DIAGNOSIS AND MANAGEMENT OF ECTOPIC PREGNANCY

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Contents:

1. Purpose & Scope:

- To encourage the use of desired terminology in such sensitive circumstances.
- To provide guidance on management of early pregnancy complications, such as pain and bleeding.
- To provide guidance on ultrasound scan interpretation in early pregnancy.
- To provide guidance on the management options of ectopic pregnancy.
- To provide guidance on ways to support patients and limit the psychological impact of their loss.
- Applies to all healthcare providers including doctors, nurses, midwives and sonographers working within the health board who come in contact/ provide care for women in their early pregnancy.

2. Terminology and Abbreviations:

LMP, Last menstrual period:	First day of the last period, regularity should be noted.
PUL, Pregnancy of Unknown Location:	No pregnancy is visualised on transvaginal scan in women with a positive urine pregnancy test.
RPOC:	Retained products of conception.
IUP:	Intrauterine pregnancy
Early IUP:	A pregnancy which is implanted normally within the uterine cavity without a visible embryo which has the potential to develop normally.
Live IUP:	A pregnancy which is implanted normally within the uterine cavity with embryonic/fetal cardiac activity. 'live' pregnancy would be more appropriate to describe a first-trimester pregnancy with evidence of embryonic/fetal cardiac activity as the word viable would imply a reasonable chance of the fetus survivability if born.
hCG:	A quantitative human chorionic gonadotrophin test.
Senior Gynaecologist:	A Gynaecology doctor with experience at ST5 Level and above.
TVS:	Trans-vaginal ultrasound scan.
TAS:	Trans-abdominal ultrasound scan.

Ectopic pregnancy: Can be uterine or extra-uterine, details as below;

Uterine ectopic pregnancy: categorised into the following:

- **Cervical Pregnancy:** the gestational sac is present below the level of the internal cervical os.
- **Caesarean scar ectopic pregnancy:** the implantation is into the myometrial defect occurring at the site of the previous caesarean uterine incision.
- **Interstitial pregnancy:** the ectopic pregnancy has implanted in the interstitial part of the fallopian tube of normally configured uterus.
  Please note that this tends to be confusedly described as cornual pregnancy which is defined below.
- **Cornual pregnancy:** The pregnancy is in the non-adapting horn of a genuine bicornuate uterus (rudimentary or non-communicating horn).

Extrauterine ectopic pregnancy: The pregnancy is outside the uterus (tubal, ovarian and abdominal)

Live ectopic pregnancy: Ectopic pregnancies which contain an embryo/fetus with evidence of cardiac activity.

Failing ectopic pregnancy: **E**ctopic pregnancy is in regression with a tendency to resolve spontaneously.

Heterotopic pregnancy: There is an intrauterine pregnancy and a coexisting ectopic pregnancy.

3. Background:

Ectopic pregnancy and miscarriage have an adverse effect on the quality of life of many women. The rate of ectopic pregnancy is 11 per 1,000 pregnancies, with a maternal mortality of 0.2 per 1,000 ectopic pregnancies, unfortunately about two-thirds of these deaths are associated with substandard care.

An individualised approach is always advisable, this guidance may need some adjustments when making management plans, therefore if a woman does not seem to fit into the mentioned criteria for a certain arm of management but deemed suitable, a senior gynaecologist should be involved in the decision making.

The emotional impact of ectopic pregnancy can be quite significant. There is limited understanding of the psychological impact of the different treatment options for ectopic pregnancy. However, in some circumstances it can lead to post-traumatic stress disorder. Sensitive approach and support would help to maximise women's emotional recovery in the short and long term.

Encourage women to engage in the decision making for the optimum treatment method and identify what support is needed for them during and after the process.

4. Points for Consideration:

1. The team providing care for women with early pregnancy complications should be aware that these can be a source of distress for the couple, the team should be trained in how to communicate such sensitive information and break bad news.

2. Women should be advised on when/how to seek advice if any change in symptoms, the below links and patient information leaflets are very useful resources. See appendix 3 for more leaflets.

NHS website, ectopic	RCOG Patient information leaflet, pain bleeding in early pregnancy	RCOG Patient information leaflet, ectopic
		

3. Women should be made aware of what to expect on each appointment and the limitations that the assessments may have.

4. Women should have a clear plan for the follow-up/recovery period.

5. Where/how to access support and counselling services and helplines.

https://ectopic.org.uk/	https://www.cruse.org.uk/,	https://www.ectopicpregnancy.co.uk/
		

6. Provide printed/accessible information leaflets to take home and read in their own time. (see appendix 3)

7. Contact number for EPAU team to be provided (01792 286868)

5. Pregnancy of Unknown Location (PUL):

Defined as positive pregnancy test with no evidence of intrauterine or extra-uterine pregnancy on TVS. All women with PUL should be suspected to have an ectopic pregnancy until proven otherwise. This is not a diagnosis but is a situation where further monitoring is required till the pregnancy is located or its resolution is confirmed.

5 – A. Clinical assessment and counselling:

- Explain to the woman that the location of the pregnancy is unknown and there is need for monitoring as it has the risk of being a life-threatening condition.
- Assure that the woman is relatively asymptomatic and has the means to attend if any change in symptoms. Explain the importance of having an adult company during monitoring period is essential due to the risk of collapse and need to call for an ambulance.
- Obtain baseline bloods, FBC, U&E's, LFT and a G+S.
- Provide written information and open access during out of hours service.
- Symptomatic women with a PUL may need to have an examination, which may include a speculum examination, swabs +/- bimanual examination depending on consenting.

5 – B. Value of serum hCG:

- Emphasis should be on the clinical assessment (symptoms and signs) over the quantitative value of hCG level.
- In general, hCG quantification should not be undertaken prior to ultrasound scan, as it can lead to false assumptions being made about the location of the pregnancy.
- hCG level is a surrogate marker for trophoblastic tissue proliferation and to be used as a tool to plan for subsequent management.
- A repeat hCG should be obtained as close as possible to 48hr from previous test, **but not earlier.**
- If symptoms change in this waiting period, the woman should call in for assessment and not wait for the blood test appointment.

- In ongoing intrauterine pregnancies, a 63% rise in hCG can be anticipated (NICE guideline [NG126]), however, 15% of these "normal rises" will be eventually diagnosed as ectopic pregnancies.

- When an hCG value of 1500 IU/L is reached, evidence of an intrauterine pregnancy should be seen on TVS (TAS "discriminatory zone" is 6000 IU/L), if no identifiable intrauterine pregnancies at such levels highly suspect an extra-uterine location of the pregnancy and seek a senior gynaecologist advice.

5 – C. Persistent PUL:

If the hCG remains at plateau or has a non-optimal rise and a pregnancy is not located despite serial ultrasound assessments the term persistent PUL can be used. No consensus has been reached for the optimum protocol of management for these cases. The opinions remain divided between conservative, medical (use of Methotrexate) and surgical (diagnostic laparoscopy) approaches, therefore a senior opinion should be sought, and management tailored for that individual patient.

Table 1. Summary of hCG levels and actions to follow

hCG level after 48hrs	Impression	Management plan
Increases by 63%	The pregnancy is likely to be intrauterine	A repeat TVS should be performed in 7 days
>/= to 1500 IU/L	Has not had a scan	Consider an earlier USS
	USS on the day: PUL	Highly suspect an ectopic
Decreases by more than 50%	The pregnancy is unlikely to be viable.	Provide information and support regarding pregnancy loss.
Between a 50% decline and a 63% rise	High possibility of an ectopic pregnancy.	Woman to be reviewed within 24 hours and her case discussed with a senior Gynaecologist.

6. Ectopic Pregnancy:

6 - A. Symptoms and signs of ectopic pregnancy on initial assessment:

Atypical presentation for ectopic pregnancy is common, all women of reproductive age should have a pregnancy test even with non-specific symptoms. Symptoms and signs of ectopic pregnancy can also be found in other conditions such as UTI, IBS etc.

Common symptoms include: Missed period, Pelvic/abdominal pain, PV bleeding (period like/spotting).

Other symptoms: Shoulder tip pain, urinary symptoms and Gastro-intestinal symptoms.

Common sign: Tenderness (abdominal, pelvic or adnexal)

Other signs: cervical motion tenderness, rebound tenderness, pallor, abdominal distention, orthostatic hypotension, shock, tachycardia and/or hypotension.

6 - B. Human chorionic gonadotrophin hCG measurements:

- Clinical symptoms should have more importance than the value of serum hCG, review the woman's condition if any symptoms change regardless of the hCG trend.
- Two serum hCG measurements should be taken as near as possible to 48 hours apart **not earlier** to determine subsequent management of a pregnancy of unknown location. Further levels should be checked only after a discussion with a senior gynaecologist.
- Regardless of the serum hCG level, women should be advised on what to expect, when to seek help and provided with our unit's contact numbers.
- If the 48hr serum hCG change is an increase of ≥63%, explain that the likelihood is an intrauterine pregnancy but an ectopic cannot be excluded. Arrange an USS in 7 days or earlier if the serum hCG levels are >1500. If no intrauterine pregnancy identified on the USS, request a senior review.
- If the 48hr serum hCG change is a drop of >50%, inform the woman that the pregnancy is unlikely to continue but this cannot be confirmed, ask her to do a urine pregnancy test in 2 weeks, if negative no further action is needed. If positive to contact EPAU. In certain cases, a repeat HCG in one week may be considered (when the levels >1000 after the drop) before moving to the above measure.
- If the 48hr serum hCG change increase <63% or drop <50%, request a senior gynaecology review.

6 - C. Ultrasound assessment:

A transvaginal ultrasound scan (TVS) should be offered to all women with early pregnancy problems unless they decline, the alternative would be a trans-abdominal ultrasound scan (TAS) that would necessitate a full bladder. Women declining TVS should be provided with an explanation of limitations with the TAS modality. If no intrauterine gestation is confirmed at TAS, the importance of early diagnosis of an ectopic pregnancy should be explained and the woman asked to reconsider whether she is willing to undergo TVS to confirm the location of the pregnancy with greater accuracy.

The ultrasound request form should state the following information:

- Correct demographics for the patient.
- The urgency of the request and relevant symptoms – pain/bleeding/passage of pregnancy tissue etc.
- LMP (last menstrual period), document regularity of periods.
- Patient has had a positive pregnancy test.
- Other relevant clinical details (such as risk factors for ectopic pregnancy).

Reports of intrauterine cystic structure with no other features to support a diagnosis of an ectopic pregnancy, may be treated as PUL. However, if the case is reviewed by a senior gynaecologist and deemed as an IUP, then there is no need for hCG monitoring. A repeat scan would be appropriate in a weeks' time. Such cases can also be collected for review on later date if a senior gynaecologist is not available/ or for a second opinion, that would be usually on Thursdays.

Ultrasound appearance suspicious of ectopic pregnancy is an empty uterus with any of the following:

- Extra-uterine gestation sac +/- yolk sac and/or fetal pole.
- Adnexal mass.
- Fluid in POD Pouch of Douglas: Not all free fluid indicate bleeding, it is quite common to see mild amount of free fluid in a normal early pregnancy. Occasionally it can represent bleeding, the exact amount of such bleeding is difficult to measure on ultrasound, however, hemoperitoneum can be categorised semi-quantitatively as:

    - Mild: when there is only echogenic fluid in the pouch of Douglas,
    - Moderate: when there are visible blood clots
    - Severe: when there are blood clots and echogenic fluid present both in the pouch of Douglas and in the utero-vesical space.
    - Presence of blood in the upper abdomen is also an indication of severe intraperitoneal bleeding.

7. Management of suspected tubal ectopic pregnancy:

All women with a suspicion of an ectopic pregnancy should have information of when and where to contact if any changes of symptoms, see summary:

Women suspected to have an ectopic pregnancy.

. Unstable haemodynamically

. Significant pain

. Unable to attend for follow-up.

. Mass ≥ 35mm.

. hCG ≥ 5000IU

. Co-existing intrauterine pregnancy, ectopic with fetal cardiac activity

. Stable haemodynamically

. No significant pain

. Able to attend for follow-up.

. Mass ≤ 35mm.

. No Co-existing intrauterine pregnancy or fetal cardiac activity

Offer surgery as first line

hCG level ≤1000

hCG level 1000-1500

hCG level 1500-5000

. Assess case complexity.

. Aim laparoscopy.

. Remember Anti-D

Offer expectant management

Offer methotrexate as first line

Offer choice of surgery or methotrexate

Salpingectomy /laparotomy

Salpingotomy

Where methotrexate not accepted by women offer surgical management

Pregnancy test in 3 weeks

Serial hCG testing

Counsel women that risk of rupture of ectopic and surgical intervention could be required.

7 - A. Expectant management:

- Inform women that available evidence suggests that about 70% of ectopic pregnancies resolve spontaneously if serum hCG is less than 1000 IU/L
- Can be **offered** to women who are stable, has no significant pain, serum hCG level of ≤ 1000, the ectopic pregnancy measuring ≤ 35mm with no fetal cardiac activity and have the means of attending for follow up.
- Can be **considered** for women who are stable, has no significant pain, serum hCG level between 1000 IU/L - 1500 IU/L, the ectopic pregnancy measuring ≤ 35mm with no fetal cardiac activity and have the means of attending for follow up.
- Repeat serum hCG levels on days 2-4-7 from original test, if the drop is by >15% repeat weekly until undetectable.
- If the value does not drop or plateau, request a senior review.
- In these cases: Inform the woman that based on limited evidence there seems to be no difference following expectant and medical management, in rupture rates, need for further treatments and future fertility outcomes.

7 - B. Medical Management:

Methotrexate should never be given at the first visit, unless the diagnosis of ectopic pregnancy is absolutely clear, and a viable intrauterine pregnancy has been excluded.

Methotrexate is the medical treatment option, it can be offered to women who are stable, have **no significant pain**, hCG serum level of ≤ 1500 IU/L, the ectopic pregnancy measuring ≤ 35mm with no fetal cardiac activity, no intrauterine pregnancy and importantly have the means of attending for follow up. When patient selection is optimised the success of methotrexate was reported to be as high as 90.7%.

After careful counselling women with serum hCG levels between 1500 IU/L-5000 IU/L can be offered a choice of medical or surgical management, if medical management is chosen, they should be given open access to the unit to attend for assessment if any concerning change to their clinical situation and be aware of the possible need for surgical intervention that could be planned or as an emergency.

7- B-1. Women should be informed about the side effects of this treatment:

1. Risk of rupture is around 7%, therefore, identify the distance between patients' primary residence and hospital location. If it will take longer than 30 minutes to attend consider alternative management options.
2. Has ***teratogenic*** effect, they should avoid pregnancy for 3 months after last dose.
3. Excessive flatulence and bloating due to intestinal gas formation,
4. GI symptoms: stomatitis/indigestion/nausea/diarrhoea.

5. Mild abdominal pain specially on day 3-4.
6. Fatigue.
7. Photosensitivity.
8. Rare: Bone marrow suppression, pulmonary fibrosis, nonspecific pneumonitis, liver cirrhosis, renal failure and gastric ulceration.

7-B-2. Contraindications for medical management:

1. Inability to attend for follow-up.
2. Known sensitivity to methotrexate.
3. Breastfeeding.
4. Current systemic infections, Immunodeficiency.
5. Known blood disorders.
6. Impaired renal or acute/chronic liver disease.
7. Peptic ulcer disease.
8. Coexisting intrauterine pregnancy (Heterotopic pregnancy), methotrexate should only be considered if the intra-uterine pregnancy is confirmed as a missed miscarriage.

7-B-3. Methotrexate administration protocol:

1. Prior to start of medical management obtain a written consent (Appendix 1) and take baseline bloods including FBC, U&E's, LFT and a G&S.

2. Day 1: Once bloods reviewed and show no concern Methotrexate dose is 50mg/m^2 given deep IM into the gluteal region.
   To calculate BSA (Body-surface area) you need the patient's weight and height. Use this website to calculate Body Surface Area (BSA) (mdcalc.com)

3. Day 4: arrange for a serum hCG level to be taken, expect a rise in up to 86% of patients However, do not act without seeking senior review.

4. Day 7: obtain a serum hCG level, FBC, U&E's and LFT, expect levels of HCG to drop by 15% relative to day 4. If the levels between day 4 & 7 have not dropped by the expected value/plateaued or risen, a second dose of methotrexate can be considered and given straight away in the opposite gluteal region. This is following a careful assessment and counselling and provided the woman is stable. A repeat TVS may be considered in limited cases if the HCG levels have sharply risen to exclude that an ectopic pregnancy has not progressed and developed fetal cardiac activity.

5. Weekly serum hCG levels should be arranged until the levels are undetectable, if static at any point request senior gynaecologist review.

7-B-4. Advise following Methotrexate administration:

1. Avoid intercourse.
2. Not to leave local area until treatment and follow up complete.
3. Avoid alcohol /non-steroidal anti-inflammatory drugs such as aspirin, Naproxen and Ibuprofen /Folic acid preps/ herbal remedies during the period of management.
4. If pain not settling with paracetamol/codeine to call in for review.
5. Avoid pregnancy for 3 months (explain that rationale behind that is due to the teratogenic effect of the medication on the embryo and although the half-life of the drug is 8 to 15 hours, its presence in the liver has been reported to last up to 116 days after exposure). Nevertheless, conception within 3 months of MTX treatment of extra-uterine pregnancy should not be considered a definite indication for termination, and further targeted fetal anatomy assessment is recommended.
6. Barrier contraception should be advised, provide information about reason for advice https://ectopic.org.uk/physical-recovery/contraception

7- C. Surgical management:

Surgical management should be **offered as a first line** for women who have any of the following:

1. Cannot attend for follow up for the expectant and medical management option.
2. Women who have significant pain.
3. Adnexal mass larger than 35mm.
4. An ectopic pregnancy with visible fetal cardiac activity on USS.
5. Serum hCG levels of 5000 IU/L or more.

If deemed safe and the expertise available the aim should be a laparoscopic intervention, a salpingectomy vs salpingotomy should be discussed with the patient. Choice of procedure will be dependent on various factors including surgeon's experience and contralateral tube's appearance. Broadly if the contralateral tube appears healthy, a salpingectomy (removal of the tube which contains the ectopic pregnancy) will be performed. If the other tube appears unhealthy/not present, a salpingotomy may be performed depending on the surgeon's experience, the patient's choice and the affected tube's status (the size of the ectopic, the amount of bleeding and how damaged it looks).

Women who had salpingectomy should be asked to do a pregnancy test in 3 weeks, if negative nothing more should be done, if positive to contact EPU.

In case of a salpingotomy, not all of the pregnancy tissue is possible to be removed, there is a risk of persistent trophoblast with the need for serum hCG level follow-up. Women should be counselled that there is a small risk (1 in 5) that they may need further treatment in the form of systemic methotrexate or salpingectomy.

Following salpingotomy women should have a **weekly** serum hCG level done from the day of surgery until a negative test is obtained.

A laparotomy would be the likely course of action if the woman is haemodynamically unstable or have previous complex abdominal-pelvic surgery or due to surgeons' expertise.

Offer anti-D immunoglobulin prophylaxis at a dose of 250 IU (50 micrograms) to all non-sensitised rhesus-negative women who have had an ectopic pregnancy managed medically or surgically, take the time of the management as the potentially sensitising event. (Within 72 hrs of medical or surgical management).

Procedure:

1. Obtain written consent, see appendix 2, if possible. If the woman is unstable a verbal consent may be sufficient, a senior gynaecologist should be immediately involved in such cases and the anaesthetic team alerted.

2. Basic bloods to be obtained including FBC, G&S. In certain cases, a point-of-care blood test will provide a rapid insight to level of internal bleeding and guide resuscitation, consider a serum lactate and a coagulation profile.

3. Prescribe the anti-D if Rh negative so it's not missed.

4. In cases where salpingotomy is performed arrange follow-up appointments at EPU to monitor the trend of hCG fall. In cases of salpingectomy advice women to do a home pregnancy test in 3weeks time, if negative no need for any further testing if positive to contact EPAU, provide EPAU contact number (01792 286868).

8. Following management of ectopic pregnancy:

A discussion about a follow up arrangement with the patient should take place post-operatively and if required an appointment should be arranged to the patient's preference (face/face vs phone call or other methods) and documented in the notes. Ideally the follow up should be within 6 weeks from the event, this is to discuss implications on future fertility and debrief about events of this pregnancy loss.

Women should be advised that according to evidence from NICE, about a third of women with ectopic pregnancy will have no risk factors identified, however, the overall risk of having a repeat ectopic pregnancy is about 18.5%. When there is a history of 1 ectopic pregnancy the risk of having a further ectopic pregnancy in subsequent pregnancies is about 10%, if the history of 2 or more ectopics, the risk would be about 25%.

They should be advised to contact early pregnancy unit once they have a positive pregnancy test if they have any symptoms. Even if they are symptom free, then an early ultrasound will be arranged at around 6-7 weeks gestation to ascertain the location of the pregnancy.

- It is equally important that the woman does not receive any future appointment letters for the pregnancy so ensure pending ANC/USS appointments are cancelled.

- Direct patients to available support after ectopic pregnancy

https://ectopic.org.uk/	https://www.cruse.org.uk/,	https://www.ectopicpregnancy.co.uk/

- Discuss pre-conceptual health optimisation, smoking cessation (smoking is a risk factor for ectopic pregnancy)

- Discuss and Offer contraception if pregnancy is not planned in the near future. https://ectopic.org.uk/physical-recovery/contraception

Appendix.1. Consent example for medical management of POUL/ectopic pregnancy

Consent Form 1: Patient agreement to examination or treatment

This form is to be used for people aged 16 years and over with mental capacity and people under16 years of age who are *Gillick* competent

Please press hard and ensure all three copies are legible

Patient details (or pre-printed label)

Patient's surname/family name .....

Patient's first names .....

Date of birth .....

☐ Male ☐ Female

NHS Number (or other identifier) .....

Special requirements

(e.g. other language/other communication method)

.....

.....

.....

(Please press hard to ensure all 3 copies are legible)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

Medical Management of Pregnancy of Unknown Location / Ectopic Pregnancy

Anaesthetic This procedure will involve:

☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation ☐ None

Any extra procedures which may become necessary during the procedure

☐ None expected ☑ Blood transfusion .....

☑ Other procedure (please specify) Surgical Intervention.

Statement of health professional (health professional must have appropriate knowledge of proposed procedure)

People aged 16 years and over (are presumed to have capacity to consent to treatment). Please tick ONE box:

☑ In my opinion there are no reasons to doubt the patient's capacity to make this decision; **OR**

☐ The patient's mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

☐ After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient **is *Gillick* competent** to make this decision.

The child has ☐ **agreed /** ☐ **declined** to involve someone with parental responsibility in this decision.

Advance decisions (for patients aged 18 years and over only)

☐ The patient has made a valid and applicable advance decision refusing this treatment/procedure **or** a treatment or procedure which may become necessary during the treatment/procedure in question.
(*Ensure the patient completes full details in the Advance decisions section on the opposite page.*)

Information about the procedure/treatment

I have explained the procedure to the patient. In particular, I have explained:

Intended benefits: To Medically manage a potential or suspected ectopic pregnancy.

Significant, unavoidable or frequently occurring risks, including any risks of particular significance to this patient:

Pain, bleeding, failure of treatment, need for further doses of same medication, Need for surgical intervetion. Medication side effects (nausea, vomiting, pain, bloating, ulcers, liver and blood disorder), anomalies if conceieved soon after treatment, Uncertain diagnosis. Future ectopic pregnancy.

I have also discussed:

☑ What the procedure is likely to involve.

☑ Any particular concerns of the patient.

☑ The benefits and risks of any available alternative treatments (including no treatment).

Please include details: Expectant and surgical options

☑ I have provided the following leaflet / cd / dvd / weblink (please specify title of the leaflet and date of issue; title of the cd/dvd and "version" if it has been amended). The Ectopic Pregnancy trust, Miscarriage association, RCOG.

Signed ..... Date .....

Name (PLEASE PRINT) ..... Job title .....

Professional registration number (e.g. GMC, NMC, GDC, HCPC etc.) .....

Contact details (if patient wishes to discuss options later) .....

Appendix 2. Consent example for surgical management of POUL/ectopic pregnancy

Consent Form 1: Patient agreement to examination or treatment

This form is to be used for people aged 16 years and over with mental capacity and people under16 years of age who are *Gillick* competent

Please press hard and ensure all three copies are legible

Patient details (or pre-printed label)

Patient's surname/family name .....

Patient's first names .....

Date of birth .....

☐ Male ☐ Female

NHS Number (or other identifier) .....

Special requirements

(e.g. other language/other communication method)

.....

.....

.....

(Please press hard to ensure all 3 copies are legible)

Name of proposed procedure or course of treatment (include brief explanation if medical term not clear)

Surgical Management of Pregnancy of Unknown Location / Ectopic Pregnancy, Laparoscopy +/- Unilateral Salpingectomy +/- Unilateral Salpingotomy

Anaesthetic This procedure will involve:

☑ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation ☐ None

Any extra procedures which may become necessary during the procedure

☐ None expected ☑ Blood transfusion .....

☑ Other procedure (please specify) Repair of Injury, Oophorectomy, Laparotomy. .....

Statement of health professional (health professional must have appropriate knowledge of proposed procedure)

People aged 16 years and over (are presumed to have capacity to consent to treatment). Please tick ONE box:

☑ In my opinion there are no reasons to doubt the patient's capacity to make this decision; **OR**

☐ The patient's mental capacity to consent to/refuse this treatment has been assessed and the patient has the mental capacity to make this decision. A note of the assessment has been placed on the patient's record.

People under 16 years of age

☐ After a full explanation of the procedure and its risks and benefits, I believe that the child has sufficient maturity and intelligence to be capable of understanding fully the treatment proposed and making a decision based on the information provided. I therefore believe that the patient **is *Gillick* competent** to make this decision.

The child has ☐ **agreed /** ☐ **declined** to involve someone with parental responsibility in this decision.

Advance decisions (for patients aged 18 years and over only)

☐ The patient has made a valid and applicable advance decision refusing this treatment/procedure **or** a treatment or procedure which may become necessary during the treatment/procedure in question.
(*Ensure the patient completes full details in the Advance decisions section on the opposite page.*)

Information about the procedure/treatment

I have explained the procedure to the patient. In particular, I have explained:

Intended benefits: To remove the ectopic pregnancy and stop the bleeding (active or potential), If tubal ectopic then remove the affected tube or remove the ectopic pregnancy tissue and leave the tube in place (if surgically possible) and if it is confirmed by laparoscopy. .....

Significant, unavoidable or frequently occurring risks, including any risks of particular significance to this patient:

Pain, bleeding, infection, bruising, scarring, wound healing problems, hernia formation. Injury to bowel, bladder, uterus, cervix, vagina, major blood vessels, nerves. Failure of laparoscopy. Return to theatre.Future ectopic pregnancy, Persistent trophoblastic tissue when salpingotomy is performed, Inability to locate the pregnancy. Clots to legs or lungs.

I have also discussed:

☑ What the procedure is likely to involve.

☑ Any particular concerns of the patient.

☑ The benefits and risks of any available alternative treatments (including no treatment).

Please include details: Expectant and medical options .....

☑ I have provided the following leaflet / cd / dvd / weblink (please specify title of the leaflet and date of issue; title of the cd/dvd and "version" if it has been amended). The Ectopic Pregnancy trust, Miscarriage association, RCOG, EIDO OG28,

Signed ..... Date .....

Name (PLEASE PRINT) ..... Job title .....

Professional registration number (e.g. GMC, NMC, GDC, HCPC etc.) .....

Contact details (if patient wishes to discuss options later) .....

Appendix 3. Links for leaflets:

Expectant management leaflet	Medical management leaflet (Methotrexate).	Surgical management leaflet	Pregnancy of Unknown Location leaflet	Ectopic Pregnancy Leaflet
The ectopic pregnancy trust				Miscarriage association

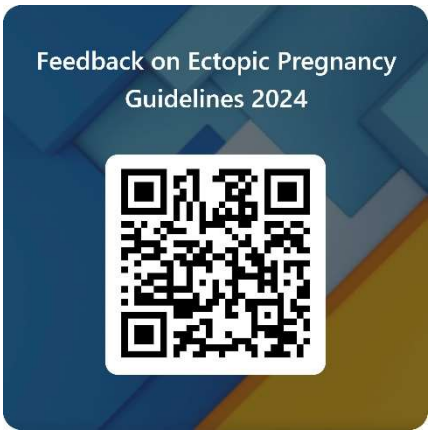
RCOG Patient information leaflet, pain bleeding in early pregnancy	RCOG Patient information leaflet, ectopic

EIDO Healthcare leaflets available on intranet link (EIDO Healthcare (eidosystems.com)) to be shared with patients as a print/PDF (not available as QR code.)

OG28 Surgery For Ectopic Pregnancy.

For Feedback, questions and comments on this guidelines please use the QR/link provided:

https://forms.office.com/e/NHM3ebBxY4



References:

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