Breastfeeding Challenges - Mastitis & Breast Abscess -

SCOPE (Area): Maternity Unit, Emergency Department, Paediatrics
SCOPE (Staff): Medical, Midwifery & Nursing

DESIRED OUTCOME/OBJECTIVE

To provide effective treatment and management of mastitis and breast abscess’ during lactation.

DEFINITIONS

Mastitis: an inflammation of the breast that may lead to an infection. It can be an inflammatory or infective process. The most common organism causing mastitis is *staphylococcus aureus*.

Breast Abscess: a localised collection of pus that forms when a bacterial infection has incomplete drainage. It can occur as a result of untreated or inadequately treated mastitis or when a mother suffering mastitis decides to wean abruptly.

ISSUES TO CONSIDER

Risk Factors

- Rapid weaning
- Unresolved engorgement
- Inadequate drainage of breastmilk
- Nipple trauma
- Trauma to breasts
- Missed feeds
- Restricting bra
- Previous mastitis
- Stress, fatigue, poor overall health and nutrition.
- Poor positioning / attachment / sucking of baby
- Yeast infection (thrush)
- Cleft lip or palate
- Short frenulum in infant (tongue tie)

Prevention

Awareness and avoidance of the causative factors of mastitis is very important in preventing the development of this complication and a subsequent breast abscess.

- Optimise breastfeeding technique. Seek advice from an experienced midwife or lactation consultant if there are any concerns with breastfeeding.
- Effective management of breast fullness and engorgement.
- Avoid constrictive clothing
- Prompt attention to any signs of milk stasis. Check for and remove any blocked milk ducts (breast lumps).
  - Apply warmth – heat pack, shower – to the affected area of the breast.
  - Gently massage the affected area toward the nipple.
Breastfeed or express the breast until the area is softened and feels more comfortable.
Repeat this process until the blockage resolves.
- Eat a well-balanced diet and ensure adequate rest.
- Good hygiene.

**Signs and Symptoms**
- Reddened area on the breast that may be tender, swollen and hot to touch, it may be localised or generalised.
- Flu like symptoms may be experienced – fever, malaise, body aches, headache, nausea and vomiting.

**PROCEDURE**

**Management of Mastitis**
1. Continue to breastfeed
   a. Prior to feeding apply warmth to the affected area to improve milk flow.
   b. Feed from the affected breast first and ensure the baby drains the breast completely before offering the second side.
   c. Gently massage the breast towards the nipple before and during the breastfeed.
   d. Change feeding position so that baby’s chin points towards affected area.
   e. Correct any positioning or attachment problems – ensure good attachment and adequate milk transfer occurs with each feed.
   f. Express the affected breast after each feed if required to ensure as complete as possible breast milk removal (electric breast pump if tolerated).
   g. Apply cool pack after completing feed and express for a few minutes to help relieve discomfort.
   h. Avoid long intervals between feeds.
   i. If the baby refuses to breastfeed – as milk may taste salty during mastitis – then express (as outlined below) and give baby the expressed breastmilk.

2. If nipples are sore or damaged the woman may prefer to rest them and express.
   a. Express with an electric breast pump three hourly. Use pump on a gentle setting, alternatively, hand express if too painful to use pump.
   b. Gently massage the breast towards the nipple before and during expressing.
   c. After expressing rub a few drops of breastmilk into the nipples and apply a purified lanolin cream sparingly to the nipple.
   d. Consider alternating between a breastfeed (as outlined above) and expressing.
   e. Feed baby with expressed breast milk by cup, finger-feed, pipette or bottle – as preferred by mother.

3. Advise use of non-steroidal anti-inflammatory to help reduce inflammatory process. Paracetamol may also help with pain relief and fever.

4. Advise the woman that she will need to rest, maintain a good fluid intake and a well balanced diet. Avoid restrictive clothing and bras.
5. Antibiotic therapy.
   a. If symptoms of mastitis are mild and have been present for less than 24 hours, conservative management, as outlined above may be sufficient. If symptoms are not improving within 12-24 hours or if the woman is acutely ill, antibiotics should be started.
   b. Oral antibiotics are recommended and should continue for 10 to 14 days to help prevent reoccurrence.
   c. If there are signs of systemic sepsis or if the woman is unable to tolerate oral antibiotics then consider admitting woman to hospital and commencing intravenous antibiotic therapy. It should continue for at least 48 hours or until substantial clinical improvement is seen if the woman is unable to tolerate oral medication.

<table>
<thead>
<tr>
<th>ANTIBIOTIC THERAPY FOR MASTITIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>First line choice</td>
</tr>
<tr>
<td><strong>Oral</strong></td>
</tr>
<tr>
<td>Flucloxacillin 500mg four times a day.</td>
</tr>
<tr>
<td><strong>Intravenous</strong></td>
</tr>
<tr>
<td>Flucloxacillin 2g every six hours.</td>
</tr>
</tbody>
</table>

6. On occasion, particularly when antibiotics are not effective, breast milk may be sent to microbiology for culture and sensitivity.

7. Avoid weaning
   a. Advise the woman that mastitis is not an indication for, nor an ideal time to wean. Weaning during mastitis increases the likelihood of developing a breast abscess; if the woman still wishes to wean it is better to do so once mastitis has resolved.
   b. Provide reassurance that breastfeeding can safely continue during the use of antibiotic and anti-inflammatory medications.
   c. If woman still wishes to wean when mastitis is present advise her to express until the mastitis is resolved and then gradually decrease the number of expressions/day over a period of a week or two, then cease.
   d. If the woman chooses to wean despite the above advice then antibiotic cover will be necessary until all lumps and inflammatory processes have resolved.

8. Vertical transmission of HIV from mother to child is more likely in the presence of mastitis.
   a. Avoid breastfeeding on affected side until mastitis resolves.
   b. Express from affected breast and discard.

9. Ongoing support and care by medical staff and a lactation consultant is required to ensure that the episode of mastitis has resolved.

10. Failure to improve after two to three days may indicate a breast abscess.

11. Inflammatory breast cancer can resemble mastitis; this condition should be considered when the presentation is atypical or when response to treatment is not as expected.
Management of Breast Abscess


2. Ultrasound can be used to diagnose an abscess.

3. Usually needle aspiration can be used to drain abscess but occasionally surgical drainage under general anaesthetic may be required.
   a. A sample of the aspirate should be sent to microbiology for culture and sensitivity.

4. Breastfeeding should continue as outline under Management of Mastitis.
   a. Unless the site of surgical incision is on the areola, or there is purulent discharge from the nipple, immediate post-operative breastfeeding will aid healing by avoiding engorgement and keeping the breastmilk flowing.
   b. Care is necessary to ensure any dressing does not impinge on the nipple and that the baby is positioned away from the wound.
   c. A hydrocolloid dressing will aid healing, absorb discharge and because it is thin, interfere less with achieving good attachment.

5. It is not uncommon for milk to drain from the wound for some weeks post-operatively. Reassure the woman that this is normal and will cease when the wound heals.

6. Advise use of non-steroidal anti-inflammatory to help reduce inflammatory process. Paracetamol may also help with pain relief and fever.

7. Advise the woman that she will need to rest, maintain a good fluid intake and a well balanced diet. Avoid restrictive clothing and bras.

8. Antibiotic therapy is required.

<table>
<thead>
<tr>
<th>Antibiotic Therapy for Breast Abscess</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First line choice</strong></td>
</tr>
<tr>
<td>Oral</td>
</tr>
<tr>
<td>Flucloxacillin 500mg four times a day.</td>
</tr>
<tr>
<td>Intravenous</td>
</tr>
<tr>
<td>Flucloxacillin 2g every six hours.</td>
</tr>
</tbody>
</table>

9. Ongoing support and care by medical staff and a lactation consultant is required.

RELATED DOCUMENTS

Internal

CPG/B028 Breastfeeding Challenges: Oversupply
CPG/B029 Breastfeeding the Healthy Term Newborn
REFERENCES


