Management of Pain During and After Delivery

Pregnant women with Opioid Use Disorder (OUD) must be reassured that their pain can and will be treated. For women on Medication for Opioid Use Disorder (MOUD), it is important to support continued treatment of pain because it is essential for their health and well-being as is expected in the care of all women.

Addressing Pain in Patients with OUD

Special considerations for patients on medication treatment for OUD

- Medications used for treatment of OUD are not sufficient alone for pain control.
- Maintenance doses of MOUD should be continued throughout labor and delivery.
- For Buprenorphine and Methadone:
  - Increase total daily dose during pregnancy
  - Increase frequency of administration to 2-4x per day
- Additional opioids may be needed if non-opioid treatments are insufficient.

Buprenorphine	Methadone	Naltrexone

• Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
• If using additional opioids for pain, may require higher doses due to the buprenorphine blocking effect (high affinity).
	• Avoid butorphanol, nalbuphine, and pentazocine in all patients with OUD or chronic opioid use as these are partial agonists and can precipitate opioid withdrawal.
	• Confirm the dose with the provider, and notify the provider of all pain medications given.
	• Baseline dose is not sufficient for analgesia.
	• Pain relief can be achieved with additional doses of methadone, split dose three times per day.
	• If patient is NPO, methadone can be given IV (if IM or SC, give half the dose divided 2-4 times per day).
		• Blocks the analgesic effects of opioids
		  ○ Oral naltrexone blocks analgesia for 72 hours after last dose.
		  ○ IM (depot) blocks analgesia for 14-25 days.
		• For acute pain management favor regional and non-opioid options.

Optimize Non-Opioid Pharmacological Options	Optimize Non-Pharmacologic Options
Acetaminophen NSAIDs (e.g., ibuprofen, ketorolac) Ketamine if available Neuraxial or regional blocks	Mindfulness, meditation Cognitive Behavioral Therapy (CBT) and other behavioral therapy Physical therapy/Light exercise Biofeedback

Opioids can be used when above strategies fail.

Managing MOUD During and After Birth

Continue methadone and buprenorphine during labor and cesarean or vaginal delivery.

- *Do not stop MOUD at the time of delivery because it puts women at increased risk for relapse, and restarting MOUD in the postpartum period is challenging.*

Prior to delivery, collaborate with anesthesia colleagues to plan pain management during and after birth.

- *Use regional analgesia if possible (epidural or spinal, regional blocks if appropriate).*
- *Maximize non-opioid pain relief (avoid NSAID prior to delivery).*
- *Pain must be treated adequately to enable mobility for newborn care and breastfeeding.*

The dose of buprenorphine or methadone may need to be increased throughout the pregnancy.

- *Due to metabolic changes during pregnancy, it is common to have to increase the frequency of methadone and buprenorphine dosing; this can be continued post-delivery while pain management is challenging.*
- *Metabolic changes gradually return to the pre-pregnancy state in the 2-4 weeks postpartum, so dosing will need to be decreased to pre-pregnancy dosing, and pain and sedation levels should be monitored.*

Continuation of MOUD in Postpartum period

- *Avoid discontinuation of MOUD for 6-12 months to minimize risk of relapse/overdose at this high-risk time.*

For questions about management of pain and MOUD in the peripartum period, call MCPAP for Moms at 855-666-6272.

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