Breastfeeding: What Every Feeding Therapist Should Know

Speaker: Katie Walsh, MA, CCC-SLP, IBCLC

Session # 35

February 8, 2019; 10:30-11:30

I. Benefits of Breast Milk
   a. There are many benefits for both mother and baby in regards to breastfeeding. Benefits for the infant include: reduction in respiratory tract infections, reduction in otitis media, reduced risk of SIDS, reduction in the incidence of NEC, and reduction in the incidence of Type 1 Diabetes (Eidelman et al., 2012).

II. Role of the Speech Language Pathologist
   a. Speech Language Pathologists working with the pediatric population in feeding and swallowing should demonstrate knowledge in the following areas: nutrition and its impact on infants and children, the implications of various diagnoses on feeding, signs of difficulty with coordination, respiratory distress and signs of aspiration as well as the implications of aspiration in an infant who is coordinating suck-swallow-breathe (ASHA, 2002).
   b. Speech Language Pathologists often work with infants who have many factors impacting their ability to feed safely and effectively. Identifying the need for supplementation is often the first step (Mahurin-Smith & Watson Genna, 2018).

III. Latch
   a. Start the infant out with their nose lined up with the mother’s nipple and their body up close to the mother (“Tummy to Mummy”). As the infant roots, the infant should open their mouth widely with a slight head tilt backward. Lower lip should latch on first. The nipple should not be placed into the infant’s mouth. When latched on, it should appear asymmetric with the lower lip further away from the nipple. (Cadwell & Turner-Maffei, 2017).
   b. When working on latch, the use of nipple shields may be beneficial. However, they should be used judiciously (McKechnie & Eglash, 2010). In premature infants, a nipple shield may result in improved milk transfer (Meier et al., 2000).
   c. In infants with cleft lip only, breastfeeding can be successful particularly if there is no alveolar ridge involvement (ABM Clinical Protocol #17: Guidelines for Breastfeeding Infants with Cleft Lip, Cleft Palate, or Cleft Lip and Palate, Revised 2013). It is important to ensure that their latch and positioning are able to compensate for the structural defect. The ability to achieve negative pressure or a vacuum effect during breast feeding is very important and may impact some infants’ ability to breastfeed (Sakalidis & Geddes, 2016).

IV. Managing Flow
   a. Suck-Swallow-Breathe coordination during breastfeeding is highly variable as the infant changes their pattern to support change in milk flow rates (Sakalidis &
Geddes, 2016). Infants utilize both non-nutritive and nutritive sucking during the breast feeding experience (Glass & Wolf, 1994).

b. The following are techniques for infant mother dyads who are having difficulty with increased flow rates. This may be evidenced by coughing, choking, excessive weight gain, color change, tachypnea, etc. Please note this list may not be all inclusive rather techniques that I most commonly use.

<table>
<thead>
<tr>
<th>Technique</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pumping prior to placing the infant to the breast</td>
<td>May decrease the volume of milk with the initial let down</td>
<td>May not leave enough milk for the infant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May ultimately increase mother’s supply</td>
</tr>
<tr>
<td>Repositioning</td>
<td>May provide increased postural support for the infant, May assist with respiratory ease during the feeding process, May allow for gravity to assist with the flow of milk</td>
<td>Some positions may be difficult to achieve in certain settings or may be difficult for the mother to maintain</td>
</tr>
<tr>
<td>Nipple shield</td>
<td>For some infants this may allow for the milk to pool in the shield. This can work well for more sensitive infants or infants who have been primarily bottle fed.</td>
<td>Can be cumbersome and may not work</td>
</tr>
<tr>
<td>Block feeding</td>
<td>For mothers with significant over supply, this can assist with decreasing the amount of milk the mother is making.</td>
<td>May “overcorrect” the situation leaving the mother with no enough milk. May be a bit uncomfortable for mother.</td>
</tr>
<tr>
<td>Pacing</td>
<td>May assist in slowing the infant down during let down</td>
<td>May be difficult to get the infant to relatch</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May cause nipple damage</td>
</tr>
</tbody>
</table>

c. The following are techniques for infant mother dyads who are having difficulty with undersupply or poor extraction. This may be evidenced by poor weight gain, dehydration, difficulty maintaining a latch etc. Please note this list may not be all inclusive rather techniques that I most commonly use.

<table>
<thead>
<tr>
<th>Technique</th>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing mothers’ supply</td>
<td>Providing adequate volume for the infant, May help increase the flow rate of let down, May increase the number of let downs mother experiences</td>
<td>May not be possible for some mothers, May be stressful</td>
</tr>
</tbody>
</table>
| **Skin to skin** | Can assist with milk supply  
Can be a calming activity for the infant and mother | Can be time consuming |
|------------------|-------------------------------------------------|----------------------|
| **Repositioning** | May provide increased postural support for the infant  
May assist with respiratory ease during the feeding process | Some positions may be difficult to achieve in certain settings or may be difficult for the mother to maintain |
| **Nipple shield** | Can assist with latch and for some infants may assist with milk transfer | Can be cumbersome |
| **Supplemental Nursing System** | Can allow for supplementation at the breast | Can be cumbersome |
| **Compression/Hand expression** | Can increase the flow or assist with let down during the breast feeding process. | Can increase the flow of breast milk to the point where some infants can no longer manage it |
| **Pumping to let down** | This is helpful for infants who have been bottle fed or will not stay latched to the breast long enough to elicit a let down. | Cumbersome |

i. Difficulty with lactation and breastfeeding is common within the first week of life. In cases of delayed transition to lactogenesis II infants are 7.1 times more likely to demonstrate excess weight loss (Dewey, Nommsen-Rivers, Heinig, & Cohen, 2003).


V. **Role of the IBCLC**
   a. The IBCLC will assess and assist the infant mother dyad to provide education and feeding support to promote direct breastfeeding. They can also provide support specific to the mother in regards to general lactation issues such as supply, engorgement, damaged nipples, etc… (IBCLE, Clinical Competencies for the Practice of IBCLC, 2018).
   b. When an infant requires supplementation, protecting the supply is a priority for the mother. An IBCLC can help guide mother through the process to determine what techniques are best for that mother (e.g. hand expression, visual imagery, pumping technique).

VI. **Resources**
   a. Apps
      i. LactMed
      ii. Breastfeeding Solutions
      iii. Baby Connect
b. Websites
   i. Breastfeed Chicago https://breastfeedchicago.org/
   ii. Medela http://www.medela.us/
   iii. Academy of Breastfeeding Medicine www.bfmed.org
   iv. International Board of Lactation Consultant examiners https://ibcle.org
   vi. La Leche League https://www.llli.org/

c. Assessment Tools. Please note this is not all inclusive of all currently available breastfeeding tools.
   i. Infant Breastfeeding Assessment Tool (IBFAT; Matthews, 1988)
   ii. Neonatal Eating Assessment Tool- Breastfeeding (NeoEat-Breastfeeding; Pados et al., 2017; Pados et al., 2018)
   iv. LATCH (Jensen, Wallace, & Kelsay, 1994).
   vi. FEES (Willette, Hinkes Molinaro, Thompson, & Schroeder, 2015).

References


