Optimizing Support for Breastfeeding
2016

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

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Dear Colleague:

Evidence continues to mount regarding the benefits of breastfeeding for women and their infants. The American College of Obstetricians and Gynecologists (the College) recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant’s first year of life, or longer if mutually desired by the woman and her infant. However, the rate of breastfeeding in the United States is only 49% at 6 months and 27% at 12 months, which is well below the Healthy People 2020 target rates of 60.6% and 34.1%, respectively.

As reproductive health experts and women’s health advocates who work with a variety of obstetric and pediatric care providers, obstetrician–gynecologists are uniquely positioned to enable women to achieve their infant feeding goals. The materials in this toolkit are designed to help you do just that. The recently revised Committee Opinion No. 658 explains how obstetrician–gynecologists and other obstetric care providers can support breastfeeding women and includes educational and policy recommendations. The Physician Conversation Guide on Support for Breastfeeding will help to initiate discussions about breastfeeding with your patients early in pregnancy or prenatal care. Breastfeeding Coding is conveniently located on the back of the card. If your patient has questions about breastfeeding, please give her a sheet from Breastfeeding: Frequently Asked Questions. Also enclosed is a breastfeeding infographic poster to hang in your office and spur conversations.

The College’s Breastfeeding Expert Work Group was instrumental in the development of this toolkit. Founded in February 2014, the Expert Work Group assists the College, specifically the Committee on Obstetric Practice in addition to other committees as appropriate, by providing expertise in breastfeeding medicine and developing and promoting breastfeeding tools and initiatives for obstetrician–gynecologists and other obstetric care providers and patients at all levels of the community. For further information on the College’s Breastfeeding Expert Work Group, breastfeeding guidance, and patient education, refer to our resources flyer and www.acog.org/breastfeeding. If you have additional questions, please e-mail us at breastfeeding@acog.org or call 800-410-ACOG (2264). If you would like to order supplementary materials, please visit us at sales.acog.org.

We hope the enclosed materials will be helpful to you, your practice team, and your patients. Thank you for your time and for joining our efforts in supporting women in achieving their breastfeeding goals.

Best,

Christopher M. Zahn, MD
Vice President, Practice Activities

Lauren Hanley, MD, IBCLC, FACOG
Chair, Breastfeeding Expert Work Group
Optimizing Support for Breastfeeding as Part of Obstetric Practice

ABSTRACT: Although most women in the United States initiate breastfeeding, more than one half wean earlier than they desire. As reproductive health experts and advocates for women’s health who work in conjunction with other obstetric and pediatric health care providers, obstetrician–gynecologists are uniquely positioned to enable women to achieve their infant feeding goals. The American College of Obstetricians and Gynecologists recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant’s first year of life, or longer as mutually desired by the woman and her infant. Because lactation is an integral part of reproductive physiology, all obstetrician–gynecologists and other obstetric care providers should develop and maintain knowledge and skills in anticipatory guidance, physical assessment and support for normal breastfeeding physiology, and management of common complications of lactation. Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant. Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace. The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding women through the infant’s first year of life, and for those who continue beyond the first year.

Recommendations

Education
- Clinical management of lactation is a core component of reproductive health care.
- Because lactation is an integral part of reproductive physiology, all obstetrician–gynecologists and other obstetric care providers should develop and maintain knowledge and skills in anticipatory guidance, physical assessment and support for normal breastfeeding physiology, and management of common complications of lactation.

Support for Breastfeeding Women
- The American College of Obstetricians and Gynecologists (the College) strongly encourages women to breastfeed and supports each woman’s right to breastfeed. The College recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant’s first year of life.
- Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant.
- A breastfeeding history should be obtained as part of prenatal care, and identified concerns and risk factors for breastfeeding difficulties should be communicated to the infant’s health care provider.
• All obstetrician–gynecologists and other obstetric care providers should support women who have given birth to preterm and other vulnerable infants to establish a full supply of milk by providing anticipatory guidance, support, and education for women. Obstetrician–gynecologists and other obstetric care providers should work with hospital staff to facilitate early, frequent milk expression.
• Women who experience breastfeeding difficulties are at higher risk of postpartum depression, and should be screened, treated, and referred appropriately.
• Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace.
• The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding women through the infant’s first year of life, and for those who continue to breastfeed beyond the first year.

Policy
• Obstetrician–gynecologists and other obstetric care providers should be in the forefront of policy efforts to enable women to breastfeed, whether through individual patient education, change in hospital practices, community efforts, or supportive legislation.
• The World Health Organization’s “Ten Steps to Successful Breastfeeding” should be integrated into maternity care to increase the likelihood that a woman achieves her personal breastfeeding goals.
• Policies that protect the right of a woman and her child to breastfeed and that accommodate milk expression, such as paid maternity leave, onsite childcare, break time for expressing milk, and a location other than a bathroom for expressing milk, are essential to sustaining breastfeeding.

Introduction
Although most women in the United States initiate breastfeeding, more than one half wean earlier than they desire (1). In addition, substantial disparities persist in initiation and duration of breastfeeding that affect population health (2). Maternity care policies and practices that support breastfeeding are improving nationally; however, more work is needed to ensure all women receive optimal breastfeeding support during their maternity stay (3). Given this mismatch between women’s intentions for and experience of breastfeeding, the previous version of this Committee Opinion was revised to address how obstetrician–gynecologists and other obstetric care providers can enable women to achieve their infant feeding intentions. As reproductive health experts and advocates for women’s health who work in conjunction with other obstetric and pediatric health care providers, obstetrician–gynecologists are uniquely positioned to enable women to achieve their infant feeding goals.

Benefits of Breastfeeding
Clinical management of lactation is a core component of reproductive health care. Enabling women to breastfeed is also a public health priority because, on a population level, interruption of lactation is associated with adverse health outcomes for the woman and her child, including higher maternal risks of breast cancer, ovarian cancer, diabetes, hypertension, and heart disease, and greater infant risks of infectious disease, sudden infant death syndrome, and metabolic disease (2, 4).

Although lactation is the physiologic norm, cultural norms for infant feeding have changed dramatically in the past century. In 1971, only 24.7% of women left the hospital breastfeeding. Since then, breastfeeding initiation rates have progressively increased. In 2011, 79% of women in the United States initiated breastfeeding. 49% were breastfeeding at 6 months, and 27% were breastfeeding at 1 year postpartum (5). Exclusive breastfeeding rates are lower (Table 1).

Breastfeeding is optimal and appropriate for most women. Contraindications to breastfeeding are few and include those women who have an infant with galactosemia, are infected with human immunodeficiency virus (HIV) or human T-cell lymphotropic virus type I or type II, and have active untreated tuberculosis or varicella or active herpes simplex virus lesions on the nipple. Most medications are safe in breastfeeding, with rare exceptions such as cytotoxic chemotherapy drugs. Use of drugs or illicit substances or treatment for such may not be a contraindication to breastfeeding. For example, women on stable doses of methadone should be encouraged to breastfeed (6, 7). There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged (8).

The Role of Obstetrician–Gynecologists and Other Obstetric Care Providers in Supporting Breastfeeding
The American College of Obstetricians and Gynecologists (the College) strongly encourages women to breastfeed and supports each woman’s right to breastfeed. The College recommends exclusive breastfeeding for the first 6 months of life, with continued breastfeeding as complementary foods are introduced through the infant’s first year of life, or longer as mutually desired by the woman and her infant. This recommendation is consistent with those of other medical and nursing organizations, such as the American Academy of Pediatrics (9) and the Association of Women’s Health, Obstetric and Neonatal Nurses (10). The College further supports public health and policy efforts to enable more women to breastfeed, including Healthy People 2020 targets for increasing
Committee Opinion No. 658

Personal experiences with infant feeding may affect their counseling. In addition, pervasive direct-to-consumer marketing of infant formula adversely affects patient and health care provider perception of the risks and benefits of breastfeeding.

Beginning conversations about lactation early in prenatal care by asking the patient and her family, “What have you heard about breastfeeding?” sets the stage for a patient-centered discussion. When taking an obstetric history, obstetrician–gynecologists and other obstetric care providers should specifically ask about any breast surgeries, prior breastfeeding duration, and any previous breastfeeding difficulties. Prior problems leading to earlier-than-desired weaning should be discussed, anticipatory guidance should be provided, and appropriate lactation support resources should be identified. The breast examination can identify surgical scars indicating prior surgery, as well as widely spaced, tubular breasts that may indicate insufficient glandular tissue (4). A breast assessment and breastfeeding history should be obtained as part of prenatal care, and identified concerns and risk factors for breastfeeding difficulties should be discussed with the woman, and communicated to the infant’s health care provider, either directly or as part of shared records. Obstetrician–gynecologist and other obstetric care providers should engage the patient’s partner and other family members in discussions about infant feeding and address any questions and concerns. This

**Prenatal Care**

The advice and encouragement of the obstetrician–gynecologist and other obstetric care providers are critical in assisting women to make an informed infant feeding decision. As when discussing any health behavior, the obstetrician–gynecologist is obligated to ensure patient comprehension of the relevant information and to be certain that the conversation is free from coercion, pressure, or undue influence (11). Families should receive noncommercial, accurate, and unbiased information so that they can make informed decisions about their health care (12). Obstetric care providers should be aware that personal experiences with infant feeding may affect their counseling. In addition, pervasive direct-to-consumer marketing of infant formula adversely affects patient and health care provider perception of the risks and benefits of breastfeeding.

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**Table 1. Healthy People 2020 Goals for Breastfeeding**

<table>
<thead>
<tr>
<th>Healthy People 2020 Goals (%)</th>
<th>Current Data (%)</th>
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<tbody>
<tr>
<td>Increase the proportion of infants who are breastfed at the following stages:</td>
<td></td>
</tr>
<tr>
<td>Ever breastfed</td>
<td>81.9</td>
</tr>
<tr>
<td>Breastfed at 6 months</td>
<td>60.6</td>
</tr>
<tr>
<td>Breastfed at 1 year</td>
<td>34.1</td>
</tr>
<tr>
<td>Breastfed exclusively through 3 months</td>
<td>46.2</td>
</tr>
<tr>
<td>Breastfed exclusively through 6 months</td>
<td>25.5</td>
</tr>
<tr>
<td>Increase the proportion of employers that have worksite lactation support programs</td>
<td>38</td>
</tr>
<tr>
<td>Increase the proportion of live births that occur in facilities that provide recommended care for lactating mothers and their babies</td>
<td>14.2</td>
</tr>
</tbody>
</table>


‡Offer onsite lactation/mother’s room, defined as a separate room that goes above and beyond the The Patient Protection and Affordable Care Act law, which requires that employees be “shielded from view” and “free from intrusion” during their break. Six percent offer lactation support services.

patient-centered approach allows the health care provider, the patient, and her family to anticipate challenges, develop strategies to address them, and collaborate to develop a feeding plan that is compatible with the family’s individual values, circumstances, and concerns. Obstetrician–gynecologists and other obstetric care providers should support each woman’s informed decision about whether to initiate or continue breastfeeding, recognizing that she is uniquely qualified to decide whether exclusive breastfeeding, mixed feeding, or formula feeding is optimal for her and her infant.

Intrapartum Care

Maternity care practices affect breastfeeding outcomes. The World Health Organization’s “Ten Steps to Successful Breastfeeding” is an evidence-based set of health care practices that support breastfeeding physiology, including early skin-to-skin care, rooming-in, and feeding on demand (see Box 1) (2). In a meta-analysis of randomized controlled trials, skin-to-skin care in the first hour of life increased breastfeeding duration by 42.6 days (95% CI, −1.7 to 86.8) (13). The Ten Steps should be integrated into maternity care to increase the likelihood that a woman will initiate and sustain breastfeeding and achieve her personal breastfeeding goals (14). Cesarean birth is associated with lower breastfeeding rates, and women who undergo cesarean delivery may need extra support to establish and sustain breastfeeding. Skin-to-skin contact is feasible in the operating room and is associated with reduced need for formula supplementation (15).

Healthy People 2020 and the Joint Commission have targeted unindicated formula supplementation as a barrier to establishing breastfeeding, and maternity care providers can provide anticipatory guidance for families regarding the rationale for avoiding early introduction of formula. Distribution of formula marketing packs reduces breastfeeding initiation and duration (16) and implies that formula is a recommended feeding method. Moreover, provision of samples implies the health care provider’s endorsement of a specific brand, which encourages families to purchase more expensive brand-name products, rather than generic equivalents (17). Such marketing should not occur in inpatient or outpatient health care settings.

For preterm infants, human milk feeding, in particular the woman’s own milk, is associated with a reduced risk of necrotizing enterocolitis (18) and other infectious morbidity. Sharing this information with women who have given birth to preterm infants and who intended to formula feed increases breastfeeding initiation and does not increase maternal anxiety (19). The obstetrician–gynecologist and other obstetric care providers should collaborate with the pediatric care provider to share this information as soon as a preterm birth is anticipated because initiation of milk expression within 6 hours of birth is associated with improved milk production (20). Drops of colostrum obtained from early expression can be used for oral care as well as for initial feedings of even the smallest preterm infant. All obstetrician–gynecologists and other obstetric care providers should support women who have given birth to preterm infants to establish a full supply of milk by providing anticipatory guidance and working with hospital staff to facilitate early, frequent milk expression.

Clinical Management of the Breastfeeding Dyad

The offices of obstetrician–gynecologists and other obstetric care providers should be a resource for breastfeeding assistance through the first year of life, and for those women who continue to breastfeed beyond the first

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**Box 1. Ten Hospital Practices to Encourage and Support Breastfeeding**

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in the skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help women initiate breastfeeding within 1 hour of birth.
5. Show women how to breastfeed and how to maintain lactation, even if they are separated from their newborns.
6. Give newborns no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in—allow mothers and newborns to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no pacifiers or artificial nipples to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer them to discharge from the hospital or birth center.


^The 1994 report of the Healthy Mothers, Healthy Babies National Coalition Expert Work Group recommended that the UNICEF-WHO Baby Friendly Hospital Initiative be adapted for use in the United States as the United States Breastfeeding Health Initiative, using the adapted 10 steps above.

*The American Academy of Pediatrics endorsed the UNICEF-WHO Ten Steps to Successful Breastfeeding but does not support a categorical ban on pacifiers because of their role in reducing the risk of sudden infant death syndrome and their analgesic benefit during painful procedures when breastfeeding cannot provide the analgesia.
year because many of the health benefits associated with breastfeeding increase with longer duration of breastfeeding. Lactation is a two-person activity, and evaluation of breastfeeding problems requires assessment of the woman and her infant, as well as the active engagement and support of her partner, extended family, or other identified support. Management of issues such as pain, low milk supply, breast infections, and maternal medication safety should, therefore, be coordinated with the infant’s care provider as appropriate. Office staff should be prepared to triage common breastfeeding concerns and to refer women, as needed, to certified lactation professionals in the community, such as an International Board Certified Lactation Consultant or Certified Lactation Counselor. Embedding lactation consultants within the offices of an obstetrician–gynecologist or other obstetric care provider may be feasible now that coverage of lactation services is included as preventive care under the Affordable Care Act (21).

Most medications are safe for use during breastfeeding. Obstetrician–gynecologists and other health care providers should consult lactation pharmacology resources, such as LactMed (22), for up-to-date information on individual medications (6) because inappropriate advice often can lead women to discontinue breastfeeding unnecessarily. Information about drug safety in pregnancy should not be extrapolated to breastfeeding, as the physiology of the placenta and breast are not the same. For example, warfarin crosses the placenta and can cause embryopathy, but minimal amounts enter breast milk, so it is considered to be safe during lactation (22). Counseling regarding medication use during lactation should address the risks of drug exposure through breast milk and the risks of interrupting lactation. After anesthesia for surgical procedures, women who have given birth to healthy infants generally may breastfeed as soon as they are stable, awake, and alert enough to hold the infant (23). Breastfeeding can be continued without interruption after the use of iodinated contrast or gadolinium (6).

Low milk supply is a common concern and may reflect misinterpretation of normal infant feeding behaviors, low production, or inadequate milk transfer (4). The most common cause of low milk supply is inadequate breast stimulation. Careful evaluation by a certified lactation professional to ensure frequent breast stimulation and milk removal is the most effective strategy to increase milk production. There is limited evidence for medications and herbal galactagogues to increase milk supply (24).

Disrupted lactation is common, with one in eight women reporting early, undesired cessation of breastfeeding because of multiple problems with pain, low milk supply, and the infant being able to latch on to the breast (25). Obstetric care providers should collaborate with certified lactation professionals and the infant’s health care provider to evaluate and manage breastfeeding problems. Even with comprehensive support, some mother–infant dyads are unable to establish sustained, exclusive breastfeeding. Women who are not able to achieve their breastfeeding intentions report considerable distress, and obstetrician–gynecologists and other health care providers should validate each woman’s efforts and experience (4). Women who experience breastfeeding difficulties are at higher risk of postpartum depression and should be screened, treated, and referred appropriately.

Although breastfeeding without introducing any complementary solids or formula will in most cases prevent ovulation and, thus, pregnancy for up to 6 months postpartum, it will do so only when women are fully or nearly fully breastfeeding and there is continued amenorrhea. Contraception is an important topic for all women, and discussion of other methods should not be delayed in breastfeeding women. Contraceptive options should be explained in detail and include nonhormonal methods (copper intrauterine devices, condoms, diaphragms) and hormonal methods (levonorgestrel intrauterine device, etonogestrel implants, medroxyprogesterone acetate injection, progestin-only pills, and combined hormonal contraceptive pills). Immediate postpartum initiation of hormonal methods is controversial (26). The Centers for Disease Control and Prevention states that the advantages outweigh the risks of progestin-only contraception immediately after birth and for combined hormonal methods at 1 month postpartum (27). Data are limited, however, and theoretical concerns exist because progesterone withdrawal after delivery of the placenta is thought to trigger onset of lactogenesis, so exogenous progesterone could prevent onset of milk production (25). Obstetric care providers should discuss these limitations and concerns within the context of each woman’s desire to breastfeed and her risk of unplanned pregnancy, so that she can make an autonomous and informed decision.

Breastfeeding in the Community
Obstetrician–gynecologists and other obstetric care providers should support women in integrating breastfeeding into their daily lives in the community and in the workplace. Before discharge from the maternity center, women should be provided with contact information for community-based lactation support. Maintaining milk supply depends largely on frequency of milk removal through breastfeeding and through expressing milk (breast pumping or manual expression) when the woman and her infant are separated. Policies that protect the right of the woman and her child to breastfeed and that accommodate milk expression, such as paid maternity leave (28), on-site childcare, break time, and a location other than a bathroom for expressing milk (29), are essential to sustaining breastfeeding. Obstetric care provider offices and hospitals can set an example through supportive policies for lactating staff, accommodations for nursing patients, awareness and educational materials, and staff training (10, 30).
For More Information

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists’ endorsement of the organization, the organization’s web site, or the content of the resource. The resources may change without notice.

ACOG has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/ObBreastfeedingSupport.

References


Breastfeeding: Frequently Asked Questions

How does breastfeeding my baby benefit me?

Breastfeeding is good for you for the following reasons:

• Breastfeeding burns as many as 500 extra calories each day, which may make it easier to lose the weight you gained during pregnancy.

• Women who breastfeed longer have lower rates of type 2 diabetes, high blood pressure, and heart disease.

• Women who breastfeed have lower rates of breast cancer and ovarian cancer.

• Breastfeeding releases oxytocin, a hormone that causes the uterus to contract. This helps the uterus return to its normal size more quickly and may decrease the amount of bleeding you have after giving birth.

How does breastfeeding benefit my baby?

Breastfeeding benefits your baby in the following ways:

• Breast milk has the right amount of fat, sugar, water, protein, and minerals needed for a baby's growth and development. As your baby grows, your breast milk changes to adapt to the baby's changing nutritional needs.

• Breast milk is easier to digest than formula.

• Breast milk contains antibodies that protect infants from ear infections, diarrhea, respiratory illnesses, and allergies.

• Breastfed infants have a lower risk of sudden infant death syndrome. Any amount of breastfeeding appears to help lower this risk.

• If your baby is born preterm, breast milk can help reduce the risk of many of the short-term and long-term health problems that preterm babies face, such as necrotizing enterocolitis or other infections.

How long should I breastfeed my baby?

It is recommended that babies exclusively breastfeed for the first 6 months of life. Exclusive breastfeeding means to feed your baby only breast milk and no other foods or liquids unless advised by the baby's doctor. Breastfeeding should continue as new foods are introduced through the baby's first year. You can keep breastfeeding after the first year as long as you and your baby want to continue. You can use a breast pump to express milk at work to provide milk for your baby when you are separated. This also helps to keep up your supply while you are away from your baby.

When can I begin breastfeeding?

Most healthy newborns are ready to breastfeed within the first hour after birth. Hold your baby directly against your bare skin (called “skin-to-skin” contact) right after birth. Placing your baby against your skin right after birth triggers reflexes that help your baby to attach or “latch on” to your breast.

How do I know my baby is hungry?

When babies are hungry, they will nuzzle against your breast, suck on their hands, flex their fingers and arms, and clench their fists. Crying usually is a late sign of hunger. When babies are full, they relax their arms, legs, and hands and close their eyes.
How do I know my baby is getting enough milk?

Your baby’s stomach is very small, and breast milk empties from a baby’s stomach faster than formula. For these reasons, you will typically breastfeed at least 8–12 times in 24 hours during the first weeks of your baby’s life. If it has been more than 4 hours since the last feeding, you may need to wake up your baby to feed. Each nursing session typically lasts 10–45 minutes. Once your breast milk transitions from colostrum to mature milk, your baby will soak at least six diapers a day with urine and have at least three bowel movements a day. After 10 days, your baby will be back up to birth weight. Although breastfeeding works for most women, it may not work for everyone.

Who can help me with breastfeeding?

- **Peer counselors**, such as those found with La Leche League and Women, Infants, and Children (WIC), are women who have experienced breastfeeding and can help with nonmedical breastfeeding questions and support. Check with your obstetrician–gynecologist or other health care provider about resources available in your area.
- **Certified lactation counselors** can teach you what you need to know to get started with breastfeeding, and **international board-certified lactation consultants** can help you navigate problems many women face while breastfeeding.
- **Hospital nurses** can help you find a comfortable position for nursing in the days after delivery.
- Your infant’s **pediatric care provider** can help answer questions about infant nutrition and infant weight gain.
- **Obstetrician–gynecologists and other obstetric care providers** can discuss breastfeeding with you during pregnancy and can help you plan for a successful start to breastfeeding. They also can help in the hospital, at your postpartum visit, and beyond.

Resources for Patients

- American College of Obstetricians and Gynecologists
  [http://www.acog.org/breastfeeding](http://www.acog.org/breastfeeding)
- American Academy of Pediatrics
  [http://www.aap.org](http://www.aap.org)
- American Academy of Family Physicians
  [http://www.familydoctor.org](http://www.familydoctor.org)
- Women, Infants, and Children—United States Department of Agriculture, Food and Nutrition Services
- La Leche League International
- American College of Nurse–Midwives
- Office on Women’s Health, U.S. Department of Health and Human Services
- International Lactation Consultant Association
- MotherToBaby
  866-626-6847
  [http://mothertobaby.org](http://mothertobaby.org)

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12345/09876 AA612A
Pertinent Medical and Surgical History: Ask about breast surgery (including reduction or augmentation and significant trauma or radiation to the chest wall), which could affect breastfeeding performance.

Medications: For chronic medications, ask what the patient knows about drug safety in lactation. Consult LactMed for long-term medications and provide her with printed resources, such as LactMed monographs or MotherToBaby fact sheets, for information on safety of medications she anticipates taking after giving birth.

Anticipatory Guidance: Begin conversations about lactation early in prenatal care using three-step counseling: 1) Ask the patient an open-ended question and listen to her response, 2) Summarize her response in your own words, and 3) Educate, addressing her concerns.

Some questions and suggestions for education:

What have you heard about breastfeeding?
- Health effects: Breastfeeding is different from formula feeding. Discuss benefits for the woman and the baby.
- Pain: Many women experience discomfort with latching in the early days as the baby draws the nipple and areola into its mouth. Pain lasting more than 20–30 seconds is a signal to adjust the baby's position, sometimes simply by shifting the baby's torso to face the woman's body. Hospital staff will help with positioning too.
- When to feed: The baby has a fuel gauge—elbows flexed and fists near the mouth means “empty” and arms relaxed means “full.” One arm flexed means “I might want dessert.”
- Making enough milk: To make lots of milk, put the baby to the breast early and often. The breasts are stimulated to make more milk by having colostrum or milk removed from them. The woman will make as much milk as her baby removes. Acknowledge that although breastfeeding works for most women, it may not work for everyone.
- Nursing in public: Discuss how to nurse discreetly, and review that the woman has a legal right to breastfeed in public. Consider timing outings and using an infant sling, a breastfeeding cover, and a breastfeeding bra. Empower women to request a private space for nursing.

What have you heard about how long to breastfeed?
- Review recommendations for 6 months of exclusive breastfeeding, continuing for 1 year or longer if mutually desired by the woman and the baby as new foods are introduced after the first 6 months.

How does your family or partner feel about breastfeeding?
- Offer to consult with unsupportive family or partner.
- Concerns about sexuality: Explore the partner's cultural values; explain the primary role of breasts as nourishment.

What are your plans for returning to work or school in the first few months after birth?
- Discuss opportunities for expressing milk at work or school. If there are none, the woman and her baby will adapt to more frequent nursing in off times. Express milk when at home for the next day's supply. The Affordable Care Act requires most employers to provide breastfeeding women with breaks to express milk in a place other than a bathroom. Find out more at http://www.dol.gov/whd/nursingmothers/.

Multiparous women: How did feeding go with your older child or children?
- Praise the patient for any previous breastfeeding. Ask about challenges she encountered and strategies for overcoming them. Offer a prenatal consult with an International Board Certified Lactation Consultant for anticipatory guidance. If the patient formula fed, explore reasons for her decision. Ask if she has considered breastfeeding.

Breastfeeding Coding

for Obstetrician–Gynecologists 2016

Commonly Used Codes for Breastfeeding

<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Breastfeeding Condition</th>
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<tbody>
<tr>
<td>O91.03</td>
<td>Infection of nipple associated with lactation</td>
</tr>
<tr>
<td>O91.13</td>
<td>Abscess of breast associated with lactation</td>
</tr>
<tr>
<td>O91.23</td>
<td>Nonpurulent mastitis associated with lactation</td>
</tr>
<tr>
<td>O92.03</td>
<td>Retracted nipple associated with lactation</td>
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<tr>
<td>O92.13</td>
<td>Cracked nipple associated with lactation</td>
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<td>O92.5</td>
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<td>O92.70</td>
<td>Unspecified disorders of lactation</td>
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<td>O92.79</td>
<td>Other disorders of lactation</td>
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<td>*O91.01-</td>
<td>Infection of nipple associated with pregnancy</td>
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<td>*O91.11-</td>
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<tr>
<td>*O92.11-</td>
<td>Cracked nipple associated with pregnancy</td>
</tr>
<tr>
<td>O92.20</td>
<td>Unspecified disorder of breast associated with pregnancy and the puerperium</td>
</tr>
<tr>
<td>O92.29</td>
<td>Other disorders of breast associated with pregnancy and the puerperium</td>
</tr>
<tr>
<td>O91.29</td>
<td>Nonpurulent mastitis associated with pregnancy, unspecified trimester</td>
</tr>
<tr>
<td>O91.22</td>
<td>Nonpurulent mastitis associated with the puerperium</td>
</tr>
<tr>
<td>*S20.121-</td>
<td>Blister (nonthermal) of breast, right breast</td>
</tr>
<tr>
<td>*S20.122-</td>
<td>Blister (nonthermal) of breast, left breast</td>
</tr>
<tr>
<td>B37.89</td>
<td>Candidiasis, breast or nipple</td>
</tr>
<tr>
<td>L01.00</td>
<td>Impetigo, unspecified</td>
</tr>
<tr>
<td>O91.02</td>
<td>Infection of nipple associated with the puerperium</td>
</tr>
<tr>
<td>Q83.8</td>
<td>Other congenital malformations of breast (ectopic or axillary breast tissue)</td>
</tr>
<tr>
<td>R20.3</td>
<td>Hyperesthesia (burning)</td>
</tr>
<tr>
<td>O92.3</td>
<td>Agalactia</td>
</tr>
<tr>
<td>O92.4</td>
<td>Hypogalactia</td>
</tr>
<tr>
<td>O92.5</td>
<td>Suppressed lactation</td>
</tr>
<tr>
<td>O92.6</td>
<td>Galactorrhea</td>
</tr>
<tr>
<td>O92.70</td>
<td>Unspecified disorders of lactation</td>
</tr>
<tr>
<td>O92.79</td>
<td>Galactocele (other disorders of lactation)</td>
</tr>
<tr>
<td>Z39.1</td>
<td>Encounter for care and examination of lactating woman (excludes encounter for conditions related to O92-)</td>
</tr>
</tbody>
</table>

The codes represented in this chart with an * require a 6th digit to specify trimester. The guidelines for 6th-digit requirements for this code set are as follows: 1 (first trimester), 2 (second trimester), 3 (third trimester), or 9 (unspecified trimester). The codes represented in this chart with an ^ require an additional digit as indicated with the dash (-). The guidelines for 7th-digit requirements for this code set are as follows: A (Initial Encounter), D (Subsequent Encounter), or S (Sequela).

If a feeding problem exists that requires the physician to spend an additional amount of time addressing the problem, the following codes are appropriate. This would include the obstetrician–gynecologist or other health care provider taking the woman’s history, examining her breasts and nipples, observing a feeding, and making a diagnosis and treatment plan for the woman:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
</tr>
<tr>
<td>99212-99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
</tr>
</tbody>
</table>
Breastfeeding Benefits

**For Mom**

Breastfeeding burns as many as 500 extra calories each day, which may make it easier to lose the weight you gained during pregnancy.

Women who breastfeed longer have lower rates of type 2 diabetes, high blood pressure, and heart disease.

Women who breastfeed have lower rates of breast cancer and ovarian cancer.

Breastfeeding triggers the release of oxytocin that causes the uterus to contract and may decrease the amount of bleeding you have after giving birth.

**For Baby**

Breast milk has the right amount of fat, sugar, water, protein, and minerals needed for a baby’s growth and development.

Breast milk is easier to digest than formula, and breastfed babies have less gas, fewer feeding problems, and less constipation.

Breast milk contains antibodies that protect infants from certain illnesses, such as ear infections, diarrhea, respiratory illnesses, and allergies.

Breastfed infants have a lower risk of sudden infant death syndrome.

If your baby is born preterm, breast milk can help reduce the risk of many of the short-term and long-term health problems.

For additional information and resources, go to [www.acog.org/breastfeeding](http://www.acog.org/breastfeeding)
Breastfeeding Resources

The American College of Obstetricians and Gynecologists (ACOG) has breastfeeding resources for patients and obstetrician–gynecologists and other health care providers. Visit ACOG’s breastfeeding web site for the most up-to-date versions of the materials below, ACOG’s breastfeeding activities, health care coverage information, and more.

www.acog.org/breastfeeding

ACOG Guidance for Obstetrician–Gynecologists and Other Health Care Providers:

◊ Committee Opinion No. 658, Optimizing Support for Breastfeeding as Part of Obstetric Practice (Open access)
◊ Committee Opinion No. 570, Breastfeeding in Underserved Women: Increasing Initiation and Continuation of Breastfeeding (Open access)
◊ Guidelines for Perinatal Care, Seventh Edition (See especially chapters 6–8, available online for members and for purchase)
◊ Physician Conversation Guide on Support for Breastfeeding (Open access)
◊ Breastfeeding Coding (Open access)

ACOG Patient Education:

◊ Breastfeeding Your Baby pamphlet (Available online for members and for purchase; also available in Spanish, open access)
◊ Your Pregnancy and Childbirth: Month to Month, Sixth Edition (Spanish version coming soon, available for purchase)
◊ You and Your Baby: Prenatal Care, Labor and Delivery, and Postpartum Care booklet (also available in Spanish, open access and available for purchase)
◊ Breastfeeding Your Baby poster (Available for purchase)
◊ Breastfeeding: Frequently Asked Questions (Spanish version coming soon, available for purchase)
◊ Breastfeeding Benefits for Mom and for Baby poster (Open access)