Women who use drugs need good information and responsive care during pregnancy

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On returning from holiday, almost the first person I saw in the surgery was Rachel, aged 26 years who had been a patient of mine for 3 years. She was receiving methadone maintenance from us, of 60mg daily, took no other drugs and rarely drank alcohol. She worked as a classroom assistant in a local primary school. She had come to tell me she was pregnant (and ask me if I had a good holiday). She had planned the pregnancy and had stopped contraception about 8 months previously. Rachel was excited and wanted the baby but she was obviously scared and had a list of questions.

As Rachel had not had a period since stopping contraception, it had taken her a few weeks to realize she was pregnant. She thought she was about 12 weeks and wanted to know what to do next. Her biggest question was could the methadone hurt her baby. We had discussed this before she stopped contraception and we know that this is the fear most frequently expressed by women who use substances that their use will cause foetal anomalies when actually it is quite uncommon.

I assured her that methadone was unlikely to cause foetal anomalies and it was certainly preferable to erratic heroin use. I explained that as heroin was a short acting drug and withdrawal causes smooth muscle spasm, the fluctuations in blood levels that occur with even fairly regular use of heroin cause repeated minor degrees of withdrawal. This in turn increases the risk of preterm delivery and growth retardation. Many published studies show that few of the drugs commonly used directly affect pregnancy and that the adverse outcomes of pregnancy are more likely to be multifactorial with deprivation together with associated factors such as smoking, poor diet, stress and chaotic lifestyle playing a major aetiological role. This is the reason that women who are pregnant and using drugs do have increased rates of

preterm delivery and low birth weight as well as an increased number of sudden infant deaths.

We decided to get a dating scan done that day and then return for a more in-depth discussion about pregnancy management. Her scan confirmed that she was 12 weeks and she was able to see the specialist midwife at the local hospital the next day for booking. Rachel chose to come to the surgery for most antenatal checks and only go to the hospital if necessary. Women who use drugs have potentially high-risk pregnancies but rarely need high technology to deal with it, therefore their management should be obstetrically led but general practitioners and midwives can deliver most of their care.

Our next discussion covered all the usual things with several additions: could she detox in pregnancy; how bad was the neonatal abstinence syndrome; what to do about her partner with whom she lived but continued to inject drugs; and would social services need to be involved.

Detoxing in pregnancy is possible but relapsing on to other drugs was potentially more damaging. It has been claimed and is still widely believed that withdrawal from opiates/opioids during pregnancy is dangerous to the foetus and should only be undertaken slowly during the mid trimester. However, while in theory rapid opiate withdrawal might be risky, in practice this does not seem to be the case, as long as drug levels reduce steadily and there aren't big fluctuations. Detoxification can therefore be carried out at any stage of pregnancy and at any speed but should only be undertaken if appropriate and if there is a reasonable prospect of success. It should be emphasized to women that stability is the most important thing and while abstinence would be a good thing not if attempting it cause instability and stress.

The other major concern expressed by pregnant drug using women is that the baby will develop withdrawal symptoms after birth. While tobacco and alcohol can cause minor withdrawals only opiates/opioids and benzodiazepines cause significant withdrawals that can need treatment. There is an overall correlation between level of drug use and severity of withdrawal symptoms but this cannot be extrapolated to individual cases. It is therefore not possible to accurately predict which babies will develop severe withdrawals or to draw conclusions about the level of the mother's drug use from the condition of the baby. Withdrawal symptoms are more severe with poly-drug use, especially combinations of opiates/opioids and benzodiazepines, and are less severe if the baby is breastfed.

Rachel next worry was easily resolved by getting her partner, Paul, into treatment with us. The social services question was tricky but two things affected this: the midwife had to refer to social services, as it was local policy for pregnant women who used drugs. And after years of working, I found it was better to get all parties involved early and have a pre-birth meeting. National Guidelines clearly state that for women like Rachel, good communication and coordination is imperative between all parties, care needs to be multidisciplinary and planned. For me, pre-birth meetings with the

parent/s in the driving seat are really helpful in achieving this.

Rachel's pregnancy developed normally and Paul stabilized on 100mg methadone. She had one attempt at reducing her methadone but found it impossible and decided to continue on maintenance. She went into labour spontaneously and had a normal delivery in hospital where the baby's neonatal withdrawals could be managed. Rachel chose to have an epidural to help with pain but if required opioids are effective.

After delivery, Lily, Rachel's daughter went to the postnatal ward with her. Rachel was given the job of scoring Lily's neonatal withdrawal symptoms. Lily became a bit fractious but Rachel was able to cope by soothing and breast feeding so she didn't require medication maybe due to the fact that methadone passes into breast milk and can help. Breast-feeding should be encouraged in all, except if the woman is HIV positive.

Lily now has a baby sister and lives with her parents Rachel and Paul, both of whom continue on methadone maintenance. Rachel continues as a classroom assistant and Paul is volunteering at a local drug service and hopes to train as a drugs worker.
If you aren't totally familiar with your local Maternity and Social Services policies around women who use drugs and are pregnant then check them out and challenge them if they aren't up to a good standard.