

Pregnancy and Liver Disease

Pages with reference to book, From 112 To 113

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Liver disease is often known to co-exist with pregnancy. Pregnancy can either occur in a woman suffering from liver disease or intercurrent liver disease may afflict a pregnant woman, or, liver disease may be peculiar to pregnancy (Sherlock, 1975). In any case, should the two occur, it is important to determine the degree to which the pregnancy affects the prognosis of liver disease and vice versa. This would in turn determine the maternal and foetal mortality and morbidity.

Of the liver diseases peculiar to pregnancy, intrahepatic cholestasis of pregnancy is the commonest (Haemmerli, 1966). This condition is not reported to have any detrimental effects on pregnancy, other than an increased incidence of post-partum haemorrhage (Friedlander and Osier, 1967). However there are reports of premature labour (Haemmerli, 1966; Steel and Parker, 1973) and foetal death (Reid et al., 1976). The recurrence rate in sub-sequent pregnancies is high.

Acute fatty liver, a condition specific to pregnancy, occurs in the third trimester. It can progress to hepatorenal failure. In a study of 50 cases, 80% of the patients died, and foetal mortality was 70% (Moldin and Johansson, 1978). Those who survived, showed complete recovery, after delivery, with absence of recurrence in subsequent pregnancies.

Hyperemesis gravidarum forms a small percentage of all cases of jaundice in pregnancy and causes mild to moderate changes in liver function (Adams et al., 1968).

Significant liver changes are not seen in eclampsia and pre-eclampsia (Sherlock, 1975), except in very severe cases, where there is a high incidence of maternal and foetal deaths. Rarely eclampsia may give rise to spontaneous rupture of the liver, presenting as acute abdomen in the third trimester. Maternal and foetal mortality are then very high (Bis and Waxman, 1976).

Viral hepatitis, especially that caused by hepatitis A virus, is the commonest intercurrent liver disease (Haemmerli, 1966). After a wide study it was concluded that the severity and, frequency of hepatitis remains unaffected by pregnancy (Haemmerli, 1966). In the underdeveloped countries, however, pregnancy does vary the course of the disease and has proved fatal for both patient and foetus, in a large number of cases (D'Cruz et al., 1968). Infection with hepatitis B virus can be transmitted to the foetus (Merril et al., 1972; Kohler et al., 1974).

Hepatotoxic drugs, taken during pregnancy, have given rise to a high incidence of maternal and foetal deaths (Davidson, 1973). Of particular importance are tetracyclines (Davis and Kaufman, 1966), diuretics (Aneckstein and Weingold; 1966) and anaesthetics. A "Foetal Alcohol Syndrome" has been described in infants born to alcoholics (Moller et al., 1979).

Prognosis for mother and foetus has proved to be poor, in patients with "Budd Chiari Syndrome" (Takeuchi et al., 1971), and those suffering from hepatomas (Hibbard, 1976).

As far as the prognosis of pre-existing liver disease is concerned, there is an increase in the severity of jaundice in familial hyper-bilirubinaemia (Haemmerli, 1966), whereas acute attacks are reported to become more frequent in patients with porphyria (Hunter, 1971).

In patients with chronic persistent hepatitis and chronic active hepatitis, the pregnancy state does not seem to have any deleterious effect on the disease, yet the foetus faces increased chances of prematurity (Steven et al., 1979). (Burslem et al., 1952) confirmed, that there is increased incidence of perinatal deaths due to variceal haemorrhage, in patients suffering from cirrhosis of the liver. A "shunt operation" before or during pregnancy, however, significantly reduced the mortality.

Therefore irrespective of the existing relationship between the two conditions, a pregnant woman with liver disease should be properly evaluated and managed, for the welfare of both, mother and foetus.

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