Reproductive years/family planning by Helen Lachmann

Dr. Lachmann talked about autoinflammatory diseases requiring treatment indefinitely and the concerns young women often have regarding compatibility of treatment with pregnancy and lactation.

For patients with well controlled disease, and contemplating starting a family, information about fertility and the potential risks due to medication for their children is very important.

She also mentioned that the advice in drug formularies is very conservative and slow to change, even when data from case reports, drug registries and controlled studies are reassuring. This is because none of the pharmaceutical companies are prepared to do trials on pregnant or nursing mothers, due to fear of litigation and they actively discourage discussions on pregnancy.

The main issue when talking about pregnancy is safety. Even in healthy women, one in 10 will have problems to conceive and 1 in 20 results in a baby which is not completely normal. When talking about AID, we should talk about untreated disease and the consequences (i.e. miscarriage, premature babies). If the patient decides to come off medication, it doesn't mean it is good for the baby, as unwell mothers make poor hosts. Discussions about drugs in pregnancy should be started early (17-18) and not when the patient is already pregnant. Once patients have been to the prenatal class, it can become competitive (i.e. other mothers trying to be as healthy as possible not to put the unborn baby at any risk; avoiding having to take medications, etc).

Colchicine is an ancient drug, which has been used for over 3,500 years and the experience has shown that there is no difference between FMF patients on colchicine and the general population.

Anti-TNF agents are not a problem, there is a large body of data. There is a paper from EULAR with consensus recommendations in pregnancy for patients on antirheumatic drugs. The outcomes in pregnancy are extremely reassuring.

As for anakinra, rilonacept and canakinumab, there isn't enough data, and this is unlikely to change due to the reasons mentioned above. The FDA has categorised Anakinra with pregnancy risk class B, whereas rilonacept and canakinumab are category C because there isn't enough human data available. None of these drugs are in category A (decades of experience needed).

For anakinra, it was shown that of 19 pregnancies, none of which had any developmental abnormalities even with follow-ups up to 8 years. It was also shown that for canakinumab, there were also no abnormalities reported, this included in a follow-up period up to 4 years.

For babies breastfed, there were no reported infections while exposed to IL-1 inhibitors in breast milk.