



FORMACIÓN ONLINE EN
*Lactancia
materna*

·y Salud Mental·
tercera edición



De Octubre de 2020 a Junio de 2021



Instituto Europeo de
Salud Mental Perinatal



LACTANCIA



Y



SUEÑO



Introducción

Precocial



Altricial



Secundariamente Altricial



Ball, H. & Russell, C. K., 2013. Nighttime nurturing: An evolutionary perspective on breastfeeding and sleep. In: *Evolution, early experience and human development*. Oxford: Oxford University Press, pp. 241-261.



Introducción

Especie	% Agua	% Proteína	% Grasas	% Carbohidratos
Humana	87.4	1.63	3.75	7
Coneja	69	11.5	15	1.2
Perra	77.3	7.5	9.5	3.3
Gata	79.5	7.5	8.5	4

Precociales/secundariamente altricial



Altriciales



Por la composición de la leche, se requieren tomas frecuentes:

- Baja en proteínas y grasas
- Alta en carbohidratos (lactosa)



Introducción



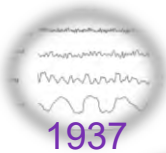


Orígenes de la Ciencia del Sueño Infantil

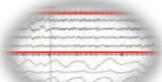
Hans Berger



1920

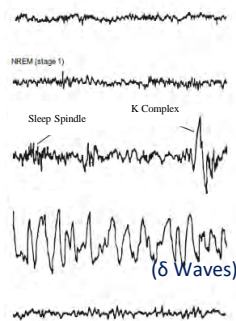


1937



1953

Siglo XX



Vigilia

(Low amplitude and high frequency waves)

Fase 1

(2%-5%)

Fase 2

(45%-63%)

Fase 3

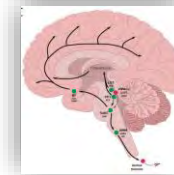
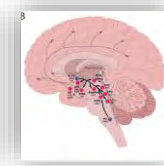
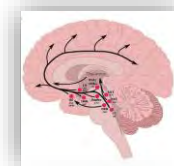
(Sueño de ondas lentas)

(20%-25%)

REM

(25%)

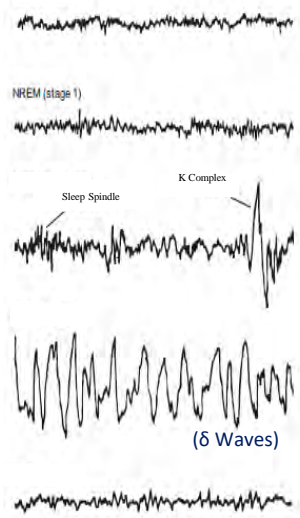
NREM





Arquitectura del Sueño

Polisomnografía



Wakefulness
(Low amplitude and high frequency waves)

Stage 1
(2%-5%)

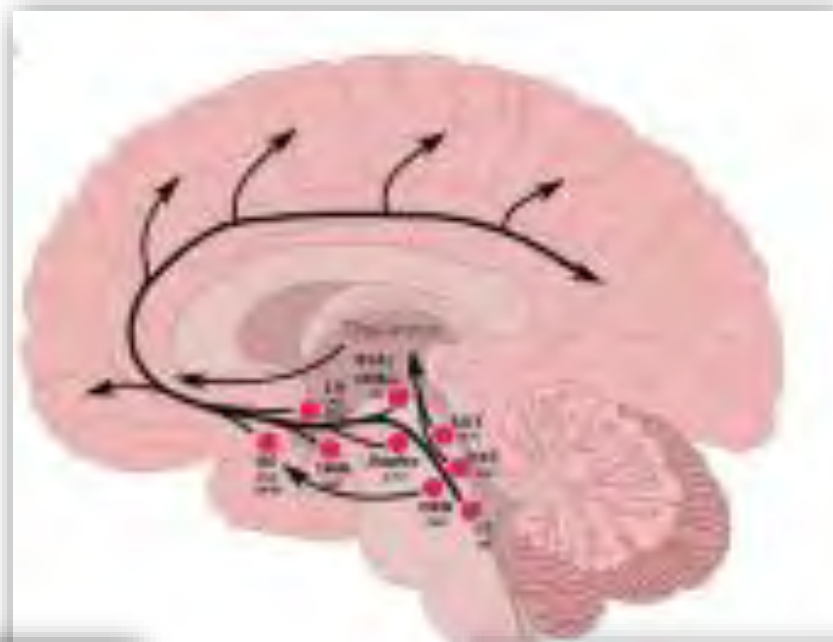
Stage 2
(45%-63%)

Stage 3
(Slow Wave Sleep)
(20%-25%)

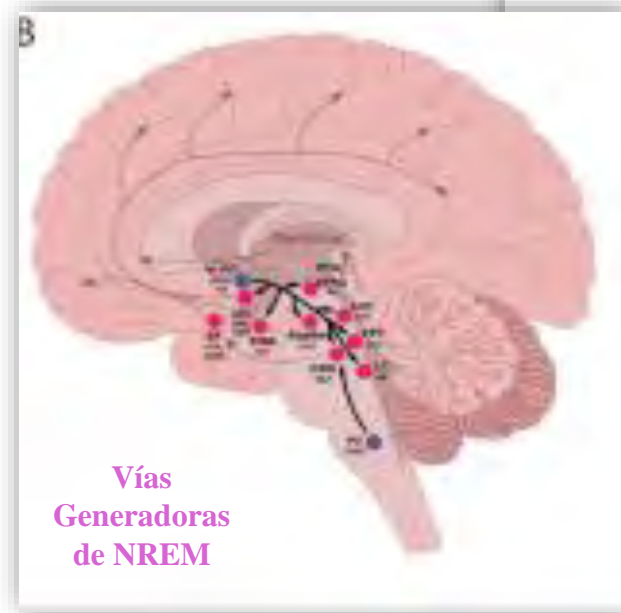
REM
(25%)

NREM

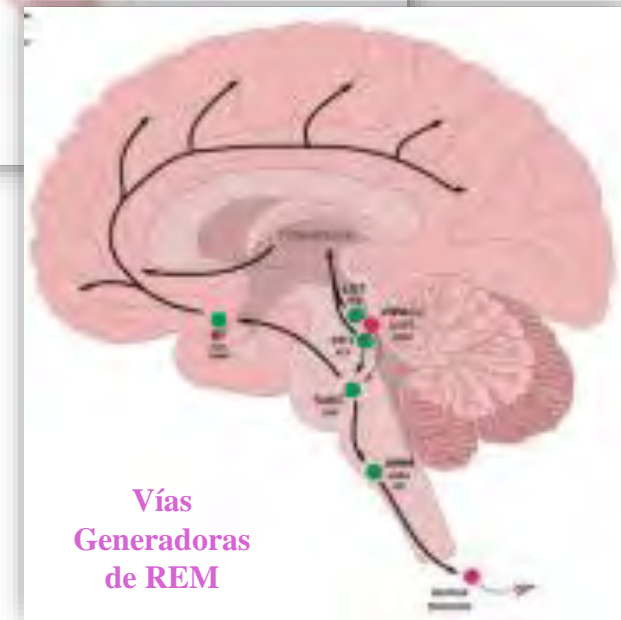
Neuroanatomía del Sueño



Sistema Despertador



Vías Generadoras de NREM

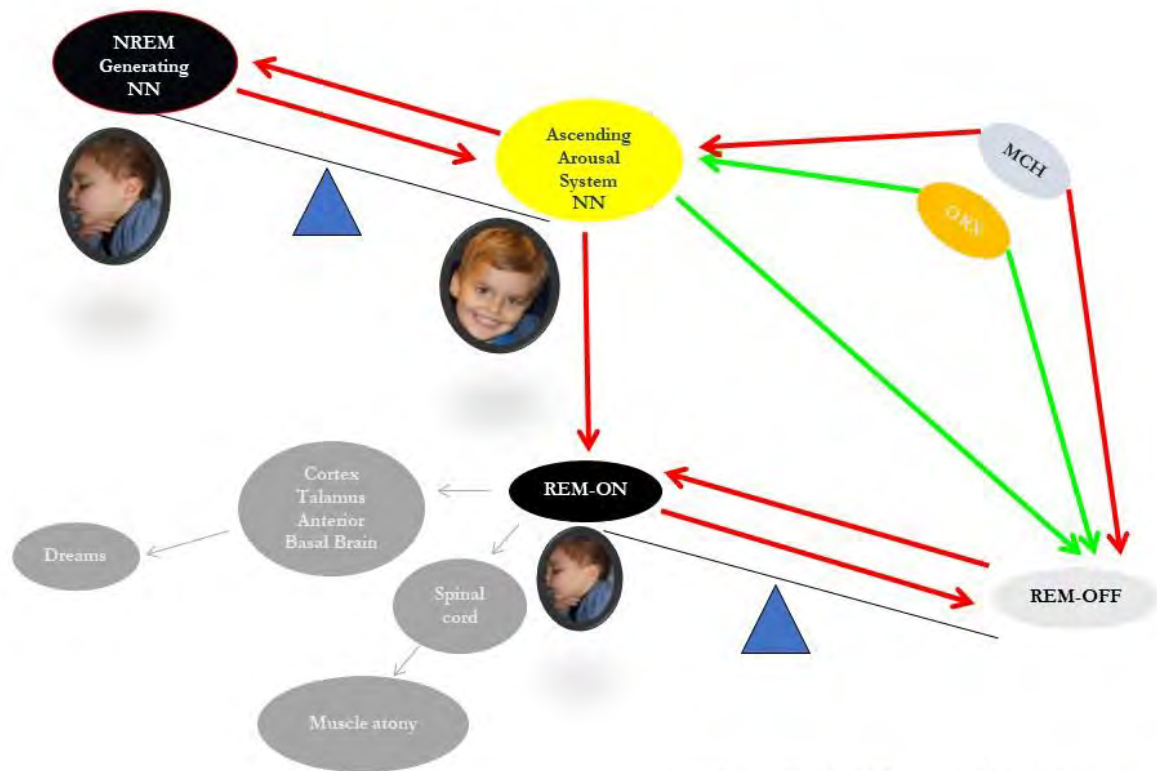


Vías Generadoras de REM



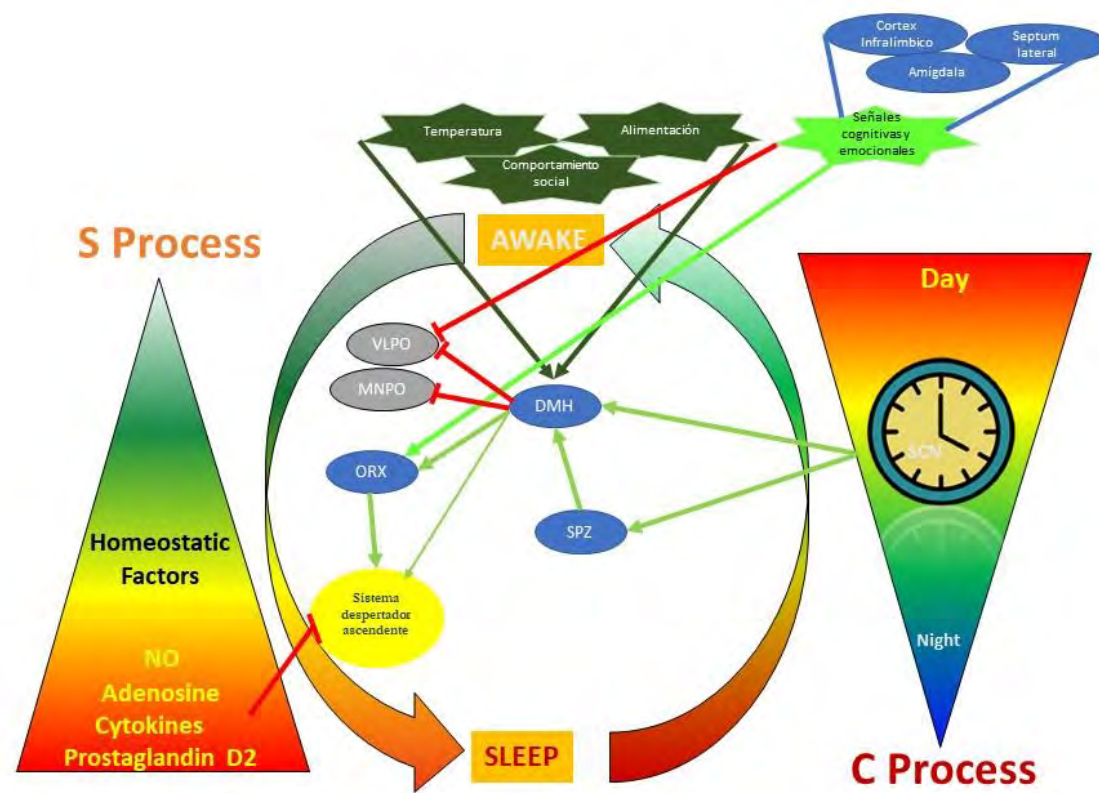
Modelo del Interruptor Vasculante

The Flip-Flop Switch Model



Fuente: C. B. Saper, P. M. Fuller, N. P. Pedersen, J. Luy T. E. Scammell, «Sleep state switching», *Neuron*, vol. 68, nº 6, pp. 1023-1042, 2010.

Regulación del Sueño





Evolución del Sueño a lo Largo de la Vida



Prenatal Sleep



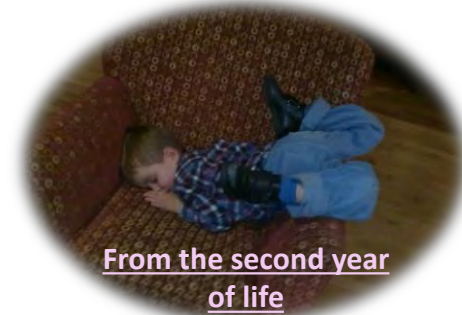
Newborn



3 months



6 months



From the second year of life

Fases de sueño y vigilia aparecen claramente en el tercer trimestre

Primero aparece el **Sueño Activo (AS)** hacia el 6º mes.

El **sueño tranquilo (QS)** aparece hacia el 7º mes.

Para la semana 30 hay un 70% de AS

También existe una fase de **Sueño Indeterminado (IS)**.

A medida que el feto se desarrolla la IS va disminuyendo, la QS aumentando y la AS se mantiene estable

Diversas condiciones en la etapa intrauterina van a influir en el sueño en la niñez.

La arquitectura del sueño en esta época parece estar relacionada con la capacidad de autorregulación durante la infancia y la adolescencia.

Pasar por las tres fases del ciclo dura unos 70-90 minutos.

El sueño del feto es independiente del de la madre

La forma de nacer (parto vaginal, cesárea de urgencia o cesárea programada) influye sobre la arquitectura del sueño.

El sueño comienza directamente en AS. 50%

Se irá produciendo una disminución de AS durante el día y un aumento de QS por la noche

Seguirá un ritmo ultradiano y poliseccional

La longitud del ciclo de sueño será unos 60 minutos en el bebé a término. (Más corto en el prematuro).

Entre la 6 y las 8 semana en la mayoría de bebés se observan los husos del sueño

A partir del segundo mes de vida las fases AS y QS se pueden empezar a clasificar como REM y NREM.

Hasta los 4 meses la AASM no se atreve a hacer recomendaciones sobre las horas que deben dormir los niños debido a la enorme variabilidad observada.

Se alinean los procesos circadiano y homeostático.

A partir de las 12-14 semanas se establece el patrón diario con un periodo más largo de sueño nocturno, periodos de sueño más cortos durante el día (siestas) y de 1 a 3 horas de vigilia justo antes del sueño nocturno.

Comienzan a desarrollarse las fases de NREM, lo que puede traducirse en más microdespertares e inestabilidad en el sueño.

Disminuye la probabilidad de que el bebé comience el sueño en AS.

Ya muestran actividad delta característica del sueño de ondas lentas.

Ya se han desarrollado en la mayoría de bebés todas las fases de NREM

El REM ocupa un 30% del total.

Ya no se distingue la fase IS.

Sus niveles de melatonina endógenos ya siguen un ciclo bien establecido.

Los bebés muestran un patrón circadiano con periodo, amplitud y actividad de fases similar a los adultos.

El sueño ya tiene la arquitectura del sueño adulto.

Entre los 2 y 3 años el sueño REM habrá disminuido hasta un 25% y el sueño NREM se habrá intensificado.

Las horas de sueño al día disminuirán del 11-14 horas en niños de 1 a 2 años a 9-12 horas en niños de 6 a 12 años y de 8 a 9 horas de 13 a 18 años.

Durante la adolescencia la cantidad de sueño de ondas lentas empieza a disminuir hasta estabilizarse en el adulto joven.

La duración del ciclo va aumentando pasando de 69 minutos en el neonato a 85-115 minutos en los niños de 8 a 12 años. En el adulto la media es de 90 minutos.





Evolución del Sueño a lo Largo de la Vida





Evolución del Sueño a lo Largo de la Vida

Sleep
11(4):387-401, Raven Press, Ltd., New York
© 1988 Association of Professional Sleep Societies

Sleep and Waking States in Infancy: Normative Studies

¿Mother?

Token Geidel
Material based on
Twelve were ap-
the absence of appropriate for gestational ages according to the intrauterine growth curve of Usher and McLean (27). They were monitored on six occasions from birth to 6 months of age (Table 1). Informed consent was obtained.

Each infant was admitted at 5:00 p.m. to the sleep laboratory for 12-hour, all-night monitoring sessions during the first week of life, and at 1, 2, 3, 4, and 6 months of age. The infants were fed during preparation for monitoring and application of electrodes. A demand feeding schedule was followed and in several instances the infants were breast fed. Arm restraints were applied before the initiation of recording. Monitoring was carried out in a darkened room adjacent to the room containing recording equipment. Room temperatures ranged between 22 and 30°C. The infants were placed in a supine or side-lying position and observed continuously with the use of a low-illumination television camera and monitor. Behaviors such as closing or opening of the eyes, startles, crying, and nursing interventions were charted on the polygraph paper.



Evolución del Sueño a lo Largo de la Vida

Sleep Medicine Reviews, Vol. 7, No. 2, pp 179–191, 2003
doi:10.1053/smr.2002.0198

Buscar

Anterior Siguiente

reviews

CLINICAL REVIEW

The development of sleep during the first months of life

Al W. de Weerd and Renilde A. S. van den Bossche

Center for Sleep and Wake Disorders, Juliana Children Hospital and MCH, Westeinde Hospital, P.O. Box 432, 2501 CK The Hague, The Netherlands

KEYWORDS

sleep, polygraphy
EEG, neonate, infant

Summary The development of sleep during the first months of life is intriguing from a scientific point of view but is interesting to the clinician as well. This review aims at providing data on sleep in "low-risk" premature neonates, neonates born at term, and infants up to the age of 6 months. The various milestones in clinical and polygraphic features of sleep allow for week-to-week assessment of brain function in normal and sick children. © 2003 Published by Elsevier Science Ltd

INTRODU

The developm
life is intriguing
and polygraphi
changes in bra
central nervous system. Clinical observation of the characteristics of sleep in neonates and infants can be used for diagnosis of brain disorders and has an important prognostic value.

Acrobat Reader

Adobe Acrobat Reader finalizó la búsqueda del documento. No se encontró ninguna coincidencia.

Aceptar

ital polygraphy, in
one knows the
exact age of the child under study. What is important is not the time that has elapsed between birth and the moment when the EEG is recorded but rather the conceptual age (CA) which is defined as the length of



Evolución del Sueño a lo Largo de la Vida

Sleep-wake cycle of the healthy term newborn infant in the immediate postnatal period

Irina Kozlovskaya
Geraldine
Clinical Neurophysiology



Conclusions: This is the first large cohort EEG study that has quantified neonatal sleep. SWC is clearly present immediately after birth, it is dominated by AS, and is influenced by mode of delivery.

Significance: This knowledge of the early neonatal EEG/SWC can be used as reference data for EEG studies of neurologically compromised infants.

channel ECG. Respiratory movements were measured using a thoracic respiratory band. Simultaneous video was also recorded to allow behavioural assessment of sleep states.



Should Neonates Sleep Alone?

Barak E. Morgan, Alan R. Horn, and Nils J. Bergman

BIOL PSYCHIATRY 2011;70:817–825

© 2011 Society of Biological Psychiatry

Methods and Materials

Nineteen normal healthy full-term neonates (37+ weeks gestation) born by cesarean participated in a within-subject design. Mothers had no psychiatric/neurological history or physical complications and all babies had good Apgar scores (Table 1). Maternal-neonate dyads were a convenience sample by virtue of mothers staying 3 days in hospital postcesarean. Routine postnatal ward care for well neonates during sleep is loose swaddling in open bassinets next to mother's bed. Mothers gave written consent on postoperative day 1. The following day, after neonatal examination confirmed them fit for discharge and pending maternal discharge, three electrocardiogram (ECG) electrodes were applied to the neonate's chest and two to the back during breastfeeding. Neonates then spent an hour in SSC and an hour in MNS (2 hours total, order randomly counterbalanced by tossing a coin). **During SSC, neonates were secured in a prone position on their mother's chest using a customized wrap-around shirt (46).** During MNS, neonates were loosely swaddled in blankets according to ward routine and **placed semiprone, left side down, facing toward mother in a bassinet next to her bed.** Level of arousal was recorded every minute using the Anderson Behavioral State Scale (39), wherein state 1 equates with quiet sleep and states 2 to 4 encompass all the stages of active sleep. An uninterrupted series of interbeat intervals (IBI)



Evolución del Sueño a lo Largo de la Vida

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© 2011 Society of Biological Psychiatry

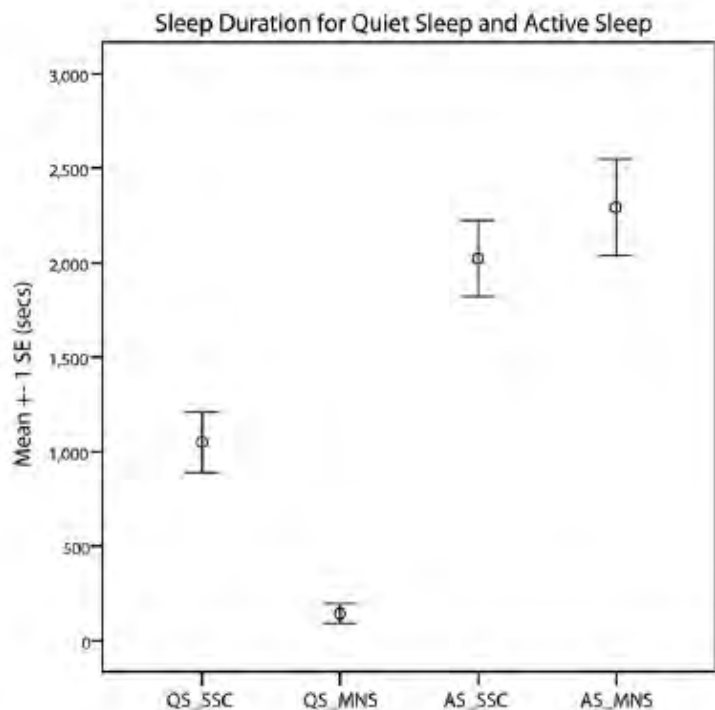


Figure 5. Sleep duration in skin-to-skin contact (SSC) and maternal-neonate separation (MNS). Quiet sleep (QS) was significantly longer in SSC (QS_SSC) than in MNS (QS_MNS) (mean_{SSC} ± SE = 1049 ± 638.8 seconds, mean_{MNS} ± SE = 142 ± 204.2 seconds, $p < .001$). Active sleep (AS) was not significantly different in SSC (AS_SSC) and MNS (AS_MNS) (mean_{SSC} ± SE = 2022 ± 201.0 seconds, mean_{MNS} ± SE = 2292 ± 256.7 seconds, $p = .403$).



Table 2. Summary of Four Temperature-Controlled Studies Reporting Decreased Quiet Sleep During MNS Compared with SSC

Study	Time	Parameter Reported	SSC Value	MNS Value	Average Quiet Sleep Decrease (%)
Begum <i>et al.</i> (61)	MNS/Early SSC	Number of infants in quiet sleep at pre-specified time points	61.5	15.4	
	Late SSC/MNS		76.9	38.5	
Messmer <i>et al.</i> (63)	Average	Percentage time spent in quiet sleep	69.2	26.95	61
	MNS before SSC		25.55	13.6	47
Lal <i>et al.</i> (62)	MNS after SSC	Number of 10-minute blocks spent in quiet sleep/hour	14.95	14.95	
	Average		25.55	14.275	44
	Day 1		3.87	2.2	
	Day 2		4.13	1.8	
Ludington-Hoe <i>et al.</i> (39)	Day 3	Not specified	3.06	2.13	
	Average		3.69	2.04	45
	2- to 3-hour matched sessions SSC/MNS		Significantly less Quiet Sleep during MNS		
Current Results	1 hour each (SSC/MNS)	Average time (seconds) spent in quiet sleep	1049	142	86

MNS, maternal-neonate separation; SSC, skin-to-skin contact.

The percentage decrease in quiet sleep ranged between 44% and 61%. The current study found an 86% decrease in quiet sleep.



Evolución del Sueño a lo Largo de la Vida

nature publishing group

Pediatric Research **77**, 10–19 (2015)

Integrated Mechanism Review

Proposal for mechanisms of protection of supine sleep against sudden infant death syndrome: an integrated mechanism review

Nils J. Bergman¹



Table 1. Studies reporting support for prone sleep: results and comments (ranked by age at first exam)

Reference ^a	Context	Prone	Supine	Author comment
(1)	Own control, <i>n</i> 28; born 25–36 wk postmenstrual age, exam at 7 d old	Quiet sleep 68% Active sleep 24% Crying 6%	Quiet sleep 40% Active sleep 43% Crying 12%	Chang: "Prone positioning improves the quality of sleep, decreases stress for ventilated preterm infants." This author: 5–7 stress responses /20 min in supine—normal hourly sleep cycling highly unlikely.



Evolución del Sueño a lo Largo de la Vida



- Bebés de **4 a 12 meses** deben dormir de **12 a 16 horas diarias** (incluidas siestas).
- Bebés de **1 a 2 años** deben dormir de **11 a 14 horas diarias** (incluidas siestas).
- Niños de **3 a 5 años** deben dormir de **10 a 13 horas diarias** (incluidas siestas).
- Niños de **6 a 12 años** deben dormir de **9 a 12 horas diarias**.
- Adolescentes de **13 a 18 años** deben dormir de **8 a 9 horas diarias**.





Sueño Consolidado y Autoconsuelo



A partir de los **6 meses** debe dormir la noche de un tirón sin despertarse de sus padres y debe despertarse tras los primeros despertares

necesita
debe
on

que esto sea así tu
Insomnio Infantil por Hábitos Incorrectos (BIC)



Sueño Consolidado y Autoconsuelo

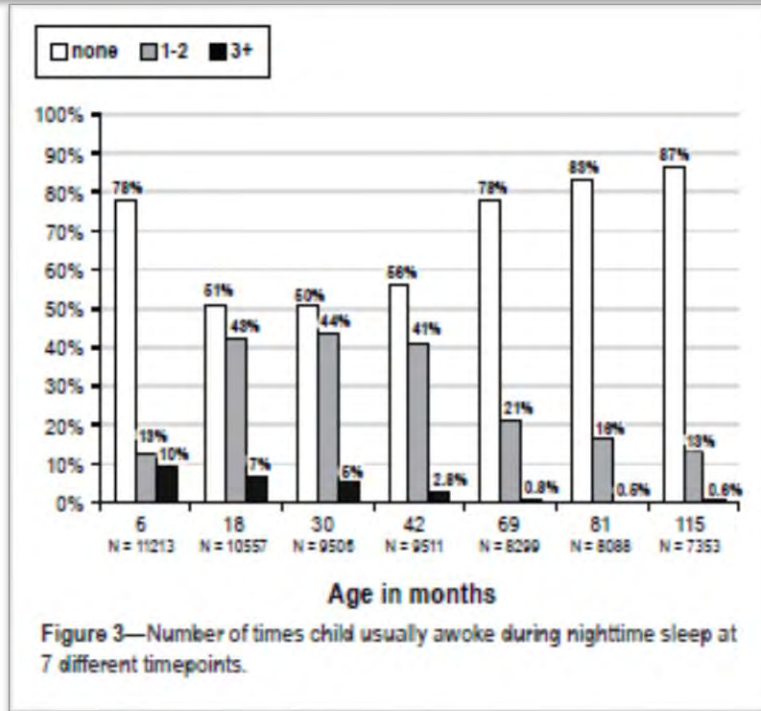
CHILDHOOD SLEEP DURATION AND ASSOCIATED DEMOGRAPHICS

<http://dx.doi.org/10.5665/sleep.1694>

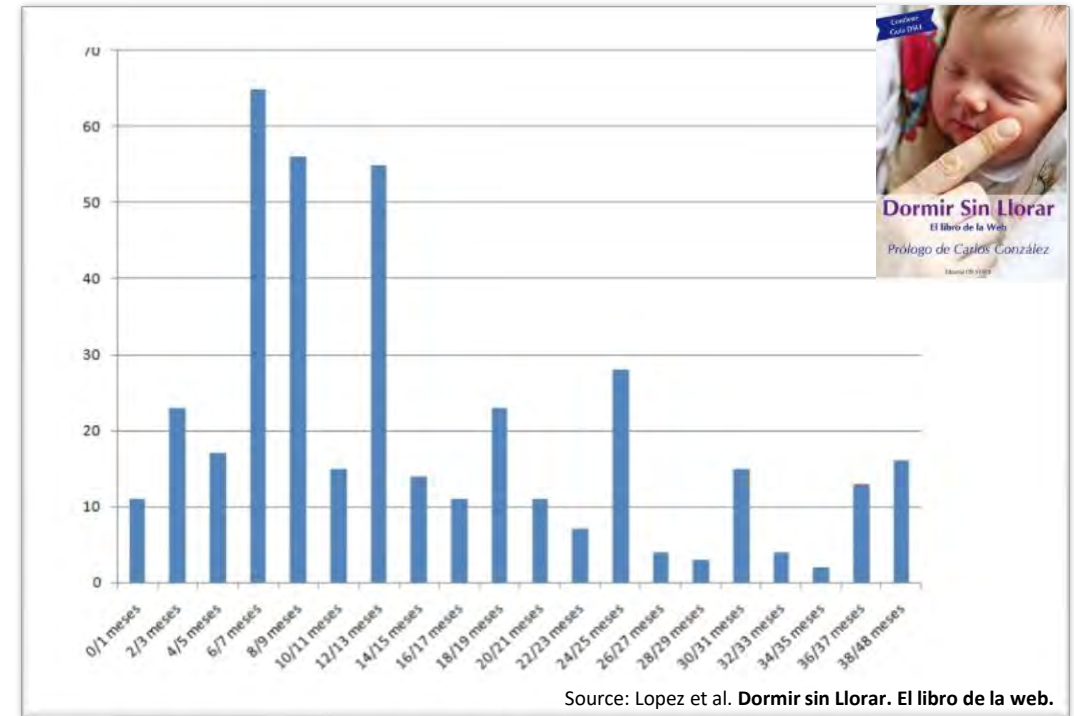
Childhood Sleep Duration and Associated Demographic Characteristics in an English Cohort

Peter S. Blair, PhD¹; Joanna S. Humphreys, MBChB¹; Paul Gringras, MBChB, MSc²; Shahrads Taheri, PhD³; Nicola Scott, D Clin Psy²; Alan Emond, MD, MBBChIR¹; John Henderson, MD¹; Peter J. Fleming, MBChB, MRCP, PhD¹

¹University of Bristol, School of Social & Community Medicine, Bristol, UK; ²King's College London, London, UK; ³University of Birmingham, Birmingham, UK



Childhood Sleep Duration and Associated Demographic Characteristics in an English Cohort. Blair, P S, et al. 3, 2012, Sleep, Vol. 35, pp. 353-360.



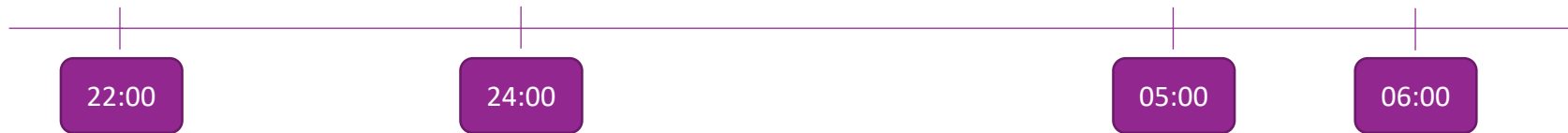


Sueño Consolidado y Autoconsuelo

LSRSP: Longest Self Regulated Sleep Period



LSP: Longest Sleep Period





Sueño Consolidado y Autoconsuelo

The consolidation of infants' nocturnal sleep across the first year of life

Jacqueline M.T. Henderson^{a,*}, Karyn G. France^b, Neville M. Blampied^a
 Sleep Medicine Reviews 15 (2011) 211–220

Sleeping Through the Night: The Consolidation of Self-regulated Sleep Across the First Year of Life

AUTHORS: Jacqueline M. T. Henderson, PhD,^a Karyn G. France, PhD,^b Joseph L. Owens, PhD,^a and Neville M. Blampied, MSc

PEDIATRICS Volume 126, Number 5, November 2010

	LSP Mx-mn (media)	LSRSP Mx-mn (media)	(horas)
1 mes	1.86-3.58 (3.57)	4.62- 6.98	
6 meses	4.76-5.97	8.50-11.64	
12 meses	4.72-6.71 (5.74)	6 -11.9	

DORMIR TODA LA NOCHE

Criterio 1: Dormir ininterrumpidamente desde las 24:00 hasta las 5:00, o sea 5 horas. Este era hasta el momento el criterio más utilizado en la bibliografía científica sobre el sueño infantil.

Criterio 2: El criterio de las 8 horas, dormir ininterrumpidamente 8 horas como mínimo entre la hora de acostarse por la noche y la hora de despertarse por la mañana

Criterio 3: Criterio compatible con la familia, o sea, el sueño es ininterrumpido desde las 22:00 hasta las 6:00.

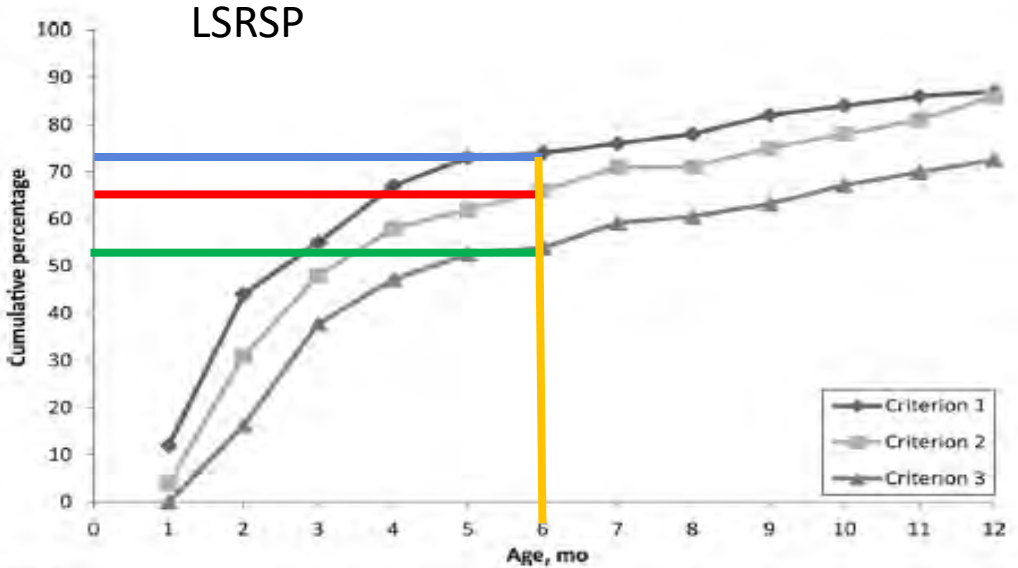


FIGURE 3 The cumulative percentage of infants who met criterion 1 (24:00–05:00 hours), criterion 2 (8 hours), and criterion 3 (22:00–06:00 hours) each month across the first year of life.



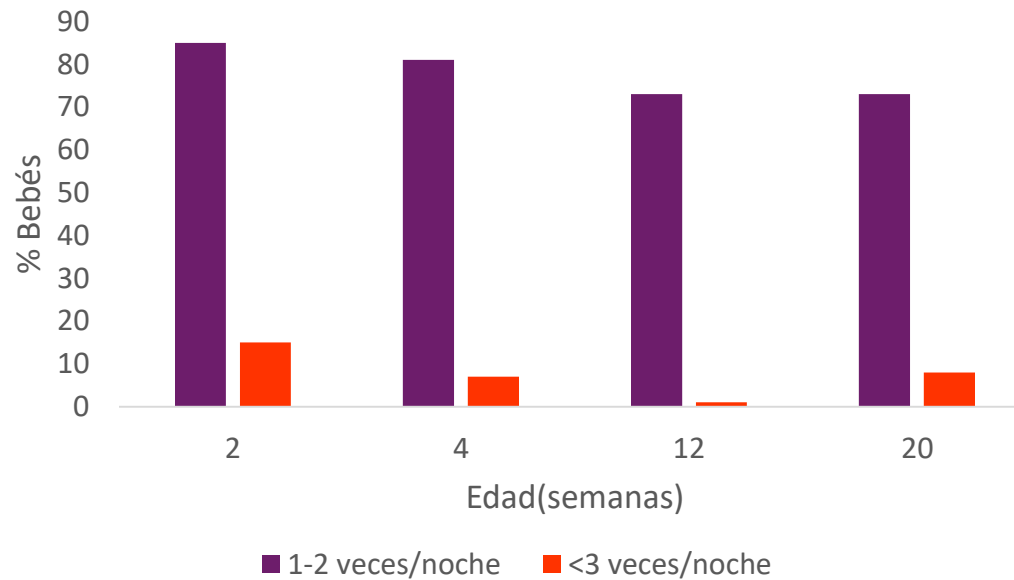
Sueño Consolidado y Autoconsuelo

Acta Pædiatr 88: 203-11. 1999

Breastfeeding patterns in exclusively breastfed infants: a longitudinal prospective study in Uppsala, Sweden

A Hömell, C Aarts, E Kylberg, Y Hofvander and M Gebre-Medhin

Section for International Child Health, Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden



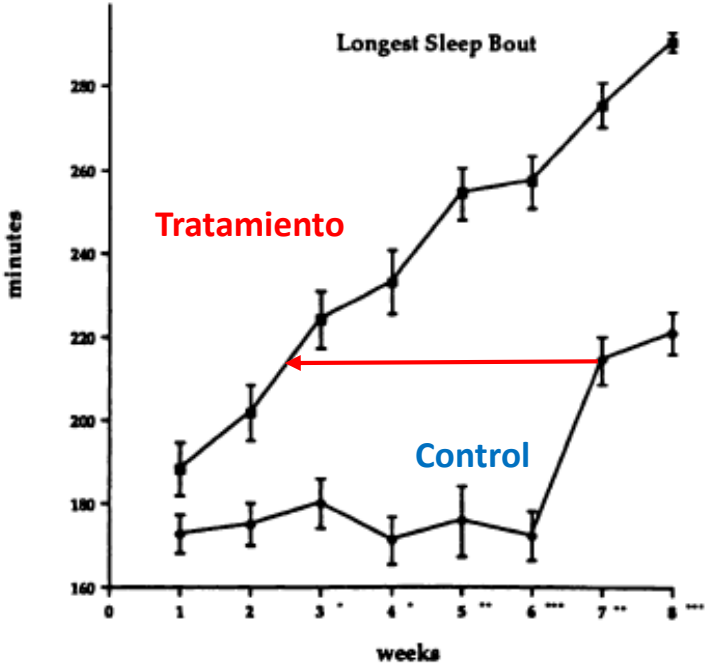
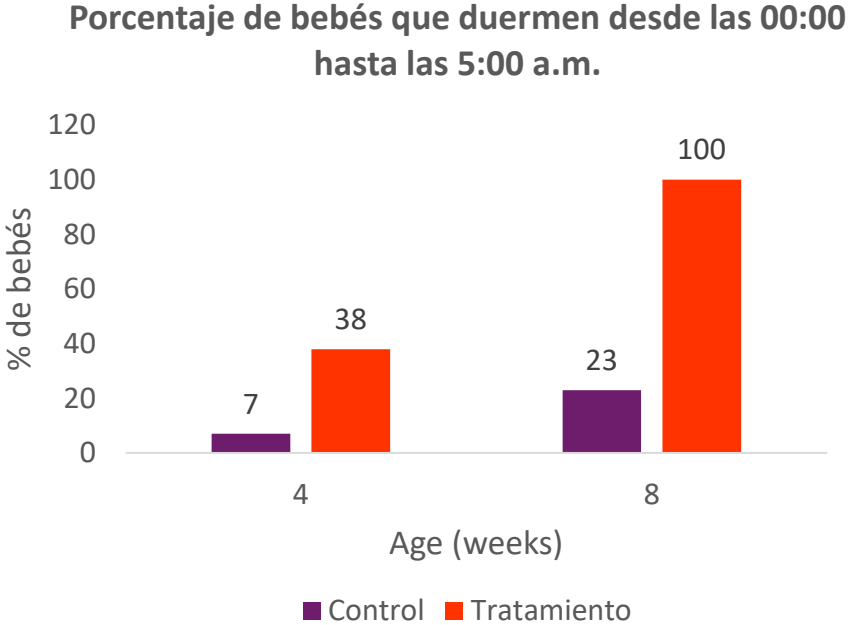


Sueño Consolidado y Autoconsuelo

Help Me Make It Through the Night: Behavioral Entrainment of Breast-Fed Infants' Sleep Patterns

Teresa Pinilla, PhD, and Leann L. Birch, PhD

Pediatrics, vol. 91, pp. 436-444, 1993.





Sueño Consolidado y Autoconsuelo

Núcleo Clínico. Originales

Hábitos adecuados compatibles

demandas

E. Estivill Sancho

Segarra Isern,
al Doménech
Dexeus de Barcelona
General de Catalunya.
Dexeus de Barcelona.
Dexeus de Barcelona.



Revista de Medicina Primaria. 2008;10:207-16

Eduard Estivill Sancho, estivill@ctv.es

Resumen

Introducción: el objetivo fue observar la sincronización del ciclo sueño-vigilia en un niño alimentado con lactancia materna a demanda exclusiva hasta los 6 meses de edad y sometido a rutinas conductuales estables que favorecieran la aparición de sueño espontáneo.

Material y métodos: se ha registrado un diario de vigilia-sueño en un recién nacido desde el nacimiento hasta los 6 meses de edad. Se registraron diariamente datos referidos al tiempo de vigilia, sueño, momento de la alimentación, deposiciones y hábitos higiénicos (baños y cambios de pañales). Se han seguido datos de su evolución cada 7 días, hasta los 18 meses de edad.

Resultados: durante la semana 1 a 7 se observa una presentación anárquica. A las 11 semanas ya duerme 8 horas durante el periodo nocturno. El progreso del número de horas dormidas durante la noche, es muy rápido entre la semana 18 a 20, durmiendo un promedio de 10,52 horas. Desde la semana 21 a la 35 el promedio es de 11,26 horas. El ritmo circadiano de vigilia-sueño se muestra por primera vez entre las 15 y 16 semanas (tres meses y medio) y persiste bien establecido hasta la actualidad (18 meses).

Conclusiones: la lactancia materna a demanda no supuso dificultad para conseguir una correcta sincronización del ritmo vigilia-sueño a partir de los tres meses y medio. Las normas conductuales sugeridas a estos papás durante la lactancia materna consiguieron los objetivos previstos: alimentar exclusivamente al niño con leche materna y conseguir una sincronización estable del ritmo vigilia-sueño. Nuestro trabajo puede ayudar en dos objetivos. El primero, fomentar la lactancia materna, el segundo prevenir el trastorno del sueño mediante la utilización de las normas propuestas.

LSP Mx-mn (media) LSRSP Mx-mn (media) (Horas)

1 Mes

1.86-3.58 (3.57)

4.62- 6.98

6 Meses

4.76-5.97

8.50-11.64

12 meses

4.72-6.71 (5.74)

6 -11.9



Sueño Consolidado y Autoconsuelo

Journal of Paediatrics and
Child Health



doi:10.1111/jpc.12089

ORIGINAL ARTICLE

Breastfeeding and infant sleep patterns: an Australian population study

Megan Galbally,¹ Andrew J Lewis,³ Kerri McEgan,² Katherine Scalzo³ and FM Amirul Islam⁴

¹Perinatal Mental Health Unit and ²Lactation Department, Mercy Hospital for Women, ³School of Psychology and ⁴School of Health and Social Development, Deakin University, Melbourne, Victoria, Australia

Breastfeeding and infant sleep patterns: an Australian population study. Galbally, M, et al. 2, 2013, J Paediatr Child Health, Vol. 49, pp. E147-E152.

...Normal sleep/wake cycles for infants who are breastfed to 6 months of age will be associated with frequent night waking. In order to maximize the health benefits to both mother and infant of breastfeeding, **professionals and parents need to adopt more realistic expectations of infant sleep patterns informed by the biology of infant sleep architecture and breast milk production and composition.** Future studies that **examine interventions for sleep in infancy** and toddlerhood should **systematically report the impact this may have on breastfeeding rates and duration for these children.** When investigating sleep concerns in infants and toddlers, studies should try to define more precisely the specific nature of the concern (e.g. night waking compared with difficulty getting to sleep or unsettled sleep) and its relationship to other aspects of the infant's routine such as breastfeeding.



Sueño Consolidado y Autoconsuelo

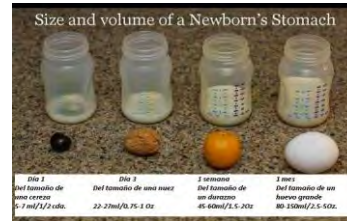
La pediatría del sueño ha en sus investigaciones ignorado e infravalorado el valor de la lactancia materna y las condiciones necesarias para que se desarrolle con éxito, ya que los estudios realizados para validar el sueño continuo en solitario y garantizar que no interfieren con el éxito el establecimiento y continuidad de la lactancia son todavía escasos, poco rigurosos y sufren de un inaceptable etnocentrismo, a pesar del interés de algunos profesionales en aplicar técnicas de adiestramiento del sueño a todos los bebés, independientemente de si son o no amamantados.



El Porqué de los Despertares Nocturnos

Pequeño tamaño del estómago del bebé

Neonatal stomach volume and physiology suggest feeding at 1-h intervals. **Bergman, N J.** 8, 2013, Acta Paediatr, Vol. 102, pp. 773-777.



Composición de la leche que requiere alimentaciones frecuentes

- Bajo contenido en grasas y proteínas.
- Alto contenido en carbohidratos (lactosa).

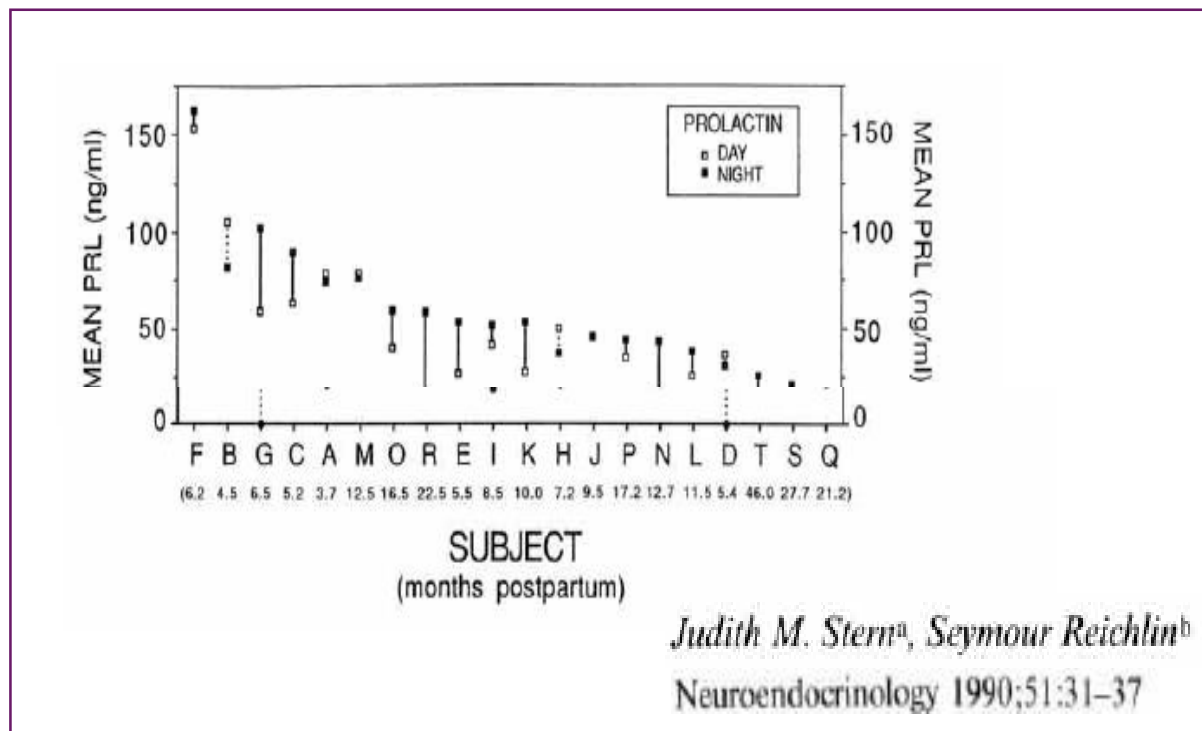
- *Breastfeeding and infant sleep patterns: an Australian population study.* **Galbally, M, et al.** 2, 2013, J Paediatr Child Health, Vol. 49, pp. E147-E152.
- *Breast-feeding, bed-sharing and infant sleep.* **Ball, H L.** 2003, Birth, Vol. 30, pp. 181-188.
- *Infant-parent co-sleeping in an evolutionary perspective: implications for understanding infant sleep development and the sudden infant death syndrome.* **McKenna, J J, et al.** 3, 1993, Sleep, Vol. 16, pp. 263-282

Especie	% Agua	% Proteína	% Grasas	% Carbohidratos
Humana	87.4	1.63	3.75	7
Coneja	69	11.5	15	1.2
Perra	77.3	7.5	9.5	3.3
Gata	79.5	7.5	8.5	4



El Porqué de los Despertares Nocturnos

Necesidad de estimulación nocturna del pecho de la madre para mantener unos niveles adecuados de prolactina.





Effecto de la Lactancia Materna sobre el Sueño

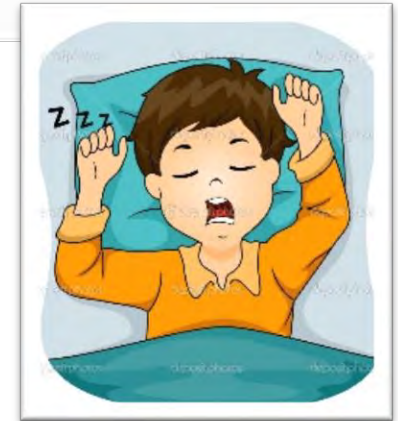


La Lactancia Materna aumenta el porcentaje de sueño de ondas lentas (sueño profundo NREM) en el bebé.

- *Sleep organization and energy expenditure of breast-fed and formula-fed infants.* **Butte, N F, et al.** 5, 1992, *Pediatr Res*, Vol. 32, pp. 514-519.
- *Assessment of nocturnal sleep architecture by actigraphy and one-channel electroencephalography in early infancy.* Yoshida, M, Shinohara, H and Kodama, H. 9, Sept 2015, *Early Hum Dev*, Vol. 91, pp. 519-526.

EFEECTO PROTECTOR SOBRE LOS DESÓRDENES RESPIRATORIOS DEL SUEÑO.

- *Breastfeeding and reduced risk of sudden infant death syndrome: a meta-analysis.* **Hauck, F R, et al.** 1, 2011, *Pediatrics*, Vol. 128, pp. 103-110.
- *Association between Breast Feeding and Paediatric Sleep Disordered Breathing: a Systematic Review.* **Ponce-Garcia, C, et al.** 4, Jul 2017, *Paediatr Perinat Epidemiol*, Vol. 31, pp. 348-362.



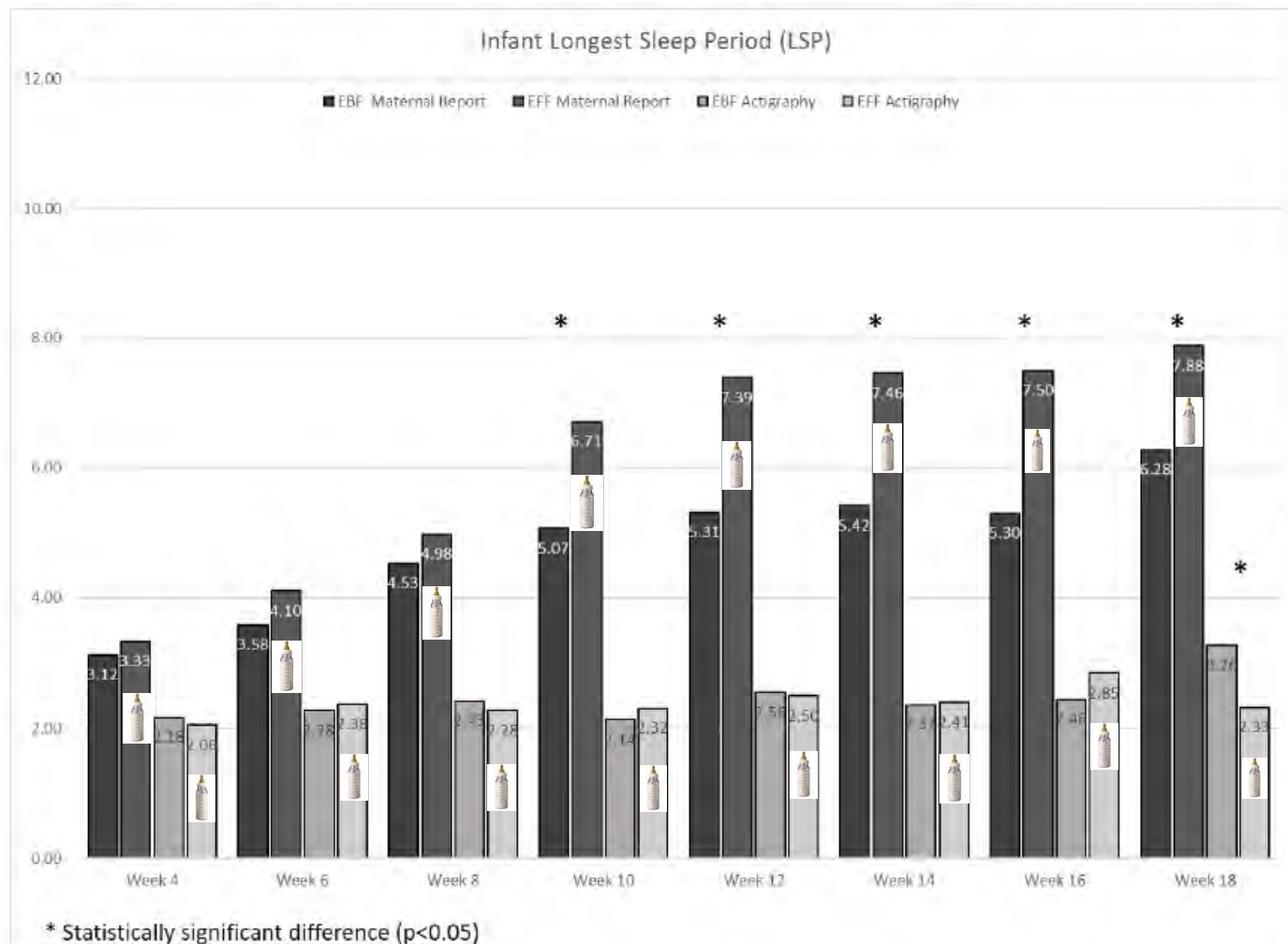
(AUNQUE PAREZCA MENTIRA) LAS MADRES QUE AMAMANTAN, Y COLECHAN, DUERMEN MEJOR.

- **Duermen más tiempo.**
 - *Breastfeeding increases sleep duration of new parents.* **Doan, T, et al.** 3, 2007, *J Perinat Neonatal Nurs*, Vol. 21, pp. 200-206..
- **Sueño más reparador (más sueño de ondas lentas).**
 - *Delta and theta power spectra of night sleep EEG are higher in breast-feeding mothers than in non-pregnant women.* **Nishihara, K, et al.** 2, 2004, *Neurosci Lett*, Vol. 368, pp. 216-220.
- **Pero las madres están más atentas al sueño de su bebé.**
 - *Discrepancies in maternal reports of infant sleep vs. actigraphy by mode of feeding.* **Rudzik, A E F, Robinson-Smith, L and Ball, H L.** September 2018, *Sleep Med*, Vol. 49, pp. 90-98.



Sueño Consolidado y Autoconsuelo

Figure 2: Maternal diary vs actigraphy reported night-time LSP for EBF and EFF infants



Discrepancies in maternal reports of infant sleep vs. actigraphy by mode of feeding. Rudzik, A E F, Robinson-Smith, L and Ball, H L. September 2018, Sleep Med, Vol. 49, pp. 90-98.



Effecto de la Lactancia Materna sobre el Sueño

EFFECTO CRONOBÍOTICO. EL RITMO CIRCADIANO DE LA COMPOSICIÓN DE LA LECHE MATERNA.

- **Melatonina.** (Breastfeeding may improve nocturnal sleep and reduce infantile colic: potential role of breast milk melatonin. **Cohen Engler, A, et al.** 4, 2012, Eur J Pediatr, Vol. 171, pp. 729-732)
- **Cortisol.** (Human milk as "chrononutrition": implications for child health and development. Hahn-Holbrook, J. et al., *Pediatr Res.* 2019, Jun, 85(7), pp. 936-942.)
- **Hormonas (leptina, prolactina, grelina, adiponectina, insulina u hormonas tiroideas).** (Human milk as "chrononutrition": implications for child health and development. Hahn-Holbrook, J. et al., *Pediatr Res.* 2019, Jun, 85(7), pp. 936-942.)
- **Aminoácidos como el triptófano, la metionina, el ácido aspártico, la histidina, la fenilalanina y la tirosina.** (Is your baby's sleep a problem? Or is it just normal? Mother-Baby sleep experts weigh in on normal infant sleep. **Cassels, T, et al.** Agosto 22, 2013, A Praeclarus press white paper 2013; August 22. Evolution of the circadian profile of human milk amino acids during breastfeeding. **Sánchez, C L, et al.** 2013, *J Appl Biomed*, Vol. 11, pp. 59-70.)
- **Nucleótidos como 5'AMP, 5'UMP, y 5'GMP.** (The possible role of human milk nucleotides as sleep inducers. **Sánchez, C L, et al.** 1, 2009, *Nutr Neurosci*, Vol. 12, pp. 2-8.)
- **Factores inmunitarios (Ig A, C3, C4, interferón, IL-6 y fagocitos)** (Human milk as "chrononutrition": implications for child health and development. Hahn-Holbrook, J. et al., *Pediatr Res.* 2019, Jun, 85(7), pp. 936-942.)
- **Minerales y micronutrientes (hierro, magnesio, zinc, sodio, potasio, vitamina E).** (Human milk as "chrononutrition": implications for child health and development. Hahn-Holbrook, J. et al., *Pediatr Res.* 2019, Jun, 85(7), pp. 936-942.)

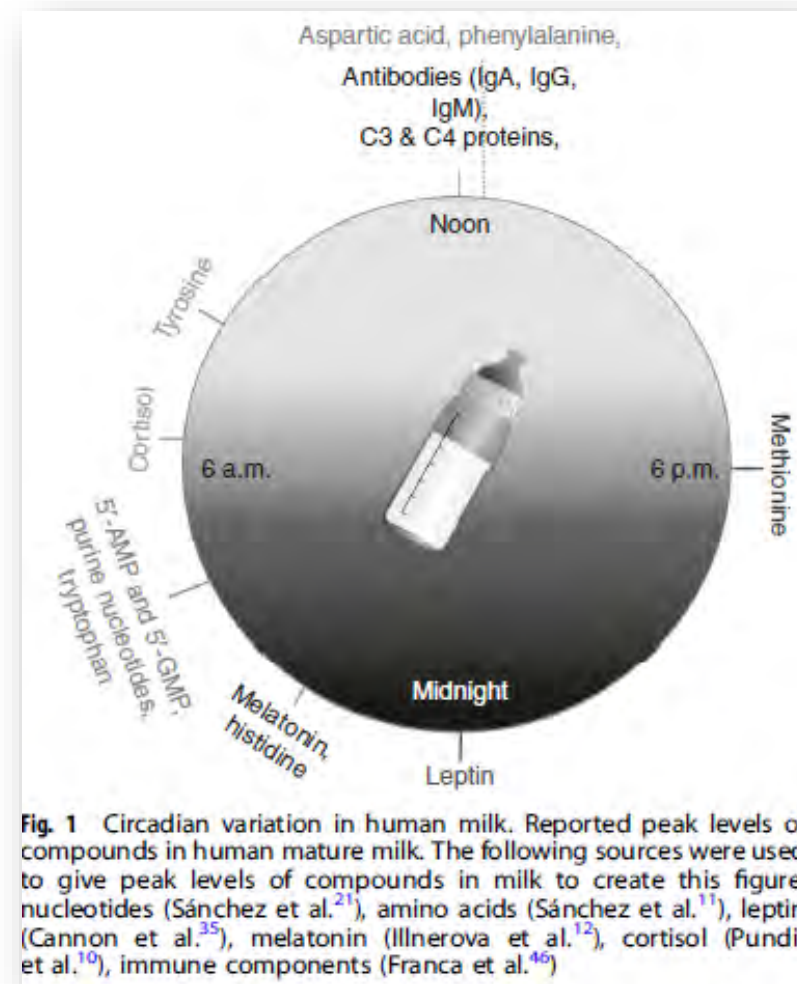


Fig. 1 Circadian variation in human milk. Reported peak levels of compounds in human mature milk. The following sources were used to give peak levels of compounds in milk to create this figure: nucleotides (Sánchez et al.²¹), amino acids (Sánchez et al.¹¹), leptin (Cannon et al.³⁵), melatonin (Illnerova et al.¹²), cortisol (Pundir et al.¹⁰), immune components (Franca et al.⁴⁶)

Fuente: **Human milk as "chrononutrition": implications for child health and development.** Hahn-Holbrook, J. et al., *Pediatr Res.* 2019, Jun, 85(7), pp. 936-942



Effecto de la Lactancia Materna sobre el Sueño

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Printed in U.S.A.

Sleep Organization and Energy Expenditure of Breast-Fed and Formula-Fed Infants¹

NANCY F. BUTTE, CRAIG L. JENSEN, JON K. MOON, DANIEL G. GLAZE, AND
JAMES D. FROST, JR.

Children's Nutrition Research Center, Department of Pediatrics, Department of Neurology, Baylor College of Medicine, and Neurophysiology Service, The Methodist Hospital, Houston, Texas 77030

MATERIALS AND METHODS

Study design. Twenty (10 breast-fed and 10 formula-fed) healthy infants were studied at 4 mo of age. Infants and their mothers were admitted to the Clinical Research Center at The Methodist Hospital, Houston, TX, and transferred overnight to

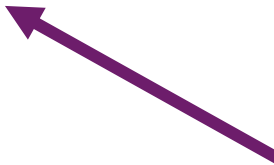
Sleep monitoring. Infants were monitored overnight. Infants were transferred to the Sleep Laboratory at approximately 1900 h. The EEG technician applied the monitoring equipment with the assistance of the mother. After the equipment was applied and tested, the lights were dimmed and the mother fed her infant. Once asleep, the infant was placed in the calorimeter. Mothers slept in a nearby room and were available to feed and quiet their infants when awakened. Monitoring ended at 0600 h. The sleep monitoring system used concurrent, graphically recorded data including two channels of EEG (C3-01, C4-02), two channels of electrooculogram, triaxial accelerometry, and oxygen saturation as detected by a pulse oximeter (Nellcor, Denver, CO) (10-12). Heart rate was obtained from the pulse oximeter; 1-min averages were stored in the microcomputer. A log of all behavioral changes or activities of the infant was kept by the EEG technician.





Lactancia Materna y Colecho

Lactancia Materna



Colecho

The First Summer (2003-2004). [Zaitsev Egor](#)



Lactancia Materna y Colecho

La razón principal que anima a las madres a coleccionar es la lactancia materna.

Reasons to bed-share: Why parents sleep with their infants . **Ball, H. L.** 2002, Journal of Reproductive and Infant Psychology, Vol. 20, pp. 207-221.

El colecho aumenta el número de tomas nocturnas.

- Randomised trial of infant sleep location on the postnatal ward. **Ball, H L, et al.** 2006, Arch Dis Child, Vol. 91, pp. 1005-1010.
- Evolutionary perspectives on mother-infant sleep proximity and breastfeeding in a laboratory setting. **Gettler, L T and McKenna, J J.** 2011, American Journal of Physical Anthropology, Vol. 144, pp. 454-462.

El colecho aumenta la duración de la lactancia materna.

- Amamantar al bebé y compartir la cama con él a los tres meses de vida se relaciona con una mayor prevalencia de lactancia materna al año. **Esparza, M J and Aizpurua, P,** Evid Pediatr. 2010; 6: 11., Vol. 6.
- Influence of Bedsharing Activity on Breastfeeding Duration Among US Mothers. **Huang, Y, et al.** 2013, JAMA Pediatr, Vol. 167, pp. 1038-1044.

El colecho favorece el descanso de la madre que amamanta.

- The effect of feeding method on sleep duration, maternal well-being, and postpartum depression. **Kendall-Tackett, K, Cong, Z and Hale, T W.** 2011, Clinical Lactation, Vol. 2, pp. 22-26.

El colecho:

- **Aumenta la producción de oxitocina.**

- El colecho:
- Aumenta la producción de oxitocina.
- Postpartum maternal oxytocin release by newborns: effects of infant hand massage and sucking. **Matthiesen, A S, et al.** 2001, Birth, Vol. 28, pp. 13-19.
- Differences in infant and parent behaviors during routine bed sharing. Compared with cot sleeping in the home setting. **Baddock, S A, et al.** 2006, Pediatrics, Vol. 117, pp. 1599-1607.

- **Aumenta la producción de prolactina y con ello favorece la lactogénesis II.**

- **Ball, H and Russell, C K.** Nighttime nurturing: An evolutionary perspective on breastfeeding and sleep. . [book auth.] Narvaez D, et al. Evolution, early experience and human development. Oxford : Oxford University Press, 2013, pp. 241-261.



El contacto estrecho entre madre y bebé desde el mismo momento del nacimiento fomenta la lactancia espontánea y favorece la lactancia materna, ayudando a los recién nacidos a preservar la energía y acelerando la adaptación metabólica, aumentando el bienestar del recién nacido.

- Método canguro en sala de partos en recién nacidos a término. **Gómez Papí, A, et al.** 1998, An Esp Pediatr, Vol. 48, pp. 631-633.
- A study of factors promoting and inhibiting lactation. **de Château, P, et al.** 1977, Dev Med Child Neurol, Vol. 19, pp. 575-584.
- Temperature, metabolic adaptation and crying in healthy full-term newborns cared for skin-to-skin or in a cot. **Christensson, K, et al.** 6-7, 1992, Acta Paediatr, Vol. 81, pp. 488-493.
- The potential benefits of infant-parent co-sleeping in relation to SIDS prevention: overview and critique of epidemiological bed sharing studies. In: Sudden Infant Death Syndrome. **McKenna, J J.** 1995, New Trends in the Nineties, ed. Rognum TO. Oslo: Scandinavian University Press, pp. 256-265.



Arquitectura del Sueño en Relación con la Lactancia Materna y el Colecho



Sueño NREM:

- **La Lactancia Materna favorece el sueño profundo de ondas lentas.**
 - Sleep organization and energy expenditure of breast-fed and formula-fed infants. **Butte, N F, et al.** 5, 1992, *Pediatr Res*, Vol. 32, pp. 514-519.
 - Assessment of nocturnal sleep architecture by actigraphy and one-channel electroencephalography in early infancy. **Yoshida, M, Shinohara, H and Kodama, H.** 9, Sept 2015, *Early Hum Dev*, Vol. 91, pp. 519-526.

- **El colecho disminuye el sueño profundo de ondas lentas y aumenta las fases de sueño ligero I y II.**
 - Maternal sleep and arousals during bedsharing with infants. **Mosko, S, Richard, C and McKenna, J.** 1997, *J Sleep res Sleep Med*, Vol. 20, pp. 142-150.
 - The potential benefits of infant-parent co-sleeping in relation to SIDS prevention: overview and critique of epidemiological bed sharing studies. In: *Sudden Infant Death Syndrome.* **McKenna, J J.** 1995, *New Trends in the Nineties*, ed. Rognum TO. Oslo: Scandinavian University Press, pp. 256-265

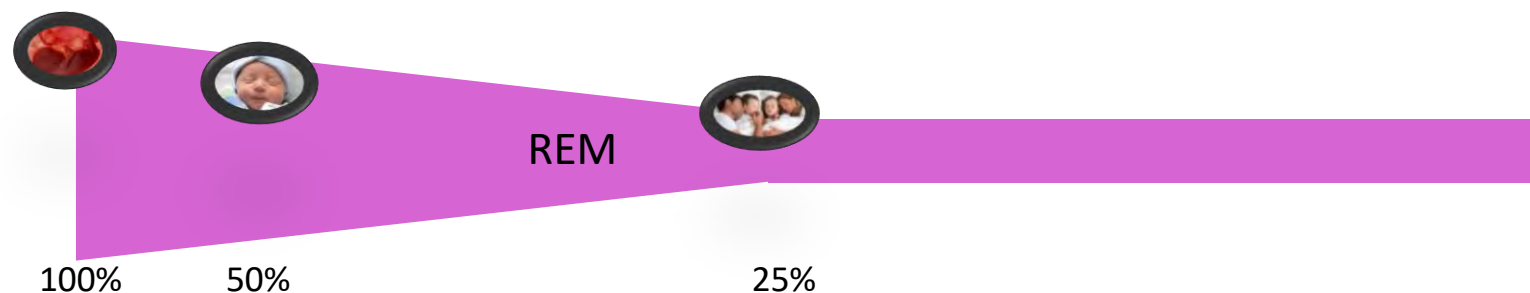




Architecture of Sleep in Relation to Breastfeeding and Co-sleeping

El sueño REM:

- **El colecho aumenta la longitud de sus episodios**
- **La lactancia materna disminuye su porcentaje total.**
 - Maternal sleep and arousals during bedsharing with infants. **Mosko, S, Richard, C and McKenna, J.** 1997, J Sleep res Sleep Med, Vol. 20, pp. 142-150.
 - The potential benefits of infant-parent co-sleeping in relation to SIDS prevention: overview and critique of epidemiological bed sharing studies. In: Sudden Infant Death Syndrome. **McKenna, J J.** 1995, New Trends in the Nineties, ed. Rognum TO. Oslo: Scandinavian University Press, pp. 256-265



- **Íntimamente relacionado con la lactancia: en experimentos con ratas las tomas se producen en fase REM.**
 - Filling the gut activates paradoxical sleep in suckling rats. **Lorenz, D N, et al.** 1998, Dev Psychobiol, Vol. 32, pp. 1-12.
- **Mayor presencia en las especies altriciales que en las precociales.**
 - Functional implications of sleep development. **Siegel, J M.** 5, 2005, PLoS Biol, Vol. 3, p. e178.
- **Importantísimo papel en el desarrollo neurológico.**
 - Potential chronobiotic role of human milk in sleep regulation. **Arslanoglu, S and Bertino, E.** 2012, J. Perinat. Med, Vol. 40, pp. 1-8.
 - Sleep tight: Exploring the relationship between sleep and attachment style across the life span. **Adams, G C, Stoops, M A and Skomro, R P.** Mar 15, 2014, Sleep Med Rev.
- **Fundamental en el procesamiento de la memoria emocional y en el desarrollo de las capacidades cognitivas y del sistema de respuesta emocional, particularmente en el desarrollo de la respuesta emocional a la madre.**
 - Infant sleep disorders and attachment: sleep problems in infants with insecure-resistant versus insecure-avoidant attachments to mother. **McNamara, P, Belsky, J and Fearon, P.** 1, 2003, Sleep and Hypnosis, Vol. 5, pp. 7-16.
- **Implicado en la regulación de los circuitos neurohormonales de la oxitocina y la prolactina, íntimamente ligados al desarrollo del vínculo madre-bebé y a la lactancia.**
 - **Forsling, M.** Neurohypophysial hormones and circadian rhythm. [book auth.] W North, A Moses and L Share. The neurohypophysis: A window on brain function. New York : The New York Academy of Sciences, 1993, pp. 382-395.
- **Papel importante en el establecimiento del tipo de apego que desarrollará el bebé.**
 - What affects the age of first sleeping through the night? **Adams, S M, et al.** 3, 2004, J Paediatr Child Health, Vol. 40, pp. 96-101.



Lactancia Materna y Colecho

ACTA PÆDIATRICA
NURTURING THE CHILD

Acta Paediatrica ISSN 0803-5253

REGULAR ARTICLE

Bed-sharing by breastfeeding mothers: who bed-shares and what is the relationship with breastfeeding duration?

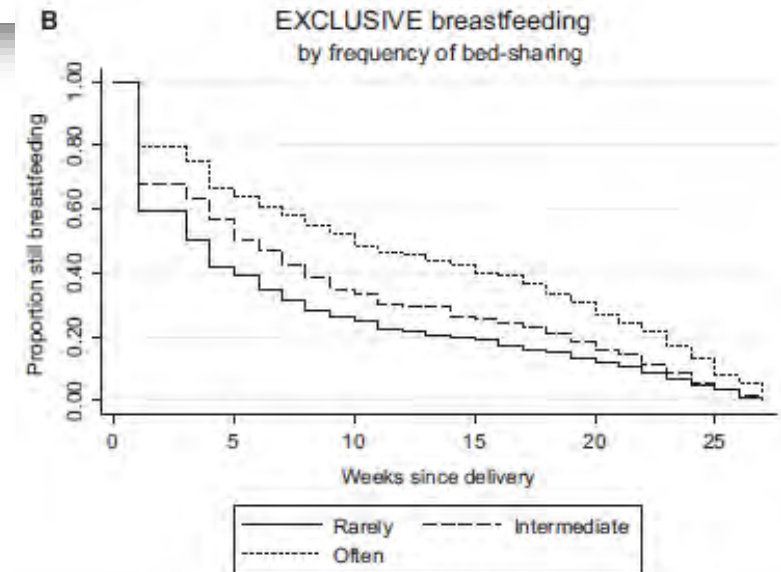
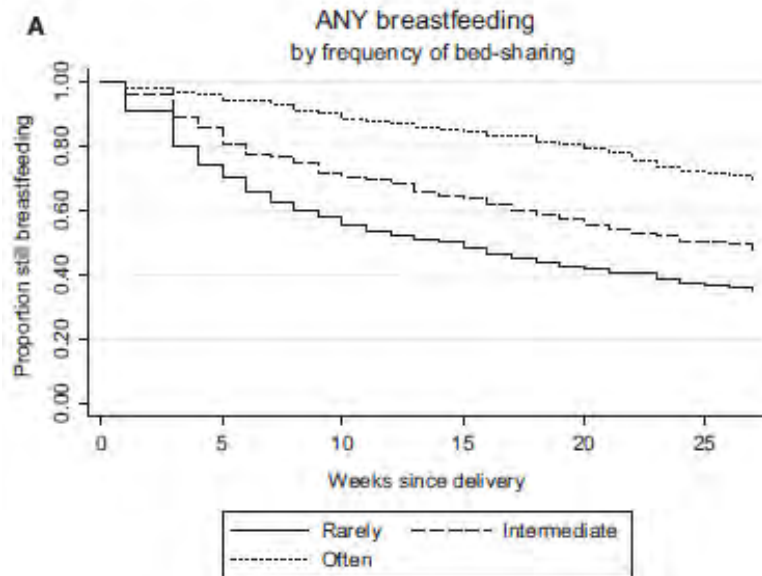
Helen L. Ball (h.l.ball@dur.ac.uk)¹, Denise Howel², Andy Bryant², Espeth Best³, Charlotte Russell¹, Martin Ward-Platt⁴

¹Parent-Infant Sleep Lab, Department of Anthropology, Durham University, Durham, UK

²Institute of Health and Society, Baddiley Clark building, Newcastle University, Newcastle Upon Tyne, UK

³Department of Paediatrics, St John's Hospital, Howden, Lothian, Scotland

⁴Newcastle Neonatal Service, Royal Victoria Infirmary, Newcastle Upon Tyne, UK





[J Community Health](#). 2017 Aug;42(4):707-715



ORIGINAL PAPER

Impact of a Randomized Controlled Trial to Reduce Bedsharing on Breastfeeding Rates and Duration for African-American Infants

Rachel Y. Moon¹ · Anita Mathews² · Brandi L. Joyner² · Rosalind P. Oden² · Jianping He³ · Robert McCarter Jr.^{3,4,5}

Abstract Bedsharing is associated with both increased breastfeeding and increased risk of sudden and unexpected infant deaths. The objective was to determine impact of sleep location and counseling about sleep location on breastfeeding exclusivity and duration in African-Americans. 1194 mothers of newborns were randomized to receive messaging emphasizing either safe sleep practices to reduce SIDS risk or safe sleep practices to prevent SIDS/suffocation. Mothers completed four interviews in the 6 months after delivery. The most common sleep arrangement was roomsharing without bedsharing (“roomsharing”). Duration of any breastfeeding was 6.1 and 5.3 weeks for infants who usually bedshared or roomshared, respectively ($p=0.01$). Duration of exclusive breastfeeding was 3.0 and 1.6 weeks for infants who usually bedshared or roomshared, respectively ($p<0.001$). Group assignment did not affect breastfeeding duration. The most common sleep arrangement for African-American infants <6 months

was roomsharing. An intervention designed to discourage bedsharing did not impact breastfeeding duration.

Keywords Bedsharing · Breastfeeding · Sleep location

Introduction

Breastfeeding confers numerous benefits upon the infant and the mother [1]. Breast milk contains maternal antibodies and micronutrients [2, 3], which protect infants from infectious diseases [4]. There is recent evidence that exclusive breastfeeding results in intestinal microbiome that supports immune function [5]. Breastfeeding is also associated with decreased infant mortality and specifically, decreased rates of sudden infant death syndrome (SIDS) [6–8]. The American Academy of Pediatrics (AAP) recommends that infants be exclusively breastfed for approximately 6 months with continued breastfeeding until 1 year or as





Lactancia Materna y Colecho



What's scary?



Bedsharing Children

Vanessa R. Axelsen,

Abstract: *Purpos among zero- to Health Program children sleep, a Mother-child dyad 629 children (me lived with both P=.008), older (O out the night (O tively). Moreover, significantly assoc Caries preventive 2015 | Last Revis*

KEYWORDS: BEDSH



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Citation: Avila WM, Pordeus IA, Paiva SM, Martins CC (2015) Breast and Bottle Feeding as Risk Factors for Dental Caries: A Systematic Review and Meta-Analysis. PLoS ONE 10(11): e0142922. doi:10.1371/journal.pone.0142922

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Published: November 18, 2015

RESEARCH ARTICLE

Breast and Bottle Feeding as Risk Factors for Dental Caries: A Systematic Review and Meta-Analysis

Walesca M. Avila, Isabela A. Pordeus, Saul M. Paiva, Carolina C. Martins*

Department of Pediatric Dentistry and Orthodontics, Faculty of Dentistry, Universidade Federal de Minas Gerais, Belo Horizonte, Minas Gerais, Brazil

* carolcm10@hotmail.com

Abstract

Understanding the role that breastfeeding and bottle feeding play in the development of dental caries during childhood is essential in helping dentists and parents and care providers prevent the disease, and also for the development of effective public health policies. However, the issue is not yet fully understood. The aim of this systematic review and meta-analysis was to search for scientific evidence in response to the question: Do bottle fed children have more dental caries in primary dentition than breastfed children? Seven electronic databases and grey literature were used in the search. The protocol number of the study is PROSPERO CRD 42014006534. Two independent reviewers selected the studies, extracted data and evaluated risk of bias by quality assessment. A random effect model was used for meta-analysis, and the summary effect measure were calculated by odds ratio (OR) and 95% CI. Seven studies were included: five cross-sectional, one case-control and one cohort study. A meta-analysis of cross-sectional studies showed that breastfed children were less affected by dental caries than bottle fed children (OR: 0.43; 95%CI: 0.23–0.80). Four studies showed that bottle fed children had more dental caries ($p < 0.05$), while three studies found no such association ($p > 0.05$). The scientific evidence therefore indicated that

breastfeeding can protect against dental caries in early childhood

medium, provided the original author and source are



Lactancia Materna y Colecho



¿Qué da miedo??

Article

Breastfeeding, Bed-Sharing, and Maternal Cortisol

Clarissa D. Simon, PhD, MPH^{1,2}, Emma K. Adam, PhD^{1,2,3},
Chelsea O. McKinney, PhD, MPH^{2,4}, Julie B. Krohn, MS, RDN, LDN^{2,5},
Madeleine U. Shalowitz, MD, MBA^{2,4}

Clinical Pediatrics
1-9
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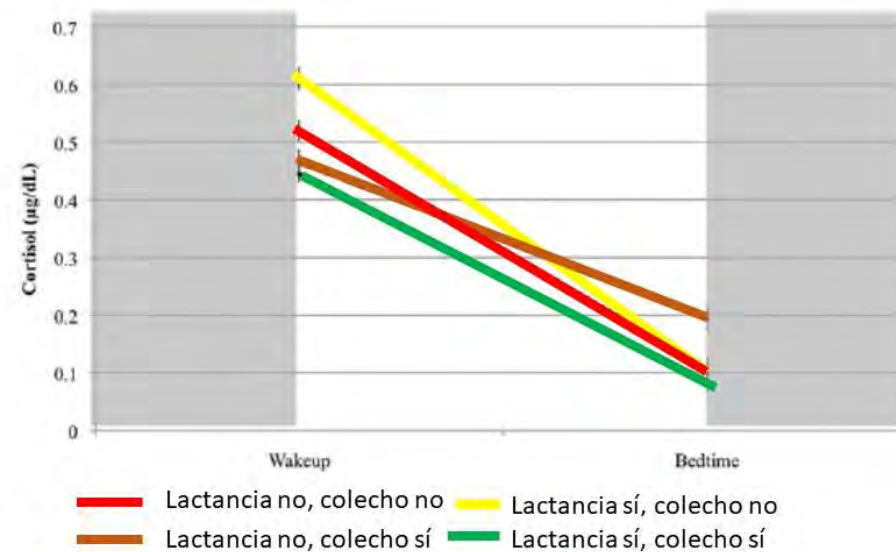


Figura 1. Cambio de los niveles de cortisol a lo largo del día dependiendo de si las madres amamantan o colechan.



Lactancia Materna y Colecho



¿Qué da miedo??

6 November 2017

RE: INSIGHT Study is written by culture, not by science

• **María J Berrozpe Martínez**, PhD Biologist. Freelance writer and researcher of primal health, breastfeeding and infant sleep. Research group "Lactancia materna y psicología perinatal" of IMMIENS-UNED

Motherhood

and

Limitaciones del Estudio INSIGHT

1. Las medidas del sueño están basadas únicamente en las **observaciones de los padres**
2. Lo que los autores consideran reglas para una **“crianza sensible”** en lo que concierne al sueño (como no amamantar ni mecer al bebé para dormir, colocar al bebé despierto en la cuna o pasarlo a su habitación a los tres meses) no son sensibles en absoluto.
3. Es evidente un **enorme sesgo cultural** en el diseño e interpretación del estudio que prevalece sobre las evidencias científicas en dos áreas fundamentales de la salud infantil: el sueño infantil y la lactancia materna.
4. **La lactancia materna** no es una forma de alimentación cualquiera y los autores no hacen diferencias entre lactancia materna, alimentación con leche de fórmula y alimentación complementaria a la hora de dar instrucciones sobre poner a los bebés a dormir en solitario.





Lactancia Materna y Colecho

¿Qué da miedo??



MSIL/SUDI



SMSL/SIDS
(150-200/100.000)

Grupo de Trabajo para el Estudio de la Muerte Súbita Infantil. *Libro Blanco de la Muerte Súbita Infantil* (3ª edición). Madrid : Ediciones Ergon, 2013.

AEA/ASSB

CD/UC

CISP/SUPC

(2,3-19 /100.000)

Sudden unexpected postnatal collapse. Monnelly, V and Becher, J C. November 2018, Early Hum Dev, Vol. 126, pp. 28-31.

(2,3-133/ 100.000)

Making the first days of life safer: preventing sudden unexpected postnatal collapse while promoting breastfeeding. Davanzo, R et al. 1, February 2015, J Hum Lact, Vol. 31, pp. 47-52.



Síndrome de la Muerte Súbita del Lactante

Sudden Infant Death Syndrome and Unclassified Sudden Infant Deaths: A Definitional and Diagnostic Approach

Henry F. Krous, MD*; J. Bruce Beckwith, MD‡; Roger W. Byard, MD§; Torleiv O. Rognum, MD, PhD||;
Thomas Bajanowski, MD¶; Tracey Corey, MD#; Ernest Cutz, MD*; Randy Hanzlick, MD‡‡;
Thomas G. Keens, MD§§; and Edwin A. Mitchell, MD|||

“Muerte inesperada y repentina de un lactante menor de un año, con el inicio del episodio letal ocurriendo aparentemente durante el sueño, que se mantiene inexplicable incluso después de una profunda investigación que incluye la autopsia completa y la revisión de las circunstancias de la muerte.”



Síndrome de la Muerte Súbita del Lactante



Triple-Risk Model (Kinney y Filiano en 1994). According to this model SIDS occurs when three factors are present simultaneously. The first factor is an underlying vulnerability in the infant; the second, a critical developmental period; and the third, an exogenous stressor. Exogenous stressors are considered to be homeostatic stressors, such as asphyxia. (*Filiano JJ, Kinney HC. A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Biol Neonate. 1994; 65:194–7*)



Síndrome de la Muerte Súbita del Lactante

Factores de Riesgo



Control prenatal inadecuado.

Dormir en decúbito prono.

Bajo peso al nacimiento.

Sintomatología de infección viral respiratoria o gastrointestinal unos días antes de la muerte.

Estacionalidad (meses más fríos).

Possible anemia in the baby

Abuso de heroína, cocaína y otras drogas por parte de la madre.

Edad del fallecimiento. La incidencia es más elevada de los dos a los cuatro meses

Abuso de alcohol durante la gestación.

Nivel socioeconómico bajo.

Madre multípara con intervalo de embarazos menor a un año.

Anemia materna.

Madre fumadora durante el embarazo y, en general, exposición al humo del tabaco pre y postnatalmente.

Alimentación con leche de fórmula y ausencia de lactancia materna.

Género masculino.

Etnia.

Temperatura de la habitación elevada o baja.

Obesidad materna.

Dormir en un sofá.

Colecho con los padres o con hermanos incrementa el riesgo, especialmente si se acompaña de tabaquismo, ingesta de alcohol, drogas y/o fármacos sedantes o tranquilizantes.

Ropa de cama en exceso, colchón blando y juguetes de peluche en la cuna.

Madre adolescente.



Síndrome de la Muerte Súbita del Lactante

BMJ
open
access to medical research

Bed sharing when parents do not smoke: is there a risk of SIDS? An individual level analysis of five major case-control studies

Robert Carpenter,¹ Cliona McGarvey,² Edwin A Mitchell,³ David M Tappin,⁴ Mechtild M Vennemann,⁵ M Smuk,¹ JR Carpenter^{1,6}

BMJ Open, vol. 3, nº 5, 2013.

ARTICLE SUMMARY

Article focus

- Is there a risk of Sudden Infant Death Syndrome (SIDS) due to bed sharing when the baby is breastfed, the parents do not smoke, and the mother does not use alcohol or illegal drugs?
- At what age is it safe to bed share?
- How is the risk of SIDS associated with bed sharing affected by other factors?

Key messages

- When the baby is breastfed and under 3 months, there is a fivefold increase in the risk of SIDS when bed sharing with non-smoking parents and the mother has not taken alcohol or drugs.
- Smoking, alcohol and drugs greatly increase the risk associated with bed sharing.
- A substantial reduction in SIDS rates could be achieved if parents avoided bed sharing.

Strength and limitations of this study

- This is the largest ever analysis of individual records of 1472 SIDS cases and 4679 controls from five major case-control studies.
- Questions on the mother's alcohol use in the last 24 h and illegal drug use were not asked in three of these studies.
- Imputation of missing data enabled a combined analysis of all the data. The analysis gives unbiased, efficient models that describe the data accurately, especially in key areas.



Síndrome de la Muerte Súbita del Lactante

Bed-Sharing in the Absence of Hazardous Circumstances: Is There a Risk of Sudden Infant Death Syndrome? An Analysis from Two Case-Control Studies Conducted in the UK



Peter S. Blair^{1*}, Peter Sidebotham², Anna Pease¹, Peter J. Fleming¹

¹ School of Social & Community Medicine, University of Bristol, Bristol, United Kingdom, ² Medical School, University of Warwick, Warwick, United Kingdom

PLoS ONE, vol. 9, nº 9, p. 107799, 2014.

Design: Combined individual-analysis of two population-based case-control studies of SIDS infants and controls comparable for age and time of last sleep.

Results: Over a third of SIDS infants (36%) were found co-sleeping with an adult at the time of death compared to 15% of control infants after the reference sleep (multivariate OR= 3.9 [95% CI: 2.7–5.6]). The multivariable risk associated with co-sleeping on a sofa (OR = 18.3 [95% CI: 7.1–47.4]) or next to a parent who drank more than two units of alcohol (OR = 18.3 [95% CI: 7.7–43.5]) was very high and significant for infants of all ages. The risk associated with co-sleeping next to someone who smoked was significant for infants under 3 months old (OR = 8.9 [95% CI: 5.3–15.1]) but not for older infants (OR = 1.4 [95% CI: 0.7–2.8]). The multivariable risk associated with bed-sharing in the absence of these hazards was not significant overall (OR = 1.1 [95% CI: 0.6–2.0]), for infants less than 3 months old (OR = 1.6 [95% CI: 0.96–2.7]), and was in the direction of protection for older infants (OR = 0.1 [95% CI: 0.01–0.5]). Dummy use was associated with a lower risk of SIDS only among co-sleepers and prone sleeping was a higher risk only among infants sleeping alone.

Conclusion: These findings support a public health strategy that underlines specific hazardous co-sleeping environments parents should avoid. Sofa-sharing is not a safe alternative to bed-sharing and bed-sharing should be avoided if parents consume alcohol, smoke or take drugs or if the infant is pre-term.



Síndrome de la Muerte Súbita del Lactante

Medidas Preventivas

1. El bebé debe dormir sobre su espalda
2. El bebé debe dormir en una superficie firme
3. **Se recomienda compartir habitación sin compartir cama**
4. Mantener los objetos blandos o la ropa de cama holgada fuera de la cuna
5. La mujer embarazada debe recibir cuidado prenatal regularmente
6. Evitar la exposición al tabaco tanto durante el embarazo como después del nacimiento
7. Evitar el consumo de alcohol y drogas tanto durante el embarazo como tras el nacimiento
8. Amamantar
9. Considerar el ofrecimiento de chupetes por la noche y en las siestas
10. Evitar el sobrecalentamiento
11. No usar en casa monitores de control de la respiración como estrategia para prevenir el SMSL
12. Respetar el calendario de vacunación
13. Evitar cualquier artefacto comercial destinado a la prevención del SMSL

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Síndrome de la Muerte Súbita del Lactante

En defensa del Colecho

Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome: To the Editor

Rafael Pelayo, Judith Owens, Jodi Mindell and Stephen Sheldon

Pediatrics 2006;117:993

DOI: 10.1542/peds.2005-2748

DOI: 10.1542/peds.2005-3103

To the Editor:
Having read your recent article¹ recommending a change to this usual strength of recommendation that all infants should use pacifiers. I am also very disturbed that Hauck et al¹ cited a "California study" in which pacifiers lowered the risk of

We agree that sharing as a group (eg, sedating me couch sharing) that the practice infants is not. There also were no policy statement supporting the combination of using pacifiers a from the infant in the same room dence of SIDS, nor was there any alternative strategies (eg, use of infants sleeping in separate room effective. A policy that requires l modify their traditional sleeping a which in turn are based on deep and beliefs, would seem to requ dence of risk associated with th

Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome

Bradford D. Gessner and Thomas J. Porter

Pediatrics 2006;117:990

DOI: 10.1542/peds.2005-2727

Several controlled studies have documented that infants who share a bed with a parent have an increased risk of SIDS. However, these studies have not taken into account the entire context in which SIDS events occur, including parental impairment at the time of the infant's death, the infant's sleep position, and whether the infant slept on an inappropriate surface such as a water bed or couch. The few controlled studies and case series that have adjusted for maternal tobacco and alcohol use have found little^{2,3} or no⁴⁻⁶ independent association between bed sharing and SIDS. We urge the AAP to consider these concerns, to closely monitor the effects of this new policy, and to support studies that will provide additional empirical evidence of the effects of these recommendations on a broad array of outcomes.

recommen-
I am also very disturbed that Hauck et al¹ cited a "California study" in which pacifiers lowered the risk of

SIDS by 90%. Intrigued, I checked this reference; it was only an abstract³ and could not be found anywhere on PubMed. It was therefore irresponsible to have included it. I saw that Dr Rachel Moon referred to this abstract when quoted in the Boston Globe.⁴ I find this highly unprofessional, and it speaks to a basic lack of fact- on the authors' and the jour-

ated that "no [financial] con- d. Dr Hauck appeared on the First Candle for 2004/2005, m the formula industry as m makers of pacifiers and representatives of acturers. The 2004/2005 board of First Candle ie president of the Juvenile Products Manu- association, an industry trade group that is ed sharing. These ties indeed may represent conflicts of interest. leeping recommendations² are flawed also, ontrolling for sleep surface or breastfeeding, all case-control studies, with their attendant urbing that the American Academy of Pedi- atrics (AAP) can publish the recommendations of a 5-person task force without consulting the much larger Section on Breastfeeding, a section that has no financial conflicts of interest.

It is unclear if any of the recommendations will decrease SIDS more than safe bed-sharing practices combined with exclusive breastfeeding (without pacifiers). The data cited are simply not convincing.



Síndrome de la Muerte Súbita del Lactante

Bed Sharing With Unimpaired Parents Is Not an Important Risk for Sudden Infant Death Syndrome: In Reply

John Kattwinkel, Fern R. Hauck, Rachel Y. Moon, Michael Malloy and Marian Willinger

Pediatrics 2006;117:994

DOI: 10.1542/peds.2005-2994

En defensa del Colecho

seling families is likely to lead to more successful implementation of all the risk-reduction guidelines. We also agree with Drs Eidelman and Gartner that it is our responsibility as health care professionals and epidemiologists to educate law-enforcement agencies of the inappropriateness of citing parents for child abuse on the basis of population-based risk analysis.

There are many cultures for which bed sharing is the norm and SIDS rates are low. However, the bed sharing practiced in those cultures is generally very different from that in the United States (eg, with firm mats on the floor, separate mats for the infant, and/or absence of soft bedding). It has not yet been determined what constitutes “safe” bed sharing. In the United States, approximately half of the infants that die from sudden, unexpected death do so while sleeping with their parents.³⁻⁵ Although the reasons for the protective effect of room sharing without bed sharing are not fully known, it is likely that when the infant is in a crib or bassinet next to the parents’ bed, it allows for maternal-infant sensory exchanges and increased infant arousals, similar to those that would be present during bed sharing. In addition, room sharing allows for easy access to the infant for breastfeeding. We too believe that breastfeeding and parent-infant bonding are extremely important, but bed sharing is not imperative for success of either or both. We encourage parents to interact, cuddle, and bond with their infants during awake times.



Speaking Out on Safe Sleep: Evidence-Based Infant Sleep Recommendations

Melissa Bartick¹ and Linda J. Smith²

Abstract

The American Academy of Pediatrics (AAP) issued recommendations in 2005 and 2011 to reduce sleep-related infant death, which advise against all bedsharing for sleep. **These recommendations overemphasize the risks of bedsharing, and this overemphasis has serious unintended consequences.** It may result in increased deaths on sofas as tired parents try to avoid feeding their infants in bed. Current evidence shows that other risks are far more potent, such as smoking, shared sleep on sofas, sleeping next to impaired caregivers, and formula feeding. **The emphasis on separate sleep is diverting resources away from addressing these critical risk factors. Recommendations to avoid bedsharing may also interfere with breastfeeding.** We examine both the evidence behind the AAP recommendations and the evidence omitted from those recommendations. We conclude that the **only evidence-based universal advice to date is that sofas are hazardous places for adults to sleep with infants; that exposure to smoke, both prenatal and postnatal, increases the risk of death; and that sleeping next to an impaired caregiver increases the risk of death. No sleep environment is completely safe.** Public health efforts must address the reality that tired parents must feed their infants at night somewhere and that sofas are highly risky places for parents to fall asleep with their infants, especially if parents are smokers or under the influence of alcohol or drugs. **All messaging must be crafted and reevaluated to avoid unintended negative consequences, including impact on breastfeeding rates, or falling asleep in more dangerous situations than parental beds.** We must realign our resources to focus on the greater risk factors, and that may include greater investment in **smoking cessation and doing away with aggressive formula marketing.** This includes eliminating conflicts of interest between formula marketing companies and organizations dedicated to the health of children.



Contents lists available at ScienceDirect

Paediatric Respiratory Reviews

Paediatr Respir Rev. 2015; 16(1): 62-67.



Review

Bed-sharing and unexpected infant deaths: what is the relationship?



Peter Fleming*, Anna Pease, Peter Blair

University of Bristol School of Social and Community Medicine, St Michael's Hospital, Southwell St, Bristol BS2 8EG.

EDUCATIONAL AIMS

The reader will come to appreciate that:

- Bedsharing with infants by parents who smoke, drink alcohol or take recreational drugs, or are sleeping on a sofa or armchair is associated with a significantly increased risk of unexpected infant death, particularly for infants less than 3 months of age and for those who were of low birthweight or preterm.
- Bedsharing by breastfeeding mothers with their infants, in the absence of the above mentioned risk factors, has not been shown to be associated with a significantly increased risk of unexpected infant death.
- There is a strong bidirectional relationship between breastfeeding and bedsharing. The benefits of breastfeeding must be considered in any advice given to mothers about bedsharing.



Síndrome de la Muerte Súbita del Lactante

En defense del Colecho

POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics



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SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment

TASK FORCE ON SUDDEN INFANT DEATH SYNDROME

4. It is recommended that infants sleep in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months.

There is evidence that sleeping in the parents' room but on a separate surface decreases the risk of SIDS by as much as 50%.^{6,8,41,42} In addition, this arrangement is most likely to prevent suffocation, strangulation, and entrapment that may occur when the infant is sleeping in the adult bed.

The safest place for an infant to sleep is on a separate sleep surface designed for infants close to the parents' bed. However, the AAP acknowledges that parents frequently fall asleep while feeding the infant. Evidence suggests that it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair, should the parent fall asleep. It is important to note that a large percentage of infants who die of SIDS are found with their head covered by bedding. Therefore, no pillows, sheets, blankets, or any other items that could obstruct infant breathing or cause overheating should be in the bed. Parents should also follow safe sleep recommendations outlined elsewhere in this statement.

Because there is evidence that the risk of bed-sharing is higher with longer duration, if the parent falls asleep while feeding the infant in bed, the infant should be placed back on a separate sleep surface as soon as the parent awakens.

available. Bedside sleepers, which attach to the side of the parental bed and for which the CPSC has published standards,²² may be considered by some parents as an option. There are no CPSC safety standards for in-bed sleepers. The task force cannot make a recommendation for or against the use of either bedside sleepers or in-bed sleepers, because there have been no studies examining the association between these products and SIDS or unintentional injury and death, including suffocation.



Síndrome de la Muerte Súbita del Lactante

En defense del Colecho

CO-SLEEPING* AND SIDS: A guide for health professionals

~700,000
babies are born each year in England and Wales¹

~350,000
babies will have slept together in an adult bed with one or both parents by three months, whether intended or not²

	1 IN 3,180	The risk of SIDS for all babies in England & Wales ¹
	1 IN 174	The risk of SIDS while co-sleeping on a sofa ^{1,9}
	1 IN 174	The risk of SIDS while co-sleeping after consuming alcohol or drugs ^{1,9}
	1 IN 787	The risk of SIDS while co-sleeping with a regular smoker ^{1,9}

IF NO BABY CO-SLEPT IN HAZARDOUS SITUATIONS, WE COULD POTENTIALLY REDUCE CO-SLEEPING SIDS DEATHS BY NEARLY 90%⁸

Last updated: October 2018
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Síndrome de la Muerte Súbita del Lactante

En defense del Colecho

IF YOU DECIDE TO SHARE A BED WITH YOUR BABY

Some parents choose to sleep with their baby in bed and some fall asleep with their baby during the night while feeding and comforting whether they intend to or not. Therefore it is very important to consider the following points:

- Keep your baby away from the pillows.
- Make sure your baby cannot fall out of bed or become trapped between the mattress and wall.
- Make sure the bedclothes cannot cover your baby's face or head.
- Don't leave your baby alone in the bed, as even very young babies can wriggle into a dangerous position.

BEWARE

- It is not safe to bed-share in the early months if your baby was born very small or preterm.
- Do not sleep with your baby when you have been drinking any alcohol or taking drugs that may cause drowsiness (legal or illegal).
- Do not sleep with your baby if you or anyone else is a smoker.
- Do not put yourself in a position where you could doze off with your baby on a sofa or armchair.





HEALTH PROFESSIONALS' GUIDE TO: "CARING FOR YOUR BABY AT NIGHT"

PROFESSOR HELEN BALL, BSC, MA, PHD
DR PETER S BLAIR BSC (HONS), MSC (LEIC), PHD (BRISTOL)



A guide for parents





Síndrome de la Muerte Súbita del Lactante

Safer sleep for babies
a guide for parents

the lullaby trust
safer sleep for babies - support for families

Basis
Baby sleep info source

Public Health England

THE BABY FRIENDLY INITIATIVE
unicef UNITED KINGDOM

Bed-sharing more safely

Whether you choose to bed-share, or it is unplanned, there are some key risks you should avoid.

It is dangerous to share a bed with your baby if:

- you or anyone in the bed has recently drunk any alcohol
- you or anyone in the bed smokes
- you or anyone in the bed has taken any drugs that make you feel sleepy
- your baby was born prematurely (before 37 weeks of pregnancy) or weighed under 2.5kg or 5½ lbs when they were born.

In these scenarios, it is always best to put baby in their own safe sleep space such as a cot or a Moses basket. Keeping the cot or Moses basket next to the bed might make it easier to do this.

Reason: studies have found that bed-sharing with your baby after drinking alcohol or using drugs has a very high risk of SIDS. Sleeping close to a smoker also greatly increases the chance of SIDS. Premature and very small babies have a greater chance of SIDS when they share a bed with an adult.

Tips for safer bed sharing

- Keep pets away from the bed and do not have other children sharing the bed
- Make sure baby won't fall out of bed or get trapped between the mattress and the wall
- Keep pillows and adult bedding away from baby
- Follow the tips if you think you might fall asleep with your baby in the bed

5

En Defensa del Colecho

https://www.basionline.org.uk/safer-sleep-info/?fbclid=IwAR0kTCO-iDPb_No55P00sBAUnA51grvDpPX4XG7cWZ-Uyl0MF7J0wdKyA4c



Síndrome de la Muerte Súbita del Lactante

En defensa del Colecho

Key principles:

- Be open and non-judgemental – families bed share at any given time for a wide variety of reasons. Shock messages that increase fear do not work.
- Beware of assumptions – breastfeeding families are not automatically 'safe' bed sharers, and neither are formula fed babies always at a much higher risk. Both groups need guidance.
- Explore – why is the family bed sharing? Do they have an alternative safe sleep place for their baby should they need it? Help them find one if not.
- Plan – every family needs a plan to avoid unsafe accidental bed sharing, and those nights when something different happens.
- Do not be afraid – to tell families if their circumstances mean they are in a high risk group and should not bed share (if they are smokers, if the baby was born prem or low birth weight, if they use drugs or drink alcohol)
- If a family's risk for SIDS is high it is important to explain why. We know from our research and discussions with parents that they are much more likely to follow advice if they understand the reason.
- Give all families the tools and information to make an informed decision with clear advice.

If parents choose to share a bed with their baby they should discuss with a professional how to:

- Ensure there are no pillows, sheets, blankets or any other items in the bed with them that could obstruct their baby's breathing or cause them to overheat. A high proportion of infants who die as a result of SIDS are found with their head covered by loose bedding.
- Make sure their baby cannot fall out of bed or become trapped between the mattress and wall
- Never leave their baby alone in the bed, as even very young babies can wriggle into a dangerous position.

Remember, bed-sharing is not a risk-free activity, and parents must take responsibility for ensuring their baby's safety. No studies have found that the parents' bed is safer than a cot beside the parents' bed.

Remember the key messages:

- Put babies on their BACK for every sleep
- In a CLEAR, FLAT SLEEP SPACE
- Keep them SMOKE FREE day and night



https://www.basisonline.org.uk/safer-sleep-info/?fbclid=IwAR0kTCO-iDPb_No55P00sBAUnA51grvDpPX4XG7cWZ-UyI0MF7J0wdKyA4c



Síndrome de la Muerte Súbita del Lactante

En defensa del Colecho



2014

COLECHO, SÍNDROME DE MUERTE SÚBITA DEL LACTANTE Y LACTANCIA MATERNA. RECOMENDACIONES ACTUALES DE CONSENSO

Comité de Lactancia Materna de la Asociación Española de Pediatría

1. La forma más segura de dormir para los lactantes menores de seis meses es en su cuna, boca arriba, cerca de la cama de sus padres. Existe evidencia científica de que esta práctica disminuye el riesgo de SMSL en más del 50%.

2. La lactancia materna tiene un efecto protector frente al SMSL y, por otro lado, el colecho es una práctica beneficiosa para el mantenimiento de la lactancia materna, pero también se considera un factor que aumenta el riesgo de SMSL por lo que no debe ser recomendado en:

- Lactantes menores de tres meses de edad.
- Prematuridad y bajo peso al nacimiento.
- Padres que consuman tabaco, alcohol, drogas o fármacos sedantes.
- Situaciones de cansancio, especialmente de cansancio extremo, como el postparto inmediato.
- Colecho sobre superficies blandas, colchones de agua, sofá o sillones
- Compartir la cama con otros familiares, con otros niños o con múltiples personas.



Parent-Infant Bed-Sharing Behavior

Effects of Feeding Type and Presence of Father

Helen Ball

University of Durham



Human Nature, vol. 17, no. 3, pp. 301-318, 2006.



El Colapso Inesperado y Súbito Postnatal



“El evento ocurrido a cualquier bebé nacido con más de 35 semanas de gestación, que está bien en el momento del nacimiento (puntuación Apgar a los 5 minutos normal y considerado suficientemente bien como para recomendar el cuidado postnatal de rutina) y que colapsa inesperadamente siendo descubierto en una situación cardiorrespiratoria extrema, lo que obliga a la utilización de reanimación mediante ventilación intermitente con presión positiva. El colapso se produce durante los 7 primeros días de vida y el resultado puede ser tanto de muerte como requerir ingreso en cuidados intensivos o el desarrollo de una encefalopatía”

WellChild, Guidelines for the Investigation of Newborn Infants Who Suffer a Sudden and Unexpected Postnatal Collapse in the First Week of Life: Recommendations from a Professional Group on Sudden Unexpected Postnatal Collapse, London, 2011.



El Colapso Inesperado y Súbito Postnatal

Factores de Riesgo

- Posición prona o “potencialmente asfixiante”.
- Madre en posición de litotomía, en contacto piel con piel con el bebé.
- Compartir cama.
- El primer intento de dar el pecho, especialmente si no es supervisado.
- Primiparidad.
- Madres y padres dejados solos en la sala de partos.
- El uso de aparatos electrónicos como móviles o *tablets* que distraen a la madre.

R. Davanzo, A. De Cunto, G. Paviotti, L. Travan, S. Inglese, P. Brovedani, A. Crocetta, C. Calligaris, E. Corubolo, V. Dussich, G. Verardi, E. Causin, J. Kennedy, F. Marrasso, T. Strajn, C. Sanesi y S. Demarini, «Making the first days of life safer: preventing sudden unexpected postnatal collapse while promoting breastfeeding.,» *J Hum Lact*, vol. 31, nº 1, pp. 47-52, February 2015.



El Inmenso Beneficio del Piel con Piel



- Disminuye el estrés.
- Junto con la lactancia materna dentro de los primeros 30 minutos tras el parto, disminuye el riesgo de hemorragia.
- Disminuye la activación del eje hipotalámico-pituitaria-adrenal durante todo el primer mes tras el parto.

- Estabiliza la temperatura del bebé, previniendo la hipotermia.
- Ayuda a estabilizar sus concentraciones de glucosa en sangre.
- Disminuye el llanto.
- Provee de estabilidad cardiorrespiratoria.
- Disminuye el sufrimiento del bebé ante las intervenciones médicas.
- Especialmente en prematuros, mejora la evolución neurológica y la adaptación gastrointestinal y propicia un sueño más saludable, así como disminuye el llanto y mejora el crecimiento.





El Colapso Inesperado y Súbito Postnatal

Medidas Preventivas

- **Evaluaciones frecuentes y repetitivas** que incluyan observaciones de la respiración, actividad, color, tono y posición del recién nacido pueden evitar posiciones que obstruyan las vías respiratorias o propicien el colapso.
- **Una monitorización continua por parte de personal especializado**, así como el uso de listas de control pueden aumentar la seguridad.
- **La estratificación de los riesgos** es también importante. Se pueden considerar en situación de riesgo los bebés que necesitaron reanimación al nacer, los que tuvieron puntuaciones bajas de Apgar, los prematuros tardíos o los bebés a término tempranos (37 a 39 semanas de gestación), los que nacieron de un parto difícil, una madre que recibió codeína o cualquier otra medicación que afecte al neonato, una madre sedada y madre o bebés excesivamente adormecidos. La falta de sueño y el cansancio de la madre deben ser evaluados.
- **Proporcionar un ambiente apropiado** con una temperatura correcta y la luz necesaria para observar cualquier cambio en el neonato.
- La **presencia de personal de soporte** como doulas o familiares puede ayudar en el cuidado y control, pero nunca debe sustituir la presencia del personal profesional especializado.
- No dejar **nunca** a la **madre desatendida** durante el piel con piel, especialmente si es primípara.
- **Asegurar la posición correcta del bebé sobre su madre**, con la nariz y la boca descubiertas y visibles. La posición prona es aceptable si el bebé está sobre su madre entre los pechos o sobre el abdomen (pero no al pecho), con la cabeza vuelta hacia un lado, el cuello recto y la boca y nariz descubiertas.
- **Evitar el piel con piel si la madre ha recibido analgésicos o parece exhausta** en el caso de que no pueda haber una monitorización continua de la diada.
- **Especialmente importante es la vigilancia intensa durante el periodo de estabilización** (las primeras 6-12 horas) que debe realizarse con personal cualificado, como comadronas o enfermeras.
- **Supervisión de la primera toma de lactancia.**
- **Evitar el uso de cualquier dispositivo electrónico por parte de la madre durante el piel con piel y la lactancia.**

L. Feldman-Winter, J. P. Goldsmith, C. O. F. A. NEWBORN y T. F. O. S. I. D. SYNDROME., «Safe Sleep and Skin-to-Skin Care in the Neonatal Period for Healthy Term Newborns.,» *Pediatrics*. 2016 Sep;138(3), vol. 138, nº 3, p. e2 0161889, September 2016.



El Colapso Inesperado y Súbito Postnatal

¿Cómo puede ser?





El Colapso Inesperado y Súbito Postnatal

¿Cómo puede ser?



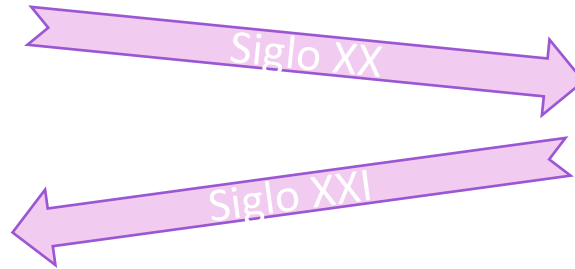


CONCLUSIONES



BREASTSLEEPING

There is no such thing as infant sleep, there is no such thing as breastfeeding, there is only breastsleeping. McKenna, J J and Gettler, L T. 1, 2016, Acta Paediatr, Vol. 105, pp. 17-21.



- **La importancia que tiene el contacto con la madre a la hora de establecer la lactancia**, la cual obliga a un importante cambio de paradigma a la hora de plantear las recomendaciones oficiales respecto al sueño infantil y, muy especialmente, respecto al colecho.
- **El sueño infantil normal y saludable sólo puede ser analizado y observado en el contexto del Breastsleeping** —esto es, dentro del contexto de la lactancia— dado el importante papel que tiene todo el intercambio sensorial entre madre y bebé implicado en la producción e ingesta de leche, sobre el metabolismo del bebé, la frecuencia de las tomas y el propio sueño de ambos (arquitectura, despertares, etc.), reflejando un sistema adaptativo altamente integrado.

Dado que la diada madre/bebé lactante presenta tantas diferencias sustanciales —conductuales y fisiológicas— respecto a la diada madre/bebé alimentado con fórmula, se hace **obligatorio darles su propia categoría epidemiológica y estimación de riesgos/beneficios.**



Fuente: Baby Sleep Information Source