Online Case-Based Learning Collaborative Series on Treating Opioid Use Disorder

OUD & Pregnancy
March 27, 2024

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FACULTY & DISCLOSURES

Name	Role	Financial Relationship Disclosures
Katy Basques, NP	Moderator & Faculty	No relevant financial relationships to disclose
Dr. Ilana Hull	Faculty	No relevant financial relationships to disclose

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.

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AGENDA

Activity	Length
Orientation and Introductions	5 Minutes
Didactic Presentation	40 Minutes
Didactic Presentation: Facilitated Discussion	15 Minutes
Faculty Real-World Case Scenario & Discussion	15 Minutes
Learner Case Discussion and Q&A	10 Minutes
Closing Announcements	5 Minutes

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HOUSEKEEPING

- This event is brought to you by the Providers Clinical Support System – Medications for Opioid Use Disorders (PCSS-MOUD). Content and discussions during this event are prohibited from promoting or selling products or services that serve professional or financial interests of any kind.
- The overarching goal of PCSS-MOUD is to increase healthcare professionals' knowledge, skills, and confidence in providing evidence-based practices in the prevention, treatment, recovery, and harm reduction of OUD.

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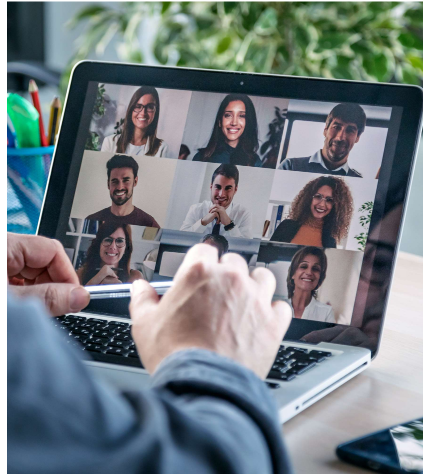
PARTICIPATION GROUND RULES

1. Please participate!
2. Everyone's experiences differ: Assume the best intentions.
3. Monitor your participation: Everyone is accountable.
4. If someone says something that is not your understanding of the evidence, ask questions and do so respectfully..



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AVOID USE OF STIGMATIZING LANGUAGE

The language we choose shapes the way we treat our patients…	
Instead of:	You can say….
addict, junkie, substance abuser	Person with a substance use disorder
Addicted baby	Baby experiencing substance withdrawal
Alcoholic	Person with alcohol use disorder
Dirty vs clean urine	Positive or negative, detected or not detected
Binge	Heavy drinking episode
Detoxification	Withdrawal management, withdrawal
Relapse	Use, return to use, recurrence of symptoms or disorder
substance abuse	Use (or specify low-risk or unhealthy substance use)
Substitution, replacement, Medication assisted treatment	Opioid agonist treatment, medication treatment

Saitz, R., Miller, S. C., Fiellin, D. A., & Rosenthal, R. N. (2020). Recommended Use of Terminology in Addiction Medicine

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PARTICIPANT INTRODUCTIONS

Please introduce yourself in the Zoom chat:

1. **Name**
2. **Professional Role**
3. **Work Setting/ Organization**
4. **Location**

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Dr. Ilana Hull, MD, MSc

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EDUCATIONAL OBJECTIVES

- At the conclusion of this activity participants should be able to:
  - Describe the trends in morbidity and mortality associated with opioid use in pregnancy
  - Discuss best practices for screening pregnant individuals for opioid use disorder
  - Summarize recommendations for the treatment of opioid use disorder in pregnancy

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Overdose is a leading cause of pregnancy-associated deaths

- 131% increase in opioid-use related diagnoses at delivery from 2010 to 2017
- 81% increase in pregnancy-related overdose deaths between 2017 and 2020
- More than 1,200 pregnant and postpartum women died of a drug overdose in 2020 in the US (1 in 6 pregnancy-associated deaths), mostly involving opioids

Han, et al. 2024
Bruzelius and Martins, 2022

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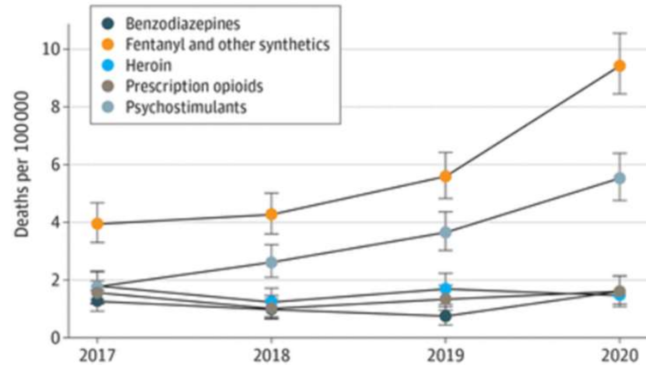
Overdose deaths driven by synthetic opioids



Bruzelius E and Martins 2022

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Effects of opioid use on pregnancy

- Lack of prenatal care
- Fetal growth restriction
- Placental abruption
- Fetal death
- Preterm labor
- Increased exposure to Hepatitis C, HIV, STI
- Co-occurring and untreated mental health conditions including depression, PTSD, and anxiety
- Neonatal opioid withdrawal syndrome (NOWS)

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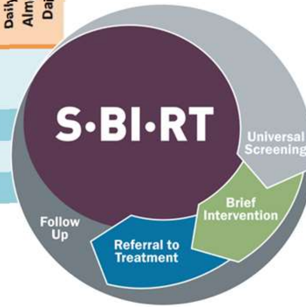
Universal screening in pregnancy is recommended

NIDA *Quick Screen* Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					



The American College of Obstetrics and Gynecology (ACOG) recommends using a questionnaire to screen all pregnant individuals for substance use. ACOG argues against universal drug testing.

Universal screening in pregnancy is recommended

5 Ps Prenatal Substance Abuse Screen

1. Did any of your *Parents* have problems with alcohol or drug use?
   ___ No ___Yes
2. Do any of your friends (*Peers*) have problems with alcohol or drug use?
   ___ No ___Yes
3. Does your *Partner* have a problem with alcohol or drug use?
   ___ No ___Yes
4. Before you were pregnant did you have problems with alcohol or drug use? (*Past*)
   ___ No ___Yes
5. In the past month, did you drink beer, wine or liquor, or use other drugs? (*Pregnancy*)
   ___ No ___Yes

Detoxification is not recommended in pregnancy

ACOG Committee Opinion 711 (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, which lead to worse outcomes"

Medications for opioid use disorder in pregnancy

- Buprenorphine and methadone have been proven to be safe and effective and are considered ***first-line medications*** in OUD in pregnancy
- Limited data for naltrexone in pregnant humans but can be considered with risk/benefit conversation, especially in individuals with period
  of abstinence (eg. inpatient treatment, current or recent incarceration)

Goals of pharmacotherapy for treatment of OUD

Similar to all patients:
- Abate withdrawal
- Treat cravings
- Reduce overdose risk
- Reduce risk of infection and other complications of ongoing use
- Reset dopamine response

Additionally:
- Reduce risk of poor pregnancy outcomes
- Allow patient to more fully engage with prenatal care

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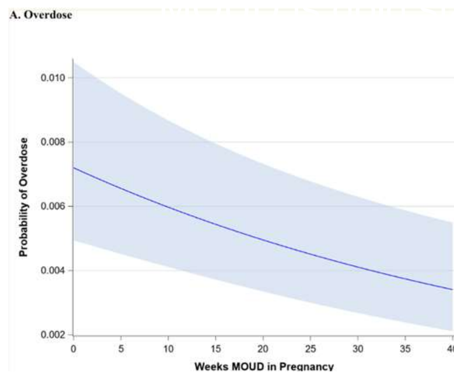
MOUD improves maternal and fetal outcomes



Krans, et al 2021

Medications for opioid use disorder (buprenorphine and methadone):
- Reduce risk of overdose death
- Improve perinatal outcomes including preterm birth and term low birthweight

Zedler 2014
ACOG 2017
Krans, et al 2021

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Low rates of utilization of MOUD

Receipt of MOUD Among Pregnant and Postpartum Medicaid Enrollees with a Clinically Documented OUD, by Race/Ethnicity and Age

Share of Pregnant and Postpartum Medicaid Enrollees with at Least 1 Claim for MOUD

Received MOUD | Did Not Receive MOUD

Overall

Overall

By Race/Ethnicity* (24 States)

White

Black

Hispanic

Roberts et al, 2023

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GU0

Unique pregnancy considerations

- Offer hospital admission for medication initiation whenever possible
- Dosing in pregnancy
- Split dosing
- Buprenorphine only vs. Buprenorphine/naloxone
- Post-operative pain control

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Slide 20

GU0 Admission to medicine? PP floor? Any advice on this? KB

Guest User, 2024-03-25T16:23:21.243

Physiologic changes of pregnancy effect pharmacokinetics

- Increased blood volume and volume of distribution (dilution effect)
- Enhanced hepatic and intestinal induction of CYP3A4 (involved in buprenorphine and methadone metabolism)
- Prolonged GI transit time can impact absorption
- Changes in serum-protein binding
- Increased GFR and renal clearance

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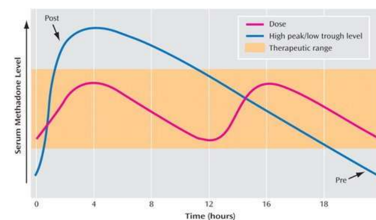
Methadone pharmacokinetics in pregnancy

- In non-pregnant individuals, methadone lasts 24 hours for control of cravings and withdrawal symptoms
- Changes in metabolism in pregnancy have demonstrated the half-life decreases to 8 hours in pregnancy
- Pregnant patients may need an increase in dose, especially in the third trimester and split dosing often optimal
- Split dosing during pregnancy is clinic-dependent, however, many clinics will make this accommodation



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Buprenorphine pharmacokinetics in pregnancy

- Buprenorphine plasma concentration is ≈50% lower during late pregnancy compared with baseline
- Many patients will need dose increase especially in late second and third trimesters
- Splitting dose to TID or QID dosing can help minimize withdrawal symptoms
- More research needed but some evidence that doses over 32mg needed to adequately manage withdrawal symptoms in pregnancy

Caritis, et al. 2017

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Buprenorphine vs buprenorphine-naloxone

- Buprenorphine monoproduct
  - Extensively studied in pregnancy
- Buprenorphine + Naloxone
  - ***2020 Systematic review found no difference in outcomes in pregnant patients prescribed buprenorphine-naloxone vs buprenorphine monoproduct***
- Buprenorphine monoproduct can require prior-authorization and pregnancy is approved condition
- Weekly injectable buprenorphine approved in pregnancy

Link, et all 2020

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Naltrexone in pregnancy

- Not considered first line in pregnancy as requires detoxification and opioid-free period
- Evidence about use and safety in pregnancy is limited
- Growing evidence to support use of naltrexone in pregnant patients who detoxify off opioids and is well tolerated by mother and fetus
- May cause difficulties with pain control after operative delivery (especially injectable form)
- No withdrawal syndrome in infant

Atluru, et al 2024

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Harm reduction still applies!!

PREGNANCY AND SUBSTANCE USE

NATIONAL HARM REDUCTION COALITION

Academy of Perinatal Harm Reduction

DIGNITY

Your Rights as a Pregnant Patient and Person Who Uses Drugs

AUTONOMY HARM REDUCTION SHARED DECISION-MAKING INFORMED CONSENT

What you should expect from providers when you are making decisions about your health care.

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Post-op pain control after c-section

Discuss cases with OB anesthesia colleagues prior to surgery whenever possible:

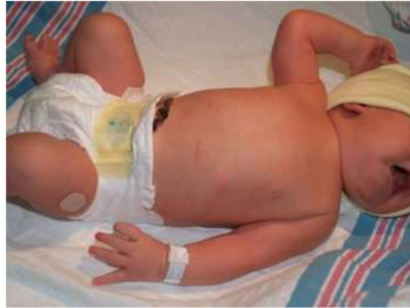
- Epidural anesthesia still effective for perioperative management
- Patients taking methadone or buprenorphine should continue medication in perioperative and postoperative periods
- Will likely require higher doses of opioid analgesia to achieve adequate post-op pain management
- Non-opioid medications: ie IV ketoralac, IV acetaminophen, gabapentin
- Transabdominal Plane (TAP) Block
- Single dose neuraxial administration of long-acting opioid (ie morphine)
- Extended epidurals
- Patient controlled analgesia (PCA)

Infant outcomes – correcting common misconceptions

- Babies are NOT born "addicted"
- Higher doses of medication do not necessarily put infant at risk of experiencing severe neonatal opioid withdrawal syndrome – maternal stability is key
- Breastfeeding is NOT contraindicated in individuals on buprenorphine or methadone

Maternal Opioid Treatment: Human Experimental Research (MOTHER) Trial: 2015

Infants exposed to buprenorphine received less morphine for treatment of NOWS, had shorter hospitalizations at birth, and had less severe NOWS symptoms



Suarez, et al. 2022

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Finnegan neonatal abstinence scoring tool

MRN NAME DOB

SIGNS
Observations from past 3–4 hours.
Start new scoring sheet each calendar day.

Birth Weight: ________ grams (x 90% = ________ grams)
Daily Weight: ________ grams

DATE:	SCORE	TIME	TIME	TIME	TIME	TIME	TIME	TIME	TIME
High pitched cry: inconsolable >15 sec. OR intermittently for <5 min.	2								
High pitched cry: inconsolable >15 sec. AND intermittently for ≥5 min.	3								
Sleeps <1 hour after feeding	3								
Sleeps <2 hours after feeding	2								
Sleeps <3 hours after feeding	1								
Hyperactive Moro	1								
Markedly hyperactive Moro	2								
Mild tremors: disturbed	1								
Moderate–severe tremors: disturbed	2								
Mild tremors: undisturbed	1								
Moderate–severe tremors: undisturbed	2								
Increased muscle tone	1–2								
Excoriation (indicate specific area) ________	1–2								
Generalized seizure	8								
Fever ≥37.2°C (99°F)	1								
Frequent yawning (≥4 in an interval)	1								
Sweating	1								
Nasal stuffiness	1								
Sneezing (≥4 in an interval)	1								
Tachypnea (rate >60/min.)	2								
Poor feeding	2								
Vomiting (or regurgitation)	2								
Loose stools	2								
≤90% of birth weight	2								
Excessive irritability	1–3								
Total score									
Initials of scorer									

Printed Name	Signature/Title	Initials	Printed Name	Signature/Title	Initials

Finnegan NAS scoring system (1975): scoring based on systemic withdrawal signs

- Score ≥8 warrants pharmacologic treatment – usually morphine

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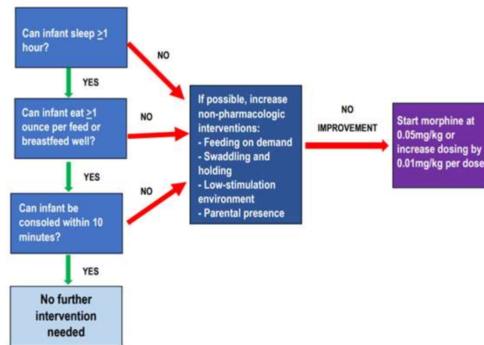
From Finnegan Scores to Eat, Sleep, Console

Newborns cared for with ESC were medically ready for discharge approximately 6.7 days earlier and 63% less likely to receive medication as part of their treatment.



Young et al. 2023

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Summary

- Screen all pregnant persons for substance use disorder
- Medications for opioid use disorder (methadone and buprenorphine) are first-line treatments and improve maternal, perinatal, and neonatal outcomes
- Pregnant individuals may require higher and more frequent dosing of MOUD to achieve stability

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CME POST-TEST QUESTION #1

What substance type was involved in the largest percentage of maternal overdose deaths in the United States between 2017 and 2020?

A. Methamphetamine
B. Heroin
C. Cocaine
D. Fentanyl and other synthetic opioids

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CME POST-TEST QUESTION #2

Which of the following is not addressed in the 5P's screening tool?

A. Partner
B. Progress
C. Past
D. Pregnancy

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CME POST-TEST QUESTION #3

Which of the following is true regarding neonatal opioid withdrawal syndrome (NOWS)?

A. Newborns are more likely to display NOWS symptoms if the parent was on a higher dose of buprenorphine or methadone.
B. Hydromorphone is used to treat withdrawal symptoms in newborns if pharmacologic treatment is needed.
C. The Eat, Sleep, Console approach is becoming the preferred method for scoring withdrawal symptoms in newborns.
D. Separating the parents from the newborn helps with withdrawal symptoms.

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CME POST-TEST QUESTION #4

What percentage of pregnant and postpartum Medicaid enrollees with opioid use disorder utilize buprenorphine or methadone as part of their treatment?

A. 10%
B. 40%
C. 80%
D. 55%

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FACILITATED DISCUSSION ON PRESENTATION

Katy Basques, NP

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FACULTY REAL-WORLD CASE SCENARIO & DISCUSSION

Katy Basques, NP

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CASE PRESENTATION

A 28 year old G3P1 at 24 weeks gestation presents to the emergency room at your hospital requesting detoxification from opioids. She has a long history of opioid use that started when she was 16. Prior to learning she was pregnant, she was using 50 bags of fentanyl daily by intravenous administration. She has been trying to cut back on the amount she is using and has switched to nasal insufflation and is currently using about 20 bags a day, just enough to manage her withdrawal symptoms. She denies use of alcohol, stimulants, benzodiazepines or other non-prescribed substances. She was on methadone in a previous pregnancy but never got to a stable dose and her son had to be in the hospital for several weeks for treatment of neonatal opioid withdrawal syndrome so she does not want to be on a medication that her daughter will be “addicted to” when she is born.

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CASE PRESENTATION DISCUSSION

Questions for discussion:

- How would you counsel this patient on her request for detoxification from opioids?
- If she is open to medications, what would her options be?
- What might be the benefits of using a medication for opioid use disorder during pregnancy?
- How would you counsel her on the risk of neonatal opioid withdrawal?
- How would her gestational age guide your decisions about medication dosing?

LEARNER CASE DISCUSSION AND QUESTIONS

Katy Basques, NP & Dr. Ilana Hull

PCSS-MOUD MENTORING PROGRAM

- PCSS-MOUD Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.
- PCSS-MOUD Mentors are a national network of providers with expertise in **addictions, pain, and evidence-based treatment including medications for opioid use disorder (MOUD)**.
- 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
- No cost.

For more information visit:
https://pcssNOW.org/mentoring/

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PCSS-MOUD DISCUSSION FORUM

Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

http://pcss.invisionzone.com/register

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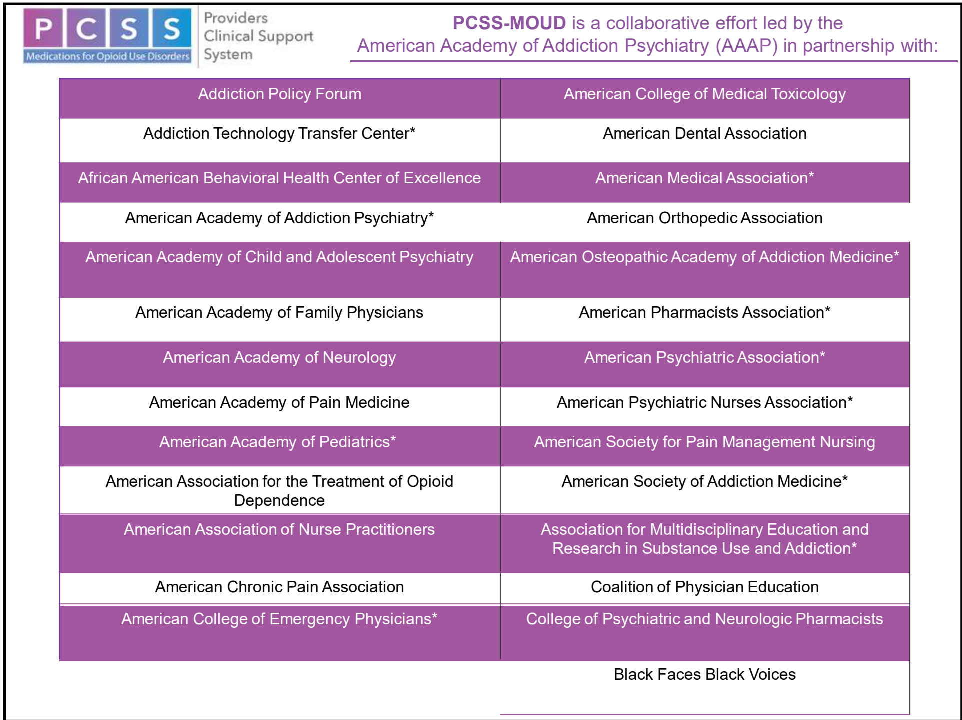
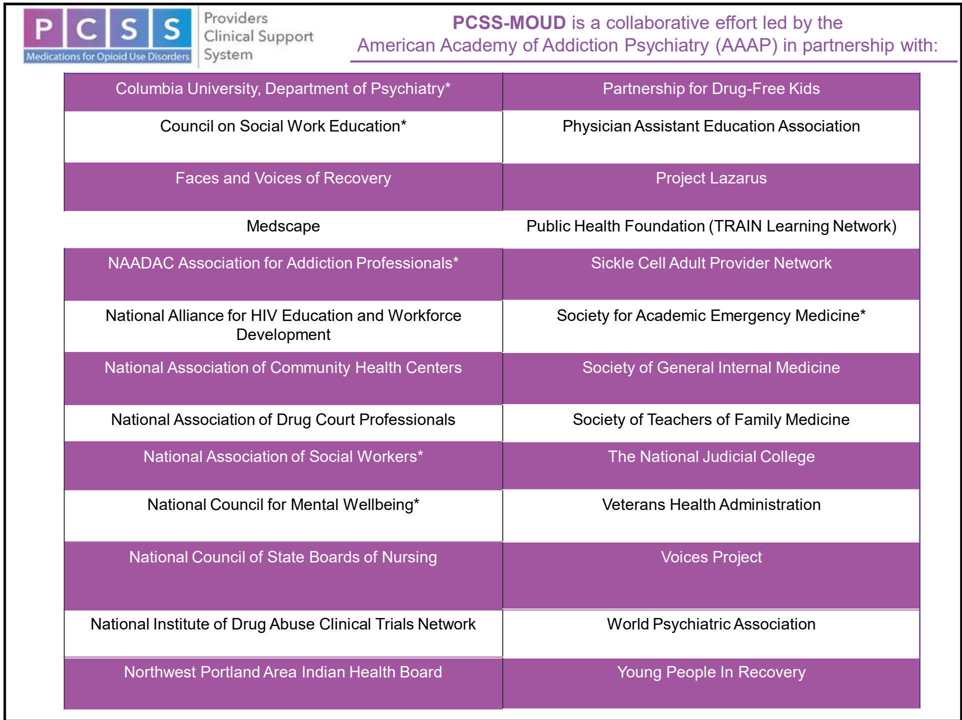


Addiction Policy Forum	American College of Medical Toxicology
Addiction Technology Transfer Center*	American Dental Association
African American Behavioral Health Center of Excellence	American Medical Association*
American Academy of Addiction Psychiatry*	American Orthopedic Association
American Academy of Child and Adolescent Psychiatry	American Osteopathic Academy of Addiction Medicine*
American Academy of Family Physicians	American Pharmacists Association*
American Academy of Neurology	American Psychiatric Association*
American Academy of Pain Medicine	American Psychiatric Nurses Association*
American Academy of Pediatrics*	American Society for Pain Management Nursing
American Association for the Treatment of Opioid Dependence	American Society of Addiction Medicine*
American Association of Nurse Practitioners	Association for Multidisciplinary Education and Research in Substance Use and Addiction*
American Chronic Pain Association	Coalition of Physician Education
American College of Emergency Physicians*	College of Psychiatric and Neurologic Pharmacists
	Black Faces Black Voices



Columbia University, Department of Psychiatry*	Partnership for Drug-Free Kids
Council on Social Work Education*	Physician Assistant Education Association
Faces and Voices of Recovery	Project Lazarus
Medscape	Public Health Foundation (TRAIN Learning Network)
NAADAC Association for Addiction Professionals*	Sickle Cell Adult Provider Network
National Alliance for HIV Education and Workforce Development	Society for Academic Emergency Medicine*
National Association of Community Health Centers	Society of General Internal Medicine
National Association of Drug Court Professionals	Society of Teachers of Family Medicine
National Association of Social Workers*	The National Judicial College
National Council for Mental Wellbeing*	Veterans Health Administration
National Council of State Boards of Nursing	Voices Project
National Institute of Drug Abuse Clinical Trials Network	World Psychiatric Association
Northwest Portland Area Indian Health Board	Young People In Recovery

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https://elearning.asam.org/oud-learning-collaboratives

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