

ABM Clinical Protocol #5: Peripartum Breastfeeding Management for the Healthy Mother and Infant at Term, Revision 2013

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A central goal of The Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

Background

HOspital policies and routines greatly influence breastfeeding success.^{1–10} The Baby-Friendly Hospital Initiative (BFHI) has defined the Ten Steps to Successful Breastfeeding, and 20 years of research has now verified that “the achievement of BFHI certification leads to substantially improved breastfeeding outcomes, especially increases in breastfeeding initiation and exclusivity.”¹

The peripartum hospital experience should include adequate support, instruction, and care to ensure the successful initiation of breastfeeding. Such management is part of a continuum of care and education that begins during the prenatal period, promotes breastfeeding as the optimal method of infant feeding, and includes information about maternal and infant benefits. The following principles and practices are recommended for care in the peripartum hospital setting.

Recommendations

Quality of evidence (levels of evidence I, II-1, II-2, II-3, and III) for each recommendation as defined in the U.S. Preventive Services Task Force Appendix A Task Force Ratings¹¹ is noted in parentheses.

Prenatal

1. All pregnant women must receive education about the benefits and management of breastfeeding to allow an informed decision about infant feeding.^{5–10} An evidence-based review of practices that improve the duration or initiation of breastfeeding found that “prenatal combined with postnatal interventions are more effective than usual care in prolonging the duration of

breastfeeding....”¹² Information and advice from a health professional early in pregnancy are also supported by the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians in their policy statements, which read “Advice and encouragement of the obstetrician-gynecologist are critical in making the decision to breastfeed”⁶ and “Family-centered care (the belief that health care staff and the family are partners, working together to best meet the needs of the patient) allows support of breastfeeding practices throughout the lifecycle to all family members.”⁹ (I, II-1, II-2, II-3, III)

2. Prenatal education should include information about the benefits to mother and baby of exclusive breastfeeding initiated in the first hour after birth.⁵ Educational materials produced by formula manufacturers are inappropriate sources of information about infant feeding.^{13,14} (I, III)
3. Maternity care includes an assessment of any medical or physical conditions that could affect a mother’s ability to breastfeed her infant. In some cases, it may be helpful to obtain a prenatal consultation with the infant’s physician or a lactation consultant or specialist and to develop a plan of follow-up to be instituted at the time of delivery.^{6–8} Women will benefit from moderated group discussions, group prenatal visits, systematic case management, or referral to a lay support organization prior to delivery.^{6–8,12} There is also good evidence that peer counseling promotes the initiation and maintenance of breastfeeding.^{15,16} (I, II-3, III)

Labor and Delivery

1. Women will benefit from the continuous presence of a close companion (e.g., doula, spouse/partner, or family

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- member) throughout labor and delivery. The presence of a doula is known to enhance breastfeeding initiation and duration.¹⁷ Many risk factors are associated with early cessation of breastfeeding, including the mean length of labor, the need for surgical intervention, and the use of pain-reducing interventions such as epidurals and other medications. These risks may be reduced by the presence of a doula.^{18–20} (I, II-2, III)
2. Intrapartum analgesia may also have an impact on breastfeeding, and consideration needs to be given to the type and dose of analgesia.^{6,21–23} Epidural analgesia, intramuscular opioids, exogenous oxytocin, and ergometrine have all been associated with lower rates of breastfeeding initiation.²⁴ (I, II-2, III)
- ### Immediate Postpartum
1. The healthy newborn should be given directly to the mother for skin-to-skin contact until after the first feeding. The infant may be dried and assigned Apgar scores, and the initial physical assessment may be performed as the infant is placed with the mother. Such physical contact provides the infant with optimal physiologic stability, warmth, and opportunities for the first feeding.^{10,25–29} Extensive early skin-to-skin contact likely increases the duration of any and exclusive breastfeeding.^{27–35} Delaying procedures such as weighing, measuring, administering eye prophylaxis as well as vitamin K, up to 6 hours after birth, and the initial bath enhances early parent-infant interaction.^{10,36} Infants are to be put close to the breast, as soon after birth as is feasible for both mother and infant, to allow for a latch and feeding, ideally within an hour of birth.^{28,31–35} This practice is to be initiated in the delivery, operating, or recovery room, and every mother should be instructed in proper breastfeeding technique.^{5,10,31,37–41} (I, II-2, II-3, III)
 2. Mother–baby rooming-in on a 24-hour basis enhances opportunities for bonding and for optimal breastfeeding initiation. Whenever possible, mothers and infants are to remain together during the hospital stay.^{10,30,35,42–45} To avoid unnecessary separation, infant assessments in the immediate postpartum time period and thereafter are ideally performed in the mother’s room. Evidence suggests that mothers get the same amount and quality of sleep whether infants room-in or are sent back to the nursery at night.^{42–44} (II-1, II-2, II-3, III)
 3. Education about the benefits of 24-hour rooming-in encourages parents to use it as the standard mode of hospital care for their families. At the same time, from a staffing standpoint, nursing personnel should arrange for time to be available to assess and document the status of the infant and infant feeding while the baby is in the family’s room.^{5,10,41,45,46} (I, II-3, III)
 4. Women may need help from healthcare providers to ensure that they are able to position and attach their babies at the breast. Those delivered by cesarean section may need additional help from nursing staff to attain comfortable positioning. A trained observer should assess and document the effectiveness of breastfeeding at least once every 8–12 hours after delivery until mother and infant are discharged. In countries where the delivery hospital stay may last up to a week, then assessment should continue until breastfeeding is successfully established.^{1,10} Peripartum care of the dyad should address and document infant positioning, latch, milk transfer, baby’s weight, clinical jaundice, and any problems raised by the mother, such as nipple pain or the perception of an inadequate breastmilk supply. Formal inpatient lactation instruction programs need to be assessed carefully for effectiveness and best practices.^{38–41} Some infants are sleepy in the first 24 hours after birth. By the second day, infants who are breastfeeding well will feed on demand. Feedings usually range from eight to 12 times or more in 24 hours, with a minimum of eight feedings every 24 hours. Limiting the time that an infant is at the breast is not necessary and may even be harmful to the establishment of a good milk supply. Infants usually fall asleep or release the breast spontaneously when satiated. (I, II-2, II-3, III)
 5. Supplemental feeding should not be given to breastfed infants unless there is a medical indication.^{10,13,47–49} Supplementation can inhibit or delay the establishment of maternal milk supply and have adverse effects on breastfeeding (e.g., delayed lactogenesis, maternal engorgement). Supplements may alter infant bowel flora, sensitize the infant to allergens (depending on the content of the feeding and method used), interfere with maternal–infant bonding, and interfere with infant weight gain.^{14,47–49} There is no role for the routine supplementation of non-dehydrated infants with water or dextrose water; in fact, this practice could contribute to hyperbilirubinemia.⁵⁰ Before any supplementary feedings are begun, it is important that a formal evaluation of each mother–baby dyad, including a direct observation of breastfeeding, is completed by a provider trained in lactation.¹⁴ (I, II-2, III)
 6. Pacifiers in the neonatal period should be used with caution. Some earlier research showed that pacifier use in the neonatal period was detrimental to exclusive and overall breastfeeding,^{51,52} while a recent Cochrane review found that pacifier use in healthy term breastfeeding infants, started at birth or after lactation was established, did not significantly affect the prevalence or duration of exclusive and partial breastfeeding up to 4 months of age.⁵³ Other recent studies suggest that the relationship among pacifiers, breastfeeding, and supplementation is more complex than previously realized.⁵⁴ (I)
 7. In general, acute infectious diseases, undiagnosed fever, and common postpartum infections in the mother are not a contraindication to breastfeeding, if such diseases can be readily controlled and treated. Infants should not be breastfed in the case of untreated active tuberculosis, or herpes simplex when there are breast lesions.^{55–57} In the case of maternal human immunodeficiency virus the World Health Organization recommends that “national authorities in each country decide which infant feeding practice, i.e. breastfeeding with an antiretroviral intervention to reduce transmission or avoidance of all breastfeeding, should be promoted and supported by their Maternal and Child Health services.”⁵⁵ Infectious peripartum varicella may require separation of the mother and newborn, limiting direct

- breastfeeding, but expressed milk can be used.¹⁰ Beyond infectious diseases, the listing of all contraindications is beyond the scope of this document, but reliable sources of information are readily available and include information about medications and radioactive compounds.^{56–63} (III)
8. All breastfed infants should be seen by a healthcare provider at 3–5 days of life or within 48–72 hours of discharge to evaluate the infant's well-being and the successful establishment of breastfeeding.^{10,64–66} Depending on the length of hospitalization or country of origin, these postpartum practices may vary. For example, in Japan and Australia the mother and infant stay for 4–5 days in the hospital, and in the United Kingdom mothers are home-visited by nurse midwives for about 10 days. (I, III) Peer-to-peer support should also be offered and has been proven to be helpful in promoting breastfeeding success.^{16,46} (I, I-2)

Problems and Complications

1. Mother–baby dyads at risk for breastfeeding problems benefit from early identification and assistance. Consultation with an expert in lactation management may be helpful in situations including but not limited to the following:
 - (a) Maternal request/anxiety
 - (b) Previous negative breastfeeding experience
 - (c) Mother has flat/inverted nipples.
 - (d) Mother has history of breast surgery.
 - (e) Multiple births (twins, triplets, higher-order pregnancies)
 - (f) Infant is early term (37–38 6/7 weeks of gestation) or premature (<37 weeks).
 - (g) Infant has congenital anomaly, neurological impairment, or other medical condition that affects the infant's ability to breastfeed.
 - (h) Maternal or infant medical condition for which breastfeeding must be temporarily postponed or for which milk expression is required
 - (i) Documentation, after the first few feedings, that there is difficulty in establishing breastfeeding (e.g., poor latch-on, sleepy baby, etc.)
 - (j) Hyperbilirubinemia
2. Discharge of mothers and babies from the hospital at less than 48 hours mandates that risks to successful breastfeeding be identified in a timely manner so that the time spent in the hospital is used to maximal benefit.⁶⁴ Recommendations for close follow-up are particularly important for dyads with early discharge.
3. If a neonate needs to be transferred to an intermediate or intensive care area, steps must be taken to maintain maternal lactation. When possible, transport of the mother to the intermediate or intensive care nursery to continue breastfeeding is optimal. If breastfeeding is not possible, arrangements should be made to continue human milk feeding for the neonate. Mothers must be shown how to maintain lactation through both manual and mechanical expression.^{5,10} There is evidence that there may be greater maternal milk production with the use of electric breast pumps compared with manual

expression alone.^{67,68} A combination of manual and mechanical expression (hands-on pumping)⁶⁹ may yield optimal milk production. (I, I-2, III)

4. If an infant is not feeding at the breast consistently and effectively at the time of hospital discharge, the mother must be shown how to maintain lactation through both manual and mechanical expression and demonstrate proficiency in emptying her breasts before she is released home.^{67,68} The possible need for supplemental feedings for the infant must be addressed, with consideration given to the choice of supplement to be used and the method of feeding. Any and all breastmilk the mother can express should be used, and it should only be supplemented further if maternal supply is inadequate. Cup feeding may help preserve breastfeeding duration among those who require multiple supplemental feedings because of the concerns regarding nipple confusion or bottle preference.⁵² The mother–infant dyad will need referral to a lactation professional for continued assistance and support.

Recommendations for Future Research

1. Controversy remains as to the effects of labor medications on breastfeeding outcomes. More studies are needed to evaluate the effects of the various labor medications available on both short- and long-term breastfeeding outcomes.
2. Despite evidence that delaying postpartum interventions to the newborn is associated with improved breastfeeding outcomes, many hospital policies still dictate immediate weighing, measuring, administering eye prophylaxis and vitamin K, and an early initial bath, all of which interfere with early and continued skin-to-skin and breastfeeding initiation. Large implementation and/or multicenter trials may be needed to ultimately influence changes in hospital policies if these findings persist.
3. The relationship between pacifiers and breastfeeding is more complex than previously realized. More research is needed to assess the effect of pacifiers on short-term breastfeeding difficulties and long-term effect on breastfeeding duration.
4. As more hospitals adopt the Ten Steps and are certified as Baby-Friendly Hospitals, we need to continue to collect data concerning which specific peripartum practices are most important in achieving desirable breastfeeding outcomes.

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