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
- Follow-up uncertain
- 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 FH present, refer to MFM
- Avoid conception for 4 months due to potential teratogenicity

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

Expectant

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

Caution
- If follow-up is uncertain

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


Queensland Clinical Guideline. Early pregnancy loss. Flowchart: F22.29-3-V6-R27

Queensland Clinical Guidelines