Ectopic pregnancy: a real issue for midwives

Laura Abbott
is an independent midwife, co-founder of 'Homebirths' and a medical adviser for the Ectopic Pregnancy Trust

Ectopic pregnancy is the third biggest killer of pregnant women in the UK. Laura Abbott outlines the symptoms and management and explores the condition's psychological and physical effects.

The possibility of true midwifery-led care with the midwife as first point of contact for women is on the horizon (Drown, 2003). With this in mind we need to be acutely aware of ectopic pregnancy. If left untreated, an ectopic pregnancy can cause collapse and death from tubular rupture and internal bleeding.

Importance of diagnosis

Ectopic pregnancy (EP) affects one in every 80 to100 pregnancies (RCOG, 2002) and is a life-threatening condition. Most EPs implant in the fallopian tube and as the pregnancy progresses, it causes bleeding and pain and if not treated in time, the tube can rupture and cause severe and fatal haemorrhage.

It is a lamentable fact that five women a year continue to die from EP. It has been reported in the last two *Confidential enquiries into maternal deaths* (CEMD) in 1997 and 2001 that the main problem was failure to suspect EP in the first place and consequently substandard care had been given. The majority of women who died had sought advice from a doctor with regards to their symptoms prior to death. This makes death from EP the third biggest killer of pregnant women in the UK, after thromboembolism and hypertensive disorders. Despite repeated advice and guidelines set out by the CEMD, the RCOG and the Royal Society of Medicine, the death rate continues to rise on a yearly basis.

From a medico-legal standpoint, the alleged breach of duty in misdiagnosing EP relates directly to the delay in diagnosis. Clements and Brennan (2000) surmised that if standard clinical guidelines set out by the RCOG were followed when women present with the symptoms of EP, then most cases of misdiagnosis and subsequent rupture would never arise. With this in mind, it is essential that any woman of childbearing age be investigated for EP if any symptoms of this condition are displayed.

Midwives are ideally placed in recognising the signs and symptoms of EP, but in practice at present we rarely see women before 12-weeks gestation.The proposals put forward by Drown (2003) to the House of Commons Health Select Committee include highlighting to women that they should be able to make direct contact with a midwife, when first pregnant, in order to access maternity services rather than via a GP. As independent midwives, we are often contacted very early on in a woman's pregnancy and preconceptionally, therefore we are often supporting women through early pregnancy. The Independent Midwives Association's (IMA) proposed 'NHS Community Midwifery Model' of care (IMA, 2003), whereby a woman chooses her midwife and the midwife is paid by the NHS a set fee per woman, is being given serious consideration by the Department of Health. As all midwives make headway towards becoming the first port of call for women, we need to be aware of the dangers of EP and refer to an appropriately qualified practitioner (UKCC, 1998) in cases of suspected EP.

Davies (2003) shares the hopes that the first professional contact for a pregnant woman should be with a midwife. After all, we are the specialists in normal pregnancy and are qualified to give total care for women from early pregnancy until the baby is 28 days old. Echoing Davies' (2003), Drown's (2003) and the IMA's (2003) proposals, this concept is not so far-fetched. We can be information-givers in areas such as nutrition, screening, choices for place of birth, as well as a source of support. However, we would also require an in-depth knowledge of EP, which threatens young women's lives.

Common causes

- Damage to the fallopian tube causing blockage or narrowing, so the eggs cannot move into the uterus
- Previous pelvic infection
- Chlamydia – this infection is becoming increasingly common in young women with one in ten 20-year-olds infected at any time (Greenhouse and Shroeder, 2002). It is therefore crucial that midwives, school nurses, health visitors and teachers are warning young women of the dangers that untreated sexually transmitted diseases can cause on their health and future fertility
- Previous appendicitis
- Infertility
- Caesarean section – with the rise in caesarean section rate in this country, this is an important factor to consider when informing women of their choices
- In many instances, the cause is not known.

Symptoms

- Abdominal pain – this is usually one sided, but not necessarily the side of the ectopic
- Bleeding usually abnormal bleeding – could be some spotting. The blood is often darker than a normal period and can be described as 'watery or prune juice coloured' (Walker, 2001). The woman may not know

she is pregnant or may think she is having an unusual period. She may have been fitted with a coil
- Shoulder tip pain – this can be caused by irritation to the diaphragm caused by internal bleeding and is a classic sign of ruptured ectopic
- Bladder/bowel problems – pain when going to the toilet. Feeling of pressure in the bowels
- Pregnancy test – this may be positive but not always
- Collapse – feeling dizzy and light-headed. Looking pale and feeling sick
- A feeling that something is very wrong: often with a feeling of impending doom (Walker, 2001).

Management of symptoms

If an EP is suspected, the woman should attend hospital. An ultrasound scan and a pregnancy test should be performed. If the test is positive and the scan shows an empty uterus, an EP is likely and needs to be ruled out. This can be done by serial blood tests every 48 hours to check the level of the pregnancy hormone beta human chorionic gonadotropin if the woman is well. A laparoscopy may need to be performed and is the preferred treatment option (Ankum, 2000). If diagnosis is made early before the tube ruptures, keyhole surgery or drug treatments such as methotrexate can be used, which can help with a quicker recovery time and increase the women's chances of future fertility.

In the latest guidelines for health professionals, Professor James Walker (2002) of the Ectopic Pregnancy Trust (EPT) states: 'Waiting to see if symptoms settle, can put the woman at great danger by increasing morbidity and mortality.'

Worryingly the CEMD 1997 to 1999 states that the majority of women who died from ruptured tubal pregnancy were 'known to have sought medical help before death' and often had symptoms that suggested a urinary or gastrointestinal disease. I reiterate again the importance of vigilance of signs and symptoms. Any woman with one-sided pain and a positive pregnancy test should be treated as having an EP until proven otherwise. An early scan to confirm that the baby is in the womb can have a dramatic effect.

Psychological impact

Every year in this country there are more than 20 000 emergency admissions to hospital for EP. The surgery has an impact on the woman's fertility, usually decreasing it by 50% or more. With reduced fertility, the loss of a baby and having emergency surgery, this can have an enormous impact on a woman's psychological health as well as her relationships. Many women who seek help from the EPT are exhibiting symptoms of post-traumatic stress disorder, experiencing flashbacks, nightmares, hypervigilance and depression (Herman, 1997). Qualitative research being undertaken by the EPT shows the emergence of common themes with regards to women's psychological health following an EP.

It is vital that midwives have an awareness of the emotional conflicts when booking a woman with a previous history of EP. Abbott (2002) suggests that an EP is similar to having 'a termination without consent'. The emerging evidence is also showing that the psychological effect can have a substantial impact on the woman's next pregnancy and put her at an increased risk of postnatal depression (Jones, 2001).

A heightened mindfulness of these facts will lead to greater empathy from midwives, doctors and nurses when talking to women who have had an EP in the past.

Failure to diagnose

The failure to diagnose this serious condition is not acceptable and something that needs to change. Two young women have died from misdiagnosed EPs in the last five months (EPT, 2003). Both women sought medical help before their collapse. However, their symptoms were dismissed as being stomach upsets. Both women were found dead by their partners the day after seeking medical advice.

More cases of this nature are coming to light, as are tragic near misses, which are leaving women and their families deeply traumatised. The message has to go out to midwives, doctors and nurses that any woman of child-bearing age presenting with the aforementioned symptoms must have EP ruled out before anything else. Women should also be informed of the signs and symptoms of EP, so they can become empowered when seeking help.

UK hospitals need to follow the lead of those establishments who are committed to a gold standard of care for treating EP.

Conclusion

Deaths from EP need to become a thing of the past. With greater vigilance from health professionals and women perhaps this is not such an idealistic concept.

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Further information

For further information, please contact the Ectopic Pregnancy Trust helpline on Tel: 01895 238025 or visit: www.ectopic.org.uk

For an information leaflet, please send a large stamped addressed envelope to:
The Ectopic Pregnancy Trust
c/o Maternity Unit
Hillingdon Hospital
Pied Heath Road
Uxbridge
UB8 3NN.