Opioid Withdrawal in Pregnancy in Acute Care Settings

Additional Clinical Guidance

- Opioid use disorder (OUD) is a treatable health condition. It is best treated with methadone or buprenorphine.
- Buprenorphine and methadone are life-saving medications for OUD that reduce the risk of all-cause mortality and overdose death by over 50%.
- Recovery often requires multiple treatment attempts. A repeat encounter is not a treatment failure, but an opportunity to reinitiate potentially life-saving medication.
- If patients continue to use other opioids while on methadone or buprenorphine, a higher dose may be needed to manage their symptoms. Therapeutic dosing should be guided by adequate management of withdrawal and cravings.
- Opioid withdrawal is excruciating. Without swift and adequate intervention, patients may self-direct discharge and be at risk for overdose, pregnancy or delivery complications, harm to the fetus/newborn, and disruptions to the family system.
- The primary goal is to provide evidence-based, patient-centered care to perinatal patients with OUD, ensuring the safety and well-being of both patient and fetus/newborn. Medications for opioid use disorder (MOUD) enable stability, facilitate bonding, and support parental and infant health.
- Pregnant and parenting patients with OUD are highly stigmatized. Stigma prevents people from seeking care and worsens health outcomes. Providers should challenge biases to provide compassionate, evidence-based care.

Assessment

- Consider screening for sexually transmitted infections, including HIV, hepatitis C virus, syphilis, gonorrhea, and chlamydia. Consider linkage to PrEP as indicated.
- Consider screening for mental health comorbidities, including anxiety, depression, and post-traumatic stress disorder.

Labs

- Drug testing is not necessary to initiate treatment of OUD.
- If drug testing is performed for clinical reasons, obtain informed consent.
- In Washington State, drug use alone does not constitute a mandatory report to Child Protective Services (CPS).

Pharmacotherapy

- Buprenorphine is a partial opioid agonist that helps minimize withdrawal and lessen opioid cravings.
- Buprenorphine has a respiratory depression ceiling and a higher affinity for opioid receptors than full agonist opioids. High receptor affinity can cause precipitated withdrawal, but it is also a protective factor against overdose death. Competitive occupation alongside partial activation reduces the risk of opioid overdose when other opioids are consumed while a patient is taking buprenorphine. Even a single dose provides protection in the high-risk 24-48-hour window after discharge.
- Doses of 16-32 mg daily are considered most effective for most patients. Doses should be adjusted based on symptoms—if they are having ongoing cravings to use, a dose increase should be considered. Higher doses do not increase the risk of neonatal opioid withdrawal and are safe during breastfeeding.
- Buprenorphine metabolizes faster later in pregnancy. Patients may require higher doses or more frequent dosing (up to every 6 hours) of sublingual buprenorphine to maintain therapeutic levels.
- Patients with OUD have increased opioid tolerance and may require higher doses of opioids for effective pain management, including during labor, delivery, and postpartum.
- Both buprenorphine and combination buprenorphine/naloxone are safe during pregnancy and lactation.

Pathophysiology

- **Severe opioid withdrawal in pregnancy is extremely high risk.** Withdrawal in pregnancy can lead to severe complications, including:
  - Maternal autonomic instability and dehydration
  - Fetal hypoxia and distress; in rare cases, fetal demise
  - Uterine irritability triggering preterm labor
  - Unregulated opioid use that may result in overdose
  - Neonatal opioid withdrawal syndrome
  - Fetal growth restriction
  - Adverse epigenetic changes, potentially affecting long-term neurodevelopmental outcomes
- Perinatal patients with OUD are at increased risk for opioid overdose, particularly in the postpartum period, due to changes in opioid tolerance.
- Neonatal opioid withdrawal syndrome (NOWS), previously referred to as neonatal abstinence syndrome (NAS), is an expected and treatable potential outcome for neonates exposed to opioids in utero.

- The risk of NOWS should not discourage buprenorphine treatment. Higher doses do not increase the risk of neonatal opioid withdrawal.

Special populations

Buprenorphine is FDA approved for patients aged 16 years and older and can be used off label in patients 13 years and older without parental consent in WA State. Pregnant patients under the age of 18 should have opiod withdrawal and opioid use disorder treated with medication.

Polysubstance use

- Active stimulant intoxication can falsely elevate the COWS score.
- Buprenorphine administration may unmask symptoms of stimulant intoxication.
- Polysubstance use is never a contraindication for initiating buprenorphine or methadone.

Administration

- Because buprenorphine is a partial agonist, if the first dose is administered too soon after recent full agonist opioid use in a patient with opioid dependence, there is a risk of precipitated withdrawal. This is a sudden worsening of withdrawal symptoms after buprenorphine administration. If this occurs, give additional doses of buprenorphine and adjunct medications to alleviate withdrawal symptoms.
- Administering buprenorphine:
  - Buprenorphine comes in film and tablet forms, and both must be taken sublingually. The medication is poorly absorbed in the stomach. It must be taken correctly to receive the benefit.
  - The patient should let the medication dissolve fully under their tongue. This typically takes 5-10 minutes, but sometimes longer. Drinking water prior to administration can help it dissolve faster. Many patients find the taste unpleasant. One way to know that the medication is dissolved and absorbed is when the taste subsides.
  - Patients should not eat, drink, or talk while the medication is dissolving.
  - To prevent oral decay, instruct the patient to rinse their mouth with water 30 minutes after administration.
- Administer adjunct medications, treating the symptoms the patient finds most distressing first.

Discharge planning

- Help the patient schedule a follow-up appointment. Hospitals enrolled in ScalaNW can call the 24/7 appointment scheduling line and receive a confirmed date, time, and location for MOUD follow up appointment during the 10-minute phone call.

- For hospitals not enrolled in ScalaNW, the Washington Recovery Helpline MOUD Locator (**online** or at 1-866-789-1511) is a useful resource for finding OUD treatment in Washington.

- Arrange follow-up appointment with an obstetric/postpartum provider. Assist the patient in scheduling a follow-up appointment, if possible. Provide referrals if needed.
- Provide the patient with a buprenorphine prescription to last until their scheduled outpatient appointment. When possible, prescribe 3 additional days beyond the appointment date to allow for barriers or rescheduling. If no appointment is scheduled, provide at least 7-14 days of medication to give the patient time to secure an appointment.
  - Patients can call the Washington Telebuprenorphine Hotline (206-289-0287) if they run out of medication prior to their follow up appointment.
- Provide the patient with discharge instructions that include the time of the last dose and when to take the next dose. Ensure the patient understands the importance of taking buprenorphine at around the same time every day.
- Many patients need adjunct medications to control withdrawal symptoms until they stabilize on buprenorphine. If needed, provide prescriptions for adjunct withdrawal management medications to cover at least 7 days.
- When possible, connect patients with supports such as social workers, care navigators, or peers to improve patient experience and strengthen linkage to care.

Patient Education

Educate the patient about:

- Buprenorphine administration:
  - Must be administered under the tongue for proper absorption.
  - It can take 5-10 minutes for the medication to fully absorb. Avoid eating, drinking, smoking, or talking during this time.
  - Drinking water prior to administration can help it dissolve faster.
  - To prevent oral decay, rinse mouth with water 30 minutes after administration.
- The risks of combining sedatives with buprenorphine, which can cause respiratory depression.
- The importance of avoiding driving or operating machinery until accustomed to the medication. Provide work notes if needed.
- Overdose prevention strategies. Ensure the patient and their support system understand when and how to use naloxone.
- The risks of change in use patterns, which can alter tolerance and increase risk of opioid overdose.