

Management of pregnant women with chronic liver disease: Key points of vigilance

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Presentation

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Pre-pregnancy counselling and multidisciplinary management are recommended for women with chronic liver disease, as cirrhosis is an independent risk factor for adverse perinatal outcomes and variceal bleeding is the main cause of decompensation during pregnancy.

KEY POINTS

- The speaker stated that maternal mortality or liver transplantation occurs in less than 1% of pregnant women with cirrhosis, while decompensation is significantly higher in those with previous decompensation, with variceal bleeding occurring in up to 62% of women who decompensate.
- The speaker reported that MELD score below 6 predicts excellent pregnancy outcome, while MELD score over 10 is predictive of decompensation, and low preconception ALBI and APRI scores predict live birth and pregnancy proceeding to term.
- Screening endoscopy should be performed within one year prior to pregnancy to assess for clinically significant varices, or during early second trimester if not done before, as endoscopy is safe during pregnancy with left lateral positioning.
- Beta blockers should be continued or initiated during pregnancy for variceal prophylaxis if no contraindication, high-risk varices should undergo endoscopic band ligation, and terlipressin is contraindicated as it can cause uterine contractions and decreased uterine blood flow.
- Vaginal delivery is preferred with mode of delivery based on obstetrical determinants only, and most drugs used in chronic liver disease management are safe and should not be stopped as this could lead to clinical deterioration.

- The speaker recommended that combined hormonal contraception should be avoided in women with history of intrahepatic cholestasis of pregnancy, pre-existing cholestatic liver disease, severe hepatitis, decompensated cirrhosis, or history of thrombosis without anticoagulation.

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