

How Breastfeeding Reduces the Risk of Obstructive Sleep Apnea

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The nutritional, immunological, and emotional benefits of breastfeeding have long been discussed. This paper will address yet another benefit of breastfeeding, that of reducing the risk of snoring and obstructive sleep apnea (OSA).

Obstructive sleep apnea is a serious medical condition involving the ability to breathe while sleeping. A simplified definition of OSA is the stoppage/blockage of airflow for at least 10 seconds in the presence of respiratory effort while sleeping. OSA is usually characterized by loud snoring, daytime sleepiness, and interrupted sleep with periods of not breathing, which usually end in a snort. Other symptoms of OSA in adults include high blood pressure, morning headaches, depression, temperamental behavior, intellectual deterioration, poor job performance, impotence in males, and short-term memory loss. Symptoms in children include snoring, headaches, hyperactivity, developmental delay, behavior problems, restless sleep, nightmares, bed wetting (1-2) and attention disorders.(3)

How is OSA related to breastfeeding? Breastfeeding is important to the proper development of the swallowing action of the tongue, proper alignment of the teeth, and the shaping of the hard palate.(4-5) Bottle-feeding, pacifier use, and infant habits such as excessive thumb-sucking, arm-sucking, etc., can cause tongue thrusts and malocclusions. Occlusion and a high palate impact the flow of air through the airway and thus may

contribute to OSA.

Based on the results of a 1973 survey,(6) the American Academy of Pediatric Dentistry noted that 89 percent of children between the ages of 12 and 17 had some form of occlusal disharmony, and that 16 percent of youth had such a severe, handicapping malocclusion that treatment was mandatory. These figures are staggering when compared to my skull research,(4) and that of others,(7-11) which shows that before the invention of the modern baby bottle about 200 years ago, people had minimal malocclusion or decay.

Labbok(12) has shown a direct relationship between length of breastfeeding and occlusion; the longer the infant was breastfed, the better was the occlusion. Other authors(13-20) have shown that bottle-feeding, pacifier use and other habits can cause problems with breastfeeding or can lead to malocclusion. Farsi(21) showed that the longer a child was breastfed, the lower the incidence of digit and pacifier sucking. Hultcrantz(22) found that 6.2 percent of the children studied snored every night by the age of 4, and another 18 percent snored when they were sick. Among the snorers, more children used pacifiers than among the non-snorers (60 percent vs. 35 percent).

An article published in 1997 by a sleep research team from Stanford describes a formula for predicting OSA.(23) It states that individuals with high palates, narrow dental arches, overjets (lower jaw retruded), and large necks who are overweight are at risk for OSA. The information is extremely significant when one realizes that evidence from skulls shows that before the invention of baby bottles and pacifiers, high palates, narrow dental arches, and overjets were rare.

A high palate can impact occlusion and breathing. It can also narrow the upper dental arch and cause a crossbite. Since the roof of the mouth is also the floor of the nose, any increase in the height of the palate decreases the volume size of the nasal chamber. This decreased size can then increase the

air resistance through the nose. High palates also lead to a narrowing of the posterior nasal aperture or choanae (skull opening at the back of the nose). A smaller opening means a narrower beginning of the soft tissue section of the airway. The narrower the beginning of the airway, the greater the risk of the airway collapsing. Skulls from eras where there was universal breastfeeding rarely have small posterior nasal apertures. Possibly, humans may not have had OSA at all before the invention of artificial nipples.

Anything placed in a child's mouth excessively other than the mother's breast can impact occlusion. The impact is affected by a number of factors, including intensity, duration, and frequency. While the soft breast adapts to the shape of the infant's mouth, anything firm requires the mouth to do the adapting.(24) In addition, during breastfeeding, the tongue moves in a peristaltic motion underneath the breast.(25-27) This motion is critical for the proper development of swallowing, alignment of the teeth, and the shaping of the hard palate. (Movement of the tongue is also a reason for clipping a tight lingual frenulum in a newborn. This will allow the tongue to compress the breast and to develop proper motion. By preventing this motion, a tight frenulum can lead to a tongue thrust with a resultant malocclusion.)

Many factors, including heredity, influence malocclusion. Because of modern medicine, babies who might have died in the past are now surviving, including those with recessive genes that might impact occlusion. Other contributing factors to malocclusion include: inter-cultural marriages, size differences in parents, tight frenulums, tongue size, tonsil size, pathology, allergies, central nervous dysfunction affecting facial muscles, and even diet.(7) These factors alone, however, cannot account for the 89 percent rate of malocclusion found in 1973. Infant habits appear to be a major contributing factor to malocclusion.

The health and economic consequences of OSA are staggering. The best

prevention is breastfeeding and keeping objects like pacifiers out of the mouth. Since craniofacial development is 90 percent complete by the age of 12,(28) it is important to intervene early.(29-35) The prevention of OSA is yet another reason that the public, health insurance companies, and health care professionals should recognize the importance of breastfeeding.

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