

CCFA Fact Sheet

NEWS FROM THE IBD HELP CENTER



PREGNANCY

Women who wish to become pregnant may be concerned about how their inflammatory bowel disease (IBD) will impact pregnancy, as well as how pregnancy will affect their condition. Having IBD does not necessarily affect the ability to have children. With the careful supervision of both a gastroenterologist and obstetrician, most women with IBD can have a healthy pregnancy and a healthy baby. However, there are some important considerations.

Conception

Generally speaking, women whose ulcerative colitis or Crohn's disease is in remission can become pregnant as easily as other women of the same age. However, women with active IBD may have more difficulty becoming pregnant. Conceiving during a disease flare is not advised. If conception occurs during a flare-up, the disease is more likely to remain active throughout the pregnancy and the risk is greater for problems such as miscarriage, premature delivery, or having a baby with low birth weight. Women who have had surgery in the pelvis, particularly a colectomy with J-pouch, may have significantly lower fertility rates. Because methotrexate can cause abortion and congenital malformations, it should be stopped 3-6 months before conception in both men and women, and should not be taken while pregnant or breastfeeding.

Pregnancy

The best time for a woman with IBD to become pregnant is when her IBD is in remission for at least 3-6 months and she is off steroids. It is also not advised that a woman become pregnant when starting a new medication.

Having active disease during pregnancy can increase the risk of having a baby born prematurely or with a low birth weight. Therefore, to maintain a state of remission and prevent IBD flares during pregnancy, it is important to continue taking prescribed medications. Many IBD medications have been shown to cause minimal risk to the pregnancy (see *Medications* section below).

Women with IBD usually have healthy pregnancies and infants. However, they are more likely to have a complication of pregnancy (such as miscarriage, premature delivery, or complications of labor/delivery) than women without IBD, even if their disease is in remission. Therefore, all women with IBD should be followed as high-risk OB patients.

Medications

In most cases, medication schedules are maintained during pregnancy. However, there are some considerations and

- **Corticosteroids.** Prednisone and other corticosteroids are low risk during pregnancy. However, it is best if women are not on steroids at the beginning of a pregnancy. If a woman becomes pregnant while on steroids, the doctor usually tries to minimize the dose. Nursing infants of women on moderate-to-high dosages of prednisone should be monitored by a pediatrician.
- **Immunomodulators.** Immunomodulators, such as Azathioprine (Imuran®), 6-mercaptopurine (6-MP, Purinethol®), and cyclosporine A (Sandimmune®, Neoral®), appear low risk during pregnancy in standard dosages. Both men and women should avoid methotrexate [see above].
- **Biologics.** Most biologics, such as infliximab (Remicade®), adalimumab (Humira®) and certolizumab (Cimzia®), are considered low risk. They also do not appear in breast milk. However, both adalimumab and infliximab cross the placenta in high levels late in pregnancy so your doctor may want to give the last dose in the middle of your third trimester.
- **Antibiotics.** If possible, these should be avoided during pregnancy.
- **Thalidomide.** Because this drug can cause birth defects and fetal death, it should always be avoided during pregnancy.

A *Pregnancy Drug Safety Chart* can be found within CCFA's *Understanding IBD Medications and Side Effects* brochure by visiting: online.ccfa.org/brochures

Diagnostic Procedures

If necessary, many diagnostic procedures—including colonoscopy, sigmoidoscopy, upper endoscopy, rectal biopsy, and abdominal ultrasound—can be safely performed during pregnancy. CT scans and standard X-rays should not be taken during pregnancy unless a medical emergency requires them. MRIs can be done safely in pregnancy, however the use of gadolinium should be avoided in the first trimester.

Surgery

Previous bowel resections do not appear to have any negative effects on pregnancy in women with Crohn's disease. Women have also had successful pregnancies after ileoanal anastomosis for ulcerative colitis—a procedure in which the colon and rectum are removed and the ileum (the last segment of the small bowel) is connected to the anus.

It appears that women who have undergone colectomies with ileostomies or J pouches for ulcerative colitis or Crohn's disease have slightly decreased fertility rates. If this procedure is not urgently needed and you plan to have children, speak with your doctor about the best timing for such surgery and the option of leaving the rectum intact. Women who have had an ileostomy can have a prolapse (drop) or obstruction of the ileostomy during pregnancy. Waiting a year after the surgery before becoming pregnant reduces that likelihood.

Women with Crohn's disease who have developed fistulas (abnormal passages) or abscesses (collections of pus) around the rectum and vagina that are active at the time of delivery should have a Caesarian section. Unless the patient's

Heredity

It is possible, but certainly not inevitable, that a child of a parent with IBD will have it too. If one parent has Crohn's disease or ulcerative colitis, the chance of a child developing the condition is approximately 2-9%. If both parents have IBD, the child's chances may be as high as 36%.

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