Why Would A Baby Not Latch?

There are many reasons a baby might refuse to take the breast. Often there is a combination of reasons. For example, a baby might latch on even with a tight frenulum if no other factors come into play, but if, for example, he is also given bottles early on, or if the mother's nipples and areolas are swollen from fluid from the fluids she received during the labour and birth, this may very well change the situation from "good enough", to "not working at all".

1. Some babies are unwilling to nurse, or suck poorly as a result of medication they received during the labour. Narcotics are responsible for many such situations, and meperidine (Demerol) is particularly bad as it stays in the baby's blood for a long time and affects the way he sucks for several days. Even morphine given in an epidural (Epimorph) may cause the baby to be unwilling to nurse or latch on, since medication from an epidural definitely does get into the mother's blood, and thus into the baby before he is born. Other interventions during labour and birth (e.g. intravenous fluids in large amounts, vigorous suctioning of the baby at birth which is simply not necessary for a healthy full term baby) can also cause difficulties with the baby latching on. For more information see the book *The Latch and other keys to successful breastfeeding,* chapter 4, Causes of Latch Problems, and/or see the *L-Eat Latch ad Transfer Tool, Step #8, N-eat* .

2. Abnormalities of the baby's mouth may result in the baby's not latching on. Cleft palate, but not usually cleft lip alone, causes severe difficulties in latching on. Sometimes the cleft palate is not obvious, affecting only the soft palate, the part inside the baby's mouth.

3. A baby learns to breastfeed by breastfeeding. Artificial nipples interfere with how the baby takes the breast. Babies are not stupid. If they get slow flow from the breast (as is expected in the first few days of life) and rapid flow from the bottle, they will not be confused—many will figure it out quite quickly, and prefer the faster flow.

4. If the mother's nipples are particularly large, or inverted, or flat, these nipple variations may make latching on more difficult, not usually impossible. However most women said to have flat or inverted nipples actually do not. In fact, nipples that look flat are almost always normal, but we live in a society where bottle feeding is still the norm, so if a mother doesn't have nipples that look like the end of a feeding bottle may be told that their nipples are flat.

5. A tight frenulum (the whitish tissue under the tongue) may result in a baby having difficulty latching on. This is not, strictly speaking, considered an abnormality, and thus, many practitioners do not believe that it can interfere with breastfeeding; many studies indicate that it can indeed interfere.

However, one of the most common causes of babies' refusing to latch on arises from the misguided belief that babies in the first few days must breastfeed every 2 hours, or 3, or on some other aberrant sort of schedule. Babies were not meant to feed by the clock even during the first days. Belief in the schedule and trying to stick to a schedule results in anxiety on the part of the staff when a baby has not fed, for example, for three hours after birth, which then results, frequently, in babies being forced to the breast when they are not yet ready to feed. When the baby is forced into the breast, and kept there by force, especially when the baby is not interested or ready, we should not be surprised that some babies develop an aversion to the breast. If this misguided approach then results in panic, and "the baby *must* be fed", alternative feeding methods (the worst of which is the bottle) are then used, resulting in worsening of the situation and the beginning of a vicious circle.

There is no evidence that a healthy full term newborn must feed every three hours (or two hours, or whatever) during the first few days. There is *no* evidence that they will develop low blood sugars if they don't feed every three hours (the whole issue of low blood sugars has become a mass hysteria in many postpartum areas which, like all hysterias, results from a grain of truth, perhaps, but actually causes more problems than it prevents, including the problem of many babies getting formula when they don't need it, being separated from their mothers when they don't need to be, and not latching on). Babies should be together, skin to skin with their mothers, most of the day (See the information sheet
Skin to Skin Contact
). When they are ready, most will start looking for the breast. Having the baby with the mother skin to skin immediately after birth and allowing the baby and the mother the time to "find" each

other will prevent most situations of the baby not latching on. Mother and baby skin to skin will also keep the baby as warm as being under a heating lamp, and, more importantly, not too warm but just right. Having the baby and mother together for 5 minutes though, is not the answer. The mother and baby should be together until the baby latches on, without pressure, without time limits ("we've got to weigh the baby", "we've got to give the baby vitamin K," etc—these procedures can wait!). This might take 1-2 hours or more.

But The Baby Is Not Latching On!

Okay, so how long can we wait? There is no obvious answer to that. Certainly, if the baby has shown no interest in nursing or feeding by 12 to 24 hours after birth, it may be worthwhile to do something, *mostly because hospital policies usually require the mother to be discharged by 24 to 48 hours* . What can be done?

1. The mother should start expressing her milk, and that milk (colostrum), either alone, or mixed with sugar water, should be fed to the baby, preferably by finger feeding (see below and the information sheet on *Finger and Cup Feeding*). ***The mother should start expressing her milk as soon as it has been decided to feed the baby off the breast or supplements are necessary*** .
See information sheet,
Expressing Milk
. If it is difficult to get colostrum (often hand expression works better than a pump in the first few days), then sugar water alone is fine for the first few days. With finger feeding, most babies will start sucking, and many will wake up enough to attempt going to the breast. As soon as the baby is sucking well, finger feeding should be stopped and the baby tried at the breast (Often a minute or two of finger feeding will do the trick). See the video clip "Finger feeding to Latch" at the website nbci.ca). Finger feeding is essentially a procedure to prepare the baby to take the breast, not primarily a method of avoiding the bottle, Though finger feeding can be used for avoiding a bottle as well, a cup is probably a better option than finger feeding. Therefore finger feeding is done
before
attempting the baby at the breast, to prepare him to take the breast.

2. Before discharge, early, competent help needs to be arranged so that the mother and baby are getting help by day four or five *at the latest*. Many babies not able to latch on in the first few days will latch on beautifully once the mother's milk supply has increased substantially as it usually does around day 3 or 4. Getting help at this time avoids the negative associations with the breast that many babies develop as time goes on.

3. A nipple shield started before the mother's milk becomes abundant (day 4 to 5) is bad practice; in fact, I believe it should never be done. Starting a nipple shield before the mother's milk "comes in" is not giving time a chance to work. Furthermore, used improperly (as we see it often being used), a nipple shield may result in severe depletion of the milk supply, and the baby refusing to ever latch on to the breast without it. See below on the importance of maintaining a good milk supply.

We're Home From Hospital, The Baby Won't Latch On. Now What Do I Do?

The single most important factor influencing whether or not the baby eventually latches on is the mother's developing a good milk supply. If the mother's supply is abundant, the baby will latch on by 4 to 8 weeks of life no matter what in almost all cases. What we try to do at the clinic is get the baby latching on earlier, so that you won't have to wait that long. So,
it is more important you keep up your supply, than avoid a bottle
. The bottle interferes, and it is better you use other methods (such as a cup) if you can, but if you feel you have no choice, you should do what you need to do.

• Learn how to get the best position and latch from an experienced lactation specialist (see also information sheet *When Latching* and see the videos at nbci.ca). As the baby comes onto the breast, compress the breast so that the baby gets a gush of milk.
Try the baby on the breast he seems to prefer, or the breast that has more milk, or the side you feel most comfortable with if neither of the previous apply, but do not start on the breast he resists more
.

• If the baby latches on, he will start sucking and start drinking (get information on how to know a baby is actually getting milk at the breast—see information sheet *Enough* and see the videos at nbci.ca).

• If the baby doesn't latch on, don't try to force him to stay on the breast; it won't work. He will either get hysterical or "go limp". Move him away from the breast and start again. It is better to go on-off, on-off several times than to push him into the breast when he hasn't latched on. Pushing the baby into the breast won't work and may cause baby to refuse even more.

• If the baby goes to the breast and sucks once or twice, he hasn't latched on *a little*; he hasn't latched on
at all.

• If the baby refuses the breast, don't keep at it until he's angry. Try finger feeding a few seconds to a minute or two, and try again, perhaps on the other side. Finger feeding is primarily used to prepare the baby to take the breast, not primarily to avoid a bottle.

• If the baby doesn't latch on, finish the feeding with whatever method you find easiest. Cup feeding works well and is better than a bottle.

• Using a lactation aid at the breast may be helpful, but often requires an extra hand. The baby is more likely to latch on if the flow is rapid, and the lactation aid increases the milk flow to the baby.

• At about two weeks after birth, a change in what you have been doing often seems to send a message to the baby that "there's more than one way to do this". If you have been finger feeding only, a change to a cup or bottle will sometimes work. If you have been bottle feeding only, switching to finger feeding may work (only before attempting the baby at the breast is good enough if finger feeding is too slow, and finishing the feeding with cup or bottle).

How to Maintain and Increase Milk Supply

• Express your milk as often as is practical, at least 8 times a day, using a reliable pump that expresses both breasts at the same time. The best time to express your milk is right after baby has a feeding. See the information sheet *Expressing Breast Milk*. Some mothers actually find expressing by hand easiest and just as productive as using a pump. Using compression while pumping increases the efficiency of pumping and increases the milk supply (another hand is helpful, but mothers have rigged up the pump so that they don't have to hold onto the tubing or flanges while pumping and thus can compress without help).

• If the baby hasn't latched on by day 4 or 5, start fenugreek and blessed thistle to increase milk flow. See the information sheet *Herbal Remedies for Increasing Milk Supply*. Domperidone may also be useful. See the information sheets
Domperidone, Starting
and
Domperidone, Stopping
.

• If you must use a nipple shield, (and we are not advising that you do), do not use one at least until the milk supply is well established (at least 2 weeks after the baby is born). **But get good hands on help first—a nipple shield is really a last resort**
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Do not get discouraged. Even if your milk supply is not up to the needs of your baby, your baby is still likely to latch on. Get good hands-on help. Do not try to do this on your own.

WHO International Code on the Marketing of Breastmilk Substitutes (1981)

and subsequent World Health Assembly resolutions.