Canterbury District Health Board
Te Poari Hauora ō Waitaha

Clinical Pharmacology Bulletin

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Antidepressants and Breastfeeding

Infant exposure to antidepressants via breast milk is generally low. Post-natal depression affects 10-15% of women and is often treated with antidepressants. The benefits of breastfeeding, and treating depression, usually outweigh any theoretical risk to the infant posed by antidepressants. It is seldom necessary to stop breastfeeding if an antidepressant is required.

Infant exposure to antidepressants via breast milk

All antidepressants transfer into milk to some degree. The extent of infant exposure depends on several factors: maternal exposure (plasma concentration), distribution of the antidepressant into milk, volume of milk ingested and infant clearance (which increases with age).

The most accurate measure of exposure is infant plasma concentrations; however, these are rarely reported. Studies more commonly measure drug concentration in milk to estimate the infant's 'dose'. This is usually expressed as a percentage of the weight-adjusted maternal dose or the relative infant dose (RID):

$$RID\ (\%) = \frac{infant\ dose\ from\ milk\ (mg/kg/day)}{maternal\ dose\ (mg/kg/day)}\ x\ 100$$

Drugs with a RID or infant plasma concentration (relative to maternal) below 10% are generally considered safe in breastfeeding. However, more caution is required if:

- the infant is premature
- the mother's dose is very high or she is on multiple psychotropic drugs
- the drug is highly toxic (not a major concern with the antidepressants currently available in New Zealand)

Pharmacokinetic considerations

Infant exposure is lower for drugs with a low fractional oral bioavailability (F). This is because less of the drug ingested via milk reaches the infant's systemic circulation.

Key prescribing points

- Switching antidepressants solely due to breastfeeding is not recommended. Women who have been taking an effective antidepressant while pregnant should generally continue on the same drug. *In utero* exposure is much greater than exposure via milk, and switching post-partum may increase the risk of relapse.
- For initiation post-partum, firstly consider any previous response to antidepressants. SSRIs have the most safety data in breastfeeding and no serious adverse effects have been observed. Choose one with a low RID if possible.
- Use the lowest effective dose.
- Reducing infant exposure by taking the dose immediately after breastfeeding is sometimes recommended, but there is little evidence to support this, and it may make breastfeeding more difficult for the mother.
- Monitor the infant for possible adverse effects (see table), recognising that these may be hard to distinguish from a simply 'fussy' baby.

Need further help?

- Search the LactMed® database for detailed information on specific drugs in breastfeeding.
- Contact Medicines Information on 03 364 0900 or medicines.information@cdhb.health.nz.

Antidepressant	RID (%)	Infant plasma concentrations	Half-life + active metabolite (hours)	F	Infant monitoring
SSRIs					
citalopram	up to 8	undetectable to up to10%	35	0.8	• sedation or irritability • poor feeding • weight gain
escitalopram	up to 8	undetectable or low	30	0.8	
fluoxetine	up to 15	variable – can be up to10%	96 + 360	0.9	
paroxetine	up to 3	undetectable or low	20	0.5	
sertraline	up to 3		26	0.5	
SNRIs					
venlafaxine	up to 12	undetectable to up to 37%	5 + 11	<0.5	
TCAs					
amitriptyline	up to 3	undetectable or low	15 + 30	0.5	As for SSRIs plus: • urinary retention • constipation
clomipramine	up to 3	undetectable or low	25 + 69	0.5	
imipramine	up to 5	low	12 + 24	0.5	
nortriptyline	up to 4	undetectable or low	30	0.6	
MAOIs					
moclobemide	up to 6	low	11	1	As for SSRIs plus: • constipation
phenelzine	no data	no data	12	0.8	
tranylcypromine			2.5	0.5	
Others					
bupropion	up to 11	undetectable or low	21 + 21	<0.5	As for SSRIs plus: • seizures
mirtazapine	up to 7		30	0.5	As for SSRIs