

Pharmacotherapy Newsletter

“Management of Pregnant Women on Pharmacotherapy”

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Pregnancy care for women with drug and alcohol use issues presents challenges for women and health and service providers involved in their care. This is acknowledged in the nationally agreed evidence based *National Clinical Guidelines for the Management of Drug Use During Pregnancy, Birth and the Early Development Years of the Newborn*.

Methadone maintenance treatment (MMT) for opioid dependent pregnant women has been standard management for over 30 years. That MMT is still considered the gold standard, is based on experience and case studies as much as well-designed clinical trials. Literature from Australia and internationally agrees that these are medically and psychosocially high-risk pregnancies and babies. Even in the presence of multiple drug use, pregnancy, birth and infant risks are demonstrably reduced for women on MMT. Mothers are more likely to remain the primary carers for their babies, including cases where child protection is involved.

Providing pregnancy care based on harm minimisation for women with opioid use can be confronting for maternity hospital staff. Midwives, medical staff, dieticians and neonatal nurses have very limited training and exposure to addiction and management of substance use. The illicit nature of drug and alcohol use appears far removed from the picture of motherhood and new babies. How well maternity services and hospitals across the state are prepared to meet the needs of these women is varied, and the often challenging behaviour in a maternity ward can be threatening for unprepared busy staff.

In recent years there has been an increase in specialist chemical dependency units (CDUs), where principles of care underpinning practice include multidisciplinary team care and counselling, continuity of carer, specialist midwifery, care management and community provider collaboration.

The significant challenges for providers are providing antenatal care that is accessible and acceptable for opioid dependent women, limiting crisis interventions, and effectively working with community providers for long-term support.

Women who are stable on pharmacotherapy prior to pregnancy, who have an ongoing supportive therapeutic relationship with their prescriber, and are psychosocially stable, generally do not require the intensive care of a specialist CDU. At the Royal Women’s Hospital (RWH) these women, following Drug and Alcohol (D&A) assessment, are offered routine pregnancy care. Some women may consider GP shared antenatal care, which could be enhanced if the shared care affiliate was also the prescriber.

Welcome to the November 2006 Pharmacotherapy Newsletter in which we are featuring “Management of Pregnant Women on Pharmacotherapy”.

Your feedback and contributions are always welcome, particularly any good news stories about clients and services.

We look forward to developing a forum for the exchange of opinions and information.

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Multidisciplinary care remains appropriate for these women due to the increased risk of relapse in pregnancy, postnatal depression, and risk to the baby of neonatal abstinence syndrome (NAS) and SIDS.

Women with complex D&A use, unstable life issues and often mental health co-morbidity, benefit from intensive antenatal care where providers are consistent and available outside regular clinic times. At RWH this care is provided by the multidisciplinary team at the Women's Alcohol & Drug Service (WADS).

Women may present out of hours to emergency departments, in crisis, or in labour with no history of antenatal care. These women are at high risk of separation from their babies due to child protection involvement. Regardless of the gestation, and with consent, methadone stabilisation is the preferred management. Following initiation of antenatal care and induction onto methadone as inpatients, women are referred to GP prescribers or specialist services and community pharmacists. WADS staff aim to support women to continue with community links if in place, and to work collaboratively with service providers and health professionals.

Engaging women in regular pregnancy care is a universal challenge for this client group. Engagement is a prerequisite for receiving care. Recent research informs us that two main reasons for women not attending antenatal care are fear of child protection and fear of judgemental attitudes. These women also have a higher rate of unplanned pregnancies and late pregnancy confirmation. Women on heroin or pharmacotherapy should be informed about menstrual irregularity and need for effective contraception. Prescribers need to be alert to the need for early identification of pregnancy and appropriate referral.

MMT remains standard practice for pregnant and breastfeeding women because of the long history of safety and efficacy. In recent years there has been improved recognition of the need to increase the dose to prevent withdrawal symptoms and suppress heroin use as pregnancy progresses. Dose increases are required because of increased metabolism and blood volume. Methadone should be titrated according to symptoms and not kept low in an attempt to reduce incidence of NAS. There is no clear dose relationship between methadone and incidence of NAS. There are still occasions however where women present on reducing doses in an attempt to be on a low dose by delivery, or to be off MMT. Reduction following birth should be gradual due to the stress of coping with a new baby.

Buprenorphine is not recommended in Australia for use in pregnancy or breastfeeding. Neither is methadone, however methadone's safety has been demonstrated over time. Women who are on buprenorphine should be informed of the lack of evidence supporting its use antenatally, and transferred onto methadone. Women who elect to remain on buprenorphine can do so with informed consent and have their de-identified details included in *The Victorian Buprenorphine in Pregnancy Register* at <http://www.rwh.com.au/wads>. Data from this register will provide some information about birth and pregnancy outcomes to support future use of buprenorphine in pregnancy.

Suboxone® (buprenorphine +naloxone combination) is not recommended in pregnancy and women who become pregnant on Suboxone® should be transferred to mono buprenorphine (Subutex®). For this reason it is important that Subutex® continues to be a treatment option for pregnant and breastfeeding women.

Withdrawal from opioids should not be attempted in pregnancy, but if it is it should be with informed consent, in the second trimester and in a supported environment with foetal monitoring. Withdrawal should be gradual using tapering doses of methadone.

Vomiting in pregnancy is a significant clinical issue as it may lead to withdrawal in both the mother and foetus. Management is described in the national clinical guidelines and may include the need for hospital admission for rehydration and improved nutrition. Consider other causes of vomiting such as urinary tract infection.

Information and secondary consultation is available at WADS on 03 9344 3631, or after hours via the hospital on 03 9344 2000 and ask for the WADS obstetrician.

A copy of the *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn* was distributed to all prescribers and appropriate agencies.

Further copies are available at: http://www.health.nsw.gov.au/pubs/2006/pdf/ncg_druguse.pdf

New Pharmacotherapy Policy

All prescribers and dosing points will have now received their package from the Department of Human Services, Drugs and Poisons Regulation Group containing: the revised Pharmacotherapy Policy, the National Clinical Guidelines for Buprenorphine and National Clinical Guidelines for Methadone. The policy and guidelines can be viewed and downloaded from: <http://www.health.vic.gov.au/dpu/pharm.htm>

Reminders for Prescribers

Permits:

Prescribers are required by law to obtain a permit to prescribe **before** treatment begins. The purpose of the legislation is to prevent concurrent treatments and eliminate the possibility of double dosing.

The Department needs to be notified of dosing point changes for pharmacotherapy clients.

Take-away doses:

It is recommended that the **Record of patient stability assessment for take-away doses** pro forma tool (Appendix 4 in the policy) be worked through with the patient and included in the patient record before deciding on the appropriate number of take-away doses.

The level of supervised dispensing for each patient should be the **highest** scored on the checklist for **any** of the criteria.

For example, if a patient scores “high” on any single criterion, they should only be eligible for high level supervised dosing e.g. a patient who scores low on 8 criteria, medium on one criterion, and high on one criterion should have high level supervised dosing.

Note: The qualifying criteria for Low Level Supervision (more than two take-away doses per week) should be achieved by a minority of patients who have exhibited

exceptionally good stability in treatment over a significant period of time (at least six months).

A patient needs to be participating in opioid substitution treatment for two continuous months and be stable to be eligible for any take-away doses.

The regular dosing point **should** be contacted as part of the assessment of stability before authorising take-away doses.

Patients who are authorised to receive buprenorphine/naloxone take-away doses should be transferred to the combination for all doses, including those administered under supervision.

Reminders for Pharmacies

Buprenorphine is an unstable drug and when supplied as a take-away dose it should be supplied in the original blister packaging where possible and not crushed.

Each single daily take-away dose of methadone or buprenorphine/naloxone should be in a separate container and must comply with the provisions of the Drugs, Poisons and Controlled Substances Act and Regulations. In addition, the following information should be included, *date, dose to be taken by name of patient. “May cause death or injury if taken by another person.”*

Doses should **never** be administered to a new patient unless the previous dosing point has been contacted and the date, time, and dose of the last dose verified.

If in doubt, don't dose.

Separate tablet crushers should be used for buprenorphine and buprenorphine/naloxone when administered in the pharmacy.

Pharmacists have an obligation to recognise the risk of dose diversion and to adopt practices that minimise it.

Patients need to be reminded that they need to wait until the buprenorphine dose has been absorbed before leaving the pharmacy.

Candida Endophthalmitis

The Drugs Policy and Services Branch of the Victorian Department of Human Services recently developed and distributed a series of three wallet-sized cards providing information for patients being treated with buprenorphine. We ask you to distribute them to clients and explain the serious nature of this infection.

Free online access to the Medical Journal of Australia article on Candida ophthalmitis associated with buprenorphine injection can be found at: http://www.mja.com.au/public/issues/182_08_180405/letters_180405.pdf

Should you require further copies of the wallet cards, please contact Richard Adezio on 9096 5985 or email Richard.adezio@dhs.vic.gov.au

Counselling On-line

As of May 2006, Turning Point offers on-line counselling supporting existing alcohol and drug counselling and treatment services by offering free, text based, confidential support and referral, 24 hours per day, 7 days per week. It can be used by anyone in Australia who has a concern about their drug or alcohol use, or who is concerned about the drug or alcohol use of someone close to them.

www.counsellingonline.org.au

For referral cards contact DrugInfo Clearinghouse on 1300 85 85 84

Working with Antisocial Presentations

Caraniche Pty Ltd is a newly established organisation. It provides a full range of psychological services, including alcohol and other drug programs in state-run Victorian prisons and community-based forensic assessment, court reports, and counselling. For further information contact: 8412 7111 or

www.caraniche.com.au

New Pharmacies

During the past five months many pharmacies have joined the group in participating in the Victorian Pharmacotherapy system.

They are:

Lalor Central Pharmacy,
367 High Street, Lalor

Gunn & McConville Pharmacy,
398 Balwyn Road, Balwyn North

Alben Nunawading Station Pharmacy,
23 Station Street, Nunawading

Carrum Downs Chemmart Pharmacy,
Shop 2 The Local Village,
1095 Frankston-Dandenong Road,
Carrum Downs

My Chemist—Ascot Vale,
189 Union Road, Ascot Vale

Leslie Roth Pharmacy,
136 Ormond Road, Elwood

Amberly Park Pharmacy,
Shop 1, 101 Seebeck Drive,
Narre Warren South

Eureka Pharmacy,
Shop G2 70 City Road, Southbank

Findlay & Weymouth Stockland
Plaza Pharmacy,
Shop 27 Stockland Plaza Shopping
Centre, Traralgon

Glengala Road Pharmacy,
66 Glengala Road, Sunshine West

Heathershaw's Central Park Pharmacy,
153 Burke Rd, Glen Iris

Burke Road Malvern Amcal Pharmacy,
255 Burke Rd (Cnr Malvern & Burke),
Glen Iris

Caulfield Plaza Amcal Pharmacy,
860 Dandenong Road, Caulfield East

Doveton Pharmacy,
2 Photinia St, Doveton

David and Ingrid Norton Pharmacy,
926 Riversdale Road, Surrey Hills

Sunshine Marketplace Pharmacy,
Shop 45 Sunshine Marketplace S/C,
80 Harvester Road, Sunshine

Eureka Medical Centre Pharmacy,
14 Albert St, Ballarat