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Family Planning Clinical Considerations for Patients with Multiple Sclerosis

Ashley Baker:
Welcome to *NeuroFrontiers* on ReachMD. I'm your host, Psychiatric Nurse Practitioner Ashley Baker, and I'm here to discuss family planning considerations for patients with multiple sclerosis with Dr. Anna Shah. She is an Assistant Professor of Neurology and the Director of Neurology Outpatient Patient Safety and Experience at the University of Colorado Anschutz School of Medicine.

Dr. Shah, thanks for joining me today.

Dr. Shah:
Absolutely. I'm happy to be here.

Ashley Baker:
Let's start with some background, Dr. Shah. Can you tell us about the prevalence of MS among pregnant women?

Dr. Shah:
Really good question. I think one of the things that we are starting to see more and more as the years develop is we are seeing that MS prevalence as a whole is increasing. Most recent estimates per the National MS Society a few years back were nearly one million individuals in the United States with MS. And what we know of that is that we see MS at a prevalence rate in women being almost two- to three-fold higher than males and then, of course, also seeing that the majority of individuals that are diagnosed with multiple sclerosis are in between the ages of 18 to 45, with around 30 being the average age, which is right around that peak of family planning. It is hard to estimate exactly how many women are getting pregnant, but we are seeing those numbers continuing to rise.

Ashley Baker:
Now why should family planning be an integral part of the comprehensive patient-centered MS Care?
Dr. Shah:
I think we often know that in our patients with multiple sclerosis, there are a lot of things that end up turning their lives upside down, and often around these ages is when people are thinking about, "When do I want children?" And two, "When do I want them if I do want them?" And I think one of the things that becomes really important for all of us, particularly neurologists, to think about is patients may not understand that there is a relationship between multiple sclerosis and pregnancy or that there is a relationship between some of the medications we use to treat multiple sclerosis, whether that's disease-modifying therapies or some of our symptomatic medications and think about that relationship with pregnancy and breastfeeding, and so it's really important for us as a medical community to make sure we're bringing that up with our patients. We know that somewhere between 30 to 50 percent of all pregnancies in the United States are unintended, and we don't have specific numbers as it relates to MS, but sometimes bringing this up regularly and for us in the medical community being aware of it allows us to counsel and hopefully prevent more unintended pregnancies in populations that might be at higher risk of side effects if they're on certain medications.

Ashley Baker:
What fears related to pregnancy and MS do patients typically have? And how do you address these concerns? Is it team-approached? Is it provider-patient? What goes into that?

Dr. Shah:
I think it varies quite a bit from person to person. Probably, the most common concern I hear about is, "Will I go ahead and pass on MS to my kid?" Or "What percentage rate is there of passing this on?" I can remember a unique conversation with a patient that when I was talking to them on a routine clinic visit about, "Are you planning on expanding your family at all in the next five years?" She said, "No." And I asked the follow-up question of "Why not?" And she said, "Well, I can't have my kids get MS." And I think it's one of those things that we don't realize what those underlying fears are until we have those discussions.

Other common fears I hear is, "Can I safely go through pregnancy?" "Can I safely take care of a kid?" "Will I become more disabled?" And those fears, I think, are actually quite commonplace, and so having that discussion as part of a routine approach in clinic, I think makes patients feel more comfortable and more at ease because it's not necessarily a fear that they're bringing up; it's something that we're just addressing as routine standard of care, similar to how we talk about fatigue or cognitive dysfunction. I think it's imperative for neurologists to be aware of that and bring that up because some patients might be too scared or might just feel as though that door is completely closed when it's not.

Ashley Baker:
So when a patient tells you that they're looking to start a family, what other clinical considerations are discussed? I'm wondering if patients are interested in group therapy or meeting with other support clinicians one-on-one.

Dr. Shah:
Absolutely. I think that peer support plays a bigger role than I think we often recognize. I know I've heard from patients that on certain social media platforms that there are groups or networks just intended for MS patients thinking about family planning or pregnancy. And I often find that that becomes incredibly helpful because sometimes it's reassuring to hear, "Hey, someone else who is in a very similar situation to me did this and did this in an in a way that was okay for them and their family."

I think involvement of other multidisciplinary care becomes important. So things I think about is some of our most patients have baseline urinary bowel symptoms or sexual dysfunction, so incorporating physical therapy, particularly pelvic floor physical therapy, or urology or urogynecology becomes really important. We know we see higher rates of both depression and anxiety during the pregnancy period and the postpartum period in patients with MS compared to their peers without MS, so not only bringing that up during routine visits but also staying ahead of this. And I'm sure you could relate to this, Ashley, in the mental health space, that sometimes it's easier to be proactive about some of these things rather than try to play catchup once the problem has presented and it's been poorly controlled for some time.

Ashley Baker:
Absolutely. Seeking that peer support can be so important when we're going through something difficult, how inspiring it can be and how comforting it can be to think about people that have already done it with success.
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Psychiatric Nurse Practitioner Ashley Baker, and I'm speaking with Dr. Anna Shah about family planning considerations for patients with MS.

Let's turn our attention to some MS therapy, Dr. Shah. What treatments are safe during pregnancy?

Dr. Shah:
So one of the challenges that I don't think is unique to MS or to neurology is data about medication safety during pregnancy usually tends to be retrospective rather than prospective, so we are gaining more and more information when we roughly think about how medications in MS and the disease modification piece, how they're split up. We generally think about the injection class, the oral class, and the infusion classes. In general, just by virtue of the size of the molecule, those medications in the oral class are not safe during pregnancy, primarily because of easy passage of those medications through the placenta to a developing fetus. The medications that have the most data behind safety for continuing during pregnancy is some of our injection medications, like glatiramer acetate.

By contrast, when we're thinking more about the infusion medications, we have more emerging data but I think still areas where we could develop more robust data. A lot of things with the infusion classes, a lot of the pathophysiology of pregnancy that we can use to our advantage is that most of those molecules are larger molecular weight. In general, molecules that are larger molecules cannot directly pass through the placenta without the presence of placental receptors, and most of those receptors develop somewhere between 16 to 20 weeks, and so sometimes utilizing that with pharmacokinetics and dynamics of certain drugs and what they're elimination looks like we can use some of these medications closer to conception. But usually in MS, fortunately, there's not really a need to continue MS medications during pregnancy. We have a certainly an increase in estrogen, progesterone, HCG, and there's also a lot of changing immune phenomena during pregnancy in a state we call immune tolerance, which essentially

from an evolutionary standpoint makes a lot of sense because we wouldn't want a mother's immune system attacking a developing fetus, so most women undergoing successful pregnancies tend to be immune-suppressed to some degree and that in a disease like multiple sclerosis, an autoimmune condition, really works to our benefit.

So I think sometimes the question we need to think about is do we even need a medication during pregnancy. Often, we'll see by about the third trimester that risk of relapses drops by about 70 percent compared to where they were before they got pregnant.

Ashley Baker:
So if a patient does relapse during the pregnancy period, how would you address that?

Dr. Shah:
I think it depends on severity of relapse. So similar to the thought of, "Do I need treatment for MS during pregnancy?" The question is if there is something that seems like a relapse, one, how certain am I that it is a true relapse because I've already alluded to the fact that that is the exception and not necessarily the rule, and then, two, is this a severe relapse where I go quality of life is severely impaired, where there's a high risk of neurologic deficit or disability associated with that.

Steroid use during pregnancy is a little bit controversial where we think about this idea of higher risk of things like cleft palate, cleft lip with steroid use, particularly in that first trimester of pregnancy. I will tell you for my patients that have had relapses during pregnancy, usually that discussion with their obstetrician has been them being very comfortable with us utilizing a short course of high-dose steroids, so that can be used.

MRI scans can also be done during pregnancy. The caveat to that is gadolinium or the contrast agent that is used should absolutely not be used unless there's a very clear discussion of risk associated with gadolinium use with the mother. Some of those risks can range up until stillbirth, so certainly something that warrants a very detailed discussion. I often in my patients that I know are actively trying to conceive will make sure I have a baseline MRI scan prior to pregnancy, so if we did need an additional scan during pregnancy if there was clinical uncertainty about some symptoms that way I could get a noncontrasted scan during pregnancy and just assess for a difference in T2 signal as opposed to feeling like I needed that gadolinium or contrast.

Ashley Baker:
So we've talked about treatment of MS during pregnancy, including relapses. What about the postpartum period? And how do you manage patients' symptoms during this time?

Dr. Shah:
I think the postpartum period is the period that most of us working with patients that get pregnant in MS worry about. So I talked about pregnancy being a relatively safe period of time for multiple sclerosis patients going down to that decrease by about 70 percent compared to prepartum on relapse rates. We see exactly the opposite in that first initial three months of that postpartum period where we see an increase in relapse rates by about 70 percent compared to where they were prepartum, and a lot of that, as you can imagine—all of those immunologic changes that I was describing—all of those get reversed. You see a sudden drop in estrogen and progesterone levels, especially with delivery of the placenta. So in general, I like to meet with most of my pregnant patients with MS during their third trimester of pregnancy to discuss postpartum planning, whether the plan is for breastfeeding or not and what our expectations are of symptoms to look out for during that period.

If my patient is not planning on breastfeeding it becomes a little bit easier to restart their disease-modifying therapy pretty soon after delivery, which then helps us control that 70 percent increase in postpartum relapse rates. If they are planning on breastfeeding, we do have a discussion. Again, there's not great randomized controlled trials looking at safety of drugs during breastfeeding, but if they are interested, we talk quite a bit about what is normal progression of breast milk. So typically, when someone starts breastfeeding or lactating, the breast milk composition usually starts off with colostrum and then transitions to transitional breast milk, and then eventually transitions to what we call mature breast milk, and that's usually about date of 10 to 14 after delivery. And most of what we understand about pharmacokinetics and dynamics of these medicines in relationship with breast milk is when we have mature breast milk, so I always emphasize that to patients because I don't know that we have enough data about some of these medicines and how much gets into breast milk during the periods of kind of that colostrum or transitional breast milk.

We think about the same thing that we talked about earlier, which is oral molecules are very small molecules, so the tendency of those to pass into breast milk is actually quite high because they're small. They can get in there. So those are usually medications that I do not recommend continuing or taking concurrently with breastfeeding just due to high amounts that get into breast milk. Similarly, some of our larger molecules, which are traditionally our infusion therapies, those are a lot harder to get into breast milk. So we know with some of our anti-CD20 therapies with the data that

we have particularly looking at rituximab and some of the more emerging data with ocrelizumab—we know the amount that gets into breast milk is much less than what the FDA considers okay, which is that relative infant dose. The last point I would bring up is we talk about symptoms quite a bit. Again, before delivery too we see those higher rates of postpartum depression and anxiety, so preparing individuals for that so they can be aware of that I think is really helpful. And then we also sometimes see worsening of MS symptoms in the setting of fatigue or sleep deprivation, which there's quite a bit of that in the initial newborn phase. So I like to educate about most of those during the third trimester so it's not a surprise.

Ashley Baker:
As we come to the end of our discussion, I think what stands out to me is that patients likely come into your office with initial fear of, "Can I get pregnant?" "If I get pregnant, how will I feel?" And to leave knowing that pregnancy is actually a period of more stability they may find shocking, as I did today learning about this subject for the first time. So I want to thank my guest, Dr. Anna Shah, for sharing her insights on family planning for patients with multiple sclerosis.

Dr. Shah, it was a pleasure speaking with you today.

Dr. Shah:
Yes, the pleasure was mine. Thank you, Ashley.

Ashley Baker:
For ReachMD, I'm Ashley Baker. To access this and other episodes in our series, visit *NeuroFrontiers* on reachmd.com where you can Be Part of the Knowledge. Thanks for listening.