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Saturday, August 10, 2019

(Plenary)

17:30 - 17:50 IBD in Special Situations - Pregnancy and Travelling

Inflammatory Bowel Disease (IBD) in special situations pregnancy and travelling

Kirsten Rosser

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IBD and pregnancy – what are the issues?

- Active IBD (especially CD) leads to adverse pregnancy outcomes
  - Decreased fertility
  - Low birth weight
  - Pre-term birth
  - Foetal loss
- Risk of adverse outcomes highest in women who have active disease at conception
- Voluntary childlessness

Pinder M, Lummis K, Selinger CP, Clin Exp Gastroenterol. 2016 Oct 14;9:325-335. eCollection 2016.

Pre-conception counselling

- Address issues leading to voluntary childlessness – Heritability
  - Absolute risk with one parent having IBD is 4% - 11% for both CD and UC
  - Risk higher if parent has CD
  - Multiple affected family members increases risk
  - Risk increases to 35% if both parents have IBD
- Ensure woman is in clinical remission (ideally for at least 3 months)
- Review nutritional status and discuss micronutrients
- Discuss smoking cessation/alcohol/recreational drugs
- Ensure up to date with cervical smears and vaccinations
- Review medications and reassure, reassure, reassure!

Pinder M, Lummis K, Selinger CP, Clin Exp Gastroenterol. 2016 Oct 14;9:325-335. eCollection 2016.

IBD medication during pregnancy – ECCO consensus statements - 2015

- **ECCO Statement 4D**

Fetal exposure to most IBD medications is considered of low risk to the child, except for methotrexate and thalidomide. Fetal exposure to thiopurines is not associated with an increased risk of infections in the first year. The risk of infection with anti-TNF agents alone or in combination with immunomodulators is controversial

- **ECCO Statement 4E**

Since detectable levels of anti-TNF in the offspring are present in the first 6 months at least, live vaccines should be avoided in this period. Current vaccination strategies with non-live vaccines do not differ from those for infants unexposed in utero to anti-TNF agents

- **ECCO Statement 4F**

Timing of the last dose of the anti-TNF drug should consider both maternal disease activity and drug placental transfer. When considered appropriate by the clinician and the patient, to limit the transport of the anti-TNF to fetus, the anti-TNF drug should be discontinued around **gestational week 24–26**

Journal of Crohn's and Colitis, Volume 9, Issue 2, February 2015, Pages 107–124, https://doi.org/10.1093/ecco-jcc/jju006

IBD medication during pregnancy – ECCO consensus statements - 2015

Drug	During pregnancy	During lactation
Mesalazine	Low risk	Low risk
Sulfasalazine	Low risk	Low risk
Corticosteroids	Low risk	Low risk, 4h delay before breastfeeding is advised
Thiopurines	Low risk, limited data on 6-TG	Low risk
Anti-TNF agents	Low risk, consider stopping around week 24 in patients with sustained remission. See text	Probably low risk, limited data
Methotrexate	Contraindicated	Contraindicated
Thalidomide	Contraindicated	Contraindicated
Metronidazole	Avoid first trimester	Avoid
Ciprofloxacin	Avoid first trimester	Avoid

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IBD medication during pregnancy – 5 ASA's and Mesalazine

- Case series, population-based cohort studies, animal studies and two meta-analyses did not demonstrate any teratogenicity nor increased risk for miscarriage or ectopic pregnancy.
- Some trials have shown a higher rate of premature birth, stillbirth, and low birthweight however active disease was a confounding factor
- A small increase in the risk for congenital malformations has only been shown in one meta-analysis but again active disease a confounder
- Sulfasalazine interferes with folate absorption so supplementation is recommended with a higher dose of folic acid than usual

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IBD medication during pregnancy – Azathioprine and 6-Mercaptopurine

- Pregnancy category D
- Foetal exposure to AZA and 6-MP has been reported in several hundreds of cases. Adverse events were an increased rate of **miscarriage**, **preterm delivery** and **low birth weight**, which could have been caused by the underlying disease rather than by the use of thiopurines.
- More recent controlled studies and a meta-analysis reported no increased risk for adverse pregnancy outcome in IBD patients treated during pregnancy with thiopurines, compared with pregnancy outcomes of IBD patients without this treatment.

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Asacol concerns 2013

- Dibutyl phthalate coating
  - Downgraded from FDA Category B to C.
  - Theoretical risk
  - Animal studies:
    - increased risk of malformations in the male urogenital tract
    - not been described in a humans
  - possibly associated with precocious puberty in humans
  - Consider switching to an alternative 5-ASA

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IBD medication during pregnancy – Infliximab and Humira

- Anti-TNF agents with active transfer across the placenta in the 2nd and 3rd trimester
- In the PIANO registry, pregnancy outcomes of 797 pregnancies were measured in women on:
  - thiopurine mono-therapy
  - anti-TNF mono-therapy
  - combination therapy
  - control group on no immunomodulators
- No differences in the rate of congenital malformations and other short-term adverse pregnancy outcomes were found between the 4 groups

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Levels of ADA and IFX in the newborn

- Study of 80 women prospectively measured maternal blood and umbilical cord concentrations at delivery, and blood levels in the infant 3 monthly until drug was undetectable
- The mean time to drug clearance was 4 months for ADA and 7.3months for IFX
- Drugs were detected in one infant at 12 months of age
- Infection risk may be higher in these infants and live vaccines should be withheld until >12 months of age
- Low rates of pre-term delivery, low birth weight or congenital abnormalities

Julsgaard M., et al, Gastroenterology. 2016 Jul;151(1):110-9.
doi: 10.1053/j.gastro.2016.04.002. Epub 2016 Apr 8.

New Zealand National Immunisation Schedule from 1 April 2018

	RV	DTaP-IPV-HepB/Hib	PCV	Hib	VV	MMR	DTaP-IPV	Tdap	HPV	Td	Influenza	HZV
Every pregnancy								Boostrix® between 28-38 weeks pregnancy			Influvac® Tetra any trimester	
6 weeks	Rotarix®	Infanrix®-hexa	Synflorix®									
3 months	Rotarix®	Infanrix®-hexa	Synflorix®									
5 months		Infanrix®-hexa	Synflorix®									
15 months			Synflorix®	Hiberix®	Varilrix®	Priorix®						
4 years						Priorix®	Infanrix®-IPV					
11 years								Boostrix®				
12 years									Gardasil® 9 two doses			
45 years										ADT™ Booster		
65 years										ADT™ Booster	Influvac® Tetra	Zostavax®

VACCINE KEY

RV: rotavirus
DTaP-IPV-HepB/Hib: diphtheria, tetanus, acellular pertussis, polio, hepatitis B, *Haemophilus influenzae* type b
PCV: pneumococcal conjugate vaccine
Hib: *Haemophilus influenzae* type b
VV: varicella (chickenpox) vaccine
MMR: measles, mumps, rubella
DTaP-IPV: diphtheria, tetanus, acellular pertussis, polio
Tdap: tetanus, diphtheria, acellular pertussis
HPV: human papillomavirus
Td: tetanus, diphtheria
HZV: herpes zoster (shingles) vaccine

The Immunisation Advisory Centre

For more details, visit immune.org.nz

April 2018

Managing a flare during pregnancy

- **ECCO Statement 5C**
- In cases of relapse, depending on the disease phenotype and activity, 5-ASA or corticosteroids are the preferred therapies. Anti-TNF agents can be considered to treat flares in appropriate situations
- Prednisone safe, evidence that it’s also safe in first trimester
- Do not start thiopurines
- Anti-TNF rescue in acute and/or severe flares

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Delivery considerations

- Most IBD patients can have a normal vaginal delivery
- Elective Caesarean delivery should be considered in patients with perianal Crohn’s disease or those who may be considering J pouch surgery in the future
- Post-partum flare less likely with quiescent disease and in those who remain on treatment throughout pregnancy

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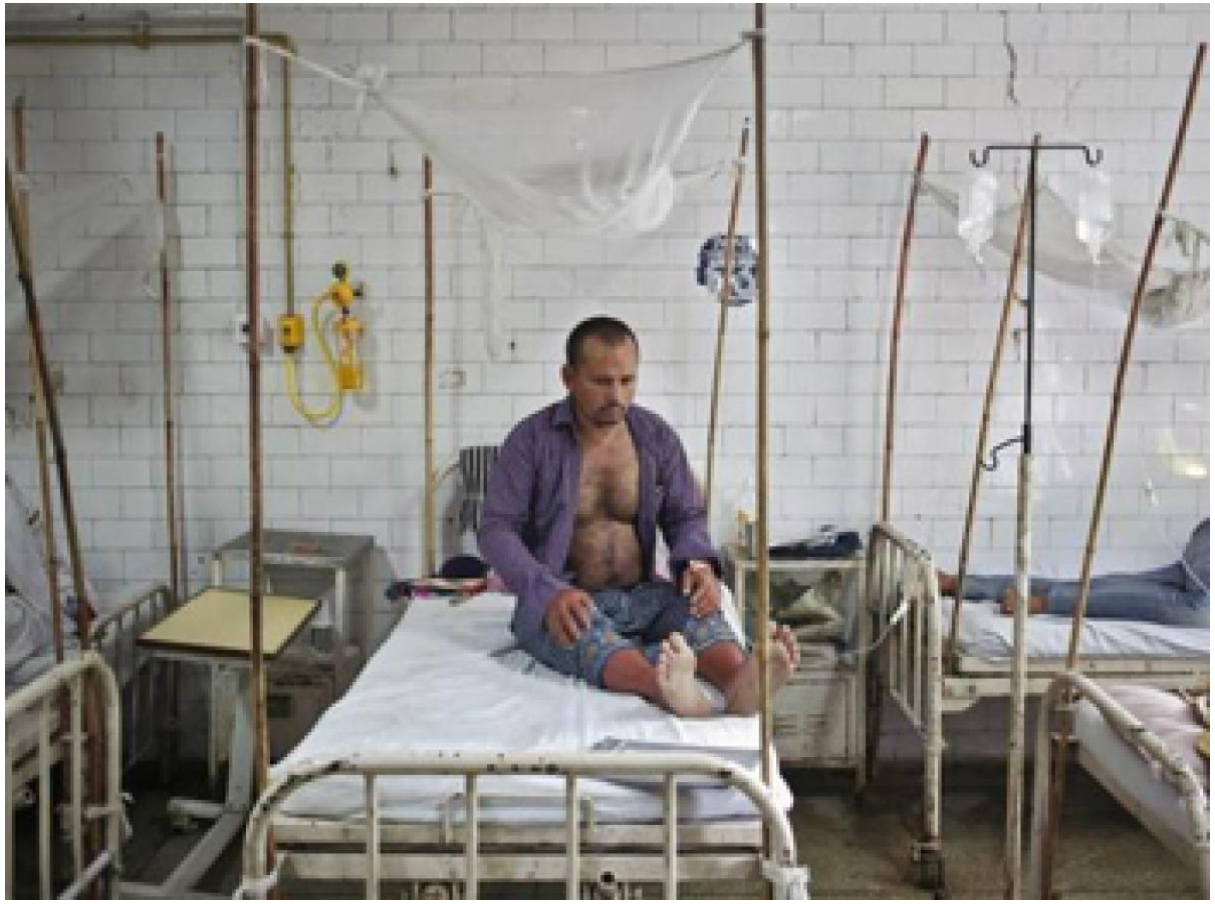
IBD and travel – how to prepare

- Travel Insurance
- Vaccinations
- Enough medication packed separately
- Extra medications i.e. steroids antibiotics
- Toilet paper
- Coins for public toilets
- Change of clothes/pads

What can go wrong?

- Admission to hospital
- Surgery
- Re-patriation to NZ
- Incontinence
  - Recommend pads
  - Carry a change of clothes
  - Access to toilets



What can patients do if things go wrong?

Practicalities of travelling with medication

- Chiller pack for Humira provided by Abbviecare
- Letter from doctor regarding injectable medications
- Transport medications in carry on luggage
- Spares in checked baggage

Useful websites and questions?

https://ibdparenthoodproject.gastro.org/

https://www.janssenpro.co.nz/

https://www.abbviecare.co.nz/

https://www.ibdpassport.com/

https://crohnsandcolitis.org.nz/

http://www.ownyouribd.co.nz/