

Pain is NOT normal!
Prevention, assessment and
treatment of sore nipples

Breastfeeding Rounds
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c/o Dr. Jack Newman

Objectives

Participants will be able to:

- Discuss the incidence of sore nipples
- Identify methods to prevent sore nipples
- Identify risk factors for early nipple trauma
- Discuss the importance of early and ongoing BF assessment (LATCH-R)
- Describe the concepts of asymmetrical latch
- Assessment and diagnosis of sore nipples
- Discuss appropriate treatment for sore nipples
- Outline aspects of community support and sources of referral



Nipple Pain

- Some nipple discomfort in the first week postpartum is not unusual.
- Fear of nipple pain, and the notion that “breastfeeding hurts” is cited prenatally as a reason for not wanting to breastfeed
- Gone are the days of “nipple preparation” to prevent anticipated pain



Incidence

- Early “normal” nipple soreness peaks between day 3-6 postpartum then resolves
- Called “transient soreness”
- One study of 100 BF women, 96% reported sore nipples in the 1st week (Zeimer et al., 1990)



Early nipple pain



- Some nipple soreness during early BF is normal
 - Heightened nipple sensitivity in late pregnancy and early BF
 - Discomfort is related to “stretching” of the collagen fibers within the nipple as baby latches and pulls nipple into mouth
 - Stretching of fibers and epithelial abrasion can occur with perfect latch
 - Unrelieved negative pressure in baby’s mouth can increase nipple tenderness
 - Is relieved when letdown of milk occurs and baby swallows
- Nipple soreness peaks on Day 3-6
- Continued nipple soreness throughout BF or after 1 week is not normal and requires intervention.

Early nipple pain

- “Mechanical” pain or trauma vs. underlying infection or condition:
 - poor positioning
 - disorganized sucking
 - friction
 - milk stasis, engorgement
 - tongue tie, high palate or cleft
 - breaking suction
 - fit and use of devices (shield, flanges, pump)



Nipple pain > 1 week

- However, nipple pain beyond this 1st week of adjustment (prolonged abnormal pain) requires action!
- Usually indicates an underlying problem which requires skilled assessment and intervention
- Poor positioning and poor latch is widely believed to be the cause of persistent nipple pain



Nipple Pain

- “Nipple pain” is second to “insufficient milk supply” for reasons why women wean prematurely
- Nipple pain can:
 - disrupt the mother/infant relationship
 - increase maternal depression, tension and mood disruption
 - lead to tissue injury and subsequent infection
 - decrease milk transfer



- Nipple pain most common in 1st time mothers
- Flat or inverted nipples, breast or nipple pain, milk stasis, & mastitis, can be related to failure to remove milk from the breast (Shrago 1992)
- Feeding problems and readmissions more likely if mother has no previous breastfeeding experience, < grade 11 education & did not attend breastfeeding classes (Edmonson et al 1997)
- Adolescent mother, <6 prenatal visits, using pacifier in 1st month and poor latch associated with cessation of exclusive BF before 6 months (Santo et al 2007)



“The best treatment
for sore nipples is PREVENTION”

The best intervention for
nipple pain is education

(Lochner & Judkins, 2009)



Prevention

- Optimal latching prevents nipple pain
- Avoid artificial nipples for 4-6 weeks; bottle sucking at the breast hurts! Different tongue movements altogether
- Feeding often and on demand (early cues)
- Keeping mom and babies together whenever possible
- Avoid interventions that can interfere with suck or separate moms and babies
- Babies learn to breastfeed by breastfeeding!

Pacifier use

- Infants given pacifiers in hospital had twice the likelihood of developing breastfeeding problems by day three postpartum (Dewey et al. 2003)
- Exclusive BF @ 4 weeks less likely if with exposure to pacifiers (Howard et al. 2003)
- Delay/space feedings, decrease supply...
- Malocclusion, otitis media.



Supplements

- Supplements within first 48hrs increased risk of breastfeeding problems by day 3 & day 7 (Dewey et al. 2003)
- Supplements (bottle or cup) detrimental to BF duration (Howard et al. 2003)



What about limiting time at breast?

- As a method to “prevent nipple pain” this has 3 potentially harmful effects:
 - delays nipple pain vs. preventing it
 - short feedings can decrease milk transfer
 - mothers signal end of feeding vs. baby
 - breaking suction can increase pain and nipple damage (Riordan, 2005)



Risk factors for early nipple trauma

- Physiologic
 - Maternal
 - Infant
- The birth experience
- The postpartum period



Maternal issues that may predispose to sore nipples

- Nipple variations
 - Physical assessment important
- Physiology
 - Maternal history important
 - Raynaud's disease
 - Dermatitis
 - Diabetes
 - Predisposed to yeast infection



Infant issues that may predispose to sore nipples

- Oral anatomy
 - Short frenulum
 - Bubble palate
 - Pierre Robin
- Energy issues



Bubble palate

37-weeker football hold



Pierre Robin



Late preterm baby



Short frenulum

Figure 1.01

Lactation, 3rd Edition
Jan Morton
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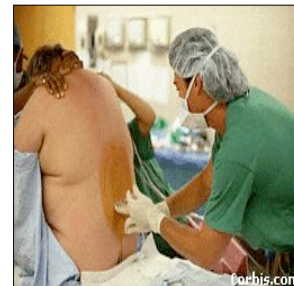
Short frenulum / tongue tie

- Srinivasan et al (BF Med 2008):
 - N=27
 - timely frenotomy and BF counselling significantly improved latch, pain and BF duration
- Geddes et al (Ped 2008):
 - N=24
 - nipple compression identified on ultrasound
 - Post frenotomy: < nipple compression, < pain, > milk transfer.
- Dollberg et al (J Ped Surg 2006):
 - N=25
 - RCT of frenotomy vs sham procedure.
 - Post frenotomy, <maternal pain (p=.001) and >latch (p=.06).

Frenotomy safe, simple and effective in alleviating limited tongue movement (milk transfer) and nipple pain.

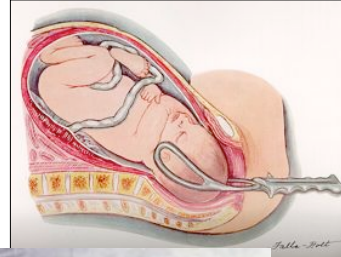
Labour and delivery practices may predispose to sore nipples

- Analgesia and anesthesia effects mother and newborn
 - Mother: slows progress of labour and effects readiness to BF
 - Newborn: decreases alertness, delays root / latch
 - Excretion longer in newborn – so effects last well beyond first few hours of life.
- Epidural analgesia can effect the newborn's early neuro motor and BF behaviour
 - See increased disorganization



The birth experience may predispose to sore nipples

- Labor interventions can affect prerequisites to BF
 - oropharyngeal coordination to latch and transfer milk from the breast
 - the ability to signal the need to feed
- Application of forceps and vacuum can disrupt bony structures, cause irritation and swelling, and affect nerve and muscle function
- All have the potential to affect the infant's ability to "coordinate" BF



Cesarean section may predispose to sore nipples

- Emergency C/S is considered a risk factor for BF difficulties
- Most stressful L&D experience
 - Stress interferes with oxytocin release and can delay lactogenesis
- BF patterns of CS mothers are different than SVD mothers
 - Significantly lower LATCH scores in C/S mothers (Cakmak, Kuguoglu, 2006)
 - L and C score lower at each assessment
 - CS mothers may require extra assistance to position infants and BF comfortably
 - LATCH scores increased over time
- Longer hospital stay associated with better BF outcomes



Practices during postpartum period may predispose to sore nipples

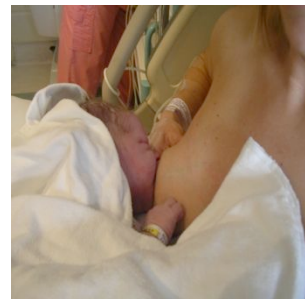


Community – Hospital - Community

“Best practice” during postpartum period

- The Basic Rules*
 - Skin-to-skin
 - Check the latch
 - Teach the “normals”
 - Trust the mother and baby

*Isabelle Cote – BFI Conference Oct 2010



STS

- What is best practice*
 - Immediately after birth until first BF
 - 60-90 minutes
 - Hands off, don't rush, let the baby latch independently
 - 8 to 12 hours per day during the postpartum period; safety issue!
 - 4 hours per day in the first 3 months
- Maximizes brain development, maternal newborn relationship and BF



*Susan Luddington – STS Conference Oct 8/10

So what does this all mean...

- Need to recognize “red flags” that have the potential to interfere with BF initiation and precipitate sore nipples
- But ... also recognize that most healthy normal newborns have the ability to latch and breastfeed well - despite “red flags”



Objective assessment of BF

- BF is not a single behavior but a series of behaviors from both the mother and baby
 - Elements of BF can be identified and assessed objectively
- Subjective assessment of BF (fair, well, poor) does not facilitate complete BF assessment
- Objective clinical assessment tool is useful to:
 - Identify and assess maternal and newborn components of BF
 - Identify early BF problems
 - Facilitate appropriate and timely intervention as required
 - Promote maternal education and self assessment of BF
 - Assist in determining discharge readiness from hospital
 - Facilitate communication among care providers across the care continuum

Objective assessment of BF with the LATCH-R Tool

- Many BF assessment tools available
- LATCH Tool designed by Jensen, Wallace and Kelsay in 1994 – to help nurses evaluate BF technique of both mother and baby
- Modeled on APGAR Score; score of 0 to 2 on 5 areas of BF assessment
- Research trial at HSC in 1995; accepted as standard of care for all BF families
 - addition of “R” - maternal responsiveness / confidence to BF
- LATCHR score at first BF and once/shift until discharge
- Continued use in the community to support BF duration

LATCH-R Intervention Guideline

- Intervention Guideline developed by HSC/WRHA to promote consistency in intervention, education and support
- Intervention based on individual components of LATCH-R score
- A component of the WRHA BF Practice Guideline
- Available on WRHA website:
 - <http://www.wrha.mb.ca/healthinfo/prohealth/womenshealth.php>

L=Latch at breast

L=2



Intervention
Reinforce good latch
and position

L=1



Intervention
Assist with optimal latch
Reinforce importance of
gums over areola

L=Latch expectations

All of the following criteria are met:

- Baby's gum line is over lactiferous sinuses and not on nipple area
- Both lips are flanged outward
- Tongue is positioned under areola (can be assessed through sublingual palpation)
- Adequate suction is demonstrated by full cheeks, no dimples (which indicate a break in intraoral suction)
- Rhythmic sucking occurs with a sustained latch and sucking occurs in bursts

A=Audible swallows

A=2



Intervention

Educate about realistic expectations for frequency and indications of swallowing

A=Audible swallows expectations

All of the following criteria are met:

- Swallowing is a necessary part of every breastfeeding
- Is seen as a “wide open” pause
- Is heard as a short forceful expiration of air
- Is spontaneous and intermittent if baby <24hr of age
- Is spontaneous and more frequent if baby >24hr of age
- As milk volume increases (3-4 days after birth), the suck-swallow ratio is 1 – 2 per second

T=Type of nipple

T=2



Intervention:
None required.
Ensure baby learns to suckle on mothers breasts.

T=1



Intervention:
Mother may require assistance with position and latch.
Ensure baby learns to suckle on mother's breasts.

T=0



T=Type of nipple expectations

All of the following criteria are met:

- Nipple / breast assessments are completed to promote the baby's ability to achieve an adequate latch
- Interventions to support latch occur when nipple deviations interfere with optimal latch

C=Comfort of breast / nipples

C=0



Intervention
Ensure proper latch
and position
Strategies to heal nipple

Intervention
Ensure appropriate care
for mastitis
Care to ensure optimal breast
drainage

C=Breast/nipple comfort expectations

All of the following criteria are met:

- Nipple / breast assessments are completed to assess / ensure comfortable latch
- Promote optimal latch and effective breastfeeding to prevent sore nipples and promote breast health
- Interventions to promote nipple and breast comfort / health occur

H=Ability to independently hold baby

H=2



Intervention
Reinforce aspects of cross cradle hold
Congratulate for independent hold and position

H=0,1



Intervention
Assist as necessary
Work towards independent positioning

H=Hold/positioning expectations

All the following criteria are met:

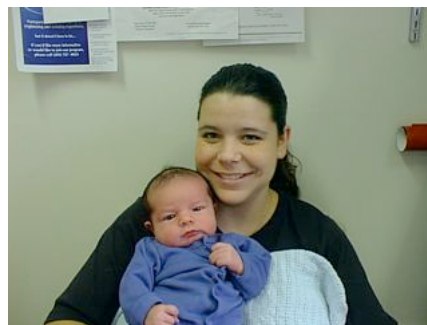
- The mother is able to independently position and latch her infant to ensure effective breastfeeding.
- The baby should be well supported at breast level
- The mother should be in a comfortable position during breastfeeding



Figure 1. Breast stabilization with towel roll. Use of a towel roll to stabilize the breast during feeding and reduce traction on Cooper's suspensory ligaments. Note the enlarged, flattened areola.

R=Maternal responsiveness / confidence

R=2



Intervention

Reinforce success with breastfeeding

Congratulate confident mothering

R=Maternal responsiveness expectations

All of the following criteria are met:

- Mother responds appropriately to early infant feeding cues
- Mother feels confident about her ability to breastfeed

LATCHR score predicts BF duration

- Kumar, Mooney et al **2006**;
 - LATCH score of >9 in first 24 hours was associated with women who were 1.7 times more likely to be BF at 6wks
- Riordan, Bibb, Miller, Rawlins **2001**;
 - Reviewed LATCH score at 24 hours, mother's feeding evaluation, intended duration of BF and BF at 6 weeks pp
- Results:
 - Mothers score correlated with HCP score (p=.003)
 - LATCH score correlated with BF at 6 weeks (p=.003)
 - "C" score was significantly lower in mothers who weaned (p=.05)
- Nipple pain important assessment criteria; predictive of BF duration
- LATCHR tool – enhances maternal education / self assessment

LATCHING 101



c/o Dr. Jack Newman

How to achieve a good latch

- Cross cradle is easiest for most mothers: “tummy to mommy”
- Mother pushes in with side of her forearm
- Hand palm up *under* the baby’s face
- Baby’s head free to tilt back in space between thumb and index



c/o Dr. Jack Newman

How to achieve a good latch

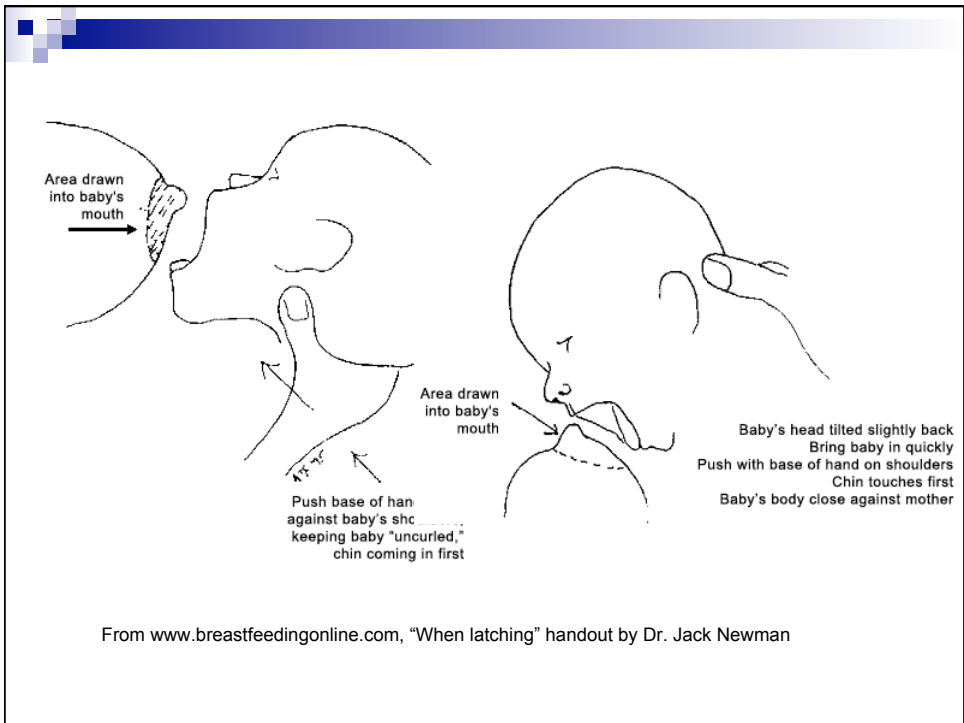
- Nipple *automatically* will point to the baby's upper lip or nose to nipple.



How to achieve a good latch

- Mother runs nipple along upper lip from one corner to the other (or runs baby's upper lip along nipple)
- Waits for the wide gape (wide-open mouth) ;
160-180 degrees, tongue down
- Brings baby *straight onto the breast, chin first*







c/o Dr. Jack Newman



c/o Dr. Jack Newman

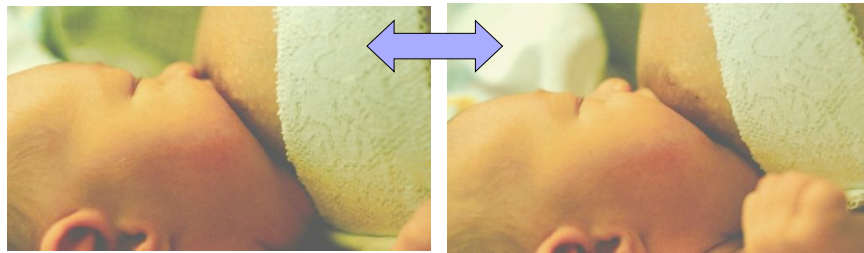
What is a good latch?

Asymmetrical Latch

- Baby's chin touches the breast.
- Baby's nose does *not*.
- Baby covers *more* of the areola with lower lip than with upper lip.
- More of the areola shows above
- Lips are flanged



Asymmetric works better!



c/o Dr. Jack Newman

Asymmetrical latch

- Off centre technique
- Maximizes contact of tongue under nipple
- Large surface contact for milk compression and tongue peristalsis
- Head is flexed back to optimize jaw dropping
- Deep breastfeeding *not* shallow nipple pinching
- Less chance of nipple abrading



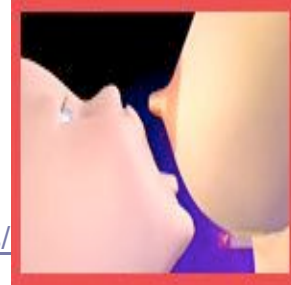
Signs of a good latch

- Cheek is smooth and not dimpled
- No clicking sounds
- Rocker motion of jaw vs. up and down
- After infant releases nipple:
nipple is not misshapen, abraded,
fissured, bruised or blanched
- Mother reports no pain!



Movie clips

- http://www.ameda.com/breastfeeding/started/latch_on.aspx
- <http://users.iptelecom.net.ua/~vylkas/kinolatch.html>
- <http://www.kellymom.com/bf/start/basics/latch-resources.html>
- <http://www.breastfeedingmadesimple.com/animatedlatch.html>



Shallow latch



c/o Dr. Jack Newman

Shallow latch



c/o Dr. Jack Newman

Better latch
But not perfect



c/o Dr. Jack Newman

Assessment and diagnosis of sore nipples

Assessment includes:

- Pain: intensity, timing, duration
- Nipple appearance:
 - Red, cracked, blistered and/or bleeding
 - Location of trauma can indicate source of pain
 - Cracks are usually on the end of the nipple
 - Baby on nipple instead of areola
 - Gums compress nipple rather than milk duct
 - Tongue causes nipple pain
- Shape of nipple after BF
 - Compression stripe - lipstick vs chapstick
- Milk supply/transfer will be affected by nipple pain



LATCHR Assessment

Infant assessment:

- L=Latch: score 0-1
 - Shallow or ineffective latch
 - Tongue not palpable under breast
- A=Audible swallows: score 0-1
 - Inadequate swallows seen / heard
- Results in decreased intake and weight loss if not assessed early



versus



LATCHR Assessment

Maternal assessment:

- C=Comfort: score 0-1
 - Pain with latch and after feedings
 - Obvious nipple trauma
 - Milk transfer / production affected
- H=Hold/position: score 0-1
 - Often not aligned or close enough to breast
- Results in pain, nipple trauma and decreased milk supply if not assessed early



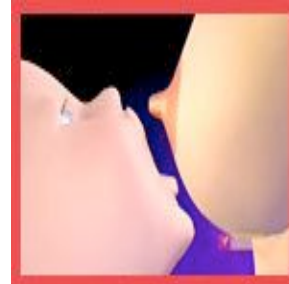
versus



Early Sore Nipples

Strategies:

- Fix the latch – teach optimal position and latch at the breast
- Asymmetric latch positions the nipple at the junction of the hard and soft palate
- Should result in comfortable BF despite early nipple trauma
- Then promote nipple healing



What if you cannot “fix the latch”?



■ Ask why?

- Infant anatomy / physiology
- Maternal anatomy / physiology
- Perinatal events
- Can contribute to poor latch and minimal intake at breast
- Can result in weight loss and insufficient energy to latch / BF nutritively
- Milk supply will be affected

■ Rx: Tincture of time

- Support infant nutrition and maternal milk supply
- Most babies will eventually BF effectively if nutritional status is maintained and milk supply optimized!

Can we help a baby latch?

- If latch is not achieved due to nipple variations, the following strategies or devices may assist:

- Breast shells: recommendations inconsistent as nipple variations will change with pregnancy and BF
- Manual stimulation / breast pumps: to evert nipples pre feedings
- Nipple everter syringe: used for 30-60 seconds pre BF to evert nipples



Latch assistance

- A **silicone nipple shield** is an *option* to consider if baby cannot attain / sustain latch
- Triggers the suck reflex through stimulation of the palate
- Remains in the correct position within the infant's mouth in the absence of strong suck pressures
- Therefore can increase sucking and volume of milk transferred
- An option when other strategies tried with little progress
- Involvement of BF specialist required



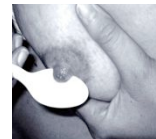
Latch assistance

- Any devices used to assist latch should be initiated with the goal of being a short term strategy while efforts are made to get baby to breast
- Babies learn to breastfeed by breastfeeding
- Most babies will learn to latch regardless of nipple configuration or early issues - therefore keep trying



Treatment for sore nipples from early trauma

- Intact dry skin is protective against infection!!
- Application of breast milk (EBM) / colostrum can treat sore nipples with minimal trauma
- EBM milk contains immunoglobulins which have been associated with prevention of infection and nipple healing (Akkuzu & Taskin, 2000).
- Mothers can be encouraged to hand express and massage a few drops of colostrum to their nipple and areolar area.



Treatment for sore nipples from early trauma

- What about lanolin preparations?
 - Prospective clinical trial compared highly purified anhydrous (HPA) lanolin vs EBM in mothers with nipple trauma (n=84) (Abou-Dakn, Fluhr, Gensch, Wockel, 2011).
 - Evaluated nipple trauma, pain and healing on Day 3, 7 and 14
 - Results on Day 7:
 - Significantly lower pain scores in HPA group (p.03)
 - Significantly less trauma on in HPA group (p.02)
 - Significantly faster healing (intact skin) within 3 days of treatment in HPA group
 - Twice as many mothers stopped BF by 14 days in EBM group
 - Conclusion: HPA lanolin is more effective and acts more rapidly than EBM alone in terms of healing nipple trauma and reducing pain
 - Creates a beneficial moist healing environment.
 - Mothers experiencing sore nipples from trauma in the early postpartum period can therefore be encouraged to apply a small amount of HPA lanolin after each feeding.
 - It is not necessary to remove HPA lanolin before the next feeding.



Treatment for sore nipples from early trauma



- Literature to support the therapeutic use of warm compresses and tea bags presents a mixed message
 - Mother's reports warm compresses are soothing and do relieve nipple pain; warm tea bags have similar effect (but onerous to use)
 - Reason for effectiveness is vasodilatation from warmth and not effectiveness of device
- Dodd, Chalmers (2002) evaluated hydrogel dressing vs lanolin to prevent nipple soreness (n=106)
 - Significant decrease in pain scores in gel pad group (p.0001) at Day 10 & 12
 - Days of use 32 vs 42 days (p<.0089)
 - Conclusion – safe and effective with ongoing education
 - Funded by manufacturer
- Glycerin-based hydrogel dressings have been associated with increased breast infections (Brent et al, 1998); applied to traumatized nipples
- Recommendation; careful use for early treatment of normal nipple soreness; should not be used on nipples with cracks, trauma (Morland-Schultz & Hill, 2005)

Later causes of sore nipples

Early and ongoing nipple trauma can predispose to infection

- Bacterial infection of breast and nipple
 - Mother symptomatic (feverish, ill)
 - Discharge of pus from nipple
 - Etiology is usually staph aureus
 - Requires antibiotic treatment
- Yeast infection of breast and nipple
 - Myriad of maternal and infant symptoms make diagnosis challenging
 - Characteristic burning shooting nipple / breast pain
 - Nipples bright pink with circular cracks at base of nipple
 - Or can be no outward signs at all!



Is it yeast?

- *Candida albicans* is an opportunistic pathogen lives in harmony with other organisms most of time
- Likes warm moist environments and sugar
- Damaged lactating breast perfect environment
- Precipitating factors include:
 - Antibiotics, oral contraceptives, steroids
 - Soothers, supplemental feeds
- Maternal and newborn presentation can include a wide array of physical complaints and infant behavioral issues



Figure 170
Breastfeeding and Infant Care, 2nd Edition
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Is it yeast?

- CANDEX Research Study (Kluka, Hamelin, Romphf)
 - Goal - to correlate symptoms with positive yeast culture
- Asked symptomatic mothers to complete symptom index tool (CANDEX)
- Swabs taken for culture from the mother's breast tissue, breast milk, infant's mouth, and diaper area.
- Results - laboratory analysis (including molecular detection techniques) confirmed that very few of the samples were positive for yeast.
- Current research has added to this debate – are these symptoms due to yeast or another organism (such as *Staphylococcus aureus*)
 - Andrews, Fleener, and Messer (2007)
 - Hale, Bateman, Finkleman and Berens (2009)

So how do we treat these symptoms?

- When mothers report intense burning nipple pain or other symptoms that may be associated with yeast, **we need to preserve BF!**
- Current practice is initial treatment with a nipple cream containing both anti fungal and anti bacterial components.
- Mothers are advised to apply the cream after every BF until pain subsides and then to reduce the frequency of application until nipple pain is resolved.
- If these symptoms are actually bacterial in origin (as the literature now suggests) resolution of nipple pain may be from the antibacterial rather than antifungal component
- Treatment options:
 - Canestan:Fucidin 1:1
 - Viaderm and APNO both contain an anti-inflammatory component
 - Decreases inflammation / irritation (often the cause of the pain)
 - No time limit on application – but wean from use ASAP and if a new irritation occurs

Treating yeast symptoms

- **Gentian violet:**
 - Potent germicide that destroys candida albicans
 - Is absorbed deeply into dermal layer
 - Used to be routine treatment for oral thrush
 - Often provides immediate pain relief
 - 0.5% to 1% GV available OTC
 - Paint mother or baby or both once a day for 4 to 7 days



What about intraductal yeast???

- If topical treatment not effective and mother reports intense shooting, throbbing breast pain, is systemic treatment the next option?
- Current recommendation: oral Diflucan for 2 to 4 weeks
 - stops candida from multiplying (does not kill organism)
 - May take several days to feel difference
 - Small amount in milk to clear intraductal yeast; safe for baby
 - Side effects: liver issues most serious but rare
 - Expensive!!
- If effective, continue with full dose and then wean
- If not effective, what a dilemma!

Raynaud's disease and nipple pain

- Severe throbbing pain despite good latch
- Often misdiagnosed as yeast
- Nipple blanches (turns white) after BF; then a classic triphasic color change occurs (white to blue to red)
- Temperature change may trigger vasospasm
- Other predisposing factors include smoking, alcohol and caffeine intake, emotional stress and some medications
- Clinically associated with Migraines
- Treatment: Nipeditpine
 - vasodilator; safe during BF
 - Morina & Winn, 2007; Anderson et al. 2004



Nipple pain due to a plugged nipple pore

- White dot, bleb or cyst on nipple tip
- Blocks the terminal opening of one or more lactiferous ducts
- May be caused by scar tissue or callous over area of nipple irritation / injury
- Or may be associated with plugged duct
 - Milk stasis results in thickened/stringy milk which plugs pore
- Pain is intense during BF as pressure builds up plugged pore
- Bleb/cyst increases in size during BF



Figure 9.11
Breastfeeding and Infant Nutrition, 2nd Edition
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Treatment for plugged nipple pore

- Open the pore to relieve the pressure
 - Warm soak to dilate duct / pore and soften skin
 - BF with optimal attachment; baby may pop pore
 - Hand express to remove strings of milk if necessary
 - Pore may need to be opened with sterile needle
- Often reforms; mothers needs instruction to deal with at home
- Nipple cream to prevent infection
- Ask why?
 - Anticipatory guidance if related to plugged duct
- Lecithin supplement to decrease PUFAs in milk (makes milk less viscous/sticky)
 - For recurrent plugged ducts/nipple pore
 - 1200 mg QID



Other causes of nipple pain

Dermatitis

- Can effect any skin including breasts
- Can be caused external or internal allergen
 - Ask what nipple ointments being used
- Eczema presents with redness, oozing, crusting; usually on both breasts
- Treatment is topical steroid
- Need to rule out Herpes if actively oozing lesions present; BF interrupted until lesions heal
- If eczema on just one nipple, need to rule out Paget's disease
 - Superficial manifestation of breast cancer



Eczema



Herpes



Paget's Disease

Resources for the prevention, assessment and treatment of sore nipples

- Prenatal teaching:
 - Most mothers make infant feeding decisions before babies arrive
 - Crucial time for informed decision making
 - Education to prepare clients to get a good start
- Step 10 of the BFHI is to:
 - Refer mothers to breastfeeding support, including public health services and support groups to foster continued BF support in the community

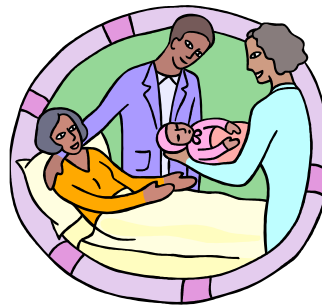
Canadian Medical Association

- Structured antepartum BF education is effective at improving both BF initiation and continuation (2 months pp, compared with usual care)
- Individual or group instruction provided by lactation specialists or nurses is effective: ↑BF knowledge, practical skills and problem-solving
- Single and/or multiple sessions effective
- Postpartum telephone or in-person support by lactation specialists, nurses or peer counsellors enhance these interventions
 - 15 studies reviewed by The Canadian Task Force on Preventive Health Care (Palda et al. 2004)



Canadian Medical Association

- Providing written materials alone does not effectively promote breastfeeding



Community BF support in Winnipeg

- Drop-in professional and peer support to BF
- One per 2 community pairing
- Available 7 days per week



Access River East, 975 Henderson Hwy, Phone 938-5000

Monday (except Holidays) 1:30-2:30 pm individual consultations
Breastfeeding support group 1:30-3:30 pm

St. Boniface/ St. Vital 6-845 Dakota Street, Phone 255-4840

Tuesday (except Holidays) 1:00 – 3:00pm individual consultation
Breastfeeding support group 1:00-3:00 pm

Fort Garry/River Heights 1155 Wilkes, Phone 940-2015

Wednesdays (except Holidays) 1:00 – 3:00 pm individual consultation
Breastfeeding support group 1:00-3:00 pm

Inkster/Seven Oaks - 3-1050 Leila, Phone 938-5607

Thursdays (except Holidays) from 1:30-2:30 pm individual consultation
Breastfeeding support group 1:30-3:30

Women's Hospital Breastfeeding Clinic - 735 Notre Dame, Phone 787-1166

Thursday from 1:00 – 3:00pm individual consultation

St. James/Assiniboine South; 2015 Portage Avenue, Phone 940-2040

Friday (except Holidays) 9:00-10:15 am individual consultation
Breastfeeding support group 10:00-11:30am

“Breastfeeding Buddies” 870 Portage Avenue, Phone 940-6669

Support Group Wednesdays 10:00 – 11:30am

Community BF support in Manitoba

- **Provincial Breastfeeding Hotline**
 - Within Winnipeg 1-204-788-8667
 - Toll free long distance in Manitoba 1-888-315-9257
 - 24 hours per day, 7 days per week
- **Mother Risk**
 - Phone 1-416-813-6780
 - Information on safety of medications and products during pregnancy and breastfeeding.
- **Winnipeg La Leche League - Phone Support and Groups – Manitoba Ph. 257-3509, www.LLLC.ca**
 - Mother to mother support
 - Phone support and groups.



<http://www.gov.mb.ca/healthyliving/nutrition/breastfeeding.html>

Comments and questions?



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