Patient education: Common breastfeeding problems (Beyond the Basics)

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BREASTFEEDING PROBLEMS OVERVIEW

Breastfeeding is universally recognized as the best way to feed an infant because it protects mother and infant from a variety of health problems. Even so, many women who start out breastfeeding stop before the recommended minimum of exclusive breastfeeding for six months. Often, women stop because common problems interfere with their ability to breastfeed. Luckily, with sound guidance and appropriate medical treatment, most women can overcome these obstacles and continue breastfeeding for longer periods.

This topic discusses common problems associated with breastfeeding and how to handle them. Other aspects of breastfeeding are discussed elsewhere. (See "Patient education: Deciding to breastfeed (Beyond the Basics)" and "Patient education: Breastfeeding guide (Beyond the Basics)" and "Patient education: Maternal health and nutrition during breastfeeding (Beyond the Basics)" and "Patient education: Pumping breast milk (Beyond the Basics)".)

INADEQUATE MILK INTAKE

The most common reason women stop breastfeeding is that they think their infant is not getting enough milk, but in many cases, the mother has an adequate supply. A true inadequate supply

can happen if the infant is unable to extract milk well or if the mother doesn't make enough milk. Unfortunately, figuring out if a mother has enough milk and if not, why not, can be challenging.

Inadequate milk production — There are a number of reasons why a mother might not make enough milk, including:

- Her breasts did not develop sufficiently during pregnancy – This can happen if she doesn't have enough milk-producing tissue (called glandular tissue) (figure 1)
- She previously had breast surgery or radiation treatment
- She has a hormonal imbalance
- She takes certain medications that interfere with milk production

Women who have had certain types of breast surgery, such as breast reduction surgery, often have trouble making enough milk. For some, breastfeeding is impossible. If you had breast surgery, ask your health care provider if the type of surgery you had would totally interfere with breastfeeding. If not, or if you are unable to get complete information on your surgery, do go ahead and try to breastfeed, but make sure your health care provider closely monitors your baby's progress. Most women who have had breast augmentation surgery (breast implants) can breastfeed successfully.

Poor milk extraction — The most common reasons infants have trouble getting enough milk are:

- They do not get fed frequently enough (which can cause milk production to slow or stop).
- They cannot latch on properly (figure 2). See latching on in this video.
- They are separated from their mother too much.
- They are fed formula.

Many babies are sleepy and difficult to keep awake during the first several days after birth. This can prevent the baby from getting enough to eat. Other babies can have trouble controlling the muscles involved in suckling, which makes it hard for them to extract milk. Feeding difficulty is especially common among premature and late preterm babies. Many mothers judge adequacy of feeding by lack of crying. This can be misleading if the baby is not getting enough milk and is overly sleepy.

Diagnosis of inadequate intake — Health care providers determine whether a baby is getting enough milk based on the following:

- **Number of feeding sessions the mother reports having** – During the first week of life, mothers with term infants (meaning they are not premature) generally nurse 8 to 12 times in 24 hours. By four weeks after delivery, nursing usually decreases to 7 to 9 times per day.

- **Amount of urine and stool the baby makes** – By the fifth day of life, infants who are getting enough milk urinate six to eight times a day and have three or more stools a day. (Once a mother's milk comes in, her infant's stool should be pale yellow and seedy.)

- **Weight of the baby** – Term infants lose an average of 7 percent of their birth weight in the first three to five days of life. They typically get back to their birth weight within one to two weeks. Once a mother's breasts fill with milk (by day three to five), her infant should not keep losing weight. If an infant has lost 10 percent of his or her weight or fails to return to his or her birth weight when expected, health care providers start to explore potential problems. Household scales are not accurate enough to detect these small weight differences. If you are using a medical scale for infants, remember to weigh the infant with the same clothes and diaper before and after the feeding.

Management of inadequate intake — If your health care provider suspects your baby is not getting enough milk, he or she will want to figure out why. To do so, the health care provider will ask you about your experiences breastfeeding and about your and your baby's medical history. A health care provider should also watch as you try to breastfeed to see if there could be something wrong with the way your baby latches on or with the baby's mouth. If so, it will be important for you to learn how to position your baby so that the baby can latch on properly (figure 2 and figure 3). If you are having trouble with this, the health care provider will direct you to community resources, often a lactation consultant, for assistance.

If your baby has a good latch, but you still have problems with inadequate milk intake, your health care provider might suggest that you try to feed more often or try to stimulate more milk production. You can do this by using a breast pump or expressing by hand, especially after a feeding (figure 4) ("Hand Expression of Breastmilk" video).

There are medications called galactagogues (or lactagogues) that supposedly increase milk production, but it's unclear whether these medications actually work and whether they are safe for a nursing baby, so we do not recommend their use.

NIPPLE AND BREAST PAIN

The second most common reason mothers stop breastfeeding early is nipple or breast pain.

The causes of nipple and breast pain include:

- Nipple injury (caused by the baby or a breast pump)
- Engorgement, which means the breasts get overly full
- Plugged milk ducts
- Nipple and breast infections
- Excessive milk supply
- Skin disorders (such as dermatitis or psoriasis) affecting the nipple
- Nipple vasoconstriction, which means the blood vessels in the nipple tighten and do not let enough blood through

Possible causes of breast or nipple pain related to the baby could include:

- Ankyloglossia (also called tongue-tie), which is when the baby's tongue cannot move as freely as it should, making it hard for the baby to suckle effectively
- Torticollis, which is when the baby's neck is twisted, making it hard for the baby to nurse from both breasts comfortably
- Birth defects in the shape of the baby's mouth that make it hard for the baby to latch on
- Uncoordinated suck, which is when the baby does not move his or her tongue in the correct rhythm to extract milk

To determine the cause of your pain, your health care provider will examine you and your baby and watch you breastfeed. He or she will also ask about your pain (when it started, what makes it better or worse) and about aspects of your health that could hold clues about the cause of your pain.

The most important part of the examination takes place when the health care provider watches you breastfeed. That's because most cases of breast pain in the nursing mother are due to incorrect breastfeeding technique. One common problem is that the baby is not latching on properly, and so injures the nipple, but also cannot empty the breast. This, in turn, can lead to engorgement, plugged ducts, and breast infections.

Nipple pain — Sore nipples are one of the most common complaints by new mothers. Pain due to nipple injury needs to be distinguished from nipple sensitivity, which normally increases during pregnancy and peaks approximately four days after giving birth.

You can usually tell the difference between normal nipple sensitivity and pain caused by nipple injury based on when it happens and how it changes over time. Normal sensitivity typically subsides 30 seconds after suckling begins. It also diminishes on the fourth day after giving birth and completely resolves when the baby is approximately one week old. Nipple pain caused by trauma, on the other hand, persists or gets worse after suckling begins. Severe pain or pain that continues after the first week after birth is more likely to be due to nipple injury.

Normal nipple sensitivity — If you have some discomfort related to normal nipple sensitivity, keep in mind that this sensitivity usually goes away after the first few suckles of a feeding and stops happening after the first week or two of nursing. If you find the "pins and needles" sensation of milk let-down to be uncomfortable, rest assured that this discomfort also resolves in the first weeks of breastfeeding. If needed, you can take acetaminophen (brand name Tylenol) to ease your discomfort.

Nipple injury — Nipple injury usually is due to incorrect breastfeeding technique, particularly poor position or latch-on. Other factors that can make pain caused by injury worse include harsh breast cleansing, use of potentially irritating products, and biting by an older infant.

Here are some things that you can do to prevent nipple injury:

- Learn how to position your baby so that the baby can latch on properly (figure 2 and figure 3). If you are having trouble with this, get help from a health care provider or a lactation consultant.
- Try to keep your nipples dry, and allow them to air-dry after feedings.
- Do not use harsh soaps or cleansers on your breasts.
- Avoid use or overuse of breast pads that have plastic backing.
- If your baby's mouth has any abnormalities, make sure to have them addressed as soon as possible. For example, if your baby has tongue-tie, surgery to release the tongue will make it easier for the baby to latch on properly.
- If your baby is biting you, position the baby so that his or her mouth is wide open during feedings. That will make it harder to bite. Also, stick your finger between your nipple and the baby's mouth any time he or she bites you and firmly say "no." Then put the baby down in a safe place. The baby will learn not to bite you.

Here are some things you can do to promote healing if your nipples are already injured:

- Always start nursing with the breast that does not have the injury.
- If your nipples are cracked or raw, you can put expressed breast milk or an ointment on them, such as purified lanolin (if you are not allergic) and cover them with a nonstick pad. This will keep the injured part of your nipple from sticking to your bra. If you think your nipple is infected or you have a rash, see your health care provider.
- Use cool or warm compresses, if they seem to help. Avoid ice.
- Take a mild pain reliever, such as acetaminophen (brand name Tylenol) or ibuprofen (brand names Advil and Motrin), before feeding.
- If nipple pain prevents your baby from emptying your breasts, try using a pump or hand expression to empty your breasts. This will give your nipples a chance to heal and prevent engorgement. Use the milk you remove to feed your baby.
- Do NOT use vitamin E oil on your nipples. At high levels, it could be toxic to your baby.

Nipple vasoconstriction — Nipple vasoconstriction is when the blood vessels in the nipple tighten and do not let enough blood through. Mothers with this problem can have pain, burning, or numbness in their nipples in response to cold, nursing, or injury. The nipples can also turn white or blue and then pink when the blood returns.

One way to tell nipple vasoconstriction apart from other causes of nipple pain is that it can be predictably triggered by cold, while other causes of pain cannot.

To manage nipple vasoconstriction, try to keep your whole body warm and dress warmly. Also, if possible, try to breastfeed in warm conditions. It might also help to avoid nicotine and caffeine as they can make the problem worse.

Engorgement — Engorgement is the medical term for when the breasts get too full of milk. It can make your breast feel full and firm and can cause pain and tenderness. Engorgement can sometimes impair the baby's ability to latch, which makes engorgement worse because the baby cannot then empty the breast.

Here are some things you can do to prevent and deal with engorgement:

- Learn how to position your baby so that the baby can latch on properly (figure 2 and figure 3). If you are having trouble with this, get help from a health care provider or a lactation consultant.
- If the engorgement makes it hard for your baby to latch on, manually express a small amount of milk before each feeding to soften your areola and make it easier for the baby to latch on (figure 4). To do this, place your thumb and forefingers well behind your areola (close to your chest) and then compress them together and toward your nipple in a rhythmic fashion. You can also use your hand to present your nipple in a way that is easier to latch on to and to help get milk out for the baby while the baby is suckling.
- You can use a breast pump to help soften your breast before a feeding, but be careful not to do it too much. Using a pump too much will stimulate your breast to make even more milk, which will make engorgement worse.
- Apply warm compresses or take a warm shower before a feeding. This can enhance let-down and may make it easier to get milk out.
- Take a mild pain reliever, such as acetaminophen (brand name Tylenol) or ibuprofen (brand names Advil and Motrin).

Plugged ducts — A plugged milk duct can cause a tender or painful lump to form on the breast. If the nipple itself is plugged, a white dot or bleb can form at the end of the nipple.

Things that can lead to a plugged milk duct include poor feeding technique, wearing tight clothing or an ill-fitting bra, abrupt decrease in feeding, engorgement, and infections.

Here are some things you can do to prevent and deal with a plugged duct:

- Learn how to position your baby so that the baby can latch on properly (figure 2 and figure 3). If you are having trouble with this, get help from a health care provider or a lactation

consultant. Make sure to vary your position during feedings so every part of the breast gets emptied. You might even try to position the baby so that his or her chin is near the plugged area because this positioning can help drain that area best. You can also try pumping or manually expressing after feedings to improve drainage. Do not quit breastfeeding, as this could lead to engorgement and worsen the problem.

- Try using warm compresses or taking a warm shower and then manually massaging your breast from the outer part of your breast toward the nipple to advance the blockage toward the nipple or in the opposite direction to clear the duct.
- Take a mild pain reliever, such as acetaminophen (brand name Tylenol) or ibuprofen (brand names Advil and Motrin).
- If your blockage does not get better within two days, see your health care provider as what appears to be a blocked duct may be something more concerning.

Galactoceles — Sometimes a blocked milk duct can cause a milk-filled cyst called a galactocele to form (picture 1). Unless they are infected, galactoceles are usually painless, but they can get quite large. If necessary, a health care provider can drain a galactocele using a needle or suggest surgery if the problem is severe.

BREAST INFECTIONS

Lactational mastitis — Mastitis is an inflammation of the breast that is often associated with fever (which might be masked by pain medications), muscle and breast pain, and redness. It is not always caused by an infection, but most people associate it with infection. Mastitis can happen at any time during lactation, but it is most common during the first six weeks after delivery.

Mastitis tends to occur if the nipples are damaged or the breasts stay engorged for too long or do not drain properly. To prevent and treat mastitis, it's important to get these problems under control.

If you have any of the following symptoms, see your health care provider:

- A firm, red, and tender area of the breast
- Fever higher than 101°F or 38.5°C
- Muscle aches, chills, malaise, or flu-like symptoms

If you do have an infection, your health care provider will probably put you on antibiotics.

Here are some things that you can do to manage mastitis:

- Take your antibiotics exactly as directed, if your health care provider prescribes them. If you don't start to feel better within two to three days of starting antibiotics, call your health care provider. You may need a different antibiotic or may have a different problem.

- Continue breastfeeding, even while you are being treated, and work on your feeding technique so that your breasts empty well.
- Take a mild pain reliever, such as acetaminophen (brand name Tylenol) or ibuprofen (brand names Advil and Motrin), if you think it could help.
- Apply cold compresses or ice packs.

Yeast infection — Many women who are breastfeeding are diagnosed with a yeast infection of the nipple or breast (also called candidal infection) based on their symptoms (primarily nipple pain). Even so, yeast infections of the nipple or breast are poorly understood, and researchers aren't sure what role they play in nipple pain.

For now, health care providers often diagnose yeast infections in women who have:

- Breast pain out of proportion to any apparent cause
- A history of vaginal yeast infections or an infant with a history of yeast infections such as thrush or diaper rash
- Shiny or flaky skin on the affected nipple
- *Candida* found in a culture of breast milk (if this test is done)

Treatments include:

- Topical antifungals – Topical antifungals are creams or gels that contain medications called antifungals, which kill yeast. Women using these agents must wipe any remaining medication they can see off of their nipples before each feeding and reapply them after each feeding. Antifungal ointments are not recommended, as the paraffins they contain could be harmful to the infant.
- Gentian violet – Gentian violet 0.25 to 1% is a purple medication that you apply to your baby's mouth with a Q-tip before a feeding. After the feeding, you apply more gentian violet to any areas of your nipple and areola that are not already purple. You do this once a day for three to four days. Gentian violet is a bit messy and can sometimes irritate the baby's mouth or the nipple area, but it is effective.
- Antifungal pills – Mothers who do not get better with the options described above can be put on prescription antifungal pills. They can continue to breastfeed while on these pills as the typical amount of drug that makes it into breast milk is safe for breastfeeding infants.

BLOODY NIPPLE DISCHARGE

Some women have bloody nipple discharge during the first days to weeks of lactation. This is more common with the first pregnancy and has been called rusty pipe syndrome. It is thought to

be caused by the increased blood flow to the breasts and ducts that happens when the mother starts making milk. The color of the milk varies from pink to red and generally resolves within a few days. Women who have bloody discharge for more than a week should be seen by a health care provider.

MILK OVERSUPPLY

Some mothers make too much milk, which paradoxically can make breastfeeding difficult. Generally, the production of milk is determined by the infant's demand, but in this case, the supply exceeds demand. The problem begins early in lactation and is most common among women having their first child.

In women with an oversupply of milk, the rush of the milk can be so strong that it causes the infant to choke and cough and have trouble feeding, or even to bite down to clamp the nipple. Infants whose mothers make too much milk can either gain weight quickly or gain too little weight because they cannot handle the flow of milk or because they do not get the last of the milk in the breast, which has the most calories.

If you have a problem with overproduction, don't worry. The problem usually goes away on its own. But tell your health care provider about it, so he or she can check whether you have any hormonal imbalances or take any medications that could make the problems worse.

Here are some things that you can do to deal with milk oversupply:

- Nurse in an upright position – Hold your baby upright to nurse and lean back or lie on your side (figure 3 and picture 2 and figure 5). This will give the baby better control of the flow of milk.
- Use your fingers to reduce the flow of milk – Try putting a scissors-hold on your areola or pressing on your breast with the heel of your hand to restrict flow.
- Give the baby control – Let your baby interrupt feedings, and burp him or her often.
- Pump very little or not at all – Avoid pumping because it can stimulate even more milk production, but you can hand-pump a little at the beginning of a feeding to relieve some of the pressure.
- Apply cold water or ice to your nipples to decrease leaking.

WHEN TO SEEK HELP

If you are unable to breastfeed due to engorgement, pain, or difficulty latching your infant, help is available. Talk to your obstetrical or pediatric health care provider, nurse, lactation consultant, or a

breastfeeding counselor. (See 'Finding a lactation consultant' below.)

WHERE TO GET MORE INFORMATION

Your health care provider is the best source of information for questions and concerns related to your medical problem.

This article will be updated as needed on our website (www.uptodate.com/patients). Related topics for patients, as well as selected articles written for health care professionals, are also available. Some of the most relevant are listed below.

Patient level information — UpToDate offers two types of patient education materials.

The Basics — The Basics patient education pieces answer the four or five key questions a patient might have about a given condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials.

Patient education: Deciding to breastfeed (Beyond the Basics)
Patient education: Breastfeeding guide (Beyond the Basics)
Patient education: Maternal health and nutrition during breastfeeding (Beyond the Basics)
Patient education: Pumping breast milk (Beyond the Basics)
Patient education: Raynaud phenomenon (Beyond the Basics)
Patient education: Constipation in infants and children (Beyond the Basics)

Beyond the Basics — Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are best for patients who want in-depth information and are comfortable with some medical jargon.

Patient education: Common breastfeeding problems (The Basics)
Patient education: Breastfeeding (The Basics)
Patient education: Weaning from breastfeeding (The Basics)
Patient education: Jaundice in babies (The Basics)

Professional level information — Professional level articles are designed to keep doctors and other health professionals up-to-date on the latest medical findings. These articles are thorough, long, and complex, and they contain multiple references to the research on which they are based. Professional level articles are best for people who are comfortable with a lot of medical terminology and who want to read the same materials their doctors are reading.

Ankyloglossia (tongue-tie) in infants and children
Breastfeeding: Parental education and support
Common problems of breastfeeding and weaning
Lactational mastitis

Maternal nutrition during lactation
Nutrition in pregnancy
Prevention of HIV transmission during breastfeeding in resource-limited settings
The impact of breastfeeding on the development of allergic disease
Safety of infant exposure to antidepressants and benzodiazepines through breastfeeding

The following organizations also provide reliable health information.

- United States National Library of Medicine

  (www.nlm.nih.gov/medlineplus/healthtopics.html)

- Centers for Disease Control and Prevention

  (www.cdc.gov/breastfeeding)

- American Academy of Pediatrics

  (www2.aap.org/healthtopics/breastfeeding.cfm)

Finding a lactation consultant — International board-certified lactation consultants, or IBCLCs, are available at most hospitals as well as privately and can be an invaluable resource for instructions about breastfeeding. La Leche League Leaders provide breastfeeding support and advice about pumping, milk storage, and return to work. The websites listed below have information about finding a lactation consultant or breastfeeding counselor.

- La Leche League International

  (www.lalecheleague.org)

- International Board of Lactation Consultant Examiners

  (www.iblce.org)

Phone: 703-560-7330

- International Lactation Consultant Association

  (www.ilca.org)

Phone: 919-861-5577

[1,2]

REFERENCES

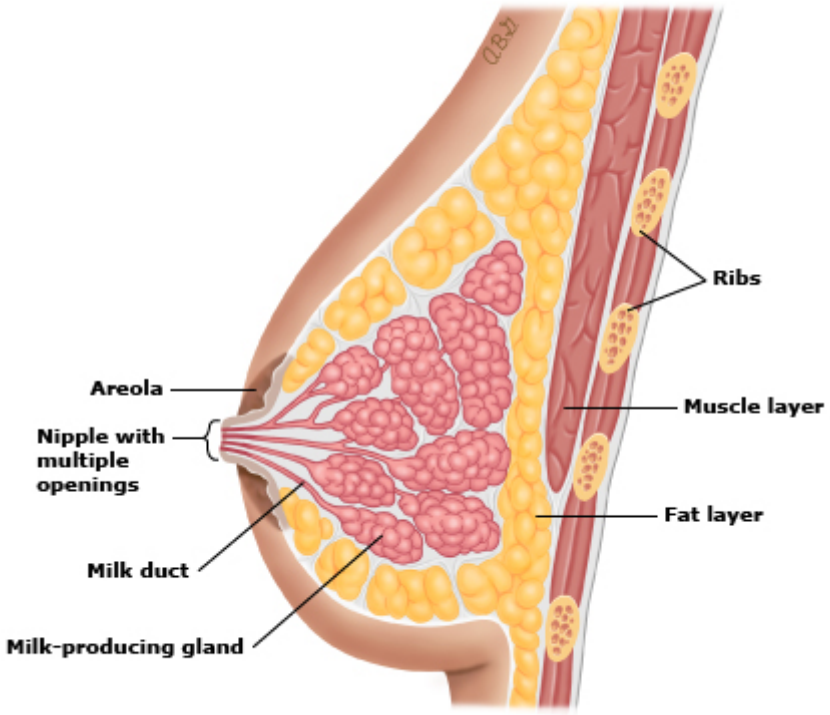
1. Lawrence RA, Lawrence RM. Breastfeeding: A Guide for the Medical Profession, 8th ed, Elsevier, 2015.

2. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. Breastfeeding Handbook for Physicians, 2nd ed, Shanler, RJ, Krebs NF, Mass SB (Eds), American Academy of Pediatrics, 2013.

Topic 1217 Version 24.0

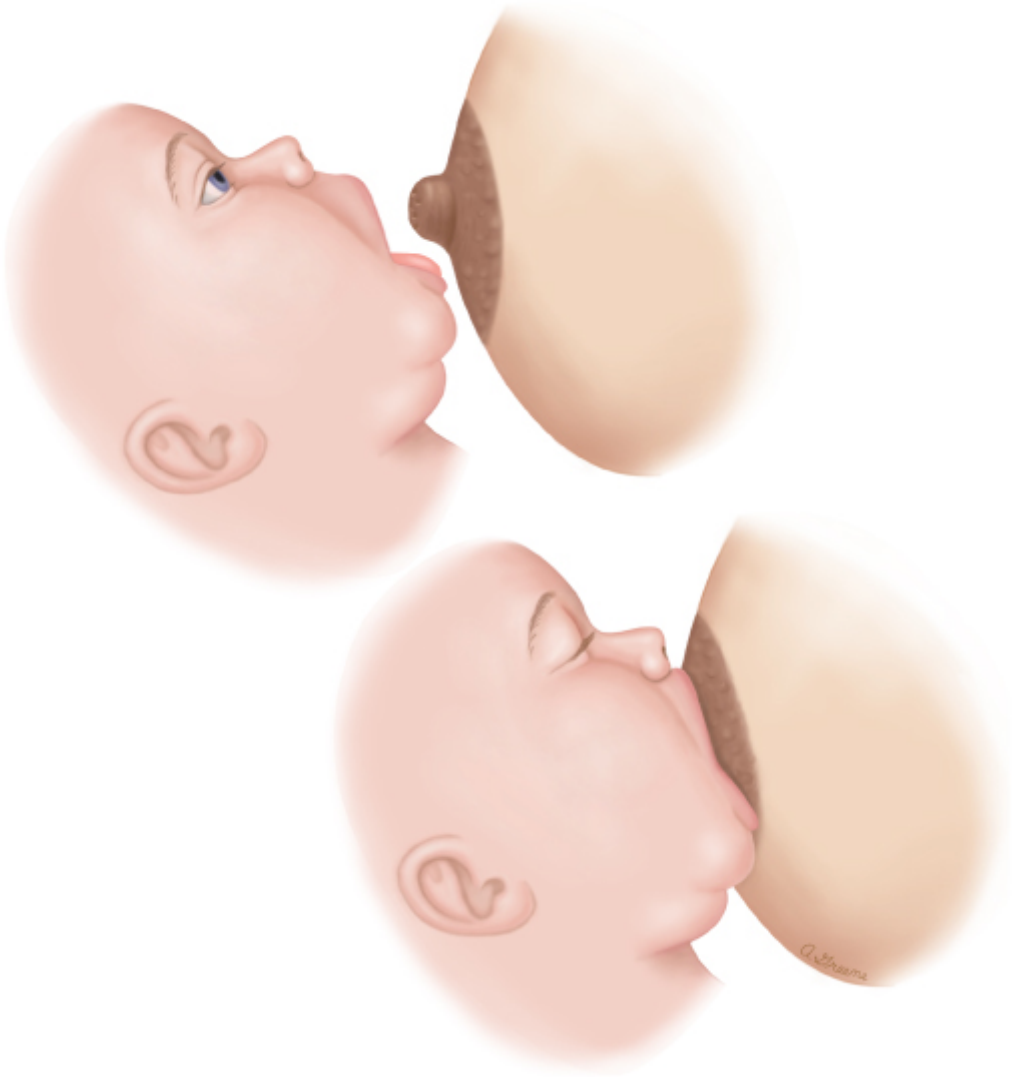
GRAPHICS

The breast



Graphic 72583 Version 5.0

Latch-on

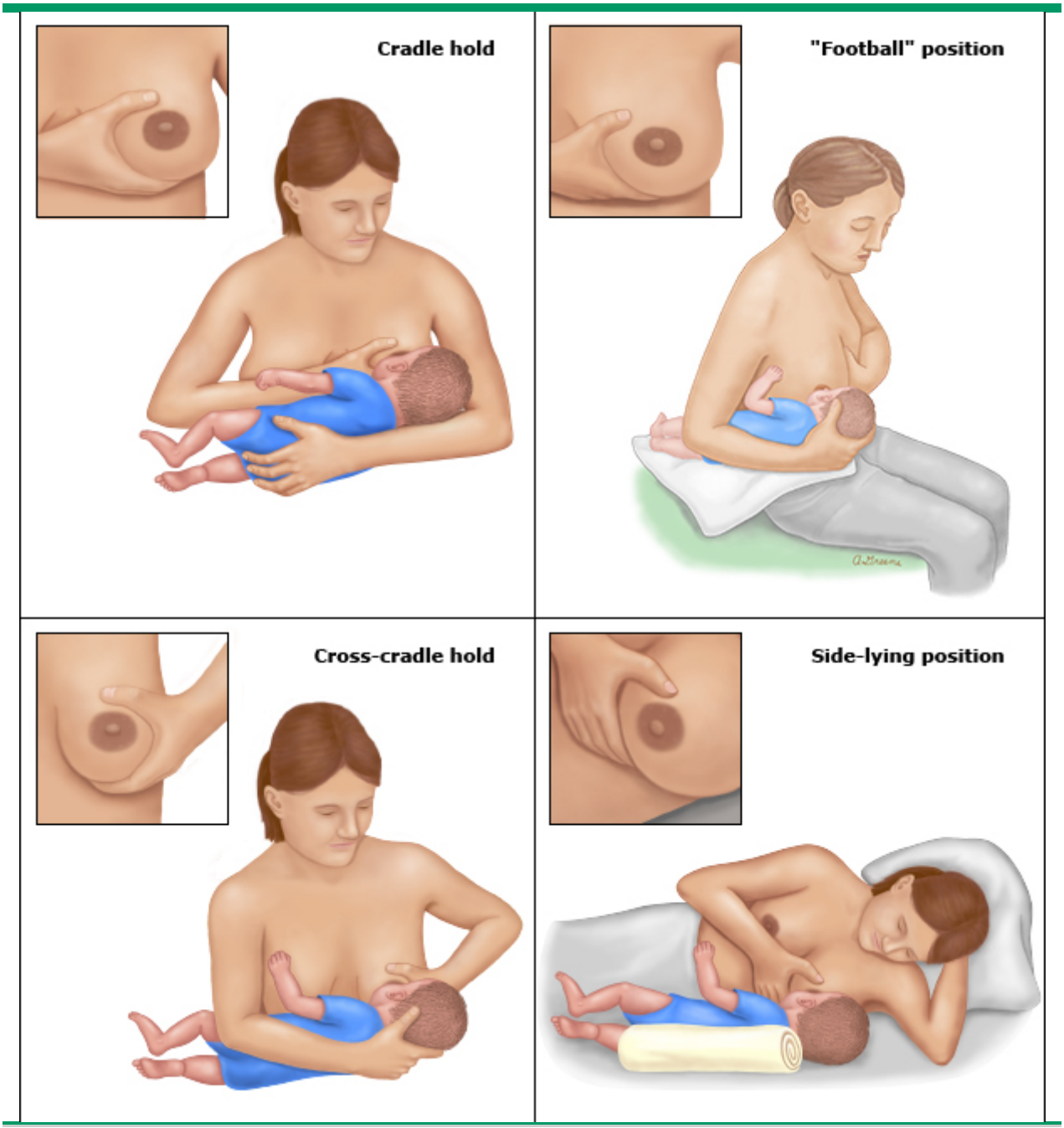


During latch-on, a baby's mouth forms a tight seal around the nipple and most of the areola (the dark skin around the nipple). Signs that your baby has a good latch-on include:

- The top and bottom lips are wide open.
- The lower lip is turned outward against the breast.
- The chin is touching the breast, and the nose is close to the breast.
- The cheeks are full.
- The tongue comes out over the lower lip during latch-on and stays below the areola during nursing.

Graphic 69241 Version 8.0

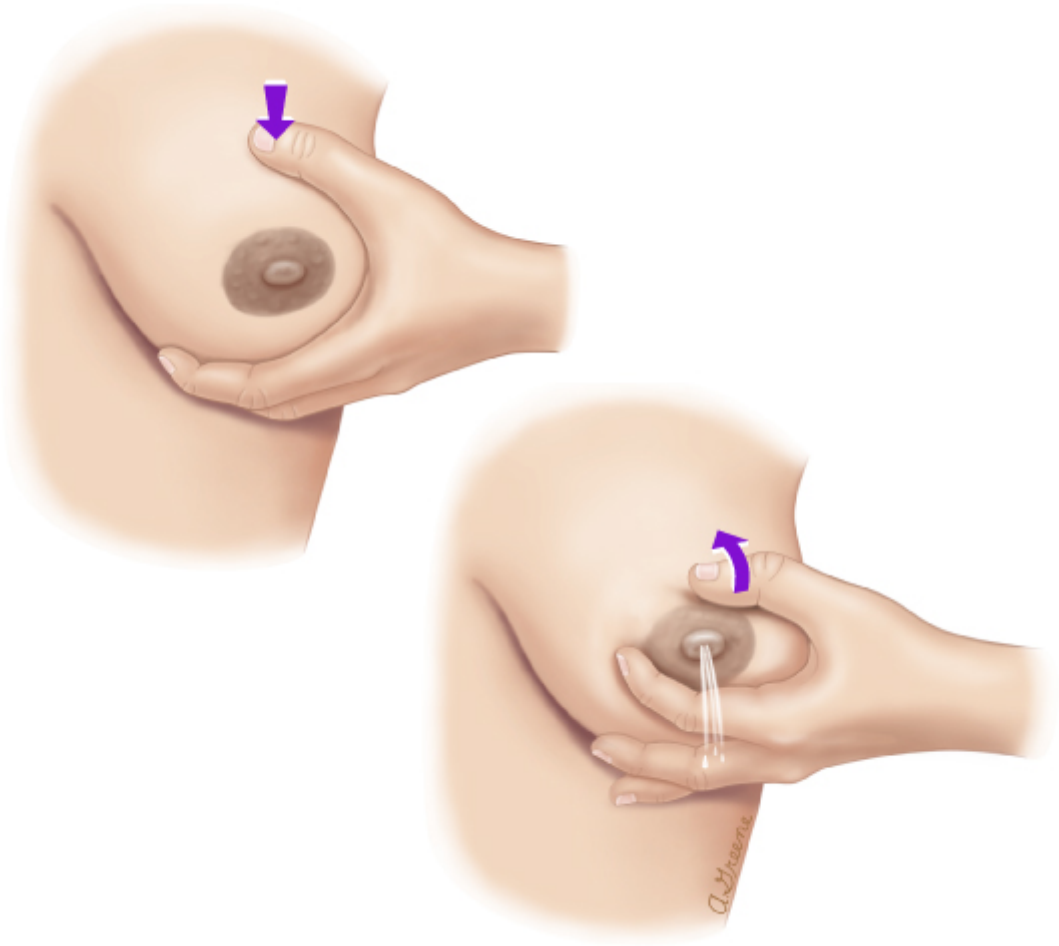
Different holds for breastfeeding



These drawings show different ways you can hold your baby for breastfeeding.

Graphic 60405 Version 6.0

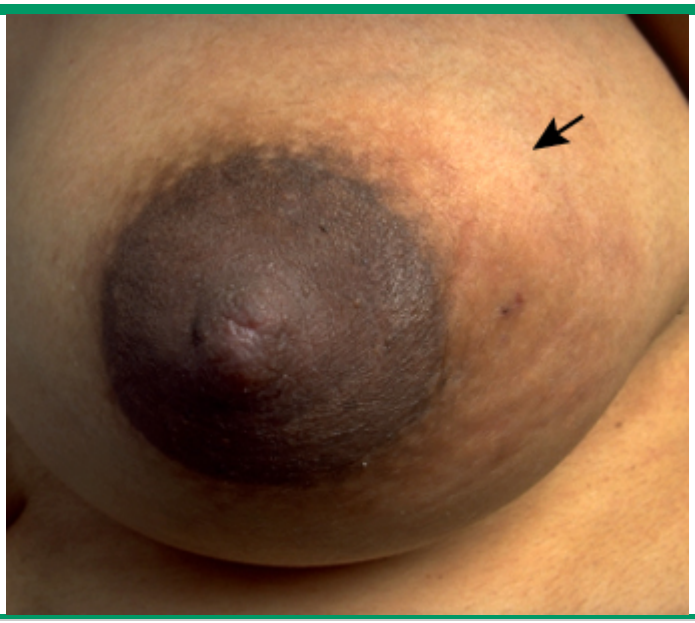
Hand expression to release breast milk



Hold your hand in a c-shape, with your thumb on top. Press your thumb gently on your breast straight back into the chest. Then, roll your thumb and fingers toward the nipple. Breast milk should come out of the nipple. Keep doing this as you move your hand around the whole breast.

Graphic 73810 Version 5.0

Blocked milk duct (galactocele)



Blocked or plugged ducts are areas of the breast where the flow of milk is blocked. They can stretch the nearby breast tissue and cause a painful breast lump (as shown by the arrow).

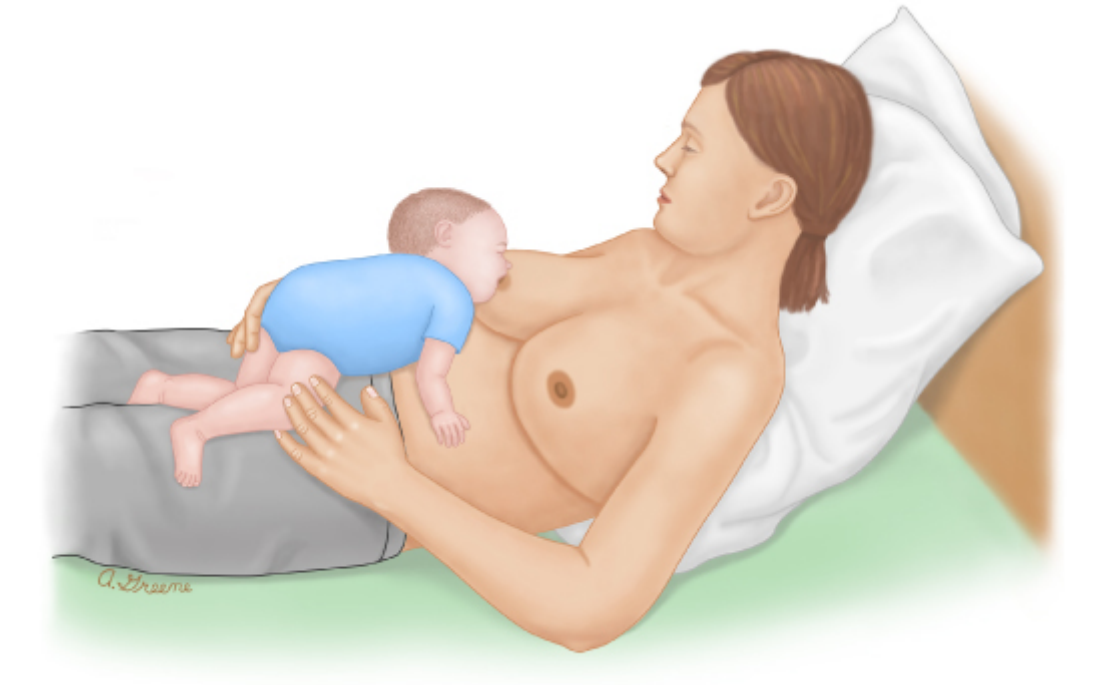
Graphic 70540 Version 6.0

Double football hold

Courtesy of Nancy Hurst, PhD, RN, IBCLC.

Graphic 52083 Version 5.0

Laid-back breastfeeding



The laid-back breastfeeding position facilitates the natural breastfeeding behaviors with the full body skin-to-skin contact between the mother and baby. It promotes a strong letdown of breast milk from the mother and allows the baby to have more control over the milk flow.

Graphic 94837 Version 2.0