

Pregnancy and birth: what to expect

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Planning to start a family, or wondering what pregnancy and birth might be like with an internal pouch or stoma? Abhilasha Patel, Consultant Colorectal Surgeon at University Hospitals Coventry & Warwickshire, answers some common questions.



Pregnancy should be a joyful time, however, for some with bowel disorders it can be a time of stress, discomfort and uncertainty. In an IA-funded study published in 2022, researchers set out to assess stoma, IBD, obstetric and neonatal outcomes in pregnant IBD patients with a stoma. The findings suggested that pregnancy for women with a stoma for IBD is associated with higher rates of Caesarean births and may result in stoma complications.

The study highlighted that if you have active IBD or if you have had surgery for IBD, especially involving the pelvis, it can be more difficult to conceive naturally.

Research undertaken confirmed: 'Of 80 pregnancies with a live infant born, ten (12.5%) were normal vaginal deliveries and ten (12.5%) were assisted (ventouse, forceps) vaginal deliveries'. Furthermore: 'In 20 (25%) pregnancies, serious stoma-related complications occurred. Prolapse of the stoma occurred in nine (11%) cases, of which only

two required an operation to correct the prolapse during pregnancy. New onset of parastomal hernia was reported in three (4%) pregnancies, of which two required surgical operative management during pregnancy'.

Although these results can appear concerning, it is important to highlight that the aim of the study was ultimately to raise awareness among clinicians of the issues faced by pregnant women with IBD related stomas, in order to improve outcomes. And despite the 'high rate of serious stoma complications, most were managed conservatively' which means only a few women required surgery; most were successfully treated with supportive measures. With this in mind, this article covers some frequently asked questions about what to expect when you're expecting with a stoma or internal pouch.

Q: What are the most common pregnancy issues with an internal pouch or stoma, and are there particular stages of pregnancy to expect them?

A: Most of the literature says that pouch function changes during pregnancy, more so during the third trimester. You may have more frequent bowel movements, occasional

seepage and may wake up at night to go to the toilet. These changes settle once you have the baby but in a small percentage of patients, they don't. No one really understands why this is but it's not to do with how the baby is delivered.

Whether you have a Caesarean or a vaginal birth doesn't seem to make any major difference to pouch function afterwards.

For stomas, it's similar. You may have higher output and mechanical problems with them, with the baby moving up towards the stoma. There may be intermittent obstruction, blocking off the stoma. However, the need for surgical intervention is low as

most of the time you can manage with conservative treatment, so you don't often need an operation to alleviate problems.

Q: Is pregnancy likely to trigger pouchitis?

A: I don't think pregnancy triggers pouchitis. It may be misconstrued as pouchitis because your pouch frequency can go up owing to hormonal changes, but it doesn't per se trigger flares of pouchitis.

Q: What should people be mindful of in terms of diet and exercise?

A: If your pouch frequency goes up, you could change your diet so that you are eating less fibre: low-residue food. You might have to take

medication to help, such as Imodium, to try and control it. And pregnancies with a stoma may see high output. It's wise to also keep an eye specifically at any mineral deficiencies, such as folic acid.

In terms of exercise, there are no restrictions on exercise for pouch. And stoma patients will be advised to do certain exercises and not others. I think this is the same irrespective of whether you're pregnant or not.



If your stoma stops working during pregnancy, present yourself as soon as possible so doctors can decide the best course of action.

Q: Towards the end of pregnancy, how might pouches and stomas be affected by the added pressure/weight of the baby?

A: The uterus sitting on the pouch isn't generally a problem. Sometimes you

can get intermittent pouch dysfunction because the pressure of the baby can prevent the pouch from filling and emptying properly. If that happens, you'll find yourself going to the toilet more often because it's not emptying fully, which is most common in the third trimester. But I don't know of any patients with pouches having to go to theatre because the uterus has completely blocked off the pouch. By some miracle it continues to work, so the only time you might need surgery is if a bowel loop above the pouch has got trapped, but that's rare.

Likewise for stomas, the uterus may push up onto the stoma. Sometimes you can get kinks of the bowel, where the bowel twists around

the stoma site because the uterus has pushed it in a certain configuration. So, you can get obstructive issues but most of the time they're resolved with bowel rest and conservative treatment. There's not often any need for surgery to fix it.

That said, there is a higher foetal mortality rate without early intervention, so if your stoma stops working during pregnancy, present yourself as soon as possible so doctors can decide the best course of action. This might be bowel rest through use of nasogastric tubes. More importantly, if you need an operation, you'll have it sooner rather than later.

Q: Does pregnancy and birth increase the risk of an internal hernia?

A: Any kind of abdominal surgery can lead to developing an internal hernia. Where the uterus is sitting on an internal pouch, the bowel can get stuck, so the risks of internal herniation would be higher.

Similarly with stomas, the bowel is attached to the surface on a pedicle, so it swings freely which means other parts of the bowel can

track around it. During pregnancy, there's not much space for the bowel to move so it's more likely to get stuck.

Q: Is giving birth naturally recommended with a pouch or stoma?

A: This is very topical debate amongst most of the Western world, and the advice is slightly different depending on where you are sitting.

The general UK consensus, from what I understand, is if you've

already had a baby vaginally before having pouch surgery, most hospitals will say you can have a normal delivery.

But if you've never had a baby and have a pouch, most will recommend a Caesarean.



Caesarean or vaginal births don't seem to make any major difference to pouch function.

The reason is that the highest chance of having perineal tears is with the first pregnancy, and if you get a tear in the vaginal or rectal area when you have a pouch, the pouch function becomes dramatically worse and is not easy to fix. It's often the case that you can't do much surgically to try and fix it, so then you end up having to defunction the pouch.

It's more the fear than the reality of that happening because the incidence of significant perineal tears across all deliveries is very small. It's just that you can't predict them.

That's the official guidance we are supposed to give patients who have pouches. I'll often

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get involved at delivery stage and end up helping the obstetric team with the Caesarean. When the patient has had previous surgery, obstetricians always have concerns about the pouch getting attached to where they're going to make the incision for the baby. C-sections are often done as a joint operation between the obstetrician and general surgeon, or involve general surgeon backup, and most of the time it's fine. I think most people would be advised to have a Caesarean.

For stomas, if you have perianal Crohn's disease (PCD), I'd recommend a Caesarean. But if you don't have PCD, you can have a normal delivery. I don't think it makes an impact on the stoma or is associated with an adverse outcome.



Hospital births are recommended in case any complications arise.

Q: Is a home birth possible?

A: Regardless of whether you have a stoma or pouch, I would recommend avoiding a home birth as they are usually offered to women who are low risk for problems during delivery. If you have a stoma or pouch, there can be complications related to your previous surgery so it would be best to deliver in a hospital setting where the relevant doctors who need to be involved can be accessed quickly.

If you have a pouch and any complications arise during delivery, it doesn't just have an impact on the baby and the mother from an obstetric point of view. It also has an impact on the pouch. You should really be under

consultant-led care rather than midwifery-led care, or midwifery-led care with close consultant supervision. If you're going to attempt a normal delivery, it's probably more important to be in a hospital environment so medical teams can intervene if there are any complications.

For some people, having a normal delivery in a normal environment is very important, but I think most patients who have a successfully functioning pouch will be quite invested in making sure it's still working well after the baby arrives, and will therefore opt for a hospital bed.

Q: Is an epidural or other standard pain relief allowed?

A: Yes, pain relief is fine for both pouch and stomas.

Q: Is postnatal recovery the same, such as pelvic floor exercises?

A: Yes, postnatal recovery measures will be the same for those with pouches, with modifications on how to undertake exercises for those with stomas.

What were your experiences of pregnancy and birth? Drop us a line if you have any anecdotes to share: editor@iajournal.co.uk

To read the full PAPooSE study, please visit: <https://onlinelibrary.wiley.com/doi/10.1111/codi.16098>