Enhancing Breastfeeding Success: The Obstetrician's Role

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July 23, 2013

Florida's Quest for Quality Maternity Care

No conflicts of interest to disclose.

Objectives

- **Identify practices in the Preconception, Antenatal, Intrapartum and Postpartum Period that can enhance success for Breastfeeding Women**
- **List maternal contraindications to breastfeeding**
- **Understand how to assess if a medication is compatible with breastfeeding and identify resources to help with this.**
- **Understand which contraceptive methods may impact breastfeeding and why.**
- **List several resources to help women get assistance when they encounter breastfeeding difficulties.**

Preconception Care:

- Women's health providers screen for history of breast disease during primary care visits
  - Surgical procedures
  - Infections
  - Family history of cancer
  - Lactation history
- This is great opportunity to discuss lactation in general and work on societal perceptions "plant the seed"
- Especially important for adolescents

When should we discuss breastfeeding during prenatal care?

- As soon as possible!
- Unless there is a question of miscarriage
- During the breast exam
- Open ended questions
- Decisions are often made prior to pregnancy or in first trimester
- Cultural norms, do you know anyone that has breastfed?

Open ended questions that may facilitate a discussion about feeding

- Have you ever thought about how you will feed your baby?
- Are you interested in learning about why breastfeeding is the healthiest option for you and your baby?
- Do you have any family members or friends that breastfed their baby?
- What are your plans regarding work outside of the home after the birth?

History/Anticipatory Guidance

- Breastfeeding History
  - Did she breastfeed in the past?
  - How long?
  - Why did she wean?
- Other relevant medical/surgical history
- Involving partner/other family /social supports
- Review resources
  - Classes, Hospital Support (Lactation, nursing, OB/CNM/pedi)
  - Community Support
- Review hospital practices that will support breastfeeding

Maternal Benefits of Breastfeeding (It's not just for babies anymore)

- Decreased Breast Cancer
- Decreased Ovarian Cancer
- Decreased Type 2 DM
- Decreased HTN, Hyperlipidemia and Cardiovascular Disease
- Less time away from work due to a sick child
- Decreased PP Hemorrhage and faster uterine involution
- Enhanced bonding and Stress Reduction
- Amenorrhea and Birth Spacing

Cardiovascular Disease and Breastfeeding

- Study in *Obstetrics and Gynecology*, 5/09 by Schwarz, et al.
- Looks at 139,681 postmenopausal women from Women's Health Initiative data
- Conclusion: women with increased duration of lactation had decreased prevalence of
  - Hypertension
  - Diabetes
  - Hyperlipidemia
  - Cardiovascular Disease
  - Minimum duration 6 months, longer duration, better outcomes.

Cost Analysis of Maternal Disease Associated with Suboptimal Breastfeeding

- Bartick, et al, July, 2013 Green Journal
- Also published pediatric cost analysis in 2010
- Looks at 5 maternal outcomes which are improved by breastfeeding
- Breast CA, Premen. Ovarian CA, Type 2 DM, HTN and MI
- Modeling /simulations which conclude a financial burden of $17.4 billion based on the high value of life lost before the age of 70.

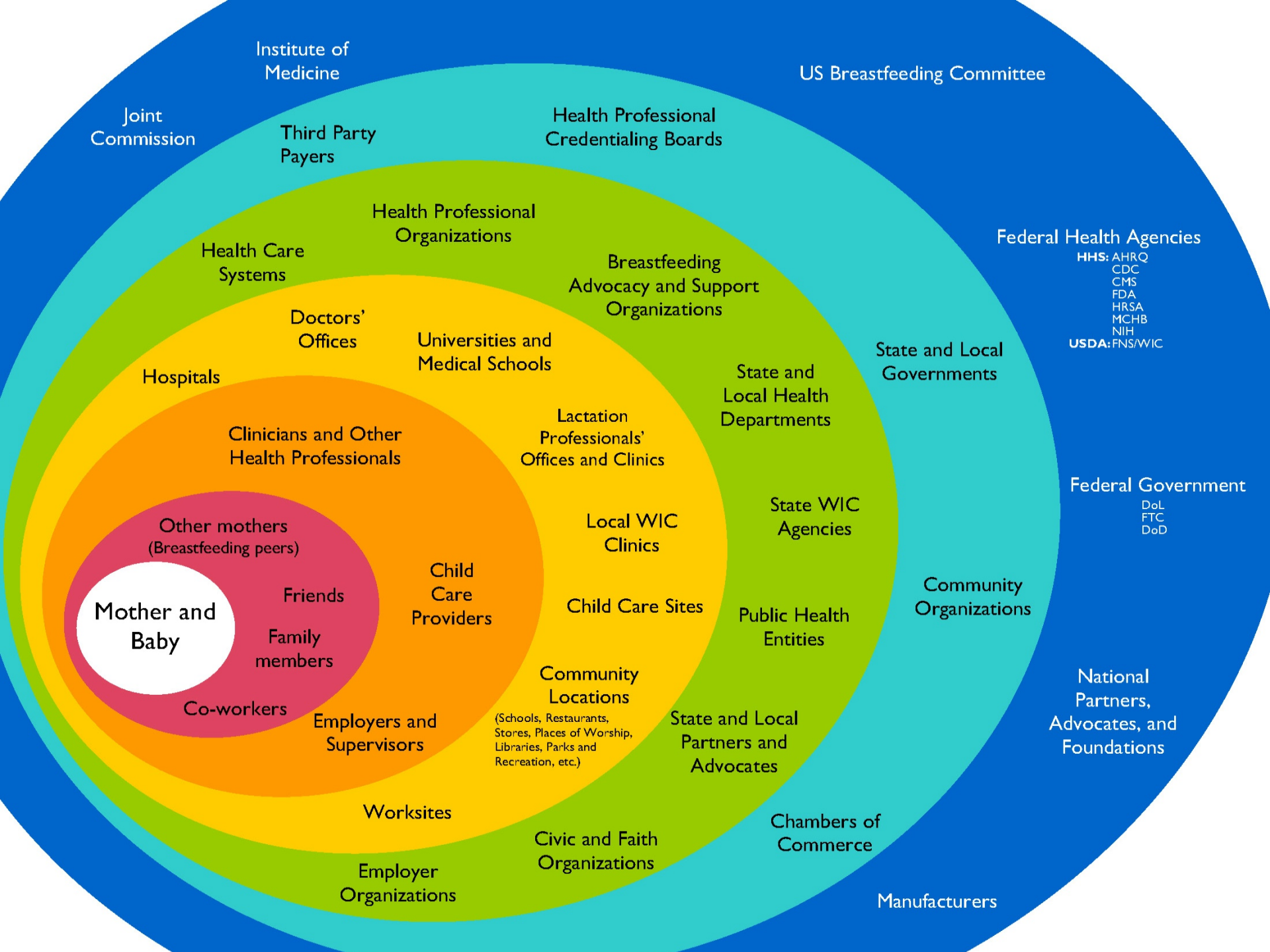
Suboptimal Breastfeeding/Maternal Disease (cont.)

- Modeling in the study found 4396 additional deaths/year
- 5000 excess cases of Breast Ca
- 53,000 cases of HTN
- 14,000 cases of MI
- This exceeds the annual premature deaths of cervical cancer (3909), asthma (3361), and influenza (3055)
- This study may underestimate because it only used 5 outcomes and there are other health outcomes that breastfeeding impacts

Key Barriers to Breastfeeding

From SG Call to Action, 2011

- Lack of knowledge
- Lactation Problems
- Poor Family and Social Support
- Social Norms
- Embarrassment
- Employment and Child Care
- **Barriers related to Health Services**


Institute of Medicine
US Breastfeeding Committee
Joint Commission
Third Party Payers
Health Professional Credentialing Boards
Health Professional Organizations
Health Care Systems
Breastfeeding Advocacy and Support Organizations
Federal Health Agencies
HHS: AHRQ
CDC
CMS
FDA
HRSA
MCHB
NIH
USDA: FNS/WIC
Doctors' Offices
Universities and Medical Schools
Hospitals
State and Local Governments
State and Local Health Departments
Lactation Professionals' Offices and Clinics
Clinicians and Other Health Professionals
Federal Government
DoL
FTC
DoD
State WIC Agencies
Other mothers (Breastfeeding peers)
Local WIC Clinics
Child Care Providers
Friends
Mother and Baby
Child Care Sites
Community Organizations
Public Health Entities
Family members
Community Locations
(Schools, Restaurants, Stores, Places of Worship, Libraries, Parks and Recreation, etc.)
National Partners, Advocates, and Foundations
Co-workers
Employers and Supervisors
State and Local Partners and Advocates
Worksites
Chambers of Commerce
Civic and Faith Organizations
Employer Organizations
Manufacturers

Fair Labor Standards Act, 3/2010 (Part of Patient Protection and Affordable Care Act, AKA Health Reform Act)

An employer shall provide:

- Reasonable break time for an employee to express breast milk for her nursing child for 1 year after the child's birth; and

- A place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

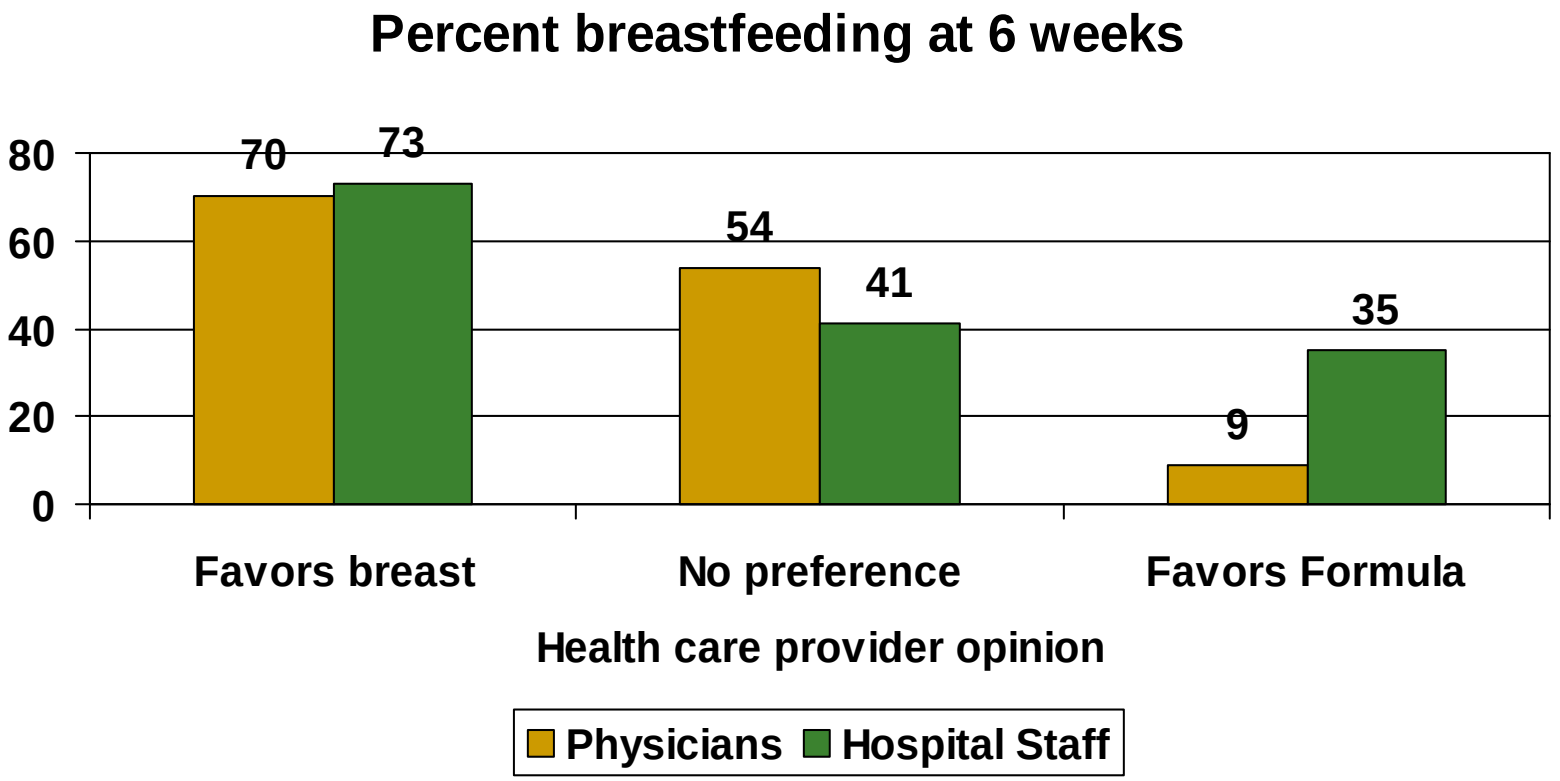
Exemptions:

- Breaks are unpaid unless a state law notes otherwise.
- If <50 employees, may be exempt if this imposes “undue hardship” due to size of business, resources and structure
- Professional/salaried employees and teachers are not included in this law.

New legislation introduced in 2013: Supporting Working Moms Act

- Senator Merkley, OR
- Congresswoman Maloney, NY
- Expands the current federal law to include about 12 million salaried employees
- This law includes elementary and secondary school teachers, not previously covered
- Also includes non-hourly paid employees

Patients listen to what their doctors say…



Send a clear message to patients:
'I recommend breastfeeding.'

DiGirolamo et al. Birth 2003;30:94-100

Maternal Contraindications to Breastfeeding (Joint Commission/US)

- HIV infection
- Human t-lymphotrophic virus type I/II
- Substance abuse and/or alcohol abuse
- Active, untreated tuberculosis
- Active untreated varicella
- Mother undergoing radiation
- Active herpes simplex with breast lesions
- Maternal meds for which Bfing contraindicated
- Maternal ICU admission (relative, but do not count in JC measure)
- Adoption/Foster care of Infant (also for JC measure)
- Previous breast surgery which prevents mother from making milk

History of Breast Injury or Surgery

- Reduction Mammoplasty
- Augmentation Mammoplasty
- Lumpectomy or Biopsy
  - Especially if significant ducts or nerves are severed/removed
  - Greatest concern are periareolar incisions
- Previous Treatment for Breast CA
- Hx of Trauma, Burns, or Chest Tube (childhood)
- Nipple Piercings with Infection or Scarring

Reduction Mammoplasty

- Repositioning of areolae and nipples likely to have difficulty with production
- Periareolar incisions may interrupt ducts and/or block milk flow into ducts
- Exclusive Breastfeeding is rare
- Can usually produce some milk
- If nipple/areola are left on pedicle and not moved, chances of success are higher

Augmentation Mammoplasty

- Usually compatible with successful feeding
- Depends upon where the implant is placed
  - Behind or in front of pectoral muscles?
- Excessively large implants may:
  - Impact filling capacity and limit storage volume
  - Restrict blood flow to mammary tissue and decrease production
- Was there an underlying abormal shape, ie tubular breasts, that may impact success

Previous Breast Cancer Treatment

- Has not been shown to increase recurrence
- May improve survival
- Usually recommended that women wait 5 years post treatment to conceive
- If pregnant sooner, can usually nurse from the unaffected breast
- Sometimes can nurse from both if surgery or XRT did not interfere
- Radiation may decrease production

Cancer Therapy

- Should not delay treatment in order to breastfeed
- Some women getting antimetabolite chemo can pump/discard until meds clear system and then feed later in the cycle
- Radiation generally compatible with breastfeeding but may impact production long term

Summary of Antenatal Education

- Discuss breastfeeding early and often
- Review benefits for mother and child
- Review practices in the hospital that will enhance success
  - Rooming In, Feeding on Demand, Skin to Skin
  - Unnecessary supplementation, Avoid pacifiers
  - Support groups and Community Resources
- Review how to combine working and breastfeeding/ pumping and how to work with employers.

Breastfeeding Friendly Office

- Posters/Art depicting breastfeeding throughout the office, multicultural women and children
- Discourage formula marketing
- Sign to remind patients that breastfeeding is encouraged in the waiting room
- Mother's room for patients and staff
- Patient and Staff Education
- Community Based Resources/Printed materials
- Prenatal Classes

Intrapartum/Early Postpartum Practices to Enhance Success

- Will be reviewed in detail during other webinars this summer
- Involve the Ten Steps to Successful Breastfeeding and the Baby Friendly Designation
- Reinforce the importance of these steps during antenatal visits and when doing births and helping women in the delivery room
- OB/CNM discussions can have significant impact: take advantage of teachable moments
- Help facilitate skin to skin as much as possible

Medications and Breastfeeding

Pearls for making the best choices

Golden Rules:

- Try to enable a scenario where mother is appropriately treated and no interruption of feeding occurs
- Only rare circumstances where breastfeeding needs to temporarily or permanently cease
- Consult your resources adequately
- Reaffirm mother's goals

US Dept. of HHS and FDA standard warning on OTC drugs:

"As with any drug, if you are pregnant or nursing a baby, seek professional advice before using this product."

Drugs may transfer into milk if they:

- Attain high concentrations in maternal plasma
  - Route of administration
  - Absorption Rate
  - Half Life
- Are low in molecular weight
- Are low in protein binding
- Pass easily into the brain (lipophillic)

But is this a problem?

Inquire about the infant/child

- Age
  - Premature babies at highest risk
  - But quantity of milk they are ingesting is often quite small
  - Maturity of organs to clear, ie liver and kidneys
- Stability of Child: unstable infants with poor GI stability may increase the risk of meds
- Is this medication used in pediatric population? Compare pediatric doses with dose obtained through milk, usually much less

Imaging and Breastfeeding

- Contrast Media for CT scan are considered safe by the ACR. (2010)
  - <1% administered maternal dose is excreted into breastmilk.
  - <1% of contrast medium in breastmilk ingested by an infant is absorbed by the GI tract
- Gadolinium Contrast for MRI
  - 0.04% excreted into milk
  - Expected dose absorbed by infant is 0.0004% of maternal dose
  - No untoward effects noted

Imaging (Continued)

- Older, more medically complex OB patients lead to more diagnostic imaging studies during lactation
- Overall, contrast enhanced media are safe and women should be advised NOT necessary to discard milk.
- Plasma T ½ 2 hours and 100% clearance in 24 hrs for both CT and MRI contrast media
- Certainly their option to discard for 2-24 hrs

Radioactive Materials

- Radioactive Iodine (^{125}I and ^{131}I): passes into milk at levels as high as 5% maternal dose (can be used for diagnosis or therapy)
- Breastfeeding should be discontinued until milk is clear (therapeutic use may be 1-3 months)
- Diagnostic studies usually 1-7 days discarding milk
- Milk can be tested for radioactivity

Other radioactive meds

- Gallium-67 discontinue for at least 72 hrs
- Technetium-99m discontinue for 24-48 hrs

- Think about if another study could be used for diagnosis without radioactive isotopes, collaborative care with team of providers.

Medications and Breastfeeding: Rules of Thumb

- Avoid using meds if not necessary
- If RID (Relative Infant Dose) is <10% most meds are safe to use. Usually <1%
- Choose drugs with published data
- Evaluate the infant for risks, ie premature or early neonatal period
- Meds used in first few days PP usually produce subclinical levels d/t low milk volume

Meds: Rules of Thumb: continued

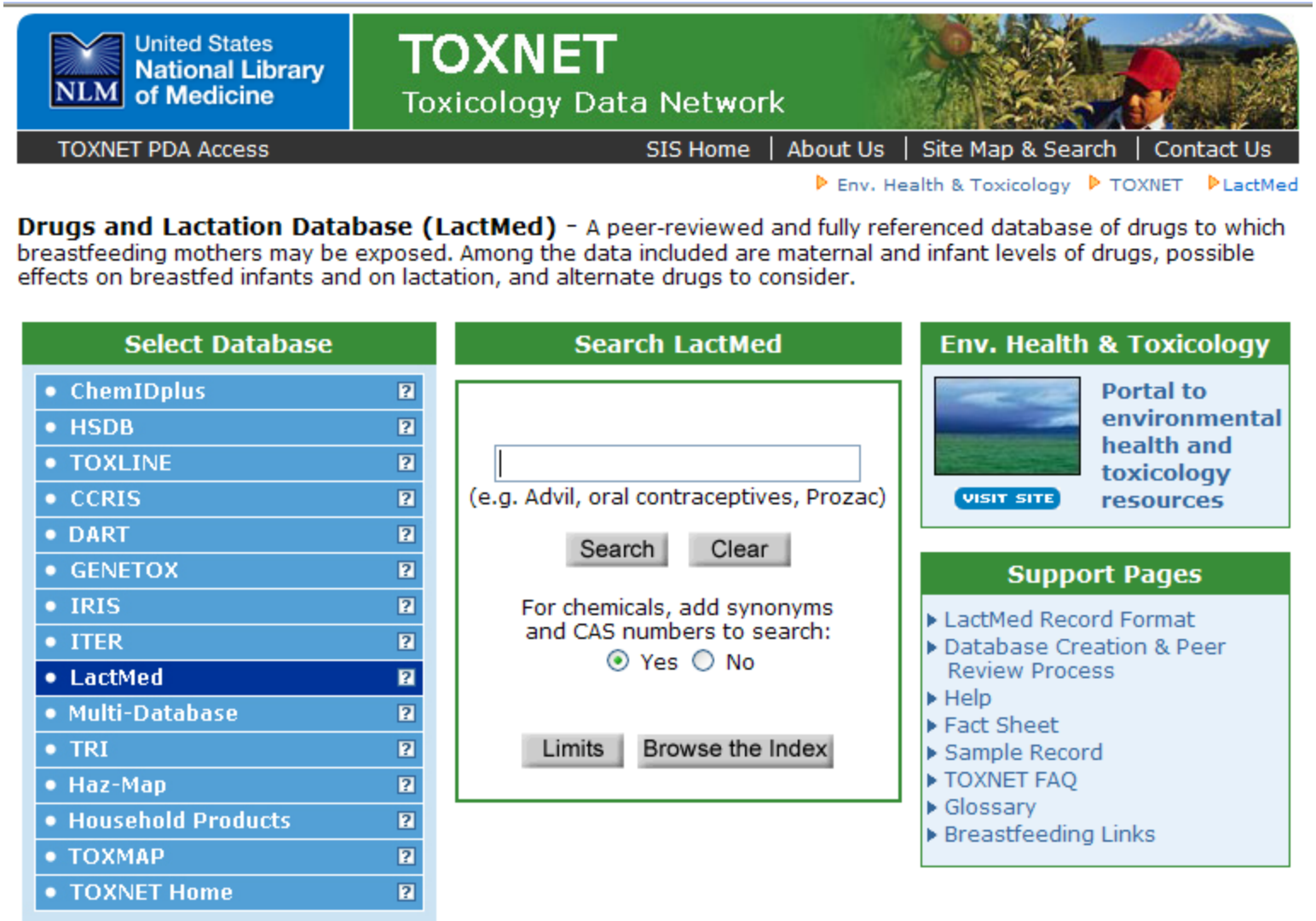
- Mothers with depression symptoms should seek treatment. Most of these meds are safe or can choose one that is safe.
- Most drugs are safe in breastfeeding mothers
- If drug is not safe, can TEMPORARILY discontinue until the drug is metabolized. Not always necessary to stop altogether
- Choose drugs with short T1/2, high protein binding, low oral bioavailability or high molecular weight.

Contraindicated for breastfeeding: Antimetabolite Chemotherapies

- In general, this is one of the few situations where women are counseled to wean during chemotherapy.
- There are some newer agents with shorter half lives where temporary discontinuation during treatment until clearance is obtained may be possible.
- Team approach with Oncologist, Pediatrician and PCP/OB.

Resources for Medication compatibility with breastfeeding

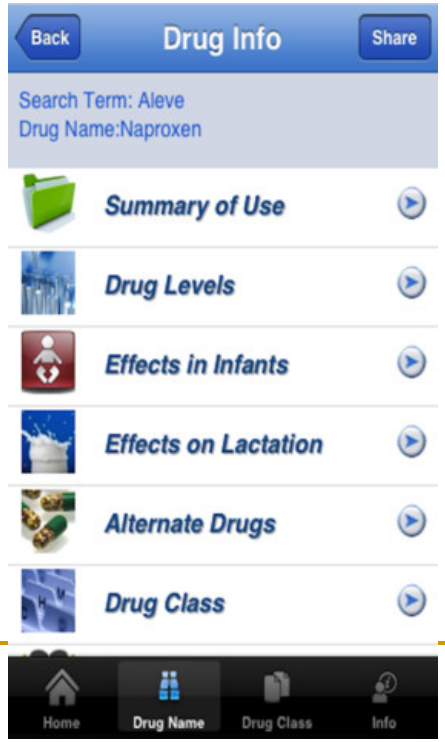
- Lactmed
  - Website
  - App
- Medications and Mother's Milk, Hale, 2012
  - Infantrisk.org
  - App
- AAP Committee on Drugs document (more dated)
- PDR (NO!!) Compiles all packages inserts standard recs are NOT to take—Poorest source of information



http://lactmed.nlm.nih.gov

Or Google "LactMed"

Lact Med
FREE!



Medications and Mothers' Milk

Tom Hale, PhD

Categories of Lactation Risk

- L1 safest: Drug has been taken by lg number breastfeeding mothers without observed adverse effect
- L2 safer: limited number of BFing women without increase in adverse effects
- L3 Possbly safe: No controlled studies in BFing women, risk is possible or controlled studies show minimal nonthreatening events

Categories:

- L4: Possibly Hazardous: Positive evidence of risk to a breastfed infant or to breastmilk production, but benefits may be acceptable to mother despite the risk in infant
- L5 Hazardous: Studies in BFing mothers demonstrate significant and documented risk to infant based on human studies, risk clearly outweighs benefit, contraindicated with lactation (3 pages out of 1000 in textbook)

Fertility and Breastfeeding: Normal menstrual cycle

- Follicular development initiated by FSH (Pituitary)
- Cont follicular growth requires FSH/E2 in response to LH (pulsatile release from pituitary)
- Midcycle → estradiol increase triggers preovulatory surges of FSH/LH
- Follicle secretes progesterone (luteinization)
- Oocyte released about 36 hrs later

Postpartum period
Characterized by:

- Elevated levels of PRL
- Low levels of gonadotropins
- Anovulation and Amenorrhea
- Pulsatile GnRH is suppressed by suckling
- Suckling also results in high PRL but unclear how this suppresses fertility
- Time of lactational amenorrhea depends upon freq and intensity of suckling
- Nipple stimulation inhibits LH/FSH

Nonlactating Women:

- Return of menses at 25 days at earliest
- Most menstruate by month 3 PP
- 90% menstruate by 6 months
- Return of ovulation at 25-35d at earliest
- 40% return by 3 months
- Ovulate about 50% of the time with first menses
- 5% chance of regaining fertility by 6 wks PP

Lactating Women

- Ovulation generally occurs before menses returns and varies 14-75%
- Longer the first menses delayed, more likely it will be ovulatory
- Cont suckling and elev PRL produce inadequate luteal function in first cycles, less likely to conceive
- EBF: First bleed generally precedes ovulation, or if +ovulation generally poor quality

Contraceptive Options:

- Nonhormonal methods
  - LAM
  - NFP methods/periodic abstinence
  - Barrier methods
  - Copper IUD
  - Sterilization
- Hormonal methods
  - OCP (combined and progesterone only)
  - Implanon
  - Progesterone IUD
  - Injectables
  - Patch/Ring

LAM Lactational Amenorrhea

- Highly effective in a variety of cultural, health care and socioeconomic settings
- Most appropriate for women who plan to EBF for 6 months.
- Optimal effectiveness, feeding should not be spaced more thatn every 4 hrs during day and 6 hrs at night
- Pumping may decrease efficacy b/c decreases suckling “vigor”

Three key questions for LAM:

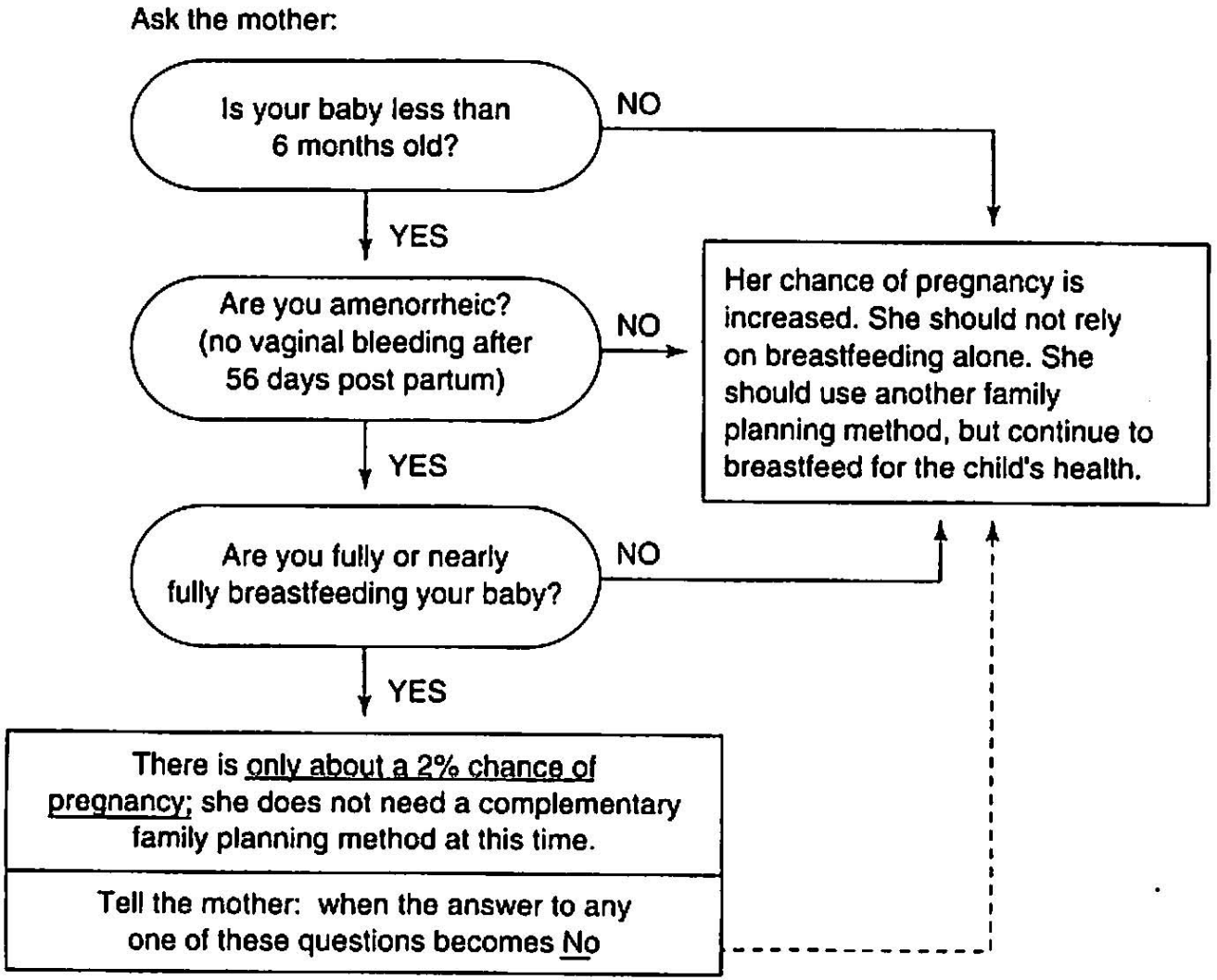


Figure 20-7. Use of lactational amenorrhea method for child spacing during first 6 postpartum months.

Natural Family Planning Methods

- Signs, symptoms or timing of presumed ovulation used to identify when abstinence is necessary to avoid conception
- No risk to lactation
- May be challenging to assess changes in mucous during lactation
- Many women have difficulty interpreting the “rules” of this method
- Failure rates can be high: typical use about 25%

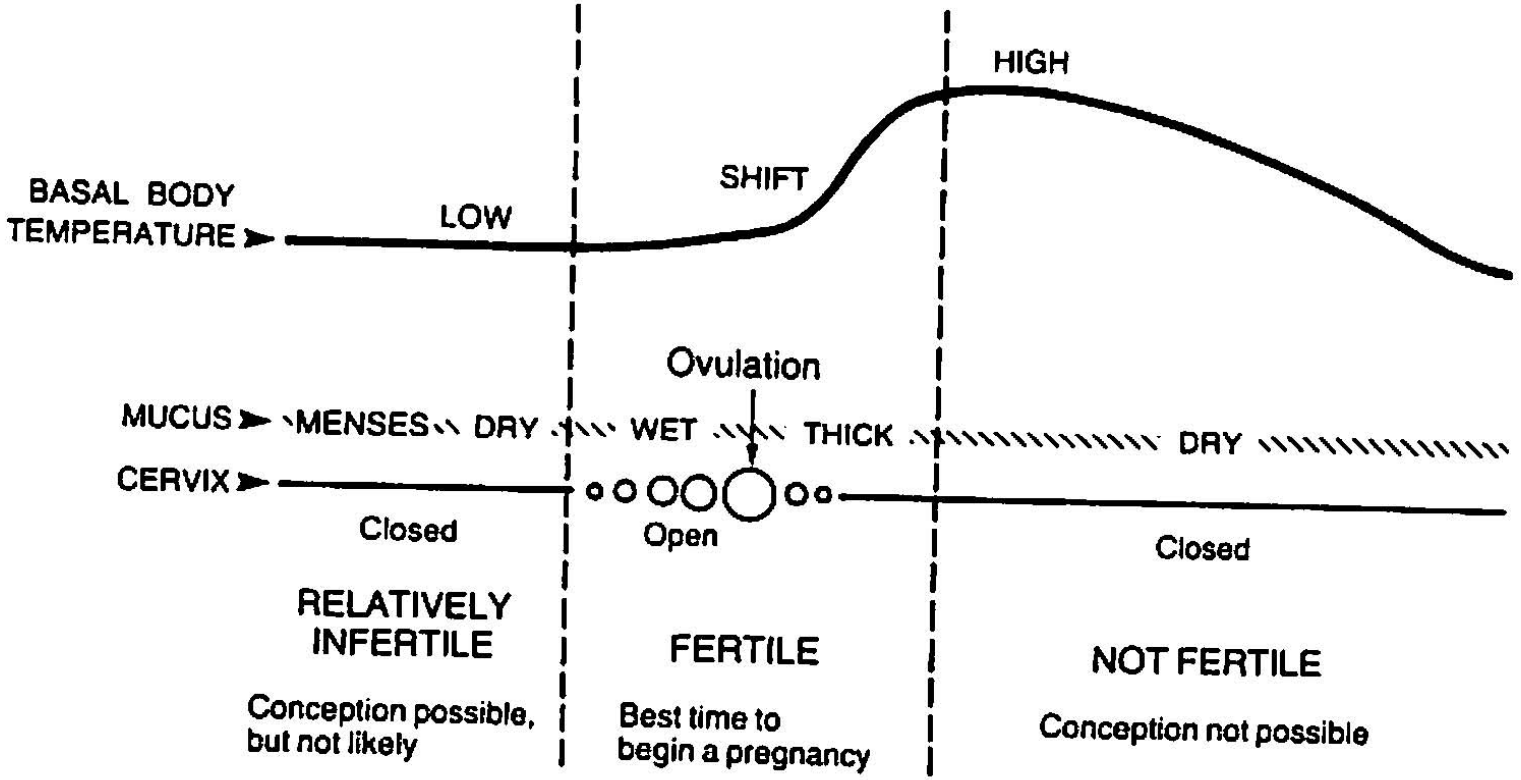


Figure 20-9. Temperature, mucus, and cervical assessments during lactation to identify ovulation. (Courtesy National Family Planning of Rochester, New York.)

Barrier Methods

- Condoms
- Spermicides
- Diaphragms
- Cervical Caps
- Sponge

- Physical and chemical Barriers
- Typical use Failure rate 10-20%
- No impact on lactation

Sterilization and Copper T IUD

- Highly effective
  - Vasectomy (1%)
  - Female sterilization (Postpartum, Interval Hysteroscopic or Laparoscopic) (0.5-2%)
  - IUD (duration 10 years) (1%)
- No impact on lactation
- Female sterilization may have a brief interruption during surgery, work with team to make sure pump available, nurse right before surgery if able. Should not have to discard milk

Hormonal Methods: General rule is to avoid estrogens if possible

- Combined OCP, Patch, Ring: all can decrease milk supply
- Progesterone methods have less impact on milk supply
  - Implanon
  - Progesterone IUD (5 year)
  - POP
  - Medroxyprogesterone Injection
- Sometimes they can alter milk supply as well

Progesterone Only Methods

- Theoretical risk of introducing too early may impact full supply being established
- Postdelivery decrease in progesterone part of the physiologic cascade to start lactogenesis II.
- Most experts recommend delay initiating these methods until full supply is established (4-6 weeks minimum)
- Rarely patients see a drop in supply even with Progesterone IUD.

Progesterone Methods Failure Rates

- Depot Medroxyprogesterone (IM q 3 months) Typical failure rate: 0.3%
- Progesterone Only Pill: 8-10% (Typical use) Perfect use: 1%
- Implant (Etonorgestrel Rod) Typical use <1%

- Also helpful for medically complicated patients that are not estrogen candidates

Postpartum Checkup: How can we help enhance breastfeeding duration and exclusivity?

- Have referral/resources for community support readily available with staff for phone calls and during appointments
- Remind patients to call the office with questions or problems relating to breast health at ANY time postpartum even after the PP exam
- Review transition of return to workforce and plans to highlight the law and offer support and advice re: expressing at work.

Postpartum: How can we help

- Positive feedback goes a long way when you discuss what the baby is feeding
- Remind patients of benefits
- Review how contraceptives will impact breastfeeding, if at all and make sure she is making informed choices
- Handouts with information on refrigeration/freezer guidelines for expressed milk

Support of continuation through first year

- Offer to provide a letter for employer reviewing the medical and economic benefits for an employee to continue to breastfeed
- Better employee retention
- Less absenteeism due to sick child
- Financially advantageous to retain breastfeeding employees rather than hire new employee
- Better work satisfaction

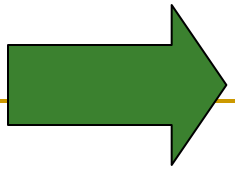
Screening Mammogram and Breastfeeding

- Older obstetric population coincides with more screening mammograms during lactation
- Should not delay screening if pt plans to breastfeed indefinitely
- Should be screened at a center that can interpret lactational changes seen on MMG
- Should empty the breast via nursing or pumping just prior to the imaging.

Resources/Links

Where providers lack confidence

- Peds/OB providers polled about where deficiencies lie:
  - Referral services
  - Returning to work/Pumping
  - Low Milk Supply
  - Breast Pain
  - Teaching Basic Skills/Evaluating Latch



Know when, and to whom, to refer – make use of lactation consultants.

Taveras, E. M., R. Li, et al. (2004). *Pediatrics* **113**(4): e283-90.

Academy of Breastfeeding Medicine http://www.bfmed.org/ Protocols:

- Hypoglycemia
- Discharge
- Supplementation
- Mastitis
- Peripartum management
- Cosleeping
- Model Hospital Policy
- Human milk storage
- Galactogogues
- Near-term infant
- Ankyloglossia
- NICU graduate
- Contraception
- The breastfeeding-friendly physician's office
- Anesthesia and analgesia
- The hypotonic infant

MA Breastfeeding Coalition
www.massbreastfeeding.org

The Best Start:

A Guideline for Healthy Term Newborns, Birth to 48 Hours

Printer friendly version avilable! Download this info to your PDA! www.massbfc.org

Core Knowledge

Incorporate these basics into ROUTINE Prenatal classes and/or visits

Inform Parents About:

- the effects of labor medications on breastfeeding.
- drug-free alternatives for labor and delivery, including use of a birth doula, if available.
- effects of breastfeeding on acute and chronic diseases of women and children, so that mother can make an informed feeding choice.

Teach Skills for Breastfeeding Success:*

- Expect to feed within the first hour of life, with skin-to-skin contact.
- Offer frequent feeds, not formula: The more the baby nurses, the more milk the mother will make.
- Say 'no' to pacifiers and bottles.
- Sleep near the baby & nurse lying down.
- Feed early and often, at the first signs of hunger.
- Wide open mouth, flared-out lips.
- Watch the baby, not the clock.
- Recognize swallowing and milk transfer.
- Avoid supplementation without medical indication.
- Breastfeed exclusively for 6 months.

Promote Time for Breastfeeding and Rest:

Suggest that parents don't let visitors interrupt or delay feedings, and be prepared to ask visitors to leave. Suggest they turn ringer off the phone and rest between feedings.

Encourage Pregnant Women

to visit meetings of community breastfeeding support groups (e.g. La Leche League).

Questions about this chart?
See our FAQs at www.massbfc.org

Core Practices

For Baby:

At birth:

- ▲ Place baby skin-to-skin immediately after birth.
- ▲ Dry baby and assess Apgars with baby on mother.
- ▲ Breastfeed within the first hour of life.
- ▲ Show mother correct latch and position: wide open mouth, flared-out lips, "nose-to-breast, chest-to-chest."
- ▲ Delay vitamin K and eye prophylaxis until after first feed, up to 1 hour.
- ▲ Delay bath until after first feed.

First 48 hours:

- ▲ Check glucose only in high-risk babies.
- ▲ Perform baby's weights, vital signs, & examinations in mother's room.
- ▲ Perform all painful procedures with baby at breast *or* skin-to-skin (includes heelsticks and Vitamin K).
- ▲ Increase breastfeeding frequency & assure swallowing if hypoglycemic, hyperbilirubinemic, or weight loss >7%.
- ▲ Avoid supplements without a medical indication.
- ▲ Follow up 2 days after discharge & again at 2 weeks.

For Mother:

- ▲ Mother sleeps near baby 24 hours a day, and has maximal contact with baby, preferably skin-to-skin.
- ▲ Staff limits visitation time when it's time for feeding and teaching.
- ▲ Mother feels strong tugging which is not persistently painful.
- ▲ Parents are aware of feeding cues & swallowing.
- ▲ Parents are given written & verbal guidance* about Skills for Breastfeeding Success.
- ▲ Mother/baby demonstrate effective breastfeeding prior to discharge.
- ▲ Mother is given contact info for community support services.

Core Support

Provide extra support and/or consider referral to certified lactation consultant in the following circumstances, due to increased risk of breastfeeding problems:

For Baby:

- birth by vacuum extraction
- continued rooting after feeding
- weight loss > 7% associated with poor feeding
- infant irritable, restless or sleepy & refusing to feed
- use of non-breastmilk fluids or pacifiers
- difficulty with latch
- no visible or audible swallowing
- no effective breastfeeding seen prior to discharge
- tongue-tie or other anatomic abnormality
- hyperbilirubinemia
- hypoglycemia (<45 by laboratory confirmation) in at-risk or symptomatic infants

For Mother:

- total labor >14 hours
- caesarean birth
- first-time mother
- flat or inverted nipples
- increased or persistently sore nipple
- prior breastfeeding problems
- use of chronic medications, to ensure safety in breastfeeding
- prior breast surgery
- type 1 diabetes
- obesity
- multiple birth
- smoking

Proper latch on

Massachusetts Breastfeeding Coalition

www.massbfc.org

MA Breastfeeding Coalition
www.massbreastfeeding.org

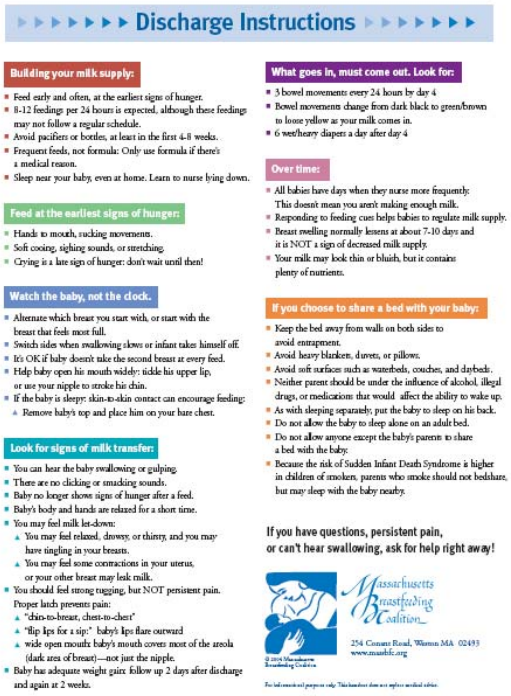
Making Milk *is Easy!*

10 Steps to Make Plenty of Milk

1. **Frequent feeds, not formula.** The more often you feed, the more milk you make. If you give formula, your baby will feel too full to nurse frequently.
2. **All you need is breastmilk!** The American Academy of Pediatrics recommends that your baby have a diet of purely breastmilk for the first 6 months – no other food or drink is needed.
3. **Feed early and often.** Feed at the earliest signs of hunger: if baby's awake, sucking on hands, moving his mouth or eyes, or stretching.
4. **If he didn't swallow, he didn't eat.** Listening for the sound of swallowing will help you know if your baby's getting enough.
5. **Say 'No' to pacifiers and bottles.** If pacifiers and bottles are used when your baby is hungry, you may not be nursing often enough to make plenty of milk.
6. **Sleep near your baby and nurse lying down.** You can rest while you feed your baby!
7. **Have baby's mouth open wide like a shout, with lips flipped out.** The tip of your nipple should be in the back of his throat. He should be directly facing you, chest-to-chest, chin-to-breast. Proper positioning prevents sore nipples.
8. **Watch the baby, not the clock.** Feed your baby when she's hungry, and switch sides when swallowing slows down or she takes herself off the breast.
9. **Go everywhere!** Plan to take your newborn everywhere with you for the first several weeks.
10. **Don't wait to ask for help, if you need it.** If you wait too long to get the help you need, it may be harder to breastfeed. Stick with it – it's worth it!

Massachusetts Breastfeeding Coalition

http://www.massbfc.org | 254 Conant Road, Weston, MA 02493 | email: massbfc@massbfc.org | webmaster: marypej@massbfc.org



Discharge Instructions

Building your milk supply:

- Feed early and often, at the earliest signs of hunger.
- 8-12 feedings per 24 hours is expected, although these feedings may not follow a regular schedule.
- Avoid pacifiers or bottles, at least in the first 4-8 weeks.
- Frequent feeds, not formula: Only use formula if there's a medical reason.
- Sleep near your baby, even at home. Learn to nurse lying down.

Feed at the earliest signs of hunger:

- Hands to mouth, sucking movements.
- Soft cooing, sighing sounds, or stretching.
- Crying is a late sign of hunger: don't wait until then!

Watch the baby, not the clock.

- Alternate which breast you start with, or start with the breast that feels most full.
- Switch sides when swallowing slows or infant takes himself off.
- It's OK if baby doesn't take the second breast at every feed.
- Help baby open his mouth widely: tickle his upper lip, or use your nipple to stroke his chin.
- If the baby is sleepy: skin-to-skin contact can encourage feeding:
  - Remove baby's top and place him on your bare chest.

Look for signs of milk transfer:

- You can hear the baby swallowing or gulping.
- There are no clicking or smacking sounds.
- Baby no longer shows signs of hunger after a feed.
- Baby's body and hands are relaxed for a short time.
- You may feel milk let-down:
  - You may feel relaxed, drowsy, or thirsty, and you may have tingling in your breasts.
  - You may feel some contractions in your uterus, or your other breast may leak milk.
- You should feel strong tugging, but NOT persistent pain. Proper latch prevents pain:
  - "chin-to-breast, chest-to-chest"
  - "flip lips for a sip:" baby's lips flare outward
  - wide open mouth: baby's mouth covers most of the areola (dark area of breast)—not just the nipple.
- Baby has adequate weight gain: follow up 2 days after discharge and again at 2 weeks.

What goes in, must come out. Look for:

- 3 bowel movements every 24 hours by day 4
- Bowel movements change from dark black to green/brown to loose yellow as your milk comes in.
- 6 wet/heavy diapers a day after day 4

Over time:

- All babies have days when they nurse more frequently. This doesn't mean you aren't making enough milk.
- Responding to feeding cues helps babies to regulate milk supply.
- Breast swelling normally lessens at about 7-10 days and it is NOT a sign of decreased milk supply.
- Your milk may look thin or bluish, but it contains plenty of nutrients.

If you choose to share a bed with your baby:

- Keep the bed away from walls on both sides to avoid entrapment.
- Avoid heavy blankets, duvets, or pillows.
- Avoid soft surfaces such as waterbeds, couches, and daybeds.
- Neither parent should be under the influence of alcohol, illegal drugs, or medications that would affect the ability to wake up.
- As with sleeping separately, put the baby to sleep on his back.
- Do not allow the baby to sleep alone on an adult bed.
- Do not allow anyone except the baby's parents to share a bed with the baby.
- Because the risk of Sudden Infant Death Syndrome is higher in children of smokers, parents who smoke should not bedshare, but may sleep with the baby nearby.

If you have questions, persistent pain, or can't hear swallowing, ask for help right away!

Massachusetts Breastfeeding Coalition

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For informational purposes only. This handout does not replace medical advice.

It's my birthday, *give me a hug!*

Skin-to-Skin Contact for You and Your Baby

What's "Skin-to-Skin"?

Breastfeeding

A Smooth Transition

Bonding

Skin-to-Skin Beyond the Delivery Room

About the research

Dept. of HHS and Office on Women's Heath, African American Breastfeeding Campaign: http://www.womenshealth.gov/itsonlynatural/

It's only natural
mother's love. mother's milk.

Womenshealth.gov
Office on Women's Health, U.S. Department of Health and Human Services

ACOG/AAP

ACOG

THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS

Thank you!
FL Breastfeeding Coalition
Dr. Joan Meek

Questions?