**CCRMC Perinatal Newsletter**

**Marijuana Use in Pregnancy and While Breastfeeding**



Marijuana crosses the placenta and may be concentrated in breast milk. There is increasing evidence that marijuana use during pregnancy may adversely impact fetal and neonatal brain development and that these effects may be long lasting. Although the effects are subtle, it appears that attention, executive function, and behavior may be altered and these effects persist from early childhood through adolescence. We want to educate women so that they understand that marijuana, like other substances and medications used during pregnancy, may pose a risk to their developing infants. The AAP advises that pregnant and breastfeeding women not smoke or ingest marijuana and babies should not be exposed to second hand marijuana smoke.  Additionally, marijuana use by a parent or caretaker of a baby, can impact their ability to respond to the baby’s physical, emotional and intellectual needs.  Be aware that many patients and their families might see marijuana as a natural substance and thus safe during pregnancy and during breastfeeding.   They may be advised by non-medical personnel to use marijuana for the treatment of nausea, anxiety, insomnia and pain.

Be sure to:

       Identify marijuana users early in pregnancy

       Advise against using any medical or recreational marijuana during pregnancy and while breastfeeding.

       Assist patients who use marijuana with managing withdrawal and other symptoms when they stop or decrease their usage.

       Advise against breastfeeding if the mother will resume or continue with frequent marijuana use post delivery

       Be aware that current state law requires postpartum to report neonatal toxicology screens positive for marijuana to Child and Family Services.  This may change in November if Marijuana is legalized in CA

Interested in more information?  Article: Cannabis, the pregnant woman and her child: weeding out the myths in the Journal of Perinatology (2014) 34, 417 – 424



**Third Trimester Labs**

We request that all patients have an RPR, HIV and CBC drawn within 8 weeks of delivery ideally at 34-36 weeks EGA. If it has been more than 8 weeks we redraw the labs urgently on L and D (so try not to draw at 32 weeks unless you know she will delivery before 40 weeks EGA).

GC/chlamydia testing is only recommended for those at increased risk of infection.

**Prenatal Panel available**

See a pregnant woman who has not made it to Healthy Start (usually with mental health conditions, no housing, legal issues, etc)? Want to order prenatal labs but starting a pregnancy episode and finding the results console overwhelming? Use the initial prenatal panel in meds and orders. Also consider an urgent or bedside dating ultrasound. This can be extremely useful when she presents later in labor or with complications. If near delivery and no care, consider sending to L and D for urgent HIV, other labs, and evaluation of gestational age.

**New Antepartum Testing Guidelines**

Good news. Changes from 2014 are minimal. The most significant change is adding induction of labor at 39-40 weeks for women who are 40 or older at their EDD. The rationale is that the stillbirth rate for women 40 and older at 39-40 weeks is similar to that of younger women from 41-42 weeks EGA. Please replace old guidelines posted with the new sheet.

Not new but reminder: When induction of labor is indicated in patients with a prior cesarean birth and no prior vaginal birth, and the cervix is unfavorable with Bishop’s < 6, we will recommend a repeat cesarean due to the lower chance of successful VBAC and the higher risk of uterine rupture. If a patient desires a vaginal delivery, schedule induction on the later side to allow the opportunity of spontaneous labor. You can schedule “induction or repeat cesarean” and we will make the assessment and discuss her options on the day she arrives after examining her cervix. Have her arrive NPO in case of a cesarean.

**Zika Virus**

Finally a virus with a name that is easy to say and spell. Unfortunately, this virus may be the cause of microcephaly and brain injury in utero. Although injury to the fetus is infrequent, it appears to be profound. Advise all pregnant women to avoid traveling to countries with Zika—consult CDC for exact list but essentially all tropical countries in the Americas. If travel must occur all precautions need to be taken to avoid mosquito bites. She should not have sex with someone who has exposure or possible infection with Zika within 2-3 weeks. If a patient returns from the area with a history of possible Zika (fever, myalgias, rash, conjunctivitis), she can be tested if within a few weeks, and if positive the fetus evaluated for microcephaly by ultrasound. The reality is that it will be very difficult to verify microcephaly prior to 24 weeks (cut off for termination) and there is no treatment for Zika or for microcephaly. Fortunately, immunity to Zika is thought to be lifelong. The illness itself is not serious except for very rare cases of Guillain-Barre.