

Blocked Ducts and Mastitis

Mastitis is a bacterial infection of the breast that usually occurs in breastfeeding mothers. However, it can occur even in women who are not breastfeeding or pregnant, and can occur even in small babies, of either sex. Nobody knows exactly why some women get mastitis and others do not. Bacteria may gain access to the breast through a crack or sore in the nipple, but women without sore nipples also get mastitis, and most women with cracks in the nipple do not.

Mastitis needs to be differentiated from a plugged or blocked duct, because the plugged or blocked duct does not need treatment with antibiotics, whereas mastitis does *often, but not always*, require treatment with antibiotics. A blocked duct presents as a painful, swollen, firm mass in the breast. The skin overlying the blocked duct is often quite red, similar to what happens during mastitis, but less intense. Mastitis is usually also associated with fever and more intense pain as well. However, it is not always easy to distinguish between a mild mastitis and a severe blocked duct. A blocked duct, can, apparently, go on to become mastitis. In France, physicians also recognize something they call *lymphangite* that is fever associated with skin which is hot and red, but there is no underlying painful mass. They do not believe this requires treatment with antibiotics. I have seen a few cases that fit this description in my practice, and indeed, the problem resolves without antibiotics. But then, often so does full blown mastitis.

As with almost all breastfeeding problems, a *poor latch*, and thus, poor draining of the breast sets up the situation where mastitis is more likely to occur.

Blocked Ducts

Blocked ducts will almost always resolve spontaneously within 24 to 48 hours after onset, even without any treatment at all. During the time the block is present, the baby may be fussy when nursing on that side, as milk flow may be slower than usual, probably due to pressure causing collapse of other ducts. Blocked ducts can be made to resolve more quickly by:

1. Continuing breastfeeding on the affected side.
2. Draining the affected area better. One way of doing this is to position the baby so his chin "points" to the area of hardness. Thus if the blocked duct is in the outside, lower area of your breast (about 4 o'clock), the football hold would be best. Another way of getting better draining of the breast is using breast compression while the baby is feeding, getting your hand around the blocked duct and using steady pressure.
3. Applying heat to the affected area (with a heating pad or hot water bottle, but be careful not to injure your skin by using too much heat for too long a period of time).
4. Trying to rest. (Not always easy, but take the baby to bed with you.)

If the blocked duct is associated with a small blister on the end of the nipple, you can open it with a sterile needle. Flame a sewing needle or a pin, let it cool off, and puncture the blister. No need to dig around. Just pop the top or side of the blister. Sometimes you can squeeze out a little toothpaste like material from the duct and the duct will immediately unblock. Or, put the baby to the breast and he may unblock it for you. Opening the blister has the added benefit of decreasing nipple pain, even if the blocked duct does not immediately resolve. Come to the clinic if you cannot do it yourself.

If a blocked duct has not settled within 48 hours (unusual), therapeutic ultrasound *often* works. This can be arranged at a neighbourhood physiotherapy office or sports medicine clinic. Many ultrasound therapists are not aware of this use for ultrasound. The dose is:

2 watts/cm², continuous, for five minutes to the affected area, once daily for up to two doses.

If two treatments on two days have not worked, there is no point in continuing with ultrasound. Get the blocked duct re-evaluated at the clinic or your own physician. Usually, however, if ultrasound is going to work, one treatment is all that is needed. Ultrasound also seems to prevent recurrent blocked ducts that always occur in the same part of the breast. **Lecithin**, one capsule (1200 mg) 3 or 4 times a day also seems to prevent recurrent blocked ducts, at least in some mothers.

Mastitis

The following is my approach to dealing with mastitis.

- If the mother has symptoms *consistent with mastitis for more than 24 hours*, she should start antibiotics. If the mother has consistent symptoms for *less than 24 hours*, I will prescribe an antibiotic, but suggest the mother wait before starting to take it. If, *over the next 8-12 hours*, her symptoms are worsening (more pain, more spreading of the redness, enlargement of the hardened area), then the mother should start the antibiotics. If, over the next 24 hours, the mother has not worsened, but not improved, she should start the antibiotics. However, if symptoms are starting to decrease, there is no need to start the antibiotics. The symptoms usually will continue to resolve and will have disappeared over the next 2 to 5 days. Fever will usually be gone within 24 hours, the pain within 24 to 48 hours, the breast hardness within the next few days. The redness may remain for a week or longer. Once improvement begins, on or off antibiotics, it should continue. If the course of your mastitis does not follow this pattern, contact the clinic.

Remember:

- **Continue breastfeeding**, unless it is just too painful to do so. If you cannot, at least express your milk as best you can in the meantime. Restart breastfeeding as soon as you are up to it, the sooner the better. Continuing breastfeeding helps mastitis to resolve more quickly. There is no danger for the baby.
- **Heat** (hot water bottle or heating pad), applied to the affected area helps healing.
- **Rest** helps fight off infection.
- **Fever** helps fight off infection. Treat fever if it makes you feel bad, not just because it is there.
- **Medication** (acetaminophen, ibuprofen) for pain can be very good. You will feel better and the amount that gets to the baby is insignificant. Acetaminophen is probably less useful as it does not have an anti-inflammatory effect.

Note: Amoxicillin, plain penicillin, and many other antibiotics often prescribed for mastitis are usually useless for mastitis. If you need an antibiotic, you need one that is effective against *Staphylococcus aureus*. Effective for this bacterium are: cephalexin, cloxacillin, flucloxacillin, amoxicillin-clavulanic acid, clindamycin and ciprofloxacin. The last two are effective for mothers allergic to penicillin. You can and should continue breastfeeding with all these medications.

Abscess: Abscess occasionally complicates mastitis. You do *not* have to stop breastfeeding, not even on the affected side. Usually the abscess needs to be drained surgically, but you should continue breastfeeding. Contact the clinic.

A lump which isn't going away: If you have a lump that is not going away or getting smaller over more than a couple of weeks, you should get it looked into. You don't have to stop breastfeeding to get a breast lump investigated (ultrasound, mammogram, even biopsy do not require you to stop breastfeeding even on the affected side). A breastfeeding friendly surgeon will not tell you that you must stop breastfeeding before s/he can do tests for a breast lump.

Questions? (416) 813-5757 (option 3) or drjacknewman@sympatico.ca or my book **Dr. Jack Newman's Guide to Breastfeeding** (called **The Ultimate Breastfeeding Book of Answers** in the USA)

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