MotherSafe NSW Medications in Pregnancy & Breastfeeding Service

The Royal HOSPITAL FOR WOMEN

COMMON COLD IN PREGNANCY AND BREASTFEEDING

Information in this leaflet is general in nature and should not take the place of advice from your health care provider. With every pregnancy there is a 3 to 5% risk of having a baby with a birth defect or developmental problem.

What is the common cold?

The common cold is a viral infection of the respiratory tract. The throat, nose, sinuses, airways and lungs are affected. Symptoms include sneezing, coughing, sore throat, blocked or runny nose, blocked ears, headache, and muscle aches. If fever occurs, it is generally very mild. Symptoms usually last for 5-7 days[1,2]. The common cold is not the same as the "flu" (influenza virus), which is a more serious viral infection.

What causes a cold?

Common colds **are not serious infections** and will get better on their own. Antibiotics do not work on infections caused by viruses, so are not necessary for colds unless there is also a bacterial infection[1,2].

Why treat a cold?

It is important to treat a fever and to avoid dehydration in pregnancy. Cold viruses are not harmful to the pregnancy however a sustained high fever may be. Symptomatic treatment will assist in making you feel better but will not necessarily alter the duration or severity of the illness[3].

Non-Drug Treatments.

- Rest will help to fight the virus and make you feel better.
- Drink plenty of non-alcoholic fluids to help loosen mucus and avoid dehydration.
- Avoid exposure to cigarette smoke.
- Sore throats or coughs may be soothed by drinking warm drinks with honey and lemon, gargling with warm salty water or sucking on throat lozenges.
- **Saline** (salt water) nasal sprays, drops or flushes or **inhaled steam** (in the shower or using a bowl of hot water) can help clear mucus, relieve sinuses or dry a runny nose[1,2].

Drugs of Choice for Pregnant Women for symptomatic relief of colds include:

Fever: Paracetamol may be taken at the recommended dose of 2 x 500mg tablets every 4-6 hours (but not more than 8 x 500mg tablets in 24 hours. It has not been shown to increase the risk for pregnancy loss or birth defects[3,4,5]. Non-steroidal Anti-inflammatory Drugs (NSAIDs) such as **aspirin** or **ibuprofen** may be used at the recommended doses from 13 to 30 weeks gestation[4,5]. **Codeine** is found in many cold and flu tablets and is considered safe in pregnancy at the recommended dose. Many cold and flu tablets contain multiple ingredients so it is best to check with your doctor or pharmacist about their safety in pregnancy.

Sore throat: Throat lozenges containing antibacterial and/or local anaesthetic agents can be used to soothe the throat. Throat gargles containing iodine can affect your baby's thyroid function if used long-term. However, short-term use of a few days at the recommended dose has not been associated with this effect[3,4,5].

Nasal Congestion: Topical nasal decongestants (sprays or drops) such as oxymetazoline and xylometazoline can be used to help a runny or blocked nose. These are considered safe to use in pregnancy[3,4,5]. These preparations should not be used for longer than 5 days as they can cause further congestion as a result of the medication. Antihistamines commonly found in cold preparations such as diphenhydramine or chlorpheniramine are also safe to use in pregnancy[3,4,5]. They may help to dry up a runny nose but are sedating so may be the preferred option for use at night.

Cough: Cough suppressants containing pholcodine, dihydrocodeine or dextromethorphan can be used to help stop a dry persistent cough. Chesty cough mixtures containing bromhexine and/or guaifenesin can be used to assist relief of a productive ('chesty') cough[3,4,5]. *There is currently no human pregnancy information on bromhexine, pholcodine and dihydrocodeine, but they are considered safe in pregnancy and breastfeeding at the recommended dose. Ensure you only take the recommended doses and see your doctor if symptoms persist*[3,4,5].

Other agents:

Pseudoephedrine and phenylephrine are the oral decongestants in many combination cold and flu tablets. There is no conclusive data that these drugs are harmful and inadvertent exposure should not be regarded as cause for concern when taken at the recommended dose. However, topical nasal decongestants are preferred[3]. *Refer to http://www.mothertobaby.org/fact-sheets/pseudoephedrine-phenylephrine-pregnancy/ for further information.*

Complementary Therapies for Treatment of Cold:

Vitamin and herbal treatments are popular for the treatment of colds and flu. There is variable evidence on the effectiveness of many of these preparations and even less information about their safety in pregnancy or breastfeeding.

Influenza Vaccine:

Influenza is a more severe viral infection and can be very serious, especially to women in late pregnancy (see MotherSafe factsheet on influenza for further information). The National Health and Medical Research Council recommend that influenza vaccine be offered to all women planning a pregnancy. It is recommended and safe at any stage of pregnancy[6].

Breastfeeding when you have a cold:

Continue to breastfeed your baby during your cold, as your baby will receive some protection from antibodies in your breast milk. As a general rule, it is best to breastfeed your baby first and then take medication.

- Ensure you rest and drink plenty of fluids (eg: water or juice).
- Use good hygiene practices to minimise the spread of infection to others
- Symptomatic treatment as for pregnancy.
- Avoid the use of aspirin for pain or fever, but ibuprofen is safe in breastfeeding[7].
- Codeine, found in many cold and flu tablets, may make your baby drowsy—especially in a younger and smaller baby and when there is a family history of codeine "allergy" or sensitivity[7]. If your baby becomes excessively drowsy, stop using codeine containing products and speak to your doctor.
- The oral decongestant, pseudoephedrine, found in some cold and flu tablets, transfers very poorly into breastmilk[7]. However, it has been associated with reducing milk supply and causing irritability to the breastfed baby. Therefore, it is not generally recommended for breastfeeding mothers. The oral decongestant phenylephrine has not been studied during breastfeeding but has poor transfer into breast milk and additionally, is widely used in paediatrics. Nasal decongestants such as oxymetazoline and xylometazoline are preferred because of their localised action and poor transfer into breast milk.[7]

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