Preventative FASD Education Event for Pregnancy Healthcare Providers

Reducing FASD

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Why is this important?

- Estimated prevalence of alcohol use during pregnancy in Canada at 10%
- Prevalence of binge drinking during pregnancy at 3.3%
- Neither measure of use has decreased (*So we need better interventions*)
- **There may be no safe lower limit for alcohol use during pregnancy**

Popova et al 2018

- Graves L, Carson G, Poole N, Patel T, Bigalky J, Green CR, Cook JL. Guideline No. 405: Screening and Counselling for Alcohol Consumption During Pregnancy. J Obstet Gynaecol Can. 2020 Sep;42(9):1158-1173.e1. doi: 10.1016/j.jogc.2020.03.002.

Recommendation

- Every visit is an opportunity for discussion about alcohol use
- *All women of childbearing age should be periodically screened for problematic alcohol use (Strong, High)*
  - *Incorporate screening for problematic alcohol use into routine women's health screening and information sharing*

Recommendation

- *All pregnant women should be screened for alcohol use by asking a single question to determine use (in a non-judgmental way) and then, if they consume alcohol, with one of the following evidence-based screening tools: AUDIT-C or T-ACE, or another evidence-based screen on provincial/territorial prenatal record. If women consume alcohol, pattern of use should be established to screen for binge drinking. (Strong, High)*

Binge Drinking

- Even a single question about binge drinking can serve as a useful screener

Johnson KE, Sobell MB, Sobell LC. Using one question to identify women at risk for an alcohol-exposed pregnancy. J Am Osteopath Assoc. 2010;110:381-4.
Balachova T, Sobell LC, Agrawal S, Isurina G, Tsvetkova L, Volkova E, et al. Using a single binge drinking question to identify Russian women at risk for an alcohol-exposed pregnancy. Addict Behav. 2015;46:53-7.

Caveats for Screening

- Unconscious biases can decrease screening
- Women most likely to miss being identified using standard screening tools are:
  - over 35 years of age
  - “social” drinkers
  - highly educated
  - history of sexual or emotional abuse (usually not volunteered, unless asked)
  - high socioeconomic status

Public Health Agency of Canada P. Knowledge and attitudes of health professional about Fetal Alcohol Syndrome: Results of a National survey. 2005.

Recommendation

- *If a positive screen is obtained, brief intervention should be provided at the same time as screening is completed. (Strong, High)*

SBIRT

- Screening, Brief Intervention and Referral to Treatment (SBIRT)
- Evidence-based approach used to identify, reduce and prevent problematic use of alcohol and other drugs
- Screening tools should always be paired with brief interventions at the time of a positive response and, if required, referral for treatment

The Three A's

- **Awareness** raising (through discussion of risks) and assessment/identification of readiness for change;

- **Advice** including provision of written materials (or web links), and discussion of strategies for reducing or eliminating problematic alcohol use; and

- **Assistance** in the form of eliciting ideas about change strategies; supporting/enhancing readiness; goal setting to reduce or eliminate alcohol use; positive reinforcement; and/or referrals to supportive services.

Recommendation

- *If a woman continues to use alcohol during pregnancy, harm reduction, treatment and social support strategies should be encouraged (Strong, High).*

Psychosocial Interventions Recommendation

Women need to be able to participate in brief interventions and treatment without undue risk of loss of child custody; where universal screening and brief intervention is implemented, policy must be aligned so that support and treatment can be encouraged by providers and accessed by women without fear. (Appropriate attention must still be given to the safety of the child.) (Strong, Moderate)

Recommendation

- *Specialized, community-based interventions need to be available and accessible for women with problematic drinking and related health and social concerns. (Strong, Moderate)*

Pharmacotherapy in Pregnancy

- Can be used in preconception period as would be routinely done with all other patients
- Limited evidence in pregnant or breastfeeding women
- Can be used in appropriate situations with psychosocial services
- May increase attaining treatment goals compared to psychosocial alone

Benzodiazepines (BZD): Pregnancy

- Diazepam is the BZD of choice to treat and/or prevent withdrawal symptoms
- Combine with supportive care, fluid replacement and nutritional supplementation including thiamine
- If delivery will be soon, consider short acting agents such as midazolam to reduce effects in the newborn; otherwise, diazepam is preferred
- Safe for short term use in pregnancy
- Use CIWA to assess symptom severity and guide dosing

Benzodiazepines: Breastfeeding

- Short acting BZD minimally excreted in breast milk
- No identified adverse effects in exposed infants
- Monitor infant for drowsiness, decreased feeding and poor weight gain

Thiamine

- Safe in pregnancy and breastfeeding women, and an essential micronutrient
- Increased thiamine to 1.4 mg per day in pregnancy and lactation
- Risk of Wernicke encephalopathy in withdrawal
  - Requires prophylaxis with parenteral thiamine (100-200mg OD) for 3 to 5 days followed by oral therapy

Naltrexone

- Use in pregnant patients with opioid use disorder suggests safe in pregnancy
- Typically used as a fixed, once daily dosing regimen (50 mg) for 3-6 months.
- Long-acting injectable naltrexone can be useful for patients unable to comply with daily oral medication
  - May be initiated while the patient is still drinking alcohol
- Minimally excreted into breast milk at dose of 50mg OD
  - Undetectable amounts and no adverse effects reported in exposed infants

Acamprosate

- Early evidence suggests safe in pregnancy
- Typically initiated 5 days after alcohol detoxification
- Full effectiveness after 5-8 days of treatment
- Standard dosing: 666 mg TID
- Prescribe with caution and only if necessary (benefit outweighs risk)

Disulfiram

- If a woman presents with a pregnancy on disulfiram, it should be discontinued immediately
- First trimester risk of fetal malformation
- In all trimesters, risk of severe hypertension and autonomic instability if there is a disulfiram-alcohol reaction

Disulfiram

- Prescribe in breastfeeding mothers with caution and only if necessary (when risk outweighs benefit) and use of other agents not possible
- Average effective dose: 250 mg per day (range 125-500 mg daily)
- Treatment may be continued for months to years depending on the patient's needs. Recommended discontinuing once long-term alcohol abstinence established

Topiramate - Pregnancy

- Should be avoided in pregnancy because it crosses the placenta.

- In some studies, an increased risk of oral clefts and an increase in small for gestational age infants

Topiramate - Breastfeeding

- Present in breast milk
- In limited studies no adverse for effects were observed in most infants; one infant had diarrhea which resolved on discontinuation of topiramate
- Not first line -- may be indicated when other agents have been ineffective or as a part of medication combination.

Gabapentin - Pregnancy

- Association with both fetal growth impairment and developmental delay in some cases

- Limited efficacy data and should not be first line

Gabapentin - Breastfeeding

- Gabapentin is excreted in small amounts in breast milk
- No adverse effects were found in exposed infants
- Potential for misuse and may be a concern in patients who already have a substance use disorder

Recommendation

When an alcohol use disorder is diagnosed, it should be documented in the baby's chart after delivery. (Strong, Low)

Mothers should be encouraged to discuss alcohol use disorder with their child's health care provider. (Strong, Low)

Final thoughts

- Alcohol exposed infants need to be documented
- FASD may explain some of the challenges experienced in care
- Remember to avoid being fetocentric…this is about making everyone healthy
- There are things we can do… office-based interventions, medical treatment, education and advocacy
- There is no wrong time to start a conversation about alcohol use

Contact

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