Recent update of management of obstetric cholestasis
Nasreen SZA

Introduction
Obstetric cholestasis is the most common liver disease in pregnancy. Fortunately this condition is rare but it is often interrupted by distressing and dangerous complications both medical and obstetric. Generalised pruritus occurring in late pregnancy in absence of dermatological abnormalities is usually due to Obstetric Cholestasis (OC). Classically the patient present with generalised itch typically worse at night and lack of sleep between (28-34) weeks gestation. Jaundice is not necessary for the diagnosis but often followed in more severe cases. The incidence is highly variable probably reflects genetic, geographic and other environmental factors. Asiatic is known to have high incidence. The most dangers of the disease are increased risk of Intrauterine Death (IUD) classically from 37 weeks, Stillborn, Featal distress, Mechoneum stain and increased incidence of preterm laboure (PTL). Pregnant women suffer from sleep disturben and postpartum haemorrage. Also the recurrence rate of OC is very high (80%).

How to diagnose
Before discussing the management we need to know how to diagnose OC. Diagnosis is simple. When pregnant women come with pruritus specially at late pregnancy and no other reasons or dermatological causes are found, OC is diagnosed. Along with other antenatal investigation, liver funtion tests should be done. Mild or moderate raised level of transaminase, specially increased Gama glutaryle transferase, Bilirubin and Bile acid are sufficient to consider to support the diagnosis.\(^1,2\) Normal Bilirubin or normal Bile acid does not exclude OC.\(^3,4\) A Viral screen for hepatitis and Autoimmune antibodies for chronic active hepatities and for Primary Biliary Cirrhosis need to be done. Ultrasonography of whole abdomen is must to exclude any obstrucion of biliary tree.

Acute fatty liver of pregnancy, Preclampsia, Hellp syndrome may need to keep in mind while dealing such cases. Dermatological diseases are the first to be counted for differential diagnosis.\(^5\)

Management
Preconceptual management is not applicable unless it occurred in a previous pregnancy. Then the patient should be counselled about possible recurrence of this condition. USG need to be done to search for cholelithiasis before getting pregnancy.

During antenatal period, chief priorities should be:
- Monitoring of foetal well being
- Timed delivery
- Maternal symptom's control
- Vit-K supplementation

Pruritus without marked biochemical alteration indicates better prognosis for the foetus than in those with frank hepatic enzyme abnormalities. Antenatal foetal surveillance should be more frequent. Foetal well being can be monitored by Kick chart, auscultation of Foetal heart rate, CTG and USG. If Foetal jeopardy is suspected biophysical profile and Dopplar study of Umbilical Arteries and Middle Cerebral Arteries to be done. In satisfactory cases pregnancy can be continued up to 37 complete weeks. There is controversy regarding time of intervention. Most of the researcher agreed to terminate at term to avoid unsee future complications. Foetal distress,
Mechoneum stain, Intrauterine Death and Stillborn are more common in advanced pregnancy.  

Therefore the couple need to be counselled regarding termination of pregnancy at 37 completed weeks. The mode of delivery will depend upon foetal condition and Bishop score. If favourable induction of labour can be done. In that case close monitoring by the help of CTG, Partograph and if possible Foetal scalp blood sampling should be carried out. Any deviation from norm necessitates immediate Caesarian Section. In some cases, pregnancy need to be terminated earlier even at 34-35 weeks of gestation. In that cases Steroid injection should be administered. So timed delivery is most essential part of management in OC.

Mothers usually suffer from intense Pruritus which disturbs patient sleep. Skin Emolient, Antihistamin can be tried but this pruritus is very resistant to treatment. Lotiocalimina, Phenol (0.5-1) in aquous cream may provide some local releif.

Drug like Chostyramine is used randomely but its success is not satisfactory. Some author found this is disappointing, on the contrary few studies showed some benefit.  

Urso deoxycholicacid (UDCA) is more effective. The dose shedule is 500 mg twice daily but it can be increased upto 2 gm/day if necessary. Most patients respond well. Sedative may be required in some patients.

Vitamin K should be routinely given to all OC patients. The idea is to prevent Postpartum Haemorrhage (PPH), It can be given as 10 mg/day. The study showed women who gets Vit-K they have less incidence of PPH. Neonatal bleeding is also less than who does not receive any Vit-K. During Antenatal period close monotoring is required. Early detection of foetal compromise can be corrected by timed intervention. LFT needs to be done twice in a week or earlier if demanded. Also LFT should be done 2 weeks after the delivery. Usually if neonate survive from all the hazards the long term sequela is very rare. Postnatally all babies should receive Vit- K even mothers got that antenatally.

Some obstetritian prefer the use of Dexamethason. But the meta analysis showed conflicting reports so Dexamethason should not be first line therapy for Obstetric Cholestasis.

All women postnatally needs to be counselled regarding high rate of recurrence (75 -80%) for next pregnancy.

They should also be informed about the risk of cholestasis with Estrogen containing oral contraceptive.

**Conclusion**

Obstetric Cholestasis is rare but its clinical importance lies in potential foetal risks which may include Prematurity, Intrauterine Death, Mechoneum stain, Stillbirth and there can be significant maternal morbidities in association with intense pruritus and PPH. Therefore appropriate management of OC is real challenge to all Obstetricians.

**References**