

Babies Who Don't Latch

Objectives

On completion of this unit, the participant will be able to:

- Describe at least three hospital policies that facilitate breastfeeding
- Describe the major components for taking a complete history and accurately assessing a breastfeeding problem
- List at least three reasons why an infant may refuse the breast
- List the six infant states and describe which are optimal for breastfeeding
- List at least three techniques to help a non-latching baby go to the breast

- 1. Policies and management that optimize good latch and suckling**
 - a. Intervention to both prevent and correct feeding problems
 - i. Early and unlimited contact between mother and baby
 - ii. Dry the infant except for his hands post birth
 - iii. Encourage early suckling
 - iv. Rooming in and unlimited physical contact
 - v. Teach the mother about infant states and baby language
 - vi. Show the mother how to massage the baby
 - vii. Teach the mother to watch and respond to infant feeding cues
 - viii. Teach correct positioning and latch technique
 - ix. Teach hand expression and have mother express a drop of milk or colostrums onto nipple to entice baby
- 2. Prevention of latch problems**
 - a. Importance of first hour
 - i. Skin-to-Skin time with mother
 - ii. 24 hour rooming in
 - iii. Responding to infant cues
 - iv. Correct positioning and latch technique
 - v. Show slides from Breastfeeding Atlas
 - b. First latch opportunity “Imprinting”
 - i. Assist dyad to have an unhurried hour of skin-to-skin after uncomplicated birth
 - ii. Watch for and respond to infant feeding cues
 - iii. Teach mother by talking through positioning and latch technique
 - c. Skin-to-Skin
 - i. Direct contact of mother and baby (without clothes or blankets between them) with infant against mother’s chest.
 - ii. Infant benefits
 1. body temperature stabilizes
 2. heart rate, respiratory rate and blood pressure normalizes
 3. less crying, more time in a quiet alert state, or in a deep sleep
 4. inoculation with normal non-pathological skin bacteria from the mother, decreasing the risk of hospital acquired skin infections
 5. inoculation of the normal flora of the mother’s mouth and respiratory tract because of her breathing on the baby
 - iii. Maternal benefits
 1. Oxytocin hormone stimulated
 - a. Helps the milk start to flow
 - b. Nature’s ‘tranquilizer’
 - c. Makes uterus contract
 2. Prolactin hormone surge
 - a. Improved milk production
 - b. Helps mother feel connected to her baby
 - c. Improved confidence in caring for baby
 - d. Flow chart for 1st day normal full term newborn. (See below)

- e. Sleepy Babies
 - i. Normal infant behavior in first 24 hours. (Awake and alert for about 2 hours after birth. Next ___ hours varies between light and deep sleep states.)
 - ii. Full term newborns have “brown fat” storages to use for energy needs
 - iii. Keeping baby warm (skin-to-skin) is a priority to preserve energy stores and increase baby’s ability to organize his behavior.
 - iv. Watching for cues: Hand to mouth, rooting, sucking, REM
 - v. Waking techniques: 5-10 minutes of gentle stimulation (stroking and talking), and positional changing to bring baby to drowsy or quiet awake state
 - vi. Skin-to-skin if unable to wake baby and return within 30-45 minutes to try again
 - vii. Other helpful techniques:
 - 1. Expressing drops of colostrums to tip of nipple to entice baby
 - 2. “Practice sucking” on adult finger. (Nurse to use gloved finger, parent may clean finger, clean fingernail.)
 - viii. Repeated reassurance to mother
 - 1. Most babies will learn to breastfeed
 - 2. “Tincture of Time” for birth recovery
 - 3. Sensible suggestions and good support
 - 4. Longer lasting problems such as poor fit (nipple size/baby’s mouth), or hypotonic or hypertonic infants may require much time and patience and specialized information

3. Management of continued non-latching infants

- a. Taking a good history and making an accurate assessment
 - i. General questions
 - 1. What does the mother state is the problem?
 - 2. What does the father/partner/family members believe is the problem?
 - 3. What does the staff indicate is the problem?
 - b. Infant History
 - i. Gestational age and birth weight
 - ii. Baby’s age, % weight loss
 - iii. Stool and urine output
 - iv. Labor and birth history
 - 1. long 2nd stage
 - 2. forceps or vacuum assisted delivery?
 - 3. Caput?
 - 4. Tight nuchal cord?
 - 5. Meconium in amniotic fluid?
 - 6. Deep suctioning or intubation?
 - 7. Shoulder dystocia?
 - v. Pacifiers/bottles?
 - vi. New behavior or no latch since birth?
- c. Feeding history
 - i. Has the infant ever had a good feeding?
 - ii. Is the problem of sudden onset?
 - iii. What does the infant do when offered the breast? (Sleepy, fussy, actively fighting, crying and struggling at the breast?)
 - iv. Does the infant seem to have difficulty latching on?



- v. Once latched, does the infant “fall off” or let the nipple slide out of his mouth?
Does she suck or just sit there? Does he gag?
 - vi. What has been tried? What has had the most success?
 - vii. Has the baby been supplemented? How? With what?
 - viii. Has mother pumped or hand expressed milk into baby’s mouth?
- d. Maternal history and breast exam
 - i. Mother’s pain level and ability to sit comfortably
 - ii. Nipple size and shape
 - iii. Areolar elasticity/edema?
 - iv. Prior breastfeeding experience
 - v. Breast health history
 - e. Observing and assessing a feeding
 - i. Assess infant for dehydration
 - ii. Assess infant for pain/discomfort
 - iii. Assess and assist with positioning
 - iv. Evaluate latch on
 - v. Evaluate infant’s alertness
 - vi. Assess for LATCH score (see chart below)
- 4. Illness or physiological phenomena that might interfere with feeding**
- a. Sepsis
 - b. Hyperbilirubinemia
 - c. Hypoglycemia
 - d. Post-hypoxia
 - e. Hypothermia
 - f. Chemical dependency (toxicology screen status)
 - g. Maternal anesthesia/analgesia
 - h. Labor or birth complications
 - i. Oral anomalies
 - j. Mother/baby separation
 - k. Forceful latch attempts with crying baby
 - l. Incorrect latch technique
 - m. Poor positioning
 - n. Nipples that are difficult for baby to latch onto (too big, too short or flat)
 - o. Engorgement, poor elasticity of areolae
- 5. Infant states and baby language**
- a. Video: Baby Talk
 - i. Organized vs. disorganized behavior
 - ii. Baby language
 - b. Baby language Brazelton infant states (modified)
 - i. Sleep
 - ii. REM sleep
 - iii. Quiet, semi-awake
 - iv. Alert, aware
 - v. Active, awake
 - vi. Crying
 - c. Infant feeds best in the quiet, alert awake or active awake states



6. Non-latching due to maternal flat or inverted nipples

- a. Assessment
 - i. Flat or inverted nipples do not mean that a mother cannot breastfeed
 - ii. Nipples exercises have not been shown to be effective in correcting during pregnancy
 - iii. Breast shells may or may not help
 - iv. Primips often have firmer breast tissue and nipples that look flat but evert with the 'pinch test'
 - v. A severely inverted nipple may have fewer ducts or abnormal ducts
 - vi. Post discharge follow-up of babies of mothers with inverted nipples is necessary to assure adequate weight gains.
- b. Interventions
 - i. Nipple rolling to stimulate nipple to become erect
 - ii. Pumping on low setting before nursing may help shape the nipple and facilitate latch on
 - iii. Nipple shields may help give the baby something longer and firmer to latch onto
 1. should not be used as first intervention
 2. usually used as more milk comes in
 3. must be sized and applied correctly
 4. infant will need frequent weight checks and breastfeeding assessments to assure adequate milk intake
 5. temporary device to achieve latch
 6. support and post-discharge follow up necessary

7. Non-latching Secondary to Engorgement/Areolar Edema

- a. Engorgement is caused by swelling of the breasts due to milk accumulation and/or excess interstitial fluid in the mother causing dependent edema
- b. There are several situations that may lead to uncomfortable engorgement
 - i. Supplements
 - ii. Delayed initiation of feedings at the breast
 - iii. Infrequent feedings
 - iv. Removing the baby from the first breast to ensure feeding from both breasts at every feeding
- c. Engorgement may cause the nipples to flatten, making it difficult for the infant to nurse
- d. Engorgement may also be very painful for the mother, but it is transitory
- e. Proper assessment and treatment will protect and encourage successful breastfeeding
 - i. Assess degree of engorgement by physical exam
 - ii. Assess for areolar edema by pressing the areola with fingertips around the nipple, applying steady pressure for about 10 seconds. If indentations (pitting) are left in the tissue, areolar edema is present
 - iii. Assess infant's positioning at the breast and ability to grasp breast and suckle
- f. Management of physiologic edema
 - i. Apply moist heat, or breast bath, or warm shower for 2-5 minutes before feedings
 - ii. Encourage frequent feedings of unlimited length (every one to three hours), letting baby soften the first side before offering the second



- iii. Instruct mother on breast massage and manual expression (or electric breast pump in extreme cases) to draw out a flattened nipple and soften the areola if needed to facilitate a better grasp by the baby
 - iv. If an electric breast pump was used, it should be one providing intermittent minimum pressure, and limited to a maximum duration of 10 minutes to avoid traumatizing the distended breast tissues
 - g. Areolar Edema
 - i. Assess for areolar edema by pressing the areola with fingertips on the areola, around the nipple, applying steady pressure for about 10 seconds. If indentations (pitting) are left in the tissue, areolar edema is present
 - ii. Assist mother to continue pressing fingertips around areolae with steady pressure for 1-3 minutes, working outward from nipple, to “push” edema out of the areolar tissue. The technique may be repeated before each feeding as needed to soften that areola and facilitate a good latch
- 8. Support for the mother and baby**
- a. Start mother pumping her breasts if the infant cannot latch
 - b. Supplement if needed by alternative methods
 - c. Pumped breast milk is first choice of supplement
 - d. Refer to Lactation Consultant
- 9. Alternative methods of supplementation**
- a. Spoon feeding
 - b. Cup feeding
 - c. Finger feeding
 - d. Supplementing at breast (SNS)



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The LATCH Scoring Table

	0	1	2
<p>L – Latch</p> <p>Reported question: How easily does your infant grasp your breast?</p>	Too sleepy or reluctant No latch achieved	Repeated attempts or hold nipple in mouth and stimulate to suck	Grasps breast and tongue down and lips flanged and rhythmic sucking
<p>A – Audible Swallowing</p> <p>Reported question: Do you hear your infant swallow?</p>	None	A few with stimulation	Spontaneous and intermittent <24 hrs old Spontaneous and frequent >24 hours old
<p>T – Type of Nipple</p> <p>Reported question: Do your nipples stand out or do they easily flatten?</p>	Inverted	Flat	Everted (after stimulation)
<p>C – Comfort</p> <p>Reported question: Are your nipples tender? Are your breasts full or heavy?</p>	Engorged or cracked, bleeding, large blisters or bruises or severe discomfort	Filling or reddened, small blisters or bruises or mild/moderate discomfort	Non-tender Soft
<p>H – Hold (Positioning)</p> <p>Reported question: Did someone help you put the baby to breast?</p>	Full assist (staff holds infant at breast)	Minimal assist (i.e., elevated head of bed; place pillows for support) Teach one side, mother does other Staff holds, then mother takes over	No assist from staff Mother able to hold position/hold infant in good alignment and achieve a successful “Latch on”

Breastfeeding Flowchart for First Day Normal Newborn

