



**Questions/Answers from the
“7 Things You Need To Know About Feeding an Infant With A Craniofacial Difference” Webinar**
presented by Erika Lee, MS, CCC-SLP, BCS-S
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Q. How do you reduce nasopharyngeal reflux other than upright positioning, rest breaks, pacing? Ever thicken feedings?

I don't have much problem with terrible nasopharyngeal reflux, unless there are other things going on with the infant (aside from an isolated cleft). I position a little more upright and slow the flow down. I don't thicken any feedings in our NICU (or with any babies) because I am not convinced it's the best thing for them. That's another seminar for another day.

Q. Great info. Many thanks. Will you address how to identify which nipple/flow rate to choose from?

I typically will start with the level 1 nipple, and then adjust down to a preemie or ultra-preemie based on my evaluation. I can't remember the last time I used a level 2 nipple with a neonate.

Q. What is the percentage of infants with CP (Cleft Palate) that can successfully DBF (direct breast feed) for full nutrition (for longer than the first few weeks). With every research study I've read, the statistics include CL/P (cleft lip/palate) combined (which skews the results since CL babies usually DBF well).

If there is just a cleft lip, that does not involve the gumline, then there should be no reason they can't DBF. A good assessment should answer all those questions.

Q. How soon post hospital d/c do your babies come to your cleft clinic for a feeding eval?

Usually one to two weeks, unless there are extenuating circumstances (no transportation, etc.). We work closely with the infant's pediatrician with weekly weight checks to assure good growth and weight gain.

Q. Do you continue to use the SFS valve (Dr. Brown's® Specialty Feeding System) after palate repair until they fully transition to the cup or do you finish out those last few bottle-fed months of infancy w/o the valve?

I don't push the issue, I don't expect an infant to use a new system that late in the game. The child usually gets pretty upset that the bottle now works differently.

Q. How would you go about addressing the need to change the primary bottle used at our hospital with babies who have a cleft palate? Do you know of research articles to support this change?

I don't know of any research articles, but I think a simple cost analysis of the bottles coupled with the financial impact on families should be enough.

Q. is there an imaging technique used frequently to ID submucosal clefts? especially if you don't have a cleft team in your hospital but suspect a submucosal cleft and need more confirmation.

No, there is no test unless you perform an MBS and note that the palate isn't swinging the way it should, or there is retrograde flow into the nasal cavity. A good oral eval should give a lot of information too.

Q. is there any reason to switch to a Haberman at an older age if babies have started feeding with Dr. Brown specialty system?

No, I wouldn't generally switch to a Haberman at an older age. Infants tend to teethe on these nipples and go through them very quickly. It's also more difficult for an infant to hold the bottle independently and stay on an appropriate flow rate.

Q. I have recently had an infant with metopic craniosynostosis that I used the premie nipple and valve. Infant had high peak arch palate and had difficulty maintaining suction while on the breast. Infant always seemed like he needed suctioning, but never improved with feeding. Have u seen this?

I have seen kids with metopic craniosynostosis. The high peak of the palate makes it difficult for the infant to adequately suck from a regular nipple or breastfeed, and then the milk could get caught in the peak and require suctioning, I suppose.