

Breast Care

during breastfeeding and preventing breast infections - mastitis

Information for parents

Mothers need to be aware of the risk factors for developing a breast infection or mastitis so they can help to prevent, identify and manage this problem should it occur.

Incidence?

- The risk of developing a breast infection is highest during the second and third week after the birth of your baby.
- Estimates of the numbers vary, from 2-7% ⁽¹⁾ to 10-20% ⁽²⁾ of women in the first few weeks of breastfeeding.
- More common after the birth of your first baby (64.2%), than with subsequent children (35.8%) ⁽¹⁾.

What is a breast infection or mastitis?

- Inflammation of breast tissue in a mother producing breastmilk. ⁽³⁾

The symptoms felt and observed by the mother for as least 24 hours include:

- Elevated temperature.
- Feeling unwell, flu-like aches, fever and shivering.
- A hot, tender spot or lump localised to one of the lobes within the breast, indicating a blocked duct.

The signs:

- Redness appearing as a flare on the surface of the breast, often in a triangular shape pointing towards the nipple.
- When mastitis does not resolve quickly it may develop to the extreme – with formation of a breast abscess.

Risk factors for Mastitis:

- Oversupply in the early weeks, while the milk supply is adjusting to baby's needs. ⁽¹⁾⁽²⁾
- A blocked duct, lumpy area indicating the breast is not being emptied well.
- Attachment difficulties, mothers who find difficulty latching baby comfortably to both breasts. ⁽³⁾
- Restriction to the flow of breastmilk due to a tight bra, ⁽³⁾ ineffective emptying of the breast using a breast pump, or holding the breast with pressure over the underlying ducts.
- Painful nipples, ⁽³⁾ caused by incorrect positioning, indicating baby is not latching correctly, resulting in shorter feeds, and less effective emptying of the breasts.

Predictors of blocked ducts which may lead to mastitis:

- Nipple damage (grazes, cracks) ⁽¹⁾⁽²⁾, baby is taking insufficient breast tissue when attaching, resulting in nipple feeding, damage to the tender nipple skin, poor milk transfer to the baby and ineffective emptying of the breast.
- Engorgement, a firm overall breast which baby is unable to effectively latch on to or breastfeed from. ⁽³⁾
- Hurried feedings, when the let down has been stimulated but baby is not given sufficient time to empty breasts. ⁽³⁾
- Sudden changes in feeding pattern – leaving the breasts overfull. (May occur if baby is given a bottle and the mother does not remove some breastmilk to keep her breasts soft and comfortable.
- Use of nipple shield for first time mothers. ⁽³⁾
- Being overtired, skipping meals and not caring for yourself
- More stressed than normal, stress can interfere with the letdown. ⁽¹⁾⁽³⁾

Prevention

Correct Attachment – prevents nipple damage

- When baby first latches and starts breastfeeding, nipple discomfort may be felt as temporary “first latch” pain which quickly fades away.
- When baby is latched on well, the nipple is drawn deep within the baby’s mouth, protecting the nipple from damage. The shape of the nipple when baby comes off should look healthy, pink and rounded, not distorted with a ridge, appear pointed or white.
- Any early nipple tenderness should be improving.
- If pain or nipple damage, cracks or blisters worsen seek professional help as soon as possible.

Wash your hands

- Maintain good hygiene, washing your hands after nappy changes and before handling your breasts.

Breast Drainage

- By the second week, baby should be attaching and suckling well, and developed a rhythmic sucking pattern with short pauses. The breasts should be comfortable and feel softer after feeding.
- Baby may be feeding from both breasts more regularly as your milk supply settles. It is still important to feed on the first breast until baby’s sucking slows down and swallowing occurs occasionally. Then offer the second breast until baby comes off spontaneously, or baby is no longer making regular sucking activity.
- If baby does not feed from the second breast and **one or both breasts remain full and uncomfortable after a feed** it is important to remove some of the milk, by gentle hand massage or expressing equipment to prevent engorgement and to soften breasts until they feel comfortable.
- A sudden change in the feeding pattern (changing the length of time baby feeds, or between feeds) may cause a temporary pooling of milk which can cause mastitis.

Take care of your breasts – identify early warning indicators:

- Gently check your breasts after feeds, especially the late night feed, or if baby drops a feed.
- You are looking for **tender spots, lumps or firm areas not drained by the baby** which may develop into a problem between feeds.
- Prompt treatment will help prevent this temporary blockage / pooling from developing into a problem if it is recognised early.

Treatment:

Empty the breast – continue breastfeeding

- You may need to wake baby, or hand express under the shower as soon as you can for regular emptying of the breast until the tender spots or lumps resolve.
- Feed baby in a position that directs baby's chin to the affected area.
- Feed baby on the affected breast first, for at least the next two feeds – do not limit sucking time. Express the second breast for comfort if necessary.

Heat, Massage & Cold

- Apply moist comfortable heat (shower, soaks, facecloths, warm packs) to the affected area for 10-15 mins before feeds. ⁽²⁾
- A warm pack may be placed over the area for up to 2 hours when resting.
- Gentle massage of any lumpy areas, towards the nipple.
- Cold packs after a feed may provide comfort, and reduce swelling.
- Cabbage leaves (washed and dried) applied to the breast for 30 mins to 2 hours to reduce swelling and engorgement. Change every 2 hours.
- Mother requires **bed rest**, and assistance with baby.

If symptoms continue for more than 12-24 hours – seek medical advice.

- **Antibiotics are best used early in the infection.**
- Research shows that an antibiotic (such as flucloxacillin) needs to be taken for 10 days.⁽²⁾ The medication is considered to be safe for the baby who is breastfeeding.⁽⁵⁾ Erythromycin is the antibiotic of choice for those who have had an adverse reaction to penicillin.⁽⁵⁾
- Hirudoid® cream may be helpful to disperse breast lumps. Ensure that the baby's mouth does not come into contact with any Hirudoid®
- Women with mastitis should not take non steroidal anti inflammatory medications (eg Voltaren®) as these medications can mask the symptoms of an infection and allow the infection to progress aggressively.

Hospital Admission

- Some mothers may require admission to hospital for intravenous antibiotics or surgical drainage of an abscess.

It is most important that breastfeeding not be stopped during treatment.⁽⁴⁾

Good drainage of the breast is essential. The baby's suckling is the most effective method of milk removal.

References

- (1) Evan M. Heads J. Mastitis: Incidence, Prevalence and Cost. *Breastfeeding Review* 3:2:Nov.1995
- (2) Royal Hospital for Women NSW *Breastfeeding Review* 3:2:Nov.1995
- (3) Risk factors for lactation mastitis, C. Featherston. *J.Hum.Lact* 1998:14(2):101-9
- (4) Inch & Renfrew 1989. Brodibb 1990. Freed, Landers and Schanler 1991 in (1).
- (5) *Drugs in Pregnancy and Lactation* 5th Ed. Briggs, Freeman & Yaffe 1998

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This leaflet provides a guide only. If you have concerns or want more information about your baby, ask the doctor or nurse providing your baby's care.