HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (Ward)		
Document:	Departmental Policy and Procedure		
Title:	Management of Tubal Pregnancy		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 Provide guidelines for effective treatment of cases of tubal pregnancy and their follow up.

2. DEFINITIONS:

2.1 **Tubal pregnancy**- the most common type of ectopic pregnancy – happens when a fertilized egg gets stuck on its way to the uterus, often because the fallopian tube is damaged by inflammation or is misshapen. Hormonal imbalances or abnormal development of the fertilized egg also might play a role.

3. POLICY:

3.1 Whenever expectant or conservative (medical or surgical) management policy is chosen, β-hCG titre and vaginal ultrasound should be available. As well, protocols for follow up and treatment using methotrexate in cases of persistent trophoblasts.

3.2 Management of tubal pregnancy in the presence of haemodynamic instability should be by the most expedient method. In most cases this will be laparotomy.

3.3 A laparoscopic approach to the surgical management of tubal pregnancy, in the hemodynamically stable patient, is preferable to an open approach.

3.4 Laparoscopic salpingostomy should be considered as the primary treatment when managing tubal pregnancy in the presence of contralateral tubal disease and the desire for future family.

3.5 Clinicians undertaking the surgical management of ectopic pregnancy must have received appropriate treatment.

3.6 Anti-D should be given to all Rh-ve women at a dose of 250 IU (50 micrograms).

3.7 Patient education about risk of having further ectopic pregnancy, proper contraception that reduces the incidence of ectopic pregnancy is recommended.

3.8 Early ultrasound in any subsequent pregnancy is mandatory to rule out another ectopic pregnancy.

4. PROCEDURE:

4.1 On Admission:

4.1.1 Usual admission procedure

4.1.2 Clinical Assessment:

4.1.2.1 Review history- LMP, previous history of ectopic pregnancy, PID, IUCD, induction of ovulation, urine pregnancy test.

4.1.2.1.1 Abdominal pain, cramping, shoulder pain.

4.1.2.1.2 Vaginal Bleeding.

4.1.2.1.3 History of previous surgery, allergy

4.1.2.2 Physical examination – vital sign.

4.1.2.2.1 Heart, chest, abdomen.

Pelvic examination.

4.1.2.2.2 Uterine size, cervical excitation and adenxeal fullness.

4.1.2.3 IV access commencement.

4.1.2.4 Investigations:

4.1.2.4.1 Bloods taken for CBC, grouping and save serum, and coagulation profile.

4.1.2.4.2 Monitor quantitative Serum BHCG – Normal, blood levels rise rapidly, doubling every 2 days and plateaus at 8-10 weeks gestation.

4.1.2.4.3 HCG with inadequate increase (66%) may suggest ectopic pregnancy. Urinalysis with microscopic exam.

4.1.2.4.4 Ultrasound findings suggestive of ectopic pregnancy:

4.1.2.4.4.1 Absence of gestational sac β-hCG 1800 IU/L.

4.1.2.4.4.2 Free fluid present.

4.1.2.4.4.3 Echogenic mass at adnexa.

4.1.2.4.4.4 Echogenic mass with free fluid.

4.1.2.4.4.5 Presence of fetal heart.

4.2 Treatment:

4.2.1 Expectant Management.

4.2.1.1 Indication:

4.2.1.1.1 Minimal pain or bleeding in reliable patient.

4.2.1.1.2 HCG less than 1000 IU/L and falling.

4.2.1.1.3 No signs of tubal rupture.

4.2.1.1.4 Adnexal mass <2 cm.

4.2.1.1.5 No embryonic heart beat.

4.2.1.1.6 Pregnancy of unknown location.

4.2.1.2 Carry out the management using an initial cut-off of serum sac β-hCG level of 1000-1500 IU and follow up every 48-72 hours.

4.2.1.3 Follow up should continue until β-hCG level drop to <20 IU.

4.2.2 Surgical Management.

4.2.2.1 Indications of surgery in ectopic pregnancy include women with the following criteria:

4.2.2.1.1 Not suitable candidate for medical therapy.

4.2.2.1.2 Failed medical therapy.

4.2.2.1.3 Heterotopic pregnancy with a viable intrauterine pregnancy.

4.2.2.1.4 Hemodynamically unstable and need immediate treatment.

4.2.2.1.5 NondiagnosticTransvaginal Ultrasound and β-hCG> 1500.

4.2.2.1.6 Advanced Ectopic Pregnancy, Previous Tubal sterilization.

4.2.2.1.7 Known tubal disease with planned in-vitro fertilization for future pregnancy.

4.2.2.2 The contraindication to surgical management is a patient with a medically treatable ectopic pregnancy and other medical conditions that would make the risk of surgery unacceptable.

4.2.2.3 Surgical Options:

4.2.2.3.1 Surgical therapy may be either open laparotomy or via the laparoscopic route.

4.2.2.3.2 Ideally, all ectopic pregnancies requiring surgery should be treated laparoscopically.

4.2.2.3.3 Risk factors for converting laparoscopy to laparotomy should be considered and include multiple prior surgeries, pelvic adhesions, skill of the surgeon and surgical staff, availability of the equipment, and condition of the patient.

4.2.2.3.4 Ectopic pregnancy treated either by:

4.2.2.3.4.1 Salpingostomy (incising the tube and removing the product).

4.2.2.3.4.2 Salpingostomy as above with closing the incision.

4.2.2.3.4.3 Salpingectomy, tubal resection either complete or partial.

4.2.2.3.5 Salpingectomy is indicated in the following situations:

4.2.2.3.5.1 The ectopic pregnancy has ruptured.

4.2.2.3.5.2 Future fertility is not desired.

4.2.2.3.5.3 This is a sterilization failure.
4.2.2.3.5.4 It is a previously reconstructed tube.
4.2.2.3.5.5 Sterilization is requested.
4.2.2.3.5.6 Haemorrhage continues after salpingostomy
4.2.2.3.5.7 The ectopic pregnancy is in the blind-ending distal segment after a previous partial salpingectomy.
4.2.2.3.5.8 This chronic tubal pregnancy.

4.2.2.4 Medical treatment:

4.2.2.5 Follow-Up:

4.2.2.5.1 Patient who have not had salpingectomy need to have weekly serial hCG levels until return to non-pregnant values. If, during this time, the HCG level either plateau or rises, treat the patient with methotrexate.

4.2.2.5.2 Patient should all be on some form of effective contraception until such time as their hCG levels have returned to non-pregnant levels.

4.2.2.5.3 Patient to be instructed to have.

4.2.2.5.3.1 Smoking Cessation
4.2.2.5.3.2 Folic Acid.
4.2.2.5.3.3 Early pregnancy clinic at 6/52 gestation in subsequent pregnancy investigation regarding underlying pathology due to past obstetric history.

5. MATERIAL AND EQUIPMENT:

N/A

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurses

7. APPENDICES:

7.1 Admission Form

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013
8.2 https://www.mayoclinic.org/diseases-conditions/ectopic-pregnancy/symptoms-causes/syc-20372088

9. APPROVALS:

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