

Intrahepatic cholestasis of pregnancy

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1 Intrahepatic cholestasis of pregnancy affects 1.5%–4% of otherwise healthy pregnancies

The condition may be associated with serious fetal complications.¹ Although the specific cause is unknown, a combination of hormonal (estrogen and progesterone) and environmental (seasonal and geographic) factors together with genetic predispositions are likely involved.²

2 Intrahepatic cholestasis should be suspected in pregnant people presenting with pruritus

Pruritus, in particular on the palms or soles and with no associated rash, that usually occurs in the third trimester of pregnancy should raise suspicion of intrahepatic cholestasis of pregnancy. The symptom results from pregnancy-induced impaired excretion of bile and resolves postpartum.

3 Measurement of nonfasting total serum bile acids is used to confirm the diagnosis

Diagnosis of intrahepatic cholestasis of pregnancy is confirmed when the level of nonfasting total serum bile acids is elevated ($\geq 19 \mu\text{mol/L}$).³ Liver function tests should be requested to exclude other causes (Appendix 1, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.220334/tab-related-content). If the level of serum bile acid is normal, blood work should be repeated weekly when the clinical picture suggests intrahepatic cholestasis. Bile acids should be measured 4–6 weeks postpartum to ensure resolution, as persistent elevation may suggest another diagnosis.

4 Ursodeoxycholic acid may improve pruritus

Treatment for pruritus using ursodeoxycholic acid is started at 13–15 mg/kg (maternal weight) in divided dosing 3–4 times daily and is titrated to a maximum of 2000 mg/d to control pruritus. This treatment does not affect concentrations of bile acids or the frequency of adverse pregnancy outcomes.³ Topical emollients and antihistamines may also alleviate pruritus.

5 Intrahepatic cholestasis may be associated with adverse pregnancy outcomes

Potential maternal outcomes include preeclampsia and gestational diabetes. Fetal outcomes may include preterm birth, meconium-stained amniotic fluid, neonatal respiratory distress syndrome and intrauterine fetal death when the concentration of bile acids is $100 \mu\text{mol/L}$ or more.⁴ Fetal surveillance with non-stress testing and ultrasonography do not predict or prevent stillbirth caused by intrahepatic cholestasis of pregnancy. Serial-fasting bile acids should be measured weekly, and delivery planned based on bile acid levels and risk factors (Appendix 2, available at www.cmaj.ca/lookup/doi/10.1503/cmaj.220334/tab-related-content).

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