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# Practice recommendations for midwives caring for women and birthing people living with inflammatory bowel disease

| Scope of the standards |
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| The following practice recommendations were developed to standardise the midwifery care given to women and birthing people living with IBD during pregnancy.<br><br>A multi-professional group of experts around IBD and maternity care was formed to develop the following practice recommendations for midwives.<br><br>These recommendations are to be used alongside the European Crohn's and Colitis (ECCO) Guidelines on Sexuality, Fertility, Pregnancy, and Lactation and the British Society of Gastroenterology (BSG) Standards for the provision of antenatal care for patients with inflammatory bowel disease within the United Kingdom and provide practice recommendations for midwives.<br><br>For women and birthing people with other medical or pregnancy complications, these recommendations should be complementary to guidelines used to provide antenatal care<br><br>As maternity care is usually provided by midwives, these standards will commence at the point of confirmation of pregnancy and will not include preconceptual care.<br><br>Authorship: |


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| Booking | |
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| **Communication** | Women and birthing people should be:<br>• supported by their midwife to identify their exact diagnosis of IBD (Crohn's disease; Ulcerative Colitis; IBD unclassified) and related treatments to community midwife to remove risk of error of misunderstanding or inaccurate documentation when referring to consultant obstetric led care.<br><br>• signposted to Crohn's and Colitis UK pregnancy information by all healthcare professionals notified of the pregnancy, which may include GP, IBD Nurse, Midwife and Gastroenterologist, surgeon and stoma nurse<br>https://crohnsandcolitis.org.uk/info-support/information-about-crohns-and-colitis/all-information-about-crohns-and-colitis/living-with-crohns-or-colitis/pregnancy-and-breastfeeding |
| **Tailor advice about medication** | All women and birthing people:<br>• should take a supplement of at least 400mcg of Folic Acid, ideally 3 months prior to pregnancy and until 12 weeks pregnant.<br><br>• should take an increased supplement of 5mg of Folic Acid until 12 weeks gestation[1 2]if taking the IBD medication sulphasalazine or have Crohn's disease in their small intestine, or have had surgery to remove part of their small intestine<br><br>• should be encouraged to discuss any concerns with their IBD medication with their IBD team<br><br>Prophylactic anticoagulation should be considered for women and birthing people with active IBD in the third trimester and should be encouraged to discuss this with their IBD team.<br><br>Aspirin is not contraindicated in IBD. If indicated (usually for reducing the risk of pre-eclampsia), this should be prescribed by obstetric/maternity services. This is usually 150mg/day. Doses of less than 300mg/day are not linked to IBD flares [3 4] |
| **Coordination of care** | Woman and birthing people should inform their IBD team as soon as possible after pregnancy is confirmed<br><br>Shared decision making principles should underpin all care decisions, and woman and birthing people should have overall ownership over their maternity care<br><br>Ensure care is integrated person centred, avoiding multiple appointments on the same day/week and utilising virtual consultation options if appropriate and preferred |


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| | All healthcare professionals involved in maternity and IBD care should directly communicate with each other and copy into all correspondence. |
| **Who to involve in care** | Referral for consultant obstetric led care is always required<br><br>Further follow-up requirements are to be decided depending on IBD course and severity and other maternal risk factors<br>The IBD team or IBD/Obstetric joint clinic (if available) should be involved<br>Women and birthing people living with IBD may be at increased risk of developing anxiety or depression during pregnancy and therefore surveillance of this should be ongoing by all involved in care and discussed[5]<br><br>Specialist support from perinatal mental health teams should be sought if needed |
| **Pregnancy** | |
| **Who/when to call for advice- midwife or IBD team – symptom confusion** | All women and birthing people to be:<br>• provided with contact numbers for IBD and maternity services, with named contacts where possible<br>• given tailored advice by their midwife and obstetrician about symptoms of preterm labour/labour and when to call the maternity unit |
| **Anaemia/iron levels** | If anaemia is diagnosed, prescribing oral iron supplementation once every other day is better tolerated than a dose daily and can be just as effective. This is prescribed by the General Practitioner.<br>Thresholds for iron supplementation should be adapted pragmatically as many patients with IBD may struggle to tolerate oral iron supplementation.<br><br>Healthcare professionals should pay attention to symptoms of anaemia in pregnancy, especially around 28 weeks, a drop in haemoglobin may be physiological if asymptomatic.<br><br>Consider Iron Infusion if symptomatic, anaemic and not responding or unable to tolerate oral iron |
| **Discussions around infant feeding** | IBD nurses/gastroenterologists/midwives should:<br>• sensitively discuss breastfeeding and infant feeding at appointments during pregnancy, which includes reasons why breastfeeding would not be recommended such as specific medications, and the benefits of breastfeeding if able to<br>• provide women and birthing people with Crohn's and Colitis UK information about medication use and breastfeeding<br>https://crohnsandcolitis.org.uk/info-support/information-about-crohns-and-colitis/all-information-about-crohns-and-colitis/living-with-crohns-or-colitis/pregnancy-and-breastfeeding |
| **Colostrum harvesting and the benefits of colostrum** | The benefits of colostrum harvesting should be discussed antenatally by the midwife before 37 weeks gestation (in the absence of obstetric complications) |


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| | Equipment for harvesting colostrum should be provided by midwives if a woman or birthing person wishes to do this and can start at 37 weeks gestation<br><br>The benefits of colostrum should be discussed if unable or does not wish to breastfeed, with the expressing of colostrum discussed and support given by the midwives to do so if wishes |
| **Labour/birth** | |
| • **Mode of birth** | Decision making about mode of birth to take into account the choice of the woman or birthing person, in consultation with the IBD team<br><br>ECCO and BSG guidance provide information on when a caesarean section is indicated as mode of delivery:<br>European Crohn's and Colitis Guidelines on Sexuality, Fertility, Pregnancy, and Lactation \| Journal of Crohn's and Colitis \| Oxford Academic (oup.com)<br><br>Standards for the provision of antenatal care for patients with inflammatory bowel disease: guidance endorsed by the British Society of Gastroenterology and the British Maternal and Fetal Medicine Society (bsg.org.uk) |
| • **Caesarean section – choice** | If a woman or birthing person requests a caesarean section but this is not indicated by IBD guidelines, then detailed documentation should include discussions by members of the midwifery, obstetric, IBD and/or colorectal surgery team about:<br>• individual wishes<br>• The increased risk of complications during and post caesarean section following previous IBD surgery |
| **Water birth or homebirth** | If disease activity means the baby is not at any increased risk during labour or birth, and there are not any other medicate or obstetric concerns then a homebirth or water birth should be supported if requested<br>If additional risk factors such as a small baby, discuss additional monitoring which may be needed and if this can be facilitated at a home birth or water birth |
| **References** | 1. Fernando Bermejo et al (2013) Should we monitor vitamin B12 and folate levels in Crohn's disease patients? *Scandinavian Journal of Gastroenterology* 48(11):1272-7<br>Should we monitor vitamin B12 and folate levels in Crohn's disease patients? - PubMed (nih.gov)<br><br>2. Hwang, MD et al (2012) Micronutrient Deficiencies in Inflammatory Bowel Disease: From A to Zinc *Inflammatory Bowel Diseases*, 18(10):1961–1981<br><br>Micronutrient Deficiencies in Inflammatory Bowel Disease: From A to Zinc \| Inflammatory Bowel Diseases \| Oxford Academic (oup.com) |

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| | 3. Parita Patel, MD et al (2021)Daily Aspirin Use Does Not Impact Clinical Outcomes in Patients With Inflammatory Bowel Disease *Inflammatory Bowel Disease* 27(2): 236–241<br><br>Daily Aspirin Use Does Not Impact Clinical Outcomes in Patients With Inflammatory Bowel Disease - PMC (nih.gov)<br><br>4. Debolt, C et al (2022) Is aspirin use associated with disease flare in pregnant women with inflammatory bowel disease? *American Journal of Obstetrics and Gynaecology* 226(1):597-598<br>Is aspirin use associated with disease flare in pregnant women with inflammatory bowel disease? - American Journal of Obstetrics & Gynecology (ajog.org)<br><br>5. Zadeh, M.A., Khajehei, M., Sharif, F., and Hadzic, M. (2012) ‘High-Risk Pregnancy: Effects on Postpartum Depression and Anxiety’. *British Journal of Midwifery* [online] 20 (2), 104–113. available from <http://www.magonlinelibrary.com/doi/10.12968/bjom.2012.20.2.104> |