



THE MIDWIVES' UNION SECTION

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Members are asked to send any helpful notes of cases, and articles for this Section to the Secretary.

A MIDWIFE'S RESPONSIBILITY IN BREAST FEEDING

By A. VALERIE GRAHAM

(Continued from September issue.)

Perhaps one of the most trying phases in breast feeding is engorgement, tending to cause trouble to the mother by pain, even to sleeplessness, and trouble to the baby, often from over-feeding or extreme difficulty in getting the milk to flow; and if engorgement has been severe it may be followed by "reaction," and the milk becomes scanty or sometimes "thin," therefore anything we can do to prevent or minimise engorgement is well worth while.

If the bowels are well regulated and the fluid intake slightly restricted the third and fourth day; and if engorgement threatens, a firm binder applied, in the place of the brassiere for 24 hours, this passes over with very slight discomfort; but should they prove troublesome, gentle stroking with talc powder from chest wall to nipple, expressing a certain amount of milk in the process, immediately before suckling, and just relieving both breasts during suckling; and if painful after the last suckling a *well rung out* hot compress under the firm binder will give the mother a comfortable night; be careful, of course, to have a hole in the centre of the compress so as not to compress the nipple. There again I think you have the advantage from getting the baby to the breast as soon as possible after delivery, early establishment of the milk seems to diminish engorgement.

Do avoid nipple-shields unless absolutely urgent; if posture and slight emptying during engorgement are studied—with very little extra care—the baby will get and hold the nipple without injury. I'm sure any form of shield—even that best of all, the all-rubber shield—does tend to reduce the milk supply. A breast pump applied to a flat difficult nipple, and the nipple immediately available for the baby, is wonderfully useful, but must not be vigorously applied, very gentle suction will raise the nipple.

Should the nipple give trouble with delicacy or soreness, glycerine and borax, gently rubbed into the nipple tip and "root," after suckling, and wiped off with a damp swab, and thoroughly dried with wool or soft linen, is, I assure you, efficacious, clean and harmless to mother and babe. Having essayed many preparations for these conditions, many of them very efficacious, but certainly not more so, and most being dirty and poisonous, I have always reverted to this, with the greatest satisfaction, but it should be

gently rubbed into the nipple tip and "root" (as with a chapped hand) not just smeared over.

If there is definite cracking or soreness (I can't tell you how rarely I have been up against them) a shield may become a necessity. Glycerine and Tannic Acid gently rubbed in, in the same way as the glycerine and borax, will work wonders. Be careful of stain on mother's clothes. If the suggested brassiere is being worn and a square of gamgee (half thickness, with gamgee side over nipple) no staining will occur.

The nipple must be washed with clear water before suckling, and a little final wipe with pure glycerine tempts baby to start easily, a very important thing with any soreness of the nipple.

The question of suckling from one or both breasts is undoubtedly a consideration for each individual case, this fact probably accounts for the decidedly opposite opinions given in many text books, some saying both breasts should always be used, some alternate breasts always. Generally where milk is scanty use both at each suckling, where plentiful, one, though at the time of engorgement it is urgent that both breasts should be relieved at each suckling: No teaching can replace observation and experience where suckling is concerned.

Every midwife should be able to teach her "mothers" how to empty the breast by hand. This is not difficult (it always surprises me how cute the mothers are in getting the knack), and its uses are many, for premature baby, for entire or complementary feeding, for emptying the breast thoroughly where the milk supply is scanty or the baby for any reason fails to empty the breast (Miss Liddiard's book on the Care of the Baby has excellent illustrations of this. A copy can be procured from the Library of the Midwives' Institute).

As regards milk, etc., for the nursing mother; milk is certainly useful during lactation, but do not overdo it, remember milk is heavy in conjunction with an ordinary diet. Fluid is essential, and a glass of hot or cold water before or at suckling time has a good effect practically and psychologically. Many mothers have the greatest faith in many proprietary milk foods, the good effects of these psychologically is undoubted, and should be rather encouraged than disparaged.

Fatigue after or during suckling is *Abnormal* and should always lead to careful investigation of life, feeding, sleep, etc. Never let anæmia pass unnoticed, either ante- or post-natally, it is a complication of pregnancy that, if treated early, responds well but rapidly increases, making cure more and more difficult if neglected; and anæmia is fatal to breast-feeding.

During twenty-one years' close contact with domiciliary and hospital patients in one of the poorest parts of London, so few babies were bottle-fed that there was difficulty in giving the pupil-midwives practical experience in artificial feeding. It was a foregone conclusion that they would breast-feed. Cracks were very rare and abscesses could be counted on the fingers of one hand, nipple-shields were things of a few days' use only and I'm certain two

things governed this "mothers'" faith in us—and "mothers'" knowledge that artificial feeding was both difficult and expensive. Early suckling and frequent supervision during suckling wherever difficulties presented.

Complementary feeding should always represent, what it should be, a temporary measure whilst breast-feeding is being adjusted or readjusted.

From the University College Hospital Breast-Feeding Clinic comes an ingenious practice of doing the complementary feed through a catheter introduced into the infant's mouth with the nipple. A No. 2 or 3 rubber catheter is attached to a glass tube which passes through a rubber cork at the teat end of an ordinary boat-shaped feeding bottle, which is encased in a flannel cover and pinned to the mother's dress on the opposite shoulder to the side of suckling. The infant is weighed and put to the breast and allowed to suck until the breast is emptied or for as long as he will do so peacefully; as soon as he begins to refuse, the catheter is pushed gently into his mouth, care being taken to make sure that it passes between his gums with the nipple. The infant does not seem to be aware of the presence of the catheter and sucks vigorously as soon as milk flows into his mouth; the rate of flow is controlled by the valve at the top end of the bottle and by the pressure of the mother's fingers on the catheter. The infant is weighed at the end of the feed and the amount of breast milk taken in addition to the complementary feed can be calculated. The breast should be finally emptied by manual expression and the expressed milk set aside for the next complementary feed. In practice it was found to be a simple procedure and easily carried out at home. It ensures the stimulation at the nipple throughout feeding. It is certainly of great interest. Ante-and post-natal exercises are certainly of the greatest value in lactation, and with the lengthened training of pupil-midwives, post-graduate course and extension of ante-and post-natal clinics, these exercises will easily become an everyday affair with pregnant and nursing mothers.

Nothing is too great or too small that may in any way help towards natural and easy breast-feeding.
