My Baby – My Feeding Plan Q&A

1) Regarding breastfeeding difficulties, in your practice what percentage is from some type of lip, lingual, or buccal tie versus neurdevelopmental immaturity?

A: Unfortunately, I am uncertain of exact percentages but I do know the debate of "tongue tie" persists. When assessing any infant, I look at oral motor coordination. I need to know the tongue's ability to extend and elevate and cup the nipple and lip's ability to flare and sustain the oral seal. If the range of motion or strength in endurance is limited, it effects the feeding. Sometimes, maternal anatomy and abundant milk flow can compensate for baby's deficits and sometimes it can make a latch nearly impossible (i.e. flat nipples). This is why it is imperative to treat each infant as an individual in your assessment and document how the deficits relate to that baby. The wide variety of how each of these factors is presented in the mother-baby dyad guides the level of concern for need of a frenulum revision with an ENT consult. And, as always, early referral and treatment is best for optimal outcomes.

2) What percentage of the infants you see were actually discharged from the NICU doing some breast feeding?

A: Infants discharged from the NICU vary in the amount of breast feeds they have completed. I would guess 90% have attempted to breast feed but 100% of those were unable to meet full intake needs on breast feeding alone and required supplementation with a pumping/bottle strategy, which is why they were referred to see OT in outpatient therapy. The majority of mothers of the premature infants that we see have decided that bottle feeding is "easier" to track volume intake for early discharge from the NICU. We recently adapted IDF at our hospital and I am looking forward to seeing if those rates of success in breast feeding improve with an earlier timeline.

3) Can you repeat daily recommended amount for 5 lb infant? (Answered during Q&A)

A: Recommendations for volumes needed for infants to gain weight and grow are often based upon providing that infant with 100-120 kcals/kg/day. We use a calculated spreadsheet that our dietitians made that considers the weight of babies from 3 lbs. up to 12 lbs. The trick in bypassing this calculation is taking that infant's weight in pounds and ounces and converting it. Example: 5 lbs. 0 oz. needs about 50 ml q 3hrs, 8x/day. 9 lbs. 0 oz. needs about 90 ml q 3hrs, 8 x/day. *These are NOT exact calculations and meant to provide approximate goals of plus or minus 10 ml per feeding. I find this "cheater calculation" especially helpful in our outpatient population and with our late pre-term population that have not required NICU admission but are only taking limited volumes. It is nice to provide parents with goals appropriate for their baby.

4) What is the difference from a lactation consultant and counselor? (Answered during Q&A)

A: The biggest distinction between these two positions is a lactation consultant has an International Board Certified Lactation Consultant (IBCLC) certification. Both work with new mothers and infants with tips and advice on the breast feeding process. In our feeding clinic, the baby is the patient. Any medical complications related to Mom's health are referred back to the OB for treatment. We work closely with our team of IBCLC's for best care of our babies and mothers.