

Breastfeeding Curriculum: LGBTQ+ Case Studies

These cases highlight breastfeeding/chestfeeding issues and concerns for LGBTQ+ (lesbian, gay, bisexual, queer/questioning, transgender, intersex, pansexual, asexual) patients. The three cases include parent concerns and discussion questions, which instructors can distribute to learners. Faculty can use them during grand rounds, noon lecture, journal club, or 1-on-1 with learners. Here are several tips for utilizing the clinical case studies:

- 1) After the case is read, ask learners to share what the parent or family's concerns might be.
- 2) Once you think the case is well understood, use the discussion questions to move the conversation to focus on possible solutions and courses of treatment.
- 3) If you do not have the opportunity for a live interaction, consider giving a case to the learners and request a written report, presentation, or poster about how he or she would approach the case.
- 4) You (or the learners) can also create your own cases as you become more familiar with what common breastfeeding issues you see in your local hospital.



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Case Study: The Mitchell Family

As part of a multidisciplinary team, you are participating in a perinatal meeting with Sam and Chad Mitchell. These fathers are preparing to welcome a child into their family using a surrogate, and this is their first opportunity to ask questions of the team regarding the initial neonatal care and possible feeding options for their newborn child. The parents are aware that your nursery has obtained a Baby Friendly Hospital designation and are wondering how these protocols can be modified to respect their family.

Parental Concerns:

- Both fathers are hoping to begin bonding with their child immediately after birth, what are some of the options available to them while their baby is in the birth hospital?
- One of Sam's sisters has a 15-month-old baby and has an abundance of stored milk which she has offered to share. Is there any concern with using this milk?
- If unable to use the paternal aunt's milk, what feeding options are available to the fathers while their infant is in the nursery?
- If they choose to use formula as the means of infant feeding, is it readily available to them in the hospital?

Questions to Consider:

- As the baby's physician, how will you address the concerns from the fathers about the ability to begin the bonding process with their infant immediately after birth? Are there other bonding opportunities you can encourage besides early direct breastfeeding/chestfeeding?
- How does human milk composition and/or nutritional content change over time, and how will this affect the parents' newborn if they were to use the Aunt's milk?
- Would your recommendations change if the human milk they were hoping to use was from someone they "met" on an informal milk sharing website or from an accredited milk bank rather than from a family member?
- How will you address the parental concern regarding the sense of judgment/guilt if the parents ultimately choose to feed formula, and how can you sensitively provide them with additional options for both in-hospital and home feeding options?

Answers

Parental Concerns:

- Both fathers are hoping to begin bonding with their child immediately after birth, what are some of the options available to them while their baby is in the birth hospital?
 - *If the gestational carrier consents, the fathers can consider being present in the delivery room.*
 - *As long as the infant does not need resuscitative care and both fathers are interested, both fathers can provide immediate skin-to-skin with their infant.*
 - *If these fathers are interested in feeding their newborn while continuing skin-to-skin, you could consider both the use of a bottle or a supplemental nursing system (SNS) that could mimic nursing without requiring the infant to latch to the fathers' chest. An SNS is typically a small flexible tube attached to a disposable bag system that, when used by a parent with anatomic breasts, can be placed alongside the nipple to simulate direct breastfeeding. This can*

serve both to ensure the infant is receiving adequate nutrition while also continuing to stimulate the breast to lactate. In the case of these parents, adjustments could be made to the feeding apparatus to simulate nipple feeding while continuing skin-to-skin contact.

- One of Sam's sisters has a 15-month-old baby and has an abundance of stored milk which she has offered to share. Is there any concern with using this milk?
 - *When considering using donor milk, parents should consider the risk of infections, improper storage, medications/substances used by the lactating individual and nutritional content of the milk.*
 - *HIV and CMV can be contracted from ingestion of infected milk. If blood is present in the milk (i.e. from cracked and bleeding nipples), there is some risk of hepatitis. Many families are comfortable with the low risk associated with a trusted family member or friend.*
 - *Expressed human milk should be appropriately refrigerated or frozen after expression.*
 - *There is the possibility of undisclosed medication or substance use from the lactated individual passing into the expressed milk. Many families are comfortable with the low risk associated with a trusted family member or friend.*
 - *Nutritional content of milk changes over time. See below for more in-depth discussion. Usually, all expressed milk is nutritionally appropriate for most newborns.*
- If unable to use the paternal Aunt's milk, what feeding options are available to the fathers while their infant is in the nursery?
 - *Donor human milk obtained through a certified Human Milk Banking Association of North America (HMBANA) has been thoroughly screened and pasteurized prior to being sent to health centers. While safe, it is important to also inform families that through the pasteurization process, certain immunological properties and nutritional components are significantly decreased. This can lead to deficient growth particularly for premature infants, however for the at-risk population (<1500g, extremely premature, existing intestinal disease) the benefit of increased tolerance of feeds outweighs the risk of poor growth. Parents are able, in some areas, to obtain pasteurized donor human milk for home use. This generally requires a physician's prescription and can be very costly. This leads some individuals to seek donor milk through informal direct milk sharing. Both the American Academy of Pediatrics (AAP) and the Academy of Breastfeeding Medicine (ABM) have statements recommending against the use of informal milk sharing to obtain human milk for infant feeding citing the increased infection risk due to non-standardized parental screening and milk processing measures. When counseling parents regarding alternative feeding methods, it is important to discuss this stance, as recent survey studies show that of those considering informal milk sharing as an option, very few will discuss this with their physician. Additionally some LGBTQIA+ parents who are utilizing a third-party surrogate will arrange with the surrogate to provide, either via direct breastfeeding or through expression, early human milk.*
 - *Commercially available formula is another option for infant nutrition.*
- If they choose to use formula as the means of infant feeding, is it readily available to them in the hospital?
 - *Yes, formula should be readily available in most, if not all, hospitals for families who choose not to or cannot use human milk.*

Questions to Consider:

- As the baby's physician, how will you address the concerns from the fathers about the ability to begin the bonding process with their infant immediately after birth? Are there other bonding opportunities you can encourage besides early direct breastfeeding/chestfeeding?
 - *More and more LGBTQIA+ couples are electing to expand their families with children, be it through adoption, surrogacy, or the pregnancy of one of the members of the relationship. This has been influenced by changes in policy around marriage equality and LGBTQIA+ parenting protections. Care in the newborn nursery presents a unique opportunity to engage all parents in the early care of infants. Though no studies have been done exclusively in cisgender gay male couples, studies have been done showing that early skin-to-skin contact between newborn infants and fathers can lead to better outcomes among infants in the NICU and increased levels of bonding between the father and infant.*
 - *By encouraging early skin-to-skin with both fathers in this scenario, you can help to engage the parental dyad in the early neonatal care with their child in ways other than initial breastfeeding.*
- How does human milk composition and/or nutritional content change over time, and how will this affect the parents' newborn if they were to use the Aunt's milk?
 - *It is important to counsel the family on balancing the risks versus the benefits of using mature milk in a newborn infant, and the transition of human milk through time. Broadly human milk can be separated into three major categories based on time and nutrient composition. While an in-depth discussion of the micronutrients in human milk are beyond the scope of this discussion, it is important to look at the changes of the major macronutrients - proteins, lipids, and sugars - over time. Colostrum, or the early milk, is relatively low in lactose and fat concentration when compared to mature milk and the protein component is primarily whey protein which is more easily absorbed by newborn infants. Colostrum is also much higher in secretory immunoglobulins and growth factors that are of utmost importance in early neonatal life. Over the transition to mature milk, lactose concentration increases up through the seventh month of lactation and lipid content increases throughout the duration of lactation. Protein content decreases through months 4-7 and then remains consistent. Another specific component which is significantly higher in colostrum is human milk oligosaccharides (HMO) which is approximately double the concentration in colostrum when compared to human milk.*
- Would your recommendations change if the human milk they were hoping to use was from someone they "met" on an informal milk sharing website or from an accredited milk bank rather than from a family member?
 - *Donor milk does carry the potential risks of the risk of infections, spoiling from improper storage, and presence of medications/substances used by the lactating individual.*
 - *HIV and CMV can be contracted from ingestion of infected milk. If blood is present in the milk (i.e. from cracked and bleeding nipples), there is some risk of hepatitis. Milk banks both screen donors and pasturize milk to negate these risks. Some donors will be willing to share their own medical testing results confirming no infections. Parents using milk from an unknown donor need to be aware of this potential risk.*
 - *Expressed human milk should be appropriately refrigerated or frozen after expression. It is possible that milk can spoil if not handled appropriately. Since the expressed milk is being*

handled by someone the parents do not know, they do not have control over initial handling and storage.

- *There is the possibility of undisclosed medication or substance use from the lactating individual passing into the expressed milk. Milk banks rigorously screen donors. Informal sharing of milk from an unknown donor does carry this risk.*
- How will you address the parental concern regarding the sense of judgment/guilt if the parents ultimately choose to feed formula, and how can you sensitively provide them with additional options for both in-hospital and home feeding options?
 - *Most importantly, all counseling needs to be done with the respect of the parents, their parental dynamic and wishes. This includes not only the ultimate feeding choice, but also affirmed pronouns, and how their child will refer to them. Assuring privacy, respect, and non-judgment should be paramount in all patient encounters.*

References:

- Scatliffe N, Casavant S, Vittner D, Cong X. Oxytocin and early parent-infant interactions: A systematic review. *Int J Nurs Sci.* 2019 Sep 12;6(4):445-453. doi: 10.1016/j.ijnss.2019.09.009. PMID: 31728399; PMCID: PMC6838998.
- Shorey S, He HG, Morelius E. Skin-to-skin contact by fathers and the impact on infant and paternal outcomes: an integrative review. *Midwifery.* 2016 Sep;40:207-17. doi: 10.1016/j.midw.2016.07.007. Epub 2016 Jul 5. PMID: 27476026.
- Nicholas J. Andreas, Beate Kampmann, Kirsty Mehring Le-Doare, Human breast milk: A review on its composition and bioactivity, *Early Human Development*, Volume 91, Issue 11, 2015, Pages 629-635, ISSN 0378-3782, <https://doi.org/10.1016/j.earlhumdev.2015.08.013>.
- Sriraman N, Evans A, Lawrence R, Noble L, and the Academy of Breastfeeding Medicine's Board of Directors. Academy of Breastfeeding Medicine's 2017 Position Statement on Informal Breast Milk Sharing for the Term Healthy Infant. *BREASTFEEDING MEDICINE* Volume 13, Number 1, 2018; Mary Ann Liebert, Inc. DOI: 10.1089/bfm.2017.29064.nks
- AAP COMMITTEE ON NUTRITION, AAP SECTION ON BREASTFEEDING, AAP COMMITTEE ON FETUS AND NEWBORN. Donor Human Milk for the High-Risk Infant: Preparation, Safety, and Usage Options in the United States. *Pediatrics.* 2017;139(1):e20163440
- Kuznetsova A, Sood N and Milanaik R. An Analysis of Parental Opinions of Human Milk Sharing Options. *Pediatrics* July 2020, 146 (1 MeetingAbstract) 144-145; DOI: https://doi.org/10.1542/peds.146.1_MeetingAbstract.144

Case Study: Ryan

You are seeing Ryan, a 28 year old pregnant individual in the third trimester, for a lactation consultation. This patient identifies as male and uses he/him pronouns. His pregnancy has been uneventful thus far and he hopes to provide human milk to his child after delivery.

Parental Concerns:

- How will lactating impact gender dysphoria?
- How will others react to seeing a man feeding a child from his body?
- Will milk supply be adequate? What can he do to optimize success?

- Can testosterone therapy and chest contouring surgeries (“top surgeries”) still be considered either during or after lactation?

Questions to Consider:

- In all lactation cases, we consider history (prenatal course, birth, past medical history, prior breast surgeries, medications, etc) when evaluating for potential lactation-related challenges. However, what factors would you ask about in this case?
- Are your waiting room, patient forms, patient handouts, exam rooms and your own use of language gender-neutral and inviting for a non-female-identifying patient?
- What will you recommend if this patient wishes to utilize gender-affirming testosterone therapy while continuing to lactate?

Answers:

Parental Concerns:

- How will lactating impact gender dysphoria? How will others react to seeing a man feeding a child from his body?
 - *Different people react differently to lactation and feeding a child. Some individuals will have worsening gender dysphoria while others will find it relieving that their mammary tissue finally has a useful and non-sexual function. Both transgender individuals and lactating individuals may receive public criticism. Working towards societal acceptance of both is important and ensuring your patient has a great support system can be useful.*
- Will milk supply be adequate? What can he do to optimize success?
 - *The concern regarding milk adequacy is no different for a transgender man that has experienced full pubertal breast/chest development and has not had chest surgery as compared to a cisgender woman. (See Module 1 and Module 2 Goal C)*
- Can testosterone therapy and “top surgeries” still be considered either during or after lactation?
 - *Lactation does not change future eligibility for any surgical or medical gender-affirming procedure. Chest contouring surgeries should not be performed during lactation but can be once lactation has ceased. Chest contouring surgery prior to lactation can interfere with lactation if ducts are severed or anatomy makes infant latch difficult but is not an absolute contraindication to future lactation. Testosterone therapy has traditionally been considered contraindicated during lactation because of testosterone’s ability to decrease milk supply and the lack of safety data regarding testosterone’s impact on infants receiving human milk. There have been recent studies that have suggested that this should be reevaluated. (See below.) Testosterone therapy prior to lactation is not a concern.*

Questions to Consider:

- In all lactation cases, we consider history (prenatal course, birth, past medical history, prior breast surgeries, medications, etc) when evaluating for potential lactation-related challenges. However, what unique factors would you ask about in this case?
 - *Many transmasculine patients may have either previously had or may be considering chest contouring surgery (aka “top surgery”). If your patient has already had surgery, learning more about that surgery can be important. If the surgery severed mammary ducts from the nipple,*

milk may not be able to be expressed out of the nipple even if lactogenesis occurs. If mammary tissue was significantly reduced, achieving adequate supply may be a concern. Some contouring surgery can lead to more difficulty in achieving deep latch. Ideally, these possible outcomes should have been discussed as part of a preoperative counseling session. Even if the patient has had surgery that left him unable to express any milk or has limited milk supply, he can still use an SNS to feed the baby from his chest with the use of donor human milk or formula if he wishes. Discussing these options can be helpful.

- Are your waiting room, patient forms, patient handouts, exam rooms and your own use of language gender-neutral and inviting for a non-female-identifying patient?
 - *Our words and environments play a big role in making a patient feel welcome. See activity.*
- What will you recommend if this patient wishes to utilize gender-affirming testosterone therapy while continuing to lactate?
 - *Traditionally testosterone is considered contraindicated during lactation due to concerns for testosterone decreasing milk supply as well as lack of safety data for infants. To our date, there are only two published reports. There is a report that describes an individual patient's experiences where a transgender man initiated testosterone therapy at 21 months post partum and continued to lactate while on testosterone for an additional 15 months. He stated there were no adverse events and that his child had normal testosterone levels. However, the paper did not share any actual data from this case. There is also a study of cisgender lactating women who received testosterone therapy either via subcutaneous pellet implantation, vaginal cream or sublingual drops. During this seven-month study, there were no adverse infant events and infant serum testosterone values remained low.*

References:

Drugs and Lactation Database (LactMed). (2018). *Testosterone*.

<https://www.ncbi.nlm.nih.gov/books/NBK5011721/>

Ferri, R.L., Rosen-Carole, C.B., Jackson, J., Carreno-Rijo, E., Greenberg, K.B., & Academy of Breastfeeding Medicine. (2020). ABM Clinical Protocol #33: Lactation care for lesbian, gay, bisexual, transgender, queer, questioning, plus patients. *Breastfeeding Medicine*. 15(5):284-293. doi: 10.1089/bfm.2020.29152

Glaser, R.L., Newman M., Parsons M., Dava, D., & Glaser-Garbrick, D. (2009). Safety of maternal testosterone therapy during breastfeeding. *International Journal of Pharmaceutical Compounding*. 13(4):314-7.

McDonald, T., Noel-Weiss, J., West, D., Walks, M., Biener, M., Kibbe, A., & Myler, E. (2016). Transmasculine individuals' experiences with lactation, chestfeeding and gender identity: a qualitative study. *BMC Pregnancy and Childbirth*. 16:106. doi: 10.1186/s12884-016-0907-y

Case Study: Josie & Kristy

Josie, a 34 yo G1P0 at 28 weeks, and her wife, 31 yo nulliparous Kristy, come to see you for a pre-birth consultation. Josie's pregnancy was achieved by IUI with donor semen and has been uncomplicated thus far. Neither Josie nor Kristy have ever lactated. They do not have any chronic health problems, take any medications nor have they had any surgeries.

Parental Concerns:

- How might not birthing or lactating impact Kristy’s “mothering” experience?
- Can Kristy also breastfeed their child?
- If Kristy does breastfeed, will this cause the infant confusion or adversely impact the infant’s nutrition?
- If Kristy does breastfeed, can they split night feedings every other night to give each mom a chance to sleep uninterrupted?

Questions to Consider:

- How does a non-gestational parent induce lactation?
- What are the risks of lactation induction?
- If two parents are providing milk, how do you ensure the baby is receiving adequate nutrition?
- What special considerations need to be considered for dual-lactating parents?

Answers:

Parental Concerns:

- Will not birthing or lactating impact Kristy’s “mothering” experience?
 - *Parenting can and does look different for almost every family! As this family’s health care provider, it’s important to use precise terminology and offer appropriate support. In this scenario, Josie is the gestational parent and biologic parent (IUI with donor sperm means that Josie’s egg was fertilized). Kristy is not the gestational or biologic parent but that certainly makes her no less of a mother. Depending on state laws, Kristy will either be able to be listed as the second parent on the birth certificate or adopt the child after birth. It is important to know what the family plans to use for names – perhaps one parent will be “Mommy” and the other “Mama.” Also ascertaining the non-gestational parent’s goals is very important.*
- Can Kristy also breastfeed their child?
 - *Induced lactation is possible! Parents who have previously provided milk to a child can “relactate” and people who have never lactated can “induce lactation.”*
- If Kristy does breastfeed, will this cause the infant confusion or negatively impact the infant’s nutrition?
 - *If both parents choose to breastfeed their child, it is important that the gestational parent preferentially directly feed the baby immediately following birth. The initial nipple stimulation and suckling will help drive the process of lactogenesis II. While her milk supply is being established, it is important to optimize nipple stimulation and breast emptying. Once the lactation relationship is well established, most infants can go back and forth between multiple sources of milk. As long as the infant is receiving an adequate volume of milk daily, it can come from multiple sources.*
- If Kristy does breastfeed, can they split night feedings every other night to give each mom a chance to sleep uninterrupted?
 - *Unfortunately, not always or at least not completely. In order to maintain milk supply, breasts need to be emptied of milk at regular intervals. If output decreases, a negative feedback loop will cause the parent to make less milk. Therefore, depending on a parent’s storage capacity, even if the baby is feeding from another source overnight, often the breasts will still need to be emptied to avoid engorgement, plugged ducts, mastitis and drop in milk supply.*

Questions to Consider:

- How does a non-gestational parent induce lactation?
 - *Induced lactation requires an artificial stimulation for lactogenesis I (usually triggered by the hormones of pregnancy) and lactogenesis II (usually triggered by delivery of the placenta, drop in progesterone and suckling). Protocols usually start 6 months prior to the planned birth of a baby. The inducing individual will start on a combined oral contraceptive pill (OCP) to mimic the hormones of pregnancy) and a pharmacological galactagogue. Domperidone is the most frequently listed agent in lactation-induction protocols but is not available in the US and has a black box warning. Reglan can sometimes be used instead. Approximately 6 weeks prior to birth of the baby, the OCP is stopped (to mimic that change in hormones at delivery) and pumping via an electric pump with hands on stimulation is encouraged 8 times per day with no more than 5 hours between pumping sessions.*
- What risks need to be considered for lactation induction?
 - *The hormones in an oral contraceptive pill include progesterone and estrogen. High estrogen is associated with an increased risk of thromboembolism. Estrogen is usually contraindicated for people with increased risk of stroke (including history of blood clots, history of migraine with aura and strong family history). Personal or family history of breast cancer should also be considered. Domperidone is not available in the US and has a black box warning due to its risk of causing prolonged QT and sudden cardiac arrhythmias and death. Reglan has also been associated with prolonged QT. Medical and family history should be obtained and baseline ECG should be considered. Most individuals who induce lactation do not achieve a full supply. Setting goals and realistic expectations can help limit disappointment and subsequent depression.*
- If two parents are providing milk, how do you ensure the baby is receiving adequate nutrition?
 - *Usually the non-gestational parent will have less of a milk supply than the gestational parent. Making sure the gestational parent is regularly emptying breasts, either through direct feeding or expression, will help ensure adequate supply is achieved and maintained. The baby should be monitored in the same ways we monitor all babies – weight gain, weighted feeds, evaluation of output.*
- Other than a family of two cisgender female parents, who else might consider induced lactation?
 - *Any adoptive parents with mammary tissue can consider induced lactation! A female parent utilizing a gestational carrier for her biological child may choose to induce lactation. Similarly, an adoptive female parent may choose to induce lactation in anticipation of an infant adoption. A transgender male or transgender female patient could induce lactation as long as breast tissue is present and mammary ducts leading to the nipple have not been severed due to prior breast surgery. There has been one published case report of success in a transgender woman. Higher doses of estrogen/progesterone were required in order to support both the gender-affirming therapy and then the increase in hormone to mimic pregnancy. The remainder of the lactation protocol was similar. There are slight variations in the protocol for individuals who have previously lactated (“re-lactation”) or individuals who are post-menopausal.*

References:

Goldfarb L and Newman J. The protocols for induced lactation: a guide for maximizing breastmilk.
https://www.canadianbreastfeedingfoundation.org/induced/regular_protocol.shtml

T Reisman and A Goldstein. Case report: induced lactation in transgender woman. Transgender Health. 2018;3(1). <https://doi.org/10.1089/trgh.2017.0044>

RL Ferri et al. ABM Clinical protocol #33: Lactation care for the lesbian, gay, bisexual, transgender, queer, questioning, plus patients. Breastfeeding medicine. 2020; 15(5).
<https://doi.org/10.1089/bfm.2020.29152.rlf>

<https://www.lli.org/breastfeeding-without-giving-birth-2/#:~:text=The%20only%20necessary%20component%20to,a%20variety%20of%20manual%20techniques.>