ASAM American Society of Addiction Medicine

THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: 2020 FOCUSED UPDATE WEBINAR

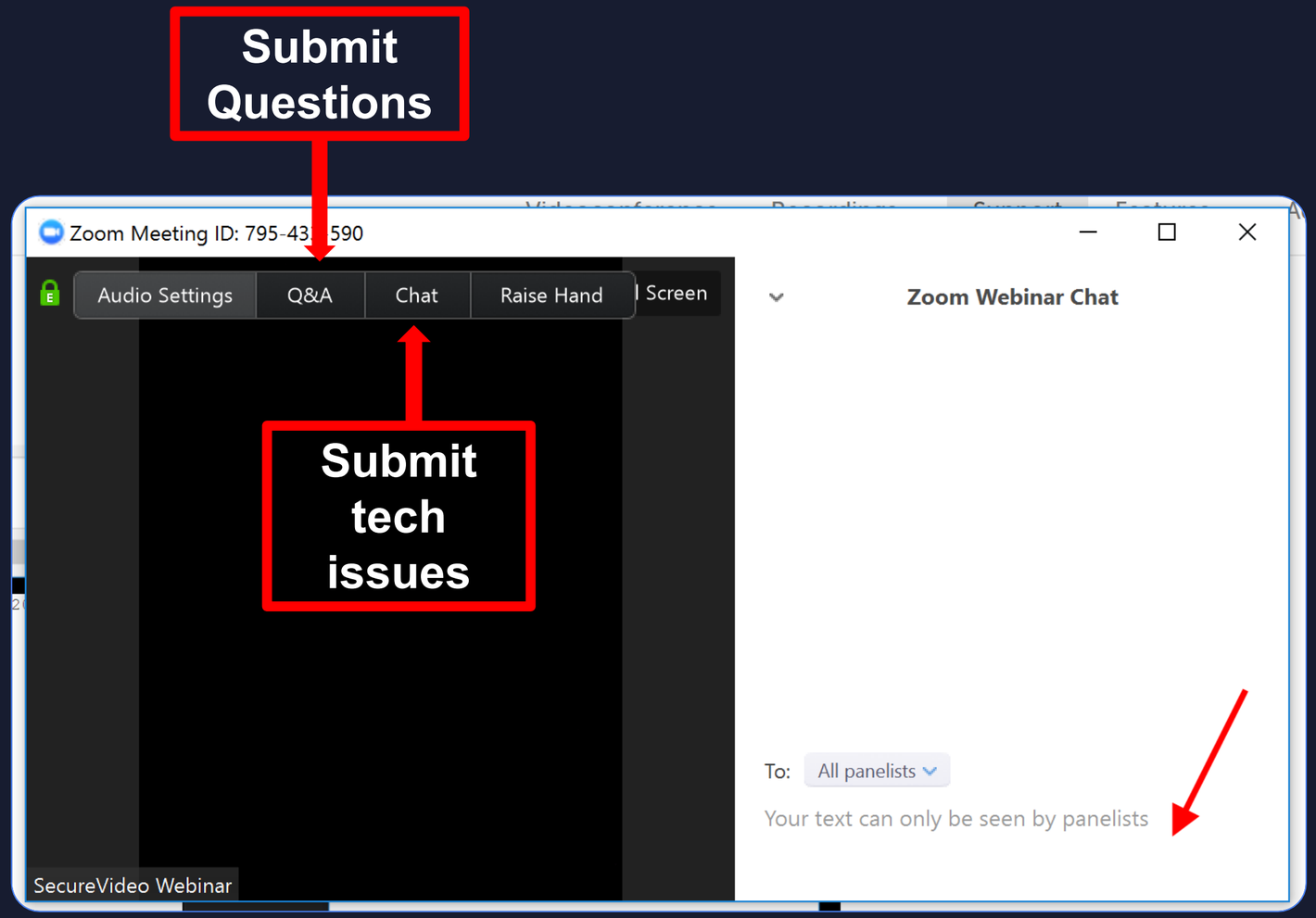
PREGNANCY

SCHEDULE

2:00 – 2:05 pm	Announcements ASAM STAFF
2:05 – 2:40 pm	Presentation DR. TRICIA WRIGHT
2:45 – 3:00 pm	Questions & Answers DR. TRICIA WRIGHT
3:00 pm	Concluding Remarks ASAM STAFF

ANNOUNCEMENTS

1. Information on obtaining your CME: Provided at the end of the webinar.
2. Attendee Audio: Your mics are automatically set to mute.
3. Questions? Type questions into the Q&A box.
4. Technical Issues? Use the chat box feature to submit questions to your hosts.

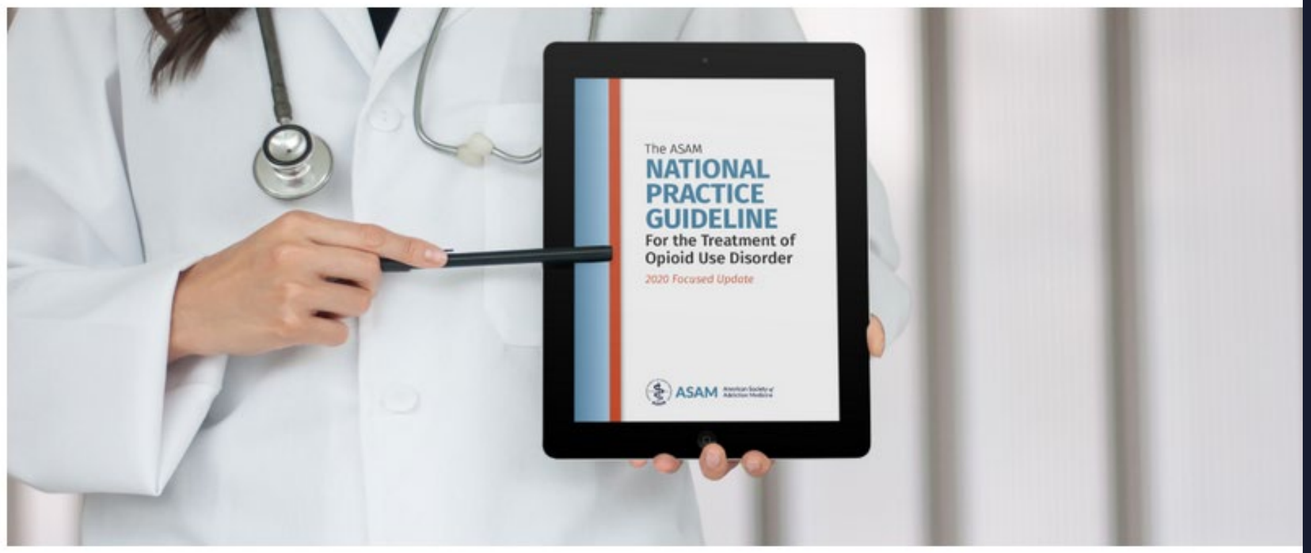


The ASAM National Practice Guideline 2020 Focused Update Webinar – Pregnant Women

Product not yet rated

Includes a Live Event on 06/30/2020 at 2:00 PM (EDT)

Overview | Speakers | Handouts | Credits & Disclosures | Contents (3)



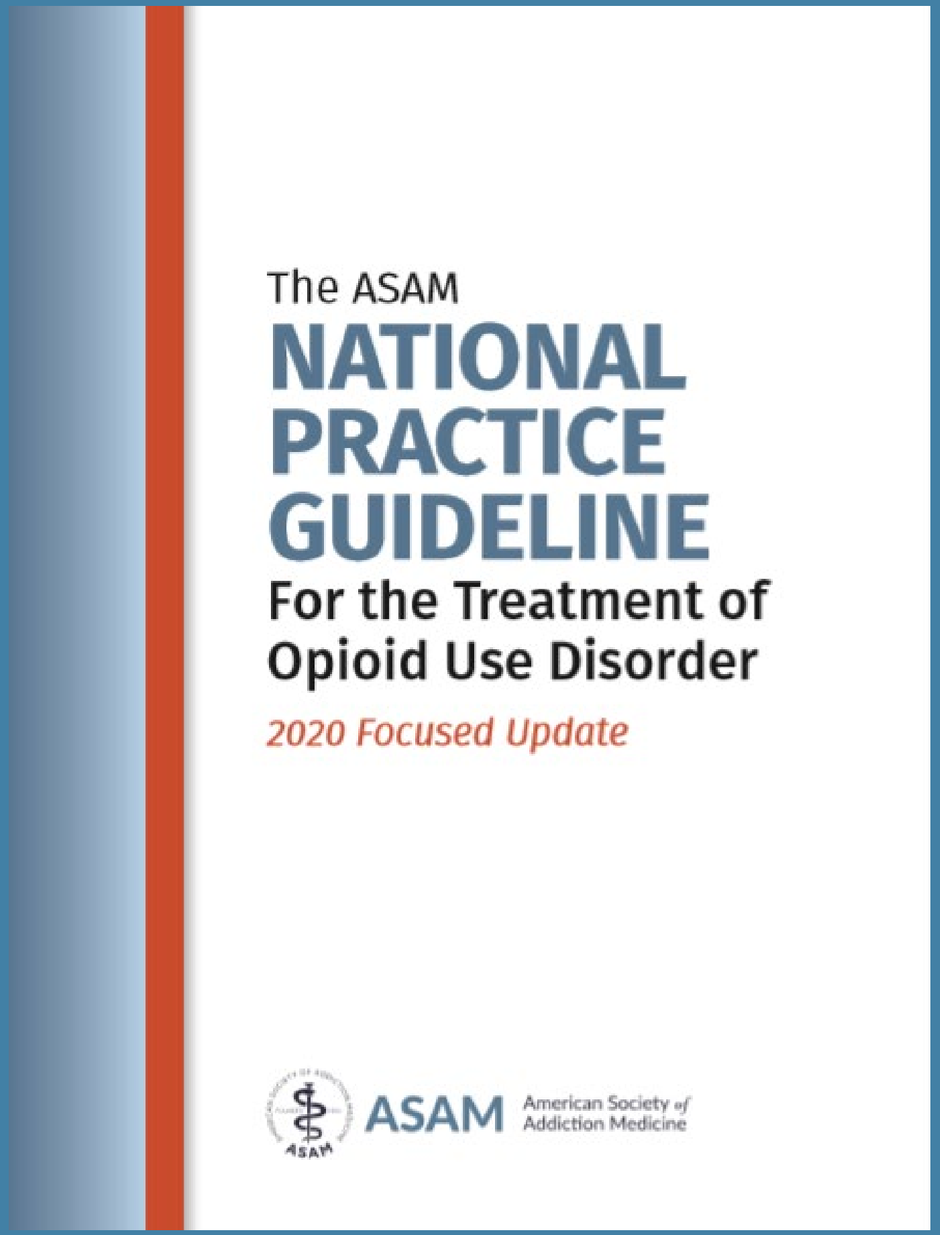
The ASAM National Practice Guideline 2020 Update Webinar – Pregnant Women

HOW TO OBTAIN CME

1. **Go to:**

https://elearning.asam.org/p/NPG2020_Webinar2

2. **Go to *Contents* tab**
3. **Complete:**
   - ❑ CME Quiz
   - ❑ Evaluation
   - ❑ Credit and Certificate



THE ASAM NATIONAL PRACTICE GUIDELINE FOR THE TREATMENT OF OPIOID USE DISORDER: PREGNANCY

PRESENTER

Tricia Wright, MD MS FACOG DFASAM

- Tricia Wright, MD MS is a Professor, Obstetrics, Gynecology & Reproductive Sciences University of California, San Francisco
- She is board certified in both Obstetrics and Gynecology and Addiction Medicine and a Fellow of the American College of Obstetrics and Gynecology and a Distinguished Fellow of the American Society of Addiction Medicine.
- She has published multiple papers on pregnancy and addiction as well as a textbook *Opioid Use Disorders in Pregnancy* published in 2018 by Cambridge University Press.

FINANCIAL DISCLOSURES

Consultant McKesson
Book Royalties-Opioid Use Disorders in Pregnancy

LEARNING OBJECTIVES

At the end of the webinar, you will be able to:

1. Summarize the guideline's treatment recommendations for the mother-infant dyad and discuss their practical implications.
2. Identify the fundamental components of an OUD patient assessment and diagnosis for pregnant and postpartum women.
3. Recognize the unique needs and treatment recommendations for pregnant and postpartum women.

PART 8:
SPECIAL POPULATIONS:
PREGNANT WOMEN

NEW AND MAJOR REVISIONS

OVERVIEW OF RECOMMENDATIONS

The **16 recommendations** in Part 8 provide guidance on the assessment and treatment of opioid use disorder among **pregnant women**.

NEW AND MAJOR REVISIONS

MAJOR REVISION

Pregnant women who are physically dependent on opioids **should receive treatment using methadone or buprenorphine** rather than withdrawal management or psychosocial treatment alone.

OPIOID EPIDEMIC - WHY WOMEN

- **Women are disproportionately represented in this epidemic:**
  - Women were more likely than men to report use of any prescription opioid (29.8% females vs. 21.1% males, p<0.001) (Green, 2009)
  - Women more likely to be given opioids for pain and higher doses (Cicero, 2009)

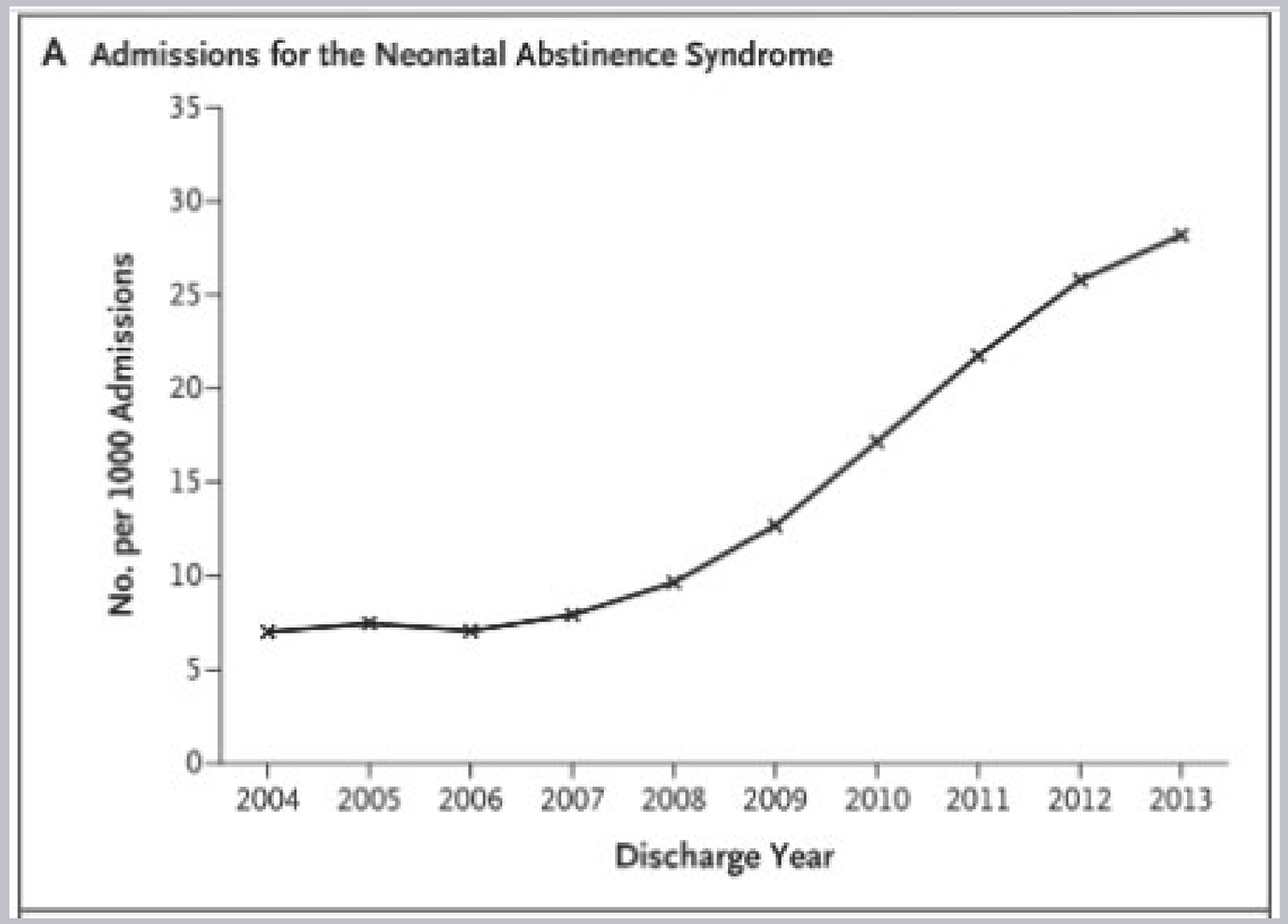
- **Women more likely to get opioids for:**
  - Fibromyalgia
  - Headache
  - Osteoarthritis
  - However, opioids are not effective in any of these.

- **Women are disproportionately represented in this epidemic**

- **Effectiveness of chronic opioid treatment for these disorders is unclear.**

- **Majority of women are of child-bearing age**

Annual NICU Admission Rates for NAS



https://www.nejm.org/doi/full/10.1056/NEJMsa1500439

Incidence Neonatal Abstinence Syndrome (NAS)

Prevention of NAS?

- Given the prevalence and costs, efforts to prevent NAS are critical
- Push for Medically-assisted withdrawal (AKA “detox”)
- Even in treatment-stable women

Why Wasn't Detox Recommended?

- Animal studies suggest risk of stillbirth with opioid withdrawal
- Human studies are mixed
- Known risk of relapse following detoxification without treatment with medication
  - Risk for relapse, overdose, and overdose death
- Greater retention in treatment and prenatal care with medication treatment

Narcotic withdrawal in pregnancy: Stillbirth incidence with a case report

JOSÉ LUIS REMENTERÍA, M.D.
NEMESIO N. NUNAG, M.D.
Bronx, New York

A stillborn infant was born to a drug-addicted mother who had withdrawal symptoms shortly before delivery. Mechanisms are presented to help explain the possible relationship between the maternal withdrawal and the fetal death. Statistics are also presented to show an increased stillborn and neonatal mortality rate in the over-all pregnant drug-addicted population.

Detoxification

Drugs in Pregnancy: Review

Opioid Detoxification During Pregnancy

A Systematic Review

Mishka Terplan, MD, MPH, Hollis J. Laird, MPH, Dennis J. Hand, PhD, Tricia E. Wright, MD, MS, Ashish Premkumar, MD, Caitlin E. Martin, MD, MPH, Marjorie C. Meyer, MD, Hendrée E. Jones, PhD, and Elizabeth E. Krans, MD, MSc

Conclusions:

- Evidence does not support detoxification as a recommended treatment intervention
  - Low detoxification completion rates
  - High rates of relapse
  - Limited data regarding the effect of detoxification on maternal and neonatal outcomes beyond delivery

(Obstet Gynecol 2018; 0:1-12)

Why Is Opioid Replacement Therapy Recommended?

- **Relapse**
- **Relapse rates with medically-assisted withdrawal (AKA ”detox”) is 17-92% average 48% (Jones, Terplan & Meyer 2017).**
- **None of the studies mentioned had long-term follow-up of mother and baby**
- **Post-partum relapse rates are high**
  - **Fatality**
  - **Long-term morbidity**
  - **Loss of custody, jobs, families, housing**

*ACOG, ASAM, WHO, AAAP, AAP

Relapse Kills

Relapse Kills

Opioids: Original Research

Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts

Davida M. Schiff, MD, MSc, Timothy Nielsen, MPH, Mishka Terplan, MD, MPH, Malena Hood, MPH, Dana Bernson, MPH, Hafsatou Diop, MD, MPH, Monica Bharel, MD, MPH, Timothy E. Wilens, MD, Marc LaRochelle, MD, MPH, Alexander Y. Walley, MD, MSc, and Thomas Land, PhD

- **Relapse is responsible for excessive mortality after periods of abstinence**
  - Incarceration
  - Treatment
  - Post-partum
- **Overdose is a leading cause of death in the postpartum period**

Medically Assisted Withdrawal (MAW) Success:

- Groups that showed success had women in controlled environments (inpatient rehab, jail, **therapeutic community**).
- **Few inpatient rehab facilities** are available for **pregnant women**
- Women-specific treatment often needs:
  - Care for other children
  - Transportation

Pregnancy:
Benefits of Opioid Agonist Therapy

Maternal Benefits

- 70% reduction in overdose related deaths
- Decrease in risk of HIV, HBV, HCV
- Increased engagement in prenatal care and recovery treatment

Fetal Benefits

- Reduces fluctuations in maternal opioid levels; reducing fetal stress
- Decrease in intrauterine fetal demise
- Decrease in intrauterine growth restriction
- Decrease in preterm delivery

Klaman SL, et al. J Addict Med. 2017

NEW AND MAJOR REVISIONS

MAJOR REVISION

A medical examination and psychosocial **assessment** are recommended when evaluating pregnant women for opioid use disorder. **Completion** of all assessments **should not delay or preclude** initiating pharmacotherapy for opioid use disorder.

If not completed before initiating treatment, assessments should be completed as soon as possible thereafter.

Rationale:
Since patients with opioid use disorder are at risk for significant harm – including overdose and overdose death – a delay in completion of each assessment should not delay treatment.

NEW AND MAJOR REVISIONS

MAJOR REVISION

A woman's decision to decline psychosocial treatment or the absence of available psychosocial treatment **should not preclude or delay pharmacological treatment**, with appropriate medication management, during pregnancy.

Rationale:

- A requirement for psychosocial treatment can present barriers to access to treatment for some patients and is not consistent with the evidence base.

Barriers for Pregnant Women

- **Lack of Screening-Anderson B et al. *J Addiction Med* 2010:3:114-21.**
  - Only 72% of Ob/Gyns felt prepared to screen
  - Only 42% used a validated screening tool
  - Perception that ”we don’t have those patients in our clinic.”
- **Fear of the fetus-non-Ob provider**
  - Perception of risk of withdrawal
  - Medico-legal risk
  - Need for monitoring
- **Fear of the drug-Ob providers-e.g. need for cross-coverage, taking up too much time in a busy clinic, pain management in L&D/postpartum**

Barriers for Pregnant Women Cont'd

- **Fear of Legal/Social Implications for the pregnant person**
  - Real risk of prosecution and loss of custody
  - Racially disparate outcomes
- **Lack of education on addiction**
  - Few medical schools teach anything about addiction
- **Lack of access to treatment/medication**
  - Lack of insurance/need for prior authorization/loss of insurance postpartum
  - Need for women centered care. Transportation, Childcare, Trauma-informed care.
- **Stigma/Bias "Women with substance use disorders particularly are likely to be stigmatized and labeled as hopeless."- ACOG, *Opioid Use and Opioid Use Disorder in Pregnancy*, August 2017.**

Pregnancy: Initial Evaluation

- **Know about specialized treatment services available in the community for pregnant, opioid-dependent patients**
  - Referral should be made regardless of the patient's decision to continue the pregnancy
- **Obtain consent to talk to her obstetric provider**

Pregnant Women

- Identify & refer urgent medical conditions
- Medical & psychosocial examination
- OB/Gynecologists be alert to signs of OUD
- Psychosocial treatment is recommended, but not required
- HIV & hepatitis (B & C) testing & counseling
- With patient consent (especially important in pregnancy), urine testing for opioids and other drugs

Opioid Maintenance Therapy

Methadone vs **Buprenorphine**

For the treatment of opioid dependence during pregnancy

MOTHER Study

- Randomized trial of methadone versus buprenorphine
- **<u>Primary outcome:</u> NAS**
  - Similar prevalence of treatment for NAS
  - Less neonatal abstinence severity and treatment (bup)
  - Shorter neonatal LOS (bup)
  - Bigger HC

Table 2. Primary and Secondary Outcomes in the Methadone and Buprenorphine Groups.*

Outcome	Methadone (N=73)	Buprenorphine (N=58)	Odds Ratio (95% CI)	P Value
Primary outcomes				
Treated for NAS — no. (%)	41 (57)	27 (47)	0.7 (0.2–1.8)	0.26
NAS peak score	12.8±0.6	11.0±0.6		0.04
Total amount of morphine for NAS — mg	10.4±2.6	1.1±0.7		<0.0091†
Duration of infant's hospital stay — days	17.5±1.5	10.0±1.2		<0.0091†
Infant's head circumference — cm	33.0±0.3	33.8±0.3		0.03
Secondary neonatal outcomes				
Duration of treatment for NAS — days	9.9±1.6	4.1±1.0		<0.003125†
Weight at birth — g	2878.5±66.3	3093.7±72.6		0.03
Length at birth — cm	47.8±0.5	49.8±0.5		0.005
Preterm, <37 wk — no. (%)	14 (19)	4 (7)	0.3 (0.1–2.0)	0.07
Gestational age at delivery — wk	37.9±0.3	39.1±0.3		0.007
Apgar score				
1 min	8.0±0.2	8.1±0.2		0.87
5 min	9.0±0.1	9.0±0.1		0.69

Summary of Outcomes

Summary of outcomes: MEANING IS UNCLEAR	FAVORS Methadone	EQUIVALENT	FAVORS Buprenorphine
Maternal			
Treatment efficacy	*better for women that failed treatment in past	X*	*can be considered reasonable first line treatment
Access to treatment			X
Retention	X		
Does not require withdrawal for initiation	X		
Treatment automatically coordinated	X		
Maternal medical complications			X
Neonatal			
Long-term outcome: data	X		
Birthweight			X
Gestational age			X
% requiring NAS treatment		X	
Severity of NAS symptoms			X
Duration of NAS treatment			X

Take-Home Methadone

- May be used during pregnancy
- Which medication depends on many factors
  - Maternal stability, need for care coordination
- Switching from methadone to buprenorphine during pregnancy is difficult, especially if on high doses

vs

Take-Home Buprenorphine

- May be used during pregnancy
- Which medication depends on many factors
  - Maternal stability, need for care coordination
- Buprenorphine may have some benefits over methadone for maternal/fetal outcomes; it is certainly not worse compared to methadone

KEY RECOMMENDATION CHANGES

The **combination buprenorphine/naloxone** product is frequently used in pregnancy and **is considered safe and effective**. Naloxone is minimally absorbed when these medications are taken as prescribed.

Rationale:

- While the evidence on the safety and efficacy of naloxone in pregnant women remains limited, the combination buprenorphine/naloxone product is frequently used and the consensus of the guideline committee is that the combination product is safe and effective for this population.

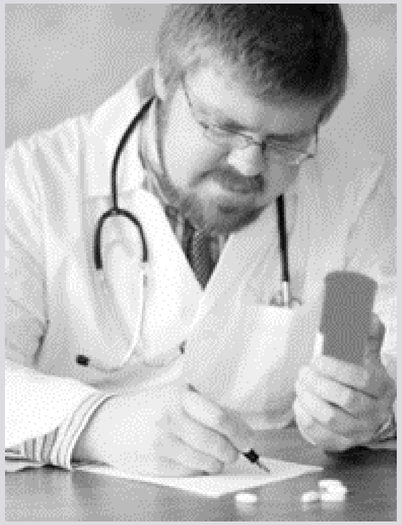
Assemble the Team:
It Takes A Village…
No Matter the Medication

(And most of us cannot coordinate the village for every patient)

Pediatrician

Community-Based Nursing

Substance Abuse Counselor



Opioid Medication Provider

Obstetric Provider

Methadone Initiation

- **Initiation of methadone**
  - As early as possible in pregnancy
  - Inpatient or outpatient
- **Inpatient initiation**
  - Enables coordination of care with Ob/Gyn, social services, pediatric consultation
  - Especially in third trimester

NEW AND MAJOR REVISIONS

MAJOR REVISION

Methadone should be initiated at a dose range of 10 to 30 mg. Incremental doses of 5 to 10 mg is recommended every 3 to 6 hours, as needed, to treat withdrawal symptoms, to a maximum first day dose of 30 to 40 mg.

NEW AND MAJOR REVISIONS

MAJOR REVISION

After initiation, clinicians should increase the methadone dose by **no more than 10 mg approximately every 5 days**. The goal is to maintain the lowest dose that controls withdrawal symptoms and minimizes the desire to use additional opioids.

Methadone Maintenance

- **Increased volume of distribution in pregnant women**
  - Increased dosing usually necessary
  - Split dosing more effective and lower side effects **for some patients**
    - May not be feasible in OTP. WHY?
- **NAS incidence not dependent on methadone dose**
  - Women should be maintained on dose that prevents cravings and illicit opioid use
  - Dosing may need to be adjusted postpartum, but often doesn’t return quickly to baseline

Fetal Well-Being

- **Growth ultrasounds should be obtained monthly, especially if mom smokes cigarettes**
  - Increased risk of intrauterine growth restriction (IUGR)
- **If non-stress tests (fetal monitoring) are necessary, should be done in the afternoon**
  - Not immediately after dosing as greater incidence of non-reactive testing
- **Encourage breast feeding**

How to Start Buprenorphine

- **Ensure moderate withdrawal before initiating treatment and quickly work to get women comfortable with small incremental dosages EX**
  - CINA 10
  - COWS 12
- **Transition from methadone to buprenorphine associated with higher rates of dissatisfaction with buprenorphine**
  - Methadone long half life
  - Higher rates of precipitated withdrawal
  - Microdosing protocols being studied
- **Preliminary fetal data reassuring**
  - Third trimester initiation usually done in hospital (coordination of care, rapid treatment of precipitated withdrawal if present)

Opioid withdrawal management with buprenorphine should not be initiated until there are **objective signs** of opioid withdrawal.

Once **objective signs of withdrawal are observed**, initiation of buprenorphine should start with a dose of 2 to 4 mg. Dosages may be increased in increments of 2 to 8 mg.

Sample Inpatient Nursing Protocol

- Admit for observation
- Obtain NST upon admission, then bid and prn for COWS > 20
- Regular diet as tolerated
- COWS score q 2hours until buprenorphine initiated
- Give initial dose buprenorphine 4 mg for COWS > 10

Sample Inpatient Nursing Protocol Cont'd

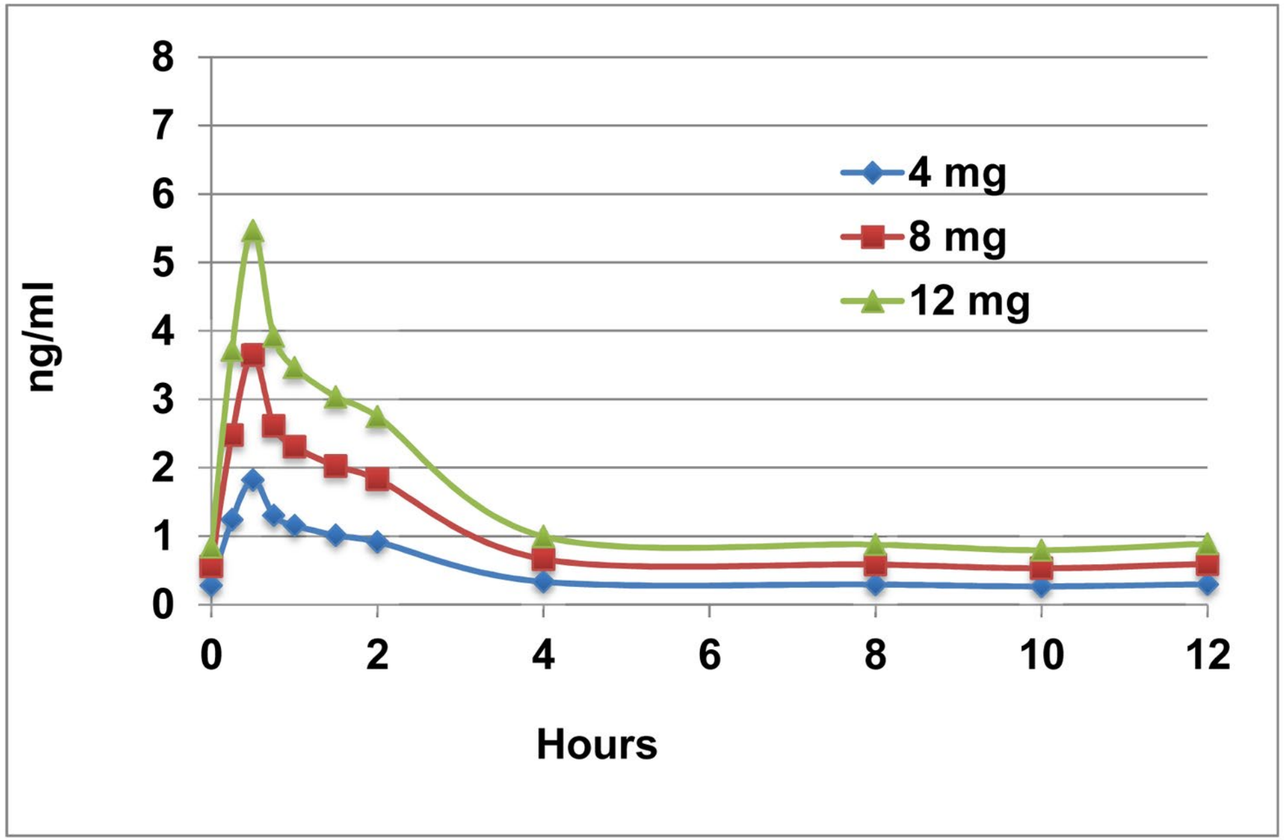
- **Observe for 60 minutes.** If tolerated and COWS > 6, give additional 4 mg. Repeat COWS q hour and give 4 mg prn COWS > 6. Total first day dose usually 12-16 mg. (occasionally can be higher).
- **Day 2 dose** is total received day 1 given in am after last dose (or at least 8 hours)
- **If switching from methadone or other long-acting opioid**, start with 2 mg
- **Can give fentanyl or additional buprenorphine for precipitated withdrawal**
- **Rarely need to give Z drugs** (zolpidem/eszopictone/zaleplon) for sleep
  - Hydroxyzine, diphenhydramine work well

Pregnant Women
Need Higher Dosing

- Volume of distribution increases (just as with methadone)
- Salivary pH decreases which may decrease absorption
- More women chose to break up pills secondary to nausea (decreased time to peak concentration)
- Dose-normalized plasma concentrations during a dosing interval and the overall exposure of BUP (AUC**0**→**12**) ~50% lower throughout pregnancy compared to the postpartum period.
- Increase in apparent clearance of BUP during pregnancy.
- **These data suggest that pregnant women may need a higher dose of sublingual buprenorphine compared to postpartum individuals.**

Bastian et al 2017

Figure 1a.



Concentration per dose 2nd trimester

Caritis et al 2017

Pregnant Women Need Split Dosing

Buprenorphine Dosing and NAS/NOWS

- There does not appear to be a relationship between dose at delivery and the risk of NAS/NOWS.
- Maternal dose alone may not fully represent the fetal exposure to buprenorphine.
- There does appear to be a relationship between the quantity of buprenorphine in meconium and the risk of NAS/NOWS.

Jones et al 2013
Kacinko et al 2007

Take Home Message:
Buprenorphine Initiation

- Initiate in outpatient setting or overnight stay
- Moderate withdrawal symptoms well tolerated by pregnant women
- Maternal withdrawal symptoms important in patient satisfaction with medication
- Dosing in smaller incremental doses helpful
- Medication adjusted frequently during initiation and over course of pregnancy
- Women have more withdrawal symptoms during pregnancy
  - Especially if initiated during pregnancy

Maintenance Therapy in Pregnancy:
Neonatal Abstinence Syndrome (NAS)

- **Generalized disorder** with dysfunction of the autonomic nervous system, GI tract and respiratory system
- **Occurs in 60-80% of infants with intrauterine exposure to opioid maintenance therapy**
- **Not all needs to be treated**
- **Onset:** majority present within 72 hours after delivery
- **Duration:** up to 4 weeks (prolonged if exposed in-utero to more than one substance associated with NAS)
- **Encourage breast feeding and rooming in.** Eat, Sleep, Console protocols show promise.

Maternal Dose and NAS Severity

- **No correlation** between maternal opioid maintenance therapy dose and the duration or severity of NAS
- **Women should be encouraged to report any symptoms of withdrawal through her pregnancy** without fear a dose increase will affect her baby's hospital stay or need for NAS treatment

Berghella et al. 2003; McCarthy et al. 2005; Cleary et al. 2010; Isemann et al. 2010; Jones et al. 2010; Seligman et al. 2011.

NEW AND MAJOR REVISIONS

MAJOR REVISION

If a woman becomes pregnant while she is receiving **naltrexone**, it may be appropriate to **discontinue the medication** if the patient and clinician agree that the risk of relapse is low.

A decision to remain on naltrexone during pregnancy should be carefully considered by the patient and her clinician and should include a discussion on the **insufficiency of research on risks (if any) of continued use of naltrexone**. If the patient chooses to discontinue treatment with naltrexone and is at risk for relapse, treatment with methadone or buprenorphine should be considered.

Rationale:
There is insufficient research on the safety and efficacy of naltrexone during pregnancy.

Opioid Use Disorder and Breastfeeding

- The transfer of methadone and into human milk is minimal and unrelated to maternal doses
- Buprenorphine has poor oral bioavailability and is also compatible with breastfeeding
  - The amount of buprenorphine in human milk is small and unlikely to have negative effects on the infant
- Both are considered Category L3 (probably compatible)

McCarthy JJ 2000; Begg EJ 2001; Jansson LM 2007 & 2008; Hale 2008; Grimm 2005; Lindemalm 2008; Ilett 2012.

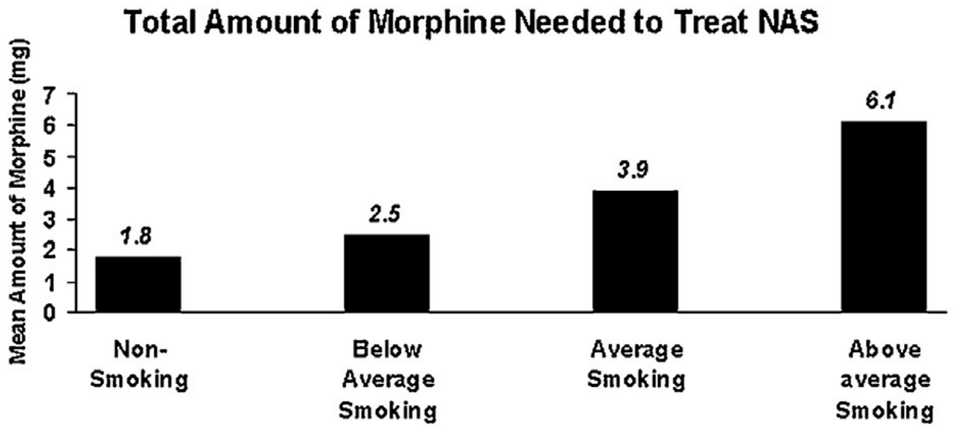
NAS and Breastfeeding

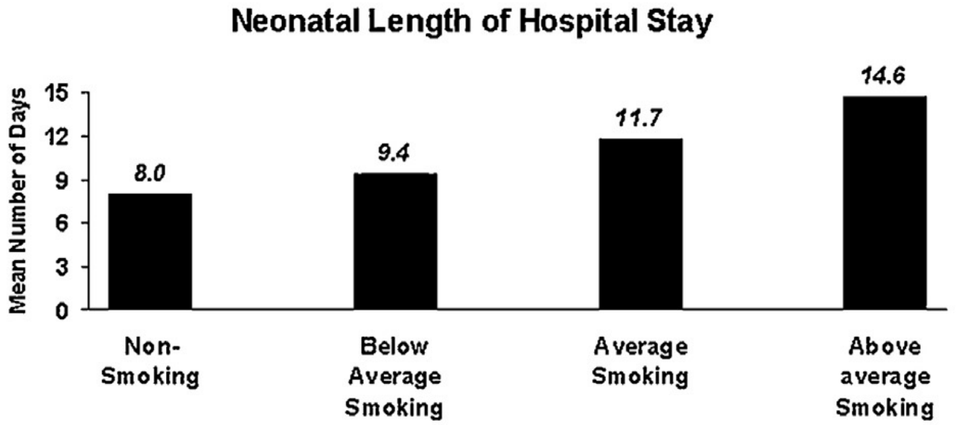
- **Benefits of breastfeeding for newborns with NAS**
  - 30% decrease in the development of NAS
  - 50% decrease in neonatal hospital stay
  - Improved mother-infant bonding
  - Positive reinforcement for maternal recovery

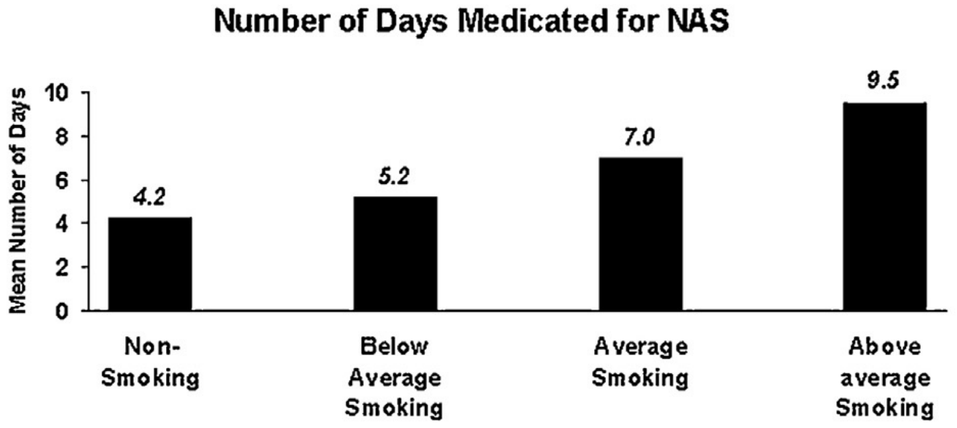
Pritham UA et al. *J Obstet Gynecol Neonatal Nurs.* 2012.
Welle-Strand GK et al. *Acta Paediatr*. 2013.
Wachman EM et al. *JAMA.* 2013.
Abdel-Latif ME et al.

“Doctor, is there ANY way to reduce the chance my baby will have withdrawal?”

Jones HE, Drug and Alcohol Dependence, 2013







Smoking Cessation

- 51% of people with a history of addiction treatment die of smoking-related causes
- 1.5 X the rate of addiction-related causes
- 63% of all women in addiction treatment smoke cigarettes
- Traditionally not addressed in SA treatment “we’ll work on one thing at a time.”
- Smoking cessation increases abstinence from drug use

SAMHSA 2011, Lemon 2003

Pregnant Women

- **Co-managed w/ OB/GYN & addiction specialist**
- **Pregnancy affects pharmacokinetics** of both methadone and buprenorphine
- **Methadone or buprenorphine** treatment initiated as soon as possible
- **Buprenorphine/NTX combo** therapy is considered safe
- **Discontinue naltrexone** if relapse risk low
- **Breastfeeding encouraged** with methadone and buprenorphine

KEY RECOMMENDATION CHANGES

Discontinuation of methadone or buprenorphine before surgery **is not required**. Higher-potency intravenous full agonist opioids may be used perioperatively for analgesia in addition to the patient's regular (pre-surgery) dose of methadone or buprenorphine

Rationale:
Research has demonstrated that the addition of full-opioid agonists can be effective for the treatment of pain in these patients. Pain treatment should be coordinated with the opioid use disorder treating clinician to help optimize pain care and reduce the potential for relapse.

Managing Pain in Opioid Dependent Pregnant Women

- Women on opioids for chronic pain
- Women on pharmacotherapy (MAT) for opioid-use disorders (e.g. methadone or buprenorphine)
- Women with untreated opioid-use disorders

Risks of Treating Pain

- Undertreatment of pain
- Triggering a relapse in women with Opioid Use Disorder (OUD)

Why is Pain so Hard to Treat?

- **High tolerance to opioid medications**
  - Increased density of mu receptors
- **Opioid-Induced Hyperalgesia (OIH)**
- **History of Trauma/Interpersonal Violence**
- **Emotional Component**
  - Worry about CPS involvement
  - Guilt about baby with neonatal withdrawal
  - Fear of relapse

Prenatal Care Management

- **Women should be encouraged to stay on pharmacotherapy for opioid use disorder.**
  - Obtain CFR (42) compliant consent to coordinate care
- Weaning/detox increases risk of relapse/adverse outcomes without significantly decreasing rates of NAS
- Women on opioids for chronic pain (who do not have an opioid use disorder) can consider weaning down during pregnancy, **but few other options for pain**
- Methadone or buprenorphine can be used to treat both pain and opioid use disorder in women with these comorbidities
- Can benefit from anesthesia consult and CBT to balance expectations/aid with pain control

Labor Management (Women on MAT or Opioids for Pain)

- **Maintain on daily dose medication (buprenorphine, methadone, opioid)**
  - Prevent withdrawal/treat underlying pain condition
- **Neuraxial anesthesia (epidural or CSE) as soon as desired**
- **No evidence women maintained on MAT tolerate labor poorly if MAT maintained**
- **Possibly avoid nitrous oxide**
  - Variable absorption
  - Dissociative
  - Increased sedation when combined with opioids
- **Avoid partial agonists (nalbuphine or butorphanol)**
  - Precipitate withdrawal

Post-partum Pain Management

- **Multi-modal**
- **Consider epidural morphine or hydromorphone prior to catheter removal**
  - Significant laceration repair or complicated delivery
  - Respiratory monitoring 24h post-procedure
- **Additional opioids prn, not ordered routinely**
  - Buprenorphine partial agonist activity can be overcome with high affinity full agonists
    - fentanyl, hydromorphone
  - Split daily buprenorphine or methadone dose qid
    - half-life for pain much shorter than for withdrawal

Post-partum Pain Management:
Vaginal Delivery

- Multi-modal
- Acetaminophen 975mg q8h PO or 650mg q6h PO
- Ibuprofen 600mg q6h PO
- If stronger NSAID needed or oral NSAID not tolerated, then ketorolac 15mg/30mg IV/IM q6h x 48h
- Non-analgesic adjunctive approaches: ice pack, heating pad, hydrocortisone, local anesthetic application to the perineum

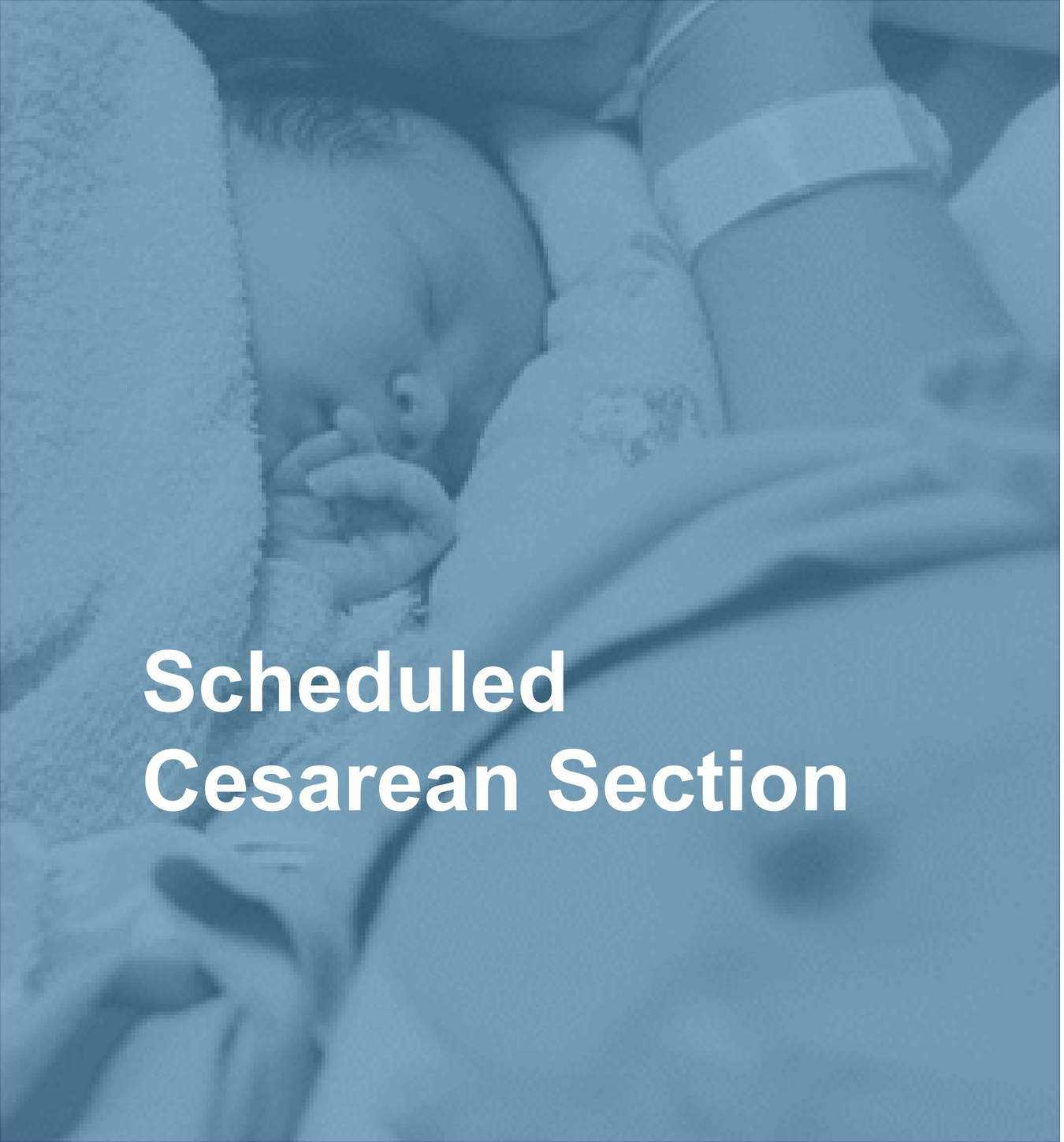
Anesthesia:
Unscheduled/Emergent Cesarean Delivery

- **Labor epidural if present**
- **Spinal**
- **General-depending on urgency/clinical situation**
- **Neuraxial morphine controversial given pruritis**
  - Fentanyl
  - Clonidine
- **TAP Blocks**
- **Low-dose (10 mg) ketamine (OIH is due to phosphorylation of NMDA receptors)**
  - One study showed less pain at 2 weeks postpartum
- **Gabapentin (600 mg) single dose**

Post-Op Pain Management

Multimodal as with vaginal delivery

- Acetaminophen 975mg q8h PO or 650mg q6h PO or 1 g q6hr IV (if not tolerating po)
- Ibuprofen 600mg q6h PO
- If stronger NSAID needed or oral NSAID not tolerated, then ketorolac 15mg/30mg IV/IM q6h x 48h
- Continue methadone and buprenorphine
    - Won’t provide adequate pain control, but is necessary to maintain baseline
- PCEA if available
- Patient-controlled analgesia (fentanyl or hydromorphone) for 24 hours



Scheduled Cesarean Section

- Pre-op consultation with anesthesia
- Counseling about expectations/coping strategies
- Continue pharmacotherapy including morning of surgery

Acute Pain
Overcoming Naltrexone Blockade

Hot plate test after XR-NXT or placebo, rats treated with opioid agonist (morphine, fentanyl, hydrocodone)

Naltrexone blocks analgesic effects of opioids at conventional doses

Naltrexone blockade can be overcome at 6-20x usual dose resulting in analgesia without significant respiratory depression or sedation

Dean RL et al. Pharmacol Biochem Behav 2008

NMT and
Emergent Acute Pain

Discontinue naltrexone (no need for taper)

Consult Anesthesia

Need to have healthcare providers specifically trained in the use of anesthetic drugs and management of respiratory effects of potent opioids

Opioid analgesics (high dose) administered under close observation

Need setting that is equipped and staffed for cardiopulmonary resuscitation.

Need to be prepared to establish and maintain a patient airway with assisted ventilation if needed

Consider nonopioids and regional anesthesia

For more info on naltrexone and pain management, can call pharmaceutical company at 1-888-235-8008

Postpartum

- **Watch for postpartum relapse triggers**
  - Postpartum depression
  - Fatigue
  - Weight gain
  - Child welfare issues
- **Encourage breastfeeding**
  - Relapse prevention
  - Bonding
  - Weight Loss
  - Infection control

Case: Susan

- 25 y/o G2P1 female referred to me at 28 weeks
- 2 years s/p residential treatment for AUD, OUD and BUD while pregnant with son
- Co-occurring bipolar I
- Relapse to alcohol, benzos and opioids-in hospital for withdrawal

Questions:

- **How should Susan be treated while in the hospital?**
- **Is her benzo use a contraindication to buprenorphine?**
- **What should her follow up be?**

Case: Susan

- Underwent 3-day MAW for benzos
- Started on buprenorphine
- Released to jail then residential treatment (was on Hope probation from earlier)
- Uneventful pregnancy
- Delivered 39 weeks
- Baby with mild NAS. Treated for 7 days

Questions:

- **How should Susan’s labor pain be managed?**
- **How should Susan be treated postpartum?**

Case: Susan

- While in IOP postpartum, relapsed to alcohol for one day
- Turned herself into PO
- Incarcerated for 2 weeks-no MAT, completely withdrew
- Came to see me. Got XR naltrexone injection x 1 dose.
- Didn’t like side effects, so didn’t continue past one month, but in continued abstinence.
- Graduated IOP and back to work until she relapsed.
- Has LN-IUS for contraception until another provider pulled it.

Question:

- **How could we help prevent her relapse?**

Minimizing Stigma

- **Substance use disorders are the most stigmatized medical condition**
- **Pregnant women with SUD are even more stigmatized**
  - Terms such as “crack baby” and “opioids tiniest victims” serve to promote this stigma
  - Babies aren’t “born addicted” they are physically dependent
- **Towards an “addictionary”**
- **Focus on person-first language**
- **Use DSM5 terminology**

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AUDIENCE Q & A

UPCOMING EVENTS

THE ASAM NATIONAL PRACTICE GUIDELINE SERIES

❑ The ASAM National Practice Guideline 2020 Focused Update Webinar: OUD and Pain	Timothy Wiegand, MD, FACMT	Tuesday, July 21 @ 1:00pm EST
❑ The ASAM National Practice Guideline 2020 Focused Update Webinar: Individuals in the Criminal Justice System	Sandra Springer, MD, FASAM	Thursday, Sept. 3 @ 12:00 p.m. EST
❑ The ASAM National Practice Guideline 2020 Focused Update Webinar: Adolescents and Young Adults	Marc Fishman, MD, DFASAM	Tuesday, Sept. 24 @ 1:00 p.n. EST

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THANK YOU.