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Jointly provided by the Annenberg Center for Health Sciences at Eisenhower and Gastroenterology and Hepatology Advanced Practice Providers.
Hepatitis B In Pregnancy

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Disclosures

Melissa Franco, PA-C

No financial relationships to disclose.
Case Study

- 37 y/o Chinese female with PMHx significant for PCOS, Hypothyroidism, Obesity, NAFLD, comes for follow up on CHB (previously on antivirals) on her first trimester of pregnancy (9 weeks pregnant). Self D/C TAF. Inquires about risk of HBV transmission if she undergoes amniocentesis.

- Asymptomatic
- Family history of HBV (father and 2 sisters)
- What tests should we order now?

- Hepatic function panel
- CBC, PT/INR
- HBeAg, HBeAb, Gt
- HBV DNA
- Viral hepatitis (HAV, HCV, HDV)
- Hgb A1C

- transient elastography
- (performed pre-pregnancy)
Results of Tests/Labs

Results:
- AP/AST/ALT: 52/14/14, TB 0.5
- PT/INR: 10.1/1.0
- WBC/PLT: 12.0/280
- HBV DNA: 2,490,000 IU/ml
- HBeAg positive, HBeAb negative
- Gt C
- HCV Ab negative, HDV Ab negative
- Hgb A1C: 5.4
- Fibroscan: 7.0 Kpa, CAP 300
- Abd US 6 months ago demonstrated mild hepatomegaly, and fatty infiltration

Any work up necessary?
- Abd US?
- Amniocentesis based on her age?

Differential Diagnosis

Chronic hepatitis B +/- NAFLD
Diagnosis

• NAFLD and chronic Hepatitis B in first trimester of pregnancy

• What management options are available for this patient?
  – Continue off TAF on her first trimester?
  – Switch to TDF on her first trimester?
  – Start TDF on third trimester?
  – Recommend against amniocentesis?
Treatment Options

• D/C TAF, and switched to TDF on her third trimester of pregnancy (week 28).
• Discussed with pt risk of HBV transmission if she undergoes amniocentesis.
• Breastfeeding is not prohibited.
• C-section not recommended.
• Need for newborn HBV vaccination and HBV immunoglobulin.
Treatment Options

- Pt decided to hold off on amniocentesis.
- HBV DNA 10,300 IU/ml (3 weeks before delivery).
- She breastfeed for 4 weeks and stopped due to difficulties with breastfeeding while on TDF.
- Her baby was tested for HBV and this was negative.
- She was switched to TAF at her 6 months follow up visit.
- 96 weeks after delivery her HBV DNA is detected at 4,250 IU/ml (persistent viremia).
Patient Follow-Up

• **Short-term plan**
  – Continue antiviral therapy (TDF)
  – Breastfeeding is not contraindicated

• **Long-term plan**
  – Continue TAF
  – Discuss importance of medication compliance
  – Need for long term monitoring as she is at risk for HCC, and fibrosis progression based on risk for NASH.
  – Counsel on alcohol abstinence
  – Counsel on NAFLD and possibility of disease progression to NASH
  – Counsel on weight loss and managing metabolic abnormalities.
Pregnancy and GI Conditions, Case Studies

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Disclosures

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No financial relationships to disclose.
Case Study

- 32 year old G4, P3, 12 weeks gestation, with 10 year history of pan ulcerative colitis. Medication include mesalamine 2400 mg daily. Higher doses not tolerated. Lives 2 hours from IBD center. No pre term labor sx
- Bloody diarrhea, weight loss, 10 plus stools day nausea x 2 weeks
- Which tests/labs should be ordered?
Results of Tests/Labs

• Results
  – CBC Hgb 8.0. Hct 32, Wbc 12,500, fecal cal greater than 1000, GI pathogen negative, BMP shows creatine 2.1

• Discuss differential diagnosis – Viral?, UC flare,

• Is any further workup necessary? Flex sig? Imaging? Which modalities are safe?

• What is the diagnosis?
Diagnosis/ Flare of Ulcerative Colitis

• Diagnosis
  – Flare of ulcerative pan colitis. Intolerant to higher doses of 5 ASA, Pregnancy followed by high-risk OB

• What management options are available for this patient? In patient or out patient?
Treatment Options

- **IV steroids/oral steroids**
  - Start Biologic? Which one and why?
  - Vedolizumab, Infliximab, Certolizumab?

- **Discuss considerations of Pregnancy, tolerance, compliance**
  - What follow-up is necessary?
  - Continue mesalamine?
Patient Follow-Up

• Patient Care
  – Short-term plan
    • Followed q 2 weeks in GI clinic, q 2 weeks with OB
    • Assess fecal cal at 3 months, assess drug levels prior to first maintenance and prior to second maintenance dose
  – Long-term plan
    • Follow q 2 month in GI clinic
    • Follow with high risk OB monthly and prn
Case Number 2: Abdominal Pain

- 24 year old at 27 weeks gestation
- Presents with Abdominal pain, leukocytosis, concern for pre term labor, no previous hx of IBD/IBS. 10 days prior had laparoscopic cholecystectomy
- Vitals T-102.1, vomiting
- Admit and what tests should be ordered?
- What is differential Dx?
Abdominal Pain DD

• Appendicitis
• Pyelonephritis
• IBD
• Post op complication
• Pancreatitis
Abdominal Pain / Results

- WBC 23,000, mild LFT inc.
- UA WNL, lipase WNL
- Negative amniocentesis
- MRI obtained-phlegmon in small bowel mesentery near distal ileum-? Perforation
Abdominal Pain/Treatment

- Emergent exploratory laparotomy – Surgery indications same for pregnant/non pregnant
- (Hemorrhage, perforation, obstruction, abscess)
- Results – ileal perforation and small bowel fistula,
- (Fat wrapping)
- Ileocolectomy with primary anastomosis was performed, Pathology showed moderate to severe chronic inflammation of small bowel, crypt abscess, 2 enterocolic fistulas
- What is the diagnosis?
Penetrating Crohn’s Diagnosis

- 4% of women with CD diagnosed during pregnancy
- Uncommon presentation, highlights abdominal pain in pregnancy has a broad d/d
- Multidisciplinary team for acute abdomen
Penetrating Crohn’s/Follow Up

- Follow up included discharge home post op and follow up with Gastroenterologist
- Should induction therapy be started? Which drug and why
- ? Azathioprine, Anti TNF, Combo, Prednisone,
- Wait for Delivery? What kind of Follow up?
Outcome of Newly Dx Penetrating Crohn’s

- Healthy Term infant by vaginal
- No poor outcomes
- Followed closely in GI monthly
- Patient started on Anti TNF after delivery
- Doing well, no further hospitalizations
- Patient reports chronic abdominal pain
Summary

• Diagnostic investigations are limited, concern for fetal radiation exposure
• Contrast CTs and enemas are avoided
• Can do MRI and US
• Flexible sigmoid can be safely performed during pregnancy
• Most IBD patients have successful and uncomplicated pregnancies!!
• Pre Term delivery and decreased neonatal weight most common complications
THANK YOU!!