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The Reproductive Journey in Inflammatory Bowel Disease (IBD)

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Disclosures

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Consultant: AbbVie, Clinical Area- IBD

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;
2. Limdi JK et al. *Inflamm Bowel Dis.* 2019;25(10):1603-1612; 3. Mahadevan U et al. *Gastroenterology.* 2019 156:1508-1524.

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

1. Bonthala, N, Kane S. *Curr Treat Options Gastroenterol.* 2018;16:86–100;
2. Mahadevan U et al. *Gastroenterology.* 2019 156:1508-1524.

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

    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[1]

Lavie et al. *Arch Gynecol Obstet*. 2020;302:611-618.

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

Delima-Karagiannis et al. *Am J Gastroenterol.* 2016;111:1305-1312.

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 pathway[1]
- Manage pregnancy
  - At least 1 visit to high-risk OB

1. Mahadevan U et al. *Gastroenterology.* 2019 156:1508-1524.

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]

1. Mahadevan U et al. *Gastroenterology.* 2019 156:1508-1524;
2. Moens et al. *Aliment Pharmacol Ther*. 2020;51(1):129-138;
3. Mahadevan U et al. *Inflamm Bowel Dis*. 2018;24(12):2494-2500.

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

Mahadevan U et al. *Gastroenterology.* 2019 156:1508-1524.

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*[1]

1. Ghorayeb J et al. *Qual Health Res.* 2018;28(8):1283-1294.

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

1. Donaldson et al. *Climacteric*. 2017;20(6):545-551;
2. Bonthala N, Kane S. *Curr Treat Options Gastroenterol*. 2018;16:86-100.

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!

Mahadevan U et al. *Gastroenterology.* 2019; 156:1508-1524.