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'This is the Electronic supplementary material for the following article:

Scott, J. A., Robertson, M., Fitzpatrick, J., Knight, C., & Mulholland, S. (2008). Occurrence of lactational mastitis and medical management: A prospective cohort study in Glasgow. *International Breastfeeding Journal*, 3(1), 21. <https://doi.org/10.1186/1746-4358-3-21>

which has been published in final form at

<https://doi.org/10.1186/1746-4358-3-21>

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**UNIVERSITY
of
GLASGOW**

**MASTITIS STUDY
MOTHER'S MASTITIS QUESTIONNAIRE**

This is the questionnaire that we would like you to fill in if, and when, you have an episode of mastitis. Please contact **Sally Mulholland** on **0141 211 5019** within 12 to 24 hours of you developing mastitis. She will discuss with you the arrangements for collecting a sample of your breast milk. This questionnaire should be completed once your mastitis has got better.

This questionnaire is designed to investigate the risk factors that might be associated with mastitis. It has been divided into three sections. Section 1 contains questions about the symptoms and treatment associated with your most recent bout of mastitis. Section 2 contains questions concerning your breastfeeding history. Section 3 contains questions about you and your baby.

Most of the questions can be answered by circling or ticking the answer that applies to you.

FOR EXAMPLE:

What colour is your hair?

- Brown 1
- Red 2
- Blonde 3
- Grey 4
- I'm not sure 5

Which sport does your child enjoy playing?

	YES	NO
Football	1	2
Cricket	1	2
Tennis	1	2
Swimming	1	2

Some questions ask you to rate your answer on a scale of 1 to 5.

FOR EXAMPLE:

Please rate how much your child enjoys playing football.

- | | | | | |
|---------------------------|---|---|---|---------------------------|
| 1 | 2 | 3 | 4 | 5 |
| hates playing
football | | | | loves playing
football |

Some questions require a written answer in the space provided.

This questionnaire will take approximately 15-20 minutes to complete. If you wish to write any further comments please do so at the bottom of the last page. **Please return the questionnaire to us in the pre-paid envelope provided.**

SECTION 1

THIS SECTION IS ABOUT THE SYMPTOMS AND TREATMENT ASSOCIATED WITH YOUR MOST RECENT EPISODE OF MASTITIS.

1. How many times have you had mastitis when breastfeeding THIS baby?

- 1
- 2
- 3
- 4

other (please indicate) _____

2. About how old was your baby when you first experienced the symptoms associated with this bout of mastitis?

_____ weeks

PLEASE RATE HOW YOUR BREAST FELT AT THE HEIGHT OF YOUR MASTITIS ON A SCALE OF 1 TO 5.

3. The area of my breast affected by the mastitis was:

1
normal
tenderness

2

3

4

5
unbearable
to touch

1
normal skin
temperature

2

3

4

5
skin was very
hot to touch

1
normal
appearance

2

3

4

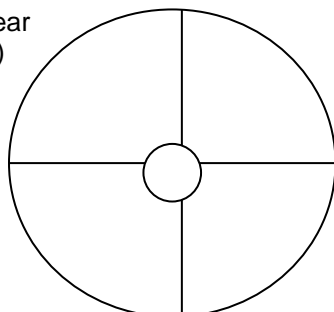
5
very red
and swollen

4. Please shade the area on the diagram to show which area of your breast(s) were affected by your mastitis

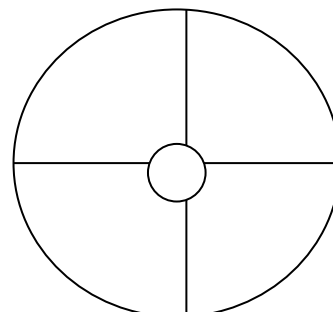
Right breast

Left breast

Right upper
quadrant (near
right arm pit)



Left upper
quadrant (near
left arm pit)



13. If you received advice from more than one source, was the information conflicting:

1	2	3	4	5
not at all conflicting				extremely conflicting

14. Please tick whether the following information was given in the treatment of your mastitis. If YES, please state the source of this information.

	YES	NO	SOURCES (e.g. GP, health visitor, midwife, La Leche Counsellor, your mother)	
Stop feeding from the affected breast	1	2	_____	<input type="checkbox"/>
Wean your baby	1	2	_____	<input type="checkbox"/>
Feed frequently from the affected breast	1	2	_____	<input type="checkbox"/>
Feed from the affected breast first	1	2	_____	<input type="checkbox"/>
Massage the affected area prior to and during a feed	1	2	_____	<input type="checkbox"/>
Discontinue the use of nipple lotions or creams	1	2	_____	<input type="checkbox"/>
		3		<input type="checkbox"/>
Apply heat to the affected area prior to and during a feed	1	2	_____	<input type="checkbox"/>
Feed with the baby's chin towards the affected area	1	2	_____	<input type="checkbox"/>
Apply cold packs after feeding	1	2	_____	<input type="checkbox"/>
Have ultrasound treatment to the affected area	1	2	_____	<input type="checkbox"/>
Other (please describe) _____				<input type="checkbox"/>
_____				<input type="checkbox"/>
_____				<input type="checkbox"/>
_____				<input type="checkbox"/>

15. Please tick which of the following steps you took to resolve your mastitis. IF YES, please show how effective you felt this treatment was in helping treat the problem.

Did you:	YES NO		EFFECTIVENESS OF TREATMENT				
	1	2	1	2	3	4	5
Stop feeding from the affected breast			not at all				very effective
Wean your baby			not at all				very effective
Feed frequently from the affected breast			not at all				very effective
Feed from the affected breast first			not at all				very effective
Massage the affected area prior to and during a feed			not at all				very effective
Apply heat to the affected area prior to and during a feed			not at all				very effective
Feed with the baby's chin toward the affected area			not at all				very effective
Apply cold packs after feeding			not at all				very effective
Have ultrasound treatment to the affected area			not at all				very effective

Other (please describe) _____

16. Were you given intravenous antibiotics to treat your mastitis? YES..... 1
NO 2
17. Were you given antibiotic (intramuscular) injections to treat your mastitis? YES..... 1
NO 2
18. Were you prescribed antibiotic tablets to treat your mastitis? YES..... 1
NO 2

IF YES, what was the name(s) and doses(s) of the antibiotic tablet prescribed?

_____	_____	_____	_____
name of antibiotic	dose	how many times per day	for how many days?
_____	_____	_____	_____
name of antibiotic	dose	how many times per day	for how many days?

19. Did you finish the prescribed course of antibiotics? YES1
NO2
20. Did the person(s) you sought advice or treatment from attempt to determine the cause of the mastitis? YES.....1
NO2

21.If YES, what was the reason given for your mastitis?

22. What do you think was the cause of your mastitis?

SECTION 2

THIS SECTION HAS QUESTIONS CONCERNING YOUR BREASTFEEDING HISTORY

23. IN THE WEEK BEFORE YOU DEVELOPED MASTITIS:

Did you experience trauma to your breast from strenuous exercise?	1 No injury	2	3	4	5 severely traumatised
Did you experience trauma to your breast from injury? (e.g. kick from toddler, hand expressing, rough foreplay)?	1 No injury	2	3	4	5 severely traumatised
Did you experience trauma to your breast from cracked or grazed nipples?	1 No injury	2	3	4	5 severely traumatised
Did you use a nipple shield when feeding?	1 Never	2	3	4	5 Always
Did you use nipple airers in between feeds?	1 Never	2	3	4	5 Always
Did you use breast pads after feeds?	1 Never	2	3	4	5 Always
Did you apply nipple creams or lotions?	1 Never	2	3	4	5 Always
Did you generally feel more stressed than normal?	1 not more stressed	2	3	4	5 extremely more stressed
Did you generally feel more tired or run down, than normal?	1 not more tired	2	3	4	5 extremely tired

24. What is your baby's preferred side for feeding?

- left breast 1
- right breast 2
- no preference 3

25. IN THE 48 HOURS BEFORE YOUR MASTITIS:

Did you suffer from:

Engorgement?	1 Not at all	2	3	4	5 extremely engorged
Did you suffer from blocked ducts?	1 Not at all	2	3	4	5 extreme blockage
Did your milk appear:	1 the same as usual	2	3	4	5 thicker than usual
Did you feed your baby?	1 much less than usual	2	3 same as usual	4	5 much more than usual
Did you give your baby complementary formula?	1 never	2	3 same as usual	4	5 much more than usual
Did you breastfeed your baby according to a preset routine?	1 never	2	3	4	5 always
Did you have to delay your baby's breastfeeds?	1 never	2	3	4	5 always
Did you experience restriction to any part of your breasts from:					
a tight bra?	1 no restriction	2	3	4	5 severely restricted
tight clothing?	1 no restriction	2	3	4	5 severely restricted
Did you wear a bra to sleep at night?	1 never	2	3	4	5 always
Was your baby difficult to attach to the breast?	1 never	2	3	4	5 always
Did your nipple generally hurt during a feed?	1 never	2	3	4	5 always
Did you have to depress your breast with your finger to allow your baby room to breathe?	1 never	2	3	4	5 always
Immediately after a breastfeed was your nipple generally:	1 normal shape	2	3	4	5 extremely misshapen

32. Did you suffer with any thrush infection in the week before your mastitis?
YES.....1
NO2

33. Were you taking any medications at the time of the onset of your mastitis? (please include oral contraceptives, medicines prescribed by your doctor, over the counter medicines and any medicines or supplements from a health food store).

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

PLEASE RETURN IT IN THE PREPAID ENVELOPE PROVIDED