Mother in the Tilt-a-Whirl Bed

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Pulmonary hypertension is an often fatal condition that can strike women immediately after giving birth. Can a mother breastfeed after experiencing such a serious complication? In this vignette, the author describes her work with a mother who experienced pulmonary hypertension and was unconscious in the intensive care unit for several days. The woman's husband knew how important breastfeeding was to this patient and asked for help in maintaining her supply.

Keywords: pulmonary hypertension; intensive care unit (ICU); breastfeeding

She is prone, belly down, unconscious, facing the floor, facing off death just after the birth of her daughter. When I am called to the adult intensive care unit (ICU), I rarely know ahead of time what I may come upon. Stroke victim? Boating accident victim? Burn victim? Regardless, they're always critical. Today, it is an upside-down mother. It's obvious, logistically speaking, that I won't be setting her up to pump for now.

When I ask to speak to her nurse, I'm approached by a bustling RN, who immediately asks why I am there. My badge does not signal my occupation, as it says only "nurse clinician." I preface by saying I work in the newborn ICU and have just come from the baby's bedside. I'm hoping this will ease what I say next. "I'm the breastfeeding consultant."

I understand ICU nurses. They are territorial and fiercely protective of their patients, a quality I admire. I underestimate how she will react. Nearly jumping back a huge step, she looks at me quizzically as if to say, "You've got to be kidding me!" As she shifts her eyes toward the patient strapped to the tilt-a-whirl bed, I give the nurse a short minute to process the fact that I indeed want to assist with breast pumping—at least, eventually, when the roto-prone bed shifts the mother upright and she's deemed stable enough. But for now, she's in acute respiratory distress, from pulmonary hypertension. The mother is carefully strapped in, while the bed rotates a complete 360-degree circle, shifting fluids away from her lungs where they've been building up. Despite the high maternal mortality rate after births in the U.S., I've seen so few mothers die after birth, I'm probably overly optimistic that this mother will survive. Clearly, the nurse doesn't share my optimism because she's been caring for the mother since the delivery.

I tell the nurse that the doctors have asked me to assess the feasibility of expressing the mother's milk. She explains that the mother is critical, that over half of women who deliver with a diagnosis of pulmonary hypertension don't make it. I assure her that I understand and let her know I'll report back to the physician caring for the mother's extremely low birthweight infant.

Two more days go by and Chris, our attending neonatologist, aware the mother is still alive, asks me to go with her to pay the patient and ICU staff a visit. When a mother is critically ill, her milk doesn't always come in, or often comes in late or in small quantities. At times, this is secondary to medicines she's received while in a critical state. I've also seen milk come in as late as 11 days after a birth instead of the usual 72 hours. I've no idea what this mom's lactation potential is.

Coming into the unit, Chris sees her counterpart in the adult world. The ICU attending doctor has just finished rounds and is giving her residents the day's parting instructions. Chris approaches the group and introduces herself with the confidence of a seasoned physician. The team perks up, interested to learn the status of the premature infant. Then she comes around to the question of pumping the mother, but before anyone can object, she builds a case for how removing milk, could actually help the mother's condition, alleviating the strain of added fluid (milk) and the swelling associated with severe engorgement from around the mother's lungs. The physician is cautiously entertaining this as an added therapeutic approach to the mother's care. In the end, the mother's doctor agrees, but asks our neonatologist to sign a legal document stating that expressing milk is in the mother's (and obviously the baby's) best interest. Once she does this, I introduce myself to the new nurse caring for the mother. She's upright now, but I have no supplies with me. This nurse has breastfed her own children and is receptive to the education and

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reassurances she is receiving from Chris. We agree that I'll return within the hour to initiate pumping while the mom is still in an upright position.

Milk pours out like a crack in a child's plastic swimming pool, steadily draining. We have collected over 3 ounces, as the mother lies motionless on the bed. I speak to her as though she were wide awake, telling her how cute her baby is, and letting her know we look forward to her first visit to the NICU. It's days before I meet a quasi-alert mother, who, though not yet speaking, seems happy that I'm pumping her, half-smiling as she watches the milk empty into the bottles, once I've moved her oily, long brown hair off her chest so she can see.

The father of the baby tells us she'd wanted to breastfeed all along. She can't speak for herself yet, so his rather talkative and assertive demeanor doesn't surprise me. Over time, the ICU staff tells me he hardly lets her speak, even when she can. Still, I don't know if this results from a sense of overprotection. Over the coming days, I can see that her family is reserved in his presence. He looks about 15 years her senior, which may play a factor.

Remarkably, as mom becomes more stable, she continues to make ever-increasing volumes of milk. Dad is vigilant in insisting the ICU staff help with pumping every 3 hours around the clock, until the two of them can manage it on their own. His forcefulness doesn't endear him, but I have to admit that she probably pumps twice as often with his advocating. When she is considered fully out of the woods, she makes a wheelchair visit to the NICU, several bottles of milk in hand. We switch her from the 2-ounce bottles to larger 4-ounce bottles, to make pumping easier and to get a nice mix of calories in all bottles. Dad has been holding

their daughter in the mother's absence, but she now sheds her gown and blissfully holds her daughter skin to skin.

Dad continues speaking for mom throughout the baby's hospitalization, only relenting when the nurses say, "We'd like mom to answer this question, if that's OK with you." Over time, they learn the art of breastfeeding together and the baby is discharged home partially breastfeeding and partially receiving her mother's expressed milk that is fortified with added protein, minerals, and calories.

Eight months after discharge, two lactation consultants drive 45 minutes to a neighboring county to participate in a fair sponsored by the county's Women, Infant, and Children (WIC) department. This family strolls up to the booth, mother holding her baby in a sling and breastfeeding as she walks. Dad begins his own PR blurb, attributing the survival of the mother and baby to the staff of an urban teaching hospital in the midwest. It's rewarding to overhear these stories, and today we're glad he's such an extrovert!

Several months after this, we receive an email from the WIC nutritionist assigned to their county. She tells us that dad is singing the praises of the lactation staff who came to their rescue when she couldn't speak for herself, and when he didn't know there was a way to preserve breastfeeding. She reiterates that they are grateful for the Lactation Consultants (LCs) who started mom on the path of nursing. The parents had been in for a well-baby check, she was still breastfeeding, still quiet in the dad's presence, but healthy—and alive. Alive!

Excerpt from: Auer, C. (2018). *Under One Sky*: Praeclarus Press. Used with permission.

Chris Auer, BSN, RNC, IBCLC, RLC, has spent the last 40 years assisting and listening to mothers, fathers, families, and healthcare providers at the University of Cincinnati Medical Center. No matter the nationality, race, or income level, a mother and father are vulnerable in the early days and weeks following birth. For 25 years, Chris provided a monthly breastfeeding lecture to pediatric residents and mentored lactation interns, combining research-based information with an emphasis on compassionate listening, empowering each mother to make her own decision as she navigates the early period of parenting. She is also a wife, mother to four adult children, grandmother of four, and spiritual companion to friends in her faith community in Spring Grove Village, Cincinnati, Ohio. Each of these, her personal connections, has in turn influenced her own perspective and journey.