

FERTILITY AND PREGNANCY

The most common age to be diagnosed with IBD is during the reproductive years making medications and treatment during pregnancy a frequent concern. Women with IBD are as likely to get pregnant as women without IBD in the same age range. However, surgery, particularly in the pelvis such as removal of the colon and rectum (total colectomy with or without a J-pouch) reduces fertility considerably. This may be due to scar tissue in the pelvis.

Once pregnant, women with IBD have higher rates of spontaneous abortion, low birth weight, and preterm birth as well as complications of labor, and thus should be followed as high risk pregnancies. Women with IBD have a one-third risk of flaring during pregnancy, similar to the non-pregnant women with IBD. Simply having IBD significantly increases the risk of a complication of pregnancy and disease activity may increase this risk further. A cesarean section is recommended for obstetric concerns only and for active perianal CD at the time of delivery. Otherwise, women with IBD can successfully have vaginal delivery. Patients with an ileal pouch anal anastomosis (J pouch) may choose elective cesarean section to preserve anal sphincter function and prevent incontinence in the future.

It is important to keep the IBD as inactive as possible during pregnancy and therefore most medications are continued during pregnancy. Sometimes obstetricians will recommend stopping IBD medications because of their FDA (food and drug administration) category, without considering the consequences on disease activity. It is therefore important that you notify your GI doctor of your pregnancy immediately and let them know if you plan to stop any medications. They will usually recommend continuing most of them.

With respect to medications during pregnancy, methotrexate and thalidomide are absolutely contraindicated during pregnancy because they are known to cause birth defects. You should be off these medications for at least 3-6 months before considering conception. The majority of other medications used in IBD are considered low risk and may be continued after a full discussion of the risks. 5-aminosalicylates are FDA category B, except olsalazine, category C, and can be continued during pregnancy and breastfeeding. Glucocorticosteroids and budesonide are category C and there is a very small chance of cleft palate if steroids are used in the first trimester. Steroids can also be used during breastfeeding. Azathioprine and 6mercaptopurine are category D, but data from the transplant and IBD literature suggest a low risk for birth defects. While breastfeeding was initially not recommended, new data suggest very little is transferred through breast milk and thus can be considered and discussed with your physicians. Infliximab (Remicade®) and Adalimumab (Humira®) are category B and appear to be low risk in pregnancy and compatible with breastfeeding. Infliximab, an IgG1 antibody, and likely Adalimumab, crosses the placenta after the first trimester and levels are detectable in the infant for up to 6 months from birth. Thus limiting use of these medications during the 3rd trimester may reduce the exposure to the newborn. If your disease is under good control, the timing of infusions and injections can be altered to avoid

administration close to delivery. This should be discussed with your physician. By crossing the placenta and being in the blood stream of the baby, these medications may affect the use of live vaccines (particularly rotavirus at 2 months of age) in the newborn although the standard vaccines given during the first 6 months are attenuated (not live) and thus can be safely administered.

SUMMARY:

- Women with IBD have the same chance of getting pregnant as women in the general population, unless they have had surgery particularly in the pelvis.
- Women should attempt conception ideally once their disease is under good control.
- Once pregnant, given the potential increased risk of complications such as preterm delivery, women with IBD should be followed as high risk OB patients with a multidisciplinary team consisting of the gastroenterologist, obstetrician and pediatrician.
- Most medications can be continued during pregnancy and breastfeeding but prior to doing so a complete discussion of risks and benefits should be had with the gastroenterologist and obstetrician.