

Breastfeeding Your Baby

1: Establishing Breastfeeding

Breastfeeding is the natural, physiologic way of feeding, and usually should be easy. The vast majority of mothers are perfectly capable of breastfeeding their babies exclusively for 4 to 6 months. Unfortunately, outdated hospital routines based on bottle feeding have made breastfeeding difficult and sometimes impossible for some mothers and babies. For breastfeeding to get going properly, there is a right way to start off which can be crucial, though it will be admitted that some mothers and babies manage even if all the principles mentioned below are not followed.

Contrary to commonly held opinion, most mothers produce, or at least are capable of producing, plenty of milk. [An adequate intake of water; 2-3 quarts a day; is important] When the baby feeds frequently, or gains poorly, or loses weight the problems usually occur because he does not get the milk which is available. A baby who does not take (latch on to) the breast properly, may not get milk well, sometimes even when the mother's milk is abundant. The important aspects of starting off breastfeeding properly, basically meant to encourage the baby to latch on properly are the following:

1. The baby is put to the breast immediately after delivery. There is no reason why the vast majority of newborns cannot be put to the breast within 30 minutes or less of birth. Although most babies will not suckle immediately, most have a quiet alert period after delivery which lasts up to 2-3 hours, during which time they are especially ready to start nursing. It is best that the baby and mother stay together during this time so that both can learn how to breastfeed without pressure (this is a learning period for both mother and baby, (even if the mother has previously breastfed).

Some babies will not start to suckle for an hour or more after delivery. This is normal, but if the baby and mother are separated before the baby starts to take the breast some babies may not be inclined to suckle for many hours more. Unfortunately, some babies become sleepier and sleepier and become more reluctant to take the breast the longer they have not fed. Most, but not all, mothers and babies will learn even if the baby cannot go to the breast immediately, but it is better for all to start early since it is impossible to predict which baby will have difficulty from a delayed start. What a wonder it is to see a baby, only minutes old, crawl up from the mother's abdomen to her breast, and latch on and start nursing. This can only happen if the mother and baby are together.

2. The baby and the mother should room in together. There is absolutely no medical reason for healthy mothers and babies to be separated after birth. Rooming in means 24 hours a day, not during the day only. It is not true that the mother is better rested if the baby is kept in the nursery during the night. On the contrary, the mother tends to be better rested if the baby and she are together during the night. Indeed, the mother and baby learn how to sleep in the same rhythm, sleeping lightly and deeply during the same time periods. They get "into synch". Thus, when the baby starts waking for a feeding, the mother is also starting to wake naturally and

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feels less tired than if wakened abruptly from deep sleep. as might happen if the baby is brought to her from the nursery.

The baby indicates long before he starts crying that he is ready to feed. At first the baby will change his way of breathing. The mother will awaken with this very subtle change in the baby's breathing, her milk will have started to flow from this signal, and a calm baby and mother can start the feeding. If the baby is not picked up or fed with the change of breathing, other signals will follow, which again allow easy nursings. But if the baby is brought from the nursery angry, and howling, and the mother is wakened from a deep sleep to feed him, this does not allow for a relaxed feeding. In fact an angry baby, even if very hungry, may refuse to take the breast.

Artificial nipples must not be given the baby.

Sucking on a bottle nipple and suckling at the breast are completely different processes. Mothers produce little milk during the first few days, and this is as nature intended. If the baby gets a bottle, (as nature intended?), even of expressed breastmilk, he learns how to suck a bottle, which is not like breastfeeding. Breastfeeding may be completely derailed. Some babies learn both ways, but many do not, and the result is that the baby may refuse to take the breast. Some babies are reluctant to take the breast even if never given an artificial nipple and there are techniques (see page on Finger Feeding) which may overcome this reluctance. But if a baby is already reluctant to take the breast, then giving a bottle or pacifier will only make the situation worse, not better.

Even one bottle can do this, if given before breastfeeding has been well established or if difficulties are already present. The range of problems which may result from the early introduction of rubber nipples includes: breast refusal, poor weight gain, high bilirubin, and sore nipples and breast infection for the mother. It is surprising that some deny the existence of 'nipple confusion'. The same people would certainly agree that a baby may prefer one sort of rubber nipple over another; that a baby may take both breasts, but prefer one side over the other, that a baby would prefer the mother's easily grasped protruding nipple over her other flatish nipple. Almost every mother's nipples are flat compared to a bottle nipple. Why cannot a baby prefer a rubber nipple over the mother's nipple? It might be noted that often those who deny the possibility of nipple confusion advise the mother to start a bottle early so that the baby learns how to use one.

4. There should be no restriction on length of feedings or frequency of feedings. Since the beginning of human existence, mothers have breastfed without the "benefit" of watches. In many parts of the world this is still true, and mothers almost universally succeed at breastfeeding. Restricting breastfeedings does not prevent sore nipples. Preventing sore nipples requires getting the baby to latch on properly. (See page on Sore Nipples). More likely than not, restricting breastfeeding may actually cause sore nipples if restriction means giving the baby bottles or pacifiers. It is better to use a lactation aid (see page on Using a Lactation Aid) to supplement a little sugar water than to give a bottle or pacifier. If a baby is at the breast for long periods, he is probably not latched on properly.

5. Supplements of water, sugar water, formula are rarely required. However, if supplements are medically indicated (true indications for supplements are rare, though this would be difficult to

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appreciate from most hospital practices), they can be given by methods other than with a bottle. With a nipple. Cup feeding and finger feeding can be used if the mother and baby are separated for medical reasons. But separation should be for true medical reasons. New mothers should resist being discharged from hospital before their babies, for example, especially if it is thought that the baby will not be in hospital much longer. Supplements should be given by lactation aid if the mother and baby are together and is used in preference to other methods. (See on Finger Feeding, Using a Lactation Device). Most supplements could, nevertheless, be avoided by helping the baby latch on properly.

6. Proper positioning and latching are crucial to success. Proper positioning facilitates a good latch. Latching on of the baby correctly will almost always prevent nipple soreness. Proper latching on will also allow the baby to obtain milk properly thereby preventing all sorts of other problems. Proper latching on needs to be shown to you with your baby by someone who knows what they are doing. It is the single most important thing that needs to be shown the new mother, and should be done on the very first day (though not necessarily on the very first feeding). Squeezing the breast and inserting the nipple into the baby's mouth is exactly the wrong way of getting a baby onto the breast.

It is not true that there is no or not enough milk for the baby during the first few days until the milk 'comes in'. There is enough, but if the baby is not latched on properly, he cannot get it. If the baby is on the breast for very long periods of time, he is probably not latched on properly.

Before you leave the hospital, you should be shown that your baby is latched on properly, and that he is actually breastfeeding, and you should be shown how to know he is actually taking milk from the breast (and not just sucking on the breast which is very different).

7. Free samples of formula must not be given to pregnant women, new mothers, or their families. These 'gifts' are gifts only for the formula companies. Free samples undermine breastfeeding by undermining the mother's confidence in being able to breastfeed. The 'informational materials' contained within contain factual errors as well as subtle and not so subtle promotion of formula feeding and undermining of breastfeeding. They are worth only a few dollars to the family who may end up paying it back at very high interest.

Under some medical circumstances, it may be unavoidable that the baby is not with you 24 hours a day, or that breastfeeding may have to be delayed for hours or days, for example. However, many such medical reasons (mothers use of medication, for example), are not true reasons for delaying or stopping breastfeeding. Get information. A little resourcefulness may allow you to avoid delaying or stopping breastfeeding. If breastfeeding cannot be started, start pumping your breasts to provide colostrum and milk for your baby and to establish the milk supply. Get help. The above principles are true under almost all circumstances.

Many premature babies, for example, are not yet to suckle at the breast at birth, and, depending on their size may not be ready for several weeks. However, it has now been shown that premature babies are ready to breastfeed long before they are ready to bottle feed. Furthermore, it is less stressful for a Premature baby to breastfeed than to bottle feed.

Questions? (416)813-5757

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2: Sore Nipples

Introduction: The best treatment of sore nipples is prevention! The best prevention is latching the baby on properly from the first day.

Sore nipples are usually due to one or both of two cases. Either the baby is not positioned and latched properly, or the baby is not suckling properly, or both. On occasion a fungal infection (due to candida albicans) may also cause sore nipples. The soreness caused by the latching and ineffective suckle hurts most as you latch the baby on and usually improves as the baby nurses. The pain from the fungal infection goes on throughout the feed and may continue even after the feed is over. Women describe knife-like pain to the first two causes. The pain of the fungal infection is often described as burning but may not have this character. Sudden, unexplained onset of nipple pain when feedings had previously been painless, is a tip-off that the pain may be due to a yeast infection, but the pain may come on gradually or may be superimposed on pain due to other causes. Cracks may be due to a yeast infection.

PROPER POSITIONING AND LATCHING.

It is not uncommon for women to experience difficulty positioning and latching the baby on. Proper positioning facilitates a good latch and good latching reduces the baby's chances of becoming gassy, and also allows the baby to control the flow of milk. Thus, poor latching may also result in the baby not gaining adequately, or feeding frequently, or being colicky

POSITIONING-For the purposes of explanation, let us assume that you are feeding on the left breast. Good positioning facilitates a good latch. A lot of what follows under latching comes automatically if the baby is well positioned in the first place.

1. Hold the baby with his head resting on your forearm just to the right of your left elbow. Your left hand is on his diaper or thigh, and the baby is turned in towards you so that he is facing straight ahead and his chest, belly and thighs are against you. His mouth should be at the level of the nipple, slightly to the right (towards your midline) of the nipple (in other words, he will be positioned in such a way that once latched on, he will cover more of the areola with the lower lip than the upper). The baby should be almost horizontal across your body.

Hold the left breast with your right hand, the thumb on top of the breast and your fingers underneath the breast, well back from the nipple, so that you don't interfere with the baby getting on. Keep your hand close to your chest wall so your fingers do not block the baby's getting on well.

2. It is often easier, at first to hold the baby in your right arm, your hand supporting the baby behind the nape of his neck (not behind his head) with your fingers (except for the thumb)

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supporting the baby's face from underneath, and your forearm supporting his back and buttocks. Hold your baby's buttocks between your chest and your forearm—this should give you good control. The baby should be almost horizontal across your body and should be turned so that his chest, belly, and thighs are against you. Hold the breast with your left hand, with your thumb on top and your other fingers underneath, fairly far back from the nipple and areola.

3. The baby should be approaching the breast with the head just slightly tilted backwards. The nipple points to the roof of the baby's mouth.

4. Now, get the baby to open up his mouth wide. The way to do this is to run your nipple, still pointing to the roof of the baby's mouth, along the baby's mouth, very lightly, from one corner of the mouth to the other. Or you can run the baby along your nipple, something some mothers find easier. Wait for the baby to open up as if yawning. **WAIT FOR HIM.** As you bring the baby towards the breast his chin should touch your breast first

When the baby opens up his mouth, use the arm that is holding him to bring him onto the breast. Don't worry about the baby's breathing. If he is properly positioned and latched on, he will breathe without any problem. If he cannot breathe he will pull away from the breast. Don't be afraid to be vigorous.

If the nipple still hurts, use your index finger to pull down on the baby's chin in order to bring the lower lip out. You may have to do this for the duration of the feed, but this is usually not necessary.

5. The same principles apply whether you are sitting or lying down with the baby. Get the baby to open wide, don't let the baby latch onto the nipple, but get as much of the areola (brown part of the breast) into the mouth as possible. (not necessarily the whole areola).

6. There is no 'normal' length of feeding time.

7. A baby properly latched on will be covering more of the areola with his lower lip than with the upper lip.

IMPROVING THE BABY'S SUCKLE

The baby learns to suckle properly by nursing and by getting milk into his mouth. The baby's suckle may be made ineffective or not appropriate for breast feeding by the early use of artificial nipples or from poor latching on from the beginning. Some babies just seem to take their time developing an effective suckle. Suck training and/or finger feeding (see Finger Feeding) may help.

“My nipple turns white after the baby comes off the breast”

The pain associated with this blanching of the nipple is frequently described by mothers as 'burning', but generally begins only after the feeding is over. It may last several minutes or more, after which the nipple returns to its normal colour, but then a new pain develops which is usually described by Mothers as throbbing'. The throbbing part of the pain may last for seconds or minutes and may even blanche again. The cause would seem to be a spasm of the blood vessel in the nipple (when the nipple is white), followed by relaxation of these blood

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vessels (when the nipple returns to its normal colour). Sometimes this pain continues even after the nipple pain during the feeding no longer is a problem, so that the mother has pain only after the feeding, but not during it. What can be done?

1. Pay careful attention to getting the baby to latch onto the breast properly. This type of pain is almost always associated with, and probably caused by other types of nipple pain; as it usually develops after other types of pain. The best treatment is the treatment of the other causes of nipple pain.
2. Heat (hot washcloth, hot water bottle, hair dryer) applied to the nipple Immediately after nursing may prevent or decrease the reaction. Dry heat is usually better than wet heat because wet heat may cause further damage to the nipples.
3. On occasion, we have used a medicated paste which dilates blood vessels on the nipples to decrease the reaction.

General Measures.

1. Nipples can be warmed for short periods of time after each feeding, using a hairdryer on low setting.
2. Nipples should be exposed to air as much as possible.
3. When it is not possible to expose nipples to air, plastic dome-shaped breast shells (not nipple shields) can be worn to protect your nipples from rubbing by your clothing. Nursing pads keep moisture against the nipple and may cause damage that way. They also tend to stick to damaged nipples. If you leak a lot you can wear the pad over the breast shell.
4. Ointments can sometimes be helpful. If you do use an ointment, use just a very small amount after nursing and do not wash it off.
5. Do not wash your nipples frequently. Daily bathing is more than enough.
6. If your baby is gaining weight well, There is no good reason the baby must be fed on both breasts at each feeding. It may save you pain, and speed healing if you feed your baby on only one breast each feed. It will help to compress the breast (Breast Compression), once the baby is no longer swallowing on his own in order to continue his getting milk. You may be able to manage this some feedings but not others. In very difficult situations a lactation aid (see Using a Lactation Aid) can be used to supplement (preferably expressed milk), so that the baby will finish the feeding on the first side.

If you are unable to put the baby to the breast because of pain, In spite of trying all the above measures, It may still be possible to continue breastfeeding after a temporary (3-5 days) cessation to allow the nipples to heal. During this time, it would be better that the baby not be fed with a rubber nipple. Use the technique called 'finger feeding' (see Finger Feeding).

Nipples shields are not recommended for sore nipples, because, although they may help temporarily, they may not. They may also cut down the milk supply dramatically, and the baby may become fussy and not gain weight well. Once the baby is used to them, it may be

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impossible to get the baby back onto the breast. In fact many women who have tried nipple shields find that they do not help with soreness. Use as a last resort only, but get help first.

Questions? (416)813-5757

Colic in the Breastfed Baby

Colic is one of the mysteries of nature. Nobody knows what it really is, but everyone has an opinion. In the typical situation, the baby starts to have crying periods which begin about two to three weeks after birth, occur mainly in the evening, and finally stop when the baby is about 3 months of age (or older). When the baby cries, he is often inconsolable, though if he is walked, rocked or taken for a drive he may settle temporarily. For a baby to be called colicky, it is necessary he be gaining weight well and be otherwise healthy.

The notion of colic to be extended to include almost any fussiness or crying in the baby, and this may be valid, since we do not really know what colic is. There is no treatment for colic, though many medications and behaviour strategies have been tried, without any proven benefit. It is admitted that everyone knows someone whose baby was cured of colic by a particular treatment. It is also admitted that almost every treatment seems to work-for a short time, anyhow.

THE BREASTFEEDING BABY WITH COLIC

Aside from the colic that any baby may have, there are three known situations in the breastfed baby which may result in fussiness or colic. Once again, it is assumed that the baby is gaining adequately and that the baby is healthy.

1. Feeding Both Breasts at Each Feeding

Human milk changes during a feeding. One of the ways in which it changes is that the amount of fat increases as the baby longer at the breast. If the mother automatically switches the baby from one breast to the other during the feed, before the baby has 'finished' the first side, the baby may get a relatively low amount of fat during the feeding. This may result in the baby getting few calories, and thus feeding frequently. If the baby takes in a lot of milk (to make up for the reduced concentration of calories), he may spit up.

Because of the relatively low fat content of the milk the stomach empties quickly, and a large load of milk sugar (lactose) arrives in the Intestine all at once. The protein which digests the sugar (lactase) may not be able to handle so much milk sugar at one time and the baby will have the symptoms of lactose intolerance; crying, gas and explosive, watery, greenish bowel movements. This may occur even during the feeding. These babies are not lactose intolerant but may appear to be so because of the sort of information women get about breastfeeding.

There is no reason to time feedings. Mothers all over the world, since before watches were invented, have breastfed successfully without being able to tell time.

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The mother should feed the baby on one breast, as long as the baby breastfeeds, until the baby comes off himself, or is asleep at the breast. If the baby feeds for only a short time only, the mother can compress the breast (see 'Breast Compression') to keep the baby nursing.

Please note that a baby may be on the breast for two hours, but may actually feed for only a few minutes. In that case the milk taken by the baby may still be relatively low in fat.

This is the rationale for compressing the breast. If, after 'finishing' on the first side, the baby still wants to feed, offer the other side.

- c) The next feeding, the mother should start the baby on the other breast in the same way.
- d) The mother's body will adjust quickly to the new method, and she will not become engorged or lop sided.
- e) Just as there should be no 'rule' for feeding both breasts at each feeding, there should be no rule for one breast per feeding. Let the baby finish on one breast. (compress milk into his mouth if necessary to keep him swallowing longer) but if he wants more, then offer the other side.
- f) In some cases it may be helpful to feed the baby two or more feedings on one side before switching over to the other side for two or more feedings.
- g) This problem is made worse if the baby is not well latched on to the breast. A proper latch is the key to easy breast-feeding.

2. Overactive Letdown Reflex

A baby who gets too much milk too quickly, may become very fussy, very irritable at the breast and may be considered 'colicky'. Typically the baby is gaining very well. Typically also, the baby starts nursing, and after a few seconds or minutes, starts to cough, choke or struggle at the breast. He may come off, and often, the mother's milk will spray. After this, the baby frequently returns to the breast but may be fussy and repeat the performance. He may be unhappy with the rapid flow, and impatient when the flow slows. This can be a very trying time for everyone. On rare occasions, a baby may even start refusing to take the breast after several weeks, typically around three months of age.

What can be done.

- a) If you have not already done so, try feeding the baby one breast/feed. In some situations, feeding even two or three feedings on one breast before changing to the other breast may be helpful. If you experience engorgement on the unused breast, express just enough to feel comfortable.
- b) Feed the baby before he is ravenous. Do not hold off the feeding by giving water. (a breastfeeding baby does not need water even in very hot weather.) or a pacifier. A ravenous baby will 'attack' the breast and cause a very active let down reflex feed the baby as soon as he shows any sign of hunger. If he is still half asleep, all the better.
- c) Feed the baby in a calm relaxed atmosphere, if possible. Loud music, bright lights and lots of action are not conducive to a successful feeding.

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- d) Lying down to nurse sometimes works very well. If lying sideways to feed does not help, try lying flat on your back with the baby lying on top of you to nurse. Gravity helps decrease the flow rate.
- e) If you have time, express some milk (an ounce or so) before you feed the baby.
- f) The baby may dislike the rapid flow, but also become fussy when the flow slows too much. If you think the baby is fussy because the flow is too slow, it will help to compress the breast to keep up the flow.

This problem is made worse if the baby is not well latched on to the breast. A good latch is the key to easy breastfeedings

On occasion giving the baby commercial lactase (the enzyme that metabolizes lactose), 2-4 drops before each feeding, relieves the symptoms. It is available without a prescription, but fairly expensive, and does not always work.

A nipple shield may help, but use this only if nothing else has helped and only if you have gotten good help without any relief.

- g) As a last resort, rather than switching to formula, give the baby your expressed milk by bottle.

3. Foreign Proteins In the mother's milk

It has been shown that some proteins present in the mother's diet may be excreted into her milk and may affect the baby. It would seem that the most common of these is cow's milk protein. Other proteins have also been shown to be excreted into some mothers' milk. The fact that these proteins and other substances appear in the mother's milk is not necessarily a bad thing, and may even be a good thing. Ask about this if you have any questions.

Thus, in the treatment of the colicky breastfed baby, one step would be for the mother to stop taking dairy products. These include milk, cheese, yogurt, ice cream and anything else which may contain milk. When the milk protein has been changed (de-natured), as in cooking for example, there should be no problem.

Please note: Intolerance to milk protein has nothing to do with lactose" intolerance. A mother who is herself lactose intolerant should also still breastfeed her baby.

Suggested method

- a) The mother should eliminate all milk products for 7-10 days.
- b) If there has been no change, the mother can re-introduce milk products
- c) If there has been a change for the better, the mother should then slowly reintroduce milk products into her diet, if these are normally part of her diet. (There is no need to drink milk in order to make milk). Some babies tolerate absolutely no milk products in the mother's diet. Most tolerate some. The mother will learn what amount of dairy products she can take Without the baby reacting.

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d) If the amount of calcium taken by the mother is inadequate, her intake can be increased by diet or calcium supplements. One week off milk products will not cause any problems. Actually, evidence suggests that breastfeeding may protect the woman against the development of osteoporosis even if she does not take extra calcium. And the baby will get all he needs.

e) The mother should be careful about eliminating too many things from her diet. Everyone will know someone who's baby got better when the mother stopped broccoli, beef, bananas, onions etc. The mother may find that she is eating white rice only. Our diets are too complex to be sure exactly what if anything, is affecting the baby.

Be patient, the problem usually gets better anyhow. Formula is not the answer, though, because of the more regular flow, some babies do improve on it. But formula is not breastmilk. In fact the baby would also improve on breastmilk from the bottle because of the regularity of the flow. Even if nothing works, time usually helps. The days and nights may seem eternal, but the weeks will fly by.

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3. Crying and comforting

BY TERESA PITMAN

AT THE MOMENT OF BIRTH, the newborn's cry is the most beautiful sound her parents have ever heard: it tells them their baby has arrived, alive and well. But that cry the sound they looked forward to so eagerly during labour can become the source of much frustration, concern and exhaustion in the weeks and months that follow.

When I was a baby, my mother was sternly advised - as were most parents at that time - never to pick me up when I cried, unless it was at a scheduled feeding time. As instructed, she tucked me into bed and left the room. I cried. After a few minutes, minutes that seemed like hours, she felt physically unable to ignore the crying any longer. She had to go in and pick me up, even though it went against everything she had been told. That's how powerful a baby's cry can be. And that cry really does cause a physical reaction, at least in mothers. One study had first-time mothers listen to a recording of a hungry baby's cries and found a temperature change and increased milk flow in the mothers' breasts. A nursing mother often finds that her own baby's cry will cause the tingling sensation in her breasts that indicates her milk is 'letting down' while the noises of other babies have no effect.

But the reactions to a baby's cry aren't always positive. The screams can reach 84 decibels (approaching the intensity of factory noise or a riveter 30 feet away) and are pitched high enough to cut through most other sounds. And some babies cry for hours. Parents can find the crying unbearably stressful, become discouraged when their efforts to stop the crying fail; or experience frightening urges to violence. (One unfailingly gentle mother recalls holding her colicky baby extra-tightly during a late-night rocking session, after she suddenly imagined

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hurling the baby through the window.) That's one reason why it helps to know the resources and techniques available to reduce crying.

How much crying is normal, there is tremendous variation between babies.

Pediatrician and author T. Berry Brazelton found some infants cried as much as four hours per day. Other researchers, focusing on colicky babies, found the infants in their study cried an average of 2.6 hours each day. At the opposite end of the scale are the babies who cry for only a few minutes total in 24 hours.

While the temperament of the individual baby is certainly an important factor, the response of the parents can significantly reduce the amount of crying. Taubman (1984) divided the infants in his study into two groups. The parents of those in Group One received the following instructions, "When crying continues despite all efforts to stop it, including feeding:

1. Put baby in crib and let him cry for up to 30 minutes.
2. If still crying, pick baby up for a minute or so to calm him, then return him to crib.
3. Repeat until baby is asleep or three hours have passed.
4. After three hours, baby should be fed."

Parents in the second group were encouraged to try "never to let your baby cry," and received a list of suggested approaches to be used to comfort the baby. This group reduced the amount of crying from an average of 2.6 hours per day to 0.8 hours: the first group showed no decrease in the amount of crying.

The list of different approaches in that experiment was important. As one father explained, "No one thing works all the time." Babies have a very limited vocabulary, and it can be hard for new parents to interpret the different cries.

A pain cry is usually the easiest to identify. It begins suddenly and sounds shrill or shrieking. Often there is an agonizing pause when the baby runs out of air and before he can take his next breath.

The hunger cry tends to build up gradually and the pitch rises and falls in a sustained cry. The baby may pause frequently as though waiting for a response, and then cry again with greater intensity.

The anger cry is lower-pitched and hoarser in sound, and may start if hunger cries are ignored for some time, or if baby is feeling frustrated.

The bored or lonely cry is a low-pitched, murmuring sound; this one can also change to an angry sound if not responded to.

The tired cry of some babies sounds like a siren; others cry with shuddering sobs when they need to sleep.

Dr. William Sears, a California pediatrician and the author of *The Fussy Baby* (Plume Books, New American Library), recommends that parents not worry about trying to analyze their baby's cry. Sears says: "Act, don't think. Be spontaneous in responding to your baby's cries.

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When your baby cries, that first little blip that comes in on your radar system is your intuition. Follow your feelings and act immediately. Your first impulse will probably be the right one."

It can help, however, to have a repertoire of comforting responses for the times when your first attempts (or the first ten!) don't work. Soothing techniques fall into five general categories: - Eliminate any physical discomfort. Opened diaper pins are rare, but it's worth checking. Could threads in the toes of baby's sleeper be tangled around her toes? Is the elastic on her pants or sleeves too tight (babies grow more quickly than we expect, and the sleeper that fit last week may be unbearably tight today). Is a fold of skin caught in the fastenings?

Is she too hot or too cold? Babies normally have cool hands and feet, so feel the back of her neck to see if she is too cold or too warm. Generally, an infant should be dressed in as many layers as an adult - on a hot day, she may be most comfortable in just a diaper.

Does she have a diaper rash? Try removing the diaper for awhile, or letting her sleep on top of a diaper, with her bottom exposed to the air.

Is there a burp that needs to come up? Some babies are more difficult to burp than others. If leaning her against your shoulder and patting her back doesn't work, try sitting her upright on lap and bending her gently forwards, then upright again. Or put her in a baby carrier and rub or gently pat her back as you walk around.

Feed the baby. Yes, he might be hungry again. The average time between feedings for a breastfed baby is about two and-a-half hours, but many babies nurse more frequently. He may have fallen asleep before he was really finished, or the milk may have let down more slowly during his last feeding. Many nursing mothers offer the breast first when their small babies cry, only moving on to other responses when nursing doesn't work.

Bottle feeding mothers should also consider that their babies may be thirsty between feedings, particularly in hot weather, and offer a bottle of sterilized water.

Recreate the conditions of the womb. There are three parts to this, and you might try each separately or combine them.

Movement is very important for babies. Before birth, the fetus is in constant motion, and a number of studies have shown that babies gain weight better and are happier if they experience movement. Many parents develop a 'baby dance,' incorporating motion in all directions. With baby in his arms, a father may shift his weight from side to side, and jiggle the baby up and down at the same time. Rocking chairs have been popular for centuries because they provide similar motion.

The most effective speed for rocking, according to research by Dr. David Pederson at the University of Western Ontario, is the same as an average walking speed - the rhythm the baby became accustomed to before birth.

Taking the baby for a ride in a pram (preferably with bouncy springs) or stroller can also provide him with the movement he needs, and in this case a bumpy pavement works better than the smooth floor of the shopping mall. A ride in the car is often very soothing, because it adds sound to the steady motion. but it works best if you can find a highway or country road stopping and starting will wake the baby up again.

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Wind-up mechanical swings work well too. Many mothers with fussy babies find that the only way they can eat meals in peace is to settle baby in the swing, wind it up, and eat quickly.

Pad the swing carefully with a blanket or towel, because a small baby can easily fall forward or slip out of position.

The second component in this 'back-to-the-womb' approach is sound. The baby, before birth, could hear not only his mother's voice from time to time, but lived with a constant background of low, rhythmic sounds from her heart, digestive system and other internal organs.

Researchers have noticed that mothers instinctively hold their babies over their hearts and make soft 'shushing' sounds when they fuss. Singing lullabies or humming to the baby can be comforting. Other babies will stop crying when they hear the sound of the vacuum cleaner, dishwasher, or washing machine. You might try putting her in an infant seat on the bathroom floor while you have a shower - the sound of running water is soothing to many babies. Or try one of the tapes that play back the sounds baby heard before birth.

Finally, the baby in the womb experiences constant contact. After birth, the need for touching and holding remains very strong. In fact, studies of 'institutional' orphanages in Britain and the U.S. after World War II revealed that originally healthy babies who are fed and kept clean, but never held or touched, fail to thrive and may eventually die.

Some babies, when set down alone, have a very strong startle reflex' and will suddenly extend their arms and legs and cry as though they think they are falling. Swaddling the baby by wrapping him snugly in a blanket can reduce this reaction and help him relax.

Massaging the baby can also provide physical contact, and sometimes will help the baby's digestive system if she has a lot of intestinal gas. Massage will rarely stop crying if the baby is already very upset, but can be effective when she is just beginning to fuss.

Have a bath with the baby. The warm water is soothing for both of you, and the skin-to-skin contact will also be comforting.

Keeping the baby in your arms, letting him sleep on his father's chest, or using a baby carrier are good ways to recreate the womb.' A 1985 study by Hunziker and Barr found that carrying babies (either in the parents' arms or in a carrier) for three hours each day significantly reduced the amount of crying.

Provide stimulation. Some babies become bored very easily, and are frustrated because they have no way of relieving that boredom.

Take her with you as you go from room to room, and talk to her about what you are doing. Attach mirror tiles to the wall beside the change table so she can see herself at changing time. Go outside if the weather is good, or to an indoor shopping mall where she can be entertained by new things to see and hear.

(Babies can also be over-stimulated. One mother found that her fussing baby actually smiled before peacefully nodding off when she finally gave up on walking, rocking, and crooning and plopped him into his crib. If your baby is saying, "Put me down and let me sleep!" you'll quickly see signs of relief when you lay him down.) Sucking is very comforting for a baby, even if he is

Breastfeeding

not hungry - He may nurse even though his tummy is full and the breast is producing just a trickle of milk, because the sucking makes him feel better. While some parents dislike pacifiers (and many babies won't have anything to do with them), others find them very helpful. A breastfed baby who rejects the pacifier because he isn't used to the rubber nipple might be happy sucking on your finger or his own thumb. Be careful, though, that the pacifier isn't being used to stretch out the time between feedings, or your baby may not gain weight properly.

Dr. E. B. Thoman of the University of Connecticut found that prompt response to baby's crying is very important. The longer the parent takes to react, the longer the baby will cry afterwards. In fact, the critical time is just 90 seconds after that, baby will take much longer to settle down and be comforted.

This is one reason that many parents find it helps to keep baby close to them at night. If they can respond to the 'pre-cry signals' their baby makes (squirming, making little noises, sucking on her hands), she will quickly settle down and everyone can get back to sleep. The baby who sleeps down the hall must cry loudly enough to wake a parent, and continue crying until someone arrives and picks her up. This can mean a wide awake and hard-to-soothe baby.

What if these techniques don't work? Evenings seem to be particularly difficult for babies, and many have a fussy period when they seem to be inconsolable.

This is often the result of tension building up during the day, and the best cure is usually prevention. The research by Hunziker and Barr, for example, found that carrying the baby during the day - when she is content or even asleep - will dramatically reduce the amount of evening crying. A gentle massage or warm bath during the late afternoon can also help baby be happier throughout the evening.

And if you can't stop your infant's crying, you can at least 'be there' for her.

One mother listened to her favourite music through earphones while she walked with her fussing baby. Margaret Kirby spent many hours rocking her crying baby and found that "eventually, she began to relax and mould her body against mine. At least she knew I cared." You might lie your baby down on her stomach and pat her back gently if she seems unhappy yet resists being held.

Are you worried about spoiling your baby by comforting him when he cries?

Several studies (including Bell & Ainsworth, 1977) have shown that babies whose parents responded promptly to their cries actually cried less by one year of age than babies whose parents were restrained in their responses or let them 'cry it out.' The babies who received prompt responses also used more social signals such as gestures and vocalizations to communicate with others.

That research should remind us that crying is, after all, the baby's only way of communicating. As you continue to respond, you will improve your interpretation of your baby's individual language of crying. At the same time, she will develop trust in you, and will become more skillful at expressing her needs. And all the hours you have spent rocking, holding, and comforting your baby will form the foundation for the life-long relationship between parent and child.

Breastfeeding

Recommended Reading

The Fussy Baby- by William Sears.

Plume books, New American Library.

Crying Baby, Sleepless Nights, by Sandy Jones,

Warner Books.

4: COLIC

When a baby cries for long periods of time, day after day, and seems impossible to sooth, she may be described as 'colicky'. However, colic is like a headache—a symptom, not a diagnosis. — and, as with headaches, there may be several possible causes.

Allergies, particularly to cow's milk, often cause colic. Lothe (1982) found that 71% of colicky babies improved when changed to non-cow's milk formula. Breastfed babies may be reacting to something in the mother's diet (such as cow's milk). However, the nursing mother should get professional advice before restricting her diet.

Colic is more common in babies when one or both parents smoke.

Premature or small for date babies are more likely to be colicky and this may relate to an immature digestive system. Small , frequent feedings sometimes helps.

Physical problems such as bladder infections, ear infections, thrush, and diaper rash cause some cases of colic.

Some babies are unusually sensitive to stimulation and find it very difficult to 'wind down' once they are upset. These babies benefit from the prevention techniques—carrying during the day—and prompt response to fussing described in the article.

In severe cases of colic, your physician may prescribe medication to relax the baby's muscles and reduce spasms in his digestive tract.

BUT IT'S DRIVING ME CRAZY!

No sound is harder to listen to than a crying baby—especially if it's your baby and you can't seem to comfort him.

Take the time to comfort yourself too.

Remind yourself that it isn't your fault and you are doing the best you can.

Remind yourself that this is only temporary and will improve within a few months.

Sleep whenever the baby sleeps.

Go out (with baby) every day, even if it's just a walk around the block or to the store.

Take turns with your spouse or a sitter so that you can have a relaxing, bath or eat a meal without interruption (wear earphones if you can't relax while hearing the baby;

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Ask for help from family and friends - a meal brought in, a load or two of laundry washed, a back-rub when you're feeling tense, a listening-ear when you need to talk. You need nurturing too.

Make sure you are eating well – you need all the energy you can get.

Get to know other parents who will share their experiences with you. Remember, though, that you know yourself and your baby best and take only the advice that you feel is right.

If you are afraid you will hurt or neglect your baby, get help immediately. Most communities have a Parents Anonymous, Parental Stress or similar phone service. Your doctor or public health nurse may also be able to help you.

Teresa Pitman, the mother of four children, teaches childbirth preparation classes, counsels breastfeeding mothers and is a freelance writer.

5. Finger Feeding

Introduction

Finger feeding is a technique which allows you to feed the baby without giving the baby an artificial nipple. Finger feeding is also a method which helps train the baby to take the breast. If you want to breastfeed successfully, it is better to avoid the use of artificial nipples before breastfeeding is well established. Finger feeding may be used if-

1. The baby refuses the breast for whatever reason, or if the baby is too sleepy at the breast to nurse well.
2. The baby does not seem to be able to latch on to the breast properly, and thus does not get milk well. (If a lactation aid can be used at the breast, it is better not to use finger feeding).
3. The baby is separated from the mother, for whatever reason.
4. Breastfeeding is stopped temporarily (there are very few legitimate 'reasons to stop breastfeeding).
5. Your nipples are so sore that you cannot put the baby to the breast; Finger feeding for several days may allow your nipples to heal without causing more problems by getting the baby used to an artificial nipple. This is only a last resort. Proper positioning and a good latch help sore nipples far more frequently than finger feeding (Handout - Sore Nipples).

Finger feeding is much more similar to breastfeeding than bottle feeding is. In order to finger feed, the baby must keep his tongue down and forward over the gums, the mouth wide open (the larger the finger the better), and the jaw forward. Furthermore, the motion of the tongue and jaw is similar to what the baby does while feeding at the breast. Finger feeding is best used to prepare the baby to take the breast. Cup feeding is usually easier and faster when the mother is not present to feed the baby.

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Please Note: If the baby is taking the breast, it is better by far to use the lactation at the breast, if supplementation is truly necessary (See- Using a Lactation Aid).

Finger Feeding (best learned by demonstration)

1. Wash your hands. Make sure that the finger nail on the finger you will use has been cut short.
2. It is best to position yourself and the baby comfortably. The baby's head should be supported with one hand behind the shoulders, the baby should be on your lap, half seated, and facing you. Any position which is comfortable, however, will do.
3. You will need a lactation aid, made up of a feeding tube (#5F, 36" long), and a feeding bottle with expressed breast milk, sugar water, or formula, depending on the circumstances. The feeding tube is passed through the enlarged nipple hole into the fluid.
4. Line up the tube so that it sits on the soft part of your index (or other) finger. The end of the tube should line up no further than the end of your ringer. It is easiest to grip the tube, about where it makes a gentle curve, between your thumb and middle finger and then position your index finger under the tube. If this is done properly, there is no need to tape the tube to your finger.
5. Using the finger with the tube, tickle the baby's lips lightly, until the baby opens up his mouth enough to allow your finger to enter. If the baby is very sleepy, but needs to be fed, the finger may be gently insinuated into his mouth. Generally, the baby will begin to suckle even if asleep, and receiving liquids will then awaken him.
6. Insert your finger with the tube so that the soft part of your finger remains upwards. Keep your finger as flat as possible. Usually the baby will begin sucking on the finger, and allow the finger to enter quite far. The baby will not usually gag on your finger even if it is in his mouth quite far, unless the baby is full or used to bottles.
7. Pull down the baby's chin, if his lower lip is sucked in.
8. The technique is working if the baby is drinking. If feeding is very slow, you may raise the bottle above the baby's head. Try to keep your finger straight, flattening the baby's tongue. Try not to point your finger up, but keep it flat, thus keeping down the baby's tongue and working the lower jaw forward.
9. The use of finger feeding with a syringe to push milk into the baby's mouth, is, in my opinion, too difficult and definitely not more effective than simply using a bottle with the nipple hole enlarged and the tube coming from it.

If you are having trouble getting the baby to latch on to or to suckle at, the breast, remember that a ravenous baby can make the going very difficult. Take the edge of his hunger by using the finger feeding technique for a minute or so minute. Once the baby has settled a little, and sucks well on your finger (usually only a minute or so), try offering the breast again. If you still encounter difficulty, do not be discouraged. Go back to finger feeding and try again later in the feed or next feeding. This technique usually works. Sometimes several days, or on occasion a week or more, of finger feeding are necessary, however.

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If you are leaving the hospital finger feeding the baby, make an appointment with the clinic within a day or so of discharge. The earlier the better.

Once the baby is taking the breast, he may still require the lactation aid to supplement for a period of time. Although the baby may take the breast, the suckle may still not be efficient enough to ensure adequate intake.

Questions? (416) 813-5757

HO #8 Finger Feeding Revised November 1995

Written by Jack Newman, MD, FRCPC

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6. Using Gentian Violet

Gentian violet (0.5-1% solution in water) is an excellent treatment for *Candida albicans*. *Candida albicans* is a yeast which may cause an infection of skin and/or mucous membranes in both children and adults. In small children, this yeast may cause white patches in the mouth (thrush), or diaper rash. When the nursing mother has a yeast infection of the nipple, she may experience severe nipple pain.

Nipple pain caused by *Candida albicans*

The pain caused by a yeast infection is generally different from the pain caused by poor positioning and/or ineffective suckling. The pain caused by a yeast infection-

1. Is often burning in nature, rather than the sharp, stabbing or pinching pain associated with other causes. Burning pain may be due to other causes, however, and pain due to a yeast infection does not necessarily burn.
2. frequently lasts throughout the feeding, and occasionally continues after the feeding has ended. This is in contrast to the pain due to other causes which usually hurts most as feeding begins, and gradually improves as the baby nurses.
3. may radiate into the mother's armpit or into her back.
4. may cause no change in appearance of the mother's nipples or areolas, though there may be redness or some scaling.
5. not uncommonly will begin after a period of pain free nursing. This characteristic alone is reason enough to try treatment for yeast.
6. may be associated with recent use of antibiotics by, the baby or mother, but not necessarily.
7. may be quite severe, may or may not be itchy.

Please note-

- a) The baby does not have to have thrush in his mouth.

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b) A yeast infection of the nipple may be combined with other causes of soreness.

Using Gentian Violet

We believe that gentian violet is the best treatment of nipple soreness due to *Candida albicans* for the breastfeeding mother. This is because it works almost always, and relief is rapid. It is messy, and will stain clothing, but not skin. The baby's lips will turn purple, but the purple will disappear after a few days. Gentian violet is available without prescription but is not available at all pharmacies. Call around before going out to get it

- 1) About 10 ml (two teaspoons) of gentian violet is plenty for an entire treatment.
- 2) Many mothers prefer doing the treatment just before bed so that they can keep their nipples exposed and not worry about staining their clothing.
- 3) Dip an ear swab (Q-tip) into the gentian violet
- 4) Put the purple end of the ear swab into the baby's mouth and let him suck on the swab for a few seconds. The gentian violet usually spreads around the mouth quickly. If it does not, paint the inside of the mouth to cover as much of the inside of the cheeks and tongue as possible.
- 5) Put the baby to the breast; in this way, both the baby's mouth and your nipple are treated.
- 6) If the baby nursed on both breasts after his mouth was treated with gentian violet, there is no need to treat again that day. If he nursed on only one breast, you should repeat the treatment for the other breast. At the end of the day, the baby has a purple mouth and you have two purple nipples.
- 7) Treat each nipple as above once a day for three days.
- 8) There is often some relief within hours of the first treatment, and the pain is usually gone or virtually gone by the third day. If it is not, it is unlikely that candida was the problem. Of course there may be more than one cause of nipple pain, but after three days the contribution to your pain caused by *Candida albicans* should be gone. Do not continue the gentian violet if no relief occurs after 3 days of treatment, instead, get more information.

All artificial nipples that the baby uses should be boiled daily during the treatment, or well covered with gentian violet. Consider stopping artificial nipples.

There is no need to treat just because the baby has thrush in his mouth. The reason to treat is the mother's and/or the baby's discomfort. Babies, however, do not commonly seem to be bothered by thrush.

If the infection recurs, treatment can be repeated as above. But if the infection recurs a third time, a source of re-infection should be sought out. The source may be the mother who may be a carrier for the yeast (but may have no sign of infection elsewhere), or from artificial nipples the baby puts in his mouth. Treatment of the mother (usually with a medication other than gentian violet) at the same time as treatment is repeated for the nipples will usually eliminate re-infection.

Questions? (416) 813-5757 Written by Jack Newman MD, FRCPC

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7. Breastfeeding and Jaundice

Introduction

Jaundice is due to a buildup of bilirubin, a yellow pigment which comes from the breakdown of old red blood cells. It is normal for red blood cells to break down, but the bilirubin formed does not usually cause jaundice because the liver metabolizes it and gets rid of it into the gut. The newborn baby, however, often becomes jaundiced during the first few days because the liver enzyme which metabolizes bilirubin is relatively immature. Furthermore, newborn babies have more red blood cells than adults, and thus more are breaking down at any one time. If the baby is premature, or stressed from a difficult birth, or more than the usual number of red blood cells are breaking down (as happens in blood incompatibility), the level of bilirubin in the blood may rise quite high.

Two Types of Jaundice

The liver changes bilirubin so that it can be eliminated from the body. If, however, the liver is functioning poorly, as occurs during some infections, or the tubes which transport the bile in which the bilirubin is dissolved are blocked, this changed bilirubin may accumulate in the blood and also cause jaundice. When this occurs, the changed bilirubin (conjugated bilirubin), appears in the urine and turns the urine brown. This brown urine is an important clue that the jaundice is not 'ordinary'. Jaundice due to conjugated bilirubin is always abnormal, frequently serious and needs to be investigated thoroughly. Except in the case of a few extremely rare metabolic diseases, breastfeeding can and should continue.

Accumulation of bilirubin before it has been changed by the enzyme of the liver may be normal 'physiologic jaundice. Physiologic jaundice begins on the 2nd or 3rd day, peaks on the 3rd or 4th day and then begins to disappear. However, there may be other conditions which cause an exaggeration of this type of jaundice, such as a more rapid than normal breakdown of red blood cells. Because these conditions have no association with breastfeeding, breastfeeding should continue. If, for example, the baby has severe jaundice due to rapid breakdown of red blood cells, this is not a reason to take the baby off the breast. Breastfeeding should continue.

Breastmilk Jaundice

There is a condition called breastmilk jaundice. No one knows what the cause of breastmilk jaundice is. In order to make this diagnosis, the baby should be at least a week old, though interestingly, many of the babies with breastmilk jaundice also have had physiologic jaundice, sometimes to levels higher than usual. The baby should be gaining well, with breastfeeding alone, having lots of bowel movements, passing plentiful, clear urine and be generally well. In

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such a setting, the baby has breastmilk jaundice, though, on occasion, infections of the urine or an underfunctioning of the baby's thyroid gland may cause the same picture.

Breastmilk jaundice peaks at 10-21 days, but may last for 2-3 months. Breastmilk jaundice is normal. Rarely, if ever, does breastfeeding need to be discontinued even for a short time. There is not one bit of evidence that this jaundice causes any problem at all for the baby.

Breastfeeding, should not be discontinued 'in order to make a diagnosis'. If, however, your doctor feels that discontinuing breastfeeding is appropriate, it would be worth trying a lactation aid with formula rather than taking the baby off the breast altogether, since this may result in difficulties with breastfeeding afterwards. However, the notion that there is something wrong with the baby being jaundiced comes from the assumption that the formula feeding baby is the standard by which we should determine how the breastfed baby should be.

This manner of thinking, almost universal amongst health professionals, truly turns logic upside down. Thus, the formula feeding baby is rarely jaundiced after the first week of life, and when he is, there is usually something wrong. Therefore, the baby with breastmilk jaundice is a concern and 'something must be done'. However, in our experience, most exclusively breastfed babies who are perfectly healthy and gaining weight well are still jaundiced at 5-6 weeks of life and even later. The question, in fact should be whether it is normal not to be jaundiced and is this absence of jaundice something we should worry about?

Not-enough-breastmilk Jaundice

Higher than usual levels of bilirubin or longer than usual jaundice may occur because the baby is not getting enough milk. This may be due to the fact that the mother's milk takes a longer than average time to 'come in'. or because hospital routines limit breastfeeding or because the baby is poorly latched on and thus not getting enough milk. When the baby is getting little milk, bowel movements tend to be scanty and infrequent so that the bilirubin that was in the baby's gut gets reabsorbed into the blood instead of leaving the body with the bowel movements.

Obviously, the best way to avoid 'not enough breastmilk jaundice' is to get breastfeeding started properly. However the answer to not enough breastmilk jaundice, is not to take the baby off the breast or to give bottles. If the baby is nursing well, more frequent feedings may be enough to help' If the baby is nursing poorly, helping the baby latch on better may allow him to nurse more effectively and thus receive more milk. Compressing the breast to get more milk into the baby may help. If latching and breast compression alone do not work, a lactation aid would be appropriate to supplement feedings.

Phototherapy (Bilirubin Lights)

Phototherapy increases the fluid requirements of the baby. If the baby is nursing well, more frequent feeding can usually make up this increased requirement. However, if it is felt that the baby needs more fluids, use a lactation aid to supplement, preferably expressed breastmilk or sugar water rather than formula.

8. You Can still Breastfeed

Introduction

Over the years many women have frequently been wrongly told to stop breastfeeding. The decision about continuing breastfeeding when the mother must take a drug, for example, involves more than consideration of whether the medication appears in the mother's milk. It also involves taking into consideration the risks of formula feeding, which are substantial, the risks of not breastfeeding for the mother, which are substantial, and other issues as well. For example, feeding a breastfeeding baby by bottle for the time the mother is on medication (rarely less than 5 days), Will usually result in the baby refusing the breast forever. On the other hand, It should be taken into consideration that some babies just will not take bottles, so the advice to stop is not only usually wrong, it is impractical as well. Furthermore it is easy to advise the mother to pump her milk when she is not feeding the baby, but adequate pumping is often very difficult to do for some mothers, With the result that the mothers may become very painfully engorged which may further lead to serious complications.

Breastfeeding and Maternal Medication

Most drugs appear in the milk but only in very tiny amounts. Although a very few drugs may still cause problems for infants even in tiny doses, this is not the case for the vast majority. Mothers who are told they must stop breastfeeding because of a certain drug should ask to be prescribed an alternative medication which is acceptable for breastfeeding mothers. It should rarely, if ever, be a problem to find such an alternative. If the prescribing physician does not know how to proceed, she should get more information. If the prescribing physician is not flexible, the mother should seek another opinion.

Most drugs may be considered safe for the mother to take and continue breastfeeding if:

1. they are commonly prescribed for infants. Examples are amoxicillin, doxycillin, most antibiotics.
2. they are considered safe in pregnancy- Drugs enter directly into the bloodstream when used during pregnancy. The baby generally gets much higher doses at a much more sensitive period during pregnancy, than during breastfeeding.

This is not an absolute however, as during pregnancy, the mother's liver and kidneys will get rid of the drug.

3. they are not absorbed from the stomach or intestines, These include many drugs which are given by injection. Examples are gentamicin, heparin, lidocaine or other local local anesthetics used by dentists

The following frequently used drugs are also generally safe during breastfeeding- acetaminophen, Tempra, alcohol (in reasonable amounts), aspirin, (in usual doses), most anti-epileptic medication, most anti-hypertensive medications, tetracycline, codeine, most non-steroidal anti-inflammatory medications, prednisone, thyroxin, propylthiouracil (PTU), warfarin, tricyclic antidepressant medications, fluoxetine (Prozac),metronidazole (Flagyl),Nix,Kwellada.

Breastfeeding

- Medications applied to the skin, or into the eyes or nose are almost all safe for breastfeeding.
 - You can still breastfeed after general, regional or local anesthesia. As soon as you are up to it. Medications you might take for pain are almost always permitted.
 - Immunizations given to the mother do not require her to stop breastfeeding (including with live viruses such as German measles, Hepatitis A and B).
- Get reliable information before stopping breastfeeding. Once you have stopped it may be very difficult to restart, especially if the baby is very young.

Breastfeeding and maternal illness

Very few maternal illnesses require the mother to stop breastfeeding. This is particularly true of infections. Most infections are caused by viruses. Most infections caused by viruses are most infectious before the mother realizes she is sick. By the time the mother has fever (or cold, runny nose, diarrhea, vomiting, rash etc), she has already passed on the infection to the baby. However, breastfeeding protects the baby against infection, and the mother should thus continue breastfeeding. If the baby gets sick he usually is less sick than if breastfeeding had stopped. But often mothers are pleasantly surprised that their babies do not get sick at all. The baby was protected by his mother's continuing breastfeeding.

The only exception to the above is HIV infection in the mother. Until we have more information, it is considered safer for the baby that the mother who is HIV positive not breastfeed, at least where the risks of bottle feeding are acceptable. There are situations, however, even in Canada, where the risk of not breastfeeding is elevated enough that the mother who is HIV positive should nevertheless breastfeed her baby. The final word is not in, however.

Most other maternal illnesses raise questions because of the drugs the mother might have to take. These should rarely be a problem (see above)

X-rays and scans: Ordinary X-rays do not require a mother to stop breastfeeding even when used with contrast (eg. IVP). A CT scan, MRI scan, even when used with contrast do not require a mother to stop. A radioactive scan (eg. lung scan, bone scan) does not require a mother to stop. The only exception is a thyroid scan. However, most of the time the scan does not have to be done. See below.

A not uncommon problem in the early months after delivery is a condition called postpartum thyroiditis, a temporary derangement in the thyroid gland's function. It is felt by some physicians that a useful test to do to help the condition is a thyroid scan. However, the test requires 04 radioactive iodine be given to the mother and this material must not be given to nursing mothers. The radioactive iodine will be found in the milk for weeks, and concentrated in the baby's thyroid. There are ways of dealing with postpartum thyroiditis without doing this test. The drugs a mother might have to take to treat postpartum thyroiditis are compatible with continued breastfeeding (e.g. propranolol, propylthiouracil)

Breastfeeding

Breast Problems

Mastitis (breast infection) and breast abscess are not reasons to stop breastfeeding. Although surgery on a lactating breast is more difficult the surgery does not necessarily become easier if the mother stops breastfeeding, as milk continues to be formed for weeks after stopping breastfeeding.

Mammograms are more difficult to read if the mother is breastfeeding, but can still be useful. Once again, how long must a mother wait for her breast no longer to be considered lactating? Evaluation of a lump can be done by other means besides mammography. Discuss options with your doctor. Let him/her know breastfeeding is important to you.

New Pregnancy

There is no reason that you cannot continue breastfeeding if you become pregnant. There is no evidence that this does any harm to you, to the baby in your womb or to the one who is nursing. If you wish to stop breastfeeding, take your time and wean slowly.

Infant Problems

Breastfeeding rarely needs to be discontinued for infant illness. Through breastfeeding, the mother is able to comfort the sick child, and, at the same time, the child is able to comfort the mother.

1. Diarrhea and vomiting intestinal infections are rare in exclusively breastfed babies. (Though loose bowel movements are very common in exclusively breastfed babies). The best treatment for this condition if the baby gets it is to Continue breastfeeding. The baby will get better more quickly on breastmilk. The baby will do well with only breastmilk in the vast majority of situations, and will not require added fluids except in extraordinary cases.
2. Respiratory illness There is a medical myth that milk should not be given to children with respiratory infections. Whether this is true or not for milk it is definitely not true for breastmilk which is not the same thing.
3. Jaundice Exclusively breastfed babies are commonly jaundiced, even until the 3rd month, though generally the yellow colour of the skin is hardly noticeable. Rather than being a problem, this is normal. (There are cases of jaundice which are not normal, but these do not require stopping breastfeeding). If breastfeeding is going well, jaundice does not require the baby to stop breastfeeding. If breastfeeding is not going well, fixing the breastfeeding will improve the jaundice, whereas stopping the breastfeeding even for a short time may completely destroy the breastfeeding. Stopping breastfeeding is not the answer.

Questions? (416)813-5757

9. Using a Lactation Aid

Introduction

A lactation aid is a device which allows a breastfeeding mother to supplement her baby with expressed breastmilk, formula or glucose water (glucose water should only be used usually in the first day or two after birth) without using an artificial nipple.

The early use of an artificial nipple may result in the baby becoming 'bottle spoiled' or 'nipple confused' because it interferes with the way a baby latches on to the breast. The better a baby latches on, the easier it is for him to get milk. If the baby does not get milk well from the breast, he may fall asleep or push away from the breast when the flow of milk slows down. Thus the baby may refuse the breast, be very fussy at the breast, gain weight poorly, lose weight or even become dehydrated. The mother may develop sore nipples.

Though artificial nipples do not always cause problems, their use when things are already going badly will rarely make things better, and usually make things worse. The lactation aid is by far the best way to supplement, if the supplement is truly necessary. (However, proper latching on of the baby usually allows the baby to get more milk, and thus it is often possible to avoid the supplement). It is better than using a syringe, cup feeding, finger feeding or any other method, since the baby is at the breast and breastfeeding. Babies (adults too) learn by doing.

Furthermore, the baby supplemented at the breast is also getting breastmilk from the breast.

A lactation aid consists of a source of fluid-usually a feeding bottle with an enlarged nipple hole-and a long, thin tube leading from this bottle. . Manufactured lactation aids are available and are easier to use in some situations, but not necessarily so. Manufactured lactation aids are particularly useful when the need for a lactation aid arises in an older baby, when a mother needs to supplement twins, when the need for a lactation aid will be long term, or whenever difficulty arises using the improvised lactation aid. Though the manufactured lactation aid is not inexpensive, the cost amounts to about equal to 3 weeks of regular milk based formula.

Please Note- Using a tube with a syringe, with or without a plunger, instead of a bottle you can simply place on a table beside you, is unnecessarily complicated and seems to add nothing to the effectiveness of the technique. On the contrary, it is more cumbersome, and often this will discourage mothers from Continuing.

Using the Lactation Aid (Improved)

The baby may be latched on to the breast first, and the tube slipped into the baby's mouth at the appropriate time. The better the latch, the better the baby will get your milk and the easier the aid will be to use. The breast should be gently moved so that the corner of the baby's mouth is seen, and the tube, held between the index finger and thumb, should be slipped into the baby's mouth when the tube is flush with the corner of the baby's mouth. Aim towards the roof of the baby's mouth. The tube is well placed when the supplemental fluid works its way down the tube at a rather rapid rate. There is usually no need to fill the tube with supplemental fluid before putting it into the baby's mouth.

Breastfeeding

2. Or, the baby is latched on to the breast and the tube, which is run along the mother's breast and nipple, at the same time. The better the baby's latch, the easier the lactation aid is to use. Also, the better the latch, the more likely and the more rapidly the baby will be able to do without the lactation aid. Therefore, proper positioning and latching on of the baby are very important.

3. The tube may be taped to the breast if the mother desires, though this is not really necessary and not always helpful.

4. The tube should not pass the end of the nipple and needs to be only just past the baby's gums to function properly. It does seem to function better if the tube is placed in the corner of the baby's mouth and enters straight into the baby's mouth over the tongue. (Point it to the roof of the baby's 'mouth). - It may be helpful for the mother to hold the tube in place with her finger, as some babies tend to push the tube out of position with their tongues.

5. The bottle containing the supplemented fluid should not ordinarily be higher than the baby's head. Keep the bottle higher only if instructed by the doctor or nurse. You may be advised to lower the bottle to favour intake of breastmilk over fluid from the bottle.

6. Unless otherwise instructed, it is best to use the tube with every feed, though some mothers find it easier not to use it during the night

7. Do not cut off the end of the tube. It works fine as it is.

8. It should not take an hour for the baby to drink an ounce of milk from the lactation aid. If it is taking this long, the tube is probably not well positioned, or the baby is poorly latched on, or both. When the lactation aid is functioning well, it takes 15-20 minutes, or less, for the baby to take an ounce of the supplement.

Cleaning the Device

1. Do not boil the tube of the non-manufactured aid. It is not made to be boiled.

2. After using the device, clean the bottle and nipple as usual. Do not boil the tube. The tube should be emptied after use and then rinsed through with hot water (suck up hot water into the tube from a cup) and then hung up to dry. Soap, though not necessary, may be used if desired, but rinse the tube well. Tubes may become stiff and unsuitable for use after about a week.

Weaning the Baby from the Lactation Device

1. Maintain contact with the breastfeeding clinic for advice about weaning the baby from the lactation aid.

Weaning the baby from the aid may take several weeks or only a short while. Do not be discouraged and do not try to force the weaning. Usually, the amount of milk required in the lactation aid increases over 1-2 weeks, then levels out for a variable period of time before decreasing. The whole process may take 2-8 weeks, although some mothers have used the device only a few days, whereas others have not been able to stop it at all. Rapid improvement sometimes occurs after a long period of little change.

Breastfeeding

Observe the baby's nursing. If you do not know how to know if the baby is drinking, ask. Put the baby onto the breast, allow the baby to nurse as long as he is suckling and drinking, then use breast compression to keep the baby drinking; then repeat the process on the second breast. You can return to the first breast and continue back and forth as long as the baby is drinking. After you have finished feeding at least on both breasts, insert the tube into the baby's mouth. Allow the baby to nurse until satisfied using the lactation aid.

4. The bottle can be lowered 6-12 inches below the baby's head, but do this only if the baby is drinking milk from the bottle very quickly.

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10. Breast milk Collection and Storage

Guidelines For Normal Newborns

Collecting Breast Milk

First, wash hands well.

Wash breast pump equipment that contacts the breast, milk, or collection containers in a dishwasher or by hand in hot, soapy water. Rinse with cold water, and air dry on a clean towel. Check with your hospital or doctor for any other instructions.

When to pump depends on you and your baby's schedule. Try to pump when the baby would normally breastfeed. Your milk supply usually is most plentiful in the morning, so that is a good time.

Be flexible. If your baby skips a feeding, nurses a shorter time than usual, or only nurses on one side, pump out the rest of the milk and save it.

Before pumping, get comfortably seated and relaxed. Pump your breasts according to the breastpump manufacturer's instructions.

Storage

There are several containers available for storing breast milk. These include specially designed plastic bags, plastic bottles or glass containers. There are advantages to each.

1. If you are going to freeze your breast milk, leave some space at the top of the container. Breast milk, like most liquids, expands as it freezes.
2. When using plastic bags, use those designed for breast milk collection. Before storing, fold the top several times and seal with freezer or masking tape. Place smaller bags in a larger bag to help protect against punctures. Medela's CSF bags come with twist ties for easy sealing and don't need to be double bagged.

Breastfeeding

4. Freeze your milk in two ounce to four ounce portions. Smaller amounts thaw quicker, and you will waste less milk if your baby consumes less than you anticipated.
5. You may continue to add small amounts of breast milk to the same container throughout the day. Chill in the refrigerator until evening. Then, freeze in appropriate amounts.
6. You may also add to already frozen milk. First refrigerate all freshly expressed milk until cold, and then add to the frozen milk. The newly added milk must be of a lesser amount than the already frozen milk.
7. If you carefully washed your hands before pumping or expressing, your breast milk will be safe for a few hours at room temperature, 68°F. Immediate refrigeration, however, is recommended.
8. Fresh milk may be stored in the refrigerator for up to 72 hours at 39°F.
9. Frozen milk may be stored in the back of the freezer portion of a refrigerator-freezer for up to six months'.
10. Frozen milk may be stored in a -20°F deep freezer for up to 12 months'.
11. Defrosted milk may be kept for up to 24 hours in the refrigerator'.

Storage Guidelines

Defrosting

To defrost frozen milk: Place milk in refrigerator the night before you're going to use it. Refrigerator defrosting takes 12 hours.

OR place the milk under warm running water or in a pan of warm water. Don't use hot water, as this can destroy some of the milk's immunological components.

Caution: Never microwave breast milk! Microwaving breast milk can change the milk's composition, and has the potential to burn your baby.

Fat in breast milk will separate and rise to the top. By gently swirling the container, you can mix any fat that may have separated.

Never refreeze thawed breast milk.

Remember, the color, consistency and odor of your breast milk may vary depending upon your diet.

Barger j and Bull P: A Comparison of the Bacterial Composition of Breast Milk

Discard any breast milk you don't use during a feeding.

Intake Guidelines

How much breast milk should you leave for your baby for each feeding? That depends on the individual infant, but here are some guidelines'.

Breastfeeding

Average intake by age:

0-2 months 2-5 oz. per feeding

2-4 months 4-6 oz. per feeding

4-6 months 5-7 oz. per feeding

Average intake by weight:

8 lbs. 21.3 oz. in 24 hours

9 lbs. 24.0 oz. in 24 hours

10 lbs. 26.7 oz. in 24 hours

11 lbs. 29.3 oz. in 24 hours

12 lbs. 32.0 oz. in 24 hours

14 lbs. 37.3 oz. in 24 hours

16 lbs. 42.7 oz. in 24 hours