Breastfeeding and Medication

Sertraline and breastfeeding

Sertraline is compatible with use during breastfeeding and the anti-depressant/ anti-anxiety SSRI drug of choice during breastfeeding because it is highly plasma protein bound and has an inactive metabolite.

Brand name: Lustral® US brands: Zoloft®

Sertraline has a long half-life metabolite that is only marginally active, unlike that in fluoxetine, and hence is unlikely to cause effects in the baby. It undergoes extensive first-pass metabolism and is 98% plasma bound. It is the preferred and most widely used SSRI in lactation.

Altshuler et al. (1995) studied one woman at three weeks and seven weeks after delivery. The lowest levels of sertraline and its metabolite were found immediately before the daily medication, as might be expected, and the highest levels five–nine hours after the dose. Drug levels were undetectable in the infant's serum and no adverse effects were noted.

Hendrick et al. (2001) studied 30 mothers and babies and found detectable levels in 24% of samples. This was more likely with younger babies and those exposed to 100 mg or more daily. They noted no adverse events.

Kristensen et al. (1998) studied eight women and their babies (average age 5.7 months) and could not detect any drug in the serum of four babies. No adverse events were noted and all babies reached their developmental milestones. She deduced a m/p ratio of 1.93 for sertraline and 1.64 for the metabolite N-desmethylsertraline.

February 2021 *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*

Stowe et al. (2003) studied 26 women taking 25–200 mg sertraline daily, 15 of whom supplied breastmilk samples. They found widely varying m/p ratios of 0.42–4.81 and that maternal daily dose, duration of medication exposure, and infant age and weight at sampling did not correlate with either detectability. No adverse events were documented.

There are multiple published studies on infants with no untoward effects noted. In almost all cases little, if any, of the drug has been detected in the infant plasma.

There is one report of an infant developing benign neonatal sleep at 4 months, which resolved at 6 months. It is unclear whether this bears any relationship with the maternal use of sertraline (Mammen et al. 1997).

Rohan (1997) reported a case of agitation that resolved spontaneously. Relative infant dose quoted as 0.4–2.2% (Hale 2017 online access).

The BNF states that it is not known to be harmful but consider discontinuing breastfeeding. This caution follows the manufacturer recommendation and does not indicate risk.