



**UW PACC**

Psychiatry and Addictions Case Conference

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**WELCOME!**

Today's Topic:

Pregnancy and Opioid Use Disorders

Should I treat pregnant women with Opioid Use Disorders?  
What about NAS? Should I taper the mom off  
Buprenorphine before delivery to avoid NAS?

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# PREGNANCY AND OPIOID USE DISORDERS

SWEDISH MEDICAL CENTER  
ADDICTION RECOVERY SERVICE

JAMES (JIM) WALSH, MD

# GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

# SPEAKER DISCLOSURES

✓ No conflicts of interest?

# OBJECTIVES

1. Be familiar with obstetrical issues related to drug use in pregnancy
2. Be able to manage opioid use disorder in pregnancy
3. Help mother on MAT prepare for delivery

# TALKING ABOUT DRUG USE IN PREGNANCY

The mother is more scared  
than you are.

The mother is desperate to hear  
that the baby is OK.

# IS THE BABY OK?

Three kinds of possible fetal injury

- teratogenic effect
- placental insufficiency
- neuro - developmental impact

# TERATOGENIC EFFECT

probably only with alcohol

cocaine use in first trimester

incidence of birth defects equal to  
non-exposed infants



# PLACENTAL INSUFFICIENCY

Poor fetal growth, preterm delivery,  
abruption (bleeding under the placenta)  
due to vasoconstriction

risks increase toward end of term

cocaine,  
methamphetamine,  
nicotine & carbon monoxide

# PLACENTAL INSUFFICIENCY

On average, the baby of mother continuing to use cocaine into 3rd trimester is 1 lb smaller than non users, but still within normal limits

# PLACENTAL INSUFFICIENCY

Cocaine use to the end of pregnancy is associated with

- 4 x preterm labor
- 5 x low birth weight
- 10 x placental abruption
- 5 x fetal demise

# DEVELOPMENTAL PROBLEMS

*Probably not*

- Excluding alcohol, deficits in global assessments (IQ, Bayley) have not been clearly attributed to substances
- It is difficult to find a proper comparator group
- Some subscores in some subsets of children have been statistically significantly below normal

*All studies confirm that growing up in a using household impacts intelligence and emotional well being*

# OPIOIDS IN PREGNANCY

Poor fetal growth

Preterm birth

Low birth weight

Preterm premature rupture of membranes

Antepartum hemorrhage

Maternal infections

# OPIOIDS IN PREGNANCY

Poor fetal growth

Preterm birth

Low birth weight

Preterm premature rupture of membranes

Antepartum hemorrhage

Use of other illicit drugs

Poor prenatal care

Social adversity.

Many of these adverse effects are felt to be secondary to poor health behaviors combined with repeated episodes of in utero opioid withdrawal.

# FETAL OPIOID WITHDRAWAL

increased fetal movements  
passage of meconium  
bradycardia

miscarriage  
preterm delivery  
intra-uterine fetal demise (stillbirth)

# METHADONE TREATMENT

Compared to heroin use, methadone treatment during pregnancy is associated with

- more consistent prenatal care,
- improved fetal growth,
- reduced fetal mortality,
- increased likelihood that the baby will be discharged home with its mother.

A significant relationship was observed between maternal methadone dosage in the first trimester and birth weight, the higher the dosage, the larger the infant.



# BUPRENORPHINE TREATMENT

Perinatal outcomes equivalent to methadone  
Less Neonatal Abstinence

# METHADONE VS. BUPRENORPHINE

- NAS
- Convenience
- Sobriety

# WHY NOT DETOX?

Relapse rates ranging from 17% to 96% (average 48%)

Of 101 patients who initiated medically assisted withdrawal only 24 were available for follow-up.

10 had completed detox,  
none went to rehab,  
only 1 was abstinent at the time of delivery  
average birth weight 5 lbs 10 oz

Only one study demonstrated a decrease in NAS.

# WHY NOT DETOX?

Relapse rates ranging from 17% to 96% (average 48%)

These were all case series, not randomized data.  
Quality of data reported is concerning.

No study of medically assisted withdrawal has examined maternal outcomes into the postpartum period, a particularly vulnerable time for relapse.

The most important variable in the ability to retain custodial care of the newborn is relapse

# AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

## Committee Opinion 2017

When opioid maintenance treatment is available,  
medically supervised withdrawal  
should be discouraged during pregnancy.

# NEONATAL ABSTINENCE TREATMENT

## Traditional treatment

Babies in NICU

Withdrawal measured with 22 element Finnegan score

Treated with morphine, tapered over several weeks

# NEONATAL ABSTINENCE TREATMENT

## Transformed treatment

Babies rooming in with mothers

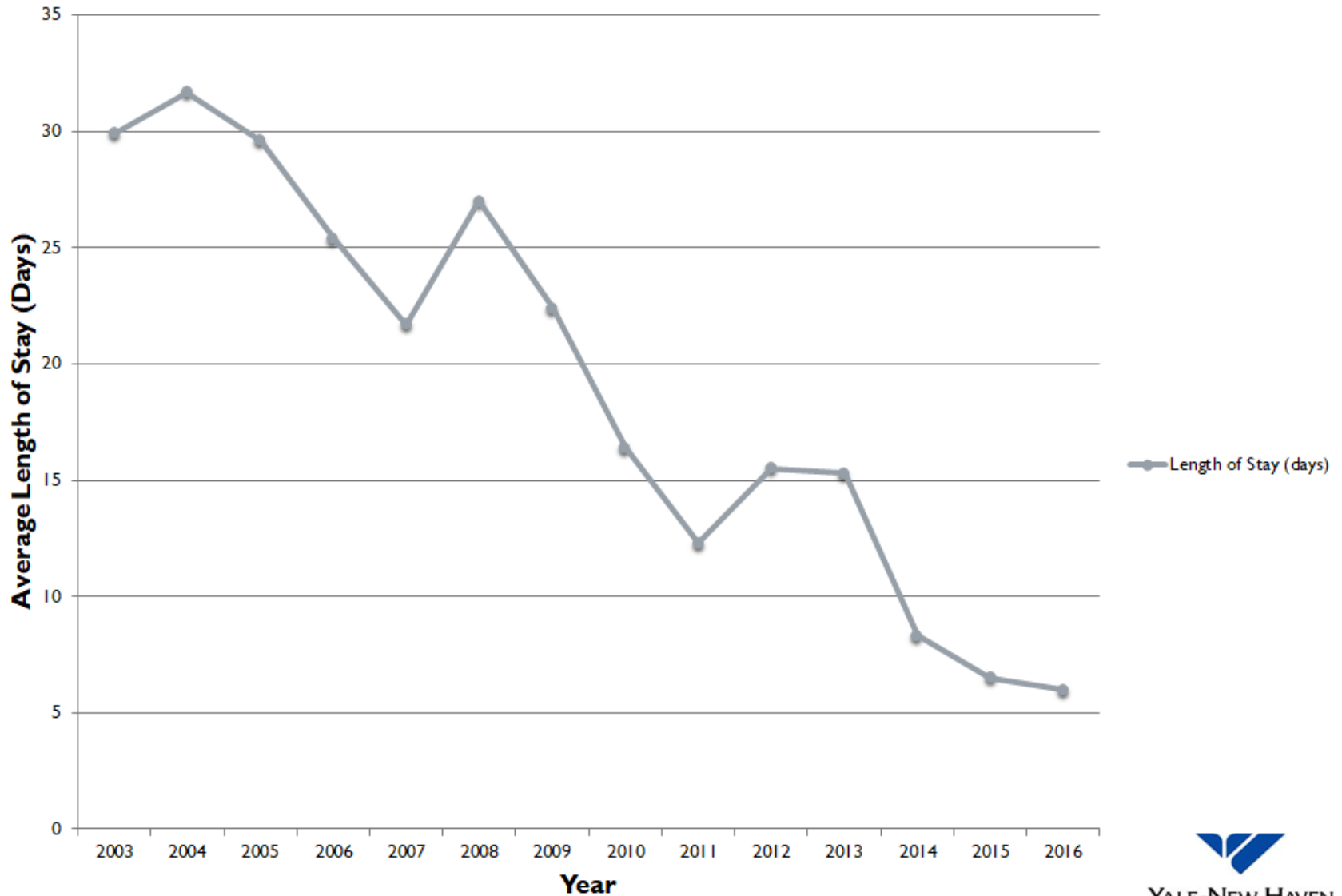
Breast feeding encouraged

Mothers supported (dyadic care)

Withdrawal measured by Eat, Sleep, Console

Treated with individual doses of morphine when needed

# TRANSFORMING NAS CARE





# WHAT WOULD YOU SAY?

Sunny is 27 years old and 33 weeks pregnant. She came to hospital “cramping” 8 days ago and was started on methadone. Her last baby was born at 34 weeks, 5 lbs 14 oz. Her cervical exam is 2 cm / 50% and fortunately hasn’t changed.

She is now stable at 70 mg qAM and a methadone clinic appt is set up for tomorrow.

“Thanks for everything you’ve done, but I can’t be on methadone. I don’t want my baby to be *born addicted*”.

# WHAT WOULD YOU SAY?

Carla is getting ready to take her baby home from the nursery after at 8 day treatment for NAS.

She started on buprenorphine program when she was 3 months pregnant and did pretty well. She had one short relapse on methamphetamine early on but has been sober since she started going to Celebrate Recovery meetings.

The delivery went great and her family was very supportive. Carla has been very attentive to the baby but feeling guilty about the NAS.

“I promised my husband I would stop the Subutex after the baby was born, but now I’m afraid... I mean what if I just start using again? What do you think I should do?”