Acute Pain in Pregnant and Post-Operative At-Risk Women

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Objectives

Learning Objectives:

1. The attendee will learn Osteopathic Manipulative Medicine options to treat pregnant and post op women for pain.
2. The attendee will learn how to assess for the risk of potential substance abuse in a pregnant or postoperative woman.
3. The attendee will have an understanding of post partum and pregnancy management that focuses on non-narcotic pain management when appropriate.
DOES IT HURT?
CAN I GET YOU
A BEER OR
SOMETHING?

WHY NO ONE USES MIDHUSBANDS.
Overview

• Substance Use Disorder Definition
• Opioid problem
• Patient types
• Options for pain management and treatment
• Cases
Addiction short Definition by ASAM

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.
DSM 5 Criteria for Substance Use Disorder

Opioid Use Disorder Criteria:

• A minimum of 2-3 criteria is required for a mild substance use disorder diagnosis, while 4-5 is moderate, and 6-7 is severe (APA, 2013). Opioid Use Disorder is specified instead of Substance Use Disorder, if opioids are the drug of abuse.

• Taking the opioid in larger amounts and for longer than intended
• Wanting to cut down or quit but not being able to do it
• Spending a lot of time obtaining the opioid
• Craving or a strong desire to use opioids
• Repeatedly unable to carry out major obligations at work, school, or home due to opioid use
• Continued use despite persistent or recurring social or interpersonal problems caused or made worse by opioid use
• Stopping or reducing important social, occupational, or recreational activities due to opioid use
• Recurrent use of opioids in physically hazardous situations
• Consistent use of opioids despite acknowledgment of persistent or recurrent physical or psychological difficulties from using opioids
• *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
• *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.
The Opioid Epidemic: Why is this a topic of concern

• Causes
• Concerns
Patient Types

- No known history of Substance Use Disorder
- Family History of Substance Use Disorder
- Known to have the diagnosis of Substance Use Disorder
I'm having a natural childbirth in that it's natural to take drugs that lessen excruciating pain.

someecards
No known history of Substance Use Disorder

- Screening
- Education
- Providing Options
- Monitoring
- Adhere to new guidelines
CAGE Questionnaire

- Have you ever felt you should cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you ever felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

Scoring:

- Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.
Opioid Risk Tool

This tool should be administered to patients upon an initial visit prior to beginning opioid therapy for pain management. A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse.

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<th>Male</th>
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<tr>
<td><strong>Scoring totals</strong></td>
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Family History of Substance Use Disorder

- Screening
- Genetic Predisposition
- Pain must be managed or patient will treat their own pain!
- Education
- Usual and customary for different procedures and childbirth.
- Presenting options.
Known Diagnosis of Substance Use Disorder

- Pain must be managed or patient will treat their own pain!
- What is usual and customary for this type of pain management?
  - Post-Operative
    - What type of surgery?
  - Labor
  - Post-Partum
ASAM’s Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids

• Pregnancy complications can occur with exposure to a number of licit and illicit substances, including, but not limited to alcohol, nicotine, cocaine, amphetamines, opioids, and benzodiazepines.
• For example, alcohol-related neurodevelopmental disorders are the leading cause of preventable intellectual disability in the US.
• Opioid-related overdose not only threatens the life of the mother, but also can lead to fetal demise.
• Opioid withdrawal may threaten the viability of the fetus through an increased potential for spontaneous abortion.
Substance misuse and addiction are associated with behaviors that increase the risk of maternal and fetal acquisition of sexually transmitted infections (STIs) such as HIV and hepatitis C and B.

Whereas 50% of pregnancies in the United States are unplanned (defined as a woman not attempting pregnancy at the time of conception), the rate may be as high as 80% among women with SUD.

Inadequately treated SUDs are associated with poor adherence to prenatal care, poor attention to maternal nutrition, and worsening of co-occurring psychiatric illness.

Although co-occurring disorders are common among all individuals with SUD, pregnant women with SUD are even more likely to have a co-occurring psychiatric illness, and postpartum depression (PPD) is more common among women with SUD compared to those without SUD.
ASAM’s Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids

- The condition almost never arises *de novo* during her pregnancy, but rather developed prior to conception.
- Often, SUD is first diagnosed during pregnancy.
- Pregnancy offers a window of opportunity for case finding, diagnosis, treatment entry and initiation of recovery.
- The professional societies of clinicians involved in the care of women and children, including ACOG and ASAM, stress the importance of working with a pregnant woman to facilitate her quitting or at least reducing substance use during pregnancy, and engaging in addiction-related treatment if necessary. These professional societies oppose criminalizing and other punitive approaches to substance use during pregnancy as they turn women away from prenatal care, thus compromising maternal and fetal well-being.
ASAM’s Public Policy Statement on Substance Use, Misuse, and Use Disorders During and Following Pregnancy, with an Emphasis on Opioids

• The American Society of Addiction Medicine recommends:
  • Screening/Prevention
  • Treatment
  • Education
  • Regulatory and Law Enforcement
CDC Guidelines (1 of 2)

Determine when to initiate or continue opioids for chronic pain
1. Nonpharmacologic therapy and nonopioid therapy are preferred for chronic pain
2. Establish treatment goals prior to starting opioids
3. Discuss risks and benefits

Opioid Selection, dosage, duration, follow-up, and discontinuation
4. Prescribe immediate-release opioids instead of extended release
5. Prescribe the lowest effective dosage
6. For acute pain prescribe three days or less
7. Evaluate benefits and harms within 1-4 weeks of starting therapy
Assessing risk and addressing harms of opioid use

8. Evaluate risks for opioid related harms
9. Use the state prescription drug monitoring program (PDMP)
10. Use UDT prior to starting and then at least annually for chronic pain
11. Avoid prescribing benzodiazepines with opioids
12. Offer evidence-based treatment for patients with opioid use disorder
Urine Drug Testing (UDT)

- UDT is not diagnostic!
- Patients with positive urine drug testing may not have substance use disorder
- Patients with negative urine drug testing may have substance use disorder
ASAM guidelines on UDT in pregnant and Postpartum women: These recommendations primarily apply to pregnant and postpartum women in general healthcare or prenatal care settings.

- Consequences and confidentiality
- Screening, assessment, and monitoring
- Patient-provider relationship
- Test considerations
- Test results
OMT IN Pregnancy

- Considerations
  - Low back pain
  - Heartburn
  - Pelvic floor pain
  - Thoracolumbar junction and diaphragm dysfunction

- Techniques
  - Modify for sitting or lateral recumbent position
TECHNIQUES

- Thoracic and lumbar soft tissue
  - Patient side lying
- OA decompression
- Thoracic inlet myofascial release
- Myofascial release of the diaphragm
- Sacro-iliac articulation
  - Patient side lying
- Pubic symphysis decompression
Post Partum OMT

• Considerations
  • Pelvic pain
  • Low back pain
  • Post partum depression

• Techniques
  • Be mindful of Cesarean incisions
techniques

• Cranial treatments
• Cervical, thoracic, lumbar spine soft tissue
• Myofascial release of the diaphragm
• Rib raising
• Pelvic diaphragm myofascial release
• Muscle energy for hip restriction
• Sacral articulation, “sacral rock”
References

CASE 1. JA. Subjective

- J is a 36 year old female who presented to the office in withdrawal after realizing that she was dependent on Tramadol and other opiates. She was taking at least 3 pills a day of anything she could get her hands on: Tylenol #3, Vicodin, Norco, and Lorazepam- .5-1 mg a few times weekly when she is withdrawing from narcotics. Tobacco- 5-10 cigarettes daily. No ETOH, no marijuana, no cocaine, no meth, She abused Adderall in past, not currently taking it, denies heroin use. Pt states she only sleeps with lorazepam, not without, Withdrawal symptoms- pain, tingling, nausea, diarrhea, irritability.

- She began using opiates after having first child. She had bad recovery after first child birth and was given opiates. She states that they were being refilled and she never stopped. Pt has two kids, had abstinence period for year. Pt has back pain, leg pain, shooting pains down legs. Pt was on sertraline, stopped one week ago. Pt was taking this for depression, 100 mg daily.

- She decided one day that she wanted to stop using, no one is pressuring her. Her husband is unaware of relapse, family does not know. Tramadol-up to 3 daily seems to be the worst withdrawal. States it feels like “brain zaps”, last dose was two days ago.
CASE 1: JA. Objective

- She presented extremely agitated and anxious. She was pacing around the room and unable to sit.
- UDS positive for benzodiazepines and opiates
CASE 1: JA. Assessment

- Opioid Dependency
- Benzodiazepine abuse
- Anxiety Disorder
CASE 1 JA Plan

• Patient started Suboxone by induction and was encouraged to go to 12 step meetings.
• 5 years later she is doing well engaged in AA and on a low dose of Suboxone.
• She stated that she wishes she were told more about what it would be like after the baby was born. She felt that she was prepared during pregnancy but not for afterwards.
CASE 2 DS Subjective

- 34 year old female seen in office for Suboxone maintenance. On 16mg a day.
- Living in Sober living, going to 12 step meetings, had a sponsor.
- Started using opiates after son was born 14 years ago. Does not have custody of him.
- Found out she was pregnant unexpectedly. Father is a younger coworker. He is not in recovery and feels she can just tough it out.
- Immediately left sober living and moved in with him. Stopped going to 12 step meetings and connecting with her sponsor.
CASE 2 DS Objective

• Was extremely excited and happy about the pregnancy.
• Urine drug screens positive for buprenorphine, benzodiazepines, THC
CASE 2 Assessment

- Opiate dependency in remission
- Cannabis abuse
- Benzodiazepine abuse
- Anxiety
- Pregnancy
CASE 2 DS Plan

• Patient told to stay on Suboxone and to meet with a high risk OB as soon as possible to verify medication and start prenatal care.
• Patient went to a general OB at a local hospital. Did not share the extent of her addiction. Did share that she was on Suboxone. Release was signed.
• OB was not monitoring urine drug screens and was not familiar with Suboxone.
• OB was concerned about anxiety and depression and wanted to refer to social worker and possibly put patient on SSRI.
CASE 2 DS Plan

- Patient started taking benzodiazepines that she “found” in the bottom of her purse and started smoking marijuana to help her morning sickness.
- She had scheduled weekly OB appointments but stopped showing up. She tried weaning herself off of Suboxone because she “just wanted to be normal”
- Due in 2 weeks. Was having a planned C-section but now looking at a Vaginal delivery
Thank YOU!

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