Guideline for the Management of Inflammatory Bowel Disease in pregnancy

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1.0 Introduction

Inflammatory Bowel Disease (IBD) incorporates a group of chronic bowel diseases and gastrointestinal diseases including Ulcerative Colitis (UC) and Crohn's Disease (CD). The aetiology of the disease is unknown. It is generally diagnosed in young adulthood and is characterised by inflammation of the gut.

Ulcerative colitis affects the mucosal layer of the large bowel whereas Crohn's disease can affect any part of the gastrointestinal tract including the peri-anal area. This can be problematic during labour and delivery.

Medical management generally involves the use of steroids, other anti-inflammatories, immunosuppressants or biological medicines. Some patients will have had one or more surgical procedures to resect inflamed bowel that has not responded to medical management.

Management during pregnancy should be multidisciplinary integrating obstetric and gastroenterology teams.

It should be noted that gastrointestinal symptoms in women with no history of IBD may be a result of IBD presenting for the first time

2.0 Objective

The aim of this guideline is to ensure timely and effective management of patients with Inflammatory Bowel Disease (IBD) in pregnancy in order to achieve optimum fetal and maternal outcomes.

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit.

4.0 Main body of the document

4.1 Antenatal Management

Multidisciplinary team care with prompt referral and communication with the gastroenterologist is paramount.
The aim is to maintain a fine balance between optimal disease control and safety of medication or surgery during pregnancy.

Consideration of surgical intervention should be the same as in the nonpregnant woman. Maternal wellbeing should always take precedence, and if surgery has clear benefits it should not be delayed.
The decision should be made by the multidisciplinary team involving an obstetrician, neonatologist, and colorectal surgeon.

If a caesarean section is to be performed at the same time as a bowel resection, then consider the administration of steroids for fetal lung maturation.

Antenatal booking

The woman will be referred for shared care and will be cared for by the multidisciplinary team including the obstetrician and gastroenterologist

First Antenatal Visit

The IBD proforma will be completed at the first hospital visit.
The following will be discussed with the woman:

- If the IBD is well controlled the risks of morbidity and mortality for the mother and baby are low
- The risk of relapse during pregnancy is comparable to the risk in the non-pregnant population (around 30%). However, the risk increases to around 66% if the IBD is active at the time of conception
- Most relapses will occur in the first trimester or in the postpartum period
- The risk of preterm birth or fetal growth restriction is increased if the IBD is active
- Previous bowel surgery does not usually affect pregnancy, however stretching of the abdomen could result in cracking and bleeding around a stoma
- Referral to the dietitian,if required, for advice regarding dietary intake
- Prescribing vitamin D 10mcg and folic acid 5mgs if not already prescribed

Medications

Most medications for IBD are safe to continue in pregnancy with the exception of Methotrexate and Mycophenolate Mofetil (see Appendix 1).

Aim to use the lowest dose necessary to control symptoms.

Discuss the benefits of continuing medication and preventing a relapse of symptoms against the risks posed by the actual medication

Assessment of fetal growth

Serial fetal growth scans will be offered to women with active IBD or women being treated with Calcineurin inhibitors or steroids

Diagnosis of IBD activity in pregnancy

When a relapse is suspected:

- Review by senior obstetrician and gastroenterologist. Management plans will be agreed by senior clinicians in discussion with the woman
- Take blood for CRP
- Consider abdominal ultrasound as first line investigation
- MRI scan (without contrast) can be performed in the second or third trimester in complex cases where the abdominal ultrasound is inconclusive
- Abdominal x-ray may be considered in specific cases to look for colonic dilatation
- Gastroscopy, sigmoidoscopy and colonoscopy can be safely performed in pregnancy

4.2 Labour and Birth

The mode of birth should be discussed, with the woman, by the MDT.

Vaginal birth is safe for the majority of women with IBD.

Planned caesarean birth is indicated in women with active perineal or rectal disease, and after restorative proctocolectomy with ilieo-anal pouch.

For women with extensive previous surgery, elective caesarean birth as a joint obstetric/colorectal procedure is appropriate.

Perianal disease can be triggered by episiotomy; therefore, episiotomies should be avoided if possible.

Women taking antenatal steroids (prednisolone equivalence of greater than 5 mg) for more than four weeks before giving birth will require parenteral (IV or IM) hydrocortisone 100mg six hourly during labour and in the immediate postnatal period to decrease the risk of adrenal crises.

4.3 Postpartum Management

An individualised plan of analgesia must to be made for each woman as NSAIDs exacerbate disease in some women and opioid analgesia can be constipating.

Most medications can be taken safely whilst breast feeding with the exceptions of methotrexate and Mycophenolate mofetil (see appendix 1).

Advise women to make a follow-up appointment with their gastroenterology team.

Women will be advised to seek pre-conceptual counselling when planning future pregnancies.

5.0 Roles and responsibilities

5.1 Midwives

Have a responsibility to work as part of a multidisciplinary team in planning care for women with IBD including early referral to services

5.2 Obstetricians

Have a responsibility to complete the IBD proforma and any actions at the initial appointment following booking. They are also responsible for planning care for women with IBD as part of the MDT.

6.0 Associated documents and references

- Kapoor D, Teahon K, Wallace S. Inflammatory bowel disease in pregnancy. Obstet Gynaecol. 2016;18:205–12.

- Komaki F, Komaki Y, Micic D, Ido A, Sakuraba A. Outcome of pregnancy and neonatal complications with anti-tumor necrosis factor-α use in females with immune mediated diseases; a systematic review and metaanalysis. J Autoimmun [Internet]. ElsevierLtd;2017;76:38–52.Availablefrom:http://dx.doi.org/10.1016/j.jaut.2016.11.004

- Pinder M, Lummis K, Selinger CP. Managing inflammatory bowel disease in pregnancy: Current perspectives. Clin Exp Gastroenterol. 2016;9:325– 35.

7.0 Training and resources

Training will be delivered as outlines in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to the guideline for the management of inflammatory bowel disease in pregnancy will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the management of inflammatory bowel disease in pregnancy will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1

Inflammatory Bowel Disease – Drug information

Drug	Safety in Pregnancy	Safety in Breastfeeding	Comments
Aminosalicylates Sulfasalazine Mesalazine	Benefits outweigh risks	Benefits outweigh risks	No increase in adverse pregnancy outcomes Doses greater than 3g/day risk of fetal nephrotoxicity Warn patients about neonatal bloody diarrhoea with Mesalazine
Steroids	Benefits outweigh risks	Benefits outweigh risks	Increased risk of PET and GDM Associated with SGA Risk of neonatal adrenal suppression with high dose and/or prolonged use
Thiopurines Azathioprine Mercaptopurine	Benefits outweigh risks	Benefits outweigh risks	No increase in adverse outcomes Less exposure to active metabolites with Azathioprine
Calcineurin Inhibitors Tacrolimus Ciclosporin	Benefits outweigh risks	Benefits outweigh risks	Associated with SGA Use only with fulminant Ulcerative Colitis
Biologics Infliximab Adalimumab	Benefits outweigh risks	Benefits outweigh risks	No increase in adverse pregnancy outcomes If able discontinue in third trimester as the highest level of transfer occurs in this period Newborn infants should not have live vaccines until biologic molecules are undetectable in neonates' blood – normally 6/12
Mycophenolate mofetil	Contraindicated	Contraindicated	Increased incidence of miscarriage and congenital malformations
Methotrexate	Contraindicated	Contraindicated	Greatest risk with high doses, seek specialist advice if pregnancy occurs within 3 months of therapy

Appendix 2
Glossary of terms
IBD- Inflammatory Bowel Disease
CRP- C- Reactive Protein
USS - Ultrasound scan
NSAIDs – Non Steroidal Anti-Inflammatories
PET – Pre-Eclampsia Toxaemia
GDM – Gestational Diabetes Mellitus
SGA – Small for gestational age
IV – intravenous
IM - intramuscular

Appendix 3 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	Guideline
Document title	Guideline for the Management of Inflammatory Bowel Disease in pregnancy
Document author (Job title and team)	Consultant obstetrician
New or reviewed document	Reviewed
List staff groups/departments consulted with during document development	Midwifery Obstetric
Approval recommended by (meeting and dates):	CBU3 overarching meeting 25/01/2023
Date of next review (maximum 3 years)	25/01/2026
Key words for search criteria on intranet (max 10 words)	IBD IBS Crohns Diverticular Hydrocortisone Prednisolone
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the FINAL version of this document	**Name: Jade Carritt** **Designation: Governance Midwife**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 overarching governance **Date approved: 25/01/2023** **Date Clinical Governance Administrator informed of approval: 23/02/2023** **Date uploaded to Trust Approved Documents page: 27/02/2023**