Recommendations

5.1 Best Practice Recommendations

Based on the available evidence, the following best practice recommendations have been made, noting that this is an emerging area of research. Recommendations are not necessarily based on the highest evidence level classification, but those considered by the expert consensus panel as having the greatest potential impact on care. Figure **3** is a print friendly infographic of key recommendations.

- **Contraception:** Counsel regarding the use of reliable contraception, especially if significant gastrointestinal side effects occur such as vomiting or diarrhea. Specifically, those using tirzepatide will need reliable non-oral contraception.
- **Proactive counseling:** Proactive counseling should be provided on an individual basis to all women regarding the risk of conceiving while using incretin-based medications. Currently, there is no clear evidence to support specific washout periods. If not already discontinued, the medication should be stopped as soon as pregnancy is confirmed. This approach may be considered in selected cases to maintain metabolic benefits, although this approach remains uncertain and the benefits should be carefully balanced against potential fetal risks.
- **Nutrition:** Women of reproductive potential using incretin-based medications should receive dietary counseling to optimize nutritional intake and reduce the risk of nutrient deficiencies, alongside physical activity advice. Upon cessation of medication, advice should be provided to mitigate weight regain.

a. Give advice regarding nutrient dense food sources where overall food intake is reduced, to mitigate appetite-driven under-nutrition. This may include suggesting alternatives to foods that are no longer tolerated.
b. Encourage a fiber- and protein-rich diet and adequate hydration as appropriate to manage GI side effects.
c. In line with national and international guidelines, recommend those seeking to conceive take supplemental folic acid and vitamin D and to optimize nutritional status prior to conception wherever possible, bearing in mind that a prenatal multivitamin and mineral supplement may be needed. In the absence of biochemical data, clinical judgment should prevail.
d. For those not seeking to conceive, a general multivitamin and mineral supplement should be recommended.

- **Selection for incretin-based medication therapy:** should prioritize women with greater metabolic burden (i.e., those with PCOS and obesity-related comorbidities) and fertility treatment eligibility needs.
- **Pregnancy:** Incretin-based medication therapy should not be deliberately continued throughout pregnancy. However, for those who have inadvertent exposure during pregnancy, reassurance should be provided that current data shows no increased risk for congenital anomalies following exposure in early pregnancy.

- **Fetal and pregnancy monitoring:**

a. Based on available data, if incretin-based medication *was* discontinued following exposure in early pregnancy, standard obstetric growth surveillance is recommended. Mothers should be directed to register with the appropriate pregnancy exposure registry by contacting the drug company that supplied the medication in question.
b. GWG should be monitored during pregnancy after discontinuation of incretin-based medication.
c. Fetal growth monitoring should be undertaken at least once in the third trimester for women with GWG outside recommendations.
d. Serial fetal growth monitoring is recommended if incretin-based medications are continued during pregnancy/beyond the first trimester.
e. Screening for GDM: When incretin-based medications are discontinued prior to conception, glycaemic testing should be performed according to national guidelines. In case of inadvertent exposure to incretin-based medication, additional glycaemic testing in early pregnancy may be considered to better estimate the risk of GDM.

- **Lactation/breastfeeding:**

a. The use of incretin-based medications during breastfeeding should be assessed on an individual basis, due to lack of evidence. This discussion should balance the well-established benefits of breastfeeding for mother and infant against theoretical risks of infant exposure.
b. If an incretin-based medication is used during breastfeeding, monitor infant growth and developmental milestones and the nutritional status of the lactating woman closely. Maternal micronutrient supplementation and assessment may be required (see nutrition recommendations above).

- **Postpartum use:** incretin-based therapy for women with previous GDM appears to be effective for weight reduction as well as improvement of glycaemic parameters. However, the optimal timing to commence and continue this therapy is unknown and should take into consideration lactation needs.
- **Multidisciplinary team support:** women of reproductive age using incretin-based medication should be supported by a multidisciplinary team, including a registered dietitian. This is particularly relevant for those who are seeking to conceive, during and after pregnancy, and for those who may have other dietary needs.

Healthy pregnancies after incretin-based medication use
Selection for incretin therapy:
Prioritize women with greater metabolic burden (i.e., those with PMOS (PCOS) and obesity-related comorbidities) and fertility treatment eligibility needs.
Proactive counselling:
Counsel on an individual basis regarding the risk of conceiving while using incretin-based medications.
If not already discontinued the medication should be stopped as soon as pregnancy is confirmed.
Contraception:
Counsel regarding the use of reliable contraception, especially if significant gastrointestinal side effects occur such as vomiting or diarrhoea.
If using tirzepatide, provide reliable non-oral contraception.
Nutrition:
Women of reproductive potential using incretin-based medications should receive dietary counselling to optimise nutritional intake and reduce the risk of nutrient deficiencies, alongside physical activity advice. Upon cessation of medication, advice should be provided to mitigate weight regain.
Pregnancy:
Incretin therapy should not be deliberately continued throughout pregnancy.
In case of inadvertent exposure, reassure that current data shows no increased risk for congenital anomalies.
Direct mothers to the appropriate pregnancy exposure registry.
Fetal and pregnancy monitoring:
Perform standard obstetric growth surveillance if incretin medication was discontinued in early pregnancy.
Monitor weight gain during pregnancy after discontinuation of medication.
Undertake fetal growth monitoring in the third trimester for women with excessive weight gain.
Perform serial fetal growth monitoring if incretin-based medications are continued beyond the first trimester.
Screening for GDM:
Perform glycaemic testing according to national guidelines when incretin-based medications are discontinued prior to conception.
In case of inadvertent exposure to incretin-based medication, additional glycaemic testing in early pregnancy may be considered to better estimate the risk of GDM.
Breastfeeding:
Due to lack of evidence, the use of incretin-based medications during breastfeeding should be assessed on an individual basis.
If used during breastfeeding, monitor infant growth, developmental milestones and the nutritional status of the mother. Maternal micronutrient supplementation and assessment may be required.
Postpartum use:
Incretin-based therapy for women with previous GDM appears to be effective for weight reduction as well as improvement of glycaemic parameters.
Optimal timing to commence and continue this therapy is unknown and should take into consideration lactation needs.
Multidisciplinary team support:
Women of reproductive age using incretin-based medication should be supported by a multidisciplinary team.
Incretin-based medications in women and reproduction: A systematic scoping review and consensus guidelines for clinical practice (2026).