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Reproductive Care in Women with MS, NMOSD and MOGAD

A 2026 update on family planning, pregnancy, postpartum and lactation

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Off-label discussion:

Many DMTs and lactation/pregnancy strategies discussed in this presentation reflect off-label use, expert consensus and post-marketing data. They do not always align with current EMA/FDA labels and should be applied within shared decision-making.

Learning objectives

Reproductive planning

Counsel women with MS, NMOSD and MOGAD on fertility, ART, and pre-conception DMT optimisation.

Pregnancy

Apply current evidence on DMT continuation/withdrawal, relapse management, and MRI use during pregnancy.

Postpartum

Risk-stratify postpartum relapses and design timely DMT restart strategies including bridging.

Lactation

Use RID, molecular and pharmacokinetic data to support breastfeeding on most modern DMTs.

Multidisciplinary care

Coordinate with maternal–fetal medicine for mood disorders, vaccines, anesthesia and delivery decisions.

Who are these women?

~3 : 1

Female-to-male ratio in MS

20 – 40

Peak age at MS diagnosis (years)

9 : 1

Female predominance in AQP4-IgG NMOSD

Implication for practice

Most women diagnosed with a demyelinating disease are in their reproductive years.
Reproductive counselling is therefore not optional — it is part of disease modification.

Modern cohorts show fertility rates lower than the general population (Italy 0.58 vs 1.29; US claims data show similar gap), driven mainly by behavioural and treatment factors rather than reduced biological capacity.

Moccia et al. JNNP 2022; Houtchens et al. Neurology 2018; Magyari/Danish MS Registry 2024.

The reproductive journey: four phases of care

01

Reproductive planning

02

Pregnancy

03

Postpartum

04

Lactation

Cross-cutting throughout: shared decision-making, multidisciplinary coordination (Neuro × OB-GYN × MFM), and equity-of-access considerations.

SECTION 01

01

Reproductive planning

Fertility counselling, ART, pre-conception DMT optimisation, and avoiding therapeutic inertia.

MS itself is not a cause of infertility

Key message

Women with MS do not have a clinically meaningful reduction in biological fertility.

Ovarian reserve (AMH, AFC) is largely preserved.

Spontaneous abortion and ectopic rates are similar to the general population.

Time to pregnancy is comparable in many cohorts.

Why are family sizes smaller, then?

- **Disease & treatment** DMT contraindications, sexual dysfunction, fatigue, depression
- **Behavioural / social** Fear of disability, parenting concerns, socioeconomic factors
- **Iatrogenic gonadotoxicity** HSCT, CAR-T, mitoxantrone, cyclophosphamide
- **Age & lifestyle** Delayed conception while optimising therapy; obesity, smoking

Magyari M, ECTRIMS 2026; Krysko KM et al. Lancet Neurol 2020; Houtchens MK et al. Neurology 2018; Hellwig K et al. Mult Scler 2009.

Assisted reproductive technology: do not delay, do not deny

0.25 → 0.26

ARR before vs. after fertility treatment (Multicenter, Graham 2023)

No ↑ relapse

OFSEP IVF cohort: 199 procedures, 115 women (Mainguy 2025)

Equivalent

ART success rates with adequate disease control (Kappelgaard 2025)

Practical recommendations

Maintain disease control during stimulation and through early pregnancy.

Continue effective DMTs (anti-CD20, natalizumab) up to and during ART when possible.

GnRH antagonists ≈ agonists for relapse risk; choice driven by reproductive endocrinology.

Consider fertility preservation BEFORE gonadotoxic therapy (HSCT, mitoxantrone, cyclophosphamide).

Standard infertility evaluation applies — same as the general population.

Graham E et al. NNN 2023; Mainguy M et al. NNN 2025; Kappelgaard L et al. JNNP 2025; Magyari M, ECTRIMS 2026.

Pre-conception consultation: a structured framework

Disease status

Recent ARR; MRI activity in last 12 months; EDSS; trajectory; serostatus (AQP4/MOG).

Current DMT

Mechanism, half-life, placental and milk transfer; need for washout vs. continuation.

Timing plan

How long to wait, optimal conception window, contraception during washout.

Risk–benefit

Risk of withdrawal-related rebound vs. fetal exposure; weighed individually.

Vaccinations

Update measles, varicella, HepB, dTaP, COVID-19, HPV BEFORE conception.

Comorbidities

Mood disorders, thyroid disease, obesity, smoking — address pre-conception.

Vukusic S et al. MSJ 2023; Krysko KM et al. Lancet Neurol 2023; ECTRIMS Workshop consensus 2026.

Avoiding therapeutic inertia in women of childbearing age

Therapeutic inertia = failing to start or escalate DMT when therapeutic goals are not met.

Women in their reproductive years are at particular risk — the wish for pregnancy too often dictates DMT choice and delays escalation.

DON'T

- Default to “safer” low-efficacy DMTs only because pregnancy may happen one day.
- Allow disease activity to accumulate while a patient is “planning”.
- Stop a working high-efficacy DMT prematurely without a clear bridging plan.

DO

- Treat to suppress activity early — pregnancy-compatible high-efficacy options exist.
- Choose DMTs whose plan supports conception (anti-CD20, natalizumab, cladribine).
- Document a personalised pre-conception, pregnancy and postpartum plan.

Vukusic S, ECTRIMS 2026; Solberg Soerensen P et al. MSARD 2021.

SECTION 02

02

DMTs around conception

Class-by-class evidence, washout intervals, rebound risk and continuation strategies.

DMT classes — implications for conception

Class	Examples	Pre-conception strategy	On DMT at conception
Platform / injectables	IFN-β, glatiramer acetate	Continue through conception (low risk)	May continue; most providers stop at conception
Oral immunomodulators	DMF, DRF, MMF	Stop at conception (insufficient data; EMA: avoid)	Discontinue, monitor
Teriflunomide	Aubagio	Accelerated elimination required (cholestyramine/charcoal)	Contraindicated
S1P modulators	Fingolimod, ozanimod, ponesimod, siponimod	Stop ≥2 mo pre-conception; bridge to high-efficacy DMT	Discontinue (teratogenic signal)
Natalizumab (NTZ)	Tysabri	Continue q6w EID; last dose ~30–34 wks	Continue
Anti-CD20	Rituximab, ocrelizumab, ofatumumab, ublituximab	Last dose pre-conception; no rush to redose postpartum	Generally compatible
Induction / pulsed	Cladribine, alemtuzumab	Complete cycles, then ≥6 mo wait before conception	Contraindicated during dosing

Adapted from Vukusic et al. MSJ 2023; Krysko et al. Lancet Neurol 2023; Hellwig et al., Landi et al., Langer-Gould et al., Thiel et al., Fink et al., ECTRIMS 2026.

Platform therapies: IFN-β, GA, fumarates, teriflunomide

Interferon-β & glatiramer acetate

- Large molecules — minimal placental transfer.
- Updated EMA/FDA labels (2019–2020) permit use throughout pregnancy.
- Compatible with breastfeeding (RID <1%).

Fumarates (DMF, DRF, MMF)

- Small-molecule prodrugs; limited registry data.
- EMA: avoid; FDA: continue only if needed.
- Lactation: very low RID (~0.007–0.02%) — emerging support.

Teriflunomide

- Contraindicated in pregnancy and breastfeeding.
- Requires accelerated elimination with cholestyramine or charcoal until plasma <0.02 mg/L.
- Confirm with two tests ≥14 days apart before conception.

Fink K, Hakkarainen 2020; Sandberg-Wollheim 2018; Ciplea 2020 & 2022; Hellwig K, ECTRIMS 2026.

Anti-trafficking therapies: high reward, real risks

S1P MODULATORS

Fingolimod • ozanimod • ponesimod • siponimod

- MCM rate ~6–7% with first-trimester fingolimod exposure (≈2× general-population baseline).
- Increased congenital heart and urinary malformations.
- Withdrawal rebound seen in 10–25% — not prevented by pregnancy.
- **Stop ≥2 months before conception; bridge to anti-CD20 or NTZ if disease activity is high.**
- *No data for ponesimod / siponimod — extrapolate cautiously.*

NATALIZUMAB

Continuation strategy preferred

- Withdrawal in pregnancy → 30–70% relapse rate; up to 10% disability accrual.
- Extended-interval dosing (q6w) through pregnancy maintains efficacy.
- Last dose typically at 30–34 wks gestation; restart within 2 wks postpartum.
- Possible neonatal effects: mild anaemia, thrombocytopenia → monitor at delivery.
- **Compatible with breastfeeding (RID ~5%, large IgG4 mAb).**

Landi D, ECTRIMS 2026; Yeh WZ et al. Neurology 2021; Hellwig K et al. JAMA Netw Open 2020.

Anti-CD20 therapies: a paradigm shift

Pre-conception dosing strategy

Last infusion before conception, then suspend dosing.

- RTX (population cohorts, MSBase): No rebound during pregnancy or postpartum, even with >12-month dose extension.
- Sweden 2006–2017 cohort: 4/76 (5.3%) relapsed — all 0–3 mo postpartum; 79% restarted within 3 months.
- First-trimester exposure (29% in MSBase OCR cohort): no excess malformation signal to date; monitor neonatal lymphocytes after late exposure.
- Ofatumumab and ublituximab: emerging registry data, similar pharmacology — same general approach.

KEY INSIGHT

Return of $CD19^+$ B cells is NOT required to redose.

B-cell repopulation does not predict return of disease activity. Extended dosing intervals (q12 mo or longer) are increasingly used in stable RRMS — supporting both pregnancy planning and breastfeeding without compromising efficacy.

Langer-Gould A, ECTRIMS 2026; Yeh WZ et al. NNN 2024; Bsteh G, Nguyen AL, et al.

Induction therapies: pulsed dosing favors conception planning

CLADRIBINE

Two annual short courses → durable effect

- Effective contraception during and 6 months after the LAST tablet (both partners).
- After 6-month wait (EU), 4-month wait (US), no detectable teratogenic effect in current cohorts.
- Allows treatment-free pregnancy and postpartum window — fewer DMT decisions during pregnancy.
- Lactation: wait 10 days after last dose (FDA/EMA); RID 2–5%, accumulating data on safe breastfeeding.

ALEMTUZUMAB

Effective — but watch the secondary autoimmunity

- Effective contraception during cycle and 4 months after each course.
- Secondary autoimmune thyroid disease in up to 30% — complicates pregnancy (preeclampsia, growth restriction, neonatal Graves).
- Active placental transfer in 2nd/3rd trimester via FcRn — avoid late-pregnancy exposure.
- DHPC concerns about immune-mediated reactions have reduced clinical use.

Thiel S, ECTRIMS 2026; DMSKW Register; Hellwig K et al.

A simplified pre-conception decision tree

STABLE on platform DMT

Continue **IFN-β or GA** throughout pregnancy or stop at conception **(preferred)**
No washout needed.

Stop fumarate at pregnancy confirmation

Stop/wash out Teriflunomid

STABLE on anti-CD20 / cladribine

Time conception 1–12 months after last dose.
No bridging usually required.

STABLE on natalizumab

Continue with q6-week EID through pregnancy.
Last dose ~30–34 wks; rapid postpartum restart.

ACTIVE / on S1P or fumarate

Bridge to anti-CD20 or NTZ.
Stop S1P ≥2 months pre-conception with active monitoring.

Always personalise: NEDA status, MRI activity, prior breakthrough, patient preference, access.

Synthesised from Krysko KM et al. Lancet Neurol 2023; Vukusic S et al. MSJ 2023.

SECTION 03

03

Pregnancy

Natural history, fetal outcomes, intrapartum relapse management, and MRI use.

MS in pregnancy — reassuring messages from natural history

↓ 70% Relapse rate in 3rd trimester (PRIMS, Confavreux 1998)

↑ 2–3× ARR in first 3 months postpartum without DMT

Neutral Long-term effect of pregnancy on disability

Modern reality

PRIMS-era patterns persist for untreated or platform-treated mothers.

But the contemporary postpartum risk profile has shifted:

- Dominated by DMT withdrawal effects (S1P, NTZ).
- Anti-CD20 and cladribine markedly reduce postpartum relapse risk — even without immediate restart.
- Exclusive breastfeeding adds modest extra protection in mild–moderate disease.

Confavreux C et al. NEJM 1998; Hellwig K et al. JAMA Neurol 2015; Vukusic S, ECTRIMS 2026.

Pregnancy and fetal outcomes — what the registries say

Miscarriage

Comparable

to the general population (Lopez-Leon 2020)

Preterm birth

Slight ↑

in older cohorts; recent treated cohorts ≈ general population

Birth weight

Similar

median weights; small ↑ SGA in higher-disability mothers

Congenital anomaly

No excess

with platform DMTs, anti-CD20 (limited 1st-trim data)

Perinatal mortality

≈ background

5/1000 in RESPONSE vs 10/1000 (France ENP)

C-section rate

Slightly ↑

but driven by obstetric not MS reasons (except severe disability)

Maillart E, ECTRIMS 2026; RESPONSE study (Maillart MSJ 2025); Lopez-Leon JN 2020; Finkelsztejn BJOG 2011.

Intrapartum relapse: when to treat

Treatment threshold: balance accelerated functional recovery against potential fetal risk.

Reserve treatment for major-symptom relapses that interfere with daily activities.

FIRST-LINE

Methylprednisolone IV 500–1000 mg/day × 3–5 days

Prednisone / prednisolone PO equivalent dosing

Safety Minimal placental transfer; no IQ/brain volume effects in offspring (Kozik 2025)

SECOND-LINE

Plasma exchange 5–7 sessions; superior for AQP4-IgG attacks

Immunoadsorption Variable schedule

Setting Steroid-refractory or severe brainstem/cord attacks

AVOID

IVIG Not recommended for relapse treatment in pregnancy

Rationale Theoretical thrombosis risk; lacks efficacy data

Exception Rescue role in NMOSD if PLEX unavailable

Houtchens M, ECTRIMS 2026; Krysko KM et al. Lancet Neurol 2023; Kozik V et al. 2025.

MRI use during pregnancy: not routine, but possible

MRI WITHOUT GADOLINIUM

Safe in any trimester when clinically indicated

- 1st-trimester MRI (n=1,737): no excess stillbirth/neonatal death (HR 1.68, NS) or anomalies (HR 1.16).
- Reserve for diagnostic uncertainty, suspected demyelinating attack, or exclusion of mimics.
- Routine surveillance MRI is generally NOT recommended in pregnancy.
- Postpartum brain volume loss is real: 1.74% annualised vs 0.16% pre-pregnancy.

GADOLINIUM CONTRAST

Avoid unless critically needed

- Gd at any time in gestation: HR 3.70 for stillbirth/neonatal death; HR 1.25 for anomaly (Ray 2016).
- If essential, use macrocyclic agent at the lowest effective dose with shared decision-making.
- Document the clinical question that cannot be answered without contrast.
- Lactation: trace Gd transfer; resume breastfeeding without interruption is generally accepted.

Ray JG et al. JAMA Neurol 2016; ACR Manual on Contrast Media; Houtchens M, ECTRIMS 2026.

NMOSD and MOGAD in pregnancy — different rules apply

NMOSD (AQP4-IgG)

Active disease through pregnancy — never stop treatment without a plan

- Postpartum ARR is the highest in any phase (up to 2.0–2.25).
- Untreated AQP4-IgG^{+}: 53% relapse rate; on continued IST: 26%.
- AZA + low-dose prednisone is a long-standing pregnancy-compatible regimen.
- Modern targeted therapies (eculizumab, ravulizumab, satralizumab, inebilizumab, RTX) used selectively — see lactation section.
- ↑ rate of preeclampsia, miscarriage in AQP4-IgG^{+}.

MOGAD

Generally stable through pregnancy; monitor closely postpartum

- ARR drops from ~0.67 pre-pregnancy to ~0 during pregnancy.
- Cluster-like relapse pattern recognised — postpartum vigilance required.
- First-line treatment: corticosteroids; PLEX for refractory/severe attacks.
- Maintenance options: AZA, MMF (avoid in pregnancy), RTX, IL-6 receptor inhibitors.

Leite MI, ECTRIMS 2026; Marignier R, ECTRIMS 2026; Herwerth M, ECTRIMS 2026.

SECTION 04

04 Postpartum

Risk stratification, mode of delivery, anesthesia, and DMT restart.

Postpartum relapse risk — old vs. modern risk factors

CLASSIC RISK FACTORS — Confavreux / Vukusic era

- Higher pre-pregnancy ARR
- Relapses during pregnancy
- Higher EDSS at conception
- Disease duration
- Younger age at MS onset

MODERN-ERA RISK FACTORS — DMT-driven

- Type & timing of DMT withdrawal (NTZ, FTY)
- Length of washout before conception
- Time since last anti-CD20 dose
- Absence of postpartum DMT plan
- Lack of exclusive breastfeeding (mild–mod MS)

Confavreux NEJM 1998; Vukusic Brain 2004; Krysko Lancet Neurol 2023; Hellwig JAMA Netw Open 2020; Yeh Neurology 2021.

Mode of delivery & neuraxial anesthesia: reassurance for OB-GYN

Vaginal vs. C-section

No difference

in postpartum relapse risk; mode driven by obstetric indication

Elective C-section

Slight ↑

in MS — likely social/preference, not biological

Neuraxial anesthesia

Safe

8 studies, n=1,315: no impact on relapse risk (p>0.05)

Epidural vs. spinal

Equivalent

for relapse outcomes; choose by obstetric/anesthetic judgment

Krysko KM, ECTRIMS 2026; Pasto et al. BMC Neurol 2012; Ioannopoulos D et al. Eur J Anaesthesiol 2025.

Postpartum DMT strategy — match urgency to drug class

Drug class	Restart timing	Bridging if needed	Breastfeeding
IFN-β / GA	Within 2–4 wks (or continue throughout)	Not required	Compatible
Fumarates	After lactation decision	INot required	Emerging support (RID <1%)
S1P modulators	Re-introduction uncommon but can restart if not breastfeeding	Switch to anti-CD20 / NTZ	Avoided — accumulation risk
Natalizumab	Within 2 wks postpartum	None if EID continued in pregnancy	Compatible (RID ~5%)
Anti-CD20	After 2 weeks if breastfeeding	-__	Compatible — RID <1%
Cladribine	Resume cycles per protocol	—	Wait 10 days after dose
Alemtuzumab	Resume cycles per protocol	—	Limited data — generally avoid

Hellwig K, ECTRIMS 2026; Vukusic et al. MSJ 2023; Krysko et al. Lancet Neurol 2023.

Special scenario: managing the natalizumab-treated mother

Pre-conception	Conception	Late pregnancy	Delivery	Postpartum
Confirm efficacy. Switch to extended-interval dosing (q6w) if not already.	Continue NTZ q6w throughout the 1st and 2nd trimesters.	Last dose ~30–34 wks. Alert neonatology to possible cytopenias.	Send cord blood for CBC and platelets if last dose <8 wks.	Restart NTZ within 2 weeks. Compatible with breastfeeding.

Withdrawal-related rebound is the dominant risk: continuation strategy outperforms discontinuation in modern cohorts.

Yeh WZ et al. Neurology 2021; Hellwig K et al. JAMA Netw Open 2020; Landi D, ECTRIMS 2026.

NMOSD & MOGAD postpartum: highest-risk window

Postpartum is the single most dangerous period for AQP4-IgG⁺ NMOSD.

Maintain or rapidly resume targeted therapy. Plan during pregnancy — do not improvise at delivery.

Eculizumab / ravulizumab

C5 inhibition; not detected in milk (eculizumab); restart soon postpartum.

Satralizumab

IL-6R blockade; case data of breastfeeding without adverse events.

Inebilizumab

Anti-CD19; same paradigm as anti-CD20 — last dose pre-conception, restart within 2 weeks postpartum.

Rituximab (off-label)

Effective bridge; RID <1%; restart promptly (within 2 weeks; reassuring breastfeeding data).

AZA + low-dose prednisone

Long-standing pregnancy/lactation-compatible regimen.

Tocilizumab (off-label)

Limited but reassuring breastfeeding data.

Marignier R, ECTRIMS 2026; Rotstein DL, ECTRIMS 2026; Kümpfel T, ECTRIMS 2026.

05

SECTION 05

Lactation

Why breastfeeding matters, drug transfer principles, and DMT-by-DMT guidance.

Why breastfeeding matters for mothers with MS, NMOSD and MOGAD

INFANT BENEFITS

- ↓ respiratory and GI infections
- ↓ otitis media, asthma, type 1 diabetes, IBD
- Transfer of protective maternal antibodies
- ↓ infant mortality and obesity
- Optimal nutrition and bonding

MATERNAL BENEFITS

- Faster postpartum recovery, weight loss
- ↓ ovarian and breast cancer risk
- ↓ type 2 diabetes, cardiovascular disease
- Exclusive BF: ↓ postpartum relapse risk in mild–moderate MS (RR 0.39)
- Maternal–infant bonding and mental-health benefits

Bove R, ECTRIMS 2026; Hellwig K et al. JAMA Neurol 2015; Krysko KM et al. JAMA Neurol 2020; Lancet Breastfeeding Series 2023.

How drugs reach the infant — and why most DMTs don't

MORE TRANSFER WHEN…

- Colostrum stage (<2–5 days)
- Smaller molecules (<800 Da)
- Lower protein binding
- Lipophilic, non-ionised drugs
- Good oral bioavailability for the infant

RELATIVE INFANT DOSE (RID)

Weight-adjusted % of maternal dosage

<10%	Acceptable for breastfeeding
10–25%	Use with caution and monitoring
>25%	Generally unacceptable

Most MS DMTs in milk: RID <1% (interferons, GA, fumarates, mAbs).

Bove R, ECTRIMS 2026; Beers JL et al. Expert Opin Drug Metab Toxicol 2025.

Lactation compatibility — at-a-glance summary

DMT	RID	Compatibility	Notes
Interferon-β (all forms)	<1%	✓ **Compatible**	Large protein, undetectable / trace levels
Glatiramer acetate	<1%	✓ **Compatible**	Large polypeptide; COBRA 18-mo offspring data reassuring
Dimethyl / diroximel fumarate	0.007–0.02%	✓ **Compatible (emerging)**	MMF half-life ~1 hr; consider timed feeding
Teriflunomide	—	✗ **Avoid**	Long half-life; accelerated elimination required
S1P modulators	—	✗ **Avoid**	Lipophilic, accumulate in milk; no human data
Natalizumab	~5%	✓ **Compatible**	IgG4 mAb; degraded in infant gut; OBSERVE study reassuring
Anti-CD20 (RTX/OCR/OFA/UBL)	<1%	✓ **Compatible**	Large IgG; minimal infant absorption
Cladribine	2–5%	△ **Wait 10 days**	After last dose; then resume breastfeeding
Alemtuzumab	—	△ **Limited data**	Avoid during cycle and 4 mo after
Eculizumab / ravulizumab	<1%	✓ **Compatible (NMOSD)**	Undetectable in milk; PNH and NMOSD data
Satralizumab / tocilizumab	<1%	✓ **Compatible (NMOSD)**	Limited but growing data; normal infant development

Bove R, ECTRIMS 2026; Rotstein DL, ECTRIMS 2026; Hale TW Lactation database; Ciplea AI et al.

06

SECTION 06

Putting it together

Mood disorders, vaccines, multidisciplinary care, equity, and the practical checklist.

Peripartum mood disorders — common, treatable, often missed

~22% Anxiety prevalence in MS

~24-80% Depression prevalence in MS (lifetime) – and increased postpartum

≈ >2× Background population rates

Management principles

- Do not withhold antidepressants on the basis of pregnancy or breastfeeding alone.
- SSRIs (sertraline, paroxetine) generally first-line in pregnancy and lactation.
- Aim for monotherapy at the lowest effective dose.
- Screen at every visit during pregnancy and postpartum (EPDS, PHQ-9).
- Postpartum: psychotherapy + pharmacotherapy; consider zuranolone for severe PPD (RID <1%).

Dobson R, ECTRIMS 2026; UK Teratology Information Service.

Vaccines: timing matters more than the disease (awareness of patients on B-cell depleting treatments, will have low rates of vaccine response)

BEFORE PREGNANCY

MMR, varicella

Live — only if not on immunosuppression; conceive after 1 month

HPV, HepB

Inactivated — anytime

COVID-19

Updated boosters as available, per patient's preference – not required

DURING PREGNANCY

Influenza

Any trimester (maternal protection)

Tdap (whooping cough)

From 16 weeks (neonatal protection)

RSV (maternal)

28 weeks onwards (non-seasonal)

POSTPARTUM / LACTATION

Catch-up MMR / varicella

Compatible with breastfeeding

Influenza / COVID-19

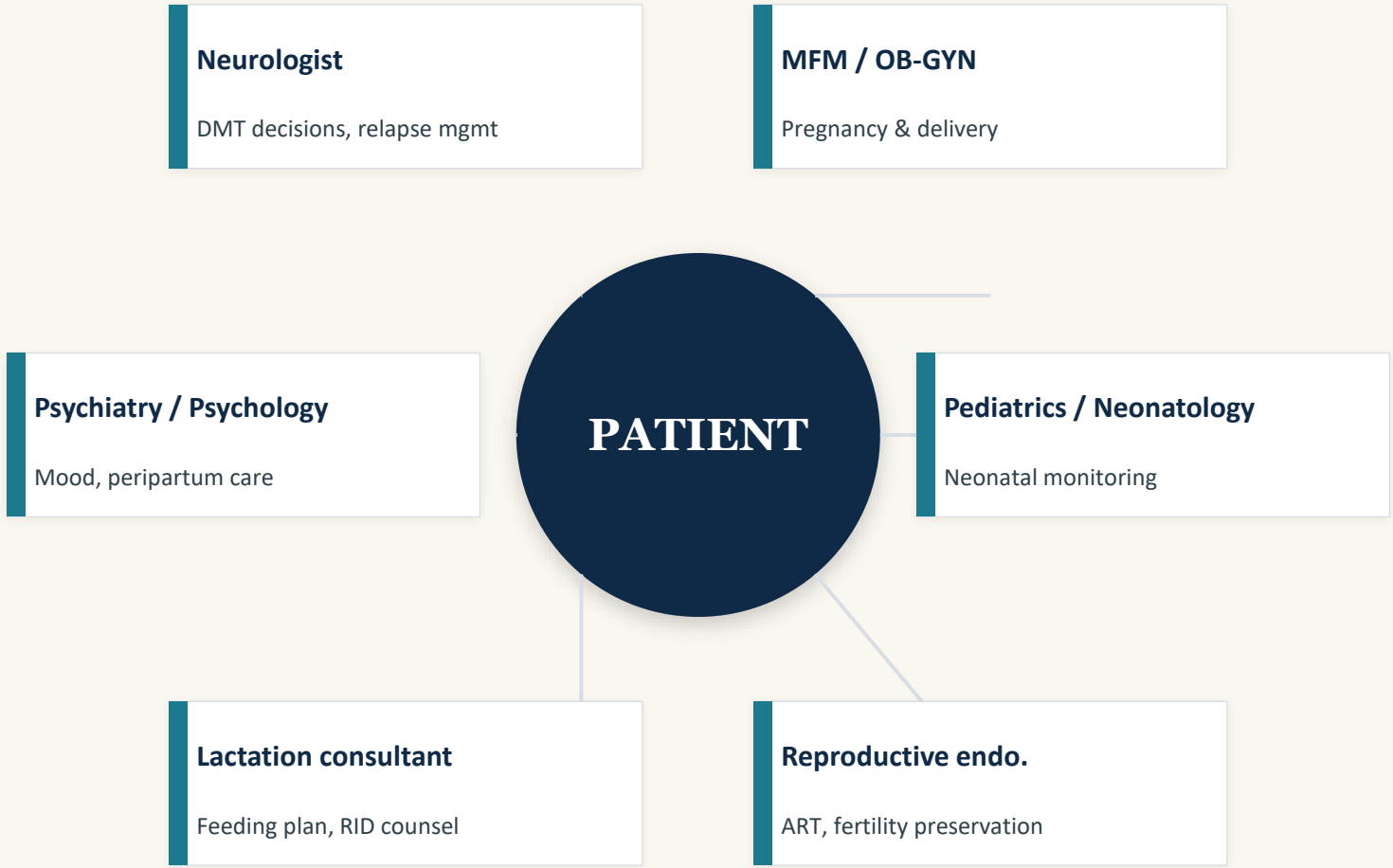
Continue as recommended

Avoid yellow fever / live

Unless travel essential

Dobson R, ECTRIMS 2026; CDC ACIP and UK JCVI guidance.

A multidisciplinary care model — neurology × OB-GYN × MFM



Designate a single point of coordination — typically the MS neurologist — and document a written shared plan.

Global perspective: access, equity and unmet needs

The evidence above assumes access to high-efficacy DMTs, MFM expertise and multidisciplinary teams. ***Most women worldwide do not have all three.***

Africa

Diagnostic delays, limited access to anti-CD20 and high-efficacy DMTs; often AZA + steroids only.

Asia

Higher NMOSD prevalence; cost of monoclonals; cultural emphasis on breastfeeding extended duration.

South America

Heterogeneous access; strong national MS societies; growing pregnancy registries.

Middle East

Variable access; consanguinity-related fertility considerations; younger maternal age.

Nevin C, Siritho S, Melo A, Bassem Y, van der Walt A — ECTRIMS 2026 Session 4.

A practical pre-conception checklist for clinic use

- ☐ 01 Confirm diagnosis (MS / NMOSD / MOGAD) and serostatus.
- ☐ 02 Document current DMT, dose, and date of last administration.
- ☐ 03 Review activity over the last 12 months: relapses, MRI, EDSS trend.
- ☐ 04 Update vaccinations BEFORE conception (live vaccines first).
- ☐ 05 Screen for and optimise mood disorders, thyroid, sleep, weight, smoking.
- ☐ 06 Plan DMT strategy: continue, switch, or extended-interval / pulsed.
- ☐ 07 Define washout period and reliable contraception window.
- ☐ 08 Discuss expected pregnancy and postpartum relapse risks.
- ☐ 09 Agree on plan for postpartum DMT restart and breastfeeding goals.
- ☐ 10 Refer to MFM / reproductive endocrinology if indicated.
- ☐ 11 Schedule postpartum neurology follow-up at ~6 weeks.
- ☐ 12 Provide written summary — for the patient AND her OB team.

Compiled from ECTRIMS Workshop 2026 consensus.

Take-home messages for 2026

01

Pregnancy is normal in women with MS.

Counsel proactively, treat effectively, and don't delay therapy because of a future pregnancy.

02

ART and pregnancy are safe with disease control.

Standard fertility evaluation; no excess relapse risk in well-controlled disease.

03

Match DMT to phase, not fear.

Anti-CD20, NTZ EID, and cladribine pulse therapy now make pregnancy planning markedly safer.

04

Postpartum is the highest-risk window.

Plan the restart during or before pregnancy, not at the 6-week visit.

05

Most modern DMTs are compatible with breastfeeding.

Use RID and pharmacology — not labels alone — to support exclusive breastfeeding when possible.

06

Care is multidisciplinary and equitable.

Coordinate with MFM, lactation, psychiatry; advocate for access where it is missing.

Future directions and open questions

Long-term maternal and offspring follow-up

Cognitive, immune and autoimmune outcomes after in-utero exposure to anti-CD20s and S1P modulators.

Pregnancy-specific PK studies

Especially for cladribine, ofatumumab, ublituximab, satralizumab, inebilizumab.

Postpartum brain volume loss and MRI studies suggesting more lesions/activity post-partum even with clinical stability

Mechanisms and reversibility — does early DMT restart change trajectory?

Personalised washout decisions

Biomarkers to predict NTZ/FTY rebound risk at the patient level.

Equity-of-access research

How do different health systems shape outcomes globally?

Patient-reported outcomes

Reproductive autonomy, decision regret, and breastfeeding satisfaction in women with MS/NMOSD/MOGAD.

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THANK YOU

Questions, discussion, and shared decisions are very welcome.

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