Kansas Breastfeeding Coalition, Inc.

Medications in Lactation:
A resource for healthcare providers

LactMed® | www.ncbi.nlm.nih.gov/books/NBK501922/
a peer-reviewed, evidence-based database maintained by the NIH

Medications & Mothers' Milk (MMM) | www.halesmeds.com
a comprehensive text revised every 2 years. Subscription-based online and mobile app versions available

Infant Risk Center | infantrisk.com | (806) 352-2519
at Texas Tech University Health Sciences Center. Calls are answered 8am-3pm Mon-Fri
See page 2 for details on lactation risk categories (L1 – L5)

Indications to review medication safety in breastfeeding:
- During prenatal care, ideally at 28-32 weeks, to provide anticipatory guidance and assist with feeding decisions
- On admission when delivery is anticipated
- When prescribing medications for a lactating patient because non-pharmacologic therapy is not available or appropriate

If members of the care team have concerns about medication exposure, milk may be expressed and stored pending a shared decision-making discussion. ***Do not discard expressed milk until shared decision-making has occurred.***

Is the med systemically absorbed?
- No → No risk to infant, reassure lactating patient
- Yes → Review medication information from **LactMed*** and **MMM*** *(subscription required)*

Is medication an L1 or L2, with reassuring summary?
- Yes → Prescribe originally selected medication
- No → Alternative medication available with similar efficacy?
  - Yes → Prescribe alternative medication
  - No → Patient requires three or more **L3*** meds, OR any **L4/L5*** meds?
    - Yes → Call **Infant Risk Center*** (806) 352-2519
    - No → Review information with lactating patient and infant's provider. Discuss risks of drug exposure via milk vs risk of disrupting breastfeeding.

Support shared decision making:
- Continue breastfeeding with medication, OR
- Express & discard milk for duration of treatment, OR
- Initiate / continue medication and wean

Counseling and follow-up:
1. Document all provider counseling regarding breastfeeding and medication/substance use in the medical record.
2. Review information from MMM and LactMed with patient and discuss risks of infant drug exposure vs. risks of disrupting breastfeeding for both parent and infant
3. Print entire LactMed monograph and Medications & Mother's Milk summary and provide copy to breastfeeding parent to share with the infant's provider.
4. With breastfeeding parent's permission, include the infant's provider on encounter documentation so that s/he can follow infant for any side effects.
5. When breastfeeding parent is taking medication and breastfeeding:
   - Encourage her to share LactMed and MMM information with her infant's provider
   - Review common / worrisome infant side effects
   - Advise her that pharmacists may instruct her not to use the drug while breastfeeding, despite safety data
   - Provide contact number for her call with questions.
   - Consider timing the dose to minimize exposure, if possible: after feeding or before prolonged infant sleep.

Lactation Risk Categories

(Thomas Hale, PhD & Kaytlin Krutsch, PhD, PharmD)

L1 - Compatible
Drug which has been taken by a large number of breastfeeding mothers without any observed increase in adverse effects in the infant. Controlled studies in breastfeeding women fail to demonstrate a risk to the infant and the possibility of harm to the breastfeeding infant is remote; or the product is not orally bioavailable in an infant.

L2 - Probably Compatible
Drug which has been studied in a limited number of breastfeeding women without an increase in adverse effects in the infant. And/or, the evidence of a demonstrated risk which is likely to follow use of this medication in a breastfeeding woman is remote.

L3 - Presumed Compatible
There are no controlled studies in breastfeeding women; however, the risk of untoward effects to a breastfed infant is possible, or controlled studies show only minimal non-threatening adverse effects. Drugs should be given only if the potential benefit justifies the potential risk to the infant. (New medications that have absolutely no published data are automatically categorized in this category, regardless of how safe they may be.)

L4 - Potentially Hazardous
There is positive evidence of risk to a breastfed infant or to breastmilk production, but the benefits from use in breastfeeding mothers may be acceptable despite the risk to the infant (e.g., if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs cannot be used or are ineffective.)

L5 - Hazardous
Studies in breastfeeding mothers have demonstrated that there is significant and documented risk to the infant based on human experience, or it is a medication that has a high risk of causing significant damage to an infant. The risk of using the drug in breastfeeding women clearly outweighs any possible benefit from breastfeeding. The drug is contraindicated in women who are breastfeeding an infant.

Medications in Lactation Quick Reference

Common scenarios in which breastfeeding and/or use of breast milk should NOT be interrupted.

General anesthesia
"Mothers with healthy term or older infants can generally resume breastfeeding as soon as they are awake, stable, and alert. Resumption of normal mentation is a hallmark that medications have redistributed from the plasma compartment (and thus generally the milk compartment) and entered adipose and muscle tissue where they are slowly released." [1] If a lactating patient is undergoing a surgical procedure, it is optimal to feed or pump right before surgery, and then feed or express milk 2-3 hours later to prevent engorgement. Morphine is the preferred narcotic for breastfeeding patients due to its poor bioavailability.

IV contrast studies
The American Academy of Pediatrics [2], the American College of Obstetricians and Gynecologists [3,4], and the American College of Radiologists [5] concur that lactation need not be interrupted after IV contrast for CT or MRI studies. *"Because of the very small percentage of iodinated or gadolinium-based contrast medium that is excreted into the breast milk and absorbed by the infant's gut, the available data suggest that it is safe for the mother and infant to continue breast-feeding after receiving such an agent."* [5] Radioactive compounds may require temporary cessation depending on half-life. See LactMed or MMM for details on specific agents.

Anticipatory guidance for prenatal consults
For general messaging on medication compatibility for breastfeeding, consider the following*: "Although many medications pass into breast milk, most have little or no effect on milk supply or infant well-being. A few medications should be avoided."* [6] Follow with guidance specific to the patient's medication needs and engage in shared decision-making.

Substance use [6,7]

Smoking, social alcohol use, and opiate replacement therapy are not contraindications to breastfeeding. A mother with active use of other substances should be counseled by her provider and the infant's provider regarding risks and benefits of continued lactation. This discussion should be documented in the chart by the physician or midlevel provider, and the resulting decision communicated to the lactation and/or nursing team.

Maternal infectious diseases and breastfeeding [2,6]

Permanent contraindications

- HIV+ and not on antiretroviral therapy (ART) or are on ART but have not achieved sustained viral suppression during pregnancy
- Human T-cell lymphotropic virus type I/II
- Suspected or confirmed Ebola virus disease

Temporary contraindications

- Active, untreated brucellosis
- Active, untreated varicella
- Active, untreated Mpox virus
- Active HSV lesion on the breast. May feed from other breast if clear of lesions
- Hepatitis C in the presence of bleeding nipples. Express and discard milk until nipples are healed.
- Active or suspected pulmonary TB. Milk may be expressed and fed to the infant by a non-infected person until the breastfeeding patient has been treated sufficiently and considered non-contagious.

References:

1) Academy of Breastfeeding Medicine. ABM Clinical Protocol #15: Analgesia and anesthesia for the breastfeeding mother, rev 2017. *Breastfeed Med.* 2017;12(9).
2) American Academy of Pediatrics. Policy Statement: Breastfeeding and the use of human milk (2022).
3) American College of Obstetricians and Gynecologists. Optimizing support for breastfeeding as partof obstetric practice. Committee Opinion No. 756. Oct 2018.
4) American College of Obstetricians and Gynecologists. Guidelines for diagnostic imaging during pregnancy and lactation. Committee Opinion No. 723. Oct 2017.
5) American College of Radiology. ACR Manual on Contrast Media. 2025.
6) Centers for Disease Control and Prevention. Contraindications to breastfeeding. Accessed 11/5/2025. https://www.cdc.gov/breastfeeding-special-circumstances/hcp/contraindications/index.html
7) Academy of Breastfeeding Medicine. ABM Clinical Protocol #21: Breastfeeding in the setting of substance use and substance use disorder, rev 2023. *Breastfeed Med.* 2023;18(10).

Seeking breastfeeding support in your area?

Kansas Local Breastfeeding Resource Directory:
www.ksbreastfeeding.org/local-resource-directory
(searchable by zip code)

Contributing Partners:

UNC School of Medicine | The University of Kansas Health System | High5 for Mom & Baby

This algorithm is designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities. The algorithm remains the intellectual property of the University of North Carolina at Chapel Hill School of Medicine (UNC) and has been adapted with UNC's permission by the Kansas Breastfeeding Coalition.

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