



with you, for you



Gloucestershire Health and Care
NHS Foundation Trust

Common Infant Feeding Problems



Candida Albicans (Thrush)

Cause: Thrush is a fungal yeast infection that usually presents after some days, or weeks of pain-free breastfeeding or course of antibiotic treatment.

Mother – Signs/symptoms

- Pink/red shiny areola,
- Permanent loss of colour in nipple,
- Cracked nipples that do not heal,
- White plaques on folds of nipple/areola skin,
- Itchy nipples, sensitive to touch and cold temperatures,
- Burning sensation in nipples,
- Severe pain when infant attaches-worsening with each re- attachment, nipple pain that intensifies during breastfeeding and after feed, shooting pain after feeds.
- Ductal thrush may present with persistent severe and burning pain-radiating throughout breast, typically after feeds.

Treatment:

- **Miconazole cream (Daktarin) 2%** is 1st choice - applied sparingly to nipple after a feed - excess to be wiped not washed off and/or **Hydrocortisone (Dactacort) 1% cream** for inflamed nipples.
- Deep breast pain may indicate Ductal Thrush - may require oral systemic treatment in addition to topical treatment - refer to GP. **Fluconazole** is not licenced for breastfeeding mothers; Consent for treatment with a product outside of its license must be obtained from the mother before treatment is prescribed by the Doctor; Please refer to <https://breastfeedingnetwork.org.uk/wp-content/dibm/thrush%20detailed%20information%20and%20breastfeeding.pdf>
- Paracetamol and Ibuprofen can be taken to relieve inflammation and pain.

Infant – Signs/symptoms

- Creamy white patches inside mouth, tongue, cheeks and lips which do not rub off easily. If rubbed off, the base is raw and may bleed.
- A white sheen on Infant's tongue/lips.
- Infant restless during feed, pulls off/away from the breast, presents as unhappy or uncomfortable due to sore mouth.
- Nappy rash, red spots, soreness to nappy area that does not heal. (Anal thrush presents as red shiny rash radiating outwards from anus- does not heal with nappy ointment)

Treatment:

- **Nystatin suspension 100,000units/ml** 4 times a day- applied with clean fingertip to affected areas to ensure effective contact with mucosa.
- **Miconazole oral gel 2%** - pea size amount applied with clean fingertip to all areas in Infant's mouth 4 times a day (**not licenced for <4months or 5-6 months if born preterm due to risk of choking.** (Prescribing Doctors must ensure carers are aware of the correct method of application). Consent for treatment with a product outside of its license must be obtained from the mother or carer before treatment is prescribed by the Doctor.
- **Miconazole cream** applied to nappy area.

Follow-up:

- Health visitor to arrange follow up within 1 week to review.

Additional Information:

- Always check positioning and attachment if mother complains of nipple/breast pain. If thrush is suspected, both mother and infant should be treated effectively and concurrently, if not treated promptly, can lead to early cessation of breastfeeding.
- Probiotics e.g. Acidophilus can help restore 'good bacteria' to manage thrush.
- Thorough hand hygiene recommended before and after application of treatment. Clothes in contact with breasts should be machine washed at 60 degrees.

Expressed breast milk can be used while treatment continues but that milk should be discarded when treatment has stopped

<https://kellymom.com/bf/concerns/child/thrush-expressed-milk/>

Colic

Cause:

The cause of colic is unknown but suggestions include indigestion, allergies or trapped wind.

Signs/symptoms:

- Usually identified by an infant crying loudly over a period of more than three hours a day for more than three days a week over a period of more than three weeks.
- Crying is usually between 6pm and midnight
- Infant may draw legs up to abdomen
- Infant may pass wind.

Treatment: There is no cure for colic but various techniques may offer some comfort:

Assess infant's general health, crying, stools, feeding, any suspected foods or milk that lessen or worsen crying.

Feeding:

- Colic in breast fed infants has been linked to ineffective attachment at the breast, therefore observe a full breast feed and correct attachment as appropriate.
- Observe for changes in sucking in the feeding cycle
- Ensure baby finishes feeding from one breast first, and then offer the other.
- Try feeding infant in a semi reclined position as shown in figure 4.
- Ensure Mother is aware of responsive feeding as it has been suggested colic is improved by feeding according to infant's needs.
- Mother may wish to consider temporarily cutting out foods that she feel may increase colic symptoms, e.g. cow's milk, dairy and diet drinks. Observe for 2 weeks to see any effect.
- For formula fed infants, feed as upright as possible keeping the teat full of milk, to reduce air swallowing.
- Changing to hypoallergenic milk or low or lactose free formula milk may be an option, but only under the guidance of a GP.

Common over the counter treatments: **Infacol** or **Colief** may provide some relief.



Suggested Strategies:

- Consider a warm bath or tummy massage for the baby.
- Take offers of support to have a break.
- If necessary, make sure infant is safe, warm, dry and fed and leave the room for ten minutes if parent needs a break.
- White noise such as washing machine may help to sooth the infant.
- A pram or car journey may help as well as walking with the infant in a sling or cuddling the infant. Stress this is a phase that will pass usually at 3-4 months.

Follow up:

Seek medical advice if:

- You are concerned about infants' health or if colic symptoms are with fever, diarrhoea, vomiting or constipation.
- If crying sounds painful, indicating injury or distress or if infant is not gaining weight and is not hungry.
- Assess mood of parent and arrange to review within a week.

Further Information: Refer to PCHR for breast feeding assessment **and** for local breastfeeding support groups please refer to BFN

<https://www.breastfeedingnetwork.org.uk/gloucestershire/> and GBSN

<https://gbsn.org.uk/groups/>

Cow's milk allergy (CMA)

Please first consider Reflux and Colic (Summary Cards in this pack)

Cause: Immune system malfunction – the immune system overreacts to one or more of the proteins found in the milk.

Signs/symptoms: Symptoms start when the infant is introduced to infant formula containing cow's milk in their diet or sometimes if the mother is breastfeeding and having dairy foods in her diet.

- skin rashes
- bringing knees up
- crying
- diarrhoea
- eczema
- vomiting
- stomach cramps
- difficulty breathing
- anaphylaxis (rare)

Treatment:

- If breastfed, trial of cow's milk free maternal diet (with Extensively Hydrolysed Formula (eHF) supplements if needed).
- Maternal supplements of Calcium and Vitamin D.
- If formula fed try different formula, if no improvement, then refer to GP for trial of eHF for approximately 2 weeks.
- If signs/symptoms improve then try cow's milk formula again / re-introduce to maternal diet if baby breastfed
- If signs and symptoms reoccur – refer to dietician and GP as probably CMA.
- If no improvement on eHF, GP to refer to paediatrician.

Follow up: Refer to GP/Dietician/Paediatrician as necessary.

Further Information:

- **The Breastfeeding Network** <https://breastfeedingnetwork.org.uk/wp-content/pdfs/cow's%20milk%20protein%20allergy%20and%20breastfeeding%202019.pdf>
- **Local Infant Feeding Information Board** <http://lifib.org.uk/>

Lactose intolerance

Lactose intolerance is quite rare and it is important to note that babies often grow out of it.

Signs/symptoms:

- diarrhoea
- vomiting
- bloated stomach
- stomach pains
- wind

It is difficult to differentiate between lactose intolerance and CMA in the first instance.

Cause: The body's inability to produce enough of the enzyme lactase in the digestive tract. Without it, lactose (the natural sugar in milk and other dairy products) cannot be digested properly, so sufferers can feel bloated or experience vomiting and stomach pains after consuming milk or milk-based products.

Treatment: With a breast fed infant the milk that baby gets early in a breastfeed is higher in lactose and lower in fat than the milk later in the breastfeed, which is higher in fat and lower in lactose. It is important baby is allowed to drain one breast before offering the other, to help minimize the amount of lactose baby receives. A formula fed baby should be referred to a GP – can be prescribed a lactose-free formula.

Follow up: Refer to GP/Dietician/Paediatrician as necessary. Extra support visits.

Further Information: Local Infant Feeding Information Board <http://lifib.org.uk/>

Mastitis

Cause: Milk stasis due to ineffective removal of milk. May be due to ineffective attachment, tongue tie, infrequent feeding or restrictive clothing.

Signs/symptoms: localised inflammation, breast pain, temperature and possible flu like symptoms.

Treatment:

- Check positioning and attachment- check the infant for tongue tie.
- No sudden cessation of breast feeding
- Feeding history and establish the cause of the problem
- Observe a full breast feed and correct positioning and attachment as required.
- Ensure frequent and effective feeding according to feeding cues.
- Start each feed with affected side for up to 3 feeds.
- Warm compress to aid milk flow. Gentle massage
- Hand express if necessary, target and frequently drain the affected area.
- Consider positioning the infant with lower jaw adjacent to inflamed area (possibly rugby ball position)
- Analgesia and Oral anti-inflammatory (**Paracetamol** and/or **ibuprofen- check for contra indications**)
- Take adequate fluids and rest
- Additional breast feeding support as required- refer to PCHR for support numbers and for breast feeding assessment.



with you, for you



Gloucestershire Health and Care
NHS Foundation Trust

For severe mastitis If there is no improvement in 12-24 hours following the onset of symptoms, despite improved drainage of the breast, or if symptoms are severe or worsen seek medical advice/GP, as antibiotics will be needed. Refer to <https://www.gloshospitals.nhs.uk/gps/gloucestershire-joint-formulary/>

Follow up: Breast feeding support.

Further information: The Breastfeeding Network
<http://www.breastfeedingnetwork.org.uk/wp-content/dibm/BFN%20Mastitis%20feb%2016.pdf>

Prevention and management of slow weight gain in the breastfed infant.

Assessment: complete breastfeeding assessment form in PCHR, monitor urine/stool output.

Individual weighing plan for infants with slow or static weight gain:

Babies not yet back up to birth weight	Plan 1, moving to plan 2, then 3 if necessary
Moderately slow weight gain	Plan1, moving to plan 2 if necessary
Very slow weight gain	Plan 1, then plan 2 if necessary
Static or falling weight	Plan 1, moving to plan 2, then 3 if necessary

Plan 1:

- Observe full breastfeed, check for effective attachment, and for changes in sucking in the feeding cycle and that baby ends the feed.
- Observe for effective sucking pattern: 1 suck to one swallow or two sucks to one swallow max.
- Ensure minimum 8 feeds in 24hours (including at night)
- Ensure mother aware of feeding cues/ need to wake baby for feeds if not waking to feed.
- Advise discontinuation of dummy use
- Recommend skin to skin contact to encourage feeding
- Refer to breast feeding support group/breastfeeding counsellor
- Consider switch feeding for 24-48 hours if baby is weak or sleepy.
- Mother to monitor output over 24-48 hours. HV to phone after 48 hours to follow-up and review.
- If no increase in wet/dirty nappies in 24-48 hours move to Plan 2.
- Repeat weighing in 1 week

Plan 2:

- Carry out plan 1, also:
- Consider switch feeding again
- Express breast milk and offer to infant by cup
- Consider referral to GP

Plan 3:

- Continue with plans 1 & 2, refer to GP, ensure frequent breastfeeds and expression of milk. Consider supplementation if weight gain remains inadequate (Refer to full guidelines).

N.B If an infant has not re-gained birth weight by 3 weeks of age or if at any time the baby develops any concerning symptoms s/he should be referred to the GP for assessment.

Consider the thresholds of Centile Chart Drops for concern about faltering growth in infants and children (NICE 2017)

Babies who cross down these channel widths should be assessed by a GP to exclude illness as a cause of the slow weight gain.

May go straight to Plan 3 if Applicable in conjunction with Plan 1&2 simultaneously.

Centile Drop	Birth Weight Centile
Drop of 1 or more weight centile spaces	Below 9th Centile
Drop of 2 or more weight centile spaces	Between 9th & 91st Centiles
Drop of 3 or more weight centile spaces	Above 91st Centile
current weight below 2nd centile	For any Centile Regarding Birth Weight

Reflux

Causes: Short, narrow oesophagus, delayed gastric emptying, immature sphincter, liquid diet.

Risk Factors Low birth weight, Cow's milk allergy, Hiatus hernia, Prematurity, Cerebral palsy.

Treatment: Breastfeeding:

- Consider 2 week trial of eliminating cow's milk from maternal diet, if this helps refer to dietician
- **Gaviscon** can be prescribed by GP and can be given before a breast feed. If this is successful **Gaviscon** should continue until weaning is established.
- Observe a full breast feed and check for effective positioning and attachment.
- Try breastfeeding infant in a semi reclined position as shown in figure 4. Positioning baby on left side after a feed can help with reflux – but should always sleep on their back.

Treatment: Formula Feeding:

- Infants may require more frequent but shorter feeds, to stop their stomach becoming too full, refer to GP to try **Gaviscon**.

Treatment for All infants':

- Make sure weight and urine output are monitored regularly.
- Try and keep baby as upright as possible during and after feeds.
- Infants with reflux often nurse well when sleepy or asleep as they are relaxed.
- Elevating the head of the cot safely (putting something underneath legs of cot) can help

Follow up: Extra support visits may be required and mother's should be advised that in most cases symptoms reduce by 6 months.

If symptoms do not improve with **Gaviscon** return to GP; Ranitidine may be considered



with you, for you



Gloucestershire Health and Care
NHS Foundation Trust

Using Basic Principles of Positioning and Attachment: Close, Head free to tilt back, Body hips shoulders In Line, Nose in line with the nipple



Figure 1



Figure 2



Figure 3

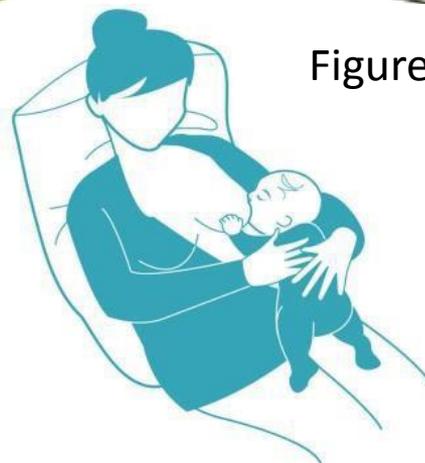


Figure 4