Ectopic pregnancy

Clinical presentation (may or may not include)
- Absence of menses
- Irregular vaginal bleeding (spotting)
- Abdominal/shoulder tip pain
- Cervical motion tenderness
- Tachycardia and hypotension
- Palpable adnexal mass (50% of women)
- Absence of IUP on USS, with a positive β-hCG

Discuss care options relevant to woman’s preferences and clinical indications

Medical
- Indications
  - Haemodynamically stable
  - No evidence of rupture
  - No signs of active bleeding
  - Normal FBC, ELFT
- Contraindications
  - Allergy to methotrexate
  - Geographic isolation
  - Potential non-compliance
  - Presence of medical conditions (review on individual basis)
  - Breastfeeding
- Caution
  - Baseline β-hCG > 5000 IU/L
  - Ectopic > 3 cm on TVS
  - Fetal heart motion present
  - Blood transfusion not an option
- Methotrexate
  - If β-hCG ≤ 3000 IU/L, IMI
  - If β-hCG > 3000 IU/L, IVI
- Ongoing management
  - EPAS or equivalent
  - β-hCG every 48 hours for 8 days
  - If resolution occurring, then weekly β-hCG until negative
  - USS if clinically indicated
  - Avoid conception until sonographic resolution

Surgical
- Indications
  - Haemodynamically unstable
  - Signs of rupture
  - Any β-hCG level
  - Persistent excessive bleeding
  - Heterotopic pregnancy
  - Contraindications to medical or expectant management
- Procedure
  - Laparoscopy method of choice
  - Laparotomy if:
    - Haemodynamically unstable
    - Laparoscopy too difficult
- Follow-up
  - GP 14 days post-surgery
  - If salpingo(s)tomy, weekly β-hCG
  - If salpingectomy, urinary β-hCG 3 weeks after surgery
  - USS if clinically indicated
- Ongoing management
  - EPAS or equivalent

Indicated only if:
- Haemodynamically stable
- No evidence of rupture
- Low and falling serum β-hCG (<1500 IU/L at initial presentation)
- Minimal/no fluid in pelvis on USS
- Tubal mass < 3 cm
- Pain free
- Woman understands need for follow-up and can access medical services

Caution
- If potential for non-compliance with follow-up

Ongoing management
- EPAS or equivalent
- β-hCG every 48 hours for 8 days
- If resolution occurring, then weekly β-hCG until negative
- USS if clinically indicated
- Avoid conception until sonographic resolution

If medical or expectant:
- Risk of rupture in acute phase from sexual intercourse or pelvic exam
- Consider alternative management if indicated (e.g. β-hCG not falling, at woman’s request, tubal rupture or ongoing pain/bleeding)

Give written information about:
- Management option chosen
- Expected bleeding/symptoms
- Resumption of menstruation
- Contraception
- Follow-up arrangements

General care considerations
- Review histopathology of POC
- If indicated, recommend RhD-Ig
- Analgesia as required
- Communicate information to other care providers (e.g. GP)
- Early USS (5–6 weeks) in next pregnancy

Consider the woman’s psychological needs and offer access to support