Key Messages for the OB/GYN Specialist

- **MS does not have a significant effect on pregnancy.** There is no significant increase in spontaneous abortions, assisted vaginal deliveries, ectopic pregnancies, cesarean deliveries, or major neonatal or obstetric complications. There is also no effect on the patient's ability to conceive. **Pregnancy, however, has a significant effect on MS.** Pregnancy is generally an immuno-protective state; the annualized relapse rate is decreased by 70% during the third trimester. The first 3 months postpartum, however, are associated with a 70% increased risk of disease relapse over baseline. Following those first 3 months, the patient's risk of relapse returns to pre-pregnancy baseline.

- **The FDA does not recommend any disease-modifying therapy (DMT) for use during pregnancy or breastfeeding.** Some DMTs are associated with a higher risk during pregnancy, and clinicians must be aware of and follow the wash-out period protocol. Despite the lack of official approval to use DMTs, no human pregnancy registries have demonstrated teratogenic effects.

- Many patients wonder when/if they should discontinue their DMT if they want to get pregnant and are concerned about how harmful a DMT could be if they had an unplanned pregnancy. **To address the patient's fears and ensure optimal care, the OB/GYN should consult with the patient's neurologist as early as possible.** Both clinicians should strive to keep the lines of communication open throughout the pregnancy.

- Data indicate that glucocorticoids, including IV and oral doses, can be used in the second and third trimesters of pregnancy if necessary to treat disease exacerbation or relapse. However, dexamethasone should be avoided because it can cross the placenta.

- **Specific treatments may be administered soon after birth to reduce the chance of a relapse.** Small studies have indicated that pulse therapy with either high dose steroids or IVIG may decrease the risk of postpartum relapses. If given, IVIG should be administered within 24 to 48 hours after birth. Monthly pulse high-dose steroids or IVIG may be used, though breastfeeding must be taken into account. IVIG is safe during breastfeeding; patients should not breastfeed within a few hours of receiving high-dose steroids.

- Patients who have recently given birth may experience symptoms that could be suggestive of a relapse or could be associated with caring for an infant, such as fatigue, confusion, impaired memory, or even depression. **It is important for the patient to be aware of these similarities and work with clinicians to differentiate between the causes so that she may avoid a postpartum relapse.**
• Breastfeeding may play a role in reducing relapses postpartum, though small studies have demonstrated that this occurs only with exclusive breastfeeding. **Generally, once a patient introduces formula feeding, she should re-initiate her DMT.**

• Although MS does not affect fertility, MS patients may be faced with infertility similar to the general population. **They may undergo in vitro fertilization (IVF), which can affect their disease course.** Gonadotropin-releasing hormone agonists (leuprolide, nafarelin) have been associated with increased relapses and disease activity in the first 3 months following IVF. This is intensified if IVF fails. Gonadotropin-releasing hormone antagonists (cetrorelix, ganirelix), however, do not have the same association with increased relapse risk. The patient is likely not receiving a DMT during this time, which may also contribute to increased relapse risk.

• **Menopause can be associated with a worsening of MS symptoms.** Small studies indicate that hormone replacement therapy can mitigate these worsening symptoms. This is also the age at which patients with relapsing MS may develop progressive disease.

• MS patients may have a difficult time maintaining their general wellbeing, including diet, exercise, vitamin D levels, cholesterol, blood pressure, vaccines, or other factors necessary for good health. **It is important for all clinicians to coordinate with each other to ensure that patients are being assessed appropriately for general wellness.**

• **A key component to successful MS care, particularly relating to women’s health, is a multidisciplinary team.** Nurses play a significant role in patient education; and neurologists and OB/GYNs should communicate about birth plans and available or existing treatments for a patient who is pregnant, breastfeeding, or in the postpartum period. Communication is a key component; and this can involve other specialists, such as those who can educate patients about diet or rehabilitation or physical therapists to assist with exercise plans, or primary care specialists who have a role in identifying age-appropriate screenings and monitoring general health.
References


