REGIONAL CONSIDERATIONS IN MANAGING
intrahepatic cholestasis of pregnancy

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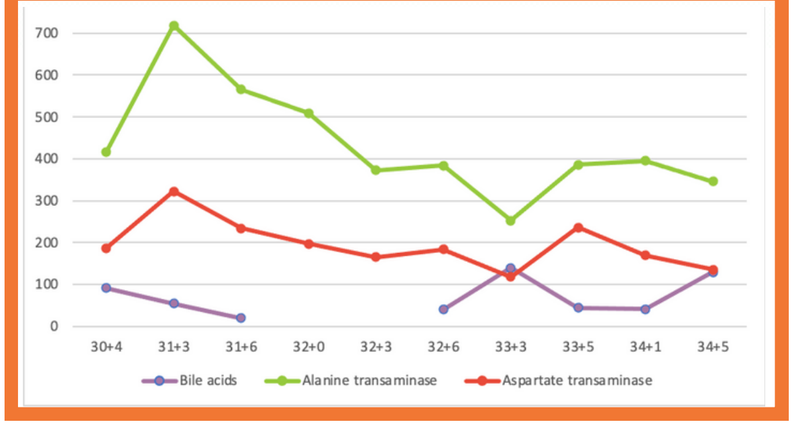
Introduction

Intrahepatic cholestasis of pregnancy (ICP), the most common hepatic disorder of pregnancy, usually develops in the latter trimesters of pregnancy (1). In the absence of other hepatic pathology, the hallmark symptom of pruritis, in addition to raised serum bile acids or liver transaminases, confers a diagnosis of ICP (1,2). ICP has an increased risk of perinatal complications, especially that of stillbirth (1,2). The management of ICP aims to improve symptoms, normalise maternal biochemistry and prevent foetal complications (1,2). In the regional setting, these women are often managed by their local obstetric departments with the input of tertiary centres and their relevant multidisciplinary teams. This case exhibits the management of ICP in a regional setting.

Case

A 29-year-old G2P1 presented with new-onset pruritis at 30+4 weeks gestation associated with a history of very dark urine, lethargy, and nausea. At this stage she was found to have raised serum bile acids and serum transaminases as seen in Table 1. As advised by the tertiary obstetric medicine team, she was commenced on ursodeoxycholic acid. Her previous obstetric history was relevant for a ventouse assisted birth with a 3B tear and 1.5L postpartum haemorrhage. After her first pregnancy, she was noted to have mildly elevated serum transaminases, and a liver USS showing possible mild fatty infiltrate and small hypoechoic region. This was surveyed with a liver CT which was negative. Her serum transaminases at the beginning of this pregnancy were normal. She did not have any family history of hepatic disease. She did not drink alcohol during or outside of pregnancy. With further transaminase derangement at 31+6 weeks (Table 1), she was admitted for inpatient monitoring of her ICP and underwent steroid loading. She had an ultrasound that showed a large for gestational age pregnancy. Due to stable serum transaminases (Table 1), she was discharged the next day. She was followed closely and had telehealth tertiary obstetric medicine input. Delivery planning began and was coordinated with a multidisciplinary approach involving the local and tertiary teams. Given a raised bile acid of 130 at 34+5 weeks and a presentation with concerns for onset of labour at 35+1 weeks, she was delivered by way of emergency caesarean section and was noted to have meconium-stained liquor. After a short stay in the special care nursery, the baby was later discharged. There were no further perinatal issues of concern. She is being followed up closely by her general practitioner postpartum, with steadily decrementing serum markers.

Table 1 - Biochemistry trend



Discussion

With the advent of telehealth in addition to integrated medical information systems, patients in regional areas have improved access to services they require. In cases where patients previously would travel long distances to access multidisciplinary care, there is now increasing flexibility without compromising morbidity and mortality outcomes (3). ICP is a complex disease, and the prospect of stillbirth risk provides great anxiety to patients and care providers, especially in a regional setting where resources are comparatively limited when compared to tertiary centres. The accessibility of various required services in the regional setting can ultimately result in safe perinatal outcomes.

References

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