

Rebecca Dekker :

Hi everyone. On today's podcast, we're going to talk with lactation specialist, molecular biologist, and Founder of [freetofeed.com](#), Dr. Trill Paullin, about her work in educating families on infant food reactivity and empowering them to reach their feeding goals.

Welcome to the Evidence Based Birth® podcast. My name is Rebecca Dekker and I'm a nurse with my PhD. I'm the founder of Evidence Based Birth®. Join me each week as we work together to get evidence-based information into the hands of families and professionals around the world. As a reminder, this information is not medical advice, see [ebbirth.com/disclaimer](#) for more details.

Hi, everyone. My name is Dr. Rebecca Dekker, pronouns she/her, and I'll be your host for today's episode. Today, I'm so excited to welcome the founder of Free to Feed, Dr. Trill Paullin. Before we interview Dr. Paullin, I want to let you know that there is a mention of the fear of an infant dying, a description of a serious infant food reaction with bloody diapers, engendered language related to lactation. If there are any other detailed content or trigger warnings, we'll post them in the description or show notes that go along with this episode. And now I'd like to introduce our honored guests, Dr. Trill Paullin, pronouns she/her, is a molecular biologist and mother to two beautiful daughters who had severe infant food reactions to proteins transferred from her diet to her breast milk. After processing the painful fact that she could potentially hurt her children through breastfeeding, she started researching how to produce milk that they could properly digest.

Dr. Trill discovered that many parents experienced the same troubling situation. She wanted to create a space for parents to find answers to their questions about infant food reactivity and empower them to reach their feeding and lactation goals. Free to Feed was born to provide the research, resources, and support that Dr. Trill wished she had early on. She started this mission by creating an annual subscription to empower parents through their food allergy journey. A tracking app built specifically for this space, personal consultations, as well as an allergy-friendly postnatal multivitamin. Free to Feed's team is hard at work, launching an at home test strip that will allow parents to analyze their own human milk for allergens. We are so thrilled that Dr. Paullin is here. Welcome to the Evidence Based Birth® Podcast. Dr. Trill, I'm so excited that you're on the podcast to talk with us today.

Dr. Trill Paullin:

Thank you so much for having me.

Rebecca Dekker :

So, can you talk to us a little bit about some of the myths related to infant food allergies? I know I've probably heard some of these myths and been indoctrinated into them myself as someone who's in the nursing profession. So, could you just walk us through, what are the basic misconceptions about infant food reactions?

Dr. Trill Paullin:

Absolutely. Thank you for that question, Rebecca. And there are so many myths around this particular topic, and I think there's a lot of reasons behind that. But as we're looking at parents trying to determine if their baby is having a food reaction issue, one of the biggest myths that we see is that they are told often that their child has what's called an intolerance, when in actuality they have an allergy. And so often times that gets our hackles up, right? We're like, oh, no, my baby has an allergy. Because when we think of an allergy, we think of a stereotypical, I have a peanut and the peanut causes my throat to swell

and I need an EpiPen and to go to the hospital. That's what we think of stereotypically when we hear allergy. But in actuality, that's just one category of a type of allergy.

That particular type is commonly in IgE-mediated allergy. And there is another subcategory of allergies that's considered a non-IgE-mediated allergy, which is a fancy way to say it's a cellular response that doesn't use the same pathway as a typical allergy. Now still an allergy. And the bad news with this type of allergy is that, one, it is really common in affecting infants. And we'll talk about the symptoms that we typically see. Two, it can't be tested for. And so, the test that we have currently available in the medical field specifically looks for IgEs. And so, if it isn't using that pathway, there's nothing necessarily to test for, not yet, anyway. But the good news with this type of allergy is that it's outgrown, which is another reason why there's a myth around whether or not your child has a food allergy or an intolerance, because eventually it's not an issue any longer, thank goodness for that.

But it is still technically a food allergy. And some of the interesting pieces, as far as if it was a food intolerance, is that technically an intolerance means that your body is unable to create the proper enzyme to break down that food. And that's not what's happening in this baby's body. So while intolerance can happen, we can have a baby who has, for example, a lactose intolerance. It's so incredibly rare that only a few babies in the entire world over the course of medical history that we've been tracking have actually had that type of intolerance. So, these babies most often have what's called a non-IgE-mediated allergy. And the good news is they're likely to be outgrown, which hallelujah for that. And the other interesting piece is that these types of allergies have different types of symptoms. So instead of that anaphylactic shock that we're used to seeing, usually for a non-IgE-mediated issue, we'll see things like rash, eczema, reflux, constipation, bloody stool, mucus-y stool, diarrhea, and a whole slew of secondary symptoms that can be impacted because of those primary issues from these non-IgE-mediated allergies.

Rebecca Dekker :

Okay. So, the first myth is that it's not an allergy; when it is, it's just a different category of allergy. It's a non-IgE-mediated allergy. And the second myth is having to do about the symptoms you'd expect to have anaphylactic shock, but this is a different kind of immune response. And I noticed when I went to your website [freetofood.com](http://freetofood.com) that you had a picture of a baby with a lot of acne all over its face. The worst baby acne I've ever seen. So, can you tell us, is that a symptom of an infant food reaction?

Dr. Trill Paullin:

Yeah, so that image on the homepage of our website is very, very similar to what my oldest daughter looked like when she was having her skin reaction issues. And so often for these children who have rash issues and skin reactivity problems with their food allergy, and not all do, some have beautifully clear skin, which is wonderful, some do not. And so often what we'll see is that that stereotypical cradle cap that they'll get will start to spread down their face and then not get any better, continue on and will fluctuate with dietary changes. The other things that we'll see are eczema. We may see some high responses. There's a number of different types of skin reactivity. And for parents who are interested, we actually have a full gallery in the blog that shows different pictures of different presentations of food reactivity for these infants.

Rebecca Dekker :

Okay. And then you mentioned blood in the stool. So, it's my understanding that you experienced this yourself as a mother. Can you tell us a little bit about what that was like to find blood in your baby's diaper?

Dr. Trill Paullin:

Yeah, today I've worked with lots of parents who have had every range of bloody stools. So, everything from a little tiny bit of blood to what we experience. And I think overwhelmingly everyone's terrified. It would be strange if you weren't, right? It's weird to see something like that and it's very jarring. In our particular situation, my oldest daughter at first was inconsolable, so it didn't matter what we did. She was constantly uncomfortable and constantly crying. And so, I took her in and said, I don't know what's wrong, but if you could, please help me. And I was just told like, "Yep, your baby has colic. Good luck with that." And a few weeks later we woke up to find her completely covered in a rash from head to toe with a massively bloody diaper and then subsequent bloody diapers after that. And you can imagine it was absolutely terrifying.

And I took a picture of it and I sent it to my husband. My husband has ulcerative colitis, and, of course, my mind went there like, oh, my gosh, our baby has ulcerative colitis. She's not going to survive. And all the awful things that your parent brain goes to. I took her back to the doctor and said, Okay, well, something's definitely wrong now. Here's her crazy bloody diaper. All that is, is blood. And at that point I was told that maybe I should consider removing cow's milk protein from my diet. And even as an expert in proteins, my whole background was scientific research in proteins. I had no idea that something that I consumed could transfer and elicit a response like that in my baby. And so, while I love cheese, I said, okay, I can remove cow's milk protein from my diet, and I did so.

And she spiraled, and she got really worse really quickly, to the point where her skin was weeping and infected and all that came out of her little body was blood. And so, I took her back and said, okay, something's very, very wrong. We got admitted to the hospital and I remember getting into the hospital room and her being hungry. And so, I started to feed her, and a medical provider walked in and gasped and said, "Oh my God, I can't believe you would poison your baby like that." And that was the beginning of our hospital visit. They put her on a 24-hour starvation diet, which is fun when you are physically the food. So, I'm in the stairwell of the hospital at this point, pumping, because they didn't have another location for me, crying. And at the end of all of this they just said, "Yep, your baby has a food allergy. We can't test her to tell you what it's to. So, your only option is to switch to a hypoallergenic formula."

And quite frankly, I was a grad student at the time and I couldn't afford the formula. So, I went from feeding my baby something that hurt her to not being able to afford to feed her at all because the formula that they recommended was \$50 a can and only last a few days. And so, I started asking the questions, then in the hospital of, okay, there has to be another option if you can make a hypoallergenic formula, can I make hypoallergenic breast milk, technically? And the answer was a hesitant, maybe. Here's just a laundry list of foods because we can't test her to try to remove from your diet. And that was all the assistance I was given.

Rebecca Dekker :

So, they've also were clueless about how to treat it. And that brings us to another myth, which is that the proteins can't transfer into your own human milk like the proteins you eat. And I remember reading that on a blog when I was breastfeeding saying, when you drink cow's milk, it doesn't matter what the cow was eating that day. You don't have reactions to it. So, can you tell us why that's not true?

Dr. Trill Paullin:

So that is another really big myth in this space on both sides of the spectrum. So, oftentimes we'll see the parents are either told that what you consume doesn't transfer to the breasts, it can't elicit a

response in the baby. Or on the other side of the spectrum, you'll hear or be told that things that you consume will be in your breasts and elicit a response for weeks on end. So just these two massive sides of the spectrum, both are incorrect, which is frustrating.

But on the side of transferability, we know now exactly what portions of these proteins are transferring and exactly how much of the protein it's transferring. And so, the misconception of what you consume doesn't transfer to your breast. And sometimes I'll hear it poised as your breasts are not made of your stomach contents. And so, while technically, yeah, that is true. Your breasts are not made up of your stomach contents, but breast milk is made out of blood and we know that the proteins and vitamins and minerals that you consume have to be broken down into smaller pieces of themselves and then naturally absorbed into your circulatory system.

That's how we utilize the food that we're consuming. So, we transfer them from our mouth to our gastrointestinal system into the circulatory system, and anything in the circulatory system can wind up in the breast. And so, we now know that while, no, we don't transfer the entirety of that protein that you're consuming, you are transferring small portions of that protein after your digestive system is done with it. So, what's fascinating, then, is in order for us to have a reaction with our infant when we are feeding, we have to have two things happen at the same time.

We have to have a parent that's transferring that specific portion of the protein that their baby is reactive to. And so that's how for some, the parent may be able to eat cheese all day every day. And the first-time baby eats cheese, there's a big reaction or like my situation where I ate cheese and it caused massively bloody stool. I'm transferring the specific portion that my baby's reacted to. So, the stars are aligning in that regard. And it's super frustrating now because we have decades of research showing that transfer and still a lot of misinformation around the fact that no, we don't transfer, and the things that we consume doesn't impact our breast milk.

Rebecca Dekker :

Okay. So, we're transferring small portions of the protein that may then trigger an immune response through the milk. Can you talk a little bit about fussiness, because I know you mentioned fussiness being inconsolable is one of the symptoms. And how can parents tell the difference between fussiness versus a food reactivity?

Dr. Trill Paullin:

Yeah, so typically for children who are fussy, inconsolable, these kinds of issues, usually there's another symptom alongside it. Meaning that there will be abnormal stool or there will be vomiting response or rash response. So typically, there isn't just, and "just" is a hard word here, but just fussiness or irritability for the child. The other thing that a parent may do, if that's what they're experiencing and not experiencing any other more egregious symptoms, is that maybe tracking for a little while may be helpful to see, oh yeah, I do see a correlation to specific things that I'm consuming that may change fussiness and having some hard data for them to go back to can be really helpful, which is one of the things that our app can help parents do as well.

Rebecca Dekker :

Okay. And what are the current statistics on the percentage of families who experience human milk feeding allergies? How common is it or rare?

Dr. Trill Paullin:

Yeah, so this may be absolutely mind blowing, but the current research of the parental reported food allergies through the breast is one in four children. So, we're looking at 25% of littles who have one or more of these symptoms and that the parents are actually able to go back and pinpoint exactly what the food was that elicited that response through their breast.

Rebecca Dekker :

And what are the most common proteins or food proteins that cause the response through the milk?

Dr. Trill Paullin:

So by and large, the number one is cow's milk protein or other mammalian milks. And typically, like sheep and goat is so structurally similar to cow's milk that if we're reactive to one, often will be reactive to the others. Cow's milk protein is by and large, about 90% of littles who have reactivity, will be reactive to cow's milk protein. From there, soy is the next most common. And then tying for third is egg and wheat. We have a whole slew of additional proteins that are likely to elicit a response in an infant. And this is also a common myth in that many times if parents are told to go on an elimination diet, they'll be told to remove the top eight or now the top nine with sesame added.

When in actuality, those specific lists in any country are specific to foods that elicit an anaphylactic shock reaction in adults and adolescents not those foods that are more likely to elicit a response in an infant. And so, for example, it's much less likely for an infant to be reacted to fish and shellfish. It's much more likely for them to be reacted to things like rice and oats. So, we have a lot of information and research around that on the website as well.

Rebecca Dekker :

And what would you say is the standard response from a medical professional, say, pediatrician, when parents are uncovering the fact that there is some kind of food allergy to their human milk and they're on a lactation journey, what is the typical medical response?

Dr. Trill Paullin:

So, I can speak to the response that I was given as well as the response of the families that I've worked with one-on-one. And I will say that it's usually in one of two camps, either, the first being that foods that you consume don't transfer, so there must be something wrong with your breast milk in general. So, the answer is to switch to a formula, or that foods that you consume transfer and stay in your breast for a really, really long time. And so being able to navigate and determine what it is that's eliciting response is impossible. And so, you should switch to a formula.

Rebecca Dekker :

And how long do the food proteins stay in your milk after you as the lactating parent have consumed that protein?

Dr. Trill Paullin:

Yeah, so what we find is that after you consume a protein, it's going to spike in concentration a few hours after you ingest it and steadily plummet from there, usually gone within eight hours. And so our typical recommendation is to give a 24-hour period just in case there's differences in your metabolism, you're feeding, things like that. What's important to mention there is that it is a little bit different from

what we understand for alcohol, where we know that cellular metabolism will naturally remove alcohol from your breast over time, where with proteins we need to actually remove the milk as well.

So oftentimes parents will say, "Well, I ate something at night and then I didn't pump for the next eight hours while baby slept. Why isn't it clear?" We need to be removing breast milk during that time. So that eight hour window is based on a normal feeding schedule of every two to three hours, then that is typical clearance time for proteins that we're consuming, which makes sense because that's how we understand transferability of things like alcohol, flavonoids, most medications, unless they're built to stay in our system for a really long time, these things transfer and clear quickly from our breast and not to be too tongue in cheek, but if my breast was made up of things for weeks on end that I consumed, then they'd be entirely made up of Ben & Jerry's.

Rebecca Dekker :

So, it only takes about eight hours of pumping on a regular feeding schedule to empty your milk of the proteins. So, when parents go on an elimination diet, what are some things that they should look for or establish? Where do they usually start and how long does it take to figure out where you're supposed to be?

Dr. Trill Paullin:

Yeah, so oftentimes there's one of three strategies that we'll typically focus on. The first is one at a time where we'll do cow's milk protein and then soy and then slowly work our way from there. The second is to do a group of foods together. And the third is called a total elimination diet or a TED in this community where we would go all the way down to just a handful of foods. And I don't recommend a TED and we only use it for very, very severe situations where we absolutely have to. But the first two options, anytime that we go on elimination diet, then typically unless there's history to tell us otherwise, then usually the elimination diet is five days to monitor for impact. And the reason why is because how we understand our transferability and baby's reactivity timing, and healing. So, once we consume a food, it's going to spike in concentration in a few hours and start to plummet.

So, we give 24 hours for that to occur, for the transfer and for the clearance, and then baby will react to that protein and that breast milk either immediately if it's an acute reaction, acute meaning it's a vomiting response or a fast rash response. Acute just means that it happens quickly and it heals quickly. Or a chronic reaction can take up to 48 hours to occur. And those are the things like the eczema that takes longer, or the diarrhea, mucus-y bloody stool. So, we give up to 48 hours for that response to occur, and then a few days for impact, a few days for us to see that there is in fact an improvement for this child.

And usually by the end of five days, if we've effectively removed the right things at the same time, we should see some kind of improvement. And that may not mean a brand new baby. For example, in my oldest case she was bleeding egregiously. So, we're not going to have just a brand new baby in five days, but we should see massive improvement by day five. And so, if that's in fact the case, we can say, okay, now we're going to allow for time for healing. And if that's not the case, she's either continued to stay the same or gotten worse, then we've likely not removed the right things at the same time. And that's what we help families navigate.

Rebecca Dekker :

And what about formula? I know you mentioned the hospital telling you your baby should go on a hypoallergenic formula. Can formula, does it contain cow's milk, proteins, and other proteins that infants can react to as well? So, it's not just babysitter or drinking human milk.

Dr. Trill Paullin:

So, the formula cells match food reactivity just like breast milk does. Meaning that we know that about one in four children are reactive to something in our diet. Same type of thing happens in formula cells where about 25% of those cells are specialized formulas, meaning that they're either broken down or they're using different proteins specifically because they elicit a response in infants. So, there's three tiers for formula. The first being just straight cow's milk or soy formula that isn't broken down in any way, shape or form. And then a second tier being those that are hydrolyzed, meaning that they're broken down into the smaller fragments, which is more likely what we'd see in the breast. These smaller fragments of proteins and then all the way down to elemental or amino acid-based formula, which is broken down to the individual amino acids, most often those are made from corn syrup solids. And while a vast majority of infants can tolerate those types of formulas, there are some littles who are reactive to some of the ingredients in them. And so, some families don't even have formula as an option to fall back to.

Rebecca Dekker :

Wow, okay. So, this is definitely a universal problem, can affect all parents who are lactating or formula feeding. And has the formula shortage had an impact on this or are there tend to be more hypoallergenic formulas available right now and less of the regular formula?

Dr. Trill Paullin:

So, the formula crisis has been devastating to our community because a vast majority of the families who have food allergy issues, if they are on a formula, they can only use one type of formula because each of the formulas has a different list of ingredients. So, for example, we may have a family who can only use a Nutramigen and they can't switch to an Elecare because Elecare uses a different ingredient deck and that elicits a rash response in their baby. But if you can't find a Nutramigen and you can locate Elecare, then you have to make a decision of, well, I need to feed my baby.

How am I going to do so and know that I'm going to elicit a response in them? So, in response, Free to Feed created a shared platform that is a free resource for families to get connected to those who have breast milk with specific elimination diets, and those who need breast milk as well as those who need specialized formula. And we've connected hundreds of families now all across the nation. Because I do breast milk research, I had a whole fleet of coolers that we could use to transport breast milk across the country. And so that fleet of coolers now is very busy shipping and helping these families who literally can't properly feed their baby right now

Rebecca Dekker :

It makes me think one in four seems like such a high number of babies who are reacting to food. Is this a problem that, did historians know if this used to be a problem hundreds of years ago, or is it more of a modern problem related to our diets? What's going on?

Dr. Trill Paullin:

Yeah, so I think the answer to that is yes on both fronts. On one side, I think the biggest piece to why it seems so incredibly prevalent right now is because of awareness. The non-IgE-mediated allergies that we talked about. Specific categories of them can be things like FPIES or allergic proctocolitis. And those two in particular did not get a code in our medical system until 2017. Even though they've been researched way back into the 50s and 60s, they didn't get an official code until very recently. And we're just now having medical providers and families who are even aware that this is a problem and how to diagnose it. I think that's a piece of the puzzle, is awareness. And then the other piece of the puzzle is yes, that it is actually increasing to a certain degree because of foods that we're consuming and our environment impacting how our immune system really interacts with the foods that we're consuming.

Rebecca Dekker :

Wow. It just gives me so much to think about. Because I'm thinking back to even my family history and my mom telling stories about one of my siblings being super colicky and other old stories of colic. How do you know the difference between colic and a food reaction in an infant? Is this something that we can tell the difference? Do you think a certain percentage of colic cases are related to reactions to what's in formula or human milk?

Dr. Trill Paullin:

Yeah, so that's another big piece. That's the awareness side of things. I hear that really often where people say, oh, my gosh, yeah, my mom talked about how my brother had colic or that my sister had really bad eczema until a certain age. So, it's a thing that is impacting us for a shorter period of time. And so, it's not captured very well. And we'll hear those stories of back in the day, but no resolution and no official diagnosis back then. It's very, very likely that a good portion of those stories were actual food reactivity that were then outgrown, thank goodness. And as far as parents today, how to navigate that is working with someone who can talk you through the other possible symptoms and help you navigate, is it likely food related? Is it something else that's happening? I would say that colic, in particular, the diagnostic criteria for colic, is that your child is crying for three or more hours a day for three or more days a week, for three weeks or longer.

And no one should be in pain that much. No one should be crying that much. And so, to have this kind of criteria of just saying, yeah, your child's a cry baby, good luck with that and sent home. I don't subscribe to the thought that anyone should be in that much discomfort for that long a period of time. And we certainly wouldn't say that to an adult, if I cried for three hours in a day, someone would care and do something about it. And so there often is an underlying cause to things like colic, if that is in fact how frequent the child is uncomfortable. Now, whether or not it's food or it's anatomically related or other, that's something that different specialists can help you work through.

Rebecca Dekker :

Can you tell us a little bit about your testing, the test kit that you're working on? Because this is the perfect marriage of your skills as a PhD-prepared molecular biologist and someone who's personally experienced this issue and then works with families around the world. So, what's going on? What are you working on with this?

Dr. Trill Paullin:

Yeah, you are 100% correct that this was a very strange, perfect storm that led to my starting this company. The interesting thing that I found is a few pieces, really. One that I feel like I can stand on the top of every mountain and scream to the top of my lungs about the myths involved in food allergies and

feeding our children. But until we can really turn the tide on all of this misinformation, it's going to continue. And I truly feel like the way to turn the tide on that misinformation is to give the power to parents. If parents could just test their milk at home at any given time and know what was in it, then we're removing a lot of that mystery of does protein transfer to your breast? How long is it there? Is my baby reactive to something that is in my diet?

So, if at home real time, you could tell what was in your breast, it would completely change our journey. And the thing that led up to this is obviously my background in molecular biology, having two little girls with food allergies. And when my second daughter was born and started presenting with symptoms, in all of the irony in the world, I was working for a dairy processing facility, so running their lab. And I learned that in the food manufacturing industry, there were simple test strips similar to what we would think of like a pregnancy test or even a COVID test. If you take an at home COVID test where it was an at home, very similar, very simple test where you would be able to tell in a few minutes if we had accidentally cross-contacted different allergens in the facility. So, a picture, a big piece of equipment that we run cow's milk on, and then soy milk on the same equipment.

We have a simple lateral flow test, a piece of paper, that tells us if we accidentally got some of that soy into the cow's milk or vice versa. And so, I'm back at work breastfeeding on an elimination diet, not able to consume the millions of pounds of food that I'm now creating in this dairy processing facility, and I'm teaching lab techs how to use this technology. And I have that really stereotypical epiphany moment of like, oh, my goodness, this would completely change my life if I just had an ingredient deck for my boob at any time. And I ran into a closet and I squirted breast milk on the thing and it didn't work. And that was four years ago. And the questions became like, okay, well, why do we do this for cows and we aren't doing this for women, and why doesn't it work?

And the answers to those questions, I think there's a huge gap in the research and understanding as it relates to women-based problems. And we don't have a test that currently works because no one up until that point had looked at what exactly does a peanut look like when it gets to the breast? And so, we worked on getting the grant and investor funding to know exactly what does each of these proteins look like in the breast so we can detect it. And now we've made the first test kit, which is so exciting. So, our first test kit detects cow's milk protein in the presence of human milk and it's ready to go, and we're ready for manufacturing. And I'm just right in the middle of a fundraiser to do so. And what a wild journey it has been.

Rebecca Dekker :

That sounds amazing. Is that something you have to go get like FDA approval for it or no?

Dr. Trill Paullin:

No. So the beauty of our product is it's informational only and it's in ingredient check for your boob. It's not necessarily testing and diagnosing your baby, and it's not anything that you're going to put in your body or in baby's body. It's just information to say, this is what's in your breast right now. So out of the gate, we'll do an FDA, what's called a 510K class one exempt product, which basically means that we're going to send to the FDA all of our regulatory policies and our quality policies and long term, our goal is to come back to the FDA and say, hey, we'd really love this to be prescribable, and here's all of our data to prove that we deserve to be prescribable. So that's a longer-term goal, but out of the gate, by having it be informational only for parents, that means that there isn't the obstacle of having to get it prescribed. You can get it anywhere.

Rebecca Dekker :

That's awesome. Well, we're so excited to see that come out. And Dr. Trill, is there any way we can follow you? What's the best way to follow your work and learn from your organization?

Dr. Trill Paullin:

So certainly, going to our website [freetofeed.com](http://freetofeed.com). You can subscribe on the homepage for updates. We have a wait list for the test kit as well. You can link to it from the homepage. We're on all of the platforms. Everything from Facebook, Instagram, TikTok, you name it. Our biggest place as far as the location that I'm most active is on Instagram. And that is me. So, if you ever have any questions or comments or concerns, if you message me there that you'll get me. And I'm happy to help any families or any professionals who need assistance on this journey.

Rebecca Dekker :

And I'd also encourage you all to definitely check out Dr. Trill's website and look at the different options there for how you can get help. And thank you so much, Dr. Trill, for coming on the podcast and taking time out of your busy schedule to educate our listeners about infant food reactivity. And it's really empowering to hear that there are steps we can take and that this is a problem that can be solved

Dr. Trill Paullin:

Yes, and that you're not alone. And wherever you're at in your journey right now, you're doing an amazing job. I'm so very proud of each and every one of your listeners who may be in the middle of their food allergy journeys.

Rebecca Dekker :

Thank you so much.

Dr. Trill Paullin:

Thanks.

Rebecca Dekker :

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