



Ankylosing Spondylitis International Federation

World-wide network of societies of patients suffering from ankylosing spondylitis or related diseases

Questionnaire on

Has drug treatment of ankylosing spondylitis any adverse effects on the offspring?

As mentioned in the introduction, anti-rheumatic drugs are still connected with great uncertainty with respect to the question which drugs taken by a future father or mother may harm the unborn child and which do not. Please help us to close this gap of knowledge.

It is important that all (male or female) patients with ankylosing spondylitis who were connected with a pregnancy ending after January 1st 2000, fill the questionnaire, irrespective of there was a drug therapy or not – we need the comparison!

Please fill the questionnaire carefully and completely.

Enter clear numbers into large boxes.

Cross small boxes for applying answers.

If you answer a question neither with „yes“ nor with „no“, we cannot count your answer!

1. Year of birth: 19

2. Gender: male female

3. In which year did you feel first symptoms of ankylosing spondylitis? In

In which year did you get the diagnosis of ankylosing spondylitis? In

4. Was the diagnosis made by a doctor? yes no

5. Do you suffer from any other chronic disease requiring regular visits to a doctor or regular intake of drugs? yes no (then continue with question 7)

6. If yes: from which other chronic disease do you suffer? (Please cross diseases present).

- High blood pressure
- Cardio-vascular disease
- Chronic lung disease (other than asthma)
- Crohn's disease
- Ulcerative colitis
- Psoriasis
- Diabetes
- Epilepsy
- Chronic liver disease
- Another chronic disease: _____

7. Do you have children? (please indicate numbers)

yes, boys and girls no

Questions concerning the pregnancies which ended after 1st January 2000:

In case that you were connected with more than one pregnancy in this period: Make copies of this questionnaire and fill one for each pregnancy.

8. Did you / the mother of your child have a pre-eclampsia (high blood pressure with increased protein in the urine and with oedema) during this pregnancy?

yes no I don't know

9. The pregnancy concluded in the year 200 with:

- a life birth (continue with question 11)
- the birth of twins (continue with question 11)
- a stillbirth (continue with question 16)
- a miscarriage (continue with question 16)
- a termination of pregnancy

10. In case that this pregnancy was terminated: Was it because of the treatment with anti-rheumatic or other drugs? yes no

11. If this pregnancy concluded with the birth of a child: In which week of pregnancy did you / the mother of your child give birth?

- before week 25 of pregnancy
- in weeks 25 to 29
- in weeks 30 to 36
- in weeks 37 to 40
- after week 40 of pregnancy

12. Gender of the child: boy girl

13. Birth weight: grams

14. Health of the newborn:

Was the child healthy yes no

Had the child anomalies (defects)... yes no
(if no: continue with question 16)

15. Kind of anomaly present at birth:

- Lip or cleft palate yes no
- Congenital heart defect yes no
- Pulmonal hypertension..... yes no
- Open belly yes no
- Diaphragmatic hernia yes no
- Malformed stomach and bowel yes no
- Malformed fingers or toes yes no
- Malformed genitals..... yes no
- Malformation of the kidney yes no
- Open back yes no
- Malformation of head and face..... yes no
- Other malformation yes no

In case of twins: 2nd child

boy girl

grams

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

yes no

16. Were you treated before this pregnancy with one or more of the following medications?

	3 – 6 months before begin of pregnancy	1 –3 months before begin of pregnancy	in the last 4 weeks before pregnancy	
Infliximab (remicade)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Etanercept (enbrel)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Adalimumab (humira)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Methotrexate	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sulfasalazine (e.g. salazopyrin)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bisphosphonates (e.g. didrocal, fosamax, actonel)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no

17. For female patients with ankylosing spondylitis: Did you receive during this pregnancy one or more of the following medications?

For male patients with ankylosing spondylitis: Did the mother of your child receive during this pregnancy one or more of the following medications?

	During the first 3 months of pregnancy	During months 4–6 of pregnancy	During months 7–9 of pregnancy	
Infliximab (remicade)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Etanercept (enbrel)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Adalimumab (humira)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Methotrexate	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sulfasalazine (e.g. salazopyrin)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Bisphosphonates (e.g. didrocal, fosamax, actonel)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Pain killers (e.g. tylenol, codeine)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Non-steroidal anti-inflammatory drugs (e.g. arthrotec, ibuprofen, indocid, naproxen, meloxicam, mobic, voltaren)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Coxibs (e.g. celecoxib, vioxx, arcoxia, prexige, arcoxia)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Corticosteroids (e.g. cortisone, prednisone)	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drugs against high blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drugs against diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drugs against depression or anxiety	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Thyroid hormone	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Drug against epilepsy	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no
Others: _____	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> yes	<input type="checkbox"/> no

Questions concerning smoking, alcohol, and smart drugs:

18. Did you as pregnant / did the mother of your child smoke during this pregnancy?

- No, did not smoke in this period yes, ca. 10 – 20 cigarettes per day
 yes, ca. 0 – 10 cigarettes per day yes, more than 20 cigarettes per day

19. Did you as pregnant / did the mother of your child drink alcoholic beverages (beer, wine, liquor, brandy) during this pregnancy?

- no or less than once per month less than every day
 less than once per week every day

20. Did you as pregnant / did the mother of your child use during this pregnancy drugs like cannabis, ecstasy, cocaine, heroin or methadone?

- no or less than once per month less than every day
 less than once per week every day

Questions concerning diseases of your partner:

21. For male patients with ankylosing spondylitis: Does the mother of your child suffer from a chronic disease?

For female patients with ankylosing spondylitis: Does the father of your child suffer from a chronic disease?

- yes no

If yes: from which disease(s)? (please cross diseases present)

- High blood pressure
 Cardio-vascular disease
 Chronic lung disease
 Crohn's disease
 Ulcerative colitis
 Psoriasis
 Diabetes
 Epilepsy
 Chronic liver disease
 Rheumatic disease: _____
 Other chronic disease:: _____

END of questionnaire, thank you!

Please send filled questionnaire to the ASIF vice president:

**Prof. Dr. Ernst Feldtkeller
Michaeliburgstr. 15
D-81671 München, Germany**