Mastitis (Waram-i-Sadi)

Causes, Symptoms, Diagnosis, Modern Treatment and the Unani Approach to Breast Inflammation

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Introduction

Mastitis is a painful inflammatory condition of the breast that occurs most commonly during breastfeeding. A woman may suddenly notice that one area of her breast has become swollen, hot, tender and painful. She may also develop fever, chills, body aches and severe tiredness.

When a breastfeeding mother experiences these symptoms, one of her biggest worries is often:

“Doctor, is there an infection in my milk, and should I stop feeding my baby?”

In most situations, the answer is **no—breastfeeding should not suddenly be stopped**. Current medical guidance generally supports continuing normal breastfeeding during lactational mastitis, including bacterial mastitis, unless a clinician identifies a specific reason not to do so. Sudden weaning may make breast congestion and inflammation worse.

Modern understanding of mastitis has changed considerably during the last few years. It is no longer viewed simply as a “blocked milk duct that becomes infected.” The **Academy of Breastfeeding Medicine describes a mastitis spectrum**, beginning with ductal narrowing and inflammation, which in some patients may progress to inflammatory mastitis, bacterial mastitis, phlegmon or breast abscess.

This change in understanding has also changed treatment. Some older advice—such as repeatedly pumping until the breast is “completely empty,” vigorously massaging a lump or applying excessive heat—is no longer routinely recommended and may actually aggravate inflammation.

In the Unani system of medicine, mastitis is traditionally discussed as **Waram-i-Sadi**, meaning inflammation of the breast. CCRUM's Standard Unani Treatment Guidelines describe Waram-i-Sadi as a breast inflammatory condition characterized by heat, redness, pain, engorgement and sometimes fever.

In my clinical approach at **Saira Health Care**, I believe the most responsible way to manage mastitis is to combine the holistic strengths of Unani medicine with the best available contemporary understanding of breastfeeding, inflammation, infection and breast disease.

The purpose is not simply to reduce pain temporarily. We must identify whether the patient has uncomplicated inflammation, bacterial infection, an abscess or another breast disorder requiring specialist investigation.

What Is Mastitis?

Mastitis means **inflammation of breast tissue**.

The breast may become swollen, warm, painful and red or discoloured. Fever and chills may occur, particularly when inflammation is substantial or bacterial infection develops.

Mastitis is most common in people who are breastfeeding, when it is called **lactational or puerperal mastitis**, but it can also occur in people who are not breastfeeding.

Although mastitis often affects one breast, both breasts can occasionally be involved.

Symptoms sometimes develop very quickly—within hours.

The patient may feel perfectly well in the morning and by evening experience considerable breast pain, chills and a flu-like feeling.

The Modern Concept: Mastitis Is a Spectrum

This is one of the most important recent advances for patients to understand.

For many years, breastfeeding mothers were told that mastitis happened because a large “plug of milk” blocked a duct. They were advised to massage aggressively and keep feeding or pumping repeatedly until every drop of milk had been removed.

Modern evidence gives us a more detailed picture.

Breast ducts are extremely small. What a woman experiences as a “blocked duct” is often better understood as **ductal narrowing caused by inflammation and swelling around the ducts**, rather than a large solid plug of milk that has to be physically pushed out.

The Academy of Breastfeeding Medicine currently describes a progression that may include:

Ductal narrowing → inflammatory mastitis → bacterial mastitis → phlegmon or abscess in some patients.

Excessive stimulation of milk production and traumatic massage can worsen edema and inflammation and may contribute to progression.

This matters because treatment aimed at “forcing out the blockage” may sometimes worsen exactly the inflammation we are trying to treat.

Ductal Narrowing or the So-Called “Blocked Duct”

A woman may notice a tender, firm area in one part of the breast without fever or feeling generally unwell.

This has traditionally been called a blocked or plugged duct.

Current guidance explains that the problem often involves microscopic ductal inflammation and surrounding tissue swelling.

It is therefore generally better to reduce inflammation and continue physiological breastfeeding rather than repeatedly squeezing the breast or pumping it empty.

If inflammation progresses, redness, swelling and increasing pain may develop.

Inflammatory Mastitis

Inflammatory mastitis develops when local ductal inflammation and breast edema become more significant.

The woman may develop:

- Increasing breast pain.
- A warm or red area.
- Swelling.
- Fever.
- Chills.
- Rapid heartbeat.
- General flu-like symptoms.

An important point is that **fever and chills do not automatically prove that bacteria are present**.

The Academy of Breastfeeding Medicine notes that a significant systemic inflammatory response can occur even without bacterial infection.

This is why not every early case automatically requires an antibiotic.

Bacterial Mastitis

Bacterial mastitis can develop when inflammation progresses and pathogenic bacteria become clinically significant.

Common organisms include species of **Staphylococcus and Streptococcus**.

The breast may become increasingly red, firm and painful, and systemic symptoms may persist.

If fever and rapid heartbeat continue for more than approximately 24 hours, or breast symptoms fail to improve despite appropriate conservative treatment, professional medical evaluation becomes increasingly important.

Unlike some older beliefs, bacterial mastitis should not automatically be considered the result of “poor hygiene.”

Current evidence does not support poor personal hygiene as the usual cause of bacterial mastitis. Routine hand hygiene and appropriate pump cleaning remain sensible, but a mother should not blame herself for developing the condition.

What Causes Lactational Mastitis?

Mastitis usually results from several interacting factors rather than one single mistake.

Oversupply of Milk

Producing substantially more milk than the baby requires can increase pressure within the breast and contribute to ductal inflammation.

Repeated extra pumping to create a large freezer supply, pumping after every feed “just in case,” or attempting to completely empty the breast may sometimes reinforce excessive milk production.

The breast responds to milk removal by producing more milk.

That is why current guidance recommends that pumping, when necessary, should generally approximate the baby's physiological needs rather than repeatedly trying to empty the breast.

Problems With Milk Transfer

Difficulty with the baby's latch or feeding mechanics may contribute to poor milk transfer and uncomfortable breast fullness.

A qualified lactation consultant can be extremely helpful in these situations.

Abrupt Changes in Feeding

Suddenly missing feeds or abruptly changing breastfeeding routines may leave the breast more congested than usual.

Excessive Pumping

Pumping can be invaluable when medically needed, but unnecessary or excessive pumping may stimulate oversupply and worsen breast congestion.

Pressure on the Breast

Very tight bras or clothing and repeated local pressure can aggravate breast discomfort in some women.

Previous Mastitis

Women who have previously experienced mastitis can be more likely to experience recurrent episodes.

When mastitis repeatedly occurs in exactly the same location, however, it should not simply be treated repeatedly without investigation. Imaging may be needed to exclude an underlying breast abnormality.

Are Cracked Nipples the Main Cause of Mastitis?

Older explanations often suggested that bacteria entered exclusively through cracks in the nipple.

Nipple injury can certainly coexist with mastitis and deserves treatment, but modern research shows that the relationship is more complex.

The Academy of Breastfeeding Medicine notes that current understanding of the human-milk microbiome does not support the simple idea that mastitis is always caused by bacteria travelling backwards through visible nipple cracks.

A cracked or painful nipple should still be assessed, particularly because it may indicate poor latch or another breastfeeding problem.

Symptoms of Mastitis

The most common symptoms include:

- Pain or tenderness in one part of the breast.
- Breast warmth.
- Swelling.
- A hard or thickened area.
- Redness or a change in skin colour.
- Burning pain while breastfeeding or even between feeds.
- Fever.
- Chills.
- Body aches.
- Fatigue and a feeling similar to influenza.

Mayo Clinic lists breast tenderness, warmth, swelling, thickening, burning pain, skin redness and systemic illness among the typical manifestations.

On darker skin, redness may be less obvious. The breast may instead appear darker, purple, dusky or simply more swollen than surrounding tissue.

Clinical assessment should therefore not depend on redness alone.

Mastitis and Breast Engorgement Are Not the Same

Engorgement commonly occurs when milk production increases during the first days after childbirth.

Both breasts may become full, heavy and uncomfortable.

Mastitis more commonly involves a particular area, often with more significant inflammation and sometimes systemic symptoms.

Engorgement does not automatically mean infection.

Similarly, repeatedly pumping an engorged breast until it feels completely empty can stimulate further milk production and perpetuate the problem.

Diagnosis

In uncomplicated lactational mastitis, diagnosis is often primarily clinical.

I begin by asking:

- When did the pain start?
- Is one breast affected or both?
- Is there fever?
- Is there a distinct mass?
- Is the mother breastfeeding directly or pumping?
- Is she producing more milk than the baby needs?
- Has she recently missed feeds?
- Is there nipple pain or damage?
- Has mastitis happened before?
- Has she already taken antibiotics?

Physical examination helps determine whether the breast primarily shows inflammatory changes or whether a fluid collection may have developed.

Most patients do not need extensive blood testing.

When Is Ultrasound Necessary?

Breast ultrasound becomes particularly useful when:

- A definite mass persists.
- An abscess is suspected.
- Symptoms are worsening despite treatment.
- A phlegmon or galactocele is possible.
- Mastitis repeatedly occurs in the same location.
- The diagnosis is uncertain.

Ultrasound can identify a fluid collection and help guide drainage when required.

Breast-Milk Culture

Breast-milk culture is not required for every first episode of uncomplicated mastitis.

However, current breastfeeding-medicine guidance suggests considering a culture when symptoms do not improve after approximately **48 hours of first-line treatment**, particularly when resistant organisms such as MRSA are possible.

Culture may also be useful in recurrent mastitis or selected higher-risk circumstances.

This allows treatment to be directed toward the actual organism rather than simply changing antibiotics repeatedly.

Should a Mother Stop Breastfeeding?

In most cases, **no**.

This is one of the strongest messages I give breastfeeding mothers.

Bacterial mastitis itself is generally **not a reason to discard breast milk or stop feeding from the affected breast**, and breastfeeding does not normally pose a risk to the healthy infant.

Sudden cessation may increase congestion and make symptoms worse.

The baby should normally continue feeding according to its usual needs.

If feeding directly becomes too painful or the baby cannot latch because of swelling, expressing enough milk to meet normal feeding requirements may be appropriate.

The objective is **physiological milk removal**, not repeatedly trying to empty the breast completely.

Special circumstances involving certain medications, maternal illness or vulnerable infants should be discussed individually with the treating doctor.

An Important Update: Do Not Over-Pump the Affected Breast

Many mothers have been told:

“Keep pumping until every drop comes out.”

Current guidance cautions against this approach.

Excessive pumping stimulates additional milk production, increases vascular congestion and may worsen inflammation.

The Academy of Breastfeeding Medicine specifically recommends that pumping should resemble normal physiological breastfeeding in frequency and volume when pumping is necessary.

Breasts are continuously producing milk and are never literally “empty.”

The goal is comfort and normal feeding—not complete drainage.

Another Important Update: Avoid Deep Breast Massage

This deserves particular emphasis.

I do **not** advise deep, forceful massage of a painful inflamed breast.

The Academy of Breastfeeding Medicine warns that deep massage can increase inflammation, edema and microvascular injury and may contribute to phlegmon or abscess formation.

If touch is used, it should be gentle.

A painful breast should not be squeezed, kneaded forcefully or treated with vigorous vibrating devices.

Pain is not proof that more pressure is required.

Cold or Heat: What Is Better?

Older mastitis advice frequently emphasized prolonged warm compresses.

Current understanding is more nuanced.

Cold packs can reduce swelling, inflammation and discomfort. The Academy of Breastfeeding Medicine specifically recommends **ice and anti-inflammatory treatment** as useful measures. It notes that heat causes vasodilation and may worsen inflammation, although some patients find limited warmth comfortable.

Updated NHS breastfeeding guidance likewise recommends cold compresses between feeds and cautions against excessive heat.

Therefore, I generally prefer to tell patients:

Use comfort measures that reduce inflammation rather than repeatedly heating and aggressively manipulating the breast.

Pain and Inflammation Control

Pain relief is an important component of treatment.

Anti-inflammatory medicines such as ibuprofen and analgesics such as paracetamol/acetaminophen are commonly used in breastfeeding patients when medically suitable.

The patient's allergies, other diseases and medications should still be considered.

Rest and adequate fluid intake are also important because mastitis can make a mother feel significantly unwell.

When Are Antibiotics Necessary?

Not every inflammatory episode requires antibiotics.

This is another major update in contemporary care.

The Academy of Breastfeeding Medicine recommends **reserving antibiotics for bacterial mastitis**, because unnecessary antibiotics can disrupt the breast microbiome and encourage antimicrobial resistance.

However, when bacterial mastitis is clinically suspected, antibiotics are important and should not be delayed unnecessarily.

The choice depends on:

- Local bacterial resistance patterns.
- Drug allergies.
- Severity of infection.
- Whether MRSA is a concern.
- Previous antibiotics.
- Culture results where available.
- Maternal and infant medical circumstances.

Breastfeeding-compatible options are available in most situations.

Patients should complete the prescribed course rather than stopping immediately when they begin to feel better.

What Is a Breast Abscess?

An abscess is a collection of infected fluid or pus within the breast.

It can develop when bacterial mastitis or a phlegmon progresses.

The Academy of Breastfeeding Medicine estimates that approximately **3–11% of women with acute mastitis may develop an abscess**.

Symptoms may include:

- A persistent or enlarging painful lump.

- Continued local redness.
- A feeling of fluid beneath the skin.
- Symptoms improving and then returning.
- Persistent pain despite antibiotics.

Interestingly, fever can sometimes improve after the infection becomes walled off, so disappearance of fever does not prove that an abscess has resolved.

Ultrasound is often helpful.

An established abscess normally requires **drainage for source control**, usually through image-guided aspiration or drainage according to the clinical situation.

Herbal medicines alone should not be relied upon to treat a confirmed breast abscess.

Phlegmon

A phlegmon is an inflammatory mass that may develop during severe mastitis before a defined abscess forms.

It can feel firm and mass-like.

Because it may later develop into an abscess, follow-up examination and sometimes repeat imaging are important.

This is another reason not to repeatedly forcefully massage a persistent breast lump.

Galactocele

A **galactocele** is a milk-filled cyst-like collection caused by obstruction of milk flow.

It may enlarge or become less prominent at different times of the day and is often less acutely painful than an abscess.

However, a galactocele can become infected.

A persistent large breast lump in a lactating woman should therefore be appropriately examined rather than automatically labelled as a clogged duct.

Recurrent Mastitis

When mastitis keeps returning, my approach is not simply to prescribe the same treatment again and again.

We need to look for the reason.

Possible contributing factors include:

- Oversupply.
- Excessive pumping.
- Repeated aggressive massage.
- Feeding or latch difficulties.
- Resistant bacteria.
- An underlying breast lesion.
- Granulomatous mastitis or another inflammatory disorder.

Current guidance recommends clinical examination and often milk culture in genuine recurrent bacterial mastitis. Repeated episodes in the **same breast location** warrant imaging to exclude an underlying abnormality.

Mastitis in Women Who Are Not Breastfeeding

Although lactation is the most common setting, mastitis can occur outside breastfeeding.

Non-lactational breast inflammation includes conditions such as **periductal mastitis** and **idiopathic granulomatous mastitis**, as well as infections and inflammatory reactions related to trauma or foreign material. Recent radiology reviews emphasize that non-lactational inflammatory breast disease can resemble malignancy and may require imaging and sometimes biopsy.

Smoking is particularly associated with some forms of periductal mastitis.

A non-breastfeeding woman with a new red, swollen or painful breast should therefore be evaluated rather than assuming the condition is ordinary lactational mastitis.

Mastitis and Inflammatory Breast Cancer

This section is extremely important.

A rare but serious condition called **inflammatory breast cancer** can sometimes resemble mastitis.

It can produce:

- Rapid swelling of one breast.

- Warmth.
- Red, purple or bruised-looking skin.
- Thickening.
- Orange-peel-like skin, known as *peau d'orange*.
- An inverted or flattened nipple.
- Enlarged lymph nodes.
- Breast heaviness or pain.

Mayo Clinic's 2026 guidance emphasizes that inflammatory breast cancer can easily be mistaken for infection. If a presumed breast infection does not improve with appropriate treatment, further imaging and sometimes biopsy are required.

This is especially important in **non-lactating patients** and in any patient whose symptoms continue, enlarge or recur.

No traditional, herbal or antibiotic treatment should be continued indefinitely without investigating persistent unexplained breast inflammation.

Mastitis According to Unani Medicine

In classical and contemporary Unani terminology, mastitis is known as **Waram-i-Sadi**.

“Waram” describes inflammatory swelling, while “Sadi” refers to the breast.

CCRUM's **Standard Unani Treatment Guidelines for Common Diseases** specifically include Waram-i-Sadi and describe it as breast inflammation associated with fever, redness, increased local heat, throbbing pain and breast engorgement.

Within the traditional Unani framework, the condition may be interpreted according to **Mizaj**, the characteristics of inflammation and the state of the four principal humours:

Dam — blood
Balgham — phlegm
Safra — yellow bile
Sauda — black bile

CCRUM's Waram-i-Sadi description particularly refers to traditional concepts involving predominance of **Dam** or Dam mixed with Balgham and accumulation or coagulation involving blood and milk.

These concepts belong to the classical Unani framework.

They should not be presented as scientifically identical to the current microbiological and inflammatory model of lactational mastitis.

Waram Harr and Inflammation in Unani Medicine

A useful recent development is a **2026 review of Waram Harr**, or hot inflammatory swelling, based on major classical Unani texts.

The review describes Waram as a fundamental concept of pathological swelling and explains classical differentiation between hot and cold inflammatory patterns, including Damwi and Safrawi forms.

Mastitis with redness, warmth and acute pain naturally has conceptual overlap with the traditional Waram framework.

From the perspective of modern practice, however, the clinician should also determine whether the patient has:

- physiological inflammation,
- bacterial infection,
- abscess,
- galactocele,
- granulomatous mastitis,
- or another breast disease.

Unani interpretation should complement—not obscure—these distinctions.

Principles of Unani Treatment in Waram-i-Sadi

The CCRUM guideline describes traditional therapeutic objectives for Waram-i-Sadi including:

Taskin-i-Waja — relief of pain.
Tahlil — resolution of inflammatory swelling.
Man'-i-Ta'affun — prevention or control of putrefaction/infective processes in the traditional framework.
Tanqiya — evacuation or removal of pathological material in appropriate circumstances.

These principles are conceptually interesting because pain control and reduction of inflammation remain central to modern mastitis management as well.

However, the exact method used must be updated according to present-day safety evidence.

An Important Point About Classical Unani Advice and Modern Breastfeeding

Traditional texts were written in a very different medical era.

Certain classical or later Unani approaches discuss reducing milk production or using local fomentations in mastitis. CCRUM's historical treatment guideline itself contains such traditional concepts.

Today we know that abruptly suppressing breastfeeding is usually **not desirable for a breastfeeding mother who wishes to continue lactation**, and contemporary breastfeeding guidance encourages normal physiological feeding rather than sudden weaning.

Likewise, prolonged intense heat and vigorous manipulation are no longer recommended for acute inflammatory mastitis.

Therefore, responsible modern Unani practice requires judgment.

Traditional principles can guide holistic management, but specific techniques should be adapted when modern evidence demonstrates a safer approach.

Ilaj-bil-Ghiza — Dietotherapy

Unani medicine gives significant importance to **Ilaj-bil-Ghiza**, or treatment through dietary regulation.

A breastfeeding mother recovering from mastitis requires adequate nutrition.

In my approach, I focus on maintaining sufficient:

- Fluids.
- Protein.
- Balanced meals.
- Micronutrients.
- Energy intake appropriate for lactation.

I do not recommend severe dietary restriction during breastfeeding simply to “cool the breast” or “dry the milk.”

A lactating mother's nutritional requirements remain significant.

Diet should support recovery, general immunity and breastfeeding rather than create additional weakness.

Ilaj-bil-Tadbir — Lifestyle and Regimental Principles

The Unani system also emphasizes regulation of lifestyle.

For mastitis, important practical aspects include:

Rest: Mastitis can make a mother feel extremely exhausted.

Adequate sleep whenever possible: This may be difficult with a newborn, but family support can be valuable.

Reduction of unnecessary stress: Emotional and physical exhaustion can make breastfeeding problems harder to manage.

Appropriate feeding routine: Feeding should follow the baby's physiological requirement without repeatedly overstimulating the affected breast.

Avoiding breast trauma: This includes tight pressure, aggressive massage and inappropriate manipulation.

I consider these aspects compatible with the holistic philosophy of Unani care.

Local Unani Measures

Classical Unani literature contains descriptions of local preparations and regimenal therapies for inflammatory swelling.

For example, CCRUM's Waram-i-Sadi guideline mentions traditional local applications prepared from **Hulba (Trigonella foenum-graecum/fenugreek)** and **Khatmi (Althaea officinalis/marshmallow)**.

Khatmi has historically been described within Unani literature as an emollient and anti-inflammatory medicinal plant used for several inflammatory conditions, including mastitis.

However, I strongly advise patients **not to place homemade herbal pastes, oils or powders on the nipple or breast immediately before feeding without professional advice**.

There are several concerns:

- Contamination.
- Allergy.
- Skin irritation.
- Infant ingestion.
- Masking progression of infection.
- Delaying drainage of an abscess.

A traditional medicine may have a legitimate historical role while still requiring modern attention to hygiene, formulation quality and breastfeeding safety.

What Does Scientific Research Say About Unani Treatment of Mastitis?

This is an area where the evidence must be presented accurately.

The **National Institute of Unani Medicine (NIUM), Bengaluru**, lists a clinical study titled *Clinical Trial & Management of Warme Saddi (Mastitis) with Unani Formulation*, published in the *Journal of Indian Medicine* in 2004. NIUM also lists a subsequent clinical study evaluating predisposing factors for mastitis.

This demonstrates that mastitis has been studied clinically within academic Unani medicine.

However, the accessible information does not provide enough high-quality modern trial data to claim that Unani treatment has a fixed cure rate or can replace antibiotics in confirmed bacterial mastitis.

The published evidence is much smaller and older than the modern evidence base for lactational management and antibiotic treatment.

Similarly, a 2026 review of the broader Unani concept of Waram Harr provides valuable classical and pathophysiological scholarship, but it is a narrative review rather than a mastitis treatment trial.

Therefore, the scientifically responsible conclusion is:

Unani medicine offers a valuable traditional framework and potentially useful supportive measures, but stronger contemporary controlled clinical trials are still needed for mastitis-specific treatments.

What About “Success Stories”?

Patients naturally find personal success stories encouraging.

But I believe an educational medical article should distinguish **personal experience from scientific evidence**.

A woman may report improvement after a herbal preparation, but mastitis can also improve spontaneously with correction of breastfeeding practices and reduction of inflammation.

A patient who receives Unani treatment at the same time as antibiotics cannot prove which component alone caused recovery.

For this reason, I would not describe anonymous case stories as scientific proof of a cure.

At Saira Health Care, I prefer to document improvement through:

- Change in pain and swelling.
- Resolution of fever.
- Clinical examination.
- Continued ability to breastfeed.
- Ultrasound when indicated.
- Resolution of abscess or inflammatory collection.
- Absence of recurrence during follow-up.

This gives us a more meaningful picture of treatment success.

My Specialized Treatment Approach at Saira Health Care

When a mother consults me with mastitis, my first priority is to determine **where she lies on the mastitis spectrum**.

I ask whether symptoms began as simple breast fullness or a tender local area, whether fever developed, whether the breast is becoming progressively more red and painful, and whether a defined lump is present.

I also assess:

- Breastfeeding pattern.
- Latch and milk transfer.
- Pumping routine.
- Possible oversupply.
- Nipple condition.
- Previous mastitis.
- Medicines already taken.
- General health.
- Diabetes or immune problems where relevant.

Then I decide whether the case appears predominantly inflammatory or whether bacterial infection or an abscess needs to be considered.

For uncomplicated inflammation, management may focus strongly on reduction of edema, physiological breastfeeding, rest and safe pain control.

When bacterial infection is suspected, appropriate antibiotic treatment is considered.

If an abscess is suspected, I do not delay imaging and drainage simply to continue oral or herbal treatment.

Alongside this, an individualized Unani assessment may consider **Mizaj, diet, general strength, sleep, digestive condition and appropriate supportive treatment**.

This is what I mean by an integrated approach.

Why I Do Not Treat Mastitis With Herbs Alone

Mastitis illustrates an important principle of responsible traditional medicine.

A plant may have anti-inflammatory activity.

Another preparation may have an analgesic effect.

A traditional regimen may improve general comfort.

But if a patient has developed a **pus-filled breast abscess**, source control through drainage is required.

Similarly, progressive bacterial mastitis may require antibiotics.

Traditional medicine should not become a reason for delaying treatment that can prevent serious complications.

The role of Unani medicine is strongest when it is applied intelligently within the patient's complete clinical picture.

Mastitis and Breastfeeding Technique

A skilled breastfeeding assessment can sometimes be as important as medicine.

A lactation specialist may assess:

- Whether the baby attaches comfortably.
- Whether milk transfer is effective.
- Whether the mother is pumping unnecessarily.
- Whether pump suction is excessive.
- Whether flange size is appropriate.

- Whether the mother has oversupply.
- Whether the feeding routine has changed suddenly.

Current NHS guidance updated in **March 2026** continues to recommend breastfeeding support and assessment of positioning and attachment when breast pain or mastitis develops.

There should be no embarrassment in asking for breastfeeding assistance.

Breastfeeding is a learned biological process for both mother and baby.

Common Mistakes I Advise Patients to Avoid

There are several practices that can make mastitis more difficult to manage:

- Forcefully massaging a painful lump.
- Excessively pumping to “empty” the breast.
- Suddenly stopping breastfeeding.
- Wearing very tight bras.
- Repeatedly applying intense heat.
- Taking leftover antibiotics without evaluation.
- Changing antibiotics repeatedly without follow-up.
- Ignoring a persistent mass.
- Applying unverified herbal substances directly to cracked nipples.
- Assuming that every red breast during breastfeeding is simply a harmless blocked duct.

Deep massage in particular is now specifically discouraged because it can worsen tissue injury and swelling.

Can Mastitis Affect Milk Supply?

Yes.

During an episode of significant inflammation, milk flow from the affected breast may temporarily decrease.

Pain, swelling and changes in breastfeeding patterns can contribute.

In many mothers the supply improves again after inflammation resolves and breastfeeding stabilizes.

The response should not automatically be to pump aggressively, because excessive stimulation can create oversupply and perpetuate the inflammatory cycle.

Is Milk From a Breast With Mastitis Safe?

For most healthy babies, yes.

Modern breastfeeding guidance states that milk from a breast affected by bacterial mastitis can generally be consumed safely, and breastfeeding normally does not have to be interrupted.

Individual advice may differ for premature, medically fragile or immunocompromised infants or depending upon particular medications.

Those circumstances should be discussed with the baby's pediatrician and the mother's treating clinician.

Mastitis and Mental Health

This aspect is easily overlooked.

A mother with severe breast pain, fever and a newborn may feel physically and emotionally overwhelmed.

She may worry that breastfeeding is failing.

She may blame herself.

She may be frightened about her milk supply.

She may also be experiencing postpartum anxiety or depression at the same time.

The Academy of Breastfeeding Medicine specifically recommends attention to **perinatal mood and anxiety disorders** in patients experiencing breastfeeding complications.

At Saira Health Care, I believe the mother should be treated as a complete person rather than as an inflamed breast.

Support from family members is valuable during recovery.

Can Mastitis Be Prevented?

It cannot always be prevented, but some risks can be reduced.

Helpful measures include maintaining comfortable physiological breastfeeding, obtaining assistance if latch or milk transfer is difficult, avoiding unnecessary pumping and oversupply, avoiding tight pressure on the breast, and seeking advice early when breast pain begins.

Repeated deep massage should be avoided.

If mastitis recurs, the underlying feeding or pumping pattern should be reviewed rather than simply prescribing preventive antibiotics. Prophylactic antibiotics have not been shown to reliably prevent recurrent mastitis and may encourage resistant organisms.

When Should a Mother Contact a Doctor?

Current NHS guidance recommends obtaining medical advice when symptoms fail to improve within approximately **12–24 hours of appropriate home care** or when the patient feels increasingly unwell.

You should also seek medical evaluation if:

- Fever is persistent.
- Redness is spreading rapidly.
- Pain is severe.
- A lump is becoming larger.
- Pus is draining from the breast.
- You feel faint, very weak or severely unwell.
- Symptoms do not improve after starting antibiotics.
- Mastitis keeps returning.
- You are not breastfeeding.
- There are unusual skin changes or nipple retraction.

When Is Urgent Assessment Particularly Important?

Seek prompt medical care if there is severe systemic illness, rapidly spreading breast inflammation, severe dehydration, a large painful breast mass, or concern for abscess.

Persistent changes such as an enlarging breast, orange-peel skin, newly inverted nipple or failure to respond to appropriate infection treatment require further investigation for conditions including inflammatory breast cancer.

Frequently Asked Questions

Is mastitis always an infection?

No. Mastitis describes inflammation, and early inflammatory mastitis may occur without bacterial infection. Bacterial mastitis is one part of the mastitis spectrum.

Should every case be treated with antibiotics?

No. Current breastfeeding-medicine guidance recommends reserving antibiotics for bacterial mastitis rather than uncomplicated inflammation.

Should I stop breastfeeding?

Usually no. Continuing normal physiological breastfeeding is generally recommended.

Should I pump the breast until it is empty?

No. Repeated extra pumping can stimulate oversupply and worsen inflammation. Pumping should generally match the baby's physiological feeding needs when it is required.

Should I massage a blocked duct hard?

No. Deep massage is specifically discouraged because it can increase inflammation, edema and tissue injury.

Is ice useful?

Yes. Cold treatment can reduce inflammation, swelling and pain.

Is heat completely forbidden?

Not necessarily. Mild warmth may feel comfortable to some mothers, but excessive or prolonged heat can increase blood flow and inflammation. Current guidance generally gives greater emphasis to cold for acute inflammatory symptoms.

Can mastitis become an abscess?

Yes. A minority of acute mastitis cases progress to a breast abscess requiring drainage.

Can a woman who is not breastfeeding develop mastitis?

Yes. Non-lactational inflammatory breast disorders also occur and deserve medical evaluation.

Can men develop mastitis?

Men have breast tissue and can develop breast inflammation or infection, although this is much less common. Any new inflammatory breast problem in a man requires medical assessment.

Can Unani medicine help mastitis?

Unani medicine contains a well-described traditional concept of **Waram-i-Sadi** and therapeutic principles addressing inflammation, pain, diet and general health. CCRUM publishes specific traditional guidance for Waram-i-Sadi, and NIUM has documented earlier clinical research into Unani mastitis treatment.

However, modern high-quality trials remain limited. Unani treatment should therefore be individualized and should not delay antibiotics for bacterial disease, ultrasound when necessary or drainage of an abscess.

Contribution of Saira Health Care in Women's Reproductive and Sexual Health

Although mastitis is primarily a breast and lactation condition rather than a sexual disorder, it occurs during an important period of women's reproductive health.

The postpartum period can involve breastfeeding difficulties, hormonal changes, vaginal dryness, painful intercourse, changes in sexual desire, emotional stress and future fertility concerns simultaneously.

At **Saira Health Care**, our wider work in the field of **sexual disorders and infertility** encourages us to look at these concerns in an integrated way.

My aim is to provide patients with:

- Confidential and respectful consultation.
- Careful identification of the underlying cause.
- Individualized Unani assessment where appropriate.
- Modern investigation when indicated.
- Evidence-based referral for gynecology, breast surgery, imaging or lactation care where required.
- Dietary and lifestyle counselling.
- Follow-up rather than unsupported promises of guaranteed cure.

I believe the best contribution we can make is to help patients receive the right treatment at the right stage while preserving respect for both traditional medical knowledge and modern clinical evidence.

About Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi, Founder and Chief Physician of Saira Health Care**, with a focused clinical practice in **Sexual Disorders & Infertility**.

My professional training includes:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

My training and clinical work in reproductive health have taught me that a patient's problem rarely exists in isolation.

A breastfeeding woman with mastitis may also be exhausted, anxious, recovering from childbirth and struggling with other postpartum reproductive-health concerns.

The physician therefore needs to listen to the whole story.

A Personal Message From Dr. Nizamuddin Qasmi

When a mother comes to me frightened because her breast suddenly became painful and red, I first explain that mastitis is usually manageable.

I also tell her not to blame herself.

Do not assume that the breast has become infected because you were “unclean.”

Do not forcefully squeeze the breast because somebody told you there is a hard lump that must be pushed out.

Do not pump continuously in an effort to make the breast completely empty.

And do not suddenly stop breastfeeding unless there is a specific medical reason.

At the same time, please do not ignore worsening symptoms.

A breast abscess requires proper drainage.

Persistent bacterial infection may require antibiotics.

A breast that remains abnormal despite treatment requires further investigation.

In Unani medicine we have a long-established understanding of **Waram-i-Sadi** and traditional methods directed toward pain, inflammation, Mizaj, nutrition and general health.

I find these principles useful when they are applied thoughtfully.

But I also believe that practising Unani medicine responsibly today means recognizing ultrasound, microbiology, lactation science, antibiotics and surgical drainage whenever the patient's condition requires them.

The objective is not to prove that one system of medicine is superior to another. The objective is to help the mother recover safely while protecting her breast health and, whenever possible, her breastfeeding goals.

Conclusion

Mastitis is an inflammatory condition of the breast, most frequently occurring during breastfeeding.

Modern understanding recognizes a **mastitis spectrum**, ranging from ductal inflammation and inflammatory mastitis to bacterial infection, phlegmon and breast abscess.

This newer understanding has changed several aspects of management.

Physiological breastfeeding is generally encouraged. Excessive pumping is discouraged. Deep aggressive breast massage should be avoided. Cold therapy and anti-inflammatory measures can provide relief, while antibiotics should be reserved for cases in which bacterial mastitis is suspected.

When an abscess forms, drainage is necessary. Persistent or recurrent inflammation requires proper investigation, particularly because non-lactational mastitis and inflammatory breast cancer can sometimes resemble ordinary breast infection.

The Unani system recognizes mastitis as **Waram-i-Sadi**, with classical principles directed toward inflammation, pain, humoral and constitutional assessment and supportive treatment. CCRUM has published formal Unani guidance for this condition, and academic Unani institutions have previously reported clinical investigation of mastitis.

At **Saira Health Care**, my approach is to use these Unani principles responsibly alongside contemporary breastfeeding and breast-health knowledge.

Mastitis should neither be overtreated with unnecessary medicines nor underestimated when serious infection or abscess is developing.

With early recognition, correct breastfeeding support, appropriate anti-inflammatory care, antibiotics when truly needed and drainage when an abscess develops, **most patients can recover successfully and continue breastfeeding if they wish to do so**.

Dr. Nizamuddin Qasmi
Founder & Chief Physician
Saira Health Care
Focused Practice in Sexual Disorders & Infertility

Medical Disclaimer: This article is intended for general education and public awareness. It does not replace examination or individualized medical advice. Breastfeeding mothers with persistent fever, worsening redness, severe pain, a growing breast lump or symptoms that fail to improve should seek medical evaluation. Non-breastfeeding patients with new breast redness or swelling should also be examined. Herbal or Unani preparations should not delay antibiotics, imaging, abscess drainage or cancer evaluation when these are clinically required.