Breastfeeding 101

Pediatrics is a funny practice in that we are primarily treating small little beings and also teaching grown ups how to care and parent these little creatures. In the very beginning of the pediatrician/parent relationship we are, in so many ways, treating 2 (and often 3) people as one. There is a lot of work going on with mom and baby as a unit, but the entire family is figuring out what their new "normal" will look like.
Most of what baby needs to thrive is intimately related to those caring for baby. Breastfeeding is a prime example of this relationship . It can be especially tricky in that we have two very distinct individuals whose physical anatomy, coordination and skill have to work together for feeding to be successful.
There are 7 different reflexes involved for baby to feed effectively. That's just in baby! That doesn't include what mom may be dealing with - the trauma of birthing (c-section or vaginally), whether or not mom had tearing, stitches, c-section staples across her lower abdomen. All these little things can make getting comfortable to begin breastfeeding a problem.
Our ask of you is that you make a commitment to breastfeeding only as long as you are enjoying it, it feels good and it adds to your experience as a mother. Our commitment to you, is that we will work with you on getting to a space where you do enjoy breastfeeding, it isn't painful, it feels good and adds to your experience as a mother. We will work as hard as you do to find this place, and we will be honest if we see you struggling and have concerns that the act of breastfeeding is not benefiting you and baby. That is our promise.
There are a number of fantastic online sources for breastfeeding moms, there are also a lot of not so great sites. Here is a list of resources I often go to when I am looking to answer a question or find reliable information.
www.physicianguidetobreastfeeding.org
www.kellymom.com
https://abm.memberclicks.net/protocols - their protocols section is entirely evidence based and offers sound information, albeit a little clinical.

Set the Scene

First things first, find a comfortable place to feed baby. Set this space up so that you can basically fall right into it and everything is Goldilocks, "just right". It's nice to have snacks and water nearby, a foot stool is also pretty handy. Once you've set the scene, make sure you have all your accessories. The boppy, breastfriend pillow, whatever. The nipplie shield, the latch assist, the syringes with expressed milk, donor milk, formula etc.

If you don't have or need these things, great! But if you need all the accessories, have them handy. Gather some blankets, burp clothes and a hair tie if you have long hair. Ok, I think you're ready.
In the early days (think first 1-2 weeks), and until baby is back to original birth weight and putting on weight without trouble, you are breastfeeding on the clock. Meaning baby needs to eat at least every 3 hours. Now, if baby wakes up sooner than the 3 hour timeline and is acting hungry, by all means feed the baby. However, if it has been 3 hours and baby is still snoozing, it's time to start the wake up process. If baby is swaddled, unswaddle and let them have access to their hands to be able to stretch and generally "wake up" . At this young age, if baby is swaddled and asleep, they will likely sleep right through a feed because they are so comfy and cozy.

How Breastfeeding is Established

In the first 2-3 days after you deliver your baby your breasts get the message that baby is now outside the uterus and needs to be fed. Colostrum is produced at this time and is probably the most important thing your baby can get, even if you don't breast feed after these few days. Colostrum is jam packed with so many beneficial components for baby. One of the coolest things that colostrum does when ingested is it coats the stomach. This provides a sense of fullness for baby and is also a laxative to get that meconium (black tarry stool) moving on out. But the big benefit? The colostrum fills in all the teeny, tiny gaps between cell structures and protects baby from germs. It literally seals off baby's internal systems from the outside world. For reference, at this age, baby's belly is about the size of a shooter marble.
From about day 3-7 the supply/demand process of milk production starts to really get underway. For this reason, it is not recommended that you pump in addition to feeding baby via the breast. If you remove more milk than baby needs, your body will think it needs to make this much and will continue to do so. Now, there are loads of reasons for your pediatric provider or lactation consultant to prescribe or recommend pumping, but if you are not explicitly directed to pump it is not recommended in the first few weeks.
This is around the time that mom's body will begin to make the transition to milk production. This is often referred to as milk "coming in". It's not like a switch gets flipped and now you have milk, its typically a gradual process that happens over 12-24 hours. However, when your body goes from not having to make milk for a baby to needing to sustain it round the clock, well that causes a lot of swelling in the tissues surrounding the milk ducts, this is what causes that engorgement many moms experience. Treat this swelling like you would treat a sprained ankle; apply ice after feedings, take antiinflammatories and rest. Luckily the need to make this amount of milk isn't as dramatic ever again. Milk production will increase incrementally from this

point on as baby's need gradually increases. At this time baby's belly is about the size of a ping pong ball. By day 7-10, the belly will be the size of a grade A egg! Some big changes in a short amount of time.

Anatomy of a Latch

Getting a pain free latch often comes down to how deep baby can get latched to the breast. The more of the breast baby has easy access to the easier it is to get a good deep latch. So, when mom is supporting the breast for latching it is important that she hold the breast with the supporting hand close to her chest wall (or where an underwire of a bra would rest). This gives the baby access to all of the areola and nipple. When latched properly, the areola is the first part of the breast to enter baby's mouth.
One of the best methods to get baby to open wide for latching is to take advantage of the gape reflex. This is when baby opens the mouth wide when there is any pressure on their chin. The chin is the first part of baby's head that makes contact with the breast for a good deep latch. When aligning baby for a good latch, start with baby's nose in line with mom's nipple. Baby can get a good smell with this positioning and generally starts to root. Baby will begin to extend their neck and put their chin in contact with mom''s breast tissue. When this contact occurs, baby's gape reflex is stimulated. Then, keeping the baby's chin in contact with the breast tissue, drag their lower lip along the underside of the breast/areola to roll the lower lip out and have baby close over the nipple. This should place the areola in the front part of the mouth, where the tongue can strip the ducts of milk against the hard palate. The nipple should rest in the juncture of the hard to soft palate, where it can stay nice and round and not be damaged. This deep latch is a much easier and more efficient way for baby to eat. It supports the natural movement of the lower law and gets baby away from the chomping often felt at the breast. Generally, when baby is latched properly their ears are in line with their shoulders and their shoulders are in line with their hips. They are skin to skin (or chest to chest) with mom and you cannot see any movement of the areola or breast tissue in or out of baby's mouth.

The Sleepy Feeder

Newborns are notoriously sleepy at the breast. When feeding baby skin-to-skin, as recommended, mom's body temperature rises to keep baby warm. You couple this warm setting with some naturally occurring hormones in the milk that help relax both mom and baby and you have a recipe for a sleepy feeder. Feeding baby naked can give you good access to tickle toes, squeeze a thigh, run a finger up and down the back, move their arm up and down, scratch their scalp…you get the idea. You can use a variety of stimuli to remind baby where they are and what they are supposed to be

doing. If all else fails, you can resort to switch feeding; offering one breast for about 5 minutes before taking baby off and switching to the other breast for 5 minutes. You would then cycle through this rotation of switching sides 2-3 times to get a “full feeding” in.

Different Latches for Breastfeeding

There are a number of ways to hold baby when feeding. The “right” or correct way is the position that is most comfortable for mom that allows baby to feed successfully. Attached are a number of names and images of different latches/holds. Regardless of the position that works best for mom, the more of the breast tissue baby has access to, the deeper the latch can be, the less pain or discomfort is experienced by mom.

Timed Feedings

Many moms are told to feed baby for 15-20 minutes from each breast for each feeding. This guideline is provided to give moms an idea of how long it may take newborns or young infants to feed fully. This is not considered an absolute if your baby is feeding actively at the breast, gaining weight well, satisfied after feeds and wetting ample diapers.

What does active feeding look like? You will hear audible swallows (they sound like “caw”, “caw”). Remember that active feeding in infants is periodic - baby will suck, suck, rest; suck, suck, rest. You should see movement in the temple with each jaw translation or suck. You can also see the breast tissue near the upper chest of mom move with each pull at the breast from baby. This is a great indicator of deep latch as well.

If you see all this and baby is done with a feeding in 7-10 minutes (sometimes even shorter), is gaining weight well, wetting ample diapers and satisfied between feeds - disregard the timed feeding recommendations.

Now, if your baby is difficult to keep awake at the breast and is spending 30+ minutes there with little active feeding, chances are this is ineffective feeding and an appointment with a lactation consultant is recommended.

A Word on Tethered Oral Tissues (TOTs)

Tongue tie remains an extremely controversial issue in pediatrics and lactation. Are we really seeing an epidemic of tongue tied infants? Are we getting better at diagnosing them? We don’t have all the answers yet but here is our stance. No amount of latch work will make a tongue tied infant feed more efficiently or alleviate all pain. These cases will need to be addressed, likely early. These sorts of tongue ties are often visible and obvious. The increase in “posterior” tongue tie diagnosis is where a majority

of the controversy lies. At the end of the day, if a baby is able to feed effectively from the breast and mom does not have pain it is unclear if these need to be addressed. There is, to date, no evidence based research to support the release of posterior tongue ties in these cases.

Likewise, there is no evidence to support EVER releasing buccal (inner cheek) ties. Anecdotally, these ties are very easy to stretch and respond to manual therapy very well.

Upper lip ties may need to be released if the upper lip is so tight it cannot maintain suction on the breast or there is early evidence of bony changes to the upper alveolar ridge (the bone where teeth will eventually erupt from).

It is well established that babies who require tissue releases benefit from body work both before and after the procedure. This can include osteopathic manipulation, chiropractic treatments, craniosacral care, occupational therapy and physical therapy

There continues to be a great deal of information coming out about TOTs and we will evaluate all the information from a critical evidence based approach before making recommendations. Personal experience and continued research is how we grow as a medical community, so this information is likely to evolve and change.

The art of breastfeeding is extremely nuanced and the journey is unique to each mom/baby dyad. When this packet does not adequately answer your questions or address your breastfeeding issues, it's a good idea to call for an individual or group lactation consult.

We look forward to working with you!

Breastfeeding Positions
EVERY NEW MOM SHOULD TRY

Cradle Hold

Laid Back after C-section

Side Lying

Upright or Koala Hold

Cross Cradle

In a Sling or Carrier

Dangle Nursing

Football Hold

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