Picasso was the avatar of Steve Jobs, because he saw elegance in simplicity. Can we apply simplicity to breastfeeding support to make a difference? Can we erase the rules, reduce the gadgets and return to a simple, consistent focus, easy to learn and easy to teach? Maybe only what really matters the most, matters at all. In these presentations, I share my thoughts on combining the latest research with the most critical, logical basic goals each new mother needs to understand, from the very first hour, regardless of the scenario of her delivery.

It’s simple to make a case for change in hospital management, when up to 20% of mothers stop breastfeeding by 1 month for primarily preventable problems. Due to demographic factors and obstetrical practices, we are challenged with a growing population of at-risk dyads, primarily those born a little early, who are notorious for suffering from breastfeeding complications. These complications relate to insufficient milk production and suboptimal milk intake and account for delayed discharge, readmission and this early sharp drop off in any breastfeeding.

A simple, proactive approach to care for all dyads might reduce the number of less remedial, time consuming breastfeeding complications. A simple, proactive approach might inspire more healthcare providers, who otherwise shy away from really “being there” to help and share the marvels of becoming a new mother.

So what might this simple, preventative strategy look like? Consider reducing the goals in the first 3 days to only three: A, B and C,. A=attachment (achieving a comfortable and effective latch), B=breastmilk (stimulating a robust supply) and C=calorie (insuring the infant’s optimal milk intake). Distill down the critical “grains of truth” about each goal to only two.

A =Attachment:
1. The longer the interval between birth and first feeding, the more likely a baby is to have a dysfunctional suck.
2. Poor attachment improves with uninterrupted contact and optimal milk production
B=Breastmilk production:
   1. Production is time sensitive and depends on the early, frequent and effective removal of colostrum from the first hour. The more colostrum removed, especially in the first hour, the more milk a mother will produce.
   2. Production, the cornerstone of breastfeeding, is the factor most strongly associated with the duration and exclusivity of breastfeeding.

C=Calorie:
   1. You can never over breastfeed a baby in the first 3 days. Put another way, the more colostrum a baby receives, the less likely he/she is to suffer the complications of underfeeding (hypoglycemia, excessive weight loss, jaundice and suboptimal growth).
   2. For the term infant, without complications, the needs are small; the reserves are adequate; focus can prioritize A (attachment) and B (breastmilk stimulation). But for the at-risk infant, the needs are higher. So prioritize C and B.

All three goals will be impacted by what a new mother does (or does not do) from the most important first hour after delivery. Learning prenataally the benefits of hand expression (and spoon feeding, if needed) gives expectant mothers the answer to many typical “what if” concerns and prepares her for whatever the outcome of her delivery may be. Unlike a machine, a mother’s touch is quite natural and does not suggest a problem or medicalize milk expression.

From Picasso to Steve Jobs, artists and inventors, and we as teachers, have found that keeping things simple is worth striving for. Building simplicity, repetition, and logic into a didactic setting is key. By making every first hour really count, offering simple skills for these first several days that could prevent the serious complications of insufficient milk production and suboptimal intake, we would enable each mother to exclusively breastfeed, while keeping her newborn safe.
References:


Carberry AE, Raynes-Greenow CH, Turner RM. Breastfeeding within the first hour compared to more than one hour reduces risk of early-onset feeding problems in term neonates: A cross-sectional study. Breastfeeding Medicine 2013 Dec; 8(6) 513-514.


Goyal NK, Attanasio LB, Kozhimannil KB. Hospital Care and early breastfeeding outcomes among late preterm, early term and term infants. Birth 2014; 41:1 330-338

Hill PD, Aldag JC, Zinaman M, Chatterton RT. Predictors of preterm infant feeding methods and perceived insufficient milk supply at week 12 postpartum. J Hum Lact. 2007 Feb;23(1):32-8


*Jones E, Crossover study measuring expressed milk with and without breast massage. Arch Dis Child Fetal Neonatal Ed. 2001;85:F91-95

Kacica, MA., Kreiger L, Johnson GD. Breastfeeding Practices in New York State Maternity Hospitals: Results from a Statewide survey. Breastfeeding Medicine 2012 7(6) 409


McLaurin KK Hall CB, Jackson EA, Owens OV, Mahadevia PJ. Persistence of morbidity and cost differences between late-preterm and term infants during the first year of life. Pediatrics 2009;123:653-9

Merekwood A., Morton JA. Inside Track: Using your hands to express your milk. J Hum Lact 2013. 29: 635


See: The Perfect Latch, Hand Expression, Maximizing Milk Production


Attachment:
A PERFECT LATCH
http://newborns.stanford.edu/Breastfeeding/FifteenMinuteHelper.html

Breastmilk Production:
STEPS for HAND EXPRESSION
http://newborns.stanford.edu/Breastfeeding/HandExpression.html

STEPS for HANDS-ON PUMPING
http://newborns.stanford.edu/Breastfeeding/MaxProduction.html

Caloric/nutritional parameters; easy to remember two 10’s and two 5’s:
• Two 10’s (approximations)
  – Weight loss is normal but not >10%
  – Regain birth weight by day 10

• Two 5’s (approximations)
  – Average size feed in first day is 5 mls (tsp)
  – Indicator of sufficient intake is bright yellow stools by day 5 (Shrago LC)