

Doctor "Where were you last night? You were not on your bed," he answered that he was in his bed, but went to the Lavatory twice. The dressing was seen which was quite alright. There was no bleeding and no other complication. On the third day after the operation, the Patient again disappeared from his bed for nearly two hours. But there was no complication and on the 21st, the dressing was shown to the Doctor and marvellous to relate was quite alright. On the 24th, the 10th day after the operation, the stitches were taken out and the wound healed by first intention.

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Methods of Successful Breast Feeding

London Teachers Group Discussion

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I should like to open this discussion on the *Methods of successful Breast Feeding* by quoting an extract from the Ministry of Health's recent report on the Breast Feeding of Infants. It says: "In short, midwives should take it for granted that mothers will breast-feed their babies, and will want to breast-feed them, and they should stress the fact that in the great majority of cases breast feeding is a simple natural process which begins easily, soon after the baby is born, and for which no elaborate preparations are necessary, only simple hygienic precautions."

Now—the mother's point of view—words only too familiar to any infant welfare clinic:—

"My milk came in with a rush; it was terribly painful and I had many sleepless nights."

"My milk left me when I got up."

"They could not get the baby on to the nipples".

"My nipples were cracked. I dreaded the feeds; they were worse than labour."

Added to these are reports of the increasing number of cases of mastitis and breast abscess in the first six weeks of lactation.

It was the mother's point of view that led to a campaign towards securing an easier lactation at the British Hospital for Mothers and Babies, Woolwich, ten to 15 years ago. The first step was the recognition that mastitis is closely dependent upon damage of the nipples' surface and next that it was the women whose breasts became engorged who were most liable to get the nipples damaged. Engorgement, therefore, must be prevented.

To safeguard the nipples, the breast pump was banished from the hospital and every over-full breast had to be relieved by hand. Owing to pressure of work this was often impossible, so it was suggested that patients should be taught the massage and expressing movements in the ante-natal clinic towards the end of pregnancy.

In the "easy" group go (a) the multipara who has fed a previous baby with no difficulty; (b) the primipara with well-shaped breasts and nipples, thin elastic skin, free protraction of nipples and a good duct supply.

In the "difficult" group are (a) the multipara who has had any difficulty with a previous lactation; and (b) the primipara with unfavourable breasts and nipples—the flat breast, thick skin, badly formed nipples—and any with a history of breast trouble at any time in life.

We always culture the colostrum of mothers who have had a breast abscess in a previous lactation.

The advice given in the first 20 weeks of pregnancy is to carry out a simple hygiene of breasts and nipples—cleansing the latter with soap and a soft flannel and not with a brush—and to wear an adequate support.

At 20 to 24 weeks both groups are advised to rub a little oil into the skin of the breasts and short talks on breast feeding are given to the primipara at the Mothers' Club.

At 24 to 28 weeks (or earlier) the treatment of the badly formed nipples of the "difficult" group is started. Breast massage is taught and carried out daily, and the formation and protraction of the nipples improved by the use of glass nipple shells, worn under a firm support. The "easy" group learns massage and the expression of a little colostrum at 36 weeks.

By the time the baby arrives the mothers are enthusiastic, skilled with their hands and quite confident in their power to breast feed.

After delivery those in the "easy" group give no trouble; they keep their breasts soft themselves, with the milk running freely, and so avoid engorgement and its pain and subsequent complications.

Mothers in the "difficult" group need more assistance from the nursing staff. We are most anxious to avoid over-filling and this is watched for with great vigilance from feed to feed. We are using Stilboestrol in small doses (5 to 10 mgm, with total of 20 to 30 mgm.) at the first threat that breast tension is rising and so we are avoiding engorgement.

After some months had passed, reports came in from the ward sisters that the girls who had been taught in the clinics were less liable to get engorged. At first this was thought to be a coincidence, but after continued observation it was confirmed and we now attribute it to the fact that the milk ducts were freed of the early sticky colostrum and rendered patent and that also, quite probably, more ducts were opened up on to the surface.

The hospital was satisfied with the value of this antenatal work but, to make certain, a controlled enquiry was undertaken in 1942-44.

Two hundred primigravidae were taken as they booked; a hundred as pupils. These were carefully taught the massage and expression six to eight weeks before term. Careful notes were taken on the formation of breasts and nipples in each case. The results were striking and the following are a few figures from the records.

		<i>Wholly breast feeding</i>	<i>Partly breast feeding.</i>	<i>Artificial feeding</i>
On discharge:	P.	97	2	1
	C.	83	12	5
At 3 months:	P.	87	2	11
	C.	65	4	31
At 6 months:	P.	83	3	14
	C.	42	5	53

(P.--Pupils. C.--Controls)

The work on lactation in the hospital is now based on this enquiry.

On booking, a general medical examination is made to ascertain that the mother is fit to breast-feed her baby. A careful inspection is made of the breasts and nipples, and then we divide the patients into two main groups.

In the few cases where engorgement occurs very suddenly, producing oedema of the breasts, nipples and ducts, feeding is withheld. The breast is not expressed but only a little gentle massage given, comfortable binder applied and Stilboestrol, in doses of 10 to 20 mgm., given four-hourly until the disappearance of all pain and tension--usually within 24 hours.

We have few rules and regulations in the wards, each mother and baby being treated, when possible, individually. But we have one Golden Rule for the pupils and that is to ask every mother at every feed if she has any pain, however slight, when the baby is feeding. If she has, the baby is taken off the breast for a few feeds and the mother expresses the milk herself, so avoiding any breach of the skin surface. If any damage can be found, by the naked eye or through a lens, it must be securely healed before feeding is resumed.

The mothers are encouraged to tell us when they feel the "draught" or the milk "coming in". Often this may coincide with the feeding time and so needs to be adjusted, as in the case of one multipara who only felt her "draught" when a train went by. She was allowed to feed at her own time and the infant flourished.

These methods do involve more work in the ante-natal department and require constant care and observation in the wards but, finally, they reduce the work of the nursing staff, and the results to the mothers themselves and the hospital make it well worth while. We have lost all fear of mastitis and breast abscesses.

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