
Guidelines for Breastfeeding

Amy L. Feldman

Abnormal weight gain, R63.5	Methicillin susceptible <i>Staphylococcus aureus</i>
Candidiasis, unspecified, B37.9	infection as the cause of diseases classified
Galactosemia, E74.21	elsewhere, B95.61
Induration of breast, N64.51	Neonatal candidiasis, P37.5
Jaundice, unspecified R17	Neonatal jaundice, unspecified, P59.9

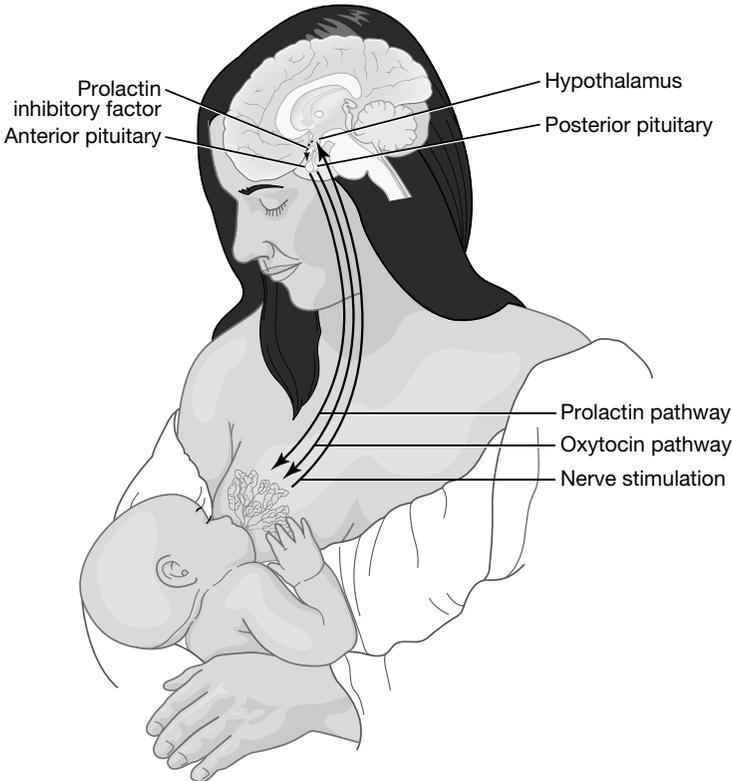
I. INTRODUCTION

- A. Breastfeeding provides optimal nutrition for newborns and infants, protecting against many diseases and infections and improving maternal and infant health. Exclusive breastfeeding is recommended by numerous public health, professional, and governmental organizations for the first 6 months of life, with continued breastfeeding throughout the first year and beyond with the addition of appropriate complementary foods. If there is a contraindication to breastfeeding or for preterm infants, using pasteurized donor human milk with fortification as needed is recommended by the AAP.

II. PHYSIOLOGY OF LACTATION

- A. Mammary glands are complex organs that function independently in response to an intricate combination of hormones and stimulation to produce milk. After expulsion of the placenta following delivery, a significant drop in progesterone readies the body for milk production (**Figure 5-1**).
- B. Oxytocin and prolactin are two of many important hormones in controlling lactation.

Figure 5-1 Physiology of lactation.



- C. Optimal milk production depends on several factors, including release of lactation hormones, frequent and effective milk removal, and adequate breast stimulation.
- D. Full lactation can be produced by breasts from 16 weeks of pregnancy.
- E. Important to understand balance of supply and demand to optimize successful lactation.
- F. Lactation begins as a result of hormonal control (endocrine) but changes to autocrine (frequent emptying of breasts) over time.

III. HUMAN MILK

- A. Human milk is exceptional in its ability to sustain appropriate growth and development for infants.

- B. “Liquid gold,” as human milk is often referred to, is living tissue, which encompasses fats, proteins, carbohydrates, antibodies, and hundreds of components.
- C. Composition of human milk changes to provide optimal nutrition as infant grows.
 - 1. Colostrum, the first milk, is produced during pregnancy and is considered the infant’s first immunization; is rich in antibodies and provides protection to the newborn from many viruses and bacteria. The volume is small in the first three days. Colostrum has fewer calories than mature milk but is rich in immunoglobulins, especially sIgA. The protein in colostrum helps to stabilize blood glucose levels in baby.
 - 2. Transitional milk is produced after colostrum and has less total protein and immunoglobulins; however, it has an increase in fat, lactose, and calories.
 - 3. Mature milk is produced as lactogenesis stage II begins. By day 5, a mother produces approximately 500 ml/day.

IV. CONTRAINDICATIONS FOR BREASTFEEDING

- A. Occasionally there are circumstances that preclude mothers from breast-feeding.
 - 1. Maternal contraindications include:
 - a. HIV-positive mother (in the United States).
 - b. Maternal drug abuse.
 - c. Maternal chemotherapy.
 - d. Herpetic lesions on mother’s nipple, areola. Expressed milk can be used from the unaffected side. Do not allow infant to come into direct contact with HSV lesions. Encourage excellent handwashing technique by mother.
 - e. Untreated, active tuberculosis. Expressed breastmilk can be used.
 - f. Varicella in mother developed 5 days prior to delivery to 2 days after delivery requires mother and baby to be separated, but expressed breastmilk can be used.
 - g. Certain radioactive compounds and few medications may require temporary cessation of breastfeeding. It is unusual for the amount of medication transferred into breastmilk to cause a problem in the infant. Drugs that are problematic for breastfeeding can frequently be substituted with drugs that are compatible with breastfeeding.
 - h. Positive HTLV-I and HTLV-II (human T-cell lymphotropic virus).

2. Infant contraindications include:
 - a. Classic galactosemia.

V. MATERNAL ASSESSMENT

- A. Assess both mother and baby for all factors that may affect the ability to successfully initiate and maintain breastfeeding.
 1. Breastfeeding goals and family support.
 2. Previous breastfeeding experience.
 3. General health and nutritional status.
 4. History of breast, nipple, or thoracic surgery.
 5. Medications, prescriptions, supplements, and OTC.
 6. Pregnancy, labor, birth history.
 7. Inverted or flat nipples.
 8. Breast assessment.

VI. INFANT ASSESSMENT

- A. General health, including gestational age.
- B. Congenital anomalies.
- C. Birth history.
- D. Medications received and procedures experienced.
- E. Initial feeding attempts, and frequency of feedings and ability to latch at breast.
- F. Has infant roomed in with the mother 24/7 to successfully breastfeed in response to hunger cues?
- G. Oral facial assessment.

VII. BREASTFEEDING IN THE EARLY DAYS

- A. Initial feedings.
 1. Facilitate skin-to-skin contact immediately after birth and as often as possible.
 2. Encourage breastfeeding within first hour after birth during quiet alert phase. Do not restrict length or frequency of feedings.
 3. Promote rooming in 24 hours a day.
 4. Encourage exclusive breastfeeding; this helps to establish and maintain a sufficient milk supply.
 5. Instruct parents and support persons in correct latch-on techniques.

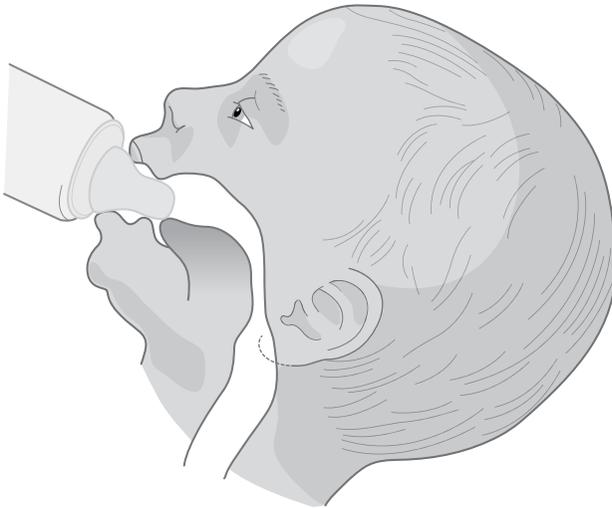
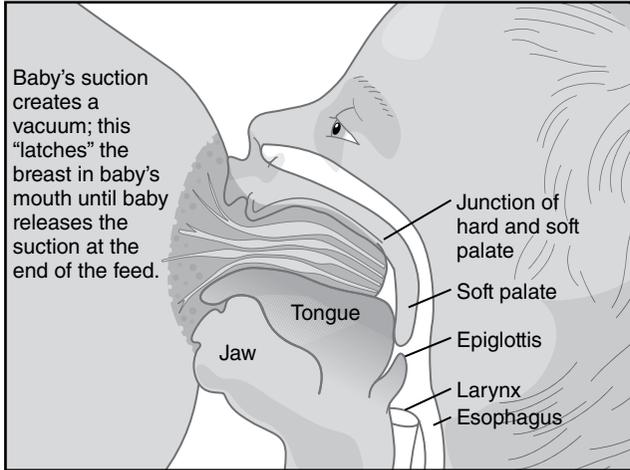
6. Educate parents and support persons regarding initial feedings of colostrum: Quantity is very small, but sufficient nutrition as baby is learning to breastfeed.
 7. Discourage use of any supplements unless medically indicated.
 8. Avoid use of bottles and pacifiers until breastfeeding is well established.
 9. Teach parents and support persons how to breastfeed in response to infant feeding cues (rooting, increased alertness, fists in mouth), at least 8–12 times/day. Crying is a late sign of hunger.
 10. Baby should finish feeding on one breast, then be offered second if he/she will take more. Fat content of milk is higher at end of feeding than at beginning. Forcing baby to switch breasts too soon may decrease amount of higher calorie milk consumed.
 11. Babies who sleep for long periods of time without eating or feed only for few minutes should be awakened and encouraged to nurse (i.e., unwrap, rub feet).
- B. Positioning and latch.
1. Mother and infant should be comfortable with infant on his/her side at nipple height supported by pillows or blankets.
 2. Support infant's head so he/she can easily reach areola without turning neck.
 3. Infant's ear, shoulder, hips should be in alignment.
 4. Mother can align her nipple with infant's nose, quickly bringing infant to breast only when his mouth opens widely, getting more of the areola on the bottom than top into his mouth, creating an asymmetrical latch (see **Figure 5-2**).
 5. Infant's lips should be flanged outward with chin touching breast. When latched properly, the tongue is drawn back to the junction of the hard and soft palate (see **Figure 5-3**).
 6. Infant's tongue will protrude over gum ridge and "cup" breast.
 7. If baby latches incorrectly, the mother should insert her clean finger to break the suction, and repeat latch-on attempts until baby is latched correctly. Mother's nails should be short to avoid injuring the baby's mouth.
 8. Common breastfeeding positions are cradle position (see **Figure 5-4**), cross cradle and football holds (see **Figure 5-5**), and side-lying position (see **Figure 5-6**).
 9. Trained practitioners should observe latch-on, milk transfer, and feeding at least once every 8 hours throughout postpartum hospitalization. Observations should be documented in the medical record.
 10. The mother's nipple should not be pinched, bruised, or creased at the end of a feeding or show any signs of damage (see **Figure 5-7**).

Figure 5-2 Positioning the baby nipple to nose.



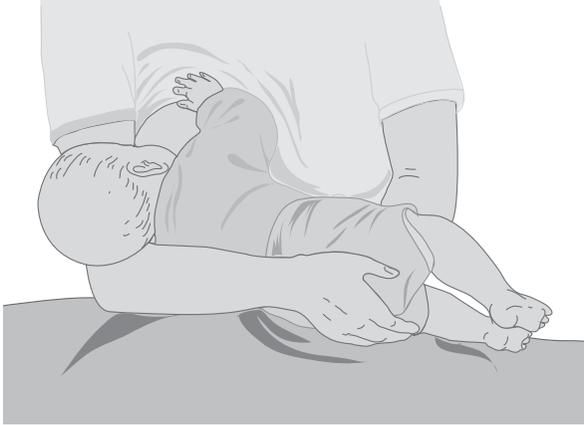
Source: Printed with permission of Catherine Watson Genna, BS, IBCLC.

Figure 5-3 Sucking action (breast and bottle).



Source: Reproduced from Lauwers J, Swisher A. *Counseling the Nursing Mother: A Lactation Consultant's Guide*. 6th ed. Burlington, MA: Jones & Bartlett Learning; 2016. Courtesy of Rebecca Glover, RN, RM, IBCLC.

Figure 5-4 Madonna (cradle) position: A) front view, B) side view.



A



B

Figure 5-5 A) Cross-cradle hold, B) football hold.



A



B

Figure 5-6 Side-lying position.



- C. Signs of milk transfer in infant.
 - 1. Observe sustained, rhythmic suck/swallow pattern with intermittent pauses.
 - 2. Listen for audible swallowing.
 - 3. Baby's arms and hands should be relaxed at the end of the feeding.
 - 4. Baby's oral mucous membranes should be moist after feedings.
 - 5. Baby should appear satisfied after feedings.
- D. Signs of milk transfer in mother.
 - 1. Mother feels strong tugging sensation when baby is sucking, which is not painful.
 - 2. Mother feels uterine contractions and increased lochia flow during initial days postpartum.
 - 3. Milk may leak from opposite breast during feedings.
 - 4. Mother may feel relaxed or drowsy during feedings.
 - 5. Breast softens after feeding (after milk supply is established).
 - 6. Nipples are elongated but not pinched or bruised after release of latch.
- E. Assessing infant weight gain.
 - 1. Parents should be aware of baby's birth and discharge weight.

Figure 5-7 Normal nipple postfeed and creased nipple postfeed.



Source: Courtesy of Linda Smith, BSE, FACCE, IBCLC.

2. Encourage parents to keep a daily journal of first week to track feedings, output.
3. Healthy, breastfeeding infants may lose 3–7% of birth weight in initial days.
4. After mother's milk is in, infant should gain 0.5–1 oz/day (4–7 oz/week).

5. Babies often regain birth weight by 10 days of age, double birth weight by 6 months, triple it by 1 year.
 6. Exclusively breastfed infants tend to be leaner than bottle-fed infants in second 6 months of life.
- F. Assessing infant output.
1. Colostrum acts as laxative, encouraging expulsion of meconium in first days.
 2. Effective and regular breastfeeding helps to prevent jaundice in early days.
 3. Infants showing signs of jaundice should be assessed carefully for ineffective breastfeeding.
 4. Babies who are breastfeeding well should have 3 or more stools/day by day 3.
 5. Bowel movements become lighter in color, then turn to a mustard color and are seedy in consistency by day 4 or 5.
 6. Inadequate stools are a red flag for ineffective breastfeeding.
 7. Stool output may decrease to one stool every few days after first few weeks.
 8. Urine output is less helpful than stool output in assessing adequate milk intake.
 9. Exclusively breastfed baby should produce 1 wet diaper on day 1, 2 on day 2, 3 on day 3, and so on, for first week.
 10. By end of first week, baby should have 6 soaking wet, pale yellow diapers/day.

VIII. SEPARATION OF MOTHER AND INFANT

- A. Pumping.
1. All mothers should be taught how to hand express their milk after birth.
 2. If a small number of feedings must be missed, the mother can hand express or, if she prefers, use a battery-operated pump to express milk from both breasts every few hours.
 3. Lengthy separation warrants use of hospital-grade, piston-style pump with double hookup system to establish, maintain, or increase her milk supply. Mothers should be instructed to pump at least 8 times/24 hours for approximately 15 minutes each session.
 4. Pumping should begin within 6 hours of birth if the infant is not able to go to breast or if there is a contraindication to breastfeeding. Hand expression is often preferred during the first 24 hours when the quantity of colostrum is small.

5. Even the smallest quantity of expressed colostrum or milk can be fed to infant via eyedropper, syringe, or cup.
- B. Milk collection and storage.
1. Recommendations for collection and storage of mother's milk for hospitalized infant differ from those of the following instructions for the well child at home.
 2. Mothers should wash hands thoroughly prior to pumping and keep nails short.
 3. Follow manufacturer's instructions for cleaning of pump parts.
 4. Glass containers or BPA-free hard plastic containers with well-fitting lids are a good choice for storing milk.
 5. Mother can encourage milk let down by looking at picture of baby, smelling piece of baby's clothing.
 6. Warm, wet washcloths on breast combined with breast massage may be helpful in starting milk flow.
 7. Breastfeeding on one breast while pumping from other breast is an option.
 8. All pumps are different. Encourage mother to find one that creates comfortable seal that provides appropriate suction. Pumping should not be painful.
 9. For specific information on storing milk for home use for full-term infants, see the Academy of Breastfeeding Medicine Revised Protocol #8 March 2010.

IX. SUPPORTING BREASTFEEDING PAST THE EARLY DAYS

- A. Follow-up.
1. Breastfeeding infants should be seen by an appropriate healthcare professional within 48–72 hours after discharge and again at 2 weeks of age for successful feeding and appropriate weight gain assessment. Infants should always be evaluated in between scheduled visits for any concerns.
 2. Breastfeeding mothers should be referred to a breastfeeding support group and local breastfeeding resources following hospital discharge.
- B. Maternal diet.
1. Encourage mother to eat a wide variety of healthy foods, eating when hungry and drinking to quench her thirst. Breastfeeding mothers should consume an additional 450–500 calories/day.
 - a. Forcing large quantities of fluids will not increase milk production.
 - b. No specific foods must be avoided by all breastfeeding mothers.

- c. Most foods do not bother most babies.
 - d. If a particular food seems to bother baby, decrease/eliminate for a week to 10 days.
 - e. Many healthcare providers recommend continuing prenatal vitamins during breastfeeding.
 2. It is recommended that all breastfed babies be supplemented with vitamin D 400 IU starting soon after birth. All infants, children, and adolescents should be receiving 400 IU/day of vitamin D.
 3. Families with significant allergies should receive knowledgeable dietary counseling regarding possible need to eliminate certain foods while breastfeeding.
- C. Growth spurts.
 1. Regardless of culture, women frequently worry about ability to provide enough milk for their baby.
 2. Teach parents that growth spurts (periods when babies want to nurse more frequently to meet rapid growth) usually occur around 2–3 weeks, 6 weeks, 3 months.
 3. Feed as often as baby wants to nurse to increase, then maintain, adequate milk supply.
 4. Reinforce concept of supply and demand.
 5. Supplementing with formula is strongly discouraged; mother's milk supply will not increase without adequate stimulation to meet baby's growing demand for more milk.
 - a. Breastfed infants have a more acidic intestinal environment than formula-fed babies early in life, which is beneficial. Bifidobacterium is the predominant intestinal bacteria in breastfed infants that has significant health benefits on the infant's immune and digestive systems. Supplementing an infant in the early days with even small amounts of formula changes the gut environment.
- D. Medications and breastfeeding.
 1. It is imperative that healthcare providers give information to mothers who breastfeed on the safety of medications based on appropriate, current research, citing the source. Each infant's individual situation must be assessed prior to determining the appropriate use of any medication during breastfeeding. An excellent reference guide such as Hale (2014) should be available in every clinical setting that deals with breastfeeding mothers. LactMed, published by the National Library of Medicine/ National Institutes of Health, is available online as a comprehensive

source of information on medications and their risks when used by breastfeeding mothers.

2. Many of the medications likely to be prescribed to breastfeeding mothers should not affect maternal milk supply or infant's safety. Ibuprofen is a commonly used analgesic postpartum and is considered compatible with breastfeeding. Penicillins and cephalosporins, along with several of the selective serotonin reuptake inhibitors (SSRIs) often used for depression, are also generally considered compatible.
3. Dose of medication transferred through breastmilk is almost always too low to be clinically significant or is poorly bioavailable to infant.
4. It is preferable for mothers to avoid using medication whenever possible.
5. Extensive benefits of breastfeeding far outweigh any potential risks in majority of cases.
 - a. Medications should be safe for infants to consume.
 - b. Choose drugs with breastfeeding information whenever possible.
 - c. Choose shortest acting form of medication.
 - d. Encourage feeding when maternal drug level is lowest.
 - e. Educate parents as to potential side effects to observe in infant, and effect on milk supply.
 - f. Be extra cautious with preterm, low-birth-weight, or sick infants.
 - g. Certain herbal substances may be harmful to infants.
 - h. Drugs of abuse are contraindicated in breastfeeding.
 - i. Temporary cessation of breastfeeding is necessary with certain radioactive compounds. Consult appropriate resources for detailed information.

E. Maternal employment.

1. Returning to the workplace while continuing to provide breastmilk for baby may initially seem overwhelming to some mothers. Strong encouragement, praise, and continuous support can make the difference between a mother being successful and giving up.
2. Women need a private, clean place to pump every few hours while separated from their infant. Encourage mothers to rent or purchase a pump that is comfortable and that is efficient for their particular needs.
3. The Patient Protection and Affordable Care Act, signed into law on March 23, 2010, requires employers with greater than 50 employees to provide break times for nursing mothers. Lactation supplies and counseling are also covered by private insurance companies but not Medicaid. Encourage patients to check with their individual policy for their specific benefits.

4. Expressed milk can be kept at room temperature (77°F) for 6–8 hours, in a cooler with an ice pack (39°F) for 24 hours, in a refrigerator (40°F) for 5 days, in the freezer compartment of the refrigerator (5°F) for 2 weeks, and in a deep freezer (–4°F) for 6–12 months.
5. Provide information on how to introduce a bottle to the infant, as well as suggestions for the caregiver that will promote extended breastfeeding (i.e., not bottle feeding immediately before mother will pick up infant, proper handling and storage of breastmilk).

X. COMMON PROBLEMS

- A. Mothers can complain about pain even when damage is not visible on the breast or nipple. Determine that baby is positioned properly at breast height with adequate support and is latching on correctly. Mothers often describe the feeling of their baby feeding as a strong tugging sensation. Breastfeeding should not be painful. Nipples do not “toughen up” as breastfeeding proceeds. Assess for other causes of sore nipples such as trauma, improper latch and release, thrush, milk plugs on nipple, incorrect use of breastfeeding devices, or a tight frenulum in the infant (see **Figure 5-8**). Paget’s disease, an uncommon

Figure 5-8 Tight frenulum.



type of breast cancer, must also be ruled out. Breastfeeding issues that do not resolve quickly should promptly be referred to pediatric or maternal experts for further management.

- B. Sore nipple management includes:
1. Assess for correct positioning and latch-on.
 2. Teach mothers how to express colostrum/hindmilk to apply to nipples after each feeding.
 3. Allow nipples to dry before putting bra back on.
 4. Offer use of breast shells to prevent clothing from rubbing against sore nipples. Instruct in proper cleaning of shells.
 5. Breastfeed from least sore side first.
 6. Change positions at each feeding to decrease pressure on sore area.
 7. Suggest moist wound healing methods (i.e., modified lanolin or hydrogel dressings).
 8. Analgesics as needed.
- C. Flat or inverted nipples.
1. Can initially make breastfeeding more of a challenge. May be difficult for baby to latch on and breastfeed well. Provide adequate support to ensure successful feedings.
 2. “Pinch test”: Determines if nipple is flat or inverted upon compression. With thumb behind nipple and first two fingers underneath, grasp about 1 in. back from base of nipple and compress skin.
 - a. Normal nipple will evert.
 - b. Flat nipple remains flat with compression.
 - c. Inverted nipple looks sunken in.
 - d. Nipples can look flat or inverted, but evert on compression.
 3. Flat or inverted management includes:
 - a. Encouraging deepest possible latch onto breast.
 - b. Make sure infant is at breast height and well supported to prevent sliding to base of nipple.
 - c. Release latch and repeat attempts until proper latch is obtained. Allowing baby to suck at base of nipple prevents stimulating milk supply and will cause sore nipples.
 - d. Encourage offering flat/inverted breast first when baby is hungriest and sucking is strongest.
 - e. Teach mother to evert nipple with gentle pulling/rolling immediately prior to latch.
 - f. Hand express a few drops of colostrum to entice baby to latch on.
 - g. Use hand/electric pump for a few minutes immediately prior to latch.

- h. If supplement is medically indicated, use expressed milk first using an eyedropper, syringe, cup, or feeding tube at the breast.
 - i. Avoid pacifiers and bottle nipples until breastfeeding is well established.
- D. Severe engorgement.
- 1. Milk stasis caused by inefficient, infrequent removal of milk results in extremely full, swollen, lumpy, painful breasts.
 - 2. Result is different from transient breast fullness associated with milk “coming in” 2–4 days after birth.
 - 3. Breastfeeding emergency: Milk stasis can cause damage to tissue, decrease milk supply, and make it difficult to impossible for infant to compress areola and remove milk.
 - 4. Severe engorgement management includes:
 - a. Analgesics as necessary.
 - b. Warm, wet compresses to breast prior to feedings to help increase milk flow.
 - c. Reverse pressure softening; soften areola using hand expression so baby can latch properly.
 - d. Use breast compression during feedings to improve milk flow. Using thumb on top of breast and fingers underneath, the mother brings her fingers together, which compresses breast.
 - e. Use of cold compresses may help to decrease engorgement after feeding. Some mothers like to use this prior to feeding as well.
 - f. Use of clean, chilled green cabbage leaves left on breast for a short period several times/day can be helpful to some mothers. Stop using this as soon as engorgement decreases.
 - g. Express milk after feeding as needed for comfort. Any expressed milk can be fed to baby using alternative feeding methods.
- E. Mastitis.
- 1. Infection of breast, usually caused by *Staphylococcus aureus*.
 - 2. Frequently occurs in upper outer quadrant of breast, often by 2–3 weeks postpartum.
 - 3. Symptoms commonly include hard, swollen, reddened area on breast accompanied by flulike symptoms.
 - 4. Difficult to differentiate between engorgement, plugged duct, mastitis (Table 5-1).
 - 5. Mastitis management includes:
 - a. Rest (decrease stress and fatigue by enlisting support from friends, family).

Table 5-1 Comparison of Findings of Engorgement, Plugged Duct, and Mastitis

Characteristics	Engorgement	Plugged Duct	Mastitis
Onset	Gradual, immediately postpartum	Gradual, after feedings	Sudden, after 10 days
Site	Bilateral	Unilateral	Unusually unilateral
Swelling and heat	Generalized	May shift; a little or no heat	Localized, red, hot, and swollen
Pain	Generalized	Mild but localized	Intense but localized
Body temperature	< 38.4°C	< 38.4°C	> 38.4°C (101°F)
Systemic symptoms	Feels well	Feels well	Flulike symptoms

Source: Lawrence RA, Lawrence RM. *Breastfeeding: A Guide for the Medical Profession*. 7th ed. St Louis, MO: Mosby; 2011, with permission from Elsevier.

- b. Antibiotics; encourage completing full course as prescribed.
 - c. Increase maternal fluid intake.
 - d. Frequent, effective emptying of breasts (important to continue breastfeeding, milk is not infected, fine for baby).
 - e. Abrupt weaning can predispose to an abscess.
 - f. Analgesics as needed.
 - g. Correct latch to prevent further nipple trauma (cracked, bleeding nipples allow bacteria to enter milk ducts).
 - h. Mother's preference of warm or cool packs for comfort.
- F. Jaundice.
1. Rarely requires cessation of breastfeeding.
 2. Pathologic jaundice, with onset in first 24 hours of life, warrants medical evaluation in addition to lactation support.
 3. Encourage early initiation of breastfeeding, then frequent, effective, unrestricted feedings to minimize jaundice.
 4. Colostrum acts as laxative, eliminating bilirubin through meconium expulsion.
 5. Physiologic jaundice, which begins 48–72 hours after birth and peaks on day 3–5, is seen in thriving infants with normal weight gain and output.

6. Observe for effective breastfeeding and continue assessment for normal weight gain and output. Onset and peak of breastfeeding associated with jaundice is similar to physiologic jaundice, but infant is fussy/sleepy with poor feeding and inadequate weight gain, output.
 7. Assist with frequent, unrestricted, effective breastfeeding.
 8. Teach parents to watch for signs of milk transfer during feedings. If necessary, express milk in addition to feedings, use alternate feeding methods to give baby milk.
- G. Thrush.
1. Often described as burning, itching, stinging lasting throughout feeding and beyond, radiating from nipple and breast to shoulder and back.
 2. Nipple or areolar skin is often red and shiny.
 3. May have period of pain-free nursing, then have sudden onset of pain.
 4. Pain from poor latch is often described as feeling like a knife or being stabbed, dissipates as feeding progresses, frequently limited to nipple and areola.
 5. Regardless of nipple pain, poor latch must be corrected immediately.
 6. Broken skin is perfect environment for organisms to invade.
 7. Signs in infant may range from nothing to white patches on buccal mucosa, tongue, and palate, which may bleed when scraped with tongue blade. Fiery red diaper rash with shiny red patches and pustules may also be present.
 8. Both mother and baby should be treated simultaneously with appropriate antifungal medications to prevent reinfection from one to the other.
 9. All objects (pumping supplies, pacifiers, bottles) coming in contact with baby's mouth should be boiled daily.
 10. Mothers should be encouraged to continue breastfeeding while treating infection.
 11. *Candida albicans* thrives in warm, moist, dark areas. Nipples can be rinsed with clear water or vinegar solution of 1 tablespoon vinegar in 1 cup of water after each feeding, exposing to air after each feeding.
 12. Bed linens, sheets, bras can be rinsed in vinegar solution after hot wash cycle. Breast pads should be disposable and changed as soon as wet.
 13. Sexual contact between mother and partner can spread infection. Partner should be treated appropriately.
- H. Weight-gain concerns.
1. Breastfed infants gaining less than appropriate amount for age should be carefully evaluated. Often, correcting latch and positioning is enough to facilitate efficient breastfeeding and improve weight gain.

2. Do not recommend formula supplementation without evaluating breastfeeding. If extra calories are needed, have mother hand express or pump in addition to breastfeeding and use alternative feeding methods to give baby breastmilk.
3. Allowing baby to finish feeding on one breast before feeding on second allows sufficient amounts of higher calorie breastmilk.
4. Review with parents appropriate signs of infant hunger, encourage frequent (8–12 or more/24 hours) unrestricted feedings.
5. Keeping written log of feedings and output is also helpful. Imperative that infant have adequate caloric intake.
6. If after evaluation and management with skilled breastfeeding consultant breastfeeding is not going well, formula supplementation may be appropriate. Plan for maintaining/increasing mother's milk supply must be implemented.
7. Return office visit within 24–48 hours to monitor situation should be scheduled. Frequent phone follow-up, support are necessary.
8. Global growth charts released by the World Health Organization (WHO) in 2006 reflect standards on how children should grow based on breastfeeding as the norm.

XI. HELPFUL BREASTFEEDING RESOURCES

- A. Locating a board-certified lactation consultant:
 International Lactation Consultant Association, 1-919-861-5577, www.ilca.org
 International Board of Lactation Consultant Examiners, 1-703-560-7330, www.iblce.org
- B. Internet resources:
 Academy of Breastfeeding Medicine, www.bfmed.org
 American Academy of Pediatrics Breastfeeding Initiatives Health Professionals Resource Guide, www2.aap.org/breastfeeding/healthprofessionaisresourceguide.html
 Baby-Friendly Hospital Initiative, USA, www.babyfriendlyusa.org
 Breastfeeding Benefits under the Affordable Care Act, www.healthcare.gov/coverage/breast-feeding-benefits/
 CDC Guide to Strategies to Support Breastfeeding Mothers and Babies, www.cdc.gov/breastfeeding/resources/guide.htm
 Human Milk Banking Association of North America, www.hmbana.com
 Infant Risk Center, 1-806-352-2519, www.infantrisk.org

LactMed, <http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

La Leche League International, www.lalecheleague.org

The Surgeon General's Call to Action to Support Breastfeeding, www.surgeongeneral.gov/library/calls/breastfeeding/calltoactiontosupportbreastfeeding.pdf

United States Breastfeeding Committee's Core Competencies in Breastfeeding Care and Services for All Health Professionals, <http://www.usbreastfeeding.org/p/cm/ld/fid=170>

U.S. Department of Labor. Wage and Hour Division (WHD). Fact sheet #73: Break Time for Nursing Mothers Under the FLSA, www.dol.gov/whd/reg/compliance/whdfs73.htm

WomensHealth.gov, womenshealth.gov/breastfeeding/

C. Book resources:

Cadwell K, Turner-Maffei C. *Breastfeeding A–Z: Terminology and Telephone Triage*. 2nd ed. Burlington, MA: Jones & Bartlett Learning; 2014.

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