National
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MS Learn Online
Feature Presentation
Family Planning with MS
Featuring Dr. Dessa Sadovnick

Tom>> Hi, I'm Tom Kimball

Tracey>> And I'm Tracey Kimball, welcome to MS Learn Online. Whether and when to have children is one of the most important and exciting decisions we make in our adult lives. That decision is made much more complicated when one or both partners has MS.

Tom>> It's an issue that's on the mind of our medical correspondent Kate Milliken. She had an opportunity to speak with Dr. Dessa Sadovnick, one of the leading experts in the area of family planning and genetics for people with MS.

>>Kate Milliken: The whole world of reproducing, having a child and having MS is something that is especially pertinent to me, because I hope to have a child. I'm in my mid-thirties and I have MS.

So, you have been doing a lot of work with people on this subject on what you would recommend for them in terms of moving forward with the idea of potential family planning. So, tell me a little bit about your work.

>>Dr. Sadovnick: Well, what we're interested in doing is we're putting together a project that's called the Multiple Sclerosis North American Pregnancy Project. And what we're looking at this stage is putting together information so that when someone asks a question such as you just asked, I'm not going to make a decision for you. But the idea is to provide you and your partner with the best information that's relevant for you in various topics so that you can make your own decisions based on valid information.

>>Kate Milliken: Let's talk about some of the factors that you will be addressing.

>>Dr. Sadovnick: Okay. Well, some of the factors include, let's start from the beginning, the whole area of conception. Many people with MS have problems with sexual functioning. They don't bring that forward often. And this is an issue in trying to conceive a child.

If you don't want to have a child, issues of birth control come up. What birth control methods are the best for someone who has MS? You have to make sure that you realize that oral contraceptives can sometimes interact with antibiotics that are given frequently for bladder infections. So, that can reduce the risk of the oral contraceptive.

You also have to think about both parents. You're a young female, but you have to remember that there are males out there who want to father pregnancies, and many of the issues we have to think about are relevant for males as well.

We also have to realize there are women out there who have secondary-progressive MS, and even primary-progressive MS, who may want to have children, they have different issues they have to consider. And then, of course, you have the planned pregnancy versus the unplanned pregnancy.

But taking all that together, the various areas that I think you have to discuss in your decision-making process include the following: They include sexual functioning, because, of course, you have to --

>>Kate Milliken: Mate?

>>Dr. Sadovnick: -- mate. It includes discussions on the effect of MS on pregnancy and pregnancy management, and this includes topics such as delivery, topics of pregnancy-related symptoms. Are they really MS symptoms? Are they pregnancy related? The management of the pregnancy, the fact that in most cases, just because a woman has MS, she's not a high risk pregnancy. These are all issues that have to be discussed.

>>Kate Milliken: Also in the pregnancy realm, obviously, in the third trimester of having most people come out symptom-free and then being doubly susceptible to an episode after pregnancy.

>>Dr. Sadovnick: Well, that again is something that has to be really researched properly, because what we don't really know about that research is most of it is based on retrospective data. Most of it is based on recall. And also we don't usually know what the woman's course was like prior to becoming pregnant.

So, it's very hard to say that this is a true 100 percent fact for all women. And one of the things we're hoping to do is do some prospective work where we're able to take what the woman's course was like before pregnancy, follow her through pregnancy after delivery, and see if there's a correlation there.

Also, whether we're talking about true relapses or pseudo relapses is something that has to be looked at. And that's actually the second major heading of our reproductive counseling. Because, as I said before, that the first topic was the effect of MS on pregnancy, and the second topic, of course, is the effect of pregnancy on MS. And this, of course, is relevant only to females. But we really need more

information on this, both the short-term effects and the long-term effects.

>>Kate Milliken: Another factor I have to believe that you deal with is telling women who have MS whether or not there's a genetic component that they might be sending down to their child.

>>Dr. Sadovnick: Both women and men. We also discuss the genetic component, because this is relevant for both males and females. We also discuss -- when I go back to the relapse rates, again, everybody focuses on females, but what about the male? What about the male who has MS? What about when his wife is pregnant and she needs much more help? What about after delivery, when she's nursing and busy with the baby and sleep is disrupted? Men have relapses as well.

>>Kate Milliken: In light of the studies that you actually -- or the programs and the people you come into contact with, what is the -- I understand that it's a personal decision, but how many people, women and men, who go through your program or talk to you, or think about these factors actually pull out of the idea of having a child?

>>Dr. Sadovnick: It's a very interesting answer. I can't give you a set number. But what I can say is after doing a lot of these reproductive counseling sessions, there -- and I don't make the decision; the couple makes the decision. I have been surprised how often people who I feel really -- my gut feeling is that they should go ahead, back out, because they don't want any risks. And other people, who probably have so many factors against them decide and go ahead.

And one concern is cognitive functioning. What you have to be aware of as well is does the person have the cognitive ability to make the informed decision? So, this is something else that has to come up, an assessment of that in reproductive counseling.

Other factors have to do with therapies. There are three types of therapies you have to consider. There are the symptom-specific therapies, the relapse-specific therapies, and, of course, the disease-modifying therapies. And this is relevant for both men and women.

Ideally, you should not be on a therapy at the time of conception. Same true for men and for women. So, the question comes up, we don't know enough about these therapies to know are any of them safe, really safe during pregnancy? Are any of them safe enough maybe for a woman to resume later on in a pregnancy? What about after delivery and breastfeeding?

What about for the male? We always think about for the woman, but you forget that male are always forming new sperm. What about the male? Should he be in a washout period if he's trying to father a pregnancy? Should he freeze his sperm?

I mean, these are all issues that you have to discuss with the patient, and I think these are all very relevant.

And a lot of people's decisions often are related to disease-modifying therapies, and how much the person actually feels that being on that therapy is keeping them well or protected. We know that there is no therapy that is known to be the cure for MS. But different people have different perspectives.

When you think of a planning pregnancy, you often think, okay, nine months of pregnancy, then you think of the three-month postpartum, because that's when, quote, the relapses tend to happen. Some people recognize a washout period before, some people don't.

But say you're going into a planned pregnancy, and say you're on a disease-modifying therapy. And these are real examples we have. All right. You're thinking about it with your partner and you're okay with your three-month washout, if you're a female, for example. Or,

if you're a male, it's really both ways. But say you're a female. You're okay with your three-month washout, which is an arbitrary figure. We don't know for sure if that's what you need, but that's what we go by right now. You're okay with your washout period.

You're okay with your nine months of pregnancy. Then you make a decision, are you going to breastfeed? Are you going to go back on therapy after delivery? So, you're talking about a 12-month period and in your mind you say, "Well, as a female, so if I'm off the medication for those 12 months, it's not that long." What about the real world?

I had the situation just recently come up. This couple had been trying to get pregnant for about a year and a half. The woman had been off her medication now for a year and a half and she's starting to have some more problems. So, the very real life question comes up: Does she stay off the medication? Does she continue to try to get pregnant and see what happens? Does she go back on the medication? Take her risks that if she does get pregnant she will wean off it once she finds out she's pregnant? Again, we don't have precise data to know the safety of conceiving on the medication, but that's her other option. And her third option is go back on the medication and give up all hope of having a child.

So, these are the types of real life situations that come up. And in the reproductive counseling, what we're trying to do with the website as well is we're trying to put this information out there so that healthcare professionals, when they're dealing with their patients, can know what factors to discuss, knowing the people in front of them, and try to raise issues that should be discussed so people can make an informed decision.

>>Kate Milliken: And I think it's very important. You brought up in such a great way the importance of making an informed decision, and also the importance of a personal choice and it obviously is not an easy one. So, I really appreciate you --

>>Dr. Sadovnick: I'd just like to add one other thing, if possible, and that is the other thing I think that is very important for people who are planning a pregnancy, it's really important to discuss with them is very often people have this idealized idea that worry about the pregnancy, you worry about having the baby, and then -- but you focus on having this little baby. And what we have to realize is that parenting is not just having a newborn, it's a life commitment.

>>Kate Milliken: That's right.

>>Dr. Sadovnick: And one of the things that we also bring up with couples to discuss is how would you cope if there was a problem and your partner with MS could not participate in the typical ways that you would expect that parent to participate? Or there's always the unknown. You know, something can happen to the other partner. Other things besides MS can come into the family.

>>Kate Milliken: Right. And these are issues that you would have even without MS.

>>Dr. Sadovnick: And talk about sort of re-evaluating, though, your role as a parent and as a spouse in terms of relationships, talking about focusing more on what you can do at different stages rather than on everything what you cannot do. And I think that that's very important.

Tracey>> Dr. Sadovnick gives us lots to think about regarding family planning.

Tom>> What stood out for me, is how important it is to be pro-active, getting as much good information as possible, and making the decision that's right for your family.

Tracey>> We'd like to thank Kate and Dr. Sadovnick for this candid and insightful interview.

Tom>> And thank you for joining us. We hope to see you again soon.