Frequently Asked Questions

A survey sent to the Section on Breastfeeding, Section on Administration and Practice Management, and Section on Early Career Physicians reveled the below frequently asked questions about breastfeeding care.

Please note, this FAQs page is NOT official AAP policy. See the latest AAP policies on breastfeeding here.

If a breastfeeding parent is taking medication for a condition, can they still breastfeed, or should I recommend that they stop breastfeeding or "pump and dump" their supply?

Many medications are safe while breastfeeding and there are excellent resources available based upon current research. There are rare circumstances in which breastfeeding should be discontinued. Cessation of breastfeeding could cause

potential harm to the mother and infant; therefore, careful consideration should be taken before making a recommendation to stop breastfeeding. Clinicians must consider several factors: the benefit the medication will give to the mother, the risk of the medication to the baby, and the risk of the medication to the maternal milk supply. The most accurate sources of information to aid clinicians about medications in breastfeeding mothers are located below. These references consider infant characteristics and drug characteristics that predict transfer into milk (Molecular weight, pKa, protein binding, lipid solubility, etc.) bioavailability, as well as infant characteristics.

- The National Library of Medicine's Drugs and Lactation Database, **LactMed**, is a searchable database of drugs and other chemicals to which breastfeeding mothers may be exposed. It is updated monthly
- Dr. Thomas Hale's "Medications and Mother's Milk", Reference book published bi-annually
- Infant Risk Center at Texas Tech University Hotline
- **MothertoBaby.org Fact Sheets** are quick and easy information on 250+ exposures (medications, cosmetics, infections, etc) and how they may impact breastfeeding
- **Clinical Report: The transfer of drugs and therapeutics into human milk: an**

What if the breastfeeding parent experiences low supply? What factors should I consider as a clinician? Is there anything the breastfeeding parent can do?

There can be many reasons why a breastfeeding parent has a low milk supply. Difficulties with latch and milk transfer are the most frequent reasons for low supply in the early days of breastfeeding; however, the reasons can vary depending on when the issue is detected and include problems with:

- Latch
- Excessive blood loss
- Hormonal problems
- Medications
- Prior breast surgery
- Insufficient breast glandular tissue

The best way to avoid problems with milk supply is to establish good breastfeeding immediately after birth. Early initiation of breastfeeding after birth, frequent breastfeeding (i.e., 8-12 times in a 24-hour period), and effective removal of breast milk helps establish breastfeeding. Breastfeeding dyads should have their latch and positioning techniques evaluated by a healthcare provider skilled in supporting breastfeeding. Breastfeeding evaluation should occur prior to discharge from the birth facility and again in the first 2-3 days after discharge. In addition to ensuring that the latch and positioning are appropriate, the clinician should take a thorough medical history, including the mother's previous breastfeeding history, and perform a breast exam to ensure that there are no other factors at play.

After a thorough assessment, if the latch and milk transfer do not seem to be the issue, the breastfeeding parent can express milk by hand or with a pump to

increase supply. To increase supply, the breastfeeding parent can breastfeed during both daytime and nighttime and avoid the use of formula

What resources can I link my breastfeeding patients to?

There are many great resources to connect your breastfeeding patients to:

- **Firstdroplets.com**
  Free, short, informative videos available in English and Spanish.
- **KellyMom.com**
  Website featuring breastfeeding, pregnancy, and parenting resources
- **#EncuentroDeMiVida** (I Find My Life)
  Website for Spanish speaking families
- **MommyMeds App**
  Free patient-focused website through Texas Tech
- **HealthyChildren.org**
  Vast library of **articles on breastfeeding** from AAP experts designed to help families become more informed and find answers to common breastfeeding questions
- **New Mother's Guide to Breastfeeding**
  Breastfeeding book for mothers, available for purchase
- **GlobalHealthMedia.org**
  Free, educational videos specifically to improve health care in resource-poor areas.

What are the milk storage guidelines?

Guidelines for milk storage can be confusing. Many common recommendations are not evidenced-based or practical, differ for term and preterm infants, and can lead to families wasting precious milk.

- **Containers.** Mothers should aim for cleanliness but realize milk is a biologic substance and full of probiotic and commensal bacteria. Hand washing, using clean or new containers, minimizing milk transfers (which waste fat and calories), and pumping directly into storage containers are recommended. Plastic or glass containers are fine, no evidence supports one over the other.
- **Cold storage.** Milk has biology that leads it to maintain its nutrient value and discourage bacterial growth when kept at room temperature or in the refrigerator. Raw milk likely has better biology than frozen with intact milk fat globules and maternal cells. After 4 hours at room temp or 4 days in the refrigerator it may be best to freeze milk for long term storage. Milk is generally considered safe for feeding for up to 12 months of freezer storage. The colder the freezer temperature the better and the less exposure to high temperatures the better. A deep freezer is better than the door of a standard freezer.
- **Free fatty acid build up.** Human milk contains lipases that continue to break down triglycerides even in frozen milk. These free fatty acids (FFA) can give the milk an unpalatable taste, but cause no GI upset, no additional bacteria, or altered nutrition. Some babies however will reject the taste of the milk, others do not seem to care. Keeping the milk colder may help slow down the

process, and mothers can consider a mini pasteurization or scald step after expression but before freezing expressed milk. Lipase is very heat sensitive and will be eliminated thus preventing the FFA build up and frustration over lost milk due to taste alone. While heating may alter some of the biology of

What considerations for breastfeeding does COVID-19 pose?

Breastfeeding can be challenging, especially for mothers with symptomatic COVID-19 infection. Breastmilk, with its factors that decrease infections and inflammation, is especially important to prevent and decrease infections in infants.

- Mothers, even those who are positive for COVID-19, can be supported to initiate breastfeeding by orchestrating immediate skin-to-skin contact followed by direct breastfeeding and rooming-in. Precautions such as wearing a mask and adhering to strict hand hygiene should be practiced.
- Mothers or their newborns that are too sick to directly breastfeed or room-in should be encouraged to express milk to provide for their infants.
- There is no reason to discharge the dyad early from the birth hospital. Before leaving the hospital, breastfeeding should be assessed and referrals for community support should be provided.
- After leaving the hospital, breastfeeding should be re-assessed by a knowledgeable clinician who can monitor for hyperbilirubinemia, adequate milk transfer, weight gain, and any maternal issues.
- Community support, with referrals to support groups, should be encouraged.

- While there have been no studies documenting the safety of vaccinating breastfeeding or lactating individuals against COVID-19, there is a low likelihood that there would be adverse events. In addition, there are reasons

How can I help breastfeeding parents who are going back to work? How can I support breastfeeding parents who are facing barriers from their employer?

Returning to work is a stressful transition for all mothers and the pediatrician can be both an emotional and practical support. The following tips have been adapted from *Breastfeeding Telephone Triage and Advice* (4th Edition):

1. **Empower and encourage meeting with supervisor:** This is good time to empower the breastfeeding parent to advocate for milk expression with their supervisor. Federal legislation requires employers to have a private cubicle or office (not a bathroom stall) and to accommodate reasonable break times for pumping milk. Working from home or part-time may also be an option.
2. **Assist with getting a good pump and resealable storage bags:** Double-sided electric breast pumps are best, provided by insurance company or WIC.
3. **Setting up breastfeeding system before starting the workday:** Setting up the pump system in advance saves time that can be used for pumping.
4. **Review good handwashing and cleaning of parts:** Wash hands before pumping, parts should be cleaned after pumping, and parts should not be placed directly in the sink.
5. **Personal cooler is best choice for human milk storage:** It is safer to store milk in a cooler than in a community-used refrigerator. Human milk will keep for 8

hours in a cooler with an ice pack.

6. **Use rule of 4s:** General guidelines for milk storage are 4 hours at room temperature, 4 days in refrigerator, and 6 months or longer in freezer. Thawed frozen milk should be used within 24 hours.
7. **Eat fresh:** Fresh or refrigerated human milk is better than frozen (to help keep immune properties intact). If freezing milk, it should be done as soon as possible after pumping. Milk should be thawed in hot water and never reheated in the microwave.
8. **Pumping in the morning is best for stockpile:** Pumping first thing in early morning (after first feeding; wait 1 hour) to have an extra supply.

When babies are not gaining weight adequately on breastfeeding alone in the first few days of life, how much additional supplementation of pumped breastmilk or formula does the infant need?

When babies are not gaining weight adequately or are losing too much weight in the first few days (ie either not following a typical weight curve or plotting >75% or 95% on NEWT curve found at www.newbornweight.org),

- The first question to ask is whether the weight loss is a problem of inadequate milk production or ineffective transfer of milk.
- If milk production appears to be adequate, the infant should be examined, the latch and comfort of the mother should be evaluated, the contour of the

nipple should be assessed, and a feeding should be attempted at the breast to assess the ability of the baby to latch and transfer milk at the breast.

- If the breastfeeding parent is experiencing nipple pain or compression with latching, it is likely that the infant will not transfer milk effectively. The compression of the nipple may impede the flow of the milk ducts. The breastfeeding parent may need assistance with achieving an asymmetric latch with the infant's lower lip far away from the nipple (at the areolar border) and their nipple near the infant's nose and pointing up to the roof of the infant's mouth. This will help ensure both comfort and effective milk transfer. It is often helpful to have the breastfeeding parent hand express milk before the baby latches and/or perform breast compression while the baby is at the breast to maximize milk transfer.
- If the latch and suck is comfortable and effective and there is no evidence of milk transfer (ie no audible swallows, or lack of settling or comfort after the feeding attempt), production may be inadequate. The first step may be to instruct the breastfeeding parent to start hand expressing or pumping milk to increase the signal to their body (as an ineffective latch may have been limiting signal). The expressed milk will increase their supply and feeding the expressed breast milk to the infant will maximize intake. Supplementation with donor milk or formula may be considered if production is less than the infant's intake needs. Breastfeeding individuals should express milk each time the infant receives supplementation to maintain signaling and production (at least 8 times in 24 hours if the baby is not feeding at the breast). Suggested intakes for healthy, term infants are given below.

Average Reported Intakes of Breastmilk in Healthy Term Infants

Age (hours): Intake (ml/feed)

≤24 hours: 2-10ml

24-48 hours: 5-15ml

48-72 hours: 15-30ml

72-96 hours: 30-60ml

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Source American Academy of Pediatrics