Treatment of Opioid Use Disorder in Pregnancy

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Disclosures

Dr. Adams: no financial disclosures to report

Dr. Bhatnagar: no financial disclosures to report
Active Polling

Open a text to 22-333

Send JACQUELYNADA867

Live polling will be included throughout today’s presentation
How does this make you feel?

Check your baggage
Trauma Informed Care

If a woman endured sexual abuse as a child:
- 6x more likely to have opioid addiction
- 4x more likely to have alcohol addiction


Mental Health

- High risk of mental health conditions: depression, history of trauma/sexual abuse, PTSD, and anxiety
- More than 30% of pregnant women with OUD screened positive for moderate to severe depression
- More than 40% reported symptoms of postpartum depression
- Increased risk of use of other substances, including tobacco, marijuana, and cocaine
# Words We Use Can Perpetuate Stigma

**DO say** | **Instead of**
--- | ---
Person with addiction | Addict, junkie, abuser
Urine showed presence of | Urine was dirty
Medication assisted treatment | Replacement therapy

[https://www.naabt.org/documents/NAABT.Language.pdf](https://www.naabt.org/documents/NAABT.Language.pdf)

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### How many have cared for pregnant women with OUD?

A. Yes - all the time  
B. Yes - infrequently  
C. No

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Statistics

- >70% of all women with OUD are of childbearing age
- 4.4% of pregnant women reported illicit drug use in the past 30 days
- 0.1% of pregnant women estimated to have used heroin in the past 30 days
- 1% of pregnant women reported nonmedical use of opioid-containing pain medication

Past Month and Past Year Heroin Use Among Persons Aged 12 or Older: 2002-2012
Source: National Survey on Drug Use and Health: Summary of National Findings, 2012

Rate of women addicted to opioids during pregnancy quadrupled in 15 years, CDC says

Prevalence of Opioid Addiction Among Pregnant Women
Nationwide, the number of pregnant women with an opioid addiction has more than quadrupled since 1999. States vary widely in the prevalence of opioid addiction among mothers delivering babies. At 49 addicted mothers per 1,000 deliveries, Vermont has the highest rate of the 28 states where data was available.

Babies in severe withdrawal per 1,000 hospital births
- More than 20 per 1,000 deliveries
- 10 to 19 per 1,000 deliveries
- 5 to 9 per 1,000 deliveries
- 1 to 4 per 1,000 deliveries
- Data not available

Source: Centers for Disease Control and Prevention, August 2016
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Effects of Opioids on Pregnancy

• Think – **high risk behavior**
• Mothers with heroin addiction are much more likely to engage in prostitution, theft, violence
• Chronic heroin use and withdrawal is associated with FGR, abruption, fetal death, preterm labor and meconium passage
• Mixed evidence of anomalies with prescription opioids – some data about codeine
Pregnancy Enhances Recovery

Pregnancy changes identity of woman and treatment represents an opportunity!

After one year of treatment:
- 66% of women who entered treatment while pregnant were abstinent, while
- 28% of non-pregnant women remained drug free (p< 0.0005)


Treatment of Opioid Addiction in Pregnancy: An Opportunity

- Early Intervention is KEY
- Medication Assisted Treatment is a crucial part of treating addiction in pregnancy
- Goal: Provide support and assistance, prevent withdrawal, encourage prenatal care adherence
- Comprehensive multi-specialty care, if possible, co-located
- Also important to care for team members providing the care
Opportunity for Education

Dependence
- Tolerance
- Withdrawal

EVERY human body is capable of dependence

Addiction
- Dependence PLUS
- Continuing behaviors despite adverse physical, legal, social consequences of behavior.

Is this possible?

Addicted To Heroin
Opioid Maintenance Therapy in Pregnancy

Benefits
- Birth weight higher than for heroin use
- Treats urges, cravings
- Reduces risky behaviors
- Improves quality of life during/after pregnancy

Risks
- Higher rates of neonatal mortality and morbidity than no substance but NOT compared to ongoing use.
- NAS
  - drugs with longer half life have lower association with NAS

Which medication is the BEST for pregnant women with OUD?

A. Methadone
B. Buprenorphine
C. Suboxone
D. Naltrexone
E. Both A&B
F. Choices A, B, & C depending on the patient
G. No medication is best
Medication Assisted Treatment (MAT)

- Methadone since the 1970s – best studied option
- Increased reliance on buprenorphine due to improved neonatal outcomes, decreased NAS

Methadone in Pregnancy

- Best studied/most evidence of long term effects
  - Studies show no cognitive change in children exposed to methadone up to 5 years of follow up
  - Studies show improved outcomes (longer without relapse) 6 months out
  - If stable on methadone, continue through pregnancy
  - Dose may need to be increased based on symptoms
Buprenorphine in Pregnancy

- A 2010 multicenter RCT showed buprenorphine-exposed neonates required less treatment for NAS, shorter hospital stays, and less medication for treatment.
- Does not require daily office visits
  - Higher risk of diversion
- Combined product with naloxone generally considered less favorable because of risk of injecting → acute withdrawal
- Newer data shows minimal increased risk of combination product with mono product when used as directed.

Comparing OMT options

**Methadone**
- Full mu agonist
- Takes time to get to therapeutic doses
- Schedule II- federal guidelines
- Daily dosing clinic
- Twice daily dosing in pregnancy

**Buprenorphine**
- Partial mu agonist
- Induction can be challenging
- Schedule III
- Office based setting
- Dose may not need to be adjusted during pregnancy
Naltrexone in Pregnancy

- Limited data in pregnancy (no evidence of harm)
- Large dropout rate
  - Requires withdrawal prior to initiation
- Can be considered if patient is stable or has comorbid alcohol abuse
Can withdrawal be safe?

- Limited and conflicting data
- Terplan et al systematic review in May 2018 showed:
  - increased risk of relapse
  - low completion rate, and
  - did not decrease NAS (due to risk of relapse)
- Minimal risk of pre-term labor

Withdrawal During Pregnancy

- Unless pt is in a controlled environment, withdrawal is not recommended
- SAMHSA just released Factsheets that recommend staying on MAT during pregnancy
- Avoid stopping opioids suddenly during pregnancy
What screening tool is best for women of childbearing age to detect OUD risk?

A. CRAFFT
B. 4Ps
C. CAGE-AID
D. DAST-10
E. TAPS

Screening

4Ps

- Parents - Did your parents struggle with alcohol or drug use?
- Partner - Does your partner have a problem with alcohol or drug use?
- Past - Have you ever had difficulties in your life because of alcohol, drugs, prescription drugs?
- Present - Have you done drugs or had alcohol in the past month?
- Any “yes” should prompt further questions.

CRAFFT

- C - Ridden in CAR with someone under the influence?
- R - Ever use substances to RELAX, feel better about yourself or fit in?
- A - Ever use substances when you are ALONE?
- F - Ever FORGET things you did while using alcohol or drugs?
- F - FAMILY or FRIENDS ever suggest you should cut down on use?
- T - Ever gotten in TROUBLE while you were using alcohol or drugs?

Two or more positives should prompt further assessment.
Antepartum Care

- Identify poor nutrition, disrupted support systems leading to social service needs, poor dental hygiene
- Use the opportunity of pregnancy to access limited resources such as addiction treatment, mental health, etc
- Screening for Hepatitis C, Hepatitis B immunity, TB
- Repeat HIV, RPR, GC/CT screening in the third trimester
- Counseling for co-existing substance abuse and tobacco use
- Comprehensive care
Comprehensive Care Approach

- Interdisciplinary care
  - Involve social work, legal aid, psych, addiction medicine, GI/ID, OB
- Consider challenges for access to care and how to overcome them
  - Incentives for compliance and participation
  - Motivational interviewing and ongoing support for recovery
- Consider group prenatal care, support groups (narcotics anonymous, group counseling, mothers’ groups)
Intrapartum Care

- Women taking methadone or buprenorphine who are in labor should have their maintenance dose continued and should receive additional pain relief
- Epidural/ other analgesic forms/ methods recommended
- Opioid agonist–antagonist drugs such as butorphanol, nalbuphine, and pentazocine should be avoided because they can precipitate acute withdrawal

Postpartum: Pain Management

- Increased pain scores than peers after vaginal delivery
  - Same amount of analgesic use postpartum
- Buprenorphine – required 47% more narcotics after cesarean
- Methadone – required 70% more narcotics after cesarean
Postpartum Care

- Follow up, follow up, follow up
- Access to mental health care
  - more than 40% reported symptoms of PP depression
  - Connect patient with primary care for coordination and management of specialist needs

Unintended Pregnancy

- 50% in general population
- **86%** in women receiving treatment for opioid use disorder
- Begin counseling early and provide information about reliable birth control

The Fourth Trimester and Beyond

Fig. 2. Opioid overdose rates among pregnant and parenting women with evidence of opioid use disorder in their lifetime delivery delivery (A) and among women with and without opioid use disorder (B). Overdose events were stratified by receipt of pharmacotherapy during the month of the overdose event (B). Data were from the National Vital Statistics System, linked with Medicaid claims data for 2015–2017. Data were limited to pregnancies occurring in 2015–2016. Source: Opioid Use in Pregnancy: Mortality and Morbidity Among Pregnant and Postpartum Women, 2015–2017. NCHS Data Brief, No. 378, 2019.

Opioid Use in Pregnancy

Opioid use in pregnancy can cause severe withdrawal symptoms in newborns, leading to higher hospital costs.

<table>
<thead>
<tr>
<th>Hospital Costs</th>
<th>Costs for newborns with no withdrawal</th>
<th>Costs for newborns with withdrawal</th>
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<tr>
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More Babies in Withdrawal

- Babies born with severe withdrawal per 15000 hospital births
- Mothers using opioids per 15000 hospital births

Source: Centers for Disease Control and Prevention
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NAS and Outcomes

- There is much we don’t know … yet.
- Many confounding factors such as tobacco, alcohol, low socioeconomic status, and lack of prenatal care.
- Rates of NAS are NOT dependent on dose of MAT during pregnancy.
- Studies have not found significant differences in cognitive development between children up to 5 years of age exposed to methadone.

OUD in Pregnancy

NAS

Prevalence of Opioid Addiction Among Pregnant Women

NAS Rates in States with and without Medicaid Coverage, by 2010-2014

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NAS: Additional Considerations

- Encourage breastfeeding
  - Importance of working with healthcare providers if relapse occurs
- Finnegan Scoring vs. Eat, Sleep, Console
  - Important to involve parents in monitoring
- Safe Sleep

In Summary…

- MAT during pregnancy is recommended
- Honesty, not perfection
- Treatment represents an opportunity for improvement in many areas
Questions?
References

- Meyer et al., “Intrapartum and Postpartum Analgesia for Women Maintained on Methadone During Pregnancy”
- Meyer et al., “Intrapartum and Postpartum Analgesia for Women Maintained on Buprenorphine During Pregnancy”
- https://store.samhsa.gov/product/SMA18-5071

Thank you