Antepartum Considerations (Marijuana):

• Because marijuana is lipophilic, once inhaled it enters the bloodstream within seconds, the brain within minutes, and crosses the placenta reaching the fetus. Levels can be detected in the cord blood or neonatal urine. Complete elimination after a single exposure to marijuana may take up to a month. Light users have the substance detected in their urine for days to weeks after use.

• Antepartum monitoring in patients using marijuana during pregnancy should be considered, as potential risks of marijuana exposure during pregnancy include the risk of anencephaly, lower birth weight, decreased height, long term behavioral and cognitive effects, dysfunctional labor, and fetal distress.

• A known antepartum risk is Cannabinoid Hyperemesis syndrome. It is rare but can occur with chronic marijuana use. It usually presents with severe abdominal pain, unrelenting nausea, and intractable vomiting where standard antiemetic therapies such as Ondanestron and Promethazine are ineffective.

• Cannabis withdrawal syndrome may present 10 hours after cessation and may peak in 48 hours. Symptoms include restlessness, anxiety, dysphoria, irritability, insomnia, anorexia, muscle tremor, increased reflexes, and autonomic effects include changes in heart rate, blood pressure, sweating, and diarrhea

Intrapartum Considerations (Marijuana):

• Complications for women who have used marijuana during pregnancy include dysfunctional
labor, precipitous labor, and meconium stained amniotic fluid.

• Low and high doses of cannabis have a cardiovascular effect on the autonomic nervous system. The resulting cardiovascular effects do have the ability to potentiate anesthetic drugs during labor resulting in a profound myocardial depression and even potential for ischemia. It is also important to note that acute marijuana abuse and intoxication can result in tachycardia and administration of atropine and epinephrine should be avoided.

• Upon admission, if a patient admits to recent or current marijuana use, vital signs should be taken as soon as possible to assure the patient is stable. After consent, a urine drug screen should also be completed to confirm if marijuana use is recent.

• Synthetic cannabinoids such as “Spice” may not show up on a standard urine drug screen and a negative drug screen does not necessarily rule out its use.

• A pain management plan should also be discussed with the patient and anesthesia should also be informed of the patient’s drug use for risk of potential complications.

• Additionally, the nurse taking care of the patient should alert anesthesia because of isolated incidents of oropharyngitis and uvular edema from cannabis inhalation. This is similar to impaired lung function from smoking tobacco and can cause airway obstruction resulting in a difficult intubation during general anesthesia

Postpartum Considerations (Marijuana):
• Marijuana use in the postpartum period is not well studied and there is limited clinical evidence to drive recommendations regarding counseling, intervention and rehabilitation.
• Mothers who use marijuana are likely to quit once discovering they are pregnant but are likely to return to using at the rate they used prior to pregnancy about 2 years after birth.
• THC can accumulate in breast milk in high concentrations and infants who are exposed will excrete it in their urine during the first 2 to 3 weeks after birth and may also show signs of sedation, reduced muscular tonus, and poor suckling. Consequently, marijuana use while breastfeeding is contraindicated.
• It is important that an interdisciplinary team be involved in the collaboration of care including social work and case management if necessary.

Antepartum Considerations (Meth):
• Associated with shorter gestational age and lower birth weight.
• Increased risk of hypertension of pregnancy, PROM, previa, abruption, premature delivery, precipitous labor, Triple I, fetal demise
• Risks of meth lower than risks of cocaine overall except for hypertension
• High concurrent use of other drugs and smoking
• More likely to have poor prenatal care
Intrapartum Considerations (Meth):
• Increased gravity/parity
• Risk for CS may be higher
• High incidence of birth defects, including cleft lip/cleft palate and intrauterine stroke
• Oily skin, grey leathery skin, acne, skin sores “meth mites”, tooth decay
• UDS with reflex positive blood testing, know your state’s requirements for consent
• Personality changes may include aggression, rage and paranoia
• Up to 10% abruption rate
• Epidurals acceptable (as with most substances) but may require higher rate
• No Nubain/Stadol/Narcan as may precipitate withdrawal

Postpartum Considerations:
• Social Service/CPS referral (know your state)
• Difficult pain control
• To breastfeed or not to breastfeed?
• NAS
• Methadone/Suboxone start/referral