More and More Breastfeeding Myths

1. Nursing mothers cannot breastfeed if they have had X-rays. Not true! Regular X-rays such as a **chest X-ray** or **dental X-rays** do not affect the milk or the baby and the mother may nurse without concern. **Mammograms** are harder to read when the mother is lactating, but can be done and the mother should not stop breastfeeding just to get this done. Furthermore, there are other ways of investigating a breast lump. Newer imaging methods such as **CTscan** and **MRI scans** are of no concern, even if contrast is used. **And special X-rays using contrast media?** As long as no radioactive isotope is used there is no concern and the mother should not stop even for one feed. Herein are included studies such as intravenous pyelogram, lymphangiogram, venogram, arteriogram, myelogram, etc. **What about studies using radioactive nucleotides (bone scans, lung scans, etc.)?** The baby will get *a little* radioactive nucleotide. However, as we often do these very same tests on children, even small babies, and the potential loss of benefits if the mother stops breastfeeding are considerable, the mother should, in my opinion, continue breastfeeding. If you feel you must stop for a period of time, express milk in advance so that the baby can be fed your milk and not formula. After two half lives, 75% of the compound will be out of your body. This is surely waiting long enough (the half life of technetium, which is used in most radioactive scans is only six hours, so that 12 hours after the injection, 75% of it will be out of your body). *The* exception is the **thyroid scan using I131.** This test **must be avoided** in breastfeeding mothers. There are many ways of evaluating the thyroid, and only very occasionally does a thyroid scan truly have to be done. If the scan must be done, doing it with **I123** requires the mother to stop nursing for 12 to 24 hours only depending on the dose. Check first before taking the radioactive iodine—the test can wait until you know for sure. In many cases where the scan must be done, it can be put off for several months. Incidentally, lung scans with radioactive contrast no longer is the best test to rule out a lung clot. CT scan is now the preferred test to prove or disprove the diagnosis. [See also handout #9a *You Should Continue Breastfeeding-1*)

2. Breastfeeding mothers' milk can "dry up" just like that. Not true! Or if this can occur, it must be a rare occurrence. Aside from day to day and morning to evening variations, milk production does not change suddenly. There are changes which occur which may make it *seem* as if milk production is suddenly much less:

- An increase in the needs of the baby, the so-called growth spurt . If this is the reason for the seemingly insufficient milk, a few days of more frequent nursing will bring things back to normal. Try compressing the breast with your hand to help the baby get milk (Handout #15, *Breast Compression*).

- A change in the baby's behavior. At about five to six weeks of age, more or less, babies who would fall asleep at the breast when the flow of milk slowed down, tend to start pulling at the breast or crying when the milk flow slows. The milk has not dried up, but the baby has changed. Try using breast compression to help the baby get more milk. See the website www.thebirthden.com/Newman.html for videos on how to latch a baby on, how to know the baby is getting milk, how to use compression.
- The mother's breasts do not seem full or are soft . It is normal after a few weeks for the mother no longer to have engorgement, or even fullness of the breasts. As long as the baby is drinking at the breast, do not be concerned (see handout 4 *Is My Baby Getting Enough Milk?*).
- The baby breastfeeds less well . This is often due to the baby being given bottles or pacifiers and thus learning an inappropriate way of breastfeeding.

The birth control pill *may* decrease your milk supply. Think about stopping the pill or changing to a progesterone only pill. Or use other methods. Other drugs that can decrease milk supply are pseudoephedrine (Sudafed), some antihistamines, and perhaps diuretics.

If the baby truly seems not to be getting enough, get help, but do not introduce a bottle that may only make things worse. If absolutely necessary, the baby can be supplemented, using a lactation aid that will not interfere with breastfeeding. However, lots can be done before giving supplements. Get help. Try compressing the breast with your hand to help the baby get milk (Handout #15, *Breast Compression*).

3. Physicians know a lot about breastfeeding. Not true! Obviously, there are exceptions. However, very few physicians trained in North America or Western Europe learned anything at all about breastfeeding in medical school. Even fewer learned about the *practical aspects* of helping mothers start breastfeeding and helping them

maintain breastfeeding. After medical school, most of the information physicians get regarding infant feeding comes from formula company representatives or advertisements.

4. Pediatricians, at least, know a lot about breastfeeding. Not true! Obviously, there are exceptions. However, in their post-medical school training (residency), most pediatricians learned nothing formally about breastfeeding, and what they picked up in passing was often wrong. To many trainees in pediatrics, breastfeeding is seen as an "obstacle to the good medical care" of hospitalized babies.

5. Formula company literature and formula samples do not influence how long a mother breastfeeds.

Really? So why do the formula companies work so hard to make sure that new mothers are given these samples, *their* company's samples? Are these samples and the literature given out to encourage breastfeeding? Do formula companies take on the cost of the samples and booklets so that mothers will be encouraged to breastfeed longer? The companies often argue that, if the mother does give formula, they want the mother to use their brand. But in competing with each other, the formula companies also compete with breastfeeding. Did you believe that argument when the cigarette companies used it?

6. Breastmilk given with formula may cause problems for the baby. Not true! Most breastfeeding mothers do not need to use formula and when problems arise that seem to require artificial milk, often the problems can be resolved without resorting to formula. However, when the baby may require formula, there is no reason that breastmilk and formula cannot be given together.

7. Babies who are breastfed on demand are likely to be "colicky". Not true! "Colicky" breastfed babies often gain weight very quickly and sometimes are feeding frequently. However, many are colicky not because they are feeding frequently, but because they do not take the high fat milk as well as they should. Typically, the baby drinks very well for the first few minutes, then nibbles or sleeps. When the baby is offered the other side, he will drink well again for a short while and then nibble or sleep. The baby will fill up with relatively low fat milk and thus feed frequently. The taking in of mostly low fat milk may also result in gas, crying and explosive watery bowel movements. The mother can urge the baby to breastfeed longer on the first side, and thus get more high fat milk, by compressing the breast once the baby sucks but does not drink. (Handouts #3 *Colic in the Breastfed Baby* and #15 *Breast Compression*). See videos at www.thebirthden.com/Newman.html

8. Mothers who receive immunizations (tetanus, rubella, hepatitis B, hepatitis A, etc.) should stop breastfeeding for 24 hours (3 days, 2 weeks). Not true! Why should they? There is no risk for the baby, and he may even benefit. The rare exception is the baby who has an immune deficiency. In that case the mother should not receive an immunization with a weakened *live* virus (e.g. oral, but *not* injectable polio, or measles, mumps, rubella) even if the baby is being fed artificially.

9. There is no such thing as nipple confusion. Not true! The baby is not confused, though, the baby knows exactly what he wants. A baby who is getting slow flow from the breast and then gets rapid flow from a bottle, will figure that one out pretty quickly. A baby who has had only the breast for three or four months is unlikely to take the bottle. Some babies prefer the right or left breast to the other. Bottle fed babies often prefer one artificial nipple to another. So there *is* such a thing as preferring one nipple to another. The only question is how quickly it can occur. Given the right set of circumstances, the preference can occur after one or two bottles. The baby having difficulties latching on may never have had an artificial nipple, but the introduction of an artificial nipple rarely improves the situation, and often makes it much worse. Note that many who say there is no such thing as nipple confusion also advise the mother to start a bottle early so that the baby will not refuse it.

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