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Psoriasis in Pregnancy

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ABSTRACT

We report a thirty-five-year-old pregnant Bahraini patient with a flare-up preexisting psoriasis during the second half of pregnancy. At 33 weeks, intra uterine growth retardation was discovered. At 38 weeks, after failed induction, a cesarean section was performed; a healthy live female baby was delivered.

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INTRODUCTION

Psoriasis is an uncommon skin disease which occurs during pregnancy; the erythrodermic (pustular) variety is very rare[1-2]. The association between psoriasis and pregnancy presents therapeutic challenge. This includes the need to deal with potentially teratogenic drugs, such as systemic steroids, cytotoxic drugs, TNF-α inhibitor drugs, and antibiotics[3]. Occasionally, ethical and psychological issues are encountered which may need a multidisciplinary approach[4].

The aim of this report is to discuss the management of these cases and to review the drugs used in the treatment of psoriasis, their safety to the unborn infant together with their long-term safety profile.

THE CASE

A thirty-five-year-old Gravida 2, Para 1, Abortion 0, at 33 weeks of gestation was referred from the dermatology clinic to the antenatal clinic for consultation. She was diagnosed to have generalized psoriasis since the age of 18. The psoriasis was controlled with topical lotions and corticosteroid creams.

In 2005, she became pregnant and progressed uneventfully until full term and gave birth to a normal healthy female baby; antenatal care was conducted in a private hospital where she denied receiving any systemic drugs for the psoriasis.

In 2006 during her last pregnancy, psoriasis flared up, an erythrodermic psoriasis was diagnosed and Remicade was prescribed which is a monoclonal antibody against tumor necrosing factor TNF-α. Remicade 250 mg was given in normal saline infusion twice weekly. In the 30th week of pregnancy, she had a generalized flare-up of psoriasis. Treatment with topical steroids resumed, but systemic therapy was stopped. While attending the antenatal clinic, she was found also to have intra-uterine growth restriction (IUGR), but no hypertension. The fetus was monitored by non-stress test, fetal physical profile, fetal parameters and Doppler studies.

The patient was induced at 38 weeks of gestation with prostaglandin vaginal tablets. After 48 hours, she did not progress to labor and she was delivered by a lower segment Cesarean section under spinal analgesia. The patient delivered a live male infant who weighed 2.4 kg. His Apgar score was 9 and 10 at birth. The postnatal period was uneventful. On the third postnatal day, systemic steroids and weekly monoclonal antibodies infusion were resumed. She was discharged on the fifth postnatal day and followed up in the postnatal and dermatology clinics.

DISCUSSION

Psoriasis is an autoimmune, inflammatory skin condition with manifestations resulting from a complex interplay between genetics and environment[1]. The incidence of psoriasis is 78.9 per 100,000 of population. Pregnancy complicated by psoriasis seems to vary according to age and race[2]. The annual incidence of this disease was also noticed to be increasing since the seventies. A recent survey from the USA suggested that the average age of diagnosis is 28 years which is a peak age for pregnancy[3]. Annually, there are approximately 65,000-107,000 births from women with psoriasis, out of which 9,000-15,000 having moderate to severe disease. This is the first case encountered in Bahrain during the last two decades.

In pregnancy, psoriasis poses a variety of problems which are due either to the condition itself or due to the treatment or the combination of these two. In general, pregnancy usually doesn't affect the course of psoriasis and it may even cause an improvement.

Methotrexate, Acitretin (Soriatane), cyclosporine, hydroxyurea and Mycofenolate mofetil (an immune suppressant) must all be avoided in pregnancy. There is insufficient information available about biologic response mediators and the risk is unknown. Most authorities, however, would agree that ultraviolet light treatment and topical steroids are fairly safe, but one should avoid using large quantities of salicylic acid and calcipotriol[5].

Infliximab (Remicade) is a relatively new drug; it is used to treat severe inflammatory conditions such as Crohn's disease, Ankylosing spondylitis, rheumatoid arthritis and psoriasis[6]. It is given in the form of infusion for the erythrodermic variety of psoriasis. Its mode of action is through blocking the tumor necrosis factor TNF-α. Infliximab clinical trials have reported no deformities in the newborns[7,8]. Additional studies are necessary to assure its safety, especially its use for psoriasis in pregnancy[9].

Counseling before pregnancy in patients with psoriasis should include discussing the possibility of the child inheriting the disease. In some centers, DNA analysis for psoriasis susceptibility gene is offered to women who have psoriasis and planning to get pregnant[10]. The teratogenic

potential of the drug used for the treatment of psoriasis should be explained to the patient. Psoriasis has been identified as an independent risk for abortion, premature rupture of membranes, and infant macrosomia; in addition, to the difficulty associated with breast feeding if the patient develops psoriatic nipples[11]. Postpartum concerns also include avoidance of exposure to excessive sunlight.

CONCLUSION

The management of the erythrodermic type of psoriasis in pregnancy was discussed. Although this condition is rare, these patients need a pre pregnancy counseling and multi-disciplinary management once they become pregnant. Adequate family planning should also be made available.

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