Breast Compression

The purpose of breast compression is to continue the flow of milk to the baby when the baby is only sucking without drinking. It is possible to know when a baby is getting milk from the breast – the pause in the chin means baby got a mouthful of milk. The longer the pause, the more milk the baby got. If baby is no longer drinking on his own or drinking is slowing down, compressions can be used to “turn sucks or nibbling into drinks”, and keep baby receiving milk. Breast compressions simulate a milk ejection reflex (let-down reflex) and stimulate a milk ejection reflex. See also our blog on breast compression.

The technique may be useful for:

- Poor weight gain in the baby
- Fussy babies
- Frequent feedings and/or long feedings
- Sore nipples in the breastfeeding parent
- Recurrent blocked ducts and/or mastitis
- Encouraging the baby who falls asleep quickly to continue drinking not just sucking
- A “lazy” baby, or baby who seems to want to just “pacify”. Incidentally babies are not lazy, they respond to milk flow, so that if flow slows, babies may start to fall asleep, or if they are older, may pull away from the breast.

Breast compression is not necessary if everything is going well. When all is going well, allow the baby to “finish” feeding on the first side and offer the other side. How do you know the baby is finished the first side? When he is just sucking (rapid sucks without pause) and no longer drinking at the breast (“open mouth wide — pause — then close mouth” type of suck). Breast compressions help baby to get the milk.

Breast compression works particularly well in the first few days to help the baby get more colostrum. Babies do not need much colostrum, but they need some. A good latch and breast compression help them get it.

It may be useful to know that:

1. A baby who is well latched on gets milk more easily than one who is not. A baby who is poorly latched on can get milk only when the flow of milk is rapid. Thus, many breastfeeding parents and babies do well with breastfeeding in spite of a poor latch, because most breastfeeding parents produce an abundance of milk. However, the breastfeeding parent may pay a price for baby’s poor latching—for example: sore nipples, a baby who is “colicky”, and/or a baby who is constantly on the breast (but drinking only a small part of the time).
2. In the first 3-6 weeks of life, many babies tend to fall asleep at the breast when the flow of milk is slow, not necessarily when they have had enough to eat and not because they are lazy or want to pacify. After this age, they may start to pull away at the breast when the flow of milk slows down. However, some pull at the breast even when they are much younger, sometimes even in the first days and some babies fall asleep even at 3 or 4 months when the milk flow is slow.

Breast compression—How to do it

(Use with the other information provided in the “Latching and Feeding Management” information sheet)

1. Hold the baby with one arm.
2. Support your breast with the other hand, encircling it by placing your thumb on one side of the breast (thumb on the upper side of the breast is easiest), your other fingers on the other, close to the chest wall.

3. Watch for the baby's drinking, (see videos) though there is no need to be obsessive about catching every suck. The baby gets substantial amounts of milk when he is drinking with an "open mouth wide—pause—then close mouth" type of suck.
4. When the baby is nibbling at the breast and no longer drinking with the "open mouth wide—pause—then close mouth" type of suck, compress the breast to increase the external pressure of the whole breast. Do not roll your fingers along the breast toward the baby, just squeeze and hold. Not so hard that it hurts and try not to change the shape of the areola (the darker part of the breast near the baby's mouth). With the compression, the baby should start drinking again with the "open mouth wide—pause—then close mouth" type of suck. Begin breast compression when the baby is not drinking much and before the baby gets too sleepy.
5. Keep the pressure up until the baby is just sucking without drinking even with the compression, and then release the pressure. Release the pressure if baby stops sucking or if the baby goes back to sucking without drinking. Often the baby will stop sucking altogether when the pressure is released, but will start again shortly as milk starts to flow again. If the baby does not stop sucking with the release of pressure, wait a short time before compressing again.
6. The reason for releasing the pressure is to allow your hand to rest, and to allow milk to start flowing to the baby again. The baby, if he stops sucking when you release the pressure, will start sucking again when he starts to taste milk.
7. When the baby starts sucking again, he may drink ("open mouth wide—pause—then close mouth" type of suck). If not, compress again as above.
8. Continue on the first side until the baby does not drink even with the compression. You should allow the baby to stay on the side for a short time longer, as you may occasionally get another letdown reflex (milk ejection reflex) and the baby will start drinking again, on his own. If the baby no longer drinks, however, allow him to come off or take him off the breast.
9. If the baby wants more, offer the other side and repeat the process.
10. You may wish, unless you have sore nipples, to switch sides back and forth in this way several times.
11. Work on improving the baby's latch.
12. **Remember, compress as the baby sucks but does not drink. Wait for baby to initiate the sucking; it is best not to compress while baby has stopped sucking altogether. Watch our videos to see how compressions are used.**

In our experience, the above works best, but if you find a way which works better at keeping the baby drinking with an "open mouth wide—pause—then close mouth" type of suck, use whatever works best for you and your baby. As long as it does not hurt your breast to compress, and as long as the baby is "drinking" ("open mouth wide—pause—then close mouth type" of suck), breast compression is working.

You will not always need to do this. As breastfeeding improves, you will be able to let things happen naturally.

The information presented here is general and not a substitute for personalized treatment from an International Board Certified Lactation Consultant (IBCLC) or other qualified medical professionals.

Questions or concerns? Email Dr. Jack Newman (read the page carefully, and answer the listed questions).
Make an appointment at the Newman Breastfeeding Clinic.