Common Problems in the First Weeks of Breast-Feeding

This is the sixth issue of the regular feature on infant feeding practices. This article is from the book, *Breast-Feeding In Practice: A Manual for Health Workers* by Elisabet Helsing and F. Savage King, published by Oxford University Press.

Early Breast Engorgement

When the milk first comes in, the breasts may feel full and uncomfortable. However, there is great individual variation. Some women have no discomfort at all, others have heavy, stony hard, engorged breasts, and pain. A brief spike of fever—even a single rigor—may occur at this time. It is sometimes called 'milk fever' and it is not due to bacterial infection, and need not cause great alarm. If it persists for more than 24 hours, though, it may be something more serious.

These symptoms are partly due to an increased amount of blood and tissue fluid in the breast, which decreases spontaneously after some days. These are also due to an excess of milk in the breasts, because at first milk production is poorly adjusted to demand, and often there is enough for two babies.

The simple answer to this problem of engorgement is to *express* the excess milk—which provides rapid relief of the pain and other symptoms. This may also perhaps, by reducing the pressure within the breasts, allow the freer drainage of tissue fluids, and quicker resolution of the condition.

Some people are afraid to express the excess milk because they fear that the breasts might continue to produce more milk than necessary—or even that the amount might go on increasing indefinitely. These fears are not justified, because after a week or two, production almost always decreases to match the demand of the infant. Also the needs of the baby increase, and it becomes more efficient at emptying the breast. At any rate, when congestion due to the blood and tissue fluid has decreased, the presure in the breasts decreases and they become more comfortable. At this later stage, you can safely stop expressing and let a mother's breasts adjust naturally to the infant's demand. There is less risk of breast abscess at this later time, too, so the need to keep on emptying the breast is less then.

In any case, the excess milk from high-yielding mothers is extremely valuable, because you can use it for other babies who are in need of extra milk. Human milk is especially important for premature babies, yet their mothers often find it difficult to express enough for them.

Too Little Milk

Just as some mothers have too much milk before their breasts have adjusted, so other mothers have too little milk at first. This does not necessarily mean that they will be less efficient milk producers later on. Many can produce enough milk and are able to feed a baby normally after two weeks or so. But during these few weeks, while she is waiting for the milk to increase, a mother is in particular need of support, encouragement, and supervision, so that she does not give up.

If in such a case, the infant loses too much weight (more than 10 per cent of its birth weight), or shows signs of becoming dehydrated, you can give it expressed breast milk (EBM) from other mothers. Or, if EBM is not available, you can give carefully controlled supplementary feeding with formula. But of course that is not nearly so good.

Sucking Difficulties

Most babies suck easily and naturally. But occasionally a baby seems to have to 'learn' to suck. The mother in such a case needs great patience. She should not give up trying, but at the same time she should not exhaust herself (or the infant) by incessantly trying to succeed. She should allow herself and her baby time to rest and regain strength in between the sucking exercise periods. Usually, the presence of a person whom she knows, and who is kind and calm is likely to help her. Sometimes, though, she is better trying alone.

A baby sucks because this is a reflex that it is born with. To start the sucking reflex, something has to touch the baby's hard palate. Normally it is the nipple that touches the palate, but to do this, it has to be able to get right inside the baby's mouth. If a *nipple is very short*, it may not go far enough into the mouth to start the reflex. This is part of the reason why flat nipples may cause problems in the early days. Most flat nipples are sufficiently protractile for normal sucking once they have been stretched a little. But some help may be necessary in the first few days.

If a *breast is engorged*, the nipple may be stretched flat and not easily protractile. The baby can only 'chew' at the tip of the nipple, and cannot get it far enough into the mouth to suck properly. As a result, the baby fails to extract milk, and also harms the nipple. The infant then becomes impatient, cries, and turns away from the breast and from the despairing mother. On such occasions, the assistance of an experienced and calm person is invaluable.

Flat Nipples

The management of flat nipples—however much engorgement contributes to the problem—is this: *first*, try to manipulate the nipple a little, to make it more erect and easy to grasp; *second*, it is often helpful to remove some of the milk so that the breast becomes

a little softer—you can either express by hand, or use a hand pump or an electrical pump if one is available; *third*, gently and patiently, put the infant to the breast for another try. One drop of milk left at the tip of the nipple may act as an 'appetizer'. *Remember that the nipple and the areola* (the dark skin around the nipple) *must both be put well into the baby's mouth.* Sometimes to do this you have to press the baby rather firmly on to the breast. Don't be afraid to do this—if you think the breast is going to block the baby's nose get the mother to use a finger to hold the breest clear of its nose—don't pull the baby's head away!

If this baby still does not succeed let it suck through a nipple shield for a few days, until engorgement subsides and the nipple has stretched.

Too Big Nipples

Sometimes *nipples are too big*. An infant may seem to gag and choke if the nipple is so long that it goes past the hard palate and touches the soft palate. It may react by fighting. When put to the breast it turns its head, cries and moves its arms and legs. This can easily be corrected by holding the infant a little away from the breast.

Too Much Milk Too Fast

A similar effect is produced when a mother has *too much milk and it flows out too fast out of the breast* due to a forceful ejection reflex. The milk fills the infant's mouth too quickly, and chokes it. In this case, the mother should express some milk before the infant feeds.

All these are reasons why a baby may seem to refuse the breast, and yet in most cases the mother has more than enough milk.

Inhibited 'Let-Down' Reflex

Sucking difficulties may also result from a child's not getting enough milk. This is usually because the reflex which is essential to enable the milk to come out of the breasts is temporarily inhibited. This is the *ejection or 'let-down' reflex*. It does not merely release the milk—but causes muscular contraction in the breast which forces the milk out. This ejection reflex can be inhibited for a number of reasons. In a maternity ward, it may be because a mother is afraid, or embarrased by the unfamiliar environment or the presence of strangers, or depressed or nervous about her motherhood or perhaps her future (remedies further discussed later in this chapter). The reflex is also inhibited if the mother worries too much about her milk, and lacks confidence in her ability to satisfy her infant.

Faulty Sucking Technique

An infant who is *used to sucking from a bottle* may have difficulty sucking from a breast. The sucking techniques employed in fact are quite different. Mavis Gunther (1973) explains it like this: "The bottle receiving mouth technique consists of rounding the lips, expecting the food to come from straight in front, and holding the tongue high and lose to the palate. It is as if the baby were guarding against having something thrust too far into his mouth, whereas the baby taking the breasts needs to use a small indrawing action to pull the nipple into a widely opened mouth. Once the baby's techniques have been adjusted to taking a bottle, it becomes much harder to get him to take the breast...Once the baby has become adept at taking the breast, competition from the bottle does not matter, the baby becomes skilled with both'.

Baby Too Tired or Weak to Suck Properly

Sedatives given to a mother during delivery may reach the foetus through the umbilical cord. The infant then may be too sleepy to suck properly. This may last for some days after birth (Kron, Stein, and Goddard : 1966).

Jaundice may have the same effect. In neither case, however, is there any reason to postpone the breastfeeding training sessions. The child should be offered the opportunity to suck even though it may not seem interested. If it can be persuaded to suck for a few minutes at a time this is very valuable, and should be repeated 6-8 times daily.

In such cases the most important task for a health worker is to keep up the mother's spirits by reassuring her that her infant will wake up soon, and become stronger and more statisfying to nurse.

Premature babies and babies with a cleft palate may also have sucking difficulties.

Sore Nipples

Another's nipples may become sore at any time during lactation, but it is more common in the early weeks. Soreness can result simply from:

(1) sudden exposure to the unaccustomed action of sucking;
(2) faulty sucking techniques; or
(3) letting the infant suck too long *in a bad position*;
(4) soreness is more likely to occur in engorged breasts; and
(5) when the nipples are flat and it is difficult for the baby to grasp the nipples properly.

Sore nipples do not have very impressive-looking wounds. Often you can only see little redness. But the nipples are so well supplied with pain fibres that very small lesions can be extremely painful. The pain is *worst* when the baby *first begins to suck*, and it is stretching the skin. It gets less as nursing proceeds, especially after the ejection reflex is working, and the milk is flowing. The early pain is often so strong that a mother may be found bracing her whole body to 'take' it'. Sometimes the severe early pain *inhibits* the ejection reflex, which leads to further problems.

Sympathy helps a great deal, and it may encourage a mother to hear that the condition seldom lasts more than a week (although one week in this case may seem a very long time for someone who has it ahead of her). There are several kinds of sore nipples: the 'positional' (erosive), the 'ulcerative' (fissure), the

'dermatitic', and the 'psychosomatic' (Gunther: 1953).

The most common kind is *the 'positional' sore nipple*. Gunther (1973) describes it as follows : 'It consists of swelling of the small projections of the nipple's skin or tiny leaks of blood into the skin, usually in a stripe across the nipple. The injured area corresponds in position to the gap between the part covered by the baby's palate (above the stripe) and the part covered by the tongue (below); this is the region of the mouth where suction is made'.

The same author describes *the ulcerative sore nipple* as : 'an opening at the base of the lines of the skin, sometime on the face of the nipple or where the nipple joins the areola'.

With both kinds, *prevention* is easier than cure. That is why we have emphasized the importance of examining nipples antenatally. If they are short, or 'flat', encourage the mother to pull them out, or to use a breast shell as described above.

When nursing, the mother must hold the boby close enough for its chin to touch her breast, and so that nipple and areola can both go completely inside its mouth.

If, in spite of taking these precautions, sore nipples start to develop, there are a number of things that have proved helpful :

- It may sound brutal—but frequent, *short* nursings promote speedy healing. It would seem logical to suppose that letting the nipples 'rest' for as many hours as possible would have a healing effect. This is however not the case. If a crust is allowed to cover the wound, it only cracks open again as soon as the baby sucks. The wound however heals in spite of frequent feeding.
- Let the baby suck first on the least affected breast. The initial sucking is the strongest, and thus the most painful. When the ejection reflex has started to work, change the infant over to the sorest side.
- If both sides are equally painful, very careful hand milking may elicit the ejection reflex, and the baby can then be put to the breast when the milk flows. If oxytocin preparation are available (either in the form of a nasal spray or of tables which are absorbed through the mucosa of the mouth) this may be the kind of situation in which they are helpful in eliciting the ejection reflex.
- Nursing the baby in a different position from usual may also help. In this way, the parts of the nipple which are subjected to most trauma by sucking are changed.
- The woman can apply a thin coat of any edible oil to the nipple between feedings. This often gives symptomatic relief. Lanolin and vaseline are good and harmless agents, and do not have to be removed before the baby sucks. But she must allow the skin to dry before she applies the ointment. Wetness, held on the skin by the ointment, makes the skin softer and weaker.
- *Never* apply tincture of benzoin or surgical spirit. They cause severe pain, and can damage the nipple skin even more.
- There are several substances of both modern and traditional origin that people claim are helpful for healing sore nipples, such as lemon juice, oestrogens, disinfectants, Vitamin-E containing ointments etc. A dilute solution of lapis (0.1 per cent) is often recommended to 'strengthen' the skin. Some of the recommended methods for treating sore nipples are dramatic, others more ordinary. In the end, only the common sense and general experience of the health worker can help her decide whether or not to encourage or discourage any particular remedy.
- If a nipple becomes extremely sore, it may become necessary to temporarily discontinue breast-feeding until the nipple responds to treatment. But it is essential, both to prevent an abscess forming and to maintain milk production, that you express the milk (either manually, or if that is too painful, with a pump). Unfortunately, in this situation, the milk production often diminishes. It may be necessary to stimulate it to increase again.

Persistent Sore Nipples

Thrush Infection

If sore nipples are persistent, it may be because the baby has a *thrush infection* in its mouth which has spread to the nipples.

Whenever a mother has sore nipples, always check her baby for thrush so that you can treat it before the soreness becomes persistent. A baby with thrush has a white coated tongue or white lesions that look like milk curds inside the cheeks. If you are not sure if they are milk or thrush, try to wipe them away. If you can remove the white easily, it is milk; if you cannot remove it, then it is probably thrush. You can treat thrush with gentian violet (0.5-1 per cent), or lapis (2 per cent) which you apply twice daily for 5-7 days, or nystatin drops or cream. If the white lesions are still present after another 5-7 days, repeat the treatment.

Fissures of the Nipples

A fissure also may be very slow to heal, specially if it is complicated by thrush infection. It may be necessary to stop putting the baby to the breast and to express the milk manually instead. Usually the milk volume decreases when you do this, but it will increase again when the nipples have healed and the baby can suck frequently again. It is resonable to apply an antiseptic cream as soon as you suspect a fissure, with the hope that it may reduce the chances of bacterial infection making the condition worse.

Another thing that may help is to use a nipple shield (of rubber or glass and rubber) temporarily. This should reduce the pain and also protect the nipple.

Dermatitis of the Nipple

Dermatitis of the nipple is a condition which you may see sometimes. The nipple looks red and sore, and the mother feels pain *all the time* while the baby

is at the breast, not just in the beginning. The nipple is tender even if you touch it with the back of the hand (Gunther: 1973).

This may be an allergic reaction to something which the woman has applied to her nipple: an ointment, detergents used for washing her brassieres or pads that are in contact with the nipple. The treatment consists primarily of removing and avoiding the irritating substance, if you can identify it. You can apply a steroid-containing cream, for instance non-greasy hydrocortisone cream (0.5 per cent) for a few days (*never more than a week*). Make sure that she washes off the cream carefully with lukewarm water before each feed, even if she is expressing the milk manually. This is to prevent the powerful steroid hormone from reaching the baby. If the diagnosis is right, this treatment is very effective.

Psychosomatic Sore Nipples

These have been described by Gunther (1973) as occurring when a mother consciously or unconsciously associates breasts or breastfeeding with some unhappy memory or feeling, for instance in connection with uncertainty of her own feelings about motherhood.

Typically, on inspection, usually one or both nipples turn pale and then suddenly blush and then turn pale again. The mother feels pain in the nipple when she feeds the baby and all the time that the baby is at the breast.

Treatment consists of finding the cause of the mother's anxiety, and then discussing it with her. Sometimes, when a woman understands her own problem, her fears decrese and her nipples no longer feel sore. At other times the problem is too great to resolve quickly enough, and may prevent her from breastfeeding successfully.

Milk Blister

An uncommon, and trivial condition. Milk gets under the superficial layers of the skin of the nipple, and you see a small white blister. It usually cures itself after a few days and the skin which covers the blister lifts off. While it lasts, feeding from the nipple may hurt.

In most instances, you can treat even very sore nipples successfully. Occasionally, however, the condition is resistant to treatment, or recurs at short intervals. This most commonly happens with a nipple of very poor protractability. In these rare cases, it may be better to stop breastfeeding instead of going through many painful attempts and failures (provided that artificial feeding can be done safely).

Sore nipples always test a mother's motivation for breastfeeding. If bottlefeeding is not really feasible, encouragement and support from the health workers is essential. If bottlefeeding is feasible, it is in the end up to the mother to decide how much trouble she is willing to take to continue breastfeeding.

Irregularities in the Ejection (The 'Let-Down' Reflex)

Many common problems with breastfeeding result from inhibition of the ejection reflex. This causes symptoms like: 'baby fussing at the breast', 'baby crying again only a short time after having been fed', or 'the milk seems suddenly to have disappeared'. To make this diagnosis, ask the woman if she feels the tense, pricking 'letdown' sensation beneath her nipples when the baby begins to suck. However, many successful nursing mothers do not feel these sensations in the early weeks of nursing and some large-breasted women never feel them at any time.

When you diagnose a mother's breastfeeding problem, this therefore may pose a small problem. On the one hand, you want to know how the reflex is functioning. On the other hand, focussing too much attention on whether or not the mother can feel the reflex may provoke enough anxiety to inhibit ejection in those women who have the reflex but not the sensation (Waletzky: 1979). Your judgment of whether the reflex works properly or not may therefore have to be based on whether the baby seems to be getting milk, rather than on probing what the mother can feel. The ejection reflex is easily influenced by the mother's psychological state. Hence treatment must be psychological more than physical.

Go through all these points with a mother who you think is affected this way:

1. Before she puts the baby to the breast, the mother should try to calm down, for instance by resting for some time, having something nice to drink, etc. This should become a ritual, repeated before *each* feeding session. For instance she might make a cup of tea and sit down and drink it, or lie down with closed eyes for five minutes.

2. Make sure she sits or lies in a comfortable position, and that she can remain undisturbed.

3. Make sure that the infant is sucking strongly in a good position, and not causing the mother pain.

4. Routine and habits may be important. If possible a mother should feed in the same place each time —i.e. in a particular corner of the house, in one special chair and so on.

5. Sometimes for this kind of problem, scheduled feeding is said to be helpful. But give the baby a say in establishing the shedule according to its needs. Starting when an infant wakes up in the morning, the mother should feed it regularly throughout the day, for instance every two or three hours, thus 'conditioning' both the breasts and the infant for scheduled feeding hours.

6. Whenever a mother feels her ejection reflex coming—even if this is outside the scheduled feeding hours, she should *always put the infant to the breast.* This is in order to establish the psycho-physiological connection between feeding the baby and ejection of the milk.

8. In extreme cases a sedative for a short period can be helpful. Chlorpromazine 25 mg three times a day for a week has been found to block the inhibition of the ejection reflex, and to help to restore the reflex. Also this drug augments the milk production by blocking the prolactin-inhibiting factor. The baby is

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DELHI

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Places of Worship

Temples

Lakshmi Narayan Temple : Popularly known as Birla Mandir, the temple was built in 1938. It houses the images of Narayana and those of Goddess Durga and Lord Shiva within its precincts.

An exquisite and inspiring *Arti* is performed every evening at sun-set.

Hanuman Mandir : On Baba Kharak Singh Marg, near the State Emporia Complex.

Churches

Free Church : Parliament Street, New Delhi : Service : English 10 to 11 am; 6 pm.

Church of Redemption : Church Road, Near Rashtrapati Bhavan : Service : English : 8 to 9 am; 6 pm; Hindi : 11 am.

Sacred Heart Cathedral : Ashok Place, New Delhi; Tel : 343593.

Mosques

Jama Masjid : Near Red Fort, about 2 kms from MAMC.

Fatehpuri Mosque : Near Chandani Chowk; about 3 kms from MAMC.

Gurdwaras

Sis Ganj Sahib : Commemorating the martyrdom of Guru Tegh Bahadur, it is a majetic and serene place of Sikh worship in the bustling Chandni Chowk.

Rakabganj Sahib : A beautiful modern structure in marble associated with the last rites after the martyrdom of Guru Tegh Bahadur: Near Central Secretariat.

Bangla Sahib : Associated with the heritage of Guru Harkishan Sahib, it is centrally situated near Connaught Place and has a spacious *Sarovar* and a well believed to have healing qualities.

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not affected, except beneficially, by improved lactation!

8. Oxytocin preparations, if available, may help elicit or enhance the reflex.

9. Once more, psychological support and practical aid from a kind experienced person is the basis for success. If a health worker cannot herself do this, she might be able to put the mother in contact with someone else who can.

For information on better maternal and infant feeding practices, write to: Infant Nutrition Information Service, C-14, Community Centre, Safdarjung Development Area, New Delhi-110 016.

A Rare Opportunity for Nurses

Delhi is being given the honour to hold for the first time an International Conference, from 28th Oct. to 6th Nov. 1984, organized by the Nurses Christian Fellowship International (NCFI) bringing together about 350 nurses from 24 countries.

The Evangelical Nurses Fellowship of India, as a member Association of NCFI, is highly pleased to extend a warm invitation to Delhi Nurses to attend the Inaugural meeting of this International event at 4 p.m. on 29th October in the New Delhi YMCA Tourist Hostel, Jai Singh Road, New Delhi-110 001.

Nurses who wish to attend may send prior intimation to the NCFI Conference Secretary, 10, Millers Road, Madras-600 010.