ILCA Report
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Anne Altshuler

General Information:
There are 21,203 IBCLCs worldwide today in 83 countries. 5,289 are ILCA members.
USLCA: 3,952 members as of 7/15/10. (More joined since).
Member benefits include low cost liability insurance ($109 per year), also available for LC students.
Future plans: On-line IBCLC exam application and recertification.
Eventually, an on-line exam.
Next ILCA conference is in San Diego, July 13 – 17, 2011.
In 2013 ILCA Conference will be in Melbourne, Australia. USLCA will host a conference in the US that year.
New quarterly Clinical Lactation Journal will be launched October/November, with Kathleen Kendall-Tackett as editor.
Jane Heinig will retire as editor of the Journal of Human Lactation December 31, 2011.
ILCA needs to cut costs following a $230,000 loss. Dues have not been raised since 2004. Will have to raise Group A members (US, Canada, etc) by 9%.
Will make a new membership category for students. And a new membership category for retired LCs age 65 and older.

Track 4: Early Problem Solving
Date: Sunday, July 25, 2010
Speakers: Nancy Hurst, PhD, RN, IBCLC; Kristina Kahney, RN, BSN, IBCLC
Texas Children's Hospital, Houston, Texas
Topic: "Suspected neonatal anklyglossia: an assessment tool and management algorithm" (page 227 of syllabus)

Hurst and Kahney work in a 76 bed Level III NICU, plus additional Level II beds.
Children's Hospital in Houston, associated with Baylor College of Medicine, a Fetal Center, and a Center for Multiples.
They presented a workshop for pediatricians and neonatologists called "Untying the Controversy on Tongue Tie: Ankyloglossia and Its Impact on Breastfeeding."
They had 4 co-presenters, including MDs.
They included ultrasounds showing milk transfer, before and after. Talked about historical perspectives and why approaches have changed, Alison Hazelbaker assessment tool, diagnosis and treatment. They developed an algorithm for management: "Frenotomy Decision Rule for Breastfed Infants." Addressed impact on breastfeeding: difficulty/inability to latch, maternal nipple/breast pain, decreased milk supply. They spoke just to the restricted movement of the tongue. Emphasized that it is the physician's role to make a diagnosis. They just describe their observations.
When ankyloglossia is suspected in the early neonatal period by physician, nurse, family or LC, they perform a Comprehensive Infant Tongue Range of Motion Assessment.

Inform the physician of the findings. Develop plan of care that includes: feed the baby, protect the milk supply, fix the problem.
They work with a pediatric ENT, speech pathologist. Assessment for tongue tie is now routinely done by the pediatrician as part of the normal exam about 90% of the time. This has been a long learning process. Infants there are now treated in a more timely fashion.

Question period: Dr. James Murphy: Incidence of anterior tongue tie is about 5%. Another 6% are posterior tongue tie. Even if mom is not sore, and there is good milk transfer, if not treated things may "go south" after two months, when mom is no longer producing like a fire hose.

Contact information:
Kristina Kahney, RN, BSN, IBCLC (936)266-2081 knkahney@texaschildrens.org
Nancy Hurst, PhD, RN, IBCLC (832)826-3612 nmhurst@texaschildrens.org
Texas Children's Hospital, 2803B Houston Avenue, Houston, TX 77009

Track 4: Early Problem Solving
Date: Sunday, July 25, 2010
Speaker: Gini Baker, RN, MPH, IBCLC (page 231 of syllabus)
Program Coordinator, Perinatal Health Services, UC San Diego
Topic: "Management of neonatal jaundice: Why are we still confused?"

Jaundice goes from abnormal to normal to abnormal to normal
Abnormal: Pathological jaundice (visible within first 24 hours)
Normal: Physiologic jaundice
Abnormal: "Starvation," or "not enough breastfeeding," or "too many visitors" jaundice
Normal: Breast milk jaundice
Need to know gestational age as well as day of life. GA + DOL = Adjusted Age.
During pregnancy there are extra red blood cells carrying oxygen. At birth, less red blood cells are needed. The extras go to the liver to be broken down. Bilirubin is a byproduct of the breakdown. Excreted through poop, stains poop brown. "Traffic jam" at the liver. If can't get out through intestine, goes to skin. If can't, goes to brain and causes problems. Colostrum is high in protein, aids the liver in breaking down red blood cells. If takes in a lot of colostrum, baby poops. Mastication and peristalsis stimulate defecation. Bilirubin levels of 6.5 to 7.5 on day 3 of life are normal physiologic jaundice. Normal levels are based on a northern European population. Levels for people from other parts of the world are normally higher. All babies have normal physiologic jaundice. Beta carotene, an anti-oxidant, makes colostrum yellow. Bilirubin is an antioxidant, too. May be protective and helpful.
Pathologic jaundice appears early, first 24 – 36 hours, most likely cause is blood incompatibility. (also hemolytic disease, metabolic disorder, birth injury, prematurity)
May need blood transfusions, phototherapy. Get mom pumping within 6 hours.
Why do babies suck? Not because they are hungry. They are born fully nourished. The high sucking need helps them to clean out the meconium. It also causes mother to lay

down prolactin receptor sites. The more the baby sucks at breast the first 5 days, the more milk volume the mother will have at 3 weeks. Milk doesn't "come in." It is already there (colostrum). Milk increases in volume around day 3 and 4. Don't say, "You have a low milk supply." Better to say "low milk volume." With subsequent babies, the leftover prolactin receptor sites from previous babies mean the milk volume increases sooner.
Kernicterus is staining of the brain. We should never see it. It results from mismanagement of breastfeeding.
Sunlight doesn't work. "Would have to fry the kid to get enough sunlight to reduce the jaundice." But it at least would give them needed Vitamin D. Since 1990 there have been 31 reported cases of kernicterus in term infants in the US who were well at the time of hospital discharge. More cases in preterm infants. Due to shortened hospital stays, increase in breastfeeding, inconsistent followup, lack of concern about high bilirubin levels. The rule of 6 – 8 wet diapers per day doesn't work with today's super-absorbant disposable diapers. Was based on cloth diapers.
Baby sleeping with open mouth is a danger sign. Not normal.
Giving water to a baby with high bilirubin does not fix the problem. Baby needs protein. Want to get peristalsis. Water decreases the ability of bilirubin to break down.
Breast milk jaundice is a biological reaction to the protein in human milk. In some babies, bilirubin doesn't bind with the breast milk in order to excrete it. Giving formula (a different protein) stimulates the liver to break down the red blood cells. Can return to breast milk in 12 – 24 hours. Have the mother pump and save the milk. Bili lights phototherapy may reduce the bilirubin level. Is the baby well hydrated? Then it is not "starvation" jaundice.

Contact information:
Gini Baker, RN, MPH, IBCLC
UC San Diego
PO Box 5068, Sun City West, AZ 85375
(619)253-4854 bakerswim@aol.com

Session A7: Date: Friday, July 23, 2010 (page 117 of syllabus)
Speaker: Suzanne Colson, PhD, MSc, BA, RGN, RM
Topic: "Yes, But Does Biological Nurturing Always Work? Part I: The Importance of Assessing Behavioral State"

Biological nurturing uses instincts and reflexes, hard-wired, spontaneous, innate behaviors. Allows babies to show built-in, inborn competencies.
Baby kneading the breast: Goats butt. Baby uses finger flexion and extension. Kneading the breasts releases oxytocin. Amniotic fluid has components that smell similar to breast milk. Amniotic fluid on baby's palms is transferred to the breast.
Have the mother in the position she chooses, in which she is most comfortable. In many videos of crawl to breast, mother is flat. Then she'd have to strain her neck to lift her head to see her baby. Try to facilitate baby gazing. It is a birth, not a delivery. Flat on

the back for the mother is a dangerous position for a baby first establishing respiration. With a blanket on top, a baby can overheat.
Prone and flat is a risk for respiratory congestion.
Mothers remember every moment of birth. It is not up to us to allow or suggest or teach a position. It is up to us to arrange the environment to support innate behaviors. Baby should be with mother at the first moments after birth, not with the father, not with the nurse.
She worked in France with Dr. Michel Odent. He said, "Don't ask a pregnant mother if the baby moves. Ask, 'Does the baby move more in the morning or in the afternoon?'" You get the same information without scaring the mother. Don't tell the mother the sex of her baby. She may already know. Or let her discover.

Session B4: Date: Friday, July 23, 2010 (page 133 of syllabus)
Speaker: Suzanne Colson, PhD, MSc, BA, RGN, RM
Topic: "Yes, But Does Biological Nurturing Always Work?
Part II. "Using Biological Nurturing for Frequently Encountered Problems."

A cot (crib) is not the right habitat for a newborn. The right place is the mother's body. She agrees with Dr. Nils Bergman on this.
Quiet alert state is the best time to initiate feeding.
Babies can change state frequently in a 20 minute period.
Light sleep develops at 28 to 30 weeks gestation.
Deep sleep develops much later, at 36 to 40 weeks gestation. Restorative and anabolic. Important to protect sleep, just as mothers protect their babies' thermal regulation, breathing. Don't wake a baby in deep sleep for a heel stick.
Babies who are healthy and full tem are well-fed at birth.
Takes average of 55 minutes for White babies to find nipple and latch on if not helped. Takes Black babies average of only 7 minutes. (Dr. Lennart Righard studies).
Guidelines for a baby not waking to feed:
Baby should be on mother's body. Your mission is to reduce interventions that interfere with a mother and baby's biological drives. Baby is born naked. Mother is mostly undressed giving birth. Getting them dressed is an intervention.
Promote a hormone-enhancing environment.
Lightly dressed babies had breastfeeding outcomes the same as skin-to-skin babies. Evidence is very strong that skin-to-skin is very important for preterm babies. The jury is still out for evidence that skin-to-skin for the first week in full term babies affects breastfeeding outcomes. Let the mother make the decision.
Colson doesn't really believe in touching a mother's breast. She might rather demonstrate on herself. Ask permission before touching a mother.
The body has a memory for pain.
If had sore nipples before, body remembers and still feels sore.
Some mothers can't give birth with people looking at them.
Some mothers can't latch baby whole being observed.
If baby latches but doesn't suck, use breast compression to get milk into baby's mouth.