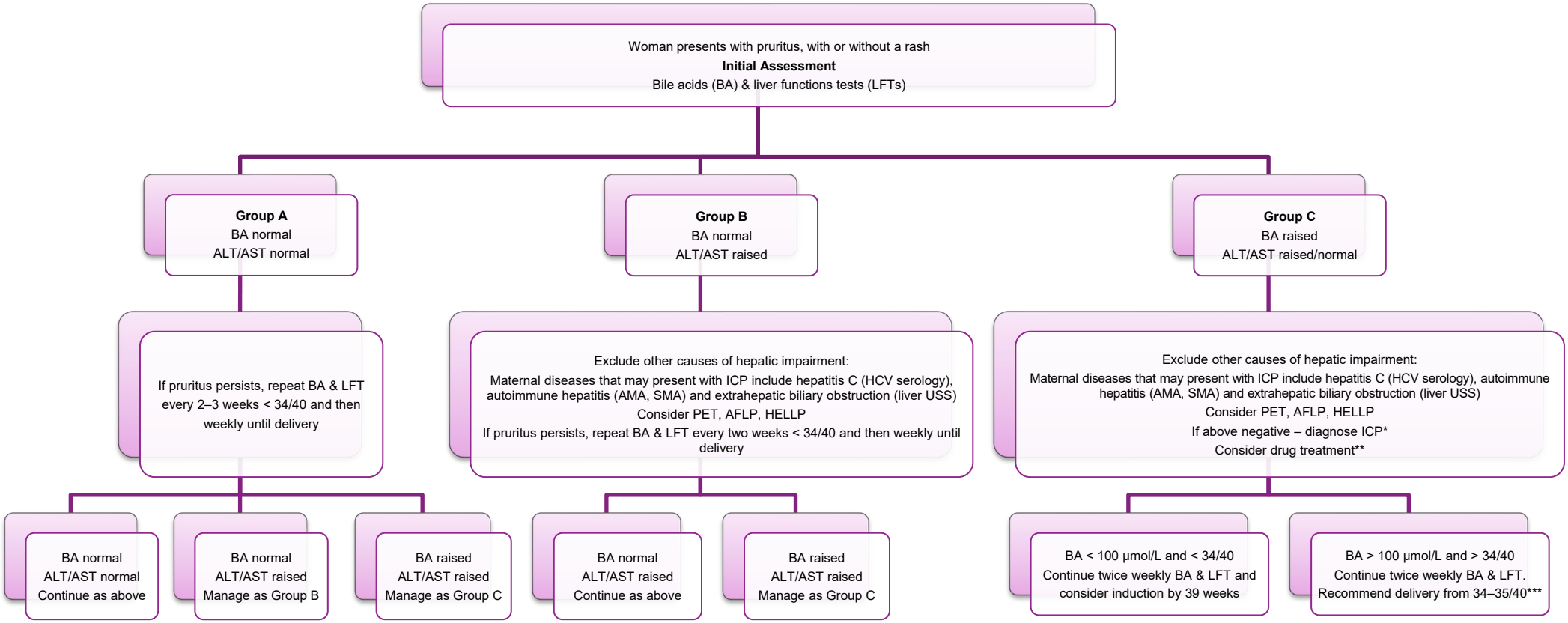
# Guideline for diagnosis, treatment and management of ICP




* With co-existing pathology, e.g. HCV/AIH, (hepatitis C/autoimmune hepatitis) the risk of adverse outcomes with high maternal bile acids for those women is likely to be the same as for women with ICP.

** The PITCHES trial (ursodeoxycholic acid v placebo) demonstrated that most women will not benefit from UDCA (ursodeoxycholic acid). Its use should therefore be considered carefully. If prescribed: starting dose is 500 mg BD with 250–500 mg increments if no improvement in symptoms or biochemistry, to a maximum dose of 2 g/day in divided doses.

Consider rifampicin as an adjunct therapy if bile acids (BA) remain > 100 µmol/L (150 mg BD increasing up to 300 mg BD), but caution is needed as the drug can worsen liver function and specialist involvement from areas such as obstetric medicine, obstetrics & gynaecology or hepatology is required to ensure screening for hepatotoxicity. Topical aqueous cream with menthol (1–2%) may help to soothe the skin. There no evidence for the use of CTGs (cardiotocographs) in monitoring an ICP pregnancy, but we appreciate that some women may find them reassuring.

*** Ovadia et al (2019) showed that risk of stillbirth is present from 35–36 weeks of pregnancy when bile acids > 100 µmol/L. Bile acids can rise suddenly and steeply (they can also fall quickly), so it is vital that regular bile acids are performed with results available within 24 hours of blood being drawn. We recommend a minimum of twice-weekly bile acids > 34/40 to increase the chances of detecting a woman whose bile acids may suddenly rise above the safe threshold and to provide reassurance for those women with the condition. Ovadia also showed no correlation between raised alanine transaminase (ALT) and stillbirth.