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Ectopic Pregnancy

"I hadn't the faintest idea what was wrong with me, but I thought I was going to die. The pain in my stomach was so bad that I couldn't stop screaming. I finally fainted. An ambulance took me to the hospital, and the next thing I remember is being in the recovery room. They told me I had an ectopic pregnancy and had lost three pints of blood and one of my tubes. I couldn't believe it—I didn't even know I was pregnant. I remember hearing my husband say, 'God's been good to us. We almost lost you.'"

Ectopic pregnancy is a life-threatening condition which has almost quadrupled in number since 1970. It is difficult to diagnose and can destroy a couple's chance of ever having children. Yet even though seventy thousand women have an ectopic each year in the United States, its enormous emotional impact is rarely discussed.

An ectopic pregnancy is one that occurs when the embryo develops outside the uterus. In ninety-five percent of all cases, the embryo grows in the fallopian tube. As it becomes bigger, it exerts pressure on the tubal walls, which do not have the ability to expand and stretch as the uterus does. Unless detected and treated early enough, the tube will burst, leading to internal hemorrhaging. The other five percent of the time, the embryo implants in the ovary, the abdomen, or the cervix, also causing serious complications as it grows. In the past, death often resulted from ectopic pregnancy. One report published over one

hundred years ago indicated that sixty-nine percent of women with ectopics died as a result. With better diagnostic and treatment techniques, the death rate has fortunately dropped sharply, to less than one in a thousand, even though the number of ectopic pregnancies continues to rise.

The experience is still a traumatic one for most families. Maria and Joe are one couple who described what happened to them. They had been about to leave on vacation to celebrate Maria's thirtieth birthday, when they found out that Maria was pregnant after three years of trying. They were both high with excitement as they flew off for a week by the ocean. Maria recalls:

> When we arrived at the hotel, I noticed that I was spotting and started feeling scared. I called my doctor back home, and he said not to worry, just to take it easy. I tried to stay in bed and lie quietly on the beach. But the next day the spotting was heavier and I began to fear I might be having a miscarriage. Joe became very alarmed and insisted that we fly home immediately since I would be better off in my own home and with my own doctor.

Joe explains what happened next:

> When the plane landed, we drove directly to the emergency room. The doctor there examined Maria and said her cervix was not dilated, so he reassured us that everything was all right. I began to feel foolish about spoiling our vacation, but we had wanted this baby for a long time and I didn't want to take any chances.

Maria continued:

> I was getting dressed the next morning to go see my own doctor when I began to feel a lot of pain and passed a very large blood clot. I thought, This is it. My heart sank. I was exhausted from the trip and very upset about losing the baby. The doctor sent me to the hospital for an ultrasound which showed that my uterus was empty. They admitted me and did a D & C that night. The doctor said he had considered that I might have an ectopic but because of the clots and my cervix dilating he decided it wasn't.
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> I was relieved at least to think it was over, and I kept thinking

about the doctor saying I shouldn't have any problems with another pregnancy. At least I could get pregnant again. But I was still very upset.

Two days later I was driving home from work and began to feel pain in my stomach. It kept getting worse, and I realized I wasn't going to make it home. I pulled over to the side of the road by a telephone booth and tried to get out of the car. The pain was so bad I almost passed out. I was terrified that I would collapse by the road and no one would find me. I hung onto the car door until I could finally see straight again. I made my way slowly to the phone, overwhelmed by excruciating pain. Miraculously, someone saw me and realized I needed help. She called my husband, while I went and lay down in the back seat of the car until Joe finally arrived.

Joe had never been so frightened. He drove Maria straight to the emergency room, and the staff there called her obstetrician. He arrived within a few minutes and was clearly shaken. Joe describes what happened then:

Maria was rushed to surgery and they wouldn't let me go with her. It seemed forever until the doctor came out again. Losing the baby was hard, but I began to realize that Maria might not make it. I felt like my life was falling apart.

Finally the doctor came out and told me he had done a laparoscopy to look inside her tubes and found an enormous amount of blood in Maria's abdomen. Her tube had burst from an ectopic pregnancy—it hadn't been a miscarriage after all. He had to remove what was left of the tube. I was so relieved that Maria was going to be okay. But at the same time I was angry. I couldn't understand why he hadn't done the laparoscopy days before and avoided all this.

Maria and Joe's experience is not that unusual, since ectopic pregnancies are often difficult to diagnose. Many times a woman does not even realize that she is pregnant, and the doctors may think that the pain is from pelvic infections or appendicitis. As in Maria's case, where the pregnancy is known, it may be assumed at first that the woman is experiencing a miscarriage. In very rare cases, an ultrasound shows a sac in the uterus suggesting a normal pregnancy, while a twin embryo is still caught in the tube.

Part of the difficulty with making a diagnosis is that the

symptoms of an ectopic pregnancy are not always the same. Some women have bleeding, others do not. The type of pain varies and may occur in different parts of the abdomen and even in the shoulders. Pregnancy tests are sometimes inaccurate. Recently developed tests are more sensitive and are able to pick up the low levels of the hormone HCG which are present with an ectopic pregnancy. Physicians now rely on the combined use of these newer sophisticated pregnancy tests and on ultrasound to see if there is a sac growing in the uterus. However, these tests may have to be repeated several times before a diagnosis is confirmed. Laparoscopy is an invasive procedure carried out under general anesthesia which allows the physician to visualize the tubes and obtain the most definitive diagnosis. It isusually done only when a uterine pregnancy is ruled out and anectopic pregnancy strongly suspected.

Because diagnostic techniques have improved and physicians are much more likely now to be checking for ectopic pregnancy, the chance of a tube rupturing has declined somewhat. If a rupture occurs, being able to assess quickly what is happening has greatly improved the chances of survival. Even so, misdiagnosis is a major reason that as many as forty women a year die from ectopic pregnancy in the United States.

Maria realized that her life had been in danger and felt fortunate to be recovering well from the surgery. She had many questions that bothered her, though:

I couldn't stop asking myself why this had happened to me, why the baby hadn't been able to grow in my uterus. What had gone wrong? My doctor explained that ectopic pregnancy is often a result of an earlier pelvic infection. I may have had an infection at some time and not even realized it. Maybe that's why I had a hard time getting pregnant, but no one seems to know for sure. I always felt so healthy, I couldn't believe this was happening to me. It's ironic—the doctor said that just two inches further and the embryo would have made it to the uterus and I would have had a healthy baby. Just two inches!

A good explanation of why an ectopic pregnancy might occur appears in Alan Guttmacher's book *Pregnancy, Birth, and Family Planning:*

> The interior of the tube is a complex labyrinth with many folds in its lining. It is not surprising that an occasional embryo loses its way, becomes stuck in the maze, and makes efforts to implant there. However, the association of ectopic pregnancy with previous tubal infection makes it likely that adhesions among the folds of the lining of the tube, due to the infection, create pockets in which the embryo is trapped.

The rise in ectopic pregnancy has been blamed in part on the national increase in PID—pelvic inflammatory disease—which is linked to sexually transmitted diseases such as gonorrhea. Infection may come from other causes as well, for example, previous abdominal surgery or intrauterine devices.

In the past, undiagnosed or untreated infections often resulted in tubes being totally blocked. With better diagnosis and the rise of antibiotics, tubes are now likely to be saved, but the scarring that remains increases the chance of ectopic pregnancy.

Other conditions besides PID may cause ectopic pregnancy: having a mother who took DES during her pregnancy, trying in vitro (test tube) fertilization, or having endometriosis. Sometimes a woman who had her tubes tied (tubal ligation) becomes pregnant and the embryo gets caught in the tube. A growing number of women are attempting to reverse tubal ligations, and this may also contribute to the increased rates. Various hormone treatments may increase the possibility of an ectopic pregnancy. As women get older, they have more time to be exposed to one of these causes, and their chance of having an ectopic pregnancy increases. Black women have almost twice the rate of white women. In fact, black women thirty-five and older have five times the rate of white women under the age of twenty-five.

All of the factors which contribute to ectopic pregnancy have increased in the last two decades. It is not surprising, then, that the rate of ectopics rose from one-half of one percent in 1970 to almost two percent in 1983, the latest year for which the numbers are available. This represents a dramatic increase from 17,800 a year to 69,600 in one year.

With the growing concern about the dangers of ectopic pregnancy, people may lose sight of the feelings of loss experienced by the parents. It is a confusing time for many people; especially

if they were not even aware of the pregnancy, the loss of a baby may seem less important than the trauma of the actual event. For some, the worries about fertility are foremost in their minds. Maria explained her reaction:

> For many months after the ectopic I had a very hard time. Although Joe was sympathetic, I still felt totally alone. I just cried and cried. Everyone else was so relieved that I had survived that they didn't want to think that there was a baby there. I feel so empty now, missing that baby I could have had, still wondering what I might have done to cause this. I had slept with other men before I met Joe. Was God punishing me for what I thought was fine then?

Joe was quiet but he had strong feelings about the loss:

> My first reaction was to want to run away. When I left the hospital, I thought, I have money in my pocket and a full tank of gas, I'll just take off. But I knew I couldn't do that. For a while I thought I was going crazy. It was too much to take—within a week we had gone from being completely happy to a feeling of despair. What kept me going was the gratefulness I felt that Maria's life had been spared and the hope that some day we might be able to have another child.

Worries about being able to become pregnant again are a major concern for families who have been through an ectopic pregnancy. In some cases both tubes are removed. Even when one remains, the chances of a normal pregnancy are greatly reduced, and the possibility exists for an ectopic pregnancy to occur in the other tube. There are no exact numbers, but the studies which have been done found that between one-third and one-half of women who have had an ectopic pregnancy eventually have a baby. The possibility becomes smaller with each subsequent ectopic pregnancy. These numbers may improve somewhat due to the availability of *in vitro* fertilization, but the success rate of this procedure is still low.

Newer surgical methods such as salpingostomy are making it possible to save the fallopian tube if it did not rupture. So far it has not been established whether this method increases the chances

of a successful pregnancy compared to those of women who have had one tube removed (in a procedure called salpingectomy). Some physicians are trying drugs to dissolve the embryo in order to avoid surgery. However, this is still experimental.

An ectopic pregnancy is a traumatic event, both physically and emotionally. It often leads to infertility and all of the stresses associated with fertility decisions and treatments. At the same time, the parents are grieving for their baby, just as other parents do who have experienced a loss. They are sad for the past and fearful for the future.

Maria and Joe consider themselves to be very fortunate. After a year of treatment to help her ovulate, Maria conceived again. She watched carefully for any sign of pain or bleeding, and Joe checked constantly to make sure she was okay. When they saw on an ultrasound that the baby was growing normally in Maria's uterus, they were thrilled. Their celebration of the pregnancy was more subdued this time, however, until Christopher was born.

Joe says now what many others who have experienced a loss also feel:

> When we think about that time, we realize how young and naive we were. We thought nothing could hurt us. Now we have a much greater appreciation of life, of Christopher, and of each other. We don't take our family for granted anymore.

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Prenatal Diagnosis and the Unwanted Abortion

"When God made all the decisions, women had no choice but to accept them. If an Act of God gave you a defective child you learned to live with perpetual grief. But there was little guilt or spiritual laceration. Now, however, that science and technology tell mothers they do not have to accept that fate, the Act of God is transformed into an act of her own. The decisions she may have to make can be harrowing."

Jessie Bernard,
The Future of Motherhood

In the past, if a husband and wife were aware of a genetic problem in the family, they often avoided having any children at all. The fear of having an abnormal baby outweighed their desire for children, and they suffered the sorrow of not raising the family they wanted. If a couple gave birth to a deformed child, they accepted him or her as best they could.

Yet in the past two decades the technological capability for prenatal diagnosis has developed at an extremely rapid rate, and, since 1973, legal abortion during the first part of a pregnancy has become available to most women. A diagnosis of abnormalities can thus be followed by an abortion (referred to as a selective abortion). As a result, a whole new set of options, experiences, decisions, and controversies has arisen in recent years.

In addition to the many practical and financial problems involved in prenatal diagnosis, parents suffer the emotional stress