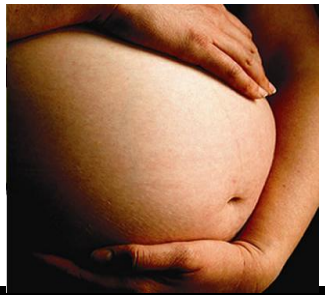
Plymouth Hospitals NHS
NHS Trust

**Antenatal Guidelines**



# No.16 Cholestasis (OC) in pregnancy

**The information below has been abstracted from the RCOG Green top Guideline no 43, April 2011.**

1. Clinical features

- Affects 0.1 - 0.7% (1-7 per 1000, i.e. 5-30 patients per year at Derriford) pregnancies
- Severe pruritus affecting limbs and trunk in the second half of pregnancy. Typically worse at night.
- Associated with malaise and insomnia.
- NO RASH.
- Abnormal liver function tests (NB use pregnancy specific reference ranges not standard hospital ranges).
- May have dark urine, anorexia, steatorrhoea.
- Recovery usual after delivery, occasionally progresses in puerperium.

2. Investigation and Diagnosis

- Careful history taking and examination of the skin should be carried out to exclude dermatological conditions.
- Diagnosis of Cholestasis is based on abnormal/raised transaminase. In these incidents there is no need to test bile acids.
- If liver transaminases are significantly raised then:
    - Exclude other causes of abnormal liver function (check viral screen for Hepatitis A,B and C, Epstein Barr, CMV.
    - Liver autoantibodies for chronic active hepatitis and primary biliary cirrhosis.
    - A liver ultrasound is recommended.
    - Bile acids for clinical chemistry.

3. Counselling

Women should be advised that:

- The incidence of premature birth, especially iatrogenic, is increased.
- There is increased likelihood of meconium passage in pregnancies affected by obstetric cholestasis.
- There have been no reports of any harmful effects to babies from OC pregnancies once they have been delivered.

- Since there is no significant elevation in risk for the mother or fetus, treatment should be for symptomatic relief only.

4. Management

- Liver function tests and Prothrombin time should be performed every 1 -2 weeks unless requested more frequently by Consultant Obstetrician or Chemical Pathologist.

No specific antenatal fetal monitoring is recommended for patients with suspected obstetric cholestasis

- Women should be offered an appointment with their named consultant at 36/40 to discuss possible induction of labour.
- Drug therapies include:

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| • Topical emollients<br>• Antihistamines may provide sedation at night but will not help itching!<br>• Antihistamines to relieve pruritus.<br>• Ursodeoxycholic acid (UDCA) 8-12 mg / kg / day in two divided doses. RCOG do not recommend use outside a clinical trial<br>• Dexamethasone RCOG do not recommend use outside a clinical trial. |

5. Maternal risks

- There is little evidence for the use of maternal Vitamin K unless there is frank steatorrhoea or prolongation of Prothrombin time. If indicated 10mg water soluble Vitamin K should be offered to the mother daily.

- The newborn should be recommended to have standard Vitamin K administration

6. Management of Labour and Delivery

- Stillbirths in obstetric cholestasis have been reported across all gestations. As gestation advances, the risk of delivery (prematurity, respiratory distress, failed induction) versus the uncertain fetal risk of continuing the pregnancy (stillbirth) may justify offering women induction of labour after 37+0 weeks of pregnancy.

- The decision should be made after careful counselling with the women and discussion with the Consultant. The case for intervention at this gestation may be stronger in those with more severe biochemical abnormality (40 mmol/L), but delivery decisions should not be based on results alone.

- Obstetric cholestasis has been linked with an increased incidence of passage of meconium, premature delivery, fetal distress, delivery by caesarean section and postpartum haemorrhage.

- In a hospital setting, the current additional risk of stillbirth in OC above that of the general population has not been determined but is likely to be small.

- Women diagnosed with OC should give birth in the consultant unit and continuous fetal monitoring offered.

## 7. Postnatal

- Check LFTs and Prothrombin time after a minimum of 10 days. This should be done via the GP surgery. If not resolved, repeat and discuss with consultant Obstetrician about further investigation / management
- Advise of high risk of recurrence in future pregnancies
- Advise to avoid contraception containing oestrogen.

## 8. Record Keeping

It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG.

All entries must have the date and time together with signature and printed name.

## Monitoring and Audit

**Auditable Standards:**
Number of cases suspected; perinatal outcome; gestational age at delivery; Documentation; postnatal follow up completion; use of maternal Vit K**;**

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

**Reports to:**
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

**Frequency of audit:**
Annual

**Responsible person:**
Obstetric registrar / consultant

## Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping
Antenatal Guideline 44 – Guideline Development within the Maternity Services

## References

Royal College of Obstetricians and Gynaecologists, 2006. **Guideline No. 43 Obstetric cholestasis**. RCOG, London.

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| **Author** | Guideline Committee, | | |
| **Work Address** | Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH | | |
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