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The merits of buprenorphine for pregnant women with opioid use disorder

Several medication-assisted treatments (MATs) for opioid use disorder were highlighted in “What clinicians need to know about treating opioid use disorder,” (Evidence-Based Reviews, CURRENT PSYCHIATRY, August 2016 p. 20-24,30-31,34,36,39) namely, methadone, buprenorphine/naloxone, and naltrexone. For treating pregnant women, methadone was the only MAT noted. Although methadone has been the standard treatment for pregnant patients with opioid use disorder for more than 40 years, recently, buprenorphine has become a reasonable alternative.¹ In the past, published data on the use of buprenorphine in these patients was limited; in recent years, studies have highlighted

use of buprenorphine and its advantages over methadone.

The landmark study, the Maternal Opioid Treatment: Human Experimental Research, a 2010 multicenter randomized controlled trial compared buprenorphine with methadone in pregnant women with opioid use disorder. The results revealed that neonates exposed to buprenorphine needed 89% less morphine to treat neonatal abstinence syndrome (NAS), 43% shorter hospital stay, and 58% shorter duration of medical treatment for NAS compared with those receiving methadone. Other advantages of buprenorphine over methadone are lower risk of overdose, fewer drug-drug interactions, and the option of receiving treatment in an outpatient setting, rather than a licensed treatment program, such as a methadone maintenance treatment program, which is more tightly controlled.¹⁻³

The previous recommendation was to consider buprenorphine for patients who refused methadone or were unable to take it, or when a methadone treatment program wasn't available. This study highlighted some clear advantages for treating this subpopulation with methadone instead of buprenorphine: only 18% of patients receiving methadone discontinued treatment, compared with 33% of those receiving buprenorphine,¹⁻³ and methadone had a lower risk of diversion.³ The accepted practice has been to recommend methadone treatment for patients with mental, physical, or social stressors because of the structure of opioid treatment programs (OTP) (also known as methadone maintenance treatment programs). However, buprenorphine can be dispensed through an OTP, following the same stringent rules and regulations.⁴

The single agent, buprenorphine—not buprenorphine/naloxone—is recommended to prevent prenatal exposure to naloxone. It is thought that exposure to naloxone in utero might produce hormonal changes in the fetus.^{1,5} O'Connor et al⁵ noted methadone's suitability during breastfeeding because of its low concentration in breast milk. Buprenorphine is excreted at breast milk to plasma ratio of 1:1, but because of buprenorphine's poor oral bioavailability, infant exposure has little impact on the NAS score, therefore it's suitable for breastfeeding mothers.⁵

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A possible solution to the 'shrinking' workforce

I would like to offer another pragmatic, easy, and quick solution for dealing with the shrinking psychiatrist workforce (The psychiatry workforce pool is shrinking. What are we doing about it? From the Editor. CURRENT PSYCHIATRY, September 2016, p. 23,24,95).

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The United States is short approximately 45,000 psychiatrists.¹ Burnout—a silent epidemic among physicians—is prevalent in psychiatry. What consumes time and leads to burn out? “Scut work.”

There are thousands of unmatched residency graduates.² Most of these graduates have clinical experience in the United States. Psychiatry residency programs should give these unmatched graduates 6 months of training in psychiatry and use them as our primary workforce. These assistant physicians could be paired with 2 to 3 psychiatrists to perform the menial tasks, including, but not limited to, phone calls, prescriptions, prior authorizations, chart review, and other clinical and administrative paper work. This way, psychiatrists can focus on the interview, diagnoses, and treatment, major medical decision-making, and see more patients.

Employing assistant physicians to provide care has been suggested as a solution.³ Arkansas, Kansas, and Missouri have passed laws that allow medical school graduates who did not match with a residency program to work in underserved areas with a collaborating physician.

Because 1 out of 4 individuals have a mental illness and more of them are seeking help because of increasing awareness and the Affordable Care Act, the construct of “assistant physicians” could ease psychiatrists’ workload allowing them to deliver better care to more people.

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Concerns in psychiatry

The August 2016 editorial (Unresolved questions about the specialty lurk in the cortex of psychiatrists. *CURRENT PSYCHIATRY*. p. 10-11,19,19A) was absolutely, right on the mark. It is heartening to realize how consistent our concerns are through our profession. Although I try to put my shoulder to the wheel to seek answers, it can become frustrating.

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