Cough and Cold Meds in Pregnancy and Lactation

full update May 2025

Commonly used drugs for cough/cold management and their safety in pregnancy and lactation are listed in the chart below. For general considerations, see **footnote a** below.

Drug	Use in Pregnancy	Use in Lactation
Nondrug therapy		
N/A	**General measures**: rest, oral hydration[15] **Nasal/sinus congestion or irritation**: nasal saline lavage or spray, nasal strips (e.g., Breathe Right), steam inhalation (e.g., using a shower or humidifier)[15,20,22,34,35] **Sore or irritated throat**: menthol throat lozenges, salt water gargle, tea with lemon or honey[20,34,35]	
Analgesics/Antipyretics: See our chart, *Analgesics in Pregnancy and Lactation*.		
First Generation Antihistamines		
Brompheniramine	• Association between first trimester brompheniramine use and congenital defects in a large cohort study (Collaborative Perinatal Project).[1] • Antihistamine exposure during the last 2 weeks of pregnancy has been associated with retrolental fibroplasia in premature infants.[1]	• No human data. Could cause irritability or sedation or reduce milk supply. Small, occasional doses acceptable. Consider taking at bedtime after last feeding.[10]
Chlorpheniramine	• Considered first-line if an oral antihistamine is needed due to long history of use and large number of exposures.[1,3] A large cohort study (Collaborative Perinatal Project) suggests low risk.[1] • Antihistamine exposure during the last 2 weeks of pregnancy has been associated with retrolental fibroplasia in premature infants.[1]	• Excretion into breast milk expected due to low molecular weight.[1] Could cause irritability or sedation or reduce milk supply. Small (2 to 4 mg), occasional doses acceptable. Consider taking at bedtime after last feeding.[10]
Clemastine (US)	• Limited human data. One cohort study (Michigan Medicaid) suggests possible association with limb reduction defects. Animal data suggest low risk.[1] • Antihistamine exposure during the last 2 weeks of pregnancy has been associated with retrolental fibroplasia in premature infants.[1]	• Excreted into breast milk.[1] Could cause irritability or sedation or reduce milk supply. Small, occasional doses acceptable. Consider taking at bedtime after last feeding.[10]

Drug	Use in Pregnancy	Use in Lactation
Diphenhydramine (e.g., Benadryl)	• Considered safe in pregnancy by SOGC.[2] • One case-control study suggests an association with cleft palate.[1] A cohort study (Michigan Medicaid) found a possible association with polydactyly.[1] • Diphenhydramine has been reported to have oxytocin-like properties when used in labor.[1] • A potential drug interaction between diphenhydramine and temazepam resulting in the stillbirth of a term female infant has been reported, and rabbit studies support an interaction.[1] Daily maternal use was associated with potential withdrawal (tremulousness, diarrhea) in the newborn.[1] • Antihistamine exposure during the last 2 weeks of pregnancy has been associated with retrolental fibroplasia in premature infants.[1]	• Excreted into breast milk.[1] Could cause irritability or sedation or reduce milk supply. Small, occasional doses acceptable. Consider taking at bedtime after last feeding.[10]
Doxylamine	• Considered safe in pregnancy.[1]	• No human data.[1] Excretion into breast milk expected due to low molecular weight.[1] Could cause irritability or sedation or reduce milk supply.[10] Small, occasional doses acceptable.[10]
Promethazine	• Most evidence suggests low risk, but one cohort study (Michigan Medicaid) found a possible association with cardiovascular defects.[1] • Evidence of respiratory depression (conflicting), impaired platelet aggregation (unknown clinical significance), and transient neonatal behavioral and electroencephalographic effects when used near term.[1]	• No human data.[1] Excretion into breast milk expected due to low molecular weight.[1] Based on limited data from other phenothiazines, short-term use should pose little risk.[10] Might interfere with establishment of lactation if given early post-partum.[10] Monitor infant for sedation.[10]
Second Generation Antihistamines		
Cetirizine (e.g., Zyrtec [U.S.], Reactine [Canada])	• Animal and limited human data suggest low risk.[1] However, chlorpheniramine is preferred, especially during the first trimester.[1]	• A preferred antihistamine at its lowest dose.[26] Levels in milk are low.[28] Could cause irritability or sedation, or reduce milk supply.[10]

Drug	Use in Pregnancy	Use in Lactation
Desloratadine (e.g., Clarinex [US], Aerius [Canada])	• A large cohort study suggests safety.[32] The investigators concluded that desloratadine can be recommended as other second-generations antihistamines (e.g., cetirizine, loratadine) during pregnancy.[32]	• Excreted into breast milk.[1] Levels in milk are calculated to be low (based on studies of loratadine), and it would not be expected to cause sedation or other effects in the infant or reduce milk supply.[10]
Fexofenadine (e.g., Allegra)	• A large cohort study suggests safety.[31] The investigators concluded that fexofenadine can be recommended as other second-generation antihistamines (cetirizine, loratadine) during pregnancy.[31]	• Excreted into breast milk.[1] Levels in milk are calculated to be low (based on studies of terfenadine), and it would not be expected to cause sedation or other effects in the infant.[10] Might reduce milk supply.[10]
Loratadine (e.g., Claritin)	• No evidence of teratogenicity in animals and limited human data.[1] However, chlorpheniramine is preferred, especially during the first trimester.[1]	• A preferred antihistamine, at its lowest dose.[26] Levels in milk are low, and it would not be expected to cause sedation or other effects in the infant. Might reduce milk supply.[10]
Antitussives/Expectorants		
Benzonatate (US only)	• No animal or human data. Use only if clearly needed.[6]	• No information.
Codeine	• Avoid in first trimester (and third trimester due to effects on newborn such as withdrawal).[1] • Cohort and case-control data suggest an association between first trimester opioid use and a variety of malformations (e.g., cardiovascular defects, cleft lip and palate, musculoskeletal defects, hernia, hydrocephaly, tongue-tie, gastrointestinal defects [first and second trimester]).[1,4,33] Findings on neural tube defects are mixed.[4,5] Codeine specifically was associated with perimembranous ventricular septal defect in the National Birth Defects Prevention Study.[25] The absolute risk of any defect is likely small.[1,4,33] • Limited (if any), efficacy for cough due to upper respiratory infection; use not recommended.[24,27]	• Not recommended (Canada: contraindicated).[12,13] Risk of fatal morphine (codeine metabolite) toxicity if mom is an ultrarapid CYP2D6 metabolizer (see footnote b).[1]

Drug	Use in Pregnancy	Use in Lactation
Dextromethorphan (in Robitussin DM, etc)	• Data from a large cohort study (Collaborative Perinatal Project) and other studies does not support an association between dextromethorphan and congenital malformations.[1] • Has not yet been shown to make cough due to the common cold less severe or resolve faster; use is suggested against.[7] • Avoid alcohol-containing products.[1]	• Levels of dextromethorphan and its active metabolite in milk are very low, and it would not be expected to affect infant. Avoid alcohol-containing products.[10]
Guaifenesin (in most Robitussin products, Mucinex, etc)	• Data from large cohort study (Collaborative Perinatal Project) suggests increased risk of inguinal hernias with first trimester use.[1] Other large studies have not identified any risks.[1] Considered compatible,[1] • Unlikely effective as an expectorant or mucolytic in acute respiratory infections.[23]	• No information. Unlikely to harm infant, especially those over two months of age. Avoid alcohol-containing products.[10]
Hydrocodone (US)	• Avoid in first trimester (and third trimester due to effects on newborn such as withdrawal).[1] • Cohort and case-control data suggest an association between first trimester hydrocodone use and a variety of malformations (e.g., cardiovascular defects, cleft palate alone or with cleft lip, perimembranous ventricular septal defect, and tetralogy of Fallot).[4,25] Findings on neural tube defects are mixed.[4,5] The absolute risk of any defect is likely small.[1,4] • Limited efficacy for cough due to upper respiratory infection; use not recommended.[27]	• Excessive sleepiness and cyanosis reported in two case reports.[10] • Active metabolite (hydromorphone) formed through CYP2D6 is more potent than hydrocodone.[10,29] • Theoretical risk of hydromorphone toxicity if mother is an ultrarapid CYP2D6 metabolizer (see footnote b).[10] • Limit dose to 30 mg daily two to three days).[10]
Decongestants		
Pseudoephedrine (in most Sudafed products, etc)	• Avoid during first trimester.[1,22] • Case-control studies suggest increased risk of ventricular septal defects, gastroschisis, and small intestinal atresia with 1st trimester pseudoephedrine use.[1,8] Data from a large cohort study (Collaborative Perinatal Project) suggests increased risk of minor malformations, inguinal hernia, and clubfoot with 1st trimester sympathomimetic use.[1]	• Excreted into breast milk.[1] Avoid if milk production insufficient or not established.[10] May cause irritability.[10]

Drug	Use in Pregnancy	Use in Lactation
Phenylephrine (nasal [US]/oral) (e.g., Sudafed PE [US])	• Avoid oral phenylephrine during the first trimester.[22] • Data from a large cohort study (Collaborative Perinatal Project) suggests increased risk of a variety of malformations, mostly minor (e.g., syndactyly, eye and ear malformations, hernia), with 1st trimester use.[1] A case-control study suggests increased risk of cardiac septal defects with 1st trimester phenylephrine use.[8] • Could reduce uterine blood flow, resulting in fetal hypoxia/bradycardia.[1] • Oral product is not effective, but still available at time of writing.[18] Nasal route has insufficient safety data in pregnancy.	• No human data. Nasal spray less likely to decrease milk production.[10]
Oxymetazoline (nasal) (Afrin [US] Drixoral [Canada], etc)	• Data from a case-control study suggest increased risk of renal malformations with 2nd trimester exposure, tracheoesophageal fistula with 1st trimeters exposure, and possibly pyloric stenosis with 1st trimester use of nasal oxymetazoline.[8] • Could reduce uterine blood flow, resulting in fetal hypoxia/bradycardia. A small study suggests it does not pose risk in healthy pregnancies but could be detrimental in women with borderline placental reserve.[1]	• No information. Little expected to reach infant through breast milk. Has been recommended over oral decongestants during breastfeeding.[10]
Xylometazoline (nasal) (e.g., Otrivin [Canada])	• Data from a case-control study suggest increased risk of tracheoesophageal fistula with 1st trimester exposure, and pyloric stenosis with 1st trimester use of nasal xylometazoline.[8] • See oxymetazoline (above) regarding effects on uterine blood flow.	• No information.
Nasal steroids		
Beclomethasone (e.g., Qnasl [US.])	• Compatible.[1]	• Amounts in breast milk probably too small to cause harm.[10] Use acceptable.[10]
Budesonide (e.g., Rhinocort)	• Compatible.[1] • A small risk of cardiac defects cannot be ruled out.[1]	• Amounts in breast milk probably too small to cause harm.[10] Compatible.[19]

Drug	Use in Pregnancy	Use in Lactation
Ciclesonide (e.g., Omnaris)	• Compatible.[1]	• Amounts in breast milk probably too small to cause harm.[10] Compatible.[19]
Flunisolide (US)	• Considered compatible, but human data is limited and bioavailability relatively high (50%).[1]	• Amounts in breast milk probably too small to cause harm.[10] Use acceptable.[10]
Fluticasone (e.g., Flonase Allergy Relief)	• Compatible.[1]	• Amounts in breast milk probably too small to cause harm.[10] Compatible.[19]
Mometasone (Nasonex 24 HR Allergy [US]; Nasonex [Canada])	• Probably compatible.[1,19]	• Amounts in breast milk probably too small to cause harm.[10] Compatible.[19]
Triamcinolone (e.g., Nasacort Allergy 24 HR)	• Compatible.[1] • A risk of respiratory malformations cannot be ruled out.[1,22]	• Amounts in breast milk probably too small to cause harm.[10] Use acceptable.[10]
Other Agents		
Echinacea	• Small cohort studies suggest no increased risk of major malformations with 1st trimester exposure.[1,14] • Echinacea is not regulated as a drug, so safety, efficacy and quality cannot be assured.[1] Echinacea contains multiple chemical constituents with no toxicology data, and potentially contaminants (e.g., lead).[1,14] • Avoid alcohol-containing products.[14]	• Excreted in breast milk.[10] Avoid.[1]
Vitamin C	• Do not exceed the tolerable upper intake level (1.8 g per day for pregnant teens 14 to 18 years of age, or 2 g/day for pregnant women over 19 years of age).[9] • One case report of anencephaly with high doses of vitamin C and other supplements.[1] • A study found no adverse effects with doses up to 2,000 mg a day.[1]	• Do not exceed the tolerable upper intake level (1.8 g per day for lactating teens 14 to 18 years of age, or 2 g/day for lactating women over 19 years of age).[9]
Zinc *Continued…*	• Do not exceed the tolerable upper intake level (34 mg/day for pregnant teens 14 to 18 years of age or 40 mg/day for pregnant women ages 19 to 50 years of age).[11]	• Do not exceed the tolerable upper intake level (34 mg/day for lactating teens 14 to 18 years of age or 40 mg/day for lactating

Drug	Use in Pregnancy	Use in Lactation
Zinc, continued		women ages 19 to 50 years of age).[11] Higher doses can cause copper deficiency in the nursing infant.[11]

Abbreviation: SOGC=Society of Obstetricians and Gynaecologists (of Canada).

a. Pregnant women are often advised to try nondrug treatments first. When these fail to relieve symptoms, medications are sometimes used. Pregnant women should be advised to check with their prescriber before taking any medication.[17] Choose symptom-targeted medications, and advise use for the shortest time necessary.[16,30] Consider limiting antihistamine use to two days, when most benefit is seen.[16] Avoid long-acting, extended-release, combination, "maximum strength," and alcohol-containing formulations.[1,10,16.30,34] Although many medications are excreted in breast milk, most have no or minimal effect on the infant or milk supply.[17] Consider drugs that can be given safely to infants.[30] Most adverse effects in breastfeeding infants have been reported in infants <6 months of age.[1]
b. **Ultrarapid CYP2D6 metabolism** occurs in up to 1% to 10% of white European or North Americans; 3% to 4% of Black Americans; 1% to 2% of Chinese, Japanese, and Koreans; and >10% in Oceanic, North African, Middle Eastern, and Puerto Rican populations, and Ashkenazi Jews.[12] In a US urban population, individuals identifying as Caucasian or Hispanic had an incidence of ~11%, with variability within subpopulations.[21]

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