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# A new policy update on breastfeeding: What all clinicians need to know

## ABSTRACT

Although the 2022 policy statement on breastfeeding from the American Academy of Pediatrics primarily addresses clinicians caring for pediatric patients, the Academy urges clinicians of all disciplines who may interact with breastfeeding mothers and babies to increase their understanding of breastfeeding and their ability to support this population. Studies published since the 2012 update continue to reinforce the cumulative short-term and long-term infant and maternal health benefits of breastfeeding and human milk consumption.

## KEY POINTS

Breastfeeding provides short-term and long-term benefits to mothers and babies.

Exclusive breastfeeding is recommended in the first 6 months and should be supported for 2 years and beyond or as long as desired by the mother and baby.

Breastfeeding support must be individualized to mothers and their infants.

Clinicians should familiarize themselves with resources for determining safety of medications, substances, and imaging.

Clinician advocacy for better support for breastfeeding patients will improve infant and maternal health outcomes and eliminate health disparities.

THE MOST RECENT POLICY STATEMENT ON breastfeeding from the American Academy of Pediatrics (AAP)<sup>1</sup> focuses on enhanced communication with and support for breastfeeding mothers and babies—ie, the breastfeeding dyad—and urges clinicians to increase their understanding of breastfeeding and their ability to support it.

For brevity, this article uses terms such as *mother* and *breastfeeding*, but the authors recognize there is terminology that may be preferred over these terms for patients depending on their gender identity and feeding method, such as *chestfeeding*, *breast-milk feeding*, *lactating parent*, and *human-milk feeding*, and efforts should be made to use the patient's preferred language in the clinical setting.<sup>2</sup>

### ■ WHO IS THE INTENDED AUDIENCE?

The updated guidelines primarily address clinicians caring for pediatric patients, but the recommendations are relevant for any clinician caring for a breastfeeding mother or infant.

### ■ WHO WROTE THE GUIDELINES?

The policy update relied on the consensus of the clinical expertise of the AAP Section on Breastfeeding Executive Committee and evidence from recently published peer-reviewed literature. No conflicts of interest were reported.<sup>1</sup>

### ■ WHICH RECOMMENDATIONS REMAIN THE SAME?

The update reinforces the importance, duration, and considerations of breastfeeding and

human milk consumption in mothers and newborns. Some of these recommendations remain unchanged from previous AAP guidelines.

### **Benefits**

Breastfeeding confers short-term and long-term benefits to mothers and infants that are important to communicate to patients, especially in the prenatal setting. The beneficial effects encompass disease processes that represent most specialties, and clinicians of all disciplines should be aware of them.

For infants, breastfeeding is associated with decreased risk of otitis media, upper and lower respiratory tract infections, asthma, bronchiolitis, necrotizing enterocolitis, atopic dermatitis, celiac disease, gastroenteritis, inflammatory bowel disease, type 1 and type 2 diabetes mellitus, leukemia, childhood obesity, and sudden infant death syndrome. Maternal benefits include lower risk of postpartum hemorrhage, postpartum depression, cardiovascular disease, hypertension, hyperlipidemia, type 2 diabetes, rheumatoid arthritis, endometrial cancer, thyroid cancer, breast cancer, and ovarian cancer.<sup>1,3-7</sup>

### **Duration**

The AAP recommends that infants be breastfed exclusively for 6 months with slow integration of complementary foods, when developmentally appropriate, at about 6 months. Earlier introduction of complementary foods can increase the risk of acute respiratory and diarrheal illnesses.<sup>1</sup>

### **Contraindications**

The policy reiterates known contraindications to breastfeeding, including galactosemia, maternal human T-cell lymphotropic virus type I or II, untreated maternal brucellosis or tuberculosis, and human immunodeficiency virus (HIV) with high viral loads. (Note: A recommendation from the US Department of Health and Human Services published after the AAP guideline allows for breastfeeding in mothers with undetected HIV viral load.<sup>8</sup>) Infants should not breastfeed from or receive milk from a breast with active herpes lesions, but babies can breastfeed from or receive milk from the unaffected breast.<sup>1</sup>

### **Special considerations**

**Maternal medications.** Most medications are compatible with breastfeeding, and information is readily available. Drugs and Lactation Database (LactMed)<sup>9</sup> of the National Library of Medicine and National Institutes of Health can be accessed online at no cost. The book *Hale's Medications and Mother's*

*Milk 2023*<sup>10</sup> is available through the libraries of many medical institutions. The website InfantRisk Center<sup>11</sup> provides information, an app for a small fee, and a free hotline with access to a trained nurse.

Medications with an L5 rating are incompatible with breastfeeding. The L5 rating means that “studies in breastfeeding mothers have demonstrated that there is significant and documented risk to the infant based on human experience...and the risk of using the drug in breastfeeding women clearly outweighs any possible benefit from breastfeeding.”<sup>12</sup> Most L5-rated medications are chemotherapeutic agents.<sup>10</sup>

**Preterm infants.** Additional benefits of breast milk include prevention of respiratory illness and improved neurodevelopmental outcomes in preterm infants.<sup>1</sup>

### **Advocacy and support**

Early clinician intervention to support breastfeeding initiation, duration, and exclusivity leads to longer duration of and compliance with exclusive breastfeeding.<sup>13</sup> Hospitals and birth centers should implement maternity care practices to encourage breastfeeding initiation, duration, and exclusivity. Initiating skin-to-skin contact and frequent breastfeeding with support as early as possible maximizes breastfeeding benefits, duration, and compliance. Clinicians are encouraged to assess breastfeeding dyads for challenges and to grow comfortable managing them or, alternatively, to cultivate appropriate referral sources and contacts for patient support.<sup>1</sup>

## **■ WHAT DIFFERS FROM PRIOR GUIDELINES?**

Since its last update in 2012,<sup>14</sup> the AAP made several new recommendations and additions to its breastfeeding policy.

### **Benefits**

Research has shown that cumulative breastfeeding time correlates inversely with maternal risk of breast, ovarian, endometrial, and thyroid cancer.<sup>15-17</sup> The updated policy addresses the effects of sociodemographic and cultural differences and other disparities on rates of breastfeeding, as well as health outcomes of populations affected by disparities.<sup>1</sup>

### **Duration**

The most publicized part of the update is support for mothers to breastfeed for 2 years and beyond. Previously, the AAP had recommended breastfeeding for at least 1 year. The change was made in response to patients reporting feeling alienated or shamed from breastfeeding longer than 1 year. Neutral,

nonjudgmental language will promote support for breastfeeding mothers and diminish shaming of their infant-feeding decisions.

Inclusive and supportive language is important for lactating mothers, especially those who choose to breastfeed beyond 1 year. Questions such as “Are you still breastfeeding?” rather than “What and how are you feeding your child?” can feel judgmental and lead to feelings of alienation and embarrassment and withholding information. The policy change was also a response to new research concluding additional benefit associated with breastfeeding beyond 1 year.<sup>15,18</sup> These recommendations align with those of the World Health Organization (WHO) and US Centers for Disease Control and Prevention (CDC).<sup>1</sup>

### Contraindications

Suspected or confirmed Ebola virus was added to the list of contraindications to breastfeeding.<sup>1</sup>

### Special considerations

The 2022 AAP policy emphasizes the need for clinicians to recognize the impact of various infant and maternal factors on breastfeeding management.<sup>1</sup>

**Maternal delayed lactogenesis II**, or a delay in the breast milk “coming in” around 72 hours postpartum, affects a special population. Maternal risk factors for delayed lactogenesis include obesity, diabetes mellitus, hypertension, cesarean delivery, and preterm labor. Monitoring the infant’s weight, intake, and output is important, as these infants are at risk for the need of supplementation with formula or donor breast milk. Mothers also need support, as they are at earlier risk of breastfeeding cessation despite the low milk supply being temporary.

**Very low birth-weight infants.** Mothers of very low birth-weight infants are encouraged to continue to use expressed breast milk to decrease the risks of necrotizing enterocolitis, late-onset sepsis, chronic lung disease, and retinopathy of prematurity in infants. Compared with term infants, late-preterm and early-term infants reportedly have decreased breastfeeding rates, stressing the need for more support for these infants.<sup>1</sup>

**Infant hyperbilirubinemia.** Increased numbers of breastfeeding sessions per day were associated with lower infant bilirubin concentrations among infants with hyperbilirubinemia. Phototherapy is not an indication for formula supplementation if the baby is hydrated or levels of bilirubin are above exchange transfusion levels. Breast milk jaundice can persist for up to 3 months, and no specific management is needed.<sup>1</sup>

**Infants at high risk of peanut allergy.** In infants with high risk of peanut allergy (severe eczema or known egg allergy), introducing peanut products as early as 4 to 6 months has been shown to decrease the risk of developing peanut allergies by over 80% at 5 years of age compared to delaying introduction until 12 months.<sup>19</sup> It is recommended that these patients consult a pediatric allergist prior to offering peanut products.<sup>19</sup>

**Adoption and surrogacy.** Breastfeeding is possible in the case of adoption or surrogacy. It requires the adopting or intended breastfeeding parent to prepare months in advance to offset the lack of typical hormonal changes that occur with pregnancy. Preparation includes taking oral contraceptive therapy and providing stimulation of the breasts every 3 hours with a breast pump.<sup>1</sup>

**Prenatal maternal opioid users.** It is preferable to breastfeed exclusively and have the mother and newborn sleep in the same room (ie, to “room in”). While this decreases withdrawal symptoms in infants, infants should be closely monitored in inpatient and outpatient settings for withdrawal symptoms.<sup>1</sup>

**Marijuana.** Although the use of marijuana is discouraged, there are insufficient data to assess the exposure effects on breastfeeding infants.<sup>1</sup>

**Smoking cessation.** Most nicotine smoking cessation products are safe for breastfeeding mothers to use. Although varenicline can be effective for nicotine smoking cessation, little is known about its safety during lactation, so it is not recommended at this time.<sup>1,9,10</sup>

**Hepatitis B virus.** In mothers known to be hepatitis B surface antigen-positive, their infants should receive the initial dose of the hepatitis B vaccine and hepatitis B immune globulin within 12 hours of birth. However, administration should not delay the initiation of breastfeeding, ideally within the first hour of birth.<sup>1</sup>

**Hepatitis C virus.** Hepatitis C is detected in maternal milk, but transmission is not documented. Breastfeeding is contraindicated only if the nipples are cracked and bleeding.<sup>1</sup>

**Mastitis.** Mastitis occurs in one-third of postpartum women and is compatible with breastfeeding. The Academy of Breastfeeding Medicine (ABM) published a protocol in 2022<sup>20</sup> that addresses the clinical spectrum and management of this inflammatory condition. Risk factors include exclusive pumping and hyperlactation. Initial management should include continued physiologic breastfeeding or pumping to comfort rather than to empty completely, ice, ibuprofen, and lymphatic drainage techniques to reduce soft-tissue edema. If no improvement is seen with conservative

measures, management may require antibiotics against *Staphylococcus aureus* (dicloxacillin 500 mg 4 times per day for 10 to 14 days).<sup>20</sup> Abscesses require drainage.<sup>1,20</sup>

**Children of gender-diverse parents.** These patients may have less access to human milk because of social and biologic constraints. Additionally, the word *breastfeeding* itself may be both triggering and inaccurate. *Chestfeeding* may be the preferred term in this population.<sup>1</sup>

**Maternal imaging.** Routine administration of iodinated contrast or gadolinium is not contraindicated in breastfeeding mothers, as very little contrast enters breast milk and an even smaller fraction is absorbed in the infant gastrointestinal system. Some nuclear medicine procedures require separation of mother and infant for 12 hours immediately after imaging because of the radioactive substances in the mother's system. Radiography and mammography are safe for breastfeeding mothers. "Trash the Pump and Dump,"<sup>21</sup> a website created by the Institute for the Advancement of Breastfeeding and Lactation Education, includes detailed evidence-based information on safety of various radiologic procedures.<sup>1,21,22</sup>

## Advocacy and support beyond pediatrics

The updated policy calls for support and advocacy beyond the pediatric community. Regardless of specialty or discipline, clinicians must be aware of rare and absolute contraindications to breastfeeding. It is also important to know which medications, procedures, and imaging modalities are compatible with breastfeeding. Ideally, this information is included in medical training. Awareness among clinicians can help mothers and their infants avoid unnecessary breastfeeding disruptions and risks associated with breastfeeding cessation.<sup>23</sup> Policies created at the federal, state, local, and workplace levels should encourage and implement strategies to support breastfeeding, including adequate universal paid maternity and partner/paternity leave, broader insurance coverage, and workplace-protected time and space to express milk and otherwise support and encourage mothers to sustain breastfeeding.<sup>1</sup>

## ■ DO OTHER SOCIETIES AGREE OR DISAGREE?

The CDC, WHO, ABM, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, United Nations International Children's Emergency Fund, and Canadian Pediatric Society all make the same duration recommendations as the AAP, including exclusive breastfeeding for the first 6 months of life, followed by slow integration of com-

plementary foods until 1 year, and encouraging breastfeeding for 2 years or longer as mutually desired.<sup>24-29</sup>

## ■ HOW WILL THIS CHANGE DAILY PRACTICE?

The AAP policy update emphasizes the breadth and depth of care needed for the breastfeeding dyad. Mothers at risk of breastfeeding challenges should be identified prenatally by their clinician and be provided appropriate education, counseling, and resources. Those with feeding challenges immediately after delivery warrant close follow-up by their primary care physician and a breastfeeding specialist. Breastfeeding medicine, an emerging specialty, can offer these families an added layer of support and expertise. The challenges mothers and infants face are varied, and the mother-infant dyad should be assessed by a clinician experienced in diagnosing and managing breastfeeding challenges.

Clinicians and other healthcare providers need to be aware of patient populations with lower rates of breastfeeding and develop interventions to ensure easy access to support. Breastfeeding support groups, printed and online educational resources, care coordinators, virtual visits, and a larger geographic presence of lactation consultants and breastfeeding medicine clinicians can ensure improved support. We encourage healthcare institutions to promote a supportive environment for breastfeeding that includes lactation training at all levels of patient-facing healthcare and to create their own evidence-based patient education breastfeeding resources or curate existing resources such as those of the ABM and the Institute for the Advancement of Breastfeeding and Lactation Education.<sup>30</sup> Clinicians and patients should be made aware of the health benefits of breastfeeding for mothers and infants and view it as a preventive health measure beyond a nutritional source for infants.

## ■ WHEN WOULD THE GUIDELINES NOT APPLY?

The new AAP policy recommendations align with those of other societal and global organizations, such as the WHO and CDC. Guidelines may be difficult to apply to all settings, as access to resources may vary. For example, the benefits of breastfeeding may outweigh the risks for mothers with HIV in resource-constrained countries. In addition, cultural norms surrounding breastfeeding inform many areas of this practice, such as duration, exclusivity, and support. While the guidelines would be difficult to implement in settings with limited public and workplace policies to support



breastfeeding, there is much work to be done at local and widespread levels to make these new recommendations applicable to all interested dyads.

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