Guidance for the Management and Treatment of Thrush (Candidiasis) in Breastfeeding

**Background**

Superficial, and particularly deeper, ductal Candida infection is widely thought to be responsible for the severe radiating nipple and deep breast pain that some women experience during and in between breastfeeds. There are generally two areas of contention as far as this entity is concerned:

- Difficulties in making the diagnosis; breast milk contains lactoferrin and other fungistatic substances; therefore culturing the expressed breast milk is unlikely to show the presence of fungi. This is reflected in the sometimes conflicting results in studies of this condition.
- The drugs used are largely “off-license” if used in either the lactating mother or her baby.

It must however be remembered that most pain, especially when feeding is being established, is almost always due to poor positioning which is a problem that can be solved without direct medical intervention as long as the mother can access experienced support and advice from breastfeeding support groups and staff (see below). Unresolved breast engorgement, eczema, Reynaud’s phenomenon and tongue-tie are other occasional causes of pain.

Features that suggest Candida as a cause for their symptoms are listed below.

**Symptoms / signs suggestive of thrush**

**In mother:**
- Increased nipple sensitivity or itchy nipples
- Maternal pain **after** feeds – not resolved by optimising positioning and attachment
- Bilateral breast pain
- Permanent loss of colour in the nipple / areola (or may appear red and shiny)
- Absence of pyrexia or red area on the breast
- History of recent antibiotic use
- Current or past nipple trauma

**In baby:**
- Signs of thrush infection in mouth / nappy area

**Action if seen by GP**

- Refer to Midwife, Public Health Nurse/Health Visitor or Infant Feeding Coordinator for assessment of breastfeeding to exclude other causes of breast/nipple pain, especially poor latch and sub-optimal positioning and attachment and to provide on-going support with breastfeeding if this has not previously been carried out.
• Treat mother and baby even if only one is symptomatic

• Refer to Breastfeeding Peer Support Service for ongoing peer support.

**Action if seen by Midwife / Public Health Nurse**

• Carry out a thorough breastfeeding assessment, including observation of a complete feed, to exclude other causes, especially poor latch and sub-optimal positioning and attachment

• If treatment is required, referral should be made to the patient’s GP, ideally following discussion to outline the assessment, diagnosis and plan of care, and treatment requested as per treatment regime.

• Refer to Infant Feeding Coordinator if requiring further assessment and ongoing support

• Refer to Breastfeeding Peer Support Service for ongoing peer support.

**Treatment regime**

**White tongue in baby & asymptomatic (or non-breast feeding) mother:**

• Some babies develop white tongues after delivery. If the mother is breastfeeding and not exhibiting pain, or if the baby is bottle-fed, nystatin oral suspension should be prescribed for baby.

**White tongue in baby & symptomatic breast feeding mother:**

**First line treatment:**

• Combination of miconazole cream for the mother and oral gel for the baby as below.

**Second line treatment:**

• If symptoms do not resolve, oral fluconazole may be necessary in the mother along with continued topical treatment for both mother and baby.

**Doses:**

**Treatment of mother**

• **Miconazole 2% cream**: apply a small amount of cream to nipples after every feed. Washing the nipples prior to the next feed is unnecessary and may cause further damage, however any cream that can be seen should be wiped off.

• If the nipples are very red and inflamed a combination of **miconazole 2% with hydrocortisone 1% cream** (e.g. Daktacort®) applied as described above may be helpful

• **Fluconazole**: Give an initial 150–300mg loading dose, and then 50–100 mg twice a day by mouth for at least ten days

• Analgesia for breast pain as necessary
Treatment of baby

- **Nystatin oral suspension**: 100,000 units (1 ml) 4 times daily after feeds
- **Miconazole oromucosal gel**: 1 ml daily gently smeared around the baby’s mouth four times a day after feeds.

Note: nystatin is **fungistatic** whereas miconazole is **fungicidal** and has been shown to be clinically better in eradicating oral *Candida* in infants (Hoppe, 1997)

Licensing Information and safety considerations

**Fluconazole:**

- Fluconazole is not licensed for use during lactation. It is however licensed for direct administration to and used in infants (including premature infants weighing <1000g). The amount of fluconazole excreted into breast milk is 0.6mg/kg/day, compared to the dose for use in babies and children of 6mg/kg/day. Therefore mothers should be reassured that the small amount of any fluconazole that they take systemically is unlikely harm the baby.

**Nystatin:**

- Nystatin oral suspension is not licensed for neonates (i.e. infants up to the age of 4 weeks) yet this is one group highly likely to receive it. The Department of Health (Non Medical Prescribing Policy 27 July 2007) has advised that Community Practitioner Nurse Prescribers may prescribe nystatin oral suspension for a neonate providing there is a clear diagnosis of oral thrush and it is within their own competency.

**Miconazole oral gel:**

- Miconazole oral gel is licensed for twice daily use in babies from 4 months of age. The licensed dose (2.5 ml) is the same whether the child is 4 months or 48 months. There is however evidence that suggests four times daily application of 1ml is more effective (Hoppe 1997).
- After more than 30 years of unchanged use the manufacturer, Janssen-Cilag, with the support of the MHRA, chose to change its licensed use in May 2008 from infants over 1 month of age to infants over 4 months. This change appears to have been brought about following a case report of a baby who choked on the gel that had been applied to the mother’s nipples (De Vries et al, 2004). Thus risks of choking seem to be related to the method of administration and parents / carers should be advised to apply small amounts of the gel at a time and to do so with a clean finger. A spoon **should not** be used to administer the gel to babies.
Multi-disciplinary working between GP, Midwife, Public Health Nurse and Breastfeeding Support Services

- Midwives, Health Visitors/Public Health Nurses are required to undertake training in breastfeeding management and attend regular updates and should be seen as professionals to whom mothers may be referred if they are experiencing nipple/breast pain.

- Specialist support for breastfeeding is also available from NHS Dumfries and Galloway Regional Infant Feeding Co-ordinator Tel: 07785398486

- NHS Dumfries and Galloway also offers a Breastfeeding Peer Support Service with Breastfeeding Peer Support Coordinators who have all received training in breastfeeding management and are allocated to each locality who work on an individual basis with women and organise peer based local support where appropriate. Referral pathway in place for Midwives/Health Visitors/PHN team.

Breastfeeding Peer Support Coordinators contact details:

- **Nithsdale**
  - Carol Donald 07785531102
  - Andrea Wilson 07785223330
  - Jill Asher 07739438428

- **Wigtownshire**
  - c/o Liz Hood 07717347082

- **Annandale and Eskdale**
  - Rachel Byers 07785521448

- **Stewartry**
  - Elizabeth Foley 07770832163

Information for pharmacists

- Information in this appendix follows the guidance for ‘off license’ use of medications in NHS Dumfries & Galloway “Policy for the Use of Unlicensed Medicines”. See Hippo - Health Services\Pharmacy\General medicines policies and procedures\General documents.

- All medications described in this policy are safe, at the doses given, for both the lactating mother and her infant in the combinations suggested above however interactions with other medications may occur.

- Pharmacists may be asked about the safety of fluconazole in breastfeeding and miconazole in young infants by GPs, other health care professionals or by mothers and should ensure that they are aware of this local guidance.

- Breastfeeding mothers requesting information/treatment for thrush directly from pharmacists, should be referred for breastfeeding assessment by a Midwife, Health Visitor/Public Health Nurse or Regional Infant Feeding Coordinator (as for GPs above).
References


Further information:


With kind thanks to NHS Fife and Wendy Jones, PhD, Pharmacist responsible for the BfN national, voluntary “Drugs in Breastmilk Helpline” and co-author of Thrush and Breastfeeding and Portsmouth City PCT for use of their resource.