About IBD Podcast Episode 92 - IBD and Pregnancy With Jill Gaidos, MD

Amber Tresca 0:07
I'm Amber Tresca. And this is About IBD. It's my mission to educate people living with Crohn's disease or ulcerative colitis about their disease and to bring awareness to the patient journey.

Welcome to Episode 92.

My guest is gastroenterologist Dr Jill Gaidos. She is an Associate Professor of Medicine in the section of Digestive Diseases and the Director of Clinical Research for the Yale Inflammatory Bowel Diseases Program. Dr Gaidos has a wide range of interests when it comes to IBD, but she has a special focus on IBDMoms, and she works with patients who have concerns about pregnancy and IBD.

We talk about how the research data that has become available over the past few years has affected the understanding of pregnancy and IBD. A few of the topics we cover include how to prepare for pregnancy, when to seek help with fertility, the current recommendations on biologics and other IBD medications, how to get everyone on the healthcare team working together, and what the chances are of passing IBD on to kids.

I hope you'll find our conversation both helpful and reassuring

Amber Tresca 1:20
Dr Gaidos, thank you so much for coming on About IBD.

Dr Jill Gaidos 1:24
Thank you so much for having me. I'm happy to be here.

Amber Tresca 1:27
I wonder First, if you would talk to me a little bit about your background and your specialty, because our topic today is pregnancy and IBD. And why this topic interests you.

Dr Jill Gaidos 1:37
So I'm an associate professor, in the section of digestive diseases at Yale. I really got interested in inflammatory bowel disease. During my fellowship, I was at the University of Florida. And I worked with a physician named Dr. John Valentine, who's now in Utah, but I just really fell in love with the complexity of the disease. I fell in love with the medical decision making because it's not algorithmic. Nobody follows the book with inflammatory bowel disease. So it's very patient centric, and very specific to each patient. So that's really what when I fell in love with inflammatory bowel disease,

Dr Jill Gaidos 2:18

I moved to Richmond, I was on faculty at the University at certain sort of Virginia Commonwealth University. And as well as at our VA Medical Center in Richmond, for nine years, really wanted to continue to grow and expand and challenge myself and learn more about inflammatory bowel disease. So I moved to Yale in August 2020, during the pandemic, which was exciting and presented lots of challenges.

Dr Jill Gaidos 2:46
But my interest in inflammatory bowel disease and pregnancy really kind of peaked after having my own children. And also, you know, just in practicing inflammatory bowel disease, when you have more than one physician involved, there's lots of opportunities for error, and miscommunication. And, really, with, you know, having healthy pregnancies and getting through pregnancy in and of itself is a challenge.

Dr Jill Gaidos 3:16
As a mother, you feel like everything you eat is going to cause some kind of congenital malformation in your baby. And it's hard, we get a lot of mixed messages. So I can't eat lunch meat, but you want me to stay on my medicine that was created to treat cancer. And that's, you know, I'm not really seeing the link there. I mean, for me, I love the education part of it. I mean, it's an exciting time. It's a scary time. It's a challenging time, but it's also an exciting time.

Dr Jill Gaidos 3:46
And so helping women be as healthy as they can going into the pregnancy and throughout the pregnancy. Is is what really gets me excited about the process and the topic. And you know, every young woman who comes to see me we talk about, are you- are you in a relationship? Are you on a contraceptive? Are you thinking about pregnancy? And I don't think a lot of GI doctors actually do that.

Amber Tresca 4:11
Yeah, I can say from my own experience, and from my work as a co-founder of IBDMoms, I know, usually that question is not asked. And it's something it's a conversation, I think that needs to start in women younger, actually, like teenagers, girls, really. But I don't think it's really thought about in that way. It's not thought about until women are older, but honestly, you need to start planning long before that.

Amber Tresca 4:38
Let's talk for a few minutes about planning because when you have IBD and especially if you have more complicated IBD complications or severe disease, you really have to plan a pregnancy. It's not something that you want to go into without having planned for it. Mostly because of the way that the disease may behave. And you know, obviously, we all want to have healthy pregnancies and healthy babies. So, what should women with IBD start to think about pregnancy and how to plan with it in terms of dealing with their IBD?

Dr Jill Gaidos 5:12

Really from our the data that we have available, we know that the most important thing is to have your disease under control prior to conception, you have the best pregnancy outcomes, meaning you go to full, you know, closer to full term, you're of a lower risk of preterm labor, preterm delivery, you're - the infant is typically larger, when you don't have active disease at the time of conception, you're actually less likely to flare during pregnancy.

Dr Jill Gaidos 5:42
If your disease is under control, at the time that you get pregnant, I think there is a little bit of a disconnect, it really depends on I think, when you were diagnosed, or a lot of our pediatric IBD patients will stay with their pediatric provider till they're 24-25. But if there's an 18 year old, who gets pregnant, then she goes to the adult GI because the pediatric GI doctors, you know, aren't as comfortable managing that. And so I think there's a little bit of disconnect in that population, because that's my missed opportunity to talk to that patient about potential pregnancy, and the importance of, you know, getting their disease under control, with my patients who were, you know, already come to see me, and they're, you know, in the reproductive age, then we do talk about it early.

Dr Jill Gaidos 6:30
And I think, I mean, I think a lot of women actually spend a lot of time trying not to get pregnant. And then they think, Oh, well, you know, I want to get pregnant. So I'm gonna start tomorrow, and it doesn't really work like that. But the planning part is, you know, making sure you're on a stable medical regimen, you know, stable treatment regimen, that doesn't involve steroids. So we try and do long term, and then to reviewing those medicines and making sure that they are safe during pregnancy, the biggest one that we recommend avoiding for at least three months, ideally six months is methotrexate.

Dr Jill Gaidos 7:06
So if you're on methotrexate - talk, and thinking, even considering pregnancy in the next year - talk to your provider about switching you to something else, because you want to make that switch, you want to have that period of time to make sure your disease stays well controlled on whatever new regimen you're on. And then, you know, getting you off of the steroids, less for fetal development. But actually, our studies show that pregnant IBD patients on steroids have a higher risk of gestational diabetes, which in and of itself has its own complications, you know, really using objective measures either getting a repeat colonoscopy, the fecal calprotectin, to test for, you know, intestinal inflammation, and making sure all of that is quiet before moving forward. Then we do the other health maintenance stuff, make sure your vaccines are up to date and make sure you've had a pap smear, total body skin exam, you don't want any surprises when you're pregnant. So just kind of call it a tune up, get your tune up.

Amber Tresca 8:03
Get all your ducks in a row. And all of this takes a lot of time. I mean, I think maybe we don't necessarily consider that. We just think, Okay, I'm going to stop doing whatever that I've been doing for birth control, and then it's going to happen. But, you know, I mean, I've known

women that the - the tune up period has, and certainly for me, this was true, the tune up period was years, like it took quite some time.

[MUSIC: About IBD Transition Piano]

Amber Tresca 8:42
Getting pregnant is a whole other situation. You get your disease under control. And then sometimes there's a bump in the road, sometimes not. I think that there is a pervasive thought that IBD will affect fertility sort of across the board. But it's my understanding that it's a lot more nuanced than that. So can you describe maybe some of the ways that IBD may affect fertility, and even some of the surgeries that IBD patients had and if they might affect fertility.

Dr Jill Gaidos 9:20
So we do know that really none of the medicines that we use to treat inflammatory bowel disease impact fertility. So, you know, being on a stable regimen, there's not one versus another, that's, you know, more likely or less likely to impact your fertility. Women who have been medically treated for their IBD do not have a decreased risk of fertility.

Dr Jill Gaidos 9:43
There have been some studies that show lower ovarian reserve for whatever that's worth. I mean, when you have a million eggs to start with having half of that you still have a good chance of pregnancy. But for surgeries, several studies have repeatedly shown that patients who have had a total colectomy with a j-pouch creation or Ileoanal pouch anastomosis, you have about a three fold increased risk of infertility. And they think it's because of just the pelvic dissection that goes on to create the J-pouch can cause some scarring in the fallopian tubes that just don't allow the eggs to travel to the uterus and get implanted and fertilized and all that good stuff that makes the baby.

Dr Jill Gaidos 10:30
So if you do require a total colectomy, having the total colectomy and an ostomy doesn't impact your fertility. So you can do it in kind of a staged approach. Have your babies, you know, family planning or you know, get all that stuff, good stuff out of the way. And then if you still want to, you could later have the j-pouch created.

Amber Tresca 10:54
So you literally just described me, like me, I had my j-pouch surgery done in 1999. They did not do laparoscopic at that time, so I did have open surgery. They didn't know a lot about fertility and how it was affected at the time, there wasn't much in the way of studies, I was warned that it could potentially affect my fertility. But also, I didn't really have a lot of choice like I had to have the surgery at that time. It was it was kind of an emergency situation. But as it turns out, my fallopian tubes were all fine and good. So it never did cause that kind of scarring. But is there a difference between the open versus the laparoscopic because women are often very, very concerned about their fertility. And if they have a choice, do you think that makes a difference?

Dr Jill Gaidos 11:49
There is I've seen one study and it's pretty small. And it looks like laparoscopic is a little bit lower risk. But I think if you have the option to just, you know, have the ostomy for a short period of time, then we know you haven't had that pelvic dissection, there's a much lower risk.

Dr Jill Gaidos 12:10
What's really important though, is there are studies actually looking at in vitro fertilization and women who have ulcerative colitis without surgery, ulcerative colitis, who've had a j-pouch, and then kind of a general population of women undergoing in vitro and they all had the same chance of becoming pregnant with each treatment. So the upside is if you do have fertility issues, after having a j-pouch, in vitro fertilization is still an option for treatment.

Amber Tresca 12:42
Right. Yeah, that's I remember going through the, the fertility testing and all of that. And somebody said something, to me that was really impactful is that they said look like you can get pregnant, we're going to make this happen, it's just the path to it might be a little different than what you had expected it to be. That, you know, that was really that was really important and impactful in my journey.

Dr Jill Gaidos 13:06
Right. And then and, too, just - just one more little comment, don't wait too long to tell your GI doctor because I know a lot of people think it's not related to GI, so we don't need to talk about it. But really, it is, you know, part of the whole plan part of the whole process part of the whole woman. And so, for women with IBD, we typically don't wait a year to consider it, you know, infertility, we would send you to a fertility doctor in six months. And so, you know, get that process started, get the evaluation started a little bit sooner, so don't feel like you have to try for two years or three years. And potentially, you know, make it even harder, because older age does increase your risk of infertility.

Amber Tresca 13:51
Yeah, and that does go on a lot with the women in the community that I've spoken to. And sometimes they mentioned how long they've been trying to get pregnant. And sometimes it is quite long, you know, 2-5. The other day, there was someone who said they were trying for 10 years, and I was like, gosh, six months, if it doesn't happen in six months, that's when you should start these discussions and be referred out to perhaps a reproductive endocrinologist or you know, someone else that can help you with this. So thank you for mentioning that because that's important to me that we get that word out about that. Like don't wait, like, you know, get that help right away.

Dr Jill Gaidos 14:27
Right. Don't suffer in silence, tell people, get help.

Amber Tresca 14:30

Right, don't suffer in silence. And then on the flip side, I always like to point out how practitioners can help patients as well. In that, please ask. Please ask your patients about pregnancy and if they're planning one, and when they're planning and do they need a referral out for any help.

[MUSIC: About IBD Transition]

Amber Tresca 14:57
Let's talk for a minute about after getting pregnant. What can people expect to either be the same or to be different about a pregnancy with IBD.

Dr Jill Gaidos 15:06
But women with IBD should have normal healthy pregnancies. I mean, that's my expectation. And that's what I tell my patients to expect. We do know that women with IBD can have smaller babies at the time of delivery, that risk is much more increased with active disease at the time of conception. So when you get pregnant, and then also, if you have a flare during pregnancy, that also can impact the fetal growth, we know there's no increased risk of congenital anomalies. So you know, you don't have a higher risk of deformity or anything like that of the baby.

Dr Jill Gaidos 15:46
Really, it should be normal, and healthy, interesting, the PIANO study, so the Pregnancy and Neonatal Outcomes in IBD, they finally published a, you know, good chunk of their current data. And they did find a slightly increased risk for spontaneous abortion. So before the pregnancy, but that was related to women who had had a spontaneous abortion before, so maybe something anatomical that's causing that, and then also women who had active disease at the time of conception. So again, it's just really important to get disease under control.

Dr Jill Gaidos 16:23
They also found that women with ulcerative colitis tended to be more likely to flare during pregnancy, which I think is interesting, because we always worry, we seem to think about Crohn's is more of a more complicated disease. And I don't know if we tend to under treat ulcerative colitis or, or if maybe mild ulcerative colitis symptoms get downplayed, because people are used to being more sick. So for me, I think it's just really important to use objective measures to assess intestinal inflammation throughout the pregnancy. fecal calprotectin is easy. Nobody likes giving a stool sample, but I like that better than doing a colonoscopy every three months, right.

Dr Jill Gaidos 17:06
So. So getting that when we've done the tune up, and we know you're, you know, your intestines are not inflamed. I want to baseline fecal calprotectin, I want to check it every three months during your pregnancy. We have studies that show you know not in Pregnant Patients, but in people with inflammatory bowel disease, that that trend actually can start to go up several months before you develop any symptoms. So for me, that's a marker that I can use and

say, Hey, it looks like this is going up, we need to talk about maybe, you know, adjusting the dose of your medicine or, you know, let me know if you start to have even mild symptoms, and we can, you know, make changes at that time.

Dr Jill Gaidos 17:46
So it's for me, it's more about proactively monitoring and making sure that, you know, the intestinal inflammation doesn't come back and get downplayed.

Amber Tresca 17:57
Right, so you're doing that fecal calprotectin every three months, how often do you see your pregnant patients in the office or otherwise, or even like lab work, like bloodwork?

Dr Jill Gaidos 18:08
I would see them every three months, and we can do a video visit and just check in and because I'm going to ask very different questions in the OB doctor is, I think if you have an maternal fetal medicine doctor involved, that's also helpful, because they will talk more about the mom and set a you know, instead of just, you know, measuring the fetal growth, and, you know, making sure the baby's growing, okay.

Dr Jill Gaidos 18:30
But for me, it's usually about every three month check in and then you know, my chart message or email, if anything changes in between that period of time to have a lot of the bloodwork is driven by OB but if you're due for anything, you know, obviously we would, you know, check all that if it needed to be updated. But as part of the tune up, we're gonna look at your iron studies, we're gonna make sure your hemoglobin looks good, we're gonna check your vitamin D, your vitamin B-12. So all that nutritional information we've already had, prior to the pregnancy, hopefully.

Amber Tresca 19:03
We touched a little bit on flare ups during pregnancy. I know that also there can be a risk of a flare up after delivery. So what's been your experience in that realm? And what should women be thinking about in terms of protecting themselves against a flare up or even like you were saying, catching it really, really early, and that you can have the healthy pregnancy and delivery and postpartum period that that we all want?

Dr Jill Gaidos 19:33
One of the things for me. So as part of that to know if you're on a medication, where we can look at drug levels, and we can look and see if you've developed antibodies, as part of the tune up, I want to make sure that your drug levels are at goal that you're not developing antibodies because that's something that I would want to fix prior to pregnancy. So if you did start to flare during pregnancy, I would know that we already had you on a good dose of drug so At that point we could talk about kind of depending on where you are in the pregnancy.

Dr Jill Gaidos 20:04

If you just need some type of rescue therapy to get you through four more weeks, and then deliver the baby, then we can do you know, short term course of steroids and just kind of tide you over and then plan to make changes, you know, after you've had the baby.

Dr Jill Gaidos 20:19
If this is early in pregnancy, I mean, if we're talking 20 weeks, and you've got, you know, a long way to go, then we can talk about, you know, really, we would manage it like we would if you weren't pregnant. So are we going to escalate the dose of your medicine? Are we going to go up? Do we need to talk about changing therapies, it's a little more concerning to change therapy, because what if it doesn't work. So maybe more likely to you know, increase your dose, or shorten your dosing interval, if, if that's possibility, we typically do not add thiopurines in the setting of pregnancy, we know that they're safe to continue. So medications like is a thigh pronunce, six MP, if you've been on it, and that's part of your stable regimen, it's safe to continue those. But we typically wouldn't add something like that, just because of the potential risk of, you know, decreasing your blood counts, causing some liver injury, things that we would monitor. And you know, if that happened, when you weren't pregnant, we would just take you off of the medicine put you on something else. And then to there's a small risk of pancreatitis, which we absolutely don't want that to happen while you're pregnant.

Dr Jill Gaidos 21:30
So the other things that we would do is we would, you know, similar to when you're not pregnant was we would make sure that it's truly inflammation that's driving your the symptoms, right. So we would check stool for infections. And just make sure you know, pregnant women can get C diff. And that would really change the management of what we would do. So we would, you know, check you for infections. If we needed to, we could do you know, an unsedated, flexible sigmoidoscopy, you know, something like that, to take a look at the disease. We can do ultrasounds, we can do MRIs to look and see if there's intestinal inflammation. But really, the workup is, you know, about the same as when you're not pregnant, just, you know, we wouldn't do CT scans, avoid radiation.

[MUSIC: About IBD Transition Piano]

Amber Tresca 22:20
You know, you're told when you're pregnant, don't eat lunch meat, because some much meat may be contaminated with a bacteria, you're told not to eat soft cheeses, right? There were things that I was told - sushi, you're told you can't have a glass of wine, even though when you're pregnant, you sometimes would really like a glass of wine. And yet, you know, we tell our women with IBD: but stay on your medication.

Amber Tresca 22:47
And medication can be something that you inject or something that you receive through an IV. And that can seem really just out of line with all of this other advice that you're getting about how to take care of your body and how to take care of your baby. But we have to make it clear to women with IBD, why they need to stay on their medication and why it's safe. And I think I

think the PIANO study has helped us a lot with that as well. So can you talk a little bit about that about biologics during pregnancy?

Dr Jill Gaidos 23:24
Yeah. So like you said, PIANO has been, you know, continually submitting information as abstracts. And now we finally have a good publication. And we have, you know, almost 1500, you know, pregnant women that were enrolled in this. And so this is the biggest source of data that we have.

Dr Jill Gaidos 23:43
I am honest with the patients, I don't try and downplay it. And I think that's really important, because it has to be the patient's decision. I have had patients who have come in and I said, you know, you're on adalimumab, you're doing great, you've got this area of inflammation in the last part of your terminal ileum, that I'm really worried if you come off, that is going to close up, and you're going to be pregnant, and we're gonna have to take you to surgery. And the woman looked at me and said, I'm not staying on it. I've had two other babies where I stopped it, and then I went back. And if anything happens, while I'm on this medicine, I'll never forgive myself, and I'm not staying on it.

Dr Jill Gaidos 24:23
And I can't fight with that, right? I mean, it's got to be her decision. And I said, you know, as long as you we've had this conversation, you are aware of the potential risks. And you know, you make your choice. But I do I, you know, I tell women that these medications, they cross into the placenta. When babies are born, they do have detectable drug levels. But the important thing is it doesn't impact their growth. It doesn't increase their risk of infections. It doesn't impact their developmental milestones. So they all roll over, you know, At key time points, they're gonna crawl when they're supposed to crawl, they're gonna talk to they're gonna learn how to read, you know, all that stuff is gonna be okay. And similarly with breastfeeding.

Dr Jill Gaidos 25:10
So these, you know, all of the biologics. So the anti tumor necrosis factor agents, the anti integrin is, you know, the vedolizumab, ustekinumab, they are detectable in breast milk. But I tell patients, you know, we have studies that showed that, you know, the blood levels of these infants, so even though they're still getting some in the breast milk, their blood levels are going down, because that's not how these medicines work. If it were detectable in their blood, when we gave it to them in their mouth, that's what we would do for patients, we wouldn't be giving them subcutaneous or IV, we would, you know, they would be oral agents by now.

Dr Jill Gaidos 25:48
So again, I tell them, I'm open and honest, because I don't want them to, you know, read somewhere and then come back and say, You didn't tell me this. But it has to be a fully informed discussion. So I say, Yes, they're going to get some in the breast milk, but it's not going to, you know, increase the risk of infections, it's not going to increase their growth, it won't increase their development, or won't impact their development.

Amber Tresca 26:11
Right. And I think that's a that's a key point that sometimes gets missed. Patients will receive that drug intravenously, or, like you said, subcutaneously, through through a shot that you give yourself or someone else gives you. But if the baby's receiving it through breast milk, they're receiving it through their tummy. And that's a very different delivery method. And it we don't give the medication to patients that way, because it doesn't really work that way. Right?

Dr Jill Gaidos 26:37
Exactly. their stomach, the baby's stomach acid is gonna kill all that stuff.

Amber Tresca 26:43
Which is good to know. Like you said, there's usually a lot of physicians involved with pregnant women that live with other conditions like IBD, you're going to have your OB, of course, you might also have a maternal fetal medicine specialist. There could also be other cooks in this kitchen. And I do hear this from women sometimes that they're getting one opinion from their GI, and then they're getting another opinion from their OB or another physician that's involved in their care. And I do wonder sometimes if it's because that the OB is are maybe not as up on the latest and the greatest with what's coming out, for instance, with PIANO. And then unfortunately, I think sometimes that falls on the patient to sort of say to their OB, yeah, but my GI is telling me that it's totally okay for me to stay on this medication throughout.

Dr Jill Gaidos 27:39
Yeah, no, I agree. It has to be, it has to be a group discussion. And I've had patients who have gone to OB, and I can pull up the OB note and it says, "Stop your Crohn's medicine." I'm like, What are you doing? What are you doing? And so I will reach out to whoever wrote that note and say, No, that's not what we're doing. Here's the latest data, call me if you have questions, but she is staying on her Crohn's medicine.

Dr Jill Gaidos 28:06
And, and I try and reach out and educate those patients, I've actually given a talk for the Yale OB residents on pregnancy and IBD, so that we can go over all of these medications and the newest data and the safety and we even talked about delivery, and safety of delivery. And just because you have a IBD, I mean, just because you have IBD doesn't mean you have to have a C-section and, and they knew most of the stuff. So I was very happy and very pleased that they had already heard a lot of this information.

Dr Jill Gaidos 28:39
But that's not the case everywhere, like you said. So I think, you know, hopefully your GI doctors had a good discussion with you and explain the data so that you as a patient can be an advocate for yourself and know that when somebody is telling you something that doesn't make sense that you do question it, and I think you can go back to your GI doctor and say, can you please reach out to my OB doctor and really put the burden on them to, you know, come up and have it really be a team effort.

Dr Jill Gaidos 29:10
It can't be a team effort, if one person is seeing you in their notes live here, and the other person is seeing you in their notes live in a completely different, you know, setting and they're not truly interacting. That's not really a team. There needs to be some communication between those providers.

Amber Tresca 29:25
Right. Yeah, I think that can be sometimes a little difficult conversation to have for patients, but it's a really important it's a really important one. And the being in different patient portals is different. I mean, I wish we had just one I guess maybe, you know, maybe in my lifetime we'll see that.

[MUSIC: About IBD Transition]

Amber Tresca 29:50
So I have another really, really big question for you. That is top of mind for a lot of people who live with IBD and And this goes for everyone, men and women. And that is about the heritability of IBD. And whether or not you're going to pass IBD, on to your kids, what are the studies saying about that now?

Dr Jill Gaidos 30:17
It's still very, very low. And it's less than, I think it's around like less than 3%. And the reason is, we don't have a clear genetic link. You know, we've found 200 genes that can be associated with ulcerative colitis, or Crohn's disease, there's some that overlap and can be predictive of both. But we know there's a lot of people who have those, your genes that don't have IBD.

Dr Jill Gaidos 30:50
So it's, you know, kind of a genetic marker that can put you at risk, but doesn't necessarily mean you're going to get it. So it's still a very multifactorial disease. So it's, we think it's patients who are genetically predisposed. So they have, you know, whatever, one of these 200 genes that put them at risk, and then there's some exposure there that happens, whether it's dietary, whether it's some infection, that turns on the immune system, and then because you have this genetic predisposition, it just doesn't turn back off, and you end up with inflammatory bowel disease.

Dr Jill Gaidos 31:25
We haven't seen a clear link, we do think there's a little bit higher risk with Crohn's disease, then with ulcerative colitis. And we know that the risk is highest if both parents have inflammatory bowel disease. But it's much, much lower than I mean, it's you can't predict it, like, you know, your chances of having blue eyes versus brown eyes. It's just really not that clear.

Amber Tresca 31:50

Right, because IBD is so complicated. And they say it's genetic, yes. But then some environmental trigger that turns it on. Yeah. And that's also why they think that there may be so many different kinds of IBD. And that it's not just Crohn's disease and ulcerative colitis.

Amber Tresca 32:07
Is there anything that we missed or anything else that you want to add?

Dr Jill Gaidos 32:10
Yes. So one of the things that struck me in the IBD population is the idea of voluntary childlessness. And it's this concept that people who may have wanted to have children have decided not to have children, because they're concerned that they will pass on the IBD to their child, or the medications that they're using would cause you know, congenital malformations or deformities in their children. And so they elect not to have children when really, they could have had children.

Dr Jill Gaidos 32:43
And so I think if having a child is something that you really want to do, talk to your GI doctor, talk to your OB about, you know, what are the real risks, listen to, you know, your podcasts, look at the PIANO data, go on the Crohn's and Colitis Foundation website and, you know, chat with someone, you know, or get into community support group and ask questions, I think, find that information because you don't want I mean, there's only a certain period of time when this is an option. And so if it's something that you really want, find out the data, find out the information because with what we know, now, it, you know, if somebody wants to have children - a child, then it should be something that they can achieve. Even you know, with inflammatory bowel disease, even with prior surgeries, you know, it is an option that is something that can really happen for them if that's something that they want.

Amber Tresca 33:42
And that's exactly why Brooke Abbot and I founded IBD moms as well as to help women and other people that want to become parents deal with these complicated issues. Dr. Gaidos, thank you so much for talking with me about pregnancy and IBD and being on medications and the risk of IBD in our children. This is all such important information. Thank you so much for the work that you do in educating your patients and educating others. And for coming on my show. I really appreciate it.

Dr Jill Gaidos 34:13
Thank you so much for having me. I really enjoyed it.

Amber Tresca 34:22
Hey super listener! Thanks to Dr Gaidos for sharing so much information about IBD and pregnancy and how people can prepare for their parenting journey. You can follow her on Twitter as @JillGaidosMD. In addition to all her work on behalf of patients, she's also a champion for female gastroenterologists, who make up only 13% of that specialty. I will put links to more information about Dr Gaidos and her work in the show notes.

I'm a mom of two kids, both born after I had j-pouch surgery. Even in the years since I was last pregnant, so much more information has become available about how IBD should be managed before and during pregnancy. I think what we've learned is really reassuring. The problem is we still have all the myths and misconceptions about pregnancy and IBD from decades past swirling around in the public consciousness. That's why Brooke Abbott and I founded IBDMoms. IBDMoms is a space for moms and moms-to-be who live with an IBD and moms of kids with IBD to find help and support. You can connect with us across all social media as @IBDMoms.

I will put all of these links in the show notes and on my Episode 92 page on AboutIBD.com.

Thanks for listening, and remember, until next time, I want you to know more about IBD.

About IBD is a production of Mal and Tal Enterprises.

It is written, produced and directed by me, Amber Tresca.

Mix and sound design is by Mac Cooney.

Theme music is from Cooney Studio.