Mother & Baby Substance Exposure Toolkit Best Practices

Best Practice No. 14

A part of the California Medication Assisted Treatment Expansion Project

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Implement care pathways for peripartum and postpartum pain management for pregnant patients without OUD to minimize opioid use

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Labor and Delivery and Treatment

Overview

Postpartum pain is common. All women experience uterine cramping in the early postpartum period that is necessary to prevent excess bleeding, and women with lacerations from vaginal birth experience perineal pain. After cesarean birth, women experience pain from the laparotomy. It is necessary to treat pain adequately to support maternal comfort and to reduce the stress response of the mother and newborn. It is also critically important to limit the amount of opioids prescribed on discharge that may lead to prolonged use and possibly misuse. Leftover medication is a common source of opioids that are diverted for misuse. The potential for diversion and misuse of opioids make it a public health priority to prescribe only the minimum amount required by the patient.

Cesarean birth is the most commonly performed surgery in the United States, yet little is known about appropriate pain management at discharge. In general, women consume half the amount of opioids prescribed to them on discharge. For example, a recent study found that the median number of opioid tablets prescribed was 40 and the median consumed was 20 (Bateman BT, et al, 2017). The amount of opioid consumed was directly proportional to the amount prescribed. However, the amount of opioids dispensed did not correlate with patient satisfaction, pain control, or the need to refill the opioid prescription. The majority of women do not require an opioid prescription after vaginal delivery. Despite the well-known risks, 29% of women were prescribed an opioid at the time of discharge after vaginal delivery.

Enhanced Recovery: There is a national effort for all surgeries to redesign care for the peri-operative period to enhance recovery. In May 2019, the Society for Obstetric Anesthesia and Perinatology (SOAP) released a comprehensive set of guidelines (see Resources) for each phase of care for women undergoing a cesarean birth known as Enhanced Recovery After Cesarean (ERAC). Every obstetric unit should strongly consider these recommended approaches. A part of enhanced recovery is optimizing care so that the need for opioid pain medications is markedly lowered and/or replaced by non-opioid approaches. A

Call to Action for ERAC with a comprehensive discussion was published in the August 2019 issue of *The American Journal of Obstetrics and Gynecology*. One of the goals is to ensure that all women have access to adequate pain control while reducing the harms of opioid exposure.

Why we are recommending this best practice

There is considerable evidence that new mothers are consistently over-prescribed opioids after delivery. Better pain control is achievable with less opioids using a multimodal approach. There is evidence that most women require fewer than 20 opioid tablets following uncomplicated cesareans and that scheduled non-opioid analgesics provide superior pain relief and facilitate reduced opioid consumption compared to PRN dosing. A similar protocol did not result in an increase in outpatient opioid refill rate.

Strategies for Implementation

- Establish a multidisciplinary team to implement a unit-wide ERAC protocol.

- Scheduled NSAIDs and acetaminophen are the first line agents for postpartum pain control. Ibuprofen 600 mg and Acetaminophen 650 mg PO Q 6 hours can be concurrent or staggered dosing. The oral route is preferred unless inappropriate.

- Offer oxycodone 5 mg PO Q6 hours PRN pain instead of the combination of APAP/oxycodone. Avoid codeine and tramadol in breastfeeding women.

- Consider a lidocaine patch for post-cesarean laparotomy pain. Consider transverse abdominus plane block immediately post-cesarean for post-incisional pain. See **Best Practice #15**.

- Evaluate the amount of opioids used by the patient in the 24 hours prior to discharge and use shared decision making to decide how many oxycodone tablets to give the patient, but limit the amount to a three-day supply or on average 15-20 tablets.

- Perineal pain requiring opioids should prompt a careful evaluation for hematoma, wound breakdown, or infection.

	Vaginal birth	Cesarean Birth
Non-opioids	• Ibuprofen 600 mg Q 6 hours. Dispense # 30, 600 mg tablets (1-week supply). • Acetaminophen 650 mg Q 6 hours. Dispense #60, 325 mg tablets (1-week supply).	• Ibuprofen 600 mg Q 6 hours. Dispense # 60, 600 mg tablets (2-week supply). • Acetaminophen 650 mg Q 6 hours. Dispense #120, 325 mg tablets (2-week supply)
Opioids	• Opioids not prescribed unless required by patient for pain control during the hospital stay.	• Use shared decision making and consider CDC safe prescribing of only 3 days' supply. • Oxycodone 5 mg Q 6 hours PRN pain. Dispense 15-20 tablets (3 days' supply).

Sample guideline for oral analgesic prescribed at discharge

Proposed guidelines for uncomplicated normal spontaneous vaginal birth (Mills JR, et al, 2019)

- **Guideline 1:** Long-term opioid use often begins with the treatment of acute pain. When opioids are started, providers should order the lowest effective dosage and prescribe no greater quantity of opioids than needed for the expected duration of pain severe enough to require opioids.

- **Guideline 2:** When starting opioid therapy, providers should prescribe immediate-release opioids instead of extended-release or long-acting opioids. This is especially important on the day of discharge.

- **Guideline 3:** Providers should avoid prescribing opioid pain medications and benzodiazepines concurrently whenever possible.

- **Guideline 4:** Nonpharmacologic therapy and non-opioid pharmacologic therapy are preferred for patients who had a normal, spontaneous vaginal delivery with no complications. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.

- **Guideline 5:** When providers identify a patient with OUD, treatment discussions should be prioritized during hospitalization, on discharge, and at the postpartum appointment.

Deep Dive

There are many elements of ERAC that can help limit opioids while providing adequate pain control.

- Neuraxial long-acting opioids.
- Non-opioid analgesia started in the operating room unless contraindicated. These are ideally started prior to onset of pain (ketorolac 15-30 mg IV after peritoneum closed and/or acetaminophen IV after delivery or PO before/after delivery).
- Consider local wound pain control such as TAP block or lidocaine patch at incision site.
- Promote return of bowel function. Constipation can lead to increased unnecessary post-operative gas pain; limiting opioids, scheduled bowel regimen, and mobilization can mitigate this.

For all patients, remember immediate skin-to-skin, early promotion of breastfeeding, early ambulation and promotion of rest periods. These all improve the maternal psyche and can improve overall perception and coping with pain.

Reference: Society of Obstetric Anesthesia and Perinatology (SOAP) Enhanced Recovery After Cesarean (ERAC) Consensus Statement, https://soap.org/SOAP-Enhanced-Recovery-After-Cesarean-Consensus-Statement.pdf

Resources

1. Sample patient-oriented teaching regarding multimodal pain management after cesarean delivery: UNC School of Medicine, Center for Maternal and Infant Health.

2. Sample discharge instructions regarding pain medication after delivery: UNC School of Medicine, Center for Maternal and Infant Health.

3. Society of Obstetric Anesthesia and Perinatology (SOAP) Enhanced Recovery After Cesarean (ERAC) Consensus Statement.

References

1. Bateman BT, Cole NM, Maeda A, et al. Patterns of Opioid Prescription and Use After Cesarean Delivery. Obstet Gynecol. 2017;130(1):29-35.
2. Fahey JO. Best practices in management of postpartum ain. J Perinat Neonatal Nurs. 2017;31:126-36.

3. Inciardi JA, Surratt HL, Cicero TJ, Beard RA. Prescription Opioid Abuse and Diversion in an Urban Community: The Results of an Ultrarapid Assessment. Pain Medicine. 2009;10(3):537-548. doi:10.1111/j.1526-4637.2009.00603.
4. Smith AM, Young P, Blosser CC, Poole AT. Multimodal Stepwise Approach to Reducing In-Hospital Opioid Use After Cesarean Delivery: A Quality Improvement Initiative. Obstet Gynecol. 2019;133(4):700-706.
5. Prabhu M, Dubois H, James K, et al. Implementation of a Quality Improvement Initiative to Decrease Opioid Prescribing After Cesarean Delivery. Obstetrics & Gynecology. 2018;132(3):631-636. doi:10.1097/aog.0000000000002789.
6. Prabhu M1, Garry EM, Hernandez-Diaz S, MacDonald SC, Huybrechts KF, Bateman BT. Frequency of opioid dispensing after vaginal delivery. Obstet Gynecol. 2018;132(2):459-465.
7. Osmundson SS, Schornack LA, Grasch JL, Zuckerwise LC, Young JL, Richardson MG. Postdischarge Opioid Use After Cesarean Delivery. Obstet Gynecol. 2017;130(1):36-41.
8. Prabhu M, McQuaid-Hanson E, Hopp S, et al. A shared decision-making intervention to guide opioid prescribing after cesarean delivery. Obstet Gynecol. 2017;130:42-6.
9. Komatsu R, Carvalho B, Flood PD. Recovery after Nulliparous Birth: A Detailed Analysis of Pain Analgesia and Recovery of Function. Anesthesiology. 2017;127(4):684-694.
10. Mundkur ML, Franklin JM, Abdia Y, et al. Days' Supply of Initial Opioid Analgesic Prescriptions and Additional Fills for Acute Pain Conditions Treated in the Primary Care Setting - United States, 2014. MMWR Morbidity and mortality weekly report. 2019;68(6):140-143.
11. Mills JR, Huizinga MM, Robinson SB, et al. Draft Opioid-Prescribing Guidelines for Uncomplicated Normal Spontaneous Vaginal Birth. Obstet Gynecol. 2019;133(1):81-90.
12. Scully RE, Schoenfeld AJ, Jiang W, et al. Defining Optimal Length of Opioid Pain Medication Prescription After Common Surgical Procedures. JAMA surgery. 2018;153(1):37-43.
13. Peahl AF, Smith R, Johnson TRB, Morgan DM, Pearlman MD. Better late than never: why obstetricians must implement enhanced recovery after cesarean. Am J Obstet Gynecol. 2019;221(2):117.e1-117.e7.

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Dr. Pamela Flood is Professor of Anesthesiology, Perioperative, and Pain Medicine at Stanford University. Her research interests include prevention and reduction of pain and opioid use in women after delivery. She divides her clinical time between labor and delivery and her outpatient pain management clinic. She clinical work is directed toward compassionate weaning of high dose opioids and management of pelvic pain syndromes.