Managing RA Flares While Breastfeeding

By Stephanie Keeling, MD

Not all clinically significant questions have been definitively answered by randomized double-blind placebo-controlled trials. The Hallway Consult department in the *Journal of the Canadian Rheumatology Association* will seek a consensus answer from rheumatologic experts for your difficult questions. Please forward questions for future issues to: *katherinee@sta.ca*.

CASE HISTORY:
Sara is a 29-year-old G1P1 patient with rheumatoid-factor-positive (RF+) and citrullinated-peptide-positive (CCP+) rheumatoid arthritis (RA), who presents to you six weeks postpartum and is beginning to flare. Prior to her pregnancy, Sara was in remission and taking methotrexate, hydroxychloroquine and etanercept. She discontinued the methotrexate three months prior to conception, and stopped the hydroxychloroquine and etanercept upon learning she was pregnant, even though she was told she could continue hydroxychloroquine throughout pregnancy. She is breastfeeding her baby and plans to do this for a minimum of an additional three to six months. What are the options to safely manage her RA and still allow her to continue nursing?

DISCUSSION:

In addition to the stresses of a new baby, the young mother in question, Sara, must also deal with the expected postpartum flare of her rheumatoid arthritis (RA) and how that affects some aspects of motherhood, such as breastfeeding. Globally recognized, the benefits of breastfeeding include the passage of protective immunoglobulins in breast milk to the newborn until his or her own immune system matures.

Generally, 90% of RA patients will flare within the first three months postpartum, and nearly all will flare by nine months postpartum.[1] Therefore, this flare-up is not at all unexpected. Ideally, Sara should have discussed breastfeeding options, if she chose to breastfeed, with her obstetrician, family physician and/or rheumatologist during her pregnancy to strategize how to address her potential disease activity and medications postpartum. Unfortunately, this does not happen as often as we would like. Approximately 70% to 80% of pregnant RA patients improve or remit by the second trimester[1,2] and do not need to see their rheumatologist. Additionally, many pregnant and postpartum women prefer to go "all natural" for as long as they can, which entails avoiding all possible medication and toxin exposures peri- and postpartum. Arguably, this may be especially true of RA patients experiencing their first pregnancy who have yet to experience a postpartum flare, and unrealistically hope that perhaps their remitted disease will not return.

At this point, it would be very safe for Sara to re-start her hydroxychloroquine (< 6.5 mg/kg daily) despite the Food and Drug Administration's (FDA) category C rating based on theoretical risks of fetal oculotoxicity or ototoxicity, or developmental abnormalities. Less than 2% of the hydroxychloroquine dose is excreted in breast milk and, therefore, it is believed to be safe by rheumatologists for breastfeeding RA patients.[3,4] Another option would be sulfasalazine, which is believed to be safe despite one report of bloody diarrhea in an infant.[5] The FDA category varies between B and D, partly reflecting conflicting studies regarding rates of neural tube, oral cleft and cardiovascular defects, only occurring during pregnancy.[6] If Sara's flare-up was aggressive, she could even consider starting combination hydroxychloroquine and sulfasalazine. However, there may be debate about the efficacy of this DMARD combination without methotrexate.

As long as Sara is breastfeeding, methotrexate, leflunomide, abatacept and rituximab are not options. Methotrexate is excreted in breast milk while leflunomide, abat-

acept and rituximab have very little data and, therefore, are not recommended.[7]

Furthermore, TNF-alpha inhibitors are controversial at the present time. One case report found extremely low levels of etanercept in a lactating mother. Of note, etanercept, a protein, may be too large to be absorbed or digested by the infant's gastric secretions.[8] Furthermore, several case reports of Crohn's-disease patients who breastfed while taking infliximab have all confirmed no infliximab present in the breast milk.[9] Despite the growing evidence that perhaps some TNF-alpha inhibitors may have a role in breastfeeding RA patients, there is no consensus on whether or not to recommend the inhibitors while breastfeeding, leading to heterogeneity amongst today's rheumatologists in what they advise. Officially, it is not advisable to breastfeed while taking TNF-alpha inhibitors until more information becomes available.

While Sara waits for her DMARDs to take effect, she will require day-to-day pain control with agents such as acetaminophen (without codeine) or non-steroidal anti-inflammatories (NSAIDs), which are felt to be safe as only small amounts are excreted in the breast milk.[7] The one exception may be acetylsalicylic acid (ASA) due to a bleeding risk to the infant. Therefore, the risks to the mother of not taking ASA must be weighed against the risk of bleeding in the infant (*e.g.*, in the situation of a patient with antiphospholipid syndrome). If NSAIDs are not enough and her disease activity is high, then steroids can also be prescribed (oral, parenteral, intra-articular). While steroids are typically secreted in breast milk, they are still felt to be safe.[7] If Sara needed doses higher than 20 mg of prednisolone equivalent per day, it would be advisable that she consider delaying her next breastfeeding session by four hours post-dose. Whether this is always practical in the day-to-day feeding schedule of an infant is another story.

In the end, how quickly and aggressively Sara flares will likely influence how long she chooses to breastfeed. Furthermore, she must be encouraged to discuss the realities of breastfeeding with the appropriate physicians. Mothers often feel as if they have to be perfect in all aspects and, as such, may have significant societal, familial and economic pressures to breastfeed. The rheumatologist can remind Sara that she cannot actively mother her newborn if she cannot function due to active disease. The risks of uncontrolled RA far outweigh the risk of terminating breastfeeding early or choosing not to breastfeed at all. Apparently, formula does not taste that bad.

References:
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Stephanie Keeling is a rheumatologist at the University of Alberta Hospital in Edmonton, Alberta.