Table 7–1 Evaluating the Effectiveness of Latch-on and Suck

Proper Alignment

- Helps keep nipple and areola in infant's mouth
- Reduces traction on mother's nipples
- Facilitates swallowing

Proper Alignment	Improper Alignment	Nursing Interventions
Infant flexed and relaxed	Muscular rigidity	Comfort and calm the infant Try a football hold to get flexion
Head and body at breast level	Head and body sagging; baby "reaching" for the breast	Provide pillows to facilitate baby's head and body at breast level
Head squarely facing breast	Head turned: • Laterally • Hyperextended • Hyperflexed	Help mother to adjust her hold Do not force baby's head against the nipple; instead, help mother to move arm to align infant
Infant's body aligned from shoulder to iliac crest	• Trunk facing the ceiling instead of skin-to-skin with mother • This results in poor compression of the sinuses and obstructed swallowing	Hold "tummy-to-tummy"

Areolar Grasp

Peristaltic motions of tongue result in effective areolar compression (i.e., compression of the lactiferous sinuses)

Proper Areolar Grasp	Improper Areolar Grasp	Nursing Interventions
Infant's mouth opens widely to cover lactiferous sinuses	Pursed lips indicate that mouth is not open wide enough	Tickle lips with nipple or finger Move mother's arm quickly toward breast when baby finally opens wide (see text)
Lips flanged outward	Lips pursed: lip(s) curled under	As above
Complete seal formed around areola; strong vacuum	Incomplete seal; baby can be easily pulled away from nipple	Hook your finger (or have mother hook her finger) under infant's chin
Approximately 1.5 inches of in areolar tissue is centered infant's mouth	Only nipple is in mouth, or nipple is not centered	Break suction and reposition
Tongue is troughed and extends over lower alveolar ridge	Tongue partially inside mouth Nurse has "biting" sensation if she inserts her finger in infant's mouth Results in sore nipples and diminished milk supply Likely to happen if infant does not open wide	Break suction and reposition

Note: Data in left column expanded from Shrago L, Bocar D. *J Obstet Gynecol Neonatal Nurs* 1990;19:209-215. Table from Biancuzzo M. *Breastfeeding the healthy newborn.* 1994:31-32. Copyright 1994 by March of Dimes Birth Defects Foundation. Reprinted by permission.

Table 7-1 Evaluating the Effectiveness of Latch-on and Suck—cont'd

Areolar Compression
Removes milk from breast

Proper Areolar Compression	Improper Areolar Compression	Nursing Interventions
Mandible moves in a rhythmic motion	Mandible moves in tiny motions up and down; appears more like "chewing" instead of gliding	Break suction and reposition
If indicated, a digital suck assessment reveals a wavelike motion of the tongue from the anterior mouth toward the oropharynx; tongue is cupped or "troughed"	Incorrect tongue motions include the following: • Side-to-side movement • Deviation of the tongue to one side • Peristaltic movement from the posterior region to the anterior region of the tongue • Frank tongue thrusting (actively pushing the finger out of the mouth with the tongue) • Diminished negative pressure • Absence of seal around lips • Tongue not troughed	Digital suck assessment is not routinely performed Break suction and reposition Suck training has been advocated[40] but has not been proven effective in well-controlled, scientific studies Sucking is a reflex, and deviations in reflexes should be followed up with a complete neurologic assessment
Cheeks full and rounded when sucking	Cheeks dimple when sucking	Break suction and reposition

Audible Swallowing
(Most reliable indicator of milk intake)

Proper	Improper	Nursing Interventions
Audible swallowing present	Lack of audible swallowing	Reevaluate alignment, areolar grasp, areolar compression
Quiet sound of swallowing is heard	No swallowing is heard	Break suction; take baby off breast and try again; be sure to get baby to open wide, which frequently solves the problem
May be preceded by several sucking motions, especially in first few days	Even after many rapid sucks, infant does not display rhythmic sucking motion and swallowing is not heard	Reevaluate latch-on Evaluate milk supply Evaluate milk-ejection reflex
May increase in frequency and consistency after milk-ejection reflex occurs	No change in observable pattern after milk ejection occurs; flutter-sucking more common	Reevaluate latch-on Evaluate milk supply Evaluate milk-ejection reflex

can assist in determining whether this observation is a breastfeeding problem or a symptom of a pathologic condition. For example, a newborn with a neurologic deficit will have poor rooting and other reflexes and may not be able to exert enough negative pressure to hold the nipple/areola in place. Infants with these types of problems are discussed in Chapter 10.

Table 7-2 Advantages and Limitations of Basic Positions

Position	Advantages	Limitations	Pertinent Points
Cradle hold	• Women are most likely to have seen this position used • Works best for most situations	• Difficult to achieve good sitting position in hospital bed; use chair if possible • Requires sitting; cesarean incision or hemorrhoids may make sitting a less desirable position	• Be sure that infant is chest-to-chest rather than chest-to-ceiling • Infant should be at the level of the nipple
Side-lying hold	• Helpful after cesarean birth • Great for nighttime feedings	• Difficult to visualize latch-on	• Be sure that infant is chest-to-chest rather than chest-to-ceiling • Use folded receiving blanket behind infant to maintain chest-to-chest position • Mother's body should be at a slight angle to the mattress, leaning backward just a bit against a pillow
Football hold	• Helpful after cesarean birth • Helpful for women with especially large breasts • Provides better visualization of latch-on process	• Often difficult to do sitting up in hospital bed	• Be sure that infant is chest-to-chest rather than chest-to-ceiling

hand is dominant. Mothers may ask what will happen if the infant feeds more often or more vigorously at the same side over a period of time. Reassure the mother that nothing "bad" happens; the uneven stimulation may result in one breast being slightly larger than the other, but the infant experiences no negative effects.

Rotating Positions. Mothers are commonly told that they must always alternate the position they use—cradle hold this time, side-lying next time, and football hold the next time. This advice is based on the idea that pressure from the infant's mouth will cause soreness to the mother's nipple. This advice is not necessarily bad, but it usually is superfluous. First, it requires the mother to learn several positions when she may be struggling to learn just one. Second, poor latch-on, in any position, is usually the cause for sore nipples; rotating the position will not prevent sore nipples if this is the root of the problem. However, rotating positions may be useful if the infant has a barracuda style of sucking.

Burping and Sleep Positions. Typically, mothers think that infants should be positioned over their shoulder and patted vigorously for burping. This is usually unnecessary. Infants can be burped simply by keeping their torso straight—explain that the "food pipe" needs to be straight. If the infant is crying, however, instruct the mother to put him over the shoulder. An infant can also be burped by sitting him on the caregiver's lap with a hand on his chest, leaning the infant forward a bit. Recommend to mothers that they give the newborn the opportunity to burp after suckling one breast, but if the infant does not burp, reassure mothers that they do not need to worry about it; some infants do not take in much air and will not need to burp. Signs that the infant needs to burp