Breastfeeding a Baby with a High Anterior Arched Palate

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Sorting through some old copies of ABM magazine earlier this year, ABM Vice Chair, Sharon Breward, came across "a classic" 2001 article. Sharon says, "I learnt so much from this article. The palate is so ignored in the TT explosion and is hugely influential on attachment".

The following case highlights the need for 'optimal attachment' rather than 'correct attachment' says Lactation Consultant Sue Saunders. We may not be offering appropriate advice if we reassure without further exploring the cause of pain. When breastfeeding a baby with a high anterior arched palate is painful, even though the baby appears to be 'correctly attached', there is a technique that may help.

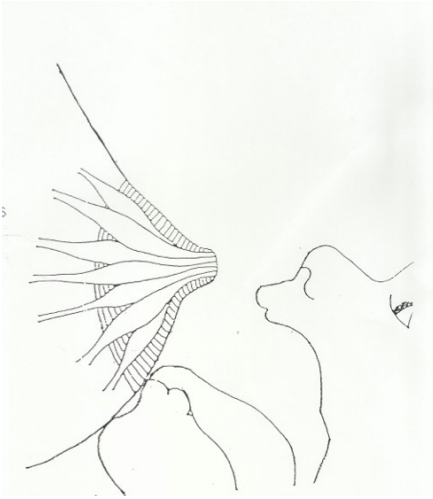

Figure 1:
Baby has wide gap with tongue down and forward. Chin on breast.

All diagrams © Sue Saunders 1997, adapted from diagrams by Ros Escott 1989

Research illustrates that skin-to-skin contact leads to the first successful breastfeed which is paramount for lactation success [1,2] and that breastfeeding frequently does not cause sore nipples.[3,4] The baby who is well attached to the breast will have his tongue extended forwards to cover his lower gum, with his mouth full of breast tissue to form a large teat that extends to the junction of the soft and hard palate. This allows him to suckle well without causing nipple and breast problems.[5,6] Two more studies by Woolridge [7,8] discuss the position of the breast in the mouth and the movements and pressures involved during suckling. The influence of the suckling technique on the success of breastfeeding has been highlighted by Righard and Alade.[9] Escott [10]

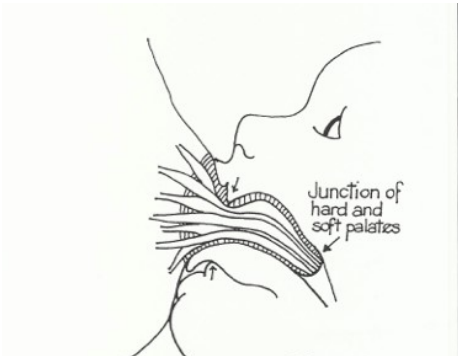

Figure 2:
OPTIMAL ATTACHMENT
Baby draws nipple and breast tissue back to the soft palate. Tongue is forward over gums, lower lips rolled out, chin against breast.

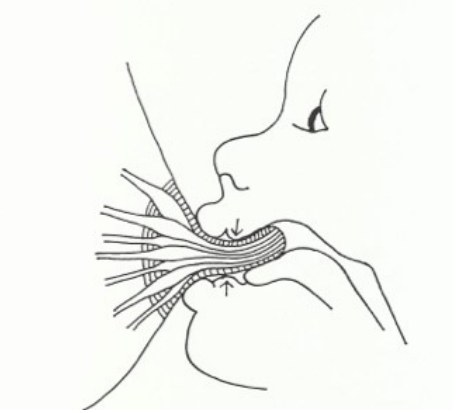

Figure 3:
POOR ATTACHMENT
Baby attached to little breast tissue, mainly nipple stem. Lips are pursed, mouth not wide open against breast. Tongue behind lower gum. Compression of the jaws gains little milk, tongue cannot work effectively.

reinforces these studies with very clear diagrams (see figures 1,2 and 3). If the baby 'looks' well attached, then how can there be a problem?

Description of the neonate's palate

The roof of the baby's mouth has been described as a broad, shallow saucer [11] and Wolf and Glass [12] emphasise the need for the hard palate to be intact, smoothly contoured, and to roughly approximate the tongue. The different neonatal hard palates have also been described [13] and categorised into types.[14] Clinicians have noted the association between the shape of the infant's palate and suckling difficulties [15 16 17] and with failure to thrive. The structure of the infant's palate may be further distorted under the influence of artificial feeding and pacifying methods.[19]

Case study

This mother was an 'experienced breastfeeder', mother of two older children, midwife and breastfeeding counsellor. This was her third baby and she was very pleased that this normal birth had been intervention-free as well as drug-free, the first labour to progress naturally. Her previous two babies had breastfed for 12 months and 11 months respectively, had never been given a bottle and were weaned onto a cup. She fed her new baby on demand. By

the end of day one, the mother felt that her nipples were becoming increasingly tender during feeds. By day two, both nipples were grazed, bleeding and tender after feeds. By day three, baby was becoming unsettled and wanted to feed frequently. The mother had never before experienced traumatized nipples. Time and time again she checked her positioning and attachment. She became more traumatized and anxious about feeding. The mother began to feel she must be 'missing something'.

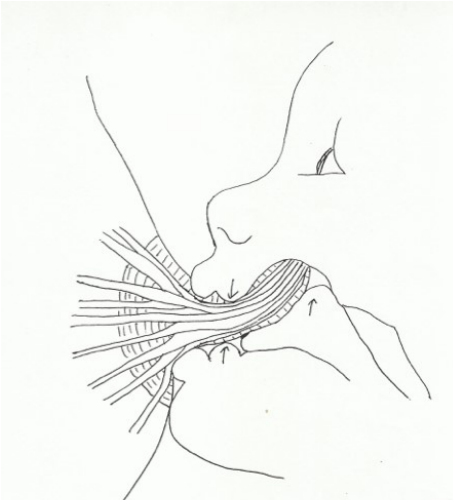

Figure 4:
High arched palate poorly

Again, she checked her positioning and attachment. Why was this happening? Why was she still so sore with each suckle and then burning after feeds? Why were her nipples bleeding and her breasts unrelieved? Was she doing anything different? Had she forgotten how to feed a newborn baby? Various midwives attended and reassured the mother, commenting that her breasts were filling well and that the baby was hungry, opened her mouth beautifully and 'looked correctly attached'. At a loss for what else to suggest they asked if she would like to try a nipple shield, which she refused.

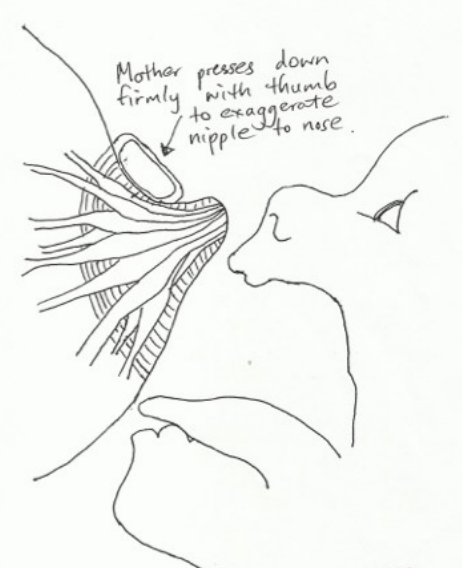

Figure 5:
Technique to optimise attachment with a high arched palate.

Consultation

On day three she was seen by the lactation consultant. The mother demonstrated how she had been positioning and attaching her baby.

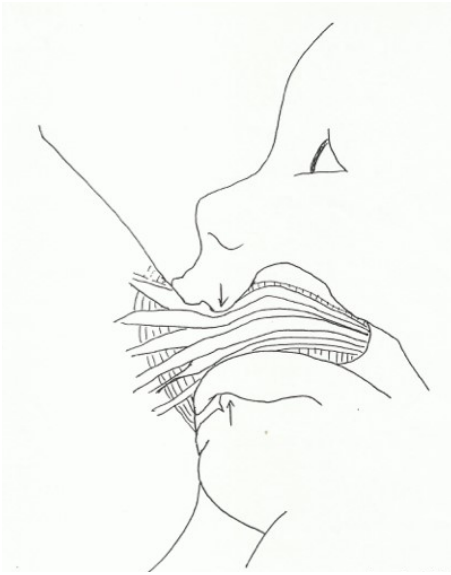

Figure 6:
Optimal attachment with a high arched palate.

Her technique appeared adequate for an optimal attachment. The mother's nipples were reasonably prominent. The breasts were uncomfortably full and both were grazed and covered in scabs. The mother was shown how to locate her lactiferous sinus; she felt that her baby's jaws reached 'that far' onto her breasts. It was doubtful that the mother was the source of the problem. Baby was hungry. She latched onto the lactation consultant's finger and displayed a strong, co-ordinated suck. Her oral mucosa felt dry and she looked markedly jaundiced. Her urinary output was reduced and her weight loss was greater than 10% of birth weight.

The lactation consultant could not detect and facial or oral abnormality, either internally or externally. The only feature of note was a very high anterior arch to the hard palate. Could this alone be enough to be the source of such pain when the attachment might 'look' wonderful? (see fig.4) A digital examination of the mother's palate showed a similar high anterior arch, but the two older children had flatter and broader palates. The mother commented that her mother had wanted to breastfeed her but had become very sore and had stopped breastfeeding after four days.

Suggestion

The lactation consultant suggested a suitable intervention to overcome this attachment problem in a way that was acceptable to the mother and the baby. The mother was reminded of the importance of her own feet support and therefore hip support. Her body position immediately felt more comfortable and this also helped to support the baby onto her side that little bit more. The baby could now access the breast from underneath. The mother expressed by hand to soften the areola and proximinal breast tissue. This enabled her baby to draw the breast tissue well back into her mouth so that the nipple could reach the junction of the soft and hard palate. As the mother needed her breasts to be drained well and often,

she was asked to offer both breasts at each feed. To prevent milk stasis if the baby refused the second breast, she could hand express until she felt comfortable.

The technique

Previous case studies [15] [18] suggest that when a variance in the structure of the palate makes appropriate attachment difficult, a process of suck training and attachment is used. However, in this case, the lactation consultant preferred to empower the mother with a simple technique to optimise the attachment (as shown in a NMAA video [20] and similar to Glover's technique [21]). It is important for the helper to have a hands-off approach so that the mother fully understands the process and becomes skilled at attaching her baby with every feed.

Gentle but firm compression was placed on the breast, opposite the baby's nose, to exaggerate the tilt of the nipple. Baby's chin was placed well back on the underside of the breast and this contact tempted her to open her mouth widely (see fig 5). The mother was supporting the baby's head at the shoulders. Without moving the baby's lower jaw, the mother then quickly brought the baby over the breast. This 'folding over' effect directed the breast tissue back to the junction of the soft and hard palates and prevented the nipple and areola from being compressed against the anterior aspect of the hard palate by the jaw and tongue (see fig 6).

Resolution

When the baby attached well, the mother noted that she only felt discomfort on initial attachment with the first few sucks, as the already traumatised tissue stretched to reach the junction of the soft and hard palates. If baby did not attach well and caused pain, the mother was advised to remove the baby immediately and try again. With optimal attachment, the baby could access and compress the lactiferous sinus; this enabled her to milk the breast more effectively, resulting in the mother commenting that her breasts were well drained and then comfortable between feeds. Baby learnt very quickly to 'come over' her mother's breast and attach herself. Her urinary output improved and the jaundice cleared quickly. By day seven, the baby had regained her birth weight and the mother was relieved to be pain free. Breastfeeding continued according to need and this baby was fed naturally for almost two years.

Conclusion

When a breastfeeding mother complains of pain and trauma and her baby is also suffering, I suggest that we need to learn to look at the whole picture and find a cause before we can offer an acceptable

intervention to overcome the problem. It is no longer acceptable to reassure or to 'do' the attachment. This experienced breastfeeding mother was considering giving up. An Office for National Statistics report [22] shows that 'insufficient milk', 'painful breasts or nipples' and a baby who refused the breast or who couldn't latch are the main reasons why women stop breastfeeding. Renfrew [23] highlights the need for helpers to have the skills of listening, looking at the whole picture and assisting appropriately.

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