CROHN'S & COLITIS UK

FIGHTING INFLAMMATORY BOWEL DISEASE **TOGETHER**

INFORMATION SHEET

PREGNANCY AND IBD

INTRODUCTION

If you have Inflammatory Bowel Disease (IBD) and are thinking of having a baby, you may be concerned about how your condition or your treatments might affect your pregnancy. You may also be worrying about whether having a baby could affect your IBD.

The good news is that, especially if their IBD is under control, most women with Ulcerative Colitis (UC) or Crohn's Disease (the two most common forms of IBD) can expect to have a normal pregnancy and a healthy baby. Also, for most women, having a baby does not make their IBD worse.

However, it is important to discuss your pregnancy with your IBD team. You may need to take special care with some aspects of your pregnancy - or perhaps change your treatment slightly.

This information sheet answers some of the most commonly asked questions about pregnancy and IBD. We also have a companion sheet, **Fertility and IBD**, which looks at IBD and conception.

HOW MIGHT MY IBD AFFECT MY FERTILITY?

More details are given in **Fertility and IBD**, but if you have inactive IBD, whether Ulcerative Colitis or Crohn's Disease, your chances of conceiving are unlikely to be affected by the disease.

If you have active IBD, especially Crohn's, you may have a slightly lower chance of conceiving. Severe inflammation in the small intestine can affect the fallopian tubes and make it more difficult to get pregnant. There is also some evidence linking Crohn's with a lower 'ovarian reserve' (eggs capable of being fertilised) in women over 30.

Surgery for IBD, especially 'pouch surgery' (an IPAA or ileo pouch-anal anastomosis operation), can affect fertility, so if you are planning a pregnancy you may wish to discuss this with your specialist or surgical team.

Most of the drugs prescribed for IBD do not affect fertility, but there are a few exceptions, such as sulphasalazine, a 5-ASA medication. This is known to reduce fertility in men. This effect is usually temporary and there are good alternatives that can be taken instead. Sulphasalazine does not affect fertility in women.

Methotrexate, an immunosuppressant, should not be taken by either partner when trying to conceive or by women while pregnant. This is because it can cause birth defects or miscarriages, and may also affect the formation of sperm.

For more details on this and other drugs to avoid while pregnant, see the section on the next page: **How safe is my medication in pregnancy?**

> "My midwife was sympathetic when I told her about my Crohn's, but she admitted she knew very little about it. As a result, my care was instead led by a consultant obstetrician. She referred to the notes provided by my IBD team. it meant that I didn't have to keep explaining my condition as everyone was in the loop about my Crohn's and my pregnancy."
>
> Cari, age 34
> Mother to one child, diagnosed with Crohn's Disease in 2007

HOW MIGHT IBD AFFECT MY PREGNANCY?

A large number of studies have looked at the effect of IBD on pregnancy, and not all the findings have been consistent. However, there is some evidence linking IBD with problems such as preterm (early) birth, babies with a low birth weight and, more rarely, miscarriages.

That said, many experts believe that disease activity can be an important factor. Several studies have shown that most women with IBD who are in remission or have only mild active disease at the time they conceive, are very likely to have a normal uncomplicated pregnancy.

In addition, for those who remain in remission, the risk of problems such as miscarriage is about the same for a woman without IBD. (Sadly, about one in five of all pregnancies is estimated to end in a miscarriage.)

You are also more likely to remain well in yourself if your symptoms are under control when you conceive.

This is why, if you are thinking of getting pregnant, most doctors will advise you to try to get your IBD under control first.

As mentioned above, research has also suggested that active disease at conception or flare-ups while pregnant may make you more likely to give birth early or have a low birth weight baby. Severe active Crohn's Disease or a very severe flare-up of Ulcerative Colitis may put you and the baby at greater risk. It is important to bear in mind that this does not always happen - many women who conceived when their disease was active or had a relapse while pregnant have gone on to have normal pregnancies and healthy babies. But, it is definitely better for you and your baby if you can keep in remission while you are pregnant. So, if your IBD symptoms do begin to get worse, consult your doctor or IBD team as soon as possible.

SHOULD I KEEP TAKING MY MEDICINES WHILE I AM PREGNANT?

In general, the evidence suggests that active Crohn's or UC may do more harm to the growing baby than most IBD medicines. So most women will be advised to continue taking their IBD medication during pregnancy. This is particularly important if you have had a recent flare-up and are trying to get it under control.

However, a small number of the drugs used for IBD are not recommended or should not be used at all by pregnant women. This means that if you are, or are planning to be, pregnant, it is important to check with your IBD team whether you need to change your drug treatment. More details on how the most common IBD drugs might affect your pregnancy are given below.

HOW SAFE IS MY MEDICATION IN PREGNANCY?

> "I was concerned that pregnancy would make my condition worse and that I would be restricted as to which drugs I could take. But I was able to take my medication into my pregnancy. After careful discussion with my IBD team, I came off the medication part of the way through, and I was luckily well for the remainder of my pregnancy."
>
> **Cari,** age 34
> Mother to one child, diagnosed with Crohn's Disease in 2007

Aminosalicylates (5-ASAs)
- Sulphasalazine (Salazopyrin)
- Mesalazine (Asacol, Ipocol, Mesren, Octasa, Pentasa, Salofalk),
- Olsalazine (Dipentum)
- Balsalazide (Colazide)

These drugs are used to treat mild to moderate flare ups of IBD and to maintain remission. They have been taken by women during pregnancy for many years, and are generally considered to be safe.

Sulphasalazine can reduce the body's ability to absorb folic acid, a vitamin known to be important to foetal development. So, if you are pregnant and on sulphasalazine, you will be advised to take higher levels of folic acid supplements.

Corticosteroids (steroids)
- Prednisolone
- Budesonide (Entocort)

These steroids are widely used to treat IBD flare-ups. Such steroids can cross the placenta but are quickly metabolised, and so are usually considered to be safe in pregnancy.

Some early research linked prednisolone treatment with a slightly increased risk of cleft palate, but more recent studies have not supported this finding. Research on the use of budesonide by pregnant women with IBD is currently very limited, but what there is has not shown any harmful effects.

Steroids are sometimes prescribed to be taken topically, as an enema or a suppository. These are also safe to use while pregnant.

Immunosuppressants
- Azathioprine (Imuran)
- Mercaptopurine (6-MP) (Purinethol)

Immunosuppressant drugs make the body's immune system less responsive. This has the effect of reducing the inflammation typical of IBD. However, a less responsive immune system may make you more susceptible to infections.

Azathioprine and mercaptopurine both cross the placenta and there have been a large number of studies looking at their effects when taken by pregnant women with IBD. Most studies have shown these drugs to be safe, although there is some suggestion they may increase the risk of a preterm birth. In general, most doctors recommend the continued use of azathioprine and mercaptopurine during pregnancy, as the risk from the drug is usually much lower than the risk to the baby if the mother's IBD relapses.

If you do have any concerns, talk to your specialist about the possible risks and benefits, so that your decision can be based on your own health.

- **Methotrexate**

Methotrexate can increase the risk of birth defects or miscarriages if taken by women at conception or during pregnancy. It may also affect the formation of sperm. Therefore, it is very important that methotrexate should not be taken by either partner when trying to conceive, or by women when pregnant. Because traces of methotrexate can remain in body tissue for some time, couples are advised to use reliable contraception while being treated with methotrexate and to avoid pregnancy for at least 3-6 months after stopping treatment with this drug.

If you find you are pregnant, or decide you would like to have a child while on methotrexate, talk to your doctor about this. Women who are the partner of a man taking methotrexate should also talk to their doctor if they discover they are pregnant or wish to conceive.

- **Mycophenolate Mofetil**
  This immunosuppressant may also cause miscarriages or birth defects if used during pregnancy. Women being treated with this drug who wish to become pregnant are usually advised to stop taking mycophenolate mofetil at least 6 weeks before conception.

- **Ciclosporin**
  This is a strong immunosuppressant usually prescribed for people with active Ulcerative Colitis that has not responded to steroids. It can be very effective and help to reduce or avoid the need for surgery.

Ciclosporin is known to cross the placenta. Studies of its use in pregnant transplant patients and in a much smaller number of pregnant women with IBD suggest ciclosporin does not seem to harm the unborn baby. However, it can have quite severe side effects, including hypertension (high blood pressure). So ciclosporin is not usually recommended in pregnancy unless there is a real risk that, without it, the mother will need an urgent colectomy (surgery to remove the bowel).

- **Tacrolimus**
  This is another immunosuppressant originally used to treat transplant patients. There is currently little evidence about its safety for pregnant women with IBD. So if you are taking tacrolimus, and you are pregnant, or thinking about becoming pregnant, it is best to talk to your IBD team about your treatment.

Biologics
- Infliximab (Remicade)
- Adalimumab (Humira)

These biologic drugs are also known as 'anti-TNF drugs' because they target a protein called TNF-alpha to help prevent inflammation and reduce the symptoms of IBD. They are increasingly used for moderate to severe IBD.

Both infliximab and adalimumab cross the placenta to the baby from about month 6 of the pregnancy.

Research is continuing into the possible effects of these drugs in pregnancy. Several studies have found that the birth outcomes for women with IBD on anti-TNF therapy while pregnant have been very similar to those for women not using anti-TNFs. Also, a recent major review concluded that, while it was still too early to say that infliximab and adalimumab are absolutely safe, there is a growing body of evidence that they are low risk during conception and for at least the first two trimesters (up to 6 months).

Currently, the manufacturers of infliximab and adalimumab still recommend caution and the use of contraception to avoid pregnancy. However, many doctors now consider that if the anti-TNF treatment is keeping the IBD in check, it may be better to continue with it during pregnancy, for at least the first six months. In some circumstances, a doctor may advise continuing with anti-TNFs throughout a pregnancy.

Guidelines suggest that doctors should discuss the risks and benefits of these drugs with each woman on an individual basis. You may find it helpful to talk through your own options with your specialist IBD team.

It is also important to be aware that babies of women who have received infliximab or adalimumab during their pregnancy should not be given 'live' vaccinations until the age of six months. Your doctor will be able to give you more information on this.

Antibiotics
- Metronidazole
- Ciprofloxacin

These antibiotics are sometimes used to treat infections linked to Crohn's Disease or pouchitis following IPAA surgery.

Metronidazole is generally regarded as low risk in pregnancy after the first trimester (months 1-3). Recent research has suggested that it may also be safe for use in early pregnancy.

Ciprofloxacin is a type of medication that research in animals has linked to bone problems. Although it has not been shown to be harmful to humans, some doctors advise against using this antibiotic during pregnancy, particularly during the first trimester.

Antidiarrhoeals
- Colestyramine (Questran)

This is a bile salt binding drug often used to treat diarrhoea associated with surgery for Crohn's. It is considered safe to take during pregnancy.
- Diphenoxylate (Lomotil)
- Loperamide (Imodium, Arret)

There is some evidence that loperamide may be linked with birth defects if taken during the first trimester (months 1-3). Guidelines suggest diphenoxylate should be used with caution. It is generally best to check with your doctor before taking these medicines when pregnant.

Antispasmodics
- Hyoscine butylbromide (Buscopan)

This over-the-counter medicine is best avoided during pregnancy.

For more information on drugs and medicines for IBD, see our specific drug treatment leaflets.

WHAT ABOUT NUTRITIONAL THERAPY?

Some people with Crohn's use an elemental or polymeric diet (the two main types of liquid feed) as part of their treatment. Both these diets may be safely used during pregnancy to treat a flare-up of disease or as a nutritional supplement. See our booklet **Food and IBD** for more information on nutritional treatment.

WHAT INVESTIGATIONS OR TESTS CAN I HAVE DURING PREGNANCY?

As someone with UC or Crohn's Disease, you may need to have an investigation or test to check on your IBD, especially if you have a flare-up. Make sure your doctor and IBD team know you are, or may be, pregnant.

Some types of investigation may need to be delayed until after you have the baby.

Ultrasound tests and, after the first trimester, MRI tests are safe to have while pregnant.

Gastroscopy, sigmoidoscopy and colonoscopy can also be safely carried out in pregnancy, although guidelines suggest that these types of tests should only be done when clearly necessary.

The guidelines also recommend that, where possible, women should have these tests during the second trimester (months 4-6) rather than earlier or later. Investigations that involve x-rays and radiation should normally be avoided by pregnant women unless absolutely essential. This includes CT scans, PET scans, and barium X-ray tests.

For more details about these tests see our information sheet: **Tests and Investigations in IBD**.

WHAT ABOUT SURGERY WHILE I AM PREGNANT?

Surgery for IBD is unlikely to be suggested while you are pregnant - unless it is felt that it would be riskier not to have the surgery. Studies have suggested that if you do have IBD surgery when pregnant, the risk is lowest if the surgery is carried out during the middle trimester (months 4-6) or if this is not possible, towards the end of the pregnancy.

HOW CAN I INCREASE THE LIKELIHOOD OF HAVING A HEALTHY BABY?

Maintaining remission
Keep in mind that if your disease is under control while you are pregnant then the baby is more likely to be healthy. So it is important to follow your treatment plan and to ensure that you are as fit as possible before and during your pregnancy.

Talk to your doctor or IBD team if you have any worries about how to manage your IBD while pregnant. In particular, tell your doctor if you have a flare-up of your IBD or are failing to gain weight as expected.

Diet
For any pregnant woman, a balanced and varied diet with sufficient calories, vitamins and minerals is important for the growth of their baby. NHS Choices has a range of information on how to stay healthy while pregnant, including information on diets (see **Other sources of information and support** at the end of this leaflet). We also have a booklet **Food and IBD** that covers healthy eating for anyone with UC or Crohn's Disease.

Having IBD, the increased nutritional needs of pregnancy may mean you need to supplement your diet, especially if you are underweight or have active disease. You may find it helpful to talk to a dietitian or your IBD team about this.

Extra folic acid may be suggested. Folic acid (also known as vitamin B9) can help reduce the risk of birth defects such as spina bifida. All pregnant women are now recommended to take a folic acid supplement for the first 12 weeks of pregnancy. The usual recommendation is 400 micrograms a day. Inflammation in the small intestine and some IBD drugs can affect how well you absorb folic acid. So, if you are on sulphasalazine, have Crohn's in the small intestine, or have had surgery to remove part of your small intestine, you may need a higher dose of folic acid, for example up to 5mg a day. Check with your doctor what dose of folic acid would suit you. You may also need extra vitamin B12, especially if you take extra folic acid.

You should not take extra vitamin A while pregnant, unless your doctor specifically advises it. Research suggests that too much vitamin A can be harmful to the baby and that most pregnant women can get all the vitamin A they need from their normal diet.

If you take steroids, calcium and vitamin D supplements can be useful to help prevent bone loss.

Iron deficiency is quite common in IBD and extra iron may be needed to meet the increased demands of pregnancy. Your doctor will be able to recommend a suitable supplement.

Alcohol
Drinking alcohol while you are pregnant can seriously harm your baby's development. The Department of Health recommends that you avoid all alcohol if you are trying to conceive or are pregnant. NICE (the National Institute for Health and Care Excellence) also advises giving up alcohol for at least the first three months of a pregnancy as it may increase the risk of miscarriage.

> "I found gentle walking helped during my pregnancy. I also did a pregnancy yoga class, which I really enjoyed as I found it relaxing."
>
> Cari, age 34
> Mother to one child, diagnosed with Crohn's Disease in 2007

Smoking
Smoking when pregnant is known to harm the baby. It has been shown to be linked to a wide range of birth defects and can also increase the risk of a miscarriage.

Smoking can also affect the mother's health, and for women with Crohn's Disease, smoking can be especially risky. Research has shown that smoking may make Crohn's symptoms worse and increase the chance of a flare-up.

If you have Ulcerative Colitis, the likely effect on your disease is less clear cut. There is some evidence that people with UC who smoke tend to have milder symptoms. However, this does not mean that smoking will necessarily improve your UC and it could cause the same direct damage to the baby as in any non-IBD pregnancy. The consensus among health professionals is that whatever type of IBD you have, it is better not to smoke.

For more information, see our information sheet: **Smoking and IBD**.

Exercise – and fatigue
Regular moderate exercise can help to keep you healthy and is important in pregnancy. Gentle exercises, such as walking, yoga and swimming, can be especially valuable. That said, it is also important not to overdo it, especially if you already suffer from IBD-related tiredness and fatigue. If you are uncertain whether a particular type of exercise would be advisable, or if you start feeling increasingly tired and exhausted, talk to your doctor or IBD team.

> "Having my two girls is by far the most amazing thing I have ever done, but it has also at times been hard. The third trimester in both pregnancies was the best time for me, I really enjoyed this stage for both – and I was well right up until the births."
>
> Debbie, age 31
> Mother to two children, diagnosed with Crohn's Disease in 2002

WILL PREGNANCY MAKE MY ULCERATIVE COLITIS OR CROHN'S DISEASE WORSE?

For most women, having a baby does not lead to a worsening of their IBD. Some research has even suggested that it may have a positive effect on the disease process in the longer term. For example, several studies have found that women with IBD had fewer relapses per year after having children than before they got pregnant.

How your IBD is likely to behave while you are pregnant appears to depend at least partly on how active your disease was when you started the pregnancy.

If you conceive when your IBD is in remission (inactive) you have a good chance of staying in remission. Studies have shown that about one in three women with UC who conceive while their disease is inactive will have a flare-up during their pregnancy.

This is a very similar rate of relapse to that for non-pregnant women with UC over nine months. The rates for women with Crohn's Disease are also very similar. If you conceive while your disease is active you may find that your symptoms remain troublesome during your pregnancy. However, others may find that their symptoms improve as their pregnancy progresses.

Some women may also experience a flare-up soon after the baby is born, and recent research suggests this is slightly more likely to happen if you have UC. It is important not to neglect your own health while focussing on your new baby. Tell your doctor or IBD team about any new or stronger symptoms.

> "I had vaginal births with both my children and I had no complications."
>
> **Debbie,** age 31
> Mother to two children, diagnosed with Crohn's Disease in 2002

WHAT SORT OF DELIVERY SHOULD I HAVE?

Most women with IBD are able to have a normal vaginal delivery. This has the advantage that it avoids the need for surgery. However, a caesarean section may be recommended by your medical team if you have active perianal Crohn's Disease.

You may also be advised to have a caesarean if you have an ileo-anal pouch. This is because there is some evidence that having a vaginal delivery when you have a pouch may lead to an increased risk of faecal incontinence. That said, other studies have not confirmed this finding.

If you do opt for a vaginal delivery but have scar tissue around your anus, your doctor may advise an episiotomy (a cut at the opening of the vagina) to prevent tearing.

Guidelines advise doctors to discuss the options with each woman on an individual basis, so do talk to your IBD specialist and your obstetrician about your own preferences and about any worries you have. Your midwife will also be able to give you helpful advice and support.

WHAT ABOUT MY STOMA?

Many women with a stoma have a normal pregnancy and delivery.

However, if you do have an ileostomy or colostomy and a stoma bag, you will probably find it helpful to tell your stoma nurse about your pregnancy at an early stage. Your nurse will then be able to talk you through any changes you might expect. For example, your stoma may change shape and become larger as your abdomen expands. It will usually return to normal after the delivery.

Occasionally the enlarging uterus can temporarily block the stoma. A change of diet may help – your stoma nurse should be able to advise you on this. You may also find there is an increase in output from your stoma during the third trimester of pregnancy. This too should resolve itself after the birth.

Most women with a stoma should be able to have a vaginal birth, but sometimes a caesarean section may be necessary.

> I was advised not to breastfeed due to the medication I was taking. I was disappointed that I couldn't but I wanted the best for my babies so I bottle-fed both children.

Debbie, age 31
Mother to two children, diagnosed with Crohn's Disease in 2002

I WANT TO BREASTFEED. WILL MY MEDICINES DO ANY HARM TO THE BABY?

Breastfeeding is important for the healthy development of a baby's immune system, and is generally recommended.

Whether it is advisable to breastfeed while on medication for IBD will depend on which drug you are taking, whether it passes through into breast milk, and in particular what is known about possible effects on the newborn baby.

Most of the drugs used to treat IBD have not been shown to be harmful to a breastfed baby. However, very few are actually licensed for use while breastfeeding. This may be because little is known about the drug's long term effect.

Some drug companies are also understandably cautious about conducting trials with breastfeeding mothers and prefer to advise against any use of their medications in this situation.

If you would like to breastfeed, talk to your doctor and your IBD team about possible problems from your medication.

Current advice, based on recent research reviews and guidelines, is likely to be as follows:

- 5-ASA drugs such as mesalazine and sulphasalazine are probably low risk for use while breastfeeding. Research has shown that these drugs are transferred into the breast milk, but in very low concentrations.
- Steroids such as prednisolone also appear in low concentrations in breast milk. Again they are generally considered safe, although if you are taking large doses of steroids (over 40mg a day) breastfeeding may not be recommended. You can reduce the effects of steroids by waiting for 4 hours after taking a dose before starting to breastfeed.
- Small amounts of azathioprine or mercaptopurine pass into breast milk. However, recent research has not found any evidence of harm in children of mothers who have breastfed while on these drugs. As a result these drugs may also now be considered to be low risk for use during breastfeeding.
- Most of the research on infliximab has suggested that it does not pass into breast milk, although traces have been found in one study. Very small amounts of adalimumab have also been detected. Research is continuing into possible effects of these biologics on the baby, especially in the longer term. Many doctors now recommend that women using infliximab or adalimumab should not be discouraged from breastfeeding.
- Breastfeeding is not advisable if you are taking ciclosporin, methotrexate, or mycophenolate mofetil. It is also better not to breastfeed while you are on antibiotics such as ciprofloxacin or metronidazole.

Our specific drug treatment leaflets have more information about all these drugs.

WHAT ARE THE CHANCES OF MY CHILD HAVING IBD?

Parents with IBD are slightly more likely to have a child who develops IBD. How likely seems to vary with the condition and is also higher in some population groups.

Estimates vary but research suggests that in general, if one parent has UC, the risk of their child developing IBD is about 2%. That is, 2 out of 100 children born to couples where one parent has UC might be expected to develop IBD at some point in their lives.

For Crohn's the risk is 5%. So, 5 out of 100 children born to couples where one parent has Crohn's might be expected to develop IBD.

If both parents have IBD, the risk can rise to above 30%. However, we still cannot predict exactly how IBD is passed on.

Even with genetic predisposition, other additional factors are probably needed to trigger IBD.

> "I was worried about my own health as well as my babies' but I luckily had a really good support network around me throughout both my pregnancies and they reassured me when I needed it."
>
> **Debbie,** age 31
> Mother to two children, diagnosed with Crohn's Disease in 2002

THE IMPORTANCE OF SUPPORT

Coping with the demands of a pregnancy can sometimes be quite a challenge, especially if you also have an ongoing disease such as IBD. Your doctor and IBD team are usually a good source of advice and support, particularly on health-related issues. Your antenatal team should be able to help with pregnancy and birth advice. Families and friends can also be a great source of help, and very important if, for example, you already have young children or elderly parents to look after.

You may also find it helpful to make contact with other pregnant women and new mums through, for example, antenatal classes or social media groups.

At Crohn's and Colitis UK, we have an information line and a helpline providing emotional support, as well as a Facebook Forum. You can find more information about these below.

HELP AND SUPPORT FROM CROHN'S AND COLITIS UK

All our information sheets and booklets are available free from our office – call or email the Information Line.

You can also download them from our website: **www.crohnsandcolitis.org.uk**

Crohn's and Colitis UK Information Line: 0300 222 5700. Open Monday to Friday, 9 am to 5 pm, except Thursday open 9 am to 1 pm, and excluding English bank holidays. An answer phone and call back service operates outside these hours. You can also contact the service by email **info@crohnsandcolitis.org.uk** or letter (addressed to our St Albans office). Trained Information Officers provide callers with clear and balanced information on a wide range of issues relating to IBD.

Crohn's and Colitis Support: 0121 737 9931, open Monday to Friday, 1 pm to 3.30 pm and 6.30 pm to 9 pm, excluding English bank holidays.
This is a confidential, supportive listening service, provided by trained volunteers and available to anyone affected by IBD. These volunteers are skilled in providing emotional support to anyone who needs a safe place to talk about living with IBD.

Crohn's and Colitis UK Forum
This closed-group community on Facebook is for everyone affected by IBD. You can share your experiences and receive support from others at:
www.facebook.com/groups/CCUKforum

OTHER SOURCES OF INFORMATION AND SUPPORT

NHS Choices Pregnancy and Baby Guide
http:/www.nhs.uk/conditions/pregnancy-and-baby/pages/pregnancy-and-baby-care.aspx
Last reviewed 17/04/2014
Next review due 17/04/2016

National Childbirth Trust
Helpline: 0300 330 0700
Email: **Enquiries@nct.org.uk**
Web: **www.nct.org.uk**

Miscarriage Association
Helpline: 01924 200 799
Email: **info@miscarriageassociation.org.uk**
Web: **www.miscarriageassociation.org.uk**

IA (Ileostomy and Internal Pouch Support Group)
Tel: 0800 018 4274 0800 018 4724
Email: **info@iasupport.org**
Web: **www.iasupport.org**

Colostomy Association
Helpline: 0800 328 42357
Email: **cass@colostomyassociation,org.uk**
Web: **www.colostomyassociation.org.uk**

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We hope that you have found this leaflet helpful and relevant. If you would like more information about the sources of evidence on which it is based, or details of any conflicts of interest, or if you have any comments or suggestions for improvements, please email the Publications Team at **publications@crohnsandcolitis.org.uk**. You can also write to us at Crohn's and Colitis UK, 45 Grosvenor Road, St Albans, AL1 3AW or contact us through the **Information Line: 0300 222 5700**.

ABOUT CROHN'S & COLITIS UK

We are a national charity established in 1979. Our aim is to improve life for anyone affected by Inflammatory Bowel Diseases. We have over 28,000 members and 50 local groups throughout the UK. Membership costs start from £15 per year with concessionary rates for anyone experiencing financial hardship or on a low income.

This publication is available free of charge, but we would not be able to do this without our supporters and members. Please consider making a donation or becoming a member of Crohn's and Colitis UK. To find out how call **01727 734465** or visit **www.crohnsandcolitis.org.uk**

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