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REVIEW

suppl. Informations

Pregnancy and contraception in systemic and cutaneous lupus erythematosus

Grossesse et contraception au cours du lupus érythémateux systémique et cutané

G. Guettrot-Imbert [a], N. Morel [a], V. Le Guern [a], G. Plu-bureau [b], C. Frances [c,d], N. Costedoat-Chalumeau [a,*]

[a] *Department of internal medicine, medical center, reference center for rare systemic and autoimmune diseases, hôpital Cochin, AP—HP, université René-Descartes, 27, rue du Faubourg-Saint-Jacques, 75679 Paris cedex 14, France*
[b] *Endocrine gynaecology unit, hôpital Cochin-Port-Royal, AP—HP, université René-Descartes, 52, avenue de l'Observatoire, 75679 Paris cedex 14, France*
[c] *Université Pierre-et-Marie-Curie, Paris 6, 75013 Paris, France*
[d] *Department of dermatology-allergology, hôpital Tenon, Paris public hospitals, 4, rue de la Chine, 75020 Paris, France*

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Contraception

Summary A causal link has long been described between estrogen and systemic lupus erythematosus activity. Contraceptive and pregnancy management is now common for lupus patients, but pregnancy continues to be associated with higher maternal and fetal mortality/morbidity in systemic lupus erythematosus patients than among the general population. Potential complications include lupus flares, obstetric complications (fetal loss, in utero growth retardation, premature birth) and neonatal lupus syndrome. Association with antiphospholipid antibodies or antiphospholipid syndrome increases the risk of obstetric complications. Anti-SSA and/or anti-SSB antibodies put fetuses at risk for neonatal lupus. Improving the outcome of such pregnancies depends upon optimal systematic planning of pregnancy at a preconception counseling visit coupled with a multidisciplinary approach. Absence of lupus activity, use of appropriate medication during pregnancy based on the patient's medical history and risk factors, and regular monitoring constitute the best tools for achieving a favorable outcome in such high-risk pregnancies. The aim of this review is to provide an update on the

* Corresponding author.
E-mail address: nathalie.costedoat@gmail.com (N. Costedoat-Chalumeau).

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management of contraception and pregnancy in systemic lupus erythematosus, cutaneous lupus and/or antiphospholipid syndrome in order to reduce the risk of complications and to ensure the best maternal and fetal prognosis.

MOTS CLÉS
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Syndrome des antiphospholipides ;
Complications obstétricales ;
Contraception

Résumé Un lien entre œstrogènes et activité du lupus systémique est décrit depuis longtemps. La gestion de la contraception et la survenue d'une grossesse sont des situations fréquentes lors du suivi des patientes lupiques. La grossesse reste associée, au cours du lupus systémique, à une morbi-mortalité maternelle et fœtale plus importante que dans la population générale. Les complications possibles sont les poussées lupiques, les complications obstétricales (pertes fœtales, retard de croissance in utero, pré-éclampsie, prématurité) et le lupus néonatal. Un syndrome des antiphospholipides ou la seule présence des signes biologiques de ce syndrome augmentent nettement le risque de complications obstétricales. La présence d'anticorps anti-SSA ou anti-SSB expose au risque, faible, de lupus néonatal chez le fœtus. La prise en charge de ces grossesses est optimisée par leur planification, idéalement au cours d'une consultation pré-conceptionnelle, et par une approche multidisciplinaire. L'absence d'activité du lupus systémique, un traitement compatible avec la grossesse, adapté aux antécédents et aux risques, ainsi qu'une surveillance régulière sont les meilleurs garants d'une issue favorable à ces grossesses à risque. Cette revue se propose de faire une mise au point sur la contraception et la prise en charge actuelle de la grossesse au cours du lupus systémique, du lupus cutané et du syndrome des antiphospholipides, afin de limiter le risque de complications et d'assurer le meilleur pronostic tant maternel que fœtal.

Systemic lupus erythematosus (SLE) is an autoimmune disease found chiefly in young women, and pregnancy is thus extremely frequent among the affected population. Despite the clear improvement in prognosis, such pregnancies continue to carry risk and optimal management thereof requires close collaboration between the various specialists involved. Ideally, pregnancy should be planned in order to reduce the risk of maternal and fetal complications. Management of pregnancy occurring during the course of SLE requires close attention to four distinct aspects: activity of the SLE, presence of laboratory or clinical signs of antiphospholipid syndrome (APS), presence of anti-SSA or anti-SSB antibodies, and adaptation of different treatments that must be compatible with pregnancy. Ideally, pregnancy should be preceded by a preconception counseling visit during which these various factors are discussed. In particular, the goal is to set up multidisciplinary management and adequate monitoring in order to anticipate any complications that might arise.

First, we shall examine the various contraceptive methods suitable for use in SLE before outlining the management of pregnancy, first in SLE and then in various types of cutaneous lupus.

Contraception

This question should be systematically addressed with female lupus patients of childbearing age, given the effect of hormones on their disease progression. In addition, contraception is essential where patients are receiving teratogenic treatments such as methotrexate, thalidomide, cyclophosphamide or mycophenolic acid [1]. The main methods are hormonal contraceptives, intrauterine devices and mechanical barrier methods (e.g., condom, diaphragm, etc.).

While a recent meta-analysis revealed no increase in risk of lupus progression with use of estrogen-progestogens [2], the studies included therein are extremely heterogeneous, rendering the conclusions difficult to interpret. The oldest studies, which are chiefly retrospective, showed a risk of increase in active episodes regardless of the dose of estrogen used. More recently, a case-control study has demonstrated increased risk of onset of SLE in women aged 18 to 45 years using estrogen-progestogen contraceptives, particularly at the start of use and with high doses of ethinyl estradiol. The relative risk (RR) was 2.52 for all women on estrogen-progestogen contraceptives (CI 95%: 1.14—5.57), 1.65 for women on second-generation contraceptive pills (CI 95%: 1.20—2.26), 1.42 for those on ethinyl estradiol at a dose of less than 30 μg, and 2.92 for those on a dose of 50 μg [3]. Conversely, two randomized studies published in 2005 in the *New England Journal of Medicine* demonstrated that estrogens did not increase the risk of onset in patients with stable SLE [4,5]. According to the authors of the studies, use of estrogen-progestogens may be envisaged in women without excessive thromboembolic risk, particularly where antiphospholipid is not being taken and where SLE is

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