cuts we use for the surgery and the gas introduced into your abdomen at the time of the surgery commonly causes shoulder tip pain. This can be treated with pain relief. You may require an injection to thin the blood down to reduce the risk of thrombosis. Please refer to our recovery after laparoscopy leaflet which can be assessed on:
https://www.ashfordstpeters.nhs.uk/early-pregnancy-unit

You should expect vaginal bleeding for up to 2 weeks which may be heavier than a period as the lining of the womb is shed.

If you have signs of infection (e.g., fever) you should seek early medical advice (usually via your GP), 111 or attend A & E if you are acutely unwell.

Conservative management

If you are well and don't have significant pain and meet other eligibility criteria, you may be offered conservative management. This is when we allow the body to absorb the pregnancy tissue without giving any medication. You will be monitored closely as an outpatient in the Early Pregnancy Unit with weekly blood tests until the pregnancy hormone returns to non-pregnant level. This may take several weeks.

You will be advised to stay in the local area and avoid sexual intercourse or strenuous activity. You should attend the Accident and Emergency department (with your report if available) immediately if you develop worsening abdominal pain, feel dizzy/faint or become acutely unwell.

intra-uterine pregnancy but can't prevent an ectopic pregnancy because the pregnancy is outside the womb.

- Smoking may slow the movement of the fertilized egg down the tube.
- In many cases the cause of the ectopic pregnancy is unknown or unexplained.

What are the treatment options?

The treatment options vary, and you will be fully involved in the decision. We will explain the benefits and disadvantages of each option and agree with you on what treatment may be most suitable for your individual case.

Some ectopic pregnancies stop developing and are gradually absorbed back into the body.

Occasionally, the ectopic pregnancy is pushed out from the end of the tube into the abdomen, and it is reabsorbed. This is known as tubal miscarriage. This may be accompanied by abdominal pain and vaginal bleeding. It can be difficult to diagnose a tubal miscarriage on scan alone because the USS features are nonspecific.

In some cases of ectopic pregnancies, treatment with an injection called Methotrexate may be an option. Please refer to the leaflet on treatment of Ectopic pregnancy with Methotrexate.

Depending on your symptoms, the findings on USS, the pregnancy hormone levels, your previous history and you preference, you may not be suitable for treatment with any of the options above and

surgical treatment is required. The aim of surgery is to remove the ectopic pregnancy to prevent this from rupturing. A ruptured ectopic may cause internal bleeding that could make you very unwell.

This leaflet is aimed at giving you more information on the conservative and surgical treatment of an ectopic pregnancy. We will discuss mainly the treatment for tubal ectopic pregnancies, the most common type of ectopic pregnancy. Please refer to the separate leaflet treatment for ectopic pregnancy with Methotrexate.

Surgical management

Depending on your clinical assessment, your doctor may advise that surgery is the best treatment for you. In most people it is a relatively quick and safe method of treatment. Studies show that it is effective and the chance of having a successful pregnancy in the future is not adversely affected by choosing this treatment over other options.

The operation is usually done by laparoscopic (keyhole) surgery under general anesthetic, with 2-3 small incisions (cuts) into the abdomen where the camera and instruments are introduced to diagnose and remove the ectopic pregnancy. This will require admission to hospital and an overnight stay may be necessary.

Rarely, keyhole surgery may not be appropriate and an open surgery through a cut along the bikini line is required. This might be because you are too unwell or technical issues with performing the keyhole surgery e.g., previous complex abdominal surgery or being overweight.

The surgeon will look at the fallopian tubes and all the other internal female (pelvic) organs to see if a cause for the ectopic pregnancy can be identified. The surgeon will inspect the other tube if present to ascertain how best to treat the ectopic pregnancy.

Depending on the agreed surgical treatment, the operation findings, the RCOG recommended treatment, the surgeon will either remove the tube with the ectopic pregnancy (salpingectomy) or, if there is only one tube or the other tube looks damaged, the surgeon will try to remove the ectopic pregnancy only and leave the tube (salpingostomy) if possible. Please be aware it may not always be possible to perform a salpingostomy e.g., the tube continues to bleed after removing the ectopic pregnancy or the tube is grossly damaged. If a salpingostomy is performed, there is a risk some pregnancy tissue may remain in the tube. After salpingostomy, you will be advised to attend weekly blood tests to ensure your pregnancy hormone level drops to the non- pregnant level. It is essential you attend these blood tests because we can't be certain the treatment has been successful until the pregnancy hormone is no longer detectable in the blood stream.

Rarely, after a salpingostomy, residual pregnancy may not resolve fully, and additional treatment may be required. This may be treated with Methotrexate or repeat surgery, rarely. There is a slightly higher risk of a future tubal pregnancy after a salpingostomy when compared to a salpingectomy.

Post-Operative Recovery

If you are Rhesus negative, we will give Anti D. Following surgery, you may have abdominal discomfort for 1-2 weeks because of the