



MEETING OF THE MINDS

WESTIN HARBOUR CASTLE, TORONTO

SATURDAY, November 15, 2025

Canada Future Directions in IBD



Co-Chairs: **Remo Panaccione**, MD FRCPC and **A. Hillary Steinhart**, MD MSc FRCPC





Workshop 3.4

Global View on Managing Pregnancy in IBD



Dr. Cynthia Seow
MBBS (Hons), MSc, FRACP

Professor
University of Calgary

Dr. Vivian Huang
BSc (Hons), MD, MSc, FRCPC

Associate Professor
University of Toronto





Objectives

- Integrate current evidence-based strategies into individualized management plans for pregnant patients with IBD
- Assess the safety profiles of commonly used IBD therapies during pregnancy and lactation
- We would like to take a moment to acknowledge the Indigenous people and traditional territories where we work and live today.

<https://pianostudy.org/conference.php>



The Helmsley PIANO Global Consensus and GRADE Statement: The Management of Pregnancy in Inflammatory Bowel Disease

Chair: Uma Mahadevan **Co-Chair:** Millie Long

10 section leads; 6 continent leads; Multi-disciplinary consultants; Patient ambassadors.

Funding: Helmsley Charitable Trust

Mahadevan U, Seow CH, Barnes EL, et al. Gut. 2025 Aug 28:gutjnl-2025-336402.

Case 1: Layla

24-year-old with Crohn's disease affecting her colon, ileum, and also has perianal disease

Layla is getting married in a few months, and asks her gastroenterologist several questions, including

- Treatment: Infliximab and methotrexate
- Will my child have IBD?
- What factors influence my ability to get pregnant?
- I may not be considering pregnancy right away, why should I see you before I plan pregnancy?



Maternal factors
impacting pregnancy



Fertility



Pre-conception
counseling and
optimization



Management of
disease activity
during pregnancy



Management
of pregnancy



IBD medications
during pregnancy



IBD medications
during lactation



Pregnancy
adverse events



Fetal and neonatal
adverse events



Vaccines

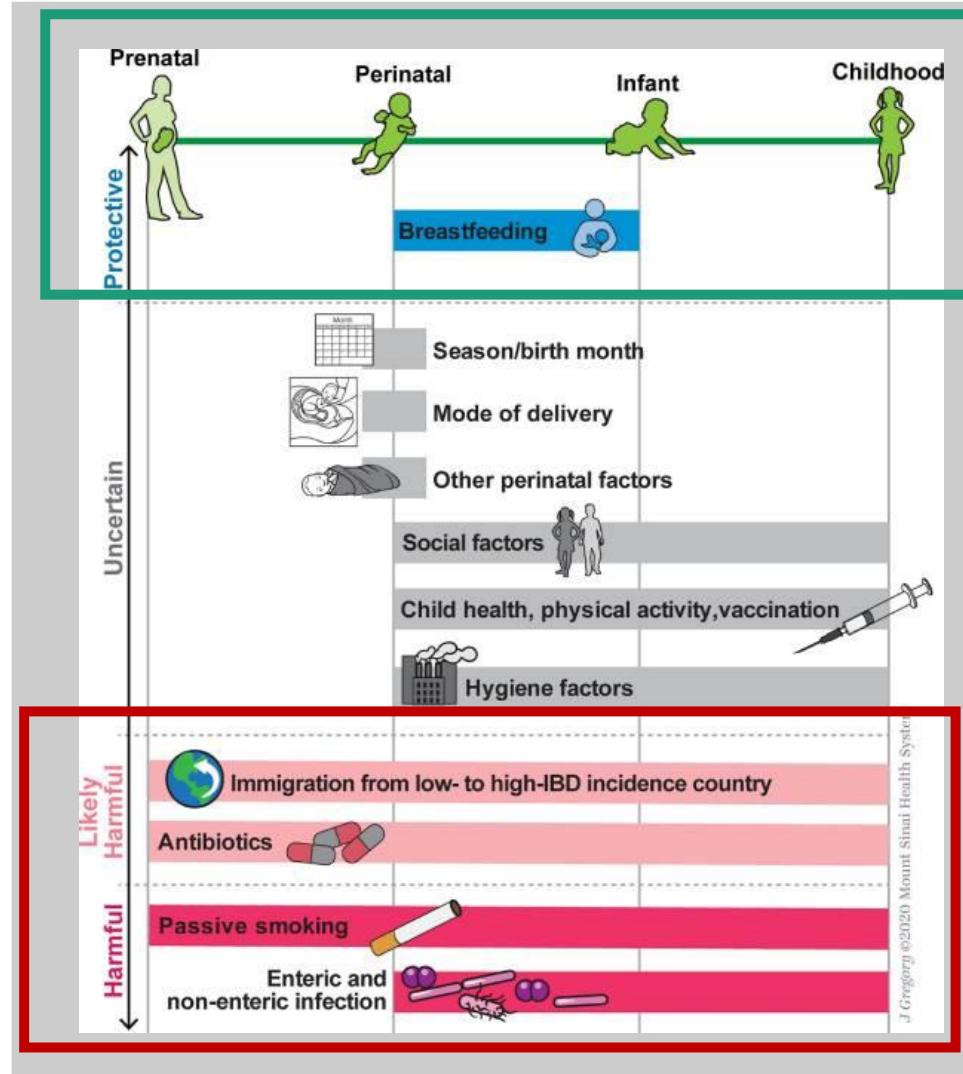
Layla: Question 1

Will my child have IBD?

Focus on modifiable factors

- prenatal vitamin
- healthy weight gain
- avoid alcohol and smoking

What is the Role of Genetics, Smoking, Diet, Infections, and Antibiotics on the Future Risk of Developing IBD?



Genetics, Environment, Microbiome

Combining **physiological biomarkers** of gut inflammation, **gut barrier function**, **fecal microbial composition** and **functional pathways** to assess the future risk of CD among healthy FDRs

Focus on what you can modify!



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adverse events



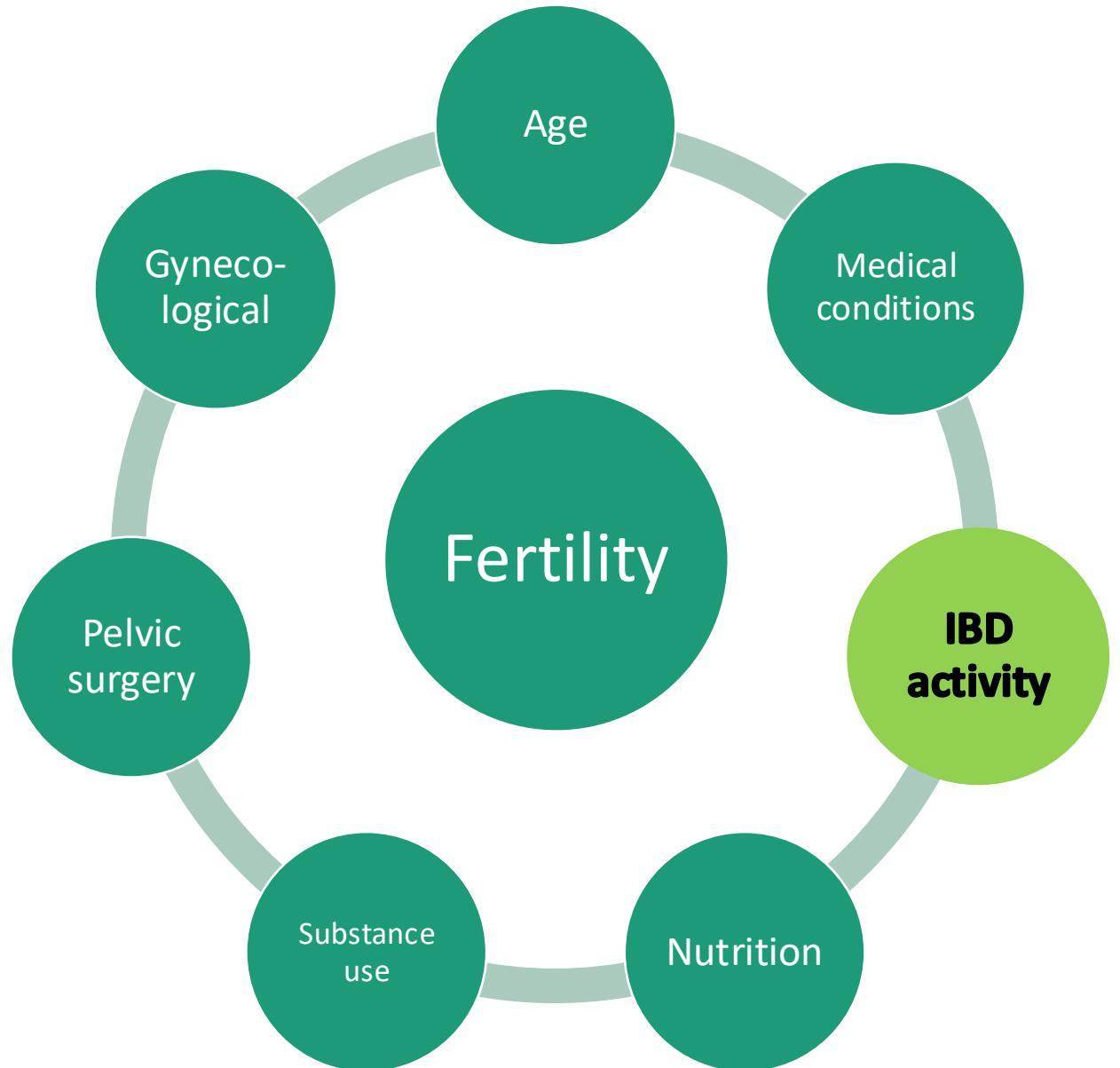
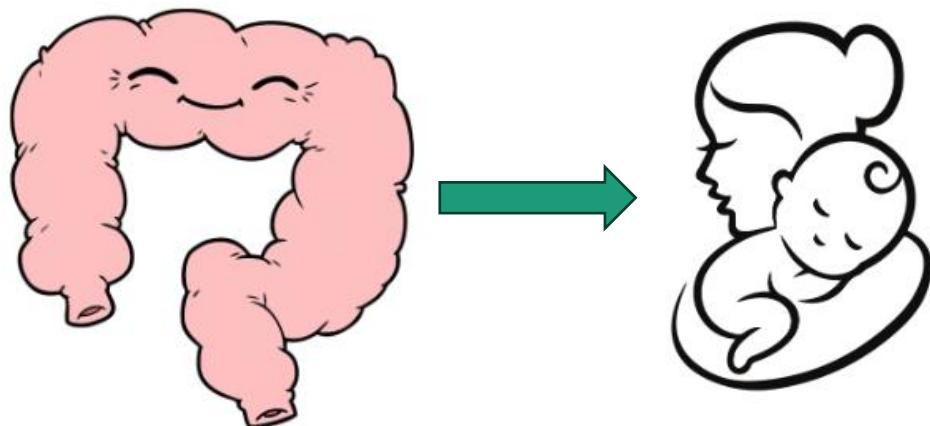
Fetal and neonatal
adverse events



Vaccines

Layla: Question 2

- What factors influence my ability to get pregnant?





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Layla: Question 3. Why should I see my IBD doctor before pregnancy? *Preconception Counselling*



Women are more concerned about IBD therapy than disease activity



Consider maternal/pregnancy and fetal outcomes

Medically optimize prior to elective conception (?surgery)

Allow 3-6 months to effect change



Healthy mum= healthy baby



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Vaccines

Sabine: Question 1

34-year-old with ulcerative colitis on mesalamine prior to and during her pregnancy.

Now 18 weeks pregnant and has noticed an increase in bowel movements (previously 1/day, to currently 4-5/day), looser stool and has noticed blood in her stool for 2 weeks.

Am I having an IBD flare or are my symptoms pregnancy related?

How do you monitor disease activity in pregnancy?

Monitor disease activity even more closely during pregnancy!



Patient messaging:

Symptoms do not always indicate active disease.

You can have active disease without symptoms.

Monitor disease activity even more closely during pregnancy!

Sabine: Question 2

Are women with IBD at increased risk of “bad” pregnancy outcomes?

Are babies born to mothers with IBD at increased risk of “bad” pregnancy outcomes?

What can I do to avoid that situation?

General advice:

- Be more concerned about active disease than active medications!
- Your body needs to be focusing on baby not on your bowels!

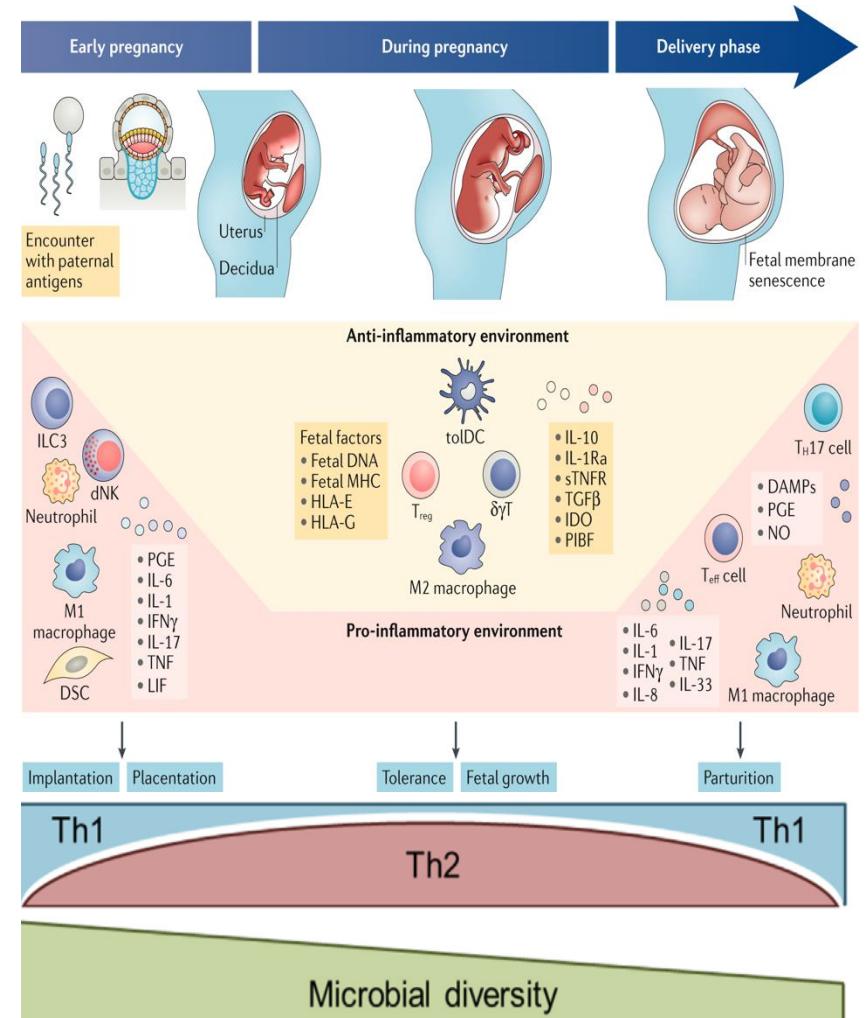
Impact of IBD on Pregnancy

- Disease activity increases the risk of adverse materno-fetal outcomes
- Ongoing disease activity
- Spontaneous abortion, stillbirth
- Small for gestational age
- Preterm birth
 - risk of neonatal infection
 - neurologic complications



Impact of Pregnancy on IBD

- Women with UC are 3-4 times more likely to flare in pregnancy than women with CD
- Is it the pregnancy or a disease flare?
 - role of non- invasive objective markers
- Treat to target irrespective of gestational age





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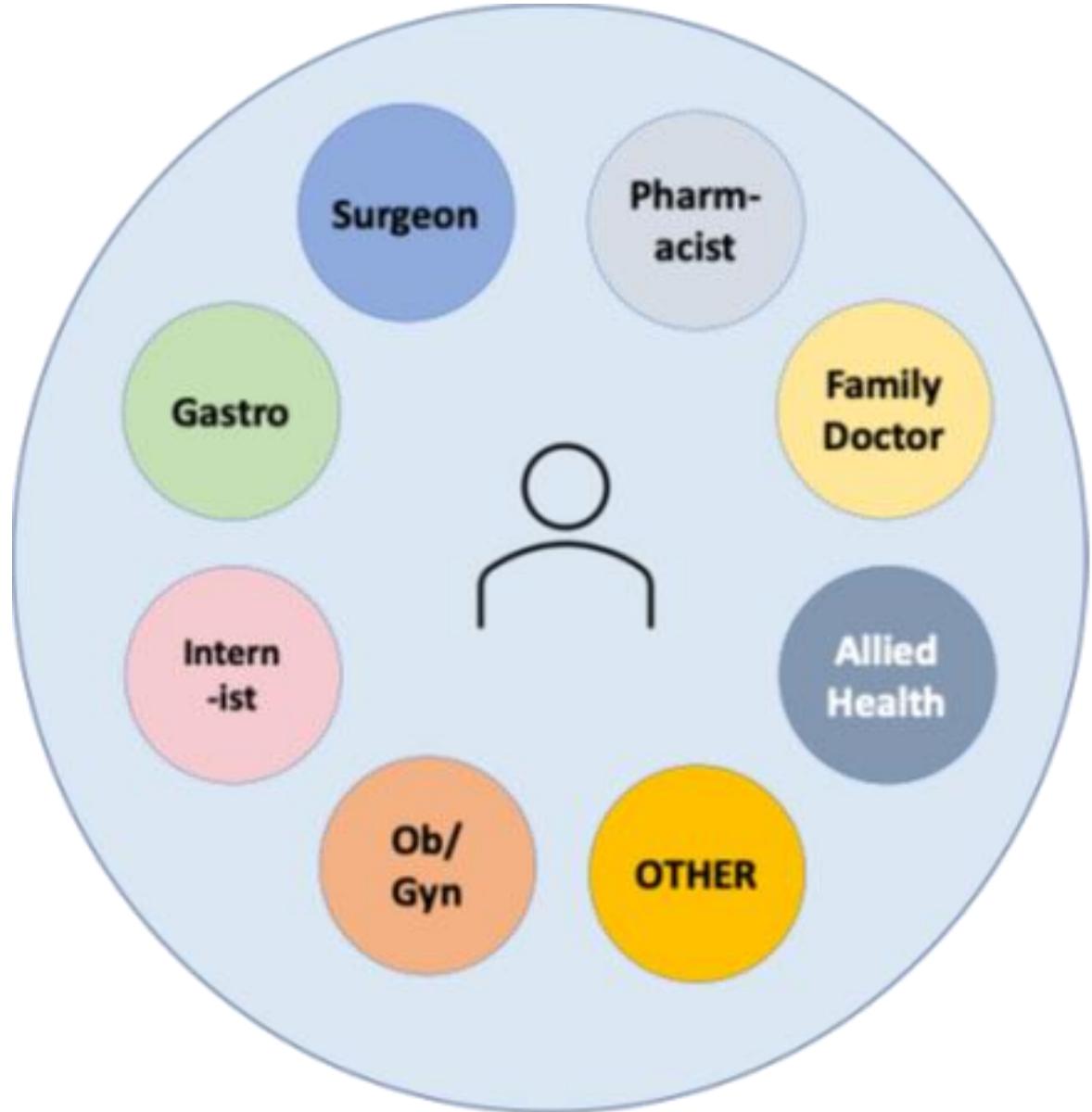
Fetal and neonatal
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Vaccines

Sabine: Question 3

- Who do I need to see during this pregnancy?
- Consider nutritional status and healthy weight gain



Sabine: Question 4

Is it safe for me to take aspirin in pregnancy?

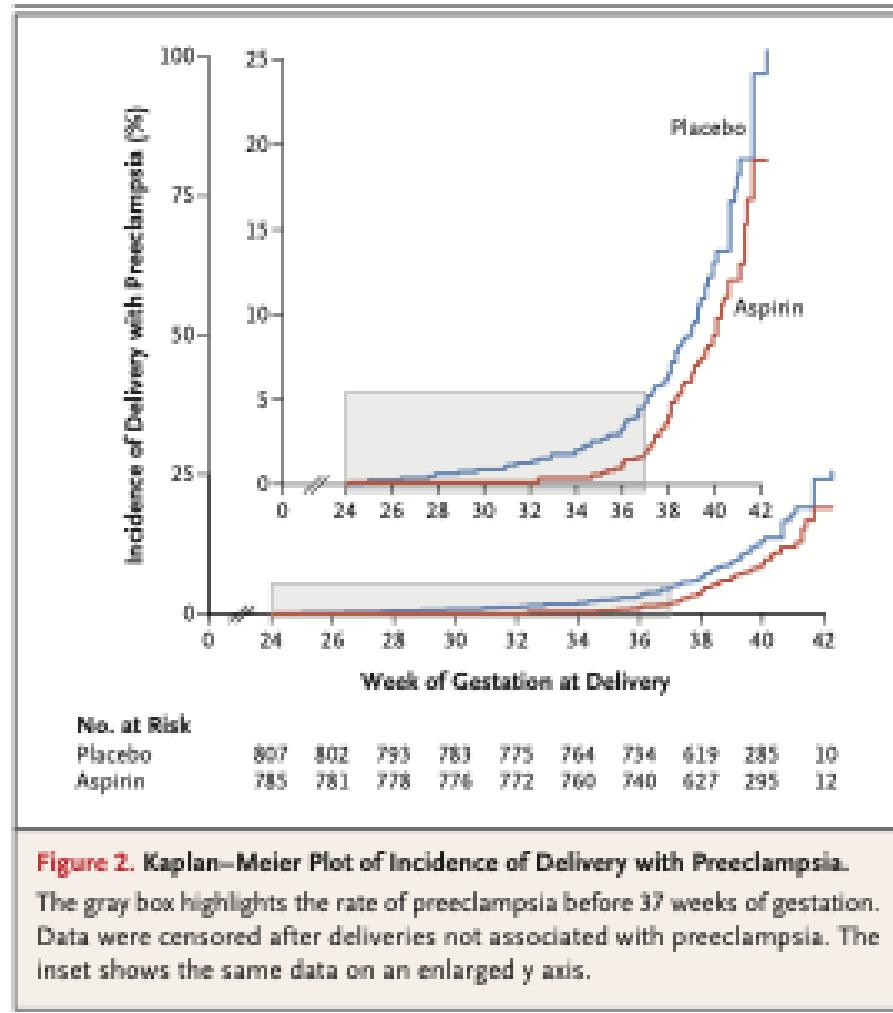


My family doc/obstetrician recommended it, why?



Multiple risk factors for the development of pre-term pre-eclampsia' – IBD is just one of them. Some provinces provide ultrasound screening at week 12 to guide decision re aspirin prophylaxis

Obstetric Care: Aspirin for the prevention of Preterm Preeclampsia by week 12-16



Aspirin 162mg (ie >150mg) in women at high risk of preterm pre-eclampsia

N=798 aspirin, n=822 placebo

OR=0.38 (95% CI, 0.20 to 0.74; P=0.004)

Aspirin was not associated with an increased risk of IBD activity

(Discuss DVT prophylaxis)

Sabine: Question 6

Do I need to have a Cesarean Delivery?

Consider:

- Gastroenterology indications
(active perianal disease, ileo-anal pouch surgery)
- Obstetric indications
- Personal preference!



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Sabine: Question 5

- Medications in Pregnancy:
- 11/39 GRADE statements
- 9/35 Consensus statements



Can I continue using my IBD medications through pregnancy?



Be more concerned about active disease than active medications!

Patient counselling: Your body needs to be focusing on baby not on your bowels!

The majority of IBD medications can and should be continued.

MILD – to – MODERATE

Aminosalicylates

5-ASA

Asacol
Mezavant
Pentasa
Salofalk
Mezera
Octasa

Sulfasalazine

Steroids

Prednisone

Budesonide CR

Budesonide MMX

Immunomodulator

Thiopurines

Azathioprine
(Imuran)
6-mercaptopurine
(Purinethol)

Methotrexate



MODERATE – to – SEVERE

Biologics/Advanced Therapies

Anti-TNF

Adalimumab
Golimumab
Infliximab

Anti-integrin

Vedolizumab (Entyvio)

Anti-IL-12/23

Ustekinumab

Anti-IL-23

Mirikizumab (Omvooh)

Rizankizumab (Skyrizi)

Guselkumab (Tremfya)

JAK inhibitor

Tofacitinib (Xeljanz)

Upadacitinib (Rinvoq)

S1P modulator

Ozanimod (Zeposia)

Etrasimod (Velsipity)

Table 9 IBD medications from preconception through pregnancy and lactation



Medication	Preconception	first trimester	second trimester	third trimester	Lactation
Aminosalicylates					
► Folic acid supplementation with sulfasalazine	✓	✓	✓	✓	✓
Thiopurine					
► Monitor metabolites, liver enzymes	✓	✓	✓	✓	✓
Methotrexate					
► Teratogen	✗	✗	✗	✗	✗
► Cessation 1–3 months prior to conception					
Corticosteroids					
► Minimise use	✓	✓	✓	✓	✓
► Employ steroid-sparing therapy					
Anti-TNF					
	✓	✓	✓	✓	✓
Anti-integrin					
	✓	✓	✓	✓	✓
Anti interleukin-12/23 or anti interleukin-23					
	✓	✓	✓	✓	✓
JAKis					
► Avoid	!	!	!	!	!
► Use only if no other viable option for maternal health					
S1P receptor modulator					
► Avoid	!	!	!	!	!
► Use only if no other viable option for maternal health					

Check mark = appropriate to use during pregnancy; ✗ = avoid during pregnancy; ! = avoid unless no viable option for maternal health.
 anti-TNF, anti-tumour necrosis factor; JAKi, Janus kinase inhibitor; S1P, sphingosine-1-phosphate.

Definitely not helped by headlines like this
 22 Sept 2025...

8:23 8 CBCNEWS

Health

Trump links autism and Tylenol during pregnancy, without conclusive evidence

U.S. president made announcement during an official appearance Monday

CBC News
 September 22, 2025



U.S. President Donald Trump at the White House on Monday.(Kevin Lamarque/Reuters)

U.S. President Donald Trump on Monday linked



Corticosteroids

- In women with IBD who are pregnant, we suggest use of **corticosteroid** therapy when clinically necessary with appropriate monitoring as data does not demonstrate an increased risk of **congenital malformations** or **infant infections**.

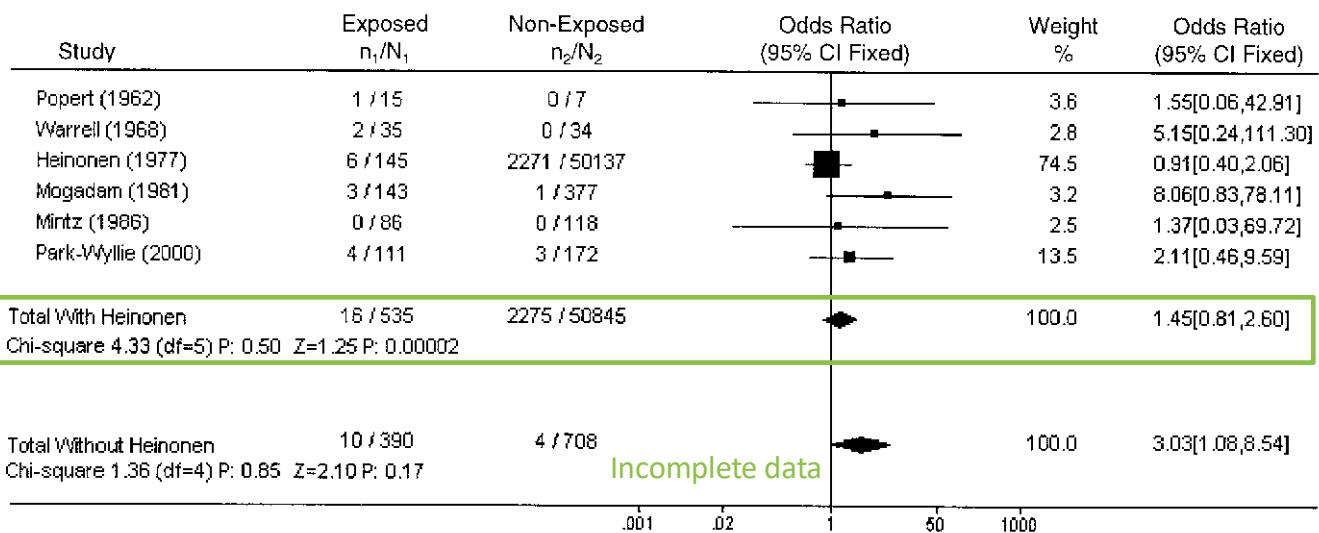


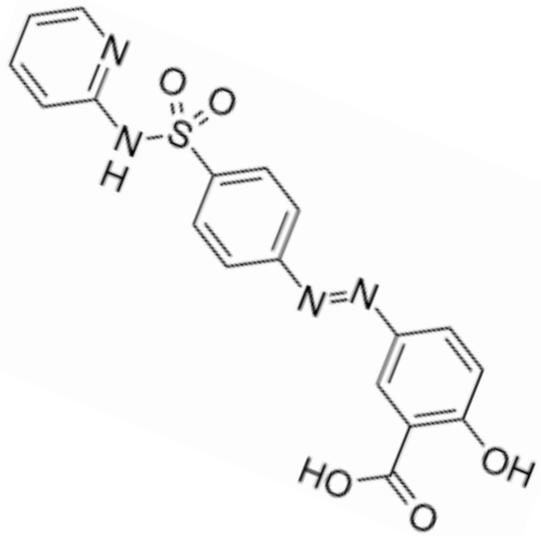
Fig. 1. Individual and cumulative Mantel-Haenszel summary odds ratio for corticosteroid-exposed cohort studies for major malformations with and without the Heinonen et al. ('77) analysis.

Congenital Malformations

Park-Wyllie 2000

5-ASA & Sulfasalazine

Practical Considerations



Medication
Non-adherence



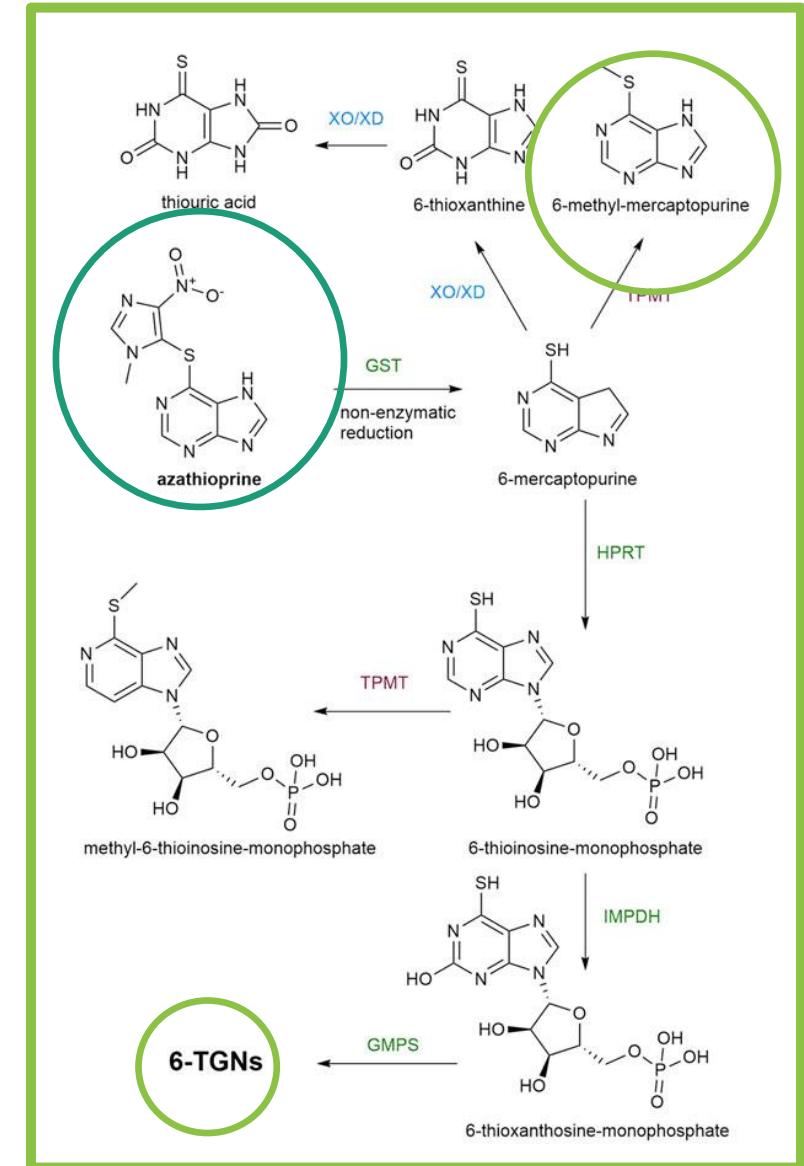
Thiopurines

No increased risk of congenital malformations or serious infections

- No increase in neonatal anemia
- Mono- vs. combination therapy
(Decision to use combination therapy is not random)

FDA, 29 April 2024 :
“Risk of intrahepatic cholestasis of pregnancy”

Intrahepatic cholestasis of pregnancy:
Incidence of 1.1% in the general population



Anti-TNF therapy (and mAbs) do not increase risk for Congenital Anomalies



Heterogeneity: $\tau^2 = 0.30$; $\chi^2 = 6.05$, $df = 3$ ($P = 0.11$); $I^2 = 50\%$

Test for overall effect: $Z = 1.74$ ($P = 0.08$)

No increased risk for congenital anomalies

Leung KK, et al. Inflamm Bowel Dis. 2021 Mar 15;27(4):550-562.

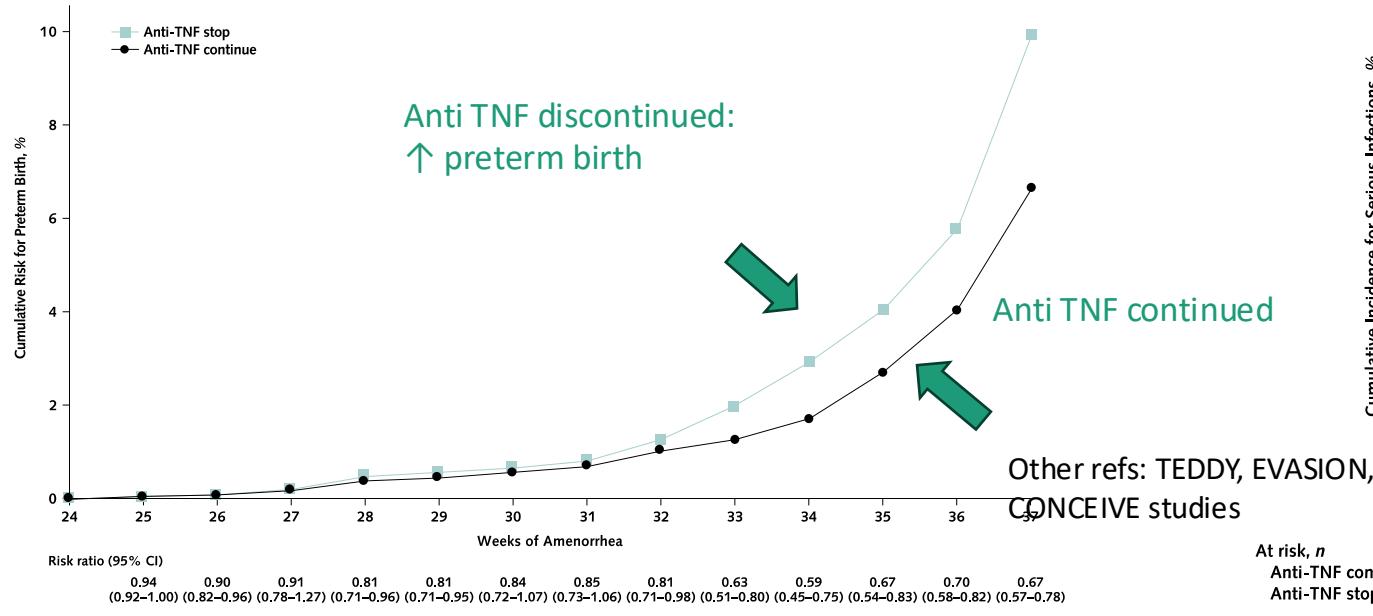
- Consider biologic plausibility
- No transplacental transfer of IgG1 in 1st trimester



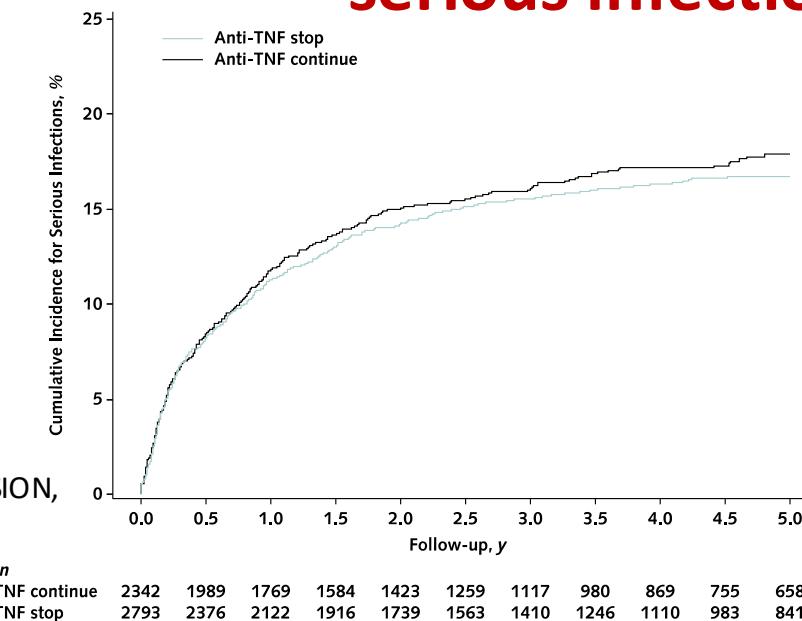
Benefits of Ongoing Anti-TNF Rx During Pregnancy (similar message for other mAbs)

vs. Risks of Rx discontinuation

Reduces preterm birth



No difference in serious infections



TNF = tumor necrosis factor.

Meyer A, Neumann A, Drouin J, et al. Ann Intern Med. 2022 Oct;175(10):1374-1382. Mahadevan U et al. Gastroenterology. 2021 Mar;160(4):1131-1139. Barenbrug L, et al. J Autoimmun. 2021 Aug;122:102676. Chaparro M, et al. Am J Gastroenterol. 2018 Mar;113(3):396-403. Luu M, Am J Gastroenterol. 2018 Nov;113(11):1669-1677. Moens A, et al. Aliment Pharmacol Ther. 2020 Jan;51(1):129-138. Meyer A, et al. Clin Gastroenterol Hepatol. 2024 Jan 8:S1542-3565(24)00010-7. PMID: 38199301. Prentice R, et al. Clin Gastroenterol Hepatol. 2024 Mar 15:S1542-3565(24)00252-0. Julsgaard M, et al. Clin Gastroenterol Hepatol. 2024 Jan 24:S1542-3565(24)00083-1. Wils P, et al. Aliment Pharmacol Ther. 2021 Feb;53(4):460-470. Chugh R et al. Am J Gastroenterol. 2024 Mar 1;119(3):468-476. Nielsen OH, et al. Clin Gastroenterol Hepatol. 2022 Jan;20(1):74-87.e3. Julsgaard M, et al. Aliment Pharmacol Ther. 2021 Nov;54(10):1320-1329.

Oral Small Molecules



- Teratogenicity in animal studies
- Shared decision making is imperative.
- If electively switching therapies, incorporate time to transition.
- If there is no other effective alternative therapy to maintain maternal health, continue therapy, given totality of data supports stringent disease control.
- Ongoing data collection and pharmacovigilance



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Vaccines

Sabine: Question 7

Can I continue using my IBD medications while breastfeeding?



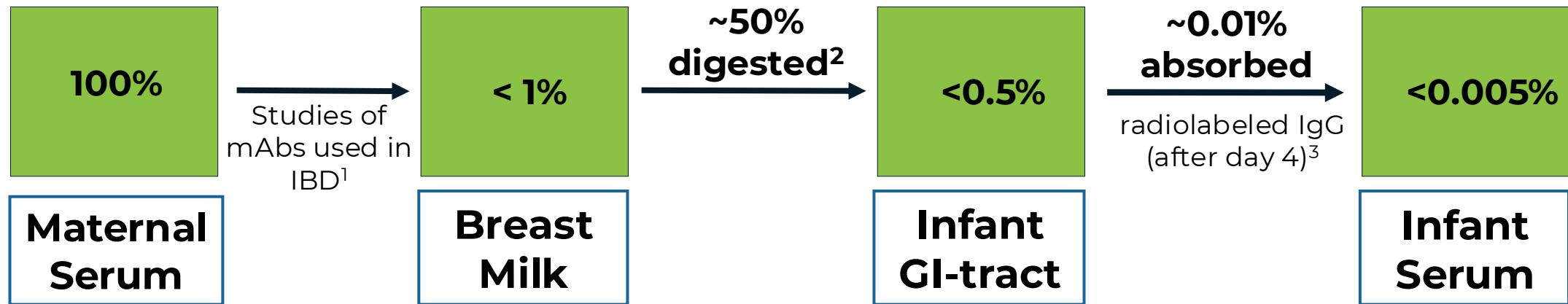
General advice:

Breastfeeding does not increase the risk of a disease flare

There is no increased risk of infection in babies who are breastfed while moms are on biologics for IBD

Monoclonal antibodies (mAbs) & breastfeeding

The estimated infant mAb exposure via breastmilk (Relative Infant Dose)



- Relative Infant Dose of $\leq 10\%$ is considered safe
- **Avoid breastfeeding if on oral small molecules**



LactRx 12+
Organization of Teratology Information Specialists
Designed for iPad
★★★★★ 5.0 • 2 Ratings
Free

Slide courtesy of Dr M. Julsgaard



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Vaccines

Sabine: Question 8

Tell me about vaccines for myself and my infant!



Which vaccines can or can't I receive?

Avoid live vaccines in pregnant women
(*regardless of medication exposure*)

Advise the dTAP, RSV vaccine, influenza
+/- COVID, pneumonia vaccines

Which vaccines can or can't my child receive?

Avoid the live BCG vaccine (only used in certain areas in Canada to prevent tuberculosis)

All other standard childhood vaccines can be given

Can receive the live oral rotavirus vaccine, and the early MMR vaccine (speak to your public health clinic)



Summary: Healthy mum = healthy baby

- Be more concerned about **active disease** than active medications!
- Risk of disease flare generally outweighs any potential risks with treatment.
- Continue IBD medications preconception, during pregnancy and while breastfeeding!
- Goal is for IBD to be in **remission** before, during, and after pregnancy!
- Protect your baby by vaccinating yourself and your baby!
- Check out this website <https://pianostudy.org>



Summary: Maternal considerations

Medications
Counseling
Aspirin
Mode of delivery

Key Points:

Reduced fertility with active disease and IFNA

No risk of flares with embryo retrieval

Increased risk of pre-term delivery

Increased risk of spontaneous abortion with active disease

Increased risk of VTE



Clinical Guidance:

- Continue all biologics and thiopurines throughout pregnancy and lactation
- Avoid small molecules during pregnancy and lactation
- Provide preconception counseling to improve outcomes
- Provide low dose aspirin to reduce pre-term pre-eclampsia
- Perform a caesarean section for delivery of active perianal fistula, rectovaginal fistula, IFNA

Recommendation

Consensus statement

Recommendation

Suggestion

Recommendation for active perianal disease

Summary: Infant considerations

Vaccines

Key Points:

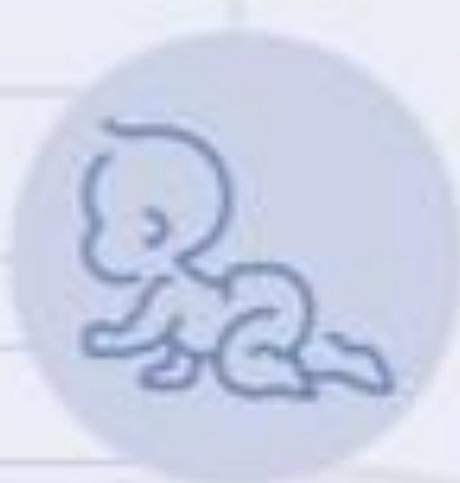
Increased risk of IBD if first-degree relative with IBD

Increased risk of low birth weight with active maternal IBD

Increased risk of NICU

Increased risk of SGA with active maternal IBD

No increased risk of infant infections, malignancy, or developmental delay with biologic exposure



Clinical Guidance:

- Inactive vaccines should be given on schedule regardless of medication exposure
- Live vaccines should be given on schedule EXCEPT BCG, which can be given after six months in infants exposed to biologics in utero

Recommendation

Recommendation against BCG vaccine

Suggestion re rotavirus vaccine



Online resources
& videos

Global Consensus on Management of Pregnancy in Inflammatory Bowel Disease



<https://pianostudy.org/>

Funded by the Leona M. and
Harry B. Helmsley Charitable
Trust



Key references

- Mahadevan U, Seow CH, Barnes EL, Chaparro M, Flanagan E, Friedman S, Julsgaard M, Kane S, Ng S, Torres J, Watermeyer G, Yamamoto-Furusho J, Robinson C, Fisher S, Anderson P, Gearry R, Duricova D, Dubinsky M, Long M; Global Consensus Group for Pregnancy in IBD. **Global consensus statement on the management of pregnancy in inflammatory bowel disease.** Gut. 2025 Aug 28:gutjnl-2025-336402. doi: 10.1136/gutjnl-2025-336402. Epub ahead of print. PMID: 40876906.
- The PIANO website
- <https://pianostudy.org/> (landing page)
- https://pianostudy.org/GCC_video/MainMenu/story.html (Patient videos)
- https://pianostudy.org/conference_videos.php (Provider videos)



Resources

- Global Consensus on Management of Pregnancy in IBD
 - <https://pianostudy.org/>
- CCC online information on fertility in IBD
<https://crohnsandcolitis.ca/support-for-you/gutsy-learning-series/Past-Gutsy-Learning-Presentations/Gutsy-Learning-Events/fertility-pregnancy-in-ibd>
- IBD Parenthood Project
 - <https://myibdlife.gastro.org/parenthood-project/>
- CCC Support and Services
 - <https://crohnsandcolitis.ca/support-for-you/Gutsy-support>
 - Crohn's and Colitis Connect, Peer Connect Events, local community chapters

