

Feasibility of early breast feeding after caesarean section

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Abstract

Breast feeding is the best way to start life. Initiation of breastfeeding is delayed in caesarean section (CS) babies. We studied the feasibility of early initiation of breastfeeds in newborns in the immediate post delivery period when the suckling reflex is powerful. Fifty consecutive mothers with elective or emergency CS, admitted to Government District Headquarters Hospital, Kumbakonam, South India, were taken up for the prospective study. All deliveries were done under intrathecal anaesthesia and babies were fed in one minute. Forty eight out of 50 babies (98%) sucked immediately. We conclude that early initiation of breast feeding is possible and successful before uterine closure in operative deliveries.

Introduction

Breast feeding is the best way to start life and early initiation decreases morbidity in infants¹. After caesarean section (CS), initiation of breast feeding is often delayed. We studied the feasibility and success of initiation of breast feeding before closure of the uterus in operative deliveries.

Objectives

1. To find out whether very early breast feeding is possible in newborn before uterine closure in operative deliveries.
2. To find out the percentage of early successful feeding in newborn.
3. To find out whether there are any untoward problems associated with this method.

Material and methods

Fifty consecutive elective or emergency CS, admitted to Government District Headquarters Hospital,

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Kumbakonam, South India, were taken up for the prospective study. Our hospital is a district hospital with 150 CS per month. All patients gave informed consent. Institutional approval was obtained. All patients received Inj. ranitidine 50 mg and Inj. metoclopramide 10 mg by intramuscular route 45 minutes before anaesthesia. After 500 ml of hydration with Ringer lactate, 1 to 1.2 ml of 5% lignocaine heavy was used in the L3-L4 interspace to achieve adequate level in all the cases. The management of anaesthesia was according to the institutional protocol. As soon as the baby was born, routine neonatal resuscitative measures were done. Inj. oxytocin 10 units in infusion and Inj. pentazocine 30 mg intravenous were given. All the neonates were put to the breast after one minute (Figure 1). The mothers were sedated but conscious. Only healthy babies were fed and the acceptability of feeds and sucking were assessed in the intra-operative period only. Any untoward preoperative event was noted.



Figure 1: Initiation of breast feeds before uterine closure

Results

The mean and standard deviation of the parturients age and weight were 23.4±3.3 years and 64.2±6.4 kg respectively. Routine investigations and preoperative assessment were normal in all the patients. The anaesthetic period was totally uneventful. All the babies had one minute APGAR of more than seven and were put to the breast by a well trained maternity

assisting nurse and fed. Out of 50 babies 48 (98%) sucked immediately. Only two babies did not suck immediately but did so after one hour. There were no untoward side effects in mother or baby.

Discussion

In operative deliveries, initiation of breastfeeding is often delayed, because mothers who have delivered via CS often need some extra time to recover before they physically feel like holding and nursing their new baby. As soon as they are fully conscious and alert and able to hold the baby, they can begin breastfeeding. Nursing as soon as possible after birth has advantages for mothers who have had CS just as it does for mothers who deliver vaginally. It promotes bonding, provides stimulation to bring the milk in sooner, releases the hormone oxytocin to help the uterus contract, provides the baby with the immunological advantages of colostrum and takes advantage of the fact that the newborn sucking urge is strongest in the first couple of hours after birth². There is an extra advantage for the CS mother; nursing during the brief period of time before the regional anaesthetic wears off provides a time of pain-free, more comfortable nursing during the baby's first feedings at the breast³. This is the advantage which we have utilized with success. Salariya EM et al⁴ after 111 normal deliveries initiated feeding in ten minutes and concluded that both early initiation and increased frequency of breast-feeding extended the nursing period, the former having the greater effect. We have done the same with CS. In a study by Barriuso Lapresa L et al⁵, the early exposure to the breast and the restriction of bottle-feed with glucose in the early hours of life favour breast feeding. Instrumental delivery acts as an adverse factor for breastfeeding. Here, in our study we have proved that even operative deliveries do not hinder early initiation of breast feeds.

Gadsden J et al⁶ in their study opined that pain may also impair the mother's ability to optimally care for her infant in the immediate postpartum period and may adversely affect early interactions between mother and infant. Pain and anxiety may also reduce the ability of a mother to breast-feed effectively. It is necessary that pain relief be safe and effective so that it does not interfere with the mother's ability to move around and care for her infant. In our cases, we have fed the babies during the presence of spinal

anaesthetic effect and hence there is no problem with pain causing the negative effect. In our pilot study, after breast feeds, we inserted an infant feeding tube in five babies to find milk. This clearly showed active feeding by the baby.

Limitations

The sample size is low, but this is an ongoing work. Regional anaesthesia with 5% lignocaine is our routine protocol and general anaesthesia was not instituted in any case. There is no mention about follow up of patients for duration and frequency of feeding.

Conclusion

Early initiation of breast feeding is possible and successful before uterine wound closure in operative deliveries.

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