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Inflammatory Bowel Disease in Pregnancy Guideline

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Document Control

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1 Introduction

Inflammatory bowel disease (IBD) usually present in young adulthood and around 50% of patients are diagnosed before 35 years of age.

Occasionally inflammatory bowel disease may present for the first time in pregnancy. Symptoms include abdominal pain, diarrhoea and rectal bleeding with mucus.

The two types of inflammatory bowel disease are Ulcerative colitis (UC) and Crohn's disease (CD). Ulcerative colitis is more common in women.
Key factors for successful pregnancy outcome are clinical remission at the time of conception and optimal disease control during pregnancy.

2 Detail of the guideline

2.1 Pre-pregnancy counselling and support

Preconception support and information should be given to women considering pregnancy. This is likely to be provided by an inflammatory bowel disease nurse specialist, however this should be followed up ideally by multidisciplinary preconception planning with a Gastroenterologist and/or an Obstetrician, if possible.

If a woman is taking mycophenolate or methotrexate, these should be stopped and replaced by suitable alternatives at least 3 months prior to starting attempts to conceive.

2.2 Effect of pregnancy on IBD

For women with disease in remission at the time of conception, the risk of flare up of IBD during pregnancy is approximately 30%, which is similar to that in non-pregnant women.
Two-thirds of women with active disease at the time of conception will have persistent flare-ups during pregnancy.
A postpartum flare up may also be seen in Crohn's disease.

Pregnant women with UC were more likely to have active disease both during pregnancy and 6 months postpartum than non-pregnant women with UC in a prospective European study published in 2013. The same study did not find a significant difference in disease course during or after pregnancy in women with CD, even if the disease was active at the time of conception.

2.3 Effect of IBD on pregnancy

If IBD is active at the time of conception, there is an increased risk of miscarriage, preterm birth and low birthweight. The risk of preterm delivery is further increased by disease flares during pregnancy.

2.4 Management

2.4.1 Multidisciplinary working

Ideally, during pregnancy, women should be cared for by specialist combined Obstetric and Medical or Gastroenterology teams. Where women are under the care of a Gastroenterology team in a different hospital to that providing their Obstetric care, efforts should be made to plan care together by regular correspondence between teams.

2.4.2 Place of delivery

In general, women will be able to deliver in their local maternity unit. Exceptions to this may include women with severe or complex disease requiring specialist Gastroenterology input who should deliver in a unit with access to this specialist care.

Women with a history of previous complex bowel surgery due to Inflammatory bowel disease should deliver in a unit with 24 hour emergency general surgical cover on site, should Emergency Caesarean Section be required, as there will be a risk of difficult abdominal access and bowel injury.

2.4.3 Medication

With the exception of methotrexate and mycophenolate mofetil, medications used to treat IBD have not been associated with significant adverse fetal outcomes.

- Aminosalicylates (e.g. mesalazine, sulfasalazine), are considered safe (up to 3g/day) during pregnancy and breastfeeding. Sulfasalazine interferes with folate synthesis; therefore women on sulfasalazine should receive high-dose folic acid supplementation, 5mg/day.

- Corticosteroids may be required during pregnancy and breastfeeding for rapid disease remission. Use of corticosteroids is associated with maternal hypertension, gestational diabetes, small-for-gestational-age infants, preterm rupture of the membranes, preterm delivery, and rarely, neonatal adrenal suppression at higher doses. The use of steroids in early pregnancy may be associated with an increased risk of cleft lip and palate. Prednisolone or Hydrocortisone are the preferred agents during pregnancy. If women have been taking steroids for more than 4 weeks before giving birth at a dose of >5mg prednisolone, parenteral hydrocortisone will be required during delivery to lower the risk of acute adrenal crisis.

- Thiopurines e.g. Azathioprine and mercaptopurine are useful to prevent recurrence and as steroid-sparing agents. Studies have found no increase in the risks of miscarriage, congenital malformations, low birthweight, preterm births or abnormal newborn growth and development. They are also relatively safe in breastfeeding as low concentrations are found in breast milk. Azathioprine is preferable to mercaptopurine.

- Calcineurin inhibitors e.g. Tacrolimus and ciclosporin may be used to treat fulminant colitis in pregnancy. There is a possible link with preterm birth, low birthweight and small for gestational age neonates. They are considered safe during breastfeeding.

- Biological therapies (anti-TNF) e.g. infliximab. There is no evidence of teratogenicity. They should be avoided in the third trimester to decrease placental transport to the fetus. TNF inhibitors do not seem to be associated with major adverse effects when used during pregnancy, but infants exposed to these drugs in utero may be at increased risk of adverse reactions to live vaccines, therefore live attenuated vaccines should be avoided in the first 6 months of life. Biologics may be used during breastfeeding although small amounts are transferred in breast milk.

- Antibiotics - a short course of metronidazole may be required for perianal CD, or as an initial treatment in a flare of CD.

2.4.4 Nutritional concerns

Deficiencies of vitamins and minerals may be present in women with IBD, for example, vitamin B12 and vitamin D deficiency, protein and fat malabsorption, low iron and low folate. Specific nutritional deficiencies should be corrected during pregnancy, and ideally prior to conception if possible.

2.4.5 Risk of Venous Thromboembolism

Active inflammatory bowel disease is considered a risk factor for VTE. All women should undergo assessment of risk factors for venous thromboembolism in early pregnancy, and thromboprophylaxis should be prescribed if indicated according to thromboprophylaxis guidelines. Risk assessment should be repeated if the woman is admitted to hospital or if she develops other problems, and again intrapartum and immediately postpartum.

2.4.6 Fetal surveillance

In women with active disease during pregnancy or those taking steroids or calcineurin inhibitors, monitoring of fetal growth by ultrasound scan is recommended.

2.4.7 Complications during pregnancy

- Women with UC may have had curative surgery in the way of a panproctocolectomy together with an ileostomy or ileoanal pouch formation. Displacement of the bowel and adhesions can occasionally result in obstruction of the ileostomy during pregnancy, which usually settles with conservative management.
- Any woman presenting with signs or symptoms of bowel obstruction during pregnancy should be referred to the general surgical on call team for urgent review.
- The indications for surgery in pregnant women are the same as in non-pregnant women, i.e. bowel obstruction, perforation, abscess, haemorrhage, toxic megacolon. The main fetal concerns are the risk of preterm delivery and fetal loss. Surgery should not be delayed if it has clear advantages. If the pregnancy has reached term or near term, a Caesarean section can be performed during the same procedure.
- If the decision is made to deliver preterm, a discussion needs to take place between the Obstetrician, Neonatologists, colorectal surgeon and the woman.
- Steroids for fetal lung maturity are recommended by intramuscular injection in the usual regimen. Oral steroids are not sufficient.

2.4.8 Mode of delivery

- Mode of delivery should be discussed on an individual basis and is usually on the basis of Obstetric indications.
- In women with Crohn's disease, there may be concerns regarding the development of perianal disease if there is vaginal trauma or episiotomy. These concerns should be weighed against the risks of Caesarean section, however if there is active perianal or rectal disease, planned Caesarean Section is recommended.
- In women with Ulcerative colitis and an ileoanal pouch, there may be concerns regarding maintaining anal sphincter function and therefore Caesarean section is recommended.
- In women with multiple bowel surgeries, a planned Caesarean section may be a safer delivery option to allow appropriate personnel to be present, however this decision should be individualised.
- Induction of labour is usually for Obstetric reasons.

2.4.9 Postpartum care

Clinicians should be vigilant for disease flare-up during the puerperium, particularly in women with UC. NSAIDs can cause exacerbation of IBD for some and opiates can cause constipation and exacerbation for women with perianal disease, therefore osmotic laxatives are advised when opiates are used.
Prior to discharge, ensure that the woman has a follow-up appointment with her gastroenterologist or IBD specialist nurse.

3 Resources for Women

3.1 Can’t Wait cards

These cards assist IBD sufferers gain access to toilet facilities in shops and elsewhere, upon presentation of the card and whilst the card is not guaranteed to provide access to toilets, the cards are widely accepted and acknowledged.

Crohn’s and Colitis UK offer a Can’t Wait card, more details can be found at https://www.crohnsandcolitis.org.uk/get-involved/become-a-member/member-benefits

The IBS Network also offers a Can’t Wait card, more information can found at https://www.theibsnetwork.org/cant-wait-card/

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