Pregnancy while breastfeeding and hormonal effects

Can you get pregnant while breastfeeding?

Yes. Breastfeeding can delay the return of ovulation, but it is not a completely reliable form of contraception unless very specific lactational amenorrhea criteria are met. The key point is that ovulation can occur before the first postpartum menstrual bleed. This means a person may become pregnant without having had an obvious period after birth.

The NHS explains that breastfeeding may reduce fertility because frequent suckling influences reproductive hormones, but the effect varies from person to person. Fertility is more likely to remain suppressed when a baby is exclusively breastfed, feeds frequently, feeds overnight, and is not receiving regular supplementation or long gaps between feeds. As feeds become less frequent, solids are introduced, formula is added, sleep stretches lengthen, or pumping replaces direct feeding for some sessions, ovulation may resume.

For anyone who wishes to avoid pregnancy, it is wise to discuss postpartum contraception before relying on breastfeeding alone. Conversely, if you are trying to conceive while breastfeeding, it may help to know that fertility can return gradually and irregularly, and cycle tracking may be less predictable during lactation.

The hormonal basis: prolactin, GnRH, LH, and ovulation

Lactational amenorrhea is driven primarily by neuroendocrine signaling between the breast, brain, and ovaries. Frequent nipple stimulation increases prolactin secretion from the anterior pituitary. Prolactin is essential for milk synthesis, but it also suppresses pulsatile release of gonadotropin-releasing hormone, or GnRH, from the hypothalamus. Reduced GnRH pulsatility leads to lower or disrupted secretion of luteinizing hormone, or LH, and follicle-stimulating hormone, or FSH. Without a coordinated LH surge, ovulation is less likely.

This suppression is not permanent and is sensitive to feeding patterns. Longer intervals between feeds, fewer night feeds, infant supplementation, and the introduction of complementary foods can reduce the hormonal signal maintaining amenorrhea. The NCBI Bookshelf overview of the Lactational Amenorrhea Method describes this biologic basis and emphasizes that the method depends on strict criteria.

The Lactational Amenorrhea Method, often called LAM, is generally considered only when all of the following apply:

The baby is younger than 6 months.
Menstrual periods have not returned.
Breastfeeding is exclusive or near-exclusive, with frequent feeding day and night.

If any of these conditions no longer applies, the likelihood of ovulation increases and another contraceptive method is usually recommended if pregnancy is not desired.

What changes hormonally when pregnancy begins during breastfeeding?

Once pregnancy occurs, the endocrine environment shifts again. Human chorionic gonadotropin, or hCG, rises early and supports the corpus luteum. Progesterone and estrogen increase as pregnancy progresses, helping maintain the uterine lining, support placental development, and prepare breast tissue for future lactation. These pregnancy hormones coexist with lactation-related prolactin

and oxytocin.

After birth, estrogen and progesterone normally fall sharply, allowing prolactin to act more strongly on the breast and establish milk production. During a new pregnancy, however, rising estrogen and progesterone can counter some of prolactin's milk-producing effects. This is one reason milk supply may decrease during pregnancy, especially in the second trimester. The change is not a failure of effort or commitment; it is a physiologic response to pregnancy hormones.

Oxytocin remains important for milk ejection, often called letdown. It is released in pulses during breastfeeding and can also contribute to uterine contractility. In many uncomplicated pregnancies, breastfeeding-related uterine sensations are mild and transient. However, people with a history of preterm birth, recurrent pregnancy loss, cervical insufficiency, unexplained bleeding, placenta-related complications, or significant uterine pain should seek individualized obstetric guidance about whether continuing to breastfeed is appropriate.

How pregnancy may affect milk supply and milk composition

Many breastfeeding parents notice a reduction in milk volume during pregnancy. The timing varies, but it is commonly reported after the first trimester as pregnancy hormones rise. Some babies and toddlers compensate by nursing more often; others become frustrated by slower flow or wean gradually.

Milk taste and composition can also change. Later in pregnancy, the breasts begin transitioning toward colostrum production for the expected newborn. Colostrum is concentrated, immunologically rich early milk. A nursing toddler may notice that milk is saltier or different in volume and may either continue nursing, nurse for comfort rather than nutrition, or lose interest.

If the breastfeeding child is under 12 months and breast milk remains a major source of nutrition, a noticeable supply drop should be discussed with a pediatrician, midwife, lactation consultant, or other qualified clinician. The child's weight gain, wet diapers, developmental stage, and intake of complementary foods or formula may need review. For an older toddler who eats a varied diet, changes in nursing may be less nutritionally significant but can

still be emotionally meaningful for both parent and child.

Common physical experiences: nipple tenderness, fatigue, nausea, and uterine sensations

Pregnancy while breastfeeding can intensify physical demands. Nipple and breast tenderness are common in early pregnancy due to estrogen, progesterone, and local breast tissue changes. For someone nursing frequently, this sensitivity can make feeds uncomfortable. Adjusting latch, limiting very long comfort feeds, changing positions, or setting gentle boundaries with an older child may help, but persistent pain, nipple trauma, fever, or localized breast redness should be medically assessed.

Fatigue can also feel more pronounced because the body is supporting early pregnancy, lactation, postpartum recovery in some cases, and daily caregiving. Nausea may make hydration and adequate calorie intake more difficult. While there is no single diet that fits everyone, pregnancy plus breastfeeding generally increases nutritional demands. Clinicians may discuss prenatal vitamins, iodine, vitamin D, iron status, calcium intake, omega-3 intake, or other needs based on diet, laboratory results, medical history, and local guidance.

Some people feel mild uterine tightening during or after nursing. This can be related to oxytocin release. Mild, brief sensations can occur, but regular painful contractions, pelvic pressure, bleeding, fluid leakage, severe abdominal pain, or reduced fetal movements later in pregnancy require prompt medical advice.

Is breastfeeding during pregnancy safe?

For many people with uncomplicated, low-risk pregnancies, breastfeeding can continue. Available clinical guidance generally treats breastfeeding during pregnancy as compatible with normal gestation when there are no risk factors requiring restriction. However, safety is not universal because obstetric risk varies.

It is especially important to consult a healthcare professional if you have a history of preterm labor, significant uterine bleeding, multiple pregnancy,

cervical shortening or cerclage, placenta previa or other placental concerns, poor fetal growth, severe maternal anemia, or any condition for which your clinician has advised pelvic rest or activity modification. In these situations, the decision about breastfeeding should be individualized rather than based on general reassurance.

Emotional safety matters too. Some parents feel aversion or agitation while nursing during pregnancy, sometimes called breastfeeding aversion and agitation. This can be distressing and is not a sign of being uncaring. Hormonal shifts, nipple pain, sleep deprivation, and sensory overload can all contribute. Support from a lactation consultant, midwife, therapist, or peer breastfeeding service can help you make a plan that respects both your wellbeing and your child’s needs.

Tandem nursing after birth

If breastfeeding continues throughout pregnancy, some families go on to tandem nurse, meaning they breastfeed the newborn and an older child during the same postpartum period. Colostrum is produced for the newborn even if an older child continues to nurse. In the early days after birth, many clinicians advise prioritizing the newborn’s access to the breast because newborn intake, weight, hydration, and jaundice risk require close attention.

Tandem nursing may increase milk removal and can sometimes feel physically intense. It may also help an older child adjust emotionally to the new baby. Boundaries are allowed: some parents choose specific nursing times for the older child, shorten feeds, or wean during pregnancy or after birth. There is no single correct approach. The best plan is one that protects newborn feeding, maternal recovery, and family wellbeing.