Breastfeeding Elective Sample History and Physical

17 July 2008, 8:45 a.m.

History of Present Admission – **Nursing Mother, Jn. R.**

Jn. R. is a 36-year-old G1P1 with a history of stroke and hypertension who, at 37 1/7 weeks of gestation, delivered a 3260 g (7 lbs, 3 oz.) girl via emergency caesarean section at 2039 last night. She went into spontaneous labor yesterday afternoon and labored for 7 ½ hours before her diastolic blood pressure dropped into the 40s, prompting the more expedient delivery method. Pre-natal course was uncomplicated. Blood type O+. Prior to admission, medicines included aspirin 325 mg daily, nifedipine 30 mg twice daily, and enoxaparin (Lovenox) 40 mg subcutaneously twice daily. She has been stable since delivery.

Breast Feeding History

Jn. R. has decided she will breast feed so she can "bond with [her] baby." She has fed her neonate three times so far, at ~2200, 0130, and at 0500 this morning, and is anxious to do so again "because J. needs it every 3 hours, right?" Each time, she reports that her daughter latches on well ("She's greedy," Jn. R. proudly stated) and nurses for about an hour before spontaneously spitting out the nipple. She has not yet nursed on more than one breast during a feeding, but does alternate which breast is used for each session. Jn. R. has special challenges due to her right-sided hemiparesis, but confidently reported, "I know I can do anything." Consequently, she has used her left hand to both manipulate her daughter into position and support her breast with little difficulty reported. She described arranging her newborn in what sounds like a variant football position for all three feedings. Her primary concern is that her hypertonic right arm and hand will "squeeze too hard" when supporting Jd. R. as she nurses on the right side. The baby has had one wet diaper and two black, tarry stools so far.

Social History

Jn. R. works for Springfield Association for Retarded Citizens (Sparc) and plans to return six weeks postpartum. She currently hopes to maintain breast feeding for as long as possible after going back to work, and is open to pumping. She wants to be as independent as possible with caring for her daughter, since she plans to re-file an order of protection against the father and the rest of her family is deceased or lives in New York City.

Past Medical History

Illnesses – chronic hypertension, stroke in 2005, history of infertility to this point.
Medicines – enoxaparin injections to continue until 6 weeks postpartum, nifedipine 15 mg twice daily (half her normal dose), and aspirin 81 mg daily.
Allergies – no known drug allergies.
Pertinent surgeries – exploratory laparotomy 10 years ago for evaluation of infertility.

Family Medical History

The patient believes she was breast fed "briefly" (a matter of weeks) as a newborn, but does not know if the father of her child was.

Physical Examination

Breast – Jn. R.'s breasts are pendulous with large, everted nipples and large areolae.

Nursing – Jn. R. is a pleasant and cooperative woman whose new baby just finished nursing for 25 minutes on her right side and is now beginning on the left. She uses the football position to nurse on the left breast with pillows supporting both her arm and her daughter. Jd. R.'s body line is perpendicular to her mother's, "belly to belly." She has a good latch on her mother's breast, with outwardly-flanged lips and her nose and chin in contact with the broad areola. Several shallow, rapid sucking movements are made with subsequent deeper sucks and evidence of swallowing. Jn. R. reports that she can feel the sensation of her child nursing, but is in no pain or discomfort. She received additional breast feeding education at this time, including signs and symptoms of breast feeding complications and availability of breast pumps through WIC for when she returns to work.

Assessment

The breast feeding dyad is a 36-year-old G1P1 status post caesarean section with right-sided hemiplegia secondary to stroke and her 12-hour-old baby girl. Jn. R. is breast feeding well despite her physical impairment, and her newborn is latching on and nursing with little trouble.

Plan

1) Check with the attending physician regarding Jn. R.'s antihypertensive and anticoagulant medicines, particularly aspirin, due to transfer of aspirin through breast milk to the newborn and resultant risk of Reyes Syndrome.

2) Assess breast feeding on the right side at a later time and address any special issues observed with Jn. R.'s weaker arm.

3) Discuss possible occupational therapy or special needs childcare class for Jn. R. per her request.

4) Reinforce breast feeding education to ensure ability of the mother to independently breast feed her child. Jn. R. has already received teaching on feeding frequency and duration, feeding cues, evidence of adequate and effective breastfeeding, different positions, and signs of correct attachment. She has also been informed about the effects of decreased nursing frequency and supplemental formula feedings on her milk supply.

History of Present Admission – **Girl Baby, Jd. R.**

Jd. R. is a 3260 g (7 lbs., 3 oz.) girl born twelve hours ago via emergency caesarean section at 37 1/7 weeks gestational age. APGAR scores were 8 and 10. Blood type is O+, just like her mother's. She has now nursed effectively four times, has voided once, and has passed meconium twice. Weight currently at 7 lbs., 1 oz..

Prenatal History – uncomplicated. Mother's chronic hypertension was well-controlled.

Social History – she will go home with her mother following discharge.

Physical Exam

Easily aroused. No acute distress. Tone is appropriate for gestational age. Medium pigmentation, with black hair and some lanugo present on his back, forehead, and temples. Mild caput present with flat fontanelles; no ecchymoses noted. Hard palate is intact. Buccal mucosa

is pink and moist. Neonatal reflexes intact, including good rooting reflex. Rhythmic suckling and swallow patterns upon attachment.

Assessment and Plan

Jd. R. is a 37 1/7 week gestational-age girl, now 12 hours old. Nursing technique is very effective. Routine follow-up next week with pediatrician after discharge for appropriate weight gain development.