Marijuana and Pregnancy: A Complex Answer to a Common Question

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Disclosures

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Objectives

- Review recommendations for screening for substance use in pregnant patients
- Review current data about the maternal, fetal, and neonatal impact of marijuana use in pregnancy
- Review current data and recommendations for counseling patients about breastfeeding and marijuana use
- Discuss screening, testing, and reporting recommendations for substance use in pregnancy, time of delivery, post-partum, and for the neonate
This shouldn’t be a new conversation

- Screening for substance use is recommended in pregnancy
  - ACOG: first prenatal visit
  - WHO: first and every prenatal visit

- Screening should include tobacco, alcohol, illicits.....and marijuana

- Common co-occurring conditions with substance use: mental health, domestic violence, legal issues, social services
What is screening?

- First recommendation is to ask…everyone.
  - “A couple of questions I ask everyone the first time I meet them…”
- Gather substance use history verbally
  - Parents?
  - Partner?
  - Past?
  - Present?
- Validated tools (SBIRT and healthteamworks)
What if they say yes?! 

- Discuss with patient her legal protection in pregnancy:
  - Colorado House Bill 12-1100 protects substance use information of the pregnant women from being used in criminal proceedings
  - However, most women are not worried at that moment about criminal proceedings: most are worried about social service involvement

- Refer for treatment

- Testing (urine, serum, hair follicle)
Keep in Mind

- Majority of women who use substances of abuse prior to pregnancy (alcohol, tobacco, marijuana, etc) will self-selectively reduce/discontinue their use after discovery of pregnancy.

- Substance use disorders are defined as “continued use despite harm”
  - So, women who continue to use in pregnancy either: 1) don’t know the potential harms, or 2) cannot stop using on their own.
Marijuana

- Legal in Colorado
- Increasingly socially accepted
- Women of reproductive age are one of the fastest growing consumers of both medical and retail marijuana
Shift in Social Acceptability

Pregnancy and pot use

21% of Americans think it's OK for a pregnant woman to use pot for nausea or pain

Among Americans who use marijuana regularly, 40% think it's OK for a pregnant woman to use pot for nausea or pain

Graphic: Yahoo News/Getty Images
Source: Yahoo News/Marist Poll April 2017
Why are pregnant women using marijuana in the first place?

- Depression
- Anxiety
- Stress
- Pain
- Nausea and vomiting
- Fun/recreation
- Other (sleep, seizures, migraine, cancer, to increase appetite)
Maternal Outcomes

- Concurrent substance use/misuse (tobacco > alcohol > prescriptions > illicits)
- Decreased prenatal care (fear)
- Intoxication: accidents, paranoia, psychosis, physical illness/toxicity
- Withdrawal (some evidence that worse in women)
- Lung complications (96% of marijuana use reported in pregnancy is used via smoking)
- Increase risk of dysfunctional labor, precipitous labor, and meconium-stained amniotic fluid
Fetal Outcomes

- THC freely crosses placenta and BBB
  - Fetal plasma concentrations equal to (or higher?) than maternal levels
- Increased rates of preterm delivery
  - Hard to separate from tobacco effects in many studies
- Low birth weight > head circ > length
- Growing evidence that THC may alter certain receptors in the brain during fetal development, particularly in limbic system and prefrontal cortex
Neonatal → Childhood Outcomes

- **Acute:**
  - Poor feeding
  - Excessive weight loss
  - Hypotonia

- **Long-term**
  - Increasing data demonstrating impairment in learning, memory, attention, school performance, growth
  - Some effects not appreciated fully until late childhood or adolescence
Breastfeeding

- Marijuana (THC) highly lipophilic
- Babies have high percentage body fat
- “Not enough data → Not recommended” is default in medicine for pregnancy and lactation
- Given moderate rate of concurrent alcohol and illicit/prescription misuse, may even be contraindicated
- Women who report decreasing use during pregnancy often increase use again post-partum
ACOG Committee Opinion No. 637

“Pregnant women or women contemplating pregnancy should be encouraged to discontinue their use of marijuana....There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged”
Testing

- Informed consent of pregnant woman **may not** be required in special circumstances
  - Admitted or previously documented alcohol or drug use
    - Maternal report
    - Prior documented intoxication or positive toxicology test
    - Known involvement in substance use treatment program
  - Unconscious or intoxicated patients
  - Unexplained mental status changes
  - Signs or symptoms of withdrawal
  - Skin lesions related to IV drug use
  - Unexplained placental abruption
  - Unexplained severe hypertension
  - Unexplained fetal demise/IUGR/SGA
  - Unexplained premature labor (with or without premature birth), ROM, or precipitous delivery
Testing

- It is strongly recommended to obtain informed consent once woman has delivered
  - While pregnant, testing without consent may be protected by medical necessity for complete/safe care
  - **After delivery, woman is no longer protected legally by HB 12-1100**
  - Women deserve to know and understand the potential outcome of toxicology testing of both her and her infant
  - Should testing or THC (and other substances) be a part of:
    - Prenatal care?
    - Labor and Delivery?
    - Only if there is a “red flag”?
Newborn Testing

- Urine (last two weeks)
- Meconium/umbilical cord (last half or so of pregnancy)
- Consent may not be required since the purpose of testing is to provide appropriate medical care for the infant
- Parents should be notified of the need for and results of testing
- Infant testing is what is required in order to make a report to social services:
  - Mom testing positive for THC is one thing
  - Baby testing positive, depending on state law, may be reportable to social services
Neonatal Withdrawal

- Substance specific, but similar features:
  - CNS dysfunction: lethargy, jitteriness, irritability, inconsolable, excessive/high-pitched cry, hypersensitivity to stimuli, tremor, seizure
  - Autonomic dysfunction: sneezing, sweating, hyperthermia, hypertension, mottling, apnea, excessive yawning, tachypnea
  - GI disturbances: ineffective feeding, excessive weight loss, excessive but ineffective sucking, excessive vomiting/diarrhea
Reporting

- All mandated reporters required to report suspected *abuse or neglect* under Colorado Children’s Code
  - 19-3-102 Neglected or Dependent Child
  - In Colorado, and infant testing positive at birth for federal Schedule I (includes THC) or Schedule II substance (if no prescription) is classified as “child abuse”
- A report does not mean mother will lose custody
- Social Service will determine next steps
The Problem

- In cases, such as infants exposed to THC, where the medical community does not have a clear avenue for addressing maternal marijuana use, referrals for treatment, infant testing and monitoring, and understanding what is mandated to report and what is not, the **legal system is being asked to pick up the slack**
- “Legal” equal safe?
- “My doctor/midwife/doula recommended it, so it must be safe”
A Needed Balance

• How can we help health care providers engage women with marijuana use in pregnancy and breastfeeding?

• How can we ensure that any legislation regarding mothers or infants testing positive for THC does not impair mother-infant bonding or increase punitive action towards mothers with substance use?

• How can we work to support much-needed research without threatening mother with reporting to social services?
References


- Meier, MH et al. Persistent cannabis users show neuropsychological decline from childhood to midlife. PNAS August 2012. E2657-E2664.


References, cont.


