How can I help to reduce healthcare associated infections?
Infection control is important to the well-being of our patients and for that reason we have infection control procedures in place. Keeping your hands clean is an effective way of preventing the spread of infections. We ask that you, and anyone visiting you, use the hand sanitiser available at the entrance to every ward before coming into and after leaving the ward. In some situations hands may need to be washed at the sink using soap and water rather than using the hand sanitiser. Staff will let you know if this is the case.

www.buckshealthcare.nhs.uk
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**Ectopic Pregnancy**

This leaflet deals with the more common questions about ectopic pregnancy.

**What is an Ectopic Pregnancy?**

An ectopic (‘out-of-place’) pregnancy is a common, serious condition affecting **1 in 80** pregnancies, which occurs when the fertilised egg implants outside the cavity of the womb.

The most common place for an ectopic pregnancy is the fallopian tube (97%), however the pregnancy may be located elsewhere. A non-tubal pregnancy may be:

- **Interstitial/Cornual** (2%) – the top corner of the uterus near the Fallopian tube
- **Abdominal** (1.4%)
- **Cervical** (0.2%) – in the cervix (neck of the womb)
- **Ovarian** (0.2%) – in or on the Ovary
- **Caesarean section scar**
- **Heterotopic** – a twin pregnancy where one is correctly placed in the womb but one is ectopic.

It is, sadly, not possible to move an ectopic pregnancy.

As the pregnancy grows the thin wall of the fallopian tube stretches causing abdominal pain and vaginal bleeding. The fallopian tube is not large enough to accommodate a growing pregnancy and if left untreated the tube may eventually rupture causing severe internal bleeding.

**Why does it happen?**

Often the reason for an ectopic pregnancy will never be determined. However, there are some known causes and risk factors:

- **A previous ectopic pregnancy.**

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**Useful contact numbers:**

**Wycombe Hospital**

EPU Clinic 08:00 – 13:00 Monday – Friday
01494 425553

**Stoke Mandeville Hospital**

EPU Clinic 08:00 – 13:00 Monday – Friday
01296 316469

Out of Hours (Stoke Mandeville Hospital) Surgical Assessment Unit (Ward 15) 01296 316500

**Further Support & Information**

**The Ectopic Pregnancy Trust**

3rd Floor
28 Portland Place
London W1B 1LY

Tel: (Helpline) **020 7733 2653** (24hour answer machine service)

[www.ectopic.org.uk](http://www.ectopic.org.uk)

**The Miscarriage Association**

17 Wentworth Terrace
Wakefield
Yorkshire
WF1 3QW

Tel: **01924 200799** (Monday – Friday 09:00 – 16:00)

[www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)

**Pregnancy Loss Support Group**

(Stoke Mandeville Hospital, Claydon Wing Annex)

First Tuesday of the month 19:00 – 20:30
Just come along or contact Rebecca on 01296 316469
Future pregnancies
The chance of a healthy pregnancy is very good and 65% women are healthily pregnant within 18 months after an ectopic pregnancy. Some studies have suggested that this figure rises to around 85% within 2 years; your chance of conceiving is dependent upon the health of your tubes.

What do I do in my next pregnancy?
You should see your GP as soon as you know you are pregnant especially if you have any abdominal pain or bleeding. It is appropriate to have an ultrasound scan when you are around 7 weeks to confirm that the pregnancy is in the womb; you may refer yourself to the Early Pregnancy Clinic for this scan.

This leaflet explains some of the most common side-effects that some people may experience. However, it is not comprehensive. If you have any further concerns or questions experience other side-effects and want to ask anything else related to your treatment please speak to the Surgical Assessment Unit on 01296 418110/811.

- Pelvic Inflammatory Disease: previous infection of the fallopian tubes caused, for example, by a sexually transmitted infection like Chlamydia.
- Fertility Treatment: There is a chance of ectopic pregnancy resulting from embryo transfer during IVF treatment as embryos can travel into the fallopian tube, for example, during the implantation stage.
- Abdominal Surgery: such as caesarean section or appendicectomy.
- Tubal Surgery: An operation on the fallopian tubes, such as sterilization, reversal of sterilization or for previous ectopic pregnancy.
- Endometriosis: cells like the ones lining the womb grow elsewhere in the body; they react to the menstrual cycle and bleed despite there being no way for the blood to leave the body. This can cause damage to the fallopian tubes.
- A contraceptive coil (IUCD): The coil prevents a pregnancy in the uterus but is less effective in preventing a pregnancy in the fallopian tube.
- The ‘mini-pill’ (progesterone-only pill): This type of contraceptive pill alters the motility of the tube i.e. the ability for an egg to move through it.
- The Morning After Pill: It is possible to become pregnant in the same cycle after trying to prevent pregnancy with emergency oral contraception.
- Cigarette Smoking: Research by the University of Edinburgh showed that smokers have an increased level of the protein PROKR1 in their fallopian tubes. The protein is instrumental in helping pregnancies implant in the womb, but when present in the fallopian tubes can hinder the progress of a fertilised egg, increasing the chances of a pregnancy being ectopic.
- Maternal age: the risk is higher amongst women over 35 years.
**How is an Ectopic pregnancy diagnosed?**

Ectopic pregnancy can be difficult to diagnose since symptoms can be mistaken for irritable bowel syndrome, gastro-enteritis, miscarriage or appendicitis.

- **By vaginal ultrasound scan.** If your scan shows no pregnancy in the womb and your pregnancy test is positive an ectopic must be considered.

- **A blood test** measuring the levels of the pregnancy hormone BhCG (and a one-off assessment of the Progesterone hormone) can be used to help make the diagnosis and determine treatment options.

It may take a few days or a few weeks before a decision can be made as other possibilities are that your pregnancy may be too early to detect on ultrasound scan, or may be a very early miscarriage. If so it may be called a pregnancy of unknown location (PUL).

The pregnancy hormone BhCG in a normal early pregnancy doubles every two days. After a miscarriage the levels drop quite quickly. In a failing pregnancy or an ectopic pregnancy the levels are often lower and may plateau or rise slowly. Blood tests alone cannot determine where a pregnancy is developing however they can help monitor patients who may have a growing ectopic pregnancy.

- **Laparoscopy** may be performed under general anaesthetic. A small cut is made in your abdomen and a tiny camera is used to visualise your fallopian tubes and internal organs. A tubal pregnancy will be treated at the same time; on rare occasions no ectopic pregnancy may be seen. This might be because there is a very early pregnancy developing in the womb or that the ectopic is too small to see at laparoscopy.

**What happens to the tissue removed at surgery?**

Pregnancy tissue removed at surgery is sent to the Histology laboratory for diagnosis (to be looked at under a microscope). The slides and blocks of wax in which the tissue is embedded are kept in the laboratory for 30 years as part of your hospital record (in line with national guidelines).

Please note that tissue kept in the laboratory consists, wherever possible, of only small amounts of tissue.

If any fetal tissue is seen it is the hospital policy to make arrangements for this tissue (except for the small amounts processed by the laboratory for diagnosis) to be buried; this is done in a sensitive manner.

You will be asked when you consent for your operation whether you agree that tissue in the laboratory can be used for teaching healthcare staff or for research. A separate information sheet is available to explain the importance of this.

**How will I feel afterwards?**

Ectopic pregnancy can be a difficult experience. As well as recovering from your operation you have to cope with the loss of your pregnancy and often the loss of part of your fertility. Your partner is likely to be suffering too and sharing your feelings often helps. There are support networks available listed at the end of this leaflet.

**What are the different methods of treatment?**

Once an ectopic pregnancy is diagnosed it can be managed
How long will I stay in hospital?
This will vary from 1 – 4 days depending on the type of surgery, but the majority of patients can expect to be discharged home within 24 hours of their operation. Stitches are usually dissolvable and should dissolve completely after 7 – 10 days.

Following methotrexate injection you will need to stay for 1 – 2 hours for observation.

When should I return to work or resume my normal activities?
Complete recovery will vary from 2 – 6 weeks depending on the type of surgery.

It is normal to experience pain for 1 – 2 weeks following surgery; it’s advisable to take regular pain relief such as paracetamol, codeine or ibuprofen to aid your recovery. If you had a laparoscopy you are likely to feel bloated for the first week with pain similar to trapped wind. This is due to the gas used during surgery to assist the surgeon in visualising the abdomen. You will feel tired, particularly if you had significant bleeding during the procedure.

You should avoid heavy lifting or vigorous housework for around 2 weeks and only undertake gentle exercise such as walking; once the wound sites have healed you resume gentle swimming.

After keyhole surgery most women do not return to work for at least 2 weeks to enable their body and emotions to heal; after major abdominal surgery this time frame increases to approximately 6 weeks.

My blood group is Rhesus negative
An injection of Anti-D will be given after your surgery.

conservatively (wait and see), medically or surgically. The treatment best suited for you would depend on the scan findings, physical symptoms, BhCG levels and your preferred choice.

Expectant management (watchful waiting)
This involves close monitoring by medical professionals instead of immediate treatment. In some cases the ectopic pregnancy dies early and is absorbed. These pregnancies resolve without treatment and the pregnancy often dies in a way similar to miscarriage. This can be confirmed by falling pregnancy hormone (BhCG) levels and no active treatment is required.

You will need to have repeated blood tests to ensure that your hCG levels are dropping, initially 48 hours apart and then weekly, until the levels have dropped to below 10 units/L. How long it takes for your hormone levels to drop can vary considerably and can take between two weeks and three months; most women’s hCG levels reach a non-pregnant state within four weeks. As long as the hCG levels are consistently dropping you can continue to be managed expectantly. You may, however, require alternative treatment if your symptoms worsen.

Medical treatment
In early ectopic pregnancies an injection of methotrexate can be used to kill the cells of the pregnancy growing in the Fallopian tube. This form of medical treatment is an alternative to surgical treatment if certain criteria are fulfilled e.g. when the BhCG levels are below 5000 units/L (the risk of rupture is higher in pregnancies with levels greater than this) and small size of ectopic pregnancy. Cornual ectopic pregnancies are often treated medically.

Your general health will be assessed for suitability for this treatment since there are some exclusion criteria.
The treatment is given by means of a single injection into the muscle. The dose is calculated according to your height and weight. Before the injection, blood tests are done to check liver and kidney function and to ensure that you are not anaemic.

Close follow-up with further scans and blood tests will be necessary. As with expectant management you will have weekly blood tests to monitor hCG levels until they drop to below 10 units/L.

You will be advised to avoid pregnancy for 3 months from the time of injection. There are some side effects with methotrexate. If you choose to have this treatment they will be explained to you in detail.

What symptoms should I look out for?
If you are being, managed conservatively or medically you will be asked to look out for symptoms suggesting the ectopic pregnancy is not responding to management. These are:

- Increasing abdominal pain (either one-sided or severe abdominal cramps) not responding to simple painkillers such as paracetamol or codeine.
- Shoulder-tip pain caused by internal bleeding irritating the diaphragm as you breathe in and out.
- Bowel or bladder problems (diarrhoea +/- vomiting, pain on opening bowels or passing urine).
- Heavy vaginal bleeding.
- Faintness or dizziness.
- Collapse.

If you have any of these symptoms, it is advisable that you come to A&E.

Surgical treatment
Surgery may be your only option if your hCG hormone level is high, if significant internal bleeding is seen on your scan or you become unwell and your health becomes at more immediate risk. Surgery may also be performed if expectant or medical management have failed.

In the majority of cases this is done by laparoscopy under general anaesthetic and usually takes approximately 30 – 60 minutes.

- A small cut is made in your abdomen below the umbilicus (belly button) and a tiny camera is used to visualise your fallopian tubes and internal organs.
- 1 or 2 further small incisions may be necessary if an ectopic pregnancy is seen to allow access for instruments to be used to remove it.
- The operation will usually involve removal of the tube and pregnancy (salpingectomy) if there is a lot of damage or bleeding to the affected tube, or
- Removal of the pregnancy only by making a small cut, leaving the tube intact (salpingotomy) if the damage is minimal.
- Your ovaries are not removed.

What are the benefits of salpingectomy (removal of the tube)?
The tube containing an ectopic pregnancy is removed to prevent severe internal bleeding. In future pregnancies the risk of further ectopic is reduced – compared to when the tube is not removed. If the other tube looks healthy future pregnancy rates are the same whether the tube is removed or saved.

What are the risks of salpingotomy (removal of the pregnancy only)?
A small amount of pregnancy tissue may remain in the tube requiring further treatment (e.g. with methotrexate). The chance of this happening is between 5 – 10%.