

ONE FAMILY PEDIATRICS | CUMMING, GEORGIA

10 Breastfeeding Questions North Atlanta Mothers Ask Most

And What a Breastfeeding and Lactation Medicine Specialist Says

Expert guidance from Dr. Hiral Lavania, MD
Board-Certified Pediatrician | Breastfeeding & Lactation Medicine Specialist | IBCLC
One Family Pediatrics | Cumming, Georgia

ABOUT THIS GUIDE

Breastfeeding is one of the most natural things in the world — and one of the most technically demanding. Most new mothers in North Atlanta leave the hospital with good intentions and incomplete information, and spend the first weeks navigating questions their discharge paperwork didn't answer.

Dr. Hiral Lavania, MD is a board-certified pediatrician and breastfeeding and lactation medicine specialist at One Family Pediatrics in Cumming, Georgia. She is also an International Board-Certified Lactation Consultant (IBCLC) — one of the few pediatricians in Forsyth and Gwinnett County who holds both credentials. In this guide, she answers the 10 questions she hears most often from new mothers in her practice — with the clinical precision and the human warmth that characterize her approach to care.

A note on terminology: Dr. Lavania holds credentials as both an IBCLC (International Board-Certified Lactation Consultant) and a Breastfeeding and Lactation Medicine Specialist. Both designations reflect the same depth of expertise. When you see references to seeking an 'IBCLC or breastfeeding and lactation medicine specialist' in this guide, that is Dr. Lavania's way of acknowledging that both credentials indicate qualified, specialized support.

This guide is for educational purposes. For personalized guidance, contact One Family Pediatrics to schedule a lactation consultation.

1 Latch Problems

Q: What are the physical signs that a baby has a shallow latch versus a deep, effective latch?

A deep, effective latch usually shows a wide gape — close to 140 to 160 degrees — with lips flanged outward like a fish, more areola visible above the top lip than below it (the asymmetric latch), chin pressed into the breast with the nose free or barely grazing it, rounded cheeks with no dimpling, and a rhythmic suck-swallow with audible or visible swallowing. Mom feels tugging or pressure but not pain after the first few seconds, and the nipple comes out rounded. A shallow latch tends to show clicking or smacking (broken suction), dimpled or hollowed cheeks, a tucked-in lower lip, the nipple emerging creased, pinched, or wedge or lipstick-shaped, pain that persists through the feed, and the baby gripping near the tip rather than drawing in areola. Those are the most reliable bedside tells.

Q: If a mother feels consistent pain during a feed, at what point should she break the suction and try again?

A correct latch should not hurt beyond a brief initial discomfort in the early days. If pain continues past those first several seconds, that is the signal to de-latch: slide a clean finger into the corner of the baby's mouth to break the seal — never pull the baby off the nipple — and try again. If nipples are damaged or baby is not gaining weight, lactation support is warranted. You can find a qualified lactation support provider at zipmilk.org.

2 Supply Concerns

Q: What are the true clinical indicators that a baby is getting enough milk — and what are common false alarms?

The reliable indicators are output and growth, not pump volume or breast feel. Babies should have the same number of wet and dirty diapers as their age in days — day 1: 1 wet, 1 dirty; day 2: 2 wet, 2 dirty; and so on. By day 4 to 5, expect about 6 or more wet diapers a day with pale urine, and frequent yellow seedy stools in the early weeks. On growth, initial weight loss up to about 7 to 10 percent is typical, birth weight is usually regained by around 10 to 14 days, and steady gain follows. Common false alarms: cluster feeding (especially evenings or growth spurts), a baby who wants to nurse again soon after a feed, breasts that feel softer once supply regulates around 6 to 12 weeks, shorter feeds as baby gets efficient, not leaking, and — the big one — a modest pump yield. A pump is a far less efficient extractor than a well-latched baby, so low output at the flange does not equal low supply.

Q: What are your recommendations for safely boosting milk supply if a lag is genuinely detected?

Soon after birth, babies should be nursing 10 to 12 times in a 24-hour period — not every 3 hours. The first-line intervention is increased effective milk removal, because supply is demand-driven: more frequent and complete drainage, confirming an effective latch and transfer, adding pumping sessions, and skin-to-skin.

3 Returning to Work

Q: How far in advance should a mother begin building a freezer stash, and what is a realistic daily target?

Freezer stash is not the usual norm. Most parents will make only enough milk to feed their baby and no more. If you have an oversupply in the mornings, you can pump excess milk after the baby has fed and freeze it for up to 4 to 6 months. It is important not to create a big oversupply, because this can result in mastitis. Start practicing with bottle feeds 2 to 4 weeks before going back to work. Aim for an average of one pump session every 2 hours across the day — but that does not have to mean clockwork. Some moms space sessions evenly at 2 hours apart, while others bunch a couple of sessions about an hour apart and then take a longer 3 to 4 hour break. Either rhythm works, as long as the daily average lands around every 2 hours.

Q: How should a mother navigate pumping rights at work, and what is ideal pumping frequency during an 8-hour workday?

Frame it early and matter-of-factly, put the schedule in writing, and ask for a specific room and roughly every-2-hours timing. In an 8-hour workday that usually means about 4 sessions of 15 to 20 minutes, mirroring the baby's feeding rhythm to protect supply.

4 Introducing Formula (Combo Feeding)

Q: What is the best strategy to introduce a bottle without causing nipple preference or disrupting supply?

Use a slow-flow nipple and paced bottle feeding, keep the baby upright, and let them work for it. Many providers suggest waiting until breastfeeding is reasonably established before regular bottles. For supply: every feed that formula replaces is a removal the breasts do not get, which signals lower demand. Either introduce gradually, or pump when you give a bottle if you are trying to hold supply steady.

Q: What formula do you recommend, and how should a combo-feeding schedule be structured?

Per the AAP, a standard iron-fortified cow's-milk-based formula is the appropriate first choice for most healthy term infants. Specialized formulas — extensively hydrolyzed, amino acid, soy — are for specific medical indications, not general use. Honest message: standard iron-fortified formula is a perfectly good supplement. Schedule is individualized — a common pattern is to nurse when together and bottle when apart, or nurse first and top up after. The structural principle that matters is maintaining your removal frequency so supply does not quietly down-regulate.

5 Nipple Pain & Damage

Q: What are the most effective treatments for healing damaged nipples quickly while continuing to nurse?

The single most effective 'treatment' is correcting the cause — which is usually latch or positioning, sometimes a tongue or lip tie, pump flange fit, or a dermatologic or infectious process. Topical wound care will not outrun an ongoing mechanical injury. For the wound itself, moist wound healing is the standard: non-lanolin based organic nipple balm, hydrogel pads, and breaking suction properly. Avoid drying out the nipples, saline soaks, and silver nursing cups.

How to distinguish normal soreness from infection: This is nuanced enough that it warrants an in-person evaluation. Conditions like thrush and vasospasm have specific treatment implications. Please speak with a physician who is also an IBCLC or breastfeeding and lactation medicine specialist — such as Dr. Lavania at One Family Pediatrics.

6 Pumping Schedules

Q: What does an ideal 24-hour pumping schedule look like in the first 2 to 3 months for an exclusively pumping mother?

The goal is to mimic a baby's frequency: roughly 10 to 12 or more sessions per 24 hours in the early weeks, including at least one overnight session while prolactin is higher, each about 15 to 20 minutes or a couple of minutes past the last drops. Once breastmilk supply is established, pumping can be gradually decreased to 8 times in a 24-hour period — but do not go past 5 hours without emptying the breast.

Q: Is power pumping something you recommend for everyday use?

No. Power pumping is exhausting work and should only be done for a short period of time, ideally with the guidance of an IBCLC or breastfeeding and lactation medicine specialist. It is not an everyday technique.

7 Tongue and Lip Ties

Q: What functional limitations in feeding warrant a revision (frenulectomy) versus monitoring?

What matters most is how your baby is actually feeding — not how the tie looks on its own. Plenty of babies have a frenulum that looks tight but feed just fine. We pay attention to function over appearance. A release is worth seriously considering when: your baby's latch and milk transfer stay poor even after good help from a lactation consultant; your baby is not gaining weight well; you have ongoing nipple pain or damage that has not improved after latch work; or your baby's tongue movement is clearly restricted in a way that affects feeding. If your baby is feeding well, or if lactation support solves the problem, watching and waiting is a perfectly reasonable path. A quick honest word on lip ties: the evidence for routinely releasing an upper lip tie is weak and still debated, as are 'posterior' tongue-ties. If someone recommends a release, it is completely fair to ask how it will help your baby's feeding specifically — and to get a second opinion before moving forward.

Q: What does aftercare look like for a baby who has just had a tie released?

Immediately, feeding or skin-to-skin at the breast for comfort and to gauge any latch change is all that needs to be done. Beyond that, aggressive stretching can result in oral aversion. In rare cases, wound exercise and mild stretching may be warranted, but overall, the evidence does not support the need for routine aggressive aftercare.

8 Breastfeeding with Flat or Inverted Nipples

Reassurance first: many flat or inverted nipples become functional with an effective latch, since the baby draws in breast tissue rather than just nipple. This is not an automatic barrier to breastfeeding.

Q: What tools or techniques help a baby latch when nipples are flat or inverted?

Helpful options include hand expression or a brief pull with a pump (or the inverted-syringe technique) to draw the nipple out just before latching, manual stimulation or rolling, and nipple shields during feeds when latch is otherwise not happening. Because nipple shields can sometimes affect long-term breastfeeding success, it is best to use one with help from a lactation consultant.

Q: If using a nipple shield is necessary, how should it be used to protect milk transfer?

Choose the thinnest appropriate size and the right fit — ideally with IBCLC or breastfeeding and lactation medicine specialist guidance — and make sure the baby latches deeply onto the shield with areola in the mouth, not just the tip. Monitor the things that actually matter: weight gain and diaper output. If transfer is in question, pump after feeds to protect supply, and aim to wean off the shield over time rather than treat it as permanent.

9 Weaning Timing & Process

Q: What is the safest way to phase out feedings without risking engorgement, clogged ducts, or mastitis?

Gradual is the whole game. Drop one feed or pump session at a time — commonly every 3 to 5 days or so — letting supply down-regulate before removing the next. Keep the first-morning and bedtime feeds for last, since they tend to be the fullest and most emotionally anchored. If a breast gets uncomfortably full, express just to comfort rather than to full drainage, since full emptying signals more production.

"The drop in prolactin and oxytocin as production falls can plausibly affect mood, and some women describe sadness, irritability, or low mood during weaning — particularly when it is abrupt. More often than not, we see this with parents who are having to wean not by choice."

— Dr. Hiral Lavania, MD — One Family Pediatrics

A note on weaning depression — in Dr. Lavania's own words:

When weaning is not your choice, the hardest part is often not the physical symptoms. It is the feeling that your body let you down, or that you let your baby down. Many parents describe a real sense of grief and even failure: a low milk supply that would not budge despite doing everything right, a medication you needed to take, a return-to-work schedule that left no room to pump, a baby who self-weaned earlier than you hoped. Feeding is so wrapped up in how we picture caring for our children that when it ends before we are ready, it can feel like a loss of something much bigger than milk.

To be very clear: needing to wean is not a failure, and it is not a measure of your love or your effort. Milk supply, work demands, health conditions, and a baby's own temperament are largely outside your control, no matter how much you wanted things to go differently. Your worth as a parent was never stored in your breast milk.

If that sense of failure starts to harden into persistent sadness, anxiety, or thoughts that you are not a good parent, please treat that as a signal to reach out to One Family Pediatrics or your OB. Those feelings are common, they are treatable, and you should not have to carry them alone.

10 Breastfeeding During Illness

Q: Should a nursing mother continue breastfeeding if she gets sick — and how does it benefit the baby?

For routine seasonal viruses, influenza, and GI bugs, the guidance is to keep breastfeeding. The baby is usually exposed before mom is even symptomatic, and continued nursing delivers secretory IgA and other immune factors that offer passive protection, while hygiene — handwashing, and a mask for respiratory illness — reduces spread.

Q: What safe over-the-counter medications can a breastfeeding mother take without risking her milk supply?

Generally, acetaminophen and ibuprofen are considered compatible for pain and fever, and dextromethorphan and guaifenesin are generally regarded as acceptable for cough. The clinically important one: pseudoephedrine has been documented to reduce milk production, so it is the decongestant to specifically avoid. Among antihistamines, the non-sedating ones (loratadine, cetirizine) are often preferred over sedating first-generation agents.

"Most medications are safe, but you can always check by reaching out to us or using LactMed (the NIH/National Library of Medicine Drugs and Lactation Database) and the InfantRisk Center (Texas Tech). We have a handout available at onefamilypediatrics.com/handouts/"

— Dr. Hiral Lavania, MD — One Family Pediatrics

BONUS: BREASTFEEDING & MEDICATIONS — A QUICK REFERENCE

One of the most anxiety-producing breastfeeding questions involves medications. Here is a quick reference framework from Dr. Lavania:

Category	Examples	Generally Compatible?	Note
	Acetaminophen, Ibuprofen	Yes	First-line choices
	Dextromethorphan, Guaifenesin	Yes	Generally acceptable
Decongestants	Pseudoephedrine	CAUTION	Documented to reduce supply — avoid
Antihistamines	Loratadine, Cetirizine	Preferred	Non-sedating preferred over first-gen
	Diphenhydramine (Benadryl)	Use caution	Sedating — discuss with provider
Antibiotics	Most common types	Usually yes	Check specific drug with LactMed

Always verify individual medications with LactMed (nlm.nih.gov/lactmed) or the InfantRisk Center (infantrisk.com) before taking anything not listed here. Handout available at onefamilypediatrics.com/handouts/

SCHEDULE YOUR LACTATION CONSULTATION AT ONE FAMILY PEDIATRICS

Dr. Hiral Lavania is one of the few pediatricians in Forsyth and Gwinnett County who holds both board certification in pediatrics and credentials as an IBCLC and Breastfeeding and Lactation Medicine Specialist. She provides comprehensive lactation support for new mothers and their babies — addressing latch, supply, pumping, weaning, and everything in between.

Well visits · Sick visits · Newborn care · Lactation consultations · CPR classes · Immunizations · Sports physicals

onefamilypediatrics.com | Cumming, Georgia | Serving Alpharetta, Duluth, Johns Creek, Roswell, Suwanee & surrounding areas

ABOUT THE EXPERT

Dr. Hiral Lavania, MD is a board-certified pediatrician, International Board-Certified Lactation Consultant (IBCLC), and Breastfeeding and Lactation Medicine Specialist at One Family Pediatrics in Cumming, Georgia. She provides comprehensive pediatric care from newborn through adolescence, with specialized expertise in breastfeeding support, lactation medicine, and newborn care for families throughout Forsyth and Gwinnett County.

The answers in this guide reflect Dr. Lavania's clinical experience and professional judgment. They are intended for educational purposes and do not constitute individualized medical advice. Every mother and baby pair is unique — for guidance specific to your situation, schedule a consultation at One Family Pediatrics.

One Family Pediatrics | onefamilypediatrics.com | Cumming, Georgia | Serving Forsyth, Gwinnett, and surrounding North Atlanta communities