All correspondence to:
The Breastfeeding Network
PO Box 11126, Paisley PA2 8YB
Admin Tel: 0844 412 0995
e-mail: druginformation@breastfeedingnetwork.org.uk
www.breastfeedingnetwork.org.uk

Antidepressants and Breastfeeding

The information provided is taken from various reference sources. It is provided as a guideline. No responsibility can be taken by the author or the Breastfeeding Network for the way in which the information is used. Clinical decisions remain the responsibility of medical and breastfeeding practitioners. The data presented here is intended to provide some immediate information but cannot replace input from professionals.

Sertraline has the lowest passage of SSRI drugs into breastmilk. Citalopram also passes into breastmilk in low levels. If a breastfeeding mother has found an antidepressant previously prescribed of benefit, that may influence the choice of drug prescribed.

It is important that post-natal depression is recognised and treated effectively as it may impair bonding between mother and child and enjoyment of an important period in the relationship. Approximately 80% of women experience post-natal blues but some 10-15% experience more severe symptoms and need medication and or counselling and cognitive behavioural therapy. Some mothers may not immediately recognise or accept that they are depressed. Some fathers may recognise the difference in their partners. Others will deny the possibility.

The symptoms of post-natal depression may include obsessive thoughts often concerning harm to the baby, hyperactivity or lethargy, weight loss, volatility of behaviour and restlessness. Some women will express suicidal tendencies. But many symptoms are non-specific e.g. feeling of tiredness and not wanting to get up, not being able to cope as the day goes on and needing to go to bed early – could describe the natural effects of caring for a new baby 24 hours a day. Some women, particularly those who are normally natural leaders, may express concern over loss of confidence.

Most anti-depressants take three to four weeks to exert maximal efficacy and it is important that the woman is informed of this. Many patients stop taking anti-depressant medication within the first four weeks having found no benefit. Initially some medicines may also make symptoms appear worse and patients need to be aware of this to ensure concordance with the drug regime.

For information on anxiety and breastfeeding see www.breastfeedingnetwork.org.uk/anxiety/

For information on OCD and breastfeeding see www.breastfeedingnetwork.org.uk/ocd/

Selective Serotonin Re-uptake Inhibitors (SSRI)

The treatment for depression usually involves SSRIs which act by inhibiting re-uptake of serotonin into neurones in the central nervous system. The majority of manufacturers have not conducted clinical trials on the use in lactation and in the Summary of Product characteristics recommend that they are not used by breastfeeding mothers. Their use is therefore off-licence and at the discretion and responsibility of the prescribing physician.

Side effects include nausea which may be particularly marked in the early weeks of therapy, diarrhoea, headache, insomnia and agitation. It may be difficult to differentiate the side effects of the

The Breastfeeding Network is a Company Limited by Guarantee Registered in Scotland Company No. 330639
Registered office Whitelaw Wells, 9 Ainslie Place, Edinburgh, EH3 6AT
The Breastfeeding Network is a Registered Scottish Charity No SC027007

drugs from the symptoms of depression so it may seem that the drugs are not being effective in the early weeks of therapy.

Sertraline (Lustral®) – has a shorter half-life. The long half-life metabolite is only marginally active, unlike that in fluoxetine and hence is unlikely to cause accumulation in the baby. There are published studies on more than 30 infants with no untoward effects noted. In almost all cases none of the drug has been detected in the infant plasma. Reported but anecdotal, evaluation of an infant exposed to 100milligrammes daily was that the child reached normal developmental milestones and weight at 3 months. There is one report of an infant developing benign neonatal sleep at 4 months, which resolved at 6 months, it is unclear whether this bears any relationship with the maternal use of sertraline. It is normally seen as the SSRI of choice for a breastfeeding mother if she has not had a previous antidepressant which was effective for her – this would then be the drug of choice.

Citalopram (Cipramil®) – There is one report of an infant exhibiting "uneasy" sleep patterns on a maternal dose of 40milligrammes/day. This resolved when the mother's dose was reduced. There are also two reports of excessive somnolence, decreased feeding and weight loss in breastfed infants. In studies no adverse effects on the babies were noted. If the baby shows less than expected weight gain it might be prudent to discontinue the drug and change to another SSRI. It should not be given concomitantly with erythromycin or fluconazole. However, the majority of breastfed babies tolerate it well.

The milk plasma ratio has been estimated to be 1.16-3, suggesting that the drug concentrates in milk. The metabolite enters breastmilk in low levels and at a normal daily intake would produce 14.6 microgrammes/Kg/day (0.7-5.9% of the maternal dose) a very low level.

Paroxetine (Seroxat®) – One case reports levels in breast milk below the level of detection in 16 infants exposed to levels up to 50milligrammes per day (dose normally 20-30milligrammes daily) through their mother's breastmilk. There are reports of neonatal withdrawal syndrome in newborns exposed to paroxetine in utero. Symptoms include jitteriness, vomiting, irritability and hypoglycaemia. Paroxetine may be difficult to stop due to discontinuation syndrome.

Fluoxetine (Prozac®) – has a very long half-life which may in theory, lead to accumulation and high levels in the infant. It has an active metabolite. Adverse effects including increased irritability and colic have been reported. One anecdotal report linking severe colic with the use of fluoxetine has been published. Hale reports personal communications, indicating that it can cause excessive sedation if used throughout pregnancy and then in subsequent lactation. It has been recommended in the past 10 years that if it is used in pregnancy that the mother is changed onto another SSRI in the 2 weeks before expected delivery. However, this is a time when women are very vulnerable and to suggest that they change a medication which is effective drug for them at this time may not be in their best interest. If it has been taken during pregnancy the baby may be very sleepy for several days and need help to obtain full milk volumes (syringe feeding, antenatal expression of colostrum etc). Symptoms seem to resolve within 5 days (Hale). If it has been shown to be effective for a mother in the past it would be the drug of choice for her regardless of the slightly higher passage into milk (Jones 2018). It is suggested that initiation in mothers of babies more than 4 months old would appear to be compatible with breastfeeding particularly if it has been shown to be effective for that woman in the past.

Other antidepressants

Venlafaxine (Efexor®) – The dose transferred to the infant is relatively high although no adverse reports have been reported. As the drug is associated with discontinuation syndrome it would be difficult for the mother to stop abruptly. In neonates, monitoring for excessive sedation and lower than expected weight gain is advisable.

The mean total drug dose reported in the infant is 7.6% of the maternal weight adjusted dose. Metabolites have been detected at low levels but infants have shown no adverse effects and would appear able to metabolise the drug. The action is similar to that of fluoxetine but with fewer anti-cholinergic effects.

Mirtazapine (Zispin®) – Mirtazapine maybe initiated if other antidepressants have proved ineffective or not been tolerated. It may also be invaluable when poor sleep is the major symptom of depression. Mirtazapine produces fewer symptoms of sexual dysfunction that have been reported in SSRIs. It can initially cause drowsiness and abnormal dreams. Care should be taken with co sleeping as natural reactions will be lessened. In a study of 8 babies whose mothers were taking up to 120mg at night. Levels of mirtazapine were only identified at a low level in one baby and were undetectable after 12 hours.

Tri-cyclic anti-depressants

Tricyclic antidepressants have been around for a considerable period and much is known of their metabolism, safety and side effects. However. the latter can be intolerable for some patients, particularly nursing mothers. Side effects include sleepiness, dry mouth, urine retention and constipation. Care should be taken with co sleeping due to the possibility of drowsiness.

Amitriptyline – The levels measured in breastmilk are low because the drug is 94.8% bound to plasma proteins. There have been no reports of adverse effects on the baby and in one study where the mother took 150milligrammes there was no detectable drug in the infant's serum.

Clomipramine (Anafranil®) – is particularly useful for panic attacks and obsessive, compulsive disorders. In one study of 4 women taking 75-125milligrammes daily, plasma levels of clomipramine in the infants were below the level of detection. No untoward effects were noted in any of the infants.

Imipramine – has an active metabolite, desipramine. At therapeutic doses it is estimated that the baby would receive 20-200micrograms / day and no adverse effects have been noted. It would be prudent to observe the baby for sedation and dry mouth.

Lofepramine (Gamanil®) – amount in breastmilk likely to be too small to present risk to breastfed baby. No precise data on transfer is available.

The use of cognitive counselling together with anti-depressant therapy has been shown to be advantageous.

Bibliography

- American Academy of Paediatrics Breastfeeding and the Use of Human Milk ; Paediatrics 2012; 129(3): 827-841 https://pediatrics.aappublications.org/content/129/3/e827
- British National Formulary
- Hale T. W Medications in Mother's Milk
- Jones W Breastfeeding and Medication, Routledge 2018
- Jones W Perinatal Mental Health and Breastfeeding Presentation https://breastfeeding-and-medication.co.uk/live-video-2/perinatal-mental-health-and-breastfeeding-2
- Kristensen JH, Ilett KF, Rampono J et al. Transfer of the antidepressant mirtazapine into breast milk. Br J Clin Pharmacol. 2007; 63:322-7.
- Klier CM, Mossaheb N, Lee A, Zernig G. Mirtazapine and breastfeeding: maternal and infant plasma levels. Am J Psychiatry. 2007; 164:348-9.
- Maternal Mental Health https://gpifn.org.uk/maternal-mental-health/
- NICE Ante-natal and Post-natal mental health CG 45. www.nice.org.uk/Guidance/CG45

- RCGP Perinatal Mental Health Toolkit https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx