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REVIEW ARTICLE

The challenges and strategies for breastfeeding in newborns with cleft lip and palate

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Headings:
Breast Feeding,
Milk,
Human,
Cleft Lip,
Cleft Palate.

Abstract

Objectives: Review strategies that facilitate breastfeeding in children with cleft palate and cleft lip. **Methods:** Narrative literature review carried out through online scientific bases. **Results:** Cleft lip and palate are congenital malformations that hinder the breastfeeding process, interfering with sucking and swallowing, which can impair child development and the mother-baby bond. Breastfeeding should be encouraged, the baby's sucking ability should be assessed, the breastfeeding should be properly demonstrated to parents, support for mothers to establish and maintain their milk supply, considering adaptive feeding equipment (specialized bottles and nipples) and education on the benefits of human milk. Even if there are factors that make breastfeeding impossible, the supply of human milk, through specialized bottles or other devices, should be encouraged, since there are nutrients that only it can offer to the newborn. Family education is an important part of successful breastfeeding and support should be started as soon as the cleft is diagnosed, during the prenatal and postnatal periods. **Conclusion:** Breastfeeding should be encouraged, and when it is not possible, breast milk should be offered. Early surgical repair (in the first two weeks of life) in simple cleft lip has increased BF rates and should be considered in services where availability is available. In addition, a support network for parents should be created, with health professionals, to provide guidance on the possibilities and success of breastfeeding, in addition to monitoring weight gain and hydration.

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INTRODUCTION

Cleft lip and palate are congenital malformations that make the breastfeeding process difficult, interfering with sucking and swallowing. Cleft lip (CL) and cleft palate (CP) are congenital orofacial structural defects that occur when the baby's lip or mouth does not develop properly. Cleft lip occurs when there is an opening between the mouth and nose, while in cleft palate there is an opening in the roof of the mouth between the oral and nasal cavities. The occurrence of cleft lip and palate is related to genetic and environmental factors, such as maternal folic acid deficiency and exposure to toxins (drugs, nicotine and alcohol)[1].

In Brazil, 1 in every 650 newborns (NB) has cleft lip and palate, with prevalence variability affected by ethnicity, geography and socioeconomic status[2]. These can affect the lip in isolation or the palate, so the difficulty faced during BF is related to the extent of the oral cleft. The degree of cleft palate is proportional to the difficulty with feeding. Patients with isolated LF can often breastfeed successfully[3]. Although variations occur, it is estimated that, of the total number of babies with CL, 50% have combined cleft lip and palate (CLP), 30% have isolated cleft palate and 20% have isolated cleft lip. Clefts are usually unilateral but can be bilateral. Of all cases, 30% are part of identified syndromes or disorders of congenital anomalies[4].

Prior to the closure of palatal defects, infants with CLP are faced with several obstacles to successful feeding. The baby's feeding process depends on the smooth synchronization of two processes, namely sucking and swallowing. Due to the abnormal oral anatomy, infants with CLP have difficulty creating oral pressure gradients, which affects muscle movements in the pharyngeal stage and delays the triggering of swallowing movements[5].

Despite advances in craniofacial and plastic surgery, dental and orthodontic care, otorhinolaryngology, audiology and speech therapy have significantly improved the results and quality of life, there is still a deficit in the nutritional function of these children, many with difficulties in receiving breast milk[2]. Several studies are surprising with the high rates of breastfeeding in NBs with LF, identifying that the use of formula normally occurs due to other situations and not because of craving. Still, they suggest that even though the NB is unable to suckle, he should be fed breast milk[6].

METHODS

PubMed 's scientific databases . The descriptors " Cleft lip and palates " and " breastfeeding ", linked by the boolean AND. After 16 articles were found, 11 that talked about the topic were analyzed. An additional search was carried out, with the same descriptors, in the journal Residência Pediátrica, of the Brazilian Society of Pediatrics, and no new articles were found.

RESULTS

According to current recommendations, breastfeeding should be exclusive until 6 months of age, and extended until 2 years or more. Breast milk represents the ideal substrate for all babies, including those with cleft palate, for whom this process may be compromised[2].

A cleft lip or FL ranges from a small notch in the upper lip to an extension in the nose, while a cleft palate (CP) ranges in severity from an opening in the soft palate to an extension in the hard palate[1]. When LP occurs, the lip is not contiguous, and when PF occurs, there is communication between the oral and nasal cavities[4]. Although an FL has a visible presentation, an FP may not be immediately detected[1]. Therefore, it is important that health professionals check the cleft palate (open and submucosal) at the initial presentation, with inspection and palpation of the palate, with a tongue depressor and flashlight to visualize the entire palate[4], preferably in the first examination of the palate. RN The possibilities of offering breast milk are different for each FP and FP, and range from positioning to reconstructive surgery (Figure 1).

The presence of cleft palates prevents proper separation of the nasal and oral cavities during feeding, which results in difficulty in sucking. It is known that only babies with smaller clefts of the soft or hard palate can create adequate suction. However, most of them cannot, because the oral cavity cannot be adequately separated from the nasal cavity during feeding[7]. Also, it compromises the precise synchronization of swallowing and breathing, necessary for feeding. Because of this, patients with cleft palate have less efficient sucking patterns, with lower rates of breastfeeding success when compared to the population without cleft. The difficulty may persist even after surgical repair. Despite this, evidence suggests that breastfeeding can begin or resume immediately after cleft lip and palate repair. Babies may need additional breastfeeding support after the clefts have been repaired[4]. Immediate feeding after palatoplasty (corrective surgery) can be done using cups or spoons, the latter being the most recommended, as there is a greater degree of oral stimulation and the promotion of muscle contraction and nerve endings when compared to the cup. In the late postoperative period, the use of suction methods can be encouraged[8].

For successful breastfeeding, it is necessary for the baby to suckle the milk, responsible for attachment to the breast, maintenance of a stable position for feeding and milk extraction[4]. Feeding difficulty is related to the size of the cleft, specific anatomical involvement and the spectrum of malformations and possible concomitant syndromes within the general category of orofacial clefts[2], in addition to the baby's maturity and oral pressure generated during feeding. Therefore, younger babies with larger clefts are expected to generate less oral pressure, with greater difficulties in breastfeeding[4].

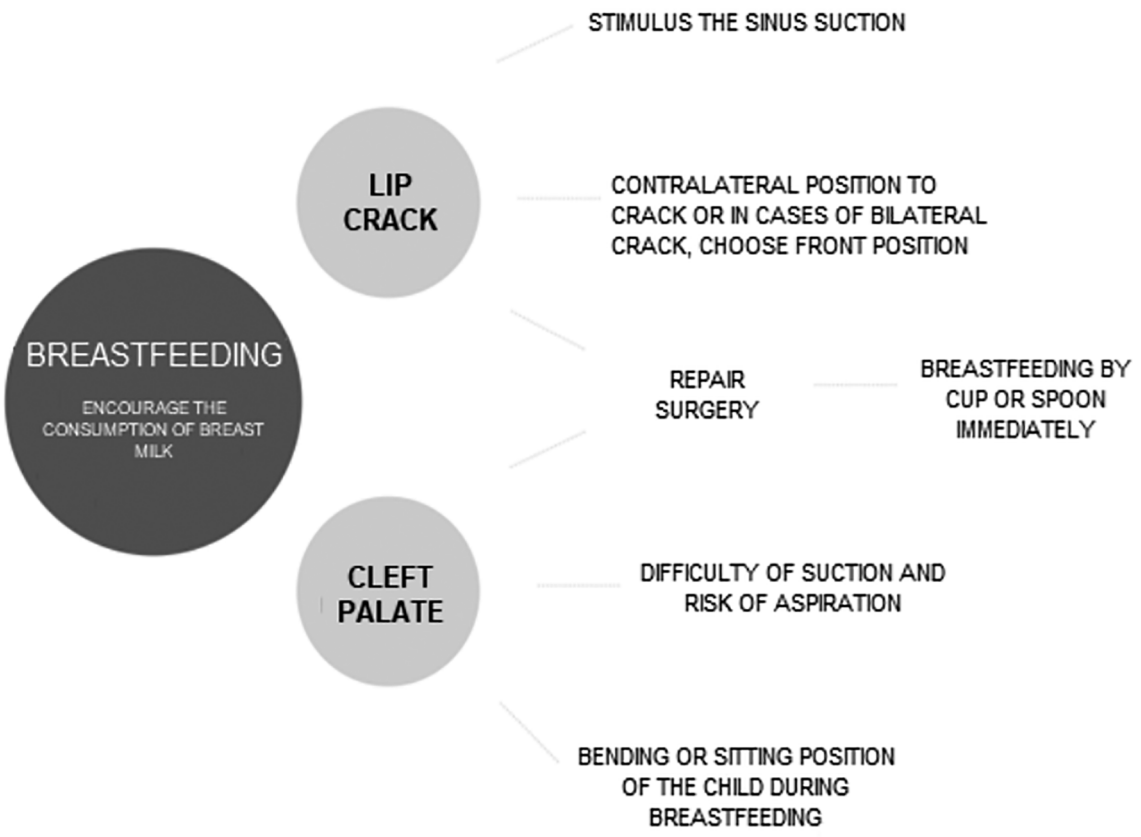

Figure 1. Strategies for breastfeeding in babies with cleft lip and cleft palate.

When evaluating a newborn with cleft lip and palate, it is important to consider the size and location of the baby's cleft, the anatomy of the breast, the parents' wishes and previous experience with breastfeeding[4]. Difficulties are less in children with only cleft lip (intact palate), which can be circumvented only with proper positioning. These are usually capable of generating suction and negative pressure when the nipple is compressed between the tongue and the maxilla[4]. It is worth mentioning that, when cleft lip and palate occurs as part of a syndrome, the breastfeeding potential must be evaluated individually, taking into account additional characteristics of the syndrome[4].

In babies with cleft palate, in addition to difficulty sucking the breast, there is communication between the oral and nasal cavity, with risk of aspiration. Some babies with small soft palate clefts can generate adequate negative pressure, but others with larger soft and/or hard clefts may not. Full-term and premature newborns may have greater difficulty generating suction pressure than older babies. In general, babies with cleft lip or palate have difficulty creating suction and negative pressure, because the oral cavity cannot be adequately separated from the oral cavity during feeding[4].

However, BF is recommended to reinforce the mother-baby bond, with guidance that the baby is always left in an inclined or sitting position so that the LM does not flow back into the nose. In newborns with CLP, milking and oral feeding using special bottles are indicated. The formulas should be used only in cases where there are contraindications for AM or in the absence of BM production.

Retrospective cohort study conducted by Burianova , et al. (2017), studied breastfeeding rates after early surgical repair, performed in the first two weeks of life. When comparing newborns with FL and those with CLP, it was found that three (6.2%) of the children in the CLP group were breastfed, 31 (64.6%) received human milk by bottle and 14 (29.2%) were formula fed. In the group with LF, breastfeeding rates were significantly higher, 44 (78.6%) were breastfed, three (5.4%) received their own mother's milk by bottle or syringe and nine (16.0%) were fed formula (3). What stands out in this study was the high rate of breastfeeding in NBs with LP, and even those who were not breastfed in the CLP group received breast milk[7].

In addition to insufficient milk transfer with impaired weight gain and growth and malnutrition, feeding difficulties can also lead to fatigue during breastfeeding, prolonged periods of breastfeeding, nasal regurgitation, learning difficulties, speech disorders, recurrent urinary tract infections. upper respiratory tract, chronic diseases of the ear - due to

nasal insufficiency and inadequate protection of the airways during swallowing - and dental problems, such as dental caries - due to the difficulty of cleaning the upper incisor teeth, due to the abnormal anatomy of the orofacial cavity[1,4]. There is evidence to support the reduction of otitis media (OM) in babies with cleft palate who are offered breast milk. The act of breastfeeding can also strengthen the speech muscles and favor normal facial formation and speech improvement[2]. In addition, difficulties faced during breastfeeding attempts can affect maternal attachment and the mother's decision to stop breastfeeding.

With regard to otitis media and secretory, a retrospective and clinical study was carried out by Aniansson , et al. (2002) containing 84 children aged between 6 and 10 years with the objective of analyzing the incidence of OM, feeding with breast milk and the use of *grommets* (ring strip or edge inserted in an orifice) in children with cleft palate or cleft lip., compared with a control group. The results of this study showed that, despite fissure repair and early and frequent treatment with *grommets*, children with CP/CLP frequently contract secretory and acute OM. The high incidence of the disease is reflected in the large number of abnormal tympanograms, the more frequent visits to the hospital because of the cleft, and the reduced duration of breastfeeding in infants with cleft palate. Of the variables tested in relation to OM in a linear regression model, the reduction in the duration of breast milk feeding was the most important, but not yet fully explained. One month of shorter breastmilk feedings increases the risk of acute and secretory OM. Therefore, this study indicates that breastfeeding alleviates OM to some extent and the effect may be beneficial for children with cleft palate who are prone to OM as a result of Eustachian tube dysfunction[9].

Breastfeeding is the preferred method of feeding, even in babies with cleft lip and palate. Breast tissue is flexible, which allows it to be molded to accommodate the oral cavity and occlude the cleft. Breastfeeding movement promotes the development and coordination of the orofacial muscles and stimulates the muscular development of the craniofacial structures necessary for speech. However, the baby's ability to suckle milk is related to the degree of fissure. Some strategies can help in breastfeeding: skin-to-skin contact of the mother with the baby, manual expression of milk, breast massage and application of hot compresses[1]. Breastfeeding refers to the direct placement of the child to the breast for breastfeeding, while breast milk feeding refers to the delivery of breast milk to the child through special bottles, cup, spoon or any other means except the breast. Breastfeeding or the provision of breast milk should be encouraged, with the correct guidance of parents on the protective benefits of breast milk[4]. The possibilities and strategies for breast milk supply are wide (Figure 2).

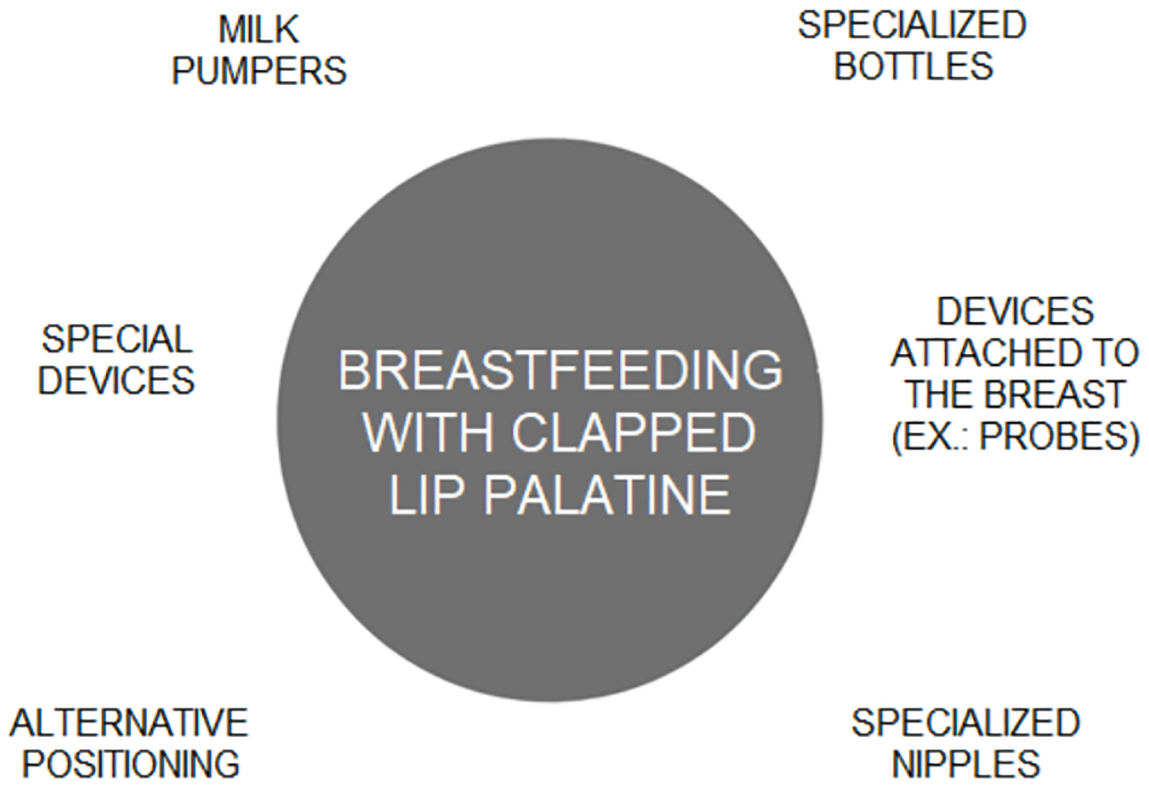

Figure 2. Strategies for breast milk supply in the presence of cleft lip and palate.

Among the factors necessary for a good breastfeeding in these NB are alternative devices attached to the breast, such as probes, which help the arrival of milk to the oral cavity. With the early adoption of adequate measures, it is possible to achieve a good development and adequate intake of the nutrients that only BM offers. If exclusive breastfeeding is not possible, a multidisciplinary team is necessary to choose other methods for feeding the baby.

Positioning during breastfeeding is important, especially in those with cleft lip and palate. In some cases, only with proper positioning is there a possibility of breastfeeding. Head support should be provided for neutral alignment of the head and neck, arms forward, midline of the trunk, flexed hips, and stabilization of the lip, cheek, and jaw to provide a platform for sucking movements. Babies with cleft palate are fed in an upright position greater than 60° to allow gravity to facilitate fluid transfer and lessen the tendency for nasopharyngeal reflux . The semi-upright position facilitates burping, limits liquid regurgitation and prevents milk from entering the Eustachian tube and middle ear space, minimizing ear infections[1].

A child with a cleft lip should be held so that the cleft is oriented towards the top of the breast. Thus, an infant with a right cleft may feed more efficiently in a crossed position on the right breast, with the infant's body positioned at the mother's side rather than on the mother's lap, with the infant's shoulders above the body. , in the left breast[4]. Thus, the mother's breast should be supported towards the most favorable or intact side of the palate, thereby preventing the nipple from being pushed into the cleft[1]. For bilateral cleft lips, a 'face to face' position may be more effective than other breastfeeding positions. For babies with cleft palate, semi-vertical positioning can reduce nasal regurgitation and eustachian tube milk flow[4]. The child can also be oriented towards the upper part of the breast, while the mother occludes the slit with her thumb. The mother can also tilt the chest downwards, in the case of a very large child[1].

In addition to positioning the baby, some strategies can be implemented. In babies with cleft lips, the cleft can be occluded with the thumb or finger, and/or supported by the baby's cheeks to decrease the width of the cleft and increase the closure around the nipple. In the case of cleft palate, the breast can be positioned towards the larger segment of the palate (the side that has the most intact bone), thus facilitating the generation of negative pressure and milk extraction, while preventing the nipple from being pushed. to the crack location. In addition, mothers can manually express breast milk into the baby's mouth, compensating for the lack of suction and compression[4].

Despite the impossibility of breastfeeding, mothers should be advised that it is possible to provide human milk to their children. It is therefore necessary to advise on available support equipment to ensure adequate milk supply. Examples of equipment are milk pumps, special bottles and adaptable equipment. Parents should receive advance guidance on effective techniques for expressing milk, along with the amount of milk needed and storage methods[4]. A critically important member of the multidisciplinary cleft team with regard to establishing and maintaining an effective diet is the cleft nurse, who provides detailed feeding instructions and support to new parents of babies with PF/FL[5]. Early counseling is essential, as mothers can be encouraged to start expressing milk in the first hours after birth [4] . Mothers should be advised and instructed to use the breast pump, handle the milk, record volumes and establish contact with the baby during and after pumping[1].

Specialized bottles can be great allies for mothers with babies with cleft lip and palate . If breastfeeding is not possible, it is one of the options of choice, as it allows the mother to be close to the baby and also for another caregiver to feed the child. In general, the success of breastfeeding with special bottles will depend on the degree of cleft and the status of the airway. Babies with a small cleft in the soft palate may be able to breastfeed. On the other hand, babies with a more significant cleft palate are likely to have considerable difficulty. However, other studies have reported that the shape or size of the cleft palate does not affect breastfeeding[5].

In addition to these, there are specialized equipment, such as compressible bottles that reduce the baby's need for suction and help with the ability to suck and swallow, offering a greater amount of milk[3]. Bottles that facilitate the flow of milk may be needed for short-term or long-term use. These may have specially designed, packable teats or use one-way valves to control milk flow[4].

In one study, when babies were fed a combination of breast milk and formula using a needleless syringe, significant increases in weight gain, faster feeding times, and greater feeding volumes were recorded. Thus, feeding with a syringe is an alternative, rated as easier and more practical[5].

A wide variety of specialized teats and nipples are available for use on babies who have FLCP or other feeding difficulties. There is a squeeze bottle with a NUK orthodontic nipple, a Mead Johnson palatable cleft ward, and a cross-cut nipple, which have all been shown to effectively support normal growth in babies with clefts. the Haberman Feeder and P-type teat, disposable syringe (no needle), Benifex cleft lip/palate cradle, cup feeding and spoon feeding can also be used as feeding interventions in cleft patients[5].

Another available device is the feeding shutter, which creates a seal between the oral and nasal cavities and controls the flow of milk. It comprises an acrylic plate inserted into the mouth over the hard palate, essentially closing the palatal defect. This feeding plate restores basic functions of chewing, swallowing and speech production until the cleft lip and/or palate can be surgically corrected. The combined use of a palatal obturator and lactation education can reduce feeding time and may be associated with good growth. There is conflicting evidence regarding the use of obturators. Some evidence suggests that those that do not facilitate feeding or

weight gain in babies with FLCP. However, other promising sources suggest that they can actually improve the feeding efficiency of these babies. A single intervention may not meet all the feeding requirements of infants with FLCP; thus, a combination of several interventions should be used[5].

In some services, patients undergo Naso -Alveolar Molding (NAM), a pre - surgical device used to rotate the alveolar segments of the cleft to the orthotopic position and mold the nose before cleft lip repair. The presence of NAM prevents traditional breastfeeding in almost all cases[3].

In a study carried out by M, Alperovich (2017) to assess breast milk consumption rates in 110 patients with oral clefts in North America treated between 2000 and 2012, it was shown that 67% received breast milk for a period of time. of time with an average duration of 5.3 months (ranging from 0.25 to 18 months), and, when used, BF constituted the majority of the diet in 75%. This study included 62 patients with unilateral cleft lip and palate, 26 patients with bilateral cleft lip and palate, 16 patients with unilateral cleft lip and 6 patients with bilateral cleft lip. Still, the most common method of providing breast milk was the Haberman feeder (75% of cases), which allows the baby to obtain milk from the nipple without sucking[3].

In a retrospective review study by[5], the frequency of breast-feeding and bottle-feeding (bottle, cup, enteral tube) was compared in infants with cleft palate. In this, breast milk consumption (26 infants were breastfed and 84 received human breast milk administered with a device) was 29.5%, significantly below the 2016 National Centers for Disease Control and Prevention statistics for receiving breast milk (81%). When z-scores for age and weight were assessed, infants with cleft palates were below normative standards, which suggests early growth impairment in infants with cleft palate. A possible etiology for poor growth is inadequate protein intake due to anatomical abnormality[2]. This study also showed lower rates of breastfeeding when compared to the research by Alperovich et al, previously mentioned. This can be explained by the inclusion of babies with isolated cleft lip, who are more likely to be breastfed or bottle fed, which are greater challenges for those with cleft palate, characterized in the study by Gottschlich , MM, (2018). In the study in question, only 7.2% of infants with cleft palate were breastfed. Low breastfeeding rates are associated with anatomical defects, however, it should not be attributed only to anatomical barriers. Other factors pointed out were the circumstances of the baby's birth. Generally, parents discover the orofacial defect at birth, with the beginning of the mother-infant relationship in stressful circumstances. The psychological shock in response to this and maternal feelings such as anxiety, fear, guilt and depression can damage the maternal-infant bond. The economic factor should also be considered as a determinant of breast milk feeding, since milk collection and specialized feeding, with special devices, as well as the administration and cleaning process, require a significant commitment of time and money. In addition, milk expression and specialized feeding instructions can be difficult to understand. Determining environmental factors found were health system processes (such as the absence of formula or supplement distribution programs), caregiver experience, access to health insurance, and accessibility of information, services, and equipment. Furthermore, the lack of differentiation between the type of cleft and severity may explain the ambiguity in the literature regarding successful breastfeeding[2]. The conclusion of the clinical studies found can be summarized in Table 1.

The experience of the healthcare team that receives the baby is also important: for most hospitals, a baby with a cleft palate is an unusual event, which can lead to breastfeeding not being seen as a priority, due to other aspects of care with the baby. cleft lip and palate. Furthermore, it is necessary to develop a safe and effective food assistance plan[2]. Mothers of children with cleft lip and/or palate may be discouraged from providing human milk by medical providers who are uncomfortable or unfamiliar with cleft feeding standards and recommendations[10]. M. Alperovich (2017) demonstrated that parents who received guidance are more likely to offer breast milk (72%) than those without counseling (44%)[3].

Antenatal lactation consultations for babies with congenital anomalies have been shown to significantly increase the onset and duration of human milk delivery after delivery. It is not known what factors influence mothers of babies with orofacial clefts to breastfeed or provide expressed human milk to their babies. Most mothers who chose to provide human milk reported at least one challenging factor, the most common being weak latch, poor sucking and lack of milk[10].

In a retrospective cohort study, when asked specifically about their challenges in expressing milk, 42% of mothers complained about their milk supply. Others reported that expressing milk was time consuming or painful. Only two mothers, however, reported difficulty accessing a breast pump. Mothers officially reported "loss of milk supply" as the most common reason to stop, but the many potential physiological and psychosocial factors that affect a mother's milk supply make this a more complex issue. Factors of gestational age, NICU stay, and even sex can potentially impact human milk supply rates in the cleft population. Mothers of premature babies and/or babies with altered health status will face more significant challenges in building and maintaining an adequate supply of milk. The institutional culture of breastfeeding and the professional's experience can positively impact the rates of initiation of human milk supply. Mothers who received prenatal counseling for the diagnosis of fetal cleft appear to initiate breastfeeding at higher than average rates and continue to provide human milk for longer periods[10].

As pointed out by some authors, it is noteworthy that many of the published studies on breast milk in the population with clefts are about how they are fed, not what they are fed with. Hence, it is important to differentiate between ''breastfeeding'' and ''breastfeeding'' (ie, delivering breast

Table 1. Analysis of randomized clinical trials.

	TITLE	AUTHORS	GOALS	METHODOLOGY	No	RESULTS
1	**Breast milk feeding rates in patients with cleft lip and palate at a North American Craniofacial Center**[3]	Michael Alperovich, Jordan D. Frey, Pradip R. Shetye, Barry H. Grayson, Raj M. Vyas.	To assess breastfeeding rates among patients with oral clefts.	Interview with parents of patients with oral clefts, about cleft diagnosis, advice received and eating habits.	110	67% received breast milk for a period of time with a mean duration of 5.3 months. When used, breast milk constituted the majority of the diet with an average percentage of 75%. The most common method of providing breast milk was the Haberman feeder at 75%, with other specialty bottles making up another 11%. Parents who received counseling (84%) were more likely to breastfeed their baby.
2	**Breastfeeding after early repair of cleft lip in newborns with cleft lip or cleft lip and palate in a baby-friendly designated hospital**[7]	Iva Burianova, Katarina Kulihova, Veronika Vitkova, Jan Janota	Assess breastfeeding after early cleft lip repair. To compare the rate of breastfeeding in newborns with cleft lip and cleft lip and palate.	Retrospective cohort study.	104	When comparing the cleft lip and cleft lip and palate groups, there were significant differences in only two items: the breastfeeding rate was significantly higher in the cleft lip group and the hospital stay was significantly shorter in the cleft lip group. The study concluded that even babies with cleft lip and palate were fed breast milk by bottle or Haberman feeder.
3	**A retrospective study identifying breast milk feeding disparities in infants with cleft palatwe**[2]	Michele M. Gottschlich, Theresa Mayes, Laura James, Jane Khoury, Brian Pan, John A. van Aalst.	To determine the frequency of breast and bottle feeding in infants with cleft palate. Compare with rates reported by the Centers for Disease Control and Prevention; Review the babies' growth status.	Five-year retrospective review. Outcomes measured were breast milk use, reported by mothers and documented in patients' electronic medical records, chronological body weight and weight for the z and z percentiles of length and weight-for-age scores.	360	Breast milk consumption (26 infants were breastfed and 84 received human breast milk administered with a device) was 29.5%, significantly below the 2016 National Centers for Disease Control and Prevention statistics for receiving breast milk (81%).
4	**Otitis media and feeding with breast milk of children with cleft palate**[9]	Gustaf Aniansson, Henry Svensson, Magnus Becker, Leif Ingvarsson	To analyze the incidence of acute and secretory otitis media (OM), breast milk feeding and eyelet use in children with cleft palate or cleft lip, compared with controls.	Retrospective and clinical study to verify the association between breast milk feeding and OM.	84	There was a correlation during the first 18 months of life between longer duration of breast milk feeding and lower incidence of acute and secretory OM in the three study groups. The incidence of otitis media was not affected by day care care, having a sibling attending day care, or family medical history.
5	**A pilot study of mothers' breastfeeding experiences in infants with cleft lip and/or palate**[11]	Alison Kaye, Carol Cattaneo, Helen M. Huff, Vincent S. Staggs.	Investigate the experiences of mothers of babies with cleft lip and palate to determine choices and factors associated with providing breast milk (BM) to their babies.	Retrospective telephone survey in a cohort of mothers of infants with CLP.	50	The majority (78%) started using LM for a median duration of 4 months, 32% provided LM for 6 months or more and 79% expressed exclusively providing LM. The lack of supply was the frequent challenge of providing BM and led to cessation in 46% of mothers. The formula was used to supplement insufficient supply or insufficient infant weight gain in 90% of mothers. 36% of mothers reported individual encouragement to provide LM, and 18% reported that they were discouraged from providing LM to their babies.

Caption: scientific articles chosen according to the methodology (clinical studies).

milk to the baby by other means; Reilly et al., 2013). It is also noted, in relation to older articles, that the period of time of breast milk use and proportion of the total diet are increasing.

Feeding difficulties and nutritional deficits must be identified and treated early, in order to ensure adequate nutrition and minimize possible complications. Weight gain of 15 to 30g per day, after the newborn's initial weight loss, must be monitored[1]. If only breastmilk feeding is inadequate, supplementary feeding should be implemented or increased[4]. Feeding difficulties tend to decrease over time, as the child with CLP develops musculature[1].

Prompt provision of clinical support has been associated with positive impacts on breastmilk use in babies with cleft lips and palates. In a study, hospital contact within 2 weeks of birth was associated with a higher frequency of breast milk intake. The best evidence in the literature indicates that timely education is a key intervention to increase the likelihood of babies with cleft palate receiving breast milk[2].

Still in relation to nutritional deficiencies, the study carried out by Dalben, et al. (2002) applied a questionnaire for 6 months to caregivers of babies with cleft lip and/or palate. The sample was divided into two age groups: 7 to 12 months and 13 to 18 months. The study showed that, at the time of the initial interview, only 3% of babies were breastfed and 81% of children were never breastfed. When caregivers were asked about the reason for stopping breastfeeding, it was found that the majority was due to the baby's inability to breastfeed. It was also observed that cleft palate presented a greater problem in breastfeeding in relation to cleft lip. Most babies with cleft lip and palate (80.5%) used the bottle in the first week of life and at the time of the interview 90.5% were still using the bottle. Regarding sugar, more than half of the babies had primary contact during the first month of life. This contact with sugar occurred mainly (75.6%) through milk. There are several other types of food that were used in the bottle, juice was the most popular (83.5%) and the percentage of babies who received soft drinks through the bottle was very high (50%). Caregivers were asked if they knew honey could cause cavities, 21% said they didn't know if honey was cariogenic . The average number of daily contacts with sugar through the bottle was also evaluated. In the 7 to 12 month old group, the mean number of daily contact with sugar was 3.95 with milk, 0.64 with tea and 1.25 with juice. Thus, there were 5.92 average daily contacts with sugar per day. In children aged 13 to 18 months, the average number of daily contacts with sugar found was 3.28 through milk, 0.67 through tea and 1.23 through juice. The average total number of daily contacts was 5.19. However, there was no statistically significant difference. Therefore, the nutritional pattern of babies with cleft lip and palate proved to be very harmful to the good development of the oral cavity due to the absence of breastfeeding, high sugar intake and high intake of fruit juice[11].

CONCLUSIONS

Breastfeeding should be encouraged, with guidance on the possibilities and success of breastfeeding and frequent monitoring of weight gain and hydration. When feeding babies with cleft lips and/or cleft palates, the baby's sucking ability should be assessed, adequate breastfeeding positioning must be demonstrated, mothers should be supported to establish and maintain their milk supply, considering adaptable feeding equipment (specialized bottles and nipples) and education on the benefits of human milk[2]. The assessment of babies with CLP should be carried out in the first hours of life on an individual basis, with determination of the sucking capacity to decide on dietary adaptations[1].

Even if there are factors that make breastfeeding impossible, the supply of human milk, through bottles or other devices, should be encouraged, since there are nutrients that only it can offer to the NB. Special feeding devices may be useful for breastfeeding or delivering breast milk to babies with orofacial clefts[2]. Dietary interventions should reduce the stress experienced by the baby and the family, promote growth and development and facilitate a normal eating pattern[5].

Health services should improve their support services and services for parents of babies with PF[2] . Family education is an important part of successful breastfeeding, and support and guidance should begin as soon as the cleft is diagnosed, during the prenatal and postnatal periods . Preparing parents before delivery seems to translate into better breastfeeding outcomes for these babies[10]. Consistent and expert advice should be provided by healthcare professionals with clinical experience in feeding babies with cleft lip and palate . An important issue to be addressed is the lack of evidence on which to base clinical recommendations. Thus, it is suggested that more studies on the subject be carried out, in order to generate high-level evidence[4].

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