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Information for you

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Obstetric cholestasis

This information is for you if you have been diagnosed with obstetric cholestasis or if you have persistent itching in pregnancy.

It tells you about:

- how obstetric cholestasis is diagnosed
- what extra antenatal care you can expect
- what this diagnosis may mean for you and your baby
- what treatments there are.

What is obstetric cholestasis?

Obstetric cholestasis is a disorder that affects your liver during pregnancy. This causes a build-up of bile acids in your body. The main symptom is itching of the skin but there is no skin rash. The symptoms get better when your baby has been born.

Obstetric cholestasis is uncommon. In the UK, it affects about 7 in 1000 women (less than 1%). Obstetric cholestasis is more common among women of Indian- Asian or Pakistani-Asian origin, with 15 in 1000 women (1.5%) affected.

What causes obstetric cholestasis?

The cause of obstetric cholestasis is not yet understood, but it is thought that hormones and genetic and environmental factors (for example diet) may be involved.

- **Hormones**
  Hormones such as estrogens, levels of which are higher in pregnancy, may affect the way your liver works and cause obstetric cholestasis.
- **Genetic and environmental factors**
  Obstetric cholestasis is more common in women from certain ethnic groups. Further evidence for a genetic component is that obstetric cholestasis appears to run in some families. If you have suffered

from obstetric cholestasis, there is a risk of recurrence in a future pregnancy (see below: 'Is there anything else I should know?').

What does it mean for me?

Obstetric cholestasis can be a very uncomfortable condition, but it does not have any serious consequences for your health.

- **Itching**
  Itching can start any time during pregnancy, but usually begins after 28 weeks. Although it often starts on the palms of your hands and the soles of your feet, it may spread over your arms and legs and, less commonly, may occur on your face, back and breasts. It can vary from mild to intense and persistent, such that it can be very distressing. The itching tends to be worse at night and can disturb sleep, often making you feel tired and exhausted during the day.
  There is no rash, but some women scratch so intensely that their skin breaks and bleeds.
  The itching gets better after birth and causes no long-term health problems.
- **Jaundice**
  A few women with obstetric cholestasis develop jaundice (yellowing of the skin owing to liver changes). Some women feel unwell and lose their appetite. Jaundice can also cause dark urine and pale bowel movements.

What does it mean for my baby?

The effects of obstetric cholestasis on your baby are still not clear:

- **Increased chance that your baby may pass meconium (move its bowels) before being born.**
  This makes the fluid around your baby a green or brown colour.
- **Increased chance of a premature birth.**
  One in 10 women with obstetric cholestasis will have their baby before 37 weeks of pregnancy; this includes women who have their labour induced.
- **Risk of stillbirth (baby born with no signs of life after 23 completed weeks of pregnancy).**
  Small research studies many years ago suggested that stillbirths may be more common among women with obstetric cholestasis and as a result labour was induced early. Recent research has shown that the risk of stillbirth is the same as in women without obstetric cholestasis (1 in 200). We do not know whether the reduction in stillbirth rate in women with obstetric cholestasis is attributable to a general improvement in obstetric and neonatal care, a general improvement in women's overall health or early induction of labour.

How is obstetric cholestasis diagnosed?

You may be diagnosed with obstetric cholestasis if you have unexplained itching

in pregnancy with abnormal blood tests (liver function and bile acid tests), both of which get better after your baby is born. It is a diagnosis that is made once other causes of itching and abnormal liver function have been ruled out.

Symptoms

Itching is very common in pregnancy, affecting 23 in 100 women (23%), but only a small proportion of those women will have obstetric cholestasis. However, itching is often the first sign of obstetric cholestasis,

often being worse at night and involving the palms of the hands and soles of the feet. Therefore, if you do have itching, it is important you tell your midwife or obstetrician.

Inspection of the skin

Your skin will be carefully examined to check that your itching is not related to other skin conditions, such as eczema. It is possible that you may have more than one condition.

Blood tests

You may be offered one or more blood tests to help diagnose obstetric cholestasis. These include:

- Liver function tests (LFTs). These involve a number of blood tests that look at how the liver is working.
- Bile acid test. This measures the level of bile acids in your blood. The bile acid level can be abnormal even if your LFTs are normal.
- Blood tests to rule out causes of other liver problems.

Some women may have itching for days or weeks before their blood tests become abnormal. If itching persists and no cause is found, the LFTs should be repeated every 1–2 weeks.

Ultrasound scan

An ultrasound scan can check for liver abnormalities and gallstones.

What extra care will I need?

Once diagnosed with obstetric cholestasis, you should be under the care of a consultant and have your baby in a consultant-led maternity unit with a neonatal unit. Depending upon your circumstances, you will be advised to have additional antenatal checks.

You are likely to have liver function tests, usually once or twice a week, until you have had your baby.

Additional monitoring of your baby may include monitoring your baby's heart rate (cardiotocography) and ultrasound scans for growth and measuring the amount of fluid around your baby. Unfortunately, none of these monitoring tests is completely reliable in preventing stillbirth.

When you are in labour, you will be offered continuous monitoring of your baby's heart rate.

Can obstetric cholestasis be treated?

There is no cure for obstetric cholestasis except the birth of your baby. Treatment may ease symptoms for most women. None of the treatments offered affects the outcome for your baby.

Treatments might include:

- Skin creams and ointments to relieve the itching. These are safe in pregnancy and may provide temporary relief.
- Antihistamines may help you sleep at night but don't appear to have much success in helping itching.
- Ursodeoxycholic acid often known as 'Urso' reduces the level of bile acids in your blood and improves LFTs. It may also help reduce the itching. There is not enough evidence to say whether ursodeoxycholic acid reduces the small chance of a stillbirth or whether it is completely safe for your baby, but it is a commonly prescribed medication for obstetric cholestasis.
- Some women have found that having cool baths and wearing loose-fitting cotton clothing helps to reduce the itching.

Vitamin K

Obstetric cholestasis may cause a problem with the clotting mechanism of your blood, making you prone to bleed for longer than usual. Vitamin K can help with this change. If your blood clotting time is prolonged, it is recommended that you take a daily dose of vitamin K to prevent complications if you start to bleed.

Even if your blood clotting is not affected, there may be a small benefit from vitamin K. There is very little up-to-date information that vitamin K is harmful for your baby in pregnancy. Therefore, you may wish to have a discussion with your doctor about whether you wish to take vitamin K or not.

Shortly after birth, your baby should be offered vitamin K, as are all babies.

When is the best time for my baby to be born?

You will have an opportunity to discuss the option of having labour induced after 37 weeks of pregnancy, particularly if your symptoms are severe or your blood tests are very abnormal. Early induction (before 37 weeks) may carry an increased chance of caesarean section and an increased chance of your baby being admitted to the special care baby unit with problems of being born early. It is difficult to predict the small risk of stillbirth if your pregnancy continues beyond 37 weeks. Your obstetrician will discuss what is best for you and your baby in your individual situation so that you can make an informed choice.

What follow-up should I have?

Obstetric cholestasis gets better after birth. However, you should have a follow-up appointment with a healthcare professional with knowledge of obstetric cholestasis 6–8 weeks after the birth of your baby. The purpose of your follow-up is to ensure that your itching has gone away and that your liver is working normally. Continuing symptoms and abnormal liver function tests may suggest a different problem after all and you should then be referred to a specialist.

Is there anything else I should know?

- There is a high chance that obstetric cholestasis may happen again in a future pregnancy: 45–90 in 100 women (45–90%) who have had obstetric cholestasis will develop it again in future pregnancies.
- If you have had obstetric cholestasis in your pregnancy, it is better to avoid the estrogen-containing contraceptive pill and you may wish to discuss alternative forms of contraception.
- Drinking alcohol does not cause obstetric cholestasis. However, it is sensible to avoid alcohol intake when pregnant, especially when there is evidence of any liver disease (see RCOG Patient Information: *Alcohol and pregnancy: information for you* at: http://www.rcog.org.uk/womens-health/clinical-guidance/alcohol-and-pregnancy-information-you).

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG guideline *Obstetric cholestasis* (April 2011). The guideline contains a full list of the sources of evidence we have used. You can find it online at: http://www.rcog.org.uk/womens-health/clinical-guidance/obstetric-cholestasis-green-top-43.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

The previous version of this information was reviewed before publication by women attending clinics in London.

A glossary of all medical terms is available on the RCOG website at http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.