

# MYASTHENIA GRAVIS IN PREGNANCY



Answers to questions you  
may have about myasthenia  
gravis in pregnancy

[www.Myasthenia.org](http://www.Myasthenia.org)



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.

### 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 plasmapheresis (PLEX) or IVIg may be used when a prompt temporary response is needed during 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).



Thymectomy should be postponed until after pregnancy.





## Myasthenia Gravis Foundation of America

**Our Vision:** A World Without MG

**Our Mission:** Create Connections, Enhance Lives,  
Improve Care, Cure MG

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*Approved by the MGFA Medical Advisory Council*