# Intrapartum Management of Women on Buprenorphine

Women on buprenorphine can generally have their labor managed like any other labor. Usual protocols for fetal monitoring and medical decision making should be applied.
The only exceptions to usual care may come when managing labor related and Cesarean section related pain.

Labor Pain

Women on buprenorphine may have a higher tolerance for opioids.

- Buprenorphine should not be discontinued in anticipation of labor. When a person is hospitalized for a reason other than addiction (e.g., labor) her hospital providers can legally order and dispense buprenorphine. Any hospital prescriber is allowed to do this.
- Epidural anesthesia for the management of labor pain is effective, appropriate and often preferred in this population.
- If opioids are used to manage pain, the provider can anticipate that the patient may require 30-50% higher doses than are typically needed.
- Providers should start with the usual dose of opioids used at their institution and, if that is not sufficient, increase the dose by 30%-50% with each dose until pain control is achieved.
    - Example protocol:
    - Fentanyl 50mcg IV for first dose (or 0.5-1mcg/kg).
    - Wait 5-10 minutes for effect.
    - If adequate analgesia is achieved, repeat at this dose at when pain returns.
    - If adequate analgesia not achieved, provide 75mcg IV.
    - Wait 5-10 minutes for effect.
    - If adequate analgesia is achieved, repeat at this dose when pain returns.
    - If adequate analgesia not achieved, provide an additional 25mcg and
    - In 30 minutes or when pain returns, provide 100mcg IV.
    - If doses greater than 100mcg are required, consult anesthesia and consider regional anesthesia.
- As with any other population, women in labor who are on buprenorphine should be involved in shared decision making conversations about pain management, and can be reassured that both an epidural and opioids are effective pain management strategies.

C-Section Pain

As with most C-sections, regional anesthesia is preferred over general anesthesia for women on buprenorphine. Spinal and epidural anesthesia are effective pain management strategies for C-section pain.

- Buprenorphine should not be discontinued in anticipation of C-section. When a person is hospitalized for a reason other than addiction (e.g. labor) her hospital providers can legally order and dispense buprenorphine. Any hospital prescriber is allowed to do this.
- Usual protocols for intraoperative pain can be used, with the caveat that higher doses of opioids may be required for optimal pain management.
- Because of the heightened fear of pain that may be experienced by women in this population, it can be useful to coach women through the experience, helping them identify the difference between the normal pressure and pulling felt during C-section and the pain that they fear.

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Post-Operative and Post-Partum Pain

- Buprenorphine should be continued post-partum. When a person is hospitalized for a reason other than addiction (e.g. labor) her hospital providers can legally order and dispense buprenorphine. Any hospital prescriber is allowed to do this.
- Pain after a vaginal birth may be adequately managed with NSAIDs, Ice packs, and other non-opioid strategies.
    - If pain is severe enough to require opioids, many women will respond well to usual doses of opioids, such as hydrocodone/APAP 5/325 or 10/500.
    - Some women will require more potent opioids at higher doses, such as oxycodone 5-10mg q 4-6 hours.
    - Providers should begin with the lower doses that are available at their institution and titrate up according to patient pain.
- Post C-section pain will typically require opioids.
    - In this case, lower dose options like hydrocodone/APAP 5-10/325-500 should be started initially.
    - If insufficient, the patient can be transitioned to oxycodone 5-10mg q 4-6 hours, titrated as needed for pain.

Breast Feeding

Women on buprenorphine should be encouraged to breast feed.

- Very little buprenorphine is found in breast milk.
- At the same time, breast feeding has been found to reduce the incidence and severity of neonatal abstinence syndrome, most likely because of the increased frequency of skin to skin contact, sucking, and holding.
- Women should receive education and lactation support.
- Neonates who are held frequently, kept in low-noise and low-light environments, and provided with frequent opportunities for suckling and feeding have lower rates and severity of neonatal abstinence syndrome. For this reason, rooming in with the mother is strongly encouraged for these newborns.

Discharge Planning

Women should continue buprenorphine after discharge. Buprenorphine therapy should be continued indefinitely, especially as the family embarks on a period of intense change, stress, and sleep deprivation. The post-partum period is a dangerous time to discontinue buprenorphine, with the risk of relapse increasing dramatically if the medication is discontinued.

- Prior to discharge, contact the patient's prenatal buprenorphine provider to confirm the plan for ongoing buprenorphine prescribing after discharge.
- If there will be a delay in re-establishing care with her buprenorphine prescriber, a provider with a DEA waiver, either on the hospital team or on her outpatient team, must write a prescription for enough buprenorphine to last until the follow up appointment. Because the discharge prescription is technically an outpatient prescription, it cannot be prescribed by clinicians who do not have a DEA waiver for buprenorphine prescribing.

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