SESSION 2

Pregnancy in IBD: Guidance from the Guidelines

CASE-BASED BREAKOUT WORKSHOP

Laura is a 25-year-old accountant with a five-year history of Crohn's ileocolitis with perianal fistula. Max is a 24-year-old engineer with a seven-year history of ulcerative colitis. They met in your waiting room and fell in love. They are now married and want to conceive. They come to see you for counseling. Laura is on infliximab monotherapy. Max is on adalimumab and a thiopurine. Laura wishes to stop the infliximab before getting pregnant. Max is on combination therapy and is worried about the safety of these agents for conception.

Decision Node 1

- What will you tell them about heredity of IBD?
- What advice will you give Laura about her wish to stop anti-TNF prior to pregnancy?
- What counsel will you give Max about the safety of anti-TNF and thiopurine therapy for conception?

Laura has been well since her diagnosis five years prior. Her perianal fistula is inactive. She feels well but reports two to four soft bowel movements per day with occasional abdominal cramps. Her complete blood count (CBC) and C-reactive protein (CRP) are normal. Her last colonoscopy and magnetic resonance enterography (MRE) were three years ago while on infliximab and her disease was in remission.

Decision Node 2

- Would you recommend any more investigations to assess disease activity?

You perform a colonoscopy, which reveals a normal colon, apart from scattered small pseudopolyps and a normal ileum. Fecal calprotectin is normal. You inform Laura that the IBD is in remission and that this is a good time to try to conceive.

Decision Node 3

- What other elements in pre-conception counselling would you discuss?

Laura returns several months later to inform you of the good news that she is eight weeks pregnant. She has decided to remain on infliximab. You see her again in follow-up at 17 weeks gestation. Her 1st trimester was uneventful. Her last infliximab dose was at

10 weeks pregnancy. She now complains of a three-week history of abdominal cramping and diarrhea with five to six loose bowel movements per day. There is no history of fever. She has not gained optimal weight. An ultrasound by her obstetrician at 12 weeks showed a normal developing fetus.

Decision Node 4

- How do you assess disease activity during pregnancy?

Her CRP is 14 mg/L, Hb 99 g/L, white blood cells normal, fecal calprotectin 475 mcg/g. Abdominal ultrasound shows thickened ileum wall consistent with active disease.

Decision Node 5

- How do you manage the patient at this time?

You decide to increase the infliximab to 10 mg/kg empirically, and do an anti-TNF level prior to the next infusion at week 18 of Laura's pregnancy. The level of infliximab is 2.1 mcg/mL. There are no antibodies. She has a significant improvement. You see her at week 28 of gestation. She is doing well in clinical remission after her second dose of 10 mg/kg infliximab. CRP and fecal calprotectin have normalized.

Decision Node 6

- How would manage the infliximab for the remainder of the pregnancy and post partum?