North Highland Mastitis and Breast Abscess Management Pathway

### Initial Assessment of patient

**Admission to Surgical Assessment**
- Refer to oncall General Surgery Consultant (x1302) OR Registrar (#1301)
- If recent breast surgery, contact operating Consultant

**Are any of the below present?**
- Signs of sepsis
- Threatened or actual skin necrosis
- Spreading cellulitis
- Diabetes
- Immunosuppression

**Outpatient management**
- Oral antibiotics (see guidance below)
- Send OP IUR to Highland Breast Unit if concerned about potential malignancy
- Needle Aspiration of superficial abscesses in primary care if experienced and confident to do so

### Examination Findings

N.B. If concerned about potential malignancy, refer to outpatient breast clinic for triple assessment. If breast pain only (no systemic signs or symptoms) give analgesia and refer back to GP

**Red, hot, painful breast ONLY**

**Lactational Mastitis**
- Advise mother to **KEEP FEEDING**, even on affected side as this is most effective drainage (Refer to NHS Highland ‘mastitis prevention and treatment policy’)
- Ensure complete drainage of breast at each feed +/- expressing
- Consider a warm compress for symptomatic relief
- Consider Antibiotics if symptoms persist or worsen after 12-24 hrs (see below)

**Non-lactational mastitis**
- Management: Antibiotics as per guidelines (see below)
  - Add anaerobic cover if smoker
  - Consider a warm compress for symptomatic relief

**Breast Abscess**
- Is there an obvious drainable collection?
  - Percutaneous drainage with 21G needle or above
- Use image guidance if implant present
- Send aspirate for culture and sensitivity
- Antibiotics as per guidelines (see below)
- Is there skin necrosis present?
  - Consider I&D with skin debridement under GA (Recurrent abscesses or necrotic lesions may be related to PVL producing Staph aureus, including MRSA. Seek advice from Microbiology)

### Antibiotic Therapy

*If systemically unwell give IV, otherwise give PO*

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>IV</th>
<th>Oral</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Line</strong></td>
<td>Flucloxacillin</td>
<td>1-2gram, 4 times daily</td>
<td>Abscess: 7-10 days</td>
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<tr>
<td>Recurrent abscess or smoker</td>
<td>Add Metronidazole</td>
<td>500mg, 3 times daily</td>
<td>Mastitis: 10-14 days</td>
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<tr>
<td>Penicillin Allergy</td>
<td>Clindamycin</td>
<td>900mg, 4 times daily</td>
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<td>(covers anaerobes)</td>
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**N.B.** For management of mastitis in lactating women, please see NHS Highland policy, which can be found on the TAM app.
If known or suspected MRSA patient, discuss with Microbiology

### Re-assess

**Is there clinical improvement?**

**Y**
- Plan for home
  - Consider step down from IV to PO if clinically well
  - Outpatient appointment with Breast Surgeons if concerned about underlying malignancy

**N**
- Request USS Breast for assessment of deeper collection – discuss with Breast Surgeon or Breast Radiologist
- Discuss current antibiotic therapy with Microbiology