FINDING HOPE WITH OMS

Webinar series

Women's Health and Living Well with MS

Wednesday, October 20th at 8pm BST

Hosted by



Professor Helen Rees-Leahy





Welcome

Women's Health and Living Well with MS

- Welcome and introductions
- Why are women more likely to have MS?
- Women's health: attitudes and experiences
- MS and women's fertility: pregnancy, breastfeeding, menopause
- Women Living well with OMS
- Q&A



Why are women more likely to develop MS?

- Approximately 3 million people with MS worldwide
 - Overall incidence 1/1000, but varies considerably by country
 - Most common disabling neurological disorder of young adults
 - Most diagnosed in their 20s and 30s
- MS is three times more common in females Why?!
 - Hormones?
 - Similar incidence pre-puberty, oestrogen related
 - Genetics?
 - S1PR2 gene, controlling blood brain barrier permeability
 - Environment?
 - Female obesity rates, vitamin D

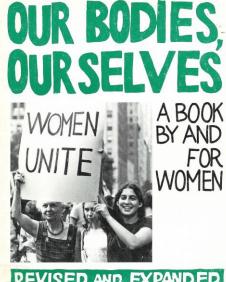


Women's Health: Attitudes and Experiences

- Do we experience MS differently?
- Is our experience of healthcare different?
- #MSexism?
- Outcomes for women with MS?



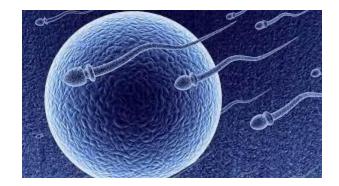
Our Bodies, Ourselves published 1970 Jean Martin Charcot first described MS in 1868



HE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE

MS and Women's Health - Fertility:

- MS has no direct effect on female fertility
 - no need to change contraceptive
- **BUT** it can cause sexual dysfunction:
 - loss of libido
 - vaginal dryness
 - inability to achieve orgasm
 - bladder symptoms
 - fatigue
 - spasticity
 - depression
- No evidence for increased risk of miscarriage
- In IVF: SHORT (antagonist) protocol is preferred





MS and Women's Health - Pregnancy and Breastfeeding:

Pre-pregnancy counselling

- No effect of MS on fertility
- Don't routinely defer DMT
- Consider effect of exposure in males
- Pregnancy does not affect long-term disability outcomes
- Relapse risk during and after pregnancy

Obstetric management and delivery

- Not automatically a high-risk pregnancy
- Can receive methylprednisolone for relapse management
- Vitamin D
- MS should not influence delivery or analgesia outside disability considerations
- Epidural or diazepam for troublesome spasticity during labour

Post-partum considerations

- Support breastfeeding alongside treatment considerations
- Methylprednisolone not contraindicated in breastfeeding
- Increased risk of post-natal depression



Symptomatic treatments

- Varying data available
- Not all need to be stopped
- Risk/benefit balance on an individual basis



Disease modifying drugs (DMDs)

- More details in figure 2
- Do not interact with OCP
- Some require washout pre-conception
- Consider additional obstetric monitoring

UK Consensus on Pregnancy in Multiple Sclerosis: ABN Guidelines, 2019

MS and Women's Health - Pregnancy and DMDs:

First line therapies		Highly active therapies	Induction therapies
First line injectables	First line oral		
Copaxone/IFN-B preparations • Safe to continue until conception • No evidence of harm to fetus • If stopped, 3/12 to reach full efficacy post-partum • Benefits of breastfeeding on treatment outweigh risks	 Teriflunomide Teratogenic animal studies Potential exposure in females via transfer in seminal fluid 2 years washout or accelerated elimination Unplanned pregnancies: accelerated elimination and high risk Breastfeeding contraindicated Dimethyl Fumarate Consider effect of GI upset on OCP Limited data in pregnancy Breastfeeding contraindicated 	 Natalizumab High risk of relapse/ rebound if stopped No specific pattern of birth defects Consider treating in pregnancy; last dose c34/40 Low absorption in breastfeeding Fingolimod Limited data 2/12 washout Unplanned pregnancy: immediately stop; high risk Breastfeeding contraindicated 	 Alemtuzumab Can try to conceive 4/12 after course of alemtuzumab Monitor for autoimmune disease during pregnancy Irradiated blood products Do not give when breastfeeding Cladribine Teratogenic in M and F Avoid pregnancy for 6/12 after treatment course Breastfeeding contraindicated
UK Consensus on Pregnancy in Multiple Scl	erosis: ABN Guidelines, 2019	Ocrelizumab • Avoid pregnancy for 12/12 • Unplanned pregnancy: immediately stop; high risk • Breastfeeding contraindicated	BB Ę

MS and Women's Health - Menopause:

- Average age is 51: "absence of periods for > 1 year"
 - Symptoms last ~4 years, (10 years in 10%)
- Significant cross-over of MS and menopausal symptoms
 - Sleep, mood, cognition, bladder function
- Conflicting evidence for reduced RR and MS disability progression "Inflamm-aging", oestrogen deficiency

Notices / Blog
Does menopause influence the course of MS?
By Dr Jonathan White MBChB MRCOG



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https://doi.org/10.3389/fneur.2021.554375

Effects of Menopause in Women With Multiple Sclerosis: An Evidence-Based Review

MS and Women's Health - HRT:

- HRT: very effective at treating vasomotor and GU symptoms
 - Generally safe small increased risk of breast & ovarian cancers, blood clots
 - Beneficial in MS?
 - Anti-depressants, clonidine, topical oestrogens



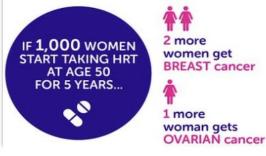
• Natural HRT: soy, black cohosh, red clover, evening primrose (limited evidence)



Royal College of Obstetricians & Gynaecologists







Cancer Research UK

Women Living Well with OMS

- Women = 80% of responders to OMS Community Engagement Survey
- OMS program: 'Pleasure, Purpose, Practice' (Rachael Hunter)
- Challenges for women in following OMS program
- OMS supports all women with MS



