Treating Pregnant Women with Opioid Use Disorder

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MAT WAIVERED PRESCRIBER SUPPORT INITIATIVE
Disclosures

There are no relevant financial relationships with ACCME-defined commercial interests for anyone who was in control of the content of this activity.
Substance Use Disorder and Pregnancy

- Women, opioid use disorder and pregnancy
- Treatment options in Pregnancy
  - Methadone
  - Buprenorphine
  - Naltrexone
  - Detoxification
- Intra-partum care
- Postpartum care
  - Post-operative pain control
  - Breastfeeding
  - Contraception
Prescription painkiller overdose deaths are a growing problem among women.

Between 1999-2010: Prescription opioid overdoses increased more rapidly among women (596%) than for men (312%).
Rates of Drug OD and Drug-related ED Visits among women 2004-2010

Women OPR DEATHS increased by 70%

Women OPR related ED visits doubled
First time heroin use by gender

Prevalence of OUD at Delivery: 1999-2014

Between 1999-2014: # women with OUD at delivery QUADRUPLED
Pregnancy and Opioid Use Disorder (OUD)

Nearly 50% of pregnant substance use disorder treatment admissions are for opioids.

Overdose mortality has surpassed hemorrhage, pre-eclampsia and sepsis as a cause of pregnancy-associated death.
Gender, Pregnancy and OUD

86% of pregnant opioid-abusing women reported pregnancy was unintended
- In general population: 31%-47% are unintended

Pregnancy can be a powerful catalyst for women to engage in treatment
- Reported \textit{substance use decreases with increasing maternal age} (NSDUH 2012-2013)
- Trend toward reduction of use over gestation
- Reported \textit{substance use decreases with increasing gestational age} (SAMHSA TEDS 2014)
ACOG Backs Buprenorphine and Methadone

- Treatment Effectiveness shown in pregnancy
- Reduce opioid use (cravings, withdrawal, euphoria)
- Increase birth at term, higher birth weights
- Prevent overdose deaths
- Prevent HIV transmission
- Support family function and appropriate parenting
Non MAT Opioids: full agonist heroin, oxycodone, Percocet, etc
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Methadone: full agonist
Activates receptor, prevents binding
Risk of sedation
Only at special clinics
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Naloxone (Narcan), Naltrexone (Vivitrol):
- Full antagonist, high affinity
**Non MAT Opioids**: full agonist
heroin, oxycodone, Percocet, etc

**Methadone**: full agonist
Activates receptor, prevents binding, risk of sedation

**Buprenorphine (Suboxone, Subutex)**: partial agonist
High affinity, ceiling effect
Risk of precipitated withdrawal
Any prescriber with X waiver

**Naloxone (Narcan), Naltrexone (Vivitrol)**: Full antagonist, high affinity
Staying well

Euphoria

Normal

Withdrawal

Tolerance & Physical Dependence

Acute use

Chronic

Opioid Agonist Therapy
No longer in the cycle

Euphoria

Normal

Withdrawal

Tolerance & Physical Dependence

Acute use

Chronic

Opioid Agonist Therapy

ASAM American Society of Addiction Medicine
Medically Assisted Withdrawal in Pregnancy is NOT Recommended

High risk of relapse
(59-90%)

Overdose mortality is associated with increased rate of relapse following detoxification
Medically Assisted TREATMENT instead of Withdrawal is Recommended in Pregnancy

Increased access to opioid agonist treatment was associated with a reduction in heroin overdose deaths

Offering pharmacotherapy for OUD in pregnancy increases*
- Treatment retention
- Number of obstetrical visits attended
- In-hospital deliveries
# TREATMENT OPTIONS FOR OUD IN PREGNANCY

## Methadone

- **Gold Standard** for opioid use disorder in pregnancy
- Pregnancy category C
  - Limited dosing flexibility
    - Split dosing in pregnancy is preferred due to increased clearance in later gestation
  - Prolonged QT syndrome
    - Baseline EKG recommended
    - Repeat EKG for dosing changes above 100mg
  - May contribute to lower birth weights when compared to Bup-exposed newborns

## Buprenorphine

- Gaining First-line recognition for treatment of opioid use disorder in pregnancy
- Pregnancy category C
- When compared to methadone:
  - Lower preterm delivery rate*
  - Higher birth weight*
  - Larger head circumference*
- Allows for adjustable dosing (split dosing)
- Treatment retention for pregnant women may favor buprenorphine over methadone(2).
Neonatal Abstinence Syndrome: Methadone and Buprenorphine

Maternal Opioid Treatment Human Experimental Research (MOTHER) : NEJM 12/2010

Double-blind, double-dummy, flexible-dosing, parallel-group clinical trial

Neonatal Outcomes: Comparing MMT (n=73) and Buprenorphine (n=58)
Neonatal Abstinence Syndrome: Methadone and Buprenorphine
Naltrexone: Emerging Data in Pregnancy

- 25 published human cases: all with normal birth outcomes
- Animal study literature does not show evidence of teratogenicity, although behavioral changes in animal offspring have been noted
- No human long-term outcomes or developmental studies available
- May be appropriate for select patients
- High maternal interest in treatment without NAS sequelae
Eat/Sleep/Console Assessment

Can infant eat ≥1 ounce per feed or breastfeed well?
- Yes
- No

Can infant sleep ≥1 hour?
- Yes
- No

Can infant be consoled within 10 minutes?
- Yes
- No

Nonpharmacologic interventions increased if possible:
- Feeding on demand
- Swaddling and holding
- Low-stimulation environment
- Parental presence

Not improved
- Start morphine at 0.05 mg/kg per dose every 3 hours or increase dosing by 0.01 mg/kg per dose

Infant is considered to be well managed and no further interventions are necessary
Eat/Sleep/Console

- An effective approach that limits pharmacologic treatment

- Infants were treated with morphine significantly less frequently than they would have been using the traditional Finnegan Neonatal Abstinence Scoring System

- May lead to substantial decrease in length of stay
Intrapartum Care

- Pharmacotherapy should be continued through labor (and postpartum) at same prenatal dose.
- Labor pain should be managed with regional anesthesia (epidural).
- Do not use mixed opioid agonist-antagonist (butorphanol (*Stadol*)/ nalbuphine (*Nubain*))
  - Will precipitate a withdrawal syndrome for women on opioid pharmacotherapy.
- Spinal anesthesia provides adequate pain control for C-sections.
Postpartum
(patient’s wishes regarding opioids postpartum should be established)

Pharmacotherapy should be continued at same dose postpartum
- Some women will require/request a dose decrease after delivery due to sedation; but any decrease should be individualized and carefully monitored
- For MMT, Postpartum fatigue and potential peak dose sedation should be anticipated; and precautions taken

NSAIDS and non-opioid pain medications should be maximized (scheduled orders; not PRN) (ketorolac, acetaminophen)

Full opioid agonists should be used for post-operative pain
- Bup and MMT patients have higher opioid requirements than general population
- Bup does not appear to prevent/block efficacy of full-opioids (Vilkins 2017)
Postpartum Monitoring and Counseling

- Frequent maternal follow up is needed

- Postpartum women are at high risk of a return to opioid use

- The first-year postpartum marks the highest risk of overdose death, with the highest rates 7-12 months after delivery
Postpartum overdose death rates
Naltrexone: Intrapartum and Postpartum

- Between 35-38 weeks gestation: women should be transitioned from IM Naltrexone to oral (Naltrexone 50mg po qd)

- With the onset of labor, women should hold oral dosing
  - Precautions allow for postoperative full opioid agonists pain control prn

- IM Naltrexone can be resumed postpartum
Breastfeeding

- Methadone and buprenorphine are SAFE in breastfeeding
  - <1% of maternal opioid intake transmitted to breastmilk

- SUPPORT breastfeeding for women on opioid pharmacotherapy
  - American Academy of Pediatrics (AAP),
  - The American College of Obstetricians and Gynecologists (ACOG),
  - The Academy of Breastfeeding Medicine (ABM)

- **Maternal benefits:** increased oxytocin levels are linked to lower stress, increased maternal-infant bonding both lower the risk of postpartum relapse

- **Newborn benefits:** reduction in pharmacologic treatment for NAS, shorter hospital stays
Contraception

- All postpartum women should be offered reliable contraception

- Contraception discussion should begin during prenatal cares and set prior to post-delivery hospital discharge

- Access to long acting reversible contraceptive (LARC) options should be readily available
References


The ASAM Treatment of Opioid Use Disorder Course: Includes Waiver Qualifying Requirements

ASAM National Practice Guideline | May 27, 2015

WHO. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014


ACOG Committee on Obstetric Practice opinion 711 https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy


Questions/Discussion
Up Next

- **Tuesday, April 28th, 2020**
  - Angella Barr, MD, Continuing the Conversation on *Treating Pregnant Women with Opioid Use Disorder*

- **Tuesday, May 12th, 2020**
  - Topic - *The Role of Substance Use Navigators (SUNs) in MAT Practice*
Resources and Materials
Pregnancy Resources and Materials
“A Collaborative Approach to the Treatment of Pregnant Women with Opioid Use Disorders”


HHS Publication No. (SMA) 16-4978
“Clinical Guidance for Treating Pregnant Women with Opioid Use Disorder and Their Infants”


HHS Publication No. (SMA) 18-5054
“Recommendations to the Indian Health Service on American Indian/Alaska Native Pregnant Women and Women of Childbearing Age with Opioid Use Disorder”

ATTC Tools for Treatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

Perspectives on Family-Centered Care for Pregnant and Postpartum Women

• http://attcppwtools.org/PPW-Monograph-4-Web.pdf
ATTC Tools for Treatment
Family-Centered Behavioral Health Support for Pregnant & Postpartum Women

Easier Together: Partnering with Families to Make Recovery Possible

Other Resources
Introducing the new 24/7 California Substance Use Line:
Free, confidential, clinician-to-clinician consultation on substance use evaluation and management

Call 1-855-300-3595 Mondays - Fridays, 6 am - 5 pm PT;
For time-sensitive questions during evenings and weekends, call 1-800-222-1222
(non-urgent questions can also be submitted online: nccc.ucsf.edu)

California is pleased to announce its new “California Substance Use Line”, offering point-of-care guidance on substance use evaluation and management. This service is open to any health care provider in California, and involves a new collaboration between California’s Poison Control System and the Clinician Consultation Center’s Substance Use Warmline.

With special expertise in medications for opioid use disorder, our addiction medicine-certified physicians, clinical pharmacists, and toxicology experts provide guidance based on established treatment guidelines, up-to-date evidence, and clinical best practices.

The California Substance Use Line is a joint program of the National Clinician Consultation Center and the California Poison Control System through the Substance Abuse and Mental Health Services Administration (SAMHSA) State Targeted Response to the Opioid Crisis Grant to the California Department of Health Care Services (DHCS)
24/7 California Substance Use Line
Clinician-to-clinician consultation and decision support

1-855-300-3595 (Mondays-Fridays, 6 am – 5 pm PT)
1-800-222-1222 after hours, weekends and holidays

Our consultants can help:

• Develop comprehensive treatment plans for special circumstances including pregnancy and postpartum, pediatric opioid withdrawal, HIV and viral hepatitis

• Identify cases of opioid withdrawal and advise on buprenorphine dosing to treat withdrawal

• Provide guidance on treatment of precipitated withdrawal

• Troubleshoot care transition planning to bridge patients to outpatient treatment

• Improve medication safety to help decrease risks of harm, including overdose

• Discuss useful care and communication strategies regarding substance use and pain

• Support any clinician caring for patients with substance use disorders, chronic pain, and behavioral health concerns
Working with communities to address the opioid crisis.

SAMHSA’s State Targeted Response Technical Assistance (STR-TA) grant created the Opioid Response Network to assist STR grantees, individuals and other organizations by providing the resources and technical assistance they need locally to address the opioid crisis.

Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Funding for this initiative was made possible (in part) by grant no. 6H79TI080816 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Working with communities to address the opioid crisis.

The Opioid Response Network (ORN) provides local, experienced consultants in prevention, treatment and recovery to communities and organizations to help address this opioid crisis.

The ORN accepts requests for education and training.

Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS), who is an expert in implementing evidence-based practices.

Funding for this initiative was made possible (in part) by grant no. 6H79TI080816 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.
Contact the Opioid Response Network

To ask questions or submit a request for technical assistance:

- Visit www.OpioidResponseNetwork.org
- Email orn@aaap.org
- Call 401-270-5900
Waiver Training for Physicians
MAT
WAIVERED PRESCRIBER
SUPPORT INITIATIVE

Could you benefit from physician consultation to provide Medications for Addiction Treatment (MAT)?

Are you seeking additional resources to help patients struggling with opioid use?

Do you have questions about best practices to provide MAT for patients with complex needs?

Request Free Technical Assistance TODAY

Make a request at www.uclaisap.org/MATPrescriberSupport/
Additional Learning Opportunities

http://uclaisap.org/MATPrescriberSupport/