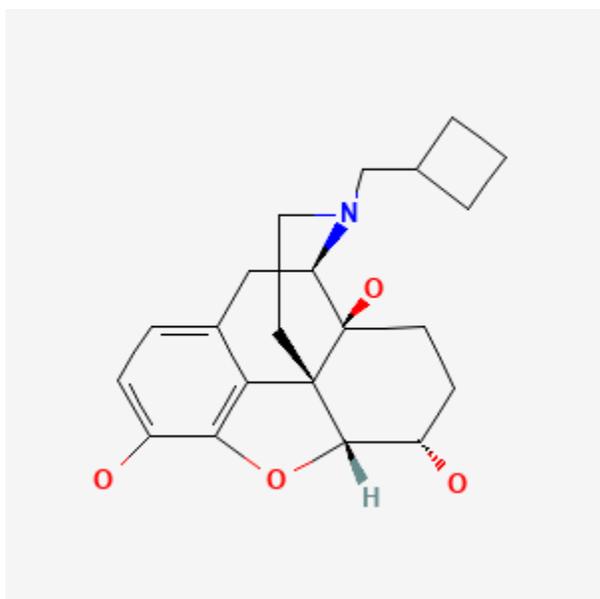




Nalbuphine

Revised: December 15, 2023.

CASRN: 20594-83-6



Drug Levels and Effects

Summary of Use during Lactation

Nalbuphine is excreted into breastmilk in amounts much smaller than the dose given to infants for analgesia. Because nalbuphine has poor oral absorption, it is unlikely to adversely affect the breastfed infant. If nalbuphine is required by the mother of a newborn, it is not a reason to discontinue breastfeeding; however, once the mother's milk comes in, it is best to provide pain control with a nonnarcotic analgesic and limit maternal intake to 2 to 3 days with close infant monitoring. If the baby shows signs of increased sleepiness (more than usual), difficulty breastfeeding, breathing difficulties, or limpness, a physician should be contacted immediately.

Disclaimer: Information presented in this database is not meant as a substitute for professional judgment. You should consult your healthcare provider for breastfeeding advice related to your particular situation. The U.S. government does not warrant or assume any liability or responsibility for the accuracy or completeness of the information on this Site.

Attribution Statement: LactMed is a registered trademark of the U.S. Department of Health and Human Services.

Drug Levels

In adults, nalbuphine has very poor oral bioavailability and is metabolized to inactive metabolites. Parenteral doses of 75 to 300 mcg/kg are used in infant and children.

Maternal Levels. Seven women who were 3 to 7 days postpartum received a single 20 mg IM dose of nalbuphine. Milk samples were collected several times beginning at 1 hour and finishing at 24 hours after the dose. The half-life of elimination from milk was about 8 hours. A reported peak milk level in one mother was about 25 mcg/L and it occurred 1 hour after the dose. The average milk level over the 24 hour study period in all 7 mothers was about 5 mcg/L (range 1.5 to 20 mcg/L).[1] Using the peak level reported in this study, an exclusively breastfed infant would receive a dosage of 3.7 mcg/kg daily, equivalent to 1.1% of the maternal weight-adjusted dosage. Using the average milk level from this study, an exclusively breastfed infant would ingest 0.75 mcg/kg daily, equivalent to 0.2% of the maternal weight-adjusted dosage or 0.25 to 1% of the infant parenteral dosage.

Eighteen women were administered nalbuphine 0.2 mg/kg intravenously every 4 hours (average 25.5 mcg/kg daily) for pain following cesarean section. Milk samples were collected every 3 hours during the second day of drug administration. Because of small milk volumes, only 32 samples from 14 of the women were collected. The average milk nalbuphine concentration was 42 mcg/L, and the average maximum milk concentration was 61 mcg/L. The authors estimated that a fully breastfed infant would receive an average of 7 mcg/kg daily which amounts to about 0.6% of the weight-adjusted maternal dosage.[2]

Effects in Breastfed Infants

Relevant published information was not found as of the revision date.

Effects on Lactation and Breastmilk

Nalbuphine can increase serum prolactin.[3] However, the prolactin level in a mother with established lactation may not affect her ability to breastfeed.

A study compared women who received nalbuphine or butorphanol during labor (n = 26) to those who received no analgesia (n = 22). The time to effective breastfeeding was longer (46.5 minutes) in the analgesia group than in the no analgesia group (35.4 minutes).[4]

A national survey of women and their infants from late pregnancy through 12 months postpartum compared the time of lactogenesis II in mothers who did and did not receive pain medication during labor. Categories of medication were spinal or epidural only, spinal or epidural plus another medication, and other pain medication only. Women who received medications from any of the categories had about twice the risk of having delayed lactogenesis II (>72 hours) compared to women who received no labor pain medication.[5]

Alternate Drugs to Consider

[Acetaminophen](#), [Butorphanol](#), [Hydromorphone](#), [Ibuprofen](#), [Morphine](#)

References

1. Wischnik A, Wetzelsberger N, Lucker PW. Elimination of nalbuphine in human milk. *Arzneimittelforschung* 1988;38:1496-8. PubMed PMID: 3196391.
2. Jacqz-Aigrain E, Serreau R, Boissinot C, et al. Excretion of ketoprofen and nalbuphine in human milk during treatment of maternal pain after delivery. *Ther Drug Monit* 2007;29:815-8. PubMed PMID: 18043481.
3. Saarialho-Kere U. Psychomotor, respiratory and neuroendocrinological effects of nalbuphine and haloperidol, alone and in combination, in healthy subjects. *Br J Clin Pharmacol* 1988;26:79-87. PubMed PMID: 3060191.

4. Crowell MK, Hill PD, Humenick SS. Relationship between obstetric analgesia and time of effective breast feeding. *J Nurse Midwifery* 1994;39:150-6. PubMed PMID: 7931694.
5. Lind JN, Perrine CG, Li R. Relationship between use of labor pain medications and delayed onset of lactation. *J Hum Lact* 2014;30:167-73. PubMed PMID: 24451212.

Substance Identification

Substance Name

Nalbuphine

CAS Registry Number

20594-83-6

Drug Class

Breast Feeding

Lactation

Milk, Human

Analgesics, Opioid

Narcotics

Narcotic Antagonists