Rochester Breastfeeding Summit

Sharon Mass MD, FACOG

Who am I?

- ACOG representative to the United States Breastfeeding Committee
- ACOG representative to the AAP, Section on Breastfeeding Executive Committee
- Editor of ACOG/AAP Breastfeeding Handbook for Physicians
- Author, revision of ACOG Committee Opinion #258, “Breastfeeding:Maternal and Infant Aspects”

Who am I really?

Ob-Gyn in private practice in Morristown, NJ

- Hospital is regional perinatal center that does 4000 deliveries/year
- Practice delivers 850/year (1:6 call)

Mother of 2 breastfed children, now ages 9, 12

Objectives

- To examine National breastfeeding policies.
- To explore the role of the physician as it pertains to breastfeeding support.
- To explore labor and postpartum interventions and their effects on breastfeeding success.
- To explore opportunities for collaboration.

National Recommendations

ACOG recommendation

- "…exclusive breastfeeding be continued until the infant is about six months old. A longer breastfeeding experience is, of course, beneficial…"

-Educational Bulletin #258, Breastfeeding: Maternal and Infant Aspects

AAP recommendation

- “Human milk is the preferred feeding for all infants, including premature and sick infants, with rare exceptions.”
- Exclusive breastfeeding for the first six months of life.
- Continuing for at least the first year of life with addition of solids
- Thereafter for as long as mutually desired by mother and child

AAP Policy Statement - Pediatrics 2005;115:496-506

Healthy People 2020 recommendations

- Increase the proportion of infants who are breastfed

	2010	2011
– EVER	74%	81.9%
– At 6 months	43.5%	60.6%
– At one year	22.7%	34.1%
– Exclusively (3)	33.6%	46.2%
– Exclusively (6)	14.1%	25.5%

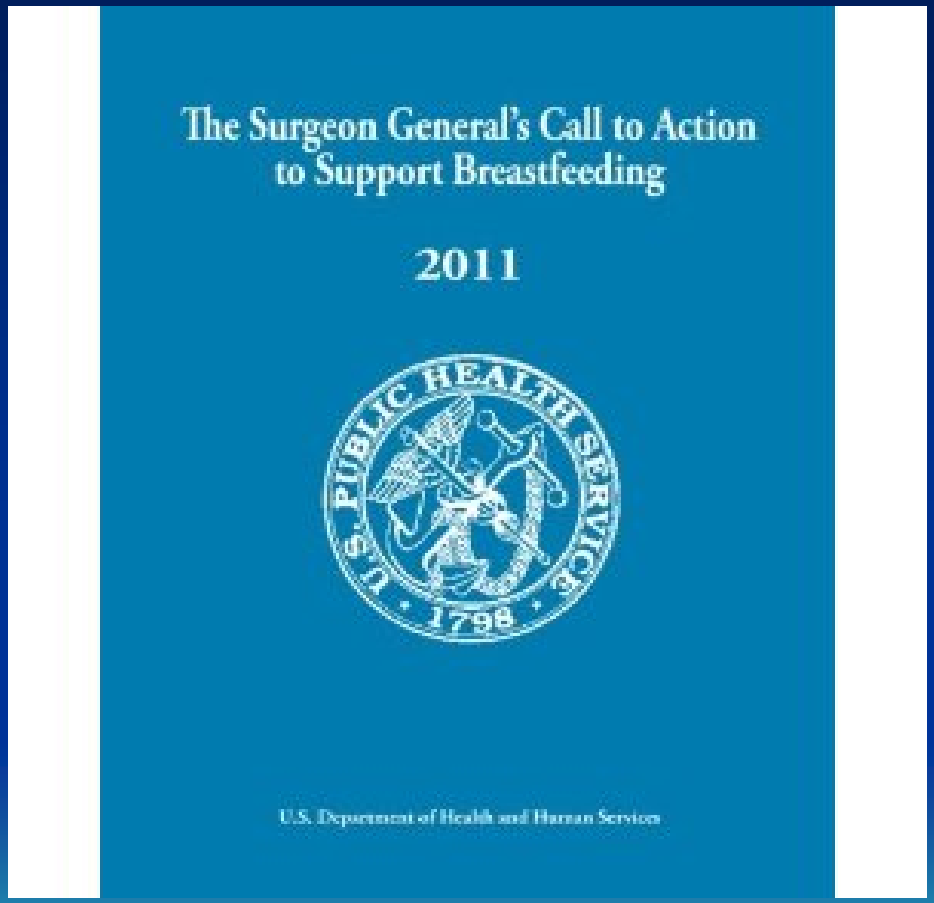
2010 JHACO Perinatal Care Core Measure Set

- Elective Delivery
- Cesarean Section
- Antenatal Steroids
- Health care-associated bloodstream infections in newborns
- Exclusive breast milk feeding

History of Federal Policy on Breastfeeding

- 1984 – First Surgeon General's Workshop on Breastfeeding
- 1990 Innocenti Declaration on the Protection, Promotions and Support of Breastfeeding
- 1995 USBC formed
- 1999 Blueprint for Action on Breastfeeding
- 2011 Surgeon General's Call to Action

The Surgeon General's Call to Action



The Actions

1. Give mothers the support they need to breastfeed their babies.
2. Develop programs to educate fathers and grandmothers about breastfeeding.
3. Strengthen programs that provide mother-to-mother support and peer counseling.
4. Use community-based organizations to promote and support breastfeeding.
5. Create a national campaign to promote breastfeeding.
6. Ensure that the marketing of infant

Actions cont.

7. Ensure that maternity care practices throughout the United States are fully supportive of breastfeeding.
8. Develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community.
9. Provide education and training in breastfeeding for all health professionals who care for women and children.
10. Include basic support for breastfeeding as a standard of care for midwives

Actions cont.

11. Ensure access to services provided by International Board Certified Lactation Consultants.
12. Identify and address obstacles to greater availability of safe baked donor milk for fragile infants.
13. Work towards establishing paid maternity leave for all employed mothers.
14. Ensure that employers establish and maintain comprehensive, high-quality lactation support programs for their employees.

Actions cont.

16. Ensure that all child care providers accommodate the needs of breastfeeding mothers and infants.
17. Increase funding of high-quality research on breastfeeding.
18. Strengthen existing capacity and develop future capacity for conducting research on breastfeeding.
19. Develop a national monitoring system to improve the tracking of breastfeeding rates asa well as the policies and

Actions that we will address today…

7. Ensure that maternity care practices throughout the United States are fully supportive of breastfeeding.
8. Develop systems to guarantee continuity of skilled support for lactation between hospitals and health care settings in the community.
9. Provide education and training in breastfeeding for all health professionals who care for women and children.
10. Include basic support for breastfeeding as a standard of care for midwives, obstetricians, family physicians, nurse practitioners and pediatricians.

Action #7 – Maternity Care Practices

- Accelerate implementation of the Baby-Friendly Hospital Initiative
- Establish transparent, accountable public reporting of maternity care practices in the United States.
- Establish a new certification program for perinatal patient care.
- Establish systems to control the distribution of infant formula in hospitals and ambulatory care facilities.

Breastfeeding and Maternity Care Practices

Proven Benefits of Breastfeeding

- Bacterial meningitis
- Bacteremia
- Diarrhea
- Respiratory tract infections
- Necrotizing enterocolitis
- Otitis media
- Urinary tract infection
- Mortality

Possible benefits to infant

- Sudden Infant Death Syndrome (SIDS)
- Insulin dependent diabetes mellitus
- Crohn’s disease
- Ulcerative colitis
- Lymphoma
- Allergic disease
- Other chronic digestive diseases
- Obesity

Benefits to mother – what we knew…

- Decreased postpartum bleeding
- More rapid uterine involution
- Lactation amenorrhea
- Earlier return to pre-pregnancy weight
- Child spacing
- Reduced risk of pre-menopausal breast cancer
- Reduced risk of ovarian cancer
- Reduction in post-menopausal hip fractures and osteoporosis

Benefits to mother – what's NEW!!

May 2009, *Obstetrics and Gynecology*

"Duration Lactation and Risk Factors for Maternal Cardiovascular Disease" Schwarz et. al

Decreased lifetime risk of…

- Hypertension (OR 0.88, P<.001)
- Diabetes (OR 0.80, P<.001)
- Hyperlipidemia (OR 0.81, P<.001)
- Cardiovascular Disease(OR 0.91, P<.008)

- Non-significant trend toward less adult obesity (P=0.7)

Economic Benefits

- If 90% of US families breastfed exclusively for 6 months, the US would save $13 billion dollars

Breastfeeding - As American as Baseball and Apple Pie…or not?

Factors associated with breastfeeding success

- Baby must emerge and be able to feed.
- Mother must be able and willing.
- Lactation must physiologically proceed normally.
- Breastfeeding must be comfortable for both.
- Surroundings and personnel must support mother and baby.

From BFHI (WHO statement)

- “ A woman’s experience during labor and delivery affects her motivation towards breastfeeding and the ease with which she initiates it.”

Obstacles to support of breastfeeding

- Lack of broad social support
- Media portrayal of bottle feeding as norm
- Insufficient prenatal breastfeeding education
- Maternal employment
- Disruptive hospital policies
- Inadequate provider education

continued…

Obstacles to support of breastfeeding

- Commercial promotion of formula

Work and Breastfeeding

- US is one of four (0f 173 countries) with no policy on mandatory paid maternity leave (others are Swaziland, Liberia, and Papua New Guinea)

The Physician

“I have my own opinion – don’t confuse me with the facts.”

-George Bernard Shaw

Breastfeeding and the Physician

Most parents choose their method of infant feeding before delivery

winikoff, o'campo

Obstetrician knowledge and attitude

- " It is the role of the ob-gyn to recommend breastfeeding to expectant mothers."
  - 88% residents
  - 82% practitioners

- "Training provided "no" or "less than adequate" preparation to support breastfeeding patients."
  - 68% residents
  - 79% practitioner

Freed

Experiences of Senior Residents Providing Breastfeeding Support

- Counseled expectant mother regarding infant feeding choice more than 5 times- 70%
- Taught new mother breastfeeding technique more than 5 times – 15%
- Had even one episode of rounds or precepting that included breastfeeding-55%

Freed

Obstetrician comfort in breastfeeding management

- Percent who were "well-qualified" to deal with complaints
  - 22.8% offer prenatal breastfeeding education
  - 17.8% help with sore nipples
  - 12.7% help with first feed
  - 10.5% help with inadequate supply
- Percent who got all nine knowledge questions correct – 9%
- Adequacy of residency training in breastfeeding medicine:

AAP survey

- 1602 fellows
- When discussing infant feeding options:
  - 65% exclusive breastfeeding
  - 20% no recommendation
  - 13% combined feeding
  - 2% exclusive formula
- Discussing the length of breastfeeding
  - 63% stated a recommendation for duration
    - 31% 6 months
    - 61% 12 months
      - Schanler 1995

Prenatal counseling

- Prenatally – 23% received counseling from their OB

- Postpartum information came from:
  - Nursing 87%
  - OB 27%
  - PEDS 33%

Izatt

Physician counseling and breastfeeding initiation

- Women who were encouraged to breastfeed were four times more likely to initiate breastfeeding than those that were not encouraged.

- Percent of low-income women who changed from bottle to breast after prenatal counselling
  - 38% if counselled
  - 8% if not

Lu, Kistin

When provider “always” or “usually” discusses breastfeeding…

- 16% of mothers recalled breastfeeding being discussed during prenatal visit with OB/midwife

- 25% recalled antenatal discussion with pediatrician

Physician counseling and breastfeeding at 6 weeks

- Perception of physician recommendation
  - 38% - physician recommends breastfeeding
  - 62% - physician had no preference

- Breastfeeding at six weeks
  - 70% who thought physician favored breast
  - 54% who thought physician had no preference
  - 9% who thought physician favored formula

DiGirolomo

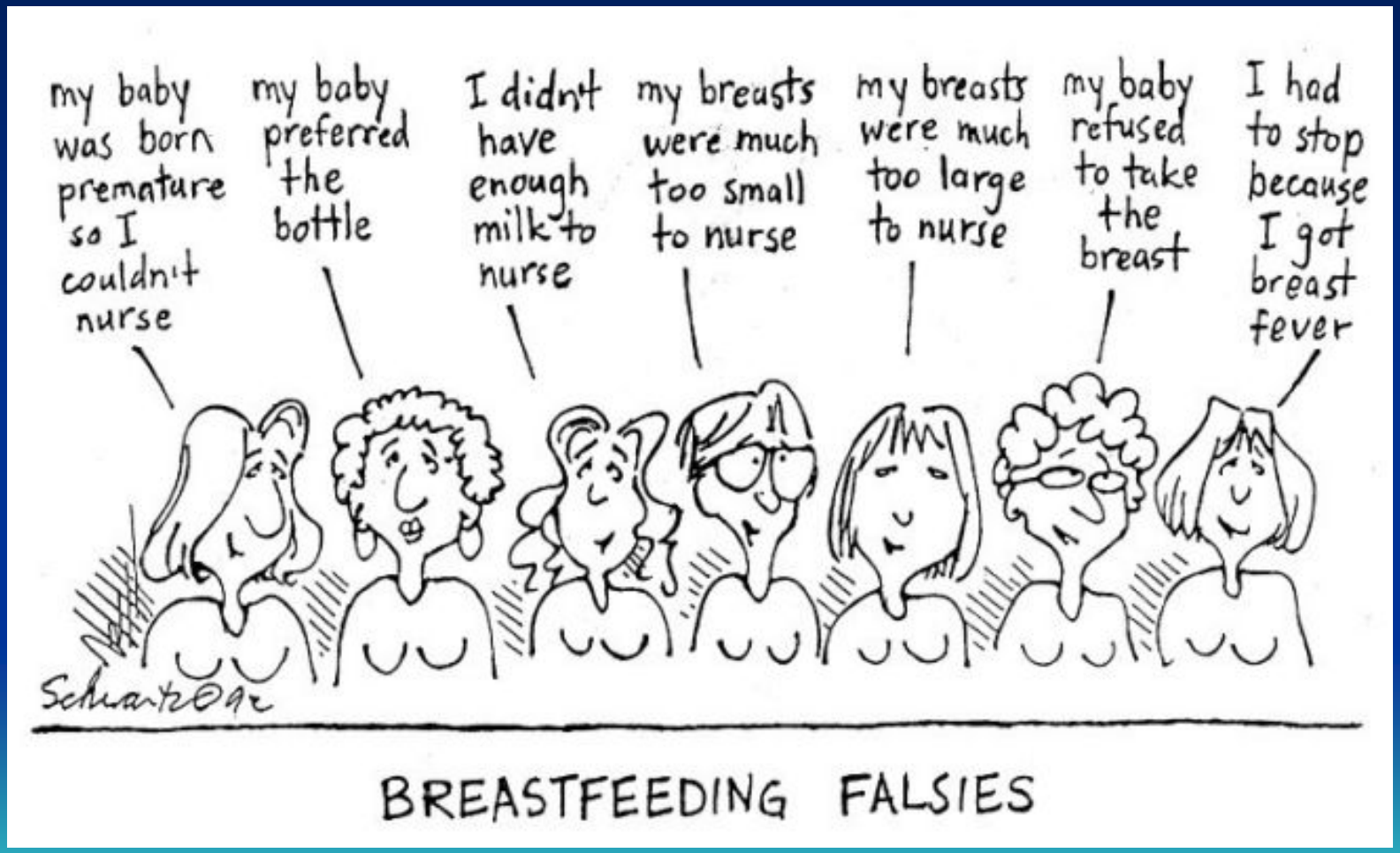
Physician counseling and breastfeeding at 12 weeks

- Discontinuation of breastfeeding at twelve weeks:
  - 40% if not encouraged
  - 30% if encouraged

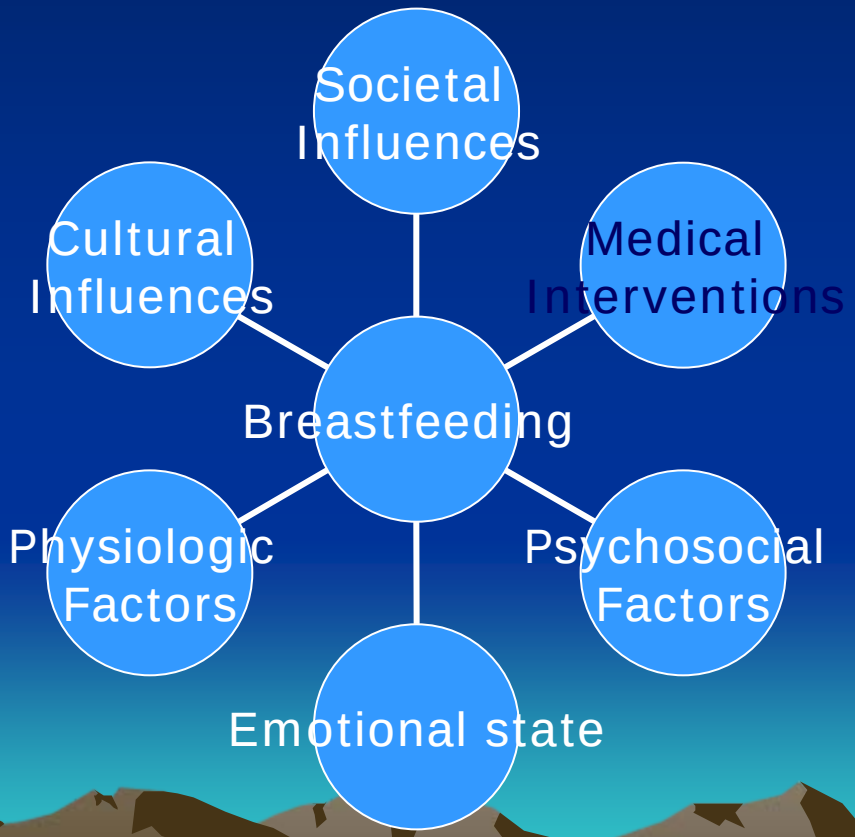
RR 0.56 (0.37-0.84)

Taveras

Factors that lead to early discontinuation



Factors Influencing Breastfeeding Success



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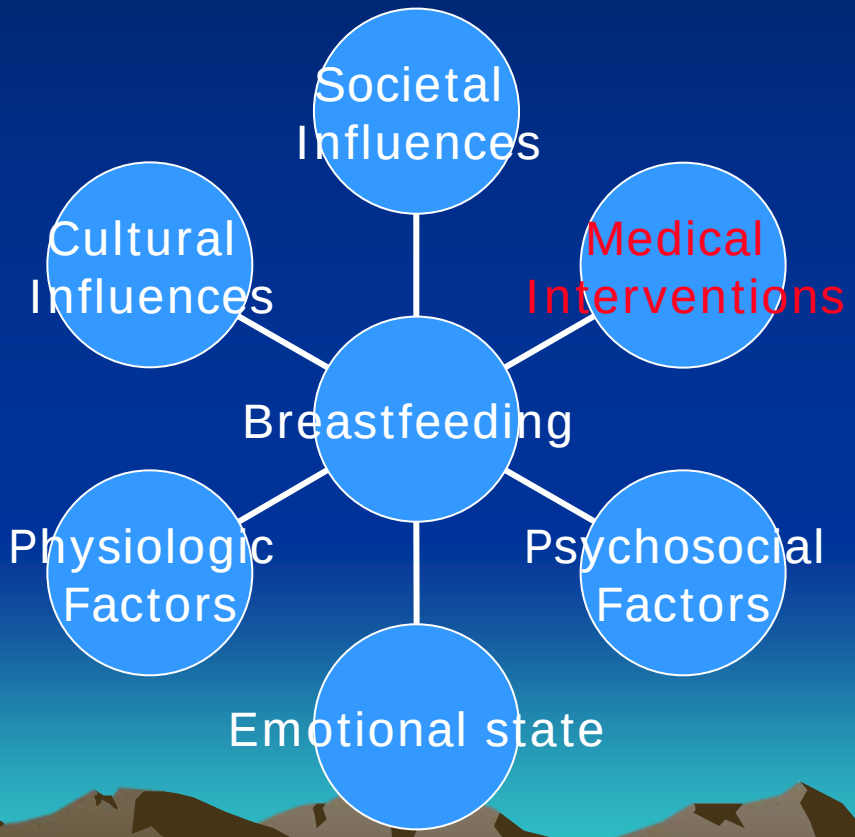


But here's the problem….

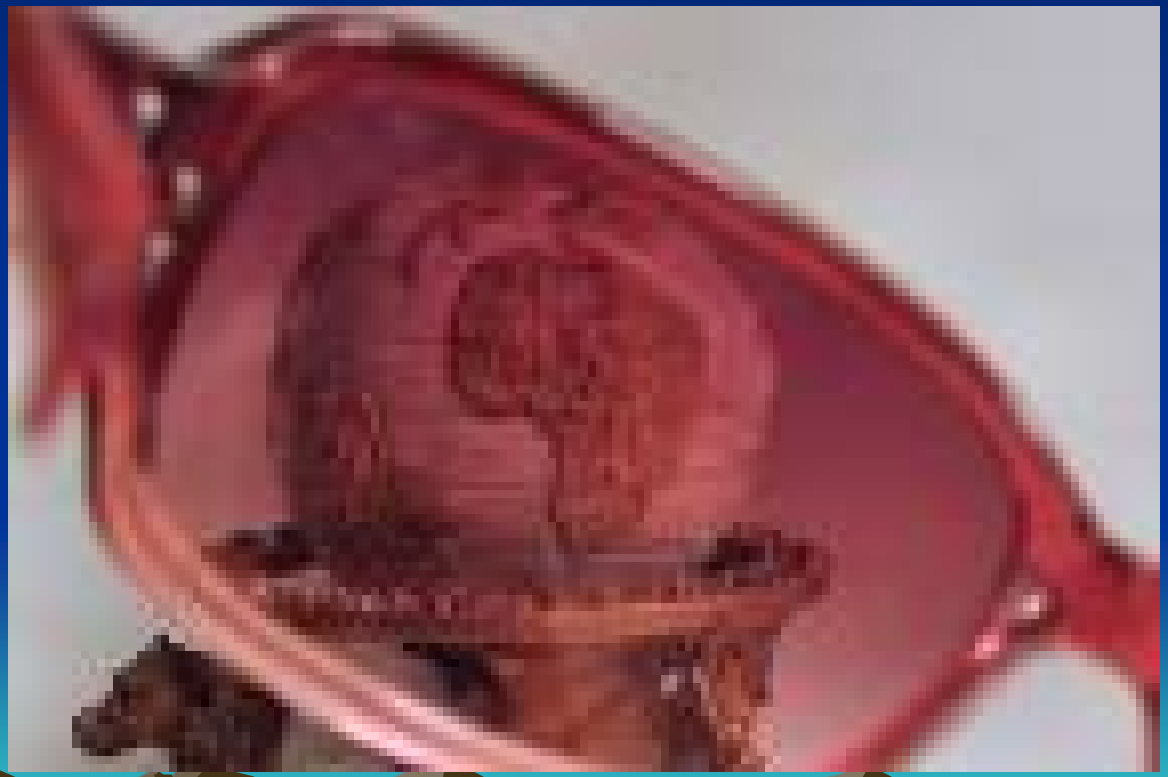
DATA

Research on birth practices and breastfeeding outcomes

- The randomized,
- controlled,
- double-blind

clinical trial is the gold standard

Viewing the world through rose-colored glasses…



Maybe it’s us….

What are labor interventions?

- Use of induction agents
- Operative intervention
- Use of anesthesia
- Lack of labor support personnel
- Use of IV
- Restriction of intake
- Cutting of episiotomy
- Post-partum medications, including contraception

BULLET-PROOF VEST

There are no level I studies…

- …looking at electronic fetal monitoring and breastfeeding success or outcomes.
- …linking position in labor and birth with breastfeeding outcomes.
- …linking eating/drinking in labor (or lack thereof) with breastfeeding outcomes.
- …linking use of forceps or vacuum with breastfeeding outcomes.

Case #1

- MB is a 28 y.o. G1 P0 at 38 3/7 weeks who presents to Labor and Delivery with contractions every five minutes.

- She is accompanied by her husband and a doula.

Labor course

- She is 3/100/-2 on admission at 10am.
- She spends a few hours laboring in the tub.
- 1pm 5/100/-1
- 4pm fully dilated
- 6pm SVD of viable female, 7lb 2 oz
- Baby skin-to-skin during laceration repair (2')

Factors that might impact breastfeeding success?

- Spontaneous labor/steady course
- Labor support personnel
- Successful birth plan – feelings of satisfaction
- Healthy baby
- Skin-to-skin

Lamaze International – “Six care practices that support normal birth”

- Labor begins on its own
- Freedom of movement
- Continuous labor support
- No routine interventions
- Spontaneous pushing
- No separation of mother and baby

Case #2

- 41 year old G1 P0 at 41 6/7 weeks. Cervix is long and closed. AFI is 6.4

- Plan for cervidil/pitocin induction

What is her success rate for vaginal delivery?

- 50%

- If cervix unripe (bishop score 4 or less) induction doubles risk of C/S
- If cervix ripe (bishop score of 5 or more) induction causes 10% chance of C/S

Clinical course

- Cervidil 8 pm
- Pitocin started at 8 am
- Cervix 3 cm at 3pm; AROM for moderate meconium; contractions painful; epidural given
- Cervix 5 cm at 6pm
- Cervix 6 cm at 8pm; no cervical change after 2 hours
- Cesarean delivery at 9 pm for arrest of dilation yields 8lb 4oz male, apgars 7,9

What criticism can you give of the labor management?

REALITY

- How many of the Lamaze guidelines would have been appropriate for this patient?
  - Movement
  - Labor support
  - No separation

Getting inside the OB's head

LABOR INDUCTION

Induction of Labor – WHY?

- Definition – to achieve vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor.
- Benefit of expeditious delivery outweigh risks of continuing the pregnancy.

Induction of labor – Indications

- Abruptio Placentae
- Chorioamnionitis
- Fetal Demise
- Gestational Hypertension
- Pre-eclampsia/ Eclampsia
- Maternal Medical Conditions (Diabetes, renal disease, APS, etc.)
- Premature Rupture of Membranes
- Fetal Growth Restriction
- Oligohydramnios
- Post-term pregnancy
- Elective

Induction of Labor – How often?

- WHO estimates that 10% of induced labors occur for medical reasons

- Overall induction – 22% of labors

ACOG practice Bulletin #107

So what is the concern?

Induction or Augmentation of labor

Confined to bed for monitoring

Increases need for pain relief (epidural)

Slowed/dysfunctional labor

More instrumentation
Or C-section

Impaired suck?

Pain/exhaustion

Impaired
breastfeeding

DATA

- No studies looking at induction or augmentation of labor and breastfeeding outcomes as a primary measure.

Let’s turn to a less controversial topic…

- HA
- HA
- HA

Getting inside the OB's head

EPIDURAL ANESTHESIA

Pain Relief on Labor

- Late 1800s – Ether
- 1930s – “twilight sleep” (morphine and scopolomine)
- Narcotics (Demerol/Penthidine)

Epidural anesthesia is a…

- "…conspiracy that undermines natural childbirth…"
- "…a woman's inalienable right to labor without pain…"

Riordan, 1997

Epidural Anesthesia – How often?

- 59% in US (National Vital Stats, 2006)

What can vary?

- Rates of use
- Choice of drugs
- Bolus, continuous infusion or patient controlled pump

Long Term effects of Epidural on Breastfeeding Success

- 191 breastfeeding women; 113 received epidural
- 92% of patients were breastfeeding at two weeks
- Labor analgesia was not associated with a reduction in breastfeeding success

- Halpern, 1999

The Impact of obstetric procedures and analgesia/anesthesia on breastfeeding

- Survey in UK on all births in one week; follow up survey 6 weeks
- Looked at effects of different factors on breastfeeding rates

Rajan 1994

Adverse Impact on Breastfeeding rates at six weeks

- Narcotic (pethidine)
- General anesthesia Admission of baby to NICU
- Cesarean delivery
- Stitches, urinary frequency, cracked nipples, engorged breasts

No impact on breastfeeding rates at six weeks…

- Induction of labor
- Length of labor
- Epidural anesthesia
- Assisted vaginal delivery

Walker, 1997

- Infant feeding as primary outcome
- Used feeding assessment tools
- Included an unmedicated control group
- Assessed infant behavior after 24 hours

Cochrane Reviews

- Selection criteria – Randomized controlled trials comparing all modalities of epidural with any form of pain relief not involving regional blockade, or no pain relief in labor.

Cochrane Review – Epidural versus non-epidural or no analgesia in labor October 2005

- PRIMARY OUTCOMES
  - Better pain relief (WMD -2.6)
  - Greater risk instrumented delivery (RR 1.38)
  - NO difference in risk of C/S
  - NO difference in long-term backache
  - NO difference in neonatal apgar scores

Cochrane Review – Epidural versus non-epidural or no analgesia in labor October 2005

- Secondary Outcomes
  - No difference in length of first stage of labor
  - Longer second stage of labor (MWD 15.55 minutes)
  - Increased use of oxytocin (RR 1.18)
  - Etc…

Cochrane Review – Epidural versus non-epidural or no analgesia in labor October 2005

- NO TRIALS REPORTED BREASTFEEDING OUTCOMES

Coming soon

- Study by Lawrence and Howard….?

ABM Clinical Protocol #15 "Analgesia and Anesthesia for the Breastfeeding Mother"

- "Unmedicated, spontaneous vaginal birth with immediate, uninterrupted skin-to-skin contact leads to the highest liklihood of baby-led breastfeeding initiation" (Rigard, Alade)

- Longer labors, instrumented deliveries, Cesarean Section and separation of mother and baby after birth may lead to higher risks of difficulty with breastfeeding initiation"

Conclusion

- There is a complex interaction between actual drug and procedure effects, maternal perceptions, and labor effects all of which may impact breastfeeding success.

- Decide which glasses you are going to use…

Getting inside the OB's head

CESAREAN SECTION

BULLET-PROOF VEST

March 24, 2010- USA TODAY "Six states see dramatic rise in C-sections"

- 1.4 million cesarean births in 2007 - highest rate ever in U.S.
- Rate rose 53% from 1996 to 2007
- Jumped 70% in six states (CO, CT, FL, NV, RI, WA)

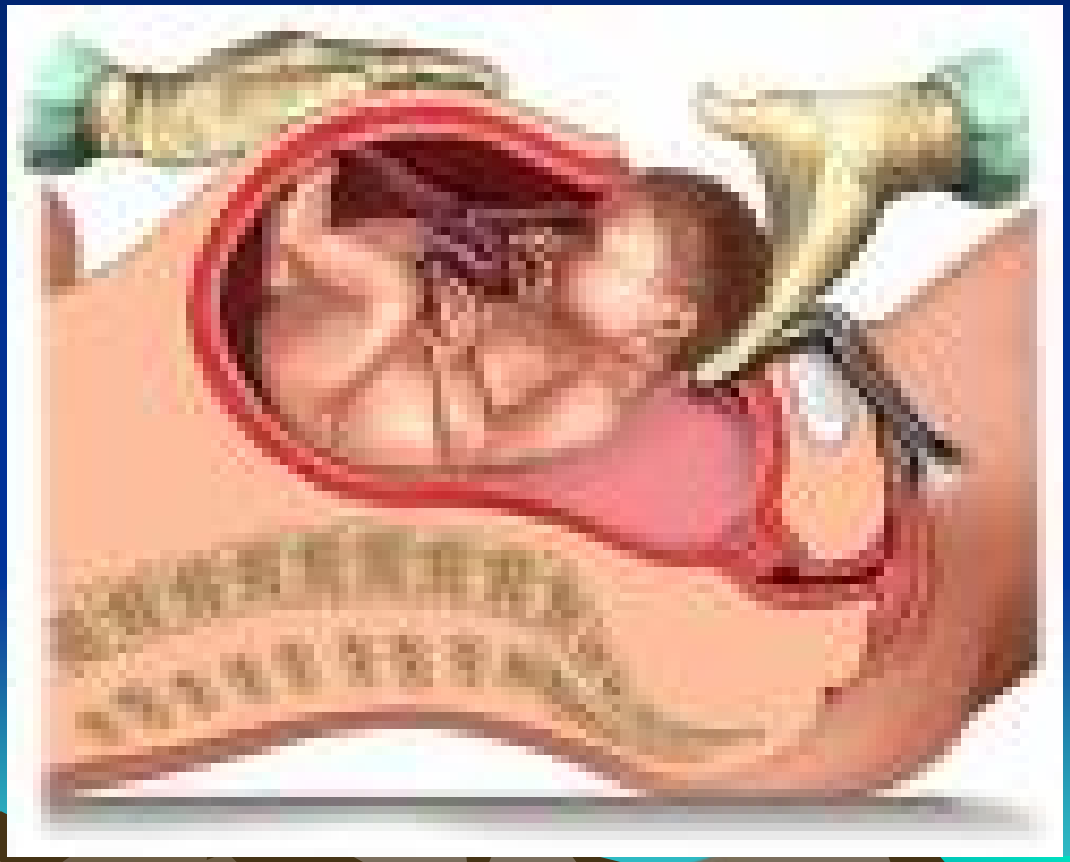
- NY 33.7% in 2007 (47% increase)
- NJ 38.3% in 2007 (60% increase)

Bad Doctor…

Blog comments

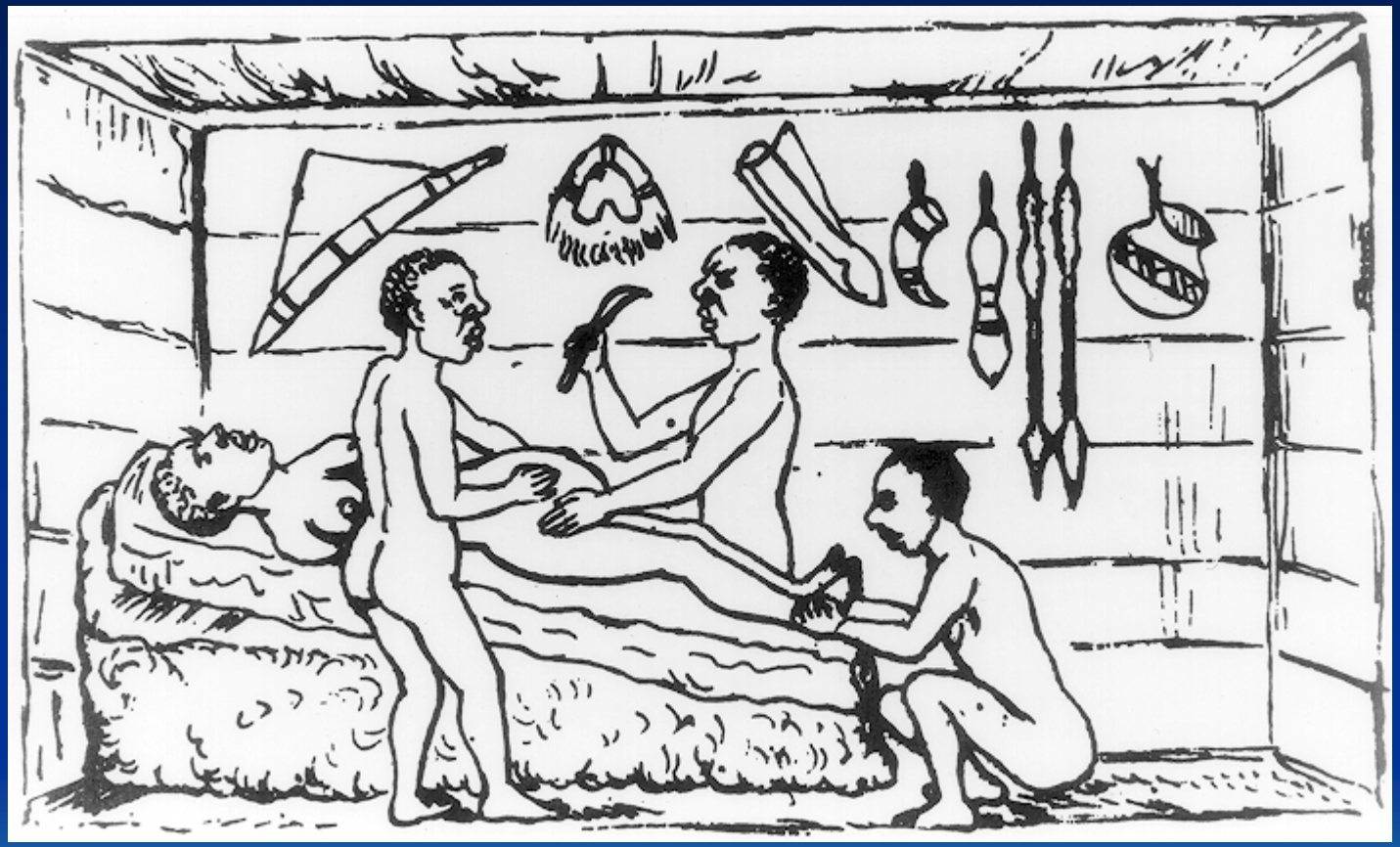
- “…the biggest reason…is because the doctors aren’t trained in vaginal births…they are trained in surgery. It’s short, sweet for them, and gets the job done. And with very few exceptions, most doctors don’t have the patience to see a birth through. They want to get home to dinner and don’t want to wait on a mother and baby taking their time in labor…” Becca

Cesarean Delivery



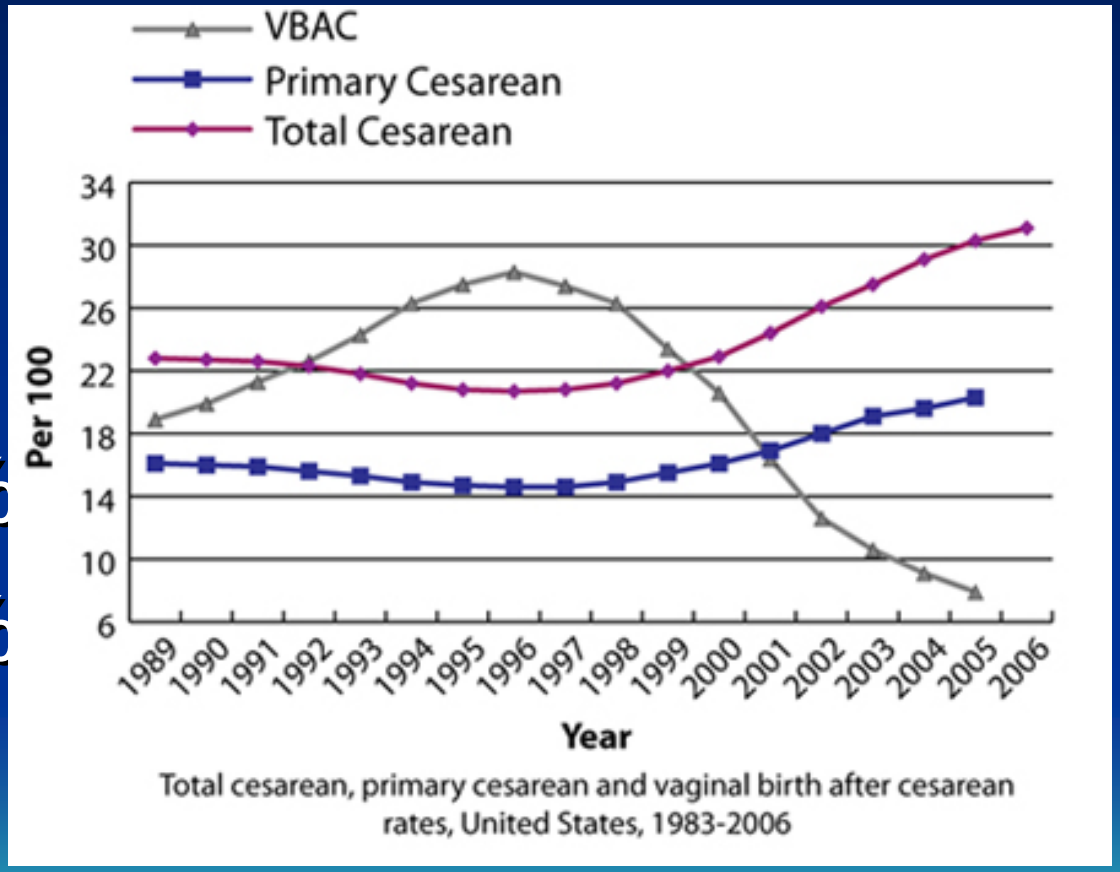
Cesarean Section - History

- Derived from latin word *Caesare,* “to cut”
- 1500s- first recorded case of surviving mother and infant pair
- Mid 1600s – case reports begin to appear
- 1846 – first use of Ether for surgery
- 1847 – introduction of hand washing



C-Section Rates

- 1910 – 0.6%
- 1928 – 3%
- 1965 – 4.5%
- 1988 – 24.1%
- 2006 – 31.1%
- 2007 – 32%



Total cesarean, primary cesarean and vaginal birth after cesarean rates, United States, 1983-2006

Theories about reasons for increasing C/S rates

- Repeat Cesarean Delivery
- Maternal Factors
- Decrease in the Rate of Breech Vaginal Delivery
- Electronic Fetal Monitoring
- Fear of Litigation
- Cesarean by maternal request?
- Convenience?

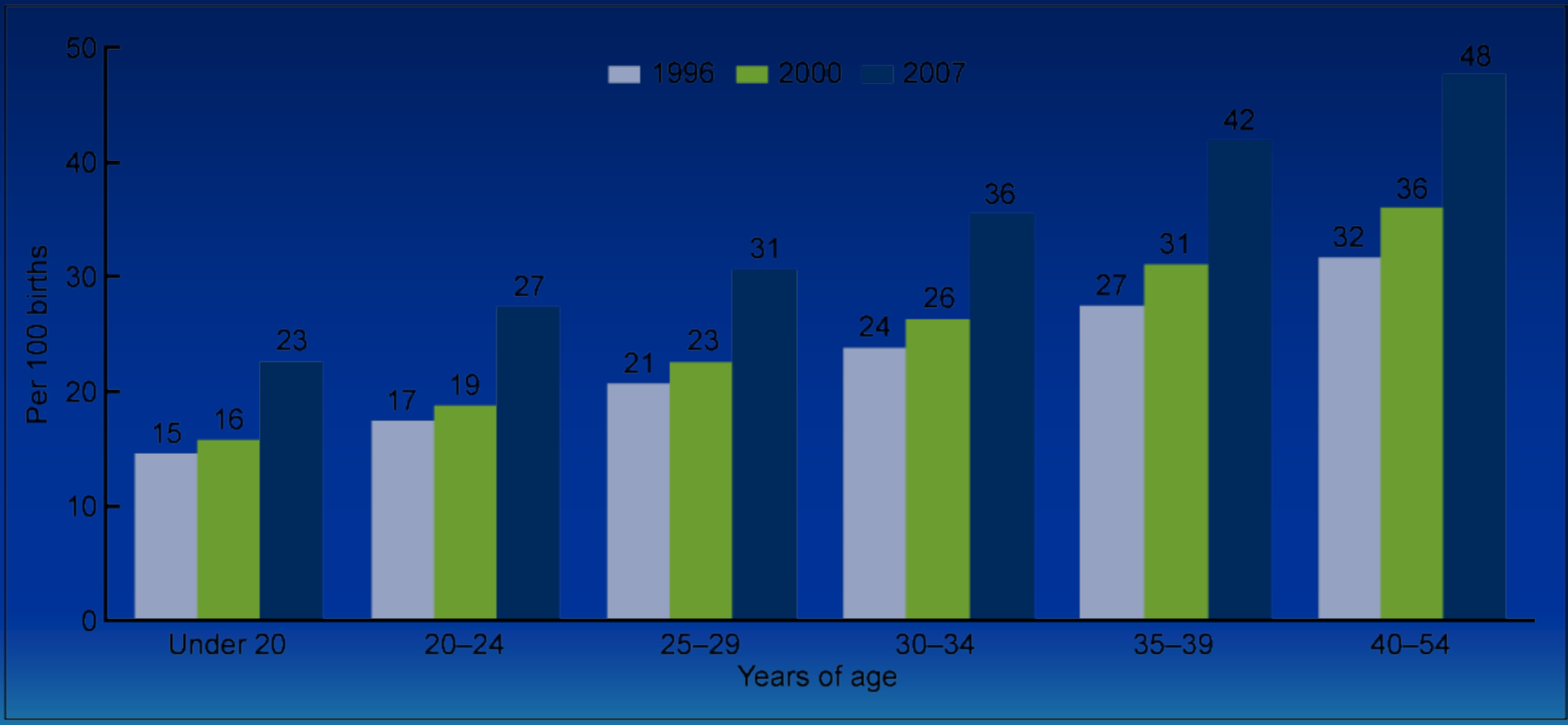
Repeat Cesarean Delivery (VBAC?)

- “Once a cesarean, always a cesarean”?
- 2010 NIH conference

Maternal Factors

- Delay in Childbearing
  - 5-17% >35
  - 2-5% >40
  - Multifetal gestation 1-3.5%
- Reduced Parity
- Medical Co-morbidities
  - Obesity >20%
  - Chronic Hypertension 2-5%

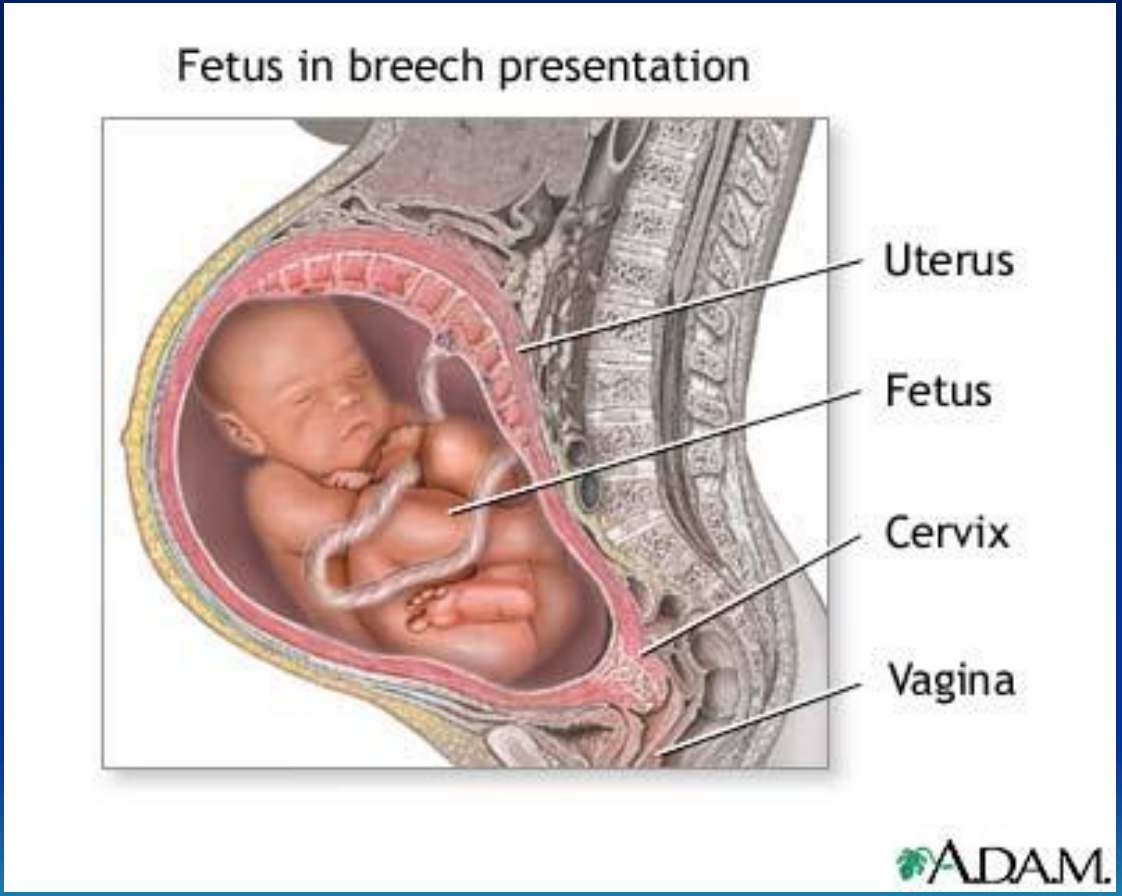
Figure 2. Cesarean delivery rates, by age of mother: United States, 1996, 2000, and 2007



SOURCE: CDC/NCHS, National Vital Statistics System.

Breech Vaginal Delivery

- 3% of term fetuses



Fear of Litigation

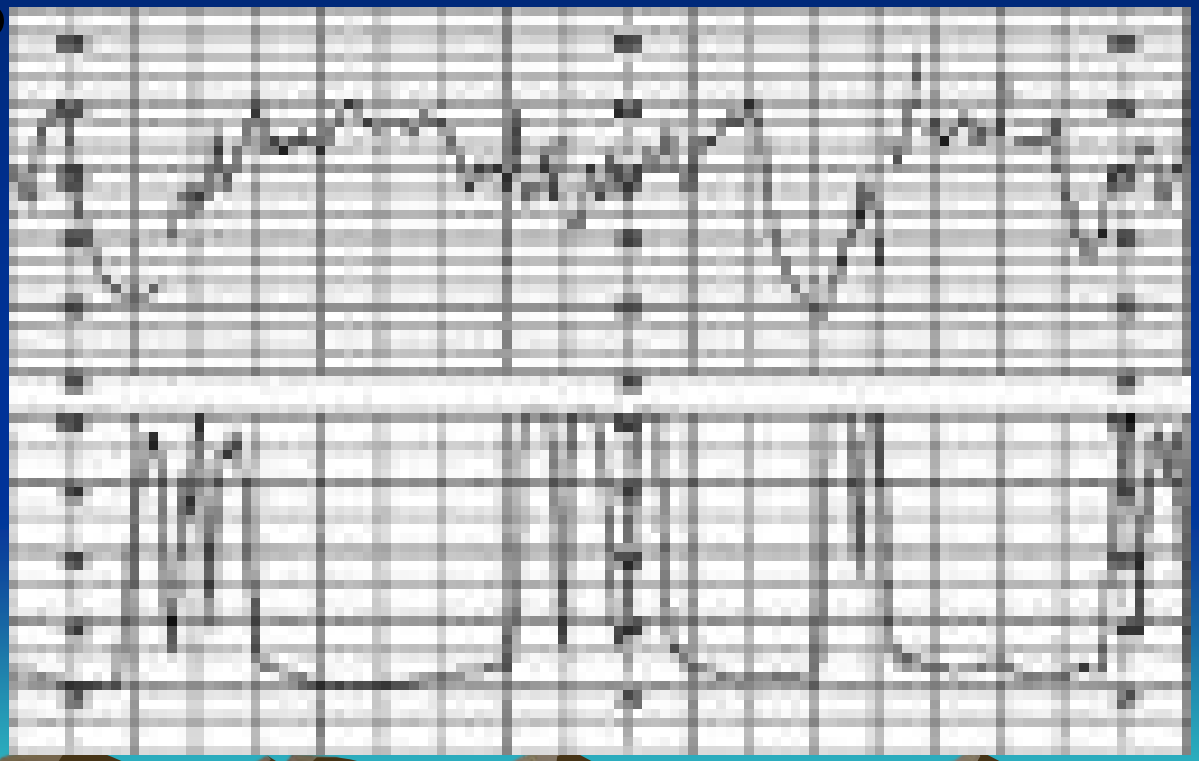
- Physicians acknowledge that decision making is influenced by medico-legal environment
- Influences performance of tests and procedures that may not be medically necessary
- Liability premiums skyrocketing
- “You will never be sued for DOING a C/S”

Liability Premiums

- Ob-gyns are the most sued physician specialists in the US
- 2003 – 76% of US obstetricians reported a litigation event in their careers
- “Medical negligence in child birth” – median award $2.3 million
- Ob premiums highest
- 1 out of 11 OB stopped delivering infants

Electronic Fetal Monitoring

- C/S for NRFHR represents 15% of C/S



Social Factors

- Convenience
- Practitioner preference
- Maternal Request

Cesarean Delivery on Maternal Request

- 1.9% 2001
- 2.3% 2003
- 2.5% 2006
- NIH Consensus Statement, 2006

Cesarean Section - Indications

- Ancient times
  - Mother dead or dying; attempt to save infant
  - Measure of last resort
- Now – Numerous maternal and fetal indications

Maternal Indications

- Prior uterine surgery
- Obstructive masses
- Prior vaginal surgery or repair
- Maternal Infection
- Maternal HIV
- Preservation of pelvic floor support
- Placenta Previa
- Placenta Accreta
- Hypertensive Disorders
- Vulvar condylomata
- Abdominal cerclage

Fetal Indications

- Malpresentation
- Twin Gestation (non-vertex first twin)
- Higher order multiples
- Congenital Abnormalities
- Non-reassuring FHR
- Conjoined twins
- Very Low birth weight
- Herpes simplex virus
- ITP
- HIV
- Absolute macrosomia

Materno-Fetal Indications

- Arrest of Dilation
- Arrest of Descent
- Cephalo-pelvic disproportion
- Placental abruption

Complications

- Maternal mortality 6-22/100,000
- Morbidity
  - Intraoperative complications
    - Uterine lacerations
    - Bladder/Ureteral Injury
    - Bowel Injury
    - Bleeding
  - Post-operative complications
    - Endomyometritis/wound infection
    - Thromboembolic complications
    - Etc.

Breastfeeding and Cesarean Section

Risks to breastfeeding success

- Delayed skin-to-skin contact
- Increased supplemental feeding
- Separation of mother and baby

Cesarean and Breastfeeding Outcomes:

- Reduction in initiation of breastfeeding, breastfeeding at 1 month and breastfeeding duration (Leung)
- Significant delay in initiating breastfeeding compared to women giving birth vaginally (Rowe-Murray)
- Planned vaginal versus planned cesarean delivery - no difference in breastfeeding outcomes at 3 months, 2 years (Hannah, Hannah)

Cesarean Section as a barrier to early initiation of breastfeeding

- Impact of Anesthesia
- Recovery Room practices
- Post-partum Floor practices
- Psychologic Factors
- Physical Factors (Pain, fatigue, restricted mobility)

Effects of cesarean delivery on Breastfeeding

- Infant not immediately put to breast
- Must allow maternal recovery
- Personal Sense of failure
- Need for pain relief

The Ten Steps – hospital policies to support breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all healthcare staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even if separated from their infants.

Hospital policies to support breastfeeding

6. Give newborn infants nothing other than breastmilk, *unless* medically indicated.
7. Practice rooming in 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial nipples or pacifiers.
10. Foster the establishment of breastfeeding support groups.

Strategies to Enhance Breastfeeding Success After Cesarean Delivery

- SUPPORT
  - More extensive assessment and support
- HOSPITAL POLICIES
  - Skin-to-skin
  - Encourage initiation in recovery room
  - Avoid nighttime supplementation

Conclusions

- More obstetric intervention *may* lead to impaired breastfeeding.
- Difficult to tease out cause from effect.
- These women may need more post-partum support.
- More studies needed.
- More education of physicians and labor and post-partum personnel needed.

The Hospital Environment

How can we assess how our hospital or birthing center is doing?

2007 CDC National Survey of Maternity Practices in Infant Nutrition and Care

mPINC

June 13, 2008 MMWR “Breastfeeding-Related Maternity Practices among Hospitals and Birth Centers”

mPINC practice domains

- Labor and delivery
- Postpartum breastfeeding assistance
- Postpartum mother-infant contact
- Postpartum feeding of breastfed infants
- Breastfeeding support upon discharge
- Staff training and education
- Structural and organizational factors related to breastfeeding

Barriers to breastfeeding related to health services

- 24% of facilities gave supplemental feeding to more than half of their healthy breastfed newborns during their post-partum stay
- 70% of facilities gave breastfeeding mothers gift packs containing formula samples

Infant Feeding Practices Survey II

- Almost half of breastfed newborns were supplemented with formula IN THE HOSPITAL

SUPPLEMENTATION

“Just give a little formula…”

- “You’re tired, you should rest. We’ll feed the baby in the nursery tonight.”
- “A little formula here in the hospital won’t hurt.”

Hospital Supplementation

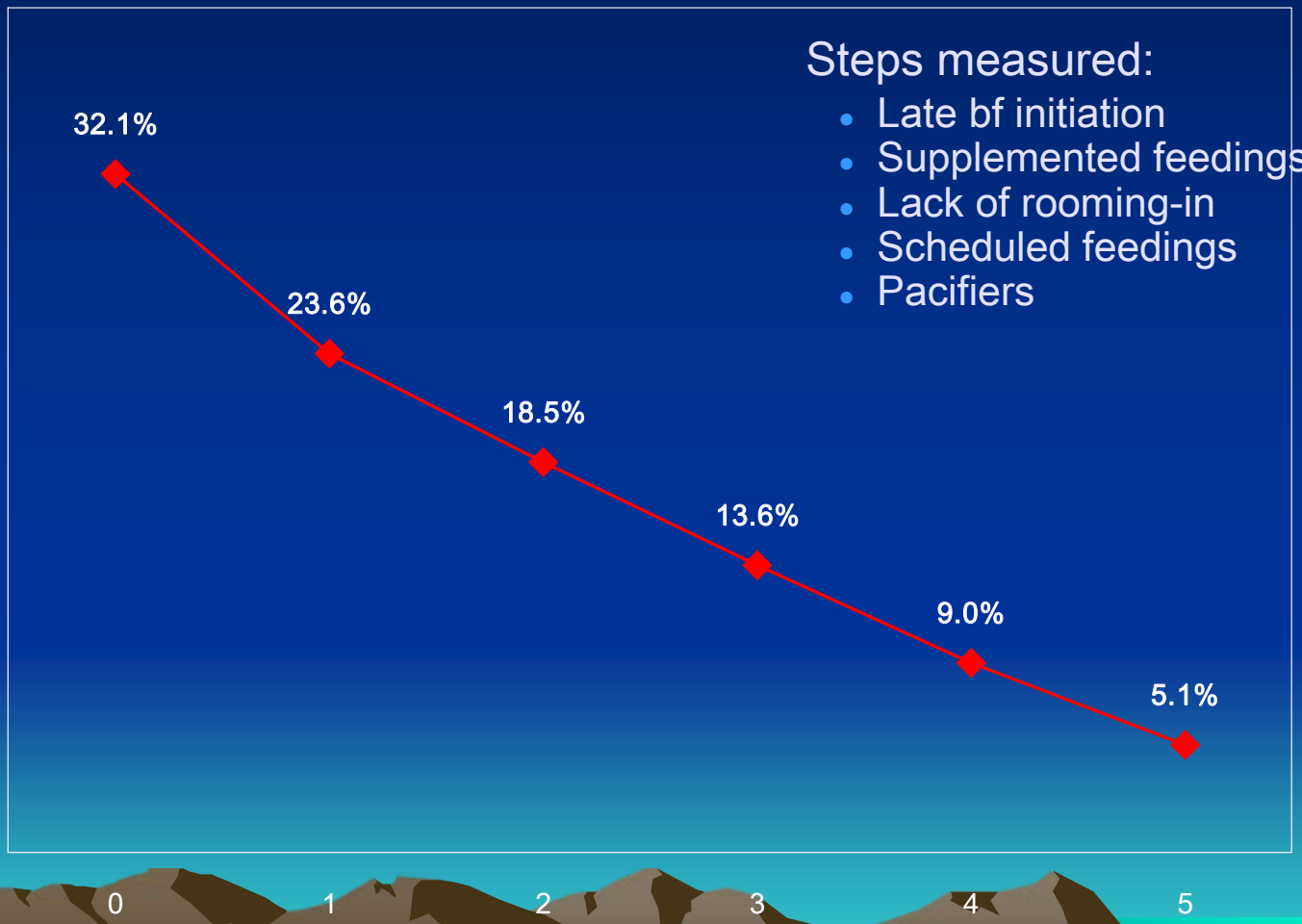
- Long breastfeeding intervals OR=1.1-1.3, p=0.0001
- More than two bottle daily OR 1.7-4.8, p=0.001
- Any supplement in the maternity ward – 3.9X higher chance of early cessation

Hall, Bloomquist

Risks of supplementation

- Interfere with the establishment of maternal milk supply (delayed lactogenesis)
- Increase risk of engorgement
- Alter infant bowel flora
- May cause nipple confusion
- Interfere with maternal-infant attachment
- Undermines maternal confidence in her ability to fully provide for her baby's nutritional needs
- Shortened duration of EXCLUSIVE and ANY breastfeeding

Number of *Baby Friendly* steps in place predicts risk of breastfeeding cessation



Source: *DiGirolamo et al., 2001*

Morristown Memorial Hospital
Morristown, NJ

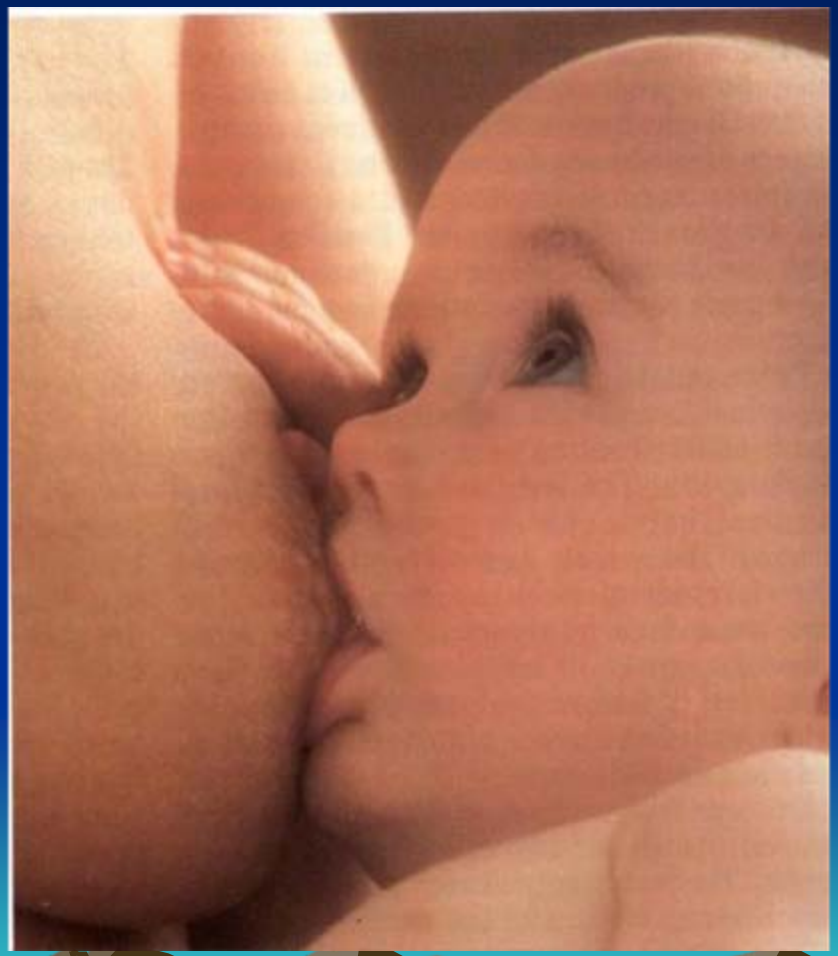
- Breastfeeding Education Program
  - Grand Rounds: OB and PEDS
  - Nursing Educational Inservice
  - Breastfeeding Protocol
  - Hospital Resource Guide for Physicians

- Patient survey

Morristown Memorial Hospital
Morristown, NJ

- Results(pre- and post-intervention):
  - Exclusive Breastfeeding 55% vs. 63% (p=0.04)
  - Increase in nighttime feeding 55% vs. 71% (p=0.001)
  - Decrease in supplementation 28% vs. 21% (p=0.001)
  - Improved provider knowledge (trend)
  - Improved provider comfort (trend)

So what can I, the busy practitioner do?



INTRAPARTUM/POSTPARTUM: Delay routine postpartum procedures

- Limit unnecessary interventions
- Place baby skin-to skin
- Initiate breastfeeding in the first hour
- Delay vitamin K and eye prophylaxis
- Assist proper breastfeeding technique
- Avoid traumatic interventions (ie: suctioning)

ABM #5, AAP section on BF Pediatrics 2005;115:496-506

POSTPARTUM: Offer resources

- Lactation consultants
  - www.ilca.org "find a lactation consultant"
- Books
- Websites

Sources of information on medications and breastfeeding

- AAP Committee on Drugs statement
- Books by Briggs, Hale
- ACOG/AAP Breastfeeding Handbook for Physicians
- http://toxnet.nlm.nih.gov (LactMED)
- www.ibreastfeeding.com
- www.e-lactancia.org/ingles/inicio.asp

ALWAYS: Educate yourself

- ACOG/AAP Breastfeeding Handbook for Physicians
  - www.aap.org
  - www.acog.org
- Academy of Breastfeeding Medicine (Protocols + Journal)
  - www.bfmed.org

Opportunities for Collaboration - local

- Speaking in the community
- Introducing yourself and providing resources to Obstetricians and Pediatricians
- Networking with other care providers
- Use mPINC and JHACO as opportunities to re-examine hospital policies

Opportunities for Collaboration - National

- AAP – Section on Breastfeeding
  - AAP residency education BPPOP
- Academy of Breastfeeding Medicine
  - www.bfmed.org
- United States Breastfeeding Committee
  - www.usbreastfeeding.org
  - “Friends of the USBC” – Donate now!

“If you wish to go fast, go alone. If you wish to go far, go together.”

-Old African Proverb

“Alone we can do so little; together we can do so much.” -Helen Keller

QUESTIONS???