Supporting and Promoting Breastfeeding in Health Care Settings: Module 4: Early Postpartum/Postnatal Care

12/18/13

Four-Part Webinar Series

- Recommendations on how to examine, counsel, and teach breastfeeding to pregnant women and new mothers
- Targeted to clinicians and other health care providers
- Providers are encouraged to complete all four modules
  - Module 1 is targeted to prenatal providers
  - Modules 2 & 3 is targeted to hospital care providers
  - Module 4 is targeted to postpartum/postnatal care providers
- Modules support Ten Steps to Successful Breastfeeding
Featured Speakers

Lorelei Michels, DO, IBCLC
Breastfeeding Medicine Specialist
Founder and Director,
Dr. Lorelei’s Healthy Beginnings –
Breastfeeding Medicine, PLLC

Disclosure Statements

The planners and presenters do not have any financial arrangements or affiliations with any commercial entities whose products, research or services may be discussed in this activity.

No commercial funding has been accepted for this activity.
Evaluations

Nursing Contact Hours, CME and CHES credits are available.
L-CERPS are available until December 2014

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• NYS Department of Health
# Overall Goals

- Provide guidance on examining, counseling, and teaching breastfeeding to women during pregnancy, delivery and postpartum
- Improve rates of successful breastfeeding

# Objectives – Module 4

- Identify how to assess breastfeeding mothers and infants in order to prevent issues before they start
- Describe how to managing common breastfeeding problems
- List ways to support successful breastfeeding during the early post-partum period
Maternal Assessment

• Ask mothers about their breastfeeding (BF) goals
• Recommend exclusive BF for as long as possible, (6 months per AAP)
• Do not assume that BF will be successful if mother has other children – ask!
• Always question formula supplementation, especially at < 4 weeks
• Support, encourage, promote confidence

AAP Recommended Breastfeeding Practices

• Formal evaluation of BF by medical professional trained in formal assessment of BF in first 24–48 hours and again at 3-5 days and 2-3 weeks of age

• Assess: general health, infant weight, BF latch, hydration, jaundice, elimination pattern
Academy of Breastfeeding Medicine
Recommended Breastfeeding Practices

- Encourage skin-to-skin contact
- Encourage maternal and infant discharge at the same time
- If mother discharged prior to infant, encourage frequent maternal visitation and mother to pump
- Recommend:
  - no pacifier use during first 4 weeks
  - avoiding use of supplemental bottles, unless medically indicated; may use lactation aid, syringe finger feeding, spoon or cup feeding

Alternative Feeding Methods

Source: Nancy E. Wight MD, IBCLC, FABM, FAAP

- Most common techniques:
  - Underdeveloped countries: CUP
  - Developed countries: BOTTLE
- Other techniques:
  - Lactation aid at the breast
  - Finger-feeding with lactation aid
  - Dropper, spoon
  - Syringe
- Goal: To establish or restore full breastfeeding
## Use of Pacifiers

- 2009 review article found early use of pacifiers may be associated with less successful breastfeeding.
- Pacifier use in the neonatal period should be limited to specific medical situations (i.e., pain relief, calming agent or enhancement of oral motor function).
- Encourage waiting until breastfeeding has been established (>4 wks of age) before use of pacifier.


## Infant Assessment: Feeding Pattern

- Infants should be breastfed on demand.
- Mother should:
  - Offer second breast
  - Alternate which breast is offered first
  - Use breast compression
- Infant may “cluster feed” and then sleep 4-5 hrs.
- Infant may feed more at night for first month.

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### Infant Assessment: Elimination Pattern

- **Day 1:** 1 void/1 meconium stool (2 stools on day 2; 3 on day 3)
- **Days 4-5:** stool should be clear of meconium (a day longer for c-section baby)
- **Day 5:** 6-8 pale or colorless voids/day
- **Days 5-7:** Loose, yellow, curd-like stools
- **More than 6 clear, wet diapers/day**
- **Infrequent stools are common after the first month in healthy breastfed infant**

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### Infant Assessment: Weight Loss

- **Average weight loss of 5-7%** Over the first 3–4 days expected
- **Loss greater than 8%** mandates careful evaluation of breastfeeding
- **Intrapartum fluid administration** can cause fetal volume expansion and greater fluid loss after birth

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Infant Assessment: Weight Gain

- Weight gain begins with increase in mother’s milk production by day 3-5
- By day 7-8, most breastfed babies regain back to birth weight
- Expect gain of 15-30 g/day (1/2 to 1 oz) or about 8 oz/wk (female) or 9 oz/wk (male) through the first 2-3 months of life
- Growth spurts at about 10 day, 3 wks, 6 wks

WHO Growth Chart: Breastfed Infants

http://www.who.int/childgrowth/standards/weight_for_age/en/
Infant Assessment - Latch

- Rooting reflex
- Wide open mouth
- Head extended back
- Mouth filled with breast tissue
- Flanged lips around the breast (“fish lips”)
- Wide angle at corner of mouth
- Suck and swallow

Signs of Incorrect Latch

- Immediate signs
  - Infant’s cheeks indenting during suckling, clicking noises, lips curled inward
  - Frequent movement of the infant’s head and lack of swallowing sounds
  - Maternal pain and discomfort

- Later signs
  - Trauma to mother’s nipples and pain
  - Poor infant weight gain
  - Low milk supply
Milk Transfer

• Teach mother to watch as baby sucks and swallows and milk is transferred; mother should look and listen for:
  – Audible swallowing
  – Sucking that begins with rapid bursts to stimulate milk let-down
  – A rhythm of sucking, swallowing, and pauses
  – Undulating tongue action

Positioning

Watch how mother positions baby for feeding and look for:

• Maternal comfort
• How infant is positioned
• Infant brought to breast, not breast to the infant
• Mother should not push on the back of infant’s head – may cause infant to arch away from the breast
Biological Nurturing/Baby-Led Nursing

- Semi-reclined position
- Infant’s hands and feet free
- Mother relaxed
- Allows instinctive behavior to occur

Managing Common Breastfeeding Issues
Sore Nipples

• Sensitivity differs from pain
• Nipple sensitivity common and transient - peaks on postpartum day 4-5
• Subsides 30 to 60 sec after suckling begins
• Resolves by 2-3 weeks
• Pain due to trauma persists past 3rd week or increases throughout feeding

Nipple and Breast Pain: What is Not Normal?

• Intense, shooting pain
• Pain throughout the feeding or between feedings
• Broken skin/bleeding, blister or color change
• A burning sensation during, after or between feedings
• Persistent soreness that does not improve after one or two days of trying to correct the problem – usually the latch
Nipple and Breast Pain: Maternal Causes

- Engorgement
- Plugged ducts
- Oronipple disproportion: wide or long nipples and infant with small oral anatomy
- Inverted nipples
- Skin problems: bacterial or fungal infection, eczema, dermatitis, psoriasis, nipple trauma
- Pumping issues: Excessive suction, nipples not centered, poor flange fit (frequently too small)

Nipple and Breast Pain: Infant Causes

- Anatomical variations: partial ankyloglossia (tongue tie), lip tie, receding chin, bubble palate
- Inappropriate sucking: tongue thrusting, bunching
- Chewing or biting
Management of Painful Nipples

- Ensure infant latches on and is removed from the breast correctly
- Teach mothers to vary position and maintain asymmetrical latch
- Discuss moist wound healing and applying breastmilk to nipples
- Suggest mother try purified lanolin or hydrogel pads
- Treat maternal, infant or pumping issues
- If intractable, consult lactation consultant or breastfeeding medicine physician

Ankyloglossia
Ankyloglossia (cont.)

• Occurrence rate: 3.2 - 4.8% consecutive term infants at birth
  – 12.8% infants with breastfeeding problems
• Presents as ineffective latch, nipple pain and/or infant with poor weight gain
• Short or tight frenulum noted; assess appearance and function of tongue
• Diagnosis and treatment vary widely, controversial

Ankyloglossia Management

• Care of mother’s nipples and change positions to prevent injuries
• Consider short and long term consequences
• Consider lactation specialist consult
• Frenotomy procedure (incision of frenulum)
• No randomized, clinical trial to date


Engorgement

- Early - begins at 48 to 72 hours (range 1-7 day)
  - Accompanies lactogenesis stage II
  - Vascular engorgement and milk accumulation
  - Resolves spontaneously
- Late
  - Due to milk accumulation
  - Poor latch, infrequent feeding, pacifiers, and/or formula use

Signs and Symptoms of Engorgement

- The breast will become hot and painful and will look tight and shiny
- With severe engorgement, milk production may stop
## Treatment for Engorgement

- Check BF positioning
- Advise mother to:
  - breastfeed frequently
  - apply warm cloth to the areola area just before BF
  - use cold compresses between BF
  - hand express or use pump minimally to relieve fullness

## Plugged Ducts

- Localized areas of milk stasis with distention of ducts (sometimes nipple blebs can be seen)
- Palpable tender lump without fever, erythema or myalgia
- Lactating breast is normally “lumpy” during first 2 months, but lumps move and are not tender
Nipple Bleb (or Blister)

- **Symptoms:**
  - Pain with BF
  - Plugged duct

- **Etiology:**
  - Incorrect latch
  - Suck difficulties
  - Overproduction
  - Nipple candidiasis

Plugged Duct - Management

- **Instruct mother to:**
  - Breastfeed frequently on affected side
  - Offer affected breast first
  - Apply moist, warm cloth to area before BF
  - Massage the lump toward the nipple gently before and during BF, which may help
  - Nurse in different positions to ensure drainage of affected area
Mastitis

- Bacterial infection of the breast which begins after 10 days postpartum
- Nipple trauma, plugged ducts, engorgement, fatigue predispose
- Redness, warmth, tenderness of one breast, usually unilateral
- Sometimes fever, chills, myalgia; stasis of milk can lead to abscess formation
- Causative organisms: *S. aureus, E. coli*, group A streptococci
Treatment of Mastitis

• Instruct mother to:
  – continue to nurse on both breasts
  – use pump or manually express milk on affected breast if nursing too painful
• Analgesics – ibuprofen 600mg q6hrs prn
• If mild, symptoms may resolve in less than 24 hours with frequent nursing or pumping; otherwise, treat with antibiotics for 10 to 14 days
• Frequent follow-up

Summary

<table>
<thead>
<tr>
<th></th>
<th>Engorgement</th>
<th>Plugged Duct</th>
<th>Mastitis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onset</strong></td>
<td>gradual, first week</td>
<td>gradual, after feeding</td>
<td>sudden, after 10 day</td>
</tr>
<tr>
<td><strong>Site</strong></td>
<td>bilateral</td>
<td>unilateral</td>
<td>unilateral</td>
</tr>
<tr>
<td><strong>Swelling</strong></td>
<td>generalized</td>
<td>localized, may shift</td>
<td>localized, red, hot</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>mild-mod, generalized</td>
<td>mild-mod, localized</td>
<td>intense, localized</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td>well</td>
<td>well</td>
<td>fever, malaise</td>
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</tbody>
</table>
Early Postnatal Problems

- Slow weight gain/not back to birth weight by day 7-8
- Maternal perception of lactation insufficiency
- Jaundice/hyperbilirubinemia

Should we supplement?
Slow Weight Gain: Breastfeeding Mismanagement

- By far the most common cause
  - Inappropriate timing and duration of feedings
  - Inappropriate supplementation
  - Unrelieved engorgement
  - Inappropriate mother/infant separation
  - Improper positioning and latch-on

*Source: Nancy E. Wight MD, IBCLC, FABM, FAAP*

- Early assistance is the key to preventing the vicious cycle of slow gain/insufficient milk

Low Milk Production Management Due to BF Mismanagement

- Assess latch and milk transfer
- Instruct to breastfeed frequently “on demand” and not limit length of feeding
- Instruct to delay bottle for at least 4-6 weeks
- Teach breast compressions
- Encourage “switch” nursing
- Instruct to avoid using pacifiers
### Low Milk Production Management Due to BF Mismanagement (cont.)

- Rule out maternal or infant abnormality; treat underlying cause, if known
- Remind mother that frequent, effective milk removal is necessary to maintain or increase milk production
- Encourage mother to keep some breastfeeding going!

### Other Reasons for Slow Weight Gain: Infant Causes - Poor Intake

*Source: Nancy E. Wight MD, IBCLC, FABM, FAAP*

<table>
<thead>
<tr>
<th>Poor suck</th>
<th>Infrequent feeds</th>
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</thead>
<tbody>
<tr>
<td>- CNS dysfunction</td>
<td>- Inappropriate hospital routines</td>
</tr>
<tr>
<td>- Prematurity</td>
<td>- Water/formula supplementation</td>
</tr>
<tr>
<td>- Neuromuscular dysfunction</td>
<td>- Pacifier use</td>
</tr>
<tr>
<td>- Abnormal sucking patterns</td>
<td>- Maternal/infant separation</td>
</tr>
<tr>
<td></td>
<td>- Sleepy baby</td>
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</tbody>
</table>
### Other Reasons for Slow Weight Gain: Infant Causes - Poor Intake (cont.)

**Source: Nancy E. Wight MD, IBCLC, FABM, FAAP**

<table>
<thead>
<tr>
<th>Structural abnormality</th>
<th>Low net intake</th>
<th>High energy requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cleft lip/palate</td>
<td>• Vomiting and diarrhea</td>
<td>• CNS dysfunction</td>
</tr>
<tr>
<td>• Short lingual and maxillary frenulum (partial ankylglossia)</td>
<td>• Malabsorption</td>
<td>• Congenital heart disease</td>
</tr>
<tr>
<td>• Micrognathia</td>
<td>• Infection</td>
<td>• SGA</td>
</tr>
</tbody>
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### Other Reasons for Slow Weight Gain: Maternal Causes

<table>
<thead>
<tr>
<th>Impaired milk ejection reflex (MER)</th>
<th>Psychological factors</th>
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<tbody>
<tr>
<td>• Pain</td>
<td></td>
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<tr>
<td>• Drugs</td>
<td></td>
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<tr>
<td>• Smoking</td>
<td></td>
</tr>
<tr>
<td>• Pituitary dysfunction</td>
<td></td>
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<tr>
<td>• Breast surgery</td>
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<table>
<thead>
<tr>
<th>Inadequate breastmilk production -- extremely rare (less than 1 in 1000)</th>
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Perceived Milk Insufficiency

- Definition: mother’s perception of lack of breastmilk and doubts about her ability to meet the infant’s needs
  - Breasts not full
  - Milk ejection not as effective
  - Infant has increased appetite
  - Infant crying without reason

* Source: Nancy E. Wight MD, IBCLC, FABM, FAAP

- Extremely common
- Mother needs lots of education and support

Medical/Surgical Cause of Low Milk Production

*Source: Jane A. Morton MD, Peds Annals, May 2003; 32(5):308-316*

- Pre-Glandular:
  - Hormonal
  - Prolactin
  - Oxytocin
  - Nutritional
  - Systemic Illness

- Glandular:
  - Primary hypoplasia
  - Secondary hypoplasia
  - Post radiation Rx
  - Post breast surgery
  - Post mastitis/abscess
Medical/Surgical Cause of Low Milk Production

Source: Jane A. Morton MD, Peds Annals, May 2003; 32(5):308-316

- **Post-Glandular**
  - Maternal-infant separation
  - Delayed initiation
  - Insufficient frequency
  - Ineffective emptying
  - Obstructed outflow
  - Engorgement/edema
  - Plugged duct
  - Impaired transfer
  - Poor latch
  - Dysfunctional suck
  - Ineffective/weak pump

“My baby is **Yellow!**”
Physiologic Jaundice

• Normal newborn jaundice
• Early onset: starts on day 2-4, peaks day 3-5, resolves by 2 weeks
• Rise and fall in unconjugated bilirubin occurs in all newborns (anti-oxidant)

Jaundice in Breastfeeding Infants

• Physiologic jaundice may be exacerbated by low milk intake
  – Low milk intake causes ↑ enterohepatic circulation
• Common in breastfed infants
• ↑ frequency of nursing (8-12x per 24hrs) ↓ likelihood of hyperbilirubinemia associated with breastfeeding
Jaundice Management

- Interrupt breastfeeding only as a last resort and only when appropriate (rare)
- Mother to continue breastfeeding and use bili blanket at bedside
- If supplementation necessary, use lactation aid
- Refer to lactation consultant early
- Follow-up is essential

Breastmilk Jaundice

- Healthy, thriving, breastfed infant with good weight gain
- Etiology is increased intestinal reabsorption of unconjugated bilirubin
- Factor in human milk that promotes intestinal reabsorption of unconjugated bilirubin
- Elevation of indirect (unconjugated) bilirubin after day 5 of life
- Persistent elevation (3 weeks to 3 months)
- Other causes of jaundice ruled out
Keys to Successful and Continued Breastfeeding

- Education
- Support
- Support
- Support
- and...

Primary Care Physician
### NYS Breastfeeding-Friendly Practice

- Designate breastfeeding champion in office
- Train all staff on an ongoing basis in skills necessary to implement and maintain a breastfeeding-friendly office policy
- Determine key breastfeeding messages and ensure consistent use
- Ensure timely follow-up, counseling and support
- Limit/ban formula and industry products in office
- Develop community-clinical linkages

### Community Support

- Knowledgeable physicians
- Lactation specialists, IBCLC and/or BF medical physicians
- Hospital support groups
- Breastfeeding cafes
- WIC programs
- Breastfeeding USA
- La Leche League International (LLLI)
Summary

- Breastfeeding is preferred feeding for almost all infants
- Parents should be informed of the benefits of BF and educated about BF expectations and common preventable situations
- Most common breastfeeding problems are preventable with proper assessment and care pre- and post-natally
- Those that are not preventable are often treatable and should not induce weaning
- Supplementation is rarely indicated and interferes with successful lactation

Summary (cont.)

- Early and frequent follow-up after hospital discharge
- Physicians should be able to identify common breastfeeding situations and treat
- More complicated breastfeeding problems should be referred to a lactation specialist
- BF should be actively supported and promoted in the medical community and society
- Women should feel comfortable continuing to BF for as long as desired
Evaluations

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