Pregnancy and Postpartum Care in Opioid Use Disorder

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Caring for Women with Opioid Use Disorder (OUD) in Pregnancy-ACOG statement

Policy Priorities

Substance Use Disorder in Pregnancy

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Advocacy

Policy Priorities

2023 Commitment to Policy Action

ACOG joins every leading medical and public health organization in approaching the problem of drug and alcohol use during pregnancy as a health concern that's best addressed through education, prevention and community-based treatment, not through punitive drug testing and reporting laws or criminal prosecution.

Research shows that obtaining prenatal care, staying connected to the health care system, and being able to speak openly with a physician about drug problems helps improve birth outcomes.

(Hei et al., 2011)
(Yazdy et al., 2013)
Kassebaum et al., 2016)
Opioid Use and Opioid Use Disorder in Pregnancy | ACOG

Care for pregnant patients with OUD

- For ALL pregnant patients
- Early universal screening
  - 1st prenatal visit
  - Validated screening tools (4Ps, 5Ps, NIDA Quick screen, CRAFFT)
  - Routine urine drug screening is controversial*
- Brief intervention
- Referral for treatment

Box 1. SBIRT: Screening, Brief Intervention, and Referral to Treatment

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use and dependence on alcohol and other substances. The SBIRT model was impelled by an Institute of Medicine (now known as the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine) recommendation that called for community-based screening for health risk behaviors, including substance use.

Screening—A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting.

Brief Intervention—A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.

Referral to Treatment—A health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

Data from SAMHSA-HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment. Available at: http://www.integration.samhsa.gov/clinical-practice/SBIRT. Retrieved March 20, 2017.

Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) | NIDA Archives (nih.gov)

Medically Assisted Withdrawal in Pregnancy (Detoxification)

- Medically supervised withdrawal is NOT recommended for pregnant women with OUD
  - Increased rate of relapse with associated overdose mortality following detoxification
  - Studies have shown that 8 out of 10 women return to drug use within a month after detoxing on their own and are at greater risk of overdose

- Pharmacotherapy – Medications for OUD (MOUD) is the recommended standard of care and the best option for a pregnant woman with OUD
  - Larger and healthier babies
  - More likely to reach full-term

(Saia et al., 2016)

Methadone

Advantages:

- Full mu opioid-agonist
- Reduces/eliminates cravings for opioid drugs
- Prevents onset of withdrawal for 24 hours
- Promotes increased physical and emotional health
- Higher treatment retention than other treatments

Disadvantages:

- Significant drug interactions
- Higher risk of overdose compared to buprenorphine
- Does not block effects of other opioids
- Lower birth weights
- Longer Neonatal Abstinence Syndrome (NAS) /Neonatal Opioid Withdrawal Syndrome (NOWS) duration
- Usually requires daily visits to treatment program
- Takes days to weeks to get to stable dose

(Jones et al., 2008)
(Meyer et al., 2007)

Buprenorphine

Advantages:

- Partial mu-opioid agonist
- Allows for adjustable dosing (split dosing)
- Lower risk of overdose
- Fewer drug interactions
- Office-based treatment
- Shorter NAS course
- Lower preterm delivery rate
- Higher birth weight
- Larger head circumference

Disadvantages:

- Lack of long-term data on fetal exposure
- Demonstrated clinical withdrawal symptoms
- Lower retention in treatment than methadone

(Kraft et al., 2017)

Naltrexone

- Nonselective opioid receptor antagonist
  - Blocks euphoric effects of opioids
- Oral form-poor adherence
- IM form-more effective in maintaining abstinence
- Data in pregnancy limited
- Unknown fetal side effects
- If patient already on treatment can consider continuing
  - Transition to oral 35-38 weeks
  - Hold in labor-allows for full opioids postpartum if needed

(Hulse & O'Neil., 2002)
(Hulse et al., 2003)
(Hulse & O'Neil., 2002)
(Farid et al., 2012)
(Jones., 2012)

Care for pregnant patients with OUD Antepartum

- Screening for Sexually Transmitted Infections
- Depression/mental health disorder screening
- Early US to confirm dating
- Anatomic ultrasound
- Consults
  - Anesthesia
  - Addiction Medicine
  - Lactation
  - Neonatology
- Close communication between OB, Peds, and OUD provider

Care for pregnant patients with OUD Intrapartum

- Continue maintenance MOUD during labor and postpartum
- Provide additional pain relief as needed
  - Opioid dependence will not affect the efficacy of local anesthetics
  - Using epidural or combined spinal-epidural analgesia is effective
  - Higher doses of opioids may be necessary due to tolerance
- Avoid treating opioid-dependent patients with mixed antagonists and agonists (butorphanol, nalbuphine) to avoid precipitating withdrawal
- Multimodal treatment
  - Nonsteroidal anti-inflammatory medications, acetaminophen, nerve blocks

(Meyer et al., 2007)

Care for pregnant patients with OUD Postpartum

- Patient's wishes to avoid use of opioids postpartum should be established
- Pharmacotherapy should be continued at same dose postpartum
- NSAIDS and non-opioid pain medications should be maximized (scheduled orders; not PRN)
- Full opioid agonists should be used for post-operative pain
  - Patients on MOUD have higher opioid requirements than general population
  - Buprenorphine does not appear to prevent/block efficacy of full-opioids
- Contraception counseling
- Lactation support
  - MOUD compatible with lactation and may reduce NOWS/NAS and have other benefits for patient and baby

(Glatstein et al., 2008)

Postpartum follow up

- Usually do not need to immediately reduce MOUD dose postpartum
  - Titrate for over-sedation if needed
- Continue MOUD in the postpartum period due to risk of relapse
- Close interval follow up
- Screening for postpartum mood disorders
- Access to support services
- Overdose training
  - Naloxone
- Collaborative care model and wrap around services

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