



Breastfeeding Update

“Metabolic Issues & Breastfeeding”

BREASTFEEDING AND OBESITY

Yvonne E. Vaucher, MD, MPH

Childhood and adult obesity has reached epidemic proportions in the US. Obesity causes serious chronic illness, including adult and adolescent-onset, non-insulin dependent, Type II diabetes. Type II diabetes is associated with the very same life threatening, metabolic and cardiovascular complications as insulin dependent, Type I diabetes which begins much earlier in childhood. Hispanic, African-American, Native American, Asian-American and Pacific Islander groups are at especially high risk for developing Type II diabetes. Prevention of obesity is now a major public health focus in the US.

Obesity ultimately arises from an imbalance between food intake and energy output. The etiology of obesity is multifactorial - a complex interplay between genetics, lifestyle, behavior, physiology and culture. Because obesity often begins in childhood, much attention has recently focused on the possible fetal and early childhood causes of obesity, especially upon the contribution of early infant feeding.

Many studies have examined the influence of infant feeding on childhood and later obesity. Most studies found that breastfeeding is associated with a lower rate of weight gain in later childhood and a slightly reduced risk of childhood and later obesity. A small, consistent protective effect of breastfeeding continues to be evident in most studies and systematic reviews after taking into account the multiple other factors that are also associated with obesity (e.g., maternal obesity, socioeconomic status, parental education, parental smoking and birth weight).¹⁻³ One meta-analysis of 9 studies with 39,00 participants, demonstrated that breastfeeding reduced the risk of childhood obesity significantly with an adjusted odds ratio of .78 (95% CI 0.71-0.85).² The protection conferred by breastfeeding is dose-related, that is, increasing amounts of breastfeeding and longer duration of

breastfeeding are associated with progressively reduced risk of overweight and obesity.⁴⁻¹⁰ Although breastfeeding is protective, other factors, such as maternal weight, are much stronger predictors of childhood overweight and obesity.

The beneficial effect of breastfeeding may be via long-term, metabolic, hormonal and behavioral effects on satiety and energy expenditure, possibly by more appropriately matching appetite and food intake with energy expenditure. It is hypothesized that breastfed babies develop better methods of self-regulating food intake compared to formula/bottle fed infants. Energy balance and body composition are under neuroendocrine control by gastrointestinal (insulin, cholecystokinin), tissue (leptin), endocrine (norepinephrine) and neurologic (serotonin, growth hormone) hormones. It is possible that bioactive components or specific nutrients present in breastmilk, independent from the act of breastfeeding itself, confer specific, long-term protection by altering the hormonal and metabolic environment of the infant. As yet unidentified, subtle, socio-cultural differences between mothers who do and do not decide to breastfeed, or physiologic differences between those infants who receive breastmilk vs. formula from the bottle, have not been addressed in any published study.

Breastfeeding, compared to formula feeding, will not prevent obesity. However, even if the protective effect of breastfeeding alone on the prevalence of obesity is small, the overall public health impact on the prevalence of childhood and adult obesity would be substantial if all US babies were breastfed as currently recommended for at least 6 months.

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BREASTFEEDING AND OBESITY

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The bottom line: The protective effect of breastfeeding on overweight and obesity is small, but real and of significant public health impact. Active promotion and support of the WHO and American Academy of Pediatrics breastfeeding guidelines could substantially reduce the burden of obesity and associated chronic disease in the US.

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Valuable New Drugs and Breastfeeding Resource

Philip Anderson PharmD, FASHP, Director, Drug Information Service, Department of Pharmacy, UCSD Medical Center, San Diego, CA has spent the last 2 years creating a database on medication use during breastfeeding for the National Library of Medicine. It is available at: <http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>. Bookmark it on your computer and spread the word.

BOOK REVIEW

AAP New Mother's Guide to Breastfeeding

Joan Younger Meek, MD, MS, RD, FAAP, IBCLC, Editor in Chief, with Sherill Tippins, AAP 2002; \$13.95
Reviewed by: James G. Murphy MD, FAAP

This handbook could easily be called "A New Parent's Guide" as it emphasizes the importance of both parents' involvement in making the decision to breastfeed given the lifestyle accommodations each must be prepared to make to optimize this undertaking. The AAP and WHO policies in support of breastfeeding are clearly stated along with the major benefits to the infant, mother and family in general.

Proper preparation for childbirth and breastfeeding requires detailed planning. Items reviewed include finding an OBGYN and Pediatrician or Family Practitioner who are both knowledgeable and supportive of breastfeeding, a baby friendly hospital, and an experienced lactation consultant to deal with any unexpected difficulties. The components of a home nursery and attendance by both partners at a comprehensive breastfeeding course are also discussed. Child care supportive of breastfeeding may be needed later. Optimal bonding and breastfeeding initiation are achieved when the common stressors have been anticipated in the planning. The Guide assists in the anticipation of normal variations in routines related to the personalities involved including the newest one joining at birth.

The maternal body changes which occur during and after preg-

nancy are put in perspective regarding breastfeeding readiness and the body's automatic adjustment of breastmilk composition for premature, term and growing infants. Appropriate inclusion of caffeine and alcohol in the maternal diet as well as the importance of obtaining a second opinion regarding the recommendation by a physician not to use a particular medication or to discontinue breastfeeding in order to take the medication are emphasized. Physicians not well trained in supporting breastfeeding often play it "safe," and, rather than research a medication, simply recommend ending breastfeeding. Not mentioned are useful texts for this purpose such as *Medication and Mother's Milk* by Thomas Hale and *Drugs in Pregnancy and Lactation* published by Lippincott-Williams and Wilkins, and that the *Physician's Desk Reference (PDR)* is rarely useful in this regard. Selection of breastfeeding oriented clothing, infant carriers, pillows, etc to make breastfeeding more fun are discussed. Considerable time is devoted to the discussion of "The Perfect Latch".

Going home with baby, monitoring urine and stool output and time and duration of feedings helps the infant's physician determine if all is going well or special assistance is needed. When to consult an expert in breastfeeding is detailed. The old saying that "planning makes perfect" is true and this Guide greatly assists the future breastfeeding mom to anticipate and plan for all essential elements to optimize breastfeeding success and make the experience a joy for the entire family.

SDCBC 2006 MEMBERSHIP DRIVE

Your continued support is needed! Become a member.

If you are interested in becoming a member or renewing your membership for 2006, please visit our website at www.breastfeeding.org or contact our office for more information at 1-800-371-MILK or email sdcbc@breastfeeding.org.

SDCBC Membership Levels

Sponsor - \$100 (*Business/Organization/Professional*)

Contributing Member - \$50 (*Individual*)

Friends of the Coalition - any amount under \$50

What is the San Diego County Breastfeeding Coalition? The San Diego County Breastfeeding Coalition is a non-profit association whose mission is to promote and support breastfeeding through education and outreach in our community. We work with many community partners in many ways, to increase breastfeeding initiation and duration rates, thereby improving the health of our community.

What are the benefits of being a San Diego County Breastfeeding Coalition Member? As a full member of the San Diego County Breastfeeding Coalition you will:

- Network with a growing body of people dedicated to the promotion and support of breastfeeding,
- Have access to lactation professionals and the most up-to-date breastfeeding resources,
- Receive a free supply of Breastfeeding Resource Guides in English and Spanish,

- Receive a discount for Coalition sponsored education programs,
- Have a home page or link, as appropriate, on the SDCBC's website: www.breastfeeding.org,
- Be listed, with a Sponsor membership, as appropriate, in the "Breastfeeding Resource Guide" without a fee.
- Receive free CME credits for Coalition meeting education programs

You can show your support of the San Diego County Breastfeeding Coalition by:

- Making a monetary contribution to support coalition activities.
- Donating your time by serving on a committee:

Advocacy/Political Action	Community Outreach
Fundraising	Membership
Professional Outreach	Research and Evaluation
- Attending Coalition meetings and providing your expertise and experience.

Interested in what we do? Attend one of our meetings! General Coalition Meetings have been held the 2nd Thursday of each odd-numbered month at Sharp Mary Birch Hospital for Women, 3003 Health Center Drive, San Diego, in the Grace Benbough Room, located on the 2nd floor, from 3:00-5:00 pm. In 2006 we will be rotating the meetings around San Diego County to enable additional participation. Please call 858-939-4175 or visit our website for locations and directions (www.breastfeeding.org).

Congratulations to UCSD Medical Center

On April 3, 2006, The University of California San Diego Medical Center became the 53rd designated "Baby-Friendly" hospital in the US. Baby-Friendly designation signifies a truly breastfeeding-supportive hospital environment and is the result of years of work on the part of hospital staff and physicians and a rigorous on-site evaluation process. The San Diego County Breastfeeding Coalition expresses its heartfelt congratulations to UCSD. For more information on UCSD Medical Center go to: <http://health.ucsd.edu> and for information regarding the Baby Friendly process go to: <http://www.babyfriendlyusa.org/eng/index.html>.

BREASTFEEDING FRIENDLY WORKPLACE AWARD

The San Diego County Breastfeeding Coalition is pleased to announce that it will be presenting its 2006 Breastfeeding Friendly Workplace Award in concert with other California counties on Wednesday, August 23, 2006. This annual award is presented in celebration of World Breastfeeding Week (August 1-7) to one or more businesses that demonstrate significant commitment to supporting their own breastfeeding employees. Past recipients include: Sharp Grossmont Hospital (2005) Solar Turbines (2004), UCSD Healthcare (2003), Naval Hospital, Camp Pendleton (2002), The City of Escondido, Kyocera, The San Diego Spirit (2001), Aetna US Healthcare (2000), Qualcomm, People's Organic Foods Market (1999), SeaWorld (1998), Naval Medical Center San

Diego (1997), and Hewlett-Packard (1996).

If your company is contributing to the health of San Diego County by providing employees with time and facilities to express milk at work, we would like to acknowledge your accomplishments. Please complete our on-line application at www.breastfeeding.org by July 30, 2006 to nominate your employer for the Breastfeeding Friendly Workplace Award. We will gladly provide a mail-in application at your request. For further information, please contact SDCBC Board Member, Eyla Boies MD at eboies@ucsd.edu.

SAVE THE DATE

May 11-12, 2006 — Rocklin Park Hotel, Rocklin Park, CA

Back to the Breast-Preserving the Breastfeeding Relationship
Information: 916-780-6454

May 26, 2006 — West Covina, CA

The Impact of Birthing Practices on Breastfeeding - A Day with Linda Smith

Citrus Valley Medical Center: Queen of the Valley Campus
Information: 213-596-5776
www.breastfeedla.org

May 26-28, 2006 — Hilton Costa Mesa, Costa Mesa, CA

Breastfeeding Now, Parenting for a Lifetime

La Leche League of So California/Nevada
Information: 1-866-818-conf
www.lalecheleaguescnv.org

July 24-26, 2006 — Mission Bay Hilton, San Diego, CA

La Leche League International, 34th Physicians Seminar on Breastfeeding: Breastfeeding: Research Into Practice

Information: 847-592-7561
www.lalecheleague.org

August 3, 2006 — Los Angeles, CA

Critical Factors in Breastfeeding Success: A Day with "Dr. Mom" Marianne Neifert
Cedars Sinai Medical Center
Information: 213-596-5776
www.breastfeedla.org

September 19-22, 2006 — Niagara Falls, New York

Academy of Breastfeeding Medicine's 11th Annual International Meeting: Current Controversies in Breastfeeding Medicine
Information: 1800-990-4ABM
www.bfmed.org

August 15-19, 2007 — San Diego, CA

Town & Country Resort & Convention Center
ILCA's Annual International Conference and Meeting

POLITICS, ADVOCACY & LEGISLATION

California Tissue Bank Law and Human Milk Storage

Nancy E. Wight MD, IBCLC, FABM, FAAP

In early November 2005, Dr. Jon Rosenberg (Infectious Diseases Branch, CA DHS) sent a message to California infection control professionals indicating that any healthcare facility that stores human milk, **even for administration to the mother's own child**, is required by California law to be a licensed tissue bank. The tissue bank law is found in Chapter 4.1 of the California Health and Safety Code (Sections 1635-1643.2). According to this law, any human milk for a mother's own infant, stored (definition is overnight or change of date) would require a tissue bank license.

The law in question and its regulations are not new. The DHS Tissue Bank Licensing Program has been licensing homologous milk banks since the beginning of the program in 1992. Recently a number of new commercial for-profit milk banks have caused them to look at existing facilities more closely. Any hospital that accepts and stores milk from one of these facilities must also be a milk bank. They did not realize, but soon found out, that storage of milk for a mother's own child by the hospital was quite common, and that in a few instances record keeping, labeling, and storage requirements for this activity were somewhat lax. The Tissue Bank Program is in the process of licensing all hospitals, but they did clarify that a consent form would not be needed or appropriate for mother's own milk.

Paul B. Kimsey, PhD, Assistant Deputy Director of the Division of Laboratory Science has stated that the tissue bank program in LFS (Laboratory Field Services) "is committed to assuring that babies in hospitals continue to receive their mother's own milk or any other medically

recommended human milk that may be provided by a licensed milk bank." He requested we contact him (Dr. Kimsey) at 510-412-5846 or Ron Harkey, Section Chief for the Tissue Bank Program at 510-620-3808 for questions or problems.

I think we all are in agreement that a mother's own milk can be literally lifesaving for her preterm infant and results in improved short and long-term outcomes for all infants. We also agree that there must be quality control policies/procedures and guidelines as to how to store and use mother's own milk safely for her own infant. Most of us believe we do a good job, using recognized national (www.hmbana.org) and California (www.cpqcc.org) guidelines. Where we disagree is the appropriateness of classifying the storage and use of a mother's own milk as a "tissue bank". As physicians, lactation consultants, nurses and hospitals, we are concerned that the gains we have made in the use of mother's milk for preterm and ill infants in California's NICUs will be lost due to burdensome regulations that discourage hospitals from collecting, storing and providing the mother's own milk to feed her own infant.

The CA Hospital Association has taken the lead in emergency corrective legislation (SB 1785, Senator Figueroa, (http://info.sen.ca.gov/cgi-bin/postquery?bill_number=sb_1785&sess=CUR&house=B&site=sen)) so that the Tissue Bank licensing law does not act as a disincentive to breastfeeding in California hospitals. Co-sponsoring organizations are being sought. If you have questions or comments, please contact Sheree Kruckenberg at the CHA (skruckenberg@calhospital.org).

GALACTOGOGUE UPDATE

Jason Sauberan, Pharm D & Nancy E. Wight MD, IBCLC, FABM, FAAP

Two recently published randomized, double-blind, placebo-controlled studies^{1,2} of galactogogues for mothers of preterm newborns have suggested that the medications metoclopramide (Reglan®) and oxytocin nasal spray are no more effective than placebo in improving breastmilk volumes in the immediate postpartum period.

In August of 1997, oxytocin nasal spray (Syntocinon®) was withdrawn from the U.S. market. However, it remains available in much of the rest of the world. Recently, investigators from the Institute of Child Health in the U.K. published results of their randomized double-blind trial of achieving enhanced milk production with maternal oxytocin nasal spray versus placebo in 42 mothers with premature newborn infants of 27 to 33 weeks gestation.¹ The spray was initiated on infant day of life one and continued for 5 days, being self-administered before each milk expression with a hospital-grade breast pump. Lactation consultation was provided on the post-partum and neonatal units, and also by the study research nurses who saw each mother at least daily during the study. There were no differences in baseline demographics between the two groups.

Based on the mothers' daily milk volume records, milk production was slightly higher in mothers using oxytocin spray only for study day 2. There was no difference in the cumulative weight of milk produced over days 1-5 between the groups. There were also no differences in the number of or the amount of time spent pumping.

In the second study², researchers at the University of Iowa randomized 57 mothers who delivered between 23 and 34 weeks of gestation to receive either metoclopramide 10 mg oral tablets or placebo tablets three times daily beginning within 96 hours after delivery. Treatment lasted for 10-days. During treatment, and for 7 days after treatment discontinuation, the mothers in the study continued to breastfeed and documented their milk expressions (volume of milk each time she expressed and the total minutes they expressed at each breastfeeding or pumping session) in a journal.

A trained lactation specialist standardized all educational materials given to the mothers at entry into the study and hospital grade electric pumps were provided to all study subjects. Volume measurements were verified twice during the 17-day study period by study investigators. Mothers in the study were contacted once every month after delivery or until they decided to stop breastfeeding.

Metoclopramide use was not associated with a significant increase in milk volume on each of the 17 days of the study, or in volume of milk produced over time between study days 10 and 17. It was also not associated with a significant increase in breastfeeding duration, which was, on average, approximately 8 ½ weeks in both groups. Additionally, no significant differences in milk volume were found among the subgroups 23–28 weeks or 28–34 weeks of gestation, although the study was not

adequately powered to detect any difference in these subgroups. There were no significant differences between metoclopramide and placebo groups in baseline obstetric characteristics, including gestational age, previous preterm birth, route of delivery, and parity.

While this study is a major improvement over previous non-randomized or non-controlled studies of metoclopramide's galactogogue effects, we don't necessarily believe it challenges the utility of metoclopramide as a lactation enhancing agent. In this study, subjects were given metoclopramide prophylactically, very early in the lactation process. They did not necessarily have faltering milk supply. Subjects also delivered preterm and were dependent on a breast pump. We in the lactation community know that metoclopramide is most commonly used as a treatment (not prophylaxis) of lactation deficiency, for women with term or preterm infants, often days to weeks after birth.

Although clinical experience and several prior studies³⁻¹⁵ have suggested metoclopramide effective in increasing milk volumes, a prospective, randomized controlled trial of 50 mothers with partial or complete lactation failure conducted in India in 1997 (16) also found no difference in successful relactation between mothers treated with metoclopramide 10 mg orally three times a day for 10 days and those mothers given no pharmacological treatment. Infants in this study were 1 to 3 months of age and were born at term or near-term. Upon study enrollment, both groups of mothers were motivated to breastfeed by, "removing their misconceptions and educating them regarding the advantages of breastfeeding. Mothers with successful relactation were introduced as the role models for others. They were encouraged to stimulate the nipple by means of nipple stroking and massaging the breast, and to suckle the infants frequently (8-10 times/day)." Bottle-feeding and pacifiers were also discontinued and proper infant positioning techniques were taught. Nipple confusion and infant frustration was identified as the most common cause of lactation failure in both study groups prior to enrollment. Baseline demographics of mothers and infants were the same in both groups.

Success was measured by the appearance of manually expressed milk, a reduction in infant supplementation volume, and infant weight gain. All but one mother in the study achieved successful relactation and there were no differences in the rates of these successful outcomes between the treatment groups. The average time to achieve partial and complete relactation was 6 and 32 days, respectively. The authors concluded that motivation, support, and proper infant positioning are the foundations of establishing successful relactation. We are inclined to agree.¹⁷

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BREASTFEEDING AND MATERNAL THYROID DISEASE

Eyla Boies MD, FAAP

Hyper and hypothyroid conditions are common in women of child-bearing age especially in the postpartum period. As a result, questions regarding breastfeeding and maternal thyroid disease, including safety of thyroid medication while breastfeeding are frequently encountered.

Hypothyroidism: It is important for the woman who is hypothyroid to receive adequate thyroid replacement during pregnancy to assure she carries a healthy fetus to term. When thyroid hormone is given to the lactating mother, it is given in amounts to attain a euthyroid state, i.e., normal levels of thyroid hormone. Thus the amount of thyroid hormone an infant is exposed to in breastmilk of a mother on thyroid replacement is the same as that in the mother who is not hypothyroid and is producing adequate amounts of her own thyroid hormone. As Dr. Ruth Lawrence states, "the mother should be permitted to breastfed without question."

In rare cases undiagnosed hypothyroidism may be the cause of insufficient milk production. When clinically indicated it may be prudent to check her thyroid stimulating hormone (TSH).

Hyperthyroidism: Clinical hyperthyroidism is rare during pregnancy (0.2% of all pregnancies). However, postpartum thyroiditis may occur in up to 5% of mothers. Postpartum thyroiditis (PPT) initially presents with an over production then after about six weeks an insufficient production of thyroid hormone. The initial hyperthyroid symptoms of PPT are generally mild and can be controlled with propranolol, a medication that is compatible with breastfeeding. Symptoms may be more severe in mothers who have Graves disease. In this case Propylthiouracil (PTU), methimazole (Tapazole), or carbamazole (derivative of methimazole) all medications that block the iodination of the tyrosine molecule thus inhibiting synthesis of thyroid hormone are indicated. An infant may develop a goiter and symptoms of hypothyroidism if exposed to these medications in sufficient doses. Methimazole is secreted into breastmilk (Milk/Plasma ratio =1). Studies by Lamberg et al and Azizi

found no adverse effect on thyroid function of infants whose mothers were taking modest doses of carbimazole and methimazole respectively. Very little PTU is secreted into breastmilk since it is highly protein bound. Kampmann, et al found no evidence of adverse effect on infant thyroid function in nine mothers taking PTU. PTU is the preferred medication in the lactating mother since very little gets into breast milk, however, when given in modest doses methimazole (up to 20 mg/day) is compatible with breastfeeding. All breastfeeding infants whose mothers are taking any of these medications should have thyroid functions closely monitored as well as careful clinical follow-up of the infant checking for signs and symptoms of hypothyroidism in the first few weeks and months of life. The older infant (> 6 months of age) who is receiving solid foods is unlikely to experience problems.

Some women who had Graves disease may have undergone thyroid ablation and be clinically hypothyroid requiring thyroid hormone replacement. It is important to know and understand that her primary diagnosis was an autoimmune process and she may still have antibodies against the thyroid that can pass across the placenta and cause transient hyperthyroidism in the neonate. We recently had such a case where a breastfeeding infant was failing to gain weight. Some providers might have first "blamed" breastfeeding as the problem. The provider in this case obtained a careful maternal and breastfeeding history, test weight after breastfeeding in the office, and thyroid function tests on the infant and made the diagnosis of transient neonatal hyperthyroidism.

The diagnostic evaluation of a lactating hyperthyroid mother can be problematic. Thyroid imaging scans using ¹³¹I are frequently used in sorting out the diagnosis of hyperthyroidism. Radioactive ¹³¹I has a long half-life and is sequestered in high concentrations in breastmilk. Based on the rate of radioactive decay breastmilk might be safe to consume 40 days after ¹³¹I administration, however, this is not known with certainty. Breastmilk would need to be counted by a gamma counter

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ASK THE EXPERT: Breastfeeding and Weight Loss



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Question: Will I really lose my pregnancy weight faster if I breast-feed?

Answer: For many years “faster weight loss” has been listed as a benefit of breastfeeding for the mother. Yet a visit to any La Leche League International conference will demonstrate that the incidence of overweight and obesity in that population is no different than the general population – it is too high in both! Does breastfeeding really improve postpartum weight loss?

Theoretically, if there were no increase in maternal energy intake during lactation, as compared with a woman’s normal, non-pregnant, non-lactating state, weight loss for every breastfeeding woman would be rapid and dramatic, on the order of 13 kg (28.6 lbs) over the first 6 months postpartum. As this rarely happens, there may be compensatory factors, such as decreased activity or increased appetite, to maintain body weight.

Most of the data on weight loss with breastfeeding has come from observational studies, which are, by nature subject to multiple confounding variables, such as maternal age, ethnicity, education, in-

come, pre-pregnancy weight, pregnancy weight gain, parity, inter-birth interval, physical activity and dietary practices. Observational studies also suffer from varying methods and timing of assessing the outcome variable: weight or body mass index (BMI). Perhaps the biggest problem is the one all breastfeeding studies face – the definition of breastfeeding. Both duration and exclusivity of breastfeeding may be important factors in weight loss.

Dr. K. Dewey reviewed the available literature and presented 3 tentative conclusions.¹ First, she found evidence for a dose-response relationship between the degree of breastfeeding and the degree of weight loss, that is, the more exclusively and longer a woman breastfeeds, the greater the weight loss. Second, the greatest weight difference between lactating and non-lactating women was found at 3-6 months postpartum. Finally, although breastfeeding does appear to enhance the rate of weight loss, at least during certain time intervals, the magnitude of this effect is small compared with other factors such as pregnancy weight gain, dietary practices and physical activity. The average difference in weight loss by 12 months postpartum between lactating and non-lactating women was about 0.6 to 2.0 kg (1.3-4.4 lbs).

There are many wonderful benefits of breastfeeding for the mother. A modest weight loss may be one of them. We certainly should not put it at the top of the list!

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prior to resumption of breastfeeding. In essence, the administration of ¹³¹I is not compatible with breastfeeding. Every attempt should be made to make the diagnosis without the use of a ¹³¹I thyroid scan.

In summary, most lactating mothers on medications for hyperthyroidism can continue to breastfeed with careful clinical and biochemical monitoring of the infant. Thyroid hormone therapy when given to the lactating mother in appropriate doses poses no risk to the infant. Radioactive ¹³¹I use in the diagnostic imaging of the thyroid is not compatible with breastfeeding. It is important to know the underlying diagnosis of a mother on thyroid hormone replacement because 5% of babies born to mothers with Graves disease will have transient neonatal hyperthyroidism. Lastly, insufficient breastmilk production may be the result of hypothyroidism.

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Breastfeeding Update

“Metabolic Issues & Breastfeeding”

SDCBC's Newsletter for April 2006
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San Diego County Breastfeeding Coalition

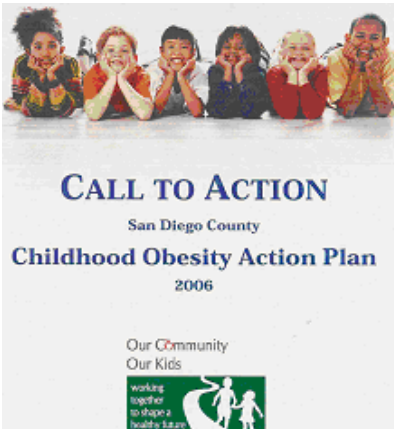
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SEE THIS NEWSLETTER ON THE WEB AT
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COMMUNITY SPOTLIGHT

San Diego County Childhood Obesity Action Plan 2006



In January of 2006. The overarching goal of the plan is improving the health of children and families in San Diego County. The plan includes strategies to educate families and providers about the importance of nutrition and exercise, as well as creating an environment / community that supports families to make healthy choices, such as walkable communities, safe routes to schools, use of school space for after-school activities, increasing accessibility to parks and open spaces.

In October 2004, the San Diego County Board of Supervisors unanimously voted to support the creation of a local Childhood Obesity Master Plan to end childhood obesity. A Steering Committee of local experts has been working for the past year and announced the Call to Action, San Diego County Childhood Obesity Action Plan to the community in

Breastfeeding is specifically addressed in Call to Action 1: County and City Governments under “G: Develop breastfeeding accommodations in public facilities, as breastfeeding helps prevent childhood obesity” and Call to Action 2: Healthcare Systems and Providers under “H. Promote breastfeeding, 30-60 minutes of physical activity and consumption of a minimum of five fruits and vegetable a day.....”. Unfortunately, an opportunity to specifically call for reduced formula marketing was missed in the general statement E under Call to Action 6: Media Outlets and the Marketing Industry: “Partner with businesses to limit advertising and promotion of unhealthy foods and beverages aimed directly at young children.”

Leaders and groups in San Diego County are being asked for commitments to do what each can do to reduce childhood obesity. Sign the Commitment of Significance Form at www.ourcommunityourkids.org/commitmentForm.html to support the campaign - i.e. what specifically can your organization do to join us in shaping a healthier future for children. For more information contact: **Cheryl Moder**, Childhood Obesity Initiative Director, Phone: 619-523-2001; Fax: 619-523-2321; Email: cheryl@modercommunications.com or **Kristin Garrett**, Executive Director, Community Health Improvement Partners, Phone: 619-515-2852, Fax: 619-239-2589, Email: kgarrett@hasdic.org.