Blocked Ducts and Mastitis

Blebs/blocked ducts/mastitis and then abscess usually occur when the breastfeeding parent has an abundant milk supply but the baby does not have a good latch. A poor latch, and thus, poor emptying of the breast sets the breastfeeding parent up for blocked ducts and mastitis. And why does the baby not latch on well?

Because of:

1. "Technique" of positioning and latching the baby. See our information sheet "Latching and Feeding Management". Also our blog the asymmetric latch
2. Use of artificial nipples such as bottles and nipple shields.
3. The baby has a tongue-tie. Some tongue-ties are obvious, but many are more subtle and require an evaluation that goes further than just looking, but includes feeling under the baby's tongue as well as knowing what to feel for. Unfortunately, few health professionals, including lactation consultants, know how to evaluate whether or not the baby has a tongue-tie. See our information sheet "Tongue-Tie, Lip-Tie, and Releases".
4. There has been a decrease in the milk supply. Late onset decreased milk supply is very common and results in the baby slipping down on the nipple and pulling at the breast. See our information sheet "Late Onset Decreased Milk Supply or Flow".

Blocked ducts

A blocked duct is a clog or blockage of milk inside a milk duct that results in a tender or painful lump or firm area in the breast. The skin around the lump may be red and warm. Generally, there is no fever. Sometimes a low fever may occur (usually less than 38.4°C/101°F). Generally, you feel well.

Blocked ducts will almost always resolve without special treatment within 24 to 48 hours after starting. During the time the block is present, the baby may be fussy when breastfeeding on that side because the milk flow will be slower than usual. This is probably due to pressure from the lump collapsing other ducts. A blocked duct can be made to resolve more quickly if you:

Continue breastfeeding on that side and draining the breast better. This can be done by:

Getting the best latch possible (see the information sheet "Latching and Feeding Management" as well as our video clips).

- **Using compression to keep the milk flowing** (see the information sheet "Breast Compression" as well as our video clips). Get your hand around the blocked duct and compress it as the baby is breastfeeding if it is not too painful to do so.
- **Feeding the baby in such a position that the baby's chin "points" to the blocked duct.**Thus, if the blocked duct is in the bottom outside area of the breast (7 o'clock), then

feeding the baby in the football position may be helpful.

Also try:

- **Applying heat to the affected area**. You can do this with a heating pad or hot water bottle, but be careful not to burn your skin by using too much heat for too long a period of time.
- **Resting**. Of course, with a new baby it is not always easy to rest. Try going to bed. Take your baby with you into bed and breastfeed him there.

Other treatments for persistent or recurrent blocked ducts:

Most blocked ducts will be gone within about 48 hours. If your blocked duct has not gone by 48 hours or so, **therapeutic ultrasound** often works. Most local physiotherapy or sports medicine clinics can do this for you. However, very few are aware of this use of ultrasound to treat blocked ducts. An ultrasound therapist with experience in this technique has more successful results.

If two treatments on two consecutive days have not helped resolve the blocked duct, there is no point in getting more treatments. Your blocked duct should be re-evaluated by your doctor or at our clinic. Usually, however, one treatment is all that is necessary. Ultrasound may also prevent recurrent blocked ducts that occur always in the same part of the breast. The dose of ultrasound is **2 watts/cm² continuous for five minutes to the affected area, once daily for up to two treatments**.

Some have used the flat end of an electric toothbrush to give themselves “ultrasound” treatment. And apparently have had good results.

Lecithin is a food supplement that seems to help prevent blocked ducts. It may do this by decreasing the viscosity (stickiness) of the milk by increasing the percentage of polyunsaturated fatty acids in the milk. It is safe to take, relatively inexpensive, and seems to work in at least some breastfeeding parents. The dose is 1200 mg four times a day.

A bleb or blister

Sometimes, but not always by any means, a blocked duct is associated with a bleb or blister on the end of the nipple. A flat patch of white on the nipple is not a bleb or blister. If there is no painful lump in the breast, it is confusing to call a bleb or blister on the nipple a blocked duct. A bleb or blister is, usually, painful and is one cause of nipple pain that comes on later than the first few days. Some get blisters in the first few days due to a poor latch.

A blister is often present without having a blocked duct.

If the blister is quite painful (it usually is), it is helpful to open it, as this should give you some relief from the pain. You can open it yourself, but do this one time only. However, if you need to repeat the process, or if you cannot bring yourself to do it yourself, it is best to go to see your doctor or come to our clinic.

- Flame a sewing needle or pin, **let it cool off,** and puncture the blister.
- Do not dig around; just pop the top or side of the blister.
- Try squeezing just behind the blister; you might be able to squeeze out some toothpaste-like material through the now opened blister. If you have a blocked duct at the same time as the blister, this might result in the duct unblocking. Putting the baby to the breast may also result in the baby unblocking the duct.

Once you have punctured the bleb or blister, start applying the "all purpose nipple ointment" after each feed for a week or so. The reason for this is to prevent infection and also to decrease the risk of the bleb or blister returning. See the information sheet "All Purpose Nipple Ointment". You need a prescription for the ointment

Mastitis

Mastitis is due to an infection (almost always due to bacteria rather than other types of germs) that usually occurs in breastfeeding parents. However it can occur in any woman, even if she is not breastfeeding and can even occur in newborn babies of either sex. Bacteria may enter the breast through a crack or sore in the nipple but those without sore nipples also get mastitis and most who have cracks or sores do not.

Mastitis is different from a blocked duct because a blocked duct is not thought to be an infection and thus does not need to be treated with antibiotics. With a blocked duct, there is a painful, swollen, firm mass in the breast. The skin overlying the blocked duct is often red, but less intensely red than the redness of mastitis. Unlike mastitis, a blocked duct is *not usually* associated with fever, though it can be. Mastitis is usually more painful than a blocked duct, but both can be quite painful. Thus seeing the difference between a "mild" mastitis and a "severe" blocked duct may not be easy – in fact, there may be no difference. It is also possible that a blocked duct goes on to become mastitis, so things become even more complicated. **However, without a lump in the breast, there is no mastitis or blocked duct for that matter**. In France, physicians recognize something they call *lymphangite* when the breastfeeding parent has a painful, hot redness of the skin of the breast, associated with fever, but there is no painful lump in the breast. Apparently, most do not believe this *lymphangite* requires treatment with antibiotics. I have seen a few cases that fit this description and yes, in fact, the problem goes away without the breastfeeding parent taking antibiotics. But then, often a full-blown mastitis also goes away without antibiotics.

If you start getting symptoms of mastitis (painful lump in the breast, redness and pain of the breast, fever), **follow the recommendations for blocked ducts** (above).

Other treatments:

If you are in so much pain that you cannot put the baby to the affected breast, continue on the other side and as soon as your breast is less painful put the baby to the breast with the mastitis. Sometimes expressing your milk may be less painful, but not always, so if you can, continue breastfeeding on the affected side. Breastfeeding parents and babies share all their germs, so do not stop on the affected side if at all possible. Your baby will be protected by breastfeeding.

Fever helps fight off infection. Adults usually feel terrible when they have a fever and you may want to bring down the fever for this reason. But you don't need to bring down the fever just because it's there. Fever does not cause the milk to go bad!

Medication for pain/fever (ibuprofen, acetaminophen, and others) can be helpful to get you through this. The amount that gets into the milk, as with almost all medications, is minuscule. Acetaminophen is probably less useful than those drugs (e.g. ibuprofen) that have an anti-inflammatory affect.

Potatoes (adapted from Bridget Lynch, RM, Community Midwives of Toronto). Within the first 24 hours of your symptoms beginning, you may find that applying slices of raw potato to the breast will reduce the pain, swelling, and redness of mastitis.

- Cut 6 to 8 washed, raw potatoes lengthwise into thin slices.
- Place in a large bowl of water at room temperature and leave for 15 to 20 minutes.
- Apply the wet potato slices to the affected area of the breast and leave for 15 to 20 minutes.
- Remove and discard after 15 to 20 minutes and apply new slices from the bowl.
- Repeat this process two more times so that you have applied potato slices 3 times in an hour.
- Take a break for 20 or 30 minutes and then repeat the procedure.

Mastitis and Antibiotics

Generally, it is better to avoid antibiotics if possible since mastitis may improve all on its own and antibiotics may result in your getting a Candida (yeast, thrush) infection of the nipples and/or breast. Our approach is as follows:

If you have had symptoms consistent with mastitis for **less than 24 hours**, we would give you a prescription for an antibiotic, but suggest you wait before starting to take the medication.

- If, over the next 8 to 12 hours, *your symptoms are worsening* (more pain, more spreading of the redness or enlarging of the painful lump), start the antibiotics.
- If over the next 24 hours, *your symptoms are not worse* but not better, start the antibiotics.
- If over the next 24 hours, *your symptoms are lessening*, then they will almost always

continue to lessen and disappear without your needing to take the antibiotics. In this case, the symptoms will continue to lessen and will have disappeared over the next 2 to 7 days. Fever is often gone by 24 hours, the pain within 24 to 72 hours and the breast lump disappears over the next 5 to 7 days. Occasionally the lump takes longer than 7 days to disappear completely, but as long as it's getting small, this is a good thing.
    - If you have had symptoms consistent with mastitis for **more 24 hours** and the symptoms have not improved, you should start the antibiotics straight away.

If you are going to take an antibiotic, you need to take the right one. Amoxicillin, plain penicillin and some other antibiotics used frequently for mastitis do not kill the bacterium that almost always causes mastitis (*Staphylococcus aureus*). Some antibiotics which kill *Staphylococcus aureus* include: cephalexin (our usual choice), cloxacillin, dicloxacillin, flucloxacillin, amoxicillin combined with clavulinic acid, clindamycin and ciprofloxacin. Antibiotics that can be used for methicillin-resistant *Staphylococcus aureus* (MRSA): cotrimoxazole and tetracycline.

All these antibiotics can be used by breastfeeding parents and do not require interruption of breastfeeding.**You should not interrupt breastfeeding if you are infected with MRSA! Indeed, breastfeeding decreases the risk of the baby getting the infection**.

Breast Abscess

A breast abscess may form when there is a long delay in treatment for mastitis, or if mastitis is not treated/ineffectively treated. An abscess is a pocket of pus formed in an infected area because the body cannot completely fight off the infection on its own. It is the body's way of preventing infection from spreading.

Symptoms often include a swollen lump usually just under the skin (usually painful to touch or squeeze) and swelling or redness in the surrounding area. You may have a fever.

If you have mastitis that has not completely resolved, or at least significantly improved, within 5 to 7 days of starting antibiotics, you should be assessed for an abscess.

The treatment of choice now for breast abscess is no longer surgery. We have had much better results with ultrasound to locate the abscess and a catheter inserted into the abscess to drain it. Breastfeeding parents going through this procedure do not stop breastfeeding even on the affected side, and complete healing occurs often within a week. This procedure is done by an intervention radiologist, not a surgeon. Ask your doctor to check out this study: Dieter Ulitzsch, MD, Margareta K. G. Nyman,MD, Richard A. Carlson, MD. Breast Abscess in Lactating Women: US-guided Treatment. *Radiology* 2004; 232:904–909

For small abscesses, aspiration with a needle and syringe plus antibiotics often is all that is necessary, though it may be necessary to repeat the aspiration more than once.

A breast lump that isn't going away.

If you have a lump that is not going away or not getting smaller over more than a couple of weeks, you should be seen by a breastfeeding-friendly physician or surgeon. You don't have to interrupt or stop breastfeeding to get a breast lump investigated (ultrasound, mammogram, CT scan, MRI scan and even biopsy do not require you to stop breastfeeding even on the affected side). A breastfeeding friendly surgeon will not tell you that you have to stop breastfeeding before s/he can do tests to investigate a breast lump.

The information presented here is general and not a substitute for personalized treatment from an International Board Certified Lactation Consultant (IBCLC) or other qualified medical professionals.

Questions or concerns? Email Dr. Jack Newman (read the page carefully, and answer the listed questions).
Make an appointment at the Newman Breastfeeding Clinic.