

PREGNANCY AND IBD

If you have Crohn's disease or ulcerative colitis and want to have children, you may have many questions—including these:

- *Will I be able to become pregnant?*
- *Will pregnancy make my IBD worse?*
- *Will the disease or the medications I take for it harm my baby?*
- *Will I be able to breastfeed?*

Each person's disease is different. Any choices you make regarding pregnancy should be made in collaboration with your gastroenterologist and obstetrician. But here are some broad answers:

CONCEPTION AND IBD

Generally speaking, women with ulcerative colitis or with Crohn's disease in remission can become pregnant as easily as other women of the same age. Women with active IBD may have more difficulty becoming pregnant. Women who have had surgery in the pelvis, particularly a colectomy with J pouch, may have significantly lower fertility rates. If it is the man who has IBD, his fertility will also be similar to the general population. However, certain active disease and certain medications like sulfasalazine (Azulfidine®) affect sperm count and quality. A man taking sulfasalazine should switch to another 5-ASA compound, with his doctor's approval. For three months before conception, men should also avoid taking methotrexate. Smoking, too, should be avoided by hopeful parents-to-be. Women should not take methotrexate within 3-6 months before or during pregnancy or while breastfeeding because of its toxic effects on the developing fetus or newborn.

EFFECT OF PREGNANCY ON WOMEN WITH IBD

Women should be well before becoming pregnant. It is not a good idea to begin a pregnancy when the disease is flaring, when the woman has recently begun a new treatment, or when she is on steroid medications. If she is already pregnant, she should continue on the regimen that has kept her well even if it includes steroids (although her doctor will try to minimize the steroid dose) except for methotrexate, which should be stopped. Some women stop their medications when they learn they're pregnant because they worry about harming the baby. If disease then flares, it can be very difficult to get it back under control and this poor health may be even more detrimental to the baby.

In some cases, IBD actually *improves* during pregnancy. That's because in all pregnancies, the body suppresses the immune system to prevent it from rejecting the fetus. In women with IBD, this phenomenon often serves to put the disease in remission. One study of women with Crohn's disease suggests that pregnancy also may protect against future flare-ups and may reduce the need for surgery. This has to do with a hormone produced by pregnant women called *relaxin* that prevents the uterus from contracting prematurely. Relaxin also may prevent the future formation of scar tissue, which frequently causes Crohn's disease patients to require surgery. However, women should not use pregnancy as a means to treat a flare-up, even if previous pregnancies induced a remission.

EFFECT OF IBD ON PREGNANCY, DELIVERY, AND THE DEVELOPING FETUS

Women with IBD usually have healthy pregnancies and healthy infants. However, they are more likely to have a complication of pregnancy than those without IBD even if their disease is in remission.. These complications include. miscarriage, premature delivery, and complications of labor and delivery. While the risk of miscarriage in the general population is one in six pregnancies, it is slightly higher in women with active IBD. All women with IBD should therefore be followed as high risk OB patients.

MEDICATIONS FOR IBD DURING PREGNANCY

In most cases, medication schedules are maintained during pregnancy. If the woman's condition changes, drugs or dosages may be altered. Here is a rundown on the most commonly used drugs:

- **AMINOSALICYLATES.** Sulfasalazine (Azulfidine®) and other 5-ASA compounds such as mesalamine (Asacol®, Pentasa®, Rowasa®, Canasa®, Lialda®), balsalazide (Colazal®), and olsalazine (Dipentum®) do not appear to increase complications or harm the fetus. Sulfasalazine may cause nausea and heartburn. As sulfasalazine lowers folic acid levels, women should be on at least 2 mg of folic acid daily. Women can breastfeed while taking a 5-ASA compound.
- **CORTICOSTEROIDS.** Prednisone and other corticosteroids are low risk during pregnancy, although it's 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 (IMMUNOSUPPRESSIVES).** Immunosuppressive drugs 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.** Infliximab (Remicade®), adalimumab (Humira®) and certolizumab (Cimzia®) are biologic compounds approved for the treatment of both Crohn's disease and ulcerative colitis (infliximab only), are all considered low risk. It also does 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.

DIAGNOSTIC PROCEDURES DURING PREGNANCY

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.

THE IMPACT OF SURGERY BEFORE AND DURING PREGNANCY

Previous bowel resections do not appear to have any negative effects on pregnancy in women with Crohn's disease. Women also have 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 also 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 condition is serious and unresponsive to drugs, surgery should be postponed until after delivery. Any abdominal surgery poses a risk to the fetus though modern surgical rates suggest it can be done safely.

NUTRITIONAL NEEDS DURING PREGNANCY

All pregnant women—including those with IBD—should eat a well-balanced diet and remain on any vitamins they were taking before becoming pregnant. That includes folic acid to prevent spina bifida and other neural tube birth defects. Folic acid (2 mg daily) is particularly important for women taking sulfasalazine, which inhibits folic acid absorption.

PASSING ON IBD

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%.

CCFA offers important resources for those with Crohn's disease or ulcerative colitis: information, guidance, support, and the latest clinical and scientific information in the field. Learn more about CCFA at www.ccfa.org. You can join your local chapter, connect with others living with these diseases, and get involved. Most of all, know that we're here for you whenever you need us. You can reach us at our Information Resource Center at 888.MY.GUT.PAIN (888-694-8872) or info@ccfa.org.

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