Breastfeeding Basics for Family Physicians

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Objectives

At the conclusion of this session, participants will be able to:

1. Evaluate infant weight gain and feeding effectiveness using clinical indicators beyond growth curves alone.

2. Differentiate common breastfeeding concerns manageable in family medicine from those requiring referral to an IBCLC.

3. Apply current evidence-based mastitis protocols and utilize evidence based resources for medication safety in lactation.

Disclaimer:

We may use pronouns like “she/her” and language like “breastfeeding”, “mother” or “mom” out of habit or convention but our intention is to be inclusive of all people who have given birth and are feeding infants with their mammary glands.

Do you take care of breastfeeding dyads in your clinical practice?

Yes 0%

No 0%

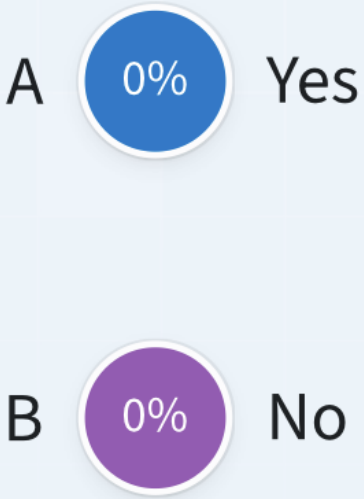
If so, do you care for them in the inpatient or outpatient setting?

Inpatient 0%

Outpatient 0%

Both 0%

Did your residency training adequately prepare you to address clinical challenges in breastfeeding in your everyday practice?



Allison and baby Caroline

Your clinic schedule today has a 4 day old newborn follow up.

Female born at 37+1 weeks via unscheduled c-section to a G2P0->1 mother for category 2 tracing, remote from delivery. Pregnancy complicated by chronic hypertension on labetalol.

Newborn course complicated by: initial low blood sugars treated with breastfeeding, oral glucose and eventual formula supplementation.

Received vit K, hep B, erythromycin ointment and nirsevimab prior to discharge.

Allison and baby Caroline

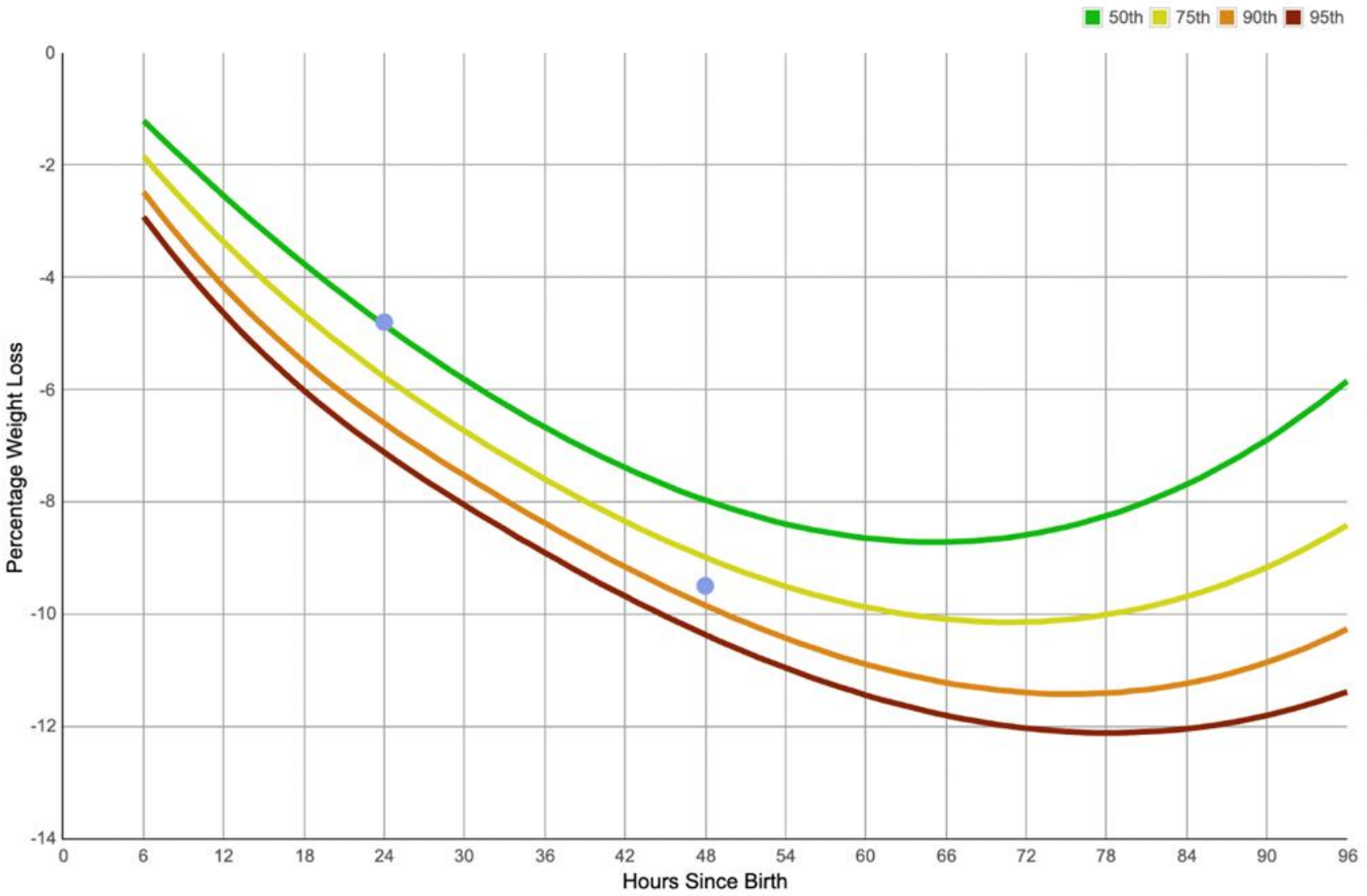
Discharge Summary:

Birthweight: 2800g

Discharge weight: 2535g (9.5% - less than 90%ile on NEWT)

Infant discharged on DOL #3. Lactation support provided. Infant sleepy at breast, mom supplementing with 10cc formula after every feed and pumping 2-3 times per day after feeding, still getting drops of colostrum. Plan for discharge home with close follow up within 24h.

TcB @ 24 HOL: 3.5mg/dL (8.2 below phototherapy threshold) - recommend clinical assessment at newborn follow up



newt.

Birth Details

Weight	Date	Time
2800 g	Feb 14	23:00

Cesarean | Breast Fed | Edit Details

Measurements

Hour	Weight	Change		
			Add New	
Birth	2800 g	—	Edit	
24	2665 g	-4.8%	Edit	x
48	2535 g	-9.5%	Edit	x

PennState Health
Children's Hospital

Medical Perspective:

In your office this morning:

Weight: 2500 g

Pulse: 140

RR: 40

What do you want to know? and how do you proceed from here?

Medical Perspective:

percentage weight loss: 10.7%

well appearing, alert

mild jaundice to chest

no uric acid crystals in diaper

Waking to feed every 2-3 hours, infant latches for 10-15 on both sides, not sure if she is hearing swallows or sucks. Feeding with 10 mls formula after every feed. 2 wet diapers yesterday and one stool, but this morning has already had 2 wet diapers and two yellow stools. Mom pumped this morning and got 20 mls. She doesn't want to be giving formula but wasn't sure what to do and they told her in the hospital she needed the formula to keep the baby's sugar up.

Medical Perspective

Next steps:

- needs a feeding plan… triple feeding vs another option?
- how do we know if the baby is feeding well?
- repeat bilirubin is up to your clinical judgement
- do you need to re-admit the baby?

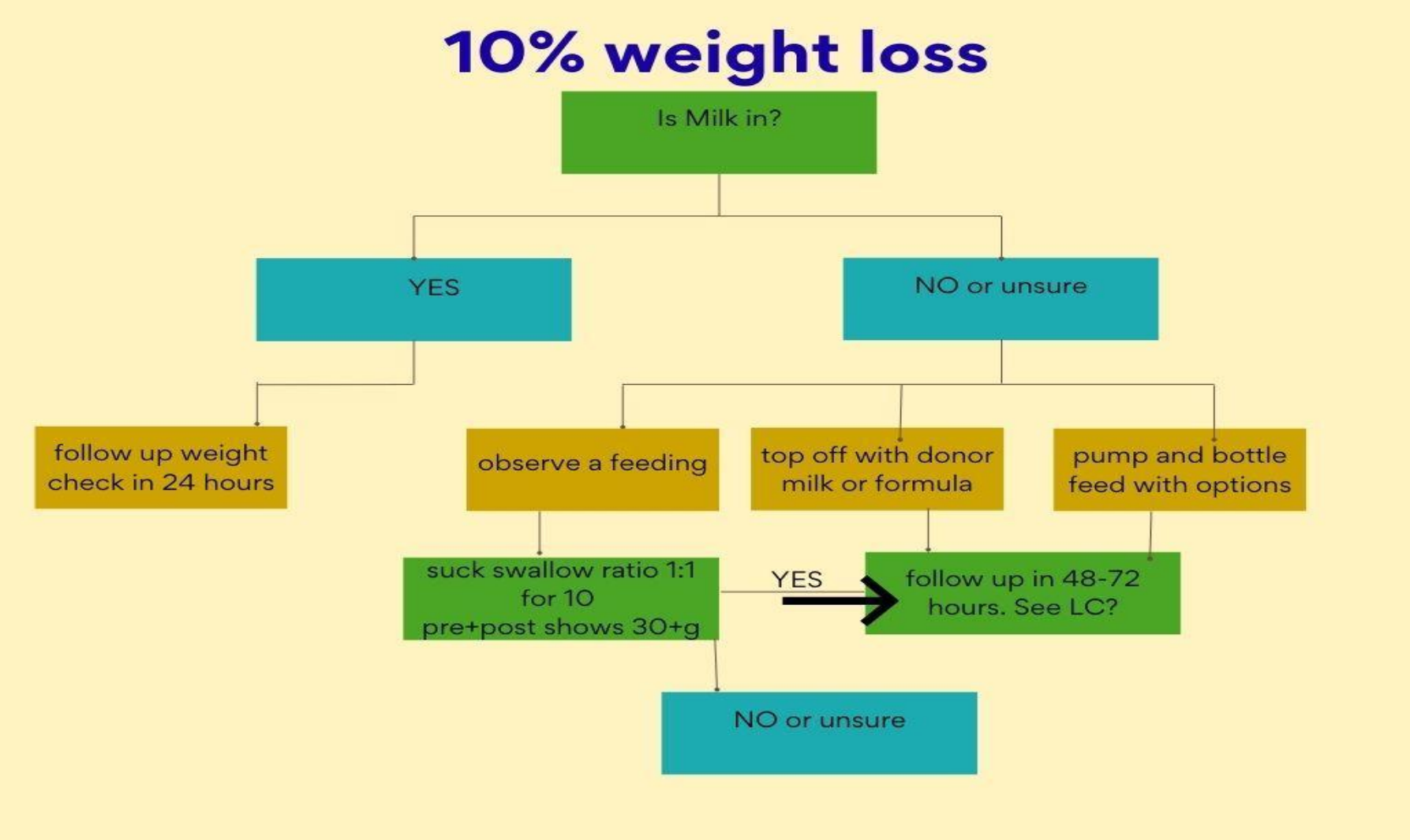
Medical Perspective

You observe a feeding and hear/notice a 1:1 suck swallow ratio, infant seems calm and satisfied after feeding, and see milk at the corners of the mouth.

You make a feeding plan and plan to see them back in the office the next day.

1. Continue to wake Caroline to feed every 3 hours, sooner if she is showing signs she is hungry.
2. If she still seems hungry after a feeding (rooting, fussing, etc) you can offer her formula or any breastmilk you have collected in your passive collector
3. If she has a bad feed (sleepy, fussy, doesn't want to latch) try pumping for the next feed and offering it to her in 1 oz increments.

IBCLC perspective



Medical Perspective:

24 hour follow up:

weight 2535g

5 pees and 5 poops in the last 24 hours

IBCLC perspective

Medical perspective:

2 week well child check:

weight 2850g (regained birth weight!)

still setting alarms to wake every 3 hours overnight to feed

Medical Perspective

1 mo WCC – in the 5th percentile for weight

Do we need to be concerned?

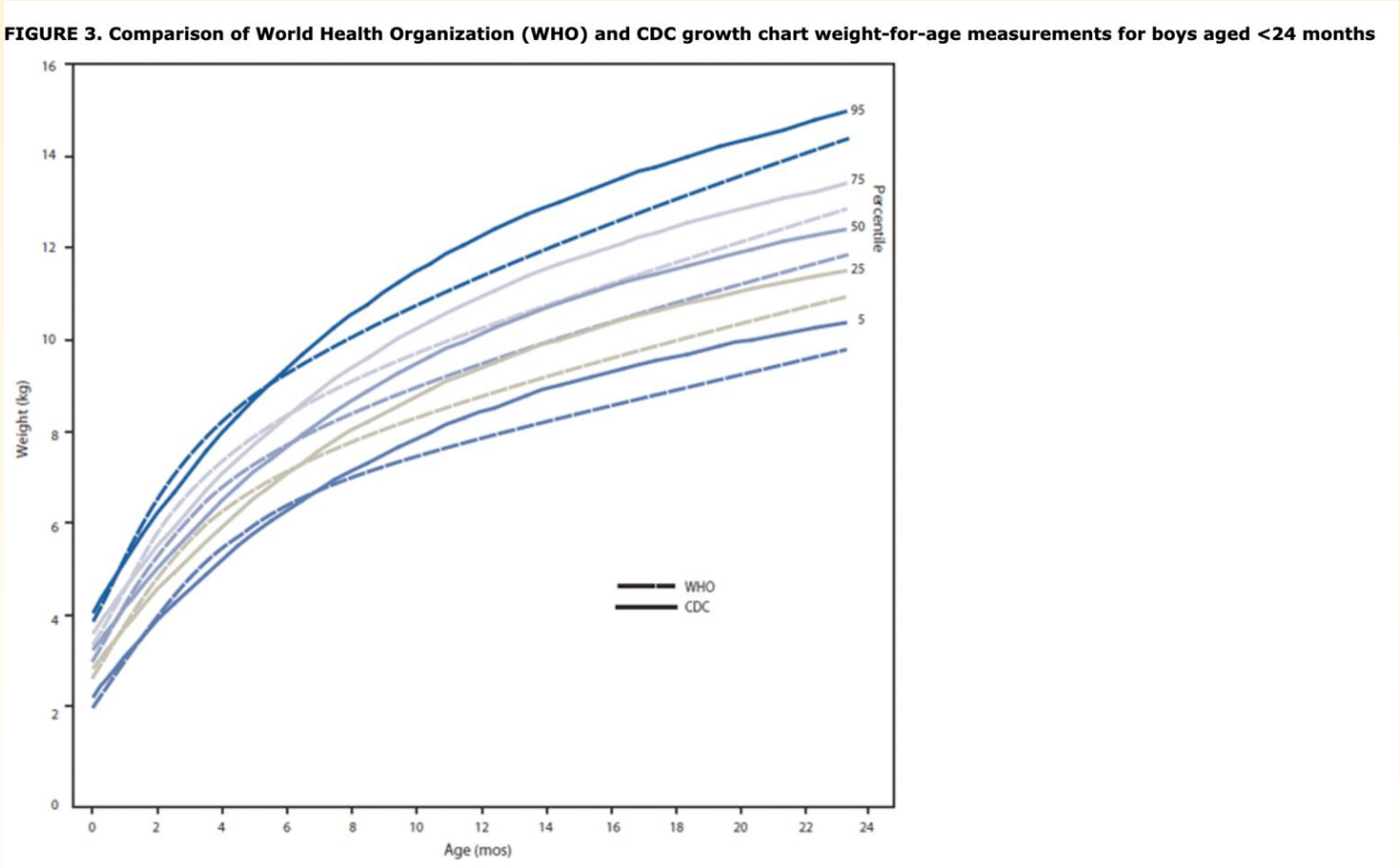


TABLE 1. Comparison of sample populations used to create the CDC and WHO growth curves for children aged <24 mos

Characteristic	CDC growth reference (2000)*	WHO growth standard (2006)†
Data sources	National vital statistics (birth weights) Missouri and Wisconsin vital statistics (birth lengths) Pediatric Nutrition Surveillance System (lengths, 0.1 to <5 mos) NHANES I (1971--1974) (12--23 mos) NHANES II (1976--1980) (6--23 mos) NHANES III (1988--1994) (2--23 mos)	MGRS longitudinal component, with sites in the following locations: Pelotas, Brazil Accra, Ghana Delhi, India Oslo, Norway Muscat, Oman Davis, California
Type and frequency of data collection	Cross-sectional data on weight and length starting at age 2 mos, with mathematical models used to connect birth weights and lengths to survey data	Longitudinal data with measurements of weight and length at birth; 1, 2, 4, 6, and 8 wks; and 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 14, 16, 18, 20, 22, and 24 mos
Sample size	4,697 observations for 4,697 distinct children	18,973 observations for 882 distinct children
Exclusion criteria	Very low birth weight (<1,500 g [<3 lbs, 4 oz])	Low socioeconomic status Birth at altitude >1,500 m Birth at <37 wks or ≥42 wks Multiple birth Perinatal morbidities Child health conditions known to affect growth Maternal smoking during pregnancy or lactation Breastfeeding for <12 mos Introduction of complementary foods before age 4 mos or after age 6 mos Weight-for-length measurements >3 standard deviations above or below study median for sex
Breastfeeding among infants in sample	Approximately 50% ever breastfed Approximately 33% breastfeeding at 3 mos	100% ever breastfed 100% predominantly breastfeeding at 4 mos 100% still breastfeeding at 12 mos Complementary foods introduced at mean age of 5.4 mos

When to refer to an IBCLC?

- Concern for low supply
- Slow weight gain
- Painful latch or nipple damage
- Questions about pumping
- Questions about returning to work
- Introducing a bottle

Two months later, Allison calls with a red painful breast. Do you...

0%
prescribe dicloxacillin 500mg q6h x 10 days

0%
prescribe cephalexin 500mg q8h x 10 days

0%
ask the patient to come in for an appointment

0%
tell the patient to call lactation, since this sounds like a breastfeeding problem

Academy of Breastfeeding Medicine, Protocol 36 - The Mastitis Spectrum

2022 revision represents a shift from thinking of mastitis as a purely bacterial problem to a spectrum:

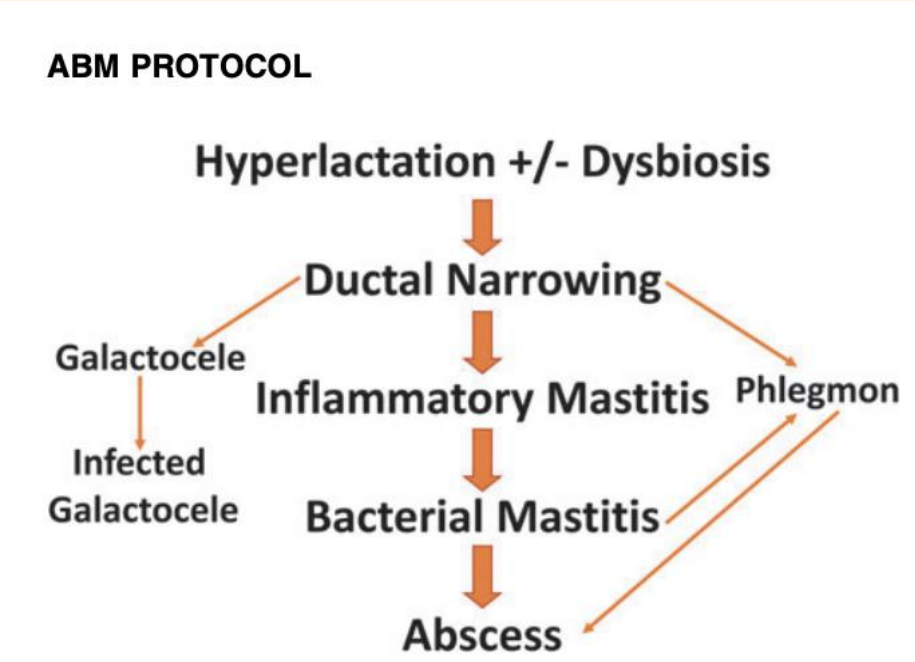


FIG. 1. Spectrum of inflammatory conditions in the lactating breast.

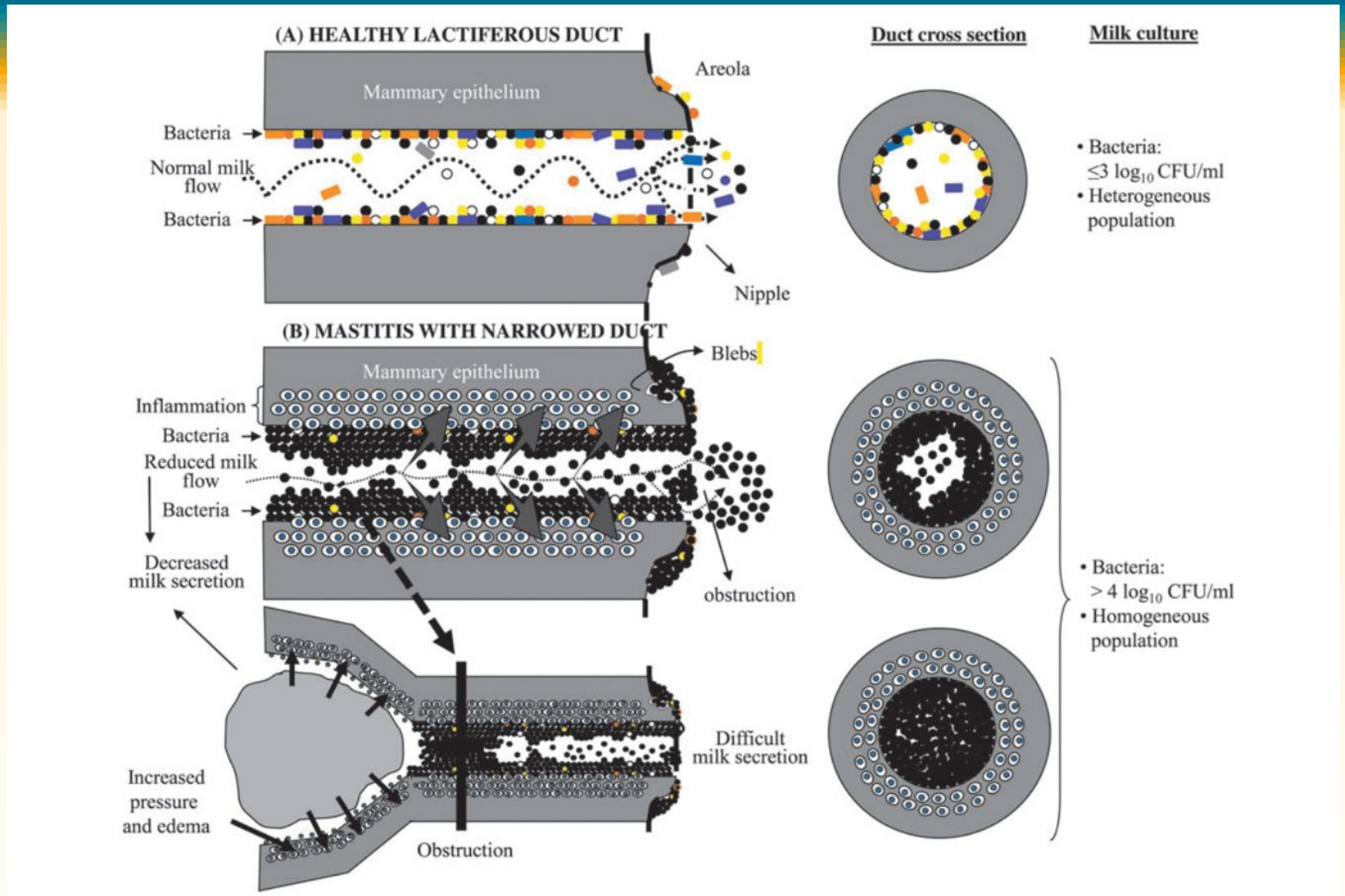


FIG. 2. Compared with a healthy lactiferous duct **(A)**, ductal inflammation can result in narrowed lumens, stromal edema, dysbiosis, nipple bleb formation, and mastitis **(B)**.

You see Allison for an office visit:

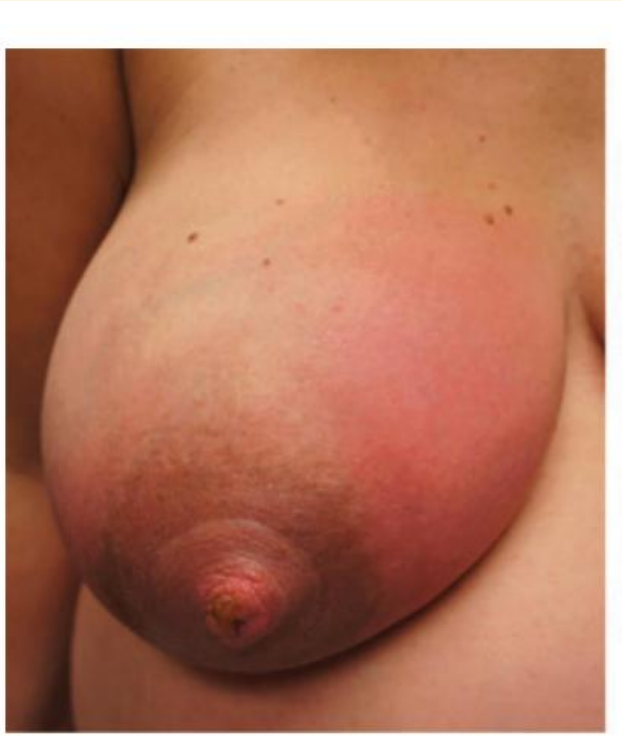
Baby Caroline slept through the night a few days ago, breasts felt engorged upon waking.

Thought she had a “clogged duct”.

Offered right breast first every feeding, tried hot showers after her sister recommended it.

Yesterday, noticed redness.

No fever but has felt generally unwell: achy, fatigued



What next?

Old advice:	New advice:
all mastitis is bacterial: antibiotics are needed	most is probably inflammatory: start with NSAIDs and ice
need to “empty” the breasts to clear out infection	feed on demand: extra feeding or pumping is probably upregulating lactation and contributing to the problem
massage to work out the clog	gentle, lymphatic massage
	Consider probiotics

Instructions to the patient:

1. Ibuprofen 600mg Q 6 hours
2. Ice the breast 15 minutes every hour while awke
3. Lymphatic massage 2-3 times a day (video)
4. Avoid pumping for the next few days if you can, do not pump extra.
5. Wear a supportive bra to reduce swelling.
6. Can consider taking a lactation specific probiotic: *Limosilactobacillus fermentum* or *Ligilactobacillus salivarius*
7. Call if you are feeling worse, not feeling better within 24-36 hours, or if you develop a fever.

What not to do:

avoid saline soaks, castor oil or other topical treatments

avoid sterilizing pump parts, household items, or the nipple

avoid unroofing “milk blebs” (these are actually inflammatory debris - treat with topical steroid)

only feed/offer the affected side first.

FIG. 20. Examples of different presentations of nipple blebs.

If bacterial mastitis, treat with:

dicloxacillin 500mg Q6H for 10-14 days

cephalexin 500mg Q6H for 10-14 days

Both are safe to use with continued breastfeeding.

If no improvement - consider obtaining sterile milk culture.

* phlegmon may require prolonged antibiotics

* abscesses require drain - consider placing a drain at the initial procedure vs. aspiration

3 month later, Allison messages you that she needs to have dental work done and the dentist wanted her to ask if it was ok to get lidocaine and amoxicillin while breastfeeding…

Respond at
pe.app/kathleenpolonch

Poll Everywhere

How do you find the answer?

0 0

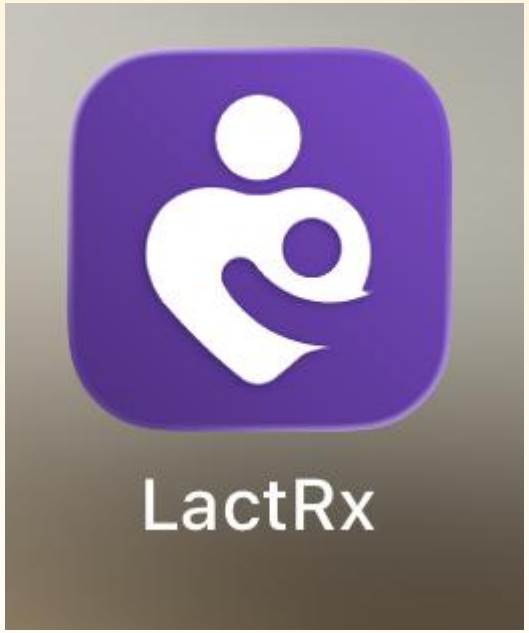
Awaiting first audience response..

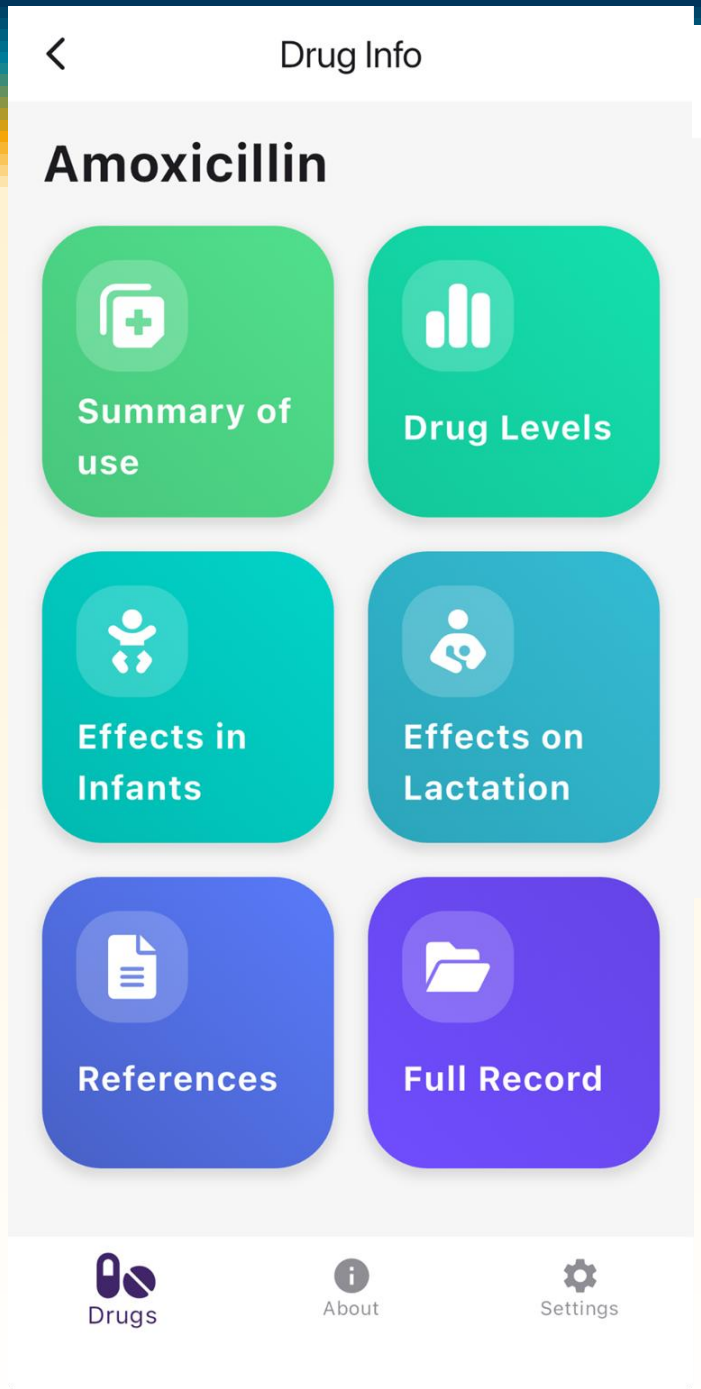
Edit

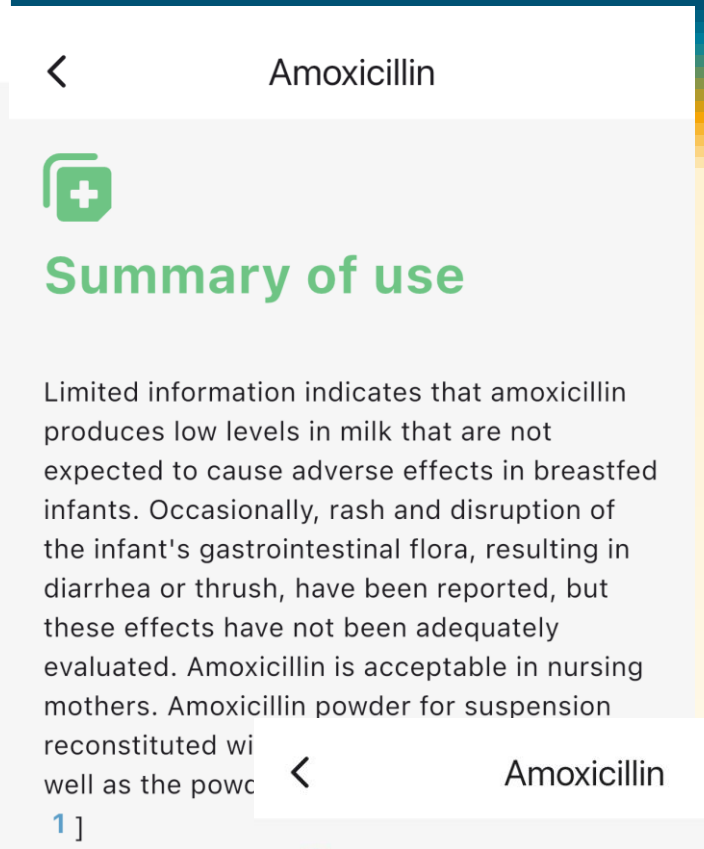
Show Responses Lock

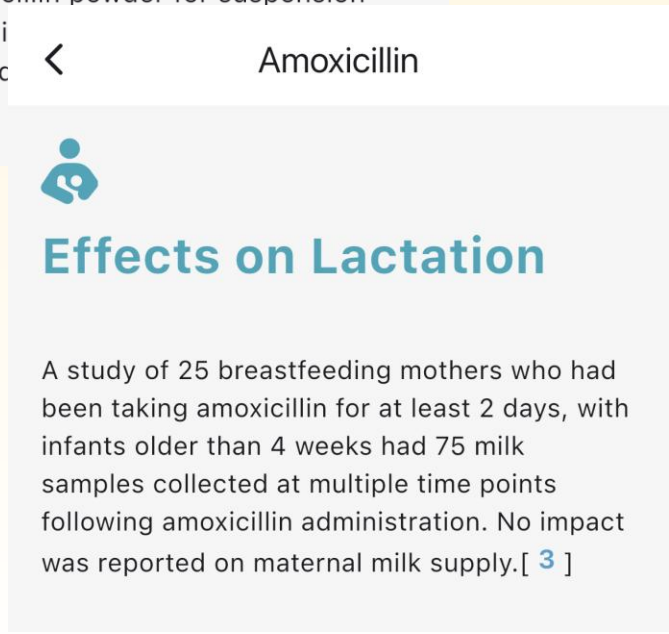
Resources

Lactmed/LactRx app



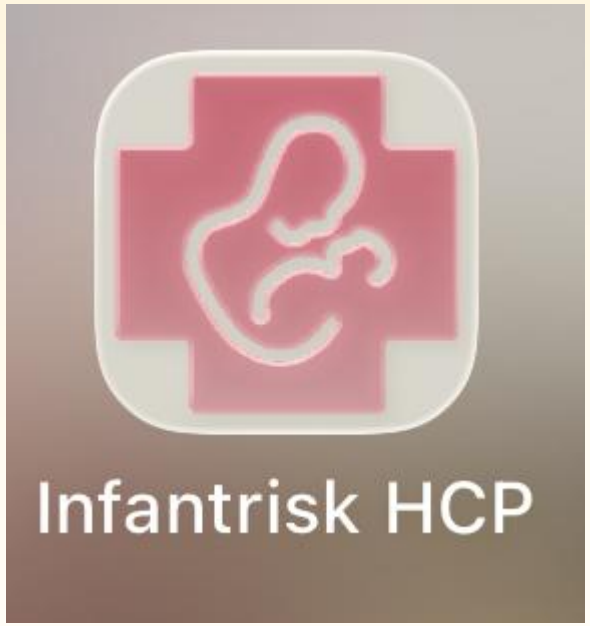


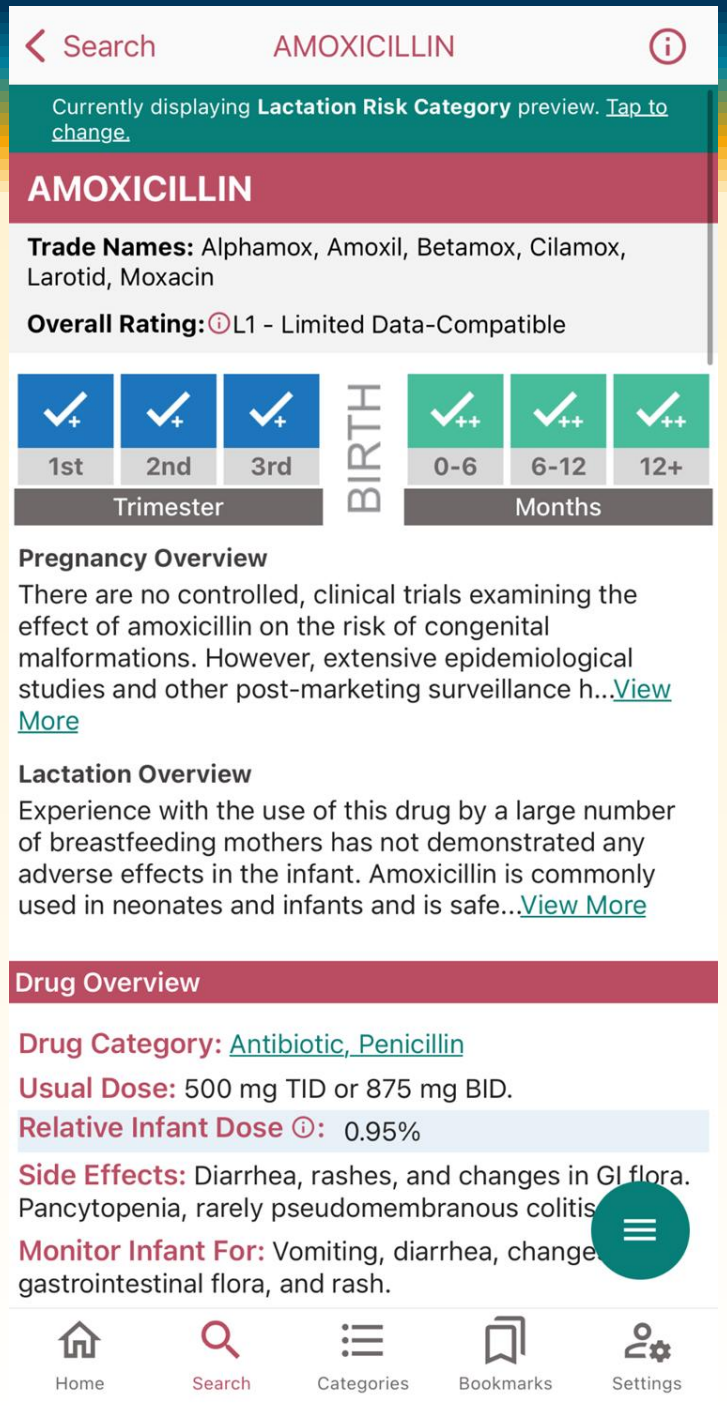


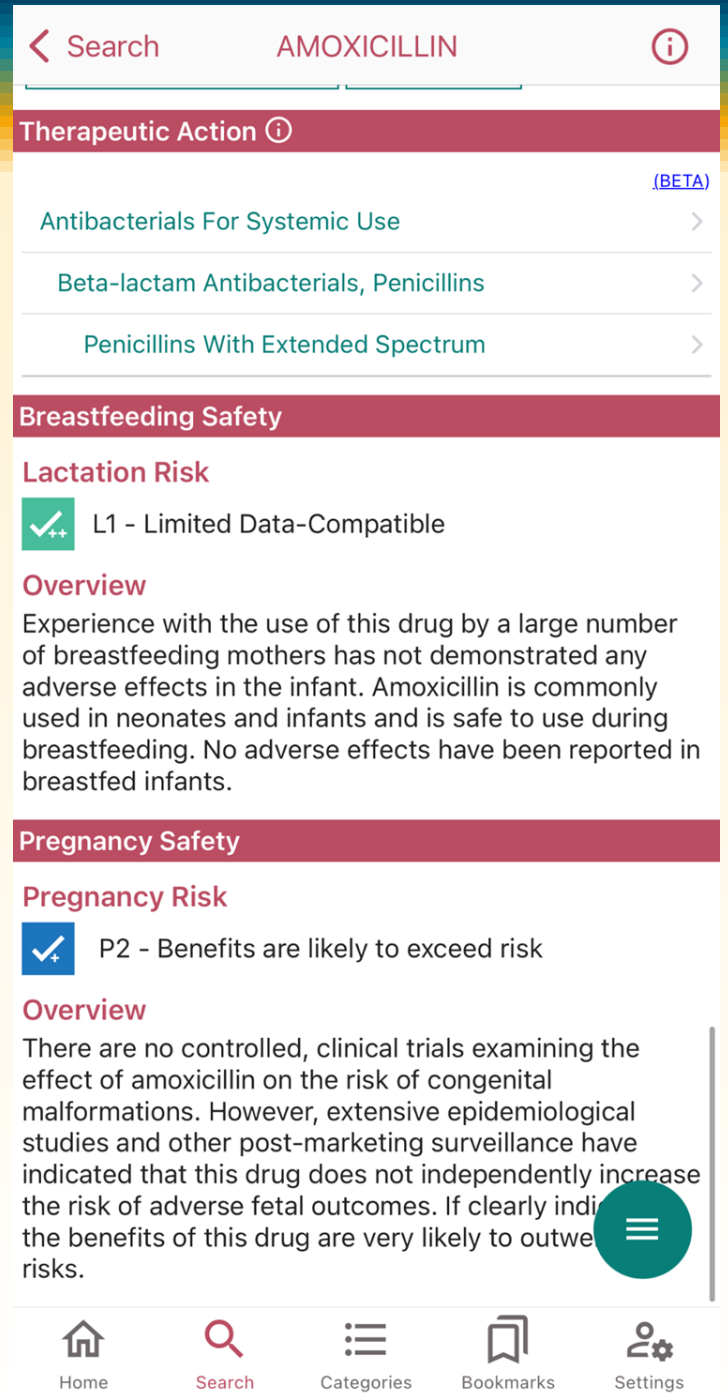


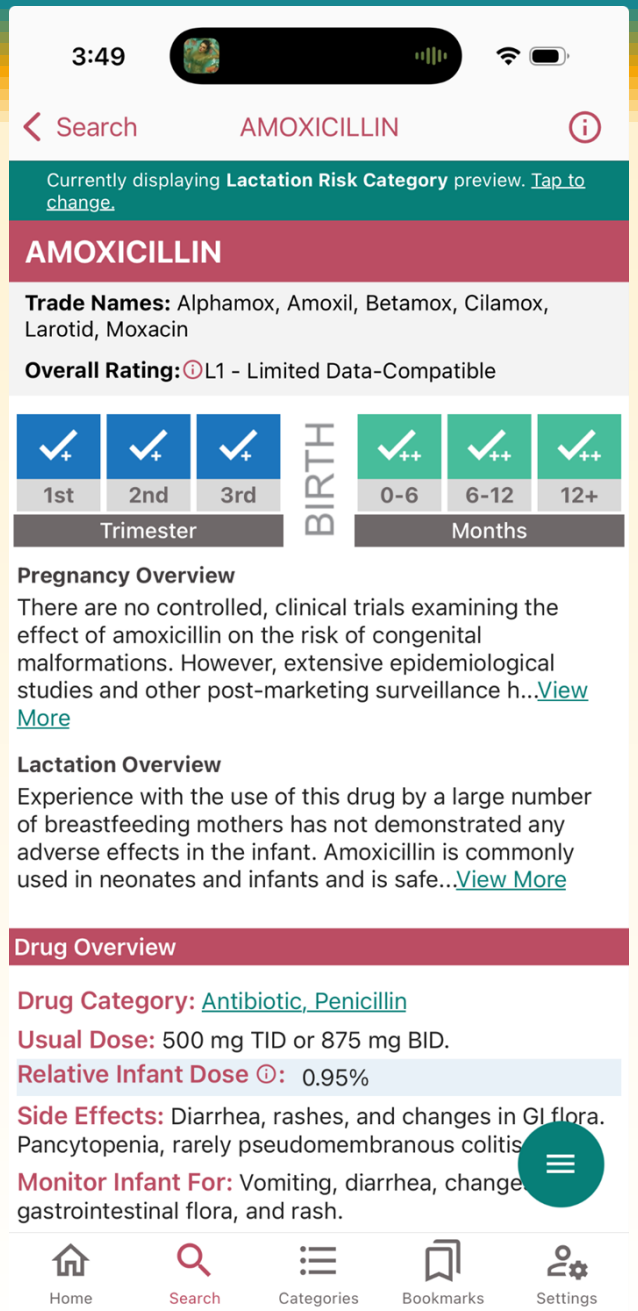
Resources

$14.99/year








3:49
Search
AMOXICILLIN
Currently displaying Lactation Risk Category preview. Tap to change.
AMOXICILLIN
Trade Names: Alphamox, Amoxil, Betamox, Cilamox, Larotid, Moxacin
Overall Rating: L1 - Limited Data-Compatible
1st
2nd
3rd
Trimester
BIRTH
0-6
6-12
12+
Months
Pregnancy Overview
There are no controlled, clinical trials examining the effect of amoxicillin on the risk of congenital malformations. However, extensive epidemiological studies and other post-marketing surveillance h...View More
Lactation Overview
Experience with the use of this drug by a large number of breastfeeding mothers has not demonstrated any adverse effects in the infant. Amoxicillin is commonly used in neonates and infants and is safe...View More
Drug Overview
Drug Category: Antibiotic, Penicillin
Usual Dose: 500 mg TID or 875 mg BID.
Relative Infant Dose: 0.95%
Side Effects: Diarrhea, rashes, and changes in GI flora. Pancytopenia, rarely pseudomembranous colitis
Monitor Infant For: Vomiting, diarrhea, change
gastrointestinal flora, and rash.
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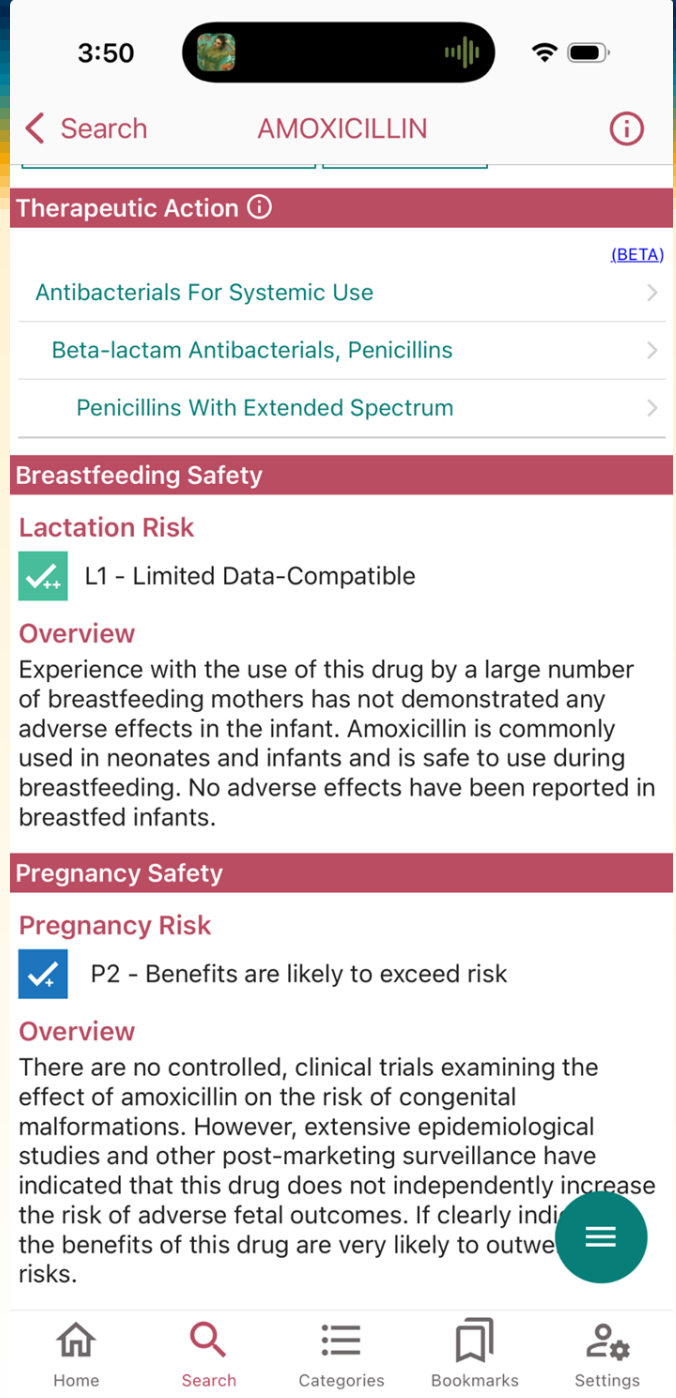
3:50
Search
AMOXICILLIN
Therapeutic Action
(BETA)
Antibacterials For Systemic Use
Beta-lactam Antibacterials, Penicillins
Penicillins With Extended Spectrum
Breastfeeding Safety
Lactation Risk
L1 - Limited Data-Compatible
Overview
Experience with the use of this drug by a large number of breastfeeding mothers has not demonstrated any adverse effects in the infant. Amoxicillin is commonly used in neonates and infants and is safe to use during breastfeeding. No adverse effects have been reported in breastfed infants.
Pregnancy Safety
Pregnancy Risk
P2 - Benefits are likely to exceed risk
Overview
There are no controlled, clinical trials examining the effect of amoxicillin on the risk of congenital malformations. However, extensive epidemiological studies and other post-marketing surveillance have indicated that this drug does not independently increase the risk of adverse fetal outcomes. If clearly indi
the benefits of this drug are very likely to outwe
risks.
Home
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MommyMeds Details

AMOXICILLIN
Benefits are likely to exceed risk

Pregnancy Info | Overview | Lactation Info

1ST 2ND 3RD — Trimester

BIRTH

0-6 6-12 12+ — Months

Drug Type: Penicillin antibiotic

Trade Names: Alphamox, Amoxil, Betamox, Cilamox, Larotid, Moxacin

Lactation Risk: L1 - Limited Data-Compatible

Pregnancy Risk: Benefits are likely to exceed risk

Side Effects: Diarrhea, rashes, and changes in GI flora. Pancytopenia, rarely pseudomembranous colitis.

3:59

MommyMeds Details

AMOXICILLIN
Benefits are likely to exceed risk

Pregnancy Info | Overview | Lactation Info

Experience with the use of this drug by a large number of breastfeeding mothers has not demonstrated any adverse effects in the infant.

Monitor Infant For

Vomiting, diarrhea, changes in gastrointestinal flora, and rash.

Alternative Medications

Ampicillin, cephalexin.

Interested in learning more?

ABM ACADEMY OF Breastfeeding Medicine®

IABLE
Institute for the Advancement of Breastfeeding & Lactation Education

Questions?

Resources

https://newbornweight.org/

https://bilitool.org/

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