GI Foundation Fellows meeting Saturday 2025

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32-year-old woman, married, no children, receptionist

No past medical or family history of note

Smokes 5 cigarettes per day, drinks 1 glass of wine daily

Diagnosed with extensive UC 18-months previously

Complicated by iron deficiency anaemia

Started on Asacol 1.6g PO BD and Pentasa suppositories

Also, oral iron

Rapidly achieved clinical remission

- 6-months later
  - Develops bloody diarrhoea (4 stools per day)
  - Abdominal cramps
  - Afebrile, PR=80bpm
  - Abdominal examination: NAD

- What investigations would you do?

- Hb 9, MCV 72, WCC 10, PLT=545
- Albumin 34
- LFTs were normal
- CRP=95
- CUE=normal, CMP=normal
- Stool MC&S: no pathogens, *C diff* negative
- Faecal calprotectin: 550

- CXR: NAD, AXR: ahaustral left colon, no TMC

- Flexible sigmoidoscopy
- Biopsies: severe active colitis, no CMV

What next?

- Asacol dose increased to 2g BD PO
- Started on prednisone 50mg/day
- Tapered over 3 months

- Symptoms resolve completely

- 5-months later, asymptomatic
- Passing 2 formed stools per day, no cramps

- Faecal calprotectin 300
- CRP=45

"I want to have a baby"

Pregnancy and IBD

- 4 clinical scenarios
- Which reflect the interface between pregnancy and IBD

1. The planned pregnancy
2. The unplanned pregnancy
3. The delivery
4. The post-partum period

IBD and fertility

"What are my chances of falling pregnant and can I improve these?"

- Fertility is reduced in active IBD

- Reasons for this are multi-factorial:
  - Fever, pain, diarrhoea, decreased libido
  - Malnutrition & LOW can cause 2º amenorrhoea
  - Inflammation in fallopian tubes/ovaries
  - Dyspareunia

- Strive for remission before conception
- Improve fertility rates

The planned pregnancy

- Will my baby get IBD?
  - Parental IBD increases the risk of IBD for the offspring
  - The risk is greater for CD and if the mom is affected
  - And is much greater when both parents are affected

- How can I make sure I have a safe and healthy pregnancy?
- A planned pregnancy offers a window of opportunity
  - To implement pre-emptive measures
  - To maximize the chance of a successful pregnancy

- Counseling is key
  - Emphasize that healthy mothers make healthy babies

Active IBD and pregnancy

- Worse maternal outcomes
  - Thromboembolic disease
  - Caesarian sections

- Worse neonatal outcomes
  - Increase in preterm delivery
  - SGA and LBW
  - Increase in neonatal ICU admission

Active IBD and pregnancy

- Conception occurring with active IBD
  - Increases the risk of persistent activity during pregnancy
  - The majority will continue to have active IBD
  - Of these 50% will deteriorate further

Delay pregnancy until in remission where possible

Remission: how deep?

Clinical remission (PROs) AND Endoscopic remission

Ulcerative Colitis	**Ulcerative colitis**
• Normalisation of SF • Absence of blood PR	• Mayo score of 0 or 1

Crohn's disease	**Crohn's disease**
• Normalisation of SF • Absence of pain	• No ulcers • Cross-sectional image if CD is beyond endoscopic reach

In patients who want to avoid endoscopy normalisation of CRP and faecal calprotectin is a reasonable alternative

What IBD medications to discontinue prophylactically?

- Methotrexate
  - Highly teratogenic in 1st trimester
  - Long half life
  - Stop 3- 6 months before conception
  - Avoid, if possible, in young woman

- JAK inhibitors and S1PR modulators
  - Stop 1 month before attempting conception

- In men: consider switching salazopyrine to mesalamine

Don’t forget Vitamin supplements

- Folate to prevent neural tube defects

- Vitamin D and calcium

- Aggressively correct iron deficiency
  - Complicates 60% of IBD
  - Aim for normal iron studies and haemoglobin
  - IVI iron if necessary
  - Best done in the pre-natal period
  - Treating severe IDA in pregnancy is complicated
  - IVI iron is contraindicated in 1st trimester

- Stop smoking and alcohol

The unplanned pregnancy

- Cannot introduce any prophylactic measures
- Start folate and vitamin supplements, treat iron deficiency
- Stop smoking and alcohol

- Stop MTX, JAKS, and S1PR modulators
- Refer for obstetric assessment
- Assess need for TOP

- Further management depends on disease activity

- If quiescent IBD then continue baseline medications

Safety of IBD drugs during pregnancy

Mesalazine
Sulphasalazine
Corticosteroids
Budesonide
Thiopurines
Ciclosporin and tacrolimus

During pregnancy	Recommendation	Comment
Mesalazine	Low risk	
Sulphasalazine	Low risk	Add high dose folate
Corticosteroids	Low risk	
Budesonide	Low risk	
Methotrexate	Contraindicated	
Thiopurines	Low risk	Do not start for the 1st time Do not increase the dose Increased risk of ICP
Ciclosporin Tacrolimus	Low risk, limited data	

Safety of IBD drugs during pregnancy

Anti-TNFs
Vedolizumab
Ustekinumab
IL-23 inhibitors (what are examples?)
Ciprofloxacin
Metronidazole
JAK inhibitors (what are examples)
S1PR modulators (what are examples)

Therapy during pregnancy	Recommendation	Comment
Anti-TNFs	Low risk	
Vedolizumab	Low risk	
Ustekinumab	Low risk	
IL-19 inhibitors	Low risk	
Ciprofloxacin	Low risk	Avoid in 1st trimester (arthropathies in children)
Metronidazole	Low risk	
JAK inhibitors	Avoid	
S1PR modulators	Avoid	

Management of active disease

- Same as the non-pregnant patient
- Ensure symptoms are due to IBD (exclude *C difficile)*

- Flexible sigmoidoscopy is endoscopic procedure of choice
- Colonoscopy is safe if necessary
- ➢ Consult Obstetrician about need for foetal monitoring

- MRE (without gadolinium) is imaging of choice
- Ultrasound is useful in early pregnancy (small uterus)
- Avoid CT and AXR (ionising radiation)
- ➢ Although risk is low

Monitoring IBD during pregnancy

- How do you monitor disease activity?

Treatment of an acute flare

- 5-ASA or steroids are safe

- Anti-TNFs, vedolizumab, ustekinumab, IL-19 inhibitors
  - ➢ Are safe and can be used to treat flares

- Infliximab can be used as salvage therapy in ASUC

- Although thiopurines are safe in pregnancy they should not be commenced for the 1st time or the dose increased
  - ➢ Take 3 months to work
  - ➢ Unacceptable risk of pancreatitis, DILI, neutropaenia

- JAK inhibitors and S1PR antagonists are contraindicated

Mode of delivery

- Primarily governed by obstetric indications

NVD

- Generally safe
- The preferred option for colostomy / ileostomy
- Microbiome differs from CS
- Avoid episiotomy in CD (but preferable to lacerations)

Caesarean section

- If active perianal disease
- IPAA to preserve sphincter function

Therapy during lactation
Mesalazine
Sulphasalazine
Corticosteroids
Budesonide
Thiopurines

Therapy during lactation	Recommendation
Mesalazine	Low risk
Sulphasalazine	Low risk
Corticosteroids	Low risk
Budesonide	Low risk
Thiopurines	Low risk

Therapy during lactation
Vedolizumab
Ustekinumab
IL-19 inhibitors
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Ciprofloxacin
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S1PR modulators

Therapy during lactation	Recommendation
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Ciprofloxacin	Low risk
JAK inhibitors	Avoid
S1PR modulators	Avoid

Vaccines in the neonate

- Inactivated vaccines
- ➢ Are recommended according to national guidelines

- In children exposed in utero to biologics
- ➢ BCG live attenuated vaccines should be withheld within the first year of life or until the biologic is no longer detectable in the infant's blood

- Rotavirus vaccine is now considered safe