tice, we experience that non-breastfeeding women with breast pain come in, that is then discovered to be pain with an orthopaedic or a musculoskeletal cause, which has nothing to do with the breast tissue. Since brand-new mothers – as is known – have a tendency to muscular tension, very often this is certainly the cause. In any case, here there is still a need for further research, but with unclear therapy-resistant pain there is one option that can be used and give the mother the possibility to do something herself.

Functional Pain

What do we do when all approaches produce no success? The ABM in its new protocol on chronic pain during breastfeeding has taken up an interesting point: Allodynia or functional pain.

Here, pain occurs even with light touch, by clothing on the skin or drying with a hand towel. In the anamnesis other chronic pain illnesses, such as irritable bowel syndrome (IBS), fibromyalgia, dyspareunia (painful intercourse) or restless legs syndrome become apparent. The functional pain is associated with depression and anxiety disorders and must be treated in an interdisciplinary way.

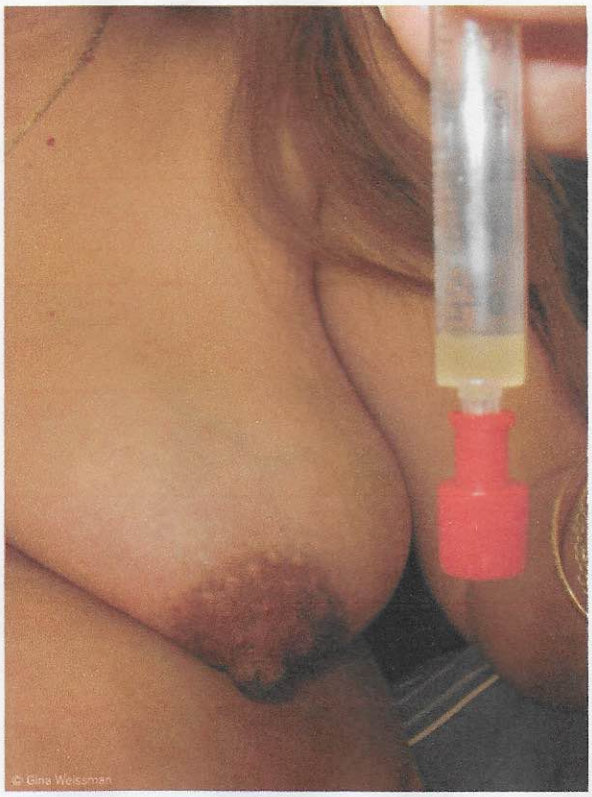
Therapeutically, for a few days, one can try to provide relief for the mother by interrupting the facilitation of the pain with a tightly scheduled pain medication. Obviously, the basic illness must be treated effectively. Psychotherapeutic counselling and, in some cases, anti-depressive therapy should be considered so that stress, pain and depression do not mutually reinforce each other and become self-sustaining.

Particularly in caring for a mother with pain during breastfeeding, it can be seen how important it is from the perspective of breastfeeding counselling, to be informed about possible causes to be able then to also work in an interdisciplinary way as much as possible – gynecologically, from an internal medicine perspective, orthopedically, neurologically, psychotherapeutically, pediatrically. Ideally, the breastfeeding counsellor has built up a network of open, breastfeeding-friendly colleagues with whom she can jointly care for mother and child

Dr. med. Alexandra Glaß

AME: A Tool to Ma Production in Chal

AME: Antenatal Manual Expression Author: Gina Weissman, DMD, RN, IBCLC



Collect the colostrum in a sterile container (e.g. syringe with a cap) and store in the freezer. Syringes are easy to use and defrost quickly.

Throughout human history, the breastfeeding mother and child have shared a very special relationship for long periods. For the modern mother, things are different.

In 2001, the World Health Organization issued a resolution that reads: "Exclusive breastfeeding for six months followed by the introduction of appropriate complementary feeding and continuation of breastfeeding for up to two years of age or beyond is optimal for the mother and child" [1]. Many mothers nowadays are already weaning before the baby is 2 weeks old.

New mothers abandon breastfeeding for two main reasons: 1) Breast pain and wounds 2) Insufficient milk, either perceived or real. With perceived insufficient milk supply, it is often the lack of support from people around her, who aren't informed about breastfeeding that influences the mother [2, 3]. Educating the nursing mother will – hopefully - prevent this.

With respect to actual milk volume, the Parker Study [4] shows us that it is important for mothers to start expressing their milk as soon as possible after birth. Furthermore, those mothers studied, who started *hand expressing milk within the first hour after birth, had 130% more milk* (3 days, 5 days, 7 days, 3 weeks and 6 weeks postpartum) than those who waited – even for a period as short as 2 hours after birth - to start expressing milk. The early expressers always had more.

We all know that it is best for baby and mother to be **breastfeeding directly from the breast** during the first hour postpartum.

ximize Breastmilk lengingCases

Unfortunately, often the baby is delivered but, for several reasons, doesn't nurse within the first hour. When I ask mothers in the maternity ward: "Did you breastfeed in the delivery room?" I hear: "I tried, but the baby didn't want to." Or "He tried, but he didn't manage it." Even though it was the mothers' original intention to nurse within that first hour, in fact less than half of them did.[5]

For most mothers, this might not be important. However, if there is potential for a real problem with milk production, expressing within the first hour, could provide a critical advantage.[6]

The message to new mothers needs to be: "If he didn't breastfeed during the first hour, start expressing your milk".[7] Whether she starts on her own or with the help of her mother, doula or partner, what is important is that she begin expressing her milk. Even if it's not collected, but just expressed into a piece of cloth, which is then put into the baby's bassinette.

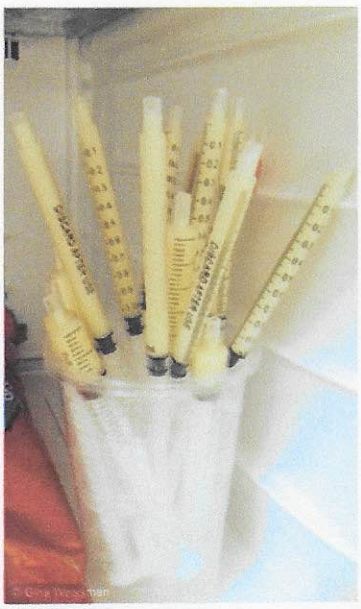
So, if we want the new mother to be able to express within the first hour, the best time to teach this would be **before** delivery.[8] In my clinic, I encourage mothers whom I consider to have a potential for an insufficient milk supply to come for a consultation at about 37 weeks of pregnancy. The mother is more open to learning new skills shortly before the birth.

During the meeting, the mother is given basic tools for the successful establishment of breastfeeding: First hunger cues; the switch nursing method; the significance of skin-to-skin contact, and rooming-in as the preferred option for mothers and babies.

I also teach them how to express colostrum. They will practice this skill during the next few weeks and by the time of birth they will be experts and will have collected colostrum that will assist them through the first days postpartum.[9]

Of course, my recommendation is, first of all, breastfeed. However, if you don't initially succeed in breastfeeding, for whatever reason, don't stress - just express.

As demonstrated in previous studies[10, 11, 12], it is advisable for diabetic mothers (including mothers with gestational diabetes, insulin dependent diabetes) to express milk before birth because the babies have a high potential to be hypoglycemic (low blood sugar), and they are at risk for a delay in lactogenesis two. They too collect the colostrum in little syringes that they bring to the birth place and are given to the baby if needed. ›



Keep the syringes frozen until labor begins.

AME: an effective tool for mothers in case breastfeeding is at risk.

THE PROTOCOL

Manually express colostrum for a total of 5 minutes each time (both breasts) as follows:

1. At 37 weeks pregnant- twice daily
2. At 38 weeks pregnant - 4 times daily
3. Collect the colostrum in a sterile container (e.g. syringe with a cap) and store in the freezer. Syringes are easy to use and defrost quickly.
4. Keep the syringes frozen until labor begins.
5. AME can continue past week 38 up until birth, 4x daily for 5 mins each time.
6. Bring the colostrum-filled syringes to the birth place in an appropriate cooler. The colostrum can be given to the newborn after each breastfeeding session. If baby and mother are separated, the colostrum can be dripped into the baby's mouth by a caretaker.
7. If possible, mother should attempt breastfeeding within one hour postpartum. If, for some reason, maternal or neonatal, the baby does not latch, manually express colostrum within one hour of giving birth. Collect the colostrum in a clean vessel if possible; if not express into a cloth diaper or sheet.

THIS PROTOCOL IS SUITABLE FOR:

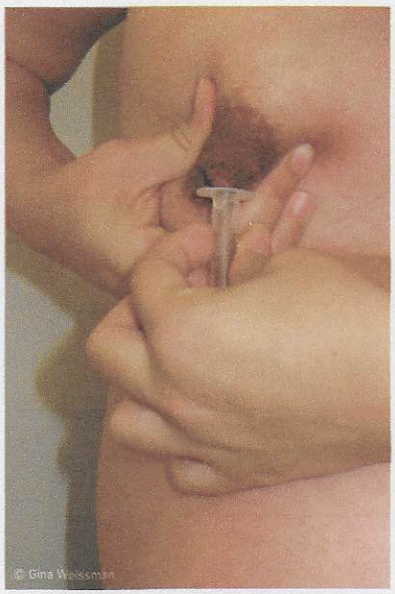
- Multiparous mothers with a history of low milk supply
- Women who have undergone breast surgery (augmentation / reduction)
- Women with hormonal fertility problems
- Women with diabetes

WHEN IS IT NOT SUITABLE?:

- Women with a high risk pregnancy who are to avoid sexual intercourse.
- If the AME causes pain in the breast or nipple or the mother feels the onset of contractions, she should consult with a physician.

› At the 2015 ABM conference in Los Angeles, I presented this idea of AME in cases with which I personally had experience. None of the mothers had gone into premature labor, which was a concern raised when I started suggesting that mothers express their milk prior to birth.[13] Many of these mothers were successfully 100 % (!) breastfeeding, while they had in their backgrounds, reasons for us to believe that they might not be able to: severe hypoplasia; breast reduction surgery; IVF at age 47; impaired health issues.

So how do you hand express?



1. Place your finger and thumb parallel to each other, about 2 cm behind the nipple.
2. Push your fingers in the direction of the ribs (into the breast)
3. Continue to press while trying to connect your fingers inside the breast and pulling the fingers around and down toward the nipple. In fact, expression is done in a circular manner and within. It is important to emphasize that the movement is done on the internal tissue and not just on the skin.
4. Express the colostrum into a syringe or cup that will be easy to drip into and easy to freeze.

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