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EDITORIAL

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Updating SIDS risk reduction advice has the potential to further reduce infant deaths in Sweden

Sweden, for the past decade, has had an enviably low SIDS rate, presumably attributable to high infant supine sleeping rates and low parental smoking rates [for the latter, 5.1% of mothers and 10.8% of fathers in 2010 (1)]. However, in most high-income countries, while SIDS (ICD-10 R95) rates have declined, there has also been an increase in rates of other sudden and unexpected infant deaths, such as ill-defined deaths (ICD-10 R99) and deaths attributed to accidental suffocation and strangulation in bed (ASSB) (ICD-10 W75) (2). Indeed, according to the Swedish National Board of Health and Welfare, in 2013, although the rate of SIDS was 3.47 per 10 000 live births (LB), the rates of ill-defined and ASSB deaths were 5.73/10 000 LB and 0.17/10 000 LB, respectively (3). It is anticipated that the updated safe sleep advice from the National Board of Health and Welfare (4) will be important in the effort to eliminate these deaths as well.

All of the recommendations – supine sleeping, avoidance of smoking and nicotine, avoidance of head covering and overheating, a separate sleep space, promotion of breastfeeding and pacifier use – are based on existing evidence from case–control studies, and many other countries have adopted similar guidelines. Nonetheless, if experience in these other countries is any guide, there may be disagreement about some of these guidelines.

A separate sleep space for the infant in the parents' bedroom has been shown to reduce the risk of SIDS (2). There continues to be controversy about this recommendation, as some parents prefer to bedshare with their infant to promote bonding and facilitate breastfeeding. Sweden has some of the highest rates of bedsharing in Europe; as many as 65% of three-month-old infants bedshare (5). There is little disagreement that bedsharing increases the risk of infant death if one or both parents is a smoker, if the adult bedsharer has drunk alcohol or used arousal-altering medications or drugs, or if the infant and adult are sleeping on a sofa or couch. All experts agree that bedsharing should never be recommended under any of these circumstances. The controversy has centred on the young (<3 months of age) infant who is breastfed, on a bed with a sober, nonsmoking parent. The two most recent studies that specifically studied these issues reached different conclusions. One large European study demonstrated a fivefold risk of bedsharing for these low-risk infants (breastfed, on a bed with sober, nonsmoking parents), compared with infants who room shared but slept in their own crib or bassinet (6). The other smaller UK study, which had more complete data on parental alcohol and drug use than the European study, demonstrated a nonsignificant increased risk of bedsharing among infants under 98 days [unadjusted odds ratio 1.6 (95% CI 0.96–2.73)] (7). However, we must remember that it is not only SIDS that is of concern. Infants who sleep alongside adults in beds are at higher risk for accidental deaths as well. Analysis of a large U.S. database of >8000 infants who died suddenly and unexpectedly found that, among infants 0–3 months of age, the predominant risk factor was bedsharing (8). Given these data, it is prudent to place the infant in a separate sleep place for the first three months of life. We would suggest that this separate sleep place be in the same room as the parents, ideally within sight, sound and touch (i.e. immediately adjacent to the parents' bed). This will allow for easy access to the infant for monitoring, comforting and feeding. The bed is a safer place for feeding an infant than a sofa or cushioned chair if there is any risk of the parent falling asleep, which often occurs, especially at night, as sofa sharing poses a much higher risk than bedsharing (2).

There has also been disagreement about pacifier use as a SIDS risk reduction strategy. While the epidemiologic data are incontrovertible (with adjusted odds ratios ranging from 0.1 to 0.6 for pacifier use when placed for last sleep) (2), many are concerned that pacifier use will interfere with breastfeeding. This issue often is raised in the delivery hospital, as more hospitals become baby-friendly. One of the requirements for a hospital to be certified as baby-friendly is that pacifiers not be given to infants, so as not to interfere with breastfeeding initiation. However, pacifier use, if introduced once breastfeeding has been established, does not interfere with breastfeeding, and we would recommend that parents of breastfed infants wait 3–4 weeks before introducing a pacifier. For formula-fed infants, a pacifier can be introduced at any time.

Breastfeeding has also been shown to protect against SIDS (2). The protective effect is dose-dependent, that is exclusivity and longer duration of breastfeeding offer more protection than partial breastfeeding and shorter duration. In Sweden, in 2010, 96.5% of infants were receiving breast milk at one week of age, with 82.9% receiving breast milk exclusively. However, by 6 months of age, only 10.6% were breastfeeding exclusively, with another 51.9% being partially breastfed. By 1 year, 0.1% were exclusively breastfed and 16.1% partially breastfed (1). While the breastfeeding initiation rate is excellent, the 6-month exclusive breastfeeding and 12-month breastfeeding rates are much lower than the WHO global nutrition target of 50% exclusive breastfeeding at six months (9) or the U.S. Healthy People 2020 objectives of 25% exclusively breastfed at six months, and 34% breastfed at 12 months (10).

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With any new recommendations, there are potential barriers to changing practice. It will be important for healthcare providers to learn why parents choose to bedshare or choose not to breastfeed. Understanding the barriers is the first step in facilitating behaviour change. Additionally, experience from other countries suggests that adoption of new sleep safety recommendations is most successful when parents hear a unified message. It will be important for all healthcare providers, including physicians, nurses, community health workers and home visitors, to reinforce these practices, so that they can be effectively adopted. Finally, it is essential to identify families who are most resistant to adopting recommended practices and institute educational activities that target these groups in particular and address their beliefs and concerns.

Rachel Y. Moon (rmoon@cnmc.org)[1,2], Fern R. Hauck[3],
1.Division of General Pediatrics and Community Health, Children's National Medical Center, Washington, DC, USA
2.Department of Pediatrics, George Washington University School of Medicine and Health Sciences, Washington, DC, USA
3.Department of Family Medicine, University of Virginia School of Medicine, Charlottesville, VA, USA

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