

---

## OBSTETRIC GUIDELINES

---

**SUBJECT:** Breastfeeding for the Term Newborn

### **OBJECTIVES**

To establish the caregiver role for the promotion and support of breastfeeding mothers and their infants

To assure that all families understand the benefits of breast feeding

To facilitate a successful experience for those who elect to breastfeed.

#### **2010 Target and 1998 baseline percentages:**

<b>Objective</b>	<b>Increase in Mothers Who Breastfeed</b>	<b>1998 Baseline (percent)</b>	<b>2010 Target (percent)</b>
16-19a	In early postpartum period	64	75
16-19b	At 6 months	29	50
16-19c	At 1 year	16	25

### **POSITION STATEMENTS**

Breastfeeding is the infant feeding method of choice, however an individual woman's feeding choice is to be respected by all health care providers:

- It decreases the incidence of diarrhea, upper respiratory tract infections, some allergies, and otitis media.
- It promotes bonding and uterine involution and inhibits bleeding due to increased oxytocin secretion.
- It is considered by many to be economical and convenient.

Promotion of breastfeeding is a responsibility of both the nursing and the primary care provider staff.

Women choosing not to breastfeed will be supported in their decision accompanied by thorough education and counseling on the range of infant feeding options.

## OBSTETRIC GUIDELINES

---

The American Academy of Pediatrics recommends breast feeding whenever possible for the first year of an infant's life.

### **DEFINITIONS**

#### **Contraindications to Breastfeeding**

There are very few circumstances when a mother should NOT be encouraged to breastfeed. Examples include:

- Mother is positive for HIV.
- Mother has active, untreated tuberculosis
- Mother and/or her infant have a positive urine or serum toxicology for an illicit drug/substance.
- Mother admits to using or has a known history of illicit drug(s) or alcohol use during pregnancy in the absence of a recent toxicology level.
- The mother is taking medications that are contraindicated with breastfeeding due to their potential toxic effect on the baby. The medications that are of greatest concern are the following:
  - Radioactive isotopes
  - Anti metabolites
  - Cancer chemotherapy agents
  - A small number of other medications. The safety of medications should be verified as to their effect before discouraging a mother to not provide milk for their baby.
- The infant with galactosemia.
- Tobacco smoking by mothers is not a contraindication to breastfeeding, but health care professionals should advise all tobacco-using mothers to avoid smoking within the home and to make every effort to wean themselves from tobacco as rapidly as possible.
- Breastfeeding mothers should avoid the use of alcoholic beverages, because alcohol is concentrated in breast milk and its use can inhibit milk production.

## OBSTETRIC GUIDELINES

---

### PROCEDURE

#### **I. The Prenatal Period**

- A. All pregnant patients should receive information on infant feeding and the benefits of breastfeeding during the prenatal period. Women who initially are undecided about or who initially decline breastfeeding as their method of feeding should be offered breast feeding information at a later point in the pregnancy.
- B. Educational materials on breastfeeding will be provided during antepartum clinic visits and following birth (well before discharge). This provides a consistent message and the mother can refer to materials to reinforce learning.

#### **II. The Postpartum Period**

- A. Infants are to be put to the breast as soon after delivery as feasible for both mother and infant. Twenty minutes post birth is the ideal goal for the initiation of breastfeeding and the optimal range falls within the first two hours of life. This includes alert and stable cesarean patients. The sucking reflex is strongest 20 - 30 minutes after birth. Delaying gratification can make it difficult for the infant to learn the sucking process later. The infant promptly receives the immunologic benefit of colostrum.
- B. Every mother should be instructed in proper infant feeding techniques. Teaching will include, but is not limited to: positioning, frequency and length of feedings, care of the breast and nipples, prevention of common problems (engorgement and sore nipples), quantity of milk, breast milk storage, use of medications, rest and nutrition. Teaching will also include infant voiding and stool patterns as well as growth spurts. The nurse shall document patient teaching and the teaching materials given to the mother.
- C. The nurse shall observe at least one breastfeeding per shift. The following assessment factors should be documented in the medical record
- D. Breastfeeding is an infant-led activity.
  - 1. The infant should feed on demand [typically 10-12 times in 24 hours, which is every 1-3 hours]. Breast milk digests in 90 minutes. Eight feedings per 24 hours is associated with increased passage of meconium and decreased bilirubin levels.

## OBSTETRIC GUIDELINES

---

2. The breastfeeding infant should **not** routinely be given supplementation of formula. Preterm or medically compromised infants may need additional nutritional support during the colostrum phase of milk production. Colostrum and breast milk can completely meet the nutritional and fluid requirements (provides 17-20 cal/oz) of the full term infant. Encouraging supplementation communicates to the mother that her milk production is inadequate. The wishes of Mothers adamant about supplementation despite educational attempts must be supported.
3. A baby who is latched on properly should nurse on at least one breast for 15-20 minutes or longer, until the baby is satisfied. The mother can then offer the other breast, however, if the baby is not interested, begin the next feeding with that breast.
4. Infants of diabetic mothers, small for gestational age (SGA) and large for gestational age (LGA) infants can breastfeed. Follow the individual protocols that apply to each situation. If the infant becomes hypoglycemic, notify the MD and the feedings will be evaluated.
5. All breast feeding mothers who are experiencing challenges to nursing, i.e., baby in the nursery, cesarean section, postpartum hemorrhage, perineal trauma or increased pain, etc, should be assisted with breast pump usage to facilitate milk production, and to provide breast milk to the baby.
6. If breastfeeding is ineffective within 24-48 hours, the mother should pump her breasts and feed the colostrum/milk to her baby. Care providers should continue to support the mother and infant's attempts to breastfeed. This support is crucial to the eventual success of the breastfeeding couplet.
7. Mothers who wish to breast and bottle feed should be encouraged to breastfeed without supplementation for at least two weeks. Exclusive breastfeeding during the first two weeks aids in the establishment of an adequate milk supply. Three to four weeks is the recommended earliest age to introduce the bottle. A slower flow nipple is recommended for infants who are breastfeeding and also taking some feeds by bottle.
8. The use of pacifiers is recognized as a patient preference however, the patient should be informed of evidence that pacifier use has been associated with early weaning.

## OBSTETRIC GUIDELINES

---

9. Bottles of formula and pacifiers will not be placed with or offered to a breastfeeding mother unless she indicates a desire, and assistance in breast feeding has been provided.
10. Mothers who are separated from their infants will be instructed on the proper use of the breast pump, storage and transportation of breast milk.
11. Care of nipples/breasts and signs of adequate feeding should be reviewed with the mother prior to discharge. Nipple/breast soreness should be evaluated whenever the mother complains of nipple/breast pain throughout the entire feeding or between feedings.

### IV. Post Hospital Discharge

- A. All breastfeeding infants should have their first checkup within 48-72 hours after discharge.
- B. A manual breast pump should be made available to all breastfeeding patients because of need for flexible solutions to feeding issues/engorgement.
- C. After discharge, mothers are instructed to call the Lactation Consultant or baby's health care providers if she needs assistance with breastfeeding after discharge:
  - *Lactation Consultant non-emergency voice mail: (312) 413-0233*
  - *All urgent concerns: **Mother should call the baby's care provider***

**LACK OF URINE OR STOOL FOR > 12 HOURS: CONTACT PEDIATRICIAN**

### A Comparison of Breast Conditions

OBSTETRIC GUIDELINES

Condition	Definition	Erythema	Skin Temperature	Edema of Skin	Description	Systemic Symptoms	Fever	Pain	Unilateral vs Bilateral	Other
Breast fullness	The breast is full of milk but without obstruction of venous or lymphatic drainage, and the milk flows readily with suckling or pumping.	No	Occasionally increased	No	Firm, heavy	No	No	No	Usually bilateral	Occurs between postpartum days 3-5 when the "milk comes in"
Engorgement	The breast is "engorged" with milk and there is obstruction of venous and lymphatic drainage, which impedes the flow of milk with suckling or pumping.	Bilateral	Generalized warmth	Yes	Hard, enlarged, shiny	May have "milk fever"	<38.4°C	Yes, generalized	Usually bilateral	Often confused with breast fullness
Blocked ducts*	The breast has an area of localized milk stasis.	Often over a palpable lump	Little or no heat	No	Single lumpy area	Unlikely	Unlikely and if present <38.4°C	Tender or pain is localized	Usually unilateral	May occur with a painful white bleb on the nipple†
Galactocele	A milk-retention cyst that is thought to result from a plugged duct.	No	No	No	Smooth rounded swelling	No	No	No	Usually unilateral	Compression of the cyst may cause milky fluid to exude from the nipple
Noninfectious mastitis†	Secondary to ineffective and/or obstructed drainage of milk from the breast.	Yes	Warm to hot	Yes	Hard, usually wedged shaped	Yes in 50-66% of women	Mild, <37.5 °C acute, >37.4°C- <38.5°C; hyperacute: >38°C	Yes, localized	Usually unilateral	See note§

OBSTETRIC GUIDELINES

Condition	Definition	Erythema	Skin Temperature	Edema of Skin	Description	Systemic Symptoms	Fever	Pain	Unilateral vs Bilateral	Other
Infectious mastitis	Results from untreated milk stasis and/or colonization with pathogenic bacteria.	Yes, usually but not always	Warm to Hot	Yes	Hard, usually wedged shaped	No in 33%-50% of women	Mild, <37.5 °C acute, >37.4°C- <38.5°C; hyperacute: >38°C	Usually	Usually unilateral but may be bilateral	See note <sup>§</sup>
Breast abscess	A localized area of infection which has formed a barrier of granulation tissue.	Yes	Hot	Yes	Swollen lump, possibly fluctuant	May or may not be present		Severe	Often unilateral but may be bilateral	In neglected cases the skin may be discolored with necrosis

Sources: World Health Organization, 2000<sup>[2]</sup>; The Academy of Breastfeeding Medicine, 2002<sup>[3]</sup>; Riordan et al., 2005<sup>[15]</sup>; Lawrence et al., 2005<sup>[17]</sup>; Fetherston et al., 2006<sup>[16]</sup>; Newman et al., 2003.<sup>[2]</sup>

\*May be referred to as "focal breast engorgement," "caked breast," or "plugged duct."

†Also termed obstructive mastitis

‡The bleb may be opened up with a sterile needle to relieve discomfort.

§The clinician cannot reliably differentiate noninfectious mastitis clinically from infectious mastitis. Treat with antibiotics if mother is toxic/acute ill, there are severe or bilateral symptoms, there are nipple fissures, or symptom resolution does not occur within 12 to 24 hours of improved milk removal.

OBSTETRIC GUIDELINES

**Treatment Options for Various Causes of Breast Inflammation**

Disease	Antibiotics	Antifungal*	Other Therapy
Blocked duct/nipple blebs	Mupirocin 2% ointment (not cream) if blocked pore (bleb) opened.	Only if recurrent or persistent culture nipple, areola, milk, and bleb if present. Rx with fluconazole (Diflucan) 200-400 mg STAT followed by 100-200 mg qd x 2-3 weeks or until blocked duct has resolved for one week.†	If no improvement in 24-48 hours, order therapeutic ultrasound 2 watts/cm <sup>2</sup> , continuous, for 5 minutes daily up to 2 days to affected region. Lecithin 1 Tb qd or 1200 mg tid to qid can be used to prevent or treat recurrences. Lecithin can be rubbed into a bleb to soften. If recurrent, suggest limited intake of saturated fats and ↑ rest.
Noninfectious mastitis	Rx as infectious if symptoms don't resolve in 12-24 hrs.	No	Hot compresses, massage affected area, frequent milk removal on affected side.
Infectious mastitis	1. Dicloxacillin (Dynapen) 500 mg qid x 10-14 days or cephalixin (Keflex) 500 mg qid x 10-14 days. If PCN allergic use clindamycin 300 mg qid or erythromycin 250 mg or 500 mg qid x 10-14 days.	If indicated based on cultures or the development of burning breast pain.	Rx as above for noninfectious. Cultures of milk and nipple indicated for acute illness, failure to respond to treatment, high suspicion of MRSA, bilateral mastitis. Infant may need to be treated concurrently particularly if Group A or B streptococcus suspected.
Recurrent mastitis	Culture and treat as appropriate for 14-30 days	Culture and treat as appropriate for 14 -30 days.	Low dose erythromycin or clindamycin may be given on a daily or weekly basis. Consider cultures and treatment with nasal mupirocin (Bactroban) if <i>S aureus</i> carrier state suspected.
Ductal infections	Culture and treat as appropriate for at least 14 days. May be prudent to treat until symptoms resolved for at least 1 week. Can start empirical Rx with clindamycin 300 mg qid or sulfamethoxazole-trimethoprim (Bactrim DS) bid.	Rx with antifungals if any signs of yeast on infant. Fluconazole (Diflucan) 200-400mg STAT followed by 100-200 mg qd x 2-3 weeks or until symptoms resolved x 1 week. Ketoconazole (Nizoral) may also be used.	Sterilize any object that comes in contact with maternal breast, breast milk or infant mouth (i.e., pumping parts, bottles, pacifiers, toys). Consider other family members as carriers if yeast recurrent.
Nipple infections	Mupirocin 2% ointment (not cream): 15 g. If no improvement culture and treat based on sensitivity results or treat empirically for yeast or consider other etiologies. Apply mupirocin or polymyxin (Bacitracin) after each nursing or pumping.	<ul style="list-style-type: none"> <li>Neonate: Nystatin (Nilstat) 100,000 units/mL. Swab inside of infant's mouth with 1 mL qid. 2 mL qid for older infants. Have infant drink what is left.</li> <li>Maternal: Nystatin (Nilstat) suspension or cream, apply topically s/p each nursing. Gentian violet 1% in 10% alcohol can be applied to the infant's mouth with a Q-tip before feeding so the mother's nipple will be coated during the feeding. Use qd x 4 days. Extend to 7 days if improvement, but no resolution. Clotrimazole cream, apply after each feeding/pumping and rub in well.</li> </ul>	The following topical Rx, Dr. Newman's All purpose nipple ointment (APNO), will Rx bacterial and yeast infections. APNO is compounded and contains: 1) Mupirocin 2% oint: 15 g; 2) Betamethasone 0.1% ointment (not cream): 15 g; 3) Add miconazole powder to formulate a final concentration of 2% miconazole. If unavailable substitute clotrimazole powder added to a final concentration of 2%. Sparingly apply APNO after each feeding and use until nipple soreness has dissipated.
Abscess (Puerperal)	<ul style="list-style-type: none"> <li>Outpatient: Dicloxacillin (Dynapen) 500 mg po qid x</li> </ul>	If indicated based on cultures or the development of burning breast pain.	I & D or use ultrasound guided needle for aspiration. Send aspirate or discharge for culture. Infants may continue nursing on

---

## OBSTETRIC GUIDELINES

---

	<p>10-14 days or clindamycin (Cleocin) 300 mg po qid.</p> <ul style="list-style-type: none"><li>• Inpatient: Nafcillin or 2.0 g q 4 hours IV or cefazolin 1.0 g q 6 hours IV or vancomycin 1.0 g q 12 hour IV.</li></ul>	<p>affected side unless the area of incision involves the areola. May treat infant concurrently if <i>S aureus</i> and should treat if Streptococcal disease present.</p>
--	--	---

BID = twice daily; IV = intravenous; MRSA = methicillin-resistant Staphylococcus aureus; po = orally; qid = four times daily; q = every; qd = every day; TID = three times daily.

Sources: World Health Organization, et al., 2000<sup>[2]</sup>; The Academy of Breastfeeding Medicine, et al., 2002<sup>[3]</sup>; Betzold, 2004<sup>[12]</sup>; Riordan, et al., 2005<sup>[15]</sup>; Fetherston, et al., 2006<sup>[16]</sup>; Lawrence, et al., 2005<sup>[17]</sup>; Newman et al., 2003.<sup>[27]</sup>

\*If *Candida* is suspected or diagnosed, mother and infant must be treated concurrently even if one is asymptomatic.

†Consider undiagnosed maternal IgA deficiency.

### References

1. American Academy of Pediatrics. (1997). Breastfeeding and the use of human milk. Pediatrics, 100, 1035-1039.
2. AAP & ACOG. (2002) Guidelines for Perinatal Care, 5<sup>th</sup> Edition. P 220-235.
3. Lawrence, R. A. (1999). Breastfeeding: A guide for the medical professional, 5<sup>th</sup> Edition. Mosby: St. Louis.
4. Riordan, J., Auerbach, K. (1999). Breastfeeding and human lactation. Jones & Bartlett: Boston.
5. Simpson, K. & Creehan, P. (2001) AWHONN Perinatal Nursing. Lippincott, New York. P 550-574.
6. World Health Organization 2000 Website. Mastitis: Causes and management. Geneva, Switzerland: Department of Child and Adolescent Health and Development; 2000.
7. The Academy of Breastfeeding Medicine Website. Clinical protocol number 4: Mastitis. Available from: [www.bfmed.org/ace-files/protocol/mastitis.pdf](http://www.bfmed.org/ace-files/protocol/mastitis.pdf) [Accessed September 10, 2006].
8. Betzold CM. Infections of the mammary ducts in the breastfeeding mother. J Nurs Pract. 2005;1:15-21.
9. Riordan J. Breastfeeding and human lactation. 3rd ed. Sudbury, MA: Jones and Bartlett Publishers; 2005.

11/07

Page 10 of 11

---

## OBSTETRIC GUIDELINES

---

10. Fetherston C, Lai C, Hartmann P. Relationships between symptoms and changes in breast physiology during lactation mastitis. *Breastfeed Med.* 2006;1:136-145.
11. Lawrence RA, Lawrence RM. *Breastfeeding: A guide for the medical profession.* 6th ed. St. Louis, MO: Mosby; 2005.
12. Newman J, Pitman T. Dr. Jack Newman's guide to breastfeeding. revised edition. Toronto, Ontario, Canada: HarperCollins Publishers Ltd; 2003.

11/07

Page 11 of 11

---

OBSTETRIC GUIDELINES

---

---

Isabelle Wilkins, MD  
Director of Maternal Fetal Medicine  
Professor of Obstetrics & Gynecology

---

Patricia Hannon, MD  
Director of Pediatric Newborn Service  
Associate Professor of Pediatrics

---

Date

---

Date

---

Patrice Perez, RN, IBCLC  
Lactation Consultant

---

Beena Peters, MS, RN  
Associate Hospital Director  
Women's & Children's Health Services

---

Date

---

Date

---

Diana Tirol, RN, BSN  
Administrative Nurse Manager  
Women's Family Health Services

---

Date