Baby Friendly & Breastfeeding Scenarios

Emilie Sebesta, MD, Sarah Gopman, MD, Miriam Bennett, IBCLC, Stephanie Andrews, IBCLC
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Objectives

- Be able to describe the Baby Friendly Hospital and the 10 Steps to Successful Breastfeeding.

- Understand your role in prenatal counseling regarding infant feeding decisions and supporting appropriate feeding practices after birth.

- Know the basics of normal breastfeeding in the early postpartum period.

- Be able to manage common breastfeeding problems and know when and how to refer breastfeeding problems to lactation professionals.
Baby Friendly Refresher

- WHO/UNICEF Program
- Baby Friendly USA administers in U.S.
- 172 hospitals designated in U.S. (6.9% of births)
- CDC Healthy People 2020 Goal is 8.1%
- Requires implementation of the Ten Steps to Successful Breastfeeding and adherence to the International Code of Marketing of Breast-Milk Substitutes
- Also aligns with mPINC and new TJC Core Measure on Exclusive Breastfeeding
Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.

2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breastfeeding.

4. Help mothers initiate breastfeeding within one hour of birth.

5. Show mothers how to breastfeed and how to maintain lactation, even if they are separated from their infants.
Ten Steps to Successful Breastfeeding

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practice “rooming in” -- allow mothers and infants to remain together 24 hours a day.

8. Encourage breastfeeding on demand.

9. Give no pacifiers or artificial nipples to breastfeeding infants.

10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.
Where UNMH Is in Pathway

- Dissemination Phase
- Designation Coming this spring/summer
- Need to improve
  - Time babies separated
  - Formula supplementation
  - Provider/Nurse Knowledge
- Also aligns with mPINC and new TJC Core Measure onExclusive Breastfeeding
No. 1: Prenatal Visit

- Christina is a 24 y.o. G1P1 meeting with you prenatally to decide if she wants you to be her baby’s pediatrician

- You ask her how she plans to feed her baby, and she says she plans to bottle feed

- Now what?

- What might be a better way to ask?
How best to approach

- Open ended questions
- Affirm her response & be ready to take the blame
- Target teaching
The decision to Breastfeed

<table>
<thead>
<tr>
<th></th>
<th>Breast</th>
<th>Bottle</th>
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<tbody>
<tr>
<td>Before Pregnancy</td>
<td>55%</td>
<td>43%</td>
</tr>
<tr>
<td>1st trimester</td>
<td>31%</td>
<td>24%</td>
</tr>
<tr>
<td>2nd/3rd trimester</td>
<td>13%</td>
<td>19%</td>
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<tr>
<td>PP</td>
<td>1%</td>
<td>14%</td>
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You encourage Christina to reconsider her decision to not breastfeed and promise you will be there to support her after the baby comes.

She responds that she has inverted nipples and didn’t do those exercises during pregnancy that you’re supposed to do so she won’t be able to breastfeed anyway.

What do you do?
Inverted Nipple
Flat and Inverted Nipples

- With assistance, babies can learn to breastfeed in almost all cases
- Evidence does not support nipple shells or other exercises (e.g., Hoffman exercises) during pregnancy to evert nipples
- Mom should receive lactation assistance after birth and may benefit from seeing a lactation specialist prenatally as well
- May need to pump before baby latches or may need nipple shield
No. 2: Postpartum 20 hours

- Rosa is a G1P1 mom with 20 hr term infant asks for formula. What do you do?

- She says the baby keeps falling asleep at her breast and doesn’t want to wake up every 2-3 hours like the nurses are telling her to do. She’s worried he isn’t getting enough milk.

- Now what?
Normal Infant Transition

- Best if explained prior to birth
- Baby alert and active for 1-2 hours immediately following birth
- Sleepy for remaining first 24 hours
- Stomach size about 20 ml
- Normal quantity of colostrum 1st 24 hours about 40-50 cc (compare to 60 cc bottle of formula)
- Recommend skin to skin
No. 3: Postpartum 36 hours

- Now Rosa says the baby is crying and wanting to be on the breast all the time.
- She feels sure she must not be making enough milk and he is crying because he is hungry
- What do you tell her?
Normal Infant Transition

- Most babies “wake up” after about 24 hours and have what is called a “feeding frenzy”
- Baby is not starving
- Recommend mom respond to initial cues when able and avoid waiting for baby to cry
- Advise mom to sleep when she is able
- Remind her THIS IS TEMPORARY
Observation
No. 4: Pain

- Theresa is a 32 y.o. G1P1 mom c/o pain with breastfeeding and wants to give her 30 hour infant a bottle

- What do you want to do?
Observation
Latch Matters

- Proper “latch” or “attachment” is the most important factor for preventing problems leading to premature weaning

- Maternal breast pain is almost always caused by poor latch
How to assess latch

Look at baby
- Lips flanged out
- Nose touches breast
- Chin against the breast
- “asymmetrical latch” is norm (more areola visible above upper lip)

Listen
- Audible swallow
- Suck-swallow or suck-suck-swallow pattern
- No clicks

Look at mother’s breast
- Not damaged
- Not shaped like lipstick
Like this
Not like this
Or like this
Observation
Tongue-Tie (Ankyloglossia)

- About 4% of infants
- May affect breastfeeding
- A lactation specialist should work with mother and baby to assess if causing problems with feeding
- Lingual frenotomy can be done in clinic or hospital
- Risks: bleeding, damage to tongue or salivary glands
Tongue-Tie

Linguval frenulum

Surgical cut releases frenulum
Another consideration re: pain

- Advise mom to get comfortable before breastfeeding
  - Lots of pillows
  - Good back support

- Advise mom to always bring baby to breast, not breast to baby

- Pain & Stress can inhibit letdown too!
Max is a 14 d.o. infant in for his first well newborn visit.
- born at 38 5/7 weeks via SVD
- latched well in the first hour of life
- no problems breastfeeding in the hospital
- Discharged at 28 hours of life with weight loss 4%
- Mom is a G2P2 who breastfed other child 2 years

Today’s weight is 8% down from birth weight

Resident working with you says mom is feeding baby every 2-3 hours and feels it is going well
No. 5: Excessive Weight Loss cont’d

- What do you do now?

- When you ask whether Max eats every 2-3 hours during the night too, Mom says he actually sleeps through the night already, from 10-6 most nights.
Nighttime Feeds

- Critical in 1st weeks to
  - Stimulate milk production
  - Ensure sufficient calories
- Higher levels of prolactin
  - Increase milk production
  - Increase maternal slow wave (deep) sleep
- Unusual to sleep through night before 6 weeks
No. 6: Excessive Weight Loss

- Henry is a 4 d.o. infant here for NBN check
  - born at 36 5/7 weeks via SVD
  - latched well in the first hour of life
  - A little sleepy first day but then mother reported he breastfed well and did not require lactation assistance
  - Discharged at 48 hours of life with weight loss 8%
  - Mom is a G2P2 who breastfed other child 2 years

- Today’s weight is 13% down from birth
No. 6: Excessive Weight Loss cont’d

- What went wrong?
- What went right?
- What would you have done differently?
- What do you do now?
How much is too much or enough?

- Weight loss
  - >7% concerning
  - >10% abnormal
  - Typical nadir day 3-5
  - Maternal IV fluid can increase

- Weight gain
  - 20-30 grams/day
  - Back to BW by 14 days

- Feeds in 1st week of life
  - 8-12/24 hours
  - May cluster feed

- Output by Day 3-4
  - 3-4 stools
  - 6+ voids
No. 6: Excessive Weight Loss cont’d

- Mom tells you
  - She feeds Henry every 2 hours during the day and 3 hours at night
  - Henry usually falls asleep on and off during his 30 minute feeds so she has been giving him EBM afterwards as well.
  - When pushed, she tells you she usually breastfeeds him but then offers the pumped milk about 1 ½ - 2 hours later in lieu of breastfeeding.
- Stools 3 times/day. Still brownish-green.
- 4-5 wet diapers/day.

- What’s wrong with this?
On exam, Henry is jaundiced to his thighs.

You check his bilirubin and it is 1 point above light level.

Now what?
Jaundice in the Breastfeeding Infant

- Formula supplementation not automatic
- Consider supplementation with EBM if needed
- “Breastfeeding” Jaundice
  - Insufficient intake
  - May result in hyperbilirubinemia requiring phototherapy
- “Breast milk” Jaundice
  - Thought to be secondary to something in breast milk
  - Prolonged (weeks)
  - Rarely requires medical intervention
  - Don’t do a “trial of formula” to see if it resolves
Late Preterm Infants

- 34 – 36 6/7 weeks
- Developmentally immature
  - Dysfunctional suck
  - Decreased suction pressure Impairs ability to
    - draw nipple into mouth
    - Prevent slipping off nipple between sucks
- Less energy stores
- Delayed lactogenesis common for mother
- 2.2 times more likely to be readmitted than term infants
Late Preterm Infant

- Early intervention critical

- Interventions should focus on:
  - Establishing mother’s milk supply
  - Ensuring baby is adequately fed

- Encourage mom to pump after feeds and offer EBM if baby cannot effectively suck with consistent swallowing for minimum of 10 minutes q 3 hours

- Infant may do better with
  - Football hold
  - Nipple shield

- Must have very close follow up post discharge
No. 7: Insufficient Milk Supply

- Glenda is here with her son Felipe for his 2 mo. WCC
- She is still breastfeeding but “had to” start giving some formula b/c she just wasn’t making enough milk
- Beginning 2 weeks ago, he became very fussy and didn’t seem satisfied with her milk
- Now he seems “prefer” the bottle, and she doesn’t think she’ll be able to keep up the breastfeeding when she returns to work next month
- What went wrong?
No. 7: Insufficient Milk Supply

- More than half of breastfeeding women believe their milk supply is insufficient.

- In fact, less than 5% of women can’t make enough milk to exclusively feed their infants for 6 months.

- Causes of insufficient milk supply:
  - Lack of sufficient stimulation
    - Infrequent feeds
  - Formula supplementation
  - Not emptying breast fully (FIL)
  - Rarely, medications, illness, stress, etc.
Instill confidence!

- You can do it. This is normal. We’re here to help.
- If mothers achieved a level of "confident commitment" before birth, they were able to withstand lack of support by significant others and common challenges.
- Without the element of "confident commitment," a decision to breastfeed appeared to fall apart once challenged. Confident commitment is a key factor for sustained breastfeeding.

No. 8: One breast isn’t working

- Jean is here with her 5 d.o. son Jeremy for his Newborn Check
- She is worried there is something wrong with her right breast
Observation (Left breast)
Plugged Milk Duct

- Painful

- Causes
  - Infrequent nursing
  - Ineffective milk removal
  - Local pressure (e.g., underwire)
  - Rarely tumor

- Treatment
  - Feed, feed, feed
  - Change baby’s feeding position
  - Pump
  - Warm, moist compresses or showers
No. 9: Plugged Duct and Fever

- Jean is back with her son Jeremy for his 1 y.o. WCC

- When you ask how things are going, she mentions that she has another plugged duct and just isn’t feeling well today

- You feel her forehead, and she is very hot
Observation
Mastitis

- **Symptoms**
  - Flu-like symptoms
  - Breast pain
  - Usually red, wedge-shaped area on affected breast

- **Causes**
  - Staph aureus, E. coli, rarely Strep

- **Treatment**
  - Antibiotics 10-14 days (dicloxacillin, may consider MRSA tx)
  - Continued breastfeeding
  - Warm, moist compresses
No. 10: Substance Abuse

- You are attending on the Mother Baby Unit of your hospital and one of the nurses informs you she told the mom in Room 12 she couldn’t breastfeed her baby because she had a history of using heroin and is now on methadone.

- Do you agree with this decision?

- What might you want to know to decide if this mom can or cannot breastfeed?

- What if she had a UDM done for preterm labor and it was positive for THC but no other substances?
Substance Abuse

- UNM has recently approved a guideline regarding breastfeeding and substance abuse based on AAP policies, ABM protocols, and research regarding the transfer of substances into human milk.

- We generally encourage breastfeeding if a mom has negative drug screens in the 90 days preceding delivery and plans to abstain while breastfeeding.

- Mothers using buprenorphine or methadone as part of a substance abuse program or who use marijuana occasionally may generally breastfeed.
Substance Abuse

- We discourage breastfeeding if a mom has had a positive drug screen (except as above) in the 30 days prior to or at delivery.

- Providers are given discretion to support or discourage breastfeeding in gray areas such as a one-time positive drug screen in the 90 days preceding delivery or when a mother’s abstinence has been while incarcerated or hospitalized.

- Communication with the mother’s providers is encouraged.

- Documentation of counseling is critical.
It’s Monday morning, and in your inbox is an e-mail from OMI.
- A patient you cared for last month died on DOL 7 when mom fell asleep on a couch with baby.
- Baby appears to have suffocated.
- Mom was taking narcotic pain reliever.

You review your notes from baby’s stay in hospital.
- On DOL 2 you came into room to examine baby and found baby asleep in bed with mom with face down between mom’s body and bed. It was very difficult to wake mom up.
- You documented a long conversation with mom about the dangers of bed-sharing especially when taking pain-killers or using other substances that could result in mental impairment.
No. 12: Hypoglycemia

- Jeremy is a 1 ½ hour old 38 week gestation infant born to a 34 y.o. mother with gestational diabetes

- Glucose is 38

- What do you do?
No. 12 Hypoglycemia cont’d

- Jeremy breastfed and you recheck his glucose an hour later. Now it is 47.

- What do you do?
No. 12: Hypoglycemia cont’d

- Screen before feeds (q 2-3 hours) until 12 hours or until glucose consistently at or above 45.

- Screen 12 hours for IDM and LGA

- Screen 24 hours for SGA and late preterm infants

- Initial screen 30 minutes post first feed with goal of first feed within 1 hour

- Don’t screen asymptomatic, term babies who are not at risk (IDM, LGA, SGA, preterm, sick)

- Symptomatic babies <40 need IV glucose