Substance Use Disorder and the Obstetrician: What Can We Do?

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Case

- 29 yo G2P1001 presents to the Emergency Department requesting methadone stabilization.
- + Urine pregnancy test
- Urine drug screen positive for opiates, benzodiazepines and marijuana
- Unsure LMP -> ED Ultrasound shows 16w4d sized fetus with +FHT
- MFM Resident paged to admit

Whose job is this?

- It is our job!
- Ob/Gyns have contributed directly to "opioid crisis"
- Substance use disorder is a common, high-risk issue in pregnant women
- Pregnancy is a window of opportunity for addressing this medical problem

- All hands on deck!

How can we help?

- Screening
- Treatment and OB Care
- Postpartum management
  - Substance Use Disorder
  - Opioid Naïve

Screening

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ASAM American Society of Addiction Medicine

ACOG COMMITTEE OPINION

Number 711 • August 2017

(Replaces Committee Opinion Number 524, May 2012)

Committee on Obstetric Practice
American Society of Addiction Medicine

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations and conclusions:

- Early universal screening, brief intervention (such as engaging the patient in a short conversation, providing feedback and advice), and referral for treatment of pregnant women with opioid use and opioid use disorder improve maternal and infant outcomes.
- Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with the pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma. Therefore, it is essential that screening be universal.
- Routine screening should rely on validated screening tools, such as questionnaires, including 4Ps, NIDA Quick Screen, and CRAFFT (for women 26 years or younger).
- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (eg, exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments.

Screening

- Screening vs. Testing
  - Screening: Asking about use of substances using a specific instrument or series of questions
  - Testing: An assay of biologic materials (blood, urine) looking for a chemical signal indicative of substance use

Screening

- What do we need if we are going to screen?

- Link to care/treatment
  - MAT
  - OB care
  - Behavioral Health

Screening Tools

- NIDA – 56% sensitive, 95% specific
- WIDUS – 61% sensitive, 81% specific
- CRAFFT – 29% sensitive, 76% specific
- 4 Ps – 74% sensitive, 37% specific
- SURP-P – 80% sensitive, 33% specific

*No screening test available with BOTH good sensitivity and specificity

Blake-Lamb, 2018

4P's Plus

•*Parents*	Did either of your parents ever have a problem with alcohol or drugs?
•*Partner*	Does your partner have a problem with alcohol or drugs?
•*Past*	Have you ever drunk beer, wine, or liquor?
•*Pregnancy*	
	–In the month before you knew you were pregnant, how many *cigarettes* did you smoke?
	–In the month before you knew you were pregnant, *how many beers/how much wine/how much liquor* did you drink?

NIDA Quick Screen

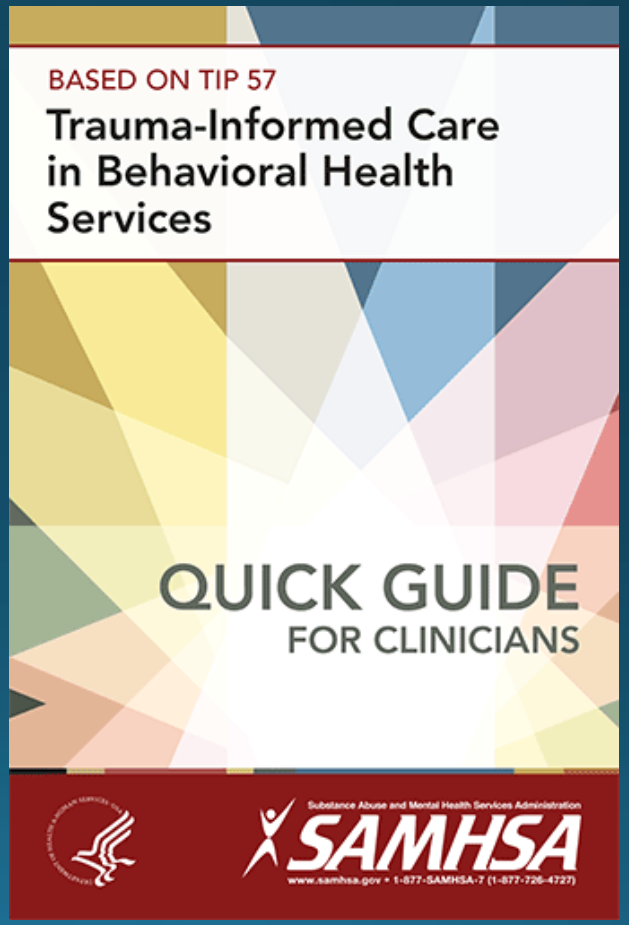
Quick Screen Question: In the past year, how often have you used the following?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
Alcohol • For men, 5 or more drinks a day • For women, 4 or more drinks a day					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

Treatment & OB Care: Approach

- Chronic disease model: We need to destigmatize
- Trauma-informed care
- All women with OUD should be offered pharmacotherapy
  - Methadone
  - Buprenorphine (Subutex, Suboxone)

Trauma Informed Care

- Realizes the widespread impact of trauma and understands potential paths for recovery
- Recognizes the signs and symptoms of trauma
- Responds by fully integrating knowledge about trauma into polices, procedures and practices
- Seeks to actively resist re-traumatization



Treatment and OB Care: MAT

Methadone

- Receipt in clinic with daily contact
- Greater adherence
- QT Prolonging

Buprenorphine

- OB can prescribe, but IMPERATIVE to incorporate mental health services
- Privacy
- Opportunity for diversion
- Less severe NAS (Jones, 2010)

Treatment and OB Care

One Stop Shop

- OB provider, MAT prescriber, mental health provider all in same location
- Bonuses: SW, addiction medicine, onsite childcare, case management, legal aid
- May be associated with stigma

Collaborative Care Model

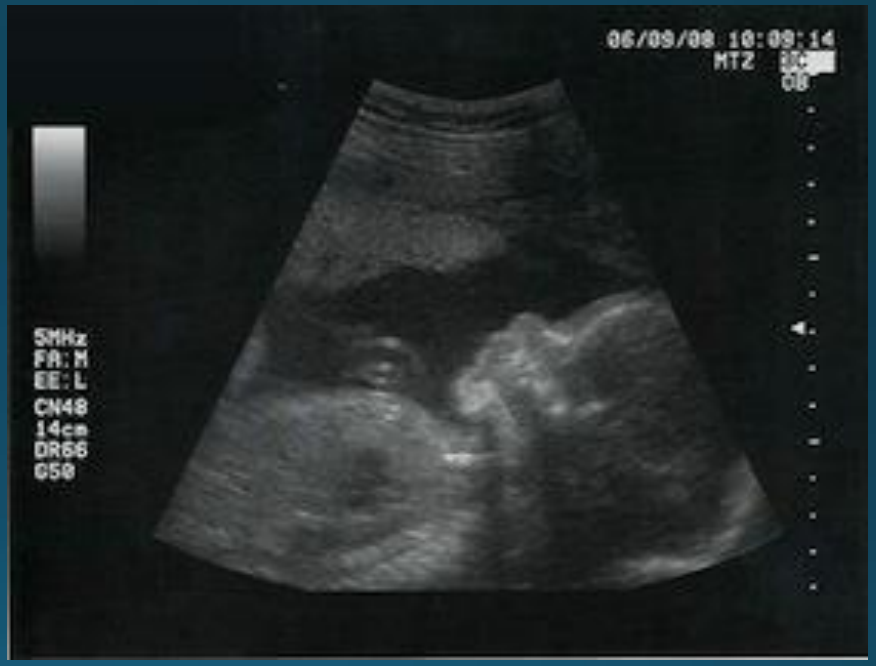
- OB provider, MAT prescriber + referral network
- Barriers: transportation, childcare

Treatment and OB Care

- Important components of antenatal counseling
  - NAS reduction: smoking cessation, benzodiazepine elimination
  - Breastfeeding
  - How to transition care postpartum
  - Overdose education and narcan kits
  - Management of coexisting medical problems (HCV, TB, HIV, STIs, psychiatric disease, dental care)
  - Shared decision making re: postpartum pain management
  - Contraception

Treatment and OB Care

- Antepartum management:
  - Detailed anatomy scan
  - 3rd trimester growth scan
  - Delivery for obstetric indications vs. CONSIDER early term delivery in the case of ongoing substance use



Treatment and OB Care

- Intrapartum management
  - Trauma-informed!
  - Continue pharmacotherapy
  - Avoid Nalbuphine, Stadol

Postpartum Management

- Support for mother as primary caregiver of the infant
- Contraception
  - Within reproductive justice framework
  - Immediate postpartum LARC
- Support for breastfeeding
- Pain management after c-section
  - Often need higher dose of opioids
  - Shared decision making and close follow-up
- Ensure comprehensive transition of care/hand-off

Pain Management: Opioid Naïve Women

- 1/300 opioid naïve women become addicted to opioids following c-section (Bateman, 2016)

Table 2. Number of Tablets Dispensed, Consumed, and Leftover for Women Who Filled a Prescription for an Opioid Analgesic After Cesarean Delivery*

	Median	25th–75th Percentile	10th–90th Percentile	Range
Tablets dispensed	40	30–40	24–45	5–80
Tablets consumed	20	8–30	2–40	0–60
Tablets leftover	15	3–26	0–36	0–59

* n=605; 10 patients who were dispensed an opioid were excluded from this analysis for missing data.

Pain Management: Opioid Naïve Women

- Educate women prior to delivery
- Routine use of opioids after uncomplicated vaginal delivery not recommended
- C-section: maximize Tylenol and NSAIDs
- Shared decision making re: quantity of Rx
  - Opioid PRN, with patient aware of what she is taking, at lowest effective dose and frequency
- Education about disposal/return

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Questions?

- Thank you!