UNMH Breastfeeding, Substance Abuse, & Infectious Diseases Guideline

Introduction

Breast milk provides optimal nutrition and opportunity for mother-infant bonding that may lead to better parenting skills. Breast milk provides benefits, including protection from infection and some forms of cancer, that cannot be provided by artificial milk (formula). Some drugs of abuse may be passed to the newborn via breast milk and be dangerous for the baby. These guidelines are intended to encourage a consistent approach between providers; however, each case should be managed on an individual basis after considering the mother's history of substance use, prenatal care, and treatment for substance abuse. When mother and baby have different providers, communication between teams is critical.

Guideline

1. Breastfeeding Supported

   1.1. Breastfeeding should be supported/encouraged in mothers who have a history of occasional use of alcohol or marijuana and who:

      1.1.1. quit when they discovered they were pregnant in the first or second trimester, or

      1.1.2. continued to use occasionally in pregnancy, i.e., small amounts and not every day, and

      1.1.3. plan not to drink alcohol or smoke marijuana while they are breastfeeding or plan only to use small amounts and not every day (i.e., occasional use vs. abuse).

   1.2. A maternal or infant urine toxicology screen positive for THC at the time of delivery should not alone preclude breastfeeding if the provider has reason to believe the mother's use is occasional, as described above, and documents his or her reasons for believing the mother's use is occasional and therefore the benefits of breastfeeding outweigh the potential risks of the infant's exposure to marijuana in the breast milk.[1]

   1.3. In a mother **with a known history of substance abuse** during the current pregnancy, breastfeeding **should be supported/encouraged** under the following circumstances:

[1] There is little evidence regarding the effect of maternal marijuana use and breastfeeding. What evidence there is suggests that the risk would only be significant when the mother is a "heavy user" of marijuana. See Djulus, et al., Nice & Luo, LactMed, ABM, and AAP Committee on Drugs.

1.3.1. Mother's urine toxicology screen is negative for illicit drugs and opiates at delivery (excepting opiates given during labor), and

1.3.2. she has had no positive urine toxicology screens in the 90 days prior to delivery (unless mom was hospitalized or in jail during entire 90 days prior to delivery; see below), and

1.3.3. she indicates she does not intend to use illicit drugs or non-prescribed opiates while breastfeeding her baby, and

1.3.4. she has received consistent prenatal care starting prior to 26 weeks estimated gestational age.

1.4. Mothers using methadone or buprenorphine may breastfeed if they are not using other drugs of abuse, are enrolled in a substance abuse program, and have a note in their chart indicating support of breastfeeding or there is an order indicating support of breastfeeding from the newborn's provider.

2. Breastfeeding Generally Discouraged

2.1. In a mother **with a known history of substance abuse** (except isolated use of marijuana) during the current pregnancy, breastfeeding **should usually be discouraged** under the following circumstances:

2.1.1. Mother's urine toxicology screen is positive for, or she admits to use of, any illicit substance or opiate at the time of delivery (excepting opiates given during labor) or during the 30 days prior to delivery or

2.1.2. mother did not receive prenatal care during this pregnancy.

2.2. Exceptions to this recommendation are permitted based on the evaluation of a licensed independent practitioner, chart documentation of the rationale for the exception, and a written order. In these situations it may be appropriate to "pump and dump" until the drugs are cleared and to check weekly maternal UDMs over the first month or longer.

3. Breastfeeding Dependent on Healthcare Provider Discretion

3.1. In a mother **with a known history of substance abuse** during the current pregnancy, breastfeeding **may be supported/encouraged or discouraged on a case by case basis with a written order** from the baby's provider in the following circumstances:

3.1.1. In the 30-90 day period prior to delivery (but not within 30 days of delivery) mother either admits to use of, or has a positive urine toxicology screen for, an illicit substance or non-prescription opiate. In this case, it is critical to talk with the mother's prenatal providers or substance abuse counselors to obtain their opinion as to whether or not this was a limited relapse and whether or not they believe mom is likely to resume use upon discharge from the hospital.

3.1.2. Mother only obtained sobriety in an inpatient setting, including incarceration. Again, provider should talk with mother's prenatal providers and/or substance abuse counselors.

3.2. If there is a question regarding whether or not it is okay for a mother to breastfeed (i.e., mother does not fall into the category where breastfeeding is generally discouraged or generally encouraged), the nurse should support a mother who wishes to breastfeed, let the mother know the plan might change, and document this, as well as the final decision by mother's and/or baby's providers, in the baby's chart.

4. Provider Considerations

4.1. When deciding whether to encourage/support a mother's decision to breastfeed in the hospital, providers may consider:

4.1.1. mother's history of drug use (e.g., serious history of abuse vs. history of occasional recreational use),

4.1.2. mother's participation in a substance abuse treatment program, and

4.1.3. mother's behavior on Mother-Baby Unit or Women's Special Care Unit (e.g., frequent absences from unit or evidence of intoxication on unit).

4.2. **In all instances where a mother's prenatal provider knows of a mother's current or past substance use or abuse, he or she should put recommendations regarding breastfeeding in the mother's chart and, when possible, communicate with the baby's provider.**

5. Provider Counseling

5.1. Whether a provider is encouraging or discouraging breastfeeding in a woman with a history of substance use or abuse, he or she must counsel the mother on the possible harm to her baby if she breastfeeds and continues to use illicit substances or non-prescription opiates or is a heavy user of alcohol or marijuana, including but not necessarily limited to:

5.1.1. mother being impaired in her ability to care for her infant,

5.1.2. baby becoming sleepy or agitated or having difficulty sleeping depending on the drug,

5.1.3. the possibility of long-term effects on her baby's neurobehavioral development, and

5.1.4. the possibility of legal repercussions if baby is found to be positive for an illicit substance or non-prescribed opiate.

6. Infectious Diseases

6.1. Mothers who are Hepatitis C or Hepatitis B positive and would otherwise be encouraged to breastfeed, may breastfeed unless:

6.1.1. they have cracked and bleeding nipples or

6.1.2. they have another contraindication to breastfeeding.

6.2. Mothers who are HIV (Human Immunodeficiency Virus) or HTLV (Human T-cell Lymphotropic Virus Type I or Type II) positive should not breastfeed.

6.3. Mothers who have active, untreated tuberculosis should not breastfeed and should be separated from their babies until:

6.3.1. the mother has received 2 weeks of treatment, and

6.3.2. it is documented that mother is no longer infectious.

6.3.3. Babies may receive mother's expressed breast milk as tuberculosis is not transmitted via breast milk.

6.4. Mothers with active HSV (herpes simplex virus) lesions on their breasts should not breastfeed. Babies may receive mother's expressed breast milk as HSV is not transmitted via breast milk.

6.5. Mothers who have contracted varicella within five days of delivery or two days postpartum should be separated from their infants but their babies may receive expressed breast milk as varicella is not transmitted via breast milk.

References

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