



Perinatal
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Promoting Breastfeeding: Our professional responsibility

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INTRODUCTION

Breastfeeding, although a natural process, does not come *naturally* to all mothers and infants. It is a learned skill. With the appropriate support, most mothers can initiate and continue breastfeeding as long as it is mutually desirable. It is important for mother and infant health care providers to understand the barriers to successful breastfeeding, and to develop the skills to support women in their desire to breastfeed.

HISTORICAL PERSPECTIVE

Mothers have been breastfeeding their infants for thousands of years. Surprisingly, bottle feeding, which is thought of as a modern development, has also likely been used since the Stone Age. Maternal deaths, and infants' inability to nurse would have prompted early attempts at bottle feeding. The earliest documented evidence dates back to ancient Cyprus, more than 4,000 years ago. "Feeding cups" have been found in a variety of ancient cultures, often in graves of infants. These cups often resemble miniature wine jugs or oil lamps, and residue of both human and animal milk has been found on them.

Throughout the centuries, human ingenuity has developed a variety of ways to provide nourishment to infants when human milk was

unavailable or insufficient. The domestication of sheep, goats and cattle provided an alternative source of milk. It was recognized very early that pure milk from these animals would not be sufficient alone. Bread, flour, butter and honey were all added at various times. Later, due to cost, milk was often excluded from these mixtures, and not surprisingly, infant mortality increased.

Another solution to infant feeding was the wet nurse. More often used by the noble classes, these young women were paid to nurse other women's children. A whole body of literature is dedicated to the practice of wet nursing. Many medieval physicians believed that characteristics of a wet nurse were passed on to the infant through her milk. In time, the practice was condemned by many, and fell from favour. Many poor girls abandoned their own children to become wet nurses in order to have better lives. It soon became apparent that infectious diseases, like syphilis, could be passed from a wet nurse to her charge.

What's Inside . . .

Promoting Breastfeeding: Our Professional Responsibility	1
For Your Information:	5
You Asked Us:	10
Upcoming Events:	11

Until recently, attempts to feed infants with human milk substitutes were associated with very high mortality rates. Modern developments in the twentieth century have necessitated and facilitated formula feeding. The industrial revolution forced many mothers to return to work earlier and more frequently than in past generations. In addition, as cities grew, close knit families and the support for breastfeeding that was natural to them, declined dramatically. The pasteurization of milk led to the ability to store it longer, with less bacterial contamination. The development of the glass bottle, rubber nipples and the ability to sterilize these utensils at home made it possible for even working families to safely bottle feed their infants. Industries studied human milk extensively, breaking it down into its essential parts, and have attempted to formulate an equivalent substitute. Much research is still focused on human milk today. Companies still try to emulate its nutritional value. Not surprisingly, much research has also been devoted to the benefits of breast milk, including its protective benefits conferred upon infants.

RECOMMENDATIONS

The World Health Organization (WHO) has published guidelines on infant nutrition. It recommends exclusive breastfeeding for six months, with only the addition of vitamins, minerals and medicines as required. Water, breast milk substitutes and other foods are excluded. Expressed breast milk, fed with a bottle, is accepted as part of exclusive breastfeeding. WHO estimates that an 8% increase in exclusive breastfeeding worldwide would reduce infant mortality by greater than 1,000,000 deaths per year¹.

Canadian guidelines, released by the Society of Obstetricians and Gynecologists (SOGC), Canadian Pediatric Society (CPS) and the Canadian Task Force for Preventative HealthCare (CTFPH), have all been adjusted to align with current WHO recommendations^{2, 3, 4}. Exclusive breastfeeding for six months, with continued breastfeeding for up to two years are the current recommendations. There is good evidence to recommend counseling women to increase the rates of and to prolong the duration of breastfeeding. Level II (cohort study) evidence shows

improved outcomes for infants who are breastfed.

In 2005, the American Association of Pediatricians published recommendations so that obstetricians would promote breastfeeding. They emphasized that human milk is species-specific, and is the best for infant feeding. The majority of the recommendations are universal and should be taken into consideration by all health care providers caring for mothers and their infants:

1. Enthusiastic promotion and support for breastfeeding, based on the published literature of its benefits.
2. Development and support of hospital policies to facilitate breastfeeding and remove barriers to breastfeeding.
3. Community efforts to provide women with adequate information to make an informed decision about breastfeeding resources.
4. Fostering acceptance of breastfeeding among the general public by promoting a normative portrayal of breastfeeding in the media and supporting sufficient time and facilities in the workplace⁵.

The literature regarding breastfeeding is extensive. In recent years, our knowledge of the benefits of breastfeeding has rapidly expanded. So, too, has our knowledge about difficulties that arise with breastfeeding and the appropriate management of these situations. There is also evidence backing the recommendation that certain mothers should not breastfeed. This includes women with certain infectious diseases, such as HIV and tuberculosis, as well as mothers using certain medications.

Breastfeeding benefits infants, mothers and the community at large. For infants, breast milk is species specific, made uniquely to meet the needs of human infants. The proteins are easily digested, and clear through developing kidneys. The minerals are available in combination to facilitate absorption. Fatty acids and cholesterol are readily available to promote brain development. Most importantly, breast milk contains a multitude of immunologically active agents to protect the infant from many infections (eg. Bacterial meningitis, diarrhea, respiratory tract infections, necrotizing enterocolitis, ear infections and urinary tract

infections). Together, these aspects of breast milk confer many benefits to the infant. It has been shown that breastfeeding may decrease the incidence of SIDS, diabetes mellitus (Types I and II), lymphoma, leukemia, Hodgkin's disease, obesity and asthma. There is a growing body of evidence that breastfeeding increases IQ later in life⁵.

There are also many benefits that mothers derive from breastfeeding. The most obvious is the close bond they are able to form with their newborns. In addition, they experience less postpartum bleeding, slower return of their menstrual cycle, earlier return to their pre-pregnancy weight and a decreased risk of breast and ovarian cancer⁵.

The health advantages for the mothers and their infants also benefit their communities. There is the potential for decreased health care spending. Well infants may contribute to a decreased cost to public health care. When parents return to work, they are less likely to be absent to care for a sick child. There are also significant environmental savings to breastfeeding⁵.

WHO and UNICEF support a program called the "Baby Friendly Initiative". Its goal is to promote breastfeeding rather than formula feeding. It awards the designation "Baby Friendly" to facilities meeting the stringent criteria of the program. There are currently four centres in Canada to have received the "Baby Friendly" designation. The criteria for this initiative include:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within one half-hour of birth.
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated.

7. Practice rooming in - that is, allow mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic⁶.

The program also restricts use by the hospital of free formula or other infant care aids provided by formula companies. This should not discourage hospitals or health care centres from adopting the basic principles of the Baby Friendly Initiative. These objectives are part of a solution to increasing breastfeeding in this country. They must also be joined by prenatal teaching and support, as well as support for the mothers after discharge from hospital. Each hospital must determine the practice best suited to their community needs, recognizing the importance of promoting and supporting breastfeeding without alienating those mothers who choose to formula feed.

One of the most common difficulties in sustaining breastfeeding is a perceived lack of milk. Many women discontinue breastfeeding because they are concerned for their infant's well being, and feel that formula may be a better option to promote adequate neonatal growth. It is important for health care providers to communicate expectation of infant weight gain and maternal milk supply, prior to the postpartum period. New mothers should know in advance that breastfed infants may lose weight in their first week of life. They should also be warned that the milk supply, while low for the first few days, is adequate to meet their infant's needs. In addition, the principle of supply and demand should be reinforced prior to delivery, and reinforced during the postpartum period.

Women who initiate breastfeeding in the hospital require continued support when they return to their homes, and later when they return to their places of work. Most importantly, women need the support of their partners to be successful with breastfeeding at home. The media frequently portrays bottle feeding as the norm, as a result, many

families have a negative view of breastfeeding. If women encounter any difficulties in the early stages of breastfeeding, too frequently they are encouraged to switch to formula. There are benefits to bottle feeding that make it attractive. It is easier to track the amount an infant is eating. It also allows for shared responsibility of the feeding. Unfortunately, bottle feeding is routinely thought of as "formula" feeding, and the use of "expressed human" milk given in a bottle is not considered as a viable alternative.

Support for breastfeeding can continue outside the home as well. Public health departments throughout this province have made great strides to promote breastfeeding. Many of these departments have special webpages dedicated to breastfeeding, and support available within the local community. It is important as health care providers, not only to promote breastfeeding from our offices, but also to know the local resources available to which women can be referred. This includes local public health departments and LaLeche League.

Breastfeeding is the best source of nutrition for most newborn infants in Canada. Most mothers are able to breastfeed. With proper teaching and support, breastfeeding initiation and continuation rates can be increased. While much effort is invested in the immediate postpartum period, support for breastfeeding needs to be much broader. Health care providers of prenatal care need to introduce the idea of breastfeeding early on. This provides mothers time to consider breastfeeding as a viable option, as well as to address potential barriers before they become deterrents. In addition, encouragement of breastfeeding needs to continue beyond discharge from hospital. Obstetricians and family doctors can inquire about breastfeeding difficulties at the six-week follow-up appointments. New mothers can be referred to a multitude of community resources, including their local health department and other breastfeeding mothers. Employers can support breastfeeding and pumping in the workplace, so that mothers returning to work early can continue to breastfeed their infants. Breastfeeding is beneficial to mothers, their infants and to society as a whole. Working together, we can promote and support

breastfeeding in our communities.

REFERENCES

1. World Health Organization, "Global Strategy for Infant and Young Child Feeding", Geneva, 2003, 8.
2. Society of Obstetricians and Gynecologists of Canada (SOGC), *Healthy Beginnings 3rd ed.*, 2005, 138-44.
3. Canadian Pediatric Society (CPS) "Exclusive Breastfeeding Should Continue to Six Months," *Pediatrics and Child Health*, 10(3), 2005, 148.
4. Canadian Task Force for Preventative Health Care (CTFPH), "Interventions to Promote Breastfeeding: Updated Recommendations from the CTFPH," London, Ontario, October 2003.
5. American Academy of Pediatrics (AAP), "Policy Statement: Breastfeeding and the Use of Human Milk," *Pediatrics*, Vol. 115, No. 2 February 2005, pp. 496-506.
6. Breastfeeding Committee of Canada, "The Ten Steps and Practice Outcome Indicators for Baby Friendly Hospitals," World Health Organization/UNICEF, March 24, 2004.

RESOURCES

1. **BREASTFEEDING COMMITTEE FOR CANADA**
PO Box 65114, Toronto, ON, M4K 3Z2
Fax: 416-465-8265
Email: bfc.can@sympatico.ca
Web: www.breastfeedingcanada.ca
Of special interest:
"Evidence-Based Benefits of Breastfeeding for the Breastfeeding Committee for Canada: A Selected Annotated Bibliography"
Go to www.breastfeedingcanada.ca
Click on sections "What's New" and "Documents"
2. **THE INFANT FEEDING ACTION COALITION (INFAC) CANADA**
Web: <http://www.infactcanada.ca/>
3. **WORLD HEALTH ORGANIZATION**
Web: <http://www.who.int/topics/breastfeeding/en>
4. **LALACHE LEAGUE INTERNATIONAL**
Web: <http://www.lalecheleaguecanada.ca/>
5. **CANADIAN PAEDIATRIC SOCIETY, DIETITIANS OF CANADA AND HEALTH CANADA.** "Nutrition for Healthy Term Infants," Minister of Public Works and Government Services, Ottawa, 1998. [internet] www.hc-sc.gc.ca



FOR YOUR INFORMATION . . .

Summary of Major Changes to the 2005 AAP/AHA Emergency Cardiovascular Care Guidelines for Neonatal Resuscitation: Translating Evidence-Based Guidelines to the NRP

USE OF OXYGEN DURING NEONATAL RESUSCITATION

Current evidence is insufficient to resolve all questions regarding supplemental oxygen use during neonatal resuscitation.

For babies born at term,

- The Guidelines recommend use of 100% supplemental oxygen when a baby is cyanotic or when positive pressure ventilation is required during neonatal resuscitation.

- However, research suggests that resuscitation with something less than 100% may be just as successful.

- If resuscitation is started with less than 100% oxygen, supplemental oxygen up to 100% should be administered if there is no appreciable improvement within 90 seconds following birth.

- If supplemental oxygen is unavailable, use room air to deliver positive-pressure ventilation.

To reduce excessive tissue oxygenation if a very preterm baby (less than approximately 32 weeks) is being electively delivered at your facility:

- Use an oxygen blender and pulse oximeter during resuscitation.

- Begin PPV with oxygen concentration between room air and 100% oxygen. No studies justify starting at any particular concentration.

- Adjust oxygen concentration up or down to achieve an oxyhemoglobin concentration that gradually increases toward 90%. Decrease the oxygen concentration as saturations rise over 95%.

- If the heart rate does not respond by increasing rapidly to > 100 beats per minute,

correct any ventilation problem and use 100% oxygen.

If your facility does not have use of an oxygen blender and pulse oximeter in the delivery room, and there is insufficient time to transfer the mother to another facility, the resources and oxygen management described for a term baby are appropriate. There is no convincing evidence that a brief period of 100% oxygen during resuscitation will be detrimental to the preterm infant.

MECONIUM

No longer recommend that all meconium-stained babies routinely receive intrapartum suctioning (i.e., before delivery of shoulders). Other recommendations about post delivery neonatal suctioning remain unchanged.

BAG-AND-MASK VENTILATION

- Call for assistance when beginning PPV.
- After beginning ventilation at appropriate rate and pressure, ask the assistant to report heart rate and breath sounds as indicators of effective ventilation. Heart rate is assessed first, and if not improving, assess chest movement and ask about breath sounds.

DEVICES FOR ASSISTING VENTILATION

Flow-controlled pressure limited mechanical devices (e.g., T-piece resuscitators) are recognized as an acceptable method of administering positive-pressure ventilation during resuscitation of the newly born and in particular the premature infant; however, self-inflating and flow-inflating bag-and-mask equipment and techniques remain the cornerstone of achieving effective ventilation in most resuscitations.

EFFECTIVENESS OF ASSISTED VENTILATION

Increasing heart rate is the primary sign of effective ventilation during resuscitation. Other signs are:

- Improving color
- Spontaneous breathing
- Improving muscle tone

Check these signs of improvement after 30 seconds of PPV. This requires the assistance of another person.

LARYNGEAL MASK AIRWAY

The laryngeal mask airway has been shown to be an effective alternative for assisting ventilation of some newborns who have failed bag-and-mask ventilation or endotracheal intubation.

USE OF CO₂ DETECTOR

An increasing heart rate and CO₂ detection are the primary methods for confirming ET tube placement.

EPINEPHRINE

If the endotracheal route is used, doses of 0.01 or 0.03 mg/kg will likely be ineffective. Therefore, IV administration of 0.01 to 0.03 mg/kg per dose is the preferred route (Class IIa). While access is being obtained, administration of a higher dose (up to 0.1 mg/kg) through the endotracheal tube may be considered (Class Indeterminate), but the safety and efficacy of this practice have not been evaluated.

RECOMMENDED DOSE

IV: 0.1 to 0.3 mL/kg of 1:10,000 solution. Draw up in 1-mL syringe

ET: 0.3 to 1.0 mL/kg of 1:10,000 solution. Draw up in 3-mL or 5-mL syringe

NALOXONE

Naloxone is not recommended during the primary steps of resuscitation.

The indications for giving naloxone to the baby require both of the following to be present:

- Continued respiratory depression after positive-pressure ventilation has restored a normal heart rate and color, and
- A history of maternal narcotic administration within the past 4 hours. There are no studies reporting the efficacy of endotracheal naloxone. This route is not recommended.
- Intravenous route preferred.
- Intramuscular route acceptable, but delayed onset of action.

TEMPERATURE CONTROL

Polyethylene bags may help maintain body temperature during resuscitation of very low birth weight (VLBW) infants.

THERAPEUTIC HYPOTHERMIA

- Hypothermia may reduce the extent of brain injury following hypoxia-ischemia.
- There is insufficient data to recommend routine use of selective and/or systemic hypothermia after resuscitation of infants with

suspected asphyxia. Further clinical trials are needed to determine which infants benefit most and which method of cooling is most effective.

HYPERTHERMIA

- Hyperthermia may worsen the extent of brain injury following hypoxia-ischemia.
- The goal should be to achieve normothermia and to avoid iatrogenic hyperthermia in resuscitated newborns.

WITHHOLDING OR WITHDRAWING RESUSCITATION

A consistent and coordinated approach to individual cases by the obstetric and neonatal teams and the parents is an important goal. Noninitiation of resuscitation and discontinuation of life-sustaining treatment during or after resuscitation are ethically equivalent, and clinicians should not hesitate to withdraw support when functional survival is highly unlikely. The following guidelines must be interpreted according to current regional outcomes:

- In conditions associated with a high rate of survival and acceptable morbidity, resuscitation is nearly always indicated. This will generally include babies with gestational age \geq 25 weeks (unless there is evidence of fetal compromise such as intrauterine infection or hypoxia-ischemia) and those with most congenital malformations.
- In conditions with uncertain prognosis in which survival is borderline, the morbidity rate is relatively high, and the anticipated burden to the child is high, parental desires concerning initiation of resuscitation should be supported.

DISCONTINUING RESUSCITATION EFFORTS

After 10 minutes of continuous and adequate resuscitative efforts, discontinuation of resuscitation may be justified if there are no signs of life (no heart beat and no respiratory effort).

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NRP Program Launch 2006:**The Canadian Context**

October 27-28, 2006

Marriott Bloor Yorkville, Toronto, ON

For more information:

<http://www.cps.ca/english/prodev/NRP/index.htm>

* for local NRP instructor course dates, see pg 10



FYI: (CONT'D)**Advanced Notice Regarding Canadian Oxygen Trial (COT)****INTRODUCTION**

Oxygen therapy was introduced into newborn care over 50 years ago. Despite that, over the years there has been much controversy and little evidence to determine appropriate and safe levels of oxygenation (1).

PROPOSED STUDY

In the fall of 2006, a trial will be started at the NICU at SJHC with the goal of evaluating the efficacy and safety of targeting lower arterial oxygen saturations. The goal is to reduce oxygen toxicity and oxidative stress in very preterm infants. The involvement of the NICU at SJHC is part of a Canada-wide trial, which is further part of a multi-national coordinated attempt at evaluating the effect of lowering arterial oxygen saturation targets with the goal of improving outcome. The Canadian trial is funded by the Canadian Institute of Health Research for approximately \$3.8 million and is proposed to recruit 1,200 patients from numerous neonatal intensive care units across Canada. The study has three main parts: an intervention where babies are randomized to high and low oxygen saturation targets, long term follow up at 18 to 24 months of age and a prospective economic evaluation.

RATIONALE AND HYPOTHESIS

Over the years, some studies have looked at the potential benefit of restricting oxygen, while others have looked at the potential benefit of being more liberal with oxygen. No clear consensus emerged. Recent studies have had better monitoring with oxygen saturation monitors and have focused on slightly higher oxygen saturations, postulating improved healing of ROP and improved growth with higher oxygen levels. These studies failed to show significant clinical benefit in either ROP progression or growth while at the same time showing possible worsening of the respiratory outcomes (2,3). The alternative hypothesis is that restricting oxygen exposure, especially early, will

improve outcome. The primary hypothesis for the COT study is that extremely preterm infants, < 28 weeks gestation at birth, are sensitive to high oxygen concentrations and will have a better outcome if their exposure to high oxygen concentrations is curtailed.

INTERVENTION

The intervention in this study is to randomize babies in a blinded way to either a low oxygen saturation target (85-89%) or a higher oxygen saturation target (91-95%). The period of intervention will be from the day of birth until the baby's first discharge home. The primary outcome will be survival to a corrected age of 18 months without severe neurosensory disability. Secondary outcomes will include ROP and bronchopulmonary dysplasia (BPD). The intervention will be blinded by randomizing oxygen saturation monitors which have been programmed to read either 3 % higher or 3 % lower than the true oxygen saturation. In this manner, all babies in this study will have an oxygen saturation target of 88-92 % while the actual oxygenation will differ from this by 3 % either up or down. Massimo Radical oxygen saturation monitors will be used for this study. Compliance to the protocol will be carefully monitored.

**REGIONAL PARTICIPATION**

This information is important regionally from both an information point-of-view, but also for level II units involved in the care of infants as they transition closer to home. Since the intervention is planned to take place until the time of first discharge home, the study saturation monitor will need to follow the babies as they are transferred to level II centres. We are hoping for cooperation from the level II centres so that the study saturation monitor will be used in these centres until the first discharge home. Further inservicing and education will take place in the fall of 2006 to make sure that participating study centres are comfortable with the protocol and the monitors. The level of information and data collection in the

FYI: (CONT'D)

goal is

to make sure that the study saturation monitor continues until the time of discharge home while minimizing the workload for level II centres. We will also need to make sure that the study protocol meets the requirements for local study ethics boards.

CONCLUSION

The neonatal team at SJHC is very excited about the potential benefits of the study. There is good rationale for suspecting that high oxygen saturations are causing injury and we are hopeful that by studying this question in this detailed and formalized way, we will be able to finally come up with a definitive answer on oxygen saturation targets that minimize the risks and optimize the benefits. Oxygen has been used clinically for over 50 years, however optimal risk/benefit has never been clearly defined (1,4,5). The goal is that in the future preterm infants will benefit from a more evidence-based approach to oxygen delivery, which will improve outcome.

For any questions please contact the London site coordinator, Dr. Henry Roukema, 519-646-6100 ext. 64361. This is meant as an introduction. More detailed information will be coming out soon.

REFERENCES

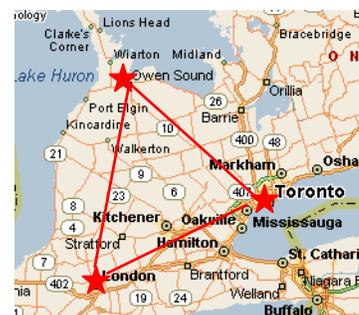
1. Tin W. Oxygen therapy: 50 years of uncertainty. *Pediatrics* 2002; 110:615-616
2. Askie LM, Henderson-Smart DJ, Irwig L, Simpson JM. Oxygen-saturation targets and outcomes in extremely preterm infants. *N Engl J Med* 2003; 349:959-967.
3. STOP ROP Investigators. Supplemental Therapeutic Oxygen for Prethreshold Retinopathy Of Prematurity (STOP-ROP), a randomized, controlled trial. I: primary outcomes. *Pediatrics*. 2000; 105:295-310.
4. Tin W, Milligan DW, Pennefather P, Hey E. Pulse oximetry, severe retinopathy, and outcome at one year in babies of less than 28 weeks gestation. *Arch Dis Child Fetal Neonatal Ed*. 2001; 84:F106-110.
5. Silverman WA. A cautionary tale about supplemental oxygen: the albatross of

neonatalmedicine. *Pediatrics* 2004; 113:394-396.

Grey-Bruce Meconium Study Extended to London Hospital

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Department of Pharmaceutical Sciences & Toxicology
University of Toronto, Toronto, Ontario

Recently the Grey-Bruce Public Health Unit, local birthing hospitals, and midwives partnered with the Hospital for Sick Children and the University of



Toronto on a joint effort to learn more about alcohol consumption during pregnancy. Resulting was the initiation of the first anonymous population study of fatty acid ethyl esters in meconium.

Fatty acid ethyl esters (FAEEs) are metabolites resulting from alcohol metabolism. The presence of FAEEs in meconium acts as an indicator of maternal alcohol consumption during pregnancy. The objective of the study is to be able to estimate the prevalence of FAEE positive meconium in order to assist the Grey-Bruce Public Health Unit to design more effective prevention programs that support healthy child development in their community.

Meconium collection began in 2004 in the Grey Bruce region. However, it was brought to the attention of investigators that some Grey Bruce residents deliver in London. As such, the study was extended to the London region to account for this loss.

The London extension launched on August 1, 2006 at St. Joseph's Hospital and will be actively collecting meconium from babies who reside in the Grey Bruce area. A collection site at the London Health Sciences Centre will be launched in the future. Once the collection from all of the sites is completed, results will be available.



FYI: (CONT'D)

Welcome

We are extremely pleased to announce that beginning this fall, Dr. Tracey Crumley will be assisting with visits to our community hospitals in her capacity as obstetrical consultant with the Perinatal Outreach Program.



Dr. Tracey Crumley, BSc, MD, FRCSC

Dr. Crumley received her Doctor of Medicine from the University of Western Ontario (1996) and also completed her residency in Obstetrics & Gynecology at UWO (2001). She did her Fellowship in Maternal Fetal Medicine at Magee Women's Hospital in Pittsburgh, PA (2001-2002). Since 2003, Dr. Crumley has been on staff at St. Joseph's Health Care London in the Dept. of Ob/GYN and is also an assistant professor at the University of Western Ontario Schulich School of Medicine & Dentistry.

Please join us in welcoming Dr. Crumley



ONTARIO
TELEMEDICINE
NETWORK



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OTN RTO

IT'S OFFICIAL

Three successful Ontario telemedicine networks have forged a new alliance, creating a single, pan-provincial organization known as the Ontario Telemedicine Network or OTN. Today, it is one of the largest and busiest telemedicine networks in the world. Effective July 1, OTN was incorporated as an independent, wholly-owned, not-for-profit entity, directly funded by the Ministry of Health and Long-Term Care (MOHLTC). Sunnybrook Health Sciences Centre currently serves as the paymaster. Building on the success of the three legacy networks — CareConnect, NORTH Network and VideoCare — the Ontario Telemedicine Network is the largest telemedicine network in the country and the second largest in North America. It serves the far reaches of the province and will connect to health care and health service providers across the continuum of care – public health, pre-hospital, acute care, community care services and long-term care.

The Perinatal Outreach Program of Southwestern Ontario congratulates the members of the three previous regional networks that have worked diligently to make this partnership a reality. By having our regional videoconferencing network linked into a provincial service, linkages with hospitals outside of our region, particularly in the northern part of the province, have been facilitated. Most notably has been the ability that this now affords us to provide the Maternal Newborn Nursing course to these northern hospitals without the need for them to pay an additional charge for videoconference bridging to our network. It is our hope that this will now facilitate new opportunities for us to share education and consultation services to various areas of the province.

FYI: (CONT'D)

Type 1 Diabetes

Can we protect our children?

Are you or your partner pregnant?

Do you, your partner or any of your children
have Type 1 Diabetes?

Recent diabetes research has pointed to a possible link between infant nutrition and the development of Type 1 (insulin-dependent, or juvenile) diabetes in childhood. TRIGR is an international study looking at infant nutrition to find out whether the number of children who develop Type 1 diabetes can be reduced.

For more information please contact:
Lynda Bere,
Study Coordinator,
St. Joseph's Health Care,
London, Ontario.
(519) 646-6000 ext. 65996

Fan Mail. . .



"I am writing in response to the Newborn Admission & Discharge Record and the Summary of Birth Forms, developed by the Southwestern Ontario Perinatal Partnership Program, which we started using in our facility last fall. The forms have cut an estimated 2 hours of charting down to 20 minutes. As one of our Doctors put it "we love these forms." Please thank the committee responsible for all their hard work developing the forms. We appreciate your efforts."

Myra Henderson
Manitoulin Health Centre, Little Current

YOU ASKED US . . .

"When and What to tell a new mother Regarding Breast Pumping"

Joanne Warren RN IBCLC
Lactation Consultant, SJHC London, ON



Over the past few months there have been several questions posed throughout the region concerning the use of breast pumps to enhance lactation. In an effort to address these concerns most efficiently, we would like to thank Joanne Warren, RN, IBCLC, St. Joseph's Health Care London for providing the following information.

Q: When should a new mother initiate breast pumping?

A: A new mother should begin pumping as soon as possible after a premature birth or between 12 and 24 hours if her infant is not latching effectively.

Q: How frequently should a new mother pump?

A: Pumping is recommended every 2 hours during the day and every 4 hours during the night for the first 10 to 14 days after the birth of a premature or ill infant. Following this, pumping should be continued every 3 hours. In other circumstances, pumping every 3 hours for a minimum of 8 pumping sessions in 24 hours is adequate.

Q: What type of breast pump should a new mother use?

A: When a premature baby is unable to effectively latch onto the breast, or if the mother is experiencing breastfeeding complications such as mastitis, a hospital grade electric breast pump such as the **Ameda Elite**, **Medela Symphony** or **Medela Lactina** is recommended.

Q: Why should a new mother use a hospital grade electric breast pump?

A: Electric and manual breast pumps vary considerably in quality and price. The pump must be efficient enough to stimulate Prolactin and Oxytocin release and to provide efficient milk removal. If the baby were not able to breastfeed, the best quality pump to protect mother's supply would be the hospital grade electric pump. Using a double breast pump kit will reduce pumping time and help peak Prolactin levels to increase milk supply.

Q: Where can a new mother obtain a hospital grade electric pump?

A: Updated Pump Rental Information pertinent to the southwest region is linked electronically to the Perinatal Outreach webpage.
<http://www.sjhc.london.on.ca/sjh/profess/periout/links.htm>
The Public Health Unit in your area can also provide this information.

UPCOMING EVENTS:

**Important
DATE!**

MARK YOUR CALENDARS . . .

MATERNAL NEWBORN NURSING COURSE

London:

Mondays: Sept. 11 – Oct. 9, 2006

St. Joseph's Health Care, London

Offered for the first time in collaboration with Fanshawe College. Also, will be offered by videoconference to all of our regional hospitals. For more information . . .

Contact:

Gwen Peterek
Perinatal Outreach Program
Phone: (519) 646-6100 ext 65901
Fax: (519) 646-6172
Gwen.peterek@sjhc.london.on.ca

21ST ANNUAL PERINATAL OUTREACH CONFERENCE

"PERINATAL HOT FLASH"

September 15, 2006

Location: Lamplighter Inn, London

Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65859

check out our webpage for topics:

www.sjhc.london.on.ca/sjh/profess/periout/periout.htm

LUNCH & LEARN VIDEOCONFERENCE SERIES

"BABY TALK – LESSONS FROM THE NICU"

SEPT. 19, 2006 Family Centred Care
OCT. 17, 2006 An Introduction to Neonatal Pharmacology
Nov. 21, 2006 Management of the Neonate on IV therapy

Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65859

Watch our webpage for further details:

www.sjhc.london.on.ca/sjh/profess/periout/periout.htm

WOMAN ABUSE IN THE PERINATAL PERIOD

November 9, 2006

Location: St. Joseph's Health Care London
(will also be videoconferenced)

Contact:

Gwen Peterek
Perinatal Outreach Program
Phone: (519) 646-6100 ext 65901
Gwen.peterek@sjhc.london.on.ca

FETAL HEALTH SURVEILLANCE WORKSHOP

September 26, 2006

Location: Strathroy Middlesex General Hospital

Contact: Mary Robertson
(519) 245-1550

REGIONAL NURSE MANAGER'S MEETING

Friday, October 13, 2006

Location: Rm E1-126 & E1-128

St. Joseph's Health Care London

Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65901

NRP Instructor Course

Nov. 1, 2006 Bluewater Health, Sarnia

Nov. 15, 2006 South Bruce Grey HC, Walkerton

Nov. 29, 2006 Stratford General Hospital

Jan. 17, 2007 St. Joseph's Health Care London

Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65859

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SOUTHWESTERN ONTARIO PERINATAL PARTNERSHIP (SWOPP) - SEMI-ANNUAL MEETING

November 24, 2006

Location: Lamplighter Inn, London

Contact: Perinatal Outreach Office
(519) 646-6100, ext. 65859

Alarm Courses - 2006

Toronto, ON Dec 3 & 4, 2006

Contact: SOGC
780 Promenade Echo Drive
Ottawa, ON K1S 5R7
Tel: 1-800-561-2416
www.sogc.org



Did you know . . .
that the Perinatal Manual is undergoing revision, after which you will be able to access, review and download individual chapters from our website? Some chapters are available online now. Go to:

www.sjhc.london.on.ca/sjh/profess/periout/periout.htm

Choose the tab marked "Manual"



This newsletter is a publication of the Perinatal Outreach Program of Southwestern Ontario.

Letters, queries and comments may be addressed to:

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To have your name included on our mailing list, please contact the above, or
E-mail: gwen.peterek@sjhc.london.on.ca
www.sjhc.london.on.ca/sjh/profess/periout/periout.htm

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