NHS
Royal Devon and Exeter
NHS Foundation Trust

Ectopic Pregnancies and Suspected Ectopic Pregnancies

Introduction

This leaflet is designed to answer some of the questions and concerns that you may have. If you have any queries after reading this leaflet, please do not hesitate to ask a member of the nursing team on the ward or the Specialist Nurse in the clinic for advice.

What is an ectopic pregnancy?

An ectopic pregnancy is when the fertilised egg (pregnancy) implants and develops outside the womb. The most common site for an ectopic pregnancy is in the fallopian tube (the tube which connects the ovary to the womb).

In some cases the pregnancy gets bigger and damages the tissue around it causing pain and bleeding. It can also break blood vessels and become a life threatening condition.

What causes an ectopic pregnancy?

There are a number of causes, although we do not always know why it happens. Sometimes the tube may be affected by a previous infection such as appendicitis or pelvic infection. Infection may result in the tubes becoming kinked or bands of scar tissue forming (adhesions). These factors can delay the passage of the egg which may then implant in the tube.

Anyone who has a past history of inflammation in their pelvis from appendicitis, infection or endometriosis (see below) may have some tubal damage which increases the chance of an ectopic pregnancy occurring.

Endometriosis is a condition where endometrial tissue (the lining of the womb), which is usually shed during your period, may be found outside the womb.

Women using the intrauterine contraceptive device (coil) as a method of contraception and have had a previous ectopic pregnancy, and those who may have had pelvic infection resulting in tubal damage, may be at risk of developing an ectopic pregnancy. The coil prevents implantation in the womb; it cannot, however, prevent implantation in the tube. Ectopic pregnancy occurs in 1 in every 70 pregnancies.

Symptoms of an ectopic pregnancy

Most cases present between the fourth and tenth week of pregnancy. Low, one sided, stomach pain is a main feature of an ectopic pregnancy. You may experience some vaginal bleeding, and/or shoulder-tip pain. Often, women may not even be aware that they are pregnant if it occurs within four to six weeks of their last period. A blood test can be taken by your GP or the hospital to determine this.

If you have persistent abdominal pain, or a sudden onset of pain, it is very important to get it checked by a doctor to rule out an ectopic pregnancy as it can be life threatening.

How can I find out if I have an ectopic pregnancy? How is it managed?

If you miss a period or have a positive pregnancy test and have abdominal pain and/or bleeding, you should contact your GP. If your GP thinks you may have a significant chance of an ectopic pregnancy, you will be sent to hospital.

The hospital doctor will ask you some questions about your symptoms and examine you. A pregnancy test will be performed either on

urine, blood or both. An ultrasound scan will be arranged which may show if there is a pregnancy in the womb. This can be done by placing a probe on the abdomen, or by putting a probe in the vagina to give a clearer picture. None of these procedures will cause a miscarriage if the pregnancy is in the womb.

If the womb is empty, but a pregnancy test is positive, an ectopic pregnancy is suspected, although a miscarriage may have occurred. An ectopic pregnancy cannot always be seen on an ultrasound scan, especially if the pregnancy is at a very early stage. Sometimes we may see a small area on the scan that could represent an ectopic pregnancy. It may be impossible however to be absolutely sure on scan. If you are well and not in severe pain, you will be investigated with a series of blood tests to monitor the pregnancy hormone. Blood will be taken every 48 hours initially to see whether the level of hormone is rising or falling. This will help to determine if the pregnancy is positioned normally in the womb or an ectopic pregnancy. The test may also be helpful in determining whether the pregnancy is continuing or miscarrying. If the pregnancy hormone indicates an ectopic pregnancy, a specialist nurse or doctor will explain the following options of treatment to you. It is quite safe to adopt a 'wait and see' approach as many ectopic pregnancies settle without treatment.

Until recently the treatment for ectopic pregnancies has been an operation, but in many cases we will be able to advise you if this approach will be suitable for you.

Conservative Management (wait and see approach)

This involves monitoring your pregnancy hormone level over a period of a few weeks, initially every 48 hours, then weekly until the hormone level is negative. When the hormone level is negative it is safe to assume that you have had a miscarriage from your fallopian tube. This is the same as having a normal miscarriage. You will be given the telephone number of the clinic and can call at any time for advice. We will also give you the telephone number for Wynard Ward for advice if the clinic is closed; this number can be used at any time of the day or night.

What to expect during this time

You can expect to get some period type vaginal bleeding that could last from a few days to a few weeks. If bleeding becomes increasingly heavy so that you are changing your pads every couple of hours, it is important that you contact Wynard Ward immediately where they will review the situation.

You will also experience some abdominal pain. As long as it is a mild period type pain, then it should settle with paracetamol. If it is more severe or you have a sudden onset of severe pain, you should contact Wynard Ward immediately for advice or immediate admission.

Surgical Management

The specialist nurse or doctor may advise you that an operation would be the safest option for you. This may be at the time of your scan or during the wait and see time. This requires a general anaesthetic. A small telescope will be passed into the tummy button using a a small cut to have a look at the womb and tubes. If an ectopic pregnancy is seen, it will need to be removed. It may be possible to remove this through the telescope but in some cases a larger cut may be made, usually on the bikini line. Sometimes the surgeon may be able to cut the tube to remove the pregnancy leaving the tube intact, or sometimes part of or the whole of the tube may need to be removed. The nursing staff and doctor will fully explain the operation you have had.

Risks of the operation

All operations carry some degree of risk. Serious complications involving a risk to your life are rare if you are otherwise reasonably healthy and not excessively overweight.

Any general anaesthetic causes risks, but considerable precautions are taken to keep these to a minimum.

Infections following surgery sometimes occur. This may be wound infection, chest infection (more common in cigarette smokers) or urine infection. Antibiotics are given during your operation to reduce the chance of these infections. More antibiotics can be given should any infection occur.

Serious problems are rare. These may be:

- **Haemorrhage:** unexpected bleeding which may require transfusion of blood (or return to the operating theatre).
- **Thrombosis:** clots in the blood that may affect the legs and/or lungs. You will be given daily injections and special stockings to wear which improve the circulation in the legs to reduce the risk of a thrombosis.
- There is also a small risk of injury to the bowel or internal organs at the time of the laparoscopy when inserting the telescope into the stomach.

General anaesthetics have some risks, which may be increased if you have chronic medical conditions, but in general they are as follows:

- **Common temporary side-effects** (risk of 1 in 10 to 1 in 100) include bruising or pain in the area of injections, blurred vision and sickness, these can usually be treated and pass off quickly.
- **Infrequent complications** (risk of 1 in 100 to 1 in 10,000) include temporary breathing difficulties, muscle pains, headaches, damage to teeth, lip or tongue, sore throat and temporary problems speaking.
- **Extremely rare and serious complications** (risk of less than 1 in 10,000). These include severe allergic reactions and death, brain damage, kidney and liver failure, lung damage, permanent nerve or blood vessel damage, eye injury, and damage to the voice-box. These are very rare and may depend on whether you have other serious medical conditions.

After the operation

You will come back from the operating theatre with a drip in the back of your arm or hand. This is to ensure you get adequate fluid and to stop you becoming dehydrated. Clips, stitches or glue will be used to close the wound. These are usually removed by the nursing staff on day four or five after your operation if you have had a cut in your tummy. If the operation was performed through the telescope, the stitches are normally dissolvable and take about ten days to go.

Many women can go home the same day as keyhole surgery, depending on their recovery from the operation. If you have any questions about your operation or concerns about the future, do not hesitate to ask a member of the nursing team or doctors as they will be willing to help.

You may feel tired when you get home and you should not do any heavy lifting or housework. You should avoid driving for 4 days after keyhole surgery. A follow-up appointment at the hospital may be arranged for you six to eight weeks after your operation, the nursing staff will advise you about this. The physiotherapist will see you while you are in hospital if you have had a larger cut in your tummy, and will explain about exercises you should do.

Medical Management

This is a treatment using a drug called Methotrexate.

Methotrexate is a medication that interferes with the actively dividing cells within an ectopic pregnancy. The drug stops the pregnancy developing any further and it is then gradually reabsorbed or is released from the tube (tubal miscarriage).

This method of treatment is only suitable for women who fit the criteria detailed below:

- The fallopian tube has not ruptured.
- The pregnancy hormone level (hCG) is low or stable.
- Ultrasound shows the presence of an ectopic pregnancy of less than 4cm and without heart activity.
- There is no significant bleeding or severe pain.
- Patients can attend for follow up blood tests and have easy access into hospital.

If you have any of the following conditions you will not be able to have treatment with Methotrexate:

- severe anaemia or shortage of other blood cells;
- kidney problems;
- liver problems;
- active infection;

- HIV/AIDS;
- peptic ulcer or ulcerative colitis.

The treatment is given by means of an injection, usually given in the buttock. Your hormone level will be checked on day 4 after the injection (when we would expect a slight rise) and day 7, and if this has fallen by 15% you will be monitored regularly with blood tests until your hormone level is less than 10. Most women only need one injection but in up to a third of cases a further injection may be required if the pregnancy hormone levels are not decreasing.

It is common to have some discomfort and pain, but as long as this is not severe and you are feeling well, this is nothing to worry about.

You will need to come straight in to hospital if your pain persists, is severe and not helped by taking simple pain killers or you feel faint. Approximately 90% of women will have their ectopic pregnancy successfully treated by medical treatment with Methotrexate, but 1:10 will need an operation either due to hormone levels not falling or because of pain or concerns of internal bleeding.

Emotional aspects

An ectopic pregnancy can be very painful and traumatic experience. It is natural to feel tearful and upset after the operation, even if you did not realise you were pregnant. You may experience a number of feelings. The sudden end to your pregnancy will have an affect on your hormone levels, which can cause your moods to fluctuate. The emotional reaction to an ectopic pregnancy can put an enormous strain on a relationship, therefore it is important to try and talk to your partner about your feelings. As well as having to come to terms with the loss or damage of your fallopian tube and the possible subsequent reduction in your fertility. Your partner may be equally as distressed as you, so take some time to talk to each other and support one another.

You may find it helpful to discuss your feelings with the nurses on Wynard, your doctor, friends and relatives. There is a nurse counsellor on the ward; if you would like to speak to her, just ask a member of the nursing team.

What about the next pregnancy?

As you have two fallopian tubes, even if you have one completely removed, you can still get pregnant. If the tube was saved during the operation, you may still be able to get pregnant through that tube. The doctor will be able to explain exactly what was done at the time of the operation, so please ask.

There is a good chance that you will go on to have a normal pregnancy, although there is a slightly higher risk of another ectopic pregnancy occurring.

In all cases, a woman who has had an ectopic pregnancy should consult their GP immediately she suspects she may be pregnant, so that the pregnancy can be monitored closely from the early stages. The GP will arrange an early scan at around six to eight weeks.

How soon can I try to become pregnant again?

If an ectopic pregnancy has been treated by Methotrexate you should not try to conceive until 3 months have passed since the treatment. Otherwise, the answer really is when you and your partner feel physically and emotionally ready.

It is probably better to wait for your periods to get back to "normal" before you and your partner try again for a baby.

If you need advice about contraception prior to discharge, please ask a nurse or doctor on the ward.

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