Breastfeeding and Medication

Breastfeeding and Lupus.

Treatment with hydroxychloroquine

Hydroxychloroquine is widely used to treat symptoms of systemic lupus erythematosus. Lupus is a chronic inflammatory auto-immune disease. It can affect the joints, kidneys, skin, heart, lungs brain and blood vessels. The peak incidence is in the 20s and 30s and affects more women (85%).

Symptoms of Lupus include arthralgia, fatigue, weight loss, butterfly shaped rash across nose and cheeks, sores in mouth and nose, depression, headache, problems with memory and thinking, chest pain when taking deep breaths, Raynaud's phenomenon Inflammation of the kidneys, blood clots due to antiphospholipid antibodies. Severe dryness of the eyes and mouth (Sjögren's syndrome) occurs in about 10% of people with lupus.

Additionally, pre-eclampsia, premature birth, intra uterine growth retardation are common necessitating additional support to establish breastfeeding. Raynaud's phenomenon is also seen and should be expected if a breastfeeding mother with lupus reports nipple pain.

Mok et al (1994) published a case study where a mother had a flare which was associated with hyper-prolactinaemia (reported in Walker). There is no suggestion that breastfeeding contributes to exacerbations. Three per cent of babies born to mothers with Lupus have neonatal lupus which presents as a temporary rash and abnormal blood counts. It usually disappears by 3-6 months and doesn't return. However, have of these babies are born with a heart condition which is permanent and is treated usually with a pacemaker (Walker).

Treatment of Lupus There is currently no cure for lupus but symptoms can be managed. Since post-partum exacerbations are common it is often suggested that a course of steroids is initiated to avoid relapse,

- Non-steroidal anti-inflammatories e.g. ibuprofen, naproxen and diclofenac
- Hydroxychloroquine
- Disease-modifying anti-rheumatic drugs (DMARDs)
- Biological therapies e.g. rituximab. They are used for patients with lupus when conventional DMARDs aren't effective. Research into their effect is ongoing.

Safety of hydroxychloroquine during lactation

Trade Name: Plaquenil

Hydroxychloroquine is a disease modifying antirheumatic drug (DMARD) used to suppress the rate of cartilage erosion. Improvement in symptoms may not be apparent for up to 6 months after commencement of treatment. If no response is seen by this stage, then therapy should be stopped. Hydroxychloroquine was detected in the breastmilk of 2 mothers receiving 400mg daily for SLE or RA (Nation 1984, Ostensen 1985). Nation calculated that the 9-month-old baby studied would receive approximately 2% of the maternal dose. No adverse effects have been reported in breastfed babies exposed to hydroxychloroquine via milk and it is considered as safe by the American Academy of Paediatrics. It has a large volume of distribution and is excreted only slowly from the body lasting for months (half-life quoted as 6-8 weeks by Motta 2005). Hydroxychloroquine concentrates in some tissues particularly the eyes which is why monitoring of patients is recommended. In a study of 119 children by Costedoat-Chalumeau (2003) no vision, hearing, growth, or developmental abnormalities were found in any of the 119 children (mean age 26 months) exposed to hydroxychloroquine during pregnancy. Motta (2005) studied 40 infants born to mothers affected by rheumatic diseases and treated with hydroxychloroquine during pregnancy in a prospective observational study. All infants, including the 24 who were breast-fed, had normal visual function and neurodevelopmental outcome. Costedoat-Chalumeau measured concentrations in breastmilk of 344 and 1424 ng/mL, which he proposed corresponds to an infant dose of 0.06 and 0.2 mg/kg/day respectively, far below the licensed paediatric dose of 5–6.5 mg/kg once daily (max. per dose 400 mg)

BNF recommends that it is avoided due to the risk of toxicity in the infant but there is substantial research that it is compatible with breastfeeding

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Information taken from Breastfeeding and Medication Published by Routledge May 2018

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

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