



Breastfeeding after Breast Augmentation and Reduction Surgeries

By **Diana West, BA, IBCLC**

As you may have noticed, quite a few women are having breast augmentation and reduction surgeries these days. Since 1997, the number of breast augmentations has increased by 208% and the number of breast reductions is up by 137%. What's unsettling about these statistics is that *nearly all of these women are in their childbearing years*. While they may not have thought about how they will feed future babies when they decide to have surgery, most will eventually become mothers and face the issue of whether or not they can breastfeed. When they get to that point, they will find that there is a lot of incorrect and misleading information about whether or not breastfeeding after breast augmentation and reduction surgeries is possible. Doctors and other health care professionals are not usually well-versed in this topic and often give mothers wrong or misleading information, leaving the mothers feeling frustrated and confused.

I experienced this frustration myself. I had breast reduction surgery in 1990 when I was 25 years old, before I ever dreamed of

having children. When my first son was born in 1995, I didn't have enough milk. I had no idea how much my surgery was a factor or what could be done to make more milk. My doctor, midwives, pediatrician, and even my lactation consultant were unable to help. So I reached out on the newly developed Internet to meet other mothers who had had the surgery and were trying to breastfeed. In 1996, four other mothers and I started an email list called BreastFeeding After Reduction (BFAR) just for women who had had breast reduction surgery and were trying to breastfeed. Together we learned ways to breastfeed successfully, which we learned didn't always mean having a full milk supply. This led to the development of the BFAR.org Web site and forums that are still very active today. Later, I expanded my research into the ways that augmentation surgeries affect milk production because I learned that even more women are having augmentations, a procedure that can reduce milk supply, as well.

One of the most common questions I hear is how to know if a mother will have a full milk supply when she has had breast augmentation or reduction surgery. It would be so easy if we could say that if she had a certain surgery and does this or that thing, then she will have a predictable result. The truth is that there are so many variables that few experiences are the same. The range of outcomes is extremely diverse and depends on many factors, including the type of surgery, the mother's state of mind, attitude, environment, support structure, and what she was able to do to prepare. Each mother's experience will be different. Some may be able to breastfeed exclusively, while others may need to supplement the baby's entire nutritional requirement. Most fall somewhere in between. Fortunately, breast tissue is remarkably resilient; almost all women who have breast augmentation and reduction surgery will be able to make some milk. But if a significant portion of the lactation system was impaired by the surgery, then the milk supply may not be enough to meet a baby's entire need.

The reality is that any surgery on the breast is likely to decrease a mother's milk-making potential because the milk-making infrastructure of glands, ducts, and nerves is almost inevitably damaged to some degree. Fortunately, the mammary system is a co-operative, redundant network of glands and ducts. Even with the most invasive surgeries, it is possible that some portion of the original number of glands and ducts will remain intact. It is even possible that those damaged by the surgery will reconnect. This is known as recanalization. Damaged nerves also repair themselves over time through a process called reinnervation. A woman can know if her nerves are intact by how much sensation she has. Nerves that are still in the process of mending often feel more sensitive but settle down as the repairs are complete. Most women have a better milk supply when the surgery occurred five or more years before pregnancy, so the longer it has been since the surgery, the better the chances are of recanalization and reinnervation. Most women who have had breast surgery find that they have more milk with subsequent babies than they did with the first because pregnancies and the process of lactation also stimulate further glandular development.

So the question isn't whether a woman will have milk, because she almost certainly will. The true question is *how much* milk will she have? The starting place is knowing what type of breast augmentation or reduction surgery was performed because some surgical techniques preserve more lactation tissue and critical nerves than others.

The reduction surgeries that have resulted in the greatest lactation capability are those in which the areolas and nipples were not completely severed, even though they may have been moved. Many women believe their areolas and nipples were severed because they have a scar around the outside of the areola. They may also know that the areola and nipple were moved, and therefore assume

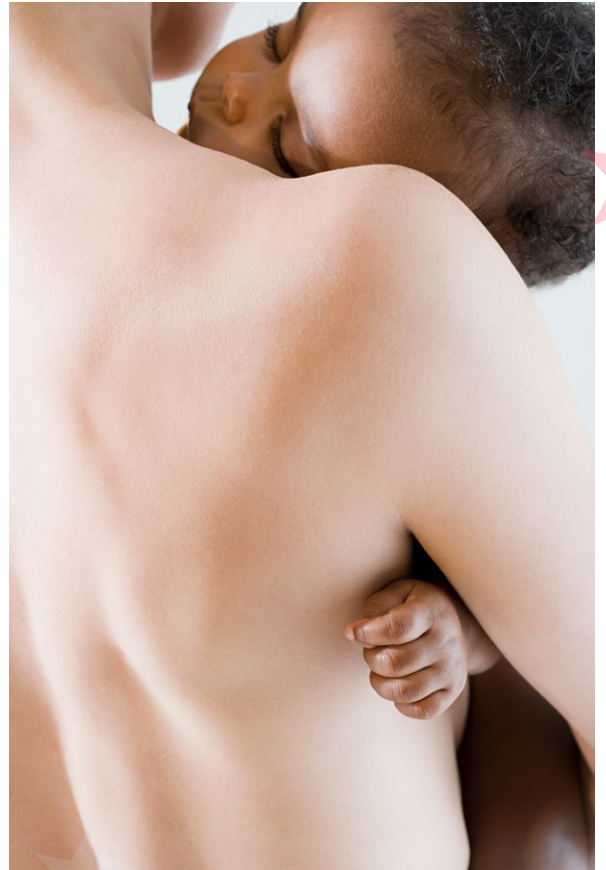
they must have been severed to do so. With surgical techniques used since 1990, this is unlikely to be the case. Most current breast reduction surgical techniques involve moving the areola and nipple attached to a wedge of tissue, called a pedicle, which remains attached to the ducts, nerves, and blood supply.

There are breast reduction surgical techniques that do completely sever the areola and nipple from the breast, which more severely reduce lactation. These techniques were commonly performed in the 1970s and 1980s before the more advanced pedicle techniques were developed. They are also

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occasionally performed on women who have such large breasts that the pedicle technique would not provide satisfactory results. Only very rarely have women with completely severed areolas and nipples produced a significant milk supply.

Similarly, the breast augmentation surgeries that result in the best lactation outcomes are those in which the incision for the implant does not sever the nerves near the areola, such as incisions in the armpit, under the breast, and at the umbilicus (navel or bellybutton). Implants placed under the muscle tend to result in better lactation outcomes than those placed over the muscle. Techniques that don't use any incisions at all, such as transplantation of the woman's own body fat and injection of hyaluronic acid are less likely to negatively affect milk production, although they can make mammograms more difficult to read.



One important consideration for women who have had breast augmentation surgery is what their breasts were like *before* the surgery. This is

important because some women have breast augmentation surgery to improve the *shape* or *spacing* of their breasts more so than the *size*. When a woman has widely spaced breasts or a particularly puffy areola, her breasts may be shaped in such a way that there is a lack of fullness underneath or on the inner sides of the breasts; this may indicate that she does not have the normal amount of lactation tissue. Not having enough milk might not just be because she had breast augmentation surgery; it also might be that she started with a lower milk-making capability than normal.

Fortunately, there is much that can be done to increase milk production. Removing extra milk in the early weeks is one of the best ways to maximize a mother's milk production capability because the more milk that's removed during this time, the more milk that the breasts develop the capability of making. So it makes sense to do some extra milk removal ▷▷



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after the baby nurses during the day, particularly in the first two weeks. Before the milk comes in around the fourth day, research has shown that it is easier and more effective to remove milk by hand expression. This is a technique that would be good to learn and practice during pregnancy when there's no pressure or expectations (research has shown that gentle hand expression during pregnancy is not likely to cause labor). After the milk comes in, pumping after baby nurses during the day with as good a quality pump as possible—ideally a rental-grade pump—is a great way to tell the breasts to set a higher milk-making capability.

It's also helpful to use breast compressions during both breastfeeding and pumping by compressing the hard tissue in the breast (which is the glandular tissue) between the fingers and thumb and holding it for about 10-20 seconds. This creates pressure inside the breast that pushes the milk out, resulting in more milk removed. If done during nursing, the baby might start gulping. During pumping, the milk will start spraying.

It is also effective to tip the pump flange down after pumping is finished and do a bit of hand expression into the flange, removing the last drops of milk. In the dairy industry, they call this "stripping" because it gets out all the rich creamy drops that line the ducts.

Many mothers who have had breast augmentation or reduction surgery also increase their milk supplies with herbal and prescription galactagogues (milk-inducing substances). The herb goat's rue in particular seems to be helpful for mothers who have had breast surgery, but there are many others that can be effective as well. (For more information about using galactagogues, see *The*

Breastfeeding Mother's Guide to Making More Milk by Diana West and Lisa Marasco.)

Mothers who have had breast surgery may find it helpful to work with a lactation professional who has expertise with low milk production because every situation is different. Sometimes the problem isn't just the mother's milk supply, but also the way the baby is removing milk. It's hard to figure out all these moving parts—this special situation requires special skills and expert help.

Breastfeeding is almost definitely more work and worry for a mother who has had breast surgery. Pumping and managing galactagogues can take a lot of time. If

optimal system, things can run very smoothly. It is also important to remember that nursing is so much more than nutrition. By breastfeeding our babies, we meet a whole range of emotional needs.

No matter how things turn out, it's important to focus on what a mother *is* able to do rather than what she *couldn't* do because every drop of human milk a mother gives her child is a precious, enduring treasure, especially when given at the breast.

Diana West, BA, IBCLC, is a La Leche League Leader and lactation consultant in private practice, co-author of the 8th edition of The Womanly Art of Breastfeeding, The Breastfeeding Mother's Guide to Making More Milk, and Breastfeeding after Breast and Nipple Procedures. She is the author of the Clinician's Breastfeeding Triage Tool and Defining Your Own Success: Breastfeeding after Breast Reduction Surgery. Diana mothers her three charming, breastfed sons in partnership with her husband, Brad, in their home in New Jersey. □

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supplementation is necessary, the efforts can sometimes seem overwhelming. And it is certainly time consuming to learn about breastfeeding after breast surgery in order to be able to do it as well as possible. But the efforts expended in supplementing are usually no more than what other bottle-feeding or partially breastfeeding mothers go through every day. And after the initial learning curve when mother and baby are working out their

For more information about breastfeeding after a breast reduction or breast augmentation surgery, go to the following websites:

www.lilusa.org/nb/nbsurgery.html
www.bfar.org
www.lowmilksupply.org