

Minutes for WALC meeting of September 17, 2004

Notes take by Cindy Rux, retiring secretary

Typing by Ruth Sweet, in coming secretary

Delinquent Resources: Carol Naze (3), Alyce Tylicki (3), Peggy Stohleim, Mary Ellen Anderson, Cindy Dibb, Wendi Rebholz (3), Janetha Johnson. Please return these materials to the next meeting. Mail to Kris Walleser if unable to attend. (Titles are listed on a separate page)

Meeting called to order by Carol Cox at 0930

Host: Children's Hospital of Wisconsin and Lisa Brock. Thank you. 32 people attended.

Announcements:

- Hale's newest Medication and Mother's Milk is now available for member distribution. In November, we'll hand out the Hale Books to those who haven't received one. Please try to attend to save postage for WALC.
- WALC membership directories are also now ready for distribution. NOTE these corrections to the directories: Donna Bisbee email address should be <mailto:dbisbee@walc.net> and Winnie Madding <mailto:wmibclc@earthlink.net>
- If anybody wants Jan Riodan's book Human Lactation, contact Cindy Dibb. We may be able to get a price break at the March WALC conference.
- Anne Altschuler shared a book Having Faith by Sandra Steingraber.
- Anne Altshuler noted an article on Erythromycin and Diflucan, a dangerous combination which may cause heart arrhythmias.
- Old audio and video tapes are for sale from the WALC library (see attached list). Contact Kris Walleser if interested.
- Pat Gima shared information from The UV Advantage by Michael Holick. It discusses Vitamin D and sun exposure.
- Educational Opportunities
 - Nov 27 to Dec 9, 2004 Sue Morrison is going with a group of LC's to Africa. Call her if interested. You would receive CERPS.
 - Oct 22, 2004 LLLI Breastfeeding Specialist Workshop Napierville IL
 - Oct 22 LLL of WI is sponsoring Diane Wiessinger in Milwaukee
 - Oct 15 & 16 ILCA Regional Conference is in Kansas City MO
 - Oct 4 & 5 Maria Biancuzzo presents 2 different conferences.

Educational Content: Reports from those attending ILCA 2004 Conference in Scottsdale AZ

There were 800 attendees. ILCA reports that it is in good financial shape. They are considering the feasibility of having a separate US National group as part of ILCA so they are not spending as much time on the US related issues. Future conferences: July 8 -12, 2005 in Chicago and July 12-16, 2006 in Philadelphia.

Speakers

- Carol Cox “Almost premature baby” and “Helping parents survive the second night”
- Winnie Mading “The medicalization of breastfeeding” and “Searching for Best Practices, Our lives in the workplace”
- Pat Gima “Mammary Candidosis among lactating women” and “Over abundant milk supply”
- Alyce Tylicki “Vitamin D levels” and “Assisting mother’s with breastfeeding after breast reduction surgery”
- Anne Altschuler “Immunology of breastfeeding”, “Jaundice and the breastfed baby” and “Bacterial contamination and over dilution of commercial infant formula feeds given by HIV positive mothers in Durban, South Africa.

These reporters have summarized this material which is attached.

Business Meeting attended by 25 members.

Called to order at 1250

Minutes from Jan 04 and May 04 were approved and seconded

Treasury: Terri reported \$4300 in our checking account.

Membership: Sandy reports 107 members.

Program Committee: Donna reports that previous meetings have been favorably received.

- Nov 16, 2004 at Waukesha Memorial. Joan Buczynski-Radomski will present her ILCA topic and Mary Pesik will speak on AAP and Breastfeeding Legislation.
- Jan 21, 2005 at Community Memorial in Menomonee Falls. [moved to St. Joe Reg MC]
- May 17, 2005 at Mauston
- Sept 16, 2005
- Nov 15, 2005

Conference committee: March 10 & 11, 2005 Paper Valley Appleton WI. Caring with Knowledge

Speakers: Marsha Walker and Nancy Wight

Topics: Human milk for the pre term infant; Hypoglycemia; The What, When Why and How of supplements; Effective discharge teaching, Ethical Issues. 11.1 contact hours.

The hotel room rate will remain the same. The postcard tickler will be out soon.

Resources: Kris reported that there are still a few over due items. Names of the people responsible were listed at the top of this report AND on an attached page with titles listed.

Old Business:

- Scholarship fund reported by Chris Raasch and Winnie Mading. Recommendations were made. Report attached separately.
- Terrell Brock Grant - Winnie Mading reported that it is to help 10 hospitals reach “baby friendly” status. It is also to help increase breastfeeding rates and it will help with training. They are in the process of rewriting this grant.

New Business:

- Joan Buczynski-Radomski has donated \$200 back to WALC from her ILCA conference sponsorship. This will be used to start an Education Fund.
- Elections for next President Elect are scheduled for Jan 2005. This person will assume the president position in the Fall of 2006. Please contact Carol Cox to nominate yourself or someone else. Carol reports favorably on this job and reminds all that she will continue as Past president to assist the new president. Election will also be held for Treasurer, Terri is willing to continue in her current position.
- WALC will donate \$100 for a memorial for Mo Eglash.
- Meals sponsored by commercial vendors such as Hollister, Medela, or any product selling company: There was a discussion as to whether or not WALC will accept this. Carol stated that it does not violate the WHO or the LC Code of Ethics. The group present voted with 10 yes and 14 no.

Meeting adjourned at 1350

DELINQUENT RESOURCES

September 2004

Carol Naze 2002 ILCA Conf Syllabus, tape on mammary candidosis, tape on engorgement

Alyce Tylicki Video Getting Started Right, Ask the experts, engorgement

Peggy Stohleim Video Lactation history

Mary Ellen Anderson tape on feeding problems

Cindy Dibb DVD Getting Started Right

Wendy Rebholz Tapes on Donor human milk, Reattaching, Breastfeeding the near term

Janetha Johnson Video and Anatomical contributions to infant suckling

WALC VIDEO AND AUDIO TAPE SALE

September 2004

VIDEOS \$1 EACH

1993 Breast feeding the seriously ill baby

1995 ILCA models for cost savings associated with breastfeeding

1996 Infant feeding in war torn Yugoslavia; Breastfeeding Promotion in a WIC setting

AUDIO TAPES \$1 EACH

1989 Psychosocial aspects of Lactation

1990 Lactoengineering; Changing hospital policies; LC law; Human milk research and the LC;
Nursing Supplementers; Non intervention counseling

1991 Breast pump research based use and guidelines; Maternal infectious disease; Infant feeding and
cognitive development; Colic and the breastfed baby; Lack of commitment in breastfeeding

1992 The Hazards of Infant formula

1993 Effects of surgery on breastfeeding; Relactation and induced lactation; Failure to thrive; Growth
patterns

1994 Hazards of infant formula; Breastfeeding mindset; The fact and factor of medications;
Breastfeeding and allergies in infants; Infant sleep; Interrelationship between neonatal jaundice and
breastfeeding adequacy

ILCA Conference Report, July 14 - 18, 2004 by Anne Altshuler

Lars Hanson, MD, PhD: The Immunology of Breastfeeding (syllabus page 681)

Immune defense:

Mammals deliver their young right next to mother's anus in order for offspring to pick up normal gut microflora. Immune system of human neonates is very small. Gut microflora is the main stimulus to its growth and its education to develop tolerance. Need for baby to be colonized with ecoli from mother's gut, so more harmful bacteria can't get a hold. A breastfed baby has all the bacteria in its gut and other mucosal surfaces coated with secretory IgA. Bacteria can't cling on to cause infections like UTI. Too slippery. Breastfeeding for 7 months protects against UTIs for up to 2 years.

2 parts to immune system:

- 1) Mother has IgG antibodies in her blood. These reach the fetus through the placenta. Antibodies and lymphocytes go to work when infection activates immune system. Induces inflammation. Takes a lot of energy. Tired, fever, pain, loss of appetite. Baby with infection doesn't grow well.
- 2) Secretory IgA antibodies in milk are produced by lymphocytes that migrate to the mammary glands from mother's gut. These lymphocytes are directed against bacteria present in mother's gut. IgA protects baby against all these bacteria. IgA is present on all mucosal surfaces. Fights infection without energy expenditure or causing inflammation. Baby has no clinical symptoms and continues with normal growth.

Anti-secretory factor (AF) found in human milk prevents or blocks inflammatory processes like diarrhea and can treat inflammatory bowel disease and other inflammatory conditions. It can be induced in mothers by having them eat a specially treated cereal. In a preliminary study in Swedish mothers, this led to a reduction in the incidence of mastitis. Inducing AF in this way may be able to prevent the sub-clinical mastitis in HIV positive mothers that increases the risk of transfer of virus through breast milk. (see pp. 98 - 99 of Immunology of Human Milk.) Research will be done to see if AF can be used to treat ongoing mastitis.

Contraception:

The strong contraceptive effect of breastfeeding, as practiced in the Lactational Amenorrhea Method (at least 10 short breastfeeds or 6 long breastfeeds within 24 hours and no more than 30 ml/week of supplemental feeds per week during the first month, less than 60 ml/week during the second month, and less than 90 ml/week during the third month) prevents more births than all the Family Planning Programs in Third World countries. LAM gave a contraceptive effect of 98.4% during the first six months and 92.2% during the first twelve months. The lower fertility resulting from LAM plus the anti-infectious properties of human milk are very effective in decreasing the infant mortality rate. A space of less than two years between babies increases the risk of dying before 5 years of age by 50%. (see Hanson, page 124).

Allergy:

Being born via C-section and erroneous hygienic measures at birth increase the risk of allergy by interfering with the normal bacterial colonization of the newborn. Early colonization of the infant's gut with a normal bacterial flora (especially gram negative bacteria) help educate the immune system in early life. The infant becomes immunologically tolerant to allergens and therefore doesn't react against them. (see Hanson, page 149). Normally there should be no harmful immune response against pollens, mites, food, etc.

Highly recommended: Lars Hanson, Immunobiology of Human Milk: How Breastfeeding Protects Babies. Amarillo, TX: Pharmasoft Publishing, 2004. 241 pages. Softcover, \$29.95. Available from Pharmasoft or La Leche League International.

Lawrence Gartner, MD. Jaundice and the Breastfed Baby. (Syllabus pp 229-234)

Nearly every new baby has physiologic jaundice of the newborn. In artificially fed babies, peaks on day 3 (at 5-6 mg/dl) and decreases to adult levels on about day 10. In breastfed babies, mature human milk enhances the intestinal absorption of bilirubin. Jaundice and serum bilirubin levels remain elevated. Gets higher on days 5-10. Called breastmilk jaundice. 1/3 of breastfed babies will have jaundice in third week. 2/3 of breastfed babies will have serum bilirubin levels of 1.5 - 20 mg/dl. Elevated serum unconjugated bilirubin may persist for up to 4 months. Breastmilk jaundice does not appear until the 5th day of life. Protective for baby. Bilirubin is a potent antioxidant. Newborns are deficient in many of the naturally occurring antioxidants. Breast nonfeeding jaundice is a different matter. This is caused by lack of calories. Generally occurs early. Rate varies by institution, and has to do with frequency of feeding. Giving water will increase the jaundice. (If an adult goes 24 hours without eating but drinks all the water he/she wants, the bilirubin level will double.) 80% of babies reported with kernicterus in last few years have been breastfed. This is an emergency, calling for quick action. All babies today with kernicterus are lawsuit cases. Should not happen. Risk factors: Asian mother, diabetic mother, premie, baby with cephalhematoma following vacuum extraction, hemolysis, hemorrhage, sepsis, poor feeding (both a symptom and a result). Ways to prevent: Promote and support successful breastfeeding. Nurse at least 8 - 12 times a day for first few days. Do not supplement with water. Watch high risk babies carefully. High risk plus early high bilirubin predicts trouble!

Baby should be seen on day 3 - 5 of life, earlier if bilirubin is higher. Babies discharged on Friday from hospital are at a dangerous disadvantage. Weigh baby, observe a feeding. If see jaundice, need to get a bilirubin. Can get transcutaneous readings, noninvasive. Need to get frequent bilirubin checks. Start phototherapy at 13-15 mg/dl range. Need to get baby fed. If cannot nurse, give elemental formula. Hydrolyzed protein preparations bind bilirubin in intestine. (Expensive, seen as medicine and temporary. Give by SNS and continue breastfeeding.) Guidelines today for exchange transfusion are less liberal than in 1994. Transfuse at 25 mg/dl for a normal baby, at 19 mg/dl for a sick baby. This is the new standard. If violated, will be the subject of lawsuits. Do not use sunlight through a window as a means of phototherapy. This practice was based on the observation that babies in the nursery nearest the windows had less jaundice than those in the center of the nursery. Not a reliable way to lower bilirubin levels. Can lead to an overheated baby. For breastmilk jaundice, if bilirubin is 20-25 and rising, can continue breastfeeding and give phototherapy. (He is not a great fan of home phototherapy.) Below 20 mg/dl and no other risk factors, don't worry.

Ted Greiner: "Bacterial Contamination and Over-Dilution of Commercial Infant Formula Feeds Given by HIV-Positive Mothers in Durban, South Africa" (syllabus pages 693-702)

We are entering an era where anecdote is king. Death by HIV is worth ten times death from other causes in the minds of some. So when children in Africa die from not being breastfed, little notice is paid. In the face of AIDS, breastfeeding promotion has pretty much collapsed. When is artificial feeding recommended for baby of an HIV positive mother:

A - acceptable (in some areas a woman may be killed if she is suspected of bottle-feeding because of having AIDS. Severe stigma associated with HIV. So mother is advised to lie and say she has insufficient milk supply or is taking a medication incompatible with breastfeeding. This perpetuates the myths that there are many reasons you can't breastfeed. Making artificial feeding the norm.)

F - feasible (access to clean water, utensils, fuel, refrigeration, etc.)

A - affordable (in South Africa, the government is paying for free formula for 6 months if mother is HIV-positive)

S - sustainable (government pays for 6 months only. Then what is baby to eat? In rainy season, roads wash out. Formula supplies can't get through. Mother gives sugar water and baby dies of malnutrition.)

S - safe - (safe water is only 20% of the issue. Must also have clean bottles. In Africa, don't have measuring cups and spoons. Bottles are the normative way to measure the dilution of the formula powder. Need both uncontaminated formula and correct dilution.)

Erika Bergstrom looked at 94 HIV-positive mothers at the Prevention of Mother to Child Transmission followup clinic at King Edward VIII Hospital, Durban, South Africa. (Nov-Dec 2002). These mothers had above average educational level: over half had 12 years of school. Only 7 had not attended high school. 72% had electric refrigerators at home. Milk samples were analyzed from bottles the mothers had prepared (ready for child to consume or used by child within past half hour). Powder to water concentration was measured. Some measured at clinic, some at home, some from observed preparation. Mothers had been advised to feed by cup (easier to clean), but all but 3 were using plastic bottles. 67% of the samples measured in the clinic were contaminated with fecal bacteria. 81% of the home samples were contaminated. 47% of the feeds prepared at home had been made 3 or more hours earlier. 47% of the feeds prepared at home were overdiluted. 67% said they always or often washed their hands before preparing the feedings. 32% sometimes or never did. Most mothers put the powder in the bottle, added water, and mixed it by holding the nipple with their fingers and shaking the bottle.

Can read full thesis at ftp://ftp.hst.org.za/pubs/pmtct/infant_milk.pdf

Greiner had just returned from the AIDS Conference in Bangkok. Several papers were presented on Mother to Child Transmission of HIV. Two studies (Ditrane, Ivory Coast, small sample) and Zhitambo, Zimbabwe, 2000 subjects) showed that there was half the transmission with exclusive breastfeeding as with partial breastfeeding.

Lancet turned down all three studies when they were submitted for publication.

ILCA Conference 2004 Report by Carol Cox

ILCA Business Meeting

It was reported there were 800 attendees at this year's conference representing 17 countries. A task force was created to consider the feasibility of forming a U.S. Lactation Consultant Association (USLCA). This is due to ILCA being unable to meet every country/affiliates needs since each affiliate has different needs worldwide.

Various countries feel ILCA in the past has dealt with more USA needs. If we had a National affiliate our needs such as lobbying the government for our breastfeeding issues could be addressed.

What would happen is our ILCA dues would be paid to the national affiliate and they in turn would pay a portion of it to the International organization. We still would get JHL as well as e-globe. ILCA will keep us posted on the task forces progress.

Almost Premature: Caring for Babies Born Between 35-39 Weeks Gestation

This session was presented by Molly Pessil BSN, IBCLC

Infants born a little premature may result in subtle immaturity that requires vigilant assessment and care to prevent subsequent problems. At birth they look vigorous and well developed but these infants are more vulnerable to hypothermia, hyper -

bilirubinemia, progressive lethargy, and poor feedings over time and have a greater than 10% weight loss if allowed to feed on demand.

Things to help these infants include skin to skin for hypothermia. Feeding baby and keeping baby warm help with hypoglycemia. Of course feeding the baby every 3H should help with hyperbilirubinemia.

To establish mom's supply she should begin pumping 12H after delivery and hand express the 1st 12H. Use of a nipple shield has been researched to help baby maintain a latch, gain weight, and is less costly emotionally and financially than other tools.

Helping Parents Survive the Second Night

Presented by Jan Barger RN, MA, IBCLC/RLC

Second night is when the baby wants to be on the breast seemingly constantly and then falls asleep at the breast and wakes as soon as put down

What probably is going on is the baby being over stimulated and also the baby starts to "wake up" after the 1st 24H. Mom is exhausted from delivery and is vulnerable to nursing staffs suggestions.

We can help mom/family by teaching them about the "second night". Reassure that this is a normal event and teach her how to deal with it.

Kangarooing decreases the number of infant arousals which will decrease the crying and also increases mom's prolactin level by 33%. Taking the baby to the nursery and giving formula will NOT help!

Mom's need to know it is OK to hold their infants, it's OK to safely sleep with their infants, and it's OK to nurse their infant whenever he/she seems hungry.

By Alyce Tylicki

Vitamin D Levels in Term Newborns at the End of Winter Daniel Hirsch, MD, FAAP, CLC

Vitamin D is a hormone formed upon exposure of the skin to the sun's ultraviolet B rays. It exerts effects on almost every organ or tissue in the body. Its actions include: calcium homeostasis, bone health, proliferation and differentiation of cell types, modulation of the immune system, facilitation of insulin secretion, downregulation of the renin-angiotensin system which helps decrease blood pressure. Factors which influence sufficient UVB light include: clothing, tall buildings, indoor lifestyle, sunscreens. pollution and, in addition: people living 40 degrees northern latitude and above between November and February are unable to synthesize sufficient vitamin D. This includes half of the US, Canada and Europe. You could according to one study get enough in the summer months to tide you over the winter months. Caucasians can get sufficient exposure with hands, feet and face two hours per week or one half hour for a baby with only a diaper. Darker skin people require five times more and African Americans ten times more. Dietary sources include salmon, mackerel, S shrimp, herring, liver, shitake mushrooms and egg yolks. When the mother is deficient the baby is born deficient. Rickets is deficiency over weeks and months. There is research linking type one diabetes. Fetal and neonatal associations include: hypocalcemia, CHF, osteopenia, IGR, slow statural growth in infancy, hypoplasia of enamel in primary teeth, and craniofacial. Adult and pediatric associations are: breast, colon and prostate cancers, lupus, rheumatoid arthritis, inflammatory bowel disease and multiple sclerosis. Dr. Hirsch's research with Hispanic Newborns in 40 degrees northern latitude showed 69% of end of winter babies were vitamin D deficient versus 3% of the end of summer babies.

Assisting mothers with Breastfeeding after Breast Reduction Surgery

Outcome Variables

Skill of Surgeon

Type of Surgery

Inferior Pedicle causes least damage and Free Nipple Graft most.

Interval of Time between Surgery and Lactation.

Recanalization and reinnervation occur and are even possible but less likely in Free Nipple Graft.

Inherent Lactation Capability

Some mothers are over producers. They may not get a full milk supply the first time around but with direct response to lactation may have an over abundant subsequent supply.

Breastfeeding Management

The problem may not be related to the surgery but to the management of breastfeeding.

Attitude and Perspective

Even 5cc per feeding is medicine and a gift to the baby.

Additional Lactation Demands equal more Regrowth

ILCA Conference Update 2004 Winnie Mading RN, IBCLC

F201 – The Medicalization of Breastfeeding – Marina Green MSN, IBCLC and Searching for Best Practices; Our Lives in the Workplace-Molly Pessl, BSN, IBCLC

Because there was a lot of overlap and intertwining of the material in these 2 sessions, I have combined the report into one.

Medicalization of many aspects of our lives is increasing. More and more aspects of everyday life comes under the jurisdiction of medicine. Our culture assumes that the medical view of life is scientific, purely objective and altruistic. This leads to increased health care costs and a diminished capacity of the population for self care. This is especially apparent in women's health areas with health care being predominantly male.

Women acquire and construct knowledge differently than men. Women's experiential knowledge is devalued and dismissed. A paternalistic view exists that medicine and its practitioners "know best". There was a brief period of empowerment in the middle of the 20th century, but in many ways this is decreasing again. In breastfeeding, even the "breast is best" approach can be an aspect of medicalization where medicine tells women what to do and how to do it.

There is a danger that we as LCs contribute to this problem when we appear to be laying down a lot of "rules" for breastfeeding. For example, "Don't use a "P" hold. The "C" is the right way." We also develop a lot of jargon like other aspects of medicine. (Asymmetric latch, MER, hyperlactation, dyads, OAL etc.) We need to beware that the terms we use to communicate with each other don't help make breastfeeding a narrow clinical specialty that only the elite group can "own".

While research is certainly of value, there will always be some aspects of breastfeeding that cannot be studied scientifically.

We are in danger of becoming such an elite group that we restrict access to becoming an LC and even wind up eating our young".

The syllabus has an especially complete content for Molly Pessl's talk, but not for Marina Green's.

WALC Scholarship Suggestions

Purpose: to support individuals desiring to become IBCLC

Paying some or all of: Courses or Exam

Cap of \$500 or \$1000. (Note, exact cap to be determined-group suggests \$300) Some paid in advance and remainder after finishing course or becoming certified.

Recipients would be required to sign a statement ahead of time stating that they will reimburse WALC if they do not finish course/pass exam. (Note: if they do not reimburse, we may need to write it off rather than pursuing legally.)

Application process:

WALC membership for at least 1 full year and have attended at least 1 meeting (or our annual conference).

2 Letters of recommendation to address.

- Ethical

- Basic interpersonal skills

- Desire to help

- Experience working with nursing moms (other than personal nursing experience)

At least 10 CERPS (or related CEUs)

At least 300 hours experience

(the above 2 within the last 2 years)

Show a need for financial assistance

We will pay toward registration or exam fee, (not housing, transportation, meals)

We need to set aside a scholarship fund in an interest bearing account.

Committee of 3 to review applications and select recipient.