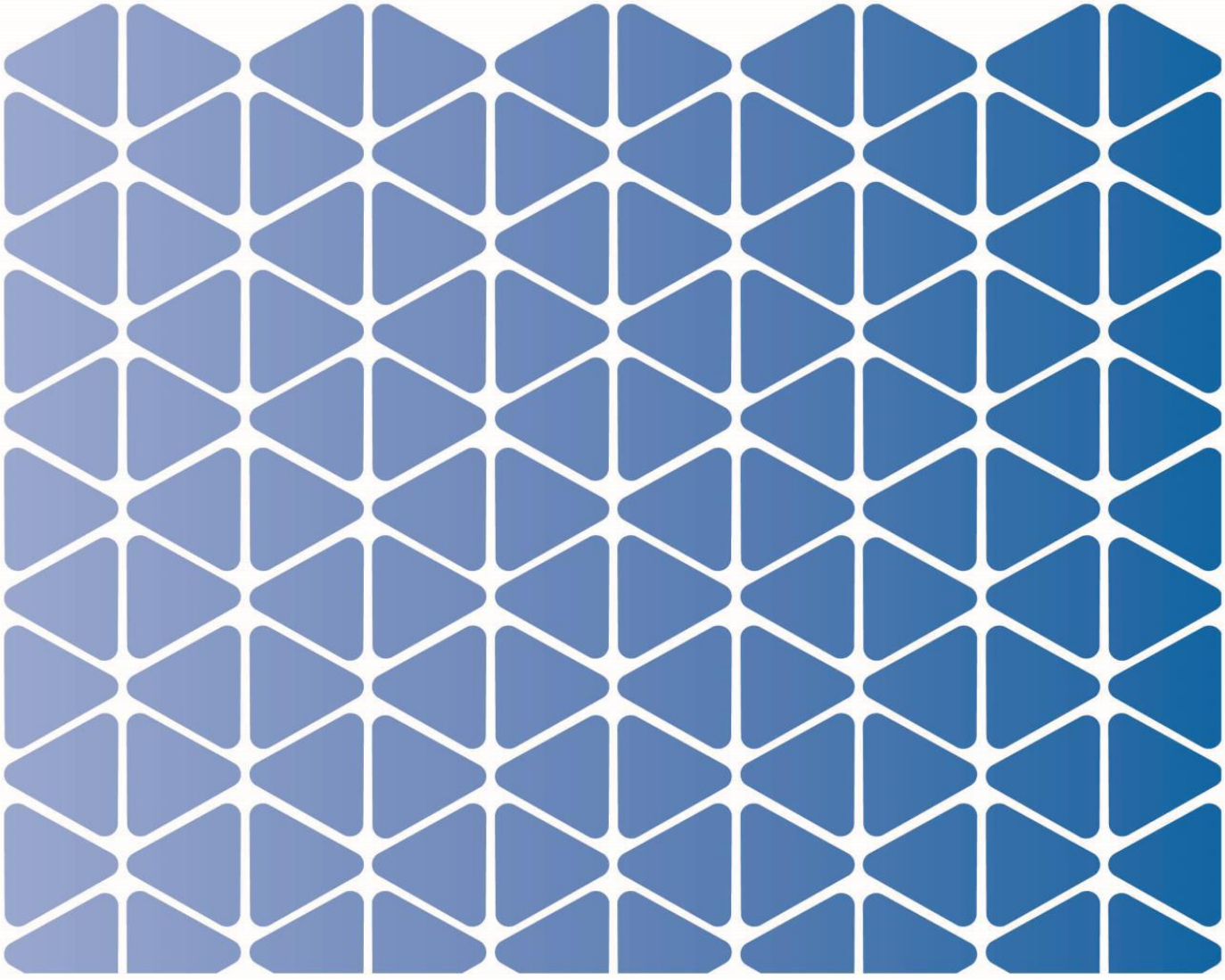
PATIENT INFORMATION

MANAGEMENT OF ECTOPIC PREGNANCY



Department of Gynaecology

Ectopic pregnancy is a relatively common, potentially 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. Unfortunately an ectopic pregnancy cannot continue or survive to deliver a healthy baby.

This leaflet explains some of the benefits, risks and alternatives of treatment. We want you to have all the information you need to make the right decision about your treatment. Please ask your gynaecology team about anything you do not fully understand or want to be explained in more detail.

We recommend that you read this leaflet carefully. You and your doctor (or other appropriate health professional) will also need to record that you agree to have a procedure by signing a consent form, which your health professional will give you.

What are the causes of ectopic pregnancy?

The most common reason for an ectopic pregnancy is damage to the fallopian tube, causing a blockage or narrowing. Conditions such as appendicitis, pelvic infection or endometriosis can damage the tube causing kinks or adhesions (internal scarring), allowing the egg to implant in the tube. In most cases, however, the cause of the ectopic pregnancy is not known.

What are the possible outcomes?

If the ectopic pregnancy continues growing the thin wall of the tube will stretch, causing pain in the lower abdomen. There may be some vaginal bleeding. The tube may occasionally rupture, causing severe abdominal bleeding, pain and collapse. Before this happens the ectopic may be diagnosed by blood tests or ultrasound scan. Once diagnosed, appropriate treatment can be offered.

Treating ectopic pregnancy

If you are well and not in severe pain, you may have blood hormone tests, repeated every 2 or 3 days, until the diagnosis is clear. If there is a high suspicion of ectopic pregnancy, a laparoscopy to inspect the tubes and treat the ectopic pregnancy may be appropriate.

If early diagnosis can be achieved before rupture of the tube, less invasive treatment can be offered. These treatments may not be appropriate for all women and you will only be offered these if they are an option in your case:

- **Treatment with drugs:**
  The drug methotrexate, which stops the pregnancy continuing, 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 in some cases. This is explained in more detail below.

- **Laparoscopic surgery:**
  Laparoscopic (keyhole) surgery may be offered to speed up your post-operative recovery if you need an operation. In some cases it might be possible to remove the ectopic pregnancy and leave the tube intact. This is usually only done if the other fallopian tube is damaged or absent (to try to improve the chances of a normal pregnancy in the future but this also increases the risk of another ectopic pregnancy). For further details on this procedure please see 'About the laparoscopic procedure' below.

About drug treatment

The advantage of drug treatment is that it avoids anaesthetic, surgery and reduces the extent of tubal damage.

- **Dose:**
  Only one injection (determined from your body weight) into the buttocks. This is only a small fraction of the dose used in cancer treatment. A second dose is needed in some cases.

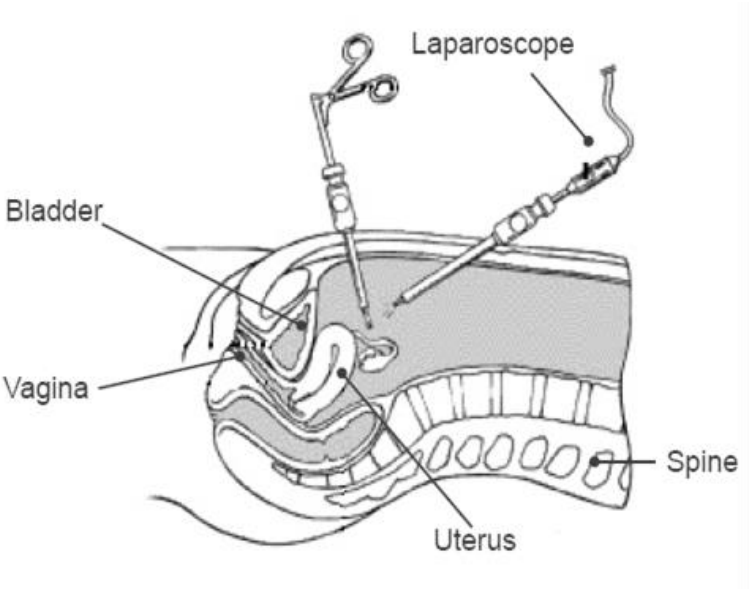
- **Tests:**
  Blood tests will be done 4 days after the injection, followed by several weekly tests to monitor the pregnancy hormone levels which should gradually return to normal.
  Serious or frequent risks with drug treatment
  - Nausea;
  - Vomiting;
  - Stomach pain;
  - Bone marrow suppression;
  - Reversible hair loss;
  - Excessive reaction to sunlight.

- **Contraception:**
  It is important to avoid becoming pregnant for at least 3 months after injection. Barrier contraception (for example a condom) is preferable.

  If there is evidence that the ectopic pregnancy is not resolving or your condition changes, it may be necessary to carry out surgical treatment. It is therefore very important that you have 24 hours direct access to the Gynaecology Unit.

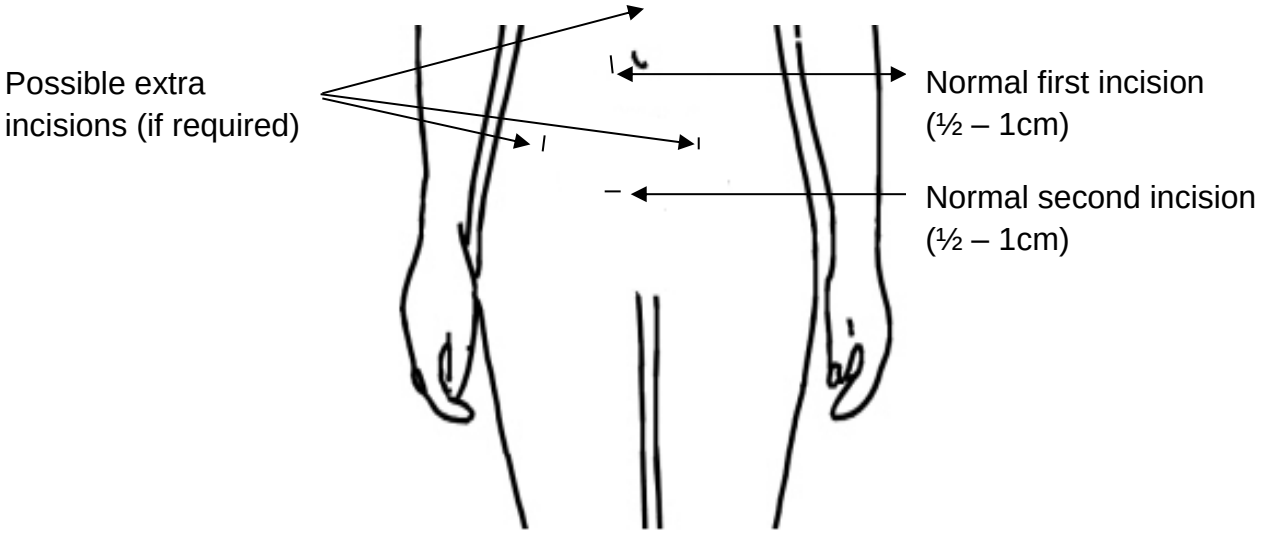
About the laparoscopic procedure

If you need a laparoscopy this section describes the details of the procedure. The aim of your surgery is to diagnose whether you have an ectopic pregnancy and to treat this accordingly. This would usually entail removal of the ectopic pregnancy and fallopian tube. Occasionally we will try to preserve the tube and remove only the ectopic pregnancy. With this 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.



Laparoscopy is a surgical procedure, which allows your gynaecologist to inspect the organs inside the pelvis and abdomen. This is performed under a general anaesthetic (when you are asleep and will feel nothing). Your doctor will insert a thin, hollow needle into the abdomen (most often through a small cut in the navel) where carbon dioxide gas is passed into the abdominal cavity. The gas gently inflates the abdomen, raising the abdominal wall above the uterus, bowel and other organs, so that visibility is increased and all areas of the pelvis can be easily inspected.

The laparoscope is then inserted. There will usually be a second incision just above the bikini line in the middle of the lower part of your abdomen. If an ectopic pregnancy is found and this can be treated through laparoscopic surgery, there may be up to four incisions in the abdomen. This allows special instruments to be inserted into the pelvis to remove the ectopic pregnancy.



Following laparoscopy when the instruments are removed the gas is released from the abdominal cavity, and a stitch may be used to close each of the small cuts. Usually, if stitches are used they will dissolve. We will tell you if they need to be removed.

Depending on what we find the laparoscopic procedure may take anywhere from 15 minutes up to an hour. Your laparoscopy may be performed in conjunction with other procedures such as a D&C (dilatation and curettage) to empty the contents of the womb.

In some cases, it may be unsafe or not possible to continue with laparoscopy and become necessary to convert to laparotomy (open surgery through a much larger incision in the abdomen). This is only done in the interests of the well-being and safety of the patient.

Serious or frequent risks of surgery

Everything we do in life has risks. Most people will not experience any serious complications from their surgery. In the case of ectopic pregnancy the risk of not having surgery is far greater than the risk of having surgery. However, you should be aware of the possible risks of this type of surgery.

Risks specifically related to surgery to remove an ectopic pregnancy include problems with:

- Damage to the fallopian tube (increasing the risk of future ectopic pregnancy);
- Failure to gain entry to abdominal cavity, so the procedure cannot be completed (and open surgery is required).

- Shoulder pain following surgery (due to some gas left behind – this settles with time).
- Uterine perforation during surgery (which will usually repair itself without any further treatment).
- Because laparoscopy requires the insertion of sharp instruments into the abdomen injury to major blood vessels, bladder, ureter, stomach and bowel is possible. This type of injury is rare. Patients who are very thin or obese, or who have had previous surgery to the abdomen, may have an increased risk for this type of injury.
- Laparotomy to repair damage to internal organs caused by the laparoscopic instruments. In the event of serious damage the surgical repairs may be extensive (1 in 1,000).
- Peritonitis is an extremely rate complication. This is an infection of the inside of the abdomen. It may not be immediately obvious and can be life threatening. In some cases, a colostomy (where the bowel empties into a bag) is created. Once again, this is an extremely unlikely complication but women undergoing laparoscopy should be made aware of this.

The general risks of surgery include problems with:

- The wound (for example, bruising, infection);
- Breathing (for example, a chest infection);
- Bladder infection;
- The heart (for example, abnormal rhythm or, occasionally, a heart attack);
- Blood clots (for example, in the legs or occasionally in the lung);
- Excessive bleeding (that may require blood transfusion);
- Keloid (a surgical scar that becomes inflamed, raised and itchy). Keloid can be irritating but is no threat to your health.

Sometimes, more surgery is needed to put right these types of complications.

The risks increase for people who are overweight and people who already have heart, chest or other medical conditions such as diabetes or kidney failure. As with all surgery, there is a small risk that you may die although this is extremely rare.

You will be cared for by a skilled team of doctors, nurses and other health-care workers who are involved in this type of surgery every day. If problems arise, we will be able to assess them and deal with them appropriately.

Your pre-surgery visit by the anaesthetist

Once you are admitted to hospital the anaesthetist will come to see you and ask you questions about:

- Your general health and fitness;
- Any serious illnesses you have had;
- Any problems with previous anaesthetics;
- Medicines you are taking;
- Allergies you have;
- Chest pain;
- Shortness of breath;
- Heartburn;
- Problems with moving your neck or opening your mouth; and
- Any loose teeth, caps, crowns or bridges.

On the day of your operation

- **Nothing to eat and drink (nil by mouth)**
  It is important that you follow the instructions we give you about eating and drinking. We will ask you not to eat or drink anything (including chewing gum or sucking sweets) for six hours before your operation. This is because any food or liquid in your stomach could come up into the back of your throat and go into your lungs while you are being anaesthetised. You may take a few sips of plain water up to two hours before your operation so you can take any medication tablets. Continue to take your normal medicines up to your surgery.

- **Delays prior to the operation**
  We appreciate how upsetting it is to need to have this surgery. Unfortunately, the majority of these operations cannot be 'planned' so they take place on the 'emergency operating list'. As other emergencies are sometimes more life threatening, and some days are extremely busy, there may be necessary delays in the time before your operation can be performed. We will try to keep you informed of any possible delays but please understand that such delays can be unexpected and unavoidable.

- **Your anaesthetic**
  We will carry out your surgery under a general anaesthetic. This means that you will be asleep during your operation and you will feel nothing. When it is time for your operation, a member of staff will take you from the ward to the operating theatre. They will take you into the anaesthetic room and the anaesthetist will make you ready for your anaesthetic.

To monitor you during your operation, your anaesthetist will attach you to a machine to watch your heart, your blood pressure and the oxygen level in your blood. General anaesthesia usually starts with an injection of medicine into a vein. A fine tube (venflon) will be placed in a vein in your arm or hand and the medicines will be injected through the tube. Sometimes you will be asked to breathe a mixture of gases and oxygen through a mask to give the same effect.

Once you are anaesthetised, the anaesthetist will place a tube down your airway and use a machine to 'breathe' for you. You will be unconscious for the whole of the operation and we will continuously monitor you. Your anaesthetist will give you painkilling drugs and fluids during your operation. At the end of the operation, the anaesthetist will stop giving you the anaesthetic drugs. Once you are waking up normally, they will take you to the recovery room.

- **Pain relief after surgery**

  Pain relief is important as it stops suffering and helps you recover more quickly. We may give you tablets or injections to make sure you have enough pain relief. Once you are comfortable and have recovered safely from your anaesthetic, we will take you back to the ward. The ward staff will continue to monitor you and assess your pain relief.

  It is important that you report any pain you have as soon as you experience it.

- **What are the risks of anaesthetic?**

  Your anaesthetist will care for all aspects of your health and safety over the period of your operation and immediately afterwards. Risks depend on your overall health, the nature of your operation and how serious it is. Anaesthesia is safer than it has ever been. If you are normally fit and well, your risk of dying from any cause while under anaesthetic is less than one in 250,000. This is 25 times less likely than dying in a car accident. Side effects of having an anaesthetic include drowsiness, nausea (feeling sick), muscle pain, sore throat and headache. We will discuss with you the risks of your anaesthetic.

After your surgery

- Once the medical team are happy with your progress, we will usually take you from the recovery room to the general ward. You will need to rest until the effects of the anaesthetic have passed. You will have a drip in your arm to keep you well-hydrated.
- You may have a tube (catheter) to drain urine from your bladder into a bag next to your bed. This will usually be removed when you are ready to get out of bed and walk around.

- Your anaesthetist will arrange for you to have painkillers for the first few days after the operation, as we mentioned earlier.
- We will encourage you to get out of bed and move around as soon as possible, as this helps prevent chest infections and blood clots. Usually, the physiotherapy or nursing team will help you with this.

Recovering from laparoscopy

After your laparoscopy, while you are still under the effects of the anaesthetic, you will be taken to the recovery room where you will be monitored by the recovery staff until you are transferred back to the ward. Back on the ward, the nursing staff will monitor your condition and take routine observations. Our medical team will explain how the surgery went and what the findings were.

Following laparoscopy, you may experience the following:

- Tiredness;
- Muscle pain;
- Mild nausea;
- Pain or discomfort at the site of the incisions;
- Pain in one or both shoulders that may extend to the neck and rib cage (this is thought to be caused by some of the gas used during the procedure being left inside your body and may last for a number of days but will gradually wear off - often lying down can help relieve the symptoms).
- Cramps (similar to period pain);
- Vaginal discharge or bleeding for a few days;
- A sensation of bloating in the abdomen.

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 tubes.

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 naturally will be reduced. The overall chances of a repeat ectopic are between 7-10% and this depends on the type of treatment carried out and any underlying damage to the remaining tube(s).

What about trying for another pregnancy?

Most doctors advise women to wait for three months to allow time for their body to recover.
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 when you suspect that you might be pregnant again. Similarly, if a period is late, if menstrual bleeding is different from normal or if there is abdominal pain, please consult your doctor.

Your Emotions

Ectopic pregnancy can be a devastating experience. You are likely to be recovering from 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 healthy, whilst at the same time be feeling extremely sad for your loss. It is possible 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.

Leaving hospital

- **Length of stay**
  How long you will be in hospital varies from patient to patient and depends on how quickly you recover from the operation and the anaesthetic. You will probably be in hospital between 1 and 3 nights after your operation.

- **Medication when you leave hospital**
  Before you leave hospital, the pharmacy will give you any extra medication that you need to take when you are at home.

- **Convalescence**
  How long it takes you to recover from your surgery varies from person to person. It can take up to 2 to 3 weeks. After you return home, you will need to take it easy and should expect to get tired to begin with.

- **Stitches**
  We usually use dissolvable stitches. If these have not disappeared after seven days, they can be removed by the nurse at your GP practice.

- **Personal hygiene**
  You may bathe or shower normally after you leave hospital.
  We recommend that you do not use tampons immediately after your procedure. Sanitary pads may be used and should be changed regularly.

- **Diet**

  You do not usually need to follow a special diet. If you need to change what you eat, we will give you advice before you go home. You should avoid constipation and straining for bowel motions and ensure that you get plenty of rest while you are recovering.

- **Exercise**

  You should do light exercise, such as walking and light housework, as soon as you feel well enough.

  Normal physical activity may be resumed when any discomfort has disappeared, and when you are feeling well enough. This may take anywhere from three days to a few weeks, depending on the nature of your procedure and your general health.

- **Sex**

  You may have sex when you feel well enough. Usually this will not be for a few weeks after surgery. If you do not want to become pregnant at this time you should use suitable forms of contraception.

- **Driving**

  You should not drive until you feel confident that you could perform an emergency stop without discomfort. If you have had a purely laparoscopic procedure you will probably be ready to drive after a few days to a week. If you have had an open procedure you may not be able to drive for a few weeks. It is your responsibility to check with your insurance company.

- **Work**

  How long you will need to be away from work varies depending on:

  - How serious the surgery is;
  - How quickly you recover;
  - Whether or not your work is physical; and
  - Whether you need any extra treatment after surgery.

  After surgery for an ectopic pregnancy you can usually return to work between 2 and 4 weeks after your operation. Please ask us if you need a medical sick note for the time you are in hospital and for the first three to four weeks after you leave.

Outpatient appointment

Before you leave hospital we may give you a follow-up appointment to come to the outpatient department, or we will send it to you in the post.

Your appointment will normally be for between 4 and 12 weeks after surgery. At this stage, we will discuss the surgery and findings in detail and recommend on-going treatment options if required.

Once you leave hospital

If you experience fever-like symptoms, or excessive pain, redness and discharge at the incision sites you should contact us.

You should report to your GP or us if you experience any of the following:

- Persistent bleeding from the vagina that is smelly or becomes heavier than a normal period and is bright red;
- Persistent redness, pain, pus or swelling around the wounds, of a fever or more than 38°c, or chills, which may indicate infection;
- Pain or burning on passing urine or the need to pass urine frequently, as this may indicate a urinary tract infection;
- Increasing nausea;
- Increasing abdominal pain with vomiting.

Contact details

If you have any specific concerns that you feel have not been answered and need explaining, please contact the following:

Worcester Royal Hospital

- Early Pregnancy Assessment Unit (phone 01905 733060)
- Gynaecology Nursing Staff, Lavender Ward (phone 01905 760586)
- Hospital Switchboard (phone 01905 763333)

Alexandra Hospital

- Early Pregnancy Assessment Unit (phone 01527 512100)
- Gynaecology Nursing Staff, Ward 14 (phone 01527 512100)
- Hospital Switchboard (phone 01527 503030)

Kidderminster Treatment Centre

- Early Pregnancy Assessment Unit (01562 823424, Bleep 3461)
- Ward 1 Nursing Staff (phone 01562 512356)
- Hospital Switchboard (phone 01562 823424)

You may also feel it is useful to talk to the Ectopic Pregnancy Trust (phone 01895 238025).

Other information

The following internet websites contain information that you may find useful.

- www.patient.co.uk
  Information fact sheets on health and disease

- www.rcoa.ac.uk
  Information leaflets by the Royal College of Anaesthetists about 'Having an anaesthetic'

- www.nhsdirect.nhs.uk
  On-line health encyclopaedia

- www.worcsacute.nhs.uk
  Worcestershire Acute Hospitals NHS Trust

If your symptoms or condition worsens, or if you are concerned about anything, please call your GP, 111, or 999.

Patient Experience

We know that being admitted to hospital can be a difficult and unsettling time for you and your loved ones. If you have any questions or concerns, please do speak with a member of staff on the ward or in the relevant department who will do their best to answer your questions and reassure you.

Feedback

Feedback is really important and useful to us – it can tell us where we are working well and where improvements can be made. There are lots of ways you can share your experience with us including completing our Friends and Family Test – cards are available and can be posted on all wards, departments and clinics at our hospitals. We value your comments and feedback and thank you for taking the time to share this with us.

Patient Advice and Liaison Service (PALS)

If you have any concerns or questions about your care, we advise you to talk with the nurse in charge or the department manager in the first instance as they are best placed to answer any questions or resolve concerns quickly. If the relevant member of staff is unable to help resolve your concern, you can contact the PALS Team. We offer informal help, advice or support about any aspect of hospital services & experiences.

Our PALS team will liaise with the various departments in our hospitals on your behalf, if you feel unable to do so, to resolve your problems and where appropriate refer to outside help.

If you are still unhappy you can contact the Complaints Department, who can investigate your concerns. You can make a complaint orally, electronically or in writing and we can advise and guide you through the complaints procedure.

How to contact PALS:

Telephone Patient Services: 0300 123 1732 or via email at: wah-tr.PET@nhs.net

Opening times:

The PALS telephone lines are open Monday to Thursday from 8.30am to 4.30pm and Friday: 8.30am to 4.00pm. Please be aware that a voicemail service is in use at busy times, but messages will be returned as quickly as possible.

If you are unable to understand this leaflet, please communicate with a member of staff.