Box 2

Pregnancy and SLE

Women with SLE should be referred for pre-pregnancy counselling. As most women who develop SLE are of childbearing age, pregnancy and the issues surrounding it are of major importance. Lupus itself does not reduce fertility however factors such as high disease activity, hypertension, lupus nephritis, anti-phospholipid antibodies and immunosuppressive therapy may alter the outcome of pregnancy.

Pregnancy can effect lupus by increasing disease activity several fold[25,26] especially if there is active disease at the time of conception. It is vital that stable disease is achieved for at least six months before pregnancy to reduce the risk of flares during, and in, the postpartum period. Other risks for increased activity are cessation of corticosteroids and hydroxychloroquine.

The presence of Ro and La antibodies is associated with around a 1% risk of congenital heart block and 10% risk of neonatal lupus rash. Anti-cardiolipin antibodies and lupus anticoagulant antibodies are associated with significant increase in pregnancy loss, intrauterine growth restriction and preterm birth.

Drugs that are safe to use in pregnancy include: prednisolone; azathioprine; hydroxychloroquine; heparin; and low-dose aspirin. At present evidence suggests that MMF, leflunomide, cyclosphosphamide and methotrexate must be avoided and should be stopped at least three months before a planned pregnancy. Warfarin should be changed to heparin and aspirin during pregnancy.