The Truth Behind Opioids in Pregnancy

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OKLAHOMA PERINATAL QUALITY IMPROVEMENT COLLABORATIVE

Caring For Pregnant Patients With Opioid Use Disorder

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Learning Objectives

After this presentation, participants will be able to:

1. Define opioid use disorder and describe its diagnostic criteria.
2. Counsel a patient on the maternal and fetal effects of opioid use in pregnancy.
3. Describe treatment options for opioid use disorder in pregnancy.
4. Discuss antepartum, intrapartum, and postpartum considerations for people with opioid use disorder in pregnancy.

Opioid Prescription Dispensing Rate by Category, Females 15-44 Years of Age, 2017-2020

- Opioid dispensing increased with increasing age.
- The opioid dispensing rate of each age group declined each year – consistent with the decline in overall opioid dispensing rates
- Despite decreases in opioid dispensing, Oklahoma continues to rank among the top 10 states for prescription opioid dispensing per capita.

Prescription Rates in Oklahoma By Age Category and Gender, 2017-2020

- When broken down by age group, opioid dispensing rates are much higher for women than for men in every age group.
- The opioid dispensing rate for both males and females declined every year and for each age category.

How To Recognize OUD

- Universal screening (not biologic)
- Examples of screening tools
  - National Institute on Drug Abuse (NIDA) Quick Screen
  - 4 P's

How To Recognize OUD

- National Institute on Drug Abuse (NIDA) Quick Screen tool:
  - In the past year, how often have you used the following?
    - *Alcohol*
    - *Tobacco products*
    - *Prescription drugs for non-medical reasons*
    - *Illegal drugs*
- 4 P's screening tool:
  - Parents
  - Partner
  - Past
  - Present

Diagnosis

	DSM-IV Abuse[a]		DSM-IV Dependence[b]		DSM-5 Substance Use Disorders[c]	
Hazardous use	X	≥1 criterion	–		X	≥2 criteria
Social/interpersonal problems related to use	X		–		X	
Neglected major roles to use	X		–		X	
Legal problems	X		–		–	
Withdrawal[d]	–		X	≥3 criteria	X	
Tolerance	–		X		X	
Used larger amounts/longer	–		X		X	
Repeated attempts to quit/control use	–		X		X	
Much time spent using	–		X		X	
Physical/psychological problems related to use	–		X		X	
Activities given up to use	–		X		X	
Craving	–		–		X	

Hasin DS, et al. DSM-5 Criteria for Substance Use Disorders: Recommendations and Rationale. Am J Psychiatry. 2013 Aug;170(8):834-851.

What Next?

- Ask the patient about their goals
  - “Is it okay if I ask you some more questions about your opioid use?”
  - “What do you think about your opioid use?”
- Refer to treatment
  - Medication for opioid use disorder (MOUD) prescriber
  - Medication-assisted treatment (MAT) program
  - Inpatient vs outpatient
  - Mental health services

Role And Significance Of Mental Health Disorders

- Many life challenges facing pregnant women with substance use disorders
- Treatment of underlying mental health disorder(s) is key

Type of mental health disorder	Rate of concurrent SUD (%)
Major depression	30.1-48.5
Bipolar disorder	3.6-6.8
Panic disorder	7.3-12
Social phobia	24.1-30.3
Simple or specific phobia	28.2-30.7
Generalized anxiety disorder	8.4-15.7

Opioids: Maternal Effects

- Risk for dependence
- Association with other risk-taking behaviors
  - Communicable diseases
- Decreased likelihood of attending regular prenatal care
- Financial and legal implications

Opioids: Fetal/Neonatal Effects

- Neonatal abstinence syndrome (NAS)/neonatal opioid withdrawal syndrome (NOWS)
- Preterm delivery
- Low birth weight
- Perinatal mortality
- Some evidence that children exposed to heroin in utero have higher risk for developmental delay, aggressiveness, hyperactivity, disinhibition
  - Confounded by family and social environment

Opioid Use Disorder Treatment In Pregnancy

- Abstinence would be ideal
  - 70% of people with OUD relapse within 6 weeks of nonmedication rehabilitation efforts
- Evidence on opioid withdrawal in pregnancy
  - Detoxification in pregnancy often unsuccessful, relapse rates >50% (strongest reason for not doing detoxification)
  - Possible increase in miscarriage rates with detoxification
    - *Based mostly on a 1973 case report and review*
    - *Defer until out of first trimester*
  - 2018 meta-analysis
    - *Evidence suggests that stillbirth may not be increased with detoxification*

Gossop M, et al. Lapse, relapse, and survival among opiate addicts after treatment. A prospective follow-up study. Br J Psychiatry. 1989;154:348-353.
Dashe JS, et al. Opioid detoxification in pregnancy. Obstet Gynecol. 1998;92:854-858.
Rementeria, JL, et al. Narcotic withdrawal in pregnancy: stillbirth incidence with a case report. Am J Obstet Gynecol. 1973;116:1152-1156.
Zuspan FP, et al. Fetal stress from methadone withdrawal. Am J Obstet Gynecol. 1975;122:43-46.
Luty J, et al. Is opiate detoxification unsafe in pregnancy? J Subst Abuse Treat. 2003;24:363-367.

OUD Treatment In Pregnancy

- Study comparing detoxification regimens in pregnant women
  - 5 groups:
    - *3-day methadone-assisted withdrawal (MAW) alone*
    - *3-day MAW followed by methadone maintenance (MM)*
    - *7-day MAW alone*
    - *7-day MAW followed by MM*
    - *Continuous MM*
- Medication-free women had poorer maternal outcomes (shorter treatment program retention, attended fewer obstetrical visits)
- Basis of current paradigm for medication-assisted treatment

Jones HE, et al. Methadone maintenance vs methadone taper during pregnancy: maternal and neonatal outcomes. Am J Addict. 2008;17:372-386.

Medication For Opioid Use Disorder (MOUD)

- Standard of care for pregnant women with opioid use disorder
  - Severity of NAS is not correlated with maternal pharmacotherapy dose
  - i.e., advise patients not to wean dose in pregnancy
- Two main options:
  - Buprenorphine (Subutex)
    - *Buprenorphine + naloxone (Suboxone)*
    - *Buprenorphine alone has higher risk for diversion*
  - Methadone
  - Both are longer-acting opioids
- Medically supervised withdrawal not recommended
  - Higher relapse rates

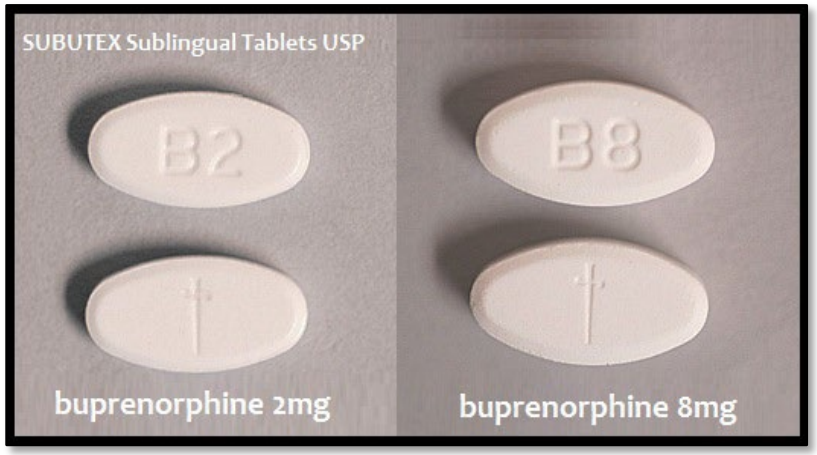
Methadone

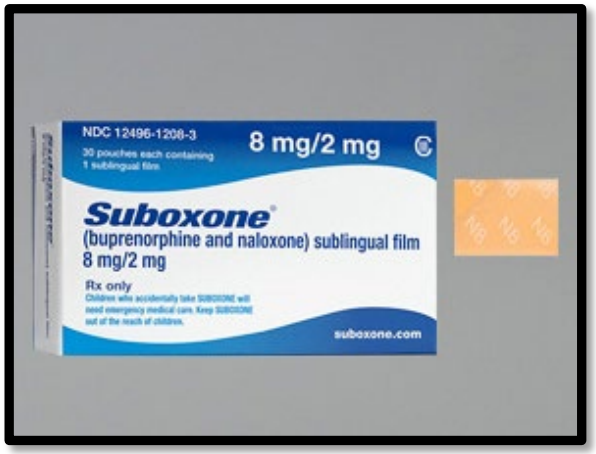
- Full mu-opioid receptor agonist
- By law, must be provided in setting of licensed opioid treatment program
- Usually requires daily visits to treatment center for dosing
- Can prolong maternal QTc interval

Methadone

- Used for decades in treatment of OUD
- Associated with:
  - *Earlier and more compliant prenatal care*
  - *Improved nutrition and weight gain*
  - *Fewer children in foster care*
- No ceiling effect
  - *Average dose 80-120 mg/day*
  - *< 60 mg/day thought to be insufficient*

Buprenorphine





- Only opioid currently approved for treatment of OUD in office-based setting

Buprenorphine

- Partial mu-opioid receptor agonist, very high affinity
  - Risk for precipitated withdrawal (e.g., in someone with recent heroin use, buprenorphine replaces heroin at mu receptor, but activates less strongly)
  - Precipitated withdrawal: why people should be in mild to moderate opioid withdrawal before initiating buprenorphine

Buprenorphine (Subutex)

Advantages:

- Less stringent dosing requirements
- Can be prescribed by certified providers rather than federally funded clinics
- Some evidence of less severe NAS compared with methadone

Disadvantages:

- May be less ideal if patient requires more structure/supervision
- Ceiling effect (24-32 mg/day)

What About Suboxone?

- Subutex = buprenorphine
- Suboxone = buprenorphine + naloxone
  - Used almost exclusively in non-pregnant patients
  - Less potential for diversion/abuse
    - *Naloxone not bioavailable when taken sublingually*
    - *If injected or snorted, will precipitate withdrawal*
  - Originally, lack of data on combination product in pregnancy – now more data indicating safety
- Some experts are moving to Suboxone in pregnancy (stay tuned!)
  - 2020 metaanalysis (Link et al) of 5 studies (1875 pregnancies) comparing combination product to buprenorphine alone and methadone
    - Outcomes similar between groups

Link HM et al. Buprenorphine-naloxone use in pregnancy: a systematic review and metaanalysis. *AJOG MFM*. August 2020.

Naloxone (Narcan)

- Reduces mortality from opioid overdose
- Prescribe for all patients who are taking opioids
- Recent programs to provide naloxone to community
- When to give:
  - If in respiratory distress or not breathing
- How to give:
  - Intranasal spray; may give second dose
  - 3-5 minutes later
  - Auto-injector
  - Call for help

Barriers To Prenatal Care For People With OUD

- Guilt
- Judgment/stigma
- Lack of knowledge by provider
- Transportation
- Housing, food, job insecurity

Prenatal Care

- Screen for substance use in all pregnant patients
- If opioid use disorder (OUD) is identified, determine desire/plan for treatment
  - First ask the patient about her goals
  - Two general aspects of treatment:
    - *Medication for opioid use disorder (buprenorphine, methadone)*
      - *If desired by patient*
      - *VERIFY DOSE if already on MOUD*
    - *Mental health provider*

Prenatal Care

- Screen for associated problems
  - *HIV, hepatitis C, hepatitis B, renal or liver disease*
- Monitor fetal growth
  - *E.g., ultrasound every 4 weeks starting at 28 weeks*
- If undergoing antenatal fetal testing for another indication:
  - *Minimize false positive results by waiting 4-6 hours after opioid dose*

Family Care Plans

Family Care Plan eLearning Training

- Prenatal precursor to the Plan of Safe Care
- Documents the pregnant person's treatment providers, supports, and resources
- Tool for empowering families as they approach the birth of a child
- Owned by the patient; can be initiated by any care provider during pregnancy

Intrapartum Care

- If on MOUD, continue maintenance dosing
  - Make a plan during prenatal care!
  - Verify dose with MAT provider
- Additional pain relief: epidural should be offered
- Avoid butorphanol (Stadol) and nalbuphine (Nubain)
  - Can precipitate withdrawal (mixed agonist-antagonist)
- Notify pediatric staff of maternal opioid use
- Limitations of urine drug screen (UDS)
    - Patient consent should be obtained
  - Remember that buprenorphine may not appear on UDS
  - Imperfect test – false negatives and false positives

Postpartum Care

- Continue maintenance doses of buprenorphine or methadone
- Maximize non-opioid medications (acetaminophen, ibuprofen, ketorolac [Toradol])
- Patients with cesarean delivery
  - Patients with OUD often have a higher requirement for pain medications
  - Maximize non-opioid medications
  - Often need additional short-acting opioids (e.g., oxycodone, hydrocodone, hydromorphone)
  - Always check PMP when prescribing narcotics
- Social Work as part of the team

Opioids And Breastfeeding

- Illicit or non-prescription opioid vs receiving treatment with MOUD (methadone or buprenorphine)
- Breastfeeding not recommended if abusing opioids
- Breastfeeding encouraged if receiving opioid-agonist treatment
  - Methadone and buprenorphine concentrations in breast milk are low
  - At methadone doses 50-105 mg/day, neonatal dose < 0.2 mg/day and unrelated to maternal dose

Jansson LM, et al. Methadone maintenance and breastfeeding in the neonatal period. Pediatrics. 2008;121:106-114.

Neonatal Abstinence Syndrome

- **Focus on what the parents CAN do**
- **Involve partner!**

What Happens After Hospital Discharge?

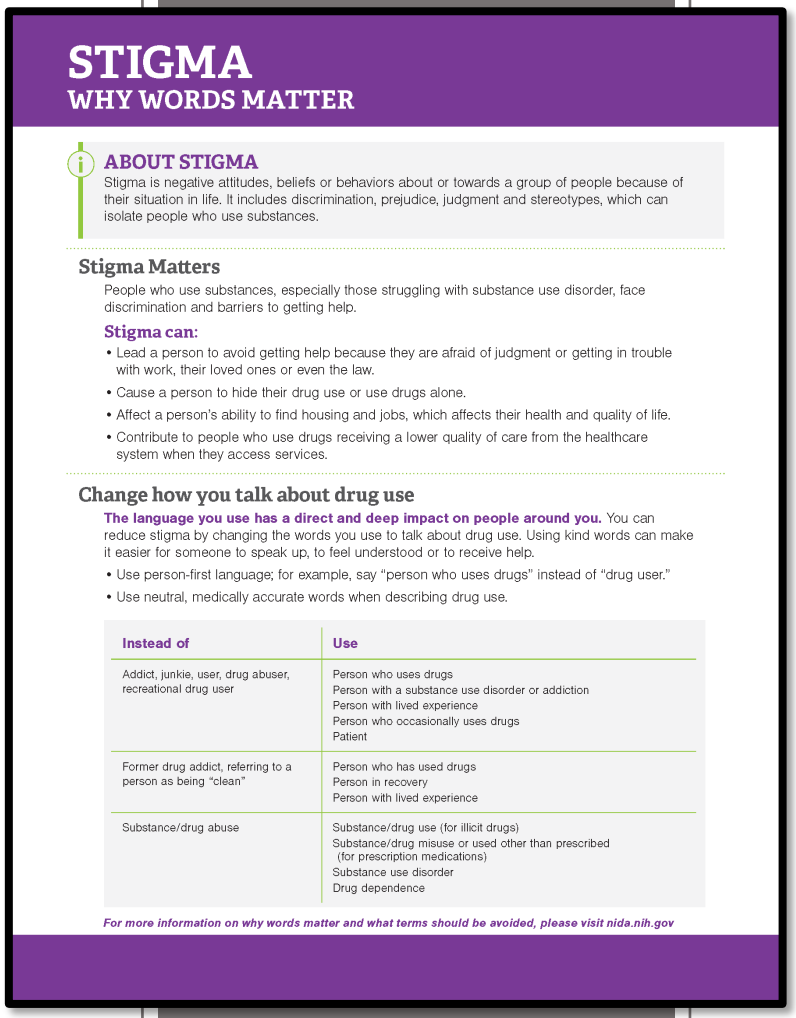
- Discourage weaning/discontinuation of MOUD
  - Discouraged in first 6-12 months postpartum
  - New life stressors
  - Sleeplessness
  - Risk of relapse and overdose
- Most maternal overdoses happen in the postpartum period
- Early postpartum follow up if possible (1-2 weeks postpartum)

What Happens After Hospital Discharge?

- Breastfeeding should be encouraged in most cases
- Continued education on importance of follow up with treatment program, behavioral health provider

Stigma

- Be aware of your attitude and behavior
- Person-first language
- Focus on the positive
- Educate others



STIGMA
WHY WORDS MATTER

ABOUT STIGMA
Stigma is negative attitudes, beliefs or behaviors about or towards a group of people because of their situation in life. It includes discrimination, prejudice, judgment and stereotypes, which can isolate people who use substances.

Stigma Matters

People who use substances, especially those struggling with substance use disorder, face discrimination and barriers to getting help.

Stigma can:

- Lead a person to avoid getting help because they are afraid of judgment or getting in trouble with work, their loved ones or even the law.
- Cause a person to hide their drug use or use drugs alone.
- Affect a person's ability to find housing and jobs, which affects their health and quality of life.
- Contribute to people who use drugs receiving a lower quality of care from the healthcare system when they access services.

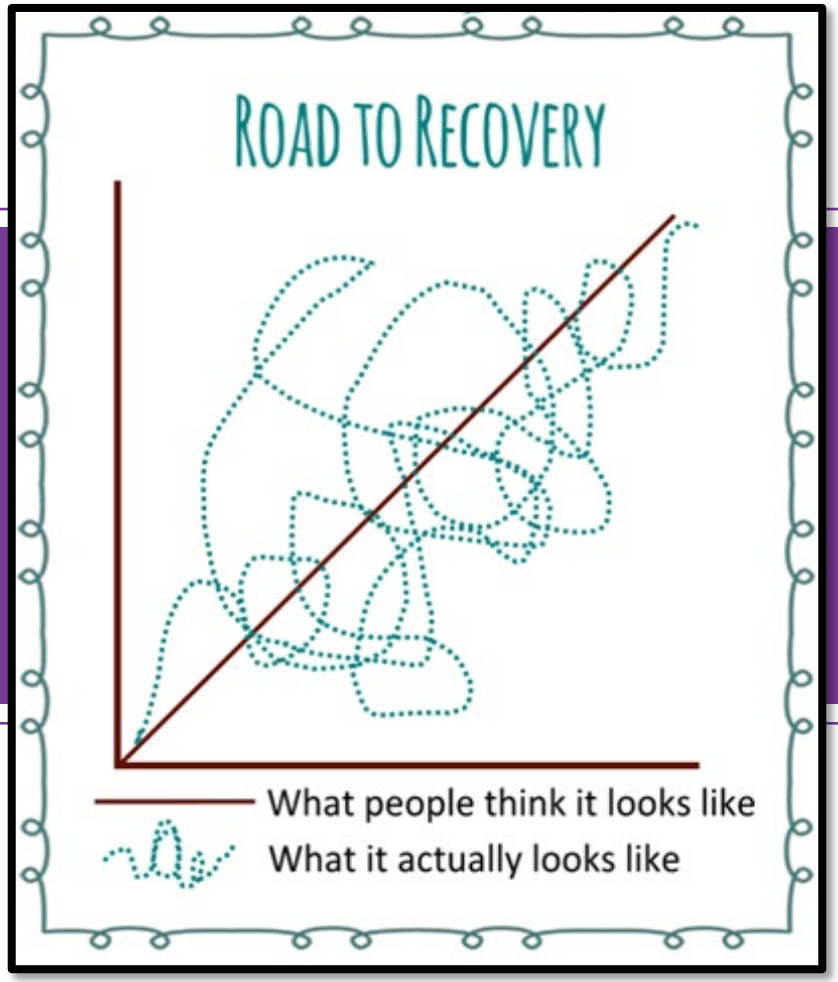
Change how you talk about drug use

The language you use has a direct and deep impact on people around you. You can reduce stigma by changing the words you use to talk about drug use. Using kind words can make it easier for someone to speak up, to feel understood or to receive help.

- Use person-first language; for example, say "person who uses drugs" instead of "drug user."
- Use neutral, medically accurate words when describing drug use.

Instead of	Use
Addict, junkie, user, drug abuser, recreational drug user	Person who uses drugs Person with a substance use disorder or addiction Person with lived experience Person who occasionally uses drugs Patient
Former drug addict, referring to a person as being "clean"	Person who has used drugs Person in recovery Person with lived experience
Substance/drug abuse	Substance/drug use (for illicit drugs) Substance/drug misuse or used other than prescribed (for prescription medications) Substance use disorder Drug dependence

For more information on why words matter and what terms should be avoided, please visit nida.nih.gov



https://recoveryresources.com.au/recovery-resources/understanding-recovery-and-change/recovery-a-non-linear-journey/. Accessed 7/6/21.

Visit opqic.org/omno for more information.

Treating Pregnant Patients With Opioid Use Disorder

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