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EDITORIAL

Dear members, dear collegues,

Feeding with a handicap is the subject of this issue. It is sometimes moving to see how mothers and fathers dealing with a handicap are raising a child. Even more when right after birth, that tiny little bundle is given to the mother and she likes to breastfeed, but needs some extra guidance instead of the well-meant but misplaced advice of her surroundings.

In my practice I supported a blind woman. She could not look if her baby had signs of hungriness, but she listened to him, to his sounds and rustling movements. And she touched him abundantly. She was very much attached to her baby. And once in her arms, she experienced the love of the natural suckling of her baby and a growing self confidence. I positively confirmed her ability to breastfeed.

We present you a well-documented article by Birgit Planitz about the physical impairments which affect the breastfeeding relationship. Additionally, Andrea Hemmelmayr writes about the stories of 8 woman with a handicap, who talk frankly about their experiences.

Dr. Gina Weissman gives us an update on a handicap of the baby: the posterior tongue tie, an often missed diagnosis. More subjects in this issue are about an abundant milksupply, which can be a problem for both mother and baby, and the management of cracked nipples.

Beside this theme-subjects, we provide you with information about the new EU Law GDPR and more information about our member-associations and last but not least, reports from ELACTA Board.

A lot to read, so turn this page quickly!
Kind regards,

Karin Tiktak
President ELACTA

IMPRINT

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With its articles, Lactation and Breastfeeding wants to go beyond expert information about breastfeeding and also stimulate discussion. Therefore, we welcome your views. Please send Letters to the Editor to the following email address:
magazin@elacta.eu

. The articles published in Lactation and Breastfeeding do not necessarily reflect the opinions of the editors or of ELACTA. Rather, they are the author's own personal views


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Breastfeeding by Women with Physical Impairments

Author: Birgit Planitz

Breastfeeding is just as individual for women with physical impairments as it is for all women. However, obstacles and barriers, which can hinder physically impaired women with breastfeeding, can be identified. These barriers are located in both the close environment of the affected women as well as in societal attitudes, in the lack of or inappropriate resources made available, but are also determined by lack of knowledge among, for example, the attending physicians. These barriers should be identified and the women should be guaranteed the best possible support to make a satisfactory breastfeeding relationship possible for the family.

In this article, an overview of the breastfeeding behavior of physically impaired women, based on a systematic literature analysis, will be given. The factors which influence breastfeeding in this context will be presented in detail. Approaches for how breastfeeding by the women affected can be supported, will be developed. As a prerequisite for this, an approach to the term "handicapped" is needed in order to understand the mechanism of exclusion and impediments to which women who are physically impaired in any way are exposed. "Handicapped" will be understood as a social construct from which a "succession of attributions, labelling and stigmatization, as well as system effects" result (Dederich 2009, 37), which lead to exclusion from societal and individually relevant areas of life. Inspired by the international classification of functionality, disability and health (ICF) it will be assumed here that obstacles arise in interaction with the environment. A woman with epilepsy, for instance, can be hindered with respect to breastfeeding, if she receives medication that is not compatible with breastfeeding; she is not hindered when medication compatible with breastfeeding is ordered. All in all, it can be seen that, internationally, few studies on the topic of breastfeeding by physically impaired women are available. Most of the studies on physically impaired women, in the context of breastfeeding, are related to the compatibility of medication and functional limitations of the women.

Figures from Great Britain suggest that, statistically, mothers who are considered to be handicapped, breastfeed less often and for shorter periods than women without impairments (Sumilo et al. 2012, Redshaw et al. 2013, s. Fig. 1). Comparable data on this from Germany is not available. In terms of numbers, in a study concluded in 2002, 9.4% of mothers were affected by impairments. Most of these women had limitations of the motor system (29.3%) followed by respiratory illnesses (14.7%) (Sumilo et al. 2012).

According to Redshaw et al (2013), physical impairments, including chronic illness, account for 49% of the limitations. Considered as problematic here, is a significantly higher rate of premature births among women with impairments (8.3% vs. 4.8%) and also low birth-weight babies (12.2% vs. 7.1%). The affected women also more frequently live under precarious financial conditions (18.8% vs. 9.5%) or have no (secondary) educational qualifications (20.4% vs 15.0%). At the age

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Bravo for putting all this together! In case of interest, more research and material on conflicts of interest and global health governance was discussed at a press conference organized by IBFAN-GIFA in May 2018 with the title Health Governance in the public interest? WHO redefines conflicts of interest and risks undermining public health mandates. Video of the conference:

www.youtube.com/watch?v=qjSu010SATo

Article on IBFAN-GIFA website:

www.gifa.org/press-conference-health-governance-in-the-public-interest-who-redefines-conflicts-of-interest-and-risks-undermining-public-health-mandates/

Alessia Bigi, IBFAN

Photo: © iStock.com/KathyDewar

„Baby" in sign language

of 7 years, the children of these mothers more often had a limiting health problem (12.0% vs. 6.2%) (Redshaw et al. 2013, p. 3). From the perspective of maternal and child health, this should be considered as a reason to particularly promote and support breastfeeding in this vulnerable group. This perspective is supported by the UN Convention on the Rights of Persons with Disabilities , which explicitly urges the achievement of equal opportunity for women in relation to family and health, such as, for example in Article 6 – Women with Impairments (UN Convention on the Rights of Persons with Disabilities, p. 1426-1427)

On the situation of mothers considered to be impaired and chronically ill

Chronically ill women often meet with skepticism when they express a wish to have a child. The women themselves seem to have a certain insight into this because they already have to deal with a great burden. But they also assume a lower acceptance by the society because they do not seem to fit the general image of a mother. The partner and the family see themselves confronted with having to take over more tasks in coping with everyday life. Women wish for concepts which factor in this necessary extra support because the sometimes time-consuming therapeutic and prophylactic measures connected with the illness in order to stabilize their health, already require a considerable investment of time (Lange et al. 2015, p. 164).

However, the need to receive support is not always realized (Hermes 2003, p. 284). Mothers, in particular, feel great pressure to perform, to make everything perfect and to prove that they are doing justice to the role of mother. Thereby, their own needs are deferred, which can lead to overload and isolation. From the outside, the impression can arise that the family effortlessly copes with daily life (Hermes 2003, 282f). This is fatal because those affected can end up in a spiral of overload.

It also seems detrimental for the affected mothers that the well-being and the health of the baby are the primary focus of the health care. In the time around becoming a mother, chronically ill women must master both the basic challenges of this phase in life as well as the special characteristics of their illness (Lange et al. 2015, p. 162). In this context, it is important that, during the postpartum period, the mothers can go back to the management of their own illness, which they can control as autonomously as possible (Lange et al. 2015, p. 167).

Because mothers considered to be handicapped find themselves, more often than other mothers do, in a delicate balancing act between the well-being of the baby and their own, it is important in counselling to keep a particularly close eye on the women. The counselling on health should not be limited to individual parameters, but should follow a holistic, psychosomatic approach.

The significance of breastfeeding for the mothers

How do the women themselves evaluate breastfeeding? In a study of women with fibromyalgia, they wanted to breastfeed, perceived success with this as a great enrichment and were frustrated by premature weaning (Schaefer 2004). For many women, breastfeeding was seen as a possibility for bonding with the baby. Breastfeeding was, in this connection, considered to be very helpful (Walsh-Gallagher et al. 2012, p. 158). Also, breastfeeding can positively influence the mother's health in connection with her (own) health problems, as has been often shown. This is particularly relevant for women with diabetes mellitus because the metabolism is rebalanced more quickly postpartum (Walker 2017, p. 664).

Frequently, women with physical impairments take great efforts into account in order to breastfeed. Certainly, women with spinal cord injuries, for example, characterize breastfeeding as "normal". With an injury above T4, however, the milk ejection reflex needs additional visual stimulation or oxytocin spray to occur. The ›

tactile stimulation is controlled by a nerve circuit between the T4 and T6 vertebrae. This route is impaired in paralyzed women. Nevertheless, they can achieve sustained breastfeeding with the additional measures (Dawood et al. 2014, p. 105).

Influencing breastfeeding through environmental factors

Assuming that the internal motivation to breastfeed is, on the whole, similar, the environmental factors, in the sense of barriers, as well as the helpful factors, should be examined. The bases for this are qualitative studies on the topical area of breastfeeding and postpartum among women considered to be disabled (see Figure 2).

Support, relations and counseling

Close relatives, in particular, are the greatest resource for supporting breastfeeding mothers. This happens both by taking over household tasks and also at the emotional level. Hereby, the support is utilized as long as it is actually needed, above all in the first weeks. Some mothers seem to enjoy the moment when they can "take over". The wish for self-determination possibly plays a role here (Prilleltensky 2003, p. 32). Babies adapt, in an age-appropriate way, to the specific features of the mother and actively support breastfeeding themselves (Ibid.) The mothers surveyed orient themselves to the insights of peers, who have had similar experiences, due to their own physical impairments, and they find this very positive (Kaiser et al., p. 131). The two groups, relatives and peers, were evaluated in all sources as resources in relation to daily life with the baby and specifically for breastfeeding. The devotion, correct professional advice and practical guidance by the nursing staff were perceived by the mothers as helpful (Prilleltensky 2003, p. 30, Schaefer 2004, p. 252). This runs contrary to some statements in which lack of professional knowledge by the nurses, but also by doctors, is lamented. This impacted the breastfeeding success very negatively, because breastfeeding was stopped due to giving medicine incompatible with it (Schaefer 2004, p. 250f). This is astonishing because, in international medical journals, the compatibility of medications with breastfeeding has be written about hundreds of times. The hindrance of "medications", can be adequately avoided by knowledgeable personnel.

Material resources, products and health care services

Not only personal support, but also material support can relieve the mother-baby pairs. Pillows play a great role in the positioning of the baby. They provide mother and baby support and, thereby, can enable breastfeeding independent of other persons ((Prilleltensky 2003, p. 30, Schaefer 2004, p. 250). Participation is facilitated when aids, such as baby carriers and baskets, are available because they make the support of a third person superfluous. Thus, helpful aids are mentioned as a frequently used resource (Kaiser et al. 2012, p. 129).

The mother's own home presents itself as a place in which mothers can find their way back to peace and their own power after discharge from the maternity hospital: A place of security and privacy (Prilleltensky 2003, p. 32). "Breastfeeding corners", whether in institutions or other places, can, from my perspective, also have a positive effect on breastfeeding, since this represents a place in which mother and baby can withdraw in peace.

The internet is also perceived by those affected as a resource and pool for information. (Kaiser et al. 2012, p. 131).

Breastfeeding duration	Disabled Women	Women without Disabilities	p-value
Sumilo et al. 2012 (Sumilo et al. 2012, p. 4–5) "Limiting longstanding illness"	Yes (n=1.705)	No (n=16.527)	p<0.001
Never breastfed	33.5 %	30.1 %	
< 1 week	12.2 %	10.5 %	
1 week – 3 months	28.7 %	26.1 %	
> 3 months	25.6 %	33.4 %	
Redshaw et al (2013) (Redshaw et al. 2013, S. 5) ‚disabled women'	Yes (n=1.482)	No (n=22.673)	p<0.001
Ever breastfed	77.3 %	84.4 %	
Full or partially breastfed in the first days of life	70.1 %	79.4 %	

Figure. 1: Comparison of breastfeeding duration (author's own representation)

In mentioning hospitals as an environmental influencing factor for the women, a contradiction was apparent: Those affected expect and hope that they will get information about breastfeeding in the hospital. However, it is exactly these expectations and hopes which, in reality, frequently seem not to be fulfilled. This seems to strongly depend on the knowledge of some of those active in treating patients (Kaiser et al. 2012, p. 1319). From this, it can be deduced that a linkage of the service providers around the birth, who can guarantee the provision of this care, would be appropriate. Breastfeeding counselling should then also be incorporated into the these networks

Conclusion

From the knowledge derived, it can be concluded that, in counseling and supporting affected families, background knowledge about the needs of the women, but also about medical and nursing matters is necessary. Effective methods to promote breastfeeding seem to be counseling by physicians, nurses and midwives. Furthermore, counselling by trained peers can be emphasized. (Balogun et al. 2016, p. 3). In structuring counseling offerings, it is important to include those affected at an early stage.

It would be desirable to have offerings close to the world in which the women live that have available a wide-range of possibilities in order that tailor-made and individual counselling and help offerings can be made. The basis for this must be the will of the public and financing by the relevant funding agency. Trans-sectoral and interdisciplinary cooperation between the individual actors in the support system would also be advantageous for the families. One must not tire of pointing out that great importance should be attached to the content-related education of health care staff, such as midwives, nurses and physicians. The content of continuing education should also include sensitization about processes which exclude people. In the planning of interventions, holistic care for the family should be the focus of the approach. This with all the needs during the time around the birth, postpartum and breastfeeding time in general, but also those that arise in special situations due to individual needs resulting from disabilities ›

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Author Country Year	Title	Study design	Representative specifics of the test subjects in the sample
Prilleltensky Canada 2003	A Ramp to Motherhood	26 individual interviews, 4 group interviews, qualitative content analyses with inductive creation of categories.	Impairment of mobility/limbs, wheelchair users (n=35). In-depth interviews: 8 mothers, 5 childless women
Thomas Great Britain 2003	Pregnancy, illness, concept of career	Explorative qualitative evaluation of in-depth interviews	Mothers with chron. illnesses or pregnancy-related illnesses n=15
Schaefer USA 2004	BF in chronical illness ... fibromyalgia	Phenomenological Study in accordance with van Manen, In-depth interviews	Breastfeeding women (with a desire to breastfeed) with fibromyalgia (n=9)
Kaiser et al. Canada 2012	Experiences of Parents with Spinal Cord Injury	Qualitative scalable content analysis of structured interviews, inductive creation of categories	Parents with spinal cord injury before the birth of the baby (n=12) 6 mothers/fathers each
Walsh-Gallagher et al. Ireland 2012	The ambiguity of disabled women´s experiences of ... mother-hood	Phenomenological longitudinal-study	Chronic illnesses, physical and sensory impairments, mild cognitive impairment
Meade et al. Australia 2013	Navigating Motherhood Choices ... Rheumatoid Arthritis	Qualitative evaluation of written reports on those affected , deductive-inductive category creation	Women with rheumatic arthritis (n-14), 8 mothers, 2 pregnant women, 2 pregnant mothers, 2 childless women

Figure 2: Overview of the studies evaluated (author's own representation)

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Despite a Handicap – Being a Member of the Senate Now Even with Baby Maile: Tammy Duckworth, Ph.D.

Tammy Duckworth, Ph.D. – Helicopter pilot, double-amputee, Veteran's advocate, agent for change, US Senator, and breastfeeding mom


Photoquelle: news.vice.com

US Senator Tammy Duckworth is no stranger to the challenges posed by physical impairment. In 2004, she was co-piloting a Black Hawk helicopter in Iraq when a rocket-propelled grenade hit it and changed her life forever. She lost both of her legs and suffered serious damage to her right arm. She spent more than a year in the hospital – recovering, being fitted with prostheses and learning to live with the "new normal".[1]

It has been every bit as busy as her old normal. She has filled a number of official roles, including positions in Veterans' Affairs in her home state and at federal level; she earned a doctorate, served two terms as a member of the US House of Representatives; she and her husband started a family; Currently, she is the junior US Senator from Illinois.[2]

It was in this role that she advocated during her 2nd pregnancy for sweeping changes in the Senate rules about the presence of children – and got these changes approved *unanimously* right after the birth of her second daughter in April 2018 – just in time to come in with her 10-day old baby for a crucial Senate vote.[3] The new rules allow male and female senators to bring infants up to age one into the chamber. Mothers may breastfeed in the chamber.[3] Commenting on the vote, Senator Duckworth said: "By ensuring that no Senator will be prevented from performing their constitutional responsibilities simply because they have a young child, the Senate is leading by example and sending the important message that working parents everywhere deserve family-friendly workplace policies."[5]

By working together, the Senate moved into the 21st Century, delivering a major victory for maternal and child health, for family welfare and for women's empowerment. Two months later, just in time for World Breastfeeding Week, breastfeeding in public was legalized in Utah and Idaho, finally making it legal in all 50 US states.[6] The Department of Labor has regulations for breaks for pumping or (more rarely) breastfeeding during working hours.[7,8] Not yet addressed comprehensively are the International Labor Organization's (ILO) recommendations for paid maternity leave both during pregnancy and postpartum. We look forward to continued progress in making paid employment compatible with parenthood.

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› [8] www.dol.gov/whd/regs/compliance/whdfs73.pdf

Breastfeeding with a Disability – It works!

Compiled by Andrea Hemmelmayr, IBCLC


Photo: © Elisabeth Simmlinger

Perhaps you are an experienced breastfeeding counselor, midwife, nurse, physician…and there is scarcely a breastfeeding problem that you believe you can't handle. And then – suddenly – a new family confronts you with a life situation which you can scarcely imagine. How do you react to parents with a disability and, in particular, what do new mothers with limitations experience when they have children and want to breastfeed them? Seven mothers and a pregnant woman with a physical disability told us about their experiences, which we will quote in the following.

The UN Convention on the Rights of Persons with Disabilities protects the right of disabled people to make a free and responsible decision about whether, when and how many children they want to have. Nevertheless, affected women struggle with prejudices, even if they have lived with their limitations for years or since birth, can lead an active, self-confident life and are able to evaluate themselves and their own bodies very well.

Elisabeth: Naturally, it takes a lot of courage and self-confidence to undertake the task of raising a child. In particular, it takes an appropriately empathetic gynecologist who tackles this business very pragmatically. What argues against it, what for it, what barriers could there be? Furthermore, we did not broadcast our desire for a child and the pregnancy. Even our own family was presented with a *fait accompli*.

Yvonne: The reaction to my wish for a child was very mixed. Many were certain that I would not be able to manage it. But I had the good fortune that my doctor supported and strengthened me a lot when I wanted to stick my head in the sand due to the negative voices.

Jennifer: Some relatives shared our joy, others reacted with incomprehension: How can someone expect a child to put up with a sick mother – I was frequently characterized as selfish

Barbara: Actually, everyone was very relaxed about it because they knew that my husband would simply compensate for everything that I can't do and that's also what happened/is happening.

The following quote tells us that the medical professionals can also reach their limits:

Ann-Katrin: I wrote to university hospitals all over Germany to question whether they could check me out, whether they were familiar with the Cantrell syndrome and if they could follow me during a pregnancy. Only the University Hospital in Heidelberg had already – in theory- dealt with the Cantrell syndrome. Living cases were unknown. Because no cases, who are older than I am, were known to the doctors, let alone that a woman with Cantrell syndrome had ever been pregnant, no-one wanted to commit themselves in their statements.

The eight women who have answered us here approached their pregnancies very consciously. They considered the degree to which their limitations could have effects on their child:

Sani: With a disability that was more pronounced than my own, I would have considered an abortion. In my case I would have accepted it (The baby is healthy!)

Nina: Naturally I worried about whether my little one would be healthy, since I took a lot of strong pain killers until the 8th week of pregnancy. However this concern was unfounded and the little man is a healthy, lively boy.

Yvonne: I had doubts about myself, whether I would really manage everything, but my doctor always said if you don't try it, you will never know how it would have been.

Barbara: Beforehand, I had a great many concerns and questions. For instance, it was completely unclear to me what I would do if I were alone at home with the baby, how I could transport the baby from A to B (i.e. from the bed to the living room).

Breastfeeding seemed to be very important to the six mothers – perhaps as a confirmation that their bodies could not only carry a baby. Moreover, their milk can further support the baby in his development and health.

Sani: Breastfeeding means a lot for me. It fills me with pride to see my baby growing from my milk. I love the intimate moments as a twosome and the peaceful, relaxed expression of the baby is magically beautiful

Nina: The closeness and the intimacy, the relaxed atmosphere, which we achieve through this, is vital for me and was even more beautiful than I expected.

Ann-Kathrin: Actually anything other than breastfeeding was out of the question. The wish to completely feed my child from my body alone and to carry on with the intensive closeness after the birth was great. Unfortunately, after my child had to be transferred to the intensive care unit following a respiratory arrest, pumping my milk was particularly important because it was the only thing that gave me the feeling of being able to do something for my child. I am still convinced that our child came out of the situation so well, only because he had received mother's milk from the start.

Sara: For me, the prospect of breastfeeding means normality and naturalness.

Jennifer: Breastfeeding gave me back my trust in my body and in myself. Naturally, my child brings stress into my life again and again, which is sometimes difficult to combine with the illness. In these situations, breastfeeding helps us to find a way back to each other. Breastfeeding is compatible with my life. For me, it is almost always the simplest and most beautiful way to organize my life with the baby.

Barbara: Breastfeeding became more and more important for me because I ›

Our Daily Heroines:

Sani
From birth, a missing link in her right arm, a shorter right arm and a smaller right hand – secondary scoliosis.

Nina
In 2008, an accident in the German Federal Army, fracture of the thoracic vertebrae, disc injury, stabilized with fixators, bone fragments can still be found in the spinal canal.

Elisabeth
from birth, no arms

Ann-Katrin
from birth „Cantrell syndrome"– she is the oldest living woman and the only mother who is living with this syndrome. (The heart is displaced to the middle and is skewed; there is an atrium-septum defect and the pericardium is missing; the lower part of the sternum is missing, therefore the heart can be seen beating from the outside; it is completely unprotected. The right lung was not fully developed, also on the right side a diaphragmatic hernia, which was surgically sealed with the liver).

Sara
from birth, missing fingers, no ankle joint and no cruciate ligaments, over about 10 years, 4 slipped discs (left food is numb) – still pregnant.

Yvonne
from her 4th year of life, after meningitis, hearing impairment, bordering on deafness.

Jennifer
from 2012, psoriasis-arthritis, fibromyalgia, loss of function of various extremities, dizziness, severe exhaustion, visual impairment, muscle pains

Barbara
paraplegic since 2001 after an auto accident, height at lumbar spine 1

had the feeling that I can do this particularly well and other things not so well (for example sitting on the floor with the baby doesn't work at all). At the beginning, I had unbelievable pain breastfeeding both children and many, many breast infections with high fevers and all the horror that one can imagine. Nevertheless, I continued to breastfeed because there was simply no alternative for me. Get up in the night as a paraplegic and make a bottle??? No thanks! With the older breastfed babies it is like a secret, which we share with someone. Only my child and I know how lovely the breastfeeding is for both of us. I love breastfeeding and I will miss it when my son doesn't want to have it anymore.

Life with a baby provides special challenges for mothers with disabilities, which they must confront with a lot of fantasy and resilience.

Sani: Since I have only one fully functional arm, I must often figure out how, despite this, I can carry my baby and also accomplish something. The greatest challenge is the first three months because the baby's head has to be supported a lot. I can only lie on my right side. So I worry about whether the one-sided breastfeeding could cause a misalignment or negatively influence my little sweetheart`s head.

Nina: I clench my teeth, despite inadequately treated pain, and carry my son just like every other mama.

Elisabeth: My husband is self-employed, we had planned ahead of time so he could be at home as much as possible in the early days. Diapering was done on the floor and we laid our little one on a blanket. If necessary, she was also transported by me through the flat with my toes. It would have been too great an intrusion in our private life to have an outside person around us, particularly since it is not always easy to assert oneself against patronizing from outside.

Yvonne: Since my first daughter was born, my life has changed very significantly. I have learned to use other senses, about which I knew nothing until then. I became more organized and self-confident.

Barbara: I hired assistants ahead of time who could assist me in the latter part of the pregnancy and afterwards with the baby. That helped me a lot and the financing is – fortunately – possible from the state in the Styria . Also, other things, which are completely normal for non-disabled mothers, were more difficult, i.e. that I need more time on the toilet and cannot simply jump up or hold the baby in my arm when urinating. So, there had to be a solution where I could put the baby safely while I disappeared for 5 minutes. At the beginning we had a cradle and then a playpen. As soon as they could get up from the floor, both children simply came with me to the toilet...

Breastfeeding itself poses special challenges for the mothers, which, perhaps, with good support (i.e. effective, but breastfeeding-friendly, pain medication) and information (i.e. breastfeeding positions which better conform to the mother's needs), might not have been quite so dramatic.

Nina: Unfortunately, from my son's 10th week of life, the pain returned worse than ever before. The orthopedist and my pain therapist have, meanwhile, accepted my wish to breastfeed, however they have little understanding of it. What they tell me is that, during the breastfeeding period, they cannot give me anything stronger than ibuprofen. Because I must manage my daily life with my baby in severe pain, where coughing, laughing or even lifting up a bottle of water is an ordeal.

Ann-Katrin: Meanwhile, I am noticing my spinal column, which has been crooked since my birth. Leaning forward while breastfeeding leaves traces. A week ago, I received a prescription for a supportive corset. I am still not as capable as before. I notice that my body needs energy in order to care for our child. I think that for, healthy mothers, breastfeeding, when it has been established functions routinely or alongside everything else.

Yvonne: In the beginning, I had to been waked up, from time to time, when my little one wanted to feed in the night. Despite all the warnings from nurses and pediatricians, we practiced the family bed and, in time, I woke up to breastfeed as soon as the baby moved even briefly.

The insufficient support that the mothers with disabilities report to us is really shocking:

Sani: While the nurses gave me super support and motivated me, unfortunately, the midwife never even looked at the breastfeeding and only said if it didn't work to give the baby a bottle. The health insurance also gave me no support in the initial period. Their message was, if I had something acute, i.e. if I had broken my arm, then I would get someone for the whole time. Since I have already always lived with it, there is no household help.

Nina: The doctors would have preferred that I raise him on the bottle, which, of course, without question, makes a child grow. Now the only hope left is that my muscles will get used to it and the pain will go away or at least will let up enough that I can lie in my bed at night without pain.

Ann-Kathrin: I was repeatedly hampered by the doctors in my wish to breastfeed. Many thought that I would put too much strain on my body. The general opinion was that the pregnancy was sufficiently exhausting for me so that perhaps my breast could not produce milk properly due to the stress.

The surprise was great as I was able to produce enough milk. I experienced the support in the hospital as inadequate. I think that the lack of time accounts for that. A midwifery student, whom I asked for help with putting the baby to breast, was admonished that she really didn't have time for this. Furthermore, I think that the nurses were of the opinion that breastfeeding had no future with me.

Yvonne: At the beginning of my first breastfeeding relationship, many obstacles were placed in my way. Although I had delivered in a baby-friendly hospital, one nurse gave me the advice that it would be better for me to give the baby a bottle because I could not hear my child. Moreover, bottle-fed babies are full longer with the bottle and my boyfriend could better support me with the bottle. But I stuck with breastfeeding, more of less, was given nipple shields and milk pumps and 6 different messages about breastfeeding. They didn't make the effort to show me and explain

how to put the baby to breast correctly. In the end, there were bleeding nipples, many tears and a baby who lost too much weight. My midwife ultimately intervened so that I was discharged home in order to get a handle on breastfeeding. I would wish for more tolerance. A disability is no reasons to deny the baby the best. I wish for much more support for kindred spirits.

Jennifer: I often experienced the counseling by the medical personnel as very one-sided. Breastfeeding seems frowned upon, the baby doesn't need it anymore after two or three months. When I had symptoms of illness, breastfeeding was always just dismissed as something unnecessary – despite my request to check with Embryotox. I would have wished for more flexibility in relation to my situation and problems. No run of the mill solutions whose conclusion was almost always weaning.

Barbara: In the LKH (hospital) in Graz, the personnel are very breastfeeding-friendly and really ALL of them made a great effort and were nice and also helped me very much with the second baby. However, with my older daughter, I could have wished that trained physicians had addressed my health problems better, so I could have continued breastfeeding then. At the time, I was confronted with suspicion about why I was still breastfeeding my toddler, etc.

Some messages in conclusion:

Sani: Please don't make comparisons with other people, who, for instance, are limited for a short time due to an injury. Somewhat more interest from the medical personnel: The impairment is not to blame for everything and a lot can be easily solved. Every expectant mama should explore the topic of breastfeeding intensively and call in real professionals.

Elisabeth: There should be self-help groups for parents with disabilities.

Barbara: My disability does complicate being a Mama in many things (i.e. when my child wants to go on the slide – that can't simply happen with my help, but only with the assistants). But exactly those things that I can do well, i.e. breastfeeding, I've done for extra long in order to make up for one thing or another. It is also important for me that my children do know that they can come to me at any time, but they must live with third-party care and the fact that they have a working Mommy. My work is also very important for me and I could not imagine a life as a full-time Mommy.

Sara: My grandma always used to say *"Child, there is a way for you to manage this. It will be different than that of healthy children: You must first find your personal way and you will see that you will be magnificent"* ♥

Andrea Hemmelmayr
lactation consultant, IBCLC

Cracked Nipples: Prevention and Management

Sore and damaged nipples are one of the more common complaints of the new mother and, due to pain, one of the most frequent reasons for early weaning. A proper breastfeeding technique is the best prevention and the key treatment, along with competent counselling.

Nipple trauma and pain have been associated with decreased breastfeeding duration, introduction of artificial infant milks and increased levels of maternal stress and other complications related to the cessation of breastfeeding. If not properly supported, women with sore or cracked nipples are prompted to wean their babies, as the pain can be unbearable. This condition may also affect the mother child-relationship, decreasing breastfeeding self-efficacy[1], though it will resolve once the pain disappears. It is also known that nipple pain can also have an inhibitory effect on the release of oxytocin and can interfere with the let-down reflex.[2]

Factors associated with cracked nipples in the first month postpartum

For many women, nipple pain appears to have the greatest intensity between the third and seventh day postpartum[3], with a peak in severity on the third day postpartum. It resolves without interventions in a few weeks.

Several factors have been identified as determinants of nipple trauma in breastfeeding mothers. Ineffective positioning and latching are two common causes of sore nipples and should always be assessed first.[4] Women using a poor breastfeeding technique showed a three-fold higher chance of presenting with cracked nipples in the first month postpartum.[5,6]

Other factors associated with cracked nipples are breast engorgement and the use of a bottle. Breast engorgement hinders proper latch-on, due to swelling, and flat nipples. Nipple trauma can cause or worsen breast engorgement, as the pain during breastfeeding experienced by the mothers may reduce the frequency and duration of feeds.

A short or tight lingual frenulum (tongue-tie) may restrict infant tongue movement and may lead to a cracked nipple. Conservative management may be possible for breastfeeding with a tongue-tie, depending on the degree of tongue movement and pain, through offering assessment and support to facilitate optimal positioning. If the mother feels unable to continue breastfeeding due to persistent pain, and/or if the baby is at risk of insufficient breast milk intake and poor weight gain related to breast refusal or difficulty latching, a frenotomy, or surgical "clipping" or "snipping" to release the frenulum, may be considered to relieve the pain, and facilitate effective latching and breastfeeding.[7] A vasospasm/Raynaud's Phenomenon causes intense pain, stinging, tingling, burning or numbness persisting after breastfeeding and this could also be a cause of early weaning.

The use of a bottle, in turn, may be associated with damaged nipples. The bottle-fed child positions his tongue to control the milk flow; using the same movements on the breast may result in nipple trauma.[8] Here again, it is possible that the pain related to nipple trauma has led the mothers to offer the bottle to their children.

It has been reported in some studies that caesarean section and delivery at a hospital not accredited by the Baby-Friendly Hospital Initiative increase the risks of cracked nipples. The pain secondary to surgery may affect the breastfeeding dyad due to shallow latch-on and poor positioning. Nevertheless, it has been demonstrated that women who undergo caesarean section show better breastfeeding performance when they are supported in breastfeeding and receive pain relievers. The use of some anaesthetics during labour or caesarean delivery may also interfere with the child's ability to suck in some cases. Only a minor incidence of cracked nipples is reported in Baby Friendly Hospitals: the routines in these maternities are designed to prevent nipple trauma. These include guidance on proper breastfeeding technique, manual expression in case of breast engorgement and recommendations to avoid the use of a pacifier/bottle until breastfeeding has been established.[5]

Incorrect or excessive use of breast pumps, e.g., not centring the pump flange over her nipple or using a high suction setting on engorged breasts represent other causes of damaged nipples.

Observation and assessment: stages of nipple trauma

Even though cracked nipples are a well-known condition and, despite advances in professional knowledge and information to the mothers about breastfeeding in recent years, nipple trauma still causes a high incidence, especially in the first 30 days postpartum. The percentage of women who stopped breastfeeding due to nipple trauma differs in different studies but is significant (30-35%).[5]

The scientific community has not adopted a shared consensus about definitions of nipple trauma and data collection methods

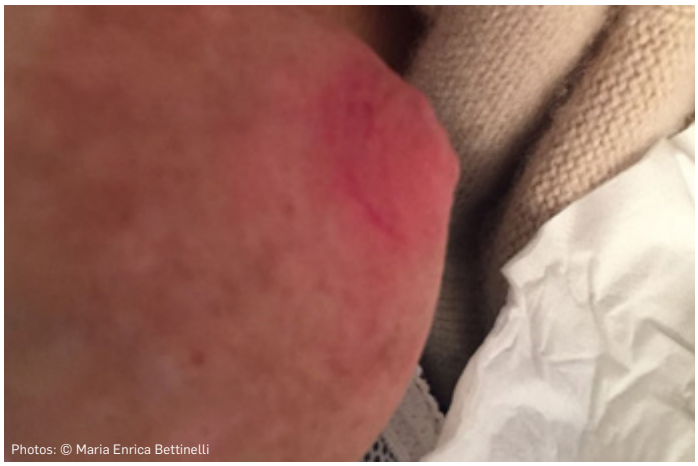

Fig. 1: Stage I

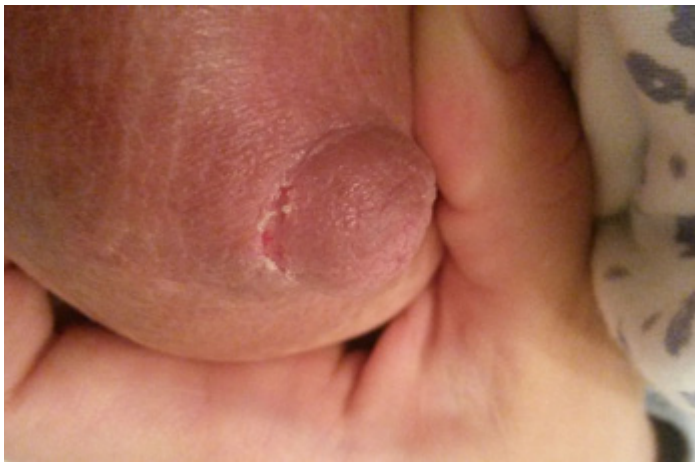

Fig. 2: Stage II

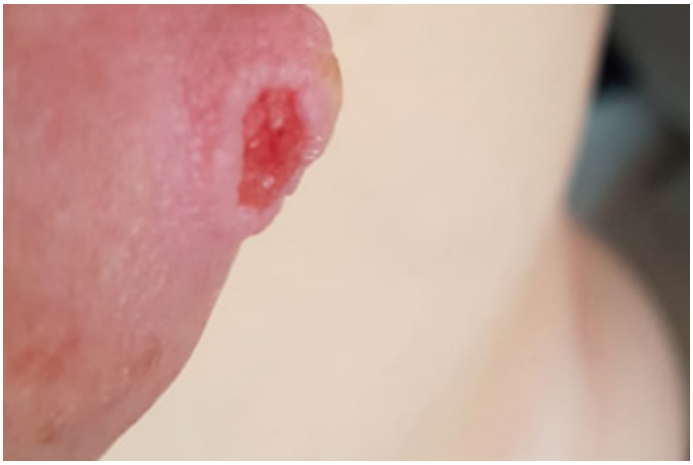

Fig. 3: Stage III

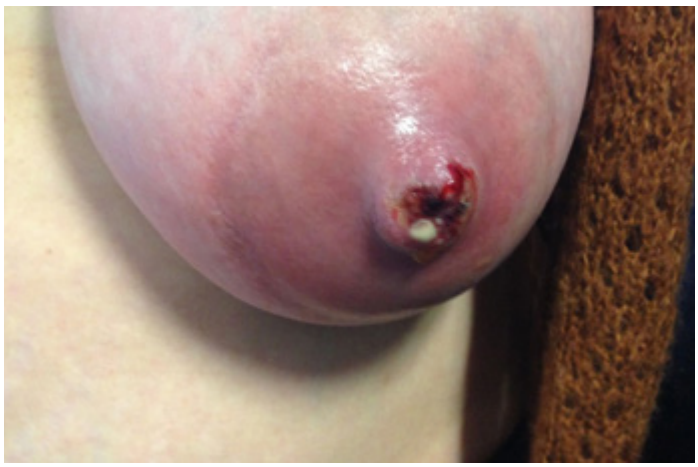

Fig. 4: Stage IV

and this can explain, at least in part, differences in the incidence of nipple pain/trauma in the literature. Mohrbacher has developed a four-stage system for rating nipple trauma to standardize the reporting and management of nipple trauma.[9]

- **Stage I (Fig.1) Superficial intact**
  Pain or irritation with no skin breakdown.
  May include: Redness, bruising, red spots, swelling.
- **Stage II (Fig.2) Superficial with tissue breakdown**
  Pain with superficial breakdown (epidermis).
  May include: Abrasion, shallow crack or fissure, compression stripe, hematoma, and shallow ulceration.
- **Stage III (Fig.3) Partial thickness erosion**
  Skin breakdown with destruction of epidermis to lower layers of dermis.
  May include: Deep fissure, blister, and deep ulceration with more advanced ulceration.
- **Stage IV (Fig.4) Full thickness erosion**
  Deeper damage through the dermis.
  May include: Full erosion of some parts of the dermis.

Unfortunately, healing damaged nipples in breastfeeding women is complicated due to repeated trauma from the infant's sucking and exposure to maternal skin and infant oral flora, predisposing the nipple to bacteria and fungal infection as staphylococcus aureus and Candida, most commonly Candida albicans (fig.1).[10] ›

Swallowed blood from cracked nipples will not harm the baby, but the cause of the cracked nipples needs to be investigated. If the lactation consultant handles breast tissue that is not intact, such as cracked or bleeding nipples, gloves should be worn. Hands should be cleaned before donning gloves and after removing the gloves.

Management of cracked nipples

The best management of nipple trauma is prevention, maternal education focused on proper latch and positioning and anticipatory guidance to promote effective positioning and latching to address the underlying causes of nipple pain, such as friction and compression. It is neither recommended nor necessary to discontinue breastfeeding to promote healing of a cracked or bleeding nipple unless the pain is intolerable, or the trauma is worsening.[11] Any temporary discontinuation must be accompanied by ongoing assessment and plans for re-establishment of feeding at the mother's breast. It is important that the mother continue to remove breast milk by expression. If the infant is unable to feed at the mother's breast, breast milk may be fed by spoon, cup, or dropper. Rapid healing usually occurs once the problem is corrected.

Many different interventions to heal damaged nipples in breastfeeding women have been evaluated. The main purpose of these interventions is to treat the underlying cause of the pain (e.g. tissue trauma or infection) and promote wound healing. To date, systematic reviews of evidence have yet to determine definitive management of sore nipples, due to few studies of good quality.[12].

Topical treatments

Most cases of persistent nipple pain with minimal trauma can be resolved by changing the positioning and latch of the infant to the breast, whereas women with visible nipple trauma may benefit from being treated with antibacterial or antifungal medication. In case of Stage I and II, low-strength antibiotics may be applied to a

cracked nipple, to prevent mastitis. The evidence does not support the use of antibiotic ointments without signs of break on the skin. Local application to the nipples is unlikely to be a risk to the infant as little is transferred to breast milk from topical application.[13] Low-strength topical steroids may be used for inflammation, hydrogels, either glycerine-based or water-based may be used in Stage I, II and III.

An "all-purpose nipple ointment" (APNO)[14] contains an antibacterial cream (mupirocin 2% ointment - 15 g), an antifungal cream (miconazole powder to give a 2% concentration), and a hydrocortisone cream (betamethasone 0.1% ointment - 15 g). The ointment is commonly recommended but not yet researched.[9],[15] Dermatologists rarely use a cream with multiple active ingredients because it is difficult to determine the source of a negative reaction.

Non-pharmacological topical treatments

A moisture barrier covers the wound to promote healing by preventing evaporation and drying. Cracks or fissures in the nipple result from insufficient moisture in the stratum of the dermis, together with friction. The moisture barrier may be an emollient, occlusive or semi-occlusive dressing.[16],[17]

Nipple Creams, Gels, and Ointments (Emollients)

Some products may be used to promote moist healing by providing a moisture barrier to cover the mother's nipple and areola, preventing evaporation and drying. However, there is little scientific evidence to support use of these products over prevention to relieve sore nipples, [3] to establish standardized dosages and applications or determine the efficacy and possible side effects for both the mother and baby. Lanolin is a single-ingredient ointment free of alcohols, detergent and pesticide residues, colour, and odour-forming impurities. It is thought to provide a bacteriostatic, semi-occlusive barrier to the skin that allows for moisture retention and enhances healing. Specific allergies (e.g. wool) would preclude the use of lanolin ointment for some women. Peppermint is thought to help skin heal and have antibacterial and anti-inflammatory properties.[18]

Dressings

Saline compresses applied to the nipple and areola are recommended by some practitioners. Some mothers may prefer to soak their breasts in a warm normal saline solution. **Warm water compresses to prevent sore nipples** were recommended in an earlier systematic review.[19] In both treatments, the area is to be allowed to dry before putting on a bra. **Glycerine-based gel dressings** are absorbent, non-adhesive pads that can be lifted from the skin without disintegrating or causing pain or trauma to new, sensitive skin. There is no evidence that glycerine gel dressings significantly improve damaged nipples.

Nipple protection devices

Breast shells are hollow plastic discs with multiple openings for air circulation worn inside the bra over the nipple and areola. They are thought to reduce pain by protecting the nipple from contact and stimulation.

Nipple Shields

Although not the first strategy recommended to manage sore nipples, short-term use of the newer ultra-thin silicone shields has been positively associated with preserving the breastfeeding relationship while mother and baby learn to breastfeed.[20] Nipple shields may provide temporary relief for a mother who is stressed or overwhelmed and prevent the introduction of a bottle. A makeshift shield of a nursing-bottle nipple should never be used. They should only be initiated by a health care provider who has the breastfeeding expertise to thoroughly assess the potential effectiveness and risks of use for that breastfeeding dyad. The baby's weight gain and the mother's breast milk supply need to be monitored closely.

To apply a nipple shield, it is important to use the correct fit and size and follow the manufacturer's instructions related to care and cleaning.

When babies are exposed to artificial nipples or fingers early they can become accustomed (imprinting) to the feeling of that object (bottle nipple, pacifier, finger) in their mouths and have difficulty accepting another object, such as a mother's nipple, in its place.[21] Silver nipple caps are used, but their efficacy is not really proved at the moment. They are also very expensive and not affordable for all moms. Also, if the mother does not clean them correctly, they are a source of infection.

LED phototherapy

LED phototherapy is thought to increase blood supply and cell proliferation and to assist with wound healing.

Expressed breast milk (EBM)

EBM is used to treat painful nipples due to its anti-infective and antiviral properties. Sometimes recommended for Stage I nipple trauma as an alternative to nipple creams or ointments, it is readily available, free and has antibacterial and bacteriostatic properties, but is not appropriate if there is broken skin, as EBM dries quickly and does not provide moist wound healing.[9]

Conclusions

Breastfeeding is a learned skill for mothers. It can take a little time to get used to the strong suckling of a healthy baby. In the early weeks, many mothers experience some nipple pain after the latch-on, that usually revolves within a few days. Allowing the child to self-attach **as often as possible,** while mother and baby both learn, decreases the risk of getting damaged nipples. The most common reason for sore and cracked nipples is a poor breastfeeding technique. Removing the cause and facilitating healing is the appropriate treatment for sore and cracked nipples. The mothers' education about correct latch-on and positioning and adequate support by health professionals and lactation experts at the first latch-on can prevent this condition: trained health workers and lactation consultant can help mothers to improve the breastfeeding technique and initiate successful breastfeeding. ›

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Too Much of a Good Thing?

What can you do when the amount of milk is greater than the demand?

Source: Andrea Hemmelmayr

Normally with breastfeeding, the amount of milk adjusts to the demand of the infant within a very short time. However, depending on the individual situation of the mother and baby, there may also be an over- or undersupply of milk.

After the start of abundant milk production (when the milk "comes-in"), milk production is regulated primarily by effective emptying of the breast. The baby's sucking stimulates the release of the maternal breastfeeding hormones via the nerve pathways:

- **Prolactin,** responsible for the milk production and
- **Oxytocin,** responsible for the milk ejection reflex

If one or both breasts are not completely emptied and, as a consequence, the milk collects in the mammary ducts and in milk blisters ("blebs") in the breast, then a biochemical feedback effect, which inhibits the milk production, occurs.

The milk stored in the breast is low in fat and rich in milk sugar (lactose). With the onset of the milk ejection reflexes (there are, as a rule, several during each breastfeed) more and more fat will be dispensed. If the baby feeds only until the onset of the first milk ejection reflex, he gets a relatively low-fat, but lactose-rich milk. If he feeds for longer, the milk will become increasingly richer in fat.

Possible symptoms of an overabundant milk production.

If the following symptoms apply to you, then discuss this, by all means, with an IBCLC lactation consultant. If incorrect measures are undertaken, the problems can be exacerbated or other problems may arise.

Mostly full, swollen and painful breasts:

- Due to this swelling, your baby may possibly have problems getting sufficient breast tissue into his mouth.
- You frequently suffer from engorgement and breast infections.

An excessively strong milk ejection reflex is frequently combined with overproduction:

- Your baby becomes restless when the milk ejection reflex occurs; he cries, pushes himself away from the breast, lets go of the breast or chokes, coughs, gags, burps and/or seems unable to swallow the milk. Breastfeeding often becomes a battle.
- Your baby begins to squeeze the mammilla (nipple) together to stop the flow of the milk. White, misshapen mammillae after breastfeeding are the consequence.
- Eventually the mammillae will become sore because of this.

Symptoms in the baby

- The breastfeeds may only last a few minutes.
- Possibly, a lot of air is swallowed and your baby must burp frequently and/or suffers from gas
- After the feedings, relatively large amounts of milk are spit up.
- Due to the large amounts of milk and calories, your baby gains extremely well or, as a result of the existing breastfeeding problems and the more limited fat content, he gains less than expected.
- Also, due to the relatively lactose-rich milk, it can happen that he has green, watery-frothy and explosive bowel movements.

Possible solutions to too much milk and/or too strong a milk ejection reflex

As described before, the level of fullness of the breast is an important factor in the regulation of the amount of milk. A certain degree of pressure and swelling of the breast is necessary to limit the increased milk production and, at the same time, it is important to prevent massive engorgement or breast infections.

- Allow yourself a little **rest**!
- **Only one breast should be offered per feeding;** the other breast only at the next feeding.
- The milk production can be reduced even more effectively with so-called **"block-breastfeeding"**. Here, the same breast should be offered within an individually chosen period of time. Thus the baby can be breastfed on demand, but he will be offered the same breast for 2, 3, 4, 5 or even 6 hours (Caution: increase the time frame slowly!) Meanwhile, the second breast can be cooled (see below). Only if there is a painful engorgement should a small amount of the excess be emptied by hand or with a pump. Thereby, the baby will, in any case, receive milk that is somewhat fat-enriched.
- In order to avoid a vicious circle of engorgement and the baby's restless behavior at the breast, a variant of this, **FDBF (Full Dra^{in}age and Block-Breastfeeding)** would be conceivable. Here, the breast is emptied with the pump as completely as possible and then block-breastfeeding is begun. In this way, the baby gets at the fat-rich hind milk and the milk flows more slowly. Should massive and painful engorgement occur again, this measure can be repeated.
- Changing the breastfeeding position or breastfeeding against gravity or **"intuitive breastfeeding"**; the mother is in a reclining position (about 45°) and the baby attaches to the breast from above.
- If your baby is struggling with a strong milk ejection reflex, you could either **trigger the milk ejection reflex by hand** or, when you feel the milk ejection reflex begin, **take the baby off the breast briefly** and let this milk run into a towel. By pressing against the breast, i.e. with the ball of your thumb, the spraying of the milk can be stopped (on the other side) or between breastfeeds.
- Cooling the free breast before, during and/or after breastfeeding and, after feeding, cooling that breast with cool packs or quark/cottage cheese or cabbage compresses.
- Many mothers describe a milk-reducing effect of sage or peppermint tea.

Photo: © Karl Grabherr

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

Taping during the Breastfeeding Period

Tapes, these colorful strips, which became famous through sports-(wo-)men, now also during breastfeeding?! Lactation consultants who tape? An introduction to clinical reasoning.

Author: Dorothea Hauswald

Photos: © Dorothea Hauswald

If the mother is relieved by taping, the baby does well. Taping creates well-being (amazingly quickly), not only offers muscular-skeletal support during the breastfeeding period and can act enormously beneficially and supportively.

This article describes indications for the application of elastic tapes in the postpartum, which are an effective option for relieving discomfort or generating a feeling of well-being and can complement breastfeeding counselling. With the help of two case studies, the physiotherapeutic diagnostic and scientific clinical reasoning (Klemme, Siegmann 2006), through which decisions about therapy during breastfeeding are made on the basis of close examination, as well as on knowledge of anatomy, physiology and pathophysiology, will be presented.

Elastic tapes, developed by the Japanese physician, Kenso Kaze, in the 1980s to relieve the pain of muscular-skeletal complaints, have become a credible, widespread medical intervention, although there are scarcely any evidence-based studies on this (cf. Gross 2015). There is, however, well-documented empirical evidence and there are countless hypotheses on the reasons for this effect (cf. Ilbeygui 2013, S. 35 ff.). At best, the tapes are effective and can trigger pain relief and feelings of well-being surprisingly quickly after they are applied. In the worst case, they appear to be ineffective, but do not exacerbate the situation. However, if they are applied incorrectly, they can also intensify the complaints, cause discomfort and provoke pathologies. For this reason, the tapes belong in the hands of trained professionals.

A variety of forms of application characterizes today's market, all the more so because today's tapes are also offered by discounters and, thus, have been introduced into daily life: (Sport)-physiotherapists tape muscle and joints to promote movement and pain reduction as well as improved performance. Osteopaths use tapes to stimulate internal organs via the skin reflex arc (visceral taping). In energetic work, acupressure points can be stimulated by tapes (for example, with cross-tapes). Taping in horses is considered to be doping and may not be used in races. The aim is always to alleviate acute pain and to enable movement. Thereby, however, taping is much more than merely sticking a colorful ribbon on the problem area, analogous to a band-aid/plaster, for the "there-where-it-hurts" method can sometimes work as a positive support, but frequently nothing happens and an effective therapeutic measure is discredited.

The therapeutic art of taping lies in identifying the pain and its causality and supporting the body with different application techniques. Thereby, the aim is to cautiously seek the root cause (diagnostic reasoning) and apply the tape accurately, which presupposes anatomical, physiological and pathophysiological knowledge (scientific reasoning).

In breastfeeding, the maternal breast, as a nutritional provider organ, is the focus. In many taping publications, breast taping in the case of engorgement/mastitis is presented in countless variations. Furthermore, the lactation consultant who is experienced with taping should precisely reflect the natural science ›

foundations, using scientific reasoning (Klemme, Siegmann 2006, p 32):

At the start of breastfeeding, there is an onset of substantial milk production in lactogenesis II (Biancuzzo 2005, S.63). The transport of the milk is initiated by the baby's demand, i.e. frequent attachment to the breast. There may be swelling and blockages in the interstitial breast tissue – even a milk blister - because the flow of water and substances from the blood capillaries must first be established and regulated. At the time of initial breast tissue swelling. A lymph tape can bring relief through promoting resorption by gentle stretching of the skin along with other measures which stimulate lymph flow (in particular lymph drainage). However, should the milk ducts be compromised due to interstitial congestion, and invasion of germs in this blockage cannot be ruled out. At this point, the lymph tape would facilitate the intake of bacteria into the lymph system and, thereby into the vascular system. In the case of mastitis, should germs cause massive problems (reddening, fever), this applies all the more so. The stimulation of the lymph flow is absolutely contraindicated with a bacterial or viral infection (Bringezu, Schreiner 2006, p. 102). Here, scientific reasoning helps avoid pathologies caused by taping.

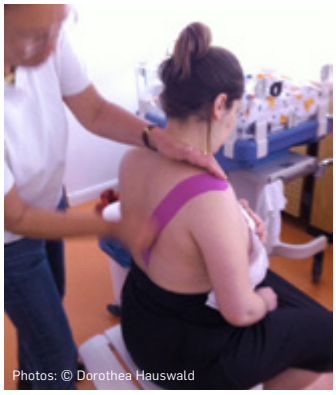
The postpartum and the breastfeeding period is a time which demands peak performance from the mother's body. When, then, is taping in this period an inexpensive and sensible strategy, in the sense of clinical reasoning, to treat problems which arise and be effective beyond the actual time of the lactation consultation? On what basic problems could taping in the breastfeeding period have an influence? A selection:

- The breast as a milk-producing and supply organ is in continuous operation. Lymph tapes or space-saving tapes (ligament or fasciae technique) can relieve the early swelling or nodes in the breast.
- Breastfeeding positions have mothers remain in one position for longer periods. The bending of the thoracic spine and the overburdening of the paravertebral musculature, which reacts with pain on stretching and with cramping, is the result of the inclination towards the baby. As a consequence, the sunken rib cage causes a postural change and muscle tension imbalances of the neck. Tapes which are applied in accordance with muscle techniques, help with tension regulation and relief, reduce pain and improve the joint mobility.
- Shortened rest periods and long periods of carrying a growing and, therefore, ever heavier child, challenge the lower back, that sometimes seems to be breaking in two. Pelvic problems (i.e., instabilities of the sacroiliac joint) seriously hinder movement and make daily life laborious and onerous. In star applied in ligament technique, relieves and support joints and helps to loosen adhesive tissue.
- The handling and holding of the infant is demanding for the hands and arms. Many newly delivered mothers develop symptoms consistent with carpal tunnel syndrome. Here too, the tapes in the muscle technique help, whereby it should be carefully considered whether pain may not also have a protective function for overburdened muscles and where exactly the tape should be applied (scientific reasoning)
- The mother's body is used in the service of breastfeeding. Maternal regeneration times and compensatory gymnastics are easily neglected so that the breastfeeding mothers quickly feel unwell and suffer from physical problems, which can, then, affect breastfeeding. At this point, the tapes then come into action as an everyday, inexpensive additional intervention.

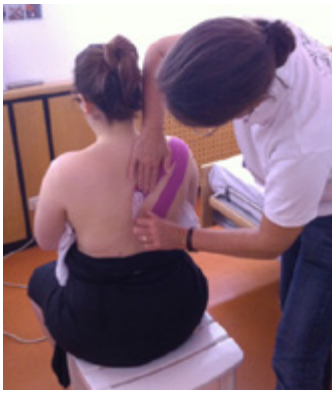
In the following, two examples from clinical practice will present the clinical thinking in applying the tapes.

1 Mrs P, as a mother of twins, had a primary Cesarean Section. In the first three days post-op, the main focus was on activating and developing self-sufficiency, the initiation of breastfeeding and bonding.

The babies thrived, the family tackled their tasks and had made themselves comfortable in the family room. On the 4th day post-op, Mrs. P complained of massive neck and back pain.



a Mrs. P describes the right shoulder-neck region as particularly cramped. Here, a clear protraction of the scapula (right more than left) with a shortening of the ventral breast musculature can be seen, I decide to apply a correction tape to the shoulder blade, which pulls the scapula in the direction of the posterior depression and relieves the descending trapezius pars muscle.

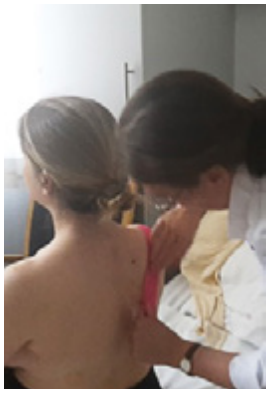


b Immediately after the tape is applied, Mrs. P. experiences pain relief. However, I am not yet satisfied with the extent of the correction and apply a second correction tape somewhat further cranially which, once again, significantly reduces the tonus in the trapezius muscle.

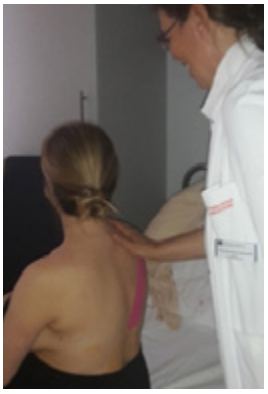
c Following the application of the scapular correction tape, Mrs. P experiences relief in her neck. However, in the area of the thoracic spine, she experiences an uncomfortable paravertebral ache. As she makes a rubbing gesture in this area (body language in the sense of a diagnosis of a Typaldos fascial distortion model, I decide to tape the relevant area using a muscle technique.

d Result: "Aaahhh" – Mrs. P experiences noticeable relief and expresses this relief with a blissful moan.
The next day, the small family was discharged feeling quite well.

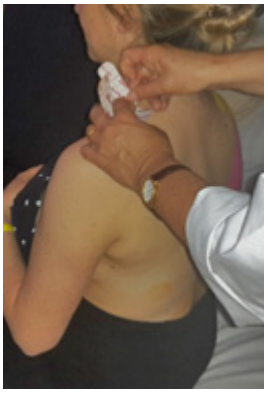
2 Mrs. H had a repeat Cesarean Section due to a chronic rectum prolapse (II. gr., II. p.). From the 2nd to the 3rd night she developed massive neck pain, especially on the right side (pain scale 4, pulling/wrenching; hypertonus M trapezius pars descendens). We mobilized the spine physiotherapeutically and worked on/developed the flat supine position with support for the head to relieve the neck area. As a complementary measure we chose taping



A strong protraction of the right shoulder is clearly recognizable in the picture, which correlates with the strong neck pain on the right a side. As support for the physiological position of the shoulder, I apply a scapula correction tape on the right side. Furthermore, in the picture is the clearly configured, tense trapezius, which was strongly hypertonic on palpitation. I decide to influence this muscle directly by using the fascia technique



b Using the fascia shifting test, by which the skin is pushed against the fascia, I test how the shifting changes the range of movement of the cervical spine rotation and through this determine the tensile direction of the fascia tape.



c Right and left, I now attach a fascia tape to the descending trapezius. Mrs. H immediately perceives a clear reduction in the neck tension and can move her head more smoothly and further. But directly ventral on the left shoulder, it still prickles.
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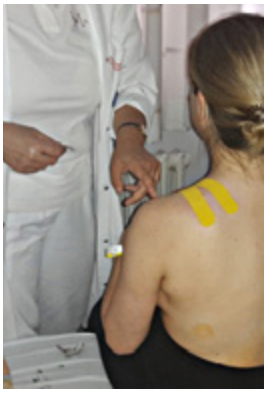
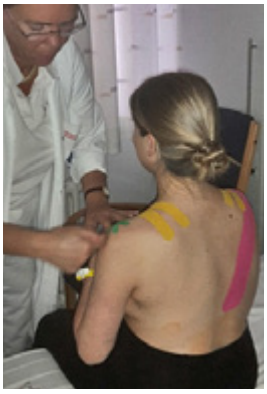


d Because this non-radiating pain only occurs in selected points (Diagnosis in the sense of Typaldos). I attach a small star (ligament technique, green). In the picture on the left, the BDL Information sheet on taping, which I discuss with Mrs. H parallel to applying the tapes and leave there for her for further information..



e Result: Mrs. H is doing much better with the tapes. "The tension in my neck is gone."

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The History of Human Milk Banks in Germany

The German history of human milk banks dates back to 1919, when the pediatrician Marie Elise Kayser founded the first human milk bank in Germany (1). Authors: Dr. Mihaela Nita, Dr. Stefanie Rosin

Photo: © Stefanie Rosin

Interestingly a directive was issued in 1952, obliging each city with a population greater than 50,000 citizens to establish a milk bank. Therefore, by 1959, a total of 86 human milk banks has been established in Germany, amounting to 62 in East Germany and 24 In West Germany. By 1989 all the human milk banks in West Germany had closed, due to aggressive formula industry marketing, HIV epidemics and little public support. Meanwhile 60 milk banks remained operational in East Germany, collecting about 200,000 liters of donor milk per year. [2] **In East Germany mothers were paid for their milk 10 East Mark per month, an important amount of money at the time.** [3]

From 1990, research indicating the benefits of breastfeeding and human milk feeding was increasingly published. Based on this research, premature babies with VLBW were increasingly provided donor milk. The obvious health benefits of this practice paved the way for the reemergence of human milk banks in Germany.[3] Currently in 2018 there are 20 active human milk banks in Germany, while three are already planned.[2] About 3,500-4,000 liters of donor milk are being processed and made available to children in need per year.[1]

A valid nationwide law for operating human milk banks does not exist in Germany. The "Guideline for the establishment and functioning of human milk banks" published by S. Springer in 1998, still represents the standard for milk banking practice in Germany until today.[1]

Efforts are made to develop uniform recommendations regarding milk banks and milk donors. An interdisciplinary project scientific advisory board has compared and summarized current guidelines from several European countries and has developed recommendations for the support of milk banks in Germany, Austria and Switzerland. These recommendations reflect the current scientific consensus and take feasibility into account.[4]

Visit of the human milk bank at the Charité Virchow Hospital in Berlin, Germany, on 15 June 2018

On the occasion of the first ELACTA Board Meeting of the new Board 2018-2020 in Berlin, 2 delegates from ELACTA visited the human milk bank of Charité university hospital Berlin on 15 June 2018.

The delegates were Dr. Mihaela Nita and Dr. Stefanie Rosin, while the guide during the visit was Dr. Monika Berns.

About the human milk bank in Berlin at Charité Virchow hospital

The human milk bank was founded in 1995, with a continuous activity since then. Working hours are usually daily from Monday to Friday and sometimes even on weekends, while 600 liters of milk are being processed annually. The human milk bank provides all the necessary donor milk for the NICU, and the neonatal and pediatric wards of the hospital.

There are six IBCLCs working in the hospital: three medical doctors and three nurses, but only one IBCLC works more than 50 % of the time as a lactation consultant. As far as possible, the whole staff attends a 20h course on breastfeeding and lactation.


Photo: © Stefanie Rosin

The human milk bank is organized in seven rooms in a circular setting: a collection room with access for donors, including refrigerators and freezers for raw milk; a large room for preparation of the milk for the wards and pasteurization of donor milk; two smaller rooms for milk storage and preparation; a large room with several freezers used for storing of pasteurized milk; and two rooms used as stores for various foods, supplements and other equipment, especially for disposable milk storage containers.

The donors are not paid for the milk but they receive equipment like breast pumps, containers and cool bags. Many donors are parents whose babies are admitted to the NICU or neonatal wards of the hospital.

Regarding the recruiting process, donors are interviewed and tested for HIV, hepatitis A, B and C, and for transaminase levels and syphilis. The raw donated milk is tested on a weekly basis for the total bacterial count. Following pasteurization with the Holder method, the human milk bank doesn't have routines of testing the donor milk further for the bacteriological status. Milk can only be pooled if it comes from the same donor, but not from different donors. The human milk bank makes great efforts to match a donor with the recipient, and remain with the same donor throughout the donation process.

Lessons learnt

The use of a big sterilizer has been proven over time to be time-consuming and not economical, and that is why the human milk bank now has switched to working only with disposable containers.

Opportunities

The human milk bank at the Charité Virchow hospital in Berlin provides the opportunity to visit the human milk bank and to volunteer in different tasks for interested professionals.

The human milk bank also announces an employed position on their team. For further information please contact Dr. Monika Berns at: monika.berns@charite.de

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› [4] V. Matthäus, N. Haiden, M. Abou-Dakn, M. Berns, K. Eglin, A. Flemmer et al, **Empfehlungen zur Förderung von Frauenmilchbanken in Deutschland, Österreich und der Schweiz,** Monatsschr Kinderheilkd (2018).

Summary Protocol General Assembly ELACTA in Rotterdam

18 May 2018 Protocol writing: Stefanie Rosin, Karin Tiktak

1. **Welcome**
2. **Operational Matters.** Present ELACTA members: 72 IBCLCs + 3 non-IBCLCs + Board 7 persons (all IBCLC). Voting Committee formed 3 persons.

3. **Report of Activities** Since 2016 ELACTA has gained 4 more member associations: ELCA (Egypt), LLCA (Latvia), ACLR (Rumania) and LCANZ (Australia &NZ). As of 2017 ELACTA comprises 24 member associations from 20 countries, plus 6 individual members, amounting to a total of 2,311. members. Board meetings took place in Greece, Germany, Switzerland, Austria and Croatia. A new website was launched and social media activities were increased. Procedures were revised; the ELACTA board drafted a Strategic Plan; conducted questionnaires and organized CERPS International in Salzburg, Austria. The L&B editorial team reports of a successful and active year in 2017. The German print version of L&B is being sent regularly to German-speaking members through their country associations, and further to about 350 single subscribers. Lactation & Breastfeeding in English is being sent regularly to the presidents of all non German-speaking member associations as a pdf file, who then in turn forward it to their members.
While the German issue of L&B is successful with regards to finances, the English issue still needs investments, mainly for translations.
The yet unclear investments for the English version caused a loss of €2640 in the magazine's balance.

4. The **Financial report of 2016- 2017** was presented by Heli Vanhatalo, board member until May 2018. The total balance after 2 years is €11,782 profit. The auditors Marga Wapenaar, Myrte van Lonkhujsen and Serena Debonnet could not carry out the auditing properly, due to the late receipt of the final report by our ELACTA accountant Mr. Wally. This delay was caused by illegible bills in Greek language causing gaps in bookkeeping. The auditors suggested to give a provisional discharge to the treasurers and the board, to enable new elections, which was agreed by the GA. The final audit will be conducted until 15 September 2018 by mandate of all presidents. The former treasurers Heli and Maja Recic together with the whole board of 2016-2018 remain responsible until they will be finally discharged. Lesson learnt for the future: Strict deadlines have to be met by the treasurer team. Bills and reports should be in English language, or translated into English. (Brief comment 18/09/2018: Majority discharge by the presidents of the member associations for budgets of period 2016-18.

5. **Discharge Board of Directors** (see above) Provisional.
Monika Jahnke, president from BDL Germany joins in the audit committee for the next term.

6. **Voting & transition of Board:** Farewell speech to Maja and Heli.
Candidates for election of the new board term 2018-2020: Karin Tiktak; Mirjam Pot; Stefanie Rosin; Marta Tunde-Muresan; Gihan Fouad; Daiva Sniukaite Mihaela Nita; Marica Bettinelli; Barbara Finderle. Elected: Karin Tiktak, Mirjam Pot, Stefanie Rosin, Mihaela Nita, Marica Bettinelli and Barbara Finderle and Daiva Sniukaite-Adner

7. **Resolutions:** Membership fees remain constant at € 13 for A countries and €8 .50 for B countries

8. **Questions** (Anja Bier) Will the ELACTA Statutes be updated? Response: At the next GA in 2020 a proposal for changes will be presented. (Anja Bier) How were the travel expenses covered? Response: ELACTA focused mainly on traveling inside of Europe to gain new member associations. Expenses to travel outside of Europe were paid by the board members on their own account. Only the official ILCA partner meeting is covered by the ELACTA budget, for the purpose of representation and exchange.

9. **Looking forward.** The board will continue developing the strategic plan and new goals. The board offers a certain amount of funds for a research project. The professional profile of lactation consultants will be translated from Dutch into the English language. We will continue our collaboration with IBLCE. CERPS International will take place in 2019 in Bled, Slovenia. We will develop a platform on European education for the IBCLC credential. The ELACTA board calls for volunteers to support the board work in several task groups. The budget projected for 2018 amounts to €36,000. The next ELACTA conference will be held in Italy in 2020.

10. **Closing**

Contributors wanted!

ELACTA Board carried out a questionnaire among the presidents of the member associations. One question was about contributing in different task groups.

1. For the task group **"Recognition & Communication"** we are searching for an IBCLC who is dedicated to the subject of the recognition of our IBCLC profession (part of ELACTA strategic plan). The candidate is expected to have excellent communication skills in English and preferably to have a good network in the field of governmental policies, as well as contacts with WHO/UNICEF, Ministry of Health. The candidate is politically engaged in putting our profession on the agenda of the EU. In case you are interested, please send an email to president@elacta.eu

2. ELACTA is also recruiting an IBCLC who can contribute to strengthening the backbone of our organisation. We have developed a strategic plan and our bylaws and statutes require an update according to this plan. If you are interested in becoming a member of this task group **"Core Values",** please send an email to president@elacta.eu

3. We are looking for a candidate who would like to participate in the task group **"Website and Social Media"**. Are you skilled in webmastering, using the possibilities of Word Press and are you handy with linking the website to Facebook? Please contact president@elacta.eu

CERPs International

30. 5.–2.6.2019 in Bled, Slovenia

Photo: © Annamartha / pixelio.de

CERPs international is a very special training offer from ELACTA – the European Lactation Consultants Alliance - for ELACTA members. An opportunity to get to know colleagues from around the world and share knowledge and experiences. Furthermore, the afternoons offer the possibility to get acquainted with the wonderful venue of Bled in the Julian Alps.
The participants design the program – for a contribution from their side, the participant fee is reduced by about € 20 (case study) – € 40 (workshop or lecture). Experience shows that about 10–12 CERPs can be earned during the training. The plan is to have a room available for German-language lectures and another one for English-language lectures.

Leisure Time:
In the afternoons, we will enjoy excursions to natural, cultural and culinary sites. The hotel is only 5 minutes away by foot from Lake Bled. Depending on the weather, we are planning different tours: A visit to Bled Castle and to the island of Vintgar Gorge. For all who like to get up early to enjoy peace and unspoiled Nature, there is an unparalleled opportunity to reach the grandiose hills above Lake Bled on forest trails and **admire the unforgettable view of the Lake!** Naturally, we will also sample local treats, among them a slice of the famous Bled Crème Cake and the Slovenian national specialty, potica, a sweet yeast bread with a walnut and date filling. (www.bled.si/en)

Cost:
The participant fee is € 150. As the number of participants is limited, please register quickly. Attention! The hotel is in great demand!
Your registration is only valid after paying the registration fee.
Rooms and prices:
www.hotelastoria-bled.com/welcome

Voices from the last CERPs-International Event in Salzburg:
Janette Timmermans (NL):
"I know that I speak in the name of all who attended CERPs International when I say that we enjoyed a fantastic and fun time. We laughed with each other and found friends for life."

Sandra Gattiker (CH):
"CERPs International is worthwhile in every respect – not only for collecting CERPs – I would participate in it again in an instant!"

Treat yourself to this unforgettable experience!

Photo: © Hemmelmayr

Learning in a jovial circle like at the CERPs International 2017 in Salzburg

EU-Data Protection Act

Since the 25th of May, 2012, the new General Data Protection Regulation (DGPR) applies in the EU and also has, to some extent, a great effect on the work of the national associations and the IBCLCs, in particular those colleagues in private practice. Lactation and Breastfeeding asked the national associations some questions about how they got along with the implementation of this data protection regulation.

Probably, both the vacation time as well as a certain insecurity with the topic of data protection were the grounds that, up until the writing of this article, we have received answers from only 10 of the 27 national associations (9 from the EU). We see that the EU-wide data protection act has also been implemented differently in the laws of the individual member states. Therefore, it is important that the associations, health care institutions and, in particular, IBCLCs in private practice, deal with the respective national laws and consult relevant specialists as needed.

Data Protection in the Alliance – Results of our Questionnaire:

› **Data Protection Declaration on the Homepage:**
A public matter, which is easy to control, is the data protection declaration on the homepage. Most of the associations (7 of 10) have published such a data protection declaration on their homepages, whereby they have used model data protection declarations (4 countries) and professional help (3 countries).

› **Dealing with the data collected:**
The associations must think about how they deal with their members' data and interested parties and document this in writing. At the time when the questions were posed, 5 countries had finished this task, while 5 countries are still in the process.

› **Data protection officer/data protection specialists:**
Here, there seem to be different requirements from country to country
9 national associations answered the question on data protection officers: 4 countries have a data protection officer from their own ranks, even if this is not necessarily legally required for small associations in their countries, while in 5 countries, such a data protection officer for the association has not been installed. 5 countries already work with together with external data protection specialists, while 4 countries have decided against that or are still considering whether such cooperation seems necessary.

› **Offers and information for the members:**
Even when the implementation of the data protection regulation is the responsibility of either the health care officials or the IBCLC, some associations provide their members with information and/or offers that can make data protection easier:

- Saving and deleting of client data: IPD (Slovakia), AICPAM (Italy)
- Secure and/or unsecure communication forms with clients: IPD (Slovakia)), VSLÖ (Austria), AICPAM (Italy), DSLS (Slovenia)
- Data security on private websites AICPAM (Italy)
- LCGB (UK) has published an article by an IBCLC in private practice in which she gives suggestions and hints on how the "GDPR/Data Protection" influences the IBCLC in private practice.

The association offers its members (for a fee):

- Ready-made, texts which also deal with data protection: AICPAM (Italy)
- A secure communication platform for client-contact: DSLS (Slovenia)

We would like to thank the following for the feedback:

AICPAM	Italy
ACLR	Romania
BDL	Germany
DACLC	Denmark
DSLS	Slovenia
ELCA	Egypt
HUSD	Croatia
IPD	Slovakia
LCGB	Great Britain
VSLÖ	Austria

Ankyloglossia

An update of the literature Authors: Dr. Gina Weissman and Dr. Yael Dubester David

Photos: © iStock/AWelshLad

Ankyloglossia (tongue-tie) is a common clinical entity occurring in between 4% and 10% of newborns.[1] It has classically been described in such terms as "tethering" of the tongue, a "heart-shaped" tongue on protrusion, and inability to protrude the tongue beyond the mandibular alveolar ridge. Possible implications are maternal pain or poor latch with breastfeeding and speech disturbances, although there is some controversy over whether, and to what degree, ankyloglossia can affect these functions.[2-3] The following article summarizes novel research findings on this topic.

Good assessment and diagnosis are important because many of breastfeeding babies with ankyloglossia will not encounter any problems.[3] Frenotomy appears to improve breastfeeding in infants with tongue-tie, but the placebo effect is difficult to quantify. A randomized controlled trial showed a significant decrease in the pain score after frenotomy versus sham procedure (the control group, in order to estimate the placebo effect). There was also a nearly-significant improvement in latch after frenotomy. Frenotomy appears to alleviate the mother's nipple pain immediately after surgical intervention. Ankyloglossia plays a significant role in some early breastfeeding difficulties and frenotomy is an effective therapy for these difficulties. Complications are rare, but it is important that it be carried out by a trained professional.[3-4]

The Academy of Breastfeeding Medicine urges that more research be undertaken so that the benefits and risks of frenotomy for ankyloglossia and its effectiveness in treating breastfeeding concerns can be better understood.[5]

The diagnosis of ankyloglossia is typically subjective, reliant on the practitioner's assessment of the limitation in tongue movement and clinical significance of the tethering.

There is very little published literature defining normal lingual frenulum variability in neonates, further complicating the issues of defining pathological ankyloglossia. In addition, the more recently defined entity of "posterior" or "submucosal" tongue tie is less obvious on examination and has no validated diagnostic criteria.

Walker et al (2018) published a prospective cohort study trying to define tip-frenulum length for ankyloglossia and its impact on breastfeeding. The purpose was to investigate the normal lingual frenulum anatomy in newborns and to evaluate tip-frenulum distance as an objective diagnostic tool for identifying newborns at risk for anterior and posterior tongue tie and breastfeeding difficulty. 100 healthy newborns were evaluated. Each newborn

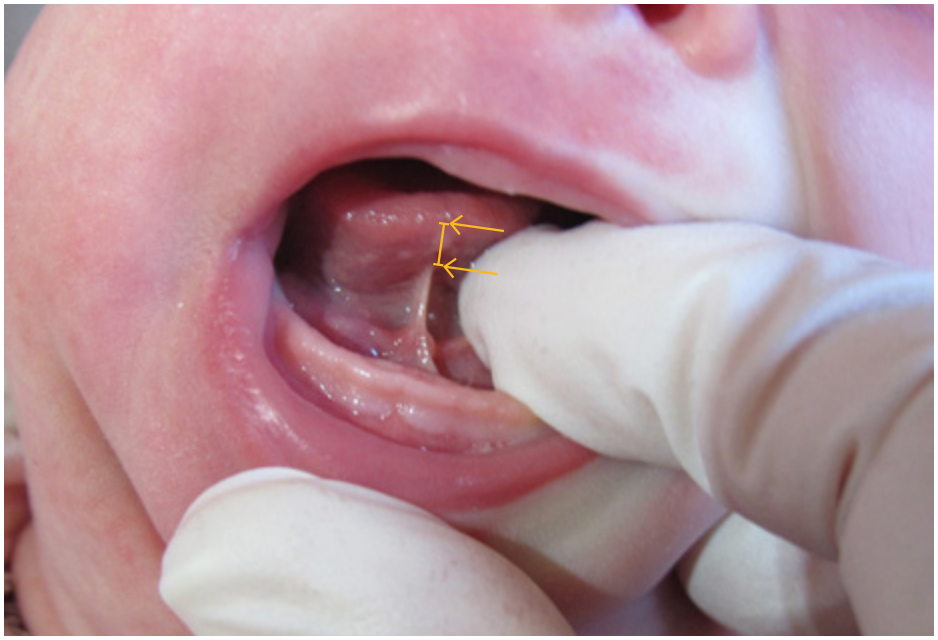

Fig. 1.: In the study of Walker et al. (2018) the distance from the tip of the tongue to the attachment of the lingual frenulum was measured.

underwent examination of the oral cavity, including inspection and palpation of the floor of the mouth for the presence or absence of a posterior band or cord.

Each subject also underwent measurement of the distance from the tip of the tongue to the attachment of the lingual frenulum (Fig. 1). The Infant Breastfeeding Assessment Tool (IBFAT) and maternal pain scale were used to evaluate the presence and quality or degree of nipple pain, rooting reflex, sucking pattern, and latch. Mothers were contacted again two weeks later. Measured tip-frenulum lengths ranged from 2 to 15 mm. Mean length from all measurements was 9.11 mm with a SD of 2.65 mm. Median length from all measurements was 10 mm.

This research recognizes that shorter tip-frenulum distances were associated with greater levels of maternal pain during breastfeeding. Tip-frenulum length may, therefore, be a helpful tool in identifying mother-newborn dyads at risk for early breastfeeding cessation. No significant differences in IBFAT scores were identified with respect to infant tip-frenulum length when considering the entire population of mothers. However, when mothers were stratified according to their level of previous breastfeeding experience, mothers with two or more previously breastfed children reported a positive correlation between tip-frenulum length and IBFAT scores. This indicates that, although a first-time mother may need more lactation assistance before determining a treatment course for a short tongue/tongue tie, a plan may be able to be more rapidly determined with a mother with more experience.

However, **the presence of a visual cord (such as anterior tongue tie) is easier to diagnose by comparison to a palpable cord (such as posterior tongue tie). Inter-rater reliability (degree of agreement among raters) for a palpable cord was substantially lower. This suggests that the diagnosis of posterior ankyloglossia by palpation of a thick, fibrous posterior cord, as described in the literature, should be interpreted with caution, particularly when considering surgical intervention.**[6]

Breastfeeding is a complex interaction involving the mother-infant dyad, with countless variables to predict its effectiveness. Further studies should be directed at investigating other diagnostic criteria to define clinically significant posterior ankyloglossia, and whether treatment with frenotomy can result in improved breastfeeding in these patients.

In order to determine the impact of surgical tongue-tie/lip-tie release on breastfeeding impairment (nipple pain, latching difficulties etc.) a prospective cohort study was published by Ghaheri et al. (2016)[7]. A total of 237 dyads were enrolled after self-electing laser lingual frenotomy and/or maxillary labial frenotomy. The study was conducted using only a 1,064-nm diode laser. According to the study authors, surgical release of tongue-tie/lip-tie resulted in significant improvement in breastfeeding outcomes. The improvements observed occurred early (1 week postoperatively) and continued to improve through 1 month postoperatively. **Improvements were demonstrated in both infants with classic anterior tongue-tie and less obvious posterior tongue-tie.** Maternal self-efficacy, nipple pain, infant reflux symptoms and the rate of milk transfer – **all were shown to significantly improve with lingual frenotomy with or without maxillary labial frenectomy,** indicating a strong consistency of treatment effect as Ghaheri et al. concluded.

However, according to Douglas (2017), studies of the efficacy of frenotomy are of poor quality and are characterized by author bias.[8] Douglas observed in her breastfeeding clinic that normal, although anatomically diverse, lingual and maxillary labial frenula are commonly diagnosed as posterior tongue-tie and upper lip-tie and referred for frenotomy. When she performs comprehensive breastfeeding assessments on babies with breastfeeding problems or fussiness, including those who have had oral surgery in the previous weeks or months, she finds a range of underlying problems that have not been properly identified and addressed, though the women have usually seen multiple health professionals. Douglas also critically analyzed Ghaheri's study on the impact of surgical tongue-tie/lip release on breastfeeding im-

pairment. She concluded that Ghaheri et al. has not reliably demonstrated benefits of laser surgery for these infants, but has confused association with causation, in the context of failure to control for multiple potential confounders. The list of problems that the mothers brought to Dr. Ghaheri might be common presentations in breastfeeding babies, with multiple causes other than oral ties. As Douglas emphasizes, **researchers need to be aware of methodological weaknesses and interpretive biases.** Ghaheri claims that many experts consider it unethical to conduct a randomized controlled trial to investigate the efficacy of laser frenotomy because the risks to mothers and babies of withholding laser surgery contradicts the basic principles of good science.

As Douglas points out, **overtreatment is a serious problem** in the provision of health care in high-income countries.

Breastfeeding families deserve the best possible science so that infants do not receive **unnecessary surgical interventions** when problems arise.[8]

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› [5] https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/11-neonatal-ankyloglossia-protocol-english.pdf

› [6] Walker RD, Messing S, Rosen-Carole C, McKenna Benoit M. **Defining Tip–Frenulum Length for Ankyloglossia and Its Impact on Breastfeeding: A Prospective Cohort Study.** BREASTFEEDING MEDICINE, Volume 13, Number 3, 2018

› [7] Ghaheri BA, Cole m, Fausel SC, Chuop M, Mace JC: **Breastfeeding Improvement Following Tongue-Tie and Lip-Tie Release: A Prospective Cohort Study.** Laryngoscope. 2017 May; 127(5):1217-1223. Epub 2016 Sep 19.

› [8] Douglas P: **Making Sense of Studies That Claim Benefits of Frenotomy in the Absence of Classic Tongue-Tie.** J Hum Lact. 2017 Aug; 33(3):519-523.

ABOUT THE AUTHORS

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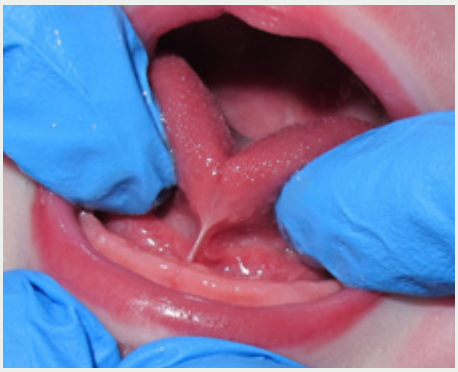
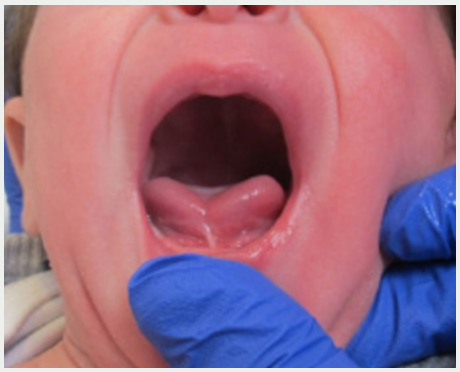
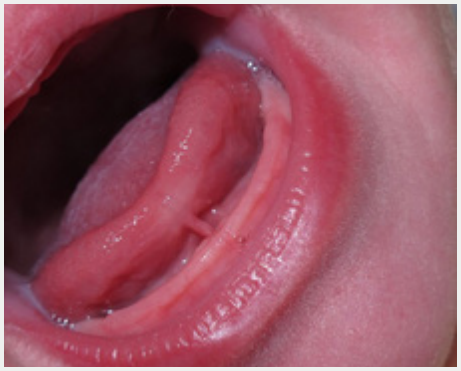
Photo gallery Ankyloglossia



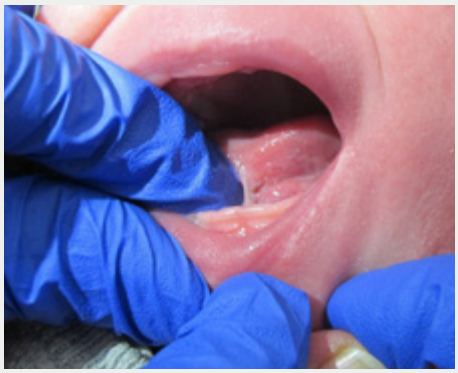
Thin type 1 – a short lingual frenum attached to a heart-shaped tip.



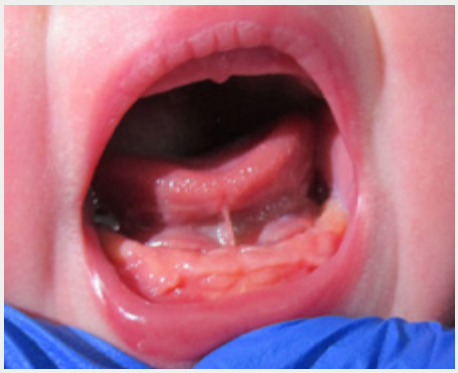
Type 1 tongue tie – a fibrous tight frenum showing restriction in tongue elevation.



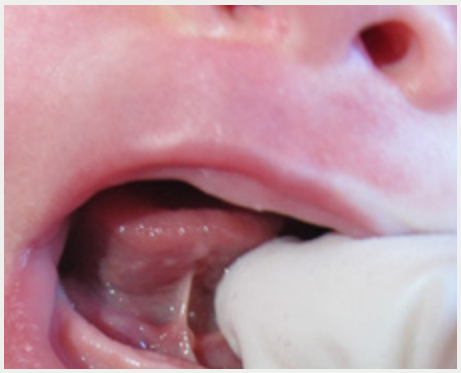
Thick type 1 – thick fibrous type 1, blanching near the tip when trying to elevate.



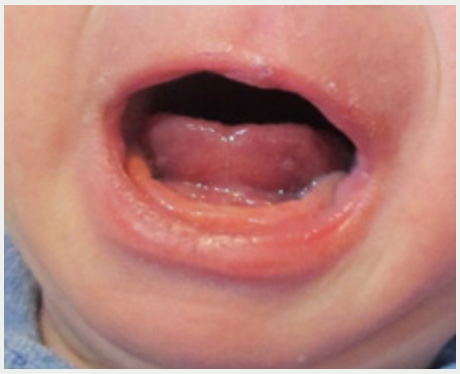
Tongue-tie Type 1 – a short tight frenum. It is hard sometimes even to insert a finger.



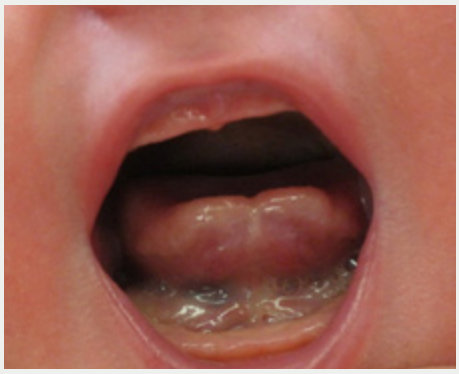
Type 2 – the frenum is attached a few millimeters from the tip, restricting the tongue movement



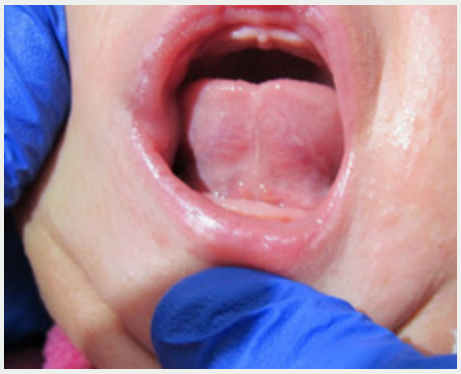
Type 3 – a short, non-elastic frenum attached to the alveolar ridge, like an Eiffel tower



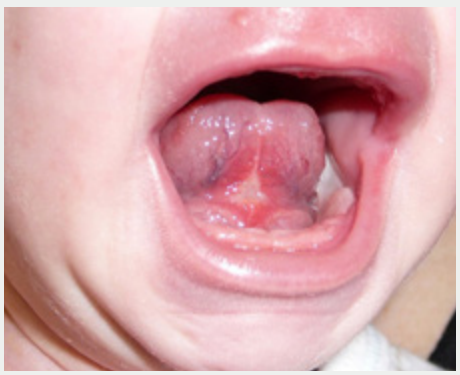
Type 4 and other issues – we can notice the a-symmetry while crying and elevation of floor of the mouth.



Type 4 palpable cord – the frenum is not visible, therefore challenging to diagnose. Mid-tongue elevation is restricted.



Type 4 slightly palpable cord – we can see the heart-shaped tip, demonstrating the tension while elavating.



There are still controversies whether to perform post op. exercises (But that is for the next article)
Post op. diamond shape area.

Breastfeeding immediately after frenotomy- biological nurturing is a good posture to achieve a breastfeeding.

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