South Eastern Health and Social Care Trust

WACH Maternity Guideline (81) 2019

SOUTH EASTERN TRUST

Title:	**EXPECTANT MANAGEMENT OF ECTOPIC PREGNANCY**				
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Ownership:	South Eastern Trust				
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Links to other policies	Early Pregnancy Scanning Guideline 2019 The Use of Intramuscular Methotrexate for the Management of Ectopic Pregnancy 2018				

Date	**Version**	**Author**	**Comments**
04/05/2018	0.1	K Steele	Initial Draft

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1.0 INTRODUCTION

1.1 An ectopic pregnancy is any pregnancy implanted outside the endometrial cavity.

1.2 In the UK the incidence is 11/1000 pregnancies.

1.3 The incidence of ectopic pregnancy in women attending early pregnancy units is 2-3%.

1.4 Risk factors for ectopic pregnancy include tubal damage following surgery or infection, smoking and in vitro fertilisation. Most women with ectopic pregnancies have no identifiable risk factors.

1.5 This guideline aims to give guidance to healthcare professionals in relation to the use of expectant management of ectopic pregnancy.

2.0 SCOPE OF THE GUIDELINE

This guideline is applicable to all pregnant women with a confirmed ectopic pregnancy who fulfil the inclusion criteria for being managed expectantly.

3.0 ROLES/RESPONSIBILITIES

3.1 Managers and clinical leads must bring this guideline to the attention of all relevant healthcare workers in order that ectopic pregnancy can be managed appropriately with a watch and wait approach in women who chose this type of management. All relevant staff should follow these guidelines.

3.2 All healthcare professionals performing early pregnancy ultrasonography must have a high index of suspicion for ectopic pregnancy when performing vaginal ultrasound in women with an empty uterus.

3.3 Continuing professional development is the responsibility of the individual practitioner

4.0 KEY GUIDELINE PRINCIPLES

Key Statement
The decision to proceed with expectant management of ectopic pregnancy must be made after discussion with a consultant, once a detailed transvaginal scan (TVS) has been performed by an appropriately trained professional to locate the pregnancy and confirm that it is ectopic. Strict inclusion criteria for this type of management must be adhered to by staff.

Guideline Principles

Ectopic pregnancies are often diagnosed early because of increasingly sensitive urinary pregnancy tests and high quality ultrasonography. Many ectopics (up to 40%) will resolve spontaneously without any intervention.

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DIAGNOSIS OF ECTOPIC PREGNANCY

4.1 Transvaginal ultrasound is the diagnostic tool of choice for tubal ectopic pregnancy. The majority of tubal ectopic pregnancies should be visible on transvaginal ultrasound (87-99% sensitivity and 94-99.9% specificity) and should be seen on the initial examination (74%).

4.2 Those not seen at the first visit will be classed as pregnancies of unknown location, often because the pregnancy is too small and it is too early in the disease process for it to be seen.

4.3 Ultrasound features:

- **Definite ectopic pregnancy**: An adnexal mass moving separately from the ovary containing a gestational sac and yolk sac or fetal pole – (SLIDING sign)
- **High probability of ectopic pregnancy:** A complex inhomogeneous mass (non-cystic adnexal mass) moving separately from the ovary – (BLOB sign) **OR** an adnexal mass with an empty gestational sac moving separately from the ovary - (BAGEL sign). This is a thick walled mass with a central cystic area.
- **Possible ectopic pregnancy:** fluid in the endometrial cavity (sometimes referred to as 'pseudosac')
  There is no specific endometrial appearance or thickness associated with ectopic pregnancy.

Free fluid in the pouch of Douglas is not diagnostic of an ectopic pregnancy.

4.4 Biochemical tests:

- A single serum βHCG cannot be used to diagnose an ectopic pregnancy. The initial level, however, is a key prognostic indicator for success of medical management with methotrexate.

MANAGEMENT OF ECTOPIC PREGNANCY

4.5 Women should be adequately counselled regarding treatment options including surgical, medical and expectant management and information leaflets given where possible.

4.6 The majority of ectopic pregnancies are managed surgically with laparoscopy preferred to laparotomy. If an ectopic pregnancy cannot be visualised with TVS performed by an experienced operator, there is a low chance of visualising an ectopic pregnancy at laparoscopy.

4.7 In women with a healthy contralateral tube, salpingotomy does not significantly improve fertility prospects compared to salpingectomy. Salpingotomy is associated with a higher rate of persistent trophoblast and therefore, serum βHCG should be repeated weekly until a negative result is obtained.

4.8 Systemic methotrexate has been shown to be equally successful to laparoscopic surgery in certain cases of ectopic pregnancy (see Guideline 'Intramuscular methotrexate in the management of ectopic pregnancy' December 2018).

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EXPECTANT MANAGEMENT

4.9 The initial βHCG is the best predictor of outcome of expectant management. Expectant management was successful in 96% of cases when initial βHCG ≤ 175 IU/L and was successful in 66% of cases when βHCG was between 175-1500IU/L. In this group with a higher βHCG, expectant management was more likely to be successful if progesterone was ≤10nmol/L.

4.10 Patients with the following characteristics may be suitable for expectant management –

- Clinically well – NEWS 0
- Pain free
- Tubal ectopic pregnancy less than 35mm diameter on TVS with no fetal heart beat
- No haemoperitoneum
- βHCG <1000IU/L
- Patient keen for expectant management
- Patient happy to attend for regular follow up and bloods (mean of 15 days is likely)

The chances of success with expectant management increase if gestational age is <42 days but 'older' pregnancies can still be considered.

4.11 Patients not suitable for expectant management–

- Cardiovascular instability
- Moderate to severe pain
- Live or viable ectopic
    - Haemoperitoneum

4.12 Management plan

- Take blood for βHCG and progesterone
- With the results refer to the expectant management of ectopic decision making tree (Appendix 1) to double check the patient's suitability
- If suitable for expectant management, repeat both bloods 48 hours later. If the HCG level has dropped by 15% or more repeat weekly until βHCG <20IU/L

4.13 Advice for women

- Do not travel
- Do not have sexual intercourse
- Return immediately if any significant increase in pain

4.14 βHCG levels may initially rise following the decision to pursue expectant management. In this circumstance, it is acceptable to continue as long as the level stays below 1000IU/L and there is no significant increase in pain. If either of these situations arise, bring the patient for review by a senior clinician which should include a vaginal scan.

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5.0 IMPLEMENTATION OF GUIDELINE

5.1 Dissemination
This guideline will be uploaded to the Intranet and an email sent to all consultant gynaecologists, trainee gynaecologists and nursing managers in Neely ward and the early pregnancy clinics for dissemination to all staff.

5.2 Resources
Information about the whereabouts of this guideline to be passed on to all staff via staff meetings, patient safety briefings and information books.

6.0 MONITORING

May be monitored by audit

7.0 EVIDENCE BASE / REFERENCES

Ectopic pregnancy, when is it OK to watch and wait? Mr Dimitros Mavrelos RCOG Northern Professional Development Conference May 2018.

Diagnosis and management of ectopic pregnancy. RCOG GTG No 21 Nov 16

Expectant management of tubal ectopic pregnancy: prediction of successful outcome using decision tree analysis. Elson et al Ultrasound Obstet Gynaecol 2004

Ectopic pregnancy and miscarriage: diagnosis and initial management (update). NICE NG10080 in development. Expected publication date April 2019

8.0 CONSULTATION PROCESS

Consultant gynaecologists, trainee gynaecologists, Neely ward and early pregnancy clinic nursing managers and Head of Midwifery and Gynaecology.

9.0 APPENDICES/ATTACHMENTS

Appendix 1 Expectant management of ectopic decision making tree

10.0 EQUALITY STATEMENT

The outcome of the Equality screening for this policy is:

No impact.

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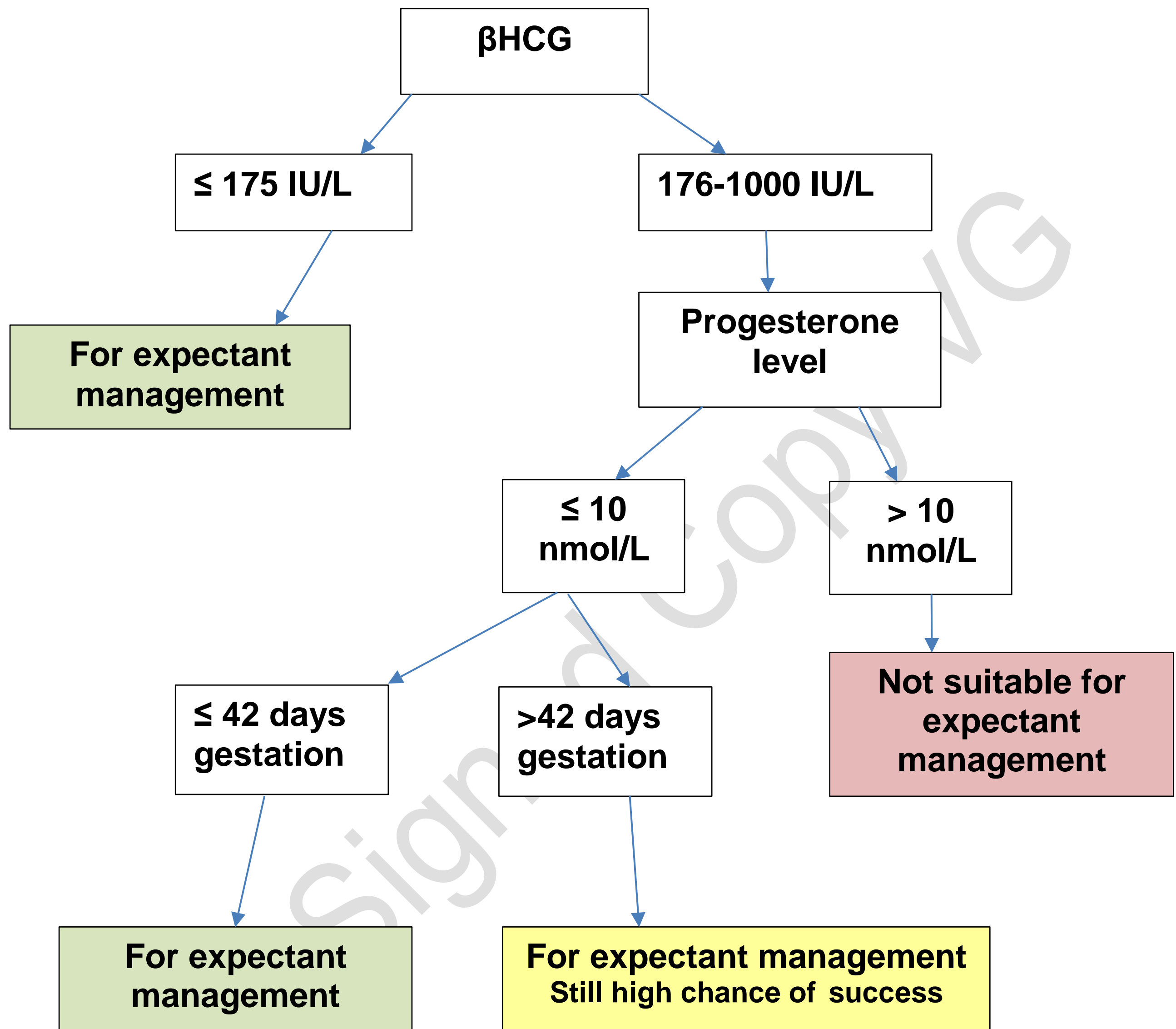
Appendix 1.
Expectant management of ectopic pregnancy decision making tree



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In all cases, watch for failure – increasing pain, signs of intraperitoneal bleeding clinically or on scan

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