Opioid Use in Pregnancy
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Over the past decade, opioid use has quadrupled in the United States, including increased use in pregnancy, leading to a fivefold increase in neonatal abstinence syndrome (NAS), a drug withdrawal that occurs in newborns exposed to opioids in utero (Reddy et al., 2017). Findings of a National Institute of Child Health and Human Development (NICHD) workshop of experts to evaluate opioid use in pregnancy and related neonatal and childhood effects were published in July 2017 (Reddy et al.), including optimal screening in pregnancy, complications of opioid use in pregnancy, and appropriate treatments for pregnant women with opioid use disorders (Reddy et al.).

There have long been concerns about targeted universal screening for substance use in pregnancy including inequities in screening among women of differing races or socioeconomic backgrounds. Pregnancy may be a rare time when a woman presents for medical care in a setting where follow up is built into the process and an opioid use disorder could be identified and treatment started (Reddy et al., 2017). The NICHD workshop participants agreed that universal screening for substance use of all types during pregnancy is ideal using validated screening tools and language so that women understand this question is asked of all who present for care (Reddy et al.).

The two most common medication-assisted therapies for opioid use are methadone and buprenorphine. Methadone has been used in pregnancy for decades but patients must be initiated on therapy as an inpatient or at a licensed outpatient methadone program (Reddy et al., 2017), both of which may present challenges. Buprenorphine can be prescribed by physicians in office settings, which can help access issues but may not get women into comprehensive addiction treatment (Reddy et al.). Newborns exposed to buprenorphine in utero had less severe symptoms of NAS than did those who were exposed to methadone including less total morphine requirements and shorter hospital stays (Reddy et al.).

Buprenorphine is the first-line treatment agent for opioid-dependent pregnant women who are accessing treatment for the first time, whereas methadone is recommended for pregnant women with a history of multisubstance abuse, previous failed attempts at detoxification, or who are currently on a methadone maintenance dose (Reddy et al.).

Labor analgesia can prove challenging, but efficacy of local anesthetics is not affected by opioid dependence. Opioids added into an epidural solution may not be as effective, so consideration may be given to using higher concentrations of local anesthetics or adding other nonopioid anesthetics to achieve adequate labor pain relief (Reddy et al., 2017). Postpartum pain relief requires use of nonsteroidal anti-inflammatory drugs (NSAIDs) with acetaminophen when safe and appropriate while continuing opioid maintenance treatments after vaginal births (Reddy et al.). For cesarean births, NSAIDs and acetaminophen when able and adding other nonopioid treatments such as gabapentin or nerve blocks may provide relief. When opioids are required, avoidance of “triggering” opioids like oxycodone is recommended with close observation for symptoms of oversedation (Reddy et al.). Postpartum is a time when opioid-naïve women are first exposed to opioids with recent data suggesting that 1 in 300 of these women will go on to become habitual opioid users (Reddy et al.).

Healthcare providers should be aware that many women do not disclose substance use in pregnancy because of fear of legal action, issues with custody, and the stigma surrounding this diagnosis (Reddy et al., 2017). Women should feel safe to access prenatal care without fear of legal or other ramifications related to disclosure of substance use (Reddy et al.). Nurses can advocate for pregnant women by explaining the screening process and promoting follow-up treatment as needed. A nonjudgmental caring nurse can be instrumental in supporting a pregnant woman and her baby through the process of treatment and withdrawal if it occurs.

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