Ectopic pregnancy

Expectant

· Haemodynamically stable

Low and falling serum β-hCG

(<1500 IU/L at presentation)

Woman accepts need for follow-

β-hCG every 48 hours for 8 days

• If resolution occurring, then

· USS if clinically indicated

Avoid conception until

sonographic resolution

weekly β-hCG until negative

up and can access medical

Minimal/no fluid in pelvis on

No evidence of rupture

Tubal mass < 3 cm

• If follow-up is uncertain

Ongoing management

EPAS or equivalent

Indicated only if:

USS

Pain free

services

Caution

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 \leq 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
 - o 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:
 - o Haemodynamically unstable
 - o 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)

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

β-hCG: human chorionic gonadtrophin, ELFT: electrolyte & liver function test, EPAS: Early Pregnancy Assessment Service, FBC: full blood count, GP: General Practitioner, GTD: gestational trophoblast disease, IMI: intramuscular injection, IU/L: international units per litre, IUP: intrauterine pregnancy, IVI: intravenous injection, MFM: maternal fetal medicine, POC: products of conception, PUL: pregnancy of unknown location, PV: per vaginam, QTC: Queensland Trophoblast Centre, RhD-lg: RhD immunoglobulin, TVS: transvaginal scan, USS: ultrasound scan, >: greater than,

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

