Choosing the Safest Psoriasis Treatment for Women of Childbearing Potential

Though treatment options are limited for psoriasis patients who are pregnant or may become pregnant, effective management is possible.

By Jerry Bagel, MD

Although many therapies have the potential to clear psoriasis, no one is more aware than the patient with the disease that it is a chronic condition that he or she likely may live with for quite some time. With a current heightened interest in metabolic syndrome and comorbidities, younger patients with the disease appear to be facing more hardships ahead when it comes to receiving the diagnosis. While emerging data may elucidate provisions regarding systemic and biologic treatments, specifically regarding immunological effects, an added concern that may restrict treatment for younger female patients is pregnancy.

Patients who may be postponing pregnancy have few treatment options, but patients who wish to become pregnant soon have even fewer options.

Apart from the effect of the disease itself on pregnancy and vice versa, it’s important that patients know how certain agents are going to affect them and how much risk is associated with various treatments. The primary concern of course is that you don’t want the patient to be taking a medication that increases the likelihood of fetal abnormalities. It is therefore crucial that patients are aware of the risks, and that they can openly communicate with you no matter what course of treatment is most appropriate.

Safety First

Systemic Therapies. Systemic therapies are the center of great concern for dermatologists treating psoriasis in women of childbearing age. Some treatments can never even be considered. For example, completely avoiding use of acitretin (Soriatane, Connetics/Stiefel) is wise mostly because Soriatane can stay in a patient’s system for more than a year. In some cases, it could last up to three years. The benefit of efficacy simply is not worth the risk.

Another systemic therapy that is best avoided in women of childbearing age is methotrexate, since it can negatively affect the ovaries. There may be long-term implications, but because these effects on the ovaries are largely unknown, I prefer not to use it in women of childbearing potential. It is also important to remember that methotrexate may also be a source of concern for men trying to conceive. I try to ensure that, for both men and women, treatment with Methotrexate is halted at least 90 days before conception.

One of the more viable systemic agents for patients who aren’t pregnant is cyclosporine, which has a relatively good safety profile in general psoriasis patients and appears to have no elevated risk in women of childbearing potential who aren’t pregnant. It is a Pregnancy Category B drug, and even though I prefer pregnant patients not to be on it, many patients in Europe are taking cyclosporine without an elevated risk of fetal abnormalities, which is something that future research should consider.

When it comes to non-systemic options, one often-overlooked therapy that I find very effective is Narrowband UVB phototherapy, which can be particularly beneficial in combination with moisturizer creams.

Steroids. Apart from being marginally effective in cases of mild-to-moderate psoriasis, topical steroids are known to be safe for women of childbearing age. However, despite the fact that most steroids don’t come with the same risks as systemic treatments, patients should probably stop taking steroids of any kind when trying to get pregnant and during pregnancy since there is potential for serious adverse events. For example, there have been some cases of cleft palate in infants of women who have used topical steroids in the first four months of pregnancy.

Biologics and Pregnancy

When it comes to biologics, the safety profiles for women of childbearing potential are similar to those for patients not of childbearing potential. However, one of the major questions with biologics as the data emerges is how the biologics are secreted in the lactating milk and how that affects the immune system of the infant. Alefacept (Amevive, Astellas), etanercept (Enbrel, Amgen/Wyeth), adalimumab (Humira, Abbott), and infliximab (Remicade, Centocor) are all particularly effective and are considered Pregnancy Category B drugs. Efalizumab
(Raptiva, Genentech) falls into Pregnancy Category C, which has prompted some physicians not to even consider it in patients of childbearing potential.

Ongoing research by the Organization of Teratology Information Specialists (OTIS) provides physicians and patients with information concerning the use of biologics in pregnancy. While the research is still being collected and assessed, some results may prove helpful for patients and physicians as they learn more about the effects of biologics on pregnancy.

In one study presented at the 2007 Annual Meeting of the AAD, pregnancy outcomes were evaluated for pregnant women exposed to etanercept vs. disease-matched controls in a six-month period. Out of 82 women enrolled, there were 42 pregnancies. Twenty-two patients who were exposed to etanercept had 21 live births, of which one had a spontaneous abortion and three had infants with congenital anomalies. The matched cohort had 15 live births, three spontaneous abortions, one elective termination, and one fetus with Down’s syndrome. The study concluded that there was no consistent pattern of abnormalities in etanercept-exposed pregnancies, and there have been no safety concerns reported.

Another study by OTIS examined adalimumab in pregnant patients over a three-year period. Of the 97 pregnancies, 42 women were exposed to adalimumab in the first trimester. Thirty-five had live births, seven had spontaneous abortions, and one child was born with congenital hip dysplasia. There was also one neonatal death at 27 weeks. Researchers concluded that patients exposed to adalimumab were at no increased risk for adverse events.

It’s important to talk to women with the potential to become pregnant about staying on safe medications before and during pregnancy. Although systemic therapies should be stopped when patients become pregnant, biologics appear to be safe until that point, even in women trying to become pregnant. Their strong safety profiles make them safer than most other systemic agents. Moreover, since most biologics have strong efficacy, the quality of life in women who are planning to become pregnant is often greatly increased. If you are concerned about patients who are trying to conceive soon but you don’t want them to be exposed to biologics or stop the biologic prior to conception, alefacept may be appropriate because it is associated with longer remissions; the best-case scenario would be if the patient goes into remission from the alefacept right before getting pregnant.

Number One Concern
Although patients cannot be on many medications for psoriasis while pregnant, it’s important to note that, in some cases, psoriasis actually improves during pregnancy due to the changes in hormones. That’s why it’s important that patients remain encouraged that their psoriasis will not stand in the way of having a baby. The best way to do this is to maintain an honest relationship with patients wherein they feel they can trust you as the physician. Monitoring their progress on whatever therapy they’re taking and taking every opportunity to speak with them, whether that’s before, during, or after pregnancy, is especially important.

For more information about OTIS, visit http://www.otispregnancy.org.