ECHO Idaho: Perinatal Substance Use Disorder

Labor and Pain Management Considerations

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Learning Objectives

• Review the physiologic considerations of pain of pain management with substance use
• Review options in labor and delivery
• Review options for management of postpartum and post surgical pain
• Review breast feeding considerations
Complex patients

• Chronic Opioid Use
  – Medical Prescription
  – Medical Addiction Treatment
  – Non-Prescribed Illicit
  – Not Disclosed
  – Recovery

• Polysubstance Use

• Mental Health Treatment
  – Antidepressants
  – Anxiolytics
  – Sedatives
  – Antipsychotics

• Disadvantaged & Distressed
  – Incarcerated
Opioids

• Modified approach will be required and is an important consideration
• But....
• Not a reason for inappropriate selection
• Not a reason for withholding
• Not a reason for inadequate dosing
Physiologic considerations

- **Hyperalgesia**: Increased sensitivity to pain often confused with drug seeking behavior and is not a marker of OUD. Hyperalgesia is distinct from tolerance or dependency.

- **Tolerance**: Tolerance is a state of adaptation in which exposure to opiates induces changes that result in a diminution of one or more of the drug’s effects over time.

- **Dependency**: Physical dependence is a state of adaptation that is manifested by a specific withdrawal syndrome – abrupt cessation, rapid dose reduction, decreasing blood level of an opiate, and/or administration of an opiate antagonist.

- **Opioid Debt**: Patients who are physically dependent on opioids must be maintained on daily equivalence (“opioid debt”) before ANY analgesic effect is realized with opioids used for acute pain management.
Labor

• Any patient receiving methadone or buprenorphine should not reduce or change their dose
• Nitrous oxide is appropriate and is encouraged
• IV narcotics – fentanyl, hydromorphone or similar short acting agents but may require higher doses
• Neuraxial analgesia (epidural) is appropriate
  – It has been shown to be effective for most women although more boluses may be required.
WARNING:

• Do not use agonists/antagonists such as nalbuphine (Nubain) or butorphanol (Stadol) because they may induce acute withdrawal in opioid dependent patients
Postpartum – Vaginal Delivery

• Continue usual daily maintenance dose of methadone or buprenorphine.
  – Split dosing of the usual daily maintenance dose may help with pain management
    • Every 6 hours for buprenorphine
    • Every 12 hours for methadone

• Use of NSAID's and acetaminophen is recommended

• Access to short acting opioids during the first 24 hours

• Dose requirements may be a higher due to lower pain tolerance.

• Breast feeding is encouraged in women receiving methadone or buprenorphine
Cesarean

- Any patient receiving methadone or buprenorphine should not reduce or change their dose prior to scheduled cesarean.
- Neuraxial analgesia (epidural or spinal) is appropriate for scheduled cesarean delivery.
Post operative cesarean

• Continue usual daily maintenance dose of MAT
• Anticipate higher pain relief requirements first 24 hours
  – Neuraxial morphine use with neuraxial injection
  – Use of PCA or PCEA may be appropriate using short acting higher potency opioids such as morphine or hydromorphone.
  – Trans abdominis plane block (TAP) can be useful if available
• After 24 hours
  – NSAIDs and acetaminophen alternating
  – Use of higher potency short acting opioids orally with anticipated doses of 50-70% higher than other patients.
Pain Management After Discharge

- 7-day opioid prescriptions should be sufficient after C-section or extreme perineal trauma.
- Duration of pain treatment should be similar to other patients.
- Transfer patients as soon as possible to non-opioid pain medications.
- Scheduled Acetaminophen or NSAIDs with short acting opioids as needed is best practice

- Patients who request additional opioids should be evaluated for possible medical or surgical complications. Consider the presence of non-obstetric complications especially depression, anxiety, insomnia and substance use disorder.
Breast feeding

• Breast feeding is encouraged in all women receiving buprenorphine or methadone.
  – Minimal amounts of these medications make their way into breast milk.
  – Potentially prevent neonatal withdrawal
  – Buprenorphine specifically is not orally active

• Codeine and tramadol are contraindicated in patients who breast feed.

• Neonates should be monitored for drowsiness, inadequate weight gain, etc.
Key Points

• Continue usual daily maintenance dose of methadone or buprenorphine
• Chronic opioid exposure may require higher dosages of medication
• Agonists/antagonists such as nalbuphine (Nubain) or butorphanol (Stadol) may induce acute withdrawal
• Duration of pain treatment should be similar to other patients
• Breast feeding is encouraged in women receiving methadone or buprenorphine
References

• ACOG committee opinion number 711, August 2017. Opioid use and opioid use disorder in pregnancy.
• Ongoing pharmacological management of chronic pain in pregnancy. Bengt Kallen and Margareta Reis. Published online May 6, 2016. Springer International publishing Switzerland.
• Patient perspectives of acute pain management in the era of the opioid epidemic. Annals of emergency medicine volume 66 number 3 September 2015
Ongoing Resources List

• Resources from today’s session and past sessions can be found in our ongoing resources list.

• https://iecho.unm.edu/sites/uidaho/download.hns?i=388