Formula Feedings

We recommend breastfeeding for all infants when possible. However, when breastfeeding is unavailable or undesired, the following formula recommendations apply.

Benefits

- Premature transitional formulas have higher contents of protein, minerals, trace elements, and long-chain polyunsaturated fats, as well as providing higher caloric intake (e.g., 22kcal/oz), compared to term formula.
- Increased energy density may be required to optimize growth in the presence of fluid restriction.
- Soy formulas are not recommended for preterm infants due to an increased incidence of osteopenia and poorer protein bioavailability.

Recommendations

- Infants with birth weight <1800g or poor growth history, fluid restriction, or abnormal laboratory indices may be discharged on premature transitional formula until 9 months corrected age.
- Healthy, larger preterm infants may demonstrate catch-up growth more quickly and uncommonly require the use of transitional formula.
- Former very low-birthweight infants should receive formula with arachidonic acid (ARA) and docosahexaenoic acid (DHA).
- Preterm infants on iron fortified premature transitional formula should be given multivitamin (0.5 mL/day) until weight is >5 kg.
- Preterm infants receiving an iron fortified term formula should be given multivitamin (0.5mL/day) until weight is >3 kg.

Growth Outcomes

- Premature infants fed formula supplemented with long-chain polyunsaturated fats (ARA and DHA) have shown improved growth and psychomotor development.
- Transitional formula may result in greater weight gain, linear growth, and bone mineralization than term infant formula.