

Patterns and Predictable Hurdles of Early Feedings

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What to expect of first feedings

- How often, how much do babies eat?
- Do we really know what is normal number of feeds?
- Is weight loss normal?
- How consistent are newborns in the first few days?

Charting by numbers and clocks is not helpful unless:

- Excessive sleepiness continues after first 24 hours
- Unless the baby is less than term
- Unless the baby is not healthy

- **Difficult for hospitals whose care is based on regimented routines/schedules**

We need to make feedings easier

- **Don't worry too much about how often, how long, how efficient of feedings in first 24 hours, if...:**
- Baby is full term
- Baby is healthy
- Our practices are not interfering
- Baby had a feed in the first few hours

Helpful information for parents

- **No rules** – just good information
- **Feed early! Feed often!**
- **Encourage (not insist)** feedings every few hours day and night – the 24 hour day! (This does not mean feed every three hours for ten minutes on each breast)
 - Frequent signaling to breasts – skin to skin, hand expression, “practice” feedings
 - Watch for feeding cues

The confusion of numbers has contributed to our challenge

- **Averages are just statistical numbers**
- They have little to do with individual mothers and babies
- “Don't try to force mothers/(babies) into an average”

How often should a baby eat?

- Average in first 24 hours = 6 feedings
- Range in first 24 hours = 3–8 feedings
- Average on day two = 7.5 feedings
- Range on day two = 5-10 feedings

(Saint, Hartmann 1984, Casey 1986, Arthur 1989, Neville 1988)

Research findings

- Research showed less hyperbilirubinemia when > 8 feeds (Yamauchi 1990)
- In Lima, Peru average # of feeds on Day Three 18x/day (Dewey 2007)
- In Davis, CA average # of feeds 10X/day
- Can we enhance feedings in US culture?
- How important are increased feedings?

How much milk does a newborn need?

Average breastmilk production

- First 24 hours – 1-2 oz/24 hours
- Postpartum day 3 – 12 oz/24 hours
- Postpartum day 5 – 18 oz/24 hours
- By two weeks of age – 24 – 30+ oz/24 hours

Milk needed to grow

- Difficult to know where these theoretical numbers come from
- Usual guide:
 - 80 ml per kilogram on Day 1
 - 100 ml per kg on Day 2
 - 120 ml per kg on Day 3
 - 150 ml per kg on Day 4 and thereafter

What Does the Research Show?

First 24 hours	37 ml (range, 7.0-122.5 ml) (Saint 1984) 45 ml (range, 10.5-112 ml) (Casey 1986) 82 ml (Arthur 1989)
Day 3	11 oz (range, 6-19 oz) (Casey 1986) 13.5 (range, 3-26 oz) (Saint 1984)
Day 5	17 oz (Neville 1988) 18 oz (range, 13-23 oz) (Casey 1986) 23.5 oz (range, 15-29 oz) (Saint 1984)
Day 6	18.5 oz (Arthur 1989)
Days 14 to 28	38.5 oz (Saint 1984)
Months 3 to 5	25 oz (Neville 1988)

Compilation of research How much does a baby eat?

Age of Baby	Average (range) volume per day	Average volume per feed
0-24 hours	37 (7-123)	7 ml
24-48 hours	84 (44-335)	14 ml
48-72 hours	408 (98-775)	38 ml
72-96 hours	625 (378-876)	58 ml
96-120 hours	700 (452-876)	70 ml

Theory versus Reality*

	Prescribed ml/kg/day	Actual* ml/kg/day
Day 1	80	15
Day 2	100	55
Day 3	120	115
Day 4	150	180

*Based on average amount mothers produce divided by average birth weight (3.5 kg)

No rules about length of feedings No rules about one or two breasts

- **Babies know how much to eat**
 - As long as baby is correctly latched
 - As long as baby can control feeding

So, why is there so much formula supplementation without much thought?

- Belief that it makes no difference
- Fear of lawsuits
- Lack of appropriate follow-up
- No confidence that there is milk
- No confidence in breastfeeding
 - Mother's request
 - Healthcare professionals

No formula supplements unless medically indicated

- Any supplementing in first 48 hours = delayed onset of Secretory Activation (lactogenesis II)
- Supplementation with bottle nipples and/or pacifier use in first 24 hours also identified with abnormal suckling in infant on day three Dewey KG et al. Pediatrics. Sept. 2003
- Need to think twice before we casually feed babies other things
- Need to think twice before we introduce equipment

Medical reasons for supplementation – mother’s milk or formula

- Hypoglycemia – risk or real
- Late preterm and preterm
- SGA infant
- Hyperbilirubinemia
- ?Weight loss in excess of 10% of birth weight and milk delayed
- Continued weight loss after Day Five

No research that says a newborn needs formula with 10% weight loss at 24-48 hours of age

- Delayed secretory activation (Lactogenesis II) would be determined if mother has no perception of milk coming in by 72 hours

How much weight loss is normal?

- The numbers are inconsistent and only averages (5-12+% loss) Dangerous to pick “a” number
- When do we need to do something?

(McDonald 2003, Noel-Weiss et al 2008, Merewood 2009)

Weight loss in term newborn

- Things to consider
 - All babies are expected to lose weight
 - When is loss physiologic or pathologic
 - What does the assessment show?
 - Why are we doing daily weights on term infants?
 - Are the weights accurate?
 - Is it the same scale?

What to supplement?

- Expressed mother’s milk, following a breastfeeding
- Donor milk if available
- Formula

How to supplement?

- Spoon
- Syringe
- Dropper
- Finger feeding
- SNS
- Lactaid
- Cup feeding
- Bottles

What about “nipple confusion”?

- Is there such a thing?
- Nipple preference?
- Most discussions are opinion-based, not science-based
- There is little evidence about the effect of any alternative feeding method on breastfeeding
- Psychological value of alternative feeding method may be great

- “Don’t put anything in a baby’s mouth except the breast until he’s passed BF 101” – Marianne Neifert, MD

Position and Latch

- Successful first feedings require:**
- Confidence in baby’s ability
 - Confidence in mother’s ability
 - Common sense
 - Some basic education
 - Sometimes good problem-solving
 - Avoiding breastfeeding dogma
 - Knowing there are many ways to do this

- Best first feeding: “Laid back”?**
- “Delivery self-attachment”
 - “Baby-led breastfeeding”
 - “Biological nurturing”

 - Do we need more methods, more names?

Basic principles

- Mom is comfortable
- Baby is comfortable
- Sitting, Mother's feet supported, arms supported, pillows as needed
- Lying down, pillows for support
 - Helpful after surgery, or with swollen perineum or when needing to “rest”

Basic principles (cont.)

- Baby at level of nipple
- Chest, abdomen and knees are facing and touching mother's body, tucked in close
- Head is facing forward, slightly extended, not arched or turned
- Ear, shoulder and hip aligned

Holding baby

- Cross Cradle Hold (alternate cradle, transition)
 - “Training wheels” for baby learning to breastfeed (D. Wiessinger)
 - Helpful with preterm infants, Down's syndrome, anytime needing more support
- Cradle Hold
- Under the arm (football, clutch)
- Straddle

Mother's Hand Positions

- To support breast for early feeds
- Regardless of position, mother's fingers are parallel to baby's lips
- "C" hold
- "U" Hold
- "V" Hold
 - May be difficult to get fingers out of the way
 - Offers little support for the breast

Mother's Hand Position

- May need to gently compress areola to get baby latched and may need to hold the shape for the whole feeding in the beginning
- "Sandwich" analogy, D. Wiessinger

When it's appropriate to "Take Charge"?

- Rationale
 - Anytime you can do it and mother can't
 - Need to get baby fed and mother still learning
 - Frustrated mother/baby
 - Difficult latch

To help latch the baby on breast

- Baby must be ready to feed
- Don't latch baby when crying
- Let him know where breast is
- Back him off a bit – keep nose near nipple
- Be patient
- Quickly pull him to breast when mouth is wide open

Inverted nipples

- Success depends on many factors:
 - Personality of baby/personality of mother
 - Degree of inversion
 - Ability to extract the nipple
 - Maximizing milk supply
- Baby only knows nipple offered
- Most mothers and babies work it out

If mother's nipples are hard to grasp

- Enhance nipple protrusion
 - Fingers
 - Pump before and after nursing
 - Hoffman's maneuvers
 - Nipple everters
 - Breast shells
 - Nipple shields
- May take several people to get baby latched
- Hand expression with pump to maximize milk production

“Asymmetric Latch”

- Emphasis on lower jaw coming up under breast
- Nose opposite nipple, chin leads
- Angling nipple toward palate
- Jaw opens asymmetrically, but latch is symmetric

How to Assess Latch: Look

- Nipple disappears
- Nose and chin close to breast
- Cheeks round and full
- Angle of lips is about 120 or more degrees

Assessment of Latch: Listen

- Quiet drawing sound, swallowing, no “clicking” or “smacking”.
- Don’t obsess with hearing swallows

Assessment of Latch: Feel

- Ask mother how it feels: should be a deep firm pull with out pain
- Many women are surprised by the strong tugging and may not experience it as pleasant at first
- Baby will find best latch, but it may not always be “according to the rules”

Is nipple pain normal?

- Studies say “yes”
- Perhaps we need to give women a more realistic idea of what to expect

“Physiologic Sore Nipples”

- Normal in the first week after birth
- Hurts at the start of the feeding
- Skin remains intact, but is sore
- Pain peaks on the 3rd day after birth
- Pain begins to subside after that

UC Davis

- 280 mother-baby pairs
- IBCLC managed
- Day 3:
 - ~ 50% had moderately sore nipples
 - ~ 75% described soreness when “mild“ was added

Helpful tips to prevent or treat sore nipples

- Early feeding assessments
- Early and knowledgeable follow-up
- Express milk before latching
- Principles of latch and positioning
- Keep milk flowing and baby sucking throughout the feeding

Teach Mother To:

- Watch cues and remove baby carefully when clearly in non-nutritive phase
- Look at her nipples after nursing for signs of trauma

Comfort Measures for Nipple Pain

- Moist compresses
 - Water as effective as or more effective than tea in 2 studies (Lavergne 1997, Buchko 1994)

Nipple infection

- Not an early cause of nipple pain (first three days), but
- A common cause of on-going nipple pain
- Staph infection secondary to nipple damage is probably most common cause of unresolved pain
- Yeast is a rare cause of pain

Breastfeeding Assessment Tools

- Replace vague terms as “BF well, fair, poor”
- IBFAT (Infant Breastfeeding Assessment Tool, Matthews)
- MBA (Mother Baby Assessment Score, Mulford)
- SAIB (Systematic Assessment of the Infant at the Breast, Shrago & Bocar)
- LATCH tool (Jensen, Wallace & Kelsey)

BARRIERS for RNs, MDs & Mothers

RNs and MDs **Mothers**

Time..... Unavailability

Skills/Knowledge Inconsistent
advice

Lack of accountability... ..Attitude

How do I deal with these barriers?

AVAILABLE.....EFFICIENT

KNOWLEDGABLE...WHAT'S IMPORTANT

ACCOUNTABLE.....MOTIVATED

As I walk into the room...

...does what I **say** (or don't say) NOW
matter?

...does what I **do** (or don't do) NOW
matter?

.

Make it SHORT and SIMPLE

Consider this a learning time

All early interactions..**ABC's**

- a) **A**ttachment
- b) **B**reastmilk Production
- c) Maternal **C**onfidence

Maternal confidence

- Generating confidence in family through our words and actions
 - Learning to feed in first day
 - Hand expression of breastmilk
 - Importance of father's role
- Celebration of birth

Find something positive to compliment or praise

- She is capable
- No labels
- Get excited!
 - “What a great job you did”
 - “Doesn't he look happy”
 - “What a smart baby”
- Avoiding negatives
- Caring, responsibility vs. authority

**MOTIVATED to Make
15 Minutes MATTER**

Make it DOABLE (effective and efficient)

- Scripts
- Prioritized agenda
- Consistent approach

**MOTIVATED to Make
15 Minutes MATTER**

Make it FUN

- Define “success”
- Identify your successes
- Enjoy personal victories

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**Honor the Parent, Honor the
Child: the Ongoing Search for
Excellence**

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**Honor the Parent
Honor the Child**

- Experiences and findings from baby parent groups
- Respect for the baby
- Respect for the parents
- A look at the influence of culture
- How can we be most helpful to parents?

**Our biology tells us to keep our
babies close, protect them, feed
them often, but...**

**Our culture tells us something
different.**

Most common stated concerns of new parents

- My baby eats all the time
- I don't have enough milk
- I can never put this baby down
- My baby cries a lot
- I need to get more sleep

What parents hear from the healthcare system

- Babies need regimentation
- Breastfeeding needs to be measured, calibrated
- Babies need to "self-soothe"
- Babies are manipulative
- Children need to know who is "boss"
- Children must be compliant
- Dependency is bad behavior
- Crying means the baby is "spoiled"

Consequences of poor advice

- Undermines confidence
 - Everything in the biology of a lactating women tells her to hold, feed protect her baby
 - The cultural messages tell her otherwise
 - The breastfeeding mother in Western culture spends much of her time "second-guessing" her actions
 - Little confidence that she is doing the right thing
- Disempowering

Why professionals contribute to parenting difficulties

- Commitment to healthcare traditions
- Authority/control
 - Notorious for our rules and regulations
 - Control of birth
 - Control of feedings
 - Control of babies/parents

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Influence of formula industry on professionals, vulnerable parents

- Money speaks - indebted
- Pseudoscience marketing is highly effective
 - Formula is just like breastmilk
 - Formula is better than breastmilk
 - “No need to give additional Vitamin D”
 - “Comfort proteins”
- Appeal to convenience for busy lives

Healthcare community

- Talk frequently about “Evidence-based Care”
- But - opinions and beliefs often dictate our care
- We have fought the biology, the science of birth, parenting
- Tradition is difficult to let go

What is the evidence?

- Newborn’s “Return to the uterus” biology
 - Skin to skin
 - Flexion and position
 - Need for motion
 - Sounds
 - Water
 - Adult contact

“My baby eats all the time” “I don’t have enough milk”

- It’s an education issue – infant biology
- Small infant stomach
- Baby’s ability to regulate fat intake, calories required
 - Oxytocin and the gut hormones
 - Provides feeling of satiety
 - Contentment
- Babies are not robots
- Babies do not understand about clocks

“I can never put this baby down”

- It’s an education issue – infant biology
- Babies are born with ~25% of adult brain growth
- Babies need continuous adult attention to stay safe and healthy
- Babies are unable to take care of themselves

“My baby cries a lot”

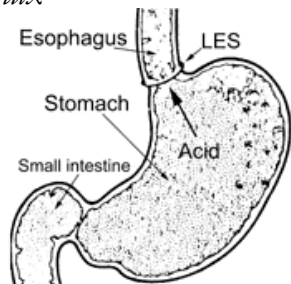
- It’s an education issue – infant biology
- Babies cry to communicate
- Crying is meant to make the adult move
- Crying is not “bad” behavior

Excessive crying

- Unexplained crying, previously referred to as “colic”
- Exists in every culture
- Difference in how cultures deals with it
- Probably little to do with the infant gut
- Neurological immaturity?
- These are frequently the victims of “Shaken Baby Syndrome”

Colic diagnosis is losing out to GERD (GORD) - *Gastroesophageal Reflux*

- Spitting up
- Crying a lot after feedings
- Spells of back arching
- More comfortable with head elevated
 - Upright feeding and sleep position



“Arsenic Hours”

- Common pattern – reported for bottle feeding and breastfeeding babies
- Late afternoon, evening crying
- Baby off and on the breast, discontent
- Mother thinks she has no milk
- Baby may be tanking up with low volume, high fat milk
- Often followed by longest sleep of day

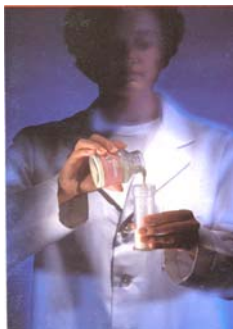
“I need to get more sleep”

- It’s an education issue – infant biology
- Sleep is a biological, instinctive need of humans
- Babies do not need to be “taught” to sleep
- Babies need to feed at night in early months
- Parents need to be close by
- Long term reliance on parents for physiologic regulation

The breastfeeding professionals have been a force in helping parents

- Became advocates for the biological approach to parenting, feeding
- However, we copied the medical model of which we were so critical

Infant feeding based on pathology



- Breastfeeding is a disease
- Subject to medical supervision /management
- Mother or baby is the problem to be managed
 - “to exercise control over ... to influence (someone) so that he does as one wishes”

Talking in medical “jargon”

- Used medical language or created “medical-sounding” language
 - Asymmetric latch
 - “Milk ejection reflex”
 - “Primary lactation insufficiency”
 - Hyperlactation syndrome

Attraction to the complex

- See ourselves as highly skilled medical practitioners
 - Sleuthing out the mysteries of exotic breastfeeding challenges
 - Fixing problems caused by someone else

Lack of team players

- Intensity and anger about our profession
 - Anonymous nasty evaluations
 - Complaints with no solutions
 - Self-promotion vs. team efforts
- A bit “full of ourselves”
 - Not crediting others
 - Cult-like followings
- Humorless

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Turmoil among our colleagues

- Protective of individual turf
- Start collecting allies
 - Battles, threats become our entertainment
- We all lose – but mostly the families we serve

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Beverly Malone

- We don't have to love our colleagues
- We don't even have to like them
- But, everyone we work with deserves non-negotiable respect

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Professionalism requires “non-negotiable respect”

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We have some choices

- Why are we in this profession?
- What makes us an expert, a professional?
- What is our message?
- How are we perceived?

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What do women want in healthcare?

- Care & Concern
- Women’s childbirth memories are taken to the grave with them
- We all have a chance to decide how we want to be remembered!

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Best Practice Requires an Empowerment model

- The mother as primary health care provider
- No one “owns” breastfeeding
 - Not the doctor
 - Not the nurse
 - Not the midwife
 - Not the lactation consultant

Parents need our help, support, not rules and authority

- Parents overwhelmed by new roles
- Parents overwhelmed by cultural dogma
- Parents overwhelmed by the breastfeeding dogma
- They need to be given caring, empowering messages that they can take care of their baby and still take care of themselves

Parents need protection

- When the system provides expertise, empowerment, support
 - Parents are able to to make good decisions
 - Intuition emerges
 - Confidence gained about decisions
 - Parents become strong advocates for child

Back to our origins?

- To be MOTIVATED, we must believe that what we do makes a difference...an opportunity worth reaching for.
