**Standards for the provision of antenatal care for patients with Inflammatory Bowel Disease:**

**A British Society of Gastroenterology position statement endorsed by the British Maternal and Fetal Medicine Society**

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This position statement aims to provide guidance for clinicians involved in the care of pregnant patients with Inflammatory Bowel Disease (IBD). The focus of the position statement is on service set up and minimum standards of care as well as audit recommendations. Detailed guidance for medical decision making is available via established European (Van der Woude et al, JCC 2015) and National (Lamb et al, Gut 2019 epub) guidelines. The working group developed the statement using a modified Delphi-process and ≥80% agreement was required for the inclusion of a statement.

**Domain 1: Set up of services**

1. To facilitate optimal care and joint decision-making, regular and effective communication between IBD and obstetric teams is required. As a minimum there should be a nominated link clinician for IBD in every obstetric unit and a nominated link clinician for pregnancy in every IBD unit. [90% agreement]
2. Specially set-up IBD pregnancy clinics can provide optimal specialised care. This is best facilitated by a joint clinic with an obstetrician clinician and an IBD clinician present during the consultation. [100% agreement]

**Domain 2: Minimum standards of care**

1. Pre-conception counselling should be available to all women with IBD to optimize preconception health. Poor patient knowledge on reproductive issues is associated with voluntary childlessness and adverse pregnancy related outcomes. Pro-active approaches to pre-conception counseling are considered the gold-standard. [100% agreement]
2. The IBD team must advise all patients with IBD who are pregnant or considering pregnancy on drug safety during conception, pregnancy and the importance of maintaining remission. [100% agreement]
3. Pregnant women with IBD should be offered consultant led obstetric care. Following initial clinic assessment care in different clinical settings may be appropriate. [100% agreement]
4. All pregnant women with IBD should be offered IBD specialist care by a consultant or IBD nurse with experience in IBD pregnancy care. [100% agreement]
5. The frequency of IBD, obstetric and or joint clinic follow-up should be determined by IBD disease activity in the absence of other obstetric concerns.
	1. Patients with mild disease can be monitored remotely (via “telephone” or “virtual” clinics) but moderate to severe disease requires follow-up by IBD, obstetric and/or joint clinics. [100% agreement]
6. All pregnant women receiving biological therapy for IBD need to receive individual advise on whether to continue or stop therapy during the 3rd trimester and when to restart therapy postpartum.
	1. This discussion and the decision need to be clearly documented.
	2. All women on biologics need to be counselled on safety aspects for the infant including vaccinations and advice on infection-related complications. [100% agreement]
7. All pregnant women with IBD should be advised on whether their IBD influences the mode of delivery
	1. A clear recommendation on optimum mode of delivery should be made well in advance of the expected delivery date. Considerations need to be made in regard to absolute contra-indications for a vaginal delivery. Gold standard is a joint IBD-obstetric decision.
	2. For patients with IPAA or perianal disease a joint approach that may include surgical input is required. [100% agreement]
8. All pregnant women with IBD should be counselled on the benefits of breast feeding with specific advice on the suitability of their medical treatment on breast feeding well in advance of the expected delivery date and the decision should be documented. [100% agreement]
9. All pregnant women with IBD should be counselled on the safety of vaccinations for the newborn. Women on relevant biological drugs should be advised that the infant should avoid the rota virus vaccination and that the BCG vaccination should be delayed. This should be documented. [100% agreement]
10. Additional growth scans in the 3rd trimester should be considered for patients with active IBD and/or other comorbidities as determined by the supervising obstetrician. [100% agreement]
11. In patients with active IBD prophylaxis against venous thromboembolism should be considered taking into account other risk factors using the RCOG VTE guidelines. [100% agreement]
12. Prior to delivery women should be advised on the plan for follow-up post partum and given contact details for the IBD service. [100% agreement]

**Domain 3: Audit of services**

1. Pregnancy related outcome data should be captured regularly where possible and should include: delivery date, mode of delivery, complications and breast feeding status.
2. Services should aim to achieve a 90% target for:
	1. Documented decision on biological therapy during pregnancy
	2. Documented advice on delivery method
	3. Documented advice on vaccination for the newborn
	4. Documented advice on breast feeding

[100% agreement]