Care of the Pregnant Patient With Inflammatory Bowel Disease

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Question 1:

How commonly does inflammatory bowel disease (IBD) first present in pregnancy? Are there unique diagnostic challenges to distinguishing IBD from other conditions during pregnancy?

Response from Dr. Mahadevan:

In the PIANO registry, our national pregnancy registry, 7 of 1,085 (0.65%) pregnant women with IBD presented for the first time during pregnancy. It is fairly rare to receive the diagnosis during pregnancy.

There are unique diagnostic challenges. Standard tests for IBD, including colonoscopy (avoided in pregnancy except in urgent cases given concerns over sedation and procedure), abdominal imaging (concerns for radiation and gadolinium), and laboratory markers (albumin, hemoglobin, and sedimentation rates all altered during pregnancy), are difficult to perform or interpret in the pregnant patient. For example, in a patient with known Crohn disease and abdominal pain, this may be Crohn disease, or constipation, or uterine expansion. We can check a sedimentation rate but that is nonspecific and raised in pregnancy. C-reactive protein may be helpful. We would avoid a colonoscopy to the ileum or a computed tomography scan or magnetic resonance imaging with gadolinium. This makes it difficult to parse out if the symptoms are vague. Of course, in a very ill patient, we would go ahead with imaging and colonoscopy as indicated.

Question 2:

Is the metabolism of IBD-specific medications altered in pregnancy and do doses need to be routinely adjusted?

Response from Dr. Mahadevan:

There are data to suggest that at least azathioprine and 6-mercaptopurine have a change in metabolism during pregnancy. Other drugs have not been studied in this situation and dose adjustment is not recommended.
Question 3:

Do you recommend any routine fetal surveillance for women with inactive or mild IBD? Do recommendations for fetal surveillance change if a woman has a flare during pregnancy?

Response from Dr. Mahadevan:

Since offspring of women with IBD are at increased risk for fetal growth restriction and small-for-gestational weight, we recommend that their maternal-fetal medicine specialist monitor for these issues per their protocols. This is regardless of disease activity.

Question 4:

Are there any neonatal adverse outcomes associated with being born during an active flare?

Response from Dr. Mahadevan:

There is an increased risk of preterm birth when a mother is flaring and a high rate of cesarean delivery overall.

Although women with IBD may have an increased risk of complications of labor and delivery (this is a collective diagnosis and may include preeclampsia, hemorrhage, etc), this has not been clearly correlated with active disease.

Question 5:

What do you recommend for managing the route of a first delivery in a patient with a history of a perianal fistula, but currently inactive disease?

Response from Dr. Mahadevan:

If the perianal disease is inactive, then mode of delivery is at the discretion of the obstetrician, and vaginal delivery can be attempted. We do recommend avoiding prolonged labor and pushing. In our region, there is a segment of the population who go to great lengths to avoid cesarean deliveries, and such traumatic labor is not good for the pelvic floor of the IBD patient.

An exception is a rectovaginal fistula. If this is inactive, but still open, we would consider cesarean delivery as the preferred mode of delivery.

Question 6:

How would you counsel a patient who has conceived less than 3 months since discontinuation of methotrexate? How would you counsel her if she conceived between 3 and 6 months after discontinuation?

Response from Dr. Mahadevan:

I would counsel them on the potential for teratogenicity and refer them to a maternal-fetal medicine specialist. I would not automatically recommend a termination.
Question 7:

Are there any circumstances in which you would recommend delaying proctocolectomy to pursue pregnancy in a patient with ulcerative colitis who strongly desires children? How do you balance fertility, surgery, and active disease?

Response from Dr. Mahadevan:

No, I would never delay proctocolectomy. The patients who need them are so ill they will have difficulty conceiving anyway. What we will do is avoid creating the ileoanal J pouch until after childbearing. In a patient with severe colitis, we have done subtotal colectomy and end ileostomy, leaving the rectum in place. This helps resolve symptoms and patients generally do well off medication. Because the pelvic cavity is not breached, fertility should not be affected. The rectum can be removed and the J pouch created after childbearing. In patients having colectomy for dysplasia, if the dysplasia is right-sided, an ileorectal anastomosis with close surveillance of the remnant rectum can be considered.