Preconception Counseling

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KEYWORDS

• Rheumatic disease • Pregnancy • Risk assessment • Communication

KEY POINTS

- Address family planning in all patients of fertile age. Physicians should actively offer information on reproduction issues to all patients, even those who do not specifically ask.
- Ideal conditions for pregnancy are: conception at a stage of remission or minimal disease activity while on stable, pregnancy-compatible medication.
- Address medication concerns and the benefits of optimal disease control in pregnancy with all patients.
- Points discussed during preconception counseling should be shared with all doctors and health professionals involved in the care of a pregnant patient.

INTRODUCTION

Given that rheumatic diseases (RDs) have frequent onset during the reproductive years as well as a female predominance, discussion of reproduction issues with patients of fertile age is an important issue. Patients often have significant information needs when it comes to meeting the challenges related to pregnancy and parenting.[1] When a patient brings up a desire for children, most rheumatologists offer preconception counseling based on clinical and laboratory assessment of the disease. The aims of counseling are to assist in planning a pregnancy and to optimize management before and throughout pregnancy. Doctors and health professionals engaging in counseling have specific goals in mind; in addition, the patient herself has special needs that must be met if counseling fulfills its intention: to secure a good pregnancy outcome for mother and child.

Information on family planning not only should be given to patients who ask for it but also actively offered to adolescent patients, to patients who are not in a relationship, and also to those who already have children provided they are aged 18 to 45 years. Partners not present at a first consultation may appear at a later point, and new

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relationships may develop over time, so that patients may desire children with a new partner even when they already have children from a previous relationship.

FERTILITY

Fertility issues should be discussed when a patient plans a pregnancy, particularly before withdrawal of effective therapy that has kept the patient in remission. Discontinuation of effective medications when pregnancy is planned may result in a flare, especially when the patient fails to conceive over a prolonged period of time.[2] Frequent monitoring after drug withdrawal and initiation of alternative therapy compatible with pregnancy are, therefore, required. Should a patient fail to conceive after more than 6 months, referral to a gynecologist and investigation of fertility of the couple is advisable (see Emily C Somers and Wendy Marder's article, "Infertility – Prevention and Management," in this issue).

CONTRACEPTION

A major point of addressing family planning in all patients of fertile age is to avoid unplanned pregnancies and the maternal and fetal risks connected with it. Counseling on and regular practice of effective birth control is the only way to prevent unplanned pregnancy.[3] It is the responsibility of the treating rheumatologist to address contraception actively in all patients at risk for unplanned pregnancy (see Lisa R. Sammaritano's article, "Contraception in Rheumatic Disease Patients," in this issue). No prescription for methotrexate, mycophenolate mofetil, cyclophosphamide, or other teratogenic medication should be given without first excluding pregnancy and ensuring comprehensive information on safe and effective birth control. Patients with active disease and a desire for children should practice effective birth control until the disease has improved or has gone into remission for at least 6 months.

THE COURSE OF RHEUMATIC DISEASE IN PREGNANCY

The type of RD influences both the effect of pregnancy on disease symptoms and the impact of the chronic disease on pregnancy (**Table 1**). Rheumatoid arthritis (RA) and other polyarticular RDs like polyarticular juvenile idiopathic arthritis (JIA) improve spontaneously during pregnancy in a major proportion of pregnant patients.[4] Axial arthritis either does not change or is aggravated during pregnancy.[5] Systemic lupus erythematosus (SLE) flares in up to 50% of pregnancies, including major organ involvement in up to 25%.[5]

The impact of RD on pregnancy largely relates to the extent of inflammation present. A disease where arthritis in peripheral joints is the predominant symptom, with no or few organ manifestations and with no or few autoantibodies, tends not to impair the course of pregnancy to a major extent. In contrast, multiorgan involvement or the presence of certain autoantibodies, as in antiphospholipid syndrome (APS), can result in several pregnancy complications with harmful effects both in mother and fetus.[4] Internal organ involvement, such as in SLE or in antineutrophil cytoplasmic autoantibody–positive small vessel vasculitis, predisposes to increased risk of various pregnancy complications (see **Table 1**).

RISK ASSESSMENT

Risk assessment for possible maternal or fetal risks during a future pregnancy is essential for counseling an individual patient and adjusting therapy.[6] Disease activity should be assessed by standard criteria. A clinical and laboratory work-up should be