An itchy pregnant woman.

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17.08.2016

PennineGPLearning

Itchy and pregnant.
How many weeks pregnant?
Any rash?
How severe?
Where is the itch?
Any pre-existing rashes or itchy skin conditions?

Patient stated she was 28 weeks pregnant.

Intensely itchy rash started on abdomen but had spread elsewhere

Brought in for review had severe urticarial rash on all over abdomen, legs, breasts, lower back.

Large plaques, coalescing. Excoriation marks.

Rang dermatology who advised over the phone she had **PUPP.**

'**pruritic urticarial papules and plaques of pregnancy**'

Polymorphic eruption of pregnancy.

Seen in clinic dermatology clinic a few days later and managed symptomatically.

Itch is the most common dermatological symptom described in pregnancy, and its incidence (any cause) is estimated to be as high as 23%

Itch in pregnancy may be caused by;

Obstetric cholestasis

Polymorphic eruption of pregnancy

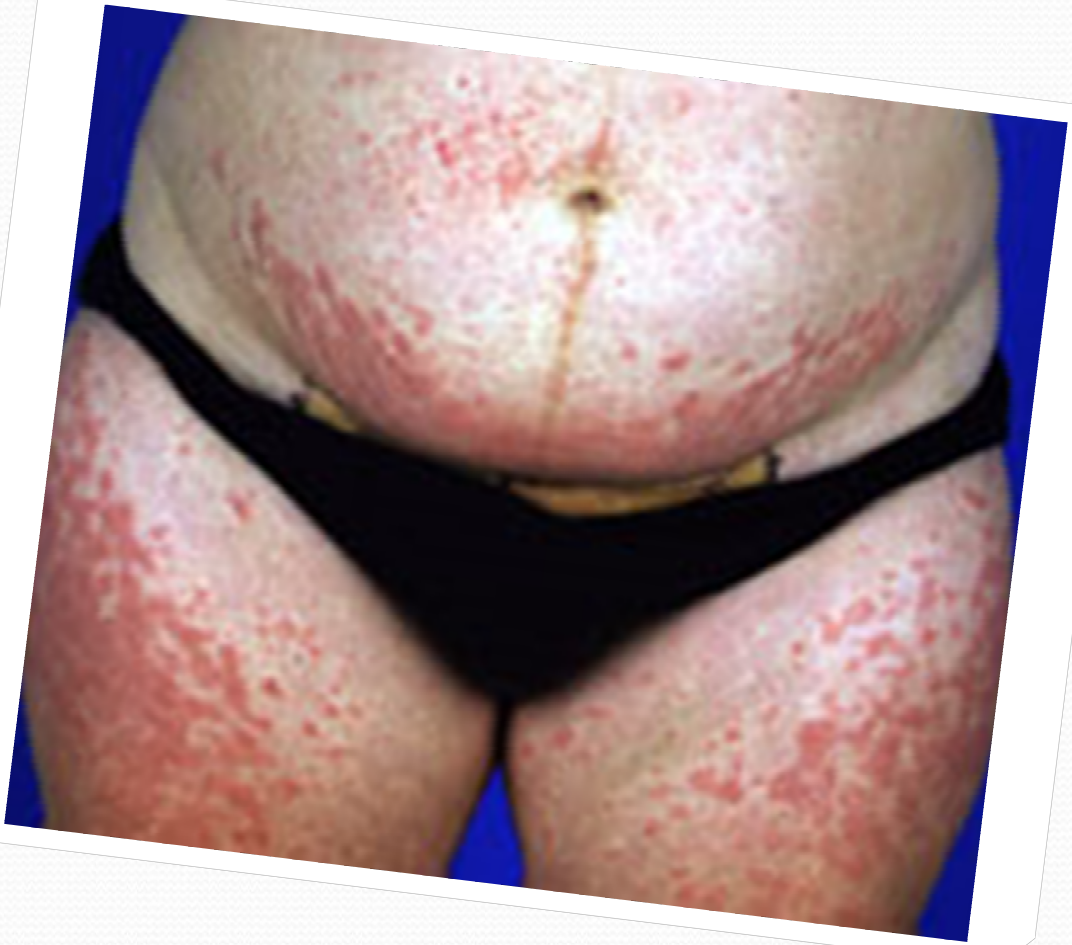
Atopic eruption of pregnancy

Pemphigoid gestationis

Polymorphic eruption of pregnancy

third trimester of 1st pregnancy
excessive weight gain or multiple pregnancy.
Erythematous, urticarial plaques and papules , intense itch.
1st appears in striae with sparing of umbilicus region.
Can become widespread and generalized.
Abnormal dermatological response to abdominal distension.
1 in 130–300 pregnancies.
Regresses within a week postpartum
rarely recurs

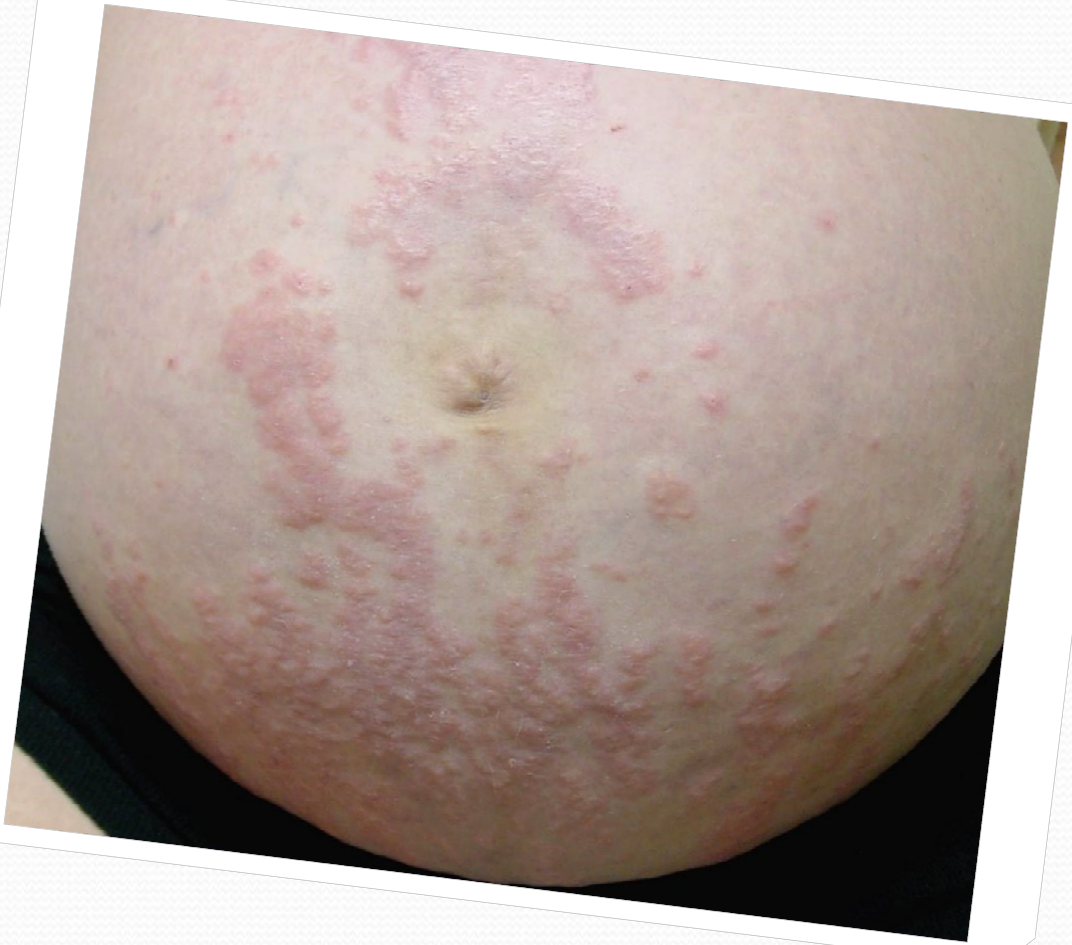
Polymorphic eruption of pregnancy



Atopic eruption of pregnancy

First trimester
eczematous, papular lesions affecting face, neck, upper chest, and flexor aspects of the limbs.
Small erythematous papules on the trunk and limbs
larger 'prurigo nodules' (firm itchy bumps) found mainly on the shins and extensor surfaces of the arms
PMH of eczema or atopy (including childhood eczema)
resolves after delivery, may recur in subsequent pregnancies.
Immunological trigger
1 in 300 pregnancies.

Atopic eruption of pregnancy



Pemphigoid gestationis

autoimmune disorder causing a bullous rash with intense itch,

third trimester.

forms tense blisters similar to those seen in bullous pemphigoid.

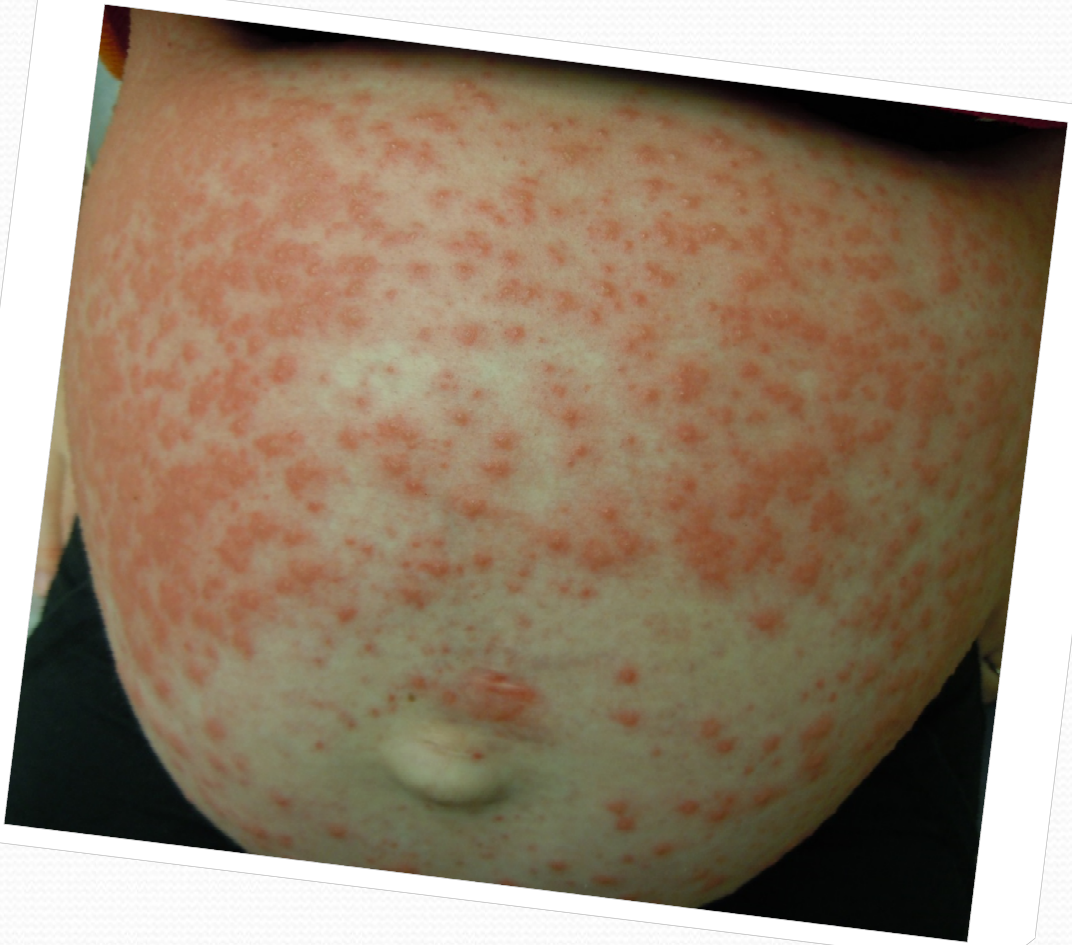
flares up at delivery, subsequent spontaneous regression over weeks to months.

Associated with an increased risk of preterm delivery and low infant birth weight.

rare, affecting about 1 in 10,000 to 1 in 50,000 pregnancies.

risk of other autoimmune disease, especially Graves' disease.

Pemphigoid gestationis



Obstetric cholestasis

most common cause of itch that presents without a rash in pregnancy.

1 in 100 pregnancies

deposition of bile salts in the skin that results from cholestasis (impaired bile flow).

can cause serious foetal complications

usually resolves postpartum. However, 45-90% recurrence rate

associated with an increased risk of:

Stillbirth

Premature delivery.

Foetal distress.

Meconium aspiration.

Vitamin K deficiency

When should I suspect obstetric cholestasis?

third trimester
soles and palms
worse at night
Severe scratching

Other clinical features:
Jaundice (present in about 10% of women).
Anorexia, malaise, and abdominal pain.
Dark urine, pale stools, and steatorrhoea

Diagnosis of obstetric cholestasis is confirmed by abnormal liver function tests (LFTs) which show deranged liver enzymes and/or **elevated serum bile acids.**
pruritus can be present for days or weeks before the development of abnormal liver function

Management of obstetric cholestasis

Arrange admission to hospital, or same-day obstetrics referral for any woman with clinical features suggesting obstetric cholestasis.

If a woman has unexplained itch but liver function tests (LFTs) and/or bile acids are normal, LFTs and/or bile acids should be monitored every 1–2 weeks until the itch resolves.

Seek specialist advice if the itch significantly worsens.

Investigations that may be carried out in secondary care include:

LFTs and bile acids.
Liver ultrasound
Viral screening, for hepatitis A, B, and C; Epstein-Barr virus; and cytomegalovirus.
Liver autoimmune screening for chronic active hepatitis and primary biliary cirrhosis (for example anti-smooth muscle and anti-mitochondrial antibodies).
Urine dipstick for proteinuria.
Blood pressure measurement.
Cardiotocography

Drug treatments that may be initiated in secondary care include:

Sedating antihistamines such as chlorphenamine or promethazine.
Vitamin K supplements.
Ursodeoxycholic acid.

Ensure that liver function tests (LFTs) are being carried out on a weekly basis
Prescribe symptomatic relief.
Emollient
Menthol 0.5% or 1% in aqueous cream
sedating antihistamine such as chlorphenamine or promethazine at night (off-label indication).

Follow up
LFTs from 2 weeks postnatally
LFTs can increase for the first 10 days postnatally
If normal advise that the condition has a 45–90% recurrence rate in future pregnancies.
If, after 8 weeks, the results are still abnormal, seek specialist advice
An alternative or additional diagnosis to obstetric cholestasis should be considered if abnormal liver function persists at this stage