

Information about Methamphetamine Use in Pregnancy

Methamphetamine use has become widespread in the U.S., particularly in the western, mountain and central states and in rural areas. This stimulant (also known as meth, ice, and crystal meth) is inexpensive and readily available because of local clandestine laboratories and a recent supply of inexpensive and very pure methamphetamine from Mexico¹. Methamphetamine can be smoked, sniffed, administered orally, or injected. During periods of repeated use, tolerance develops, enabling users to administer amounts that would be fatal under other circumstances. It can produce cardiovascular, neurological, digestive and psychiatric symptoms. Acute discontinuation of methamphetamine use can produce withdrawal symptoms such as depression, anxiety, fatigue, paranoia, and aggression.

The effects of maternal methamphetamine use can not be separated from other factors. As with drugs such as cocaine, pregnant methamphetamine users rarely use methamphetamine alone. Alcohol, cigarettes and marijuana are often used with methamphetamine. Pregnant methamphetamine users may also have poor diet and lack of adequate prenatal care. Therefore, even when poor birth outcome appears to be associated with methamphetamine exposure it may be due to these concurrent maternal health behaviors². The National Toxicology Program, U.S. Department of Health and Human Services, Center for the Evaluation of Risks to Human Reproduction (CERHR), expert panel report on methamphetamine concluded that “in terms of the potential adverse reproductive and developmental effects of methamphetamine exposure, studies that focused upon humans were uninterpretable due to such factors as a lack of control of potential confounding factors and the issue of the purity and contaminants of the methamphetamine used by the drug abusers³.”

There is no syndrome or disorder that can specifically be identified for babies who were exposed in utero to methamphetamine. The term “meth baby” or “ice baby” is stigmatizing and should not be used.

It is important for the clinician to remember that alcohol and cigarette use during pregnancy are the most prevalent and impacting substances of abuse on the fetus. Alcohol consumption during pregnancy is a leading preventable cause of mental retardation, developmental delay and birth defects in the fetus⁴. Smoking during pregnancy has been causally linked to premature rupture of membranes, low birth weight and perinatal mortality, including SIDS⁵. Therefore all pregnant women should be routinely asked and counseled about all substance use.

(continued)

The role of the women's health clinician is to identify methamphetamine use as well as the use of other substances and to support the pregnant woman. Mandated reporting of pregnant women for substance use may endanger the relationship of trust between the physician and patient, placing the obstetrician in an adversarial relationship with the patient and possibly creating conflict with the therapeutic obligation⁶. If pregnant women become reluctant to seek medical care because they fear being reported for illegal drug use, these strategies will actually increase the risks to the woman and the fetus rather than reduce the consequences of substance abuse⁷. Seeking obstetric-gynecologic care should not expose a woman to criminal or civil penalties or the loss of custody of her children⁸. If methamphetamine use is suspected, the medical provider should discuss the suspicion with the patient and, if drug testing is to be carried out, to inform the patient about the nature and purpose of the test and how the test results will be used and to gain her consent for testing. Because of the possible implications of a positive drug screen, the rights of patients to autonomy and privacy are to be respected⁹. Methamphetamine has a strong addictive quality and referral to a substance abuse treatment program is encouraged.

References

-
- ¹ Zernike K. Potent Mexican meth floods in as states curb domestic variety. *New York Times*. January 23, 2006
 - ² Woulde T, LaGasse L, Sheridan J, Lester B. Maternal methamphetamine use during pregnancy and child outcome: what do we know? *The New Zealand Medical Journal* 2004;117:1180. Accessed at <http://www.nzma.org.nz/journal/117-1206/1180/> on 1/27/06.
 - ³ Center for the Evaluation of Risks to Human Reproduction. NTP-CERHR Expert panel report on the reproductive and developmental toxicity of amphetamine and methamphetamine. National Toxicology Program. National Institute of Environmental Health Sciences. NIH Publication No. 05-4474, July 2005. Research Triangle Park, NC. pg. 191
 - ⁴ American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special Issues in Women's Health. Washington DC ACOG. 2005. Pg. 122
 - ⁵ American College of Obstetricians and Gynecologists. Committee Opinion No. 316: Smoking cessation during pregnancy. Washington DC. ACOG. 2005.
 - ⁶ American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special issues in Women's Health. Washington DC, ACOG. Pg. 120
 - ⁷ American College of Obstetricians and Gynecologists. Committee Opinion No. 294 At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice... Washington DC, ACOG. 2004
 - ⁸ American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications. in Special issues in women's health. Washington DC, ACOG. Pg. 117
 - ⁹ American College of Obstetricians and Gynecologists. Substance use: obstetric and gynecologic implications in Special issues in women's health. Washington DC ACOG. 2005. Pg. 117.