

## Breastfeeding After Cosmetic Breast Surgery

Dr. Gina Weissman  
DMD, RN, IBCLC, FABM

### Augmentation and Reduction surgery



The question we should ask ourselves is not: Is she able to breastfeed after surgery or not  
but rather: **To what extent is she able** (Harris et al., 1992)

### Factors that influence milk production and transfer

- Incision (of the nerves or gland)
- Time since the surgery
- Pre-operative mammary gland potential
- Breastfeeding management
- Previous Breastfeeding experience
- Mothers' attitude towards breastfeeding

### The incisions

The 4th intercostal nerve is critical for:

- Breastfeeding (Neifert 1992)
- MER (Schlenz et al., 2000)
- Milk transfer (Ramsay et al., 2004)

Two amazing abilities:

- Recanalization - breast tissue is re-grown, a cut-off milk duct reconnects, and new ducts develop.
- Reinnervation - A process where nerve endings grow back over time: 1mm a month
  - 6-12 months to renew (Shaw et al., 1997)
  - The more time that has gone by- The better

**Breast augmentation**

Five questions to ask:

1. When did you have the surgery?
2. How much was put in?
3. What did you have before?
4. Do you have the medical records?
5. What are your breastfeeding goals?

Options for implant placement:

- Submuscular
- Sub-glandular
- ❖ Implant directly under the mammary gland could cause pressure on the gland

Implant insertion methods:

- InfraMammary
- PeriAreolar
- TransAxillar
- TransUmbilical (TUBA)

Complications:

- Rupture
- Capsular contracture
- ALCL Anaplastic Large Cell Lymphoma
- Re-operation
- Breastfeeding Failure

### Does Silicone transfer into the milk?

- No reason for Augmented mothers not to Bf (Berlin 1994)
- Silicone levels in mothers with augmented breasts are similar to silicone levels in the normal population (Semple et al., 1998)
- “So far, we have not found any problems in babies, other than some diarrhea from large exposures.” (Hale 2014)
- silicone by nature is extremely inert Is unlikely to be absorbed in the gastrointestinal tract by a nursing infant (Medications & Mothers' Milk 2017)

“Women who have undergone breast enlargement surgery are at risk for having an insufficient milk supply. Factors to do with the surgery itself, short term and long-term complications, influence the ability to breastfeed exclusively” (Michalopoulos K, 2007)

### **Breast Reduction**

All reduction techniques can affect breastfeeding (Souto, 2003; Widdice, 1993)

#### Reduction techniques:

- Pedicle technique - Nipple-Areola complex are connected to blood supply throughout the surgery
- Free Nipple Graft - Nipple-areola complex is completely severed from the breast and then re-connected
- WISE Pattern T
- Vertical technique
- Liposuction

Higher breastfeeding rates with Pedicle techniques (Marshall, 1994 Sandsmark, M., et al 1992)

Free nipple graft is associated with low success rate for breastfeeding (Marshall et al.,1994)

Some women did produce and secrete milk (Ahmed, and Kolhe, 2000 )

Other factors that can challenge breastfeeding:

- BMI (Cruz 2007)
- Hormonal Imbalance
  - PCOS (Marasco et al., 2000)
  - Hypothyroid Imbalance (Marasco, 2006)
- Diabetes (Hartmann and Cregan, 2001)

**Breastfeeding management:**

- Latch on challenges
- MER challenges
- Engorgement
- Possible low milk supply: Ongoing assessment
- Specific support

Latch-On Challenges:

- Latch challenges
- More pain and sores
- More Vasospasm
- "Nipple Nudge"

How do we maximize milk production?

- Antenatal appointment
- Teach Manual expression
- Avoid Engorgement

Specific support

- Don't be too optimistic, but don't be pessimistic
- Celebrate small victories
- Breastfeeding can be satisfactory also with supplements (Kakagia, 2005)



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