

The Blueprint for Tolerance

ASCIA 2025/2026 Clinical Guidelines: Infant Feeding for Food Allergy Prevention

A Clinical Playbook for Healthcare Providers and Parents. Translated from the 16-Recommendation Update.

A Paradigm Shift in Allergy Prevention

STRUCTURAL SUMMARY

The 2025/2026 Australasian Society of Clinical Immunology and Allergy (ASCIa) update overturns outdated avoidance strategies. Informed by a systematic review using the AGREE II framework and a Delphi consensus panel, the new mandate is active, timely introduction.

This playbook synthesizes the 16 official recommendations into actionable clinical protocols.

EVIDENCE BADGES: VISUAL LEGEND



High / Moderate Evidence

Driven by randomized controlled trials like LEAP and EAT.



Expert Consensus

Achieved >75% Delphi panel agreement where trial data is lacking.



Very Low Evidence

Recommendations based on limited or single-trial data.

Phase 1 Foundation (Birth – 4 Months): Maternal Diet & Formula



RECOMMENDED

Breastfeeding

Exclusive breastfeeding is highly encouraged until around 6 months.

Maternal Diet

Maintain a normal, unrestricted diet. Removing common food allergens from a breastfeeding mother's diet does not prevent infant food allergy and compromises maternal nutrition (Rec 12).

NOT RECOMMENDED

Hydrolysed Formulas

Neither partially nor extensively hydrolysed infant formulas prevent food allergy (Rec 13).

Soy Formulas

No evidence supports soy-based formula for allergy prevention (Rec 14).

Alternative Proteins

Goat, sheep, rice, oat, pea, or coconut formulas are entirely unstudied and not recommended for prevention (Rec 15).

The First-Week Vulnerability Window

Very Low
Evidence



Days 1 to 7

Core Directive

Avoid transient supplementary feeding with **cow's milk-based formula** in the first week of life for healthy, breastfed infants.

Clinical Rationale

Avoiding temporary **cow's milk top-ups** in the critical first 3-7 days of life may decrease the risk of cow's milk sensitization and allergy.

Practical Implication

Only utilize **cow's milk formula top-ups in week one** if **medically required** and given with explicit **parental consent**. If regular use is anticipated, the risk profile

Phase 2 The Critical Window (4 to 6 Months): Starting Solids

Moderate
Evidence

The Window of Opportunity Curve



Signs of Developmental Readiness

- ✓ 1. Good head and neck control, can sit upright with some assistance.
- ✓ 2. Loss of the tongue-thrust reflex, allowing food to stay in the mouth.
- ✓ 3. Shows an interest in food, including watching others eat and reaching for food.
- ✓ 4. Opens mouth when food is offered and can swallow food.

The Priority Allergens: Egg & Peanut

Moderate
Evidence

EGG (Rec 3)

Timing: Soon after starting solid foods.

Texture Directive: Must be well-cooked (e.g., mashed well-cooked egg mixed with vegetable puree). Do not use raw or lightly cooked egg due to infection risk and higher allergenicity.

Clinical Note: Pasteurized raw egg powders used in trials are not recommended for practical home use.

PEANUT (Rec 4)

Timing: Soon after starting solid foods (optimally 4-6 months).

Texture Directive: Thinned smooth peanut butter, finely ground peanut, or peanut flour mixed into tolerated food.

Clinical Note: Never whole nuts or pieces (choking hazard for under 4 years).

Erasing the Two-Tier System: Risk Diagnostics



High Risk Infants

Infants with severe eczema (particularly within first months), existing food allergies, or a family history of allergy.

Standard Risk Infants

No family history, no early eczema.

UNIFIED PROTOCOL

**Timely Introduction
(4-6 Months)**

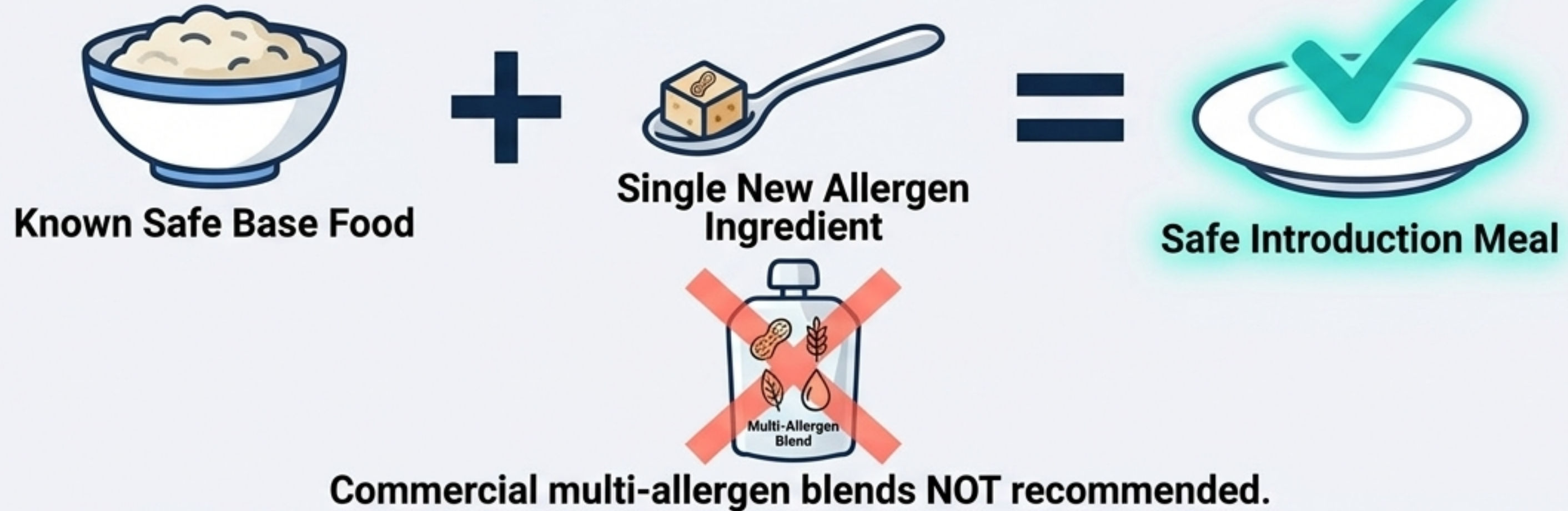
Clinical Insight:

Post-hoc analysis from major trials revealed that **earlier introduction** of egg and peanut reduced allergy risks equally across both high-risk and low-risk cohorts. Creating different timelines based on risk profile causes unnecessary confusion and delays. The protocol is universal.

Phase 3 Diversification: The “Rule of One”

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Consensus

The Rule of One Plate



The Rule

Introduce only one new common food allergen at a time at a single meal (Rec 2).

The Rationale

This precise, isolated introduction allows parents and clinicians to easily and accurately identify the trigger food if an allergic reaction occurs.

Expanding the Diet: The Extended Allergen Family

Very Low
Evidence

The Big Two: Peanut & Egg

Specific 4-6 month
optimal window.

Backed by high-certainty
trial data.

The Extended Family

The List

- Cow's milk, wheat, soy, tree nuts (cashew, walnut), sesame, fish, shellfish (Rec 5).

The Timeline

- Introduce throughout the first year of life.

The Strategy

- Prioritize foods that are part of the family's usual diet. Environmental exposure without consumption is a risk factor; regular family consumption makes maintenance easier.

Critical Caveat: If an infant is diagnosed with an allergy to one specific food, do not delay the introduction of other common allergens (Rec 6).

The Mechanism of Tolerance: Skin vs. Gut

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Never smear food onto the skin to test for an allergy (Rec 8).

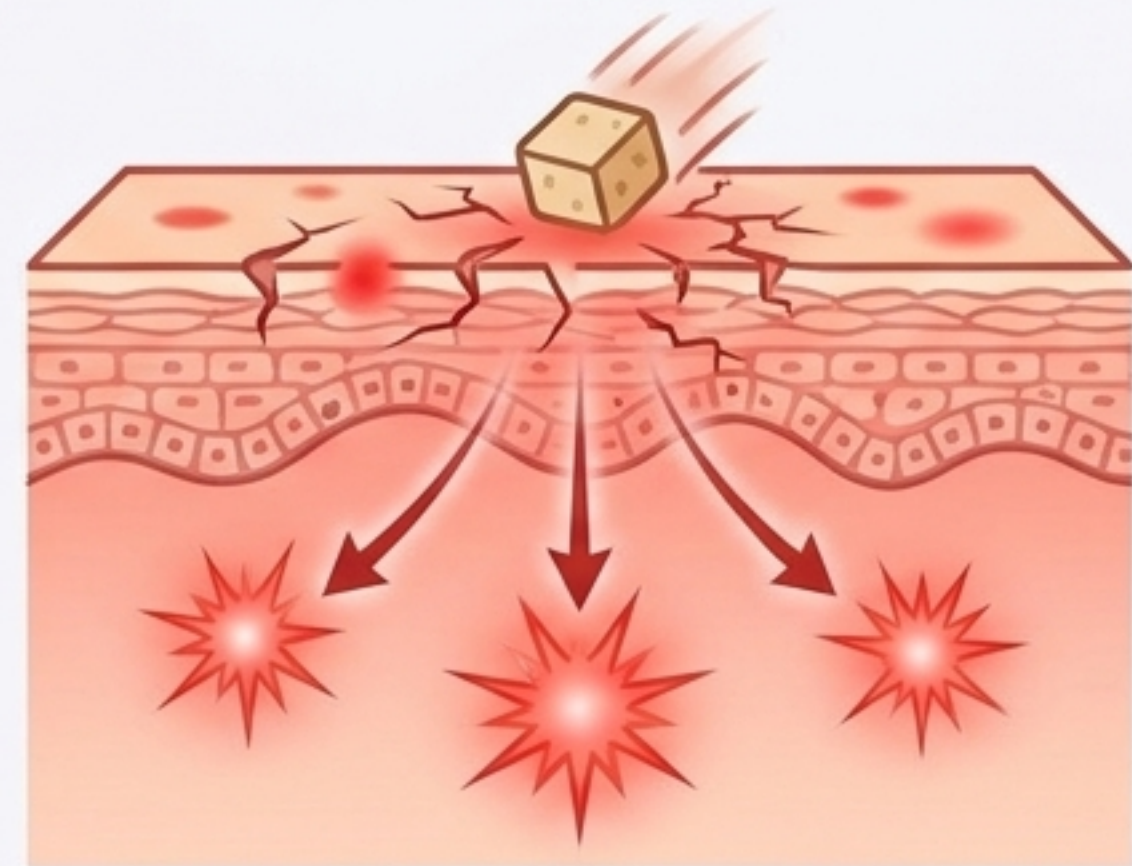
The Gut Route



Oral Tolerance

True immunological tolerance is built via oral consumption and digestion.

The Skin Route

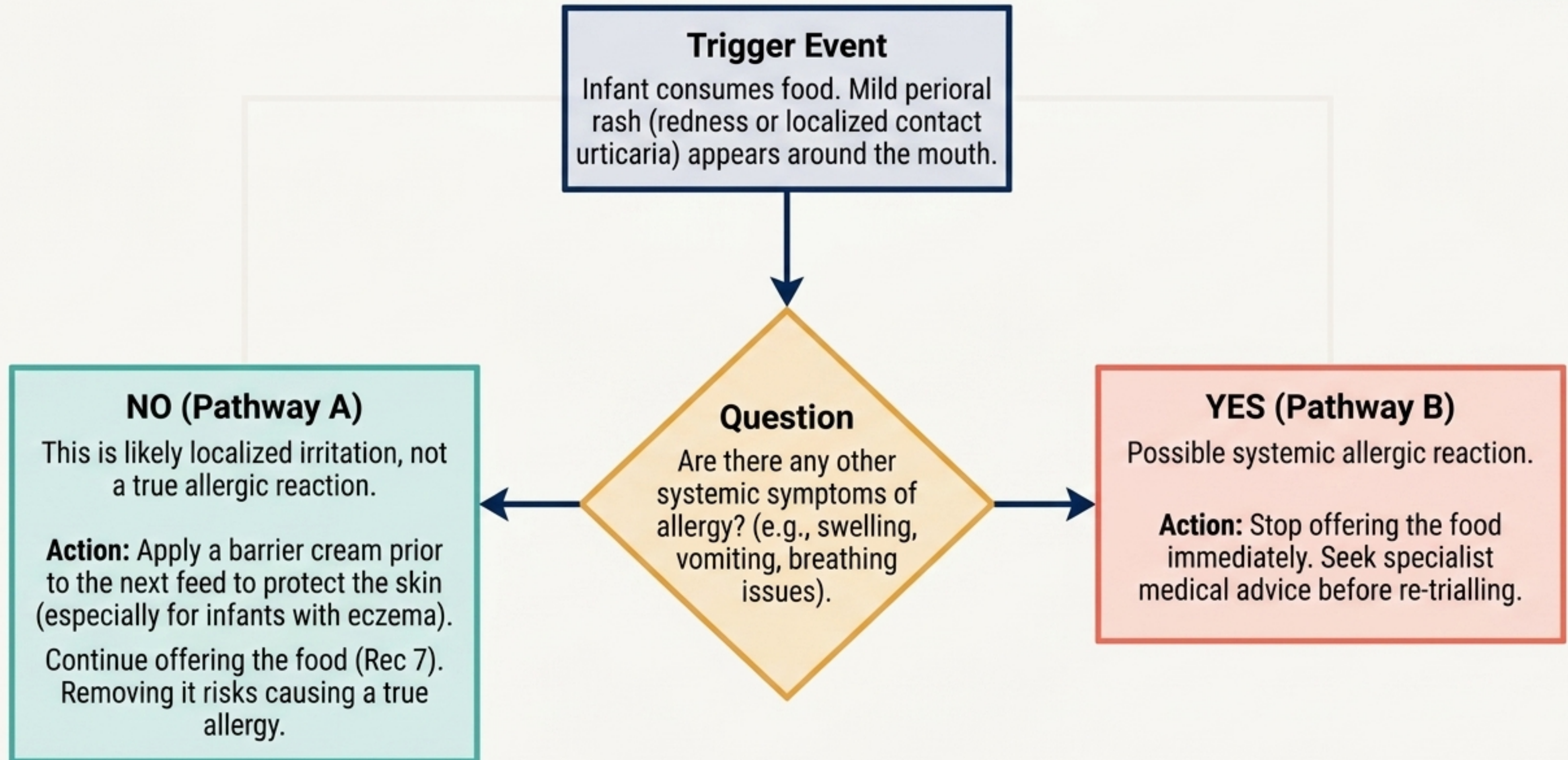


Allergic Sensitization

Frequent skin contact with food allergens without oral consumption is a risk factor for allergic sensitization. The skin will often show localized irritation or redness that is not an IgE-mediated allergy.

Troubleshooting the Perioral Rash

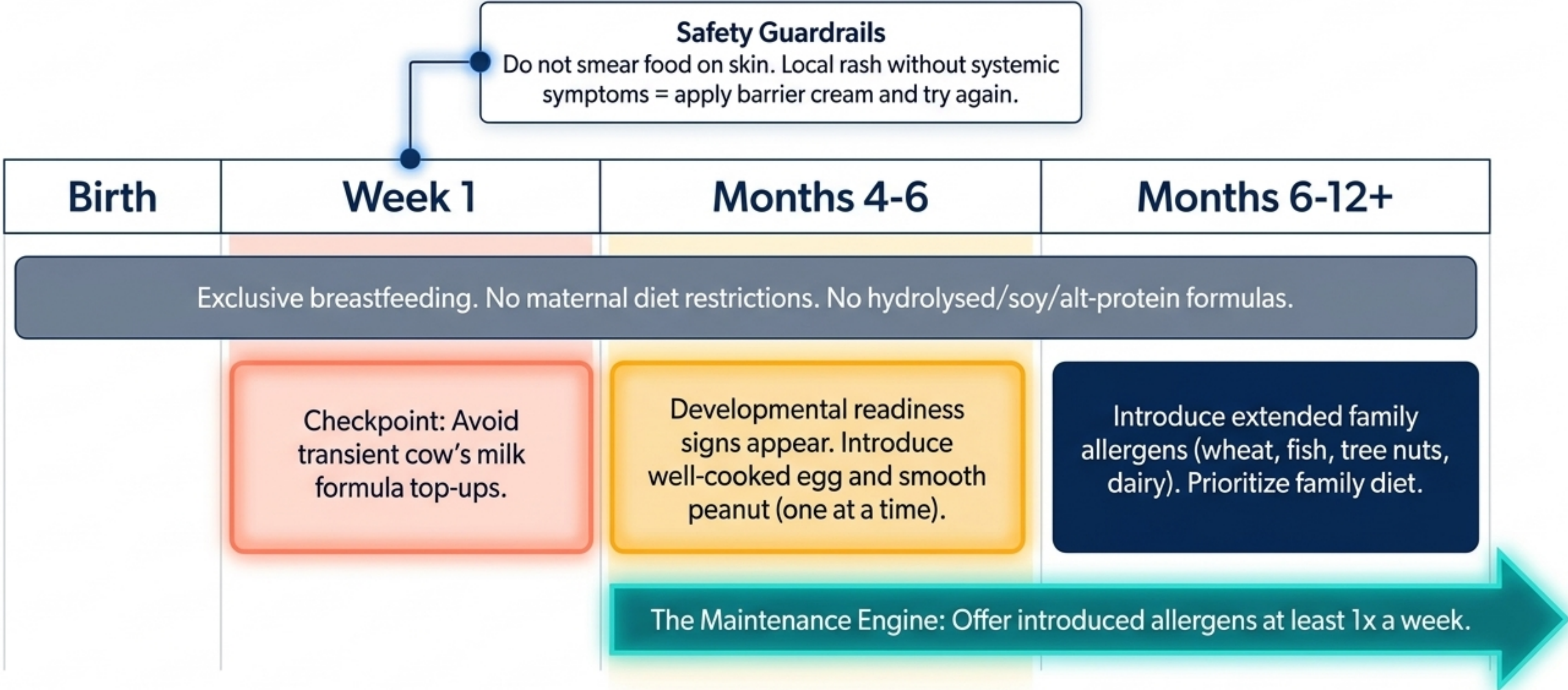
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Phase 4 Maintenance: The “Once a Week” Engine



Synthesis: The 2025 Clinical Protocol Dashboard



This blueprint represents the unified ASCIA strategy to actively build lifelong immunological tolerance.