

Acute inflammation of the breast

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Mastitis refers to inflammation of the breast tissue that may or may not be accompanied by infection. Acute mastitis can occur in lactating as well as non-lactating women, with the former being more common. Lactational (puerperal) mastitis The incidence of acute mastitis in lactating mothers varies from 3% to 20%. Most cases are caused by *S. aureus* and, if hospital acquired, may be due to methicillin-resistant *S. aureus* Aetiology Mastitis may be bacterial or non-bacterial. Bacteria may enter the nipple through a cracked or retracted nipple. In many cases the lactiferous ducts get blocked by epithelial debris, leading to stasis, which is followed by infection. Once within the ampulla of the duct, staphylococci cause clotting of the milk and then multiply within the clot. Abscess formation is most commonly seen at two stages during lactation: in the first month after the first childbirth owing to inexperience or inappropriate and inadequate breastfeeding; and at weaning owing to engorgement and trauma to the nipple by the baby's teeth. Clinical features Initially there is generalised cellulitis, which if left untreated progresses to suppuration and abscess formation. An abscess presents as a fluctuant lump (in a deep-seated abscess fluctuation may be absent) with pain, signs of inflammation, fever, malaise and difficulty in feeding. It may also be associated with enlarged tender axillary nodes. Ultrasonography reveals cellulitis (seen as an area of increased echogenicity) and liquefaction necrosis (pus is seen as a hypoechoic collection with floating debris that changes with posture). Management During the cellulitic stage, the patient should be treated with anti-staphylococcal antibiotics such as cloxacillin, flucloxacillin or erythromycin. Breastfeeding from both the breasts should be encouraged 2-hourly, followed by emptying the breast. A breast support garment, cold compression on the breast and analgesia aid in symptomatic relief. Any pus seen on ultrasonography should be aspirated and sent for culture and sensitivity. Contrary to the practice of incision and drainage, in a breast abscess ultrasound-guided drainage gives an excellent cosmetic result, does not hamper breastfeeding and can be done as a day-care procedure with a high rate of non-healing milk fistula. In abscesses >3 cm in diameter or those containing more than 30 mL of pus (assessed on ultrasonography), a vacuum suction catheter is inserted under ultrasound guidance to drain (58.5). The patient should be reviewed on alternate days by clinical examination and ultrasonography. Any residual collection should be aspirated. The antibiotics are modified according to the microbiological culture report. In patients with a suction drain, the catheter is irrigated with cold normal saline (cold to reduce pain) on each visit until complete resolution. Antibiotics should be continued for 14 days.

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