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Family Planning with MS: Case Perspectives

Announcer:
Welcome to CME on ReachMD.

This activity, titled "*Family Planning with MS: Case Perspectives*" is provided in partnership with TOPEC Global and is supported by an independent educational grant from Merck KGaA, Darmstadt, Germany.

Before starting this activity, please be sure to review the disclosure statements as well as the learning objectives.

Your host is Dr. Jiwon Oh.

Dr. Oh:
Looking beyond the more direct impacts of multiple sclerosis, or MS, like its comorbidities, MS can also affect patients' relationships and life choices, including those choices around when, how, and if to bear child. In fact, the debate surrounding how to manage MS patients during the childbearing years is becoming increasingly common with the release of new data, so how can we apply this new

information to the management of our patients?

This is CME on ReachMD, and I'm Dr. Jiwon Oh. Today I'm with Dr. Maria Houtchens, who will provide insights on how to manage a common case seen by physicians managing patients with MS.

Dr. Houtchens, welcome.

Dr. Houtchens:
It's a pleasure to be here. Thank you.

Dr. Oh:
So let's jump right in, Sharon is a 33-year old married mother of a 7-year-old son. She was diagnosed with RRMS 3 years ago and has been on interferon-beta since diagnosis. Sharon's disease has not been very active, and she is now discussing with her neurologist that she has, unexpectedly, learned she is 7-weeks pregnant. She does not want to terminate her pregnancy. She and her husband are concerned about the risk of continuing her MS medication since she is now well into the first trimester

So Dr. Houtchens, what might you tell Sharon?

Dr. Houtchens:
So, I'm very glad to help take us through this case. It's a very common scenario indeed, and I see many Sharon's in the course of every month. So, there is accumulating evidence that we currently have that having been exposed any of the injectable medications, specifically interferon betas or glatiramer acetate, is not detrimental or harmful to the developing fetus or to mother. So, it's very important, because especially as the case would be with interferons, it's a different understanding that we have now than compared to what we used to have 10-15 years ago when there was a concern that interferon could increase the risk of miscarriage, and there was a general distrust and worry, I would say, about having mothers with MS or future mothers with MS being exposed to these drugs. Now after many years of evidence-gathering, we understand much better that these drugs indeed appear to be safe, they are safe with early pregnancy exposure, and we now have thousands of cases that have been reported as exposed to either glatiramer acetate or interferons in various meetings and presentations and publications, and it's from that evidence that we understand that it's really not increasing the risk of side effects or complications. Now, we need to be careful here because this really only applies, as far we know today, to the injectable treatments. There is a recent consensus statement put out by neurologists specializing in multiple sclerosis and women's health in the United Kingdom discussing these subjects, and they also support the notion that mothers with MS exposed to these treatments in early pregnancy really shouldn't choose to terminate the pregnancy for that reason alone. There could be other reasons, concerns, of course, but just exposure to these treatments

should not be a cause for pregnancy termination. We now understand that well, and that's what we counsel and advise our patients on. Similar guidance is provided by our German colleagues, where they have significant experience with pregnancy data collection and women with multiple sclerosis, and here in the United States, especially in Boston, we are also on the forefront of this clinical research and provide, again, very similar recommendations to patients. This is not to say that we recommend that our patients continue with treatments throughout pregnancy. It really is decided and determined on case-by-case basis. As we understand today, pregnancy is "a good enough" treatment for multiple sclerosis just by itself, likely related to hormonal shifts and fluctuations and other potential influences that we don't yet understand well, but many of our patients, I would say most of our patients, feel well and do quite well in pregnancy. Their relapse rate goes down, they feel better symptomatically at times, so there's probably no general recommendation that all patients should be exposed to injectable treatments throughout pregnancy. However, if an individual patient, if there's a concern about the individual patient, about a particular exposure or about disease that's not well controlled, hasn't been well controlled prior to pregnancy onset, those cases could be advised to remain on the injectable treatments. Again, it's an individualized approach, and it's not the off-the-wall recommendation for all patients. Now, this is quite different from what we would be discussing with Sharon should she have been on some of the other disease-modifying therapies that we have available today.

So, with fingolimod, the recommendation is to discontinue treatment two months prior to start of conception attempts, and we know that with discontinuation of treatment with fingolimod, there could be a potential for rebound effect, with disease reactivation, that we can sometimes see. With teriflunomide as another good example of some potential challenges with management, the current recommendation states that if a patient is exposed to teriflunomide or if she is desiring a pregnancy within the next 6 to 12 months or so, then teriflunomide needs to be washed out, and we can do that. There's a protocol that we use. We can do that very effectively, but again, it introduces another level of complexity to the management of a patient. Tecfidera is a short half-life agent, dimethyl fumarate, so that drug is cleared out of the system very, very quickly, and there is no need to wash it out, to discontinue it for weeks to months prior to pregnancy onset. So, it's a little bit easier to manage than considering the alternatives that we just discussed of oral treatments. And then if we talk about infusion therapies, those are monoclonal antibodies and very complex biologic mechanisms through which they exert their effects on the maternal system, and probably at best to see and discuss specific management guidelines related to monoclonal antibodies and pregnancy MS with a specialist who really understands these products and these drugs and how to help a patient go through the safest process in the process of becoming pregnant.

Dr. Oh:

For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Jiwon Oh, and today I'm speaking with Dr Maria Houtchens about multiple sclerosis and family planning.

So based on your advice, Dr. Houtchens, Sharon discontinues her interferon-beta before the end of the first trimester and has had a relapse-free pregnancy, and the birth of a healthy baby girl is expected any day now. Sharon originally had decided to breastfeed, but she's now reconsidering. What would you tell Sharon about breastfeeding and the likelihood of relapse in the post-partum period?

Dr. Houtchens:
That's another excellent question, and I'm glad we have a chance to discuss it briefly today.

So, we generally tell our patients that, you know, you will likely do well in pregnancy, you could have a postpartum exacerbation. So, the risk of having postpartum relapse appears to be related to how active or stable patient's disease was in a year or two years prior to pregnancy. So, we oftentimes make a determination as to the safety of breastfeeding and not going back on disease-modifying therapy based on how this patient's multiple sclerosis has been behaving prior to pregnancy, also what type of treatment this person has received prior to pregnancy, and we are trying to take into consideration, of course, a woman's desire to breastfeed or desire to non-breastfeed. There is some data to suggest that exclusive breastfeeding for the first two months postpartum appears to possibly decrease the risk of postpartum relapses. This data is from California from Kaiser Permanente group, and it's really the only such study that suggests exclusive breastfeeding is beneficial. Other studies suggested that exclusive or nonexclusive breastfeeding is neutral. Certainly, no study suggested that it's harmful. So, if we believe that it's safe to keep the patient off disease-modifying therapy, then we would certainly make recommendation that breastfeeding is appropriate and could be pursued if possible. We do recommend because of the data I just mentioned to you that exclusive breastfeeding is preferable to nonexclusive breastfeeding. Exclusive breastfeeding also appears to change some immune factors in the maternal system to promote more of an anti-inflammatory response overall compared to nonexclusive or no breastfeeding. If a woman decides that she is not going to breastfeed, then certainly returning to disease-modifying therapy is quite appropriate. Now, there is some data that's emerging in the last few years suggesting that intramuscular interferon beta and also subcutaneous interferon beta 1-alpha appear to penetrate into maternal breast milk at miniscule amounts, and the supposed or anticipated exposure to these drugs for a baby is really tiny and likely non-biologically significant, especially considering that these drugs are biologically active in the mom through parenteral administration, through injections, and then baby would be receiving them orally in very, very small amounts. So, we could consider in some of our patients, certainly, the possibility that they might return to an interferon treatment and breastfeed at the same time. I would say that this is probably not currently the standard of practice, but this is certainly an option to explore in a patient,

such as Sharon here in our case, who has had quite stable disease, is quite happy to be receiving interferons, hasn't had a lot of relapses, appears to really want to breastfeed, and then had the concerns or questions about that related more to her disease and the treatment options rather than having change of heart about breastfeeding itself.

Dr. Oh:
Those are all really important things to consider, Dr. Houtchens, for both during and after pregnancy.

And with those key points in mind, I want to thank my guest for helping us better understand how we can help our patients manage MS during the childbearing years.

Dr. Houtchens, it was great speaking with you today.

Dr. Houtchens:
You're very welcome. Thank you for inviting me.