Family Planning for Patients With Inflammatory Bowel Disease in the Post-Dobbs Era

Lori M. Gawron, MD, MPH,[1] Jessica B. Johnson, MD,[2] Ann D. Flynn, MD,[2] and Alexandra L. Woodcock, MD[1]

[1]Division of Family Planning, Department of Obstetrics and Gynecology, University of Utah School of Medicine, Salt Lake City, Utah

[2]Division of Gastroenterology, Hepatology, and Nutrition, Department of Internal Medicine, University of Utah School of Medicine, Salt Lake City, Utah

Corresponding author:
Dr Lori M. Gawron
Department of Obstetrics and Gynecology
HELIX Building 5th Floor
30 North Mario Capecchi Drive
Salt Lake City, UT 84132
Tel: (801) 213-2419
Fax: (801) 585-5146
E-mail: lori.gawron@hsc.utah.edu

Abstract: Federal protections for abortion care in the United States ended in June 2022. For people with inflammatory bowel disease (IBD) who are capable of pregnancy, the implications of an unwanted or mistimed conception, particularly in the setting of active disease flares or teratogenic treatment, are precarious and geographically variable. Prioritizing evidence-based and person-centered counseling for preconception health and contraceptive care needs is important during health care visits and not limited to reproductive health providers. Development of multidisciplinary clinics or complex contraception clinics in high-volume IBD centers can support time-sensitive counseling and services for patients. This article reviews reproductive considerations for people with IBD, particularly in the setting of legislative restrictions in the post-Dobbs landscape.

Keywords
Inflammatory bowel disease, reproductive health, family planning, preconception counseling, contraceptives, venous thromboembolism, teratogen

The *Dobbs v Jackson Women's Health Organization* US Supreme Court decision on June 22, 2022, ended the federal protections for abortion care that had been in place under *Roe v Wade*. As a result, abortion access is geographically variable with many states completely banning abortion or setting gestational age limits for care.[1] Given this, management of unwanted or high-risk pregnancy has become difficult for many US residents to access.[2] In this landscape, in order to respect reproductive autonomy, as well as prevent maternal morbidity as a result of high-risk pregnancies, it is important for all medical specialists who interact with people capable of pregnancy to understand the full range and availability of family planning services. This article provides a review of family planning for patients with inflammatory bowel disease (IBD), including contraceptive counseling considerations and strategies to align gastroenterology and reproductive care.

Family Planning and Inflammatory Bowel Disease

IBD is commonly diagnosed during reproductive years,[3] encompassing menarche to menopause or roughly age 15 to 49 years. A person capable of pregnancy may spend roughly 3 to 5 of their reproductive years trying to get pregnant, pregnant, or postpartum, and another 3 decades avoiding unwanted or mistimed pregnancy.[4] Timing of pregnancy is important for people with IBD. Conception during active disease flares may increase risk of adverse pregnancy outcomes, including cesarean delivery, preterm birth, and low birth weight.[5] Thus, routine discussion of family planning goals, including preconception and contraception counseling, is important for any person with IBD who can become pregnant,[6] those at significantly higher risk for pregnancy-related morbidity and mortality, and those who have higher rates of unintended pregnancy. A study found that documentation of family planning discussions at gastroenterology visits is infrequent, particularly related to specific contraceptive recommendations to effectively prevent pregnancy when undesired or high risk.[7] Given the precarious nature in the post-Dobbs landscape of managing unwanted and/or mistimed pregnancies by abortion, all health care providers should participate in reproductive counseling, particularly regarding contraception, at each encounter with IBD patients who can become pregnant to ensure timely access to family planning services.

Contraceptive Counseling Considerations

Although method efficacy may vary, consistent use of contraception is the most reliable way to decrease risk of unwanted or mistimed pregnancy.[8] This requires access to the full range of contraceptive options, at the time people need them, without barriers to initiation or method switching.[9] Research has found that only approximately half of people with IBD at risk of pregnancy received a prescription contraceptive, and use of highly effective, long-acting reversible contraception, such as intrauterine devices (IUDs) or subdermal contraceptive implants, was lower than in the general population.[10,11] Decisions to use—or not use—certain contraceptive methods may be related to patient or practitioner misinformation, misperceptions regarding personal fertility potential, disease activity or treatments, risks of combination hormonal contraception (CHC) methods, or other personal reasons.[10,12] As patient experience, including their needs, values, and preferences, is an essential element of quality health care, shared decision-making should be incorporated into contraceptive counseling as part of patient-centered family planning care.[13] Although all methods of contraception are options for people with IBD who are capable of pregnancy, individual considerations regarding safety, efficacy, acceptability, and access should be discussed.[9] For IBD practitioners, understanding these tenets of counseling will ensure an evidence-based and person-centered approach that will support patients in their family planning desires.

Efficacy of Contraceptive Methods

In the post-Dobbs period, people may prioritize contraceptive method efficacy, particularly in the setting of legislative restrictions if a method were to fail. In addition, contraceptive method efficacy counseling and consideration of the implications of method failure take on greater importance for people with IBD who have high disease activity or are planning surgical timing. Furthermore, contraceptive efficacy becomes critical for patients receiving IBD treatments that are known to be teratogenic (methotrexate and thalidomide) or that have limited data on teratogenicity.[14] Contraceptive methods are tiered by efficacy with IUDs and implants as the most effective, with typical use failure rates of less than 1%. Short-acting, reversible methods, including pills, patches, rings, and injections, have failure rates of 6% to 12% with typical use. Behavioral and barrier methods may have failure rates of 18% or higher owing to user dependence of the methods.[15] For IBD patients who choose contraceptive methods with higher failure rates and have high associated risks with pregnancy, counseling on emergency contraception is important.[16] Emergency contraceptive pills, including ulipristal acetate and oral levonorgestrel, can be prescribed for advance provision.[16] Because the mechanism of action for oral emergency contraceptive pills is delay of ovulation, they will not interfere with an already fertilized egg, and are thus not abortifacients. The most effective emergency contraceptive method is an IUD insertion within 5 days of un- or under-protected intercourse,[17] but logistical barriers and personal preference limit use of this option. Identifying options for faster access to care in health systems can address some logistical barriers.

Safety of Hormonal Contraception Methods

The US Centers for Disease Control and Prevention Medical Eligibility Criteria for Contraceptive Use serves as clinical guidance for method safety in the setting of chronic disease, including IBD.[15] Confusion on safety profiles often arises regarding hormonal contraception.[12] Combination pills, the transdermal patch, and the vaginal ring are the only hormonal methods that contain estrogen, the hormone associated with increased risk of venous thromboembolism (VTE). In healthy people capable of pregnancy without known prothrombotic conditions,

Table. Prescription Contraceptives and Their Considerations With IBD

Method	Hormone(s)	Target level	Delivery	Dosing frequency	Ovulation suppression	IBD-specific considerations
CHC (pills, patches, rings)	Estrogen and progestin	Systemic	Oral	Daily	Yes	Conditions where risks likely outweigh benefits of use: Active or extensive disease, surgery, immobilization, long-term corticosteroid use, vitamin deficiencies, fluid depletion[a] JAK inhibitors may have an increased risk of VTE when used concurrently[b]
Progesterone-only pills	Progestin	Systemic	Oral	Daily	No	None
DMPA injection	Progestin	Systemic	Intramuscular or subcutaneous	Every 3 months	Yes	Long-term corticosteroid use[c]
Etonogestrel implant	Progestin	Systemic	Subdermal	5 years	Yes	None
Levonorgestrel-releasing IUD	Progestin	Local	Intrauterine	8 years	No	None
Nonhormonal, copper-containing IUD	N/A	Local	Intrauterine	10 years	No	None

Adapted from Curtis et al.[15]

CHC, combination hormonal contraception; DMPA, depot medroxyprogesterone acetate; IBD, inflammatory bowel disease; IUD, intrauterine device; JAK, Janus kinase; N/A, not applicable; VTE, venous thromboembolism.

[a]With mild IBD and no other VTE risk factors, the benefits of CHC outweigh the risks.

[b]A risk vs benefit discussion needs to occur.

[c]DMPA use can cause a reversible decrease in bone mineral density. However, if a patient with IBD is corticosteroid-dependent or otherwise at risk for osteopenia, a risk vs benefit discussion needs to occur.

use of oral CHC increases risk of VTE from 2 to 10 per 100,000 to 7 to 10 per 100,000.[18-20] As the risk of VTE is 3 to 35 times higher in pregnancy and postpartum,[21] the benefits of use of estrogen-based contraceptive methods for people with IBD outweigh this low absolute risk for most patients trying to avoid pregnancy.[15] If IBD activity escalates and a patient is unable to tolerate oral options, is on long-term corticosteroids, has decreased mobility, or is planning for surgery with associated VTE risks, re-evaluation of benefits and risks with ongoing estrogen use needs to occur. Furthermore, if a patient is taking Janus kinase inhibitors, which have been associated with increased VTE risk, a risk vs benefit discussion is recommended prior to concurrent use of estrogen-containing contraceptives.[22] Other hormonal contraceptive methods, including emergency contraceptive pills, are progestin-only options, which overall do not increase risk of VTE.[15] These options include hormonal (levonorgestrel) IUDs, depot medroxyprogesterone acetate (DMPA) injections, progestin-only pills, and subdermal contraceptive implants. All of these methods may be used without restrictions in IBD patients based on safety data.[15] Differentiating between combination and progestin-only methods and avoiding confounding estrogen-associated risks with all hormonal methods will support evidence-based counseling for patients with IBD seeking to avoid pregnancy. The Table is a useful resource for IBD-specific considerations of prescription contraceptive methods approved by the US Food and Drug Administration.

Adverse Effect Profiles of Contraceptive Methods

Despite safety of contraceptive methods for people with IBD, some adverse effects of different methods should be individually considered. For example, prolonged DMPA use can cause a reversible decrease in bone mineral density; however, if an IBD patient is corticosteroid-dependent or otherwise at risk for osteopenia, a risk vs benefit discussion should occur.[15] If a patient is using anticoagulant medications or has oligomenorrhea resulting in heavy menstrual bleeding, hormonal methods may improve bleeding profiles, whereas the nonhormonal IUD may worsen bleeding.[23] Mood changes are also a known risk with some

hormonal methods,[24] and, given the association between IBD and depression,[25] consideration of worsening symptoms may be a cause for method change. Because adverse effects of contraception are a common reason for method discontinuation,[26] establishing a follow-up and method transition plan at the time of new method initiation can improve adherence and avoid interim risk of unprotected intercourse and pregnancy.

Acceptability and Access to Contraceptive Method Selection

Although people with IBD may prioritize safety or efficacy in their contraceptive method selection owing to their IBD-associated pregnancy risks,[27] they will still have personal and/or partner preferences that influence acceptability of method selection.[10] Patients may have fears regarding an IUD or implant insertion, desire a method that improves acne or menstrual headaches, or prioritize one with a specific bleeding profile.[28] Additionally, access barriers may limit selection from the full range of contraceptive methods, despite user preference. For example, a patient may be un- or under-insured, and method cost may be a barrier to use.[29] Access to refills and prescription renewals may be a challenge for some patients. If a patient is in a coercive relationship or attempting to escape an abusive relationship, reliance on a partner-controlled method, such as condoms, may not be reliable. In sum, the best contraceptive method for any individual is the one that is safe and that the patient is most comfortable using, regardless of other characteristics a practitioner may find most desirable.

Counseling Patients With Unwanted or High-Risk Pregnancy

In the setting of unwanted or high-risk pregnancy, reproductive options counseling and time-sensitive care coordination should occur, particularly in the post-Dobbs era. This diagnosis may be made during the IBD visit, and initiation of counseling by the IBD practitioner with referral to a reproductive practitioner will decrease delays in time-sensitive care.[30] This counseling begins with a discussion of a positive pregnancy test in an unbiased approach and ends with a presentation of options: adoption, parenting, and abortion. Regardless of the comfort level of the practitioner having this discussion, the practitioner should ensure that patients have referrals and follow-up needed to help them with their decision, whatever that is.[31] IBD practitioners should include a discussion of disease-related pregnancy risks and dispel any misinformation the patient may have that could influence their pregnancy decision.[32] Although it is not reasonable for all IBD practitioners to be up-to-date on the varying, state-level abortion restrictions, they can reach out immediately to the reproductive health practitioner who cares for their IBD patients in pregnancy. This would be an appropriate first step, if desired by the patient. Patients may also access information, care coordination, and financial assistance if out-of-state travel is needed through the National Abortion Federation at www.prochoice.org.

Strategies to Align Family Planning and Inflammatory Bowel Disease Care

Breaking down silos of care related to IBD and reproductive health to meet patients' needs and support reproductive autonomy has never been more time-sensitive than post-Dobbs. Seeking collaboration with Complex Family Planning subspecialists, Maternal-Fetal Medicine subspecialists, or reproductive health providers with interest in caring for medically complex patients is a first step.[30] High-volume IBD clinics may consider initiating an interdisciplinary clinic to optimize access to contraception for their patients. Many academic centers have created complex contraception clinics to meet contraceptive needs of all patients for whom contraceptive care is more challenging, including IBD patients. These clinics can improve cross-specialty and subspecialty communication and patient access to information about risks of IBD in pregnancy and preconception risk mitigation. Regardless of available resources, all health care providers have a responsibility to incorporate family planning counseling into routine care of IBD patients. Additionally, identifying care pathways in each health system and at a state and regional level can ensure that supportive and time-sensitive family planning services for IBD patients—and all people capable of pregnancy—are available in this evolving and restrictive legislative environment.

Conclusion

Practitioners of all specialties who care for people capable of pregnancy are likely to encounter patients experiencing unwanted and/or high-risk pregnancies. The options available to each patient in the post-Dobbs landscape vary across the United States as a result of state-level restrictions, limits to health system–level resources, and individual patient challenges. IBD practitioners have opportunities to offset some of these barriers through patient counseling and interdisciplinary relationship building. Restrictions will continue to evolve. Thus, development of local networks among health care providers will increase awareness of changes to reproductive care and facilitate referrals and resources for patients in a time-sensitive fashion to avoid adverse outcomes.

Disclosures

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