

Screening, brief intervention, and referral to treatment for opioid and other substance use during infertility treatment

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Opioid use and misuse have reached epidemic proportions in the United States, especially in women of childbearing age, some of whom seek infertility treatments. Substance use is much more common than many of the conditions routinely screened for during the preconception period, and it can have devastating consequences for the woman and her family. Substance use can worsen infertility, complicate pregnancy, increase medical problems, and lead to psychosocial difficulties for the woman and her family. The reproductive endocrinologist thus has an ethical and medical duty to screen for substance use, provide initial counseling, and refer to specialized treatment as needed. This article provides an overview of screening, brief intervention, and referral to treatment (SBIRT), a public health approach shown to be effective in ameliorating the harms of substance use. (Fertil Steril® 2017; ■:■-■. ©2017 by American Society for Reproductive Medicine.)

Key Words: Assessment, alcohol use, infertility, opioid use disorders, SBIRT, tobacco use

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Substance use is common in women of childbearing age. Approximately 55% of women drink alcoholic beverages, 23% smoke cigarettes, and 10% use either illicit drugs or prescription drugs without a prescription (1). Although most women are able to quit or cut back harmful substances during pregnancy and pregnancy attempts, many are unwilling or unable to stop. National survey data indicate that during pregnancy, 10% of women drink alcohol (4% binge, i.e., have five or more alcoholic drinks on the same occasion on at least 1 day in the past 30 days.), 15% smoke cigarettes, and 5% use an illicit substance (1). This makes substance use as or more common than many conditions routinely screened for and assessed dur-

ing preconception and prenatal care, such as rubella, cystic fibrosis, diabetes, thyroid disease, anemia, postpartum depression, or preeclampsia. Moreover, substance use during pregnancy is both costly and harmful. Substance use during pregnancy is associated with poor pregnancy outcomes, including preterm birth, low birth weight, birth defects, developmental delays, miscarriage, and neonatal abstinence syndrome (NAS) (2). Long-term effects on the mother and infant include medical, legal, familial, and social problems, some of which are lifelong and costly (2, 3). The United States is currently in the midst of an epidemic of opioid use, overdose deaths (4), and NAS (5). Because of increased opioid prescribing by physicians, many

women have developed an opioid use disorder (6). These women are often seen by reproductive endocrinologists for infertility and chronic pain.

Few data are available describing the incidence of substance use and substance use disorders (SUDs) in women undergoing infertility treatments, but it has been shown that women with infertility are at higher risk of developing alcohol use disorders (7) and likely opioid use disorders as well. This is logical given that many of the risk factors for substance use are more common in women with infertility, including depression (8, 9), anxiety (10), older age, and higher education levels (11).

In addition, several addictions increase the risk of infertility, including tobacco use, alcohol misuse, marijuana use, and opioid use and misuse. Tobacco use by women has been shown to delay conception by a year or more (12) and doubles the risk of infertility as well as decreases ovarian reserve (13). Alcohol use disorders are associated with a broad spectrum of

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reproductive disorders, including amenorrhea, anovulation, luteal phase dysfunction, hyperprolactinemia, increased risk of spontaneous miscarriage, and impaired fetal growth and development (i.e., fetal alcohol syndrome) (10). Marijuana has been shown to increase menstrual irregularity as well as decrease oocyte retrieval (14). Opioids have a direct effect on the hypothalamic-pituitary axis, thus increasing the incidence of oligomenorrhea and irregular menses (15). Not only are women with SUDs seen more often by reproductive endocrinologists, they are also more likely to have worse outcomes from infertility treatments than women without SUDs.

As women are more likely to be prescribed opioids for chronic pain (16, 17), have a greater incidence of chronic pain conditions such as fibromyalgia, chronic pelvic pain, and migraine headaches (17), and require more opioids for the treatment of pain (16), many women with infertility will be using opioids, either by prescription or illicitly. One study showed that 10% of women had been prescribed an opioid pain reliever during the prenatal period (18). Currently in the United States on average 21,000 women per month (0.9%) use opioids during pregnancy (19). Opioid use during pregnancy is associated with preterm birth, poor prenatal care, and neonatal opioid withdrawal syndrome (NOWS) also known as NAS (2, 19). As NOWS incidence is at epidemic proportions (5), clearly prevention of opioid-exposed pregnancies is of utmost importance in stanching this epidemic.

Given that, by definition, pregnancies conceived with infertility treatments are planned, preconception counseling should include screening for substance use. Providers of infertility treatments have an ethical obligation to screen for and provide referral to treatment of couples who may not provide a healthy home environment for the children created by artificial means (20). Parents with substance use disorders are more likely to have child welfare involvement for maltreatment and neglect as well as family disruption. Though substance use in of itself should not be construed as child abuse (21), the risk for child abuse is 2 to 13 times higher for children when one or both parents have SUDs (22).

Substance use disorders are a chronic relapsing condition similar to diabetes, hypertension, or asthma. Just as infertility providers would ask about these conditions and refer to treatment to ensure the mother is at optimum health before infertility treatments, the infertility provider should screen for substance use, counsel on safe and unsafe use, and refer to treatment if needed. This article provides a practical approach to screening for harmful substance use that may interfere with fertility, prove harmful to the developing fetus, and prove detrimental to the family unit if not treated. In addition, the article educates infertility providers in screening, brief intervention, and referral to treatment (SBIRT), a public-health approach to substance use that has been shown to decrease harmful substance use and improve pregnancy outcomes (23, 24).

SCREENING

Screening for substance use should be universal, as SUDs occur in every socioeconomic class and racial and ethnic group, and, as mentioned earlier, may be even more common among women seeking infertility treatments. Moreover, screening

based on “risk factors” such as late entry to prenatal care or prior poor birth outcome potentially leads to missed cases and can exacerbate stigma and stereotype (25). Universal screening is recommended by many professional organizations, including the American Society for Reproductive Medicine (ASRM) (20), American College of Obstetricians and Gynecologists (ACOG) (21), the American Academy of Pediatrics (AAP) (26), the American Medical Association (AMA) (27), and the U.S. Centers for Disease Control and Prevention (CDC) (28). Screening for tobacco use, at-risk drinking, illicit drug use, and prescription drug misuse should occur at the initial consultation visit as well as periodically during the course of infertility treatment, especially after failed courses of treatment.

Most of the studies looking at screening have focused on using instruments, such as TWEAK (T = tolerance, W = worried, E = eye-opener, A = amnesia, K = cut down) (29) or T-ACE (T = tolerance, A = annoyed, C = cut down, E = eye-opener) (30). These instruments have the advantage of being validated, and most are fairly sensitive though they only screen for alcohol (and only heavy alcohol use). The CAGE (31) questionnaire (C = cut down, A = annoyed, G = guilt, E = eye opener) that most were taught in medical school has not been validated in pregnant women. The Alcohol Use Disorders Identification Test (AUDIT-C) is a short, three-question test that can be used to screen for alcohol use with a cutoff of 0 for pregnant women and ≥ 3 for nonpregnant women (32) (Fig. 1).

The 4Ps screener (33) (Table 1) and modifications (34) have been extensively studied in pregnancy and have the advantage of being able to be added into an intake form, such as the ACOG intake form, in an innocuous and often effective way (as will be discussed in the section on assessment). It also screens for other substances besides alcohol. This initial screening can be done by anyone in the practice, with follow-up evaluation by the provider.

The barriers to implementing instrument-based screening include patient discomfort and lack of literacy, staff resistance due to time pressures, and organizational issues such as lack of administrative support (35). Integration into the practice’s flow can be eased by incorporating screening tools into the electronic medical record systems (EMR) or by using a computer-based approach, which may diffuse the discomfort women feel in disclosing a behavior about which they are embarrassed, but this has not been compared with clinician-administered screening in pregnant women (36). All positive screens require follow-up evaluation by the provider.

To counteract some of the institutional barriers to instrument-based screening, Wright et al. (23) recommended using three open-ended questions regarding use of tobacco, alcohol, and other drugs (the NIDA Quick Screen) (29): “In the past year how many times have you drunk more than 4 alcoholic drinks per day? Used tobacco? Taken illegal drugs or prescription drugs for non-medical reasons?” Again, this can be easily incorporated into the initial intake paperwork; just as a provider would go over a patient’s relevant health history, this can be reviewed and positive answers explored in more detail. Women are also more likely to report lifetime use or use before their pregnancy attempts than they are to disclose use during pregnancy because of the risks and stigma involved.

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