

Opioid use During Pregnancy: Highlights from new Clinical Practice Guidelines

The Society of Obstetricians and Gynaecologists of Canada



INTRODUCTION

- As the world continues to struggle with the opioid epidemic, studies suggest an increasing trend of opioid use among pregnant women worldwide.
- Overdose is a leading cause of maternal death, yet most health care providers do not receive specific training in evidence-based opioid use disorder (OUD) screening or treatment during pregnancy and the post-partum period.
- Opioid use during pregnancy is associated with adverse maternal and fetal outcomes, including preterm birth, small for gestational age; opioid use may affect neurodevelopment with life-long impacts.

AIM

This study was designed to develop evidence-based recommendations for obstetrical providers related to opioid use during pregnancy and breastfeeding.

METHODS

- PubMed and the Cochrane Library databases were searched from August 2018 until March 2023 using following MeSH terms and keywords (and variants): opioids, illicit drugs, fertility, pregnancy, breastfeeding, and aging. Recommendations were developed, based on evidence, and geared toward healthcare providers caring for pregnant/post-partum patients.
- Recommendations for clinical practice were developed and the evidence was summarized.
- The authors rated the quality of evidence and strength of recommendations using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach.
- The Guidelines will be published in the *Journal of Obstetrics and Gynaecology Canada* in August 2023.

HIGHLIGHTS FROM SUMMARY STATEMENTS:

- Pregnant women who use illicit opioids are at increased risk of sexually transmitted infections, being victims of and/or participating in violence and other illegal activity, concurrent mental health disorders, polysubstance use, poor nutrition, and reliance on social assistance.
- During pregnancy, physiological changes can affect the pharmacokinetic properties of opioids.
- Prenatal opioid exposure can cause neonatal opioid withdrawal syndrome.
- Patients undergoing opioid agonist therapy may require higher doses of short-acting opioids for analgesia or high-affinity opioids for pain management.
- Opioids are safe for pain control in labour for pregnant patients on opioid agonist therapy; but higher doses may be required than in those who are opioid-naïve.
- To help pregnant patients transition from illicit opioid use to oral opioid agonist therapy in the antepartum period, methadone or slow-release oral morphine may be preferable to buprenorphine/naloxone, as they do not require a period of opioid abstinence before beginning therapy.

HIGHLIGHTS FROM RECOMMENDATIONS:

- HCPs should conduct **universal screening** for substance use and OUD in pregnant patients.
- HCPs must **discuss risks and benefits** of prescribed opioids for chronic pain with pregnant patients.
- For treatment of opioid-responsive chronic pain and opioid agonist therapy for OUD, HCPs should start treatment at the **lowest effective dose and increase dose as the pregnancy progresses** because of associated physiological changes; the infant should be observed for signs of withdrawal.
- HCPs should **consider the suppression of fetal heart rate due to opioids** and reduced variability and accelerations in fetal heart rate at the opioid's biological peak.
- HCPs should **recommend epidural analgesia early in labour** for women with OUD; this may mitigate the hyperalgesia caused by chronic opioid use.
- HCPs should **recommend treatment with opioid agonist therapy for pregnant patients with OUD**; buprenorphine/naloxone in pregnancy is safe.
- HCPs should **not taper the opioid dose or to detoxify patients with OUD during pregnancy**, but the patient may make an informed decision to undergo this process, and the opioid dose should be slowly tapered to the lowest effective dose.
- Although there is a paucity of research on naloxone rescue medication in pregnancy, **naloxone should be administered** by any trained bystander or medical professional for resuscitation if opioid overdose is suspected in a pregnant patient, as preventing the mother's death from opioid overdose is the top priority.

GAPS IN EVIDENCE:

- Use of opioid antagonists (naltrexone and naloxone) for pregnant women with opioid use disorder remains understudied, and there are gaps in knowledge concerning the safety and efficacy of opioid antagonists in pregnant women.
- Effects of prenatal exposure, including impacts of neonatal withdrawal, have not been well-established with respect to long-term effects, including epigenetics.
- More information is required on the safety and effects of naloxone rescue during pregnancy.

CONCLUSIONS

- Opioid use during pregnancy and in the postnatal period presents a unique set of complex challenges, necessitating specific expertise and counseling for clinical management (i.e., methadone treatment, pain management during labour, neonatal opioid withdrawal syndrome, nutritional status, and maternal withdrawal).
- Comprehensive programs that offer prenatal care, opioid treatment, and psychosocial interventions are the best option for pregnant patients with opioid use disorder.
- Exploring opioid use through a trauma-informed approach provides the health care provider and patient with an opportunity to build a strong, collaborative, and therapeutic alliance.
- It is important that HCPs understand the impact opioids can have on pregnant women and support them to make knowledgeable decisions about their health.

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