Using Opioids Safely: Opioid Misuse in Women

Pain management and addiction treatment guidelines are gender blind, yet differences exist in pain-related variables and risk factors for opioid use disorder for women versus men. A need exists for gender-specific interventions and awareness, around non-pharmacologic interventions for pain, expansion of pharmacotherapy coupled with behavioral health services, trajectories to addictions, and trauma-informed care.

**Sex Differences in Pain**

Pain is reported more frequently by women than by men. Part of the difference is based on pain related to reproductive anatomy/physiology, but women also are more commonly afflicted with several chronic pain syndromes including fibromyalgia, migraine and tension headaches, irritable bowel syndrome, carpal tunnel syndrome, multiple sclerosis, and rheumatoid arthritis, and as well as mental health disorders that can exacerbate pain and/or complicate management.

**Opioid Use in Women and Women of Child-Bearing Age**

- Between 2008 and 2012, more than one-quarter of privately insured women ages 18–44 and more than one-third of women in the same age range enrolled in Medicaid filled a prescription for an opioid medication.
- Although overdose deaths remain more common in males, overdose deaths from opioid analgesics and heroin use have increased proportionally more in women and continue to increase.
- Women tend to use substances differently than men do; compared with men, women use opioids to deal with negative emotions; to relax, reduce stress, focus attention, increase confidence; to lose weight, increase energy; and more likely to mix opioids with other sedatives, a risk factor for mortality.

**Risk Factors for Opioid Use Disorder in Women**

- Girls in the 12-17 age group are slightly more likely than boys to have used any psychotherapeutics, including opioid analgesics, for nonmedical reasons.
- Women who are experiencing or who have experienced psychological and emotional distress or trauma are at risk for prescription opioid misuse; such trauma often begins in childhood. Intimate partners, rather than peers, are more likely to introduce women to illicit substances.
- Compared with men, women can become dependent using a smaller amount of drugs for a shorter amount of time, tend to use opioid analgesics for longer periods and in higher doses than men, and report higher pain levels and lower function.
- Healthcare professionals tend to miss signs of addiction in women, especially in older women and younger girls and substance use, including opioids, in women progresses more quickly to addiction and to the onset of medical problems and disorders, so women tend to enter treatment at later stage of addiction.
- Pregnancy is a key opportunity to address OUD, but delivery should be followed by pharmacotherapy for the mother and continuation of intensive psychosocial services for both the mother and the infant.
- Significant barriers for women seeking treatment are:
  - Prejudice against individuals who misuse opioids
  - Negative attitudes toward medication-assisted treatment, especially for pregnant and parenting women
  - Potential legal consequences related to using opioids while pregnant or parenting.
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Opioid Use in Pregnancy-Neonatal Abstinence Syndrome

The increasing use of opioid analgesics has also affected patterns of use by women of childbearing age and is associated with an increasing prevalence of newborns who display symptoms of opioid withdrawal after delivery. Opioids are the most common illicit substance for which pregnant women seek treatment, and the surge in NAS has disproportionately affected in rural areas and substantial variation exists among states. Improving care for the maternal-infant dyad begins with screening and access to treatment for opioid use disorder. There is wide variation in the care of opioid-exposed newborns and a lack of consensus exists around optimal diagnostic and treatment strategies.

Neonatal abstinence syndrome (NAS) is a constellation of physiologic and neurobehavioral manifestations (drug withdrawal syndrome) exhibited by newborns who have been exposed in utero to prescription or illicit drugs capable of producing tolerance and physical dependence. NAS most commonly occurs in neonates with sufficient exposure to prescription opioids, buprenorphine or methadone in the context of medication assisted therapy, or illicit opioids, including heroin. Typically manifesting in the first day or two of life, affected neonates may “exhibit hypertonia, autonomic instability, irritability, poor suckling reflex, impaired weight gain, and less commonly seizures.”

Although medically-appropriate opioid use in pregnancy is not uncommon, there has been a renewed focus on maternal opioid dependence, opioid exposure during pregnancy, and infants born with NAS.

- During the period from 1999-2014, the national prevalence of opioid use disorder documented at delivery hospitalizations increased more than 300%. Since 2012 the incidence more than tripled to approximately 20 per 1000 live births among pediatric hospitals.
- Aggregate hospital charges for NAS increased from $732 million to $1.5 billion (P<0.001), with 81% attributed to state Medicaid programs in 2012.
- NAS incidence varied by geographic census division, with the highest incidence rate (per 1000 hospital births) of 16.2 in the East South Central Division (Kentucky, Tennessee, Mississippi and Alabama) and the lowest in West South Central Division Oklahoma, Texas, Arkansas and Louisiana 2.6 (95% CI 2.3 to 2.9).
- The rate of neonatal intensive care unit (NICU) admissions for NAS increased from 7 cases per 1,000 admissions in 2004 to 27 cases per 1,000 admissions in 2013.
- In September 2013 the FDA instituted a black box warning for extended-release opioids, warning of “life-threatening neonatal opioid withdrawal syndrome” despite the fact that there is no evidence of infant death from this syndrome.

For further information on opioid use and the treatment of opioid use disorder in pregnancy see the ACOG Committee Opinion.
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Citations


Hudak ML, Tan RC; Committee on Drugs; Committee on Fetus and Newborn; American Academy of Pediatrics. *Pediatrics*. 2012 Feb;129(2):e540-60.


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Citations continued


