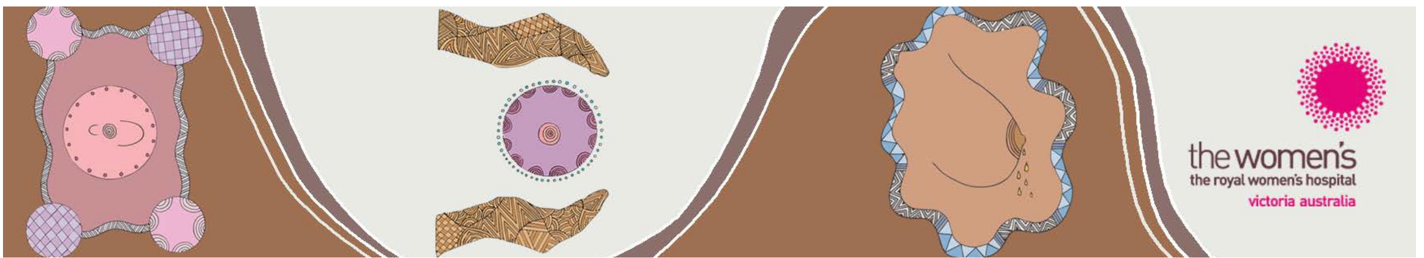

Using buprenorphine & naloxone (Suboxone™) during pregnancy and breastfeeding

About buprenorphine

Buprenorphine has been available in Australia since 2000. It is an alternative treatment to methadone opiate substitution therapy.

Buprenorphine is used to treat addiction to heroin, morphine, pethidine, codeine or oxycodone. It is a tablet taken under the tongue or inside of the cheek and its trade name is Subutex®.

Suboxone® is a combination of two medicines: buprenorphine and naloxone. Suboxone is now considered safe to use in pregnancy. If you are using heroin or other opiates, it is unlikely that you will be started on Suboxone in pregnancy as this will cause rapid withdrawal for you and your baby, which is not safe. Talk to your doctor or midwife for more information.

A slow-release injectable buprenorphine called Buvidal® is now available and is given once a week to once a month. It is safe to use in pregnancy and breastfeeding. Discuss this option with your doctor or midwife.

Buprenorphine is longer acting than most other opioids and therefore can be taken once a day or even every two days. During pregnancy, a daily dosage is recommended to provide a more stable environment for you and your baby. When you are on the correct dose of buprenorphine, it will stop you, and therefore your baby, from experiencing withdrawal symptoms and cravings. This is very important for your unborn baby's health.

If you are using heroin or other prescription opioids and experiencing physical withdrawal symptoms when you do not use, methadone or buprenorphine stabilisation is recommended.

Buprenorphine (or methadone) should be started as soon as possible after your pregnancy has been confirmed or continued if you are already on a buprenorphine program. However, if you are on a high dose of buprenorphine at the start of pregnancy, your doctor may advise changing your treatment to methadone since the dose of your medication may need to increase during the pregnancy. The maximum dose of buprenorphine is 32mg and higher doses have no further benefits.

You can discuss the advantages and disadvantages of methadone or buprenorphine treatment with your health professional. This will help you to make an informed decision about management during your pregnancy. An inpatient methadone or buprenorphine stabilisation program is available through some Drug and Alcohol withdrawal "detox" units. Ask your doctor or midwife about this program.

Withdrawing "cold turkey" from any opioids including methadone, buprenorphine, and prescription opioids or heroin is strongly discouraged during pregnancy. This is due to the risk of miscarriage, premature labour, fetal death and possible return to dependent heroin/opiate use.

Effects on pregnancy

Buprenorphine is safe to use during pregnancy and breastfeeding. It has been shown to improve pregnancy outcomes for women who are addicted to opioids. Buprenorphine does not increase the risk of birth abnormalities in infants.

The benefits of buprenorphine are:

- stabilisation of lifestyle without a need to use drugs
- providing a stable environment in your body for your baby, which can improve the health and growth of your baby
- reduced risk of blood borne viral infections including Hepatitis C and HIV.

Counselling in pregnancy

Counselling can help you to get access to a buprenorphine or methadone treatment program. It can also help you avoid relapsing to drug use. Counselling can also help you to stay on the program after your baby is born.

Pregnancy care

All pregnant women need pregnancy care with a doctor or midwife. These are regular visits throughout your pregnancy. The number of visits you have will depend on your particular needs. Pregnancy care is very important to make sure that you are healthy, and your baby is growing well. Routine investigations such as blood tests, ultrasounds and a health screen are included in pregnancy care.

Your dose of buprenorphine may need to be increased during pregnancy, especially in the later months. This is due to a number of things, such as:

- increased volume of fluid in your body
- the drug is broken down or “metabolised” faster by the placenta and fetus
- your kidneys are excreting more or removing the by-products of buprenorphine from your body through urine.

You may need dietary supplements such as iron and calcium during your pregnancy. All women should take folate before conceiving and for at least the first three months of their pregnancy.

Eating well during pregnancy and whilst you are breastfeeding is important for the health of you and your baby. Good dental care is also important for all pregnant women.

Breastfeeding

If you are stable on any type of buprenorphine, then breastfeeding is usually encouraged. The amount of buprenorphine or Suboxone® excreted in breast milk is very small and unlikely to have any adverse effect on your baby. If you plan to stop breastfeeding your baby, you will need to do so slowly and with support from your maternal and child health nurse (MCHN). If you stop breastfeeding suddenly, you are withdrawing the small amount of buprenorphine the baby is getting through breast milk and they may have withdrawal symptoms.

Do not breastfeed your baby if you are using heroin or ‘ice’, or if you are HIV positive.

Your baby’s care after the birth

A doctor will check your baby after the birth.

When you have been a regular user of opioids (including buprenorphine) during pregnancy, your baby is at risk of developing Neonatal Opioid Withdrawal Syndrome (NOWS) or infant withdrawal. It is also called Neonatal Abstinence Syndrome.

NOWS is a condition which can be treated safely and effectively. It is not possible to reliably predict before birth which babies will develop NOWS. NOWS is not related to your dose of buprenorphine but if you are using other drugs as well as buprenorphine such as heroin, crystal methamphetamine (‘ice’) or benzodiazepines (‘benzos’), your baby is more likely to need medication to help them through their withdrawal.

Most babies will show some signs of withdrawal and will need to stay in hospital for five days for observation. Withdrawal symptoms can vary from mild, which can be managed by supportive care (cuddling, time with parents, wrapping, a quiet environment and using pacifiers) to more marked symptoms, which will need medication. Research suggests that around 50 percent of babies will show signs of withdrawal that are severe enough to require medication (usually oral morphine) and will need specialised care in a newborn intensive care unit.

Sudden Unexpected Death in Infancy

Sudden Unexpected Death in Infancy (SUDI; includes SIDS) is a sleep related death in the first year of life.

If you smoke, use drugs, alcohol or medicines that make you feel drowsy, sleeping with your baby is very dangerous. Anything that makes you sleep deeply will make it hard for you to respond properly to your baby's needs and ensure their safety.

Safe Sleeping Guidelines

The six ways to sleep your baby safely and reduce the risk of Sudden Unexpected Death in Infancy (SUDI) are:

1. Sleep baby on their back
2. Keep head and face uncovered
3. Keep baby smoke free before and after birth
4. Safe sleeping environment night and day. No soft surfaces or bulky bedding
5. Sleep baby in safe cot in parents' room
6. Breastfeed baby.

For more information, speak with your midwife or doctor or visit
rednose.com.au/section/safe-sleeping

For more information

Women's Alcohol and Drug Service

Royal Women's Hospital
8.30am–5.30pm Monday to Friday
(03) 8345 3931
wads@thewomens.org.au

On the Women's website

Pregnancy, drugs & alcohol information
thewomens.org.au/wm-pregnancy-drugs-alcohol

Prescription opioids fact sheet
thewomens.org.au/fs-op

DirectLine

DirectLine is part of Turning Point's state-wide telephone service network, providing 24-hour, seven-day counselling, information and referral to alcohol and drug treatment and support services throughout Victoria.
DirectLine is a free, anonymous and confidential service.
1800 888 236

Quit

Visit this website to help you quit smoking or help you find out more about how smoking harms you.
137 848 | quit.org.au

Red Nose

1300 308 307 | rednose.com.au

Disclaimer: This fact sheet provides general information only. For specific advice about your healthcare needs, you should seek advice from your health professional. The Royal Women's Hospital does not accept any responsibility for loss or damage arising from your reliance on this fact sheet instead of seeing a health professional. If you require urgent medical attention, please contact your nearest emergency department.
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