



## Complete Summary

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### GUIDELINE TITLE

Transitioning the breastfeeding/breastmilk-fed premature infant from the neonatal intensive care unit to home.

### BIBLIOGRAPHIC SOURCE(S)

Academy of Breastfeeding Medicine. Transitioning the breastfeeding/breastmilk-fed premature infant from the neonatal intensive care unit to home. New Rochelle (NY): Academy of Breastfeeding Medicine; 2004 Sep 17. 12 p. [21 references]

### GUIDELINE STATUS

This is the current release of the guideline.

## COMPLETE SUMMARY CONTENT

SCOPE  
METHODOLOGY - including Rating Scheme and Cost Analysis  
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## SCOPE

### DISEASE/CONDITION(S)

- Infant health/nutrition
- Prematurity (<37 weeks gestation)

### GUIDELINE CATEGORY

Evaluation  
Management  
Prevention  
Risk Assessment  
Treatment

### CLINICAL SPECIALTY

Family Practice  
Nursing  
Nutrition  
Obstetrics and Gynecology  
Pediatrics

## **INTENDED USERS**

Advanced Practice Nurses  
Allied Health Personnel  
Dietitians  
Nurses  
Physician Assistants  
Physicians

## **GUIDELINE OBJECTIVE(S)**

To optimize nutritional support of premature infants who are breastfeeding and/or receiving human milk after they are discharged from the hospital

## **TARGET POPULATION**

Premature infants being discharged from a neonatal intensive care unit to home who are breastfeeding and/or receiving human milk

## **INTERVENTIONS AND PRACTICES CONSIDERED**

1. Pre-discharge assessment, discharge planning
  - Feeding plan
  - Nutritional assessment
    - Type, amount, and method of feeding, adequacy of growth and nutrition
    - Optimal versus suboptimal assessment
2. Post-discharge assessment
  - Nutrition monitoring at one week post-discharge: intake, growth, biochemical indices, nutritional status
    - Optimal nutritional status (intake, growth, biochemical indices)
    - Suboptimal nutritional status (latch, milk transfer/volume, maternal milk content, frequency of breastfeeds, maternal satisfaction, need for feeding device, test weighing, ongoing nutritional monitoring)
  - Nutrition monitoring at one month post-discharge
    - Optimal nutritional status (intake, growth, biochemical indices)
    - Suboptimal nutritional status (milk production, breastfeeding, ongoing assessment)
3. Transition to post-discharge nutrition for infants with optimal assessment
  - Infant receiving fortified human milk with/without preterm formula
    - Change to unfortified human milk ad libitum by one week prior to discharge

- Asses mother's supply
  - Mother continues to express or pump milk
  - Trial without formula
  - Iron supplement
  - Multivitamin
  - Infant receiving unfortified human milk: continue iron, multivitamin and diet after discharge
4. Transition to post-discharge nutrition for infants with suboptimal assessment
- Infant receiving fortified human milk
    - Change to unfortified human milk ad libitum by one week prior to discharge plus enriched post-discharge formula
    - Mother continues to express or pump milk
    - Evaluation of adequacy of breastfeeding in infant with suboptimal assessment: latch, milk transfer/volume, maternal milk content, frequency of breastfeeds, maternal satisfaction, need for feeding device or supplemental feeding
    - Consideration of feeding devices, including nipple shield and supplementary nursing device
    - Iron supplements
    - Multivitamin
  - Infant receiving unfortified human milk
    - Add feedings of enriched formula
    - Iron supplement
    - Multivitamin
5. Post-discharge
- Enriched post-discharge formula
  - Hindmilk use
  - Continuity of care
  - Support for breastfeeding mothers of premature infants
    - Measuring milk intake at home
    - Triple feeding
    - Partial breastfeedings
    - Community resources

## **MAJOR OUTCOMES CONSIDERED**

- Nutritional status of infant
- Infant growth (weight and length)
- Biochemical indices (phosphorus, alkaline phosphatase, blood urea nitrogen)
- Maternal satisfaction

## **METHODOLOGY**

### **METHODS USED TO COLLECT/SELECT EVIDENCE**

Searches of Electronic Databases

### **DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE**

An initial search of relevant published articles written in English in the past 20 years in the fields of medicine, psychiatry, psychology, and basic biological science is undertaken for a particular topic. Once the articles are gathered, the papers are evaluated for scientific accuracy and significance.

#### **NUMBER OF SOURCE DOCUMENTS**

Not stated

#### **METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE**

Expert Consensus (Committee)  
Weighting According to a Rating Scheme (Scheme Given)

#### **RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE**

##### **Levels of Evidence**

I Evidence obtained from at least one properly randomized controlled trial

II-1 Evidence obtained from well-designed controlled trials without randomization

II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group

II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.

III Opinions of respected authorities, based on clinical experience, descriptive studies and case reports; or reports of expert committees

#### **METHODS USED TO ANALYZE THE EVIDENCE**

Systematic Review

#### **DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE**

An expert panel is identified and appointed to develop a draft protocol using evidence based methodology. An annotated bibliography (literature review), including salient gaps in the literature, are submitted by the expert panel to the Protocol Committee.

#### **METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Expert Consensus

## **DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS**

Not stated

## **RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS**

Not applicable

## **COST ANALYSIS**

A formal cost analysis was not performed and published cost analyses were not reviewed.

## **METHOD OF GUIDELINE VALIDATION**

External Peer Review  
Internal Peer Review

## **DESCRIPTION OF METHOD OF GUIDELINE VALIDATION**

Draft protocol is peer reviewed by individuals outside of lead author/expert panel, including specific review for international applicability. Protocol Committee's sub-group of international experts recommends appropriate international reviewers. Chair (co-chairs) institutes and facilitates process. Reviews submitted to committee Chair (co-chairs).

Draft protocol is submitted to The Academy of Breastfeeding Medicine (ABM) Board for review and approval. Comments for revision will be accepted for three weeks following submission. Chair (co-chairs) and protocol author(s) amends protocol as needed.

Following all revisions, protocol has final review by original author(s) to make final suggestions and ascertain whether to maintain lead authorship.

Final protocol is submitted to the Board of Directors of ABM for approval.

## **RECOMMENDATIONS**

### **MAJOR RECOMMENDATIONS**

#### **Pre-discharge: Discharge Planning**

- A. The clinician should work with the mother to devise a feeding plan well before the actual date of discharge. Rooming-in by the mother for a few days prior to discharge during this transition period is strongly recommended. The baby will preferably be on exclusive breastmilk, either suckling straight from the breast and/or by use of expressed breastmilk. Less often, the plan may include a combination of breastmilk (directly from the breast and/or expressed) and formula.

- B. The following aspects of the current feeding plan should be assessed when making post-discharge plans.
1. "Type" of feeding: unfortified human milk, fortified human milk, formula, or a combination.
  2. "Amount of feeding": milk intake (cc/kg/day)--this includes either measuring the mothers' pumped milk volume or performing 24 hour test weights (Meier et al., 1994) for infants who feed at the breast. If the baby is already growing adequately, it is not typically necessary to perform test weights.
  3. "Method" of feeding: oral (breast, bottle, cup, supplemental nursing device, other, or a combination of methods) versus, or in combination with, tube feeding (nasal or orogastric), or use of a feeding device (e.g., gastrostomy tube).
  4. "Adequacy of growth": In-hospital growth noted as daily rate of weight gain and weekly rate of length gain calculated and/or plotted on appropriate growth charts (see the Table below).
  5. "Adequacy of nutrition": In-hospital biochemical nutritional status, when feasible (see the Table below).

*(Note: It is recognized that biochemical monitoring is not feasible in all settings. In such situations, dietary adequacy is based on optimal growth and absence of clinical rickets)*

6. Summary of current nutritional assessment: optimal vs. sub-optimal
  - a. Optimal Status (includes ALL of the following)
    - i. Infant can achieve entire intake orally, by breastfeeding and/or alternate methods.
    - ii. Volume of intake is approximately 180 cc/kg/day or more. (Rarely, lower volumes will be adequate—if both of the following criteria are met, iii and iv).
    - iii. Growth (weight and length) is within normal limits or improving.
    - iv. Biochemical indices (phosphorus, alkaline phosphatase, blood urea nitrogen) are within normal limits (see the Table below) or improving.
  - b. Sub-Optimal (includes ANY one or more of the following)
    - i. Infant's intake is <160 cc/kg/day (with rare exceptions). Infant cannot consume all feedings orally.
    - ii. Growth is less than adequate (weight gain <20 grams/day and/or length gain <0.5 cm/week).
    - iii. Biochemical indices are abnormal and are not improving.

C. Transition to Post-Discharge Nutrition for infants with "Optimal Assessment"

1. If the infant has been receiving fortified human milk with/without preterm formula, the diet may be changed to unfortified human milk ad libitum, by breastfeeding and/or alternative feeding methods, at least one week before anticipated discharge.
  - a. Prior to this transition it is necessary to assure that mother's milk supply is appropriate for a trial of breastmilk without fortification. This can be done by reviewing the mother's pumping record. Ideally, the mother has been pumping/expressing breastmilk regularly. It is recommended

that the mother continue pumping or expressing milk at least three times/day in order to have an "oversupply" to facilitate adequate volume consumption by the premature infant at the breast. For some mothers, pumping after each feeding ensures optimal drainage of the breast, optimal milk production, and expression of the highest fat content (hindmilk) for supplemental feedings. This technique of breastfeeding, then feeding previously pumped breastmilk, and then pumping any residual volume from the breast is termed "triple feeding."

**Note:** *In many areas manual expression is the norm and/or only available method for milk expression. Preliminary evidence suggests that greater volumes may be obtained with electric, hospital-grade pumps (Ramsethu, Jeyaseelan & Kirubakaran, 1993). Therefore, whenever possible, use of the latter is recommended.*

- b. For infants receiving formula supplements, a trial without formula is appropriate while increasing human milk intake to approximately 180 cc/kg/day, if possible. Use of hindmilk to increase caloric intake for some feedings may be appropriate.
- c. Add iron, 2 mg/kg/day

**Note:** *If enriched post-discharge formula is used, a decrease in the quantity of iron and multivitamin supplementation is indicated. Generally, if formula constitutes about 50% of the diet, the dose for iron is 1 mg/kg/day and multivitamin preparation is 1/2 the doses listed below.*

- d. Add a complete multivitamin preparation. (Dosed to receive at least the following amounts of vitamin A [1500 IU/day], C [20 to 70 mg/day] and D [400 IU/day]; vitamin C requirements of preterm infants are poorly studied. B vitamins are also necessary for the former premie receiving unfortified human milk. Typically, appropriate amounts of all vitamins will be provided by infant milk volume intake [MVI] [preparations at 1 cc/day]). See note above under iron above C1(c) if providing enriched post-discharge formula supplements.
- e. Monitor milk intake and growth (weight and length) during this week. Volumes of pumped/expressed milk and 24 hour test weights (for infants fed at the breast) should be recorded during this period (Meier et al., 1994).
- f. If intake and growth are adequate, continue this diet after discharge
- g. If intake and growth are sub-optimal

*Follow D (d) below*

- 2. If the infant has been receiving unfortified human milk
  - a. Continue iron (2 mg/kg/day)
  - b. Continue multivitamin preparation (See dosing above, C.1(c))
  - c. Continue this diet after discharge

D. Transition to Post-Discharge Nutrition for infants with "Sub-Optimal Assessment"

1. If the infant has been receiving fortified human milk
  - a. Change the diet to unfortified human milk, with/without preterm formula, ad libitum (by breastfeeding and/or alternative feeding methods) plus a minimum of 2 to 3 feedings of enriched postdischarge formula prepared per manufacturer instructions (~22 kcal/oz) at least one week before anticipated discharge.

*(Note: Many neonatologists and institutions add powdered discharge premilk to expressed breastmilk to provide enriched feeds while still providing the advantages of breastmilk. There is no evidence to recommend for or against this practice. This use of powdered premature formula is off-label and the potential for error is great, so be advised to be extremely cautious if using this approach.)*

- b. Recommend the mother continue pumping or expressing milk at least three times/day (See C.1 (a) above.)
- c. Monitor milk intake and growth during this week
- d. Assess adequacy of breastfeeding and address problems or potential problems
  - i. Latch
  - ii. Milk transfer/milk volume. If lactation has been suppressed and/or baby is not adequately draining the breast it may be necessary to intervene to increase volume (i.e., increased pumping after feeds and/or pumping at some feeds and feeding the expressed milk in lieu or in addition to feeding at the breast.) (Please also see The Academy of Breastfeeding Medicine Protocol #9 titled "Use of Galactagogues In Initiating or Augmenting Maternal Milk Supply.")
  - iii. Maternal milk content – Consider the use of hindmilk for some feedings to increase caloric content. This must be considered in conjunction with milk transfer and volume as it may be particularly important if the baby is getting only foremilk and leaving hindmilk.
  - iv. Frequency of feeds at breast (please note that with "sleepy preemies" subtle feeding cues may be missed)
  - v. Optimize milk transfer. Suggested techniques may include pumping or expressing to let down before putting baby to breast and/or using breast compression during feedings.
  - vi. Maternal satisfaction. Mothers may have preferences regarding timing of feeds, feeding devices, etc. that fit best with the family's needs and can be accommodated without compromising the infant's nutrition.
  - vii. Consider use of a feeding device
    1. Nipple shield to improve milk transfer (Kirsten, Bergman, & Hann, 2001)

*(Note: any mother who is discharged using a nipple shield must have close monitoring by a competent lactation professional in place to monitor for potential associated complications)*

2. Supplemental nursing (feeding tube) device while at breast
  3. May be able to use nipple shield and supplemental nursing device together effectively (e.g., by placing tube inside nipple shield so when baby suckles, the volume of milk available for transfer is increased.
  4. Test weighing (Meier et al., 1994)
- e. Monitor milk intake and growth (weight and length) during this week. Record volumes of pumped/expressed milk and 24-hour test weights (for infants fed at the breast) during this period (Meier et al., 1994)
  - f. If intake and growth are adequate during this week after switching:
    - i. Add iron (1 to 2 mg/kg/day), depending on how much formula is fed
    - ii. Add multivitamin preparation (1/2 to full dose described above C.1 (c)), depending upon how much formula is fed
  - g. Continue this diet after discharge
2. If the infant has been receiving unfortified human milk, assess the adequacy of breastfeeding and address problems or potential problems as above, D.1(d).
    - a. If addressing any existing breastfeeding problems does not result in "optimal assessment", add 2 to 3 feedings of enriched post-discharge formula prepared per manufacturer instructions (~22 kcal/oz) (*See note under D. 1(a) above*). Ensure that the mother is expressing milk to maintain and optimize her milk production. Anticipate at least one more week of continued hospitalization before discharge.
      - i. Monitor milk intake and growth during this week.
      - ii. Continue iron and multivitamin supplement.
      - iii. If the feeding assessment continues to be sub-optimal after one week, increase the number of feedings of enriched post-discharge formula *or* increase the concentration of enriched formula to 24 to 30 kcal/oz.

### **Post-Discharge Assessment**

- A. Nutrition monitoring one week after discharge
  1. Assess intake
    - a. History
    - b. Observation of feeding
    - c. Consider test weighing if concerns persist (Meier et al., 1994)

2. Growth—weight and length (see the Table below).
3. Biochemical indices of nutritional status (see the Table below).
4. Reassess nutritional status as "Optimal" vs. "Sub-optimal".
  - a. Infants with an "Optimal" assessment may be re-evaluated at one month after discharge (See III.B, below)
  - b. For infants with a "Sub-optimal assessment"
    - i. Assess adequacy of breastfeeding
      1. Latch
      2. Milk transfer/volume
      3. Maternal satisfaction
      4. Milk content—consider hindmilk
      5. Consider use of feeding devices
        - a. Nipple shield to improve milk transfer (Meier et al., 2000)
        - b. Test weighing (Meier et al., 1994) to evaluate milk volume
    - ii. If addressing any existing breastfeeding problems does not result in an "optimal assessment", add additional feedings of enriched post-discharge formula, prepared as below, per clinical judgment according to the individual infant's assessment:
      1. Prepared per manufacturer instructions (~22 kcal/oz)
      2. Concentrated to 24 to 30 kcal/oz
      3. Ensure mother is expressing milk to maintain and optimize her milk production.
    - iii. Frequent follow-up visits for on-going nutritional monitoring

B. Nutrition monitoring one month after discharge

1. Assess intake
  - a. History
  - b. Observation of feeding
  - c. Consider test weighing if concerns persist (Meier et al., 1994)
2. Growth—weight and length (see the Table below).
3. Biochemical indices of nutritional status (see the Table below).
4. Reassess nutritional status as "Optimal" vs. "Sub-optimal".
  - a. Infants with an "Optimal" assessment may be re-evaluated at every two months to one year corrected age.
  - b. For infants with a "Sub-optimal assessment"
    - i. Ensure optimal milk production, breastfeeding
    - ii. Add additional feedings of enriched post-discharge formula, individualizing preparation either: Prepared per manufacturer instructions (~22 kcal/oz) *or* concentrated to 24 to 30 kcal/oz
    - iii. Frequent follow-up visits for on-going nutritional monitoring.

C. Once nutrition has been optimized, nutritional monitoring can occur every two months until one year corrected age.

- D. With regard to enriched formula, a few studies have demonstrated a positive effect on growth using enriched formulas for 6 to 9 months. Until more definitive data are available for breastfed former preemies, we recommend continuing an enriched post-discharge formula for a minimum of 6 months.

### **General Strategies**

- A. Enriched post-discharge formula is used because it provides greater nutrient intake than term infant formula. Human milk fortifier usually is not recommended post-discharge because its nutrient content is too great for the infant at the time of discharge, it is expensive, and very difficult to prepare according to specifications.
- B. Hindmilk, if used, will provide extra calories (estimated at 22 to 24 cal/oz), but provides no increase in the intake of minerals or protein. (Hindmilk is the fat-rich milk that occurs at the end of the feeding.)
- C. It is imperative that the hospital physician communicates with the physician who will provide follow-up care to ensure that the desired plan is carried out and convey any unique concerns about growth, diet, feeding patterns and biochemical monitoring.

### **Support for Breastfeeding Mothers of Premature Infants**

- A. Support mothers to initiate kangaroo (skin to skin) care as early as possible in-hospital. (Schanler, 2001; Kirsten, Bergman, & Hann, 2001)
- B. Encourage mothers to express their milk soon after delivery and approximately every 3 hours on an on-going basis. Aim for at least 8 pumping sessions in 24 hours, so that if pumping does not occur exactly every 3 hours, sessions will not be missed. Instruct mothers on the use of effective breast pumping methods, either electric rental-grade or effective manual pumps, or manual expression. Whenever possible, electric rental-grade pumps should be used for maximal stimulation, particularly for the establishment of milk supply. Skin-to-skin contact, simultaneous milk expression, and non-nutritive suckling at the breast may facilitate the establishment of the milk supply.
- C. Educate mothers that early feeding behaviors will emerge during skin-to-skin holding, and that mothers can follow the infant's cues for early feeding attempts. Mothers should understand that early feeding attempts are gradual, and not expected to result in a full feeding for the infant.
- D. Sustained suckling with swallowing for five minutes is one indicator that the infant may be ready to transition from nasogastric tube to breastfeeding (Kliethermes et al., 1999; Valentine & Hurst, 1995). Other studies suggest that early introduction of oral feeding hastens the development of oral motor skills (Simpson, Schanler, & Lau, 2002). Nursing supplementers may provide additional volume (Meier, 2001).
- E. Have trained personnel evaluate breastfeeding (position and latch) on a regular basis. A correct latch is critical for efficient milk removal.
- F. Monitor mothers for nipple soreness. If present, this may be an indication of shallow latch. Temporary use of silicone nipple shields is a helpful adjunct for milk transfer and more efficient latch-on for premature infants with shallow latch (Kirsten, Bergman, & Hann, 2001).
- G. If the infant is achieving partial intake directly at the breast, consider "triple feeding"—put the baby to breast, supplement with expressed breastmilk or formula (at breast with the supplemental nursing [tube feeding] device or

- after the breastfeeding), and then pump or express milk afterward to maintain the milk supply.
- H. If the baby is discharged home with partial feedings at the breast, consider a scale sensitive enough to distinguish milk intake for home use to help with the transition to total feedings at the breast.
  - I. Refer and coordinate supportive care services such as, community support, visiting nurse, lactation consultant visits, social services, and Women, Infants and Children (WIC).

<b>Table. Biochemical* and Growth Monitoring for Premature Infants in the Post-Discharge Period. (Modified from Hall, 2001; Schanler, 2003)</b>	
<b>Parameter</b>	<b>Action Values</b>
<b>Growth</b>	
Weight gain	<20 g/day
Length increase	<0.5 cm/wk
Head circumference increase	<0.5 cm/wk
<b>Biochemical Markers</b>	
Phosphorus	<4.5 mg/dL
Alkaline phosphatase	>450 IU/L
Blood urea nitrogen	<5 mg/dL

\*It is recognized that biochemical monitoring is not feasible in all settings; presence of absence of clinical rickets then becomes a substitute parameter.

### **CLINICAL ALGORITHM(S)**

A clinical algorithm for Transitioning the Breastfeeding/Breastmilk-fed Premature Infant from the Neonatal Intensive Care Unit to Home is provided.

## **EVIDENCE SUPPORTING THE RECOMMENDATIONS**

### **REFERENCES SUPPORTING THE RECOMMENDATIONS**

[References open in a new window](#)

## **TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS**

The type of evidence supporting the recommendations is not specifically stated.

The recommendations were based primarily on a comprehensive review of the existing literature. In cases where the literature does not appear conclusive, recommendations were based on the consensus opinion of the group of experts.

## **BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS**

### **POTENTIAL BENEFITS**

Appropriate and effective transitioning for the breastfed/breastmilk-fed premature infant from the neonatal intensive care unit to home

### **POTENTIAL HARMS**

Not stated

## **QUALIFYING STATEMENTS**

### **QUALIFYING STATEMENTS**

A central goal of the Academy of Breastfeeding Medicine is the development of clinical protocols for managing common medical problems that may impact breastfeeding success. These protocols serve only as guidelines for the care of breastfeeding mothers and infants and do not delineate an exclusive course of treatment or serve as standards of medical care. Variations in treatment may be appropriate according to the needs of an individual patient.

## **IMPLEMENTATION OF THE GUIDELINE**

### **DESCRIPTION OF IMPLEMENTATION STRATEGY**

An implementation strategy was not provided.

### **IMPLEMENTATION TOOLS**

Clinical Algorithm  
Foreign Language Translations

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

## **INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES**

### **IOM CARE NEED**

Getting Better  
Staying Healthy

**IOM DOMAIN**

Effectiveness  
Patient-centeredness

**IDENTIFYING INFORMATION AND AVAILABILITY**

**BIBLIOGRAPHIC SOURCE(S)**

Academy of Breastfeeding Medicine. Transitioning the breastfeeding/breastmilk-fed premature infant from the neonatal intensive care unit to home. New Rochelle (NY): Academy of Breastfeeding Medicine; 2004 Sep 17. 12 p. [21 references]

**ADAPTATION**

Not applicable: The guideline was not adapted from another source.

**DATE RELEASED**

2004

**GUIDELINE DEVELOPER(S)**

Academy of Breastfeeding Medicine - Professional Association

**SOURCE(S) OF FUNDING**

Academy of Breastfeeding Medicine

**GUIDELINE COMMITTEE**

Academy of Breastfeeding Medicine Protocol Committee

**COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE**

*Committee Members:* Caroline J. Chantry, MD, FABM, *Co-Chairperson*; \*Lori Feldman-Winter, MD; Cynthia R. Howard, MD, MPH, FABM, *Co-Chairperson*; \*Richard J. Schanler, MD

\**Lead author(s)*

**FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST**

None to report

**GUIDELINE STATUS**

This is the current release of the guideline.

## **GUIDELINE AVAILABILITY**

Electronic copies: Available in Portable Document Format (PDF) from the [Academy of Breastfeeding Medicine Web site](#).

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

## **AVAILABILITY OF COMPANION DOCUMENTS**

The following is available:

- Procedure for protocol development and approval. Academy of Breastfeeding Medicine. 2007 Mar. 2 p.

Print copies: Available from the Academy of Breastfeeding Medicine, 140 Huguenot Street, 3rd floor, New Rochelle, New York 10801.

A Japanese translation of the original guideline document is available from the [Academy of Breastfeeding Medicine Web site](#).

## **PATIENT RESOURCES**

None available

## **NGC STATUS**

This NGC summary was completed by ECRI Institute on November 5, 2007. The information was verified by the guideline developer on November 12, 2008.

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