

Lactation and Medication Safety

Nearly all medicines are fine during breastfeeding. Check LactMed (the free NIH database) when you are unsure.

THE ONE-LINE TRUTH

Most medicines are safe while breastfeeding — only a tiny bit gets into milk.

The chain — how it unfolds

1. Mother takes a medicine; it enters her bloodstream. — why: Any drug absorbed from the gut, inhaled, or injected travels through the blood to reach its target — and blood also feeds the mammary glands.
2. The drug diffuses from blood into breast milk. — why: Milk is made from blood, so small, fat-loving, or poorly protein-bound molecules slip across the capillary membrane into milk naturally — no pump needed, just concentration gradient.
3. The baby nurses and swallows the milk (plus trace drug). — why: Every feeding delivers a small dose to the baby. How much depends on milk concentration, how much milk the baby drinks, and how often they nurse.
4. The drug is absorbed in the baby's gut and reaches their bloodstream. — why: Some drugs break down in stomach acid or aren't absorbed well (e.g., heparin, insulin) — those are safer. Drugs absorbed intact (e.g., sedatives, antibiotics) can affect the baby.
5. The baby's immature liver and kidneys clear the drug slowly. — why: Newborns have lower enzyme activity (especially CYP450s and glucuronidation) and slower kidney filtration, so drugs hang around longer and can build up with repeated feeds.
6. Drug accumulates or causes side effects if the dose is high enough. — why: Sedatives → drowsiness, poor feeding. Antibiotics → diarrhea, rash. Morphine (from codeine) → pauses in breathing (apnea). NSAIDs (usually safe) → rare gut bleeding if high dose. The baby's small size magnifies risk.
7. The team monitors the baby and adjusts or stops the medicine if needed. — why: Signs of toxicity (lethargy, poor weight gain, rash, GI upset) prompt a safety check. Often switching drugs or timing doses solves it without stopping breastfeeding.

- 8.** In most cases, breastfeeding continues safely with the right medicine choice and monitoring. — why: Only a handful of drugs truly require weaning. The proven harms of stopping breastfeeding (more infections, allergies, less bonding, no antibodies) usually outweigh the tiny risk from medicine in milk — so the default is to keep nursing and pick a compatible drug.

Spot it — what you see, and why

- Mother needs to take medicine while breastfeeding: Many health problems (like infections, pain, or long-term illness) happen during the months or years a mother nurses her baby, so she may need treatment to stay healthy while still making milk.
- Worry that medicine will pass into breast milk: Nearly all medicines move from the mother's blood into her milk in small amounts because milk is made from blood; the amount that gets through depends on the drug's size, how it dissolves, and how tightly it sticks to proteins.
- Baby seems extra sleepy or fussy after mother takes certain medicines: Some drugs (especially sedatives, opioids, or medicines that act on the brain) can reach high enough levels in milk to make a baby drowsy, less interested in feeding, or irritable because the baby's liver and kidneys are still learning to clear drugs.
- Baby has a rash, diarrhea, or vomiting that started when mother began a new medicine: A few medicines (like antibiotics) can upset the baby's gut bacteria or trigger an allergic reaction when they pass through milk, causing rash, loose stools, or throwing up.
- Decrease in milk supply after starting a medicine: A small group of drugs (especially pseudoephedrine, high-dose estrogen birth control, or bromocriptine) can lower prolactin (the hormone that tells the breast to make milk) or dry out body fluids, so less milk is produced.
- Mother stops breastfeeding because she fears the medicine is unsafe: Conflicting advice or incomplete information can lead a mother to believe she must quit nursing, even when the drug is actually safe or a compatible alternative exists, causing unnecessary loss of breastfeeding benefits.

Red flags — act now

- Baby becomes hard to wake, feeds poorly, or breathes more slowly than usual after mother takes medicine (especially opioids, sedatives, or muscle relaxers)
- Baby develops a new rash, severe diarrhea, blood in the stool, or repeated vomiting shortly after mother starts a new drug
- Sudden large drop in milk supply or baby stops gaining weight appropriately after mother begins a medication

- Mother has a serious infection, blood clot, seizure, or mental-health crisis and is not receiving treatment because of breastfeeding concerns
- Infant is premature, under one month old, or has kidney or liver problems and is exposed to a drug that accumulates in the body

Treat it — in this order

1. Check LactMed (NIH database) for every medicine before prescribing or continuing it in a nursing mother → This tells you whether the drug passes into milk in meaningful amounts and whether it has caused harm in real babies. It replaces guessing with evidence and prevents avoidable injuries.
2. Avoid codeine and tramadol completely; use acetaminophen or ibuprofen for pain instead → Codeine and tramadol are broken down unpredictably (due to genetic variation in the enzyme CYP2D6). Some babies get dangerously high levels that slow breathing and can cause death. Acetaminophen and ibuprofen pass into milk in tiny, safe amounts.
3. Use sertraline or paroxetine (not fluoxetine) when treating postpartum depression in nursing mothers → Sertraline and paroxetine have shorter half-lives and lower milk concentrations, so less builds up in the baby over time. Fluoxetine has a very long half-life and can accumulate in the baby's blood.
4. Time medicine doses right after baby finishes nursing (when possible) → The medicine peaks in mom's blood and milk a few hours after she takes it. If she nurses right before taking the dose, the next feeding happens before the peak, so the baby gets a smaller amount.
5. Teach mother to watch for drowsiness, poor feeding, rash, fussiness, or breathing changes in the baby and report within 48 hours → Most medicine reactions in babies show up within the first few days. Early detection lets you stop or switch the medicine before serious harm happens.

Your top priorities at the bedside

1. Check the specific medicine name and dose in LactMed database before the mother takes her next dose — why: LactMed provides evidence-based data on how much medicine passes into breast milk and actual reports of infant effects, which prevents giving unsafe drugs that could harm the baby
2. Assess the baby for signs of medicine side effects including unusual sleepiness, poor feeding, irritability, rash, or any behavior change — why: Babies cannot tell us they feel sick, so observation catches early toxicity (poison effects) from medicines in breast milk before serious harm like breathing depression or dehydration occurs

3. Teach the mother to take her medicine dose right after the baby finishes breastfeeding — why: Medicine levels in blood and breast milk peak 1 to 3 hours after taking a dose, so dosing right after feeding allows time for levels to drop before the next feeding when possible