Planning to become pregnant? You may wonder how psoriatic disease may affect you and your baby.

Psoriasis disease is genetic, passed from generation to generation, although it is not currently understood how it is inherited. Scientists believe there are two things that normally cause a person to develop psoriasis or psoriatic arthritis. First, the person must inherit specific genes for psoriatic disease. Second, the person experiences a trigger that cause a flare.

Symptoms of psoriasis and psoriatic arthritis can increase or decrease during and after pregnancy. Approximately two out of three pregnant women see an improvement in symptoms during pregnancy. Others see a worsening. Flare-ups can also occur during the postpartum period, most often in the immediate weeks following delivery.

Changes in severity of psoriatic symptoms vary by individual and from pregnancy to pregnancy. Speak with your health care provider about:

- Changes in your psoriatic symptoms during or after pregnancy
- Medicines and treatment plans before, during and after pregnancy
- Risks of adverse effects to you or your child

Although it may be difficult or embarrassing, please speak with your practitioner offering care during pregnancy and childbirth about your psoriatic disease, possible genital involvement and if vaginal delivery is possible.

**Which medicines are safe?**

You’ll have to adjust your treatment plan to manage symptoms of your psoriatic disease and reduce possible risks to your unborn child. It is important to balance the benefits and risks of treatment options before, during and after pregnancy. This is a very personal decision for you and your partner. Both men and women with psoriatic disease have to think about how treatments can affect the ability to have a child and the possibility of increasing the risk of birth defects. It is important to discuss the safety of treatment options with your health care provider when planning to become pregnant.

The U.S. Food and Drug Administration (FDA) requires labels on medicines to include information about risks of using the drug during pregnancy and nursing and the effects on fertility. Drugs were previously grouped into categories: A, B, C, D or X. These old categories stood for different levels of risk for negative side effects. The FDA has ordered these pregnancy categories to be removed because they were confusing and not accurate.

Always speak with your health care provider about the safety of your medications. It’s important to understand that in every pregnancy, a woman starts out with a 3 to 5 percent chance of having a baby with a birth defect, pregnancy loss or other negative outcome. This 3 to 5 percent chance is called the background risk. Drug labels describe the potential of the drug to increase the background risk.

If you’re on medications for your psoriatic disease and you’re planning to become pregnant or you’re already pregnant, talk to your health care provider about signing up for a pregnancy registry. A pregnancy registry is used to keep track of women who are on a drug during pregnancy. This helps scientists to better understand the effects of a drug on the mother and her child. Pregnancy registries that are drug-specific include Soriatane (855-0850-2138), Cyclosporine (888-522-
5581) and Enbrel (800-772-6436). A pregnancy registry managed by the Organization of Teratology Information Specialists (OTIS) is studying multiple drug treatments for psoriatic disease (877-311-8972).

**Topicals**

Topical treatment is the first-line therapy recommended for pregnant and nursing women. Of the topical options, moisturizers and emollients such as petroleum jelly are the safest. Next are low-to-moderate strength topical steroids. Lastly, high-potency topical steroids should be used only as needed in the second or third trimesters.

Absorption of topical medicines through the skin can occur. The possibility of absorption is higher when they are applied under occlusion or wrappings, over large areas of skin, or in large quantities. It is important to discuss your treatments, even over-the-counter medications, with your health care provider.

**Phototherapy**

Narrowband ultraviolet light B (UVB) is safe and can be considered the second-line treatment for pregnant and nursing women, following topicals. If narrowband UVB is not available, then broadband UVB may be used. Combination treatments of UVB with tar or anthralin are also safe and effective treatment options for pregnant and nursing women. With phototherapy, sunscreen should be applied on the face to prevent the appearance of brown spots.

PUVA is a treatment with a light-sensitizing medication, called psoralen, and exposure to ultraviolet light A. This type of phototherapy should be avoided before and during pregnancy. Both psoralen and UVA light can cause birth defects if used by a man or a woman during the time of conception. PUVA can also cause birth defects to your unborn child if used during pregnancy. This also applies to bath PUVA, where the entire body is soaked in a tub of water that contains psoralen.

**Systemics**

We recommend you avoid the use of systemic medications when trying to conceive, during pregnancy and during nursing. This is because your child is at a higher risk of being exposed to the drug compared to topicals. We know that traditional systemics such as methotrexate and Soriatane (acitretin) can cause birth defects and pregnancy loss and are present in breast milk. We don’t know what effect newer biologics may have on pregnant women or an unborn child. It is also unknown if the medicines pass into breast milk in nursing women. Because these risks are unknown, if you are considering pregnancy or are pregnant, you should work closely with your health care provider to weigh the benefits and risks of using these drugs. Your provider can help to develop treatment plans to reduce risks and exposure for you and your child.

**For more information**

- National Psoriasis Foundation: [www.psoriasis.org](http://www.psoriasis.org)
- MotherToBaby: [www.mother2baby.org](http://www.mother2baby.org)