Breast or Chest Surgery or Injury and Lactation

How does a history of breast or chest surgery affect lactation?

- Minor surgeries such as a lumpectomy or breast implants are not expected to impact milk production.
- Breast or chest surgery or injury to the breast or chest earlier in life, before puberty, can sometimes impact the development of milk-making tissue.
- Most people who have a breast reduction are expected to have low milk production in the affected breast(s). The type of breast reduction surgery can impact the degree to which it impacts lactation. However, regardless of technique, it is best to assume that milk production may be low, so breastfeeding infants should be followed very closely to monitor their growth. All individuals who are breastfeeding after breast reduction should be cared for by breastfeeding-knowledgeable health professionals, lactation specialists, or Breastfeeding and Lactation Medicine physicians.
- Individuals who have undergone gender-affirming top surgery may or may not have remaining glandular tissue that will produce milk after birth, as this depends on the degree of breast tissue removal. Those who want to directly feed the baby after top surgery often refer to this as chest feeding, and it can be helpful to have a prenatal consultation to discuss options for chest feeding. While chest feeding is possible after top surgery, milk production is likely to be very low.
- Breast implants (augmentation surgery) typically do not impact milk production. However, if breast implants were done because the breasts were unusual looking, extremely small, or different sizes there may be “low glandular tissue.” This means that the underlying breast tissue may not have developed normally and may not produce adequate amounts of milk for an infant. It is reasonable to meet with a breastfeeding medicine physician during pregnancy to discuss risk of low production.
    - The most common surgery for breast implant placement is the “inframammary” procedure, in which an implant is inserted in the fold where the breast meets the chest wall, under the muscle. This method is not expected to impact milk production, as neither the glandular tissue nor nerves are affected.
    - The material used in implants is considered inert and will not enter the milk. Therefore, implants are not contraindicated when breastfeeding.
- Mastitis, plugged ducts, or low milk production are not expected to be complications of smaller breast biopsies or lumpectomies.

How can I increase milk production following breast reduction or top surgery?

Let your baby’s doctor, obstetrician or midwife know that you had previous breast or chest surgery or chest trauma. We recommend a prenatal visit with a breastfeeding medicine specialist or lactation consultant.

- Feeding the baby directly at the breast or chest for every feeding is often more effective at increasing milk production than relying on a breast pump, unless the infant is premature, weak, or sleepy.

- If you are pumping instead of breastfeeding, use a high-quality double-electric pump. There are many high-quality personal pumps readily available. You do not need to use a "hospital-grade pump" as they are not shown to be more effective that good quality personal double electric pumps. Visit this video for flange sizing (https://www.youtube.com/watch?v=TpAnNNpRwx8).
- After your baby is born, hand-express colostrum after each feeding in the first few days and offer this back to you baby. Nurse your baby often, at least every 2-3 hours day and night for the first week to establish milk production. If your baby is not gaining weight during the first week, and you are instructed to supplement your baby after nursing, please see a lactation consultant or breastfeeding medicine specialist as soon as possible for guidance.
- Your infant's weight needs to be followed closely with regular weight checks until the infant is gaining well, for the first 2 months postpartum. Ask your infant's primary care office for weight checks. These may need to be done more frequently than they would routinely be scheduled. In addition, public health nurses, parent-infant support groups, and stores specializing in lactation supplies have scales to weigh babies. Some have even used a scale at a grocery store, postal office, or other type of mail/shipping store when other options for weighing a baby are difficult to access. A good rule of thumb is that by day 4 or 5 of life, a newborn infant should be gaining 30 grams, or 1 ounce, a day for the first 3.5-4 months of life, after which point weight gain slows. The best way to determine if the amount of weight gain is appropriate is by having the physician review the infant's growth chart.
- If your production is low and you must supplement with donor milk or formula, you can do this at the breast or chest with a feeding tube or with a commercial product such as the Supplemental Nursing System (SNS) or Lact-Aid. Long-term supplementation at the breast can help some babies maintain interest in directly feeding. It can also provide effective stimulation for your milk production. A lactation specialist can help teach you how to use this.
- See a breastfeeding medicine specialist in your region (https://lacted.org/providers-world-lactation-map/) for medical evaluation of low production. Breastfeeding medicine specialists can prescribe medications to increase milk production.
- Supplementation with donor human milk rather than formula is a safe option in some communities. Please contact your local lactation specialist to learn more about resources for safe donor human milk in your region. If you choose to participate in informal human milk sharing, you should never pay for the actual milk, as this increases risks related to this practice.