

**12.6 LACTATING MASTITIS, BREAST ENGORGEMENT OR BREAST ABSCESS**

TITLE	DESCRIPTION
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 <i>Staphylococcus aureus</i> . Occasionally 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:	<p><b>Should Include:</b></p> <ol style="list-style-type: none"> <li>1. Recently weaning or currently breastfeeding history.</li> <li>2. Review of medical history including postpartum, contraceptive, and sexual history.</li> </ol> <p><b>May Include:</b></p> <ol style="list-style-type: none"> <li>1. Painful breastfeeding.</li> <li>2. Fever, chills, fatigue, diffuse myalgia, or flu-like symptoms.</li> <li>3. Sore, cracked nipples, breast pain, breast mass.</li> <li>4. Frequently symptoms are most common in one breast, but can occur in both breasts.</li> </ol>
OBJECTIVE:	<p><b>Should Include:</b></p> <ol style="list-style-type: none"> <li>1. Vital signs.</li> <li>2. Assessment of affected breast reveals palpable, tender mass with induration, erythema, and may have axillary lymphadenopathy.</li> </ol>
LABORATORY:	None necessary. *Culture of breast milk is not recommended.
ASSESSMENT:	Engorgement, mastitis, or breast abscess.
PLAN:	<p>Mastitis treatment options (treat with one of the following):</p> <ol style="list-style-type: none"> <li>1. Dicloxacillin 500mg every 6 hours for 10 days orally OR</li> <li>2. Amoxicillin/Clavulanate 875mg every 12 hours or 500mg every 8 hours for 10 days orally OR</li> <li>3. Cephalexin 500mg every 6 hours for 10 days orally OR</li> <li>4. If beta-lactam allergy: use Clarithromycin 500mg orally every 12 hours for 10-14 days.</li> </ol> <p>If suspected MRSA infection, begin one of the following antibiotics and consider urgent referral:</p> <ol style="list-style-type: none"> <li>1. Clindamycin 300mg orally every 8 hours for 10-14 days OR</li> <li>2. Trimethoprim-sulfamethoxazole 1 DS tablet orally every 12 hours for 10-14 days.</li> </ol> <p>Engorgement treatment options include:</p> <ol style="list-style-type: none"> <li>1. Supportive therapy including: adequate fluid intake, acetaminophen 500mg orally every 4 hours PRN or NSAIDs 600mg orally every 6 hours PRN.</li> <li>2. Encourage to continue breastfeeding and completely empty breast(s). Consider</li> </ol>

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	<p>applying warm pack to breast.</p> <p>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.</p> <p>Breast abscess:</p> <ol style="list-style-type: none"> <li>1. Consider U/S of the affected breast (if question of abscess).</li> <li>2. Referral PCP or ER for treatment.</li> </ol>
EDUCATION:	<ol style="list-style-type: none"> <li>1. Review importance of emptying breast and optimizing breastfeeding techniques.</li> <li>2. Counsel importance of well-fitted, non-underwire bra.</li> <li>3. If engorgement, review signs and symptoms of mastitis.</li> <li>4. Encourage adequate fluid intake.</li> <li>5. Advise client about the importance to complete course of antibiotics as directed.</li> <li>6. If no relief of symptoms or symptoms worse in 24 hours, to seek medical attention.</li> <li>7. Provide referral to Certified Lactation Consultant if breastfeeding support desired.</li> </ol>
REFERRAL TO MEDICAL PROVIDER:	<ol style="list-style-type: none"> <li>1. Client with abscess or significant breast abnormalities.</li> <li>2. If unresponsive to treatment or allergies to antibiotics. If unresponsive to antibiotic may be possible MRSA infection.</li> <li>3. Any client with inflammatory breast lesion, with no recent history of breastfeeding, to rule out inflammatory breast cancer.</li> </ol>
REFERENCES:	<ol style="list-style-type: none"> <li>1. <a href="http://www.llusa.org">La Leche League</a>. <i>www.llusa.org</i> (Retrieved 2/9/2017).</li> <li>2. <i>Medscape</i>. <a href="http://emedicine.medscape.com/article/2028354-overview">Mastitis Empiric Therapy</a>. (<a href="http://emedicine.medscape.com/article/2028354-overview">http://emedicine.medscape.com/article/2028354-overview</a>) (Retrieved 2/9/2017).</li> <li>3. <i>Women's Medical Protocols</i>. <a href="http://whcc.labiomed.org/book/3.4.3%20Breastfeeding%20Complications%20Engorgement,%20Mastitis,%20Breast%20Abscess.pdf">Breastfeeding Complications: Engorgement, Puerperal or Lactational Mastitis or Breast Abscess</a> (2014). <a href="http://whcc.labiomed.org/book/3.4.3%20Breastfeeding%20Complications%20Engorgement,%20Mastitis,%20Breast%20Abscess.pdf">http://whcc.labiomed.org/book/3.4.3%20Breastfeeding%20Complications%20Engorgement,%20Mastitis,%20Breast%20Abscess.pdf</a> (Retrieved 2/9/2017).</li> </ol>