# Psoriasis Tx Deemed 'Challenging' in Pregnancy

BY DIANA MAHONEY

BOSTON — Data suggesting that pregnant women with psoriasis have poorer outcomes than those without it highlight the need for more research to determine whether the outcome discrepancies are a function of the disease itself, comorbidities, or treatment side effects, according to Dr. Alexa Boer Kimball.

"We know that pregnancy can have an impact on psoriasis—studies have shown that about 50% of women report improvements; 15%-25% worsen; and the rest don't change—but we know less about the effect of psoriasis on pregnancy," said Dr. Kimball of the department of dermatology at Harvard Medical School in Boston.

In a case-control study of 145 live births in women with psoriasis between 1998 and 2004, investigators at Ben Gurion University of the Negev in Beer-Sheva, Israel, demonstrated an association between pregnancy complications and psoriasis. Specifically, recurrent abortions and chronic hypertension were significantly associated with psoriasis in a multivariate analysis, and psoriasis was an independent risk factor for cesarean delivery (J. Reprod. Med. 2008;53:183-7).

"The findings are not really surprising when you think about the [inflammatory bowel disease] literature and the lupus literature, for example. It's clear that systemic autoimmune diseases can have adverse effects on pregnancies," Dr. Kimball said at the American Academy of Dermatology's Academy 2009 meeting.

"Unfortunately, our knowledge about pregnancy outcomes in psoriasis is very limited, which in turn limits the treatment guidance that we can offer." This is due, she said, to the dearth of literature on the topic, the exclusion of pregnant women from most clinical trials, and the low enrollment in pregnancy registries.

Further, said Dr. Kimball, the various regulatory agencies are not consistent in interpreting numerical data regarding drug safety in pregnancy.

In one study comparing the pregnancy risk classification of 236 commonly used drugs by three international regulatory agencies—the U.S. Food and Drug Administration, the Australian Drug Evaluation Committee, and the Swedish Catalogue of Approved Drugs—only 26% of the drugs were placed into the same risk category, she said (Drug Saf. 2000;23:245-53).

"Theoretically, these groups should be looking at the same data and arriving at essentially the same conclusions. The fact that they're not tells you that there is a substantial subjective review component to how we evaluate this information," she said.

For these reasons, providing therapeutic guidance to pregnant women with psoriasis is "incredibly challenging," Dr. Kimball said. The challenge is exacerbated by several social and environmental considerations, including the fact that "women today are under extraordinary pressure not to expose their babies to unknown and unnecessary risks, which may make them more likely to forego therapy that they might actually need," she said. "In counseling these patients, there really obviously has to be a very open communication about that, although you really can't make the choice for them. It's a very personal decision about the risks they're willing to take."

Similarly, there is tremendous pressure on women to breastfeed for long periods of time, which can also have an impact on treatment decisions. "A woman may decide to hold off on treatment while she's breastfeeding, and again that's a personal decision, but recognize that it may be a really substantial sacrifice, and in cases of psoriatic arthritis in particular, it may not be all that good for them over time," she said.

In addition to helping patients determine how to proceed with treatment once they are pregnant, patient counseling should address exposures that might have already happened. "The critical period in all pregnancies for fetal malformations is early, in the first trimester, and lots of women are exposed to drugs before they even know they're pregnant," said Dr. Kimball.

**Putting a patient's risk into context is difficult given the limited and conflicting information available. 'At the end of the day, you really have to guide women about the personal nature of these choices.'**

"In situations involving major risks, referral to a genetics counselor can be useful, but it's also important to remind patients that, under the best of circumstances, not all pregnancies turn out perfectly. The developmental disorder rate [in the general population] is about 3% at birth and about 8% by age 5. It's important to give that information to women so they don't feel overly guilty about the choices they're making," she said.

"So what can we actually recommend?" Dr. Kimball asked. "For first-line therapy, moisturizers can be used with reckless abandon, and low-potency topical steroids have been determined to not be a risk." Systemic steroids, on the other hand, should be avoided in the first trimester because of the association with cleft palate, she said.

The second-line treatment algorithm includes narrow band ultraviolet B (UVB) phototherapy, if feasible, "but this may be a challenge if, for example, the pregnant woman has other kids at home or just doesn't have the flexibility in terms of scheduling," Dr. Kimball said. "Home UVB is an option, and tanning beds—although problematic for other reasons—in a severe patient might be worth considering if they really have no other options."

Concern regarding the possibility that folate levels might be affected by light therapy, Dr. Kimball noted, has been put to rest by a new study showing that UVB phototherapy does not influence serum and red cell folate levels in psoriasis (J. Am. Acad. Dermatol. 2009;61:259-62).

The question of heat exposure has not been addressed, however. "There are recommendations against hot tubs and hot baths in the first trimester, for example, because of potential injury to the fetus, so if you have someone way up on the light scale, that might be something worth thinking about."

Tumor necrosis factor inhibitors fall under third-line therapies. "Obviously we have limited data on these. They are generally risk category B, so most people feel reasonably comfortable if we had to go that direction, but there are potential risks that are unclear," Dr. Kimball said.

Cyclosporine, which was the therapy of choice prior to the biologics era, is another third-line treatment, said Dr. Kimball. "Although cyclosporine is [risk] category C, we probably have the best information about this drug due to the transplant registries that are out there," she noted.

It is associated with a low birth rate and prematurity, "so there are known risks associated with it, but malformations do not seem to be an issue." Systemic steroids in the second and third trimester would be another third-line option if needed, she said.

Among the systemic therapies to avoid in pregnancy are PUVA, which can potentially lead to premature labor or fetal abnormalities; methotrexate, which is a teratogen and immunogen; and systemic retinoids, which are also known teratogens, Dr. Kimball said.

With respect to methotrexate in pregnancy, "the current recommendation extends to males, who should be advised to cease its use for 3 months prior to conception because of theoretical concern about chromosomal abnormalities," she noted.

Regarding topical therapies, tazarotene, anthralin, calcipotriol, and coal tar should be avoided as well, said Dr. Kimball.

In all cases, putting a patient's risk into context is difficult given the limited and conflicting information that is available, Dr. Kimball said. "At the end of the day, you really have to guide women about the personal nature of these choices," based on experience and the information that is available.

In order to improve research in this area, it is imperative that health care providers and patient advocacy organizations encourage individuals with psoriasis to enroll in pregnancy registries, Dr. Kimball stressed. "Pregnancy registries are one of our most valuable tools for collecting information about how to best manage and counsel women prepartum, during pregnancy, and post partum, yet they are so [undersubscribed]. This is something that we can help change."

Dr. Kimball said she has served as a consultant and an investigator for Amgen Inc., Centocor Inc., Abbott Laboratories, NeoStrata Co., and Galderma; she is an investigator for Stiefel Laboratories Inc.; and she has a fellowship program funded by Centocor. ■