Letter to the Editor

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Where the Pendulum of Expectant Management of Ectopic Pregnancy Should Rest?

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Dear Sir,

By reporting successful surgical treatment of tubal pregnancy in the British Medical Journal in 1884, Robert Lawson Tait (1845-1899) [1] made a revolutionary statement recommending the adoption of extirpative treatment of ectopic pregnancy. Enormous progress has been made during the twentieth century in the management of ectopic pregnancy. Preservation of future fertility became possible with the introduction of conservative surgical procedures, expectant management, and the use of methotrexate [2]. However, in spite of the progress, the optimal treatment of ectopic pregnancies remains far from satisfactory. The question of expectant management is a difficult one, especially because there is a recent trend to treat tubal pregnancies more conservatively. It is usually accepted that if the patient with a presumptive ectopic pregnancy and declining β -subunit of human chorionic gonadotropin (β hCG) is asymptomatic or has only mild discomfort, surgery is unnecessary and expectant management is warranted [3]. However, tubal rupture could occur with declining and low β hCG levels [4] and with any initial level [5]. Therefore, the distinction between patients with unruptured ectopic pregnancies that will undergo spontaneous resolution or are destined to rupture is a primary goal in the management of ectopic pregnancy. Recently, some attempts were made towards resolution of this quandary. One study suggested that expectant management could be offered in declining β hCG levels only with an initial β hCG of $< 2,000$ mIU/ml [6]. Another study has shown that expectant management is more

successful in patients with an initial β hCG of $< 1,000$ mIU/ml [7].

Since 1990, a conservative treatment protocol [8] has been used in our department. Between January 1, 1990 and October 31, 1993, 173 patients were treated in accordance with our protocol. Briefly, symptomatic patients were treated surgically; patients with declining β hCG, irrespective of the initial level, entered expectant management, and patients with rising levels of β hCG were treated surgically when the β hCG level rose above 2,500 mIU/ml (2nd International Standard). The cutoff point for β hCG of 2,500 mIU/ml was set based upon our previous retrospective analysis of 134 consecutive patients with tubal pregnancies [5]. We had 60 patients with declining β hCG, spontaneous resolution occurred in 37 (61.6%) and 23 (38.3%) failed to escape surgical treatment. The initial level of β hCG in patients with spontaneous resolution was $1,758.8 \pm 1,528.3$ mIU/ml (range 210-6,000), while in the failure group it was $7,620.0 \pm 6,300.9$ mIU/ml (range 2,500-18,600).

Our experience is in agreement with previous data [4, 6, 7] that expectant management of ectopic pregnancy with declining β hCG levels should be carried out only in patients fulfilling the criteria for good prognosis. Good prognosis in our experience is an initial β hCG level of $< 2,500$ mIU/ml (2nd International Standard). In conclusion, in order to cease the swing of the pendulum of ectopic pregnancy management, a prospective, randomized multicenter, clinical trial comparing all the available alternative treatments is needed.

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