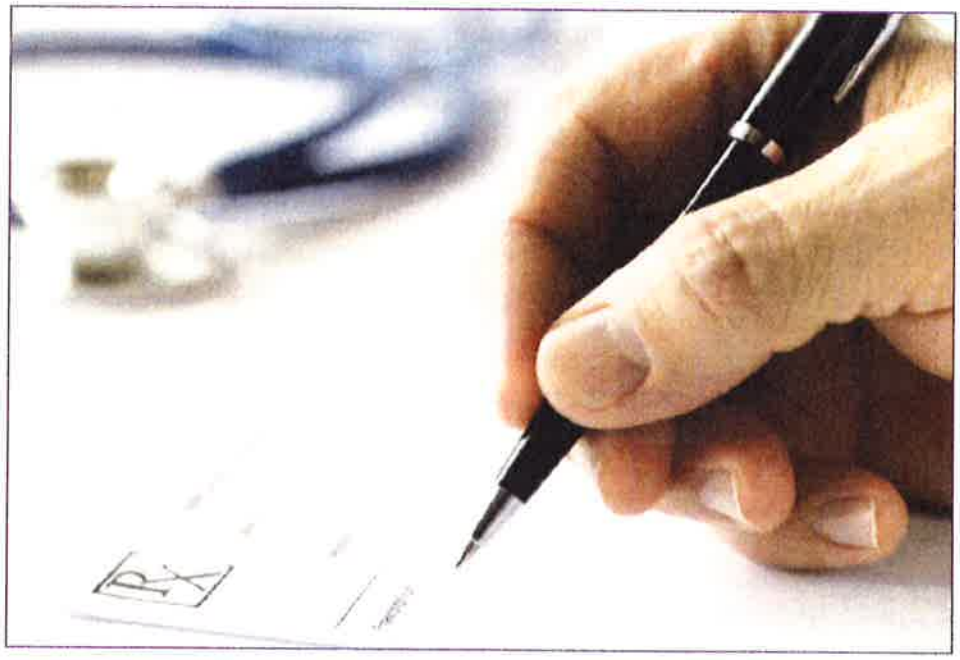
Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Recommendations and Reports / Vol. 65 / No. 1
March 18, 2016

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016



Continuing Education Examination available at http://www.cdc.gov/mmwr/cme/conted.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

Full report available:

https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

Excerpts:

- Pg 13-14:

  … Opioids used in pregnancy can be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with birth defects, including neural tube defects (*139*,*140*), congenital heart defects (*140*), and gastroschisis (*140*); preterm delivery (*141*), poor fetal growth (*141*), and stillbirth (*141*). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome (*142*). Patients with mental health comorbidities and patients with histories of substance use disorders might be at higher risk than other patients for opioid use disorder (*62*,*143*,*144*).
  …

- Pg 26-27:

  Pregnant Women

  Opioids used in pregnancy might be associated with additional risks to both mother and fetus. Some studies have shown an association of opioid use in pregnancy with stillbirth, poor fetal growth, pre-term delivery, and birth defects (contextual evidence review). Importantly, in some cases, opioid use during pregnancy leads to neonatal opioid withdrawal syndrome. Clinicians and patients together should carefully weigh risks and benefits when making decisions about whether to initiate opioid therapy for chronic pain during pregnancy. In addition, before initiating opioid therapy for chronic pain for reproductive-age women, clinicians should discuss family planning and how long-term opioid use might affect any future pregnancy. For pregnant women already receiving opioids, clinicians should access appropriate expertise if considering tapering opioids because of possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal (see Recommendation 7). For pregnant women with opioid use disorder, medication-assisted therapy with buprenorphine or methadone has been associated with improved maternal outcomes and should be offered (202) (see Recommendation 12). Clinicians caring for pregnant women receiving opioids for pain or receiving buprenorphine or methadone for opioid use disorder should arrange for delivery at a facility prepared to monitor, evaluate for, and treat neonatal opioid withdrawal syndrome. In instances when travel to such a facility would present an undue burden on the pregnant woman, it is appropriate to deliver locally, monitor and evaluate the newborn for neonatal opioid withdrawal syndrome, and transfer the newborn for additional treatment if needed. Neonatal toxicity and death have been reported in breast-feeding infants whose mothers are taking codeine (contextual evidence review); previous guidelines have recommended that codeine be avoided whenever possible among mothers who are breast feeding and, if used, should be limited to the lowest possible dose and to a 4-day supply (203).

FEDERAL GUIDELINES FOR OPIOID TREATMENT PROGRAMS

January 2015

SAMHSA

Full report here: http://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/PEP15-FEDGUIDEOTP

Pg 4: These guidelines pertain to "opioid agonist treatment medications that are approved by the Food and Drug Administration: Currently, these drugs are methadone and pharmaceutical products containing buprenorphine.

Excerpts:

- Pg 25
  For women with childbearing potential, the physician conducts an assessment for pregnancy and reviews the results of a pregnancy test before initiating medically supervised withdrawal. For pregnant patients, the physician should not initiate withdrawal before 14 weeks or after 32 weeks of gestation. When the patient experiences intolerable withdrawal symptoms or actual or potential relapse, the physician should consider halting the withdrawal process and possibly restoring the patient to a previously effective dose. Patient and physician together may decide that an additional period of maintenance is necessary before further medically supervised withdrawal is attempted.

- Pg 27
  Administrative discharge of a pregnant patient is a medically high-risk undertaking. As with all patients, interventions to address problematic behavior should be intensive and begin at the earliest suggestion of concern. **Transfer to treatment in another program is preferable to medically supervised withdrawal in pregnancy.** It may be helpful for the program to establish transfer agreements for treatment for this purpose in advance of the need. In the rare event a pregnant patient is administratively withdrawn and discharged, the program must ensure referrals are followed through to completion. Provider(s) should carefully follow up the patient's pregnancy and opioid use disorder.

- Pg 30
  As of this writing, both methadone and buprenorphine are Pregnancy Category C drugs that call for a careful risk/benefit analysis, but for which there is no known teratogenic effects to the human fetus when medication is taken as directed and relapse is avoided. **Both medications produce opioid dependence in the newborn which requires assessment and monitoring and may require specific medical care.** Although the level of evidence supporting buprenorphine maintenance during pregnancy is not as voluminous as that supporting methadone maintenance treatment, decisions need to factor in access and the specific needs and goals of the patient.

- Pg 32
  NEONATAL ABSTINENCE SYNDROME

  Neonatal abstinence syndrome is a group of problems that occur in a newborn who was exposed to medications or drugs in utero. Babies of mothers who drink alcohol during pregnancy may have a similar condition. **Infants prenatally exposed to opioids may experience hyperactivity of the central and autonomic nervous systems. This causes symptoms affecting the gastrointestinal**

tract and respiratory system. Signs of withdrawal from opioids may begin at any time, from minutes to hours to 2 weeks after birth; however, most appear within 72 hours. Neonatal abstinence syndrome will require management with a regimen of opioid agonist medication in tapering doses for approximately half of opioid-exposed infants. This often requires extended inpatient hospitalization and supportive care.

Programs should make certain the newborns of OTP patients receive prompt medical evaluation if signs or symptoms of neonatal abstinence syndrome appear after discharge from the hospital. (Access: http://vec.chop.edu/healthinfo/neonatal-abstinence-syndrome.html.) This means that mothers must be educated about neonatal abstinence syndrome, its symptoms, its potential effect on their infants, and need for treatment should it occur.

- Pg 42

Consistent with best practices for developmentally appropriate treatment, family involvement is an expectation of treatment for young adults (18-24 years). Onsite education and training for all patients who are parents should be available. Children of patients in medication-assisted treatment may have special mental health and cognitive needs, especially if there has been physical or sexual abuse or neglect. Children should be permitted inside the treatment program under parental supervision. When appropriate, program staff should refer patients who are parents to resources and services in parenting skills and child care as well as parent support groups.

OTPs also should provide reproductive health education for all patients and, when needed, make appropriate referrals for contraceptive services.

…

Patients may be in withdrawal or intoxicated during the first days of treatment; therefore, their orientation to treatment occurs at the time of admission and when they are stabilized. Orientation to treatment comprises continuous education via multiple modalities (e.g., verbal, written, video) in individual and/or group settings.

- Pg 76

Appendix D
CONSENT TO PARTICIPATION IN OPIOID PHARMACOTHERAPY TREATMENT
For Female Patients of Childbearing Age: There is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that I should tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.