

## PRACTICAL PARENTING

## Back to Sleep and Tummy Time

“Back to Sleep” and “Tummy Time” are two phrases with which most pediatricians are very, very familiar. However, while the concept seems simple – a baby should be supine when asleep, and prone when awake – in reality it is confusing for parents and providers alike.

A new parent recently told me, “I’m confused. Someone told me that it was important to let my baby play on his tummy, but when he was born the nurses told me that babies should always be on their backs.” To parents, “Back to Sleep” and “Tummy Time,” may seem like conflicting advice.

Expert recommendation for sleep position is very clear, based on the existing data: Infants should be placed in a wholly supine position for sleep (in other words, not even a little bit on the side) on a firm surface, without surrounding soft objects (Pediatrics 2005;116:1245-55). However, even this recommendation is not made universally by individual providers. In fact, although the number of deaths attributed to sudden infant death syndrome (SIDS) has decreased by more than 50% since the “Back to Sleep” recommendations were first made by the American Academy of Pediatrics in 1992 (Pediatrics 1992;89:1120-6), a recent survey of doctors who care for infants revealed that just fewer than 70% recommend exclusively supine sleep positioning (Clin. Pediatr. 2007;46:791-800). A majority of parents reports placing children in a supine sleep position, although there are racial and ethnic disparities (with black infants being much more likely to sleep in a prone position and having accordingly higher rates of death attributed to SIDS).

The evidence base regarding “Tummy Time” is still developing, although the evidence appears to be rela-

tively consistent in supporting this concept. A 2003 American Academy of Pediatrics policy statement recommends that infants spend time in the prone position when “awake and being observed” in order to prevent positional skull deformities (Pediatrics 2003;112:199-202).

Evidence also suggests that a supine sleep position can lead to delayed acquisition of early motor milestones, and that these effects may be mitigated by more time spent prone while awake. However, most of the studies looked only at infants aged 4-6 months. The few data that exist, along with anecdotal experience, suggest that these differences do not persist, and most authors emphasize the continued importance of the supine sleep position to decrease the risk of SIDS (Dev. Med. Child Neurol. 2005;47:370-6).

So, how to counsel our patients in a way that is clear and not seemingly contradictory? A qualitative study of black mothers’ attitudes about sleep positioning suggested that they were more likely to discount recommendations for safe sleep position when they felt that they had been given contradictory advice or had observed contradictory behavior (J. Pediatr. 2010;157:92-7). To me, this reinforces the idea that it is important to be consistent and clear in our messages about sleep position.

My approach is to discuss safe sleep position at every visit during the first year of life, always being clear that I recommend back sleeping. I start by asking, “Does your baby sleep on his back, side, stomach?” Then I respond to that answer, and clarify whether the baby always sleeps in that position or if the position changes depending on the circumstance. If babies are not always sleeping in a supine position, I try to assess the family’s questions and concerns, and respond to those in a

culturally sensitive way. Perception of risk is also important, so I often say, “SIDS is a rare thing, and it doesn’t happen to most babies, but you never want to be the person it happens to because once it does, there is no going back.” Sometimes I share that I have had patients in my practice who have died of SIDS.

When I discuss tummy time recommendations (usually not until the baby is at least 1-2 months of age), I tell parents that it is good for babies to spend time each day “practicing their push-ups.” I then reinforce that it is important for babies to always sleep on their backs, but while they are awake and being watched by an adult they should spend some time playing on their stomachs, even for very short periods. I let parents know that babies who are used to sleeping on their backs may not like being on their stomachs, and that’s completely okay. They should just play while their baby is enjoying it and then can move onto something else. I also discuss that it is important for babies not to spend extended periods of time in car seats, bouncy seats, or baby swings, and that a simple blanket on the floor is a great place for an infant to play.

I admit that in my opinion, reducing the risk of SIDS is the most important thing to focus on, so I always return to the “Back to Sleep” recommendations to ensure that parents understand the basic concept: back to sleep, tummy to play. ■



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## SUBSPECIALIST CONSULT

## Vision Screening, Examination, and Referral

Screen for vision concerns at every well-child visit. I recommend a consistent method of screening so you and your staff develop a skill set and yield consistent results. The screening method varies by the age and cooperation of the child, so it is useful to establish protocols for the pre-verbal child and for an older child who can actively participate in visual acuity testing.

The American Academy of Pediatrics has a wonderful publication with vision screening recommendations for pediatricians. The AAP’s policy statement on “Eye Examination and Vision Screening in Infants, Children, and Young Adults” contains consensus-driven information of high value to pediatricians (<http://tinyurl.com/3o6papp>).

Importantly, keep in mind that many children old enough to participate in vision testing often perform poorly on initial testing.

There is a large learning curve, and a child who performs poorly the first time will often do very well on the second test. So it’s a good idea to retest before refer-

ring a child to a specialist for poor vision.

If the child is cooperative, you can retest during the same visit and save the patient a return trip to your office. If the child fails visual acuity testing twice, that is when I would refer to an eye specialist.

Pediatricians are essentially looking for reduced vision, misalignment of the eye, and any anatomic abnormalities of the eye.

More specifically, you are screening for amblyopia, which can occur in up to 4% of the population; strabismus or eye misalignment; and anatomic concerns including ptosis, abnormal size of the eye, or a white pupil that suggests a cataract or a retinoblastoma.

A positive finding on almost every aspect of screening indicates need for referral of the patient to a specialist.

In contrast, acute abnormalities such as redness of the eye, minor injuries, and allergic conjunctivitis can be managed well in your office.

Keep in mind that failure to respond to initial treatment is an indication for referral. If you treat a child for red eye,

for example, and the eye does not improve quickly, referral is warranted. Importantly, it is not usually an indication to change their antibiotic drop or switch them to another treatment. Although most of the time a simple problem may be the culprit, a red eye also can signal a more serious condition.

Referral of any child who screens positive for an eye concern or fails to initially respond to treatment generally requires no additional evaluation in the primary care setting. Just send the child along with a note explaining your concern and outlining any special circumstances that might not emerge on routine history taking with the parents. We’ll take it from there.

In addition to the AAP guidelines, I recommend two mnemonics to assist primary care physicians during eye evaluation. A stretched version of MVP, the MVPe mnemonic can guide assessment and ensure that a quick examination is complete:

► **M** stands for motility. Are the eyes straight and do they move normally?

► **V** is vision assessment.

► **P** is pupil assessment. Are the pupils equal, round, and reactive? Do you see an

afferent defect (decreased pupillary response to light in the affected eye), or an abnormality such as a white pupil or pupillary asymmetry?

► **e** is external exam. Assess surrounding structures, including the eyelids and eyelashes, for any abnormality.

► **a** is for the anterior segment. Evaluate the cornea, the lens, and other structures.

These are the critical components of a pediatrician’s regular eye examination. These steps should take you a very short amount of time.

If you have a particular interest in eye disorders and some practice and skill at ocular examinations, you can consider adding three supplementary components to your assessment. I call these the ophthalmic version of CPR for the pediatrician:

► **C** is for confrontational visual field testing.

► **P** is for pressure.

► **R** is for retina. ■

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