This is the Electronic supplementary material for the following article:


which has been published in final form at https://doi.org/10.1186/1746-4358-3-21

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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?

<table>
<thead>
<tr>
<th>Sport</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Football</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Cricket</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tennis</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Swimming</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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  2  3  4  5
   normal tenderness  2  3  4  unbearable to touch
   
   1  2  3  4
   normal skin temperature  2  3  4  skin was very hot to touch
   
   1  2  3  4
   normal appearance  2  3  4  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
   Right upper quadrant (near right arm pit)

   Left breast
   Left upper quadrant (near left arm pit)
5. How long did it take before your breasts returned to normal? ____________ days

6. At the height of your mastitis was your temperature:

Below 37.4°C 37.5 to 38°C 38.1 to 38.5°C 38.6 to 40°C over 40°C

IF YOU DON’T KNOW what your temperature was please estimate using the following scale

Normal slightly elevated high very high extremely high
Below 37.4°C 37.5 to 38°C 38.1 to 38.5°C 38.6 to 40°C over 40°C

7. If your temperature was elevated, how long did it take for your temperature to return to normal?

Within 24 hours 24-48 hours more than 48 hours

8. Did you experience chills associated with your mastitis?

1 2 3 4 5
Not at all Severe shaking and chills

9. Did you experience flu like aching?

1 2 3 4 5
Not at all Severe flu Like aching

10. Did you feel so ill you were confined to bed? YES..............1

NO ..............2

11. If YES, please circle the length of time:

Less than 24 hours 24-48 hours more than 48 hours

12. Did you receive advice regarding the treatment of your mastitis from:

YES NO

General Practitioner 1 2
Midwife 1 2
Health visitor 1 2
La Leche League 1 2
Other (please specify) ______________________________
13. If you received advice from more than one source, was the information conflicting:

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>not at all conflicting</td>
<td></td>
<td></td>
<td></td>
<td>extremely conflicting</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Did you:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stop feeding from the affected breast</td>
<td>1</td>
<td>2</td>
</tr>
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<td>2</td>
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<tr>
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<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

**EFFECTIVENESS OF TREATMENT**

<table>
<thead>
<tr>
<th>Effectiveness</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>not at all</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>very effective</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>name of antibiotic</th>
<th>dose</th>
<th>how many times per day</th>
<th>for how many days?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. Did you finish the prescribed course of antibiotics?  
   YES ............ 1  
   NO ............. 2

20. Did the person(s) you sought advice or treatment from attempt to determine the cause of the mastitis?  
   YES........... 1  
   NO ............ 2

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
SECTION 3 SOME QUESTIONS ABOUT YOUR BABY AND YOU

26. Has your baby been diagnosed with any of the following conditions since birth?
   tongue tie ................................................. 1
   high palate ................................................ 2
   sucking disorder ......................................... 3
   none of the above ....................................... 4

IN THE WEEK BEFORE YOUR MASTITIS:

27. Did your baby suffer from:
   thrush of the mouth ....................................... 1
   thrush of the anal or genital area ...................... 2
   neither of these ........................................ 3

28. Did your baby suffer from any illness?  YES ................................................ 1
    NO .......................................................... 2

29. If YES, please describe ________________________________ __________________

30. Do you have anaemia?  YES ................................................ 1
    NO .......................................................... 2
    Not that I am aware of .................................. 3

31. Were you sick in the week before your mastitis?
   (e.g. flu, Cold, asthma etc.?)  YES ................................................ 1
    NO .......................................................... 2

   If YES, please describe ________________________________ __________________
32. Did you suffer with any thrush infection in the week before your mastitis?

YES ........................................ 1

NO ......................................... 2

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