THE MOTHER WITH IBD

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Women are often diagnosed with IBD during their childbearing years. Disease activity may reduce the ability to conceive and increase the risk of spontaneous abortion and preterm birth, making disease control vital to a healthy pregnancy and infant. Ideally, women should be in a durable remission on stable maintenance medication prior to conception. The majority of medications used in IBD are low risk.[1]

Azathioprine and 6-mercaptopurine are FDA category D, yet the evidence in IBD suggests that they are low risk.[2] They are also compatible with lactation.[3] Anti-tumour necrosis factor (TNF) agents – infliximab, adalimumab, certolizumab, and now golimumab – (category B) are considered low risk during pregnancy and compatible with lactation. Infliximab and adalimumab are IgG1 antibodies and are actively transported across the placenta in the second and third trimester.[4,5] Levels of drug are detectable in cord blood at birth and in the infant for up to 6 months. Certolizumab is a Fab' fragment that crosses the placenta only passively, and levels are minimal at birth. While the use of adalimumab and infliximab alone during pregnancy has not been associated to date with any increase in infections or immune development, infants exposed *in utero* should not receive live vaccines for the first 6 months of life. The mother and the pediatrician should be aware of this as well; all standard vaccines can be given on schedule and with good response. To minimize placental transfer, in my practice, I give the last dose of infliximab around week 32 of gestation and the last dose of adalimumab at weeks 36 to 38. A patient who has active disease should continue treatment on schedule. Certolizumab requires no change to timing of dosing or vaccination. However, all infants exposed to anti-TNF agents *in utero* should be monitored closely by their pediatrician for unusual infections.

References

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