THE "INFO"-HALER

TAKE IN THE INFORMATION

An easy to understand, informative newsletter for our patients of all ages from the *Allergy &: Asthma Associates of Michigan, P. C.*

ASTHMA IN PREGNANCY

Asthma is a chronic, persistent disease of the airways characterized by bronchospasm, inflammation, and increased mucous production. During an asthma attack, the airways narrow and breathing becomes difficult. Symptoms include coughing, wheezing, shortness of breath, chest tightness, and reversible airflow obstruction. Asthma may be the most common and potentially serious illness that can occur during pregnancy. In pregnancy, a mother is breathing for two. The unborn fetus depends on oxygen from the mother for growth and survival. Oxygen dissolved in the mother's blood is transferred through the placenta to the fetus. Asthma that is uncontrolled during pregnancy can produce serious maternal and fetal complications.

The overall incidence of asthma during pregnancy is between 0.4% and 1.3%. The risk is greater for women who have been diagnosed with asthma before becoming pregnant. Asthma may occur for the first time during pregnancy, or it may change during pregnancy. In general the effects of pregnancy on asthma can be summarized by the rule of one-third. One-third of all pregnant asthma patients have symptoms that improve during pregnancy, onethird have symptoms that remain the same, and one-third have symptoms that become worse. Asthma usually follows the same course it followed in the first pregnancy with subsequent pregnancies. Typically the women who have worse symptoms during pregnancy are those that have more difficult to manage asthma. It is extremely rare for pregnant women with adequately controlled asthma to have trouble with asthma during labor and delivery. Most women revert back to their pre-pregnant asthma status within three months after delivery.

There is no reason to avoid or fear pregnancy with asthma. When asthma is well-controlled, pregnant women have normal pregnancies with little or no increased risk to themselves or their fetuses. Asthma, however, must be aggressively managed in pregnancy. Pregnant women must see their asthma physician as soon as they know they are pregnant, and routinely throughout the pregnancy. They must have a clearly defined treatment plan for management of acute and chronic exacerbations of asthma. Peak flow rates and pulmonary function studies should be monitored regularly throughout the pregnancy. Contact with substances that trigger asthma attacks should be strictly avoided (i.e. smoke, irritants, allergens, pets, dusty and damp environments, exposure to people with respiratory infections, etc.). Allergy injections should not be started during pregnancy, but can be safely continued during pregnancy; however, the dose and concentrations of the injections should be carefully monitored and may need to be adjusted. There is evidence that allergy injections may provide the baby with some protection against developing allergic disease.

Pharmacotherapy during pregnancy differs little from routine asthma management. It would be ideal if asthma could be managed without medications at all, but this is most often not the case. As a general rule, however, asthma should be managed with the lowest amount of medicine needed to effectively control the symptoms. The benefits of asthma medications always need to be weighed against the potential risks of side effects to the unborn baby. It has been proven that inadequately controlled asthma can be dangerous to the mother and fetus. If the mother has trouble breathing the fetus has trouble getting oxygen. Risks of premature birth, low birth weight, and infant death are then increased. Scientific evidence indicates that it is safer to take medication, then to have an asthma flare up. Most medications have not been established as safe for pregnancy, but usually this does not imply that they have been found to be unsafe either. Asthma drugs have not been proven safe in pregnancy as it is difficult to do adequate studies in pregnant women to prove them safe. Animal studies suggest that most drugs are probably safe. New guidelines urge

pregnant women with asthma to carry their rescue inhalers with them at all times and use them as needed for rapid relief of asthma symptoms. All drugs. however, should be used only with a doctor's recommendation, specific dosing instructions, and the approval of the patient's obstetrician.

In general. asthma medications that are safe in pregnancy are safe for nursing mothers as well. Approximately 10% of all medicines do enter breast milk by diffusion from plasma. The milk concentrations, however, are very low and it would be unusual for an infant to receive a dose sufficient to produce toxic effects. To be safe, a nursing mother should let her pediatrician know all the medications she is taking and check with him before adding new medications.

Asthma is a very preventable and manageable airway disease. All asthma patients should work closely with their asthma specialist to remain in control of their asthma. Pregnant women are breathing for two. Maternal oxygenation must remain greater than 95% to assure adequate fetal oxygenation. Asthma is not a significant risk factor for pregnancy when well managed. All pregnant women with asthma should receive ongoing asthma therapy during the pregnancy.

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