

Choices



Pregnancy and MS



Multiple sclerosis information

www.ms-uk.org

Welcome to this Choices leaflet about pregnancy and MS...

MS-UK believes in listening to the voices of people affected by multiple sclerosis (MS) to shape the information and support we provide. It is these people that bring us perspectives that no one else can give.

For every Choices booklet we produce, MS-UK consults the wider MS community to gather feedback and uses this to inform our content. All our Choices booklets are then reviewed by the MS-UK Virtual Insight Panel before they are published.

This Choices booklet has been designed with you in mind. We hope it will answer some of your questions and also provide some first-hand experience from those who have been in your position - people who can truly understand and empathise with your current thoughts and feelings.

Every time you find bold text with quotation marks like this, it is a quote directly from someone affected by multiple sclerosis

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Pregnancy and MS

Multiple sclerosis (MS) affects more women than men and is most commonly diagnosed between the ages of 20 and 40 – an age at which people may be thinking about starting a family or extending the family they already have.

The subject of pregnancy and MS is one that should ideally be discussed early on in your diagnosis. The conversation should be open and honest from the outset to make sure appropriate support is available. It is important people feel comfortable discussing family planning with their medical team. Becoming pregnant following a diagnosis of MS comes with more questions and considerations.

Diagnosis can be a difficult and confusing time. Coming to terms with what that means and the impact it may have on your future can be equally hard. The question of family planning may be a subject that comes up in your thoughts as well as whether having MS means you can no longer consider having a family. If the conversation is brought up early by neurologists and MS nurses, this will hopefully make patients feel more at ease, understanding that MS does not mean an end to this hugely important and momentous part of life.

More recent research is suggesting earlier treatment should be given to help reduce disease activity and therefore prevent long term disability (1). There are many questions around MS treatments and whether they can continue to be taken throughout conception, pregnancy and beyond. In 2019 a new consensus for pregnancy care in MS was published. The consensus was endorsed by the Association of British Neurologists (ABN) and

was put together by experienced health professionals including MS specialist nurses, neurologists, obstetricians, and midwives and included feedback from people with MS (2).

The consensus helps to support couples who are planning a pregnancy, information around medication management during pregnancy, birth-related guidance and advice for the postpartum period.

Questions that can arise following a diagnosis and when considering family planning may include

- Will MS affect my fertility and chances of conceiving?
- Can I take disease modifying therapies (DMTs) whilst trying to conceive and during pregnancy?
- Can DMTs affect a man's fertility?
- Does pregnancy improve MS or make it worse?
- Can I still choose to breastfeed?
- Am I more at risk of relapse?
- Will my children go on to develop MS?

In this booklet, we answer these questions and provide information to support the journeys of people looking to have children and what support is available.

Pre-pregnancy counselling

The UK consensus on pregnancy in MS states the importance of proactively discussing family planning with MS patients as early on in their diagnosis as appropriate. This is known as pre-pregnancy

counselling. This should be repeated regularly, at least annually, and is particularly important when discussing DMTs (2).

The management of pregnancy in MS has improved in recent years and is far more widely discussed, even with those patients where family planning is not currently on the horizon but should be something to consider for your potential childbearing future.

If you are of childbearing age or think you would like to start a family in the future, and are currently in the process of discussing DMTs, do not be surprised if your healthcare team have these kinds of discussions with you. It may bring about conversations earlier than expected, but it is important to discuss and carefully consider the impact of drug therapies. Some can stay in the body for a longer time than others and several DMTs are not advisable to continue when trying to conceive.

If your healthcare team have not had these types of conversations with you yet but the subject has been on your mind, do not be afraid to start the conversation yourself. Shared decision making between yourself and your healthcare team is important.

If you feel that you have the support from your partner and others, you can do it

The question lies in whether you start with a drug therapy that you may then need to change in the future if you decide to try for a family, or do you start with a treatment that is considered safe during conception and pregnancy, so you do not have to stop treatment and potentially expose yourself to a higher risk of relapse? This is an important and valuable conversation to have with your MS nurse and neurologist. This will also depend on how active your MS is, and the risk versus benefit of each drug therapy will also need to be discussed.

For men, there is unfortunately not much research on what DMTs are safe to be on when trying to conceive. This subject should be discussed with your MS nurse and neurologist to decide on the best course of action.

Pre-pregnancy counselling should be a continued conversation at routine appointments as life and situations can change. It is important for you to feel comfortable speaking to MS nurses and consultants about this subject, and the UK consensus should encourage healthcare teams to keep the conversation open.

Conception

There is no research to suggest that MS directly affects fertility, and it does not increase the risk of miscarriage. People with MS are considered to have the same ability to conceive as those without the condition (3).

However, the symptoms of MS (and some medications) may cause issues for both women and men, when trying to conceive, for example, sexual dysfunction, such as loss of libido, and specifically for men - erectile dysfunction and inability to achieve

orgasm. Other symptoms of MS can indirectly cause issues, such as fatigue, spasticity, bladder dysfunction and depression. If these symptoms are causing issues, referrals can be made to appropriate specialists (2).

If you require assistance in conceiving, research has shown that there may be an increased risk of relapse following the use of some IVF treatments. This should not deter you from seeking assisted conception, and IVF medical teams should liaise with MS teams before treatment is started so you are fully supported (4).

Disease Modifying Therapies (DMTs)

In previous years, the use of DMTs was deferred by many and not started until families were complete. However, this meant that many women were experiencing disease progression and delaying treatment was no longer seen to be advisable.

DMTs are now used much earlier on in diagnosis as research shows that treating MS earlier leads to better outcomes. Considerations will need to be made between yourself and your consultant when discussing what options are available.

Despite lack of research, the panel of medical professionals involved in the UK consensus states the interferons (Avonex, Betaferon, Extavia, Plegridy and Rebif) along with glatiramer acetate (Copaxone) are safe to continue at least up until conception. There is evidence to suggest that some have less risk than others. Copaxone is the only DMT that holds a licence for use in pregnancy (2).

The UK consensus also states natalizumab (Tysabri) can be considered as a treatment throughout pregnancy, with the

last dose to be at around 34 weeks gestation. It is important to consider the risks versus the benefits, as Tysabri can increase the risks of relapse and cause a rebound effect if stopped (2).

Alemtuzumab (Lemtrada) is an annual infusion, over five consecutive days for the first dose and then over three consecutive days a year later. The UK consensus says that you can try to conceive four months after the course. This may be an option for those with more active forms of the condition as it effectively gives you a much larger window of time.




I had to plan my pregnancy and finish the two-year course of Lemtrada. I also had to wait six months after the end of the course




The daily tablet fingolimod (Gilenya) requires a two-month washout period before trying to conceive and must be stopped immediately if pregnancy occurs whilst taking the drug.

You must wait six months following a course of cladribine (Mavenclad) before trying to conceive, and you must also wait 12 months following ocrelizumab (Ocrevus) treatment.

For teriflunomide (Aubagio), a two-year washout is required, or



Explore options with your neurologist as there may be compatible treatments or timelines that do not impact on treatments etc



an accelerated elimination, meaning specific drugs can be given to eliminate teriflunomide from the system over the course of 11 days. It is unlikely to be offered to those who may be planning a family in the future. It is highly contraindicated in pregnancy due to the potential increased risks of the baby having birth defects. This is the same for both men and women. If conception occurs whilst taking this drug, an accelerated elimination must take place as soon as possible.

Aubagio can be transferred in semen and a small study shows that it can be detected at low levels in the woman too. Men must continue to use barrier methods of contraception during treatment and for two years after stopping treatment.

DMTs should not suddenly be stopped when you become pregnant. It is important to contact your MS team as soon as possible for advice.

Vitamin D

There is much research suggesting people with MS should take high dose vitamin D (5). Vitamin D also plays an essential role in the reproductive function of both women and men. Therefore, it is

suggested that both women and men with MS who are trying to conceive take a vitamin D supplement and, for the woman, this should be continued throughout the pregnancy.

A study on vitamin D supplementation suggests that those with neurological conditions should consider taking a dose of between 1000-4000IU per day, before and during pregnancy (6). If you have any concerns about the dosage you should be taking, speak to your consultant or MS nurse for further information.

Having MS does not automatically mean a pregnancy should be considered high risk and most women are looked after by midwife-led care. However, for some people it can give peace of mind to know they are consultant-led. This can be dependent on the area you live.

Pregnancy management

The standard advice for all pregnant women remains the same for those with MS. For example, there is an emphasis on not smoking, the encouragement of pelvic floor exercises and taking all of the recommended supplements.

During pregnancy, it is advisable for your midwife to know who your MS nurse is and vice versa. This will help them work together to provide you with the best support and to monitor both the pregnancy and any potential impact on your MS.

It can be helpful for midwives to attend MS appointments, if possible, or vice versa. This can be reassuring should you require additional support during birth and beyond. We appreciate this may not always be possible, and if not, you can

always request to speak to a consultant.

Risk of relapse

The UK consensus states that pregnancy does not increase the risk of active MS. The majority of women remain well throughout pregnancy and may even see an improvement in symptoms.

However, symptoms such as fatigue can worsen, especially in early pregnancy, although this is likely because of pregnancy rather than MS. Poor sleep throughout pregnancy can also affect fatigue levels, which may impact other symptoms such as spasticity, balance, cognition, and others. Other symptoms such as bladder problems can worsen, particularly in the later stages due to the pressure of the uterus. Balance and mobility can also be affected in the later stages due to the weight of the baby.

Some women may experience relapses during pregnancy. These can be treated with steroids at any stage of the pregnancy. It is thought that the risk of relapse is still the same as that of women with MS who are not pregnant (2). If an MRI is required to assess a relapse, this is not contraindicated at any time throughout the pregnancy, although gadolinium contrast dye would need to be avoided (7).

Urinary tract infections (UTIs) are generally more common during pregnancy. MS is impacted when infection is present in the body, therefore UTIs should always be ruled out before suggestion of a relapse. UTIs can cause a temporary worsening of MS symptoms. It is advisable to seek medical advice at the earliest signs of UTI.

Research suggests that relapse rates increase during the first few months postpartum. The risk is likely to be higher in those who

were taking high-efficacy drugs, such as fingolimod (Gilenya) and natalizumab (Tysabri) pre-conception as their disease activity is higher to begin with (8).

Symptom management

For several symptom management treatments, the same guidelines will be applicable as they are to the general population. The UK consensus for pregnancy in MS plans to develop further, more specific guidelines in due course.

If you are taking symptom management medications it is helpful to discuss them with your medical team. They can help you decide if you still need them and if alternatives can be offered, if necessary. It is important to remain well, particularly during pregnancy and when caring for a new baby.

Not all treatments will need to be stopped and the risk versus benefit will be measured on an individual basis. If you have any concerns about any symptomatic treatment you may be taking, speak to your MS nurse. It may be that referral to an obstetrician is required if you are not already under consultant-led care.

With neuropathic pain, for example, many of the most used medications for MS are still safe for use in pregnancy. Amitriptyline is commonly used to treat pain in pregnancy as well as being used to treat neuropathic pain in MS. This is usually offered first. Pregabalin and gabapentin, both used for neuropathic pain in MS, are also used in pregnancy, although less commonly (9).

The medication most prescribed for spasticity is baclofen. It is important that it is not suddenly stopped when you find out you are pregnant as this can be dangerous to you and potentially

to your baby. Always speak to your medical team first. For many women, it may be considered necessary to continue baclofen during pregnancy. It will not mean extra monitoring is required throughout pregnancy, but you may be offered an earlier scan in the first trimester (10).

Bladder issues are a common symptom of MS. They are also common during pregnancy. Urinary incontinence can be caused by hormonal changes during pregnancy and due to the extra pressure of the baby on the bladder. It would generally not be treated with medication. Pelvic floor exercises are recommended for all women during pregnancy and referrals to physiotherapy can be offered if required.

However, if you have urinary incontinence because of MS, you may already be taking medication. The only treatment that has some research for use in pregnancy is oxybutynin, although the studies are only small. It is generally not recommended unless necessary. This comes back to the subject of risk versus benefit. If urinary incontinence is a major issue, conversations should be had with your medical team to discuss whether it may be best to stay on medication to try to manage the symptom as best as possible (11).

Fatigue is a difficult MS symptom to manage. Combine that with pregnancy-related fatigue and it can become even more tricky. The only approved medication for fatigue in MS is amantadine (12). However, guidance for the drug states to avoid it in pregnancy (13). According to the NICE guidelines, other suggested ways to help manage fatigue include mindfulness-based training, cognitive behavioural therapy, or fatigue management (12). A referral to any of these can be made by your GP and/or MS nurse. Gentle exercise can also be considered, such as yoga. Specific pregnancy yoga courses can be found in

most areas and the NHS website also has some prenatal and postnatal yoga videos to follow (14).

Disease Modifying Therapies (DMTs)

If you are taking a DMT you may find you will receive consultant-led care throughout your pregnancy. You will likely have had many conversations with your MS team about whether you should continue your treatment or not.

Glatiramer acetate (Copaxone) is the only DMT that is currently licenced for use during pregnancy, although there is no research to suggest that any of the injectable drugs pose any risk to the baby (2).

The UK consensus suggests that as relapse rate is likely to fall during pregnancy, there may be no need to continue taking injectable therapies. However, when restarted they can take several months to reach full efficacy again meaning they may not provide any reduction in relapse rate during those first few months (2). It is important to have discussions with your medical team about the pros and cons of continuing these kinds of treatments throughout pregnancy.

For women with higher levels of disease activity, natalizumab (Tysabri) is most likely to be used throughout pregnancy. If you are already taking it before conception, it can be more detrimental to stop treatment, as after 12 to 16 weeks you are at increased risk of the rebound effect, meaning a much higher risk of relapse. It is recommended the last dose be given around 34 weeks gestation and be restarted within 8-12 weeks of the last dose to reduce the chances of rebound. During pregnancy, rather than have treatment every four to six

weeks, infusions can be offered every eight weeks. This helps to reduce drug exposure during pregnancy but does not reduce the effectiveness of the drug. After your baby is born, treatment can return to monthly or six-weekly as soon as your MS team give the go-ahead (2).

Conversations should always be had with your neurologist as to what is best for you and your pregnancy. There is no one answer for all, and each person is looked at on a case-by-case basis, weighing up the risks versus benefits for you and your MS, as an individual.

Referrals

Pregnancy management should include referrals to other medical teams should they be required. If you have more significant MS symptoms, for example, spasticity or higher levels of weakness in the pelvis and/or legs, a referral should be placed to a neuro physiotherapist early on. A neuro physiotherapist can work with you and your obstetric team to put a plan in place for labour and delivery.

If you are finding bladder or bowel issues to be heightened because of pregnancy as well as in relation to your MS, a referral to a continence nurse may be helpful. You may need support from a physiotherapist as well to ensure you are doing your pelvic floor exercises correctly.

A referral to neuro rehabilitation maybe required postnatally if at any point you are experiencing difficulties that may impact your ability to care for baby or yourself. For example, you may need something to help with holding the baby safely if weakness in the arms is experienced. A baby carrier could be a simple solution.

Accessing this kind of support does not mean you are any less of a parent to your baby. In fact, by accessing support, it can help you to be the best parent you can be.

Labour and delivery

The UK consensus states that MS should not have any influence over the type of delivery you can opt for. MS should not limit birthing options and will very much depend on the individual on a case-by-case basis (2).

Your medical team should work with you to ensure you have choices and understand your options.

If it is possible for your MS nurse and midwife to meet when it is time to discuss birth plans and birth choices, pain relief can be explored and what may or may not be suitable. Make sure it is all documented in your record as this will assist your medical team on the day. It can also be helpful to meet with or at least speak to an anaesthetist. Do not be afraid to ask for a meeting if it gives you peace of mind and ensures your choices are supported by your medical team.

If spasticity or mobility are an issue this will be taken into consideration when planning the most appropriate obstetric care. Medication such as benzodiazepines (diazepam) can be offered during labour if spasticity or spasms are becoming troublesome and impacting birthing positions.

Water births can be an option if your birthing unit or hospital has them available. Bear in mind, that if you are normally troubled with heat intolerance, you may not want to stay in the water too long if you find the warmer water affects your fatigue levels or

other symptoms. Using the pool intermittently may be an option and it should not be discounted as one of your choices.

The use of epidural is not contraindicated for people with MS, and studies show it does not increase the risk of postpartum relapse or disease progression (15). Epidurals can be a useful way of helping to manage fatigue throughout labour. They can allow some respite from contractions and help to conserve energy in the earlier stages of labour.

MS does not mean you need to have a caesarean section (CS). A planned CS will be offered if there is a pregnancy-related medical reason, such as the baby is breech, or you have a low-lying placenta. As with epidurals, CS is considered safe for women with MS and does not impact postpartum relapse risk or disability progression (15). Recovery from CS can take longer so this should be considered.

If you feel you would prefer an elective CS as you may have concerns for delivery because of MS-related symptoms, such as fatigue, spasticity, and muscle weakness, speak to your obstetric and MS medical teams to discuss all your options. It is important the right plans are put in place to support all your needs.

Postpartum support

Having a new baby requires time to adapt, whether you have MS or not. The first few weeks can be tiring as you recover from the birth, adjust to less sleep and all the other demands a new baby brings. It is important to make sure you have enough support during this time.

It may be a good idea to contact friends and family before the

baby arrives to discuss how they can help, should you need it. Finding out who your health visitor is and what your local support options are can be reassuring. Your midwife and MS team should discuss support plans with you in advance of the birth. Whatever you can do to prepare for potential additional support can make life easier should you require it.

If you do not have family or friends close by there are organisations which can provide practical support such as Home-Start, a local community network of volunteers who are trained in offering expert support to new families who need it due to physical health problems, post-natal depression, and many other reasons. They provide compassionate help and support, without judgement. You can find your local Home-Start support by searching via postcode on their website www.home-start.org.uk.

Another option may be to find a doula for support. Doulas can provide support throughout pregnancy, birth and the postpartum period. They can provide information and advocacy and offer practical and emotional support to the whole family. They do not carry out a set of specific tasks, they will do whatever is needed, within reason. For example, they may help around the house, help with older siblings, or look after the baby whilst mum (and partner) sleeps. They can prepare meals, walk the dog, and even stay overnight to help new parents get more sleep.

Postpartum doulas can work with families in the first few months following birth. They may only be required for a few weeks, but this can be much longer depending on the needs of the family.

Doulas are a chargeable service, however, Doula UK offers the Doula Access Fund for those who may be 'experiencing financial hardship'. They have an eligibility criteria which includes those with a disability. A referral to the access fund can be made by

a health professional or social worker. You can find a doula, by searching via postcode on their website. www.doula.org.uk

Your health visiting team will be able to let you know of other support available. Many areas will have a family wellbeing service or something similarly titled.

Postpartum relapse

The risk of relapse following the birth of your baby increases for the first three months (16). It is suggested that if you had a higher level of disease activity and relapse rate before pregnancy, this would lead to an increase of relapse postpartum. If you had higher levels of disease activity before pregnancy, you should be closely monitored by your neurology and obstetric teams.

It is important to have conversations with your neurologist to discuss when you need to go back on a DMT to help reduce the chances of relapse. This is very individual and even more reason to have discussed options during pregnancy, so you are prepared and have a plan in place once the baby is born.

Studies show that exclusive breastfeeding can have a positive impact on the reduction of postpartum relapse in MS (17). It is thought that breastfeeding can be protective against relapses, however, more studies are required to support this.

Breastfeeding

There is no reason why a woman with MS cannot breastfeed. In other words, MS does not prevent breastfeeding.

However, this will very much depend on how your MS is affecting

you. If you have highly active MS and you are at increased risk of postpartum relapse, your neurologist may suggest getting back on treatment as soon as possible. Your care is of paramount importance. This may mean you cannot breastfeed, depending on which DMT you need to go on. Once again, a risk versus benefit ratio must be discussed.

Colostrum harvesting

If you wish to breastfeed but restarting treatment postpartum has been advised which is preventing you from doing so, perhaps you may wish to look into antenatal colostrum harvesting. This can be beneficial for those who require medications which are incompatible with breastfeeding right after birth (18).

Antenatal colostrum harvesting involves hand expressing milk (colostrum) in the last couple of weeks of pregnancy only. It mustn't be started too early. Your midwife can advise on the best time to start. Always be guided by your obstetric team and discuss with them if you would like to harvest your colostrum.

Colostrum is produced by the female body before the actual milk starts once the baby is born. Only very small amounts of colostrum will be produced antenatally, but every droplet will be beneficial to your baby. Your midwife will be able to help you with this and can provide you with small sterile syringes to store the milk in. These can be stored in the fridge or freezer and then given to your baby directly to feed once they are born (18). For more information, please discuss with your midwife, or contact your local La Leche League breastfeeding support group.

If you wish to breastfeed, discuss this with your MS team during pregnancy. It might be that a plan needs to be put in place

regarding any medication you may need once baby arrives. For example, there are some symptom management drugs that cannot be taken whilst breastfeeding, so alternatives can be investigated.

Expressing

The UK consensus suggests that women who are breastfeeding should consider expressing breast milk and storing it in the freezer. This can be helpful in cases of relapse, or times, when severe fatigue means breastfeeding may not be possible and therefore feeding can be shared with others (2).

Steroids

If you experience a postpartum relapse whilst breastfeeding and steroids are needed, such as methylprednisolone, the UK consensus states there is no need to stop breastfeeding (2). The treatment does cross into the breast milk, but only at a very low level.

Disease Modifying Therapies (DMTs)

The UK consensus says that some DMTs can be taken whilst breastfeeding. It states that any potential risks to the baby from being on the treatment are outweighed by the benefits of breastfeeding. These include all the injectable drugs, beta interferon and glatiramer acetate (Avonex, Betaferon, Extavia, Plegridy, Rebif and Copaxone). Therefore, it is to be encouraged for women to breastfeed, if they wish, whilst on these drugs (2).

All other DMTs are contraindicated whilst breastfeeding, except for natalizumab (Tysabri). The drug does transfer into breast milk and the amount of which does increase with time. However,

the UK consensus believes that despite this transfer, the drug is not absorbed by the baby and therefore breastfeeding can be encouraged (2).

Vitamin D

Vitamin D supplementation should be continued postpartum and given to the baby, in line with standard guidelines (19).

Studies show that if you take between 400IU to 2,000IU, and exclusively breastfeed, this does not provide enough for the baby as well as the mother. Baby will need to be supplemented according to pediatric nutritional guidelines, which is 400IU (10mcg) (20).

If you take a higher dose, such as 4,000IU, it is possible that milk levels will provide enough vitamin D to meet the guidelines for the baby. Therefore, you would not need to give them their own supplement, but this will depend on your own vitamin D levels (20). It would be advisable to have your levels checked postpartum to ensure you are taking enough vitamin D to supplement both yourself and your baby. However, if you are deficient and require a higher dose, you will need to make sure you are not taking too much so that it can harm your baby. Please always discuss this with your healthcare professionals.

Postpartum depression

It is important that postpartum depression (also known as postnatal depression) is discussed with new parents, as research shows there is an increased risk in both mothers and fathers with MS (21). Your MS team should be aware of this and your midwife, health visitor and GP should all provide

appropriate support. They should ensure you know the signs and symptoms and know how to access help and support should you require any (2).

Risk of developing MS

MS is not a hereditary condition. Therefore, it is not directly passed from parent to child.

Around 1 in 500 people in the general population have MS in the UK (22).

It is thought that there is a genetic susceptibility to the condition and that MS develops as a result of environmental influences on those who are genetically susceptible (23).

As family members share some of the same genes, there is a greater risk of developing MS if it is in your family. However, many people have MS and do not have any family connections. Studies suggest that the more closely related the higher the risk. For example, there is a greater risk in siblings, especially identical twins, than there is from parent to child (24).

Tips from other parents

- I would say that MS won't and can't stop you from having a child, but you may need help from others
- Learn to rest and take time out when your baby is doing the same

- Take help whenever offered, go easy on yourself, avoid social media comparisons and be your own best friend
- Be easy on yourself, get as much help as you need, and listen to your body
- Gather information before making any decisions, inform yourself and openly discuss things with your medical team
- Don't push yourself too hard once baby is here – take care of yourself, it is important to look after you!
- Although we all know the benefits of breastfeeding don't worry if you find it difficult or can't. I had to compromise and express my milk so that my husband could help me and I could get some rest
- Having MS can class you as high risk, but that doesn't mean you can't have a natural birth. Discuss it with your midwife and MS nurse and form a birth plan to suit you

Further information

Disability, Pregnancy & Parenthood

Practical information and peer support for disabled parents

www.disabledparent.org.uk

Doula UK Support for the whole family, during pregnancy, birth and postpartum. www.doula.org.uk

Home-Start A community network of trained volunteers to support families with young children. www.home-start.org.uk

La Leche League GB

Breastfeeding support. www.laleche.org.uk

MuMS Online support for mums with MS

www.facebook.com/groups/351614711568755

MS Pregnancy Register A study helping the MS register to understand what it is like to be pregnant with MS. The findings could help to influence how pregnant women with MS are treated in the UK www.ukmsregister.org/pregnancy

MS Register A UK study to help increase understanding of what it is like to live with MS. www.ukmsregister.org

Remap Custom made equipment to help disabled people live more independent lives. www.remap.org.uk

About MS-UK

MS-UK is a national charity formed in 1993 supporting anyone affected by multiple sclerosis. Our hope for the future is a world where people affected by MS live healthier and happier lives.

MS-UK has always been at the forefront of promoting choice, of providing people with all the information and support they need to live life as they wish to with multiple sclerosis, whether that be through drugs, complementary therapies, lifestyle changes, a mixture of these or none at all.

We will always respect people's rights to make informed decisions for themselves.

The MS-UK Helpline

We believe that nobody should face multiple sclerosis alone and our helpline staff are here to support you every step of the way.

Our service is informed by the lived experience of real people living with MS, so we can discuss any treatments and lifestyle choices that are of benefit, whether they are clinically evidenced or not.



New Pathways

Our bi-monthly magazine, New Pathways, is full of the latest MS news regarding trials, drug development and research as well as competitions, special offers and product reviews. The magazine connects you to thousands of other people living with MS across the country.

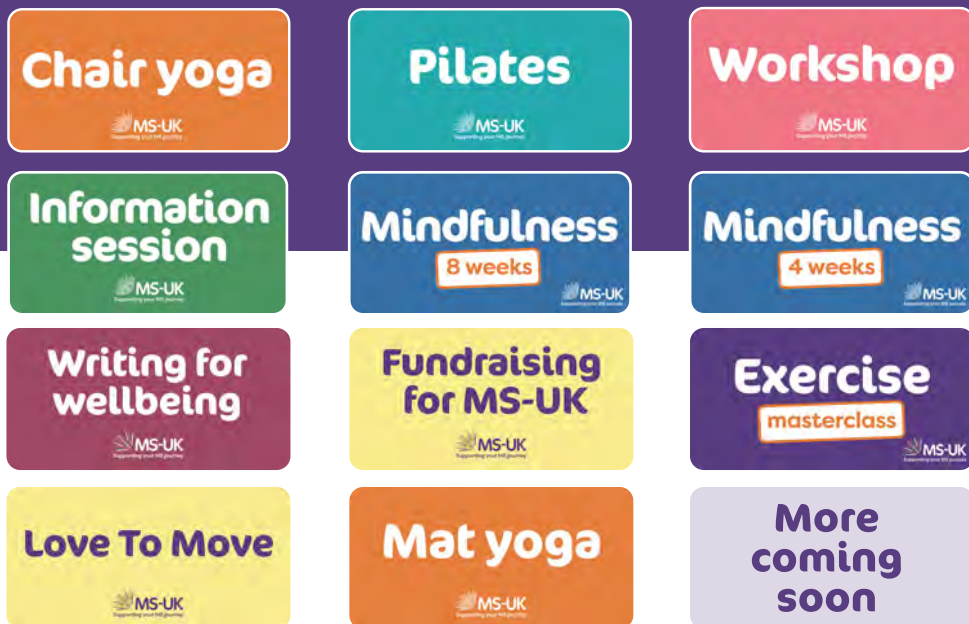
Available in print, audio version, large print and digitally.

About MS-UK

Peer Support Service

Our Peer Support Service enables people to connect with others in a safe space and share experiences on topics of interest. Our Peer Pods take place regularly and are all volunteer led. Please visit the website to find out more www.ms-uk.org/peer-support-service or email peersupport@ms-uk.org.





Online activities

MS-UK offers a variety of online activities to stay active and connected for those affected by MS and manage their symptoms to live happier and healthier lives. Activities include exercise sessions, mindfulness courses, chair yoga classes, information sessions and workshops. Visit our website to explore and find out more.

E-learning

Do you work with or support someone living with MS and want to increase your understanding and knowledge of this long-term health condition? Professionals at MS-UK have created accredited Learning courses that can help you do this. Visit <https://ms-uk.org/excellence-ms/> to find out more.

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MS-UK
D3 Knowledge Gateway,
Nesfield Road,
Colchester,
Essex, CO4 3ZL

www.ms-uk.org

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MS-UK Helpline
0800 783 0518
info@ms-uk.org



Registered Company Name

Multiple Sclerosis-UK Limited, trading as MS-UK

Company Number 2842023

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VAT Number 632 2812 64

Registered Office D3 Knowledge Gateway,
Nesfield Road, Colchester, Essex, CO4 3ZL



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