Virtual APA meeting: Importance of helping pregnancy women with SUDs

by Alison Knopf

In “Substance Use Disorders in Perinatal Women,” Kimberly Yonkers, M.D., gives a sobering presentation on the consequences of substance use in pregnant women, on the women themselves, their pregnancies, and their offspring, in the perinatal period. Yonkers’ presentation took place April 25 as part of the American Psychiatric Association’s (APA’s) virtual online annual meeting; the meeting itself, scheduled to be in Philadelphia, was canceled due to COVID-19. Yonkers’ presentation touched on social justice as well as medical issues.

Startlingly high percentages of women use opioids (4%) as well as other substances. Yonkers is not judgemental. She thinks of substance use in pregnancy in different ways. “I’m not going to say good, bad, and ugly, because it’s too pejorative,” said Yonkers, who is director of psychological medicine and the Center for Wellbeing of Women and Mothers of the Yale School of Medicine. Substance use decreases during pregnancy, so that is good. But 80% relapse to alcohol use after pregnancy, so she refers to pregnancy as a “pause,” usually followed by the “bad” relapse.

Alcohol use stops earlier than many of the other substances during pregnancy. But for cigarettes, it appears harder for them to stop smoking. “This may be a nice model for the relative average addictive potential of drugs — we don’t know,” said Yonkers. “But this can give us a window into the use of various substances and the ability of people to stop using them, at least during pregnancy.”

For those who do stop smoking, they relapse to smoking almost immediately after delivery, she said. There are much lower rates of relapse to cocaine. “That’s kind of nice, and we’d like to understand what is about that process that enabled this period of wellness,” she said.

Effects of stimulants

For women who used stimulants in pregnancy, there are effects, such as jitteriness and sleep disorder, on the newborn just days after delivery, perhaps from residual toxicity from the substance, or from withdrawal.

But there are confounding issues. “When you’re working with pregnant women, these are usually cohort data, not controlled,” she said. Potential sources of confounding include the type of substance exposure (co-occurring use of substances, especially the legal ones — alcohol and tobacco), pre- and postnatal environment (food insecurity, domestic violence, housing problems), and genetic issues.

There are long-term effects of prenatal exposure to cocaine, including dose-related differences in attention control, diminished response initiation, deficits in learning, initiation of alcohol and marijuana, and the postnatal environment. Again, she stressed the confounding influences, recalling the “crack baby” data that actually reflected high rates of poverty in these families, not the effects of the drug itself, she said.

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Kimberly Yonkers, M.D.

There can be dire consequences for women who use stimulants during pregnancy, including cardiovascular issues, seizures, and even maternal death. National Vital Statistics data show rates of maternal mortality from 2008 to 2016. Overall deaths increased by 34%, which is “terrible” in terms of maternal mortality in general. “But when you look at opioid-related deaths, it skyrocketed — they doubled,” she said. “We have to not only take care of kids and offspring; we have to take care of moms.”

Opioid epidemic

Pregnant women aren’t immune to the opioid epidemic ravaging the country, and these babies are more likely to be smaller, and as many as 80% of the babies have withdrawal symptoms. Depending on when the pregnant woman used heroin, the withdrawal can show up 10–12 hours after delivery; if the mother is taking methadone or buprenorphine therapeutically, the withdrawal effects may not show up for two or three days.

One of the best solutions is to breastfeed, but these babies have sucking problems as part of withdrawal, said Yonkers. “We’re giving the moms the most difficult babies” to breastfeed, she said. Other strategies are being tried now, such as rooming in, swaddling the babies, and only giving the babies medication if they can’t be soothed and can’t eat. “We’ve had great success at our home institution at keeping babies out of the NICU” using these strategies, said Yonkers.

Cannabis

There is some toggling between increases and decreases on self-reports, but overall, women who go into pregnancy are more likely to be using cannabis. “We can anticipate that we’re going to be seeing a lot more cannabis-exposed pregnancies,” said Yonkers.

“Some people think cannabis is benign,” she said, but it’s important to remember that it crosses the blood-brain barrier, and can affect whether the baby is born earlier. The compounds also come out in breast milk. “It’s not a lot, but in babies who have a developing brain and a developing blood-brain barrier, we don’t have a context for this,” said Yonkers. “We don’t know what’s safe and what’s not.”

Licit substances

“I want to remind folks that the licit substances are the most problematic,” said Yonkers, noting that smoking is very difficult to quit. Smoking in pregnancy is one of the most profound predictors of fetal growth restriction. And it was connected to drinking.

Fetal alcohol system and fetal alcohol effects are still seen across the world, resulting in delayed motor and speech, neurodevelopmental problems, and behavior problems. However, there are environmental issues here too. In a 2014 meta-analysis...
said Yonkers. In two states — Alabama and South Carolina — women have been convicted for drug use during pregnancy. “When we look at health equity, part of health equity is how much money people have, what resources they have and where they live,” Yonkers said.

In a “bundle” produced by the Council on Patient Safety and Women’s Health Care promoted by the American College of Obstetricians and Gynecologists, one of the pillars is recognition and prevention, said Yonkers. “They advocate screening all pregnant women for substance use disorder,” she said, adding that based on the data she presented, it’s clear that “if you’re not universally screening, you are missing people.”

That doesn’t mean “grabbing a urine test from every woman,” said Yonkers. “It just means asking her and, ideally, engaging her in treatment.”

**Autism prevalence increases from 1 in 60 to 1 in 54: CDC**

*by Alison Knopf*

The prevalence of autism spectrum disorder (ASD) is now one in 54 children based on 2016 data, up from one in 60 in 2014, according to the Autism and Developmental Disabilities Monitoring (ADDM) Network of the federal Centers for Disease Control and Prevention (CDC). The surveillance program estimates ASD prevalence among children aged 8 living in 11 sites. The CDC also found that the prevalence of ASD varied considerably across these sites.

The earlier children with ASD are treated, the better the outcomes, research shows.

The prevalence of ASD has been going up since the surveillance numbers first came out for 2000, when it was one in 150. The earlier children with ASD are treated, the better the outcomes, research shows. Fewer than half of children with ASD had been evaluated by 3 years of age.

There was no difference in ASD prevalence between 8-year-old black and white children, although there were continuing disparities between these in early evaluation and diagnosis. Hispanic children were identified as having ASD less frequently than either white or black children.

**Study methods**

The 11 ADDM sites are in Arizona, Arkansas, Colorado, Georgia, Maryland, Minnesota, Missouri, New Jersey, North Carolina, Tennessee, and Wisconsin. Surveillance is conducted first by a review and abstraction of comprehensive evaluations that were completed by medical and educational service providers in the community, and then by a review of clinicians who determined ASD case status, using the criteria in the *DSM-5*. The information was for 2016.

**Study results**

For 2016, across all 11 sites, ASD prevalence was one in 54, and 4.3 times as prevalent among boys as among girls.

Among children with ASD for whom data on intellectual or cognitive functioning were available, 33% were classified as having intellectual disability (IQ below 70).

**Implications**

The findings show how important it is to evaluate and detect ASD across disparate communities, the authors write.

The prevalence estimate of ASD is 10% higher in 2016 than it was in 2014, and 175% higher than it was in 2000 and 2002, when the first estimates were reported. Changes could reflect differences in practices for identifying ASD, changes in the data available to the surveillance system, or unknown factors, the researchers write.

For the first time since ADDM began, no statistically significant difference was found in the overall ASD prevalence among black and white children, which might indicate progress toward earlier and more equitable identification of ASD. But black children with a co-occurring intellectual disability were still less likely than white children with a co-occurring intellectual disability to have been evaluated by age 3. In addition, black children were diagnosed 6 months later than white children.

Two other surveys (the National Survey of Children’s Health and the National Health Interview Survey) measure ASD prevalence by asking parents and