Sucking on the ‘emptied’ breast: non-nutritive sucking with a difference

Indira Narayanan, R Mehta, D K Choudhury, B K Jain

Abstract
A simple method to promote the use of human milk and subsequent breast feeding in low birthweight infants was evaluated in 32 babies. In the 'intervention' group (n=16; mean (SD) weight 1559 (228) g and length of gestation 33-2 (1-8) weeks), infants were allowed to suckle at the breast when their general condition permitted after as much milk as possible had been expressed, and were then given the full required feeds by tube. Full breast feeding was started as soon as the infant could suck adequately. Sixteen control infants (mean (SD) weight 1605 (198) g and length of gestation 34-1 (2-4) weeks), were breast fed in the conventional manner only after it had been established that they could suck well; until then they received all their feeds by tube. After discharge the mean (SD) periods of exclusive and total breast feeding were longer in the group that had received the intervention (3-7 (1-3) and 5-1 (2-2) months, respectively) than among the controls (1-9 (0-6) and 3-3 (1-9) months, respectively).

This 'intervention' method helps to promote milk formation, provides sucking experience for low birthweight infants without interfering with their nutritional intake and consequent weight gain, and encourages subsequent breast feeding with its well recognised advantages.

When human milk is used to feed low birthweight infants, continued flow of milk may present problems especially if weight and gestation are low, the suck is weak, and the period of separation long. Maternal anxiety and medical problems make things worse. Giving the mothers emotional support by encouraging early contact and participation in the non-specialised care of their infants is helpful.1 2

Initiating and maintaining breast feeding in a young low birthweight infant before he or she is fully ready for it may result in inadequate weight gain or even weight loss. Initially, therefore, sucking was permitted for only a brief period. The number of episodes and sucking time were gradually increased, care being taken to monitor the weight daily until the infants were allowed to suck for as long as they wanted to before tube feeds, the end point being when the infant stopped sucking on his own. As infants became stronger, full breast feeding was started and this gradually replaced the combination of 'emptied' breast sucking and tube feeding. A single bottle feed was tried to start with to judge the infant's sucking capacity before initiating full breast feeds.

Control infants were treated in a similar manner as far as intermittent tube feeds were concerned, and were also given to mothers to hold and cuddle. They were, however, put to the breast in the conventional manner only after it had been established that they could suck adequate volumes from trial feeds; gradually, then, all tube feeds were replaced by breast feeds. The bottle was not used routinely for giving breast milk.

An attempt was made to allay alternate mothers to the intervention and control groups,
but this was impossible as the procedure so
captured the fancy of mothers that whenever they
saw another mother carrying out the procedure
they insisted on following suit. We therefore
evaluated a small group of mother-infant pairs
(n=8) as controls treated in the conventional
manner and after all these had been discharged
we initiated the intervention group (n=8) and
then repeated the cycle. Permission was
obtained from mothers for the intervention, but
it was merely a formality. Statistical analysis
was by Student's t test and the χ² test as appro-
priate.

Results
The hospital where the study was carried out
catered to a mixture of social classes. As state-
ments regarding income were invariably unreli-
able, emphasis was laid on maternal education;
this is shown in table 1 together with other
maternal characteristics such as age, experience
of breast feeding, presence of older women in
the home, and outside employment. In the
intervention group 81% and in the control
group 88% had had some form of education.
There were no significant differences between
the groups for any of the variables.

The intervention could be started when an
infant was aged 10 (2) days. Initially tiny pre-
term babies merely 'mouthed' the nipple when
put to the breast but they soon established defi-
nite sucking, which subsequently was noted to
be well sustained with bursts of sucking activity
alternating with periods of rest. No infant had
any episodes of choking during the interven-
tions or during the subsequent introduction of
the feeding tube. Aspiration before starting
feeds showed either no milk or—in older infants—less than 5 ml.

Table 2 shows characteristics of the infants.
Again there were no significant differences
between the two groups in sex distribution,
mean birth weight, gestation, or presence of
early neonatal problems such as birth asphyxia,
respiratory distress, or hyperbilirubinaemia.
The duration of parenteral fluids and the
various types of milk feeds were similar in the
two groups, as were the weight at discharge and
duration of hospital stay.

A separate evaluation of the weight gain was
made among infants weighing less than 1500 g
(10 in the intervention group and nine among
controls). As shown in the figure weight gain
was similar in the two groups. Table 3 shows
the final outcome noted at follow up, which was
carried out until breast feeding was completed.
Three infants in the intervention group and six
controls were already receiving supplementary
milk feeds at the time of discharge. Two infants
in the control group were not breast fed at all
after discharge, the mothers saying that they did
not have sufficient milk. These differences,
however, were not significant in this sample

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**Table 1: Maternal characteristics**

<table>
<thead>
<tr>
<th></th>
<th>Intervention group (n=16)</th>
<th>Control group (n=16)</th>
<th>χ²</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (SD) age (years)</td>
<td>27.5 (3.6)</td>
<td>28.6 (3.6)</td>
<td>t=0.87</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nil</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast feeding experience</td>
<td>9</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential older women</td>
<td>7</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside employment</td>
<td>5</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Table 2: Infant characteristics**

<table>
<thead>
<tr>
<th></th>
<th>Intervention group (n=16)</th>
<th>Control group (n=16)</th>
<th>t</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No of boys</td>
<td>9</td>
<td>11</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) birth weight (g)</td>
<td>1559 (228)</td>
<td>1605 (198)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) gestation (weeks)</td>
<td>33.2 (1.8)</td>
<td>34.1 (2.4)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>No with early neonatal problems</td>
<td>5</td>
<td>4</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>No on parenteral fluids</td>
<td>10</td>
<td>9</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) duration (days) of parenteral feeding</td>
<td>11.5 (3.5)</td>
<td>11.8 (4.1)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Milk feeds</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressed human milk alone</td>
<td>5</td>
<td>5</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Enriched expressed human milk (see text)</td>
<td>5</td>
<td>6</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Expressed human milk and formula</td>
<td>6</td>
<td>7</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) hospital stay (days)</td>
<td>24.3 (9.5)</td>
<td>23.1 (9.8)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>

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**Table 3: Outcome**

<table>
<thead>
<tr>
<th></th>
<th>Intervention group (n=16)</th>
<th>Control group (n=16)</th>
<th>t</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>No on artificial milk at discharge</td>
<td>3</td>
<td>6</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>No not breast fed after discharge</td>
<td>7</td>
<td>10</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) duration of exclusive breast feeding (months)</td>
<td>3.7 (1.3) (n=13)</td>
<td>1.9 (0.6) (n=10)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
<tr>
<td>Mean (SD) duration of total lactation (months)</td>
<td>5.1 (2.2) (n=16)</td>
<td>3.3 (1.9) (n=14)</td>
<td>t</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>
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size. On the other hand, the period of exclusive breast feeding and the total duration of lactation were significantly longer in the intervention group.

Discussion
In 1983 Bernbaum et al noted that sucking on a pacifier enhanced the maturation of the sucking reflex, improved weight gain, and even reduced hospital stay. Paediatricians in developing countries usually discharge low birthweight infants far earlier than their Western counterparts. A higher proportion of mature infants with retarded growth in the Third World is one of the reasons that we are able to initiate oral feeds earlier. Overcrowding and potential risk of infection in some units are additional motivating factors for early discharge. Under these circumstances the use of pacifiers to stimulate the more premature and very low birthweight infants cannot be recommended because their use is likely to be perpetuated and could further predispose to infection, particularly after discharge from the hospital, as well as interfere with breast feeding.

The potential risk of HIV infection has unfortunately had a detrimental influence on the use of donor breast milk, and policies not only vary in different units, but need to be revised periodically to suit changing local requirements. Where breast milk is used, however, promotion of subsequent breast feeding must also be a priority.

A number of methods have been tried to initiate early oral feeding both in hospitals and in the community in the Third World. The innovative 'kangaroo' method with close early contact and start of breast feeding has aroused considerable interest. The use of a spoon, cup, or an easily cleaned traditional feeding device are also widely used in developing countries. A controlled trial of skin to skin contact by the kangaroo method in a developed country has also shown that it has a beneficial influence on breast feeding. Preterm infants are handicapped by their limited intakes, initially poor ability to suck, and speed with which they tire, and a balance has to be maintained between energy intake and expenditure so that optimal weight gain can be ensured. Excessive physical stress, as in early initiation of breast feeding, may result in inadequate intake and poor weight gain. This applies even to sucking on the 'emptied' breast described in this paper, as excessive sucking in the early stages may not be suitably compensated for by the nutritional intake.

Interestingly, Bernbaum et al attributed the increased weight gain that they noted in infants who sucked pacifiers to one or more of the following reasons: sucking was believed to stimulate secretion of sublingual lipase with associated improved fat absorption from formulas; it also resulted in better oxygenation and decreased restless activity. These findings were supported by Field et al10 and Measal and Anderson. In the present study, however, we did not note an improved weight gain in the infants. Possible explanations for this finding could be that raw human milk containing lipases was the main milk used in both groups and also that even control infants had some sucking experience as they tended to suck on the orogastric feeding tube. The recent study by Ernst et al has also failed to show improved weight gain and decreased hospital stay with non-nutritive sucking on a pacifier.2 When the sucking is at the breast, however, the impact on lactation that we have shown in this study seems to be appreciable. In developed countries where mothers and staff are motivated to use human milk, continuation of milk flow and emotional satisfaction should be benefits. In developing countries, use of human milk has a significant influence on the infective morbidity and mortality in high risk infants. Even in units where infections may not be a major problem it is still important to ensure that the long term outcome is acceptable if the resources and efforts expended on these infants at risk in the neonatal special care unit are to be justified. In this context longer periods of exclusive and total lactation can influence more long term infective morbidity after discharge particularly among the less privileged groups, and emotional satisfaction is an added bonus.

As noted earlier, most of the mothers in this study had had some education. In the Third World it is this group that does not seem to be so successful in sustaining lactation,4 and hence the findings in this report are all the more important.

We have since found this intervention to be of use also in larger full term infants who are convalescing from illnesses such as birth asphyxia, respiratory distress, or major infections, at a stage when the infants are improving but are not strong enough to accept full direct breast feeds. The weaker, younger, smaller, and more preterm infants do not suck strongly enough to swallow any appreciable volumes, and the few ml sucked by the stronger, older, larger, and more mature ones not only contain the fat rich hind milk, but also do not seem to interfere with subsequent tube feeds. With better observation even 'trial' bottle feeds can be dispensed with, as the occurrence of good sustained sucking at the emptied breast can be made out to determine the stage at which direct breast feeding can be introduced.

In conclusion, this is a simple intervention, which is useful not only to stimulating sucking...
but also to promote maternal milk flow and pro-
longing lactation in mothers of high risk infants,
with all its attendant benefits.


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**Prorenin and diabetes**

Outside the entrance to our hospital there appeared a large poster proclaiming that Susan stands in the shadow of diabetes and its complications. The need to collect money, it seems, overrides any possible adverse effect on young patients of such advertising even in the minds of those who run the national charity for people with diabetes.

A prime aim of treating childhood diabetes must be to prevent the adult complications if possible and several ways of identifying diabetic children at risk have been proposed.¹ Fifteen years ago Dr John Luetscher and colleagues at Stamford University, California, reported finding 'big renin' in the plasma of diabetic patients with nephropathy,² and in a recent article in the *New England Journal of Medicine* (1990;323:1101–6) Wilson and Luetscher show that plasma prorenin activity is raised in children who later develop retinopathy or nephropathy. They studied 135 patients in a children's diabetic clinic. Albuminuria or retinopathy began to appear from the age of 12 years. About 80% of the patients who developed these complications had raised plasma prorenin at some time and this could be found in some patients up to three years before the appearance of the complication though in others the latent interval was apparently much shorter.

There seems to be little point in measuring plasma prorenin before the age of 10. Young children have relatively high values, which gradually decline to between 9 and 12 years of age. In this study young children who initially had values above the normal limit for age had normal values on repeat testing.

Over the age of 10 a high plasma prorenin may precede microangiopathy. It remains to be seen whether attempts at better diabetic control in these patients might prevent or delay the complications.

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