# Lactating Mastitis, Breast Engorgement or Breast Abscess

## Definition
Breastfeeding can be complicated by breast engorgement, mastitis, or breast abscess. Inflammation of the breast with or without infection has a variety of etiologies and presentations that range from the fairly benign blocked milk duct to more serious breast abscess. Mastitis occurs in as many as 1/3 of breastfeeding women in the U.S. with 10% leading to the formation of breast abscess. Mastitis usually caused by *Staphylococcus aureus*. Occasional women can experience symptoms of nipple candida infection which include symptoms of nipple and areola itching, erythema, and/or shiny white patches which will require antifungal treatment.

## Subjective
Should include:
1. Recently weaning or currently breastfeeding history
2. Review of medical history including postpartum, contraceptive, and sexually history

May include:
1. Painful breastfeeding
2. Fever, chills, fatigue, diffuse myalgia, or flu-like symptoms
3. Sore, cracked nipples, breast pain, breast mass
4. Frequently, symptoms most common in one breast, but can occur in both breasts

## Objective
Should include:
1. Vital signs
2. Assessment of affected breast reveals palpable, tender mass with induration, erythema, and may have axillary lymphadenopathy

## Laboratory
None necessary.

*Culture of breast milk is not recommended.*

## Assessment
Engorgement, mastitis, or breast abscess

### PLAN
**Mastitis** treatment options (treat with one of the following):
1. Dicloxacillin 500mg every 6 hours for 10 days orally  **OR**
2. Amoxicillin/Clavulanate 875mg every 12 hours or 500mg every 8 hours for 10 days orally  **OR**
3. Cephalexin 500mg every 6 hours for 10 days orally  **OR**
4. If beta-lactam allergy: use Clarithromycin 500mg orally every 12 hours for 10-14 days

If suspected MRSA infection, begin one of the following antibiotics and consider urgent referral:
1. Clindamycin 300mg orally every 8 hours for 10-14 days  **OR**
2. Trimethoprim-sulfamethoxazole 1 DS tablet orally every 12 hours for 10-14 days

**Engorgement** treatment options include:
1. Supportive therapy including: adequate fluid intake, acetaminophen 500mg orally every 4 hours prn or NSAIDs 600mg orally every 6 hours prn.
2. Encourage to continue breastfeeding and completely empty breast(s). Consider applying warm pack to breast.
3. If client desires to discontinue breastfeeding, advise the importance of wearing a good support bra, avoiding excessive breast stimulation, and application of a cold pack to the affected area.
4. Breast abscess:
   1. Consider U/S of the affected breast (if question of abscess)
   2. Referral to clients primary care or ER for treatment

### CLIENT EDUCATION
1. Review importance of emptying breast and optimizing breastfeeding techniques.
2. Counsel importance well-fitted (non-underwire) bra
3. If engorgement review signs and symptoms of mastitis
4. Encourage adequate fluid intake
5. Advice client about the importance to complete course of antibiotics as directed.
6. If no relief of symptoms or symptoms worse in 24 hours, to seek medical attention.
7. Provide referral to Certified Lactation Consultant if breastfeeding support desired.

CONSULT/ REFER TO PHYSICIAN

1. Patient with abscess or significant breast abnormalities.
2. If unresponsive to treatment or allergies to antibiotics. If unresponsive to antibiotic may be possible MRSA infection.
3. Any client will inflammatory breast lesion, with no recent history of breastfeeding, to rule out inflammatory breast cancer.

References: