40TH ANNUAL CONTEMPORARY ISSUES IN OB/GYN

Beyond the Bump

Managing Opioid Use Disorder with Buprenorphine

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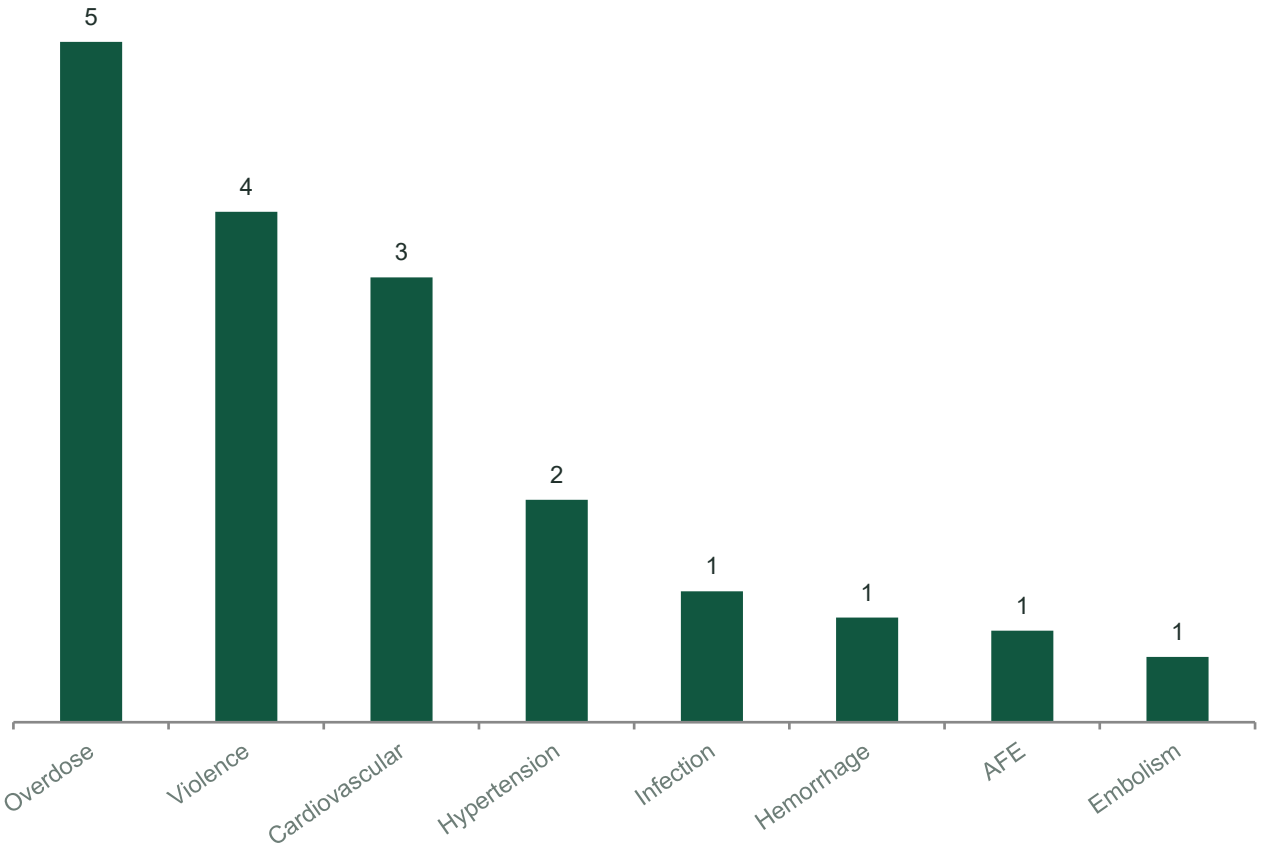
Disclosures

- Consulting/speaking honoraria received from Braeburn Inc.
- This presentation was developed independently.
- Content is expert opinion, not the official position of Braeburn, Meharry, or the University of Tennessee.
- Not intended for every clinical situation; does not replace clinical judgment.

Forget about postpartum hemorrhage

1 in 4

maternal deaths are now from overdose, suicide, or homicide, no longer obstetric complications.



From 2018–2023 these nearly equaled the combined toll of cardiovascular disease, infection, hypertension, and hemorrhage. Azad et al., NEJM 2026

This is now your job

Federal mandate

The MATE Act (2023) ended the X-waiver. Any DEA-registered clinician is now expected to treat OUD.

You are the medical home

For many pregnant and postpartum patients, OB/GYN is the only consistent point of care.

A high-leverage window

Frequent visits, real motivation, and care coordination make pregnancy the moment to engage.

The danger is postpartum

Handoffs fail and treatment lapses, the highest-risk window for relapse and overdose.

What we're not covering

So we can spend the time on what you'll actually use on Monday.

- The opioid crisis
- Incidence & prevalence
- The screening-tool zoo
- Methadone & naltrexone
- CYP enzyme minutiae
- Comorbid psychiatric work-up

What opioid use disorder actually is

- A chronic, relapsing medical condition, not a moral failing or a simple choice.
- Hallmark: compulsive use and loss of control despite clear harm.
- Runs on a craving → use → withdrawal loop; over time the brain stops finding reward anywhere else.
- Buprenorphine occupies the same receptors and stabilizes that loop, without the highs and crashes.

Treat it like diabetes or hypertension: the goal is long-term management, not a cure.

01

Pharmacology & Formulations

How buprenorphine works, and the menu of options

The formulations

1

Sublingual

- Tablet or film
- Mono vs combo (± naloxone)
- Daily dosing

2

Intravenous

- Inpatient use
- For hyperemesis or when SL isn't tolerated

3

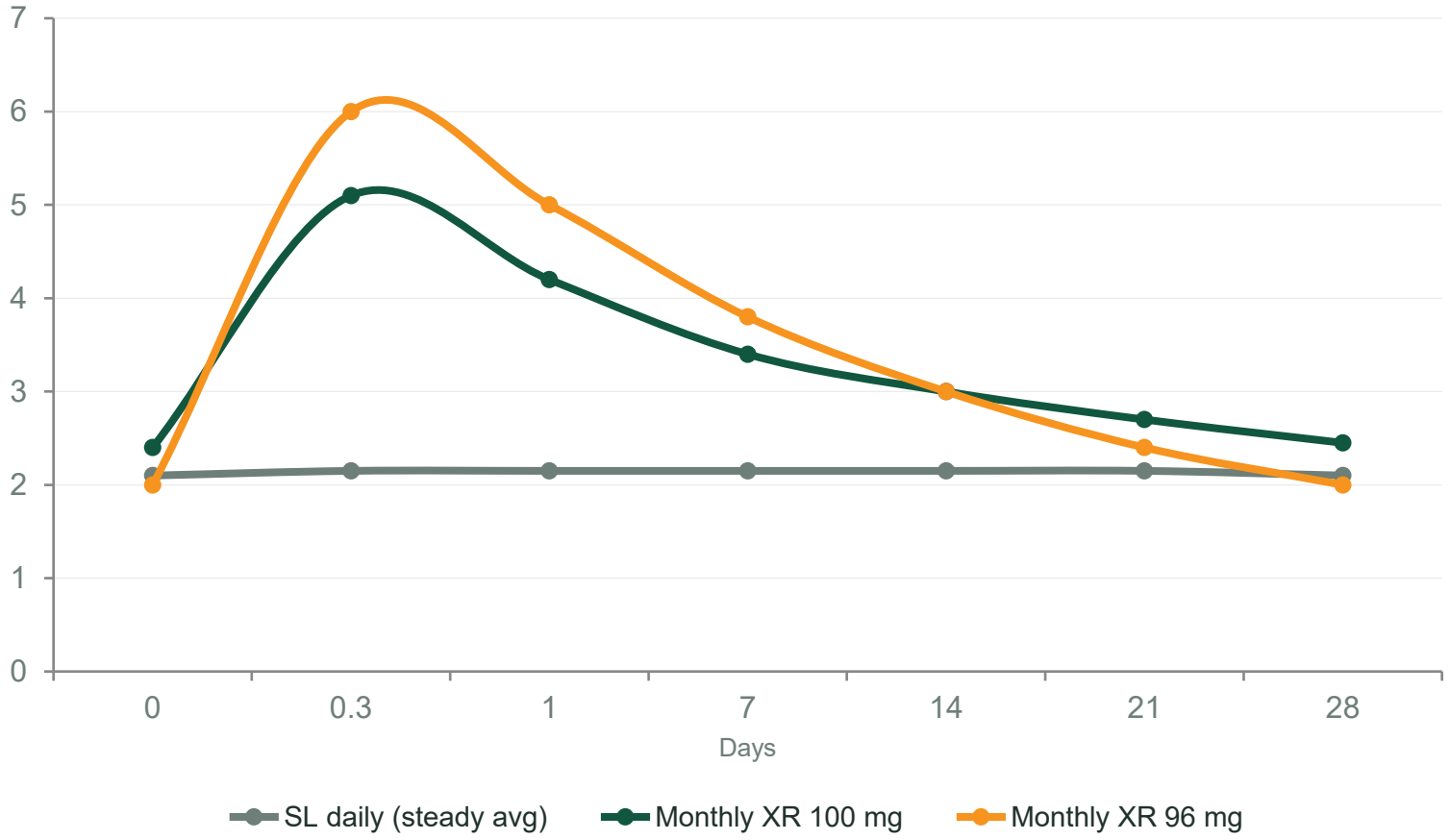
SQ injectable (XR)

- Weekly extended-release
- Monthly extended-release
- Steady levels, fewer doses

Why buprenorphine

1. **Built-in safety** — Partial agonist with a ceiling on respiratory depression; hard to fatally overdose on alone.
2. **Stability, not a high** — High receptor occupancy blocks illicit opioids and smooths the craving–withdrawal cycle.
3. **Timing matters** — Given too soon after a full agonist it can precipitate withdrawal; fentanyl complicates the timing.
4. **Pregnancy shifts dosing** — Clearance rises in later pregnancy; expect to raise the dose or split it, not lower it.

Treat symptoms, not plasma levels



Levels fluctuate by formulation; dose to the patient's symptoms and stability, not to a target number.

02

Starting Treatment

Who benefits, how to induce, and the clinic pathway

Who benefits most from long-acting injectable?

- History of relapse or return to use
- Adherence challenges or missed doses
- Treatment fatigue with daily dosing
- Trouble with the sublingual route (taste, dental, hyperemesis)
- Diversion, loss, or theft risk
- Unsafe or insecure home storage
- Risk of pediatric exposure at home
- Already comfortable with injectables

Standard induction (outpatient)

1 Before

Confirm OUD; check last use and withdrawal (COWS). PDMP + UDT. Counsel on precipitated withdrawal.

2 Day 1

At COWS ≥ 8–12: give 2–4 mg SL, reassess in 45–90 min, repeat to symptom control (typically 8–12 mg).

3 Day 2–3

Target 12–16 mg/day (some need up to 24). Split dosing in pregnancy. Follow up within 24–72 h.

Low-dose (micro) induction

For patients who can't tolerate a period of abstinence, add bupe alongside the full agonist.

Day	Buprenorphine (SL)	Full agonist
1–2	0.5 mg once → BID	Continue usual dose
3–4	1–2 mg BID	Begin taper if tolerated
5–6	4 mg BID → 8 mg/day	Taper / discontinue
7	**12–16 mg/day**	Discontinued; maintenance

Direct-to-inject & ED initiation

- Weekly XR can start new patients: a 4 mg SL test dose, then 16 mg → 8 mg within 3 days.
- ED- and hospital-initiated XR is validated (ED-INNOVATION; JAMA WATERS).
- Safety-net clinics describe direct-to-inject starts with weekly XR and close follow-up.

< 1%

precipitated withdrawal with XR-buprenorphine in the ED study; the fear is largely overstated.

The clinic pathway

1

Screen

Universal, non-judgmental screening at entry to prenatal care

→

2

Diagnose

Confirm DSM-5 OUD and severity; clarify the opioid and route

→

3

Start

Same-day MOUD when feasible; baseline labs; naloxone

→

4

Support

Warm handoff to behavioral health; follow-up and coordination

03

Pregnancy, Labor & Postpartum

Managing buprenorphine across the perinatal course

Choosing a formulation in pregnancy

- Mono-product was historically preferred; emerging evidence supports the combo when used as directed.
- Choose by diversion risk, stability, local norms, and coverage, not dogma.
- Avoid destabilizing switches during pregnancy without a clear reason.
- Monthly injectable use is growing postpartum; pregnancy data remain limited (case-by-case).

Maintenance: dose to stability

- Dose to suppress withdrawal and craving and block illicit opioids, typically 8–24 mg/day.
- Split dosing (BID–TID) is common in late pregnancy as clearance rises.
- Monitor stability, adherence, and co-use; loop in behavioral health.

Do not taper to “protect the baby.” Lower doses don't reliably reduce neonatal withdrawal and they raise relapse risk.

Labor, delivery & cesarean analgesia

- Continue buprenorphine through labor and postpartum; stopping worsens pain control and relapse risk.
- First-line: neuraxial techniques plus scheduled acetaminophen and NSAIDs.
- Adjuncts: regional blocks, ketamine, clonidine/dexmedetomidine per anesthesia.
- If full-agonist opioids are needed, expect higher doses and monitor sedation closely.
- Avoid mixed agonist–antagonists (butorphanol, nalbuphine); they can precipitate withdrawal.

Postpartum: the highest-risk window

- Sleep loss, pain, mood disorders, and lost prenatal supports all drive relapse.
- Ensure no-gap continuation: discharge scripts, prior-auth planning, a visit within 1–2 weeks.
- Provide naloxone for the patient and household; counsel on safe storage.
- Offer contraception, including LARC, integrated with MOUD visits.

The last guaranteed contact

Postpartum discharge may be the final healthcare touchpoint for months.

Breastfeeding & neonatal care

- Breastfeeding is encouraged when the parent is stable on MOUD with no contraindications.
- Buprenorphine transfer into milk is low; monitor infant feeding and sedation as usual.
- Set expectations for neonatal opioid withdrawal (NOWS); optimize rooming-in and skin-to-skin first.
- Coordinate with pediatrics/neonatology prenatally; use non-stigmatizing language.

High-risk co-use

- Benzodiazepines add respiratory and CNS depression, but don't withhold MOUD for benzo use.
- Mitigate instead: slow titration, coordination, a taper plan, and no new benzo starts.
- Screen for alcohol use disorder and counsel on combined sedatives.
- Stimulants: contingency management and harm reduction; buprenorphine still treats the OUD.
- Provide naloxone universally and educate support persons.

04

The Bottom Line

A case, the key argument, and what to take home

Case: 28-year-old G2P1 at 18 weeks

The patient

- Daily fentanyl use; last use this morning
- Prior precipitated withdrawal after a standard induction
- Comorbid anxiety; intermittent non-prescribed clonazepam
- Wants prenatal care and “doesn't want to be sick”

Discussion

- Induction strategy and setting?
- How to handle the benzodiazepine co-use while starting?
- What to document and how to coordinate with L&D and neonatology?

THE ONE THING TO REMEMBER

Give XR buprenorphine before discharge.

It converts a fragile transition into a protected interval: immediate receptor occupancy and a time buffer through the most relapse-prone period.

Take-home points

1. MOUD saves lives in pregnancy and postpartum; OB/GYN can and should deliver it.
2. In the fentanyl era, micro-induction is often the safest path around precipitated withdrawal.
3. Continue buprenorphine through delivery; use multimodal analgesia; avoid mixed agonist–antagonists.
4. Dose to maternal stability; never taper to reduce neonatal withdrawal.
5. Postpartum continuity, naloxone, and contraception are core, not optional.
6. **XR before discharge is the highest-leverage move you can make.**

Questions & discussion

“It's never medication vs. no medication, it's treated illness vs. untreated illness.”