### ECTOPIC PREGNANCY

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<th>DEFINITION</th>
<th>Ectopic pregnancy is defined as a pregnancy which implants outside the endometrial cavity. The most common site of ectopic pregnancy is within the fallopian tube. About 2% of all first trimester pregnancies in the US are ectopic. Ectopic pregnancy is the leading cause of first trimester maternal death. Early diagnosis is associated with significantly less morbidity and mortality.</th>
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| SUBJECTIVE | May include:  
1. Subjective symptoms of early pregnancy.  
2. Amenorrhea  
3. Recent onset of abnormal vaginal spotting or bleeding which usually occurs within 4-8 weeks after last normal menstrual period.  
4. Abdominopelvic pain, which is usually unilateral and colicky/cramping in character, but may be bilateral or generalized.  
5. Presence of risk factors: history of PID, infertility, prior ectopic pregnancy, tubal surgery (including tubal occlusion or ligation), current use of IUD or progestin-only contraceptives, artificial reproductive technology (e.g. IVF).  
6. No symptoms or risk factors.  
Must exclude:  
1. Weakness, dizziness or syncope.  
2. Pain referred to shoulder.  
3. Heavy vaginal bleeding or passage of products of conception. |
| OBJECTIVE | May include:  
1. Abdominal tenderness.  
2. Light uterine bleeding or spotting.  
3. Cervix softened, bluish, tender, with closed os.  
5. Softened lower uterine segment.  
6. Uterus normal size to slightly enlarged, globular, tender.  
7. Adnexal mass or tenderness.  
Must include stable vital signs.  
Must exclude:  
1. Overt manifestations of hypovolemic shock, such as hypotension, pallor, tachycardia, cold-clammy skin.  
2. Loss of consciousness.  
3. Open cervical os.  
4. Heavy vaginal bleeding or passage of products of conception. |
| LABORATORY | Must include:  
1. Positive sensitive urine pregnancy test.  
2. Baseline hematocrit/hemoglobin.  
May include vaginal ultrasound. If vaginal ultrasound done, no intrauterine pregnancy should be seen. |
| ASSESSMENT | Possible ectopic pregnancy. |
| PLAN | 1. If patient is hemodynamically unstable, has heavy active bleeding, or severe anemia:  
   a. Call paramedics.  
   b. Administer oxygen  
   c. If possible, start IV fluids pending arrival of emergency transport. |
| PLAN (Continued) | 2. If patient stable but has signs or symptoms of ectopic pregnancy or on ultrasound has free fluid in cul-de-sac, consult with MD or receiving ER regarding interim management and transport to ER for prompt evaluation.  
3. If patient’s vital signs are normal, she is asymptomatic and not anemic and she desires pregnancy termination, refer to ER for management and to rule out ectopic pregnancy.  
4. If patient’s vital signs are normal, she is asymptomatic, not anemic and she is able to return for follow-up, consult MD. If MD agrees:  
   a. Start evaluation at this visit:  
      1) Obtain quantitative serum human chorionic gonadotropin (hCG) levels. In some practices serum progesterone levels are also recommended.  
      2) Start prenatal vitamins one tablet orally daily.  
      3) Advise patient to have someone available at all times to drive her to ER if needed for increased bleeding pattern, symptoms of dizziness or lightheadedness.  
      4) Tell patient to stop contraception (if possible) and to avoid all coitus until diagnosis clear. Strict pelvic rest is needed.  
      5) Schedule patient to return in 48 hours.  
   b. When patient returns in 48 hours:  
      1) Reassess her symptoms, vital signs, hemoglobin.  
      2) If any worsening of signs or symptoms, refer to ER.  
      3) If she continues to be stable, consult MD.  
      a) If original hCG level was at or above the local discriminatory zone (1500-2,500 IU/mL), obtain prompt transvaginal ultrasound to locate pregnancy.  
         1) If intrauterine, start pregnancy care.  
         2) If no intrauterine pregnancy seen or if free fluid seen in cul-de-sac, consult MD and refer to ER.  
      b) If original level was below local discriminatory zone, repeat hCG levels (use same lab). Have patient return in 48 hours for re-evaluation. Advise to go to ER as above.  
      c) If also using progesterone levels, consult MD about how to integrate those levels into management plan. In general progesterone less than 5 mg/mL with inappropriate increases in hCG is associated with an abnormal pregnancy.  
Note: Watch for increase of at least 53% between measurements of hCG. Stable, asymptomatic patients with appropriate increase hCG levels can be followed up until their levels reach 1,500-2,000 IU/mL and ultrasound can reliably detect intrauterine pregnancy (verify presence of double decidual sign without yolk sac or embryo). If hCG levels do not rise by 53% at any time, refer to ER for evaluation (ectopic pregnancy, or abnormal intrauterine pregnancy). |
| PATIENT EDUCATION | 1. Patients who are being referred to the ER:  
   b. Help her contact family, if needed.  
2. Patients who are being followed in the office for evaluation:  
   a. Counsel that her diagnosis is not clear (early intrauterine or ectopic pregnancy).  
   b. Explain importance of monitoring for signs or symptoms of ruptured ectopic pregnancy.  
      1) She should not be left alone.  
      2) Transportation to ER must be available 24 hours if needed due to possible ectopic rupture. |
| REFER to MD/ER | 1. Refer to ER: unstable patients, symptomatic patients and those with probable ectopic pregnancy or ongoing abortion.  
2. Consult MD: women with possible ectopic pregnancy if they are stable but symptomatic.  
3. Consult MD if patient had artificial reproductive technology procedure to create pregnancy to evaluate for possible heterotrophic pregnancies (one intrauterine with an ectopic twin) or multifetal pregnancies. |