PN Update
Women's, Children's and Family Health

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Women's, Children's and Family Health

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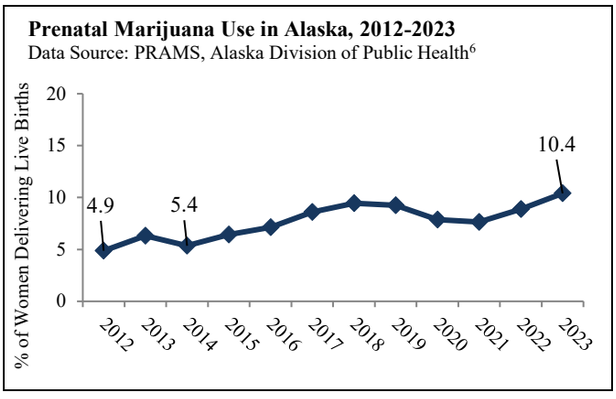
Cannabis use in pregnancy and lactation

Summary: In an environment of rising rates of cannabis use, approximately 40-50% of health care providers do not respond with clear recommendations when pregnant women disclose cannabis use.[1,2] This Bulletin summarizes what is known about the effects of prenatal cannabis exposure and provides recommendations for providers caring for pregnant women who disclose cannabis use.

What is cannabis? Colloquially known as marijuana, Cannabis refers to products derived from the plants *Cannabis sativa*, *indica*, and *ruderalis*. The primary psychoactive substances in cannabis are Tetrahydrocannabinol (THC) (most potent) and cannabidiol (CBD). THC is highly lipophilic; it permeates cells easily, crosses the placenta, and is stored in fat tissue.[3] THC acts on receptors which are present from early stages of embryonic development.[2, 4] Cannabis can be inhaled, ingested, or applied topically, vaginally, or rectally, with onset and duration of action varying on consumption method.[4]

Legal Cannabis Use in Alaska[5]: Alaska legalized medical marijuana in 1998 and recreational marijuana in 2014. Since 2014, there has been a steady increase in use both in the general Alaskan population and in pregnant and postpartum women.[6] A concurrent rise the THC potency of commercially available cannabis products elevates concern about potential adverse health impacts, including those for developing fetuses.[3,4]

There are no medical indications for the use of cannabis in pregnancy.[4]



Patient Perception of Perinatal Cannabis Use (PCU):

Pregnant women weigh their understanding of the benefits of PCU with their uncertain perception of risks.[7,8] Patients report using cannabis during pregnancy for symptom/disease management, harm reduction (perceiving fewer risks with cannabis than other substances or using cannabis to reduce their use of other substances), perception of safety and benefit, or Cannabis Use Disorder (CUD).[8, 9, 10] Providers need to consider and address misperceptions of safety and alternative sources of information. When providers do not offer clear communication during prenatal visits, it can be construed to mean that PCU does not involve risks to their pregnancy.[3, 7]

Patients report getting information on cannabis use during pregnancy from their family, the Internet[3], and cannabis retail stores. In a national study, 69% of retail locations recommended cannabis for morning sickness, insomnia and/or pain.[11, 12]

Maternal outcomes related to cannabis use

Nausea and vomiting: Cannabis use in the 3 months prior to conception and in the first trimester is associated with increased rates of nausea and vomiting and may cause Cannabinoid Hyperemesis Syndrome.[14]

Severe Maternal Morbidity (SMM): Co-occurring cannabis and nicotine use shows increased risk of SMM.[15]

CUD: Among pregnant women who continue to use cannabis, data shows approximately 18% meet diagnostic criteria for CUD.[12]

Fetal Outcomes with Prenatal Cannabis Exposure (PCE):

While there is no phenotypic syndrome associated with PCE, cannabis use is not recommended in pregnancy because of the absence of safety data, known physiological interactions with the developing brain, and emerging evidence of potential harm. Current research shows a dose- and timing -dependent relationship to effects. Generally, fetal concentration of THC is approximately 10% of maternal concentration.[4,16] Additional research is needed to further elucidate the relationship of mode of ingestion, potency, and timing of cannabis use on fetal development. [16, 17, 18]

Birth outcomes: In utero cannabis exposure is independently associated with increased odds of low birthweight, small for gestational age (SGA), increased admission to Neonatal Intensive Care Unit (NICU), and preterm birth.[4, 16, 17, 18]

Long term: While more research is needed to fully understand specific long-term impacts of cannabis use during pregnancy, there is a growing body of evidence for risks. Impact can be seen in the areas of social/emotional development, showing an increase in hyperactivity and aggressive behavior in childhood[18,20], and cognitive effects, including a decrease in some areas of executive function[20], language, and memory, with less consistent findings for other cognitive and neurological effects [18,20]

Co-occurring cannabis and nicotine use: increase in NICU admission, infant death, preterm birth, and SGA.[15]

Lactation: There is limited research on the effects of infant exposure to cannabis through breast milk.[13] Dependent on the mode of consumption, peak cannabis concentrations in human milk usually occur within 1-hour post ingestion and dissipates over time with a half-life of 17 hours and up to 6 weeks for clearance.[13]

Recommendations for providers:

- **Ask specifically about cannabis use**: many women do not disclose when asked broadly about drug use or smoking.[4]
- **Inquire non-judgmentally** about a patient's reasons for use, alternatives, options, and related factors (i.e. partner use). [4, 10, 12, 13] The decision to use cannabis is often not binary (to use/not use).[10]
- **Address the symptoms/issues cannabis is being used to manage**. Discuss the risks/benefits of alternative therapies to treat conditions.[10]
- **Educate** on risks of cannabis use in pregnancy and lactation.
- **Encourage cessation** and/or reduction of cannabis use.[4, 13, 17]
- Use **Motivational Interviewing** techniques to elicit intrinsic behavioral change and patient-centered goal setting.[4]
- **Assess for Cannabis Use Disorder (CUD).**
- **Consider the WEED mnemonic**:
  Welcome questions about cannabis use.
  Explore alternatives to cannabis for common pregnancy ailments such as anxiety and nausea.
  Explain potential risks of cannabis use.
  Deliver a health-positive message by recommending cessation of cannabis use during pregnancy/breastfeeding and a decrease in dose and frequency of use for patients who are not able or willing to stay abstinent.

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Further Provider resources on supporting perinatal individuals experiencing substance use disorders:

- WCFH Publication: Legal is not the Same as Safe. This and other free publications available using the order form: https://health.alaska.gov/media/ueyhm5g1/form_perinatalhealthpublicationorders.pdf
- Alaska Department of Health and Social Services. *Marijuana Use and Public Health in Alaska -2020*. Anchorage, Alaska: Office of Substance Misuse and Addiction Prevention, Division of Public Health, Alaska Department of Health and Social Services; January 2020.
- Academy of Perinatal Harm Reduction
- Weitzman Institute
- Screening and Treatment for Maternal Mental Health and Substance Use Disorders
- CDC: Cannabis and Pregnancy
- SAMHSA: Marijuana and Pregnancy
- Patient handout from MothertoBaby: https://mothertobaby.org/fact-sheets/marijuana-pregnancy/pdf/
- Alaskaquitline.com: 1-800-QUIT-NOW (1-800-784-8669)