Suchterkrankung und Frauengesundheit:
Herausforderungen, Versorgung und Perspektiven
Jahreskongress der DGSuchtmedizin e.V. 2026

Frauengesundheit bei substanzabhängigen/substituierten Patientinnen

Dr. med. Jan-Peter Siedentopf

Ambulanz für Suchterkrankungen und Infektionen in der Schwangerschaft
Klinik für Geburtsmedizin
Campus Virchow-Klinikum
Charité - Universitätsmedizin Berlin
Augustenburger Platz 1
13353 Berlin
infektionsambulanz@charite.de

Interessenkonflikte

Vortragshonorare:

Hexal

Indivior

Camurus

SynlabAcademy

Gilead

Beratertätigkeit:

Camurus

Forschung:

Biotest



Aquarell „ Alter Hof Ziegenstr. 8“, Bernd Fröhlich 2014 (Privatbesitz)

Dieser Vortrag wird von der Hexal AG, Industriestraße 25, 83607 Holzkirchen finanziert. Hexal AG ist jedoch nicht für den Inhalt des Vortrages verantwortlich.

Thema und Inhalt des Vortrages obliegen der wissenschaftlichen Freiheit des Referenten.

Frauengesundheit
Leipzig, 6.11.2026
Dr. Jan-Peter Siedentopf

Frauen in Substitutionsbehandlung

Opiate und Hormone

- Heroinkonsum beeinflusst den Menstruationszyklus
- Zusätzlich Stress und ggf. inadäquate Ernährungssituation verstärken dies (Extremfall: Anorexie)
- Methadon beeinflusst den Zyklus weniger

Patientinnen mit sekundärer Amenorrhoe „vermissen“ ihren Zyklus nicht – und bemerken nicht wenn dieser wegen einer Schwangerschaft ausbleibt…



RESEARCH REPORT

Menstrual cycle length during methadone maintenance

John Schmittner, Jennifer R. Schroeder, David H. Epstein & Kenzie L. Preston

Intramural Research Program, National Institute on Drug Abuse, National Institute of Health, Baltimore, MD, USA

Correspondence to:
John Schmittner
Intramural Research Program
National Institute on Drug Abuse
National Institute of Health
5500 Nathan Shock Drive
Baltimore
MD 21224
USA
Tel: 410 550 1254
Fax: 410 550 1528
E-mail: jschmitt@intra.nida.nih.gov

Submitted 27 April 2004;
initial review completed 23 July 2004;
final version accepted 12 January 2005

ABSTRACT

Aims While the menstrual disruption of heroin has been demonstrated, there are few published data concerning methadone maintenance and menstrual function. This study was conducted to evaluate whether cycle length was more regular during methadone maintenance.
Settings An out-patient research treatment program in Baltimore, Maryland, USA.
Participants A total of 191 heroin and cocaine-using women from two clinical trials, lasting 25–29 weeks; each woman was maintained on 70–100 mg of methadone.
Measurements Start/end dates of each menses were collected.
Design Menstrual patterns were classified as regular, irregular, transient amenorrhea, persistent amenorrhea or cycle restart. Repeated-measures regression modeling determined correlates of cycle length and predictors of long cycles (> 40 days) and short cycles (< 20 days). Bleeding episodes were defined as 1 or more bleeding days, bound by at least 2 non-bleeding days. Correlates/predictors examined were body mass index, drug use, methadone dose and race.
Findings In the 133 women for whom menstrual patterns could be determined, cycle-length irregularity was common: irregular, 62 (46.7%); regular, 37 (27.8%); cycle restart, 16 (12%); persistent amenorrhea, 11 (8.3%); transient amenorrhea, seven (5.3%). Each additional week on methadone maintenance was associated with decreased risk of long (OR = 0.96, $P < 0.01$ and short (OR = 0.92, $P < 0.01$) cycles. Of 27 women with secondary amenorrhea pre-study, 16 (59%) restarted menses. Positivity for opioids or cocaine was not significantly associated with short or long cycles.
Conclusions Cycle length begins to normalize during methadone maintenance. Menses resumption may occur. Methadone maintenance, despite interfering with menstrual function in an absolute sense, may interfere less than illicit heroin abuse.

KEYWORDS Amenorrhea, heroin, menstruation, methadone.

INTRODUCTION

Opiate dependence is associated with significant morbidity and mortality[1–4], much of which is reduced by methadone maintenance [5–9]. One form of morbidity that has been clearly demonstrated in heroin users is disruption of menstrual function [10–12].

The degree to which methadone affects menstruation is less clear. There is a paucity of research in this area. Published information is sparse. A MEDLINE search of the terms 'methadone' and 'menstruation' from 1969 to 2003 yielded only eight references. Some studies have shown little or no improvement [11–12], while others report definite improvement [1,3–14]. Furthermore,

© 2005 Society for the Study of Addiction doi:10.1111/j.1360-0443.2005.01091.x

Ungeplante Schwangerschaften

- Höhere Schwangerschaftsrate als Vergleichspopulation
- Höhere Rate an Schwangerschaftsabbrüchen
- ca. 50% nutzen keine Kontrazeptiva
- 27,6 waren im Jahr zuvor schwanger
- 75,5% davon ungeplant

Insbesondere bei der Neueinstellung auf eine Substitution sollte ein Aufklärung über geeignete Kontrazeptive Maßnahme erfolgen.



Australian and New Zealand Journal of Obstetrics and Gynaecology 2012; **52**: 146–150 DOI: 10.1111/j.1479-828X.2012.01413.x

Original Article

Unplanned pregnancy and contraceptive use in women attending drug treatment services

Kirsten I. BLACK,[1] Christine STEPHENS,[2] Paul S. HABER[2,3] and Nicholas LINTZERIS[3,4]

[1]*Discipline of Obstetrics, Gynaecology and Neonatology, Central Clinical School, Royal Prince Alfred Hospital, University of Sydney, Camperdown,* [2]*Drug Health Services, Sydney Local Health, District,* [3]*Discipline of Addiction Medicine, Faculty of Medicine, University of Sydney, Sydney, and* [4]*Drug and Alcohol Services, South East Sydney Local Health District, c/o The Langton Centre, Surry Hills, NSW, Australia*

Background: At an international level, there are calls for a greater focus on women and harm reduction in recognition that female drug users have a unique set of issues that are not routinely assessed in drug treatment programs.
Aims: To assess the pregnancy history, current pregnancy risk and contraceptive use of nonpregnant women attending opioid treatment programs (OTPs).
Methods: This study involved a structured questionnaire survey of 204 women attending outpatient OTP services within the Sydney South West Area Health Service.
Results: Two hundred and four women of 302 (67.5%) enroled in OTPs at the time completed surveys. Key findings were high pregnancy rates, with 28.9% of women reporting six or more pregnancies, high rates of adverse pregnancy outcomes (miscarriage, termination and stillbirth) compared with national data and poor uptake of contraception, with only 54.7% of sexually active women not wanting to get pregnant using a method. Women expressed diverse preferences for the type and location of women's health services they felt would meet their needs.
Conclusion: Women in OTP clinics have unaddressed reproductive health issues, particularly around contraception. Addressing these will potentially minimise the risk of material deprivation and social exclusion in these women and improve their well-being through greater control and choice over their fertility. Current women's health service provision in OTP programs involves referral to external services, but an integrated model of care may best address the unmet contraceptive needs of these women.

Key words: contraception, substance-related disorders, unplanned pregnancy.

Introduction

Women account for approximately 30–40% of clients attending alcohol and drug treatment services, yet women's sexual and reproductive health is not routinely addressed by services.[1] Regular substance use can have a myriad of effects upon women's sexual health – including patterns of contraception, irregular menstrual history, sexually transmitted diseases, sexual abuse and increased risk of cervical neoplasia.[2–6] These may be a result of the effects of substance use (eg dependence or regular intoxication upon alcohol, stimulants, benzodiazepines or opioids), social determinants of health (socio-economic status, ethnicity and education status), and/or poor access or utilisation of appropriate health services.

The maternal and fetal impact of drug use in pregnancy has received substantial research attention,[7–13] yet to date there has been little assessment of the health needs of nonpregnant women attending drug and alcohol treatment services. A survey of 40 female narcotic addicts attending a methadone clinic, undertaken in 1977, found that compared with university students these women had a history of poor reproductive health outcomes, poor contraception use and general health impairment.[5] A more recent study, undertaken in rural Australia, found that of 23 women on a methadone program, 14 were sexually active and four of these used no contraception.[14]

A number of barriers to women in substance use treatment accessing contraception services have been identified. One barrier is that women erroneously believe

Correspondence: Dr Kirsten I Black, Discipline of Obstetrics, Gynaecology and Neonatology, Central Clinical School, University of Sydney, Level 4, Building 63, Royal Prince Alfred Hospital, Camperdown, NSW, Australia.
Email: kirsten.black@sydney.edu.au

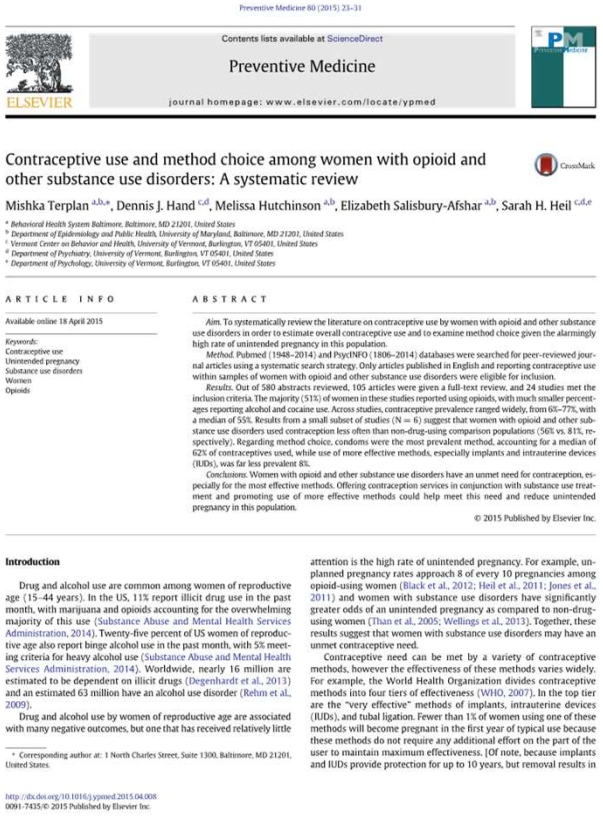
Received 14 July 2011; accepted 25 December 2011.

© 2012 The Authors
ANZJOG © 2012 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Kontrazeption

- oft Bedarf nicht erfüllt
- unsicher Kontrazeptionsmethoden
- Berücksichtigung der Lebensumstände ist besonders wichtig
- Wahrnehmung der Bedürfnisse

Adäquate Kontrazeptionsberatung ermöglicht reproduktive Autonomie und hilft Belastungen durch ungeplante oder ungewollte Schwangerschaften zu vermeiden.



Preventive Medicine 80 (2015) 23–31

Contents lists available at ScienceDirect

Preventive Medicine

journal homepage: www.elsevier.com/locate/ypmed

Contraceptive use and method choice among women with opioid and other substance use disorders: A systematic review

Mishka Terplan [a,b,*], Dennis J. Hand [c,d], Melissa Hutchinson [a,b], Elizabeth Salisbury-Afshar [a,b], Sarah H. Heil [c,d,e]

[a] Behavioral Health System Baltimore, Baltimore, MD 21201, United States
[b] Department of Epidemiology and Public Health, University of Maryland, Baltimore, MD 21201, United States
[c] Vermont Center on Behavior and Health, University of Vermont, Burlington, VT 05401, United States
[d] Department of Psychiatry, University of Vermont, Burlington, VT 05401, United States
[e] Department of Psychology, University of Vermont, Burlington, VT 05401, United States

ARTICLE INFO

Available online 18 April 2015

Keywords:
Contraceptive use
Unintended pregnancy
Substance use disorders
Women
Opioids

ABSTRACT

Aim. To systematically review the literature on contraceptive use by women with opioid and other substance use disorders in order to estimate overall contraceptive use and to examine method choice given the alarmingly high rate of unintended pregnancy in this population.

Method. Pubmed (1948–2014) and PsycINFO (1806–2014) databases were searched for peer-reviewed journal articles using a systematic search strategy. Only articles published in English and reporting contraceptive use within samples of women with opioid and other substance use disorders were eligible for inclusion.

Results. Out of 580 abstracts reviewed, 105 articles were given a full-text review, and 24 studies met the inclusion criteria. The majority (51%) of women in these studies reported using opioids, with much smaller percentages reporting alcohol and cocaine use. Across studies, contraceptive prevalence ranged widely, from 65–77%, with a median of 55%. Results from a small subset of studies (N = 6) suggest that women with opioid and other substance use disorders used contraception less often than non-drug-using comparison populations (56% vs. 81%, respectively). Regarding method choice, condoms were the most prevalent method, accounting for a median of 62% of contraceptives used, while use of more effective methods, especially implants and intrauterine devices (IUDs), was far less prevalent 8%.

Conclusions. Women with opioid and other substance use disorders have an unmet need for contraception, especially for the most effective methods. Offering contraception services in conjunction with substance use treatment and promoting use of more effective methods could help meet this need and reduce unintended pregnancy in this population.

© 2015 Published by Elsevier Inc.

Introduction

Drug and alcohol use are common among women of reproductive age (15–44 years). In the US, 11% report illicit drug use in the past month, with marijuana and opioids accounting for the overwhelming majority of this use (Substance Abuse and Mental Health Services Administration, 2014). Twenty-five percent of US women of reproductive age also report binge alcohol use in the past month, with 5% meeting criteria for heavy alcohol use (Substance Abuse and Mental Health Services Administration, 2014). Worldwide, nearly 16 million are estimated to be dependent on illicit drugs (Degenhardt et al., 2013) and an estimated 63 million have an alcohol use disorder (Rehm et al., 2009).

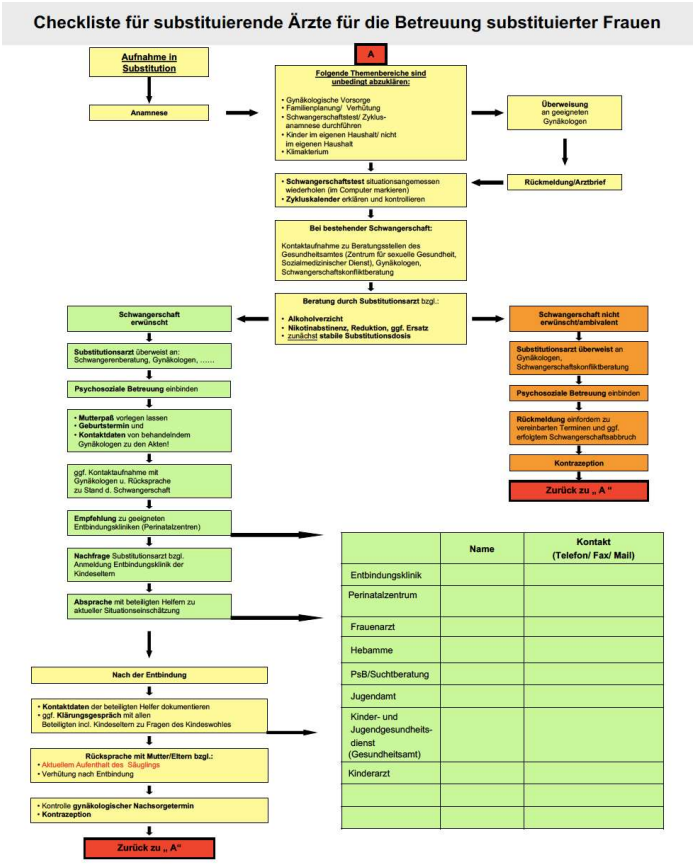
Drug and alcohol use by women of reproductive age are associated with many negative outcomes, but one that has received relatively little attention is the high rate of unintended pregnancy. For example, unplanned pregnancy rates approach 8 of every 10 pregnancies among opioid-using women (Black et al., 2012; Heil et al., 2011; Jones et al., 2011) and women with substance use disorders have significantly greater odds of an unintended pregnancy as compared to non-drug-using women (Than et al., 2005; Wellings et al., 2013). Together, these results suggest that women with substance use disorders may have an unmet contraceptive need.

Contraceptive need can be met by a variety of contraceptive methods, however the effectiveness of these methods varies widely. For example, the World Health Organization divides contraceptive methods into four tiers of effectiveness (WHO, 2007). In the top tier are the "very effective" methods of implants, intrauterine devices (IUDs), and tubal ligation. Fewer than 1% of women using one of these methods will become pregnant in the first year of typical use because these methods do not require any additional effort on the part of the user to maintain maximum effectiveness. [Of note, because implants and IUDs provide protection for up to 10 years, but removal results in

* Corresponding author at: 1 North Charles Street, Suite 1300, Baltimore, MD 21201, United States.

http://dx.doi.org/10.1016/j.ypmed.2015.04.008
0091-7435/© 2015 Published by Elsevier Inc.

Checkliste Substitution

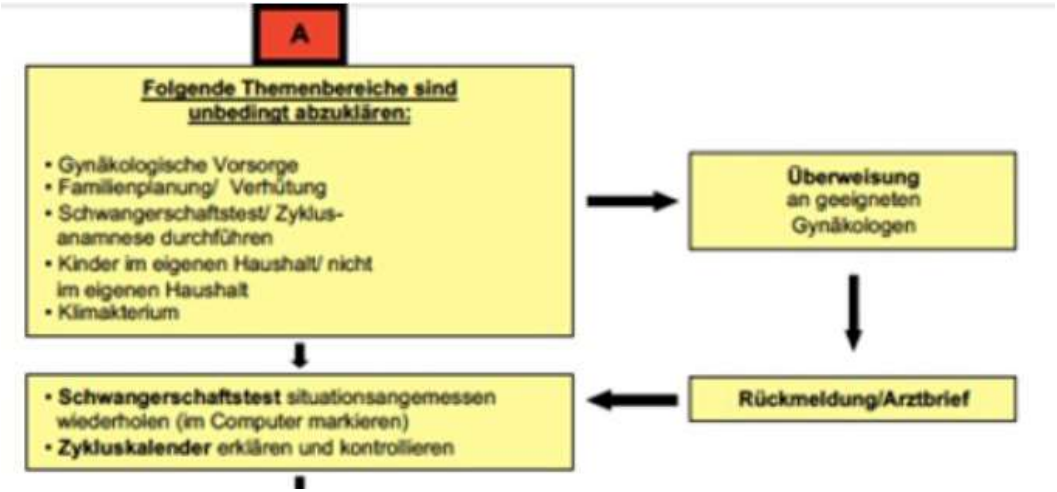


Richtlinie der Bundesärztekammer zur Durchführung der substitutionsgestützten Behandlung Opioidabhängiger/ Opioid-Agonisten-Therapie (OAT):

- Abklärung einer eventuell bestehenden Schwangerschaft
- Hierbei ist auch die Situation gegebenenfalls in häuslicher Gemeinschaft mitlebender Kinder zu berücksichtigen.
- Bei vorliegender Schwangerschaft sind Behandlungsabbrüche nach Möglichkeit zu vermeiden, da in diesen Fällen eine besondere Gefährdung für das ungeborene Leben besteht.

© 2011 Nagel, Höppner, Fry, Siedentopf Checkliste für substituierende Ärzte für die Betreuung substituierter Frauen - infektionsambulanz@charite.de

Checkliste Substitution



Bei Substitutionsbeginn aufklären und ggf. bei der Umsetzung behilflich sein, im Verlauf regelmäßig nachfragen:

- *Gynäkologische Vorsorge (Kontakt kennen)*
- *Kontrazeption*
- *mögliche Risiken für Kinder im Haushalt bedenken (auch bei Männern!)*
- *Klimakterium*
- *Mammographiescreening*

© 2011 Nagel, Höppner, Fry, Siedentopf Checkliste für substituierende Ärzte für die Betreuung substituierter Frauen - infektionsambulanz@charite.de

Frauengesundheit
Leipzig, 6.11.2026
Dr. Jan-Peter Siedentopf

Risiken durch Substanzkonsum in der Schwangerschaft

Obwohl dies für die Therapie der Schwangeren eine große Relevanz haben kann, ist es für die Auswirkung auf die intrauterine Entwicklung unerheblich, ob die Schwangere die diagnostischen Kriterien einer Suchterkrankung erfüllt oder nicht.



Lithographie „Elend“, Käthe Kollwitz 1944 (Privatbesitz)

Risiken durch Substanzkonsum

Risiken der Substanzen

Alkohol
Rauchen/Nikotinkonsum
Cannabis und Kombination Alkohol/Cannabis
Kokain
Crystal Meth
Opiate/Opioide
Psychopharmaka
Schwarzmarktbeimischungen...

Risiken der Konsumform

Infektionen, Thrombosen, Sepsis

Risiken der Beschaffung

Prostitution, Kriminalität, Gewalt, Infektionen, Verwahrlosung, Inhaftierung

soziale und psychosoziale Risikofaktoren bzw. Belastungsfaktoren

Frauengesundheit
Leipzig, 6.11.2026
Dr. Jan-Peter Siedentopf

Alkoholkonsum in der Schwangerschaft

- Alkohol tritt zu 100% auf den Fetus über
- Der Alkoholspiegel kann über dem der Mutter liegen
- Der Fetus baut Alkohol 10 mal langsamer ab
- Alkohol hemmt die Zellteilung
- Alkohol zerstört Zellen
- Alkohol tritt in die Muttermilch über



www.doreengadenne.de

https://register.awmf.org/assets/guidelines/022-025l_S3_Fetale-Alkoholspektrumstoerungen-Kinder-Jugendliche-Diagnostik-Intervention_FASD_2025-11.pdf
Siedentopf et al. Deutsches Ärzteblatt 2004

Es gibt KEINE „sichere“ Alkoholmenge

Rauchen/ Nikotinkonsum

Empfängnis und Schwangerschaft

- **Verminderte Fruchtbarkeit und Empfängnisbereitschaft**
- **Eileiter- und Bauchhöhlenschwangerschaften**
- **Fehlbildungen**
- **placenta praevia**
- **Funktionseinschränkungen und vorzeitige Lösung der Plazenta**
- **Vorzeitiger Blasensprung**
- **Vorzeitige Wehen**
- **Fehl-, Früh- und Totgeburt**
- **Wachstumsretardierung**

Geburt

- **Geburtskomplikationen**
- **erhöhte Sterblichkeit unter der Geburt**

Stillzeit

- **Entzugserscheinungen**
- **Plötzlicher Kindstod (SIDS)**
- **Stillschwierigkeiten**
- **Koliken**

Kindheit

- **Mittelohrentzündungen**
- **Atemwegserkrankungen (Erkältung, Bronchitis, Asthma)**
- **Beeinträchtigung der Lungenfunktion**
- **Intellektuelle, emotionale und Verhaltensstörungen (ADS, HKS)**
- **Höhere Wahrscheinlichkeit für frühen Tabakkonsum**

Suchttherapie 2011; 12(3): 105-108
Z Geburtshilfe Neonatol 2008; 212(3): 77-79

Alkohol und Cannabis

In Kombination mit Alkohol führte eine sonst „unproblematische“ THC-Dosis bei trächtigen Ratten zu einer signifikant höheren Zahl an untergehenden (apoptotischen) Zellen.

Cannabinoids Enhance Susceptibility of Immature Brain to Ethanol Neurotoxicity

Henrik H. Hansen, PhD,[1,2] Birte Krutz, MD,[1,3] Marco Sifringer, PhD,[3] Vanya Stefovska, MD, PhD,[3] Petra Bittigau, MD,[1] Fritz Pragst, MD,[4] Giovanni Marsicano, PhD,[5–7] Beat Lutz, PhD,[5,6] and Chrysanthy Ikonomidou, MD, PhD[3]

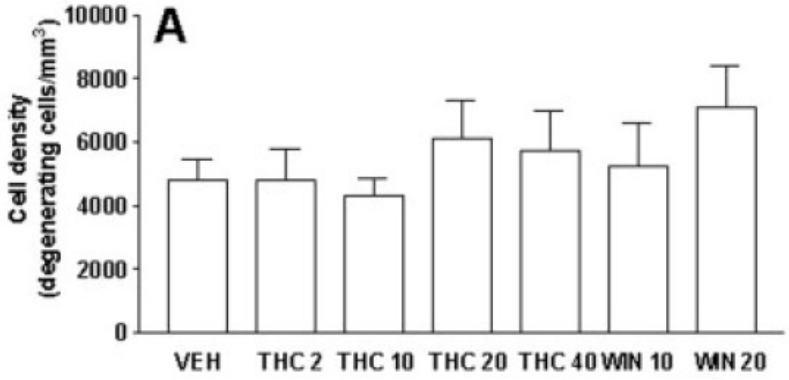
Objective: Marijuana and alcohol are most widely abused drugs among women of reproductive age. Neurocognitive deficits have been reported in children whose mothers used marijuana during pregnancy. Maternal consumption of ethanol is known to cause serious developmental deficits.

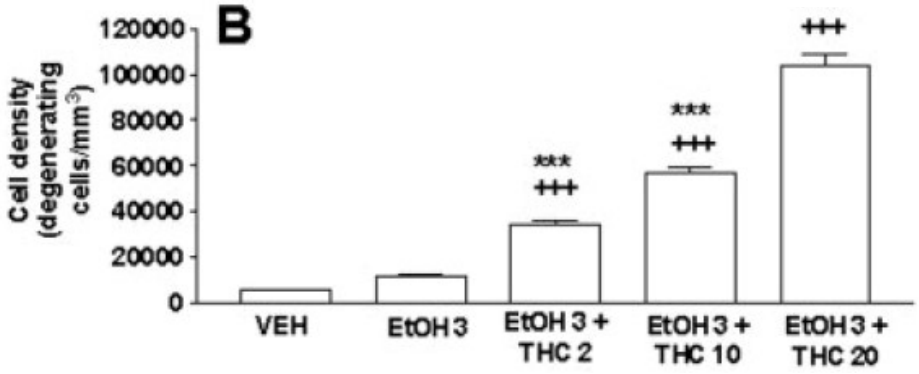
Methods: Infant rats and mice received systemic injections of Δ^9-tetrahydrocannabinol (THC; 1–10mg/kg) or the synthetic cannabinoid WIN 55,212-2 (1–10mg/kg), alone or in combination with subtoxic and toxic ethanol doses, and apoptotic neurodegeneration was studied in the brains.

Results: Acute administration of THC (1–10mg/kg), the principal psychoactive cannabinoid of marijuana, markedly enhanced proapoptotic properties of ethanol in the neonatal rat brain. THC did not induce neurodegeneration when administered alone. Neuronal degeneration became disseminated and severe when THC was combined with a mildly intoxicating ethanol dose (3gm/kg), with the effect of this drug combination resembling the massive apoptotic death observed when administering ethanol alone at much higher doses. The detrimental effect of THC was mimicked by the synthetic cannabinoid WIN 55,212-2 (1–10mg/kg) and counteracted by the CB_1 receptor antagonist SR141716A (0.4mg/kg). THC enhanced the proapoptotic effect of the $GABA_A$ agonist phenobarbital and the *N*-methyl-D-aspartate receptor antagonist dizocilpine. Interestingly, infant CB_1 receptor knock-out mice were less susceptible to the neurotoxic effect of ethanol. Furthermore, the CB_1 receptor antagonist SR141716A ameliorated neurotoxicity of ethanol.

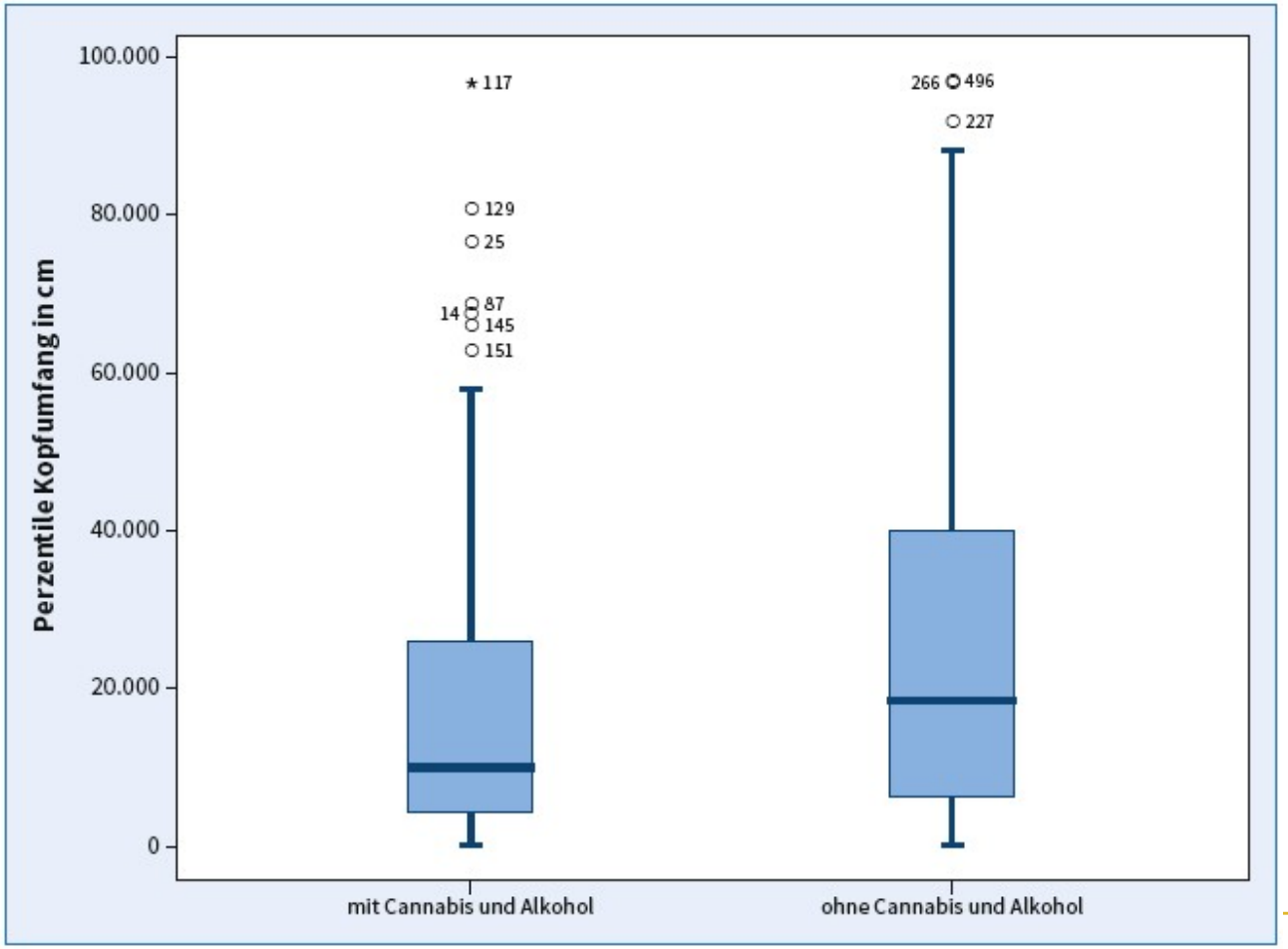
Interpretation: These observations indicate that CB_1 receptor activation modulates GABAergic and glutamatergic neurotransmission and primes the developing brain to suffer apoptotic neuronal death.

Ann Neurol 2008;64:42–52





Alkohol und Cannabis in der Schwangerschaft



Siedentopf, Nagel: Rausch, 12. Jg. 1/2 2023

Frauengesundheit
Leipzig, 6.11.2026
Dr. Jan-Peter Siedentopf

Folgen von Opiatkonsum in der Schwangerschaft

Morphinisme et grossesse (1883)

- Intrauterine Entzugssymptome
- Entzug in der Schwangerschaft verursacht vorzeitige Wehen
- Wachstumsstörung durch Morphinkonsum
- Dosisreduktion um Entzug des Kindes zu verhindern

„Cette dernière considération légitime la cure graduelle pendent la grossesse.“



Charles Samson Féré (1852-1907)

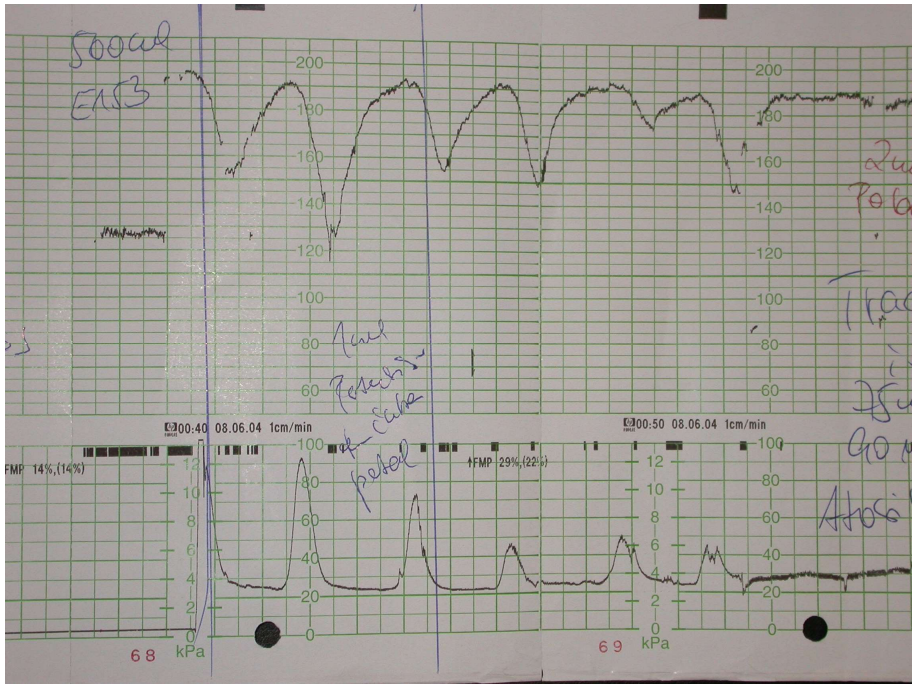
Literatur: Féré, Comptes rendus de la société de biologie 1883; 35: 526-528.

Frauengesundheit
Leipzig, 6.11.2026
Dr. Jan-Peter Siedentopf

Intrauteriner Opiatentzug

- Vierfach erhöhte Rate von intrauterinem Fruchttod
- Kurze Halbwertszeit von Heroin ist dafür (mit-)verantwortlich
- Grundlegende Rationale für die Substitution bei Schwangeren

„…would it be wiser to encourage methadone programs to „maintain“ rather than „withdraw“ the addict during pregnancy?“



Akuter intrauteriner Opiatentzug nach zweimaliger i.v. Naloxongabe

Literatur: Rementeria, AmJObstGynec 1973; 116: 1152-1156.
Bild: Siedentopf

Newborn Abstinence Syndrome

(bedingt) objektivierbar durch den Finnegan- Score

ZNS

Tremor
Irritabilität, motorische Unruhe
schrilles, unmotiviertes Schreien
verkürzte Schlafphasen
Krampfanfälle

Vegetativ

Fieber, Schwitzen, Niesen, Gähnen

Gastrointestinal

Erbrechen
dünne Stühle

Respiratorisch

Tachypnoe, Dyspnoe, Apnoe



Loretta Finnegan,Kazan, RU, 2008 © Jan-Peter Siedentopf

Addict Dis. 1975;2(1-2):141–158
JMIR Pediatr Parent. 2024 Feb 28;7:e50575

Eat, Sleep, Console

Beurteilt werden das Trink- und Schlafverhalten, sowie die “Tröstbarkeit”.
Es wird jeweils ein Punkt vergeben, wenn eine der Vorgaben nicht erreicht wird:

- **Essen:**

  Das Kind trinkt ausreichend und effektiv an der Brust, bzw. selbstständig 30ml pro Mahlzeit aus der Flasche (am 1. Lebenstag mindestens 5-10 ml, am 2. Lebenstag mindestens 10-20 ml, am 3. Lebenstag mindestens 20-30 ml) Erfolgskontrolle durch tgl. Gewichtskontrollen.

- **Schlafen:**

  Das Kind schläft mindestens 1h ununterbrochen

- **Tröstbarkeit:**

  Schreit das Kind, so lässt es sich innerhalb von 10 Minuten beruhigen (Trinken, Körperkontakt, …)

Medikamente zur Substitution

Methadon-Razemat (MDN) ist das welt- und deutschlandweit am häufigsten eingesetzte Substitutionsmedikament.

Substituierende Ärzte sind sicher im Umgang mit MDN.

Bezüglich der Anwendung von MDN in der Schwangerschaft besteht die umfangreichste Datenlage.

Auf Grund des „fehlenden“ D-Methadons enthält **Levomethadon** eine geringere Substanzmenge als das Razemat.

Buprenorphin führt zu einem geringeren und kürzeren Neugeborenen-Entzugssyndrom.

Quellen: Fischer et al. Addiction 2000; 95: 239-244.
Siedentopf, Nagel GebFra 2004; 64: 711-718.
Mücke et al. Klin. Padiatr. 2017; 229: 32-39.

Medikamente zur Substitution

Morphinsulfat (retardiertes Morphin) soll besser verträglich sein und damit eine bessere Haltequote erzielen. Stillen nicht möglich.

Diacetylmorphin stark reglementierte Vergabe, kurze Halbwertszeit, eigentlich besonderer Patientengruppe vorbehalten – ggf. nachteilig für Beurteilung der „Erziehungsfähigkeit“.

Die **Wahl des Substitutionsmittels** wird von gesetzlichen Regelungen, der eigenen Erfahrung (Patientin und Arzt/Ärztin) und dem erwarteten Nutzen beeinflusst. Ggf. kann ein Ausschleichen mit dem Originalpräparat erwogen werden.

Quellen: Holbrook et al. DrugAlcDep 2013; 132: 329-334.
www.dgsuchtmedizin.de; 01.12.2015.
siehe BtMVV

Vorteile von Buprenorphin

REVIEW doi:10.1111/add.13462

Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: a systematic review and meta-analysis of safety in the mother, fetus and child

Barbara K. Zedler[1], Ashley L. Mann[1], Mimi M. Kim[2], Halle R. Amick[1], Andrew R. Joyce[1], E. Lenn Murrelle[1] & Hendrée E. Jones[3,4]

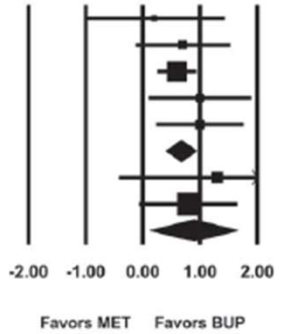
Venebio Group, LLC, Richmond, Virginia, USA,[1] Center for Biobehavioral Health Disparities Research, Division of Community Health, Duke University, Durham, NC, USA,[2] UNC Horizons, Department of Obstetrics and Gynecology, School of Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC, USA[3] and Departments of Psychiatry and Behavioral Sciences and Obstetrics and Gynecology, School of Medicine, Johns Hopkins University, Baltimore, MD, USA[4]

b. Head circumference (cm)

Group by Study Design	Study	Difference in means	Lower limit	Upper limit	BUP	MET	Relative weight
OBS	Kakko, 2008	0.20	-1.02	1.42	13	9	4.7
OBS	Metz, 2011	0.70	-0.12	1.52	26	51	10.5
OBS	Meyer, 2015	0.60	0.27	0.93	361	248	63.4
OBS	Whitham, 2010	1.00	0.11	1.89	30	22	9.0
OBS	Welle-Strand, 2012	1.00	0.25	1.75	49	90	12.4
OBS		0.68	0.41	0.94			
RCT	Jones, 2005	1.30	-0.40	3.00	8	11	20.0
RCT	Jones, 2010	0.80	-0.05	1.65	58	73	80.0
RCT		0.90	0.14	1.66			

Statistics for each study — Difference in means and 95% CI

Random effects meta-analysis
OBS: N=899; I^2=0%
RCT: N=150; I^2=0%



Weights are from random effects meta-analysis. Size of the data markers reflects the study weight. Note that 'Favors BUP' and 'Favors MET' are on opposite sides of the line of no effect compared to the forest plots for harm outcomes.

Figure 4 (a) Birth weight; (b) head circumference associated with buprenorphine compared with methadone

Conclusion:
Moderately strong evidence indicates lower risk of preterm birth, greater birth weight and larger head circumference with buprenorphine treatment of maternal opioid use disorder during pregnancy compared with methadone treatment, and no greater harms.

Systematic review of the literature
Zedler et al. Addiction 2016

Buprenorphin als Depot

JAMA Internal Medicine

RCT: Extended-Release vs Sublingual Buprenorphine in Pregnancy Through 12 Months Post Partum

POPULATION

140 Women



Adults with opioid use disorder and a singleton pregnancy at 6-30 wk estimated gestational age

Mean age, 31 y

SETTINGS / LOCATIONS



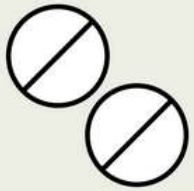
13 US sites

INTERVENTION

140 Participants randomized



69 Extended-release buprenorphine
Weekly injections (target dose, 24 mg); monthly injections offered post partum if not breastfeeding



71 Sublingual buprenorphine
Buprenorphine tablets and/or buprenorphine/naloxone film (target dose, 16 mg/d)

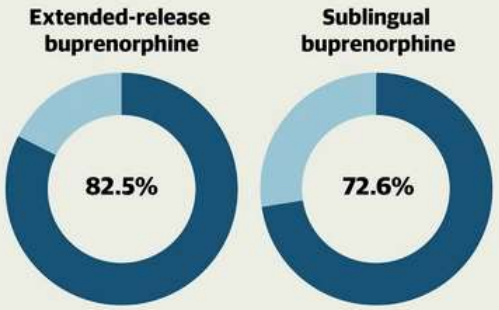
PRIMARY OUTCOME

Illicit opioid abstinence during pregnancy, defined as the proportion of weekly urine drug screens negative for fentanyl, morphine, codeine, ethylmorphine, heroin, hydrocodone, hydromorphone, methadone, and oxycodone

FINDINGS

Illicit opioid abstinence during pregnancy was significantly greater for the extended-release buprenorphine group compared with the sublingual buprenorphine group

Percentage negative weekly urine drug tests



Absolute risk difference, 9.84 percentage points; 95% CI, 1.72-17.95 percentage points; *P* = .009

© AMA

Winhusen TJ, Lofwall MR, Kropp F, et al. Extended-release vs sublingual buprenorphine in pregnancy through 12 months post partum: a randomized clinical trial. *JAMA Intern Med.* Published online March 16, 2026. doi:10.1001/jamainternmed.2026.0057

Therapieoptionen

- „laissez faire“
- „harm reduction“

- Substitutionsbehandlung
  - dauerhafte Substitution
  - Substanzwechsel
  - Dosissteigerung
  - Dosisteilung
  - Dosisreduktion
  - andere Darreichungsform

- „warmer“ Entzug
- Abstinenz



Foto: Jan-Peter Siedentopf, 2013

Stillen

- ⇨ Wunsch der Mutter
- ⇨ individuelle Abwägung
- ⇨ Hebammenbetreuung
- ⇨ keine Maximaldosis
- ⇨ Beigebrauchsfreiheit
- ⇨ Verantwortungsbewusstsein
- ⇨ externe Betreuer
- ⇨ auch bei HIV-Infektion mit Virussuppression
- ⇨ nicht unter retardiertem Morphin



Lucas Cranach d. Ä. 1509; Foto: Jan-Peter Siedentopf

DAIGNET.de: Leilinie Schwangerschaft (2025)
Kashiwagi M et al. Opiatabhängigkeit und Stillen. Geburtsh Frauenheilk 2005; 65: 938-41
AAP, Committee on drugs.Pediatrics 2001; 108:776-789.







Fotos: Jan-Peter Siedentopf

Kontakt

Ambulanz für Suchterkrankungen und Infektionen in der Schwangerschaft

OA Dr. Jan-Peter Siedentopf (Leiter)

Klinik für Geburtsmedizin
Campus Virchow-Klinikum
Charité - Universitätsmedizin Berlin
Augustenburger Platz 1
13353 Berlin
Tel.: 030 450 664 112
Fax: 030 450 564 925

infektionsambulanz@charite.de

