A Novel Approach to Correct Retracted Nipples

Retracted nipples is a very common problem with a reported prevalence of 9.8% in pregnant mothers [1]. It is also a very important cause of lactation failure due to inability of baby to suckle at breast. Usual methods to treat retracted nipples include manual eversion of nipples by fingers (Hoffman technique), using syringe pump, and breast shield [2]. Breast shield is no more recommended because of fear of creating nipple confusion and infection. Use of manual eversion and syringe pump singly or in combination are mostly successful in treating retracted nipples. A few more non surgical methods like suction pump fitted bra and breast jewellery to maintain protectility of the nipples have been described. In resistant cases, surgical correction can be done but it is possible only before pregnancy.

Recently, in a primiparous mother, who presented to us with grade 2 retracted nipples (Han and Hong classification) [3], these methods failed to correct the condition. Baby was given expressed breastmilk by spoon. However, the parents were very keen to establish breastfeeding. As the conventional methods to correct the retracted nipples had failed, we requested the father to suck at nipples of his wife frequently to correct the retracted nipples. The first concern of the father was that while sucking at breast, milk will go in his mouth. We reassured him that this human milk will not cause any untoward effects even if swallowed. Father agreed and over next one week the problem had improved.

When other conventional methods fails to correct retracted nipples, often due to insufficient mechanical suction, husband can be used as a good suction machine. The natural relations between husband and wife should overcome any inhibitions for some thing which will go a long way for their baby. Vigorous sucking by husband will not only help in correcting retracted nipples but will also improve lactation by stimulation of prolactin and oxytocin reflexes.

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First Dose of Measles Vaccine after 12 Months of Age

When measles vaccine was included in our national Universal Immunization Program in 1985, the schedule was to give one dose between 9 and 12 months of age. With the emphasis on immunization coverage assessment at the end of the first year of life, 9-12 months was interpreted by health workers as the exclusive age window for the vaccine and children who missed it within that window were not given it at a later age. This was recognized and corrected by the National Technical Advisory Group on Immunization (NTAGI), resulting in a Government Order to ensure that a dose of measles vaccine should be given to all children up to age 5 (personal communication, John TJ, co-chair, NTAGI). Despite these guidelines, many health workers still believe that by 12 months the window for the vaccine is over. We illustrate this with a case report to highlight the need for wider publicity to ensure that the vaccine is not denied to any child on the basis of age.