

Breast Feeding – Mastitis and Breast Abscess Treatment and Prevention

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1. Purpose of guideline

The purpose of this guideline is to assist clinicians with the management and treatment of non-infective and infective mastitis and breast abscess within Te Whatu Ora | Te Toka Tumai Auckland.

2. Definitions

Term	Definition
Engorgement	Lactogenesis II occurs between 3-5 days postpartum, late onset can be as late 9-10 days. Engorgement presents as bilateral breast pain, firmness and swelling due to interstitial oedema and hyperaemia.
Ductal Narrowing	An area of engorgement within the breast ductal system. An infection is not necessarily present, but it may progress to mastitis.
Inflammatory Mastitis	Ductal narrowing progresses to increasing erythematous, oedematous painful region of the breast, with systematic signs and symptoms such as fever chills, and tachycardia. An infection may or may not be present.
Bacterial Mastitis	Progresses from ductal narrowing and inflammatory mastitis and presents as cellulitis that can spread to different quadrants of the breast, with persistence systemic symptoms.
Lactational Phlegmon	A heterogeneous, complex and ill-defined fluid collection in the setting of inflammation that worsens into a firm mass like area without fluctuance.
Lactational Abscess	Progresses from bacterial mastitis or phlegmon to an infected fluid collection that necessitates drainage
Galactocele	Develops when ductal narrowing obstructs milk flow that it collects in a cyst like cavity. Presents as a firm mass and their size may increase or flocculate over the day

3. Incidence

Mastitis is a common condition in lactating people and contributes to early weaning. The incidence is as high as 3% to 20% in the first six months after birth. Most cases occur in the first six weeks but can occur at any time during lactation or pregnancy. Approximately 3 to 11% of cases of acute mastitis develop into a breast abscess (Mitchell et al., 2022).

Prompt effective management and treatment of the mastitis helps reduce the risk of a breast abscess developing and early weaning.

4. Pathophysiology of mastitis

Scientific evidence now demonstrates that mastitis encompasses a spectrum of conditions resulting from ductal inflammation and stromal oedema i.e. ductal narrowing, inflammatory mastitis, bacterial mastitis, phlegmon, abscess, galactocele, and subacute mastitis. The breast is a gland comprised of multiple alveoli, which produce milk, and have a complex and interlacing series of

ducts, which transfer the milk to the nipple. When these ducts become narrowed, removal of milk becomes obstructed, and mastitis can develop. These ducts can be narrowed by both internal obstruction (caused by an accumulation of bacteria, dead cells, and cholesterol) and by external pressure, and pressure from inflammation of surrounding tissue.

The lactating breast is a dynamic gland that responds to internal and external hormonal stimulation. Compared with a static repository such as the urinary bladder, the breast requires feedback inhibition to regulate milk production. Reducing milk removal may transiently increase pain and erythema from alveolar distention and vascular congestion; however, it ultimately prevents future episodes as feedback inhibitor of lactation (FIL) and other regulatory hormones activate and decrease milk production (Fernández, 2020).

Mammary dysbiosis, or disruption of the milk microbiome, results from a complex interplay of factors, including maternal genetics and medical conditions. These factors contribute to the development of mastitis: hyperlactation/oversupply, exposure to antibiotics, use of probiotics, use of a nipple shield, regular use of breast pumps, caesarean births and other circumstances that alter the milk's microbiome (Fernández, 2020).

If ductal narrowing and alveolar congestion are worsened by overstimulation of milk production, then inflammatory mastitis can develop, and acute bacterial mastitis may follow. This can progress to phlegmon or abscess, particularly in the setting of tissue trauma from aggressive breast massage. Subacute mastitis occurs in the setting of chronic mammary dysbiosis, with bacterial biofilms narrowing ductal lumen (Fernández, 2020; Johnson et al, 2020).

5. Management of Mastitis Spectrum conditions

The diagnosis of mastitis is based on clinical signs and symptoms and these can develop rapidly. Both infectious and non-infectious mastitis present with symptoms suggestive of an infection even in the absence of a causative organism. In both types, the symptoms may be severe enough to indicate treatment with antibiotics (Mitchell et al., 2022).

5.1 Diagnosis

5.1.1 Signs and symptoms of mastitis

- Painful, red, hot, swollen area of breast, it may be wedge-shaped
- Skin may be red, shiny and tight with red streaks
- Temperature of 38.5°C or greater
- Flu-like symptoms.

5.1.2 Assessment

- Comprehensive breastfeeding history
- Examination of breasts and nipples
- Temperature, pulse, and respirations (TPR), blood pressure (BP)
- Document management and treatment recommendations in clinical record.
- *Observe a breastfeed
- *Oral examination of the infant including TABBY (Tongue-tie and breastfed babies) assessment

**A lactation consultant (LC) can be called via the switchboard to undertake a breastfeeding assessment and TABBY-tongue tie assessment if the baby is with the mother.*

Hours Monday to Friday 7.00-15.00, phone 021 869 485 (there is limited cover over the weekends). Alternatively email can be sent to WHlactationservice@adhb.govt.nz if no LC is

available and we will follow up ASAP. It's preferred that the baby is with the mother if she is still breastfeeding.

5.2 Investigations

Routine investigations on admission if patient has temperature > 38.5°C

- Bloods - Urea and Electrolytes (U&Es), Full Blood Count (FBC) and C-reactive protein (CRP).

Milk cultures are not routine and guidance suggests breast milk culture and sensitivity are done only if:

- Mastitis is severe and recurs or has an unusual presentation
- If there is no response to antibiotics within two days, to evaluate for resistant or less common pathogens such as Staphylococcus aureus (MRSA) or if the patient is allergic to the usual therapeutic antibiotics.
- How to collect breast milk culture:
 - Clean the nipple and areola: Both a topical antiseptic solution and washing with warm water and soap with air-drying have been proposed. There are no data to determine which is better to remove skin flora while preserving the integrity of the nipple and areolar skin.
 - Use sterile gloves to express milk.
 - Collect 5–10 mL milk in a sterile container.
 - No contact should be made between nipple and sterile container.
 - Send as “body fluid culture” rather than “wound culture.”
(Mitchell et al., 2022; WHO, 2000)

5.3 Treatment of mastitis

Evidence now suggests that it is best to reduce inflammation of the surrounding tissue and down regulate the milk supply in the affected breast rather than over stimulating the supply by excessive breastfeeding and pumping to drain. Overstimulation of milk production exacerbates ductal narrowing, oedema and alveolar congestion and inflammatory mastitis may progress to acute bacterial mastitis.

- Icepacks can be applied for 10 minutes, at 30-minute intervals and prn
- Administer regularly anti-inflammatory medication i.e. ibuprofen
- Adequate pain relief i.e Paracetamol, or morphine if pain is severe. Codeine phosphate is contraindicated in breastfeeding people.
- Avoid restrictive undergarments and clothing. Tubi grip stockinet can reduce oedema and provide non-restrictive support.
- Rest the breast - DO NOT try to drain the breast by pumping or by excessive breastfeeding (the Feedback Inhibitor of Lactation (FIL) will stop the build-up of milk behind the blockage).
- Do not over stimulate the milk supply, physiological breastfeeding or only express what baby needs.
- Support rooming-in; the infant remains with the mother.
- The baby may continue to feed from the affected breast, if milk is flowing easily from other areas of the breast. If the pain is impacting on the let-down reflex, commence feeding on the unaffected breast then swap back to the affected side once milk is flowing. If baby won't or can't latch, commence hand expressing or physiological pumping on affected breast.
- Allow let down to flow if this occurs while baby is feeding on the other breast.
- Hot showers and heat is not recommended as this may exacerbate inflammation.
- DO NOT massage the inflamed area. This will result in further tissue damage and further inflammation.
- Regular lymphatic drainage prior to feeding/expressing may help reduce inflammation. i.e. GENTLE strokes of the breast, from the nipple towards the clavicle and axilla, whilst the woman is lying supine or semi reclined, for 10 min before breastfeeding or expressing.



- Reduces swelling by assisting movement of lymph fluid, decreasing edema
- Technique
 - "Very gentle touch/traction of skin - "like petting a cat"
 - The purpose is to lift skin to allow flow of lymphatic drainage and vascular decongestion
 - Ten small circles at junction of internal jugular and subclavian veins
 - Ten small circles in axilla
 - Continue with light touch massage from nipple towards clavicle, axilla
- Start during pregnancy if experiencing painful rapid breast growth, and use as needed postpartum for engorgement

PhysicianGuideToBreastfeeding.org

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- Sunflower or soy lecithin 5–10 g daily by mouth may be taken to reduce inflammation in ducts and emulsify milk. (Mitchell 2020)(Chan 2003). **Note:** lecithin and dietary supplements are not regulated by Medsafe and not funded for use in hospital or community in New Zealand.
- Ultrasound scan (USS) is needed if an abscess is suspected.
- Therapeutic ultrasound uses thermal energy to reduce inflammation and relieve oedema. It is performed by trained physician or physiotherapist daily until relief is achieved (breast setting is 1 MHZ intensity and 2.0W/cm² for five minutes) (Mitchell et al., 2022)
- Intravenous (IV) fluid therapy may be required if clinically dehydrated and there is a tachycardia.
- Patients are not advised to stop abruptly breastfeeding or wean at this time. Best practice if a patient wishes to wean, is to do so slowly once they have recovered. If supply is significantly reduced and the patient wishes to wean, do not increase breastfeeding on the affected side or expressing to increase supply if weaning is in progress.
- Mothers should be reassured their baby will not be harmed by breastfeeding during mastitis.
- Monitor the adequacy of the milk supply by observing the infants' output and weight. Depending on the severity of the mastitis, supplementary feeds may need to be considered if milk supply is significantly compromised (Mitchell et al., 2022).
- Provide patient information sheet *Mastitis – Breast Infection* available from <https://www.nationalwomenshealth.adhb.govt.nz/assets/Womens-health/Documents/Mastitis-information-sheet-February-23-WH059.pdf>. See [Appendix 1](#) for example of pamphlet.

Note: Breast pumps can be loaned from Ward 98 if required, phone 24980 to request one. When using a breast pump, it is vital to ensure that the funnel of the pump attachment is the correct size, so as not to cause nipple pain and trauma. The nipple should not touch the sides of funnel during expressing or have too much breast pulled into the funnel. Sizes available are 21mm, 24mm, 27mm, 30mm, 36mm. Clean equipment with hot soapy water after each use and sterilise in Sterinova 1 tablet daily.

5.3.1 Pharmacological treatment

If symptoms of mastitis are mild and have been present for less than 24 hours, conservative management as above may be all that is required for resolution. However, if symptoms are not

improving within 12-24 hours or the woman is acutely ill, antibiotics should be started, and the patient should seek urgent advice from the Lead Maternity Carer (LMC) or General Practitioner (GP).

Women who are unwell and have signs of systemic sepsis are to be admitted for treatment with IV antibiotics and continue until substantial clinical improvement. Daily review of antibiotics should be undertaken with a change to oral therapy to complete the course.

Antibiotic therapy for mastitis and breast abscess:

All listed antibiotics are compatible with breastfeeding	
Treatment duration should be five days	
First line:	
Route	Medicine
Oral	Flucloxacillin 1 g three times a day
IV	Flucloxacillin 1 g 6 hourly
If patient is allergic to penicillin (except delayed hypersensitivity):	
Route	Medicine
Oral	Cefalexin 500 mg 6 hourly
IV	Cefazolin 1 gm 8 hourly
If patient has a history of delayed penicillin hypersensitivity:	
Route	Medicine
Oral	Clindamycin 450 mg 8 hourly (Infectious Disease approval required)
IV	Clindamycin 600 mg 8 hourly (Infectious Disease approval required)

5.4 Follow up and recurrent mastitis

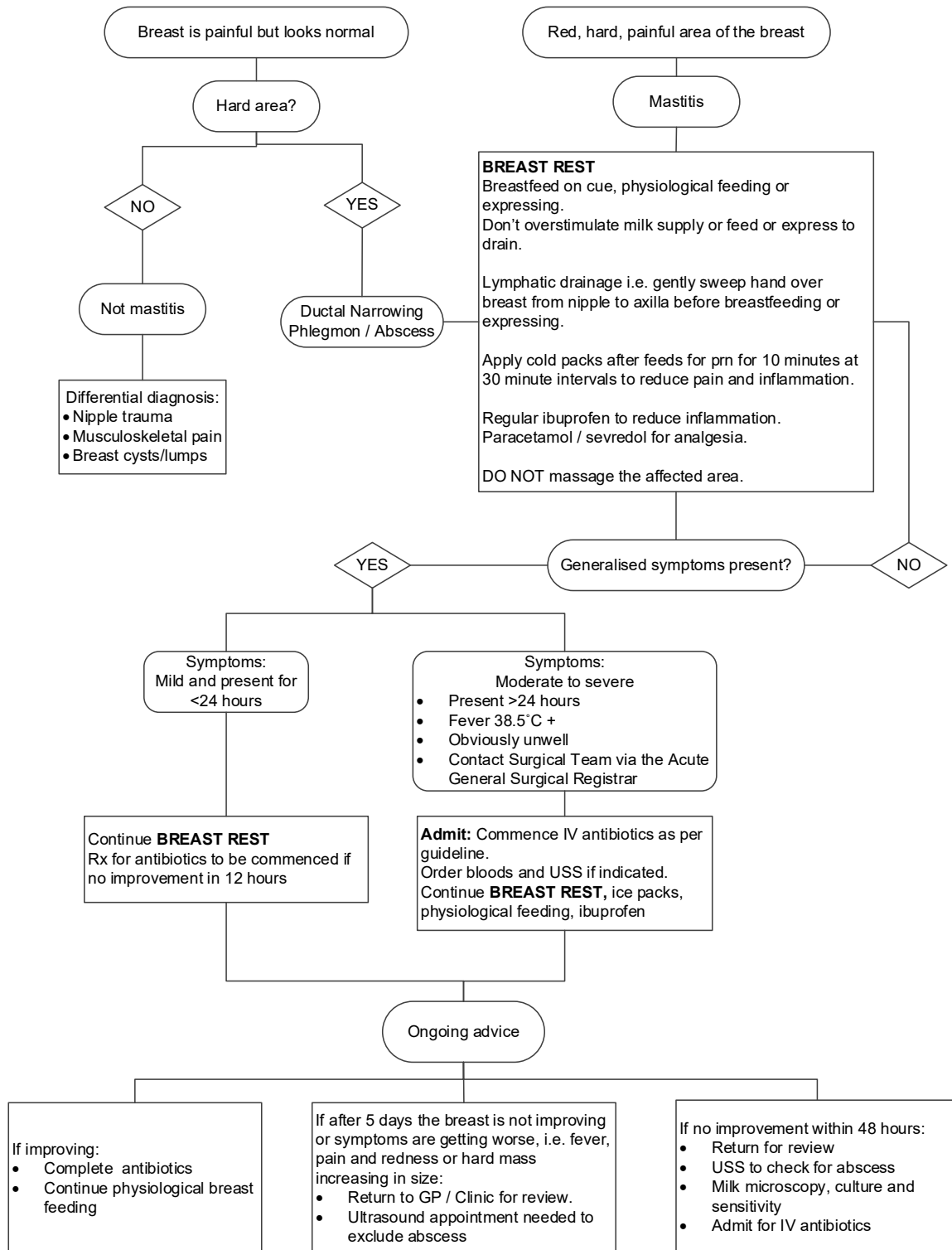
- Clinical response to the above management is typically rapid and dramatic.
- Follow up should be with Lead Maternity Carer, GP or lactation consultant.
- Recurrent mastitis may occur if there are continued unresolved issues with oversupply. Mothers who experience persistent high milk production despite eliminating iatrogenic causes of excessive milk removal may require additional pharmacological treatment for hyperlactation (Johnson et al., 2020)
- If symptoms fail to resolve, or there are more than two or three recurrences of mastitis in the same location, evaluation and ultrasound investigation is required to rule out an underlying mass, abscess formation, inflammatory or ductal carcinoma. The following tests should be conducted:
 - Milk Culture
 - Referral for ultrasound (at Mammography Department, Level 6, Greenlane Clinical Centre)
 - Bloods - urea and electrolytes, full blood count, c-reactive protein.
 - Referral to breast clinic as clinically indicated by results.

5.5 Mastitis care pathway

Points of entry into the mastitis care pathway may be via:

- Adult Emergency Department (AED)
- Clinical Decision Unit (CDU)
- Women's Assessment Unit (WAU)

5.5.1 Assessment and management of lactating women presenting with breast pain and possible mastitis



Source: The Royal Women's Hospital, Melbourne

6. Management of Breast Abscess

Approximately 3% to 11% of mastitis cases result in a breast abscess. If the initial systemic symptoms and fever have resolved, but a well-defined area of the breast remains hard, fluctuant, red and tender, despite appropriate management, then an abscess should be suspected. (ABA 2020)

6.1 Diagnosis

6.1.1 Signs and symptoms of breast abscesses

- Well-defined fluctuant lump in the affected breast
- Pain in the affected breast
- Redness, swelling, and tenderness in an area of the breast
- Fever and malaise may or may not be present
- Enlarged axillary lymph nodes.

6.1.2 Assessment

- Women who present with an encapsulated abscess may have no systemic symptoms but will present with a breast lump and usually describe a recent episode of mastitis.

6.2 Investigations

- All confirmed or suspected breast abscesses should either be referred for an USS, or admitted into hospital for appropriate management, treatment and referral.
- Refer to the Breast Care team via the acute general registrar and lactation consultant, and the Obstetric team if under 6 weeks postpartum. See [Appendix 2: Referrals to breast care team flowchart](#).

6.3 Treatment of breast abscess

- Diagnostic breast ultrasound to check for an abscess at Mammography Department, Level 6, Greenlane Clinical Centre, or Ultrasound Level 9 Te Toka Tumai
- Aspiration under local anaesthetic with ultrasound guidance is the preferred approach for management of lactation breast abscess.
- Serial aspirations may be necessary which are diagnostic as well as therapeutic.
- Send the aspiration for culture and sensitivity.
- Management of breast abscess following aspiration is per management of mastitis.

6.4 Surgical management

- Surgical drainage and placement of a drain maybe necessary if the abscess is very large and does not respond to aspiration, or if there are multiple abscesses or associated skin breakdown. Careful consideration of surgical incision placement is important for aiding independent drainage and to avoid the fifth and sixth intercostal nerves supplying sensation to the nipple and feedback for let-down of milk. If possible avoid the areola and nipple area, so breastfeeding and/or expressing can continue unhindered post procedure.
- If no drain is needed post operatively the wound can be covered with an absorbent foam dressing (such as Mepilex®) or a clear waterproof dressing. If there is a large wound loose packing with ribbon dressing (such as Aquacel®) may be required with regular changing of the packing to allow healing by secondary intention.
- Refer to district nurses or GP to provide on-going care of the wound once discharged from hospital.
- Antibiotics should follow drainage of abscess.

6.5 Breastfeeding following aspiration / surgical drainage

- Positioning of the baby may need to be modified to avoid pressure on the aspiration/ incision site.
- If the baby is unable to feed directly from the affected area, the breast should be expressed in response to infant feeding until breastfeeding can resume.
- It is important to note that the breastfeeding infant's mouth should not come into contact with purulent drainage or infected tissue.
- The lactation consultant may need to be involved in patient's discharge planning, management and care.

7. Supporting evidence

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8. Associated documents

- Breastfeeding Policy
- Breastfeeding and Anaesthesia
- Hand Hygiene - Infection Prevention
- Sepsis during pregnancy and postpartum
- Storage, handling and thawing of expressed breast milk (EBM)
- Mastitis – Breast Infection patient information sheet available from <https://www.nationalwomenshealth.adhb.govt.nz/assets/Womens-health/Documents/Mastitis-information-sheet-February-23-WH059.pdf>

9. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Te Toka Tumai Auckland guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

10. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed **before** the scheduled date, they should contact the owner or [Document Control](#) without delay.

Appendix 1: Patient information sheet

Available to download from <https://www.nationalwomenshealth.adhb.govt.nz/assets/Womens-health/Documents/Mastitis-information-sheet-February-23-WH059.pdf>

Te Whatu Ora
Health New Zealand
Te Toka Tumai Auckland


Mastitis - Breast Infection

Mastitis is an infection /inflammation of the breast. Your breast has lots interwoven tubes (ducts) carrying the milk to the nipple. They can get narrowed or blocked, and then the breast may get sore lumps that are swollen and red. This is the start of mastitis, and it's most often caused by having too much milk. If it goes untreated it can become an infection in the breast. Recently the way we treat and help you recover from mastitis has changed this is the latest information.

What is mastitis?

- Breast swelling with warm painful, red areas and lumps
- You are likely to feel unwell, hot and cold, achy and shivery
- You may have a fever over 37.5 (sometimes mastitis feels similar to getting the flu)

** If you have symptoms of mastitis under six weeks post birth contact your Lead maternity Carer-LMC immediately, over 6 weeks post birth see your GP.*



Mastitis examples

Breastfeeding with Mastitis

- Keep breastfeeding your baby, this is not a good time to stop.
- Offer both sides as you would normally but **be careful to not overstimulate milk production in the affected breast.**
- Keep breastfeeding from the sore breast if baby will nurse and milk is flowing freely.
- It is ok if the let-down milk comes out from the sore breast. Allow it to flow.
- If baby won't take the sore side, try some hand expressing or brief gentle pumping **only** if the milk is flowing.
- As things improve, baby will be able to come back to feeding both sides.
- If you are only pumping for your baby, just pump as normal, just what baby needs, (not more than usual).
- It is safe for baby to keep breastfeeding when you have mastitis and are taking pain relief or antibiotics. No harm will come to baby.

Do these things to help heal your mastitis

- Apply icepacks to breast lumps not the nipple (for 10 minutes every 30 min initially)
- DO NOT massage the lumps down towards the nipple, it may make it worse.
- DO NOT pump to drain after breastfeeding; we want to **decrease** the milk supply.
- Avoid heat, it can increase swelling.
- Take Ibuprofen, it can reduce swelling (200-400mg 6hrly with food as needed)
- Take paracetamol for fever and pain (1gm 6hrly as needed)
- Wear a supportive top or bra between feeds if this helps.
- Rest up, eat and drink and get support around the house and with baby if you can.

Women's Health Information Unit info@adhb.co.nz Unique ID: WH059 Version: Date published: Reviewed: February 2023 Authorized by: Te Kāwanatanga o Aotearoa New Zealand Government

Haere Mai Welcome | Manaaki Respect | Tūhono Together | Angamua Aim High

Do Lymphatic Drainage: Gentle breast stroking helps to reduce swelling. Do this while lying back, with very light gentle strokes on the breast from nipple to armpit and collarbone, as shown in the picture. This can be done as often as you like, most importantly before feeding or pumping.

**Picture used with permission from Dr Katrina Mitchell*



Other things that may help

Sunflower lecithin can be taken to reduce swelling and unblock ducts; it is a very natural and a common food additive and there are no known problems or concerns taking it when breastfeeding. Daily dose 3600-4800mg a day Take 1200mg 4 times a day for 2 weeks then slowly decrease week by week. If blocked ducts have healed it can be stopped but if they reappear, taking lecithin might be needed until you stop breastfeeding.

When to get more help with Mastitis: If the above tips have not improved your symptoms within 12 to 24 hrs, or you feel unwell with a high fever, please contact your Lead Maternity Carer (LMC) if under 6 weeks post birth. If more than 6 weeks after birth, see your General Practitioner (GP).

They will likely prescribe some antibiotics 5-7 day course is recommended; please ensure you finish all the tablets.

We encourage you to keep breastfeeding. If your mastitis is severe or keeps coming back, you might need admission to hospital for IV antibiotics please seek advice from your Lead Maternity Carer (LMC) or General Practitioner (GP).

You may also like to see a lactation consultant; under 6 weeks post birth referral is via your LMC, or you can seek one privately fees apply.

Women's Health Action Breastfeeding Support directory: <https://www.womens-health.org.nz/find-your-breastfeeding-support/>

Appendix 2: Referral to Breast Team flowchart

