Gallstones in pregnancy

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Acute cholecystitis is the second most common non-obstetric indication for surgery in pregnant women. Hormonal (oestro gen) changes during pregnancy increase cholesterol secretion and progesterone reduces bile acid secretion, reducing the abil ity of bile to solubilise cholesterol; bile becomes supersaturated with cholesterol. Progesterone also slows gallbladder emptying, which further promotes the formation of stones owing to bile stasis. Prepregnancy obesity , multiparity , increasing age and genetic predisposition are risk factors. Acute right upper quadrant/epigastric pain in pregnancy may be due to severe pre-eclampsia and the HELLP syndrome (haemolysis, eleva ted liver enzymes, low platelet count), acute fatty liver, abruptio placentae, uterine rupture or intra- amniotic infection. USG and non-contrast MRI are acceptable diagnostic modalities. For women in their first trimester, the mainstay of treatment for mild cases is conservative. Non-steroidal anti-inflammatory drugs are e ff ective analgesics but are generally avoided in pregnancy , especially after 32 weeks of gestation, because of potential adverse fetal e ff ects, e.g. premature closure of the ductus arteriosus. In the second trimester, with moderate or severe disease, good surgical candidates (American Society of Anesthesiolo gists [ASA] I or II) should undergo cholecystectomy during their initial hospitalisation as there is a high risk of recurrence or serious complications. In the third trimester, non-opera medical management with antibiotics and fluid therapy should be initiated. The patient should be re-evaluated after delivery . Generally , a waiting period of 6 weeks following delivery is pre ferred to allow the mother to recover from the delivery , bond with the infant and regain her strength.

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