Challenges of Substance Use Disorder in Pregnancy and Breastfeeding

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Disclosures

- Dr. Adams has nothing to disclose with regard to commercial relationships.
- The content of this presentation does not relate to any product of commercial interest.
- Dr. Adams has no financial relationships to disclose.
- Dr. Adams would encourage you to the ACOG District 11 Opioid Use Disorder Bundle 1 & 2 from which some information was retrieved and is duly noted on those slides.
- The ACOG District 11 Opioid Use Disorder Bundle is a comprehensive guide for the appropriate care of this population with extensive resources.
References


Objectives

- Overview of SUD
- Prenatal Care and Practice Considerations
- Intrapartum and Postpartum Management
- Neonatal Abstinence Syndrome
- Breastfeeding
Substance Use Disorders

When recurrent use of a substance cause;
- clinical and functional impairment &
- failure to meet major responsibilities (work, school, home)

it is deemed a substance use disorder.
Substance Use Disorders

- Alcohol Use Disorder
- Stimulant Use Disorder
- Hallucinogen Use Disorder
- Tobacco Use Disorder
- Cannabis Use Disorder
- Opioid Use Disorder
Opioid Abuse Disorder

- Manifestations
  - Physical Opioid Dependence
  - Opioid Addiction
Physical Opioid Dependence

- The body physiologically adapts to opioids over time
- Discontinuation or rapid dose reduction or the administration of antagonists (Naloxone) or agonist-antagonists (pentazocine) results in withdrawal symptoms
Opioid Withdrawal Symptoms

- Anxiety or general discontent
- Restlessness, sweating, tremor
- Nausea, vomiting, diarrhea
- Abdominal cramps
- Dilated pupils, watery eyes
- Fast heart rate, goosebumps, excessive yawning
Management Of Acute Withdrawal

- Recognize symptoms
- Contact MAT (Medication-Assisted Treatment) provider if patient is in treatment
- SBIRT
- Initiate MAT for those who are willing
- Develop a system of follow-up for those who refuse.
SBIRT

S
- Universal Screening

B
- Brief Intervention

RT
- Referral for Treatment
Opioid Addiction

- Chronic Disease
- Dysfunction in brain reward, motivation and memory
- Pathological pursuit of reward/relief by opioid use is the result
- Cycles of relapse and remission
- Progressive without treatment
Where Pain Relievers Were Obtained for Most Recent Nonmedical Use among Past Year Users Aged 12 or Older: 2012-2013

More than One Doctor (2.6%)  Free from Friend/Relative (53.0%)
One Doctor (21.2%)  
Other¹ (4.3%)  Bought on Internet (0.1%)
Drug Dealer/Stranger (4.3%)
Bought/Took from Friend/Relative (14.6%)

Source Where Friend/Relative Obtained
One Doctor (83.8%)
More than One Doctor (3.3%)  Free from Friend/Relative (5.1%)
Bought/Took from Friend/Relative (4.9%)
Other¹ (1.2%)
Drug Dealer/Stranger (1.4%)
Bought on Internet (0.3%)

¹The Other category includes the sources "Wrote Fake Prescription," "Stole from Doctor's Office/Clinic/Hospital/Pharmacy," and "Some Other Way."
Note: The percentages do not add to 100 percent due to rounding.

https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
DSM-V Diagnostic Criteria: OUD & SUD

- Taking the opioid in larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do so
- Spending a lot of time obtaining opioid
- Craving or strong desire to use opioids
- Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
- Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Consistent use of opioids despite acknowledgement of persistent or recurrent physical or psychological difficulties from using opioids

- 2 – 3 = mild
- 4 – 5 = moderate
- ≥ 6 = severe
Don’t Go It Alone!

A Collaborative approach leads to:

- Improved communication
- Better patient management
- Reduced gaps in care
- Better outcomes
Prenatal Care - The Office

- Identification of local resources
- Team education in the merits of early screening and management
- Screening tools – history taking
- Screening tools - testing
Prenatal Care

ACOG
- Assess all pregnant women for SUDs
- Screening is part of comprehensive obstetric care and is done in partnership with the pregnant woman.
- SBIRT improves maternal and infant outcomes.
SBIRT

S
- Universal Screening

B
- Brief Intervention

RT
- Referral for Treatment
Urine Testing

- Confirms suspected opioid use
- Requires consent and compliance with state laws
- Misses alcohol, tobacco, some synthetic opioids, some benzodiazepines and some designer drugs
- Tests current or recent use but not sporadic use
- Positive testing is not in itself diagnostic of OUD
Patient Interaction

Avoid dehumanizing, demeaning, demoralizing language:
- Addict
- Drug abuser
- Clean vs. Dirty
- Crazy vs. Normal
Patient Interaction

Use people first language
- Persons have a problematic existence with drugs
- Person with substance use disorder
- In recovery
- The baby has had a substance exposure
Withdrawal During Pregnancy

- Not recommended
- Low rate of completion
- High rate of relapse
- Does not avoid all NAS cases
- Increased risk of morbidity
- Low tolerance and risk of overdose
- Increased mortality

- MAT with methadone or buprenorphine is the recommended treatment in pregnancy
Methadone in Pregnancy

- Initiation of treatment may be easier
- Initiation of therapy does not precipitate withdrawal
- Better treatment retention
Buprenorphine in Pregnancy

- Reduced risk of overdose during induction
- Fewer drug interactions
- Less severe NAS
- Outpatient therapy not requiring daily visits
Intrapartum

- Collaborative effort between anesthesia, nursing, obstetrical provider
- Intrapartum analgesia should be the same as for any other woman
- Difficult IV access should be assessed as may be an obstacle to IV hydration and pain management
- Methadone or buprenorphine should be continued through labor
Intrapartum

- Safe labor management options
  - Neuraxial (epidural and intrathecal) opioids
  - Natural pain management (acupuncture, TENS)
  - Nitrous oxide
  - Doula support
Intrapartum

Drugs that precipitate withdrawal:
- Nalbuphine
- Butorphanol
- Opioid agonist - antagonist
Cesarean Birth: Anesthesia Assistance

Transversus Abdominis plane block (TAP)
- Ultrasound guided regional anesthetic technique that blocks T6 – L1
- Reduces postoperative opioid consumption and opioid-related side effects
- Improves postoperative pain control
- Improves patient satisfaction
Neonatal Abstinence Syndrome

- Drug withdrawal syndrome that opioid-exposed neonates may experience after birth with signs that can include:
  - Increases muscle tone
  - Poor eating, vomiting, diarrhea
  - High pitched and long duration crying
  - Difficulty sleeping
  - Tremors or shaking
  - Fever or sweating
  - Frequent yawning, sneezing
  - Difficulty breathing
  - Skin breakdown
  - Possible seizures
NYS Neonatal Abstinence Syndrome Rate

New York State neonatal abstinence syndrome (NAS) crude rate per 1,000 newborn discharges (any diagnosis)

Source: https://www.health.ny.gov/statistics/opioid/
https://www.acog.org/About-ACOG/ACOG-Districts/District-II/Opioid-Use-Disorder-in-Pregnancy
Postpartum

Key ideas:
- Patients should be reassured that their pain will be addressed
- Medications for MAT should not be assumed to cover postpartum pain
- MAT should not be adjusted nor interrupted for pain management
Vaginal Delivery

- Non-opioid analgesics should be adequate – NSAIDS, acetaminophen
- Sitz baths, ice packs, anesthetic spray, topical creams
- Early ambulation is encouraged
Cesarean Birth

- Require 70% more opiates for pain management
- Do not withhold medication but limit length of dosing
- Reduce dosing by adding secondary agents – NSAIDs, acetaminophen
Cesarean Birth: Anesthesia Assistance

Patient controlled analgesia (PCA) pump/ PCEA (epidural)
- Effective as long as 24 hours post-op
- Autonomy for patient
## Reduction of Prescribing

<table>
<thead>
<tr>
<th>Outcome</th>
<th>30 or Fewer Tablets (n=237)</th>
<th>31-40 Tablets (n=299)</th>
<th>More Than 40 Tablets (n=69)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied or very satisfied with pain relief</td>
<td>200 (84.4)</td>
<td>252 (84.3)</td>
<td>56 (81.2)</td>
<td>.501</td>
</tr>
<tr>
<td>Patient’s perception of opioid quantity dispensed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too little</td>
<td>35 (14.8)</td>
<td>29 (9.7)</td>
<td>6 (8.7)</td>
<td>.032</td>
</tr>
<tr>
<td>Just right</td>
<td>134 (56.5)</td>
<td>179 (59.9)</td>
<td>33 (47.8)</td>
<td></td>
</tr>
<tr>
<td>Too much</td>
<td>49 (20.7)</td>
<td>62 (20.7)</td>
<td>25 (36.2)</td>
<td></td>
</tr>
<tr>
<td>Experienced an opioid-related side effect</td>
<td>111 (46.8)</td>
<td>185 (61.9)</td>
<td>49 (71.0)</td>
<td>.001</td>
</tr>
<tr>
<td>Required a refill of opioid</td>
<td>14 (5.9)</td>
<td>15 (5.0)</td>
<td>4 (5.8)</td>
<td>.873</td>
</tr>
<tr>
<td>Pain score at week 1*</td>
<td>4 (3-5)</td>
<td>4 (2-5)</td>
<td>4 (2-5)</td>
<td>.034</td>
</tr>
<tr>
<td>Pain score at week 2*</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>2 (1-3)</td>
<td>.630</td>
</tr>
<tr>
<td>No. of tablets consumed</td>
<td>15 (5-24)</td>
<td>20 (10-32)</td>
<td>32 (14-50)</td>
<td>.001</td>
</tr>
</tbody>
</table>

Data are n (%) or median (interquartile range) unless otherwise specified.
* Pain score (0-10).

Source: Bateman B. et al Obstet Gynecol 2017

Over prescribing opioids may lead to patients consuming greater amounts of opioids which may predispose patients to higher consumption without improved pain control.

WHC providers can play an important role in decreasing the supply of opioid medication by adopting more judicious prescribing patterns and by counseling women about the importance of safe leftover medication disposal.
Breastfeeding

- The American Academy of Pediatrics and American College of Obstetrics and Gynecology both consider breastfeeding to be the normative standard for infant feeding and nutrition.

- The U.S. Department of Health and Human Services has put breastfeeding among its Healthy People Objectives.

- It has set 81.9% as its “ever breastfed” goal for 2020 and we are in line to achieve this goal and beyond.
Breastfeeding

Health Benefits of breastfeeding include improvements in:

- SIDS
- Otitis media rates
- URTI & LRTI
- Asthma
- RSV
- Necrotizing enterocolitis
- Inflammatory bowel disease
- Celiac disease
- Gastroenteritis
- Obesity
- Type 1 & 2 diabetes
- Leukemia: ALL & AML
- Atopic Dermatitis
Breastfeeding

- Breastfeeding should be encouraged for all women who are on a stable dose of methadone or buprenorphine and have no other contraindications.
Summary

- Comprehensive obstetric care should include screening for substance use at the first prenatal visit in a partnership relationship with the pregnant woman.

- Patients seeking prenatal care are likely to be motivated. Patients feel respected when spoken to with language that reduces stigma, and reflects our current understanding of evidence-based.

- Team collaborations to provide prenatal, intrapartum and postpartum care improves ultimate outcomes.
The Collaborative Process

- Set the stage for collaboration
- Engage key stakeholders and establish work groups
- Define shared goals
- Identify strategies and jointly monitor outcomes
Personal Space
References


