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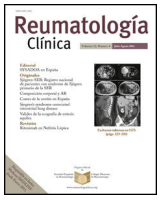

Letter to the Editor

When the usual doses are not enough☆

Cuando las dosis habituales no son suficientes

Dear Editor,

Rheumatoid arthritis (RA) is an inflammatory autoimmune disease[1]. Its prevalence is high, between .5%–1%, predominantly female, it appears at any age and sometimes overlaps with the reproductive period[2].

The evolution during pregnancy is variable, with 48–86% of patients improving, but approximately 29% reactivate, especially in the first trimester, with a consequent increased risk of prematurity, pre-eclampsia, intrauterine growth restriction and the possibility of caesarean section[3].

The management of RA during pregnancy is complex given that minimal inflammatory activity must be achieved with limited use of drugs due to their safety profile[1].

If its effects in maternity require treatment with anti-TNFα, this may be maintained during gestation[2]. In the study by Clowse et al.[4] no differences were found on comparing patients who received certolizumab pegol during gestation with the general population in relation to miscarriages or congenital malformations. The starting dose is 400 mg administered at weeks 0, 2 and 4. This is followed by a maintenance dose of 200 mg every two weeks or in case of clinical stability 400 mg per month can be titrated[5].

The aim of this letter is to report a case in which certolizumab was used at a dose higher than that established in the technical data sheet, with good gestational and newborn development during the first two years of life.

The patient was a 33-year-old woman with a history of seropositive and erosive RA diagnosed at the age of 16. She was being treated with certolizumab. Due to the couple's infertility, they resorted to in vitro fertilisation with their own eggs. Given the clinical stability, she was withdrawn prior to in vitro fertilisation and was maintained on cortisone treatment at a dose of 5 mg every 12 h.

A two-chorionic - biamniotic pregnancy was confirmed. In the ninth week of gestational age she presented a severe reactivation of her disease, presenting seven swollen joints (NAT), eight painful joints (NAD) and an assessment of 7/10 on the visual analogue scale (VAS). Analytically, the erythrocyte sedimentation rate (ESR) was 33 mm/h and the C-reactive protein (CRP) was 2 mg/L. Corresponding to a 5.75 on the Disease Activity Score (DAS28).

Despite an intra-articular injection of 40 mg of triamcinolone acetonide in the left knee and an increase in prednisone to 10 mg every 12 h, no improvement was achieved, so certolizumab 200 mg every 15 days was reintroduced, associated with a decrease in prednisone to 5 mg daily.

At 26 weeks' gestation, the inflammatory activity persisted, showing a DAS28 of 6.59, so it was decided to increase the frequency of administration of certolizumab to 200 mg every 10 days, an indication that is off-label, for which she signed the informed consent form. Prednisone was maintained at 5 mg every 12 h. The patient showed a marked improvement showing a NAT of 2 and NAD of 0, ESR of 14 mm/h, which represents a DAS28 of 2.24.

At the same time, she was closely monitored in a high-risk obstetric clinic, with good control until week 30, when arterial hypertension was detected. At 36 weeks, labour was induced due to mild pre-eclampsia. She gave birth to two healthy boys of 2,500 and 2,600 g. During their first two years of life, they have shown a normal postnatal and psychomotor development.

The decision to increase the dose of the biological treatment was made on the basis of adjusting the medication to weight, given that she had a body mass index of 39.2, which represents type II obesity, and also because of the significant inflammatory activity she presented. She was followed up in a pregnancy and arthritis unit where rheumatology, gynaecology and paediatrics are jointly involved. Multidisciplinary management of these patients is essential for the safety of both mother and baby.

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Outcomes of Pregnancy in Women With Idiopathic Inflammatory Myopathies in Africa

Dear Editor,

Idiopathic inflammatory myopathies (IIMs) are associated with adverse pregnancy outcomes in Caucasian and Asian populations,[1,2] but this issue is unclear in Africa. For the purpose of this paper, we conducted a systematic review of the literature to identify studies on IIMs and pregnancy in Africa from electronic and hand searches up to March 4, 2021, using key search terms referring to IIMs, pregnancy and African countries as per the United Nations Classification.[3]

Of 118 records retrieved from PubMed, Embase, Africa Journals Online and hand searches, we included 4 relevant case reports and 2 case-series[4–9] from Gabon, Mali, Morocco, Senegal and Tunisia. The search strategy in PubMed and Embase as well as the study selection process are summarized in the Supplementary Table and the Supplementary Figure. Included records report a total of 18 singleton post-IIM pregnancies and 10 singleton pre-IIM pregnancies in 12 women aged 26–42 years at conception. Among women with ethnicity data, 6 were Black Africans, 1 Black Caribbean and 1 North African. Specified IIM subtypes were overlap myositis ($n=4$), dermatomyositis ($n=4$) and immune-mediated necrotizing myopathy ($n=2$). Regarding pre-IIM pregnancies, there were only 2 adverse pregnancy outcomes: medical termination of a pregnancy (for unspecifed cause) and one stillbirth. In women with post-IIM pregnancy data, 8 of 18 pregnancies were successful. Adverse maternal outcomes recorded in post-IIM pregnancies were premature delivery ($n=4$), cesarean section ($n=3$), medical termination for unspecified causes ($n=3$) and pulmonary infection ($n=1$). Adverse fetal/neonatal outcomes were pre-term birth ($n=4$), neonatal death ($n=2$), small for gestational age ($n=2$), stillbirth ($n=1$) and neonatal lupus ($n=1$) (Table 1).

Maternal and offspring outcomes of pre- and post-IIM pregnancies are poorly characterized in Africa. It remains unknown whether the observed adverse outcomes were coincidental or connected with IIMs, although this small pooled sample likely suggests together with studies from other regions[1,2] that, increased rates of adverse outcomes may be observed in women (and their infants) with IIMs in Africa as well. There is a need for a prospective multicenter African registry to better assess the link between IIMs and adverse pregnancy outcomes, as well as the impact of pregnancy on IIM activity in Africa.

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Conflicts of interest

The authors declare no conflict of interest.

Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at doi:10.1016/j.reuma.2021.04.005.