PREGNANT WOMEN AND OPIOID USE DISORDER

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INTRODUCTION

- Increasing rate of opioid use disorder among women, including pregnant women, is requiring increasing medical and social services
- Pregnant women who use opioids – either prescribed or illicit – will have baby who is affected by that use.
  - Neonatal Abstinence Syndrome (NAS) – which is treatable
- Abrupt discontinuation of opioid use during pregnancy can result in premature labor, fetal distress, and miscarriage.
- Relapse of illicit opioid use is also a concern when opioid use is stopped suddenly – potentially resulting in overdose
- The use of Medication Assisted Treatment (MAT) is recommended as best practice for the care of pregnant women with opioid use disorder (American College of OB/GYN Committee of Healthcare for Underserved Women & American Society of Addiction Medicine, 2012)
- Buprenorphine and methadone have both been shown to be safe and effective treatments for OUD during pregnancy. (Jones HE, et al, NEJM 2010)

INTRODUCTION CONTINUED

- MAT is the use of medications IN COMBINATION with counseling and behavioral therapies
- Medications used for MAT: Buprenorphine and Methadone
- These medications are proven to:
  - Stop and prevent opioid withdrawal
  - Reduce opioid cravings
  - Allow patient to focus on individualized care – pregnant women can focus on the developing fetus

BACKGROUND

This is not new –

“The use of MAT, in combination with counseling and behavioral therapies, and access to a range of supportive services, such as housing and employment services, assists the mother in achieving a more stable life (Newman & Kagen, 1973; Finnegan, 1991; CSAT, 2005).”

“In turn, it also stabilizes the intrauterine environment and avoids subjecting the fetus to repeated episodes of withdrawal, which places the fetus at higher risk for morbidity and mortality (Kaltenbach & Finnegan, 1998; Jones et al., 2005; CSAT, 2005).”

OPIOID USE DISORDER (OUD) AND PREGNANCY

- Unfortunately, not uncommon
- Goal is to protect and support both mother and fetus
- Current Standard of care for opioid use disorder is to refer for Medication assisted therapy (MAT) – methadone or Buprenorphine
- MAT will result in Neonatal Abstinence Syndrome – which is treatable
  - Less severe when mother receives MAT than in absence of MAT (Brogly SB, et al. AM J Epidemiology 2014 and Fajemirokun-Odudeyi O, et al. Eur J Obstet Gynescol Reprod Biol 2006)
  - Reduction of MAT medications to reduce NAS is not supported by research (Kaltenbach K, et al. Obstet Gynecol Clin North Am (1998)

Abrupt discontinuation of opioids in an opioid-dependent pregnant woman can result in pre-term labor, fetal distress, and/ fetal demise

MAT WITH BUPRENORPHINE

- Buprenorphine/Naloxone medication is allowed during pregnancy
- Recent literature reports reduced NAS in infants born to women treated with Buprenorphine/Naloxone over Buprenorphine alone
- Appropriate dose of Buprenorphine/Naloxone will vary – dose should be adjusted until the patient has no signs of withdrawal.
- First 2 trimesters top dose should be 16-4 mg daily in divided doses
  - 95% of receptors are covered by this dose
  - Pain and stress may require increased dose
- Third trimester may require increased doses – but not more than 24-6 mg/day

OUD AND PAIN MANAGEMENT

- Intrapartum care –
  - Appropriate pain management
  - Buprenorphine/Naloxone may be dosed at lower doses and more frequently
- Postpartum care
  - Proper dosing and pain management to avoid relapse and overdose
    - Buprenorphine/Naloxone is an excellent pain management medication in addition to an MAT medication
  - Provide discussion for adequate contraception
  - MAT is compatible with breastfeeding
  - Neonatal Abstinence Syndrome is expected

DISCRIMINATION AND STIGMATIZATION

- Women with a SUD and pregnancy face terrible discrimination and stigmatization
- Education of those who are in contact with pregnant women is required – very difficult to change biases
- Healthcare workers with stigma and bias can result in both under-reporting of drug use and insufficient medication dosing. (OWH. White Paper: Opioid Use, Misuse, and Overdose in Women 2016. Thigpen J & Melton ST. J Ped Pharm Ther 2014.)
- Nonjudgmental approach - Earn trust of mother → better for mom and baby

CIRCLE THE WAGONS!

- Women who use opioids and are pregnant warrant a team approach to care
- Locally: Healthy Moms (The Wright Center) and Free2BMom (Geisinger)
- This team includes:
  - Child welfare – baby and other children?
  - Welfare of mom – is she living in a safe environment?
  - Medical – OB, pediatrics, MAT, and mental health care
  - Balance between protecting mother and protecting baby
    - Child Welfare agencies support families while monitoring child safety

WHAT TO DO IF A PREGNANT WOMAN CONFIDES THAT SHE IS USING SUBSTANCES

- First – thank her for trusting you enough to confide in you!!!! This is a huge step and very difficult for this patient
- Contact Free2BMom or Healthy Moms immediately – this patient needs a great deal of care to help her and her baby.
  - Both should be available on an emergency basis
- Greatest concerns are overdose or withdrawal – both are imminent threats to mom and baby
- Offer patient support and compassion

MAT FOR PREGNANT WOMAN

- Induction of Buprenorphine can be very difficult in this population
- Induction should be handled by provider with experience
- MAT includes either Buprenorphine or Methadone
  - Buprenorphine/Naloxone can be used safely in women who are pregnant – recent literature reports reduced neonatal abstinence syndrome
- Care must be taken to avoid withdrawal – especially precipitated withdrawal if transitioning to buprenorphine

MOTHER USING OPIOIDS

- Transition to Methadone – safe as low risk for withdrawal
- Transition to Buprenorphine – consider conducting induction in a labor and delivery setting for close monitoring
- Consider inpatient care if possible (can be difficult to find for pregnant women)
  - Mother must be in moderate withdrawal for induction.
  - Comfort meds must be carefully used
    - Clonidine is a category C and should be used cautiously.
    - Hydroxyzine should NOT be used – especially 1st trimester
    - Pepto-Bismol should not be used in 2nd and 3rd trimester
    - Ondansetron (Zofran) may be safe

BUPRENORPHINE INDUCTION

- Once a patient is in moderate withdrawal
  - Buprenorphine/Naloxone film 8-2 mg – cut into ¼'s
  - Place ¼ film (2-0.5 mg) under tongue and dissolve
  - Wait 30 minutes and place another ¼ film (2-0.5mg) under tongue
    - If precipitated withdrawal occurs place 2 films (16-4 mg) Suboxone in mouth – one film in each side of mouth between cheek and gum.
      - Call ambulance
  - Continue with dosage 4 hours later

TRANSITION TO METHADONE

- Should only be completed by a trained provider
- Methadone is a full agonist with potential for misuse
  - Risk of overdose
- May be associated with higher treatment retention
- Less chance of withdrawal – especially precipitated withdrawal
- Direct observation of therapy (DOT) carried out daily for new patients
- If able to divide methadone doses – smaller doses more frequently throughout day → less NAS. (McCarthy JJ. Et al. J Addict Med 2015)

NEONATAL ABSTINENCE SYNDROME (NAS)

- Signs of intoxication or withdrawal:
- Autonomic instability; CNS irritability; feeding difficulties (sucking difficulties); instability in heart rate; respiratory rate; temperature control; hyperactivity; irritability; hypertonia; hypotonia; sleep disturbance; high-pitched cries.
- Treatment – supportive
  - Reduce ambient lighting and noise
  - Swaddling
  - Small frequent feedings
  - IV fluids if necessary
  - Followed for 72 - 96 hours

NAS

- Pharmacotherapy is indicated if:
  - Seizures
  - Poor feeding/diarrhea or vomiting → dehydration or excessive weight loss
  - Inability to sleep
  - Significant autonomic instability with bradycardia or tachycardia, apnea or tachypnea, or temperature instability (not due to infection)
  - If infant appears very ill or signs of other comorbid medical conditions
- NAS Differential Dx: Sepsis, hypoglycemia, perinatal anoxia, intracranial bleeding, and hyperthyroidism

TREATMENT ACCESS BARRIERS

- Prior to COVID only 52% of MAT clinics accepted pregnant patients
- During COVID this dropped to 34% MAT clinics accepted pregnant patients
- 57% of clinics offered detox to pregnant patients → which is lacks supportive evidence
- Pregnant patients often are stuck between OB/GYN requiring the patient be in treatment at an MAT clinic and MAT clinic demanding an OB/GYN → communication between professionals is a problem with this clientele.

Lensch A, Hairston E, et al, Pregnant Patients Using Opioids: Treatment Access Barriers in the Age of COVID-19. J Addict Med. Volume 00, Number 00 2021

QUESTIONS