Learn simply

Mastitis

Mastitis[1]

Symptoms and/or signs suggestive of mastitis

- Identify risk factors for breast infection[1]
- Confirm the diagnosis[2]
- Exclude contraindications to breastfeeding[3]
- Exclude other causes of breast discomfort or fever[4]

No evidence of septicemia[5]

- Outpatient management
- Overcome ductal obstruction by continuing breastfeeding or pumping
- Symptomatic relief
- *Consider starting oral antibiotics (such as dicloxacillin)*

Follow clinical response as outpatient

Good response

- Continue to follow clinical response on an outpatient basis

Poor response

- Consider infection with resistant organisms or non-compliance with recommendations
- **Consider further imaging studies to exclude septic pelvic thrombophlebitis or starting empiric anticoagulation therapy**
- Exclude breast abscess[7]
- If continued ductal obstruction or bloody nipple discharge, consider breast consult to exclude underlying mass lesion/malignancy

Evidence of septicemia[6]

- **Inpatient management**
- Check blood and urine cultures, CBC, chest x-ray
- **Initiate intravenous antibiotic therapy**
- Consider infectious disease consult, if indicated
- Overcome ductal obstruction by continuing breastfeeding or pumping
- Symptomatic relief

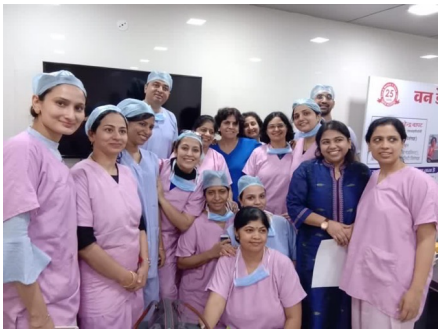
Follow clinical response as inpatient

Poor response

- Consider infection with resistant organisms or non-compliance with recommendations
- **Consider further imaging studies to exclude septic pelvic thrombophlebitis or starting empiric anticoagulation therapy**
- Exclude breast abscess[7]
- If continued ductal obstruction or bloody nipple discharge, consider breast consult to exclude underlying mass lesion/malignancy

Good response

- Discharge home once afebrile and asymptomatic for 24–48 hours
- Follow-up as an outpatient in ½–1 weeks



1. Mastitis refers to a regional infection of the breast parenchyma, usually by Staphylococcus aureus. Women at greatest risk are those who have experienced mastitis in a prior pregnancy, unilateral breast engorgement, and those with excoriation or injury of the nipple.

2. Mastitis is a clinical diagnosis with fever >100.4F (38.0C), chills, and focal unilateral breast erythema, edema, and tenderness with or without an elevated white blood cell count. It is more common in primiparous patients (>50%) and usually occurs during the third or forth week postpartum.

3. Whenever possible, breastfeeding should be encouraged. Breastfed infants have a lower incidence of allergies, gastrointestinal infections, ear infections, respiratory infections, and (possibly) higher intelligence quotient (IQ) scores.

4. Women who breastfeed appear to have a lower incidence of breast cancer, ovarian cancer, and osteoporosis. Breastfeeding is also a bonding experience between infant and mother. Under certain conditions, however, breastfeeding may be detrimental to the fetus. Contraindications to breastfeeding include infection with HIV, cytomegalovirus, and/or chronic hepatitis B or C.

5. Breastfeeding is also contraindicated if the mother is on certain drugs, such as radioisotopes and certain cytotoxic agents.

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1. Mastitis should be distinguished from breast engorgement, which typically occurs on days two to four postpartum in women who are not nursing or at any time if breastfeeding is interrupted. Conservative measures (pressure, ice packs, analgesics) are usually effective for the management of breast engorgement.

2. Bromocriptine should not be used because of reports of serious adverse events (including seizures, strokes, and other cardiovascular events).

3. Other causes of fever that should be excluded in the puerperium include endometritis, urinary tract infection/pyelonephritis, ear and throat infections, pneumonia, and (rarely) septic pelvic thrombophlebitis.

4. Mild mastitis without evidence of septicemia can be treated as an outpatient with oral antibiotics (dicloxicillin or cephalexin) for coverage of staphylococcus aureus, the most likely organism.

5. Continuing breastfeeding or pumping is very important as well as managing engorgement and improving breastfeeding techniques. Finally, analgesia and local treatment of any nipple excoriations will provide symptomatic relief.

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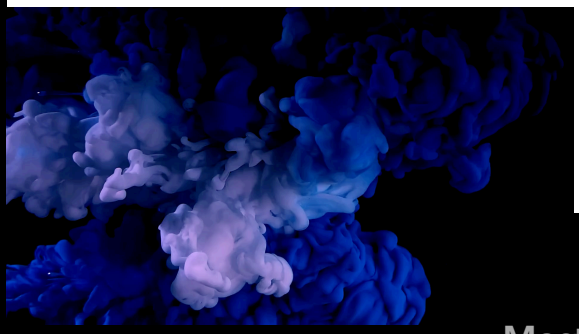
1. Severe mastitis with evidence of septicemia or mastitis that has been refractory to outpatient management should prompt admission and treatment with intravenous antibiotic therapy. Cultures from the affected nipple should be considered in view of the rising prevalence of MSRA mastitis.

2. These patients need to be screened for a concurrent abscess, which will require parenteral treatment with vancomycin.

3. Approximately 5–10% of women will develop a breast abscess. Diagnosis can be made clinically and confirmed by ultrasonography, if indicated. Although surgical drainage was the historical approach, ultrasound-guided percutaneous drainage is now the standard of care with greater efficacy and lower recurrence rates.

4. Smoking cessation should be encouraged to avoid recurrence. Patients >35 years old should also be evaluated for occult malignancy.



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