UTHSCSA Radiology Breast Abscess Protocol
(for Emergency and Outpatient Providers)

If signs and symptoms are consistent with breast abscess:
-For unfunded patients, please send the patient to the UH Emergency Department.
-For emergency providers, consultation with surgical oncology is advised regardless of funding status. Note that admission is not required in unfunded patients. Unfunded patients who qualify for discharge from the ED may be followed up through "Continuity of Care" and the protocol below may be utilized.
-If the patient is funded and not requiring admission, see protocol below.

1. Establish care with a clinician familiar with the ongoing management of breast abscesses and related conditions (surgical oncology).
2. Start antibiotics or change antibiotics if patient not responding
    a. Typical coverage should include Staphylococcus and Streptococcus
        i. Dicloxacillin 500 mg qid x 7-10 days
        ii. Clindamycin 300 mg qid x 7-10 days
        iii. Keflex 500 mg qid x 7-10 days
3. Schedule patient for breast abscess drainage at CTRC (call Mammo resident or fellow via the UH Radiology Help Desk at 210-358-8532)
    a. These can be added on as "urgent" or "stat" studies
    b. Enter orders in Sunrise for labs as needed (gram stain, culture, sensitivity, etc.)

*** If after hours (holidays, weekends or weekdays 5pm-8am), complete steps 1, 2,and 3b above and discharge or observe the patient as clinically indicated. Appointments can be made on the subsequent weekday at 8 am by the provider or patient. If the patient is clinically deterioating and prompt drainage is required, send the patient to the ED and contact the Surgery oncology (GSC) resident on-call. ***

Breast abscess drainage (performed by UTHSCSA/CTRC Breast Imaging service)

1. Ultrasound guided
2. 11 gauge needle placed in abscess
3. Drainage of fluid performed and sent for labs as ordered
4. Cavity flushed with sterile saline (if indicated)

Following abscess drainage

1. Patient must have appointment with a clinician familiar with the ongoing management of breast abscesses and related conditions.
    a. Re-consult Radiology for ultrasound and/or aspiration if persistent clinical symptoms
2. Repeat abscess drainage for reaccumulation up to 3 times
    a. Most abscesses will resolve by that time
    b. Unlikely to resolve without further management if still reaccumulating after 3 drainages
    c. Consider surgical consultation (surgical oncology service – GSC).
3. Consider switching antibiotics if repeated accumulation (review of antibiotic sensitivities could be helpful)

UTHSCSA Radiology Breast Abscess Protocol
(for Emergency and Outpatient Providers)

If abscess persists after multiple drainages (up to 3)

1. Consider breast surgical debridement due to potential breast scar and disfigurement or milk fistula
2. Abscess that fails to resolve despite multiple percutaneous drainages could be caused by residual cavity, septations or loculations, occult malignancy, non-bacterial infections, or other processes such as granulomatous mastitis. Surgical exploration and biopsy may be indicated. At this point, surgical oncologic consultation is recommended.

*****Followup imaging appointment 21 days after initiation of therapy is required. *****

Scheduling: (210) 450-3833 (Debbie Mason); 210-450-1513 (CTRC); 210-358-6605 (Brady Green campus)
Contacts: Debbie Mason, Dr. Dornbluth, Dr. Otto, Dr. Kist

References

1: Trop I, Dugas A, El Khoury M, Boileau JF, Larouche N, Lalonde L. Breast Abscesses: evidence-based algorithms for diagnosis, management, and follow-up. Radiographics. 2011 Oct;31 (6):1683-99.

2: Vashi R, Hooley R, Butler R, Geisel J, Philpotts L. Breast imaging of the pregnant and lactating patient: physiologic changes and common benign entities. AJR Am J Roentgenol. 2013 Feb;200(2):329-36.