

Lactation & Breastfeeding

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EDITORIAL

Dear members, dear colleagues,

in the year the first human being set foot on the moon, my mum gave birth to me in the Harbour Hospital in Rotterdam.

In Dutch, the technical term for the first week after birth is the “kraam week”. Traditionally the word „kramm“ means “an enclosed space”, “a booth”, a place where a woman gives birth. The bed, where she ought to stay for the first ten days, is called the “kraam bed”. The mum is called the “kraam woman” and the health-care that assists her in the first week the “kraam care”.

It was a very stressful vacuum delivery. I was the first live birth after a lot of miscarriages. The umbilical cord was wrapped twice around my neck, my colour was blue and I was put in the incubator right away. Once my mum had recovered a bit, they took her in her bed down the hallway so that she was able to look at me through a window. Parents were not allowed to enter the incubator ward.

After a few days she could touch me and I could smell my mum for the first time. Lactation consultants did not exist. During our contact moments the nurse helped me to latch. It seems that I was biting according to my mum’s story. I did not know how to suckle well. After exercising at her breast, I was taken back to the nursery again. The nurses fed me with bottles. Babies were only allowed to leave the nursery for the visits of their father or for breastfeeding. My mum was hospitalized for ten days, which was normal in those days. At nighttime I was kept in the nursery with my peers without a mum during the whole night.

At home my mum was given Parlodel to stop lactation and the district nurse pumped out the remaining milk with her hands.

In that era, we were drifting further away from the ways of nature. Now, luckily, it seems that nature has taken over again. We now understand that the very first week after birth is crucial and special. In most cases the “kraam woman” is at home with her baby in her arms or beside her while she sleeps. Especially in the first week after birth, I want to encourage all health workers to take care of the breastfeeding couple. We can ensure the success of a life time experience.

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President of ELACTA*

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Observation in Dr. Jack Newman's Breastfeeding Support Clinic in August

Stefanie Rosin, PhD in Health Sciences, IBCLC, LLL leader^[1]



From left to right: Dr. Jack Newman, Dr. Stefanie Rosin, Maria Cecilia Lameiro, IBCLC, Clinical Practice Co-Coordinator

After initially postponing my visit because of my younger son's graduation, I finally made it in August 2016 to Dr. Newman's clinic in Toronto, Canada. I got to know him personally in Bucharest, Romania, where he held several presentations at a breastfeeding conference organized by ProMAMA Center Association^[2] from May 8 – 10, 2014^[3] by my friend and colleague Dr. Marta Tunde-Muresan. Before this event, he had very promptly and competently helped several moms of my lactation practice by e-mail consultation. As a pediatrician, he could answer questions that exceeded my competence as an IBCLC. I was excited to learn more about his clinic with its worldwide reputation of competence and excellence in breastfeeding support.

After a breathtaking flight over Greenland I arrived in Toronto after only 9 hours from Berlin. Very soon my experience with the breastfeeding clinic got started. The first lactation consultant I observed was very experienced and a long-term member of the clinic staff. She has specialized in latching "non-latching babies" and it soon showed, how specialized this expert team is, because it was worth coming to Toronto for the first consultation alone. With a lot of creativity and tricks Shery worked with the baby, including feeding him pumped breastmilk from a cup several times, at the same time watching baby's abilities to lick the milk and work with his tongue. Further, an exercise ball was used with Mum slowly bouncing while trying to latch baby, which might calm down babies and make them more prone to latch. "Breastfeeding

is natural, but has to be learnt by mother and baby", as the LC Maria explains to mothers seeking support. All in all the staff has great skills and a remarkable repertoire in latching infants, without using nipple shields^[4]. Instead they rather show mums breast compression, and support the milk flow with the lactation aid, if necessary, to motivate baby at the breast.

In Dr. Newman's clinic mothers learn the asymmetric latch, just as in the Norwegian clinics, where I was able to do an observational internship in breastfeeding clinics and other facilities in 2010. Asymmetric means that the nose of baby is being aligned to the nipple. When baby opens her mouth wide, she also tilts her head back and reaches for the breast. "All mammals reach to nurse", Shery explained. When latched, baby's chin is deep

Newman's Breastfeeding 2016



© Stefanie Rosin

Shery Leeder supporting mother Jandy to latch baby Max

in the breast, while the nose is free and placed in some distance from the breast. Both the Norwegian lactation consultants I met during my internship and Dr. Newman and his staff are convinced that the asymmetric latch is superior and causes least or no problems for mum. "Breast and nipple pain are common, but not normal.", as Maria explains. The asymmetric latch is supposed to be deeper than the symmetric one, leading to optimal breast tissue intake, reduced risk of sore nipples and engorgement, and also less vasospasm because of less clamping of the breast, which might prevent the blood from flowing consistently to the nipple^[5].

The Newman clinic also emphasizes the importance of showing mothers good drinking at the breast. Therefore all mums are shown the pause in the chin when in-

fants swallow the milk, compared to only nibbling at the breast. This can be watched in Dr. Newman's freely accessible videos in numerous languages^[6]. Good drinking also prevents babies from fussing or falling asleep at the breast, thus missing out on sufficient milk intake. Milk supply and milk flow can be supported by using galactagogues, which are prescribed as needed in the clinic^[7].

Another personal reason for my visit to the Newman clinic was my wish to learn how to practically assess baby's mouth. I wished this would have made part of my initial education as an IBCLC, together with support of the latch, both as practical training. Again, my experience lived up to my expectations. I was able to watch the assessment of babies' mouths several times, based on the Hazelbaker assessment >



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To observe at the International Breastfeeding Centre, please contact admin@ibconline.ca

› tool. I could also hold the light during the procedure of tongue and/or lip tie release, which took on average 10 seconds. Before the release, at least 2 staff members assess the situation, the lactation consultant and the doctor on duty. The physician conducts tongue tie and lip tie releases only after extensive consultation and written consent of the parents. During my observation time in the clinic I was allowed to assess several infants' mouths with sterile gloves, due to my long years of experience as an IBCLC. I also got the opportunity to observe a special case: A baby was introduced with a so-called ranula. The release was not possible within the clinic, because for this special case oral surgeons were required to prevent unnecessary bleeding. I further observed babies of different ages, and realized that a tongue and lip tie release in the early days can be very effective in preventing further problems with breastfeeding, not only with regard to mother's potential pain and low milk supply. Even more impressive for me to observe was how different infants re-learn how to suck after the release. The 3-day old infant I observed was able to get a deep latch and suck with very good drinking right after the release, without needing any assistance. On the other hand, babies of several months of age had visibly more difficulties to latch on and drink well after the release, which they had to re-learn nearly from scratch, needing support and practice. This shows how an early intervention can make a great difference to the mother-baby dyad.

Jack Newman himself aims at spreading the news by his numerous international presentations that mothers do need such practical support for successful breastfeeding. "Babies learn to breastfeed by breastfeeding," he explains. From his perspective, a good latch should be the central goal of breastfeeding support, and should also be named more explicitly in the ten steps to successful breastfeeding. Lactation consultants should learn in their initial training and therefore be capable of showing

mothers not only by verbal explanations, but also by hands-on support, how a good latch is initiated. Before the hands-on help, they should ask the parents for permission for touching both mother and baby, which represents a good practice standard in the clinic. According to Dr. Newman, "breastfeeding problems are cumulative". Therefore getting a good latch and knowing when milk is being transferred to baby should be a central part of lactation consulting, to ensure efficient and pain-free breastfeeding, as the major consultation goal.

I have learned a lot from my observation, and I hope to return soon to beautiful Toronto with its very warm summer, comparable to Southern European countries. I have been told that winters can be very cold, too with -20°C and more. Toronto is also a tourist spot, including the Great Lakes, Niagara Falls, Toronto Island, lots of art and culture, the harbor front walk and of course the skyline with the CN tower.



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EDITORS' NOTE

The attitude presented in this contribution towards nipple shields may arouse astonishment, disbelief or also approval in the reader. We have taken these contradictory reactions as a reason to publish a statement by Dr. Jack Newman in our edition 1/2017 as well as an article that deals with possible and useful fields of application examining the scientific aspects at the same time.

Please send your letters to the editor to: magazine@elacta.eu



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“Power-Pumping” – Super Stimulation For Milk Production

Your milk production is lagging behind your expectations? You want to or must quickly increase your milk production?

Author: Andrea Hemmelmayr, IBCLC

Perhaps your baby cannot (yet) suck effectively enough or is too weak to adequately empty the breast. Perhaps you are separated from your baby because your baby is ill or premature or you must return to your job soon. Possibly, you might need to produce milk for twins or more. Perhaps you have, up until now, lacked the necessary competent support and counselling so the baby’s sucking problem has been overlooked. Possibly, there has been no adequate information available for you. Moreover, many breastfeeding mothers who are pumping observe that their milk production declines at around 6 weeks or in particular stressful situations. “Power pumping” is intended to be supplementary stimulation of the breast when the baby’s sucking or other pumping phases with the milk pump cannot sufficiently increase or maintain the milk production.

The natural sucking behavior of a healthy, active newborn ensures that the mother’s milk production is stimulated optimally. Over the course of the day (frequently in the evening), most newborns or older babies who need to stimulate their mothers’ milk production have phases of short frequent breastfeeds only interrupted by brief pauses. “Power pumping” imitates the baby’s so-called “cluster feeding phases”. (If you are dependent on the pump or your baby cannot adequately empty the breast). With “cluster feeding” or “power pumping” the pumping pauses are brief and prevent the prolactin levels (prolactin = milk producing hormone) from falling back to its basis level. Instead, higher production of prolactin occurs. This has a positive effect on milk production. Furthermore, the milk produced in the brief pauses in pumping is collected straightway and makes space for further milk production.

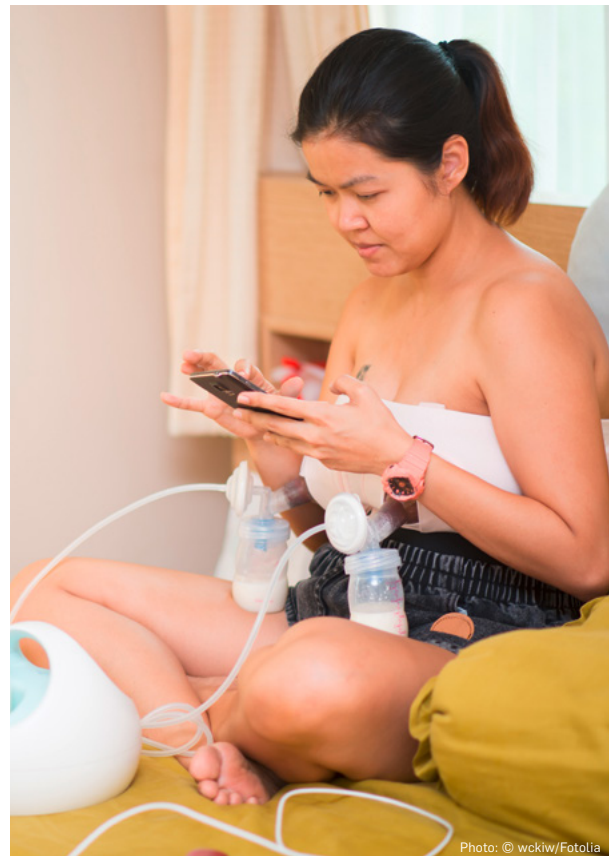


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Normal pumping of mother’s milk and “power pumping”:

In the first 7-10 days (in the time during which milk is being built up) a mother who is dependent on the milk pump should pump 8-12 times in 24 hours to maintain the milk production. After this period at least 5x or, better, 6-8 times daily. If the baby is able to suckle directly on the breast – at least partially – then, depending on the baby’s ability, this can result in fewer pumping phases.

Some of these pumping sessions could be replaced or supplemented by “power pumping”. Please select those methods which can be best carried out. Adaptations are possible and desirable. The important thing is the frequent pumping phases and the brief pauses in between.

Pumping phases and pauses with a double pump set	Power Pumping ca. 6 × daily	Power Pumping 2 × daily	Power Pumping 1 × daily	Power Pumping 1 × daily
Pump	5 min	10 min	20 min	15 min
Pause	5 min	10 min	10 min	10 min
Pump	5 min	10 min	10 min	15 min
Pause	5 min	10 min	10 min	10 min
Pump	5 min	10 min	10 min	15 min

Practical Tips for “Power Pumping”:

- › Use an effective pump with a double pump set. You can also do “power pumping” with a single pump. However, the single pumps are mostly less effective. Pumping also takes more time and you lose the valuable pauses that you could use for yourself (with the single pump, the other breast is pumped instead of pausing)
- › Even if “power pumping” takes up to an hour, you only need to put the pumped milk in the refrigerator at the end of the pumping phase.
- › Use the pauses to drink a little, to have a small snack, to have a shower and/or to massage the breast
- › If you use pump bras, then you have your hands and head free for other things
- › Don’t worry if you can only get drops of milk during “power pumping”. The goal is not to immediately pump the milk that is needed, but to give the breast the necessary signals for milk production.
- › Stay flexible and tolerant with yourself. The background for “power pumping” is the more frequent breastfeeds which should stimulate the milk production. Look for the variety of pump that best fits your daily schedule and/or combine the pumping with breastfeeding or pump directly after breastfeeding. Better to pump once for 5 minutes than not at all!
- › Use the time of “power pumping” for yourself. Read a good book, enjoy a small snack, spoil yourself and let yourself be spoiled
- › Try to remain patient and to think positively. For many women, a noticeable increase in the amount of milk can be seen within 3 days. Other mothers need up to 14 days to achieve the maximum effect of “power pumping”.
- › An International Board Certified Lactation Consultant (IBCLC) can inform you about further measures to promote milk production and pumping and work out a plan with you for transitioning from pumping to breastfeeding that is doable for you and your baby.
- › You can be proud of yourself and your efforts even under possibly difficult conditions.



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IBCLC

International Board Certified Lactation Consultants are the only internationally approved breastfeeding and lactation specialists having a medical background.

The decision to breastfeed or not to breastfeed has short- and long-term impact on the health of child and mother. However, breastfeeding sometimes turns out to be difficult and perhaps professional, competent assistance is needed.

Contact your IBCLC

Pain During Breastfeeding

A challenge for breastfeeding counselling Author: Dr. Alexandra Glaß, M.D., IBCLC



Pain during breastfeeding is arguably among the most important and difficult problems which confronts us as IBCLCs. Difficult due to the diversity of possible causes, important because pain during breastfeeding is among the most frequent reasons for premature weaning, especially if the pain continues for a long time. The Academy of Breastfeeding Medicine (ABM) classifies pain during breastfeeding as chronic if it continues for more than two weeks. Such pain is often associated with depression. The two can mutually reinforce each other. So our responsibility is immense.

Therefore, it makes sense to have an overview of the most frequent causes and the therapy for them to be able to act systematically.

Suboptimal Attachment Technique

As is well-known, one of the most frequent and most prominent grounds for painful breastfeeding is a suboptimal attachment technique. If we notice this while we are observing a breastfeed, it should be optimized:

Are mother and baby lying or sitting tummy to tummy? Are both comfortable? Is the baby's mouth wide open, lips flanged outwards, chin and nose on the breast? How does the baby behave at the breast, when does he let go and how does the nipple look then? Many problems can already be solved here. If not, we need to look further for causes.

Milk Blister

Many things jump out at us, so to speak, when we are observing - such as a milk blister after breastfeeding: a white or yellow blister covered with skin, which is particularly visible after a painful breastfeed. The milk duct behind it is blocked up, painful and often reddened.

If the baby is first put to the affected side - possibly even using gravity with, for instance, the mother bent over the baby in a hands and knees position, the blister often clears up quickly. Also, if possible, a warm moist compress can be placed on the nipple before breastfeeding. If these measures don't help, the blister should be opened under sterile conditions. This works well with a sterile hollow needle, stuck in at an angle. With quick attachment, ➤

the milk duct can then be emptied well. The milk may be thickened or crumbly but this does not harm the baby. Often women suffer repeatedly from milk blisters. In that case, it can be helpful to minimize stress and to avoid animal and saturated fatty acids. A tablespoon of lecithin daily, taken regularly over a long period is thought to have an emulsifying action and to improve the fluidity of the milk long-term.

A too short frenulum

If the child has anatomical peculiarities, such as a high palate and a pronounced frenulum, mothers often get in touch due to the baby's insufficient weight gain. Their own pain during breastfeeding is frequently pushed into the background. So, frequently the pain may first become apparent during the discussion.

The triad of pain during breastfeeding + insufficient weight gain + a high palate should also make us think about a too-short frenulum! The exact diagnosis is not always as simple as one might think. While the anterior frenulum, which causes the typical grooving of the tip of the tongue is obvious but the posterior frenulum is not always recognizable at first glance. By contrast to the transparent membrane of the anterior frenulum, the posterior frenulum is thicker, white and looks like connective tissue. It is located further towards the middle on the underside of the tongue up to the base of the tongue. It feels firm under the finger like a tight obstruction. Possibly the baby can reach his tongue over the dental ridge - at least with a slightly open mouth - so that a normal range of motion for the tongue is assumed - incorrectly. Should the baby open his mouth wide to breast-feed, the tongue no longer comes forward sufficiently. Quite the contrary, the tongue then often retreats. When the baby is crying, so-called cupping of the tongue can be observed. The tip comes up, the sides do as well, but at the mid-back, the tongue remains fixed to the base. During breastfeeding, the babies often let go, compensate with strong jaw movements and lose the vacuum.

The high palate mostly develops in utero due to limited tongue mobility. Because the optimization of the attachment technique is not possible in this constellation, a frenotomy is indicated. Unfortunately, this is not always easy. Not all physicians do this procedure. At least, this is my experience from Hannover and is also frequently reported from other parts of Germany.

Larger wound on the nipple

When a mother comes to us with a larger wound on the nipple, which does not heal despite correct attachment and good care? If the wound is open, oozing and also does not react to cleaning and superficial use of an antibiotic cream, taking an antibiotic often helps. In such cases, it is actually worthwhile taking a smear from the base of the wound in order to treat the antibiogram correctly. As a rule, however, these wounds react well to cephalosporin.

Mastitis and abscess

Procrastinating treatment with these kinds of wounds not only endangers the breastfeeding relationship, but also carries the risk of mastitis or an abscess - both of which are reasons known to physicians for causing painful breasts and painful breastfeeding. If, after 24 hours of redness and fever using conservative measures (rest, regular breastfeeding, cooling), the symptoms of mastitis have not significantly decreased, it should be treated with 500 mg of dicloxacillin or flucloxacillin 4x a day.

Mastitis mostly responds well to cephalosporin. However, when there is an allergy to penicillin, cephalosporin should be avoided due to the frequent cross allergy between penicillin and cephalosporin. It is important to always treat with antibiotics long enough - in this case that means 10-14 days. Microbiological cultures from the milk do not make sense because mother's milk suppresses the growth of germs and the actual infection is in the surrounding tissue, not in the milk ducts. In the case of mastitis, the milk contains more living immune-competent cells, which are also demonstrable, but in daily practice that does not really help us. If an abscess occurs despite antibiotic treatment, it should be aspirated by needle under ultrasound. This can be necessary several times. In this case, the doctor performing it can usefully create a culture from the aspirate in order to treat the antibiogram correctly and rule out multi-resistant organisms. The well-known operative clean-up with an incision, contra-incision and tabs should be reserved for therapy-resistant cases and the rare case of strongly chambered abscesses. And, in most cases, needle aspiration should be avoided.

Milk duct infection

Less well-known, but also caused by bacteria, is the bacterial milk duct infection. Due to bacterial colonization with biofilm formation, constant throbbing pain, often on both sides, results. It occurs during and after breastfeeding, but is strongest during the milk ejection reflex. In addition, the breast is sensitive in the lower quadrants. The breast itself looks unremarkable. By contrast to mastitis, the infection here is in the milk ducts. Therapy is also with antibiotics

Thrush

With thrush, the breast can look unremarkable from the outside even though the mother presents herself with severe pain. She reports a knife-sharp burning pain during the milk ejection reflex and between breastfeeds. The nipple can be unremarkable with thrush that is only in the milk ducts. If the nipple is also affected, we see a pink, scaly, itchy areola, possibly with small pimples. The baby may also show signs of thrush, such as a whitish coating in his mouth that cannot be wiped off. For this reason, he may also cry at the breast or refuse it. There may also be thrush in the diaper area. But the baby can also be completely unremarkable. Nevertheless, his mouth should be treated with the appropriate gel so as not to infect his mother again should he have a candida infection that has gone unnoticed.

Frequently, patients are sent to my practice so "The doctor can do a smear test", in the expectation that the diagnosis could then be confirmed black on white. Frequently the patient is not happy if the doctor does not want to do a smear test. Smears from mother's milk do not function well because the living immune-competent cells and lactoferrin prevent the growth of fungi and bacteria. Smears of the skin will almost always reveal staph aureus and often candida species as well because these live primarily on the skin but, with an intact skin, do not cause any problems.

Thus, for understandable reasons, the diagnosis of thrush mostly takes place clinically. If attachment and sucking are correct, vasospasm ruled out or treated, pain as described above? Then thrush treatment with fluconazole should be given with 400 mg on day 1, then 200 mg daily until there have been several symptom-free days (the ABM Protocol suggests 200 mg initially, then 100 mg following that). Then, when the mother is symptom-free, the diagnosis of milk duct thrush can be made by inference.

**Stretching
the breast
muscle as
a treatment
of Mammary
Constriction
Syndrom**



© Andrea Hermelmayr

Breastfeeding during this therapy is possible with no limitations. What is important here is the oral treatment of the infant and good hygiene (hand towels, pacifier, bras etc.). The use of artificial nipples and supplementation with infant formula which, by contrast to mother's milk, does not hinder the growth of bacteria and fungi, have been mentioned in several publications as risk-factors for candida infections. Fluconazole therapy is expensive when it is given in sufficient dosages and for sufficient time. For this reason too, it makes sense to clarify beforehand whether thrush is likely.

The most important differential diagnosis: Vasospasm

With a vasospasm, the mamilla turns white or occasionally, depending on the skin tone, blue. This is accompanied by strong pain radiating deep into the breast. Attachment is also painful due to nipples that quickly become sore and heal poorly as a result of the frequently insufficient blood circulation. Furthermore, the nipples turning white is, in itself, very painful. This can also occur independently of breastfeeding, between breastfeeds, when it is cold, after showering, when opening the refrigerator etc. Mothers who smoke, have migraines or have even observed symptoms of true Morbus Raynaud, during which the tips of the fingers become cold and bloodless, are particularly at risk. In the literature, the connection between high doses of magnesium during pregnancy has been described. Abrupt stoppage (of magnesium) towards the end of or after the pregnancy appears to promote the occurrence of vasospasms. Hence the recommended therapy: Avoid the cold, actively arrange for warmth. Improve attachment and treat accompanying infections if necessary. Many women have had good experience with the use of high doses of magnesium and calcium, which,

after the onset of improvement, is slowly phased out. Furthermore, high doses of Vitamin B6, lecithin or evening primrose oil, as well as the homeopathic spascupreel, can be helpful.

In most cases, these measures will be sufficient if the mother attaches her baby correctly. Some women have reported to me about having discernible vasospasms for the entire breastfeeding period which, however, are no longer painful after a while. It helps the mother to know that time works in her favor. With these measures, pain-free breastfeeding is almost always possible.

Only in rare cases must we fall back on prescription medication. With the therapy-resistant pain caused by vasospasms, which has been treated with the measures thus far described, treatment with the calcium antagonist, nifedipine, is indicated. Nifedipine acts to expand the blood vessels and is approved for treatment of Raynaud's syndrome. The dosage is either 1x daily 30 mg of the slow-release form or 3x daily 10 mg of the immediate release form. With this therapy too, it can be several days before a clear improvement occurs

The Mammary Constriction Syndrome

A little researched reason for chronic pain during the breastfeeding period was described by Newman and Kernerman: the mammary constriction syndrome. Here, a tense pectoral muscle reduces the blood flow to the breast and nipple. The treatment involves vigorous massage of the pectoral muscle and the serratus muscle and stretching of the pectoral muscle. For this, the areas above, under, right and left of the breast are vigorously massaged several times a day and the breast muscle is stretched, standing, for instance, in a door frame (see picture). In my view, this approach is quite plausible. Almost every day in the gynaecological prac- >



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› tice, we experience that non-breastfeeding women with breast pain come in, that is then discovered to be pain with an orthopaedic or a musculoskeletal cause, which has nothing to do with the breast tissue. Since brand-new mothers – as is known – have a tendency to muscular tension, very often this is certainly the cause. In any case, here there is still a need for further research, but with unclear therapy-resistant pain there is one option that can be used and give the mother the possibility to do something herself.

Functional Pain

What do we do when all approaches produce no success? The ABM in its new protocol on chronic pain during breastfeeding has taken up an interesting point: Allodynia or functional pain.

Here, pain occurs even with light touch, by clothing on the skin or drying with a hand towel. In the anamnesis other chronic pain illnesses, such as irritable bowel syndrome (IBS), fibromyalgia, dyspareunia (painful intercourse) or restless legs syndrome become apparent. The functional pain is associated with depression and anxiety disorders and must be treated in an interdisciplinary way.

Therapeutically, for a few days, one can try to provide relief for the mother by interrupting the facilitation of the pain with a tightly scheduled pain medication. Obviously, the basic illness must be treated effectively. Psychotherapeutic counselling and, in some cases, anti-depressive therapy should be considered so that stress, pain and depression do not mutually reinforce each other and become self-sustaining.

Particularly in caring for a mother with pain during breastfeeding, it can be seen how important it is from the perspective of breastfeeding counselling, to be informed about possible causes to be able then to also work in an interdisciplinary way as much as possible – gynecologically, from an internal medicine perspective, orthopedically, neurologically, psychotherapeutically, pediatrically. Ideally, the breastfeeding counsellor has built up a network of open, breastfeeding-friendly colleagues with whom she can jointly care for mother and child



Dr. med. Alexandra Glaß

AME: A Tool to Manage Milk Production in Challenge

AME: Antenatal Manual Expression Author: Gina Weissman, DMD, RN, IBCLC



Collect the colostrum in a sterile container (e.g. syringe with a cap) and store in the freezer. Syringes are easy to use and defrost quickly.

Throughout human history, the breastfeeding mother and child have shared a very special relationship for long periods. For the modern mother, things are different.

In 2001, the World Health Organization issued a resolution that reads: “Exclusive breastfeeding for six months followed by the introduction of appropriate complementary feeding and continuation of breastfeeding for up to two years of age or beyond is optimal for the mother and child” [1]. Many mothers nowadays are already weaning before the baby is 2 weeks old.

New mothers abandon breastfeeding for two main reasons: 1) Breast pain and wounds 2) Insufficient milk, either perceived or real. With perceived insufficient milk supply, it is often the lack of support from people around her, who aren’t informed about breastfeeding that influences the mother [2, 3]. Educating the nursing mother will – hopefully – prevent this.

With respect to actual milk volume, the Parker Study [4] shows us that it is important for mothers to start expressing their milk as soon as possible after birth. Furthermore, those mothers studied, who started *hand expressing milk within the first hour after birth, had 130% more milk* (3 days, 5 days, 7 days, 3 weeks and 6 weeks postpartum) than those who waited – even for a period as short as 2 hours after birth - to start expressing milk. The early expressers always had more.

We all know that it is best for baby and mother to be **breastfeeding directly from the breast** during the first hour postpartum.

Maximize Breastmilk Challenging Cases

Unfortunately, often the baby is delivered but, for several reasons, doesn't nurse within the first hour. When I ask mothers in the maternity ward: "Did you breastfeed in the delivery room?" I hear: "I tried, but the baby didn't want to." Or "He tried, but he didn't manage it." Even though it was the mothers' original intention to nurse within that first hour, in fact less than half of them did.^[5]

For most mothers, this might not be important. However, if there is potential for a real problem with milk production, expressing within the first hour, could provide a critical advantage.^[6]

The message to new mothers needs to be: "If he didn't breastfeed during the first hour, start expressing your milk".^[7] Whether she starts on her own or with the help of her mother, doula or partner, what is important is that she begin expressing her milk. Even if it's not collected, but just expressed into a piece of cloth, which is then put into the baby's bassinette.

So, if we want the new mother to be able to express within the first hour, the best time to teach this would be **before** delivery.^[8] In my clinic, I encourage mothers whom I consider to have a potential for an insufficient milk supply to come for a consultation at about 37 weeks of pregnancy. The mother is more open to learning new skills shortly before the birth.

During the meeting, the mother is given basic tools for the successful establishment of breastfeeding: First hunger cues; the switch nursing method; the significance of skin-to-skin contact, and rooming-in as the preferred option for mothers and babies.

I also teach them how to express colostrum. They will practice this skill during the next few weeks and by the time of birth they will be experts and will have collected colostrum that will assist them through the first days postpartum.^[9]

Of course, my recommendation is, first of all, breastfeed. However, if you don't initially succeed in breastfeeding, for whatever reason, don't stress - just express.

As demonstrated in previous studies^[10, 11, 12], it is advisable for diabetic mothers (including mothers with gestational diabetes, insulin dependent diabetes) to express milk before birth because the babies have a high potential to be hypoglycemic (low blood sugar), and they are at risk for a delay in lactogenesis two. They too collect the colostrum in little syringes that they bring to the birth place and are given to the baby if needed. >



© Gina Weissman

Keep the syringes frozen until labor begins.



AME: an effective tool for mothers in case breastfeeding is at risk.

THE PROTOCOL

Manually express colostrum for a total of 5 minutes each time (both breasts) as follows:

- 1 At 37 weeks pregnant- twice daily
- 2 At 38 weeks pregnant - 4 times daily
- 3 Collect the colostrum in a sterile container (e.g. syringe with a cap) and store in the freezer. Syringes are easy to use and defrost quickly.
- 4 Keep the syringes frozen until labor begins.
- 5 AME can continue past week 38 up until birth, 4x daily for 5 mins each time.
- 6 Bring the colostrum-filled syringes to the birth place in an appropriate cooler. The colostrum can be given to the newborn after each breastfeeding session. If baby and mother are separated, the colostrum can be dripped into the baby's mouth by a caretaker.
- 7 If possible, mother should attempt breastfeeding within one hour postpartum. If, for some reason, maternal or neonatal, the baby does not latch, manually express colostrum within one hour of giving birth. Collect the colostrum in a clean vessel if possible; if not express into a cloth diaper or sheet.

THIS PROTOCOL IS SUITABLE FOR:

- Multiparous mothers with a history of low milk supply
- Women who have undergone breast surgery (augmentation / reduction)
- Women with hormonal fertility problems
- Women with diabetes

WHEN IS IT NOT SUITABLE?:

- Women with a high risk pregnancy who are to avoid sexual intercourse.
- If the AME causes pain in the breast or nipple or the mother feels the onset of contractions, she should consult with a physician.

- › At the 2015 ABM conference in Los Angeles, I presented this idea of AME in cases with which I personally had experience. None of the mothers had gone into premature labor, which was a concern raised when I started suggesting that mothers express their milk prior to birth.^[13] Many of these mothers were successfully 100% (!) breastfeeding, while they had in their backgrounds, reasons for us to believe that they might not be able to: severe hypoplasia; breast reduction surgery; IVF at age 47; impaired health issues.



Gina Weissman, DMD, RN, IBCLC

IBCLC since 1999; Doctor of medical Dentistry (DMD), Registered Nurse
Dr. Weissman is the Director of HalavM Breastfeeding clinic and Lactation Consultant Education Program for professionals. She also works as a lactation consultant nurse in the maternity ward of Laniado hospital in Israel. She practiced mothering through breastfeeding with her four sons

So how do you hand express?



1. Place your finger and thumb parallel to each other, about 2 cm behind the nipple.
2. Push your fingers in the direction of the ribs (into the breast)
3. Continue to press while trying to connect your fingers inside the breast and pulling the fingers around and down toward the nipple. In fact, expression is done in a circular manner and within. It is important to emphasize that the movement is done on the internal tissue and not just on the skin.
4. Express the colostrum into a syringe or cup that will be easy to drip into and easy to freeze.

- › ^[4] **Association of Timing of Initiation of Breastmilk Expression on Milk Volume and Timing of Lactogenesis Stage II Among Mothers of Very-Low-Birth-Weight Infants** L. A. Parker, S. Sullivan, C. Krueger, and M. Mueller **BREASTFEEDING MEDICINE** Volume 10, Number 2, 2015, DOI: 10.1089/bfm.2014.0089
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Breastfeeding: Smart, Cool and Career-right

Survey of lactation consultants on an improved framework of breastfeeding support



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This study is based on responses to a bilingual questionnaire in German and English, provided by experts taking part in three international breastfeeding conferences. The following article reflects the study results: <http://internationalbreastfeedingjournal.biomed-central.com/articles/10.1186/s13006-016-0072-y>

More results and the full questionnaire can be found in Stefanie Rosin's dissertation study: <http://pub.uni-bielefeld.de/publication/2663500>

Participants: Practitioners in breastfeeding support from highly industrialized countries from 5 continents

Three-hundred-and-one participants responded to the questionnaire at 3 international breastfeeding conferences in 2008: The VELB (now ELACTA)/ ILCA and ABM conferences in Vienna, Austria; and the annual meeting of LLL Germany. Participants came from nearly all continents with the exception of South America. They were from 34 countries, of which 98% were

highly industrialized; one third German residents and nearly one third resident in Austria. About half of the participants were nurses, nearly 18% midwives, nearly 15% physicians, 6% researchers, 13% officials of the healthcare system, 1 doula and 9% came from professions other than healthcare. 75% of participants were qualified IBCLCs, 24% were qualified in volunteer breastfeeding support (La Leche League/LLL, Australian Breastfeeding Association/ABA, Arbeitsgemeinschaft Freier Stillgruppen= Work group of free breast- >

> feeding support groups/AFS), and about 10% had double qualifications (e.g. IBCLC+LLL). Three participants were male. The study aimed at learning more about the current situation of lactation consultants, and about priorities for protecting, promoting and supporting breastfeeding.

Work situation, contentedness, motivation and acceptance of lactation consulting

Remuneration

The ratio of unpaid to paid lactation professionals was 1:3. However, a clear distinction of paid and unpaid breastfeeding counselling was difficult, since even in a paid setting unpaid work was being done. Several paid lactation professionals worked unpaid overtime to be able to provide adequate breastfeeding support besides their daily routines, e.g. on hospital wards; while several free-lance LCs had to finance their lactation consulting otherwise, e.g. by lecturing. Three respondents stated that they had to pay all continuing education by themselves. Overall, 7% of participants rate their remuneration as higher than average, 59% as adequate and 34% as insufficient.

Work situation

Lactation professionals considered an upgrade of their profession, regarding remuneration and working opportunities as very important (90%) and expressed a wish for further professionalization of their relatively young profession (42%). Two respondents wrote:

“Health policies should support lactation professionals” and “create career opportunities”. In open-ended responses, lactation consultants expressed their wish for official recognition, acknowledgement and respect for their work (14%). Three respondents wrote: “Lactation consulting should be a stand-alone profession”, “integrated in the healthcare system” and “paid to the full expenditure of work”. Two participants expressed a wish to “participate in decision-making and “gain power over budget and time management”. Several respondents lamented the lack of exclusive working opportunities as lactation consultants with adequate payment, be it in a free-lance or employed work setting. They expected health insurance companies to integrate this service into healthcare, thus acting for their very own interest of short, middle and long-term cost savings and prevention.

The majority of lactation professionals believe they are making a difference with their work (87.5% “agree” vs. 12.5% “disagree”) and that it is the task of healthcare providers to re-build a breastfeeding culture (75.3% “agree” vs. 24.7% “disagree”). Respondents stated that the lack of other healthcare professionals’ training in breastfeeding support undermines lactation consulting and results in conflicting advice to families, thus also disabling integrated breastfeeding support within healthcare. To tackle this shortcoming, respondents suggest basic training in breastfeeding support, such as the UNICEF/WHO 20-hour course, for all healthcare providers; and the IBCLC accreditation as standard training for those directly involved in maternity care (90%). This measure is aimed at improving interdisciplinary co-operation and implementing a continuum of competent breastfeeding support into healthcare, thus also facilitating timely referrals to lactation professionals.

Motivation and contentedness

When asked whether they felt valued, lactation professionals stated that they felt their work was highly appreciated by families, but not sufficiently valued by superiors and colleagues. In responses to open-ended questions, respondents stat-

MOTIVATION This desire motivates me in my work as a lactation professional	MEAN VALUE (Scale 1-3) ^a	FREQUENCY OF SELECTION n (%)
To promote bonding	2.11	158 (52.5)
To empower women	2.06	148 (49.2)
To support children's right to human milk	2.31	144 (47.8)
To promote health	2.02	112 (37.2)
To rebuild a breastfeeding culture	1.58	92 (30.6)
To support families	1.85	81 (26.9)
To share my experience with breastfeeding	1.72	29 (9.6)
To promote my own career	1.4	15 (5.0)
Other ^b	2.43	11 (3.6)
To protect the environment	1.5	6 (2.0)

Table 1:
Sources of motivation for lactation professionals (only 3 choices)

^a 3 = Most important reason for my personal motivation, 2= Second most important reason for my personal motivation, 1= Third most important reason for my personal motivation

^b Sources of motivation expressed by respondents: To enable bonding for social welfare, to provide up-to-date information and optimal support for breastfeeding mothers, to reduce women's unnecessary suffering, to protect families from the unscrupulous tactics of the breastmilk substitute industry, to promote human oral tactile imprinting, to help mothers follow their instinct, to reduce costs, to enjoy networking with other breastfeeding professionals, to partake in an interesting and fascinating job.

ed that they would feel more appreciated if they were better paid (12.5%), were acknowledged as professionals (14.1%) and received greater appreciation in general (18.4%). Table 1 shows the priority ranking of sources of on-the-job motivation, as defined by lactation professionals. In this item, respondents had the opportunity to choose only 3 points from a given list to determine priority motivations. In the table's footnotes further motivating factors can be found, that participants added in their responses to open-ended questions.

When asked about contentedness on the job, two thirds of survey respondents were content with their current job situation, of which 14.5% were "very content" and 53.5% were "rather content". Only a total of 21.4% of respondents stated that they were "discontented" with their current situation, of whom 19.1% were "rather discontented" and 2.3% were "totally discontented". Even though the majority of respondents were content overall, when asked what makes them content/discontented, nearly equal numbers of responses for both categories were provided in responses to open-ended questions (79% contented vs. 73% discontented). Contentedness was ascribed to success as breastfeeding counsellors, including positive feedback from mothers (39%), progress

in increasing breastfeeding rates (11%), progress towards Baby-Friendly accreditation, implementing breastfeeding policies (8%) and a supportive work environment (20%). Discontentedness was associated with making slow progress, misleading advertisements from the industry for artificial products (13%), lack of funding and health policy support to protect and promote breastfeeding (20%), ignorance and non-supportive attitudes of other healthcare providers (16%), lack of support and pay for lactation consulting (12%) and lack of adequate support for families (12%).

Acceptance of lactation consulting

Practitioners in breastfeeding support were asked to evaluate how they felt their service and advice were accepted, put into practice or supported by the mothers and their social environment (Figure 1). According to respondents, mothers are the most accepting of advice provided by lactation consultants, followed by fathers and then relatives, all still scoring within the positive range. Healthcare providers scored two thirds within the positive and one third within the negative range. According to lactation professionals, society is rather unsupportive, scoring predominantly within the negative range; the mother's work environment is even more so; and the

least likely to support lactation professionals' advice are the media.

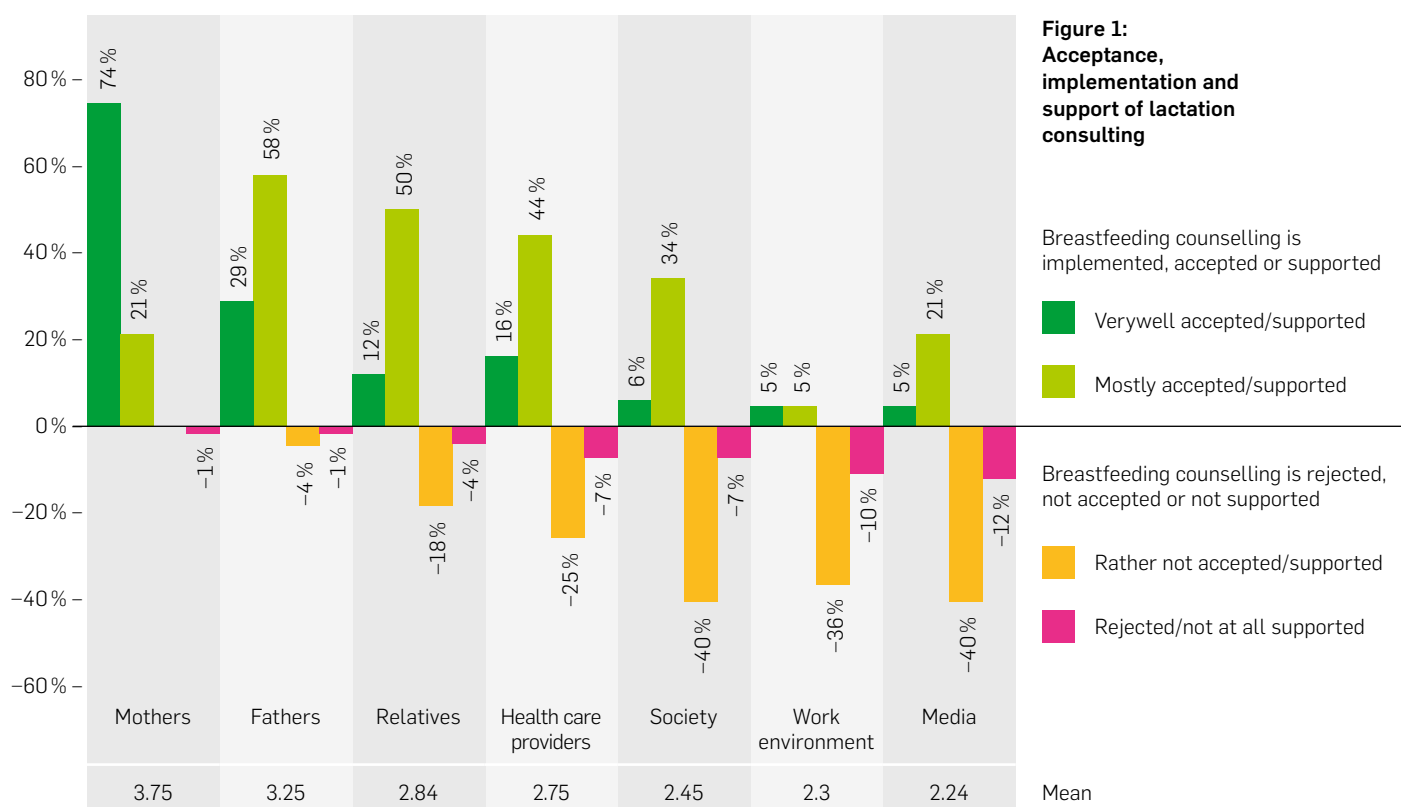
Acceptance of the WHO recommendation for breastfeeding

Respondents stated that while healthcare providers in their work environment seem to be supportive of breastfeeding in general (76.1% "supportive" vs. 23.9% "non-supportive"), they are rather non-accepting of the WHO recommendation to breastfeed exclusively for 6 months and then to continue breastfeeding up to 2 years and beyond (37.5% "supportive" vs. 62.5% "non-supportive"). Nearly half of the lactation professionals stated that, in their perception, mothers were open to WHO breastfeeding recommendations (52.4% "not open" vs. 47.6% "open").

Priority measures to protect, promote and support breastfeeding, according to survey participants

First priority for improved breastfeeding promotion: Integrated care in breastfeeding support

Integrated care is defined as the collaboration of all healthcare providers in a patient-centered approach, be it in a healthcare team, such as on maternity ward, or between different levels of healthcare, e.g. between hospital and private prac-



tice. Respondents considered consistency of care and collaboration of healthcare providers within breastfeeding support as the first priority to enable successful breastfeeding. The importance of integrated care is also reflected in the „Baby-Friendly“ accreditation, with “the 10 steps to successful breastfeeding” representing an integrated care pathway within the relevant setting (e.g. the hospital). Additionally, respondents considered it crucial to implement continuity and consistency of breastfeeding support into the entire healthcare system.

Parents are often not empowered to make an informed decision for breastfeeding

The described inconsistency of care in breastfeeding support undermines breastfeeding success, since families receive conflicting advice from healthcare providers. Respondents placed special emphasis on the lack of training and competence of medical doctors in breastfeeding support. Given their elevated hierarchical position and responsibility for integrating and coordinating healthcare providers and healthcare services, e.g. in their role as family doctors and primary caregivers, their lack of competence in breastfeeding support contributes noticeably to the failure of integrated care. However, without consistent evidence-based information, including the practical how-to of breastfeeding, parents are not enabled to make an informed choice, thus reducing their infant feeding choices.

Healthcare system incentives for breastfeeding support are lacking

To enable integrated care in breastfeeding support, healthcare system incentives are indispensable. However, most healthcare systems in industrialized countries do not integrate lactation consulting as a healthcare service, thus lacking incentives for competence in breastfeeding support. This lack of competence undermines both integrated care in breastfeeding support and breastfeeding success. Moreover, the profession of midwives, too, lacks integration into healthcare, with a negative impact on both natural birth and breastfeeding. Besides these deficits, study participants pointed out that parents cannot make use of breastfeeding support as a free healthcare service, as another missing healthcare system incentive.

Political framework is inadequate

Deficits in breastfeeding support were mainly ascribed to malfunctioning health policies at all levels (regional, national and global), with participants claiming that policies to protect and support breastfeeding were either lacking or failing. Therefore respondents listed health policies to protect and promote breastfeeding second in their priority ranking after integrated care. In open-ended responses, they described in detail their suggested measures for improved health policies to facilitate breastfeeding support (see Table 3 and additional file 2 of the IBJ article). Three participants suggested:

- › “More focus of health policies on early prevention, nutrition policy and ethics” (Germany/ Gynecologist/ IBCLC)
- › “Economic interests should no longer be the priority in health policies” (Germany/ Bank clerk/ LLL)
- › „Create an image of breastfeeding as smart, cool and career-right“ (Norway / Gynecologist / Healthcare provider)

Norway has created a favorable framework of breastfeeding support after decades of breastfeeding promotion

Compared to all other survey participants, only Norwegian participants felt adequately supported by mothers and fathers (100 % vs. 95 %), relatives (100 % vs. 74 %), other healthcare providers (100 % vs. 65 %), the work environment (100 % vs. 36 %), society (100 % vs. 45 %) and media (100 % vs. 33 %) ($P < 0.05$). Thus Norwegian respondents placed all members of society including politicians, whom they added to the given items, within the “very well” or “rather well accepted, implemented or supported” range. Norwegian residents think that their National Breastfeeding Committee successfully promotes breastfeeding, more so than respondents from other countries (100 % vs. 52 %), that policy implementation is successful (100 % vs. 24 %), and that therefore national media campaigns are less important (75 % vs. 2 %). They also show a higher rate of agreement with statements such as “healthcare providers support breastfeeding” (100 % vs. 76 %) and “mothers are open to following WHO recommendations” (100 % vs. 47 %). Finally, they tend to be more content with their current situation (100 % vs. 76 %). Residents from Sweden tended to replicate the results of their Norwegian colleagues.

Norway’s successful breastfeeding promotion, which is reflected in high breastfeeding rates for an industrialized country, is not a coincidence. In a nutshell, Norway already fulfills many of the claims raised in this study: Peer support groups spread rapidly in the 1970s, thanks to the easy access to leadership of the breastfeeding support group „Ammehjelpen“, which contributed to about a 40 % increase in breastfeeding rates. Quality of breastfeeding support in obstetric institutions was ensured by the standard accreditation of Baby-Friendly Hospitals in the 1990s, which has been expanded to other healthcare settings, such as well-baby clinics and communities. Furthermore, Norway has an uninterrupted tradition of midwife-led births as optimal precondition for breastfeeding, their own training system in the field of breastfeeding addressing all healthcare providers, an agreement with the formula industry on their adherence to the International Code of Marketing of Breast-milk Substitutes, and has both a National Resource Center for research, and an NBC cooperating with the government to continually improve breastfeeding support. All these measures suggest that Norway has come closest to creating an image of breastfeeding as “smart, cool and career-right”, as one Norwegian participant described it.

Strengthening and tasks of the National Breastfeeding Committee

Participants wish to have a strong and influential National Breastfeeding Committee, adhering to the International Code of Marketing of Breast-milk Substitutes, endowed with the necessary funds, personnel and influence to fulfill their manifold tasks, and have a noticeable impact on healthcare and society to make both breastfeeding-friendly. Besides the core tasks of NBCs with only marginal progress in recent decades in industrialized countries (maternal leave, spreading of BFHI, legislation and policies for breastfeeding promotion), their new tasks, as defined by respondents, are mainly information policies and PR (see Figure 1 in the IBJ article).

Figure 2 reflects a model of family-centered integrated care in breastfeeding support, consistent with study results on the defined levels of integrated care.

Future prospects

When asked about the expected development of breastfeeding within the next 15-20 years, the majority of lactation professionals believe that a breastfeeding culture will be re-established slowly but surely (69.1% “probable” vs. 26.6% “improbable”). They also anticipate, however, that “substitute producers will keep their market share” within the same period (71.8% “probable” vs. 24.9% “improbable”). In open-ended responses participants explained this paradoxical statement by estimating that producers would shift their portfolio, e.g. to more toddler or care products etc. Respondents were ambivalent about whether people will be compelled to come back to breastfeeding in the next 15-20 years due to climate change (48.5% “probable” vs. 48.2% “improbable”) or the economic crisis (36.9% “probable” vs. 57.8% “improbable”), with the majority believing that a deteriorating economy will not lead to more breastfeeding.

Open-ended responses about the development of breastfeeding in the near future (15-20 years) showed that 16.9% of

respondents are predicting a positive outcome, including an increase in breastfeeding rates, 3% expect stagnation and 6.6% are predicting a decrease in breastfeeding rates. This article ends with selected comments from participants.

Decreased breastfeeding rates in the next 15-20 years (7%):

- > “The continuing increase in obstetric interventions (e.g. CS) will have a negative impact on breastfeeding success, initiation and duration” (Germany / General Nurse / AFS)
- > “The negative impact of the modern work environment on initiation and duration of breastfeeding will continue” (Germany / Maternity Care Nurse / IBCLC)
- > “The substitute industry will continue to undermine breastfeeding with less-than-scientific research and language of influence” (USA nationality, resident in Germany / Lactation Consultant / IBCLC + LLL)
- > “The social gap will widen because of the disintegration of social support networks” (Germany / homemaker / LLL)

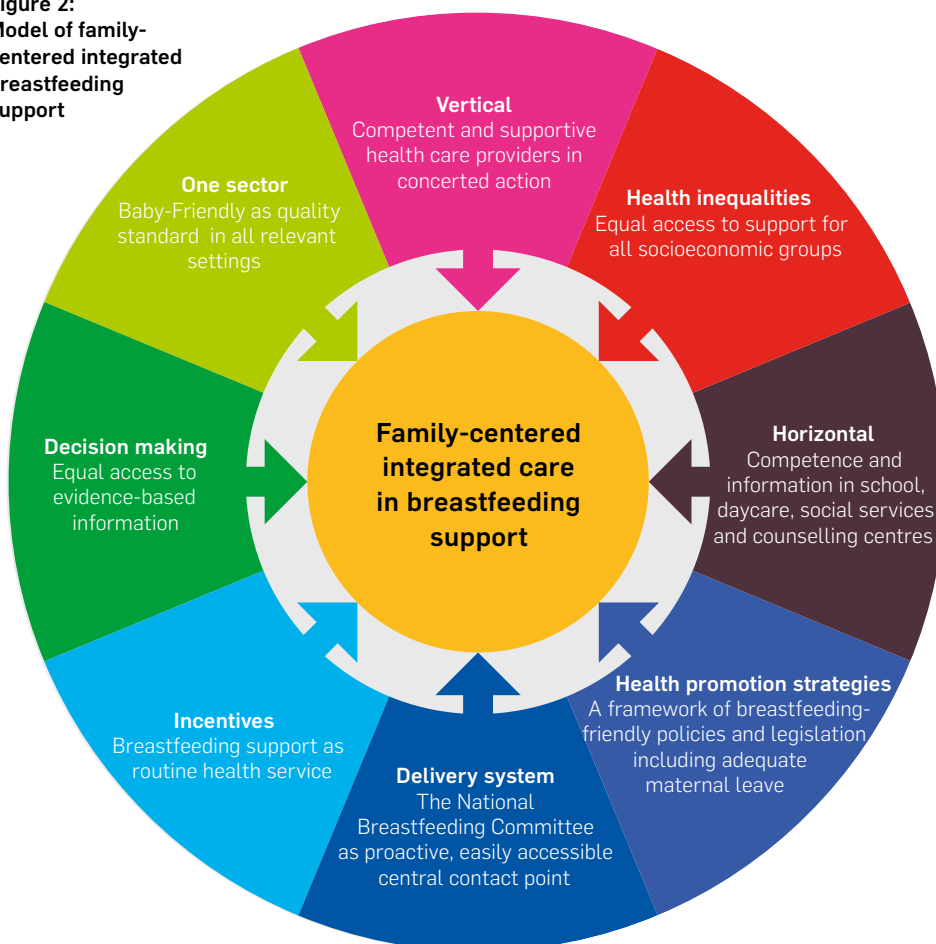
Stagnation of breastfeeding rates (3%)

- > “Bad family policies will force us to fight only to keep the status quo” (Austria / Lactation Consultant / IBCLC)
- > “On the one hand awareness will rise; on the other hand substitute producers will fight to keep their market share” (Germany / General Nurse / IBCLC + LLL)
- > “No progress if professional organizations and politicians don’t wake up soon” (Germany / Pediatrician / IBCLC)

Increased breastfeeding rates (17%)

- > “Breastfeeding will gain significance and value as the best and healthiest choice for both mother and baby” (USA / Lactation Consultant / IBCLC)
- > “Increase of breastfeeding rates because of diligent work of lactation consultants, better information and rising awareness” (Germany / Lactation Consultant / IBCLC + LLL)
- > “The breastfeeding culture will be re-established” (Switzerland / Midwife / IBCLC)
- > “Women will reconquer their right to breastfeed” (Switzerland / Midwife / Healthcare Provider)
- > “Babies will be exclusively fed on human milk” (Australia / Midwife / IBCLC)

Figure 2:
Model of family-centered integrated breastfeeding support



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AICPAM Conference from 21st to 22nd October 2016 in Bologna, Italy

Report by Stefanie Rosin



As first Secretary of ELACTA, I attended the conference of the Italian professional association of IBCLCs AICPAM by invitation of the president Gerardo Chirichiello and the Vice President Miriam Lelli (<http://aicpam.org>). At this conference, I also got to know Rosemarie Gruber, a former board member of the German speaking Italian association VSLs from Southern Tyrol (www.stillen.it).

I had heard Suzanne Colson before, who is specialized in laid back breastfeeding, and used her method ever since in my own lactation consulting. I found her Bologna presentation highly interesting. Her presentation included videos, and well-known notions with counterpoints, dealing with the art of supporting mothers in a natural breastfeeding position with as little interference as possible, respecting the mother-infant intimacy. She pointed out that we as healthcare providers should perceive mothers more as experts for their children and consider this while consulting a breastfeeding mother.

Further, Italian doctors, nurses and midwives presented their practical experience, how they enable skin-to-skin contact under special circumstances, such as Caesarian section or premature babies, with skin-to-skin being the main conference topic.

Bologna is also worth seeing with many medieval churches, the oldest university of Europe, the Two Towers as the landmark of Bologna and more.



From left to right: Stefanie Rosin (ELACTA), Gerardo Chirichiello (AICPAM), Miriam Lelli (AICPAM), Regina Masaracchia Patitò (Author, IBCLC, nurse)

CERPs International 24.–28. 5. 2017 in Salzburg/Austria



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Are you an IBCLC and an ELACTA member at the same time? Do you want to combine the useful with pleasure by studying with colleagues from all over Europe and later on explore the city of Salzburg and its surroundings? Talking, laughing, discussing topics and having fun together while collecting CERPs.

In order to do justice to all the colleagues coming from various countries of Europe, there are two lecture rooms. In one of those rooms lectures and discussions are held in German whereas in the other room lectures and discussions are in English.

You can get involved in shaping the programme by holding an interesting lecture or presenting an exciting case study and thus reduce your own participation fee.

In the afternoon we are planning to go on culinary and cultural trips in and around Salzburg.

Allow yourself this unforgettable experience and register as soon as possible as the number of participants is limited.

Our hotel is: www.hotel-gerl.at



FURTHER INFORMATION

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- › Working together to pursue the goals as stated in the "Vision" of ELACTA
- › Reading and replying to mail/e-mail: commenting documents on request
- › For the total work in this function: an average of 5 hours a week
- › IBCLC certificate
- › Attending personal board meetings about 3 times a year for 3 days
- › Preparing and attending Skype board meetings once a month
- › Working with Excel, Dropbox, Skype

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If this description suits you, please send your application including your CV before December 15th 2016 to secretary@elacta.eu. The person of choice is requested to join our next board meeting in Switzerland January 27th and 28th, 2017.

For inquiries about ELACTA board work, please contact president@elacta.eu.

Meeting ELACTA with BDL on 9th September 2016 in Berlin

Report by Stefanie Rosin



From left to right:
Karin Tiktak President ELACTA,
Maja Recic Deputy-Treasurer ELACTA,
Stefanie Rosin 1st Secretary ELACTA,
Monika Jahnke President BDL,
Mirjam Pot Vice President ELACTA,
Heike Behrens Co-Chair BDL,
Barbara Finderle 2nd Secretary ELACTA
 (co-opting board member).
 Missing on this picture:
Heli Vanhatalo 1st Treasurer ELACTA

On the occasion of our ELACTA board meeting in Berlin from 09 – 11 September 2016, we invited the German BDL board for a meeting. Monika Jahnke as the president of the German Professional Association of German Lactation Consultants BDL (Berufsverband deutscher Laktationsberaterinnen) came together with Heike Behrens from Berlin, co-chair, to represent the BDL. This year, September rather appeared like midsummer, and so was the afternoon of 9th September, when we met in the beautiful garden of our accommodation in Berlin. First we made an introduction round to exchange about our manifold activities to support breastfeeding, be it in a voluntary, professional or political scope of action. BDL reports that their first priority is to obtain regular payment from health insurance companies for lactation consulting. However, this challenge has shown to be hard to achieve. Unfortunately, not only LCs, but also German midwives are currently fighting for their profession, which are both not sufficiently supported by the German healthcare

system and government. Currently only midwives get paid for a limited number of lactation consultations in Germany, while BDL has made great efforts to have lactation consulting acknowledged by the German healthcare system. In spite of all these efforts including networking with contact persons from the German government, the progress continues to be slow. However, quite recently, IBCLCs in Germany were officially acknowledged as “lactation therapists” (Laktationstherapeutin). ELACTA presidents suggest to develop a professional profile for LCs, which has recently been accomplished by the Dutch Association of Lactation Consultants, with the support of an agency. There will be a follow-up on this topic, with ELACTA to support the efforts of BDL by establishing a contact to the Dutch people in charge.

We discuss the next conference in Rotterdam in 2018. Monika Jahnke suggests locating one of the next conferences in Germany.

Monika Jahnke also suggests to design a booklet cover with the ELACTA logo on it

for the mothers’ and infants’ health booklets for pregnancy and post-partum, while the cover sizes should be adaptable for all the different European formats of booklets.

After an intense exchange and an enjoyable dinner together, representatives of BDL and ELACTA part, both looking forward to meet again soon, and for sure in Rotterdam in 2018.

Making a Healthy Start Possible For Every Baby

Attention to proper support for breastfeeding in the House of Parliament in the Netherlands

Author: Teddy Roorda, President NVL



Meeting of dutch breastfeeding organizations (Platform Boerstvoeding and National Breastfeeding Council)

As part of National Breastfeeding Week, the Breastfeeding Platform and the National Breastfeeding Council presented a petition to the spokespersons for Public Health in Parliament. The petition is the kickoff for drawing more attention to optimal guidance on breastfeeding. Obviously, this is the choice of mother and child first. More than 80 percent of mothers in the Netherlands start breastfeeding after birth. The majority of these mothers quit breastfeeding in the first month. Reasons for quitting breastfeeding vary, but there is one common denominator: good guidance by an expert would absolutely have made the difference - a difference for both mother and child because every suckling child has a better starting position when it comes to his or her health.

In the petition, Hester Rippen, president of the National Breastfeeding Council, pointed out that the right expertise is not available everywhere and change is needed. „All relevant health institutions should operate according to the Baby Friendly WHO / UNICEF program“. Rip-

pen urged the spokespersons of PvdA, GroenLinks, VVD, CU, PvdD, PVV, CDA, D66, SP who were present to place this subject on the political agenda to discuss with the Minister of Health, Welfare and Sport. Also, the return to work was mentioned as a tipping point. The female MPs present recognized themselves in this. Often, it also appears to be difficult in the House of Parliament to find the time and space to pump, even if there is a room available for this purpose. The spokespersons reacted positively to the proposal to ask the Minister of Social Affairs and Employment to investigate the barriers to breastfeeding in the workplace.

Breastfeeding assistance and resources must be reimbursed by the health insurance

Teddy Roorda, President of NVL and spokeswoman for the Breastfeeding Platform, outlined existing concerns about the accessibility of lactation care. The parliamentary spokespersons also thought it appropriate to provide this form of coun-

seling, especially for the sake of the child. Roorda expressed her astonishment that guidance on bottle feeding (such as pre-verbal speech therapy), by contrast to breastfeeding support, is reimbursed by the health insurance. Reimbursement should also be the case for support for breastfed infants. Therefore, the Breastfeeding Platform and the National Breastfeeding Council argue for the inclusion of lactation care and resources in the basic health insurance, with the child as a patient, so that low-income groups, in particular, have access to good coaching.

A first step

This petition is the first step in arranging for specialized mother-child care so that mothers who want to breastfeed are guided optimally. In the coming weeks and months, the Breastfeeding Platform and the National Breastfeeding Council will continue their efforts to draw the utmost attention to the points above. It is time to ensure a healthy start for all mothers and babies.

New Figures on the Health-Protective Effect of Breastfeeding

Zsuzsa Bauer, Ph.D.

In an analysis, Melissa C. Bartick, Eleanor Bimla Schwarz, Alison M. Stuebe and other colleagues in the USA have presented new figures on the health-protective effect of breastfeeding. Thereby, in a computer simulation, they have modelled two hypothetical cohorts. In one “optimal group”, 90% of women breastfed in accordance with the recommendations of the American Academy of Pediatrics (AAP; 6 months of exclusive breastfeeding and continued breastfeeding until at least 1 year). In the “sub-optimal group”, the women breastfed in accordance with the current US breastfeeding rates (Figure 1). In their computer simulation, the authors generated data for both the children and the mothers on the frequency and the cost of illnesses as well as premature deaths, which would have been preventable by optimal breastfeeding. They come to the conclusion that breastfeeding has a much greater significance in the prevention of illnesses and deaths than has been assumed up to now. Most striking about the results was that the majority of the excess deaths and costs (almost 80%) occurred among the mothers.

Overview of the Method

The authors used the so-called Monte Carlo method for the analysis: Here, parameters describing the population were estimated with the help of a computer simulation. The basis of the simulation was a hypothetical cohort of 1.994 million mothers aged 15 to 70 and their 3.75 million children up to the age of 20. These numbers are meant to represent the reality in the USA.

For the children, nine illnesses were considered, for which the severity and frequency can be reduced by optimal breastfeeding according to the latest scientific knowledge: leukemia, acute otitis media, Crohn’s disease, ulcerative colitis, gastrointestinal infections, lower respiratory tract infection requiring hospitalization, obesity, necrotizing enterocolitis as well as sudden infant death syndrome. By contrast to earlier studies, diabetes type 1, asthma and atopic dermatitis were not considered because current studies have not been able

to establish a strong connection between non-breastfeeding and these illnesses.

For the mothers, breast cancer, pre-menopausal ovarian cancer, type 2 diabetes mellitus, hypertension and myocardial infarction were considered.

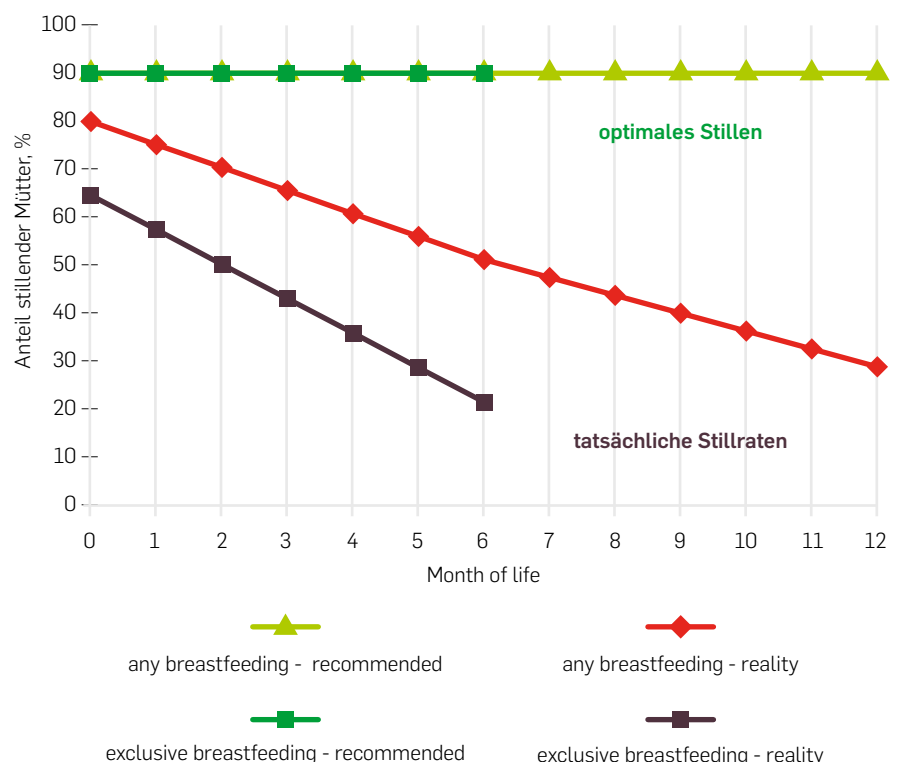
To determine the number of excess illnesses and deaths occurring due to suboptimal breastfeeding, the authors referred to studies on each of the illnesses considered, which identified the risks of the illness depending on breastfeeding/not breastfeeding. Bartick et al did not collect new data. Causality between suboptimal breastfeeding and excess illnesses/premature deaths was hypothetically assumed because no clear evidence can be produced due to the study methods of the original studies (all of them observational). For the determination of costs, the authors also used studies as well as health insurance data.

The most important results

The analysis showed significantly more incidences of illness due to suboptimal breastfeeding among the children than among the mothers (Table 1, left side) but, surprisingly, the mothers were affected much more frequently by premature deaths than the children were. The health care expenditures for the mothers were also significantly higher. In the hypothetical cohorts, there were 3,340 premature deaths due to suboptimal breastfeeding which, in 78% of the cases, affected the mothers. Infants died primarily from sudden infant death syndrome or necrotizing enterocolitis.

The medical costs of sub-optimal breastfeeding for the total cohort over their entire life spans were estimated at three billion (3,048,640.752) US\$. The total costs, considering in addition, the non-medical costs as well as the “societal” costs

Figure 1. In the analysis, optimal breastfeeding according to AAP recommendations and the actual US rates were compared.



of premature deaths, were estimated at 14 billion (14,216,498.022) US\$.

The authors also determined the so-called “number needed to treat” (NNT) (s. Table 1, right side). This is a statistical measure in medicine, which expresses how many patients must be treated so that one case (i.e. myocardial infarction or death) can be prevented. Rather than medical treatment, the figures in this study related to optimal breastfeeding. The authors determined that optimal breastfeeding compares favorably with routinely recommended public health interventions including aspirin for secondary prevention of cardiovascular events (NNT: 333 for secondary cardiovascular events).

Conclusions

The authors conclude that optimal breastfeeding represents a clear advantage for public health with respect to many illnesses. They urge that considerably more efforts be undertaken to effectively support mothers with breastfeeding: among other things, paid maternity leave, better access to adequate breastfeeding counselling and the implementation of hospital routines that promote breastfeeding.

The great achievement of Bartick et al is that they express the abstract results of many studies on the connection between breastfeeding and the risk of illnesses in concrete and better understandable effects – that is, as preventable cases of illness and death as well as costs. Furthermore, for the first time, they have included in one study both the pediatric and the maternal illnesses of a single hypothetical cohort.

The limitation of the analysis is that it is a theoretical model with many hypothetical assumptions, which may not necessarily be correct. So, for instance, causality was assumed (i.e. suboptimal breastfeeding causes (!) premature death from myocardial infarction) which might not be 100% the case. Probably myocardial infarction, hypertension, diabetes, etc. and suboptimal breastfeeding may, in part, be attributable to joint factors (i.e. insulin resistance or, for example, generally difficult living circumstances) and only, to a limited extent, mutually dependent. Nevertheless, the authors have made great efforts to achieve a realistic estimate and, where there is doubt, they worked with conservative numbers. Therefore, more likely they have under- rather than overestimated the health protective effect of optimal breastfeeding.

Table 1: Extract from the results: Cases averted per 100,000 women by optimal breastfeeding as well as the number of optimally breastfeeding women, to prevent a case (illness or death)

Erkrankungen	Cases averted by optimal breastfeeding per 100,000 women		Number of optimally breastfeeding women to prevent 1 case*	
	Disease	Premature deaths	Disease	Premature deaths
Child disease				
Leukemia	9	2	10,796	54,505
Acute otitis media	30,182	n/a	3	n/a
Crohn's disease	7	n/a	13,717	n/a
Ulcerative colitis	7	n/a	14,669	n/a
Gastrointestinal infections	128,316	n/a	0.8	n/a
lower respiratory tract infection requiring hospitalization	1,048	2	95	50,108
Necrotizing enterocolitis	68	10	20	141
Obesity	2,272	n/a	44	n/a
Sudden Infant Death Syndrome	n/a	25	n/a	4,056
Premature deaths Children	n/a	36	n/a	2,764
Maternal disease				
Breast cancer	252	42	397	2,379
Pre-menopausal ovarian cancer	1	0.4	92,713	237,079
Type 2 diabetes mellitus	618	24	162	4,218
Hypertension	1,805	16	55	6,192
Myocardial infarction	426	49	235	2,023
Premature deaths Mothers	n/a	131	n/a	761
Child and maternal total				
Total number of deaths	n/a	168	n/a	597

Extract from Bartick et al., 2016; n/a = not applicable

* These figures are equivalent to the figure widely used in medicine „Number needed to treat“ (NNT).



Dr. phil. Zsuzsa Bauer

Has been working in research and journalism on biomedicine as well as nursing science for many years. Her current focus is on publications in the field of breastfeeding support.



SOURCE:

Melissa C. Bartick, Eleanor Bimla Schwarz, Brittany D. Green, Briana J. Jegier, Arnold G. Reinhold, Tarah T. Colaizy, Debra L. Bogen, Andrew J. Schaefer, Alison M. Stuebe: **Suboptimal breastfeeding in the United States: Maternal and pediatric health outcomes and costs.** *Maternal & Child Nutrition* 2016;1-13.

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