Pregnancy and Psoriasis

The majority of women develop psoriasis before the age of 40. This means it often occurs during the years when women may be planning to start a family.

Many women find that their psoriasis changes during pregnancy, possibly due to hormonal fluctuations and the increased amount of oestrogen in their body. Most of those who notice changes see an improvement in their psoriasis; however, some may find that their psoriasis remains or worsens during pregnancy. Psoriasis may also come back after giving birth, but for many people this simply means it returns to how it was before the pregnancy.

Treating psoriasis during pregnancy needs careful planning with your healthcare team. The treatments listed below may be suitable during pregnancy, but doctors often take a cautious approach. If you have any concerns at all as to which treatments to use during pregnancy, please discuss these with your GP, dermatologist or midwife.

Possible treatments for use in pregnancy:

Many topical treatments can be used during pregnancy and for many people, they will be able to continue their usual skincare routine while pregnant.

Topical treatments that may be suitable include:

Emollients – preparations used to re-hydrate and soften the skin, and to treat dry, scaly skin conditions. Some preparations are added to the bath or used instead of soap. Others may be applied directly to the skin (please contact Psoriasis UK for a comprehensive list of emollients). These should be used either alone or alongside other treatment.

Topical steroids in pregnancy

Topical steroids are treatments that are applied directly to the skin. These are commonly used to treat small patches of psoriasis in pregnancy. High potency steroids should be avoided if possible.

Topical steroids – During breastfeeding

Topical steroids that are applied to the breast or nipple area should be wiped off before breastfeeding or coming into contact with your baby's skin and mouth. Wash your hands well

after applying the treatment. You should discuss any questions about breastfeeding with your healthcare provider before the baby arrives.

Ciclosporin – In pregnancy:
If you are planning to become pregnant or are pregnant talk to your dermatologist or other healthcare professional before starting or continuing ciclosporin. They can discuss the benefits and risks and whether ciclosporin is suitable for you and your baby and whether any extra monitoring is needed for you both. If you become pregnant while taking ciclosporin, contact your healthcare team as soon as possible.

Ciclosporin – During breastfeeding:
If you are planning to breastfeed or are breastfeeding, talk to your dermatologist or other healthcare professional as soon as possible before starting or continuing ciclosporin.

Other treatments that could potentially be used in pregnancy include:

Biologics – There is increasing evidence for the safe and effective use of biologics in psoriasis that has not responded to topical therapies during pregnancy, however due to the limited data available, most biologics are only used during pregnancy if there is a very clear need. Some biological treatments for psoriasis can cross the placenta, especially during the last 3 months of pregnancy, meaning the medicine can reach the baby.

- **Certolizumab pegol (Cimzia)** – Certolizumab pegol crosses the placenta very little, so only tiny amounts usually reach the baby. For this reason, if you need a biologic for psoriasis or psoriatic arthritis, you may be switched to certolizumab pegol during your pregnancy. It has reassuring safety data and may be used throughout the whole pregnancy if needed.

  Although the risk of certolizumab pegol causing harm to the pregnancy or unborn baby appears to be very low, it cannot be completely ruled out. If you are pregnant or are planning to become pregnant, please discuss with your dermatologist as they will be able to advise on your individual circumstances.

If you receive a biologic during pregnancy, some vaccinations for your baby may need to be delayed until the age of 6-12 months after birth as they can potentially affect the baby's immune system. In particular, live vaccines for the baby (such as the oral polio vaccine; rotavirus vaccine; measles, mumps, and rubella (MMR) vaccine; and the BCG vaccine) must be postponed.

It is important to discuss this with your baby's healthcare team before the baby receives any vaccinations since the advice will be based on your information about which biologic you have had and when it was given as well as the needs of your baby.

The table below may be used as a guide, although it is advised to discuss all treatment options with your healthcare team when you are pregnant or thinking of becoming pregnant:

	Topicals	**Second line treatments / Systemics**	**Biologics**
Treatments considered suitable for use	Emollients Topical steroids (Mild, moderate or potent)	Ultraviolet B (Folic acid levels should be monitored during this treatment)	Certolizumab pegol (Cimzia)
Relatively safe but caution advised	Coal Tar products (Should be avoided in the first trimester and used with caution in the second and third trimester in small amounts only if absolutely necessary)	Ciclosporin	Biologics including adalimumab, etanercept and infliximab may occasionally be used in the first trimester if your healthcare team thinks they are needed.
Treatments to avoid	Calcipotriol derivatives such as Dovonex, Dovobet and Enstillar Any products containing retinol	Methotrexate Acitretin Psoralen plus ultraviolet A	
Treatments with unknown effects		Apremilast Fumaric acid esters Some Biologics such as Secukinumab, Ixekizumab, Ustekinumab, Guselkumab, Risankizumab, Brodalumab Hydroxycarbamide	

Treatments to avoid in pregnancy:

Methotrexate – Methotrexate should not be used during pregnancy as it can interfere with how the body uses folic acid**.** Both men and women should wait at least three months after stopping methotrexate before trying for a baby and should use contraception during this time. For men, the possible risk to the baby is based mainly on theory rather than clear evidence.

Acitretin - Acitretin should not be used during pregnancy because it can cause serious birth defects. It is recommended that treatment with acitretin be stopped for 3 years before trying to conceive.

Coal Tar Products - There is limited evidence of the safety of coal tar in pregnant women, but its use should be avoided during the first trimester and then used with caution during the second and third trimesters only if needed. It is usually only prescribed if the expected benefit to the mother outweighs the potential risk to the baby.

Calcipotriol - Calcipotriol is not usually used during pregnancy because it's not known if it may cause problems with how your baby develops.

It is advisable to check with your relevant healthcare professional (GP, midwife, dermatologist or pharmacist) as well as the patient information leaflet (PIL) of individual treatments for guidelines on how to use during pregnancy.

Treatments whose safety in pregnancy is not yet established: -

Vitamin D Products – As there is inadequate data for the use of Dovobet, Enstillar and Dovonex in pregnancy, it is generally advised that these are only used when clearly necessary. You should check the PIL of individual treatments for further guidance.

Oral Systemics - Most oral systemics will not be prescribed during pregnancy, unless the psoriasis is particularly severe and is a risk to the mother's health. Ciclosporin may be the most likely to be offered, but only under specialist supervision. If you are planning a pregnancy, are pregnant or are breastfeeding, talk to your dermatologist or other healthcare professional before starting or continuing ciclosporin. They can discuss whether ciclosporin is suitable for you and whether any additional monitoring is needed

Other biologics – Your dermatologist or rheumatologist can discuss the potential benefits and risks of continuing treatment during pregnancy with you, considering how your psoriasis or psoriatic arthritis might be affected if treatment is stopped or changed. This will help you make an informed decision together about the best approach for you and your baby.

Many women will only need topical treatments to treat their psoriasis while pregnant. However, for those women who do require treatment with systemics or biologics where their psoriasis is more widespread, discussion should take place with your healthcare team.

Can psoriasis and/or PsA affect pregnancy?

Psoriasis may be associated with some factors that can affect fertility and pregnancy:

- **Emotional well-being:** The stress, social stigma, and impact on self-esteem that often come with psoriasis can affect a person's overall health and well-being, which may indirectly influence fertility.

- **Medical Treatments:** Some systemic medications used to treat psoriasis may not be safe during pregnancy. Because of this, it is very important for patients to talk with their healthcare team about birth control and planning for a family.

- **Health and Lifestyle Factors:** People with psoriasis are more likely to have other health conditions such as depression or adopt habits like smoking. These factors are already known to make getting pregnant more difficult and so can potentially increase the risk of complications, such as miscarriage.

A large UK study has found that women with psoriasis had a slightly higher chance of pregnancy loss than women without psoriasis. The difference was small, and the study cannot show that psoriasis itself causes pregnancy loss. If you have psoriasis and are planning a pregnancy or are pregnant, it is sensible to discuss your psoriasis and its treatment with your healthcare team.

For more information, or for a list of resources used in the production of this information sheet, please contact Psoriasis UK.

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