Drug Addiction in Pregnancy

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ACOG SOUTH DAKOTA SECTION LEGISLATIVE CHAIR
- I have no financial or conflict-of-interest disclosures
Objectives

- Discuss the signs and symptoms of opioid use in pregnancy
- Discuss the effects of opioid use on pregnancy, as well as the effects of pregnancy on opioid addiction
- Discuss management of opioid dependence in pregnancy
- Discuss chronic pain management in pregnancy
- Review available resources for maternal and neonatal support during and after pregnancy
- Discuss relevant social and legal issues
- Discuss use of other substances in pregnancy
The Scope of the problem

- Opioid use and opioid use disorder in pregnancy have increased along with the national epidemic.
- In 2007, 23% of Medicaid patients filled an opioid prescription in pregnancy.
- Five-fold increase in antepartum opioid use from 2000-2009.
- Neonatal abstinence syndrome (NAS) increased from 1.5/1000 to 6/1000 births between 1999 & 2013, costing $1.5 billion in related annual hospital charges.
- Maternal mortality review committees have identified substance use as a major risk factor for maternal deaths.
Opioid use disorder

- DSM V replaced “opioid abuse” and “opioid dependence” with “opioid use disorder”
- Criteria includes 11 symptoms, with severity defined by the number of symptoms present
- Important to differentiate between medically-indicated opioid use, opioid misuse, and untreated opioid use disorder
- Occurs across all races and socioeconomic strata
<table>
<thead>
<tr>
<th></th>
<th>DSM-5 Diagnostic Criteria for Opioid Use Disorder*</th>
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<tbody>
<tr>
<td>1</td>
<td>Opioids are taken in larger amounts or duration than intended</td>
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<td>2</td>
<td>Persistent desire/unsuccesful efforts to cut down or control opioid use</td>
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<td>3</td>
<td>A great deal of time is spent obtaining, using, or recovering from the effects of opioids</td>
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<td>4</td>
<td>Craving</td>
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<td>5</td>
<td>Recurrent use of opioid results in failure to fulfill major role obligations at work, school, or home</td>
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<td>6</td>
<td>Continued use despite social/interpersonal substance-related problems</td>
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<td>7</td>
<td>Important social, occupational, or recreational activities are given up or reduced because of substance use</td>
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<td>8</td>
<td>Recurrent use in hazardous situations</td>
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<td>9</td>
<td>Continued use despite knowledge of having a persistent or recurrent opioid-related physical or psychological problem that is likely caused or exacerbated by opioid use</td>
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<tr>
<td>10</td>
<td>Tolerance^</td>
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<tr>
<td>11</td>
<td>Withdrawal^</td>
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**Severity:** Mild: 2-3 symptoms, Moderate: 4-5 symptoms, Severe: \(\geq\) 6 symptoms

\* The information above is only an overview of the criteria used. Consult the DSM-5 before making a diagnosis.

\^ Note: This criterion is not considered to be met for patients taking opioids solely under appropriate medical supervision.

Screening for Drug and Opioid use disorders

- Screening should be done at the first prenatal visit
- Screening should be universal
- Patient is ideally alone
- Providers should protect patient autonomy, confidentiality, and the integrity of the patient-physician relationship
- Know your state’s laws regarding disclosure of substance use disorder
- SBIRT = Screening, brief intervention, referral to treatment
- 4P’s, NIDA Quick Screen, CRAFFT Substance Abuse screen for adolescents and young Adults
Screening Tools: 4P’s

- Parents: Did any of your parents have a problem with alcohol or drug use?
- Partner: Does your partner have a problem with alcohol or drug use?
- Past: In the past, have you had difficulties in your life because of alcohol or other drugs, including prescription medications?
- Present: In the past month, have you drunk any alcohol or used other drugs?
<table>
<thead>
<tr>
<th>Quick Screen Question:</th>
<th>Never</th>
<th>Once or Twice</th>
<th>Monthly</th>
<th>Weekly</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In the past year, how often have you used the following?</strong></td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>• For men, 5 or more drinks a day</td>
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<tr>
<td>• For women, 4 or more drinks a day</td>
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<td>Tobacco Products</td>
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<td>Prescription Drugs for Non-Medical Reasons</td>
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<tr>
<td>Illegal Drugs</td>
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</table>
Urine Drug Screening

- Perform only with the patient’s consent and in compliance with state laws
- Inform the patient of the potential ramifications of a positive test result, including any mandatory reporting requirements.
- Know limitations of UDS:
  - Positive result is not diagnostic of opioid use disorder
  - Negative test does not exclude sporadic use
  - May not detect synthetic opioids, benzos, and "designer drugs"
  - False positive tests can occur with immune-assay testing and legal consequences can be devastating for the patient. Know your lab’s test and request confirmatory testing with mass spectrometry and liquid or gas chromatography be performed as appropriate.
Urine Drug Screen – South Dakota

- Consent is required for maternal urine drug screen
- If patient is unable to consent, others may consent for her, in the following order:
  - Appointed Legal Guardian of the Person
  - Attorney in Fact under a Durable Power of Attorney for Health Care
  - Spouse, if not legally separated
  - Adult child
  - Parent
  - Adult Sibling
  - Grandparent or Adult Grandchild
  - Adult Aunt or Uncle, Adult Cousin or an Adult Niece or Nephew
  - Close Friend
Managing pain in pregnancy

Before prescribing opioids in pregnancy:
- Ensure opioids are indicated
- Maximize non-opioid therapy, including exercise, physical therapy, behavioral approaches, and non-opioid medications
- Discuss the risks and benefits of opioids, including the risk of physiologic dependence and the risk of neonatal abstinence syndrome (NAS)
- Take a thorough history of substance use and review the PDMP.

For reproductive age women who are not pregnant, discuss family planning and effects on pregnancy.

If opioid therapy is indicated, do not hesitate to prescribe based on a concern for NAS alone.
Untreated Heroin Addiction

- Associated with lack of prenatal care
- Increased risk of fetal growth restriction, abruptio placentae, fetal death, premature labor, and meconium
- Associated with engagement in high-risk activities, such as prostitution, trading sex for drugs, and criminal activities
  - Higher exposure to STI’s, violence, and legal consequences such as loss of child custody, criminal proceedings, or incarceration.
Management of Opioid Use Disorder in Pregnancy

- Pregnancy offers an opportunity with increased motivation for treatment
- Agonist therapy is recommended (methadone, buprenorphine)
- Medically-supervised withdrawal is associated with high rates of relapse and poor outcomes
Opioid agonist therapy with methadone along with counseling and behavioral therapy has been the mainstay of heroin addiction treatment in pregnancy since the 1970s.

Multifold rationale:
- Improves adherence to prenatal care and addiction treatment programs
- Prevents opioid withdrawal symptoms
- Reduces risk of obstetric complications

A list of local treatment programs can be found at the Substance Abuse and Mental Health Services Administration’s website: http://dpt2.samhsa.gov/treatment/directory.aspx

In SD, Sioux Falls Treatment Center, LLC is the only one listed
Methadone

- Dispensed on a daily basis by a registered opioid treatment program
- Significant pharmacokinetic interactions with other medications, such as anti-retrovirals, and can prolong QTc interval in a dose-related fashion
- May require dose adjustments, particularly in the third trimester
- Split dosing may be necessary due to rapid metabolism
- If started in pregnancy, titrate until asymptomatic
- Inadequate dosing can result in withdrawal signs and symptoms, cause fetal stress, and increase likelihood of relapse and treatment discontinuation.
Methadone and NAS

- Incidence and duration of NAS does not differ based on maternal dosage of methadone treatment.
- No benefit to attempting to decrease methadone dose.
- Some studies find lower rates of NAS when split dosing regimens are used.
Buprenorphine

- Partial agonist
- Patients need to be able to reliably self-administer medication and maintain adherence to treatment program
- To find a registered prescriber, go to www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator
- FDA recently approved a long-acting implant – no safety data in pregnancy at this time
Buprenorphine and naloxone combined formulation

- Available with naloxone, an opioid antagonist
- Naloxone is not orally active but will cause severe withdrawal if injected
- Used to reduce diversion
- Has not been recommended in pregnancy to avoid potential prenatal exposure to naloxone, especially if injected
- Recent studies have found no adverse effects, so may start to be used in pregnancy in the future
# Methadone vs Buprenorphine

## Methadone
- Less risk of diversion given close supervision
- Better choice for less reliable patients
- Significant drug interactions
- Often requires dose adjustments
- Requires daily visits

## Buprenorphine
- Overdose less likely (partial agonist)
- Fewer drug interactions
- Does not require daily visits
- Less need for dosage adjustments
- Less severe NAS
- Rare reports of hepatic dysfunction
- Lack of long-term data on infant and child effects
- Increased risk of diversion
Switching between methadone and buprenorphine

- If a pregnant woman is receiving methadone, she should NOT transition to buprenorphine due to risk of precipitated withdrawal.
- OK to transition from buprenorphine to methadone.
- Consider and counsel on lack of long-term data on buprenorphine in pregnancy. If patient is unwilling to accept that risk, she should transition to methadone.
Medically Supervised Withdrawal

- Associated with high relapse rates, 59-90%
- Risks of relapse include:
  - Increased transmission of communicable disease
  - Accidental overdose due to loss of tolerance
  - Obstetric complications
  - Lack of prenatal care
- Often requires prolonged inpatient care and intensive outpatient behavioral health follow-up
- Early reports raised concern of increased risk of fetal stress and fetal death. More recent studies find no clear evidence of risk, but long-term follow-up is lacking, particularly with regard to relapse rates.
Naltrexone and Naloxone

Naltrexone

- Nonselective opioid receptor antagonist
- Blocks euphoric effects of opioids
- Long-acting injectable more effective than oral form
- Research is pregnancy is lacking
- Decision to continue in pregnancy for a woman already taking naltrexone should involve careful discussion of lack of safety data vs risk of relapse with discontinuation

Naloxone

- Short-acting opioid antagonist
- Can be life-saving in the event of opioid overdose
- Although induced withdrawal may contribute to fetal distress, naloxone SHOULD be used in pregnant women in the case of maternal overdose to save the woman’s life
- Many states (including SD) authorize prescribing naloxone to a third party, such as a family member or caregiver, who may be able to assist in an overdose
Comorbidities of opioid use disorder

- **Mental health conditions**
  - Depression, anxiety, trauma, PTSD

- **Use of other substances**
  - Alcohol, tobacco, marijuana, cocaine, methamphetamine

- **Poor nutrition**

- **Increased risk of communicable disease**

- **Disrupted or absent support systems**
  - Referral for specialized multidisciplinary care
Antepartum Care

- Testing for STI’s and other infectious agents: HIV, Hep B/C, chlamydia, gonorrhea, syphilis, and tuberculosis. Consider repeat testing in third trimester.
- Hepatitis B vaccination is recommended for all pregnant patients who are Hep B sAg negative but at risk of infection.
- Screening for depression and other mental health conditions.
- Consultations as indicated:
  - Anesthesia
  - Pain management
  - Pediatrics
  - Maternal-fetal medicine
  - Behavioral health
  - Nutrition
  - Social services
Antepartum Care (cont)

- Anticipatory breastfeeding guidance – should encouraged in women who are stable on opioid agonists, are not using illicit drugs, and have no other contraindications (such as HIV)
- Close communication between OB provider and pediatric team prior to delivery. Consider neonatal consultation if indicated.
- Screen for other substance use, particularly tobacco and alcohol, and offer cessation services
- Care should be coordinated between obstetrical provider and addiction medicine provider
  - Obtain 42 CFR Part 2-compliant consent for release of information to allow communication between providers
  - https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines
Intrapartum Care

- Continue maintenance dose of methadone or buprenorphine in labor and postpartum, and inform patients of this plan to reduce anxiety.

- Provide additional pain relief as needed. In general, higher doses will be needed due to tolerance.

- Epidural or spinal anesthesia should be offered.

- Avoid opioid agonist-antagonist drugs (e.g., butorphanol, nalbuphine, and pentazocine) – can precipitate acute withdrawal. Keep in mind that not all patients disclose their opioid use. Best to avoid these medications all together if possible.

- Buprenorphine should not be given to a patient on methadone.
Intrapartum Care (cont)

- Notify pediatric staff of all infants exposed to opioids to ensure appropriate screening for NAS
- Consider anesthesia consult for pain management
- Multimodal pain approach: neuraxial analgesia, NSAIDs, tylenol
Postpartum Care

- Continue opioid agonist therapy postpartum
- If methadone dose was increased during pregnancy, there is no need for immediate dosage reduction.
  - Reduction should be titrated to signs and symptoms of sedation, particularly at peak of dosing (2-6 hours)
- Buprenorphine patients typically do not require dose adjustments in pregnancy and should not require adjustments postpartum
- Use other sedating medications with caution, such as benzos, Ambien, antihistamines
Postpartum care (cont)

- Postpartum period is a time of increased vulnerability
- Higher rates of relapse
- Potential relapse triggers include:
  - Loss of insurance and access to treatment
  - Demands of caring for new infant
  - Sleep deprivation
  - Threat of loss of child custody
Postpartum care (cont)

- Substance use and overdose are increasingly found to be a major contributing factor to pregnancy-associated deaths in the United States
- Screen for postpartum depression and offer treatment
- Provide access to adequate postpartum psychosocial support, including substance use disorder treatment and relapse prevention programs
- Provide patients with overdose training, preferably with co-prescription of naloxone
Postpartum care (cont)

- Unintended pregnancy rates among women with substance use disorders are approximately 80%
- Discussion of full range of contraceptive options should begin during prenatal care
- Consider immediate postpartum long-acting reversible contraception
  - Highly effective and convenient
  - IUD, Nexplanon
Breastfeeding

- Beneficial for both mothers and babies in women on methadone or buprenorphine therapy
- Decreased severity of neonatal abstinence
- Shorter hospital stay for infants
- Contributes to maternal-infant attachment
- Provides immunity to infant
- Should be encouraged in women who are not using illicit drugs and have no other contraindication (such as HIV infection)
- Women should be counseled about the need to suspend breastfeeding in the event of a relapse
Breastfeeding (cont)

The American Academy of Pediatrics recommends breastfeeding for women taking methadone or buprenorphine REGARDLESS of maternal dose

- Transfer to breastmilk is minimal.

Ultra-rapid conversion of codeine to morphine can result in high levels of morphine in blood and breast milk

FDA states that breastfeeding is not recommended while using medications containing codeine or tramadol

- If a codeine-containing medication is considered the preferred choice, the risks and benefits and reasoning behind the FDA warning should be discussed with each family

Neonatal Abstinence Syndrome

- Drug withdrawal syndrome that may result from chronic maternal opioid use during pregnancy
- Expected and treatable condition seen in 30-80% of women taking opioid agonist therapy
- Characterized by disturbances in GI, autonomic, and central nervous systems
- Symptoms: Irritability, high-pitched cry, poor sleep, uncoordinated sucking reflexes (poor feeding)
- Increased incidence and severity with additional exposures, including nicotine, SSRI, and benzodiazepines
NAS (cont)

- Methadone
  - May appear anytime within first 2 weeks of life, usually within 72 hours
  - Lasts several days to weeks
- Buprenorphine
  - Symptoms appear within 12-48 hours, peak at 72-96 hours
  - Resolves by 7 days
- Improved outcomes with validated screenings: e.g., Finnegan Scale
- Each nursery should develop an evidence-based, written policy to assess and treat an infant with NAS, and women should be informed of the key components of this policy
Breastfeeding decreases duration and severity of NAS and should be encouraged.

Families should be encouraged to visit and care for their infants.

Resources to optimize collaboration, diagnosis and treatment are available at:

- [www.opqc.net/patients-providers/%20NAS](http://www.opqc.net/patients-providers/%20NAS) (Includes Finnegan scale)
Evidence-based approach to NAS

- Guidelines issued in 2012 by the American Academy of Pediatrics based on decades of research indicate that treatment is not necessary for every infant exposed to opioids in utero.

- Neonates with known or expected exposure to maternal opioid use should be monitored in a low-stimulus environment for symptoms of NAS for up to 1 week, depending on the type of maternal opioid use and timing of last drug taken before birth.

- Infants with mild to moderate NAS symptoms should not be treated with opioid replacement drugs. The use of the Finnegan NAS scale will identify the appropriate treatment course for these infants.

- Nonpharmacologic therapy should be used as a first-line intervention for infants with neonatal withdrawal including:
  - rooming-in (caring for the mother and newborn together in the same room immediately from birth) rather than NICU placement
  - comfort care (swaddling and skin-to-skin contact between mother and baby)
  - minimizing environmental stimuli
  - promoting rest and sleep
  - providing sufficient caloric nourishment for weight gain (high caloric formula or breast milk with supplement)
  - encouraging most mothers to breastfeed, regardless of current opioid use

- Neonates requiring greater intervention as determined by the Finnegan scale can be treated with a methadone or morphine dose.
Long-Term Infant Outcome

- Evaluated via several observational studies
- Challenges include isolating effects of opioid agonists from other confounding factors:
  - Use of other substances (tobacco, alcohol, non-medical drugs)
  - Exposure to environmental and other medical risk factors (e.g., low socioeconomic status, poor prenatal care)
- No significant differences in cognitive development between children up to age 5 exposed to methadone in utero and control groups matched for age, race, and socioeconomic status
  - Groups were often lower in both groups compared with population data
- Preventive interventions that focus on supporting mothers and other caregivers, enriching the early experiences of children, and improving the quality of the home environment are likely to be beneficial
Legal and Social Issues

- Physicians must advocate for this often-marginalized group
  - Seek to improve availability of treatment and ensure patients are not criminalized for seeking care
  - Every leading medical and public health organization that has addressed this issue — the AMA, ACOG, ACNM, AAP, APHA, AAFP, ASAM and MoD — has concluded that the problem of drug and alcohol use during pregnancy is a health concern best addressed through education, prevention and community-based treatment, not through punitive drug laws or criminal prosecution.
  - Research shows that whether or not a pregnant woman can stop her drug use, obtaining prenatal care, staying connected to the health care system, and being able to speak openly with a physician about drug problems helps to improve birth outcomes.
Legal and Social Issues

- Substance abuse during pregnancy in South Dakota is considered child abuse and grounds for civil commitment.
  - The term “abused or neglected child means” a child "who was subject to prenatal exposure to abusive use of alcohol, marijuana, or any controlled drug or substance not lawfully prescribed by a practitioner as authorized by chapters 22-42 and 34-20B";

- Consent is required for UDS in South Dakota

- New law allows for newborn toxicology without parental consent if they have reason to believe based on medical evaluation of the mother or infant that the mother used a controlled substance for a nonmedical purpose during pregnancy
  - Must then report positive results
# Legal and Social Issues

<table>
<thead>
<tr>
<th>Does Not Support Healthy Outcomes for Mom &amp; Baby</th>
<th>Supports Healthy Outcomes for Mom &amp; Baby</th>
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<tbody>
<tr>
<td>Overtreatment of NAS in NICUs</td>
<td>Appropriate comfort care in low-stimuli environment and pharmacological therapy where indicated</td>
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<tr>
<td>Criminal penalties for women and doctors</td>
<td>Public health approaches focused on prevention and treatment</td>
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<tr>
<td>Mandatory urine testing</td>
<td>Screening dialogue/questionnaire with patient consent</td>
</tr>
<tr>
<td>Mandatory reporting to law enforcement or child protective services (CPS)</td>
<td>Statistical reporting to department of health or direct reporting to CPS only for actual indications of impaired parenting</td>
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<tr>
<td>Overreliance on fragmented PDMPs</td>
<td>Safe prescribing and initial check of PDMPs</td>
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<td>Punitive drug treatment courts</td>
<td>Family-centered drug treatment programs</td>
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<tr>
<td>Restrictions on medication access and forced withdrawal</td>
<td>OAT with methadone or buprenorphine for women and protections for treating physicians</td>
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<tr>
<td>Misleading drug prescribing warnings</td>
<td>Evidence-based labeling of opioid medications</td>
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<tr>
<td>Anti-family, one-size-fits-all drug treatment programs</td>
<td>Family-centered, community-based, outpatient treatment</td>
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<tr>
<td>Coercive referrals for fertility control</td>
<td>Counseling on pregnancy planning, prevention and contraception</td>
</tr>
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<td>Losing sight of the real harms of alcohol and cigarette use during pregnancy</td>
<td>Continued focus on the greatest preventable health threats—alcohol and tobacco use during pregnancy</td>
</tr>
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</table>

Source: ACOG Government Affairs
Problem: Access to treatment

- Most drug treatment programs are NOT tailored to pregnant or parenting women.

- The few drug treatment facilities in the US accepting pregnant women rarely provide child care, do not account for the woman’s family responsibilities, and do not provide treatment that is affordable.

- Very few treatment programs give priority access to pregnant women.

- A woman should not be separated from her family in order to receive appropriate treatment. Substance abuse treatment that supports the family as a unit has been proved to be effective for maintaining maternal sobriety and child well-being.

- Mothers receiving therapeutic opioid maintenance treatment prescribed by their physicians should not be pressured to detox by court-ordered drug treatment programs.
Other Substance Use in Pregnancy

- Alcohol and tobacco use remain the greatest preventable threats to a healthy pregnancy.
- Curbing the use of alcohol and tobacco before and during pregnancy will yield the greatest public health gains for maternal and child welfare and must remain our primary objective.
- Tobacco and alcohol dependence during pregnancy may independently cause NAS in infants; however, the symptoms may be more subtle than with opioids.
- Decades of evidence have shown that alcohol and cigarettes—unlike opioids—cause long-term serious health consequences for mothers and infants, including prematurity. Smoking is the number one risk factor for delivering a baby prematurely.
- Polysubstance use is common among women who use drugs. Those who misuse prescription medication or take illegal drugs also tend to smoke and use alcohol. Concurrent use of alcohol and cigarettes can explain many harmful pregnancy outcomes often attributed to other illicit substances.
Alcohol Use in Pregnancy

- A serious consequence of alcohol use during pregnancy, fetal alcohol syndrome (FAS) is the most common preventable cause of mental retardation.

- There is no safe level of alcohol consumption during pregnancy and no period during pregnancy is safe for alcohol consumption. Alcohol readily crosses the placenta and can cause life-long physical and neurobehavioral effects on the developing baby.

- About 10% of women use alcohol during pregnancy, and about 5% report binge drinking.

- Education and intervention counseling during pregnancy is effective for many pregnant women who drink.
Smoking in Pregnancy

- Despite the well-known health risks associated with smoking during pregnancy, about 11% of women smoke during pregnancy.

- Smoking during pregnancy is associated with risks to the fetus and infant including:
  - low birth weight
  - Prematurity
  - abruptio placentae
  - sudden infant death syndrome (SIDS)
  - increase in childhood respiratory illnesses as well as possible cognitive effects

- For the pregnant woman, smoking increases the risk of:
  - preterm delivery
  - preterm premature rupture of membranes (PPROM)
  - placental complications of pregnancy (Previa, accreta, etc)
  - ectopic pregnancy
  - spontaneous abortion

- Successful smoking cessation strategies supported by clinical evidence are available and should be integrated into routine prenatal care.

- 50-60% of those who quit in pregnancy will relapse postpartum – discuss/support in third trimester
Marijuana Use in Pregnancy

- Most commonly used illicit drug in pregnancy, prevalence 2-5%
- Growing number of states are legalizing marijuana
- Concerns regarding impaired fetal neurodevelopment
- Adverse effects of smoking to mother and fetus
- OB providers should NOT suggest or prescribe marijuana for medicinal purposes during preconception, pregnancy, & lactation
- Pregnant women or women contemplating pregnancy should be encouraged to discontinue use of marijuana (consider alternative therapies if used medicinally)
- Marijuana use should be discouraged during lactation due to insufficient data for evaluating effects on breastfeeding infants
Methamphetamine Use in Pregnancy

- Continues to increase in the US since the 1980s
- Endangers maternal health
- Increases risk of low birth weight and small for gestational age infants
- May increase risk of neurodevelopmental problems in children
- UDS may detect meth but should be done with consent after counseling regarding ramifications of a positive result
- Women reporting continued use of meth in pregnancy should be referred for treatment and followed up with serial ultrasounds to assess fetal growth
Conclusion

- Early universal screening, brief intervention, and referral improve maternal and infant outcomes
- Contraceptive counseling and access should be a routine part of substance use disorder treatment
- Pregnancy should be co-managed by obstetric provider and addiction specialist
- Consider modifying care as appropriate (expanded STI screening, additional ultrasounds for growth as appropriate, consultations with other healthcare providers as needed)
- Opioid agonist therapy is preferred to medically supervised withdrawal in pregnancy
Conclusion (cont)

- Infants should be monitored for signs/symptoms of NAS by pediatric provider.
- Multidisciplinary long-term follow-up should include medical, developmental, and social support.
- Criminal sanctions in pregnancy reduce access and compliance with care and are associated with poorer maternal and infant outcomes.
- Obstetric providers have an ethical responsibility to their pregnant and parenting patients with substance use disorder to discourage the separation of parents from their children solely based on substance use disorder, suspected or confirmed.
Resources

- EXCELLENT SITE WITH LINKS TO MULTIPLE ADDITIONAL RESOURCES
  - www.acog.org/More-Info/OpioidUseinPregnancy

- Screening Tools:
Resources


- Naloxone prescriptions and laws:
  - [www.drugabuse.gov/related-topics/naloxone](http://www.drugabuse.gov/related-topics/naloxone)
  - [www.prescribetoprevent.org](http://www.prescribetoprevent.org)
Resources

- Neonatal Abstinence Syndrome (NAS)
  - www.opqc.net/patients-providers/%20NAS


- Inpatient Recovery, family friendly:
  
  Jackson Recovery Women and Children’s Center
  3200 W 4th Street
  Sioux City, IA 51103
  Phone: (712) 258-4578 Fax: (712) 258-1061
The End – Whew!

Questions?

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