Pain Management in OUD during Labor and Delivery

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- Patients on MAT still need pain relief during labor and delivery.
- Shared decision making: Pain management should be provided in the safest and most effective way possible, consistent with the patient’s wishes.
- Use the clinical exam rather than the patient’s prescribed dose of MAT to guide pain relief during pregnancy.
- Remember to use multimodal therapy for postoperative pain management including nonsteroidal therapy (intraoperative ketorolac or IV acetaminophen, if appropriate), spinal or epidural morphine, oral acetaminophen and PCA for breakthrough pain.
- Use PCA dosing “by demand” only (no basal rate).
- Monitor patient for respiratory depression.
Provide L&D Staff Training on Intrapartum Pain Management

- Avoid mixed antagonist/agonist preparations such as nalbuphine (Nubain), butorphanol (Stadol) and pentazocine (Talwin).
- Doulas may help with psychosocial support and pain relief.
- Continue usual dose of medication-assisted therapy during labor and hospitalization. Consider split dosing provides pain relief.
- Use neuraxial anesthesia and consider early epidural.
- Use alternative pain management: nitrous oxide, mindfulness and relaxation training, gabapentin, ketamine can be used.
Labor analgesia

- Continue maintenance opioid agonist in labor (Methadone and Buprenorphine) in addition to other medications.
- Using epidural or combined spinal-epidural analgesia is effective, safe and helpful.
- Solutions of higher concentration of opioids may be necessary.
- One study showed women on buprenorphine needed 47% more opioid analgesic than naïve women.
• Opioid dependence will not affect the efficacy of local anesthetics.
• Using epidural or combined spinal-epidural analgesia can help with both planned SVD and C/S. Engage anesthesia early.
• Discuss labor and pain management early (prenatally) to avoid anxiety.
• Avoid treating opioid-dependent patients with mixed antagonists and agonists (Nubain) to avoid precipitating withdrawal. Watch for w/d in patients not disclosing SUD.
• Consider dividing daily dose buprenorphine and methadone into TID or QID dosing to help with pain management.
Post vaginal delivery analgesia

- Focus on multimodal therapies.
- Can usually be achieved with NSAIDS and acetaminophen (unless they have Hepatitis-C)
- Continue MAT at pre-delivery dose (consider split dosing).
- Watch for over-sedation.
- Use ice packs, Sitz baths and analgesia creams liberally.
For scheduled or urgent Cesarean Section

- Regional anesthesia is preferred using spinal, epidural or combined spinal-epidural.
- Use intrathecal or epidural opioids do help but they may not be as effective in controlling pain as in non-OUD patients.
- Patient–controlled administration pumps (PCA) can be used but may require higher doses. Use as on-demand (not as a basal rate).
- Continue MAT as pre-delivery (dosing q6-8 hours may helpful with some pain relief).
- Monitor for over sedation.
- Avoid using benzodiazepines and zolpidem to decrease respiratory depression.
Postoperative pain management

- C/S: use PCA (on-demand), scheduled regimen of nonsteroidal and acetaminophen mixed with narcotics.
- Use short-acting opioids post C/S for pain relief.
- Send home with no more than #20 (acetaminophen and oxycodone) and set expectations for refill.
- Avoid trigger medications (oxycodone alone).
- Vaginal delivery: nonsteroidal anti-inflammatory and acetaminophen preferred. Use topical analgesics for perineal pain relief.
Postpartum support

• Set expectations prior to delivery.
• Use allied health professionals to provide in-depth and consistent follow up.
• Discuss storage and disposal of leftover medications.
• Mother-baby dyad is beneficial for both mother and baby. Advocate for low stimulation environment, nonsmoking and breastfeeding.
• Contraceptive counseling is important immediately postpartum.
• Encourage lactation counseling to promote and support breastfeeding.
How much pain medication is really needed?

- Telephone survey of 720 post Cesarean patients at 6 academic medical centers.
- Called patients 2 weeks after discharge to gather information regarding type of pain med, amount used, amount left over, pain control.

- 85% filled an opioid prescription
- 59% White race, 15% Black
- 77% Private insurance, 20% Medicaid

Table 2

The number of tablets dispensed, consumed, and leftover for women who filled a prescription for an opioid analgesic after cesarean delivery.

<table>
<thead>
<tr>
<th></th>
<th>Median</th>
<th>25th–75th percentiles</th>
<th>10th–90th percentiles</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tablets dispensed</td>
<td>40</td>
<td>30 to 40</td>
<td>24 to 45</td>
<td>5 to 80</td>
</tr>
<tr>
<td>Tablets consumed</td>
<td>20</td>
<td>8 to 30</td>
<td>2 to 40</td>
<td>0 to 60</td>
</tr>
<tr>
<td>Tablets leftover</td>
<td>15</td>
<td>3 to 26</td>
<td>0 to 36</td>
<td>0 to 59</td>
</tr>
</tbody>
</table>

*N=605; 10 patients who were dispensed an opioid were excluded from this analysis for missing data.
Table 3
Patient outcomes stratified by tertiles of the number of opioid analgesic tablets dispensed.

<table>
<thead>
<tr>
<th></th>
<th>Tertile Dispensed</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>≤ 30 Tablets (n=237)</td>
</tr>
<tr>
<td>Satisfied or very satisfied with pain relief, n (%)</td>
<td>200 (84.4)</td>
</tr>
<tr>
<td>Patient’s perception of opioid quantity dispensed, n (%)</td>
<td></td>
</tr>
<tr>
<td>Too Little</td>
<td>35 (14.8)</td>
</tr>
<tr>
<td>Just Right</td>
<td>134 (56.5)</td>
</tr>
<tr>
<td>Too Much</td>
<td>49 (20.7)</td>
</tr>
<tr>
<td>Experienced an opioid-related side-effect, n (%)</td>
<td>111 (46.8)</td>
</tr>
<tr>
<td>Required a refill of opioid, n (%)</td>
<td>14 (5.9)</td>
</tr>
<tr>
<td>Pain score at week 1, median (IQR)</td>
<td>4 [3, 5]</td>
</tr>
<tr>
<td>Pain score at week 2, median (IQR)</td>
<td>2 [1, 3]</td>
</tr>
<tr>
<td>Number of tablets consumed, median [IQR]</td>
<td>15 [5 to 24]</td>
</tr>
</tbody>
</table>

Conclusions

- Median number prescribed 40.
- Median number used 20.
- Median number leftover pills was 15.
- 95% had not disposed of extra meds when asked.
- Positive association between the number dispensed and the number consumed.
- Number of opioids dispensed did not correlate with patient satisfaction, pain control, or need to refill pain medication.
Summary

• Set expectations early and use shared-decision model for number of medications sent home with.
• Patients on MAT still need pain control, may need increased dose.
• Regional anesthesia is important. Adjuvant therapy is useful. PCA on demand only.
• Avoid agonist/antagonist combination products (Nubain/Stadol).
• Post vaginal delivery patients usually do well with nonnarcotic meds.
• Post Cesarean Section patients may need slightly more medication in the hospital but send home with lower number narcotic pills (#20).
• Post C/S patients (even not on MAT) do well with 20 narcotic pills.