Promoción de la lactancia en el prematuro

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3° Congreso Argentino de Neonatología

Agenda for today

- Data on EBF rates for term and preterm infants in Brazil
- Challenges to breastfeed a preterm infant
- Policies to promote, support and protect BF – neo-BFHI
- Methods for transition to BF: translactation and responsive feeding
- Reccomendations for practice

Call for action: save preterm babies

- 35% neonatal deaths due preterm birth complications
- 15 milion babies are born prematurely
- Over 1 milion die every year and survivors face many disabilities
- Feasible, cost-effective interventions, such as **brestfeeding and KC** can help to save preterm babies lives

(WHO, 2012)

Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect

Cesar G Victora, Rajiv Bahl, Aluísio J D Barros, Giovanny V A França, Susan Horton, Julia Krasevec, Simon Murch, Mari Jeeva Sankar, Neff Walker, Nigel C Rollins, for The Lancet *Breastfeeding Series Group**

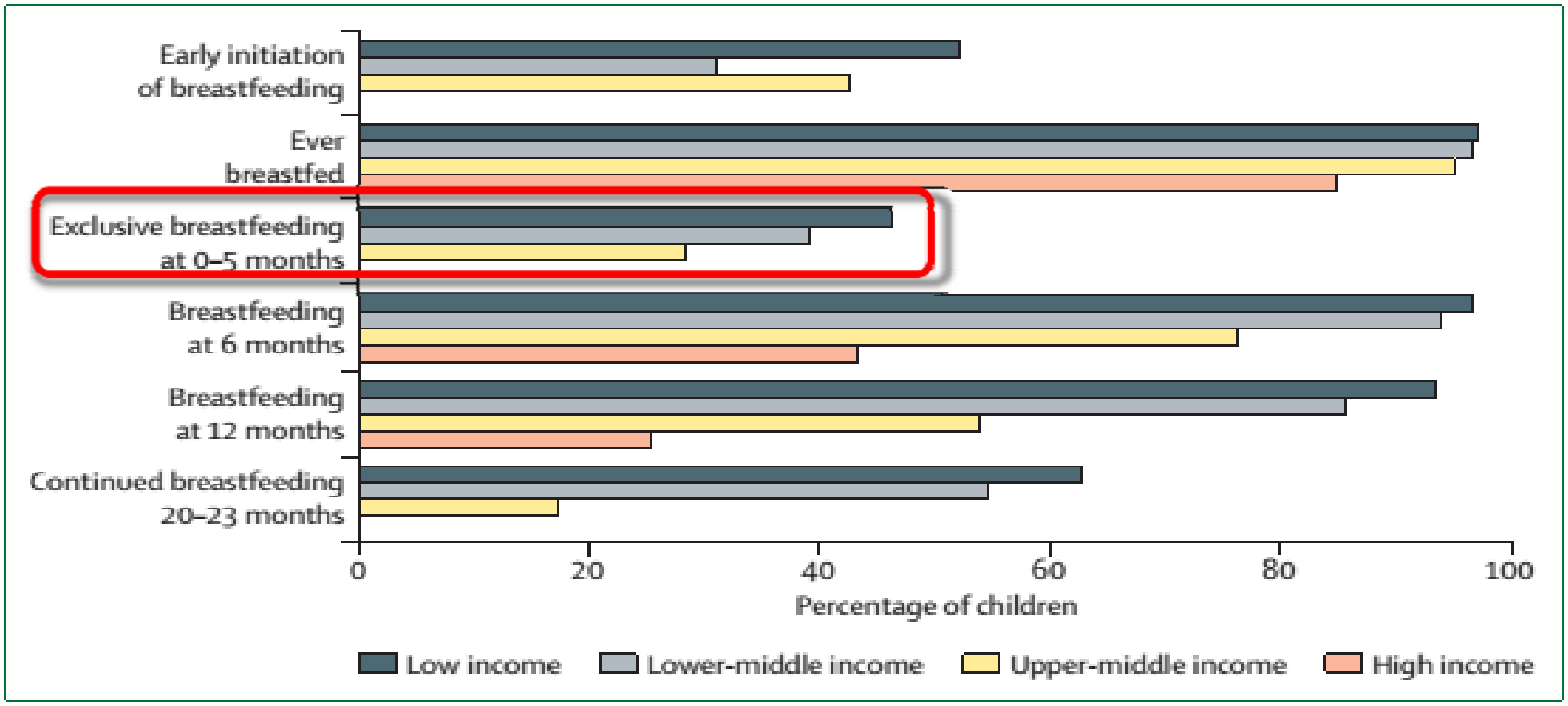
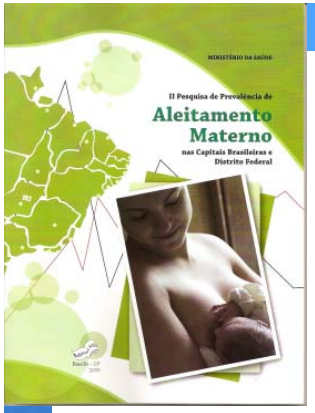
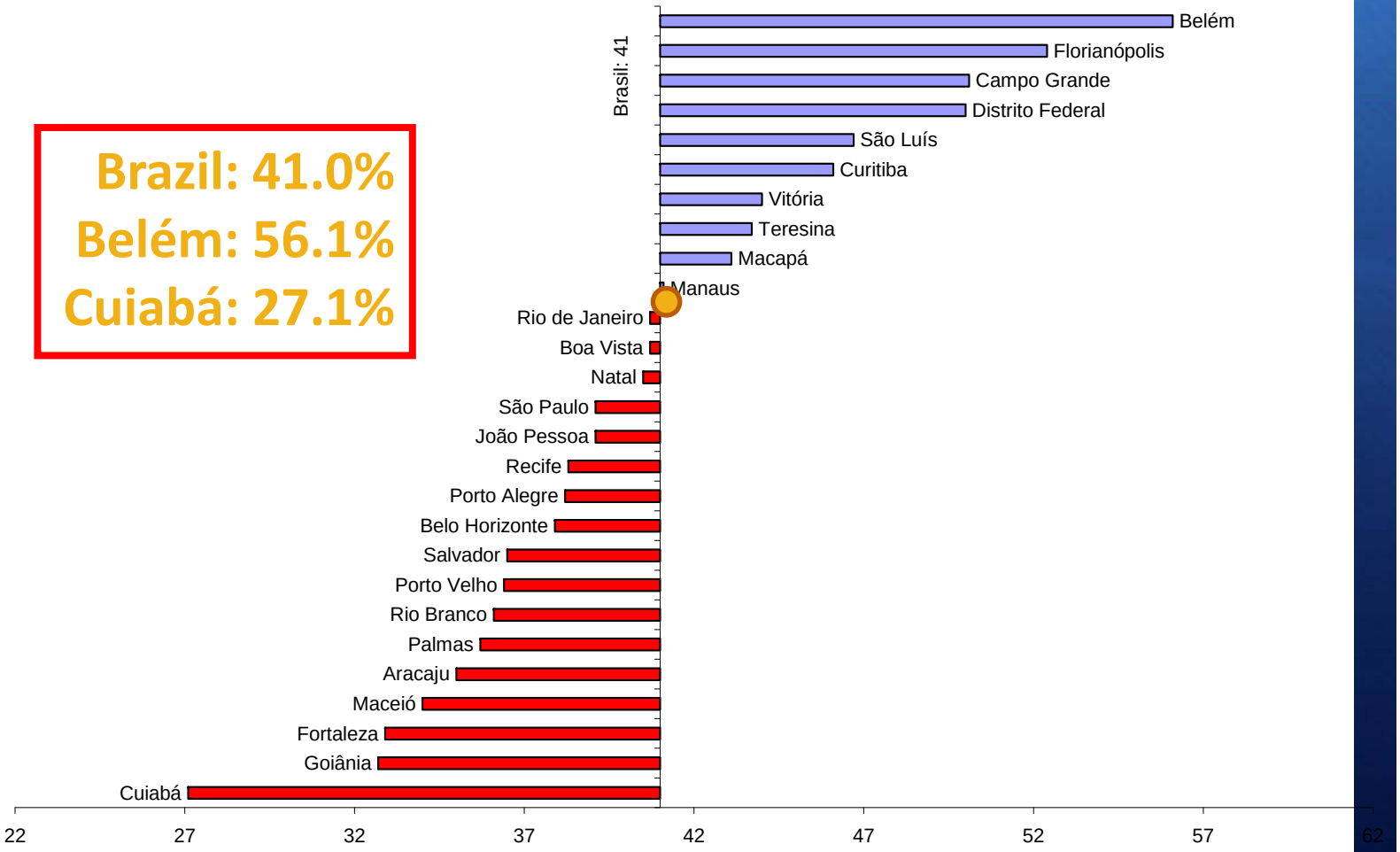


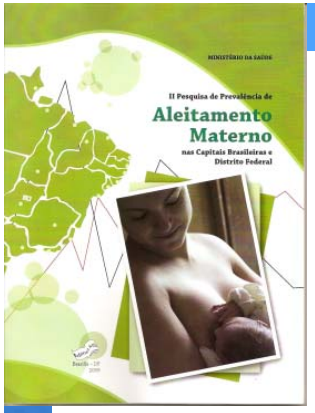
Figure 2: **Breastfeeding indicators by country income group in 2010**
Data are from national surveys that used standard indicators, and were weighted by national populations of children under 2 years. Data for up to 153 countries.



Exclusive Breastfeeding < 6 Months BRAZILIAN PROVINCES, 2008

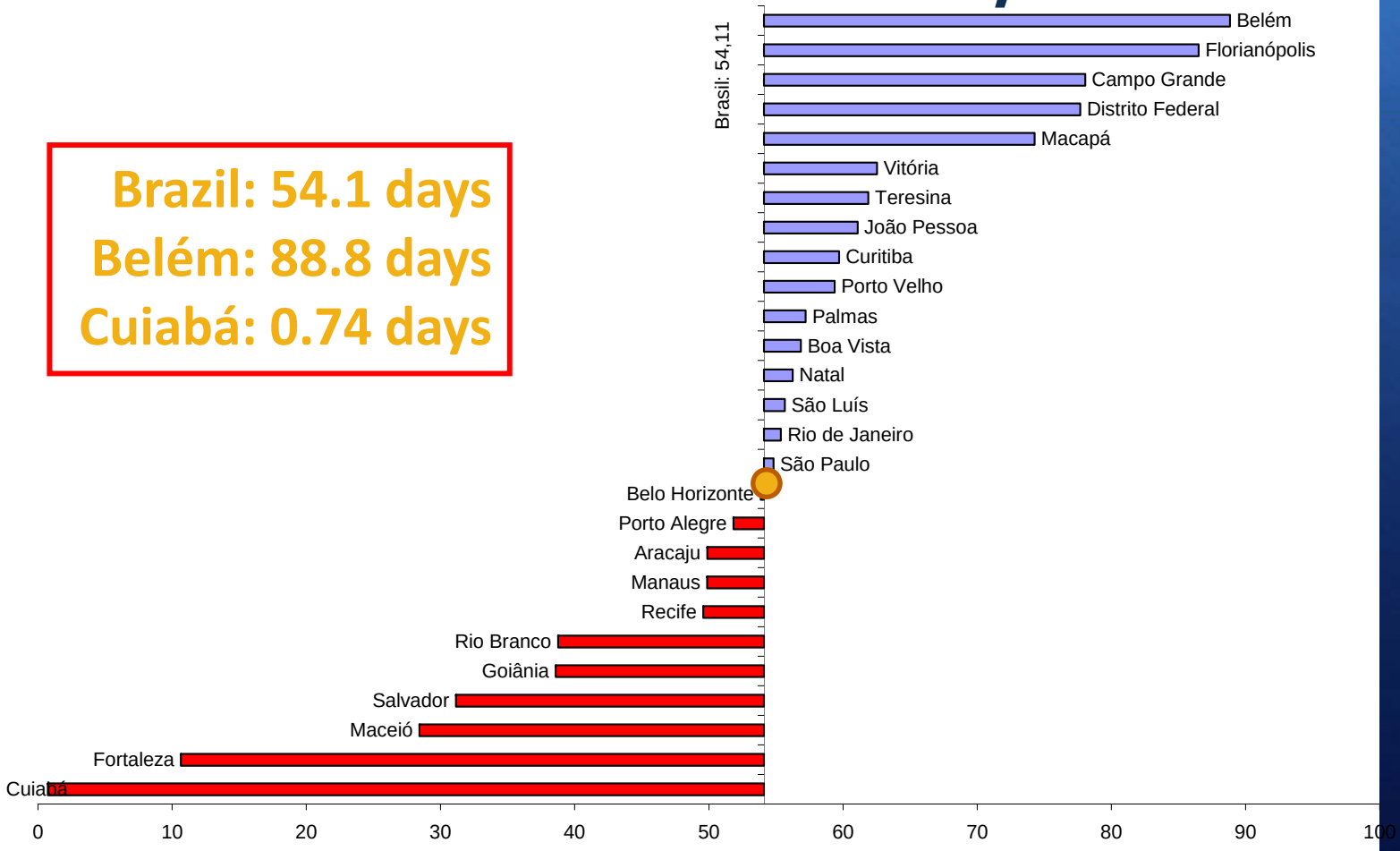
Brazil: 41.0%
Belém: 56.1%
Cuiabá: 27.1%

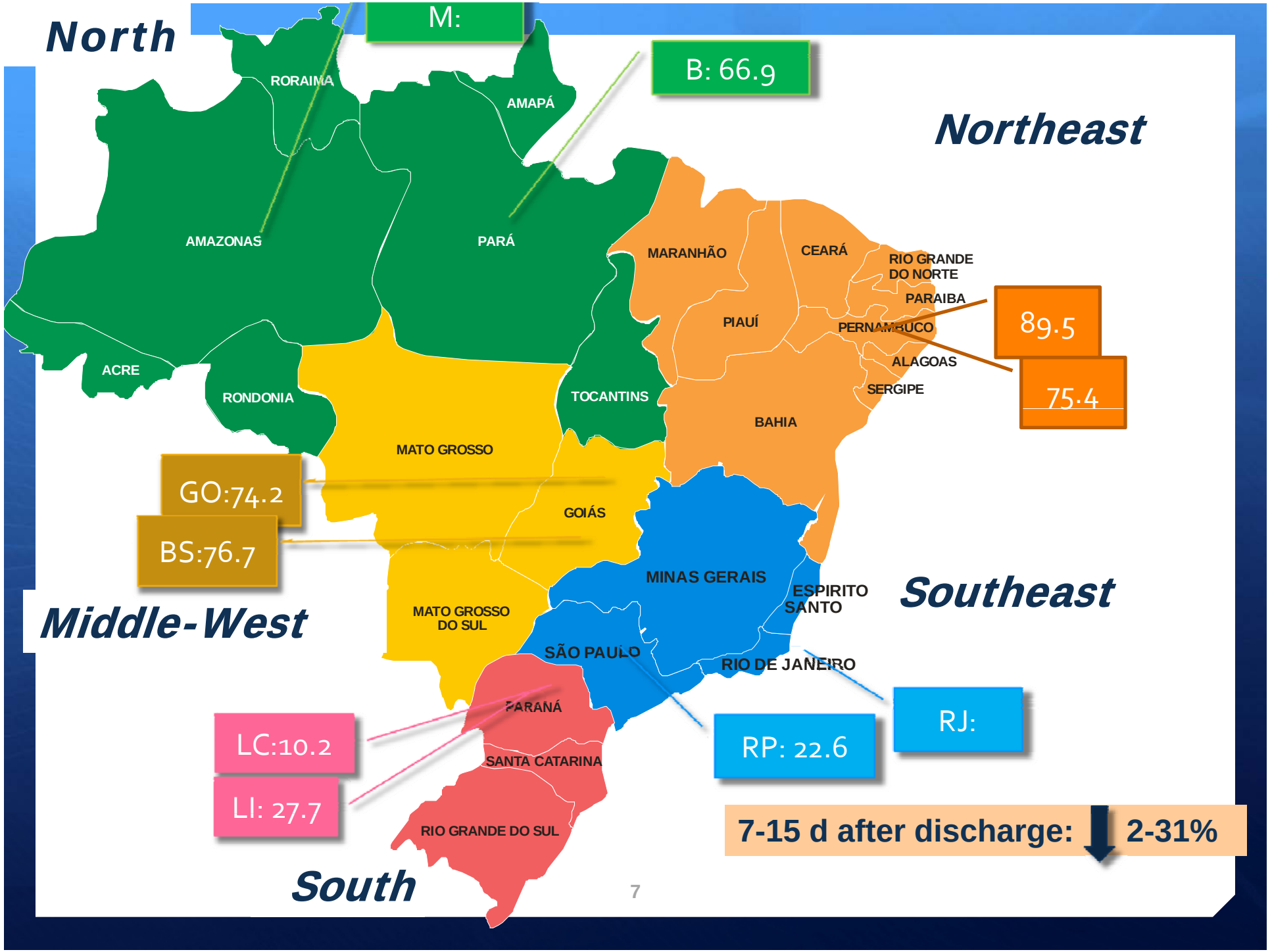




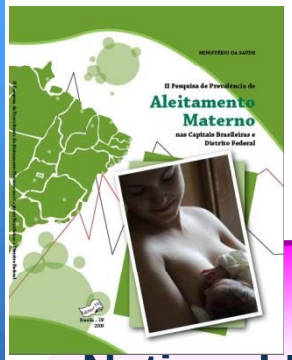
Median Duration of Exclusive Breastfeeding BRAZILIAN PROVINCES, 2008

Brazil: 54.1 days
Belém: 88.8 days
Cuiabá: 0.74 days

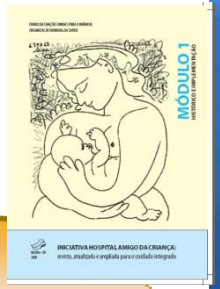



North
M:
RORAIMA
AMAPÁ
B: 66.9
Northeast
AMAZONAS
PARÁ
MARANHÃO
CEARÁ
RIO GRANDE DO NORTE
PARAIBA
PIAUÍ
PERNAMBUCO
89.5
ALAGOAS
75.4
SERGIPE
ACRE
RONDONIA
TOCANTINS
BAHIA
MATO GROSSO
GO:74.2
GOIÁS
BS:76.7
MINAS GERAIS
ESPIRITO SANTO
Southeast
Middle-West
MATO GROSSO DO SUL
SÃO PAULO
RIO DE JANEIRO
RJ:
PARANÁ
LC:10.2
RP: 22.6
SANTA CATARINA
LI: 27.7
RIO GRANDE DO SUL
South
7-15 d after discharge:
2-31%

NATIONAL POLICY: PROMOTION, PROTECTION AND SUPPORT TO BREASTFEEDING



Primary care
Breastfeeding Network
Brazil



National Research of Prevalence of BF

Hospital Care
BFHI
KMC

Método Canguru

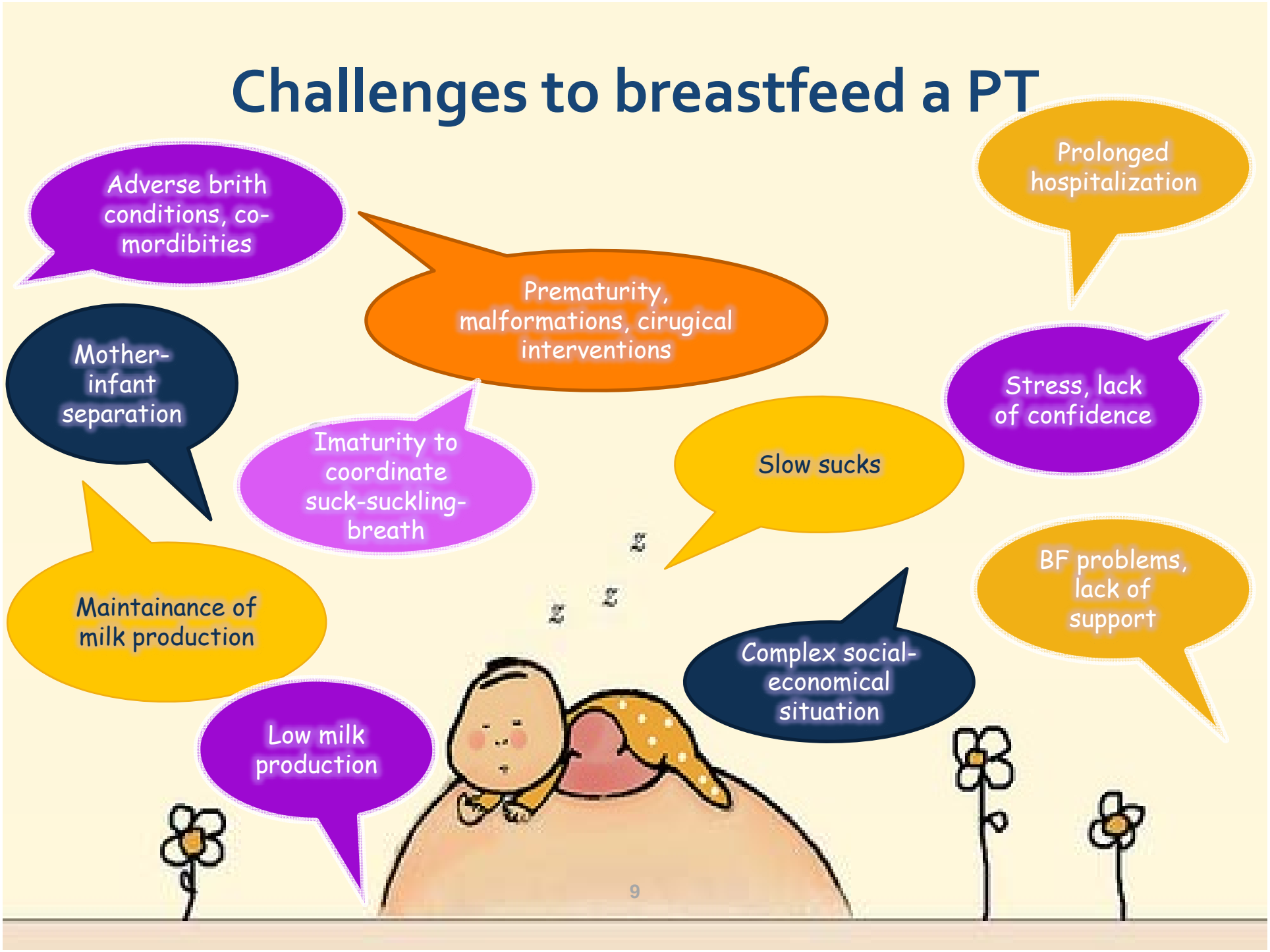
PROMOTION, PROTECTION AND SUPPORT TO BREASTFEEDING

Marketing

Human Milk Bank Network

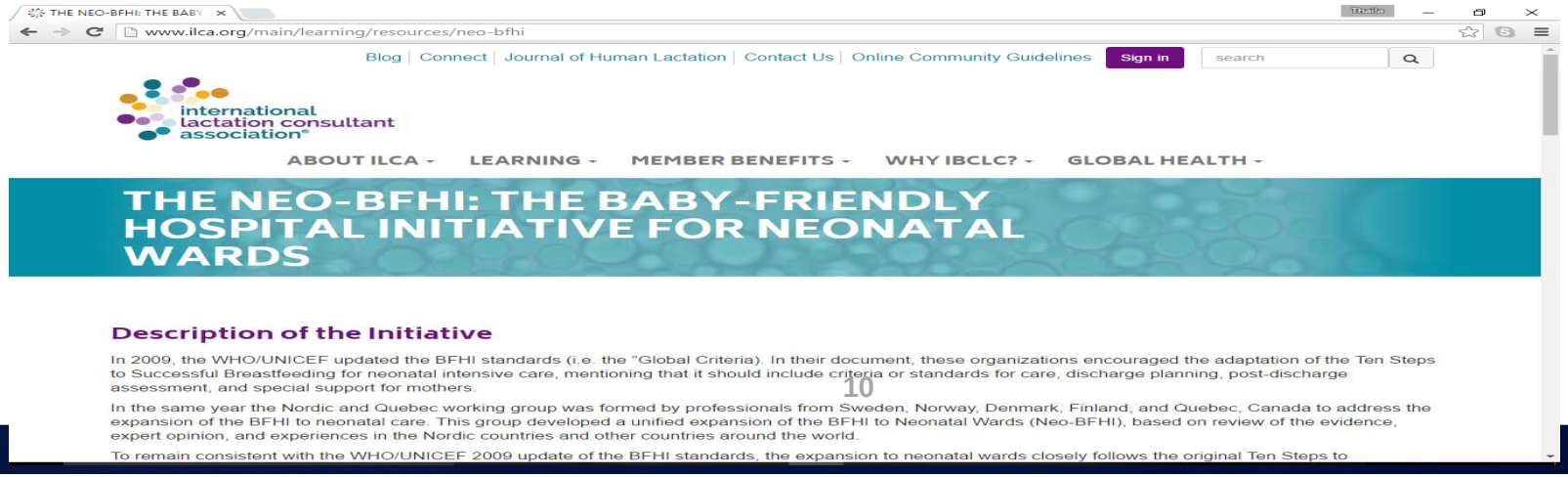
Legal Protection to Breastfeeding

Challenges to breastfeed a PT



New package of interventions for the preterm newborn in NICUs

- Considers particular needs of the preterm or ill infants in the NICU
- Provides differentiated approach to offer the support required by the mothers and families of preterm infants
- Compliance with the original BFHI (Unicef, WHO)



Three Guiding Principles

1. The staff approach to the mother must focus on the individual mother and her situation
2. The facility must provide family-centered care, supported by the social and physical environment in the unit
3. The facility must ensure continuity of care: that is, continuity of pre-, peri-, and post-natal, and post-discharge care

+ the Ten Steps and the Code…

The Three Guiding Principles

Special Report

International Lactation Consultant Association
A Worldwide Network of Lactation Professionals

Journal of Human Lactation
28(3) 289–296

DOI: 10.1177/0890334412441862
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Expansion of the Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations for Three Guiding Principles

Kerstin Hedberg Nyqvist, RN, PhD[1], Anna-Pia Häggkvist, RN, MSc, IBCLC[2], Mette Ness Hansen, RN, IBCLC[2], Elisabeth Kylberg, PhD, IBCLC[3], Annemi Lyng Frandsen, RN, IBCLC[4], Ragnhild Maastrup, RN, IBCLC[5], Aino Ezeonodo, RN, CEN, CPN, CNICN, MHC[6,7], Leena Hannula, RN, MNSc PhD[7], Katja Koskinen, RN, IBCLC[8], and Laura N. Haiek, MD, MSc[9]

Abstract

The World Health Organization/United Nations Children's Fund *Baby-Friendly Hospital Initiative: Revised, Updated, and Expanded for Integrated Care* (2009) identifies the need for expanding the guidelines originally developed for maternity units to include neonatal intensive care. For this purpose, an expert group from the Nordic countries and Quebec, Canada, prepared a draft proposal, which was discussed at an international workshop in Uppsala, Sweden, in September 2011. The expert group suggests

J Hum Lact, 2012, 28(3), 289-96

"Baby-Friendly" care requires that the nurses' role shifts from primary caregiver…

…to educator and supporter of the infant's parents as primary caregivers in the NICU.[14]

The expanded Ten Steps and the Code

Special Report

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Expansion of the Baby-Friendly Hospital Initiative Ten Steps to Successful Breastfeeding into Neonatal Intensive Care: Expert Group Recommendations

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Abstract

In the World Health Organization/United Nations Children's Fund document *Baby-Friendly Hospital Initiative: Revised, Updated and Expanded for Integrated Care*, neonatal care is mentioned as 1 area that would benefit from expansion of the original Ten Steps to Successful Breastfeeding. The different situations faced by preterm and sick infants and their mothers, compared to healthy infants and their mothers, necessitate a specific breastfeeding policy for neonatal intensive care and require that health care professionals have knowledge and skills in lactation and breastfeeding support, including provision of antenatal information, that are specific to neonatal care. Facilitation of early, continuous, and prolonged skin-to-skin contact (kangaroo mother care), early initiation of breastfeeding, and mothers' access to breastfeeding support during the infants' whole hospital stay are important. Mother's own milk or donor milk (when available) is the optimal nutrition. Efforts should be made to minimize parent–infant separation and facilitate parents' unrestricted presence with their infants. The initiation and continuation of breastfeeding should be guided only by infant competence and stability, using a semi-demand feeding regimen during the transition to exclusive breastfeeding. Pacifiers are appropriate during tube-feeding, for pain relief, and for calming infants. Nipple shields can be used for facilitating establishment of breastfeeding, but only after qualified support and attempts at the breast. Alternatives to bottles should be used

J Hum Lact, 2013, 29(3):300-9.

The expanded Ten Steps and the Code

Step 1: Have a written BF policy that is routinely communicated to all health care staff.
Step 2 : Educate and train all staff in the specific knowledge and skills necessary to implement this policy.
Step 3: Inform hospitalized pregnant women at risk for preterm delivery or birth of a sick infant about the benefits of BF and the management of lactation and BF.
Step 4 : Encourage early, continuous and prolonged mother-infant skin-to-skin contact/ Kangaroo Mother Care.
Step 5 : Show mothers how to initiate and maintain lactation, and establish early BF with infant stability as the only criterion.
Step 6 : Give newborn infants no food or drink other than breast milk, unless medically indicated.
Step 7 : Enable mothers and infants to remain together 24 hours a day.
Step 8 : Encourage demand BF or, when needed, semi-demand feeding as a transitional strategy for preterm and sick infants.
Step 9 : Use alternatives to bottle feeding at least until BF is well established, and use pacifiers and nipple shields only for justifiable reasons.
Step 10: Prepare parents for continued breastfeeding and ensure access to support services/groups after hospital discharge.

Compliance with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.

Methods for transition to BF

Translactation

(Aquino et al., 2009)

+Mothers produces at least 2/3 – 100% of required milk volume

+Transition from gavage to oral feeding and the transposition from tube feeding to breastfeeding

+Prefer mother's fresh milk

+Fix a 20-mL pistonless syringe to the mother's lap and attach to a number 4 gastric tube, the punctured end of the tube is placed at the level of the nipple

+Benefits

Methods for transition to BF

Cup feeding

+Wrap infant securely in a blanket with his/her hands tucked in a midline position and held upright. Place the rim of the cup at the infant's lower lip so that milk just touch the lip. Do not not pour into the infant's mouth. Leave the cup so the infant can "lap" or "sip" the milk

+does not interfere in BF, provides the infant positive oral, tactile, and auditory stimulation, exposure to the smell and taste of breast milk, tongue and motor skill experience, and the ability to control feeding pace

+not ease technique, too slow, prone to spillage, insufficient intake, increases the risk of choking or aspiration

+compared cup vs. bottle-feeding

+infants becoming accustomed to cup-feeding over time and resisting breastfeeding???

+indicated for term, healthy and stable preterm (Dowling et al., 2002; Mcnniey et al., 2016)

Translactation vs. Cup feeding

- RCT (64 mother-infants, < 32 weeks GA and < 1500g)
- Translactation (TL) vs. Cup (CP) for transition from gavage to BF
- Preterm Oral Feeding Readiness Assessment Scale (PROFAS)
- Assessment BF status at discharge, 15 days, 1 and 2months after
- Higher EBF rate at 15 days after discharge (TL=62.1% vs. CP=31.4%)
- 81% higher risk of full weaning after 15 days for CP group
- longer EBF duration (TL=163 days vs. CP=146 days)
- *"Translactation is more effective during the transition from gavage to EBF in very preterm infants in regards to greater prevalence, duration and less risk of weaning at 15 days after hospital discharge"* (Rossetto, 2011)

Not recommended

Methods for transition to BF

Responsive / Semi-demand feeding

- feeding PT infants in response to their hunger and satiation cues, rather than at scheduled intervals and with a predefined amount of milk
- Prescribed total daily volume
- Mother offers breast often day and night + supplementation (cup, tube) as needed
- Baby weighed daily (before and after feeding) or when mother think is needed
- Maximum interval 5-6hs
- Trieste protocol (Davanzo et al., 2014):
  - 32-36 weeks PCA, exclusive enteral nutrition with at least 1 successful breastfeed in the previous 24 hours with a minimum intake of 10 mL per feed
  - adequate weight gain (minimum 15 g/d) in the past 7 days for infants 32-34 weeks,
  - breast milk production greater than 200 mL/day, motivation to breastfeed the infant, ability to provide an extended presence in the NICU

(Davanzo et al., 2014)

Methods for transition to BF

Responsive / Semi-demand feeding

Infant cues

+ quiet wakefulness, hand-to mouth gestures, finger or fist sucking, arm waving, kicking, stretching, bicycling legs, and grunting

+ Cry (late sign, waste energy, poor latching)

(Watson; Mcguire, 2015)

Methods for transition to BF

Key aspects for sucess

- Parents can stay with infant 24h/7d - also intensive care
- Early and continuous Kangaroo Care
- Infant: No stressful experience before nursing (diaper change)
- Monitoring (ECG, saturation)
- Nurse present whole first breastfeeding session
- Not restrict frequency/day or duration/session
- Realistic expectations
- Plan together with mother = pathway to EBF (when her goal)

Methods for transition to BF

Responsive feeding / Semi-demand feeding

+Cochrane Systematic Review (9 RCTs, 582 infants)

+clinically stable preterm infants , fully enterally fed and at transition from intragastric tube feeds to oral feeds (generally between 32 and 36 weeks' PMA)

+Infant-led feeding, ceased only in response to satiation cues (sleep of failure to maintain sucking)

+Benefits

- + earlier hospital discharge, lower PMA at discharge, shorter duration of the transition phase from tube to full oral feeds
- + slightly lower levels of milk intake and rates of weight gain

+Caution: very low quality studies

+Need to evaluate other measures

(Watson; Mcguire, 2015)

But when is it safe to initiate BF in infants < 32 weeks PCA?

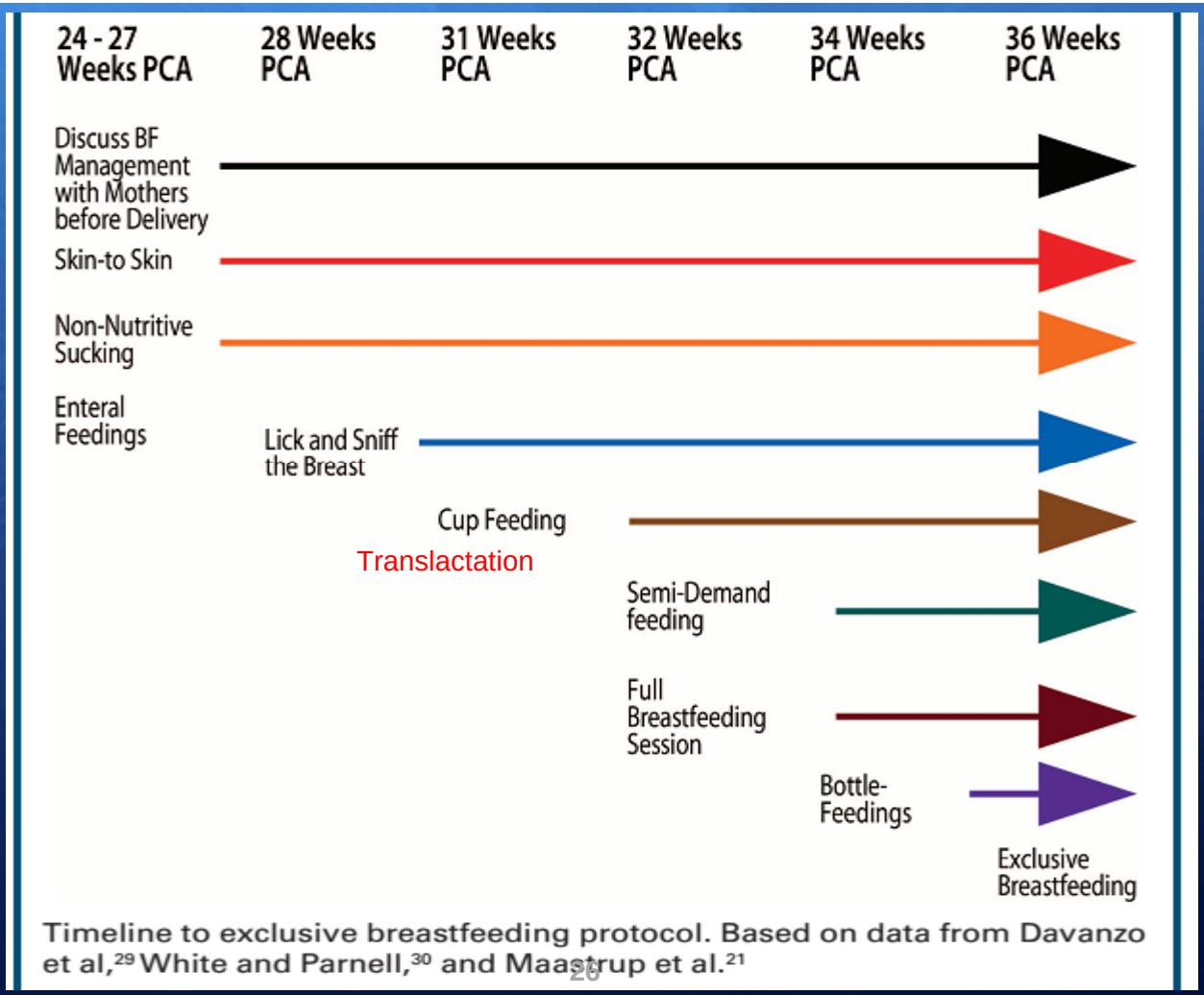
- infant exposure to the breast may safely occur before < 32 weeks' PCA when infants are physiologically stable.
- the time to transition from initial exposure to the breast with a lick and sniff to a complete BF session varies on the basis of individual infants' physical health and neurodevelopment
- joint admission of mother and infant to the NICU, 24-hour accommodations for mothers, daily KC, cue-based feeding, alternative feedings methods of enteral tube feeding (eg, cup feeding, translaction), and minimal use of pacifiers during the infants' transition to BF

(Lucas; Smith, 2015)

When Is It Safe to Initiate Breastfeeding for Preterm Infants?

Advances in Neonatal Care • Vol. 15, No. 2 • pp. 134–141

Ruth F. Lucas, PhD, RNC, CLS; Rebecca L. Smith



Timeline to exclusive breastfeeding protocol. Based on data from Davanzo et al,[29] White and Parnell,[30] and Maastrup et al.[21]

(Lucas; Smith, 2015)

Recommendations for practice

- Support KC within 24 h of delivery and then frequently and continuously
- Facilitate mothers pumping after delivery and maternal presence at the bedside
- Assess signs of feeding readiness to initiate BF
- Encourage mothers to BF when infants demonstrate feeding cues
- Offer NNS sucking before transitioning to BF.

(Lucas; Smith, 2015)

Recommendations for practice

- Continued support of BF
- Supplement infant with enteral feeding if infant shows no feeding cues 4 -6h after last BF
- Enroll infants 32 to 36 wks' PCA for semidemand feeding after 1 to 3 successful BF in previous 24 h
- Facilitate BF support by lactation consultants, peer BF counselors, and professional medical team for mothers and infants to transition to exclusive BF
- Avoidance of BTL
- Assess infant weight before and after BF.

(Lucas; Smith, 2015)

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THANK YOU! QUESTIONS?

IHAC-NeO

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