American College of Rheumatology

Empowering Rheumatology Professionals

Exploring PsA and Reproductive Health

Case by Case

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Learning Objectives

At the end of this presentation, learners will be able to:

- ❑ Discuss effects of Psoriatic Arthritis (PsA) on pregnancy
- ❑ Explain potential adverse pregnancy outcomes associated with PsA
- ❑ List the impact of drugs used in the treatment of PsA during pregnancy and lactation
- ❑ Recognize that women with PsA have a risk of flare post-partum
- ❑ Demonstrate successful use and integration of the ACR Reproductive Health in Rheumatic Diseases guidelines into patient care

Psoriatic Arthritis (PsA)
at a glance

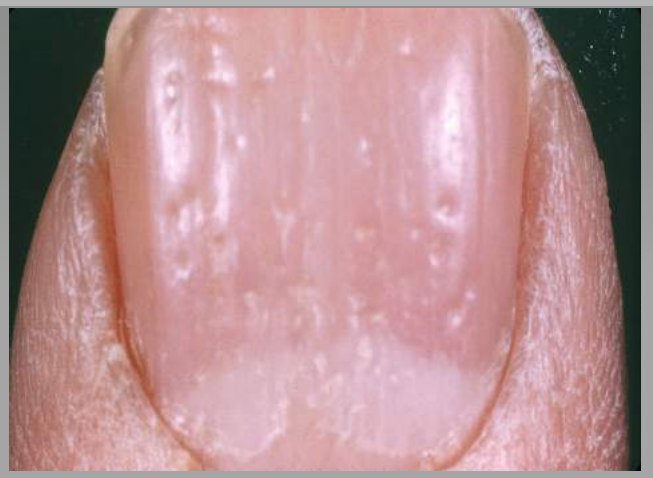
DISEASE OVERVIEW

- PsA is a ***chronic inflammatory arthritis*** that occurs in some people with skin psoriasis
  - (About 30% of people with psoriasis also develop PsA)
- PsA typically ***affects the large joints***, especially those of the lower extremities, distal joints of the fingers and toes, and can affect the back and sacroiliac joints of the pelvis
- Though there is ***no cure, there are treatments available*** to help stop disease progression, lessen pain, protect joints and preserve a range of motion
- PsA can ***occur due to complex interactions*** between the environment and a genetically predisposed individual

Psoriatic Arthritis (PsA)
at a glance

COMMON SYMPTOMS

- ❑ Fatigue
- ❑ Tenderness, pain and swelling over tendons
- ❑ Swollen fingers and toes
- ❑ Stiffness, pain, throbbing in one or more joints
- ❑ Reduced range of motion
- ❑ Nail changes, such as pitting or separation from the nail bed



Psoriatic Arthritis (PsA)

at a glance

DEMOGRAPHICS

- PsA typically appears in people between the ages of 30 and 50, but can begin as early as childhood
- Men and women are equally at risk of developing PsA
- People of all races & ethnicities can develop psoriasis and psoriatic arthritis

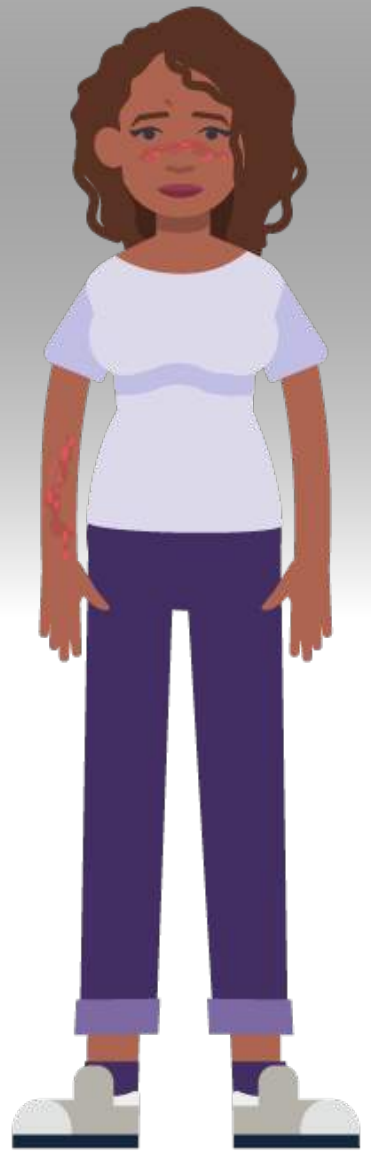
CASE 1 - TAMMY

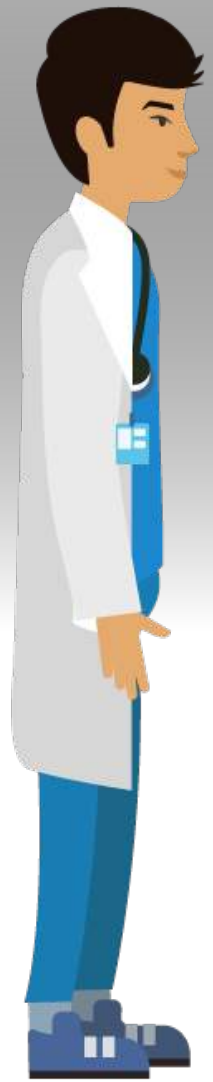
Psoriatic Arthritis and
Reproductive Health

Meet Tammy

23yr old African American female

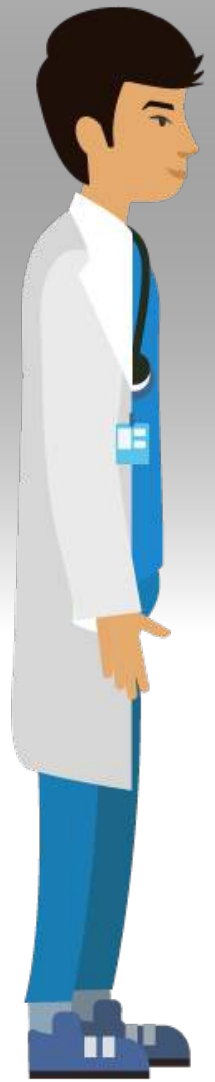
- ❑Recently diagnosed with PsA after many years of Psoriasis
- ❑Has uncontrolled disease given new diagnosis





Hi Tammy,
how is everything going since we last met?

Hi!
things aren't going so well.
I have a lot of joint aches and pain.
This rash is also not going away, and my rheumatologist thinks I need to start oral meds. It's all so overwhelming and confusing!



I understand and it is normal to feel overwhelmed with everything. Let us talk through your concerns today; let me see how I can help answer some of the **questions you may have**.

Thank you!

First of all, what is Psoriatic Arthritis?

Can you help me understand more about it?

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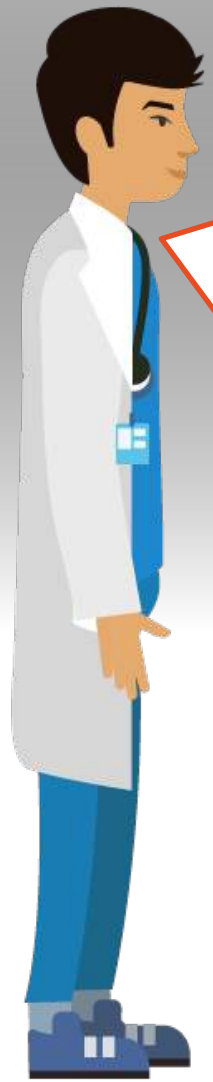
Tammy

Great! I am glad you asked that question.

Both Psoriasis and Psoriatic Arthritis are immune-mediated conditions that are the result of **an over-active immune system**.

Psoriatic Arthritis results in inflammation in the synovial lining of the joints. If left untreated for long, it can lead to joint damage and destruction.



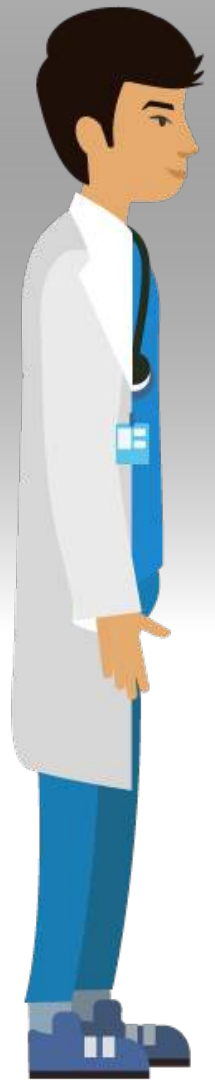
It also has several other features

including enthesitis which refers to inflammation at the entheses, the sites where ligaments and tendons connect to the bones. Dactylitis refers to inflammation or swelling of an entire finger or toe. These are common features seen with the disease.

Fortunately, we have several treatments

for the condition and in most cases we can successfully treat and manage the condition without further joint pain and damage.

What is the **prevalence** of this in the population?



Psoriatic Arthritis is seen in
approximately 30% of patients with Psoriasis.

It can start at any age, but is typically seen between the ages of 30-50 years. Most commonly it starts several years after Psoriasis (typically 5-10 years) but sometimes it can present before the onset of the skin disease. We would focus on early recognition and treatments of the disease.

Is this **genetic**?

If I have a child, will my child also get Psoriatic Arthritis?

That is a great question!

At this time, we think that Psoriasis and Psoriatic Arthritis arise from **a complex interaction between the environment in a genetically pre-disposed individual**.

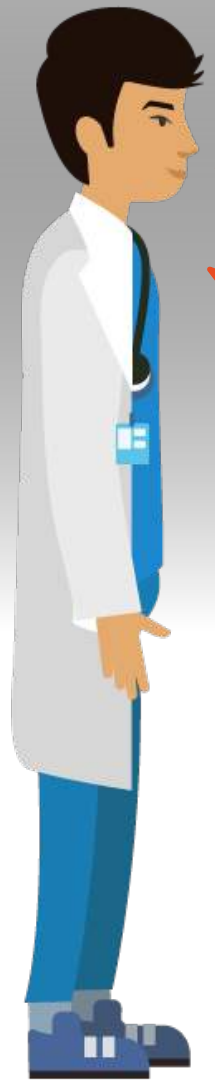
Several studies have implicated a genetic link. For example, one study noted patients with first degree relatives were noted to have a risk ratio of 40 as compared to the general population of developing Psoriatic Arthritis.

However,

several environment factors also play a role.

We know infections, trauma, stress, obesity, and smoking have all been implicated in triggering Psoriatic Arthritis in a genetically susceptible person.

Thus, your child may have a higher risk of developing Psoriatic Arthritis when compared to the general population but there may be several other environmental factors at play.



Are you thinking about **getting pregnant** in the next year?

I don't know.

I haven't thought about it that much.
Maybe, but I am not sure at the moment.

Well, I am so glad we are talking about it now Tammy!

I wanted to highlight with you that we

would like to see your Psoriatic Arthritis well controlled before

you plan for pregnancy. Making sure your disease is well controlled and you are on the right medications ensures that you have a safe outcome with your pregnancy.

Now that we are discussing this, can you tell me some **contraception options** you recommend for me?

Of course!

Here is a list of possible contraception methods.

I can highlight with you the advantages and disadvantages of each of the options.

Tammy

HOW WELL DOES BIRTH CONTROL WORK?

What is your chance of getting pregnant?

Really, really well

The Implant	IUDs	Copper IUD	Sterilization
Works, hassle-free...	Up to 5 years	Up to 7 years	Up to 12 years	Forever

Less than 1 in 100

Pretty well

The Pill	The Patch	The Ring	The Shot
For it to work best, use it...	Every. Single. Day.	Every week	Every month	Every 3 months

6-9 in 100, depending on method

Not as well

Use a condom with any other method for protection from STDs.

Pulling Out	Fertility Awareness	Internal Condom	Condom

For each of these methods to work, you or your partner have to use it every single time you have sex.

12-24 in 100, depending on method

FYI, without birth control, over 90 in 100 young people get pregnant in a year.

BEDSIDER Bedsider.org

Bixby Center for Global Reproductive Health

Beyond the Pill beyondthepill.ucsf.edu

CASE 1 – TAMMY
Learning Points

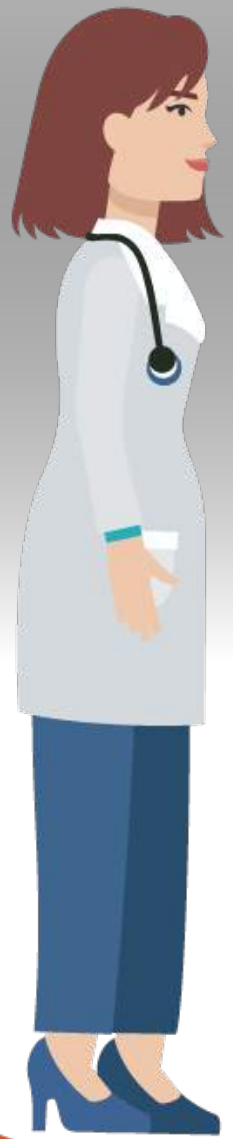
- PsA is an autoimmune condition resulting in inflammatory arthritis seen in approximately 30% of patients with Psoriasis
- A multi-faceted approach to pregnancy planning is essential in women of childbearing age as uncontrolled disease activity and medications used to treat the condition can result in adverse pregnancy outcomes

CASE 2 - LACEE

Hi, I'm Lacee!

32yr old Caucasian female

- ❑Two month follow up after PsA diagnosis
- ❑Medications: adalimumab & MTX

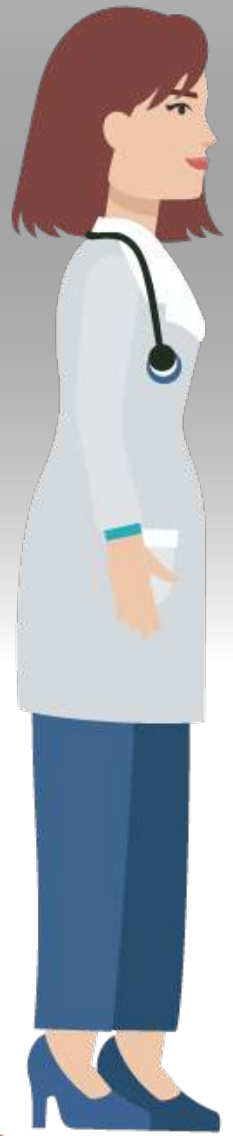


Lacee,

I'm happy you are doing well and have noted improvement in your symptoms since you started on adalimumab and MTX.

I'd like to take some time today and talk about family planning. During our first appointment you mentioned that you currently do not have children and you are on birth control.

Yes, that is correct.

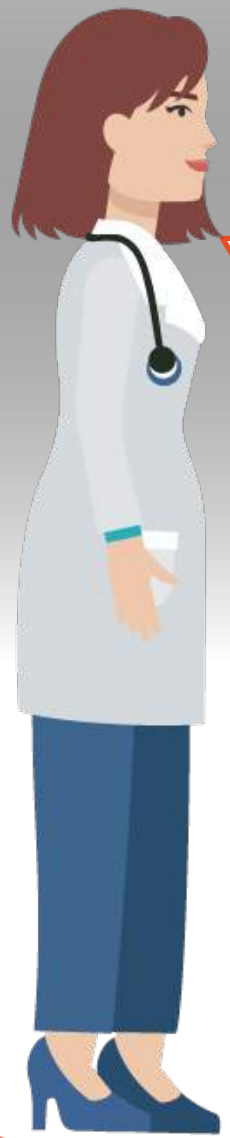


Do you and your partner have **plans for starting a family?**

Yes, we have been talking about when we would like to start having children. Ideally, we had hoped to try and become pregnant **in the upcoming year**.

But now with this diagnosis of PSA and taking these new medications we are just not certain what we should do.

What are your thoughts?



As you may recall,

when you started on MTX we discussed that it is not safe to become pregnant while taking this particular medication.

This is why I wanted to make certain you were on birth control with no immediate plans to become pregnant. We will need to make a plan to discontinue this medication at least 1 to 3 months before you try to become pregnant.

Let's look at this HANDOUT

which reviews important information about pregnancy planning. You can take it home and review it with your partner after we are done with it today.

Pregnancy Planning for WOMEN with Psoriatic Arthritis

Pregnancy Planning for WOMEN with Psoriatic Arthritis

STEP 1

To have the safest pregnancy possible:

- Use medications on the GREEN list
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?

- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms c/w iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time?

- Continue or start GREEN list medications
- Discuss with your doctor and talk about a switch from RED list meds to GREEN list meds
- Discuss any other medications with your obstetrician

STEP 4

Which doctors should you talk with?

- Rheumatology provider
- Maternal-Fetal Medicine Specialist
- Local Obstetrician (OB)
- Dermatology provider

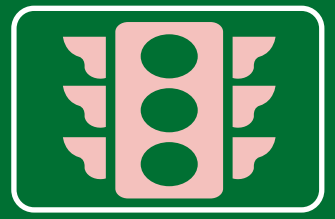
So here on this first page is a checklist to help guide you, it's broken down into steps.

The FIRST STEP is to make certain you are on medications that are

on the GREEN LIST.

We will go over that in more detail next.

Pregnancy Planning for WOMEN with Psoriatic Arthritis



GREEN List *(good to go)*

- Sulfasalazine
- Prednisone <20 mg a day
- Tumor necrosis factor inhibitors (TNFi)

(TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

GREY list *(talk to the rheumatologist)*

- Janus kinase inhibitors (Tofacitinib, Baricitinib, Upadacitinib)
- Apremilast
- Abatacept
- Interleukin 17 inhibitor (Secukinumab, Ixekizumab)
- Interleukin 23 inhibitor (Guselkumab)
- Interleukin 12/23 inhibitor (Ustekinumab)
- Rituximab
- Non-steroidal anti-inflammatory agents (safe for use in 1st trimester, discuss with rheumatologist about discontinuing at 20 weeks of gestation*)

RED list *(STOP)*

- Methotrexate
- Leflunomide

*Additional FDA recommendation details here

It is also important that your PSA activity is as low as possible.

STEP 2

describes what this means. "Minimal skin Psoriasis, minimal signs of joint inflammation and no flares in six months".

STEP 3

is taking a closer look at your current medications. If you are already on medications that are on the GREEN LIST, we do not need to make any changes with these. As you can see these include sulfasalazine, azathioprine, TNF – this includes adalimumab which you are currently taking and prednisone less than 20 mg daily.

Pregnancy Planning for WOMEN with Psoriatic Arthritis

STEP 1

To have the safest pregnancy possible:

- Use medications on the GREEN list
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

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- Discuss any other medications with your obstetrician

STEP 4

Which doctors should you talk with?

- Rheumatology provider
- Maternal-Fetal Medicine Specialist
- Local Obstetrician (OB)
- Dermatology provider

The GREY LIST

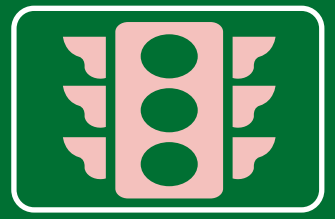
includes medications that we would need to discuss further and decide together if they should be continued. These include JAK's, apremilast, abatacept, il-17, il-23, il-12/23 and rituximab. You are not on any of these. So, we do not need to worry about them.

On the RED LIST are medications that need to be stopped

before pregnancy which include MTX and leflunomide. You are on MTX so we would need to stop this for 1 to 3 months before pregnancy as we discussed earlier. If needed to keep your disease activity low we could add one of the medications from

on the GREEN LIST.

Pregnancy Planning for WOMEN with Psoriatic Arthritis



GREEN List *(good to go)*

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(TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

GREY list *(talk to the rheumatologist)*

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- Non-steroidal anti-inflammatory agents (safe for use in 1st trimester, discuss with rheumatologist about discontinuing at 20 weeks of gestation*)

RED list *(STOP)*

- Methotrexate
- Leflunomide

*Additional FDA recommendation details here

Also, in **STEP 3**

we would want you to start a **prenatal vitamin** and discuss other medications you may be taking with your obstetrician.

STEP 4

lists the **health care providers you should be talking with** to ensure a safe pregnancy and childbirth. This includes your rheumatologist, maternal-fetal specialist, your OB and dermatologist.

The **HANDOUT** also includes **information for men** with PsA and planning to have a child that you can look at if you want.

MEN with Psoriatic Arthritis planning to father a child

MEN with Psoriatic Arthritis planning to father a child

STEP 1

To have the safest pregnancy possible:

- Discuss medications with your rheumatologist
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?

- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms c/w iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time?

- Discuss medications with your rheumatologist
- Note: Sulfasalazine can decrease sperm count and quality

STEP 4

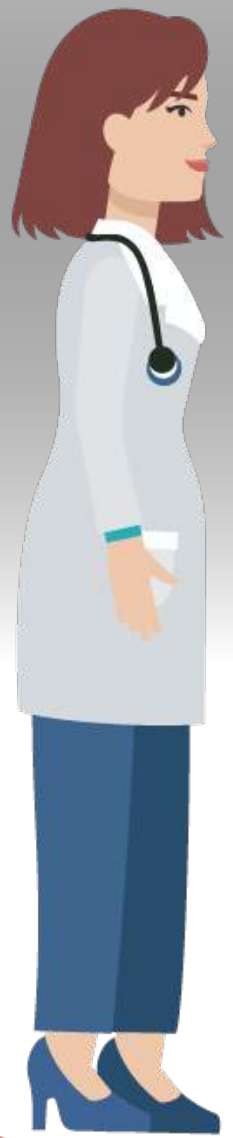
Which doctors should you talk with?

- Rheumatology provider
- Dermatology provider

This is so helpful.

I like that it is broken down into steps, seems less overwhelming than I thought.

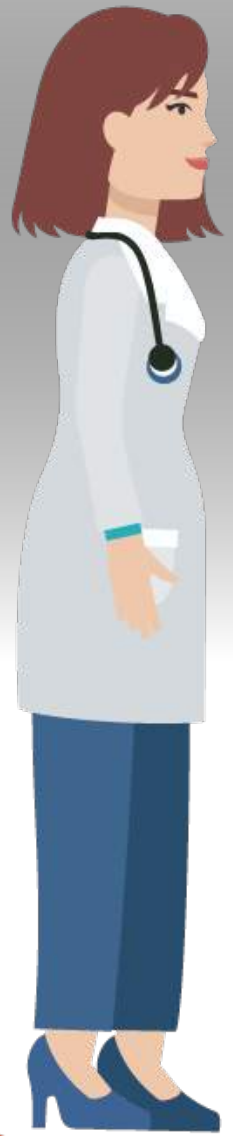
Even with these steps, **are there still risks for me and my baby** during pregnancy?



Yes, there are some risks. These include developing diabetes and HTN during pregnancy, preeclampsia and possible need for an emergency c-section. After the baby is born you may experience a flare of your joint or skin symptoms.

This is why we recommend a team of specialists, we will work together to insure the safest possible pregnancy and childbirth for you and your baby.

Thank you, this sounds reasonable, I'm happy we took the time today to talk about this.



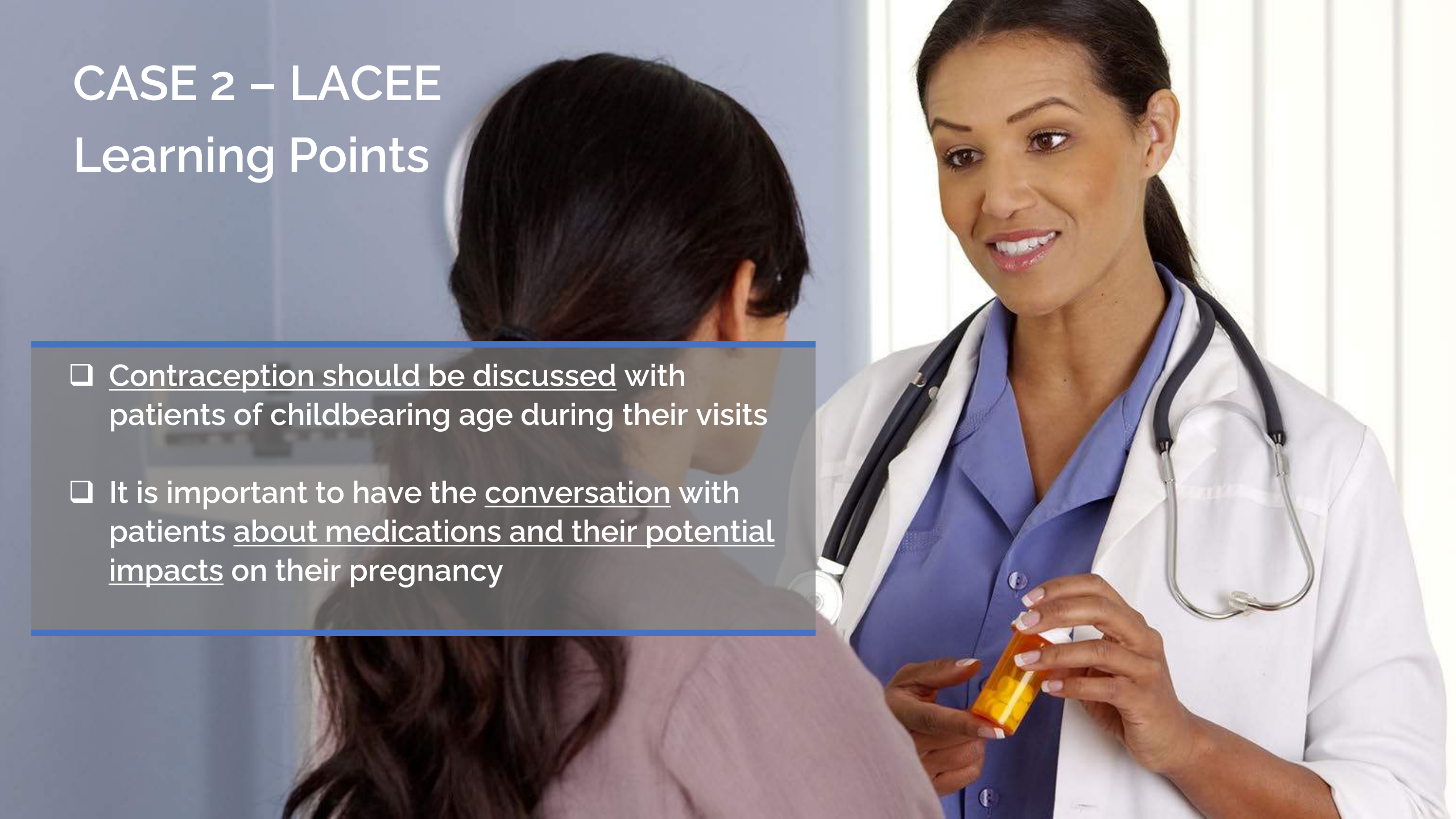
We will continue to discuss this at your next appointment.

If you or your partner have any questions, please feel free to reach out to me sooner, if needed. Also write down your questions so we can go over them at your next appointment.

I will do that. Thank you for taking time today to talk about this with me. I feel much better now, but I'm sure I'll have more questions.

I will share this HANDOUT with my partner. I'm sure he will have questions also.

CASE 2 – LACEE Learning Points



- Contraception should be discussed with patients of childbearing age during their visits
- It is important to have the conversation with patients about medications and their potential impacts on their pregnancy

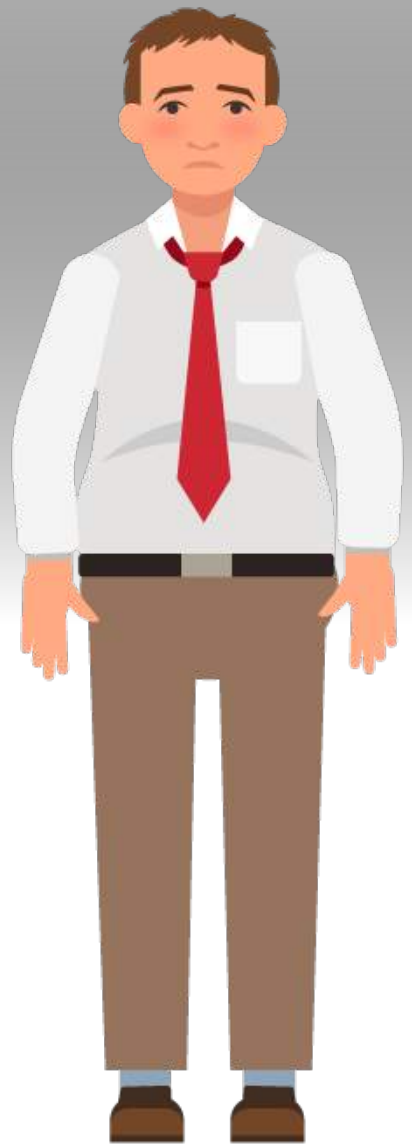
CASE 3 - JACK

Meet Jack!

45 yr old Caucasian male

Diagnosis

- ❑ Skin Psoriasis for 12yrs
- ❑ PsA for 3yrs



Treatment

Jack's file

- Low dose corticosteroids (7.5 mg/d prednisone), topical steroids, Sulfasalazine (SSZ), various NSAIDs since diagnosis. Remains on meloxicam 7.5 mg/d about 5 days a week.

- Two years ago, because his skin PsO and PsA were both active, sulfasalazine was stopped, and methotrexate (MTX) was added. MTX was escalated to a dose of 17.5 mg/week but attempts at increasing the dose were not tolerated (GI side effects, slight increase in liver function tests).

- One year ago, again because of active disease, a TNF inhibitor was added to his MTX. On this regimen, he has done better, but still has some skin PsO active (about 5% BSA) and 2 swollen and tender joints.

Reason for Visit

At his last visit,

Jack said his wife of 5 years, who is 35 years old, said that she really wanted to have a family. She and Jack had always agreed they wanted children, but Jack has several concerns.

Jack

Hi Jack! How are you?

Hi Doctor, I am doing well and have some questions.

My wife and I would **really like to have children** but because of my skin lesions mostly and in part due to my arthritis I have **difficulties with sexual intimacy**.

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Jack

What specific difficulties?

Well, sometimes it can be **painful** and embarrassing.

Is my disease **transmissible**?

Let us discuss what can help.

But rest easy: **it is not contagious**.

Also, we have many treatment options that can significantly help both your skin and your joints.

That's good news. How about **my medications**?

Will they affect current treatments/my ability to become a father or have any effects on my children? Should we stop them?

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Jack

Reproductive health is important for both men and women. However, there are some differences.

Looking at your case and your medications, there should be no problem with you continuing your TNF inhibitor. As far as your methotrexate, the **most recent consensus is that there should not be a strict contraindication to fathering a baby while on methotrexate**.

However, for full disclosure, the package insert for methotrexate from decades ago urged men to hold on taking methotrexate before trying to conceive. This is related to the fact that methotrexate, in much larger doses than what is used in rheumatology, had been used as a chemotherapy for certain types of cancer.

In theory, such types of cancer medications can interfere with the development of certain cell types and might make it harder to conceive.

As I said, more recent consensus is that stopping methotrexate is not absolutely necessary for males trying to father a child.

Nevertheless, **if you wish to stop the methotrexate, the main potential downside is that your PsA could become more active.** Hopefully that does not happen if you remain on the TNF inhibitor. You should not go back on sulfasalazine as this drug can lower sperm counts.

MEN with Psoriatic Arthritis planning to father a child

STEP 1

To have the safest pregnancy possible:

- Discuss medications with your rheumatologist
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?

- Minimal skin and nail Psoriasis
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STEP 3

Are your medications right for you at this time?

- Discuss medications with your rheumatologist
- Note: Sulfasalazine can decrease sperm count and quality

STEP 4

Which doctors should you talk with?

- Rheumatology provider
- Dermatology provider

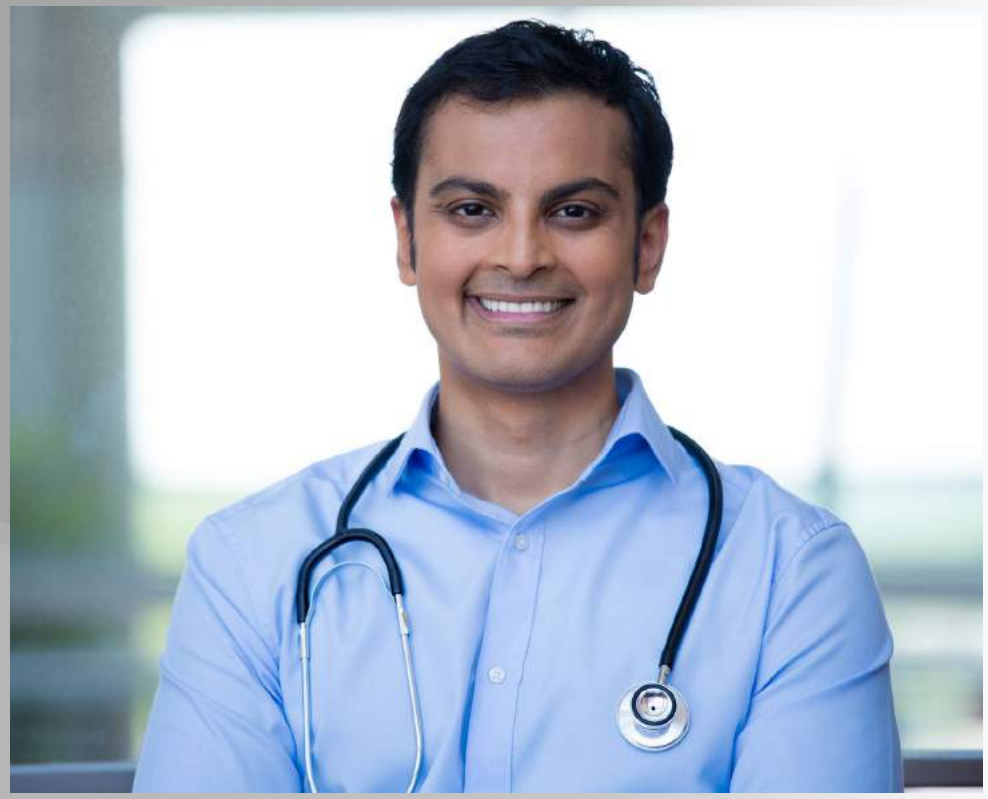
MEN with Psoriatic Arthritis planning to father a child

Medications to discuss with your rheumatologist

- Apremilast
- Abatacept
- Interleukin 17 inhibitor (Secukinumab, Ixekizumab)
- Interleukin 23 inhibitor (Guselkumab)
- Interleukin 12/23 inhibitor (Ustekinumab)
- Janus kinase inhibitors (Tofacitinib, Baricitinib, Upadacitinib)
- Leflunomide
- Methotrexate
- Non-steroidal anti-inflammatory agents
- Sulfasalazine
- Tumor necrosis factor inhibitors (TNFi)
  (TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

Note: Medications listed here appear to be safe in the context of family planning for men with rheumatic disease. Discuss these medications with your rheumatologist.

CASE 3 – JACK
Learning Points



Family planning is a discussion to have with male patients.

CASE 4 - TERRI

I'm Terri and very pregnant!

36 yr. old Asian American Pacific Islander

- ❑ Diagnosed with PsA
- ❑ In her second trimester of pregnancy

Terri's file

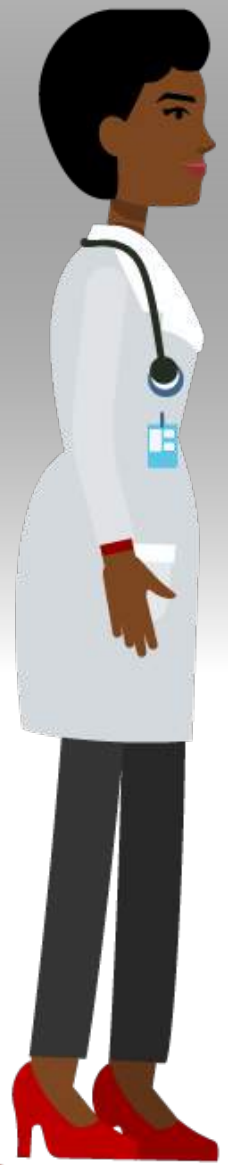
History

- She presents {2nd trimester} to her primary care clinic.
- This is her first pregnancy.
- Her disease is well-controlled with adalimumab and naproxen 500 mg twice a day.
- Her rheumatologist told her that adalimumab is safe to use during pregnancy, but she is unsure if or when to stop it during pregnancy.
- She has continued naproxen and has no plans to stop it during pregnancy.

Reason for Visit

- She is worried that her disease might become more active during pregnancy.
- She has also heard that some women with PsA flare after pregnancy and is worried that this will happen to her.
- She also is unsure if she can take adalimumab or naproxen while breastfeeding.

Terri



Hi, Terri! How are you doing!

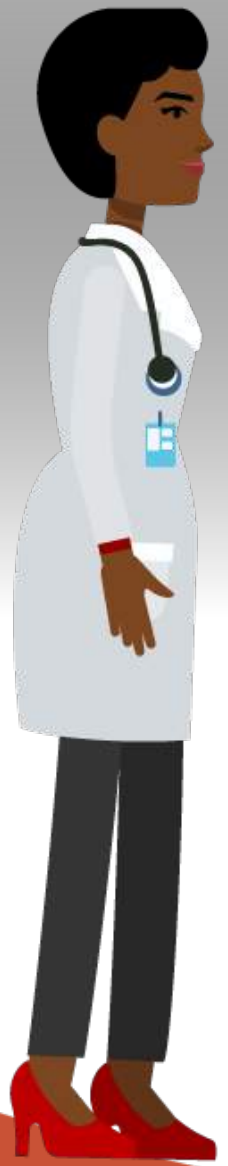
I'm doing fine, doc. I'm about **20 weeks pregnant** and my OB says the baby is doing great.

I'm so happy to hear that. How are you feeling?

I'm feeling OK.

I saw my rheumatologist a few weeks ago, and he says that my psoriatic arthritis is under good control. I agree—my skin has really cleared up and my joints feel fine except **my low back**.

That **pain has started up again**, just a little bit, and after I've been standing for a while.



Oh no, Terri.

Is it **like the low back pain that you had** when you were first diagnosed with psoriatic arthritis?

No, not at all. This is just a dull ache.

My rheumatologist says that a lot of women with psoriatic arthritis get low back pain around their second trimester.

It's the ligaments loosening. He told me I can continue my naproxen for now and that might help. He also advised me to use acetaminophen when needed or a heating pad applied just to my back and not my stomach.

Hmmm. I agree,

I'd recommend using the acetaminophen and the heating pad for the back pain.

But you're at 20 weeks of pregnancy now. I'd actually like to consider stopping the naproxen at this point. We used to stop nonsteroidal anti-inflammatory drugs like naproxen in the 3rd trimester to prevent circulation problems in the baby. But the FDA recently recommended that we stop nonsteroidal anti-inflammatory drugs at around 20 weeks of pregnancy to prevent kidney problems in the baby.

So this is new information but I would definitely be in favor of talking with your rheumatologist about stopping the naproxen or any other nonsteroidal anti-inflammatory drug at this point.

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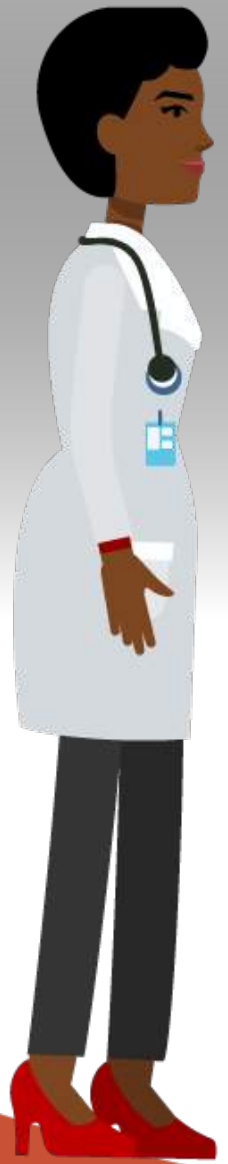
I'm so glad you told me that.

Well, I can stop the naproxen and switch to acetaminophen. But what about my adalimumab?

My rheumatologist told me that it's safe to use that through pregnancy and even when I'm breastfeeding. Is there new information about that?



No, that's still considered safe.

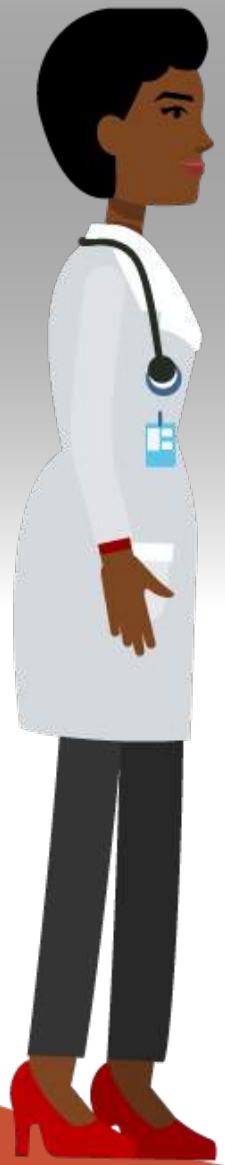
As we've already reviewed together,

adalimumab doesn't cause birth defects or any major organ problems for the baby.

Now, some rheumatologists will recommend that patients whose diseases are really well-controlled can stop their adalimumab at around 32 weeks of pregnancy and restart it when they're breastfeeding. But other rheumatologists recommend that patients should continue adalimumab through pregnancy. The reason is because adalimumab can pass the placenta at later stages of pregnancy, and theoretically could lead to immunosuppression of the baby.

Well, I was planning on breastfeeding the baby.

Does adalimumab pass through the breastmilk too?



The general consensus is medications that are safe during pregnancy are generally safe during lactation.

So the fact that adalimumab is safe during pregnancy suggests that it is safe during lactation.

It's also a really big and bulky molecule, so it doesn't seem to pass into the breastmilk or immunosuppress the baby.

OK,

that reassures me with the breastfeeding issue.

But **I'm still feeling really torn** about whether or not I should continue adalimumab through this pregnancy or stop it at 32 weeks. I always trust your perspective on things.

How do I make this decision? What's best for the baby?

Terri, this is a

good conversation for you to have with your rheumatologist,

especially as you transition into the third trimester. I suspect your rheumatologist is going to see how you're feeling and examine you, and advise you about what your best options might be. But my own perspective here is that your health is central to this conversation, Terri. You need to be able to physically function.

Remember where you were at the very beginning of this journey, right when your disease had just been diagnosed?

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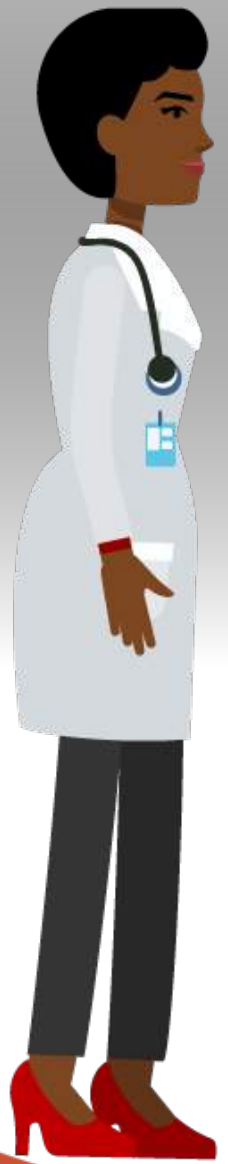
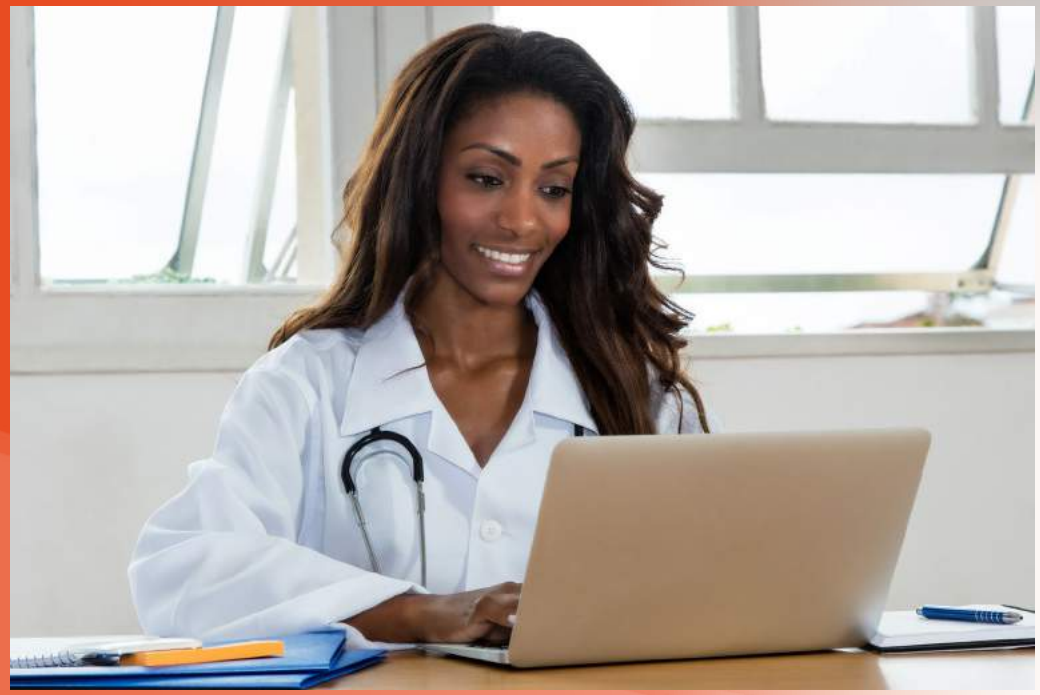


We don't want you to experience that level of pain and disability again. And it's also going to be hard to manage diapering and feeding and clothing a baby if your disease isn't well-controlled.

So, **it's really important that you and your rheumatologist consider your needs** too, and balance that with the risk that your baby might be a little more immunosuppressed if you continue adalimumab

Yes, I'll never forget that. You remember too. My hands were so swollen I couldn't make a fist. I couldn't even button my own shirts or pants. And the rash was so itchy and uncomfortable.

CASE 4 – TERRI
Learning Points



- One of the best things to ensure a healthy baby is to have a healthy mother
- Medications that are safe during pregnancy are generally safe during lactation

Key Messages

- ***PsA is an autoimmune condition*** resulting in inflammatory arthritis seen in approximately 30% of patients with psoriasis
- ***A multi-faceted approach to pregnancy planning is essential*** in women of childbearing age as uncontrolled disease activity and medications used to treat the condition can result in adverse pregnancy outcomes
- ***Contraception should be discussed*** with patients of childbearing age during their visits

Key Messages

- It is important to have the ***conversation with patients about medications and their potential impacts*** on their pregnancy
- ***Family planning*** is a discussion to have ***with male patients*** as well
- One of the best things to ensure ***a healthy baby is to have a healthy mother***
- ***Medications*** that are safe during pregnancy are generally safe during lactation

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Q & A

Exploring PsA and Reproductive Health


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Thank You
Let us know what you learned!
Please remember to take your post-test!
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