Breastfeeding the Baby
with Reflux

La Leche League International
Mothers know when their babies are hurting. Sudden inconsolable crying, frequent night-waking, spitting-up, and feeding problems all send the message that something is not right. So mothers worry and wonder and talk it over with the baby’s doctor.

In recent years, pediatricians have come to believe that many of these symptoms are caused by a condition called gastroesophageal reflux (GER). This means that the muscle at the opening to the stomach, which normally keeps milk and food in the stomach until it is emptied into the small intestine, opens at the wrong times. This allows stomach contents to back up into the esophagus, the muscular tube that leads from the throat to the stomach. Adults experience reflux episodes as heartburn. In babies reflux can lead to vomiting, colicky crying, sudden waking at night, even refusal to eat.

Reflux often goes along with immaturity. Some babies with reflux symptoms may improve once they are past six months of age and outgrow the problem by one year, sometimes it takes longer. Treating reflux focuses on reducing the baby’s discomfort until his digestive system matures and symptoms disappear.

While GER seldom becomes a serious medical problem, caring for a baby made unhappy by GER is challenging. When babies fuss and cry, mothers tend to blame themselves or their milk. They lose sleep because of night-waking. Finding out that a physical problem is at the root of the baby’s misery often helps parents cope with the symptoms.

GER is less common and less severe in breastfed babies. If your baby is suffering with GER, it’s important to remember that your milk is still the best possible food for your baby. Any feeding problems caused by GER can be resolved or handled, and you and your baby will both benefit from continued breastfeeding.

How is GER diagnosed?

Once thought to be rare in infants and children, pediatricians now believe that GER is quite common. The diagnosis is usually made based on parents’ description of their baby’s behavior. Symptoms of GER vary from baby to baby, so parents and doctor have to look at the whole picture in deciding whether or not GER is the cause of a baby’s discomfort. Symptoms and complications of GER include:

- sudden or inconsolable crying,
• severe pain,
• food refusal, or seemingly constant eating and drinking,
• frequent spitting up or vomiting,
• vomiting hours after eating,
• slow weight gain,
• poor sleep patterns,
• difficulty swallowing,
• gagging or choking,
• frequent red or sore throat,
• frequent burping or hiccuping, and
• respiratory problems—asthma, bronchitis, wheezing, labored breathing, pneumonia, and apnea.

Many normal, healthy babies will have some of these symptoms without having a reflux condition. However, many babies with only a few of these symptoms have a severe reflux problem. Usually, reflux is not considered to be a problem unless the baby is really miserable or is experiencing complications from inflamed tissues in the esophagus or aspirated stomach content.

There are several tests that physicians use to diagnose GER, but the results may be inconclusive. Your own observation and reporting of symptoms are the most valuable tools your baby’s doctor has to diagnose GER.

Why my child? The majority of babies with reflux suffer these symptoms for no apparent reason. However, some children are more likely than others to have this condition. The preterm baby is often diagnosed with GER along with other problems that are a result of immaturity. Babies with other health problems—such as neurological or muscular difficulties, cystic fibrosis, asthma, and other lung problems—also frequently suffer from reflux. Many babies on apnea monitors because they are at risk for Sudden Infant Death Syndrome (SIDS) are found to have GER.

When will he get better? The onset of reflux symptoms may be gradual. Many parents report that their baby never seemed completely happy but got markedly worse around two to four months of age. Because some pediatricians lack familiarity with reflux, some babies are not diagnosed properly for a long time. The condition usually improves by baby’s first birthday. Some babies show improvement sooner, some take longer. Just as every baby is different, every baby’s experience with reflux varies—sometimes dramatically.

What are the treatment options? Parents can consider a number of options for treating their baby with reflux. Positioning the baby to be as upright as possible as much of the time as possible is usually recommended. Thickening the baby’s liquids with cereal is often recommended for even the very young baby. Doctors may suggest that a nursing mother eliminate certain foods from her diet. If none of these measures makes a difference in the baby’s condition or the baby continues to
be unhappy and suffers further health problems, the next step is to offer medications to reduce acid and help the stomach to empty faster. Surgery is a last resort, reserved for babies who show no response to other treatments and who have dangerous complications of GER.

**Breastfeeding the Baby with GER**

All parents want to give their babies the very best start. Breastfeeding remains unchallenged as the best source of nutrition for babies. Human milk has the perfect balance of protein, fat, amino acids, vitamins, minerals, iron, and calcium for human babies. Breast milk serves as baby’s first immunization, providing protection from common illnesses as well as health problems in later life. Breastfed babies have a lower incidence of ear infections, allergies, respiratory disease, gastrointestinal illness, and Sudden Infant Death Syndrome.

Breastfeeding benefits the mother, too. Mothers who breastfeed have protection from breast, ovarian, and uterine cancer that bottle-feeding mothers do not. The breastfeeding mother may also have fewer urinary tract infections as well as reduced risk of osteoporosis. Breastfeeding even helps in weight loss after childbirth.

**Breastfeeding benefits for babies with GER.** It is important to remind yourself of these benefits of breastfeeding for mother and baby. Sometimes, it is easy to become wrapped up in the reflux problem and forget about the basics. The benefits of breastfeeding are even more important for a baby with GER than for a baby not bothered by this condition.

Breastfed babies with reflux have been shown to have fewer and less severe reflux episodes than their artificially fed counterparts. Some breastfed babies with reflux have few symptoms. Human milk is more easily digested than formula and is emptied from the stomach twice as quickly. This is important since any delay in stomach emptying can aggravate reflux. The less time the milk spends in the stomach, the fewer opportunities for it to back up into the esophagus. Human milk may also be less irritating to the esophagus than artificial formulas.

One of the most important benefits of breastfeeding for mother and baby is the closeness. Loving and caring for a baby who is often miserable can be difficult. It is easy to become overwhelmed by all the special care and to become overstressed by the baby’s crying and fussing. Breastfeeding mothers get a hormonal boost that helps them cope with stress. Prolactin, the hormone that regulates milk production, and oxytocin, the hormone that triggers the let-down reflex, also provide the mother with much-needed feelings of relaxation. Breastfed babies nurse frequently, and the mother’s body responds to her baby’s nursing by making more milk. This supply and demand system helps a mother learn to respond to her baby’s needs very early. Learning to respond quickly to a baby is very important when he has reflux. He needs to know that his mother cares, even if she can’t eliminate his pain.
Laura Barmby, author of this booklet, is a La Leche League Leader in Maryland and a Board member for the PAGER Association. She and her husband, Scott, are the parents of Julia and Rex. Her experience with Rex led to her interest in the topic of gastroesophageal reflux. Here is her story.

When I brought home our perfect baby boy, I was really excited about having another baby to love and nurture and nourish by breastfeeding. In the beginning, although he went on and off the breast frequently and didn’t nurse for very long, we just attributed it to his having a different style and assumed that he would settle into a pattern soon. However, instead of becoming a better nurser, as most babies do with age, he became worse. First, he began to refuse to nurse except at night; soon he refused to nurse almost entirely. His weight gain, which had been fine before, stopped abruptly.

When our baby was four months old, I called the doctor in tears because I just couldn’t get him to eat. We talked about his nursing patterns, and the doctor said, “With the symptoms you are describing, I think your baby has reflux.”

In a few days, we went to the hospital to have some testing to confirm the reflux and how serious it might be. There are several tests used for this purpose. The one they chose for him was called scintigraphy. We brought a bottle of expressed breast milk to which a technician added a small amount of radioactive material. Then our son was placed on a table that had a camera inside which would record the passage of milk until it left his stomach. In this way, they could see if the milk returned up the esophagus and how long it took to leave the stomach. The doctors at the hospital told us that the reflux was very obvious, and our physician confirmed this.

What a relief to know that our baby’s behavior was not a result of bad parenting or breastfeeding failure! I knew now that there was nothing wrong with me, my milk, or my breasts. My husband and I reconfirmed our commitment to breastfeeding. We knew that my breast milk was the best food for our baby; we just had to encourage him to eat.

We spoke to other parents whose breastfed babies had reflux and found that, like ours, their babies had fewer complications of reflux than babies fed formula. We became committed to helping others continue breastfeeding, the best method of feeding for mother and baby. This led to our association with PAGER, an organization devoted to helping parents of children who have gastroesophageal reflux and eventually led to the writing of this booklet.
A mother who is breastfeeding learns to trust her natural mothering instincts. By continuing to nurse her baby, knowing that her milk is helping him grow and develop, the mother gains a big boost in confidence. She is the only one who can provide her baby with superior nutrition. Doctors and nurses can do many things to help a baby with reflux, but they can’t breastfeed him.

**Problems with feeding.** Breastfeeding the baby with reflux may not be an easy task. These babies are smart! They often figure out that when they eat, they have pain. Refusing to eat makes sense to them as a way of alleviating pain. Other babies with reflux find that a trickle of milk is soothing, and so they want to nurse constantly and never seem satisfied. Still others may guzzle down milk from the breast and spit much of it back up minutes after a feeding. Any of these situations can cause parents to question whether breastfeeding really is best for their baby.

However, switching to formula does not make feeding easier. For bottle-feeding, you have to have all the equipment. The formula has to be chosen. Most parents switch formulas frequently when their baby has reflux, hoping to find one that the baby will tolerate. Formula allergies are not uncommon in the baby with reflux. That means more discomfort for baby and more doctor visits and bills. Many babies end up on prescription formulas that cost a huge amount of money, and these costs are often not reimbursed by health insurance. When the baby refuses to eat, the formula has to be discarded and then prepared again later. Feeding problems persist, but now the baby is missing out on all the benefits of breastfeeding.

There is always a fresh supply of breast milk. It is extremely rare for a baby to have any allergy to breast milk. Breast milk is easily prepared: no mixing, measuring, or sterilizing. And, of course, breast milk is free!

**Breastfeeding Basics**

The basics of breastfeeding are the same for babies with reflux as for other babies, but when you have a baby with a problem, you may need to pay closer attention to how the baby is nursing at the breast. If nothing else, knowing that your baby is nursing well will reassure you that breastfeeding is right for your baby. And a good knowledge of the basics of breastfeeding will help you analyze and solve any problems that might arise.

Although breastfeeding is a natural process, it may not come naturally to new mothers. Today’s women don’t grow up watching other women nurse their babies, so they may feel awkward at first. Breastfeeding is a learned art. Like all other arts, it may take some practice before both mother and baby become adept.

**Positioning.** How a newborn is positioned at the breast is very important in preventing sore nipples as well as ensuring that the baby milks the breast effectively. How you position a baby with GER at the breast may also help the milk stay in his stomach. There are many options from which to choose when positioning your
baby at the breast. As your baby gets older, the details of positioning will come naturally, and the two of you are sure to have a favorite (maybe unusual) position.

Many mothers find the traditional cradle hold to be the easiest. The mother sits up, perhaps with a pillow behind her back for support, and holds the baby’s head in the crook of her elbow, with her hand holding the baby’s buttocks or thigh. The baby should be lying on his side, facing in toward the mother. He should not have to turn his head to take the breast, and his mouth should be right at nipple level. It might take two or three pillows to get him to the proper height. For a baby with reflux who has problems with choking during feedings, the mother might modify this position by leaning back slightly, supported by pillows, so that her breast is angled up and the baby’s neck and throat are a little higher than the nipple. A baby with reflux may have fewer problems with keeping the milk down if he is held somewhat upright during feedings, well supported on mother’s arm or with firm pillows.

Many mothers have found that nursing lying down is comfortable for them and their babies. When the baby has reflux, you might want to try lying on your back with the baby on top of you, tummy to tummy. This position is usually more comfortable if you are in a reclining position as opposed to flat on your back. The baby nurses with his face down into the breast. This position can help if the baby reacts strongly to the milk ejection reflex or if the baby gags or chokes. If you are nursing lying down side-by-side with your baby, elevate his head on your arm while he nurses. Use a pillow behind your lower back so that you can angle your body slightly away from your baby to get the nipple at the right height.

You may want to try nursing while standing up and walking around. Sometimes the motion will calm a fussy baby or distract a reluctant eater into taking the breast. A sling or front carrier for the baby may help. Make sure that the baby is positioned so that he is not bent in the middle and does not have to turn his head or strain to reach your breast.

As you have probably guessed by now, there are as many nursing positions as there are nursing couples. So be creative; find what works for you two.

**Latching on.** It is important to make sure that the baby is latched on to the breast properly when nursing. An improper latch-on means that the baby cannot get enough milk and the mother may get sore nipples. You should support your breast while the baby nurses with your thumb on top, fingers underneath. (This is necessary with newborns, though less needed as baby grows.) The baby should open his mouth very wide, like a yawn, when taking the breast. To get the baby to open wide, try tickling his lips with the nipple. Wait for him to open wide and when he does, quickly pull him into the breast. He should have a large portion of the areola in his mouth. His lips are flanged out and relaxed, and his tongue is cupped beneath the areola. If the baby will not open wide enough, you can open his mouth wider by gently but firmly pulling down on his chin with the index finger of the hand supporting the breast.
When a baby is latched on and sucking well, you will see a “wiggle” in front of his ears as he moves his jaw to suck. After your milk lets down (some mothers notice a tingling in their breasts, others don’t feel anything), you should hear the baby swallowing after every one or two sucks. In most situations, it’s best to let the baby decide when he’s had enough milk from one breast and is ready for the other.

**Frequency.** Most breastfed babies are not shy about letting you know when it’s time to nurse. But when reflux complicates feeding, mothers may have to do some reminding. The baby should be feeding at least every two to three hours during the early weeks, or eight to twelve times a day. Wake the extra-sleepy baby to nurse if necessary.

The baby should nurse well and long from one or both breasts during each feeding. Watch the baby’s sucking. If the baby is sucking and swallowing effectively, let him finish that breast. If he is not sucking or swallowing well, you may try switch nursing to encourage him to nurse longer. This means switching breasts several times during the feeding whenever the baby stops nursing well. Make sure that you hear ten to twenty minutes of sucking and swallowing during each feeding. It is important for the baby to get the calorie-rich hindmilk, which comes at the end of each feeding. The hindmilk is responsible for a good part of the baby’s weight gain.

**Getting enough.** Many parents wonder how to tell if their baby is getting enough breast milk. An easy way to make sure the baby is getting enough fluids is to count wet diapers and bowel movements. At least six wet cloth diapers or five wet disposable diapers a day are a sign that the baby is getting enough fluids. At least two to five bowel movements a day should be seen in the breastfed baby younger than six weeks. When the baby gets older, frequency of bowel movements may vary. A breastfed baby’s stool should be yellow to yellow-green to tan in color and loose and unformed in consistency. Green, watery stools are a sign that the baby may not be getting enough hindmilk, the high-fat, calorie-rich milk that comes at the end of each feeding.

Breastfed infants can gain at a different pace than their formula-fed counterparts, so weight gain, although important, is not the only way to be sure the baby is getting enough. In breastfed babies weight gain slows around four to six months of
age. In the second half of the first year, breastfed babies are often a bit leaner than formula-fed infants, although weight gain is highly individual.

Sleepytime. Your baby’s naptime can be the best time to get a little extra milk into his body. If you lie down with him to nurse, you’ll get some extra rest, too. Don’t overlook night feedings, either. If the baby wakes frequently to feed, it may be the silver lining in an otherwise dark cloud. Babies with reflux tend to wake more often, so take advantage of this opportunity to nurse your baby.

Many families choose to keep their breastfeeding baby in bed with them to make nighttime feedings easier. This can mean more sleep for the entire family, not just mother. Many women can fall right back to sleep after their baby begins to nurse. A recent study found that babies who sleep with their mothers nurse almost three times as often as do babies whose mothers are in adjacent rooms. This can be a real help in getting a reluctant nurser to eat more. Night-nursing may also help to soothe the baby who wakes frequently. You’ll get more rest by nursing this baby in bed than you would getting up to walk him back to sleep.

Positioning the baby for sleep is perhaps the most troubling aspect of caring for a baby with reflux. If your doctor has recommended that your baby sleep in an inclined position, you may want to explore your options. Many breastfeeding mothers enjoy having their baby sleep with them and nurse during the night. Your doctor may recommend that the baby sleep in a crib with the mattress elevated to a 45 degree (or greater) angle. You could move the crib next to your bed, remove the legs or casters, and lower the height of the crib so that when elevated, the baby’s head is at the same level as your mattress. In this way, you would be able to comfort and nurse the baby more easily. Or you may decide that you’d like to try having your baby sleep in your bed, even if this means the baby sleeps flat on the mattress rather than in an inclined position. Your doctor may agree to let you experiment with different sleep options for a week or two to see what makes a difference for you and your baby.

Overcoming Common Challenges

There can be some unusual challenges to breastfeeding the baby with reflux. One of the greatest difficulties a mother faces is that her baby is so unhappy. It is important to have good support for your family and yourself when things get stressful. When caring for the baby becomes trying, ask a friend, family member, or neighbor to come in and help—by starting (or even bringing) dinner, for example, or watching the baby while you take a nap or a relaxing soak in the tub. If you take care of yourself, taking care of the baby can be a little less overwhelming.

The reluctant nurser. Reflux typically causes pain when the infant eats. It is no surprise, then, that some babies with this condition often don’t want to eat. There are many ways to coax a baby to nurse:
• The first step is to make the baby as peaceful and calm as possible. You can start by finding an area that is free of distractions. A dark, quiet room can help.

• Give the baby lots of skin contact and extra cuddling. Strip the baby to his diaper and remove your shirt while nursing. The baby may respond well to this extra touching and warmth.

• Try nursing when the baby is sleepy, either at naptime or bedtime. You can even nurse the baby while he is sleeping. Many breastfed babies with reflux nurse well when sleeping because their reflux seems not to bother them as much. (Babies fed formula tend to have more severe reflux at night.)

• Learn different positions to nurse. Lying down is a good start if you are going to feed when the baby is sleepy; that way, you can get extra sleep, too.

• Some babies enjoy nursing while you are standing or walking around. A baby sling is very helpful; it allows you more freedom by keeping your hands free and can help baby stay in the upright position.

• Some babies love a bath. Try taking your baby into the big tub with you and nursing there.

Not all of these hints will help all babies with reflux. Try several until you learn which ones work for you and your baby.

It is very important to keep in touch with your baby’s doctor during severe cases of food refusal. If you and the doctor decide that the baby needs a supplement, try not to be discouraged. It is usually only a temporary measure until the baby is doing a little better. A supplement does not have to be formula given in a bottle! You make the best supplement in your breast milk. You can pump at the end of each feeding to obtain the rich hindmilk and use that as a supplement.

You can give the extra milk by cup, syringe, spoon, or a nursing supplementer (a device that allows supplements to be given through a tube while the baby sucks at the breast or on a parent’s finger). You don’t have to use an artificial nipple. Some breastfed babies will refuse a rubber nipple. Very young babies can become nipple-confused if they are given rubber nipples. This means that they try to use their bottle-feeding technique on the breast. This doesn’t work, and they have to be re-taught how to breastfeed.

**Poor weight gain.** Poor weight gain often goes hand in hand with food refusal. Keep track of the number of wet diapers and the number of bowel movements your baby has each day. This can be helpful in determining that the baby is getting enough to eat.

You should be nursing frequently and letting the baby finish one breast before switching sides, if possible. If the baby seems to lose interest or is easily distracted, you may need to switch sides repeatedly during each feeding to make sure that he does get a good amount of milk from at least one breast during each feeding.

When weight gain needs to be checked often, there are scales available for rent
that not only show a baby’s weight gain but also determine the amount of breast milk he is getting at each feeding. All cases of poor weight gain should be followed by a physician.

**Frequent feeders.** Some babies with reflux may want to breastfeed often, even constantly, because the milk acts as a natural antacid and suckling itself can be soothing. However, if the baby overfills his stomach capacity, reflux symptoms can worsen. In this case, it may be helpful to limit nursings to one breast for a two to three hour period before switching to the other side. This way the milk flows more slowly, the baby won’t overfill his stomach, and he’ll swallow less air, especially as the milk lets down. Gentle but thorough burping will also help this baby keep his milk down.

**Sore nipples.** Sore nipples can be a problem for a mother who is breastfeeding regardless of whether her baby has reflux. When the baby is on and off the breast as frequently as most babies with reflux are, many mothers do get sore nipples. Two factors usually cause sore nipples: incorrect positioning at the breast and poor latch-on. Pay close attention to these every time you put the baby to breast. If you are unsure that your technique is correct, have someone help you. Your local La Leche League Leader or a friend who has nursed a baby are good choices. Using Lansinoh® for Breastfeeding Mothers can relieve pain and help your nipples to heal. (See listing at the end of this booklet.) Expressed milk applied after each feeding can also help.

By all means, continue to nurse even if your nipples are sore, and do not limit the time your baby nurses. Newborns need to nurse 10 to 12 times in a 24-hour period. Most sore nipples are caused by poor latch-on, and cutting back on breastfeedings will not improve a baby’s ability to nurse. (Of course, cutting nursing time could also cause problems for the baby from not getting enough milk.) Avoid nipple shields; they can contribute to a nursing problem and lead to decreased milk supply. It should not hurt to breastfeed. If you are having problems with sore nipples, talk to a La Leche League Leader or someone else knowledgeable about latch-on and sucking difficulties.

**Vomiting.** There are often many clues that a baby may be having a problem with reflux. Food refusal and general unhappiness can be attributed to many different things. Poor weight gain can result from a variety of causes. The clue that often leads some doctors to suspect reflux is severe vomiting that does not improve. Almost all babies spit up to some degree. Severe vomiting is so unpleasant to most parents that this is the most frequent complaint doctors may hear about babies with reflux.

When you have a baby who vomits frequently, try feeding small amounts at each feeding and feed more frequently so that the baby is not ravenous. If the baby will stay on one breast for a sufficient time, the mother can use one breast per feeding. Burping can really help to cut down on vomiting. Not all babies with reflux vomit.
Vomiting may be more frequent if the baby has a problem with delayed emptying of the stomach. Breast milk is digested easily and in half the time of formula, so this is one situation where breastfeeding’s benefits are clear.

**Can pacifiers help?** For some babies with GER, pacifiers may be helpful. For other babies, pacifier use could be a disaster. Confused? Read on.

Some babies with reflux do not have a problem with food refusal; they eat and eat and eat. These babies find nursing to be soothing because each sip of milk washes down some acid from reflux. The problem may be that they continue to nurse long past the time they need to fill their tummies. They nurse to the point that they seem to vomit every time they eat. If this description fits your baby, pacifier use may be a help. If the pacifier is given when the baby is not nursing for food (sucking slowly and less frequently, not a lot of swallowing), it may be soothing to him and a relief to you. The careful use of a pacifier may help your baby keep from overfilling his tummy and subsequently vomiting.

If your baby does not want to nurse and getting him to eat is a battle, forget the pacifier. All soothing for this baby should be at the breast. Any use of a pacifier means the baby is spending that much less time at the breast. The lack of time at the breast may also affect your milk supply.

Pacifiers should never be used until breastfeeding is well established. Well established means the baby nurses well, the mother’s milk supply is adequate, there are no other problems associated with sucking, and the baby is several weeks old.

**Treating Reflux**

Treatment for reflux aims to help the baby be more comfortable and to lessen the opportunities for reflux episodes to occur. Your doctor will have some suggestions for you to try. It’s up to you to observe your baby and decide which techniques are helpful.

**Tracking down possible allergies.** When reflux is suspected, the doctor may suggest that the mother eliminate some foods from her diet, since allergies are a possible cause of reflux problems. Sometimes there is an improvement in the baby’s condition, but in many cases there is no improvement. The only way to test for a possible allergy is to eliminate that food from the diet for two to three weeks and see if symptoms disappear. If an improvement is noticed, the mother can then reintroduce suspect foods one at a time to her diet. A reaction can take as long as 10 days to occur. This can be a long process, and it is important that the mother maintain adequate nutrition at this time.

If an allergy is found in the baby, then it is advisable to delay introduction of solid foods as long as possible to avoid further problems. Foods which may cause allergic reactions can include eggs, dairy products, oranges, tomatoes, fish, peanuts,
corn, wheat, and soy. Some mothers have also found that eliminating caffeine, nicotine, and artificial flavorings and preservatives is helpful.

**Positioning.** Most doctors who suspect reflux in an infant will recommend that the baby be positioned upright in hopes that gravity may help lessen reflux. This may make a difference for some babies. It is often recommended that the baby be kept in a vertical position immediately following feeding and as frequently as possible.

Some baby seats and car seats can make the baby uncomfortable and aggravate reflux because they bend him in the middle and put pressure on the stomach. A baby seat or car seat may not offer enough support to keep a young baby in the ideal upright position. A good alternative is to use a front carrier, a sling, or (for older babies with good head and neck control) a backpack. As an added bonus, babies who are held more generally cry less.

**Thickening.** Another common recommendation is that parents thicken the liquids that their baby receives by adding cereal to the bottle. The theory is that thick food has a harder time bouncing back up the esophagus, but research has not proven this to be effective. You should be aware that giving bottles of thickened milk, even thickened breast milk, can interfere with breastfeeding. If you and your doctor decide this is worth a try, you may want to do it only on a trial basis to see if there is any improvement in your baby’s health or demeanor.

In order to avoid using a bottle, try offering your expressed breast milk with the added thickener by spoon or cup.

**Medications.** When changes in positioning or feeding don’t seem to help, medication can be used to lessen problems with GER. Some of the medications commonly used lessen the amount of intestinal gas or neutralize stomach acids. Others cause the stomach to empty more quickly. Your report on how well a medication works will help your doctor decide on the best course of treatment for your baby.

A cautionary word about medications: Many babies with reflux are on multiple medications. It is important that the parents keep accurate records so that everyone involved in caring for the baby is kept up to date. Write down the name and exact dosage of any medications prescribed for your child. Also write down the strength of the medication as some medications have different concentrations. Be sure to check your information against the prescription label every time you have a prescription filled. Dosages of reflux medicine for children are often unfamiliar to pharmacists, and handwriting can be misread. It is also vital that you be aware of possible drug interactions. Check with your doctor or pharmacist before adding a new prescription. Make sure everyone who cares for your child’s health is aware of all the medications that your baby is taking. Also check with your doctor before giving any over-the-counter medication. Finally, as a breastfeeding mother, if you are prescribed a medication, check with the baby’s doctor before taking it. There may be possible concerns about drug interaction with the baby’s medication. Many doctors are unsure about the effects on babies of medication given to breast-
feeding mothers. For more information about drugs in breast milk consult a La Leche League Leader. She can give you references to share with your doctor.

**Testing and hospitalization.** If reflux is causing serious problems for your baby, it may happen that your baby has to be hospitalized or may have to undergo testing at the hospital. If handled properly, the disruption to the breastfeeding relationship can be minimized. Inform the medical team of the importance of breastfeeding to you and your child. Try to stay with your baby the whole time he is hospitalized. Your presence is very important to him in this frightening, new environment. Even if you can’t nurse him, you can pump your milk, and it may be possible to give him this expressed milk in connection with various tests for GER. Pumping is also important to maintaining your milk supply.

Most tests can be done without discontinuing nursing. Nuclear medicine tests where the baby is given a radioactive isotope in milk can be performed using expressed breast milk. If these tests are necessary, it can help to bring someone with you—not only for moral support, but to coax the baby to take the bottle if he has not had a bottle previously. A cup or spoon could also be used to administer the necessary dosage.

If surgery is called for, the requirements for fasting are different for breastfed babies than for formula-fed babies. In many cases, three hours is considered adequate fasting time prior to surgery for the breastfed baby. For more information on caring for a breastfed baby in the hospital, see *Babies and Children in the Hospital*, listed in the Resources.

**Communicating with Your Baby’s Medical Team**

It is important to set up good lines of communication between your family and your baby’s doctors and nurses. Treatment of reflux can be difficult. Some babies respond well to certain measures that have no apparent benefit to other babies. Sometimes the parents and doctors have to go through many different treatment options to see an improvement. Sometimes the baby outgrows the problem before a good treatment option is discovered. It is important to set goals for your baby’s treatment, and all involved should be working toward the same goals. When your doctor plans a course of treatment, be sure to ask, "What do you hope to accomplish by doing XYZ?" You may also want to set up a time frame for treatment. You might ask, "If XYZ treatment is going to make a difference for our baby, when could we reasonably expect to see an improvement?"

If you feel uncomfortable about a particular step in your baby’s treatment, please tell your doctor. He or she may be able to alleviate some of your concerns or explain other options to you. You are also within your rights to get another medical opinion before your baby undergoes any treatment or invasive testing procedures.
Your doctors want to help you and your baby. Sometimes, though, their suggestions can disrupt the breastfeeding relationship. Continue to remind them of the importance of breastfeeding to you and your baby, both for emotional reasons and for the health benefits. When your medical team makes suggestions that help you continue to nurse your baby, thank them! When they give advice that works well for you, let them know. They may then feel more confident about suggesting the same thing to another family.

If you have questions before an appointment, write them down. It is very easy to forget even an important question when you are getting new information about your baby’s condition. It may be helpful to bring another adult with you so that someone can write down the doctor’s instructions while you hold and care for your baby.

When you involve yourself as much as possible in your child’s treatment, several things are likely to happen. You will gain the respect of your child’s medical team. When they know that you have a good understanding of his condition and his treatment, they will listen more to what you may say about any problems. They will know that they are talking to an informed parent, not a hysterical one. It also empowers parents to be involved in the decision-making process of their baby’s treatment. When you are involved, you can reassure yourself that you are doing the best for your baby. You may not be a physician, but you are the expert on your baby.

Help for Stressed-Out Families

It is important to get as much help and support as possible for your family when going through the stresses of dealing with an unhappy baby. It is very easy to become so involved in the care of the baby that the outside world disappears. The whole family may suffer when a baby has reflux. Moms and dads are on an emotional roller coaster, and they may not be getting much sleep. Brothers and sisters not only have to cope with having a new baby in the house, but this baby gets so much attention that everyone else’s needs may take a back seat.

Solutions to these stresses are available, but you have to seek them out. Many people won’t be aware of what you are going through if you don’t tell them. Be specific! Tell friends and relatives how your whole family is upset by the difficulties of having a baby with this condition. Ask for specific help. A big relief for you might be having help with meals, so that you don’t have to worry about what’s for supper while you’re trying to care for and comfort a hurting baby. Groups of friends may be able to arrange to bring meals to you on a regular basis. You will find that people want to help you if you can just get up the nerve to ask. Neighbors might be able to come sit with your baby while you take a shower or a much-needed walk to clear your head and remind yourself that there is still a world out there.

It can be easy to isolate yourself when your baby has reflux. Don’t! If your baby vomits a lot with reflux, make sure you have plenty of towels and changes of
clothing for you and him, but do get out of the house and do the things you would normally do. A change of scene may be good for both of you. For example, my son loved to be outside, so we spent many afternoons at the pool. He would sit in his stroller or car seat and watch all the other kids playing and be happy. This also helped my daughter, who was two at the time, because she could play and I could play with her. Get a baby sling and head for the zoo or aquarium or anywhere else that sounds like fun. It may be a little more difficult planning these trips, but enjoy each moment as best you can.

One of the most important things for me was to try to maintain a positive attitude. Many people did not realize the turmoil that my life was in because I refused to let it pull me down into whining and complaining (well, at least on most days). I would always say to myself, "It could be worse. At least my baby has good health other than reflux. He has all his fingers and toes, he has a sweet disposition when he is not in pain, he has a terrific smile, and he is going to get better. This will not last forever!"

Remember that last point above all. Your baby will get better. In most cases, he will be better in a year; in other cases, well before two years. Rarely does reflux last beyond a baby's second birthday. One day, I hope that reflux will be just a memory for you, as it is for our family.
Where To Find Help

The following is a list of organizations where you can go for help and publications/products that may be helpful to families.

**La Leche League International**
P.O. Box 4079  
Schaumburg, IL 60168-4079 USA  
phone (847) 519-7730 or (800) LA LECHE  
fax (847) 519-0035  
www.lalecheleague.org  
The world resource on breastfeeding. Books, tapes, and pamphlets on breastfeeding and related topics. Also home of the Center for Breastfeeding Information, which has just about anything ever written on the subject of breastfeeding in medical journals and other professional publications.
LLL is an international breastfeeding support organization with a network of local accredited Leaders who are able to assist with breastfeeding. Call for a free copy of the LLLI Catalogue and referral to a local Leader.

**International Lactation Consultant Association**
1500 Sunday Dr., Suite 102  
Raleigh NC 27607 USA  
phone (919) 861-5577  
fax (919) 787-4916  
www.ilca.org  
They can refer you to a local lactation consultant.

**Pediatric/Adolescent Gastroesophageal Reflux (PAGER) Association**
P. O. Box 486  
Buckeystown, MD 21717 USA  
(301) 601-9541  
www.reflux.org  
PAGER Association is a national organization that provides information and support to families whose children have reflux. They have brochures, hold monthly meetings, and publish a monthly newsletter.

**Publications**


**Lansinoh® for Breastfeeding Mothers**

Provides soothing relief and accelerated healing for sore nipples. Created especially for nursing mothers,

Lansinoh® is the world’s purest lanolin. Does not have to be removed prior to nursing. Available from La Leche League International, local LLL Groups, and many drug stores.