Breastfeeding and Medical Conditions

Vermont Child Health Improvement Project
“Improving Breastfeeding Support in Primary Care Settings”

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Objectives

• To review issues related to breastfeeding infants with certain medical conditions including:
  – Prematurity
  – Hypotonia
  – Cleft lip/palate
  – Opiate withdrawal
  – Tongue tie

• To offer resources for managing these infants
Patience and Creativity!
Helpful Positions

Feeding Positions: Cross-Cradle

Feeding Positions: Football/Clutch

Laid Back

Modified football hold

Images from Stanford, Children’s Hospital of Minnesota
Dancer’s Hold

- Thumb and index finger support baby’s jaw
- Bottom 3 fingers support breast
- Gives more head/jaw support
- Good for late preterm, hypotonia
Other Helpful Holds

U-Shaped Hold

C-Shaped Hold
Late Preterm

• Alternative positions

• Mother may need to pump to maintain supply if suck is weak or disorganized

• Early supplementation if needed

• More prone to jaundice
Former Premature Infants: Outpatient Issues

- Transitioning off nipple shield
- Building/maintaining milk supply - don’t use up freezer milk without pumping to offset!
- Transitioning from bottle to breast
- Oral aversion issues
Hypotonia/Down Syndrome

- Support head/neck and breast
- Patience - longer feedings
- Wealth of online support
- Pumping may be necessary to maintain supply

https://www.childrensmn.org/Manuals/PFS/Nutr/018723.pdf
Cleft Lip

• Often not an issue

• Breast tissue (or thumb) can usually fill gap

• Suction still possible since palate intact
Cleft Palate

- Upright feeding
- Baby may straddle mother
- Hand expression into baby’s mouth - same idea as Pigeon or Haberman feeders
- Usually need some supplementation as well
- Pumping usually necessary
- Cleft palate team
Thailand study 2010

- 20 infants
- Trained nurse assisted postpartum
- Hand expression
- Weight gain, comfort, urine/stool output
- Start pumping on first day
- 16 infants exclusive BF 3-4 months
- (2 infants 6 mos, EBM until 15,18mos; 2 infants <2mos)

Pierre Robin Sequence

• Primary defect = micrognathia

• Often associated with U-shaped cleft palate

• Support jaw, sit upright/forward (laid back)

• Sometimes tongue is surgically tethered to alveolar ridge to prevent hypoxia

• Hand expression, pumping, supplementation usually needed
Neonatal Abstinence

- Breastfeeding encouraged if in treatment program
- Eases withdrawal symptoms
- Skin to skin
- Tight swaddle, frequent sucking
- Disorganized suck common - pacifiers, fingers
- Increased caloric need
Tongue Tie
Hazelbaker Assessment

• Function:
  – Lateralization
  – Lift
  – Extension
  – Spread, cupping
  – Peristalsis, snapback

• Appearance:
  – shape of tongue
  – Elasticity and length of frenulum
  – Location of attachment- tongue, alveolar ridge
Coryllos-Watson Grading System

Location of frenulum attachment:

- Type 1 - tip of tongue
- Type 2 - 2-4 mm behind tip
- Type 3 - mid-tongue
- Type 4 - base of tongue

- 75% are Type 1 or Type 2
Post-frenotomy
Frenotomy (30) vs sham procedure (28)

Nipple pain scale and BF Assessment tool

2 week f/u visit

Frenotomy group improved in pain scores vs sham group (p<0.001)

BF scores improved in frenotomy group (P=0.029)
Hogan et al. Randomized controlled trial of division of tongue-tie in infants with feeding problems

- 57 cases of tongue tie with BF problems

- 28 babies immediate frenotomy → 27 had improvement in BF, one remained on nipple shield

- 29 controls without immediate frenotomy → one improved, 28 did not. At 48h, all 28 offered frenotomy and 27/28 improved and BF normally
Posterior Tongue Tie

• Decrease lift and extension of tongue:
  – decreased milk transfer
  – nipple pain
  – poor weight gain
• Membranous posterior tongue tie = Grade 3
• Thick submucous posterior tongue tie = Grade 4
• Increased risk of scarring, need for revision (Grade 4)
• Dentist, ENT, or Oral Surgeon
Tongue Elevation

Normal elevation

Restricted elevation - Possible posterior tongue tie
How to Assess for Posterior Tongue Tie

• Observe tongue elevation

• Push on sides (underneath tongue) and frenulum may become apparent

• No standard assessment criteria

• No good data
• 311 patients with tongue tie (85% posterior)

• Retrospective surveys up to 4 years later

• Improved latch and decrease in pain (p<0.001)

• No controls
Lip Tie

- One case report
- Many anecdotal reports
- Laid back breastfeeding position, breast compressions may help
- Dental issue- space between teeth
Raynaud’s Syndrome

• Blanching nipples followed by cyanosis, erythema (white → blue → red)
• Response to cold, breastfeeding
• Intense nipple pain!!!!!!
• Diagnosis requires symptoms when not BF
• Treatment= 2 week course of Nifedipine, may need to repeat 1-2 times.
Medications while breastfeeding

• Very few contraindicated: ergotamines, amphetamines, chemotherapy, statins

• Resources:
  – AAP Section on Breastfeeding
  – Thomas Hale, Medications and Mother’s Milk

• Contrast media- American College of Radiology 2013
  – Breastfeeding acceptable
Domperidone

- Not FDA approved as galactagogue
- Many studies show efficacy
- Available by mail order, in Canada, some FAHC providers
Resources

• Lintilhac Breastfeeding Clinic (FAHC Midwives) (847-2237)
  – Tricia Cassi, IBCLC

• VCH Lactation Clinic (Children’s Subspecialty Ctr) (847-8200)
  – Molly Rideout, MD, IBCLC, FAAP
  – Anya Koutras, MD, IBCLC, FAAFP

• Newborn Nursery Lactation Consultants, Private IBCLC’s

• Feeding Team at FAHC- for non-breastfeeding related feeding issues such as oral aversion or dysfunctional suck (847-3970)

• Lawrence Kotlow, DDS- Albany NY for submucosal tongue tie (posterior), lip tie
Newborn/Lactation Clinic at VCH

• Weekly clinic or as needed
• Inpatient consults
• For infants with medical issues
• Works in conjunction with Lintilhac Breastfeeding Clinic at FAHC (Ob/Midwives)
KEEP CALM AND SUPPORT BREASTFEEDING