

Sore Nipples

Introduction

The best treatment of sore nipples is *prevention*. The best prevention is getting the baby to latch on properly from the first day.

Sore nipples are usually due to one or both of two causes. **Either the baby is not positioned and latched properly, or the baby is not suckling properly, or both.** However, babies learn to suck properly by getting milk from the breast when they are latched on well. (They learn by doing). Thus, “suck” problems are often caused by poor latching on. Fungal infection (due to *Candida albicans*) may also cause sore nipples. Vasospasm (due to poor latching and or a fungal infection) may also cause sore nipples (see below). The soreness caused by poor latching and ineffective suckling hurts most as you latch the baby on and usually improves as the baby breastfeeds. The pain from the fungal infection goes on throughout the feed and may continue even after the feed is over. Women describe knifelike pain from the first two causes. The pain of the fungal infection is often described as burning, but may not have this character. A new onset of nipple pain when feedings had previously been painless is a tip off that the pain may be due to a yeast infection, but the pain may be superimposed on pain due to other causes. Cracks *may* be due to a yeast infection. Dermatologic conditions may also cause late onset nipple pain. There are several other causes of sore nipples.

Proper Positioning and Latching (See Handout *When Latching*)

It is not uncommon for women to experience difficulty positioning and latching the baby on. Proper positioning facilitates a good latch and good latching reduces the baby's chances of becoming "gassy", and also allows the baby to control the flow of milk. Thus, poor latching may also result in the baby not gaining adequately, or feeding frequently, or being colicky (handout #2 "*Colic in the Breastfed Baby*"). See also www.drjacknewman.com for videos that show how to latch a baby on, how to know a baby is getting milk and how to use compression.

Positioning—For the Purposes of Explanation, Let Us Assume That You Are Feeding On the Left Breast

(See handout *When Latching* and the videos at www.drjacknewman.com)

Good positioning facilitates a good latch. A lot of what follows under latching comes automatically if the baby is well positioned in the first place.

At first, it may be easiest to use the cross cradle hold to position your baby for latching on. Hold the baby in your right arm, pushing in the baby's bottom with the side of your forearm so that your hand turns palm upwards. This will help you support his body more easily, and also bring the baby in from the correct direction so that he gets a good latch. Your hand will be palm up under the baby's face (not shoulder or under his neck). The web between your thumb and index finger should be behind the nape of his neck (not behind his head). The baby will be almost horizontal across your body, with his head slight tilted backward, and should be turned so that his chest, belly and thighs are against you *with a slight tilt* so the baby can look at you. Hold the breast with your left hand, with the thumb on top and the other fingers underneath, fairly far back from the nipple and areola.

The baby should be approaching the breast with the head *just slightly* tilted backwards. The nipple then automatically points to the roof of the baby's mouth.

Latching

1. Now, get the baby to open up his mouth wide. The way to do this is to run your nipple, still pointing to the roof of the baby's mouth, along the baby's *upper lip (not lower)*, lightly, from one corner of the mouth to the other. Or you can run the baby along your nipple, something some mothers find easier. Wait for the baby to open up as if yawning. As you bring the baby toward the breast, only his chin should touch your breast. Do not scoop him around so that the nipple points to the middle of his mouth. Instead the nipple should still be pointing to the roof of the baby's mouth.
2. When the baby opens up his mouth, use the arm that is holding him to bring him straight onto the breast. Don't worry about the baby's breathing. If he is properly positioned and latched on, he will breathe without any problem as his nose will be far away from the breast. If he cannot breathe, he will pull away from the breast. If he cannot breathe, he is not latched properly. Don't be afraid to be vigorous.
3. If the nipple still hurts, use your index finger to pull down on the baby's chin in order to bring more breast tissue into the mouth. You may have to do this for the duration of the feed, but this is usually not necessary. **The pain will usually subside. Do not take the baby on and off the breast several times to get the perfect latch. If the baby goes on and off the breast 5 times and it hurts, you will have 5 times more pain, and worse, 5 times more damage. Fix the latch when putting him to the other breast, or at the next feeding.**
4. The same principles apply whether you are sitting or lying down with the baby or using the football hold. Get the baby to open wide; don't let the baby latch onto the nipple, but get as much of the areola (brown part of breast) into the mouth as possible (not necessarily the whole areola).
5. There is no "normal" length of feeding time. If you have questions, call the clinic.
6. A baby properly latched on will be covering more of the areola with his lower lip than with the upper lip.

Improving the Baby's Suck

The baby learns to suckle properly by breastfeeding and by getting milk into his mouth. The baby's suckle may be made ineffective

or not appropriate for breastfeeding by the early use of artificial nipples or from poor latching on from the beginning. Some babies just seem to take their time developing an effective suckle. Suck training and/or finger feeding (handout *Finger and Cup Feeding*) may help, but note, taking the baby off the breast to finger feed instead is not a good idea and should be done as a last resort only.

Vasospasm: “My Nipple Turns White After the Baby Comes Off the Breast”

The pain associated with this blanching of the nipple is frequently described by mothers as "burning", but generally begins only after the feeding is over. It may last several minutes or more, after which the nipple returns to its normal colour, but then a new pain develops which is usually described by mothers as "throbbing". The throbbing part of the pain may last for seconds or minutes and then it is possible the nipple will turn white again and the process repeats itself. The cause would seem to be a spasm of the blood vessels (often called “vasospasm” or Raynaud’s Phenomenon) in the nipple (when the nipple is white), followed by relaxation of these blood vessels (when the nipple returns to its normal colour). Sometimes this pain continues even after the nipple pain during the feeding no longer is a problem, so that the mother has pain only after the feeding, but not during it. What can be done?

1. Pay careful attention to getting the baby to latch onto the breast properly. This type of pain is almost always associated with and probably caused by whatever is causing your pain during the feeding. The best treatment for this vasospasm is the treatment of the other causes of nipple pain. If the main cause of the nipple pain is fixed, the vasospasm also disappears.
2. Heat (hot washcloth, hot water bottle, hair dryer) applied to the nipple immediately after breastfeeding may prevent or decrease the reaction. Dry heat is usually better than wet heat, because wet heat may cause further damage to the nipples.
3. Vitamin B6 multi complex can also be used, as can magnesium with calcium. On occasion, we have had to use an oral medication (nifedipine) to prevent this type of reaction. For more on these treatments see handout *Vasospasm and Raynaud’s Phenomenon*

General Measures for Nipple Soreness

1. Nipples can be warmed for short periods of time after each feeding, using a hair dryer on low setting.
2. Nipples should be exposed to air as much as possible, **except when there is vasospasm**.
3. When it is not possible to expose nipples to air, plastic dome-shaped breast shells (**not** nipple shields) can be worn to protect your nipples from rubbing by your clothing (use the largest hole available so your nipple is not rubbing against the plastic). Breastfeeding pads keep moisture against the nipple and may cause damage that way. They also tend to stick to damaged nipples. If you leak a lot you can wear the pad over the breast shell.
4. Ointments can sometimes be helpful. If using an ointment, use just a very small amount *after* breastfeeding and **do not** wash it off. We use an “all purpose nipple ointment” (APNO) that we find very useful. See handout *Candida Protocol* for the recipe. Note, once any ointment or cream is applied to the nipples they are no longer air drying.
5. Do not wash your nipples frequently. Daily bathing is more than enough.
6. If your baby is gaining weight well, there is no good reason the baby *must* be fed on both breasts at each feeding. It may save you pain, and speed healing if you feed your baby on only one breast each feed. It will help to compress the breast (handout *Breast Compression*), once the baby is no longer swallowing on his own in order to continue his getting milk. You may be able to manage this some feedings, but not others. In very difficult situations, a lactation aid (handout *Lactation Aid*) can be used to supplement (preferably expressed milk), so that the baby *will* finish the feeding on the first side. ***Taking the baby off the breast is a last resort.***

If you are unable to put the baby to the breast because of pain, in spite of trying all the above measures, it may still be possible to continue breastfeeding after a temporary (3-5 days) cessation to allow the nipples to heal. During this time, it would be better that the baby *not* be fed with a rubber nipple. Of course it is also best for you and the baby if the baby is fed your expressed milk. Feed the baby with a cup or use the technique called “finger feeding” (handout *Finger and Cup Feeding*). Once again, it should be emphasized that this is a last resort and taking a baby off the breast should not be taken lightly. Furthermore, it often doesn’t work.

We do not recommend nipple shields because, although they sometimes help temporarily, they often do not. In fact, they may often increase the degree of trauma to the nipples. They may also cut down the milk supply dramatically, and the baby may become fussy and not gain weight well. Once the baby is used to them, it may be impossible to get the baby back onto the breast. Use as a last resort only but **get help first**.

Questions? Email Jack Newman at drjacknewman@sympatico.ca, or Edith Kernerman at breastfeeding@sympatico.ca or consult: Dr. Jack Newman’s Guide to Breastfeeding (called *The Ultimate Breastfeeding Book of Answers* in the USA) or our DVD, *Dr. Jack Newman’s Visual Guide to Breastfeeding*; or *The Latch Book and Other Keys to Breastfeeding Success*; or *L-eat Latch & Transfer Tool*, or the *GamePlan for Protecting and Supporting Breastfeeding in the First 24 Hours of Life and Beyond*. See our website at www.drjacknewman.com. To make an appointment email breastfeeding@ccnm.edu and respond to the auto reply or call 416-498-0002.

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