Breastfeeding and Medication

Antibiotics and Breastfeeding

Babies exposed to antibiotics through their mother's milk may become temporarily lactose intolerant exhibiting loose bowel motions, sometimes colicky pains and sometimes vomiting. This does not mean that breastfeeding needs to be interrupted as the mother will also be passing on antibodies to the infection that she has. It may, however, be distressing.

Some antibiotics effect babies more than others.

Some individual babies respond more acutely than others.

The table below shows the compatibility of commonly prescribed antibiotics with breastfeeding.

Antibiotics are acknowledged to be overused which is one of the reasons that Multiple Resistant Staphylococcus aureus (MRSA) and Clostridium difficile have become more widespread. It is sensible to consider whether a mother needs to be treated with antibiotics before exposing both her and her breastfed baby. Babies exposed to antibiotics via their mother's breastmilk may develop symptoms of colic, abdominal discomfort and diarrhoea. These are an inconvenience and not a reason to suspend breastfeeding.

Research undertaken in Canada in 1993 (Ito et al. 1993) showed that 15% of women prescribed antibiotics chose not to take the medicine and continue to breastfeed, rather than expose their baby to a risk which they had been assured was minimal. By contrast, 7% stopped breastfeeding during therapy despite reassurance. The research team also examined the reporting of adverse effects by mothers made aware of potential diarrhoea in the child with antibiotics passing through breastmilk. Although more women warned of side effects reported clinical effects which they had noted and judged to be due to the medication, than those not made aware, the difference is not statistically significant (87% compared with 68%). No difference in compliance with the antibiotic regimen or breastfeeding pattern, were noted between the two groups (Taddio et al. 1995).

Delayed prescriptions for antibiotics may be useful in minimising exposure of mother and child. These follow recommendations from the doctor that the 'infection' may be self-limiting but if symptoms develop further or fail to resolve in the following 48 hours, then the course of antibiotics should be taken. Little et al. have suggested restricting the use in the treatment of otitis media, upper respiratory infection and sore throat ((Little 2002; 2005; 1997) beginning the public health message about reducing the use of antibiotics. It may also be useful in the management of mastitis.

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Compatability of antibiotics during lactation		
Penicillins		
penicillin V, amoxycillin, co-amoxiclav, co-fluampicil, flucloxacillin		licensed for use in children
Cephalosporins		
cefaclor, cefalexin, cefadroxil, cefradine, cefuroxamine		licensed for use in children
Macrolides		
erythromycin, azithromycin, clindamycin, clarithromycin		Observe for pyloric stenosis in neonates but current evidence is that the risk is low.
Aminoglycosides		
Gentamycin:	oral bioavailability <1%	will only pass into milk in first few days
Vancomycin	oral bioavailability negligible	will only pass into milk in first few days
Teicoplanin	no studies but oral bioavailability low	licensed for use in children
Quinolones		
Ofloxacin	plasma protein binding 32%, oral bio-availability 98%, relative infant dose 3.1%	Avoid if possible because studies limited
Levofloxacin	enantiomer of ofloxacin, relative infant dose 10.5% - 17.2%.	Avoid if possible.
Moxifloxacin	no studies	Avoid if possible
Norfloxacin	no studies	Avoid if possible
Ciprofloxacin	plasma protein binding 40%, oral bio-availability 50-85%, relative infant dose 0.44% - 6.34%	Given directly to young rats causes a type of juvenile arthritis but not seen in the amount passing through breastmilk. Chaelated by calcium in milk, Avoiding breastfeeding for 3 to 4 hours after a dose. Use only if no other antibiotic is suitable
Tetracyclines		
Doxycycline		weeks as chaelated by calcium in milk, avoid long term use
Tetracycline, lymecycline, oxytetracycline		avoid long term use
Other antibiotics		
Trimethoprim	relative infant dose 3.9-9%.	Licensed for paediatric use.
Nitrofurantoin		Licensed for paediatric use. Use with care in G6PD-deficient infants (rare).
Metronidazole	plasma protein binding <20%, oral bio-availability complete, relative infant dose 12.6-13.5%	Studies show no untoward effects at a dose of 200-400mg three times a day. Said to alter taste of milk
Meropenem	oral viovailability nil	will only pass into milk in first few days

January 2022 *The information on this sheet is based upon my professional experience as a pharmacist with a specialised interest in the safety of drugs in breastmilk, supported by evidence from expert sources. However, I cannot take responsibility for the prescription of medication which remains with the healthcare professionals involved. I am happy to discuss the evidence by email wendy@breastfeeding-and-medication.co.uk*