|  |
| --- |
| **Woman & Children’s Health****Maternity Guideline** |

**Mastitis Prevention and Treatment**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Owner(s) (Names and designations)** | **Author(s) (Names and designations)** | **Version, Date written** | **Reason for Review** | **Ratified by and Date** | **Expiry Date** |
| Rachel Hillan R.M ,IBCLC Contributions from Deborah Senior R.Mi and Sharyn Mckenna. JB and JH |  | Version 1 |  | Ratified by PNCT Dec 2005 |  |
| Kate Battersby R.M |  | Version 2 Written October 2008  | Minor amendments | Ratified by PNCT December 2008 |  |
| Kate Battersby R.MMarion Copeland R.M |  | Version 3Sept 2009 |  | Ratified byPNCT July 2009Release date: 28/09/09 | Review date June 2012 |
| Marion Copeland, Specialist Midwife Infant Feeding  | Marion Copeland, Specialist Midwife Infant Feeding | Version 4 May 2012  | Due for review | Ratified by PNCT May 2012 | Review date: May 2015 |
|  |  | 4.1 | New NBT format |  |  |
| Marion Copeland, Specialist Midwife Infant Feeding |  | 5 | Due for review | Ratified By Guideline Meeting July 2020 | Review Date:July 2023 |

**Patient information on app/ website: Yes**

**If Breastfeeding isn’t going well**

**BEST PRACTICE POINTS.**

* Women should be advised to report any signs and symptoms of mastitis including flu like symptoms, red, tender and painful breasts to their healthcare professional urgently.
* Women with signs and symptoms of mastitis should be offered assistance with positioning and attachment and advised to continue breastfeeding and/or hand expression to ensure effective milk removal; if necessary, this should be with gentle massaging of the breast to overcome any blockage.
* Full assessment should be undertaken including feeding history and the physical examination of both mother and baby.
* If Symptoms are severe advise Paracetamol and Ibuprofen and contact Breast Care Centre 011741(47000) to ask for review by breast care surgeon. If out of hours or breast care centre unable to review contact CDS for review by Obstetrician.
* Consider antibiotics promptly if symptoms continue for more than 24 hours.
* If an abscess is suspected an urgent referral should be made to the Breast centre and USS arranged
* If Breast Abscess suspected and unable to contact the Breast Care Centre please call Surgical Registrar for opinion.

**CONTENTS**

Best Practice Points 2

Incidence and Aetiology 3

Predisposing Factors 3

Diagnosis 4

Mastitis assessment and management

in the community 4

Mastitis management and assessment

in hospital 5

Breast Abscess 5

Further information and References 6

**Incidence and Aetiology**

Mastitis is a painful inflammatory condition of the breast, which may or may not be

accompanied by infection [WHO 2000]

 The incidence of Mastitis in breastfeeding women is reported as being between 10% and 33%[ WHO 2000, Dixon and Khan 2011]

The condition varies in severity from local inflammation with tenderness and redness through to more serious symptoms of fever, abscess and septicaemia. Breast abscess can occur in 1-3% of mothers who have mastitis.[ BMJ 2014]

If infection is present the commonest organism is Staphylococcus Aureus

**The main cause of Mastitis is inefficient removal of milk as a result of suboptimal positioning and attachment and/or restriction on the timing and length of breastfeeds.**

**Predisposing factors**

* Damaged nipples
* Long gaps between feeds or scheduled feeds
* Poor latch to breast
* Ineffective removal of milk
* Oversupply of milk or engorgement
* Pressure on breast tissue [tight bra, car seat belt]
* Nipple bleb or blister
* Maternal fatigue or stress.

 [AMIR 2014 NICE 2018]

**Diagnosis of mastitis**

* Red area on breast
* Full and engorged breast
* Breast feels tender.
* Mother feels she has a high temperature
* Mother feels unwell.

**Mastitis assessment and management in the community**

If a mother reports any of the signs of mastitis she needs to be reviewed face to face, if this is not possible then at least video consultation so that the midwife can see both breasts. (NICE 2015)

If symptoms are mild offer support;

* Positioning and attachment
* Responsive feeding
* Paracetamol and ibuprofen
* Encourage rest and good fluid intake
* Keep bra off as much as possible
* Warm flannels may be helpful
* Gentle expressing if breast very heavy and baby has not emptied breast [for a few minutes only to avoid overstimulation.]
* Suggest mother see leaflet; <http://www.breastfeedingnetwork.org.uk/wp-content/dibm/BFN%20Mastitis%20feb%2016.pdf>
* Advise mother that if symptoms do not improve in 12-24 hours she should contact her GP for antibiotics [flucloxacillin first line treatment]
* Advise mother that if symptoms get worse and she feels more unwell she should contact GP or phone CDS if out of hours.
* Consider referral to the infant feeding team for follow up

If symptoms are severe;

* + - Large red area on breast
		- Very painful breast
		- Both breasts are red and painful
		- High temperature
1. Advise Paracetamol and Ibuprofen.
2. Midwife / Dr to contact the Breast Care Centre ext 47000 to ask for review by breast care surgeon.
3. If out of hours or breast care centre unable to review contact CDS for review by Obstetrician. A referral should be made to the Breast Care Centre at the earliest opportunity.

**Mastitis management and assessment in hospital.**

Investigations

Maternal observations and examination of both breasts.

Consider milk culture if;

* Mastitis is severe or recurrent
* If there is a nipple fissure which looks infected
* Mother reports deep burning pain in breast.
* Sample collected for milk culture should be a “clean catch”

Management of mastitis in hospital;

Follow NBT sepsis guidelines.

* Flucloxacillin 500mg QDS for 10-14 days is the first line treatment
* Paracetamol and ibuprofen as first choice for pain-relief
* Feeding history
* Support with positioning and attachment
* Support mother to understand responsive feeding and the importance of frequent feeds
* Gentle expressing if necessary to soften breast after or before a feed, careful not to over stimulate milk production.
* Consider tongue tie [ especially if nipple damage and/or recurrent mastitis]
* Consider referral to infant feeding team for follow up.

**If Mastitis is severe a referral to the Breast Centre should be made.**

**Breast Abscess**

In around 3% of women with mastitis, an infective area will localise and an abscess will develop. This can either happen as part of an acute episode or after a course of appropriate treatment.

Signs of breast abscess;

* typically a well-defined red, firm extremely tender swelling
* Sometimes with overlying oedema.

**If there is large area of redness on the breast or any mass felt in the breast or an abscess is suspected, refer urgently to the breast care centre office hours [ ext 47000] for USS and review**.

**If in doubt refer to breast care centre for review.**

**Out of hours refer to the on call surgical registrar**

A woman with a breast abscess should be reassured that she is likely to fully recover and is able to continue breastfeeding without causing harm to the baby.

**Risk to the Infant**

Even in cases where breast milk contains pus, or *Staph. Aureus* is present, the WHO advice based on a number of studies is that ongoing breastfeeding during mastitis is generally safe. The only exception to this is when a mother is HIV positive, in which case she should avoid feeding from the affected side until fully recovered.

**Maintaining lactation when a woman has mastitis or breast abscess is important both for her own recovery, and for her infant’s health.**

**Stopping breastfeeding during an attack of mastitis does not help the mother to recover; on the contrary, there is a risk that it can make her condition worse. Furthermore, if a woman stops breastfeeding before she is emotionally ready, she may suffer considerable emotional distress (WHO 2000].**

**Further Information**

[**NICE CKS: Mastitis and Breast Abscess**](http://cks.nice.org.uk/mastitis-and-breast-abscess)Revised October 2018

[**WHO: Mastitis Causes and Management**](http://apps.who.int/iris/bitstream/10665/66230/1/WHO_FCH_CAH_00.13_eng.pdf)2000

[**Breastfeeding Network: Mastitis and Breastfeeding**](http://www.breastfeedingnetwork.org.uk/wp-content/dibm/Mastitis%20printable%20version.pdf)

[**The NHS Website: Mastitis**](http://www.nhs.uk/Conditions/Mastitis/Pages/Introduction.aspx)

**References**

Amir L, Academy of Breastfeeding Medicine Protocol Committee. ABM clinical protocol #4: Mastitis, revised March 2014. *Breastfeed Med*. 2014;9(5):239–243.

Amir L, Forster D, McLachlan H, Lumley J. Incidence of breast abscess in lactating women: report from an Australian cohort. BJOG: An International Journal of Obstetrics and Gynaecology. 2004;111(12):1378-1381.

[Mastitis Causes and Management](http://apps.who.int/iris/bitstream/10665/66230/1/WHO_FCH_CAH_00.13_eng.pdf) WHO Geneva 2000

[NICE CKS Mastitis and Breast Abscess: Background Information](https://cks.nice.org.uk/mastitis-and-breast-abscess#!backgroundSub). Revised October 2018

NICE (2015) Postnatal care up to 8 weeks after birth Clinical guideline [CG37]. [Online] <https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations> [accessed] 02/07/2020

NHS (2019) Mastitis. [Online] <https://www.nhs.uk/conditions/mastitis/> [accessed] 02/07/2020