



Primary care prescribing guidelines for specialist infant formulae

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<http://www.northoftyneapc.nhs.uk/documents/guidelines-and-statements/>

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Introduction

These updated guidelines were developed by the dietitians from Newcastle upon Tyne Foundation Trust, Northumbria Healthcare Foundation Trust and the North of Tyne (NoT) QIPP group and amalgamated with those prepared and approved for use within Gateshead in consultation with Gateshead CCG and Secondary Care Trusts. They are intended to assist GPs and Health Visitors with information on the use of prescribable infant formulae, in line with ACBS indications, for the treatment of cow's milk protein allergy (CMA) and lactose intolerance; as well as advice for primary care prescribers on the use of formulae for pre-term, faltering growth and Gastro-Oesophageal Reflux Disease (GORD).

Whilst these guidelines advise on appropriate prescribing of special infant formulae, breast milk remains the optimal milk for infants. Breastfeeding should be promoted and encouraged where it is clinically safe to do so, and the mother is in agreement.

This guide gives information on some common conditions requiring prescribable infant formulae. The guidelines are targeted at 0-12 months, however some of the products can be used past this age and advice on these are included in the guidelines.

These guidelines advise on:

- Initiating prescribing
- Quantities to prescribe
- Which products to prescribe for specific conditions
- When onward referral for dietetic and or specialist care should be considered

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Quantities of specialised formula to prescribe

Prescribing guide for quantity of infant formula to be supplied

Powdered formula – initial prescriptions should be for 1-2 tins to ensure the formulation is acceptable and reduce avoidable wastage

Age of child	Number of tins for 28 days
Under 6 months	10-12 x 400g tins or 5-6 x 800g tins
6-9 months	10 x 400g tins or 5 x 800g tins
9-12 months	7 x 400g tins or 4-5 x 800g tins
Over 12 months*	7 x 400g tins or 4-5 x 800g tins

*Requires review by dietitian to assess continued need for formula

- This table provides guidance ONLY and recent correspondence from paediatrician or paediatric dietitian should be referred to.
- These amounts are based on infants (including pre-term infants) under 6 months being exclusively formula fed and drinking 150ml/kg/day of normal concentration formula.
- Some children may require larger quantities e.g. those with faltering growth.
- For infants requiring high calorie formula, a Paediatric Dietitian should advise on the appropriate amount to be prescribed; Pre-term formulae - powder preparations ONLY, liquid Preterm infant milk formulae products should not be prescribed.
- Review repeat prescription quantity at 3 monthly intervals and adjust according to current requirements.
- Prescription for infant formula may be required up until 2 years (if allergy persists), and beyond for older patients with severe allergy who are unable to tolerate commercial cow's milk substitutes. This will be on the advice of the Paediatric Dietitian.
- Best practice to make up infant feeds by reconstituting formula powder using water at a temperature of 70°C or above.¹ To help minimise the microbiological risk to infants. NB: with the introduction of probiotics in new or reformulated infant formula it is advised manufacturing notes and guidance on making up the feeds should be consulted before using.
Water should be freshly boiled and then left to cool for no more than 30 minutes, so that it remains at a temperature of at least 70°C.
- It is not advisable to make up bottles in advance.

Cow's Milk Protein Allergy (CMA)

Background

The MAP Guideline (Milk Allergy in Primary Care) for Primary Care Management of mild to moderate non-IgE cow's milk allergy has been approved for implementation by the Northern Paediatric Allergy Group NPAG, and is derived from the NICE guideline 116 relating to food allergy in children and young people, it covers the diagnosis and assessment of food allergy in children and young people in primary care and community settings.

Key points for cow's milk allergy

- Adverse reactions to foods, mainly cow's milk protein are most common in the first year of life.ⁱⁱ In infancy the main non IgE mediated atopic symptoms are atopic dermatitis, gastrointestinal (GI) symptoms (diarrhea, blood in stools, vomiting, abdominal distension, colic and constipation) and recurrent wheeze and/or rhinitis.
- All children following a CMA free diet should be referred to a Paediatric Dietitian.
- Paediatric Allergy Services are available at North Tyneside General Hospital and the Great North Children's Hospital, Newcastle upon Tyne for infants and children with suspected IgE mediated allergies.
- Paediatric allergy and eczema services are available at the Queen Elizabeth Hospital, Gateshead and The Great North Children's Hospital Newcastle upon Tyne for infants and children with IgE and non IgE mediated allergy.
- Paediatric Specialist Services at the Great North Children's Hospital, Newcastle upon Tyne for all regional referral for Food Protein Induced Enterocolitis Syndrome (FPIES).

Calcium supplementation

- Breast fed infants can display symptoms, as some cow's milk protein from the mother's diet may be present in breast milk. Advise exclusively breast feeding mothers to exclude all CMP from their own diet and recommend they are prescribed calcium (1000mg) and Vitamin D (10mcg) supplements, see [North of Tyne & Gateshead APC Formulary](#)
- **First line choice**
 - Calcium carbonate 1.5g & colecalciferol 10micrograms (400 units) - Accrete® -Film coated tablet containing calcium carbonate 1.5g and colecalciferol 10 micrograms (400 units)
- **Second line choices**
 - Calcium carbonate 1.5g & colecalciferol 10micrograms (400 units) - Evacal D3® - Chewable tablets containing calcium carbonate 1.5g and colecalciferol 10 micrograms (400 units) -approved as a chewable option and also to be used in patients with peanut and soya allergy

- Calcium Phosphate & Vitamin D (Calfovit D3®) Powder in sachets – calcium phosphate 3.1g (1.2g calcium) & Vitamin D3 800 units
- Calcium & Ergocalciferol tablets - Tablets – calcium lactate 300mg, calcium phosphate 150mg (Ca 97mg, 2.4 mmol) & ergocalciferol 10 micrograms (400 units)

Guidance notes for Suspected Cow's Milk Allergy

For Breastfeeding Infants:

Breast milk is the ideal choices for the infant with CMA with maternal exclusion of CMP. Consider CMP free diet for mother for a minimum of 2 weeks whilst the child is deemed cow's milk protein allergic. Initial advice can be sought from the Health Visitor. If formula top-ups are needed for a child who is otherwise breast fed choose an AAF.

For Formula Fed infants - General principles / frequently asked questions (FAQs)

- For infants over 17 weeks, check if weaning foods have been introduced and ensure these are milk free. Refer to a paediatric dietitian if not already done so.
- Try a straight swap to the new formula as any benefits of excluding the allergen will not be seen until all the old formula is excluded. Acknowledge that EHF/ AAF vary in palatability and perseverance is needed, especially with older infants. It is recommended that incremental weaning onto the new formulae is followed as depicted in the box below. If infants refuse EHF/ AAF, consider mixing this with their current formula to help with taste tolerance.

Mixing and titrating formulae - for a 120ml / 4 fl.oz bottle

Step 1: mix 90 ml / 3 fl.oz usual formula with 30 ml / 1 fl.oz new EHF/ AAF

Step 2: mix 60 ml / 2 fl.oz usual formula with 60 ml / 2 fl.oz new EHF/ AAF

Step 3: mix 30 ml / 1 fl.oz usual formula with 90 ml / 3 fl.oz new EHF/ AAF

Step 4: give 120 ml / 4 fl.oz new EHF/ AAF and continue with this.

NB: Transition to EHF/ AAF should take no longer than 48 hours

- Total symptom resolution is not immediate in most infants. In those with more severe symptoms requiring AAF it can take over 3 weeks to achieve improvement from symptoms.
- When starting EHF/AAF infants can suffer more wind, but this usually improves.
- Check that medicines are free from CMP (e.g. teething powders / colic preparations).
- It is advisable to inform parents/guardians that these formulas contain glucose, so that they may pay special attention to dental hygiene as new teeth appear.
- Green stools are normal for infants on EHF / AAF as the milk feed is hydrolysed or denatured to amino acids.
- Babies over the age of 12 months should be seen by a dietitian to review the need to continue formula. Some infants will require a prescribable formula up to 2 years of age. Children with multiple allergies may require specialist formulae over 2 years of age.
- The Paediatric Dietitian will review and inform the GP of all planned monitoring, the follow up intended and provide guidance to parents on weaning and the ongoing need for formula milk. Typically the Paediatric Dietitians will recommend challenging with small amounts of cow's milk from the age of 12-18

months, as per guidance of the cow's milk protein re-introductory ladder in Non IgE mediated cow's milk allergy. In cases of IgE mediated allergy the challenge needs to be under medical supervision.

- A prescription for a child older than 18months should only be issued if requested by a Paediatric Dietitian for a specified reason(s) (e.g. diet providing insufficient calcium and iodine due to dietary exclusions).
- The Paediatric Dietitian will regularly assess the infant's nutritional intake to promote a balanced diet. Infants on a CMP free diet may require a calcium and/or vitamin D supplement to achieve this.
- Babies of vegan mothers who choose not to breast feed and wish to feed a vegan formula may choose to use a soya formula but this should not be prescribed by the GP.

Prescribable Specialised Infant Formula for Cow's Milk Allergy

Product Name	Age	Product Description
Extensively hydrolysed formula (EHF) - products contain similar amounts of calcium		
Nutramigen 1 with LGG (Mead Johnson)	400g	From birth Casein based for use with mild to moderate symptoms of CMA
Nutramigen 2 with LGG (Mead Johnson)	400g	From 6 months Casein based <i>Follow on</i> use with mild to moderate symptoms of CMA
Similac Alimentum (Abbott Nutrition)	400g	From birth Casein based for use with mild to moderate symptoms of CMA
SMA Althera (SMA Nutrition)	450g	From birth Whey based for use with mild to moderate symptoms of CMA – lactose content 50% w/w
Milupa Aptamil Pepti 1	400g 800g	From birth Whey based used with mild to moderate symptoms of CMA – lactose content 40% w/w
Milupa Aptamil Pepti 2	400g 800g	From 6 months Whey based <i>Follow on</i> for use with mild to moderate symptoms of CMA – lactose content 40% w/w
Amino Acid based formula (AAF) (NB: only 10-30% of patients with CMPA will require an AAF)		
SMA Alfamino (SMA Nutrition)	400g	From birth Amino acid formula used for more severe symptoms of CMA
Nutramigen Puramino (Mead Johnson)	400g	From birth Amino acid formula used for more severe symptoms of CMA
Neocate LCP (Nutricia)	400g	From birth Amino acid formula used for more severe symptoms of CMA
Soya Formula (SF) (Not suitable as a first line product for CMA treatment)		
SMA Wysoy (SMA Nutrition)	430g 860g	From 6 months Can be considered for use in certain infants over 6 months who have shown no soya allergy
Extensively hydrolysed formula with MCT (Not routinely used for treatment of CMA, to be started in secondary care ONLY)		
Pregestimil Lipil (Mead Johnson)	400g	From birth Casein based extensively hydrolysed formula with 54% fat at MCT oil
Pepti-Junior (Cow & Gate)	450g	From birth Whey based extensively hydrolysed formula with 50% fat as MCT oil
Amino Acid Formula (To be started in secondary / tertiary care ONLY)		
Neocate Spoon (Nutricia)	37g	From 6 months Amino acid based weaning product used supplement the diet with energy, vitamins and minerals for infants following a CMP free diet.
Neocate Active (Nutricia)	63g	Over 1 year High kcal amino acid based formula for children with CMA and multiple food allergies. Not required routinely for all infants over 1 year of age.
Neocate Advance (Nutricia)	100g 50g	Over 1 year High kcal amino acid based formula used as a sole source of nutrition. Not required routinely for all infants over 1 year of age.

Secondary Lactose Intolerance

In infants primary lactose intolerance is rare; generally lactose intolerance is secondary to gastroenteritis and is transient. Primary lactose intolerance does not usually present until later childhood or adulthood.

Symptoms & Diagnosis

- Usually occurs following an infectious gastrointestinal illness but may be present alongside newly or undiagnosed coeliac disease.
- Rarely seen in exclusively breastfed babies.
- Symptoms include abdominal bloating, increased (explosive) wind, and loose watery stools.
- Lactose intolerance should be suspected in infants who have had any of the above symptoms that persist for more than 2 weeks.
- Resolution of symptoms within 48 hours of withdrawal of lactose from the diet confirms diagnosis.
- **Vomiting, eczema, persistent colic or constipation are NOT features of lactose intolerance – see suspected CMA.**

Treatment

- Treat with lactose free formula for 6-8 weeks to allow symptoms to resolve. In some cases symptoms may last up to 3 months.
- Standard formulae and/or milk products should then be slowly reintroduced to the diet after 6-8 weeks.
- In infants who have been weaned, lactose free formula should be used in conjunction with a low lactose/lactose free diet (Northumbria Healthcare NHS Foundation Trust see local low lactose diet advice sheet).
- It is advisable to inform parents/guardians that these formulas contain glucose, so that they may pay special attention to dental hygiene as new teeth appear.
- In children over 1 year who previously tolerated cow's milk, there is no need to prescribe lactose free formulae. Suggest use of lactose free full fat cow's milk which can be purchased from supermarkets (Lactofree® brand).

Onward Referral

- If symptoms do not resolve when standard formula and /or milk products are reintroduced to the diet, refer to secondary or specialist care.

Product Name		Age of use	Product description
Residual lactose formula			
Enfamil O'Lac (Mead Johnson)	400g	From birth	Casein based lactose, sucrose and fructose free formula
Aptamil Lactose Free (Milupa)	400g	From birth	Casein based lactose and sucrose free formula
SMA LF (SMA Nutrition)	430g	From birth	Whey based lactose free formula

Note

- Lactose free formulae can be bought at a similar cost to standard infant formulae and prescribers should consider the need to prescribe. Lactose free formulae are available from supermarkets and many pharmacies will stock on demand. Healthy start vouchers can be used towards the cost of lactose free infant formulae.
- Soya formula (SMA Wysoy®) should not routinely be used for patients with secondary lactose intolerance. It should not be prescribed at all for those under 6 months of age due to high phytoestrogen content ^v.

Guidance for concerns about colic

- In most cases of colic, no underlying cause can be found.
- Addressing parental concerns is often the best way to cope with colic. Reassure parents that colic will resolve.
- Parents may wish to purchase colic remedies such as Dentinox, Infacol or Gripe Mixture. Although there is no good evidence of effectiveness, parents may perceive this to be beneficial.
- Lactase for the relief of symptoms associated with lactose intolerance (Colief) is **Non-Formulary**: there is limited evidence of effectiveness and use contraindicates DH guidanceⁱⁱⁱ on the preparation of infant formula.
- For unresolved severe colic, consider CMA.

Pre-Term Infants

- These infants will have had their pre-term formulae commenced on discharge from a neonatal unit.
- It is started for babies born before 34 weeks gestation, weighing less than 2kg at birth.
- These formulae should not be used in primary care to promote weight gain in term infants.

Onward Referral

- These infants should already be under regular review by a paediatrician or paediatric dietitian.
- If there are concerns regarding growth whilst the infant is on this formula, referral to a paediatric dietitian should be made.
- If there are concerns regarding growth at 6 months corrected age or at review one month after these formulae are stopped, refer to a paediatric dietitian for assessment.

Review and discontinuation of treatment

- Monitoring of growth (weight, length and head circumference) should be carried out by the Health Visitor while the baby is on this formula.
- These products should be discontinued by 6 months corrected age (EDD + 26 weeks).
- Not all babies need these formulae for the full 26 weeks from expected date of delivery (EDD).
- If there is excessive weight gain at any stage up to 6 months corrected age, the infant should be transferred onto a standard formula.

6 months corrected age = EDD + 26 weeks

Product Name		Age of use	Product description
SMA Gold Prem 2 (SMA Nutrition)	400g	Birth to a maximum of 6 months corrected age	A nutrient rich post discharge formula to promote catch up growth in small for gestational age or preterm infants
Nutriprem 2 Powder (Cow and Gate)	900g	Birth to a maximum of 6 months corrected age	A nutrient rich post discharge formula to promote catch up growth in small for gestational age or preterm infants
Nutriprem 2 Liquid (Cow and Gate)	200ml	This product should not routinely be prescribed	A nutrient rich post discharge formula to promote catch up growth in small for gestational age or preterm infants Only prescribe if there is a clinical need (e.g. immunocompromised infant)

Faltering Growth

Symptoms and Diagnosis

- Diagnosis is made when the growth of an infant falls below the 0.4th centile or crosses 2 centiles downwards on a growth chart.
- It is not possible to detect faltering growth without using appropriate growth charts.
- The length of an infant needs to be measured to properly interpret changes in weight.
- It is essential to rule out possible disease related/medical causes for the faltering growth e.g. immune deficiency, iron deficiency anaemia, constipation, CMA, GORD or a child protection concern. If identified appropriate action should be taken.

Onward Referral

- Infants with faltering growth should be referred to paediatrics and paediatric dietetic services without delay.

Treatment

- Prescribe an equivalent volume of high energy formula to the child's usual intake of formula until an assessment has been performed and recommendations made by a paediatrician or paediatric dietitian.
- Where all nutrition is provided via NG/NJ/PEG tubes, the paediatric dietitian will advise on appropriate monthly amounts of formula required which may exceed the guideline amounts for other infants.

Review and Discontinuation of Treatment

- All infants on high energy formula will need growth (weight and length) monitored to ensure catch up growth occurs.
- Once this is achieved the formula should be discontinued to minimise excessive weight gain. This should be done under paediatric dietetic supervision.

Product Name		Age of use	Product description
SMA High Energy (SMA Nutrition)	250ml carton	Birth to 18 months	0.91 kcal/ml high energy infant formula
Similac High Energy (Abbott Nutrition)	120ml bottle 200ml bottle	Birth to 18 months or 8kg	1.0kcal/ml high energy infant formula
Infatrini (Nutricia)	100ml bottle 200ml bottle 500ml pack	Birth to 18 months or 9kg	1.0 kcal/ml high energy infant formula
Infatrini Peptisorb (Nutricia)	200ml bottle	Birth to 18 months or 9kg	1.0 kcal/ml high energy, extensively hydrolysed, infant formula. Should be started in secondary care.

Gastro Oesophageal Reflux Disease (GORD)ⁱⁱⁱ

Symptoms and Diagnosis

- Gastro Oesophageal Reflux (GOR) is a normal physiological process that usually happens after eating in healthy infants and presents as effortless regurgitation of feeds. Give advice about GOR and reassure parents and carers that in well infants, effortless regurgitation of feeds:
 - is very common (it affects at least 40% of infants)
 - usually begins before the infant is 8 weeks old
 - may be frequent (5% of those affected have 6 or more episodes each day)
 - usually becomes less frequent with time (it resolves in 90% of affected infants before they are 1 year old)
 - **does not usually need further investigation or treatment.**
- Gastro Oesophageal Reflux Disease (GORD) starts when the symptoms of reflux become severe, causing troublesome symptoms and /or complications.
- When reassuring parents and carers about regurgitation, advise them that they should return for review if any of the following occur:
 - the regurgitation becomes persistently projectile
 - there is bile stained (green or yellow green) vomiting or haematemesis (blood in vomit)
 - there are new concerns, such as signs of marked distress, feeding difficulties or faltering growth
 - there is persistent, frequent regurgitation beyond the first year of life.
- In infants, children and young people with vomiting or regurgitation, **look out for the 'red flags' in table 1**, which may suggest disorders other than GOR. Investigate or refer using clinical judgement.
- In most cases of GORD, no underlying cause can be found, although GORD may be associated with CMA.

Onward Referral

- Infants with faltering growth with GORD should be referred to paediatric services.
- If symptoms do not improve one month after commencing treatment refer to a paediatrician for further investigations since CMA can co-exist with GORD. If CMA suspected see CMA guidance.

'Red flag' symptoms suggesting disorders other than Gastro Oesophageal Reflux (GOR)

Symptoms and signs	Possible diagnostic implications	Suggested actions
Gastrointestinal		
Frequent, forceful (projectile) vomiting	May suggest hypertrophic pyloric stenosis in infants up to 2 months old	Paediatric surgery referral
Bile-stained (green or yellow-green) vomit	May suggest intestinal obstruction	Paediatric surgery referral
Haematemesis (blood in vomit) with the exception of swallowed blood, for example, following a nose bleed or ingested blood from a cracked nipple in some breast-fed infants	May suggest an important and potentially serious bleed from the oesophagus, stomach or upper gut	Specialist referral
Onset of regurgitation and/or vomiting after 6 months old or persisting after 1 year old	Late onset suggests a cause other than reflux, for example a urinary tract infection (also see the NICE guideline on urinary tract infection in children) Persistence suggests an alternative diagnosis	Urine microbiology investigation Specialist referral
Blood in stool	May suggest a variety of conditions, including bacterial gastroenteritis, infant cows' milk protein allergy (also see the NICE guideline on food allergy in children and young people) or an acute surgical condition	Stool microbiology investigation Specialist referral
Abdominal distension, tenderness or palpable mass	May suggest intestinal obstruction or another acute surgical condition	Paediatric surgery referral
Chronic diarrhoea	May suggest cows' milk protein allergy (also see the NICE guideline on food allergy in children and young people)	Specialist referral

Symptoms and signs	Possible diagnostic implications	Suggested actions
Systemic		
Appearing unwell Fever	May suggest infection (also see the NICE guideline on feverish illness in children)	Clinical assessment and urine microbiology investigation Specialist referral
Dysuria	May suggest urinary tract infection (also see the NICE guideline on urinary tract infection in children)	Clinical assessment and urine microbiology investigation Specialist referral
Bulging fontanelle	May suggest raised intracranial pressure, for example, due to meningitis (also see the NICE guideline on bacterial meningitis and meningococcal septicaemia)	Specialist referral
Rapidly increasing head circumference (more than 1 cm per week) Persistent morning headache, and vomiting worse in the morning	May suggest raised intracranial pressure, for example, due to hydrocephalus or a brain tumour	Specialist referral
Altered responsiveness, for example, lethargy or irritability	May suggest an illness such as meningitis (also see the NICE guideline on bacterial meningitis and meningococcal septicaemia)	Specialist referral
Infants and children with, or at high risk of, atopy	May suggest cows' milk protein allergy (See CMA guidance)	Specialist referral

Treatment

- If the infant is thriving and not distressed reassure parents and monitor.
- In formula-fed infants with frequent regurgitation associated with marked distress, use the following stepped-care approach:
 - review the feeding history, then
 - reduce the feed volumes only if excessive for the infant's weight. Average requirements of formula are 150ml/kg/day for babies up to 6 months, which should be offered over 6-7 feeds, then
 - offer a trial of smaller, more frequent feeds (while maintaining an appropriate total daily amount of milk) unless the feeds are already small and frequent, then
 - suggest parents could purchase thickened formula to trial.
- For breastfed infants arrange a breastfeeding assessment (e.g. by health visitor, breastfeeding coordinator or peer supporter)
- In either breastfed or bottle fed infants if the advice above does not help and the infant continues to have marked distress then trial alginate therapy. Alginate therapy should be given for a trial period of 1-2 weeks and if successful can be continued, but trial stopping at intervals to see if still required.
- If further pharmacological treatment is necessary refer to NICE Guidance (NG1)¹¹¹

Review and Discontinuation of Treatment

- Review after one month.
- Infants with GORD will need regular review to check growth and symptoms.
- Since GORD will usually resolve spontaneously between 12-15 months, cessation of treatment can be tried from 12 months.

Specialised Infant Formula for use in GORD

Product Name	Suitability	Product description
Over the counter thickened formula		
Cow & Gate Anti-Reflux (Cow & Gate)	900g From birth	Formula containing carob bean gum. Thickens on mixing and remains thick on contact with gastric acid.
Aptamil Anti-Reflux (Milupa)	900g From birth	Formula containing carob bean gum. Thickens on mixing and remains thick on contact with gastric acid.
Over the counter / Prescribable thickening formula		
SMA Staydown (SMA Nutrition)	900g From birth	Formula containing corn starch. Thickens on contact with gastric acid
Prescribable thickening formula		
Enfamil AR (Mead Johnson)	400g From birth	Formula containing rice starch. Thickens on contact with gastric acid

Notes:

- Thickened products containing carob bean gum thicken on mixing and will require a faster flow teat.
- Thickening products react with stomach acid, thickening in the stomach, so a faster flow teat is not required. **These products should not be used with medications such as ranitidine or proton-pump inhibitors.**
- Thickened and thickening formulae are not suitable to be made with 70°C water (as advised in DH guidance). Alert parents/carers to use the guidance for preparation on the tin.
- Infant Gaviscon® contains sodium, and should not be given more than 6 times in 24 hours or when the infant has diarrhea or fever.
- When using Infant Gaviscon®, each half of the dual sachet is identified as 'one dose'. To avoid errors, prescribe with directions in terms of 'dose'.
- Do NOT prescribe Gaviscon® concurrently with a thickened feed or thickening agent due to risk of bezoar formation

References

- i DH guidance on preparation of formula <https://www.gov.uk/government/publications/advice-on-preparation-of-formula-milks-restated>
- ii [Vandenplas Y et al: Guidelines for the diagnosis and management of cow's milk allergy in infants. Arch Dis Child 2007; 92:902-8.](#)
- iii Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people NICE guideline (NG1) Published: 14 January 2015. See: <http://www.nice.org.uk/guidance/ng1/resources/gastrooesophageal-reflux-disease-recognition-diagnosis-and-management-in-children-and-young-people-51035086789>