Breastfeeding & Psychiatric Medications

Given the prevalence of psychiatric illness during the postpartum period, a significant number of women may require pharmacological treatment while nursing. Appropriate concern is raised, however, regarding the safety of psychotropic drug use in women who choose to breastfeed while taking these medications. While many women with postpartum illness delay treatment because they are worried that the medications they take may harm the nursing infant, the accumulated data indicates that the risk of adverse events in the nursing infant is low.

General Principles

Given the many benefits of breastfeeding, some women taking psychiatric medications may wish to nurse their infants. When making this decision, several variables must be considered. These include the known and unknown risks of medication exposure for the baby via breast milk, the effects of untreated illness in the mother, and the benefits of and maternal preferences for breastfeeding. There are established health benefits of breastfeeding for babies and mothers.

Efforts have been made to quantify the amount of psychotropic medications and their metabolites in the breast milk of nursing mothers. In order to more accurately measure the infant’s exposure to medication, serum drug levels in the infant have also been assessed. From the available data, it appears that all medications, including antidepressants, antipsychotic agents, mood stabilizers, and benzodiazepines, are secreted into the breast milk. However, concentrations of these agents in breast milk vary considerably. The amount of medication to which an infant is exposed depends on several factors: factors pertaining to the specific medication, the maternal dosage of medication, the frequency of dosing and infant feedings, and the rate of maternal drug metabolism.

The decision to breastfeed while taking medications is more complicated when a baby is premature or has medical complications. The nursing infant’s chances of experiencing toxicity are dependent not only on the amount of medication ingested but also on how well any ingested medication is metabolized. Most psychotropic medications are metabolized by the liver. During the first few weeks of a full-term infant’s life, there is a lower capacity for hepatic drug metabolism, which is about one-third to one-fifth of the adult capacity. Over the next few months, the capacity for hepatic metabolism increases significantly and, by about 2 to 3 months of age, it surpasses that of adults. In premature infants or in infants with signs of compromised hepatic metabolism (e.g., hyperbilirubinemia), breastfeeding typically is deferred because these infants are less able to metabolize drugs and may be more likely to experience adverse events.

Antidepressants

Antidepressants in general are considered to be relatively safe for use during breastfeeding when clinically warranted, and SSRIs in particular are one of the best studied classes of medications during breastfeeding. Excellent and thorough reviews on the topic of antidepressants and breastfeeding have been published (Burt 2001; Weissman 2004). In the most rigorous studies, nursing women have repeatedly provided breast milk samples and infant blood samples in order for investigators to quantify medication exposure to the infant.

Data have accumulated regarding the use of various antidepressant medications during breastfeeding. Available data on the use of tricyclic antidepressants (TCAs), fluoxetine, paroxetine, and sertraline during breastfeeding have been encouraging and suggest that the amounts of drug to which the nursing infant is exposed is low and that significant complications related to neonatal exposure to antidepressants in breast milk appear to be rare. Typically very low or non-detectable levels of drug have been detected in the infant serum, and one recent report indicates that exposure to medication in breast milk does not result in clinically significant blockade of serotonin (5-HT)
reuptake in infants.

Although less information is available on other antidepressants, serious adverse events related to exposure to these medications have not been reported. There have been a small number of case reports of adverse events in infants exposed to antidepressants in breast milk, including jitteriness, irritability, excessive crying, sleep disturbance, and feeding problems. In many cases it has not been possible to establish a causal link between these events and exposure to drug.

Many clinicians and their patients ask which antidepressant is the “safest” for breastfeeding. It is somewhat misleading to say that certain medications are “safer” than others. All medications taken by the mother are secreted into the breast milk, and there is no evidence to suggest that certain antidepressants pose significant risks to the nursing infant.

In terms of selecting an appropriate antidepressant, one should try to choose an antidepressant for which there are data to support its safety during breastfeeding (i.e., sertraline, paroxetine, fluoxetine, tricyclic antidepressants). However, some situations may warrant the use of antidepressants with less available safety data. For example, if a woman has responded to a particular antidepressant in the past, it would be reasonable to consider using that antidepressant again. If she has been taking an antidepressant during the course of her pregnancy and has been doing well, it would be prudent to continue with that same antidepressant after delivery, as switching to another antidepressant may put her at increased risk for relapse.

We do not regularly measure drug levels in the breastfeeding mother or baby; however, there may be certain situations where information on exposure to drug in the child may help make decisions regarding treatment. If there is a significant change in the child’s behavior (e.g., irritability, sedation, feeding problems, or sleep disturbance), an infant serum drug level may be obtained. If levels are high, breastfeeding may be suspended. Similarly if the mother is taking a particularly high dosage of medication, it may be helpful to measure drug levels in the infant to determine the degree of exposure.

Anti-Anxiety Agents

Given the prevalence of anxiety symptoms during the postpartum period, anxiolytic agents are often used in this setting. Data regarding the use of benzodiazepines have been limited; however, the available data suggest that amounts of medication to which the nursing infant is exposed are low. Case reports of sedation, poor feeding, and respiratory distress in nursing infants have been published; however, the data, when pooled, suggest a relatively low incidence of adverse events in infants exposed to benzodiazepines in the breast milk.

Mood Stabilizers

For women with bipolar disorder, breastfeeding may pose more significant challenges. First, on-demand breastfeeding may significantly disrupt the mother’s sleep and thus may increase her vulnerability to relapse during the acute postpartum period. Second, there have been reports of toxicity in nursing infants related to exposure to various mood stabilizers, including lithium and carbamazepine, in breast milk.

Lithium is excreted at relatively high levels in the mother’s milk, and infant serum levels are about one-third to one-half of the mother’s serum levels. Reported signs of toxicity in nursing infants have included cyanosis, hypotonia, and hypothermia. Although breastfeeding typically is avoided in women taking lithium, some women may choose to use lithium while nursing. In this setting, the lowest possible effective dosage should be used and both maternal and infant serum lithium levels should be followed. In collaboration with the pediatrician, the child should be monitored closely for signs of lithium toxicity, and lithium levels, thyroid stimulating hormone (TSH), blood urea nitrogen (BUN), and creatinine should be monitored every 6-8 weeks while the child is nursing.
Several recent studies have suggested that lamotrigine reaches infants through breast milk in variable doses, with infant serum levels ranging from 20%-50% of the mother’s serum concentrations. In addition, maternal serum levels of lamotrigine increase significantly after delivery, which may contribute to the high levels found in nursing infants. None of these studies have reported any adverse events in breastfeeding newborns. To read more on the safety of lamotrigine versus lithium, please reference this past blog.

One worry shared by clinicians and new mothers is the risk for Stevens-Johnson syndrome (SJS). This is a severe, potentially life-threatening rash, most commonly resulting from a hypersensitivity reaction to a medication, which occurs in about 0.1% of bipolar patients treated with lamotrigine. Thus far, there have been no reports of SJS in infants associated with exposure to lamotrigine. In fact, it appears that cases of drug-induced SJS are extremely rare in newborns. Despite the variable levels of medication found in infants in studies to date, none of these studies have reported any adverse events in the breastfeeding newborns. More research is required to assess the safety of lamotrigine in nursing infants, and decisions regarding the use of this drug in breastfeeding women involves a careful consideration of the risks and benefits of using this medication.

Although the American Academy of Pediatrics has deemed both carbamazepine (Tegretol) and valproic acid (Depakote) to be appropriate for use in breastfeeding mothers, few studies have assessed the impact of these agents on infant well-being. Both of these mood stabilizers have been associated in adults with abnormalities in liver function and fatal hepatotoxicity. Hepatic dysfunction secondary to carbamazepine exposure in breast milk has been reported several times. Most concerning is that the risk for hepatotoxicity appears to be greatest in children younger than 2 years of age; thus, nursing infants exposed to these agents may be particularly vulnerable to serious adverse events. In those women who choose to use valproic acid or carbamazepine while nursing, routine monitoring of drug levels and liver function tests in the infant is recommended. In this setting, ongoing collaboration with the child’s pediatrician is crucial.

### Antipsychotic Agents

Information regarding the use of antipsychotic drugs is limited and is particularly lacking for the newer atypical agents. While the use of chlorpromazine has been associated with adverse events including sedation and developmental delay, adverse events appear to be rare when medium- or high-potency agents are used.

Less data, however, is available on the atypical antipsychotic agents. Data on clozapine suggest that it may be concentrated in the breast milk; however, there are no data on infant serum levels, making it difficult to interpret the relevance of this finding. Given the severity of adverse events associated with clozapine exposure in adults (i.e., decreased white blood cell count), the use of this medication should be reserved for those with treatment-refractory illness, and monitoring of white blood cell counts in the nursing infant is mandatory.

There is very limited data on the use of other atypical antipsychotic agents during lactation; however, limited data available on olanzapine, risperidone, and quetiapine suggest that the excretion of these medications in breast milk is low and that adverse effects appear to be rare. Monitoring of the infant is encouraged, as there has been one report of an infant who had sedation on a higher dose of olanzapine, which resolved after the mother’s dose was halved to 5mg/day. To date, there have been no reports on the use of the antipsychotic medications, ziprasidone (Geodon) and aripiprazole (Abilify) while breastfeeding.

### Treatment Guidelines

Consultations regarding the safety of psychiatric medications in breastfeeding women should include a discussion of the known benefits of breastfeeding to mother and infant and the possibility that exposure to medications in the breast milk may occur. Although routine assay of infant serum drug levels was recommended in earlier treatment guidelines, this procedure is probably not warranted; in most instances low or non-detectable infant serum drug
levels will be evident and serious adverse side effects are rarely reported. This testing is indicated, however, if neonatal toxicity related to drug exposure is suspected. Infant serum monitoring is also indicated when the mother is nursing while taking lithium, valproic acid, carbamazepine, or clozapine.

We have varying amounts of study pertaining to individual medications, with SSRIs being among the best studied medications in breastfeeding. Also, data that is available informs most specifically on the short-term safety of these medications, and long term systematic data are unavailable. Therefore, in each individual case, the known and unknown risks of exposure must be balanced with the risks of untreated maternal illness in the mother and her desire to breastfeed.

More Information

For the latest information on breastfeeding and psychiatric medication, please visit our blog.

For additional resources related to breastfeeding please visit the Breastfeeding Library.

How do I get an appointment?

Despite the high rate of postpartum depression seen in women after childbirth, the illness is frequently not treated because of women’s wish to breastfeed. Clinical consultation is offered to women who may benefit from use of medication while breastfeeding, taking into account all available information regarding the safety of this practice during lactation. Consultations regarding treatment options can be scheduled by calling our intake coordinator at 617-724-7792.

At this time the Center does not have any active studies investigating breastfeeding and psychiatric medications. New studies may become active in the near future. In order to remain informed about any studies for which you may be eligible, click here.