Nipple pain in breastfeeding

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Case history

Sandra B, a 27 year old woman, presents with a 4 day history of intense nipple pain associated with breastfeeding her 15 month old son. In the early months of breastfeeding she had experienced burning nipple pain, which had been diagnosed as a candidal infection, and had resolved with oral nystatin capsules and miconazole oral gel on the nipples and in the baby's mouth. Breastfeeding had been going well until 2 weeks ago, when the baby developed oral thrush following a course of antibiotics. Four days ago, Sandra's nipples were becoming painful and she thought the nipple thrush was recurring. Despite commencing antifungal treatment, the nipple pain had become unbearable 3 days ago and she had been unable to continue breastfeeding.

Question 1

What are the likely causes of the sudden onset of nipple pain in a breastfeeding woman?

Question 2

Examine *Figures 1 and 2*. What is the most likely diagnosis?

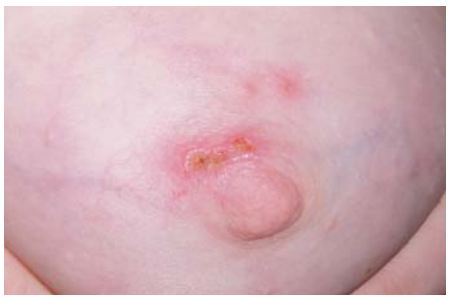

Figure 1. Lesions on nipple

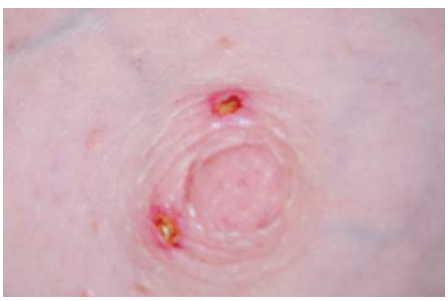

Figure 2. Lesions on nipple

Question 3

How should this problem be managed?

Question 4

What general advice would you give Sandra?

FEEDBACK

Answer 1

- Candida infection
- Eczema/dermatitis
- Vasospasm
- Pregnancy
- Trauma, eg. a bite
- Herpes infection.

Answer 2

Figures 1 and 2 show discrete lesions, making herpes virus infection the most likely diagnosis. A swab of the nipple lesion confirmed the diagnosis by detecting herpes simplex virus type 1 by polymerase chain reaction (PCR). Neither Sandra nor her husband had a history of herpes lesions.

Answer 3

Usually a mother will avoid breastfeeding because of extreme pain. She should be advised not to breastfeed until the lesions have healed.[1,2] The infection often originates in the baby's mouth, especially in toddlers.[3] On examination, this toddler had small ulcers present inside the lower lip. Case reports describe transmission of the virus to intact skin as a special form of herpetic infection, similar to herpetic whitlow and herpetic sycosis (inflammation of

the hair follicle).[4] Treatment with antiviral medication can be oral or topical depending on the severity of the infection. A topical antiseptic such as Betadine cold sore ointment also reduces secondary bacterial infection. In this case, the toddler was well and did not require treatment. Babies in the neonatal period need to be under specialist care as neonatal herpes may be fatal.[5]

Answer 4

Extra care with personal hygiene should be emphasised because of the possible transmission of herpes virus to the cornea.

A CAUTIONARY TALE

Sandra's husband, Brian, developed a sore eye 3 days after Sandra's nipple herpes was diagnosed. He attended his general practitioner who diagnosed conjunctivitis and prescribed chloramphenicol eye drops. He felt worse the following day and was reviewed by the GP who added oral antibiotics. Several days later the pain became severe, with pus and sores surrounding the eye. Brian was then diagnosed with herpes, and prescribed oral acyclovir, as well as acyclovir eye ointment and chloramphenicol eye drops. Beware the unilateral red eye!

Conflict of interest: none declared.

References

1. Lawrence RA, Lawrence RM. Breastfeeding: a guide for the medical profession. 5th edn. St Louis (MI): Mosby Inc, 1999.
2. ACOG practice bulletin. Management of herpes in pregnancy. Number 8, October 1999. Clinical management guidelines for obstetricians-gynecologists. Int J Gynaecol Obstet 2000;68(2):165–173.
3. Sealander JY, Kerr CP. Herpes simplex of the nipple: infant-to-mother transmission. Am Fam Physician 1989;39(3):111–113.
4. Dekio S, Kawasaki Y, Jidoi J. Herpes simplex on nipples inoculated from herpes gingivostomatitis of a baby. Clin Exp Dermatol 1986;11(6):664–666.
5. Sullivan-Bolyai JZ, Fife KH, Jacobs RF, Miller Z, Corey L. Disseminated neonatal herpes simplex virus type 1 from a maternal breast lesion. Pediatrics 1983;71(3):455–457.

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