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# Inflammatory Bowel Disease (IBD) in Pregnancy

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*No Disclosures

# Goals of Today's Talk

- Broadly understand the different types of IBD and how each type impacts pregnancy differently
- Understand the different types of medical and surgical therapy for IBD and how it relates to pregnancy

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# Types of IBD

- Ulcerative colitis (UC) is a chronic inflammatory disorder of the colonic mucosa. This disorder is characterized by superficial mucosal intestinal inflammation that extends in a contiguous fashion beginning at the anal verge to involve a portion of the colon or the entire colon
- Crohn's disease (CD) is a chronic disorder of the GI tract characterized by transmural intestinal inflammation that has a propensity to involve almost any portion of the GI tract, from the mouth to the anus. The most common site of involvement is the ileocecal region.

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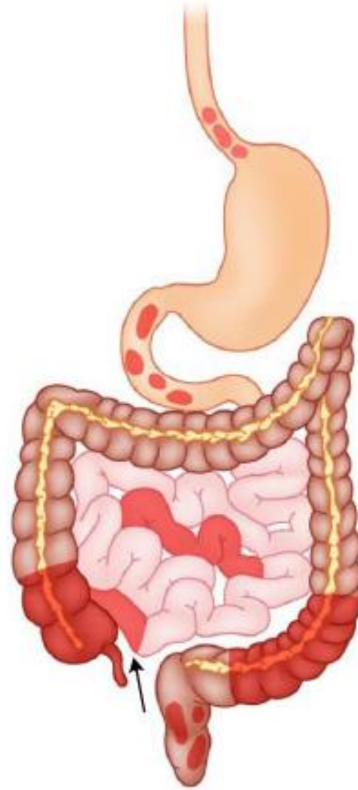
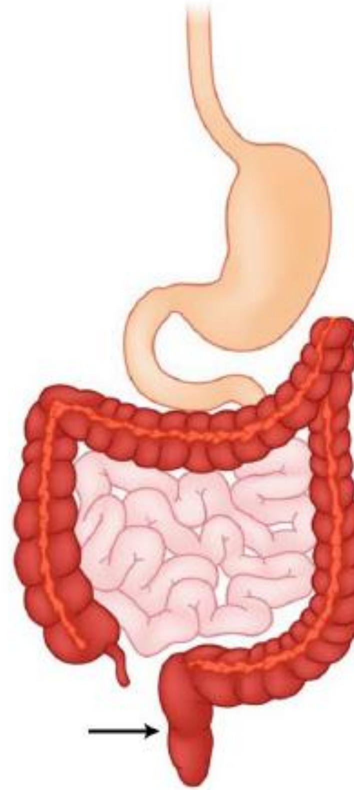
# Types of IBD



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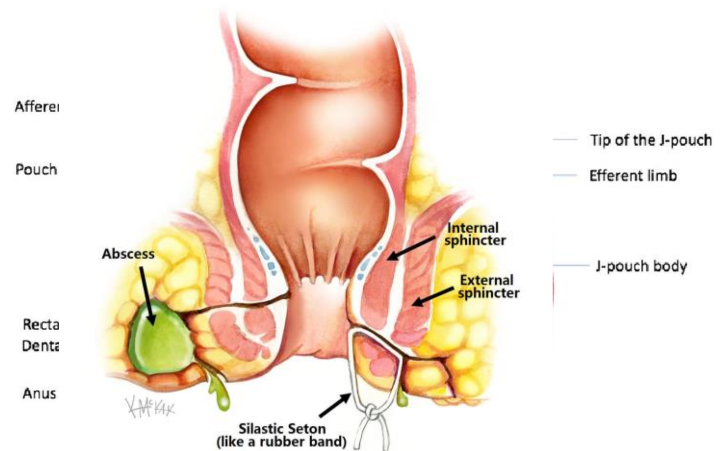
# Treatment of IBD

- Immunosuppression
  - Steroids (acutely)
  - 5-ASA medications (eg-mesalamine)
  - Biologics (eg-Infliximab, Adalimumab, Vedolizumab)
  - Immunomodulators (eg-Azathioprine, Methotrexate)
- Surgery
  - IPAA (J-pouch) in UC patients
  - Diverting ostomy
  - Bowel resections
  - Perianal setons



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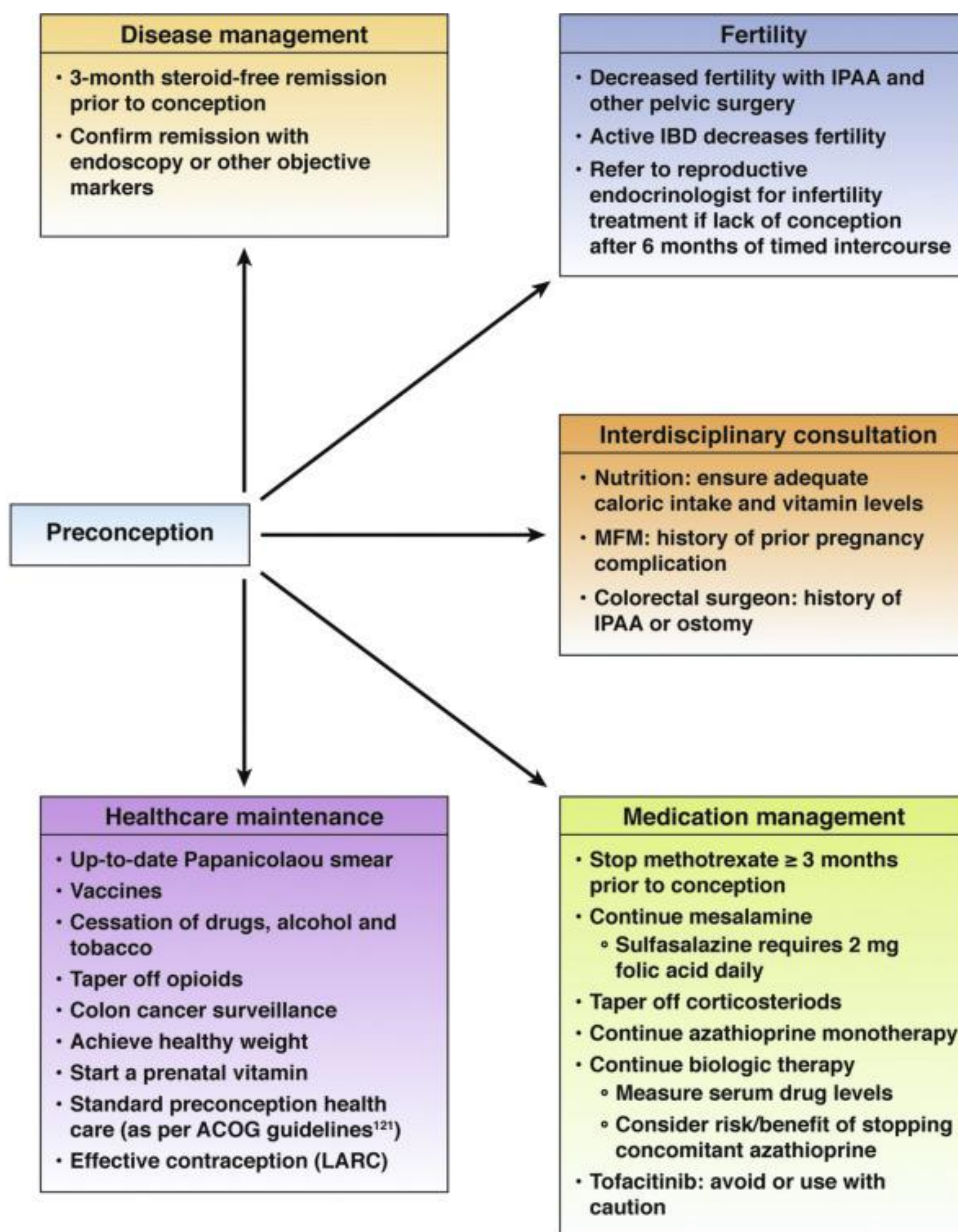

# Case 1

- 29 year old woman with a history of medically refractory UC and subsequent IPAA comes to discuss fertility. She is having trouble getting pregnant. She denies symptoms of active IBD, but does have 6 BMs/day. What is your next step?
  A. Discuss fertility rates with IPAA and refer to REI
  B. Refer to gastroenterology for pouch assessment
  C. Check a stool c diff
  D. Check IBD serologies
  E. All of the above

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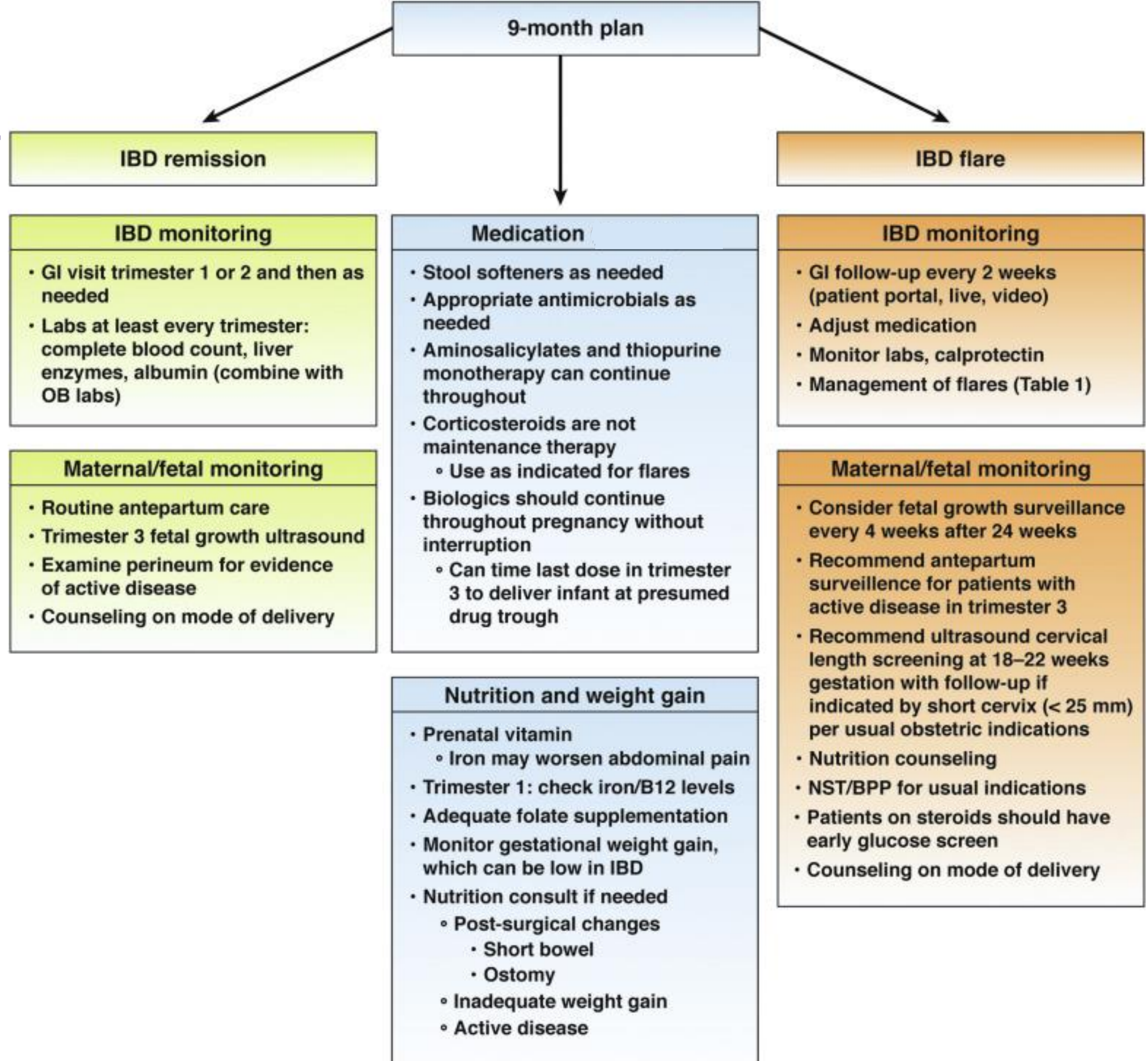

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| Medication | Maintenance dosing recommendation |
|---|---|
| Aminosalicylates | Maintain prepregnancy dosing |
| Mesalamine | All preparations are now phthalate-free |
| Sulfasalazine | Consider 2-mg folate supplement in pregnancy<br>Azulfidine EN contains phthalate |
| Immunomodulators | Dosing may be altered due to increased renal clearance with pregnancy. Therapeutic drug monitoring recommended |
| Cyclosporine (calcineurin inhibitor) | Limited data in pregnancy suggest associations with hypertension, gestational diabetes, preterm birth, low birthweight/SGA. Used as a salvage therapy. |
| Methotrexate | Contraindicated in pregnancy. Stop 3 months before conception. |
| Thiopurines (azathioprine, 6-mercaptopurine) | Continue as monotherapy<br>In appropriate patients, consider cessation of thiopurine as combination therapy, given possible association with increased infant infections.<br>Use with caution in combination with allopurinol, which carries potential embryo toxic effects |
| Small molecules | |
| Tofacitinib | Limited human data. Consider other options, particularly in first trimester |
| Biologics | Maintain prepregnancy dosing<br>Continue dosing throughout all 3 trimesters<br>If possible, plan final dose according to drug half-life to minimize transfer |
| Adalimumab | Plan final pregnancy injection 2–3 wk before EDC and resume postpartum[a] (1–2 wk if weekly dosing) |
| Certolizumab pegol | May continue scheduled dosing throughout pregnancy. |
| Golimumab | Plan final pregnancy injection 4–6 wk before EDC and resume postpartum[a] |
| Infliximab | Plan final pregnancy infusion 6–10 wk before EDC and resume postpartum[a] (If every-4-wk dosing, then 4–5 wk before EDC)<br>Base dosing on prepregnancy weight during pregnancy and immediate postpartum |
| Natalizumab | Plan final pregnancy infusion 4–6 wk before EDC and resume postpartum[a] |
| Ustekinumab[b]/ Vedolizumab[b] | Plan final pregnancy dose 6–10 wk before EDC and resume postpartum[a] (If every-4-week dosing, then 4–5 wk before EDC) |
| Corticosteroids | Reserved for active flares in pregnancy.<br>Not recommended for planned maintenance therapy during pregnancy. |
| Antibiotics | Reserved for perianal disease and pouchitis and not recommended for planned maintenance therapy (amoxicillin/metronidazole preferred over ciprofloxacin) |

# Case 2

- 26 year old woman with penetrating perianal CD treated with Infliximab and Azathioprine in remission with mucosal healing is 3 months pregnant. She wants to know what to do with her medications. Should she:
  A. Stop both medications
  B. Stop Azathioprine but continue Infliximab
  C. Stop Infliximab but continue Azathioprine
  D. Continue both medications
  E. Both B and D

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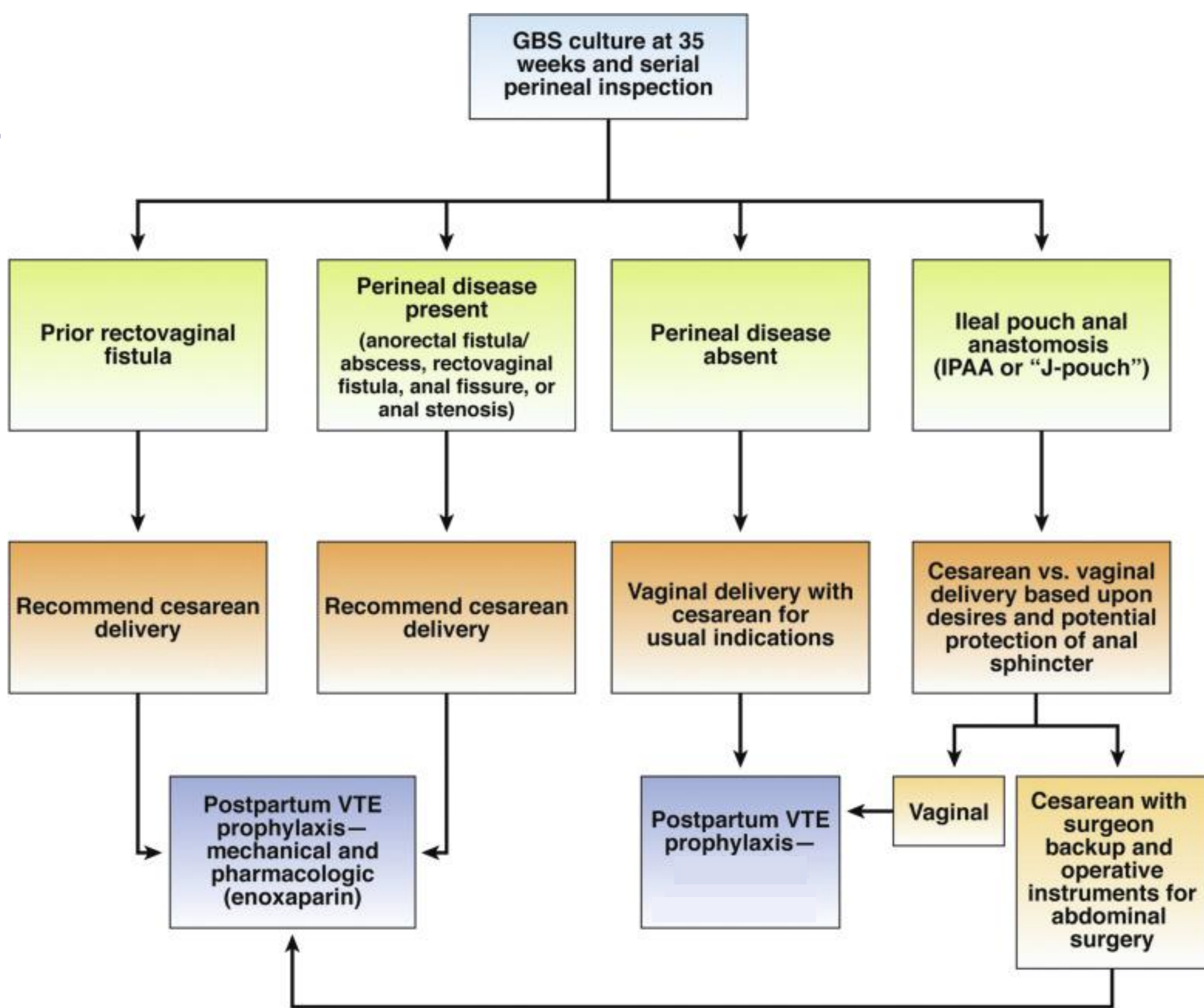


Abbreviations used: GBS, Group B streptococcus; VTE, Venous thromboembolic disease

# Case 3

- 31 year old woman with a history of medically refractory UC and subsequent IPAA comes to her 36 week visit. She wants to discuss delivery options? You advise:
  A. Vaginal delivery
  B. Planned cesarean section
  C. Have her meet with a colorectal surgeon and GI
  D. B and C
  E. All of the above

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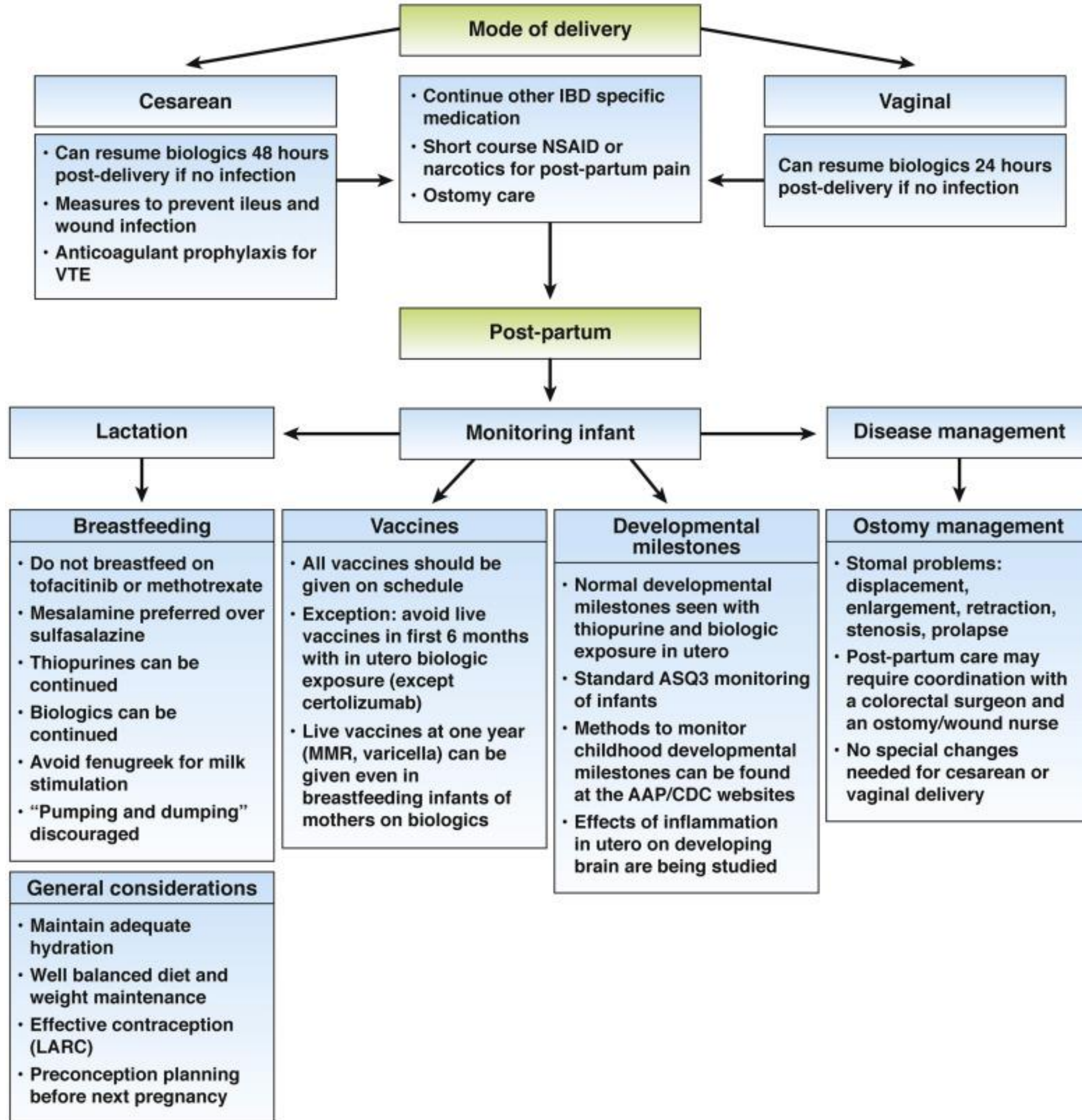

# Summary

- Preconception
  - Health maintenance, medication safety, sustained disease remission (3 months)
- Pregnancy
  - Monitor disease activity, use steroids only for flares, attempt to adjust biological timing, delivery options based on prior surgeries and disease distribution
- Postpartum
  - Avoid live vaccines < 6 mo old in infants of moms on biologics, VTE prophylaxis

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# Questions?

# References:

Inflammatory Bowel Disease in Pregnancy Clinical Care Pathway: A Report From the American Gastroenterological Association IBD Parenthood Project Working Group (AGA Guidelines)
PubMed ID: 30658060

Inflammatory Bowel Disease and Pregnancy (ACG Guidelines)
PubMed ID: 36194035