It’s Not Yeast: Re-classification of Candida Diagnoses in the Lactating Breast (#787800)

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BACKGROUND

• Healthcare providers treating lactating women for nipple and breast pain often attribute symptomatology to superficial or intraductal Candida infection.
• However, no definitive scientific evidence exists to support yeast as an etiologic agent in this population.
• Multiple other diagnoses may present with pain, erythema, and pruritis.

OBJECTIVE

We sought to determine the frequency of accurate diagnosis of Candida in symptomatic breastfeeding women and evaluate patterns of alternative diagnoses.

METHODS

We conducted a retrospective chart review of women referred for evaluation during lactation to a single breast surgeon between July 2016 and August 2019. Women who presented with a referring diagnosis of “yeast” were included in the analysis.

RESULTS

• Twenty five women met inclusion criteria. The mean age was 32 (range 24-43); mean weeks postpartum was 21 (range 2-72). Fifteen patients (60%) were white, while seven (28%) were Hispanic, two (8%) Asian, and one (4%) Middle Eastern.
• Patients had been diagnosed with Candida for the following complaints: nipple and/or breast pain (n=17), white nipple lesion (n=8), skin erythema and pruritis (n=4), and/or infant diagnosis of thrush (n=7). Eleven had multiple symptoms.
• All reported minimal to no improvement on any anti-fungal therapy including topical nystatin (n=11), topical miconazole (n=5), gentian violet (n=3), coconut oil (n=3), all-purpose nipple ointment (n=7), and/or oral fluconazole (n=13). Ten patients were using more than one agent.
• Due to lack of resolution, patients were referred for further evaluation.
• To establish a diagnosis and develop a treatment plan, in addition to history and physical examination (Figure 1), milk culture was obtained in four women, punch biopsy in one, and core needle biopsy in one.

• No woman was confirmed to have a diagnosis of superficial nor intraductal Candida. Final diagnoses are listed in Table 1.
• Treatment included discontinuation of anti-fungals as well as the following interventions: antibiotics and probiotics for subacute mastitis; 0.1% triamcinolone cream for nipple blebs and dermatitis; heat therapy for vasospasm; discontinuation of pumping for hyperlactation and milk crust; and, anti-depressant and counseling for depression.
• All women experienced resolution of symptoms on definitive therapy (range 2-42 days).

CONCLUSIONS

• While lactation consultants and physicians traditionally have attributed persistent nipple and breast pain in breastfeeding to a diagnosis of Candida, this cohort demonstrates that clinicians should consider multiple other conditions in their differential, both at presentation and when patients fail anti-fungal therapy.
• Accurate, timely diagnosis is crucial as pain is a risk factor for premature cessation of breastfeeding, and prompt symptomatic resolution occurs on appropriate therapy.

Table 1. Final diagnoses of the 25 women referred for Candida.

<table>
<thead>
<tr>
<th>Final diagnosis</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subacute mastitis</td>
<td>8</td>
</tr>
<tr>
<td>Nipple bleb</td>
<td>6</td>
</tr>
<tr>
<td>Dermatitis</td>
<td>6</td>
</tr>
<tr>
<td>Vasospasm</td>
<td>2</td>
</tr>
<tr>
<td>Milk crust</td>
<td>1</td>
</tr>
<tr>
<td>Hyperlactation</td>
<td>1</td>
</tr>
<tr>
<td>Postpartum depression</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 1. Clinical appearance of nipple areolar complex of select patients.