Allergies and Breastfeeding

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Do breastfed babies get allergies? How do we manage them?
Overview: Allergies and Breastfeeding

1. To what extent are food allergens transmitted via breast milk?
2. Food allergy and breastfeeding
3. Eczema and breastfeeding
4. Colic and breastfeeding
5. Allergy prevention and breastfeeding
Overview: Allergies and Breastfeeding

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Breastfeeding and allergen transmission

- Breast is best for various reasons:
  - ensures optimal nutrition
  - supports humoral and cellular immunity
  - protective intestinal microbial population
- Breast milk content adapts to the changing needs of the baby
- Foods and proteins are already highly “filtered” and “processed” by the time they pass through into breast milk
- The vast majority of babies tolerate breast milk extremely well
- There is evidence that recognisable food proteins can pass into breast milk
Breastfeeding and allergen transmission

- Breast milk contains a number of substances which make the transmitted allergens well tolerated:
  - Processed allergen
  - Allergen specific IgG
  - Soluble IgA
  - TGF B
  - Vitamin A
  - Optimal microbiota
Breastfeeding and allergen transmission

• Despite this protective milieu, occasional aberrant response to transmitted allergens
How much allergen is transmitted via breastmilk?

- **Amount of allergen transmitted:**
  - allergen-dependent
  - varies from one mother to another (permeability of mammary epithelium)
  - varies from feed to feed

- Benn et al PAI 2014
Breastfeeding and allergen transmission

- **Cow’s milk proteins:**
  - Beta lactoglobulin passes into breast milk in small amounts: equivalent to an extensively hydrolysed formula
  - There may be cross reactivity between human milk proteins and bovine milk proteins
  - Cow’s milk particles pass into breastmilk 1-12 hours after maternal ingestion
    - Host A. Clin Exp Allergy 1990;20:383
Breastfeeding and allergen transmission

- **Egg allergens:** Ovalbumin found in breast milk 2-6 hours after ingestion *Fukushima Am J Clin Nutr 1997;65:30*

- **Peanut protein:** Secreted into milk 1-3 hours after maternal ingestion, but only in 48% of lactating women
  - *Vadas et al JAMA 2001; 285: 1746*
Breastfeeding and allergen transmission

• **Wheat gliadin** excreted 2-4 hours after ingestion  
  *Chirdo et al Scand J Gastro 1998;33:1186*

• **Soya isoflavones** pass into breastmilk
  
  • **Atanaskovic. Endocrine, metabolic and immune disorders 2014;14: 63**
Breastfeeding and allergen transmission

- **Other substances in breastmilk:**
  - Particles of gas-forming foods can be transmitted in breast milk
  - Alcohol and caffeine can be transmitted
  - Strong flavours eg garlic can be transmitted.
Breastfeeding and allergen transmission: Summary

- Foods and proteins are transmitted via breast milk but are already highly “filtered” and “processed” by the time they pass through into breast milk.
- The vast majority of babies tolerate breast milk extremely well.
- Allergens transmitted via breast milk are usually presented in a protective way but occasionally in an allergenic form.
Overview: Allergies and Breastfeeding

1. To what extent are food allergens transmitted via breast milk?
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Food Allergies in Young Children: The Big 6
Breastfeeding and food allergies

1. In theory, any allergen may be transmitted via breastmilk and set up an allergic response

2. But remember- allergen modification and “protection” via breastmilk

3. Therefore, allergies on breastmilk are rare. Much more common to see allergies arising when supplementary or complementary feeds are introduced.
Classification of adverse reactions to food

Food Hypersensitivity

Non-allergic food hypersensitivity
- Unknown mechanism
- Metabolic e.g. lactose intolerance

Food Allergy (immune-mediated)
- IgE-mediated
- Mixed IgE-and non-IgE-mediated
- Non IgE-mediated
Manisfestations of food allergies

**IgE mediated**
- General
- Anaphylaxis
- Cross reactivity syndromes

**Mixed IgE and non-IgE mediated**
- Eosinophilic oesophagitis
- Eosinophilic gastroenteritis
- Dietary protein enteropathy
- Asthma
- Atopic eczema

**Non-IgE mediated**
- Allergic proctocolitis
- FPIES
- Coeliac disease
- Contact dermatitis
- Heiner’s syndrome
- GI motility disorders
Breastfeeding and food allergies

1. IgE-mediated (immediate type) food allergies are particularly rare via breastmilk, and cause “immediate” type symptoms (rashes etc) 1-12 hours after maternal ingestion of allergen.

2. We do have good examples of delayed type allergies whilst babies are breastfed: NB cow’s milk

3. The trick is to avoid “blanket elimination” of foods from a mother’s diet when allergies are suspected, but rather to have expert testing and very targeted elimination.
Manifestations: IgE mediated allergies

- Usually manifest when supplementary feeds/solids introduced
- Occasionally during exclusive breastfeeding
- Symptoms in infant from minutes to 2 hours after the feed during which allergen transmitted
- Delay in transmission of allergen hence not always immediately obvious
IgE mediated: Manifestations
IgE mediated manifestations
IgE mediated manifestations

- NB atypical presentation...lethargy, cyanosis, floppiness in infants
Non-IgE mediated cow’s milk allergy

**FOOD ALLERGY**

- **IgE mediated**
  - General
  - Anaphylaxis
  - Cross reactivity syndromes

- **Mixed IgE and non-IgE mediated**
  - Eosinophilic oesophagitis
  - Eosinophilic gastroenteritis
  - Dietary protein enteropathy
  - Asthma
  - Atopic eczema

- **Non-IgE mediated**
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Non-IgE mediated cow’s milk allergy

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Non-IgE mediated reactions

- Involve cell mediated immunity
- Variety of presentations
- Symptoms of a more chronic nature, and are not closely associated with ingestion of an offending food
- Most commonly involves cow’s milk and soya
Non-IgE CMPA: manifestations in the infant

- **Allergic proctocolitis:**
- Fresh bleed PR in thriving child, breast or formula fed
- Exclusion of CM from maternal diet results in resolution of symptoms within 72-96 hours in most cases
- 5% won’t improve adequately and will need an amino acid formula
Non-IgE CMPA: manifestations in the infant

- **Dietary protein enteropathy**: Food allergy leads to distorted villous architecture and consequent absorption disturbances; protracted diarrhoea, vomiting, bloating and failure to thrive.

- **FPIES**:
  - Profuse vomiting/diarrhoea 1-3 hours after ingestion of allergen
  - Chronic FPIES: vomiting, diarrhoea, FTT
Non-IgE CMPA: manifestations in the infant

- **Allergic eosinophilic oesophagitis:**
- Refractory GORD
- Most commonly CMP
- Has been described in exclusively breast fed babies.
Non-IgE CMPA: manifestations

• **Motility disturbance:** Mast cells and eosinophils interact with the enteric nervous system (‘neuro-immune’ interaction) to cause motility disturbance
  – Vomiting
  – Colic*
  – Treatment resistant GORD*
  – Constipation
Colic

“Colic PLUS” think of CMPA
Diagnosis of IgE-mediated Food Allergy

- In breast fed babies not as easy to recognise due to time delay
- History
- Skin Prick Tests
- Specific IgE
- Components
- Food challenges
Diagnosis of IgE-mediated Food Allergy

Skin Test
1. Several allergens are introduced to the skin
2. The test is positive if the skin shows a reaction.
Diagnosis of IgE-mediated Food Allergy

- Remember: Positive SPT/IgE test means sensitisation but not necessarily allergy! (especially in eczema)
- **Allergy=sensitisation+ other proof**
- Higher values of SPT/sIgE more suggestive of allergy but do NOT predict severity of reaction
Diagnosis of Non-IgE CMPA

- Diagnosis difficult: symptoms may occur hours to days after ingestion
- Diagnosis mainly by clinical history
- Little role for SPT/sIgE/patch testing
- Role for biopsy: eosinophilic conditions
- *Improvement on elimination diet (3-4 weeks) and worsening on reintroduction*
Management of food allergy during breastfeeding

• If infant symptomatic owing to dietary protein triggers in breastmilk - maternal avoidance of targeted foods
• No blanket elimination diets
• Appropriate formula if supplementary feeds needed
• Avoid offending food when solids introduced
Management: IgE mediated allergies

1. Dietary elimination of antigenic proteins:
   - maternal elimination of allergen if breastfeeding
   - if formula fed: extensively hydrolysed or amino acid formula
   - If on solids: label reading

2. Dietary substitution: e.g. soya formula* an option in 90% of IgE mediated CMPA

3. New and experimental: anti IgE, Specific Oral tolerance induction

4. Regular follow up preferably by an allergist
Hydrolysed formulas

Degree of hydrolysis

- Regular
- Partially (HA) (<5000 Da)
- Extensively (<3000 Da)
- Amino acid
Hydrolysed formulas

Degree of hydrolysis

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- Extensively (<3000 Da)
- Amino acid
Other formulas in IgE mediated CMPA

- Goat’s milk- 80-90% homology with Cow’s milk- NO
- HA formulas: contain intact cow’s milk protein- NO
Management: non IgE mediated allergies

- Continue breast feeding + maternal elimination diet (95% success):
  - proctocolitis: improve in 48-72 hours
  - enteropathy: may take 2-3 weeks
- Formula: First choice=eHF
- If fails or if maternal elimination during breastfeeding has failed: AA formula
- 50-60% co-allergy of soya with non IgE mediated CMPA
- Remember maternal supplementation eg calcium
If no response to maternal elimination

• ? Elimination not complete
• ? Additional foods need elimination
• ? Symptoms unrelated to food allergy
• ? Infant actually reacting to breastmilk proteins which are cross reacting with CMP (rare: need to stop breast feeding and give AA formula)
AA formula recommended if:

- IgE mediated CMPA at risk of anaphylaxis
- EoE
- Ongoing symptoms on EHF
- Ongoing symptoms after maternal elimination of allergen
Timing of reintroduction of allergens

- IgE-mediated reactions:
  - Be guided by SPT/bloods/history of dietary indiscretions
  - Review every 6-12 months
  - Reintroduction under physician supervision
Timing of re-introduction of allergens

- **Non IgE mediated reactions:**
- Introduction of CMP/soya into maternal diet: usually 9-12 months
- Introduction of CMP/soya into infants’ diet:
  - 9-12 months proctocolitis (home)
  - 1-2 years in enteropathy (home)
  - 12-18 month after last reaction in FPIES (supervised)
- “regression” - then stop, try again 2-3 months later
- Wise to perform SPT/sIgE before re-introduction in case of “conversion” to IgE mechanism
Timing of reintroduction of allergens

- Non IgE mediated reactions:
- Concept of “milk ladder” (baked milk-eHF-yoghurt-cheese-CM)
Food Allergies Manifesting upon Weaning

• First allergy manifestation in a breastfed baby may occur during intro of formula feeds or solids
Food Allergies Manifesting upon Weaning

- Investigate and eliminate appropriately

- If mother consuming that allergen and baby asymptomatic during breastfeeding, then she can continue consumption!
Case 1: IgE-mediated Cow’s Milk allergy

- DW, a bouncing 8 month old boy brought in for a second opinion
- Breast fed (1-2 top ups after birth)
- Eczema from 6 months
- At 7 months age, first introduction of yoghurt- flushing and hives immediately; no respiratory symptoms
Case 1:

- Paediatrician did blood tests:
  - Cow’s milk protein  1.41
  - Soya 0
  - Cod 0
  - Peanut 0.13
  - Egg white 0.08
Case 1

• Paediatrician diagnosed him with cow’s milk allergy and advised totally cow’s milk protein free diet.
• Advised amino acid as milk of choice as mum was worried about ongoing exposure via breast milk.
Case 1- possible pitfalls?
Case 1- pitfalls

- Was it really cow’s milk allergy?
- Breast feeding not OK?
- AA formula as first line milk choice?
- Dietician?
- Action plan?
- Follow up plan?
Case 1- further management

- Detailed history- e.g tolerated purity biscuits (baked milk)
- Examination thriving baby with patches of moderate eczema: eczema responded well to topical treatment
Case 1: Further management

- **SPT**

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<tr>
<td>Positive control</td>
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Case 1: further management

• Soya challenge- passed
• Reassured that breast feeding was fine (no overt reactions whilst on breast milk)
• Advised that soya formula was an option if supplementary feeds needed/planned
• Continued ingestion of “baked” cow’s milk
• Action plan+ antihistamine
• Dietician referral
• Review 6 monthly
Case report 2

• PdV : 6 month boy, refluxy, growth 25% centile
• Breast fed
• Initial “taste” of formula milk at 6 weeks: vomited after a while
• 5 months- 90 mL formula milk- vomited about 2 hours later, profusely→ER
• HA formula: 2 hours later vomited
• Teaspoon of yoghurt: violent vomiting 2 hours later
Case 2

- Allergy blood tests negative to cow’s milk - perplexed patient and doctor
- Management: AA formula, breastmilk and avoidance of cow’s milk, soya, wheat, egg, nuts.....
Case 2: Pitfalls
Case 2: Pitfalls

• Over-reliance on allergy tests when the history is key
• Blanket elimination diets
Case 2

• **Further Management:**
• Allergy Consult
• We repeated SPT to common allergens: negative
• Diagnosed FPIES to cow’s milk
Case 2:

- Extremely careful home soya challenge: passed!
- Breast fed with maternal elimination of cow’s milk
- Soy formula if needed supplementary feeds
- Advised to introduce all other solids as usual into maternal and infant diet, except cow’s milk
Case 3

- 3 month old baby with severe colic, reflux, constant discomfort and crying, sleeplessness during breast feeding
- Trial of maternal elimination of CMP and soya for 3 weeks: little difference
- Trial of AA formula (mom expressed): vast improvement, “different child”
- After 3 weeks, reintroduction of breast milk- “disaster”
Case 3 ctd

- SPT at 5 months to common food allergens: negative
- Trial of eHF at 6: failed. Back on AA formula
Case 3:

- Non IgE mediated reaction; enteropathy
- Cross reaction between breastmilk proteins and cow’s milk proteins
- A rare case when breast feeding needed to be discontinued
Lactose Intolerance: the great imitator

Cow’s Milk

Sugar
Lactose

Protein
Cow’s milk protein

whey

casein
Classification of adverse reactions to food

Food Hypersensitivity

Non-allergic food hypersensitivity
- Unknown mechanism
- Metabolic e.g. lactose intolerance

Food Allergy
- IgE-mediated
- Mixed IgE- and non IgE-mediated
- Non IgE-mediated
Lactose intolerance

- Lactose = disaccharide of glucose + galactose
- Primary CHO found exclusively in milk of mammalian origin (NB humans too!)
- Hydrolysed by Lactase enzyme into its simple sugars which are easily absorbed

\[ \text{lactase} \]

- Lactose \[ \rightarrow \] glucose + galactose
Lactose intolerance

• Unabsorbed lactose
  – Draws fluid and electrolytes into intestine
  – Acts as base for intestinal bacteria: produce gas

  – Diarrhoea, flatulence, abdo pain 30 min - 2 hours after ingestion of milk
Diagnosis of lactose intolerance

1. Symptoms: green frothy loose stools, abdo cramps, nappy rashes
2. Symptoms resolve when lactose removed and return when reintroduced
3. Low stool pH and reducing substance+
4. (Hydrogen breath test following lactose load)
5. Lactose tolerance test
Treatment of lactose intolerance

• Lactose free/reduced diet
• Options for formula milk: Soya or lactose-free
• If breast fed: reduce foremilk (e.g., block feed one breast at a time)
  - lactase enzyme drops
• Secondary lactose intolerance: 2-4 weeks then lactase levels recover
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Breastfeeding and eczema
Eczema in the Young Child

Specific Immunological responses

Inhalable respiratory allergens  Food allergens  Microbial agents

Cells and mediators in skin immune system

ATOPIC DERMATITIS

SKIN BARRIER DYSFUNCTION

Irritants  heat  humidity  stress

Non-specific responses
Eczema in the Young Child

- miserable, itchy
- infection
- FTT
- markedly ↑ risk food allergy
The association between food allergy and eczema

- 30-40% of children with moderate to severe eczema have associated IgE mediated food allergy.
Food Allergies and Childhood Eczema

- Food allergy plays a role in causation in 15-20% of cases of atopic dermatitis.
- NICE and other guidelines for eczema: moderate to severe eczema < 6 months age: trial of extensively hydrolysed formula or maternal elimination of CMP.)
Food Allergies and Childhood Eczema

• Test for food allergy in children with:
  ➢ Moderate to severe eczema, especially if not responding to standard treatment
  ➢ Eczema of early onset (< 6 months)
  ➢ If there is a history suggestive of immediate food allergies
  ➢ If there is a history of recurrent worsening of eczema after ingestion of a certain food.
Food Allergies and Childhood Eczema

• No role for “blanket” elimination of foods in eczema, including maternal diet if lactating
• Many children with eczema have positive allergy tests but will tolerate the food
• Food allergy needs to be proven before recommending specific elimination diets!
• Generally, if foods seem to be tolerated with no obvious immediate symptoms, and eczema is treatment responsive, then foods do not need to be eliminated regardless of allergy test results
• We can actually “create” allergies by eliminating foods unnecessarily
Association between food allergies and eczema:

The role of eczema in the pathogenesis of food allergies
Eczema in the Young Child

- Early onset eczema < 3 months → massive increase in food allergies
- Allergens enter via defective skin barrier and escape gut "tolerance"
Overview: Allergies and Breastfeeding

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Colic and Breast feeding
1. Descriptions/definitions

- Minor GIT problems=extremely common in 1st year of life, a source of great anxiety
- Fussiness=discontentment/discomfort that is difficult to soothe
- “Colic” used broadly to refer to prolonged excessive crying or unsettled periods for no apparent reason
Descriptions/definitions

- Parental perception/expectations certainly play a role in defining a child as colicky
Normal Infant Crying

Total daily crying time (hours)

- Week 3: 0 hours
- Week 6: 2 hours
- Week 9: 2 hours
- Week 12: 0 hours
Normal Infant Crying

Total daily crying time

Week 3
Week 6
Week 9
Week 12
Normal Infant Crying

Total daily crying time

Week 3 | Week 6 | Week 9 | Week 12
Possible aetiological factors

- Feeding practice
- Physiological immaturity
- Infant temperament
- Motility issues
- Disturbed microflora
- Excessive gas
Possible aetiological factors

- Lactose intolerance
- Feeding practice
- Physiological immaturity
- Infant temperament
- Disturbed microflora
- Excessive gas
- Motility issues
- GORD
- Hypersensitivity to stimuli
- Cow’s milk protein allergy
Cow’s milk protein allergy in colic

- True cow’s milk allergy 2-5%; colic in 20-40%
- CMPA causing “fussy” babies = non-IgE mediated variety
- No simple tests except elimination-reintroduction
- Consider in fussy baby+ other symptoms eg resistant GORD, eczema, FTT
Cow’s milk protein allergy in colic

• Simple colic does not respond to cow’s milk exclusion! (Evans, Lancet 1981)
• A general reduction in caffeine, alcohol and gas-forming foods should be considered in severe colic
Cow’s milk protein allergy in colic

• Blanket exclusion of multiple allergenic foods NOT warranted.
• In selected patients, “COLIC PLUS” consider cow’s milk free diet during breastfeeding for 2-3 weeks. If no response, revert to normal diet
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Infants at high risk of allergy

- no family history  ➔  10-15% chance of allergy
- 1 parent/sibling with allergy  ➔  40% chance of allergy
- 2 parents with allergy  ➔  70-80% chance of allergy
Infants at high risk of allergy

- no family history
  - 10-15% chance of allergy
- 1 parent/sibling with allergy
  - 40% chance of allergy
- 2 parents with allergy
  - 70-80% chance of allergy

“HIGH RISK”
Allergy Prevention Strategies

- The perinatal period is a critical one for “programming”
- Environmental influences (e.g. microbiota; antigen exposure) can lead to epigenetic events→ influence allergy
Timing of Interventions

1. Diet during pregnancy and lactation
2. Exclusivity and duration of breastfeeding
3. Which formula to use
4. Introduction of solids
5. Nutritional supplementation (e.g. probiotics, LCPUFA)
Allergy Prevention Strategies: Breast milk

**Allergy Prevention**

- **Allergen Reduction**
  - e.g. breastfeeding; hydrolysed formulas; solids introduction strategies

- **Enhancing Immune maturation**
  - e.g. Maternal diet; pre- and probiotics; n3-PUFA
Summary of Allergy Prevention Strategies

Diet during pregnancy and lactation:

1. Maternal avoidance of allergenic foods such as egg, dairy, peanut is not recommended during pregnancy.

2. No special diet is required for the lactating mother (except if the infant is already showing manifestations of particular allergies).

3. There is no clear evidence to support the use of supplements such as probiotics, fish oil supplements, and vitamin D during pregnancy and lactation.
Exclusivity and duration of breastfeeding:

1. Exclusive breastfeeding for 4-6 months is recommended; thereafter not much protection against allergies

2. Ideally there should be an overlap between breastfeeding and solids introduction

Summary of Allergy Prevention Strategies

Formula milk?

1. No formula milk is better than breastmilk for allergy prevention

2. If exclusive breastfeeding is not possible for the first 4 months, there is no clear evidence that a documented hypoallergenic formula is beneficial.

3. There is no evidence for use of soya milk (or milk of other mammalian origin such as goat’s milk) as an allergy prevention strategy.
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6. Conclusion
Summary: Breastfeeding and allergies

• Allergens DO get transmitted via breast milk, but generally in a protective form
• Rarely, in breast fed babies we can get allergies, via food proteins carried in milk- usually delayed type allergies such as proctocolitis.
• The most common allergens transmitted via breastmilk and causing symptoms are cow’s milk and soya.
Summary: Breastfeeding and allergies

- Blanket elimination diets during breastfeeding are unnecessary and nutritionally damaging.
- Vast majority can continue breastfeeding with targeted exclusions by the mother (remember: involve dietician, give calcium supplements).
- 5% won’t improve adequately and will need an amino acid formula.
- Breastfeeding still has a role to play in allergy prevention, mostly in the first 4-6 months.
Thank you!

Every time I cry they stick a boob in my mouth

I LOVE MY LIFE

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