
JANUARY 30 – FEBRUARY 1, 2026
2026
ACG'S IBD SCHOOL &
ACG BOARD OF GOVERNORS /
ASGE BEST PRACTICES COURSE
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2025
ACG'S HEPATOLOGY
SCHOOL & SOUTHERN
REGIONAL POSTGRADUATE COURSE
DECEMBER 5-7, 2025 | RENAISSANCE HOTEL, NASHVILLE, TN
Register online: meetings.gi.org
ACG

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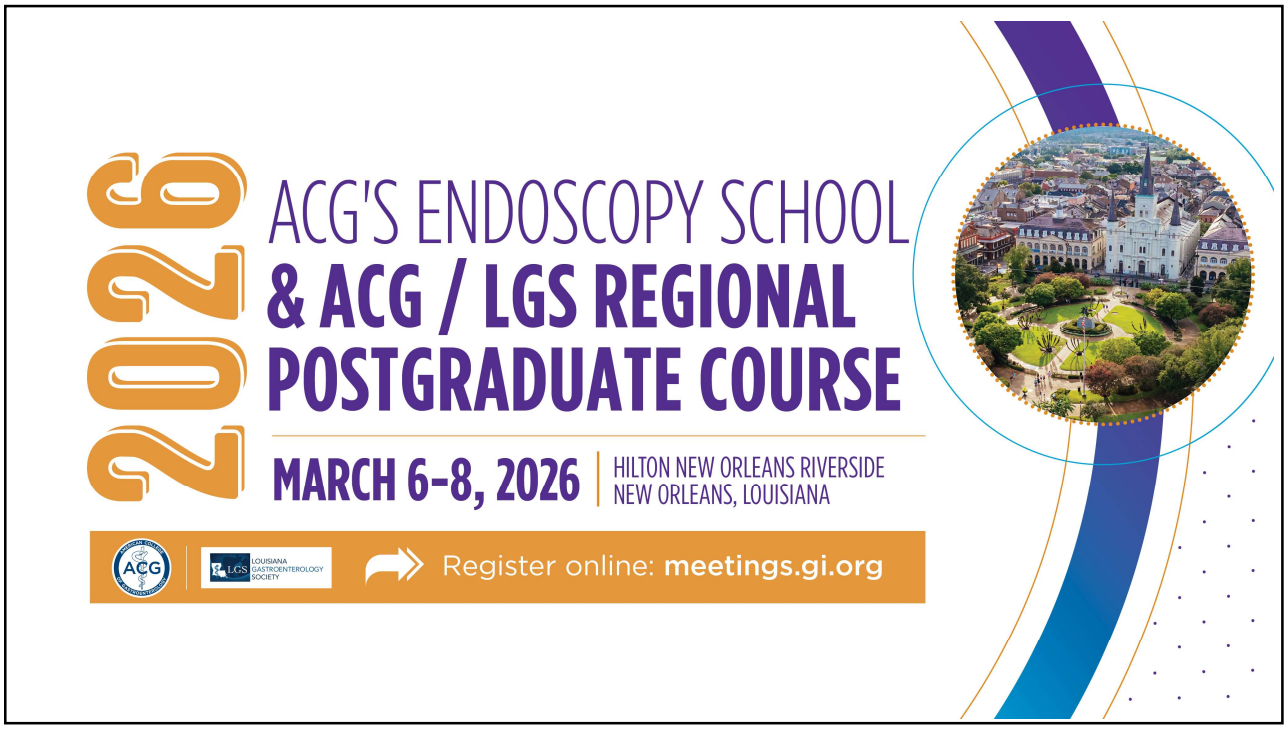
2026
ACG'S ENDOSCOPY SCHOOL
& ACG / LGS REGIONAL
POSTGRADUATE COURSE
MARCH 6-8, 2026
HILTON NEW ORLEANS RIVERSIDE
NEW ORLEANS, LOUISIANA
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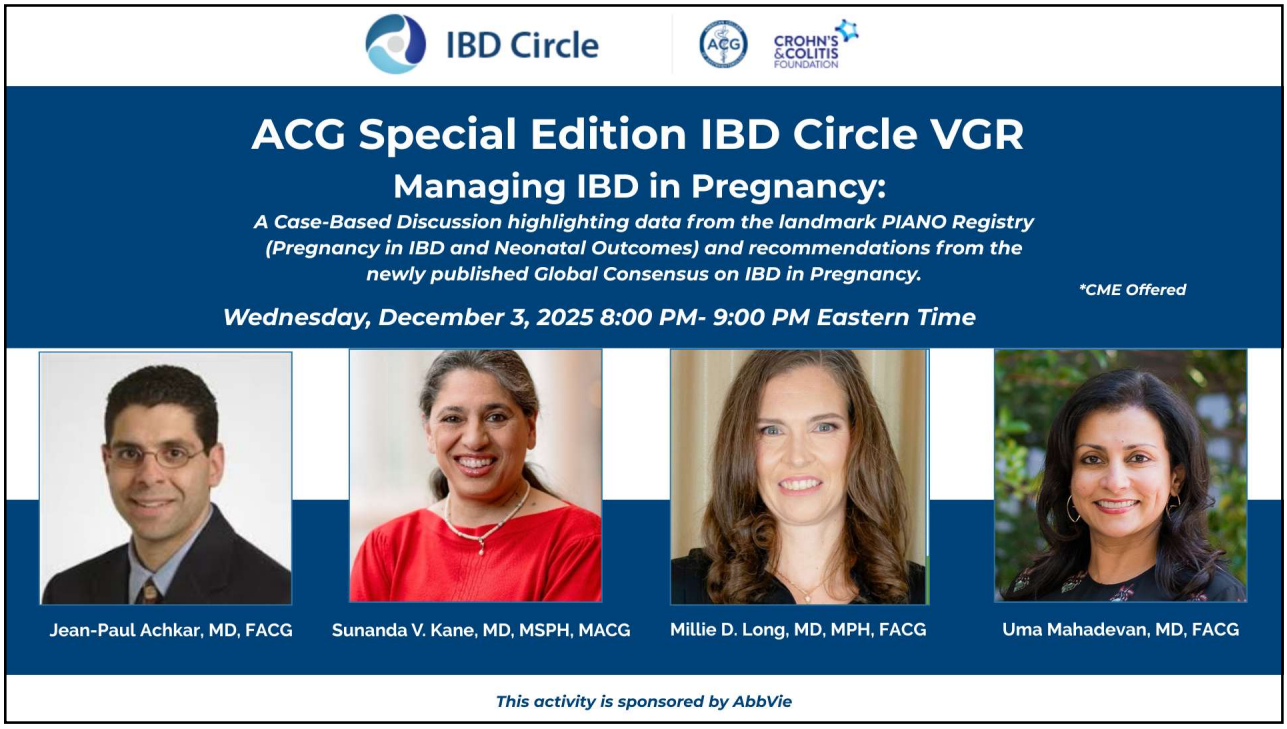
IBD Circle
CROHN'S & COLITIS FOUNDATION
ACG Special Edition IBD Circle VGR
Managing IBD in Pregnancy:
A Case-Based Discussion highlighting data from the landmark PIANO Registry (Pregnancy in IBD and Neonatal Outcomes) and recommendations from the newly published Global Consensus on IBD in Pregnancy.
*CME Offered
Wednesday, December 3, 2025 8:00 PM- 9:00 PM Eastern Time
Jean-Paul Achkar, MD, FACG
Sunanda V. Kane, MD, MSPH, MACG
Millie D. Long, MD, MPH, FACG
Uma Mahadevan, MD, FACG
This activity is sponsored by AbbVie

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Virtual Grand Rounds

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# Participating in the Webinar

All attendees will be muted and will remain in "Listen Only Mode"

Type your questions here so that the moderator can see them.
Not all questions will be answered but we will get to as many as possible.

A handout with the slides and room to take notes can be downloaded from your control panel.


Moderators:
Sunanda V. Kane, MD, MSPH, MACG
and
Jean-Paul Achkar, MD, FACG

Exit

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# ACG Virtual Grand Rounds

## Join us for upcoming Virtual Grand Rounds!


**Week 49 – Thursday, December 4, 2025**
ACG's 2025 Practice Management Summit – Course Highlights
Faculty: Andy Tau, MD, and Kunjali Padhya, MD, FACG
At Noon and 8pm Eastern


**Week 50 – Thursday, December 14, 2025**
ACG Guideline: Diagnosis and Management of Gastric Premalignant Conditions
Faculty: Douglas R. Morgan, MD, MPH, FACG
Moderator: Juan E. Corral, MD, MPH
At Noon and 8pm Eastern

Visit **gi.org/ACGVGR** to Register

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ACG Virtual Grand Rounds

# Disclosures

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**Millie D. Long, MD, MPH, FACG:**
AbbVie: Advisory Board, Consultant; BMS: Consultant; Eli Lily: Consultant, Research Grant; Intercept: Consultant; Janssen: Consultant; Pfizer: Advisory Board, Consultant, Research Grant; Prometheus: Consultant; Roivant: Consultant; Takeda: Advisory Board, Consultant, Research Grant; Target RWE: Consultant;

**Uma Mahadevan, MD, FACG:**
Abbvie: Consultant; Abivax: Consultant; Bristol Myers Squibb: Consultant; Celltrion: Consultant; Disc: Consultant; Enveda: Consultant; Genentech: Consultant; Gilead: Consultant; Janssen: Consultant; Leona M and Harry B Helmsley Trust: Grant/Research Support; Lilly: Consultant; Merck/Prometheus Biosciences: DSMB; Pfizer: Consultant; Rani Therapeutics: Scientific Advisory Board; Takeda: Consultant; Trex: Consultant; UpToDate: Royalties.

**Sunanda V. Kane, MD, MSPH, MACG:**
Boerhinger Ingelheim: Consultant; Bristol Meyers Squibb: Advisory Committee/Board Member; Fresenius Kabi: Advisory Committee/Board Member; Gilead: Advisory Committee/Board Member; Janssen: Consultant; Lilly: Advisory Committee/Board Member; Pfizer: Advisory Committee/Board Member; Takeda: Advisory Committee/Board Member; UptoDate: Independent Contractor

**Jean-Paul Achkar, MD, FACG:**
No relevant financial relationships with ineligible companies.

**All of the relevant financial relationships listed for these individuals have been mitigated*

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# Managing IBD in Pregnancy: A Case-Based Discussion

Jean-Paul Achkar, MD, FACG

Sunanda V. Kane, MD, MSPH, MACG

Millie D. Long, MD, MPH, FACG

Uma Mahadevan, MD, FACG

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## Case 1

- 35 year old with recently diagnosed Crohn's- has 15 cm of ileal inflammatory disease and mild symptoms which has responded to budesonide. Has not been on any other therapy.
- Initiation of maintenance therapy has been discussed but she would like to pursue pregnancy ASAP and asks:
  - Is it OK for me to try to get pregnant now?
  - Are there any particular medications that might be better in my situation?

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# Case 2

- 26 yr old with Crohns ileocolitis in remission on q 6 week Ustekinumab biosimilar
- She has recently gotten married and wants to start a family
- What are the important concepts and questions you want to discuss with her?

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# Case 3

- 30 yr old with history of Crohns ileocolitis and perianal disease, on infliximab infusions 5 mg/kg every 7-8 weeks calls to say she is now 10 weeks pregnant
- She has concerns as this was unexpected and has been told she should not be pregnant and certainly needs to stop her infusions which have kept her perianal disease well controlled
- What do you tell her?

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# Case 4

- 27 year old with pan ulcerative colitis, is 20 weeks pregnant and calls to say that she is having diarrhea and some rectal bleeding.
- She takes only mesalamine for her disease, she has been afraid of anything more aggressive in the past but is motivated to have a healthy baby
- What do you do now?

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# Case 5

- 27 yo female with UC that has been difficult to manage- prior treatment has included infliximab, vedolizumab and Ustekinumab
- She is currently on Upadacitinib and is feeling well. Recent fecal calprotectin was 40.
- She would like to pursue pregnancy but has read about concerns with Upadacitinib.

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CROHN'S & COLITIS FOUNDATION
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Managing IBD in Pregnancy: A Case-Based Discussion
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Pregnancy in IBD And Neonatal Outcomes
Global Consensus for the Management of IBD in Pregnancy
Uma Mahadevan MD
Lynne and Marc Benioff Professor of Gastroenterology
Director, Colitis and Crohn's Disease Center
University of California, San Francisco
Funded by the Leona M. and Harry B. Helmsley Charitable Trust

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There are **limited human data** on the safety of new therapies during pregnancy.

For IBD patients, **stopping medication increases disease activity**, leading to higher risks of maternal and fetal complications.[1]

*Mahadevan U, Long MD, Kane SV, et al. Pregnancy and Neonatal Outcomes After Fetal Exposure to Biologics and Thiopurines Among Women With IBD. Gastroenterology. Mar 2021;160(4):1131-1139. doi:10.1053/j.gastro.2020.11.038*



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# Background: Global Consensus Group

Universal guidelines with consistent interpretation of data and sensitivity to regional differences

Healthcare professionals and patient advocates from around the globe

Follows GRADE and RAND methodologies

**Funding**: Helmsley Charitable Trust



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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
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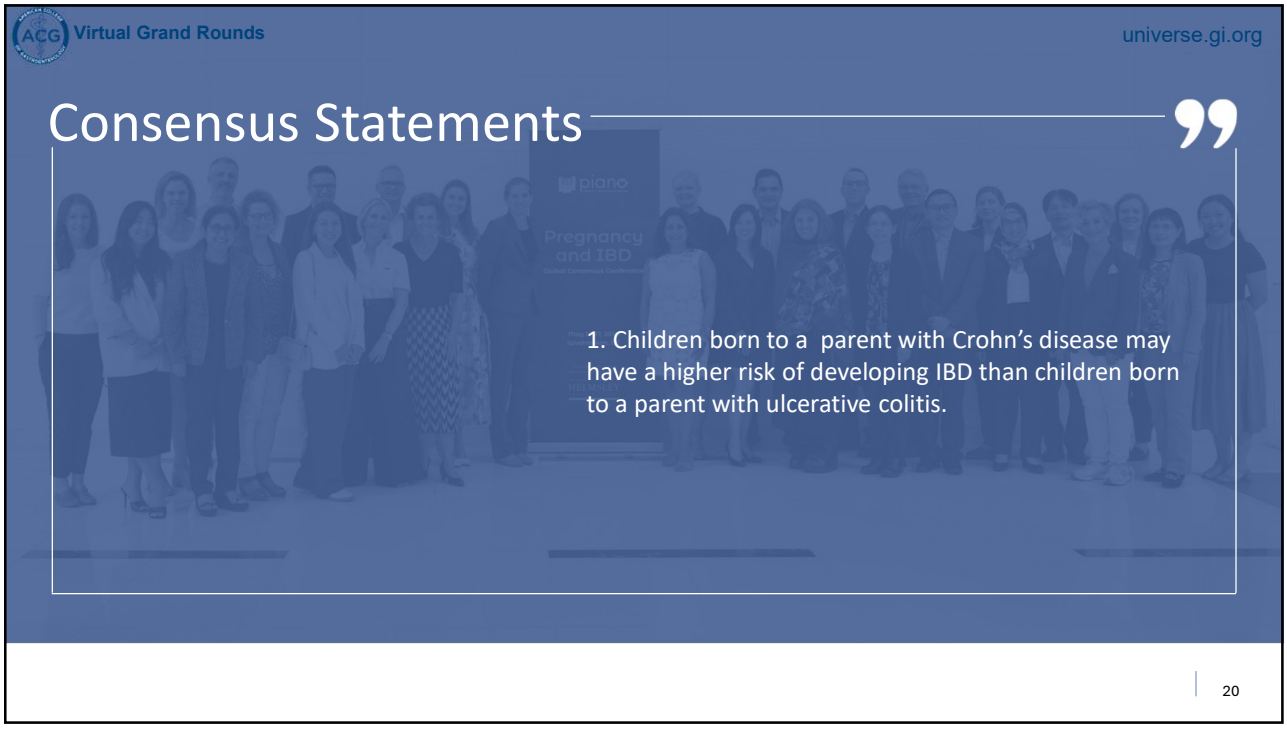
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Consensus Statements
1. Children born to a parent with Crohn's disease may have a higher risk of developing IBD than children born to a parent with ulcerative colitis.
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# Does Maternal Inflammation in Pregnancy Affect Placental Function in Women with IBD?

Abnormal placentation is linked to major obstetrical complications.

Maternal inflammation affects placental function and raises the risk of miscarriage, preterm birth, and small-for-gestational-age infants.

It is likely that IBD negatively affects development or function of the placenta.

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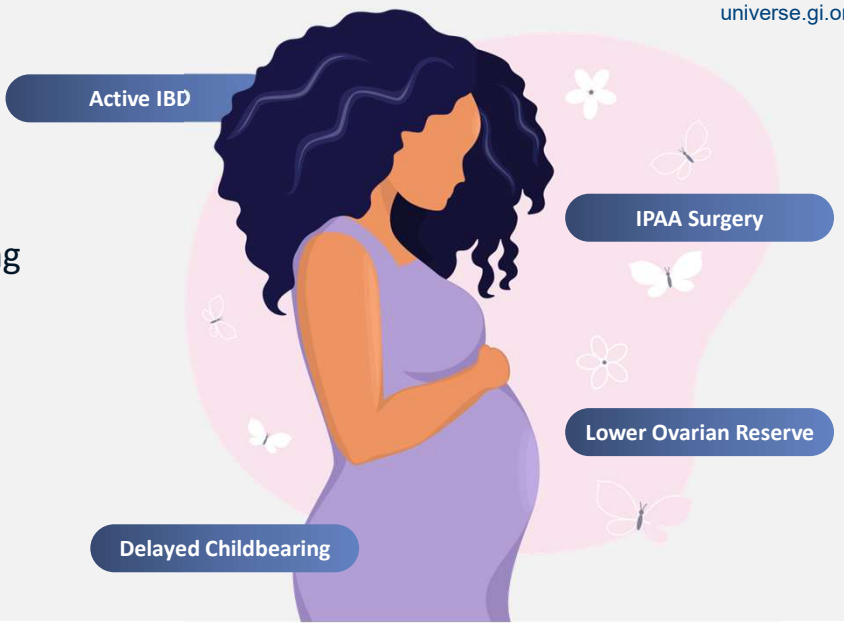
Key factors contributing to reduced fertility in women with IBD

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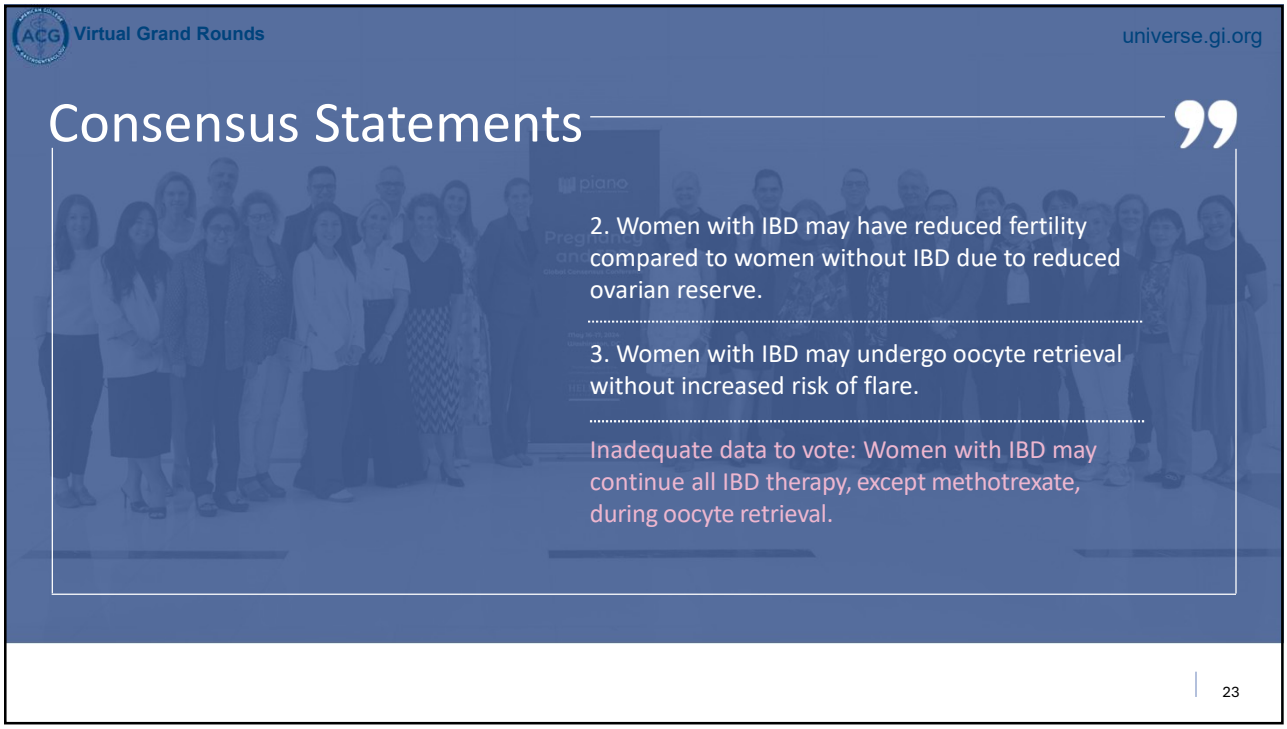
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Consensus Statements
2. Women with IBD may have reduced fertility compared to women without IBD due to reduced ovarian reserve.
3. Women with IBD may undergo oocyte retrieval without increased risk of flare.
Inadequate data to vote: Women with IBD may continue all IBD therapy, except methotrexate, during oocyte retrieval.
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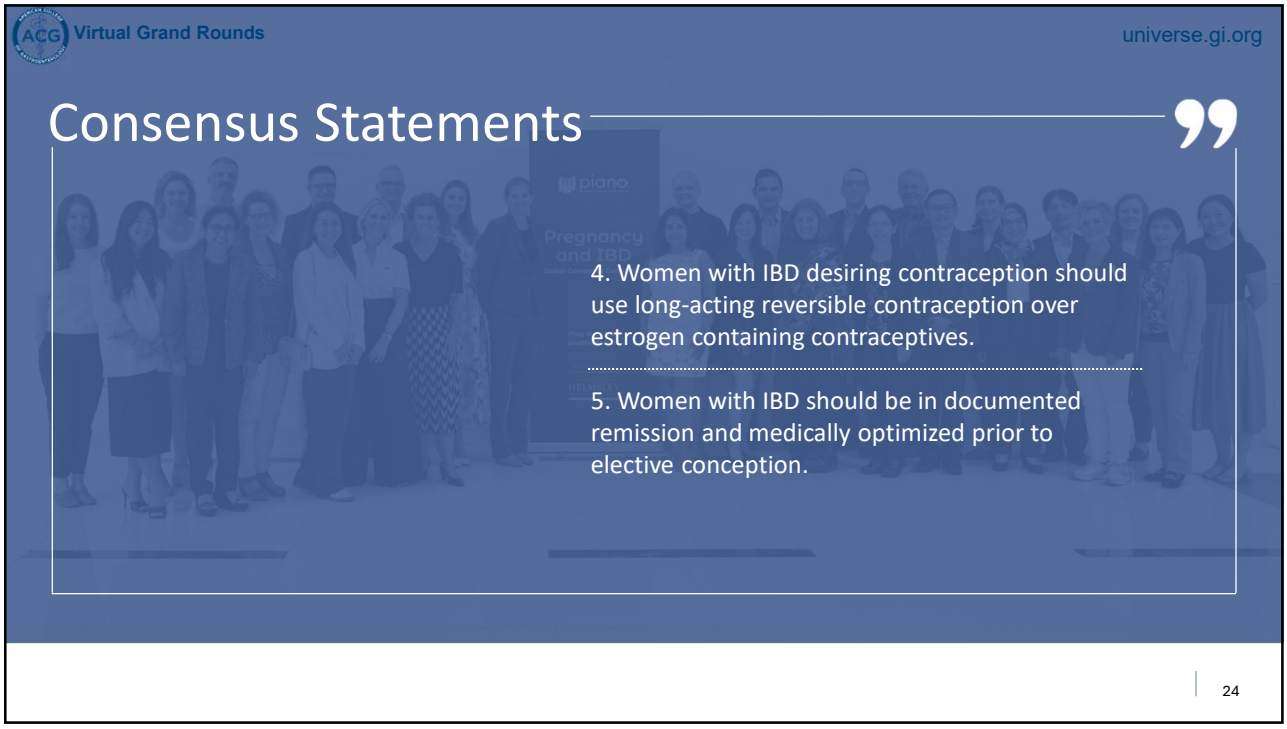
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Consensus Statements
4. Women with IBD desiring contraception should use long-acting reversible contraception over estrogen containing contraceptives.
5. Women with IBD should be in documented remission and medically optimized prior to elective conception.
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# Contraception Options

1

**Barrier methods:** Least effective but protects against STIs (sexually transmitted infections).

2

**Oral contraceptives:**

- **Combined (estrogen + progesterone)**: Increased risk of VTE (venous thromboembolism), human error, and absorption issues.
- **Progesterone-only**: No increased VTE risk but still affected by human error and absorption.

3

**Long-Acting Reversible Contraception (LARCs):** Most effective, no estrogen, no increased risk of VTE.

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# Pre-conception counseling and recommendations

- Cessation of substances
- Stop teratogenic medications
- Achieve disease remission (3-6 months prior to conception)
- Nutritional assessment and prenatal vitamins
- Weight management
- Vaccinations
- Preconception Maternal Fetal Medicine
- IBD treatment plan
- Fertility Specialist
- Physical activity

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# Consensus Statements

6. Endoscopy during pregnancy among women with IBD is low risk but should only be performed if it may change management.

7. If cross-sectional imaging is needed during pregnancy, intestinal ultrasound and magnetic resonance imaging without gadolinium are preferred to computed tomography.

8. Fecal calprotectin is useful for monitoring disease activity in pregnant women with IBD.

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| | Assessment of Disease Activity | Comment |
|---|---|---|
| Laboratory Tests | Serum Inflammatory markers C Reactive Protein, Sedimentation Rate | Can be elevated from pregnancy |
| | Fecal Calprotectin | Effective for monitoring in pregnancy |
| | Serum Drug Concentrations | May vary in pregnancy |
| Cross-sectional imaging | Intestinal Ultrasound | Low risk: Accurate in trimester 1,2 but technically challenging in trimester 3 |
| | Computed Tomography | Relatively safe. The cumulative radiation exposure of a single CT scan (~ 50 mGy) is below the level of concern |
| | Magnetic Resonance Imaging | Low risk. Avoid gadolinium (potential teratogen) during first trimester |
| Procedures | Endoscopy | Low risk: Can be performed if indicated and will change management |
| | Surgery | Perform if indicated regardless of trimester. Should be done at expert centers Indications: acute refractory colitis, perforation, abscess, refractory hemorrhage, bowel obstruction |

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# Consensus Statements

9. Pregnancies for women with IBD should be considered as high risk for complications.

10. Women with current or past history of rectovaginal fistulas should deliver by cesarean delivery.

11. Women with IBD should be assessed early in pregnancy or preconception for nutritional status, weight gain and micronutrient deficiency.

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# Pre-eclampsia is one of the leading causes of maternal and perinatal morbidity and mortality.

Women with IBD may have an increased risk of preterm pre-eclampsia.

Low dose aspirin may prevent pre-eclampsia in at-risk patients.

*Boyd et al, PLOS One, 2015*
*Tarar et al, Int J Colorectal Dis, 2022*
*Rolnik et al NEJM, 2017, Duley et al, Cochrane Database Syst Rev, 2019, Boyd et al PLOS One, 2015, Prakash et al Inflamm Bowel Dis, 2023, Stephansson et al, Clin Gastroenterolo Hepatol, 2010, Tandon et al Aliment Pharmacol Ther, 2020, Patel et al, Inflamm Bowel Dis, 2021, DeBolt et al, Dig Dis Sci. 2024, Yu et al, ACG ASM, 2023.*

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# Women with IBD may have an increased risk of preterm **pre-eclampsia**

Pre-eclampsia (PE) typically affects 2%–5% of pregnant women and is one of the leading causes of maternal and perinatal morbidity and mortality

**Danish National Birth Cohort (>85,000 women) 1996-2002**

- CD 278, UC 388
- Overall preeclampsia rate not elevated HR 1.21 [0.76-1.95]
- Severe preeclampsia elevated in women with IBD **HR 2.24** [1.05-4.8]

**National inpatient survey (US 2016-2018)**

- 8,079,828 pregnancies (CD 8,475, UC 5,665)
- CD preeclampsia / eclampsia **aOR 1.52 [1.15-2.02]**
- UC preeclampsia / eclampsia aOR 1.05 [0.68-1.64]

Boyd et al, PLOS One, 2015
Tarar et al, Int J Colorectal Dis, 2022

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# What does "high risk pregnancy" mean in different health care environments?

- Specialist IBD pregnancy clinics
- Maternal-Fetal medicine clinics
- Education for midwives concerning risks and what to look for

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# Evolving guidelines emphasize controlling disease activity for both maternal and fetal health.

Yet taking IBD medications have limited safety data for mother and child.

Deescalating therapy or stopping biologics before the third trimester led to more disease flares.

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# Medications in Pregnancy

| | |
|---|---|
| 1 | Pregnant women are not included in IBD clinical trials |
| 2 | Unmeasured confounding is innate to uncontrolled studies |
| 3 | Existing disease activity impacts decision to continue or discontinue therapy – the decision is not random! |
| 4 | Low event rates for adverse events |
| 5 | Small cohort sizes |
| 6 | Congenital malformations occur in 5-8% of all births |
| 7 | Preterm birth (9.9% of births) predisposes to neonatal infection |

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# Consensus Statements


12. Women with IBD who are pregnant and with active disease should start or optimize the same appropriate therapies as in nonpregnant patients, except for thiopurines, methotrexate, janus kinase inhibitors and sphingosine 1 receptor modulators.

13. In women with IBD who continue thiopurines during pregnancy, precaution should be taken for intrahepatic cholestasis by measurement of liver enzymes, metabolite levels and consideration of split dosing.

14. Women with IBD who are pregnant and have infections, fistula or pouchitis that require antibiotics may take an appropriate course of a low-risk antibiotic.

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# Consensus Statements


15. Women with IBD may initiate or continue calcineurin inhibitors (cyclosporine and tacrolimus) during pregnancy with careful monitoring if there are no viable alternate treatment options available.

16. Women with IBD who are pregnant or attempting conception should continue biosimilars to existing biologics.

17. Women with IBD who are pregnant or attempting conception should continue anti-interleukin-23 therapy throughout pregnancy (mirikizumab, risankizumb, guselkumab).

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# Consensus Statements


Women with IBD should discontinue:

18. Ozanimod ( at least 3 months)
19. Etrasimod (at least 1-2 weeks)
20. Tofacitinib (at least 4 weeks)
21. Upadacitinib (at least 4 weeks)
22. Filgotinib (at least 4 weeks)

...prior to conception unless there is no effective alternative therapy to maintain maternal health

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# Consensus Statement 13: Thiopurines

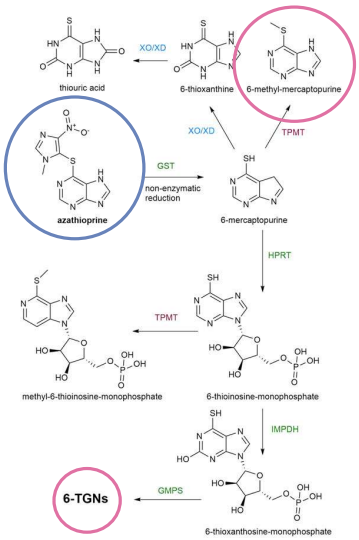
*Recent FDA announcement, 29 April 2024*
**"Rare risk of intrahepatic cholestasis of pregnancy"**
Incidence of 1.1% in the general population

IBD data: Prentice 2024, Selinger 2023, Kanis 2021

## Practical considerations

Split dosing of thiopurine; Allopurinol co-therapy has limited safety data; Use of thioguanine; or Biologic monotherapy

Shunting to the 6-MMP pathway




MMP:TGN increases over pregnancy
Jharap 2014, Flanagan 2021

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# IBD Medications from Pre-conception through Pregnancy

| Medication | Pre-conception | 1st Trimester | 2nd Trimester | 3rd Trimester |
|---|---|---|---|---|
| **Aminosalicylates**<br>• Folic acid supplementation with Sulfasalazine | ✓ | ✓ | ✓ | ✓ |
| **Thiopurine** | ✓ | ✓ | ✓ | ✓ |
| **Methotrexate**<br>• Teratogen:<br>• Cessation 1-3 months prior to conception | × | × | × | × |
| **Corticosteroids**<br>• Minimize use<br>• Employ steroid sparing therapy | ✓ | ✓ | ✓ | ✓ |



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# IBD Medications from Pre-conception through Pregnancy and Lactation

| Medication | Pre-conception | 1st Trimester | 2nd Trimester | 3rd Trimester |
|---|---|---|---|---|
| **Anti-Tumor Necrosis** | ✓ | ✓ | ✓ | ✓ |
| **Anti-Integrin** | ✓ | ✓ | ✓ | ✓ |
| **Anti IL-12/23 or Anti IL-23** | ✓ | ✓ | ✓ | ✓ |
| **JAK Inhibitors**<br>• Avoid<br>• Use only if no other viable option for maternal health | ! | ! | ! | ! |



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# Pregnancies in the tofacitinib overall and UC clinical programs

In the **overall global tofacitinib clinical program**,[a] a total of 184 pregnancies were identified:

- Maternal exposure: 85
- Paternal exposure: 99

There were **40 pregnancies** in the tofacitinib **UC clinical program:**

## Maternal exposure

16 cases of maternal exposure

Median age

29.5 years

(range 24–41)

Number of days between the last menstrual period and last tofacitinib dose:

64 and 106 days

Tofacitinib 5 mg BID (2 patients)

6–69 days

Tofacitinib 10 mg BID (12 patients)

## Paternal exposure

24 cases of paternal exposure

(included 2 cases from the same patient)

[a]Includes RA, PsA, AS, JIA, UC and PsO clinical programs

AS, ankylosing spondylitis; BID, twice daily; JIA, juvenile idiopathic arthritis; PsA, psoriatic arthritis; PsO, psoriasis; RA, rheumatoid arthritis; UC, ulcerative colitis

DDW 2024: Mahadevan

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- 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

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# Monoclonal antibodies (mAbs) & breastfeeding

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


**For most drugs, a weight-adjusted percentage of the maternal dosage (Relative Infant Dose) of ≤ 10% is considered relatively safe.[1,2]**

In infants exposed *in utero* to *infliximab, adalimumab, vedolizumab* or *ustekinumab*, maternal breastfeeding did **not** affect neonatal clearance of the drug.[4-6]

1.LaHue SC et al. Neurol Neuroimmunol Neuroinflamm 2020 , 2.Sah BNP et al. Front Nutr. 2020,
3.Krysko KM et al. Lancet Neurol 2023, 4.Julsgaard M et al. Gastroenterology 2016,
5.Julsgaard M et al. AP&T 2021, 6.Julsgaard M et al. Clin Gas Hep 2024.



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# Consensus Statements


**Mothers with IBD currently on:**

23. 5-aminosalicylates/sulfasalazine
24. Thiopurines
25. Corticosteroids
26. Anti-tumor necrosis factor agents (Infliximab, adalimumab, golimumab, certolizumab)
27. Anti-integrins (vedolizumab, natalizumab)
28. Anti-interleukin-12/23 and anti-interluekin-23 (ustekinumab, risankizumab, mirikizumab, guselkumab).
29. Biosimilars

**...may breastfeed**



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# Consensus Statements

30. Mothers with IBD currently on sphingosine 1 receptor modulators (etrasimod or ozanimod) should not breastfeed .

31. Mothers with IBD currently on janus kinase inhibitors (tofacitinib, upadacitinib, filgotinib) should not breastfeed.

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## Safe to Breastfeed On

- 5-ASAs
- Sulfasalazine
- Thiopurines
- Corticosteroids
- Anti-TNFs
- Anti-integrins
- Anti-IL-23s
- Biosimilars

## Avoid Breastfeeding On

- S1Ps
- JAK inhibitors
- Methotrexate

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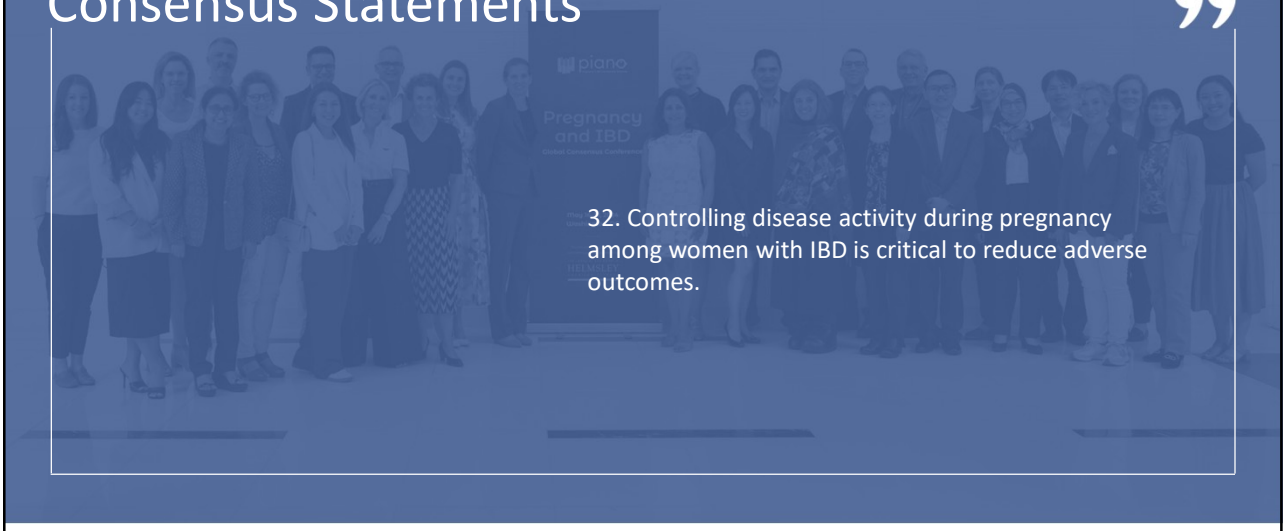
# Consensus Statements




32. Controlling disease activity during pregnancy among women with IBD is critical to reduce adverse outcomes.

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# Pregnancy and Neonatal Adverse Events

Increased risk of low birth weight with active maternal IBD

Increased risk of Neonatal intensive care unit

Increased risk of small for gestational age with active maternal IBD

Increased risk of pre-term delivery

Increased risk of spontaneous abortion with active disease

Increased risk of venous thromboembolism

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# Consensus Statements

33. Inactive vaccines should be given on schedule to infants of women with IBD regardless of in utero IBD medication exposure.

34. Children exposed to janus kinase inhibitors or sphingosine 1 receptor modulators in utero may receive live vaccines after one month of age.

35. Live vaccines can be given to infants of mothers breastfeeding while on biologics.

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# Live attenuated Rotavirus vaccine

**Infants exposed *in utero* to anti-TNF**

309 infants → **live attenuated Rotavirus vaccine** → **no serious adverse events**.[1-5]

Systematic review and meta-analysis: **low risk of minor adverse event** (fever/diarrhea) (6/46, 15%).[3]

**Canadian Immunization Research Network:**[4]

- IFX (67/191 [35%]), ADA (49 [26%]), UST (18 [9%]), VDZ (17 [9%])

191 exposed
178 (93%) in T3

187 recommend to vax

168 initiated rotavirus vaccine

No serious adverse reactions

1. Chaparro et al. J Crohns Colitis. 2023. 2. Benchimol et al. J Can Assoc Gastroenterol. 2021,
3. Goulden et al. Rheumatology (Oxford). 2022;
4. Fitzpatrick et al. Lancet Child Adolesc Health. 2023,
5. Gisbert et al. J Crohns Colitis. 2023

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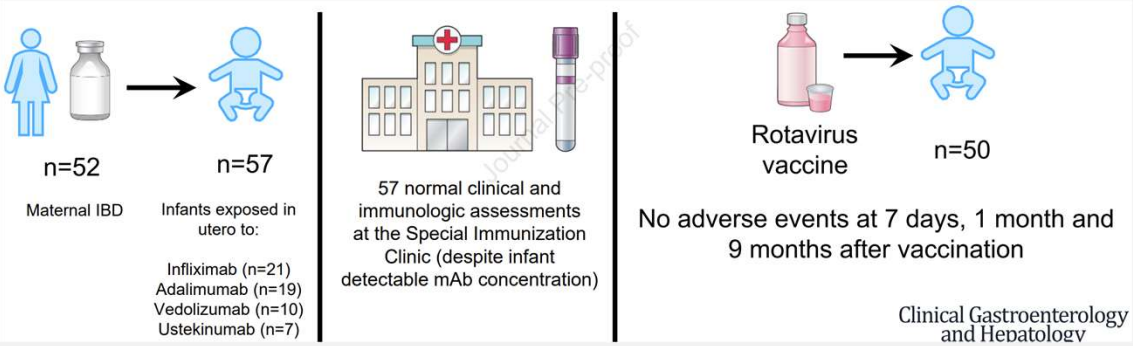
# IBD Data: Safety Rotavirus Vaccine

Live Rotavirus Vaccination Appears Low-risk in Infants Born to Mothers with IBD on Biologics




Ernest Suarez et al. Clin Gastroenterol Hepatol. 2024 Jul 30



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# Summary

**Key Points:**

- Reduced fertility with active disease and IPAA
- No risk of flare with oocyte 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 with pregnancy and lactation
- Provide preconception counseling to improve outcomes
- Provide low dose aspirin to reduce pre-term preeclampsia
- Perform a cesarean section for delivery if active perianal fistula, rectovaginal fistula, IPAA



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# Summary

**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

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piano
Pregnancy in IBD And Neonatal Outcomes

## Questions?

To enroll in the PIANO registry for US residents: pianostudy.org

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# Questions

Jean-Paul Achkar, MD, FACG

Sunanda V. Kane, MD, MSPH, MACG

Millie D. Long, MD, MPH, FACG

Uma Mahadevan, MD, FACG

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# GI Innovation Through Collaboration

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