NHS Highland

Policy on treatment of breast thrush while breastfeeding

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- Neonatal unit/SCBU

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INTRODUCTION

What is thrush? (Candida albicans)

Thrush is a fungal infection and can occur any time while the mother is breastfeeding. Candida albicans thrive in moist, warm, dark areas and the breasts are ideal to harbour this fungus. Candida infections most commonly occur where there has been a breakdown in the integrity of the skin or mucous membrane. The widespread use of antibiotics now in the ante and intra-partum period encourages the overgrowth of candida albicans.

Diagnosis of breast thrush

There is no real diagnostic test available, although the breastfeeding network (BFN) 2013 have suggested taking a black charcoal media swab from both mother's nipples and baby's mouth to confirm presence of either candida albicans or bacterial infection.

It is vitally important that a clear and in-depth breastfeeding history is taken and a breastfeed is observed by a trained health professional. In doing so, other potential problems can be eliminated and a clear thrush diagnosis can be made. It is also important to consider that there will be cases where a mother will display symptoms and signs of thrush while the baby will be symptom free and vice versa.

SYMPTOMS

For the breastfeeding mother

- Nipple pain that begins after a period of pain free feeding
- Pain is not improved by effective attachment
- Cracked nipples which are difficult and slow to heal
- Pain is often described as severe in nature – burning and stabbing
- Pain commences during the feed – not at the start and continues after the feed has ended, sometimes for as long as an hour
- Loss of colour to the nipple or areola
- Sensitive nipples and areola
- History of recent antibiotic therapy
- History of recent episode of vaginal thrush
- Pain will always occur in **both** breasts due to the baby transferring the infection form one to the other breast
- Absence of a pyrexia

For the baby when breastfeeding – <u>NOTE: INFANTS MAY HAVE NO SYMPTOMS</u>

- Inability to sustain a latch due to oral pain
- Frustration at breast – going on and off
- Crying
- Nappy rash which doesn't improve with simple treatment
- Can have oral plaques in mouth
- Whitish sheen to saliva and inside the lips and gums (Mohrbacher and Stock 2003)
- Breast refusal
- Colic symptoms: infants may be windy, fretful and find it hard to settle (The Breastfeeding Network 2003a)
- Poor weight gain

It is vital for a health professional trained in breastfeeding management to observe a full breastfeed prior to diagnosing thrush and/or commencing thrush treatment. This will usually be done by either the local midwife or health visitor. The reasoning behind this is to rule out any other causes for the

mother's symptoms. When referring a mother to the G.P, the health professional is encouraged to have observed a full breastfeed prior to referring to G.P.

Effective positioning and attachment is crucial to ensure adequate milk production, milk transfer and breast health. This should be the primary concern when assessing any breastfeeding problem. Once effective positioning and attachment is confirmed then other causes of nipple pain can be considered.

Other causes of nipple pain

- Eczema
- Tongue tie in the baby
- Reynaud's syndrome
- Milk bleb or white spot
- Bacterial infection which will may appear as a sloughy discharge

Self help to treat thrush

- Pain killers are encouraged to relieve the pain experienced from thrush – over the counter analgesics such as paracetamol and ibuprofen are ideal.
- Continue to breastfeed as thrush will not harm your baby
- Personal hygiene is important to stop cross –infection. Good hand washing from all the family is required
- If a dummy, nipple shield, teat, bottle or plastic toys are used by the baby ensure that these are carefully washed and sterilised while the infection lasts – if the mother has other children make sure that their toys that come in to contact with the baby are carefully washed too to save cross contamination.
- Any milk which has been expressed and stored in the freezer during the time when you have had thrush should be discarded.

Some mothers find reducing the amount of sugar and yeast in their diet helps but this has not been researched.

BOTH MUM AND BABY MUST BE TREATED TOGETHER

PRESCRIBING FOR THRUSH IN LACTATING WOMEN

Surface thrush

- Miconazole 2% Cream for surface thrush. Best practice is to apply a small amount more frequently after every feed rather than the licensed twice daily treatment. Any cream which can be seen should be wiped off gently prior to the next feed to reduce further nipple damage. If no cream is visible then no need to wipe off[1, 10]. Use for 10 days after the symptoms have subsided or more specialist help is obtained.
- The baby should also be treated as per below.

Ductal thrush

- In addition to miconazole 2% cream; Fluconazole orally 100mg as a loading dose then 50mg B.D daily for 10 to 14 days[2, 3, 4, 5, 10].
- If pain has not improved in 2 to 3 days, increase dose to 100mg twice daily
- If symptoms are very severe or prolonged, give doses up to 400mg as a loading dose followed

by 100mg twice daily for 10 to 14 days[3].

Prescribing for oral thrush in babies

- **First line treatment**: Neonates and children – Nystatin 100,000 units/ml oral suspension, 1ml four times daily after feeds or food[6, 10].
- **Second line treatment**: Neonate to 2 years - Miconazole oral gel, 1 ml in the mouth 4 times a day after feeds or food, smeared around the mouth **(unlicensed under 4 months)**[1, 6, 10]. Apply to all areas of the mouth, cheeks, roof of mouth and the tongue with a clean fingertip. Ensure that the gel does not obstruct the mouth. DO NOT apply the gel to the back of the throat, and the full dose may need to be divided into smaller portions[7]. Continue for 10 days, or 48 hours after the symptoms have subsided. Nystatin suspension does not adhere so well as Miconazole oral gel[1, 2].
- Nurse prescribers can prescribe these treatments.

NOTE: the Summary of Product Characteristics (SPC) for Miconazole (Daktarin) oral gel does not recommend the use of oral gel in any patient less than four months old (and cautions against use in any pre-term infant less than 6 months old)[7]. This could be because of a case report in 2004 when a 17 day old child in the Netherlands, born at 36 weeks, choked on some of the viscous gel and gel was then removed form the back of the throat. There were another 9 cases reported in the Netherlands, 7 of which occurred in babies less than 2 months old.

Use of Miconazole and Fluconazole in breastfeeding

- Miconazole Cream is not absorbed through the skin to a great extent, and topical use during breastfeeding requires no caution in use[3, 4].
- Fluconazole passes into breast milk to reach concentrations lower than those in plasma[8]. It is licensed to be used in breastfeeding after a single use of a standard dose 200 mg or less[8]. It is not licensed in breastfeeding after repeated use or after high doses[8]. An infant will receive between 10 to 22% of the weight adjusted maternal dose which is equivalent to about 0.2 to 0.5mg/kg/day for the infant[3,4]. This is well below therapeutic doses of e.g. 3 to 12mg/kg every 72 hours, 48 hours, or daily, depending on the age of the child[6]. Preterm neonates weighing less than 1000g have received fluconazole prophylactically[9]. It is generally considered acceptable to take fluconazole whilst breastfeeding, and to take the dose after the last breast feed if possible.[3]

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