

Revisiting Engorgement and Mastitis
Angela Smith, RN, CM, BA, IBCLC

(ILCA 2002)

Engorgement vs. normal fullness

Full, tender, warm, heavy, relieved after a feed, good milk flow is normal.

True engorgement is full, tight & shiny, hot & heavy, unrelieved after a feed, poor milk flow.

Not “engorged” if there is good milk flow.

Risk factors

Infrequent or inadequate emptying of the breasts

Mothers with small breasts

Mothers with high rate of milk production

Limited mother/infant contact in early days

Management of Normal Fullness

Reassurance, comfort measures, cold packs, analgesia if needed, good positioning & attachment.

Management of True Engorgement

Reassurance, comfort measures, cold packs, stronger analgesia, good positioning & attachment.

Options for Management of True Engorgement

Express by hand prior to feeding to get flow going and soften nipple and areola.

Supervise feeding

Cold packs between feeds (but not right before a feeding)

One breast per feed

Possibly: After baby is finished, use a breastpump to totally empty breast

Often this milk is very yellow and thick, can look like egg yolk.

Might take an hour to pump off after a feeding.

Extremely gentle massage.

Many other options have been suggested but most are unproven

Did NOT recommend heat for true engorgement

Heat stimulates MER, but if the milk can't get out it just makes the engorgement worse.

Heat should only be used if there is good milk flow.

Cabbage leaves--wash them well first

May act as an irritant (sulphur) drawing extra blood flow in the area which dilates capillaries, which helps to relieve engorgement and allow milk to flow.

If hideously engorged, sometimes it's better to give analgesics, cold pack the breasts for several hours and just leave everything alone.

Mastitis: Signs & Symptoms

Red area on breast that is tender and hot

Elevated temperature

Flu like symptoms such as hot/cold shivers, joint aches and pains.

This is a **normal** response to an inflammatory process, not necessarily evidence of infection.

Non Infective Mastitis

In established lactation the junctions between secretory cells should be tight.

In milk stasis the pressure builds up so that the tight junctions switch to leaky, and milk leaks into the interstitial tissue and irritates it.

Increased pressure can occur with:

- Ineffective milk removal

- Blocked duct

- Missed feed (mom gets too full, has MER, milk has nowhere to go)

Sodium levels go up, lactose concentrations go down.

Inflammatory or infective mastitis?

Difficult to differentiate

Signs and symptoms are the same

Breastmilk naturally contains bacteria, but normally flushed out with the flow of breastmilk

Flow is sluggish with blocked ducts, engorgement, etc.

Injury to the nipple (break in skin integrity) results in increase in infective mastitis.

Management of Mastitis

Reassurance, develop plan, observe a feed.

Start on affected side for next 2 feeds

Direct baby's chin to the affected area

- If upper area of breast, straddle sit with gentle massage

Ensure thorough milk removal

Rest, fluids, analgesia/antipyrexial medication

Antibiotic if, after two feeds, it's getting worse rather than better

Warm/moist or cold packs between feeds

Breast Abscess

Preventable, almost always follows inappropriate/ineffective management of mastitis.

Risk factors:

- Delay in therapy

- Failure to drain the affected breast

- Avoiding breastfeeding on the affected side

- Abrupt weaning

- Poor choice of antibiotics

- Antibiotic resistance

- Refusal to take antibiotics or incomplete course taken

IBCLC responsibilities

Ensure accurate education given to new mothers

Ensure management plan for engorgement or mastitis

Follow up

Medications That Affect Prolactin Secretion Thomas Hale, PhD

(Tidbits from his talk at ILCA 2002)

Depo-provera

He doesn't think it should be given in the first few days after delivery; should wait for the receptor sites to be gone.

Reglan recommendations

10-15 mg. 3 times/day

Should see an increase in production within 2-3 days, stop if nothing in a week

Probably useful to measure Prolactin prior to treatment (in the AM), if it's high then Reglan probably won't work

Be sure to taper it off at the end

Domperidone

Manufacturer lost the patent rights this year so they definitely have no interest in pursuing FDA approval (too costly, they'd never make any money)

10-20 mg. 3 times/day recommended dose

Very low concentrations found in breastmilk

Can cause headaches/gastric distress but none of the sedation or depression that Reglan can cause

Drugs that Inhibit Prolactin

Ergotamines

Dostinex (cabergoline) drug of choice for lactation suppression

Parlodel (bromocriptine)

Anti-parkinson drugs

New Unpublished Data on Sudafed (pseudoephedrine)

One 60 mg. tablet can decrease milk production from 3-59%

If prolactin levels are lower there is more of a decrease

Therefore, the farther out from delivery, the greater the decrease in milk production

He was asked but did not have a recommendation for what to take for a cold, etc.

Track 5 at the ILCA conference. Track 5 includes Managing Breastfeeding in Difficult Maternal-Child Medical Situations, Polycystic Ovarian Syndrome: Does it Have an Effect on Milk Supply?, and Colitis in the Breastfeeding Baby

COLITIS IN THE BREASTFEDING BABY. Presented by Joan Fisher, RN, BN, IBCLC (since 1985)

Exclusively breastfed infants who develop mucousy, bloody stools are usually removed from the breast and given lactose-free, hydrolyzed protein, or amino acid formulas. Ms Fisher works with mothers to offer lactose-free breastmilk. She accomplishes this with the addition of liquid lactase to expressed breastmilk. This treatment is a part of her plan for the resolution of the colitis when other measures have not resolved the problem..

Breastfed babies who are most susceptible to developing colitis:

- Have mothers with bountiful milk supplies (over-supply) and strong MERs.
- Have gained weight very quickly and appear to be thriving
- Have responded to growth spurts with frequent feeding (10 days, 3 weeks 6 weeks)
- Are under 3 months of age.

The progression of colitis is from liquidy, yellow stools to frequent (12-16 a day) loose, green (undigested lactose), mucousy stools, then to blood in the stools. Many concerned mothers with babies who cry throughout the day are ignored because baby is gaining weight.

Causes of colitis in breastfed infants:

- Foremilk/hindmilk imbalance... the major cause, contributing to the others.
- Dietary protein allergies, ie cows milk protein
- Antibiotics
- Post-infection inflammation
- All of the above

If there is foremilk/hindmilk imbalance and others of the above factors are added then severe colitis occurs. Even if there are other factors involved, foremilk/hindmilk imbalance correction will greatly reduce the effect of the other factors.

First and most important step is reduction in the milk supply to correct foremilk/hindmilk imbalance. This is followed by elimination of the offending dietary proteins and examination of maternal meds [including iron in prenatal vitamins and additional iron supplementation PWG]. Many times these measures resolve the bloody, mucousy stools within 76 hours. If there is not resolution, then lactase-treated expressed milk is given to the baby until the intestines are healed.

Prevention:

- Watch for oversupply potential from the beginning... large amount of colostrum is a sign.
- Mothers with possible oversupply (or a history of such) should feed only one breast at any feeding under 3 hours—even from the beginning.

After milk is in, over 6 heavy wet diapers a day and rapid weight gain are red flags for oversupply. Treat immediately to reduce supply.

Warn a mother with resolved over-supply problems to stay with one breast per feed through any growth spurts that occur. Watch for frequent feedings.

Ms Fisher warns that a mother with oversupply or potential oversupply "should not get near an electric breast pump." With the supply-reduction plan, if the un-used breast grows painfully full hand expression or a hand pump is used to express a small amount of milk for relief. Milk left in the breast will reduce the supply.

Ms Fisher's lactase-treated breastmilk is created by adding 5 drops or more of lactase to room-temperature breastmilk and letting it sit for 2 hours then refrigerating until used. "Overdose is impossible. There are no reactions of any kind from liquid lactase."

On the tape of this presentation Ms Fisher covers several case studies and their effective resolution.

WALC has copies of this tape and others, for use by our members.

Submitted by Pat Gima