50. Webster JR, Chappell L, Cheng F, Breeze AC, Lucas N, Plaat F, et al. Operative delivery rates following induction of labour for obstetric cholestasis. Obstet Med. 2011;4(2):66–9.
51. Furrer R, Winter K, Schaffer L, Zimmermann R, Burkhardt T, Haslinger C. Postpartum blood loss in women treated for intrahepatic cholestasis of pregnancy. Obstet Gynecol. 2016;128(5):1048–52.
52. National Institute of Health and Care Excellence. Postnatal Care. NICE guideline [NG194]. London: NICE; 2021.
53. Faculty of Sexual and Reproductive Healthcare. UK medical eligibility criteria for contraceptive use. London: FSRH; 2016.
54. National Institute for Health and Care Excellence. Menopause: diagnosis and management. NICE guideline [NG23]. London: NICE; 2015.
55. Shaw D, Frohlich J, Wittmann BA, Willms M. A prospective study of 18 patients with cholestasis of pregnancy. Am J Obstet Gynecol. 1982;142(6 Pt 1):621–5.
56. Savander M, Ropponen A, Avela K, Weerasekera N, Cormand B, Hirvioja ML, et al. Genetic evidence of heterogeneity in intrahepatic cholestasis of pregnancy. Gut. 2003;52(7):1025–9.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.**How to cite this article:** Girling J, Knight CL, Chappell L; on behalf of the Royal College of Obstetricians and Gynaecologists. Intrahepatic cholestasis of pregnancy. BJOG. 2022;129(13):e95–e114. https://doi.org/10.1111/1471-0528.17206

BJOG An International Journal of Obstetrics and Gynaecology

APPENDIX 1

Explanation of guidelines and evidence levels

Clinical guidelines are: 'systematically developed statements which assist clinicians and patients in making decisions about appropriate treatment for specific conditions'. Each guideline is systematically developed using a standardised methodology. Exact details of this process can be found in Clinical Governance Advice No. 1 *Development of RCOG Green-top Guidelines* (available on the RCOG website at http://www.rcog.org.uk/green-top-development). These recommendations are not intended to dictate an exclusive course of management or treatment. They must be evaluated with reference to individual patient needs, resources and limitations unique to the institution and variations in local populations. It is hoped that this process of local ownership will help to incorporate these guidelines into routine practice. Attention is drawn to areas of clinical uncertainty where further research may be indicated.

The evidence used in this guideline was graded using the scheme below and the recommendations formulated in a similar fashion with a standardised grading scheme.

Classification of evidence levels

1++	High-quality meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias
1–	Meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a high risk of bias
2++	High-quality systematic reviews of case–control or cohort studies or high-quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2–	Case–control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal
3	Non-analytical studies, e.g. case reports, case series
4	Expert opinion

Grades of Recommendation

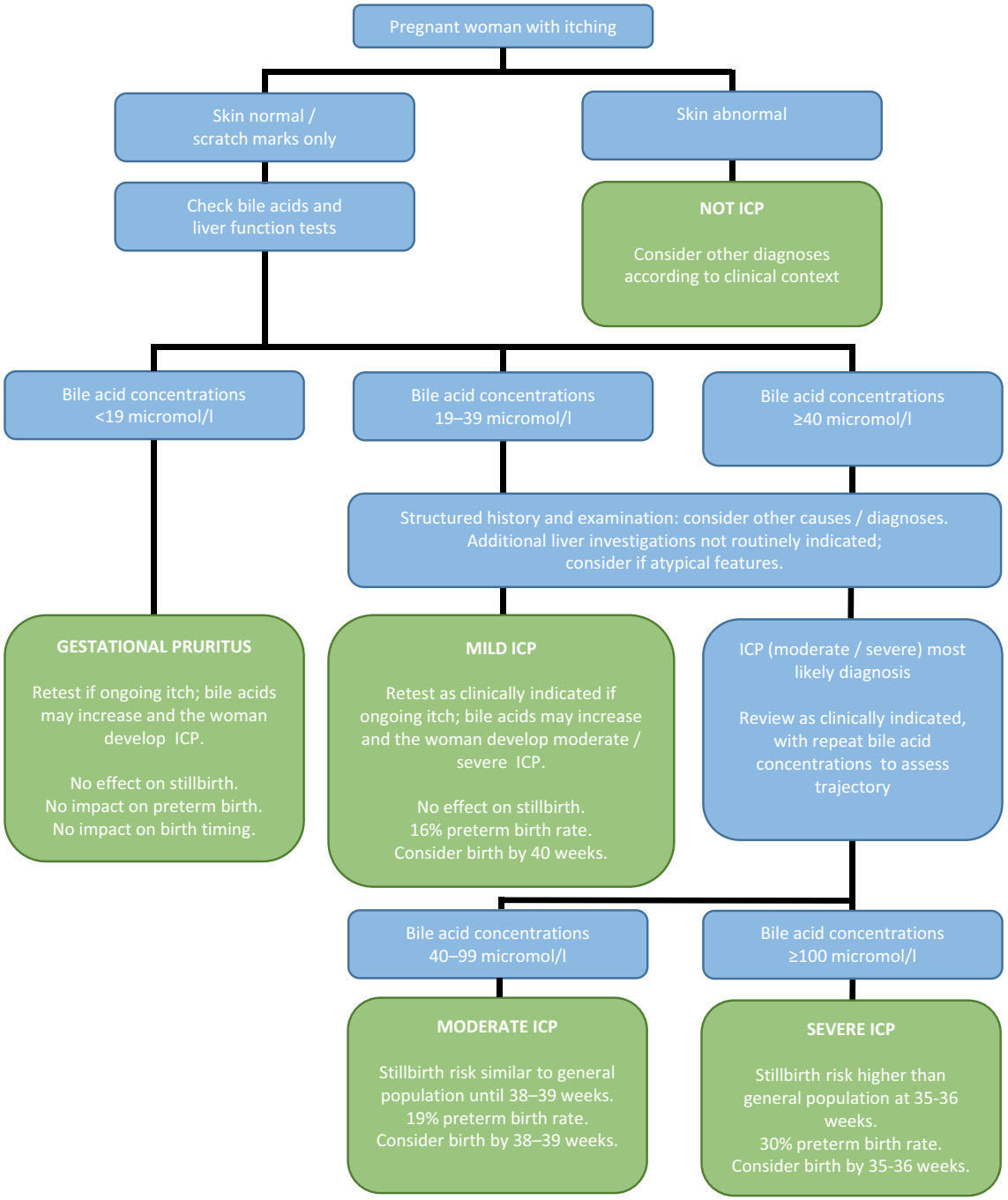
Grade of Recommendation: A	At least one meta-analysis, systematic reviews or RCT rated as 1++, and directly applicable to the target population; or a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results
Grade of Recommendation: B	A body of evidence including studies rated as 2++ directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 1++ or 1+
Grade of Recommendation: C	A body of evidence including studies rated as 2+ directly applicable to the target population, and demonstrating overall consistency of results; or Extrapolated evidence from studies rated as 2++
Grade of Recommendation: D	Evidence level 3 or 4; or Extrapolated evidence from studies rated as 2+

Good Practice Points

Grade of Recommendation: ✓	Recommended best practice based on the clinical experience of the guideline development group

APPENDIX 2

Flowchart for the care of pregnant women with itching



Figures above relate to singleton pregnancy with no other risk factors.

Comorbidities (particularly pre-eclampsia and diabetes) or other obstetric risk factors (such as multifetal pregnancy), are associated with increased risk of stillbirth and should be taken into consideration when planning management.

Additional liver investigations may be considered in women with atypical features (e.g. early onset, marked transaminitis, jaundice, fever, or in whom postpartum resolution does not occur). These investigations may include liver ultrasound, viral hepatitis screen, liver autoimmune tests, and/or coagulation screen.

BJOG An International Journal of Obstetrics and Gynaecology

APPENDIX 3

Summary of care for pregnant women with itching and normal skin

	Otherwise uncomplicated low risk singleton pregnancy[a] Itching with normal skin/excoriations Peak total BA concentration, micromol/L			
	<19 micromol/L	**19–39 micromol/L**	**40–99 micromol/L**	**≥100 micromol/L**
Initial diagnosis	Pruritus gravidarum	Mild ICP	Moderate	Severe ICP
	Structured history and examination, no additional or alternative causes identified			
If itch persists, frequency of BA	1–2 weekly	1–2 weekly	1–2 weekly	Only if will impact care plans
Risk of stillbirth compared with general obstetric population [0.18–0.75]	Unchanged	Unchanged 0.13%	Unchanged until 39 weeks, 0.28%	Raised, 3.44%
Timing of mode of birth	No impact	Consider planned birth by 40 weeks	Consider planned birth at 38–39 weeks	Consider planned birth at 35–36 weeks
Preterm birth rate, spontaneous and iatrogenic	Unchanged	16%	19%	30%
Role for routine use of UDCA	No	No	No impact on stillbirth	No impact on stillbirth
Additional liver investigations[b]	Not indicated routinely. Consider for women with atypical features (e.g. early onset, marked tranaminitis, jaundice, fever, or in whom postpartum resolution does not occur)			

[a] For pregnancies with other obstetric or medical conditions, these should be taken into consideration when deciding management options.

[b] Such as liver ultrasound, viral hepatitis screen, liver autoimmune tests. ICP, intrahepatic cholestasis of pregnancy; UDCA, ursodeoxyxholic acid.

This guideline was produced on behalf of the Royal College of Obstetricians and Gynaecologists by:
Miss J Girling FRCOG, London; Dr CL Knight MRCOG, London; Professor L Chappell FRCOG, London.

and peer reviewed by: Dr EA Bonney MRCOG, Leeds Teaching Hospitals NHS Trust, Leeds; Dr J Allison MRCOG, NHS Fife, Kirkcaldy; Dr G Sayed FRCOG, Hamad Medical Corporation, Qatar; Dr D Fraser FRCOG, Norfolk and Norwich Universitiy Hospitals NHS Trust, Norwich; C Ovadia MRCOG, King's College London, London; C Williamson FRCS FMedSci, King's College London, London; A Ikomi, Mid and South Essex NHS Trust, Billericay; Dr T Everett MRCOG, Leeds Teaching Hospitals NHS Trust, Leeds; ICP Support; The Royal College of Midwives; UK National Screening Committee; British Maternal and Fetal Medicine Society.

Committee lead reviewers were: Dr B Magowan FRCOG, Melrose and Dr MA Ledingham FRCOG, Glasgow.

The chairs of the Guidelines Committee were: Dr B Magowan FRCOG, Melrose and Dr MA Ledingham FRCOG, Glasgow.

The final version is the responsibility of the Guidelines Committee of the RCOG.

DISCLAIMER

The Royal College of Obstetricians and Gynaecologists produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of clinical data presented by the patient and the diagnostic and treatment options available.
This means that RCOG Guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

The guideline will be considered for update 3 years after publication, with an intermediate assessment of the need to update 2 years after publication.