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Intrahepatic Cholestasis of Pregnancy and Its Outcome

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ABSTRACT
Intra hepatic cholestasis is a rare syndrome which occurs during late second trimester and early third trimester of pregnancy[1]. It's the second most common cause of jaundice in pregnancy after viral hepatitis, we are reporting a case of primi with term-pregnancy came with pruritis and yellow discolouration of the sclera. Investigation showed abnormal LFT, gastroenterologist opinion was taken and suspected ICP and was conservatively managed. Patient underwent emergency caesarean section in view of fetal distress. Postoperatively, patient was symptomatically improved.

Keywords: *Intrahepatic cholestasis of pregnancy, emergency caesarean section, liver function test, fetal distress, pruritis.*

INTRODUCTION
ICP is hepatic dysfunction characterised by pruritis, elevated aminotransferases and bile acid levels with insidious onset in second or third trimester of pregnancy and spontaneously relieved after delivery. Occurrence ranges from 0.1%-15.6% worldwide. Between 2%-5% of all pregnancies are affected globally[2]. It is associated with maternal and fetal complications. It's also known as icterus gravidarium. Exact underlying etiology is not known. Risk factors are family history, maternal age >35years, multiple pregnancy, previous H/O ICP, more common in winter months. Common symptoms are pruritis (mostly on palm, sole) worse at night, nausea, vomiting, jaundice, steatorrhea[3]. Confirmatory diagnosis for ICP is deranged LFT and presence of icterus.

Case Report
Booked Primigravida with term gestation came to Antenatal checkup complaints of itching on palm and sole in the past 3 days as well as yellow discoloration of sclera. on examination pulse 82 bpm BP 130/80 mmHg. CVS and RS NAD, per abdomen Scratches were seen all over the abdomen uterus was term size cephalic Presentation fetal heart rate was good per vaginal examination cervix was favourable pelvis is adequate induction was done in view of decreased fetal movements with cervi prime gel emergency caesarean section was done. Male baby weighing 3kg was extracted. Post-operative period was uneventful.

DISCUSSION
First case was reported in 1883, but the disease remained unnamed until mid-1950. In 1998, Shornick introduced the term ICP[4]. Increase bile acids which damage the placenta due to vasoconstriction of chorionic vessels of the placenta leading to oxygen deprivation which results in fetal death. Increase bile acids stimulates prostaglandins release which leads to myometrial contraction causing preterm labour. There is an association between increased bile acids and increased glucose intolerance which leads to GDM. Complications are preterm (19-60%), meconium stained liquor (27%), fetal bradycardia (14%), fetal distress (22-41%), sudden IUD (0.4-4.1%), pre-eclampsia[5]. The management includes fetal and biochemical

surveillance-weekly fetal CTG, weekly LFT. pharmacological management-Ursodeoxycholic acid 300mg BD*3days; provides symptomatic relief and reduces the risk to the fetus, induction of labour. Kong et al concluded that when compared with control groups, ursodiol mitigated pruritus. Walker et al found that although ursodiol likely diminishes the pruritis of ICP, the overall effect is minimal.

CONCLUSION

ICP is a significant risk to both mother and fetus, it may occur at any time during pregnancy. Diagnosis and early treatment is necessary to prevent fetal complications.

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