Inflammatory Bowel Disease in Women

Discussion of sex-specific issues in inflammatory bowel disease (IBD) often revolves around one issue: pregnancy. Many women with IBD are of reproductive age, and these patients often voice their concerns about fertility, the effect of their disease on pregnancy (and vice versa), and the use of medications during pregnancy. Recent research has shown that a healthy pregnancy is possible in most women with IBD. However, both clinicians and patients should keep in mind several important considerations. As noted in The Crohn's & Colitis Foundation of America's pregnancy fact sheet (available at www.ccfa.org/assets/pdfs/pregnancy-factsheet.pdf), it is recommended that conception occur when a patient's IBD has been in remission for at least 3 months, the patient is not taking corticosteroids, and the patient is not beginning a new therapy. Most medications for IBD can be safely continued during pregnancy, which is important to keep the disease in remission and avoid IBD flares. Active disease may be associated with risks. Of course, careful supervision under the care of a gastroenterologist is essential for maximizing outcomes.

In a feature article in this issue of *Gastroenterology & Hepatology*, Drs Elizabeth Rosenblatt and Sunanda Kane consider related issues such as fertility and contraception as well as other important sex-specific concerns. They explore the research surrounding IBD and impaired body image and sexuality, increased risk of cervical cancer, and low bone mineral density. According to the authors, as the field of IBD evolves into personalized medicine, sex is one of the factors that should be considered in the decision-making process.

In another feature article, Drs Eileen Kim, Rebecca Voaklander, Franklin E. Kasmin, William H. Brown, Rifat Mannan, and Jerome H. Siegel explore autoimmune pancreatitis, which can be a diagnostic challenge in the West due to the prevalence of immunoglobulin G4 seronegativity. The authors discuss the differences between types 1 and 2 autoimmune pancreatitis, outline the shortcomings of the classification system presently being used, and suggest a more inclusive view of the disease.

The third feature article focuses on wireless video capsule endoscopy. Drs Ryan Scott and Robert Enns outline the numerous recent technological and clinical advances of this minimally invasive technology and discuss the next steps of research in this area. Although video capsule endoscopy is used mainly for the management of obscure gastrointestinal bleeding and suspected Crohn's disease, this tool has many other indications, including the evaluation of celiac disease, assessment of small bowel tumors, and surveillance of hereditary polyposis syndromes.

Two columns this month involve the gut microbiota. In the Advances in Hepatology column, Dr Jasmohan S. Bajaj examines the role of the gut microbiota in liver disease, particularly nonalcoholic fatty liver disease, nonalcoholic steatohepatitis, cirrhosis, and hepatic encephalopathy. In the Advances in IBD column, Dr David T. Rubin explores recent research on fecal microbiota transplantation (FMT) in patients with IBD. FMT has been shown to be effective in the treatment of *Clostridium difficile* infection, but in IBD, it is currently restricted to the research setting.

In our other columns, Dr Rebecca Fitzgerald discusses screening for Barrett esophagus with a nonendoscopic sponge capsule, Dr Michel Kahaleh outlines pancreatic pseudocyst drainage using lumen-apposing metal stents, and Dr Brooks Cash explores a novel peppermint oil formulation for dietary management of irritable bowel syndrome.

I hope that you enjoy this issue.

Sincerely,

Gary R. Lichtenstein, MD, AGAF, FACP, FACG