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Antidepressants and Breastfeeding

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The antidepressant of choice is sertraline. Citalopram also passes into breastmilk in low levels.

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.

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.

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 was below the level of detection. No untoward effects were noted in any of the infants.

Dothieprin (Prothiaden®) – At a dose of 75milligrammes/day a concentration of 11micrograms/L has been estimated to be consumed by the infant, equivalent to 1/650 of the adult dose. No adverse

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effects have been noted in the infants despite numerous studies. This drug is less frequently used now.

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.

Selective Serotonin Re-uptake Inhibitors (SSRI)

The newer treatment for depression involves SSRIs which have far fewer side effects than tri-cyclics and 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. They are safer than the tri-cyclics in overdose. It may be difficult to differentiate the side effects of the drugs from the symptoms of depression so it may seem that the drugs are not being effective in the early weeks of therapy.

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. He has recommended that if it is used in pregnancy that the mother is changed onto another SSRI in the 2 weeks before expected delivery. It is suggested that use in mothers of babies more than 4 months old would appear to be safe. It may be difficult to switch anti-depressants at this late stage of pregnancy.

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

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 micrograms/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.

Other antidepressants

Venlafaxine (Efexor®) – 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. 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.

Progesterone injections and pessaries

It has been suggested that post-natal depression and pre-menstrual disorder may be linked to low progesterone levels. Dr Katarina Dalton advocated the use of progesterone injections for the first 10 days after birth followed by the use of progesterone (Cyclogest®) as a suppository or pessary 400milligrammes twice a day until periods return and for the last 14 days of the cycle thereafter. This is safe to use in lactation but should be accompanied by adequate carbohydrate consumption (every two hours by day). This treatment has not been proven by double blind trials and is now somewhat controversial. However if the mother does not wish to take anti-depressant medication it may provide some support, if only at a placebo level.

Treatment depends on a risk: benefit assessment for each mother: baby pair. However it must be borne in mind that many mothers with depression report that it is the only part of their life which they feel is under their control and at which they can succeed. Advising a mother to cease breastfeeding in order to administer anti-depressant medication should be undertaken as a last resort. Should mothers need to be admitted to hospital, it should be in a mother and baby unit allowing her to continue to care for her infant.

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

Bibliography

- American Academy of Paediatrics Policy Statement; Paediatrics 2001; 108(3): 776-789
- British National Formulary
- Hale T. W Medications in Mother's Milk
- Jones W Breastfeeding and Medication, Routledge 2018
- NICE Ante-natal and Post-natal mental health CG 45. www.nice.org.uk/Guidance/CG45