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Breastfeeding experience of women after mammoplasty

Experiência de amamentação de mulheres após mamoplastia

Experiencia de lactancia de mujeres después de mamoplastía

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ABSTRACT

Objective: To describe and interpret the experience of breastfeeding among women who underwent mammoplasty surgery prior to motherhood. **Method:** A descriptive, qualitative study developed with women attended at a Human Milk Bank between 2014 and 2015. Data analysis was based on the content analysis method and supported by the Interactive Theory of Breastfeeding. **Results:** 13 women participated in the study. Four categories emerged: 1) Success (or lack thereof) in Exclusive Breastfeeding: influence of maternal and child biological conditions; 2) Maternal feelings: perception about breastfeeding; 3) Decision making on the continuity of breastfeeding or the use of formula; 4) The role of health professionals in protecting, promoting and supporting breastfeeding: Information (or lack thereof) on the implications of the surgery. **Conclusion:** Unfavorable biological conditions of the women who underwent mammoplasty generated unsuccessful experiences in exclusive breastfeeding and limited their decision-making, despite their desire to breastfeed.

DESCRIPTORS

Breast Feeding; Mammaplasty; Breast Implantation; Weaning; Nursing Theory; Milk Banks.

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INTRODUCTION

Some women seek breast surgery for aesthetic or therapeutic reasons in a period of life in which pregnancy and breastfeeding are not being considered, and/or in which there is no questioning regarding the influence of surgery on breastfeeding[1].

Data from the *International Study on Aesthetic/Cosmetic Procedures* of 2013 point to Brazil as the second highest country in number of reduction (77,644) and/or augmentation (313,703) mammoplasties[2]. The country ranked second in the world ranking of breast surgeries at 14.9%, very close to the 15% of the United States. The most sought breast surgeries by women were breast augmentation and correction of sagging breasts, both occupying second place in a comparison between the two countries with 12.7% and 9.2%, respectively[2]. Among adolescents, plastic surgeries increased by 141% between 2008 and 2012[3]. Despite the increase in the number of aesthetic plastic surgeries and the risks and limitations they can bring to breastfeeding[4], few studies have been produced to clarify the experiences, meanings and feelings of women who have experienced this process. The benefits of breastfeeding for women, children, the family and society are unquestionable, especially related to better maternal and neonatal health indicators, as well as a reduction in neonatal mortality and health spending[5]. However, reduction or augmentation mammoplasty influence the conditions for breastfeeding, providing consequences on decision making by women regarding the choice to start breastfeeding, or its duration[4-8].

The start and duration of breastfeeding partly depend on women's ability to decide what they think is best, and most women are encouraged to choose breastfeeding. This choice represents decision making that is influenced by cultural, social and economic factors and support systems[4-5]. In the particular case of those submitted to mammoplasty, the effects of surgery may create conditions that cause this decision making substantially different from those women without previous exposure to mammoplasty[6-8]. Thus, the present study asks: What is the experience of women submitted to mammoplasty in relation to breastfeeding? The objective was to describe and interpret the experience of breastfeeding among women who underwent mammoplasty surgery prior to maternity.

METHOD

In order to understand the complexity of the study, the Interactive Theory of Breastfeeding was used, which is a medium-range theory that proposes to describe, explain, predict and prescribe the phenomenon of breastfeeding, examining the factors that precede, influence and affect the breastfeeding process. Based on scientific evidence and Imogene King's Open Systems Conceptual Model, this theory was deductively developed to compose 11 interrelated concepts and to address breastfeeding as a process of dynamic interaction. This theoretical choice is based on three reasons: its level of coverage (medium-range), which makes the inferences about empirical data closer to reality than in the adoption of a conceptual model or great theory; the focus of theory (breastfeeding); and its interactional philosophical nature, making the experience between personal, interpersonal and social systems more understandable and explicit. In addition, it incorporates elements that may facilitate a description of the breastfeeding experience among women who underwent mammoplasty, among them: biological conditions; the maternal role; the organizational systems for protecting, promoting and supporting; and women's decision-making. By recognizing that successful breastfeeding requires adequate biological and maternal conditions for the mother and the child such as anatomy of the woman's breasts, milk production, anatomy and physiology of the child's stomatognathic system, the Interactive Theory of Breastfeeding can contribute to understand the present qualitative study[9].

This is a descriptive study carried out in a University Hospital in the state of Espírito Santo, Brazil. Women who met the following inclusion criteria participated in the study: those who underwent reduction and/or augmentation mammoplasty; who were breastfeeding; and who were registered and served by the Human Milk Bank of the Hospital (the research scenario) from July 2014 to July 2015. As exclusion criteria, we considered those women who lived in municipalities outside the metropolitan region, and those who underwent bariatric surgery. From the total of 20 women attended at the service within the study period, 13 met the proposed criteria and accepted to participate in the study. The field work was carried out after approval by the Ethics and Research Committee under CAAE No. 30385714500005060.

For data collection, an interview was conducted that was guided by a semi-structured script containing: sociodemographic data of the woman (age, marital status, educational level, family income, work occupation, use of alcohol and tobacco during pregnancy); questions about gestation (number of pregnancies, of prenatal consultations and type of delivery); questions about breastfeeding (type of breastfeeding, breast size, nipple type, prenatal guidelines); questions about the surgery (type, reason, time, surgical incision); questions about the implant (type, place of insertion and size); in addition to newborn data: gender, gestational age at birth according to the Capurro method, Apgar in the first minute, breastfeeding in the first hour of life and birth weight. Women were also asked: *How was the breastfeeding experience for you*?

The interview was scheduled by telephone, and was conducted in a private and reserved room at the woman's home or at the Human Milk Bank after their appointments. Each interview lasted approximately 30 minutes. The statements were recorded using an MP3 system and transcribed in-full to form the textual corpus of analysis. To ensure anonymity, the participants were identified by the letter E, following the order of interviews (E1, E2, E3..., E13).

Categorical content analysis according to Bardin[10] was applied in its three phases: 1) pre-analysis, with exhaustive reading of the empirical material; 2) exploration of the material to confer intelligibility to the recording units; and

3) treatment of results, inference and interpretation in light of the Interactive Theory of Breastfeeding and the scientific literature on the subject.

During the pre-analysis, statements unrelated to the question formulated in the interview were eliminated from the textual corpus; for the material exploration we tried to give completeness to the statements so that the content was explicitly presented. In the treatment of the results, we looked for word classes and word radicals that allowed for grouping the contents into nuclei of meanings, forming a word tree and their relationships between them.

The data were subsequently interpreted based on the Interactive Theory of Breastfeeding, especially its conceptual structure and its relational affirmations. Thus, four empirical categories emerged from this analysis: Success (or lack thereof) in Exclusive Breastfeeding: influence of maternal and child biological conditions; Maternal feelings: an expression of the woman's perception about breastfeeding; Decision making on the continuity of breastfeeding or the use of formula; The role of health professionals in protecting, promoting and supporting breastfeeding: Information (or lack thereof) on the implications of breast surgery.

RESULTS

The 13 women who underwent reduction and/or augmentation mammoplasty prior to having children were between 29 and 39 years, 76.9% were married, 46.2% had higher education, 46.2% had family income between six and 10 minimum wages, and 53.8% were employed. None of the subjects consumed alcohol or tobacco (cigarettes) during pregnancy. Regarding the clinical profile, 61.5% were primiparous and 61.5% underwent cesarean delivery. Regarding the newborns, 61.5% were female, 92.3% were born full term, 69.2% were born with Apgar between 8 and 10, 84.6% were breastfed in the first hour of life, and 84.6% were born weighing more than 3 kg.

Success (or lack thereof) in Exclusive Breastfeeding: influence of maternal and child biological conditions

Regarding the biological conditions, a predominance of women with normal/medium size breasts and protruding or semi-protruding nipples were observed. Most were submitted to breast reduction surgery or to reduction and augmentation mammoplasty, with a T-inverted and periareolar incision, more than 5 years before becoming pregnant.

Although the majority (84.6%) of the newborns were breastfed within the first hour after birth, the duration of exclusive breastfeeding was not maintained, since only three women continued to do it exclusively at the time of the interview. Table 1 characterizes the biological conditions of the participants and the type of breastfeeding performed. This initial characterization is relevant for interpreting the women' speeches, and pointed to unsuccessful efforts to exclusively breastfeed, which in a way would emerge in counterpoint to the external conditions of their breasts and nipples.

Table 1 – Characteristics related to the biological conditions of women with mammoplasty and the type of breastfeeding – Vitória, ES, Brazil, 2014-2015.

Clinical Variables	N	%
Size of the breasts		
Normal/Medium	8	61.5
Hypertrophic	5	38.5
Type of nipple		
Protruding or semi-protruding	12	92.3
Pseudo-inverted (Flat or inverted)	1	7.7
Type of surgery		
Augmentation mammoplasty	2	11.8
Reduction mammoplasty	7	76.9
Reduction and augmentation mammoplasty	4	23.5
Surgery time		
< 5 years	2	11.8
5-10 years	6	35.3
11-15 years	5	29.4
> 15 years	4	23.5
Type of incision surgery		
T-inverted and Periareolar	11	91.7
Inframammary	2	8.3
Type of breastfeeding		
Exclusive	3	23.1
Non-exclusive	10	76.9
Total	**13**	**100.0**

For women who underwent mammoplasty prior to the experience with motherhood, the success or failure of breastfeeding was a latent and concealed experience until they realized that biological possibilities after the surgery could limit their breastfeeding process.

She sucked my breast well, but no milk came out, I had milk, I felt my breast full, but the milk wouldn't come out. I did everything I could to try to breastfeed (E4).

I had difficulty to breastfeed, the nursing technician would squeeze my breast hard and there were basically (only) two breast ducts that would gush milk, and the rest just dripped some milk, and I had a lot of fissures (E7).

I had difficulty during breastfeeding, I didn't have ... enough milk to breastfeed him, my milk came out, but it was very little (E11).

The unsuccessful experiences of breastfeeding pointed to biological conditions related to breast reduction surgery such as few functioning breast ducts, full breasts but no efficiency for milk ejection and low milking yield. These difficulties only added to the typical problems of breastfeeding such as nipple fissures, for example.

These statements contain elements that indicate damage to ducts, glandular tissue or breast innervation. These aspects led to functional impacts such as low milk production and engorgement due to lack of milk flow, as expressed in the following statements.

My milk began to dry, the production slowed down until my breasts stopped filling up (E13).

I thought I had low milk production, but the milk wouldn't flow because my breasts were engorged, it happened a few times (E3).

My breast was full with milk, I felt my breast full of milk! But the milk wouldn't flow (E2).

Inadequate child latching refers to the biological conditions of the child with ineffective mother-child interactions. Incorrect positioning of both (mother and child) and poor suck-latching of the child on the breast marked the testimony of women who were unable to breastfeed.

I had little milk, but even with the low production she continued breastfeeding (E1).

Well, at first she couldn't latch on, she didn't know how to latch properly, then when she learned the correct latch my milk production was already low (E5).

She didn't correctly latch, her mouth was too small, so adjusting her latch to the breast was a long process (E10).

These testimonies demonstrate interaction between biological conditions of mothers and children with effects on breastfeeding, especially due to particularities of breasts that were surgically reduced, determining visible external modifications *(milk flowing from (only) two ducts)* and invisible and internal modifications *(feeling the breast full but no milk flow)*. These were determining factors for the majority of women to stop exclusive breastfeeding.

All women who could not breastfeed underwent surgical reduction with T-inverted and periareolar incision, while two of those who managed to maintain exclusive breastfeeding underwent augmentation mammoplasty with inframammary surgical incision, and one underwent reductive surgery with T-inverted and periareolar incisions, and they were primiparous.

Experiencing failure resulting from a decision made in the past, which for most of them had been over 5 years ago, has produced feelings that influenced their perceptions on breastfeeding and their role as a mother.

Maternal feelings: an expression of the woman's perception about breastfeeding

The interviewed women experienced feelings and emotions during their attempts to breastfeed regarding the mother-child interaction. Negative perceptions related to the failure and positive perceptions related to success have been pointed out.

Negative feelings of sadness *(crying)*, frustration, worry and guilt predominated, which added to the suffering, nervousness, anxiety and *awful feelings.*

I cried a lot because I really wanted to, we are aware of the benefits of breastfeeding. For me it was sad because I couldn't breastfeed. It was frustrating, that is the truth (E2).

It was very frustrating when I couldn't breastfeed, I cried a lot ... I felt very guilty. (E3).

Breastfeeding was very difficult, I suffered a lot from it. I was very nervous, very anxious (E7).

Breastfeeding was something I wanted to do very much and I couldn't do it. When I think about it, about everything that I've been through, I feel very frustrated (E5).

For those who experienced negative feelings, the breastfeeding journey was traumatic and difficult.

My breastfeeding experience was very traumatic. I felt awful when I saw that I did not have enough milk. It was very difficult, both for me and for him (the baby), I never thought about giving up, but I couldn't breastfeed, and I even put the blame on myself a bit (E11).

The positive feelings that two women expressed were a result of the idealized unconditional motherly love regarding motherhood and their persistence in maintaining breastfeeding.

Breastfeeding is very good, despite all the difficulty in the beginning. It's you showing your love as a mother for your child. (E10).

So far I've been able to breastfeed, he's 4 months old and only feeds on the breast (E9).

Negative (most of the reports) and positive feelings (only 2 out of 13) respectively represent failure, which has led to failure of breastfeeding, and to success, in the persistence in continuing to breastfeed.

Decision making on the continuity of breastfeeding or the use of formula

Of the 13 participants, 10 supplemented the child's nutrition with formula due to the proven low milk production and lack of milk flow either by translactation or by using a bottle. In their speeches, they said that the milk was not enough and could not sustain the child, who had had progressive weight loss as verified in the assessments in childcare follow-ups. Attempts to breastfeed have exhausted the woman and the child. Furthermore, women's statements highlight translactation to be a difficult, demanding, tiring and laborious procedure.

I didn't have milk, any milk, so since the hospital I started giving formula. I gave the formula by translactation every time (E11).

Every time I gave her formula I did it by translactation. It must have been at every 2 hours too. Up to 5 months I fed her formula (only) by translactation (E12).

Little milk came out and it didn't satisfy her, she started to lose a lot of weight, and she got nervous. Then, around the seventh day I started giving her formula using the probe. I always used the translactation and it was quite tiring, especially in the middle of the night, so I ended up introducing the bottle (E5).

Doing translactation was difficult. She did not know how to suck the bottle, but I was so tired of doing the translactation, she was already five and a half months old, so I gave her the bottle. The pediatrician said that she was losing weight, she lost 500 g and there was nothing else I could do. I had to supplement (E7).

I don't have much milk. He breastfeeds, breastfeeds, breastfeeds and he is not satisfied, he is only satisfied when I give him the formula using the probe (E13).

My baby started to lose a lot of weight, I did not even realize that I had low milk production, so we started to supplement with formula and my baby gained weight and returned to normal (E3).

During the first month I offered my milk and the complement only using a finger. When he turned 1 month I introduced the bottle (E2).

Certainly women's decision-making was 'limited' to the child's survival conditions, which led to introducing supplementation with formula due to successive weight losses as early as the first week of life. The child's well-being prevailed over the woman's desire to maintain exclusive breastfeeding, while revealing the differentiated conditions for women who underwent mammoplasty prior to motherhood.

The role of health professionals in protecting, promoting and supporting breastfeeding: information (or lack thereof) on the implications of the surgery

Most women were unaware of the influence of the surgery they had undergone on the breastfeeding process. Any risk associated with failure to breastfeed was not explained to them.

The doctor didn't explain to me about the possibility of the surgery influencing breastfeeding (E2).

The doctor didn't even bring up the subject that the surgery could influence breastfeeding (E6).

At no point did the doctor explain to me about the possibility of the surgery influencing breastfeeding (E8).

Others, however, claim to have asked questions about these possible implications, however the professionals ensured them that the surgery would not have any negative effects on breastfeeding.

The doctor assured me that it wouldn't influence breastfeeding (E7).

At the time of the surgery I asked the doctor about the possibility of the surgery influencing breastfeeding, but he said that there were no problems at all, that the surgery wouldn't influence breastfeeding (E13).

A fewer number of women received information about the possible consequences of the surgery to breastfeeding; however, at that moment in life in adolescence, they were unaware of the importance of breastfeeding for their child and themselves.

I remember that the doctor said something, that I could have difficulty in breastfeeding, but at that time at 13-14 years of age I didn't know what it was to breastfeed, I wasn't aware of the importance of breastfeeding (E3).

The women reported that when faced with difficulties in breastfeeding, they sought support at the Human Milk Bank and from health professionals (nurses and pediatricians), receiving guidance, help, support and comfort.

I think the work of the Milk Bank is very important. You give us comfort. Even to learn how to handle the baby, about feeding them, you help us to understand and value what we do (E11).

I went to the Human Milk Bank several times, they helped me to get her on my breast to nurse. There was a day that I went there three times, on the same day, to check her nursing schedule. (...) They taught me how to do the translactation with the formula at the maternity and also at the Human Milk Bank, I would breastfeed and also do the translactation (E5).

I came to Human Milk Bank once and received help with breastfeeding, and a nurse also helped me at home (E2).

The nurse came to my house and massaged my breast before I started nursing, and she would put milk in the nipple. She helped me a lot. (...) I went to Milk Bank to ask for guidance, and there they taught me how to use the probe, and then I started to use the probe (E4).

DISCUSSION

Many of the negative or positive feelings expressed by the women participating in the study are the same as those experienced by others who also engage or try to breastfeed. However, the particular conditions of the biological changes after the breast reduction or augmentation surgery influenced decision making, limited by the child's survival needs. This decision was based on different elements that other women have, and which are not related to mammoplasty prior to breastfeeding.

The biological conditions of the women generated unsuccessful experiences for exclusive breastfeeding. Their breasts presented characteristics and functions that limited breastfeeding such as a reduced amount of ducts, even though the residual mammary glands are active and functioning. Lactation occurs at cellular, molecular and behavioral levels, including the anatomy of the woman's breasts, breast milk production and the anatomy and physiology of the stomatognathic system in newborns[9].

Thus, the lactation process is essential for breastfeeding, ensuring the means for women to provide human milk to the child, regardless of whether she is in the immediate or late postpartum period. Otherwise, there may be problems such as hypogalactia or hyperlactation, or even behavioral conditions that affect the onset and duration of breastfeeding[11-13].

Reduction mammoplasty was the type of surgery that most of the research participants underwent before they became mothers, and the one that had the most negative impact on exclusive breastfeeding when compared to breast augmentation surgery. However, both surgeries had a negative impact on breastfeeding when compared with no surgery[8]. Also, lactation can be affected by the technique used during surgery, as it can change the integrity and functioning of the mammary structure[6-7]. The probability of exclusively breastfeeding in the first month of life among women submitted or not to mammoplasty is very different. Those who did not undergo surgery are 80% likely to exclusively breastfeed, whereas those submitted to augmentation mammoplasty with a prosthesis implant are 54% likely, and those who underwent a reduction surgery, just 29%[8]. Among those who undergo reduction surgery, some are unable to exclusively breastfeed their children up to the sixth month[6-7], which is in line with the participants' experiences.

A systematic review suggests that women undergoing augmentation mammoplasty with a prosthesis implant will exclusively breastfeed for less time than those without breast augmentation[8]. Added to these limiting conditions is the consequent problem of breast engorgement which impairs milk flow, the woman's comfort and correct latching of the child, thereby contributing to the appearance of nipple fissures[14-15]. All these adverse situations are potentially amplified by the structural and functional changes of the breasts after surgery.

In the relational assertions of the Interactive Theory of Breastfeeding, its relational proposition fulfills its descriptive and explanatory role, considering that the biological conditions of the woman interfere in the mother-child interaction dynamic, the mother's role and the woman's decision-making[9]. This seems to explain the findings of this study, which found that the biological conditions preceded successful and unsuccessful outcomes regarding exclusive breastfeeding. It can happen that the conditions of breast development of the women generate interference in the breastfeeding process; however, those who underwent mammoplasty carry limiting factors which alter the structure and functioning of breast tissue, increasing the interference spectrum over biological conditions.

Certainly the speeches describing sadness, frustration and guilt reflect negative feelings of failure in breastfeeding, which are part of the repertoire of so many other testimonies of women who desire and try hard to maintain breastfeeding, regardless of the biological conditions associated with surgery[16-17]. However, among women who undergo breast surgeries, these emotions collide with the desire and persistence for maintaining breastfeeding with relactation and formula. Based on the knowledge of the benefits of breastfeeding, concern for the child's health assumes a more relevant aspect in the day-to-day of women who could not exclusively breastfeed[11].

Two propositions of the Interactive Theory of Breastfeeding apply to this situation: *If breastfeeding succeeds, there will be satisfaction* and *The transactional achievement of breastfeeding reduces the stress of both mother and child*. The conceptual framework of the theory positions the biological conditions of the woman and the child, the woman's perception of the child and her decision-making, with all of these elements on the same level encompassing breastfeeding as a dynamic mother-child interaction[9].

The maternal role, a more external element of the conceptual framework of the theory, relates to aspects transmitted from mother to daughter. In some cultures and social groups, failure to breastfeed brings a sense of only partial achievement in this role[12]. The success of exclusive breastfeeding is directly related to postponing the introduction of liquids of any nature, based on the belief that the breast milk supply is sufficient to nourish the child, that the breast milk is healthier and stronger, thus making the woman feel safe and confident about this practice, visualizing herself as capable of producing well-being for the child[18]. Maternal personality traits are more associated with duration than with the initiation of breastfeeding. The expression of positive feelings is more common among women who feel more secure in the act of breastfeeding, prolonging breastfeeding duration, despite biological and social barriers, particularly among those with more social support and knowledge[19].

According to the findings of this study, limited decision making was another characteristic feature of women who experienced breastfeeding after mammoplasty surgery. According to the International Classification for Nursing Practice (ICNP®), decision-making is a process that includes determining a course of action "based on relevant information, the potential consequences of each alternative and resources"[20]. What was verified in the testimonials was the absence, uncertainty or irrelevance of important information about the effects of mammoplasty on breastfeeding. These aspects influenced the decision making for the surgery, and later they generated a selection of secondary alternatives due to the insufficient biological resources to support exclusive breastfeeding.

In the Interactive Breastfeeding Theory, the concept of decision making is derived from the Imogene King Conceptual Model, which understands it as a process in which "individuals or groups make a choice between alternatives to achieve the proposed objectives"[9]. Unlike most women, participants' choices were limited to the type of resource to be used in complementary nutrition. When this is related to reports of disinformation, failures in organizational systems, in the role of protection and promotion of breastfeeding, the continuity of women's existence can be verified, and not only during the period of maternity.

A French study found that surgeons did not systematically provide information about breastfeeding, even when requested[4]. Even when informed, women may not have the necessary resources to choose the best alternative either due to problems of understanding information or immaturity, for example. Surgeries performed in adolescence or early youth occur when breastfeeding and pregnancy compete with more immediate and concrete plans, for example, with the desire for an ideal of beauty[1-3].

The Interactive Theory of Breastfeeding points to the woman's body image as a precursor to breastfeeding, which converges with the findings of this study. This theory also states that the body image of the woman breastfeeding also interferes in her decision making; however, it does not explicitly state the particular condition of many participants when their body image refers to their impression on their body in relation to the esthetics of their breast[9]. At this point, the present study advances in validating the theory, originally contributing with important empirical contextualization of the theoretical assertion.

We must emphasize that for young women without children it would be an important surgical procedure to seek at all costs to preserve lactation capacity of those who want to breastfeed in the future[4,6-7], or even to encourage performance of the surgery in a later stage of life when they had the resources for better decision-making, particularly with consistent and truthful information. The decision-making of these women was limited, in which most of them disregarded the effects of mammoplasty on breastfeeding, facing doubts and/or questions only years after the surgery when they became pregnant[1,21].

In the conceptual framework of the theory, organizational systems of protection, promotion and support are related to other previously discussed elements, emerging as compensation resources to deal with the constraints arising from inadequate biological conditions for breastfeeding[9]. Community-based interventions include counseling or education groups and social mobilization through wide-ranging media campaigns as well as support from health professionals as part of a continuous and quality process, providing effective resources to support breastfeeding[22]. Thus, the behavior of health professionals should turn to contribution and support, to empowering the mothers, who in turn wish to breastfeed, but who sometimes need support to achieve this goal[9,11,17].

The findings of the study show that intercrossing women's experiences of breastfeeding after mammoplasty surgery with the theoretical middle-range explanatory model of the Interactive Breastfeeding Theory may be a process to be considered and prioritized in the breastfeeding clinic. The true biological conditions of women which are often unknown until they try to breastfeed, were determinants in their ability or capability of choosing to breastfeed, bringing relevant implications for professional actions in the protection, promotion and support of breastfeeding.

Regarding limitations of the study we can highlight the recent character of applying the Theory, the small sample and the reality of a group that attended the Human Milk Bank. The complexity of the investigated phenomenon demands that the application of the Interactive Breastfeeding Theory as an explanatory model should be circumscribed to the interactive paradigmatic scope of the Theory, and the use of other theories is advisable when the paradigmatic approach is different.

As for the number of participants, 13 may represent a sampling that does not allow for generalizations for population groups, nor does it apply to all types of mammoplasty.

CONCLUSION

The experience of breastfeeding among women after mammoplasty was analyzed according to preceding factors (lack of information), influence (change in biological conditions) and which are consequent to the breastfeeding process (failure in exclusive breastfeeding). All of these aspects are central to Interactive Breastfeeding Theory to describe and explain the reasons for failure, limited decision-making and feelings of frustration, sadness and guilt.

Most women were unsuccessful to exclusively breastfeed and had to complement the breastfeeding experience, performing translactation or finger feeding at almost every feeding.

The inadequate biological conditions of women influenced the perception of negative feelings about breastfeeding. Moreover, the unfavorable biological conditions, probably due to structural and functional losses in the breasts, limited the decision-making of women regarding the complementary feeding of the child with formula by translactation or bottle, distancing themselves from their legitimate interests of exclusive breastfeeding.

The efforts undertaken by women to initiate and maintain exclusive breastfeeding were exhaustive and persistent, reaching predominant breastfeeding; at the same time they raised questions about their female ability to exercise the maternal role in breastfeeding.

It can also be pointed out that the fact that few women are informed about the role of mammoplasty, the risks and the consequences in breastfeeding when obtaining informed consent for performing the surgery. Thus, in relation to organizational systems based on professional actions, there is a need to consistently inform women who seek breast surgeries regarding possible complications and the potential risk for lactation.

As an implication for the practice, proper use of medium-range nursing theories stands out when in fact it functions as an adequate reference for developing studies on phenomena of interest in nursing science, as is the case in caring for woman and child in breastfeeding.

From the clinical point of view, protection, promotion and support for breastfeeding involves respecting the biological and behavioral conditions of women and children through active and culturally sensitive listening to the problem presented by each woman.

RESUMO

Objetivo: Descrever e interpretar a experiência de amamentar entre mulheres que realizaram a cirurgia de mamoplastia antes da maternidade. **Método:** Estudo descritivo, de abordagem qualitativa, desenvolvido com mulheres atendidas em um Banco de Leite Humano, entre 2014 e 2015. A análise de dados baseou-se no método de análise de conteúdo e fundamentou-se na Teoria Interativa de Amamentação. **Resultados:** Participara 13 mulheres. Emergiram quatro categorias: (In)Sucesso na Amamentação Exclusiva: influência das condições biológicas materna e da criança; Sentimentos maternos: percepção sobre amamentação; Tomada de decisão na continuidade da amamentação ou uso de complemento; Papel dos profissionais de saúde na proteção, promoção e apoio a amamentação: (Des)Informação sobre as implicações da cirurgia. **Conclusão:** As condições biológicas desfavoráveis das mulheres que realizaram mamoplastia geraram experiências de insucesso com a amamentação exclusiva e limitaram sua tomada de decisão, a despeito do desejo de amamentar.

DESCRITORES

Aleitamento Materno; Mamoplastia; Implante Mamário; Desmame; Teoria de Enfermagem; Bancos de Leite.

RESUMEN

Objetivo: Describir e interpretar la experiencia de amamantar entre mujeres que realizaron la cirugía de mamoplastía antes de la maternidad. **Método:** Estudio descriptivo, de abordaje cualitativo, desarrollado con mujeres atendidas en un Banco de Leche Materna, entre 2014 y 2015. El análisis de datos se basó en el método de análisis de contenido y se fundó en la Teoría Interactiva de la Lactancia. **Resultados:** Participaron 13 mujeres. Emergieron cuatro categorías: Éxito o fracaso en la Lactancia Exclusiva: influencia de las condiciones biológicas materna y del niño; Sentimientos maternos: percepción acerca de la lactancia; Toma de decisión en la continuidad de la lactancia o uso de complemento; Papel de los profesionales sanitarios en la protección, promoción y apoyo a la lactancia: (Des) Información acerca de la implicaciones de la cirugía. **Conclusión:** Las condiciones biológicas desfavorables de las mujeres que realizaron mamoplastía generaron experiencias de fracaso con la lactancia exclusiva y limitaron su toma de decisión, a pesar del deseo de amamantar.

DESCRIPTORES

Lactancia Materna; Mamoplastia; Implantación de Mama; Destete; Teoría de Enfermería; Bancos de Leche.

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