**Breastfeeding problems**

Breastfeeding problems such as breast pain, [nipple pain](https://cks.nice.org.uk/breastfeeding-problems#!backgroundsub:2), low-milk supply (true and perceived) and oversupply of milk may lead to a mother stopping breastfeeding before she wants to.

This guidance is for Health Visiting, FNP and Baby Steps staff to support them to:

* Help prevent breastfeeding problems
* Recognize breastfeeding problems promptly.
* Manage breastfeeding problems in primary care, where appropriate.
* Assess the woman and infant, and follow specialist infant feeding service referral pathway if needed

It is based on NICE Clinical Knowledge summaries (Jan 2017) and NICE quality standard statement 5: Women receive breastfeeding support from a service that uses an evaluated, structured programme. For full document and references see: <https://www.nice.org.uk/guidance/qs37/chapter/quality-statement-5-breastfeeding>.

The table below is an outline of breastfeeding problems symptoms, causes and management. This is displayed in alphabetical order.

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| **Predisposing factors** | **Symptoms** | **Management** |
| **Blocked ducts:** | | |
| Milk stasis, due to ineffective removal of milk from part of the breast.  Suboptimal positioning and attachment, infrequent breastfeeds, or the infant not being fed responsively.  Tight clothing or trauma to the breast, which may obstruct milk flow. | Warm, red area of discomfort on the breast.  Blocked ducts may lead to the formation of a milk-filled cyst (galactocele), mastitis and/ or breast abscess. | Advise on frequent feeding from the affected breast.  Advise on the use of heat packs or a warm shower for symptom relief.  Advise on wearing a well-fitting bra and clothing that does not restrict the breasts.  Advise on gentle massage of the breast, using a firm movement towards the nipple, to help relieve the obstruction.  If there is a white spot (bleb) on the nipple tip, advice on bathing then gently rubbing the area with a warm, damp towel? |

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| **Ductal infection** | | |
| May be caused by   * Milk stasis, due to ineffective removal of milk from part of the breast. * Sore cracked nipples * Blocked ducts | There may be deep burning, aching, or shooting breast pain that occurs during and between feeds.  Pain may radiate down the arm or into the chest wall or back.  There may be erythematous, flaky or shiny skin of the nipple, or a nipple fissure.  Purulent exudate or crust may suggest associated bacterial infection. | Promote effective milk removal from the breast through good positioning and attachment and hand expression, breast pump if preferred by mother.  Refer to GP |

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| **Predisposing factors** | **Symptoms** | **Management** |
| **Engorgement** | | |
| Breast pain due to engorgement typically starts in the first few days after birth whilst breastfeeding is becoming established, it is often bilateral and worse before a feed. It can also occur in established breastfeeding with less frequent or restricted breastfeeding. | Infant attachment may be difficult due to breast fullness and milk flow is reduced.  The woman may have a mild, short-lived fever.  The whole breast is typically swollen and may be shiny  The nipple may be stretched and look flat in appearance | Advise the woman to feed her infant with no restrictions on the frequency or length of feeds.  Advise on self-management techniques such as simple analgesia (for example paracetamol) for pain relief, breast massage after feeds, and hand expressing of milk to relieve full breasts.  Advise on the use of heat packs or a warm shower before feeding or expressing milk which can stimulate milk let-down, or the use of cold packs after feeding or expressing, to relieve pain and oedema.  Advise on wearing a well-fitting bra and clothing that does not restrict the breasts.  Initial breast fullness and nipple discomfort in the first few days post-partum which may be normal as the milk 'comes in'. This should improve as maternal milk supply adjusts to the infant's needs. |

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| **Galactocele:** (other terms are milk cyst or lacteal cyst) | | |
| This is a cyst containing milk and can be caused by inefficient emptying of the breast and/ or blocked ducts. They occur during or shortly after lactation | Presents as a smooth, firm, round, painless breast swelling which can cause milky nipple discharge when pressed. | Advise the mother to continue breastfeeding.  Refer the mother to the specialist infant feeding service and/ or GP to confirm the diagnosis and discuss treatment options, if needed. |

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| **Predisposing factors** | **Symptoms** | **Management** |

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| **Low milk supply:** | | |
| There are a variety of causes of low milk supply in women who are breastfeeding, and more than one cause may co-exist at one time. True maternal low milk supply is unusual, and there may be a subjective maternal perception of insufficient milk supply, if other causes have been excluded or are unlikely.  If the infant takes only some of the milk from the breast then milk production decreases, as effective milk removal is needed to stimulate milk supply. This is usually due to:  Insufficient access to the breast (short or infrequent feeds, no night feeds; use of a dummy, nipple shield, or giving supplementary feeds other than breast milk, which result in reduced suckling at the breast and subsequently reduced milk production).  Ineffective removal of milk due to incorrect infant positioning and attachment and/or tongue tie.  Maternal depression, stress, and/or anxiety, which may result in a reduced response to infant feeding cues and a reduced frequency of feeds, which leads to reduced stimulation of milk production.  **Low milk supply can also be caused by maternal prolactin deficiency as seen in the examples below:**   * Anterior pituitary dysfunction, caused by retained placental fragments, severe post-partum haemorrhage, or post-partum pituitary necrosis (Sheehan's syndrome, rare). * Thyroid disorders, for example hypothyroidism or post-partum thyroiditis. * Eating disorders, such as bulimia. * Drugs, such as oestrogen, combined hormonal contraceptives, dopamine, ergotaminepyridoxine, nicotine, alcohol. * Maternal anatomical conditions, such as hypoplastic breasts (rare, characterized by widely spaced breasts with prominent areolas, due to insufficient glandular tissue); breast reduction surgery (may interfere with normal nipple sensation which affects milk supply). | There are numerous presentations for this:   * Slow to regain birth weight * Faltering growth * Frequent feeding * Feeding for very long or very short feeds * Fussy at the breast * Unsettled between feeds * Less than six wet nappies in 24 hours * Less than 2 bowel movements (soft yellow stools) in 25 hours (first six weeks) * Jaundice * Sleepy * Mum may have sore nipples, blocked, ducts, mastitis etc.   This list is not exhaustive | * + - Health professional to check positioning and attachment     - Observe for possible tongue tie using BTAT assessment.     - Advise increasing skin-to-skin contact both during and between feeds.     - Responsive feeding with no restrictions on the frequency or length of feeds     - Offering both breasts at each feed, and alternating between breasts.     - Advise on expressing milk after feeds, particularly by hand to stimulate milk production.   + Manage any underlying [cause](https://cks.nice.org.uk/breastfeeding-problems#!backgroundsub:3) in the infant or woman that may be contributing to a low milk supply, specialist infant feeding service and/or GP referral may be required.   + If faltering growth follow SBC faltering growth guidelines. * If maternal retained placental fragments or infection are suspected refer to GP, as may need treatment * Referral to specialist infant feeding service required if any of these conditions are known or suspected and linked to low milk supply. |

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| **Predisposing factors** | **Symptoms** | **Management** |
| **Mastitis or breast abscess** | | |

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| * Often follow on from other breastfeeding difficulties or problems such as sore and cracked nipples, incorrect positioning and attachment, untreated blocked ducts. | * The woman often has a fever and flu like symptoms. * Mastitis may present with a hard painful swelling in a wedge-shaped distribution in one breast and sometimes both breasts, with redness of the overlying skin. * Mastitis may be infectious or non-infectious, and is usually secondary to milk stasis. * Non-infectious mastitis is more likely where there is no nipple damage, and poor drainage of one part of the breast due to external pressure such as tight clothing, car seat belts, or extended intervals between feeds. * Infectious mastitis is more likely if there is a nipple fissure or damage, which may become infected, or if milk stasis persists. * A continuum may exist from a blocked duct or engorgement leading to mastitis which may develop into a breast abscess. * A breast abscess may present with a worsening painful breast lump, which is red and inflamed and can have a white area at the centre. There may be a persistent fever and flu like symptoms.   See the CKS topic on [Mastitis and breast abscess](https://cks.nice.org.uk/mastitis-and-breast-abscess) for more information. | * Reassure the womanthat her breast should return to normal size, shape, and function after adequate treatment. * Advise the woman to continue breastfeeding if possible (including from the affected breast). Assist the woman in improving the infant's attachment to the breast, this will improve milk removal and prevent nipple damage. If required, refer to the specialist infant feeding service for additional support. * If breastfeeding is too painful, or the infant refuses to breastfeed from the affected breast, advise the woman to express the milk, ideally by hand or pump if preferred until she is able to resume breastfeeding from both breasts. * If the affected breast is not completely empty after feeding, advise the woman to express the remaining milk (by hand or using a breast pump). * If the woman does not wish to continue breastfeeding, give advice on [stopping breastfeeding](https://cks.nice.org.uk/mastitis-and-breast-abscess#!scenariorecommendation:3/-417798), this should be done gradually to prevent worsening of the condition. * **Identify and manage any** [**predisposing factors**](https://cks.nice.org.uk/mastitis-and-breast-abscess#!cksbackgroundquestionchild) **for mastitis.** For example: * Advise the woman to rest and avoid wearing a bra, especially at night. * If there is nipple soreness or damage offer appropriate advice, see[: Nipple soreness - management](https://cks.nice.org.uk/topic-under-review) below. * **To relieve pain and discomfort:** * Self-medication of a simple analgesic, such as paracetamol or ibuprofen. See the CKS topics on [Analgesia - mild-to-moderate pain](https://cks.nice.org.uk/analgesia-mild-to-moderate-pain) and [NSAIDs - prescribing issues](https://cks.nice.org.uk/nsaids-prescribing-issues) for more information. * Advise the mother to place a warm compress on the breast, or bathe or shower in warm water, to relieve pain and help milk to flow. * **Referral to GP: If** the mother has a nipple fissure and/or symptoms have not improved (or are worsening) after 12–24 hours despite effective milk removal refer to the GP for consideration of antibiotics. * **Advise the woman to seek immediate medical advice if** symptoms fail to settle after 48 hours of antibiotics treatment. * **Give advice on** [**measures to prevent recurrence**](https://cks.nice.org.uk/mastitis-and-breast-abscess#!scenariorecommendation:3)**:** to include responsive feeding, effective positioning and attachment, prevention and management of blocked ducts. * **If a breast abscess is suspected immediate referral to GP required and notify specialist service.** |

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| **Predisposing factors** | **Symptoms** | **Management** |

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| **Milk oversupply** | | |
| There are a variety of causes of milk oversupply in women who are breastfeeding, and more than one cause may co-exist at one time such as:   * Natural tendency to oversupply. * Expressing in excess of baby’s needs. * Switch feeding or not completing feed from one breast before offering the second breast. | * Milk oversupply is common in the first few weeks post-partum, as the mother adapts to the infant's milk supply needs.   The mother may have:   * Breast fullness and possible engorgement or blocked ducts. * A painful, forceful milk let-down reflex. * Milk leakage and/or milk spraying from the opposite breast when feeding.   **The infant may have:**   * Choking and spluttering when let-down occurs. * Colic, or frequent explosive loose stools. * Rapid or excessive weight gain. | * + - Ensure that the woman is aware of early feeding cues that suggest an infant is hungry, so that breastfeeds are initiated at appropriate times.     - Advise that if the infant is unable to attach effectively to the breast due to breast fullness, it may be helpful to hand express a small amount of milk until the flow slows down, and then try to attach the infant to the breast.     - Advise on feeding from one breast for each feed, to help reduce milk supply.     - If a forceful let-down reflex continues, advise the woman that lying down on her back to breastfeed may be helpful.     - Advise on avoiding milk expression by hand or breast pump between feeds, if possible, to reduce overstimulation of milk supply.   + **If symptoms do not improve as expected with appropriate treatment, consider referral to the specialist infant feeding service for further advice on management.** |

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| **Predisposing factors** | **Symptoms** | **Management** |

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| **Nipple damage** | | |
| * Ineffective infant positioning and attachment is the most common cause of nipple damage. Abnormal compression of the nipple between the tongue and palate may cause suction trauma. * Infant anatomical conditions such as ankyloglossia (tongue-tie) may cause restricted tongue movement due to an abnormally short or thickened lingual frenulum, which may affect the infant's ability to suck; * Cleft lip and/or palate may also cause nipple damage by affecting infant attachment to the breast. * Maternal anatomical conditions such as flat or inverted nipples (especially if non-protractile) may affect infant attachment. Nipple protractility usually improves in the first week post-partum. | May present as red, inflamed, cracked, bleeding and/or squashed nipples | * + - Support the mother with optimal positioning and attachment, it may be that she has to try several positions to find the most effective for her and her baby.     - Advise the woman to continue breastfeeding wherever possible, and advise that reducing the duration of feeds is unlikely to relieve nipple pain.     - Complete BTAT assessment and follow Tongue tie pathway.     - Advise on stopping the use of nipple shields or breast shells, if appropriate, as these may contribute to incorrect positioning and attachment.     - Advice on considering the application of expressed breast milk, if the nipple skin is cracked, fissured, or there is nipple exudate. If symptoms persist, consider whether nipple infection is present and refer to GP.     - If there is suspected Thrush (Candida) refer mother and baby to the GP |

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| **Predisposing factors** | **Symptoms** | **Management** |

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| **Nipple infection** | | |
| * The association of Candida infection with nipple pain remains controversial, but if pain persists after effective positioning and attachment, Candida infection should be considered. There may be signs of associated infant oral or nappy area Candida infection, or infection may follow maternal or infant antibiotic treatment. See the CKS topics on [Candida - skin](https://cks.nice.org.uk/candida-skin) and [Candida - oral](https://cks.nice.org.uk/candida-oral) for more information. * Bacterial infection may result from damaged skin over the nipple area being rapidly colonized with *Staphylococcus aureus*, which may be asymptomatic or may cause clinical infection. See the CKS topic on [Impetigo](https://cks.nice.org.uk/impetigo) for more information. * Bacterial and candida infection may co-exist. |  | * Refer to GP and or Specialist infant feeding service. |

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| **Predisposing factors** | **Symptoms** | **Management** |
| **Nipple vasospasm or Raynaud's disease of the nipple** | | |
| This is caused by episodic vasospasm and ischaemia of the small blood vessels of the nipples, often triggered by exposure to cold temperatures. | * Nipple pain is typically intermittent, and present during and immediately after breastfeeds, and in between feeds if exposed to cold temperatures * Blanching of the nipple may be followed by cyanosis and/or erythema. * Nipple pain resolves when the nipple returns to its normal colour. * It is more common in women with a known personal or family history of Raynaud's phenomenon of the digits, and it may be associated with other connective tissue disorders, such as rheumatoid arthritis or scleroderma. | * + - Advise on avoiding exposure to the cold, wearing warm clothing, and breastfeeding in a warm environment.     - Advise on self-management techniques such as the use of heat packs or a warm shower following a breastfeed or when there is breast pain.     - Advise on avoiding caffeine and stopping smoking which can cause vasoconstriction, if appropriate. * If symptoms persist, consider referral to GP and or specialist infant feeding service. |

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| **Predisposing factors** | **Symptoms** | | **Management** |
| **Skin conditions:** | | | |
| * Atopic eczema on and around the areola may be triggered by skin irritants. Irritant contact dermatitis may be caused by breast pads, soaps, detergents, fragrances, and topical creams. Allergic contact dermatitis may be caused by lanolin, beeswax, chamomile, topical antibiotics, and fragrances. | * Presents as an itchy, inflamed, skin rash. | * + - If there is suspected eczema, advise on avoiding possible triggers if appropriate, such as lanolin, beeswax, or chamomile in nipple creams; soap, shampoo, and fragrances. Possible referral to the GP to review emollient use, which should be applied after a breastfeed.     - Psoriasis may flare up post-natally, or as a response to skin injury from infant attachment, sucking, or biting if there is suspected psoriasis, refer to the GP for treatment, if using emollients this should be applied after a breastfeed.     - Paget's disease of the nipple may mimic eczema, but is usually unilateral, persistent, and unresponsive to treatment for eczema. In addition, there may be skin ulceration or erosions. If there is suspected Paget's disease of the nipple, arrange an urgent GP appointment for referral to a breast specialist. See the CKS topic on [Breast cancer - recognition and referral](https://cks.nice.org.uk/breast-cancer-recognition-and-referral) for more information. | |

**Offer information on local and national breastfeeding support groups and organisations, such as:**

* **Breastmates** https://www.swindon.gov.uk/breastmates
* **The Association of Breastfeeding Mothers** (website available at <https://abm.me.uk/>) which has a breastfeeding counsellor telephone helpline (0300 330 5453) and provides written information on breastfeeding issues.
  + - **The Breastfeeding Network** (website available at <https://www.breastfeedingnetwork.org.uk/>) which runs the national breastfeeding helpline (0300 100 0212) and provides written information on breastfeeding issues.
    - **The La Leche League GB** (website available at <https://www.laleche.org.uk/>) which runs a telephone helpline (0345 120 2918), provides online help, runs local meetings, and provides written information on breastfeeding issues.
    - **The National Childbirth Trust** (website available at <https://www.nct.org.uk/>) which runs a telephone helpline including breastfeeding support (0300 330 0700), runs antenatal courses, and provides written information on breastfeeding issues and infant feeding.
  + **Offer written information on optimal infant positioning and attachment, such as:**
    - The NHS Choices leaflets:
    - [Breastfeeding: the first few days](http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/breastfeeding-first-days.aspx)
    - [Breastfeeding problems](http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/problems-breastfeeding.aspx)
    - [Breast pain and breastfeeding](http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/breast-pain-and-breastfeeding.aspx)
    - [Sore or cracked nipples when breastfeeding](http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/sore-cracked-nipples-breastfeeding.aspx)
    - [Breastfeeding and thrush](http://www.nhs.uk/Conditions/pregnancy-and-baby/Pages/breastfeeding-and-thrush.aspx).

The Department of Health leaflet

[Off to the best start. Important information about feeding your baby](http://www.clch.nhs.uk/media/163989/start4life_off_to_the_best_start_leaflet.pdf) which gives tips on breastfeeding technique, indicators of effective attachment, and information on how to express milk.

**Assessment and management of breastfeeding problems:**

* + Complete a BFI breastfeeding assessment and plan of care with the mother
  + [Observes the mother breastfeeding and expressing milk](https://cks.nice.org.uk/breastfeeding-problems#!diagnosissub) to check and give advice on:
    - Optimal infant positioning and attachment to the breast.
    - Hand and if using a pump breast pump, milk expressing technique.
    - Refer to Breastmates for ongoing support with positioning and attachment and social support
    - Specialist Infant Feeding referral if problem not resolved after assessment, plan and evaluation of plan

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