Fertility and Pregnancy for people with Inflammatory Bowel Disease
by Dr Emma Flanagan – 23rd February 2019

Dr Flanagan is a Gastroenterologist at St. Vincent's Hospital in Melbourne, working in a specialized clinic for women with IBD i.e. Crohn's or UC who are planning a pregnancy or are pregnant. The clinic has been running for a couple of years and both public and private patients are welcome. A large proportion of these patients with IBD end up having surgery, so there is often an overlap between surgery, having an ostomy and planning a pregnancy. Therefore the clinic works closely with other treating clinicians including the surgeon and the obstetrician.

This clinic is very relevant for IBD patients as they tend to get diagnosed when they are in the reproductive age group 15 – 30 years old.

Successful pregnancies can be achieved with IBD/ surgeries eg ileostomy.
Prior to the time when they want to get pregnant it is important that the inflammatory bowel disease is controlled either medically or surgically in order to improve their fertility and pregnancy outcomes.

Planning with clinicians, doctors and surgeons - ask questions of your treating team, everyone is different so discuss your concerns with your specialist rather than relying on information that comes from inaccurate sources or sources that do not relate to you.
Concerns often include will fertility be affected because of IBD? Actually it is thought to only be reduced following pelvic surgery, such as removal of the rectum, or when patients have active Crohns disease in the small bowel, which can sometimes affect the ovaries and fallopian tubes.

Patients with UC who have had pelvic surgery- fertility may be reduced after pouch surgery due to adhesions or internal scarring which might block the passage of the egg from the ovary to the fallopian tube. However with laparoscopic or keyhole surgery fertility is thought to be less affected. IVF rates have shown to be similar in patients who have had pouch surgery.

Early referral to a fertility specialist is recommended following removal of the rectum for consideration of IVF because a tubal obstruction can be the cause of infertility.

Recommendations – Planning

Attempt to get pregnant when the disease is under control and when the obstetrician, surgeon & gastroenterologist in the treating team think it is the best time for the patient.
Ideally have the disease in sustained remission and well controlled six months before attempting to get pregnant. If relevant have a colonoscopy and/or stool test for faecal calprotectin to ensure that there is no inflammation in the bowel.

Immunisation status - a check up with the GP is recommended for pre pregnancy blood tests.

Folate supplement should be started before getting pregnant and continue during pregnancy. Particularly important for patients with small bowel Crohns & problems with folate absorption.

Not smoking or drinking alcohol enables the body to be as healthy as possible and also achieving a normal weight range - low BMI can be associated with irregular ovulation, resulting in problems with conceiving while a high BMI can be associated with gestational diabetes.

Risks of flare up during pregnancy

Associated with the amount of disease the patient had just prior to pregnancy - so if patients have active disease at the time of conception then these patients can have active disease during the pregnancy. Unfortunately active disease in pregnancy can be linked with a higher risk of miscarriage & babies being born early and with a low birth weight.

IBD drugs in relation to fertility and pregnancy

One of the biggest concerns for patients, and often the patient receives mixed messages from clinicians who do not specialize in this area, so always check with your specialist first. Most IBD medications are considered low risk, with the exception of methotrexate, which should be ceased.

Management of an Ostomy during pregnancy

Have regular contact with your Stomal Therapy Nurse, as the abdomen of a pregnant women grows there can be changes in the size and shape of the stoma, and it is recommended not to change to different appliances by yourself - use the expertise of a stoma nurse. Rarely the uterus enlarges and blocks the bowel causing an obstruction, if this occurs you need to notify your surgeon promptly.

Dietary advice is usually the same as post operatively, keep well hydrated particularly if you suffer from morning sickness. You might need to use a mirror to perform ostomy care due to enlargement of the abdomen.

Review with the treating team should be at least once per trimester and then 6 weeks after delivery but more regularly if having problems. In addition visit the obstetrician regularly.

Mode of Delivery

Guided by your obstetrician but also discussed with the IBD team & your surgeon, it should be a planned approach. It is possible for women with IBD to have a vaginal delivery even if you have a colostomy or ileostomy. A c-section is generally recommended if there is active perianal Crohns disease or if a patient has had an ileo-anal pouch. Once again discuss this with your IBD team, surgeon & obstetrician.

Breastfeeding

Is beneficial for both mother and baby and is recommended. Majority of the medications used for IBD are considered low risk in breastfeeding (except for methotrexate) – discuss with your treating doctor.

Hereditary Links

The chance that a child with one parent with IBD will develop the disease is about 5% to 8%.

Fertility concerns for Males suffering from IBD

It is not thought that IBD itself affects male fertility but obviously issues such as fatigue & poor body image can affect libido etc. and make it more difficult to conceive.

Men who have had a pouch operation or their rectum removed there may be problems afterwards in terms of having an erection; the problem may only be temporary or successfully treated with medication. Therefore it is recommended by surgeons that males undertake sperm banking prior to surgery.

Conclusion
There are good pregnancy outcomes for patients with IBD including following surgery.
Most of the medications used for IBD are considered safe except for methotrexate

Plan early with your treating team and get an early referral to a fertility specialist if you are having trouble conceiving.
Once pregnant have regular contact with your STN and your obstetrician, surgeon & IBD team at least once per trimester.
Discuss with your surgeon before getting pregnant post surgery.

QUESTIONS: Just a few of the questions asked.
If a patient has an ileostomy from UC should they have their family prior to the formation of a J Pouch?

That is generally the recommendation.

Is it harder to conceive with a J Pouch?

It can be harder but still possible and you might need IVF

Is a dietician part of your team?

Yes in our IBD clinic there is a dietician attached, and there should be one at each hospital & clinic.

Do many of the major hospitals have these specialized clinics?

No St Vincent's hospital in Melbourne set up the first clinic for patients with IBD wanting to get pregnant or who are pregnant. Private and public patients can be referred to our clinic from other clinicians or hospitals. The clinic can help with extra information or reassurance. Unfortunately does not cater for males.

This is general advice; it is always recommended to discuss your concerns regarding fertility and pregnancy with your individual treating specialists