

Ectopic Pregnancy

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Epidemiology

- 1-2/100 known pregnancies
- 2/1000 women at risk for pregnancy
- #1 cause maternal death in 1st half pregnancy
- 15% maternal deaths
- After 1st ectopic, 7-13x increase risk recurrence



Risk Factors

Definite

- PID
- Prior tubal surgery
- Current IUD use
- Previous ectopic

Possible

- Progestin only contraception
- Prior pelvic surgery
- Infertility
- Ovulation induction
- Smoking



History

- Classic - pain, amenorrhea, vaginal bleeding
- Now, with excellent early HCG testing, often don't develop all these
- Inquire about previously described risk factors
- ANY pregnant pt with pain or bleeding -
THINK ECTOPIC



Physical Exam

- R/O hemodynamic instability - if NOT stable, think ATLS and get help
- Pelvic - look for adnexal mass, though corpus luteum often present concurrently



Lab Testing

- CBC, Blood Type
- QUANTITATIVE HCG
 - $> 1500-2000$ - should be able to visualize IUP with TV US on reliable machine
 - $< 1500-2000$ - cannot always see viable IUP, but may be able to see suspicious adnexal mass



Quantitative HCG

- If hemodynamically stable, but qHCG too low to rule in IUP, follow qHCG as outpt
- Will double every 48 hrs on average, with minimum increases of 66% every 48 hrs, and 114% every 72 hrs.
- Once in discriminatory zone, get US
- Strict precautions as outpt



Abnormal HCG's

- If rising abnormally and not yet in discriminatory zone, think SAB vs Ectopic
- Ob Consult - consider D&C to evacuate uterus, check path.
- If no POC, follow qHCG - if not dropping rapidly, consider further treatment (MTX vs L/S)



Progesterone

- Much studied for prediction of viable IUP
- > 25 ng/ml, 70% viable IUP vs 1.5% ectopic
- Problems - not sensitive or specific enough
- Lab often mail-out or only run weekly



Culdocentesis

- Description of procedure
- Not used as frequently with sensitive HCG level and TV US
- Still useful on ship or in operational setting for evaluating acuity of patient
- 70-90% pts with hemoperitoneum (Hct>15%) have ectopic



Treatment

- Based on clinical situation - reliable pt, confidence in diagnosis, severity of symptoms
- Options - observation; methotrexate; salpingostomy; salpingectomy
- Observation **ONLY** when pt refuses all other options



Methotrexate

- When pt is asymptomatic for rupture, and meets several criteria (US findings, lab test levels, reliability for FU, etc)
- Check CBC, LFT, Chem 7, Blood type
- Dose 50 mg/m² IM x 1
- FU - qHCG post-injection day 4 and 7 - if <15% qHCG decline in one week, repeat dose or consider surgery



Surgery

- Symptomatic for rupture or impending rupture; fails MTX criteria; poor FU
- Consider laparoscopy or laparotomy for salpingostomy or salpingectomy
- If salpingostomy or question of persistent trophoblastic tissue, follow qHCG to zero



Prognosis

- Depends on condition of tubes, type of treatment, extent of damage
- MTX - subsequently, 80% will become pregnant, with a 13% ectopic rate
- Salpingostomy - 60% will have an IUP, with 13-16% ectopics; similar for salpingectomy



CAUTIONS

- Pregnant and pain/bleeding -
THINK ECTOPIC - ECTOPIC KILLS
- Blood Type if bleeding - Rhogam if Rh-
- Close FU until CONFIRMED IUP
- Heterotopic pregnancy if using fertility
meds

