Letters to the Editor

Treatment of Chagas Disease in Breastfeeding Dyads

Original Article: Neglected Parasitic Infections: What Family Physicians Need to Know—A CDC Update

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To the Editor: We thank Drs. Cantey, Montgomery, and Straily for their informative update on neglected parasitic infections.[1] The authors state that treatment for Chagas disease should be avoided during breastfeeding, suggesting that treatment should be delayed until after lactation has ceased. The Centers for Disease Control and Prevention (CDC) website cites medication safety concerns without specifying what those concerns are.[2]

Current evidence in the National Library of Medicine's Drug and Lactation Database supports the safety of benznidazole and nifurtimox (Lampit) for the treatment of Chagas disease in breastfeeding dyads. Although levels of medications in breast milk can vary from maternal serum levels, the relative infant dose of these medications was much lower than newborn dosing. Available studies showed no adverse effects in infants of mothers taking either medication.[3,4]

We are concerned that avoiding these medications during breastfeeding could cause a prolonged delay of treatment. Many women in the United States bear children and breastfeed in tandem and may be continuously pregnant or breastfeeding for many years. According to the American Academy of Family Physicians, the optimal duration of breastfeeding is at least two years for infant and maternal health.[5] Additionally, premature cessation of breastfeeding for treatment should be avoided because of significant risks of harm to the dyad.[6]

We suggest that lactating individuals and their physicians make a shared decision about the timing of treatment. Family physicians are uniquely skilled in their ability to care for both members of the breastfeeding dyad and must be knowledgeable of best practices for breastfeeding and medical care. In addition, fully informed physicians can appropriately counsel patients on risks and benefits.

Physicians should consult reliable resources before making treatment decisions for lactating patients. Fortunately, most medications are safe during breastfeeding. The National Library of Medicine's Drugs and Lactation Database (https://www.ncbi.nlm.nih.gov/books/NBK501922/) and the InfantRisk Center (https://www.infantrisk.com/infantrisk-center-resources) provide accurate medication information. The Academy of Breastfeeding Medicine publishes free, evidence-based protocols for several medical conditions (https://www.bfmed.org/protocols). The Institute for the Advancement of Breastfeeding & Lactation Education (https://lacted.org) provides high-quality CME for medical professionals.

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In Reply: We thank Drs. Morrison, Natrajan, and Snow for their comments related to our article.[1] We agree that patients who are lactating and

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their physicians should make a shared decision about the timing of treatment.

The U.S. Food and Drug Administration (FDA) label for Lampit states that the published literature suggests that infants would ingest a daily dose of less than 15% of the recommended daily dose for pediatric patients with Chagas disease. There have been no reported adverse effects on the small number of infants exposed to the medication during lactation. The FDA recommends that infants exposed to the drug should be monitored for adverse effects (i.e., vomiting, rash, decreased appetite, pyrexia, and irritability).[2]

The FDA label for benznidazole states that limited published data indicate benznidazole is present in human milk at infant doses of 5.5% to 17% of the maternal weight-adjusted dosage. There are no reports of adverse effects in the breastfed infant. However, because of the potential for serious adverse reactions, patients should be advised that breastfeeding is not recommended during the mother's treatment.[3]

Although infants with Chagas disease are treated with higher doses of the medication than a child would likely ingest through breast milk, the uninfected child would gain no benefit from the treatment but be exposed to any risk posed by exposure to the medication.

There may be circumstances where the physician and patient decide there is a benefit of treating the mother while breastfeeding (e.g., the patient has early indications of reactivation of chronic Chagas disease associated with a low CD4 T cell count due to HIV coinfection). In these limited circumstances, considering the current FDA labeling, prescribing Lampit with a warning to monitor the child for symptoms of severe adverse reactions could be an option. Ideally, the physician-patient discussion would include the patient's plan for the timing of future pregnancies and the potential benefit of initiating treatment immediately.

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The findings and conclusions expressed in this letter are those of the authors and do not necessarily represent those of the Centers for Disease Control and Prevention.

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