Dr David Rowbotham

Gastroenterologist, Auckland

GI Illness in Pregnancy - Concurrent Workshop Repeated

Saturday, 11 June 2011	Start 2:00pm	Duration: 55mins	Sigma
	Start 3:05pm	Duration: 55mins	Sigma

GI illness in pregnancy

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The Leeds Teaching Hospitals NHS
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AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

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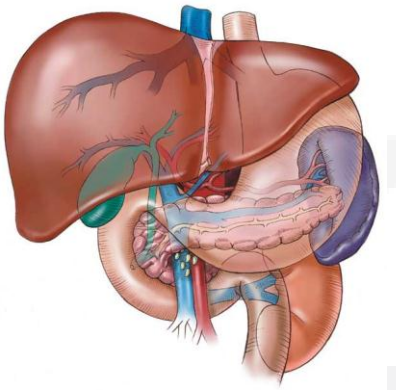
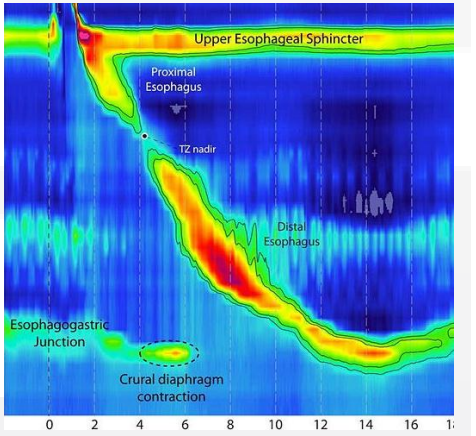




My background …

- University of Newcastle upon Tyne
- Specialist Gastroenterology Training Leeds/Bradford & London
- Hepatology Training Leeds & London
- Specialist Gastroenterologist & Physician, Auckland Hospital since 1999
- OE (SE London) 2004 – 2007
- Clinical Director & Gastroenterologist 2008

Overview

Pregnancy-related

- Hyperemesis Gravidarum
- Fatty Liver of Pregnancy
- HELLP syndrome

Non-pregnancy related

- GORD
- IBD
- IBS
- Viral hepatitis
- Gallstones

- Drugs in pregnancy

Hyperemesis Gravidarum

- Extreme, persistent nausea and vomiting
- Often leads to dehydration, weight loss
- Grazing … small and frequent
- Dry foods / Carbonated drinks can be helpful
- Vitamin B6 (<100mg/day)
- No evidence that any Rx works
- Admit

Acute Fatty Liver of Pregnancy

- Microvesicular infiltration of hepatocytes
- Rare
- Commoner: multi-gestations / underweight
- Third trimester
- Symptoms: N & V (75%)
  Abdo pain – epigastric (50%)
  Anorexia
  Jaundice

Acute Fatty Liver of Pregnancy

- PET at diagnosis or during illness (50%)
- Lab tests:
  - ↑ ALT / bilirubin
  - ↑ WBC
  - ↓ platelets (DIC and ↓↓ antithrombin III)
  - ↓ glucose
- Associated with inherited defect in mitochondrial oxidation of fatty acids (LCHAD)
- LCHAD infants: risk of non-ketotic hypoglycaemia

Acute Fatty Liver of Pregnancy

- Diagnosis – think about it
- Large clinical overlap with HELLP syndrome
- Liver biopsy is diagnostic (but rarely used)

- Treatment is delivery (LSCS)
- Liver tests/coagulopathy then begin to normalise
- Prognosis: good if diagnosed and treated early
- Recurrence?

HELLP Syndrome

- Haemolysis, Elevated Liver enzymes, Low Platelets
- Probably severe form of PET

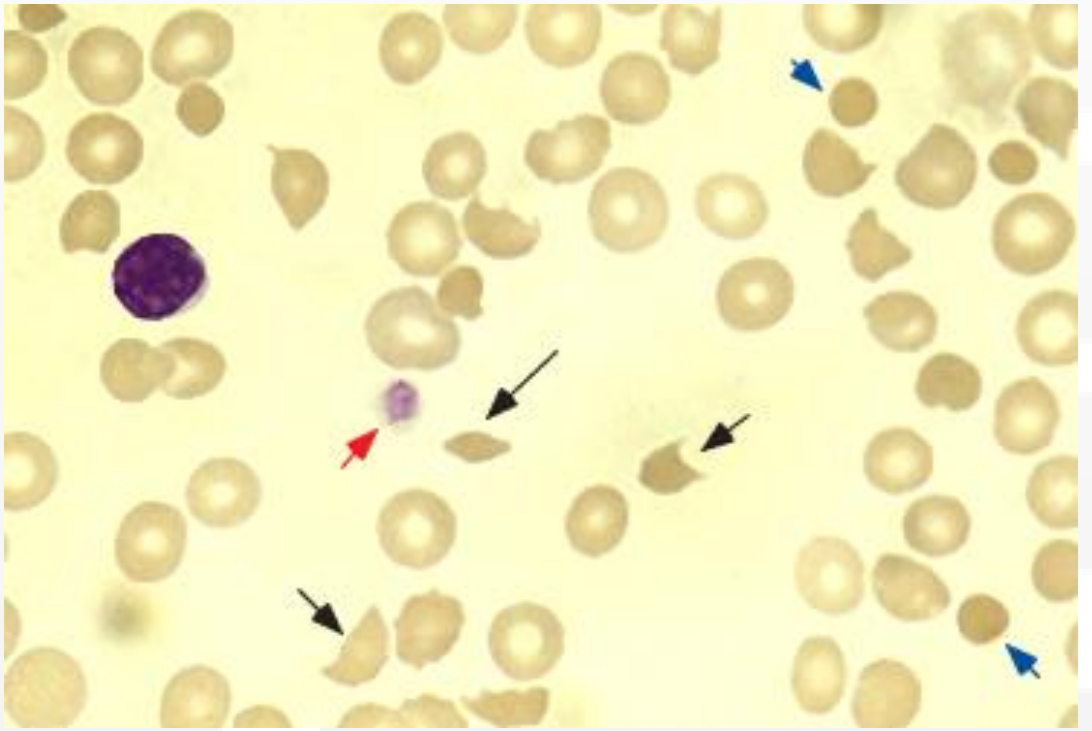
- Incidence approximately 1 in 1,000 pregnancies
- Majority diagnosed between 28 – 36 weeks

- Symptoms: Abdominal pain (upper)
  N & V / malaise
  ↑ ALT / LDH

HELLP Syndrome

- Serious potential morbidity:
  - DIC
  - Abruption
  - Liver haematoma / rupture / infarction
  - ARF
  - Pulmonary oedema

HELLP Syndrome



HELLP Syndrome

- Differential diagnosis:
  - TTP
  - Acute fatty liver of pregnancy
  - Gastroenteritis / hepatitis
- Management usually prompt delivery (if >34 wks)
  - Vaginal delivery optimal
  - BP control
  - IV magnesium
  - Platelet transfusion

GORD

- Why do pregnant women reflux?
- Management:
  - Postural/dietary factors
  - Barrier
  - Anti-secretory
  - Promotility
- PPI's don't stop reflux
- How to take PPIs for best effect

IBD

- “Rule of thirds”
- Pharmacological management is unchanged
- 5-ASA (mesalazine)
- Probiotics
- Thiopurines

- Prednisone

IBD

- Anti-diarrhoeals
- Antibiotics

- Cyclosporin
- Infliximab / Adalimumab

IBS

- Not a diagnosis of exclusion
- Common precipitants
- What the colon is designed for …
- Probiotics
- Lactulose often causes increased bloating
- Bulking laxatives best first line

Viral Hepatitis

- A
- B (delta)
- C
- E
- G
- Other

Gallstones

- Mostly can wait until after pregnancy

- If need to intervene:
  - ERCP
  - Laparoscopic cholecystectomy
  - Percutaneous cholecystostomy

Drugs in Pregnancy

- All drugs are poisons!

- Trimester 1: Organogenesis / cellular differentiation
- Trimester 2: Tiny to small
- Trimester 3: Small to big enough to survive (& hurt!)