Infant Abstinence Syndromes

A. Knowledge

- Prevalence and patterns of substance abuse among pregnant women 1991 NIDA studies
  - as many as 375,000 babies (11%) are born in this country having been exposed to drugs
  - 10% of women of childbearing age admit to using illicit drugs
  - 4.5% of women used cocaine during the pregnancy
  - 17.4% of women used marijuana during the pregnancy
  - 73% of women used alcohol during the pregnancy
- U.S. House of Representatives' Select Committee on Children, Youth, and Families reports a threefold increase in substance abuse during pregnancy since 1985
- Transplacental transmission of psychoactive drugs
- Medical consequences of substance abuse during pregnancy since 1985
- Transplacental transmission of psychoactive drugs
- Medical consequences of substance abuse during pregnancy
  - Spontaneous abortion
  - Placental abruption
  - Premature birth
  - Low birth weight
  - SGA for wt/ht/hc
  - CNS damage leading to impaired neurodevelopment
  - Increased incidence of SIDS
  - Malformations
  - Congenital anomalies/dysmorphism
- Characteristic Neonatal Abstinence Syndromes (NAS)
  - Narcotics, sedative/hypnotics, ethanol
- Differential diagnoses of NAS in neonates with in utero drug exposure
  - Cerebral infarction/other CNS abnormalities
  - Metabolic disturbance
- Diagnoses associated with neonatal abstinence syndromes
  - Prematurity
  - Congenital anomalies
  - HIV infection
- Diagnosis/Assessment of Neonatal Abstinence Syndromes
  - Toxic screen analysis/deciding whom to test
  - Role of maternal and or neonatal testing
  - Potential specimens for analysis

Urine
Blood
Meconium
Hair

NAS scoring and its limitations

Other assessment tools

Cranial tomography
Cranial ultrasound

Management of Neonatal Abstinence Syndromes

Pharmacologic
Non-pharmacologic

B. Skills

Recognition of Neonatal Abstinence Syndromes

Using objective criteria for deciding whom to test

Interviewing mothers re: gestational drug use in order to make accurate diagnosis of NAS

Maternal education of anticipated clinical course must be done sensitively and must focus on:

need for diminished environmental stimulation
tendency for infants to have poor bonding
need at times for pharmacologic intervention

Developmental assessment of infant, child over ensuing time

Assessment of maternal child interaction

C. Attitudes

Sensitivity to needs and feelings of patient/families

Recognition of and willingness to deal with parental guilt

Recognition of parental frustration with an irritable infant who may bond poorly and may not be easily consoled

Recognition of potential for continued drug exposure via breast milk or passive inhalation

D. Barriers

Difficulty in uncovering substance abuse during pregnancy

Ethical implications of selective toxic screen testing based on economic, social and ethnic origins

Physician ignorance of street drugs, their names, costs, adulterants, and toxicity

Stereotyped image of "the typical drug user" prevents appropriate identification of exposed newborns

E. Advocacy

Political: continued support of government and community based drug interdiction/prevention/treatment efforts

Educational: Creation of widespread education programs specifically on the Neonatal Abstinence Syndrome, primarily in prenatal centers but also as part of school health education

Legal: De-emphasize gestational abuse as a crime which has prosecution as a potential consequence; rather emphasize treatment and prevention of addiction

Advocacy for the establishment of inpatient facilities for post partum mothers and infants to assist in management, and provide support and education during period of NAS

Provide inservice training to other health professionals, particularly obstetricians, postpartum nurses, visiting nurses and social workers

References

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