MACS
Maryland Addiction Consultation Service
for MOMS

POSTPARTUM PAIN MANAGEMENT FOR PEOPLE WITH SUBSTANCE USE AND USE DISORDERS

Courtney Townsel MD MSc
MACS for MOMs

LEARNING OBJECTIVES

1. Recognize effective pain management strategies for postpartum individuals with SUD/OUD after cesarean or vaginal births.

2. Assess the benefits and risks of opioid-sparing strategies for postpartum individuals with opioid use disorders.

3. Highlight the role of multidisciplinary collaboration in managing pain for pregnant individuals with substance use disorders.

4. Identify emerging guidance for postpartum pain management in patients with SUD/OUD

MUTUAL MISTRUST

- **Individuals with SUD**
  - Discrimination and stigma
  - Labeled as “drug seeking”
  - Experience of under-treatment of pain
  - Historically marginalized communities less likely to receive adequate pain management or SUD treatment

- **Clinicians**
  - Lack of education about SUD/OUD
  - Bias against SUD
  - Feeling manipulation
  - Fear/avoidance

CONTENTS: HEALTH DISPARITIES: ORIGINAL RESEARCH

Racial and Ethnic Inequities in Postpartum Pain Evaluation and Management

Johnson, Jasmine D. MD; Asiodu, Ifeyinwa V. PhD, RN; McKenzie, Christine P. MD; Tucker, Christine PhD, MPH; Tully, Kristin P. PhD; Bryant, Katherine MA, MSPH; Verbiest, Sarah DrPH, MSW; Stuebe, Alison M. MD, Msc

LEVEL OF EVIDENCE

- Fundamentally **evidence informed**
- Not evidence-based

Figure 2. Publication type and counts according to journal type since 1975 indicating an increase in peer-reviewed publications on peripartum pain management in people with opioid use disorder over time. OBGYN indicates obstetrics and gynecology.

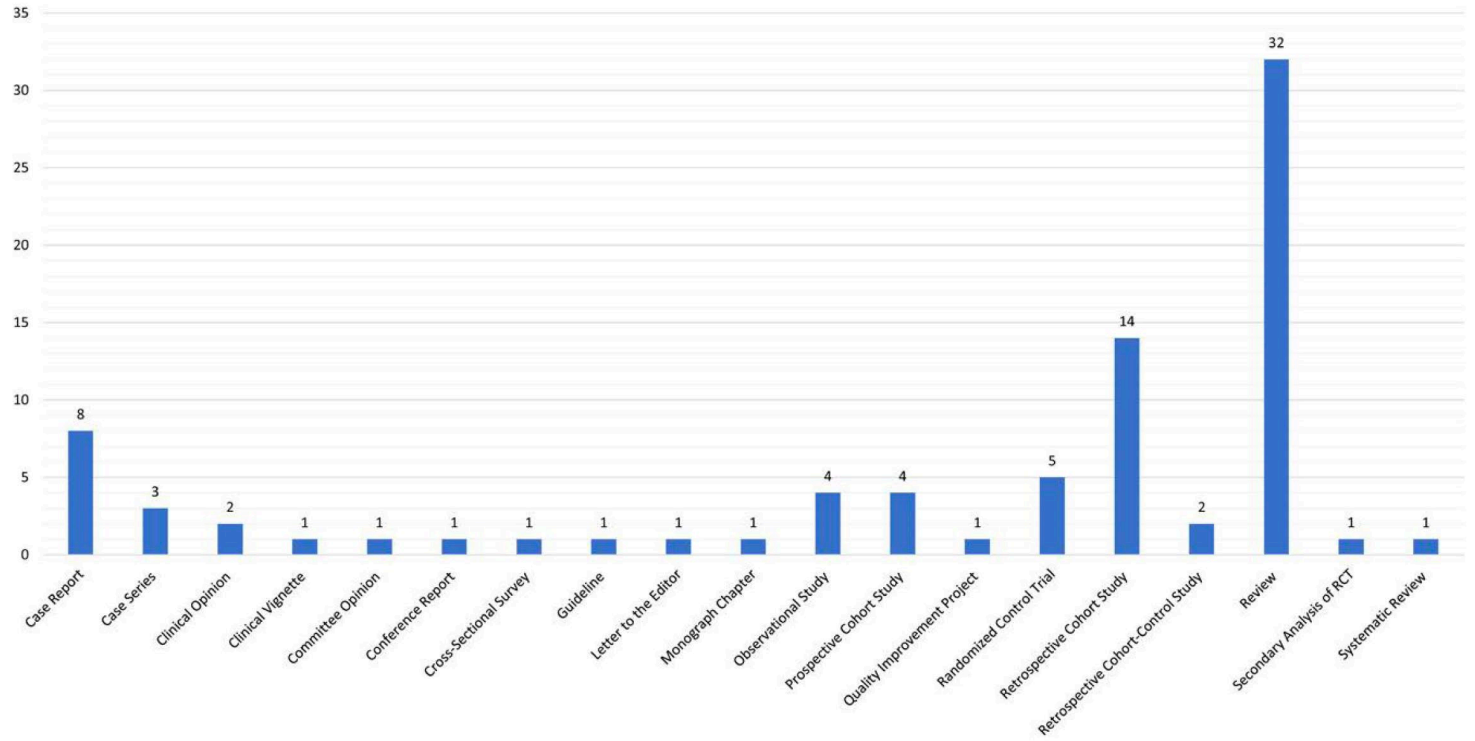


Figure 3. Study methodologies and counts within the study period 1975 to 2020. A disproportionate number of narrative review articles have been published, followed by retrospective studies and case reports. Only one systematic review and 5 randomized trials were published in the study period. RCT indicates randomized controlled trial.

SYSTEMATIC REVIEW ARTICLE

A Systematic Scoping Review of Peridelivery Pain Management for Pregnant People With Opioid Use Disorder: From the Society for Obstetric Anesthesia and Perinatology and Society for Maternal Fetal Medicine

Grace Lim, MD, MSc,*† Mieke Soens, MD,‡ Anne Wanaselja, MD,* Arthur Chyan, MD,‡ Brendan Carvalho, MBBS, FRCA,§ Ruth Landau, MD,‖ Ronald B. George, MD,¶ Mary Lou Klem, PhD, MLIS,# Sarah S. Osmundson, MD, MS,** Elizabeth E. Krans, MD, MS,† Mishka Terplan, MD, MPH, FACOG, DFASAM,†† and Brian T. Bateman, MD, MSc§

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- Individuals taking **methadone** versus matched control (n=68)
- MOD
  - Vaginal (n=35)
  - Cesarean delivery (n=33)
- Individuals taking methadone:
  - **No difference in intrapartum pain scores**
  - **Longer admission** for vaginal delivery, delivery to discharge and admit to discharge
  - **Higher pain** scores postpartum
  - **70% higher** oxycodone intake

Intrapartum and Postpartum Analgesia for Women Maintained on Methadone During Pregnancy

Marjorie Meyer, MD, Katherine Wagner, MD, Anna Benvenuto, Dawn Plante, RN, and Diantha Howard, MS

Table 3. Oxycodone Equivalent Use and Pain Score Per 24 Hours Postpartum

	Vaginal (n=35)			Cesarean (n=33)		
	Methadone	Control	*P*	Methadone	Control	*P*
Oxycodone equivalents (mg)	12.7±32.1	6.8±12.7	.33	91.6±51.8	54.0±18.6	.001
Acetaminophen	1,611±930	2,039±987	.06	2,780±1,019	2,880±1,119	.72
Ibuprofen	990±533	1,189±643	.12	1,991±270	1,959±574	.76
Pain score	2.7 (1.9, 5.0)	1.4 (0.5, 3.0)	.001	5.3 (4.1, 6.0)	3.0 (2.2, 3.9)	.001

Data are mean±1 standard deviation or median (25th, 75th percentiles).
Oxycodone use was calculated by calculating the cumulative oxycodone equivalents (see Materials and Methods) and dividing by the duration of hospitalization after delivery (up to 72 hours; reported as per 24 hour increments).

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- Individuals taking **buprenorphine** versus matched control (n=63)
- MOD
  - Vaginal (n=42)
  - Cesarean delivery (n=19)
- Individuals taking buprenorphine:
  - **No difference in intrapartum scores**
  - **Higher pain scores**
  - **47% higher** oxycodone intake

Intrapartum and postpartum analgesia for women maintained on buprenorphine during pregnancy

Marjorie Meyer [a,*], Gretchen Paranya [a], Ananda Keefer Norris [a], Diantha Howard [b]

Table 2
Oxycodone equivalent use and pain scores per 24 h.

	Vaginal (n = 42)[a]			Cesarean (n = 19)		
	Buprenorphine	Control	p	Buprenorphine	Control	p
Oxycodone equivalents (mg)	11.8 ± 24.8	5.4 ± 10.4	0.10	89.3 ± 38.0	60.9 ± 13.1	0.004
Acetaminophen (mg)	2676 ± 1018	2507 ± 856	0.42	3252 ± 662	3392 ± 768	0.56
Ibuprofen (mg)	1695 ± 604	1543 ± 541	0.22	1947 ± 463	1996 ± 591	0.79
Pain score	2.7 (1.7, 4.0)	2.1 (1.2, 3.0)	0.006	5.1 (4.1, 6.1)	3.3 (2.5, 4.1)	0.009

Data are mean ± 1 standard deviation or median (25th, 75th centiles). Data for vaginal birth reflect the first 24 h postpartum. Data for cesarean delivery reflect the cumulative data divided by the duration of hospitalization following delivery in 24 h increments up to 72 h. Oxycodone use was calculated by calculating the cumulative oxycodone equivalents (see Section 2).

[a] Two pair omitted from postpartum analysis because of postpartum tubal ligation within the first 24 h.

Table 3
Oxycodone equivalent use and pain score by duration after cesarean delivery.

	0–24 h (n = 16)[a]			25–72 h (n = 19)		
	Buprenorphine	Control	p	Buprenorphine	Control	p
Oxycodone equivalents (mg)	113.9 ± 52.7	79.5 ± 19.6	0.036	82.1 ± 40.6	50.0 ± 12.5	0.001
Pain score	5.5 (4.4, 6.0)	3.5 (3.1, 4.5)	0.003	4.7 (3.4, 5.9)	3.3 (2.5, 4.5)	0.03

Data are mean ± 1 standard deviation or median (25th, 75th percentiles).

[a] Three pair in which one patient received patient controlled epidural analgesia were omitted from analysis (buprenorphine = 3 (2 for intractable pain; one planned)).

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- Retrospective cohort study
- Inclusion: history of OUD or chronic pain at single perinatal clinic
- Jan 2019-Aug 2021
- 3 patient groups
  - OUD on medication
  - OUD maintaining abstinence
  - Chronic pain using opioids

Peahl AF, Keer E, Hallway A, Kenney B, Waljee JF, **Townsel C.** Postpartum Opioid Prescribing in Patients with Opioid Use Prior to Birth. Am J Perinatol. 2024 May;41(S 01):e1459-e1462. doi: 10.1055/s-0043-1767816. Epub 2023 Apr 10. PMID: 37037203.

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

Patient characteristics	Total (N=69)	OUD on medication (N=46)	OUD maintaining abstinence (N=14)	Chronic pain using opioids (N=9)	P-value
Opioid prescription	15 (21.7)	8 (17.4)	3 (21.4)	4 (44.4)	0.18
After vaginal birth	3 (6.5)	0 (0)	2 (16.7)	1 (25)	0.05
After cesarean birth	12 (52.2)	8 (50)	1 (50)	3 (60)	>.99
Opioid prescription size*	112.5 (37.5-187.5)	131.3 (37.5-165)	52.5 (22.5-75)	243.8 (150-510)	0.19
Refilled prescription†	6 (40)	2 (25)	1 (33.3)	3 (75)	0.31

Peahl AF, Keer E, Hallway A, Kenney B, Waljee JF, **Townsel C.** Postpartum Opioid Prescribing in Patients with Opioid Use Prior to Birth. Am J Perinatol. 2024 May;41(S 01):e1459-e1462. doi: 10.1055/s-0043-1767816. Epub 2023 Apr 10. PMID: 37037203.

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- Refill rates for people with OUD/chronic pain 2-4x higher for vaginal and cesarean birth than the general population at same institution

- Overall opioid prescribing rates for patients with OUD and chronic pain after cesarean birth were much lower than for patients without these conditions over the same period (52.2% vs. 80.0%)

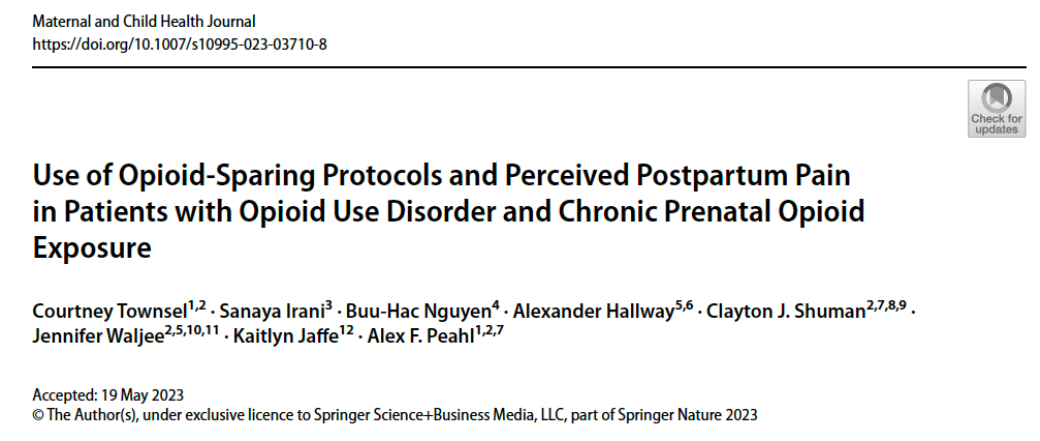
- **Why?**
  Systemic bias, patients with a history of OUD or chronic pain being offered opioid medications less frequently?
  These patients may worry about getting opioid medications?
  Maybe felt their pain was well controlled with opioid-sparing protocols?

Peahl AF, Keer E, Hallway A, Kenney B, Waljee JF, **Townsel C.** Postpartum Opioid Prescribing in Patients with Opioid Use Prior to Birth. Am J Perinatol. 2024 May;41(S 01):e1459-e1462. doi: 10.1055/s-0043-1767816. Epub 2023 Apr 10. PMID: 37037203.

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- Qualitative study
- Phone survey to assess postpartum pain experiences for people with prenatal opioid exposure
- Jan 2020-Aug 2021
- 18 participants: majority NHW (100%), with Medicaid insurance (78%) and multiparous (100%)
- Vaginal delivery- no Rx, Cesarean birth- 50% Rx



Maternal and Child Health Journal
https://doi.org/10.1007/s10995-023-03710-8

Check for updates

Use of Opioid-Sparing Protocols and Perceived Postpartum Pain in Patients with Opioid Use Disorder and Chronic Prenatal Opioid Exposure

Courtney Townsel[1,2] · Sanaya Irani[3] · Buu-Hac Nguyen[4] · Alexander Hallway[5,6] · Clayton J. Shuman[2,7,8,9] · Jennifer Waljee[2,5,10,11] · Kaitlyn Jaffe[12] · Alex F. Peahl[1,2,7]

Accepted: 19 May 2023
© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2023

Townsel C et al. Use of Opioid-Sparing Protocols and Perceived Postpartum Pain in Patients with Opioid Use Disorder and Chronic Prenatal Opioid Exposure. Matern Child Health J. 2023 Aug;27(8):1416-1425.

Table 3 Joint display of qualitative participant perceptions of pain management, stratified by delivery type and pain score[a]

Group	n (%)	Key theme	Representative quotes	Age	MOUD
Vaginal delivery, lower pain score	7 (39)	Non-opioid medications sufficiently addressed minor pain	I did not have a lot of pain, so I did not need help managing it	28	Buprenorphine
			Tylenol was the most helpful. Nothing would have helped more that I know of	33	Buprenorphine
Vaginal delivery, higher pain score	3 (17)	A range of alternative pain remedies were helpful, but did not entirely address pain	I used cold compresses, Tucks pads with agent, numbing pain and I lived off that. I might have appreciated something else in addition to this but for the most part I was pain free and satisfied	39	Buprenorphine/naloxone
			I felt like once I had the baby, I was less important. I wanted pain relief, but I was less heard once the baby was born	28	Buprenorphine/naloxone
Cesarean delivery, lower pain score	4 (22)	Hospital-administered pain relief was helpful, but temporary	The epidural [kept it in 24 h after delivery]	37	None
			[The anesthesia tap] helped a little bit with the pain but the side effect of the leg numbness was difficult to deal with	28	Buprenorphine
Cesarean delivery, higher pain score	4 (22)	Prescription medications were helpful for patients' moderate to intense pain	The doctors prescribing the right medications	28	Methadone
			The pain medications were the most helpful	30	Buprenorphine/naloxone

[a]Lower pain score was defined as self-rated score of < 5 on scale of 1–10 in seven days after hospital discharge; higher pain score was defined as a score of ≥ 5

MOUD: medication for opioid use disorder

Townsel C et al. Use of Opioid-Sparing Protocols and Perceived Postpartum Pain in Patients with Opioid Use Disorder and Chronic Prenatal Opioid Exposure. Matern Child Health J. 2023 Aug;27(8):1416-1425.

PAIN EXPERIENCE FOR BIRTHING PEOPLE WITH OUD

- 10 patients interviewed about opioid overdose risk and prevention strategies
- Personal risk of opioid overdose in the postpartum period
  - all (10/10, 100%) reported themselves as having "no risk at all"
- 5/10 (50%) reported having access to a naloxone kit at home
- 8/10 (80%) reported knowing how to use naloxone
- Importance of access to a naloxone kit
  - 5/10 (50%) thought it was "very important"
  - 5/10 (50%) deemed it "not important"

Townsel C et al. Use of Opioid-Sparing Protocols and Perceived Postpartum Pain in Patients with Opioid Use Disorder and Chronic Prenatal Opioid Exposure. Matern Child Health J. 2023 Aug;27(8):1416-1425.

OPIOID OVERDOSE PREVENTION

Accidental Poisoning or Drug Overdose During Pregnancy

Accidental poisoning or drug overdose is the leading cause of pregnancy-associated death in Michigan. Understanding the risks of drug use during pregnancy and how to prevent overdoses can help prevent these deaths. This handout will:

- Define pregnancy-associated death
- Explain other leading causes of pregnancy-associated death in Michigan
- Explain the rise of opioid-affected births in Michigan and how to prevent opioid overdose during pregnancy

What is pregnancy-associated death?

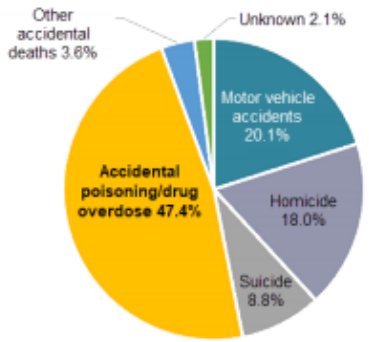
Pregnancy associated death is dying while pregnant or within 1 year of the end of a pregnancy due to a cause unrelated to pregnancy.

What causes pregnancy-associated death?

The most common cause of pregnancy-associated injury deaths in Michigan is accidental poisoning/drug overdose (45 out of 100 or 45%).

What are the other causes of Pregnancy-Associated Deaths in Michigan?

This chart shows the causes of pregnancy-associated deaths in Michigan and their percentages from 2011-2016. Accidental poisoning/drug overdose is the leading cause of death (47 out of 100), followed by motor vehicle accidents (20 out of 100), homicide (18 out of 100) and suicide (9 out of 100).

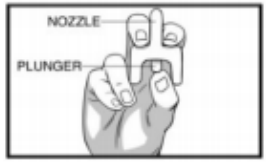


Opioids and pregnancy

- Opioid-affected births have quadrupled (increased by 4) over the last 10 years, to 6.5 affected out of 1000 births.
- Opioid use in pregnancy increases the risk of maternal death (death of the mother) and increases the risk of life-threatening health issues.

How can an opioid overdose be stopped?

Naloxone (Narcan, ®Evzio®) is a drug (nasal spray) that temporarily reverses the dangerous effects of an opioid overdose. It stops an overdose caused by opioid pain medication, methadone, buprenorphine or heroin. It helps a person to breathe again and wakes them up. The images here only show what Naloxone looks like. Visit the resources below to learn how to give Naloxone.



Where can I learn more?

- People at risk for overdose and their families can learn to spot an overdose and save a life. Scan this QR code with a smartphone to view a video on how to give Naloxone during an opioid overdose, or visit: https://tinyurl.com/ukyjj3z.
- A step-by-step guide for giving Narcan can be found here: http://michmed.org/rnw59.

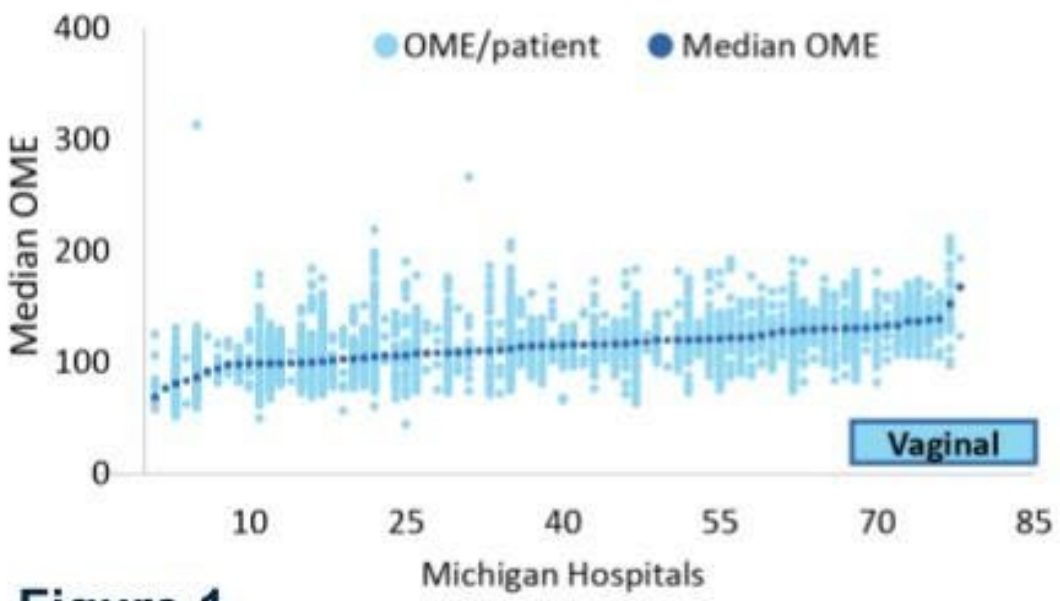
Postpartum Opioid Prescribing Contributes to the Opioid Crisis

1 in 75

birthing people who receive an opioid prescription develop New Persistent Opioid Use (NPOU) in the year postpartum

Peahl et al 2020, *AJOG*

Wide Variation in Postpartum Opioid Prescribing Across MI



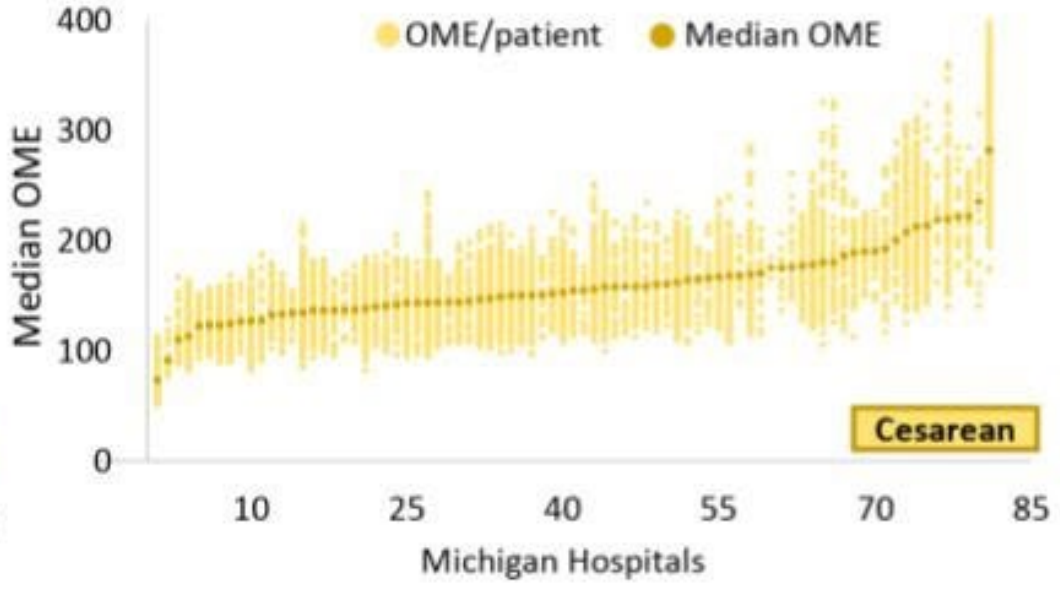


Figure 1.

This variation represents an opportunity for improved pain management

Wide Variation in Postpartum Opioid Prescribing Nationally

Adjusted* odds of filling a postpartum opioid prescription

	Vaginal Birth aOR (95% CI)	Cesarean Birth aOR (95% CI)
Northeast	1 (ref)	1 (ref)
Midwest	1.93 (1.70-2.18)	1.81 (1.57-2.09)
South	2.29 (2.04-2.58)	2.15 (1.89-2.45)
West	2.27 (2.01-2.58)	2.07 (1.79-2.38)

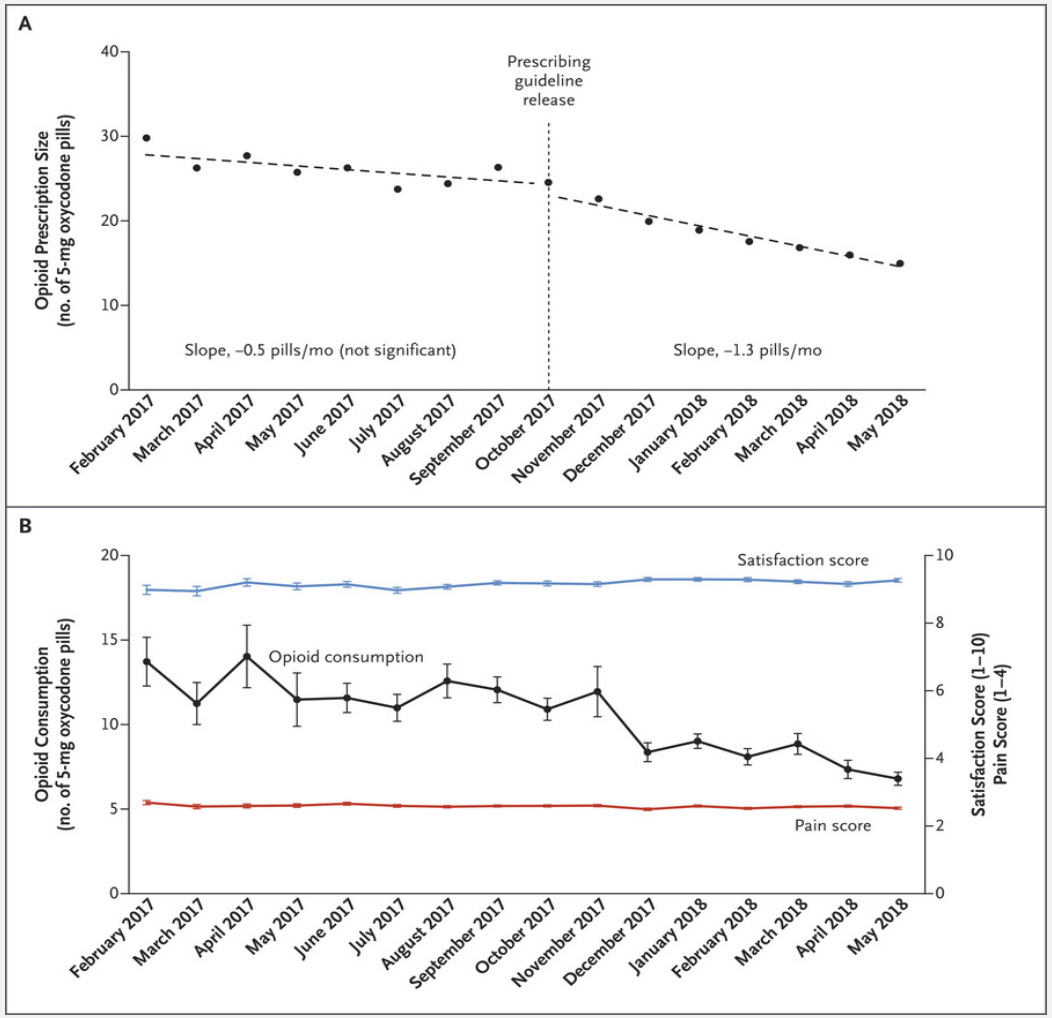
Models adjusted for patient demographics (e.g., age, education), chronic conditions (e.g., pain condition, Bateman CMI); pregnancy procedures

This variation represents an opportunity for improved pain management

CPGs Can Reduce Opioid Prescribing without Compromising Pain Management

- CPG developed for 9 procedures
- Statewide dissemination through MSQC (BCBS CQI)
- Interrupted time series: 11,716 patients, prescription & patient-reported data
  - 80% decrease in opioid Rx
  - Equivalent pain scores & satisfaction
  - Decreased disparities

Maternity care can reduce opioid prescribing while maintaining excellent pain outcomes…
but we have work to do!



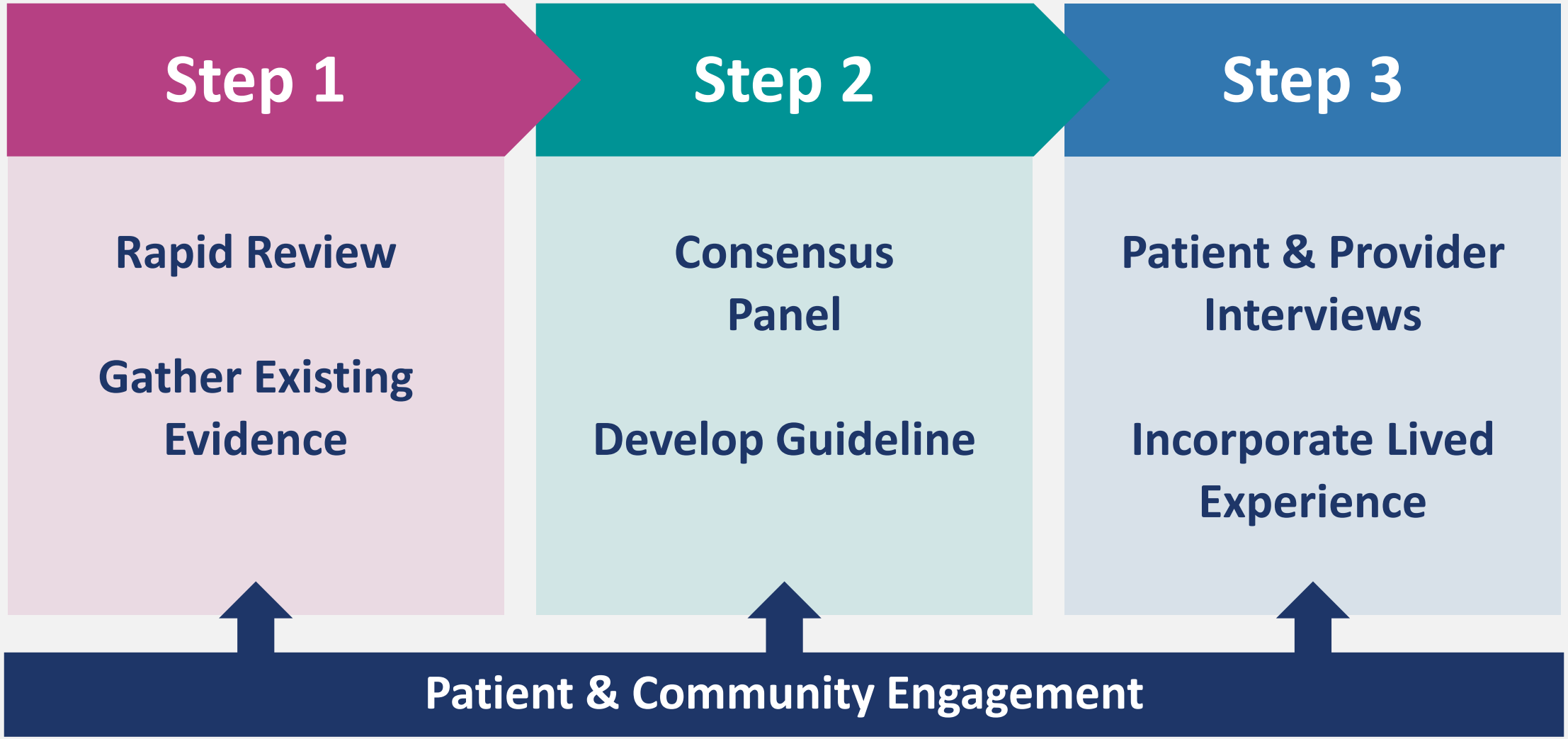
Vu et.al., 2019. NEJM..

Emerging Clinical Practice Guidance (CPG)

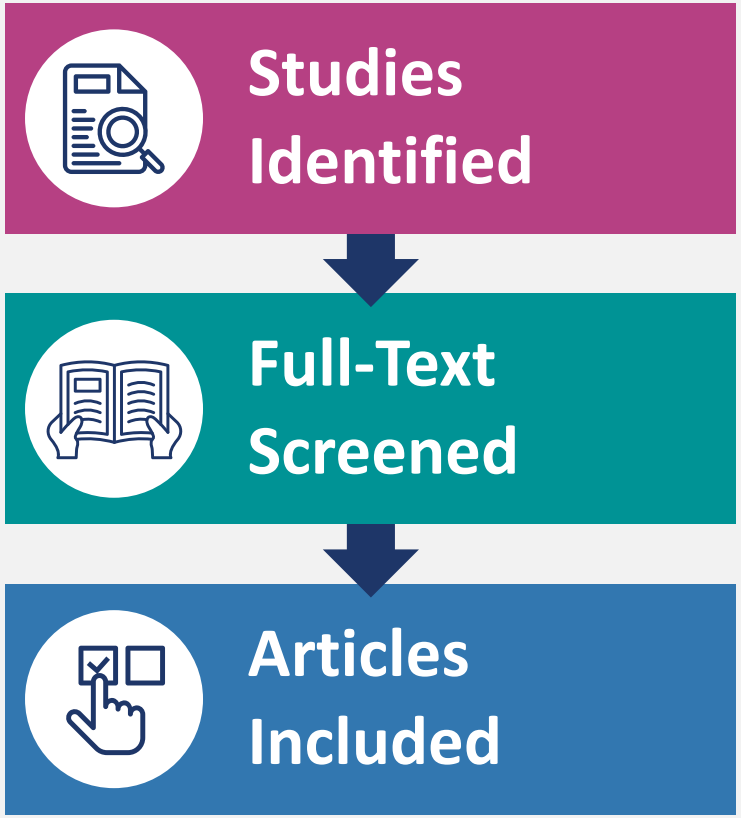
Optimal Pain Management FOR Tailoring Care

FDA Sponsored U01 grant to develop comprehensive, patient-centered, clinical practice guideline for postpartum pain management across populations and procedures.

COMFORT Guideline Development



Phase 1 Systematic Review



Vaginal Birth

Cesarean Birth

2787

701

41
7 RCT, 34 Observational
ROB: Low (5), Moderate (11), High (11)

105
25 RCT, 80 Observational
ROB: Low (12), Moderate (27), High (37)

*Quality assessed using Cochrane ROB tools

Phase 2 Consensus Panel

Population

Patients who cannot receive NSAIDs/acetaminophen

Procedure

Cesarean birth, postoperative day 2

Intervention

Opioid prescription size

Scenario

For a patient who cannot receive NSAIDs/acetaminophen, who has an uncomplicated cesarean birth, and is being discharged on postoperative day 2, how appropriate are the following opioid prescription sizes?

0, 1-5, 6-10, 11-15, 16-20, 21-25, >25

Phase 2

Complex Pain Subgroup

Population

Birthing people with OUD/Complex Pain

Procedure

All procedures

Intervention

All interventions

Principles based approach

Collected existing content from current recommendations.

Incorporated expert guidance/experience

Synthesized principles for management

Phase 2 Consensus Panel

Specialty	Members
Maternal-Fetal Medicine	2
Ob/Gyn	3
Certified Nurse Midwife	1
Anesthesia	3
Pain Medicine	2
Surgery	1
Addiction Medicine & Family Medicine	1
Emergency Medicine	1
Pharmacy	1
Psychiatry/Psychology	2
Pediatrics	2
Nursing	1
Lived Expertise	0 (3 Non-Voting)

NPWH The National Association of Nurse Practitioners in Women's Health

ACOG The American College of Obstetricians and Gynecologists

American College of Nurse-Midwives

AWHONN

ashp pharmacists advancing healthcare®

APhA American Pharmacists Association
For Every Pharmacist. For All of Pharmacy.

Society for Maternal-Fetal Medicine

ASAM American Society of Addiction Medicine

Recommendations

CPG Components

Education & Counseling

Scheduled Non-Opioid Medications

Non-Pharmacologic Strategies

Inpatient Strategies

Tailored Opioid Prescriptions

Principles-Based Approach to Patients with OUD & Complex Pain

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Strong, Low to Moderate)

1. Implementation through health equity lens and maintaining patient centeredness
2. General Principles
3. Management of individuals on long-term opioid therapy or on medication for OUD
4. Enhancements to recommendations
    - Education and Counseling
    - Scheduled non-opioid medications
    - Tailored opioid prescribing
    - Inpatient-only considerations
    - Non-pharmacologic strategies
5. Postpartum considerations

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

General Principles

- Recognize individual variation:
  - Consider the spectrum of opioid use
  - Consider the effects of opioid use on postpartum pain
- Develop multidisciplinary pain plans
  - **Ideally, establish multidisciplinary pain plans prior to admission**
  - If not set prior to the admission, consider a multidisciplinary approach, using telemedicine if needed
- Use shared decision-making with awareness of stigma

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Management of Individuals on Long-Term Opioid Therapy or on Medication of Opioid Use Disorder

- Patients should be offered MOUD in pregnancy
- MOUD selection should be made with a person-centered approach
- Naltrexone is not considered a first-line medication in pregnancy
- Continue buprenorphine and methadone during the birth hospitalization; consider split dosing
- Consider how MOUD affects common pain management medications (i.e., avoid mixed agonist-antagonists: butorphanol)
- Health system leaders should work to ensure multiple forms of MOUD are available for admitted patients

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Enhancements to Recommendations

Principles

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Good Practice Point)

Principles

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Additional Counseling Topics:

- Heightened risk of overdose in the postpartum period.
- Importance of treating pain for healing and recovery (OUD: reduced return to use)
- Neonatal Opioid Withdrawal Syndrome and neonatal respiratory depression
- How to return to usual opioid regimen
- Offer Naloxone and provide educations

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Strong, Low to Moderate)

Principles

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Additional Strategies:

- Consider extended courses of Ketorolac (24-48 hours)

Recommendation 3:
Tailored Opioid Prescriptions

Providers should use prescribing benchmarks for individual populations and procedures to determine appropriate ranges of opioid prescription sizes for shared decision-making with patients.

Recommended opioid prescription size in number of 5mg tablets of oxycodone.

Routine Vaginal Birth, VBAC	Vaginal birth with 3rd or 4th degree laceration	Postpartum sterilization with minilap	Cesarean birth discharged on POD2	Wound vacuum	Peripartum hysterectomy	Dilation and curettage	Uterine artery embolization	Postpartum endometritis, antibiotics complete
0 tablets	0-5 tablets	0-5 tablets	0-15 tablets	0-15 tablets	0-15 tablets	0 tablets	0 tablets	0 tablets

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Good Practice Point)

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Additional Strategies:

- Confirm existing opioid prescriptions with prescribing provider, patient, and PDMP where appropriate
- Prioritize return to pre-procedural regimen as soon as possible and coordination of prescribing with usual prescriber.
- If an opioid prescription is needed:
  - Prescribe on an as needed basis, not on a set interval.
  - Prescribe only the quantity likely to be used, not to exceed 2-3 days, unless extenuating circumstances.
  - Prescribe immediate-release/short-acting
  - Base prescription size on opioid needs 24 hours prior to d/c
- Close follow-up to re-evaluate pain control is preferable to automatic refills, to provide a time for reevaluation of pain management.

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Strong, Low to Moderate)

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Additional Strategies:

Consider extended courses of Ketorolac (24-48 hours)

When possible, connect patients with a therapist trained in Cognitive Behavioral Therapy prior to birth

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Strong, Low to Moderate)

- Education & Counseling
- Scheduled Non-Opioid Medications
- Tailored Opioid Prescriptions
- Non-Pharmacologic Strategies
- Inpatient-only Strategies

Additional Strategies:

Long-acting neuraxial opioids combined with NSAIDs and Acetaminophen are typically effective for pain relief, and is best-practice for cesarean

Because traditional pain management strategies are potentially less efficacious, patients should be closely monitored. Consider:

- Transversus Abdominis Plane/Regional Block
- IV-PCA with on-demand low-dose opioids
- Low-dose IV ketamine

Recommendation 6:

Principles-Based Approach to Patients with OUD & Complex Pain

Maternity care professionals should use a principles-based approach to postpartum pain management for patients with OUD, chronic pain, and complex pain accounting for the characteristics of the birthing person. (Good Practice Point)

Postpartum Considerations

- Encourage rooming in and breastfeeding
- Counsel patients about the need to discontinue breastfeeding in the event of return to non-prescription opioid use
- Ensure postpartum follow-up with SUD provider

SUMMING IT UP

- Data are **very scant**
  - Almost entirely case report/case series based

- Continue MOUD including buprenorphine and methadone
    - MOUD is NOT analgesia
    - Avoid opioid antagonist

- **Treat with multi-modal approach**
    - Neuraxial as appropriate
  - **Non-pharmacological treatment**
    - Doulas
    - Peer support
    - Empathy
  - **Short-acting opioids**

- Don’t forget the naloxone co-prescription

SUMMING IT UP

- TREAT OUD/SUD prenatally, intra-partum and postpartum
  - People come when they are ready. It's on us to be ready for them.
- Have an approach.
  - Having a plan is better than no plan, even if it is an evidence – informed plan
- Under-treating pain undermines trust and communication.
  - Ignoring pain is probably the worst thing we can do.
- Address stigma and bias with ALL members of team.
  - It just takes one comment to send the house of cards crashing.
- This is an area that needs MORE research.

MACS
Maryland Addiction Consultation Service *for MOMS*

Maryland Addiction Consultation Service (MACS) for Maternal Opioid Misuse (MOMs)

Provides support to maternal health providers and their practices in addressing the needs of their pregnant and postpartum patients with substance use disorders (SUD), particularly opioid use disorder (OUD).

All Services are FREE

- Phone consultation for clinical questions
- Education and training opportunities related to substance use disorders and pregnancy
- Assistance with addiction and behavioral health resources and referrals
- MACS for MOMs TeleECHO Clinics: collaborative medical education through didactic presentations and case-based learning