OKLAHOMA OPIOID PRESCRIBING GUIDELINES

RISKS OF OPIOIDS IN PREGNANCY: WHAT YOU NEED TO KNOW

Note: These guidelines do not replace clinical judgment in the appropriate care of patients. They are not intended as standards of care or as templates for legislation, nor are they meant for patients in palliative care programs or with cancer pain. The recommendations are an educational tool based on the expert opinion of numerous physicians and other health care providers, medical/nursing boards, and mental and public health officials.[1,2,3,4] Although the recommendations do not include language on Oklahoma's opioid-related laws, it is imperative that providers maintain compliance.

! Opioids pose a risk to all patients. Some evidence suggests that opioids do not differ from nonopioid medication in pain reduction, and nonopioid medications are often better tolerated, with greater improvements in physical function.

The use of opioids for the treatment of pain in women of childbearing age:

1. The risk of pregnancy should be considered when prescribing opioids to women of childbearing age, and women of childbearing age should be informed of the risk of opioid use during pregnancy.
2. If opioids are prescribed to women of childbearing age, consider contraceptive treatment and pregnancy testing as a part of ongoing monitoring.
3. All patients should receive early screening for substance use disorder. When indicated, patients should receive in-practice intervention and be referred to appropriate treatment for a full, individualized assessment to determine the intensity and duration of care.

The use of opioids for the treatment of pain during pregnancy:

1. Consider nonpharmacologic therapies and/or nonopioid pain medications, such as acetaminophen, when providing pain control to pregnant patients experiencing acute pain. Use of non-steroidal anti-inflammatory drugs (NSAIDs) during the first and third trimester **(greater than 32 weeks gestation)** may be associated with increased risk of fetal harm. Pregnant patients should be counseled not to use any NSAIDs, including over-the-counter, unless instructed. In the second trimester, NSAIDs may be considered for short courses, **no more than 48 hours.**
2. When opioids are considered for the treatment of acute pain in pregnant patients, the risks of such medications should be reviewed with the patient. These risks include preterm delivery, low birth weight, and neonatal abstinence syndrome (NAS).
3. If opioids are deemed necessary, use the lowest effective dose of immediate-release opioids, for no more than 3-7 days duration. Acute prescribing of opioids should never transition to chronic opioid administration without careful consideration.
4. When opioids are prescribed during pregnancy for chronic pain, consultation with a high-risk obstetrics specialist as well as a pain specialist should be considered. Consider co-prescribing naloxone for patients with increased risk of opioid overdose.
5. Patients should be counseled to store medications securely, never to share them with others, and to properly dispose of medications.

The use of opioids for the treatment of pain following delivery:

1. For postpartum analgesia, consider methods that provide adequate pain relief with the least maternal risk, including the least risk of impacting a woman's ability to care for her newborn.
2. The majority of postpartum pain does not require pharmacologic therapies; consider nonpharmacologic methods such as heat, cold, and sitz baths.
3. Non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen often provide sufficient pain control for women experiencing mild to moderate pain. Pain management should focus on function rather than elimination of pain.
4. If opioids are deemed necessary for severe pain, such as with cesarean delivery or perineal laceration, use the lowest effective dose of immediate-release opioids, for no more than 3-7 days duration. Long-acting or extended-release opioids are rarely indicated and should be avoided.
5. For routine vaginal deliveries, nonpharmacologic and pharmacologic therapies are important components of postpartum care. A stepwise, multimodal approach emphasizing nonopioid medication as first-line therapy is safe and effective for vaginal births. Opioids are an adjunct for patients with uncontrolled pain despite adequate first-line therapy (i.e., nonopioid therapies as above). When prescribing opioids at postpartum discharge, a shared decision-making approach with the patient can optimize pain control while minimizing opioid use. Providers should use the lowest effective dose of immediate-release opioids and prescribe no more than 3-7 days duration. Long-acting or extended-release opioids are rarely indicated and should be avoided.

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The use of opioids for the treatment of pain in women who are breastfeeding:

1. The American Academy of Pediatrics advises providers to use the most comprehensive and current database of drugs that affect infants and/or lactation. This information is available at LactMed (http://toxnet.nlm.nih.gov).

2. Early breastfeeding by patients who received medications during delivery poses little risk to the infant. However, breast milk concentrations of codeine and morphine are equal to or somewhat greater than maternal plasma concentrations. Therefore, breastfeeding infants will be exposed to the opioids consumed by their mothers. Medications should be taken after breastfeeding, if possible, to maximize the time between taking the medication and breastfeeding, and thus minimize drug transfer through breast milk.

3. When considering treatment of acute pain in patients who are breastfeeding, nonopioid pain medication such as acetaminophen should be used first.

4. Maternal use of aspirin should be avoided, as aspirin persists in maternal milk for up to 24 hours, and neonatal metabolism is slow.

5. While limited use of codeine is likely to be safe in breastfeeding mothers, chronic use should be avoided.

6. Use caution when prescribing oxycodone to breastfeeding mothers, especially within two months of delivery, due to the risk of neonatal sedation.

7. Normeperidine can pass into breast milk, and the half-life of normeperidine is markedly prolonged in newborns. Therefore, repeated use of meperidine should be avoided.

8. Breastfeeding should be encouraged in the opioid-dependent mother maintained on buprenorphine or methadone if there are no medical contraindications to breastfeeding (including, but not limited to, HIV infection and/or active illicit drug use). Refer to existing breastfeeding guidelines and consult with a substance abuse treatment provider.

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