Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting: https://reachmd.com/programs/cme/clinical-challenges-of-ibd-management-pregnancy-considerations-and-shared-decision-making/15521/

Released: 06/08/2023
Valid until: 06/09/2024
Time needed to complete: 15 minutes

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Clinical Challenges of IBD Management: Pregnancy Considerations and Shared Decision-Making

Announcer:
Welcome to CME on ReachMD. This activity, titled *"Clinical Challenges of IBD Management: Pregnancy Considerations And Shared Decision-Making,"* is provided by the American Gastroenterological Association and Partners for Advancing Clinical Education, in partnership with Practicing Clinicians Exchange and Clinical Care Options, LLC.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Meyers:
Hello, and thank you for your participation in this educational program entitled IBD Resource Center for Primary Care and Gastroenterology Professionals: Your One-Stop Shop for Managing IBD. This module is part of a core IBD curriculum provided by the American Gastroenterological Association, and Partners for Advancing Clinical Education in partnership with Practicing Clinicians Exchange, and Clinical Care Options. This activity is supported by educational grants from Amgen, Ferring Pharmaceuticals, and Takeda Pharmaceuticals USA.

I'm Abigail Meyers, an Instructor in Surgery and Physician Assistant with Colon and Rectal Surgery at Mayo Clinic in Rochester, Minnesota.

This is a third of six Medical Minute presentations, and today I'll be discussing pregnancy considerations and shared decision-making. The objectives for this Medical Minute are for you to be better able to explore strategies for the management of IBD in women who are pregnant or lactating or planning to become pregnant. It will also help you be better able to engage patients in their IBD management with a shared decision-making approach.

So we will start navigating IBD care and family planning with a case study of Crystal, who is a 34-year-old female with Crohn's ileocolitis diagnosed in December 2018. She has a history of perianal disease. She recently found out that she is pregnant. She is allergic to azathioprine, and currently uses infliximab 5 milligrams per kilogram every 6 weeks for her Crohn's disease. She's an elementary school teacher, she's married and has two children already. She doesn't drink alcohol or use illicit drugs or tobacco. So let's think about what we could recommend for her prenatal care, and if we would need to make any adjustments to her medications in regards to her new pregnancy.

When assessing a patient who is newly pregnant, we need to assess the status of their IBD. We can do that with different imaging modalities as well as endoscopy. Ultrasound is considered low risk, and is generally safe to the fetus. MRI can be used without gadolinium. Flexible sigmoidoscopy without sedation or preparation can be performed throughout pregnancy. Colonoscopy, as well as any sedated procedure should be performed after 24 weeks and requires a documentation of discussion, and really should be reserved for situations where there may be life-threatening colonic disease.

We understand that childlessness in IBD can be based upon a lack of knowledge and discussion with gastroenterology. It can be based upon lack of knowledge or misinformation about the disease itself or the medications that a patient may be taking to manage their

disease. There are many misperceptions in regards to pregnancy and breastfeeding, such as that the drugs are harmful in conception or pregnancy, or that they should be continued during a pregnancy, or that it's not possible to breastfeed, or that patients must have a Cesarean section if they have a diagnosis of inflammatory bowel disease. But the facts are that managing IBD with appropriate medication actually reduces risk of flares. It supports a healthier mom and it supports a healthier pregnancy. Flares actually increase pregnancy risk both to the mother and to the fetus. So medications really should not be changed or modified without consultation with a healthcare professional. Most of the IBD medications are safe during breastfeeding, and patients with IBD can certainly undergo standard vaginal delivery in most cases.

We need to identify that pregnancy and disease activity is one of the key factors. Patients who conceive during remission, about 80% of those patients will remain in remission throughout their pregnancy. Women with IBD who conceive during active disease have increased risk of having active disease or worsening inflammatory bowel disease throughout the duration of their pregnancy.

So we need to address our patient's concerns about conception, medication management, and treatment because often our patients are overestimating the heritability of their IBD. They're overestimating the risks of the IBD therapies on fetal development and pregnancy outcomes overall. And they're often underestimating the risk of active disease on maternal and neonatal outcomes.

Pregnancy and neonatal outcomes after exposure to biologics and thiopurines has been studied with the PIANO study. This has demonstrated there is no increase in congenital malformations, spontaneous abortions, preterm birth, low birth weight, or infections in the first year, except in preterm birth. However, maternal IBD activity is associated with increased spontaneous abortion.

We will briefly touch on medication classes and compatibility with pregnancy as well as special considerations within those drug classes. Amino salicylates overall are compatible with pregnancy. It is important to note sulfasalazine will require increased folic acid to 2 milligrams per day during pregnancy. Steroids should continue to be used with caution, especially in our pregnant population. Immunomodulators are compatible with pregnancy, except for methotrexate, which is contra indicated due to embryo fetal toxicity including fetal death. Anti-TNF biologics are compatible with pregnancy. It's important to note that weight-based infliximab needs to be dosed on prepregnancy dosing. Non anti-TNF biologics are compatible with pregnancy. And again, with ustekinumab, we will need to maintain our prepregnancy dosing if giving an IV induction dose. JAK inhibitors currently have limited data in pregnancy, and so it's not currently advised.

When we discuss lactation and breastfeeding education for our patients, there is an AGA IBD Parenthood Project Working Group that has made some recommendations. For amino salicylates, mesalamine, balsalazide, and balsalazine are preferred to sulfasalazine. There is no indication of harm from breastfeeding with the use of biologics. Methotrexate is not recommended for breastfeeding, nor are the JAK inhibitors at this time. We no longer need to educate our patients that they need to quote, pump and dump, end quote for using thiopurine medications. This is not necessary and is not effective.

When we discuss modes of delivery for our patients with inflammatory bowel disease, we've seen that women with Crohn's disease are more likely to have a Cesarean section rather than the general population. Whereas the ulcerative colitis cohort seems to have a similar Cesarean section rate comparable with the general population. However Cesarean section could be recommended for women with perianal disease, and we could even consider that has a recommendation in patients with an ileal pouch, anal anastomosis.

When we talk about whether a patient should have a C-section or not, we think about preservation of the anal sphincter function, maintenance of continence overall, and development of any de novo perianal disease after a potentially traumatic birth. This is where we really need to engage our patients and shared decision-making, discussing risks and benefits in a mutual respectful conversation.

So to summarize, pregnancy considerations in inflammatory bowel disease, we need preconception counseling at the time of initiation of any therapy for inflammatory bowel disease. This helps to increase the awareness in that potentially voluntary childlessness but not be chosen for our patients based upon a lack of knowledge alone. We need to support that biologic medications are safe and effective during pregnancy and breastfeeding to our patients. We need to highlight that active disease is actually a risk factor for spontaneous abortion and other complications like preterm birth and small for gestational age. Newer small molecule agents do not yet have strong data in pregnancy and are currently not recommended at this time.

When we're using shared decision-making in IBD care, let’s talk about Crystal again. She's 34. She's concerned about the safety of her baby while taking the IBD medications. She read some information online about side effects and how they can impact her pregnancy outcomes. And she wants to discuss the safety of therapy while breastfeeding after her delivery. So what types of strategies would be used to engage her in shared decision-making to help her be aware of the options that exist for a safe outcome for her pregnancy?

Well, let’s start by understanding that patients believe that it's really important to be involved in their medical decisions. Specifically, they are looking at those types of medications that are efficacious as well as decreased accuracy events with medications. They're looking towards their healthcare professionals to discuss those risks to them, to keep them actively engaged in the decision about what medical

therapy may be best for them and their particular disease situation. A lot of times patients believe there's this materialistic or paternalistic relationship where a healthcare professional disseminates information and tells the patient what they need to do. Sometimes they provide just information about their disease overall, but what patients are really looking for is a shared decision-making process, perhaps that healthcare professional that provides information and recommendations but opens up the floor for a discussion where a patient is free to offer their own information and their own recommendations of what they've read. And a lot of times we can circle back to our patients and help to dispel some of the myths as we talked about with pregnancy, but also to help them understand what is effective, what is going to be the decreased adverse risks for our patients. By having this continuum of a conversation with our patients, that actually improves outcomes overall for our patients. This is important to show that when we include our patients in the decision, they stay on their medications longer, and they feel better about this decision overall.

This is a cross-sectional survey of patients with autoimmune disorders. So not just IBD, but patients receiving biologic therapy. There's survey data that's linked to administrative claims for 6 months prior to and after initiating biological therapy. So shared decision-making actually improves rates of patient satisfaction, adherence, and decreases healthcare costs overall when we involve the patients in actively participating in their healthcare.

When we're talking about risks with our patients, it's important to use terms that our patients can understand. Using absolute risks are going to be better than using relative risks, and avoiding decimals. Oftentimes, I will tell a patient an anti-TNF increases your risk for lymphoma to 4 out of 10,000. When you're not on an anti-TNF therapy, your regular risk is 2 out of 10,000. We keep the same denominator so they understand how that risk increases by using a certain agent. We can use visual aids to help by turning our numbers into pictures. And we can give perspective to other disease and life risks. I've heard some of my colleagues talk about risks of car accidents and deaths associated with other things in comparison to risks associated with medical therapies.

Now it's important to note shared decision-making isn't appropriate in all clinical scenarios where the treatment option is clear. For example, you need anticoagulation for an emboli. But if there's more than one treatment option available, it's very reasonable to talk about options for effective therapies. What happens if we intervene early? What types of risks are associated with different therapies? What safety considerations? And what types of risks are associated with natural progression of the disease should the patient choose not to intervene?

Find other educational offerings from Section 2 of this program at the links on this slide. Additional program components will be released soon. Find more CCO and PCE educational coverage on IBD and more online.

Announcer:
You have been listening to CME on ReachMD. This activity is provided by the American Gastroenterological Association and Partners for Advancing Clinical Education, in partnership with Practicing Clinicians Exchange and Clinical Care Options, LLC.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.