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a multivariate analysis of infants <750 g (**Table II**) with confounders selected as described in the Methods section. Although the difference of PNAC is more pronounced between groups in the subgroup <750 g (**Table I**), statistical analyses again failed to demonstrate a significant effect of SMOF-LE for prevention of PNAC (**Table I** and **Table II**).

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Funded by the Austrian Science Fund (FWF, KLI99-B00). Study lipids were supplied free of charge by Herba Chemosan (Graz, Austria). Fresenius Kabi (Graz, Austria) provided funding to employ a clinical research nurse. Both companies had no role in the study design, the collection, analysis, and interpretation of data, the writing of the report and the decision to submit the manuscript for publication. A.R. received funding from Fresenius Kabi (Graz, Austria) to employ a clinical research nurse for the current study. The other author declares no conflicts of interest.

Table II. Multivariable analysis on the risk for PNAC, infants <750 g

	Intention to treat (n = 96)		
	aOR	95% CI	*P*
SMOF-LE	0.243	0.054-1.086	.06
Male sex	3.836	0.836-17.612	.08
NEC/FIP/GI surgery	2.840	0.752-10.726	.12
Time on parenteral nutrition (d)	1.046	1.014-1.078	.01
Z score of birth weight	0.444	0.190-1.040	.06

FIP, focal intestinal perforation; *GI*, gastrointestinal; *NEC*, necrotizing enterocolitis.
Analysis by intention to treat. Binary logistic regression analysis showing the aOR for the effect of SMOF-LE on PNAC compared with S-LE. Adjusted for male sex, "compound outcome of NEC, FIP, and GI surgery," time on parenteral nutrition and the z score of birth weight. *P* values of < .05 were considered statistically significant.

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Advocating for a cautious, conservative approach to screen time guidelines in young children

To the Editor:

The commentary by Straker et al[1] purports that there are conflicting guidelines about children's screen time among 2 current early years policy documents in Australia. In our opinion, pitting potential health harms against potential education benefits is not in the best interest of children, as systematic reviews of the evidence show that their learning, development, and health are tightly interconnected.[2-4] We agree that it would be ideal to have better evidence about the impact of newer technologies such as mobile phones and tablets. These newer technologies and some applications may promote more active experiences, but the evidence is not available to assure us that their excessive use is any less harmful to health than earlier media technologies. When creating the sedentary behavior component of the current Australian 24-hour Movement Guidelines,[5] there was no evidence that could be located through systematic reviews—of both the health and education literatures—that these technologies are potentially less harmful than existing screen technologies upon which most of the evidence was based to inform the Guidelines—not just in Australia,[5] but also in Canada,[6] the United Kingdom,[7] and South Africa.[8]

The amount of time a child spends in front of a screen does matter to their health, development, and well-being; evidence supports this and the Australian Guidelines are identical to the American Academy of Pediatrics[9] and the Canadian Paediatric Society[10] recommendations in relation to the amount of time recommended (which was not cited in the commentary). These are to limit media to 1 hour or less per day for children older than 2 years and to avoid digital media use in children younger than 18-24 months. It is important to also note the American Academy of Pediatrics summary point "for children younger than 2 years, evidence for benefits of media is still limited. There continues to be evidence of harm from excessive digital media use."

We advocate for a more cautious, conservative approach and to develop guidelines based on what is known and expert consensus on how to apply this in an ever-changing world, as was done in the development of the Australian, Canadian, United Kingdom, and South African Guidelines. A more cautious approach should take precedence, as dictated by the principle of *primum non nocere*, until we have evidence of the anticipated benefits and the absence of harms related to use of newer screen-based technology in the early years. In our opinion, it is not responsible to accept that new technologies and content and functions are being unleashed on millions of young children and their parents, without any substantive evidence that they are beneficial, or at the very least not harmful.

Acknowledgments available at www.jpeds.com

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Reply

To the Editor:

We thank Oakley et al for contributing to the debate on this important contemporary child health and development topic. Like us, they recognize that guidelines should support the best interests of children, and that having conflicting guidelines that are pitted against each other is not helpful.

Where their opinion diverges from ours is in what is the best way forward.

Given the importance and complexity of digital technology use by young children, we believe specific screen use guidelines are required, and that such guidelines should consider the whole child and be based on all available evidence and expert opinion. This is what the American Academy of Pediatrics,[1] the Canadian Paediatric Society,[2] and Early Childhood Australia[3] have done. The advice from these organizations focuses on screen use, and they were able to provide useful information not only on the amount of time of use, but also on the nature of use including content and context.

We suggest there is a problem with "movement" guidelines being focused on screens, rather than physical activity, sedentariness, and sleep. Movement behaviors are obviously critical to child health and development, and clear guidelines and messaging about these behaviors may result in better health outcomes when not confounded with screen use. Historically, parent reporting of leisure screen time was used as a proxy for young children's sedentary time. However, wearable monitors now provide more detailed and accurate measures of the amount and pattern of young children's movement, enabling movement guidelines to have a more robust evidence base.[4]

We welcome further debate on the 5 steps we proposed on providing greater consistency in advice regarding young children and digital technology, and other suggestions readers may have, on how to best promote children's screen use/nonuse behaviors that support their health and development.

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