Ectopic Pregnancy

Ectopic pregnancy should be considered in all women of childbearing age (12 to 50) who present with abdominal pain, collapse or dizziness and feeling faint. A careful menstrual history must be taken and pregnancy test should be checked. The incidence is 1:100 pregnancies and is increasing year on year.

Ectopic pregnancy usually presents after 6 to 8 weeks of amenorrhoea, although this can be earlier, or later up to 12 weeks.

Pregnancy tests are positive in most cases, although serum BHcG rises more slowly than in normal pregnancies and tests may be negative if very low levels of BHcG are present. If there is a history of amenorrhoea, the patient thinks she is pregnant or there are risk factors or clinical features suggestive of ectopic pregnancy then a blood BHcG sample should be sent.

Factors which increase the risk of ectopic pregnancy include:
- Previous confirmed ectopic pregnancy (recurrence rate 7-10%)
- Previous tubal surgery including sterilisation and reversal of sterilisation.
- Previous pelvic/low abdominal surgery such as appendicectomy and ovarian surgery
- Pelvic inflammatory disease
- Endometriosis
- IUCD
- Salpingitis

Presentation
- Generalised lower abdominal pains (often prodromal)
- PV bleeding, often scanty
- PV dark watery discharge ("prune juice")
- Sudden onset of severe abdominal pain
- Lateralisated pelvic pain
- Localised abdominal tenderness
- Shoulder tip pain
- Feeling faint/fainting
- Diarrhoea +/- vomiting
- Peritonitic abdomen
- Circulatory collapse
- Sudden death

Management

1. Patients with positive PDT/BHcG who have risk factors for ectopic pregnancy should be assessed according to the pregnancy pathway. If they have no localising signs, normal vital signs and no other features suggestive of ectopic pregnancy they should have blood taken for BHcG, FBC and Group and Save. An appointment should be made for follow up at the next available Early Pregnancy Clinic. They should be told to return to the Emergency Department immediately if they develop any features of ectopic pregnancy.
2. Patient with clinical features of ectopic pregnancy in the presence of positive PDT/BHcG should have their observations recorded and the EWS must be calculated.

**Haemodynamically normal patients with minimal pain and scant bleeding:**
- IV access
- Bloods for BHcG, FBC, G&S
- Analgesia as per protocol (avoid NSAIDs)
- Refer to Gynae SHO for review - may be suitable to be seen on C20 if beds are available.

**Patients with evidence of shock [tachycardia, hypotension, increased respiratory rate], decreased level of consciousness or EWS of 3 or more:**
- Move to cubicle in main majors area or resus i.e. not suitable for assessment in cubicle E.
- Seek help: A&E Senior doctor and gynae SHO to be asked to attend immediately. The on-call Gynae Registrar should be informed of the patient. If, during normal working hours i.e. Monday to Friday 9 to 5, the Gynae registrar is not available to speak to the on-call Consultant should be made aware of the patient.
- IV access, 2 large bore cannulae.
- FBC, U&E, X-Match 2 units.
- Fluid resuscitation.
- Haemodynamically unstable patients in whom ectopic pregnancy is suspected will need to go to theatre for urgent surgery.

**General Information**

Ectopic pregnancy is now treated in many ways:
- Surgical laparotomy and salpingectomy
- Laparotomy and salpingotomy. There is no evidence that salpingotomy is preferable to salpingectomy, although there may be preservation of function of the Fallopian tube with the former.
- Laparoscopic salpingectomy/salpingotomy.
- Medical treatment using Methotrexate to induce chemical termination of pregnancy.
- Expectant management: for a select group of women who present early with little pain or symptoms it may be appropriate for the ectopic pregnancy to be monitored using serial BHcG measurements as the pregnancy may resolve spontaneously.

There are still deaths of young women from ectopic pregnancy each year. It is vital that a high index of suspicion is maintained and appropriate action taken. As previously stated, ectopic pregnancy must be considered in all women of childbearing age presenting with symptoms which may be related. No woman, in whom ectopic pregnancy is suspected, should be discharged from the Emergency Department. Please discuss with senior doctor if you are not sure.