

# Information for you

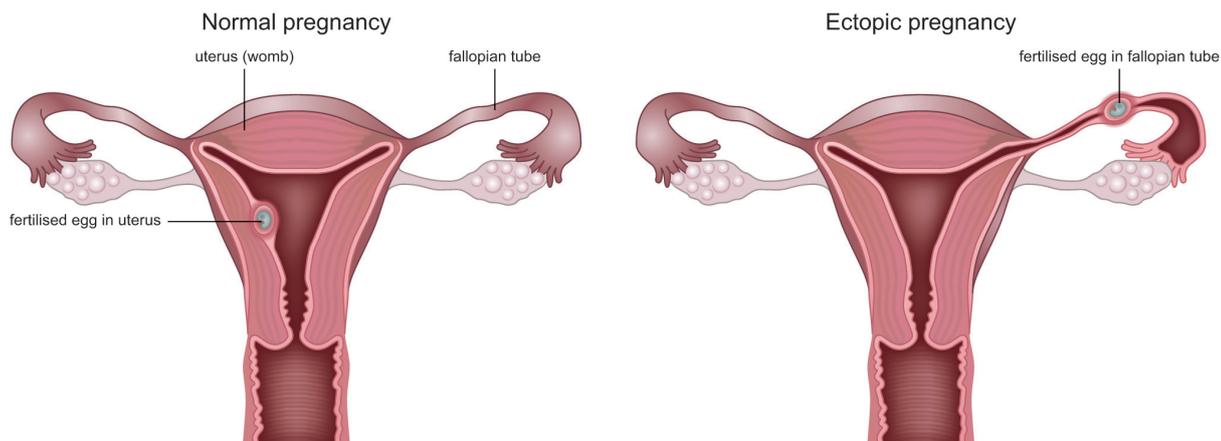
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## An ectopic pregnancy

### What is an ectopic pregnancy?

An ectopic pregnancy is when a pregnancy starts to grow outside the uterus (womb). In the UK, one in 90 (just over 1%) pregnancies is an ectopic pregnancy.

When you become pregnant, the sperm and egg meet in the fallopian tube (the tube that carries the egg from the ovary to the uterus). Usually, the fertilised egg moves into the uterus for the pregnancy to grow and develop. If this does not happen, an ectopic pregnancy may start to develop in a fallopian tube (sometimes known as a tubal pregnancy). An ectopic pregnancy can occur in places other than a fallopian tube, such as in the ovary (rarely) or inside the abdomen (very rarely).



This information is about an ectopic pregnancy in the fallopian tube. A pregnancy cannot survive in this situation and – sadly – cannot lead to the birth of a baby.

This is because as the pregnancy gets bigger it can:

- run out of space to grow in the fallopian tube
- rupture (burst) the fallopian tube, causing severe pain and internal bleeding. This is a potentially life-threatening situation for you.



## What are the symptoms of an ectopic pregnancy?

Most women get physical symptoms in the sixth week of pregnancy – about two weeks after a missed period. You may or may not be aware you are pregnant if your periods are irregular or if the contraception you are using has failed.

Each woman is affected differently by an ectopic pregnancy. Some women have no symptoms, some have a few symptoms while others have many symptoms. Because symptoms vary so much, it is not always straightforward to make a diagnosis of an ectopic pregnancy. The symptoms of an ectopic pregnancy may include:

### Abnormal bleeding

You may have some spotting or bleeding that is different from your normal period. The bleeding may be lighter or heavier than normal. The blood may be darker and more watery.

### Pain in your lower abdomen

This may develop suddenly for no apparent reason or may come on gradually over several days. It may be on one side only.

### Pain in the tip of your shoulder

This occurs due to blood leaking into the abdomen. This pain is there all the time and may be worse when you are lying down. It is not helped by movement and may not be relieved by painkillers.

### Upset tummy

You may have diarrhoea or pain on opening your bowels.

### Severe pain/collapse

If the fallopian tube ruptures and causes internal bleeding, you may develop intense pain or you may collapse. This is an emergency situation. In rare instances, collapse is the first sign of an ectopic pregnancy.

## Should I seek medical advice immediately?

Yes! An ectopic pregnancy can pose a serious risk to your health. If you have had sex within the last 3 to 4 months (even if you have used contraception) and are experiencing these symptoms, get medical help immediately. Seek advice even if you do not think you could be pregnant.

You can get medical advice from:

- your general practitioner or midwife
- the A&E department at your local hospital
- an Early Pregnancy Unit (details of the unit nearest to you can be found at [www.earlypregnancy.org.uk/FindUsMap.asp](http://www.earlypregnancy.org.uk/FindUsMap.asp))
- NHS on 111.

## Am I at increased risk of an ectopic pregnancy?

Any woman of childbearing age who is having sex could have an ectopic pregnancy. You are at an increased risk of an ectopic pregnancy if:

- you have had a previous ectopic pregnancy
- you have a damaged fallopian tube. The main causes of damage are:
  - previous surgery to your fallopian tubes, including sterilisation
  - previous infection in your fallopian tubes (see RCOG patient information [Acute pelvic inflammatory disease: tests and treatment](#))
- you become pregnant when you have an intrauterine device (IUD/coil) or if you are on the progesterone-only contraceptive pill (mini-pill)
- your pregnancy is an in vitro fertilisation (IVF) or intracytoplasmic sperm injection (ICSI) pregnancy
- you are over 40 years old
- you smoke.

## How do I get a diagnosis?

Most ectopic pregnancies are suspected between 6 and 10 weeks of pregnancy. Sometimes the diagnosis is made quickly, but if you are in the early stages of pregnancy, it can take longer (a week or more) to make a diagnosis of an ectopic pregnancy.

Your diagnosis will be confirmed by the following:

### Consultation and examination

The doctor will ask about your medical history and symptoms. The doctor will examine your abdomen and may also do a vaginal (internal) examination. You should be offered a female chaperone (someone to accompany you) for this. You may also wish to bring someone to support you during your examination.

If you have not already had a positive pregnancy test, you will be asked for a urine sample so this can be tested for pregnancy. If the pregnancy test is negative, it is very unlikely that your symptoms are due to an ectopic pregnancy.

### Ultrasound scan

Most women are offered a transvaginal scan (where a probe is gently inserted into your vagina) to look at the uterus, ovaries and fallopian tubes. If you are in the early stages of pregnancy, you may be offered another scan after a few days when it may be easier to see the pregnancy.

### Blood tests

- A test for the level of the pregnancy hormone human chorionic gonadotrophin (hCG) or a change in this level every few days may help to give a diagnosis.
- A test for the level of the hormone progesterone may be taken.

### Laparoscopy

If the diagnosis is still unclear, an operation called a laparoscopy may be necessary. This operation takes place under a general anaesthetic. The doctor uses a small telescope to look at your pelvis by making a tiny cut usually into the umbilicus (tummy button). This is also called keyhole surgery.

If an ectopic pregnancy is detected, treatment may take place during the same operation.

## What are the options for treatment?

Because an ectopic pregnancy cannot lead to the birth of a baby, all options end the pregnancy in order to reduce the risks to your own health. Your options depend on:

- how many weeks pregnant you are
- your symptoms
- if there has been a lot of bleeding inside your abdomen
- the level of hCG
- your scan result
- your general health
- your personal views and preferences – this should involve a discussion about your future pregnancy plans
- the options available at your local hospital.

The options for treatment are listed below – not all will be suitable for you.

### Expectant management (wait and see)

Ectopic pregnancies sometimes end on their own – similar to a miscarriage. Depending on your situation, it may be possible to monitor the hCG levels with blood tests every few days until these are back to normal (see **Follow-up appointments: what happens next?**). Although you do not have to stay in hospital, you should go back to hospital if you get any symptoms. You should be given a direct contact number for the emergency or gynaecology ward at your hospital.

Expectant management is not an option for all women. It is usually only possible when the pregnancy is still in the early stages and when you have a few or no symptoms. Up to 29 in 100 (29%) women undergoing expectant management may require additional medical or surgical management.

### Medical treatment

In certain circumstances, an ectopic pregnancy may be treated by medication (drugs). The fallopian tube is not removed. A drug (methotrexate) prevents the pregnancy from developing and so the ectopic pregnancy gradually disappears. The drug is given as an injection. If your pregnancy is beyond the very early stages or the hCG level is high, methotrexate is less likely to succeed. Many women experience some pain in the first few days, but this usually settles with paracetamol or similar pain relief. Although long-term treatment with methotrexate for other illnesses can cause significant side effects, this is rarely the case with one or two injections to treat ectopic pregnancy.

You may need to stay in hospital overnight and then return to the clinic or ward a few days later. It may be sooner if you have any symptoms. It is very important that you attend your follow-up appointments (see **Follow-up appointments: what happens next?**).

- Fifteen in 100 (15%) women need to have a second injection of methotrexate.
- Seven in 100 (7%) women will need surgery, even after medical treatment.

### Surgery

The aim of surgery is to remove the ectopic pregnancy. The type of operation you have will depend on your wishes or plans for a future pregnancy and what your surgeon finds during the operation (laparoscopy).

To have the best chance of a future pregnancy inside your uterus, and to reduce the risk of having another ectopic pregnancy, you will usually be advised to have your fallopian tube removed (salpingectomy).

If you only have one tube or your other tube does not look healthy, this already affects your chances of getting pregnant. In this circumstance, you may be advised to have a different operation (salpingotomy). This operation aims to remove the pregnancy without removing the tube. It carries a higher risk of a future ectopic pregnancy but means you retain the possibility of a pregnancy in the uterus in the future. Some women may need to have a further operation to remove the tube later if the pregnancy has not been completely removed.

An operation to remove the ectopic pregnancy will involve a general anaesthetic. The surgery will be either:

- Laparoscopy – the stay in hospital is about 1 to 2 days and the recovery is about 2 to 4 weeks (see RCOG patient information [Recovering Well: information for you after a laparoscopy](#)).
- Open surgery – known as a laparotomy – is performed through a larger cut in your lower abdomen. It is usually done if severe internal bleeding is suspected. You will need to stay in hospital for 2 to 4 days. It usually takes about 4 to 6 weeks to recover.

There are risks associated with any operation. This may be due to the use of an anaesthetic or the operation itself. Your surgeon and anaesthetist will discuss these with you.

## What do I need to know to make an informed decision?

When an ectopic pregnancy is confirmed, and if the fallopian tube has not ruptured, your doctor should discuss your options with you.

Make sure you:

- fully understand all your options
- ask for more information if there is something you do not understand
- raise your concerns
- understand what each option means for your fertility (see **What about future pregnancies?**)
- have enough time to make your decision.

## In an emergency situation

If the fallopian tube has ruptured, emergency surgery is needed to stop the bleeding. This is achieved by removing the ruptured fallopian tube and pregnancy. This operation is often life-saving. Your doctors will need to act quickly and this may mean that they have to make a decision on your behalf to operate. In this situation you may need a blood transfusion (see RCOG patient information [Blood transfusion, pregnancy and birth](#)).

## Follow-up appointments: what happens next?

It is important that you attend your follow-up appointments. The check-ups and tests you have will depend on the treatment you received.

## Expectant management

Your doctor will need to check your blood levels of hCG every few days until normal levels are reached. This is to ensure that the pregnancy has completely ended. You may need further ultrasound scans.

## Medical management

You will need to return twice in the first week and then once a week to check your blood levels of hCG. It may take a few weeks to ensure the pregnancy has completely ended and you may need further ultrasound scans. During this time, you should not have sex. You should avoid getting pregnant by using reliable contraception for at least 3 months.

## **Surgical management**

You may be offered a follow-up appointment with your gynaecologist, particularly if you have had an emergency operation. If you have not had your fallopian tube removed, you will need to have your hCG level checked until this is back to normal.

## **What about future pregnancies?**

For most women an ectopic pregnancy occurs as a 'one off' event and does not occur again. The chance of having a successful pregnancy in the future is good.

Even if you have only one fallopian tube, your chance of conceiving is only slightly reduced. The overall chance of having an ectopic pregnancy next time is between 7 and 10 in 100 (7–10%). However, this depends on the type of surgery you had and any underlying damage to the remaining tube(s).

In a future pregnancy, you may be offered an ultrasound scan at 6 to 8 weeks to confirm that the pregnancy is developing in the womb.

If you do not want to become pregnant, seek further advice from your doctor or family planning clinic as some forms of contraception may be more suitable after an ectopic pregnancy.

## **How will I feel afterwards?**

The impact of an ectopic pregnancy can be very significant. It can mean coming to terms with the loss of a baby, with the potential impact on future fertility or with the fact you could have lost your life. Each woman copes in her own way – an ectopic pregnancy is a very personal experience. This experience may affect your partner and others in your family as well as close friends.

It is important to remember that the pregnancy could not have continued without causing a serious risk to your health.

Before trying for another baby, it is important to wait until you feel ready emotionally and physically.

However traumatic your experience of an ectopic pregnancy has been, it may help to know that the possibility of a normal pregnancy next time is much greater than the possibility of having another ectopic pregnancy. If you have any questions, make sure you speak with your midwife, general practitioner or gynaecologist.

## Sources and acknowledgements

This information is based on the Royal College of Obstetricians and Gynaecologists (RCOG) guideline *The Management of Tubal Pregnancy* (published by the RCOG in 2010). This information will also be reviewed, and updated if necessary, once the guideline has been reviewed. The guideline contains a full list of the sources of evidence we have used. You can find it online at: [www.rcog.org.uk/womens-health/clinical-guidance/management-tubal-pregnancy-21-may-2004](http://www.rcog.org.uk/womens-health/clinical-guidance/management-tubal-pregnancy-21-may-2004).

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This information has been reviewed before publication by women attending clinics in Kilmarnock, London and Wrexham.

A glossary of all medical terms is available on the RCOG website at <http://www.rcog.org.uk/womens-health/patient-information/medical-terms-explained>.

### A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit [www.rcog.org.uk](http://www.rcog.org.uk) for the most up-to-date version of this guideline.