

Beyond the Basics of Latch

SUPPORT STRATEGIES FOR HELPING BABIES WHEN THE BASICS AREN'T ENOUGH



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Objectives

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After today's presentation, participants should be able to...

- Understand how to assess more complex breastfeeding situations
- Identify the root cause(s) of the feeding issue at hand
- Implement personalized care plans to help dyads coping with unique issues
- Utilize critical thinking skills when supporting dyads through challenging feeding situations


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Dedication, Declaration

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This presentation is dedicated to the many, many dyads I have worked with whose cases taught me to think outside the box.

I have no conflicts of interest to declare.



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In a perfect world...

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- In a perfect world, every baby would latch beautifully right after delivery and breastfeed happily ever after....



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In the real world...

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- In reality what we often see is that most moms and babies need a *little* help to get breastfeeding off to a good start. Many dyads need a *lot* of help. And a few mother/baby pairs need a *miracle* to breastfeed successfully.
- How can we best help those tough cases?

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What goes wrong?

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Some reasons babies struggle to latch and/or Bf well:


- Structural issues - asymmetry, neuromuscular impingements
- Physical discomfort – caput, cephalohematomas, broken clavicle, birth trauma, hip dysplasia, deep suctioning, separation, etc
- Respiratory concerns – laryngomalacia, tachypnea, s:sw:br coordination issues, etc
- Medical issues – neurological, congenital, cardiac issues, etc
- Digestive issues – reflux, allergies, poor gut motility, etc
- Acclimated to feeding tools – nipple shield, bottle flow, finger feeding, etc
- Prematurity – late pre-term, preterm, etc
- Oral restrictions/issues – tongue/lip tie, oral motor issues

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Assessment strategies

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- When assessing latch and feeding problems, what assessment tools do you use to help you better understand the issue at hand?
 - Latch scores?
 - Checklists?
- How long do you get to spend with the dyad? Do you assess them both together? Do you observe a full feeding?




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Latch Assessment

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- Are we having moms and babies with less breastfeeding problems the more latch scoring systems, techniques and rules we invent?
- Do various ways of rating latch and position really give us meaningful information?
- How can we perform a more meaningful assessment so that our care strategies actually work?
- *"I am still in pain and baby still can't feed well but the LC said our latch looked good!" NOT OKAY*




Do you think this mom is thinking about her LATCH score?

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The first step...

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- Before we can start to help a struggling dyad latch and feed successfully, we must be good detectives to figure out the root cause(s) of their feeding challenges. This is done by:
 - A thorough intake and birth/health history
 - Physical assessment of the dyad (maternal breasts, infant structure, oral anatomy, tone, respiration, etc)
 - Feeding observation/assessment
 - What is happening on baby's side? Mom's side?
 - Form a working hypothesis of the issue(s) at hand and begin to implement targeted ideas



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Personalized care

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Questions to ask yourself

- What does **this** dyad need to be breastfeeding well?
- What does baby need to feel comfortable?
 - Direction of ease, flow rate, sensory/state regulation, stability, respiration, digestion, structural issues, tool adjustment
- What does mom need to feel comfortable?
 - Nipple care, pain relief, re-positioning, sensory support, postpartum healing, more/less flow, tool adjustment
- How to balance short-term goals vs. long term goals
 - A quick fix may be desired but oftentimes the care plan must be implemented in stages, remain their cheerleader

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What works...

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Some basic pointers can help you remember what to work with when helping with challenging Bf situations:


- Utilize baby's/mother's direction of ease/physical comfort, consider digestion, medical issues too
- Babies are creatures of habit – what shape/smell/flow are they used to? How can you replicate that at the breast as you work towards optimal feeds? Older babies may take longer time adjusting.
- Are the tools in use helping or hindering?
- Patience and practice – boob boot camp or baby steps?...know the baby/mother

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Case 2: Baby Owen

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Why won't he latch: Suck dysfunction... or is it?



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Case 2: History

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- Infant – 5 wks old, NSVD @ birth center @ 41w4d, double shoulder dystocia, intense delivery. Poor suck from birth, frenotomy of the labial and lingual frenulum performed 1 wk PP. Has had CST.
- Maternal –G3P1, Hx PCOS, fertility issues, blood sugar issues during pregnancy controlled by diet, prolonged pushing stage during delivery. Mother pumps 8-12x/day, yields 90-120ml per session

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Case 2: Subjective

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- The mother reports that...
- The infant has never successfully latched/transferred, hates post frenotomy stretches
- They have been working with another provider that thinks the baby has no suck reflex, wants to refer for VFSS
- Current routine is to try at breast with shield, then pump/bot feed 60-100ml (dr.brown's wide)
- They feel there has been a lack of progress and they want further support

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Case 2: objective

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- **Infant:**
 - 10lb 14.1oz, skin tone/turgor WNL.
 - Oral assessment: labial and lingual frenotomy incision sites healing WNL. Oral motor: cheek tone and tongue cupping moderate, suck reflex noted.
 - observed feed: baby latched well (first time ever mom reports) with nipple shield and enticing baby to breast with syringed milk. Mature suck burst pattern noted, no s/s suck disorganization or dysfunction. R/L 100 ml transferred.
- **Maternal assessment:**
 - Breasts/nipples WNL. Improperly fitted nipple shield noted.

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Case 2: Assessment

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- Intense birth, double shoulder dystocia, tongue/lip tie may have set the baby up for structural and neuromuscular impingement that impacted feeding early on.
- Upon oral motor assessment the baby has functional feeding abilities with no s/s suck disorganization or dysfunction.
- The current issue= baby used to feel of a bottle nipple and flow rate

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Baby Owen: Visit #1

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Case 2 Summary : Baby Owen

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What worked and why

- Work with what baby knows (plastic + flow) Adding flow to latch attempts was key (ample squirting to entice!)
- Using a properly fitted shield helped things stay in place and allowed baby to transfer well
- Allowing the baby's body to go in its direction of ease
- Making post frenotomy care fun and playful
- Choosing a more appropriate bottle
- Making bottle less fun, breast more fun

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Example: Shield fit

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Above: Poorly fitted shield

Below: Better fitting shield

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Example: Some useful tools

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Syringe for enticing/adding flow

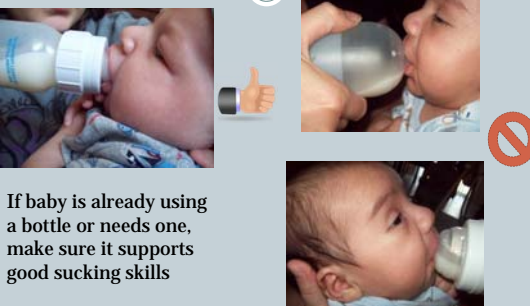
Bottles baby may do better with

5 fr in bottle, in shield to add flow, at bare breast in use

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Example: Better gape/flow with bottle

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If baby is already using a bottle or needs one, make sure it supports good sucking skills

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Case 2: Follow up notes

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- **f/u visit 1 week after:**
 - M reports 2 successful nipple shield/Bf session per day now
 - B happy w/ oral/post frenotomy work now
 - B still gulps 100ml via bot in 7 min (preemie nipple started)
 - M feels supply dipped a bit (herbs started)
- **f/u visit 2 weeks after:**
 - M reports 3+ successful shield/Bf session/day, B satisfied after Bf
 - M supply is up
 - bottle going better/slower
 - M wants to wean off shield – during this visit baby latched to bare nipple 1st time – family thrilled

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Baby Owen: Visit #2

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Baby Owen: Final Notes

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- After about 3 weeks of lactation support and 'practice' for Owen, he is now a fully, exclusively breastfeeding baby!
- The parents are so very happy. The mother even delayed her return to work so she could focus on enjoying what she never thought would be possible, breastfeeding her baby!



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Baby Owen: Final Notes

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"The first place I ever took Owen on my own with no bottles, or nipple shields or milk syringes packed was the Japanese garden.
It was about a week after I decided to cold turkey on the bottles when Owen was about 8 weeks old. I was so surprised that we were able to go from needing all the props to just bare boob in a week.
Having the experience of just sitting down on a bench and feeding him simply when he was hungry was one I will never forget."



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Case 2: Baby Desmond

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Why won't baby latch well? Reflux or is it?



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Case 2: Subjective/History

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- **Maternal:**
 - G3P1, planned home birth NSVD @40wks
 - Bf – intense pain w/ latch. occasionally pumps (poor quality, used)
 - no known health issues
- **Infant:**
 - mild tachypnea first few hours PP then WNL
 - Bf issues from beginning
 - slow wt gain, tries to latch on/off all day, always seems hungry.
 - Bottle: 'breastflow' 1-2x/day

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Case 2: Objective (visit 1)

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- **Infant:**
 - 3 wk old, 8lb10.6oz (bwt 8lb 9oz)
 - Oral assessment: class III lingual and maxillary frenum attachment, restricted mobility/functionality
 - Observed feed-R/L 38ml transfer, some clamping/tongue snapback noted mid feed, frequent on/off behaviour, B unable to sustain long/active Bf session.
- **Maternal**
 - Breast health WNL (no stasis, infection, tissue WNL, etc)
 - Nipple pain reported
 - Supply down regulated d/t poor milk removal

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Case 2: Assessment and Plan after 1st Visit

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- Oral restrictions seem to be the primary cause of slow wt gain and maternal pain.
- Addressing restrictions, protecting milk supply and ensuring adequate intake for baby = primary plan
- Lactation support post frenotomy suggested

3 weeks post frenotomy...

- Baby is doing better, gaining weight, maternal supply is WNL
- Mom still complains of baby popping on and off, acting fussy at breast and clamping
- Ped think its reflux and refers mom back to me
- What could still be going on???

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Case 2: video clip of visit 2

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Case 2: Visit #2

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- Why is this showing up now???
 - Better function post frenotomy = more milk transfer = more respiratory compromise
- What do we see/hear?
 - Prominent stridor, increased effort, stress, retractions, respiratory pauses, arching/pulling away (but no reflux...downside of phone triage and not watching a feed)
- What helped?
 - Referral for VFSS to r/o aspiration, safe lactation plan (position, pacing), educating mom (not oversupply!)

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Case 2: Position/Pacing/Extension

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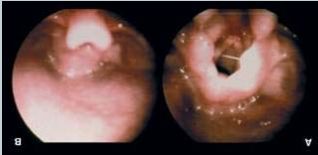
Case 2: example of laryngomalacia

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There are many causes of stridor and respiratory concerns but laryngomalacia is the most common one (approx 80%)



Normal larynx



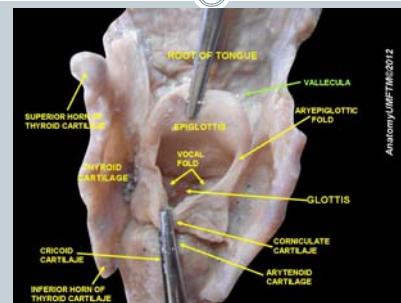
Laryngomalacia (note the epiglottic, arytenoid, and tubular collapse)

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Photos courtesy of Dr. Cecile Sulman

Anatomy of a swallow

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Swallow study



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Case 3: Baby Lars

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Why can't this baby latch well? Tongue tie or is it?



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Case 3: Subjective/History

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- **Infant:**
 - homebirth @40w3d, NSVD, no complications.
 - baby was always in the same position in utero.
 - Bf (latch issues) + bot feed EBM. Scant stooling.
 - PCP suspects TT/LT.
- **Maternal:**
 - G2P1, extreme 'toe curling' nipple pain
 - feeling overwhelmed and weepy.
 - Wants to exclusively Bf
 - Pumps every 3-4hr, yields 1oz/breast.

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Case #3 brainstorm...

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- Great intake question: "Did you feel your baby move a lot or were they always in the same position, did you always feel kicks/punches in the same area?"
- Babies will grow into the space available to them—in utero restrictions, uterine shape, multiples, large fibroids, short cord, low fluid levels, etc can all impact the available space.
- What does lack of space/ability to move mean for feeding?

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Case #3 brainstorm...

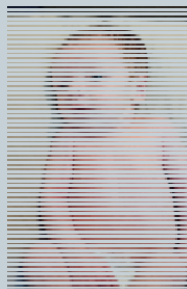
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What do you notice about his body alignment?

What impacts may it have on feeding?

Try to tilt head, flex and swallow. How does it feel?



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Structure checklist

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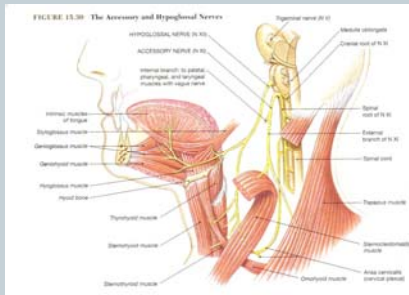
- Some things to ask yourself when assessing structure:
 1. How does baby's body look when naturally resting?
 2. Are the shoulders and hips even?
 3. Are there more creases on one side of the neck than the other?
 4. Are eyes, nares, ears aligned? Clogged tear duct? Flattened ear?
 5. How is tone (hypo/hyper)?
 6. What do you know about their in utero positioning? Mode of delivery?

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Appreciation of Anatomy...

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Appreciate the complexities of anatomy, get to know the structures and what you are observing. What muscles, fascia, nerves may be compromised when structure is not aligned?



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Case 2: Objective

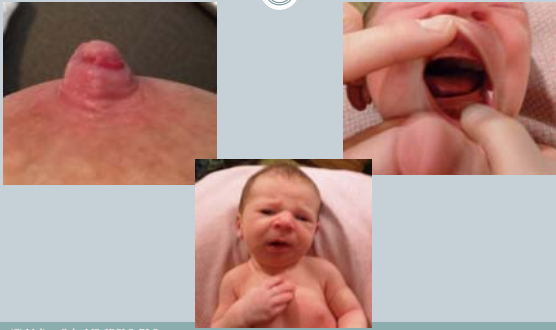
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- Infant: 2wks, Weight: 7 lb 10.5 oz (bwt 8 lb 6 oz), skin tone WNL. Oral: palate WNL, maxillary labial frenulum class 3 (fairly flexible), lingual frenulum WNL. Structural : prominent structural asymmetry, neuromuscular impingements, prominent s/s torticollis (L SCM), asymmetry of the jaw, maxilla and mandible, etc observed feed: with adjusted positioning some improvement in maternal comfort was noted, infant not satisfied post Bf, post Bf -EBM via bot.
- Maternal: bilateral nipple damage, partial thickness wound on left nipple, no s/s engorgement/plugged ducts.

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Case 2: photos

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Case 2: Assessment

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- Latch/nipple pain and damage seem due to the infant using excessive compression due to his structural restrictions/asymmetry. Pediatric bodywork is essential in order to support better latch
- Oral restrictions of the labial and lingual frenulum do not seem to be an issue.
- Due to the severity of damage, some resting/pumping and feeding the infant away from the breast for 24+ hr may be warranted
- Due to the pain and poor latch, sub optimal milk transfer has been happening over the past 10 days, infant intake/maternal milk supply seems to have been compromised.
- Emotional support is advised so the mother can continue to work towards her bf goals

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Case 2: Plan


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- Nipple care (wash, ointment, fresh pads)
- Pump (bigger flanges) needed bigger) if too sore to Bf or in between feeds if possible
- Slow flow bottle when needed
- Weekly bodywork for the infant (PT, CST, Chiro, etc)
- intake and weight gain goal discussed
- Pain relief + herbal galactogogues
- Continued lactation and mood support

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Oral asymmetry: before and after

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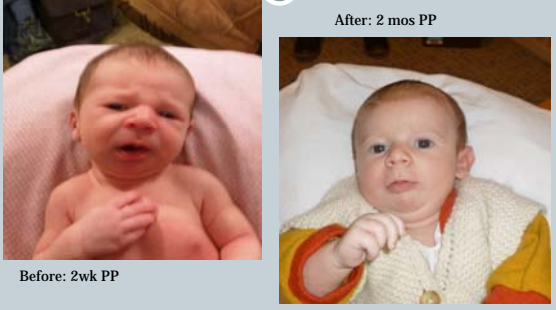
Before: 2wk PP

After: 2 mos PP

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Torticollis: before and after

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Before: 2wk PP

After: 2 mos PP

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Latch support: Bodywork

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When infants have structural concerns, gentle manual therapy can play a vital role. It helps:


- Unwind neuromuscular impingements and structural issues
- Release compensatory behaviors/patterns
- Provides healthy sensory input, regulates nervous system



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Bodywork

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- Who to refer to? Depends on who is available in your area! Some types of providers include:
 - Chiropractors, Craniosacral Therapists, Bowen Therapists, Massage Therapist, Physical/Occupational Therapists, Osteopaths, etc
- Points to keep in mind:
 - Do they have pediatric experience? (babies are NOT little adults!)
 - Do they do any intraoral work?
 - Are they open to collaborating/learning more?
 - Experience it yourself before referring, work as a team!
- Some online articles on gentle, pediatric bodywork:
<http://kellymom.com/bf/concerns/child/cst/>

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Case 3: Summary

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- Comprehensive assessment and understanding of structure is needed (don't jump to TT ?)
- Sustainable game plan needed
- Some cases are 'in it for the long haul' cases – tincture of time, baby steps, healing up were all needed here
- Remind mom of their progress
- Know your community resources for body work, mood support, etc
- B was exclusively Bf by 2 mos...mom called 2.5 years later asking how to wean 😊

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Case 3: Cuteness and Symmetry!

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Case 4: Baby Rosa

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Why can't this baby latch? Suspected tongue tie, sleepy feeder, poor suck...what is going on?



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Case 4: Subjective/History

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- Maternal:G1P1, thyroidectomy 2012, takes levothyroxine 125mcg, Singulair 10mg, prenatal. Mother is pumping 3-6x/day (yields 4-6oz). Feels she has received mixed advice from various providers, feels confused about many aspects of feeding.
- Infant: NSVD @41wk, cephalohematoma, jaundice requiring phototherapy, infant is mostly finger fed 2-3 oz expressed breastmilk or formula with an occasional bottle rotated in. reported voids/stools WNL. Had ENT consult, ENT uncertain if frenotomy needed, referred to LC. Suck/feeding issues from beg.

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Case 4: Objective

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- Infant: 1mos, 8lb 13.6oz (bwt 7lb 15oz) skin tone/turgor WNL. Oral assessment: labial frenulum class IV attachment (fairly flexible, some tension noted), lingual frenulum WNL. oral motor: cheek tone - poor, lateralization/cupping -moderate, elevation/extension WNL, palate WNL. Prominent cephalohematoma on L parietal noted. Observed feed: with adjusted latch and positioning the infant was able to latch well and transferred R/L 30 ml MOM + 70 ml tube at breast.
- Maternal :Breasts/nipples WNL. Supply has been slightly down regulated by the mother going long stretches of time without pumping.

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Case #4 brainstorm

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How might this impact feedings and oral function/tone?

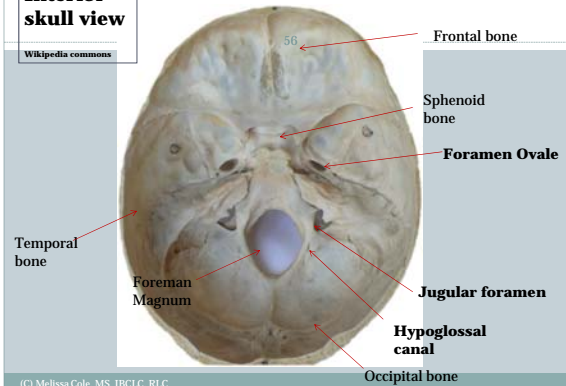
"Why didn't anyone tell me?"

How might this baby be feeling? What cranial nerves may be impacted?

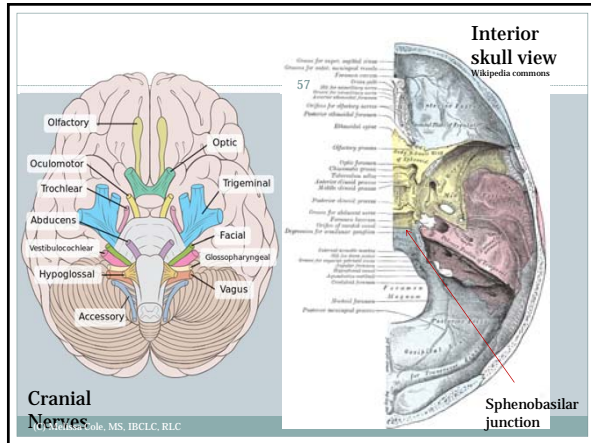
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Interior skull view

Wikipedia commons



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Cranial Nerves

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Fascial tissue

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Photo from: <https://www2.aofoundation.org/>

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Case 4: Assessment

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- Baby is acclimated to passive way of finger feeding, a change in feeding tools plus adding flow to the breast via supplemental nursing system should help transition the baby back to the breast.
- The mother has been going long stretches, up to 8 to 11 hours, overnight with no milk removal. Infrequency of milk removal can be impacting supply
- The lingual frenulum is WNL, labial frenulum is slightly tight but no maternal pain during today's visit and the infant latched quite well.
- Underlying issues (weak cheek tone, lingual lateralization, cephalohemata) impact infant comfort when held in certain positions. Addressing the hematoma, oral motor concerns and feeding basics is advised. Address vagal function and state regulation.
- A proactive approach towards infant intake/feeding skills, maternal milk supply and comfort and the overall feeding process is highly advised coupled with ongoing lactation support.
- The mother was pleased with how the feed went and feels much more hopeful now. Some targeted oral motor work and craniocervical work was done during today's consultation and the infant replied positively to these care strategies.

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Case 4: Plan

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- Aim for 8-10 active feeds/day. Weight gain goal is approx 1/2 - 1oz gain per day (avg 5-7 oz per wk). watch for 5-8 clear voids and at least 1-2 stools per 24 hours.
- Your baby will expect approx 2.5-3.5 oz per feed (24-32oz/day)
- Oral motor work as discussed (aim for doing the work approx every feed or at least 4-6 x/day, keep it playful and fun, state regulation activities. CST/PT weekly.
- Position baby as shown (football on hematoma side, - avoid pressure, cradle on other)
- follow-up lactation care as needed + bodywork for baby
- Don't go longer than 4-5 hr at night between Bf/pump sessions and approx 2-3 hr in day (goal = 8-10 active milk expressions in 24 hr). pump after feeds until we can see baby more actively transfer. follow up in 1 week.

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Case 4: Summary

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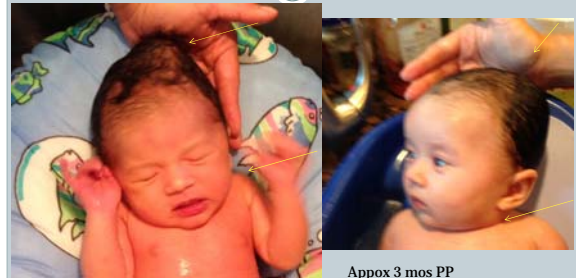
- Issues such as oral tone and caput/cephalohemtoma often get overlooked as a cause for infant feeding issues
- Oral motor work, creative positions and bodywork are often essential before successful feeding can begin
- Finger feeding can create narrow gape/passive feeds – choose tools that support goals
- M had 2 more f/u appts. Baby is now Bf very well, 2 mos after initial visit M came in for bot feeding support but no Bf concerns



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Case 4: photos

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Approx 1 mos PP

Approx 3 mos PP

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Some notes on stability and support

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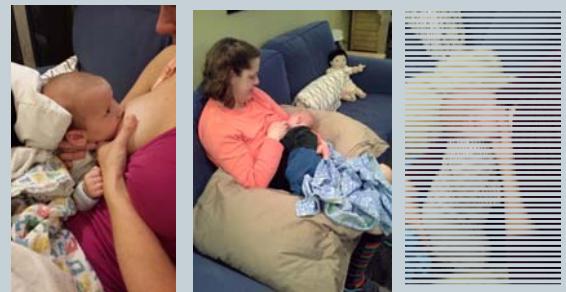
- Providing stability and support is often needed. For many babies, for many reasons, there are often aspects of oral weakness.
- Stability can come in the form of careful positioning, a nipple shield, gentle facial support, pacing, etc.
- Safe handling & support techniques, controversy, appropriate for baby/situation



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Breastfeeding stability and support options

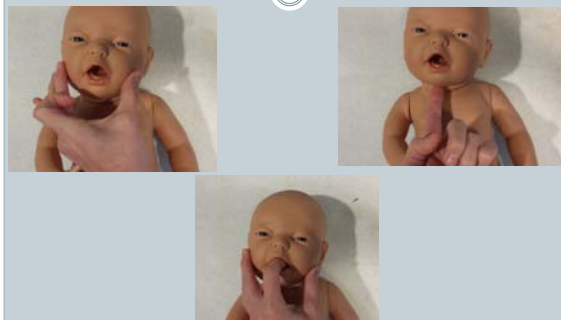
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Gentle support points

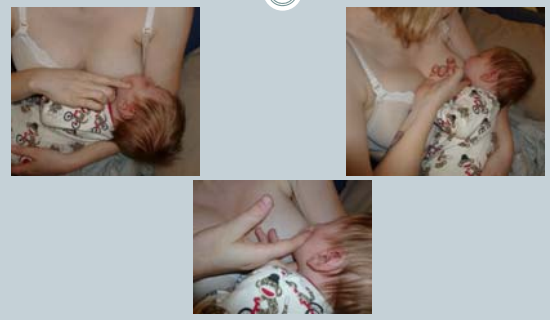
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Variations on Support Points

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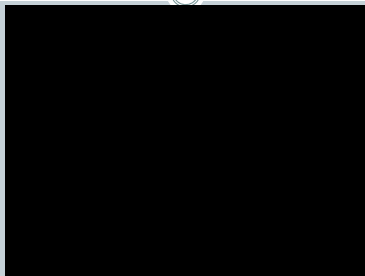
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Breastfeeding support: Cheek Support 67



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Sample mouth work and exercises: Stewart's Video 68




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Remember the rules when the basics aren't enough! 69

- There are no rules
- Ditch latch scores and subjective assessment tools
- Avoid 'cookie-cutter' approaches and care plans
- Forgot the text book, look at the baby and mom
- Think outside of the box
- Rethink tools, nothing is inherently good or evil
- What is sustainable for the dyad?
- Never say never
- *"Be a skilled clinician, not a feeding technician!"*

— John Chappel, RPT




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Remember the rules when the basics aren't enough! 70


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Thank you! 71



For questions or bibliography request,
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