OBSTETRICS

Clinical care for opioid-using pregnant and postpartum women: the role of obstetric providers

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We review clinical care issues that are related to illicit and therapeutic opioid use among pregnant women and women in the postpartum period and outline the major responsibilities of obstetrics providers who care for these patients during the antepartum, intrapartum, and postpartum periods. Selected patient treatment issues are highlighted, and case examples are provided. Securing a strong rapport and trust with these patients is crucial for success in delivering high-quality obstetric care and in coordinating services with other specialists as needed. Obstetrics providers have an ethical obligation to screen, assess, and provide brief interventions and referral to specialized treatment for patients with drug use disorders. Opioid-dependent pregnant women often can be treated effectively with methadone or buprenorphine. These medications are classified as pregnancy category C medications by the Food and Drug Administration, and their use in the treatment of opioid-dependent pregnant patients should not be considered "off-label." Except in rare special circumstances, medication-assisted withdrawal during pregnancy should be discouraged because of a high relapse rate. Acute pain management in this population deserves special consideration because patients who use opioids can be hypersensitive to pain and because the use of mixed opioid-agonist/antagonists can precipitate opioid withdrawal. In the absence of other indications, pregnant women who use opioids do not require more intense medical care than other pregnant patients to ensure adequate treatment and the best possible outcomes. Together with specialists in pain and addiction medicine, obstetricians can coordinate comprehensive care for pregnant women who use opioids and women who use opioids in the postpartum period.

Key words: opioid-agonist, opioid use, substance use

Opioid use disorders during pregnancy represent a long-standing health issue in the United States.[1] Over the last decade, the use and misuse of prescription opioids by pregnant women has increased dramatically from 1.2 per 1000 hospital live births in 2000 to 5.6 in 2009. Closely related, neonatal abstinence syndrome (NAS) incidence increased from 1.2 to 3.4 per 1000 hospital live births.[2] Ideally, obstetrical care for pregnant women who use opioids should be provided in the context of comprehensive care programs that include prenatal care, specialized drug addiction treatment, mental health care, and health education.[3] However, most pregnant women who use opioids in the United States are not enrolled in such programs.

Pregnancy presents providers the opportunity to screen for and assess substance use, to offer brief intervention, and to refer women to specialized treatment as indicated (Table 1). Obstetrics providers have a unique opportunity to incorporate these services into routine obstetrical care and to coordinate specialized treatment for their patients who use opioids throughout pregnancy and into the postpartum period. Research on pregnant women with opioid use disorders has focused largely on supportive care and opioid-agonist pharmacotherapy.[4] We review clinical care issues that are related to illicit and therapeutic opioid use among pregnant women and women in the postpartum period and outline the major responsibilities of obstetrics

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TABLE 1
Case examples for various points of contact

Prenatal care	Triage	Labor and delivery
Cases		
A 32-year-old G3P2 came for an initial prenatal visit at 7 weeks' gestation. She started taking prescribed oxycodone for low back pain 4 years ago after the birth of her second child. After 1 year of taking the medication as prescribed, she began to run out early and started buying the medication from a coworker. She now takes 12-15 oxycodone tablets daily. When she found out she was pregnant, she tried to stop on her own; however, after 3 days, she became very sick and returned to her use.	A 24-year-old G1P0 was examined at 20 weeks' gestation because of vaginal bleeding. She has made several prenatal care appointments but had missed them all. She had been using methadone maintenance pharmacotherapy on and off over the past 4 years and was enrolled currently in a methadone maintenance program that she attended daily.	A 23-year-old G4P2 was seen at 34 weeks' gestation in active labor. She indicated that this was her first contact with an obstetrical provider since becoming pregnant. She appeared intoxicated and admitted to heroin use.
Necessary elements of obstetrics care		
Review medical care	Review medical care	Review medical care
Review obstetrical care	Review obstetrical care	Review obstetrical care
Screen for drug use	Screen for drug use	Screen for drug use
Screen for comorbid conditions	Screen for comorbid conditions	Screen for comorbid conditions
Screen for social service needs	Screen for social service needs	Screen for social service needs[a]
Refer to specialist care	Refer to specialist care	Refer to specialist care[a]
Sexually transmitted infection prevention counseling	Sexually transmitted infection prevention counseling	Sexually transmitted infection prevention counseling[a]
Contraceptive counseling	Contraceptive counseling	Contraceptive counseling[a]
Pain management for back pain	Pain management for labor and delivery	Pain management for labor and delivery
Breastfeeding counseling	Breastfeeding counseling	Delivery
Referral to postpartum care	Referral to postpartum care	Breastfeeding counseling
		Referral to postpartum care

[a] After delivery.

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providers who care for these patients. This article represents the formal conclusions from the proceedings of the *Expert Meeting on Perinatal Illicit Drug Abuse* that was convened by the US Centers for Disease Control and Prevention in Atlanta in September 2012.

Prenatal care

Pregnant women who use opioids should receive all elements of routine prenatal care (Tables 1 and 2). Because they often are judged by family and friends, feel guilt, and experience stigma for their substance use during pregnancy, they may expect to be similarly judged and poorly treated by healthcare providers. Providers who project a caring and nonjudgmental attitude can build strong rapport with these patients, engender trust, and facilitate effective communication.[5] This approach decreases patient anxiety, improves effective coping abilities, yields more productive patient-provider interactions, improves prenatal care attendance, and leads to better clinical outcomes.[6] Techniques to build empathy with even the most difficult patients include establishing and maintaining eye contact, allowing the patient to speak without interruption, using nonverbal cues (eg, nodding) to indicate active listening, using the patient's own words to summarize what was heard, and asking for any needed clarification.[5,7] The use of simple language to convey instructions and the reason for and the nature of any anticipated medical procedures helps to build trust and may improve adherence to treatment and care.[8,9]

Importantly, excellent patient-provider rapport increases the likelihood that the patient will disclose an accurate history of licit and illicit substance use. Verbal, written, or computer-assisted questioning about patient history and current drug use is the gold standard for substance-use screening. Urine drug testing can also identify women who use drugs, but it should never replace written or verbal screening because biologic tests cannot diagnose a drug-use disorder or its severity, nor can it determine use quantity, frequency, or route of administration of a given drug. Before urine drug testing, providers should obtain the patient's consent and explain the reasons for and limitations of any such test. Because false-positive rates for these tests can be as high as 5%, a