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COMMITTEE ON NUTRITION: BABY FOOD AS SPECIAL DIETARY FOODS

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COMMITTEE ON NUTRITION

BABY FOOD AS SPECIAL DIETARY FOODS

"BABY FOODS" have been regarded as "Food for Special Dietary Uses" under federal Food, Drug, and Cosmetic Act regulations that have been in effect since 1942. The current revision of the FDA regulations proposes to continue this classification (Federal Register, December 14, 1966; 31 F.R. 15730).

A recent article in the *New England Journal of Medicine*[1] objects to classifying infant foods as "Food for Special Dietary Uses" in the recently proposed revision of the federal Food and Drug regulations. The authors appear to be unaware that "baby foods" have been regarded as "Food for Special Dietary Uses" for a quarter of a century. The proposed revisions make no substantive changes in the current regulations affecting "baby foods."

In practical terms, this section of the regulations provides that if a food represented by the manufacturer for use by infants, specifically those less than 12 months of age, contains two or more ingredients, these shall be listed on the label. The label needs to indicate the specific plant or animal source of each ingredient and the common or usual name of each ingredient, including spices, flavorings, and colorings. This is important since typical "baby foods" may contain as many as 10 to 12 ingredients in addition to the principal one. They may combine a variety of additives, including flavoring agents, preservatives, antioxidants, emulsifiers, nutrients, and special fat ingredients.

Special feeding problems are of common occurrence in pediatric practice. It is impossible for the physician to identify the cause of food idiosyncrasy unless he has knowledge of the specific nature of all food consumed. There can be no question, therefore, that physicians and parents have need for fully informative labeling of foods offered for inants and small children. The present and proposed labeling requirements provide this information.

The Committee is informed that the classification of "baby foods" as "Food for Special Dietary Uses" is a deterrent to the sale of these products in certain countries where this designation limits distribution to drug outlets rather than food stores. The Committee takes no position on this aspect of classification; it does strongly urge retention of a requirement for fully informative labeling to protect American infants.

The Committee on Nutrition of the American Academy of Pediatrics endorses without reservation the language and the intent of the current regulations 125.5 and the revision, 125.4(a) and (b).[2] The net effect of these regulations will be to maintain fully informative labeling of commercially prepared infant food to the end that knowledge of the food content by physician and parent will insure safety, health, and sound nutrition for the infant.

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2. Federal Register, Vol. 31, pp. 15730-15736, December 14, 1966.

COMMITTEE ON FETUS AND NEWBORN

COMMENTS ON HEALTH LEGISLATION, MEDICAL RESEARCH, AND NEW NURSERY DESIGN

THE physical design of and routine practices in neonatal units (especially nurseries for high-risk infants) are presently influenced almost entirely by considerations related to the risk of spreading infection in the nursery by fomites and personnel. The role of nursery design and specific routines in preventing epidemics is considered so important that the details are encoded in many local, state, and federal health laws or regulations. These are enforced by periodic inspections and conformity is made a prerequisite for official approval, allocation of funds, etc. Although there is little reason to doubt that these policies have had the effect of reducing the incidence of nursery epidemics, there is growing concern that official rigidity in these matters may interfere with optimal care of the very ill infant, as well as with research designed to improve care and find solutions to the overall problems of neonatal mortality and morbidity.

Infections are an important and frequent cause of disease in the newborn. They are, however, clearly outdistanced by major non-infectious disorders that account for the majority of deaths and brain damage in the neonatal period (respiratory distress, asphyxia, acidosis, hypoglycemia, and hyperbilirubinemia). Some of the precautionary techniques used to reduce the risk of infections have the practical disadvantages of making it difficult (1) to approach the neonatal patient and (2) to apply modern diagnostic maneuvers and therapeutic aids in order to improve the neonatal patient's chances for intact survival. As a result the nursery-based infants in this country are, in general, quite well protected from the risks of nosocomial infections; but, they receive less than ideal management for cardiorespiratory disorders, a major cause of neonatal mortality.

It is obvious that new solutions are required to solve the problem of hospital care of the sick neonate. Unfortunately, both the search for new approaches to neonatal care and the application of some newly established knowledge are now being impaired by rigid rules and construction codes which do not permit innovation. Although these rules cannot be completely abandoned until safe alternatives have been demonstrated, the Committee believes that public health administrators and hospital committees must permit cautious, responsible exploration and evaluation of new approaches to the multiple problems involved.

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