Facts about SIDS, Suffocation, and Sleep-related Infant Deaths

Linda J. Smith, MPH, IBCLC
Oct 8, 2013

1. SIDS, Suffocation, and other sleep-related infant deaths are different entities.
   a. SIDS is a diagnosis of exclusion. SIDS is neither suffocation nor smothering.
      i. Triple Risk Theory: Vulnerable baby; outside stressor; critical period of development[1].
      ii. Incidence: More in males; most are between 1-6 months, peak between 2-4 months.[2, 3]
      iii. Documented risk factors:
         1. Prenatal smoking (5-fold risk); any smoking in the household increases risk 2-17 fold.[4, 5]
         2. Prone position on any flat surface (possibly a form of asphyxia)[6]
         3. Formula feeding (53% higher risk)[7]
   iv. SIDS is not related to sleep surfaces nor bedpartners. About 18% of cases occur in cribs, 18% alone on adult beds, and 16-20% in day care settings.[8]
   b. Smothering is not SIDS. Most sleep-related infant deaths are smothering, not SIDS.
      i. Highest risk: couches, sofas, recliners whether sleeping alone or with someone.[9] (see 2b)
      ii. High risk: Sharing any sleep surface with a drunk or drugged human [10]
      iii. High risk: Prone position on any surface (except on an awake human’s body) [11]
   c. SIDS and Sleep-related deaths are more prevalent when the baby is unattended – that is, out of visual and auditory distance of a responsible adult.[12]

2. There are significant methodological flaws in virtually all SIDS and SUDI research studies
   a. SIDS vs. Smothering: definitions are mixed and poorly defined in many studies. Quality of studies is inconsistent; there are no well-defined control groups in most studies.
   b. “Bed” is poorly defined and could be safe or unsafe surfaces including sofas or recliners. Ohio data collection does not differentiate “bed” from “sofa” or other unsafe surfaces.
   c. “bed partner” could be the mother or others, including non-parents. Breastfeeding mothers sleep differently with their babies than anyone else.[13-15] Ohio data collection is inconsistent in defining bedpartner(s).
   d. Alcohol use is often not reported, even though highly relevant. Ohio data collection does not routinely include drug or alcohol screening on the deceased infant or adults in the household.
   e. Feeding method is often not reported, even though highly relevant. Ohio data collection does not routinely collect current infant feeding method at a death scene.
   f. Smoking (prenatal or after) is often not reported, even though highly relevant. Ohio data collection is inconsistent regarding maternal prenatal smoking and current smoking in the house at a death scene.

3. “Co-sleeping” and “bedsharing” are different entities and poorly defined in research.
   a. “Co-sleeping” can mean anything; usually means the infant is in the same room as another human; “bedsharing” usually means the infant is on the same sleep surface as another human. In neither case is the safety of the sleep surface or bedpartner consistently defined, nor the portion of the day or night that either occurs and the relationship to the time/situation of the infant’s death.
   b. SIDS rates are declining at the same time bedsharing related to breastfeeding is increasing.[16] At least 2/3 of breastfeeding mothers bedshare at least part of the night. About 1/3 of formula-feeding mothers bedshare at least part of the night.[16]
   c. Warnings to “never bedshare” are often ignored entirely by the highest-risk groups. [17, 18]
   d. When mothers are warned to “never bedshare,” a high percentage will take their baby to the couch for naps and/or at night, thus increasing the risk. [19-21]

4. Formula-fed infants have significantly higher rates of SIDS and other causes of morbidity and mortality than partially-breastfed infants. Exclusively breastfed infants of nonsmoking parents have the lowest rates of SIDS and overall mortality. [7]

5. There are numerous federal initiatives currently underway to increase breastfeeding rates among black and other minority populations.[22] All “safe sleep” recommendations should be compatible with other health initiatives including but not limited to breastfeeding and maternity practice initiatives and campaigns.
References


© Linda J. Smith, MPH, IBCLC
Linda.Smith@wright.edu or lindaj@bfirc.com
937-438-9458