Infant feeding - nipple and breast pain in lactation

1. Purpose

This document outlines the guidelines for pharmacological and non-pharmacological management of lactating women with nipple and breast pain at the Women's. This guideline is related to the RWH Breastfeeding Policy. Breastfeeding Policy

2. Definitions

Not applicable

3. Responsibilities

All staff involved with the diagnosis and management of lactating women with nipple and breast pain must be aware of this guideline to ensure safe and appropriate management. This includes doctors, lactation consultants, midwives, nurses and pharmacists.

4. Guideline

Nipple pain and damage is one of the most common reasons for early cessation of breastfeeding. Most women experience some nipple tenderness during the first week of establishing breastfeeding. However, pain which is severe, persistent or occurs between feeds should be investigated. Nipple damage is a key indicator of a breastfeeding problem and increases the risk of mastitis, infant formula supplementation and maternal anxiety.

The nipple and breast pain algorithm at the end of this document is a useful tool in deciding the cause and management of nipple and breast pain. This algorithm will link to other clinical guidelines for specific management of nipple and breast pain.

4.1 General signs and symptoms of nipple pain

Nipple pain and damage should be assessed and it presence should be documented on the care plan or progress notes. Painful nipples may appear undamaged or have visible nipple trauma. Nipple trauma ranges from mild inflammation, small blisters and grazes through to compression stripes, cracks and fissures. Other nipple pathology includes:

- Exudate or yellow crust
- Plaques or flaky skin
- Shiny skin
- Pustules
- Blanching.

4.2 Causes of nipple and breast pain

Poor positioning is the commonest cause of nipple pain and trauma, but it is important to consider that there may be more than one problem.

Mechanical

- Poor positioning and attachment is the most common cause.
- Blocked duct
- Nipple variations such as flatness, retraction, inversion
- Inappropriate use of breast pump - pump shield too small for nipple size, suction too high
- Infant with very strong sucking vacuum
- Infant biting nipple
- Anatomical variations in the infant such as:

- A high arched, flattened or bubble palate
- Disorganised sucking action
- Tongue-tie (ankyloglossia)

Physiological

- Breast engorgement
- Nipple vasospasm
- Hormonal sensitivity for example during ovulation, menstruation or a new pregnancy.

Dermatological

- White spot (blocked nipple pore)
- Eczema/dermatitis

Infective

- Mastitis
- Bacterial infection
- Candida infection
- Herpes simplex

4.3 General management

Management involves identification of the cause, initiation of appropriate treatment and facilitation of healing. A full breastfeeding assessment should be conducted.

General management

- Offer the least sore nipple first
- Soften the areola if engorged prior to attachment
- Stimulate let-down before attaching the infant to the breast
- Correct positioning and attachment; try different positions
- Treat any associated engorgement
- Apply warm compresses for 5 minutes after feeds for pain relief
- Use moist wound healing principles; apply purified lanolin or hydrogel dressings after feeds
- The application of expressed breast milk is commonly prescribed
- Reassurance and support for the mother are vital.

If the nipples are too sore to feed

- The woman may need to 'rest and express' the affected nipple until pain subsides. This may be for a few feeds or a few days; may be from one or both breasts.
- If using a breast pump to express, ensure that the breast shield flange is not too small and suction pressures are comfortable for the woman. The nipple should have adequate movement in the breast shield tunnel, without blanching or pinching the nipple.
- Express enough to drain the breast well to prevent engorgement or mastitis and protect milk production.
- Feed the infant the expressed breast milk by spoon or cup. Avoid use of bottles and teats if possible particularly in a very young infant and if the cause of nipple trauma is poor attachment.

  See Appendix 1 for Nipple and breast pain in lactation management algorithm:

Management of vasospasm

- Vasospasm is often precipitated by cold temperatures, trauma or poor attachment and so reduction of these is the primary treatment.
- Nipple warmers heat packs and avoiding exposure to cold may be all that is needed if nipples are undamaged and attachment is painless.
- As vasospasm may be worsened by medications that cause vasoconstriction, nicotine or caffeine these should be avoided.
- Dietary supplementation with magnesium (1-2 x 300mg tablets daily) and fish oil may be helpful.
- Some women may benefit from treatment with nifedipine (20-30mg slow release daily), a calcium channel blocker that induces vasodilation.

5. Evaluation, monitoring and reporting of compliance to this guideline

Compliance to this guideline or procedure will be monitored, evaluated and reported through the following:

- Breastfeeding Service Lactation Consultants when called to provide consultations for women presenting to the Women's with nipple and breast pain will review the documented treatment plan to determine consistency with this guideline.
- Where a treatment plan does not comply with this guideline, the LC will report to the CMC (Lactation) for care review and appropriate follow up .
- The Breastfeeding Service will review all reported clinical incidents of non-compliance reported through the clinical incident program and develop an action plan to address issues as required.

6. References

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7. Legislation/Regulations related to this guideline

Nil

8. Appendices

Appendix 1: Nipple and breast pain algorithm

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Appendix 1

Algorithm: Nipple and breast pain in lactation

Nipple or breast pain in lactation algorithm