

Understanding Postpartum Pain in the Context of Substance Use

- Nearly all birthing individuals experience some degree of postpartum pain.
- Effective postpartum pain management [is essential](#) for patient care and particularly important for individuals with substance use disorders (SUD).
 - Postpartum pain is well documented to be undertreated in people with OUD/SUD.
 - Patients with opioid use disorder (OUD) receiving [methadone](#) or [buprenorphine](#) frequently report higher postpartum pain scores and may require more analgesia than matched controls.
- Concerns about relapse, overdose, and stigma can complicate pain management decisions.
- [Poorly controlled pain](#) may undermine recovery, increase distress, and contribute to disengagement from care.

Clinical Considerations

- **Stigma Creates Barriers to Effective Pain Care**
 - Patients with SUD often experience stigma, undertreatment of pain, and mistrust of healthcare systems.
 - Clinicians may have concerns related to opioid prescribing, relapse risk, or insufficient training.
 - Addressing stigma is an essential component of effective pain management.
 - Develop an individualized pain plan with the patient before delivery when possible, involving the multidisciplinary care team and considering the patient's prior experiences, preferences, and concerns. Discuss expected pain and recovery.
- **Continue Medications for OUD During Hospitalization**
 - Continue methadone or buprenorphine during labor, delivery, and postpartum hospitalization.
 - Consider split dosing (e.g., every 8-12 hours) when appropriate.
 - Avoid mixed agonist-antagonist opioids (e.g., butorphanol, nalbuphine) that may precipitate withdrawal.
 - Avoid co-administering sedative hypnotics (e.g., benzodiazepines) with opioids/MOUD due to increased risk of respiratory depression; do not abruptly discontinue benzodiazepine therapy.
 - Naltrexone is not first-line medications for OUD in pregnancy. Patients maintained on it require an individualized plan, since it blocks the effect of standard opioid analgesics.
 - *MOUD treats OUD but does not provide adequate analgesia for postpartum pain.*
- **Use a [Multimodal](#) Pain Management Approach**
 - Use scheduled acetaminophen and NSAIDs when appropriate. Consider an extended course of ketorolac (24-48 hours) if not contraindicated.
 - Incorporate cognitive behavioral therapy, peer support, education, and doula support.
 - For cesarean birth, long-acting neuraxial opioids combined with scheduled NSAIDs/acetaminophen are best practice; consider TAP/regional block, IV-PCA, or low-dose ketamine if additional analgesia is needed,



Clinical Considerations, Continued

• Use Opioids Thoughtfully When Needed

- Individualize opioid quantity and duration based on pain, function, delivery-related injury, and opioid tolerance; some patients with OUD may require more analgesia or a longer course.
- Use immediate-release opioids on an as-needed basis.
- Reassess ongoing pain, medication use, and cravings before changing or renewing prescriptions; respond to misuse with supportive reassessment and coordination with the OUD treatment provider.
- Confirm existing opioid prescriptions with the prescribing provider, patient, and PDMP where appropriate.

• Overdose Prevention and Follow-Up

- Offer naloxone and overdose education to the patient and support person.
- Discuss safe medication storage and disposal, and, if the patient prefers, help from a trusted support person to manage medication.
- Arrange a check-in within a few days of discharge to reassess pain and adjust the plan; coordinate follow-up with substance use treatment providers.

Reach out to MACS for MOMs with questions related to the initiation and maintenance of MOUD along with any general support requests when working with pregnant and postpartum patients with substance use disorders and chronic pain.

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