Women and opioid use disorder: Optimizing care during pregnancy and beyond

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• Dr. Fogger has nothing to disclose.
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Objectives
By the end of the presentation, attendees will be able to:
1. Discuss the benefits of medication assisted treatment (MAT) for pregnant women.
2. Describe the management of women on MAT during pregnancy and the postpartum period.
3. Identify implications of maternal substance use and MAT for neonates.
Addiction

- Addiction is a primary, **chronic disease of brain** reward, motivation, memory and related circuitry
- Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations
- Reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors

Differences

- Dependence:
  - syndrome of specific withdrawal symptoms following reduction or cessation of drug use
  - does not equal a substance use disorder
- Addiction:
  - must meet criteria

4 C’s of Addiction

- Loss of control
- Compulsive use
- Continued use despite harm
- Craving
History

• The opioid epidemic in the United States touches many American families

• Misuse of pain medications and heroin speak to the underlying issues of a substance use disorder
  • fuel overdose deaths
    • Leading cause of accidental death in the US


Marked Geographic and Temporal Variation in Overdose Deaths: Estimated Age-adjusted Death Rates for Drug Poisoning by County

Women

• % of pregnant who use opioids
  • Tripled in past 10 years
    • 1.2% of all pregnant women used in 2012
    • # of infants ↑ nearly fivefold annually from 1.19 to 5.63 per 1,000 births

Women and Risk

• Women’s risk of overdose and Opioid used disorder (OUD) higher than men
• often have more chronic conditions treated with opioids
  • more exposure to opioids
  • become addicted more often than men
  • on a smaller dose
  • over a shorter period of time.

Opioid Use Disorder (OUD)

Heroin Use in Pregnancy

• Often pregnant women with OUD seek care
  • late in pregnancy, if at all
• Women present for care are often sicker than men
  • Medical, behavioral, psychosocial and social
Pregnancy Considerations

- Abrupt discontinuation of opioids in pregnancy associated with increased risk
  - Abruptio placentae
  - Intrauterine growth restriction
  - Preterm labor and birth
  - Intrauterine passage of meconium and neonatal aspiration
  - Fetal distress
  - Fetal death


Rationale for Pharmacotherapy

- Substance use disorders are a chronic condition.
- Medications can target neurotransmitters involved in the reinforcing and anxiolytic effects.
- Beneficial in combination with non-pharmacologic therapy
  - including counseling and other behavioral therapies
- Can reduce relapse and help maintain abstinence.
- Reduces the risk of HIV, Hep C & B transmission.

Fetal and Neonatal Effects of Methadone

- Low rates of teratogenic outcomes
  - Small relative risk of congenital malformations
- Neonatal opioid withdrawal syndrome occurs in 94% of newborns born to women who use methadone
- Higher doses of medication required to treat neonatal opioid withdrawal syndrome when methadone used in pregnancy over buprenorphine
- No known correlation between methadone dose and neonatal opioid withdrawal syndrome

Kocherlocota (2014)
Implications for Breastfeeding

• Breastfeeding encouraged
• Increases bonding
• Decreases symptoms associated with neonatal opioid withdrawal syndrome
• As infants weaned off breastmilk, weaned off medication naturally

Keough & Fantasia (2017)

Neonatal Abstinence Syndrome

• Finnegan Neonatal Abstinence Scoring System
• Time to re-evaluate
• Non-pharmacologic vs pharmacologic treatment


Medication Assisted Treatment

• Methadone—highly regulated
  • only provided by Opioid Treatment Program
• Naltrexone—daily or monthly IM
  • All prescribers within their scope of practice
• Buprenorphine or buprenorphine with naloxone
  • MDs with DEA license and SAMHSA waiver to prescribe to 30 patients initially
  • now (July 16) request to increase practice up to 275 patients
  • CARA act July 2016: NPs and PAs

Abstinence/Risk Reduction

• Although patient may commit to abstinence:
  • Powerful unconscious internal signals may override goal.
    • Signals hijack the brain often below the person’s awareness.
    • Individual seeks relief through return to chemical use.

Methadone

• High potential for diversion
• Risk of overdose
• Does not cause opiate positive toxicology test
• Can only be prescribed for pain
  • Controlled Substance Act 1970
• Only Opioid treatment program - and it is inexpensive
• Alternative
  • Buprenorphine – partial agonist
    • Less respiratory depression in OD
    • With naltrexone– prevents diversion to IV use

Buprenorphine

• Partial opioid agonist.
• Can be used for tapering protocol for detox or opioid therapy.
• Less stigma than Methadone.
• Initial dose
  • 4-8 mg per day
  • increased to between 16-32mg several days
Buprenorphine/Naltrexone

- Buprenorphine/naltrexone 4:1
  - Limited absorption of Naltrexone sublingually
  - Almost complete first pass metabolism
    - Limited availability
  - May be safer due to ceiling effect in dose increases
    - Unlikely death from OD
  - Does not diminish testosterone as does methadone
    - Less sexual impairment with men

Naltrexone

- Opioid use must be stopped
  - at least 7 days prior to starting naltrexone
- Assess pregnancy status
- Blocks pain relief from opiate medications
  - Does not reduce effectiveness of local and general anesthesia
  - Non-narcotic pain relievers can be utilized

Choices

- Methadone and Buprenorphine
  - Effective-opiate dependence in pregnant women
    - Little risk to fetus
      - similar pregnancy outcomes
    - Benefit of MAT for the safety of the mother and health of the neonate.
    - In some states
      - Medicaid will only cover buprenorphine
Restrictions on Prescribing

- **Any provider** with controlled substance privileges can prescribe buprenorphine
  - acute withdrawal in an inpatient setting
- **To prescribe for maintenance**
  - Need waiver from SAMHSA as per special requirements noted in CARA
  - Bill signed into law at the end of July 2016
  - Training 24 hours
    - requirements for NPs available free at AANP & APNA websites

Barriers to Treatment

- Only 20% of adults with OUD get treatment
  - Cost and access reported as primary barrier
- Insurance coverage
  - 28 states cover all three medications through Medicaid state pharmacy program
  - Some have lifetime limitations
  - May require prior authorization, step therapy, or fail preferred medication first policy

Vulnerabilities

- Psychological and emotional distress has been identified as a risk factor
- Women more likely to have co-existing disorders:
  - anxiety, depression, PTSD, eating disorders and agoraphobia with and without panic
- May use to cope with negative emotions.
Implications

• NPs have the opportunity to:
  • Improve practice outcomes with women with opioid use disorder
  • Treat women using office based MAT
    • Especially during pregnancy and postpartum

References