

Assessing suck and tongue movements – Catherine Watson Genna

Cathy went over oral anatomy and I was reminded how the tongue muscles interdigitate. If the frenulum goes *into* the tongue, baby will have more trouble after frenotomy. She didn't talk exclusively about tongue-tie, but I found that the most useful information from the session.

In evaluating tongue mobility, check with the mouth wide open.

- Tongue lift – usually when baby is crying the tongue is up as far as possible. Should be able to lift at least halfway to the palate.
- Extension/protrusion – touch the middle of the outside of the gum ridge, tongue should be able to extend well over the gum ridge. Needs to be able to stay over the gum ridge during sucking.
- Lateralization – touch the sides of the outside of the gum ridge (not the top) – tongue should move sideways toward your finger without flipping up on the side away from your finger.
- If baby can't keep his tongue over the gum ridge on your finger, he's not going to be able to breastfeed.
- May also note: sucking blister, very bowed upper lip (cupid's bow), bunched tongue, furrow in the tongue; a very short jaw will accentuate a tongue-tie.

If baby is tongue-tied, this limits the movement of the hyoid bone, which is attached only to muscles. Some babies can't open wide enough, some open too wide so that the back of the tongue pulls the front off the breast. Blanching of the tongue or gumline is also abnormal.

She described the "Murphy Maneuver" to assess the insertion point of the frenulum – press the frenulum from the front in the midline and observe where the tongue dips down.

If baby is swallowing fast he's swallowing small amounts; if you're seeing deep, slow sucks he's swallowing lots.

Cathy also mentioned using large nipple shields for babies with respiratory problems to pull in as much breast as possible. 24mm, or a German company makes 28mm nipple shields: Mamivac by KaWeCo.

Techniques with large, voluptuous breast tissue – Angela Smith and Decalie Brown

Handout: Breastfeeding With Large Breasts: www.breastfeeding.asn.au/bfinfo/large.html

Other useful tips:

- Positioning baby in mother's lap so that she has both hands to support the breast.
- Using a small mirror to help with latch if mom can't see her nipple.

- Using a scarf to lift and support the breast – just needs to be tied the first time so it’s the right length and after that can just flip it over her shoulder.
- Using a twin pillow to support both breast and baby.
- Need to be concerned about the weight of the breast if it’s on baby’s chest.
- Reverse pressure softening and/or teacup hold (wedge of skin at the corner of baby’s mouth) if nipples are flat.

Identifying and remediating sore nipples – Barbara Wilson-Clay

Primary causes of sore nipples:

- Early, expected hormonal changes increase nipple sensitivity – heightened sensitivity due to increased prolactin after delivery. Nipples do not “toughen up.”
- Suction lesions.
- “Fit” issue (size disparities between infant mouth and maternal nipple).
- Basic positioning and latch issues.
According to the literature, postpartum women have more vulnerable skin and somewhat depressed immune systems.

Secondary causes of sore nipples:

- Infection (bacterial, fungal, viral) – baby should be handed directly to mother after birth so he gets colonized with her bacteria. If baby has thrush, mom should rinse her nipples after feeding.
- Dermatoses (contact, autoimmune).
- Pump trauma – flange size issues, inappropriate suction levels.
- Vasospasm.

Communicating with other care providers (since many of the causes need medical intervention):

- Reports should specifically describe what we’re seeing rather than diagnose.
- Help the mother with more effective communication with her care provider – use pain scales, describe clearly what is going on and how long it’s been happening, help her seek a second opinion when appropriate.

Nipple vasospasm tricks and treatments – Diana West

She described and demonstrated the color changes associated with vasospasm.

- Nipple or the tip of the nipple blanches or turns white.
- May turn blue or purple or red as the circulation returns before nipples return to their normal color.

The pain ranges from minor discomfort to severe pain, and is worse with cold. Pain may be described as burning or throbbing.

Causes:

- “Poor circulation,” family history of Raynaud’s phenomenon.
- Injury – nipple damage from poor attachment or from thrush.

Treatment options:

- Avoiding triggers – keep nipples warm, don't expose them to cold air. Showed breast warmers from Australia that reflect body heat: www.simplesolutions-int.com.au
- Nifedipine – lowest dose usually works.
- To stop an attack - get behind the nipple with your fingers, pinch and pull forward and hold until the pain eases, at least a minute.

Integrating the new latching information – Diane Wiessinger

Diane talked about Suzanne Colson's work and how we are now learning that babies latch by feel and not by sight – touching the lip and keeping the breast away is like blindfolding us and touching a spoon to our lip and trying to find the food. It's more likely that babies find the breast by "cheek sweep." If baby is on mom's chest, he'll have his head turned—when his cheek touches the breast and he roots, he turns toward the nipple with his mouth open and latches. She talked about how mothers her age (and mine) typically held their babies on their backs so they had to turn their heads to latch on – and they usually did! Even though the on-the-back-with-the-head-turned wasn't a great way to position babies, it did seem to elicit rooting, cheek sweep, and latch.

From her abstract: "Higher primates are a mainly vertical species, designed to squat and therefore to have a "long waist," and preferring en face connection with their young. For each of these reasons, they tend not to hold their babies horizontally for feeding. Their lower jaw recedes, requiring head extension for a wide-open mouth. As "carry species," they feel positionally stable when their ventrum is in full contact with their mother."

"Positional stability is important to virtually all newborn mammals. When gravity works with it, the baby has full frontal contact with his mother and/or surrounding surfaces, his hyoid is stabilized, he is able to reach with his mandible, his rooting reflex is stimulated, the head is brought back to the breast with each head bob, and flailing is virtually eliminated."

How to size pump flanges – Dee Kassing

Dee described how she offers flange fitting as part of her private practice. She finds that mothers may need a different size or even a different brand for each breast (ex. Medela for one breast, Pumpin' Pal for the other). Pumpin' Pal flanges need to be centered left to right, but the nipple may need to be closer to the top or the bottom to pump most effectively.

Her clues that the current flange may be incorrect:

- Pain when using pump at highest suction level
- Breasts obviously not drained after pumping
- Condensation in the tubing