ABOUT THE AUTHORS

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Dr. Vivian Huang is an Associate Professor and Clinician investigator in the Division of Gastroenterology at Mount Sinai Hospital and the University of Toronto. Dr. Huang completed medical school and Internal Medicine residency at Queen's University, followed by a gastroenterology fellowship at the University of Toronto, and an Advanced Inflammatory Bowel Disease (IBD) fellowship at the University of Alberta. She practices P4 (predictive, preventive, personalized, participatory) medicine to optimize maternal, fetal and neonatal outcomes in IBD through clinical innovations in patient and physician education, and e-health strategies. She developed the Northern Alberta Preconception and Pregnancy in IBD clinical research program in Edmonton, AB in 2014 and then the Mount Sinai Hospital Preconception and Pregnancy in IBD clinic and research program in Toronto, ON in 2018. She also created the Multidisciplinary Care in IBD (MCIBD) CME program in 2016 for clinicians who care for people with IBD. She received the Crohn's and Colitis Canada and Pfizer Canada Women in IBD: Emerging Researchers Award in 2020, the Canadian Association of Gastroenterology Young Scholar in Quality Innovation Award in 2023, and the UHN/SHS Quality Innovation award in 2024 for her work in Pregnancy and IBD management and education. She is lead author or co-author of over 70 research articles and two book chapters, and is one of two Canadian committee members of the Global Consensus Conference: Pregnancy and IBD.

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Dr. Astrid Williams has recently joined the team at the inflammatory bowel disease (IBD) centre of BC from Australia. From 2018 to 2023, she was a Staff Specialist Gastroenterologist at Liverpool Hospital in Sydney. She completed her medical degree and physician training in Sydney, Australia with obtainment of the Royal Australasian College of Physicians Fellowship in Gastroenterology in 2015. In addition, she completed an IBD Fellowship and Masters of Health Science through the University of British Columbia in Vancouver between 2015 to 2017. She continues to be actively involved in the delivery of multi-disciplinary IBD and general gastroenterology clinical care, research, and teaching. Her clinical activities include the delivery of both the paediatric to adult IBD transition and pregnancy in IBD sub-speciality clinics. She is a mother of three children, enjoys running and is passionate about the environment.

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Pregnancy in Inflammatory Bowel Disease (IBD)

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Key Takeaways
Preconception assessment and counselling is recommended for women with IBD who are contemplating pregnancy, ideally occurring at least 3 to 6 months prior to attempts at conception
Most IBD therapies are recommended to be continued throughout pregnancy and lactation to minimize the potential detrimental impact of active disease on infant and maternal outcomes
Consideration of aspirin commencement for preterm preeclampsia prevention is recommended, prior to 16 weeks gestation, in women with IBD, especially if additional risks for preeclampsia development
Infants exposed to biologics in utero can receive inactive vaccines and Rotavirus live vaccine per schedule.

Introduction

Inflammatory Bowel Disease (IBD), including Crohn's disease (CD) and ulcerative colitis (UC), currently affects nearly 1% of the Canadian population, with the incidence rising most rapidly among the pediatric age group, while the prevalence is highest in the young adult age group.[1] Many patients will be managing their IBD during their formative years of life, such as when they are starting relationships, potentially planning families, or experiencing pregnancy. We summarize the most recent recommendations from the Global Consensus Statement on the Management of Pregnancy in Inflammatory Bowel Disease from 2024,[2] highlighting key updates since the 2016 Canadian Toronto Consensus Guidelines.[3] Guidelines such as the Global Consensus Statement provide practical tips for all clinicians to incorporate into their clinical practice, helping them to comfortably manage IBD during pregnancy.

Global Consensus Statement on the Management of Pregnancy in IBD

What is the Global Consensus?

Given the ever-changing landscape of IBD management, including IBD therapies, several regional health care system-specific guidelines have been created for the management of IBD during pregnancy. The Helmsley PIANO Expert Global Consensus provides evidence-based recommendations to health care providers regarding caring for women with IBD from fertility through pregnancy, delivery, and considerations for their offspring. Where sufficient data was available, the consensus utilized the GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology based on a thorough literature review. For areas with insufficient data for GRADE, expert consensus was achieved through RAND (Research And Development) panel voting in May 2024.

A) Hereditability and Preconception Considerations

The consensus has highlighted that preconception counselling reduces the risk of disease relapse during pregnancy and lowers the risk of a low-birth-weight infant, most likely due to improving patient knowledge and optimizing disease control. For those who require contraception, including for the indication of allowing time to optimize disease control, the consensus advised long-acting reversible contraception over estrogen-containing contraceptives.

B) Fertility and Assisted Reproductive Treatments

Women with IBD may experience decreased fertility compared to women without IBD, particularly if they have active IBD or a

history of Ileal Pouch Anal Anastomosis (IPAA). The consensus has suggested that assisted reproductive technology (ART) may have similar effectiveness in women with IBD compared to women without IBD, as measured by live birth rates. In addition, the consensus suggests that women with IBD who have undergone pelvic surgery for IBD show comparable in vitro fertilization (IVF) effectiveness compared to women with IBD without such surgical history. Therefore, if fertility challenges persist despite adequate control of their IBD, a referral to a fertility specialist familiar with IBD and its therapies should be offered to the patient. It is also important to understand that current evidence does not show an increased risk of disease flare associated with oocyte retrieval procedures.

C) Pregnancy

The consensus has classified pregnancies for women with IBD as high risk for complications given the increased risk for adverse pregnancy outcomes and the need for more intense monitoring of the mother and fetus. Pregnant women with IBD are at increased risk for adverse maternal outcomes, and the consensus suggests prescribing low dose aspirin (162 mg) starting at 12–16 weeks of gestation as a preventive strategy for the development of preterm pre-eclampsia. Although concerns have previously existed regarding the risk of IBD flares from the use of NSAIDs, studies have shown that low dose aspirin during pregnancy does not increase flare risk.

Regarding IBD therapies during pregnancy, the consensus recommends continuing maintenance treatment with 5-ASA, sulfasalazine, and thiopurines, and using corticosteroids when clinically necessary. It was recommended to discontinue methotrexate at least 3 months prior to conception. Contrary to the Toronto Consensus Statements where alterations in third trimester dosing were considered, the consensus advises continuing maintenance anti-tumour necrosis factor (TNF) therapy throughout pregnancy without change in dose or dosing strategy to reduce maternal disease activity and the risk of preterm birth. It also supports continuing maintenance combination therapy with an anti-TNF agent and thiopurine therapy throughout pregnancy. Earlier concerns about increased risks of congenital malformations or infant infections from these therapies has been disputed. Regarding newer advanced therapies, the consensus suggests continuing maintenance therapy with vedolizumab and ustekinumab throughout pregnancy. For anti-interleukin (IL)-23 therapies, data were insufficient to issue a GRADE recommendation; however, the consensus suggests that these therapies could be continued in women with IBD who are pregnant or attempting conception. Finally, regarding small molecules, the expert consensus recommends discontinuing Janus kinase (JAK) inhibitors and sphingosine 1-phosphate (S1P) modulators prior to pregnancy and provides guidance on washout intervals prior to conception. One should also consider the time to segue to another appropriate IBD therapy to maintain disease remission. However, it was acknowledged that some patients with IBD may have refractory disease and may require continuation when “there is no effective alternative therapy to maintain maternal health.”

D) Delivery Planning

Delivery methods have generally varied by obstetrical health care provider, however, most women with IBD are candidates for vaginal delivery. Cesarean section is recommended for women with active perianal CD to prevent worsening of perianal involvement. For women with IBD and prior IPAA it is suggested (conditional recommendation) to undergo cesarean delivery, aimed at reducing the risk of pouch dysfunction from a complicated vaginal delivery.

E) Infant Vaccinations

A notable change in the consensus recommendations compared to the 2017 Toronto Consensus Guidelines is that infants exposed to biologics in utero can receive the live rotavirus vaccine in addition to inactivated vaccines per the standard schedule. This conditional recommendation is based on both retrospective and prospective studies, including the largest and only prospective study on rotavirus vaccination in infants exposed to biologic agents in utero, conducted by the Special Immunization Clinics of Canada, demonstrating this strategy to be low risk.[4]

F) Breastfeeding

Breastfeeding is encouraged for women with IBD whenever possible, as it may provide protective benefits against the development of IBD in the infant, in addition to other general health benefits. Breastfeeding is considered compatible with most IBD therapies, excluding methotrexate. There is limited safety data on JAK inhibitors, and S1P modulators, therefore, breastfeeding should be avoided whilst taking these therapies.

Conclusions

Recommendations for the management of IBD during the reproductive stages of life remains an integral component of the delivery of longitudinal, multi-disciplinary IBD care. As evidence continues to evolve, regular updates to these recommendations are necessary. Accordingly, the release of the Global Consensus Statements on Management of Pregnancy in IBD is exciting, as they offer timely and highly relevant guidance.

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