Session 18

Olu Sangodeyi: Which SUD population is best suited for Methadone and not Suboxone

- Dr. Hayes: For pregnant patients, if someone is currently on methadone or has done well in the past, I will start methadone. Otherwise, I think all patients should be started on buprenorphine first. Two reasons: 1) There is a lot less neonatal opioid withdrawal with buprenorphine. 2) It is fairly easy to transition a pregnant patient from buprenorphine to methadone if the buprenorphine does not work for them. It is pretty much not recommended to transition them to buprenorphine if methadone does not work for them.

Dr. Hayes: After finishing my slides, I found several other interesting studies. I will put these in the chat at the appropriate times.

Teresa Ainsworth: Hi Leslie! Shout out from Rochester NY

- Dr. Hayes: Hi Teresa! Nice to see you!

Adam Lake: I feel like I'm getting mixed messages from different speakers about the A118G OMPR1 genotype - I'm unsure what I'd put on an exam question

Teresa Ainsworth: what outliers/trends do you find in your ethnic groups?

- Dr. Hayes: I mention later in the talk that Black and Hispanic people are more likely to be incarcerated for drug crimes.
- Dr. Hayes: My Hispanic population tends to use much more in families.

Sunil Khushalani: Are there are any good basic reviews that explain the genetics of addiction in an easy to understand way?

- Dr. Hayes: I actually found the ASAM Essentials chapter on this topic to be useful. There was a really good article from Time magazine on epigenetics a few years back. I will see if I can find it.
- Dr. Hayes: https://time.com/3911161/explaining-epigenetics-the-health-buzzword-you-need-to-know/
- Dr. Hayes: Explaining 'Epigenetics': The Health Buzzword You Need to Know. Time Magazine. June 2015

Andrea Leigh Lubeck: ARE you using Subutex for pregnant women?

- Dr. Hayes: I am. I am waiting for someone to come out with a national guideline that states we can use the combination product. I don't ever want to have a patient think that their miscarriage or stillbirth was a result of the combo product, and as long as the TIPS and other guidelines state that, I am worried they might think that.
- Sean Leonard: Agree.

Doug Coslett: If a pregnant pt (second trimester) wants to wean off buprenorphine, is there a greater risk of fetal demise?

- Dr. Hayes: If done slowly and carefully, probably not, but there is a huge risk of maternal relapse, especially post partum.

Jodi Carbone: what is the current recommendation for tx during preganacy... bupe or bupe/nal ?

- Dr. Hayes: See my answer below. It is definitely shifting towards the combination product. However, most of the guidelines still recommend the mono product.
- Jodi Carbone: so for board purposes bupe, for clinical practice combined?

Mileidys Gomez Gonzalez: Pt on Suboxone maintenance who gets pregnant, should I continue her o Suboxone or switch to buprenorphine?

- Dr. Hayes: I generally discuss the reasons that we might consider switching (mostly just not as much study), but I think if they want to continue the combination product, it should be fine.

Adam Lake: are there risks of rx stimulants in pregnancy at therapeutic doses?

- Dr. Hayes: The main risks of cocaine and methamphetamine during pregnancy are due to the constriction of the blood vessels. This is much less likely with therapeutic use. They don't really have a risk for birth defects.

Russel Coutinho: what drug for pregnant depression ?

- Dr. Hayes: Sertraline has the most study. They are generally all fairly safe. However, they all do have a risk for neonatal withdrawal.

Dr. Hayes: Obtaining care for either pregnancy or for OUD is much more difficult in rural areas, with obtaining care for both being especially difficult. NAS RCORP Conference July 21. Maternal Treatment Approaches to Reduce NAS

Denise Szczucki: is there a preferred benzodiazepine in pregnancy? say for alcohol detox or severe acute panic?

- Dr. Hayes: Not alprazolam, which is the most risky. I generally use clonazepam.
- Denise Szczucki: thank you

Juliette: Due to the affect on the hypothalamic pituitary axis, women with OUD may not even know they are pregnant, so urine hcg testing is important.

- Dr. Hayes: Absolutely

Dr. Hayes: "Only 33% of obstetricians usually or always advised MAT to pregnant women with OUD. Confidence in treating pregnant women who use opioids (aPR: 1.3, 95% CI: 1.0-1.8) and knowledge that substance use services were covered under the Affordable Care Act (aPR: 1.4, 95% CI: 1.1-1.8) were associated with advising MAT.

Ko JY, Tong VT, Haight SC, Terplan M, Snead C, Schulkin J. Obstetrician-gynecologists' practice patterns related to opioid use during pregnancy and postpartum-United States, 2017. J Perinatol. 2020;40(3):412-421. doi:10.1038/s41372-019-0535-2"

Dr. Hayes: "Pregnant patients are significantly less likely to be given an appointment by a buprenorphine prescriber than non-pregnant patients.

61% vs 74% Patrick SW, Richards MR, Dupont WD, et al. Association of Pregnancy and Insurance Status With Treatment Access for Opioid Use Disorder. JAMA Netw Open. 2020;3(8):e2013456. doi:10.1001/jamanetworkopen.2020.13456

53% vs 83% Stephen W. Patrick MD, MPH, MS, Melinda B. Buntin PhD, Peter R. Martin MD, MSc, Theresa A. Scott MS, William Dupont PhD, Michael Richards MD, PhD & William O. Cooper MD, MPH (2019) Barriers to accessing treatment for pregnant women with opioid use disorder in Appalachian states, Substance Abuse, 40:3, 356-362, DOI: 10.1080/08897077.2018.1488336"

Dr Luther: For family medicine doctors who do OB and are well versed in AM for pregnant women (follow standards of care) do you still recommend getting an AM specialist and/or a perinatologist involved?

- Dr. Hayes: I do, mostly because many I tend to be super cautious, and it is also the only place I can get a really good ultrasound. I think it is reasonable to not to do so if you are following guidelines.
- Dr Luther: i used to do OB in a rural setting and now have a former partner who is interested in this very thing. Patients unwilling to "go to the big city" to see AM or perinatology.

Juliette: For board purposes, are we to follow ACOG guidelines on changing bup/nx treatment to mono-bupe?

Sean Leonard: I had a patient with hepatitis C who became pregnant. I did a literature search and reached out to specialists, and was told to wait until after delivery to treat her Hepatitis C. However the risk of vertical transmission is not 0, but no information regarding pregnancy implications of Mavyret and other hep c meds is not available. Animal studies show no fetal implications unless 1.5x to 51x dosing. Thoughts?

- Dr. Hayes: I have not currently seen anyone treating pregnant patients, although they are now treating lactating patients.

Megan Miller, MD: OB/GYN - there is more than one study showing the combination buprenorphine product is safe in pregnancy, and the most recent ASAM guidelines state that it can be used as a first-line agent in pregnancy. We use the combination product routinely, and do not automatically switch women to the mono product in pregnancy if they were stable on the combination. I also find that pregnant women do best on the medication they think will work for them.

- Dr. Hayes: I agree. I am hoping that in the next year or two, all the guidelines will be in alignment, and I can just recommend the combination product without any worries.

Saad: Any data on IM Naltrexone safety during pregnancy?

- Sree Atluru: I'm writing a systematic review on this with Chuck Schauberger and Marcela smid: essentially it is anesthesiology limiting; data in animal studies doesn't show harm. More coming soon!
- Dr. Hayes: I look forward to seeing the review. As I stated above, the biggest problem is starting it.

Erin Barnes: SO hard to ever get anyone who has had regular bup to then tolerate the suboxone. So many don't do as well on the suboxone as the regular subutex due to that low level headache, nausea, etc.

- Dr. Hayes: I agree. It is my biggest frustration with the monoproduct use during pregnancy.
- Adam Lake: I've had some success changing to the zubsolv product, has a different flavor too, just like the mono product is a different flavor than the suboxone product
- Sean Leonard: Are we talking generic or brand name Suboxone? I find that the name brand has less nausea and headaches associated. The generic formulations, especially the ones in the yellow packaging is terrible, and has more side effects and lower potency.

Terry Horbal: Would you start bup during regnancy with microdosing?

- Dr. Hayes: I would love to do this. Last time I looked, which was a couple months ago, there is absolutely no data. However, I think this is where we will be going.

Sarah Kattakuzhy: Is there any evidence that a lower dose of buprenorphine during pregnancy will result in a lower likelihood of NOWS?

- Dr. Hayes: There is no correlation between dosage and neonatal opioid withdrawal syndrome.

Sean Leonard: I will typically increase patient's subutex dose in the 3rd trimester (usually from 8mg BID to TID) to accommodate the 3rd trimester fluid volume increase, to prevent drug dilution (volume of distribution). Do you do this?

- Dr. Hayes: Yes. There is also increased metabolism.

Sree Atluru: For the board exam: with a NOWS question should we answer follow Finnegan scale over eat-sleep-console(ESC)?

- Dr. Hayes: They will probably not make you choose between them. I would probably know the criteria for Finnegan, as that might come up.

Doug Coslett: What is the Finnegan scale ?

- Dr. Hayes: Finnegan scale looks at about fifteen different criteria, including eating, sleeping, and crying, but also tremors, skin rash, muscle tone, and yawn. Truthfully, we don't care if the baby is tremulous or yawning as long as they are eating, sleeping, and able to be consoled.

Cameron Duffy: What are current studies showing with reduced risk of NOWS with breast-fed neonates?

- Dr. Hayes: NOWS is definitely decreased with breastfeeding.

Robyn Chatman MD MPH FAAFP: Please talk about how to handle the conversation to report the patient who continues to use cocaine during pregnancy.

- Dr. Hayes: I would explain that I have to make the report. Talk about what is likely to happen. Talk to them about the importance of a plan. Talk to them about being honest. Have them get a safety monitor if needed. Have the conversation in an informative manner, rather than a punitive or threatening manner.

Brian Pratt: Is there good data on tapering off buprenorphine during pregnancy

J Chen: Why Naloxone/Bupre not advisable for pregnant women? Naloxone is a proven teratogen or harmful to fetus?

- Megan Miller, MD: There is more than one study showing bup/nal is safe in pregnancy. Not only is naloxone not a teratogen, but if taken correctly, it is minimally absorbed. ASAM guidelines state it can be used as a first-line agent.

Pninit: What about the outcomes in children when they are removed from their mothers care vs. staying with a parent who is using?

Norma Naghaviani: Do you automatically decrease dose of MTD post partum?