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MEDIA RELEASE

INFLAMMATORY BOWEL DISEASE AND PREGNANCY: NEW REVIEW

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WOMEN with inflammatory bowel disease (IBD) who wish to have children have an excellent chance of a successful pregnancy if the pregnancy is planned, if conception occurs when IBD is in remission, and if there is pre-conception counselling, according to the authors of a Narrative Review published in the *Medical Journal of Australia*.

Active IBD – a chronic disease that affects women in their childbearing years – can lead to adverse pregnancy outcomes, "including spontaneous abortion, pre-term births and low birthweight", the authors, Dr Sally Bell and Dr Emma Flanagan, both gastroenterologists at St Vincent's Hospital Melbourne, wrote.

However, pre-conception counselling, including "discussions regarding the importance of optimising disease control before and during pregnancy as well as the medication management plan for pregnancy", has been shown to improve pregnancy outcomes.

"Patients should ideally undergo pre-conception counselling and disease assessment 6 months before conception to ensure that the disease is in remission and that patients have a clear understanding of the recommendations for the management of their IBD in pregnancy," Bell and Flanagan wrote.

The majority of women with IBD who take maintenance medication will need that medication throughout pregnancy to prevent potentially harmful flare-ups of the disease.

"Non-compliance with maintenance therapy during pregnancy occurs frequently and a common reason for this is the fear of medication adverse effects on the baby," Bell and Flanagan wrote.

However, most IBD medications are considered safe in pregnancy and breastfeeding, except for methotrexate, which must be stopped 6 months prior to conception, because it is teratogenic.

"IBD activity should be carefully monitored during pregnancy using non-invasive techniques, and disease flares during pregnancy should be treated promptly with escalation of therapy in consultation with the patient's IBD specialist," they wrote. "In the event of a disease flare during pregnancy, the patient's gastroenterologist should be contacted promptly and appropriate escalation of therapy should be arranged.

"Mode of delivery should be determined by obstetric need; however, caesarean delivery is preferred for women with a history of ileal pouch anal anastomosis surgery or active perianal Crohn's disease.

"The most important factor in optimising pregnancy outcomes for women with IBD is to ensure their disease is in remission before and during pregnancy," they concluded.

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