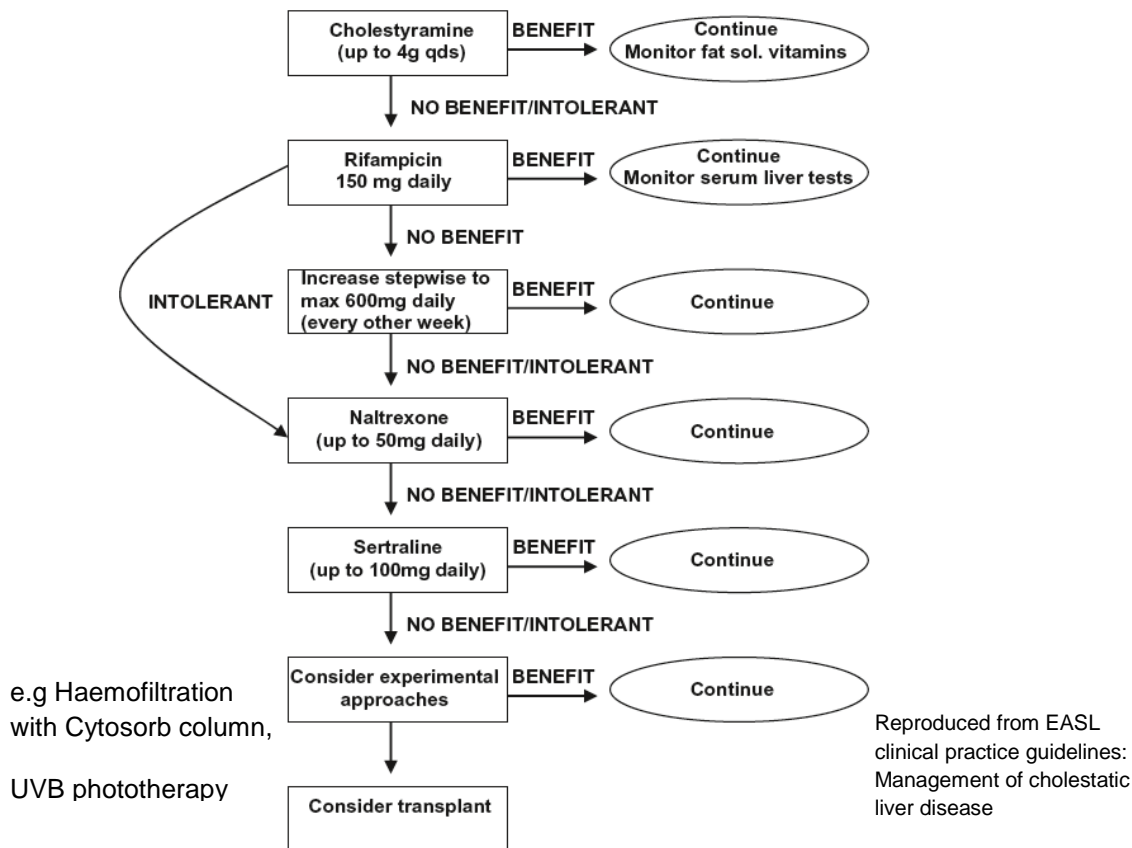


Pruritus in Liver Disease - Full Clinical Guideline

Reference no.: CG-T/2012/216

Management of Pruritus in Liver Disease

The pathogenesis of pruritus in cholestasis is not known. Management is based around the theory that an accumulation of bile acids in the skin and/or elevated endogenous opioids are responsible. **Ursodeoxycholic acid** (UDCA) is used in the treatment of PBC/ PSC, but is not a treatment for pruritus (may cause itch), except in the management of cholestasis of pregnancy. Pruritus is not histamine mediated, but sedating **antihistamines** are widely prescribed and may give some relief.



Cholestyramine: Binds bile acids, preventing absorption from terminal ileum. 80-85% of patients completely or partially respond within 4-11days. Side effects include unpleasant taste, fat malabsorption, constipation, anorexia and intestinal discomfort. Interferes with the bio-availability of several drugs, including UDCA, thyroxine, digoxin and OCP. Other medications should be taken at least 1hr before or 4hrs after Cholestyramine. Greatest amount of BA is present in GB before breakfast ∴ patients with an intact GB should take Cholestyramine 4g 30min before and 30min after breakfast. A third dose should follow lunch.

Naltrexone: Patients with cholestasis may exhibit an opioid withdrawal-like reaction. Start with 12.5mg (1/4 tablet) and increase by 12.5mg every 3-4 days up to maximum 50mg daily.

Rifampicin: Warn patients re discolouration of bodily secretions. A drug-induced hepatitis is seen in up to 12% of patients with cholestatic liver disease. Regular monitoring of LFTs, particularly in the first 2 months is essential.

Further reading:

[EASL Clinical Practice Guidelines: Management of cholestatic liver diseases J Hepatol 2009](#)
 Begasa, N. The pruritus of cholestasis. J Hepatol 2005; 43: 1078-88
 Mela, M et al. Pruritus in cholestatic and other liver diseases. Aliment Pharmacol Ther 2003; 17:856-70

1. Documentation Controls

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Review Date:	December 2021
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