OPIOIDS DURING PREGNANCY & POSTPARTUM: What's a Family Doctor to Do?

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FMF
Family Medicine Forum
Forum en médecine familiale

Palais des congrès de Montréal

THE COLLEGE OF FAMILY PHYSICIANS OF CANADA
LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

Presenter Disclosure

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Relationships with financial sponsors:

- Any direct financial relationships, including receipt of honoraria: No
- Membership on advisory boards or speakers' bureaus: No.
- Patents for drugs or devices: No
- Other: N/A

Disclosure of Financial Support

No external support

OPIOIDS DURING PREGNANCY AND POSTPARTUM:

WHAT'S A FAMILY PHYSICIAN TO DO?

FMF 2023

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Date :

NOVEMBER 11, 2023

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LEARNING GOALS

1.Identify current recommendations for care related to opioid use during pregnancy

2. Describe options for management of opioid use disorder in pregnancy

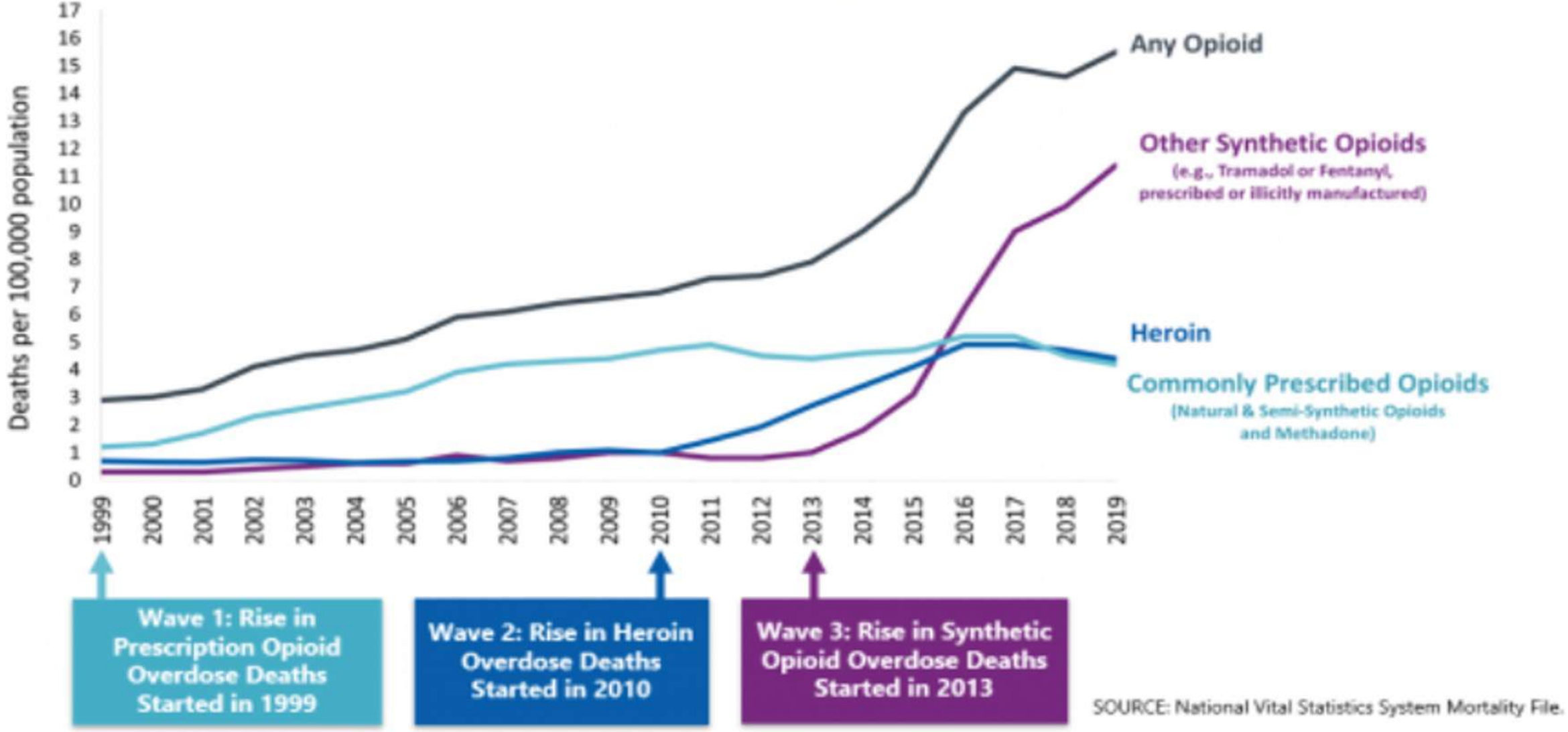
.

3. Manage opioid use during pregnancy and postpartum

Guideline No. 443a: Opioid Use Throughout Women's Lifespan: Fertility, Contraception, Chronic Pain, and Menopause

Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding

Three Waves of the Rise in Opioid Overdose Deaths

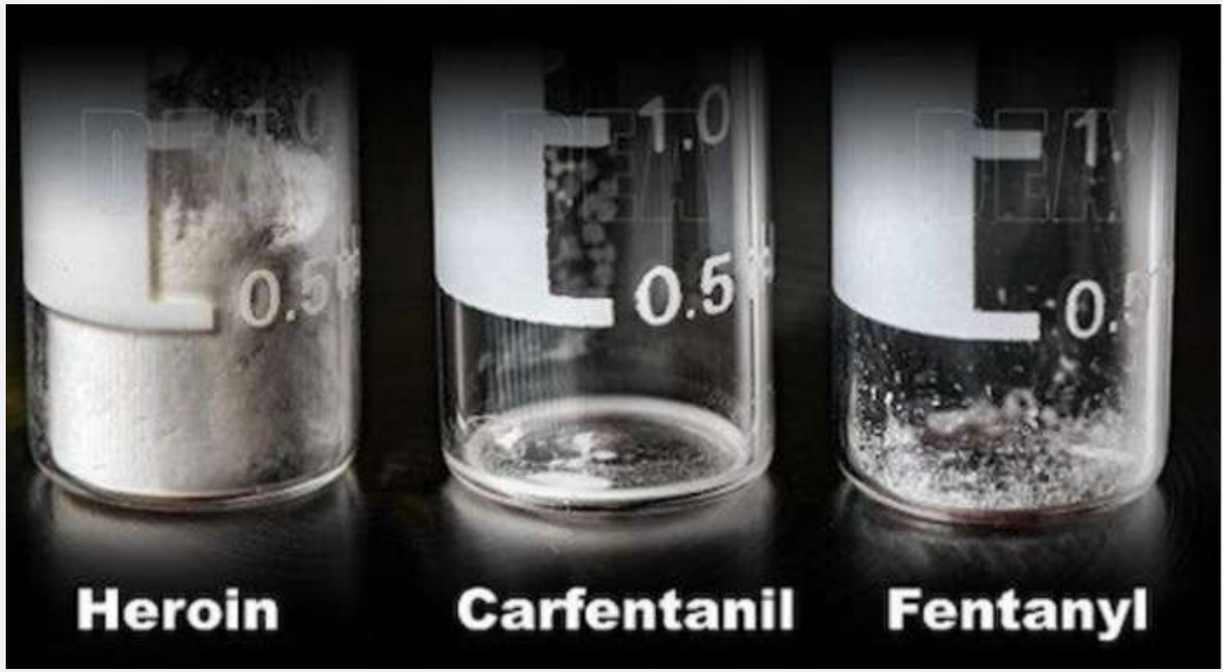


SOURCE: National Vital Statistics System Mortality File.

- Prior to 2011/2012, nonmedical ***prescription opioid*** use was the 4th most common substance used and led to climbing rates of opioid-related harms and opioid poisoning (oxycontin era)
- Over the past 10 years, ***fentanyl, carfentanil, and other synthetic analogues*** have entered and dominated the illicit drug market

WHAT IS FENTANYL?

- A synthetic (man-made) opioid 50x more potent than heroin and 100x more potent than morphine
- Can also be illegally made (illicitly manufactured fentanyl) and mixed into other drugs like methamphetamines or crack
- Fentanyl-analogues such as carfentanil, are sold because of their fentanyl-like effect and are often even more potent (and linked to overdose deaths)



How is Fentanyl used?

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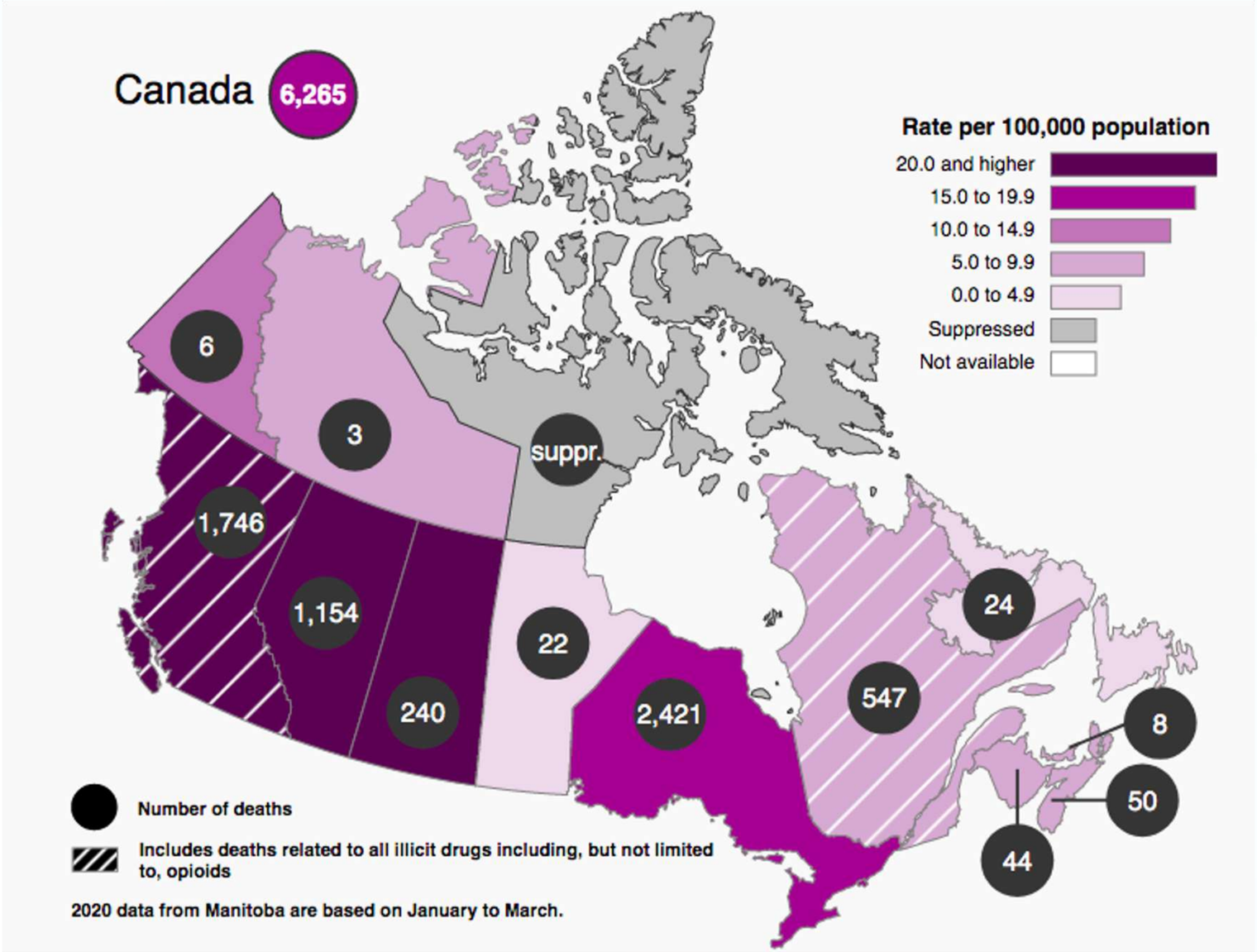
Snorted

Injected

Smoked

Chewed

Opioid Overdose Crisis:
22,828 opioid-toxicity deaths from 2016-Mar 2021



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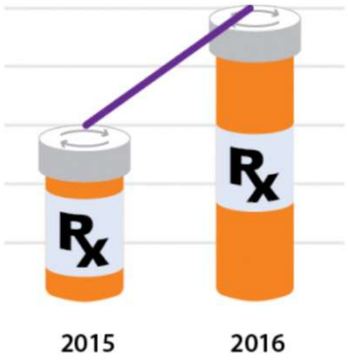
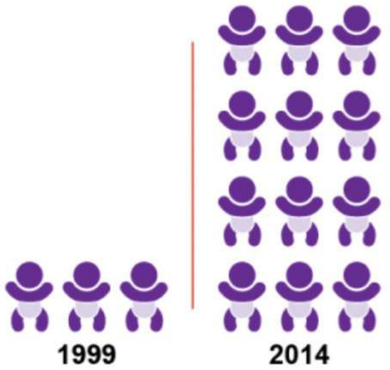
OPIOIDS IN PREGNANCY: Why do we care?

The Toll



The rate of overdose deaths among women

Opioid use disorder has gone up more than 4 times among pregnant women.



4 times as many infants were born with neonatal abstinence syndrome (NAS) in 2014 than in 1999.

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CASE: STEPH

39F has never been pregnant, irregular periods

FERTILITY

Has not used birth control most of her adult life
Until approx 2 months ago, had a severe opioid use disorder, now she’s on methadone
She wants to get pregnant

4 months after starting methadone she spontaneously gets pregnant

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SUMMARY STATEMENTS

Opioid use can cause hormonal changes, and chronic use is associated with **hypogonadism (moderate),amenorrhea, and oligomenorrhea (high).**

Opioids Long-term opioid use may cause i**nfertility, and primary ovarian insufficiency, and early menopause (moderate)**.

For women with an opioid use disorder, the **transition to long-acting opioids (methadone or buprenorphine/naloxone) may improve fertility** ;illicit (short-acting) opioids are associated with reduced fertility (high).

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CASE: FIONA

CHRONIC PAIN & PREGNANCY

WHAT'S A FAMILY DOC TO DO?

- 27 yo patient on disability with dx of chronic myofascial back pain
- Inherited in your practice: 12 oxycodone-acetaminophen/ day and have been working to slowly wean - she's currently on 8 tabs
- Presenting with positive pregnancy test
- Wanting to continue pregnancy
- **Wants to know: What to do with the rx?**

Benefits of continuing opioids in pregnancy

- Ongoing pain control
- Known analgesic entity
- Lack of destabilization
- Unlikely to be teratogenic

Risks of continuing opioids in pregnancy

- ?Preterm labour /Low birth weight
- Dose increases required
- Combination of long/short acting
- Neonatal opioid withdrawal (NOWS)

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RECOMMENDATION

Chronic Pain: Risk - Benefit Discussion

Health care providers must have a conversation with their pregnant patients concerning the risks and benefits of prescribed opioids for chronic pain, to **weigh the likelihood of increased pain when reducing or stopping medication against potential adverse effects on the pregnancy** from continuing therapeutic doses of pain medication (strong, high).

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DOSE INCREASES

Current:

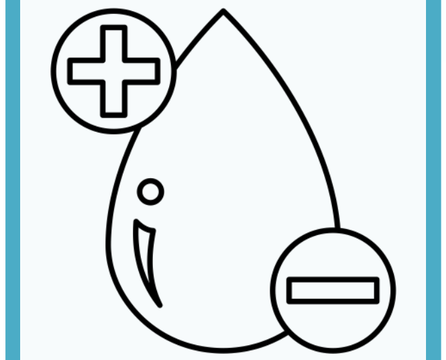
- 2 tabs oxycodone-acetaminophen QID (8 tabs)
- 1 tab = 5 mg of oxyocodone
- 40 mg oxycodone = 60 mg of morphine
- Consider a 20-30% dose increase
- Trial 3 tabs QID for 1-2 weeks (90 mg of morphine)

Future:

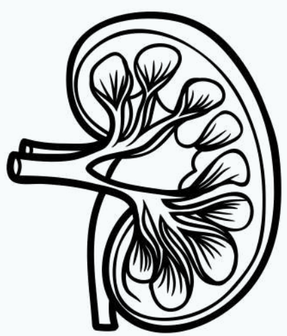
- if still experiencing withdrawal / w/d mediated pain trial long-acting med
- Add 20-30% of total dose as long acting
- Methadone/buprenorphine and SROM have most evidence from the OAT literature

Metabolic Changes in Pregnancy

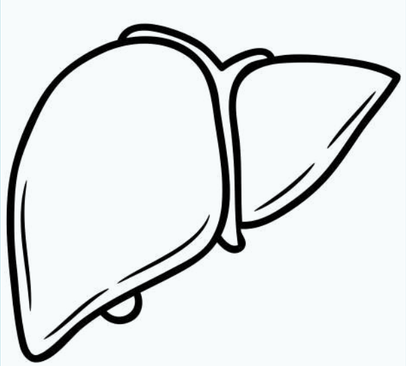
Leads to dose increases and the need for split dosing



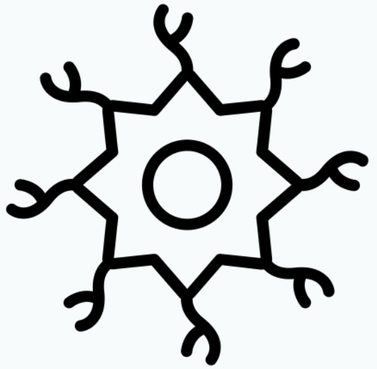
Increased Plasma Volume



Increased Renal Blood Flow



Hepatic Metabolism Induction



Tissue Binding

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FIONA'S IN MORE PAIN DESPITE TAKING 8 TABS OF OXYCODONE-ACETAMINOPHEN DAILY

Physiological changes in pregnancy lead to increased metabolism

- Dose changes will be needed
- What are we trying to prevent?

Prescribing Pearls:

- No maximum or "watchful" dose in pregnancy
- May have to add long acting in addition to short acting
- **Goal: avoid withdrawal**

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RECOMMENDATION

Chronic Pain: Titration to lowest effective dose but adjust for metabolic changes in pregnancy

Health care providers should titrate opioid treatment for chronic, non-cancer pain management in pregnant women to the **lowest effective dose, with the understanding that the dose may need to be increased because of the metabolic changes caused by pregnancy** (strong, high).

CASE: GINA IS LATE TO CARE

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OPIOID USE

Gina is G6P5 at ? 20w gestation, NFA, using non-prescribed opioids

She presents today for her first prenatal visit
She wants to continue the pregnancy and your office has already ordered an ultrasound for tomorrow

Is there any different blood work you would order?
Any other special infectious testing needed?
Any considerations re: opioid use?

INCREASING RATES OF STI / BBI IN SUDS

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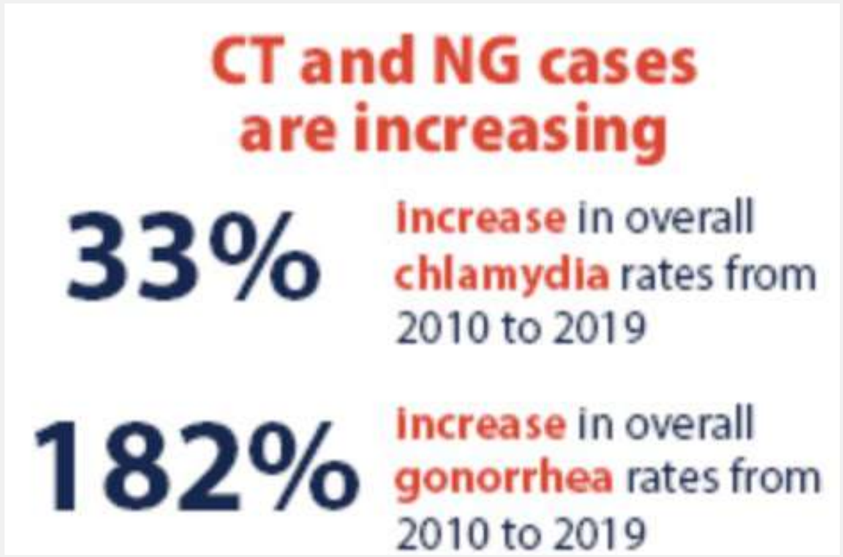

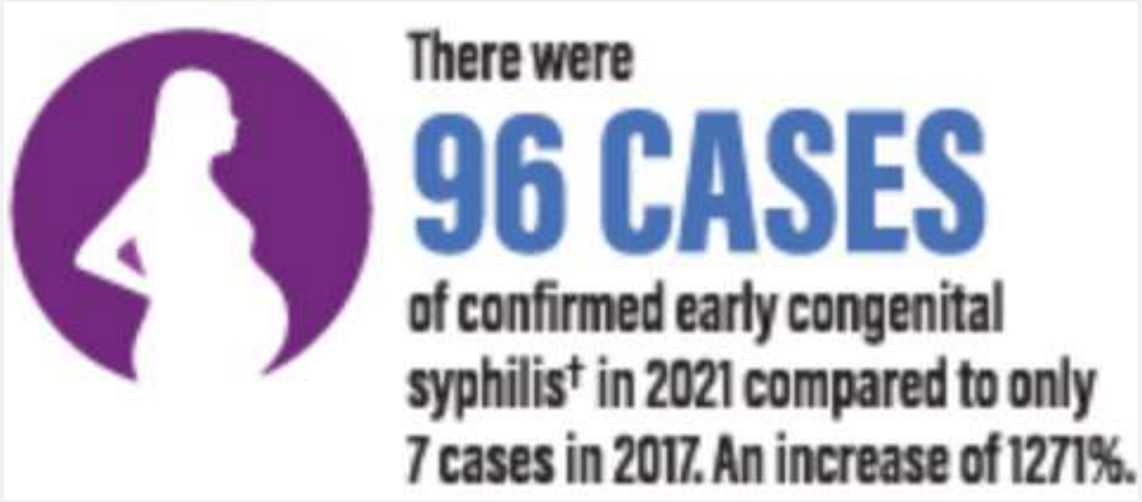

HEALTH CARE

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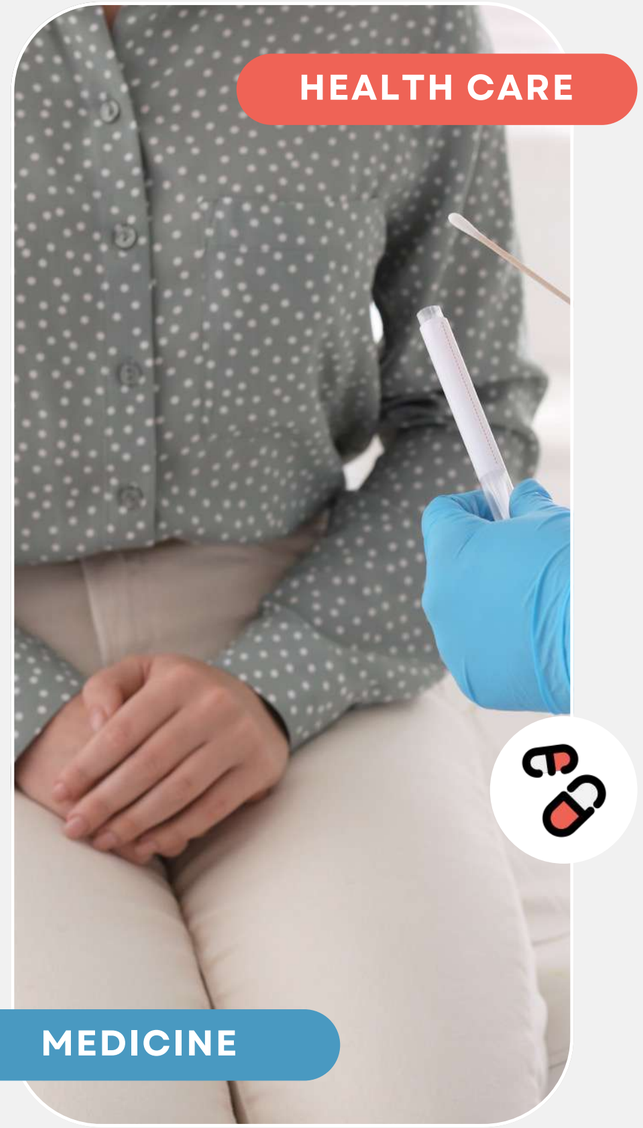
20% CT missed with Urine Naat!

SELF-SWABS FOR GC/CT

Urine NAAT for GC/CT inaccurate for symptomatic & asymptomatic patients

Active substance use (non-prescribed opioids associated with):

- Higher risk of all STIs
- Higher risk of survival sex, sexual coercion, sex work, sex trade



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RECOMMENDATION

Add Hepatitis C Testing & Swabs for GC/CT in High-Risk Patients (not urine NAAT, if possible)

Health care providers should screen pregnant women with opioid use disorder or a history of intravenous drug use for **hepatitis C**, hepatitis B, syphilis, and HIV (strong, moderate).

They should also consider collecting (or having the patient collect) **vaginal swabs to test for chlamydia and gonorrhea** (strong, moderate).

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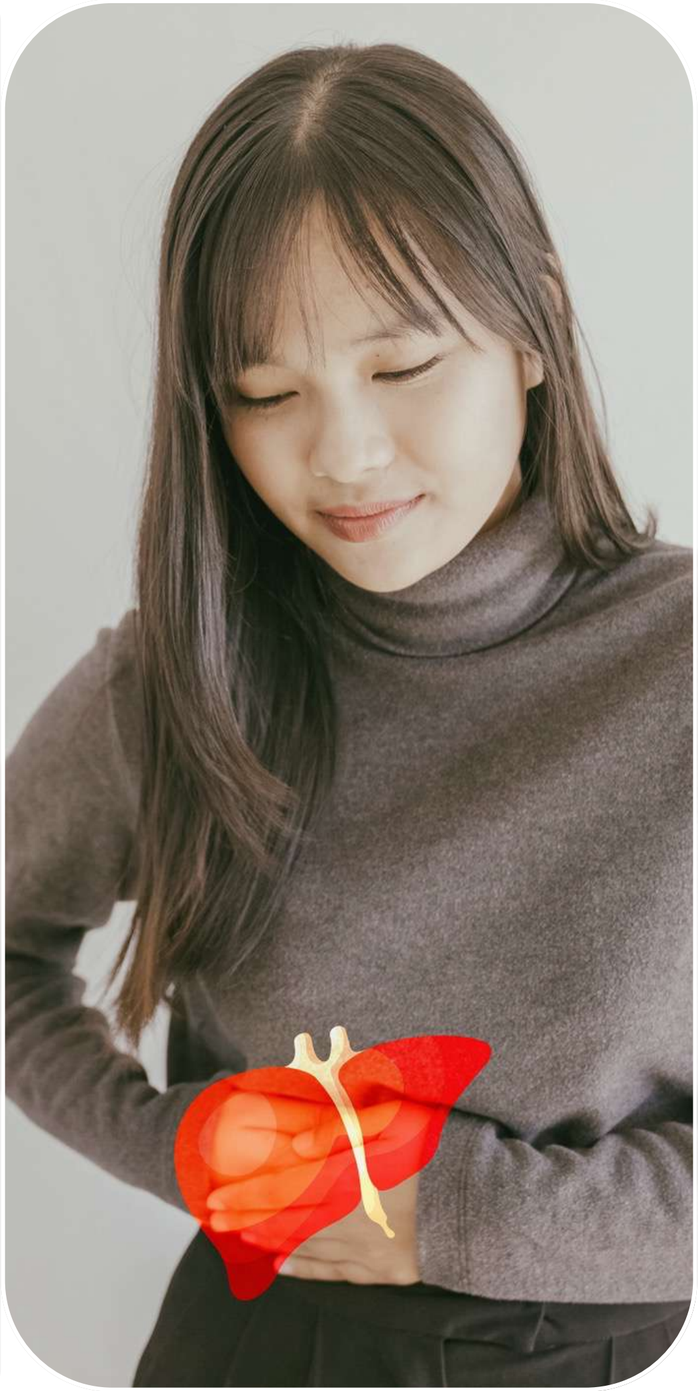

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GINA: HEPATITIS B RISK FACTORS

On routine blood work Gina HCV Ab + and RNA +

- Sent off Hepatitis serology with the RNA
- Non-immune to hepatitis B
- Grew up in Ontario, where Hepatitis B vaccination occurred in Grade 7
- Was in and out of foster homes - unlikely got vaccinated

Standard Schedule: 0, 1, 6 months

OR

Accelerated Schedule: 0, 1, 2, 12 months

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RECOMMENDATION

Pregnancy can be an important time for vaccination with Hep B

For women with ongoing risk factors for hepatitis B, health care providers should **offer hepatitis B vaccine on an accelerated schedule to pregnant women** who are not immune to hepatitis B infection (strong, high).

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GINA WANTS TO START OAT

SHE'S BEEN ON BOTH METHADONE AND BUPRENORPHINE IN THE PAST

She's using fentanyl every few hours

Doesn't think she'd be able to tolerate any withdrawal

Not keen to start bup/nlx because of withdrawal and how long micro-dosing might take

She's wondering if methadone is dangerous to the baby?

HEALTH CARE

MEDICINE

Systematic Review

Buprenorphine vs. Methadone

Michael Kinsella, Lucy O. E. Halliday, Martin Shaw, Yasmin Capel, Scott M. Nelson & Rachel J. Kearns (2022)Buprenorphine Compared with Methadone in Pregnancy: A Systematic Review and Meta-Analysis, Substance Use & Misuse, 57:9, 1400-1416,

Buprenorphine

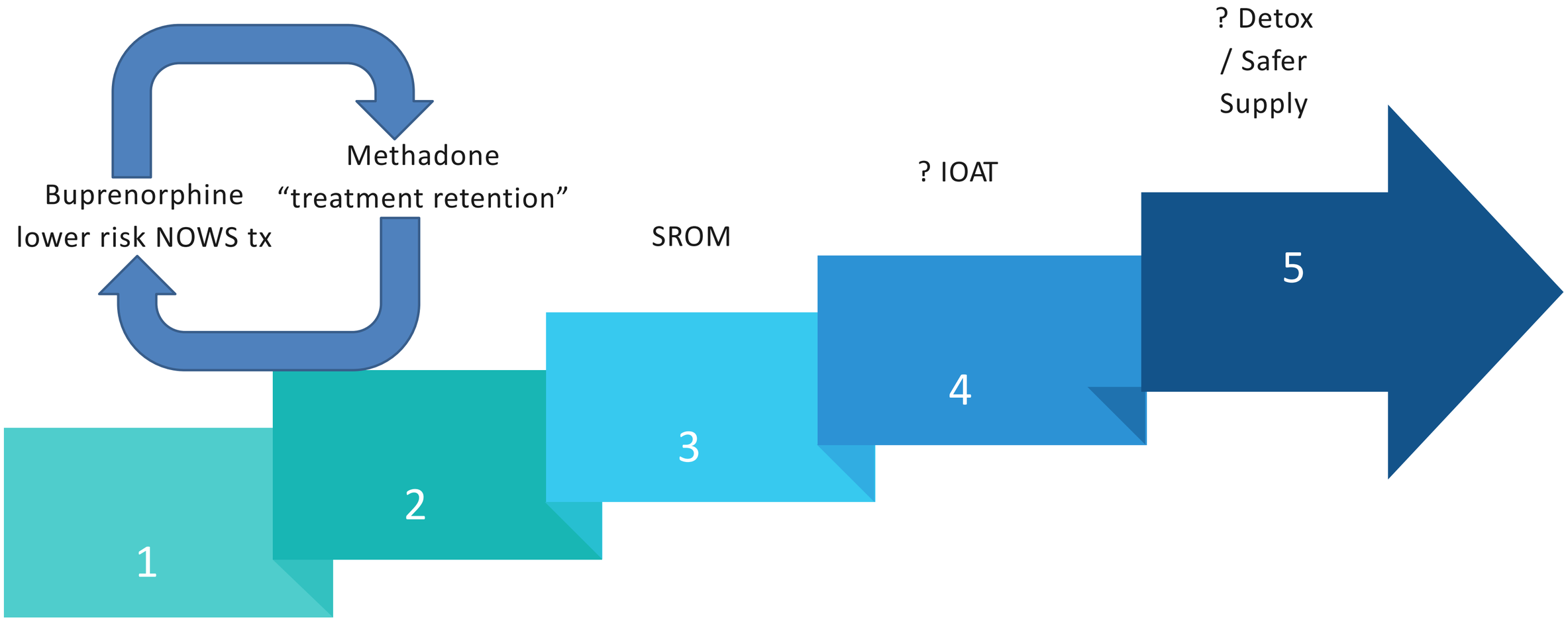
Buprenorphine was associated with; greater offspring birth weight; body length at birth and reduced risk of prematurity

Methadone

Associated with more severe OUD, more medical complexity and therefore may not be captured in the systematic review

SUMMARY: OAT IN PREGNANCY

Bottom Line: Choose OAT that is appropriate for the patient, avoid detoxification (more later)



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RECOMMENDATION

Health care providers should recommend treatment with opioid agonist therapy for pregnant women with opioid use disorder, initiating treatment at the lowest effective dose and increase the dose as the pregnancy progresses because of physiologic changes.

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CASE: FINLEY

Finley has ben stable on bup/nlx for 3 years

- Currently 12 weeks pregnant
- Planned pregnancy
- Never pregnant before
- She wants to taper

Questions?

- **Can she stay on bup/nlx?**
- **Should she taper?**

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RECOMMENDATION

Buprenorphine-Naloxone -No Need to Switch Products

Health care providers can **safely recommend buprenorphine/naloxone in pregnancy** based on current data. Consequently, switching patients to a buprenorphine-only product is not necessary (strong, high).

DOSE REDUCTION: CHALLENGES

DOSE TAPERING WHILE METABOLISM IS CAUSING A PHYSIOLOGICAL TAPERING?

Suggest reducing dose by no more than 10% q 1-2 weeks

Example: Patient started at 16 mg of bup/nlx daily
Reduction 1-2 mg
Suggestion: 14 mg daily x 1 week and reassess
As the dose decreasese the total dose able to reduce becomes more difficult
Imagine the patient is on: 2 mg (smallest reduction is 1/4 of 2 mg tab) - what do we do when we get to 1.5 mg?

Detoxification

- While actively decreasing the opioid dose; have a metabolic dose reduction as well
- Remember physiological changes will result in a natural taper in the effective dose
- Tapering assocciated with VERY high risk of relapse particularly in those newly stabilized

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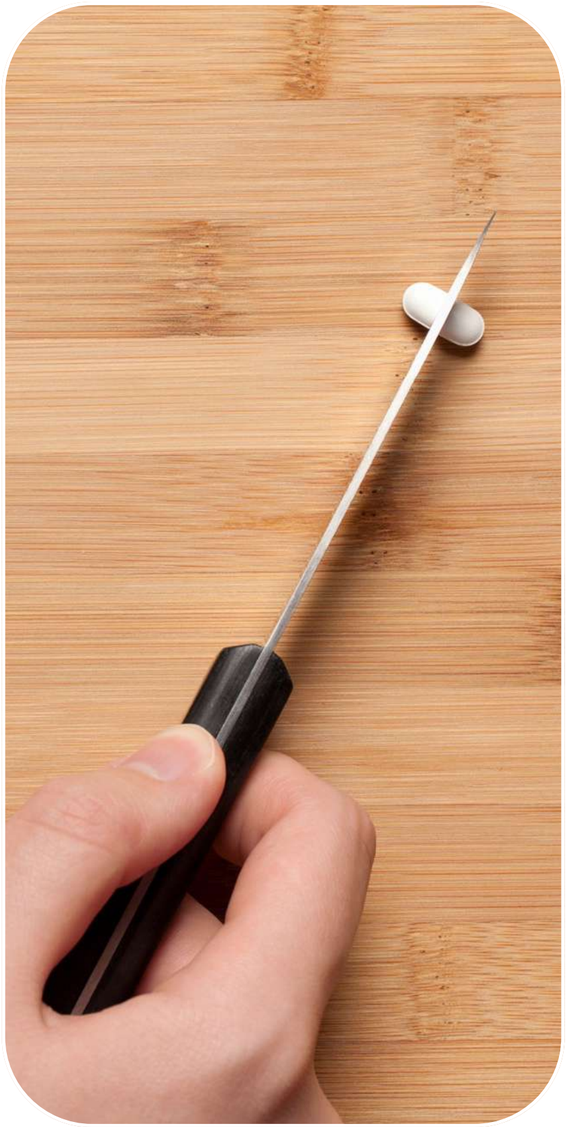
RECOMMENDATION

Avoid Tapering - Tapering Must be Done Slowly

Obstetrical care providers **should not attempt to taper the opioid dose or to detoxify (taper completely) in women with opioid use disorder during pregnancy** (strong, high).

However, following a discussion of the obstetrical and fetal risks of tapering or detoxification, the patient may make an informed decision to undergo this process. In this case, the **opioid dose should be slowly tapered to the lowest effective dose** (strong, low).



FINLEY CONT'D BUP BUT NOW: DOSE IS NOT LASTING 24H

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- Finley is on 16 mg but dose is not lasting 24 h and she's having cravings
- Increase by 20-30%; consider split dosing
- Can try 2 mg increase - 8 mg q AM & 10 mg qPM
- May have to increase up to 5 times per day to get relief of withdrawal
- **What if you reach 24 mg or 32 mg in divided doses?**

DOSE INCREASES

Physiological changes in pregnancy lead to increased metabolism

- Increase in circulating volume
- Increase in hepatic metabolism
- Increase in renal excretion
- Fetal hepatic metabolism (T3)
- **Increases will be needed throughout pregnancy**

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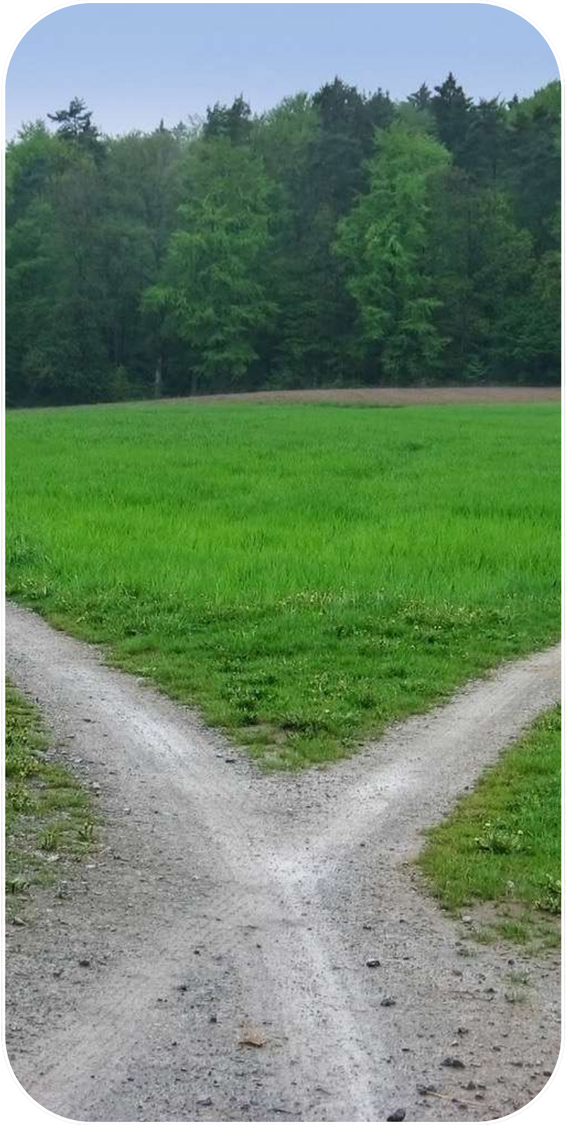
RECOMMENDATION

Split dosing is supported for Opioid Agonist Therapy

Obstetrical care providers should consider **dose increases and split doses of methadone or buprenorphine for opioid use disorder to prevent withdrawal and relapse** during pregnancy because of the increase in metabolism of opioids as pregnancy progresses (strong, high).



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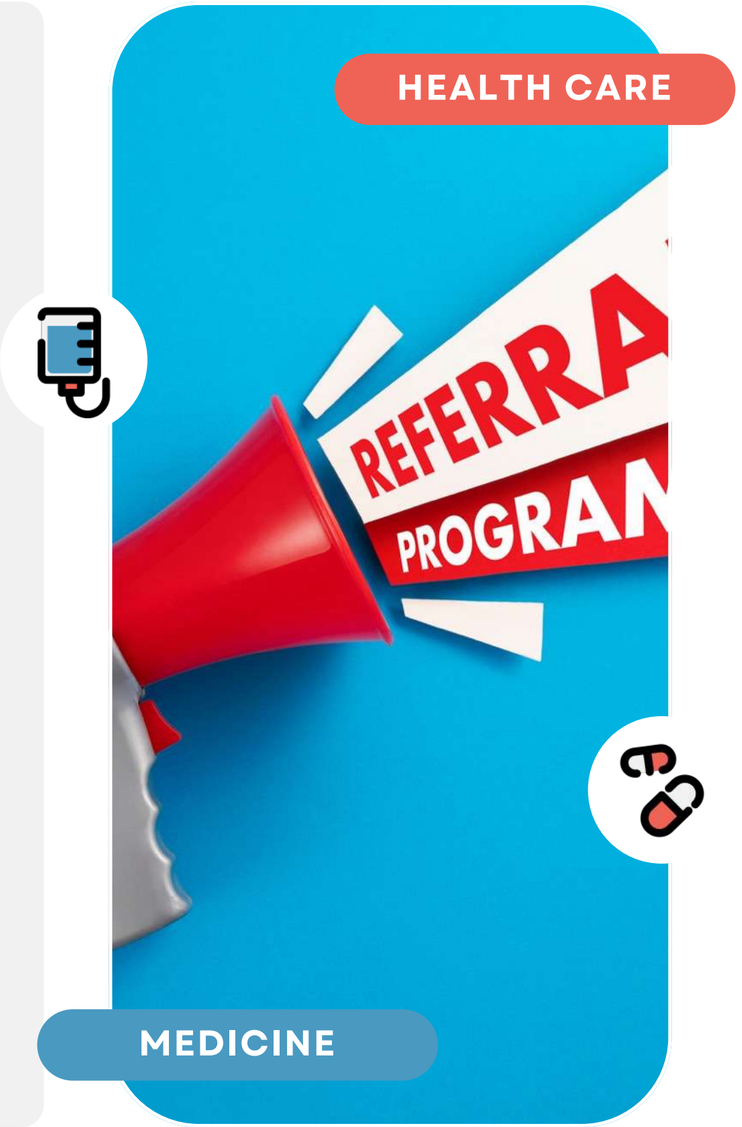
REFERRAL FOR ONGOING CARE?

Finley is now 16w and informs you of her first midwifery intake appointment next week

Finley is hoping to a deliver at home or the local birth centre in order to avoid any child protection involvement

Finley is now on a stable dose of bup 12 mg SL BID
What are the maternal and fetal considerations for ongoing care and delivery?



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RECOMMENDATION

Integrated care is evidence-based

Pregnant patients with opioid use disorder **should be referred to integrated care programs,** when these are available and accessible (strong, moderate).

Delivery should take place in a centre that can provide monitoring for NOWS and iInfants exposed to opiates during pregnancy The infant should be observed carefully during the neonatal period for signs of withdrawal (strong, high).

CASE: AMAYA

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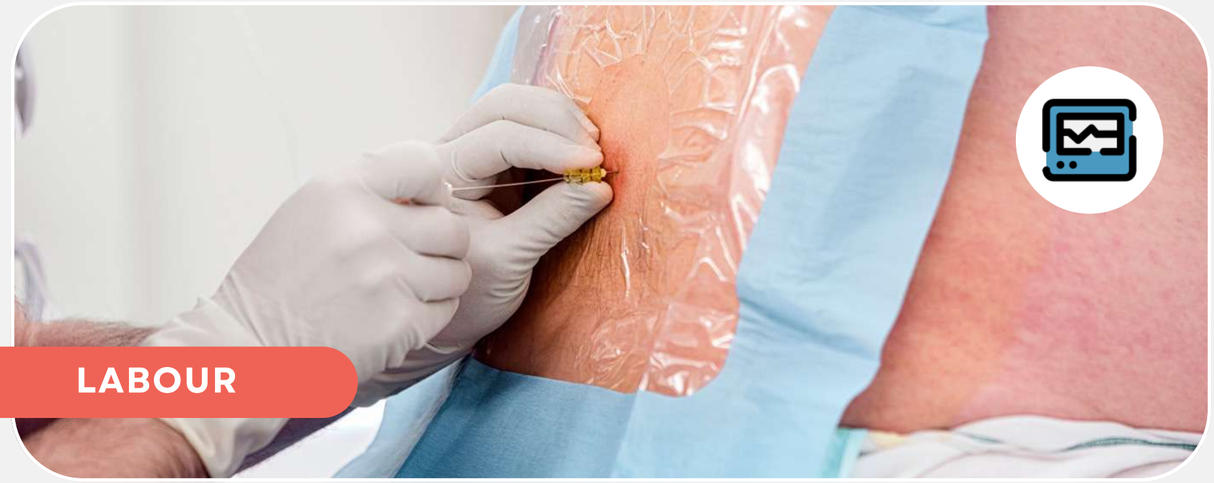
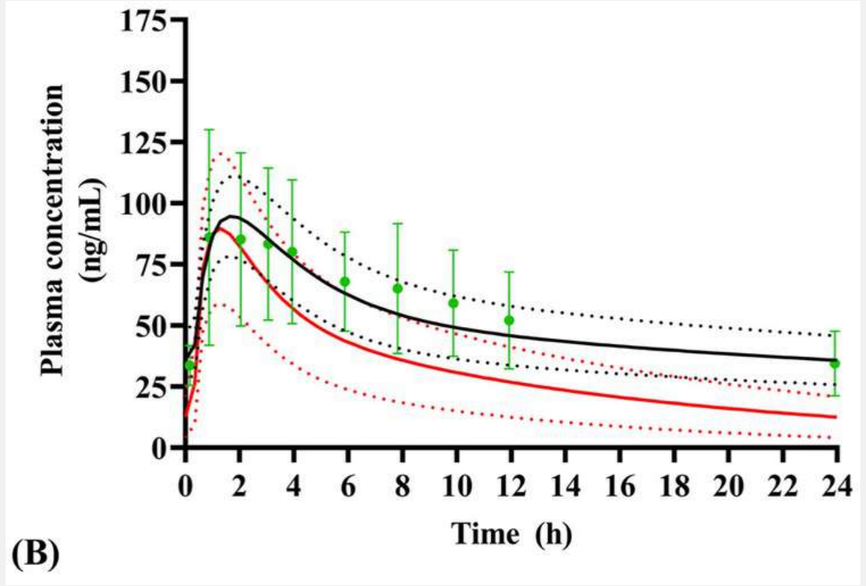


LABOUR

AMAYA recently stable (4w) on methadone

G1P0 at 40 weeks, presents with SROM (clear fluid) in active labour, GBS negative

She wants to be admitted for an epidural but also requesting to leave for one-last smoke
The nurse is concerned because the FHR baseline is 110, with minimal variability and no decels/accels
Her methadone dose was last taken approximately 2 hours ago



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RECOMMENDATION

Methadone and buprenorphine both Suppress FHR and variability

When interpreting antepartum and intrapartum non-stress tests and fetal heart surveillance, health care providers should **consider the suppression of fetal heart rate due to opioids and reduced variability and accelerations in fetal heart rate at the opioid's biological peak** (strong, moderate).

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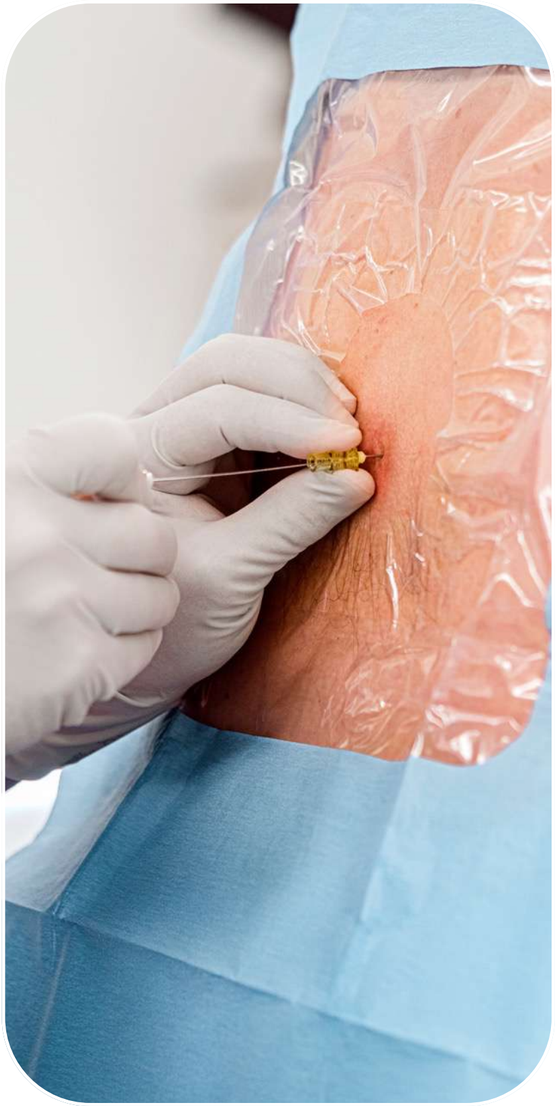
RECOMMENDATION

Epidurals may mitigate hyperalgesia

Health care providers should **recommend epidural analgesia early in labour for women with opioid use disorder, as this may mitigate the hyperalgesia** caused by chronic opioid use (strong, moderate).



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RECOMMENDATION

Nicotine replacement therapy may reduce pain sensitivity

Health care providers should **offer nicotine replacement therapy to pregnant patients with concurrent nicotine and opioid use,** in conjunction with a discussion of risks and benefits, in settings where access to tobacco or cigarettes is limited (i.e., in hospital during the intrapartum and postpartum periods) **as a way to reduce pain sensitivity** (strong, low).

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AMAYA WANTS TO BREASTFEED

LACTATION

Amaya delivered a baby about 4 hours ago

The nurse is wondering if Amaya can breast feed while on methadone?
She's been abstinent from non-prescribed substances for 4 weeks

She's been stable on her current dose of methadone for 10 days

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RECOMMENDATION

Patients on stable doses of OAT / opioids for CNCP can breastfeed

Health care providers should recommend **against using non-prescribed opioids, illicit opioids, or other non-prescribed substances while breastfeeding** (strong, moderate), but **women receiving stable doses of opioid agonist therapy or opioids for chronic pain should be supported to breastfeed** (strong, moderate).

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AMAYA WANTS TO WAIT FOR BABY #2

She’s wondering if there is anything she can take now rather than waiting 6 weeks

She’s only ever taken birth control pills and has trouble remembering them
She wonders if her methadone will impact the effectiveness of contraception

Would our conversation be different if we had the conversation prior to delivery?

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RECOMMENDATION

Consider immediate post-partum contraception (LARCs)

For women who use opioids, health care providers should recommend l**ong-acting reversible contraceptives** (subdermal implants or intrauterine devices) for contraception (strong, high).

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LEARNING GOALS

1.Identify current recommendations for care related to opioid use during pregnancy

2. Describe options for management of opioid use disorder in pregnancy

.

3. Manage opioid use during pregnancy and postpartum

THANK YOU

FOR YOUR ATTENTION

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Guideline No. 443a: Opioid Use Throughout Women's Lifespan: Fertility, Contraception, Chronic Pain, and Menopause

Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding

Thank you!

Please fill out your session evaluation now!

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