The Outpatient Breastfeeding Champion Program Session 4

IABLE

Institute for the Advancement of Breastfeeding & Lactation Education

1

1

- The Instructor has no conflicts of interest to disclose
- Continuing medical education credits (CMEs) and continuing education recognition points (CERPs) for IBCLE are awarded commensurate with participation and complete/submission of the evaluation form
- CMEs can be used for nursing credits

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Building Breastfeeding-Knowledgeable Medical Systems & Communities

2

Session 4 OBC

- Sore Nipples- The Most Common Causes
- Managing Nipple Sores
- Breast Swelling and Engorgement
- Infant Biting
- Infectious Causes of Breast/Nipple Pain
- Non-Infectious Causes of Breast/Nipple Pain

3

3

Objectives for Session 4

- Describe at least 4 common causes of nipple and breast pain during lactation.
- Identify 3 main pieces of advice to give individuals who call with cracked sore nipples.
- Manage initial recommendations for sore nipples over the phone.

4

4

Objectives for Session 4

- Describe
  - 3 instructions typically given to the lactating parent with acute mastitis.
  - How to advise the lactating parent who might have shingles or herpes on a breast.
  - Typical advice given to an individual with clogged ducts.
  - How to identify and advise care of vasospasm.
  - Initial advice in the care of nipple dermatitis.

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Mom calls you on day 4 pp because her baby, who was nursing fine, now won't latch. Her breasts feel very heavy, and the infant is crying. Your initial recommendations are:

A. The baby might be sick and should be seen ASAP
B. Her breasts are probably engorged, and the baby cannot grasp the breast. Express some milk so the breast is more compressible.
C. She should bottle feed the baby because the baby clearly does not want to nurse anymore.

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A parent calls concerned that their term 10-day old baby is nursing too often, every 2 hours, and that his partner does not have enough milk. He reports 3 stools & 6 wet diapers/day. When seen on day 3, the baby's weight was up 1 oz (30g) from day 2. **You advise:**

A. Everything sounds fine, keep the 2-week exam appt. The feeding frequency sounds normal.
B. Ask family to come in for a visit and weight check.
C. Advise the lactating parent to switch to pumping and bottle feeding so they can measure the amount of milk she has.

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This same baby comes in for a weight check. You advise:

Birth Weight	8 lb 0 oz (3628g)
Day 2	7 lb 9 oz (3430g)
Day 3	7 lb 10 oz (3460g)
Day 10	7 lb 12 oz (3520g)

A. Things are fine, your baby gained another 2 oz and has another 4 days to get to birth weight.
B. The baby is gaining slowly, lets try to figure out why this is.
C. The parent's milk production is low, and formula should be given after breastfeeding.
D. B&C

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Mom calls and states that her 3-week-old baby is nursing too often. He wants to nurse every 45 minutes most of the day and never seems satisfied. Her breasts feel larger, and they leak. You advise:

A. Your milk production is probably low. Give a supplement of formula after nursing.
B. Your baby is falling asleep at the breast, try to keep the baby awake while feeding. No need to worry.
C. Please come in for a visit, to check the infant's weight and observe feeding.

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Dad mentions at the 2 week visit that his baby is nursing every hour overnight, and sleeps in the day. He wonders what to do. You advise:

A. He should get up, give the baby a bottle, and let mom get some rest.
B. Don't let the baby sleep away the day. Try to feed the baby often in the day and try to keep the baby up in the evening.
C. It is normal, mom should nap in the day with the baby so that she has the energy to be up with the baby at night.

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A lactating parent calls, reporting that their 3-week-old is fussy and has not stooled for 2 days. They believe their milk production is low because the baby wants to constantly breastfeed. The other parent wants to give a bottle to the baby. You advise:

A. Although this might be a growth spurt, the baby should come in for a weight check.
B. Because the baby is 3 weeks old, she is in a growth spurt. It will improve in a few days.
C. The baby is probably having a reaction to something in the parent's diet, so the parent should just pump and give the baby formula for now.

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Dad calls because he wants to give their 1-week-old a pacifier. All the baby wants to do is suck at the breast, and he is sick of it. You advise:

A. Let me talk to mom.
B. Let's see the baby in the office. It would be great if both parents could come.
C. It is fine to give a pacifier if the baby is nursing at least every 3 hours.
D. A & B

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At her term baby's 4-week visit, mom wonders if she still needs to wake the baby up every 3 hours at night to nurse. The baby's weight is great. You advise:

A. Limiting the night-time break to 5 hours in the first few months postpartum will help to maintain milk production.
B. Given the baby's young age, it is reasonable to wake the baby up after a 5-hour break for feeding.
C. It is fine to let the baby sleep as long as they want. No need to get up to pump.
D. You need to feed the baby every 3 hours at night for at least a few months.
E. A & B

13

13

Finding Additional Lactation Help in Your Community

- The Triage Tools default to referral to lactation consultants/physicians/providers
- Not all communities or individuals have access to these levels of care
- Please share other resources you are aware of in your community, such as doulas, local breastfeeding support groups, or a breastfeeding coalition.

14

14

Breast Pain and Nipple Soreness

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Myths re Sore Nipples

- Having to 'toughen up'
- The baby having a strong suck
- Nursing the baby too much or too long

16

16

Nipple Pain Starts Early

- Up to 96% of lactating individuals have nipple pain at some point
  - 43% with sore nipples at hospital D/C
  - 73-76% with sore nipples at 3 days pp
  - 19-26% having cracks

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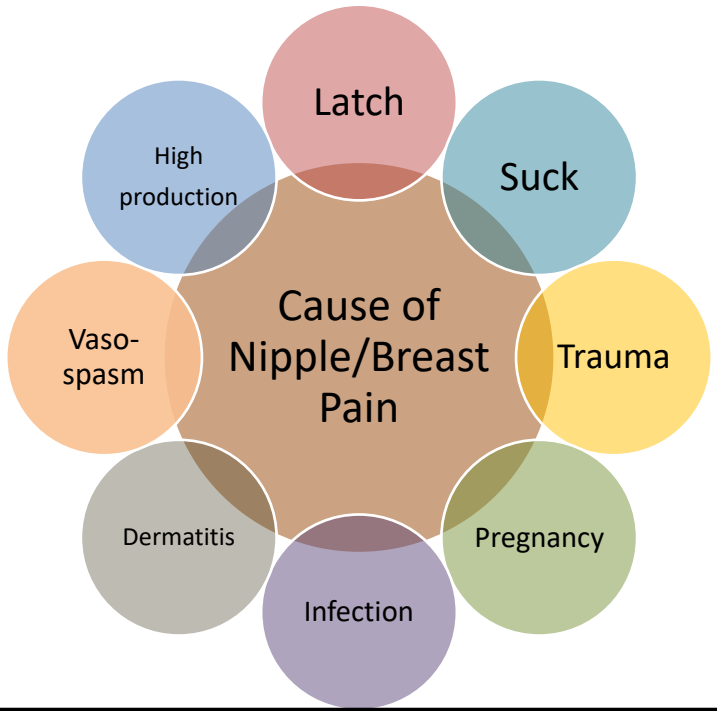

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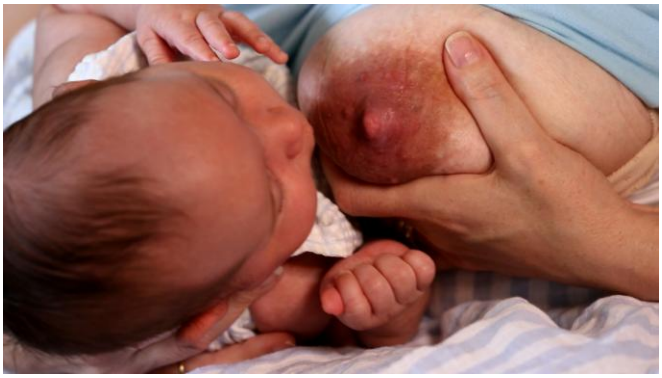

Engorgement

- Days 3-5 postpartum
- Major reason for sore nipples
  - Leads to a shallow latch

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Review of Engorgement Treatment

What are means of treating engorgement?

What is the best way to prevent engorgement?

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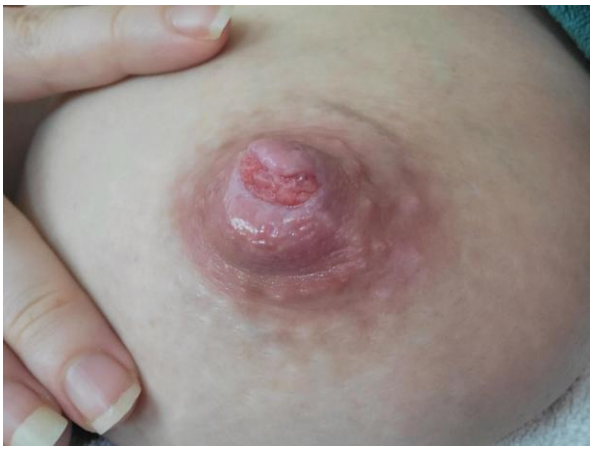
What is the most likely reason for nipple wounds like this on day 4 postpartum?

What can we recommend to help heal her nipple wound?



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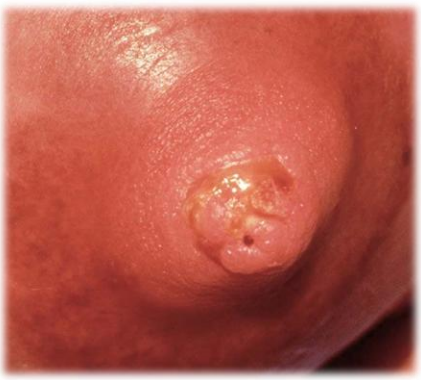
Nipple Wound Treatment

- Moist wound healing
  - Treat open nipple wounds like burns or skin abrasions
  - Keep covered with moist substance and nonstick cover
    - Prevents sticking to bra/breast pad. Sticking re-injures the nipples when nipples are uncovered
    - Prevents scabbing
    - Healing is faster
    - Alleviates nipple pain between feeds



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Options for Moist Wound Healing

- Moist barrier
  - Coconut oil or olive oil
  - Lanolin- but increases risk of rash
  - Nipple balm
  - Medicinal honey
  - APNO should NOT be used
    - No role for steroids/ antifungal/antibacterial ointments for wounds
- Nonstick cover
  - Nonstick pads
  - Hydrogels
  - Parchment paper

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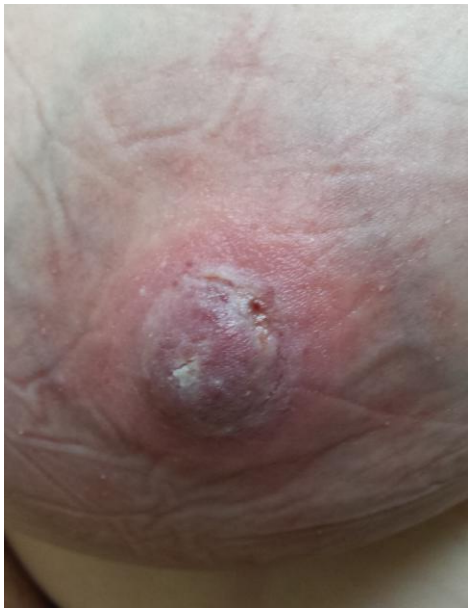
Triage Tool Sore Nipples Group 2



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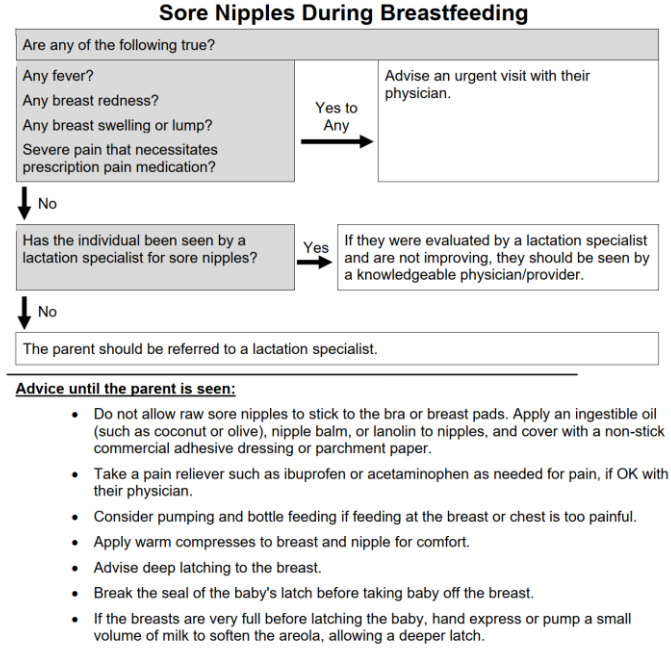
- This is your second baby
- Your baby is 3 weeks old
- You had cracks of your nipples in the hospital, then the pain seemed to improve, and now the nipples hurt again. The cracks are not healed yet.
- It hurts to latch the baby on.
- You don't know if you can keep nursing the baby with this degree of pain.
- You don't have a fever, redness or swelling



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Discussion Sore Nipple Case

- What are some pieces of advice that can help this parent right away, to decrease their pain?
- What are things that you can do as a breastfeeding champion to help this mom, if she comes in to see you in person?

26

26

Underlying Problem	Management Strategy
Infant movement limitations due to torticollis, fractured clavicle, etc	Work on positioning, and refer for more help for underlying problems
Prematurity/Low tone/sleepiness	Limit time at breast, pump to maintain production, supplement
Broad flat nipples	Roll out nipples before latch, soften areola
Overactive letdown	Change positioning, reduce milk production
Infant disinterest due to low flow	Supplement with a feeding tube at the breast/chest
Oral defensiveness	Bottle/finger feeding, speech eval
Tight lingual frenulum	Clip the tongue tie
Oromotor dysfunction	Speech eval
Latch refusal	Infant-led latch

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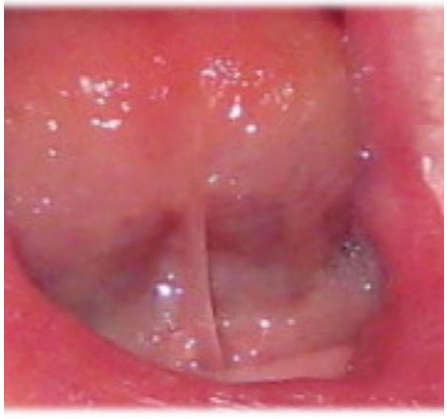

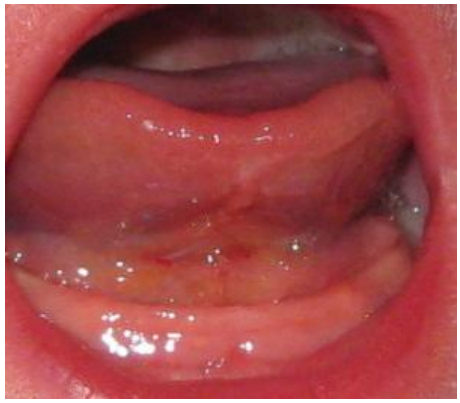

Before clipping

After clipping

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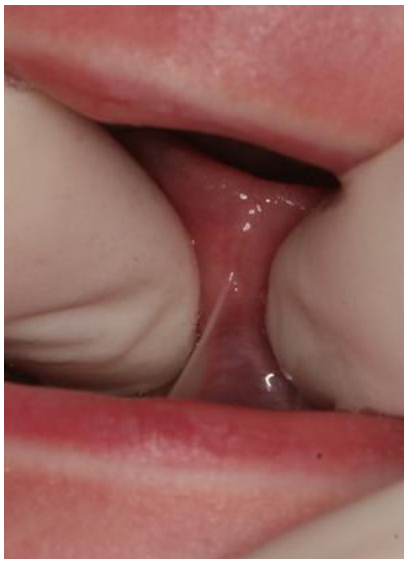
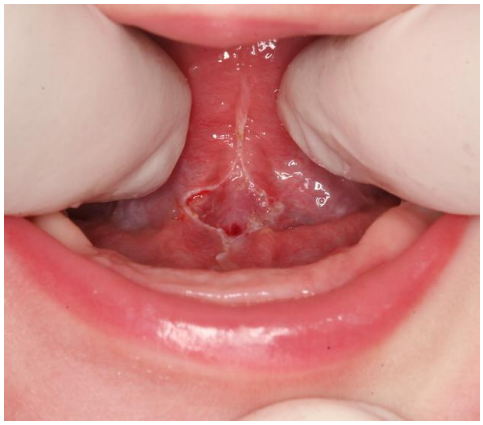


Before treatment



After laser treatment

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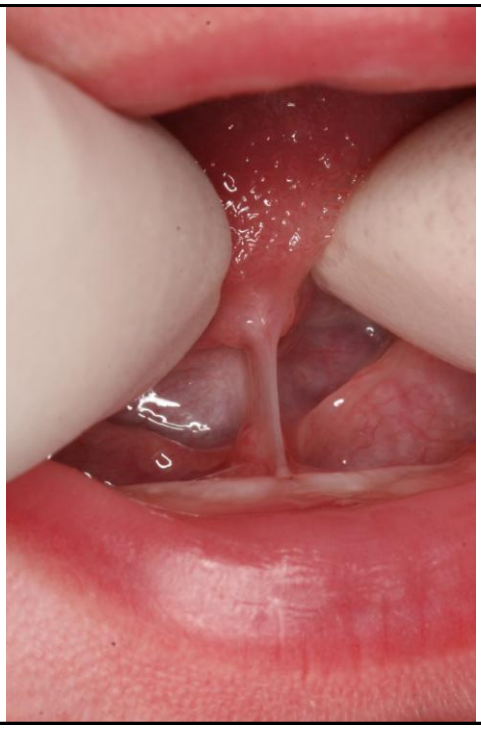

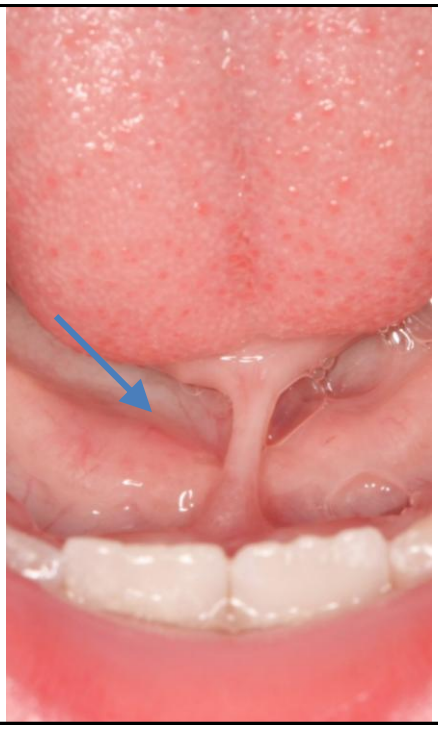

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Hyperlactation= Over-Production

- Common symptoms
  - Pain mainly when breasts are full
  - Frequent breast fullness
  - Recurrent mastitis
  - Infant struggling to manage heavy letdown
  - Infant feeds on one side for short periods
  - High production when pumping
    - People who are well matched typically express 3-5 oz (90-150ml) every 3 hours

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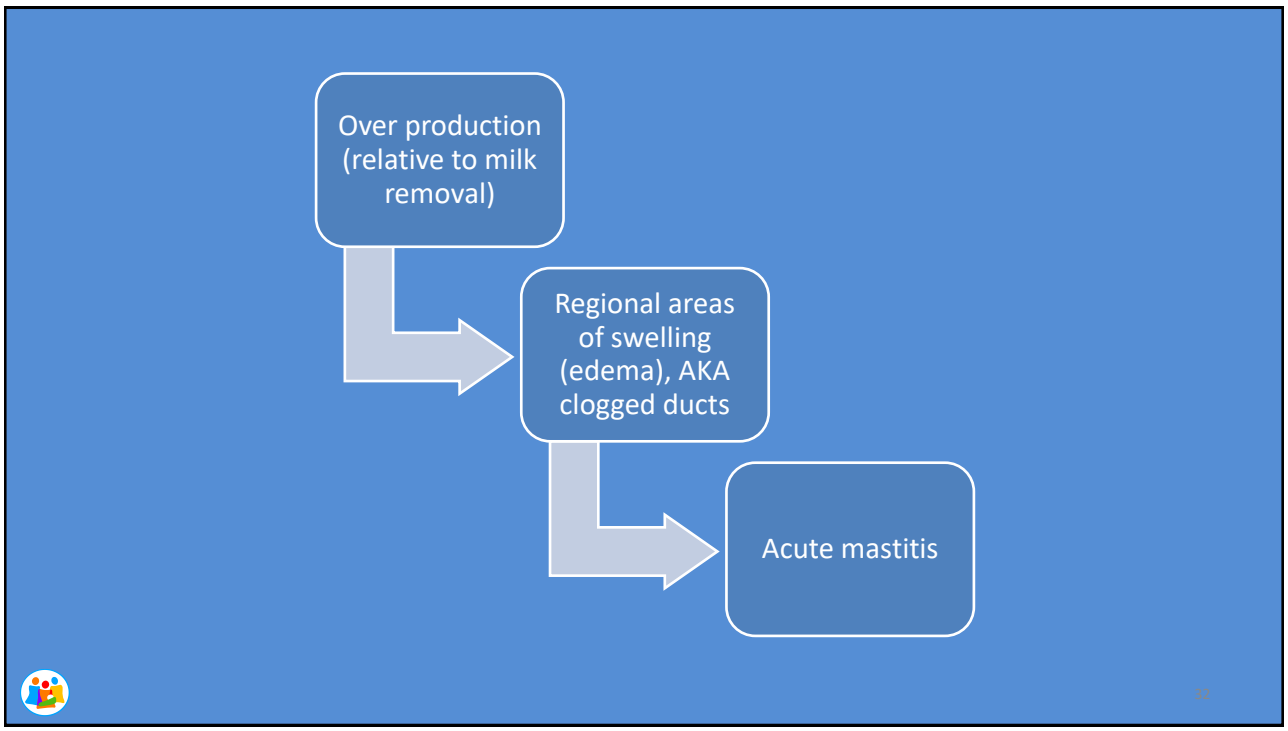

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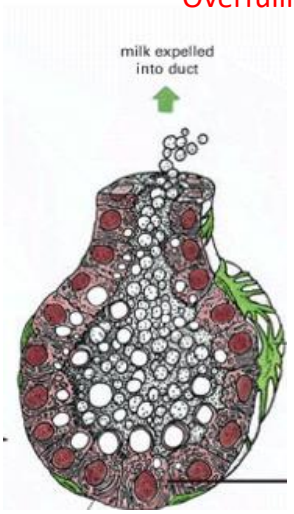
Overfullness => areas of swelling (clogs) => mastitis



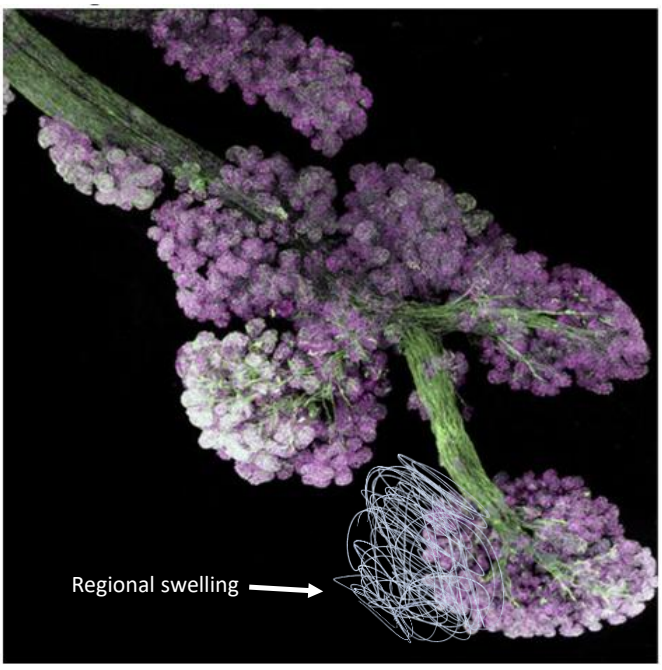
Normally milk stays inside the alveolus and is expelled thru the ducts

When overly full, milk will leak out between the cells, causing areas of swelling around the alveoli

33

What are Clogged Ducts?

- A swollen area of the breast
- The milk in the swollen region cannot move through the ducts until the swelling resolves
- When the swelling resolves, clots of milk are sometimes expressed
- There is no such thing as a 'plug in a duct'



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35

Risk Factors for Clogged Ducts

All situations are associated with insufficient milk removal=> alveolar distension=> fluid moving from alveoli to surround regions in the breast

- High milk production
- Return to work
- Irregular feeding/pumping
- Poor pump fit
- Change in feeding positions
- Restrictive clothing or other external compression

36

Symptoms of Clogged Ducts

- Tender localized area of fullness
- Pain radiates to/from the nipple during nursing
- No/minimal breast redness, no fever
- Drop in milk production because the breast does not completely empty

37

37

Treatment of Clogged Ducts

- Remain with normal routine of nursing/pumping
  - Do NOT increase demand
- Ice for swelling and comfort
- No aggressive massage, just light lymphatic massage
- Vary nursing positions
- If the swollen region does not resolve in 48 hours, needs a visit
- Lecithin 1200mg 2-4 a day for prevention may help (no evidence)

Source: US Breastfeeding Committee

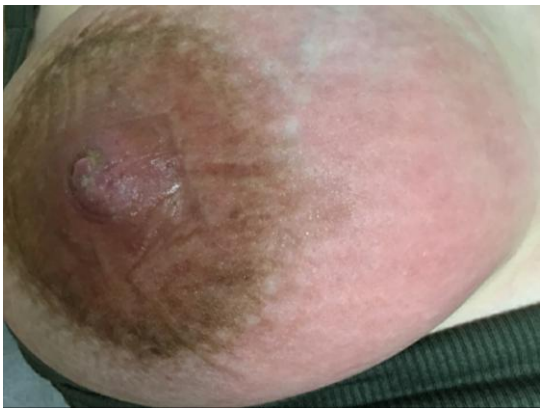
38

38

39

Acute Mastitis Symptoms

- Flu symptoms
- Breast pinkness- early stage
  - Harder to identify on darker skin
- Breast swelling and redness later
- Possible nipple sores
- Often preceded by clogged ducts



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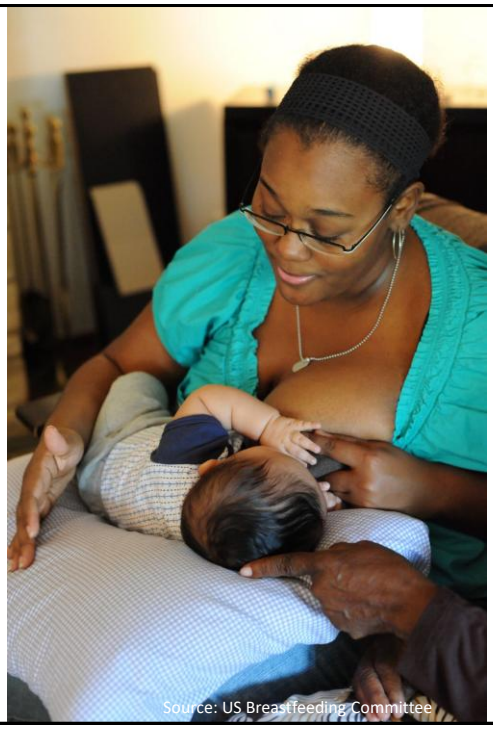


Risk Factors for Mastitis

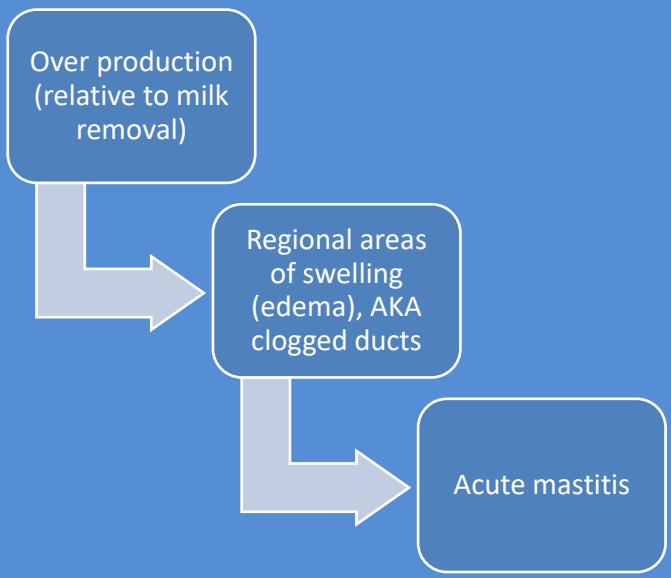
- The first 26 weeks postpartum
- Nipple wounds
- Staph aureus in milk or having a staph infection elsewhere such as cesarean incision
- High milk production and/or an imbalance of milk production relative to milk removal

Source: US Breastfeeding Committee

Wilson E, Wood SL JHL 2020 online; ABM Mastitis Protocol 2022, bfmed.org

42

Most mastitis is due to recent clogged ducts, so are not infectious. Antibiotics are often not needed



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Noninfectious vs Infectious Mastitis Difficult to Determine Difference

Non-Infectious

- No fever or possibly low grade
- Systemically feels OK
- Mild or no breast redness
- Breast pain/tenderness
- Typically improves in 48 hours

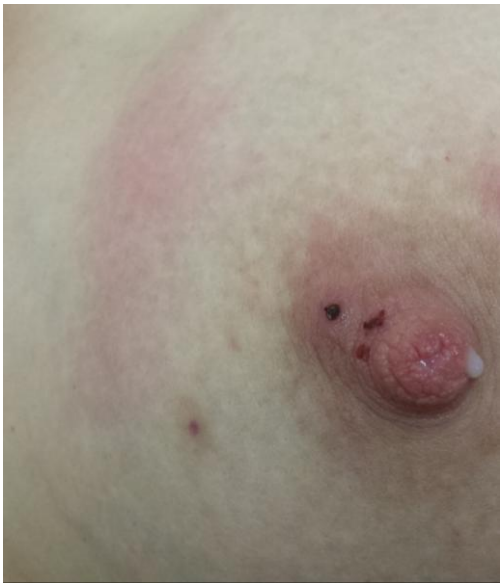
Infectious

- High fever
- Dizziness, nausea, weakness, headache and other systemic symptoms
- Breast redness and warmth
- Breast pain/tenderness
- May worsen over 48 hours

44

Mastitis Treatment

- Determine if due to overproduction or over-fullness
- Rest
- Cool compresses to reduce swelling
- Stay on a regular nursing or pumping schedule (do not over-pump)
- Anti-inflammatories- ibuprofen as needed for pain, fever.
- Antibiotics if ill, or not improving in 24 hours



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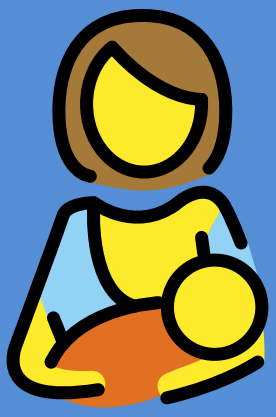
What NOT to do for mastitis!

- Avoid deep massage or vibration- this damages tissue, creating abscesses and larger areas of inflammation
- Avoid increasing frequency of nursing or pumping- more milk production will worsen swelling



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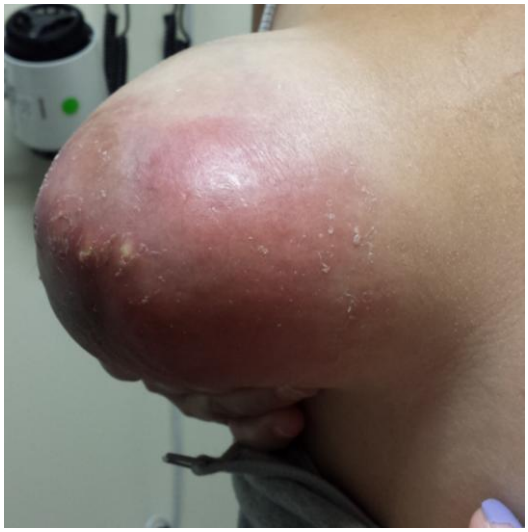
Abscesses during Lactation

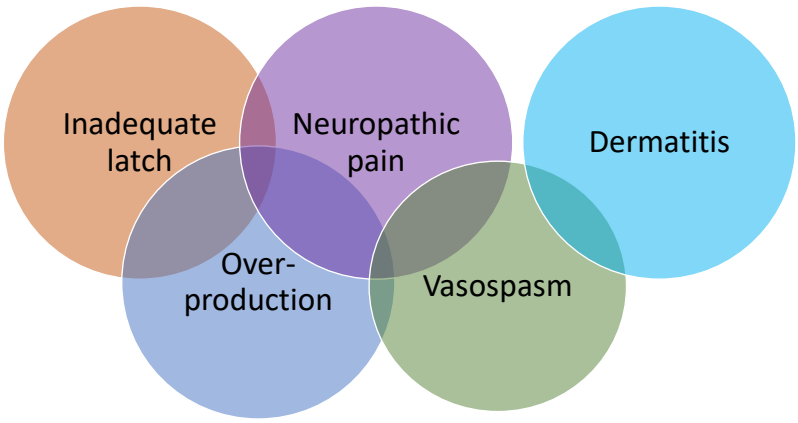


- Isolated regions of infected fluid in the breast
- Often arise from deep massage/vibration in the setting of clogged ducts.
- Require drainage
- Continue antibiotics, rely on culture results
- Continue nursing or pumping; do not increase frequency of drainage
- Baby may nurse if milk is not purulent

47

47

A mother and infant see you at a 6-week postpartum visit. The baby has been nursing well but latch still hurts. The nipple pain improves somewhat during nursing, but then after nursing, mom notices sharp, deep aching and burning sensations in her nipples that radiate into her breasts.
What are the most likely reasons?



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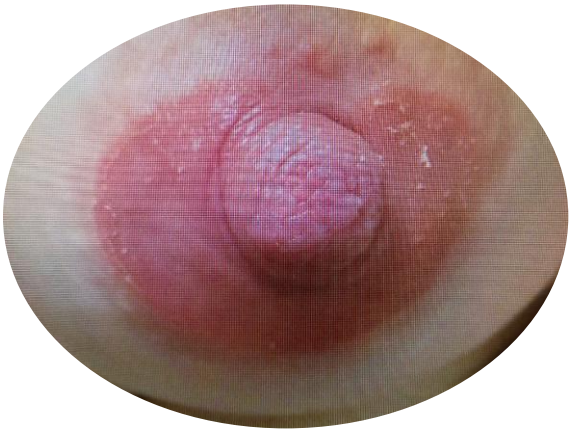
Common Causes of Nipple Dermatitis



- History of skin disease, e.g., eczema or psoriasis
- Reaction to an exposure on the nipple/areolar region

49

49

Symptoms of Dermatitis

- Itchiness, pain
- Red and/or scaly
- May start during pregnancy or any time postpartum

50

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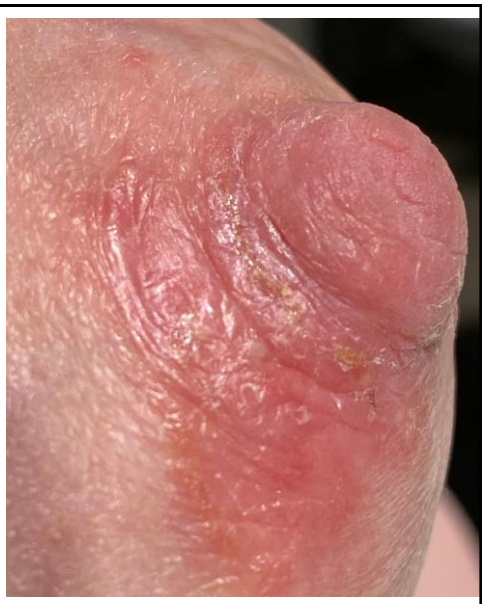
Treatment of Dermatitis

- Identify underlying cause
- Avoid irritants
- Frequent repeated moisturization with an oil/non-petroleum jelly
- Topical steroids are typically needed
  - see her primary care provider or dermatologist for treatment



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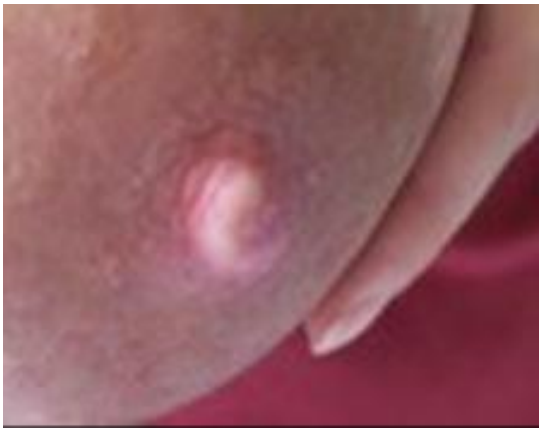
Classic Presentation for Nipple Vasospasm

- Nipple turns pale-blue-red
- Burning nipple pain
- Sharp breast pains
- Pain lasts variable duration of time
  - Color changes occur with pain
- Triggered by cold
  - Not just associated with feeding
- Often worse for people with overproduction



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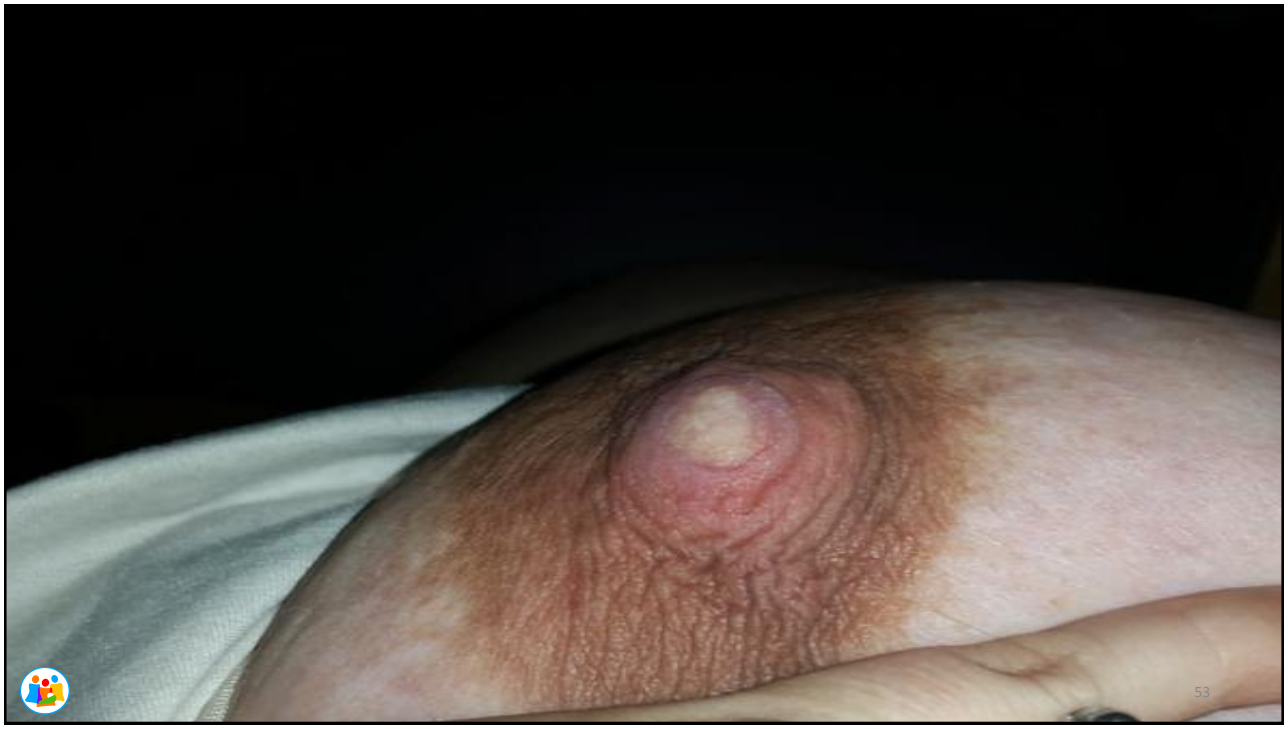

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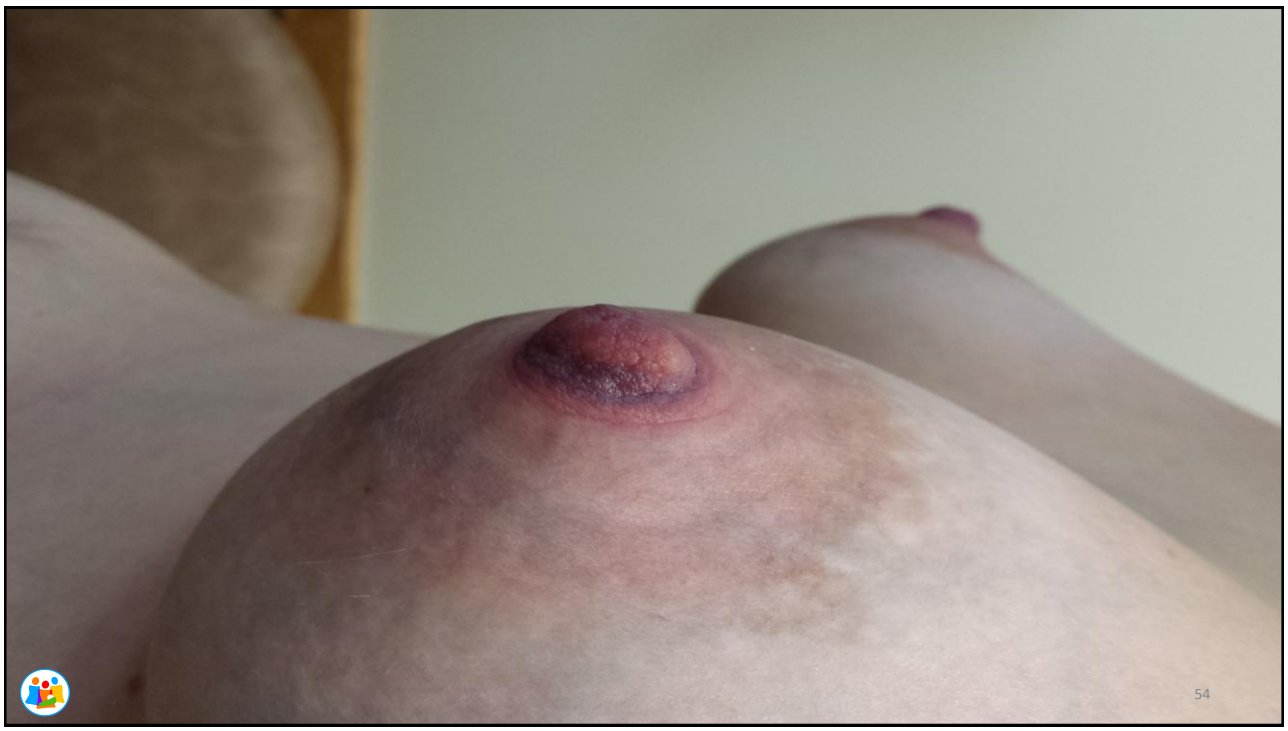

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Treatment of Vasospasm

- Avoid infant biting
- Apply heat immediately after nursing
- Keep breasts warm
  - Flannel or wool pads
  - Foot warmers applied to backs of nursing pads- do not allow these to directly touch the breast/nipple!
  - Medications

Source: US Breastfeeding Committee

55

55

Neuropathic Nipple/Breast Pain

- Pain starts early postpartum
  - Occasionally during pregnancy
- Nipples often appear normal
- Pain includes:
  - Sensitivity
  - Constant tenderness
  - Pain with pumping or breastfeeding
    - Throughout feeding/pumping and afterwards
- Not necessarily with over-production
- May be associated with anxiety/depression
- Often severe enough to wean
- Most effective treatment includes antidepressants

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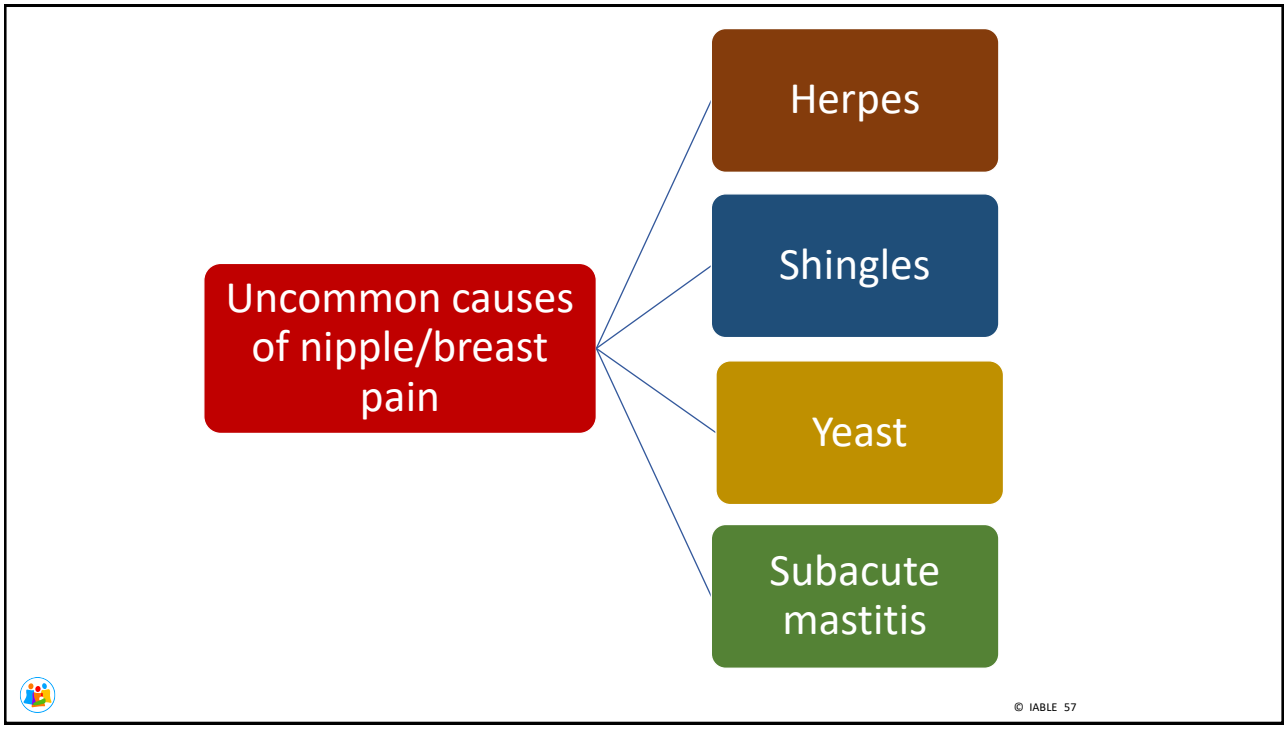

Uncommon causes of nipple/breast pain
Herpes
Shingles
Yeast
Subacute mastitis
© IABLE 57

57


Herpes Simplex on The Breast
58

58

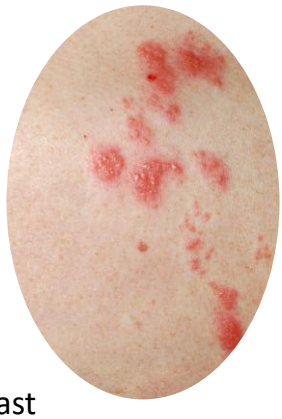
Herpes on the Breast

- Herpes Simplex
  - Can cause herpes in infant
  - The lactating parent is infected from nursing toddler with cold sores
- Management
  - Avoid direct contact of lesions with baby
  - Express and discard milk on affected breast
  - OK to nurse on an unaffected side
    - Often is on both breasts
  - Cover lesions until scabbed over
  - Anti-viral medication

59

59

Shingles on the Breast



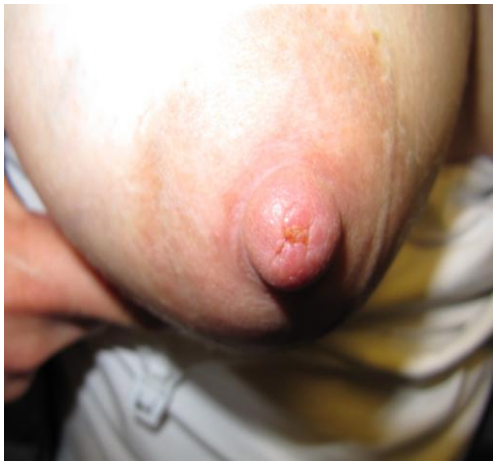
- Shingles- reactivated chickenpox
  - Blisters spread chickenpox
- Occur on 1 side of body
- Can develop over 1 breast region
- Management
  - Avoid direct contact of lesions with baby
  - Express and discard milk on affected breast
  - OK to nurse on the other side
  - Cover lesions until scabbed over
  - Anti-viral medication

60

60

Symptoms of Subacute Mastitis or Mammary Dysbiosis

- Usually nipple pain
- Deep breast pain after feeding
- Breasts feel tender/bruised
- Recurrent clogged ducts
- Nipple scabs



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61

Management of Subacute mastitis

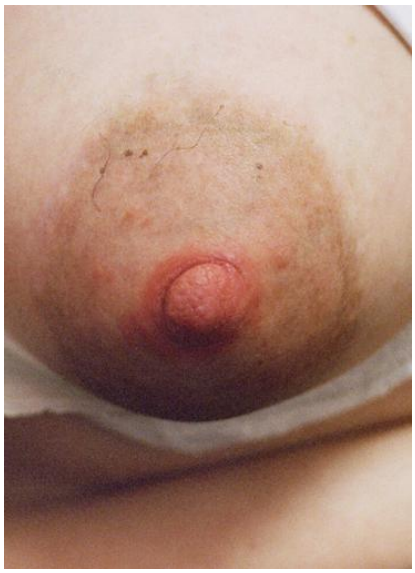
- This is a bacterial-overgrowth situation
- Breast exam and breastmilk culture
- Reduce over-production of milk
- Antibiotics based on culture results
- Probiotics with Lactobacillus Salivarius and Lactobacillus Fermentum
  - Uncertain if it will help
- Refer to breastfeeding specialist for management if possible

62

62

When Yeast is Suspected

- Classic nipple symptoms described as tender, burning, 'shards of glass' pain, itchiness
- Nipple/areolar region is red, shiny, with pimply satellite lesions
- More likely if the infant has moderate oral thrush
- Usually due to dermatitis or subacute mastitis, and rarely due to yeast



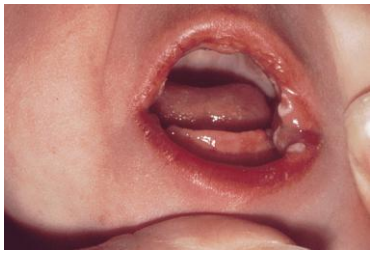
Nipple with dermatitis, not yeast

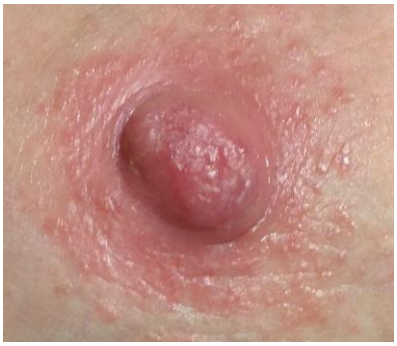
63

63

When to Consider Yeast Treatment

- Classic symptoms (on previous slide)
- Dermatitis is ruled out
- Infant has known oral thrush
- A culture or swab is positive for yeast
- Treatment is often oral antifungals for the mother/parent.





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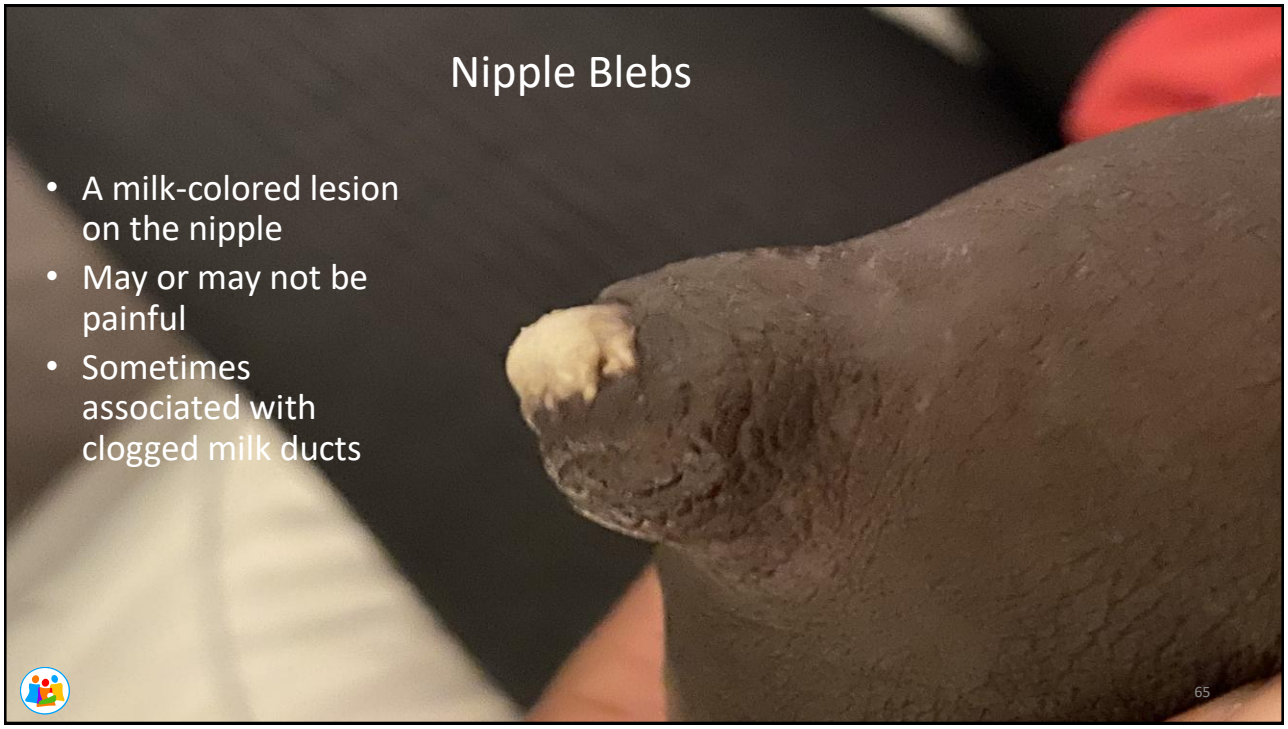
Nipple Blebs

- A milk-colored lesion on the nipple
- May or may not be painful
- Sometimes associated with clogged milk ducts



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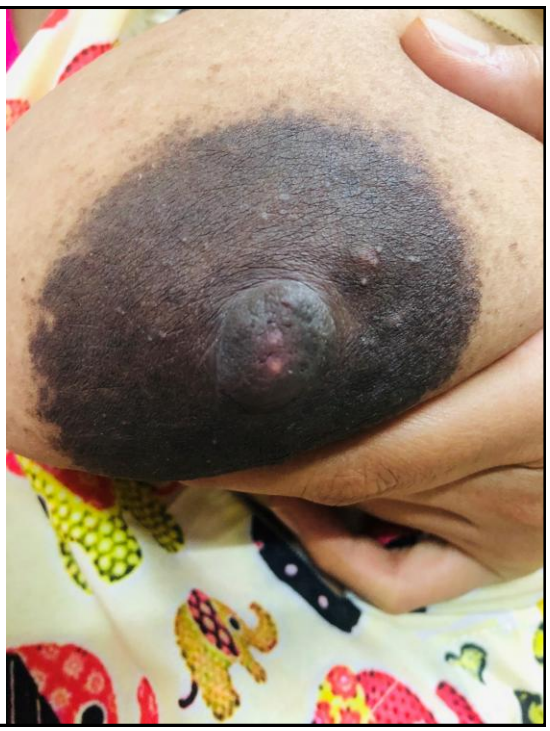
Bleb Treatment

- Treatment
  - If no pain and no underlying clogged duct, no need for treatment
  - If recurrent, best to manage underlying overproduction or clogged ducts
  - Steroid ointment may help
  - Surgical unroofing does not help



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Infant Biting

- Most often during teething
- Other causes:
  - Bite reflex
  - Rapid or heavy milk flow

67

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68

Conclusions for Session 4

- The most common causes of sore nipples are positioning and latch issues
- Breast engorgement during the first week increases the risk of nipple trauma
- People with sore nipples who are not improved by changes in positioning and latch should be referred to a knowledgeable provider

69

69

You are seeing mom & her term healthy infant at 14 days postpartum. She complains that her nipples are sore when the baby latches on and the pain continues throughout feeding. When the baby comes off the breast, the nipple looks pinched and pale. You advise:

A. You have vasospasm of your nipples. Use heat on your breasts after nursing.
B. You likely have a yeast infection of your nipples. You will need to contact your provider for treatment.
C. You need to have the latch checked. Either I can do this or let's have a lactation consultant see you.

70

70

A lactating individual who is 6 weeks postpartum reports stinging burning nipple pain for 1 week. Prior to this, they had no lactation problems. They would like to know what could possibly be wrong. **You advise:**

A. Your baby may not be latching properly.
B. You might have over-production, causing fullness and breast discomfort.
C. Your let-down is too fast, causing the baby to pinch the nipple.
D. You might have vasospasm.
E. You might a nipple/areolar rash.
F. All of the above are possible.

71

71

A mother who is 20 days postpartum reports that her nipples are still cracked, sore, and the sores stick to her breast pad. She denies deep breast pain, fever or breast redness. Breastfeeding hurts with latch and improves during feeding. **You advise:**

A. You need to see a lactation specialist.

In the meantime, apply breastmilk, coconut oil, or lanolin and a nonstick pad over the wounds after each nursing.

B. Your nipples won't heal until you stop nursing. Just pump and bottle feed for now.

C. Use a nipple shield to reduce pain and allow the sores to heal.

72

72

A lactating individual who is 3 months postpartum reports nipple redness with burning, stinging pain for 2 weeks. People on their Facebook support group suggested that they may have thrush. They wonder what you think. **You advise:**

A. You should be seen by a lactation consultant or breastfeeding medicine specialist to evaluate your pain.
B. Yes, it sounds like yeast. Call your physician for medication.
C. It sounds like vasospasm. Use heat on your nipples after nursing.
D. You should throw out your stored breastmilk in case it has yeast in it.

73

73

Mom calls 4 months postpartum reporting recurrent clogged ducts. She finds that they usually resolve in about 24 hours, but this one has been present for 4 days. She has no fever, chills or redness of the breast, but the area is tender. **You advise:**

A. Come in to be seen to have that area checked.
B. Try to nurse frequently, pump after nursing, use heat and massage as much as possible. IF it still is not gone in 3 days, call back. Watch for signs of infection.
C. You probably have too much milk, you should stop pumping so much extra milk.

74

74

A parent calls 7 mo postpartum with a recent diagnosis of shingles by their physician. They describe painful red skin lesions along the upper back and onto the R breast, involving the nipple. The physician advised weaning and the parent wants your opinion. **You advise:**

A. The baby is now old enough to be safely exposed to these shingles lesions, so no worries, keep nursing.
B. It is best to not nurse from that breast. Express and dump the milk until the lesions on the nipple and sores are dried up. Keep the area covered.
C. Don't nurse from the R breast, but you can express milk from that breast and give it to the infant.

75

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A mother with her 4mo old reports that her infant is teething and wonders how to prevent biting. She was told that babies need to wean when teeth come in. **You advise:**

A. Yes, sometimes babies bite. Good luck.
B. Pump and bottle feed when teething seems the worst.
C. Babies bite most often at the end of feeding. Keep the baby deeply latched to prevent biting. Take her off when she is biting and no longer seriously drinking.
D. Make sure to respond loudly and clearly, to scare the baby into never doing that again.

76

76