Overcoming challenges faced by breastfeeding mothers

Lisa H Amir, Anita Bearzatto

Background

Women who are breastfeeding often consult their general practitioner (GP) with concerns about nipple and breast pain, or the adequacy of their milk supply. Common concerns for their breastfed infant include slow weight gain, ‘fussiness’ with breastfeeding and ‘funny stools’.

Objectives

This article offers suggestions for clinicians to support breastfeeding women and their infants.

Discussion

Good attachment to the breast is important to reduce nipple pain and trauma, and to ensure adequate breast drainage and ongoing milk supply. Other causes of nipple pain include vasospasm, dermatitis and infection. Breast pain may be due to blocked ducts, mastitis or abscess. Very early mastitis may be treated by improved emptying. Slow weight gain in a breastfed infant may indicate a medical problem or low supply of breast milk. Some infants have breastfeeding challenges because they are small or premature, or from anatomical issues affecting feeding. In such cases, further help from a lactation consultant may be beneficial.

The postpartum period is a time when new mothers and their infants attend general practices frequently. Breastfeeding rates are high in the early weeks, yet many women seek help while they are learning this new skill. General practitioners (GPs) can provide support to families while they manage the common concerns and diseases related to breastfeeding and the young infant.

Maternal factors

Nipple pain from breast attachment

Many new mothers experience sore or damaged nipples in the early days and weeks of breastfeeding. The best way to minimise pain and damage is to help mothers learn how to attach the infant to the breast. There is no one correct way to do this, and many mothers complain of feeling confused by the wide range of advice given by health professionals. Every baby–mother dyad is unique; no two mouth and nipple shape pairings are the same, even between twins. The general principles are that the infant should be close to the mother’s body and take a wide mouthful of breast.

Here is one useful method:

- The mother should be sitting comfortably, preferably in a chair where she can lean backwards. She should be encouraged to wriggle forward in the chair, and then lean back, adopting a semi-reclining, ‘deck chair’ position. Her feet should be on the ground, back supported and shoulders relaxed down (Figure 1). This is the opposite of the commonly seen posture of a woman leaning hunched over the infant with one hand holding the infant’s head or neck and the other holding her breast.
- The infant should be lying across the mother’s body, with the nose lined up with the mother’s nipple.
- Bring the infant’s chin towards the breast and wait for their mouth to open wide.
- The infant’s head should be tilted slightly back in a ‘drinking position’ as they are brought to the breast (Figure 2).
- The mother supports the infant across the back with her arm, not gripping the head or neck.
provide some relief, although it is not clear if they aid wound healing on the nipple.

Nipple infection
When the nipple is damaged and purulent exudate is visible, a bacterial infection is likely. Swabbing is not usually necessary. Mupirocin ointment is effective against Staphylococcus aureus and can be applied three times a day after feeds.\(^5\)

When nipple pain is persistent and occurs constantly, not just on attachment, Candida infection may be considered. The areola usually appears pink and may be associated with radiating breast pain. Characteristically, nipple thrush occurs after a course of antibiotics in women who are prone to vaginal thrush. Treatment regimens are varied.\(^6\) Burning pain is non-specific and the differential diagnoses include nipple trauma and vasospasm.

Rarely, a Herpes simplex infection presents as an isolated, extremely painful vesicular eruption that develops into sores on the nipple and areola.\(^7\) This can be confirmed by Herpes polymerase chain reaction (PCR). The infant should not breastfeed or drink expressed milk from the affected side until the sores have healed.

Nipple vasospasm
Another cause of radiating nipple and breast pain is vasospasm (or Raynaud’s phenomenon of the nipple). Women typically experience pain when the temperature drops, and may notice that the nipple tip becomes white or sometimes purple in the cold. Most women with nipple vasospasm can manage by keeping their nipples warm, wearing heat packs or insulated breast pads and taking a magnesium supplement (up to 600 g).\(^8,9\)

A minority of women who have significant vasospasm pain may require medication to relieve the pain. If required, nifedipine can be used, starting with a low dose (20 mg slow release daily) and monitoring closely for adverse effects.\(^10\)

Nipple eczema/dermatitis
Nipple atopic eczema or contact dermatitis usually occurs in mothers feeding slightly older infants, often around six months of age. Women describe a red, itchy rash that tends to spread, but with a definite edge. It is safe and effective to prescribe a strong steroid, such as mometasone ointment daily, with instructions to apply thinly after the infant has had a feed, for up to 10 days.\(^11\) If a rash is crusty or weepy, a secondary bacterial infection is likely and should be treated as well. If the rash does not respond, the rare breast cancer, Paget’s disease, should be considered.\(^11,12\)

Persistent pain
Persistent pain with breastfeeding can be complex and multifactorial. Clinicians should consider management of mechanical influences, such as poor latching or ongoing
pump use and central nervous system modulation mediated by cognitive and social states, and predisposing factors, as described in the Breastfeeding pain reasoning model.\

**Blocked ducts**

Some women develop recurrent blocked ducts – lumps occurring within the breast, but without fever or the systemic symptoms of mastitis. These are usually caused by poor drainage of milk and it is worthwhile spending time to address the possible causes (eg tight clothing, pressure from a hand or a seat belt, sleeping on the stomach). Blocked ducts may occur after longer than usual breaks between breastfeeding, or expression or excessive arm exercise. Sometimes a blockage on the nipple tip (visible as a white spot) is responsible for the obstruction. The blister can be lifted with a needle tip or, if persistent, a daily dab of steroid ointment (eg mometasone) covered with plastic wrap to increase absorption could be tried.\

**Mastitis**

In mastitis, a segment of the breast is red, swollen and tender, and there is concurrent fever, myalgia, shaking, headache and nausea. If recognised very early, mastitis can be managed by increasing milk drainage from the breast (eg increasing feeds and/or expressing), applying heat before a feed and cold packs after a feed. Very gentle massage of the affected area during feeding may help. Analgesia, such as an oral nonsteroidal anti-inflammatory drugs (NSAIDs), is recommended.

If symptoms persist for longer than 24 hours, if the woman is unwell, or if the nipple is obviously damaged and a portal for bacteria, an anti-staphylococcal antibiotic such as flucloxacillin or cephalaxin (500 mg qid) should be commenced. If the woman does not respond within 48 hours, consider admitting the patient to hospital for intravenous antibiotics, and sending a sample of the milk for culture to rule out a methicillin-resistant Staphylococcus aureus. Probiotics – strains of Lactobacilli isolated from human milk – may be a new strategy to treat and prevent mastitis, but clinical evidence is currently lacking.

A breast abscess may occur about one week after the initial infection, causing localised symptoms, and can be confirmed by diagnostic ultrasonography. The acute systemic symptoms may have resolved. The abscess can be drained under ultrasound visualisation with co-administration of an anti-staphylococcal antibiotic. Women can continue to breastfeed, but require support as this is often a distressing experience.\

**Low supply of breast milk**

A common concern of mothers who are breastfeeding is low supply of breast milk. For some mothers, this may represent a perceived rather than real issue of low supply. Providing information on what constitutes ‘normal’ newborn feeding behaviour may provide reassurance. For example, it is normal for infants to ‘cluster feed’ during a particular part of the day. A change to an infant’s feeding pattern, such as increased frequency of feeds, or a feeling of softer breasts, may concern the mother; however, these may be normal changes that are unrelated to a lowered supply.

It is normal for the mother to produce a small volume of colostrum in the days after the birth. At around day three postpartum, the process of ‘the milk coming in’ (secretory activation) occurs and milk is produced in larger volumes. From this point, breast milk production is predominantly under autocrine control. This means that as more milk is extracted through breastfeeding or expressing, more milk will be made. Thus, newborn babies should be kept close to the mother and offered frequent breastfeeds (eight or more feeds per 24 hours). Practices such as introducing spacing of feeds, pacifiers, formula feeds and nipple shields can potentially interfere with this physiological process of milk production.

Low supply of breast milk may be caused by postpartum haemorrhage, retained placenta, maternal illness, under-developed breasts (insufficient glandular tissue) or past breast surgery. Sleepiness or illness in an infant, or poor latch, may also contribute to a lowered maternal milk supply. In addition to increasing the frequency of feeds, the mother may consider expressing her milk or commencing a galactagogue such as domperidone (10 mg tds).

**Medications for breastfeeding women**

Most breastfeeding women need to take medications, either short term or longer term for chronic conditions. It is important to understand that the breastfed infant receives a much smaller amount of maternal medications than the fetus is exposed to during pregnancy. Clinicians should not rely on the product information as their only source for safety recommendations during lactation (see Table 1 for reliable sources).
Infant factors

Slow weight gain in the breastfed infant

Slow weight gain in an infant may be the first sign of low breast milk supply in the mother. Some infants may have reduced urine output and reduced bowel motions, or are unsettled.

If slow weight gain is thought to be due to the infant’s inadequate intake, the aim is to give the infant more calories while trying to build up the mother’s breast milk supply by increasing the frequency of feeds. If slow weight gain persists, the mother may need to give complementary feeds via a bottle, syringe, cup or supplemental feeding line. Expressed breast milk, formula or donor milk can be used.

‘Fussy’ breastfeeding infants

Breastfeeding can become challenging for the mother when infants become ‘fussy’ at the breast. In some cases, infants may even refuse to breastfeed. Common causes of fussiness with feeding include latching issues, low supply or oversupply of breast milk, or infant discomfort. Causes of discomfort include gastrointestinal (e.g., gastroesophageal reflux disease [GERD]) or musculoskeletal (e.g., torticollis) issues. Management of these problems includes addressing possible maternal and infant factors and referral to a lactation consultant.

Infants with feeding challenges

Breastfeeding may be more challenging for infants born prematurely and for low birth weight infants. Late-preterm (34–36 weeks gestation) infants may appear mature, but are often poor feeders. Challenges with feeding also occur in infants with abnormalities of their oral anatomy, such as cleft lip/palate, laryngomalacia or tongue tie, or experiencing trauma from delivery (e.g., cephalhaematoma). Referral to a lactation consultant is recommended for these infants.

‘Funny stools’ in the breastfed infant

Parents often become concerned with changes to their infant’s stools. In many cases, informing parents on what constitutes ‘normal stooling’ can provide reassurance. In the first six to eight weeks, a fully breastfed infant should pass two or more soft motions per day. In some cases, fewer motions may indicate inadequate milk intake. From eight weeks, the stooling patterns can be highly variable, ranging from a motion after every feed to one every 10 days. Stools of a breastfed infant can vary in colour and consistency. Commonly, they have an offensive smell and appear loose like seedy mustard or pumpkin soup. If an infant is happy and gaining weight appropriately, further investigation is not required.

Frequent, loose, green or frothy stools may be caused by lactose overload. These infants typically feed well, gain a lot of weight and their mothers often have an oversupply. Symptoms may improve if the infant is fed predominantly from one breast per feed because emptying the first breast more fully reduces the risk of the infant receiving too much foremilk (higher volume, lower fat milk).

Infants with a viral illness of the gut or upper respiratory tract may pass green, mucousy stools. Persistent green stools in an infant may also be a result of the breastfeeding mother consuming a lot of green vegetables, green food dye, medications or supplements. Infants starting solids will often have significant changes to the colour and consistency of their stools.

Implications for general practice

New mothers have many concerns about infant feeding and newborn behaviour. GPs need to provide support and appropriate advice, including referral to lactation consultants where indicated. Clinical practice guidelines are available to guide doctors caring for breastfeeding women, and good information is available online for families (Table 2).

Table 2. Other resources about breastfeeding

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<tr>
<th>For health professionals</th>
<th>For parents</th>
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<tr>
<td>Breastfeeding clinical practice guidelines (Royal Women’s Hospital)</td>
<td>Australian Breastfeeding Association (includes useful table about expressing and storing breast milk) (Royal Women’s Hospital)</td>
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<tr>
<td>Academy of Breastfeeding Medicine protocols (25 guidelines for the care of breastfeeding mothers and infants)</td>
<td>Breastfeeding fact sheets (Royal Women’s Hospital)</td>
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<td><a href="http://www.bfmed.org/Resources/Protocols.aspx">www.bfmed.org/Resources/Protocols.aspx</a></td>
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**References**


**Correspondence** afp@racgp.org.au