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## **Managing common maternal related breastfeeding challenges**

Infant feeding: is the twelfth series of 'Midwifery basics' targeted at practising midwives. It aims to provide information to raise awareness of the impact of the work of midwives on women's experience and encourage midwives to seek further information through a series of activities. In this seventh article Joyce Marshall considers a range of maternal related issues that pose challenges for breastfeeding mothers.

### **Introduction**

In the UK around 30 percent of mothers experience breastfeeding challenges in the early weeks and only around a quarter are still exclusively breastfeeding when their baby is six weeks old (McAndrew *et al.* 2012). Midwives have a responsibility to provide support to breastfeeding women (NICE 2006) and the most recent infant feeding survey shows that women who receive help or support are more likely to continue breastfeeding (McAndrew *et al.* 2012). The challenges most commonly experienced by women in the first two weeks of breastfeeding include the baby finding it difficult to latch on to the breast and/or breast discomfort or painful nipples (McAndrew *et al.* 2012). Reasons why a baby may be sleepy or not attach well at the breast have been discussed in an earlier article in this series (Marshall 2013). Many of the maternal related challenges can be resolved if identified early and attention given to improving positioning and attachment enabling women to continue to breastfeed.

### **Scenario**

Gail has been breastfeeding baby Carla for a week now since her birth. A few days after she came home from hospital she had experienced some soreness whilst feeding and her nipples had become cracked. The community midwife watched Carla breastfeed and made some suggestions to Gail to help her to position Carla differently. This helped and Gail's nipples have since been healing well but today she is feeling unwell with flu-like symptoms and has noticed a reddened area on the outer aspect of her left breast.

### **Sore and painful nipples**

Many women experience some nipple tenderness in the first few days as they and their baby learn the skill of breastfeeding but this should not last long and should not be painful. Sore nipples are most likely to occur if the baby is not positioned and/or attached well at the breast. Attachment is how the baby

takes the breast into her mouth to enable her to feed and positioning is how the mother holds her baby to enable her to attach (UNICEF Baby Friendly Initiative UK 2009). If a baby has taken a large mouthful of breast tissue into her mouth then the mother's nipple will be protected at the back of the palate rather than rubbing against the hard palate. If when a baby releases the breast the nipple is misshapen this means the baby could be better attached or positioned more optimally. Nipple pain and trauma can cause a mother to become anxious leading to a tendency to feed less often, also the release of oxytocin may be inhibited so that milk may not flow as easily which can compound the problem. If a mother is experiencing sore and/or traumatized nipples the midwife should take a lactation history, observe a complete breastfeed to assess the baby's position and attachment and sucking pattern, and assess the baby to exclude anomalies such as tongue-tie. If a mother has flat or inverted nipples she should be reassured that the baby will be able to breastfeed as babies feed from the breast rather than the nipple. Nipple pain may be associated with other conditions of the breast such as engorgement or thrush (discussed below) and can also be caused by other conditions such as eczema, dermatitis or Raynaud's syndrome (Anderson *et al.* 2004). Nipple trauma can provide a portal for organisms to enter the breast causing either bacterial or fungal infection.

### **Activity 1**

Consider a variety of different ways of explaining to mothers how to position and attach their baby on to the breast. Mothers learn in different ways so it is useful to have a range of resources to help with this. The graphic of a baby attaching on the breast may be useful for some mothers and can be found at: <http://www.bestbeginnings.org.uk/5-graphic-of-a-baby-attaching-on-the-breast/067348cf-7dd7-46cb-8f8b-9ae5ddaad028> Read some articles about Raynaud's syndrome (e.g. Anderson *et al* 2006 is available electronically). Ensure you can recognise the symptoms of and treatment for Raynaud's syndrome.

### **Engorgement**

A mother's breasts may be very full when the milk 'comes in' between the 3<sup>rd</sup> and 6<sup>th</sup> day after giving birth and this is usually resolved easily if the baby is feeding effectively at the breast. It is important for the midwife to be able to distinguish between full breasts, which are firm and full often with a marbled appearance, and engorged breasts that are painfully full, shiny and oedematous with reddened areas (World Health Organisation 2000). If a woman's breasts are engorged the milk does not flow well because the breasts are not only full of milk but also tissue fluid and venous and lymphatic drainage are

obstructed (UNICEF Baby Friendly Initiative UK 2009). The nipple sometimes becomes flattened and the surrounding areola much firmer making it more difficult for the baby to attach and feed well and this can lead to damaged nipples.

Engorgement can be prevented by ensuring milk is removed regularly and efficiently by making sure the baby is fully attached to the breast, positioned optimally and is feeding often. If observed, engorgement needs to be treated quickly otherwise a woman's milk supply may diminish and stasis of milk may result in blocked ducts and mastitis. If the baby is finding it difficult to attach to an engorged breast gentle hand expression may be required to soften the breast tissue. If the breasts are still full after the baby has fed further expression may be needed. Warmth on the breasts may help the milk to flow more easily and mother may require analgesia such as paracetamol or ibuprofen.

## **Activity 2**

If there is a build-up of breastmilk in the breast what is present that causes a reduction in milk supply? Access the internet and find a video clip explaining hand expression that you think would be useful for women to watch.

## **Mastitis**

Mastitis is an inflammatory response within the breast which is usually caused by stasis of milk. When not adequately drained from the breast the milk collects in the alveoli causing increased pressure and distension which can often be felt as a tender, palpable lump. When this occurs components of the milk are forced through the cell walls into the capillaries or tissue and these trigger an immune response (Deshpande 2007). Mastitis can happen at any point during lactation but most occur in the first 12 weeks postpartum, most commonly in the second and third week (World Health Organisation 2000).

If a breastfeeding mother has flu-like symptoms mastitis should always be suspected as this can be the first sign (Noonan 2010). A mother with mastitis may complain of general aches and pains, headache and chills and fever and a red, swollen area of the breast may be visible (Riordan & Wambach 2010). To diagnose mastitis it is important to take a breastfeeding history from the mother and to identify any likely causal factors (Pollard 2012). Any factor that leads to the breast not being fully drained can predispose to mastitis. Commonly this can be poor positioning and attachment leading to inefficient milk transfer but can also be factors such as the baby having limited time at the breast, missed feeds

through for example supplementary bottle feeds or use of a dummy or the baby having a short frenulum (tongue tie). Sore and cracked nipples can lead a mother to delay feeding and can also mean that bacteria can enter the breast more easily. If there has been pressure on the breast for any length of time, for example from a tight bra or a mother holding her breast whilst feeding the milk flow can be reduced (Riordan & Wambach 2010).

When a mother has mastitis it is most important to ensure the baby feeds as much as possible and that breast drainage is achieved (UNICEF Baby Friendly Initiative UK 2009). It may be helpful to feed from the affected breast first. It is also important to observe a breastfeed and ensure good positioning and attachment. A warm compress may be helpful to help the milk flow. If the baby does not feed well on the affected breast then the milk should be expressed. Sometimes babies are reluctant to feed; possibly due to the milk tasting more salty than usual because the inflammatory response causes the junctions between the cells in the alveoli to open allowing sodium and immunoproteins to pass through (World Health Organisation 2000). This is usually temporary lasting about a week. Non-steroidal anti-inflammatory medication such as Ibuprofen 400mgs three times a day can be given to reduce the inflammation and pain as long as the mother does not suffer from asthma or stomach ulcers (The Breastfeeding Network 2009). Paracetamol 1g four times a day may also be given to relieve pain and reduce pyrexia but Aspirin should not be taken by breastfeeding women (The Breastfeeding Network 2009). If there is no improvement seen, infection may be present and antibiotics required.

### **Activity 3**

Mastitis often starts with a blocked milk duct. What might you say to a woman to help to prevent this? When would be the best time to education women about the possibility of milk ducts becoming blocked? Read about white spot on the nipple at: <https://www.breastfeeding.asn.au/bfinfo/white-spot-nipple>

### **Thrush (candida albicans)**

Thrush causes an agonizing pain in both breasts after feeds and rarely occurs in the first six weeks after birth (The Breastfeeding Network 2012). It is important that thrush is correctly diagnosed to avoid unnecessary treatment of mother and baby (Jones & Breward 2010) as nipple and/or breast pain is much more likely to be due to the need to improve positioning and attachment. Signs and symptoms of nipple thrush include: sudden onset of painful feeding after experiencing pain-free feeding, nipples

redder than normal and unusually sensitive, signs of fungal infection in the baby, and the baby may be unsettled or 'fussy' during feeding. It is always important to watch a baby feed and to rule out other possible reasons for breast pain, such as tongue tie, Raynaud's syndrome or allergies to ointments or breast pads that may cause nipples to flake and itch (Jones & Breward 2010). If thrush is identified treatment should be started as soon as possible for both mother and baby. Thrush can be just on the nipple and this should be treated with topical application of antifungal cream (such as Miconazole 2%) applied sparingly to the nipples after every feed. The baby should be treated with oral antifungal gel at the same time. Thrush can also infect the milk ducts in the mother's breast and this would require systemic treatment if topical treatment is not effective.

#### **Activity 4**

Read the leaflet 'Frequently Asked Questions on Thrush and Breastfeeding' available on The Breastfeeding Network website. Look up the drugs that are likely to be used to treat thrush in the British National Formulary.

#### **Reflection on the scenario**

Gail has received support from the community midwife to help her to breastfeed more effectively and reduce the soreness she experienced in the first few days. However she is now feeling unwell. What is the most likely cause of her flu-like symptoms? What is the initial treatment for this? What information will she require about feeding? What might you suggest to help her feel better?

#### **Conclusion**

Maternal-related breastfeeding challenges are relatively common and distressing for mothers. If not recognised and resolved quickly mothers are likely to stop breastfeeding. Midwives should be alert to the signs and symptoms of these conditions as they have an important role to play in correctly diagnosing them and offering relevant evidence-based information to enable resolution and continued breastfeeding.

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