Q&A Sessions

Treating Pregnant Women with Opioid Use Disorder

Featuring Angela Barr, MD

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Question: Do you usually use buprenorphine mono in pregnancy or buprenorphine with naloxone? Could you address naloxone safety in both pregnancy and breast feeding?

Answer: Suboxone contains naloxone along with buprenorphine, as opposed to Subutex, which is buprenorphine alone. I sometimes transition patients to mono therapy with Subutex simply because we don't really have complete data as to the safety of adding naloxone. There is data out there that shows there's little risk, but because there is the alternative of Subutex, I use that. I do, however, give patients choice to use Suboxone. Subutex mono form usually comes in tablet. In general, I change over to the mono product. In this day and age, there's no reason to continue using the combination product if it's not strictly needed.

Question: In clinical practice, are we waiting for the infant to sleep and eat prior to starting morphine intervention?

Answer: Yes, it's still a scaling system. You're assessing and asking yourself, "Do they eat this much?" "Do they sleep this much?" "Are they able to be consoled?" We use basic assessments like this. I'd suggest still managing the baby as you normally would when it comes to comfort. If discomfort is detected, you can change the environment with stimulation and swaddling.

Question: When do you recommend tapering post-partum?

Answer: I recommend approaching that when the patient is stable, and I give this answer very deliberately. I don't think you should give precise guidelines on tapering, because each patient is very individual. In treating each patient, you need to assess how they are doing. Take note of any major milestones, their stability with family members, stability with housing, and so on. I always talk with patients about how they're feeling on the medicine. Usually, about a year or two after initiating treatment, we'll start to have a conversation about tapering.

Question: Physiologically, how do buprenorphine or methadone affect receptors in the brain?

Answer: It's basic medication kinetics. Heroin is a fast-acting drug that hits the receptor quickly and makes a quick exit too, which is why people like it so much. Other short-acting opioids, like

Percocet, function in a similar way. However, the brain's receptors quickly adapt, and you soon need more of the drug to achieve the same euphoric feeling. Receptors are always trying to maintain homeostasis in your system.

Buprenorphine and methadone, on the other hand, are very long-acting. Buprenorphine has a high affinity for the opioid receptor, and it also leaves that receptor very slowly. If there are other opiates in the system at the same time, it *still* clings to the receptor. Buprenorphine and methadone help to stabilize the receptor, thereby also helping to stabilize the patient and his or her withdrawal symptoms.

Question: Is there any correlation between neonatal abstinence syndrome and buprenorphine dosage?

Answer: Yes, clinically speaking, I've had patients on higher doses who have experienced this. The severity of the syndrome is likely related to the dose of buprenorphine.

Question: Have you ever used SSRIs to help a patient taper off their last 1mg of buprenorphine?

Answer: Yes. Although this is very individualized and can't always be recommended.

Question: Does methadone have same effect on the kappa receptor?

Answer: No.

Question: Please comment on whether or not it's a good idea to taper off buprenorphine completely.

Answer: I think planning with the patient and understanding their personalized view of how buprenorphine fits into their life is important. At some point, people may not be able to afford the medication. You have to prepare for that possibility. The landscape is changing for the better as far as availability goes, but it's far from certain. I ask the patient: What is it that you really want? Do you want to be off the medicine simply because you want to be off it, or are you okay with being on low dose? Sometimes it's a mental stigma type of thing, and patients feel that they must go off the medication. Again, it's very individualized and there's no right or wrong answer to this.

***Additional questions derived from chat*:**

Is there progress educating residential programs on the effectiveness of MAT?

Yes.

I know there is a big push in primary care to provide MAT, but how about in OB/GYN?

There is an overall big effort to educate on the effectiveness of MAT in multiple settings. Primary care has more concentrated efforts because primary providers generally have the most contact with patients. However, within the OB/GYN discipline, there have been concerted efforts through publications and guidelines to update and inform providers as a whole.