

Later Breastfeeding Problems Ongoing Support of the Breastfeeding Mother

Andrea Windom, MSN, PMP, IBCLC
Kaiser Permanente Medical Center,
Vallejo
University of California, San
Francisco
July 25, 2006



Plugged Ducts

- **Tender area or painful lump in breast that does not resolve with feeding**
 - Feels overly full
 - Usually unilateral
 - Overlying skin may be red
 - Most common during early weeks of nursing
 - More common in winter months

Causes of Plugged Ducts

- **Incomplete drainage of the breast due to**
 - A missed feeding or increased interval between feeds
 - An abundant milk supply
 - Mothers of multiples
 - Obstruction of milk ducts
 - Tight bra, especially those with under wire
 - Restrictive clothing
 - Baby carriers with tight straps

Preventing Plugged Ducts and Mastitis

- **Deep latch**
- **Frequent nursing with complete breast emptying**
- **Uninterrupted feedings that are not timed**
- **No supplements unless medically indicated**

Preventing Plugged Ducts and Mastitis

- **Show mother how to maintain her milk supply, even if she is separated from her baby or having difficulty latching him/her**
- **Teach mother about importance of breast emptying, choosing a bra that fits well, and taking care of herself**

Treatment of Plugged Ducts

- **Remove the bra if ill-fitting or uncomfortable**
- **Apply moist heat for 15-20 minutes before nursing**
- **Nurse frequently, at least every two hours**
 - Begin with affected side
 - Try positioning baby's chin close to plugged duct

Treatment of Plugged Ducts

- **Gently massage the breast while nursing**
- **Massage breast in shower with soapy hands**
- **Be alert for signs of infection: fever, chills and achiness**
- **Any breast lump that does not resolve after one week should be evaluated by a physician, NP or CNM**

Plugged Nipple Pore

- **A plug of dried milk or secretions in a nipple pore, possibly causing poor drainage of duct**
- **Nipple is normal in color but a white blob is visible on tip, especially after nursing**
- **Treat as with plugged duct**
- **May require removal with sterile needle if persistent**

Mastitis

- **Cellulitis of the interlobular connective tissue of the mammary gland**
 - Localized symptoms
 - Tenderness or pain
 - Redness
 - Heat
 - Induration
 - Systemic symptoms
 - Fever, usually $>101^{\circ}$
 - Malaise
 - Nausea and vomiting

Incidence of Mastitis

- **2.5-26% incidence (Marshall et al, 1975; Niebyl et al, 1985)**
- **Most often occurs in the first three months**
- **More common in winter months**
- **Usually unilateral**
- **Levels of sodium and chloride elevated, especially in chronic or recurrent cases**

Portal of Entry and Causative Organisms

- **Lactiferous ducts to a secreting lobule**
- **Nipple fissure to periductal lymphatics**
- **Hematogenous spread**
- **Most common organisms**
 - Staphylococcus aureus
 - Escherichia coli
 - Streptococcus
 - Suspect if mastitis is bilateral

Predisposing Factors of Mastitis

- **Poor drainage**
- **Presence of an organism**
- **Cracked or painful nipples**
 - Mother may avoid complete emptying
 - Allows entry of organism
- **Lowered maternal defenses**
 - Stress
 - Fatigue
 - Anemia

Treatment of Mastitis

- **Bed rest**
- **Remove bra if tight or uncomfortable**
- **Moist heat 15-20 minutes before nursing**
- **Nurse frequently, begin on affected breast**
 - If baby premature or ill, check with pediatric provider
- **If nursing is painful or not emptying completely, express milk instead of or in addition to nursing**
- **Monitor fever**
 - Acetaminophen or ibuprofen to reduce fever and pain
- **Consider 1000 mg vit C qid to speed healing**
- **Increase fluid intake**

Antibiotics for Mastitis

- **In very low grade mastitis, some women may choose above treatment alone for 48 hours to avoid antibiotics**
- **When antibiotics used, should be continued for 10-14 days**
 - Dicloxacillin
 - Keflex
 - Augmentin
 - PCN allergic: clindamycin or erythromycin
 - MRSA: vancomycin, clindamycin or rifampin

Recurrent Mastitis

- **Caused by delayed or inadequate treatment of the initial disease**
- **Mother and infant should be examined and circumstances reviewed**
- **Culture milk**
 - Mother washes breast and hands, discards 1st 3 mls
 - Collects 5-1 mls for culture in sterile container
 - Positive culture is bacteria $>10000/ml$ and leukocyte count $>10,000,000/ml$

Recurrent Mastitis

- **Aggressive course of rest, nourishment, stress management and complete drainage of breast**
- **Antibiotics for full 14 days**
 - Most common reason for recurrence is that mother stopped medication when she began to feel better

Chronic Mastitis

- **Chronic bacterial infection**
 - Give low dose antibiotics for duration of lactation, e.g. Keflex 250 mg bid
- **Breast abscess**
- **Fungal infection**
- **Underlying breast disease, especially if unilateral**
 - Cyst
 - Galactocelle
 - Tumor

Breast Abscess

- **A rare complication of mastitis, in which an accumulation of pus is walled off within the breast**
- **Suspect when mastitis symptoms prolonged more than 2 days after antibiotics started and a lump is present**
 - Lump may be hard or soft, does not change with nursing
- **Treatment**
 - Antibiotics
 - Series of needle aspirations
 - Surgical drainage

Nursing After Abscess

- **Mother may be advised not to nurse on affected breast for about four days**
 - Provide her with a DME pump and instruct to empty q 4 hrs
 - Discard expressed milk
- **Continue nursing on unaffected breast if able**

Nursing After Abscess

- **Surgeon advises when nursing may resume**
 - Once breast surgically drained, OK to resume as long as incision and drainage tube sufficiently away from areola so not to be involved in feeding (Lawrence, 2005)
- **Once nursing resumes, incision may leak milk 3-4 wks**
 - Ductal system interrupted by surgery or rupture
 - Mother should compress leaking area with gauze for feeds

Yeast or Fungal Infection of Breast

- **Invasion of the breast by a yeast infection or a fungus such as *Candida albicans***
- **Increasing incidence in recent years: approximately 18%**
- **Usually diagnosed by nature of the discomfort**
 - Nipple pain
 - Often described as burning
 - Not related to a poor latch
 - Late onset
 - Stabbing or shooting breast pain
 - Skin may be shiny and peeling/flaking
 - Breast surface may itch

Increased Risk of Breast Yeast Infection

- **Antibiotic treatment**
 - Treatment for Grp B Strep doubled incidence (Dinsmoor et al, 2005)
 - Infant oral thrush
 - Vaginal yeast infection
 - Diabetic mother

Treatment of Fungal Infections

- **Mother**

- Topical antifungal to nipples and areolas after each feeding or every 2 hours
- Keep breast clean and dry
 - Fresh bra daily, change breast pads frequently, air/light exposure

- **Infant**

- Oral Nilstat 1.0 ml po qid x 2 wks, or prn thrush + 3 days
- Topical antifungal with each diaper change prn yeast rash

Treatment of Fungal Infections

- **Artificial nipples**
 - Sterilize daily during treatment
- **Persistent, specific maternal symptoms**
 - Consider culturing milk
 - Systemic antifungal Diflucan 200 mg loading dose then 100-200 mg daily for 14 days

Case Study - Theresa

Theresa is happily nursing her healthy 2 month old daughter. The good news is that the baby slept through the night last night. The bad news is that today she feels like she might have a breast infection because she feels a lump on the UOQ of her right breast. She asks your advice.

- What questions do you have for Theresa?
- What is your assessment?
- What treatment would you advise?

Two Days Later ...

Theresa calls again. She has been applying moist heat, nursing frequently and massaging the lump and it initially seemed better but hasn't completely resolved. Now she has a fever of 101° with headache, chills and body aches. The baby is fine and eager to nurse. Should she let her?

- What is your assessment?
- What is your plan?
- What do you expect her PCP to advise?

And Finally ...

Theresa's symptoms resolved after taking Dicloxacillin for 10 days. She was well for a week or two but now wonders if the infection could be back. She is having burning breast pain especially after feeding. It is worse on the right than on the left. She is anxious to re-start antibiotics in order to ward off another bad case of mastitis. So far she has no fever.

- More questions for Theresa?
- Your assessment?
- Your advice?

Nursing After the Neonatal Period

Video

- **The Clinical Management of Breastfeeding, Part 2: Putting It All Into Practice**
- **Module Nine: Pediatrics and Well Baby Care**
- **Vida Health Communications, 1999**

AWONN Video, Module 9

Questions?

Selected References

- Francis, Merrill, J. et al. (2004). Diagnostic value of mammary candidosis among lactating women. Journal of Human Lactation 20(3), 288-295
- Huggins, K (2005). The Nursing Mother's Companion, 5th Ed. Harvard Common Press, Boston, MA
- Lawrence, R.A., & Lawrence, R.M. (2005) Breastfeeding: A Guide for the Medical Profession, 6th Ed. Mosby, Philadelphia, PA