Virtual Colorado MAT Learning Forum

"PERINATAL ADDICTION MEDICINE: PEARLS AND UPDATES"

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OCT 3, 2019

Monthly Webinars

- ***Virtual CO MAT Learning Forum***

  1st Thursday 12:30pm-1:30pm

  REGISTER

- ***Induction Basics: Tips from the Trenches****

  2nd Tuesday 7:30am-8:30am

  REGISTER

  **same topic each month*

- ***Denver Health Learning Collaborative***

  3rd Wednesday 12:15pm-1:15pm

  REGISTER

Denver Health Addiction Journal Club

2019 Dates

- Tuesday, September 24
- Tuesday, October 22
- Monday, November 10
- Monday, December 16

Time; noon to 1 pm

To join; email ITMATTTRs2@UCDENVER.EDU

Perinatal Addiction Medicine: Pearls and Updates

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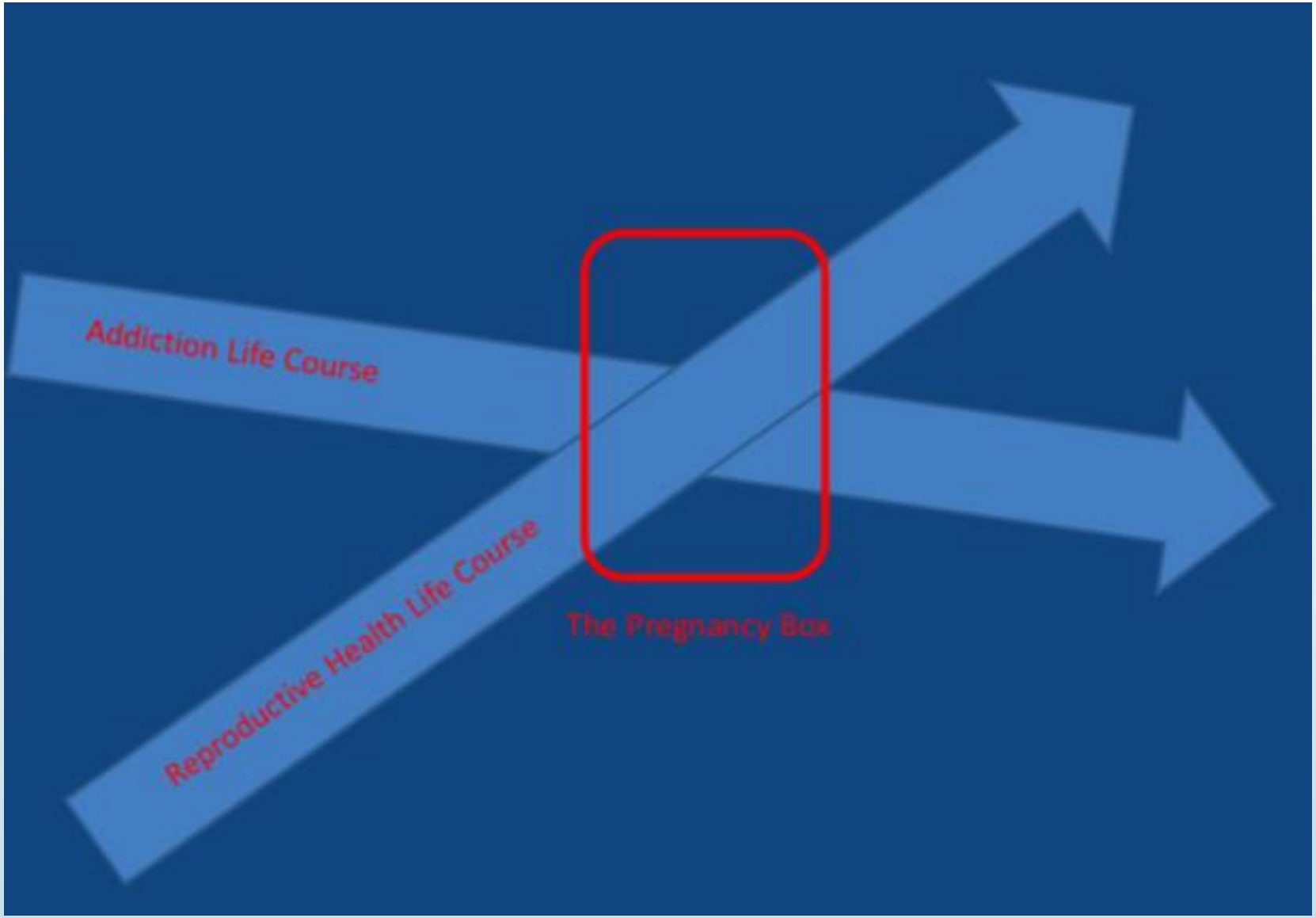
Addiction Medicine
Assistant Professor, Department of Family Medicine

*Please credit Dr Klie for any slides you choose to use in your own presentation.

Why do pregnant women use substances?



Mishka Terplan, MD

Epidemiology

Estimates vary between 2-24%, depending on screening tool used:

Illicit Substances 5-7%	Alcohol 8-10%	Nicotine 15-16% (nicotine alone)

Many of these urine toxicology reports do not account for prescription substances

1 in 20 women with Medicaid received opioid prescription in pregnancy

Biased information: minority women (particularly black women) over-represented in toxicology testing and reporting

Maternal Risks

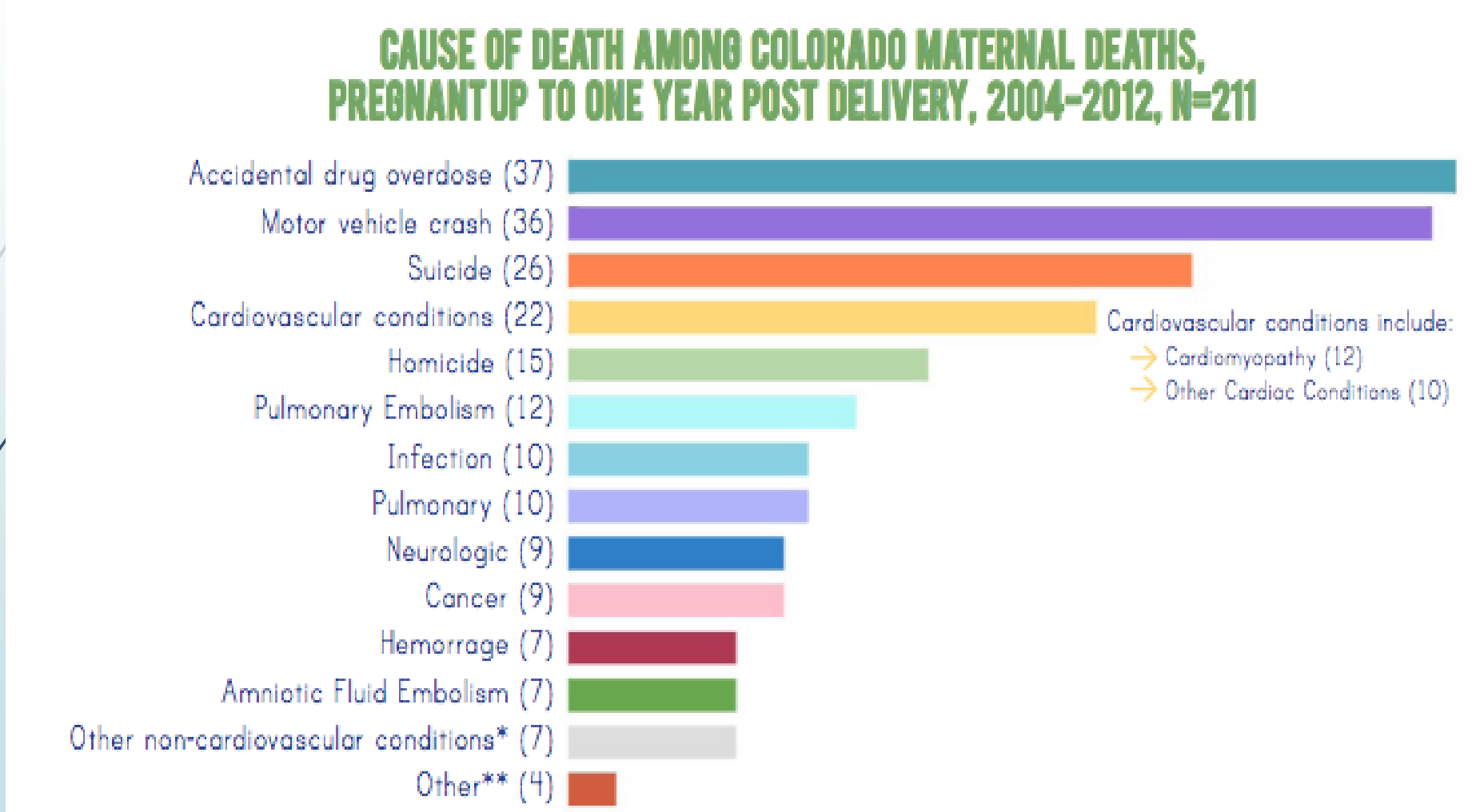
- Risks related to lack of prenatal care
  - Pre-eclampsia/Eclampsia
  - Miscarriage, premature ROM, premature labor
  - Placenta previa, accreta
- Risks related to Substance Use
  - Bacteremia, endocarditis
  - Infectious disease, STIs (HIV, Hep C, Hep B)
  - Overdose

The most common reason for women not presenting for prenatal care is not lack of care for themselves or their unborn, it is **fear:** being “found out”, being reported to social services, and losing custody of infant (or other children)

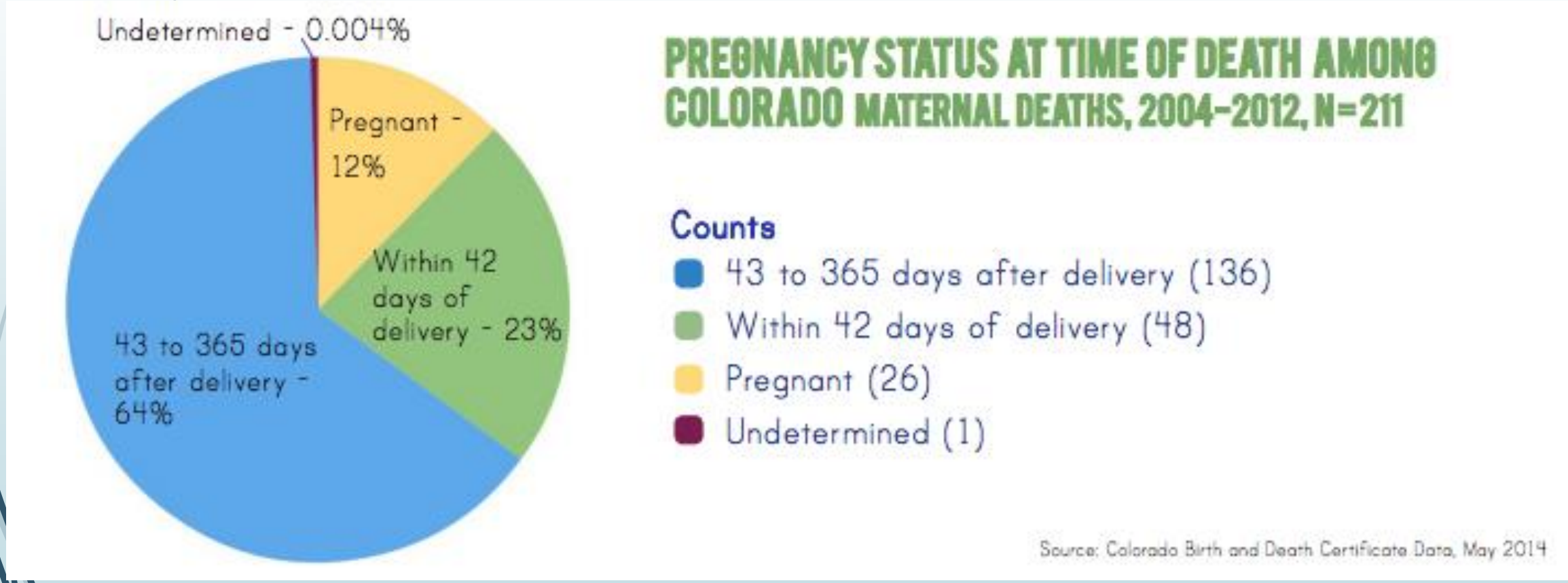
Fetal Risks

- Pre-term delivery
- Intra-uterine growth restriction
- Low birth weight (SGA)
- Placental insufficiency/abruption
- Amnionitis
- Birth defects
- Fetal Alcohol Effects/Spectrum Disorders
- Neurocognitive impairment
- *Neonatal Abstinence Syndrome (NAS) → Neonatal Opioid Withdrawal Syndrome (NOWS)*

Maternal Deaths in CO



Post-Partum Deaths in CO



Trauma and Substance Use

31% of women with injection substance use reported physical and sexual trauma within the past year

In one study, 90% of women enrolled in a methadone clinic reported lifetime experience of IPV

Women with trauma history more likely to develop physical dependence on a substance (26%) vs women without trauma history (5%)

Highest correlation between physical/sexual abuse and opiates, alcohol, and cocaine

What about pregnancy?

- Many studies find between 33-67% of women with SUD in pregnancy have a childhood history of sexual abuse
- 30-60% met criteria for diagnosis of PTSD (compared with 11% of women in a general population)

Bidirectional Relationship

Does trauma lead to substance use?

OR

Does substance use lead to trauma?

"It is hard to get sober if you

can't be safe,

and it's hard to get safe if you

can't stay sober"

~Carole Warshaw, M.D. from Complex Connections: Intimate Partner Violence (IPV) and Women's Substance Use and Recovery

2/3 of women with co-occurring mental health concerns

>60% women with SUD report history of and/or current-intimate partner violence

Low rates of receipt of reproductive health care = >80% pregnancies unplanned

Higher rates of infectious disease, poverty/unstable housing, correctional system involvement

Toxic Stress

Substance Use in Pregnancy

OUD and Pregnant Women

- For pregnant women with Opioid Use Disorder:
  - Pharmacotherapy is the evidence-based treatment Recommendation
    - Methadone
    - Buprenorphine
    - Naltrexone (?)
  - Withdrawal (detox) from opioids is not recommended
    - Risk for avoidable maternal-fetal stress
    - High rates of relapse
    - Higher risk for overdose/death after period of abstinence
- All care providers have a role in evaluating and caring for pregnant women with substance use

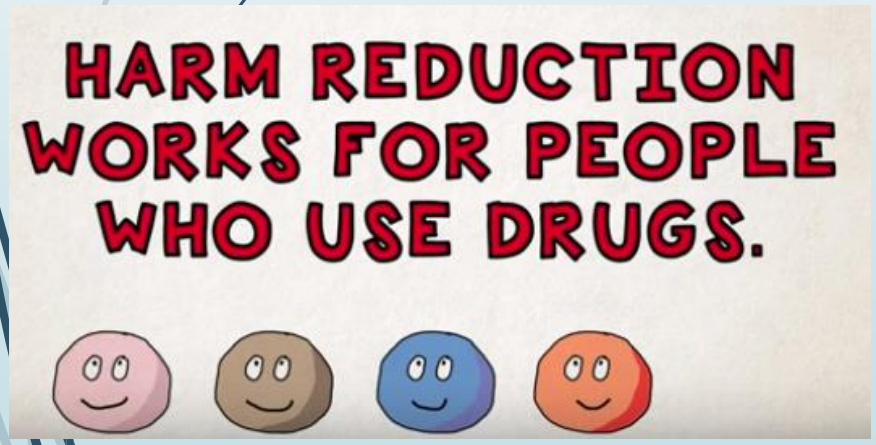
Treatment options for opioid use disorder in pregnancy

- Detoxification
- Methadone
- Buprenorphine
- Naltrexone/Vivitrol?
- Harm Reduction

Harm Reduction

Keep the door open!

- Providing prenatal care, even if woman does not become sober, is the largest step in reducing harm to her and fetus



https://www.youtube.com/watch?v=W7epsLmN604

Harm reduction is not condoning use

- Referral to syringe access programs
- Prescribe Naloxone (Narcan)
- Offer infectious disease screening (more than once)
- Pre-Exposure Prophylaxis

Barriers to Engagement in Care

Stigma typically associated with substance use <<<Use in Pregnancy

Avoidance of "the radar" (prenatal care, substance treatment, pregnancy support programs, mental health care) due to fear of detection, and subsequent involvement with Social Services

Many women associate any detection of use with immediate loss of custody of child (other children at home and/or child of current pregnancy)

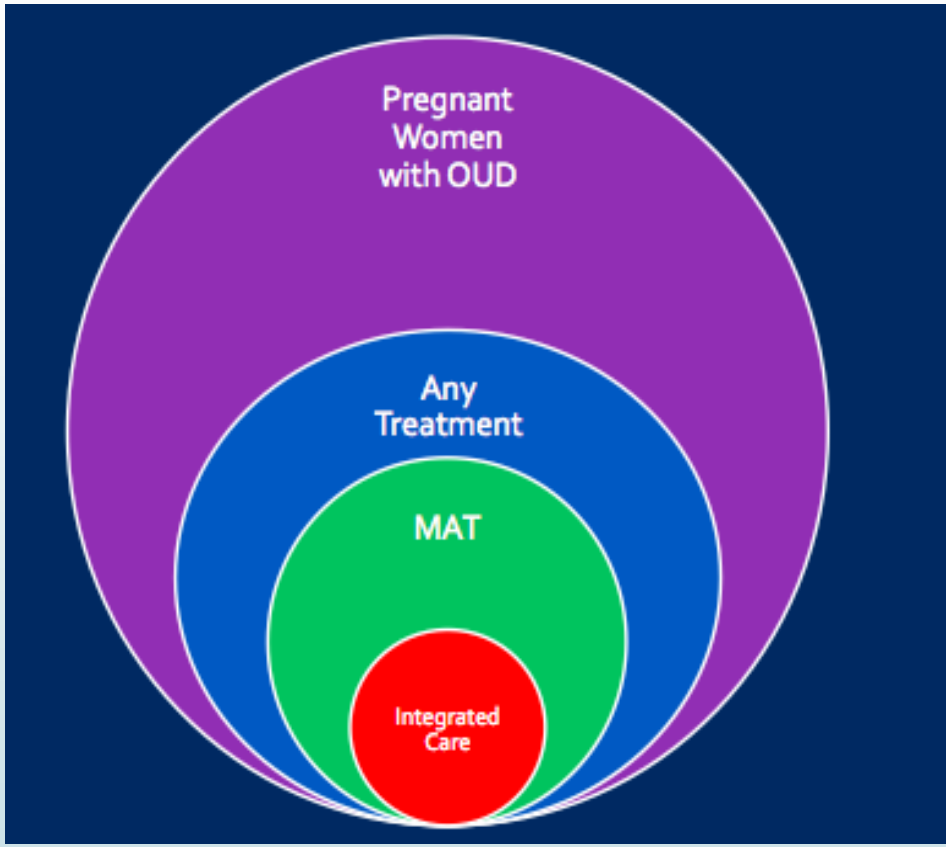
General lack of access to treatment in non-urban areas, while women are more likely to have unintended pregnancy at younger ages in rural communities

Additional Needs: Integration of Services

Treatment models exist: and work!

Comprehensive, integrated services are needed for pregnant women—but not only for time-limited event of pregnancy, and should include:

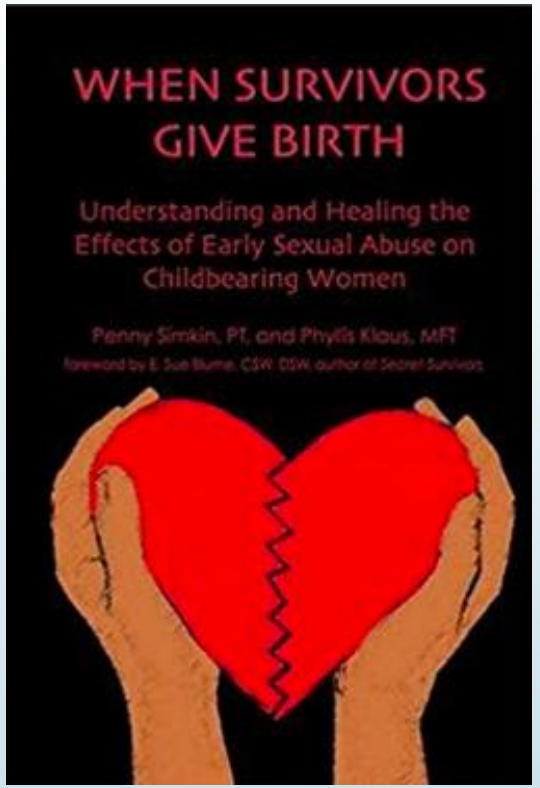
- substance use treatment/MAT
- peripartum medical care
- mental health care
- parenting support/child care services
- reproductive health/contraception support
- legal, housing, resource support
- trauma-informed, gender specific care



Terplan ASAM Presentation 2017

Pearls: Preparing for Birth

- Help women demystify birthing process in trauma-sensitive way
- Doula support whenever possible
- Continue usual dose of methadone or buprenorphine as close to home dosing schedule as possible
- Consider timing of naltrexone, especially Vivitrol carefully
- Do not expect any pain relief from patient's medication. Their dose of methadone or buprenorphine is their baseline.
- Epidurals work just as well
- Maximize non-opioid pain control measures (NSAIDs, apap, TAP block, On-Q, etc)
- Ok to use opioids for severe pain, allowing for tolerance: patient will likely require higher dose opioids than opioid naïve patient



Pearls: Breastfeeding

- Methadone and buprenorphine are safe and compatible with breastfeeding, at any dose. Naltrexone is likely safe, although less data available.
- It is ok for mothers to change (increase or decrease) their medication dose as determined with provider while breastfeeding
- When they are ready to stop breastfeeding, very unlikely infant will experience any withdrawal
- Different hospitals have different policies about length of time required in sobriety to provide breastfeeding support. Know your local birthing hospital policies!

Pearls: NAS/NOWS

- "Expected, temporary, and treatable"
- Not related to maternal dose of methadone or buprenorphine
- Evaluated now with Eat Sleep Console (vs Finnegan)
- Non-pharmacologic management is priority: Moms are good for babies! Rooming in, breastfeeding, skin to skin, use of pacifier, low stimulation environment
- Medications (methadone, morphine) are used only if necessary, for shortest length of time possible
- Baby may transfer to NICU if requires medication
- Will (most likely) be off all medications before leaving hospital

Longer-Term Outcomes for Children

- Literature is spare and inconsistent with regard to long-term outcome measures for children with prenatal opioid exposure
- "Opioid exposure" is a heterogenous exposure, but is often studied lumped all together
- Hard to control for other substance exposures/toxic stress/genetic risks
- Risk of falling into "single cause fallacy": If a child experienced NAS and later has developmental delay, assuming causality between NAS and developmental delay misses the larger context in which developmental delays are understood to be multifactorial
- Good data suggesting typical development for infants exposed to treatment opioids: buprenorphine or methadone
- Risk of not receiving MAT>>>>>Risk of physical/mental development differences

Alcohol

- Most teratogenic of all substances used in pregnancy
- FAS: fetal alcohol syndrome/FEA: fetal alcohol effects
- There is no safe amount of alcohol or time of consumption in pregnancy
- Alcohol readily enters breastmilk, women should use extreme caution when drinking alcohol while breastfeeding, follow lower-risk drinking guidelines, and allow 2-3 hours to elapse between drinking and feeding
- Consider naltrexone. Although data is not robust, risk of naltrexone <<< risk of alcohol.
- Detoxification should be managed with benzodiazepines (not phenobarbital)
- Recommend choline (and other micronutrient) supplementation: 900mg/day goal for fetal neuroprotection

Marijuana

- "We don't know enough" no longer valid argument for ignoring marijuana use in pregnancy
- Increased risks for small babies (IUGR), early babies (preterm delivery), stressed babies (meconium passed in utero), and dead babies (stillbirth)
- Neonatal withdrawal symptoms noted (poor feeding, poor tone/hypertonicity, irritability)
- Longer-term data for child/adolescent development concerning for later effects: attention, memory, school performance, behavior
- Infant toxicology positive for THC at time of birth is reportable
- Not recommended to breastfeed with ongoing marijuana use

Tobacco

Most common substance used in pregnancy

Right behind alcohol as far as data for risks to pregnancy and longer-term infant/child

Increases risk for small, early, stressed, stillbirth babies

Increased risks for SIDS (risk doubles from zero to 1 cig/day), asthma, ear infections, learning and behavioral problems

NRT and bupropion are recommended, in addition to behavioral modification/motivational enhancement therapies

Mommy and Me Tobacco Free through WIC

Pearls: Testing and Reporting (know your state!)

- After delivery, pediatric care team will seek parental consent to test infant's urine and/or meconium/cord
- Infant urine shows last 1-2 weeks of pregnancy exposure
- Meconium and cord show exposure from about 20-24 weeks of pregnancy on
- Reportable event is infant's toxicology result, including THC
- Infant toxicology positive for mom's treatment medicine is not reportable unless other concern for infant safety
- Report to social services does not equal open case or removal of custody necessarily
- Being in treatment is seen positively by social services

Thank You!

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OB Addiction Medicine clinic-University: 720-848-1060

General Outpatient Addiction Medicine-University: 720-848-3037

*Please credit Dr Klie for any slides you choose to use in your own presentation.

Future Webinars

Nov 7; Stimulant Use Disorder – Current State of the Evidence and Novel Approaches
Dec 5; TBD

See our website for previous presentations & resources as well as upcoming topics

https://www.practiceinnovationco.org/itmatttrs2/mat-forum/