Family Planning: Contraception

An unintended pregnancy can have significant effects on a patient with MS, particularly if she has uncontrolled MS. Family planning is an important part of managing your MS, and there are many available birth control methods to assist with this. Sterilization and long-acting reversible contraceptives (implants and intrauterine devices [IUDs]) result in less than 1 pregnancy per 100 women. Long-acting reversible contraceptives are encouraged as a first-line option for most women (including those with MS). They have a high satisfaction rate and are effective for several years before they must be replaced. Hormonal injections, pills, patch, and vaginal ring are not quite as effective, resulting in an average of 5 pregnancies per 100 women. The rhythm method, withdrawal, spermicides, sponges, diaphragms, and male and female condoms are the least effective of these methods, resulting in more than 15 pregnancies in 100 women.

Family Planning: In Vitro Fertilization

If you are having trouble conceiving, you may wish to discuss this with your OB/GYN and also see a reproductive endocrinologist (physician who specializes in infertility). For women who are interested in undergoing in vitro fertilization, you must first consider the effects that this may have on your MS. In vitro fertilization involves an egg being fertilized outside the body and being transferred to the woman’s uterus. In vitro fertilization can have a significant impact on MS, particularly if it fails. MS patients who use gonadotropin-releasing hormones to assist with in vitro fertilization may have an increased risk for MS relapse and disease activity. Gonadotropin-releasing hormone agonists (but not antagonists) have been associated with this risk.

Pregnancy and MS

MS does not have a significant effect on pregnancy. There is not an increased risk of complications, assisted vaginal delivery, or cesarean sections. Pregnancy, however, does have an impact on MS. There is a decreased risk of relapse during your third trimester and the risk of relapse increases from prepregnancy levels during the first 3 months after giving birth. After the first 3 months postpartum, the risk returns to your prepregnancy level.

Disease-modifying Therapy and Pregnancy

The Food and Drug Administration (FDA) has not approved any disease-modifying therapy (DMT) for use during pregnancy or breastfeeding. Most DMTs require a washout period, and some are associated with higher risks if used during pregnancy. Studies of DMTs in pregnant women with MS have not shown any major negative effects, though there is not enough information for the FDA to recommend the use of DMTs during pregnancy. Despite the lack of recommendations, some
clinicians may use glatiramer acetate to treat a patient during pregnancy. It has also been suggested that glatiramer acetate and the interferon betas do not require any washout. Some patients may feel very anxious that they have discontinued their DMT, and the decision to do this should be carefully considered by both you and your health care team.

It may be difficult to weigh the risks and benefits of stopping your DMT to try to get pregnant. It is important for your MS to be well controlled before trying to get pregnant because this can help reduce your risk of relapse both during and after pregnancy. Risk factors associated with postpartum relapses include a higher relapse rate in the year before pregnancy, higher disability level, and relapse during pregnancy. Studies have shown that if you have used a DMT in the 2 years prior to pregnancy, this may reduce your risk of postpartum relapses. If you do have a relapse during pregnancy, corticosteroids can be used to bring the relapse back under control. Corticosteroids are considered safe during the second and third trimesters of pregnancy.

**Childbirth and MS**

Though there are some genetic factors implicated in the development of MS, the risk of an MS patient passing MS to her child is low. Children of MS patients have approximately a 2% to 2.5% increased risk over the general population.

No DMT is approved for use during breastfeeding, and it is not recommended that a patient resume a DMT if she is breastfeeding. Some DMTs are potentially more harmful than others if used while breastfeeding. Similar to pregnancy, some clinicians may use glatiramer acetate. Studies have shown that women who exclusively breastfeed (not using any formula) may be somewhat protected from postpartum relapses. The data, however, are not conclusive. At the very least, breastfeeding is not harmful and may be beneficial to your MS. Once you begin to use formula, however, this potential protective effect can begin to disappear, and you should speak to your clinician about resuming your DMT. It is also important to establish a breastfeeding plan with both your neurologist and OB/GYN. If you are not planning to breastfeed, you can resume your DMT immediately.

Following childbirth, it is important for the new mother to have a support system. This can be a stressful time, which can potentially increase your risk for relapse. You should also speak to your clinicians about differentiating symptoms of a relapse from what may naturally occur with a newborn, such as fatigue. It is important to follow up with your neurologist if you feel that something is wrong.
Resources

http://www.nationalmssociety.org/Living-Well-With-MS/Family-and-Relationships/Pregnancy
http://www.nationalmssociety.org/Living-Well-With-MS/Family-and-Relationships/Intimacy
http://www.nationalmssociety.org/Resources-Support
http://www.overcomingmultiplesclerosis.org/About-MS/Pregnancy-and-MS/