Letters to the Editor

Ultrasound diagnosis of ectopic pregnancy

Sir,

It is with great interest that I read the recent article by Dr Condous evaluating the diagnosis of women at risk for ectopic pregnancy (Condous et al. 2006). The methods modelling the outcomes of patients using a number of protocols advocated to diagnose a pregnancy of unknown location are sound. However, I disagree with his conclusion that ‘there is no role of uterine curettage in the contemporary diagnostic workup of women with a pregnancy of unknown location’.

What Dr Condous has very convincingly demonstrated is that some of the rules used in protocols designed to define viability are too strict. I agree. There is an evolving literature demonstrating that there are pitfalls in the diagnosis of women at risk for ectopic pregnancy. The use of a low discriminatory zone may increase the sensitivity of the diagnosis of ectopic pregnancy but will sacrifice specificity, resulting in potential interruption of a viable gestation if the intervention is premature. Thus, clinicians should be using a relatively high discriminatory zone rather than a low discriminatory zone (Seeber and Barnhart, 2006).

Perhaps of greater importance is the clinical rule defining a viable gestation using serial hCG values. We have established that the 99% confidence interval surrounding the normal curve of a viable pregnancy presenting with pain and bleeding is a 52% rise in 2 days (Barnhart et al., 2004), not the 66% rise derived by Kadar in the mid 1980s (Kadar and Romaro, 1988). There are reports demonstrating potentially viable intrauterine pregnancies with a slope as low as 30% (Seeber et al., 2006). The data presented by Dr Condous confirm that with conservative definitions of non-viability, the chance of interrupting a viable gestation can be minimized to <1% (protocol 4) or to 0% (protocol 1), but a uterine evacuation is still necessary in 54–58% of cases.

Dr Condous’ fine work improving the ultrasound diagnosis of an early ectopic gestation will ultimately limit the number of times a uterine curettage is necessary. However, this expertise is not evident in all clinical units. Moreover, his data do not negate the fact that a true non-viable pregnancy of unknown location still has only two possible outcomes: Spontaneous abortion and ectopic pregnancy. Assuming the presence of either can result in over-treatment with methotrexate or can put a woman at risk for rupture.

The morbidity and mortality of ectopic pregnancy have declined because of good clinical care and surveillance. A conservative approach in delaying intervention until the possibility of a viable pregnancy is clearly warranted. The possibility of rupture needs to be weighed against the possibility of interrupting an intrauterine pregnancy. If the possibility of viability has been eliminated, a uterine curettage is often a valuable tool in the diagnosis and treatment of women at risk for an ectopic pregnancy. I advocate making a definitive diagnosis whenever possible to reduce disease- and treatment-related morbidity.

I congratulate Dr Condous on this presentation of an excellent data set that advances the evaluation of women with a pregnancy of unknown location. It is unfortunate that Dr Condous’ bold statements in the title, abstract and discussion are misleading. My interpretation of the data presented is that we need to be more conservative in our rules defining a non-viable pregnancy.

References


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