Postal Registration No. TN/CH/(C)/59/2023-2025
Registered News Paper Posted at Egmore R.MS. Patirika Channel.
Licensed to post without prepayment TN/PMG/(CCR)/WPP-500/2023-2025

RNI NUMBER : TNENG/2004/14197
RDISNo. 6342/98

Medi Quest BRS Hospital

A monthly News letter from BRS Hospital

MATERNAL ISSUES IN BREAST FEEDING

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Price Rs. 5/- Only

March - 2025

Medi - 20

Quest - 03

Yearly Subscription

Rs 50/- only

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The following problems in the mother is common ground between the Pediatrician and Obstetrician which comes as an obstacle to successful breast feeding .

1. Nipple Sensitivity
2. Sore Nipples/Nipple Injury
3. Areolar Dermatitis
4. Candidal Infection of the Nipples
5. Infant Biting the nipple
6. Breast Engorgement
7. Plugged Ducts
8. Galactoceles
9. Breast Infections (Bacterial)

a. Lactational Mastitis
b. Breast Abscess

1.Nipple Sensitivity

Differentiate sore nipples from nipple sensitivity

Normal nipple sensitivity

Nipple sensitivity is usually limited to the first few suckles of the feed and is thought to be related to the negative pressure on the duct that have not yet filled with milk
The latch on pain should not persist throughout the whole feeding and should resolve completely after the first week or two.

2.Sore Nipples due to Nipple injury

Nipple pain due to trauma persists at the same or an increasing level throughout the nursing episode. Severe pain that extends beyond the first postpartum week is more likely due to nipple injury.
Nipple injury is due to
1.Incorrect breast-feeding technique
Poor position or latch on incorrect position
2.Tongue tie in the neonate

General management:

Prevention:
1. The most effective techniques for preventing nipple trauma are proper positioning and latch of the infants.
Anticipatory guidance should be given regarding prevention of breast engorgement.
Engorgement interferes with latch on leading to nipple injury
Conversely
Nipple pain leads to poor extraction of milk resulting in engorgement
2.Identifying tongue tie in the infant.

Care of traumatized nipple

Mother nurses on unaffected side
Consider pumping and giving EBM
If the is nipple cracked, an antibiotic ointment like Mupirocin applied and non stick pad is used to cover affected area

Check for candidal infection and culture drainage if present.

Treatment :
Warm or cold compress with pain killers.
Nipple pain decreases by 7-10days whatever the intervention.

3.Areolar Dermatitis

Eczema can present as red scaly rash . Management, use medium potency steroids. Remove visible topical agents before breast feeding . EBM applied before feeds will be effective in their removal .

4. Candidal infection

Many women are diagnosed with a candidal infection with the complaint of sore nipples, especially when these symptoms occur in association with infant thrush and breast pain out of proportion to physical findings, which include shiny or flaking skin of the affected nipple.

Treatment :
Topical miconazole or clotrimazole. Topical ketaconazole should be avoided in due to potential hepatotoxicity for the infant
Prior to each feeding remove residual medication using (olive oil or coconut oil) rather than soap and water which can irritate the nipple
Remove and reapply after each feeds
Refractory symptoms can be treated with oral fluconazole

5.BITING
Due to natal teeth : advised removal.

Due to eruption of decidual teeth : Keep infant close to breast while feeding with mouth wide open which prevents baby`s latch from becoming shallow on the nipple

If biting occurs at end of feed :
The most effective thing one can do is to calmly remove the baby from the breast (with little finger) and say something like “no biting.” Stop nursing immediately and remove the little biter for a few seconds or a few minutes (mother needs to be the judge of how long is best.) If he really wants to keep nursing, he'll be upset and the mother can give him another chance. If he wasn't really that interested in nursing, he may just start playing with toys.

What NOT to do if baby bites:
NEVER scream or yell. This is the most important thing to do and is of course hard. Many babies are so scared of yelling that they go on a nursing strike . Screaming or yelling will not stop baby biting – it will only cause problems. Often his feelings will be hurt and he will begin to cry. This is negative reinforcement and is not effective.

6.Breast Engorgement

Engorgement occurs from interstitial edema with onset of lactation after birth, or at the other times during lactation with accumulation of excess milk due to a mismatch between production and extraction.

Clinical Manifestations :
Breast fullness, firmness, accompanied by pain and tenderness.

Among mothers the affected area varies with primary areolar involvement or more peripheral involvement, and in some a combination of two. Systemic signs are not prominent.

Management
Effective management hinges on adequate removal of milk.
If areola is involved manual expression of small amounts of milk before the feeding will soften the areola and facilitate latching

Hand expression is accomplished by placing the thumb and fore fingers well behind the areola toward the chest wall and then compressing them together and toward the nipple in a rhythmic fashion.
Applying warm compression may facilitate expression.

7.Plugged ducts

Localised areas of milk stasis clinically manifest as painful palpable lumps without systemic findings.

Management

Optimize feeding technique
Emptying the breast is the most effective manner to open the blockage and drain area of congestion
Pumping or hand expression after the feeding may improve clearance
Mothers should be counselled not to stop breast feeding
Manual massage from affected area towards nipple to try remove the blockage

8.Galactoceles

Galactoceles are milk retention cysts that result from a blocked milk duct. They present as cystic swelling, they are usually painless if not infected

Management

In mothers with diagnosis of galactocele repeated aspiration or surgical excision if necessary only if it bothers the mother.
Breast feeding generally can continue during aspiration or excision

Breast infections

9.Lactational Mastitis

Localised inflammation of the breast that is associated with fever, myalgias, breast pain and redness.
It is most common first 6weeks post-partum. It occurs in the setting of prolonged engorgement or poor drainage

Treatment

NSAIDS, cold compresses, complete emptying of breast (breast feeding, pumping and or hand expression) cessation of lactation not required.

These measures with administration of antibiotic therapy with activity against S.Aureus.

(Cephalexin 500mg QID, Clindamycin 450mg TDS)
The optimal length of treatment not certain 10-14 days reduce risk of relapse . A shorter course of 5-7 days can be used if the response to therapy is rapid and complete.
Lactional mastitis if not checked leads to breast abscess.

10.Breast Abscess

Patients with primary breast abscess present with localized, painful inflammation of the breast associated with fever and malaise, along with a fluctuant, tender, palpable mass. The time course is variable; mastitis and abscess may present concurrently or abscess may develop 5 to 28 days following treatment for mastitis .

The diagnosis of breast abscess should be suspected based on clinical manifestations (localized inflammation of the breast associated with fever and a fluctuant, tender, palpable mass). The diagnosis may be confirmed via ultrasonography demonstrating a fluid collection. Ultrasound imaging may be used for guided aspiration of the collection

Treatment:

Antibiotics, needle aspiration or surgical drainage. In the setting of lactational infection milk drainage either by breast feeding or pumping is important for resolution of infection and relief of discomfort.

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Owned and Published by Dr. Madhusudhan 28, Cathedral Garden Road,Chennai - 34.
Printed by S. Baktha at Dhevi Suganth Printers 52, Jani Batcha Lane, Royapettah, Chennai -14.
Publication on : Final week of every month posted on 29.03.2025