

338 Pregnant Woman Currently Breastfeeding

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Definition/Cut-off Value

Pregnant woman who is currently breastfeeding.

Participant Category and Priority Level

Category	Priority
Pregnant Women	1

Justification

Generally, it is considered safe for most women to continue breastfeeding while pregnant and can be sustained for as long as mutually desired by the mother and child (1). The assignment of this risk is not intended to discourage women from continuing breastfeeding during pregnancy, but rather to highlight the need to review the mother's medical history and diet along with her breastfeeding goals.

Incidence rates of breastfeeding while pregnant among U.S. mothers have not been reported recently. The National Health and Nutrition Examination Survey (NHANES) III indicated that between 1988 and 1994 only 5% of North American breastfeeding women were pregnant (2).

Research on breastfeeding during pregnancy, especially among U.S. populations, is very limited; however, some studies have examined the relationship that this practice has on birth outcomes, such as preterm delivery, miscarriage, and birth weight. During breastfeeding, stimulation of the nipples causes the secretion of the hormone oxytocin, which can result in contractions of the uterus (3). It has been suggested that these contractions may induce labor and therefore increase the risk of delivering prematurely in some women; however, this is not a concern for the typical low risk pregnancy (1, 4, 5). In a small retrospective study of 57 U.S. mothers with an unknown previous pregnancy outcome, most did not notice any uterine contractions specific to breastfeeding. The women that did notice uterine contractions specific to breastfeeding gave birth to healthy babies (6).

Studies of pregnancy-breastfeeding overlap among women with a history of preterm delivery or miscarriage are presently lacking in the scientific literature. As a result, these women should be encouraged to talk with their health care provider about their breastfeeding goals and report any uterine contractions (1). For more information on premature delivery, see risk #142 Preterm or Early Term Delivery or risk #311 History of Preterm or Early Term Delivery.

Several studies of pregnancy-breastfeeding overlap have been conducted with women without a history of preterm labor or miscarriage, and no statistically significant increased risk of premature delivery were reported (7, 8). One retrospective study compared the outcomes of pregnancies in mothers with no history of premature delivery or miscarriage that had one full-term infant and continued breastfeeding during pregnancy to a control group of comparable age and pregnancy history that stopped breastfeeding at least three months before becoming pregnant. Fewer pregnancies (7.3%) in the breastfeeding group resulted in spontaneous

abortion than the control group (8.4%) (7). In a systematic review of all of the relevant literature published between 1990 and 2015, none of the studies reviewed reported significant differences in the numbers of premature births between pregnant mothers who breastfed and non-breastfeeding pregnant mothers, even when breastfeeding duration, the number of feedings, or birth interval were controlled for (9). These results provide evidence for continued support of breastfeeding during pregnancy for mothers with no previous history of preterm labor or miscarriage.

Several studies have also examined the effect of breastfeeding during pregnancy on the birth weight of the infant. These studies reported similar mean birth weights between infants born to mothers who breastfed during pregnancy and those who did not. (5, 8, 10, 11)

When a woman is pregnant or breastfeeding, she has a higher need for certain vitamins and minerals and may have greater caloric needs as well. The same is true for a woman who is pregnant while breastfeeding. It is important to note that caloric needs must be individualized based on current weight, physical activity, and recommended maternal weight gain for weight status (i.e., underweight, normal weight, overweight, or obese). For more information about maternal weight gain, see risk #131 *Low Maternal Weight Gain* or risk #133 *High Maternal Weight Gain*.

Implications for WIC Nutrition Services

WIC staff can support pregnant women who are breastfeeding by:

- Considering personal feelings about breastfeeding while pregnant as well as personal breastfeeding goals with the currently breastfed child.
- Referring mothers who have a history of premature labor or miscarriage and those who are concerned about uterine contractions to their health care providers.
- Providing nutrition education that supports an overall healthy diet, including:
 - Limiting calories from added sugars and saturated fats.
 - Choosing a variety of fruits and vegetables, whole grains, and fat-free or low-fat dairy products.
 - Eating protein-rich foods such as poultry, fish, beans, eggs, nuts, and lean meats. Pregnant women, including those who are breastfeeding, should avoid eating shark, swordfish, king mackerel, or tilefish due to concern for high levels of mercury. White (albacore) tuna should be limited to no more than 6 ounces per week (12).
 - Drinking plenty of fluids. During breastfeeding, fluid needs may increase, and mothers may notice that they are thirstier than usual. Women should drink enough water and other fluids to quench their thirst. A common suggestion is to drink a glass of water with every breastfeeding session (13).
- Monitoring weight status throughout the pregnancy to ensure appropriate weight gain.

- Providing tips for reducing nipple soreness or breast tenderness if women report these concerns. Hormonal changes during pregnancy lead to nipple soreness and breast tenderness in some women (3).
- Informing women that the older child that is breastfeeding may notice some changes in the human milk and wean on his/her own. Although human milk continues to be nutritionally sound throughout pregnancy, the composition of it may change, which might change the way the milk tastes. For some women, their milk production may also decrease as their pregnancy progresses. These factors can lead the breastfeeding child to wean on his/her own before the baby is born. (1)
- Issuing Food Package VII to the mother until her older infant turns one, as long as she is partially (mostly) breastfeeding.
- Providing anticipatory guidance on tandem nursing, which is the practice of breastfeeding two or more children of different ages at the same time. This may ease the older child's adjustment to the new baby, address the mother's own desire to maintain closeness with the older child, and even make child care easier in some cases as both children are fed and comforted on the breast. This may also allow the mother and children to fulfill the American Academy of Pediatrics' recommendation to continue breastfeeding for as long as mutually desired by the mother and child (14).

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Minnesota Department of Health - WIC Program,
85 E 7th Place, PO BOX 64882, ST PAUL MN 55164-0882;
651-201-4444, health.wic@state.mn.us, www.health.state.mn.us; to obtain this information in
a different format, call: 651-201-4444