No. 349, October 2017 (replaces No, 256, April 2011)

No. 349-Substance Use in Pregnancy

This Clinical Practice Guideline has been prepared by the principal authors and reviewed by the Maternal-Fetal Medicine, Clinical Practice—Obstetrics, Medico-Legal, and Guideline Management and Oversight committees* and approved by the Board of The Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Pregnancy, substance-related disorders, substance use, neonatal abstinence syndrome

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J Obstet Gynaecol Can 2017;39(10):922–937

https://doi.org/10.1016/j.jogc.2017.04.028

Abstract

Objectives: To improve awareness and knowledge of problematic substance use in pregnancy and to provide evidence-based recommendations for the management of this challenging clinical issue for all health care providers.

Options: This guideline reviews the use of screening tools, general approach to care, and recommendations for the clinical management of problematic substance use in pregnancy.

Outcomes: Evidence-based recommendations for screening and management of problematic substance use during pregnancy and lactation.

Evidence: Updates in the literature were retrieved through searches of Medline, PubMed, and The Cochrane Library published from 1996 to 2016 using the following key words: pregnancy, electronic cigarettes, tobacco use cessation products, buprenorphine, and methadone. Results were initially restricted to systematic reviews and RCTs/controlled clinical trials. A subsequent search for observational studies was also conducted because there are few RCTs in this field of study. Articles were restricted to human studies published in English. Additional articles were located by hand searching through article reference lists.

Values: The quality of evidence was rated using the criteria described in the Report of the Canadian Task Force on Preventive Health Care. Recommendations for practice were ranked according to the method described in that report.

Benefits, Harms, and Costs: This guideline is intended to increase the knowledge and comfort level of health care providers caring for pregnant women who have substance use disorders. Improved access to health care and assistance with appropriate addiction care lead to reduced health care costs and decreased maternal and neonatal morbidity and mortality.

Recommendations

1. All pregnant women and women of child-bearing age should be asked periodically about alcohol, tobacco, prescription, and illicit drug use (III-A).
2. When testing for substance use is clinically indicated, urine drug screening is the preferred method (II-2A). Informed consent should be obtained from the woman before maternal drug toxicology testing is ordered (III-B).

Table 1. Key to evidence statements and grading of recommendations, using the ranking of the Canadian Task Force on Preventive Health Care

Quality of evidence assessment[a]	Classification of recommendations[b]
I: Evidence obtained from at least one properly randomized controlled trial.	A. There is good evidence to recommend the clinical preventive action.
II-1: Evidence from well-designed controlled trials without randomization.	B. There is fair evidence to recommend the clinical preventive action.
II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group.	C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.
II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in the category.	D. There is fair evidence to recommend against the clinical preventive action.
III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.	E. There is good evidence to recommend against the clinical preventive action.
	I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

Taken from: Task Force on Preventive Health Care. New grades for recommendations from the Canadian Task Force on Preventive Health Care. CMAJ 2003;169:207e8.

[a]The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

[b]Recommendations included in these guidelines have been adapted from the Classification of recommendations criteria described in the Canadian Task Force on Preventive Health Care.

3. Policies and legal requirements with respect to drug testing of newborns may vary by jurisdiction, and caregivers should be familiar with the regulations in their region (III-A).
4. Health care providers should employ a flexible and harm reduction approach to the care of pregnant women who use alcohol, tobacco, or drugs. Pregnant women at risk for problematic substance use should be offered brief interventions and referral to community resources for further psychosocial interventions (II-2B).
5. Women should be counselled about the risks of periconception, antepartum, and postpartum substance use (III-B).
6. Health care providers should offer smoking cessation interventions to all pregnant smokers. Psychosocial interventions should be considered first-line (I-A). Nicotine replacement therapy and/or pharmacotherapy can be considered if counselling is not successful (I-A).
7. The standard of care for the management of opioid use disorders during pregnancy is opioid agonist treatment with methadone or buprenorphine. Other sustained-release opioid preparations are also an option if methadone or buprenorphine is not available (I-A).
8. Opioid detoxification should be reserved for selected women because of the high risk of relapse to opioids (II-2B).
9. Opioid-dependent women should be informed that neonates exposed to heroin, prescription opioids, methadone, or buprenorphine during pregnancy are monitored closely for symptoms and signs of neonatal withdrawal (neonatal abstinence syndrome) (II-2B). Hospitals providing obstetric care should develop a protocol for assessment and management of neonates exposed to opioids during pregnancy (III-B).
10. Women who become pregnant while on methadone should continue on methadone maintenance therapy and should not switch to buprenorphine due to the risk of opioid withdrawal (I-A).
11. Women who become pregnant while on buprenorphine/naloxone should be switched to buprenorphine monoproduct. Combination product should be continued until the monoproduct becomes available. Women taking buprenorphine should only switch to methadone if the buprenorphine monoproduct is not accessible and/or the woman feels that she is not responding to the current treatment (II-1A).
12. Health care providers should advise pregnant women to abstain from or reduce cannabis use during pregnancy to prevent negative long-term cognitive and behaviour outcomes for exposed children (II-1A).
13. Antenatal planning for intrapartum and postpartum analgesia may be offered for all women in consultation with appropriate health care providers (III-B).
14. Pregnant women on opioid agonist treatment should be encouraged to breastfeed regardless of the maternal dose, in the absence of an absolute contraindication (II-2B). Women with active substance use should be encouraged to discontinue alcohol or other drug use while breastfeeding, and the risks and benefits of breastfeeding versus breast milk exposure to substances should be discussed (II-2B).

ABBREVIATIONS

ATOD	alcohol, tobacco, and other drugs
BI	brief intervention
HCV	hepatitis C virus
HIV	human immunodeficiency virus
MMT	methadone maintenance therapy
NAS	neonatal abstinence syndrome
NRT	nicotine replacement therapy
OAT	opioid agonist treatment
RCT	randomized controlled trial
UDS	urine drug screening
WHO	World Health Organization