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Perinatal News & Events

Cincinnati Children's Perinatal Outreach Program

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Inside this Issue

The Compatibility of Breastfeeding and Opioid Maintenance Therapy in New Mothers

Providers in our region have observed a dramatic increase in the number of infants born exposed to opiates *in utero*. The number of hospitalizations associated with exposure to opiates in newborns has increased by 540% from 2004 to 2011 in the state of Ohio. In addition to managing neonatal abstinence syndrome (NAS) in these infants, clinicians are often challenged with whether they should support or discourage breastfeeding. On the one hand, among mothers actively abusing or misusing opiates, there is a real risk of transferring dangerous levels of the abused drug to the infant through breastfeeding. On the other hand, for mothers who are currently stable in their recovery from substance abuse and are on opioid maintenance therapy, breastfeeding could provide important benefits to the couplet. In addition to providing the newborn with optimal nutrition and protection from common childhood illnesses, breastfeeding has been demonstrated to lessen the symptoms of NAS and to decrease the need for pharmacologic therapy. Furthermore, breastfeeding has been shown to lower the risk of maternal child abuse and to attenuate maternal anxiety, both of which may be especially important for these high-risk couplets.

There are **two main questions** when considering the decision to support or discourage breastfeeding in the context of opiate exposure:

- Is the mother is stable in her recovery?
- Is her current maintenance regimen is compatible with breastfeeding?

For guidance in answering the first question, we have drawn upon the **Academy of Breastfeeding Medicine** clinical protocol on breastfeeding for the drug-dependent woman, where it is recommended that breastfeeding can be encouraged in women who are engaged in substance abuse treatment and who have abstained from drug use within 90 days prior to delivery. In cases where there is a history of relapse during the pregnancy but no evidence of abuse or misuse within 30 days prior to delivery, providers should carefully evaluate the circumstances and determine the appropriateness of breastfeeding on an individual basis. Breastfeeding should be discouraged if there is ongoing or recent (within 30 days of delivery) abuse or misuse. For more details, see the link listed in resources, on page 2.

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Breastfeeding and Opiod Maintenance Therapy *continued from page one*

With regards to the second question, summaries of the most common opiate maintenance drugs—methadone, buprenorphine, and naltrexone—and their compatibility with breastfeeding can be found at the **National Library of Medicine LactMed** database. Maternal use of any narcotic during breastfeeding has the potential to increase the risk of sedation and respiratory depression in the newborn; however, the risk is greatly diminished in the breastfed infant who had been exposed to the same drug *in utero*. Methadone has greatly diminished in the breastfed infant who had been exposed to the same drug *in utero*. Methadone has been the most extensively studied. The estimated neonatal dose of methadone through breast milk is approximately 1-3% of the mother's weight-adjusted dose. Breastfeeding is widely regarded as appropriate for the methadone-maintained woman, but she should be counseled that abrupt discontinuation of breast milk may cause rebound symptoms of NAS. Buprenorphine is excreted into breast milk at low levels, but has poor oral bioavailability in infants and thus is considered compatible with breastfeeding. For Naltrexone, less data are available, but it appears to be minimally excreted into breast milk and is considered compatible with breastfeeding.

Thus, based on the available evidence, appropriate use of methadone, buprenorphine, or naltrexone as part of opiate maintenance therapy is compatible with breastfeeding. Therefore, these mothers should be encouraged and supported in their efforts to breastfeed, while at the same time informing the mother to be aware of the slight possibility of sedation in the infant.

Laurie A. Nommsen-Rivers, PhD, RD, IBCLC
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Cincinnati Children's Hospital

Resources

Link to American Academy of Breastfeeding Medicine Protocol # 21:
Guidelines for Breastfeeding and the Drug-Dependent Woman:
http://www.bfmed.org/Media/Files/Protocols/Protocol%2021%20English.pdf

Link to LactMed:
http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT

Cradle Cincinnati

Cradle Cincinnati reached several milestones in February: we held our first community advisory meeting, released our 2013 data report, and announced the 2013 city and county infant mortality rates. We had a fantastic turnout at our community meeting on February 18 – over 130 representatives from the local government, maternity hospitals, health departments, and community organizations. At this meeting, we released our 2013 data report as well as the 2013 infant mortality rates – 8.9 deaths per 1,000 live births in Hamilton County and 9.9 deaths per 1,000 live births in the city of Cincinnati. Both rates are the lowest in city and county history, and represent a decrease of 3.3% over the previous year, respectively. While both exceed the national average of 6.1, we have a growing community of partners gathering to collectively address this issue. The conversation on infant mortality is spreading beyond the healthcare and public health fields, thanks in part to the media coverage our meeting received from several local outlets.

cradle cincinnati
every baby, every day

Coming up in March, we are launching our new website. In addition to our data report, it will feature a community resource guide, which provides contact information for prenatal care, support groups, food assistance, smoking cessation, and everything in between. This guide is ideal for expecting and current moms as well as community agencies serving these populations.

For more information on Cradle Cincinnati, or to view our data report and community resource guide, please visit **www.cradlecincinnati.org**.

Ryan Adcock, Executive Director

Ohio Perinatal Quality Collaborative

The Ohio Perinatal Quality Collaborative (OPQC) is proud to announce two new, statewide quality improvement initiatives: **The Neonatal Abstinence Syndrome (NAS) Project** and **The Progesterone Project**. Both projects were launched at our OPQC Learning Session in Columbus, OH on January 27, 2014, and will contribute to OPQC's mission to reduce preterm births and improve perinatal and preterm newborn outcomes in Ohio.

The NAS Project

It is estimated that one infant is born addicted to narcotics every hour in the United States. The NAS epidemic is steadily increasing, overwhelming social service systems and public payers. In Ohio in 2011, treating infants born with NAS cost more than $70 million and nearly 19,000 inpatient days. Preliminary data from pilot work funded by the Ohio Children's Hospital Association (OCHA) estimates that up to 50% of neonates with NAS in Ohio were not receiving optimal care, despite evidence-informed data and national guidelines that exist to indicate best practices for identification and treatment of these infants. Thus, there is substantial opportunity for improvement, and reducing variation in identification and treatment will correct deficiencies in both under-identification, and under- and overtreatment.

- **The aim of the OPQC NAS Project is to increase the identification of and compassionate withdrawal treatment for full-term infants born with NAS, thereby reducing the length of stay for these infants by 20% across participating sites by June 30, 2015.**

With funding from the Ohio Department of Medicaid, OPQC will test strategies for implementing evidenced-informed treatment protocols to all 37 Level 2 and Level 3 NICUs across Ohio, and will then disseminate identification protocols to all Level 1 hospitals.

The Progesterone Project

Ohio currently ranks 35th in infant mortality and 31st in prematurity, and prematurity is the leading cause of neonatal morbidity and mortality. Further, women identified as having a shortened cervix or women with a previous history of spontaneous premature birth face increased odds of pre-term birth (PTB). Progesterone is an evidence-based therapy shown to reduce PTB by more than 30% in women with prior PTB and/or short cervix. American College of Obstetrics and Gynecology (ACOG) recommendations, released in 2012, support supplemental progesterone to reduce the risk of PTB in these patients.

- **The aim of the OPQC Progesterone Project is to reduce the rate of premature births in Ohio < 37 weeks by 10% and births < 32 weeks in Ohio by 10% by July 1, 2015 by increasing the screening, identification, and treatment of pregnant women at risk for preterm birth who will benefit from progesterone.**

OPQC will test strategies for implementing this medication in 20-40 outpatient clinics that are identified by our 20 charter OPQC OB sites and then will disseminate to the other 87 maternity hospitals in Ohio.

*You can learn more about OPQC by going to our website, **www.opqc.net**, and by following us on Twitter @OhioPQC.*

Kate Haralson, MPH
Ohio Perinatal Quality Collaborative

PERINATAL INSTITUTE

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Our mission is to improve the health of newborn infants through innovation in clinical care, education and research.

www.cincinnatichildrens.org

www.cincinnatichildrens.org/perinatal

Perinatal Resource Directory

Mark Your Calendar!

THIRTEENTH ANNUAL REGIONAL PERINATAL LEADERS' SUMMIT

October 17, 2014

Sabin Auditorium Cincinnati Children's Hospital

Announcements

Butler County Partnership to Reduce Infant Mortality 1st Annual Fundraising Gala

6:00-8:00 pm, Monday, April 7, 2014
Fitton Center for Creative Arts, Hamilton
For more information, contact: BOH@butlercountyohio.org

Butler County Partnership to Reduce Infant Mortality

4:00-6:00 pm, April 8, 2014
Butler County Educational Service Center
For more information, contact: bailerj@butlercountyohio.org

Fetal Infant Mortality Review (FIMR)

3:30-5:00 pm, Thursday, April 17, 2014
Cincinnati Health Department
Please contact Corinn Taylor at (513) 357-7266 if you would like to attend.

Perinatal Community Action Team (PCAT)

2:30-4:00 pm, Thursday, April 24, 2014
Cincinnati Children's, Vernon Manor 2.020
For more information, contact: kathy.hill@cchmc.org

Resolve Through Sharing® (RTS) Bereavement Training

7:30 am-4:30 pm, May 14-15, 2014

RTS Coordinator Training

8:00 am-3:30 pm, May 16, 2014
Cincinnati Marriott RiverCenter
Brochure and registration are available at: www.bereavementservices.org

Cincinnati-Dayton Combined Perinatal Nurse Manager Meeting

9:30 am–3:30 pm, Friday, May 16, 2014
Cincinnati Children's Liberty Township, a2.034-36
For more information, contact: kathy.hill@cchmc.org

Cincinnati Children's