OPIOID ABUSE/ADDICTION IN PREGNANCY

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Neither myself nor any member of my family has a financial arrangement related to the content of this activity or any supporters of this program.

OBJECTIVES

- Recognition of opioid addiction in the pregnant patient
- Identification of the standard treatment for the opioid addicted pregnant female
- Management of pain in women on opioid maintenance therapy
- Awareness of Neonatal Abstinence Syndrome
SOME STATISTICS

- Prevalence of opioid use in pregnancy 1-21%
- >54,000 pregnancies in the US affected by opioid abuse
- Opioid use in 1st trimester increased from 8-20% over 2005-2009

TERMINOLOGY

- Physical Dependence – cessation of the drug results in withdrawal
- Addiction/Dependence – loss of control, compulsive use, use in spite of consequences
- *Prescription Drug Abuse – taking a medication without a prescription or in a way other than as prescribed
- Pseudoaddiction – drug seeking secondary to unrelieved pain

* 3rd most common drug category of abuse

Sally

Sally is a 20 year old female who is pregnant with her first child. She says she thinks she is due in 6 or 7 months. She has not sought prenatal care earlier because she is unmarried and fears the repercussions of her mother who is governor of your state.
RECOGNITION

• Screening Questionnaire – all pregnant patients
  – Example: 4 P’s (Parents, Partner, Past, Present)
• Know physical manifestations of use and withdrawal – look at pupils!
• Has she been compliant with prenatal care?
• Look up PDMP data
• Urine drug screening ?? – (consent, panel, reporting)

Sally

Sally answers “no” to the screening 4P’s, but she refuses to consent to the routine UDS “because there is no reason for that”.
When you look up PDMP data, you see that she has been prescribed hydrocodone the past 8 months by three different physicians. When you add them up, Sally could be taking 8-10 hydrocodone tablets/day!

Now what?

CLINICAL MANIFESTATIONS OF OPIOID WITHDRAWAL*
*(onset 4-72 hours)

• Vital Signs
  – Tachycardia
  – Hypertension
  – Fever
• Central Nervous System
  – Irritability
  – Insomnia
  – Yawning
• Musculoskeletal
  – Aches
• Eyes
  – Pupillary dilation
  – Lacrimation
• Nose
  – Rhinorrhea
• Skin
  – Piloerection
• Gastrointestinal
  – Nausea
  – Vomiting
  – Diarrhea
OBSTETRIC COMPLICATIONS OF OPIOID DEPENDENCE

- Miscarriage
- Abruptio Placentae
- Preterm Labor
- Fetal Distress
- IUGR
- Fetal Death

Sally

- Ask her about drug/alcohol use
- Present PDMP data
- Review possible complications to her and to fetus
- Discuss confidentiality and reporting
- Refer to MM or BM clinic
- Assure her you will "stick with" her throughout

TREATMENT

- OPIOID ASSISTED THERAPY (O.A.T.)
  - Methadone
  - Buprenorphine
WHY MAINTENANCE?

1. To prevent complications of opioid withdrawal
2. To prevent fetus from being exposed to erratic opioid levels
3. To encourage prenatal care
4. To reduce exposure to “drug culture”
5. Breast feeding is not contraindicated.

METHADONE

- Gold standard
- Must be through licensed program
- Dispensed daily
- Some recovery services provided
- Dosage adjusted to avoid withdrawal
- For acute situation, any physician can prescribe for up to 3 days

BUPRENORPHINE

- MD must be credentialed to prescribe
- Office based setting - 2-3 times/week
- No long term data on infant/child effects
- Less severe neonatal abstinence syndrome (NAS)
- Single agent product, no naloxone
- Must be in moderate withdrawal before initiating
INITIATION OF OPIOID ASSISTED THERAPY (O.A.T.)

1. Start at 10-20mg of methadone or 2-4mg of buprenorphine

2. Titrate for relief of withdrawal symptoms

Sally

Sally is scared of O.A.T. She states, “I don’t want my baby to go through withdrawal when it’s born. I’ll just taper myself off slowly. I’ve done it before”.

Now what?

DETOXIFICATION

• Not recommended

• Risk of withdrawal

• High relapse rate

• Ideally in 2nd trimester
INTRAPARTUM AND POSTPARTUM PAIN MANAGEMENT OF WOMEN ON O.A.T.

1. Continue maintenance doses.
2. Should receive analgesia as if not on O.A.T.
3. Higher doses of opioids will be necessary
4. Avoid agonist - antagonist meds – stadol, nubain

PAIN MANAGEMENT IN WOMEN IN RECOVERY FROM OPIOIDS

• Treat like any other patient
• Discuss treatment plan with patient
• Encourage increased recovery activities
• Be cautious with outpatient prescriptions

NEONATAL ABSTINENCE SYNDROME (NAS)

• Incidence: 60-80%
• Onset: 2-3 days up to 3-4 weeks
• Duration: 10-42 days
• Symptoms: irritability, high pitched cry, tremors, poor feeding, frantic sucking, v/d
TREATMENT OF NAS

A. Pharmacologic: oral morphine, methadone

B. Symptomatic: loose swaddling, decreased stimuli, pacifier, slow rocking

SUMMARY

• Early identification improves maternal/infant outcomes

• Prenatal care and addiction treatment should be integrated

• Know available resources!

REFERENCES
