NATIONAL CURRICULUM IN REPRODUCTIVE PSYCHIATRY

Substance Use Disorders
Alcohol Use Disorder
Progressive Case Conference
Trainee Guide

Contributors
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Session
Sessions are typically designed to last 90 minutes but can be modified for a longer or shorter session by either presenting both or one of the cases. During the session, the cases will be distributed to trainees and will be read along by a resident volunteer. The entire group will then discuss the case as well as formulate the diagnosis and treatment approach based on facilitator guided questions. This session can be run by a single facilitator who oversees the entire group.

Learning Objectives
1. Describe the DSM-5 diagnostic criteria for alcohol use disorder (AUD)
2. Explain the risks of alcohol use in pregnancy and lactation
3. Discuss treatment options for AUD in pregnancy
4. Describe the management of alcohol withdrawal in pregnancy
5. Discuss considerations related to child protection reporting of alcohol use in pregnancy

Part 1:

You are working in an integrated care setting in the OB clinic at your institution. You receive a call from a certified nurse midwife at the clinic. She is requesting a curbside on a patient who she saw in clinic earlier in the day. She tells you that the patient, Jessica, is a 24 year old G2P1 female who presents for her first OB appointment at 24 weeks pregnant. According to the midwife, Jessica reported that she discovered she was pregnant by a home pregnancy test after missing her monthly menstrual cycle. She had planned to seek routine prenatal treatment earlier on in the course of her pregnancy but felt ashamed because she had planned to quit drinking alcohol though has been unable to do so. She repeatedly stated," I just thought I would be able to get my drinking under control." Her continued inability to decrease her intake has led to her feeling increasingly ashamed. She was initially ambivalent about the pregnancy and has since decided that she is excited about the baby though is very anxious and concerned about her inability to stop drinking alcohol. She now realizes that she can't do this on her own and comes to the midwife seeking assistance, in addition to routine prenatal care.

1) Does this patient have Alcohol Use Disorder?

2) What additional historical information do you want to know before making recommendations?

3) What objective data (labs, Physical exam) would you like to check?

4) The provider asks if she should report this patient to child protective services for lack of prenatal care and drinking. How would you counsel this provider?

Part 2:

Upon further questioning, the midwife reports that Jessica has struggled with alcohol use since age 18. Jessica reports that she started drinking alcohol at this age following a rape by a family member. She began using alcohol as a way to "forget about the pain." Her use escalated quickly, and she reports a history of frequent blackouts, 3 DUIs (for which her driver's license has subsequently been revoked), and inability to maintain a job due to her drinking. She reports that she was drinking a fifth of a gallon of whiskey per day prior to finding out she was pregnant. Since she found out she was pregnant, she has cut down, and reports current use of approximately 2 shots of whiskey per day plus a 6-pack of beer. She denies other substances other than cigarettes, around one pack per day. She denies any history of complicated withdrawal (seizures or delirium tremens). She reports that her longest period of abstinence from alcohol was when she was pregnant with her first child, who is now 3 years old. She was able to quit drinking during this pregnancy but quickly resumed following the pregnancy. Her 3 year old daughter is currently living with her older sister, as placed by child protective services, due to a house fire during which she was found to be intoxicated, though she has regular supervised visits. When asked what helped her to maintain her sobriety from alcohol during the time that she was pregnant previously, she says that her mother was a major source of support and she been living with her mother during the time. She denies seeking treatment during this period and says that she was able to do it on her own with the support of her mother. She is frustrated with herself that she has been unable to quit this pregnancy. She notes that her mother died a year and a half ago and this was a major loss. She reports domestic violence in her current relationship with a man, who is the father of her baby. She describes symptoms consistent with PTSD. She denies any passive death wish, suicidal ideation, and homicidal ideation. She reports a family history of addiction issues (alcohol primarily), and is unable to identify anyone who is supportive of her since her mother passed away. Vital signs are within normal limits, and she does not exhibit flushing, diaphoresis, tremor, or sequelae of liver disease on exam.

1) What should the midwife tell the patient about the risks of her drinking during pregnancy?

2) The midwife asks "How do I get her to stop?"

3) What treatment do you recommend?

Part 3:

You are now working on the psychiatry consult service at your institution's women's hospital. Jessica presents to the hospital at 34 weeks and 3 days for cramping and contractions. She was evaluated by the OB team and determined not to be in labor, but to have pyelonephritis. She is being treated appropriately for this. You receive a consult from the OB team for assistance with evaluation for alcohol withdrawal and treatment recommendations. You go to see Jessica, and she reports that she did not follow-up with recommended treatment and was lost to follow-up, despite efforts by her midwife and social worker at the clinic to reach out. She feels even more guilty now than she did before, and repeatedly states, "I just couldn't get it together." There was continued violence in her relationship with her partner as well as a host of other stressors, including financial issues. Her prenatal care was therefore very limited. She reports that she was able to cut out whiskey on her own but has continued to drink 6 beers daily throughout her pregnancy and has continued to smoke cigarettes. She denies any physical symptoms of withdrawal at time of admission and vital signs and exam are unremarkable.

1) What treatment do you recommend at this point?

2) How would you prepare this patient for the delivery and the postpartum period?

3) How would this case be different if Jessica were also concurrently using benzodiazepines and heroin?

Part 4:

A. The decision to proceed with delivery is made at 34 weeks and 6 days given continued poorly controlled blood pressure and subsequent fetal distress. The baby goes to the neonatal intensive care unit for monitoring and is treated appropriately and has been placed in foster care by child protective services. While seen in the postpartum ward, Jessica continues to voice feeling very ashamed and guilty about the situation, and reports that she is now motivated to engage in treatment given that she wants to do anything it takes to return baby to her custody. She is in agreement with attending an intensive outpatient program for the treatment of her alcohol use disorder.

1) How would you counsel her with respect to her desire to continue breastfeeding?

B. Following several months of treatment, she is scheduled with you at your institution's psychiatry clinic. She is thrilled to report to you that she has abstained from using alcohol and her baby is now back in her custody at age 4 months. She has broken up with her boyfriend, obtained a protective order and is living in a shelter for women who are survivors of intimate partner violence. She continues to smoke cigarettes, although is open to discussing tobacco cessation strategies. **See Tobacco Use Self-Study for more information.**

1) What can you recommend to the patient regarding longer term treatment?

References

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