The Reproductive Journey in Inflammatory Bowel Disease (IBD)

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Disclosures

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The Female Reproductive Journey

- Adolescence/puberty
- Sexual activity – preconception counseling
- Fertility
- Pregnancy
- Child birth
- Breast feeding
- Raising children
- Menopause
Adolescence/Puberty

- Body image
- Intimacy
  - Disclosure of IBD
  - Symptoms may interfere
  - Fear of rejection
- Menarche – may be delayed with active disease, are underweight or malnourished
Contraception

• 50% of all pregnancies are unplanned
  – Teens and perimenopausal at highest risk
  – Sexually active women are all at risk for pregnancy, and the risks of contraception must be weighed against the risk of an unintended pregnancy, not weighed against contraceptive nonuse

• Forms of contraception
  – Hormone-based contraception
    • 2-fold increased VTE risk over baseline in those using estrogen-based methods such as combination pills, the patch, or the ring.
  – LARC
    • IUD
    • Implants

1. Hashash JG, Kane S. Gastroenterol Hepatology. 2015;11(2):96-102;
Special Considerations: Contraception

• Need for highly effective contraception while on methotrexate (teratogen)
  – Recommend contraception to avoid pregnancy during treatment and for 3 months after discontinuing therapy when trying to conceive
  – Mixed data on male fertility
    • Recommended that males discontinue 3 months prior to planned conceive

Special Considerations: Contraception

- Caution is advised during pregnancy with tofacitinib
  - Possible risk of embryo-fetal toxicity based on animal data
  - Recommend contraception to avoid pregnancy during treatment and for 4 weeks after discontinuing therapy when trying to conceive
Sexual Activity & Preconception Counseling

• Have the conversation early!

• Counsel women to conceive when in remission:
  – ~80% of women with IBD who conceive while their disease is in remission, the IBD tends to remain in remission throughout the pregnancy and postpartum period
  
  \textit{versus}

  – If conceive when disease is active: 66% continue to have active disease or experience worsening of their IBD

• Best pregnancy outcomes are when women stay on medication
  – Most women still believe medications are harmful to baby or will adversely effect the pregnancy
  – Some women get false or misleading advice from their OB-GYN
Fertility & Conception

- If in remission, fertility rates same as general population
- Active disease is associated with decreased fertility
  - So best if patient is stable on maintenance medications for 3 months prior
  - Consider baseline drug level before conception
- Voluntary childlessness rate high (17% vs 6%)
- Use of assisted reproductive technology (ART)
  - While less successful in pregnancy rates in those w/ IBD
  - Have comparable pregnancy outcomes than those without IBD

Effect of Active IBD on Pregnancy

• Active disease at conception associated with disease relapse during pregnancy with OR 7.66 (3.77-15.54)

• UC patients experienced relapse more often than CD: OR 3.71 (1.86-7.4)

• Active disease in nulliparous women lead to more spontaneous abortion and LBW

Pregnancy

- Manage disease
  - Visits each trimester, and post partum
  - Folic acid supplementation
  - Check common labs
  - Assess disease activity
  - Remember Rule of 3: 1/3 remission, 1/3 active/flare, 1/3 no change
  - Disease activity associated with miscarriage, premature birth, low birth weight, C-section, small for gestational age
  - See clinical care pathway¹

- Manage pregnancy
  - At least 1 visit to high-risk OB

Special Considerations: Medications in Pregnancy

- Ustekinumab & Vedolizumab
  - Plan final pregnancy dose 6-10 weeks before EDC\(^1\)
  - Pregnancy outcomes with Vedo similar to anti-TNFs\(^2\)

- Tofacitinib
  - Limited data, consider other options, especially in first trimester\(^1,3\)

Delivery/Childbirth

- C section planned for RV fistula and active perianal disease
- Patients with IPAA need surgical weigh in on delivery method
- Vaginal delivery does not affect later risk of development of IBD
- Dosing of biologics after delivery
  - Dose based on pre-pregnancy weight
  - 24 hrs. after delivery, 48 hours after C-section
- If C section, anticoagulant prophylaxis

Post-Partum

• 20% will flare within 6 months of delivery
• Assess for post partum depression
• Monitor disease
• Monitor infant
• Monitor lactation
Breastfeeding/Lactation

- No tofactinib or MTX
- Thiopurines, biologics are fine
- Mesalamine over sulfasalazine
- Pre-conception planning
- Infant – no live vaccines for first 6 months if infant had exposure to biologics
- Developmental milestones met, in those with thiopurine and biologic exposure
IBD & Motherhood

• Qualitative study about women with IBD and their transition to motherhood

• Found “blurred lines”: central concept – offers a novel frame for understanding the transition to motherhood with IBD through identifying parallels between having IBD and becoming, and being, a mother

• Parallels clustered into three main themes: Need for Readiness, Lifestyle Changes, and Monitoring Personal and Physical Development

Raising Children

• Continue routine GYN care
  – HPV vaccine
  – Pap smears
• Continue routine health maintenance
• Continue IBD related care
• Assess for anxiety & depression
Menopause

- Younger age of diagnosis of IBD correlated with younger age of menopause\(^1\)

- Estrogen/HRT may be protective:
  
  2008 study found that postmenopausal women with IBD on hormone replacement therapy were 80% less likely to have an IBD flare compared to postmenopausal IBD counterparts not on HRT\(^2\)

- Bone health
  
  - DEXA
  
  - Calcium and vitamin D

Conclusion & Take-Home Points

- Women with IBD have unique needs throughout their lifetimes
- Remember pre-conception counseling – before they become pregnant in ALL childbearing women with IBD
  - Clear risk of increased risk of AE with increased disease activity
  - Medications generally safe in pregnancy
- Start the conversation with your female patients!