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BED SHARING AMONG SIX-MONTH-OLD INFANTS IN WESTERN SWEDEN.

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Abstract

In spite of several reports of an increased risk of SIDS in connection Aim: with bed sharing, it is not an uncommon practice. The aim of this study was to examine bed sharing at six months of age and the factors that are associated Our cohort comprised 8,176 randomly chosen families. with bed sharing. Methods: At six month of age the families received an invitation to the study, with a questionnaire, which was completed by 5,605 families (response rate 68.5%). 19.8% of the families bed shared. In the multivariate analysis, we Results: found a correlation between breast-feeding and bed sharing (breast-feeding at 6 months: OR 1.94; 95% CI 1.56, 2.41). Moreover, we found an association with 3+ nightly awakenings at six months (2.70; 2.20, 3.32). It was more common to share a bed if the parent was single (2.04; 1.19, 3.51) and less common if the infant was bottle fed in the first week (0.70; 0.54, 0.90). Never using a pacifier was We found a associated with a higher frequency of bed sharing. Conclusion: correlation between breast-feeding and bed sharing as well as with sleeping problems and a single parent. A lower percentage of infants sleeping in the parental bed was seen in association with formula feeding in the first week after birth.

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Perinatal outcome of illicit substance use in pregnancy-comparative and contemporary socio-clinical profile in the UK.

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Abstract

The aim of the study was to determine the contemporary socio-clinical profile and perinatal outcome of illicit substance use in pregnancy in a large UK city and compare with published literature. Cases were identified retrospectively from the 'cause for concern' referrals over 5 years (2003-2007). Data was collected on mother-infant pair from medical notes and laboratory records. Chi-square and Mann-Whitney U tests were used where appropriate for statistical analysis. One hundred sixty-eight women were identified as using illicit substance in pregnancy. Smoking (97.4%), unemployment (85.4%) and single status (42.3%) were frequent. Besides controlled use of methadone, heroin, cannabis and benzodiazepines were the most commonly used drugs. Hepatitis C prevalence was high (29.9%) despite low antenatal screening rates (57.7%). Neonatal morbidity was related to prematurity (22.9%), small for dates (28.6%) and neonatal abstinence syndrome (NAS; 58.9%). By day 5 of life, 95.1% of the babies developing NAS and 96.1% of those requiring pharmacological treatment were symptomatic. Of the infants developing NAS, 31.7% required pharmacological treatment. A total of 82.5% babies went home with their mother, and 21.2% were placed on the Child Protection Register. Only 14.3% were breast feeding at discharge. Illicit substance use in pregnancy continues to be associated with significant maternal and neonatal morbidity, and the socio-clinical profile in this decade appears unchanged in the UK. Hepatitis C prevalence is high, and detection should be improved through targeted antenatal screening. Where facility in the community is unavailable, 5 days of hospital stay is sufficient to safely identify babies at risk of developing NAS. Most babies were discharged home with their mother.

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Treatments for breast engorgement during lactation.

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Abstract

BACKGROUND: Breast engorgement is a painful and unpleasant condition affecting large numbers of women in the early postpartum period. During a time when mothers are coping with the demands of a new baby it may be particularly distressing. Breast engorgement may inhibit the development of successful breastfeeding, lead to early breastfeeding cessation, and is associated with more serious illness, including breast infection.

OBJECTIVES: To identify the best forms of treatment for women who experience breast engorgement.

SEARCH STRATEGY: We identified studies for inclusion through the Cochrane Pregnancy and Childbirth Group's Trials Register (February 2010).

SELECTION CRITERIA: Randomised and quasi-randomised controlled trials where treatments for breast engorgement were evaluated.

DATA COLLECTION AND ANALYSIS: Two review authors assessed eligibility for inclusion and carried out data extraction.

MAIN RESULTS: We included eight studies with 744 women. Trials examined a range of different treatments for breast engorgement: acupuncture (two studies), cabbage leaves (two studies), cold gel packs (one study), pharmacological treatments (two studies) and ultrasound (one study). For several interventions (ultrasound, cabbage leaves, and oxytocin) there was no statistically significant evidence that interventions were associated with a more rapid resolution of symptoms; in these studies women tended to have improvements in pain and other symptoms over time whether or not they received active treatment. There was evidence from one study that, compared with women receiving routine care, women receiving acupuncture had greater improvements in symptoms in the days following treatment, although there was no evidence of a difference between groups by six days, and the study did not have sufficient power to detect meaningful differences for other outcomes (such as breast abscess). A study examining protease complex reported findings favouring intervention groups although it is more than 40 years since the study was carried out, and we are not aware that this preparation is used in current practice. A study looking at cold packs suggested that the application of

cold does not cause harm, and may be associated with improvements in symptoms, although differences between control and intervention groups at baseline mean that results are difficult to interpret.

AUTHORS' CONCLUSIONS: Allthough some interventions may be promising, there is not sufficient evidence from trials on any intervention to justify widespread implementation. More research is needed on treatments for this painful and distressing condition.

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Alternative versus conventional institutional settings for birth.

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Abstract

BACKGROUND: Alternative institutional settings have been established for the care of pregnant women who prefer and require little or no medical intervention. The settings may offer care throughout pregnancy and birth, or only during labour; they may be part of hospitals or freestanding entities. Specially designed labour rooms include bedroom-like rooms, ambient rooms, and Snoezelen rooms.

OBJECTIVES: Primary: to assess the effects of care in an alternative institutional birth environment compared to care in a conventional institutional setting. Secondary: to determine if the effects of birth settings are influenced by staffing, architectural features, organizational models or geographical location.

SEARCH STRATEGY: We searched the Cochrane Pregnancy and Childbirth Group's Trials Register (31 May 2010).

SELECTION CRITERIA: All randomized or quasi-randomized controlled trials which compared the effects of an alternative institutional maternity care setting to conventional hospital care.

DATA COLLECTION AND ANALYSIS: We used standard methods of the Cochrane Collaboration Pregnancy and Childbirth Group. Two review authors evaluated methodological quality. We performed double data entry and have presented results using risk ratios (RR) and 95% confidence intervals (CI).

MAIN RESULTS: Nine trials involving 10684 women met the inclusion criteria. We found no trials of freestanding birth centres or Snoezelen rooms. Allocation to an alternative setting increased the likelihood of: no intrapartum analgesia/anaesthesia (five trials, n = 7842; RR 1.17, 95% CI 1.01 to 1.35); spontaneous vaginal birth (eight trials; n = 10,218; RR 1.04, 95% CI 1.02 to 1.06); breastfeeding at six to eight weeks (one trial, n = 1147; RR 1.04, 95% CI 1.02 to

1.06); and very positive views of care (two trials, n = 1207; RR 1.96, 95% CI 1.78 to 2.15). Allocation to an alternative setting decreased the likelihood of epidural analgesia (seven trials, n = 9820; RR 0.82, 95% CI 0.75 to 0.89); oxytocin augmentation of labour (seven trials, n = 10,020; RR 0.78, 95% CI 0.66 to 0.91); and episiotomy (seven trials, n = 9944; RR 0.83, 95% CI 0.77 to 0.90). There was no apparent effect on serious perinatal or maternal morbidity/mortality, other adverse neonatal outcomes, or postpartum hemorrhage. No firm conclusions could be drawn regarding the effects of variations in staffing, organizational models, or architectural characteristics of the alternative settings.

AUTHORS' CONCLUSIONS: When compared to conventional settings, hospital-based alternative birth settings are associated with increased likelihood of spontaneous vaginal birth, reduced medical interventions and increased maternal satisfaction.

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