Treatment of Perinatal Opioid Use Disorder

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KEYWORDS

• Opioid use disorder • Pregnancy • Medication-assisted withdrawal • Buprenorphine • Methadone • Opioid agonist therapy

KEY POINTS

- Identification of perinatal opioid use disorder is improved by using validated screening questionnaires, understanding the limitations of urine drug screens, reviewing prescription drug monitoring programs, and nonjudgmental clinical care.
- Opioid agonist therapy is the standard of care for pregnant women with Opioid Use Disorder, however medication- assisted withdrawal is an increasingly common practice.
- Based on available data and addiction clinical care, we provide guidance for obstetricians to assist pregnant women in making an informed medication treatment choice that is best for women and their families.
- Choosing a treatment to assist pregnant women in their recovery ultimately produces the best outcome for women and their children.

INTRODUCTION

The epidemic of opioid use, misuse, and opioid use disorder (OUD) in the United States is well-known to extend into pregnancy. Prescription opioids are dispensed by pharmacies to 14.4% to 21.1% of all pregnant women.[1,2] Pregnant women dispensed 2 or more prescription opioids suggesting a long-term pattern of opioid use, occurs in 3% to 5% of women and has increased 4-fold over the past decade.[1] The prevalence of opioid abuse or dependence among pregnant women has more than doubled from 1.7 per 1000 deliveries in 1998 to 3.9 per 1000 deliveries in 2011 with the most substantial increase occurring in 20- to 34-year-old women.[3] All indications are that these rates are still rising.

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Perinatal OUD is a major public health problem because of its impact on maternal, fetal, newborn, and child health, as well as excessive use of health care resources.[3,4] Extant literature describing the maternal, obstetric, and newborn risks associated with OUD is well-established and is associated with a 4.6-fold increased risk for maternal death at delivery as well as an increased risk for intrauterine growth restriction, placental abruption, prematurity, blood transfusion, stillbirth, cesarean delivery, preeclampsia, or eclampsia.[3] A well-known consequence of opioid use in pregnancy is newborn opioid withdrawal syndrome (NOWS), formally known as neonatal abstinence syndrome, with 60% of newborns exhibiting withdrawal symptoms after delivery.[4] Over the past decade, the incidence of NOWS in the United States has increased approximately 400%, from 1.2 per 1000 hospital births in 2000 to 5.8 per 1000 hospital births in 2012. In 2012, on average, 1 infant was born every 25 minutes in the United States with signs of opioid withdrawal, costing $1.5 billion dollars, with Medicaid covering 80% of these costs.[4]

Despite the significant and costly maternal, fetal, and newborn effects of perinatal OUD, there is a paucity of comprehensive treatment programs for pregnant women with substance use disorders.[5–7] Only 19 states have funded substance abuse treatment programs for pregnant women, and only 12 states provide priority to pregnant women to receive substance abuse treatment.[5–7] Further, stigma is a potent barrier to care as well as lack of adequate childcare and fear of criminal or child welfare consequences.[5] As a result, few pregnant women receive treatment for substance use disorders during pregnancy.

The challenges of identifying, managing, and treating OUD combined with the paucity of treatment resources for this population places an unfair burden on front-line obstetricians. Additionally, treatment with opioid agonist therapy (eg, methadone or buprenorphine) versus medication-assisted withdrawal is controversial. Front-line providers are currently providing care to this population and would greatly benefit from practical clinical guidance based on the current evidence.

In this article, we provide front-line providers with practical clinical information to assist in the identification and treatment of pregnant women with OUD. In addition, we review the evidence to date examining the risks and benefits of opioid agonist therapy and medication-assisted withdrawal for the treatment of perinatal OUD. We provide practical clinical tools for patients and providers to help guide medication treatment choices. We provide further guidance on how to counsel patients about these treatment choices as well as the need for relapse prevention therapy and regular follow-up care for the treatment of OUD.

SCREENING FOR SUBSTANCE USE

Validated Screening Questionnaires

Early identification of pregnant women with opioid use is vital to improving outcomes for mothers, infants, and children. National and international organizations including the American College of Obstetricians and Gynecologists, Substance Abuse and Mental Health Services Administration, American Society for Addiction Medicine, World Health Organization, and United Nations recommend routine universal screening for substance use performed in partnership, and with the consent of, pregnant women using brief validated screening tools and mutual dialogue.[8–14] These professional organizations recommend screening at the initial prenatal care visit, and at several points throughout prenatal care, to facilitate the early identification and implementation of comprehensive prenatal and substance abuse treatment.[8,10,11,15] Although there are many validated instruments to screen for alcohol use during