Breastfeeding and Maternal Smoking

I wish to address the statement regarding maternal smoking and breastfeeding. In your article, it states, "Maternal smoking is not an absolute contraindication to breastfeeding but should be strongly discouraged, because it is associated with an increased incidence in infant respiratory allergy." After this false information, you have cited reference 102. I scrolled down to the references to find this information and see that it was taken from Pediatric Allergy and Immunology 2009;20(1):30–34. However, the content of this reference must have been misunderstood. It states, "Exposure to maternal smoking in the first year of life interferes in breast-feeding protective effect against the onset of respiratory allergy from birth to 5 yr." This being true, it states nothing of the fact that it "increases incidence" of infant respiratory allergies but that it lessens the protective effect against it. A mother who is smoking while nursing, most likely was a mother who was smoking while pregnant, which means the baby has already been exposed to nicotine. Encouraging a smoking mother not to breastfeed can cause the newborn to go through nicotine withdrawal after birth. Also, the protective effects in the mother’s milk far outweigh the small amount of nicotine that passes through the breast milk. The infant is going to be exposed to smoking in any case because of maternal use of cigarettes, and therefore the benefits of breast milk to that infant would actually prove more important than to an infant in a non-smoking household. Please reconsider the wording in your article. Many physicians are already severely uninformed regarding the benefits of continued breastfeeding, and giving this false information to them only compounds the problem. Thank you for your time and understanding.

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Breastfeeding and Atopic Dermatitis

I recently read the policy statement on breastfeeding and found it disappointing. The 1997 (updated 2005) statement was a well-researched, thorough document that appeared to take all research into account.

Concerning and breastfeeding and atopic dermatitis, the new statement reads: “There is a protective effect of exclusive breastfeeding for 3 to 4 months in reducing the incidence of clinical asthma, atopic dermatitis, and eczema by 27% in a low-risk population and up to 42% in infants with positive family history.”

The studies cited are a 2007 AHRQ report (Ip, Chung et al) on breastfeeding, and a 2008 (Greer et al) analysis to support their claim that breastfeeding aids in prevention of eczema.

The 2007 AHRQ report (which cites no studies on this subject published after 2002) concludes: “Available evidence from one well-performed systematic review/meta-analysis on full term infants in developed countries suggests that exclusive breastfeeding for at least 3 months was associated with a reduction in the risk of atopic dermatitis in those subjects with a family history of atopy.”

The 2008 analysis (Greer et al, which cites no research post 2005) on infant feeding and allergic disease, made these conclusions: “In summary, for infants at high risk of developing atopy, there is evidence that exclusive breastfeeding for at least 4 months or breastfeeding with supplements of hydrolyzed infant formulas decreases the risk of atopic dermatitis compared with breastfeeding with supplements of standard cow milk-based formulas. On the basis of currently available evidence, this is less likely to apply to infants who are not at risk of developing atopy, and exclusive breastfeeding beyond 3 to 4 months does not seem to lead to any additional benefit in the incidence of atopic eczema.”

I would like to know where the 27% and 42% numbers come from.

There have been at least 5 studies in the past few years that have not found breastfeeding protective for atopic dermatitis, some of which find an increase with breastfeeding.

The rest of this policy statement is not much better. In Table 2, dose responses for reductions in obesity, diabetes, cancer, and asthma are given, when recent research is mixed at best as to whether breast milk is preventative.

I feel that this policy statement is a poor example of an analysis of available research and information. I hope the American Academy of Pediatrics will look at this report with a critical eye and rework it, taking all available research into account.

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Donor Human Milk for Preterm Infants

The evidence appraisal in this revised American Academy of Pediatrics policy statement endorses the practice of supporting mothers to express breast milk for their preterm infants using evidence-based interventions. The challenge is to ensure that these are implemented consistently and broadly, and especially to vulnerable and socially disadvantaged women who are less likely to provide expressed breast milk. However, the statement recommending that preterm infants should receive “Pasteurized donor human milk, appropriately fortified” if the mother’s own expressed breast milk is unavailable is not supported fully by the current evidence. Whether donor human milk is the optimal alternative when maternal milk is not available requires consideration of feasibility, costs, acceptability, and the effect on other important clinical outcomes, principally growth and development. Although good-quality evidence applicable to the modern context of neonatal nutritional care is emerging, additional large, pragmatic randomized controlled trials are needed to provide more reliable and precise estimates of effect size and to explore cost-effectiveness. I am concerned that, without qualification, the advice in this American Academy of Pediatrics Policy Statement may have the unintended consequence of discouraging clinicians and service users from developing and participating in randomized controlled trials to address the remaining uncertainties.

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Policy Statements on Breastfeeding and Human Milk: Additional Comments

The American Academy of Pediatrics publishes periodical breastfeeding policy statements; the latest updated previous recommendations and added new topics. These statements have long been a reference for clinical pediatricians and public health professionals worldwide. Accustomed to the breadth of research in these statements and knowing their importance, I felt the lack of 2 topics of current interest to pediatricians and public health workers: pollutants in breast milk and interactions between of vaccines and breastfeeding.

POLUTANTS IN BREAST MILK

Environmental pollutants and hazardous substances have become part of modern life as a result of widespread use coupled with inadequately controlled (or unenforced) environmental policies. Because of their ubiquity, they reach all forms of life, entering and contaminating aquatic and terrestrial food chains; at the top of the ladder, we find breastfed babies. Only under exceptional circumstances (such as after accidents) does the occurrence of environmental chemicals in breast milk result in a recommendation to avoid breastfeeding. Indeed, most studies of background exposure suggest that breastfeeding can counter subtle adverse effects associated with in utero maternal exposure to neurotoxic or endocrine-disruptor substances.

Progress in analytical techniques has boosted studies dealing with milk composition of potentially harmful environmental contaminants. As a result, studies have shown the presence of (organic and inorganic) environmental pollutants in maternal blood and breast milk, raising concerns for pregnant and breastfeeding mothers. However, statements issued to health professionals and mothers have not always considered the results that may ensue. Geraghty et al reported the negative impact of poor reporting...
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/content/130/2/e461.2.full.html