Question 1:

Do breastfeeding women lose more weight postpartum than women who do not breastfeed? Is weight loss encouraged or discouraged, and should it be used as a factor for developing personal breastfeeding goals?

Response from Dr. Stuebe:

On balance, moms who breastfeed lose more weight than moms who don't. In a large observational study in Denmark, authors found that nursing moms retained less weight at 6 months postpartum,¹ and a recent UK study found that the longer a woman had breastfed, the lower her BMI was in her 50s.² For the individual woman, weight loss during breastfeeding is ultimately about calories out versus calories in. Exclusive breastfeeding burns about 500 calories a day, which is like spending 45 minutes on a treadmill at the gym—but if you eat an extra 500 calories, neither breastfeeding nor running on the treadmill will help you to lose weight.

There's good data that it's safe for moms to exercise and to lose weight while breastfeeding. In a randomized controlled trial of weight loss intervention among overweight lactating women, women lost 0.5 kg a week while breastfeeding without adversely affecting their infants' growth.³
Question 3:

If a woman gives a history of not being able to breastfeed in a past pregnancy, what are key questions to ask her about that previous experience? Is a breast exam during the next pregnancy helpful in diagnosing those women without enough breast tissue? Absent tubular breasts, Sheehan’s syndrome, and radiation to the breast, what are the most common reasons for physiologic incapability to breastfeed?

Response from Dr. Stuebe:

Low milk supply can reflect pre-glandular, glandular, or post-glandular problems. Pre-glandular problems reflect the mother’s endocrine physiology, such as Sheehan’s syndrome, hypothyroidism, or retained placenta. There’s some recent evidence suggesting that insulin resistance may also affect milk supply. Glandular problems refer to lack of sufficient glandular tissue in the breast, or lack of lobular development during pregnancy, which can manifest as absence of breast changes. (Continued, next page)
Post-glandular problems are problems with milk removal—either because the baby’s suck does not adequately remove milk, or because the mother is separated from her infant and is not expressing milk as frequently as she needs to in order to sustain her supply.

This differential diagnosis informs the history that I take. Is there a history to suggest Sheehan’s syndrome, retained placenta, insulin resistance, or exposure to exogenous hormones? Were there breast changes during pregnancy? Does she have a history of breast reduction, augmentation, or severe mastitis that may have compromised her glandular tissue? And was she separated from her infant in the first hours or days of its life?

A breast exam can be helpful, although there are not prospective studies validating physical exam findings as predictive of breastfeeding outcome. However, widely-spaced breasts with minimal growth during pregnancy in the setting of a history of low milk supply would raise my suspicion for insufficient glandular tissue.

When I see mothers prenatally with a history of disrupted lactation, I emphasize the factors that we can modify this time. Post-glandular problems are the most common cause of insufficient milk supply, and they can be prevented by good maternity care, including immediate, prolonged skin-to-skin contact at birth and minimizing separation of mom and baby. If the infant has to go to the NICU, early hand expression and pumping are essential.

I also emphasize that, regardless of how much milk a mother produces, she can nurture her baby at the breast. For mothers who make enough milk to meet their baby’s needs, we recommend exclusive breastfeeding. However, for mothers with compromised milk supply, there’s can be benefit for both mother and baby in putting baby to breast, even if there are no calories transferred. Suckling stimulates oxytocin release for the mother, enhancing bonding and attachment, and babies can be comforted by the touch, sound, and smell of mom. Breastfeeding can be a nurturing connection, not just a transfer of nutrients, and a mother doesn’t need to make milk to nurture her baby at the breast.

**Question 4:**

Are there therapies for inverted nipples as a cause for breastfeeding difficulties?

**Response from Dr. Stuebe:**

True inverted nipples are uncommon, and they can be diagnosed by compressing the areola between the thumb and forefinger. This compression will cause an everted or flat nipple to protrude, whereas an inverted nipple will retract. Prenatal manipulation of inverted nipples does not improve breastfeeding outcomes. In a small, randomized trial among women with inverted nipples, those who were advised to wear breast shells were less likely to initiate or continue breastfeeding than controls. In the same study, Hoffman’s exercises to stretch the nipple did not improve breastfeeding rates. After delivery, women with flat or inverted nipples may benefit from extra support from an International Board Certified Lactation Consultant (IBCLC), who can help the baby to latch effectively and reduce nipple trauma.
Question 5:

Is breastfeeding a more effective way to drain the breast than pumping? With mastitis is there any advantage to starting each breastfeeding episode on the infected breast because the infant is hungrier and will drain that breast more effectively?

Response from Dr. Stuebe:

A healthy, term baby is generally better at emptying the breast than a mechanical pump. Some women who feed effectively at the breast produce very small amounts of milk when pumping. It’s important to share this with mothers, who may try pumping “to make sure I’m making enough milk” and then worry that they have a supply problem, even when their baby is growing well. For mothers with mastitis, I focus on finding the least painful way to empty the breast, and that varies with the mother and the baby. If the baby sucks really vigorously at the beginning of a feeding, the mother may not be able to tolerate starting on the affected breast, and she may be better off starting on the unaffected side. In other cases, mothers prefer to pump during the acute episode, because they have more control over the rate and intensity of suction that’s applied.

Question 6:

Should mothers feed on an every two-hour schedule or should they feed when the baby is hungry and ready to suckle? Sometimes babies can go longer than two hours between feedings. Is that a problem as long as they feed well when they do feed?

Response from Dr. Stuebe:

I counsel moms to watch the baby, not the clock. Putting the baby to breast at the earliest signs of hunger ensures that he or she is ready to root and latch, not frantically hungry. I do not generally recommend waking a baby or offering the breast if he or she is not displaying feeding cues. However, infants who are late preterm, early term, or not gaining weight appropriately after the first few days of life may need to be awakened to feed. In these situations, consultation with the pediatric provider and/or an IBCLC is key to support the dyad until the baby is on a good growth trajectory.

Question 7:

Why is dicloxacillin used for mastitis? How quickly should the mother respond to the antibiotic therapy?

Response from Dr. Stuebe:

The most common pathogen in mastitis is Staphylococcus aureus, which is why dicloxacillin is used as first-line therapy. However, with the increasing prevalence of methicillin-resistant S aureus (MRSA), it’s important to be vigilant for lack of response to therapy. At the University of North Carolina, we have a phone triage protocol for mastitis (http://mombaby.org/PDF/mastitis-phone.2.0.pdf). We counsel mothers that their symptoms should not progress after the first 12 hours of antibiotics, and they should be improving within 24–48 hours. If they are not responding, we have a protocol (http://mombaby.org/PDF/abscess_packet.pdf) to see mothers in the office for a complete evaluation. Mastitis is just one possible cause of febrile illness in a postpartum woman, and a careful history and physical exam are needed to exclude other causes of fever. If the exam is consistent with mastitis, we obtain milk cultures, and we may switch empirically to either clindamycin or Bactrim to cover MRSA. If an abscess is suspected, we obtain a breast ultrasound.
Question 8:
What is the best way to drain an abscess diagnosed on ultrasound: needle aspiration or incision and drainage?

Response from Dr. Stuebe:
We use needle aspiration as our first line, because it is less invasive and is highly effective. In a published series of 89 women with puerperal breast abscess, 97% resolved with ultrasound-guided drainage. Several aspirations may be needed before the abscess resolves.

Question 9:
Are there other conditions that can mimic thrush on the mother’s nipples?

Response from Dr. Stuebe:
Damaged nipples are a common cause of early weaning, and treatment begins with evaluation of the “Oro-Boobular Interface.” In most cases, a problem with the infant’s latch or the pump flange fit is causing recurrent trauma, and the trauma has to be corrected for the nipple to heal.

The differential diagnosis for nipple skin breakdown includes bacterial superinfection, irritant dermatitis, contact dermatitis, and thrush. Studies suggest that yeast is more commonly present on the nipples of women with pain than those without pain, but a substantial proportion of women with pain do not have culture or PCR evidence of yeast. In our breastfeeding-associated pain protocol (http://mombaby.org/PDF/PainProtocols.v3.pdf), we treat traumatized nipples with either a barrier ointment, such as petrolatum or zinc oxide, or with topical mupirocin, which covers both yeast and staph. If we suspect contact dermatitis, we use a topical steroid.

Women who describe shooting, burning pain often have vasospasm, which may present with blanching or purple discoloration of the nipple-areolar complex. Exposure to cold triggers vasospasm, and mothers typically describe pain getting out of the shower or entering the frozen food section of the grocery store. Ibuprofen and warm gel packs inserted into the bra after feeding can markedly improve symptoms. For women with a partial response to heat, we use nifedipine XL 30 mg daily.

Question 10:
Do pituitary prolactinomas affect breast feeding?

Response from Dr. Stuebe:
Two recent case series have looked at risk of prolactinoma recurrence after pregnancy and breastfeeding. Both studies found that neither prolactinoma nor hyperprolactinemia recurrence risk was related to breastfeeding duration. The authors concluded that women with prolactinomas should not be discouraged from breastfeeding. In a 1987 case series, women who had undergone surgical resection of a prolactinoma had lower prolactin levels and were less likely to be exclusively breastfeeding at one month than those treated with bromocriptine.
References


