Breast-feeding problems

Breast-feeding is universally recognised as the first step in promoting the health and wellbeing of the child. However, women often stop breast-feeding in the early weeks after delivery when they encounter or perceive problems. This clinical review article in the BMJ provides useful advice on how to recognise and manage the common breast-feeding problems we are likely to encounter in primary care (BMJ 2014;348:g2954).

For all suggested medications please check the BNF and local guidelines prior to prescribing.

Mastitis

The term mastitis should be reserved for conditions that involve breast inflammation and systemic symptoms. There is typically a wedge-shaped area of the breast that becomes red, firm and tender. Milk or milk products get into the bloodstream causing systemic symptoms such as fever, rigors, lethargy, myalgia, depression, nausea and headache.

Mastitis may be caused by a bacterial infection or may be non-infectious. Infection is more likely in the early weeks post-partum or where there is obvious nipple damage.

When should you use antibiotics?

Research evidence on the use of antibiotics for mastitis is lacking. Current recommendations from WHO and expert opinion are:

- If acutely unwell or nipple damage, start antibiotics immediately.
- If not, consider the following for 24h (if these fail, after 24h, then consider antibiotics):
  - Increase breastfeeding frequency
  - Improve infant attachment
  - Position the infant with their chin pointed towards the affected area
  - Apply heat (shower, warm facelcloth, heat pack) before the feed
  - If the infant is not feeding well then express milk by hand or pump focusing on the affected area.

Staph. aureus is the commonest pathogen. Usual treatment is with flucloxacillin but consult local guidelines. Small amounts of flucloxacillin are present in breast milk but this is not known to be harmful to infants.

If symptoms do not resolve within 48h or the mastitis is particularly severe or unusual, WHO advise sending a clean-catch milk sample for culture.

If the affected area of the breast remains firm after feeds then a deep abscess may be present and the woman needs an ultrasound scan.

Nipple pain

Poor infant attachment is the commonest cause of nipple pain and damage. Health professionals can help mothers optimise attachment to the breast; the input of health visitors and community breast-feeding clinics are invaluable. NICE support treatment for infant tongue tie where this is present in the context of breast-feeding difficulties.

Nipple damage

- When the skin of the nipple is damaged, it is rapidly colonised with Staph. aureus.
- To aid healing, nipples should be washed daily and the application of purified lanolin may help.
- In severe or resistant cases, application of a topical antibiotic can be used, e.g. mupirocin ointment applied sparingly three times daily after breast-feeding for up to 10d. Systemic absorption of topical preparations is expected to be minimal so unlikely to cause adverse effects in breast-fed infants.

Herpes simplex

- Herpes simplex is a rare cause of painful, discrete sores around the areolar or nipple.
- In suspected cases, newborn infants should not be allowed to breast-feed and breast milk should be expressed and discarded (to maintain milk supply) until lesions have healed.

Dermatitis

- Skin conditions including eczema, dermatitis and psoriasis may affect the nipple and areolar. Eczema may be atopic or secondary to creams and devices such as breast pumps.
- Treatment involves application of a moderate potency topical steroid such as mometasone once daily after a feed (no need to wash off) for up to 10d. Any excess should be wiped from the nipple area before feeding.
- Don't forget about the possibility of Paget's disease in women with a unilateral nipple/areolar rash that does not respond quickly to topical steroids and refer appropriately.

Fungal infection

- Candidal infection of the nipple and breast presents as a persistent burning in the nipple with pain during and after feeds. Pain
may radiate into the breast, particularly after feeds.
- Infants may have signs of oral thrush (white lesions on buccal mucosa), but signs of thrush in infants are often not present.
- Management includes topical antifungals applied after feeding for the mother's nipples (miconazole gel or cream) and infant's mouth (miconazole gel or nystatin oral drops) with oral antifungal treatment (fluconazole) for the mother. The most commonly used dose of fluconazole is 400mg once followed by 200mg daily for at least 2w (It is unclear if this is based on consensus or evidence and seems slightly excessive to us!) (LactMed - the breastfeeding section of the US TOXNET database).

**Nipple vasospasm**
- Blood flow to the nipple is reduced leading to blanching or purple/blue colouration and pain.
- The condition tends to occur in thin women with poor circulation who may have a personal or family history of Raynaud's phenomenon.
- Primary vasospasm may present before breast-feeding.
- Secondary vasospasm is more common and usually develops after nipple pain, damage or infection.
- The first step in management is avoidance of cold temperatures, e.g. cover nipples immediately after feeds, apply heat and wear warm clothes.
- If conservative management fails then nifedipine, starting at 20mg slow release once daily, can be used.

**Low milk supply**

The most common reason women give for stopping breast-feeding is not producing enough milk. However, this is often the woman's perception rather than the supply actually being inadequate. Feeds may become shorter as breast-feeding is established but breast-fed babies may continue to feed up to 10 times a day. Monitoring infant weight gain is the best way to assess milk supply. An adequate milk supply requires regular removal of milk, normal hormone levels and enough mammary tissue. Causes of inadequate supply include:
- Hypoplastic breasts: in this condition, which affects a small number of women, there is a lack of glandular breast tissue. Breasts are usually widely spaced with apparently prominent areolas.
- Breast surgery that interferes with nipple sensation can compromise the local (autocrine) control of ongoing milk supply as the breast milk is removed.
- Breast reduction surgery.
- Retained placental fragments may reduce milk production due to persistently raised level of progesterone.
- Abnormal thyroid function.
- Large post-partum haemorrhage, possibly due to a transient lack of blood supply to pituitary gland affecting early post-partum prolactin production.

To increase milk supply better breast drainage is required:
- Ensure effective infant attachment.
- Offer both breasts at each feed or switch feeding (switch sides frequently for sleepy babies).
- Express milk after feeds.
- If the above measures fail, a galactogogue, such as domperidone 10 or 20mg three times a day, can be considered but the evidence is not strong and further research is needed. Do also note that since this paper was written the MHRA have issued a warning about domperidone.

**Domperidone (MHRA Drug Safety Update May 2014)**
- Concerns have been expressed about the risk of cardiac arrhythmias (QTc prolongation, torsades de pointes and ventricular tachycardia) with domperidone. This has been found to be particularly the case at high doses (>30mg daily) and use for prolonged durations. The MHRA have made no specific recommendations about domperidone in respect of use to increase breast milk supply. Remember, domperidone is contraindicated in individuals where cardiac conduction is or could be impaired or in those with heart failure or those taking other QTc prolonging drugs/potent CYP3A4 inhibitors, e.g. fluconazole, itraconazole (your computer prescribing system should warn of these interactions).
- Given the limited evidence, perhaps the role for domperidone to promote breast milk supply is limited.
**Breast-feeding problems**

- Breast-feeding problems, including mastitis, nipple pain or poor milk supply, may result in cessation of breast-feeding.
- Mastitis may be infectious or non-infectious. Antibiotic prescribing can be delayed for 24h unless the women is acutely unwell or has signs of nipple damage.
- Nipple dermatitis can be managed with mometasone once a day for 10d.
- Fungal infection of the nipple or breast can be managed with topical antifungals for the infant’s mouth and mother’s breast along with oral fluconazole for the mother.
- Nipple vasospasm may mimic the pain felt in fungal infections of the breast and nipple, consider this diagnosis in women with a personal or family history of Raynaud’s phenomenon.
- The adequacy of milk supply is best assessed by infant weight gain. In cases of poor milk supply, try measures to improve breast drainage.

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Do you know what breast-feeding support services are available in your area? Could you make a list for your own use and share it with your colleagues? (Don't start from scratch - talk to the health visitors!!)

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**For professionals:**

The academy of breast feeding medicine clinical protocols including mastitis and galactogogues: [www.bfmed.org](http://www.bfmed.org)

LactMed: This is a subsection of the US TOXNET database which provides a free searchable drug database with information about the safety of use in breast-feeding mothers: [http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm](http://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm)

**For patients:**

A resource for mothers from The Breast Feeding Network UK. Links to illustrations of good attachment: [www.breastfeedingnetwork.org.uk](http://www.breastfeedingnetwork.org.uk)

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*We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save in so far as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.*

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*March 2016*
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Birmingham Sat 19 Mar
Bristol Wed 11 May
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London Fri 13 May
London Sat 14 May
Newcastle Wed 18 May
Sheffield Thur 19 May
Manchester Fri 20 May
Birmingham Sat 21 May
Norwich Tue 24 May
Chelmsford Wed 25 May
London Thur 26 May
Belfast Wed 8 June
Oxford Fri 30 Sep
Southampton Sat 1 Oct
Cardiff Wed 5 Oct
Exeter Thur 6 Oct
London Fri 7 Oct
London Sat 8 Oct
Leeds Wed 12 Oct
Liverpool Thur 13 Oct
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Birmingham Sat 15 Oct
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London Wed 19 Oct
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Newcastle Fri 24 Jun
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London Fri 1 Jul
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Leeds Thur 10 Nov
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2015 has seen the biggest shake up in cancer in the last 10 years with the publication of the updated NICE guidelines on suspected cancer. If, like many of us in England & Wales, you are still finding your way around them, then this course will definitely help!

London Thur 17 Mar
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Leeds Thur 16 June
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Bristol Thur 23 June
London Fri 24 June
Manchester Thur 10 Nov
Birmingham Fri 11 Nov
Cambridge Thur 17 Nov
London Fri 18 Nov
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The Effective Consultation Course
The Course focuses on behaviours which enhance effective use of time in the consultation. Efficient consultations reduce clinical risk and lower the risk of complaints and lawsuits. The course uses the rich evidence base on which consultation behaviours enhance effectiveness and how to go about learning them. We focus on actions and you will leave with many practical tips to use in your consulting room the following day.

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- The Telephone Consultation Course (location).............................   (date).........................
- The Effective Consultation Course (location).............................   (date).........................
- The Medically Unexplained Symptoms Course (location).............................   (date).........................

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- Women’s Health Update Handbook £70
- Cancer Update Handbook £70

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