

# Choices



## Pregnancy and MS



Multiple sclerosis information

# Welcome to this Choices booklet about pregnancy and MS...

MS-UK listens 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 of 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**

# Contents

|  |           |
|--|-----------|
| <b>Pregnancy and MS</b> _____                    | <b>4</b>  |
| <b>Pre-pregnancy counselling</b> _____           | <b>6</b>  |
| <b>Disease modifying therapies (DMTs)</b> _____  | <b>7</b>  |
| <b>Conception</b> _____                          | <b>13</b> |
| <b>Pregnancy management</b> _____                | <b>15</b> |
| <b>Postpartum support</b> _____                  | <b>21</b> |
| <b>Risk of your children developing MS</b> _____ | <b>27</b> |
| <b>Tips from other parents</b> _____             | <b>28</b> |
| <b>Further information</b> _____                 | <b>29</b> |
| <b>About MS-UK</b> _____                         | <b>32</b> |
| <b>Sources</b> _____                             | <b>36</b> |

# Pregnancy and MS

Multiple sclerosis (MS) affects more women than men and is most commonly diagnosed between the ages of 20 and 40. It is during this period of life that many people are 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 to feel comfortable discussing family planning with your medical team, as becoming pregnant following a diagnosis of MS comes with many questions and considerations.

Life after an MS 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. For example, does having MS mean you can no longer consider starting a family or having more children? If the conversation with neurologists and MS nurses is started early, this will hopefully make you feel more at ease. Not least it can help with understanding that MS does not mean an end to, what is for many people, a hugely important and momentous part of life.

Research by MS neurological experts suggests that treatment should be given as early as possible to help reduce disease activity and long-term disability (1). However, there are many questions around MS treatments and whether they can continue to be taken throughout conception, pregnancy and beyond.

In 2019 a new UK consensus for pregnancy care in MS was published. It 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, inform around medication management during pregnancy, offer birth-related guidance and provide 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 while providing information to support the journeys of people with MS who are looking to have children.

## Pre-pregnancy counselling

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.

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

If you are of childbearing age 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 you feel that you have the support from your partner and others, you can do it**

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

The initial question lies in whether you start with a DMT 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? This is an important and valuable conversation to have with your MS nurse and neurologist. Considerations may include how active your MS is and the risk versus benefit of each drug therapy.

For men, there is unfortunately very little 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.

## **Disease modifying therapies (DMTs)**

As we have mentioned, for people with MS who are taking a DMT, it is important to be aware of the choices available when it comes to family planning. This should form part of the pre-pregnancy counselling discussion. Below we take a look at potential DMT issues concerning conception, during pregnancy and postpartum.

### **During conception**

In previous years, the use of DMTs by many women who were planning to have children was deferred and not started until their families were complete. However, this meant that some women were experiencing the progression of their condition and delaying

treatment was no longer seen to be advisable. As we touched on earlier in this booklet, DMTs are now used much sooner post-diagnosis as research shows that this leads to better outcomes in the longer term.

Considerations will need to be made between you and your consultant to identify available and appropriate treatment options. Below we look at UK consensus guidance when taking certain DMTs whilst trying to conceive.

## **Beta interferon and glatiramer acetate**

While more research is needed regarding the use of DMTs for women who are looking to conceive, the panel of medical professionals involved in the UK consensus states that the injectable beta interferon DMTs (Avonex, Plegridy and Rebif) along with glatiramer acetate (Copaxone and Brabio) are safe to use during periods of conception and beyond.

## **Natalizumab**

The UK consensus also states natalizumab (Tysabri) can be considered as a treatment during conception and throughout pregnancy. It is important to consider the risks versus the benefits, as stopping natalizumab treatment can increase the chances of relapse and cause a rebound effect (2). Since the consensus was published a biosimilar version of natalizumab is now available, under the brand name of Tyruko. The approach to take should mirror that of Tysabri, however speak to your MS team for their confirmation.

## **Alemtuzumab**

Alemtuzumab (Lemtrada) is administered via an annual infusion, undertaken over five consecutive days for the first dose and then

over three consecutive days one year later. The UK consensus says that you can try to conceive four months after a course of treatment. 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 to conceive.

## **Fingolimod**

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.

## **Cladribine**

The UK consensus panel advises that you must wait six months following a course of cladribine (Mavenclad) before trying to conceive. Mavenclad is taken as a tablet via two courses, one year apart.

## **Ocrelizumab**

It is advised that women accessing ocrelizumab (Ocrevus) treatment should wait at least 12 months from the date of treatment before attempting to conceive. This DMT is now available via infusion or injection, both of which are administered every six months.

## **Teriflunomide**

For the daily tablet teriflunomide (Aubagio) a two-year washout period is required for women who wish to conceive or alternatively undergo an accelerated elimination. This involves specific drugs which are given to eliminate the drug from the system over the course of 11 days. Teriflunomide 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. If conception occurs whilst taking this drug, an accelerated elimination must take place as soon as possible.

With men, teriflunomide can reduce sperm counts and male-to-female transfer of sperm may result in low levels of teriflunomide being present in the female.

It follows that methods of contraception must be used while being treated with teriflunomide and for two years after treatment cessation.

## During pregnancy

DMTs should not suddenly be stopped when you become pregnant, and you should receive consultant-led care through your full-term.

Ideally you should speak to your MS team prior to conceiving so that you are suitably prepared in advance. However, like many things in life, when it comes to pregnancy, advanced planning may not always be possible. Therefore, it is important to contact your MS team as soon as possible after your pregnancy is confirmed for advice about the most appropriate approach.

The 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 a risk (2).

The UK consensus suggests that as relapse rates are 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 during pregnancy. If you are already taking natalizumab before conception it can be more detrimental to stop treatment, as after 12 to 16 weeks from the date treatment ceases you are at increased risk of the rebound effect, hence at a higher risk of relapse. It is recommended that the last dose be given around 34 weeks gestation and be restarted within 8-12 weeks of that dose to reduce the chances of rebound. As stated earlier in this booklet, a biosimilar version of natalizumab is now available under the brand name Tyruko. The approach to take during pregnancy should mirror that of Tysabri, however speak to your MS team for their confirmation.

During pregnancy, rather than have natalizumab 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 its effectiveness. After your baby is born, treatment can return to monthly or six-weekly as soon as your MS team give the go-ahead (2).

## Postpartum

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, the amount of which increases over 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).



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



## **Further DMT considerations**

Since the 2019 UK consensus was published, the authors have updated their evidence base to suggest that anti-CD20 therapies ocrelizumab (Ocrevus) and ofatumumab (Kesimpta) may be considered safe to use by women looking to conceive, potentially during pregnancy and whilst breastfeeding. However more research is required to determine longer term impacts (3).

Conversations should always be had with your neurologist as to what DMT approach is best for you before, during and after 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.

### **More information**

Our Choices Disease modifying therapies booklet provides further reading about the different DMTs that are used to treat MS. Visit [www.ms-uk.org/disease-modifying-therapies-choices-booklet](http://www.ms-uk.org/disease-modifying-therapies-choices-booklet)

Aside from DMTs, there are many other things to be aware of and consider during conception, pregnancy and postpartum.

## **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 (4).

However, the symptoms of MS, and the effects of 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 have an indirect impact, such as fatigue, spasticity, bladder dysfunction and depression. If these are causing problems with conception, 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 specialist teams before treatment is started, so that you are fully supported (5).

## Vitamin D

There is much research suggesting people with MS should take high dose vitamin D (6). 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 (7). If you have any concerns about the dosage you should be taking, speak to your consultant or MS nurse for further information.

**Go for it! Make sure you take vitamin supplements for a few months before and during pregnancy. Don't let MS put you off starting a family**

### More information

Our Choices Vitamin D booklet takes a deeper dive into the link between this nutrient and MS, including the latest

research. Visit, [www.ms-uk.org/vitamin-d-and-multiple-sclerosis-choices-booklet](http://www.ms-uk.org/vitamin-d-and-multiple-sclerosis-choices-booklet)

## Pregnancy management

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

The general advice for all pregnant women, including those with MS, remains the same. For example, there is an emphasis on not smoking, the encouragement of doing pelvic floor exercises and taking all of the recommended supplements. The latter includes folic acid, vitamins D and C and iron (8).

During pregnancy, it is advisable for your midwife to know who your MS nurse is and vice versa. This will help them to 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 also impact symptoms such as spasticity, balance and cognition. Other symptoms such as bladder problems can worsen, particularly in the later stages due to the pressure placed on it by the uterus. Balance and mobility can also be affected in these later stages due to the weight of the baby.

Some women may experience relapses during pregnancy and these can be treated with steroids if desired (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 (9).

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 a UTI.

## **Symptom management**

Most symptom management treatments for women with MS during pregnancy will follow the same guidelines as those applied to the general population. The UK consensus for pregnancy in MS plans to develop these further, introducing 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 to decide if you still need them and if more suitable alternatives can be offered. It is important to remain well, particularly during pregnancy and when caring for a new baby, and this includes the monitoring of symptom specific treatment strategies.

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.

## Pain

For neuropathic pain most of the commonly used medications are still safe for women during pregnancy. Amitriptyline is an option 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 (10).

## Spasticity

The medication most prescribed for spasticity management 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 taking 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 (11).

## Bladder

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 (12). 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, or try to manage the symptom without it, as best as possible.

## Fatigue

Fatigue is a common MS symptom which can be difficult to manage. Combine that with pregnancy-related fatigue and management can become even more tricky. The only approved medication for treating fatigue in MS is amantadine (13). However, guidance for the drug states to avoid use during pregnancy (14).

According to the NICE guidelines, other suggested ways to help manage fatigue include mindfulness-based training, cognitive behavioural therapy and fatigue management courses (13). 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 (15).

### **More information**

Our Choices range of booklets include many symptom-specific booklets, including ones which provide focused information about addressing spasticity, pain, bladder problems and fatigue management. Visit, [www.ms-uk.org/multiple-sclerosis-choices-booklets](http://www.ms-uk.org/multiple-sclerosis-choices-booklets)

### **Referrals**

Pregnancy management should include referrals to other medical teams as and when they are required.

If you have more significant MS symptoms, for example, are experiencing increased spasticity or higher levels of weakness in the pelvis and/or legs, a referral should be placed to a neuro physiotherapist as soon as possible. They can work with you and your obstetric team to put a bespoke 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.

Alternatively, you may need support from a physiotherapist, for example to ensure that you are doing your pelvic floor exercises correctly.

Whatever additional support you may need, referrals can help you and your baby to stay safe throughout pregnancy and beyond.

## Labour and delivery

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

Your medical team should work with you to ensure that 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 choices. This may include pain relief which can be explored and a suitable approach agreed. Make sure your agreed approach is 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 for example) 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 (16). 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 (16). 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 of your options. It is important that the right plans are put into place to support all of 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 others 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.



**Some family and friends helped by bringing food**



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.

Another option may be to find a doula for support. Doulas can assist you throughout pregnancy, birth and the postpartum period. They can provide information and advocacy, plus offer practical and emotional support to the whole family. They do not carry out a set of specific tasks and will do whatever is needed, within reason. For example, they may offer support around the house, help with older

siblings, or look after the baby whilst mum and partner get a well-earned rest.

Postpartum doulas can work with families during 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 disadvantage and financial hardship. They have an eligibility criterion which takes into account disability. A referral to the access fund can be made by a health professional or social worker.

We referred to the importance of referrals during pregnancy, and this remains the case postpartum. For example, a referral to neuro rehabilitation may be required postnatally if at any point you are experiencing difficulties that may impact your ability to care for baby or yourself. This may include support to help with holding the baby safely if weakness in the arms is experienced. A baby carrier could be a simple solution.

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 (17). It is also suggested that if you had a higher level of disease activity and relapse rate before pregnancy, this may lead to an increase in relapses

postpartum. It follows that this risk is likely to be higher in those who were taking high efficacy drugs pre-conception as their disease activity is elevated to begin with (18). Ideally every woman affected by MS should be closely monitored by their neurology and obstetric teams during the early postpartum period.

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.

## 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.

Studies show that exclusive breastfeeding can have a positive impact on the reduction of postpartum relapse in MS (19). A systematic review of studies looking at the protective role of breastfeeding for women with MS concluded that exclusively breastfeeding until solids are needed could have a protective effect for at least one year postpartum (20). However, more research is required to underpin these findings.

If breastfeeding is important to you, 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.

## Colostrum harvesting

If you wish to breastfeed but restarting treatment postpartum has been advised and is preventing you from doing so, perhaps you may wish to investigate the potential benefits of antenatal colostrum harvesting. This can be beneficial for those who require medications which are incompatible with breastfeeding right after birth (21).

The process involves hand expressing milk which your body produces, known as colostrum, in the last couple of weeks of pregnancy only. It must not be started too early. Your midwife can advise on the best time to start. Always be guided by your obstetric team and speak 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 kept in the fridge or freezer and then given to your baby directly to feed once they are born (21). For more information, please discuss with your midwife, or contact your local La Leche League breastfeeding support group.

## 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 such as methylprednisolone are needed, 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.

## Vitamin D

Vitamin D supplementation should be continued postpartum and given to the baby, in line with standard guidelines (22).

Studies show that if you take between 400IU to 2,000IU per day and exclusively breastfeed, this does not provide enough for the baby as well as the mother. It is suggested that your baby will need to be supplemented according to paediatric nutritional guidelines, which is 400IU (10mcg) daily (23).

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 (23).

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 (24). Your MS team should be aware of this and your midwife, health visitor and GP should all provide appropriate support. They should ensure you are aware of the signs and symptoms and know how to access support should this be needed (2).

### More information

Home-Start – Your local Home-Start support can be found on their website via their search facility. [www.home-start.org.uk](http://www.home-start.org.uk)

Doula UK – You can find a local doula by searching via postcode on their website. [www.doula.org.uk](http://www.doula.org.uk)

La Leche League GB – Provides breastfeeding support and access to local groups, which can be found on their website. [www.laleche.org.uk](http://www.laleche.org.uk)

Remap – This is a charity that makes custom made equipment to help disabled people live more independent lives. [www.remap.org.uk](http://www.remap.org.uk)

## Risk of your children developing MS

It is estimated that there are 150,000\* people in the UK diagnosed with MS, with around 135 people diagnosed each week (25).

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

However, 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 susceptible (26).

As family members share some of the same genes, there is a greater risk of developing MS if it is in your family. Studies suggest that the more closely related you are to someone with an MS diagnosis, the higher the risk. For example, the chance of a child with a parent who has MS developing the condition is approximately two per cent over their lifetime (27).

### **More information**

Our Choices What is MS? booklet delves deeper into the potential causes of MS, including further information about genetic susceptibility. Visit, [www.ms-uk.org/what-is-multiple-sclerosis-choices-booklet](http://www.ms-uk.org/what-is-multiple-sclerosis-choices-booklet)

## **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

**Enabled2Parent** – Is a UK based charity which offers a range of support for disabled parents, including planning for a baby, support during pregnancy and postpartum.

<https://enabled2parent.org/index.html>

**MuMS UK** – This is an online support group open to mums with MS. [www.facebook.com/groups/351614711568755](http://www.facebook.com/groups/351614711568755)

**MS Register** – This a UK study to help increase understanding of what it is like to live with MS by capturing real world data from members of the MS community. [www.ukmsregister.org](http://www.ukmsregister.org)

**MS Pregnancy Register** – A UK-based study which helps the MS register to understand what it is like to be pregnant with MS. The findings could influence how pregnant women with MS are treated in the UK. [www.ukmsregister.org/pregnancy](http://www.ukmsregister.org/pregnancy)





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Supporting your MS journey

# Give a gift that lasts all year

Make a regular donation to MS-UK  
and get your **free MS-UK pin badge**.

[www.ms-uk.org/regular-donations](http://www.ms-uk.org/regular-donations)



# About MS-UK

MS-UK is a national charity 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.

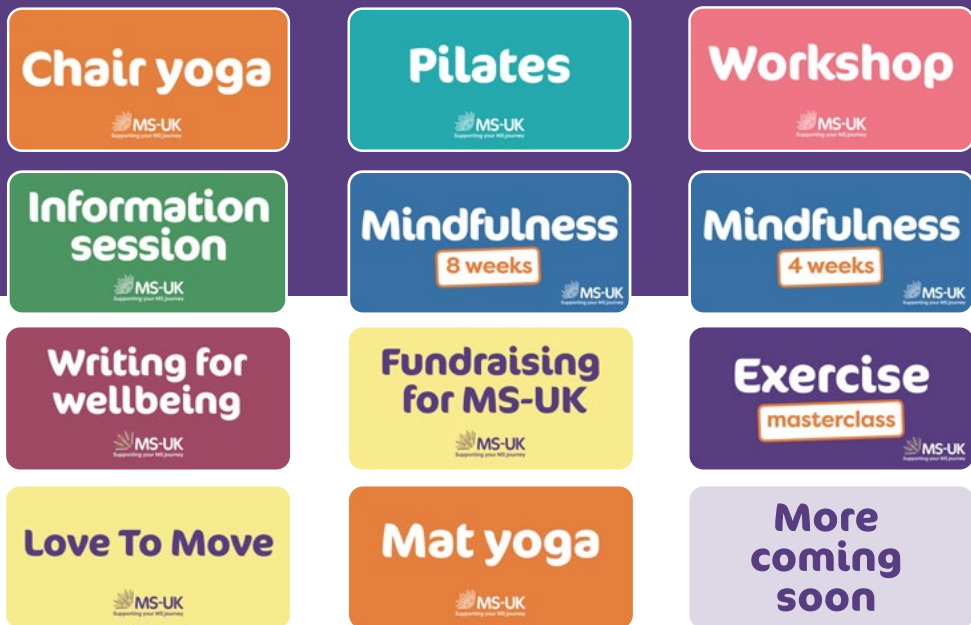
Visit [ms-uk.org/new-pathways-magazine](https://www.ms-uk.org/new-pathways-magazine)

# 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 [ms-uk.org/peer-support-service](https://www.ms-uk.org/peer-support-service) or email [peersupport@ms-uk.org](mailto:peersupport@ms-uk.org).





## MS-UK's online activities

MS-UK offers a variety of online activities for those affected by MS to stay active, connected with others and to manage their symptoms to live happier and healthier lives. Activities include exercise sessions, mindfulness courses, chair yoga classes, information sessions and workshops. To get involved, please go to [www.ms-uk.org](http://www.ms-uk.org) or email [register@ms-uk.org](mailto:register@ms-uk.org).

## MS-UK eLearning

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 an accredited eLearning course that can help you do this. Visit [www.ms-uk.org/ms-awareness-e-learning](http://www.ms-uk.org/ms-awareness-e-learning) to find out more.

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