Preface

Everyone agrees that breastfeeding is best. The benefits are countless, and more and more mothers are trying to nurse their babies. We are told that breastfeeding is an inherent skill that mothers and babies just naturally know how to do. For the most part this is true. But not always. When breastfeeding doesn't happen easily, it can be due to a simple problem, such as an improper latch or a sleepy baby. But often there are more significant problems: Once-full breasts now only produce a few ounces of milk… the baby takes leisurely hour-long feeds, then gets hungry an hour later… the baby cries at the breast and becomes frantic… the mother experiences pain every time her baby latches on. Talk to a mother with cracked, bleeding nipples, and watch her cringe at the mere thought of her crying baby's mouth, and you'll see how bad it can get.

I discovered these symptoms myself with the birth of my daughter 12 years ago, while I was at the end of my residency. Memories of that time are a blur of exhaustion and frustration. Lucy nursed almost constantly, every hour for 45 min. My nipples were raw, cracked, and very painful, but because my baby seemed healthy, I thought this was normal. Lucy's pediatrician and my own doctor both told me that everything was fine and that I should just "wait out" the pain—it would stop eventually. She was gaining weight slowly, but within normal parameters.

After about 3 weeks, I visited a breastfeeding support group run by a lactation consultant (LC). She disagreed with the doctors and said that there was indeed a problem, and that I should pump and supplement with formula. She also suggested I see an LC privately. Money was tight back then, but I was determined to give my daughter the best start possible. So I paid the LC fee of $250 per visit, and I rented a hospital-grade breast pump for $80 per week.

I pumped frequently and regularly, even when there was nowhere to do it privately—there is no oasis of quiet in a hospital for a resident. But, to my horror, I was never able to get more than 2 oz of milk a day from both breasts combined. I was starving my baby. I sought help from doctors and told them that I wasn't making enough milk. Every one of them dismissed my concerns, saying, "Oh, you have milk" (but I didn't) or "Everyone can breastfeed, you must be doing something wrong." I was a breastfeeding failure. No one listened to me. But even if they had, I was naïve to the fact that no one had answers.

Breastfeeding is unique in medicine in that there is no specialty dedicated to diagnosing and treating issues with breastfeeding. Every other human function has medical specialists trained to understand its intricacies and fix problems. Not so for breastfeeding. Lactation consultants, as good as they are, vary in training and experience. As of now, although there is board certification (IBCLC), there is no licensing board.

In the past, women turned to their mother or grandmother for help. The community of women knew how to make it work, what tricks to try. But after formula became available and women went to work, fewer mothers breastfed. Babies were born in hospitals instead of at home with midwives. Over time, the art of breastfeeding was lost. It seems reasonable nowadays to ask your doctor for advice, but what doctor knows anything practical about breastfeeding? Your OB/Gyn gets you as far as the delivery, and then the pediatrician takes over. Somewhere in the middle is that mother–baby unit. Depending on the training and personal experience, you will get widely variable—and often wrong—information.

Look beyond the clinician and you can see another reason why there is such a gap in our medical knowledge. Breastfeeding has a lot of "moving parts." In the mother, there are hormones, specialized breast tissue, breast anatomy, and even the psychological contributions to milk production. In the infant, there are anatomical configurations, the gape, the reflexes, and the suck. Mother and baby must function properly independently *and* together as a breastfeeding unit. As if that wasn't enough of a challenge, the dynamics of breastfeeding change over time, from the first latch through weaning. Medical research provides us with many details regarding discrete slices of the breastfeeding experience, but since there is no dedicated specialty, the disparate findings are left unconnected to a whole picture.

My training was as an Ear Nose and Throat surgeon (Otolaryngologist). The first breastfeeding case I saw in practice was referred by an LC who believed that the baby had tongue tie (ankyloglossia), when the lingual frenulum is so short, thick, or tight that the tongue cannot move freely. Tongue tie was just beginning to be recognized as an important breastfeeding issue—the first tangible anatomic abnormality to break through the fuzzy mist of psychological rationalizations for why some mothers and their babies had a difficult time establishing a breastfeeding connection. My daughter was not even a year old at the time, so my breastfeeding failure was still fresh. It was a rush not only to be able to identify why the baby couldn't feed but also fix the problem.

I began to get more and more referrals from LCs and—eventually—from pediatricians for babies with various feeding problems. I started trying to quantify the breastfeeding experience by measuring everything that was measurable: infant gape, facial angle, frenulum thickness, palate arch, jaw size, breast shape, nipple size, et cetera. In the early days, all the cases were for tongue tie. Now, mother–baby dyads are referred to me for a number of different problems, but I see myself in all the mothers…and I see my daughter in all the infants. I want to keep as many mothers as possible from being labeled breastfeeding "failures."

After spending more than a decade researching and treating breastfeeding problems, I now know that there is no way I could have breastfed Lucy successfully at that time, no matter how much I pumped or how much money I paid. There was no one to diagnose and treat us. And even if there had been, by the time I realized there was a problem, it was too late.

Since then, I have treated thousands of babies, with a success rate of approximately 90 %…and most requiring only one office visit. I have developed a methodology to help bring mothers and infants together without pain, frustration, or multiple consults. In cases where surgery is necessary, it is possible to offer evidence (and advice) that will help the mother come to a decision more quickly and with less doubt than she might otherwise experience.

Notes About This Book

It is stipulated and acknowledged that breastfeeding is good for infants, mothers, families, and communities. This book does not discuss the specific value of breastfeeding; the value is recognized and assumed to be generally true. Instead, this book focuses on the interactive act of breastfeeding—what it should look like and what happens when something goes wrong.

Because this book reveals so much new information, it is not always possible to provide source references for the information given. The work simply hasn't been done outside my own clinical practice and research.

Final note: When discussing mother–infant interactions, I will use masculine pronouns (he, him) for the baby. This is done only to avoid subject confusion, given that the mother always takes the feminine pronouns (she, her). It's a grammatical choice, not a political one.

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