The Frequency and Resolution of Nipple Pain When Latch is Improved in a Private Practice

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This study examined the frequency and resolution of nipple pain in 61 consecutive cases in a private practice. Out of 61 consultations, 37 mothers reported pain during feeds, either exclusively or combined with another problem. For 24 of these 37 mothers, the pain ended by improving the latch. For the 13 other mothers, there were additional problems associated with the pain that required further intervention. The majority of consultations for pain were resolved simply by improving the baby's positioning at the breast. This implies that it is important to address latch issues from the very first days of the baby's life.

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Introduction

Nipple pain and inadequate weight gain are two common reasons for breastfeeding cessation. After leaving the maternity hospital, mothers often have difficulty finding help if they have breastfeeding problems. The author is an IBCLC in private practice who provides lactation support to families at any time during their breastfeeding experiences. The author noted that consultations frequently involved working with mothers to improve the babies' latch, with nipple pain as the presenting problem. Given the frequency with which nipple pain and latch appeared to be the presenting problem, she sought to systematically evaluate the proportion of women seeking her services for nipple pain that could be improved simply by improving the baby's latch.

Method

The data included all consultation files from January 4, 2010 through February 22, 2010. This represented 59 cases and 61 consultations. All the cases were included, regardless of the age of the baby or the reason given by the mother for the consultation. All the mothers lived in France, in the region of Ile de France (the large region including and surrounding Paris). The consultations were conducted in the home (N=49), in the office (N=10), or by telephone (N=2).

The author asked each woman the following question during the consultation: "Do you feel pain when your baby latches on to the breast or during the feed?" The mothers' responses indicated whether pain was their presenting problem, either exclusively or combined with another problem.

In all the cases of pain, the baby's latch was evaluated and the mother was offered suggestions for improving the baby's positioning at the breast. The pain was re-evaluated after latch improvement. The absence of pain was the criteria for saying that simple improvement of the latch was sufficient to resolve the pain problem. For each mother-baby couple, latch difficulties, and any of the other problems which might have led to pain at latching, were noted. This information was included in the mother's file, and data for this study were coded from the mothers' files.

Results

The age of the babies seen in consultation varied from four days old to one year. The average age was 32 days. Sixty-two percent of the 61 consultations were for breast pain. Pain may have been the only reason given for the consultation, or there may have been another problem, such as an insufficient weight gain, mastitis, problems with the feeding rhythm, or premature weaning. Many of these issues are linked to breast pain because a baby who hurts his mother when breastfeeding may have an inefficient suck, which can lead to inadequate weight gain. The baby's inability to empty the breasts sufficiently can lead to mastitis, and the baby might nurse continuously to build up an inadequate milk supply. All of these problems can lead to premature weaning.

The consultations for pain represented almost two thirds of the author's consultations during these two months. Some women waited several months, and one of them a whole year, before consulting because they had been told at the maternity hospital that it was normal to have breast pain during breastfeeding.

Sixty-five percent of the breast-pain cases resolved simply by improving the latch of the baby. In all these cases, the mothers declared that it was the first time that they had been shown how to offer their breast to their babies in a way that didn't hurt.

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Thirty-five percent of the pain cases associated with an incorrect latch co-occurred with another problem. These problems included:

- Dermatological conditions, such as eczema or sebaceous cyst
- Short lingual frenulum
- Jaw problems, including hypertonicity of the jaw, or asymmetrical jaws
- Candidiasis
- Bacterial infection in the breast
- Sucking problem in the baby

In all these cases, it was necessary to treat both the baby's latch and the other causes of the pain.

The most common latch issues were as follows:

- The baby did not open his mouth sufficiently. The nipple was centered in the baby's mouth, or the upper lip was not being stimulated.
- The baby opened his mouth correctly but then shut it because he was held too far from the breast. The baby had to lower his head to take the breast, the mother bent forward to bring the baby to the breast, or the mother pressed on the chin of the baby.
- The baby turned his head to take the breast because the mother positioned him with his stomach facing upwards, often by placing him on a breastfeeding pillow that was not the right height.

To help these babies latch onto the breast without provoking pain, two positions were used by the author, depending on the case.

- Placing the baby in the cross-cradle position, as described by Dr. Jack Newman and Teresa Pitman (2006). The baby is held tightly against the mother's body, stomach to stomach, his head is in a slight backwards extension and his chin touches the breast first. The mouth is wide open and the nipple is directed towards the upper lip.
- The Biological Nurturing™ position as described by Dr. Suzanne Colson (2005; 2008; 2011). The mother is in a semi-lying or semi-sitting, laid-back position. The baby is placed stomach to stomach on his mother and can use his feet to direct himself towards the breast. His head is in a slight backwards extension and the baby opens his mouth very wide to take in the breast.

For women using a breastfeeding pillow, the author suggested that they either abandon it, or use a firm pillow that is placed high enough to allow the baby to be at breast height.

Discussion

Nipple pain was a common problem reported by mothers in this private practice. This study is small and the results cannot be generalized to all private practices without further research. Nevertheless, it is interesting to note that all the women suffering from pain when latching on—whose pains were resolved by improving the latch—reported that they had not received prior assistance in latching the baby in a way that did not cause pain. Each of these women was seen by the author subsequent to their stay in the maternity ward.

In addition, it can be noted that helping mothers improve their latch represents the essential work of the author's practice. These findings suggest that there is a lack of information given to mothers in the hospital. This could be due to personnel that are insufficiently trained, limited time spent with mothers (usually due to a lack of personnel in the hospital), and limited number of lactation consultants in French hospitals. Further, hospital personnel may believe that they have given the information to the mother, but the mother may not have understood or really received it.

In a certain number of cases, the women who came to consult had already consulted with other healthcare providers for these pains, and were treated for a yeast or bacterial infection, or they had been told to clip a baby's tongue-tie, without verifying and improving the latch. In all these cases, these first treatment attempts were ineffectual because the underlying problem, the inadequate latch, was not addressed.

Further, it must be noted that French women do not have easy access to correct photos or drawings of appropriate latch. The photos used in publications about breastfeeding mostly show babies taking the breast without properly opening their mouth. Since most women have never seen a breastfed baby in their circle of acquaintances, they no longer receive this information via informal, mother-to-mother channels and must rely upon maternity personnel. However, three days spent in the maternity hospital cannot replace the saturation of information they would have received during childhood had they grown up in a breastfeeding culture.

Conclusion

A good latch is essential to assure a comfortable and effective feed. This latch should be shown to women in such a way that they are capable of replicating it once they are alone with their babies. This type of support takes time and mothers do not always get it. Therefore, lactation consultants in private practice have an important role to play in providing this type of support for mothers. The majority of the author's consultations are focused on improving the latch. A future study can address pain management in breastfeeding women on a larger scale.

References

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A New Report Available from Amnesty International

Deadly Delivery: The Maternal Healthcare Crisis in the USA

Women have a greater lifetime risk of dying in pregnancy-related causes in the USA than women in 40 other countries. For women of color the risks are especially high. Despite the huge sums of money spent on the healthcare system, women continue to face a range of obstacles in obtaining the services they need. This report shows the human cost of these systemic failures and highlights the steps that are urgently needed to move towards a healthcare system that respects, protects and fulfills the human right to health without discrimination.

http://www.amnesty.org/en/library/info/AMR51/007/2010/en

British HIV Association Releases a New Position Statement on Breastfeeding with HIV in the UK

Pamela Morrison describes this statement as the first from any industrialized country to support HIV+ mothers who want to breastfeed, so long as they are adherent to antiretroviral therapy (ARV) and have an undetectable viral load.

> The value of exclusive breastfeeding is also stressed. This is in line with recent research showing that adequate maternal ARV and exclusive breastfeeding for up to 6 months can reduce the risk of postnatal transmission of HIV to 0-1%. While WHO issued revised infant feeding recommendations in 2010, suggesting that each country should formulate its own single policy to prevent postnatal infection in HIV-exposed babies, recommending either breastfeeding with maternal and/or infant ARV, or formula-feeding, the new BHIVA/CHIVA Position Statement has gone one step further to include both options (*WABA Newsletter*, 2010, 9-1).

To read the full report, http://www.bhiva.org/documents/Publications/InfantFeeding10.pdf