

PREGNANCY AND THE OSTOMATE

The management of a pregnant patient with a stoma is uncommon. There is no large published series and most reviews consist of information obtained from questionnaires sent to patients who have had a pregnancy associated with a stoma, the most common of which is an ileostomy. Colostomy and urinary diversion are infrequent.

Prior to pregnancy it is obvious that marital and sexual adjustment is necessary and infertility and dyspareunia may be a problem. Inflammatory bowel disease is the major indication for the ileostomy. As well as ulcerative colitis, other conditions, such as Crohn's disease, idiopathic megacolon and familial polyposis coli are also causes for an ileostomy. Urinary diversion is usually necessary in patients with Spina Bifida or congenital urinary tract anomalies.

MANAGEMENT

It is important to commence any management with pre-conceptual counselling and to correct any folate or B12 deficiency. Physical fitness and healed abdominal scars are important prior to conception.

Where there is intestinal diversion for Crohn's disease the possibility of recurrent disease during pregnancy should be kept in mind. In those women with ulcerative colitis this is usually cured by surgery and any problems in pregnancy are related usually to the ileostomy.

COMPLICATIONS

Complications can occur throughout pregnancy and these can be divided into the various stages of pregnancy and delivery.

1st Trimester. Complications are unlikely in the first trimester, although ileostomy dysfunction has been described. This may be due to iron supplementation.

2nd Trimester. If the uterus is retroverted uterine incarceration of the enlarging uterus can occur. At this stage stomal prolapse is possible and hyperemesis may result.

3rd Trimester. The most serious complication seen in patients during pregnancy is intestinal obstruction. This must be suspected if there is vomiting and abdominal pain and early diagnosis by plain x-ray of the abdomen is essential. Conservative treatment is the treatment of choice and this consists of nasogastric suction and intravenous therapy. Fluid and electrolyte imbalance is corrected. If conservative management fails then surgical treatment is necessary and this may require Caesarean section at the same time to empty the uterus in order to allow access to the obstructed bowel.

Stomal prolapse or stomal retraction may occur during advanced pregnancy and again these are best treated conservatively at that time but may require surgical correction during the puerperium.

There are no specific problems seen in the puerperium.

MANAGEMENT DURING LABOUR

A vaginal delivery is preferred and can be achieved in the majority of cases. In a combined series one hundred and ten pregnancies were reviewed (*addition of published reviews personal data*). Of these one hundred and five progressed to full term and in five cases there was early pregnancy loss. Seventy-five of the women achieved a spontaneous vaginal delivery and there were fifteen Caesarean sections and fifteen assisted vaginal deliveries.

Routine Caesarean section is advisable as it increases the morbidity and mortality for the patient. The stoma does not constitute a contraindication to vaginal delivery and in most cases the disease process for which the stoma was performed is quiescent.

In conclusion, pregnancy in woman with a stoma is not contraindicated and there are no specific hazards to the baby. It is important to address the psychological aspects that are common in these women.

Antenatal care has to be meticulous and foetal growth restriction, if it occurs, is not usually the direct result of a stoma but may be the result of the primary disease for which the stoma is performed. It may of course be secondary to unrelated obstetric conditions. The most serious complication in pregnancy is of intestinal obstruction. This should be recognised quickly and treated in the first instance conservatively. Surgical treatment may be necessary.

Appropriate contraception is important so that these patients may recover from the pregnancy and any malabsorption that may have occurred and resulted in iron, folic acid or vitamin B12 deficiency.

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