BREAST infection protocol

If widespread cellulitis or fever/systemically unwell or sepsis or necrotising fasciitis
Admit and treat with IV antibiotics (refer to appropriate guidelines in Microguide for antibiotic choices)

If patient clinically stable and well:
Discharge with oral treatment (see below) and arrange prompt review in breast clinic *if necessary* (see below referral criteria) or to their GP

Consider possible diagnosis:

Mastitis - Inflammation of the breast, pain, swelling, warmth with or without a collection/fever.

Inflammatory Breast Cancer - discolouration of the breast, diffuse swelling with Oedema, no infection, no fever, not post-partum and not periductal mastitis. Refer to Breast Clinic

* for infection associated with breast implant please refer to Breast Unit and/or Microbiology direct for advice

Lactational (usually peripheral in the breast)		**Periductal (around the areola) (Non lactational)**	
Without abscess/or collection	**With abscess**	**With abscess**	**Without abscess**
	Aspiration for pus- Pus sent for M,C&S Warn patient that aspiration may trigger further discharge Can be aspirated: a)By the clinical team free-hand with Emla cream and local anaesthetic if superficial, pointing or well localised b) Under ultrasound guidance (**organised through The Breast Centre - please refer patient**) if deep seated or poorly localised. If systemically well, can be as outpatient. Most patients can avoid incision, drainage and packing of cavity in theatre if aspirated early and repeatedly in outpatient setting (A&E or SAU or Breast Clinic). Ideally patients shouldn't be taken to theatre for incision without prior consultation with the breast team as there is the risk of significant scarring **unless the patient is septic/pointing abscess +/- skin necrosis**.		
-**Flucloxacillin** 500mg-1g qds PO *If penicillin allergy(type 1 reaction)* **Clarithromycin** 500mg BD PO ***Plus*** Continue breastfeeding If possible or express milk from affected breast to prevent accumulation	**Flucloxacillin** 1g qds PO *If penicillin allergy(type 1 reaction)* **Clarithromycin** 500mg bd PO ***Plus*** Continue breastfeeding If possible or express milk from affected breast to prevent accumulation	**Flucloxacillin** 1g qds PO **plus Metronidazole** 400mg tds PO(5-7 days) *If penicillin allergy(type 1 reaction)* **Clindamycin** 450mg qds PO ***Plus***: STOP smoking and/or improve glycaemic control if diabetes	**Flucloxacillin** 1g qds PO **plus Metronidazole** 400mg tds PO *If penicillin allergy(type 1 reaction)* **Clindamycin** 450mg qds PO **plus Metronidazole** 400mg tds PO ***Plus***: STOP smoking and/or improve glycaemic control if diabetes

Duration
The optimal length of therapy is not certain; **5- to 7-day** course can be used if the response to therapy is rapid and complete-REVIEW patient to assess response then; (if necessary, the duration may be extended to 10 to 14 days)
Criteria for referral to Breast Clinic for follow up:
Need for aspiration under USS guidance Need for mammography (40 years +) after resolution of inflammation (periductal Mastitis?) Need for Incision and drainage Recurrence of symptoms (please send pus/specimen for Actinomyces and if recurrent Staph. Aureus request PVL testing) **Contact:** fax patient's details, phone number and presenting complaint to the **Breast Centre – Llandough Hospital fax number 02920715742 or telephone 02920715741.** **Clinics run on Mondays, Thursdays, Wednesday and Friday mornings**
Criteria for referral to GP for follow up for resolution of symptoms:
Simple sebaceous cyst treated with oral antibiotic Simple Lactational Mastitis Simple periductal mastitis