

The resolution of a breast abscess using *Lac humanum*

Patricia Hatherly BA DipEd IBCLC BHSc(Hom)

Although it is an extremely carbon-neutral activity, the community is considerably advantaged from an economic perspective in several ways if lactation rates in the community are high. Additionally, both babies and mothers derive considerable health and psychological benefits from breastfeeding so the resolution of any breast pathology during breastfeeding is a most useful clinical outcome.²

Rarely does breastfeeding proceed smoothly as the breast contains a host of organisms that may proliferate given the ideal conditions for doing so, and a lactation offers such a possibility. Common aetiologies at that time include: missing feeds, local trauma (such as from being hit or wearing a tight bra or seatbelt or the prolonged use of a nipple shield all of which may confine the ducts), poor diet and the need for good quality rest.

Mastitis, with its symptoms of reddened indurated breast and general malaise and fever is the most common breast pathology which presents for treatment in the post partum period. The offending organisms may include: *Staphylococcus epidermidis*, *Staphylococcus aureus*, (which is usually associated with sub-clinical signs of recurring low-grade fever only), α -Haemolytic *Streptococcus*, non Haemolytic *Streptococcus*, *Enterococcus*, *Escherichia coli* and *Candida albicans*.⁶ In about 1% of cases where tuberculosis is endemic, tuberculous mastitis may occur and the infant may develop tuberculosis of the tonsils.¹ If the mastitis travels from one breast to the other it usually indicates *Streptococcus B₈* so *Streptococcinum* 200C is a useful adjunct to the chosen Simillimum.

Another possibility is a breast abscess which is, however, a rare event. The definitive clinical sign is a localised, pale pink circumscribed area under which lies an indurated white area that is tender and warm to touch. Unlike mastitis there is generally an absence of fever and malaise. The symptoms are local and confined to the breast alone and it is often associated with throbbing pain.

This can be treated with *Silica* 200C. However, with this approach, resolution is protracted. As an abscess is an indication that the Vital Force has walled off the infection (most likely a streptococcal infection), personal clinical experience suggests that the most practical and expeditious resolution to the problem is to give the indicated Simillimum and refer the woman for surgery.

Best-practice treatment usually involves a small incision into which a drain is introduced. In some instances where the incision has been extensive due to the abscess being deep-seated, severing of a duct may occur. Usually the wound is packed. However, if it is not, this may result in the troublesome loss of milk through the incision site during breastfeeding. Once the drain is removed the mother can apply a sterile gauze pad to the wound and hold it firmly during a feed. She can continue to breastfeed, and complete healing usually takes 3-4 weeks and can be assisted with the use of *Calendula* 12 C taken orally and (if necessary) *Calendula* tincture applied topically as a lotion. Care needs to be taken with the use of *Calendula* with it only being employed after the removal of the drain and when the wound needs no longer to be packed daily with sterile gauze.

With a more superficial abscess (and if a post-surgical pump of the breast shows no frank pus in the ducts), feeding can resume immediately. If a purulent discharge from the ducts persists, regular pumping of the breast (with discarding of the milk) is necessary until the milk runs clear. This usually only takes a few days after which, feeding can resume from the affected breast. Meanwhile breastfeeding may proceed from the non-affected breast.

The mother can be well supported through this by the administration of the appropriate Simillimum. Both *Hepar sulph* and *Silica* in low potencies are useful if the ducts discharge pus. Clinical observation can describe the *Hepar sulph* discharge as being distinctly cheesy in both texture and smell while that of *Silica* is thick, yellow-green and perhaps blood-streaked. Although I have not used it in this instance, *Myristica seb* is another possibility.³

Farokh Master has, however, reported the successful use of *Lac humanum* in curing a breast abscess without the need for surgery⁷ and I can confirm this with the case highlighted below.

The Case:

A lady 21 years old, of tiny stature and a *Calc-sil* constitution, came for assistance with mastitis associated with the use of a nipple shield because there have been on-going attachment issues following the birth of her daughter, a month previously.

The pregnancy (although unplanned and with the added complication of her being a Uni student having just moved in with her boyfriend) went well. The birth was uneventful; a 6 hour labour followed by a 1 hour second stage. No drugs were used and the baby had no vaccinations. Her milk took 5 days to come in but the baby was back to her birth weight within 10 days. The baby is accepting the breast well just so long as her mother uses a nipple shield.

She's presented with a reddened shiny area situated medially above the nipple of the left breast. It's been there for 10 days and she's tried *Phytolacca* 200C 4x daily as a water potency (with succussions) for the past week. For the past few nights she's also been using a cabbage poultice over the area during sleep.

She has a headache which she particularly notices at night when she wakes to feed the baby. It's across her forehead and into her temples. It is not better by sleep.

She's been trying to increase her water intake but isn't particularly thirsty. During the pregnancy she craved milk. However now she's craving sweets ++; chocolate; lollies; marshmallows; chocolate cake; apple strudel and custard...comfort food.

She's constipated and needs prunes to help her move her bowels which occurs every 2-3 days. This is her usual pattern and her bowels have always been sluggish. Another symptom that persists is a ganglion on her left wrist.

She's been dreaming of the baby. A re-occurring dream is of waking to feed her and not remembering just where she'd put her.

Emotionally she's distraught and not coping without her mother who had come each day to support her during the early days but is now pulling back. She usually copes well and has a good sense of herself..."I hate being ignored" is how she described herself to me when we met a year previously when I took the initial case.

Although "mastitis following parturition" is a keynote for *Phytolacca* it is my clinical experience that this occurs in the first week when oedema proliferates as a consequence of the extra maternal blood volume re-routing itself to the breasts to facilitate lactogenesis which is hormone-driven. In women with non-elastic breast tissue and/or a sluggish lymphatic system, mastitis often results at that time and is well-addressed with *Phytolacca* 200C used aggressively in a water potency.³

Since a month has passed and she has no generalised symptoms of mastitis which include fever, body aches and increased thirst, I diagnosed that she had an abscess and we discussed her options.

Generally I refer such patients off for surgery since the Vital Force has walled off the infection and the surgery is fairly straightforward and the baby can go back to the breast quite quickly. Giving *Silica* in low potency following the surgery helps to facilitate drainage from the affected area in the breast. I use 6C in a water potency tds with succussions and then may follow it with *Calendula* 12C to facilitate granulation.

She was distraught at this suggestion as she didn't want to go back to hospital. Generally she found the midwives were of little help to her regarding how to care for her baby following the birth and she was very grateful that her mother moved in for a week to nurture her and show her how to look after her baby. At the beginning of the second week her husband went back to work and her mother pulled back slightly to give her a reality check. The realisation that this is for real hit her about then with the added complication of knowing that, by having a baby, she'd isolated herself from her friends/peer group since they were all still carefree Uni students.

She told me "my mother is my only friend at the moment" and there was obvious resentment about her pulling back. It was at this time that the abscess (indurated anger) began to form.

Since this was a clear-cut case of *Lac-h* and since Farouk Master has suggested it in a 200C for breast abscess, I decided to treat her homoeopathically as she did not want to go back to hospital. I advised an ultrasound and she went and had one the next day.

Rationale for the Simillimum:⁵

Anger towards mother

Isolation from the group

Ego (usually strong) detached from, and in need of nurturing herself

Desire for sweets; comfort food and her strong desire for milk

Aching in forehead and temples

Dreams of the baby, and breastfeeding

Cancer miasm is indicated in the dream of loss/misplacement and the ganglion and there's cancer on her father's side with both his parents having died from cancer.

Rx: 1/3/06 *Strep* 200C alternating with *Lac-h* 200C tds for 3 days
The next day the area gathered into a pussy lump which was sore and angry.
The next day it burst with pus and blood oozing out.

I then changed the prescription to *Silica* (low potency) and she was given 30C which was the lowest that her mother had to hand; (I would have preferred 6C or 12C) tds in a water potency.

The area began to leak milk the next day which is a sign that the pocket of pus had cleared. Within 2 days the area began to scab over and no more medicine was given and the area healed nicely leaving a small scar. At no time was feeding disrupted and she breastfed with no further problems until her baby was 18 months old.

References:

- (1) Gupta R et al, 1982, Tubercular mastitis *Int Surg* 67: 422
- (2) Hatherly P, 2004, *The Homœopathic Physician's Guide to Lactation* Luminoz Pty Ltd Brisbane pp 55-82
- (3) *ibid* p134
- (4) *ibid* p132
- (5) Houghton J, Halahan E, 1992, *The Homœopathic Proving of Lac humanum*, self-publication, United Kingdom
- (6) Marshal BR et al, 1975, Bacterial isolates from breastmilk during sporadic puerperal mastitis *JAMA* 233: 1377
- (7) Master FJ, 2002, *The Lacs in Homœopathy*, Lutra Services BV, The Netherlands p124
- (8) Schreiner RL, 1977, Possible breastmilk transmission of group B streptococcal infection (letter to the Editor) *J Pediatr* 91: 159

This paper was presented at the 6th Australian Homœopathic Medicine Conference: **Evidence and Efficacy** held in Sydney NSW 13-14th September 2008