

Preconception or Pregnant IBD Patients Checklist 2014

Who this applies to:

- 1) Male and female patients of reproductive age with IBD (even consider transition patients as teens and early 20s patients are starting relationships, in relationships, considering relationships etc)
- 2) Even if the patient is not currently considering pregnancy or family planning, still open the conversation to the patient so they do not feel embarrassed or worried about asking sensitive questions

Things to discuss with the patient (depending on individual situation):

- 1) **Current and future family planning** - Do they think they might want to have children, or have they decided they do not want to have children, or are they unsure? Build the relationship with the patient so that they feel comfortable that they can ask questions about family planning at any point in time. If the patient does not want to have children, an additional question about the factors leading up to their decision is encouraged as patients may be misinformed about genetic or medication risks.
- 2) **Genetic risk** – This is generally considered to be less than 10%, but it is higher if the patient has family history of IBD.
- 3) **Fertility** – Generally, if a patient is in clinical remission, fertility is similar to that of the general population. However, individual circumstances can affect fertility such as other comorbidities (smoking, malnutrition), reproductive history, other medications, BMI. Active IBD and history of IBD surgery ileal pouch anal anastomosis can decrease fertility.
 - a. Stage patient with endoscopy and/or FCP and/or imaging before attempting conception, if there is any concern about them being in clinical remission. Re-stage patients who have not been staged within the last year; even if patients are in clinical remission, it is important to do this given the disconnect, particularly for Crohn's, between symptoms and burden of disease.
 - b. Suggest all patients be on prenatal vitamins (iron and folate) if they are considering pregnancy
 - c. For patients who have risk factors for infertility, either associated with their IBD or not, consider referral to a fertility specialist after 6 months of trying to conceive.
- 4) **Pregnancy** - Patients with IBD should be considered high risk pregnancy even if they have inactive disease. Although not all studies are consistent, most show that patients with IBD have an increased risk of small for gestational age infant, preterm birth, and caesarean section. The risk for preterm birth is even higher when the patient has active disease.
 - a. Suggest referral to maternal fetal medicine clinic at RAH or FMC (especially if on immunomodulators and/or biologics).
 - b. Refer to an obstetrician with experience in the management of pregnant IBD patients.
 - c. Patients should be seen each trimester to ensure medication adherence and disease remission.
- 5) **Medications** – Counsel the patient on medication adherence and medications that can be used during pregnancy and breastfeeding, depending on which medications they are on or may require.
 - a. Contraindicated:
 - i. Methotrexate – should be stopped 6 months before attempting conception (both males and females) and avoided during pregnancy and breastfeeding.
 - b. Best to avoid if possible:
 - i. 1st trimester – prednisone due to possible association with neonatal cleft palate

- ii. 1st trimester – metronidazole due to risk of neonatal cleft palate
- iii. During pregnancy – ciprofloxacin due to risk of neonatal arthropathy
- c. Should continue during pregnancy if required for maintenance:
 - i. Biologics (Infliximab, Adalimumab, Golimumab) – Note: If the patient cannot stop these medications without flaring, they can be taken throughout the entire pregnancy. Otherwise, follow the guidelines below.
 - 1. Infliximab - aim to give last dose at 30 to 32 weeks but if patient is on a more frequent dose, the last dose may be given closer to 34 weeks.
 - 2. Adalimumab – aim to give last dose at 32-34 weeks but may have to continue up to 36 weeks, if on weekly dosing.
 - 3. Golimumab – there are no published studies with a non-exposed control group. Given that it is also an IgG antibody it would have the same transplacental issues as Infliximab and Adalimumab. According to Janssen there have been 47 reported cases of pregnancy but without a control group we are unable to calculate a risk of adverse outcomes. Of the live births that were reported (26/47) there were no cases of congenital anomaly.
 - 4. If the patient is due for their medication at the time of delivery, these biologics can be restarted 24 to 48 hours after uncomplicated vaginal delivery. It is safe to restart 48 hours after an uncomplicated caesarean section, assuming there are no concerns about infection.
 - 5. Re-load if having active symptoms, or if there was a long hiatus in therapy, otherwise resume with the regular schedule.
 - 6. Infants should NOT get any live vaccinations for at least 6 months as anti-TNF has been detected as long as 6 months in neonates. If a live vaccine is required before 6 months of age, anti-TNF levels must be measured in the infant to ensure it is undetectable.
 - 7. PIANO study (large USA registry of pregnant women on biologics) shows no adverse effect on developmental milestones up to 4 years old among infants exposed to biologics in utero.
 - ii. Imuran/6MP
 - 1. A recent human study showed a small risk of neonatal anemia. The clinical significance of this is yet unknown as there was no control group of non-thiopurine exposed neonates in this study. There is data to suggest an association with preterm birth- however this could be related to disease activity not the drug itself.
 - iii. Aminosalicylates
 - 1. If on Asacol, the DBP coating has shown risk of genital defects in animal studies with very high doses. Consider switching to another 5-ASA in the preconception period, but if the patient is doing well, and already pregnant we recommend not changing formulations of 5-ASA .
 - iv. Sulfasalazine
 - 1. Ensure the patient is on folate 2mg daily.
 - v. Topical therapies
 - 1. No increased risk of premature delivery.
 - 2. 5-ASA enemas and suppositories, cortifoam enemas can be continued.
 - vi. Steroids if required for acute IBD flare
 - 1. Prednisone – best to avoid in 1st trimester if possible (risk of cleft palate).
 - 2. Budesonide – one study in CD patients, no significant risk of cleft palate.
 - 3. Steroid use during pregnancy is associated with maternal gestational diabetes and risk of preterm birth, low birth weight, and possible early infant infection (PIANO study).

However these associations may be due to the active disease. We recommend all patients who require steroids during pregnancy have their care transferred to high risk obstetrics.

4. Patients on steroids during pregnancy may require stress-dose steroids around delivery time particularly if a caesarean section is planned, but this needs to be discussed with the obstetrician, and considered on a case by case basis.
- d. Can continue during breastfeeding:
 - i. Biologics
 1. Very miniscule amounts have been detected in breast milk, but thought to be digested as a IgG protein.
 - ii. Imuran/6MP
 1. Consider pump and dump for the first 4hrs after consuming medication.
 - iii. Aminosalicylates
 1. Rare reporting of neonatal diarrhea from 5-ASA hypersensitivity.

6) Effects of IBD on pregnancy

- a. Fertility is similar to that of the general population, if the disease is well controlled.
- b. IBD patients have a slight increased risk of small for gestational age infants, premature birth and cesarean section.

7) Effects of pregnancy on IBD

- a. The 2013 APT article N. Pedersen from ECCO matched CD pregnant to CD not pregnant and UC pregnant to UC not pregnant. There was no evidence of an increase in flare in CD compared to controls. In UC the RR for disease relapse was 2.19 during pregnancy and 6.22 post partum.

8) Delivery

- a. In most cases, the mode of delivery is at the discretion of the obstetrician.
- b. In Crohn's patients with active peri-anal disease a c-section is recommended.
- c. In patients with an IPAA, the mode of delivery should be a case-by-case discussion. Vaginal delivery seems to be safe, but may be associated with pouch and anal dysfunction in a small group of patients. In contrast, caesarean section preserves pouch function, but also has inherent risks including the risk of surgery and subsequent small bowel obstruction. Therefore, the final decision will likely depend on the size of the fetus, discussion with patient and input from obstetrician and colorectal surgeon.

Consider referral to Pregnancy in IBD consultation and research clinic <http://pregnancy.ibdclinic.ca/>