Complete Summary

GUIDELINE TITLE

Breastfeeding and the use of human milk.

BIBLIOGRAPHIC SOURCE(S)

Gartner LM, Morton J, Lawrence RA, Naylor AJ, O'Hare D, Schanler RJ, Eidelman AI. Breastfeeding and the use of human milk. Pediatrics 2005 Feb;115(2):496-506. [216 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline. It is intended to replace the previously issued policy statement of the American Academy of Pediatrics (AAP).

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SCOPE

DISEASE/CONDITION(S)

Acute and chronic diseases that may be influenced by breast feeding, including those affecting infant and maternal health

- Child health: Diarrhea, respiratory tract infections, otitis media, bacteremia, bacterial meningitis, urinary tract infection, necrotizing enterocolitis, sudden

infant death syndrome, insulin-dependent (type 1) and non-insulin dependent (type 2) diabetes mellitus, lymphoma, leukemia, Hodgkin disease, overweight and obesity, hypercholesterolemia, and asthma
- Maternal health: Postpartum and menstrual bleeding, osteoporosis, hip fractures, ovarian cancer, and breast cancer

GUIDELINE CATEGORY

Prevention

CLINICAL SPECIALTY

Family Practice
Nursing
Nutrition
Obstetrics and Gynecology
Pediatrics

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

- To promote breastfeeding of infants as the foundation of good feeding practices and healthy development
- To present recommendations on breastfeeding practices and the role of pediatricians in promoting and protecting breastfeeding

TARGET POPULATION

Pregnant women in the prenatal, perinatal, or postpartum period and their infants

INTERVENTIONS AND PRACTICES CONSIDERED

1. Breastfeeding (human milk feeding)
2. Patient education
3. Formal evaluation of breastfeeding
4. Vitamin K and D supplementation of infants (Note: fluoride supplementation is considered but not recommended during the first 6 months.)
5. Patient referral to breastfeeding support groups

MAJOR OUTCOMES CONSIDERED

- Rates of breastfeeding initiation and duration

- Incidence and/or severity of acute and chronic illness (for both children and women)
- Risk of acute and chronic diseases (for both children and women)
- Health care costs
- Employee absenteeism for care attributable to child illness

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not stated

COST ANALYSIS

The guideline developers reviewed published cost analyses.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Multiple American Academy of Pediatrics (AAP) committees and the AAP Board of Directors reviewed the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Recommendations on Breastfeeding For Healthy Term Infants

1. Pediatricians and other health care professionals should recommend human milk for all infants in whom breastfeeding is not specifically contraindicated and provide parents with complete, current information on the benefits and techniques of breastfeeding to ensure that their feeding decision is a fully informed one (Gartner, 1994; American Academy of Pediatrics [AAP] Committee on Nutrition, "Breastfeeding," 2004; Position of the American Dietetic Association [ADA], 2001).
    - When direct breastfeeding is not possible, expressed human milk should be provided (Schanler & Hurst, 1994; Lemons, Stuart, & Lemons, 1986). If a known contraindication to breastfeeding is identified, consider whether the contraindication may be temporary, and if so, advise pumping to maintain milk production. Before advising against breastfeeding or recommending premature weaning, weigh the benefits of breastfeeding against the risks of not receiving human milk.
2. Peripartum policies and practices that optimize breastfeeding initiation and maintenance should be encouraged.
    - Education of both parents before and after delivery of the infant is an essential component of successful breastfeeding. Support and encouragement by the father can greatly assist the mother during the initiation process and during subsequent periods when problems arise. Consistent with appropriate care for the mother, minimize or modify the course of maternal medications that have the potential for altering the infant's alertness and feeding behavior (Kron, Stein, & Goddard, 1966; Ransjo-Arvidson et al., 2001). Avoid procedures that may interfere with breastfeeding or that may traumatize the infant, including unnecessary, excessive, and overvigorous suctioning of the oral cavity, esophagus, and airways to avoid oropharyngeal mucosal injury that may lead to aversive feeding behavior (Widstrom & Thingstrom-Paulson, 1993; Wolf & Glass, 1992).
3. Healthy infants should be placed and remain in direct skin-to-skin contact with their mothers immediately after delivery until the first feeding is

accomplished (Righard & Alade, 1990; Wiberg, Humble, & de Chateau, 1989; Mikiel-Kostyra, Mazur, & Boltruszko, 2002).

- The alert, healthy newborn infant is capable of latching on to a breast without specific assistance within the first hour after birth (Righard & Alade, 1990). Dry the infant, assign Apgar scores, and perform the initial physical assessment while the infant is with the mother. The mother is an optimal heat source for the infant (Christensson et al., 1992; Van Den Bosch & Bullough, 1990). Delay weighing, measuring, bathing, needle-sticks, and eye prophylaxis until after the first feeding is completed. Infants affected by maternal medications may require assistance for effective latch-on (Righard & Alade, 1990). Except under unusual circumstances, the newborn infant should remain with the mother throughout the recovery period (Sosa et al., 1976).

4. Supplements (water, glucose water, formula, and other fluids) should not be given to breastfeeding newborn infants unless ordered by a physician when a medical indication exists (AAP Committee on Nutrition, "Breastfeeding," 2004; AAP & American College of Obstetricians and Gynecologist [ACOG], 2002; Shrago, 1987; Goldberg & Adams, 1983, Eidelman, 2001).
5. Pacifier use is best avoided during the initiation of breastfeeding and used only after breastfeeding is well established (Howard et al., 1999; Howard et al., 2003; Schubiger, Schwartz, & Tonz, 1997).
    - In some infants early pacifier use may interfere with establishment of good breastfeeding practices, whereas in others it may indicate the presence of a breastfeeding problem that requires intervention (Kramer et al., 2001).
    - This recommendation does not contraindicate pacifier use for nonnutritive sucking and oral training of premature infants and other special care infants.
6. During the early weeks of breastfeeding, mothers should be encouraged to have 8 to 12 feedings at the breast every 24 hours, offering the breast whenever the infant shows early signs of hunger such as increased alertness, physical activity, mouthing, or rooting (Gunther, 1955).
    - Crying is a late indicator of hunger. Appropriate initiation of breastfeeding is facilitated by continuous rooming-in throughout the day and night (Procianoy et al., 1983). The mother should offer both breasts at each feeding for as long a period as the infant remains at the breast (Anderson, 1989). At each feed the first breast offered should be alternated so that both breasts receive equal stimulation and draining. In the early weeks after birth, nondemanding infants should be aroused to feed if 4 hours have elapsed since the beginning of the last feeding.
    - After breastfeeding is well established, the frequency of feeding may decline to approximately 8 times per 24 hours, but the infant may increase the frequency again with growth spurts or when an increase in milk volume is desired.
7. Formal evaluation of breastfeeding, including observation of position, latch, and milk transfer, should be undertaken by trained caregivers at least twice daily and fully documented in the record during each day in the hospital after birth (Riordan et al., 2001; Hall et al., 2002).
    - Encouraging the mother to record the time and duration of each breastfeeding, as well as urine and stool output during the early days of breastfeeding in the hospital and the first weeks at home, helps to facilitate the evaluation process. Problems identified in the hospital

should be addressed at that time, and a documented plan for management should be clearly communicated to both parents and to the medical home.

8. All breastfeeding newborn infants should be seen by a pediatrician or other knowledgeable and experienced health care professional at 3 to 5 days of age as recommended by the American Association of Pediatrics (AAP) ("Management of hyperbilirubinemia," 2004; AAP Committee on Practice and Ambulatory Medicine, 2000;"Hospital stay for healthy term newborns, 1995).
    - This visit should include infant weight; physical examination, especially for jaundice and hydration; maternal history of breast problems (painful feedings, engorgement); infant elimination patterns (expect 3-5 urines and 3-4 stools per day by 3-5 days of age; 4-6 urines and 3-6 stools per day by 5-7 days of age); and a formal, observed evaluation of breastfeeding, including position, latch, and milk transfer. Weight loss in the infant of greater than 7% from birth weight indicates possible breastfeeding problems and requires more intensive evaluation of breastfeeding and possible intervention to correct problems and improve milk production and transfer.
9. Breastfeeding infants should have a second ambulatory visit at 2 to 3 weeks of age so that the health care professional can monitor weight gain and provide additional support and encouragement to the mother during this critical period.
10. Pediatricians and parents should be aware that exclusive breastfeeding is sufficient to support optimal growth and development for approximately the first 6 months of life* and provides continuing protection against diarrhea and respiratory tract infection (Popkin et al., 1990; Bachrach, Schwartz, & Bachrach, 2003; American Academy of Family Physicians [AAFP], 2001; Ahn & MacClean, 1980; Brown, Dewey, & Allen, 1998; Heinig et al., 1993; Kramer & Kakuma, 2002; Chantry, Howard, & Auinger, 2002; Dewey et al., 2001; Butte, Lopez-Alarcon, & Garza, 2002). Breastfeeding should be continued for at least the first year of life and beyond for as long as mutually desired by mother and child (Sugarman & Kendall-Tackett, 1995).

    *There is a difference of opinion among AAP experts on this matter. The Section on Breastfeeding acknowledges that the Committee on Nutrition supports introduction of complementary foods between 4 and 6 months of age when safe and nutritious complementary foods are available.

    - Complementary foods rich in iron should be introduced gradually beginning around 6 months of age (Dallman, 1990; Domellof et al., 2002). Preterm and low birth weight infants and infants with hematologic disorders or infants who had inadequate iron stores at birth generally require iron supplementation before 6 months of age (AAP Committee on Nutrition, "Breastfeeding, " 2004; AAP Committee on Fetus and Newborn & ACOG, 2002; AAP Committee on Nutrition, "Nutritional needs," 2004; Pisacane, De Vizia, & Valiente, 1995; Griffin & Abrams, 2001; Dewey et al., 1998). Iron may be administered while continuing exclusive breastfeeding.
    - Unique needs or feeding behaviors of individual infants may indicate a need for introduction of complementary foods as early as 4 months of age, whereas other infants may not be ready to accept other foods until approximately 8 months of age (Naylor & Morrow, 2001).

- Introduction of complementary feedings before 6 months of age generally does not increase total caloric intake or rate of growth and only substitutes foods that lack the protective components of human milk (Cohen et al., 1995).
- During the first 6 months of age, even in hot climates, water and juice are unnecessary for breastfed infants and may introduce contaminants or allergens (Ashraf et al., 1993).
- Increased duration of breastfeeding confers significant health and developmental benefits for the child and the mother, especially in delaying return of fertility (thereby promoting optimal intervals between births) (Huffman et al., 1987).
- There is no upper limit to the duration of breastfeeding and no evidence of psychologic or developmental harm from breastfeeding into the third year of life or longer (Dettwyler, 1995).
- Infants weaned before 12 months of age should not receive cow's milk but should receive iron-fortified infant formula ("Iron fortification of infant formulas," 1999).

11. All breastfed infants should receive 1.0 mg of vitamin K_1 oxide intramuscularly after the first feeding is completed and within the first 6 hours of life ("Controversies concerning vitamin K," 2003).
    - Oral vitamin K is not recommended. It may not provide the adequate stores of vitamin K necessary to prevent hemorrhage later in infancy in breastfed infants unless repeated doses are administered during the first 4 months of life (Hansen & Ebbesen, 1996).
12. All breastfed infants should receive 200 IU of oral vitamin D drops daily beginning during the first 2 months of life and continuing until the daily consumption of vitamin D-fortified formula or milk is 500 mL (Gartner & Greer, 2003).
    - Although human milk contains small amounts of vitamin D, it is not enough to prevent rickets. Exposure of the skin to ultraviolet B wavelengths from sunlight is the usual mechanism for production of vitamin D. However, significant risk of sunburn (short-term) and skin cancer (long-term) attributable to sunlight exposure, especially in younger children, makes it prudent to counsel against exposure to sunlight. Furthermore, sunscreen decreases vitamin D production in skin.
13. Supplementary fluoride should not be provided during the first 6 months of life ("Recommendations for using fluoride," 2001).
    - From 6 months to 3 years of age, the decision whether to provide fluoride supplementation should be made on the basis of the fluoride concentration in the water supply (fluoride supplementation generally is not needed unless the concentration in the drinking water is <0.3 ppm) and in other food, fluid sources, and toothpaste.
14. Mother and infant should sleep in proximity to each other to facilitate breastfeeding (Blair et al., 1999).
15. Should hospitalization of the breastfeeding mother or infant be necessary, every effort should be made to maintain breastfeeding, preferably directly, or pumping the breasts and feeding expressed milk if necessary.

Additional Recommendations For High-Risk Infants

- Hospitals and physicians should recommend human milk for premature and other high-risk infants either by direct breastfeeding and/or using the mother's own expressed milk (Schanler, 2001). Maternal support and education on breastfeeding and milk expression should be provided from the earliest possible time. Mother-infant skin-to-skin contact and direct breastfeeding should be encouraged as early as feasible (Charpak et al., 1997; Hurst et al., 1997). Fortification of expressed human milk is indicated for many very low birth weight infants (Schanler, 2001). Banked human milk may be a suitable feeding alternative for infants whose mothers are unable or unwilling to provide their own milk. Human milk banks in North America adhere to national guidelines for quality control of screening and testing of donors and pasteurize all milk before distribution (Hughes, 1990; Human Milk Banking Association of North America, 2003; Arnold, 1990). Fresh human milk from unscreened donors is not recommended because of the risk of transmission of infectious agents
- Precautions should be followed for infants with glucose-6-phosphate dehydrogenase (G6PD) deficiency. G6PD deficiency has been associated with an increased risk of hemolysis, hyperbilirubinemia, and kernicterus (Kaplan & Hammerman, 1998). Mothers who breastfeed infants with known or suspected G6PD deficiency should not ingest fava beans or medications such as nitrofurantoin, primaquine phosphate, or phenazopyridine hydrochloride, which are known to induce hemolysis in deficient individuals (Kaplan et al., 1998; Gerk et al., 2001).

Conclusions

Although economic, cultural, and political pressures often confound decisions about infant feeding, the AAP firmly adheres to the position that breastfeeding ensures the best possible health as well as the best developmental and psychosocial outcomes for the infant. Enthusiastic support and involvement of pediatricians in the promotion and practice of breastfeeding is essential to the achievement of optimal infant and child health, growth, and development.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is not specifically stated.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Child Health Benefits

- Human milk-fed premature infants receive significant benefits with respect to host protection and improved developmental outcomes compared with formula-fed premature infants.
- Research in developed and developing countries of the world, including middle-class populations in developed countries, provides strong evidence that human milk feeding decreases the incidence and/or severity of a wide range of infectious diseases including bacterial meningitis, bacteremia, diarrhea, respiratory tract infection, necrotizing enterocolitis, otitis media, urinary tract infection and late-onset sepsis in preterm infants. In addition, postneonatal infant mortality rates in the United States are reduced by 21% in breastfed infants.
- Some studies suggest decreased rates of sudden infant death syndrome in the first year of life and reduction in incidence of insulin-dependent (type 1) and non-insulin-dependent (type 2) diabetes mellitus, lymphoma, leukemia, and Hodgkin disease, overweight and obesity, hypercholesterolemia, and asthma in older children and adults who were breastfed, compared with individuals who were not.
- Breastfeeding has been associated with slightly enhanced performance on tests of cognitive development. Breastfeeding during a painful procedure such as a heel-stick for newborn screening provides analgesia to infants.

Maternal Health Benefits

Important health benefits of breastfeeding and lactation are also described for mothers. The benefits include decreased postpartum bleeding and more rapid uterine involution attributable to increased concentrations of oxytocin, decreased menstrual blood loss and increased child spacing attributable to lactational amenorrhea, earlier return to prepregnancy weight, decreased risk of breast cancer, decreased risk of ovarian cancer, and possibly decreased risk of hip fractures and osteoporosis in the postmenopausal period.

Health Care Costs

There is a potential for decreased annual health care costs of $3.6 billion in the United States; decreased costs for public health programs such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); decreased parental employee absenteeism and associated loss of family income; more time for attention to siblings and other family matters as a result of decreased infant illness; decreased environmental burden for disposal of formula cans and bottles; and decreased energy demands for production and transport of artificial feeding products. These savings for the country and for families would be offset to some unknown extent by increased costs for physician and lactation consultations, increased office-visit time, and cost of breast pumps and other equipment, all of which should be covered by insurance payments to providers and families.

POTENTIAL HARMS

Not stated

CONTRAINDICATIONS

CONTRAINDICATIONS

Breastfeeding is contraindicated in infants with classic galactosemia (galactose 1-phosphate uridyltransferase deficiency); mothers who have active untreated tuberculosis disease or are human T-cell lymphotropic virus type I- or II-positive; mothers who are receiving diagnostic or therapeutic radioactive isotopes or have had exposure to radioactive materials (for as long as there is radioactivity in the milk); mothers who are receiving antimetabolites or chemotherapeutic agents or a small number of other medications until they clear the milk; mothers who are using drugs of abuse ("street drugs"); and mothers who have herpes simplex lesions on a breast (infant may feed from other breast if clear of lesions). In the United States, mothers who are infected with human immunodeficiency virus (HIV) have been advised not to breastfeed their infants.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The recommendations in this statement do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Role of Pediatricians And Other Health Care Professionals In Protecting, Promoting, and Supporting Breastfeeding

Many pediatricians and other health care professionals have made great efforts in recent years to support and improve breastfeeding success by following the principles and guidance provided by the American Association of Pediatrics (AAP), the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and many other organizations. The following guidelines summarize these concepts for providing an optimal breastfeeding environment.

General

- Promote, support, and protect breastfeeding enthusiastically. In consideration of the extensively published evidence for improved health and developmental outcomes in breastfed infants and their mothers, a strong position on behalf of breastfeeding is warranted.
- Promote breastfeeding as a cultural norm and encourage family and societal support for breastfeeding.
- Recognize the effect of cultural diversity on breastfeeding attitudes and practices and encourage variations, if appropriate, that effectively promote and support breastfeeding in different cultures.

Education

- Become knowledgeable and skilled in the physiology and the current clinical management of breastfeeding.
- Encourage development of formal training in breastfeeding and lactation in medical schools, in residency and fellowship training programs, and for practicing pediatricians.
- Use every opportunity to provide age-appropriate breastfeeding education to children and adults in the medical setting and in outreach programs for student and parent groups.

Clinical Practice

- Work collaboratively with the obstetric community to ensure that women receive accurate and sufficient information throughout the perinatal period to make a fully informed decision about infant feeding.
- Work collaboratively with the dental community to ensure that women are encouraged to continue to breastfeed and use good oral health practices. Infants should receive an oral health-risk assessment by the pediatrician between 6 months and 1 year of age and/or referred to a dentist for evaluation and treatment if at risk of dental caries or other oral health problems.
- Promote hospital policies and procedures that facilitate breastfeeding. Work actively toward eliminating hospital policies and practices that discourage breastfeeding (e.g., promotion of infant formula in hospitals including infant formula discharge packs and formula discount coupons, separation of mother and infant, inappropriate infant feeding images, and lack of adequate encouragement and support of breastfeeding by all health care staff). Encourage hospitals to provide in-depth training in breastfeeding for all health care staff (including physicians) and have lactation experts available at all times.
- Provide effective breast pumps and private lactation areas for all breastfeeding mothers (patients and staff) in ambulatory and inpatient areas of the hospital.
- Develop office practices that promote and support breastfeeding by using the guidelines and materials provided by the AAP Breastfeeding Promotion in Physicians' Office Practices program.
- Become familiar with local breastfeeding resources (e.g., Women, Infants and Children (WIC) clinics, breastfeeding medical and nursing specialists, lactation educators and consultants, lay support groups, and breast-pump rental stations) so that patients can be referred appropriately. When specialized breastfeeding services are used, the essential role of the pediatrician as the infant's primary health care professional within the framework of the medical home needs to be clarified for parents.
- Encourage adequate, routine insurance coverage for necessary breastfeeding services and supplies, including the time required by pediatricians and other licensed health care professionals to assess and manage breastfeeding and the cost for the rental of breast pumps.
- Develop and maintain effective communication and coordination with other health care professionals to ensure optimal breastfeeding education, support, and counseling. AAP and WIC breastfeeding coordinators can facilitate

collaborative relationships and develop programs in the community and in professional organizations for support of breastfeeding.
- Advise mothers to continue their breast self-examinations on a monthly basis throughout lactation and to continue to have annual clinical breast examinations by their physicians.

Society

- Encourage the media to portray breastfeeding as positive and normative.
- Encourage employers to provide appropriate facilities and adequate time in the workplace for breastfeeding and/or milk expression.
- Encourage child care providers to support breastfeeding and the use of expressed human milk provided by the parent.
- Support the efforts of parents and the courts to ensure continuation of breastfeeding in separation and custody proceedings.
- Provide counsel to adoptive mothers who decide to breastfeed through induced lactation, a process requiring professional support and encouragement.
- Encourage development and approval of governmental policies and legislation that are supportive of a mother's choice to breastfeed.

Research

- Promote continued basic and clinical research in the field of breastfeeding. Encourage investigators and funding agencies to pursue studies that further delineate the scientific understandings of lactation and breastfeeding that lead to improved clinical practice in this medical field.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1997 Dec (revised 2005 Feb)

GUIDELINE DEVELOPER(S)

American Academy of Pediatrics - Medical Specialty Society

SOURCE(S) OF FUNDING

American Academy of Pediatrics

GUIDELINE COMMITTEE

Section on Breastfeeding

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Section on Breastfeeding, 2003-2004: *Lawrence M. Gartner, MD, *Chairperson*; Jane Morton, MD; Ruth A. Lawrence, MD; Audrey J. Naylor, MD, DrPH; Donna O'Hare, MD; Richard J. Schanler, MD; *Arthur I. Eidelman, MD, Policy Committee Chairperson

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

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GUIDELINE AVAILABILITY

Electronic copies: Available from the American Academy of Pediatrics (AAP) Policy Web site.

Print copies: Available from the American Academy of Pediatrics, 141 NW Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927; Web site, http://www.aap.org/

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on April 27, 1999. The information was verified by the guideline developer on July 13, 1999. This NGC summary was updated by ECRI on February 23, 2005. The information was verified by the guideline developer on May 2, 2005.

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