

NIPPLE PAIN OR DAMAGE IN THE POSTPARTUM PERIOD

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Provide support and education to woman experiencing nipple pain and/or nipple damage in the postpartum period.
- Ensure adequate intake for neonate of woman experiencing nipple pain and/or damage.

2. PATIENT

- Postnatal woman and neonate

3. STAFF

- Nursing and midwifery staff
- Student midwives under supervision of a registered midwife

4. EQUIPMENT

- Nil

5. CLINICAL PRACTICE

- Commence the Breastfeeding Assessment tool found in the Maternal Clinical Pathways for Normal Vaginal Birth/ Caesarean Birth within 24 hours of birth
- Obtain verbal consent from woman to examine breasts and nipples (Refer Appendix 1)
- Perform hand hygiene as per infection prevention and control policy
- Observe positioning and attachment of neonate at breast with the woman's consent
- Provide education on optimal positioning, attachment, and hand expressing
- Observe nipple shape on detachment to assist in assessment of attachment
- Obtain consent to examine neonate with attention to oral cavity. Refer to ankyloglossia policy if tongue-tie suspected
- Ensure education on expressing and storage of breastmilk and methods of providing supplementation to her neonate, if woman is unwilling or unable to breastfeed directly
- Refer the woman to educational leaflets on expressing and storage of breastmilk and care of lactational aids
- Encourage unrestricted skin to skin contact for breastfeeding dyad
- Demonstrate spoon, cup or finger feeding techniques as per policy
- Refer woman to "Breastfeeding in the First Week" handout for an explanation of expected neonatal output to assess adequacy of intake
- Complete consent for formula supplementation and file in medical record if supplementation with formula is required or requested by woman
- Document observations and interventions in electronic medical record for woman and neonate
- Develop a feeding plan in conjunction with the woman's breastfeeding goals and give her a written copy
- Re-assess nipple pain/damage at subsequent breastfeeds and update feeding plan appropriately
- Discuss plan with lactation consultant and refer woman to breastfeeding discussion group held on postnatal ward and afternoon Breastfeeding Support Unit(BSU) drop-in, if woman remains an inpatient
- Discuss ongoing support after discharge from hospital – Child and Family Health Centre and breastfeeding groups, Australian Breastfeeding Association, Midwifery Support Programme/Midwifery Group Practice midwives, BSU at the Royal Hospital for Women in the first 2-3 weeks postpartum

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6. DOCUMENTATION

- Maternal Clinical pathway
- Neonatal Clinical pathway
- Medical Record – maternal and neonatal

7. EDUCATIONAL NOTES

- The Royal Hospital for Women is a Baby Friendly Health Initiative accredited facility and abides by the 10 Steps to Successful Breastfeeding
- A common reason for the early cessation of breastfeeding is painful nipples
- A number of maternal and neonatal causes of nipple pain have been identified or postulated:
 - Poor skin health e.g. eczema, thrush
 - Dietary deficiencies
 - Flat or retracted nipples
 - Use of nipple shields
 - Lack of nipple exposure to light and air
 - Breast engorgement
 - Nipple vasospasm
 - Incorrect positioning of neonate at the breast
 - Unrelieved negative pressure and breaking suction incorrectly
 - Incorrect sucking action
 - Mouth or palatal abnormalities
 - Local staphylococcus aureus infection
- It is important to provide support with correct positioning and attachment to avoid damage from nipple trauma, to favour improved healing and to ensure optimal breastmilk transfer to neonate
- Expressed breastmilk is applied to the painful/damaged nipple due to its anti-infective and antiviral properties
- Breastmilk is a natural agent that is biologically made for the body with no secondary effects. It is always readily available and can be used across all social and economic groups
- The Cochrane database review found that there was insufficient evidence to recommend any one treatment for nipple pain or trauma. This review found that, regardless of the treatment used, most women's pain reduced to mild levels by days 7-10 postpartum
- Hydrogel pads are advertised to have properties that improve healing such as capacity for absorption, being non adherent, bacteriostatic, having an antifungal agent, protecting against friction and relieving nipple pain. However, these should not be recommended as high infection rates have been identified with their use
- Hepatitis C is not transmitted through breastmilk. Women with hepatitis C are encouraged to breastfeed. However, as hepatitis C is spread by blood, if cracked or bleeding nipple/s occurs, breastfeeding from that breast should be temporarily suspended. Breastmilk expression should continue to promote milk supply but discard breastmilk until bleeding has ceased
- The American Center for Disease Control states a woman with Hepatitis B and cracked and/or bleeding nipple/s should express her breastmilk and discard until bleeding has ceased. It is encouraged to seek lactation support during this period to maintain breastmilk supply

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- NSW Health PD2017-013 Infection Prevention and Control Policy.
- NSW Health PD2010_019 Breast Milk: Safe Management
- Breastfeeding – Protection, Promotion and Support
- Breastfeeding – Delayed Onset Lactogenesis II, Early Intervention and Management
- Breastfeeding Support Unit (BSU)
- Supplementary Feeding of Breastfed Neonate in the Postpartum Period

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9. RISK RATING

- Medium

10. NATIONAL STANDARD

- Standard 5 – Comprehensive Care

11. REFERENCES

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REVISION & APPROVAL HISTORY

Endorsed Maternity Services LOPs 8/3/19

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APPENDIX 1

Description of Damage/Pain	Possible Cause	Suggested Management
Nipple ridging or compression stripe with/without broken skin	Inadequate breast tissue in the baby's mouth. Sometimes this may happen when a firm and full breast causes the nipple to flatten and baby unable to latch deeply.	Encourage wide open gape with asymmetrical latch (baby's nose equal to nipple prior to latching) and chin tucked into breast. If breast firm and full, express milk prior to latching baby.
Cracks around the base of nipple shaft after a breastfeed	Dragging of breast tissue due to poor positioning of the baby at the breast. Initial latching may have been correct but over the course of a feed, the mother allows the baby to slip back. (This is often more common in multiparous women)	Education of the mother regarding optimal positioning of the baby at the breast throughout the entire feed; keep baby's chin into breast; Rub EBM around nipple base prior to latching baby; Encourage the mother not to wear restrictive bra or clothing during first few weeks of breastfeeding.
'Lipstick' shaped nipple distortion after a breastfeed	Tongue is trapping the nipple tip against the roof of the mouth and the gums are compressing the nipple shaft rather than the breast. This is caused by inadequate amounts of breast tissue in the baby's mouth and the infant being too far up over on the breast. Sometimes this may happen when a very full breast causes the nipple to flatten.	Educate the mother regarding asymmetrical latching. If on improvement of latching distortion does not show signs of resolving then the introduction of alternating the baby's position at the breast, may alleviate the temporary discomfort (e.g. alternating between underarm hold, cradle hold, or laid back breastfeeding).
Blisters or starburst- shaped redness on nipple face	Suction trauma created by sustained negative pressure from an inco-ordinate suck, low supply or incorrect use of breast pump.	Encourage mothers to offer breast with early feeding cues and to massage breast and hand express prior to latching infant to encourage let down and moisten nipple. Encourage baby to have a wide, open gape with asymmetrical latch and chin tucked into breast by having baby's nose equal to nipple prior to latching. Education of the mother regarding use of massage & hand expressing prior to application of the breast pump. Examine mother and infant for conditions that may cause inability to latch effectively or low supply.
Yellow exudate or slow healing painful fissure or crack on or around nipple	Possible infected nipple from sustained nipple damage from poor breastfeeding	Review of nipple by medical officer for possible nipple swab and oral antibiotics as per Mastitis. Discuss options of feeding if too painful to B/F, such as 'rest and express'. Education to mother regarding optimal hygiene, optimal breast drainage and signs and symptoms of mastitis.

Painful nipples with no obvious damage, distortion or blanching	Pregnancy - Hormonal changes BF – Poor positioning or latching at breast – over time may cause visible damage	Reassure; Supportive, comfortable cotton bra; Observe breastfeed & ensure optimal positioning and latching; Express & rub EBM onto nipple prior to latching baby; If pain persists apply warm moist washcloth to nipple prior to latching baby; Review mother and infant for factors that may limit optimal latching. Refer mother to Lactation Consultant, Senior Midwife or Educator for review.
Painful white spot on nipple face	Blocked nipple pore (can lead to blocked duct and mastitis)	Warm moist compress on nipple &/or gently rubbed over nipple prior to latching baby; lancing the spot with a sterile needle may be required followed by hand expressing to remove thickened milk out of nipple pore; baby can then be latched; Ensure good milk flow through nipple pore. If reoccurs may need compresses of olive oil on cotton ball over nipple. If white spot does not hurt and milk flow is not blocked, it can be ignored.
Well demarcated erythematous rash, which may be dry, scaly or weepy with vesicles	Nipple eczema dermatitis - Women may have history of eczema; irritant or allergic contact dermatitis	Wear cotton bra; Avoid hot showers & soap or shampoo on nipples, wash with sorbolene; avoid using any products on the nipples except for ultra-purified lanolin; shower after swimming; Topical corticosteroid ointments are the main method of treatment & may be used for up to 7 days. Apply sparingly after a BF. Mometasone furoate (Elocon) QD or methylprednisolone aceponate (Advantan) QD. If appears infected, antibiotic TX may be necessary. If eczema appears on one nipple only, consider referral to medical officer to rule out Paget's Disease.
Painful itchy pink/red/shiny or dry and flaky nipples	Nipple thrush – Can occur after recent maternal history of antibiotic use, vaginal thrush or fungal infection in household, oral thrush or fungal nappy rash in infant	Optimal hygienic practices; keep nipples dry and air when possible; daily bra changes and wash bra in hot water and sun dry; diet modification (avoid yeasts, moulds, alcohol, sugar and starchy foods); Oral Acidophilus; Antifungal treatment preferably topical gels to nipples as well as baby QID for 1 week, then for another week once a day after signs & symptoms disappear. If pain improving, continue treatment but if not improving, consider oral fluconazole 150mg capsules, one capsule every second day for 3 doses.

Intense nipple pain, with burning & tingling associated with blanching of the nipple	Pregnancy – Nipple vasospasm – Mother may have family hx of circulation problems/Raynaud's phenomenon BF – As above or with nipple compression	Keep warm & limit temperature changes of body; limit caffeine & smoking; Increase aerobic exercise; Supplements of fish oil, magnesium, evening primrose oil may be helpful; Observe BF & ensure optimal positioning & latching. If compression persists – manually reshape nipple after a feed; Warm compress to nipple after a feed; Women can squeeze base of nipple and push forward; Medical review - may require treatment with Nifedipine in sustained release formulation providing 30-60mg per day.
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Table reproduced from St George Hospital Clinical Business Rule, Damaged and/or painful nipples during pregnancy and breastfeeding – Management. November 2015.