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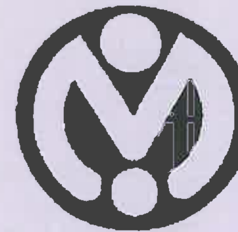

New Zealand College of Midwives [Inc]

NEWSLETTER

Volume 4, Number 1 : August 1991

Restructuring

AGM

Drugs and Breast Feeding

- **How long will you need to take this drug?** Any drug to be used long term (weeks or months) must be evaluated thoroughly. Some doctors believe that if a drug has been taken throughout pregnancy, it will cause few problems during lactation; others believe that such long-term exposure may compound matters.

- **Does your family have a history of allergy to this type of drug?** Try to avoid drugs that have caused an allergic reaction among immediate family members. Also remain alert to the possibility of a non-inherited allergy or sensitivity. A mother and father who are not sensitive to penicillin can have a baby who is.

- **Is a quick-acting form of the drug available?** If so, this may be the drug of choice. A longer-acting form can require your baby's liver to work harder and may accumulate in the baby's system.

- **Can you take the drug immediately after nursing?** In most cases, this will allow the drug to reach its peak point and begin to decrease before the next feeding, thereby exposing baby to the lowest possible concentration. Be sure to ask about the onset and duration of the peak period, and try to avoid nursing during this time.

- **What side effects have been seen in babies who have ingested this drug?** Even after deciding on a safe drug, be on the lookout for possible side effects. If baby becomes sleepy or listless, nurses less often, acts fussier than usual, or develops a rash, diarrhea, or vomiting, contact your practitioner and see about changing either the dosage or the medication.

- **What is the shortest period required for taking this drug?** In general, the sooner you can discontinue treatment, the better for all concerned. Nevertheless, many women have breastfed successfully while on extended drug therapy.

- **Will the drug affect your production of milk?** Some drugs decrease the milk supply, and others inhibit the let-down reflex. If a medication is needed, try to find one that will not interfere with the physiology of breastfeeding.

- **Can you switch to a different drug with fewer side effects?** In many cases, your healthcare provider will be able to suggest an option that poses fewer risks to baby. In every instance of prescription, you can at least *ask* about other possibilities.

FROM THE BOM

We have completed our first year. It has been a lot of fun and hard work and we have learnt a great deal about many things. It has been especially rewarding making contact with so many members throughout New Zealand. Thank you for your support.

NEWS & VIEWS

AGM

The AGM took place at Wellington Polytechnic on 2nd August. It was wonderful to see so many from throughout the country, to catch up with old friends, and to see lots of newer midwives supporting their College.

The Annual Reports illustrated how much has been going on in the College.

A number of remits suggested changes in the NZCOM structure. It was decided that restructuring would be looked at comprehensively at regional level.

Maori Nurse Joins National Committee

It was with great pleasure we welcomed Mina Timu Timu onto the National Committee to represent Maori nurses. Mina is a midwife at Taranaki Base Hospital. We look forward to this new partnership.

Mina will be working on our bicultural workforce project. Kia ora.

Goodbye to National Committee Members

We have seen a number of changes at National Committee:

Kathy Glass – Wanganui/Taranaki
Angela Kennedy – Nelson
Suzanne Johnston – Otago
Anne O'Connor – Canterbury/West Coast

molecules can be bonded and passed from the body. Any molecules not broken down in this way may accumulate and cause toxicity. Another complication might arise: in the process of utilizing most of its protein sites for drug metabolism, the newborn's liver may not be able to break down the bilirubin that also needs to be processed. The resulting amounts of bilirubin can be unusually high and may cause jaundice. Drugs such as acetaminophen (Tylenol, Datril, and Anacin) have been shown to displace the breakdown of bilirubin.[6] Even drugs that are safe during pregnancy, when the mother's body is processing them, may not be safe during the early days of lactation, when the baby's liver must break them down on its own.

Age plays a major role in a baby's ability to metabolize drugs. Premature babies with immature digestive systems may have too few liver enzymes and other detoxifying agents to successfully break down and excrete drugs from the body. Many full-term newborns are still not mature enough to metabolize drugs. After one month of age, some babies can effectively handle certain types that they could not assimilate earlier, especially sulfa medications.[7] Older babies, who ingest greater amounts of breastmilk (and possibly drugs), are better prepared to metabolize many of these substances. Later, with the introduction of solids, breastmilk will comprise a smaller part of baby's diet, and the percentage of drug intakes will likewise decrease.

The impact of a drug also hinges on whether it is fat soluble or water soluble. A mother who knows how a particular drug dissolves can adjust her baby's feedings accordingly. Drugs that bind to fats are usually passed along to baby both as a feeding progresses and in the middle part of the day. In other words, the fat content in milk increases as a feeding goes on; it also increases from morning to midday, and then drops off toward evening. A mother taking a fat-soluble medication can reduce the duration of feedings and nurse less at midday; baby can be satisfied with more frequent nursings at other times of the day. Conversely, a drug that is water soluble tends to appear in the earlier skim portion of the milk. In this case, a mother can express a small amount of milk before feeding her baby.

The solubility factor varies among different medications in the same drug family. For example, the barbiturates pentobarbital and secobarbital are

of this a General Meeting of ASIM stated that complete and credible statistics on home birth do not exist, and refusal to supply statistics is based on concern about the methods in which statistics are collected, analysed and presented. ASIM also requested that these statistics be subjected to an independent assessment before publication in AMJ. Dr John Stevenson feels that the situation is serious enough to consider a court injunction to prevent publication. Publication of this "stubborn anti-midwife attack" will result in these statistics being quoted for decades to come by anti-home birth obstetricians and statisticians.

Henny Ligtermoet claimed that using PNMR as an assessment tool sucked home birth back into the medical/hospital system. She quoted Professor Alfred Rockenschaub of Vienna who refers to the manipulation of statistics by perinatologists. She also had a letter from Dr Kathy Mead, Secretary of Health Care Committee of NHMRC and convenor of the Homebirth Guidelines Working Party, which quoted from the 1987 NHMRC Report:

> "It is highly unlikely that an appropriately controlled study of home births with sufficient statistical power to unequivocally answer questions of relative safety of home birth versus hospital birth could ever be carried out."

In addition to this study there was a 'study' in S.A. of 802 home births over a period of 11 years, 1976-1987, involving five GP's and 11 midwives. Over this period there were 11 PN deaths (and 2 SIDS). However, sinced 1987 there have been no further PN deaths; also these were compared with the average of PN hospital deaths, 1982-1984, when perinatal mortality was lower than in the 1970s. Furthermore, there were more than 300 home births during the survey period which were not included, apparently these statistics were lost!

Midwives were also upset that Hilda (in HBA Newsletter No 27) correlated PNMR with long-term morbidity. Judith Lumley who spoke on 'Understanding and Interpreting Homebirth Statistics' refuted this as an "inappropriate" concept first floated by some bloke named Nixon (not the ex-USA President).

in conjunction with other drugs or with specific foods, and that the same dosage may have different effects on people of different weights and metabolic rates.

Many variables affect the passage of drugs into breastmilk. For one, their level of concentration depends on how they enter the mother's body. Drugs administered intravenously enter the bloodstream directly and appear highly concentrated, whereas those administered orally or intramuscularly take longer to reach the bloodstream and, in the process, become more dilute. Drugs that are less highly concentrated in the bloodstream are usually less highly concentrated in the breastmilk.[2]

For another, some drugs bind to proteins in the mother's blood system, whereas others do not. Among those that do, some portion of the drug attaches to protein cells, while another portion remains freely circulating. Only these free-circulating molecules can pass through into breastmilk. The protein-binding capacity of a drug thus limits to some degree the concentration that baby receives.[3]

Various other characteristics of a drug determine just how much of it might be passed along to baby. For example, highly alkaline drugs (those with high pH values) pass into the milk at higher levels than do more acidic drugs (those with lower pH values). And drugs composed of large molecules, such as insulin and heparin, are unable to enter the milk supply at all.[4]

Dosage, frequency, and timing often come into play. Higher doses of a drug and higher frequencies of administration may transfer greater concentrations into the milk supply. It is important to realize that each drug has a certain *peak-effect level*, a point at which its action - and its passage into the breastmilk - is maximized. Beyond this point, the drug's effectiveness subsides, as does its level of concentration in the milk. To evaluate the peak effect for any particular drug, one must discover how long it takes to reach its peak point and how long lasting its peak period is. With this information, a nursing mother can reduce her baby's exposure to the drug by coordinating feeding times with nonpeak periods of drug activity.

From Cot Death Prevention Programme Dept of Health 1991

For the first time there is solid evidence on which to base intervention to prevent SIDS.

HOW MIGHT THESE CHILDCARE PRACTICES INCREASE THE RISK OF SIDS?

SLEEP POSITION AND COT DEATH

Several groups of both New Zealand and overseas SIDS researchers have suggested that babies who sleep on their front during infancy are at increased risk of SIDS. Studies in Australia(6), Hong Kong(7), France(8), Netherlands(9) and the UK(10) have made observations very similar to our own. However, apart from the recent study from the UK many studies did not look at position babies were put down to sleep as compared to position found dead. Most have not taken into account possibly confounding factors such as socio-economic variables and birth weight in their analysis. Data from the New Zealand Cot Death Study strongly suggests that babies that sleep on their front at the vulnerable age of SIDS are at much higher risk and that this effect does not disappear when possible confounding factors are taken into account.

Why might prone sleeping be dangerous for infants?

The main risks attributed to prone sleep position relate to risk of upper airway obstruction, especially in combination with the infants becoming too hot. At two to three months of age babies when they lift their heads while lying prone are more likely to put their head face down instead of putting their head down face to side. If this happens they are likely to become hyperthermic because the face is the most important heat exchange part of the body, especially in infants who are already very well insulated(11).

What might we be giving up if all babies are slept on their sides or back?

While it is frequently stated that babies lying on their backs are at risk of aspiration of stomach contents if they vomit while lying on their backs, there is no good evidence to support this assertion. Interestingly, countries where babies are routinely put to sleep on their backs show that aspirations (as well as SIDS) is rare. There is, however, some evidence that infants with significant gastro-oesophageal reflux have less reflux in the prone position and also that infants put to sleep in the prone position tend to go to sleep more readily and spend less time crying. There will still be some medical situations where lying prone is safer. These are: (1) clinically significant gastro-oesophageal reflux and (2) infants with Pierre-Robin syndrome.

SMOKING AND COT DEATH

The central question is whether smoking causes SIDS or is only an association seen because of other related factors such as low birth weight and poorer socioeconomic conditions. Data from the New Zealand Cot Death Study shows that the adverse effect of maternal cigarette smoking persists when other

New Zealand Family Planning Association (Inc)

NZ Family Planning Association (Northern Region) offer a 2-day theoretical course on smear taking and bimanual examination entitled "Pelvic Examination Course", to be held in Auckland.

This would be particularly suitable for midwives who are now able to take cervical smears, but feel they lack the necessary underlying knowledge on normal life span changes of the cervix, the pathophysiology of cervical cancer and how to detect these normal and abnormal changes.

The last 2 courses for the year are 3rd & 4th September, and 19th and 20th November – Cost $200.

Limited clinical experience could be offered.

For further information and brochure, please contact:

Carol Cox Ph: (09) 3600-360
PO Box 68-245
Newton
Auckland

Isis, Essense of Love and Wisdom

Isis is the ancient goddess of love, wisdom and mothering whom I had thought was a myth until I experienced her energy. She is channelled by Jenny Trow. Jenny and her husband David are both powerful healers and teachers in their own right.

Isis says she has come back at this time to help people regain their power, so there can again be a balance of the male and female energies. Birth at this time is for women, not only a purging but a healing and regaining of power. Isis says midwives are so important in being with women during this process that she is willing to run a workshop specifically for us in September. I have no idea exactly how she will run the session. All I know is others who have attended her workshops have gained what they needed and for each of us that is different.

If you feel this workshop is something you would like to attend, please contact either myself or Rosie Handscomb.

Di Webb

Thursday: 26 September
Time: 9.30am–4.30pm (bring lunch to share)
Venue: Vision Seminars, Stone St, Miramar, Wellington
Cost: $25 (may be paid on the day)
Contacts: Di Webb – (04) 885380; Rosie Handscomb – (04) 725837

FUTURE EVENTS

August/ September: *Spiritual Midwifery Seminar Series*–Shivam Rachana "To awaken the spirit of midwifery and recover its art". Seminars in Taupo and Nelson.

Contact: Lydia Millar, 38 Rimu Street, Taupo; Karyn Patterson, Nelson, ph 80172.

3-4 Sept & 19-20 Nov: *NZ Family Planning Association (Northern Region) Pelvic Examination Course*
2-day theoretical courses on smear taking and bimanual examination entitled Pelvic Examination Course, to be held in Auckland.

Contact: Carol Cox, PO Box 68-245, Newton, Auckland. Tel. (09) 3600-360.

15-20 September: *Symposium on Professional Training for Safe Motherhood at 13th World Congress of Gynaecology and Obstetrics (FIGO).*

Contact: Congress Secretariat, c/- Department of Obstetrics and Gynaecology, National University Hospital, Lower Kent Ridge Road, Singapore 0511, Republic of Singapore. Tel: 65 777 0313 or 65 775 4420. Fax: 65777 3121.

16-18 September: *Australian College of Midwives 7th Biennial Conference* Perth, Western Australia.
Theme: "Birthdays, Birthways".

Contact: ACMI 91 Conference, PO Box 553, Subiaco 6008, WA. Tel: Australia (09) 279 7328.