Nipple Pain and Breastfeeding

- Up to 90% of nursing mothers experience nipple pain at first.
- Tugging and pulling is common.
- Pinching, sharp pain or more than "mild tenderness" is likely from an incorrect latch.

Causes of nipple pain

1. Poor latch is the most common cause of nipple pain.
2. Plugged milk duct on the nipple / bleb / blister
3. Nipple vasospasm
4. Infection of the nipple: Yeast and/or Bacteria
5. Eczema on nipple

GENERAL MANAGEMENT OF NIPPLE PAIN

Pain meds: Ibuprofen or Tylenol

Breast pads: Use disposable or washable. No plastic lining.
Hydrogel pads (Soothies/ComfortGel) should be cleaned after each use and replaced every 3 days.

Pump: -If pain is unbearable, pump in place of nursing until trauma heals.
-Be sure the pump flange is the proper size. It should be large enough so the nipples don't rub on the inside of the tunnel.
-It should be small enough so that not too much breast tissue is sucked into the tunnel.
-Suction strength should be strong but comfortable.

Shield: -These are usually used for babies who refuse to latch, but it might alleviate latch pain until nipple trauma heals.
-Don't allow baby's mouth to slide on and off the shield while nursing.

Topical treatment:

- Allow breastmilk to air dry on nipples, as antibodies help healing.
- Lanolin can be used to prevent dryness.
- Medicated creams can promote faster healing of traumatized nipples as the latch is corrected.
  - "**Triple Nipple Cream**" is a mixture of prescription strength antibiotic, antifungal and steroid cream that requires compounding at a pharmacy. It is sometimes expensive and difficult to obtain in a timely manner.
  - Individual over the counter creams will work just as well as the prescription mixture.
    Clotrimazole (antifungal) cream
    1% hydrocortisone (steroid/anti-inflammatory) cream
    Bacitracin (antibacterial) ointment

The creams can be mixed together in equal amounts. The ointment doesn't mix well with the creams, so can be applied separately at alternating times.

  - Instructions: Apply a VERY SMALL AMOUNT only to the affected part of the nipple.
    Rub in gently and completely. Do not wipe off even if baby goes right back to breast.
    Decrease use as nipples feel better after 2-5 days.

Latch concerns: -Get help with latch technique and positioning baby.
-Ask for an assessment for tongue tie if technique is good but pain persists. A simple procedure might help.
-Before unlatching baby, break the suction/seal by putting your finger into the corner of baby's mouth.

Nipple vasospasm / decreased blood flow

Symptoms of vasospasm:

- When nipple pain persists even though latch technique appears correct and there is no obvious trauma to the nipples, vasospasm may be the issue.
- Typically the nipples throb, burn, and turn white and/or red or purple when cold air contacts wet nipples when baby unlatches.
- Pain also occurs when NOT breastfeeding, such as when mom opens the refrigerator door or goes outside into the cold.

Two common *misdiagnoses:*

1. A painful white ridge may form on the nipple from a poor latch. This is not from vasospasm.
2. A nipple yeast infection may burn. If treatment for yeast fails, consider vasospasm.

Management of vasospasm:

- Keep a heating pad nearby to quickly cover the nipples upon unlatching.
- Keep breasts/nipples warm by wearing warm clothes, wool breast pads and nurse in a warm place, such as under a blanket.
- Avoid caffeine and nicotine, as they constrict blood vessels.
- For severe symptoms, ***Nifedipine*** can be considered. It is a "heart drug" used to treat hypertension, angina and arrhythmias. It dilates blood vessels and increases blood flow to affected areas. It is effective and safe to use while nursing, but drug treatment is a last resort for intolerable symptoms that don't improve with other options.
  Dosing is 5mg 3 times per day or a 30mg slow-release tab daily. Take for 2 weeks. A 2nd or 3rd course may be needed and some may need treated until nursing is stopped.
  Side effects include headache, dizziness, low blood pressure, flushing and fast heart rate.

Anderson JE, Held N, Wright K. Raynaud's phenomenon of the nipple: a treatable cause of painful breastfeeding. Pediatrics 2004; 113: e360–e364.

Plugged nipple duct / milk blister / nipple bleb

- Skin cells or a fatty substance plugs the milk duct opening on the nipple, leaving a very painful small white pimple, blister or bleb on the nipple.
- Since milk can't get out, it pools in the milk ducts in that area of the breast and can become infected.
- Milk supply may decrease since the milk cannot be removed.
- Management:
  - Soften the "bleb" with a warm compress and lift it up with a sterile needle.
  - Massage the breast to empty out the pooled milk, which may squirt out under pressure.
  - If this issue recurs, it may help to decrease the suction strength when pumping.

Eczema (dermatitis)

- Mothers with eczema are prone to outbreaks on their nipples during breastfeeding.
- Nipples may be itchy, painful and burn.
- A red rash may suddenly appear with later oozing, crusting and open sores.
- A chronic rash may appear red, dry and scaly. Yeast and bacteria can enter open areas and cause secondary infection.
- **Treatment:** Steroid cream, antibiotic and/or antifungal cream, as prescribed by a healthcare provider.

Yeast infection (Candida Albicans)

- Yeast is normal in moist areas of the body but will sometimes overgrow and cause symptoms.
- It is very contagious, and may cause thrush in baby's mouth, yeast diaper rash, vaginal yeast infection in mom, nail infections, "jock itch," and yeast infection of the nipples. Continue to nurse through a yeast infection.
- Milk pumped during a yeast infection is OK to store and for baby to drink.

NIPPLE YEAST INFECTION: Burning, shooting nipple pain which sometimes radiates through breast.
Nipples are itchy, flakey, red, puffy, shiny, perhaps with a pink rash with small blisters or white spots.

PREVENT SPREAD of yeast:

- Toys, pacifiers, nipple shields, bottles, pump parts, and other things in contact with baby or nipples should be boiled for 1 0 minutes daily or washed in the dishwasher.
- Use disposable paper towels when possible and wash bath towels after EACH use.
- Wash cloth diapers, breast pads, and bras in hot soapy water. Add 1 cup of vinegar to rinse water. Iron them or dry in a hot dryer.

TREAT NIPPLES AND BABY'S MOUTH AT THE SAME TIME!

Nipples:
- *Clotrimazole* 0.1% cream (OTC) after nursing until resolved OR
- *Fluconazole* 400mg tab x1, then 100mg tab twice per day by mouth for at least 2 weeks or until pain resolves. (prescription needed)

Baby's mouth:
- *Nystatin suspension* 1ml painted in mouth 4 times per day for 2 weeks and until no visible thrush for 2-3 days. (prescription needed)

Gentian Violet 0.5% for 3-4 days will treat baby's mouth AND mother's nipples (OTC)

1. This is VERY MESSY and stains skin and clothing. Undress baby to the diaper.
2. Apply *Vaseline* to the outside of baby's mouth and lips (to keep them from staining purple).
3. Dip a *Q-tip* in **0.5%** *Gentian Violet* and let baby suck on it. Paint areas inside the mouth that didn't turn purple.
4. Nurse both breasts and nipples will turn purple. Paint nipples with a swab to completely cover.
5. Purple will disappear after a few days.
6. If mouth sores occur, stop treatments. Sores should go away within 24 hours.

Bacterial infection

- When nipple pain and trauma fail to improve despite management discussed above, there may be an underlying bacterial infection that warrants treatment. Recent studies show that about 50% of nursing mothers with deep breast or nipple pain will culture positive for staphylococcus aureus bacteria on the nipples.
- Continue to nurse through a bacterial infection.
- Some experts recommend treating mom with oral antibiotics for 4-6 weeks because it is much more effective in reducing pain than topical ointments and can reduce the risk of developing mastitis.

  Specifically, in a prospective cohort study of 84 nursing mothers with cracked, sore nipples, there was a 79% improvement with oral antibiotics, as compared with a 16% improvement with topical mupirocin antibiotic alone. All patients improved with antibiotic use regardless of the presence of S. aureus or not, so it appears that the anti-inflammatory properties of the antibiotics may have also played a role in improving the symptoms of these nursing mothers.

  Eglash A, Plane MB, Mundt M. History, physical and laboratory findings, and clinical outcomes of lactating women treated with antibiotics for chronic breast and/or nipple pain. J Hum Lact 2006; 22: 429–433.

Treatment options for bacteria:

Mupirocin 2% ointment after nursing until resolved (prescription needed)

Oral antibiotics: *Cephalexin* 1000–1500 mg/d
Augmentin 1000–1500 mg/d
Dicloxacillin 750 mg/d
Treat 2 weeks, preferably 4–6 weeks.