Lactation Suppression

University Hospitals of Leicester NHS Trust

Trust ref: C27/2017

1. Introduction and who the guideline applies to:

This guideline is intended for the use of clinicians caring for postpartum women in whom lactation suppression is required (most commonly following late fetal loss, stillbirth or neonatal death, although may also be considered in women with a blood borne infection in whom breastfeeding is contraindicated).

Related UHL Documents:

Termination of Pregnancy in the Second or Third Trimester
Intrauterine Death in the Second Trimester or Stillbirth

Background:

Offering lactation suppression to women who have had a late fetal loss, stillbirth or a neonatal death is considered good practice (RCOG green top guideline 55). Cabergoline can be used to successfully suppress lactation in >90% of women, with few adverse side effects. It is contraindicated in women with pre-eclampsia and hypertension.

2. Guideline Standards and Procedures

2.1 Lactation suppression discussion

- Lactation suppression should be discussed with all women who have a late fetal loss, stillbirth or neonatal death.

- Different methods of lactation suppression should be discussed including both pharmacological and non-pharmacological methods. Women should be advised that more than one-third of women who opt for non-pharmacological methods will be troubled by significant discomfort. There is no recommended lower gestation limit to advise regarding lactation suppression, however it is reasonable to consider it from 16 weeks onwards.

2.2 Cabergoline.

Women who would prefer pharmacological lactation suppression should be prescribed Cabergoline.

Cabergoline successfully suppresses lactation completely in 78% of women, with partial suppression in a further 15% of women, with few adverse effects.

Contraindications:

- It should not be prescribed for women with pre-eclampsia or hypertension.
- Other contraindications include severe hepatic dysfunction, history of puerperal psychosis, cardiac valve disease, and pulmonary, pericardial and retroperitoneal fibrotic disorders.
- It should not be prescribed to women with sensitivity to ergot alkaloids, or women on antipsychotic medication

Side effects:

Side effects are rare. The commonest are dizziness and headache (approximately 5% of women experience each of these). Less common side effects include abdominal pain, nausea, vomiting and hypotension.

Cautions:

- Do not prescribe with macrolide antibiotics (e.g. erythromycin, clarithromycin) as these increase the risk of side effects from Cabergoline.
- Manufacturer advises avoid pregnancy for 1 month after administration
- Blood pressure should be checked periodically in the days after administration – blood pressure should be checked prior to discharge home, then the community midwife should check blood pressure within 48 hours of discharge home.

Dosage for prevention of lactation:

Prescribe Cabergoline 1mg po as a single dose only within 24 hours of the birth.

Dosage for suppression of established lactation:

Prescribe Cabergoline 250 microgram po every 12 hours for 2 days (total of 4 doses).

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
All women experiencing stillbirth, neonatal death, or late intrauterine fetal death should be offered lactation suppression advice	Retrospective audit	Consultant Obstetrician/Bereavement Specialist Midwife	2 yearly	Perinatal mortality group

5. Supporting References

European Multicentre Study Group for Cabergoline in Lactation Inhibition. Single dose cabergoline versus bromocriptine in inhibition of puerperal lactation: randomised, double blind, multicentre study. BMJ 1991;302:1367–71.

Late Intrauterine Fetal Death and Stillbirth (Green-top Guideline No. 55) RCOG London 2010 (last accessed 23/09/2021)

6. Key Words

Blood borne infection, Breastfeeding, Cabergoline Neonatal death, Stillbirth

---

The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

EDI Statement

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs.

CONTACT AND REVIEW DETAILS			
Guideline Lead (Name and Title) P McParland Consultant Obstetrician J Dickens Bereavement Midwife			**Executive Lead** Chief Nurse
Details of Changes made during review:			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
October 2018	V2	P McParland and J Dickens	Gestation for giving Cabergoline lowered to 16 weeks
September 2021	V3	P McParland and J Dickens	Format update only
October 2024	V4	K Snutch R Crook	Added inclusion cases of late fetal loss