

## [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. Mother and baby skin to skin contact immediately after birth for at least the first hour or two will frequently result in a baby latching on all by himself with a good latch. See the information sheets *Breastfeeding—Starting Out Right* and *The Importance of Skin to Skin Contact*.

Early onset nipple pain is 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 infections of the nipple (due to *Candida albicans*) may also cause sore nipples. Vasospasm (which is due to irritation of the blood vessels in the nipple from poor latching and/or a fungal infection) may also cause sore nipples (see the information sheet *Vasospasm and Raynaud’s Phenomenon*). The soreness caused by poor latching and ineffective suckling hurts most as you latch the baby on and usually improves as the baby breastfeeds. However, if damage is severe, the soreness of a poor latch and/or ineffective suckling may go on throughout the feeding. The pain from the fungal infection often goes on throughout the feed and may continue even after the feed is over. Women describe knifelike pain from the a poor latch or ineffective sucking. The pain of the fungal infection is often described as burning but it does not have to be burning in nature. A new onset of nipple pain when feedings had previously been painless is a tip off that the pain may be due to a Candidal infection, but a Candidal infection may also be superimposed on other causes of nipple pain, so there was never a pain free period. 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 information sheet *When Latching*)

It is not uncommon for women to experience difficulty positioning and latching the baby on. If the mother positions the baby well, she facilitates the baby’s getting a good latch and a good latch not only decreases the risk of the mother becoming sore, but also reduces the baby’s chances of becoming “gassy” because a good latch allows the baby to control the flow of milk better. Thus, poor latching may also result in the baby not gaining adequately, or feeding frequently, or being colicky (see the information sheet *Colic in the Breastfed Baby*). See also [nbc.ca](http://nbc.ca) 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 information sheet *When Latching* and the videos at [nbc.ca](http://nbc.ca))

*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 for many mothers 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 (towards the ceiling). This will help you support his body more easily as the baby's weight is on your forearm rather than your wrist or hand. Holding the baby like this also will 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 upwards* 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, just a tickle, 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 (not scooped around) 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 since 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 quick.
3. If the nipple still hurts, use your index finger to pull down on the baby's chin; this will bring more of your breast into the baby's mouth. You may have to do this for the duration of the feed, but not usually. *The pain should 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, and the baby and you will both be frustrated.** Adjust 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 or cradle 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.

See the video clips at the website [nbc.ca](http://www.nbc.ca)

### **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 (See the information sheet *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 the nipple may 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 as best possible. 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 usually 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 the information sheet *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 which are not, in our opinion, a good treatment for sore nipples or any breastfeeding problem for that matter) 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 our 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 the information sheet *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, but be careful, not all mothers can feed a baby on only one breast at every feeding or even at all. See the video clips at the website [nbc.ca](http://www.nbc.ca) so that you know when the baby is drinking (or not). It will help to compress the breast (see the information sheet *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 (see the information sheet *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” (see the information sheet *Finger an 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/or 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?** First look at the website [nbc.ca](http://www.nbc.ca) or [drjacknewman.com](http://drjacknewman.com). If the information you need is not there, go to *Contact Us* and give us the information listed there in your email. Information is also available in **Dr. Jack Newman’s Guide to Breastfeeding** (called **The Ultimate Breastfeeding Book of Answers** in the USA); and/or our DVD, **Dr. Jack Newman’s Visual Guide to Breastfeeding** (available in French or with subtitles in Spanish, Portuguese and Italian); and/or **The Latch Book and Other Keys to Breastfeeding Success**; and/or **L-eat Latch and Transfer Tool**; and/or the **GamePlan for Protecting and Supporting Breastfeeding in the First 24 Hours of Life and Beyond.**

**To make an appointment online with our clinic** please visit [www.nbc.ca](http://www.nbc.ca). If you do not have easy access to email or internet, you may phone (416) 498-0002.

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