

important to be exposed to than others. Sesame can be introduced in a safe form, such as hummus or tahini paste mixed with other pureed foods. Fish and shellfish may be introduced when an infant is tolerating appropriate staged foods (see [Appendix A](#) for suggested foods containing these major allergens); more guidance on fish consumption can be found at the US Food and Drug Administration website.¹¹¹ Once these foods are eaten and tolerated, they should be incorporated regularly into the infant's diet, again in accordance with family and cultural preferences, because there are no data to determine the amounts and frequencies of which to consume these other foods.^{6,16}

CONCLUSIONS

There is strong evidence that early introduction of peanut and egg within the first year of life can prevent the development of food allergy to these respective foods. Screening infants for evidence of sensitization to peanut and/or egg before initial introduction is not required, though this may be a preference-sensitive care choice for some families. If screening is performed, the clinician should encourage consideration for offering all sensitized infants an OFC to determine an objective outcome of allergy or tolerance, rather than rely on poorly predictive values of sensitization. The key is to minimize delay when peanut is to be introduced, in particular if in-office introduction cannot be done promptly after screening. If considered, an OFC should be prioritized to be done shortly after testing, to minimize delays and maximize benefit. With respect to other potentially allergenic foods (CM, soy, wheat, tree nut, sesame, fish, shellfish), there are observational data suggesting harm from intentional delayed introduction, and although no RCT suggests benefit from early introduction of these items, there are no data suggesting that doing so beginning at around 6 months of life is harmful. Along these lines, observational data support a potentially beneficial preventative effect for a diverse and varied infant diet in the first year of life without suggestion of harm, which would be in accordance with not delaying the introduction of any potentially allergenic food. There is no clear preventative role for the use of any form of HF for the specific prevention of food allergy as opposed to the prevention of other potential atopic manifestations. Exclusive breast-feeding for at least 4 to 6 months has not been associated with protection against the development of food allergy (with or without excluding any food in the maternal diet while doing so), though exclusive breast-feeding has multiple other health benefits to the child and is universally encouraged. Prenatal or perinatal maternal or infant use of supplements also has no clear role in the prevention of food allergy, though maternal probiotic omega-3 fatty acid supplementation may protect against the development of milk and egg sensitization in the infant.

These recommendations are aimed to help inform the primary care and allergy practicing clinician regarding the best current practices for infant feeding and food allergy prevention. These have evolved considerably since the last AAAAI update in 2013, as well as the NIAID-AG in 2017, and likely will continue to do so, requiring an iterative process to maintain an up-to-date knowledge base to best advise all stakeholders, with a focus on the United States and Canada as represented in this consensus document.

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