The Miscarriage Association

Acknowledging Pregnancy Loss

Ectopic Pregnancy

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and members of the Ectopic Pregnancy Support Network

If you would like information, support or simply to talk to someone else who has been through the experience of ectopic pregnancy and who can offer understanding and support, please contact:

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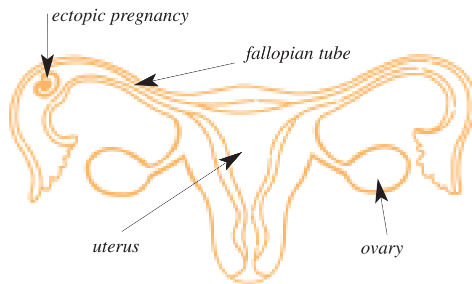
Ectopic Pregnancy is a common, life-threatening condition affecting 1 in 100 pregnancies. It occurs when the fertilised egg implants outside the cavity of the womb. Most ectopic pregnancies develop in the Fallopian tube, the tube which connects the ovary to the womb. As the pregnancy grows it causes pain and bleeding. If it is not treated quickly enough it can rupture the tube and cause abdominal bleeding, which can lead to maternal collapse and death.



Ectopic pregnancy

What are the causes of Ectopic pregnancy?

The fertilised egg normally spends 4-5 days traveling down the tube from the ovary to the cavity of the womb where it implants about 6-7 days after fertilisation. The most common reason for an ectopic pregnancy is damage to the Fallopian tube, causing a blockage or narrowing. There could also be a problem with the walls of the tube, which should normally contract and waft the fertilised egg into the womb. Conditions such as appendicitis or pelvic infection can damage the tube by causing kinks or adhesions, thus delaying the passage of the egg, allowing it to implant in the tube. In most cases, however, the cause of the tubal implantation is not known.

What are the possible outcomes?

In many cases the ectopic pregnancy dies quickly and is absorbed before a period is missed or after minor symptoms or signs of pain and bleeding. In such cases ectopic pregnancy is rarely diagnosed and a miscarriage is thought to have occurred. Nothing needs to be done in these circumstances.

If the ectopic does not die, the thin wall of the tube will stretch, causing pain in the lower abdomen. There may be some vaginal bleeding at this time. As the pregnancy grows the tube may rupture, causing severe abdominal bleeding, pain and collapse. Before this happens the ectopic may be diagnosed by blood tests which show that the normal pregnancy hormones are not rising as fast as they should be.

What are the symptoms?

Any sexually active woman of child-bearing age who has lower abdominal pain might be suspected of having an ectopic pregnancy until proved otherwise. The pain may have begun suddenly and there may or may not have been vaginal bleeding. Most cases present between the 4th and 10th week of pregnancy with any of the following symptoms:-

- **One-sided abdominal pain** This can be persistent and severe, but may not be on the side of the ectopic.

- **Shoulder-tip pain** This may occur due to internal bleeding irritating the diaphragm.

- **Pregnancy test** This may be positive, but not always. Specialised blood tests are sometimes required to confirm this.

- **Abnormal bleeding** The woman may not know she is pregnant and may be experiencing an unusual period. She may have a coil (IUCD) fitted. The bleeding may be heavier or lighter than usual and prolonged. Unlike a period, this bleeding is dark and watery, sometimes described as 'like prune juice'.

- **A missed or late period** A pregnancy may be suspected and pregnancy symptoms experienced e.g. nausea, painful breasts or a swollen abdomen, but no bleeding.

- **Bowel pain** Pain when having a bowel movement or passing urine.

- **Collapse** The woman may be feeling light-headed or faint, and often this is accompanied by a feeling of something being very wrong. Other signs such as paleness, increasing pulse rate, sickness, diarrhoea and falling blood pressure may also be present.

- **No symptoms** Some women have no symptoms at all. For this reason it is very important that anyone who has had a previous ectopic pregnancy should have an ultrasound scan at around six weeks of pregnancy (that is, six weeks after her last period) to check that the pregnancy is in the womb.

How is it managed?

If an ectopic pregnancy is suspected, the woman should attend the hospital. An ultrasound scan and a pregnancy test will be done. If the scan shows an empty uterus but the pregnancy test is positive, an ectopic pregnancy is likely, although the pregnancy may be too early to see on scan or a miscarriage might have occurred. Even with a vaginal scan it is not always possible to see an ectopic pregnancy on a scan.

If the woman is well and not in severe pain, she may have blood hormone tests, repeated every two or three days, until the diagnosis is clear. If there is a high suspicion of ectopic pregnancy, or the woman develops worsening signs, a laparoscopy to inspect the tubes is done. If the diagnosis is obvious, however, abdominal surgery to remove the ectopic is more likely and blood transfusions may be required to replace blood lost.

If early diagnosis can be achieved before rupture of the tube and the appropriate facilities are available, less invasive treatment can be offered:

- **Surgery to preserve the tube** In some cases, it might be possible to remove the ectopic pregnancy and leave the tube intact. This is done to try to improve the chances of a normal uterine pregnancy in the future, but it also increases the risk of another ectopic pregnancy.

- **Treatment with drugs** Alternatively, the drug methotrexate, which destroys the pregnancy, could be used. This can be injected into the muscle so that it reaches the ectopic pregnancy through the bloodstream, which means surgery can be avoided. It can also be injected directly into the ectopic pregnancy under laparoscopic or ultrasound guidance.

- **Keyhole surgery** If the surgeons are trained in laparoscopic – or keyhole – surgery, it might be possible to remove the ectopic pregnancy this way. It can be possible either to remove the tube containing the ectopic pregnancy or sometimes just to remove the ectopic pregnancy and leave the tube behind.

These modern treatments are dependent upon expert surgical skills, good ultrasound scanning and efficient laboratory testing. They are not universally available as they are undergoing research and evaluation. There are advantages and disadvantages to all treatment options. With treatments that remove the ectopic pregnancy but leave the tube behind, there is a risk that the ectopic pregnancy is not completely treated

so a second course of treatment may be necessary. Removal of the whole tube containing the ectopic pregnancy is the only sure way of treating the ectopic pregnancy first time round.

Who is at risk of ectopic pregnancy?

Any sexually active woman of childbearing age is at risk of an ectopic pregnancy. However, ectopic pregnancies are more likely if you have had:-

- **Pelvic Inflammatory Disease** If there is a past history of pelvic pain due to infection of the fallopian tubes (e.g. by chlamydia).

- **Endometriosis** This could have caused tubal damage.

- **Abdominal surgery** Any previous abdominal surgery such as caesarean section, appendectomy or ectopic pregnancy can increase the risk.

- **A Coil (IUCD) fitted** The coil prevents a pregnancy in the uterus but is less effective in preventing a pregnancy in the tube.

- **are on the progesterone-only contraceptive pill (mini pill)**The progesterone-only pill alters tubal motility and has been linked to a slightly increased rate of ectopic pregnancy.

How does it affect future fertility?

If one of the tubes has ruptured or was removed, a woman will still continue to ovulate as before, but her chances of conceiving will be reduced to about 50%. If the tube is saved, the reduction is less and her chance of pregnancy will rise to around 60%.

The overall chances of a repeat ectopic are between 7-10% and this depends on the type of surgery carried out and any underlying damage to the remaining tube(s). When one Fallopian tube is damaged (because of adhesions, for instance), there is an increased chance that the second tube may be damaged also. This means not only that the chance of conceiving is less than normal, but also that there is an increased risk of a further ectopic pregnancy. In cases associated with the IUCD (coil), there does not appear to be an increased risk of future ectopic pregnancy if the coil is removed.

What about trying for another pregnancy?

Most doctors advise women to wait for at least three months to allow time for their body to recover, although individual circumstances may vary. Emotional recovery after ectopic pregnancy is very individual; some women want to get pregnant again immediately, while others find the thought of another pregnancy very frightening. You and your partner are the best judges of when – or perhaps whether – you are emotionally and physically ready to try again.

Care in the next pregnancy

If you have had an ectopic pregnancy you should consult your doctor immediately you suspect that you might be pregnant again, so that you can be monitored closely. Similarly, if a period is late, if menstrual bleeding is different from normal or if there is abdominal pain, you should ask to be examined, reminding the doctor, if necessary, of the previous ectopic pregnancy.

Your Emotions

Ectopic pregnancy can be a devastating experience. You are likely to be recovering from major surgery; you have had to cope with the loss of your baby and often the loss of part of your fertility; and you may even not have realised that you were pregnant.

Your feelings may vary considerably in the weeks and months after your loss. You may feel very relieved to be free from the pain and grateful to be alive, whilst at the same time be feeling extremely sad for your loss. It is likely that you will have been rushed into the operating theatre, with very little time for psychological adjustment. Much of what happened will have been out of your control and this can leave you in a state of shock.

The sudden end to your pregnancy will have left your hormones in disarray, and this can make you feel depressed and extremely vulnerable. In addition, the distress and disruption to family life resulting from the abrupt ending to a pregnancy – especially when combined with the need to recover from major surgery – can be difficult to deal with. Anxiety about the future can add to your distress.

Your Partner's Emotions

The emotional reactions to ectopic pregnancy can put great strain on a relationship. The experience may bring you and your partner closer together but you might find that your partner seems unable to understand your feelings or to respond in the way you might have expected.

You and your partner may feel differently about what has happened. His main concern is likely to be your well-being, especially after what may have been an emergency or life-threatening situation in which he perhaps felt powerless to help. He may feel that he has to hide his own feelings of loss or grief in order to be strong and supportive - a role which many men are expected to play. It may simply be that you each deal with or express your feelings in different ways and this can lead to misunderstandings. If you can share your thoughts or emotions, this may help you both to get through this very distressing time. The Miscarriage Association leaflet *Men and Miscarriage* may also be helpful.

Questions you may want to ask your doctor:

Were there any abnormalities found during surgery?

Your doctor should be able to tell you the condition of your reproductive organs and in particular the state of your Fallopian tube(s). You may want to ask about cysts, endometriosis, adhesions, evidence of infection and any other problems which could affect your becoming pregnant or carrying a baby to term.

When may we resume sexual intercourse?

Your doctor will probably wish to examine you a month or so after surgery, and it is probably best to wait until after this check-up. If you do not want to become pregnant at this time, ask about suitable forms of contraception.

When should I return to work or to my normal activities?

You have probably had major abdominal surgery and will need time to recuperate - possibly around six weeks. Your doctor will advise you on returning to normal activities or strenuous physical tasks, sport etc.

We do hope that you have found this leaflet useful and that you will draw comfort from knowing that you are not alone.

The Miscarriage Association has a network of volunteers who have been through the experience of ectopic pregnancy and who can offer understanding and support. If you would like to talk to one of these volunteers, please contact us at the address at the front of this leaflet.

Useful reading

Small Sparks of Life, by Lysanne Sizoo
Gopher Publishers, 2001
ISBN 90-76953-26-0
Paperback: £7.99

Hidden Loss: Miscarriage and Ectopic Pregnancy, edited by V. Hey, C. Itzin, L. Saunders and M.A. Speakman
Women's Press 1995, 1996
ISBN 0-7043-44572
Paperback: £7.99

Acknowledgements

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- the Ectopic Pregnancy Trust for their support in earlier revisions. The Ectopic Pregnancy Trust aims to raise awareness of ectopic pregnancy, to campaign for improvement in its diagnosis and management, and for research into its causes, treatments and prevention. The Trust can be contacted at The Maternity Unit, Hillingdon Hospital, Pield Heath Road, Uxbridge, Middlesex UB8 3NN. Tel: 01895 238025.

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