Answers to questions you may have about myasthenia gravis in pregnancy

If you are a woman with myasthenia gravis (MG) and are considering pregnancy, you will want to discuss your plans with your MG treating provider well in advance. This will permit adequate time for you and your provider to make any adjustments to your MG treatment plan, allowing for the best outcomes with the least risks for you and your baby. You and your health care providers will also want to discuss the safety of your current treatment plan during a pregnancy and the avoidance or discontinuation of any therapies that might have unwanted effects on the growing fetus. The impact of changes in your treatment plan on your own health is also an important consideration.

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The MGFA mission is to facilitate the timely diagnosis and optimal care of individuals affected by myasthenia gravis and closely related disorders and to improve their lives through programs of patient services, public information, medical research, professional education, advocacy and patient care.

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MYASTHENIA GRAVIS IN PREGNANCY

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Treatment During Pregnancy

The treatment of MG in pregnancy is similar to treatment in non-pregnant patients. The majority of patients under good control prior to pregnancy will remain stable throughout the pregnancy. When there is worsening, it is more likely to occur in the weeks after the delivery of your baby.

Oral pyridostigmine (Mestinon®) is the standard first-line treatment during pregnancy. Intravenous anticholinesterase inhibitors (like pyridostigmine) should not be used during pregnancy as they may produce uterine contractions. However, these should be administered during labor in place of oral dosing.

Prednisone is the immunosuppressant agent of choice during pregnancy. When prednisone is insufficient or poorly tolerated, azathioprine or cyclosporine are considered relatively safe by a consensus of MG experts. However, some MG experts are opposed to using azathioprine in pregnancy.

Either lasmapheresis (PLEX) or IVIg may be used when a prompt temporary response is needed during pregnancy.

Thymectomy should be postponed until after pregnancy.

Planning the Delivery

You should carefully consider where you will give birth. Whenever possible, most pregnant women want the obstetric team who has cared for them throughout the pregnancy to deliver the baby and care for them in the postpartum period. During the course of the pregnancy, the MG provider and the obstetrics team must be in communication about the treatment plans, the progress of the pregnancy, and plans for delivery. There may be advantages to choosing an obstetric team that performs deliveries at the same medical center where you are treated for MG. Home births and deliveries at birthing centers outside of large hospital centers are typically not recommended for patients with complex medical issues. Maternal MG presents with special considerations for the infant as well as the mother. Babies whose mothers have MG may need special care immediately upon delivery (see "Transient Neonatal MG" below).

Labor & Delivery

As a pregnant woman with MG, you can expect to have a typical labor and a spontaneous vaginal delivery. Consultation with an anesthesiologist before labor commences is advised. Regional anesthesia is recommended when vaginal delivery is expected. Magnesium sulfate, frequently used for preeclampsia and eclampsia is not recommended in patients with myasthenia as it can precipitate a myasthenic crisis.

Transient Neonatal MG

Infants born to mothers with autoimmune MG typically will need to be examined immediately after birth and observed by skilled neonatal doctors and nurses for the first 3 to 4 days for any signs of transient myasthenic weakness, even if the mother's myasthenia is well-controlled. A small number will require some very short-term support of breathing and feeding. Infants with transient neonatal myasthenia do not continue to have myasthenia once auto-antibodies passed from mother to baby through the placenta have been removed or spontaneously broken-down.

Reference

Sanders, DB, et al. (2016). International consensus guidance for management of myasthenia gravis: Executive Summary Neurology: 87(4), 419-425.