# Ectopic pregnancy: a literature review

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**INTRODUCTION:** Ectopic pregnancy is a condition in which the developing blastocyst implants in a location other than the endometrium of the uterine cavity. The most prevalent extrauterine location is the fallopian tube, which accounts for 96% of all ectopic pregnancies. Modifiable risk factors are associated with ectopic pregnancy, in particular smoking, although the role of residual confusion remains uncertain. The reported incidence has varied across time and patient populations and is difficult to estimate from available data due to the fact that inpatient treatment has decreased and outpatient visits for single ectopic pregnancies have increased. It is estimated that 1% to 2% of all spontaneous pregnancies are ectopic, and the incidence increases to 2.1% to 8.6% of pregnancies with assisted reproductive technologies. **OBJECTIVE:** To review the literature regarding ectopic pregnancy, describing its risk factors, clinical picture and treatment. **METHODOLOGY:** This is a narrative literature review, with data survey in Scielo and PubMed. Complete articles were included, in English, Portuguese and Spanish, published from 2010. Duplicate papers were excluded, as well as those that were incomplete or in other languages. **RESULTS AND DISCUSSION**: Ectopic pregnancy is considered one of the world's leading causes of maternal mortality during the first trimester of pregnancy, accounting for 5% to 10% of all maternal deaths in countries with scarce resources. The main cause of ectopic pregnancy is disruption of the normal tubal anatomy by factors such as infection, surgery, congenital anomalies, or tumors. The highest risk is associated with a history of previous ectopic pregnancy or tubal surgery. Another risk factor found is pelvic inflammatory disease. Infertility has been presented as an important factor when the subject is ectopic pregnancy, presenting a two to three times higher incidence of this type of implantation. Other very prevalent risk factors are smoking (two to four times the risk), exposure to diethylstilbestrol (four times the risk), vaginal douching (up to three times the risk), increasing age, and endometriosis. The most effective protection against an ectopic pregnancy is to use a modern contraceptive method and thus reduce the risk of unintended pregnancy. A cornual pregnancy is when the blastocyst implants in the interstitial portion of the

fallopian tube, being the proximal segment that is embedded in the muscular wall of the uterus. Cornual pregnancies can be misdiagnosed as intrauterine because they are partially implanted in the endometrium. One clue to correct diagnosis is their eccentric location. As for the clinical picture, the most common presentation is first trimester vaginal bleeding associated or not with abdominal pain. Ectopic pregnancy can also be asymptomatic. In symptomatic cases, clinical manifestations appear within six to eight weeks after the last normal menstrual period. Tubal rupture can result in intra-abdominal bleeding and the patient usually presents with severe or persistent abdominal pain or hemodynamic instability. Regarding the diagnosis, this should be suspected in a pregnant patient without evidence of an intrauterine pregnancy by transvaginal ultrasonography, abnormally increasing serum human chorionic gonadotrophin, visualization of an inogenous complex extraovarian adnexal mass, extraovarian adnexal mass containing an empty gestational sac, or intraperitoneal bleeding, abdominal pain, or vaginal bleeding. The main differential diagnoses of ectopic pregnancy are miscarriage, cervical polyp, gestational trophoblastic disease, and subconic hematoma. Ectopic pregnancy is a potentially fatal condition. The three approaches to the management of ectopic pregnancy are surgery, treatment with methotrexate, or expectant management. With early diagnosis, most patients with ectopic pregnancy can be treated on an outpatient basis with methotrexate. The remaining patients will require surgery. Indications for surgical therapy include hemodynamic instability, suspected or risk factors for rupture, contraindications for methotrexate or failure of medical therapy, suspected or impending tubal rupture, or if other options fail. It is thus considered the treatment of last resort and there are few contraindications. There are two surgical approach options for tubal pregnancy. Salpingectomy which is the removal of the fallopian tube and salpingostomy in which a tube is incited to remove the tubal pregnancy but leaves the rest of the tube intact. Both seem to have similar fertility outcomes in subsequent pregnancies. **CONCLUSION:** The insertion of women in the labor market, the increased use of assisted reproduction methods, and the choice to have a late pregnancy have increased the incidence of ectopic pregnancies. This incidence has been difficult to measure due to the success of drug treatment, which leads to lower numbers of records regarding this type of pregnancy. The choice for surgical treatment is limited to special cases, such as tubal rupture, large volume mass, contraindication of drug therapy and hemodynamic instability.