

Fertility After Ectopic Pregnancy

Natural Conception, One Remaining Fallopian Tube, Recurrent Ectopic Pregnancy, Tubal Damage, IVF and an Integrative Unani Approach

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A Message I Give Every Patient After an Ectopic Pregnancy

When a woman comes to me after an ectopic pregnancy, one of her first questions is usually:

“Doctor, can I become pregnant normally again?”

Another patient asks:

“One fallopian tube has been removed. Does that mean I now need IVF?”

Some women are afraid to become pregnant again because they worry:

“What if the next pregnancy is also ectopic?”

These concerns are completely understandable.

An ectopic pregnancy can be physically dangerous, emotionally traumatic and frightening for someone hoping to have a child.

But my first message to most patients is reassuring:

Having one ectopic pregnancy does not mean you have lost your fertility.

Most women can still achieve another pregnancy, and the probability of the next pregnancy developing normally inside the uterus is substantially greater than the probability of another ectopic pregnancy.



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RCOG currently states that future pregnancy prospects are generally good and that, even after removal of one fallopian tube, natural conception is only slightly reduced when the remaining tube is healthy.

However, an ectopic pregnancy is also an important **fertility warning sign** because it can indicate underlying disease of the fallopian tubes.

Therefore, fertility after an ectopic pregnancy should not be judged simply by asking:

“Was the tube removed or saved?”

I want to know:

Why did the ectopic pregnancy happen?

What condition is the other fallopian tube in?

Was there previous pelvic inflammatory disease?

Is endometriosis present?

Was infertility already present before the ectopic pregnancy?

How old is the woman?

What is the male partner's fertility status?

Those questions determine future fertility much more accurately.

What Is an Ectopic Pregnancy?

An ectopic pregnancy occurs when a fertilized egg implants somewhere outside the normal cavity of the uterus.

More than 90% of ectopic pregnancies occur in a:

Fallopian Tube

and are therefore called:

Tubal Ectopic Pregnancies.

Less commonly, ectopic implantation can occur in sites such as:

- the cervix,
- cesarean-section scar,
- ovary,
- abdominal cavity,



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- interstitial or cornual region.

An ectopic pregnancy cannot develop normally into a viable baby and, if untreated, can rupture and cause severe internal bleeding.

ACOG describes tubal rupture as a potentially life-threatening emergency requiring urgent medical or surgical treatment.

Why Does an Ectopic Pregnancy Occur?

For pregnancy to develop normally, several events must occur.

After ovulation:

1. the egg enters the fallopian tube;
2. sperm travel through the uterus into the tube;
3. fertilization usually occurs in the tube;
4. the early embryo travels toward the uterus;
5. it enters the uterine cavity and implants.

If the tube has been damaged or its normal movement has been disturbed, the embryo may not reach the uterine cavity in time.

It can implant within the tube instead.

The Fallopian Tube Is More Than a Hollow Pipe

Patients often imagine the fallopian tube as a simple open tube.

It is much more sophisticated.

Inside it are delicate cells and microscopic cilia that participate in transporting:

- sperm,
- egg,
- early embryo.

Therefore, a fallopian tube can sometimes appear “open” while functioning imperfectly.

Previous inflammation or surgery can affect:

- ciliary movement,
- muscular contractions,



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- internal architecture.

This is one reason ectopic pregnancy can occur even when there is no obvious complete blockage.

Major Risk Factors for Ectopic Pregnancy

Current ACOG guidance identifies several important risk factors, including:

- previous ectopic pregnancy,
- previous fallopian-tube surgery,
- previous abdominal or pelvic surgery,
- pelvic inflammatory disease,
- certain sexually transmitted infections,
- endometriosis,
- cigarette smoking,
- infertility,
- assisted reproductive technology such as IVF,
- maternal age above 35.

A 2025 systematic review and meta-analysis similarly found strong associations between ectopic pregnancy and previous ectopic pregnancy, PID, infertility and previous abdominal or pelvic surgery.

Importantly:

many women with ectopic pregnancy have no identifiable risk factor.

ACOG estimates that approximately half have no recognized risk factor beforehand.

Therefore, an ectopic pregnancy should never automatically be interpreted as proof that a woman had a previous infection or did something wrong.

Previous Pelvic Inflammatory Disease

Pelvic inflammatory disease—PID—is particularly important because inflammation can scar the fallopian tubes.

PID may follow infection with organisms such as:



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- chlamydia,
- gonorrhea,

along with other reproductive-tract organisms.

Tubal scarring can both:

- reduce fertility,
- increase the risk that a fertilized embryo implants inside the tube.

ACOG identifies PID-related tubal scarring as an important cause of both infertility and ectopic pregnancy.

Endometriosis

Endometriosis can affect fertility through several mechanisms.

It may produce:

- pelvic inflammation,
- adhesions,
- distortion of the normal relationship between the ovary and tube.

ACOG includes endometriosis among the recognized ectopic-pregnancy risk factors.

Therefore, an ectopic pregnancy in a woman with severe endometriosis may represent part of a broader fertility problem rather than an isolated event.

Previous Tubal Surgery

Previous surgery involving the fallopian tubes can increase ectopic-pregnancy risk.

Examples include:

- previous ectopic surgery,
- tubal reconstruction,
- sterilization procedures.

Any procedure that changes normal tubal anatomy can potentially influence embryo transport.

Smoking



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Smoking has also been associated with ectopic pregnancy.

The mechanism may involve effects on:

- tubal movement,
- ciliary function.

A woman wishing to conceive after an ectopic pregnancy should therefore be strongly encouraged to stop smoking if she currently smokes.

It reduces an avoidable reproductive risk even though it cannot eliminate ectopic pregnancy completely.

Infertility Itself Is a Risk Factor

Women who already have difficulty conceiving have a higher ectopic-pregnancy risk.

This may partly occur because the underlying cause of infertility—such as tubal disease—is also a risk factor for ectopic implantation.

Therefore, when a woman who previously struggled with infertility experiences an ectopic pregnancy, I do not assume that treating the ectopic has corrected the original infertility problem.

Can IVF Cause an Ectopic Pregnancy?

IVF reduces dependence on the fallopian tubes because fertilization takes place in the laboratory and the embryo is placed inside the uterus.

However:

IVF does not reduce ectopic-pregnancy risk to zero.

Assisted reproductive technology is itself associated with an increased ectopic-pregnancy risk compared with spontaneous conception in some populations.

Therefore, even after IVF, women with previous ectopic pregnancy deserve early confirmation that the pregnancy has implanted inside the uterus.

Symptoms of an Ectopic Pregnancy

Early ectopic pregnancy may initially resemble any normal pregnancy.

There may be:



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- missed period,
- breast tenderness,
- nausea,
- positive pregnancy test.

Possible warning symptoms include:

- vaginal bleeding,
- lower abdominal pain,
- one-sided pelvic pain,
- lower back pain.

More concerning symptoms of rupture can include:

- sudden severe abdominal or pelvic pain,
- shoulder-tip pain,
- dizziness,
- weakness,
- fainting.

These require urgent medical attention.

Why Ectopic Pregnancy Matters for Future Fertility

An ectopic pregnancy can influence future fertility in several different ways.

First

The underlying disease that caused the ectopic pregnancy may already have damaged the tubes.

Second

The ectopic pregnancy itself may damage the affected tube.

Third

Emergency surgery may sometimes require removal of that tube.

Fourth

Previous ectopic pregnancy increases the risk of another ectopic pregnancy.



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But these facts should not automatically be translated into:

“You will be infertile.”

That conclusion is usually incorrect.

What Is the Chance of Another Ectopic Pregnancy?

After one ectopic pregnancy, the risk of another one increases.

RCOG currently estimates the recurrence risk at approximately:

7–10%

after a previous ectopic pregnancy.

For comparison, the general UK pregnancy population risk is just over 1%.

This means something very important:

after one ectopic pregnancy, another ectopic pregnancy is possible—but a normal intrauterine pregnancy remains much more likely.

That is the message I want patients to remember.

Why Does Recurrence Risk Increase?

The reason is usually not that the body has “learned” to make ectopic pregnancies.

Rather, some of the underlying risk factors may still be present.

For example:

- the remaining tube may have previous inflammation,
- PID may have affected both tubes,
- endometriosis may remain,
- previous surgery may have altered pelvic anatomy.

This is why understanding the original cause matters.

How Does a Previous Ectopic Pregnancy Affect Fertility?

Future fertility depends strongly upon:

- the condition of the opposite tube,



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- previous infertility,
- underlying tubal disease,
- female age,
- ovarian reserve when relevant,
- male fertility.

Research examining reproductive outcomes after ectopic pregnancy has consistently found the health of the contralateral—opposite—fallopian tube to be one of the most important determinants of future fertility.

Can I Become Pregnant Naturally With One Fallopian Tube?

Yes.

This is one of the most important points in the article.

A woman does not need two fallopian tubes in order to conceive naturally.

If:

- at least one ovary functions,
- ovulation occurs,
- the remaining tube is healthy,
- sperm parameters are adequate,

natural pregnancy may still occur.

RCOG states that the chance of conception is only **slightly reduced** when one tube remains healthy.

Does the Egg Have to Come From the Ovary on the Same Side?

Not always.

The reproductive system is not as rigidly divided as:

“right ovary → right tube”

and

“left ovary → left tube.”

The remaining fallopian tube can sometimes capture an egg released from the opposite ovary.



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Therefore, removal of one tube does not necessarily mean conception is possible only every second month.

This is another reason women with one healthy tube may still conceive naturally.

One Fallopian Tube Does Not Automatically Mean IVF

I frequently see patients who have been told:

“One tube has been removed, so IVF is your only option.”

That is not automatically correct.

If the remaining tube is healthy and the other fertility factors are favourable, natural conception may still be entirely reasonable.

IVF becomes more relevant when:

- the remaining tube is blocked,
- severe tubal damage exists,
- hydrosalpinx is present,
- age makes waiting less advisable,
- another major infertility factor exists.

Fertility After Salpingectomy

Salpingectomy

means surgical removal of the affected fallopian tube.

NICE guidance recommends salpingectomy for women requiring surgery for ectopic pregnancy when the other tube appears healthy and there are no additional major infertility risk factors.

This recommendation can surprise patients.

They often think:

“Surely saving the affected tube must always give me better fertility.”

But that is not necessarily true.

If the tube containing the ectopic pregnancy is badly damaged and the opposite tube is healthy, retaining a damaged tube may provide little fertility advantage while leaving a greater risk of:



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- persistent ectopic tissue,
- future ectopic pregnancy.

Does Removing One Tube Cut Fertility in Half?

No.

Human fertility does not operate that simply.

Removing one tube does not mean:

“50% fertility.”

When the other fallopian tube is healthy, RCOG describes the reduction in natural conception chances as only slight.

The condition of the remaining tube matters much more than simply counting whether there are:

- one,
- two tubes.

Fertility After Salpingotomy

Salpingotomy

or salpingostomy means opening the affected fallopian tube and removing the ectopic pregnancy while attempting to preserve the tube.

This may be considered when fertility would otherwise be seriously compromised—for example when:

- the opposite tube is damaged,
- there is only one functional tube.

NICE specifically recommends considering salpingotomy instead of salpingectomy when other infertility risk factors such as contralateral tubal damage are present.

Does Salpingotomy Always Preserve Fertility Better?

No.

This is important.



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Preserving the anatomical tube does not necessarily mean preserving normal tubal function.

A tube that has already developed an ectopic pregnancy may be:

- scarred,
- inflamed,
- structurally abnormal.

Randomized evidence summarized in systematic reviews has not shown a clear long-term intrauterine-pregnancy advantage for salpingotomy compared with salpingectomy when the opposite tube is healthy.

This is why removal of a badly affected tube is often reasonable when the other tube is normal.

Salpingotomy Has an Important Disadvantage

After salpingotomy, pregnancy tissue may sometimes remain inside the tube.

This is called:

Persistent Trophoblastic Tissue.

NICE advises women undergoing salpingotomy that up to approximately:

1 in 5

may require further treatment with:

- methotrexate,
- or later salpingectomy.

For this reason, hCG must be followed until appropriately negative.

Fertility After Methotrexate Treatment

Some early, stable ectopic pregnancies can be treated medically with:

Methotrexate.

Methotrexate stops rapidly dividing pregnancy tissue from continuing to grow.

The pregnancy is then gradually absorbed.



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A major advantage is that surgery—and therefore surgical removal of the tube—may be avoided.

Does Methotrexate Damage Future Fertility?

Available evidence is reassuring.

RCOG states that methotrexate treatment for ectopic pregnancy is **not known to reduce the ovaries' future ability to produce eggs.**

Studies of women undergoing assisted reproduction before and after ectopic-pregnancy methotrexate have similarly found no meaningful reduction in:

- ovarian reserve,
- antral follicle count,
- egg retrieval,
- fertilization,
- subsequent ART outcomes.

Therefore:

methotrexate should not be viewed as a medicine that permanently damages the ovaries when appropriately used for ectopic pregnancy.

Methotrexate Does Not Guarantee the Tube Is Normal

This distinction is equally important.

Avoiding surgery preserves the tube anatomically.

But the original condition that allowed the ectopic pregnancy to develop may still be present.

Therefore, methotrexate treatment does not prove that:

- the tube is healthy,
 - another ectopic pregnancy cannot occur.
-

When Can Pregnancy Be Attempted After Methotrexate?

Current RCOG guidance advises waiting approximately:



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3 months

after methotrexate treatment before trying for another pregnancy.

NHS guidance provides the same recommendation because methotrexate interferes with folate metabolism and can harm a developing embryo if conception occurs too soon after treatment.

This is different from simply waiting until the first period returns.

Patients should follow the specific advice given by the team that administered methotrexate.

What About Folic Acid After Methotrexate?

Folic acid is generally avoided while methotrexate is actively treating the ectopic pregnancy because it may interfere with the medicine's action.

After treatment has been completed and hCG follow-up is satisfactory, preconception folate can be restarted according to the treating clinician's advice.

Women should not restart supplements during active methotrexate treatment without discussing this with their healthcare team.

When Can Pregnancy Be Attempted After Surgery?

There is no one universally proven interval suitable for every woman.

RCOG emphasizes waiting until the woman feels:

- physically recovered,
- emotionally ready.

In routine practice, NHS guidance commonly advises waiting until approximately **two menstrual periods** have occurred following non-methotrexate treatment before trying again.

The appropriate interval may differ if there were:

- surgical complications,
- severe blood loss,
- infection,
- additional reproductive surgery.



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The operating gynecologist's advice should take priority.

Fertility After Expectant Management

Some small, stable ectopic pregnancies resolve without:

- methotrexate,
- surgery.

This is called:

Expectant Management.

The patient requires careful serial monitoring, particularly with:

- hCG measurements,
- clinical observation.

Once the ectopic pregnancy has completely resolved, future fertility can still be good.

The underlying condition of the tube—not simply the fact that expectant management was used—remains important.

Treatment Method Is Not the Only Determinant of Fertility

Patients often ask:

“Which treatment gives the best future fertility?”

The answer cannot be based only on:

- methotrexate,
- salpingectomy,
- salpingotomy.

A systematic review comparing management approaches found differences in observational pregnancy rates, but treatment groups also differ in disease severity and patient selection; the underlying health of the reproductive tract remains extremely important.

In clinical practice, some of the strongest determinants are:

- health of the opposite tube,
- previous infertility,



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- age,
- other pelvic disease.

What About an Ectopic Pregnancy After IVF?

If the ectopic pregnancy occurred after IVF, the next treatment plan should review:

- tubal anatomy,
- presence of hydrosalpinx,
- uterine cavity,
- embryo-transfer history.

If significant hydrosalpinx is present, treatment of the hydrosalpinx before another embryo transfer may improve the implantation environment.

The updated **2026 NICE fertility guideline** recommends laparoscopic salpingectomy or tubal occlusion for hydrosalpinges before IVF.

What Is Hydrosalpinx?

A hydrosalpinx is a severely damaged fallopian tube that becomes:

- blocked,
- dilated,
- filled with fluid.

Common causes include:

- pelvic inflammatory disease,
- previous infection,
- previous tubal surgery.

Hydrosalpinx can reduce natural fertility because the tube functions poorly.

It can also reduce IVF success because fluid from the damaged tube may enter the uterine cavity and interfere with implantation.

Hydrosalpinx Before IVF



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The 2025 WHO infertility guideline and updated NICE guidance recommend treatment of significant hydrosalpinx before IVF in appropriate patients.

Possible approaches include:

- salpingectomy,
- tubal occlusion.

The exact approach depends on:

- adhesions,
- surgical accessibility,
- ovarian blood supply,
- previous operations.

Should Every Woman Have an HSG After an Ectopic Pregnancy?

No.

Not every woman needs immediate tubal testing simply because she has experienced one ectopic pregnancy.

If she has:

- one healthy-looking remaining tube,
- no previous infertility,
- younger reproductive age,
- no major tubal risk factors,

a period of natural attempts may be reasonable.

However, earlier tubal assessment becomes more relevant when there is:

- previous PID,
- endometriosis,
- previous infertility,
- recurrent ectopic pregnancy,
- known damage to the other tube,
- difficulty conceiving afterward,
- older reproductive age.



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HSG After Ectopic Pregnancy

Hysterosalpingography — HSG

is an X-ray examination in which contrast is introduced into the uterus.

It can help determine whether the remaining tube is:

- open,
- blocked,
- dilated.

It can also reveal some features of tubal architecture.

The **2025 WHO infertility guideline recommends either HSG or HyCoSy for women with infertility and suspected tubal disease.**

HyCoSy

Hysterosalpingo-Contrast Sonography — HyCoSy

uses:

- ultrasound,
- contrast medium

rather than conventional X-ray imaging.

It can assess whether contrast passes through the fallopian tubes.

WHO considers HSG and HyCoSy acceptable alternatives depending upon:

- expertise,
- availability,
- allergy considerations.

Does an Open Tube Mean a Normal Tube?

Not necessarily.

This is one of the limitations of tubal-patency testing.

An HSG may tell us:



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“Contrast passed through.”

That does not prove that the tube's:

- cilia,
- muscular function,
- internal architecture

are completely normal.

Therefore, a woman can theoretically have a patent tube and still remain at increased ectopic-pregnancy risk.

Role of Laparoscopy

Laparoscopy can directly evaluate:

- fallopian tubes,
- adhesions,
- endometriosis,
- pelvic anatomy.

It is more invasive than HSG or HyCoSy and is not routinely required in every patient.

Updated NICE fertility guidance notes that laparoscopy with dye can be especially useful when important comorbidities such as:

- previous ectopic pregnancy,
- PID,
- endometriosis

make pelvic pathology more likely and laparoscopy is clinically justified.

When Should Fertility Be Investigated?

After an ectopic pregnancy, I individualize the timing.

I do not necessarily tell every woman:

“Try for one year first.”

A previous ectopic pregnancy is already a clue that tubal-factor fertility may deserve attention.



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Earlier investigation becomes especially appropriate when:

- the remaining tube is known to be abnormal,
- the woman is 35 or older,
- previous infertility existed,
- PID or severe endometriosis is present,
- more than one ectopic pregnancy has occurred.

ASRM recommends initiating infertility assessment without unnecessary delay when there is a known condition associated with infertility.

If the Remaining Tube Is Healthy

If:

- the woman is relatively young,
- cycles are regular,
- the remaining tube appears healthy,
- the male partner's semen is satisfactory,

natural conception may remain the most appropriate first approach.

IVF does not need to be started simply because one tube was removed.

If the Remaining Tube Is Blocked

If the remaining fallopian tube is seriously blocked, natural fertilization may not be possible.

Treatment options depend upon:

- location of blockage,
- degree of tubal damage,
- woman's age,
- ovarian reserve.

Options may include:

- selected tubal surgery,
- IVF.



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Latest WHO Guidance on Tubal Infertility

The **2025 WHO global infertility guideline** provides useful age- and severity-based recommendations.

For women younger than 35 with **mild-to-moderate tubal disease**, WHO suggests that tubal surgery can be considered before IVF.

For women younger than 35 with **severe tubal disease**, IVF is generally preferred.

For women aged **35 or older with tubal infertility**, WHO generally favours IVF because waiting for surgery and subsequent natural conception may cost valuable reproductive time.

These recommendations are conditional and based on low-certainty evidence.

Individual counselling remains essential.

Why Age Matters After an Ectopic Pregnancy

Suppose two women each lose one fallopian tube.

Patient A

Age 25.

Other tube healthy.

No other infertility factor.

Natural conception may remain very favourable.

Patient B

Age 39.

Other tube mildly damaged.

Three years of infertility before the ectopic pregnancy.

The fertility strategy should be very different.

Age affects:

- egg quantity,
- egg quality,
- how long it is reasonable to continue low-probability treatment.



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Therefore, the number of tubes alone does not decide the treatment.

IVF After Ectopic Pregnancy

IVF can be extremely valuable after significant tubal damage.

During IVF:

- eggs are retrieved directly from the ovaries,
- sperm and egg are combined in the laboratory,
- an embryo is placed inside the uterus.

The fallopian tubes are therefore largely bypassed.

This makes IVF particularly useful when there is:

- bilateral severe tubal disease,
 - absent tubes,
 - severe hydrosalpinx after appropriate treatment.
-

If Both Fallopian Tubes Have Been Removed

Natural conception is not possible if both fallopian tubes have been completely removed because sperm and egg cannot meet naturally.

However:

the ovaries can still produce eggs.

If the uterus and ovaries are otherwise suitable, IVF can allow pregnancy by:

- retrieving eggs directly from the ovaries,
- creating embryos in the laboratory,
- placing an embryo inside the uterus.

Therefore:

absence of both fallopian tubes does not mean the woman cannot carry a pregnancy.

Does Removing the Tube Reduce Ovarian Reserve?

A correctly performed salpingectomy usually aims to preserve ovarian blood supply.



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However, the fallopian tube and ovary have anatomical vascular connections, so careful surgery is important, particularly:

- before IVF,
- when ovarian reserve is already reduced.

For most patients, one salpingectomy does not mean ovarian function has been lost.

Do I Need ICSI After an Ectopic Pregnancy?

Not because of the ectopic pregnancy itself.

ICSI is mainly used for indications such as:

- significant male-factor infertility,
- previous fertilization failure,
- selected laboratory circumstances.

If the sperm parameters are normal, tubal infertility alone does not automatically mean ICSI is required.

Conventional IVF may be appropriate.

Risk in the Next Pregnancy

Because recurrence risk is higher after one ectopic pregnancy, the next pregnancy should be monitored earlier than an ordinary pregnancy.

RCOG advises women with a previous ectopic pregnancy to contact a healthcare professional early and notes that an ultrasound at approximately:

6–8 weeks

may be offered to confirm that the pregnancy is developing inside the uterus.

This is one of the most important practical steps after a positive pregnancy test.

What Should I Do as Soon as the Pregnancy Test Is Positive?

After a previous ectopic pregnancy:

contact your gynecologist or early-pregnancy service early.

Depending upon the individual history, assessment may involve:



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- serial beta-hCG,
- early transvaginal ultrasound.

The purpose is to determine:

where the pregnancy is located.

Symptoms should not be awaited before seeking early advice.

Early Ultrasound

At very early gestational ages, an ultrasound may not yet show a pregnancy.

Therefore, timing matters.

RCOG suggests an early scan at approximately:

6–8 weeks

following a previous ectopic pregnancy.

Earlier evaluation may be necessary if:

- pain,
- bleeding,
- dizziness

develops.

Emergency Symptoms During the Next Pregnancy

A woman with previous ectopic pregnancy who becomes pregnant again should seek urgent medical care for:

- strong one-sided abdominal pain,
- severe pelvic pain,
- shoulder-tip pain,
- dizziness,
- fainting,
- heavy bleeding.

A history of ectopic pregnancy should always be mentioned to the emergency team.



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Does the Next Pregnancy Need to Be High Risk?

Not necessarily throughout the entire pregnancy.

Once an early ultrasound confirms a normally located intrauterine pregnancy, the specific danger of another tubal ectopic pregnancy for that pregnancy has largely been resolved.

Further antenatal care then depends on:

- maternal age,
- medical history,
- obstetric factors.

Can Another Ectopic Occur After IVF?

Yes.

Therefore, even after IVF:

do not assume that a positive pregnancy test automatically means an intrauterine pregnancy.

Early ultrasound remains appropriate, especially in women with:

- previous ectopic pregnancy,
- tubal disease.

What About Heterotopic Pregnancy?

A heterotopic pregnancy means there is:

- one pregnancy inside the uterus,
- another pregnancy outside the uterus

at the same time.

It is rare in natural conception but occurs more often after assisted reproductive treatment than in spontaneous pregnancy.

Therefore, finding an intrauterine pregnancy after ART does not always completely eliminate ectopic concerns if significant symptoms continue.

Urgent clinical assessment is still required when symptoms are suspicious.

Fertility After Recurrent Ectopic Pregnancy

A second ectopic pregnancy is understandably frightening.

The fertility assessment becomes more important because repeated ectopic pregnancy suggests substantial underlying:

- tubal disease,
- pelvic pathology.

The condition of any remaining tube should be assessed carefully.

IVF may become a much more attractive option when natural conception would expose the woman to repeated low-probability or high-risk attempts.

Emotional Recovery Matters

An ectopic pregnancy is not simply a “medical event.”

It is:

a pregnancy loss.

Many patients experience:

- grief,
- anxiety,
- fear of another pregnancy,
- guilt,
- anger,
- depression,
- sexual avoidance.

ACOG and NHS guidance recognize the emotional impact of ectopic pregnancy and the potential value of counselling or pregnancy-loss support.

I encourage patients to give emotional recovery the same seriousness as physical recovery.



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Fear of Intercourse After Ectopic Pregnancy

Some couples become afraid that intercourse itself caused the ectopic pregnancy.

It did not.

Once medical treatment is complete and the clinician confirms that intercourse is safe again, ordinary sexual activity does not “push” an embryo into the fallopian tube.

However, anxiety can create:

- reduced desire,
- painful intercourse,
- pelvic-floor tension,
- avoidance.

These problems may need separate sexual-health counselling.

Ectopic Pregnancy Is Not a Woman's Fault

Nothing about ectopic pregnancy should be used to blame the woman.

She did not cause the pregnancy to implant in the wrong location through:

- exercise,
- ordinary intercourse,
- work,
- travel,
- daily activity.

The event is usually related to biological and tubal factors that were outside her control.

The Unani Perspective on Fertility After Ectopic Pregnancy

As a physician trained in **Unani medicine** and working with patients with sexual disorders and infertility, I approach recovery after ectopic pregnancy as part of the patient's complete reproductive health.

Traditional Unani medicine gives importance to:

- **Mizaj**, or constitutional temperament,
- nutrition,



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- digestion,
- menstrual health,
- uterine wellbeing,
- sleep,
- physical recovery,
- emotional wellbeing,
- sexual health.

These areas can be particularly valuable after:

- pregnancy loss,
- surgery,
- anemia from bleeding,
- emotional distress.

However, ectopic pregnancy requires an extremely important medical distinction.

A current ectopic pregnancy is a potentially life-threatening condition.

It cannot be relocated into the uterus with:

- Unani medicine,
- herbs,
- massage,
- supplements.

Suspected or confirmed ectopic pregnancy requires appropriate modern gynecological management.

Unani Medicine Should Never Delay Ectopic Pregnancy Treatment

This needs to be stated clearly.

If a woman has:

- positive pregnancy test,
- pelvic pain,
- abnormal bleeding,



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- suspected ectopic pregnancy,

the priority is:

urgent diagnosis and evidence-based treatment.

Depending upon the case, treatment may involve:

- close expectant monitoring,
- methotrexate,
- surgery.

Attempting to treat an active ectopic pregnancy only with herbs or Unani medicines can delay necessary care and allow:

tubal rupture and life-threatening internal bleeding.

Where Unani Medicine May Be Useful

After the acute ectopic pregnancy has been safely resolved, individualized Unani supportive treatment may have a role in helping the patient's broader recovery.

Depending upon the individual, this can focus on:

- nutritional rehabilitation,
- digestive health,
- menstrual wellbeing,
- recovery after blood loss,
- general physical strength,
- sleep,
- anxiety,
- sexual confidence,
- overall reproductive health.

These are clinically meaningful goals.

Can Unani Medicine Repair a Damaged Fallopian Tube?

The responsible answer is:



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there is currently insufficient high-quality evidence that Unani medicine can reliably reverse severe fallopian-tube fibrosis or reconstruct a badly damaged tube.

A physically scarred tube is a structural reproductive problem.

If HSG, HyCoSy or surgery shows:

- severe tubal destruction,
- hydrosalpinx,
- complete obstruction,

a herbal medicine should not be presented as a guaranteed way to rebuild the tube.

Published Unani Evidence on Tubal Infertility

There is limited published Unani literature concerning tubal-factor infertility.

For example, a National Institute of Unani Medicine case report described conception after Unani treatment in a 25-year-old woman with unilateral tubal blockage.

This is interesting and supports further research.

However:

it was one case report.

The patient had **unilateral** blockage, meaning pregnancy could potentially occur through the opposite functioning tube.

Therefore, this report does not prove that the treatment anatomically reopened a scarred tube.

It certainly cannot be extrapolated to:

- bilateral severe tubal disease,
 - hydrosalpinx,
 - destroyed fimbriae.
-

How I Integrate Unani Medicine Responsibly

At Saira Health Care, my approach is not:

Unani versus modern fertility medicine.

My approach is:



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use each treatment where it is medically appropriate.

For example:

Active ectopic pregnancy

Requires evidence-based gynecological management.

Severe tubal damage

May require surgery or IVF.

Nutritional weakness, menstrual wellbeing and recovery

May be areas where individualized Unani supportive care can contribute.

Anxiety and sexual-health problems after pregnancy loss

Require compassionate reproductive and sexual-health management.

This is what I consider responsible integrative care.

Special Treatment Planning by Dr. Nizamuddin Qasmi

When a woman consults me after an ectopic pregnancy, I do not begin by prescribing a “fertility medicine.”

I first ask:

Where was the ectopic pregnancy located?

How was it treated?

Was methotrexate used?

Was salpingectomy performed?

Was salpingotomy performed?

How did the other fallopian tube look during surgery?

Was PID present previously?

Is endometriosis suspected?

Was infertility present before the ectopic pregnancy?

How old is the patient?

Are the menstrual cycles regular?

What is the ovarian reserve where appropriate?



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What does the husband's semen analysis show?

This allows me to estimate the actual reproductive situation rather than treating the history of ectopic pregnancy alone.

What “Special Treatment” Means at Saira Health Care

Specialized care means identifying which reproductive pathway offers the patient the best realistic opportunity.

It does not mean:

one medicine for every woman after ectopic pregnancy.

Consider several different patients.

Patient One: One Tube Removed, Other Tube Healthy

A 27-year-old woman underwent salpingectomy.

The opposite tube appeared completely healthy.

She has:

- regular ovulation,
- no previous infertility,
- normal semen analysis in her partner.

She may still have a very good chance of natural conception.

Immediate IVF may be unnecessary.

Patient Two: Methotrexate Treatment

A 30-year-old woman was treated successfully with methotrexate.

She has no known tubal disease.

She should:

- complete hCG follow-up,
- wait the recommended three months,
- then attempt pregnancy if otherwise appropriate.

Methotrexate itself should not make her believe her ovarian reserve has been damaged.



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Patient Three: Previous PID and Ectopic Pregnancy

A 31-year-old woman has:

- previous PID,
- one ectopic pregnancy,
- difficulty conceiving afterward.

I would have greater concern about bilateral tubal disease.

Tubal evaluation using:

- HSG,
- HyCoSy,

may be appropriate.

Patient Four: One Tube Removed and Other Tube Hydrosalpinx

This is very different.

Natural conception may be severely impaired.

If IVF is planned, the hydrosalpinx may first require:

- salpingectomy,
- tubal occlusion.

Current 2026 NICE guidance recommends treatment of hydrosalpinges before IVF.

Patient Five: Age 39 With Significant Tubal Disease

In this patient:

time is also a fertility factor.

Spending several years attempting low-probability reconstructive or empirical treatment may reduce ovarian-age-related fertility.

Current WHO guidance generally favours IVF for women aged 35 or older with significant tubal-factor infertility.

Patient Six: Ectopic Pregnancy Plus Male Infertility

Suppose the remaining fallopian tube is healthy.

But the male partner has:

- severe oligospermia.

The ectopic pregnancy is no longer the only fertility problem.

The couple needs a combined treatment plan.

This is why I repeatedly emphasize:

infertility belongs to the couple—not automatically to the woman.

Saira Health Care's Contribution to Sexual Disorders and Infertility

At **Saira Health Care**, our contribution in post-ectopic fertility care is centred on helping patients move from:

fear

to:

a structured reproductive plan.

We focus on several principles:

Do not assume one tube means infertility.

Do not assume saving a damaged tube always preserves fertility.

Do not repeatedly prescribe antibiotics when there is no active infection.

Do not promise that herbal medicine can rebuild severe tubal scarring.

Do not rush every patient directly into IVF when natural conception remains reasonable.

Do not delay IVF for years when severe tubal disease and reproductive age make it the more appropriate treatment.

This balanced approach is particularly important in infertility care.

Why the Male Partner Should Be Evaluated

If pregnancy does not occur, I recommend evaluating both partners.

The woman may have:

- one remaining tube,



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while the man may simultaneously have:

- low sperm concentration,
- poor motility,
- azoospermia,
- varicocele,
- sexual dysfunction.

ASRM recommends parallel evaluation of the male partner during infertility investigation where appropriate.

Treating only the tubal history could therefore miss half of the fertility problem.

Natural Pregnancy After Ectopic Pregnancy

For many patients, the most important message is:

natural pregnancy is often still possible.

RCOG specifically reassures women that future successful pregnancy prospects remain good after ectopic pregnancy, including for many women with only one fallopian tube.

The exact probability cannot be predicted from one number because it depends upon:

- age,
 - tube health,
 - previous fertility,
 - ovulation,
 - sperm.
-

What I Tell Patients Who Are Afraid to Try Again

I often tell patients:

“Your fear is understandable, but one ectopic pregnancy does not mean every future pregnancy will be ectopic.”

The recurrence risk is approximately:

7–10%.



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This means the chance that the next conception is **not** ectopic is much greater.

What changes is not whether pregnancy should ever be attempted.

What changes is:

how early we monitor the next pregnancy.

What I Tell Patients About One Remaining Tube

I explain:

“You do not need two tubes to become pregnant naturally.”

The important question is:

Is the remaining tube healthy enough to transport sperm, egg and embryo?

If yes, natural pregnancy remains possible.

If no, IVF may provide a route that bypasses the damaged tube.

What I Tell Patients After Methotrexate

I explain three things clearly.

First:

complete your hCG follow-up.

The risk of rupture does not disappear immediately after the injection. ACOG stresses the importance of continued follow-up until treatment is complete.

Second:

avoid pregnancy for approximately three months.

Third:

methotrexate treatment is not known to permanently reduce ovarian egg production.

What I Tell Patients After Salpingectomy

I explain:

“The tube was removed because your safety was the priority.”

Removing a badly affected tube does not mean fertility treatment automatically failed.



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If the other tube is healthy:

natural conception may still be entirely possible.

What I Tell Patients Before IVF

Before proceeding directly to IVF after an ectopic pregnancy, I review:

- the remaining tubal anatomy,
- hydrosalpinx,
- ovarian reserve,
- age,
- sperm.

If hydrosalpinx is present, treating it before embryo transfer can be important.

IVF should be used because the couple's reproductive biology indicates it—not simply because the patient is frightened after an ectopic pregnancy.

Frequently Asked Questions

Can I become pregnant again after an ectopic pregnancy?

Yes.

Most women retain the possibility of future pregnancy.

RCOG states that future successful-pregnancy chances are generally good.

Can I become pregnant with one fallopian tube?

Yes.

If the remaining tube is healthy, natural conception may still occur and overall fertility may be only slightly reduced.

Does removing one fallopian tube reduce fertility by 50%?

No.

Fertility is not determined by simply dividing by the number of tubes.

The health of the remaining tube and other fertility factors are more important.



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What is my risk of another ectopic pregnancy?

After one previous ectopic pregnancy, RCOG estimates recurrence at approximately:
7–10%.

Does that mean there is a 90% chance the next pregnancy will be normal?

Not exactly.

The 7–10% figure describes recurrence among subsequent pregnancies, but other outcomes such as miscarriage can also occur.

It does show that another ectopic pregnancy is far from inevitable.

Why can ectopic pregnancy happen again?

Underlying tubal disease may still be present.

Risk factors include:

- previous ectopic pregnancy,
- PID,
- tubal surgery,
- endometriosis,
- smoking,
- infertility,
- ART.

Does salpingectomy make me infertile?

Not automatically.

If the opposite tube is healthy, natural conception remains possible.

Is salpingotomy better for fertility?

Not necessarily.



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When the other tube is healthy, randomized evidence has not established a clear long-term fertility advantage over salpingectomy.

Salpingotomy may be particularly valuable when the other tube is damaged.

Why would my doctor remove the entire tube?

A severely damaged tube can:

- function poorly,
- retain ectopic tissue,
- increase future ectopic risk.

Current NICE guidance recommends salpingectomy during surgery when no major additional infertility risk factor exists.

Can part of the ectopic pregnancy remain after salpingotomy?

Yes.

NICE advises that up to approximately one in five women undergoing salpingotomy may require further treatment.

Does methotrexate reduce egg count?

Current evidence is reassuring.

RCOG states that methotrexate used for ectopic pregnancy is not known to reduce the ovaries' ability to produce eggs.

Does methotrexate reduce AMH?

Available studies have not shown a clinically meaningful long-term reduction in ovarian reserve after ectopic-pregnancy methotrexate treatment.

How long should I wait after methotrexate?

Current guidance commonly recommends:

at least three months



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before trying to conceive.

How long should I wait after surgery?

The interval is individualized.

RCOG emphasizes physical and emotional readiness, while NHS guidance commonly suggests allowing approximately two menstrual periods after non-methotrexate treatment.

Follow your surgeon's advice.

When should folic acid be restarted after methotrexate?

Folic-acid-containing supplements are generally avoided during active methotrexate therapy.

Restarting preconception folate should be discussed after the treating team confirms that methotrexate treatment and follow-up are complete.

Should I get an HSG after ectopic pregnancy?

Not every patient needs immediate HSG.

It becomes particularly useful when:

- conception is delayed,
- the other tube may be damaged,
- PID/endometriosis is present,
- another tubal risk factor exists.

WHO recommends HSG or HyCoSy to evaluate suspected tubal-factor infertility.

What is HyCoSy?

HyCoSy is an ultrasound-based tubal-patency test using contrast introduced through the cervix.

It can be used as an alternative to HSG.



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Can an HSG prove that the tube works normally?

No.

It mainly demonstrates whether contrast passes through.

A patent tube can still have microscopic functional damage.

If both tubes are blocked, can I become pregnant naturally?

If both tubes are completely nonfunctional or blocked, natural fertilization becomes extremely unlikely or impossible.

IVF can bypass the tubes.

Can I become pregnant if both tubes have been removed?

Not naturally.

But pregnancy may still be possible through IVF if:

- ovaries produce eggs,
 - the uterus is suitable.
-

Does IVF prevent another ectopic pregnancy?

No.

IVF substantially bypasses normal tubal fertilization but does not eliminate ectopic pregnancy completely.

When should I have a scan in the next pregnancy?

RCOG recommends early contact with healthcare services and notes that ultrasound at approximately:

6–8 weeks

may be offered following a previous ectopic pregnancy.

Should I wait for pain before getting an early scan?

No.



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Women with a previous ectopic pregnancy should arrange early assessment once pregnancy is known.

What symptoms require emergency care?

Seek urgent care for:

- sudden severe pelvic or abdominal pain,
- shoulder-tip pain,
- fainting,
- severe dizziness,
- weakness,
- heavy bleeding.

These can indicate ruptured ectopic pregnancy.

Can ectopic pregnancy cause infertility even if the tube is not removed?

Yes.

Underlying or subsequent tubal damage may affect function even when the tube remains anatomically present.

Does PID increase the chance of ectopic pregnancy?

Yes.

PID can cause tubal scarring and is an established ectopic-pregnancy risk factor.

Does endometriosis increase ectopic risk?

Yes.

ACOG recognizes endometriosis as a risk factor.

Does smoking matter?

Yes.

Smoking is associated with increased ectopic-pregnancy risk.



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Stopping smoking is advisable.

Can Unani medicine treat a current ectopic pregnancy?

No Unani or herbal treatment should replace appropriate medical or surgical management of a suspected or confirmed ectopic pregnancy.

Ectopic pregnancy can rupture and cause life-threatening bleeding.

Can Unani medicine help after an ectopic pregnancy?

It may be used as part of individualized supportive care after the acute pregnancy has safely resolved.

Possible areas include:

- nutrition,
 - digestion,
 - recovery,
 - menstrual health,
 - emotional wellbeing,
 - sexual wellbeing.
-

Can Unani treatment reopen a damaged fallopian tube?

There is currently insufficient high-quality evidence that Unani medicines can reliably reverse:

- severe tubal fibrosis,
 - hydrosalpinx,
 - major post-inflammatory tubal destruction.
-

Is there any Unani research on tubal infertility?

A published case report described conception following Unani treatment in a woman with unilateral tubal blockage, but this was one patient and does not prove anatomical reopening of the blocked tube.



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Can Unani medicine be combined with IVF?

Potentially, as supportive care where clinically appropriate.

All herbs, supplements and Unani medicines should be disclosed to the IVF team to avoid:

- drug interactions,
- treatment interference.

A Message From Dr. Nizamuddin Qasmi

When a woman tells me:

“Doctor, I had an ectopic pregnancy. Will I ever have a baby?”

I do not answer that question from the word:

“ectopic.”

I look at the complete reproductive picture.

If one tube was removed but the other is healthy, I tell her:

Natural pregnancy may still be very possible.

If both tubes are severely damaged, I explain:

**We should not waste valuable reproductive time pretending the tubes are normal.
IVF may be the more effective route.**

If she received methotrexate, I reassure her:

Methotrexate is not known to permanently reduce ovarian egg production.

If she becomes pregnant again, I advise:

Do not wait for pain. Arrange an early pregnancy scan.

That is how fertility after ectopic pregnancy should be managed:

with hope, but also with accurate diagnosis.

My Clinical Philosophy at Saira Health Care

At **Saira Health Care**, I approach fertility after ectopic pregnancy through five questions:



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1. Is the previous ectopic pregnancy completely resolved?

hCG follow-up must be completed where required.

2. What condition are the fallopian tubes in?

This may require review of surgery findings, HSG, HyCoSy or other appropriate assessment.

3. What is the woman's reproductive age and ovarian situation?

Waiting has different implications at age 25 and age 39.

4. Has the male partner been evaluated?

A semen abnormality can coexist with tubal disease.

5. What is the most efficient route to pregnancy?

That may be:

- natural conception,
- tubal surgery in selected cases,
- IVF.

Individualized Unani supportive treatment may be incorporated alongside this pathway when appropriate.

Latest Medical Understanding — 2026 Update

Future pregnancy prospects are generally good

Current RCOG information emphasizes that successful future pregnancy remains likely for many women, even after one tube has been removed.

Recurrence risk remains increased

After one ectopic pregnancy, the overall risk of another is approximately:

7–10%.

The remaining tube matters greatly

The health of the opposite fallopian tube is one of the most important determinants of future natural fertility.

Salpingectomy does not automatically reduce fertility more than tube-preserving surgery



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When the opposite tube is healthy, randomized comparative evidence has not shown a clear long-term fertility advantage from salpingotomy.

Methotrexate does not appear to damage ovarian reserve

Current clinical guidance and research remain reassuring regarding later ovarian function.

Pregnancy should be avoided for three months after methotrexate

This remains current RCOG/NHS advice.

HSG or HyCoSy are appropriate for suspected tubal infertility

The 2025 WHO infertility guideline recommends either option.

Age changes how tubal infertility should be treated

WHO's 2025 guideline generally favours IVF for:

- severe tubal disease in women under 35,
- tubal infertility at age 35 or older.

Hydrosalpinx should be addressed before IVF

The updated **2026 NICE fertility guideline** recommends salpingectomy or tubal occlusion for hydrosalpinges before IVF.

The next pregnancy deserves early localization

RCOG recommends early contact and an ultrasound at approximately 6–8 weeks after a previous ectopic pregnancy.

Conclusion

Fertility after an ectopic pregnancy is often much better than patients initially fear.

An ectopic pregnancy does increase the risk of another ectopic pregnancy, but it does **not** mean that all future pregnancies will be ectopic.

Current RCOG information estimates the recurrence risk at approximately:

7–10%.

At the same time:

a normal intrauterine pregnancy remains substantially more likely than another ectopic pregnancy.

Even when one fallopian tube has been removed:

natural conception remains possible.

If the remaining fallopian tube is healthy, RCOG states that fertility is generally only slightly reduced.

Future fertility depends more broadly upon:

- health of the remaining tube,
- underlying PID or endometriosis,
- previous infertility,
- female age,
- ovarian reserve where relevant,
- male fertility.

The method used to treat the ectopic pregnancy is only one part of the story.

Methotrexate treatment is not known to permanently reduce ovarian egg production, although pregnancy should generally be avoided for approximately three months afterward.

If infertility develops after an ectopic pregnancy, modern investigation may include:

- HSG,
- HyCoSy,
- pelvic imaging,
- ovarian assessment,
- semen analysis.

The **2025 WHO infertility guideline** recommends HSG or HyCoSy when tubal-factor infertility is suspected.

When significant tubal disease exists, treatment depends upon:

- disease severity,
- reproductive age.

For younger women with limited tubal disease, reconstructive surgery may sometimes be considered.

For severe tubal disease—and particularly for women aged 35 or older—IVF is often the more efficient treatment strategy according to current WHO guidance.



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Hydrosalpinx deserves particular attention because it can reduce IVF implantation success; updated 2026 NICE guidance recommends treating significant hydrosalpinx before IVF.

From the **Unani perspective**, individualized supportive care may contribute to:

- nutritional recovery,
- digestive health,
- menstrual wellbeing,
- physical recovery,
- emotional health,
- sexual wellbeing.

These are meaningful parts of comprehensive reproductive care.

However:

a current ectopic pregnancy is a medical emergency risk, not a condition to treat solely with Unani or herbal medicine.

And:

established severe fallopian-tube fibrosis cannot currently be claimed to be reliably reversed by Unani medicines.

At **Saira Health Care**, my approach is therefore integrative, fertility-focused and diagnosis-led:

make sure the previous ectopic pregnancy is completely resolved, determine the condition of the remaining reproductive tract, evaluate both partners, allow natural conception when it remains reasonable, investigate tubal disease when indicated, move toward IVF when structural damage or reproductive age makes it appropriate, and use individualized Unani supportive care where it can improve the patient's overall reproductive and sexual wellbeing without delaying effective treatment.

The most important message I want every patient to remember is:

An ectopic pregnancy changes how we monitor your next pregnancy—it does not automatically take away your chance of motherhood.

And when the next pregnancy test becomes positive:

contact your healthcare provider early and confirm the location of the pregnancy by early ultrasound.



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About the Author

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BUMS — Hamdard University, Delhi

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Certificate in Infertility — MGBIMS, Delhi

Certificate in Urology — London, UK

Masters in Male Infertility — MasterHealthPro (HealthPro)

Integrated Sexual and Reproductive Health (ISRH) — UNFPA

Dr. Nizamuddin Qasmi's clinical practice at **Saira Health Care** has a focused emphasis on sexual disorders, male and female reproductive health and infertility.

His approach to fertility following ectopic pregnancy emphasizes identifying the patient's actual reproductive potential rather than assuming infertility simply because one ectopic pregnancy has occurred.

Depending upon the clinical circumstances, evaluation may include:

- detailed pregnancy and surgical history,
- assessment of the remaining fallopian tube,
- HSG or HyCoSy where indicated,
- pelvic ultrasound,
- evaluation for PID or endometriosis,
- ovarian and ovulatory assessment,
- ovarian-reserve assessment where clinically relevant,
- male-partner semen analysis,
- sexual-health evaluation,
- coordination with gynecologic surgery or IVF/reproductive-medicine services.

Where clinically appropriate, individualized principles of Unani medicine may be integrated to support nutritional, menstrual, general reproductive, emotional and sexual wellbeing without replacing emergency ectopic-pregnancy care or evidence-based management of structural tubal disease.

Medical Disclaimer

This article is intended for health education and public awareness. It does not establish an individual diagnosis and does not replace care by an appropriately qualified gynecologist, early-pregnancy specialist or fertility specialist.

An ectopic pregnancy can rupture and cause life-threatening internal bleeding.

Anyone who is pregnant or may be pregnant and experiences:

- significant one-sided pelvic pain,
- sudden severe abdominal pain,
- shoulder-tip pain,
- fainting,
- marked dizziness,
- weakness,
- abnormal vaginal bleeding

should seek urgent medical assessment.

A suspected or confirmed ectopic pregnancy should never be treated solely with herbal, Unani or nutritional remedies.

Methotrexate requires appropriate medical selection and follow-up until treatment is complete. Pregnancy should generally be avoided for at least three months after methotrexate treatment unless the treating specialist gives different individualized advice.

After a previous ectopic pregnancy, early assessment in the next pregnancy is recommended because recurrence risk is higher.

Women with persistent infertility after ectopic pregnancy may require evaluation of:

- fallopian-tube patency,
- ovarian function,
- uterine factors,
- the male partner.

No medicine—Unani, herbal or conventional—should be claimed to reliably reconstruct severely scarred fallopian tubes or eliminate the possibility of recurrent ectopic pregnancy.



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