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LETTERS

NICE ON ECTOPIC PREGNANCY AND MISCARRIAGE

Authors' reply to Bourne and colleagues

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In response to Bourne and colleagues' comments[1]:

1 The guideline development group (GDG) recommended that women with a pregnancy of uncertain gestation, in pain, or at greater than six weeks' gestation be referred to an early pregnancy service. We felt that immediately referring all women with bleeding but no pain at less than six weeks' gestation would result in unnecessary and uninformative scans, but agreed that women with continuing or worsening symptoms should be referred to exclude ectopic pregnancy. The recommendation that most women see another clinician before referral aimed to ensure that resources are targeted to optimise care of women with early pregnancy complications.

2 The GDG recommended serum human chorionic gonadotrophin (HCG) measurements as a triage tool, to focus surveillance on women at higher risk of ectopic pregnancy. However, we emphasised that symptoms take precedence over biochemical tests and that locating the pregnancy was important for women with high HCG ratios, which is why a repeat scan was recommended.

3 Health economic analysis is vital in ensuring appropriate allocation of resources. The GDG felt that the associated benefits of negating the risk of terminating a viable pregnancy and avoiding intervention meant that expectant management for a defined period would be acceptable or preferable for many women. However, expectant management is not always appropriate and the guideline details when other treatments should be offered.

4 The GDG agreed that few units have the capacity to safely manage ectopic pregnancies expectantly and therefore other topics were prioritised. Methotrexate is recommended under specific circumstances, including the absence of an intrauterine pregnancy on ultrasound. To avoid misdiagnosis, it is recommended that serum HCG is not used to determine pregnancy location and scans are interpreted by clinicians experienced in diagnosing ectopic pregnancy.

5 The GDG made recommendations that accounted for variation in scanning ability, including recommending a second opinion or repeat scan. We support calls for improved training; however, National Institute for Health and Clinical Excellence guidelines generally do not consider matters that are the responsibility of professional organisations.

6 The GDG did not feel that seven day cover would have large financial implications. We did not foresee a 24 hour service and anticipated that multiple units could cooperate to provide cover.

7 Recommending that women can access early pregnancy services seven days a week does not imply that units operating five day services would be closed. The recommendations merely indicate that systems should be operational to enable women to access other facilities when they are not open.

Further details are available in the full version of the guideline on the NICE website (http://guidance.nice.org.uk/CG154/Guidance).

Competing interests: See www.bmj.com/content/345/bmj.e8136.

Full version at www.bmj.com/content/345/bmj.e8136/rr/624254.

1 Bourne T, Barnhart K, Benson CB, Brosens J, Van Calster B, Condous G, et al. NICE guidance on ectopic pregnancy and miscarriage restricts access and choice and may be clinically unsafe. *BMJ* 2013;346:f197.

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