

Breastfeeding: What You—and Your Patients—Need to Know

Provide both prenatal education and peripartum support

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Despite compelling scientific evidence of the crucial importance of breastfeeding to maternal and child health, bottle-feeding is the norm in the United States. In this country, 40% of infants never taste their mothers' milk, and 80% are bottle-fed by the time they reach the age of 6 months.¹ However, bottle-feeding is, at best, a barely adequate substitute for breastfeeding. The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding of infants for the first 6 months after birth; it also advocates that breastfeeding be continued for at least an additional 6 months while solid foods are added.²

We primary care providers have the opportunity to influence the infant feeding decision positively, but we must do more than say "breast is best." We must:

- ◆ Enthusiastically promote breastfeeding.
- ◆ Provide accurate information about breastfeeding.
- ◆ Understand the many social and cultural barriers to breastfeeding that a woman may face.
- ◆ Offer compassionate support.

Unfortunately, surveys have shown that many clinicians are ill-prepared to provide lactation management as part of routine care for pregnant women and new mothers.^{3,4} Breastfeeding issues are underrepre-

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ABSTRACT: Breastfeeding is of vital importance to the health of both mother and child. Despite this, bottle-feeding remains the norm in this country. Primary care providers are in a unique position to promote breastfeeding with a comprehensive program of lactation management. They can offer perinatal education early during pregnancy to stress the advantages of breastfeeding and correct misconceptions; help ensure that hospital practices facilitate breastfeeding immediately after delivery and eliminate barriers to its initiation; and encourage continued nursing for at least 12 months. Donor human milk and skin-to-skin nurturing while bottle-feeding are options for women who cannot breastfeed. (*Women Health Primary Care* 1998;1(7):599-611)

sented in medical school curricula and residency training programs.

This article will outline what clinicians need to know about breastfeeding; it will also discuss how clinicians can educate, support, and counsel their patients. It will describe the basic components of a lactation management program, beginning with prenatal education. Next, it will offer strategies for peripartum support and guidelines for breastfeeding. Finally, it will outline an approach to counseling women who cannot or should not breastfeed.

PRENATAL EDUCATION

Primary care providers can have a positive impact on the infant feeding decision. Many women decide whether they want to breastfeed before they become pregnant, and most have made their decision by the second trimester of pregnancy. Prenatal education has been shown to be effective at increasing the rates of breastfeeding.⁵

Begin early: Begin at the first prenatal visit, and target your educational messages toward the specific concerns or misconceptions of the prospective mother and her support persons. Also, provide an office environment that encourages breastfeeding; display literature that supports breastfeeding, rather than infant formula advertising.⁶

Stress the advantages: The medical literature abounds with evidence regarding the advantages of

breastfeeding.⁷⁻⁹ The documented health risks of artificial feeding for the infant and the mother are listed in Table 1. When you are talking to prospective parents, stress the importance of this decision, just as you discuss with your patients other lifestyle choices that affect their health.

Primary care providers have many opportunities to promote breastfeeding. Take advantage of such “teachable moments.” When a newly pregnant mother visits your office with a bottle-fed child suffering from recurrent otitis media, asthma, or nursing bottle caries, she may be particularly receptive to the idea that breastfeeding may decrease the risk of such diseases in the new baby. Similarly, a woman with breast or ovarian cancer may be eager to tell her pregnant daughter or daughter-in-law that breastfeeding may decrease their risk of these cancers.

Address maternal concerns:

During the prenatal period, determine the mother’s concerns about breastfeeding and counsel her accordingly. Ask “What questions do you have about breastfeeding?” rather than “Are you planning to breastfeed or bottle-feed?” The former question emphasizes that breastfeeding is the norm, whereas the latter implies that breastfeeding and bottle-feeding are equally desirable. Common maternal concerns about breastfeeding are listed in Table 2. Remember, though, not to overlook any questions the baby’s father or other relatives may have. Whatever the concerns are, it is important to validate them before correcting any misconceptions.

A woman who has previously given birth may have special concerns. If she bottle-fed her other children, ask her why she chose that option and discuss her feelings about breastfeeding the new baby. If she had difficulty with previous attempts at breastfeeding or if she had to wean prematurely, offer

Table 1. Risks of artificial feeding

For infants
Increased incidence or severity of
Diarrhea
Lower respiratory tract infection
Otitis media
Bacteremia
Bacterial meningitis
Botulism
Urinary tract infection
Necrotizing enterocolitis
May increase risk of
Sudden infant death syndrome
Insulin-dependent diabetes mellitus
Crohn’s disease
Ulcerative colitis
Lymphoma
Allergic diseases
Chronic digestive diseases
For mothers
Results in
Increased postpartum bleeding
Delayed uterine involution
Increased menstrual blood loss in the early postpartum period
Is associated with
Delayed return to prepregnancy body weight
Premature resumption of ovulation, leading to shorter child-spacing intervals
Suboptimal postpartum bone remineralization, possibly leading to increased incidence of postmenopausal hip fractures
Increased risk of ovarian cancer and premenopausal breast cancer
<small>Data adapted from American Academy of Pediatrics Work Group on Breastfeeding. <i>Pediatrics</i>. 1997.²</small>

guidance to help prevent similar problems.

If the woman has never attempted breastfeeding, it may be due to unsupportive relatives or lack of confidence. On occasion, a woman will adamantly refuse to consider breastfeeding. Although a woman with a strong dislike of breastfeeding may have varied reasons for that dislike, consider the possibility that such a woman may be under extreme stress—even

abuse. (Very low rates of breastfeeding have been reported among victims of domestic violence.¹⁰)

A woman may be reluctant to begin breastfeeding because her workplace is not supportive of nursing and she will be unable to continue to breastfeed exclusively once she returns to work. Encourage her to start breastfeeding because even a few weeks of nursing can provide her baby with an invaluable start in life. Also mention that, because of the reduced incidence of illness among breastfed babies, continued nursing (supplemented with bottle-feedings while she is at work) may result in less absenteeism from her job and thus may even enhance her work performance and satisfaction.¹¹

Some maternal concerns about breastfeeding are based on misinformation or lack of information. Once these concerns are identified, accurate information can be provided. Often, women are primarily concerned about emotional and/or cultural issues. They require active listening, a nonjudgmental attitude, and anticipatory guidance from the primary care provider. Open communication with both the mother and her support persons can help overcome cultural and psychologic barriers.

However, even when the risks of artificial feeding are clear and the barriers appear surmountable, some women still choose to bottle-feed. As long as they make an informed choice, it is their decision. If a woman plans to bottle-feed, consider teaching her to bottle-feed “like a breastfeeder”¹² (techniques are described later in this article); also encourage her to put the baby to the breast at least once (“You may never really know how you will feel unless you try it”).

If a woman is undecided, educate her about breastfeeding according to her concerns. She—as well as the woman who is determined to breastfeed—should be

encouraged to attend breastfeeding classes and/or La Leche League meetings.

Because the information on breastfeeding that is found in popular parenting books varies in quality, you should provide mothers with a list of current, accurate, and practical books. Recommended books and organizations that provide educational materials on breastfeeding are listed on page 603. Also included there are a number of resources for clinicians who wish to further update their knowledge about breastfeeding.

PERIPARTUM SUPPORT

Hospital practices: These can have a significant impact on breastfeeding success.^{13,14} As the expected date for delivery approaches, inform your patient about potential hospital barriers to breastfeeding and take steps to avoid them.

Crucial for breastfeeding success are the initiation of breastfeeding immediately after birth, prevention of mother-infant separation, and avoidance of unnecessary infant feeding supplements. Write specific hospital orders for your patient that are consistent with optimal breastfeeding management. The Baby-Friendly Hospital Initiative, developed by the World Health Organization and the United Nations Children’s Fund, provides evidence-based guidelines for breastfeeding support in maternity facilities (Table 3).¹⁵ Encourage family members to give the mother and baby as much time together as possible to establish the breastfeeding relationship.

There is increasing evidence that labor analgesia, including epidural agents, can interfere with breastfeeding in some babies.¹⁶ Thus, unnecessary labor interventions should be avoided whenever possible. Consider delaying an-

Table 2. Common maternal concerns about breastfeeding

- A woman may be reluctant to breastfeed if she is:
- ◆ Not convinced of the importance of breastfeeding.
 - ◆ Worried about the quantity and/or quality of the milk she will produce.
 - ◆ Concerned about pain and/or difficulty with breastfeeding.
 - ◆ Embarrassed or “turned off” by the idea of breastfeeding or by the need to expose her breast.
 - ◆ Concerned about either a lack of support or perceived pressure to breastfeed from her baby’s father, friends, or relatives.
 - ◆ Anticipating returning to work in an unsupportive work environment, and thinking that it is not worth starting to breastfeed.
 - ◆ Concerned about a perceived contraindication to breastfeeding.
 - ◆ Worried that her other children will “feel bad” because they were bottle-fed.

algic administration, using non-pharmacologic techniques of pain management, and/or employing doulas (trained lay persons) during labor to help prevent early breastfeeding problems.

Follow-up care: Regular postpartum evaluations help ensure early identification of problems and provide reassurance to the mother and her family. A breastfed neonate born to a primipara or to a mother who has never successfully breastfed before should be evaluated within a week after birth (within 1 or 2 days after discharge if there was no evidence of consistently successful latch-on in hospital). If the mother has breastfed successfully in the past and the early postpartum breastfeeding initiation was uneventful, follow-up 2 weeks after birth is reasonable.

Follow-up intervals thereafter should be individualized. If breastfeeding is proceeding uneventfully and the mother has appropriate support, the routine pediatric follow-up schedule is appropriate. When there are problems with breastfeeding, however, more frequent visits and referral to a lacta-

tion consultant may be needed.

Drug therapy: To avoid the need for premature weaning when a lactating woman requires drug therapy, consult reliable sources (such as those listed on page 603) to select an agent that does not contraindicate breastfeeding. Most medications get into mother’s milk in very small and, usually, clinically insignificant quantities. Clinical decision-making regarding drugs and lactation must balance the potential risk the drug presents to the baby against the documented risks of untimely weaning. The following AAP guidelines may be helpful¹⁷:

- ◆ Ask yourself if drug therapy is really necessary.
- ◆ Choose the agent that is safest for the nursing infant.
- ◆ Consider measuring blood concentrations of the drug in the infant, if you are concerned that the selected agent may pose a risk.
- ◆ Minimize drug exposure to the infant by instructing the mother to take the drug immediately after she has breastfed and/or just before the infant is likely to sleep for a long period.

BREASTFEEDING GUIDELINES

Most breastfeeding problems can be prevented (or treated) by frequent and unrestricted feedings, proper positioning of the baby at the breast, and correct latch-on at the areola. Recommend the following practices to help ensure successful breastfeeding:

Feed on demand: Breastfeeding should begin immediately after the birth. Early, frequent feedings are crucial—both to the mother’s milk supply and to her confidence. Avoid specifying any intervals between feedings. A mother whose baby “cluster feeds” (feeds several times in close succession instead of at discreet 2- to 3-hour intervals) may mistakenly believe that she

does not have enough milk. Instead, instruct the mother to allow her baby to self-regulate its feeding.

“Demand” feeding requires that the mother watch for early feeding cues from the baby, such as rapid eye movements, lip-smacking, rooting, or sucking on hands. The mother should put the baby to the breast when she observes these cues, rather than waiting for the infant to cry. A crying baby may be too hungry to learn to feed at the breast, and the mother may feel rejected. During the early weeks of nursing, the baby should receive a minimum of 8 to 12 feedings every 24 hours.

Correct positioning and latch-on: To evaluate sore nipples and infant latch-on or suckling problems, directly observe a nursing session. A mother usually experiences some nipple pain at initial latch-on during the first week of nursing. However, nipple pain that persists throughout a feeding or that does not resolve within a week warrants prompt evaluation.

If a baby does not latch on or suckle effectively, the mother can feed it her expressed milk with a cup, spoon, or syringe. A bottle is not recommended because it can aggravate poor suckling. Expressing colostrum by hand is preferred to pumping it. Early during lactation, the small quantities of colostrum produced may be lost in the pump flange or tubing; this may undermine the mother’s confidence in her milk supply.

Check for adequate intake: Indicators that the baby



is receiving enough colostrum are an increase in the volume and frequency of meconium stools and at least 1 wet diaper (with clear to light-yellow urine) for each day of life. After the mother’s milk secretion begins (on the second to the fifth postpartum day), at least 2 to 4 mustardy curdy stools and 5 to 6 wet disposable diapers (or 6 to 8 wet cloth diapers) every 24 hours signal good intake.

The baby should lose no more than 7% of its birth weight after delivery and should regain its birth weight within 2 weeks. Thereafter, the baby’s weight should increase by an average of 4 to 7 oz each week. In addition to low stool and urine output and weight loss, other early signs of poor intake in a neonate include:

- ◆ Uric acid crystals (“brick dust”) in urine after the fourth day of life.
- ◆ Weak sucking efforts with a tendency to fall asleep within seconds of latching on the breast.
- ◆ Excessively lengthy feedings with little or no softening of mother’s breasts.
- ◆ Exaggerated physiologic jaundice.
- ◆ Lethargy.

A baby exhibiting any of these signs should be promptly assessed. If the baby is dehydrated and/or malnourished, feeding and hydration must be given by the most expedient means available; the breastfeeding problems should be evaluated and corrected as soon as possible thereafter. If the baby is not dehydrated or malnourished, reasonable actions include increasing the frequency of feedings

Table 3. Ten steps to successful breastfeeding*

All facilities that offer maternity services and neonatal care should follow these guidelines to provide optimal support for breastfeeding:

1. Create a written breastfeeding policy and routinely communicate it to all health care staff.
2. Train all health care staff in skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers to initiate breastfeeding within a half hour of giving birth.
5. Show mothers how to breastfeed, and how to maintain lactation—even if they must be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.
7. Allow mothers and infants to remain in the same room together, 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to these groups when they are discharged from the health care facility.

* These guidelines are adapted from the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) Baby-Friendly Hospital Initiative. Data extracted from Saadeh R, Akre J. *Birth*. 1996.¹⁵

Breastfeeding: information resources

FOR CLINICIANS

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Cunningham AS, Jelliffe DB, Jelliffe EF. *Breastfeeding, Growth and Illness: An Annotated Bibliography*. New York, NY: UNICEF; 1992.

Hale TW. *Medications and Mothers' Milk*. 7th ed. Amarillo, Tex: Pharmasoft Medical Publishing, 1998.

Institute of Medicine. Committee on Nutritional Status During Pregnancy and Lactation. *Nutrition During Lactation*. Washington, DC: National Academy Press, 1991.

Lawrence RA. *Breastfeeding: A Guide for the Medical Profession*. 4th ed. St. Louis, Mo: Mosby-Year Book; 1994.

Mohrbacher N, Stock J. *The Breastfeeding Answer Book*. Schaumburg, Ill: La Leche League International; 1997.

Stuart-Macadam P, Dettwyler KA, eds. *Breastfeeding: Biocultural Perspectives*. Hawthorne, NY: Walter de Gruyter Inc; 1995.

FOR PATIENTS

Jones C. *Breastfeeding Your Baby: A Guide for the Contemporary Family*. New York, NY: Macmillan Publishing Co; 1993.

La Leche League International. *The Womanly Art of Breastfeeding*. 36th ed. Schaumburg, Ill: La Leche League International, 1997.

In addition to the references cited in this article, a number of books and articles are available to help you increase your knowledge of lactation and breastfeeding. Publications that you may recommend to your patients and organizations that can provide more information about breastfeeding are also listed.

Pryor G. *Nursing Mother, Working Mother*. Boston, Mass: The Harvard Common Press; 1997.

Renfrew M, Fisher C, Arms S. *Bestfeeding: Getting Breastfeeding Right for You*. Berkeley, Calif: Celestial Arts; 1990.

ORGANIZATIONS

The Academy of Breastfeeding Medicine
P.O. Box 15945-284
Lenexa, KS 66285-5945
(913) 541-9077
Fax: (913) 541-0156
E-mail: shime@applmeapro.com

Baby-Friendly USA
8 Jan Sebastian Way, No. 13
Sandwich, MA 02563
(508) 888-8044

Best Start, Inc
3500 East Fletcher Avenue
Suite 519
Tampa, FL 33613
(800) 277-4975
(Offers breastfeeding promotional materials targeted to adolescent parents.)

Childbirth Graphics
P.O. Box 21207
Waco, TX 76702-1207
(800) 299-3366, x 287
(Offers catalog with educational materials for health care providers and parents.)

Health Education Associates, Inc
8 Jan Sebastian Way
Sandwich, MA 02563
(508) 888-8044
(Offers educational pamphlets, including low-literacy materials.)

Human Milk Banking Association of North America, Inc (HMBANA)
8 Jan Sebastian Way, No. 13
Sandwich, MA 02563
(508) 888-4041
or (508) 888-8809
Fax: (508) 888-8050
E-mail: milkbank@capecod.net

International Lactation Consultants Association
4101 Lake Boone Trail, No. 201
Raleigh, NC 27607
(919) 787-5181
Fax: (919) 787-4916
E-mail: ilca@erols.com

La Leche League International
1400 North Meacham Road
P.O. Box 4079
Schaumburg, IL 60168-4079
(847) 519-7730
Fax: (847) 519-0035
Website: www.prairienet.org/llli/

United Nations Children's Fund (UNICEF)
3 UN Plaza
New York, NY 10017
(212) 326-7000
(Offers excellent resources for training health care providers in lactation management and the implementation of the Baby-Friendly Hospital Initiative.)

Wellstart International
4062 First Avenue
San Diego, CA 92103-2045
(619) 295-5192

and, possibly, referring the mother to a lactation consultant, who can further assess the adequacy of the baby's sucking and/or mother's milk supply. If all breastfeeding problems have been corrected but there is still no evidence of increased intake, look for other causes of failure to thrive in breastfed babies (Table 4).

Avoid supplements and pacifiers: Early use of supplements^{18,19} or pacifiers²⁰ is associated with a decreased duration of breastfeeding. Supplemental bottle-feeding reduces the frequency and effectiveness of feedings at the breast; this can lead to maternal breast engorgement, mastitis, and insufficient milk production, as well as neonatal jaundice or failure to thrive. Also, supplemental formula feedings can sensitize atopy-prone babies and possibly lead to the development of eczema, asthma, or allergies.²¹

Bottles should not be used to feed the baby for at least the first 3 to 4 weeks of nursing, until lactation is established. Thereafter, if bottles must be used, they should be equipped with slow-flow nipples (no milk should drip out when the bottle is turned upside down). Tell the mother to introduce the bottle slowly. The baby should draw the nipple in and far back toward the soft palate; its lips should flange outward, not just pucker around the tip of the nipple.

Extend nursing: The AAP recommends that breastfeeding continue for at least 12 months. Alternative milk sources (formula before 12 months of age; cow's milk, soy milk, and toddler formulas after 1 year) do not provide the species-specific nutrients that mother's milk provides, nor do they contain any of the immunoprotective factors that mother's milk offers.²² Mother's milk is the best source of milk for an atopy-prone child with cow's milk protein allergy or soy protein allergy.

Table 4. Causes of failure to thrive in breastfed babies

Maternal causes
<p>Poor milk production</p> <p>Hypothyroidism Sheehan's syndrome Retained placental fragment Acute maternal illness Intake of drugs or herbs that reduce supply (eg, nicotine, bromocriptine, sage) Severely restricted maternal diet Rare hypoplastic breast syndrome History of breast reduction or implant surgery</p> <p>Inhibited let-down (milk ejection reflex)</p> <p>Pain from episiotomy or cesarean section scars Stress</p>
Infant causes
<p>Poor intake</p> <p>Poor suckling (because of labor medications, neurological anomaly, hyperbilirubinemia, metabolic disease) Structural abnormality (eg, high arched palate, submucosal cleft, ankyloglossia)</p> <p>Low net intake</p> <p>Malabsorption Chronic congenital infections (eg, those due to cytomegalovirus)</p> <p>High energy requirement</p> <p>Congenital heart disease Small size for gestational age</p>

Continued nursing also provides a unique source of comfort for the child, and many mothers feel that the special closeness with their child is diminished by premature weaning. Early weaning also confers some potential health risks to mothers: the incidences of osteoporosis and of breast, ovarian, and uterine cancer tend to be increased not only in mothers who never breastfed, but also in those who breastfed only for short periods. In addition, the optimal weight loss obtained through breastfeeding depends on extended nursing.

Because breastfeeding beyond 6 months is not the norm in this country, many new mothers do not anticipate breastfeeding for more than a few weeks or months. At the very least, encourage mothers to meet their personal goals for breastfeeding duration; also, inform them of the optimal duration in hope that they will reconsider an unrealistically brief goal.

Mothers may receive negative messages that increase in direct proportion to nursing duration. Even persons who support breastfeeding may be uncomfortable at the sight of an older child breastfeeding. Some mothers who nurse beyond a few months become "closet nursers" and may be reluctant to disclose their continued breastfeeding even to their physicians.²³ Make it clear to your patients that extended nursing is desirable.²⁴ Consider referring a woman who is concerned about this to a mother-to-mother support group, such as La Leche League.

COUNSELING

For some women breastfeeding is contraindicated; for others, breastfeeding may not be possible for physical reasons. Both groups of women should receive empathetic support and be provided with suitable alternatives.

Contraindications: There are few absolute contraindications to breastfeeding. The only true maternal contraindication in this country is HIV infection. A mother with active tuberculosis may breastfeed after she has received an appropriate antituberculous drug regimen for 1 to 2 weeks. A mother who contracts varicella within 5 days before to 2 days after giving birth may breastfeed once it is safe for her to be in contact with her baby.

Galactosemia is the only infant condition that absolutely contraindicates breastfeeding. Oral infection with the herpes simplex virus contraindicates feeding at the

breast until the lesions have healed; until then, the baby should receive expressed mother's milk. An infant with phenylketonuria should breastfeed and receive phenylalanine-free formula; in ad-

dition, phenylalanine metabolites should be monitored. This approach produces a better developmental outcome than does phenylalanine-free formula alone.²⁵

Most medications are compat-

ible with breastfeeding.¹⁷ However, a woman should not breastfeed if she is receiving a cancer chemotherapeutic agent, methotrexate, lithium, or a radioactive isotope. (She should be encouraged, however, to express her milk for the duration of the treatment to keep up her milk supply and, whenever possible, to resume breastfeeding when the treatment ends. When a woman receives a radioactive isotope for diagnostic purposes, the isotope with the shortest half-life should be used; the expressed milk can be stored and fed to the child after 5 half-lives have expired.)

Bromocriptine is also contraindicated during lactation, not because of potential harm to the child, but because it inhibits the milk supply (consider using it with caution in a breastfeeding mother with a prolactinoma who has an oversupply of milk). Illicit drug use contraindicates breastfeeding, although methadone maintenance therapy (up to 20 mg/d) is allowable.

The AAP has identified other drugs that do not contraindicate breastfeeding, but that should be used with caution in this setting, either because adverse effects in nursing infants have been reported or because the effects on the child are unknown. These drugs include antidepressants, anxiolytics, and antipsychotic medications.

Clinical judgment should be used and decisions individualized; factors to consider include the pharmacologic characteristics of the drug, age of the child, and frequency of breastfeeding. Often, there is at least one medication in a drug category that poses less of a risk than do the others.²⁶ As stated previously, the known risks of premature weaning and artificial feeding need to be balanced against the potential risk of the medication.

Physical problems: A mother may be physically unable to supply enough milk for her baby for a number of reasons. She may have

PRIMARY POINTS

Breastfeeding

The American Academy of Pediatrics recommends breastfeeding of at least 12 months' duration as the optimal method of infant feeding. Yet, in the United States, 40% of infants never taste their mothers' milk, and 80% are bottle-fed by the time they reach 6 months of age.

Women make the infant-feeding decision early—many decide before they become pregnant, and most do so before they reach the second trimester. Thus, prenatal education about breastfeeding is best begun early.

Hospital practices have a significant impact on breastfeeding success. Hospital personnel should ensure that breastfeeding begins immediately after birth, that no formula supplements are given to the baby unless medically indicated, and that mother and child are allowed to room together 24 hours a day.

The frequency of breastfeeding should be determined by early feeding cues from the baby, such as rapid eye movements, lip-smacking, rooting, and sucking on hands. During the early weeks of nursing, an infant should breastfeed a minimum of 8 to 12 times daily.

When caring for nursing mothers, delay interventions (if possible) that may cause them to wean prematurely. When drug therapy is required, an agent that minimizes the risks to the infant should be chosen. There is usually an effective medication that is compatible with breastfeeding.

Maternal contraindications to breastfeeding include infection with the human immunodeficiency virus; drug therapy with a cancer chemotherapeutic agent, methotrexate, lithium, or a radioactive isotope; and current illicit drug use. Galactosemia is the only infant condition that absolutely contraindicates breastfeeding.

a compromised milk supply because of poor lactation management, use of supplemental feedings, or premature weaning; she may have a history of breast reduction or implant surgery; rarely, she may have breast hypoplasia; or she may be an adoptive mother.

Whatever her reason for not being able to breastfeed, a woman should not be patronizingly reassured that formula is just as good as human milk. Instead, acknowledge her loss and thereby facilitate her grieving. Also, inform her that, unless a condition that absolutely contraindicates breastfeeding is present, she can still nurture her baby at the breast using supplemental donor milk or formula.

Donor human milk is particularly helpful if the baby is at high risk of complications from formula. The Human Milk Banking Association of North America is an excellent resource. If donor milk is not available, validate any guilt feelings the mother may have about feeding with formula and provide empathetic support.

When breastfeeding is not possible, encourage the mother to "bottle-feed like a breastfeeder."¹² By holding her baby skin-to-skin throughout feedings and continuing to cuddle the infant afterwards, a woman can approximate some of the features of the breastfeeding relationship. She also should be encouraged to switch the baby from side to side when feeding to improve its hand-eye coordination.

When a mother has an inadequate milk supply and supplemental feedings are required for an extended period, a tube feeding system may be placed at the breast. This allows emptying of the breast and increases the mother's milk

supply. Even a little mother's milk is beneficial to the infant, and the skin-to-skin nurturing at the breast benefits both mother and child. 🐾

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