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Family Planning with MS: Closing the Gaps

Dr. Oh:
Family planning creates many questions for patients, male and female; and when that patient has multiple sclerosis, MS, the number of concerns only increases. With recent data, and new therapy options practitioners are experiencing more and more challenging questions about the management of MS and family planning.

This is CME on ReachMD, and I'm Dr. Jiwon Oh. Today I'm with Dr. Luigi Lavorgna, who's going to review our first challenging patient case with us, and Dr. Patricia Coyle, who will provide insights on our second case focused on both partners will be discussed next.

Dr. Lavorgna, Dr. Coyle, welcome to you both.

Dr. Oh:
So let's just jump right in here, Dr. Lavorgna, and review the first case together. Alice is a 23-year-old female who was diagnosed with RRMS at the age of 22 following an episode of optic neuritis and suggestive lesions on a prior MRI. She's at her neurologist's office for a 1-year check-up. She had been prescribed interferon-beta and has not shown any worsening disease activity in the last year. Three months ago, Alice got married, and she now has questions about starting a family.

So Dr. Lavorgna, what advice would you give her to begin the family planning discussion?

Dr. Lavorgna:
Okay. Okay, this question is the first question about the parenthood that I received after diagnosis. Every patient wants to know if his or her life will be with the possibility to have a family. And the family planning is one of the most important issues from the beginning of the disease. This patient – this female – this young female patient is a very – is very important for our job, because our job is to say the right things in the right way because we know that MS, multiple sclerosis, doesn't act on the possibility to have a family. And also the pregnancy and the possibility to have a family does impact on MS course. If you have MS, and you have a dream to make a family, you have to make family. There is no – there is no – there is no issue about your – your parenthood and that you about it.

Okay, traditionally, we have – we have drugs therapies that in many studies showed there is no impact on the pregnancy, on the health of the baby, and on the disease of the female. But – and with the new drugs we have now at disposal with the people – for the people with MS – now we have some problems because many of these new drugs has an impact. And maybe when a female wants to make a baby – wants to be pregnant, maybe the first person that has to know this condition is her neurologist, because for many drugs we make – the female has to discontinue the therapy before she – before pregnancy, but not with the traditional drugs.

Dr. Oh:
Now a few weeks later, Alice is back in her neurologist's office with her husband, John. He has a number of additional questions about starting a family, specifically relating to the impact of MS on the health of the child before and after birth, as well as how pregnancy might affect Alice's MS. How would you respond to John's concerns, Dr. Lavorgna?

Dr. Lavorgna:
I respond to John in a very simple way, because there is no study that showed that MS can impact on the health of a child. And there is

no possibility that MS is a genetic disease, that the boy or the girl can – has same disease of their mother. The science is very sure about that. Now, after 30 years of studies, we can be sure that a child of the patients – female, but also male patients, are a normal baby; not impact on the health of this baby.

Oh. I think that – this is a very important question. Because the pregnancy, many times is, for nine months the perfect – the perfect therapy for the disease. Because many, many cases during pregnancies, the female doesn't have any relapse. Sometimes after – after the pregnancy, during – after childbirth, sometimes their relapse begins again. And for this – for this reason, we tend to make in therapy again the female – the female after pregnancy, if her story is a story of an active disease before the pregnancy. If before the pregnancy the disease was quiet, we can take time after childbirth. But if the disease is very active or simple active after the pregnancy, maybe it's better to make in therapy again after childbirth. Because just in that case, we can – we can avoid the many relapses after pregnancy.

And lastly, how might your recommendations to Alice and John be different should she have relatively active MS at the outset of starting family planning?

Dr. Lavorgna:
Yes, for this couple, we have to investigate the story before the pregnancy of the woman because the activity before the pregnancy are the most important issue to consider – to consider to make a gain in therapy after pregnancy. In my experience – in my experience, sometimes it's better to make therapy with one of the drugs of the DMDs, this is more defined drugs that, in a traditional way, we can use during the pregnancy. Then after the decision to make – to make a baby, many times I use interferons, also copolymer-I, glatiramer acetate to – like a bridge therapy just for the time of the pregnancy, childbirth, and breastfeeding. And that way, we have a modulation of immunity system of the patients during these months. And maybe we have the best conditions to again make it in therapy after breastfeeding.

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 Drs. Patricia Coyle and Luigi Lavorgna about multiple sclerosis and family planning. So I'd like to turn to you now, Dr. Coyle, and get your thoughts on the following patient.

Samuel and Victoria have been married for 3 years; he is 27 and she is 24. They wish to start a family but are concerned since Samuel was diagnosed with MS at 25. Although he is well functioning and shows no obvious disability, Samuel is concerned his MS or the DMT he is currently using will affect his fertility and result in a miscarriage or some type of genetic abnormality. He indicated he was willing to stop taking his medication until Victoria becomes pregnant.

So Dr. Coyle, how would you counsel Samuel and Victoria as they plan a family?

Dr. Coyle:
So I think this points out a very important feature, and mass effects young people; and therefore, family planning might be a very important topic. And I think it's important to bring it forward so that you're introducing it, and patients can ask specific questions. It also points out, although we really focus on women with MS, there's a significant minority – 25% of MS individuals who are men. And it's important to be able to counsel them appropriately as well. It's interesting that there seems to be really a knowledge gap with regards to family planning and the impact of disease-modifying therapies. In one recent series, about 40% of women with MS, and almost 75% of men with MS did not know if specific disease-modifying therapies being taken by men with MS had any effect on pregnancy or could harm their non-MS female spouse. So this is a real knowledge gap, clearly. Now there has been a lot of focus on pregnancy in MS, and we know that MS does not affect the ability to become pregnant or to have a normal pregnancy and, bring to fruition a normal baby. When we look at the studies focusing on men with MS, they're much more unusual. I can think of a British Columbia study and an Italian study that really focused on men with MS who became fathers. And although the numbers are not huge, and those are two studies that focused on men compared to many more studies that focused on women with MS, it was very reassuring. A man having MS, his duration of disease, his disability had no impact on the pregnancy of his wife. Normal babies, normal size, normal weight, normal gestational age. And in the Italian study, they compared MS men who were taking a disease-modifying therapy versus those that were not, and who fathered a child, and the disease-modifying therapies had no impact on spontaneous abortions or congenital malformations. So these are very, very comforting studies that indicate a father having MS doesn't have a negative impact on pregnancy. Now the American Academy of Neurology, AAN practice guidelines from 2018 call out among all the disease-modifying therapies too for considerations for men taking the DMT if they're going to father a child. It was cyclophosphamide, which is not an FDA-approved agent for MS, and is very rarely used at the current time, and teriflunomide, one of our oral agents that we know can enter semen. But in a recent study of 10 men taking teriflunomide, and they looked at their female non-MS spouse, 6 had no detectable levels of teriflunomide at all. The other 4 had very, very mild or low levels of teriflunomide. So this is reassuring that, at least for the oral DMT teriflunomide, if the man is taking it, you can actually check his spouse's blood level to see if there is anything to be concerned about.

With the other DMTs, there is really no worry whatsoever with the man taking the disease-modifying therapy. So really, the information that I would provide to Samuel and Victoria is no special concerns based on Samuel having MS. If he's not on teriflunomide, there's no concern and no worry about coming off any of the other FDA-approved disease-modifying therapies. Would I do special genetic testing on the pregnancy? Not because of the MS, not because of the MS. MS does not convey a high-risk pregnancy; so it would be independent factors. We now have pretty broad genetic testing that is possible during pregnancy. And I think the decision to do that or not would be made independent of the MS of the father, I think the age of the mother, et cetera.

Dr. Oh:
So based on Sam's situation, Dr. Coyle, what are the key points to consider for both male and female patients with MS that are planning for a family?

Dr. Coyle:
So I think the key points are to bring into the open are family planning. Open up that dialogue, open up that discussion, and speak very frankly. I think we can have very reliable data that says that having MS for the women or the man who is looking to become a parent does not convey any special risk to the child. For the majority of disease-modifying therapies, it is really not an issue, and I think open dialogue, communication, and knowledge is power. So this is a very important topic to discuss.

Dr. Oh:
Those are all really important things to consider. And with those key points in mind, I want to thank my guests for helping us better understand how we can help our patients manage MS during the childbearing years.

Dr. Dr. Coyle, Dr. Dr. Lavorgna, was great speaking with you both today.

Dr. Coyle:
Thank you. I'm delighted to be participating in this very important topic. Thank you. I was delighted to participate.