Nipple Pain and Breastfeeding

- Up to 90% of nursing mothers experience nipple pain at first.
- Feeling tugging and pulling is normal.
- 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. Yeast infection of nipple
5. Bacterial infection of nipple
6. Eczema on nipple
7. Psoriasis on nipple
8. Herpes Simplex Virus on nipple (do NOT nurse)

General management of nipple pain
- Ibuprofen or Tylenol
- Spread breastmilk over the nipples and air dry (antibodies in breastmilk help healing).
- Use disposable or washable breast pads. Avoid plastic lined breast pads as they retain moisture.
- Hydrogel pads:
  - Soothies (Lansinoh) or ComfortGel (Ameda)
  - Place on nipples after nursing.
  - Replace at least every 3 days.
  - Clean with soap and water after each use.
- The pump flange size should be large enough that the sides of the nipple do not rub on the inside of the barrel during suction.
- Pump in place of nursing until pain is under control and nipple trauma has healed if pain is unbearable.
- Lanolin cream is commonly used as preventive care.
- Although controversial, judicious use of creams on the nipples can help traumatized nipples heal faster as the latch is corrected.
- An example is called “Triple Nipple Cream,” (prescription required) which has 3 ingredients.
  - The antibiotic and antifungal removes bacteria and yeast to promote faster healing.
  - The steroid component calms inflammation and thus lessens pain, but if used for too long, can cause thinning of the skin.
  - Cream should be applied in very small amounts after nursing and rubbed in gently.
  - Do not wipe off even if baby goes right back to breast.
  - Gradually decrease use as nipples feel better after 2-5 days.

A poor latch is the most common cause of nipple pain/trauma
- Latch technique is discussed elsewhere.
- Severe soreness, blisters, cracks or bleeding should prompt a latch assessment.
- Consider tongue tie if technique is good but latch pain is persisting. A tight web of tissue under the tongue may restrict tongue movement, and clipping the extra tissue might help.
- “Break the seal/suction” when unlatching by sticking your finger into the corner of baby’s mouth.
- Help the milk “let down” before latching to the sore nipple by massaging the breast first.

- First nurse on the less sore side until milk lets down, and then switch.
- Allow time for the nipples to heal by pumping instead of nursing for a day or two.
- If using a nipple shield, make sure baby latches deeply and doesn’t slide on and off the shield.

Plugged nipple duct / milk blister / nipple bleb
- Skin cells or a fatty substance plugs the opening of a milk duct 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.

Nipple vasospasm / decreased blood flow
- 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.
- Note these 2 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 warm environments 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.


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Nipple Pain

Yeast infection (Candida Albicans)
- Yeast is normal in moist areas of the body but will sometimes overgrow and cause symptoms.
- It spreads easily and is very contagious.
- The baby may have thrush in the mouth and a yeast diaper rash, while mom has a vaginal yeast infection 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.

SYMPTOMS of nipple yeast infection:
- Burning, shooting nipple pain which sometimes radiates through breast.
- Nipples itch and are flakey, red, puffy, and 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 10 minutes daily or washed in the dishwasher.
- Wash cloth diapers, breast pads, and bras in hot soapy water.
- Add 1 cup of vinegar to the rinse water.
- Dry in a hot dryer or iron them.
- Use disposable paper towels instead of cloth.
- Wash bath towels after each use.
- Family members with a yeast infection (vaginal, toe nail, jock itch) may pass it back if not treated also.

TREAT mom’s nipples AND baby’s mouth at the same time!

Nipples:
Clotrimazole 0.1% cream after nursing until resolved
(no prescription needed) 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)

Another option is Gentian Violet 0.5% daily for 3-4 days.
(no prescription needed)

Treat both baby’s mouth and mom’s nipples as follows:
1. Undress baby to the diaper. It is very messy and stains skin and clothing. Apply Vaseline to the outside of baby’s mouth and lips (to keep from staining purple).
2. 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.
3. Nurse both breasts and nipples will turn purple. Paint nipples with swab if not completely purple. Purple will disappear after a few days.
4. If mouth sores occur, stop treatments and sores should go away within 24 hours.

Eczema (dermatitis)
- Mothers with underlying eczema may be prone to outbreaks on their nipples during breastfeeding.
- Nipples may be itchy, painful and burn.
- A red rash may suddenly appear with later oozing, crustig 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.

Bacterial infection
- When nipple pain and trauma fail to improve despite management discussed above, there may be an underlying bacterial infection that warrants treatment.
- Continue to nurse through a bacterial infection.
- 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.
- 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.