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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



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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



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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.
- Opioid dependence and pregnancy: minimizing stress on the fetal brain. American Journal of obstetrics and gynecology March 2017.
- Ongoing pharmacological management of chronic pain in pregnancy. Bengt Kallen and Margareta Reis. Published online May 6, 2016. Springer International publishing Switzerland.
- Clinical correlates of prescription opioid analgesic use in pregnancy. Maternal child health Journal March 2015.
- Patient perspectives of acute pain management in the era of the opioid epidemic. Annals of emergency medicine volume 66 number 3 September 2015



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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>