“Don’t try to win over haters, you are not the jackass whisperer.”
Dependence versus Addiction

- **Dependence** - once the drug is stopped, a predictable physiological withdrawal syndrome occurs.
- **Addiction** - the compulsive use, loss of control and continued use despite adverse consequences; hallmark is *cravings*.
1930’s Mental Health Treatment
What’s the picture that changes the face of addiction? (David Kirby)
Does this change the face of drug addiction?
Thumb?
Underground Healthcare
Withdrawal Syndrome

• Short acting opioids (heroin, oxycodone, hydrocodone)
  – Develops with 4-6 hours, progresses to 72 hours, subsides in a week

• Long acting opioids (methadone, Oxycontin)
  – Develops in 24-36 hours, may last for several weeks

• Obsessive thinking and cravings may persist for years

• Fetal death is a risk in pregnant women not treated for opioid addiction because the offspring experience acute opioid abstinence syndrome (*Obstet Gynecol Clin North Am* 1998;25:139-51)
Effects on Pregnancy Outcomes

- 1st trimester - codeine can cause congenital heart defects
- No increase in the risk of birth defects after prenatal exposure to oxycodone, propoxyphene and meperidine
- Heroin - fetal growth restriction, *abruptio placentae*, fetal death, pre-term labor and intrauterine passage of meconium *(effects of repeated withdrawal on placental function)*
- Risk of woman engaging in prostitution, theft and violence
  - Sexually transmitted diseases
  - Becoming victims of violence
  - Legal consequences - loss of child custody, criminal proceedings or incarceration
Screening in Pregnancy

• Part of complete obstetric care

• Should be done in partnership with the pregnant woman

• *Non-judgmental approach*

• Screening- 4 P’s, CRAFFT
Pregnancy Substance Abuse Red Flags

- *Seek prenatal care late in pregnancy*
- Poor adherence to their appointments
- Poor weight gain
- Sedation, intoxication, withdrawal symptoms, erratic behavior
- Track marks, abscesses, cellulitis (injection sites)
- Positive serology for Hepatitis B&C, HIV
Treatment

• Methadone- standard of care since the 1970’s

• Rationale for treatment- prevent complications of illicit opioid use and narcotic withdrawal

• Goals- encourage prenatal care and drug treatment
  – Reduce criminal activity
  – Avoid risks associated with the drug culture

• Comprehensive opioid-assisted therapy that includes prenatal care reduces the risk of obstetric complications (SAMSHA/CSAT February 9, 2012)
Neonatal Abstinence Syndrome

• *Methadone/buprenorphine (Subutex/Suboxone) do not* prevent NAS

• **NAS is an expected and treatable condition** - need collaboration among treating specialties

• Hyperactivity of the central and autonomic nervous systems
  – Uncontrolled sucking reflexes- leads to poor feeding
  – Irritability
  – High pitched cry
Timing of NAS

• *Methadone*- symptoms appear within 72 hours and can last for days and weeks

• Buprenorphine (*Subutex/Suboxone*)- symptoms appear within 12-48 hours and usually resolve within 7 days
  
  – (Drug Alcohol Depend 2003; 70:S87-101)
Opioid Replacement in Pregnancy

• Should be titrated until the woman is asymptomatic - withdrawals and cravings

• Systematic literature review- severity of NAS does not appear to differ based on the maternal dosage of methadone*

• Buprenorphine is the only approved opioid for the treatment of opioid dependence in an office-based setting
  • *Addiction 2010; 105:2071-84
Buprenorphine vs. Methadone

- **Advantages** - lower risk of overdose, fewer drug interactions, ability to treat as an outpatient, evidence of less severe NAS*

- **Disadvantages** - liver dysfunction, lack of long term data, dropout rate due to dissatisfaction with the drug, risk of precipitated withdrawal, increased risk of diversion
  

• Buprenorphine (Subutex/Suboxone) or methadone in 175 opioid-dependent pregnant women

• Buprenorphine neonates required:
  – 89% less morphine to treat NAS
  – 43% shorter hospital stay
  – 58% shorter duration of medical treatment for NAS
Forced Tapering During Pregnancy

• Goal- relief of withdrawal symptoms and cravings; **PREVENT RELAPSE**

• *Not recommended during pregnancy because of association with high relapse rates*

• If attempted, 2nd trimester under the supervision of a physician experienced in perinatal addiction treatment

• Coordination between the ObGyn and Addiction Medicine Specialist is important
  • *(Am J Addict 2008; 17:372-86)*
Summary

• Early ID of pregnant opiate-addicted women improves mother and infant outcomes

• *Contraception counseling should be routine*

• Should be co-managed by the ObGyn & Addiction Medicine specialist

• *Medically supervised withdrawal should be discouraged during pregnancy*

• Monitor infants for NAS
Dr. Ignaz Semmelweis
Can We Safely Detox Pregnant Women?

• Towers, Craig; University of Tennessee at Knoxville

• *American Journal of Obstetrics and Gynecology*

• 301 Patients detoxed over 5.5 years

• Design: looking at fetal demise and pre-term labor for pregnant women being detoxed from opioids

• In Tennessee: > $60 million annually
## Results

<table>
<thead>
<tr>
<th>Four Methods of Detoxification</th>
<th>NAS Rate</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Detox of Incarcerated Pts.</td>
<td>18.5%</td>
<td>108</td>
</tr>
<tr>
<td>Inpatient Detox with Intense Counseling</td>
<td>17.4%</td>
<td>23</td>
</tr>
<tr>
<td>Inpatient Detox without Counseling</td>
<td>70.1%</td>
<td>77</td>
</tr>
<tr>
<td>Slow Outpatient Buprenorphine Detox</td>
<td>17.2%</td>
<td>93</td>
</tr>
</tbody>
</table>
Contact Information

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• Like our Facebook page and give us a follow on Twitter!

• “Removing stigma will save lives.”