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THU0136

TNF INHIBITORS IN PREGNANCY: STOP, REDUCE OR CONTINUE? – OBSERVATIONS FROM A PREGNANCY OUTPATIENT CLINIC

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Background: Women with active Rheumatoid Arthritis (RA) are more prone to relapses and complications during pregnancy. The potential risks of disease activation and treatment during gestation should be weighed in a shared decision prior to conception. An increasing number of women who wish to conceive are being treated with TNF inhibitors (TNFi). Some wish to discontinue or at least reduce therapy while pregnant and require information on opportunities and risks.

Objectives: To study the outcome of pregnancies in women with RA who either discontinued, reduced or maintained their TNFi treatment after conception.

Methods: Pregnancies from an outpatient pregnancy clinic were evaluated before conception, during each trimester and postpartum. Clinical characteristics, disease activity (DAS28-CRP), medication use and pregnancy outcome were analysed. A flare was defined as increase in clinical activity leading to intensified treatment (new treatment with prednisolone or increase in dosage ≥ 5 mg/day and/or treatment with intraarticular glucocorticoids and/or (re-)treatment with DMARDs/TNFi). All women received extensive counselling before pregnancy based on current knowledge and subsequently decided to continue or stop TNFi at conception. If they stayed on TNFi and were in remission, women received the suggestion to stretch the therapy intervals in a disease activity guided manner.

Results: After exclusion of one miscarriage, 56 completed pregnancies were enrolled and grouped according to their decision to stop (group 1) or continue (group 2) TNFi therapy during pregnancy. The latter were subdivided into those who could stretch the therapy intervals (group 2a) and those who could not (group 2b). Group 1 also contained seven women who received Tocilizumab or Rituximab until conception. Despite low disease activity (DAS ≤ 3.2) at conception in all groups, a higher flare rate during pregnancy and postpartum was observed after discontinuation of TNFi. In addition, a higher dose of oral prednisolone and more frequent intraarticular therapy was reported in group 1 (table 1). Postpartum, 38.9% restarted TNFi therapy. About half of the women who chose to stay on therapy during gestation were able to stretch the injection interval of their TNFi, which was either Adalimumab (every 3.0 weeks), Certolizumab (median every 4.0 [min 4.0, max 5.0] weeks) or Etanercept (median every 3.0 [min 2.0, max 6.0] weeks) (Table 2). Relapse rate as well as prednisolone consumption was comparable between group 2a and group 2b.

Abstract THU0136 –Table 1.

	TNFi exposure until conception (N=37)	Pregnancies with ongoing TNFi exposure (N=19)	
		Successful reduction (N=9)	No reduction possible (N=10)
Patient characteristics at conception			
Age (years), median (IQR)	32 (29-36)	32 (30-34)	36 (34.25-36.75)
Disease duration (months), median (IQR)	80 (48-204)	96 (84-276)	70 (54-109.5)
Seropositivity, n (%)	21 (56.8%)	5 (55.6%)	8 (80.0%)
DAS28, median (IQR)	2.8 (2.5-3.1)	2.9 (2.5-3.0)	2.7 (2.6-2.9)
Prednisolone (mg/day), (median, IQR)	5.0 (5.0-7.0)	5.0 (3.5-5.0)	5.0 (3.5-5.0)
Sulfasalazine, n (%)	2 (5.4%)	3 (33.3%)	-
HCQ, n (%)	1 (2.7%)	2 (22.2%)	3 (30.0%)
Pregnancy outcomes			
DAS28-CRP ≤ 3.2, n (%)			
1 st trimester	23 (62.2%)	8 (88.9%)	8 (80.0%)
2 nd trimester	16 (43.2%)	8 (88.9%)	8 (80.0%)
3 rd trimester	23 (62.2%)	8 (88.9%)	8 (80.0%)
3 months postpartum	18 (48.6%)	7 (77.8%)	7 (70.0%)
6 months postpartum	28 (76.5%)	7 (77.8%)	8 (80.0%)
Flare during pregnancy, n (%)	25 (67.6%)	-	2 (20.0%)
Flare postpartum, n (%)	19 (51.4%)	2 (22.2%)	2 (20.0%)
Preterm birth ¹ , n (%)	10 (27.0%)	1 (11.1%)	-
Low birth weight ² , n (%)	7 (19.0%)	-	-
Breastfeeding, n (%)	25 (67.6%)	9 (100.0%)	9 (90.0%)
Glucocorticoid use during pregnancy			
Prednisolone (mg/day), (median, IQR)			
1 st trimester	10.0 (5.0-10.0)	5.0 (5.0-5.75)	5.0 (3.5-5.0)
2 nd trimester	10.0 (10.0-15.0)	5.0 (5.0-5.75)	5.0 (3.5-7.0)
3 rd trimester	10.0 (9.5-13.0)	5.0 (5.0-5.0)	5.0 (3.5-7.0)
Of those taking prednisolone – taking ≥ 10mg/d, n (%)			
1 st trimester	15 (65.2%)	1 (16.7%)	2 (20.0%)
2 nd trimester	23 (85.2%)	-	2 (20.0%)
3 rd trimester	18 (75%)	-	1 (10.0%)
Intraarticular prednisolone therapy, n (%)	17 (45.9%)	-	1 (10.0%)

¹ delivery $\leq 36+6$ weeks of gestation, ² birth weight < 2500 g, HQ = hydroxychloroquine

Table 1

Abstract THU0136 –Table 2.

	No TNFi	Adalimumab	Certolizumab	Etanercept
Women on therapy at preconception				
All Groups, n (%)	7 (12.5%)	7 (12.5%)	18 (32.1%)	23 (41.1%)
Group 1, n (%)	7 (18.9%)	4 (10.8%)	8 (21.6%)	18 (48.6%)
Group 2a, n (%)	-	1 (11.1%)	5 (55.6%)	3 (33.3%)
Group 2b, n (%)	-	2 (20.0%)	6 (60.0%)	2 (20.0%)
Women of group 2a during pregnancy				
Therapy interval (weeks), median (min-max)	-	3.0	4.0 (4.0-5.0)	3.0 (2.0-6.0)

Conclusion: Women with RA who discontinue TNFi at conception face a higher risk of flares during pregnancy and often have an increased demand for steroids to control disease activity. When in remission under ongoing TNFi therapy during pregnancy, it seems possible and safe for women to reduce the frequency of injections in a disease activity guided manner. These real-world data will help to provide women with comprehensive advice on treatment options and risks regarding TNFi therapy at pregnancy counselling.

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THU0137

SUBCLINICAL THYROID DYSFUNCTION IS A CARDIOVASCULAR DISEASE RISK IN FEMALE RHEUMATOID ARTHRITIS

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Background: Rheumatoid arthritis (RA) is a multisystem autoimmune disease that proved to be associated with other autoimmune diseases particularly hypothyroidism. Subclinical hypothyroidism had been reported in RA. As well, RA patients are at double the risk of cardiovascular diseases (CVD). The increased risk of CVD is not fully explained by the