Balancing two lives: Optimising IBD management in pregnancy

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The speaker presented that active IBD disease, not medications, drives pregnancy complications, and that most IBD therapies including biologics can be safely continued during pregnancy to maintain remission.

KEY POINTS

- The speaker stated that outcomes such as small for gestational age, low birth weight, and preterm birth are 2 to 3 times more likely when IBD is active during pregnancy, emphasizing that disease control is the priority.
- Biologics can be maintained throughout pregnancy according to the speaker; the PIANO registry and long-term follow-up data (extending to 17 years) showed no increased risk of congenital malformations, infections, or neurodevelopmental problems with in-utero exposure.
- The speaker noted that biologics do not cross the placenta in the first trimester but undergo active transport starting in the second trimester, with infant exposure sometimes exceeding maternal levels by delivery.
- Methotrexate must be stopped 1 to 3 months before conception due to teratogenicity; S1P1 modulators and JAK inhibitors should also be stopped per labeling, with adequate washout and transition time to alternative therapies.
- For newer agents like IL-23 inhibitors, the speaker reported reassuring early data (e.g., risankizumab in over 400 women showed very low event rates comparable to the general population), though follow-up remains limited.
- In the Q&A, the speaker stated that for unplanned pregnancy on a JAK inhibitor, switching to an alternative therapy should be considered if the patient is in the first trimester and other effective options are available, with individualized decision-making in specialized centers.

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