Supporting Breastfeeding
The How-To Guide for Primary Care

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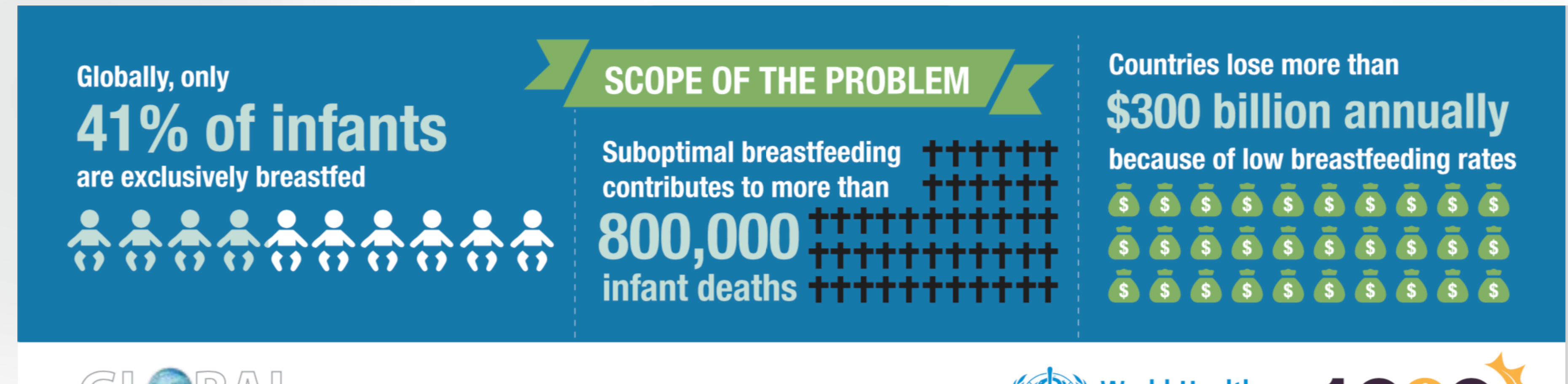
BREASTFEEDING

It Rocks!

Disclosures:

- Dr. Raimondi and Dr. Kearns have no conflicts to disclose. We are two Family Doctors who are passionate about breastfeeding because we believe it can save the world.

The World Health Organization recommends Exclusive Breastfeeding x 6 mo then continued Breastfeeding + food to 2 years and beyond!



WHATS THE DIFFERENCE ?

What is Breastmilk ?
Nutrition
Immune function (IgA +live cells + oligosaccharides)
Pre/Probiotics -building the microbiome
Hormones
Developed by EVOLUTION to meet the needs of our species.
What you need to breastfeed: breasts and some support.

What is formula ?
An attempt by industry to mimic breastmilk
It provides nutrition WITHOUT the hormonal and immune function.
Formula can and should be used when indicated, but it is NOT EQUAL TO BREASTMILK
What do you need to formula feed? Clean water, heat, money , bottles, soap, more money and LITERACY.

DID YOU EVER WONDER WHAT'S IN... ?

BREASTMILK

FORMULA

WHAT BABIES ARE FED MATTERS

Benefits of Breastfeeding:
A Timeline of the First Year

The first few days
Benefits:
Colostrum milk gives baby antibodies and the perfect nutrition.

Breastfeeding helps moms recover from giving birth.

Four to six weeks
Benefits:
You are building baby's immune system.

Milk at this stage helps prevent digestive issues, food and respiratory allergies later in life, and chest infections until up to seven years of age.

Two months
Benefits:
The risk of a baby getting SIDS if they are breastfed for two months is 62% lower than those who are not.

After two months of breastfeeding, baby will also have a reduced risk of food allergies at three years of age.

Three to four months
Benefits:
After three months of breastfeeding, baby has a reduced risk of developing asthma and childhood Type 1 diabetes.

Mothers have a lower risk of postpartum depression up to four months after giving birth.

Six months
Benefits:
With at least six months of breastfeeding, mothers have a reduced risk of breast cancer.

Baby has a lower risk of ear infections and a 19% lower risk for childhood leukemia.

Nine months
Benefits:
Breastmilk continues to fuel your baby as they become more active and independent.

Breastfeeding comforts your baby as they experience growth spurts, teething and the occasional bump or bruise.

One year
Benefits:
Breastfeeding for one year saves a ton of money on formula.

Breastfeeding for one year means your baby is less likely to become overweight later in life and will have a lower risk of heart disease as an adult. Babies that are breastfed for one year are also less likely to need orthodontia or speech therapy.

ASK yourself , If BF is the Gold standard, are these really benefits?

Supporting Breastfeeding: The How-To Guide for MD's:

Objectives:

LEARN HOW TO:

- 1. Start before the baby arrives
- 2. Set NORMAL expectations
- 3. Assess latch
- 4. Know when baby is getting enough milk (or not)
- 5. Avoid sabotaging the breastfeeding relationship
- 6. Assess and treat the common complications
- 7. Give families some resources

1. Start before the baby arrives

- **CANADIAN TASK FORCE ON PREVENTATIVE HEALTHCARE LISTS COUNSELLING ON BREASTFEEDING AS GRADE A RECOMMENDATION** . (specifically as it relates to reduce GI/ Resp infections in NB)
- **Good evidence that both antepartum and postpartum counselling prolong breast feeding duration.**

1. Start before the baby arrives

- **Explore ideas/feelings/fears/expectations** : Does mom want to breastfeed? Explore reasons for or against. What exposures to breastfeeding has she had with with friends and in the community?
- **Past History** : Has mom breastfed before? How long? Was it successful? Was it a positive experience? What problems if any did she have ?
- **Social** : What are her supports like at home? What is her financial situation? When will she have to go back to work? Can she get a pump from her insurance company?

1. Start before the baby arrives

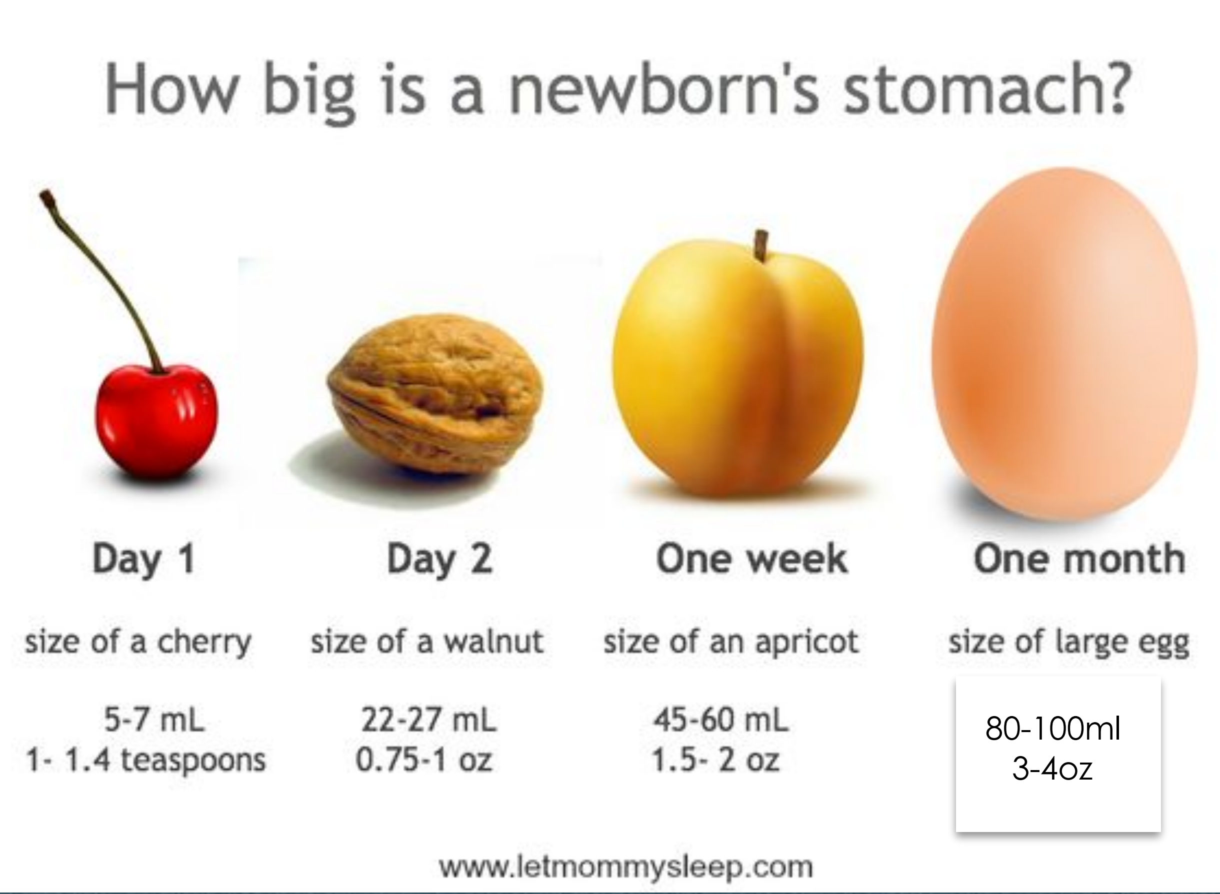
- Empower Women with Knowledge !
- Teach that is is a learned skill (not an innate ability) and it is hard for everyone - she will learn with her baby.
- Anticipate and Educate : Does she have risk factors for lactation problems?
  - PCOS, T2DM, GDM, hypothyroidism, obesity, IVF , breast surgery, inverted or flat nipples, hypoplastic breasts, previous problems breastfeeding.
- Consider referral to Lactation Consultant / Specialist prenatally!
- Encourage a Breastfeeding class for the family or Online reading/videos books .

2. Set normal Expectations

- Discuss what its REALLY like to have a newborn and what normal infant feeding behaviours are like.
  - Cluster feeding is normal in the early days and is not an indication of low milk
  - Milk will take 2-4 days to come in (sometimes longer if c/s , GDM) and colostrum during this time is all baby needs
  - Babies want to stay with mom skin to skin , they do not like to be put down .
  - EXHAUSTING , EMOTIONAL, PAINFUL - - IT SHALL PASS .
  - Discuss how they will enlist family and friends to help, and limit guests.

2. Set NORMAL expectations

- Best ways to promote milk production after birth:
  - Skin to skin
  - Latching in the first hour after birth
  - Frequent good quality latching and **hand expression.**
  - https://med.stanford.edu/newborns/professional-education/breastfeeding/hand-expressing-milk.html
  - On demand feeding.
  - Letting mom rest when she can



FACT: volume /day a baby will take is 24oz/day
After 6 months this slowly DECREASES to about 16-20oz by 1 yr

- **How long should a newborn baby be at the breast**
  - As long as the baby wants to be ! Frequent stimulation early on is important to bring in mom's milk and to establish milk supply
- **When should a newborn baby be offered the breast ?**
  - Anytime they display hunger cues, latch them.
  - Offer both breasts until baby is no longer interested in latching.
  - Not sure if baby is hungry? Place baby in between breasts, tummy facing mom, skin to skin and look for rooting behaviours.
- **You can not overfeed a baby at the breast !**

Baby Feeding Cues (signs)

- Stirring
- Mouth opening
- Turning head
- Seeking/rooting

MID CUES - "I'm really hungry"

- Stretching
- Increasing physical movement
- Hand to mouth

LATE CUES - "Calm me, then feed me"

- Crying
- Agitated body movements
- Colour turning red

Time to calm crying baby

- Cuddling
- Skin to Skin on chest
- Talking
- Stroking

(HMMU 131022)

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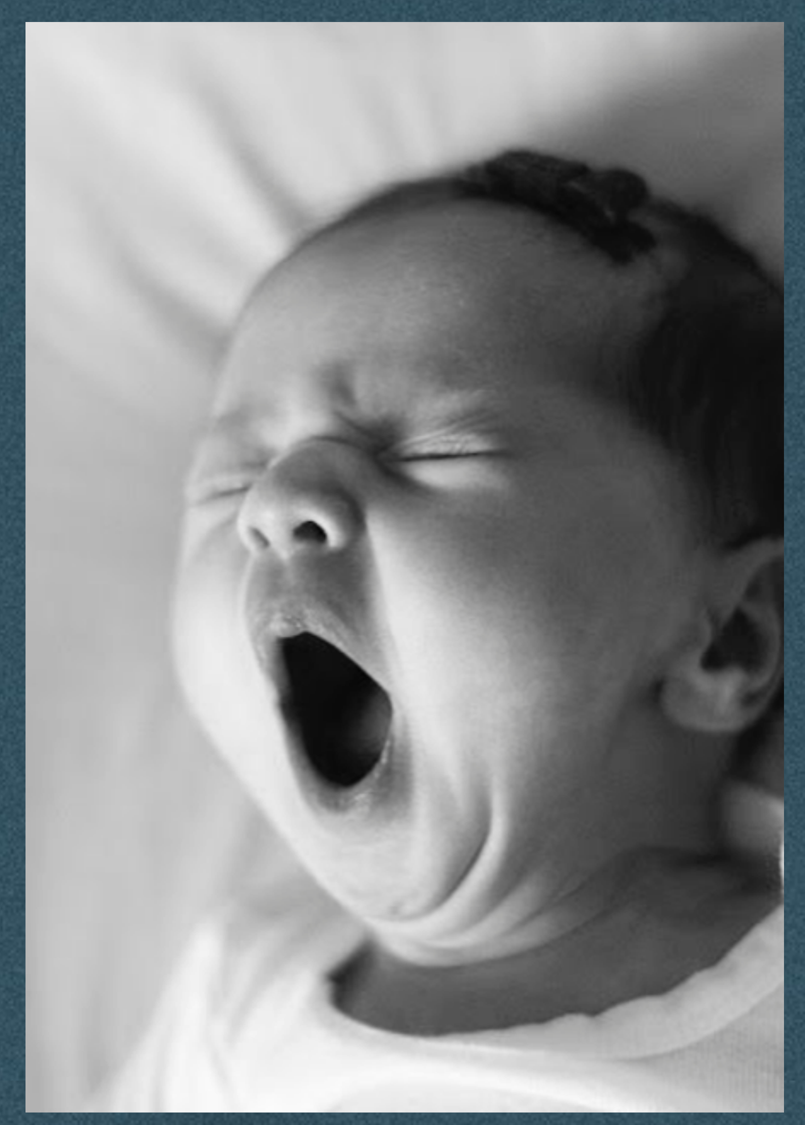
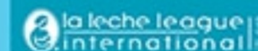
2. Setting NORMAL expectations Breastfeeding at night

- Babies will wake up to nurse at night , and what is normal is variable , some continue to wake to nurse at night into toddlerhood.
- There is **NOTHING WRONG WITH NURSING A BABY TO SLEEP** . It is only a problem if it is a problem for the family.
- Evidence tells us that exclusively breastfeeding moms are getting the most sleep !
- ASK about WHERE the baby is sleeping. Breastfeeding Families will often turn to co-sleeping on a same surface. EDUCATE how this can be done more safely .



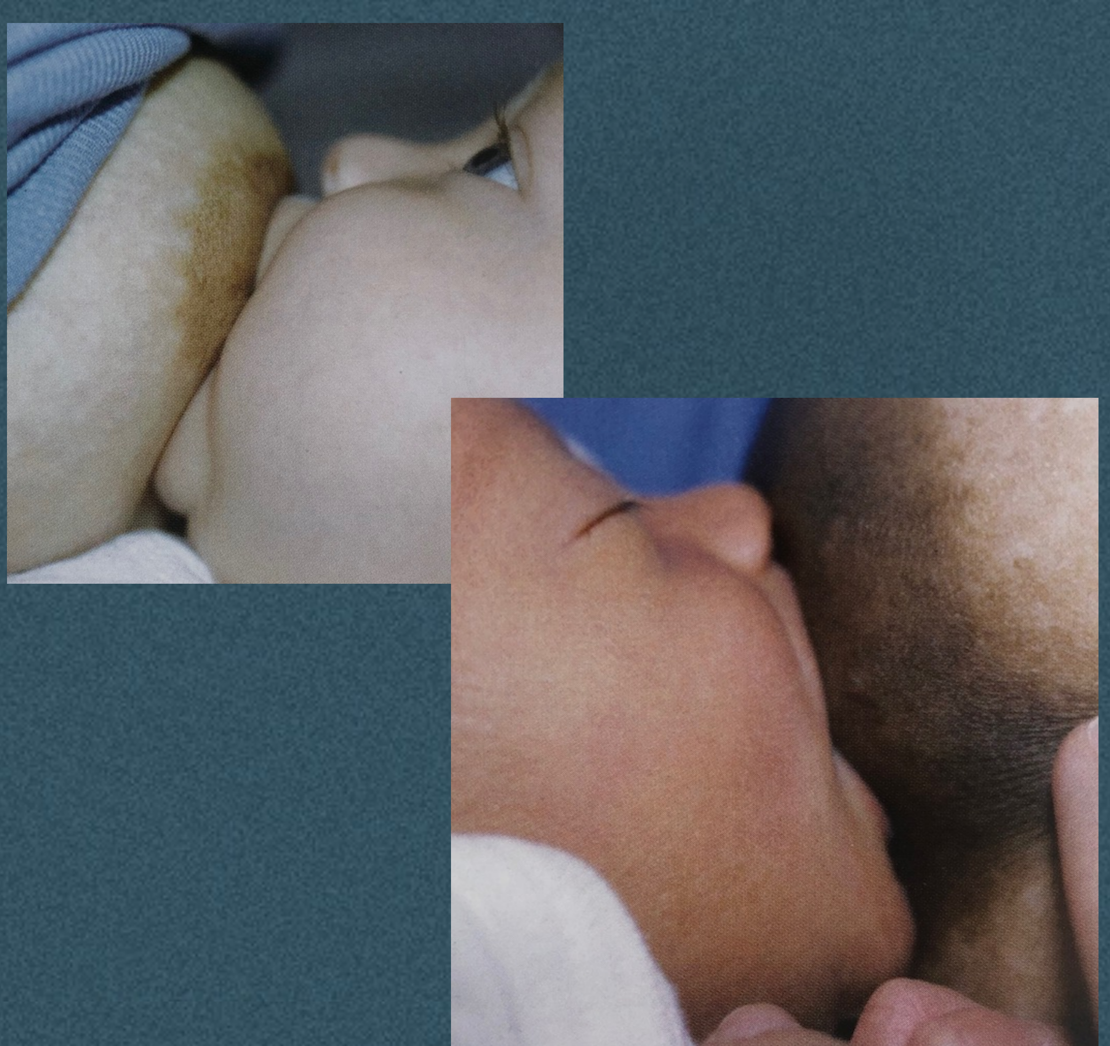
Set NORMAL expectations: Breastfeeding at night

- Recognize that due to frequent feeds , and maternal exhaustion families do bring their babies to bed with them.
- Families will lie to you because they feel guilty and scared.
- I encourage you to read: Academy of Breastfeeding Medicine Protocol about this topic. https://abm.memberclicks.net/assets/DOCUMENTS/PROTOCOLS/6-cosleeping-and-breastfeeding-protocol-english.pdf
- BOOK: SWEET SLEEP by La Leche League



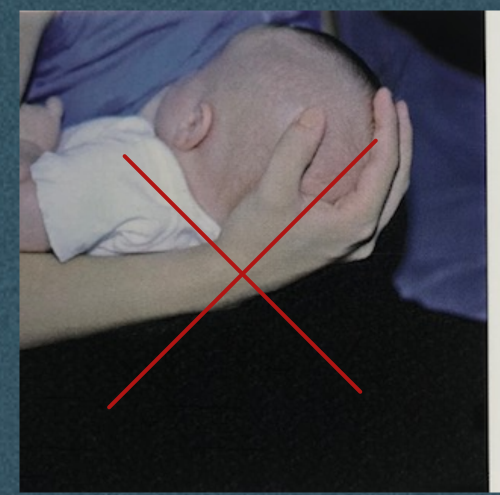
3.LATCH
Assessing the Latch

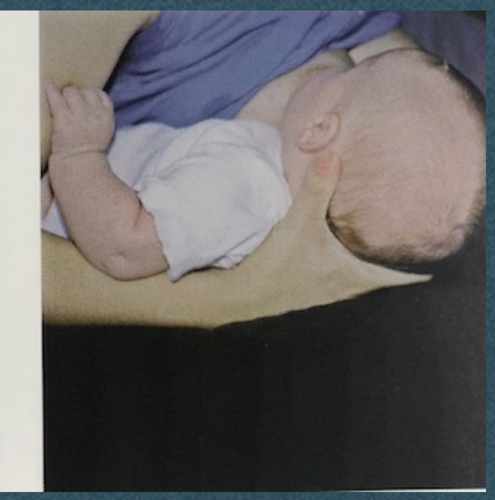
- A good deep asymmetric latch :
  - Is pain free
  - Baby's head is extended
  - Lips are flanged out ~150 degree angle
  - Mouth has whole nipple and most of the bottom of areola in mouth
  - Chin is touching the lower breast
  - Nose is free to breathe
  - Tongue is extended to cover the lower gums
  - Of note - clicking when feeding is a potential sign that the seal is being broken

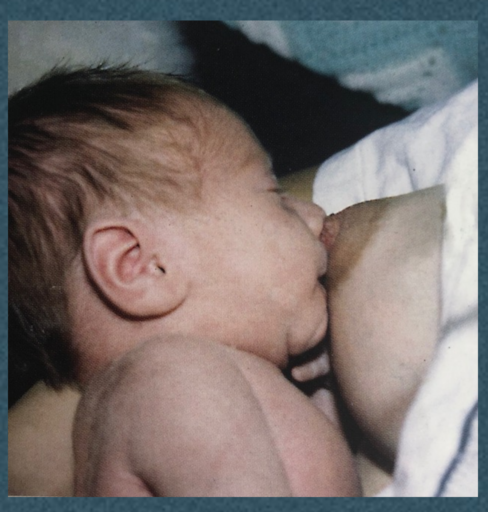


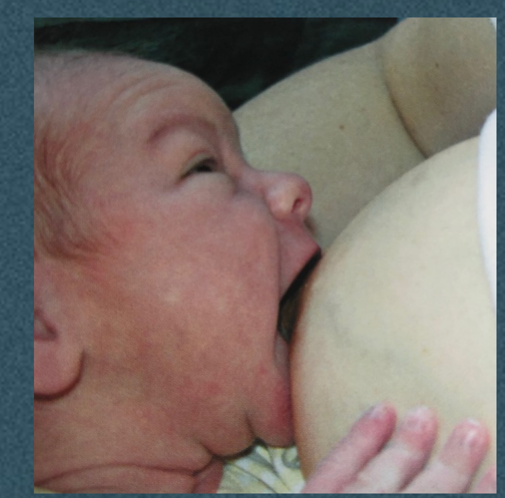
3. LATCH

- Latching the baby
  - Start with laid back, cradle/cross cradle or football
  - Bring baby to breast (NOT breast to baby)
  - Tummy to Tummy - baby facing their food
  - Mom’s arm/hand supports baby at shoulder blades (not back of head)
  - Nipple to nose
  - Chin first to breast to elicit wide open mouth
  - If needed, bring the baby's body forward to help them get on
  - Compress breast near areola if needed to help baby get a deep asymmetric latch









3. Latch
Assessing the Latch

- https://www.breastfeedinginc.ca/videos/really-good-drinking/

- https://www.youtube.com/watch?v=0WWzPBI7kEg&index=6&list=PLwzVxzHU8IkuXDDnsh8cJ8SLf11Iu0HBn&t=0s

- https://www.breastfeedinginc.ca/videos/nibbling/

4. Is baby getting enough milk?

- Soft signs :
  - signs of milk transfer : audible swallows , visible suck and swallow with a pause. Mom's breasts going from fuller to softer.
  - Voids & stools. 1-2 for each DOL until day 3-4. After that stools are yellow and seedy. Voids are > 6/day once the milk comes
- Hard signs : WEIGHT
  - Weight loss <10% of BW
  - Return to birth weight by 2 weeks of age
  - Daily weight gain of 20-30g /day once back to BW

Why baby is not gaining weight ?

A good history and physical for mom and baby can help narrow down the ddx

SUPPLY- LOW PRODUCTION	TRANSFER/LATCH :	BABY FACTORS
1) Hypoplastic Breasts 2) Separation of mom and baby (nicu, c/s) 3) Obesity 4) Diabetes (PCOS,1,2, GDM) 5) Maternal stress (long labour, hemorrhage) 6) Placental Retention 7) Hypothyroidism 8) Breast surgery 9) Breast/Nipple Anatomy 10) Infertility / IVF 11)Advanced Maternal Age 12)Early use of OCP	1) flat or inverted nipples 2) Tongue tie /Lip tie 3) Swelling /engorgement 4) Infrequent feedings / misinterpretation of feeding cues	1) Sleepy baby (preterm, or early term, jaundice) 2) Neurologic , hypo or hypertonia 3) Oral anatomy (ties, palette, clefts) 4) Metabolic disorder 5) Torticolis 6) Exaggerated birth weight due to IV Fluids /C/S (use 24 hr wt)

What to do when baby is not gaining weight ?

Involve an LC

- **Step One: Feed the baby**
  - Put baby to breast first - 8-12 times/day with breast compressions . https://www.youtube.com/watch?v=RymUDeCAt18&index=7&list=PLwzVxzHU8lkuXDDnsh8cJ8SLf11lu0HBn
  - Offer baby supplement during (w/ SNS) or after breastfeed - mothers milk first, then donor milk if available, then formula.
  - Paced bottle feeding with a preemie nipple.
    - Allows you and baby to control flow and volume intake to avoid overfeeding baby and to keep it similar to feeding at the breast

Step One: Feed the baby
Step Two: Protect the milk supply
Step Three: Protect Direct Breastfeeding

What to do when baby is not gaining weight?

- **Step two: Protect / Increase the milk supply**
  - Empty breasts 8-12 x per 24 hours
  - Skin to skin - LOTS!
  - Correct latch
  - Breast compressions
  - Pump or hand express 10-15 mins after every feed to ensure milk is drained and for increased stimulation
  - Look for reversible causes of low supply: hypothyroidism, retained placenta, exhaustion, early contraceptives.

Step One:
Feed the Baby

***Step Two:
Protect / Increase the Milk Supply***

Step Three:
Protect Direct Breastfeeding

What to do when baby is not gaining weight?

- **Galactagogues:**
  - Herbs - Fenugreek, Blessed Thistle, Goat's Rue
  - Domperidone
    - Increases prolactin by blocking dopamine, allowing unopposed elevated prolactin levels
    - Max effect around 2 weeks
    - Dose: 20-30 mg tid
    - Usual course: can continue until weaning
    - Possible side effects: ? heart arrhythmia

Step One:
Feed the baby

***Step Two:**
Protect the milk supply*

Step Three:
Protect Direct Breastfeeding

4. Is my baby getting enough milk?

- **Step three: Protect ability to directly breastfeed**
  - Use alternative feeding methods to bottle (spoon, cup, syringe, finger, SNS)
  - If bottle feeding:
    - Do paced feeds: https://www.youtube.com/watch?v=OGPm5SpLxXY&index=1&list=PLwzVxzHU8lkuXDDnsh8cJ8SLf11lu0HBn
    - Use preemie nipples
  - Do not separate mom and baby

Step One:
Feed the baby

Step Two:
Protect the milk supply

***Step Three:**
Protect Direct Breastfeeding*

5. Avoid sabotage

- **Sabotage#1: Scheduling feeds**
  - There is no number of hours a baby *should* go between feeds
  - There is no age or weight at which baby *should* sleep through the night
  - Spacing feeds/sleep training may reduce mom’s supply and end the breastfeeding relationship early due to variability in mom’s storage capacity and the frequency of feeds needed to maintain her supply.
- **Solution: FEED ON DEMAND.**

5. Avoid sabotage

- **Sabotage #2: Perceived low supply/ unnecessary supplementation**
  - Cluster feeding is normal any time of day but especially during peak of purple crying in the evening hours. A crying baby is not necessarily hungry. But a top up might make them sleepy (like Turkey dinner!).
  - Problem with supplementing consistently:
    - Makes mom feel her milk is “not enough”
    - Decreases the ”demand” part of the supply-demand system for milk production and leads to lower supply
- **Solution: SET NORMAL EXPECTATIONS.**

5. Avoid sabotage

- **Sabotage #3: Pumping and dumping**
  - Almost never necessary
  - Some exceptions:
    - Some radioisotopes (ex: radioactive iodine)
    - Methotrexate
    - Lithium
    - Codeine
  - Not necessary for many, including:
    - Alcohol
    - MRI, CT
    - General anesthetics
      - The risk is sedation in mom, not effect of substance on baby. So if she is awake and alert, enough to safely breastfeed, she can.
- **Solution: LOOK IT UP.**
  - Infantrisk app

Anesthesia & Breastfeeding:
More Often Than Not, They Are Compatible

In this issue, Lee et al.[2] randomized laboring patients to different concentrations of epidural fentanyl. There was no difference in successful breastfeeding outcomes at 6 weeks.

Breastfeeding is important to infant health. Receiving anesthesia should not affect mom's ability to breastfeed, or the safety of her breastmilk.[1-4]

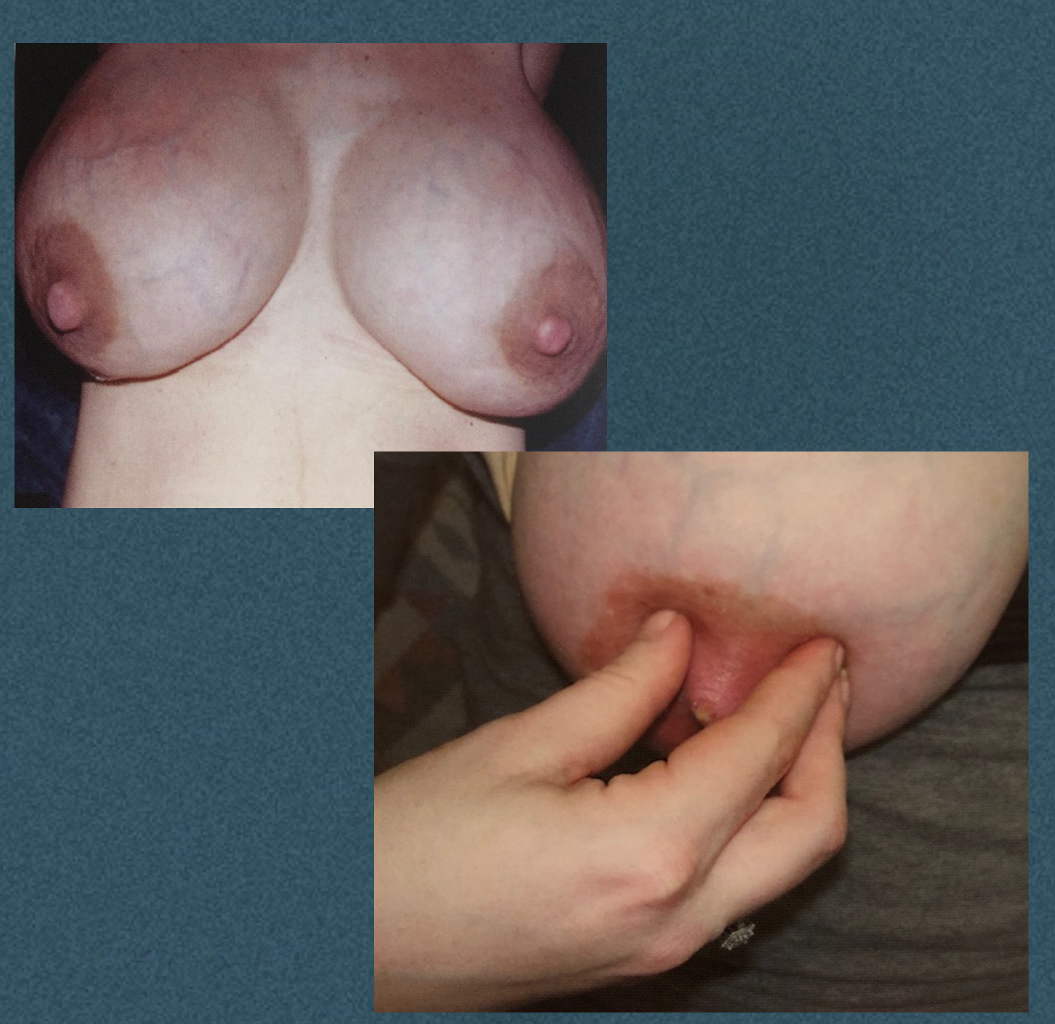
Perioperative Administration

Category	Drug	Recommendation
Benzodiazepines	Midazolam	PROCEED
Hypnotics	Propofol	PROCEED
Hypnotics	Etomidate	PROCEED
Hypnotics	Ketamine	No Data
Hypnotics	Volatile anesthetics	PROCEED
Opioids	Fentanyl (single dose IV)	PROCEED
Opioids	Morphine	Monitor closely
Opioids	Hydromorphone	Monitor closely
Opioids	Meperidine	AVOID
Paralytics	Succinylcholine	PROCEED
Paralytics	NMBAs	PROCEED
Reversal	Neostigmine/ glycopyrrolate	PROCEED
Antiemetics	Ondansetron	PROCEED
Antiemetics	Dexamethasone	PROCEED
Antiemetics	Metoclopramide	PROCEED
Local anesthetics	Lidocaine	PROCEED
Local anesthetics	Bupivicaine	PROCEED

"A general principal is that a mother can resume breastfeeding once she is awake, stable, and alert after anesthesia has been given."[2]

6. Common complications

- **ENGORGEMENT**- common in early days once milk comes in
  - Prevent by feeding baby on demand, skin to skin
  - latch may be difficult, painful
  - Treat with ice (not heat), NSAIDS, and hand expressing only until comfortable or you will prolong the course
  - Reverse pressure softening to assist latch



6. Common complications

NOT LATCHING

NEWBORN PERIOD Under 1 mo	NOT NEWBORN Over 1 mo
1) SLEEPY BABY : Preterm/early term Jaundice What to do : express and spoon/cup/finger feed . Let the baby get calories and grow/ develop enough to feed.	1) BOTTLE PREFERENCE : usually from a faster bottle flow and infrequent direct breastfeeding What to do : slow the flow at the bottle : root for bottle, paced bottle feeds . Skin to skin with mom. Keep offering the breast, use compressions to increase flow. A nipple shield can help get baby back to breast.
2) CRYING/FUSSY What to do : Calm baby before bringing to breast . Skin to skin, wait for routing behaviours. Feed baby more often, educate about early feeding cues.	2) STRIKE A strike is temporary . Common causes are teething, illness , change in flow. What to do : keep offering breast and maintain supply
What it isn't : low supply	What it isn't : self weaning (babies do not self wean until after 2.5 years).

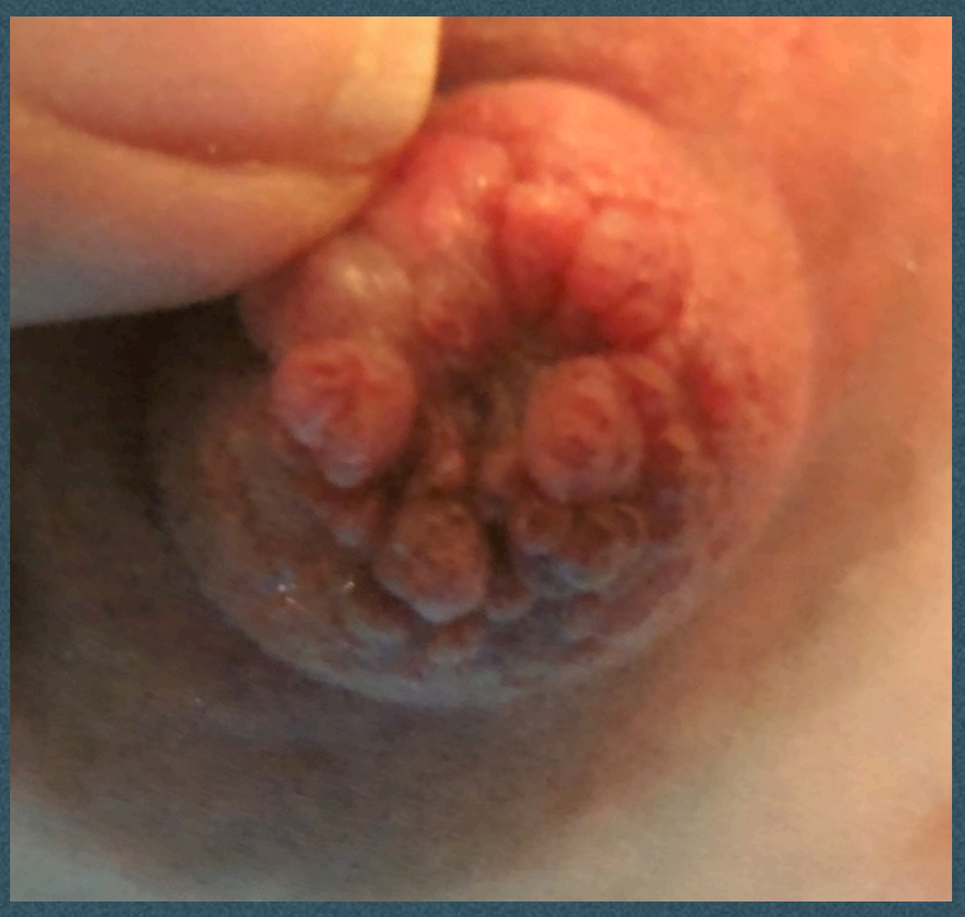
FEED THE BABY

PROTECT THE SUPPLY

DIRECT BABY BACK TO BREAST

6. Common Complications
Nipple Pain

- Second Most common reason to wean after perceived low supply
- Is associated with depression (chicken or egg?)
- Important to take a full hx, and EXAMINE THE NIPPLE
- If starting a treatment, follow up and reassess
- APNO is almost never the answer
- Do not be afraid to use NSAIDS



Raspberry nipple (trauma)

NIPPLE PAIN

When did it start ?

From 1st latch

NORMAL — Most women describe pain in the beginning .
This pain should improve with time and last <30sec
This should not result in trauma .

LATCH — The cause of most pain is a poor latch.
Moms and babies are learning . Teach them how.

ANATOMIC
- Mom : flat nipple/engorgement
- Baby : tongue/lip tie/mouth shape

TRAUMA — Early trauma can result from a poor latch making pain persist despite correction

VASOSPASM — This pain is typically immediately after latch is released. Nipple will turn white.

Started later on?

LATCH — Has something changed ?
Latch more shallow?

TRAUMA — Whats new ? Pumping ,biting , distracted babe?

BLEB — White spot on nipple - blocked
Duct -needs unroofing

DERMATITIS — hx eczema, psoriasis
contact derm. Pagets.
Rxn to topical cream?

INFECTION — Any break in skin can put mom
At risk of infection:
Viral, bacterial, yeast

VASOSPASM

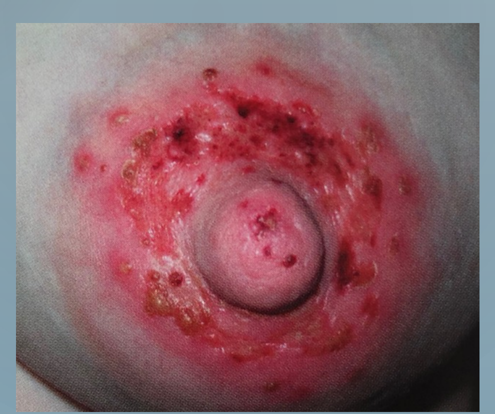
TIP: do Bhcg!

NIPPLE INFECTIONS

Fix the initial trauma

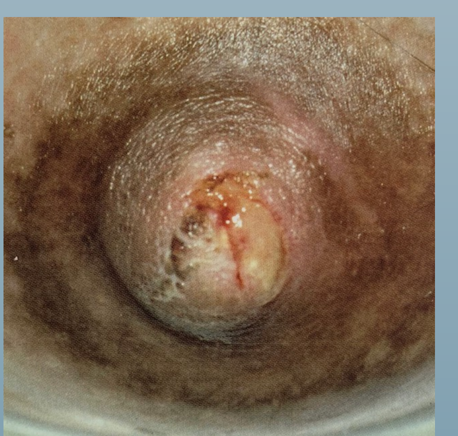
VIRAL:
Usually: HSV (Can be HFM-coxsackie)
Hx: previous episodes on nipple or elsewhere.
Episodes on partner

Looks like : vesicles/ulcers.
Swab/Culture if unsure
can cause death in infants
TX: Pump to save supply
Avoid direct feeding on affected side.



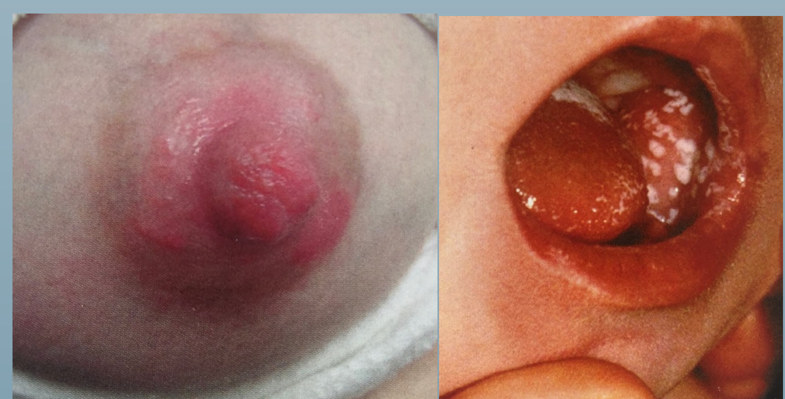
BACTERIAL:
Usually: Staph / other skin bugs
Hx : trauma, looks like: redness, yellow pus/crusts.
can lead to mastitis and abscess.

TX: no systemic sx - topical abx
Consider oral if not resolving or has progressed

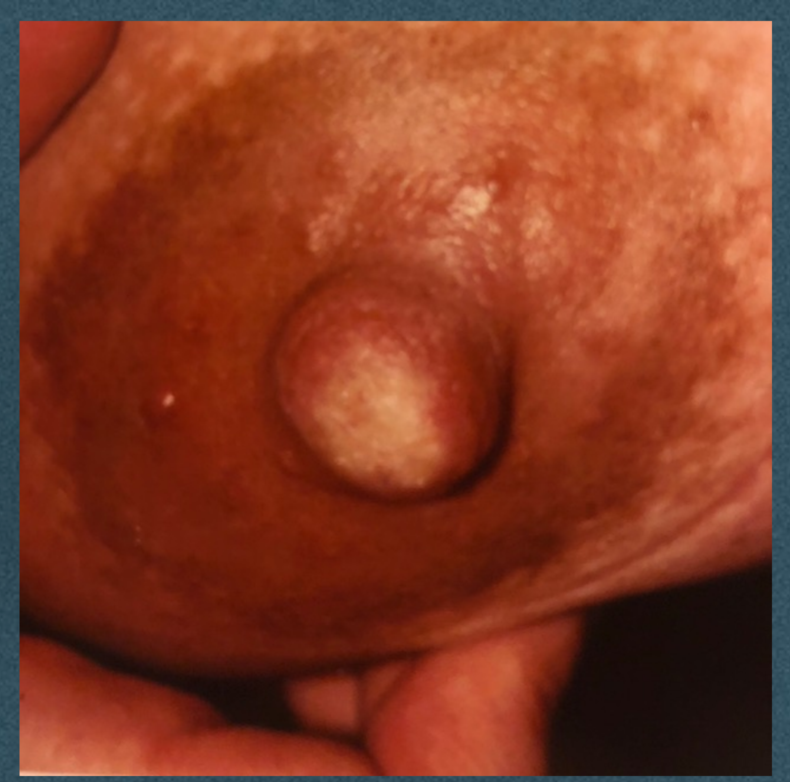


YEAST:
Usually : candida
Hx: antibiotic use, diabetes, thrush lesions on baby (mouth or bum). Shooting pain to chest wall.
can affect baby too (pain, latch, wt)

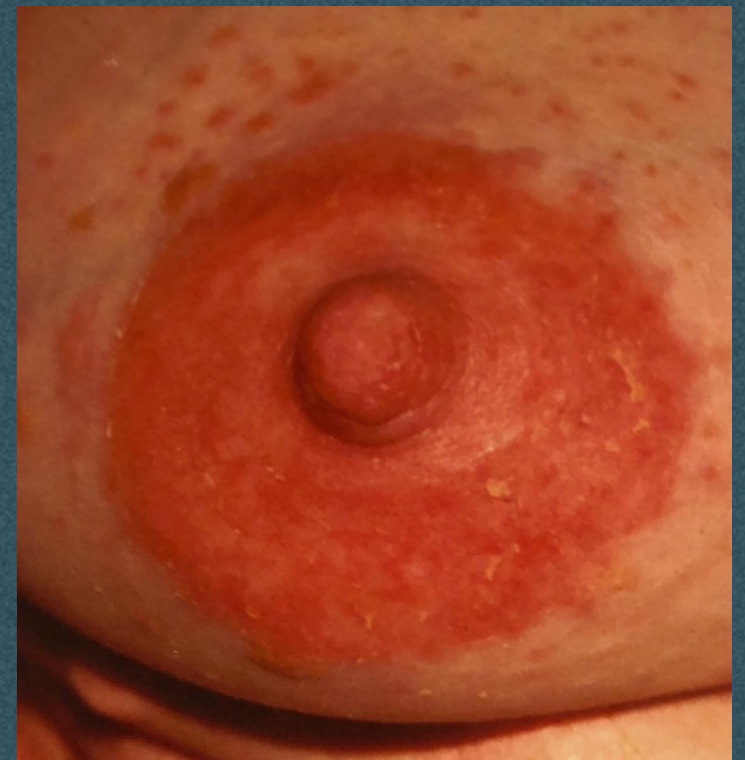
TX: treat mom + baby
mom: Oral Fluconazole 400mg loading then 200mg OD until pain free. (2-4 wks)
Or topical Miconazole Q post feeds.
Baby: Fluconazole solution or Nystatin (some resistance). Paint baby's mouth after every feed.
Wash all pacifiers /teats if using.



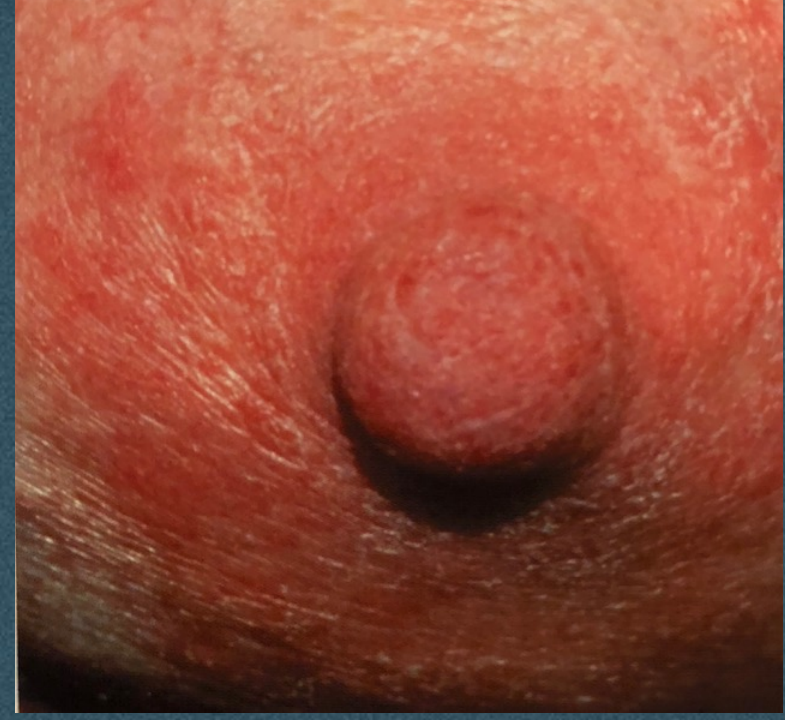
6. Common complications
Nipple Pain



VASOSPASM
- use heat
- nifedipine PO 20-30mg /day



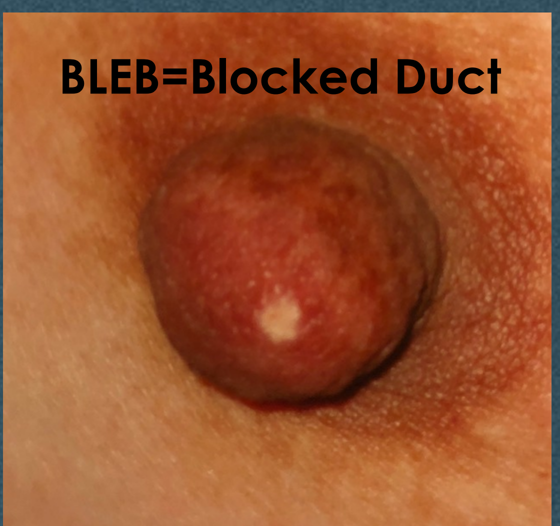
ECZEMA
-topical steroid

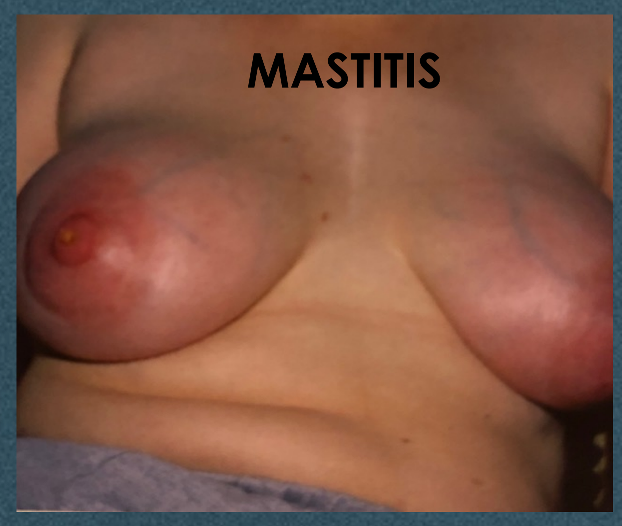


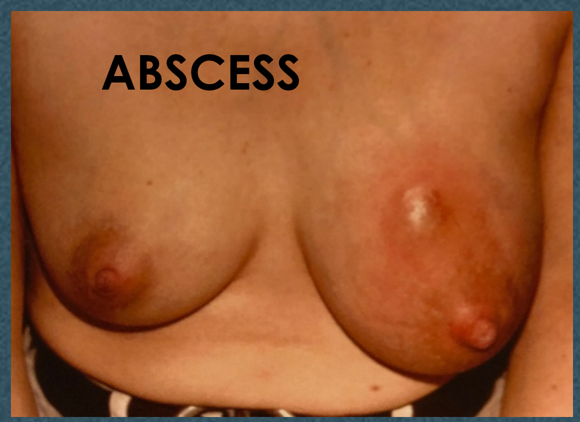
PSORIASIS
-topical steroid

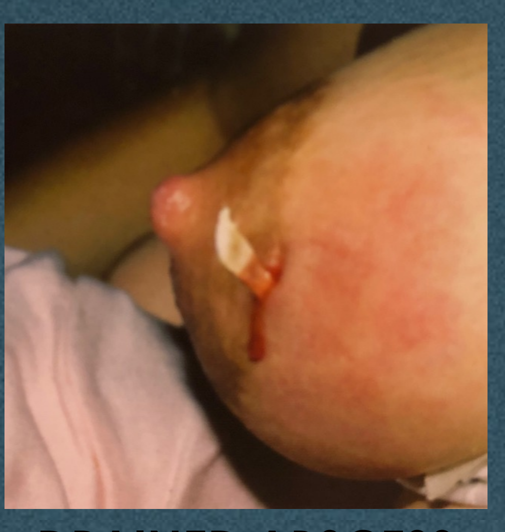
6. Common complications

- **Milk bleb, blocked duct, mastitis, abscess**
  - bleb: moist heat , triamcinolone 0.1% or olive oil on a cotton ball - and gentle abrasion
  - Empty empty empty (absolutely continue to feed baby from affected side)
  - Heat, hand expression, NSAIDS and vibration (HACK - ELECTRIC TOOTHBRUSH)
  - Change baby's position, Dangle Feed.
  - Physiotherapy (Donna Sarna Prairie Trails Physio Creekside)
  - Mastitis: add Keflex 500mg QID 10 days
  - Abscess : needs surgical drainage
  - If recurrent
    - Lecithin 1200mg QID
    - Recurrent Mastitis - think MRSA, abscess, cancer





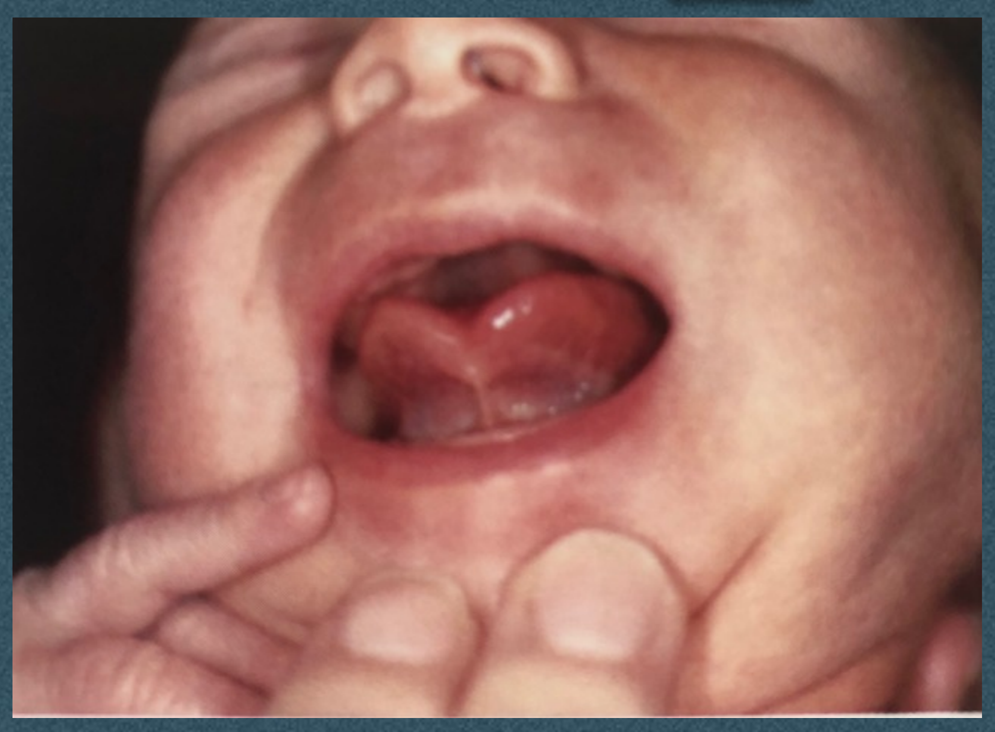




DRAINED ABSCESS

6.Common complications Tongue Tie

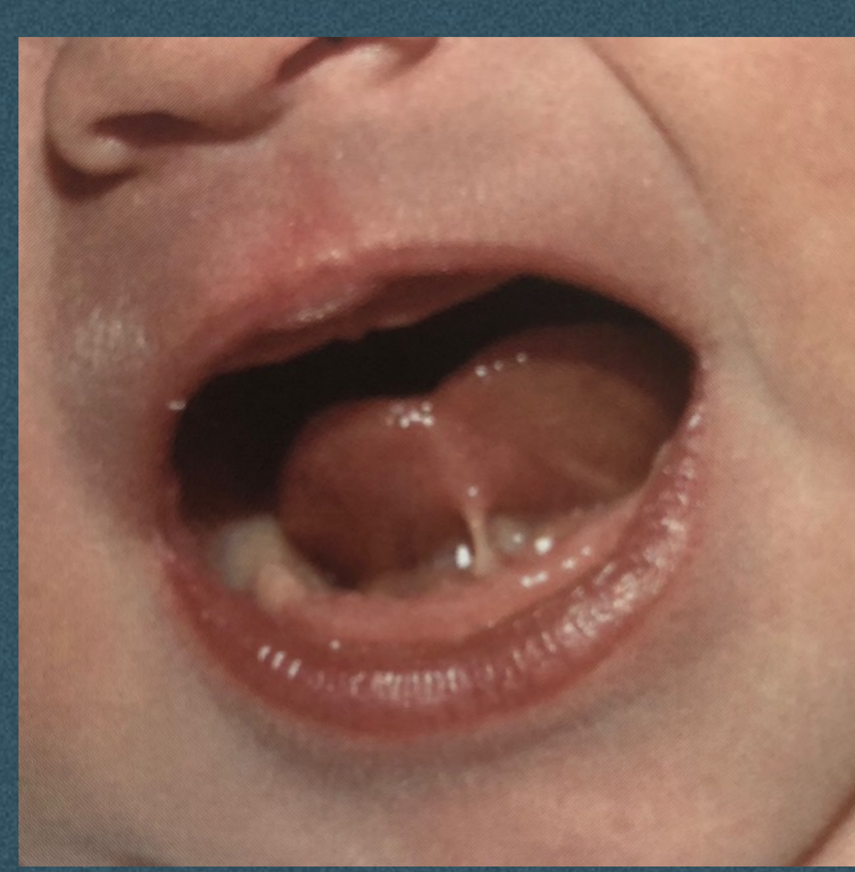
- Congenital condition that runs in families
- 2-10% of term infants M>F
- Problems : nipple pain, low milk supply, poor milk transfer, dentition, speech problems and changes to facial appearance.
- NO STANDARDIZED DX TOOL
- 25% of TT babies have bf trouble, 3% of babies without TT had trouble (MESSNER 2000)
- 2nd most common cause of nipple pain (Kent 2015)
- Sometimes frenotomy doesn't solve the BF problem. (may not be an isolated issue, or the issue at all, **do a full evaluation**)



This baby did not have any breastfeeding problems

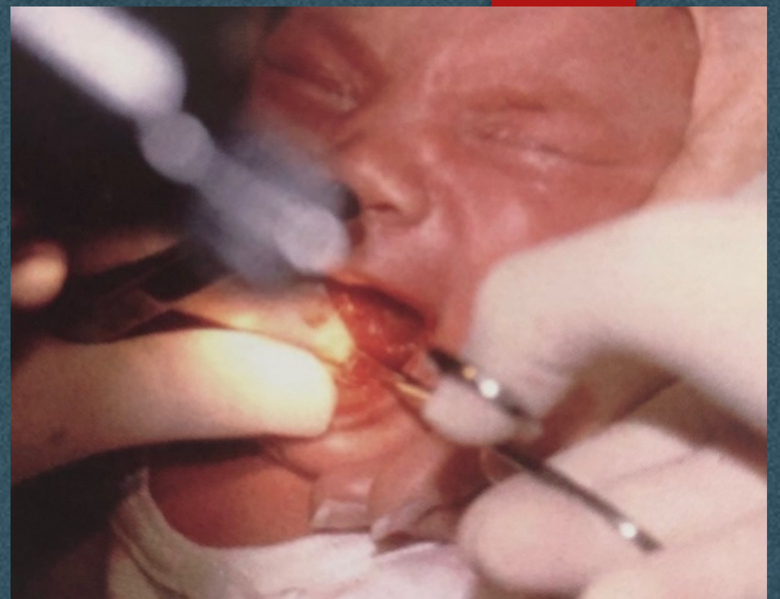
6. Common complications Tongue Tie

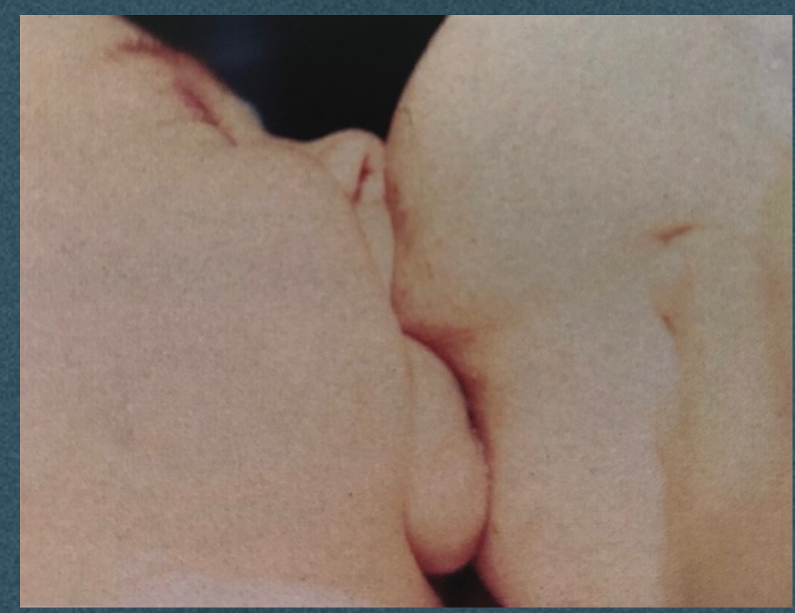
- Evaluate **FUNCTION** not APPEARANCE
- https://www.drghaheri.com/blog/2014/2/15/how-to-examine-a-baby-for-tongue-tie-or-lip-tie
- The baby needs to be able to create negative pressure to remove milk from the breast. The seal can be broken with clicking or slurping/clucking.
- 4 movements of the tongue :
  - **LIFT**- tip should touch upper gum ridge when mouth is wide open, the mid tongue should lift to roof of mouth.
  - **EXTENSION**-over the lower gum ridge and beyond lower lip, may see a heart shaped tip
  - **CUPPING**-inability to form a central groove impairs ability to organize fluids for safe swallowing
  - **LATERALIZATION**- sideways movement



6. Common Complications Tongue Tie

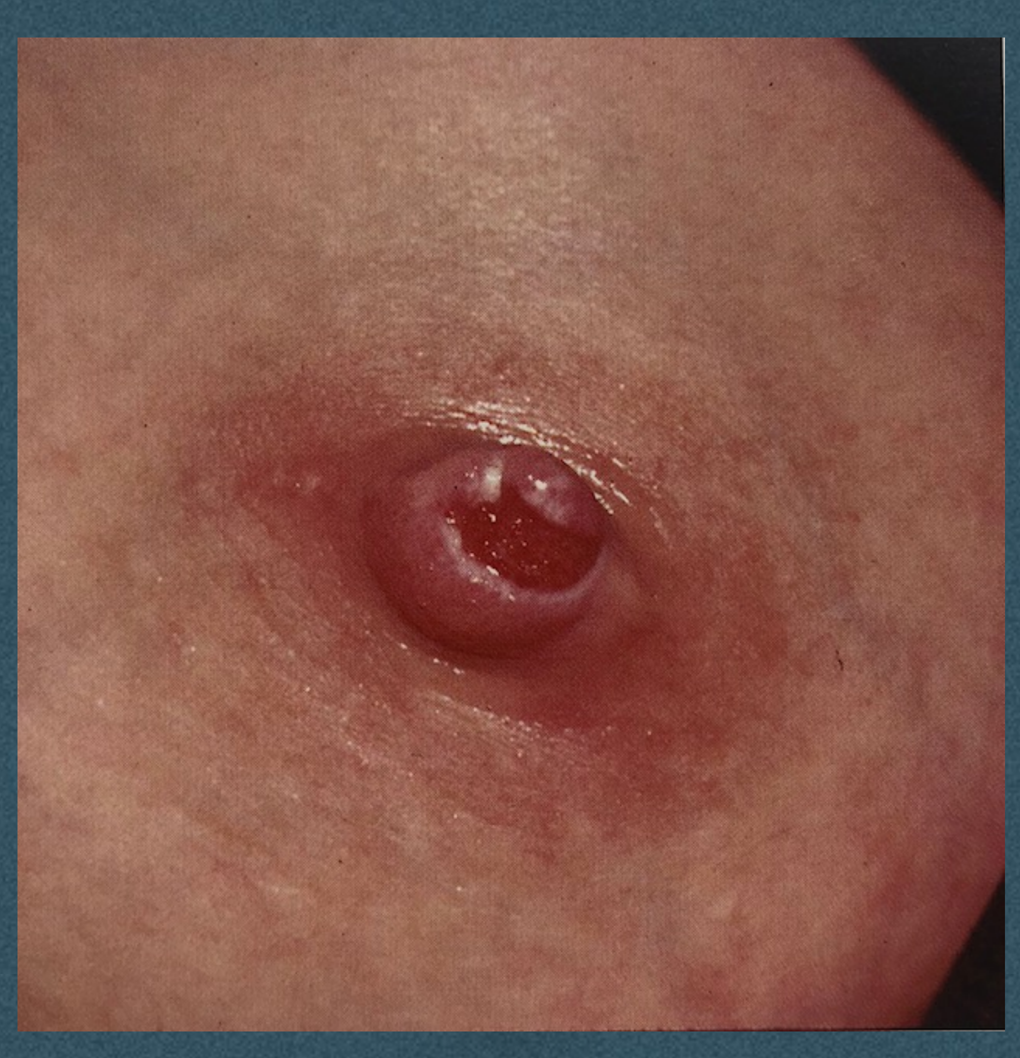
- Frenotomy - simple procedure that can save the BF relationship!!!!
  - In MB, there is no specific billing code for Frenotomy
  - Paediatric dentists will do these, and charge 700+dollars (please make sure they have an insurance plan)
  - Paediatric surgery will do these and do prioritize these cases. Send to Dr. Melanie Morris at Children's Hospital.
  - If you are not sure if frenotomy is needed ask an IBCLC opinion.
  - Babies can feed immediately post procedure and mom's often notice an immediate benefit !
  - Post frenotomy massage/exercise is controversial as there are few studies. They are not hard or painful, and can prevent resealing of the release. https://www.drghaheri.com/aftercare/





6. Common Complications Nipple Wounds That Won't Heal :

- FIX LATCH/ REMOVE TRAUMA
- AVOID STEROIDS (incl. APNO)
- MOIST WOUND HEALING (lanolin)
- KEEP WOUND CLEAN. Saline soaks and pat dry.
- Consider using : nursicare pads, medihoney, cotton washable breast pads
- Consider underlying infection
- Please encourage pain control (ADVIL!)
- Option to exclusively pump/hand express until healed on affected side.
- Please follow up and reassess your ddx.



6. Common complications

- **OVERACTIVE LET DOWN**
  - Signs that this is a problem:
    - fussy/gassy baby, choking and sputtering at the breast, clicking, latching and unlatching.
    - mom is leaking, spraying, engorged.
  - Solutions :
    - Wait - baby will be able to handle as gets bigger
    - Express first into a towel /pump a bit
    - Position baby against gravity
    - Block feed
    - Reassure / Support the family

LAID BACK

SIDE LAYING

SEATED STRADDLE

7. Resources for mom when things get confusing, hard, & exhausting:

- Websites:
  - Kellymom.com
  - Nancymorbacher.com
  - Breastmilksolutions.com (designed for health professionals)
  - Baby Friendly MB https://www.gov.mb.ca/health/bfm/index.html
  - lllc.ca 204-257-3509
  - Healthy Baby MB https://www.gov.mb.ca/healthychild/healthybaby/csp.html
    - call 204-945-1301 (in Winnipeg) or 1888 848 0140
- Books:
  - Breastfeeding Made Simple: Seven Natural Laws for Nursing Mothers (Nancy Mohrbacher and Kathleen Kendall-Tackett)
  - The Womanly Art of Breastfeeding (LLLI)
  - JACK NEWMAN - Empowering Parents , Jack Newman's Guide to BF
  - SWEET SLEEP (LLLI)

7. Resources for mom when things get confusing, hard, & exhausting:

- Local Support:
  - La Leche League Canada (Online/ in person/phone) lllc.ca 204-257-3509
  - BREASTFEEDING DROP-IN SUPPORT http://www.wrha.mb.ca/breastfeeding/clinics.php
  - COPING WITH CHANGE (Birth Centre) 204-947-2422 ext. 113 or email mothersprogram@womenshealthclinic.org
  - The nest http://www.nestfamilycentre.com/services/#classes

7. Resources for mom when things get confusing, hard, & exhausting:

- Local Professional Support:
  - Public health (home visits by RN's and assessment with lactation consultant)
  - BREASTFEEDING HOTLINE 204-788-8667
  - Private pay LC's in the Community https://www.birthrootsdoulas.com/breastfeeding-1/
  - **Winnipeg Breastfeeding Centre (FREE for families! Covered by MB HEALTH)**
    - www.wpgbreastfeedingcentre.com
    - On FACEBOOK!

Resources for Healthcare Providers

- bfmed.org (Academy of Breastfeeding Medicine)
- kellymom.com
- INFANTRISK (APP), www.infantrisk.com, LactMed
- Jack Newman Website www.Breastfeedinginc.ca www.ibconline.ca
- breastmilksolutions.com
- dr.ghaheri.com
- www.wpgbreastfeedingcentre.com

Resources for this talk

- J Wanderer, J Rathmell. Anesthesia and Breastfeeding: More often than not they are compatible. Anesthesiology10/2017 Vol 127
- Wilson-Clay Hoover. The Breastfeeding Atlas sixth edition (PHOTO CREDIT)
- Breastfeeding and Radiologic procedures Can Fam Physician. 2007 Apr; 53(4): 630–631.

Excess Weight Loss in First-Born Breastfed Newborns Relates to Maternal Intrapartum Fluid Balance

Caroline J. Chantry, Laurie A. Nommsen-Rivers, Janet M. Peerson, Roberta J. Cohen, Kathryn G. Dewey

- La Leche League International Website
- kellymom.com
- Infantrisk.com

- Anyone still awake ?

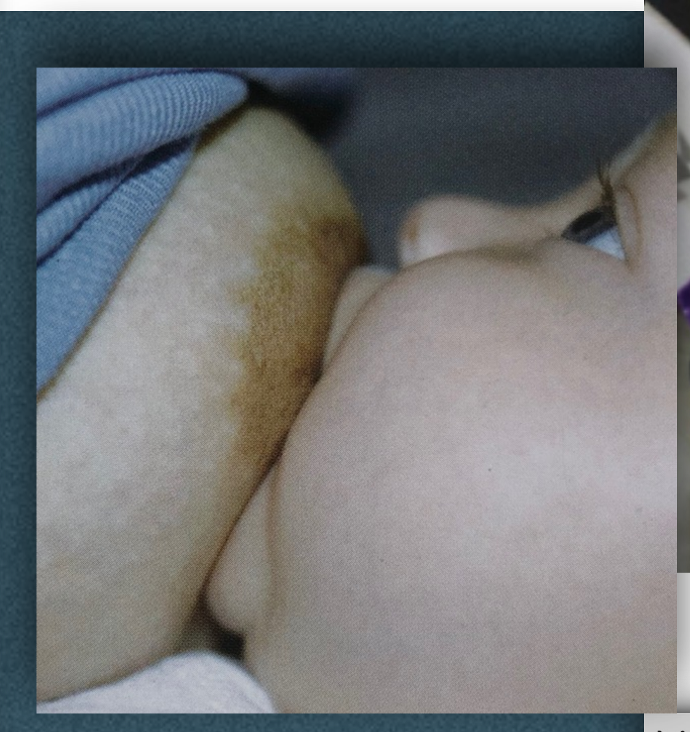
Supporting Manitoba families in reaching their breastfeeding goals

Dr. Katherine Kearns

BSc, MD, CCFP, IBCLC

Dr. Christina Raimondi

BSc, MD, CCFP, IBCLC



wpgbreastfeedingcentre.com

Winnipeg Breastfeeding Centre
191 Marion St, ph 204-231-1724