Dr. Brown's Medical Webinar Garcia/DeLuca 7.27.23
Q and A

Q: (In the study discussed) What was the % who were discouraged from providing breastmilk?
A: In the 2018 Kaye, et. al study that was discussed, only 36 percent of mothers reported individual encouragement to provide human milk, and 18% reported they were specifically discouraged from providing human milk for their infants.

Q: Do you have any specific recommendations of nipple shields for infants with orofacial clefting?
A: Nipple shields are designed to support the infant's latch when a mother has flat nipples or inverted nipples. If an infant has a cleft palate a nipple shield will typically not improve the infant's suction nor milk transfer, as the infant cannot generate negative pressure.

Q: Do you provide families with scales if they desire to breastfeed so they can do pre and post weights? If you do provide scales, which types do you offer?
A: Our team does not provide scales to our parents, yet we can provide information on infant scales available commercially on Amazon or other retailers. When using this method it's important to train the families and have a professional (lactation consultant or SLP) monitoring volume intake when infant is directly breastfeeding.

Q: What is the name of the supplement that increases production of hind milk?
A: Sunflower Lecithin

Q: How are the Haaka and hands free style pumps helpful or not helpful re this subject?
A: The Haaka Manual Breast Pump is designed to collect the mother's letdown on one breast while the infant is breastfeeding on the alternate side. As our infants with CP +/- CL cannot effectively transfer milk from the breast it will not work as intended, but could be a good collection tool if mother hand-expresses throughout the day to increase her supply. Conversely, The Haaka Colostrum Collector is a tool that can collect, store, and feed mothers' colostrum to our infants with CP+/- CL.

Regarding hands-free pumps, they are great for emergencies but as far as keeping and maintaining supply for a mother who is exclusively pumping, they are not recommended. They don't have the same suction strength as your traditional pumps and mothers are unable to use "hands-on" pumping as discussed in the presentation. With that said, if using these discreet hands-free pumps is the only way mother can express her breastmilk (demanding job, does not have breaks in day, has many children to care for, etc.) then go with it. Some human milk is better than none.

Q: Is there research showing differences/comparisons for hand expression (HE) during direct breast feeding (vs no HE) similar to the pumping information you presented?
A: I am not aware of any studies that have looked at this.

Q: To clarify, is breastfeeding for babies with cleft palate not recommended because it is unsafe or because it is inefficient/ineffective? Is breastfeeding for pleasure recommended?
A: Infants with a cleft palate have an obligatory anatomical difference (example- an unrepaired cleft palate) thus they cannot generate the negative pressure required for milk transfer. As such, they will not be able to be efficient exclusive breast feeders.

Q: Why are some prenatal counselors/clinicians recommending specific bottle/nipple BEFORE the baby is even born or seen? What are some ideas you have to alter this practice?
A: During prenatal counseling, I educate the family in the resources available and take their lead regarding their preferences. I briefly discuss the pros/cons of the bottles available and ask the family which bottle they prefer to "trial" first when baby arrives. Of course, we discuss every baby has unique feeding needs and that ultimately the infant drives this decision. In full transparency, we do find that the Dr. Brown's SFS is the bottle that is most often recommended, due to a combination of clinical findings and family preferences.

Q: What is the name of the last "system" you showed - the mom who is breastfeeding with the line of tubing?
A: The Supplemental Nursing System (SNS) by Medela.

Q: Do you guys happen to have any numbers on how many of your families are successful with hand expressing/compressing with breastfeeding with infant with CLP? Do they do it exclusively or still supplement via bottle?
A: In our combined years of working with this population (28 years) we have not worked with an infant with CP who has been successful with hand expressing/compression of the breast with direct breastfeeding exclusively. All mother-infant dyads we have supported required bottle feeding to meet their infant's growth needs.

Q: Can someone please repeat the level of nipple you'd typically start a full term infant with?
A: We typically start with a level 1 nipple and advance/downgrade flow rate dependent on infant's feeding characteristics.

Q: Are you always getting proof that the cleft is isolated prenatally?
A: Cleft lip can typically be identified on prenatal ultrasound. Cleft palate is typically NOT identified in-utero.

Q: When using SNS with a baby w/CP, how is facilitated milk transfer happening since they have little to no ability to achieve suction? Are you pulse squeezing the SNS with the timing of the sucks (which is extremely difficult)?
A: When using the SNS, milk transfer from the SNS tubing occurs by gravity. There is a clamp on the tubing that when released, milk will free flow through the tubing. Flow rate is controlled by the height of the system.

Q: Is there ever indication of FEES versus VFSS for swallow assessment in your cases?
A: Completing an instrumental swallow study is very infant specific. The clinician should select the exam that will provide the most information to maximize safety and support developmental feeding plan. A VFSS would provide more information about the infant's feeding as it provides information

about all phases of the swallow from a lateral projection –where compression, suction, and suck bursts could be objectively reviewed.

Q: If mom would like to put baby to breast for bonding and milk production, as well as facilitate stimulation, do you have mom attempt prior to bottling with SFS or after? And typically, how long do you recommend they attempt this for?
A: I have struggled with this question and don't have a blanket recommendation. In the first few weeks of life, even bottle feeding with a specialty bottle may be fatiguing for the infant and this may result in deep or active sleep post feeding. Conversely, if an infant is brought to breast in the crying state and is hungry, the infant may become frustrated as milk -transfer is disordered. I now educate the families on these states and recommend bringing the baby to the breast for bonding when infant is in a quite alert to active alert state. I usually don't put a time limit on this for an infant that has optimal weight gain, I simply encourage the mother to follow infant's lead. I also encourage skin-to-skin, primarily in the post-natal period in between feedings and wearing baby when able.

Q: You recommended semi inclined 60 degree angle for positioning. Do you ever recommend elevated side lying?
A: Positioning recommendations are always infant specific. Semi-inclined is where we typically start and then use elevated sidelying as therapeutic intervention as warranted.

Q: In the case study, what was the routine and time frame for mom pumping, using supplemental nursing system, then offering EBM via specialty feeder? To best set parents up for success if they attempt this option, the above is useful to know!
A: Agreed! Due to time constraints, we didn't have time to elaborate. Here is your question answered by the mother in our case study. Mom's response highlights the need for professionals to be supportive of mothers' desires to breastfeed while simultaneously providing realistic recommendations as to not create increased social-emotional stress on the feeding dyad.

Mother's answer: "I exclusively pumped from the beginning every 2 hours, which eventually went up to 3, then 4 hours as recommended by my lactation consultant. I would attempt the SNS system first thing in the morning, when Arwen woke up. I found that she was too tired in the afternoon. While it was recommended to use the SNS system every time I fed, I found it to be so stressful, time consuming, and frustrating for us both. I feel like by using it once a day, I got that breastfeeding bond I so desperately wanted, while also not stressing either of us out more. This carried on for about a month before Arwen decided that she preferred the bottle because it was easier for her".

Q: Does anyone know why Dr. Brown's does not sell the blue cleft valves separately? So the parents don't have to buy an entire bottle to get replacement valves.
A: (Answered by Dr. Brown's Medical) The Dr. Brown's® Specialty Feeding System is also sold in retail, and the Child Product Safety Improvement Act (CPSIA) sets the standard of how the product is sold. The SFS was tested as a fully assembled bottle system to pass testing according to the CPSIA requirement and consequently must be sold as a complete bottle system. Please note that extra valves do come with the purchase of the SFS. Every bottle within a case of 12 bottles has a valve with 12 extra valves also found within ease case of the following item numbers: SB412-MED and SB812-MED.

Q: I often use the pigeon nipple or the Dr. Browns (Specialty Feeding System) - I do really appreciate the flow changes of the Dr. Browns but sometimes I find the larger Pigeon can help with the larger clefts. Do you have any thoughts on that?
A: Bottle selection is infant specific. Flow rate, nipple shape, and nipple pliability are part of the nipple feature match with the infant's oral motor skills and feeding patterns. The Pigeon nipple has a faster flow rate, thus it would be recommended for an infant to have age-appropriate suck rhythm and a suck swallow breath ratio for PMA. With that said, anecdotally we have found the Pigeon to be helpful for those infants with bilateral cleft palate that are PMA and can tolerate the flow rate.