Approved by Quality & Patient Care Committee
3 March 2016

SUPPRESSING LACTATION AND WEANING

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Assist and support woman who decides to suppress lactation and choose to formula feed their infants.
- Support woman who has experienced a stillbirth, perinatal loss or neonatal death with lactation suppression
- Support woman who suppresses lactation for an acceptable medical indication
- Provide education and support for woman who wishes to wean early in their postpartum period.

2. PATIENT

- Newly birthed or lactating woman

3. STAFF

- Medical and nursing and midwifery staff
- Enrolled/Endorsed/Mother craft nurses

4. EQUIPMENT (as required)

- Firm (not tight) and Supportive bra or top
- Cool cloths or chilled clean cabbage leaves

5. CLINICAL PRACTICE

- Discuss strategies to manage suppression that are relevant and acceptable to the woman depending upon her circumstances
- Provide written information appropriate to woman's situation
- Identify if suppression is going to occur in the immediate postpartum period or the woman has established lactation

IMMEDIATE SUPPRESSION OF LACTATION POST BIRTH:

- Avoid unnecessary breast stimulation**.**
- Express breast only for comfort
- Wear a firm supportive bra or top
- Apply cool cloths, gel packs or cabbage leaves as required
- Maintain normal fluid intake
- Allow leakage of breastmilk to occur, sufficient expression to maintain comfort may be required
- Advise the woman regarding options for analgesia
- Discuss the role and the potential side effects of pharmacological suppression of lactation with the woman
- Administer medication if requested by woman and ordered by a medical officer
- Do not breastfeed/give baby any expressed breastmilk once pharmacological treatment initiated (1)

NON PHARMACOLOGICAL METHODS FOR LACTATION SUPPRESSION

Non pharmacological methods to suppress lactation are used to help women alleviate lactation naturally. These methods include:

- Avoid tactile stimulation.
- Apply ice packs or cabbage leaves to assist and relieve any pain or swelling.

SUPPRESSING LACTATION AND WEANING cont'd

- Educate the woman to wear a firm bra day and night for breast support.
- Apply breast pads to assist in soaking up any milk leakage. Encourage to change pads if they become soaked.
- Hands express a little milk for comfort.
- Encourage her to wear a firm but not tight supportive bra
- Advise the woman regarding options for analgesia
- Encourage fluids
- Encourage the women to lay on her back or on one side with an extra pillow support to support her breasts. If she would like to lie on her front, place a pillow under her hips and stomach to ease the pressure on her breasts. A soft towel or cloth nappy can be placed across her breasts to soak up any leaking milk.
- If a woman requests pharmacological suppression it must be prescribed by a medical officer and potential side effects of pharmacological suppression of lactation discussed with the woman.

PHARMACOLOGICAL METHODS FOR LACTATION SUPPRESSION

Pharmacological interventions have been used to suppress lactation after childbirth and decrease associated symptoms. Currently there is no universal guideline for the most appropriate approach for suppressing lactation in postpartum women.

The drug of choice at the Royal Hospital for Women is currently Cabergoline (Dostinex) is a treatment reported and used for mothers with hypergalactia . In low doses cabergoline has been reported to decrease milk supply. It does however have side effects, interactions and contra-indications for use (1, 2). Use of Cabergoline for lactation suppression or hypergalactia is an off label indication, this must be explained to the patient and consent documented.

Carbergoline suppresses lactation and inhibits the release of prolactin from the anterior pituitary gland (3). This action is similar to that of Bromocriptine, another prolactin-inhibiting agent (2). The oral doses ranged from 0.4 mg to 1 mg, usually given as a single dose within 24 hours of delivery; however it may be given as a divided dose over 2 days (1, 3) the 1-mg dose appears to be the most effective for long-term suppression of lactation. The manufacturer states that 'carbergoline should not be used to suppress physiologic lactation because of the known toxicities associated with bromocriptine, when used for this purpose these toxicities include hypertension, stroke, and seizures' (1, 2, 3, 4)

Dosage	Side Effects	Drug Interactions	Contraindications/Precautions
1mg **Cabergoline** orally during the first day but preferably within the first 12 hours of birth (single dose of 2 x 0.5mg tablets) (1, 2)	Headache, dizziness, fatigue, orthostatic hypotension, nose bleed (1, 2)	Interaction is more common with anti-emetics commonly used in the postpartum period. Do not use with other dopamine antagonists such as metoclopramide, the phenothiazine's, butyrophenones and thioxanthines as these may reduce the prolactin lowering effects (1, 2)	**Contraindications:** Hypersensitivity to the drug, other ergot alkaloids or to any of the excipients, pre-eclampsia or postpartum hypertension. **Precautions:** Renal disease, Raynaud syndrome, liver disease, pulmonary or cardiac fibrotic disorders, gastrointestinal bleeding, history of psychosis, hypotension (1, 2)

SUPPRESSING LACTATION AND WEANING cont'd

SUPPRESSION OF ESTABLISHED LACTATION: MASTITIS AND BLOCKED DUCTS

Lactation suppression can result in Mastitis. If the breasts are left very full, there is a risk that one or more of the ducts that carry milk to the nipple will become blocked.

- Refer to Mastitis (Lactational)Treatment Policy
- Advise woman experiencing Mastitis to wait until the infection has cleared before they decide to wean
- Recommend gradual suppression of lactation to reduce risk of mastitis and breast abscess
- Reduce the number of breastfeeds or breast expressions gradually over several days/weeks and ensure the breasts remain comfortable
- Prescribe antibiotic therapy as per Mastitis (Lactational) Treatment policy for at least 10-14 days or longer as required. If signs and symptoms persist including erythema, lumpy or painful areas in the breast, continue treatment (Refer to Mastitis (Lactational) Treatment policy).
- Increase gradually the length of time between expressions as the condition improves then only express once a day, until cease.
- Give expressed breast milk to infant unless contra-indicated

WEANING

- Discuss and provide specific strategies for gradual weaning that are consistent with the age of the infant and cultural beliefs
- Avoid abrupt or sudden weaning as this may pose a risk for Mastitis and breast pain
- Discuss with mother/ partner/carer feelings for wanting to wean.
- Individual baby led weaning may occur over weeks or months
  Mother -baby led weaning.
- Encourage the woman to drop one feed every few days.
- Express for comfort as required, slowly reduce. Watch for any signs of mastitis, such as redness, pain or flu-like symptoms. If these occur, continue to express until resolved and contact a healthcare professional – General Practitioner, Australian Breastfeeding Association or Early Childhood centre
- When breasts feel comfortable, drop another feed.
- Continue to reduce feeds in this way, usually about one feed a week (5)

6. DOCUMENTATION

- Integrated clinical notes
- ObstetriX
- Maternal medication chart

7. EDUCATIONAL NOTES

- The Royal Hospital for Women supports all women on their feeding choices. It promotes a baby friendly environment for all pregnant and birthing women. The hospital supports the right of the individual to make an informed decision with infant feeding in accordance with the implementation standards of "The Ten Steps to Successful Breastfeeding" (6, 7)
- Women deciding not to breastfeed may experience potential stress and grief. Midwives, medical officers and CMC lactation services are to support all women's feeding decisions.
- Women who decide to suppress their lactation in the early postpartum period may experience breast pain, engorgement and milk secretion during the days following the delivery, until lactation is suppressed spontaneously. Appropriate management should help diminish the milk supply and minimise the risk of complications. The application of cold therapy may be soothing, is unlikely to cause harm, and cabbage leaves are readily available as an effective treatment for engorgement. Analgesia is effective for engorgement breast pain and if not contraindicated (3, 8, 9)

SUPPRESSING LACTATION AND WEANING cont'd

- Women who suppress lactation for a stillbirth, perinatal loss or neonatal death require additional support and be referred to a social work or perinatal mental health services (10, 11).
- Mothers who are HIV positive are advised not to breastfeed their babies (See policy directive) to prevent vertical transmission to their infant (12).
- Medical indications for lactation suppression, e.g. women who are on antineoplastic medications or who have a have total bilateral mastectomy will need to be supported with their lactation suppression.
- Pharmacological or non-pharmacological suppression options should be offered to all women. Pharmacological side effects are to be clearly explained, discussed and documented when ordering drugs for lactation suppression.
- Cabergoline (Dostinex) is the medication of choice for women who decide to suppress their lactation. The recommended following regime for Cabergoline (Dostinex) has been suggested[4]: 0.25mg Cabergoline orally every 12 hours for 2 days for a total of 1.0mg (i.e. 4 doses of ½ tablet or 0.25mg). It should be noted that this is an unlicensed indication (1, 2, 3, 13)
- Bromocriptine is not used to suppresses lactation. It has been withdrawn in the US and other countries because it increases the risk of maternal stroke, seizures, cardiovascular disorders, death and possibly psychosis (4, 14, 15, 16).
- Women who have had a stillbirth, perinatal loss or /neonatal death may choose to lactate then suppress gradually as it helps with their grieving process (10, 11). Midwives, medical officers and CMC Lactation need to provide support for these women who choose this option for lactation suppression.
- Rebound lactation has been documented within one to two weeks after initial pharmacological suppression treatment i.e. resumption of milk supply as demonstrated by filling of the breasts and possible leakage of milk. The woman needs to be informed of this possibility (17)
- Women with an established supply will benefit from gradual weaning, it is important for the physical and emotional wellbeing of both the mother and child. Abruptly suppressing an established supply increases the risk of blocked ducts, mastitis and breast abscess. Gradual weaning allows the fat tissue to replace glandular tissue. The levels of protective factors in breastmilk increase during the weaning period providing a final boost to the baby's immune system and protect the woman against breast infections (6, 17, 18).

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- NSW Health PD2011_042. Breastfeeding in NSW: Promotion, Protection and Support

9. RISK RATING

- Medium

10. NATIONAL STANDARD

- Standard RH – Reducing Harm

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SUPPRESSING LACTATION AND WEANING cont'd

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NB: *(**This policy was due for review 23rd March 2015, but has not been updated).**
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SUPPRESSING LACTATION AND WEANING cont'd

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Acknowledgement: GE2010_006 Suppression of Lactation - NSCCAHS

REVISION & APPROVAL HISTORY
Reviewed and endorsed Lactation Working Party February 2016
Approved Quality & Patient Safety Committee 21/6/12
Reviewed Obstetric LOPs Committee May 2012
Reviewed 2007/08
Approved Quality Council 20/9/04
Reviewed by Lactation CNC July 2004
Approved RHW Council 25/6/01

FOR REVIEW : MARCH 2019