Common Breast Problems in the Early Postpartum Period
Reassure, Recommend, or Refer?

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LEARNING OBJECTIVES

• Recognize the signs and symptoms of breastfeeding problems that are most likely to appear in the first few days or weeks postpartum, including sore nipples, physiologic engorgement, pathologic engorgement, and mastitis.
• Recognize the progressively worsening conditions that occur if sore nipples and physiologic engorgement are not resolved.
• Compare and contrast signs and symptoms of physiologic engorgement, pathologic engorgement, and mastitis.
• Determine if early breastfeeding problems that can occur in the first few weeks of breastfeeding should be handled by phone, in person, or referred to another professional.
• Discuss clinical strategies for breast/nipple problems that can occur in the first few weeks of breastfeeding.

ABSTRACT

Uh-oh. You see that swelling or red streakiness on her breasts, but you’re not actually sure if that’s just a minor deviation from normal, or if it’s a problem that needs more specialized attention. She says she has sore nipples, but you’re not sure if they are related to the baby’s latch, the pump, or something more ominous. And, in truth, you aren’t sure how or even if the nipple problem figures into the breast problem. She depends on you, and you really aren’t sure what to advise her to do next. The goal of this learning program is to help you decide how to handle the most common breast/nipple problems that occur during the early postpartum period—telephone advice, in-person visit, or referral to another professional.
Topical Outline

I. ENGORCEMENT\(^{1-17}\)
   A. PHYSIOLOGIC ENGORCEMENT
   B. PATHOLOGIC ENGORCEMENT
   C. MANAGEMENT OF ENGORCEMENT

II. MASTITIS
   A. ETIOLOGY:
   B. ONSET OF SIGNS AND SYMPTOMS
   C. SIGNS/SYMPTOMS OF INFECTIOUS MASTITIS

III. SIMILAR BUT DIFFERENT CONDITIONS
   A. CONDITIONS
   B. SIMILARITIES AND DIFFERENCES
   C. KEYS

IV. SORE NIPPLES\(^{46}\)
   A. FOUR MAIN CAUSES
   B. INTERVIEWING FOR POSSIBLE CAUSALITY

V. RED FLAGS FOR FOLLOW-UP
   A. PRE-EXISTING OR PERSISTING RISK FACTORS
   B. FOLLOW-UP STRATEGIES AND GUIDELINES

VI. SUMMARY & CONCLUSIONS FOR TODAY

VII. REFERENCES
Materials and Resources

- Audio learning program
- Post-test items that are similar to those found on the lactation exam.

Vocabulary

Abscess
Bilateral
Mastitis
Pathologic engorgement
Physiologic engorgement
Plugged (obstructed, blocked) duct
Unilateral

Criteria for Earning Credits

- See the ReadMeFirst document in your account.

Accreditation

This learning program has been approved for:

- 1.5 contact hours for nurses.
- 1.5 L-CERPs by Gold Standard Resources (DBA Breastfeeding Outlook) which is accredited as a long-term provider (#CLT108-22) by the International Board of Lactation Consultant Examiners.

- 1.5 CEUs for doulas pending
I. Engorgement

A. Physiologic Engorgement
1. Causes of physiological engorgement
   a. milk is “coming in”
   b. due to unrelieved negative pressure
   c. generally resolves or at least subsides within the first few days.
2. Signs/Symptoms of Physiologic Engorgement
   a. May have slight fever (< 38.4º)
   b. Breasts
      (1) Size: overall enlargement
      (2) Shape: Some breast distension
      (3) Symmetrical; equally awful!
      (4) Feeling of firmness
      (5) Discomfort
      (6) Color: may be somewhat red, or red-streaky or may not be discolored at all
      (7) Swelling can diminish milk flow
3. Distortion of nipple/areola
   a. Flattening of nipples (and subsequent difficulty latching)
   b. Firmness or hard areola (and subsequent difficulty latching)
   c. Increased incidence of traumatized nipples

B. Pathologic Engorgement
1. Signs/Symptoms of Pathologic Engorgement
   a. Breasts
      (1) Size: overall enlargement
      (2) Shape: Severe breast distension; breasts may be standing at a 90-degree angle; sometimes distended up to the woman’s clavicles
      (3) Symmetrical; equally awful!
      (4) HARD
      (5) Painful breasts
      (6) shiny, taut skin
      (7) Color: may be red, or red-streaky
      (8) Swelling can diminish milk flow
2. Distortion of nipple/areola
   a. Flattening of nipples (and subsequent difficulty latching)
   b. Firmness or hard areola (and subsequent difficulty latching)
c. Increased incidence of traumatized nipples

**C. Management of Engorgement**

1. Frequent, effective emptying of the breast!
2. Warmth on the breast for a few minutes to move the milk
3. Ice after the feeding or any time thereafter for as long as needed. (Need a cloth between the ice pack and the skin!)
4. Massage breasts before and during feeding
5. Cabbage leaves\(^3\)\(^9\)\(^18-21\) (evidence for this is a little shaky, but any lactation expert will tell you it works!)
7. Physiologic engorgement could be managed by phone, if all was otherwise going well. Key is whether the milk is being effectively removed.
8. Pathologic engorgement almost always requires an in-person assessment. Usually, the root of the problem is that milk is not being removed, and the reason for that must be explored. Difficult latch is often part of the problem. (Either the cause or the result of engorgement.)
9. Much has been written on engorgement which is much more detailed than what is here.\(^1\)\(^-17\)
Common Breast Problems in the Early Postpartum Period

- Lack of or Inefficient Milk Removal
- Engorgement
  - Physiologic
  - Pathologic Engorgement
- Plugged Duct
- Mastitis
- Abscess
II. Mastitis

A. Etiology:
1. Almost always staph
2. Occasionally strep

B. Onset of Signs and Symptoms
1. Gradual onset if following engorgement or a plugged duct.
2. Can have a very sudden onset
3. Mastitis is often preceded by a “hot spot” (plugged duct.)
4. Severity and recognition of true mastitis
   a. Signs/symptoms easily identifiable
   b. Signs/symptoms subtle and ambiguous

C. Signs/Symptoms of Infectious Mastitis
1. Systemic signs/symptoms
   a. “Flu-like” symptoms (chills, fever, achiness, headache, malaise)
   b. Temperature > 38.4° C
2. Local signs/symptoms
   a. red “area” looks and feels hot, hard, tender, swollen, miserable
   b. usually unilateral; if bilateral, causative organism probably strep.
   c. often in right, upper, outer quadrant
   d. deep breast aching
   e. Hard, hot, red, accompanied by fever and flu-like symptoms
3. Risk Factors and Contributing Factors
   a. Plugged duct
   b. “cutting into the flesh”
   c. infants with nose that has positive culture for staph
   d. Multips—yes, multips!—are at greater risk for mastitis
   e. Anyone who is ever at high risk for infections, e.g., diabetics.
4. Clinical Management Strategies
   a. Dr. Marianne Neifert says, “Heat, rest, empty breast.”
   b. Refer for medical management. Antibiotics. Usually, anything less than a 10-14 day round is ineffective.
   c. If symptoms do not begin to subside by 24-48 hours after antibiotics have been started, BEWARE!
   d. Plenty of fluids, just as with any infection.
e. Watch for further developments.
5. This is only tip of the iceburg! More on this topic!16 17 22 25-45

III. Similar but Different Conditions

A. Conditions
1. Physiologic engorgement
2. Pathologic engorgement
3. Plugged Ducts
4. Mastitis
5. Abscess (not in today’s content)

B. Similarities and Differences

C. Keys
1. color, location, shape of the lesion
2. accompanying symptoms (i.e., subjective reports of pain) from the mother.

Concept Attainment Exercise:
Physiologic engorgement, pathologic engorgement, and mastitis are written in 3 circles in Figure 1. Write the sign, symptom, or characteristic in the correct circle. Overlapping signs and symptoms should go in the overlapping area.

- Abnormal but not infectious
- Bilateral
- Breast firmness
- Breast fullness
- Breast hardness
- Breasts at right angle to chest wall
- Discomfort
- Firm or hard areola
- Flu-like symptoms
- Infectious
- Normal
- Pain
- Red streaking
- Reddened area
- Shortened nipples
- Skin very taut and shiny
- Temperature < 38.4
- Temperature > 38.4
- Unilateral
Figure 1. Similar and Different Signs/Symptoms

- Physiologic Engorgement
- Mastitis
- Pathologic Engorgement
IV. Sore Nipples

A. Four Main Causes

1. Transient, physiologic issues
   a. i.e., negative pressure exertion in the early days when supply is low.

2. Incorrect attachment or removal of the infant at the breast

3. Use or misuse of equipment or products, most notably:
   a. Pump issues
   b. Problems with the capabilities/limitations of the pump, or worn-out pump parts
   c. Poor fit of the flange
   d. User error

4. Pathologic issues
   a. Maternal origin, e.g.,
      (1) e.g., candidiasis
      (2) allergic problems, etc.
   b. Infant origin, e.g., craniofacial anomalies that cause friction or other trauma on nipple tissue, e.g., short frenulum, cleft lip, etc

B. Interviewing for Possible Causality

1. “How old is your baby?”

2. “Are you pumping, or is your baby suckling at the breast, or both?”

3. “Does your baby seem satisfied at the end of the feeding?”

4. “Do your breasts feel differently at the end of the feeding than they did before starting?”

5. “Do you see anything on your nipples? (e.g., broken skin, discoloration, blood, scab, etc.)?”

6. “Does your baby have any problems with his lips, gums, chin, or tongue?”

C. Short Vignette

Mrs. A. is 2 days postpartum. She is at home now, and has a 0.5 mm vertical crack on her nipple. What questions would you ask her? When you observe a feeding and/or pumping, what would you look for FIRST? What is she at risk for?
V. Red Flags for Follow-Up

One time my boss asked me, “So how do you know which patients need a follow-up call?” I just intuitively “know” but she insisted that I write something up for the staff. This is the list that I came up with at the time, and it has proven to work well over the years.

A. Pre-existing or Persisting Risk Factors

1. Delayed or restricted or non-exclusive breastfeeding

2. Adequate milk volume is questionable
   a. Mother has had prior medical or surgical conditions that could compromise milk production.
   b. Mother has lifestyle habits e.g., smoking that can interfere with production
   c. Medications that can reduce milk volume or interfere with milk let-down.
   d. Other situations—including stress—that can affect overall hydration status or ability to have milk ejection reflex.

3. Milk volume cannot meet infant’s need
   a. Infant has high metabolism, e.g., a baby with a cardiac defect
   b. Other situations

4. Adequate milk transfer is questionable
   a. Mother has sore nipples
   b. Infant does not have audible swallowing.
   c. Lack of infant alertness or inappropriate sleep-wake states.
   d. Hyperbilirubinemia (baby is sometimes too lethargic to get a good feeding.)

5. Other
   a. Lack of social support or downright undermining of her efforts to breastfeeding
   b. Poor maternal self-esteem and self-confidence, or frequently expressing doubts about breastfeeding.

B. Follow-up Strategies and Guidelines

1. Timely follow-up

2. Weight checks are crucial

3. Observation and documentation of voiding and stool patterns.

4. Pathology can sometimes go undetected
VI. Summary & Conclusions for Today

• The most likely breast problems—including sore nipples, physiologic engorgement, pathologic engorgement, and mastitis, are all different problems that occur in the early postpartum period, but each problem can and often does overlap with the other. By recognizing the common signs and symptoms, it is fairly easy to determine if the problem or problems can be adequately handled by an in-person or telephone visit, or if the mother should be referred to another professional. Some problems that exist in the first few days postpartum are red flags for follow-up. Mothers should be reassured that, as my friend Debi Bocar RN PhD IBCLC says, “Most breastfeeding problems are transient and solvable.”

Suggested answers for Vignette with Mrs. A: If she is 2 days postpartum and has a 0.5 mm vertical crack on her nipple, the most likely explanation is that the baby does not have a deep latch. If he does not have a deep latch, he might not be transferring milk well. A good question to ask would be whether her breasts feel different at the end of the feeding. An affirmative answer to this question would add credibility to the idea of a shallow latch. (Answer does not need to be affirmative in order to continue pursuing the possibility of a shallow latch.) Complications? A cracked nipple is often associated with later development of mastitis. Our skin is our largest organ of defense, and when the skin is broken, it’s a portal of entry for bacteria.
VII. References


