AMERICAN COLLEGE of RHEUMATOLOGY

Empowering Rheumatology Professionals

Facilitator's Guide for Exploring PsA and Reproductive Health

Case by Case

https://acrreprohealthinitiative.com/

ACKNOWLEDGEMENTS

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Its contents are solely the responsibility of the authors and do not necessarily reflect the official views of Pfizer, Inc.
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AUTHORS

Mehret Birru Talabi, MD

Linda Grinnell-Merrick, NP

Sonam Kiwalkar, MD

Arthur Kavanaugh, MD

Vagishwari Murugesan, MD

Notes:

Getting Started

Exploring PsA and Reproductive Health, Case by Case is a program designed to educate prescribing providers and their healthcare teams on how to manage and treat Psoriatic Arthritis (PsA) in patients of reproductive age. Utilizing the 2020 American College of Rheumatology (ACR) Guidelines for Reproductive Health in Rheumatic Disease as the foundation, this program will explore the importance of shared decision making with patients, medications compatible with pregnancy and lactation, as well as how to educate patients on how to prepare for the best pregnancy outcomes given their disease status. Using multiple case studies with women and men, this program will walk providers through the appropriate considerations, lab tests, and conversations that non-rheumatology and rheumatology providers should be aware of to provide the best care for their patients and their growing families.

Objectives of This Presentation:

At the end of this presentation, learners will be able to:

- ❑ *Discuss effects of Psoriatic Arthritis (PsA) on pregnancy*
- ❑ *Explain potential adverse pregnancy outcomes associated with PsA*
- ❑ *List the impact of drugs used in the treatment of PsA during pregnancy and lactation*
- ❑ *Recognize that women with PsA have a risk of flare post-partum*
- ❑ *Demonstrate successful use and integration of the ACR Reproductive Health in Rheumatic Diseases guidelines into patient care*

Length of the Activity:

The presentation and discussion should last between 60-75 minutes.

What You Need:

- ❑ Computer and audio/visual equipment for projection of the PowerPoint presentation to the audience
- ❑ *Guide for Exploring PsA and Reproductive Health, Case by Case,* PowerPoint presentation
- ❑ Facilitator's Guide/Presentation script
- ❑ PsA Handouts (4)

Importance of Evaluation: the Pre & Post Test

To continue to improve this education for others, it is important that we get feedback on:

- ❑ *What are the participants learning from this session?*
- ❑ *How can this session be improved?*
- ❑ *What additional information would be helpful?*

Please be sure to encourage your learners to take the pre-test prior to the session, and the post-test at the completion of the session. If you have questions, please speak with your organization's point of contact.

Slide 4: Learning Objectives

Learning Objectives

At the end of this presentation, learners will be able to:

- ***Discuss effects*** of Psoriatic Arthritis (PsA) ***on pregnancy***
- Explain potential ***adverse pregnancy outcomes*** associated with PsA
- List the ***impact of drugs used*** in the treatment of PsA during pregnancy and lactation
- Recognize that women with PsA have a ***risk of flare post-partum***
- Demonstrate successful use and integration of the ***ACR Reproductive Health in Rheumatic Diseases guidelines*** into patient care

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Slide 5: Disease Overview

Psoriatic Arthritis (PsA)
at a glance

DISEASE OVERVIEW

- PsA is a ***chronic inflammatory arthritis*** that occurs in some people with skin psoriasis
  - (About 30% of people with psoriasis also develop PsA)
- PsA typically ***affects the large joints***, especially those of the lower extremities, distal joints of the fingers and toes, and can affect the back and sacroiliac joints of the pelvis
- Though there is ***no cure, there are treatments available*** to help stop disease progression, lessen pain, protect joints and preserve a range of motion
- PsA can ***occur due to complex interactions*** between the environment and a genetically predisposed individual

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Slide 6: Common Symptoms

Psoriatic Arthritis (PsA)
at a glance

COMMON SYMPTOMS

- ❑ Fatigue
- ❑ Tenderness, pain and swelling over tendons
- ❑ Swollen fingers and toes
- ❑ Stiffness, pain, throbbing in one or more joints
- ❑ Reduced range of motion
- ❑ Nail changes, such as pitting or separation from the nail bed

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Slide 7: Demographics

Psoriatic Arthritis (PsA)

at a glance

DEMOGRAPHICS

- PsA typically appears in people ***between the ages of 30 and 50***, but can begin as early as childhood
- ***Men and women*** are equally at risk of developing PsA
- People of ***all races & ethnicities*** can develop psoriasis and psoriatic arthritis

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Slide 8: CASE 1 - TAMMY

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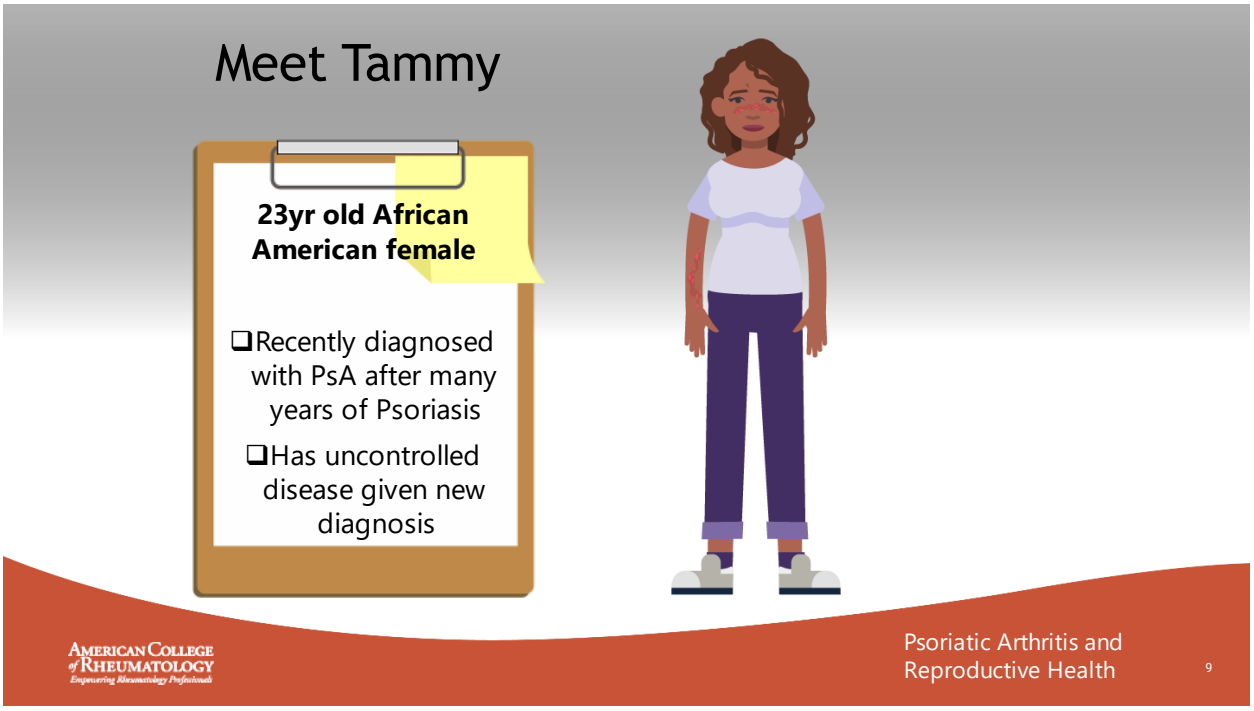
Slide 9: MEET TAMMY



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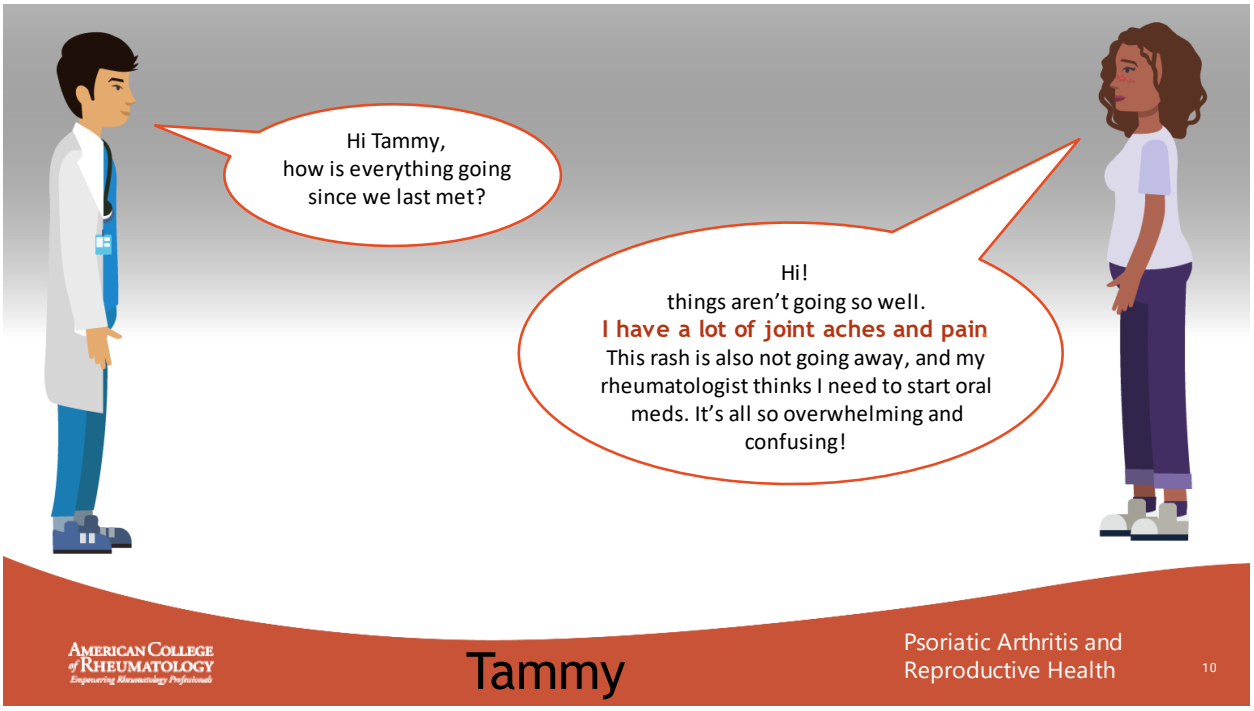

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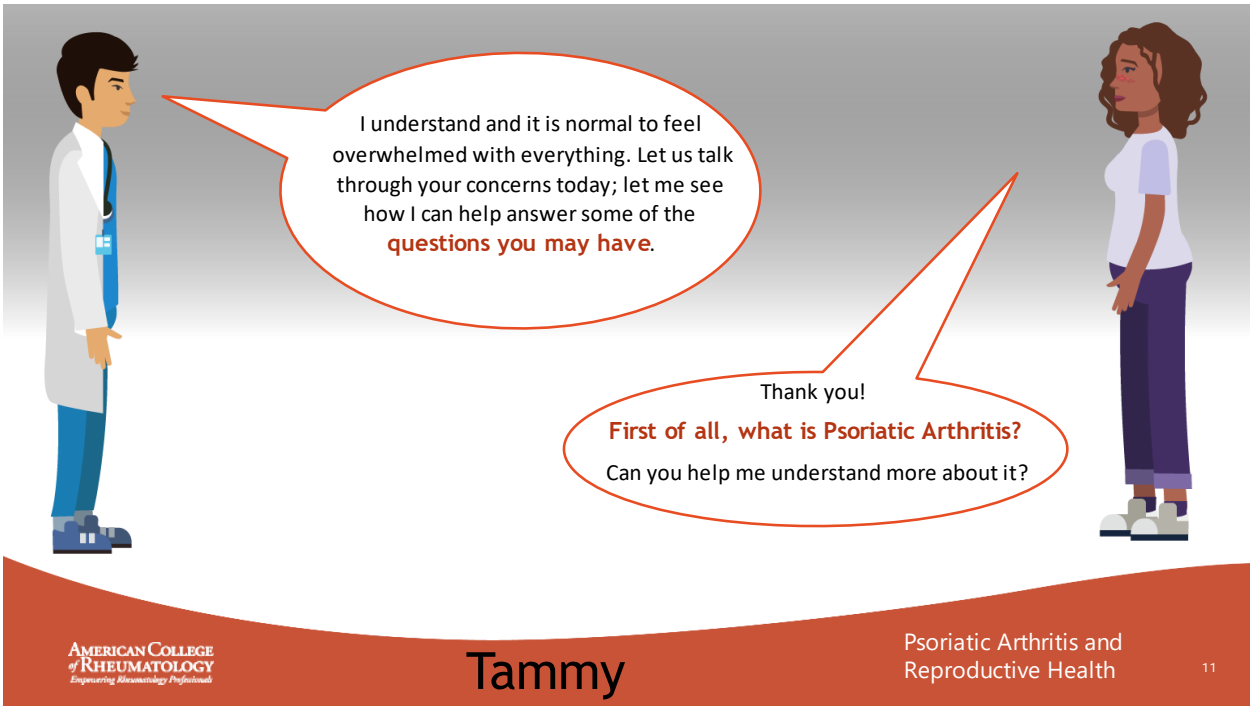

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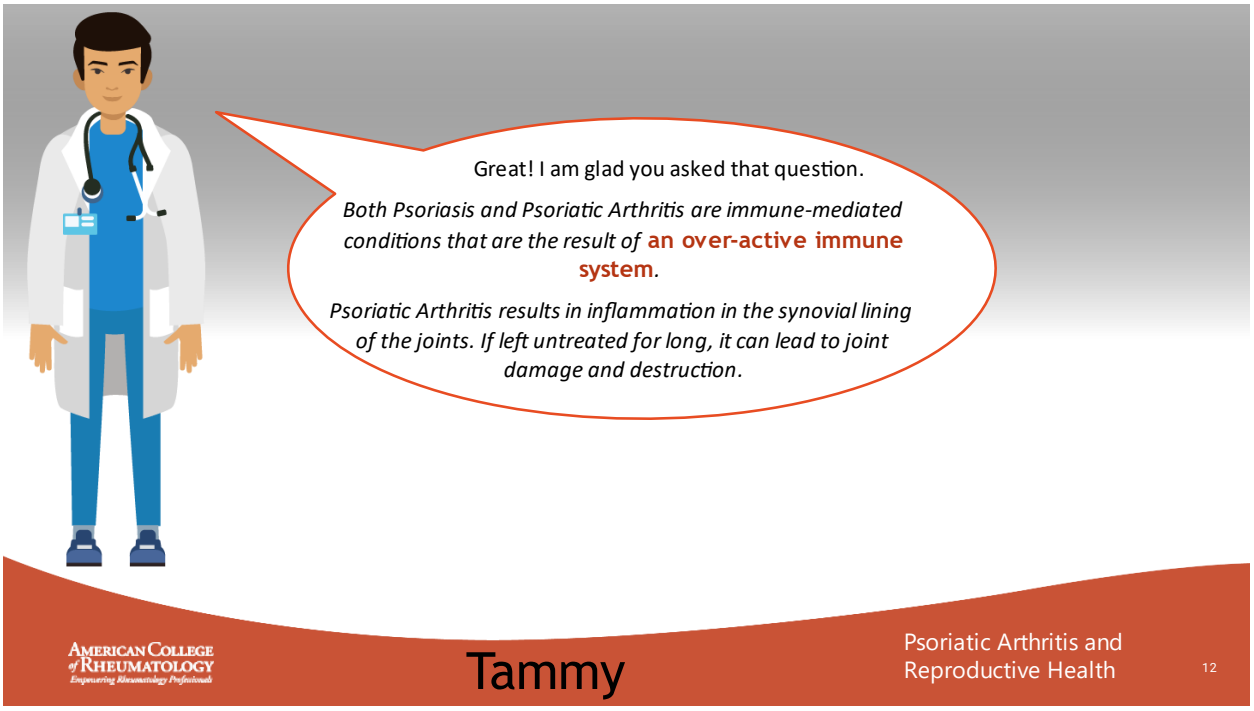

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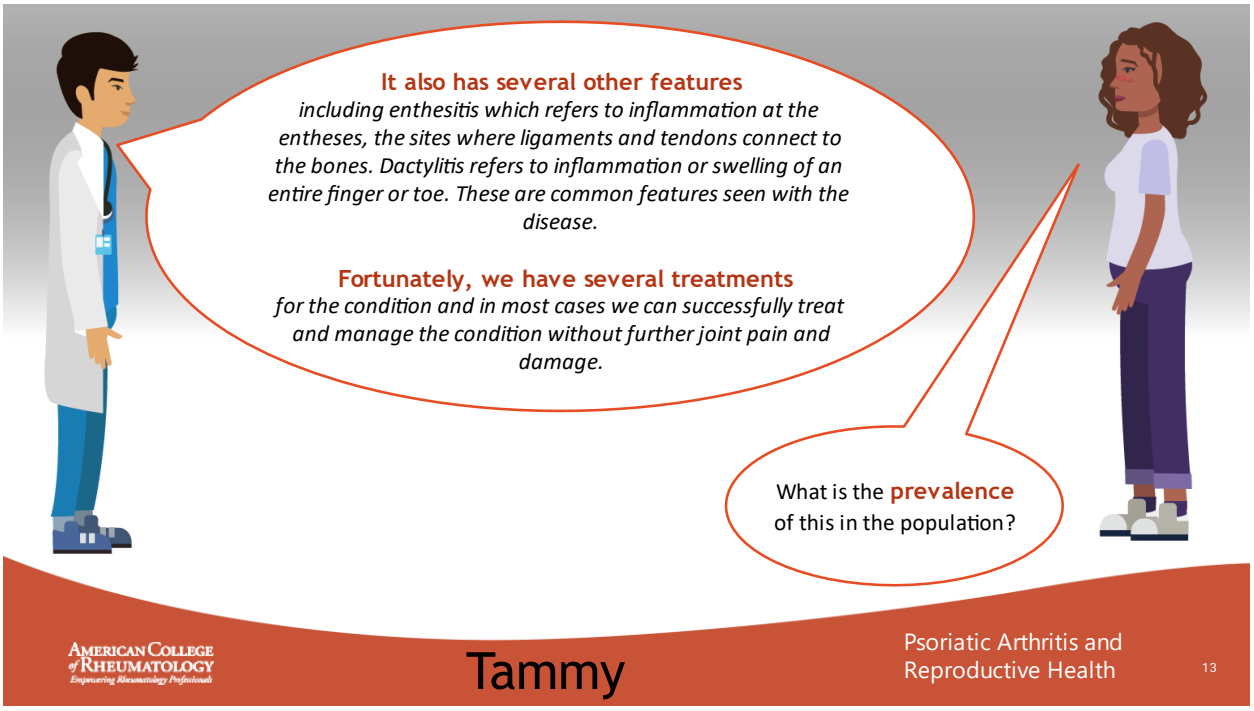

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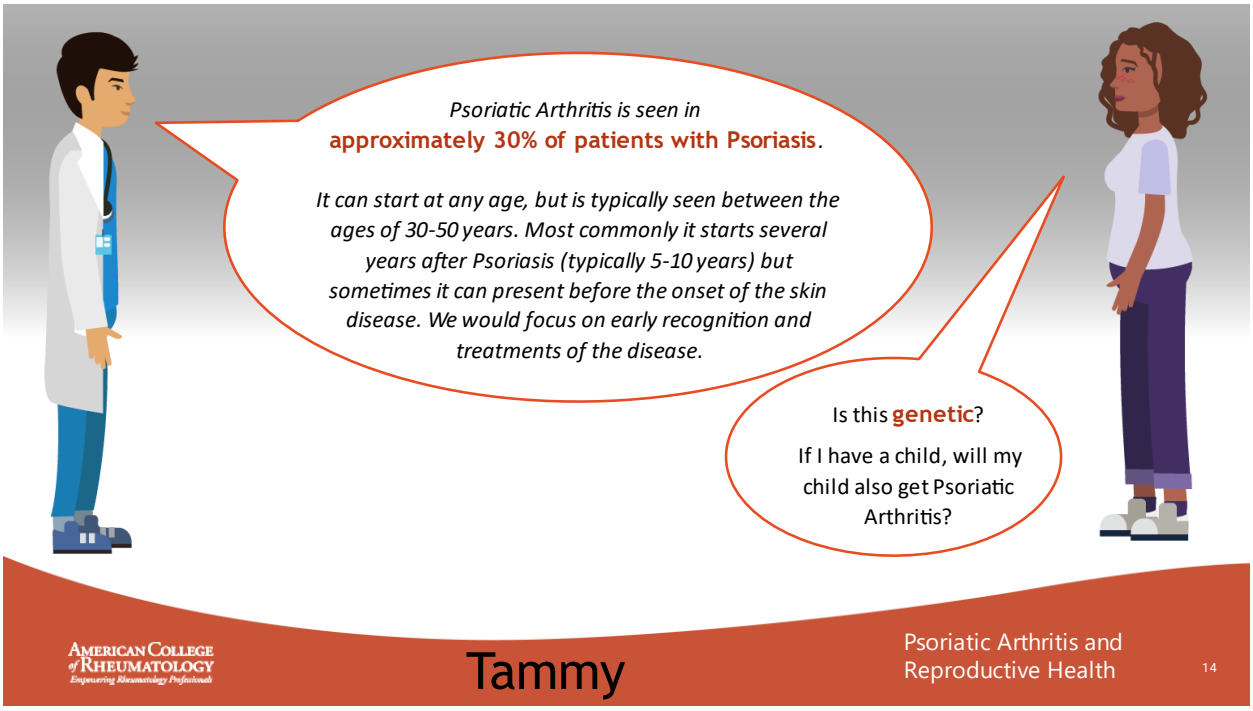

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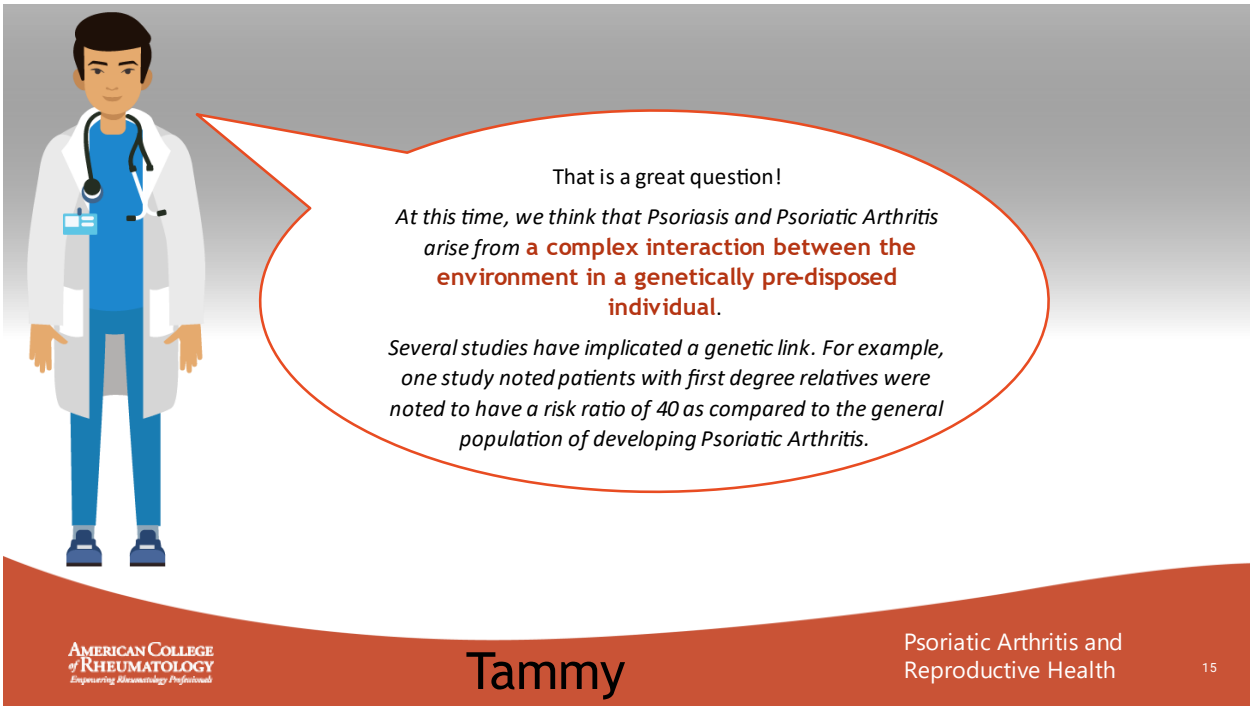

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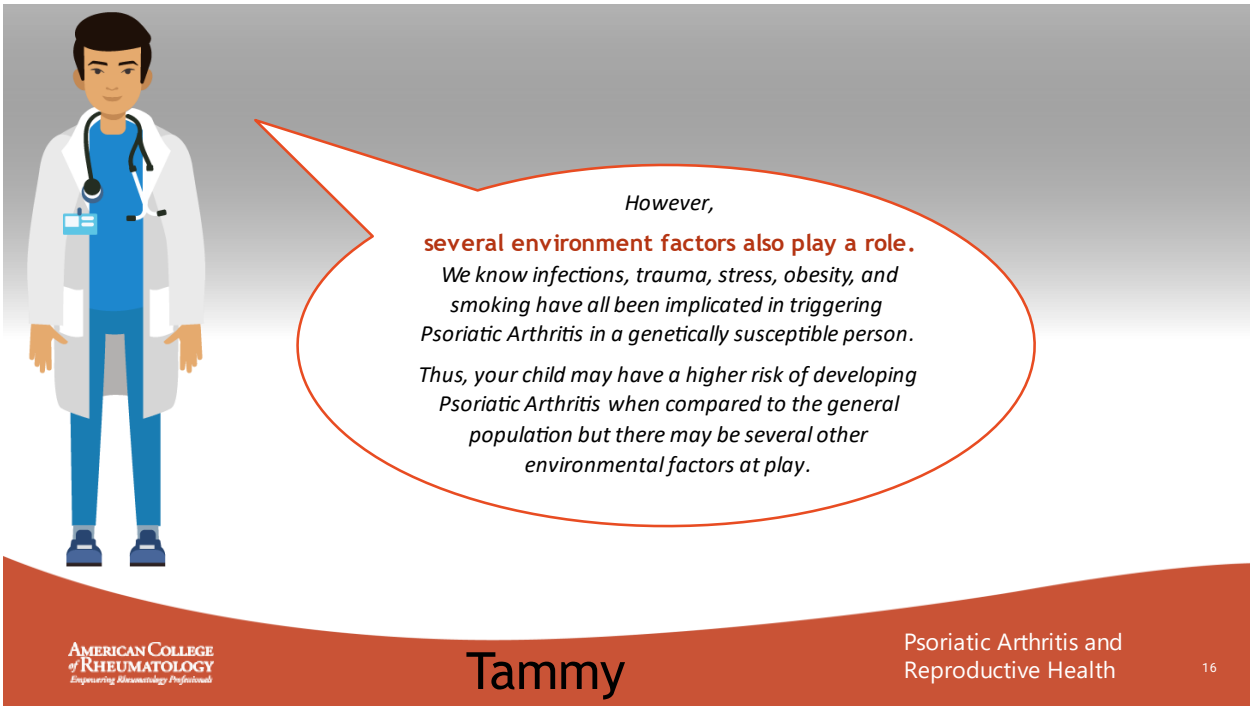

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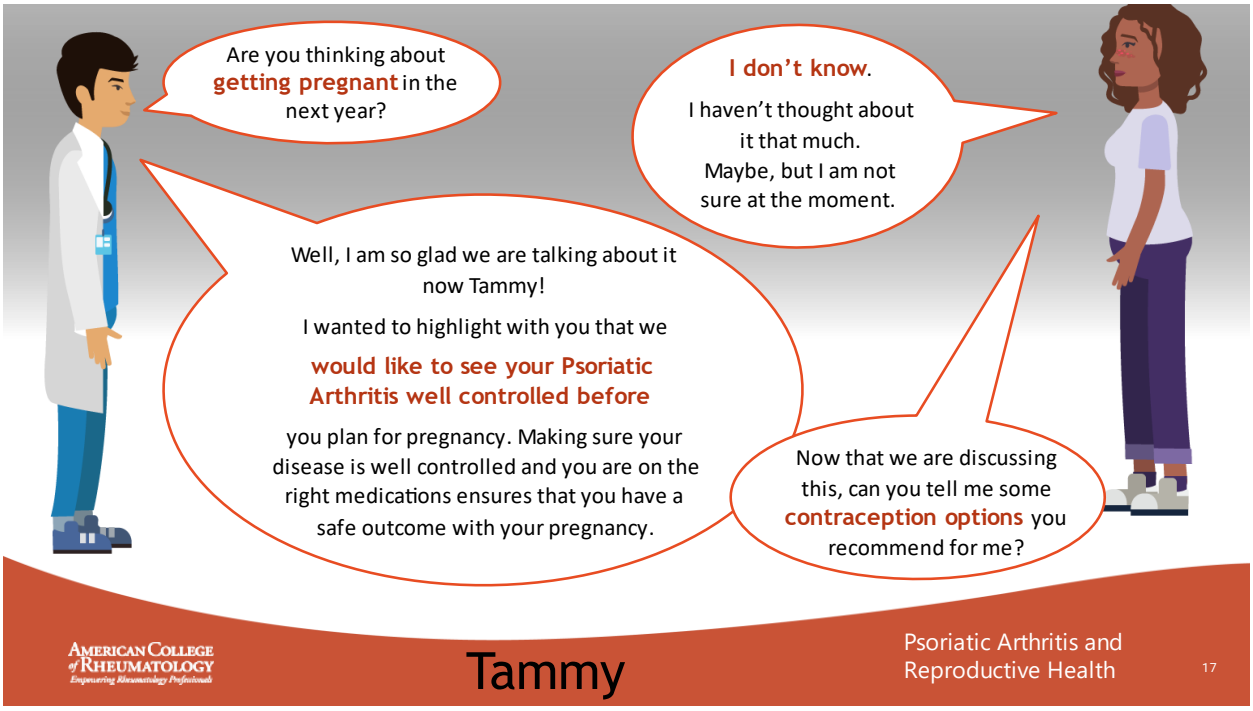

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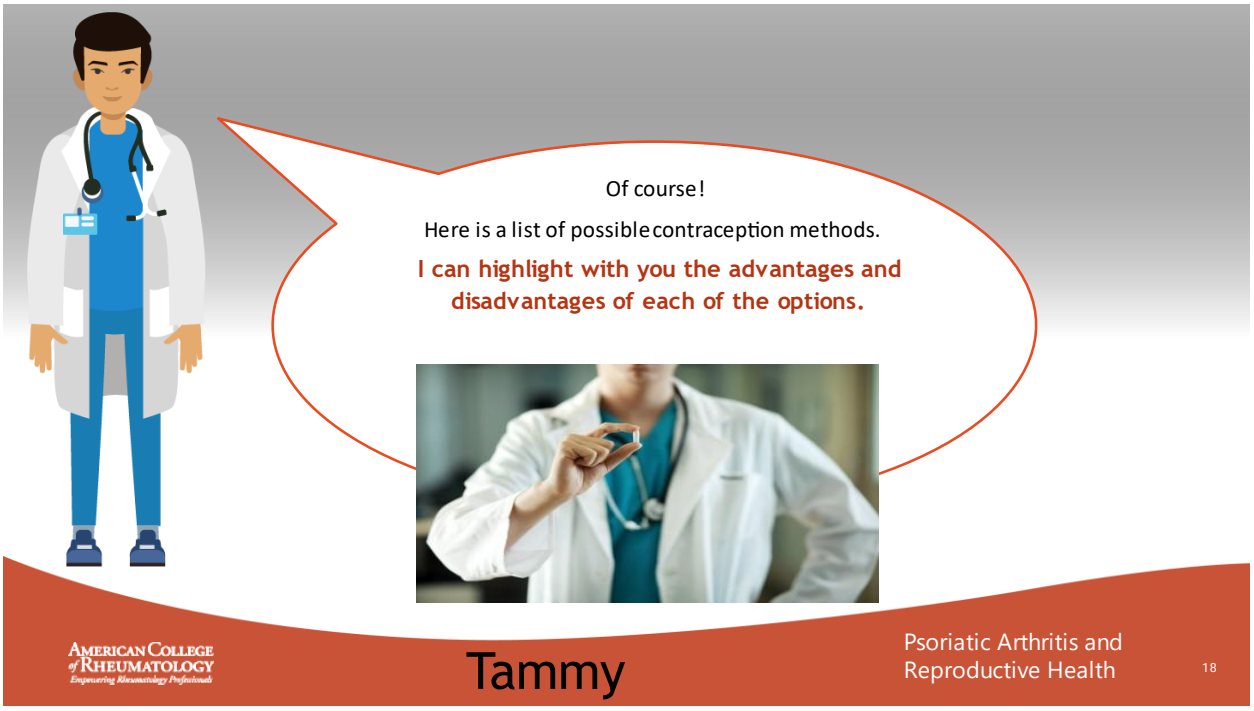

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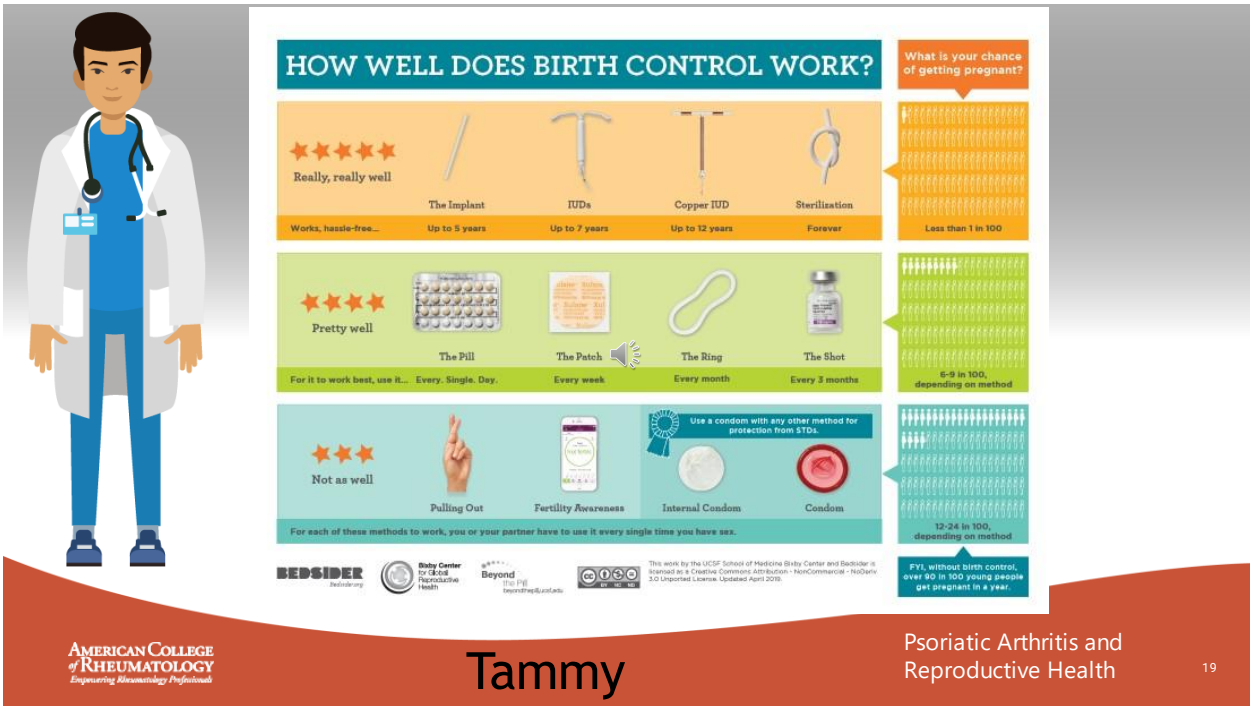
Slide 19: BIRTH CONTROL CHART



VOICEOVER TEXT

Provider: Okay here is a chart we can look at together. Let's start at the bottom and work through the top. Overall, without any form of birth control, 90 out of 100 women would become pregnant in a year.

When it comes to contraception, we have lots of options to work with based on your comfort level. Effectiveness of the contraceptive is one way to look at it but there are also several other considerations. These include convenience, affordability, reversibility, side effect profile, method of use, partner preference, duration of time needed as well as unique benefits of one contraceptive over the other, such as lighter menstrual periods, protection against sexually transmitted infections, as well as reduction in the risks of certain types of cancers. Additionally, we want your decision to be compatible with your religious beliefs and cultural practices. That is why this is a shared decision-making process, so I want you to ask me lots of questions and feel comfortable with whichever method you choose!

Our least effective options include pulling out and fertility awareness. Condoms are moderately effective, but they have an additional benefit of preventing STDs. In all 12-24 out of every hundred women may get pregnant if only using these methods.

In the second tier of contraceptive options are pills, patch, the ring and shot. These methods work well and are effective. About 6-9 out of every 100 women still have a chance of pregnancy using these methods. For them to be effective, they must be taken, every day, every week or every month depending on the method.

On the third tier and all the way at the top are methods that work well. These include implants, IUD which are effective for several years at a time. A more permanent option is of course sterilization. Less than 1 in 100 women would become pregnant in this option. What questions do you have for me?

Tammy: Thank you. This is very helpful.

Slide 20: CASE 1 LEARNING POINTS

CASE 1 - TAMMY
Learning Points

- PsA is an autoimmune condition resulting in inflammatory arthritis seen in approximately 30% of patients with Psoriasis
- A multi-faceted approach to pregnancy planning is essential in women of childbearing age as uncontrolled disease activity and medications used to treat the condition can result in adverse pregnancy outcomes

Psoriatic Arthritis and Reproductive Health

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Slide 21: CASE 2 - LACEE

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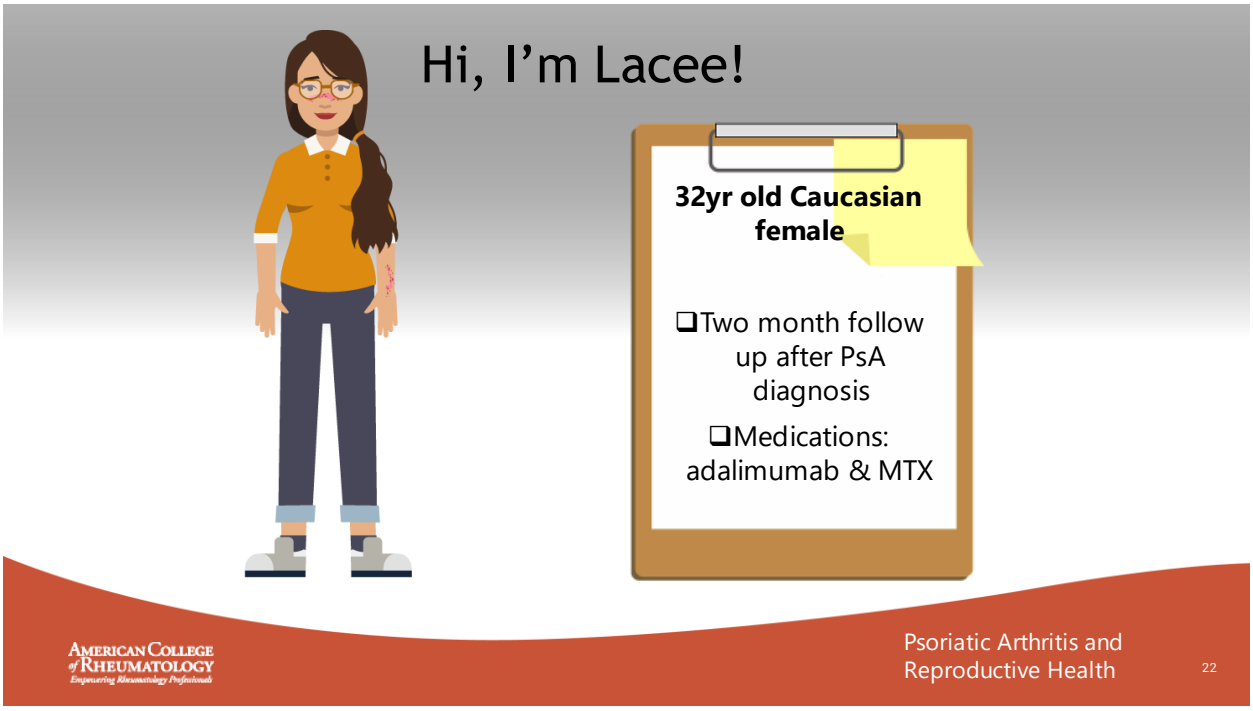
Slide 22: MEET LACEE



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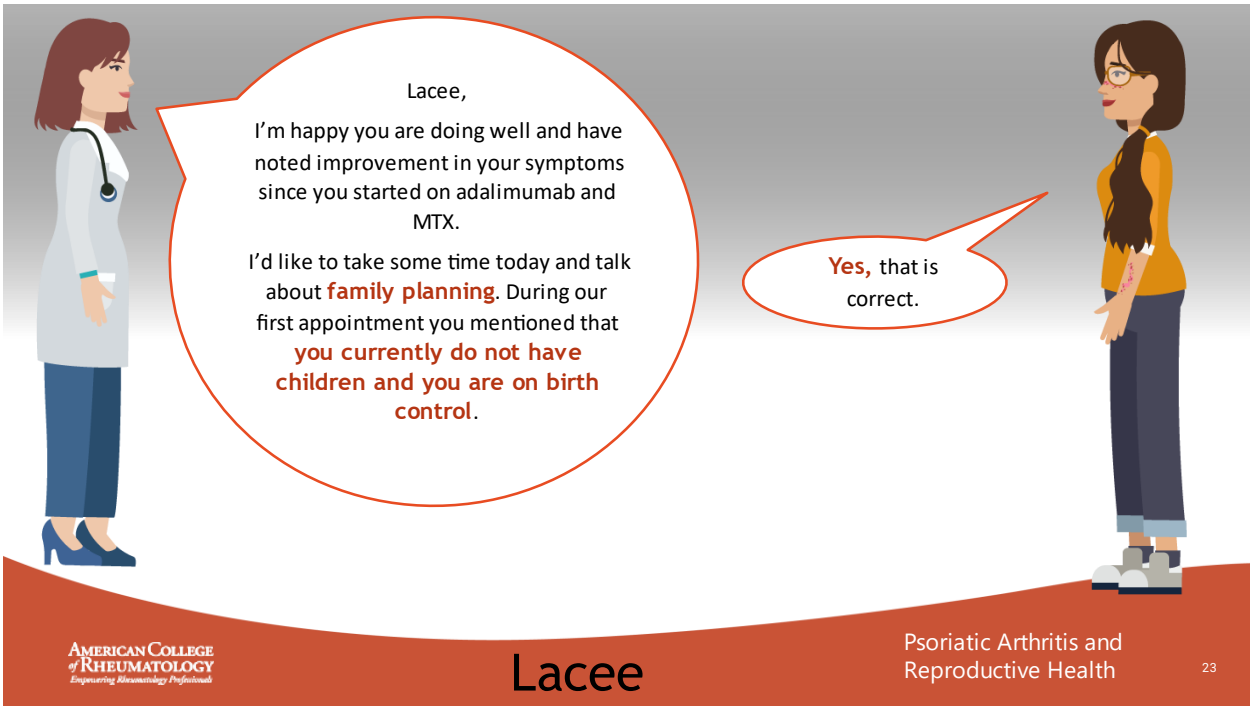
Slide 23: CONVERSATION



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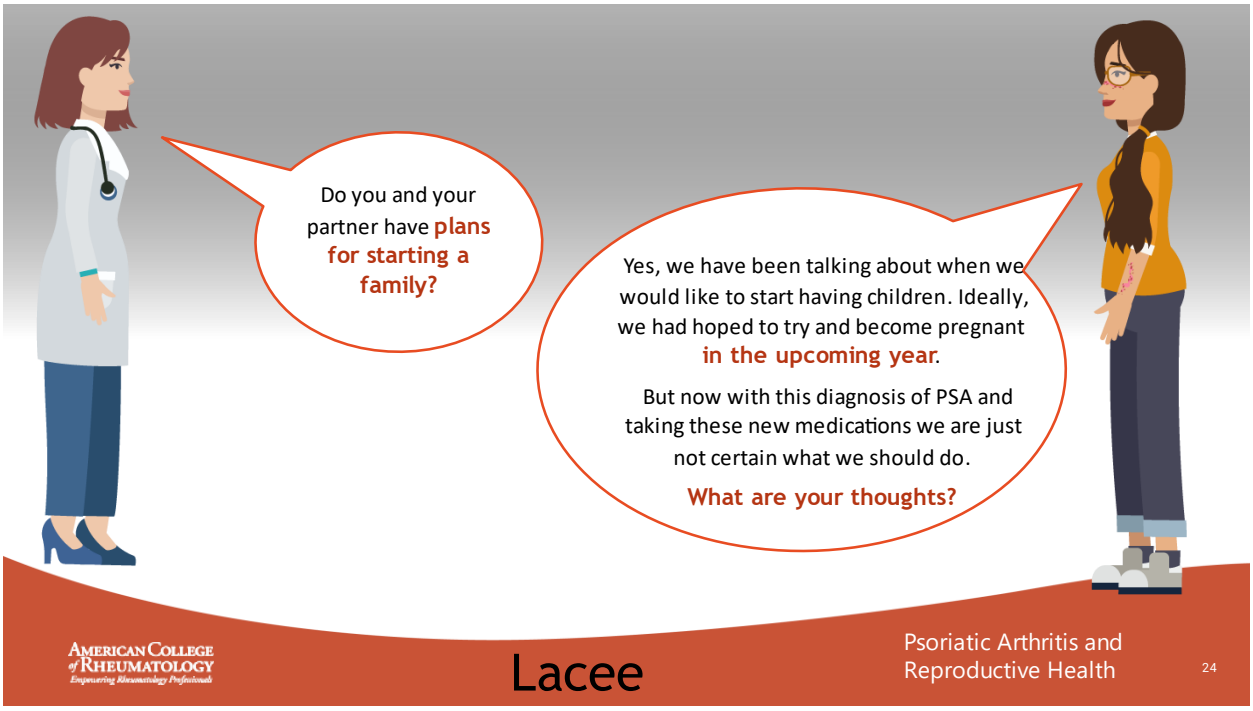
Slide 24: CONVERSATION



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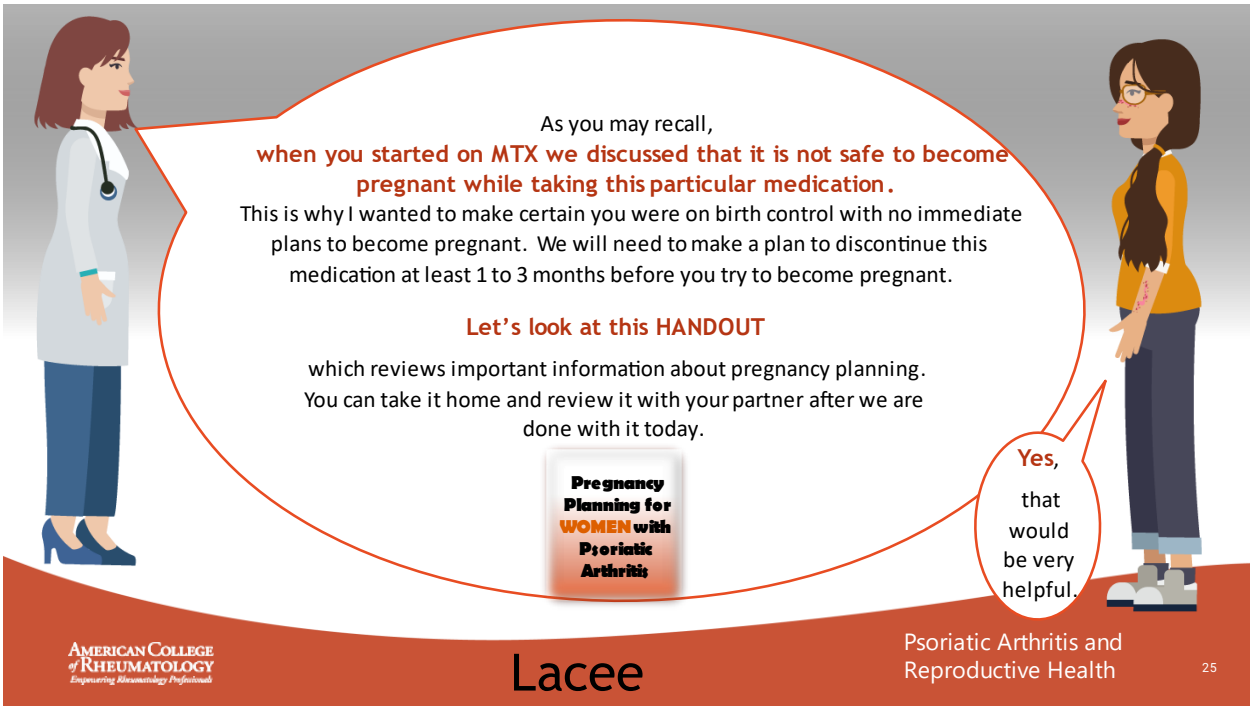
Slide 25: CONVERSATION



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Slide 26: PREGNANCY PLANNING – 4 STEPS (HANDOUT)

Pregnancy Planning for WOMEN with Psoriatic Arthritis

STEP 1

To have the safest pregnancy possible:
- Use medications on the GREEN list
- Keep your Psoriatic arthritis activity as low as possible

STEP 2

Is your Psoriatic arthritis well controlled?
- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms consistent with iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time
- Continue or start GREEN list medications
- Discuss with your doctor and talk about a switch from RED list meds to GREEN list meds
- Discuss any other medications with your obstetrician

STEP 4

Which doctors should you talk with?
- Rheumatology provider/Dermatology provider
- Maternal-Fetal Medicine Specialist
- Local Obstetrician (OB)
- Dermatologist

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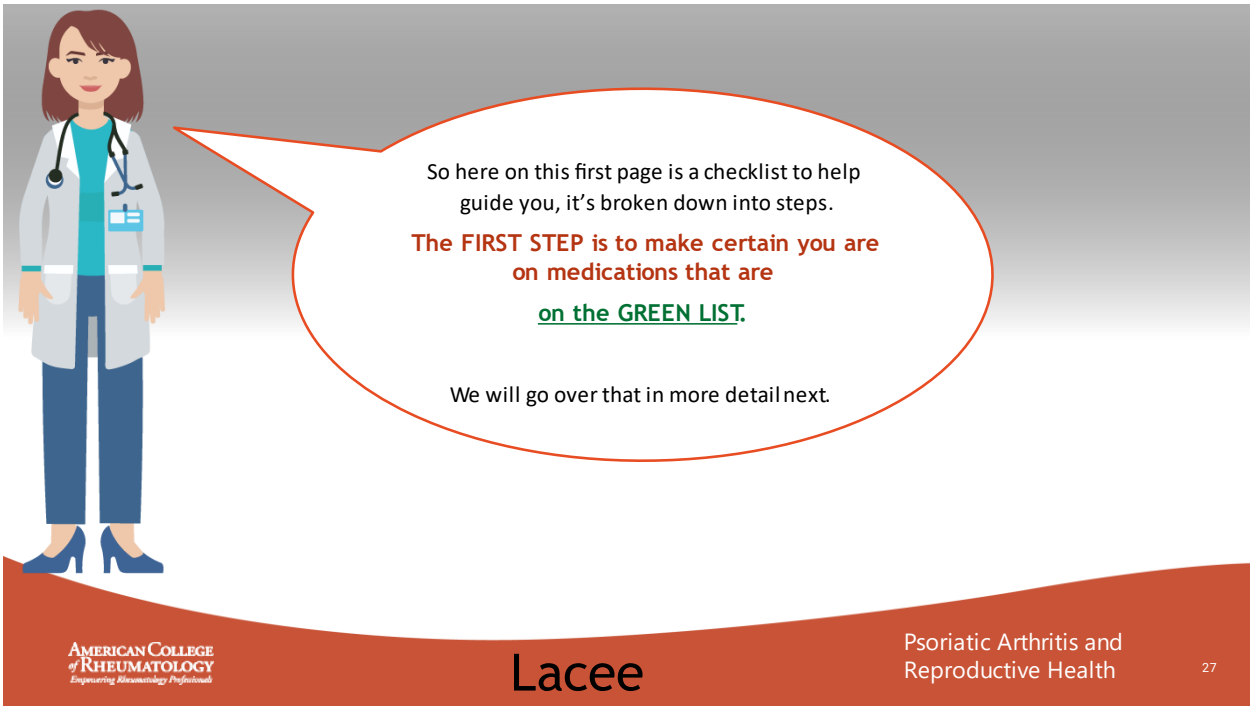
Slide 27: PREGNANCY PLANNING – STEP 1



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Slide 28: MEDICATION LIST (HANDOUT)

Pregnancy Planning for WOMEN with Psoriatic Arthritis

GREEN List *(good to go)*

- Sulfasalazine
- Prednisone <20 mg a day
- Tumor necrosis factor inhibitors (TNFi)

(TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

GREY list *(talk to the rheumatologist)*

- Janus kinase inhibitors (Tofacitinib, Baricitinib, Upadacitinib)
- Apremilast
- Abatacept
- Interleukin 17 inhibitor (Secukinumab, Ixekizumab)
- Interleukin 23 inhibitor (Guselkumab)
- Interleukin 12/23 inhibitor (Ustekinumab)
- Rituximab
- Non-steroidal anti-inflammatory agents (safe for use in 1st trimester, discuss with rheumatologist about discontinuing at 20 weeks of gestation*)

RED list *(STOP)*

- Methotrexate
- Leflunomide

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*Additional FDA recommendation details here

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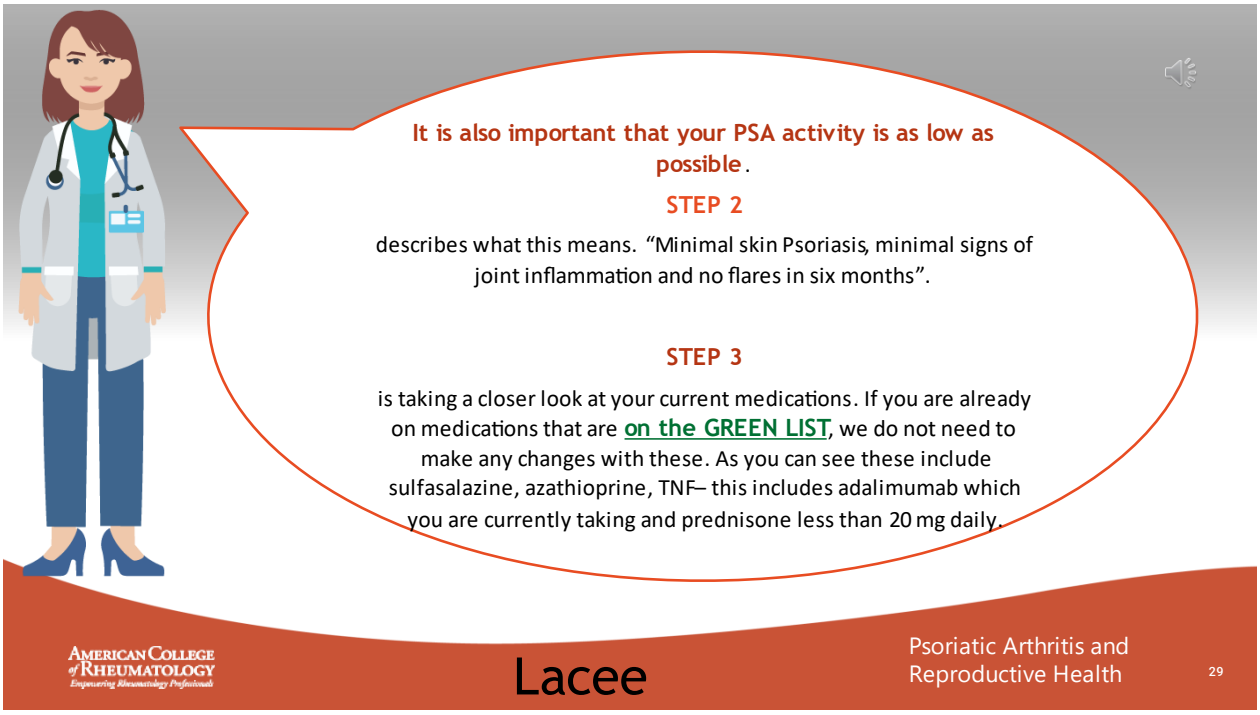
Slide 29: PREGNANCY PLANNING – STEP 2 & 3



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Slide 30: PREGNANCY PLANNING – STEP 2 & 3

Pregnancy Planning for WOMEN with Psoriatic Arthritis

STEP 1

To have the safest pregnancy possible:
- Use medications on the GREEN list
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?
- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms c/w iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time?
- Continue or start GREEN list medications
- Discuss with your doctor and talk about a switch from RED list meds to GREEN list meds
- Discuss any other medications with your obstetrician

STEP 4

Which doctors should you talk with?
- Rheumatology provider
- Maternal-Fetal Medicine Specialist
- Local Obstetrician (OB)
- Dermatology provider

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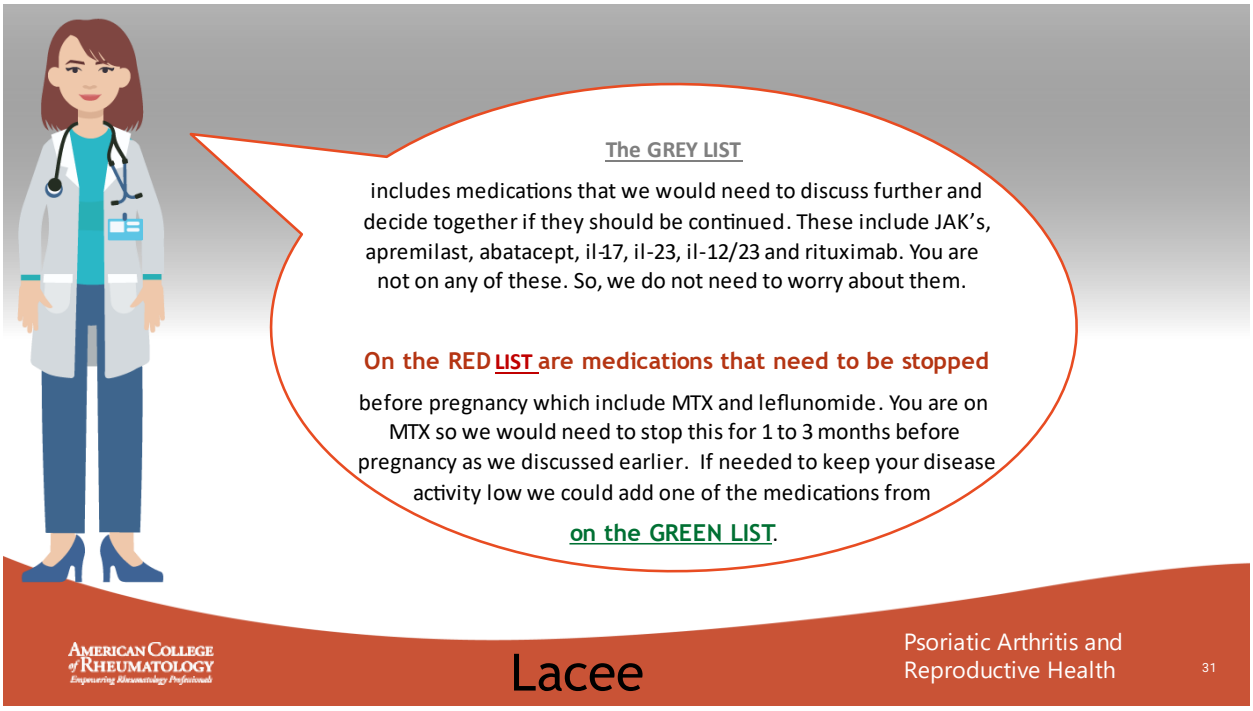
Slide 31: PREGNANCY PLANNING – MEDICATIONS



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Slide 32: MEDICATION LIST (HANDOUT)

Pregnancy Planning for WOMEN with Psoriatic Arthritis

GREEN List ***(good to go)***

- Sulfasalazine
- Prednisone <20 mg a day
- Tumor necrosis factor inhibitors (TNFi)

(TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

GREY list ***(talk to the rheumatologist)***

- Janus kinase inhibitors (Tofacitinib, Baricitinib, Upadacitinib)
- Apremilast
- Abatacept
- Interleukin 17 inhibitor (Secukinumab, Ixekizumab)
- Interleukin 23 inhibitor (Guselkumab)
- Interleukin 12/23 inhibitor (Ustekinumab)
- Rituximab
- Non-steroidal anti-inflammatory agents (safe for use in 1st trimester, discuss with rheumatologist about discontinuing at 20 weeks of gestation*)

RED list ***(STOP)***

- Methotrexate
- Leflunomide

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*Additional FDA recommendation details here

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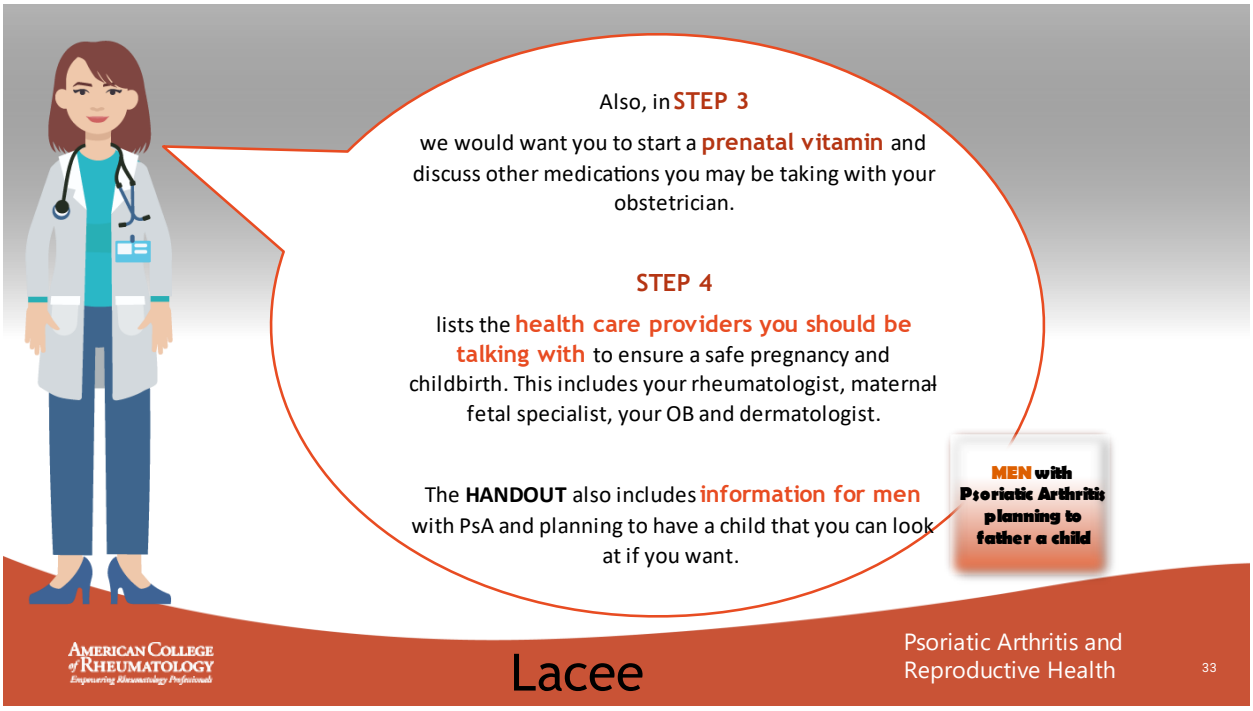
Slide 33: PREGNANCY PLANNING – STEP 3 & 4



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Slide 34: PREGNANCY PLANNING – STEP 3 & 4

MEN with Psoriatic Arthritis planning to father a child

STEP 1

To have the safest pregnancy possible:
- Discuss medications with your rheumatologist
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?
- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms c/w iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time?
- Discuss medications with your rheumatologist
- Note: Sulfasalazine can decrease sperm count and quality

STEP 4

Which doctors should you talk with?
- Rheumatology provider
- Dermatology provider

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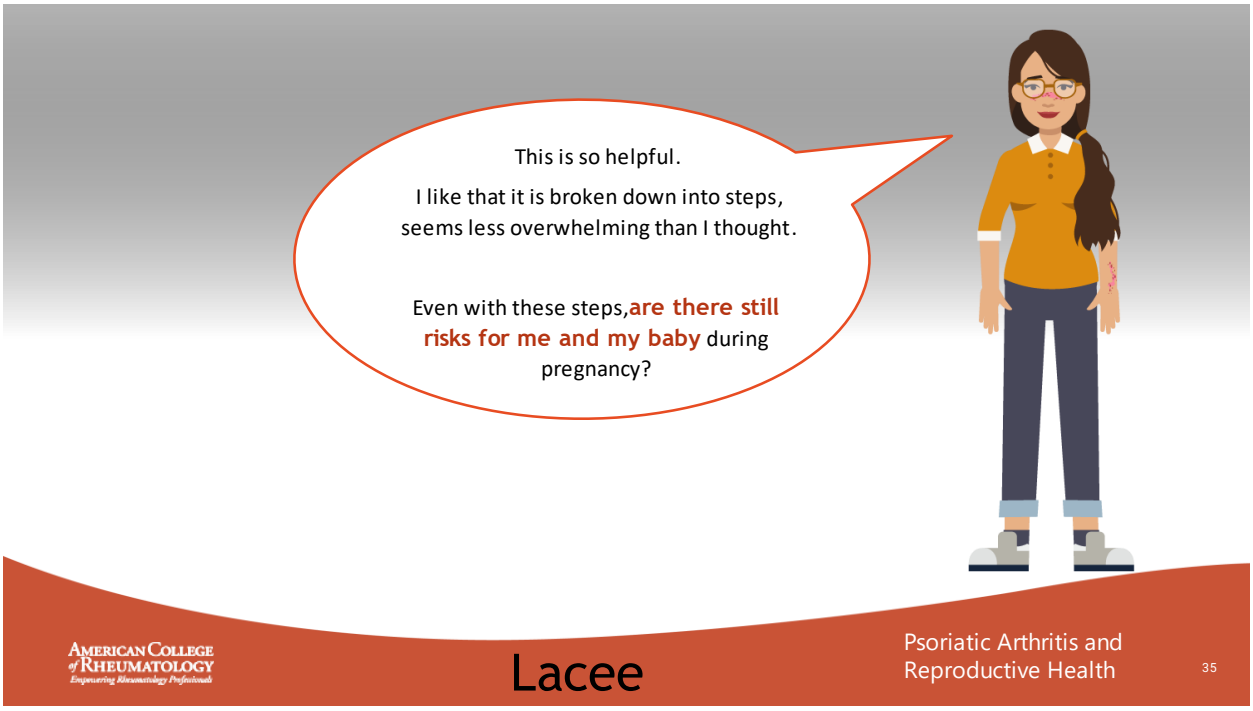
Slide 35: CONVERSATION



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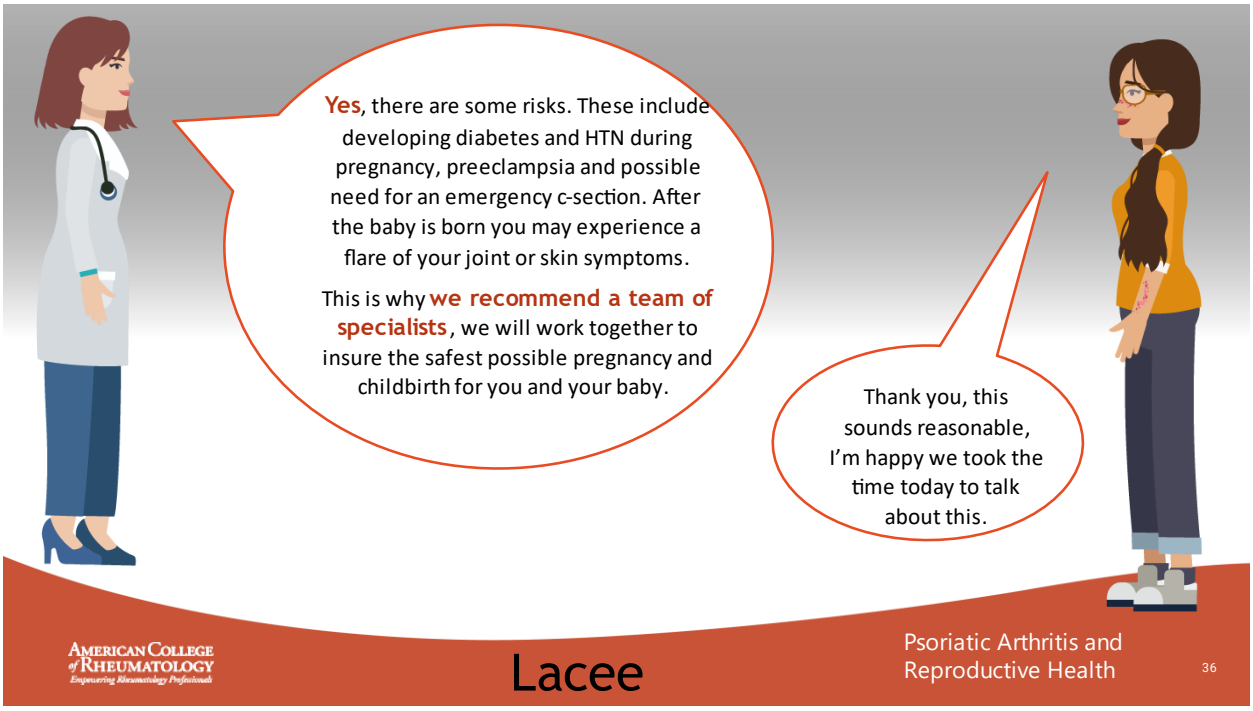
Slide 36: CONVERSATION



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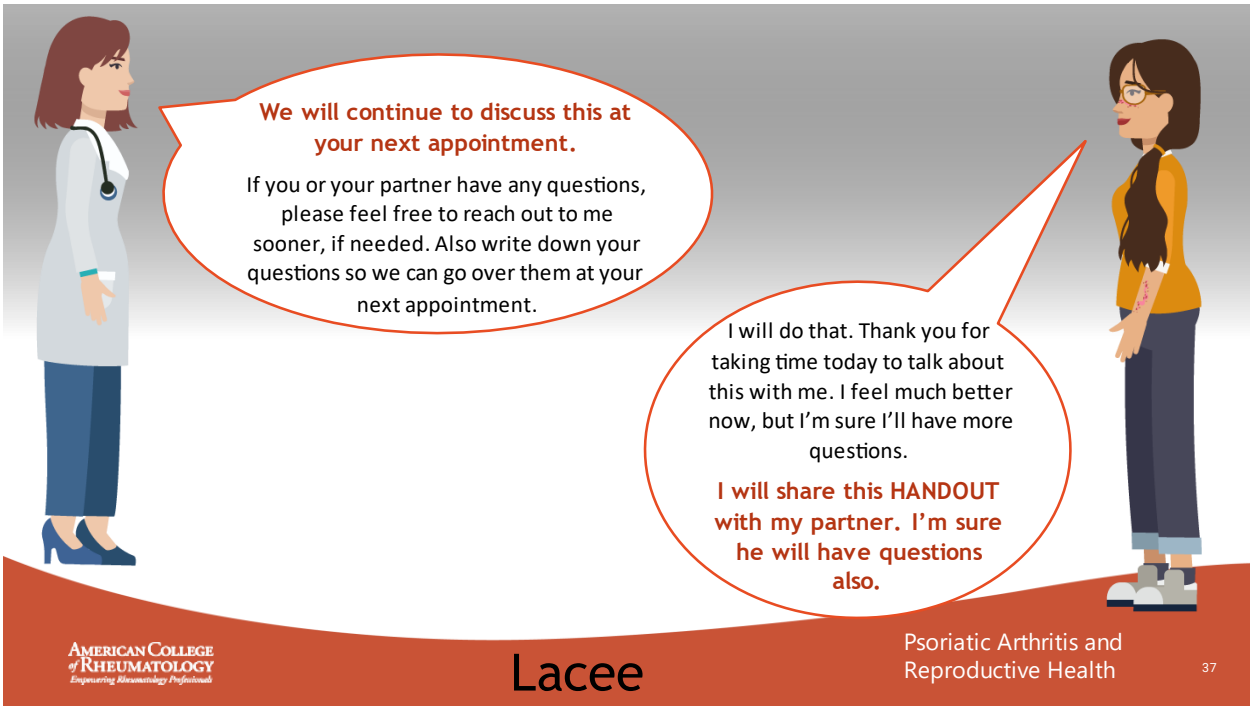
Slide 37: CONVERSATION



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Slide 38: CASE 2 LEARNING POINTS

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Slide 39: CASE 3 - JACK

CASE 3 - JACK

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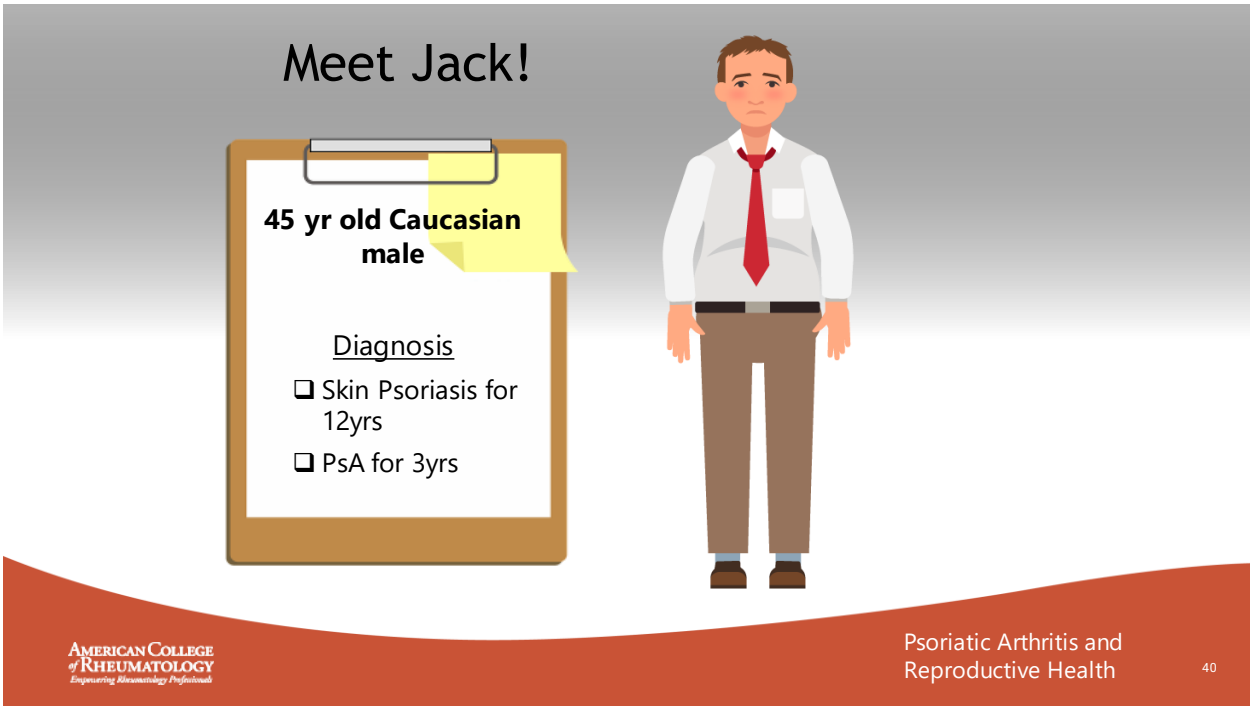
Slide 40: MEET JACK



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Slide 41: JACK'S FILE

Jack's file

Treatment

- Low dose corticosteroids (7.5 mg/d prednisone), topical steroids, Sulfasalazine (SSZ), various NSAIDs since diagnosis. Remains on meloxicam 7.5 mg/d about 5 days a week.

- Two years ago, because his skin PsO and PsA were both active, sulfasalazine was stopped, and methotrexate (MTX) was added. MTX was escalated to a dose of 17.5 mg/week but attempts at increasing the dose were not tolerated (GI side effects, slight increase in liver function tests).

- One year ago, again because of active disease, a TNF inhibitor was added to his MTX. On this regimen, he has done better, but still has some skin PsO active (about 5% BSA) and 2 swollen and tender joints.

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Slide 42: JACK'S VISIT

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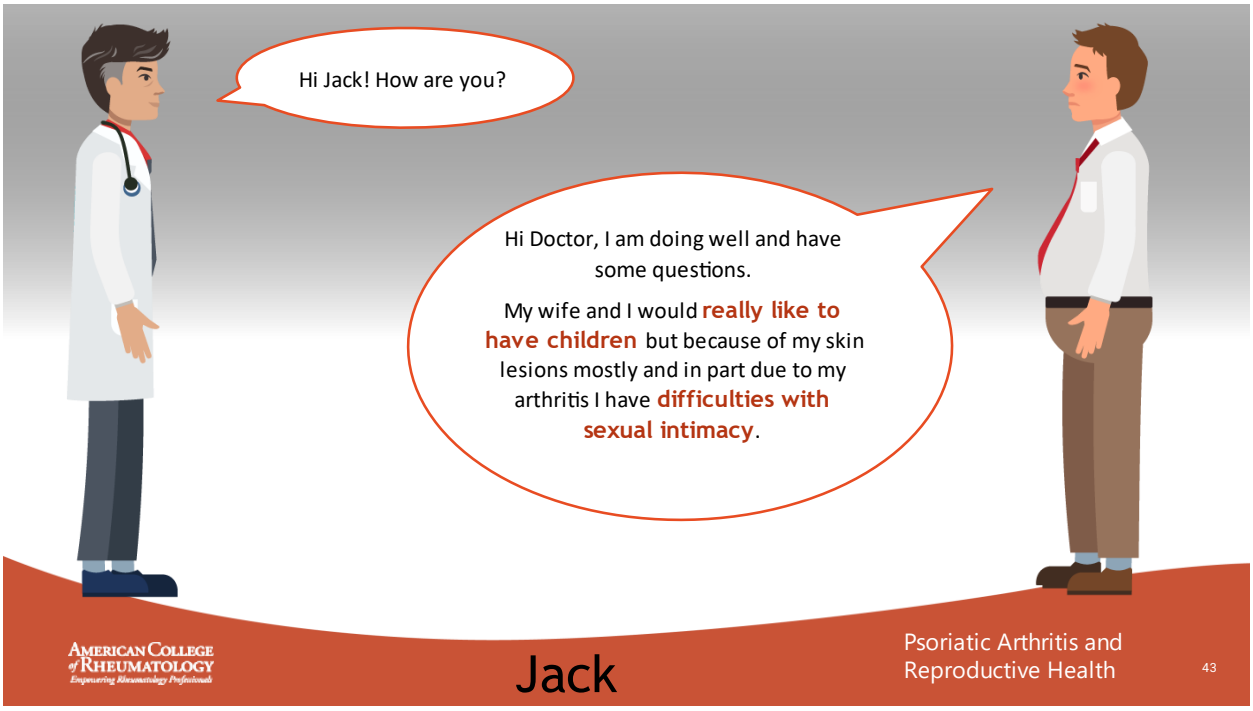
Slide 43: CONVERSATION



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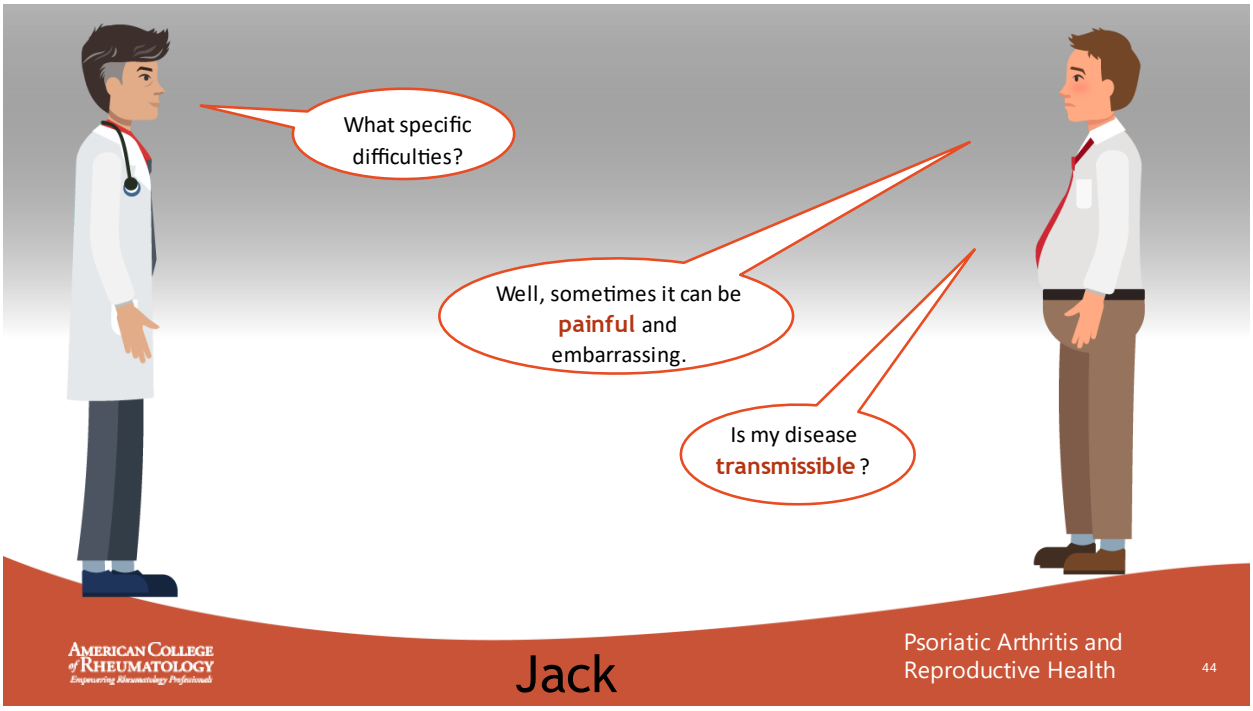
Slide 44: CONVERSATION



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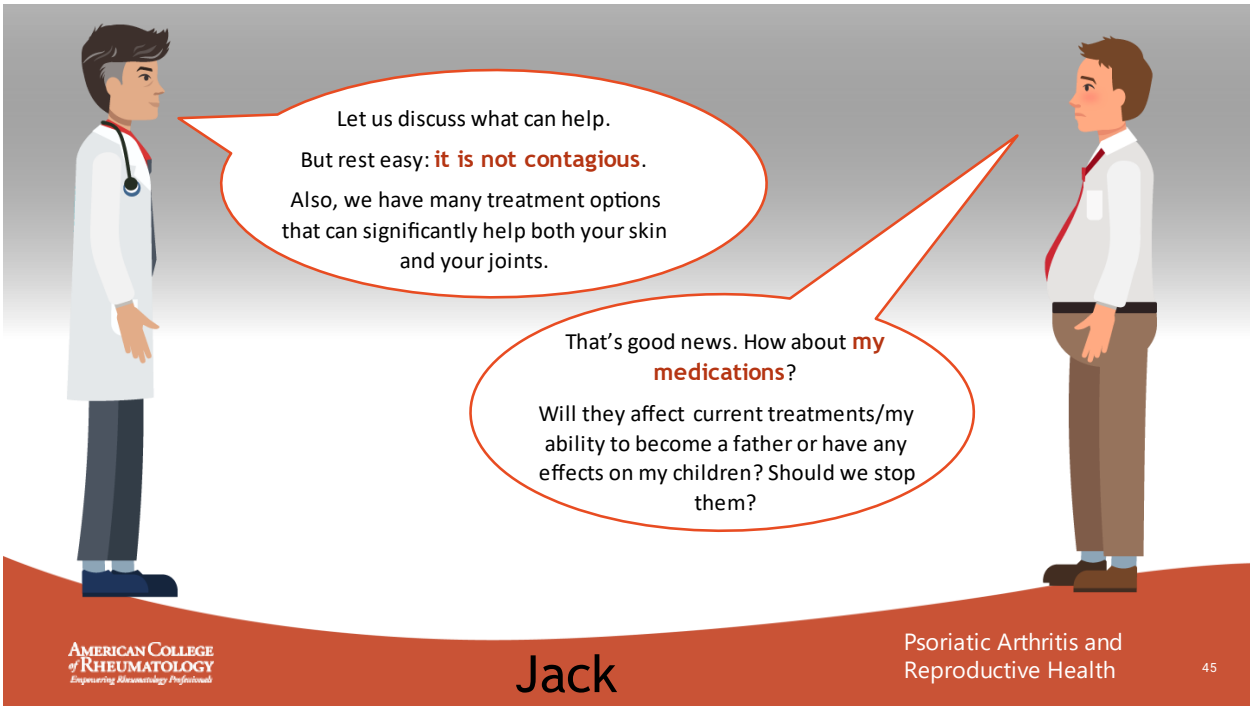
Slide 45: CONVERSATION



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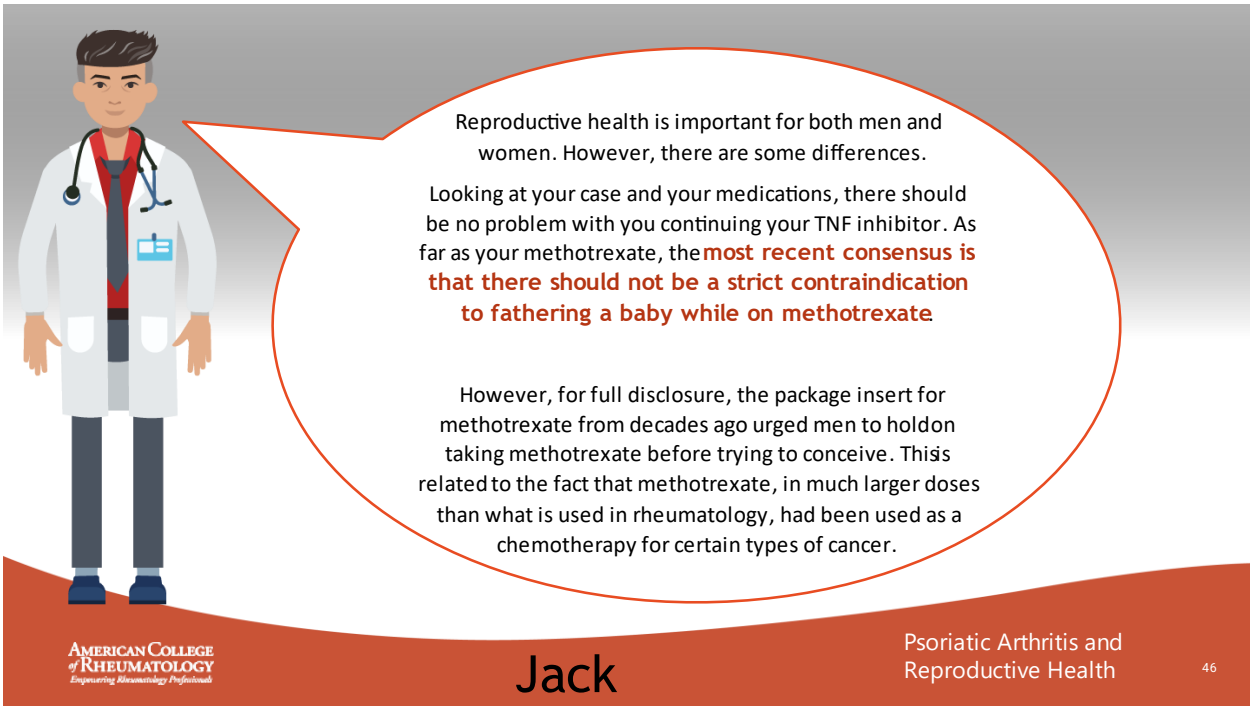
Slide 46: CONVERSATION



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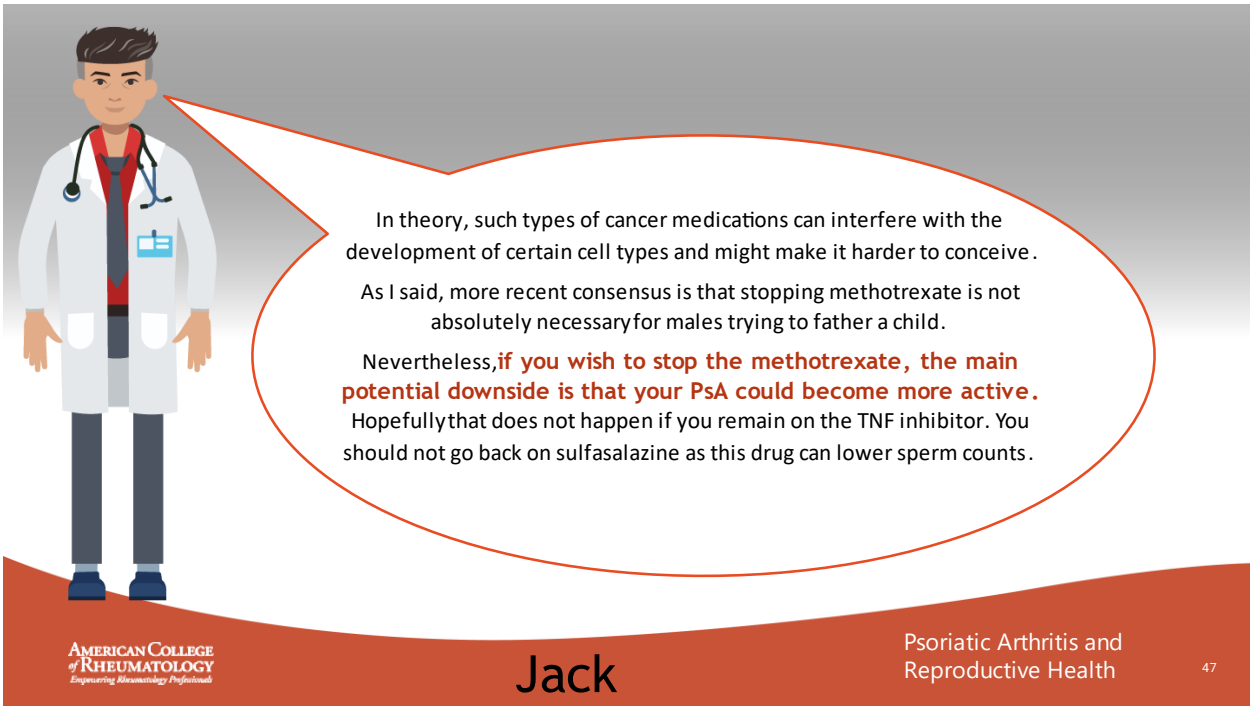
Slide 47: CONVERSATION



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Slide 48: PREGNANCY PLANNING – 4 STEPS

MEN with Psoriatic Arthritis planning to father a child

STEP 1

To have the safest pregnancy possible:
- Discuss medications with your rheumatologist
- Keep your Psoriatic Arthritis activity as low as possible

STEP 2

Is your Psoriatic Arthritis well controlled?
- Minimal skin and nail Psoriasis
- Minimal signs of joint inflammation
- No recent signs/symptoms c/w iritis, inflammatory bowel disease, enthesitis, dactylitis
- No flares in the last 6 months

STEP 3

Are your medications right for you at this time?
- Discuss medications with your rheumatologist
- Note: Sulfasalazine can decrease sperm count and quality

STEP 4

Which doctors should you talk with?
- Rheumatology provider
- Dermatology provider

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Slide 49: MEDICATION LIST

MEN with Psoriatic Arthritis planning to father a child

Medications to discuss with your rheumatologist

- Apremilast
- Abatacept
- Interleukin 17 inhibitor (Secukinumab,Ixekizumab)
- Interleukin 23 inhibitor (Guselkumab)
- Interleukin 12/23 inhibitor (Ustekinumab)
- Janus kinase inhibitors (Tofacitinib, Baricitinib, Upadacitinib)
- Leflunomide
- Methotrexate
- Non-steroidal anti-inflammatory agents
- Sulfasalazine
- Tumor necrosis factor inhibitors (TNFi)
  (TNFi = Adalimumab, Etanercept, Infliximab, Certolizumab, Golimumab)

Note: Medications listed here appear to be safe in the context of family planning for men with rheumatic disease. Discuss these medications with your rheumatologist.

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Slide 50: CASE 3 LEARNING POINTS

CASE 3 - JACK
Learning Points

Family planning is a discussion to have with male patients.

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Slide 51: CASE 4 - TERRI

CASE 4 - TERRI

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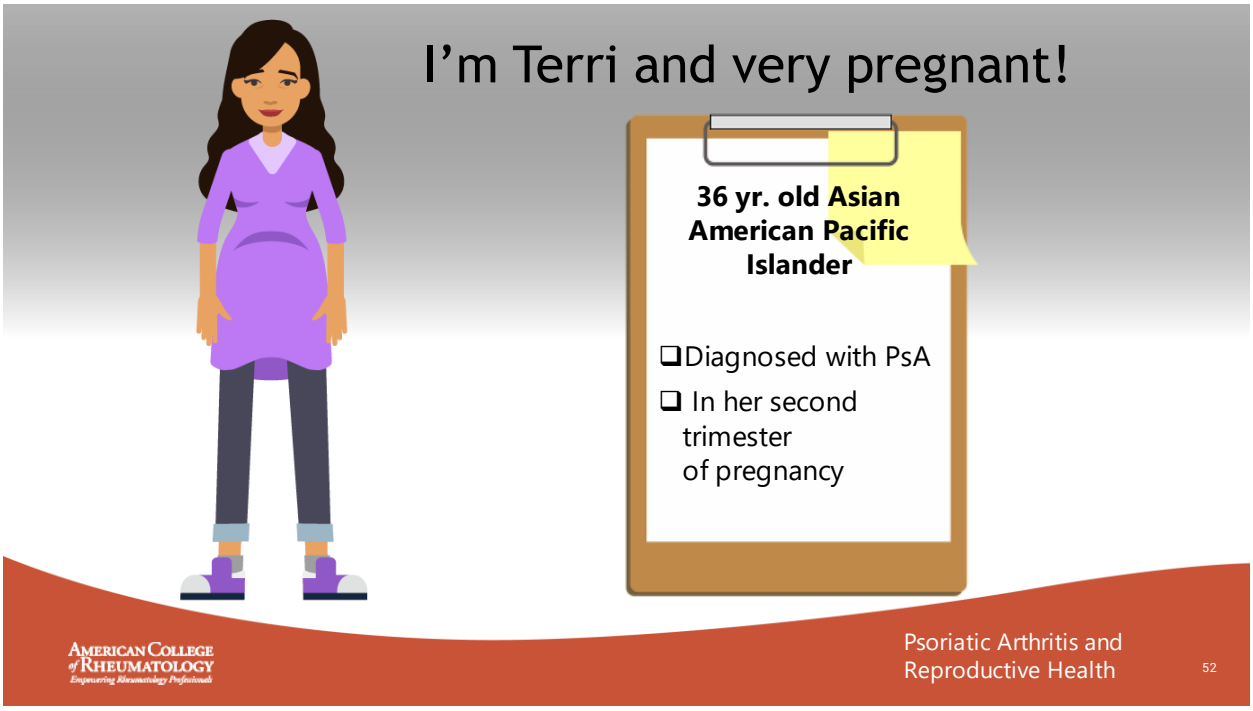
Slide 52: MEET TERRI



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Slide 53: TERRI'S FILE

Terri's file

History

- She presents {2nd trimester}to her primary care clinic.
- This is her first pregnancy.
- Her disease is well-controlled with adalimumab and naproxen 500 mg twice a day.
- Her rheumatologist told her that adalimumab is safe to use during pregnancy, but she is unsure if or when to stop it during pregnancy.
- She has continued naproxen and has no plans to stop it during pregnancy.

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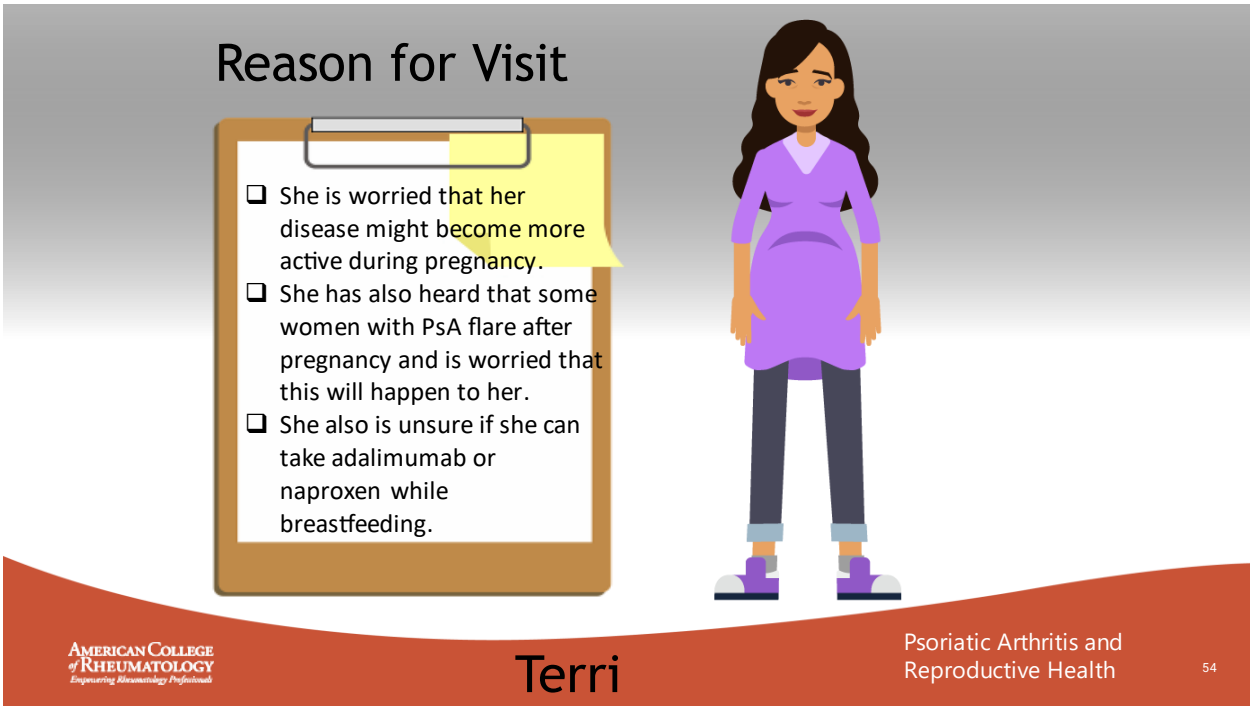
Slide 54: TERRI'S VISIT



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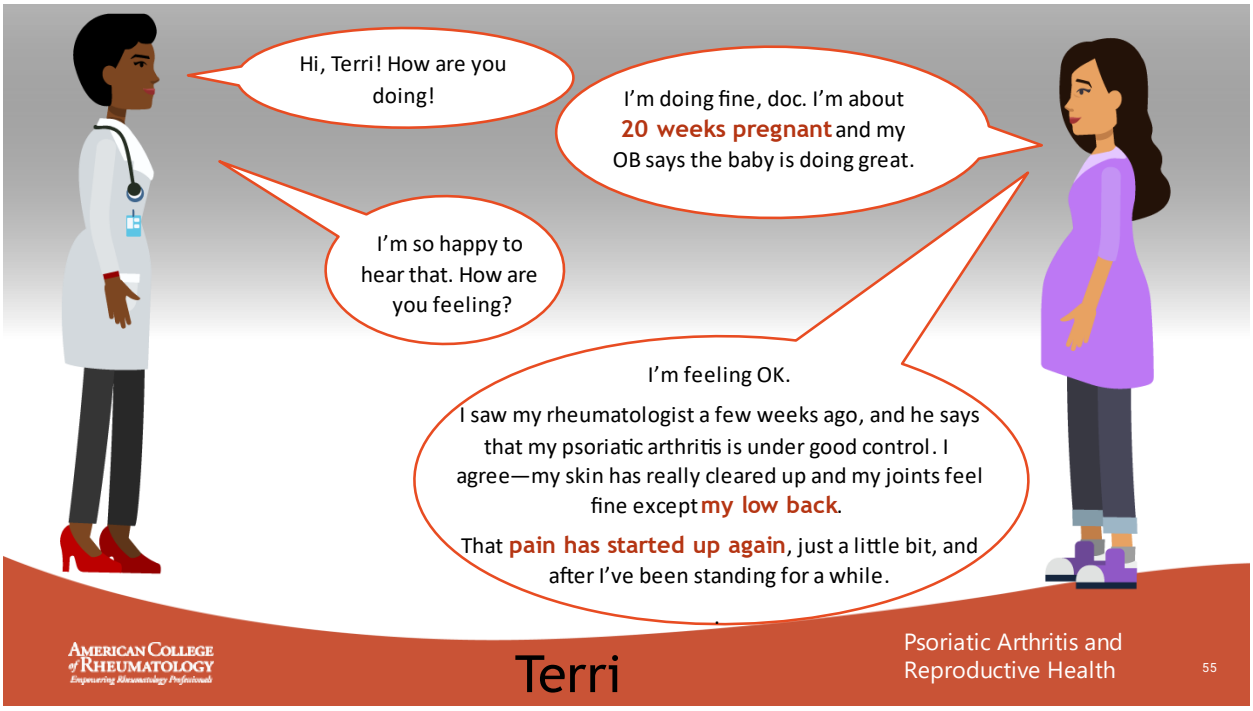
Slide 55: CONVERSATION



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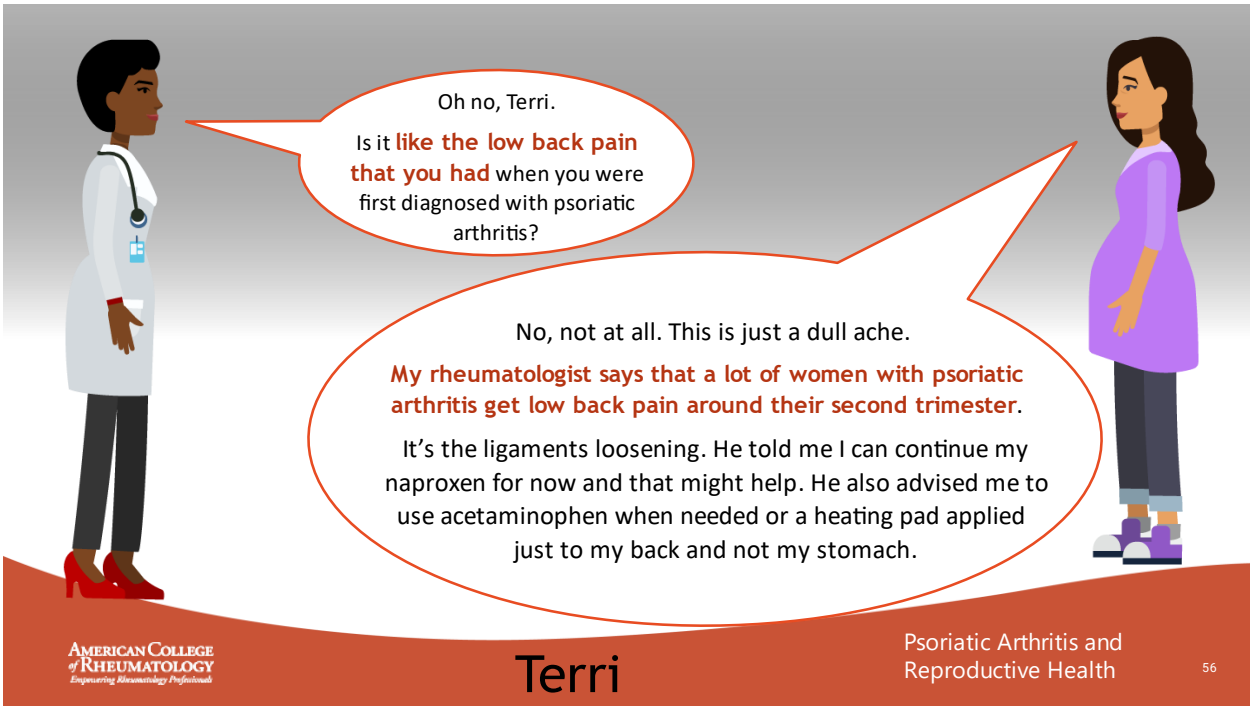
Slide 56: CONVERSATION



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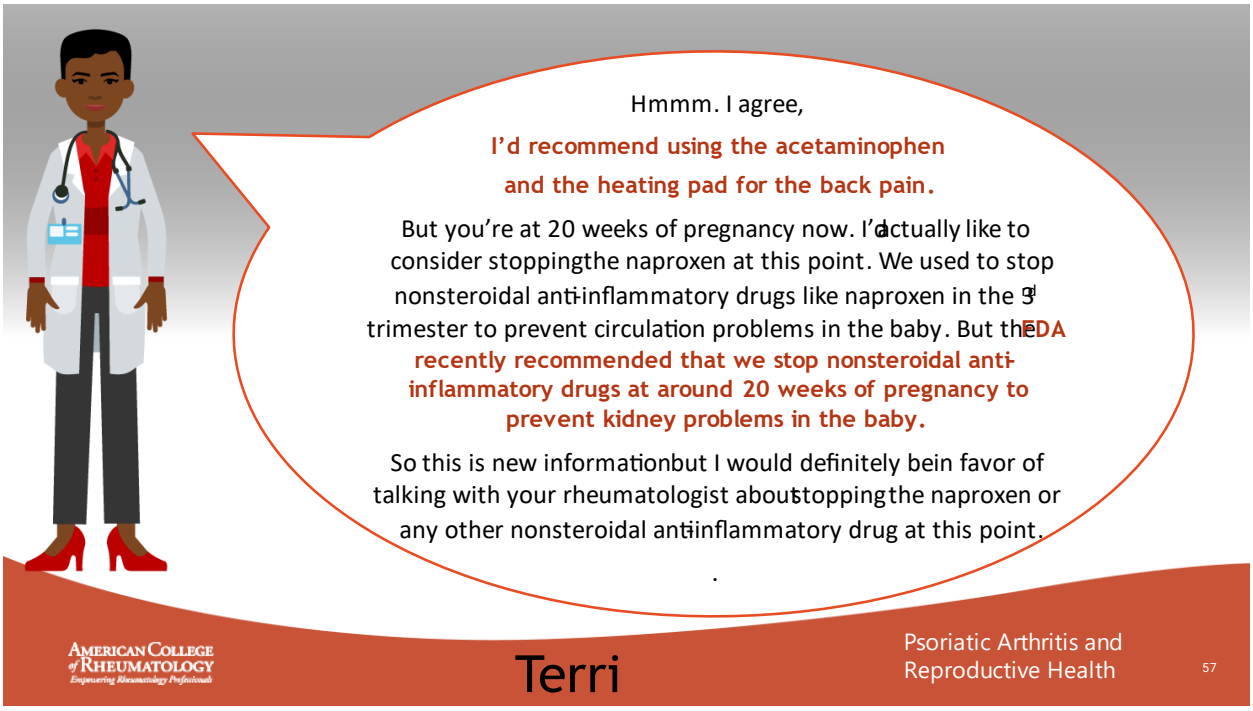
Slide 57: CONVERSATION



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Slide 58: CONVERSATION

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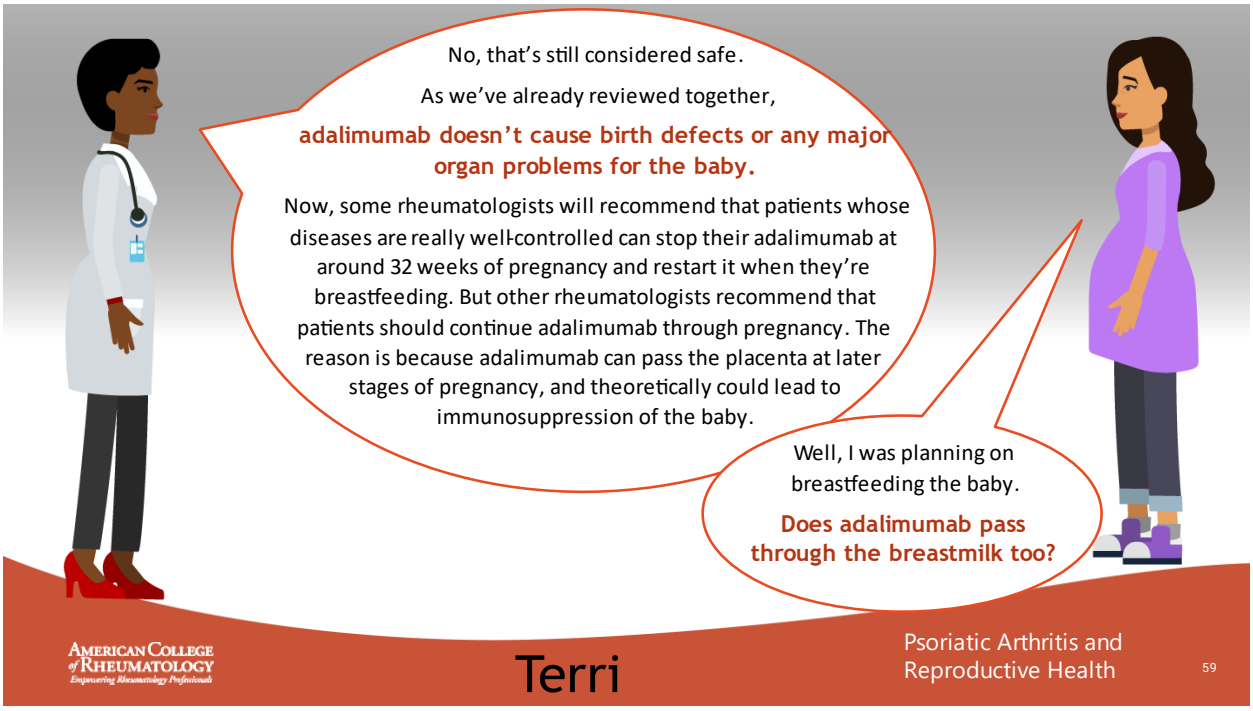
Slide 59: CONVERSATION



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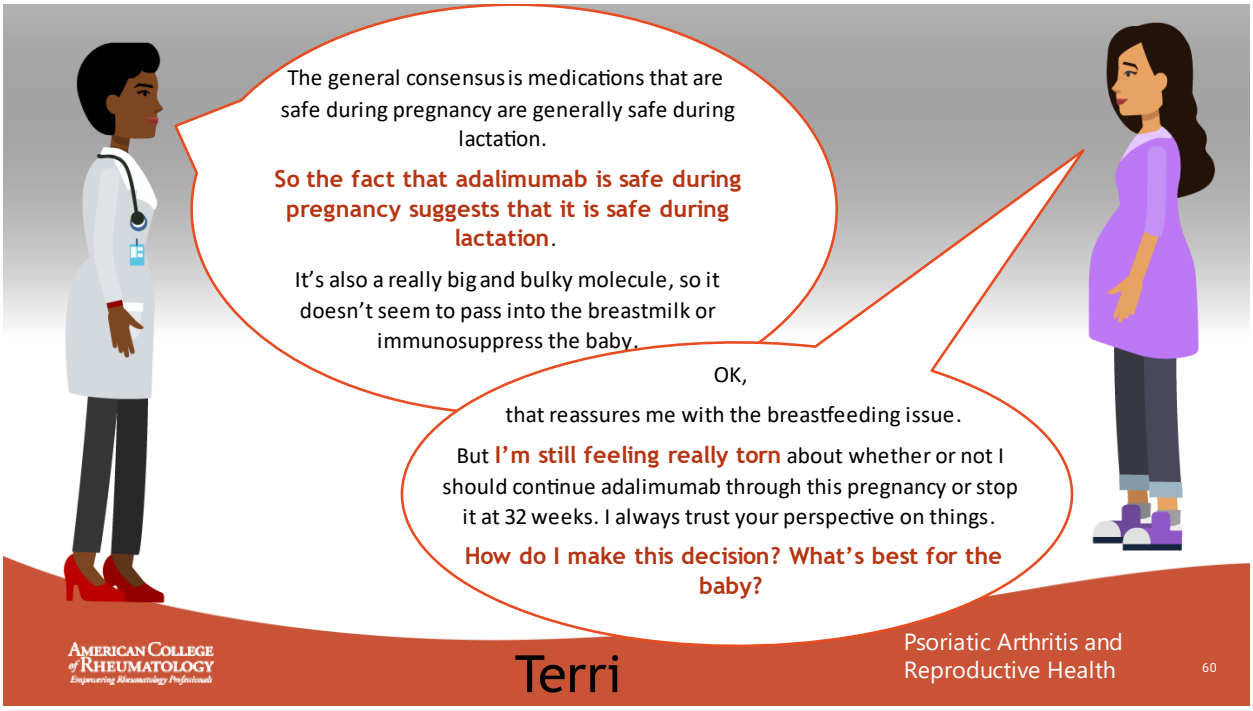
Slide 60: CONVERSATION



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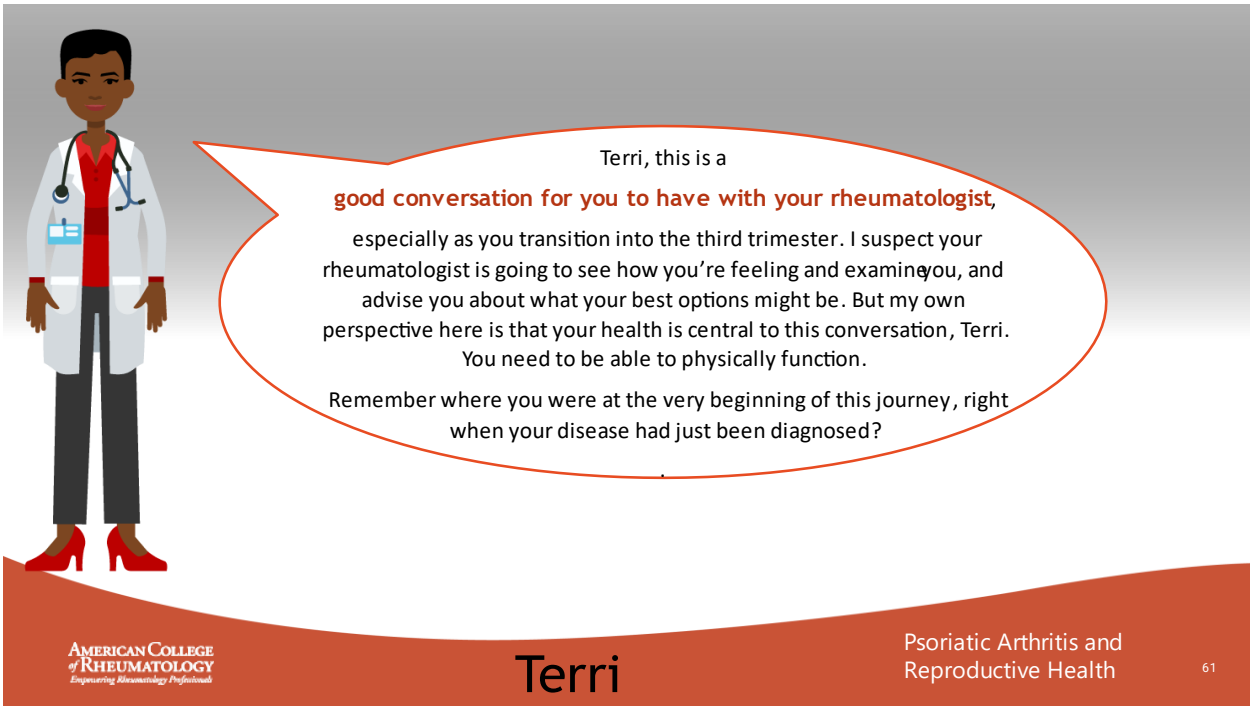
Slide 61: CONVERSATION



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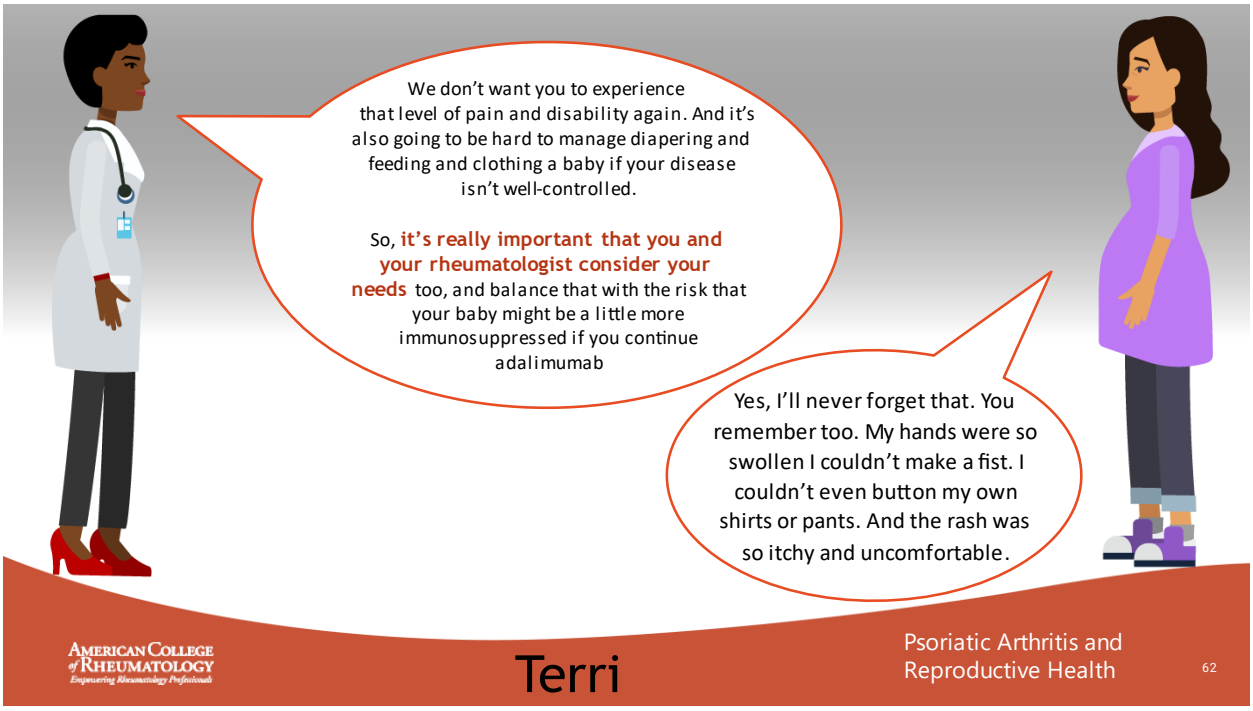
Slide 62: CONVERSATION



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Slide 63: CASE 4 LEARNING POINTS

CASE 4 - TERRI
Learning Points

- ❑ One of the best things to ensure a healthy baby is to have a healthy mother
- ❑ Medications that are safe during pregnancy are generally safe during lactation

Psoriatic Arthritis and Reproductive Health

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Slide 64: KEY MESSAGES

Key Messages

- ***PsA is an autoimmune condition*** resulting in inflammatory arthritis seen in approximately 30% of patients with psoriasis
- ***A multi-faceted approach to pregnancy planning is essential*** in women of childbearing age as uncontrolled disease activity and medications used to treat the condition can result in adverse pregnancy outcomes
- ***Contraception should be discussed*** with patients of childbearing age during their visits

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Slide 65: KEY MESSAGES

Key Messages

- It is important to have the ***conversation with patients about medications and their potential impacts*** on their pregnancy
- ***Family planning*** is a discussion to have ***with male patients*** as well
- One of the best things to ensure ***a healthy baby is to have a healthy mother***
- ***Medications*** that are safe during pregnancy are generally safe during lactation

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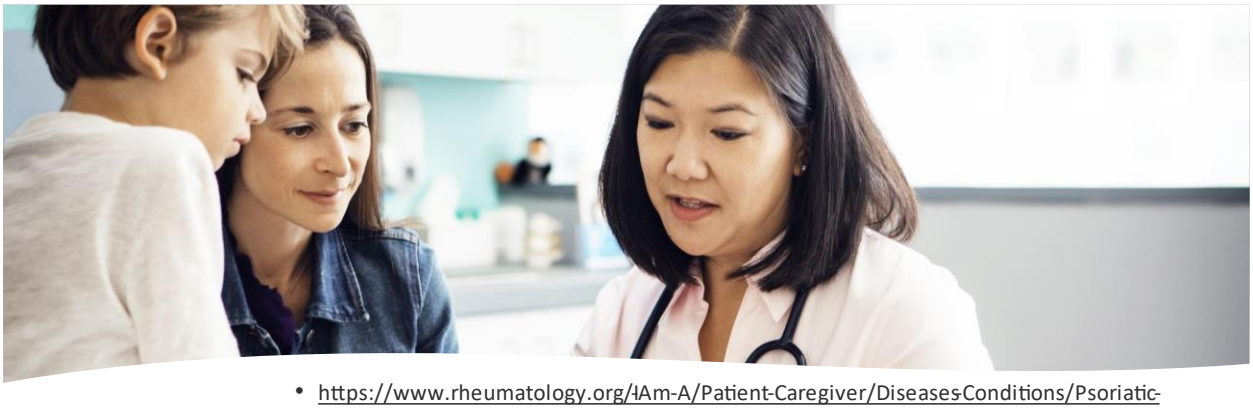
Slide 66: REFERENCES



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Psoriatic Arthritis and Reproductive Health

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Slide 67: Q & A

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Slide 68: CONTACT INFO

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CONCLUSIONS

Facilitator Notes:

- ❑ Thank participants for attending *Exploring PsA and Reproductive Health, Case by Case*

- ❑ Remind participants about the importance of their feedback and emphasize that they take the post-test assessment. Allow 10 minutes for the post-test to be completed.

- ❑ If you are comfortable, consider offering your contact information to participants in case they have questions after today's session.