

Obstetric Cholestasis and Intrahepatic Cholestasis of Pregnancy Diagnosis and Management Clinical Guideline

V4.0

November 2025

Summary

Flowchart for the care of pregnant women with itching is available at following webpage:

[Intrahepatic cholestasis of pregnancy - RCOG](#)

[Intrahepatic cholestasis of pregnancy patient information leaflet - RCOG](#)

1. Aim/Purpose of this Guideline

- 1.1. To increase awareness of Obstetric Cholestasis (OC)/ Intrahepatic Cholestasis of Pregnancy (ICP) to provide an evidence-based guideline and an agreed effective management plan of the condition.

This guidance has been updated according to the RCOG Guidance: Intrahepatic cholestasis of pregnancy: Green-top Guideline No. 43, June 2022.

- 1.2. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.
- 1.3. This version supersedes any previous versions of this document.

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2. The Guidance

2.1. Introduction

- 2.1.1. Pruritus in pregnancy is common, affecting 23% of pregnancies, of which a small proportion will have Intrahepatic cholestasis of pregnancy. Intrahepatic cholestasis of pregnancy previously referred to as Obstetric Cholestasis. The incidence of Intrahepatic cholestasis of pregnancy is 0.7% of pregnancies in multi-ethnic populations, and 1.2%–1.5% of women of Indian-Asian or Pakistani-Asian origin.

- 2.1.2. Potential fetal risks may include spontaneous preterm birth and iatrogenic preterm birth, meconium-stained liquor, fetal distress, delivery by caesarean section and stillbirth. Although stillbirth is quoted as being increased in ICP, recent evidence has shown that the risk of stillbirth associated with ICP is only in cases in which the peak Bile Acid levels exceed 100 $\mu\text{mol/L}$ at any point. There is no association between increases in ALT and stillbirth in ICP regardless of the increase.
- 2.1.3. There can be maternal morbidity in association with the intense pruritus and consequent sleep deprivation.

2.2. Overview

- 2.2.1. ICP is characterized by unexplained pruritus, typically worse on the palms and soles during the night and vary in intensity and usually no rash (excoriations only).
- 2.2.2. Alternative diagnoses (such as pre-eclampsia) should always be considered before a diagnosis of ICP is made; it is also possible for other conditions to co-exist.
- 2.2.3. The diagnosis of ICP should be considered in pregnant women who have itching in skin of normal appearance and raised peak random total bile acid concentration of 19 $\mu\text{mol/L}$ or more.
- 2.2.4. This diagnosis should be confirmed in the postnatal period at least 4 weeks after birth, with resolution of itching and liver function tests returning to normal (including bile acids).
- 2.2.5. Terminology for pregnant women with itching of normal skin:

Diagnosis	Clinical Features
Gestational pruritus	Itching and peak bile acid concentrations. <19 $\mu\text{mol/L}$
Mild ICP	Itching and raised peak bile acid concentrations. 19 - 39 $\mu\text{mol/L}$.
Moderate ICP	Itching and raised peak bile acid concentrations. 40 - 99 $\mu\text{mol/L}$.
Severe ICP	Itching and raised peak bile acid concentrations. ≥ 100 $\mu\text{mol/L}$.

2.3. Pathway for referral

- 2.3.1. Pregnant women with itching in the second and third trimesters of pregnancy without a rash will be suspected to have ICP and should be assessed by the community midwifery team.
- 2.3.2. Women with a rash should be referred to the GP.

2.4. Initial assessment for diagnosis of intrahepatic cholestasis of pregnancy

- 2.4.1. A detailed history should be taken including the following:
- Pattern of itching.
 - Change in stools/urine/skin colour.
 - Family history or personal history of cholestasis (or gallstones).
 - Multiple pregnancy and Hepatitis C (earlier onset before 26 weeks).
 - Drug history- herbal remedies or recent antibiotics.
- 2.4.2. Diagnostic criteria:
- Persistent pruritus- commonly in the beginning third trimester
Pruritus precedes abnormal LFTs.
 - Bile Acids ≥ 19 micromol/l.
 - One or more abnormal LFT.
 - Absence of other liver pathology.
 - Postnatal resolution of symptoms.

Based on a recent meta-analysis, consensus is now that the diagnosis of intrahepatic cholestasis of pregnancy requires elevated maternal bile acid (BA) concentrations, and pregnant women with itching and isolated raised transaminases alone (with normal bile acid concentrations) should not be given a diagnosis of ICP.

2.4.3. Investigations:

LFT and Bile Acids	• In case of persistent pruritus with normal bile acids: repeat every 1-2 weeks as itch usually precedes OC. • In OC repeat in one week then individualise monitoring plan as per 2.5.2.
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Routine use of other investigations (liver autoimmune tests, hepatitis C screening, coagulation tests and liver ultrasound) is no longer recommended.

Additional investigations (including for hepatitis C) should be considered in women and pregnant people with an atypical or uncertain picture of ICP. This may include women with markedly elevated transaminases, early onset of ICP in the first or second trimester, a rapidly progressive biochemical picture, any features of liver failure or evidence of acute infection, or if resolution does not occur after birth.

2.4.4. Possible differential diagnosis:

Possible differential diagnosis	
Pruritus without rash	Obstetrics cholestasis. Pruritus gravidarum.
Pruritus with rash	Polymorphic eruption of pregnancy. Pruritic folliculitis. Prurigo. Pemphigoid gestationis. Eczema.
Pruritus with abnormal LFT	Biliary obstruction. Acute cholecystitis. Viral hepatitis. Auto immune liver disease. Drug reaction. Congenital. Gilbert's syndrome.
Abnormal LFT without pruritus	Hyperemesis Gravidarum. HELLP. AFLP Viral Hepatitis and 'isolated raised bilirubin'.

2.5. Antenatal Management

2.5.1. Antenatal care for the patient:

2.5.1.1. Women with ICP should be under consultant led care.

2.5.1.2. Women who develop pruritus and abnormalities in liver function/ bile acids in the first or second trimester (especially in the first trimester) are more likely to have an underlying genetic predisposition or an alternative or additional diagnosis. These cases should be discussed with a hepatologist.

- 2.5.1.3. Women with ICP may have a higher chance of developing pre-eclampsia or gestational diabetes. They should have regular blood pressure and urine monitoring. Additional testing for gestational diabetes is not currently recommended. Testing for gestational diabetes should be according to national guidance.

2.5.2. Monitoring of bile acids:

Following two bile acid results ranged ≥ 19 micromol/L:

Time frames for monitoring bile acids	
Mild ICP. 19 - 39 micromol/L.	Weekly testing from 36 weeks.
Moderate ICP. 40 - 99 micromol/L.	Weekly testing from 34 weeks.
Severe ICP. ≥ 100 micromol/L.	Consultant review for ongoing management plan.

2.5.3. Treatment options:

2.5.3.1. General Advice for Women:

- Have frequent tepid baths.
- Try not to get too hot.
- Wear loose cotton clothing.
- Gently scratch skin with a baby's soft hairbrush if necessary.
- Lower fat intake.
- In severe cases of sleep deprivation and anxiety signpost to support networks (e.g., British Liver Trust).

2.5.3.2. Drugs that can commonly cause cholestasis should be avoided (Erythromycin, Augmentin and Flucloxacillin) unless benefits outweigh the risks.

2.5.3.3. There are no treatments that improve pregnancy outcome (or raised bile acid concentrations) and treatments to improve maternal itching are of limited benefit.

2.5.3.4. Consider topical emollients such as aqueous cream (with or without menthol added) to ameliorate skin symptoms.

- 2.5.3.5. Consider antihistamine agents, such as chlorphenamine, particularly at night although the effectiveness of this treatment is uncertain in women with ICP.
- 2.5.3.6. Do not routinely offer ursodeoxycholic acid for the purpose of reducing adverse perinatal outcomes in women with ICP.
- 2.5.3.7. Consider maternal vitamin K treatment only if there appears to be reduced absorption of dietary fats (e.g., presence of steatorrhea) and/or evidence of abnormal prothrombin time if coagulation studies are performed.

2.5.4. Fetal Monitoring

- 2.5.4.1. There is no evidence that a specific method of antenatal fetal monitoring is considered to be reliable or recommended for the prediction of fetal death in ICP. Ultrasound, biophysical profile and cardiotocography (CTG) are not reliable methods for preventing stillbirth in ICP. The decision about the frequency and type of fetal monitoring is based on the risk assessment of each individual case.
- 2.5.4.2. Women should be encouraged to report any concerns on fetal movements and report immediately for assessment at maternity unit if they have any concerns.
- 2.5.4.3. Antenatally women should be aware that:
 - Women with moderate or severe ICP have a higher chance of both spontaneous and iatrogenic preterm birth.
 - Women with moderate or severe ICP that they have an increased chance of having meconium-stained amniotic fluid during labour and birth.
 - Babies of women with moderate or severe ICP that their baby are more likely to receive neonatal care.
- 2.5.4.4. Offer patient information leaflet to all patients with ICP.
Available on: [Intrahepatic cholestasis of pregnancy | RCOG](#)

2.6. Intrapartum and postpartum management

- 2.6.1. Delivery is recommended on a consultant led unit.
- 2.6.2. Close monitoring during induction and fetal monitoring in labour should be offered.
- 2.6.3. Timing of delivery and intrapartum fetal monitoring:

See table below:

Type of ICP	Timing of delivery	Advise on risk of stillbirth	Advise on fetal monitoring in labour
Mild ICP (peak bile acids 19–39micromol/L) and no other risk factors.	Offer planned birth from 40 weeks gestation or sooner if maternal morbidities such as severe maternal pruritus.	Advise women that the risk of stillbirth is similar to the background risk.	- There is insufficient evidence for or against CEFM in women with peak bile acids below 100micromol/L. A shared decision can be made based on co-morbidities and preferences. - Women with moderate ICP should be informed about risks of meconium-stained amniotic fluid and babies needing neonatal care.
Moderate ICP with peak bile acids 40–99micromol/L and no other risk factors.	Offer planned birth at 38–39 weeks' gestation.	Advise women that the overall risk of stillbirth is similar to the background risk until 38–39weeks' gestation.	
Severe ICP with peak bile acids 100micromol/L or more.	Consider planned birth at 35-36 weeks gestation.	Advise them that the risk of stillbirth is higher than the background risk (3.44% in the 2019 Lancet meta-analysis).	Offer continuous electronic foetal monitoring (CEFM).

2.6.4. The presence of comorbidities (such as gestational diabetes, pre-eclampsia, multifetal pregnancy) appear to increase the risk of stillbirth and may influence decision making around timing of planned birth. Note that in one retrospective study referenced in the RCOG guideline, Stillbirths with ICP in twin pregnancies occurred between 33–35 weeks' gestation, compared to 36–38 weeks' gestation among singletons (NEW 2025).

2.6.5. There is no evidence of an increased risk of postpartum haemorrhage in uncomplicated ICP.

2.7. Postnatal follow up and contraception

2.7.1. Women should anticipate itching and raised maternal bile acid concentrations to resolve after birth.

2.7.2. For women who have uncomplicated ICP, follow-up LFT and bile acids should be arranged 6 weeks after birth with the GP to confirm resolution of ICP.

2.7.3. If itching or biochemical abnormalities persist beyond 6 weeks postpartum, consider other diagnoses depending upon the history and examination findings. Referral to a hepatologist may be considered.

2.7.4. Patients should be informed about the increased recurrence rate of ICP in successive pregnancies. At booking in subsequent pregnancies, baseline measurement of liver function tests and bile acid concentrations should be performed in order to establish that these are normal. They should only be repeated if clinically indicated.

2.7.5. Contraceptive options:

2.7.5.1. Copper-bearing intra-uterine devices, levonorgestrel-releasing intra-uterine systems, progestogen-only implant, progestogen-only injectable, and progestogen-only pill can be used without restriction in women with a history of ICP (UKMEC category 1).

2.7.5.2. Combined hormonal contraception can be used in women with ICP (UKMEC 2) provided they do not also have a history of contraception related cholestasis.

2.7.5.3. Patient should be made aware of increased risk of OC in other family members.

2.8. Summary of care for pregnant women with itching and normal skin is available at following appendix 3 of the following document:

[Intrahepatic cholestasis of pregnancy - Girling - 2022 - BJOG: An International Journal of Obstetrics and Gynaecology - Wiley Online Library.](#)

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Number of cases of OC a year and CTG compliance with no CTG monitoring against outcome.
Lead	Day Assessment Unit and Ante Natal Ward Manager.
Tool	Day Assessment Unit audit database to be kept of all women seen with OC. To record outcome of pregnancy. Whether CTG monitoring was undertaken in an otherwise normal pregnancy.
Frequency	Annual review of the data.
Reporting arrangements	Reported though the Maternity Patient Safety Forum.
Acting on recommendations and Lead(s)	Day Assessment Unit and Antenatal Ward Manager.

Information Category	Detail of process and methodology for monitoring compliance
Change in practice and lessons to be shared	Reported though the Patient Safety Management Forum.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity And Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Obstetric Cholestasis and Intrahepatic Cholestasis of Pregnancy Diagnosis and Management Clinical Guideline V4.0
This document replaces (exact title of previous version):	Obstetric Cholestasis Diagnosis and Management Clinical Guideline V3.2
Date Issued/Approved:	November 2025
Date Valid From:	November 2025
Date Valid To:	November 2028
Directorate / Department responsible (author/owner):	Sophie Haynes Obstetric Consultant
Contact details:	01872 255019
Brief summary of contents:	To give guidance to obstetricians and midwives on the management of women with Obstetric Cholestasis (OC).
Suggested Keywords:	Obstetric Cholestasis, OC, Cholestasis, itching, Piriton, Bile Acids, LFTs, intrahepatic.
Target Audience:	RCHT: Yes CFT: No CIOB ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guideline Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None
Related Documents:	• RCOG Green-top Guideline No. 43. Obstetric Cholestasis June 2022.

Information Category	Detailed Information
	• Kenyon AP, Tribe RM, Nelson-Piercy C, Girling JC, Williamson C, Seed PT, et al. Pruritus in pregnancy: a study of anatomical distribution and prevalence in relation to the development of obstetric cholestasis. <i>Obstet Med.</i> 2010; 3(1): 25– 9. • Szczech J, Wiatrowski A, Hirnle L, Reich A. Prevalence, and relevance of pruritus in pregnancy. <i>Biomed Res Int.</i> 2017; 2017: 4238139. • Williamson C, Geenes V. Intrahepatic cholestasis of pregnancy. <i>Obstet Gynecol.</i> 2014; 124(1): 120– 33. • Walker I, Chappell LC, Williamson C. Abnormal liver function tests in pregnancy. <i>BMJ.</i> 2013; 347: f6055. • Ovadia C, Seed PT, Sklavounos A, Geenes V, Di Ilio C, Chambers J, et al. Association of adverse perinatal outcomes of intrahepatic cholestasis of pregnancy with biochemical markers: results of aggregate and individual patient data meta-analyses. <i>Lancet.</i> 2019; 393(10174): 899– 909. • National Institute of Health and Care Excellence. Diabetes in pregnancy: management from preconception to the postnatal period. NG3. London: NICE; 2020. • Chappell LC, Bell JL, Smith A, Linsell L, Juszcak E, Dixon PH, et al. Ursodeoxycholic acid versus placebo in women with intrahepatic cholestasis of pregnancy (PITCHES): a randomised controlled trial. <i>Lancet.</i> 2019; 394(10201): 849– 60. • Liu X, Landon MB, Chen Y, Cheng W. Perinatal outcomes with intrahepatic cholestasis of pregnancy in twin pregnancies. <i>J Matern Fetal Neonatal Med.</i> 2016; 29(13): 2176– 81. • Kawakita T, Parikh LI, Ramsey PS, Huang CC, Zeymo A, Fernandez M, et al. Predictors of adverse neonatal outcomes in intrahepatic cholestasis of pregnancy. <i>Am J Obstet Gynecol.</i> 2015; 213(4): 570.e1– 8. • Grymowicz M, Czajkowski K, Smolarczyk R. Pregnancy course in patients with intrahepatic cholestasis of pregnancy treated with very low

Information Category	Detailed Information
	doses of ursodeoxycholic acid. <i>Scand J Gastroenterol</i>. 2016; 51(1): 78– 85. • Baliutaviciene D, Zubruviene N, Zalinkevicius R. Pregnancy outcome in cases of intrahepatic cholestasis of pregnancy. <i>Int J Gynaecol Obstet</i>. 2011; 112(3): 250– 1. • Geenes V, Chappell LC, Seed PT, Steer PJ, Knight M, Williamson C. Association of severe intrahepatic cholestasis of pregnancy with adverse pregnancy outcomes: a prospective population-based case–control study. <i>Hepatology</i>. 2014; 59(4): 1482– 91. • Iliodromiti S, Mackay DF, Smith GC, Pell JP, Nelson SM. Apgar score and the risk of cause-specific infant mortality: a population-based cohort study. <i>Lancet</i>. 2014; 384(9956): 1749– 55. • Lai S, Flatley C, Kumar S. Perinatal risk factors for low and moderate five-minute Apgar scores at term. <i>Eur J Obstet Gynecol Reprod Biol</i>. 2017; 210: 251– 6. • National Institute of Health and Care Excellence. Intrapartum care for healthy women and babies. Clinical guideline [CG190]. London: NICE; 2014. • Puljic A, Kim E, Page J, Esakoff T, Shaffer B, LaCoursiere DY, et al. The risk of infant and fetal death by each additional week of expectant management in intrahepatic cholestasis of pregnancy by gestational age. <i>Am J Obstet Gynecol</i>. 2015; 212(5): 667.e1– 5. • Lo JO, Shaffer BL, Allen AJ, Little SE, Cheng YW, Caughey AB. Intrahepatic cholestasis of pregnancy and timing of delivery. <i>J Matern Fetal Neonatal Med</i>. 2015; 28(18): 2254– 8. • Webster JR, Chappell L, Cheng F, Breeze AC, Lucas N, Plaat F, et al. Operative delivery rates following induction of labour for obstetric cholestasis. <i>Obstet Med</i>. 2011; 4(2): 66– 9. • Lee RH, Kwok KM, Ingles S, Wilson ML, Mullin P, Incerpi M, et al. Pregnancy outcomes during an era of aggressive management for intrahepatic cholestasis of pregnancy. <i>Am J Perinatol</i>. 2008; 25: 341–5. • Rioseco AJ, Ivankovic MB, Manzur A, Hamed F, Kato SR, Parer JT, et al. Intrahepatic cholestasis of pregnancy: a retrospective case–

Information Category	Detailed Information
	control study of perinatal outcome. Am J Obstet Gynecol 1994;170:890–5. - British Medical Association, Pharmaceutical Society of Great Britain. Vitamin K. British National Formulary. London: British Medical Association, Pharmaceutical Society - British Liver Trust. Intrahepatic Cholestasis of Pregnancy. 2018 Intrahepatic Cholestasis of Pregnancy (ICP) - British Liver Trust - Caroline Ovadia et al. Association of adverse perinatal outcomes of intrahepatic cholestasis of pregnancy with biochemical markers: results of aggregate and individual patient data meta-analyses. Lancet 2019; 393: 899–909
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
February 2014	V1.0	Initial Issue.	Karen Stoyles, Antenatal Ward Manger
January 2017	V1.1	Reviewed and updates to 2.5 and 2.6.	Magda Kudas, Antenatal Ward manager
April 2018	V1.2	Section 2.10 updated.	Magda Kudas, Antenatal Ward manager
June 2019	V2.0	Section 2.8 and 2.10 updated.	Magda Kudas, Antenatal Ward manager

Date	Version Number	Summary of Changes	Changes Made by
May 2020	V2.1	1.4. – inclusivity statement. Add in 30-minute assessment on arrival to Delivery Suite and six hourly reviews whilst in labour 2.11.3. 2.11.4.	Julie Walton, Audit midwife
September 2022	V3.0	Full document review and addition to point 2.11.2.	Sophie Haynes Obstetric Consultant
January 2024	V3.1	Updated in line with national guidance.	Amr Mohammed, Obstetrician
June 2025	V3.2	Updated to include induction gestation for twin pregnancies.	Robert Harper, Obstetric Consultant
November 2025	V4.0	Full review with no changes required.	Sophie Haynes, Obstetric Consultant

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This document is only valid on the day of printing.

Controlled Document.

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team
richt.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Obstetric Cholestasis Diagnosis and Management Clinical Guideline V4.0
Directorate and service area:	Midwifery and Obstetrics.
Is this a new or existing Policy?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Maternity Guidelines Midwife.
Contact details:	01872 255019.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To give guidance to obstetricians and midwives on the management of women with Obstetric Cholestasis (OC).
2. Policy Objectives	Ensure timely diagnosis and management of Obstetric Cholestasis in pregnant women. Ensure the correct follow up for women, who have been diagnosed with Obstetric Cholestasis, in the postnatal period.
3. Policy Intended Outcomes	Treatment of Obstetric Cholestasis in pregnant and newly delivered women.
4. How will you measure each outcome?	Data collection and audit with compliance monitoring tool.
5. Who is intended to benefit from the policy?	Pregnant and newly delivered women with Obstetric Cholestasis.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	- Workforce: Yes - Patients/ visitors: No - Local groups/ system partners: No - External organisations: No - Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	Please record specific names of individuals/ groups: Maternity Guideline Group.
6c. What was the outcome of the consultation?	Guideline agreed.
6d. Have you used any of the following to assist your assessment?	National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys: No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Maternity Guidelines Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
[Section 2. Full Equality Analysis](#)

Appendix 3. Summary of care for pregnant women with itching and normal skin.

[Intrahepatic cholestasis of pregnancy - Girling - 2022 - BJOG: An International Journal of Obstetrics and Gynaecology - Wiley Online Library.](#)