Update on Restless Legs Syndrome Management during Pregnancy

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KEYWORDS

• Restless legs syndrome • Pregnancy • Lactation • Management

KEY POINTS

- Reassurance and nonpharmacologic strategies—moderate exercise, stretching, massage, and good sleep hygiene—are first-line and effective for most cases.
- Iron repletion, either oral or intravenous, is the cornerstone of therapy and should precede any pharmacologic intervention.
- Medication is reserved for severe cases; carbidopa/levodopa or gabapentin may be considered for persistent symptoms, and low-dose opioids only for very severe, refractory restless legs syndrome.

RESTLESS LEGS SYNDROME IN GENERAL

Restless legs syndrome (RLS), also known as Willis–Ekbom disease, is a common sensorimotor disorder characterized by an urge to move the legs, usually accompanied by unpleasant sensations that occur or worsen during rest and in the evening or night, and are relieved by movement.[1] Diagnosis is clinical and based on the 5 essential criteria proposed by the International RLS Study Group, supported by normal neurologic findings, the presence of periodic limb movements during sleep, a positive family history, and a favorable response to dopaminergic therapy. No specific biomarker or laboratory test is available to confirm the diagnosis.

RLS affects approximately 5% to 10% of the general population, with prevalence increasing with age and showing a clear 2 fold female predominance.[2] In population-based studies, prevalence rates range from 5% to 15% in Western countries and tend to be lower in Asian populations,[3] likely reflecting genetic and environmental influences. Genetic susceptibility is important, with familial clustering observed in 50% to 90% of idiopathic cases and several genetic loci (such as meis homeobox 1 [MEIS1], BTB domain containing 9 [BTBD9], and mitogen-activated protein kinase kinase 5 [MAP2K5]) implicated in dopaminergic and iron-regulatory pathways.[4] Despite its often intermittent course, RLS exerts a substantial burden on sleep quality, mood, and daily functioning.[5] The overall quality-of-life burden is comparable to that observed in chronic systemic diseases such as diabetes mellitus or rheumatoid arthritis. Persistent symptoms are associated with depressive mood, anxiety, and reduced work productivity, emphasizing that RLS is not a benign condition but one with substantial public health impact.[6]

RLS may occur as an idiopathic condition or as a secondary form associated with iron deficiency, chronic kidney disease, peripheral neuropathy, or pregnancy, which represents one of the strongest physiologic risk factors for its onset. Women are

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Abbreviations	
AASM	American Academy of Sleep Medicine
FDA	Food and Drug Administration
IRLSSG	International Restless Legs Syndrome Study Group
IV	intravenous
RLS	restless legs syndrome
TOMAC	tonic motor activation

more frequently affected, particularly after pregnancy; parity contributes significantly to this sex difference, with risk increasing almost linearly with the number of pregnancies (odds ratio 1.98 for 1 pregnancy, 3.04 for 2 pregnancies, and 3.57 for 3 or more pregnancies).[7] Recognition of RLS is particularly relevant in women of reproductive age. Given its strong link with iron metabolism and hormonal changes, pregnancy may unmask or exacerbate underlying susceptibility. Understanding RLS as a chronic but potentially modifiable disorder provides an essential foundation for managing its unique challenges during pregnancy and lactation.

RESTLESS LEGS SYNDROME DURING PREGNANCY

Sleep problems are among the most frequent complaints during pregnancy, reflecting physiologic, hormonal, and psychological changes across gestation.[8] As pregnancy progresses, increased body size, frequent nocturia, gastroesophageal reflux, back pain, and fetal movements contribute to sleep disruption. Hormonal fluctuations involving progesterone, estrogen, and cortisol alter sleep architecture and circadian rhythms, while rising progesterone levels in early pregnancy increase daytime sleepiness. Toward the third trimester, insomnia and sleep fragmentation become more prominent, and the prevalence of sleep disorders such as obstructive sleep apnea and RLS rises markedly.[9]

RLS represents one of the most frequent specific sleep-related disorders in pregnancy. According to a recent systematic review and meta-analysis including more than 59,000 women, the pooled prevalence of RLS in pregnant women is 21.4% (95% confidence interval, 17.7–25.1), approximately 2 to 3 times higher than in the general female population.[10] Geographic variability has been reported, ranging from around 18% in Asian countries to more than 25% in Europe.[11]

The clinical course of RLS during pregnancy is typically transient but highly variable. Symptoms usually begin or worsen in the second trimester, peak in the third trimester, and remit spontaneously within days or weeks after delivery.[12,13] In most cases, RLS resolves within 1 month postpartum, although up to one-third of women continue to experience residual or recurrent symptoms after childbirth.[14] Recurrence in subsequent pregnancies is common, reported in more than 60% of women with previous gestational RLS, and women who experience transient RLS during pregnancy have a 4 fold higher risk of developing chronic idiopathic RLS later in life.[15] Risk factors for RLS during pregnancy include previous RLS, positive family history, multiparity, and low ferritin levels.[13,16]

The impact of RLS during pregnancy extends beyond sleep discomfort. Women with RLS are more likely to experience poor sleep quality, excessive daytime sleepiness, and impaired daytime functioning. In a cohort of over 1500 women, Dunietz and colleagues[17] demonstrated that RLS was independently associated with a 2 fold higher odds of poor sleep quality (OR 2.2) and nearly doubled risk of daytime sleepiness and functional impairment. Moderate-to-severe symptoms are reported in 20% to 50% of affected women, leading to significant distress and insomnia.[13,17] Beyond maternal sleep, RLS has been linked to adverse pregnancy outcomes such as gestational hypertension, pre-eclampsia, gestational diabetes, preterm birth, and postpartum depression, although results remain partly inconsistent across studies.[18]

Collectively, these findings underscore that RLS in pregnancy is a prevalent and clinically relevant condition rather than a benign discomfort. Its recognition is essential not only for improving maternal sleep and quality of life but also for potentially reducing associated pregnancy complications and long-term risk of developing chronic RLS.[19]

MANAGEMENT OF RESTLESS LEGS SYNDROME DURING PREGNANCY AND LACTATION

Before discussing the management of RLS during pregnancy and lactation, it is important to first outline the latest clinical practice guidelines, which include significant updates to pharmacologic treatment strategies. According to the 2025 American Academy of Sleep Medicine (AASM) clinical practice guideline, the management of RLS is based on a structured, evidence-based approach that emphasizes iron repletion, avoidance of aggravating factors, and the use of specific pharmacologic agents with established safety and efficacy profiles.[20] Before starting pharmacologic therapy, potential aggravating factors such as alcohol, caffeine, and certain medications including antihistaminergic, serotonergic, and antidopaminergic

drugs should be identified and eliminated when possible. It is also important to screen for and treat coexisting sleep disorders, particularly obstructive sleep apnea, which may worsen RLS symptoms. All patients with clinically significant RLS should undergo assessment of iron status, including serum ferritin and transferrin saturation. Iron supplementation is recommended when ferritin is 75 ng/mL or less or transferrin saturation is below 20%, preferably using oral iron preparations, whereas intravenous (IV) iron is considered when ferritin levels are between 75 and 100 ng/mL or when oral iron fails to correct deficiency.

In terms of pharmacologic treatment, the 2025 guideline represents a significant shift from earlier recommendations. Gabapentinoids—gabapentin enacarbil, gabapentin, and pregabalin—are now considered first-line therapies for adults with RLS because of their efficacy and low risk of augmentation. Among iron therapies, IV ferric carboxymaltose is strongly recommended for patients with low ferritin or low transferrin saturation, and oral ferrous sulfate or other IV iron formulations such as low–molecular weight iron dextran or ferumoxytol can also be used when appropriate.

Dopaminergic agents including levodopa, pramipexole, ropinirole, and rotigotine are no longer recommended for standard use because of the high long-term risk of augmentation, although they may still be considered for short-term treatment in carefully selected patients who prioritize immediate symptom relief. For refractory or severe cases, the guideline suggests the cautious use of extended-release oxycodone or other opioids after careful assessment of risks and benefits. Dipyridamole and bilateral high-frequency peroneal nerve stimulation are also proposed as conditional treatment options supported by moderate evidence. Medications such as carbamazepine, clonazepam, valproic acid, valerian, and cabergoline are discouraged due to limited efficacy or unfavorable safety profiles.

Despite these comprehensive updates, the guideline does not include specific recommendations for pregnancy or lactation, likely due to the absence of high-quality clinical trials in these populations. To date, the only consensus-based recommendations remain those from the International Restless Legs Syndrome Study Group (IRLSSG) published in 2015, which provide guidance on diagnosis and treatment during pregnancy and lactation.[19] Readers are strongly encouraged to consult this guideline for practical recommendations and safety considerations specific to these populations.

Since then, no new interventional data have emerged to inform treatment strategies in this subgroup. Therefore, the following discussion on management during pregnancy and lactation draws primarily from the IRLSSG consensus statement, partially adapted by the general treatment principles of the recent AASM guideline.

PREPREGNANCY PLAN AND DISCUSSION

Because pregnancy represents a high-risk period for both the onset and exacerbation of RLS, management should ideally begin before conception. Women of reproductive age with pre-existing RLS or identifiable risk factors—such as a family history of RLS or symptoms in a prior pregnancy—should receive prepregnancy counseling focused on disease optimization and risk reduction. This preparatory phase offers an opportunity to achieve stable symptom control, minimize pharmacologic exposure, and correct modifiable factors, particularly iron deficiency. The IRLSSG and subsequent reviews emphasize individualized planning that balances maternal well-being, fetal safety, and the anticipated natural course of RLS during gestation.[18,19]

When pregnancy is anticipated, clinicians should review all current medications and discontinue, when feasible, drugs that may aggravate RLS or pose potential teratogenic risks. Dopaminergic agents, gabapentinoids, and opioids are generally avoided during conception and early gestation unless symptoms are severe and nonpharmacologic measures have failed. Women using these agents should taper under medical supervision several weeks before conception to allow for drug washout and to evaluate baseline symptom severity. Prepregnancy counseling should include education on the typically transient nature of pregnancy-related RLS, reassurance about symptom improvement after delivery, and emphasis on nonpharmacologic strategies, including good sleep hygiene, moderate physical activity, and avoidance of known aggravating factors such as caffeine, nicotine, and serotonergic antidepressants.

Iron deficiency is a well-established risk factor for both idiopathic and pregnancy-related RLS. During pregnancy, iron demands increase substantially due to plasma volume expansion and fetal growth, often resulting in a 30% to 50% reduction in ferritin levels even in otherwise healthy women.[21,22] Because low ferritin is associated with both the onset and severity of RLS symptoms, restoration of adequate iron stores before conception is a key preventive measure. Current guidelines recommend assessing serum ferritin and transferrin saturation in women with a history of RLS who are planning pregnancy. Iron supplementation should

be initiated if ferritin is below 75 μg/L, with oral iron therapy preferred initially and IV iron considered if absorption is poor or ferritin remains below 30 μg/L despite supplementation. Early correction of iron deficiency not only reduces the likelihood of RLS recurrence or worsening during pregnancy but also supports optimal fetal neurodevelopment.

GENERAL PRINCIPLES OF MANAGEMENT

The management of RLS during pregnancy and lactation requires a careful balance between maternal symptom relief and fetal safety. Most women experience mild-to-moderate, self-limited symptoms that improve after delivery, and conservative measures are usually sufficient. Pharmacologic treatment should be reserved for cases of severe, persistent distress that substantially impairs sleep and daily functioning, with preference for the lowest effective dose and shortest possible duration.[19,20]

Avoiding Aggravating Factors

Clinicians should first identify and minimize factors that can exacerbate RLS symptoms. These include caffeine, nicotine, alcohol, antihistamines, serotonergic antidepressants, dopamine antagonists, and untreated sleep apnea. Pregnant women should be screened for sleep fragmentation, iron deficiency, and comorbid insomnia. Avoiding prolonged inactivity and maintaining gentle physical activity throughout pregnancy may help prevent symptom exacerbation.

Maintaining Good Sleep Hygiene

Promoting healthy sleep habits is a fundamental component of RLS management during pregnancy. Recommendations include maintaining regular sleep–wake schedules, engaging in moderate evening activity (such as stretching or walking), and using relaxation techniques before bedtime. Optimizing the sleeping environment, reducing evening exposure to electronic screens, and avoiding heavy meals before bedtime can further improve sleep quality.

Consider Nonpharmacological Management First

Consistent with IRLSSG guidelines, nonpharmacologic therapy should be the first-line approach in all pregnant women. Effective options include moderate exercise, yoga, stretching, massage, warm baths, and pneumatic compression devices, all of which have demonstrated symptom relief without adverse effects. Although evidence remains limited, these interventions are safe and can be recommended as adjuncts.

Iron Supplementation

Iron deficiency is the most consistent biochemical correlate of pregnancy-related RLS. Serum ferritin and transferrin saturation should be evaluated in all symptomatic women. According to the IRLSSG and AASM recommendations, oral iron supplementation is indicated if ferritin is below 75 μg/L, and IV iron should be considered if ferritin remains below 30 μg/L or oral therapy is poorly tolerated. Restoring iron stores early in pregnancy reduces symptom severity and may prevent postpartum persistence.

Use of Medication with Lowest Effective Dose and Shortest Duration

If nonpharmacological and iron supplementation strategies fail and symptoms remain moderate to severe (IRLS score >20), medication may be considered. The guiding principle is to use the lowest effective dose for the shortest necessary duration, ideally limited to the third trimester when organogenesis is complete. Pharmacologic treatment should be individualized after thorough counseling regarding risks and benefits, with regular reassessment of need and prompt discontinuation postpartum if symptoms remit.

NONPHARMACOLOGICAL MANAGEMENT

Nonpharmacologic strategies are the cornerstone of managing RLS during pregnancy. Given the self-limited nature of most pregnancy-related cases and the need to minimize medication exposure, conservative interventions should be implemented first, emphasizing safety, accessibility, and maternal comfort. Reassurance plays an important therapeutic role, as RLS frequently shows a substantial placebo response—estimated at approximately 40% in clinical trials—which may enhance the perceived and actual benefit of supportive and behavioral interventions.[23]

Moderate Exercise

Regular, moderate physical activity—such as walking, swimming, or low-impact aerobic exercise—can significantly reduce RLS symptoms and improve sleep quality. Exercise promotes better iron utilization, enhances peripheral circulation, and reduces venous stasis, all of which may mitigate the sensory discomfort characteristic of RLS. However, excessive or strenuous exercise, especially late in the day, should be avoided as it may exacerbate symptoms or disrupt sleep.

Yoga, Stretching, Massage, and Pneumatic Compression

Relaxation-oriented activities including yoga, gentle stretching, and massage therapy have been shown to alleviate tension and restlessness, although supporting evidence remains limited.[24,25] Yoga combines light physical movement, breathing control, and mindfulness, potentially improving both mental well-being and sleep continuity. Local massage of the calves and thighs, warm baths, and application of mild pressure (eg, with pneumatic compression or simple pumping exercises) can provide temporary relief by enhancing blood flow and activating sensory counterstimulation pathways. These interventions are noninvasive and considered safe when applied appropriately in healthy pregnancies.

Tonic Motor Activation

Tonic motor activation (TOMAC), a form of high-frequency noninvasive peroneal nerve stimulation, represents an emerging nonpharmacologic therapy for RLS. Clinical studies in nonpregnant adults demonstrated that TOMAC effectively reduced RLS symptom severity, with over 70% of participants achieving "much" or "very much improved" status after 24 weeks, without serious adverse effects.[26] Mechanistically, TOMAC activates the peroneal nerve to induce tonic contraction of the tibialis anterior muscle, mimicking the symptom-relieving effect of voluntary leg movement while remaining compatible with sleep.[27] The therapy has received Food and Drug Administration (FDA) clearance for medication-refractory RLS and appears cost-effective compared to standard care.[28]

However, TOMAC has not been systematically evaluated in pregnancy, and safety data for fetal exposure are lacking. Although the stimulation is localized and does not involve pharmacologic agents or systemic current flow, theoretic concerns remain regarding electrical stimulation during gestation. Until formal safety studies in pregnant women are conducted, TOMAC should not be recommended during pregnancy and may be considered only postpartum if symptoms persist and noninvasive behavioral measures are insufficient.

PHARMACOLOGIC MANAGEMENT

Pharmacologic therapy for RLS during pregnancy is reserved for women with moderate-to-severe symptoms that persist despite optimization of nonpharmacological measures and correction of iron deficiency.[8] Any medication use should follow the principles of minimal effective dosing, limited duration, and individualized risk–benefit assessment. The decision to initiate drug therapy should be made collaboratively with the patient, ideally involving obstetric and sleep medicine specialists, given the paucity of controlled safety data in pregnant populations.

Iron Therapy

Iron supplementation represents the first-line pharmacologic treatment of RLS during pregnancy. Pregnancy is associated with a progressive decline in serum ferritin, often falling below the threshold associated with symptom exacerbation. The IRLSSG recommends maintaining serum ferritin above 75 μg/L in all symptomatic women. In accordance with the 2025 AASM guideline, transferrin saturation should also be maintained above 20%, as values below this level indicate inadequate iron availability and justify supplementation.[20] Therefore, pregnant women with serum ferritin levels below 75 μg/L or transferrin saturation below 20% should receive iron therapy.

Oral iron therapy (ferrous sulfate 325 mg, providing ~65 mg elemental iron, 1–3 times daily) should be started when ferritin is less than 75 μg/L. It is safe in all trimesters and during lactation, though gastrointestinal intolerance (constipation and nausea) may limit adherence. Concurrent intake of vitamin C and administration can enhance iron absorption; however, the safety of vitamin C supplementation during pregnancy remains uncertain and is therefore not recommended.[18]

IV iron should be considered for moderate-to-severe RLS when serum ferritin is less than 30 μg/L, oral absorption is inadequate, or symptoms persist despite oral supplementation. According to the 2025 AASM guideline, ferric carboxymaltose is the preferred IV preparation for RLS, supported by robust efficacy and safety evidence. In pregnant women, comparative data show that both ferric carboxymaltose and iron sucrose are well tolerated, with only mild, transient adverse reactions and no fetal safety concerns.[29] Ferric carboxymaltose offers the practical advantage of higher single-dose administration with fewer infusions, making it particularly suitable when rapid iron repletion is needed. IV iron therapy should be limited to the second and third trimesters, as safety data in early pregnancy remain insufficient. Correction of iron deficiency often leads to substantial improvement or remission of RLS symptoms, reinforcing iron repletion as the cornerstone of treatment during pregnancy.

Dopamine Agonists

Dopamine agonists, such as pramipexole, ropinirole, and rotigotine, are effective for idiopathic

RLS, but their use in pregnancy is generally not recommended due to insufficient safety data and potential interference with prolactin and lactation. Available case reports and registry data suggest that levodopa/carbidopa may be relatively safe when used intermittently for severe, refractory symptoms. Historical use of levodopa in pregnancy (primarily for Parkinson's disease) has not shown teratogenicity, but data are limited and mostly anecdotal. Bromocriptine, an older dopamine agonist with extensive obstetric use to suppress lactation, is classified as relatively safe in pregnancy, but its short duration and inconsistent efficacy make it a secondary option. If a dopamine agent is deemed necessary, the lowest effective dose should be used in the second or third trimester only, with discontinuation before delivery to avoid neonatal withdrawal or lactation suppression.

Gabapentinoids

Gabapentin and pregabalin act as $\alpha 2\delta$ calcium-channel ligands and have established efficacy for RLS, especially in patients with comorbid insomnia, anxiety, or neuropathic discomfort. However, their safety during pregnancy remains uncertain. Gabapentin is classified as FDA Pregnancy Category C, with animal studies showing developmental toxicity but limited human evidence of teratogenicity. Observational data from epilepsy and neuropathic pain cohorts indicate a possible small increase in the risk of major congenital malformations but not consistent across studies.

Pregabalin has even less safety data. Several registry and cohort analyses have suggested a slightly increased risk of congenital malformations, growth restriction, and central nervous system abnormalities, though results are inconsistent and confounded by comorbidities. In the IRLSSG 2015 consensus guideline, pregabalin was rated as "use with caution" during pregnancy and lactation because of insufficient human data and higher potential teratogenicity signal compared with gabapentin.

Given this limited evidence, gabapentinoids should be avoided during early pregnancy and considered only when iron repletion and nonpharmacologic measures fail, and symptoms are intolerable. If used, gabapentin (*100–300 mg* at bedtime, titrated cautiously) is generally preferred over pregabalin due to more safety experience in human pregnancies. During lactation, gabapentin is excreted into breast milk in low concentrations and is considered compatible with breastfeeding, though infant monitoring for sedation is advised.

Clonazepam

Clonazepam, a long-acting benzodiazepine, has been historically used as adjunctive therapy for RLS to reduce sleep-onset insomnia and nighttime awakenings, particularly when symptoms are accompanied by anxiety or hyperarousal. However, evidence for its efficacy in primary RLS is limited. The 2025 AASM guideline specifically recommends *against* its standard use because of very low certainty of benefit and potential adverse effects including tolerance, dependence, and next-day sedation.

During pregnancy, benzodiazepines cross the placenta and have been associated, in some cohort studies, with a small increased risk of cleft lip or palate and neonatal adaptation syndrome (hypotonia, respiratory distress, and irritability). Although more recent meta-analyses suggest that the absolute risk is low, clonazepam should be considered only as an adjunctive option, when disabling insomnia or anxiety persists despite optimal iron repletion and nonpharmacologic measures. In such cases, short-term, low-dose administration (*0.25–1 mg* at bedtime) may be considered during the late second or third trimester after detailed counseling about potential risks.

During lactation, clonazepam is excreted into breast milk in small amounts and may cause infant sedation or feeding difficulties, particularly in premature neonates. If prescribed postpartum, maternal dosing should be minimized and infants monitored for somnolence and weight gain.

Opioids

Opioids should be reserved as a last-line option for very severe, very refractory RLS during pregnancy—defined as symptoms causing extreme distress or functional impairment (IRLS score >30) that persist despite adequate trials of nonpharmacologic interventions, normalization of iron stores (ferritin $\geq$75 μg/L), and failure to respond to at least 1 nonopioid pharmacologic therapy such as a gabapentinoid.

Most opioids readily cross the placenta and can cause neonatal respiratory depression, withdrawal, and dependency with chronic exposure. Nevertheless, low-dose intermittent use (eg, *tramadol 50–100 mg/d* or *oxycodone 5–10 mg/d*) has been described in exceptional cases without evidence of teratogenicity. Their use should be considered only after multidisciplinary consultation and with careful maternal–fetal monitoring.

If opioids are required, they should be used short-term and at minimal effective doses, preferably in the third trimester only, under obstetric

supervision. Tramadol is preferred over classic opioids because of its shorter half-life and partial serotonergic mechanism, though the risk of neonatal withdrawal remains. During lactation, short-acting opioids at low doses can be used cautiously, with careful monitoring for infant sedation and feeding difficulty.

SUMMARY

RLS is among the most frequent sleep-related conditions during pregnancy, affecting approximately 20% to 25% of women, with prevalence peaking in the third trimester and declining rapidly after delivery. Recent large-scale studies, including the Life-ON prospective cohort,[13] confirmed that RLS symptoms often remain stable across trimesters but may persist into the postpartum period in a subset of women. Family history, prior RLS episodes, low ferritin, and history of depression are consistent risk factors. Iron deficiency remains the most reproducible biochemical correlate, and correction of iron stores frequently leads to symptom improvement or remission.

Pregnancy-related RLS is typically transient and benign; however, up to one-fifth of women experience severe to very severe symptoms associated with sleep deprivation, mood disturbance, and impaired quality of life. Although causal relationships with adverse obstetric outcomes remain debated, RLS is clearly linked to poor sleep quality and daytime dysfunction, which may indirectly affect maternal well-being. Moreover, transient RLS during pregnancy confers a 4 fold higher risk of developing idiopathic chronic RLS later in life, underscoring the importance of recognition and follow-up.

Management should follow a stepwise approach. Nonpharmacologic strategies and iron repletion are first-line interventions, consistent with IRLSSG and AASM guidelines. Pharmacologic treatment is reserved for women with disabling, refractory symptoms after optimal iron correction and behavioral measures. Among available agents, oral and IV iron (ferric carboxymaltose or iron sucrose) have the best safety evidence for use after the first trimester. Dopaminergic agents and $\alpha 2\delta$-ligands may be considered only for severe cases when benefits clearly outweigh fetal risk, whereas opioids or benzodiazepines are last-line adjuncts for very severe, refractory RLS. Collaborative care between obstetricians, neurologists, and sleep specialists is essential to optimize maternal comfort while minimizing medication exposure. Future studies should clarify safe dosing regimens, longitudinal outcomes, and nonpharmacologic innovations during pregnancy and lactation.

CLINICS CARE POINTS

- RLS affects about 1 in 4 pregnant women, most often emerging in the second or third trimester and remitting soon after delivery.
- Family history, prior RLS, multiparity, low ferritin (<75 μg/L), and depression are major risk factors.
- Screening for RLS should be incorporated into prenatal care, especially in women reporting insomnia or leg discomfort.
- Assess ferritin and transferrin saturation in all symptomatic women; treat if ferritin less than 75 μg/L (oral) or less than 30 μg/L (consider IV iron after first trimester).
- Prioritize nonpharmacologic interventions—moderate exercise, stretching, massage, pneumatic compression, and sleep hygiene—before medications.
- Reassure that symptoms are typically transient and improve postpartum; provide education to reduce anxiety and sleep disruption.
- Pharmacologic therapy should be individualized, using the lowest effective dose for the shortest possible duration after failure of conservative measures.
- Dopamine agonists and gabapentinoids may be considered only for severe, refractory cases after risk–benefit discussion; avoid in early pregnancy.
- Opioids and clonazepam are last-line options, restricted to very severe, refractory RLS with disabling insomnia or anxiety.
- Follow-up is warranted postpartum, as women with pregnancy-related RLS have an increased risk of developing chronic idiopathic RLS later in life.

DECLARATION OF ARTIFICIAL INTELLIGENCE AND ARTIFICIAL INTELLIGENCE-ASSISTED TECHNOLOGIES IN THE WRITING PROCESS

During the preparation of this article, the author used ChatGPT in order to polish the English language. After using this tool/service, the author reviewed and edited the content as needed and takes full responsibility for the content of the publication.

DISCLOSURE

The authors have nothing to disclose.

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