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some saline flush with 5 ml of saline can be injected first, and then aspirated before 1 ml of 50 mg MTX is injected into the EP. Follow up with serial measurement of quantitative serum B-HCG level must be done every 2-3 days to make sure of complete resolution of the EP.

Laparoscopic linear salpingostomy, along the anti-mesenteric border of the tube, where most of the swelling is, followed by aspiration of blood and clots trapped inside the tube, then removal of the ectopic and trophoplastic tissue from the wall of the tube with atraumatic laparoscopic grasper, flushing the inside of the tube and stabilising all bleeding points. It is advised to inject diluted vasoconstrictives into the mesosalpinx just underneath the EP before you start slicing.

In extreme cases, one can do segmental resection of the tube where the EP is followed by end-to-end anastomosis of the tube, all in one session. Fertility can be maintained in such a case, especially when the other tube is compromised.

On rare occasions, conservative management and observation may be advised. That is usually limited to conditions when tubal spontaneous abortion has occurred, and the clinician believe that the EP has been expelled from the end of the tube, into the peritoneal and pelvic cavity. It is exceedingly rare that the EP that expelled from the tube can attach itself somewhere in the pelvic or peritoneal cavity and revive again. The patient should be monitored with frequent office or outpatient visits, repeated ultrasound and most important measurement of quantitative serum B-HCG level till we obtain at least one if not two reading of less than 4-5, indicating complete disappearance of the B-HCG from the circulation.

Now, I need to expand on the use of cytotoxic medical treatment of EP. Methotrexate is the drug of choice for EP. The dose chosen for this drug is 50 mg per square meter of body surface area. I clinical use, the dose usually vary from 75 to 190 mg, given as single dose IM. When the dose was chosen in 1980s, it was chosen on empirical basis. I'm not quite sure why the 50 mg was chosen. I review the published medical literature, and couldn't find a single trial where 50 mg MTX was compared with 40, 60, 80 or 100 mg per square metre. It was also quoted that the success rate of 50 mg is 80-90% success rate based on few number patients' trial. I have to question few things here;

- I doubt the success rate is as high as they claim it to be. In my practice, I observed a success rate of only 70-75%. That means almost a failure rate of medical treatment of 25-30%. In my personal opinion that failure rate is too high.
- The selected dose of 50 mg, never took account of patient's body habitué, the level of serum B-HCG (whether it is 50 or 5000), the size of adnexal mass as measured on ultrasound (whether it is 1 or 5cm) and whether there is gestational sac visible in the adnexa, with or without fetal pole and fetal heart beat. These are very serious shortcoming that was not taken into account when deciding on 50 mg dose. It is probable that they wanted to be on the safe and low dosage side. The criticism here is, they never tried higher dose, especially in the conditions that logically needs higher dose; e.g. higher BMI, high serum level of B-HCG at initiation of treatment and development of gestational sac in adnexa.
- The safety range of MTX is huge, and it has been used up to a maximum dose of 20,000 mg a day. If the safety margin of the drug is that high, why do we use minuscule dosage (75-190 mg) as we do today. It is not make sense.
- Finally, lack of adequate clinical trials with higher or other dosage than 50 mg per square metre, is very surprising to me, that the whole profession accepted the 50 mg dosage without any challenges.

I would like to suggest that we should give double the recommended dose that everyone uses. In other words, we should be giving 100 mg per square meter of body surface, in the following conditions;

- If the patient in moderate degree of pain, and is keen to resolve her EP faster.
- If the serum level of B-HCG is over 1,000.
- If the adnexal mass is more than 1cm in maximum diameter, on endovaginal ultrasound exam.
- If the patient BMI is higher than 30.
- I hope gradually, this dose of 100 mg/sq metre should be given to everyone who wants to avoid tubal rupture, emergency laparoscopy or laparotomy for significant intra-abdominal bleeding.

With early detection, high degree of suspicion of EP and adequate use of dosage of MTX, we can avoid emergency surgery and the life threatening condition of EP.