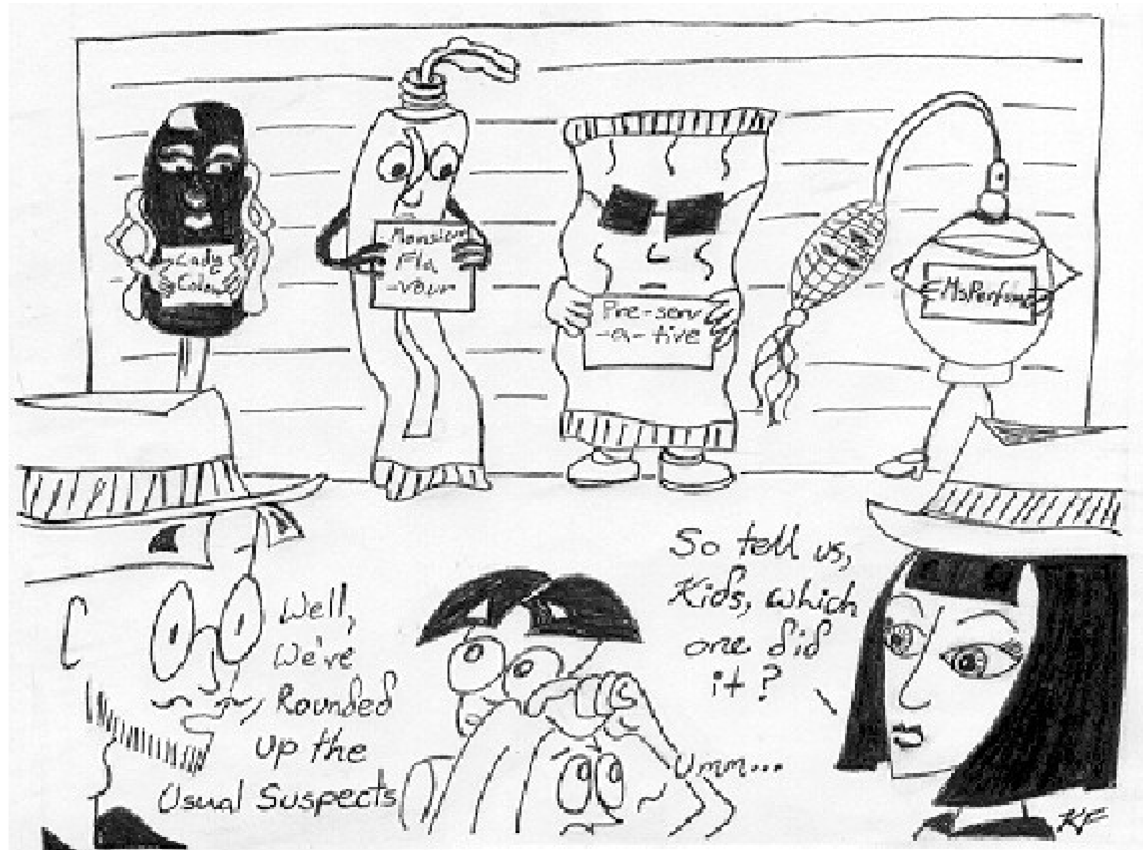
FI is ‘adverse reaction to foods’ i.e. toxicology
Q: What foods are poisonous?

- What foods are ‘poisonous’ is not clear – check in nutrition texts
- Remember: “*There are no poisonous substances, only poisonous doses*” &

  “*One man’s meat is another man’s poison*”

  e.g favism - broad beans - a genetic group
- Q: **content** of suspect substances in foods

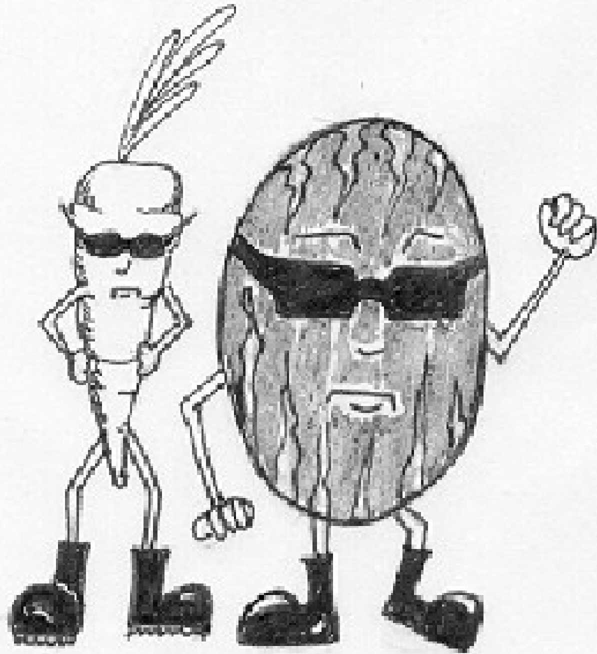
The usual suspects



What are the suspect substances?

- Present Ho – salicylates, amines, glutamates and many additives - have DBPCT
  - but - analysis of salicylate did not correspond to patient tolerance e g apples, onions
  - but - many families have aspirin sensitivity
  - complicated as amount varies with variety, amount of ripening & season
  - Q: natural benzoates, other compounds
  - Q: natural flavours - my Ho

Levels of ‘werry bad’!



More grey areas

- All is <u>not known</u> re *suspect substances*
- Q: role of whole foods eg wheat & milk
- UK Ho – ‘few foods diet’ so takes longer
- Q: not “Is it allowed?” > “Is it tolerated?”
- *Physiology in the individual* is <u>not known</u>
- My Ho sulphotransferases - varies over life, in family members, & with Total Body Load
- Q: Are body smells intermediary metabolites?

Adverse reactions > individual diet

- "**The aim of the diet therapy is to find the diet therapy**" for each individual

- Evidence has a **history** - thinking over 35 yrs
- Evidence has a **present** - current Ho each patient is a new case study
- Evidence has a **future** – genetics, immune sys interacting with pharmacology
- Next 35 yrs – enjoy new info for me!!

Considered hypothesis, test, review,

then

next hypothesis

test

review

then

next hypothesis

test

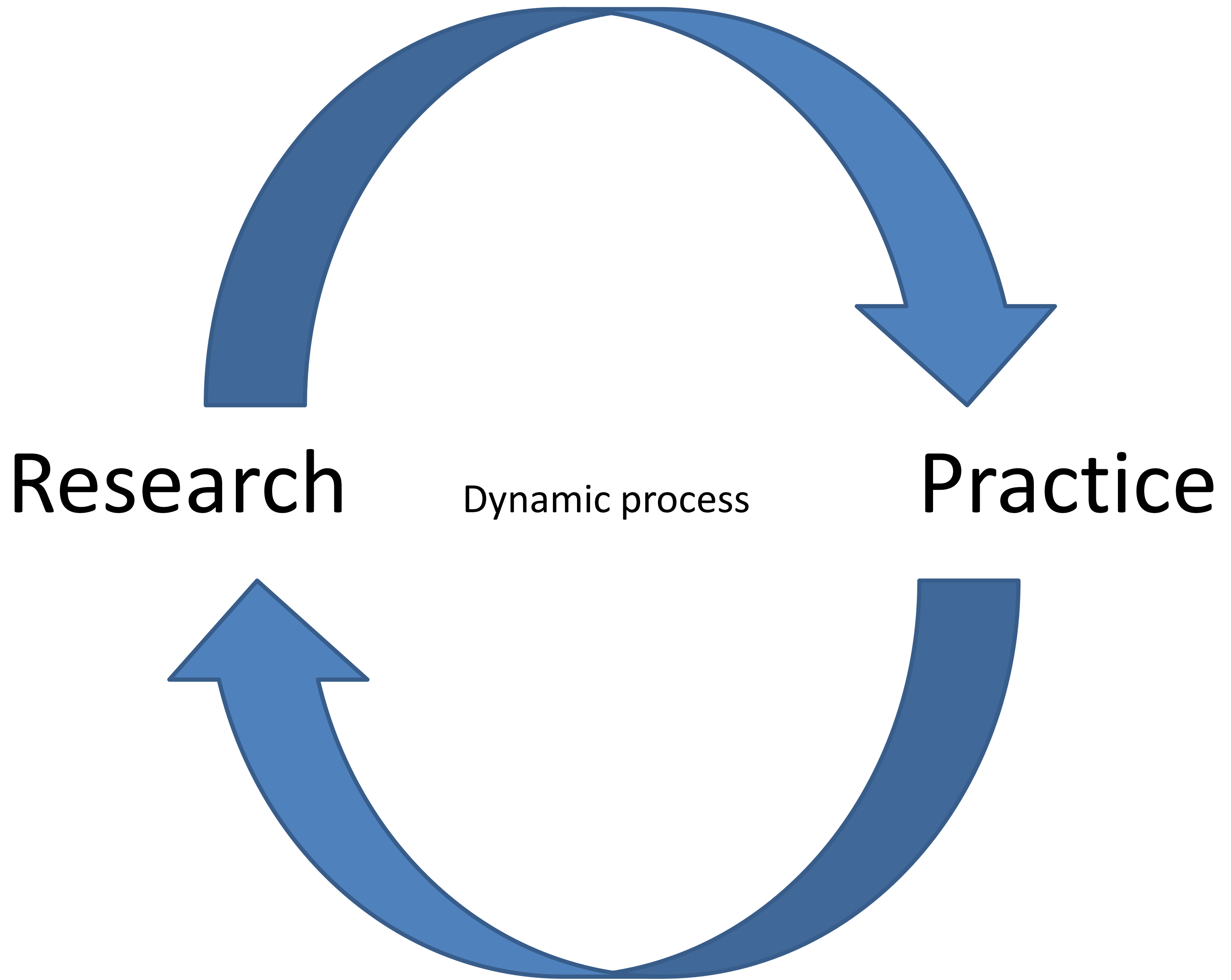
review

then

next hypothesis

test

review


Research
Dynamic process
Practice

Practice informs evidence

- Tolerance adds to salicylate data. See history
- Chems “aggravate the underlying condition”
- Smells matter, & Flavour in food
- Family Sensitivity History gives data
- Total Body Load – relevant environment
- Individual differences eg amine tolerance
- Info from different ages and symptoms

All inform practice and research

The total body load

Practice > description of the group

- In practice diet practice is based on the understanding of the *physiology and the food content* eg FODMAPS
- Or on understanding of eg *gut flora* eg use of antibiotics and pro and prebiotics
- Q: **Who do you choose for which diet treatment?**
- In Food Sensitive can use knowledge of sample

Food intolerant	FODMAPS	Probiotics
Foods usually causing reactions	Different foods usually causing reactions	Effect of usual food not relevant
Multi system symptoms	Variety of gut symptoms	Those reported to benefit
Family Sensitivity History & aspirin		? Genetic diffs
Smell sensitive pain sensitive		
Supersensitive to sensory input		
Supertasters Cravings w'thdrawl		
Individua diffs		

The family sensitivity history

Treatment options for FI and Reflux

- From evidence:-
- Reflux – thickening of feeds
- Allergy – allergy tests basis of practice
- Adverse reactions – exclude suspect foods
- Now DBPCTs – exclude suspect chemicals
- New buzz word > ‘personalised medicine’ >>> “**personalised diet therapy**’
- Diet is for patient <u>not</u> for particular symptoms

In animal care

- With the best care
- With a homogenous sample genetically

- 2% do not thrive

- How does this apply to the genetic variety in human babies?

To Treatment pathway

- Each baby is a product of its environment internal, metabolic and external
- Each baby has its own variety of symptoms – physical, sleep, mood, activity etc
- Each baby has its own variety of food intolerances
- Each will add evidence to add to your evidence based practice.

Diet investigation resources

- *My Self Help book: Are You Food Sensitive? available from www.FoodIntolerancePro.com*
- *Dietitians Manual – in professional pack*
- *Fussy Babies > Fussy Baby*
- *Dietitians Association of Australia - DINER*
- *RPAH handbook www.allergy.net.au*
- *Dietitians at a hospital near you, or listed in the phone book in private practice.*