A Provider's Guide to Opioid Use in Breastfeeding Individuals

2025 Update

Canyons, Desert, and Peaks Regions

This is a practice guideline to improve pain management practices for breastfeeding individuals in both the inpatient and outpatient setting. It is based primarily on the recommendations and practice parameters of the American College of Obstetricians and Gynecologists (ACOG), the U.S. Food and Drug Administration (FDA), American Academy of Pediatrics (AAP), and the Academy of Breastfeeding Medicine (ABM). (*See references on page 6 for links*)

Key Points

Opioids can be safely prescribed for pain management in breastfeeding individuals.

- Effective pain management is crucial for postpartum or post-surgical mothers and can significantly impact breastfeeding success.[1]

Implement a multimodal approach to pain to limit usage of opioids.[2-4]

- First-line pharmacotherapy recommended are non-opioid analgesics such as acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs).
- If pain is not managed, consider adding opioids to scheduled non-opioids to control breakthrough pain.

When prescribing opioids:

- Avoid using codeine or tramadol due to an FDA safety alert about adverse effects in breastfed infants, such as respiratory complications, difficulty nursing, and excessive sleepiness.[5]
- Educate patients to monitor self and their infants for signs of opioid-related side effects.[2-6]
- Offer naloxone to all patients prescribed opioids, especially those at high risk of overdose (e.g., ≥50 morphine milligram equivalents (MME)/day, history of substance use disorder, sleep-disordered breathing)[7]
- Generally, oxycodone is preferred over hydrocodone, hydromorphone, and morphine as an oral option.[8]
- When possible, avoid opioids combined with other analgesics such as acetaminophen.[1-4]
- Continue opioid agonists (e.g., methadone, buprenorphine) postpartum for treating opioid use disorder, regardless of delivery method. Encourage breastfeeding if stable on these medications.[9]

What's inside?

Intermountain Measures

- Percentage of patients prescribed opioids (>50 MME/day) with a concomitant prescription of naloxone.
- Post C-section opioids consumed (MME or pills).
- Percentage of C-sections that are opioid free.

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Multimodal Stepwise Approach to Pain Management [1-4]

Implement a multimodal approach to minimize opioid use, including non-pharmacologic options (such as ice, heat, or abdominal binders) and non-opioid medications (such as acetaminophen, NSAIDs, or topical anesthetics).

Begin with prescribing regularly scheduled alternating doses of acetaminophen and a nonsteroidal anti-inflammatory drug (NSAID) for at least 3 – 5 days after the procedure. See Table 2 for recommended dosing

If pain is not managed with first-line non-opioid analgesics and non-pharmacologic options

Consider adding opioids to the scheduled non-opioids to control breakthrough pain. Limit outpatient opioid prescriptions to a supply of ≤ 5 days.
(See Table 1 below and Table 2 for instructions and recommended dosing)

Table 1. Considerations for Prescribing Opioids to Breastfeeding Individuals

Topic	Key Points
Limit Amount	• Prescribe the lowest effective dose and maximize intervals between doses to control pain.[1-3,6] • Titrate dose based on response. [1-4,6] • Limit the quantity of pills prescribed to avoid an excess of unused opioids. [1-4]
Safety	• Offer naloxone to all patients prescribed opioids, especially those at high risk of overdose (e.g., ≥50 MME/day, history of substance use disorder, sleep-disordered breathing).[7] • Avoid using codeine or tramadol due to an FDA safety alert regarding adverse effects in breastfed infants, such as respiratory complications, difficulty nursing, and excessive sleepiness.[5] • Generally, oxycodone is preferred over hydrocodone, hydromorphone, and morphine as oral option.[8] • Avoid opioids formulated with other analgesics such as acetaminophen when possible.[1-4] See Table 2. • Continue opioid agonists (e.g., methadone, buprenorphine) postpartum for treating opioid use disorder, regardless of delivery method. Encourage breastfeeding if stable on these medications. Advise patients not to abruptly stop breastfeeding, as this can cause withdrawal symptoms in the infant, such as tremors, diarrhea, and vomiting. [9] Contact Acute Pain Services for guidance.
Counsel Patient	• Discuss risks and benefits with the patient. Emphasize that effective pain management reduces postpartum depression risk and enhances bonding and breastfeeding success. Explain the risk of dependency and potential for central nervous system (CNS) depression.[1,2,6] • Emphasize importance of taking the opioids as directed and monitoring of self and their infant. If any of the below symptoms appear, have them contact their provider. Breathing changes or somnolence should be treated as an emergency. [2,3,6] – Constipation – Respiratory depression – Poor weight gain in infants – Difficulty breathing – Somnolence • Opioids are safe when taken as directed. If a patient is concerned about opioid levels in breast milk, inform them that the highest concentrations occur 1 – 2 hours after ingestion. Advise nursing immediately after taking opioids to minimize the amount in breast milk and reduce the likelihood of needing to nurse during the peak potency window. [1,10-13] • Emphasize the benefits of breastfeeding and importance of feeding or pumping to keep milk supply.[14,15] • Instruct patient to call their provider if they still need regular doses of prescription medication or if the pain gets worse after one week. • Have patient check with baby's pediatrician before taking ANY additional pain medication prescribed by another provider. • Instruct patient on the dangers of acetaminophen overdose.
Surgery Considerations	• Patient should advise surgical team that they are breastfeeding. • Surgical anesthetics, excluding opioids, pose very low risk to breastfed infants. Most anesthetics are rapidly eliminated from the body or do not concentrate in human milk. Once the effects of anesthesia have worn off, it is safe to resume breastfeeding.[3,6] • Breastfeeding individuals should pump milk in the days leading up to surgery to ensure availability for the infant during surgery and recovery. Pump just before going to the operating room and immediately after surgery to maintain milk supply and prevent breast engorgement.

Table 2. Pain Management Pharmacology in Breastfeeding Individuals: Recommended Dosage

Drug*	Dosage	Notes
Non-opioid analgesics		
Acetaminophen (Tylenol®)	325 – 650 mg by mouth every 4 – 6 hours as scheduled for pain.	**Preferred non-opioid pain medication.** For moderate pain, dose may be increased to 1 g every 6 hours. May warrant PRN on specific-patient basis. Do not exceed 4 g in 24-hr period. While opioid-acetaminophen combination products should be avoided, account for grams of acetaminophen from these products if they are prescribed.
Ibuprofen (Advil®, Motrin®)	600 – 800 mg by mouth every 6 – 8 hours PRN as scheduled for pain for 10 days	**Preferred non-opioid pain medication.** Take with food. May warrant PRN for specific-patients. Do not exceed 3.2 g in 24-hr period. Works best if taken in regular intervals.
Opioids** (Limit outpatient opioid prescriptions to a supply of ≤ 5 days)		
Oxycodone	2.5 – 10 mg by mouth every 4 – 6 hours PRN for severe / breakthrough pain	**Preferred opioid pain medication.** Titrate based on response. Recommend ≤ 30 mg in a 24-hr period.† AAP does not recommend use in nursing mothers, while ABM and ACOG do not mention a clearly preferred opioid.
Hydromorphone (Dilaudid®)	2 – 4 mg by mouth every 4 – 6 hours PRN for severe / breakthrough pain	Titrate based on response. Recommend ≤ 12 mg in a 24-hr period. †
Morphine sulfate IR	5 – 15 mg by mouth every 4 – 6 hours PRN for severe / breakthrough pain	Titrate based on response; optimal dosage is influenced by several factors. Contact your clinical pharmacist or Acute Pain Services for assistance. While AAP notes morphine may be a safer opioid since metabolism to the active metabolite is not influenced by CYP2D6, ABM and ACOG do not mention a clearly preferred opioid.
Combination Opioids (Not Preferred)		
Hydrocodone / acetaminophen (Hycet®, Lortab®, Norco®)	5 mg / 325 mg – 10 mg / 325 mg by mouth every 4 – 6 hours PRN for severe / breakthrough pain	Titrate based on response. Do not exceed 30 mg for hydrocodone † and 4 g for acetaminophen in 24-hour period. If hydrocodone is selected, be sure to remove scheduled doses of acetaminophen that would exceed 4 g recommendation. AAP recommends cautious use in nursing mothers while ABM and ACOG do not mention a clearly preferred opioid.

* Immediate-release medications are preferred over extended-release medications. [1,2]

** These recommendations are for standard use in an uncomplicated patient. For patients with complex pain management needs, such as those with opioid tolerance or those on buprenorphine/methadone, please consult your pharmacist or the Acute Pain Service for assistance.

† Recommended max dose for opioid may be exceeded if clinical circumstances or pain level warrant. Use best clinical judgement.

Patient Education and Other Provider Resources

- Fact Sheet for Patients and Families: Breastfeeding and Opioid Pain Medication English / Spanish
- Facility lactation service
- UpToDate® Lexidrug™
- Drugs for Pregnant and Lactating Women via ClinicalKey®
- LactMed database
- Hale's Medications and Mothers' Milk
- MotherToBaby supported by the Organization of Teratology Information Specialists (OTIS)

AAP = American Academy of Pediatrics; **ABM** = Academy of Breastfeeding Medicine; **ACOG** = American College of Obstetricians and Gynecologists; **CYP2D6** = cytochrome P450 2D6 isozyme; **IR** = immediate release; **PRN** = as needed

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This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Women's Health and Neonatal Clinical Program. womenandnewborns@imail.org

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