Pregnancy with autoimmune diseases and chronic illness

Why autoimmune disease can change pregnancy risk

Autoimmune diseases occur when the immune system targets the body’s own tissues. Pregnancy requires a finely balanced immune state: the maternal immune system must tolerate the fetus while still protecting against infection. This does not mean pregnancy is simply "immunosuppressed"; rather, immune activity shifts across gestation, which can alter the course of autoimmune disease.

Some autoimmune conditions improve during pregnancy, while others may flare or remain unpredictable. Rheumatoid arthritis, for example, may improve for some patients during pregnancy but flare postpartum. Systemic lupus erythematosus can flare during pregnancy, particularly if active near conception. Inflammatory bowel disease is more likely to remain stable if it is well controlled before pregnancy, but active disease can increase obstetric risk. Multiple sclerosis relapse rates may decrease during later pregnancy for some patients but rise after delivery.

Potential complications vary by condition and severity, but may include miscarriage, preeclampsia, fetal growth restriction, preterm birth, thrombosis, placental insufficiency, cesarean birth, and postpartum disease flare. These outcomes are not inevitable. The goal is not to frighten patients, but to

identify modifiable risks early and monitor carefully.

Preconception planning: the best time to reduce risk

For many chronic illnesses, the safest pregnancy begins before conception. A preconception visit allows clinicians to assess disease activity, organ involvement, medication safety, blood pressure, kidney function, nutritional status, vaccination needs, and reproductive goals. If possible, this should happen before stopping contraception.

In several autoimmune diseases, clinicians often recommend attempting conception when the condition has been in remission or low disease activity for a period of time. For lupus, stable disease for at least several months before conception is commonly emphasized because active lupus, especially lupus nephritis, is associated with higher risks for both the pregnant patient and fetus.

A preconception plan may include:

Reviewing diagnosis, disease severity, flare history, and organ involvement
Checking relevant labs such as kidney function, urine protein, blood counts, liver enzymes, inflammatory markers, thyroid function, and disease-specific antibodies
Updating medications to pregnancy-compatible options when needed
Discussing folic acid, nutrition, exercise, sleep, and mental health support
Planning which specialists should be involved during pregnancy and postpartum
Clarifying when to seek urgent care for symptoms such as chest pain, severe headache, shortness of breath, neurologic symptoms, heavy bleeding, or reduced fetal movement later in pregnancy

Medication decisions: do not stop treatment without guidance

Medication review is often the most anxiety-provoking part of pregnancy planning. It is understandable to want to minimize fetal exposure, but untreated maternal disease can also pose significant risk. For many autoimmune conditions, maintaining disease control is a key part of fetal protection.

Some therapies are commonly continued in pregnancy when clinically appropriate.

Hydroxychloroquine is often used in lupus and is generally considered pregnancy-compatible; continuing it may reduce lupus flare risk. Low-dose aspirin may be recommended for some patients at increased risk of preeclampsia, including certain autoimmune or renal conditions, but it should be used under clinician guidance. Corticosteroids, some immunosuppressants, anticoagulants such as heparin in selected patients, and biologic therapies may be considered depending on the condition, trimester, and risk-benefit profile.

Other medications are contraindicated or require careful timing before conception because they can harm fetal development or pregnancy outcomes. Examples may include certain teratogenic immunosuppressants, some disease-modifying drugs, particular blood pressure medications, and selected anticoagulants or retinoid-type agents, depending on the diagnosis. Because medication safety depends on dose, indication, gestational age, alternatives, and maternal risk, decisions should be individualized by the prescribing clinician and pregnancy care team.

A useful principle is to ask three questions at each medication review: What is the risk of the medication? What is the risk of stopping it? What is the safest effective alternative if a change is needed?

Disease-specific issues to discuss with your care team

Although every person’s case is unique, certain autoimmune conditions raise specific pregnancy considerations.

Systemic lupus erythematosus: Active disease, lupus nephritis, hypertension, kidney impairment, and certain autoantibodies can increase the risk of preeclampsia, fetal growth restriction, preterm birth, and flare. Anti-Ro/SSA and anti-La/SSB antibodies may be associated with neonatal lupus and, rarely, congenital heart block, so fetal monitoring may be recommended.

Antiphospholipid syndrome: This condition is associated with blood clots and pregnancy morbidity, including recurrent pregnancy loss, fetal growth restriction, preeclampsia, and placental complications. Management may involve anticoagulation and low-dose aspirin for some patients, but this must be directed by specialists.

Rheumatoid arthritis and inflammatory arthritis: Symptoms may improve, remain stable, or worsen. Postpartum flares are common enough that a postpartum medication and feeding plan is worth discussing before delivery.

Inflammatory bowel disease: Active disease at conception is associated with a higher chance of active disease during pregnancy. Maintaining remission is often a major goal, and medication continuity may be safer than a flare for many patients.

Myasthenia gravis: Symptoms can fluctuate during pregnancy and postpartum. Some medications used in obstetrics or anesthesia may worsen weakness, so the delivery team should know the diagnosis well in advance.

Autoimmune thyroid disease: Thyroid hormone requirements can change during pregnancy. Both overt hypothyroidism and hyperthyroidism can affect pregnancy, so thyroid function is usually monitored and managed carefully.

Chronic kidney disease, type 1 diabetes, hypertension, and other chronic illnesses: Even when not classically autoimmune, these conditions can overlap with autoimmune disease and influence pregnancy risk. Preconception optimization of blood pressure, kidney function, glucose levels, and medication safety is especially important.

Monitoring during pregnancy

People with autoimmune disease or chronic illness may be offered more frequent visits, additional laboratory testing, and ultrasound surveillance. The exact plan depends on diagnosis, disease activity, medications, prior pregnancy history, and the presence of complications.

Monitoring may include:

Blood pressure checks and screening for preeclampsia
Urine testing for protein, especially in kidney disease or lupus nephritis
Blood counts, liver and kidney function tests, thyroid tests, inflammatory markers, or disease-specific serologies
Fetal growth ultrasounds when placental insufficiency or growth restriction is a concern

Fetal echocardiography or rhythm surveillance in selected pregnancies with specific antibodies
Medication level or safety monitoring for certain therapies
Assessment for thrombosis symptoms in higher-risk patients

Pregnancy symptoms can overlap with disease symptoms. Fatigue, joint discomfort, shortness of breath, swelling, headaches, and nausea may be common in pregnancy but can also signal complications. A low threshold for contacting the care team is appropriate when symptoms are new, severe, persistent, or different from baseline.

Birth planning, anesthesia, and hospital communication

Autoimmune disease alone does not always require cesarean birth. Many people can plan for vaginal birth if there are no obstetric contraindications. However, some complications, such as severe preeclampsia, fetal growth restriction with abnormal testing, placenta-related problems, or maternal instability, may lead to induction or cesarean delivery.

A birth plan for chronic illness should be practical and medical as well as personal. It may include medication timing, stress-dose steroid considerations for some long-term steroid users, anticoagulation timing around neuraxial anesthesia, infection precautions for immunosuppressed patients, and disease-specific anesthesia concerns. For example, myasthenia gravis can affect medication choices during labor, surgery, and postpartum care.

It is reasonable to ask for a written plan shared among obstetrics, maternal-fetal medicine, anesthesia, the relevant specialist, and the postpartum team. This helps reduce confusion during urgent situations and supports respectful, coordinated care.

Postpartum: the fourth trimester matters

The postpartum period is not simply the end of pregnancy risk. Immune and hormonal shifts, sleep disruption, blood loss, infection risk, medication changes, and the physical demands of newborn care can contribute to flares or complications. Some conditions, including rheumatoid arthritis, lupus, multiple sclerosis, thyroid disease, and inflammatory bowel disease, may worsen after

delivery in certain patients.

Postpartum planning should include follow-up timing with specialists, blood pressure monitoring when indicated, thrombosis prevention if prescribed, wound care after cesarean or perineal injury, mental health screening, feeding plans, and medication compatibility with breastfeeding or chestfeeding. Many medications are compatible with lactation, but this needs individualized review.

Emotional health deserves the same seriousness as physical health. Chronic illness can amplify anxiety about symptoms, medication exposure, parenting capacity, or traumatic prior medical experiences. Support from perinatal mental health professionals, social workers, patient organizations, doulas familiar with medical complexity, and trusted family or friends can be protective.

How to advocate for yourself in complex care

Living with chronic illness often means becoming an expert in your own body. In pregnancy, that expertise matters. Bring a concise medical summary to appointments, including diagnoses, surgeries, major flares, organ involvement, medications, allergies, antibody status if relevant, and emergency considerations. If something feels different from your usual baseline, say so clearly.

Helpful questions include:

Is my disease stable enough for pregnancy, or should we optimize first?
Which medications should I continue, stop, switch, or time carefully before conception?
Do I need maternal-fetal medicine care or a delivery hospital with higher-level services?
What complications are we watching for in my specific situation?
What symptoms should prompt urgent evaluation?
What is the postpartum flare prevention and follow-up plan?

A supportive care team should take your reproductive goals seriously while being honest about risk. Shared decision-making means you are not dismissed, blamed, or left alone with uncertainty; you are given clear information and compassionate guidance.