SURGICAL MANAGEMENT OF ECTOPIC PREGNANCY

AIM

Outline the surgical management of tubal ectopic pregnancy.

BACKGROUND

Surgical management remains the first line treatment in ectopic pregnancy when a patient’s condition is unstable. It should also be considered where there are contraindications to medical and expectant management options. Open laparotomy is indicated in situations where the patient is haemodynamically unstable or the size of the ectopic pregnancy indicates laparotomy is required. Laparoscopic surgery is preferred with the advantage of less adhesion formation along with shorter hospital stay, lower cost, less blood loss and lower analgesia requirements. Haemoperitoneum is not a contraindication for performing laparoscopic surgery. There is limited research demonstrating a proven significant advantage of salpingostomy compared to salpingectomy. Risks associated with salpingostomy include persistent trophoblast and a small risk of bleeding postoperatively. In the presence of a healthy contra lateral tube there is no clear evidence that salpingostomy should be used in preference to salpingectomy. When there is a desire for future fertility and the presence of contra lateral disease laparoscopic salpingostomy should be considered. Mandatory follow up with hCG serial monitoring is required where salpingostomy has been performed. Fertility rates have been found to be comparable between salpingostomy or salpingectomy in the situation of a normal contra lateral tube. Pregnancy rates following surgery or methotrexate treatment have not been found to be significantly different.

KEY POINTS

1. Surgical treatment becomes a necessity when a patient is:
   - Haemodynamically unstable
   - Confirmed impending or ongoing rupture of the ectopic pregnancy
   - Co-existing intrauterine pregnancy
   - Contraindication of medical treatment

2. In a patient who is haemodynamically unstable immediate resuscitation and the surgical procedure which prevents further blood loss quickly should be used - usually this involves a laparotomy. Transfer to theatre should not be delayed by attempts to establish a normal circulating plasma volume.
3. A laparoscopic approach to the surgical management of tubal pregnancy in the haemodynamically stable patient is preferable. Experienced operators may be able to safely manage women laparoscopically - even those with a large haemoperitoneum.

4. Salpingectomy is the standard procedure. However laparoscopic salpingostomy should be considered when managing tubal pregnancy in the presence of contra lateral tubal disease and the desire for future fertility. Follow up for salpingostomy should include mandatory serial $\beta$hCG.

**FOLLOW UP**

1. All patients investigated for possible ectopic pregnancy should be advised to seek medical attention immediately if symptoms change.

2. Negative laparoscopies should be followed up with serial serum $\beta$hCG.

3. All women treated for ectopic pregnancy should be counselled regarding the risk of recurrence.

4. Ensure Anti D immunoglobulin is given to all non- sensitised women who are Rhesus Negative.

5. If histology shows no chorionic villi or fetal tissue, the case should be reviewed by the consultant and the patient advised for follow up.

6. Following conservative surgery, $\beta$hCG should be monitored weekly (this may take up to 10 weeks to return to normal). If $\beta$hCG is rising, request ultrasound scan and consider further treatment (either laparotomy or methotrexate).

7. Refer to Clinical Guideline *Diagnosis of Ectopic Pregnancy* for $\beta$hCG screening levels

**REFERENCES**


