



Statement by The National Infant Feeding Network: December 2014

Thrush

Thrush in lactating women is often over-diagnosed, but as yet there is no everyday substitute for using clinical skills to reach a diagnosis (1).

If the mother has never experienced pain free feeds, attention should first focus on improving attachment.

Other causes of nipple pain, such as bacterial infection, vasospasm, Reynaud's syndrome, eczema or dermatitis, may also be mistaken for thrush.

However, nipple soreness and persistent pain, not relieved by mechanical changes and **after a period of pain free feeding**, may be due to thrush.

There is no reliable clinical definition of thrush, (1) but it has been suggested that, as with vaginal thrush, aggregate symptoms have a higher predictive value than a single symptom. (2, 7)

These symptoms may include

- Burning sensation in nipples, especially after feeds
- Itchy nipples which may also be extremely sensitive to any touch - even to loose clothing
- Persistent loss of colour in the nipple / areola (or they may appear red and shiny)
- **Nipple pain which:**
- Becomes more intense as the feed progresses - and can last for up to an hour after the feed.
- Occurs in both nipples, (except possibly in the early stages), because the baby transfers the infection during feeding.
- Which does not respond to improved attachment, the application of heat, or alternative methods of milk removal.

The mother may have a recent history of:

- Antibiotic therapy (2, 3, 4, 8)
- Nipple trauma (2, 3)
- Vaginal thrush (2, 3)

Deep, shooting pains radiating into the breast tissue (ductal pain), which occur during and between feedings may well be due to sub-optimal attachment.

If thrush is suspected, both mother and baby should be treated effectively and concurrently.



The treatment of choice for topical thrush is

Miconazole (Daktarin) cream (2%) applied sparingly to the mother's nipples after every feed.

If nipples are very inflamed, hydrocortisone (1%) as well. A combination cream or ointment (Miconazole 2% with hydrocortisone 1%) may also be used.

Second line treatment: Fluconazole 150–300 mg as a single dose followed by 50–100 mg twice a day for 10 days. Continue topical treatment in both the mother and the infant.

Persistent or systemic/ductal Candida may require longer (14 – 28 days) treatment. (9)

When to investigate

Swabs are not usually required but standard bacteriology swabs may be taken for microscopy and culture if:

- The diagnosis is unclear, or bacterial infection is suspected
- There is no improvement after initial treatment
- Systemic treatment is considered (5)

However

- At least 50% of lactating women will have Staph Aureus on their nipples, many without symptoms (1)
- Staph Aureus and Candida can co-exist
- Standard charcoal skin swabs identified only around 10% of Candida infections in a recent prospective cohort study (1)
- The detection rate in human milk is even lower, due to the presence of lactoferrin in milk (1, 7)



References

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