

Breastfeeding FAQs

Talking Points on Frequently
Asked Questions about Nursing

A Guide for Physicians

American Academy of Pediatrics
New Jersey Chapter
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Breastfeeding FAQs
Talking Points on Mothers Frequently
Asked Questions about Nursing
A Guide for Physicians

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New Jersey Chapter

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Prenatal Period Nursing Questions

Mother: “My nipples are inverted. Will I be able to nurse my infant?”

Background information for the practitioner:

Women with inverted nipples can breastfeed. In most situations, the nipple will evert in the infant’s mouth as the baby sucks.

For those mothers who do encounter challenges with infant latching, a lactation consultant can teach moms how to “shape” the nipple, as well as how to ideally hold the breast. Additionally, infants may latch easier when they are placed in certain breastfeeding positions, such as the football position. Use of a breast pump to pull out the nipple immediately prior to feeding may also help.

The use of breast shells, which apply gentle suction on the nipples in order to achieve nipple eversion, are controversial. Medical evidence does not strongly demonstrate that breast shells cause nipple eversion. Additionally, some experts have concerns that recommending the use of breast shells during pregnancy may send an unintended message to the mother that she is going to have trouble breastfeeding, when that may not be at all true.

Mothers may ask about a nipple manipulation technique, known as Hoffman’s exercises, to help evert nipples during pregnancy. There is no evidence that this kind of exercise is effective. Additionally, Hoffman’s exercises may potentially induce uterine contractions.

Inverted nipples sometimes evert during pregnancy and also become more stretchable with each subsequent pregnancy.

Talking points:

- **Yes, you can nurse your baby**
- **In most cases, babies will be able to stretch the nipple out when it is in the mouth**
- **If issues come up, a lactation consultant has the expertise to help you use certain techniques and infant holding positions to help the baby latch**
- **Inverted nipples loosen up and sometimes even begin to protrude out during pregnancy. They also become more and more flexible with each subsequent pregnancy**

Mother: “My bra cup size is an A. Am I going to have trouble nursing?”

Background information for the practitioner:

Women who wear an A cup size bra can successfully nurse their infants. Their babies tend to feed somewhat more frequently when compared to women who have larger cup sizes.

Talking point:

You can successfully nurse your baby if your bra cup size is A

Mother: “I am a Hepatitis B carrier. Can I nurse my baby?”

Background information for the practitioner:

Studies have shown that moms who are hepatitis B carriers can safely nurse their infants as long as the baby receives Hepatitis B vaccine and Hepatitis B immunoglobulin within 12 hours of birth. Subsequent Hepatitis B vaccines are given at 1-2 months of age and 6 months of age

Talking Points:

- **You can nurse your baby**
- **Your baby’s doctor and the hospital should make sure that the baby receives the Hepatitis B vaccine and the Hepatitis B immunoglobulin (HBIG) within the first 12 hours of life**
- **Subsequent Hepatitis B vaccines will be given at 1-2 months of age and at 6 months of age**

Mother: “I am a hepatitis C carrier. Can I nurse my baby?”

Background information for the practitioner:

Though the transmission of Hepatitis C is theoretically possible, the chance of transmission is exceedingly low. The Center for Disease Control states that “there is no evidence that breastfeeding spreads Hepatitis C virus” and that “HCV positive mothers should consider abstaining from breastfeeding if their nipples are cracked or bleeding”.

Talking Points:

- **The government agency, The Center for Disease Control (CDC), states that there is no evidence that breastfeeding spreads Hepatitis C**
- **There is a theoretical risk of transmission through milk, but the chance of transmission is thought to be exceedingly low**
- **The CDC also states that mothers with Hepatitis C should consider abstaining from breastfeeding if nipples are cracked or bleeding**

Mother: “I have HIV. Can I nurse my infant?”

Background information for the practitioner:

Though this is a controversial issue worldwide, in the United States, it is not recommended that HIV positive mothers breastfeed.

Talking points:

- The American Academy of Pediatrics and the Center for Disease Control do not recommend that mothers who are HIV positive nurse their infants
- There are other ways to physically feel close to your baby such as holding and cuddling
- Recommendations are different for women in developing countries where exclusive breastfeeding provides the best outcomes for infants

Mother: “I had breast surgery in the past. Will I be able to nurse my baby?”

Mammopexy (breast lift surgery)

Background information for the practitioner:

Mammopexy (breast lift) procedures generally do not cause milk production problems. It is unlikely that duct tissue or nerve fibers would be damaged during this kind of procedure.

Talking point:

You have an excellent chance of successfully nursing the baby

Breast Augmentation (breast implants)

Background information for the practitioner:

The majority of mothers who have had a breast augmentation procedure can fully nurse their infants; however, some may only be able to partially nurse their infants. The following must be considered when assessing for future nursing challenges:

- Whether the mother originally had normal breasts or had evidence of breast hypoplasia (such as tubular shaped breasts along with wide spacing of breasts)
- if nerves or ducts were severed during the procedure (this is not usually the case)

If a woman who had breast augmentation originally had breasts that were normal in regard to tissue volume and shape, the chances of producing ample amounts of milk are good. Regarding women with underlying insufficient glandular tissue, most can provide some mother’s milk for their babies. It is important that the mother understands that if this is the case, nursing is still worth it. She and her baby still will maintain better health than if mother’s milk isn’t given. Additionally, because breast tissue actually grows with each successive pregnancy, these mothers may produce more milk with each subsequent infant.

Surgical approach influences outcome. The four augmentation approaches are transaxillary, transumbilical, inframammary and periareolar. Fortunately, most surgeons tunnel the devices through axillary or umbilical sites. These two procedures, and the inframammary approach in certain instances, are less likely to disrupt nerves and ducts. The periareolar approach, which is rarely performed, significantly increases the risk of nerve damage. Nerve damage disrupts the necessary signals needed for hormone release.

The bottom line is that the majority of women who have undergone breast augmentation can successfully nurse. If the mom's original breast shape was unusual or if the past history is unclear, follow the baby's weight weekly. Have the mom follow bowel movements and urine frequency carefully (see page 12 on assessing milk volume).

Talking Points:

- You should nurse your baby. Mother's milk will help maintain your baby's good health and helps your body stay healthy too. Nursing gives you an opportunity to experience physical closeness with your baby.
- The chances are very good that you will produce breast milk. A lot will depend on the type of procedure your surgeon used and the underlying reasons why the procedure was done to begin with. Surgeons usually choose a surgical approach that will preserve nerve fibers and ducts if at all possible. Overall, most moms can produce a full amount of milk, though some produce a partial amount of milk.
- We will follow you and baby weekly for awhile to make sure that we pick up any issues, should they develop
- Consider checking the website, www.bfar.org, which is devoted to helping nursing moms who have had breast surgery.

Breast Reduction

Background information for the practitioner:

Most moms with a history of breast reduction surgery can breastfeed to a certain degree. Very few may be unable to produce milk; however, they can still experience the physical closeness associated with nursing by using a supplemental lactation aid. This device delivers nutrition (supplementation) through a tubing system that is taped to the breast. The degree of milk production depends on the surgical approach. Fortunately, most plastic surgeons have become more cognizant of the impact of breast reduction surgery on future lactation. Efforts are made to spare nerve fibers and duct tissue as much as possible.

Approaches include the Pedicle Technique and the Free Nipple Graft Technique.

Surgeons rarely use the Free Nipple Graft Technique. In addition to removal of some duct tissue, the nipple areolar complex is entirely removed and reimplanted at a higher position. Nerve tissue is completely severed during this process. Following the Free Nipple Graft Technique, women lose nipple sensation. Without nerve signals, the required hormonal process needed for lactation is gone; however, nipple sensation has been noted to reoccur in some women, particularly if five years has passed since surgery. Additionally, duct recanalization has also been observed to reoccur five years post-surgery as well. This increases the chance that some milk will be produced.

The pedicle technique is more commonly used. The nipple and areola are moved into a higher position while remaining attached within a “pedicle” that is comprised of breast nerve fibers and a bundle of ducts. Women are able to partially nurse their infants; however, severed ducts may recanulate over time, especially if it has been more than five years since the surgery had been performed. This may enable her to make even more milk than expected.

Many women are uncertain about which surgical technique was used. Regardless, the initial management approach is to monitor closely.

The bottom line is that women should initiate full nursing but their infants should be monitored weekly or, in some cases, biweekly for a while so that adjustments in management can be made (see page 12 on assessing milk volume).

Talking points:

- You should nurse your infant
- Most moms who have had breast reduction surgery can make some milk. The amount varies from woman to woman; however, every drop of milk helps baby maintain good health. Nursing helps maintain your good health as well.
- Regardless of potential milk volume issues, all women have the opportunity to experience physical closeness with their babies through nursing. If you are one of the few that is unable to make milk, a milk supplement (human donor milk or infant formula) can be given through a special feeding tube taped at the breast. This will allow you to still experience a special physical closeness with your baby during feeding
- The website BFAR.org is devoted to helping moms who have had breast reduction nurse their infants.
- We will follow you and baby at least weekly for awhile to make sure that we pick up an any issues should they develop

Lumpectomy

Background information for the practitioner:

A lumpectomy procedure generally does not cause milk production problems. In the *unlikely* event that duct tissue or nerve fibers would be damaged during this kind of procedure, a mother could still nurse fully on the unaffected side and partially on the other.

Talking point:

- You have an excellent chance of successfully nursing the baby
- You may have some difficulty early on with engorgement next to the area of the incision but this resolves with time. Pain reliever, such as acetaminophen or ibuprofen, can help overcome any discomfort and is safe to use while breastfeeding.

Mastectomy

Background information for the practitioner:

A mother with a past history of undergoing a unilateral mastectomy should be able to nurse on the unaffected side.

Talking Points:

- You can fully nurse your infant on your unaffected breast
- Your unaffected breast has the ability to make double the amount of milk because it will be doubly stimulated by the baby

Mother: “Can an adoptive mother nurse?”

Background information for the practitioner:

Adoptive mothers may wish to nurse in order to experience a desired physical closeness with their infants, as well as to obtain optimal health outcomes for their infants and themselves.

Adoptive mothers can nurse their babies. While a few can fully breastfeed, most produce a partial milk supply. A few may not produce milk but can still enjoy the closeness associated with direct nursing by using a supplemental lactation aid. This device delivers nutrition through a tubing system that is taped to the breast. It can be used by mothers who have a partial milk supply as well.

Various approaches help induce lactation. Approach will depend on how much notice the mother has regarding the baby’s arrival. In general, using an electric breast pump ahead of time is helpful, but mothers can still be successful if there is not any notice. Though domperidone is used successfully worldwide, it is not currently FDA approved; however, some specialists order it through US compounding pharmacies. Domperidone is thought to be helpful in inducing lactation. Though it is helpful, some breastfeeding medicine physicians feel that it is not absolutely essential for success.

Your local breastfeeding consortium may help identify a lactation consultant and breastfeeding medicine physician who focuses on management of adoptive nursing.

Talking Points:

- Nursing will help you experience a desired physical closeness with your baby. It will help you and baby obtain optimal health outcomes.
- While it is ideal to implement a lactation plan ahead of time, it is still very possible to successfully nurse your baby on short notice
- Most moms can produce some amount of milk for their babies. A few can fully breastfeed or work up to full breastfeeding, while a few are not able to produce milk
- Your local breastfeeding consortium may help identify a lactation consultant and breastfeeding medicine physician who focuses on management of adoptive nursing

Mother: “Breastfeeding did not work with my first child. What makes you think that I will succeed with this baby?”

Background information for the practitioner:

In general, nursing a baby becomes easier with each subsequent child. Physical changes in the breast occur with every successive pregnancy. Breast glandular tissue volume increases. The nipples and areola progressively become more stretchable. It is thought that the number of prolactin receptors on individual lactocyte cells accumulate with every subsequent child, leading to increasing ease of milk production.

Medical evidence shows that mothers who deliver infants at hospitals that adopt the World Health Organization Baby Friendly Hospital Initiative’s Ten Steps to Successful Breastfeeding, are more likely to continue exclusively breastfeeding months after discharge. Once at the hospital, mother can have some direct input into three of these steps (assuming mother-infant stability): skin to skin contact starting within an hour of life, uninterrupted rooming in with baby and adherence to exclusive breastfeeding.

Early skin to skin contact within the first hour of life is associated with the continuance of exclusive breastfeeding months after hospital discharge. It is also associated with more stable infant blood sugars, as well as a more stable blood pressure, pulse and temperature, starting in the delivery room. Additionally, early nipple suckling leads to a surge of maternal oxytocin and to uterine contractions. Studies show that this is correlated with less maternal blood loss and anemia. Early suckling helps baby to identify and establish its food source, as it reaps the reward of milk letdowns. Behaviorists believe that this early identification results in imprinting . While laying on its mother’s chest, the infants well developed sense of smell allows it to identify oils emitted by Montgomery glands on the areola. With near proximity to these oils, the baby will use this sense of smell to nudge and navigate its body toward the nipple. Direct skin to skin contact within one hour of life can be practiced by women who deliver vaginally or who undergo a cesarean section.

Uninterrupted rooming in with baby is also associated with a solid establishment of exclusive breastfeeding. Close proximity of baby allows for early recognition of subtle infant feeding cues. This is the period when a baby will most easily latch to the breast. Busy nursery personnel are unlikely to notice these subtle cues. It is not until a baby appears frenzied or is crying that staff recognize that the baby is hungry; however, babies latch poorly, if at all, in a frenzied or tearful state. Escalating frustration on the part of baby, mother and staff may then result, as infant and mother repeatedly perceive latching in a negative manner. Additionally, though parents may perceive that they will rest more soundly if their baby is placed in the nursery, a recent study concluded that parents sleep just as well, if not better, when uninterrupted rooming in is practiced.

Exclusive breastfeeding is the goal because it is associated with maintenance of optimal health outcomes. It is also associated with a longer duration of breastfeeding following hospital discharge. Several important health outcomes are listed in the talking points below.

TALKING POINTS:

- In general, nursing becomes easier with each baby you have
- You have more breast tissue now than you did before. This tissue does not disappear. Breast tissue actually grows from one pregnancy to the next

- **Your nipples and areola are more stretchable now because you have nursed before**
- **Your milk cells have been “primed” from the last pregnancy experience, so it is going to be easier for these cells to produce milk**
- **It is unlikely that your baby will have the same problem as your other child. If you do notice the same or a different problem, seek help right away by calling me, as well as a lactation consultant.**
- **You can increase the chances that nursing will be successful this time around by delivering at a hospital that embraces the World Health Organization’s Ten Steps to Successful Breastfeeding**
- **During labor, try to minimize the amount of pain medication you receive if you feel you are able. This will increase your baby’s alertness. If you need pain medication during labor, we will help your baby get through any grogginess, should it occur. Remember that you might need to be a little more patient with baby’s nursing skills at first if he or she is groggy. Hang in there-it will get better in time.**
- **Certain measures will increase the chances that nursing will go smoother this time around. Make sure that, assuming you and baby are stable after delivery, that you nurse your baby within the first hour of life. Keep the baby’s skin right on the skin of your chest as much as possible. Keep your baby in your hospital room all the time. Make sure that you exclusively breastfeed him or her unless there is a clear medical reason for you not to, that is approved by a doctor.**
- **Remember that nursing your baby is worth doing. Both you and your baby will maintain optimal health by breastfeeding. For baby, this means better protection from infection (colds, ear infections, pneumonia, infectious diarrhea), a stronger immune system (less type1 diabetes, Crohn’s disease, ulcerative colitis, eczema, asthma and certain food allergies) as well as lower rates of obesity, type 2 diabetes and leukemia in the future. SIDS is also noted less often in infants who are nursed. If your baby is born prematurely, your milk will decrease the risk of developing serious bloodstream infections, life-threatening intestinal infections(known as necrotizing enterocolitis), as well as help him or her make more rapid progress in feeding. Mothers who nurse experience lower rates of postpartum bleeding, anemia, postpartum depression, as well as lower rates of future breast cancer and ovarian cancer. You also lose approximately 500 calories per day while nursing, which may help you get back to your pre-pregnancy weight quicker!**

Mother: “I have lots of food allergies. I was told that this would affect my baby if I breastfed and that I should give my baby hypoallergenic formula instead.”

Background Information for the Practitioner:

There is no medical evidence that severe maternal dietary restriction of foods while nursing leads to lower rates of allergy or of atopy in general. However, consumption of human milk is associated with a lower risk of eczema, asthma and some food allergies, especially in those with a family history of atopy. Though the formula industry advertises that hypoallergenic formulas decrease the risk of such entities, medical evidence is insufficient to warrant these claims.

TALKING POINTS:

- **Mother’s milk optimally protects a baby from asthma, eczema and some allergies. Though the formula industry advertises that hypoallergenic formulas decrease the risk of allergies, there is insufficient medical evidence that it in fact does this**
- **Additional health outcomes for mother and baby can only be obtained through mother’s milk. Choosing hypoallergenic formula instead of your own milk for your baby would leave both you and baby at increased risk of many diseases.**

Nursing and Infant Feeding Behavior

Mother of a one month old: “My baby has not had a bowel movement in five days. Is she constipated?”

Background information for the practitioner:

Bowel movement frequency in nursing infants varies widely. In the first three weeks of life, three to twelve yellow seedy daily stools are generally expected. While some infants continue with this pattern, others begin to have fewer stools each day. Some nursing babies can store up their bowel movements for up to seven days. The stools of Infants who adopt this pattern are voluminous and yellow. The consistency is similar to mustard, rather than hard or pasty. This is not considered constipation, but rather a common normal variant that only requires reassurance.

Constipation, defined as hard pasty infrequent stools, is exceedingly rare in an exclusively breastfed infant. It can be noted if a mother has introduced infant formula. If the mother describes hard or pasty stools be sure to ask her if she has recently introduced infant formula or is giving cereal early for some reason. This information offers an opportunity for you and the mom to discuss any previously undisclosed feeding issues. Constipation may also occasionally be observed in older infants after solids have been introduced

TALKING POINTS:

- **Some nursing babies normally start having fewer stools as they approach one month of age. Storing bowel movements for up to seven days is common in exclusively nursed babies.**
- **Typically, upon finally having a stool, the baby releases a huge amount of yellow seedy stool that is the consistency of mustard**
- **This is not constipation because the stool is soft rather than hard.**
- **If your baby’s belly becomes unusually distended or he starts vomiting, call immediately because something not associated with a normal stool pattern may be going on**
- **It is also not normal to go without having a stool in the first few weeks of life when healthy breastfed infants typically have at least 3 yellow seedy stools per day. If stooling is less frequent during this time period an assessment is warranted**

Mother: “My baby nurses too much. What’s wrong?”

Background information for practitioner:

Parents often misinterpret normal nursing behaviors. Erroneous conclusions follow, often resulting in unnecessary nursing problems. Nursing infants generally feed about ten to twelve times over a 24 hour period, but these feedings are not evenly spaced. It is normal, especially in the first six weeks of life, for babies to cluster their feedings for a segment of the day. While cluster feeding, babies will feed hourly for up to six hours before the feeding frequency tapers off. Undue anxiety is alleviated if parents are given a “heads up” early on that this normal feeding pattern occurs in most nursing babies. Assure them that while an infant cluster feeds, he or she not only takes the milk that the breast has made, but that the baby can actually induce milk cells to produce milk while he or she sucks. This is why the breast is never truly considered empty: **the more suck, the more milk.**

Some mothers are erroneously taught that the baby must finish each breast within a certain time period. This leads to parental misinterpretation when a baby does not follow this “rule” (most won’t). Babies grow best when they are allowed to feed off a breast until they let go or finish retrieving and swallowing milk.

Some babies enjoy nonnutritive sucking on the breast once he or she is done feeding. This is different from nutritive sucking, where the infant is actively ingesting milk. Babies who are using a nutritive suck will be actively swallowing. Mother will see movement under the chin followed by movement in the upper anterior neck as the baby gulps during swallowing. She may hear a gulp. Babies who are finished feeding but are just “hanging on” to the breast for comfort will not be making gulping movements. It is okay for the baby to do this if the mom is agreeable. If not, she can remove the baby from the breast. If the baby protests, rather than using a pacifier, one of the parents may consider allowing baby to suck on a parent’s finger (after washing hands).

Another source of parental anxiety occurs during growth spurts, which typically occur at ages 3 weeks, 6 weeks and 3 months. The growth spurts are accompanied by hourly and frenzied feedings that can last up to 48 hours. If parents are not given a “heads up” that baby is approaching the age of an expected growth spurt, they may erroneously interpret their baby’s ravenous feeding pattern as a milk supply issue. Remind them that there will be plenty of milk to support this growth spurt. The baby will drink what is in the breast and then make the milk cells make more milk as he or she sucks. Remember: **the more suck, the more milk.** A day of sleepiness may follow growth spurts. It should not be misinterpreted as lethargy.

The most common question parents have is “how do I know there is enough?” Our culture is very quantitative in nature. Not seeing what comes out of the breast during a feeding can cause uneasiness. Use three measurements to explain how to tell: stool number, urine void numbers and weight, assessed in 24 hour intervals (see page12 on assessing milk volume)

TALKING POINTS:

- Nursing babies generally feed 10-12 times a day, but it is not evenly spaced
- It is unnatural and counterproductive to put the baby on an even schedule

- Young babies less than six weeks of age will cluster their feedings (cluster feeding) during a segment of the day. When this occurs, they will want to feed hourly for 3-6 hours. This is normal.
- The more your baby sucks and feeds, the more milk is produced. Remember: **the more suck, the more milk**. Your breasts are never truly empty because the baby will drink what the breasts have made and then force the milk cells to make milk as he or she is sucking.
- Keep in mind that your baby will go through growth spurts at 3 weeks, 6 weeks and 3 months of age. The growth spurts are accompanied by hourly and frenzied feedings that can last up to 48 hours. There will be plenty of milk to support this growth spurt. The baby will drink what is in the breast and then make the milk cells make more milk as he or she sucks. Remember: **the more suck, the more milk**. A day of sleepiness may follow growth spurts.
- You and I will continue to track the baby's weight, stool frequency and urine frequency to make sure all is well

Mother: "How do I know that my baby is getting enough of my milk?"

Background information for the practitioner:

Our culture values measurement. As a result, some parents may feel uneasy about nursing because they mistakenly perceive that there is no quantitative process associated with it. It is important that they understand that measurements exist which assure that nursing is going well. These measurements typically include stool output, urine voids and weight.

Stool number should generally range from 3-12 per day; however, this daily frequency may begin to taper off in some infants starting around three or four weeks of age (see page 10) These infants may stool as infrequently as every five to seven days, even though they demonstrate normal urine output and weight gain. With the exception of this known variation in stool pattern, generally a stool number of at least three daily bowel movements will reliably indicate adequate nutrition and hydration.

Stool frequency may also slow down if infant formula is introduced.

Stool color helps the practitioner understand whether milk volume is appropriately increasing. Color indicates that mom and baby are moving through stages of lactogenesis at an appropriate pace. Lactogenesis I is associated with the presence of colostrum and dark (meconium) stools. The beginning of Lactogenesis II is associated with breast fullness that is associated with a copious amount of milk and greenish transitional stools. Bowel movements turn yellow as this stage solidifies and the transition toward the mature milk of lactogenesis III begins. Continued production of meconium on or after day of life five is correlated with a delay in the Lactogenesis II stage and potential low intake.

Stool color also changes with alterations in the intestinal environment. Stool may darken if infant formula has been introduced or if the infant has intestinal problems such as allergic colitis.

Expected urine void frequency is as follows:

EXPECTED URINE VOIDS:

DOL1	DOL2	DOL3	DOL4	DOL5	DOL6	>DOL6
1 void	1-2 voids	2-3 voids	3-4 voids	4=5 voids	≥ 6 voids	≥ 6 voids

It may be difficult to detect urine voids due to the super absorbency of some diapers. Use of diapers with urine indicator lines is helpful. Alternatively, a square of toilet tissue can be placed inside the diaper. This square will readily absorb urine, aiding in urine void detection.

Urate crystals (“brick dust”) are only marginally significant early on. The crystals may be significant if still present on day of life five or beyond. At that point urate crystals may signify delay in the second stage of lactation, known as Lactogenesis II. In this stage, a surge of prolactin hormone release occurs, resulting in a copious milk production. The presence of urate crystals, as it relates to delayed Lactogenesis II, should only be interpreted in conjunction with data about stool number/quality, urine output and weight.

The majority of both nursing infants and infant formula fed babies lose weight initially. This represents expected post-delivery diuresis. Most nursing infants reach the nadir of weight loss at 3-4 days of age. If weight loss is 7-9% of birth weight, this is a signal to investigate whether there may be a problem. It does not necessarily mean that supplementation should be prescribed. If by day of life five the baby has lost 10% of birth weight *and* there is a delay in Lactogenesis II, where copious milk would have been expected, supplementation is often necessary. One exception would be if a mother received excess intravenous fluid in labor. In this situation, an excessive infant diuresis follows, resulting in excessive weight loss; however, these infants have appropriate stool frequency and urine voids and there is no delay in Lactogenesis II.

If intake is thought to be inadequate, supplementation may be supplied by the mother’s own milk (for instance if the baby is unable to sufficiently retrieve milk from the breast), human donor milk from a milk bank or infant formula. If infant formula is indicated, 15-20 ml of hypoallergenic formula should be given after each (or alternatively every other) nursing session. This is ideally administered through a tiny cup, a syringe, a plastic spoon or supplemental lactation aid. Early bottle introduction may occasionally lead to a preference toward the bottle over nursing at the breast that is hard to undo. This phenomenon may be related to ease of bottle flow and the observation that directly nursed and bottle fed infants use their tongues, buccinator and masseter muscles differently to order to retrieve milk.

Weight gain is noted to start soon after the second stage of lactation, Lactogenesis II, begins. This is the stage where copious milk is produced in response to an increased release of prolactin hormone from the pituitary gland. For nursing babies, birth weight is reached between day of life ten and fourteen. Expected weight gain is ¾ to 1 ounce per day until six months of age. After six months of age, ½ to ¾ of an ounce per day is expected.

Nursing infants who are growing normally may appear as though they are falling in percentiles at about six

months of age if the old US growth charts are used rather than the new CDC-WHO growth charts that are now recommended (see page 15). The old charts are thought to reflect an element of obesity that has crept into US growth chart data in the past few decades. The new charts, which should be used in all infants (breastfed and infant formula fed), reflect how healthy infants and toddlers *ought* to grow.

Remember that breast pumps are very unreliable indicators of breast milk volume capability (see next question).

Talking Points:

- There are ways to know that your baby is receiving the right amount of mother's milk. You will keep track of stools and urine wet diapers. I will track the baby's weight to know that all is going well.
- If your baby has less than three bowel movements a day, let me know. This can still be normal (especially if the baby is beyond three or four weeks old), but I will have to ask a few more questions to make sure it is okay
- Your baby should have a minimum number of urine wet diapers each day (go over the urine void chart printed above). You may want to use diapers with a urine indicator line or slip a square of toilet tissue in the diaper so that you can easily tell that the diaper contains urine.
- I will keep track of weight and let you know if there is any concern
- Keep in mind that your baby may cluster feed or feed ravenously during growth spurts. Your breasts will make plenty of milk during these prolonged and frenzied feeding episodes. As your baby sucks the milk cells in your breasts make more milk.

Mother: "I'm only getting one ounce out of each breast with my breast pump. Does this mean that my baby is not getting enough milk?"

Background information for the practitioner:

Breast pumps are not as efficient at retrieving mother's milk as is a baby. For instance, it is entirely possible that a pump may only retrieve an ounce per session while a baby could retrieve 3 ounces while directly breastfeeding.

While some women easily retrieve milk through pumping, many factors may be present that inhibit appropriate letdown in other women. This includes stress (lack of sleep), anxiety (ie., watching the pump bottle fill) and inexperience . Additionally, it is thought that pumps may more easily retrieve milk from the anterior portion of the breast, while babies more easily retrieve milk from both anterior and posterior breast regions.

Techniques are available to help enhance retrieval of milk via breast pump; however, success varies from mother to mother. These may include use of warm compresses and massage five minutes prior to nursing.

Looking at the infant (or a photo of baby), smelling baby's used blanket or hearing a recording of baby's cry help stimulate the letdown reflex. Covering the pump bottles with a paper towel and tape decreases anxiety and facilitates the letdown reflex. Massaging the breast while using a breast pump helps. Alternating back and forth between the use of an electric double pump and hand expression of milk is useful.

The most important point to make with the mom is that the milk pumped out is not representative of the baby's ability to retrieve milk while nursing. Pump volume is not equivalent to volume retrieved through direct nursing.

TALKING POINTS:

- **There is no correlation between what is pumped out of the breast and what the baby gets through direct nursing. They are two very different ways of removing milk. The pump isn't going to be as efficient as a baby in pulling milk out of a breast**
- **The way for you to know if your baby is taking in the right amount of mother's milk is:**
 1. **Keep track of the number of urine voids in a 24 hour period**
 2. **Keep track of the number of bowel movements in a 24 hour period. If there are three or more, your baby is taking in enough milk; however, if your baby is three weeks of age, we will have to take into account that the bowel movements of many healthy babies begin to naturally taper to as few as one every five to seven days**
 3. **I will routinely be keeping track of your baby's weight at the office.**

Mother: "Is my six month old growing okay? He looks pudgy but I've been told that his weight has gone down on his growth curve"

Background information for the practitioner:

The normal growth pattern of nursing infants diverges from infants who are fed infant formula. Typically used US growth charts reflect the growth of infants and children who have been formula fed for the most part. Additionally, these older US growth curves are thought to include an element of obesity that has crept into data over several decades.

The World Health Organization embarked on a worldwide study that examined how infants and children ideally grow. In 2010, the Center for Disease Control adopted the WHO growth charts for all children (both breastfed and formula fed) for ages 2 years and under.

Infants who are growing normally may appear as though they are falling in percentiles at about six months of age, if they are plotted on the older US growth charts, rather than on the new CDC-WHO growth charts.

If you are still using the old growth chart and encounter an infant who appears to be falling in percentiles,

download and plot the data on the CDC-WHO growth chart at www.cdc.gov/growthcharts/who_charts.htm.

Consider universally instituting the new charts in your practice for all patients who are two years and under.

Talking Points:

- Some nursing infants may appear to fall off a growth curve around 6 months of age if the correct growth curve is not used
- I will make sure that your baby's growth data is plotted on new standard curves that reflect optimal infant growth. This will help me understand if your baby's growth is okay

Mother: "My mother wants to know why I'm still nursing my two year old but my child still wants to nurse. Do I have to wean him from nursing?"

Background information for the practitioner:

The American Academy of Pediatrics and its Section on Breastfeeding recommends breastfeeding for *at least* the first 12 months of age but beyond if mutually desired by mother and baby. Iron-fortified complementary foods and other typical pureed solids are started at six months of age. Though nursing for at least 12 months is the minimum, worldwide, most children nurse until 3 or 4 years of age. This age appears to be the time children will naturally wean themselves from the breast both in developed and developing countries. Human milk continues to be a sound nutritional product beyond 12 months of age. Additionally, the risk of maternal breast and ovarian cancer diminishes as the duration of nursing increases.

Talking points:

- Though our culture is just getting used to the idea of nursing for longer than age 12 months, children in most other countries nurse until ages three or four years. This includes both developed and underdeveloped countries
- Mothers' milk continues to be a sound nutritional substance in the childhood years. It is good for your baby.
- Nursing your baby beyond a year of life may help decrease your risk of certain health conditions later in life, including breast and ovarian cancer
- It may be comforting to join a breastfeeding support group for extra encouragement

Mother: "Why do my breasts appear softer now? They were fuller when my baby was younger. Am I losing my milk supply?"

Background information for the practitioner:

Many nursing women notice that their breasts seem softer and somewhat reduced in size as their infants reach

two to four months of age. Though their infants are thriving, they question whether their milk supply is beginning to diminish. Mothers need reassurance that these breast changes are normal and expected. There is plenty of milk for the baby.

Talking Points:

- Breast size and firmness naturally changes as your baby gets older.
- Mothers breasts are suppose to look smaller and feel softer at this point
- As long as your baby is gaining the right amount of weight and is urinating at least six times a day, all is well. If you are having difficulty determining urine frequency, use a diaper with a urine indicator line or slip a square of toilet tissue in the diaper so that you can more easily detect the presence of urine.

Mother: “I have a cold. Is it safe to nurse my baby?”

or

“I have diarrhea. Is it safe to nurse my baby?”

Background information for the practitioner:

In addition to it being a sound nutritional food, human milk contains medicinal-like substances that decrease the risk of contracting infection. In the event of infection, ingestion of human milk is correlated with a decrease in the duration and severity of infant illness. Examples of anti-infective agents in mother’s milk include IgA, lactoferrin, lysozyme and maternal white blood cells. The role of maternal IgA is particularly important in fighting off common infant respiratory and gastrointestinal infections.

A baby is exposed to the mother’s infectious respiratory or oral secretions for about two days prior to the appearance of maternal symptoms. With initial maternal exposure to a virus, the mother’s body starts making the IgA needed for her to fight her own infection. This maternal IgA , which is tailor-made to fight off the specific infection, also quickly moves into her milk. IgA in human milk then lines infant respiratory and digestive system mucosa, helping the baby to fight off infection. This is why a mother who is ill should ideally nurse her baby frequently.

If the mom is placed on medication, check a reliable medication and lactation source to make sure the medication is okay (most medications are okay, but pseudoephedrine can diminish milk volume) . See Appendix A for these sources. Remember that the Physician Desk Reference and Epocrates are ultraconservative sources to use when checking medications in lactating mothers. They will often recommend against breastfeeding even though experts have determined that a medication is compatible.

TALKING POINTS:

- Your baby has already been exposed to your germs, through your respiratory secretions and hands (for colds) or saliva and hands(for diarrhea), starting a few days before you even knew you were sick

- **When you give the baby your milk you also give extra “medication” to your baby because it contains substances that help baby fight off your infection**
- **Your body has been making milk protector substances, known as antibodies, starting from the moment you got the germ. This substance has already been helping your baby. These protectors are lining the inside of your baby’s system. The more mother’s milk, the more milk protector substances accumulate in your baby. If your baby does get your symptoms, the protectors will help diminish the duration and severity of the illness. This is why you should frequently nurse your baby**
- **Another reason to frequently nurse is because slowing down nursing can lead to clogged ducts and a breast infection, known as mastitis. This would only make you sicker.**
- **It is okay for you to take acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) for pain or fever-it won’t hurt your baby. You can still nurse if you have a fever-it won’t harm your baby**
- **Most cold medications are okay for moms to use, but avoid taking cold medications that contain pseudoephedrine because it can slow down your milk volume. For instance, it is okay for you to take medications that contain products such as dextromethorphan and guaifenesin for your cold. You can also use nasal saline spray and a cool mist humidifier to help your symptoms.**
- **Ask any nearby family members to help you if you are feeling really sick. They may be able to help take care of other children and assist with household chores. Call your doctor. If your doctor prescribes medication, I will be glad to check that it is compatible with nursing.**

Maternal Medical Conditions and Procedures

Mother: “My doctor has ordered a CT scan with contrast. Do I have to stop nursing?”

Background information for the practitioner:

It is safe for a nursing mother to have a CT scan with contrast. She does not need to “pump and dump” following the procedure.

Few radiocontrast materials require pumping and discarding milk for a prescribed period of time; however, most do not. See Appendix B for a complete list of contrast materials and how they relate to lactation :

Talking Points:

- It is okay for you to have the CT scan with contrast. You can nurse right after the procedure
- If any further radiologic procedures with contrast are ordered, call me and I will check this for you

Mother: “I have to have a root canal done tomorrow. How soon can I nurse after it’s done? Do I have to ‘pump and dump’?”

Background information for practitioner:

Very little local anesthesia leaves the injected area and enters the breast compartment. This tiny amount quickly leaves the breast tissue. Local anesthesia will not harm the baby. The mother can nurse after the procedure. No “pumping and dumping” is necessary.

Anesthetic gases leave the breast compartment at the same rate as they leave the mother’s central nervous system tissue. Therefore, as soon as the mom is alert, she can nurse. No pumping and discarding of milk is necessary.

Talking Points:

- Regarding numbing injections in the gums, it is okay to nurse right after you have received a numbing injection
- If you receive “laughing gas”, you can nurse as soon as you feel alert

Mother: “I’m feeling exhausted, achy all over and my left breast is very sore in one place. My doctor says I have mastitis and has placed me on an antibiotic. Can I still nurse my baby?”

Background information for practitioner:

The mother has signs and symptoms of mastitis. Mastitis signs and symptoms vary. Some mothers report an area of redness and tenderness on the breast without any other symptoms while others have full blown signs and symptoms including extreme exhaustion, body achiness, and fever. Sometimes a mom will simply report that she has the flu because she feels tired and achy. Be sure to ask her if she has an area of breast redness and tenderness because she might not realize that achiness, exhaustion and fever may be observed in those who have mastitis.

Check if the underlying cause of the mastitis is due to a relatively rapid decrease in feeding frequency

Full term infants can continue nursing on both breasts while the mother has mastitis. It is important for the mother to frequently empty her breast through nursing in order to facilitate healing.

Just about every antibiotic is okay for maternal use (including the quinolones) Check a reliable lactation and medication source such as the LactMed web site or Hale’s *Medication and Mother’s Milk* if you are not sure (see Appendix A). Remember that the Physician Desk Reference and Epocrates are ultraconservative sources to use when checking medications in lactating mothers. They will often recommend against breastfeeding even when experts have stated that a certain medication is indeed compatible with breastfeeding.

Mothers are typically placed on cephalexin 500mg TID for 10-14 days or dicloxacillin 500 mg QID for 10-14 days. Other antibiotics that cover staphylococcus and streptococcus pyogenes are also acceptable. Clindamycin would be an acceptable alternative for penicillin allergic individuals.

Continued duct stasis in someone with mastitis may lead to abscess formation. A discrete round tender lesion is noted. Incision and drainage is necessary if an abscess forms.

TALKING POINTS:

- **Continue feeding your baby on both breasts**
- **You must remove milk from your breasts frequently, preferably by direct nursing, in order to heal. Drainage of the breast by feeding helps prevent the development of a breast abscess**
- **Prior to feeding, a warm compress for about 5 minutes will loosen material within the breast ducts. When the infant is ready to nurse, place him or her on the problem side first. Position the baby so that the nose points toward the clogged area. Massage the firm problem area while the infant is feeding. When your baby is finished feeding, use of a cold compress will provide comfort. This will also help reduce breast swelling**

- It is okay for you to nurse your baby if you have a fever. You may take acetaminophen (Tylenol) or ibuprofen (Motrin or Advil). It won't hurt you baby
- You will need an antibiotic. Just about every antibiotic is safe to take while nursing. I am glad to look up any medication that you are given in order to double-check this

Mother: “Do I have to stop nursing in order to get a mammogram?”

Background information for the practitioner:

Lactating women can get a mammogram without weaning the infant from the breast. The lactating breast is more dense compared to the breast of nonlactating women. This density diminishes when milk is removed.

Have the mother nurse her baby or pump her milk just prior to the procedure.

Help the mom identify a local radiologist who has experience reading mammograms of lactating women

Talking points:

- You can have a mammogram done if you are a nursing mom. You do not need to wean your baby. The mammogram should not be delayed
- The mammogram procedure will not change the quality of your milk
- Bring your baby with you and have him or her nurse just prior to the mammogram. Bring your breast pump with you in case the timing is such that your baby won't nurse
- I will help you find a radiologist who is used to reading the mammograms of nursing moms
- Breast cancer can and does affect lactating breasts so evaluation should not be delayed

Mother: “My doctor wants me to receive a flu shot and a Tdap vaccine. Is it safe to nurse my baby if I receive these vaccines?”

Background information for the practitioner:

Breastfeeding mothers can receive routine vaccinations. If traveling abroad, Yellow Fever vaccine cannot be administered to any mother breastfeeding an infant less than nine months old. See Appendix A for reliable medication information resources.

Talking Points:

- It is safe for nursing moms to receive routine vaccines. If traveling, Yellow Fever vaccine is incompatible with breastfeeding if the baby is less than 9 months old.
- It is particularly important that moms and dads (and all adults who will be around the baby) receive the influenza and Tdap vaccines. This helps decrease the risk that baby will get very sick from the flu or from whooping cough

Mother: “I need to get a cortisone shot in my shoulder. The specialist told me to ask you how much I can receive if I still want to nurse the baby”

Background information for the practitioner:

A dose up to 80mg of intrasynovial methylprednisolone can be given without significantly impacting human milk, according to Hale’s *Medications and Mothers Milk*.

Talking Points:

- I will provide your specialist with the dose of medication that is safe for nursing mothers.
- It is okay for you to additionally take ibuprofen (Advil, Motrin) and acetaminophen (Tylenol) for pain. It won’t harm your baby
- If your specialist prescribes any other medications, I would be glad to check my sources to make sure that they are compatible with nursing (most are)

Diet, Exercise and Cosmetics

Mother: “Does my baby need iron drops?”

Background information for practitioner:

The AAP Section on Breastfeeding has clarified that full term nursing infants do not routinely need iron supplementation. Iron in human milk is twenty times more absorbed by the infant gut compared to infant formula. Extra iron is added to cow milk when infant formula is manufactured, due to its poorer absorption in the human gut. Iron absorption in nursing babies is facilitated by breastmilk lactoferrin. Lactoferrin also functions as an anti-infective agent for the baby, as long as it isn't rendered ineffective by iron supplements. As an anti-infective agent, lactoferrin keeps iron-dependant pathogen colony counts down in the gut.

The best way to prevent iron deficiency in the first 6 months of life is delivery with delayed cord clamping. Iron supplements may be necessary in breastfeeding infants if there are conditions that place the infant at increased risk such as prematurity, low iron stores at birth and bleeding. Healthy breastfed infants can begin receiving iron supplements in the way of iron-fortified complementary foods beginning at six months of age.

Talking Points:

- For healthy full term breastfed babies, there is no need for infant iron supplementation because a product in human milk, called lactoferrin, allows iron in human milk to be 20 times more absorbed from the gut compared to infant formula. Lactoferrin also functions as an infection protector for the baby, as long as it isn't rendered ineffective by iron supplements
- At 6 months of age additional iron may be introduced in the form of iron-fortified foods.

Mother: “Does my baby need a vitamin D drops?”

Background information for practitioner

The American Academy of pediatrics recommends that breastfeeding infants receive 400 IU of vitamin D by giving supplemental vitamins beginning soon after birth.

Talking Points:

- Yes. The American Academy of Pediatrics recommends that nursing infants take 400 IU of vitamin D a day
- This does not represent a unique inadequacy. All commercial milk products, including infant formula, do not naturally have enough vitamin D as well. This is why cow milk, including infant formula, gets vitamin D fortified at the factory. An infant would need to ingest one liter of fortified formula or milk per day to meet the recommended dose of 400 IU per day. In a similar way, human milk gets D “fortified” when D drops are given separately to baby.

- The most available way to get vitamin D is in the form of a multi-vitamin drops, even though the other vitamins in these drops are unnecessary; however, separate vitamin D drops can be purchased in some stores or be ordered through the internet. The concentration varies between brands; therefore, parents should check the package for the appropriate volume that should be administered

Mother: “I’m a vegan. Do I have to do anything special with my diet?”

Background information for practitioner:

Vegetarian mothers who practice a vegan or macrobiotic diet can nurse their infants; however, these moms need vitamin B12 supplementation. The National Institute of Health’s Office of Dietary Supplements states that lactating women require 2.8 mcg of vitamin B12 a day.

Though mother’s milk quality will not suffer if she is deficient in calcium or zinc, the mom should take adequate calcium and zinc for her own health. The recommended daily calcium dose for adult nursing moms is 1000mg and 1300mg for teen nursing moms. The recommended daily dose of zinc for adult nursing moms is 12 mg and 13mg daily for nursing teen moms.

Talking Points:

- **Moms who practice a vegan or macrobiotic diet can breastfeed.**
Mothers should take a vitamin supplement that includes 2.8mcg of vitamin B12 a day
- **As with all nursing babies, 400 IU of vitamin D for baby is recommended**
- **There is no need for infant iron supplementation in full term babies because a product in human milk, called lactoferrin, allows iron in milk to be 20 times more absorbed from the gut when compared to infant formula. Lactoferrin also functions as an infection protector for the baby, as long as it isn’t rendered ineffective by iron supplements (see page 23 regarding iron requirements and special circumstances)**
- **All adult women, whether they are breastfeeding or not, require the standard 1000mg of calcium (1300mg for teen moms). Your baby will get enough calcium from your milk even if you don’t consume enough daily calcium, but you should make sure that you take in enough calcium for your own health. Alternative sources of calcium include either using a supplement or eating a balanced diet .**
- **Your baby will get enough zinc from your milk even if you are zinc deficient. However, for your own health, you should consider ingesting 12 mg of zinc a day if you are an adult nursing mom and 13 mg if you are a teen**

Mother: “I’m going to a wedding this weekend. Can I drink a glass of wine? What do I do with my milk?”

Talking points:

- **An occasional alcoholic drink (once or twice a week) is acceptable**
- **Yes, you may have one glass of wine or champagne. Here are the limits:**
 - 12 ounces of beer**
 - 4 ounces of wine**
 - 1 ounce of whiskey or hard liquor**
- **You can nurse your baby two or more hours after you have finished your alcoholic beverage .There is no need to “pump and dump” your milk because the alcohol will be out of the milk by then**
- **Despite the myth that beer promotes milk letdown, studies show that this is not true**
- **Milk test strips are unnecessary and have not been sufficiently studied**
- **You should avoid excessive drinking as this may impair your baby’s milk intake and may have harmful effects on brain development**

Mother: “Can I drink a cup of coffee?”

Talking Points:

- **One moderately potent cup of coffee or one cup of tea per day is safe for you to drink. If you want more, switch to the decaffeinated type for the rest of the day**
- **Most infants will show signs of jitteriness with consumption of 5 cups of coffee**
- **Remember that some sodas and occasionally medications (some pain medications, cold remedies and diet pills) also contain caffeine**
- **If your baby was born prematurely and has not reached his or her due date yet, hold off on caffeinated coffee or tea until this point in order to avoid jitteriness.**

Mother: “I am a cigarette smoker. Should I nurse?”

Talking Points:

- **Yes, you should still nurse, even if you haven’t been able to quit smoking cigarettes. Your baby will best maintain good health if he or she receives your milk. Your health will be better maintained now and in the future if you nurse.**
- **Nursing infants of smokers have less colds than infant formula fed infants of smokers**
- **Make sure that you smoke outside of your house or apartment so that the baby does not breath in the cigarette smoke (smoke travels from room to room even with the door shut)**

- Smoking after nursing rather than before nursing the baby is preferable but not mandatory
- If it has been too hard to quit, consider cutting down to help your own health
- Some women who smoke tobacco have problems with maintaining a good milk supply. You and I will monitor your baby's growth by checking output and weight in order to pick up on any issues early, should they arise.

Mother: "If I go on a diet, will it impact my milk?"

Talking points:

- A moderate diet where you lose 3-4 pounds a month will not impact your milk
- Don't decrease your dietary intake to less than 1800 calories a day
- Don't use weight loss medication
- Make sure that you eat a well balanced diet
- Stay away from fad diets

Mother: "Can I work out at the gym?"

Talking points:

- After receiving post-delivery approval from your obstetrician, you can and should exercise for your own health and well-being
- It is okay to nurse your infant after a workout. An occasional baby may notice a change in the taste of the milk, but most don't

Mother: "Can I color my hair if I am nursing?"

Talking Point:

Yes, you can color your hair. There is no evidence that hair dye affects your milk

Mother: "Can I straighten my hair if I am nursing?"

Talking Point:

Yes. There is no evidence that hair straightener causes problems with mother's milk. As a precaution, make sure that you don't have sores or scratches on your scalp.

Mother: "I want to get Botox on my forehead. Can I still nurse my baby?"

Talking point:

The amount of Botox used cosmetically is very unlikely to have any impact on mother's milk

APPENDIX A

MEDICATION AND LACTATION: RELIABLE SOURCES

Lactmed <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

Medications and Mother's Milk Tom Hale, PhD

Lactation Studies Center University of Rochester 585-275-0088

The transfer of Drugs and Other Chemicals Into Human Milk. AAP Committee on Drugs.
PEDIATRICS Vol. 108 No. 3 September 2001, pp. 776-789.

<http://aappolicy.aappublications.org/cgi/content/full/pediatrics;108/3/776>

Infant Risk Center, Texas Tech University, Health Sciences Center, (806) 352-2519 (Monday-Friday 8am-5pm Central Time)

APPENDIX B

Use of Radiocontrast materials in Nursing Mothers*

Radiocontrast Not Requiring Breastfeeding Interruption

Barium Sulfate (Anatrast, Baricon, Baro-cat, Barobag, Barosperse, Bear-E-Yum CT, Bear-E-Yum GI, Cheetah, Enecat CT Medescan, Enhancer, Entrobar, EntroEase, EnteroEase Dry, Epi-C, Flo-Coat, HD 85, HD 200 Plus, Imager ac, Intropaste, Liqui-CoatHD, Liquid Barosperse, Medebar Plus, Prepcat, Tomocat, Tonopaque)

Gadolinium-containing Radio-Contrast Agents

Gadobenate (MultiHance)
Gadodiamide (Omniscan)
Gadopentetate (Magnevist, Magnevistan, Magnograf, Viewgam)
Gadoteridol (Prohance)
Gadoversetamide (Optimark)

Iodinated containing radiopaque medium (Ionic and Nonionic)

Diatrizoate (Angiovist, Cardiograf, Cystograf, Ethibloc, Gastrovist, Hypaque, Reno-30, Reno-60, Reno-Dip, Reno-M, Retrograf, Sinograf, Urovist)
Iodipamide (Cholograf, Sinograf)
Iodixanol (Visipaque)
Iohexal (Accupaque, Myelo-Kit, Omnigraf, Omnipaque, Omnitrast)
Iopamidol (Gastromiro, Iopamiro, Iopamiron, Iopasen, Isovue, Isovue-M, Jopamiro, Niopam, Pamiray, Radiomiron, Scanlux, Solustrast)
Iopanoic acid (Biliopaco, Cistobil, Colegraf, Colepak, Neocontrast, Telepaque)
Iopromide (Colegraf, Proscope, Ultravist)
Iothalate (Angio-Conray, Conray-30, Conray-43, Conray-60, Conray 325, Conray-400, Cysto-Conray, Cysto-Conray II, Vascoray)
Ioversol (Optiject, Optiray)
Ioxaglate (Hexabrix, Hexabrix 160, Hexabrix 200, Hexabrix 320)
Ioxitalamic acid (Telebrix)
Metrizoate (Angiocontrast, Isopaque)
Metrizamide (Amipaque)

Radiocontrast Agent Requiring Interruption

Mangafodipir Trisodium (Teslascan) Interrupt breastfeeding for 4 hours followed by pumping and discarding milk once

*See Appendix A to obtain additional information on radiocontrast material