Mastitis and Breast Abscess

Disclaimer

Contents

Red Flags

- Skin dimpling or peau d'orange
- Mastitis in woman who is not breastfeeding
- Unresponsive to antibiotics after 10 days

Background

About Mastitis and Breast Abscess

- *Mastitis (inflammation of the breast):*
  - *Common in breastfeeding women – usually infective but may be inflammatory.*
  - *Ineffective milk removal due to poor positioning or attachment, or infrequent feeds may predispose to mastitis.*
  - *Continued breastfeeding from the affected breast is essential to ensure effective milk removal.*

- *Breast abscess:*
  - *Area appears hard, painful, reddened, and may feel fluctuant.*
  - *Usually preceded by mastitis.*

- *Galactocele:*
  - *Cyst with milk-like fluid – presents during or soon after stopping lactation.*
  - *Smooth, round, non-tender mass – usually resolves with one aspiration.*
  - *Not associated with systemic symptoms.*

- *Inflammatory breast cancer:*
  - *Can present during pregnancy and while breastfeeding.*
  - *Needs to be excluded if symptoms of mastitis do not resolve with treatment.*
  - *Very uncommon.*

Assessment

Examine every patient who complains of breast pain.

1. **Ask** and record if the patient identifies as being of Aboriginal or Torres Strait Islander origin. Consider the **specific cultural and spiritual needs** of each patient.

   ➢ ***Ask if the patient identifies as being of Aboriginal or Torres Strait Islander origin***
   If a patient or their family want to know why you are asking this question, you may reply with:
   - *We ask this question of everyone.*
   - *It enables us to help you access extra services that are funded for Aboriginal and Torres Strait Islander peoples, such as support to buy medications and extra funded visits with some health care providers.*
   - *This information helps our practice and the health care providers we refer you to, to provide culturally safe care.*

   For more information, see principles for care provision for Aboriginal and Torres Strait Islander Peoples.

   ➢ **Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People**
   - ***Advice for communicating with Aboriginal and Torres Strait Islander people***
     - *Encourage patients to book a longer consultation, to allow sufficient time for discussion and building trust.*
     - *Only use traditional terminology such as "Aunty" and "Uncle" if invited to do so.*

- *Consider the role of factors such as gender, kinship, family ties, language barriers and socio-economic issues.*
- *Offer the patient:*
  - *the option of seeing a health professional of the same gender or if this is not possible, referral to another service.*
  - *the option to have support person present, such as a family member, a community member, or an Elder.*
  - *access to funding assistance to overcome any identified or potential financial barriers e.g., ITC Funding. See also Care Coordination and Supplementary Services (CCSS).*

- ***Acknowledge and respect how cultural, spiritual and historical beliefs and experiences impact on decision-making.***
  - *Aboriginal and Torres Strait Islander knowledge, values, beliefs, cultural needs, and health history may strongly inform decision-making processes about treatment and ongoing care.*
  - *If possible and if requested by the patient, support the inclusion of cultural practices e.g., involvement of a traditional healer, or performing ceremonies.*

- Be aware the term "survivor" may have negative connotations for historical reasons.

- Proactively explore and monitor symptoms of pain.

- ***Considerations for assessing and managing pain in Aboriginal and Torres Strait Islander people***
  - *Aboriginal and Torres Strait Islander patients may not actively report pain or other needs.*
    - *Offer patients the option to discuss their needs with a health professional of the same gender.*
    - *If available, use a pain tool that is culturally appropriate for the local community.*
    - *Allow sufficient time to discuss and explain the options, usage, and side-effects of pain relief in full.*
    - *Be aware of:*
      - *significant cultural practices regarding which family members can assist with providing pain relief, and how pain medication is administered.*
      - *fears that pain relief medicines may accelerate the passing of the patient.*

➢ ***Considerations when discussing family with Aboriginal and Torres Strait Islander people***

For Aboriginal and Torres Strait Islander people:

- *the concept of family is broader than being genetically related.*
- *be sensitive when taking a family history, as discussing members of the stolen generation may be distressing*
- *Be sensitive when referring to people who have died – check and ask permission. There may be cultural taboos in discussing Sorry Business (referring to people who have died).*
- *Be supportive and understanding if appointments are missed, and facilitate follow-up or rebooking.*

➢ ***Appointments for Aboriginal and Torres Strait Islander people***

- *Patients who identify as Aboriginal and Torres Strait Islander people may have complex factors e.g., family and community responsibilities, or previous experiences with mainstream medical services, that make it difficult for them to attend appointments.*
- *The following supports may facilitate this process:*
  - *Recall and reminders*

- *ITC funding*
- *Referral to an Aboriginal Liaison officer, support, or health worker.*

➢ *Aboriginal and Torres Strait Islander people are more likely to have multiple co-morbidities that can impact treatment outcomes.*

➢ *Ensure contact details are up to date. If available, use assessment tools and resources designed specifically for Aboriginal and Torres Strait islander people.*

➢ ***Aboriginal and Torres Strait Islander assessment tools and resources***
- *See SCNAT-IP – online tool that assesses the supportive care needs of Aboriginal and Torres Strait Islander cancer patients and their families.*

2. Take a history of any predisposing factors.
   ➢ ***Predisposing factors***
   - *Incomplete drainage of the breast secondary to:*
     - *Poor positioning and attachment*
     - *Missed or interrupted feedings*
     - *Tongue tie*
     - *Oversupply of breast milk or engorgement with poor milk removal*
     - *Rapid or sudden weaning*
     - *Ineffective pumping*
   - *Illness in mother or baby*
   - *Premature baby*
   - *Damaged nipples*
   - *Previous mastitis or abscess*
   - *Previous breast surgery or injury*
   - *Restrictive clothing*

3. *Check for signs and symptoms of:*
   ➢ ***mastitis and breast abscess***
   - *Tender, hot, swollen section of breast*
   - *Temperature of ≥ 38°C*
   - *Systemically unwell, malaise, chills, or rigors*
   - *Flu like symptoms, headache, muscle and joint pain*
   - *Reactive lymphadenopathy of axillary nodes*

   ➢ ***Possible inflammatory breast cancer***
   - *Mastitis:*
     - *accompanied by skin dimpling or peau d'orange.*
     - *in a non-breastfeeding patient.*
     - *that is not responsive to antibiotics after 10 days.*
     - *accompanied by a strong family history of breast or ovarian cancer.*

   For more information, see Cancer Australia – Advice About Familial Aspects of Breast Cancer: Categories of Risk.

➢ ***Symptoms and signs of breast thrush***
- *Due to Candida species, usually albicans*
- *Shooting, stabbing or deep aching breast pain*
- *May radiate to back or arm*
- *Breast will appear normal*

- *Baby may have white plaques in mouth*

4. If redness and discomfort in the absence of infection, consider a **blocked milk duct.**
   - ***Blocked milk duct***
     - *Usually comes on gradually and affects only one breast.*
     - *A plugged duct typically feels more painful before a breast feed and the removal of milk brings relief and a reduction in size of the hard area.*
     - *Fever and systemic symptoms are absent.*
     - *For more information see Australian Breastfeeding Association – Blocked Ducts.*

5. Consider early breast ultrasound if abscess is suspected.

Management

Practice Point

Aspirate and/or drain breast abscess

- Antibiotics alone are not sufficient for breast abscess – aspiration and/or drainage is required.

If patient identifies as Aboriginal or Torres Strait islander, understand their specific cultural and spiritual needs when discussing and delivering treatment options.

➢ Cultural and spiritual considerations for Aboriginal and Torres Strait Islander People
- Offer referral to culturally appropriate social and emotional wellbeing services.
- Consider including an expert in the multidisciplinary team, to provide culturally appropriate care to Aboriginal and Torres Strait Islander people.
- Provide culturally appropriate information or resources about the signs and symptoms of recurrent disease, secondary prevention, and healthy living

Mastitis

1. Provide breastfeeding advice
   - Encourage effective and frequent milk removal from the affected breast by feeding infant.
   - Feed from the affected side first.
   - Gently massage from the affected area towards the nipple as the infant feeds or when expressing.
   - Consider feeding position changes to help drainage including positioning the infant so that the chin or nose is pointed to the affected area.
   - If pain is inhibiting let-down of milk, begin feeding on the unaffected breast. Switch to the affected breast after milk let-down.
   - Take simple analgesia (paracetamol or ibuprofen) as required, and apply cold packs after feeding.
   - Encourage rest, extra fluid intake, and consider supports required.

2. If breastfeeding and expressing to comfort is not effectively draining the breast, refer for breastfeeding support.

3. Start **antibiotic treatment** if infective mastitis:
   - is accompanied by systemic symptoms.
   - occurs with cracked nipples.
   - has not resolved despite the patient continuing to breastfeed for 12 to 24 hours.

- ***Antibiotics***

  Staphylococcus aureus *is the most common organism. Treat with:*
  - *Dicloxacillin or flucloxacillin 500 mg orally, 6-hourly for at least 5 days.*
  - *If allergic to penicillin, use cephalexin 500 mg orally, 6-hourly for at least 5 days.*
  - *If immediate hypersensitivity to penicillin, use clindamycin 450 mg orally, 8-hourly for at least 5 days.*

4. Review patient after 48 hours.
   - Typically response to treatment is rapid.
   - If no response or symptom is progressing consider **differential diagnoses**, and investigate with ultrasound and breast milk culture and sensitivity.
     - **Differential diagnosis**
       - Resistant bacteria
       - Breast abscess
       - Galactocele
       - Underlying benign mass
       - Inflammatory breast cancer
       - Carcinoma

Breast abscess

1. Start or recommence **antibiotics** as for infective mastitis.
   - ***Antibiotics***

     Staphylococcus aureus *is the most common organism. Treat with:*
     - *Dicloxacillin or flucloxacillin 500 mg orally, 6-hourly for at least 5 days.*
     - *If allergic to penicillin, use cephalexin 500 mg orally, 6-hourly for at least 5 days.*
     - *If immediate hypersensitivity to penicillin, use clindamycin 450 mg orally, 8-hourly for at least 5 days.*
2. Arrange radiology drainage of abscess until resolved. Multiple aspirations are usually required.
3. Arrange immediate breast surgery assessment if:
   - patient is systemically unwell or septic.
   - abscess fails to settle.
4. Encourage and support continued breastfeeding and breast drainage, if possible, and refer for breastfeeding support.
5. Continued milk production without milk removal will increase risk of complications. If requiring sudden weaning, undertake **lactation suppression.**
   - ***Lactation suppression***

     Medical lactation suppression is only indicated in instances of major postpartum mastitis.

     Cabergoline is the drug of choice. Bromocriptine is no longer used.
     - *Cabergoline 1 mg orally as a single dose, or*
     - *Cabergoline 250 micrograms orally 12 hourly for four doses.*

     Non-pharmacological lactation suppression is indicated in other instances in which breastfeeding needs to be ceased.

Breast thrush

1. If nipples are cracked, burning or stinging, apply **topical treatment** after feeds. This does not need to be removed before the next feed.
   - ***Topical treatments***
     - *Miconazole oral cream or gel following each feed*

- *Nystatin cream following each feed*

2. Treat breast thrush with **oral antifungals**.
    - ***Oral antifungals***
        - *Commence with fluconazole 150 mg orally, once daily every second day for 3 doses.*
        - *Repeat this course if pain still significant.*
        - *Finish treatment with a course of oral nystatin, 2 capsules of 500,000 units three times a day until 50 capsules are consumed*

3. Treat the baby's oral thrush if affected with miconazole gel.

Galactocele

1. If asymptomatic and not infected, do not aspirate. Reassure.

2. Arrange aspiration under ultrasound control if persisting after breast feeding has ceased. A single aspiration is usually sufficient for resolution of galactocele.

Inflammatory breast cancer

If persisting red, inflamed, oedematous breast with a mass or diffuse induration despite treatment, telephone a breast surgeon or breast surgery registrar to arrange a breast surgery assessment within 2 weeks.

Referral

- Surveillance for previously diagnosed Barrett oesophagus Arrange immediate breast surgery assessment if:
    - patient is systemically unwell or septic.
    - abscess fails to settle.
- If persisting red, inflamed, oedematous breast with a mass or diffuse induration despite treatment, telephone a breast surgeon or breast surgery registrar to arrange a breast surgery assessment within 2 weeks.
- Arrange radiology drainage of breast abscesses in patients who are not septic.
- Arrange breastfeeding support if required.
- If Aboriginal or Torres Strait Islander patient, offer referral to specific Indigenous services. For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

    - ***Referral Options for Aboriginal and Torres Strait Islander people***
        - *For hospital referrals, consider engaging support from the Aboriginal Hospital Liaison Officers.*
        - *For community referrals, consider referral to an Aboriginal Community Controlled Health service.*
        - *For care coordination, support and advocacy throughout treatment, consider referral to Care Coordination and Supplementary Services (CCSS).*

Information

For health professionals

Royal Women's Hospital – Clinical Guidelines:
Infant Feeding: Breast and Nipple Thrush
Mastitis and Breast Abscess
The Academy of Breastfeeding Medicine – ABM Clinical Protocol #4: Mastitis

For patients

Better Health Channel – Indigestion
Gastroenterology Society of Australia (GESA):
Gastroscopy (Upper Endoscopy)
Heartburn (Oesophageal Reflux)
HealthInfo – Understanding Gastroscopy
The Royal Women's Hospital – Mastitis

Last Reviewed: December 2019

Disclaimer