Safety Action Series

An Interdisciplinary Look at Obstetric Care for Women with Opioid Use Disorder
Speakers

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Disclosures

- Jessica Coker, MD has no real or perceived conflicts of interest.

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Objectives

- Brief Review of Pain Basics
- Discuss Methods to Reduce Opioid Use and Prescriptions for OUD Prevention
- Brief Review of treating Opioid Use Disorder (OUD) during pregnancy
- Review prenatal, intrapartum, and postpartum clinical pathways for women with OUD
- Examine safe pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics
A Case Example

- 30 year-old G2P1 presents at 39+0wga for scheduled repeat Cesarean delivery.
- History of chronic pain on chronic opioids (Oxycodone 10mg TID)
- Chronic pain related to MVA trauma requiring pelvic reconstruction and hardware. Awaiting revision until after pregnancy.
- In PACU after uncomplicated Cesarean Delivery, reports uncontrolled pain
- Consulted Women Health Psychiatry who has been managing her chronic pain during pregnancy
- Started on Fentanyl patch 25mcg and hydromorphone PCA continued until steady state with the patch and plan to transition to oral opioids once pain controlled
Case, continued

- On POD#1 pain continued and Fentanyl patch increased to 75mcg per Women’s Health Psychiatry and PCA discontinued. Transitioned to as needed IV hydromorphone 1mg Q2hr
- POD#2: Fentanyl patch in place, plan to transition to oral oxycodone. Diagnosed with postpartum endometritis and received antibiotic therapy and current pain regimen continued
- POD#3: IV hydromorphone tapered from 1mg to 0.5mg. Oxycodone 30mg Q4 hours prn breakthrough pain started
  - Equal-analgesic dosing for the IV hydromorphone she had been requiring
- Goal: taper to her baseline Oxycodone dosing by 5-7 days postpartum
  - Daily taper of the Oxycodone
  - Set boundary to remove the prn or “once only” doses of IV opioids
Pain Basics

• Definition: unpleasant sensory and emotional experience associated with actual or potential tissue damage

• Classified on duration, location, etiology & intensity

• Acute Pain
  – Present less than 6 months
  – Main area of focus for postpartum/postsurgical pain management

• Chronic Pain
  – Present more than 6 months, persisting beyond acute disease, or after completion of tissue healing

[Diagram of pain measurement scale]
Pain Basics

• Subjective
  – No test available to measure
  – Rely on patient report of severity and description

• 3 Types of Pain
  – Nociceptive: Visceral or Somatic
  – Neuropathic
  – Inflammatory

http://projects.hsl.wisc.edu/GME/PainManagement/index.html
Postpartum Pain Management: 
ACOG Committee Opinion 742

• Pain and fatigue most common problems women report in early postpartum period
• May interfere with ability to care for herself and infant
• Untreated pain associated with increased risk of:
  – Persistent/chronic pain
  – Greater opioid use
  – Postpartum depression
• Lower Opioid Dose
  – Helps facilitate early ambulation
  – Improves a woman’s ability to care for her newborn
  – Minimizes drug transfer to breast milk
Postpartum Pain Management: ACOG Committee Opinion 742

- **Shared decision-making** approach to discharge opioid prescription can optimize pain control while decreasing number of pills prescribed
  - Stepwise approach enables effective, individualized care
  - Pain is multifactorial
- 1/300 opioid naïve women exposed to opioids after cesarean delivery become persistent opioid users
- **Opioids** should be reserved for treating breakthrough pain when combination of neuraxial analgesia and nonopioid adjuncts inadequate
Postpartum Pain Management: Multimodal Approach

- Mainstay of treatment is Multimodal Approach
- Early Recovery after Surgery (ERAS) protocols for post cesarean management includes multidisciplinary approach to improve postsurgical care
  - Associated with shorter length of stay
  - Commonly included elements:
    - Early oral intake
    - Mobilization
    - Removal of urinary catheter

References:

Reducing Opioid Use in the Postpartum Period: Vaginal Delivery

• Most common sources of pain: breast engorgement, contractions, perineal lacerations

• Examples of non-opioid pain management:
  – Cold Packs to the breasts, assess neonate’s latch if nipple pain severe
  – Heat packs on the abdomen
  – Topical anesthetics to the perineal laceration
  – Oral analgesics (NSAIDS, acetaminophen)

• Retrospective study of 1,345,244 women who underwent vaginal delivery found that 28.5% dispensed an opioid within 1 week of delivery

ACOG Committee Opinion Number 742: Postpartum Pain Management. Obstetrics & Gynecology: Vol 132, No. 1, July 2018
Reducing Opioid Use in the Postpartum Period: Cesarean Delivery

• Neuraxial opioids provide greater postpartum analgesia
  – Many women require additional medications as analgesic diminishes
• Standard adjuncts: oral NSAIDS, acetaminophen, opioids
• Additional Adjuncts: Local Anesthetics with wound infiltration or transverse abdominis muscle block
• Single Dose Dexamethasone being incorporated into recovery protocols:
  – Reduces post-operative nausea/vomiting
  – Improves analgesia
• Opioids should be reserved for breakthrough pain on as needed basis
  – No longer recommended to schedule
Post-Cesarean Multimodal Regimen

• Scheduled NSAID
  – Ketorolac
    • Scheduled dosing for the first 24 hours postoperatively
  – Ibuprofen

• Scheduled Acetaminophen

• PRN opioid
  – Remove combination pills from order set
  – At UAMS we use oxycodone as the opioid

• Gabapentin not recommended for routine use as treatment for acute pain

ACOG Committee Opinion Number 742: Postpartum Pain Management. Obstetrics & Gynecology Vol 132, No. 1, July 2018
Opioid Prescribing Stewardship

• Overprescribing leads to leftover medications into communities for diversion, misuse, accidental ingestion

• Bateman et al found that only 50% of pills prescribed were consumed and that 95% of women had not disposed of the leftover pills at time of interview
  – Higher than previously report of 75% of patients not disposing properly of leftover opioids
  – Higher number of consumed pills when higher dispensed independent of patient characteristics
  – No correlation to patient satisfaction, pain control or need for refill (5%) and amount dispensed

• Osmundson et al found average duration of use was 8 days after discharge and 75% had excess pills remaining
  – Median equivalent of 10 remaining pills of 5mg oxycodone
Elimination of Routine Use of Opioids After Cesarean Delivery

• 2019 publication describing an institution initiative

• The Initiative:
  – Eliminated routine ordering of oral opioids after routine Cesarean delivery
  – Implemented Guidelines for ordering short course of opioids when deemed necessary
  – Coupling opioid prescribing at discharge to patterns of opioid requirement during hospitalization with shared decision-making

• Only 40% received discharge prescriptions compared to 91% pre-intervention

• Pain scores and patient satisfaction similar
• Fentanyl patch discontinued POD#3 after 72 hours in place.

• On POD#6, Oxycodone taper in place. Patient stated pain not well controlled, that she was pushing her self to do more to get home, that team not listening to her pain – Multidisciplinary meeting held with patient and her spouse.

• Goal discharge dose: Oxycodone 10mg Q6h prn severe pain with enough pills only to get to her outpatient appointment in 10 days with Women Health Psychiatry
Navigating the Difficulties of Patients with Chronic Pain Postpartum

• Be Cognizant of equal-analgesic dosing
• Set Goals for patient and reinforce
  – Initial post-operative goals: shower, ambulate, feed baby
• Utilize multidisciplinary approach
• Reinforce importance of adhering to discharge prescriptions and not taking beyond prescription
• Reinforce the concern for safety and avoiding development of substance use disorder
Opioid Stewardship is Key

The Opioid Epidemic in America

The Research Behind Understanding, Preventing and Treating Addiction

Data from the U.S. National Institute on Drug Abuse indicates:

- Roughly 21-29% of patients prescribed opioids for chronic pain misuse them
- Between 8-12% develop an opioid use disorder
- An estimated 4-6% who misuse prescription opioids transition to heroin
- Approximately 80% of people who use heroin first misused prescription opioids


https://ngageittec.com/2018/05/deep-dive-the-opioid-tsunami/
The rate of overdose deaths among women rose 20% in one year.

Opioid use disorder has gone up more than 4 times among pregnant women.

4 times as many infants were born with neonatal abstinence syndrome (NAS) in 2014 than in 1999.

Health Outcomes

Opioid use disorder during pregnancy has been linked to:

- Preterm Birth
- Low Birthweight
- Breathing Problems
- Feeding Problems
- Maternal Mortality

Medication-assisted treatment is STANDARD OF CARE for ANYONE at risk of relapse

- Goal = reduce risk of relapse and increase adherence to prenatal care
- Both methadone and buprenorphine are options
- “Neonatal abstinence syndrome is an expected and treatable condition”
Medication ASSISTED Treatment

RECOVERY VERSUS SOBRIETY

What is the goal for treatment?
SOBRIETY

RECOVERY
Challenges during Labor and Delivery

- Patient education on Neonatal Abstinence Syndrome
- Contraception Education
- Breastfeeding Education
- Peripartum Pain Relief
- Risk of Relapse in the Postpartum Period
- Management of Neonatal Abstinence Syndrome
Mechanism of Action of BUP vs. other Opioids

Buprenorphine MOA

Full agonist: Heroin and others

Partial agonist: Buprenorphine

Ceiling effect
- Limit to respiratory depression
- Safety
- Limit to euphoric effects
- Patients can limit intake

Mechanism of Action of BUP vs. other Opioids

Buprenorphine MOA

*Also includes morphine, oxycodone, etc.

Pain Relief Strategies during Delivery

• Evidence base is very limited, NO RCTs
• UpToDate → most completed reference
• Opioid requirements may be 30 to 100 percent higher
• Co-morbid substance use (tobacco) and psychiatric disorders make this more complicated
• More challenging when women are taking BUP

Vaginal Delivery

• Nonopioid analgesics
• Acetaminophen, ibuprofen, ketorolac
• Topical anesthetics
• Scheduled medications for the first few days are typically more helpful than PRN
Cesarean Delivery

- Institutional Variability, multiple approaches
- Non-opioid analgesics, scheduled
- Opioids have been used including: hydromorphone, oxycodone, morphine, tramadol
- If these opioids are used, may need to get over the “buprenorphine hump”
Our Approach (Scheduled/Unplanned)

- Epidural with combination of bupivacaine + fentanyl + clonidine
- Epidural remains placed for at minimum 24 hours
- **At time of surgery**, fentanyl 50 or 75 mcg patch is placed on patient (takes 12-14 hours for effect), may need 2\textsuperscript{nd} one on POD\#3.
- Scheduled non-opioid analgesics
- Stop buprenorphine and restart once fentanyl patch is removed
CLINICAL GUIDANCE FOR TREATING PREGNANT AND PARENTING WOMEN WITH OPIOID USE DISORDER AND THEIR INFANTS

Conclusions

• Pregnant women with opioid use have challenges during the perinatal period

• Opioid stewardship is important for all providers

• Medication assisted treatment + therapy is essential for recovery

• Future research focusing on pain management during the postpartum period is needed; however, proactive education and support is crucial
Q&A Session

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