

## The Maintaining Cause of Poor Diet during Lactation

Taking a complete life-story history is what we do as homœopaths. However it is also vital for a diet history to be collected especially when dealing with mothers and babies during the primal period.

As the time for Birth approaches the mother's levels of copper maximise under the influence of oestrogen to ensure effective contractions and a straightforward delivery. As a consequence her zinc levels drop (and that's why stretch marks become an issue at that time; they're one of the signs of zinc-deficiency) and this may become problematic in the early weeks of lactation as zinc is a co-factor for lactase. This enzyme is responsible for breaking down lactose in the milk and no babies have a full complement of enzymes at birth; they build gradually during the early weeks after birth.

Other zinc deficiency signs in the mother include: acne and poor wound healing; alopecia; brittle nails and white spots on nails; loss of taste and smell; poor appetite; itchy skin; low stomach acid levels resulting in loud intestinal gas (lots of flatus is always a good clinical sign that zinc levels are low); poor memory; depression and low immunity.

So, a lack of sufficient zinc in the maternal diet after the birth is one of the main drivers of GIT disturbance in the infant. It is complicated when the mother has a fast flow as the gut becomes overwhelmed with a volume of milk that is not able to be appropriately "dealt" with due to enzyme insufficiency; and is further complicated when the maternal diet has a preponderance of simple carbohydrates at the expense of protein and good fats with some supplementary complex carbohydrates. Such diets drive up the levels of lactose in the milk.

So, *simillimum* notwithstanding, attending to the mother's diet becomes a maintaining cause when the presenting complaint is colic or "diarrhoea". Most newborns pass some stool after a feed but this should settle to one to two movements a day the consistency of gravy and a golden colour. Having said that, some babies pass stool infrequently and may go several days without a movement and that's within the range of normal so long as the movement is of a good consistency and colour. A baby with intestinal disturbance passes noisy frothy stools which may contain mucous. The mucous occurs as a consequence of villi shedding due to GIT inflammation.

As a general rule mothers need a protein intake at the end of pregnancy and for the first six months of the lactation (i.e. until the baby begins a supplementary diet) of 1 gram per kilogram of her ideal weight. An average sized woman is about 60 kilos so her diet during the early months of lactation should aim for 80 protein grams a day supplemented by a range of good fats and complex carbohydrates in the form of vegetables and grains and avoidance (in the short term) of simple carbohydrates such as fruit. Any food with an "ose" should be put aside until the baby's stool is of a desirable consistency; particularly dairy if the Tubercular miasm is active.

To avoid undue stress associated with measuring and weighing food, the simple instruction of suggesting that the mother eat five times daily and ensure that, on each occasion, she includes a protein food that covers the palm of her hand, makes it easy for her and generally suffices. Good zinc sources of protein include organic beef and lamb; all seafoods but especially oysters; organic

eggs and nuts and seeds. Cashews, pumpkin and sunflower seeds are excellent sources so emphasis needs to be on them in the early weeks. A zinc supplement can be considered in the short term until the diet covers the mother's nutritional needs.

This case highlights the importance of getting the nutrition right.

A female infant, whose birth weight was 2.6kg, was brought to the clinic at 14 weeks weighing just 3.5 kg. There has been no weight gain for the past four weeks. Prior to that, weight gain was only 100 grams a week (under the recommended 150 grams per week). The baby is long, very thin, pale and listless. She is passing stool up to five times a day and it's explosive and watery and full of mucous.

The mother has a very good supply of milk and a fast flow such that the baby is unsettled at the breast as she cannot cope with the strong letdown and fast volume of milk delivered quickly. The mother offers both breasts at each feed.

The mother weighs 63 kg but her protein intake is low (about 30 grams/kilo of body weight). Her diet is low in fat and protein and the majority of her calories come from simple carbohydrates.

- Breakfast consists of Special K with tinned peaches and pineapple juice
- Morning tea is an apple or banana
- Lunch is a salad sandwich or roll and fruit (usually a banana) and water to drink
- Afternoon tea is a cup of tea and some Milk Arrowroot biscuits
- Dinner is chicken stir fry or "meat and veg" with a glass of wine. She has ice cream occasionally

The baby was given a stat dose of Silicea 30C and the mother instructed to increase her protein to 80 protein grams a day and to include a range of good fats and complex carbohydrates by having vegetables at both lunch and dinner along with some grains and to avoid simple carbohydrates until her baby achieved a satisfactory weekly weight gain and was stooling normally. She was also shown how to feed the baby enface (i.e. to have her sit astride the mother's thigh and feed in an upright position) and to use just one breast at a time over a two-hour period. The baby put on 250 grams the next week and weight gain then remained steady and the stool pattern normalised.

When there is an oversupply of milk, using one breast lessens production of milk and maximises fat intake for the baby. Its fat that slows down gut motility and puts weight on the baby. I explain to mothers that it helps to imagine one breast feeding as offering the soup, followed by the main meal and then dessert. If the baby is allowed to go back to the breast again within two hours it's a bit like having more dessert (i.e. the fat-rich hind milk) and this will satiate the baby who will then have a good sleep and wake ready to feed from the other breast.

As a general rule the need to feed from two breasts comes into play when the baby goes through his first big growth spurt and demands the breast lots over a 48 hour period while he builds the supply to maintain him at his increased size. Breastfeeds then are best done with a short feed from the first breast and then a longer feed from the second to which the baby can return for a top up if necessary.