Managing Opiate Use Disorder in the Perinatal Period

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Didactic Speaker Disclosures

No conflicts of interest to share.

Learning Objectives

- Recognize prevalence of, and history of discrimination toward patients with OUD in pregnancy.
- Counsel patients on available treatment options for OUD in pregnancy.
- Compare and contrast buprenorphine vs methadone vs non pharmacologic therapy for OUD in pregnancy.
- Discuss the implications of the rise in fentanyl use on initiation and provision of MOUD.
- Develop postpartum pain management plans for patients with MOUD.
- Describe basics about care for infants exposed to MOUD during pregnancy.

Outline

Overview of OUD in Pregnancy

Treatment of OUD

- Why MOUD?
- Buprenorphine Basics
- Methadone Basics
- Selecting an agent

Postpartum Considerations

- Pain control
- Infant care
- Breastfeeding

Acronyms

- Opioid Use Disorder – OUD
- Medications for opiate use disorder- MOUD
- Preterm Labor – PTL
- People who use drugs – PWUD
- Neonatal Opioid Withdrawal Syndrome- NOWS
- Neonatal Abstinence Syndrome- NAS
- Intrauterine Fetal Demise- IUFD

Overview: OUD in Pregnancy

Increasing Prevalence of OUD in Pregnancy

Histories of Punitive Policies

- Criminalization of parent
  - Murder charges, child endangerment etc.
- "Fetal Personhood Movement"
- 23 states and the District of Columbia consider substance use during pregnancy to be child abuse under civil child-welfare statutes (Guttmacher Institute)
- Compulsory treatment statutes
- Punitive policies associated with increased poor outcomes
  - "chilling effect" on seeking care
  - NAS rate increases with explosion of criminalization laws
- Disproportionate impact on women of color, people requiring public defense

Treatment of OUD in Pregnancy

Treatment: to detox or not to detox?

- Mixed data!
- Concern for PTL, IUFD – data not clear
  - "If you are in withdrawal the fetus is in withdrawal"
- Increased risk of return to use
- No change in NOWS
- Often driven by false beliefs about opiates in pregnancy
  - No birth defects
  - "Born Addicted" vs dependent
  - Breastfeeding and opiates

Treatment: MOUD

ACOG STATEMENT 2017:

- *"For pregnant women with an opioid use disorder, opioid agonist pharmacotherapy is the recommended therapy and is preferable to medically supervised withdrawal because* ***withdrawal is associated with high relapse rates, ranging from 59% to more than 90%, and poorer outcomes.*** *Relapse poses grave risks, including communicable disease transmission, accidental overdose because of loss of tolerance, obstetric complications, and lack of prenatal care."*

Treatment options

- Buprenorphine
- Methadone
- Naltrexone/Vivitrol - data forthcoming
- Detoxification – not recommended

- The most effective treatment is the treatment the parent is willing to engage with.

Buprenorphine Basics

- Partial agonist at mu opioid receptor, modest antagonist at kappa opioid receptor
  - Reduced overdose potential due to ceiling effect for respiratory depression
- Extensive first pass in liver – 50-60% sublingual bioavailability
  - Oral administration ineffective
- Suboxone vs Subutex
- Naloxone is a deterrent, will only precipitate withdrawal if used intravenously
- Duration of action is 24-48 hours; analgesic effect 6-8 hours (no ceiling effect for analgesia)

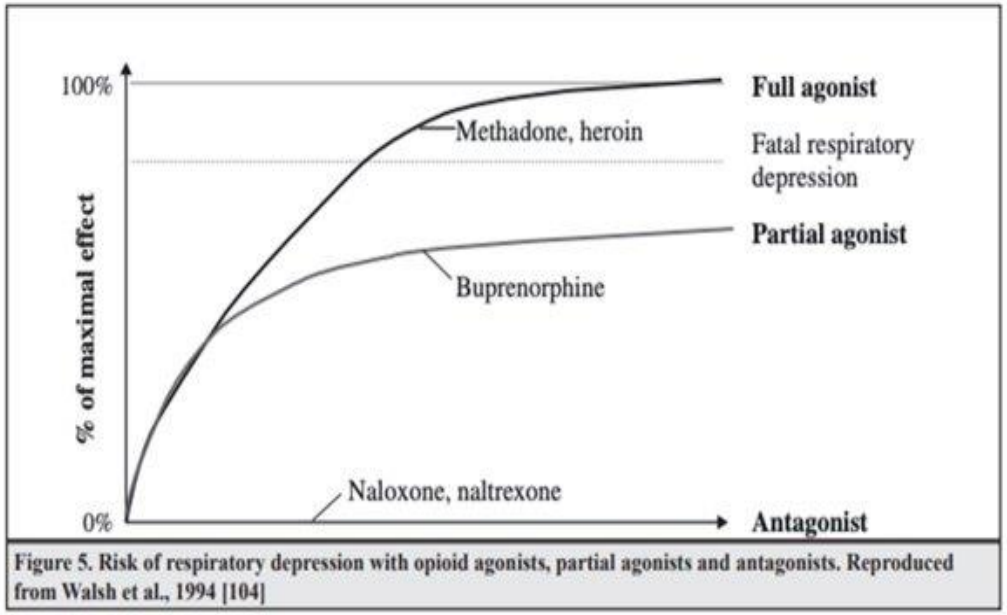


Figure 5. Risk of respiratory depression with opioid agonists, partial agonists and antagonists. Reproduced from Walsh et al., 1994 [104]

Buprenorphine: Prescribing

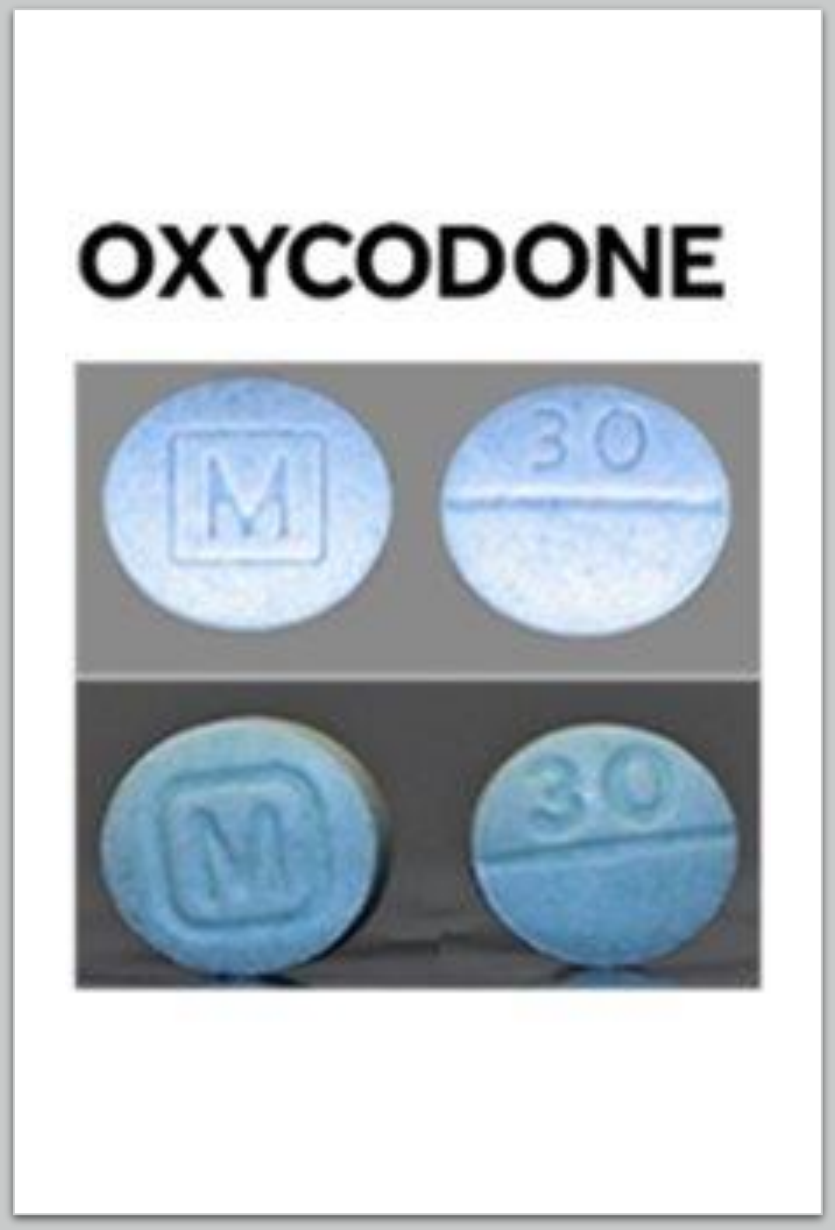
- Changes by current Data 2000/X-waiver requirements:
  - **Mandatory training**: Eliminated if treating <30 patients at one time. Still required for providers treating > 30 patients at one time
  - **Ability to refer to counseling and ancillary services**
  - **Special registration with SAMHSA and DEA**: Still required for all providers seeking to prescribe buprenorphine to patients with opioid use disorder

- Traditional Initiation
  - ~12 hrs after last short acting opioid
  - ~72 hours after last long acting opioid
  - Ancillary withdrawal meds: hydroxyzine, tizanidine, gabapentin, dicyclomine, ondansetron
  - 2mg q2hr x 2 doses at least then 8mg BID

- Microdosing Initiation
  - Concurrent dosing with full agonists
  - Staring with 0.5mg daily
  - 5-7 days
  - "A few receptors at a time

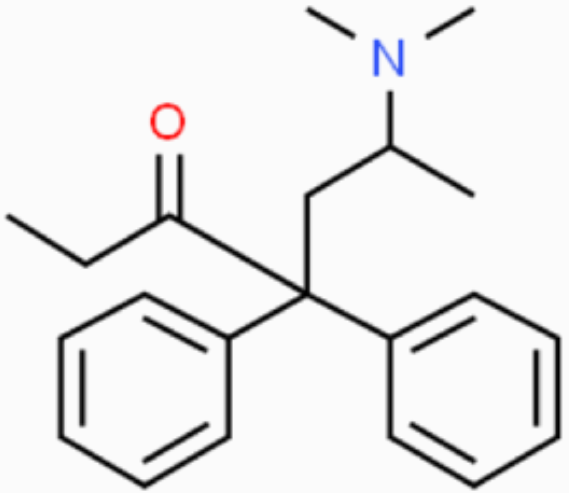
Buprenorphine and Fentanyl

- Fentanyl is the most widely available opiate on the street these days
  - Synthetic, pressed pills
  - "Percocet/Perc 30's", "Blues"
  - Often marketed as oxycodone
- Chronic fentanyl use and lipophilicity, accumulation
- Precipitated withdrawal
  - 39.5% at 24 hours vs 15% with control
- Implications for buprenorphine initiation
  - Higher "MED"
  - Prolonged abstinence (48 hrs+)
  - Microdosing, concurrent dosing



Methadone Physiology

- Full Agonist μ-opioid receptor
- Weak NMDA-antagonist
- 17x different rates of clearance from metabolism (CYP 3A4)
- Metabolism determines effective dose
- Pregnant people (fast metabolizers) will often benefit from split dosing
- No dose/tolerance ceiling



Methadone in Pregnancy

- Pregnant people often hesitant to increase dose in pregnancy
- “Typical” dose 80-120mg/day – dose is unique like a fingerprint
- Oral dose ≠ risk for NOWS
- Metabolism of body > opioid tolerance
- Split Dosing
- Outpatient Treatment Program dispensing only

TY WRIGHT The New York Times/Red

Treatment: selecting MOUD agents

Buprenorphine

- Buprenorphine 24mg = ~ methadone 60mg
- Office based – not daily dosing
- Widespread availability, primary care etc.
- Good for pts with concurrent benzodiazepine use, history of methadone overdose, prolonged QTc
- Decreased NOWS severity (MOTHER Study)
- May be difficult to initiate at later GA
- Can be difficulty for folks using high morphine equivalents, fentanyl

Methadone

- Buprenorphine 24mg = ~ methadone 60mg
- Often subjectively superior for individuals using higher level of substances
- Opioid treatment program (OTP) - daily dosing
- Transport barriers
- Only available in certain geographic regions
- May be best option for patients who have struggled with buprenorphine
- Improved treatment retention (MOTHER Study)

Other Postpartum Considerations

Pain control in the peripartum patient on MOUD

- **Continue methadone or buprenorphine!**
- **Consider "proactive" analgesia**
  - Pre-incisional local anesthetic wound infiltration, TAP Block
  - Administration of Tylenol + NSAID (+/- gabapentin) preoperatively
- **Maximize and schedule multimodal pain therapy**
  - NSAIDs (given perioperatively have opioid sparing effect)
  - Tylenol
  - Lidocaine patches (reduced pain scores in first 36hr compared to placebo)
  - Gabapentin
  - Abdominal binder
- **Consider higher potency opioids if indicated**
  - Favor scheduled over PRN
  - Favor PO over IV

Infant Care

- NAS or NOWS – normal result of MAT not failure
- No proven fetal long-term sequela to MAT
- Eat, Sleep, Console
- Long term outcomes; mixed data; postnatal environment confounders
- CPS involvement, support, First Clinic

Chestfeeding

- Safe to chestfeed while on MAT
- Milk excretion is minimal
- Essential bonding w/ parent
- Eat, Sleep, Console
- Institutional Policies

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