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
• Serial β-hCG as per methotrexate protocol
• USS in one week then as clinically indicated
  • If fetal heart present, refer to MFM
• Avoid conception for 4 months due to potential teratogenicity

Expectant

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

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

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

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 salpingos(tomy, weekly β-hCG until negative
• If salpingectomy, urinary β-hCG 3 weeks after surgery
• USS if clinically indicated
• Optimal conception interval unknown (0–3 months common)

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


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Queensland Clinical Guidelines, Queensland Health