

Surgical management of ulcerative colitis in an ongoing pregnancy: report of a case and literature review

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Dear Editor:

Severe ulcerative colitis (UC) often requires surgical management. When surgery is indicated during pregnancy there is understandably great concern regarding the possible adverse effects of surgery on both mother and foetus. This concern is heightened in early pregnancy when it is not possible for delivery and operative intervention to coincide. We present a case of a subtotal colectomy and ileostomy during the second trimester with a successful pregnancy continuing after surgery.

During the management of this patient, we found there were few reports of pregnant women requiring surgery for severe UC, particularly when the pregnancy was required to continue in the post-operative period. Alongside this, we present a review on the impact of surgery for UC in pregnant women with pregnancy continuing after surgery.

The present case involves a 27-year-old woman with known UC, 25 weeks pregnant. The patient had experienced daily mild rectal bleeding since conception which had been managed with oral prednisolone and mesalazine. The patient presented to our hospital reporting 2 weeks of severe abdominal pain and profuse bloody diarrhoea. Rigid sigmoidoscopy showed severe colitis, so maximal medical therapy was commenced. The patient failed to show a complete response to medical therapy and proceeded to undergo a subtotal colectomy with terminal ileostomy and mucous fistula.

The post-operative period was uneventful, and the patient was discharged promptly. The patient gave birth to a healthy child by spontaneous vaginal delivery at 32 weeks.

We identified 38 cases of UC managed by surgical intervention during pregnancy [1]. Surgical intervention coincided with Caesarean section or delivery in 16 patients, with the pregnancy continuing after surgery in the remaining 22 cases. In the later group, the median age of the patients was 29 years (18–35 years), 59 % of whom were in their second trimester. Twenty-one procedures were documented in 20 women: 14 women underwent subtotal colectomy and ileostomy, 1 woman had total colectomy and ileostomy, 4 women had a colostomy and ileostomy and 1 patient each underwent terminal ileostomy and transverse colostomy alone. There were five cases of foetal mortality and three of maternal mortality. All the cases of maternal mortality were associated with foetal mortality. All cases of maternal and foetal mortality were reported prior to 1974. Maternal morbidity was documented in five women, including splenic rupture, two abscesses and one case of wound infection. One patient who underwent colostomy and ileostomy required subtotal colectomy 7 days later.

Surgery for UC during pregnancy historically carried significant risk for both mother and foetus. This case adds to the evidence that surgery for UC during pregnancy can be undertaken with minimal maternal and foetal morbidity, let alone mortality. Following any surgical intervention, it is possible for the pregnancy to continue safely. When indicated, surgical intervention for UC should not be delayed because of fears of adverse effects on pregnancy. Evidence concerning the outcomes of surgery for UC in pregnancy is scarce, and we feel it is important this information is reported.

Reference

1. Dozois EJ, Wolff BG, Tremaine WJ et al (2006) Maternal and fetal outcome after colectomy for fulminant ulcerative colitis during pregnancy: case series and literature review. *Dis Colon Rectum* 49(1):64–73

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